Fast Track Pathway Tool for NHS Continuing Healthcare

October 2018 (Revised)

Published March 2018

July 2020 version including new consent to CHC

Fast Track Pathway Tool for NHS Continuing Healthcare October 2018 (Revised) East Sussex Version V.1 October 2018

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**(APPENDIX) Consent and Capacity Information V12**

**Consent Form for Participating in the NHS Continuing Healthcare Process and for Information Sharing** **with** **Family / Friend(s) / Advocates.**

This form is to enable CCGs to satisfy the Common Law Duty of Confidentiality and for Medico-Legal reasons. Under the General Data Protection Regulation consent is not required for the processing of personal and healthcare data in the context of NHS Continuing Healthcare.[[1]](#footnote-1).

|  |  |
| --- | --- |
| **Surname/Family name**  **of individual being assessed** |  |
| **First name/s** |  |
| **Date of birth** |  |
| **NHS number (or other identifier)** |  |
| **Permanent address** |  |
| **Telephone number** |  |
| **Responsible Professional[[2]](#footnote-2) Name** |  |
| **Job title** |  |
| **Organisation** |  |
| **Contact details for responsible professional** | Email:  Telephone: |
| **Date form completed** |  |

***To be retained in individual's records/notes.   
All relevant sections to be completed by the responsible professional.***

This form relates to consent to completion of the NHS Continuing Healthcare Checklist (screening tool), the completion of a full assessment for NHS Continuing Healthcare, and the sharing of personal health and social care information in order to[[3]](#footnote-3):

a) determine eligibility for NHS Continuing Healthcare (CHC)[[4]](#footnote-4)

b) assist in care and support planning[[5]](#footnote-5)

|  |  |
| --- | --- |
| **Does the individual have any communication difficulties that may impact upon their ability to consent?** | **Yes / No**  **(Please delete as appropriate)** |
| If yes, how have these been addressed? Describe what steps have been taken to enable the person to make the informed decision themselves (e.g. use of interpreter or communication aids, ensuring they have all the relevant information in an accessible form, considering times of day when their ability to understand is better, treating a medical condition which may be affecting their mental capacity, involving someone who knows them etc.) | |

*N.B. Under the Mental Capacity Act a person must be assumed to have capacity unless it is established that they lack capacity; a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.*

**Assessment of Individual’s Mental Capacity**

Mental capacity should be assessed at the time the decision needs to be made,bearing in mind that mental capacity is always decision specific and time specific and can fluctuate.

|  |  |
| --- | --- |
| **Are there any issues arising that may lead you to suspect that the individual may lack capacity to give their consent to participate in the NHS Continuing Healthcare assessment process and to share information with family/friend(s)/ advocate?** | **Yes / No**  **(Please delete as appropriate)** |

**If no, please complete Part 1 only.**

**If yes, i.e. there is evidence that the person has difficulty consenting or making decisions, proceed to Part 2.**

**PART 1**

**Consent for individuals that have mental capacity**

|  |  |
| --- | --- |
| ***Cross to indicate*** | **Statement from responsible professional:** |
|  | I have explained the process and purpose of the CHC assessment |
|  | I have advised the individual of how their health and social care information may be used, and that it will be shared for this assessment process with a number of different health and social care professionals and, with agreement, relevant family/friend(s)/advocate. |
|  | I have explained that if the Checklist indicates that a full CHC assessment is required, this does not mean they will necessarily be found eligible for CHC. Alternatively, where the Fast Track Pathway Tool is appropriate I have explained its purpose and implications. |
|  | I have explained to the individual that they can withdraw or amend their consent at any time, should they decide to do so (as well as the potential consequences of doing this). |

|  |  |
| --- | --- |
| **Has the individual been given a copy of the NHS Continuing Healthcare and NHS-funded Nursing Care Public Information Leaflet?** | **Yes / No**  **(Please delete as appropriate)** |

