Herefordshire Council

Agenda

Adults and wellbeing scrutiny committee

Date:	**Thursday 20 September 2018**
Time:	**2.00 pm**
Place:	**The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Ruth Goldwater, Democratic Services Officer** Tel: 01432 260635 Email: councillorservices@herefordshire.gov.uk

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Agenda for the meeting of the Adults and wellbeing scrutiny committee

Membership

Chairman	**Councillor PA Andrews**
Vice-Chairman	**Councillor J Stone**
	Councillor MJK Cooper
	Councillor PE Crockett
	Councillor CA Gandy
	Councillor JA Hyde
	Councillor D Summers

Agenda

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details any details of members nominated to attend the meeting in place of a member of the committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by members in respect of items on the agenda.	
4.	**MINUTES** To approve and sign the minutes of the meeting held on 17 July 2018.	7 - 12
5.	**QUESTIONS FROM MEMBERS OF THE PUBLIC** To receive questions from members of the public. *Deadline for receipt of questions is 5pm on Friday 14 September 2018. Accepted questions will be published as a supplement prior the meeting.* *For guidance on how to submit a question to the committee, please see: https://www.herefordshire.gov.uk/getinvolved* *Please submit questions to: councillorservices@herefordshire.gov.uk*	
6.	**QUESTIONS FROM COUNCILLORS** To receive questions from councillors. *Deadline for receipt of questions is 5pm on Friday 14 September 2018. Accepted questions will be published as a supplement prior the meeting.* *Please submit questions to: councillorservices@herefordshire.gov.uk*	
7.	**NHS CONTINUING HEALTHCARE FRAMEWORK APPLICABLE TO HEREFORDSHIRE** To inform the Adults and wellbeing scrutiny committee of a review that has been undertaken in relation to the application of the National Health Service Continuing Healthcare (CHC).	13 - 58

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- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
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Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Tuesday 17 July 2018 at 10.00 am

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice-Chairman)

Councillors: PE Crockett, CA Gandy, JA Hyde and D Summers

In attendance: **Councillors P Rone (Cabinet Member) and AR Round**

Officers: **J Coleman, J Higgins, S Vickers**

Healthwatch: **I Stead**

2gether NHS Foundation Trust: **J Melton**

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillor MJK Cooper.

2. NAMED SUBSTITUTES (IF ANY)

There were no substitutes.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MINUTES

RESOLVED:

That the minutes of the meeting held on 16 May 2018 be confirmed as a correct record and signed by the chairman.

The chairman noted that the item on continuing healthcare was not on the agenda due to a request from the Clinical Commissioning Group to ensure their governance process was met. This would now be covered at a specially convened meeting on 20 September 2018.

In response to comments made at a recent meeting of Full council, the Chairman wished it to be emphasised that the service previously based at 1 Ledbury Road was run by Wye Valley NHS Trust and not Herefordshire Council, and it was the decision of Wye Valley NHS Trust to close the setting and not the decision of Herefordshire Council.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

6. QUESTIONS FROM COUNCILLORS

There were no questions from councillors.

7. DEPRIVATION OF LIBERTY SAFEGUARDS

The specialist services manager presented her report which highlighted the current position with regard to deprivation of liberty safeguards (DOLS).

She explained that the purpose of DOLS was to protect members of the public in hospital or residential or nursing home settings where they lacked capacity to agree to be there. DOLS did not apply to people outside of a registered care home or hospital setting.
By way of background, she made the following points:

- DOLS had been in place since 2008 in response to changes to the Mental Health Act to address a gap in the law, known as the Bournewood gap, where there was no legal process to legally authorise someone's deprivation of liberty as a requirement of the Human Rights Act.
- The initial common assumption had been that DOLS applied where someone objected to the arrangements made on their behalf, but in 2014 major case law redefined DOLS and determined that the objection was not the over-riding or relevant factor but whether or not someone was free to leave; whether the person had continuous supervision; or was under continuous care which infringed or restricted them.
- This meant that more people met the criteria and this had significant implications in Herefordshire where casework increased 15-fold compared with 10-fold nationally. This led to local authorities being unable to meet demand and therefore meet legal responsibilities within required timeframes, resulting in backlogs. In Herefordshire this backlog had reached nearly 600 cases but despite pressures, had now reduced to 290.

The manager described how the arrangements worked locally:

- The backlog was carefully triaged in terms of risks to the individual, using the ADASS prioritisation tool to ensure people at high risk were assessed in a timely manner.
- The triage system looked at a range of factors as they affected the individual, including the level of restrictions, the family's and power of attorney's views and safeguarding issues, to reduce impact of restrictions.
- The process was intensive and involved 6 assessments, which covered age, mental capacity, whether there was anyone who was granted powers such as lasting power of attorney, who it was that was objecting, doctor's eligibility

assessment, doctor's mental health assessment, and best interest assessment to determine that criteria was met and that it was in the person's interest and proportionate to the risk of harm.

- The process was complex, and required a senior officer for final authorisation. The authorisation could last up to 12 months, after which, if the person were in the same setting, it would be necessary to repeat the process. Although a streamlined process was in place to make it quicker, it still took time to evidence the 6 assessments.
- The requirements meant that the process took time and effort for the 13000 referrals, with a backlog of 290, although compared with other authorities, this was good service performance.

The director for adults and wellbeing commented that some councils had invested funding to clear their backlogs but the funding had to be sustained to keep up with demand. Practitioners across the country had led the development of new processes and forms to make it as streamlined as possible but anyone under DOLS authorisation had to have their case reviewed, making the processes necessarily repetitive, and it was often the case that people could be on DOLS authorisation for several years, so the numbers continued to grow.

A member welcomed the clarity of the presentation and commented on the need to get the approach to DOLS right and manage the many steps required. However for some people, following their first DOLS authorisation lasting 12 months, would need this repeating in some cases over many years, therefore calling for more streamlining of the process. From a national point of view, this needed addressing as adult social care budgets were under more pressure than ever, and the demand for DOLS was set to increase.

The service manager explained that the government was looking at the process and had concluded that a different approach was needed, and that a white paper was produced last March to create liberty protection safeguards and to look at where time may be extended after initial authorisation. However, this remained in process and was not expected to become law until 2020. She added that the costs for each assessment were significant, and the council was spending £350 per assessment and £175 on a doctor's report, although the fees for best interest assessors had been reduced to £250 and the doctor's assessment was reduced where the doctor was carrying out more than one assessment in the same setting. The cost of the DOLS scrutiny and administration of the process also had to be factored in as well as the cost of the authoriser's time at senior level.

The director added that there had been a judicial review and £34m had been allocated, although the impact was in the region of £450m to £600m for local authorities.

In answer to a question from the chairman regarding the appeals process, it was explained that there was a separate element through the Court of Protection if someone indicated they were objecting, and the arrangements would then be considered by a judge. This was a High Court process which had significant cost implications for instructing barristers.
The process also required the input of a relevant person's representative to advocate for the person and although family members were sought there were many occasions where there was no family member to do this and so it was necessary to appoint someone through a contracted advocacy service.

Over all, this was a costly process, which also required DOLS authorisations to be reviewed whenever there was a change of circumstances and to ensure that the prioritisation within the backlog of casework was appropriate.

The deputy solicitor to the council outlined that in terms of introducing the anticipated changes to legislation, this would take time to go through the parliamentary process, and be subject to further amendments, so changes were not likely until 2020.

In answer to a question from the chairman regarding the high number of referrals, the service manager explained the context of there being 24% of the older age population with dementia.
There was a signification number of referrals owing to this including hospital admissions which fall to the local authority to respond to, although Wye Valley NHS Trust tried to ensure appropriate referrals and there was case law to make this clearer. She added that on average per week there were between 25 and 30 referrals and around 30% were hospital referrals.

A member asked about the efficacy of the screening tool and whether this would be reviewed. The service manager confirmed that families were generally content with system, although any feedback from families tended to be in relation to the DOLS initiation and the onerous process.

The vice chairman asked about the current budget, which was £150k less than last year, and whether there were any implications with regard to adult social care funding pressure.
The director confirmed that the DOLS budget was overspent last year by £150k. This year the budget was set at same rate and the service was asked to avoid overspending. To do this, efficiencies would be achieved by negotiating with assessors to reduce fees and achieve economies of scale. It was noted that demand was likely to increase and that authorisations would need to be repeated, so it was a key aspect of managing the situation was to prioritise in terms of risk using the ADASS prioritisation sheet.

In answer to a member's question around the role and involvement of power of attorney the service manager clarified that for lasting power of attorney for health and welfare, the person would be involved in the process and their views taken into account. They would have the final say on the DOLS and would have to be assured that the arrangements were appropriate. The director added that the lasting power of attorney did not have authority to deprive someone of their liberty so there had to be statutory process.

The service manager clarified a point for a member about annual assessments by outlining the recording and flagging system which enabled individual cases to be tracked. Since March 2018, this tracking was being managed through the Mosaic information management system.

A member noted that the required process was being followed and that there was confidence that officers were reviewing the backlog of cases. However, the process was appalling and a letter should be sent to the government to say that it was not fit for purpose and calling for urgent review, especially at a time when councils were under such pressure.
The director explained that there was already a paper before parliament, but suggested that the committee could address both the local MPs about the delays in new legislation and ask them to speed the process up. ADASS were leading the way and had already highlighted the risks and asked the government to look at long term funding solutions for adult social care. Discussion took place around the merits of this and whether ADASS carried more weight in seeking this outcome, and it was clarified that Herefordshire had already responded to the white paper consultation along with many other local authorities.

