 

**NHS CONTINUING HEALTHCARE FAST TRACK TOOL**

**CARE & SUPPORT PLAN**

Please complete all sections and provide as much detail as possible; incomplete forms will be returned to the referrer for more information, which may delay commissioning a care package for the individual.

**Please send completed FTCHC application to:**

[somicb.chc.fasttracks@nhs.net](mailto:somicb.chc.fasttracks@nhs.net)

|  |
| --- |
| **THE FAST TRACK TEAM ARE AVAILABLE BETWEEN: 09:00hrs – 17:00hrs MONDAY – FRIDAY**  **TELEPHONE NUMBER: 01935 385233**  **We aim to process all Fast Track CHC applications within 48 hours**  **(Mon to Fri between 9am – 5pm) Please do not contact FT CHC unless you have not had a response within 48 hours.** |

**THIS DOCUMENTATION IS NOT TO BE KEPT IN THE INDIVIDUALS HOME**

**NHS PROFESSIONAL COMPLETING ASSESSMENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | Role: |  |
| Tel No: |  | | Bleep: |  |
| Email: |  | | | |
| Alternative Contact Details: | |  | | |
| Date of Fast Track Assessment: | |  | | |

**PATIENT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title |  | Name of Individual: |  | | |
| Home Address: | |  | | | |
| NHS Number: | |  | | GP/Surgery |  |
| DOB: | |  | | Wishes to be called: |  |
| Tel No. | |  | | Individual’s Mobile: |  |
| Sex: | | Male  Female | | Marital Status: |  |
| Next of Kin Information | | Contact Details:  To Include Full Address and Telephone Numbers for CHC to correspond with the next of kin. | | Name:  Address:  Contact: | |
| Relationship to Individual: | |  | |

**CONSENT TO SHARE INFORMATION**

Consent is not required from the individual for sharing their information with those who have a statutory involvement in the NHS CHC assessment process, for example Health and Social Care professionals. This is because there is a legal requirement for sharing to take place between organisations and professionals involved in the NHS CHC assessment process.

Consent is required to share health and care information with a third party such family, friends or advocates.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please complete appropriate section** | | | | |
|  | The individual consents to the people named below being involved in their CHC Fast Track application. They understand that relevant and necessary health and social care information about them may be shared with the named individuals for the purposes of this NHS CHC Fast Track process. They understand that they can withdraw or amend this consent at any time.  Please confirm details of who the individual has consented for their information to be shared with  **Name:**  **Relationship:**  **Contact Details:** | | | |
|  | Consent to share information with third parties not given. | | | |
|  | The individual **does not have capacity** to consent for information sharing with family, friends or representatives in relation to the CHC Fast Track process. There is a **Lasting Power of Attorney** (LPoA) registered with the Office of the Public Guardian or a **Court Appointed Deputy** (CAD)  Details of LPoA or CAD:  Name: **…………………………………………………………………**  Relationship: **…………………………………………………………………**  Address: **…………………………………………………………………**  Tel No: **…………………………………………………………………**  Please confirm details of who (family, friends, representatives) the information can be shared with  **Name:**  **Relationship:**  **Contact Details:** | | | |
|  | The Individual does **not have capacity** to consent for information sharing with third parties in relation to the CHC Fast Track process and a mental capacity assessment has been undertaken and the decision to share information in relation to the Fast Track CHC process is being made in the **best interests** of the individual after consultation with family, friends and representatives.  MCA Documentation and Best Interest Process Documentation Attached  ***(NB this documentation is mandatory for this fast track application to be processed)***  Provide details of who (family, friends, representatives) the information can be shared with as agreed in a best interest decision:  **Name:**  **Relationship:**  **Contact Details:** | | | |
| Yes    No | Is an **Advocate or IMCA** Involved?  If Yes, please provide the details:  **Name:**  **Contact Details**: | | | |
| **AGREED CARE & SUPPORT PLAN TO MEET CARE NEEDS** | | | | |
| **What is my health condition and how does it affect me?**  Describe how the individuals care needs have unexpectedly and rapidly deteriorated and altered in the last 2 – 3 weeks. | |  | | |
| **What is currently working well, and what is not working well?** | | **Please provide details of any existing care package**  Name of care agency/ Micro providers:  Frequency of visits daily/weekly:  Funding of carers:  self-funding  ASC  Does the individual live alone: Yes  No  Spouse / Family / Unpaid support involvement in providing care for this individual between care visits and overnight:  Further information to support care package: | | |
| **What care provision and support would be beneficial in improving my quality of life?**  Individuals preferred place for end of life care?  Please indicate 2 choices if Nursing Home placement is being requested or a locality. | |  | | |
| Are there any existing **Safeguarding** concerns for this individual? Please detail: | | | | |
| **Breathing:** Including issues with shortness of breath, positioning, suction, oxygen therapy, mechanical ventilation, chest drains and prescribed medications for breathing: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans for carers to follow:** |
|  | | | |  |
| **Nutrition – Food & Drink:** Including PEG management, weight, special dietary needs, management of swallowing difficulties and SALT assessment recommendations: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Continence: Bladder & Bowel Management:** Including toileting, catheter care, stoma care, nephrostomy care, continence issues, products / medication required: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Personal care – Skin:** Including Washing/showering & dressing, skin conditions, prescribed creams, Pressure areas, Waterlow score, current wound care, equipment: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Mobility:** Identified risk factors (e.g., falls, wandering), moving and handling needs and equipment required. State if the individual is independently mobile / if they can transfer / level of mobility: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Communication:** Including level of support required and any problems with hearing / eyesight, ability to communicate needs verbally / non-verbally, any related anxieties, frustration, use of equipment and time related strategies: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Psychological and Emotional Needs:** Including anxiety / depression, distress, mood, motivation, awareness / insight of diagnosis & prognosis: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Cognition:** Including memory, orientation, confusion, attention / concentration, ability to carry out executive functions and capacity/variable capacity to make decisions:  Please document any conversations regarding discharge planning/POC at home | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Behaviour:** Including challenging behaviour, risks to self and others, intensity, frequency and any triggers, is there a need for 1:1 care: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Medications and Symptom Control:** Including pain management, frequency and route of administration, any allergies, and problems with concordance and ability to self-medicate or who will administer medications, current medications in syringe driver: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Altered State of Consciousness**: Include if unrousable, TIA, epilepsy, seizures, rescue medications including frequency, intensity and predictability and treatment plan: | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Sleeping & Night needs:** Detail end of life night time care needs including if requires s/c JIC meds, terminal agitation, safety concerns. | | | | |
| **Care needs and risks identified by assessment:** | | | | **Current Interventions and management plans** **for carers to follow:** |
|  | | | |  |
| **Any Other Care Needs or Impacting Factors:** | | | | |
| **Risks identified by assessment:** | | | **Current Interventions and risk management plans** **for carers to be aware:** | |
| * **Falls** * **Seizures** * **Challenging Behaviour** * **Family dynamics** * **Animals in the home** * **Professional’s concerns** * **Any other additional information** | | |  | |