|  |  |
| --- | --- |
|  | **The individual has given consent but is physically unable to sign the form on the next page for the following reasons:** |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name (PRINT) |  | Signature |  |
| Job Title |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Cross to indicate*** | **Statement of Consent from Individual:**  ***Please read this carefully (or ask someone to read it to you) and tick/confirm those statements below that you agree with. You have the right to change your mind or withdraw your consent at any time*** | | |
|  | I consent to participating in the NHS Continuing Healthcare (CHC) assessment as explained to me. | | |
|  | I have been advised and understand that health and social care professionals involved in the assessment to determine eligibility for CHC will need to share information between them about my needs and will store this information securely. | | |
|  | I understand that I can withdraw my consent to participating in the assessment process at any time, and that by withdrawing my consent this may affect the ability to provide me with appropriate services to meet my needs. | | |
|  | I consent to any relevant family/friend(s)/advocate being involved in my assessment as considered appropriate and understand that my personal health and social care information may be shared with them for the purposes of this assessment. | | |
| **OR** | | | |
|  | I limit my consent to the following specific family/friend(s)/advocate being involved in my assessment and understand that my personal health and social care information may be shared with them for the purposes of this assessment. | | |
| **Name** | | **Relationship** | **Address and telephone number** |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| **OR** | | | |
|  | I do not consent to any family/friend(s)/advocate being involved in my assessment nor to my personal health and social care information being shared with them. | | |
|  | I understand that I can withdraw my consent to sharing information with specific family/friend(s)/advocate at any time. | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual (PRINT) |  | Individual’s signature |  |
| Date: |  | | |

*\*N.B If the individual has given consent but is physically unable to sign the form please confirm and give reason on page 3 above.*

**PART 2**

**Where there is a** **reasonable belief that the individual concerned may lack mental capacity to consent**

1. **Assessor Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of responsible professional completing the mental capacity assessment | |  | |
| Job Title |  | Date of Assessment |  |

Before assessing whether the individual lacks mental capacity to consent to participation in the CHC assessment process or the sharing of information with family/friends/advocates, you should consider:

* whether the individual might regain or acquire capacity to consent in the future and, if so,
* whether the NHS Continuing Healthcare assessment process can be delayed until they are able to give consent.
* whether advocacy services would be beneficial to the individual in order to support them in making or being involved in decision-making

1. **Mental Capacity Assessment**

On the date given above and in relation to the decision whether or not to give consent to participating in the CHC assessment and for the sharing of personal health and social care information with family/friend(s)/advocate for this purpose:

|  |  |
| --- | --- |
| 1. **Is the person able to understand the information relevant to the decision? *(i.e. Were you satisfied that the person could understand the nature of the decision, why the decision needed to be made at the time and whether they could understand the likely effects of deciding one way or another or making no decision at all?)*** | **Yes / No**  **(Please delete as appropriate)** |
| Please give reasons: | |
| 1. **Is the person able to retain the information long enough to use it to make the decision?** *(i.e. long enough to complete the decision-making process, including making and communicating their decision. Consideration should be given to the use of notebooks, photographs, videos, voice recorders, posters etc. to help the person record and retain the information)* | Yes / No  **(Please delete as appropriate)** |
| Please give reasons: | |
| 1. **Is the person able to use or weigh up this information as part of the decision-making process?** *(e.g. to consider the consequences, benefits and risks, of making the decision one way or another or making no decision at all? Understand the pros and cons)* | Yes / No  **(Please delete as appropriate)** |
| Please give reasons: | |
| 1. **Is the person able to communicate their decision?** *(Verbally, using sign language or by any other means?)* | Yes / No  **(Please delete as appropriate)** |
| Please give reasons: | |

*In order to establish that someone does not have the mental capacity to make a particular decision the assessor must have a* ***reasonable belief*** *(i.e. on the balance of probabilities) that they lack mental capacity. If the answer is ‘YES’ to* ***all*** *the above questions, the person must be assessed to have the mental capacity to make the decision themselves.*

*An answer of ‘NO’ to* ***any one*** *of the above four questions indicates that the person lacks mental capacity to make the decision in question if the reason for this is because they have an impairment or a disturbance in the functioning of their mind or brain.*