RESOLVED
That

a) **the current position for DOLS be noted;**
b) **that the current process in place locally for DOLS be accepted; and**
c) **the executive be asked to write to the Department of Health and the two local Members of Parliament asking for improvements to the legislation to be expedited.**

8. COMMITTEE WORK PROGRAMME 2018-19

Members considered the draft work programme for the current municipal year.
The following points were noted:

- It would be a challenge to cover business in the time before the purdah period commenced ahead of the council election in May 2019.
- A report on the issue of continuing healthcare was planned for the meeting on 20 September, once it had passed through the governance process for the Clinical Commissioning Group.
- An item covering the draft domestic abuse strategy be considered on 20 September following a member's workshop this afternoon.
- Consideration of the annual budget was identified for the meeting on 2 October, subject to meeting the timeline for governance of this item. It was noted that the process for budget recommendations would be for the adults and children's scrutiny committees to pass their comments to the general scrutiny committee for collective submission.
- A report on public health activity was timely, for the new director of public health to present her proposals for delivery and to show how they fit with national programmes. The report would need to show how initiatives would have impact, and it was agreed that Healthwatch be invited to contribute to this item. It was noted that there was a children's scrutiny spotlight review on children's dental health and childhood obesity which incorporated good work by Healthwatch with the public, and that there was a link to adult dental health and obesity as a family wide issue. This item was identified for the 2 October meeting and would include public health improvement plans that had been set by the directorate. It was agreed to share these plans for the committee to identify specific focus areas, although an ensuing discussion suggested the inclusion of flu vaccination promotion for the health and care workforce.
- It was suggested to consider the matter of the Clinical Commissioning Group and Wye Valley NHS Trust's plans for responding to housing growth in the county and the corresponding demand for services. It was noted that the effects across the Sustainability and Transformation Partnership footprint would need to be included in this. Timing for this item would be the 29 January 2019 meeting.
- An update on Home First be included on 19 March 2019, which would include input from Healthwatch on their work in this area.
- A service review on Addaction to be included on the agenda for 19 March 2019.
- An update on WISH was suggested, which could be covered by way of a briefing note.

RESOLVED
That

a) **subject to the additions and amendments discussed, the draft work programme for 2018-19 be agreed; and**
b) **where recommendations have been made to the executive, these be collated on an action tracking document for review and follow-up.**

The meeting ended at 11.37 am **Chairman**

Meeting:	Adults and wellbeing scrutiny committee
Meeting date:	Thursday 20 September 2018
Title of report:	NHS Continuing Healthcare Framework applicable to Herefordshire
Report by:	Director for adults and wellbeing

Classification

Open

Decision type

This is not an executive decision

Wards affected

All Wards

Purpose and summary

To inform the Adults and wellbeing scrutiny committee of a review that has been undertaken in relation to the application of the National Health Service Continuing Healthcare (CHC). The review was jointly commissioned by the council and the Herefordshire Clinical Commissioning Group (CCG) and the terms of reference for the review were:

- An analysis of CHC data, locally and nationally;
- Current understanding amongst staff;
- Relationships across the council and the CCG allied to CHC;
- Trends allied to activity over an eighteen month period;
- To identify the case for change based on staff understanding and nationally available data To identify ways to improve professional and clinical relationships;
- Finally to make recommendations for the way forward.

Attached to this report – Appendix 1 provides a summary of the final review report.

To afford the opportunity to the Adults and wellbeing scrutiny committee to review the draft action plan that has been jointly developed with the CCG to take matters forward to improve the operation of systems and processes applicable to CHC, and identify any recommendations the committee wishes to make with a view to securing further improvement.

Further information on the subject of this report is available from
Robert Vickers, email: Robert.Vickers2@herefordshire.gov.uk

Recommendation(s)

That the Adults and wellbeing scrutiny committee review the robustness of the action plan at appendix 2 and determine any recommendations it wishes to make to either the council's executive or the Herefordshire Clinical Commissioning Group in order to secure further improvement.

Alternative options

1. It is a function of the committee to make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive and to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area, and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised. As such there are no alternative recommendations.

Key considerations

2. NHS Continuing Healthcare (CHC) is a package of continuing care that is arranged and funded solely by the NHS as part of the duty to provide healthcare services. It applies where the individual is assessed as having a primary health need. A primary health need defines who is eligible for CHC. A person is judged as having a primary health need through a CHC assessment which looks at the totality of a person's relevant needs. These are measured against the following criteria:

    - Nature, the particular characteristics of an individual's needs, which can include physical, mental health or psychological;
    - Intensity, the severity of needs present and the support required;
    - Complexity, this is how the needs present and interact to increase the skills required to support; and
    - Unpredictability, the degree to which needs fluctuate and thereby create challenges in managing them.

3. A jointly commissioned review of CHC and the associated actions aimed to enhance relationships, establish greater understanding and joined ownership of operational systems and processes in relation to CHC.

4. The review coincided with a national revision of the CHC Framework as many health and social care systems had experienced challenges in terms of application. The review in Herefordshire was jointly commissioned by the council and the CCG and arose because of an apparent shift in the numbers of individuals eligible for CHC. The review has analysed CHC data, both locally, regionally and with comparator CCGs, looked at trends over an 18 month period and taken a view with regard to relationships between the Council and the CCG. The review has identified a number of recommendations.

5. Appendix 1 contains a summary of the review, in the form of a slide deck and a draft action plan to take forward the review report recommendations is at appendix 2.

Appendix 3 shows the Herefordshire CCG benchmark against recognised statistical neighbours CHC Eligibility by 50k Population

6. It must be noted that this review did not:

- Review any individual cases or any decision making
- Formally review or evaluate the operational functioning of decision-making processes
- Review by attending any operation forum or committees

The review report recognises the impending revision to CHC and a revised 2018 National Framework which sets out the principles and processes of NHS Continuing Healthcare and NHS funded Nursing Care. The guidance replaces the previous version of the National Framework published in November 2012 and will be implemented on 1st October 2018. It will include practice guidance to support staff to deliver NHS Continuing Healthcare. This revised 2018 National Framework follows an extensive period of external engagement with stakeholders across the NHS, councils and patient representative groups. The 2018 National Framework has been collaboratively written by the Department of Health, NHS England and councils.

7. In addition to the 2018 revision of the National Framework there is also an update to the Practice Guidance and the annexes which accompany the Framework. This captures the CHC Checklist, Decision Support Tool and the Fast Track Pathway Tool, all aimed to support and aid user applications. There are also some minor changes to key domain wordings and descriptions which are the building blocks to CHC multi-disciplinary team working and recommendations. The updated tools should be used from 1 October 2018 but the changes planned locally following the review report will reflect the national revised operating position.

8. The 2018 National Framework is intended to:

- Provide greater clarity to individuals and staff, through a new structure and style;
- Reflect legislative changes since 2012 National Framework was published, primarily to reflect implementation of the Care Act 2014.
- Clarify a number of policy areas including:
    - Setting out that the majority of NHS CHC assessments should take place outside of hospital settings. This will support accurate assessment of need and reduce unnecessary stays in hospital; N.B. - his will be reliant on having discharge to assess pathways in place within Herefordshire.
    - Providing additional advice for staff on when individuals do and do not need to be screened for NHS CHC in order to reduce unnecessary processes and to respond to a greater call for clarity on this;
    - Clarifying the main purpose of the three and twelve month reviews is to review the appropriateness of the care package, rather than reassess eligibility. This should reduce unnecessary reassessments.
    - Introducing new principles for CCGs regarding local resolution process for situations where individuals who request a review of CHC eligibility

decision. The aim is to resolve such situations earlier and establish greater consistency.

- Providing clearer guidance, including dedicated sections on – the roles of CCG and Local Authorities, NHS-funded Nursing Care, inter-agency disputes, well managed needs and the Fast Track Pathway Tools.

9. Importantly, none of the 2018 amendments and clarifications to the National Framework, annexes or national tools are intended to change the eligibility criteria for NHS CHC. All those involved with NHS CHC should become familiar with the revised positions. The National Framework sets out the principles and processes for NHS CHC and NHS Funded Nursing Care. As indicated the revised position operable from 1 October 2018 will replace the existing position which was implemented in November 2012.

10. At the heart of the National Framework is the process for determining whether an individual is eligible for CHC or NHS-funded Nursing Care. An individual is eligible for NHS CHC if they have a primary health need. This is a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing all of the individual's assessed health and associated social care needs. In order to determine whether an individual has a primary health need, a detailed assessment and decision-making process must be followed, as set out in the National Framework. Where an individual has a primary health need and is therefore eligible for NHS CHC, the NHS is responsible for commissioning a care package that meets the individual's health and associated social care needs.

11. The National Framework is underpinned by Standing Rules Regulations, issued under the National Health Service Act 2006. The regulations, referred to henceforth as the Standing Rules, require CCGs to have regard to the National Framework. This revised National Framework takes account of legislative changes brought about by the Care Act 2014, which preserves the existing boundary and limits of local authority responsibility in relation to the provision of nursing and/or healthcare.

12. The individual, the effect their needs have on them, and the ways in which they would prefer to be supported should be kept at the heart of the process. Access to assessment, care provision and support should be fair, consistent and free from discrimination. CCGs, the NHS Commissioning Board (NHS England), and Local Authorities have legal duties and responsibilities in relation to NHS CHC. Those eligible for CHC continue to be entitled to access to the full range of primary, secondary and other health services.

13. Key Definitions: NHS CHC means a package of care and support of on-going care that is arranged and funded solely by the NHS, where the individual has been assessed and found to have a primary health need as set out in the National Framework. Such care is provided to an individual age 18 years and over to meet health and associated social care needs that have arisen as a result of disability, accident or illness; NHS-funded Nursing Care is the funding provided by the NHS to Care Homes with nursing to support the provision of nursing care by a registered nurse. In all cases individuals should be considered eligible for NHS CHC before a decision is reached about NHS-funded Nursing Care.

14. The review that has been undertaken within Herefordshire has endeavoured to further understanding on a number of levels to aid operational practice and ensure appropriate outcomes for individuals requiring care and support. The review report recommendations have been accepted by both organisations and actions are now in train to respond appropriate. Key actions will involve a revised Dispute Resolution Policy to assure individual casework situations, policy and practice to ensure application of the national

framework to be applied from 1 October 2018, training to raise awareness amongst staff to support application and regular officer meetings to enhance communication and coordination of CHC. These actions are complementary to the Action Plan attached to this report.

15. In terms of a social care need, the Care Act 2014 states that an individual has eligible needs, where these needs arise from or relate to, a physical or mental impairment which results in them being unable to achieve two or more of the following outcomes which is, or is likely to have a significant impact on their wellbeing –

- Managing and maintaining nutrition;
- Maintaining personal hygiene;
- Managing toilet needs;
- Being appropriately clothed;
- Being able to make use of home safely;
- Maintaining an habitable home environment;
- Developing and maintaining family or other personal relationships;
- Accessing and engaging in work, training, education or volunteering;
- Making use of necessary facilities or services in local communities, including public transport and recreational facilities and services; and
- Carrying out any caring responsibilities the adult has for a child.

