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

Version: 2.0
Review Date: September 2023

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*

LCEG approval 06/10/2022
Amended and re-circulated May 2023 (V2)

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**.

Where should I send the completed CHC FT form to?

Forms should be submitted to your local ICB Continuing Healthcare team.

Document review

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

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

Continuing Health Care (CHC) Fast Track Care Plan

SECTION 1: PERSONAL INFORMATION		
NHS Number: Click or tap here to enter text.	Surname: Click or tap here to enter text.	
First Name: Click or tap here to enter text.	Middle Name: Click or tap here to enter text.	
Preferred Name: Click or tap here to enter text.	Date of Birth: DOB (DD/MM/YYYY)	Age: Age
Declared Gender: Choose an item. Is declared gender the same as gender assigned at birth: Yes ☐ No ☐ Further information:Click or tap here to enter text.		
Sexual Orientation: Choose an item.	Ethnicity: Choose an item. If other, please state: Click or tap here to enter text.	
Usual Address Home Address: Click or tap here to enter text. Contact Number: Click or tap here to enter text.	**Current Location** (if not at home) Address: Click or tap here to enter text. Contact Number: Click or tap here to enter text.	
List Known Disabilities: Click or tap here to enter text. Additional Details: Click or tap here to enter text.		
First Language: Enter Language Preferred Language: Enter 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: Choose an item. If other, please state: Click or tap here to enter text.		
Religious/ Spiritual Needs: Click or tap here to enter text.		

Communication Needs: Click or tap here to enter text.	
Next of Kin Details Name: Click or tap here to enter text. Address: Click or tap here to enter text. Contact Number: Click or tap here to enter text. Relationship:Click or tap here to enter text.	**Carer Details** (if different from Next of Kin) Name: Click or tap here to enter text. Address: Click or tap here to enter text. Contact number: Click or tap here to enter text. Relationship: Click or tap here to enter text.
SECTION 2: CONTACT DETAILS OF PROFESSIONALS INVOLVED	
General Practitioner	**Social Worker/Care Manager** (if applicable)
Name of GP Practice: Click or tap here to enter text. Contact Number: Click or tap here to enter text. Email address (if applicable): Click or tap here to enter text.	Name: Click or tap here to enter text. Contact Number: Click or tap here to enter text. Email address: Click or tap here to enter text. The details provided above are for: ☐ Social Worker ☐ Care Manager
Nursing Team	
Contact Number (if applicable): Click or tap here to enter text. Email address (if applicable): Click or tap here to enter text.	
Other key services involved (e.g., Mental Health services, Learning Disabilities services etc). Please provide details if applicable Click or tap here to enter text.	
SECTION 3: DIAGNOSIS AND CLINICAL CONDITION	
Primary diagnosis leading to referral: Choose an item. Please state if other:Click or tap here to enter text.	
Is the patient aware of diagnosis? Yes ☐ No ☐ If not, why not? Click or tap here to enter text.	Is the family/carer aware of diagnosis? Yes ☐ No ☐ If not, why not? Click or tap here to enter text.

Name: Click or tap here to enter text.	NHS Number: Click or tap here to enter text.	Date of Birth: Click or tap here to enter text.	NHS London

Other Diagnoses: Click or tap here to enter text.

Prognosis (if known): Click or tap here to enter text.

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

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

Cardiopulmonary Resuscitation (CPR) Status: Click or tap here to enter text.

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

Date discussion took place: Click or tap here to enter text.

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

If so, name of person the discussion was held with: Click or tap here to enter text.

Date discussion took place: Click or tap here to enter text.

Summary of DNACPR discussion with family or reasons why discussion has not yet taken place:
Click or tap here to enter text.

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
Click or tap here to enter text.

Is monitoring required by a nurse for medication? If yes please provide Yes ☐ No
☐details i.e., insulin, warfarin
Click or tap here to enter text.

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

Click or tap here to enter text.

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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? Choose an item.

List the patient's support network Click or tap here to enter text.

How will the carers gain access to the property? Click or tap here to enter text.

Is a key safe code required? Yes ☐ No ☐

If yes, please provide the key safe code: Click or tap here to enter text.

Where will the patient be set within the environment? Choose an item.

Preferred place of care Choose an item.

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): Click or tap here to enter text.

Recommended discharge destination (if known): Click or tap here to enter text.

Address of recommended discharge destination (if known): Click or tap here to enter text.

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

Yes ☐ No ☐

If yes, please give details Click or tap here to enter text.

Equipment

List of identified equipment required to support care

Equipment	**In-situ or on order**	**Date Due (for ordered items)**
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date
Click or tap here to enter text.	Choose an item.	Date

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

Further information (if applicable)

Click or tap here to enter text.

Attach Occupational Therapy (OT) assessment (if available)

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

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:
Click or tap here to enter text.

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? Click or tap here to enter text.

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

If yes, please state if any risks known: Click or tap here to enter text.

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?
Click or tap here to enter text.

Patient Assessed Needs

Current functional ability re: activities of daily living (for example washing and dressing, toileting, meal preparation, tidying the house, shopping etc)
Click or tap here to enter text.

Current mobility and transfer level (please consider the highest level of variability and include number of carers required)
Click or tap here to enter text.

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

If yes, please attach moving/handling risk assessment.

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

Intervention of Care	
Symptom	**What support is needed from care provider?**
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Identified needs	**What support is needed from care provider?**
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.
Choose an item.	Click or tap here to enter text.

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**
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Email	Phone Number
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Email	Phone Number
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Email	Phone Number
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Email	Phone Number
Choose an item.	Click or tap here to enter text.	Click or tap here to enter text.	Email	Phone Number

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 Click or tap here to enter text.
How is the care funded? Choose an item. Details if other: Click or tap here to enter text.
Predicted Date of Discharge (if applicable): Click or tap here to enter text.

Name:Click or tap here to enter text.	NHS Number:Click or tap here to enter text.	Date of Birth:Click or tap here to enter text.

NHS London

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**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
	TOTAL NUMBER OF CARE HOURS PER WEEK										

Additional Support If Required	**Hours / week**
Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.
Total number of hours per week	Click or tap here to enter text.

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: Click or tap here to enter text.

Date completed: Click or tap here to enter text.

Email: Click or tap here to enter text.

Contact details: Click or tap here to enter text.

ICB OFFICIAL USE ONLY:

CHC FT CARE PLAN APPROVAL			
Approved by	**Name:** Click or tap here to enter text.	**Designation:** Click or tap here to enter text.	**Date of Approval:** Click or tap here to enter text.
Signature: Click or tap here to enter text.			

Appendices:

How to embed attachments
National Consent profroma