1. **Functioning of the Mind**

|  |  |
| --- | --- |
| **Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?[[6]](#footnote-6)** | **Yes / No**  **(Please delete as appropriate)** |
| **If yes,** please state the nature of the impairment (e.g. dementia, acquired brain injury, learning disability, acute confusional state, short-term memory loss, concussion, symptoms of drug / alcohol use) and the basis of this information (e.g. recent clinical assessments, established diagnosis etc.) | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Based on the above information, my judgement is that,**  **............................................................. *(Name of person being assessed)***  ***has the mental capacity / does not have the mental capacity (delete as appropriate****)*  *to make a decision regarding consent* *to participating in the NHS Continuing Healthcare assessment process and the sharing of personal health and social care information with family/friend(s)/advocate in order for this assessment to take place.* | | | |
| Assessor Name (PRINT) |  | Assessor Signature |  |
| Job Title |  | Date |  |

1. **Where the individual, following a mental capacity assessment, is found not to have capacity to make a decision to consent** **to participating in the NHS Continuing Healthcare assessment process and the sharing of personal health and social care information with family/friend(s)/advocate, please check and confirm whether either of the following have been appointed:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Name/address/telephone** |
| Someone with a Registered Lasting Power of Attorney (Health and Welfare) |  |  |  |
| Court appointed Deputy (Health and Welfare) |  |  |  |

***If either of the above have been appointed, the responsible professional must ask to see a certified copy of the relevant legal document and a copy should be made and retained on the individual’s file.***

If yes to either of the above, then that person has the authority to give or decline consent on behalf of the individual and therefore must be contacted and their decision respected and recorded below:

|  |  |
| --- | --- |
| **Does the person with relevant authority give permission on behalf of the individual for them to participate in the NHS Continuing Healthcare assessment and for their personal and healthcare information to be shared with family/friends/advocate as appropriate? Also, has the individual with relevant authority been advised that information about the individual will be shared between professionals for the CHC assessment process?** | **Yes / No**  **(Please delete as appropriate)** |
| Reasons for decision: | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of person with relevant authority (PRINT) |  | Signature of person with relevant authority |  |
| Date: |  | | |
| Name of responsible professional (PRINT) |  | Signature of responsible professional |  |
| Date: |  | | |

*If a decision has been made by a court appointed deputy or by someone with lasting power of attorney (health and welfare) the remainder of this form should not be completed.*

**If the individual lacks mental capacity and there is no-one with an LPA or a Deputy with the relevant authority (i.e. to make health and welfare decisions), a best interest decision must be made by the responsible professional.**

The Mental Capacity Act requires the best interest decision maker to consult with family/friends (and/or advocacy service if appropriate) before making a best interest decision. However, as noted in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (see paragraphs 77-81), it is likely that it will be in an individual’s best interest to have an assessment for CHC and for information about their health and welfare to be shared for this purpose.

|  |
| --- |
| **Please give details regarding any consultation you have made with family/friends and the outcome of this:** |
|  |

**Decision**

|  |  |
| --- | --- |
| **Is it in the individual's best interest to be assessed for NHS CHC and for information about their health and welfare to be shared for this purpose?** | **Yes / No**  **(Please delete as appropriate)** |
| Reasons for decision: | |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Nurse Assessor (PRINT) |  | Signature of Nurse Assessor |  |
| Date: |  | | |
| Name of relevant family member / representative |  | Signature of relevant family member / representative |  |
| Date: |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Accessible Information** | | | | | | |
| Does the patient/representative have a disability, impairment or Learning Disability that requires an alternative communication format? | | | | Yes / No  ***(Please delete as appropriate)*** | | |
| If yes please advise who requires the alternative communication format: | | | |  | | |
| **If yes please select the reason for an alternative communication format** | | | | | | |
| d/Deaf | |  | Hearing impairment / loss | | |  |
| Blind | |  | Sight impairment / loss | | |  |
| Deafblind | |  | Disability | | |  |
| Other *(Please provide details)* | |  |  | | | |
| **If yes please select the preferred alternative communication format** | | | | | | |
| Large Print | |  | Easy Read | | |  |
| Braille | |  | British Sign Language | | |  |
| Audio Format | |  | Email / Electronic Format | | |  |
| Other *(Please provide details)* | |  |  | | | |
| Does the patient/representative have a problem with understanding or speaking English? | | | | | Yes / No  **(Please delete as appropriate)** | |
| If yes please advise who requires the alternative communication format: | | | | |  | |
| If yes please advise CHC what their preferred language is: | | | | |  | |
| Patient’s Name: |  | | Signature: | |  | |
| Patient’s Date of Birth: |  | | Date: | |  | |