(Section 22 of the Care Act places a limit on the care and support that can be lawfully provided to individuals by councils, that limit is set out in Section 22(1)).

Community impact

16. In accordance with the adopted code of corporate governance, Herefordshire Council must ensure that it has an effective performance management system that facilitates effective and efficient delivery of planned services. Effective financial management, risk management and internal control are important components of this performance management system. The council is committed to promoting a positive working culture that accepts, and encourages constructive challenge, and recognises that a culture and structure for scrutiny are key elements for accountable decision making, policy development, and review.

17. The National Framework Revisions, the local Review of CHC and the proposed Action Plan to implement Review Report Recommendations will support two of the council's corporate plan priorities (2017 – 2020) ensuring that residents are able to live safe, healthy and independent lives and that commissioning organisations secure better services, quality of life and value for money across the sector.

18. The Action Plan will provide assurance that health and social care are working in conjunction with the National Framework to enable appropriate responses to individual resident's needs.

Equality duty

19. Under section 149 of the Equality Act 2010, the "general duty" on public authorities is set out as follows:

A public authority must, in the exercise of its functions, have due regard to the need to –

(a) Eliminate discrimination, harassment, victimisation and any conduct that is prohibited by or under this Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

20. The Equality Act 2010 established a positive obligation on local authorities to promote equality and to reduce discrimination in relation to any of the nine 'protected characteristics' (age; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; race; religion or belief; sex; and sexual orientation). In particular, the council must have 'due regard' to the public sector equality duty when taking any decisions on service changes. The review of NHS CHC will ensure that the above protected characteristics are embedded in systems, processes and practice to ensure positive service user outcomes.

Resource implications

21. There are no resource implications associated with the recommendation. If the committee makes any recommendations the resource implications of those recommendations will inform a decision by the executive or CCG about a response to those recommendations.

22. There are no resource implications associated with delivering the action plan as it is seeking adherence to the revised national Framework and improved practice guidance

23. The Review Report identified that Herefordshire CCG spend on CHC for 2016/17 was £12.1m and the forecast for 2017/18 was £11.6m. This forecast reduction in expenditure was in contrast to increased demand being seen across the system, so suggests an apparent shift in the numbers eligible for CHC which would have impacts for individuals but equally the Council in terms of funding responsibilities.

24. The review coincided with a national revision of the CHC Framework due to many health and social care systems experiencing challenges in terms of application of the framework. The review analysed CHC data, both locally, regionally and with comparator CCG's, developed an understanding amongst staff, looked at trends over an 18 month period and has taken a view with regard to relationships between the Council and the CCG. The review has identified recommendations to support the case for change and to assure continuous improvements. By implementing these recommendations and adhering to the revised national framework, there may well be a shift in numbers eligible for CHC, but this will be a by-product of applying the policy correctly and in a timely manner.

Legal implications

25. It is a function of the committee to:
    - make reports or recommendations to the executive with respect to the discharge of any functions which are the responsibility of the executive; and
    - to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised

Further information on the subject of this report is available from
Robert Vickers, email: Robert.Vickers2@herefordshire.gov.uk

26. Section 1 National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) requires the Secretary of State to continue the promotion in England of a comprehensive health service, designed to secure improvement a) in the physical and mental health of the people in England and b) in the prevention, diagnosis and treatment of illness.

27. Section 3 of the 2006 Act requires CCGs to provide a range of services, to such an extent as they consider necessary to meet all reasonable requirements.

28. As stated in paragraph 9 of this report there is a 'limit to social care' under the Care Act 2014. Section 22 of the Act provides that if a person has needs above a certain level (referred to as the Coughlan criteria, following the Court of Appeal judgement in R v North and East Devon Health Authority ex parte Pamela Coughlan 1999), it is unlawful for social services to fund their care and all their health and social care needs must be funded by the NHS.

29. Statutory Guidance to the Act under the heading NHS Continuing Care states that "if following an assessment, a person is not found to be eligible for NHS CHC, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part funding the package of support. A joint package of care could include NHS funded nursing care and other NHS services that are beyond the powers of a Local Authority to meet".

30. The recommendations of the report ensure that the council continues to comply with its statutory duties under the Care Act 2014 and associated Statutory Guidance.

Risk management

Risk Opportunity	Risk Mitigation
That local health and social care systems are not adhering to the national continuing healthcare framework as revised.	An independent review has been completed into the application and operation of continuing healthcare within Herefordshire to establish a shared understanding.
The review has resulted in a joint Action Plan, which when delivered will ensure adherence to the national revised framework. However a risk remains that the parties to the review do not implement the action plan as agreed within the timescales and resources available leading to reputational risks, legal challenge and escalation and a shunting of costs.	The Council and the CCG have established a Senior Officer Steering Group to oversee the progression of the Action Plan, to develop and implement a Dispute Resolution Policy and to ensure adherence to the national framework and shared decision making.

Consultees

31. None.

Appendices

Appendix 1 Review Report Slide Deck

Appendix 2 Review Report Recommendations Action Plan

Appendix 3 Herefordshire CCG benchmark against recognised statistical neighbours CHC Eligibility

Background papers

None identified

Further information on the subject of this report is available from
Robert Vickers, email: Robert.Vickers2@herefordshire.gov.uk

APPENDIX 1

Herefordshire Continuing Healthcare Review Final Report

June 2018

Angela Parry

APRA Management Ltd

Herefordshire Council

Apra

NHS Herefordshire Clinical Commissioning Group

Aims

- What is the CHC in Herefordshire – how are we doing?
  - Analyse CHC data - local and regional
  - Understanding amongst staff
  - Relationships across CCG and Council
  - Trends over 18 months
- Identify any case for change
- Can we make improvements to the process?
- Can we improve our relationships?
- Recommendations for the way forward

CHC Review Project

Herefordshire Council

Apra

NHS Herefordshire Clinical Commissioning Group

Data analysis & Local Interviews

National Picture

Local Picture over an 18 month period

- Data taken from national quarterly benchmarking information reported to NHSE and reported regionally

Interviews:

- ASC Staff
- Children's Services
- Performance
- Finance
- CHC Team (CCG)

Findings and Observations

Recommendations

Herefordshire Council
Apra
NHS Herefordshire Clinical Commissioning Group

National Picture

National Picture

This local review was carried out during a period of national discussion about the future of CHC and took into account the changes due in October 2018 (see slides 9 and 10) as part of the recommendations. However, the national picture at the time was as follows:

High number of assessments and screenings being conducted that do not lead to eligibility for CHC

- In 2015/16 77,000 people were assessed for CHC
- Of those assessed, 26% were deemed as eligible.

The level at which the Checklist threshold is set

- 86% of CCG staff surveyed thought the Checklist threshold was too low, resulting in screenings that could have been avoided and patients' expectations being raised.
- Completing the screening process could raise the expectations of individuals and their families that they are eligible for CHC when they are actually far from eligibility

The impact of the location in which individuals are screened for CHC

- That same data shows that 80% of respondents thought that the setting of the screening has an impact on the outcome. It is deemed as good practice to avoid carrying out the DST in an acute setting.
- Recovery, recuperation and rehabilitation is required before screening and assessment for long-term care needs to take place.

A variation in training across the country

- Data shows that training is not well co-ordinated (for both CCG and Social Care staff with regard to the checklist and the DST.

Issues with the challenges to individual decisions process

- There is evidence of a lack of clarity and consistency around the process, and distress is being caused to individuals and their families or carers as a result.

A lack of clarity around the three and twelve month review purpose and processes

- There is evidence of variation in the review processes and inconsistency and stakeholders have called for more clarity from the National Framework.

Background – Duties 1

- 'NHS Continuing Healthcare' (CHC) means a package of continuing care that is arranged and funded solely by the NHS as part of the duty to provide healthcare services. It applies where the individual is assessed as having a primary health need.
- Assessments and decision making about eligibility for CHC will be undertaken within 28 days of the completion of the CHC Checklist to ensure individuals receive the care they require in the appropriate environment and without unreasonable delay.
- The CCG will arrange for an assessment by a multi-disciplinary team, and the DST will be completed and used to inform the decision about whether the individual has a primary healthcare need. The decision as to whether or not a person meets the criteria for CHC will be made by the team.
- Ratification ensures the DST is completed fully, in accordance with the National Framework, supported by robust clinical evidence and completed in an appropriate manner. Ensures that the DST has a clearly stated recommendation from the MDT and seeks further clarification as required.
- Where an individual qualifies for CHC the NHS funds and delivers both health and social care services to the patient.

Background – Duties 2

- Local Authorities have duty to assess anyone who appears to be in need of community care services and to notify the CCG if someone may need health provision.
- NHS bodies should notify local authorities if there is a potential need for community care services.
- CCGs are required to provide care/after care for people who are/have suffered from illness, if considered appropriate for NHS treatment.
- The National Assistance Act 1948 prohibits local authorities from making provision that is 'authorised or required' to be provided by the NHS and the Health & Social Care Act 2001 prohibits LAs from providing registered nursing.
- Balance between LA and CCG responsibilities has been subject of key court judgments.
- The CCG is responsible for all aspects of commissioning for those eligible for CHC, including securing ongoing case management for those in receipt of CHC
- The CCG is responsible for monitoring quality, access and patient experience in the context of provider performance
- CCGs should take a strategic as well as an individual approach to commissioning. There is an expectation of partnership working between LAs and CCGs.

Background – Primary Health Need

A 'primary health need' defines who is eligible for CHC.

A person is judged as having a primary health need through a CHC assessment, which looks at the totality of a person's relevant needs in order to then determine whether overall the needs, risks and care interventions are health needs. These are measured against the following criteria:

- **Nature**: the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity**: both the extent ('quantity') and severity ('degree') of the needs and the support required to meet them, including the need for sustained/ongoing care ('continuity').
- **Complexity**: this is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.
- **Unpredictability:** the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

Defining whether somebody has a 'primary health need' is complex. The professionals involved make a judgement based on the comprehensive evidence considered and the use of the Decision Support Tool to analyses the evidence in a consistent manner. Due to this complexity, however, both patients and professionals sometimes find the concept of a 'primary health need' difficult to interpret and understand.

