London: Standardised Pan London Continuing Health Care (CHC) Fast Track Care Plan

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This document will continue to be reviewed and re-released to reflect new and emerging evidence. Please email england.londoncagsupport@nhs.net to request the most recent version.

This London guide is designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published.

Document Layout

- *Pages 3- 9: CHC Fast Track Care Plan*
- *Pages 10-11: ICB agreement approval of care plan & Appendices*

How to use this document:

This document is to be used to provide the care plan that supports the CHC Fast Track tool, to ensure a robust person-centred care plan that reflects the unique needs of a person with a rapidly deteriorating condition who may be entering a terminal phase of life. It is imperative that those completing and reading this care plan understand that the care plan **does not affect the decision to agree the eligibility**, but its completion is essential to enable an effective discharge /provision of care that meets the person's needs.

There are two aspects to the overall fast track pathway. The first step is to ensure the NHS Continuing Health Care Fast Track (CHC FT) pathway tool is completed for approval of eligibility. The second step is completion of the CHC FT Care Plan.

Who can complete the NHS CHC FT Pathway Tool (Step 1):

The CHC FT pathway **tool** should be completed by a suitably appropriate clinician who is accountable for the person's care.

The 'appropriate clinician' should be knowledgeable about the individual's health needs, diagnosis, treatment or care and be able to provide an assessment of why the individual meets the fast-track pathway tool criteria[1].

Who can complete the CHC FT Care Plan (Step 2):

The CHC FT Care Plan can be **completed by a number of health and social care professionals** involved in the care of the person. This can include a multi-disciplinary team inclusive of Medical, Nursing and Allied Health Professionals. Social Care and Third Sector may also be involved for aspects of the care plan. A CHC FT Care Plan **is not the sole responsibility of a specialist palliative care team**. They may be involved in contributing to the overall completion of the CHC FT Care Plan. Time is the most important currency when people enter this phase of life and therefore, time should not be lost attempting to ensure all professionals have contributed if the information is available through electronic care records. **CHC FT Care Plans should be prioritised by those completing them to support a peaceful and dignified death**.

[1] Fast-track pathway tool for NHS continuing healthcare guidance - GOV.UK (www.gov.uk)

Name:	NHS Number:	Date of Birth:

Continuing Health Care (CHC) Fast Track Care Plan

SECTION 1: PERSONAL INFORMATION		
NHS Number:	Surname:	
First Name:	Middle Name:	
Preferred Name:	Date of Birth: (DD/MM/YYYY)	Age:
Declared Gender: Is declared gender the same as gender assigned at birth: Yes ☐ No ☐ Further information:		
Sexual Orientation:	Ethnicity:	
Usual Address Home Address: Contact Number:	**Current Location** (if not at home) Address: Contact Number:	
List Known Disabilities: Additional Details:		
First Language: Preferred Language: If the patient has a preferred language, please tick the option that applies: ☐ Preferred language used in addition to first language ☐ Preferred language replaces first language ☐ Preferred language used together with first language		
Religion/Belief:		
Religious/ Spiritual Needs:		

Name:	NHS Number:	Date of Birth:

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Communication Needs:	
Next of Kin Details Name: Address: Contact Number: Relationship:	**Carer Details** (if different from Next of Kin) Name: Address: Contact number: Relationship:

SECTION 2: CONTACT DETAILS OF PROFESSIONALS INVOLVED

General Practitioner	**Social Worker/Care Manager** (if applicable)
Name of GP Practice: Contact Number: Email address (if applicable):	Name: Contact Number: Email address: The details provided above are for: ☐ Social Worker ☐ Care Manager

Nursing Team

Contact Number (if appliable):

Email address (if appliable):

Other key services involved (e.g., Mental Health services, Learning Disabilities services etc). Please provide details if applicable

SECTION 3: DIAGNOSIS AND CLINICAL CONDITION

Primary diagnosis leading to referral:

Please state if other:

Is the patient aware of diagnosis? Yes ☐ No ☐ If not, why not?	Is the family/carer aware of diagnosis? Yes ☐ No ☐ If not, why not?