1. This revised tool accompanies the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2018 (the National Framework) and the NHS Continuing Healthcare Checklist (the Checklist) and the Decision Support Tool for NHS Continuing Healthcare (DST). This is the version that Clinical Commissioning Groups (CCGs) and NHS England[[7]](#footnote-7)1 should use from 1st October 2018. Please use the tool in conjunction with the National Framework, with particular reference to paragraphs 216-245.
2. Standing Rules Regulations[[8]](#footnote-8)2 have been issued under the National Health Service Act 2006[[9]](#footnote-9)3 and directions are issued under the Local Authority Social Services Act 1970 in relation to the National Framework.

## What is the Fast Track Pathway Tool?

1. Individuals with a rapidly deteriorating condition that may be entering a terminal phase, may require ‘fast tracking’ for immediate provision of NHS Continuing Healthcare.
2. The intention of the Fast Track Pathway is that it should identify individuals who need to access NHS Continuing Healthcare quickly, with minimum delay, and with no requirement to complete the Checklist or the Decision Support Tool (DST). Therefore, the completed Fast Track Pathway Tool, which clearly evidences that an individual is both rapidly deteriorating and may be entering terminal phase, is in itself sufficient to establish eligibility.

## Who can complete the Fast Track Pathway Tool?

1. In Fast Track cases, the Standing Rules state that it is an ‘appropriate clinician’ who determines that the individual has a primary health need. The CCG must therefore determine that the individual is eligible for NHS Continuing Healthcare and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay.
2. An ‘appropriate clinician’ is defined as a person who is:

a) responsible for the diagnosis, treatment or care of the individual under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed; and

b) a registered nurse or a registered medical practitioner.

1. 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.
2. An ‘appropriate clinician’ can include clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided they are offering services pursuant to the 2006 Act.
3. Others, who are not approved clinicians as defined above, but are involved in supporting those with end of life needs, (including those in wider voluntary and independent sector organisations) may identify the fact that the individual has needs for which use of the Fast Track Pathway Tool might be appropriate. They should contact the appropriate clinician who is responsible for the diagnosis, care or treatment of the individual and ask for consideration to be given to completion of the Fast Track Pathway Tool.

## When should the Fast Track Pathway Tool be used?

1. The Fast Track Pathway Tool must only be used when the individual has a rapidly deteriorating condition and may be entering a terminal phase.
2. The Fast Track Pathway Tool replaces the need for the Checklist and the Decision Support Tool (DST) to be completed. However, a Fast Track Pathway Tool can also be completed after the Checklist if it becomes apparent at that point that the Fast Track criteria are met.
3. The Fast Track Pathway Tool can be used in any setting. This includes where such support is required for individuals who are already in their own home or are in a care home and wish to remain there. It could also be used in other settings, such as hospices.
4. If an individual meets the criteria for the use of the Fast Track Pathway Tool then the Tool should be completed even if an individual is already receiving a care package (other than one already fully funded by the NHS) which could still meet their needs. This is important because the individual may at present be funding their own care or the local authority may be funding (and/or charging) when the NHS should now be funding the care in full.
5. The completed Fast Track Pathway Tool should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed:

a) ‘rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and

b) ‘may be entering a terminal phase’ is not intended to be restrictive to only those situations where death is imminent.

It is the responsibility of the appropriate clinician to make a decision based on whether the individual’s needs meet the Fast Track criteria.