Changes to CHC guidance from October 2018

Local Dispute Resolution

- The revised Framework includes a requirement that all CCGs must have a local resolution process for resolving disputes about eligibility with individuals.
  - CCGs must develop, deliver, and publish a process that is fair and transparent, including applicable timescales. The aim is to resolve such disputes earlier, and more consistently.
  - Local resolution procedures should include a two stage local resolution process, including an informal discussion, followed by a formal meeting if necessary.
  - Individuals must receive clear and comprehensive explanations of the rationale for the CCG's decision, even if this does not result in a change in the original decision.

Discharge to Assess

- The majority of CHC assessments should take place outside of acute hospital settings; to support accurate assessments and to reduce unnecessary stays in hospital.
  - To reinforce this, advice is given that it should not be usual practice for an individual to be discharged directly from hospital into long term residential care.
- Further guidance is provided about the circumstances in which individuals do not need to be screened for CHC in an effort to reduce unnecessary assessments and provide greater clarity in this area.
  - CCGs must consider the provision of additional NHS services to support individuals until they are appropriately assessed for CHC, however the revised Framework sets out that if the individual can be safely discharged to an existing care package this should take place under existing commissioning arrangements. Reimbursement would be backdated to the date of discharge if the individual was subsequently deemed eligible for CHC.

Changes to CHC guidance from October 2018

Reviews

- There is now a clear focus on reviews being primarily to check that the patient's care package is working well, not on reviewing eligibility. Eligibility should only be reviewed if the CCG can demonstrate that the needs have substantially changed. Where eligibility reviews are carried out, they must – like the first full assessment – involve a multidisciplinary team and use the Decision Support Tool.

MDTs

- The **make-up of the multidisciplinary team has been clarified**, clarifying that the assessment co-ordinator (usually the 'nurse assessor') must not dominate proceedings. Instead, the whole process must be multidisciplinary throughout.

The Care Act

- The Framework has been updated to reflect the implementation of the Care Act 2014. As such, it makes clear that the eligibility criteria must be applied to everyone equally, regardless of where they receive their care.
- The definition of a social care need has been updated in alignment with the Care Act 2014, making it clearer and narrower. This should make it easier to make the important distinction of when a care need is 'social' or 'health', and to judge whether the health needs of the patient are more than incidental or ancillary to their social care needs and therefore count as 'primary health needs'.

Clarity on top-ups

- The update makes it clear that it is the responsibility of CCGs to meet assessed health and wellbeing needs in full. It also provides guidance around the very limited circumstances in which patients can legitimately pay a top-up, i.e. for non-needs-based services such as hairdressing.

CCG Responsibility

It has been made clear that where CHC processes are outsourced to Commissioning Support Units, CCGs remain responsible for all decisions of eligibility.

Local Picture

Local Picture

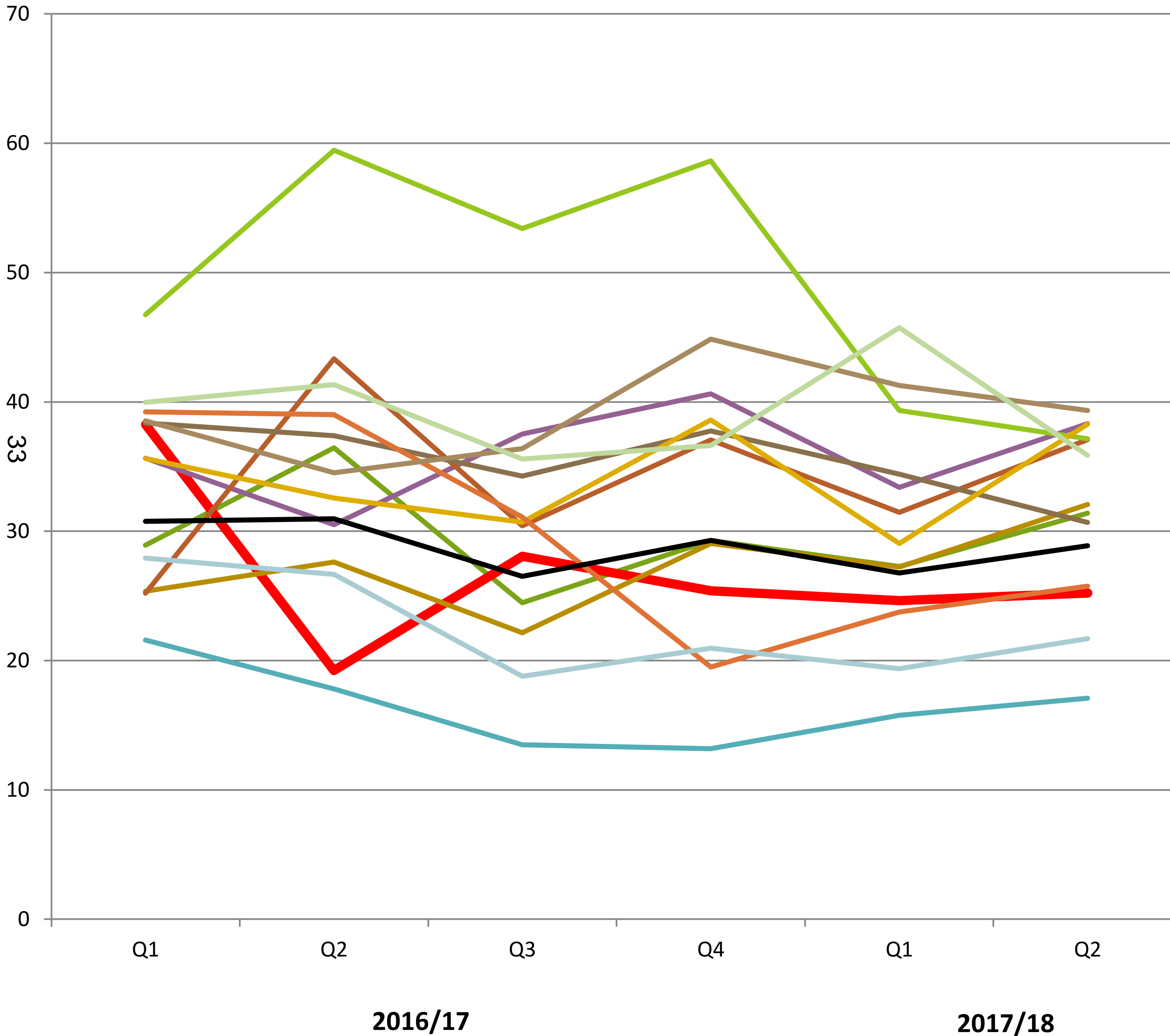
The review was asked to consider:

- Checklist activity
- Newly eligible CHC patients
- Total CHC numbers
- FNC vs CHC
- Overall CHC financial picture
- Relationships across the system
- Positive practice
- Challenges that have arisen

The review was not asked to consider:

- The detail of specific, disputed cases
- The Appeals process
- How decisions have been reached across the system
- A detailed review of the cost of care across the health and social care market

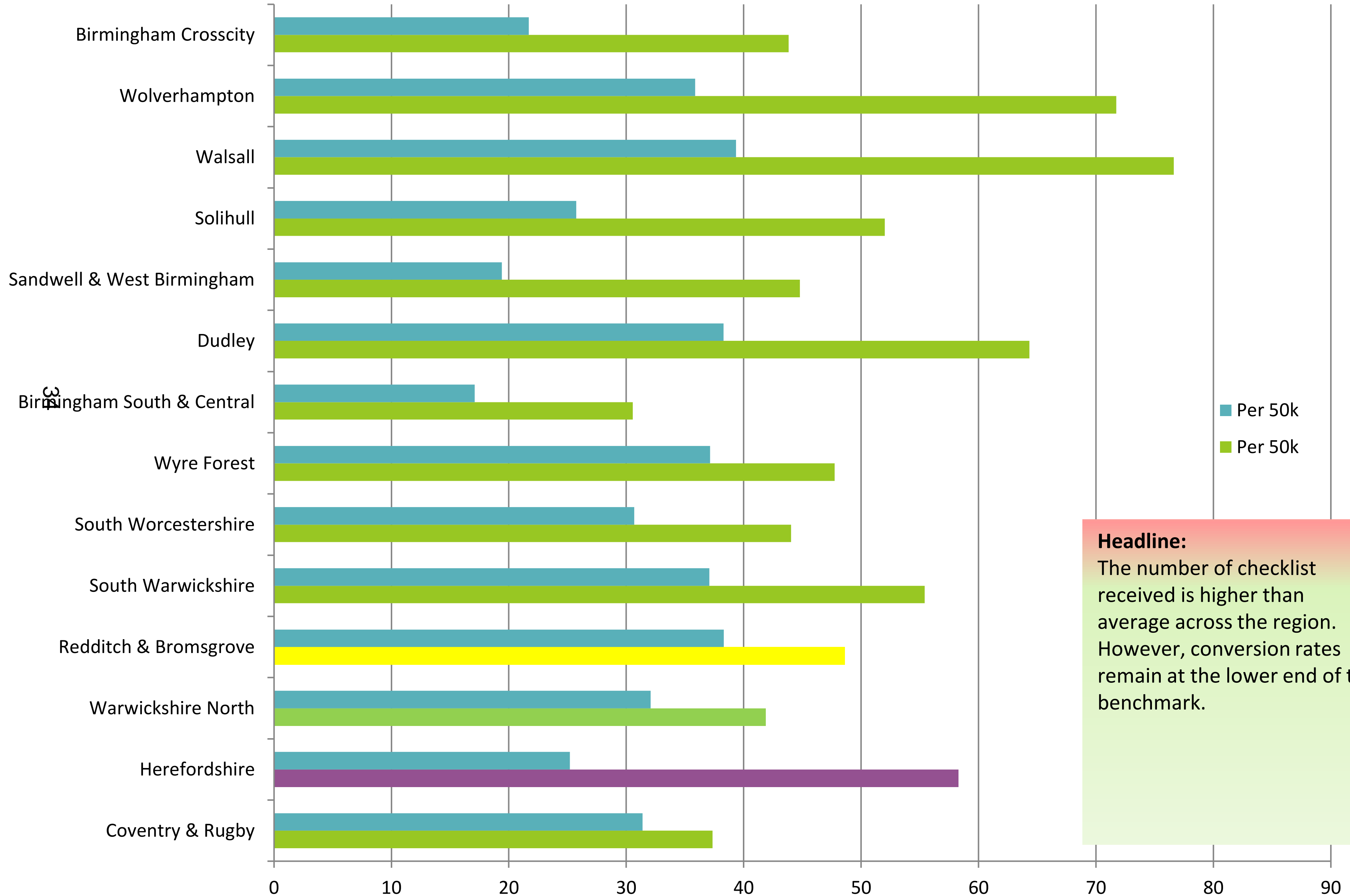
CHC newly eligible cases (per 50k of population) - Regional



