## Fast Track Pathway Tool for NHS Continuing Healthcare

To enable immediate provision of a package of NHS Continuing Healthcare

Date of completion of the Fast Track Pathway Tool \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name D.O.B. DOB

NHS number:

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| Permanent address and telephone number | Current location (if different from permanent address) |
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Gender \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ensure that the equality monitoring form at the end of the Fast Track Pathway Tool is completed

Contact details of referring clinician (name, role, organisation, telephone number, email address)

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| The individual fulfils the following criterion:They have a rapidly deteriorating condition and the condition may be entering a terminal phase. For the purposes of Fast Track eligibility this constitutes a primary health need. No other test is required.  |
| Brief outline of reasons for the fast-tracking recommendation:Please set out below the details of how your knowledge and evidence of the patient’s needs mean that you consider that they fulfil the above criterion. This may include evidence from assessments, diagnosis, prognosis where these are available, together with details of both immediate and anticipated future needs and any deterioration that is present or expected. |
| (continue overleaf) |
| Please continue on separate sheet where needed. This should include the patient’s name and NHS number, and also be signed and dated by the referring clinician. |

I, an appropriate clinician, confirm that I have explained to the individual/their representative (tick as appropriate):

the reasons why a Fast Track application for NHS Continuing Healthcare has been made to the ICB.

that the purpose of this is to enable the individual’s needs to be urgently met as they have a rapidly deteriorating condition which may be entering a terminal phase.

that their needs and the effectiveness of their care arrangements may need to be reviewed. There may be certain situations where a change in needs indicates that it

is appropriate to review eligibility for NHS Continuing Healthcare, which could potentially affect the funding stream depending on the outcome of the review.

Please ensure this form is sent directly to the ICB without delay

 Name and signature of referring clinician Date

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 Name and signature confirming approval by ICB Date

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About you — equality monitoring

We collect equalities information to meet our duties under the Equality Act 2010 and develop our insights into CHC patients and ensure we provide appropriate care. The categories included in the questions may not be exhaustive or reflect how you feel or identify. We will be reviewing these to align with approaches across Government. Filling these in is optional, and you do not have to provide an answer if you do not wish to do so.

Please provide us with some information about yourself. We collect information to help us understand whether people are receiving fair and equal access to NHS Continuing Healthcare (CHC) via the [NHS CHC Patient Level Data Set (PLDS)](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdigital.nhs.uk%2Fdata-and-information%2Fdata-collections-and-data-sets%2Fdata-sets%2Fcontinuing-health-care-data-set%2Fcontinuing-health-care-patient-level-data-set&data=05|01|Alexandra.Ostendorf%40dhsc.gov.uk|119fe136c12d434e338b08da27880ce0|61278c3091a84c318c1fef4de8973a1c|1|0|637865762542945475|Unknown|TWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D|3000|||&sdata=%2FwQZjI%2BazdZre6g3bOdZOowvicbzpVuGJxq625%2BT1jI%3D&reserved=0) which is used to help achieve better patient outcomes, better experiences and better use of resources in CHC. The lawful basis for collecting this information is Article 6 (1) (c) of the GDPR enacted by the Data Protection Act 2018. Please note that NHS CHC PLDS data is pseudonymised for analysis purposes. This means that identifiers such as names, NHS numbers and dates of birth are removed. Detailed information about the use of individual’s identifiable data is publicly available at [https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/gdpr/gdpr-register](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdigital.nhs.uk%2Fabout-nhs-digital%2Four-work%2Fkeeping-patient-data-safe%2Fgdpr%2Fgdpr-register&data=05|01|Alexandra.Ostendorf%40dhsc.gov.uk|119fe136c12d434e338b08da27880ce0|61278c3091a84c318c1fef4de8973a1c|1|0|637865762542945475|Unknown|TWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D|3000|||&sdata=hxf4ApAyRdEyAK0qaBm83DjjrOhGA1KqtvjzAJarhUI%3D&reserved=0)

#### 1 What is your gender?

Tick one box only

☐ Male

☐ Female

☐ Indeterminate (unable to be classified as either male or female)

☐ I prefer not to answer

#### 2 Which age group applies to you?

Tick one box only

☐ 18-24

☐ 25-34

☐ 35-44

☐ 45-54

☐ 55-64

☐ 65-74

☐ 75-84

☐ 85+

☐ I prefer not to answer

#### 3 Do you have a disability as defined by the Equalities Act 2010?

Tick one box only.

The Equality Act 2010 defines a person with a disability as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities.

☐ No

☐ Yes

☐ I prefer not to answer

#### 4 What is your ethnic group?

Tick one box only.

##### A White

☐ British

☐ Irish

☐ Any other White background, write below

Click here to enter text.

##### B Mixed

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

☐ Any other Mixed background, write below

Click or tap here to enter text.

##### C Asian or Asian British

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Any other Asian background, write below

Click here to enter text.

##### D Black, or Black British

☐ African

☐ Caribbean

☐ Any other Black background, write below

Click here to enter text.

##### E Other ethnic group

☐ Chinese

☐ Any other ethnic group, write below

Click here to enter text.

Prefer not to say

☐ I prefer not to answer

#### 5 What is your religious or belief system affiliation?

Tick one box only.

☐ Baha'i

☐ Buddhist

☐ Christian

☐ Hindu

☐ Jewish

☐ Muslim

☐ Pagan

☐ Sikh

☐ Zoroastrian

☐ Other

☐ None

☐ Prefer not to answer

☐ Unknown

**Continuing Health Care (CHC) Fast Track Care Plan**

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| **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 languagePreferred language replaces first languagePreferred language used together with first language |
| Religion/Belief: |
| Religious/ Spiritual Needs: |

Choose an

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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 WorkerCare 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 nurseto ensure effective symptom and pain management associated with a rapidly changing Yes Noand/or deteriorating condition?Is the individual on oral medication? Yes NoIs the individual taking medication from a dossett box? Yes NoDo they need prompting with medication from the dossett box? Yes NoWill the individual be at home with end of life medication? Yes NoDoes the individual need a nurse to administer medication at home? Yes No If yes, please detail medication(s) that require a nurse to administerIs monitoring required by a nurse for medication? If yes please provide Yes No details i.e., insulin, warfarinIs any medication given via an artificial route e.g. PEG? Yes NoPlease 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 NoIf yes, please give details |

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| **Equipment**List of identified equipment required to support care |
|  | **Equipment** | **In-situ or on order** | **Date Due (for ordered items)** |  |
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| Is all required equipment and home set up in place for safe care? Yes Further information (if appliable) | No |  |  |
| 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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| **Accommodation and Environment**Does the property have adequate heating and running water?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? If a risk has been identified, how will it be managed?Are there pets in the location of care? If yes, please state if any risks known: | YesYesYes | NoNoNo |
| 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? YesIf yes, please attach moving/handling risk assessment.*Instructions on how to add an attachment can be found at the end of this care plan.* | No |  |

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|  | **Intervention of Care** |  |
|  | **Symptom** | **What support is needed from care provider?** |
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|  | **Identified needs** | **What support is needed from care provider?** |
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| **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** |
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| **FAST TRACK DOMICILIARY CARE PACKAGE PLAN** |
| **EXISTING CARE PROVISION** |
| Does the patient have an existing care package? Yes NoIf yes, please provide further information such as name, contact details |
| How is the care funded?Details if other: |
| Predicted Date of Discharge (if applicable): |

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| **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. 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** |
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|  | **TOTAL NUMBER OF CARE HOURS PER WEEK** |  |
| **Additional Support If Required** | **Hours / week** |
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| **Total number of hours per week** |  |

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| 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:**

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