1. An individual may at the time of consideration be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected in the near future. In these cases it may be appropriate to use the Fast Track Pathway Tool in anticipation of those needs arising and agreeing the responsibilities and actions to be taken once they arise, or to plan an early review date to reconsider the situation. It is the responsibility of the appropriate clinician to base their decision on the facts of the individual’s case and healthcare needs at the time.

## How should the Fast Track Pathway Tool be used?

1. Appropriate clinicians should complete the attached fast-track documentation and set out how their knowledge, and evidence about the patient’s needs, leads them to conclude that the patient has a rapidly deteriorating condition and that the condition may be entering a terminal phase.
2. It is helpful if an indication of how the individual presents in the current setting is included with the Fast Track Pathway Tool, along with the likely progression of the individual’s condition, including anticipated deterioration and how and when this may occur. However, CCGs should not require this information to be provided as a prerequisite for establishing entitlement to NHS Continuing Healthcare.
3. Whilst the completed Fast Track Pathway Tool itself is sufficient to demonstrate eligibility, a care plan will be required which describes the immediate needs to be met and the patient’s preferences. This care plan should be provided with the Fast Track documentation, or as soon as practicable thereafter, in order for a CCG to commission appropriate care.
4. The setting where an individual wishes to be supported as they approach the end of their life may be different to their current arrangements (e.g. even though they are currently in a care home setting they may wish to be supported in their family environment).The important issue is that (wherever possible) the individual concerned receives the support they need in their preferred place as soon as reasonably practicable, without having to go through the full process for consideration of NHS Continuing Healthcare eligibility.

## How should the individual/representative be involved?

1. The overall Fast Track process should be carefully and sensitively explained to the individual and (where appropriate) their representative.
2. It is also important for the CCG to know what the individual or their representative have been advised about their condition and prognosis and how they have been involved in agreeing the end of life care pathway.
3. Clinicians completing the Fast Track Pathway Tool should make the individual aware that their needs may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review.

**Careful decision-making is essential in order to avoid the undue distress that might result from changes in NHS Continuing Healthcare eligibility within a very short period of time**

## 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.**

Male / Female / Transgender

**Gender:**

**NHS number:**

|  |  |
| --- | --- |
| **Current Location of Patient:**  **Permanent address:**  **Telephone Number:**  **Lives alone: Yes No** | **GP Name:**  **Surgery:**  **Telephone Number:** |
| **Name of Next of Kin / Primary Contact:**  **Relationship:**  **Address if different to the above:**  **Telephone Number:**  **Power of Attorney in place: Yes /No**  **Name of person holding Power of Attorney and their contact detail:**  **Power of Attorney for: Health / Welfare /**  **Finance** | **N.B. All contact details as below.**  **Lead co-ordinator / Clinician in the community e.g. D.N. / Hospice Team / G.P.**  **Contact details of referring clinician :**  **Name:**  **Title / Qualification:**  **Organisation:**  **Telephone Number:**  **e-mail:**  **Fax Number:** |

**Please ensure that the equality monitoring form is completed.**

## Fast Track Pathway Tool for NHS Continuing Healthcare

To enable immediate provision of a package of NHS Continuing Healthcare

|  |
| --- |
| The individual fulfils the following criterion:  He or she has 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. |
| *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 CCG.

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 may be subject to a review, and accordingly that the funding stream may change subject to the outcome of the review

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

Name and signature of referring clinician Date

|  |  |
| --- | --- |
|  |  |

Name and signature confirming approval by CCG Date

|  |  |
| --- | --- |
|  |  |

**Please complete to support this application for Fast Track:**

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Domain** | **Description** | **Description of nursing needs and evidence of GSF1 Prognostic Indicators** |
| **Breathing** | **Shortness of breath**  **Tracheostomy in-situ**  **Oxygen therapy** |  |
| **Nutrition** | **Able to take food and drink by mouth.**  **Requires assistance with eating and drinking.**  **Dysphagia present.**  **Risk Feeding**  **Nutritional Intake currently**  **Weight**  **BMI** |  |
| **Continence** | **Indwelling catheter / stoma**  **Single or doubly incontinent** |  |
| **Skin Integrity** | **Risk of skin breakdown.**  **Waterlow / Purpose T Score**  **Pressure damage - grading of pressure area.**  **Dressing regime.**  **TVN Input**  **Pressure relieving equipment in place** |  |