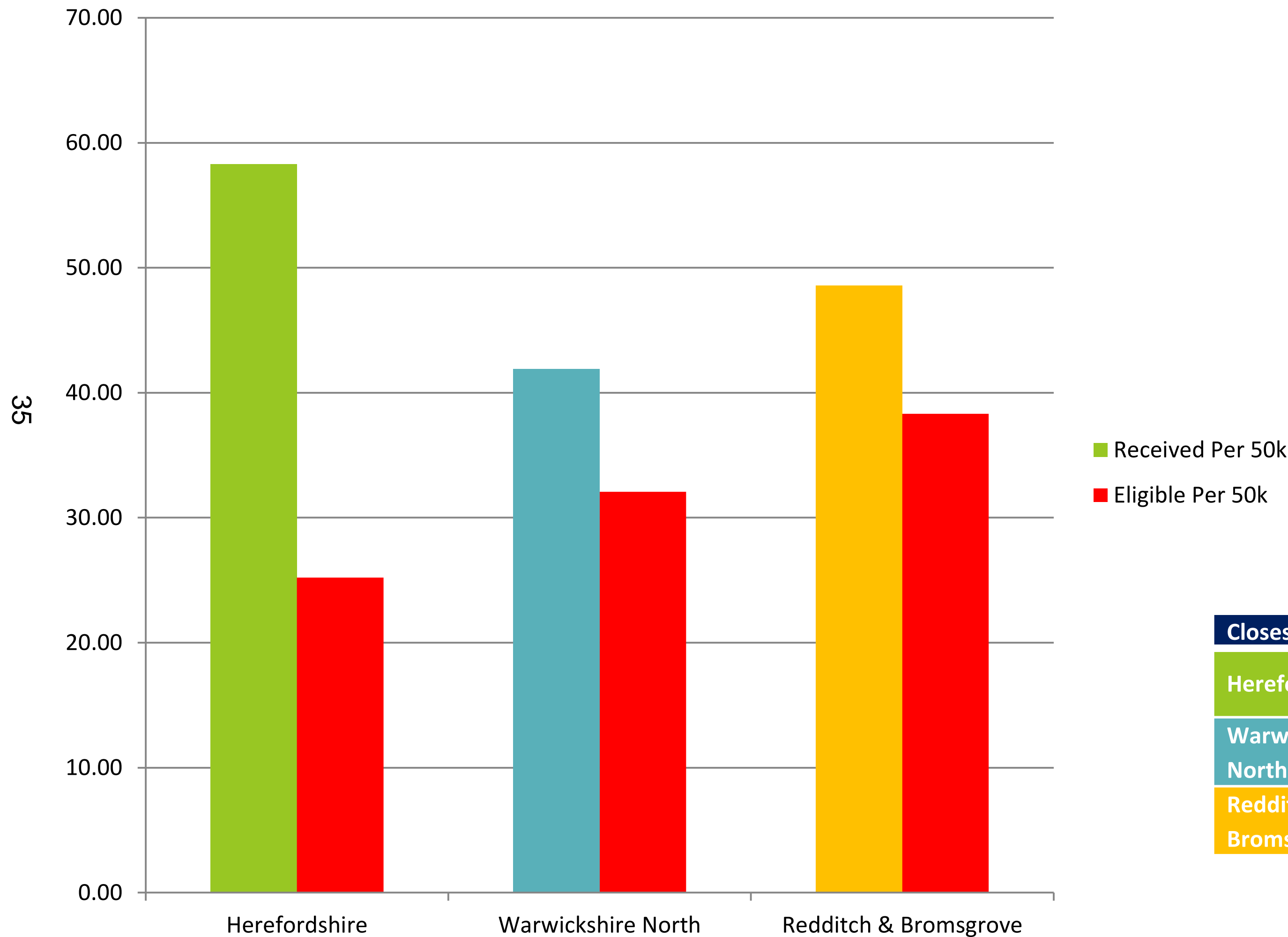
Headline:
Over the 18 month period, the number of new CHC eligible patients has fallen significantly in Herefordshire, from 38.53 to 25.21 (closer to regional average)
Regional average has remained broadly similar – 30.76 to 28.87.

- Coventry & Rugby
- Herefordshire
- Warwickshire North
- Redditch & Bromsgrove
- South Warwickshire
- South Worcestershire
- Wyre Forest
- Birmingham South & Central
- Dudley
- Solihull
- Walsall
- Wolverhampton
- Birmingham Crosscity
- West Midlands

Checklists Received Per 50k Converted to CHC (Q2 17/18) in Region



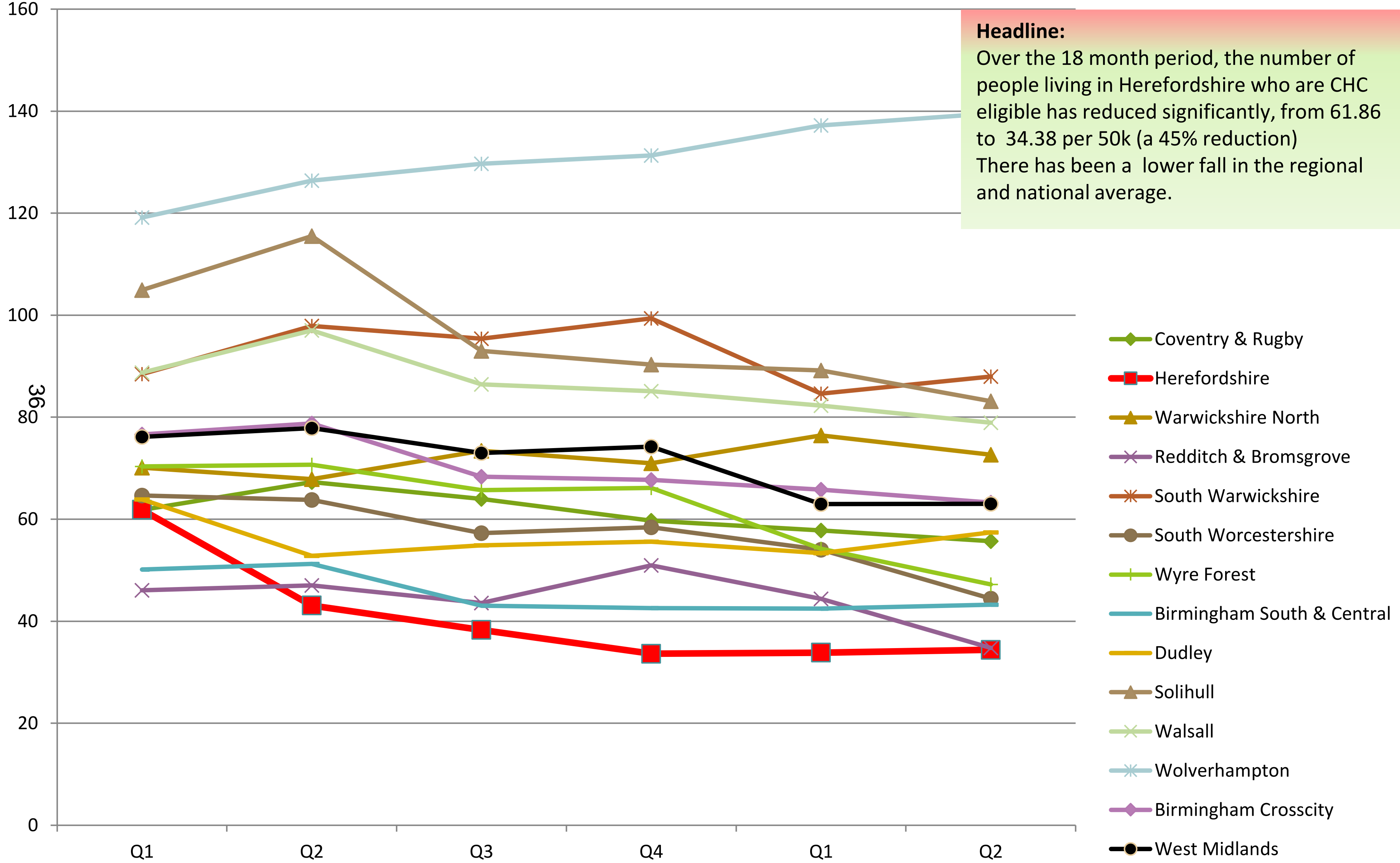
Checklists Received Per 50k Converted to CHC (Q2 17/18) Closest CCG neighbours by population



Headline:
The most recent data shows that Herefordshire has a higher number of referrals than its closest neighbours by population. It has a low number of CHC eligible patients.
This is consistent with the view of both CCG and ASC staff.

