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| **Fast Track Care Plan** | |
| **Patient Details**  **Name:**  **Address**:  **Postcode:**  **Telephone:**  **Does the patient live alone? Nursing Home** | **Next of Kin / Primary Contact:**  **Patient and/or representative aware of palliative diagnosis?**    **Relationship (PoA or other):**  **Address:**  **Telephone:**    **Mobile:** |
| **GP Name:**  **Practice:** | **Telephone Number:** |
| **Other Professionals (District Nurse, Community Matron, MacMillan Nurse)** | |
| **Name: Title:**  **Location: Email:**  **Contact Numbers:**  **Name: Title:**  **Location: Email:**  **Contact Numbers:**  **Name: Title:**  **Location: Email:**  **Contact Numbers:** | |
| **Any other significant medical history:** | **Existing Care Package and Provider:**  **Is the care package funded by the Local Authority or the patient? (please provide details)** |

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| **Care needs**  **Assistance required** | | **Please provide details of need** | | | | | | | | |
| **Personal care/Mouth care/Skin integrity/ Repositioning** | |  | | | | | | | | |
| **Nutrition/Hydration** | |  | | | | | | | | |
| **Medication management.**  **Symptom control/management?** | |  | | | | | | | | |
| **Continence** | |  | | | | | | | | |
| **Mental Health/ Psychological and Emotional support/ Communication** | |  | | | | | | | | |
| **Mobility/Safety.**  **Risk management.** | |  | | | | | | | | |
| **What is the patient/representative preference for care?** | |  | | | | | | | | |
| **Additional needs?** | |  | | | | | | | | |
| **Does the level of need indicate that a care home placement should be considered?** | | **Yes** | | | | **No** (please comment) | | | | |
| **Care Package Required** | | | | | | | | | | |
| **Number of homecare agency visits required per day?** | **Number of agency carers required per visit?** | | **Length of homecare visits?**  *PLEASE DETAIL IN COLUMNS BELOW*  *(i.e: 30mins /45mins/ 60mins)* | **Number of District Nurse visits per day?** | | | **District Nurse interventions required?** | | | |
| **08:00-**  **10:00** | **10:00-**  **12:00** | | **12:00-**  **14:00** | **14:00-16:00** | **16:00-18:00** | | | **18:00-20:00** | **20:00-22:00** | **Night** |

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| **What outcomes does the patient/family expect to see?** | **How will they do this?** |
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| **Informal/Family support**  *(Shopping, Meals, Who lives with or nearby, Friends support)* | **Environmental Issues**  *(Access, Key Safe in place?, Equipment in place, Oxygen User, Pets in the house)* |
|  | Is there a key safe in place? **Yes / No**  **If yes, please provide code.** |

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|  | **Weekly** | **Annually** | **One off payments** |
| **Indicative budget/Adam cost** |  |  |  |
| **Money Out** |  |  |  |
| **Does this balance (+/- saving/overspend)** |  |  |  |

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| Name of Referrer |  |
| Title of Referrer |  |
| Contact Number/Bleep |  |
| Signature of Referrer |  |
| Date of Referral |  |

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| **Referral Address** | | |
| *Please forward Fast Track referral to the relevant Continuing Healthcare team below.*  *Tick relevant box.* | | |
| **East Cheshire CCG**  CHC / Complex Care Team, 1st Floor, West Wing, New Alderley House, Macclesfield District General Hospital Victoria Road, Macclesfield, SK11 3BL. Tel. No. 01625 663808. | |  |
| **Vale Royal & South CCG**  CHC / Complex Care Team, Bevan House, Nantwich, CW5 5RD  Tel No. 01270 275298 | |  |
| **West Cheshire CCG**  CHC / Complex Care Team, 1829 Building, Liverpool Road, Chester, CH2 1HJ  Tel. No. 01244 650399 | |  |
| **Wirral CCG**  CHC / Complex Care Team, Old Market House, 3rd Floor East Wing, Hamilton Street, Birkenhead, Wirral, CH41 5AL  Tel. No. 0151 514 2302 | |  |
| **Notification of Change in Circumstance**  Please notify the Continuing Healthcare team when a change occurs. | | **Please indicate with an**  **x** |
| Care package is no longer required. | |  |
| Care package needs to be changed. | |  |
| Patient requires care home placement. | |  |
| Name of Referrer |  | |
| Title |  | |
| Contact Number |  | |
| Signature |  | |
| Date |  | |
| **For Continuing Healthcare Team use only** | | |
| ***6 Week Telephone Review***  ***Fast Track Eligible Yes / No*** | | |
| ***3 Month Review***  ***Fast Track Eligible Yes / No***  ***Full CHC Process commenced Yes / No*** | | |
| CHC Nurse Name ……………………………………………………………….  CHC Nurse Title………………………………………………………………….  CHC signature……………………………………………………………………  Date………………………………………………………………………………. | | |