**Please complete to support this application for Fast Track Funding:**

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Domain** | **Description** | **Description of nursing needs and evidence of GSF1 Prognostic Indicators** |
| **Mobility** | **Able to weight bear.**  **Requires assistance to weight bear, transfer. Or confined to one position (bed or chair).**  **Falls risk**  **WHO Performance Status 0-4**  **Mobility Equipment in place** |  |
| **Communication** | **Able to communicate clearly.**  **Unable to reliably communicate either verbally or non-verbally.**  **Inability to communicate any of their needs.** |  |
| **Psychological/**  **Emotional** | **Psychological and emotional needs are not impacting on health and well-being.**  **Evidence of mood disturbance or anxiety.**  **Signs of withdrawal.** |  |
| **Cognition** | **No evidence of impairment, confusion or disorientation.**  **Some memory issues that require supervision.**  **Difficulty even with supervision, prompting to make decisions about key aspects of their lives.** |  |

**Please complete to support this application for Fast Track Funding:**

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Behaviour** | **Compliant with care.**  **‘Challenging behaviour’ that follows a predictable pattern.**  **‘Challenging behaviour that poses a risk to self, others or property.** |  |
| **Drug Therapies & Medication** | **Able to take oral medication?**  **Syringe driver set-up?**  **JIC box available?**  **‘HOOF’ completed?**  **Who is responsible for administering medication?** |  |
| **Altered States of Consciousness** | **Transient Ischemic Attacks (TIAs)**  **Epilepsy**  **Vasovagal Syncope**  **General drowsiness, for example would not constitute an ASC for the purposes of this domain unless associated with a diagnosed clinical condition** |  |

**1 Prognostic Indicator Guidance (PIG) 4th Edition Oct 2011© The Gold Standards Framework Centre in End of Life Care CIC, Thomas.K et al.**

**Name of patient: NHS Number:**

|  |
| --- |
| **Special Instructions** |
| **Please provide information on this section in regards to any other additional information that needs to be considered or providers need to be aware of i.e. pressure care, PEG / RIG / JEG in place, Allergies, Infection Control issues, Oxygen requirements, Syringe Driver, Pleural Drainage, Tracheostomy, End of Life, referrals to other professionals i.e. OT, Physio, SALT, Dietician:** |
|  |
| **Is there a DNAR in place: Yes / No Dated:**  **If not in place has this been discussed: Yes / No**  **Any additional information in regards to the above:** |
| **Briefly what care is required:**  **Package of Care at Home:**  **Nursing Home:** |

**About you – equality monitoring**

Please provide us with some information about yourself. This will help us to understand whether everyone is receiving fair and equal access to NHS continuing healthcare. All the information you provide will be kept completely confidential by the Clinical Commissioning Group. No identifiable information about you will be passed on to any other bodies, members of the public or press.

1 What is your sex?

Tick one box only.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Male |  |  |  |  |  |  |  |
| Female |  |  |  |  |  |  |  |
| Transgender |  |  |  |  |  |  |  |

2 Which age group applies to you?

Tick one box only.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 0-15 |  |  |  |  |  |  |  |
| 16-24 |  |  |  |  |  |  |  |
| 25-34 |  |  |  |  |  |  |  |
| 35-44 |  |  |  |  |  |  |  |
| 45-54 |  |  |  |  |  |  |  |
| 55-64 |  |  |  |  |  |  |  |
| 65-74 |  |  |  |  |  |  |  |
| 75-84 |  |  |  |  |  |  |  |
| 85+ |  |  |  |  |  |  |  |

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)?

Tick one box only.