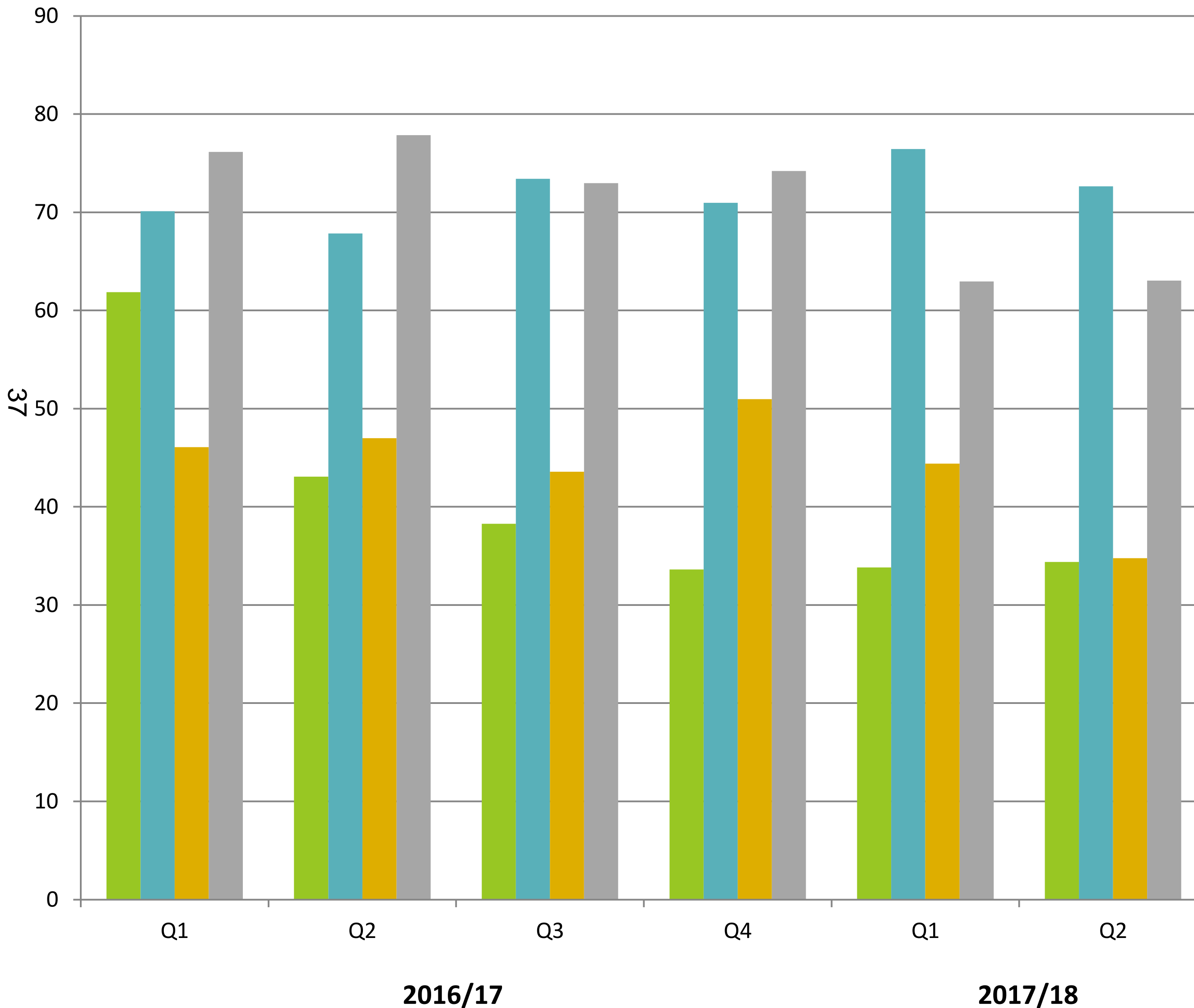
Closest CCG Population	
Herefordshire	**181,500**
Warwickshire North	**182,600**
Redditch & Bromsgrove	**170,800**

Individuals eligible for NHS CHC (Standard NHS CHC and Fast Track) at quarter end per 50,000



*Sandwell and West Birmingham – data error. Unavailable

Eligible for NHS CHC (Standard NHS CHC & Fast Track) at quarter end per 50,000



Headline:
Herefordshire was in line with its closest neighbour in terms of population at the beginning of the period. Numbers of CHC eligible patients were broadly similar.

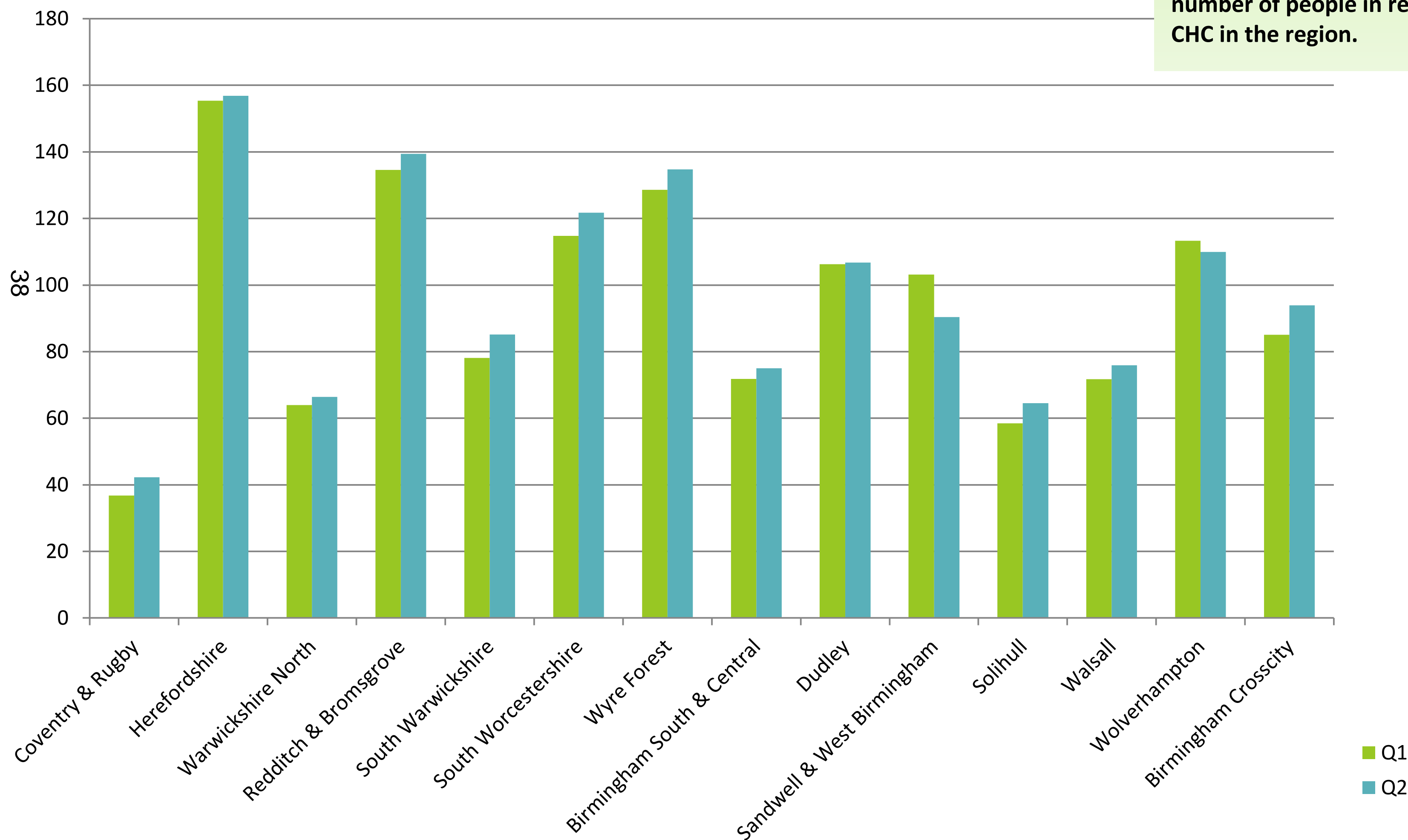
Over 18 months, it has seen the largest decrease in numbers and remains the CCG area with the lowest number of people eligible (per 50k) for CHC funding in the West Midlands Region.

Closest CCG Population	
Herefordshire	181,500
Warwickshire North	182,600
Redditch & Bromsgrove	170,800
West Midlands Average	N/A

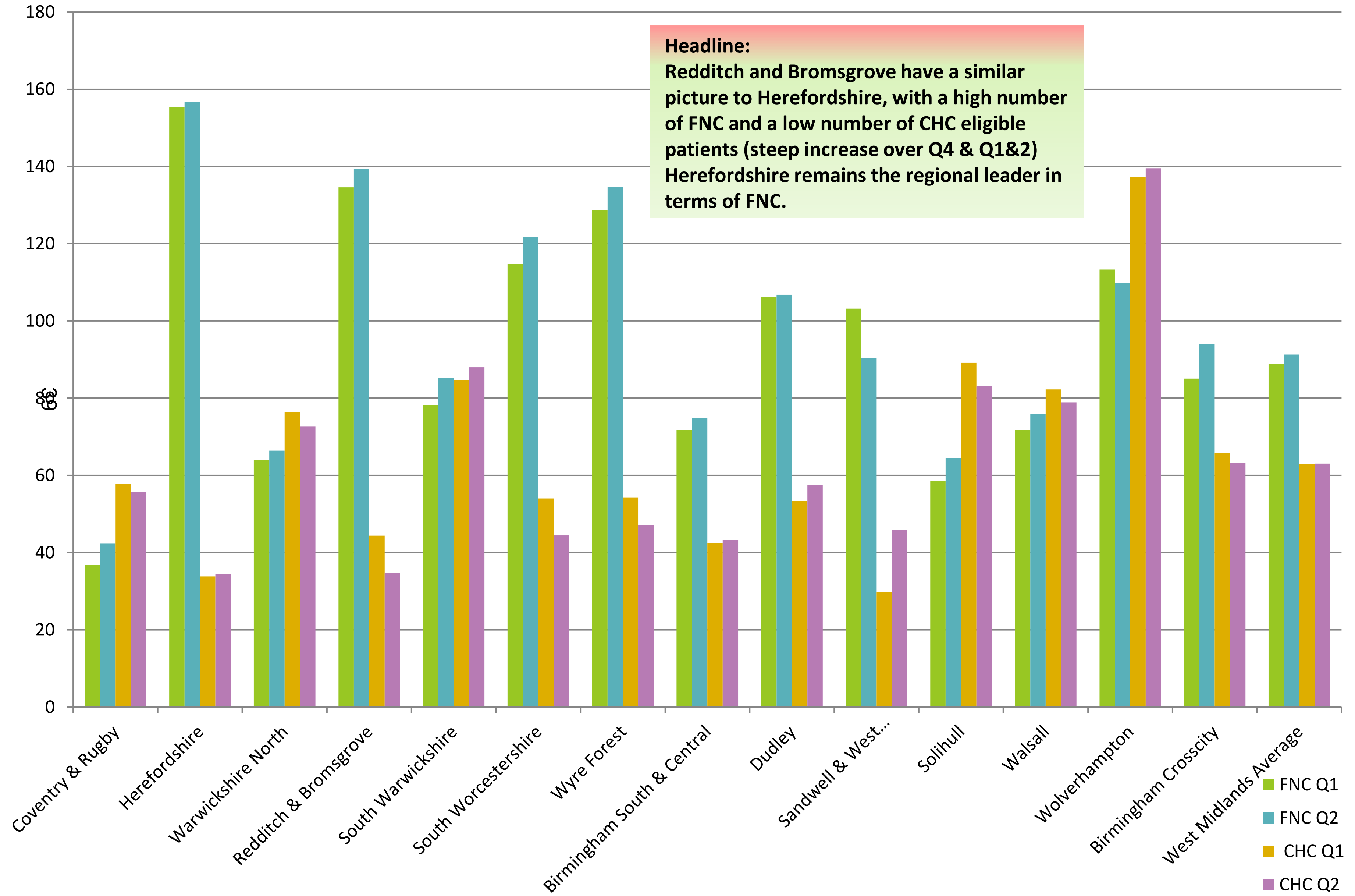
NHS Funded Nursing Care 2017/18 per 50k population- Regional

