

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

Version: 3

Review Date: 16/10/26

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*

# A blue and white logo  Description automatically generatedHow 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 criteria1.

# 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**

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| **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 [ ]  Not known [ ]  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. |
| 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. |
| **Preferred place of care:** Choose an item.If ‘other’ please give details: Click or tap here to enter text. |
| If patient requires a care home setting, does the patient, relative, friend, carer or advocate have a preference on which area and why? Click or tap here to enter text.***Please note: It may not always be possible for patients to be placed in their preferred place of care*** |
| List known disabilities:Click or tap here to enter text.Additional details:Click or tap here to enter text.  |
| First language: Click or tap here to enter text.Preferred language: Click or tap here to enter text.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 |
| Communication needs: Click or tap here to enter text. |
| 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. |
| **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**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. [ ]  Not yet known as going to be moving out of area |  **Social worker/care manager** (if applicable)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 |
| **Community 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. |



Choose an



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| **SECTION 3: DIAGNOSIS AND CLINICAL CONDITION** |
| Primary diagnosis leading to referral: Choose an item. Please give more detail on primary diagnosis (e.g. type of cancer) and specify if ‘other’:Click or tap here to enter text. |
| Other diagnoses: 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. |
| 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. |
| Does the patient have a Universal Care Plan? Yes [ ]  No [ ]  Will be completed [ ]  |
| Does the patient have a communicable infection e.g. Clostridium difficile/MRSA/flu etc.? Yes [ ]  No [ ] If yes please give further details: Click or tap here to enter text. |
| **Current medication**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 registered nurse to administer or monitor medication at home? Yes [ ]  No [ ]  If yes, please detail medication(s) that require a nurse to administer or monitor  e.g. 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 driversClick or tap here to enter text. |



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| **SECTION 4: PLACE OF CARE (not applicable for nursing home placements)** |
| **Residential status**Does the patient live alone? Yes [ ]  No [ ] If no who does the patient live with? Choose an item.Further details about who patient lives with: Click or tap here to enter text. |
| How will the carers gain access to the property? Click or tap here to enter text.Does the property have a key safe? 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. |

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| **Equipment**List of identified equipment required to support care |
|  | **Equipment** | **Status** | **Date due (for ordered items) if known** |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
|  |  Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |  |
| 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* |

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| 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.* |
| Any other relevant informationClick or tap here to enter text. |



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| **Accommodation and environment (not applicable for nursing home placements)**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 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 or smokers in the location of care? Yes [ ]  No [ ]  Not sure [ ] If yes, please state if any risks known: Click or tap here to enter text. |

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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:Click or tap here to enter text.Would the patient/family wish to continue with the existing agency (if applicable): Yes [ ]  No [ ]  |
| How is the care funded? Choose an item.Details if other: Click or tap here to enter text. |



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| **SECTION 5: CARE AND SUPPORT NEEDS** |
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|  | **Intervention of care** |  |
|  |  **Symptom** |  **Specify if ‘other’ selected and for each explain 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. |
|  | **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. |

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|  | **MDT Support** |
|  | **Which of the following professionals will continue to be involved. Please provide their name and contact details.** |
|  | **Professional** | **Organisation** | **Email and phone number** | **New referral or update given?**  |
|  | Choose an item. |  Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
|  | Choose an item. |  Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
|   | Choose an item. |  Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
|  | Choose an item. |  Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
|  | Choose an item. | Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |
|  | Choose an item. |  Click or tap here to enter text. | Click or tap here to enter text. | Choose an item. |



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| **SCHEDULE OF CARE AND SUPPORT (not applicable for nursing home placements)** |
| **Visit time** | **Tasks/responsibilities** | **Descriptions of carer (ICB to complete)** | **How long is the visit?** | **Mon**No. of carers | **Tues** No. ofcarers | **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 e.g. laundry, shopping, housework. Please give further details about individualised needs. If 24 hour care is required please specify type of 24 hour care**  | **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. |

 If a 24 hour or live-in carer is required, is there a separate room for them to rest in? Yes [ ]  No [ ]  Not applicable [ ]

Has the patient been involved in setting up and agreeing 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 [ ]



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| 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.Phone number: Click or tap here to enter text. |
| Signature:Click or tap here to enter text. |

**ICB OFFICIAL USE ONLY:**

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| **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:

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| [How to embed attachments](https://mcusercontent.com/daf5e1d407fd9b49395150827/files/72d4c5c6-0da1-de0d-3083-a42acacf1411/CHC_Fast_Track_Care_Plan.01.docx) |
| [National consent proforma](https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2FNationalCHCWorkforceDevelopment%2Fview%3FobjectID%3D137101157) |