The Disability Discrimination Act (DDA) 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.

|  |  |
| --- | --- |
| Yes |  |
| No |  |

4 What is your ethnic group?

Tick one box only.

|  |  |  |
| --- | --- | --- |
| **A White** | | |
| British |  |  |
| Irish |  |  |
| Any other White background, write below | | |
|  | | |
| **B Mixed** | | |
| White and Black Caribbean |  |  |
| White and Black African |  |  |
| White and Asian |  |  |
| Any other Mixed background, write below | | |
|  | | |
| **C Asian, or Asian British** | | |
| Indian |  |  |
| Pakistani |  |  |
| Bangladeshi |  |  |
| Any other Asian background, write below | | |
|  | | |
| **D Black, or Black British** | | |
| Caribbean |  |  |
| African |  |  |
| Any other Black background, write below | | |
|  | | |
| **E Chinese, or other ethnic group** | | |
| Chinese |  |  |
| Any other, write below | | |
|  | | |

5What is your religion or belief?

Tick one box only.

Christian includes Church of Wales, Catholic,

Protestant and all other Christian

denominations.

|  |  |  |
| --- | --- | --- |
| None |  |  |
| Christian |  |  |
| Buddhist |  |  |
| Hindu |  |  |
| Jewish |  |  |
| Muslim |  |  |
| Sikh |  |  |
| Other, write below | | |
|  | | |

6 Which of the following best describes your

sexual orientation?

Tick one box only.

Only answer this question if you are aged **16**

years or over.

|  |  |  |
| --- | --- | --- |
| Heterosexual / Straight |  |  |
| Lesbian / Gay Woman |  |  |
| Gay Man |  |  |
| Bisexual |  |  |
| Prefer not to answer |  |  |
| Other, write below | | |
|  | | |

**Name of patient: NHS Number:**

**This part of the form is only to be completed by the CHC Duty Nurse upon speaking to the patient and / or NOK / Representative and as required the referrer.**

**Please ensure that an explanation of Fast Track funding has been given and the process for review.**

|  |
| --- |
| **Please provide information on the following:** |
| **Current location of the Patient i.e. Hospital, Hospice, Nursing Home, Home Address:** |
| **Expected date of discharge if in Hospital or Hospice:** |
| **If in hospital are all discharge arrangements in place including the ordering of medication, oxygen, equipment etc.** |

|  |  |  |
| --- | --- | --- |
| **Please provide information on the following:** | **Yes** | **No** |
| **Is the patient known to a Hospice?**  **Please specify which Hospice:** |  |  |
| **Is support being offered by the Hospice at the present time?**  **Please specify type of input in place Active / Support:** |  |  |
| **Contact person and number at the Hospice for the patient:** | | |

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Nursing Home Placement** | | |
| **Please provide information for the following:** | **Yes** | **No** |
| **Is the patient already in a Nursing Home?**  **Name:** |  |  |
| **Type of Nursing Home required to meet need**  **Standard:**  **EMI:** |  |  |
| **Location Postcode to be considered for radius of Nursing Home to be sourced:** | | |
| **Does the patient have a preferred Nursing Home they would like CHC to contact for placement? – There is no guarantee that this will be agreed but it will be considered.** | | |
| **Funding of current Nursing Home Placement if applicable:**  **Social Service funded / Direct Payment:**  **Privately funded:** | **Please tick √** | |

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Please provide information for Transport:** | **Yes** | **No** |
| **Is Transportation required?** |  |  |
| **Access to the building:**  **Stairs**  **Wide Door frames**  **Narrow Corridor space** |  |  |
| **Stretcher required** |  |  |
| **Chair required** |  |  |
| **Weight Bearing** |  |  |
| **Weight: Height:** |  |  |
| **Co-operative with Moving & Handling**  **Give detail as required:** |  |  |
| **Syringe Driver in place** |  |  |
| **Oxygen in place** |  |  |
| **Tracheostomy in place** |  |  |