Current averages per 50k:
National: 85.96
West Midlands: 91.27
Herefordshire:: 156.83

Headline:
Herefordshire has a high number of patients in receipt of Funded Nursing Care (FNC). This could help to explain why Herefordshire has the lowest number of people in receipt of CHC in the region.

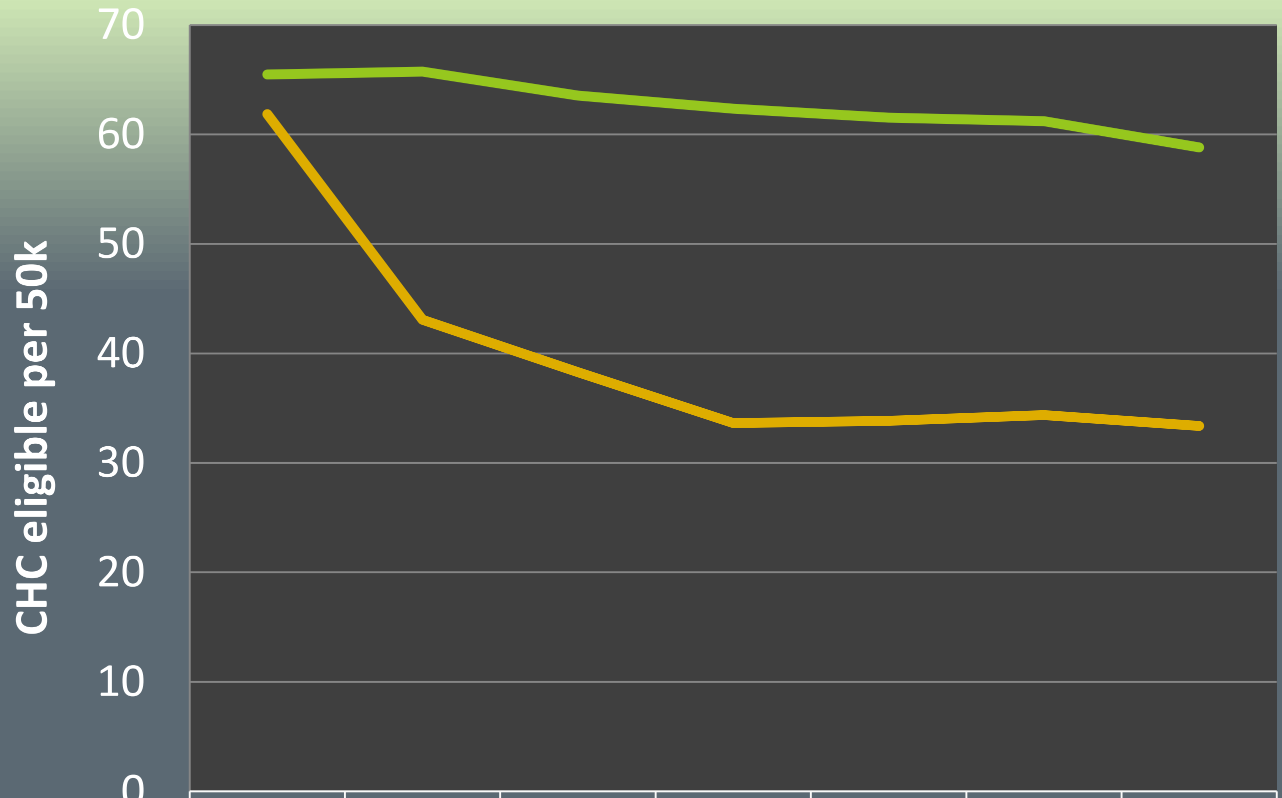


CHC vs FNC - Regional



Hereford CHC in the National Context

Headline:
Herefordshire has historically been below average when benchmarked against the national data set. Nationally, there has been a slight dip in CHC eligibility and Q3 17/18 shows that Hereford has its lowest number eligible since the start of the review period.

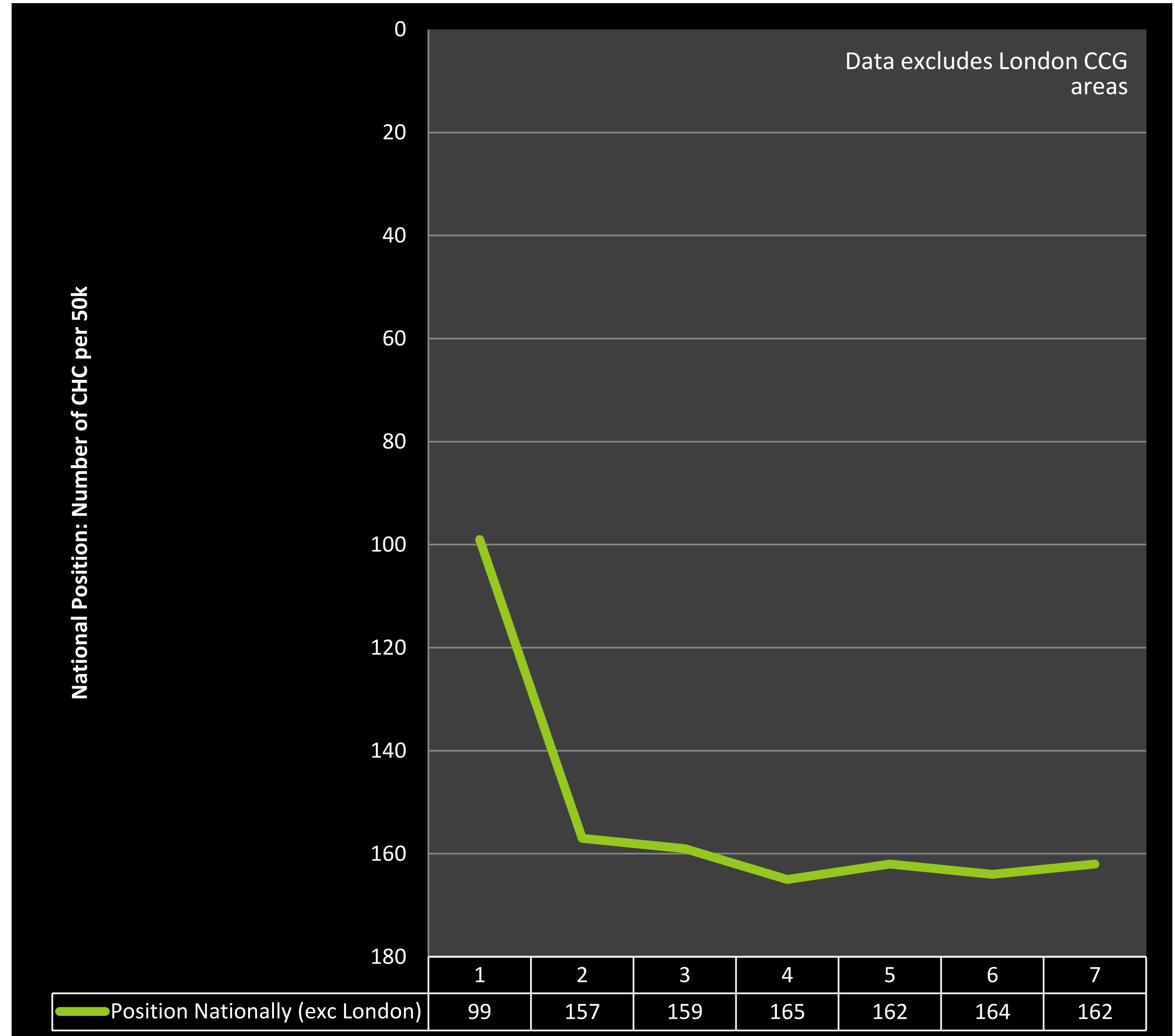


	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
England - average per 50k	65.47	65.73	63.54	62.3	61.54	61.22	58.82
Hereford CHC per 50k of population	61.86	43.07	38.28	33.62	33.84	34.38	33.37

Herefordshire CHC in the National Context – 177 CCG areas

Headlines:

1. **Herefordshire has fallen from 99th to 162nd in England, in terms of the number of people per 50k of population, who are eligible for CHC funding.**
2. **This is surprising; in England, in terms of population, Herefordshire is:**
   i) in the top quartile for population over the age of 65 – 63/293 – 24% (above national average)
   and
   ii) top third for population over the age of 85 – 78/293 – 4% (also above national average) *



	1	2	3	4	5	6	7
Position Nationally (exc London)	99	157	159	165	162	164	162

* Source: Office for National Statistics - Overview of the UK population: July 2017