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Other Diagnoses:

Prognosis (if known):

Is the patient aware of their prognosis? Yes ☐ No ☐

Is the family/carer aware of prognosis? Yes ☐ No ☐

Cardiopulmonary Resuscitation (CPR) Status:

Has the DNACPR status been discussed with the patient? Yes ☐ No ☐

Date discussion took place:

Has a discussion about DNACPR taken place with patient's family/carer? Yes ☐ No ☐

If so, name of person the discussion was held with:

Date discussion took place:

Summary of DNACPR discussion with family or reasons why discussion has not yet taken place:

Current Medication

Does the patient have a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition? Yes ☐ No ☐

Is the individual on oral medication? Yes ☐ No ☐

Is the individual taking medication from a dossett box? Yes ☐ No ☐

Do they need prompting with medication from the dossett box? Yes ☐ No ☐

Will the individual be at home with end of life medication? Yes ☐ No ☐

Does the individual need a nurse to administer medication at home? Yes ☐ No ☐

If yes, please detail medication(s) that require a nurse to administer

Is monitoring required by a nurse for medication? If yes please provide details i.e., insulin, warfarin Yes ☐ No ☐

Is any medication given via an artificial route e.g. PEG? Yes ☐ No ☐

Please provide details of any other medication needs for the individual not covered above – e.g. syringe drivers

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SECTION 4: PLACE OF CARE

Residential Status

Does the patient live alone? Yes ☐ No ☐

If no – who does the patient live with?

List the patient's support network

How will the carers gain access to the property?

Is a key safe code required? Yes ☐ No ☐

If yes, please provide the key safe code:

Where will the patient be set within the environment?

Preferred place of care

Please Note: It may not always be possible for patients to be placed in their preferred place of care

Date of planned discharge (if applicable):

Recommended discharge destination (if known):

Address of recommended discharge destination (if known):

Is there a discrepancy between preferred place of care and recommended destination?

Yes ☐ No ☐

If yes, please give details

Equipment

List of identified equipment required to support care

Equipment	In-situ or on order	Date Due (for ordered items)

Is all required equipment and home set up in place for safe care? Yes ☐ No ☐

Further information (if appliable)

Attach Occupational Therapy (OT) assessment (if available)

Instructions on how to add an attachment can be found at the end of this care plan

Name:	NHS Number:	Date of Birth:

Accommodation and Environment

Does the property have adequate heating and running water? Yes ☐ No ☐

If no, please state who is arranging and state date they will be in place:

Are there any identified risks/other associated with the location of care? Yes ☐ No ☐

If a risk has been identified, how will it be managed?

Are there pets in the location of care? Yes ☐ No ☐

If yes, please state if any risks known:

Is there an option of providing a live-in carer? Yes ☐ No ☐ Not sure ☐

SECTION 5: CARE AND SUPPORT NEEDS

New referral to the District Nurses completed Yes ☐ No ☐ N/A ☐

If patient requires a care home setting, does the patient, relative, friend, carer or advocate have a preference on which area & why?

Patient Assessed Needs

Current functional ability re: activities of daily living (for example washing and dressing, toileting, meal preparation, tidying the house, shopping etc)

Current mobility and transfer level (please consider the highest level of variability and include number of carers required)

Has a moving/handling risk assessment been completed? Yes ☐ No ☐

If yes, please attach moving/handling risk assessment.

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Intervention of Care	
Symptom	**What support is needed from care provider?**
Identified needs	**What support is needed from care provider?**

MDT Support

Which of the following professionals will continue to be involved. Please provide their name and contact details.				
Professional	**Name**	**Organisation**	**Email**	**Phone Number**

Name:	NHS Number:	Date of Birth:

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FAST TRACK DOMICILIARY CARE PACKAGE PLAN
EXISTING CARE PROVISION
Does the patient have an existing care package? Yes ☐ No ☐ If yes, please provide further information such as name, contact details
How is the care funded? Details if other:
Predicted Date of Discharge (if applicable):

Name:	NHS Number:	Date of Birth:

SCHEDULE OF CARE AND SUPPORT											
Visit Time	**Tasks/ Responsibilities**	**Descriptions of carer (ICB to complete)**	**How long is the visit**	**Mon** No. of carers	**Tues** No. of carers	**Wed** No. of carers	**Thurs** No. of carers	**Fri** No. of carers	**Sat** No. of carers	**Sun** No. of carers	**Total number of carer hours per week**
	TOTAL NUMBER OF CARE HOURS PER WEEK										

Additional Support If Required	Hours / week
Total number of hours per week	

Name:	NHS Number:	Date of Birth:

Has the patient been involved in setting up and agreeing to this care plan?	Yes ☐	No ☐
If no, has the patient's representative been involved in setting up and agreeing to this care plan?	Yes ☐	No ☐
Name and Designation of person completing care plan: Date completed: Email: Contact details:		

ICB OFFICIAL USE ONLY:

CHC FT CARE PLAN APPROVAL			
Approved by	**Name:**	**Designation:**	**Date of Approval:**
Signature:			

Appendices:

How to embed attachments
National Consent profroma