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Package of Care** | | |
| **Please provide information for the following:** | **Yes** | **No** |
| **Is the patient already receiving a Package of Care?** |  |  |
| **Which Agency is providing the Package of Care if it is already in place?**  **Please specify currently;**  **What care is being provided:**  **Number of carers required per care call:**  **Times of care calls:**  **Length of care calls:** | | |
| **Funding of care currently:**  **Social Service funded / Direct Payment:**  **Privately funded:** | **Please tick √** | |
| **Please provide information for the following:** | **Please tick √** | |
| **Care package Required (confirm Home Care Policy):**  **One call per day**  **Two calls per day**  **Three calls per day (maximum day package)**  **Waking nights: 1 2 3 (Please tick √)**  **Live in**  **Notional Budget (set amount of hours given to an**  **agency to provide the care max 21hrs)** |  | |
| **Number of carers required per call:**  **One**  **Two**  **Special Requirement i.e. Bariatrics (4 carers)** |  | |

|  |  |
| --- | --- |
| **Length of calls: Morning 60 45 30**  **(in minutes) Midday 45 30 15**  **Evening 60 45 30** |  |
| **If a Live in Carer is requested who will provide the 2hrs Carers Break?** | |
| **Who will provide food preparation, support with domestic duties including shopping? (please explain that CHC do not offer this facility)** | |

**Name of patient: NHS Number:**

**Name of patient: NHS Number:**

|  |  |  |
| --- | --- | --- |
| **Please provide confirmation on the following:** | **Yes** | **No** |
| **Is a Carers Assessment required?**  **Referral made to Adult Social Care - Date:** |  |  |

|  |  |  |
| --- | --- | --- |
| **Please provide information for the following in regards to Equipment:** | | |
| **Lifeline Alarm**  **Is Lifeline in place: Who is the Lifeline funded by:**  **Is Lifeline required:** | | |
| **Key Safe**  **Is Key Safe required: Yes / No**  **If the property is not owned does the Landlord given permission for the Key Safe to be installed: Yes / No**  **Who will give access to property if there is no Key Safe?** | | |
| **Equipment in place** | **Yes** | **No** |
| **Assessed by Occupational Therapy (OT) for equipment**  **Date:** |  |  |
| **Assessed by Physiotherapy for equipment**  **Date:** |  |  |
| **Hospital Bed** |  |  |
| **Pressure Mattress** |  |  |
| **Hoist & Slings** |  |  |

1. The lawful basis for the processing of personal and healthcare data for NHS Continuing Healthcare is contained within article 6 (1) (e) and 9 (2) (h) of the General Data Protection Regulation (GDPR) as enacted by the Data Protection Act 2018. [↑](#footnote-ref-1)
2. In this context the ‘responsible professional’ means the professional who is responsible for obtaining consent, normally at Checklist stage. Since the Checklist can be completed by a range of professionals any of these could be the ‘responsible professional’ in terms of gaining consent. [↑](#footnote-ref-2)
3. Consent is not required to share information within Health and Social Care Organisations, because the

   Quality and Safety Act 2015 puts a legal duty on these Organisations to share information where it is needed

   for the direct care of that patient, or to facilitate the provision of care. [↑](#footnote-ref-3)
4. ‘determine eligibility’ includes resolving any dispute regarding eligibility at local level or, where necessary,

   through the Independent Review Process operated by NHS England. [↑](#footnote-ref-4)
5. including care and support planning in situations where the individual is not found eligible for CHC but

   requires some other publicly funded care [↑](#footnote-ref-5)
6. In the case PC & Anor v City of York Council (2013) EWCA Civ 478 it was clarified that it is important to

   assess whether the person is able to make the decision in question before considering whether they have an

   impairment of the mind or brain. [↑](#footnote-ref-6)
7. 1 For the purposes of this document references to CCGs after this point also include NHS England where it is responsible for commissioning services for an individual for whom a Fast Track Pathway Tool has been completed. [↑](#footnote-ref-7)
8. 2 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the Standing Rules”) [↑](#footnote-ref-8)
9. 3 National Health Service Act 2006 (c.41), (“the 2006 Act”). [↑](#footnote-ref-9)