**NAME OF CLINCIAL CO-ORDINATOR IN THE COMMUNITY**

|  |  |  |  |
| --- | --- | --- | --- |
| District Nurse team: |  | DN accepting the referral: |  |
| Contact number: |  | Email: |  |
| Date Contacted: |  | By Whom? |  |

**INDIVIDUAL’S PERSPECTIVE**

**(Including Wishes, Preferences, Beliefs, Values and Spirituality)**

|  |  |
| --- | --- |
| Is the Individual/Representative aware of prognosis? | Yes No |
| Is there a ‘Treatment Escalation Plan’ for the Individual? | Yes No |
| What is the Resuscitation Status of this Individual?  How will the Carer’s access this information? | |

**FAMILY / CARER’S PERSPECTIVE**

|  |  |
| --- | --- |
| Have you considered if a referral to Social Services for a Carers Assessment is required to support the individual’s main carer – and actioned this if appropriate? | Yes No |
| **Has the eligibility criteria for Fast Track CHC been explained to the family in detail:**   * The individual must have **rapidly deteriorating** condition and may be entering the terminal phase of their life. * Not all applications will meet eligibility criteria, and alternative funding may be required to fund the individuals care / nursing home placement. * If awarded FTCHC, the individual will be reviewed within 8 weeks and elements of the care package or funding may be withdrawn if no longer appropriate, or the individual no longer meets the eligibility criteria for FTCHC funding (individual no longer rapidly deteriorating) * It is not always possible or safe to replicate support services at home that are available in NHS settings or nursing homes (24-hour nursing care or immediate assistance from a carer) * The number of daily personal care visits/ night care to meet the individual’s needs and be provided by FTCHC is assessed by the clinician – any additional support requested by the individual/their family may need to be provided by alternative means such as by family support or neighbourhood community support.   **The individual and their representative have been informed of the FTCHC eligibility criteria above and have been given a “Fast Track funding” Information Leaflet:**    Yes  No give details:  **Additional information discussed with family / family comments regarding information given above:** | |

**SUMMARY OF THE ASSESSED CARE REQUIRED OVER A 24 HOUR PERIOD TO BE COMMISSIONED BY FAST TRACK CONTINUING HEALTHCARE**

|  |  |  |  |
| --- | --- | --- | --- |
| Please specify the number of staff required for each intervention, and please include the duration and frequency of each call | | | The commissioned care providers will not undertake domestic duties, pet care, shopping, nursing tasks or support the care of another family member living at the property. |
| **Time Period of call**  (morning, lunch, tea, evening, night visits or time critical visits) | **Number of carers required to maintain care needs:** | **Duration of this call**  (30 / 45 / 60 mins or nights) | **Tasks for the carers to undertake at each visit as identified in the Current Interventions and Management Plans** |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Has the referrer discussed the requested care package with the individual and family and do they agree? | | Yes No | If not discussed, please detail: |

|  |  |
| --- | --- |
| Are ‘Just In Case’ medications in place for this Individual with a community MAR chart? | Yes No |

**EQUIPMENT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **List what equipment is required** | **Equipment Code** | **Is it insitu?** | **Needed for discharge?** | **Has it been ordered?** | **Date of delivery** |
|  |  | Yes No | Yes No | Yes No |  |
|  |  | Yes No | Yes No | Yes No |  |
|  |  | Yes No | Yes No | Yes No |  |
|  |  | Yes No | Yes No | Yes No |  |
|  |  | Yes No | Yes No | Yes No |  |
|  |  | Yes No | Yes No | Yes No |  |

**About the patient — 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 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 other belief system affiliation?**

Tick one box only.

☐ Baha'i

☐ Buddhist

☐ Christian

☐ Hindu

☐ Jewish

☐ Muslim

☐ Pagan

☐ Sikh

☐ Zoroastrian

☐ Other

☐ None

☐ Prefer not to answer

☐ Unknown

**6 Which of the following best describes your sexual orientation?**

Tick one box only.

☐ Heterosexual or Straight

☐ Gay or Lesbian

☐ Bisexual

☐ Other sexual orientation

☐ Prefer not to answer

Other, write below

Click here to enter text.