Conversations with CCG Staff

	2015/16	2016/17	2017/18			
	Year End	Year End	Q1	Q2	Q3	+/-
CHC Fastrack Cases Eligible	71	14	18	19	19	-52
CHC Non Fast track Eligible	110	88	87	86	83	-27
Residential	104	59	64		59	-45
Non Residential	77	43	41		43	-34
Total CHC Funded	181	102	105	105	102	-79
Joint Funders	53	55	68	68	61	+8
Total funded (full and joint)	234	157	173	173	163	-71
Trend in funded placements	N/A	-77	+16	0	-10	
	N/A	**DOWN**	**UP**	**SAME**	**DOWN**	

Review observations and findings 1

- CCG maintain that there is a high number of inappropriate CHC checklist referrals
  - Referrals were lower than regional average in Q1, but increased in Q2 (above national and regional average) – this is consistent with CCG view, as interviews took place towards the end of Q2.
  - ASC accept that there is limited understanding of CHC criteria amongst some frontline staff
- Trust between the two organisations is good at a personal level, however, with regard to CHC, there is concern from both organisations re: lack of understanding of values, priority outcomes and patient/service user need.
- CCG lead the CHC process, at front line level with regard to referrals and decisions, which is as it should be; however there is a need for more engagement and joint working throughout the process.
- There is a good relationship, at senior leadership level, between the two organisations
- It is agreed across both organisations that there is a firm approach CHC
  - "very robust" according to the CCG
  - "hard line" according to the Council
  - decisions and disagreements can cause difficulties for front line relationships and therefore could compromise patient care.
- ASC accept that there may be some inconsistencies in relation to checklists, but maintain that more consideration needs to be given to their view

Review observations and findings 2

- DSTs are not consistently agreed via a panel process. Although the decision is made in good faith by CCG staff, ASC staff do not always have involvement.
- There are trust issues with regard to “independence” when a decision is made; this is due to the large reduction in CHC eligibility decisions over the last 18 months
- DSTs carried out in acute settings - from 33% in Q1 down to 16% in Q2 – This is good practice and should be maintained. This practice may have impacted on eligibility figures, as people can be assessed as eligible when in crisis in an acute setting, incorrectly.
- CHC nurses were more concerned about inappropriate community hospital checklists and are concerned that they are not recorded as DSTs in an “acute setting”
- There are a number of assumptions made about the CHC pathway in Herefordshire re: knowledge, skills and budgets – this is not discussed across the organisations in any formalised way
- Number of people newly eligible for CHC remains slightly below regional average
- Number of people eligible for CHC funding in Herefordshire remains the lowest in the region

Review observations and findings 3

- High numbers of FNC eligible patients show that there is need for health funding; it is the complexity of the individual and the level of funding that is being questioned
- There have been no large fluctuations in numbers of home care or residential placements for older people over the period. However, there has been no real reduction, even with the changes to front door policy and demand management.
- There is concern that there has been a reduction to CHC eligibility within the self funding population – further information/evidence needed
- CCG colleagues agree that there has been a change in the CHC process in Herefordshire. For the period assessed, CHC nurses have been applying the guidance more rigorously than before
- CCG colleagues accept that changes to practice went ahead without ongoing discussion with the Council which may have resulted in budgetary implications and relationship difficulties
- There is limited health funding awarded to children in Herefordshire. This is seen to have an impact on transitions and ultimately to adult services, not just with regard to funding packages, but to SW support teams

In Quarter 3

- DSTs in a hospital setting – 13% (National Average 19%)
- 10% of the 48 non fast track cases assessed were found to be eligible for CHC (National Average 26%)
- Similar numbers of cases ineligible matched the number eligible in the quarter

Recommendations 1

Proposed Action for Herefordshire County Council and Herefordshire CCG

A clear action plan and agreed governance across the key organisations should be in place to implement the following:

Reform and redesign of the CHC Pathway

1. Joint redesign of the pathway with local partners (health, social care, voluntary sector)
2. Issues to be raised and resolved in a workshop format – look at our culture and understand how each organisation operates
3. Local CHC protocol to be devised and implemented (as per revised CHC guidance)
4. Clear escalation process when decisions are disputed (in process, to be finalised)
5. CHC Ratification Panel to be agreed, terms of reference to be reviewed and attended by key ASC and CCG staff
6. Discuss the possibility of rotation of Chair or develop a Vice Chair role
7. Finance/performance to report on trends to a joint quarterly meeting to form an overview of the impact of any changes in process or practice
8. Match and understand local and regional data with national data on a quarterly basis (across both organisations)
9. Continued and continuously improved advice and information to self funders and families about the process (particularly in care homes)
10. Consider the potential of implementing a “Trusted Assessor Model”
11. Monitoring and action re: high profile delays
12. Clarity from the CCG that there has been change to the CHC approach in Herefordshire and clarity for the Council as to where, within the process, this change has taken place. This will give the Council and understanding of why numbers have fallen so dramatically.

Recommendations 2

Proposed Action for Herefordshire County Council and Herefordshire CCG

20. Embed SW professionals to be embedded within the CHC team
    - Consider CHC funding for one SW to permanently sit within the team (guidance is clear that all management is funded by the CCG
    - Consider rotating nurses and SWs through both SW and CHC teams to encourage a “team” culture across disciplines

12. Clear recording re: H@H – how many cases are diverted away from CHC and what is the ongoing impact

13. CCG to investigate reasons for reduced CHC eligibility (bottom quartile) whilst population trends place the county in the top quartile of +65s and top third of +85s

14. Incorporate a person centred approach to CHC package planning (July 2017 Skills for Health – Framework) in order to remove concerns when service users move to full CCG package care

15. Independent desktop reviews of contested DSTs and of a set number each quarter (dip sampling)
    - This will ensure that there is agreement between both parties re: application of the guidance

16. Joint DST workshops for joint learning and a consistent approach

17. Note takers/ admin who can independently minute key meetings (example: safeguarding)

18. Continue the good work re: reducing acute setting assessment and remove CHC screening from hospitals too
    - Develop a local tool to decide health or social care pathways out of hospital (Norfolk 5Qs?)
    - Clarity around what an acute setting is in Herefordshire – e.g. community hospitals

Recommendations 3

Proposed Action for Herefordshire County Council and Herefordshire CCG

19. Regular commissioning reviews of high cost packages (also for CHC funded packages) that focus on the package rather than eligibility (as per new CHC guidance)
20. Training

    Training for key ASC staff who attend MDT meetings
    - Non clinical CHC Guidance (social work perspective)
    - Joint training re: DST to be provided by agreed trainers
    - Joint training re: Outcomes and Person Centred Care
21. Management of the CHC team and pathway to sit within the CCG (rather than CSU) to offer a more localised approach to CHC and to package management and to address some of the perceptions around the local CHC team. It has been made clear in the new guidance that where CHC processes are outsourced to Commissioning Support Units, CCGs remain responsible for all decisions of eligibility. It would make sense for the team to sit within the CCG for this reason.
22. CCG to test cases where FNC has been awarded with regard to complexity to ensure confidence with regard to high numbers of FNC eligibility and to take a joint approach with HCC on scope and findings
23. Review the understanding of “managed need” across the organisations (with independent support) to reach a common understanding
24. Review the understanding of “double scoring” within domains (with independent support) to reach a common understanding
    - Primary Health Need is about whether the totality of a person’s health needs are more than incidental or ancillary to their social care needs – regardless of whether arbitrary thresholds are met.

NHS Herefordshire

DRAFT V2

Continuing Healthcare Review July 2017

Action Plan

Executive lead	HCCG – Helen Richardson Chief Nursing Officer	LA – Steven Vickers Director of Adults Social Services
Operational Lead	Nicky Warman Lead Nurse CHC	Robert Vickers Assistant Director of Adults Social Services

Issue	Action	Lead	Completion date
1. Recommendations from Joint Review Report			
Joint redesign of the pathway with local partners (health, social care, voluntary sector	Undertake joint process mapping exercise in two parts in workshop format A. Joint pathway re-design B. Process mapping internally to mirror Ops policy	HCCG	September 18
Issues to be raised and resolved in a workshop format – look at our culture and understand how each organisation operates	To be undertaken as part of previous action	HCCG	September 18
Local CHC protocol to be devised and implemented (as per revised CHC guidance	Ops Policy to be revised to reflect CHC in-housing within CCG, National Framework revisions and any process changes which happen as a result of this action plan.	HCCG	October 18

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Clear escalation process when decisions are disputed (in process, to be finalised)	Dispute Resolution Process to be finalised and agreed by CCG/ LA	HCCG/LA	August 18
CHC Ratification Panel to be agreed, Discuss the possibility of rotation of Chair or develop a Vice Chair role	Terms of reference to be reviewed and agreed	HCCG/LA	September 18
Finance/performance to report on trends monthly to a central meeting for overview of the impact of any changes in	This already occurs report is presented at finance and resource committee. Additional reports now to be presented quarterly at quality committee	HCCG	Complete
Match and understand local and regional data with national data on a quarterly basis (across both organisations)	CCG quarterly reporting to HCCG Quality committee	HCCG	Complete for HCCG
Continued advice and information to self funders and families about the process (particularly in care homes)	Post funded via BCF to provide support to patients that are self-funding	LA/HCCG	Complete
Consider the potential of implementing a "Trusted Assessor Model"	This potential development will be considered following the embedding of changes to current operational practices. To be discussed as part of STP development work to ensure consistency of approach The CCG will work with Worcestershire CCG (STP)	HCCG	October 18
Monitoring and action re: high profile delays	Already in place and reviewed weekly with CCG and reported to NHSE as part of assurance meeting To be included in regular meeting with LA	HCCG/LA	September 18
Clarity from the CCG that there has been change to the CHC approach in Herefordshire and clarity for the Council as to where, within the process, this change has taken place. This will give the Council and understanding of why	Review of processes by regional team using KLOE re eligibility Review of current processes to ensure alignment with new national framework	HCCG	October 18

DRAFT

numbers have fallen so dramatically.			
Embed SW professionals to be embedded within the CHC team ▪ Consider CHC funding for one SW to permanently sit within the team (guidance is clear that all management is funded by the CCG) ▪ Consider rotating nurses and SWs through both SW and CHC teams to encourage a “team” culture across disciplines	Review the role of the current social worker within the quality team with potential to remodel role to support CHC This recommendation is not supported by the LA	HCCG/LA LA	September 18
Clear recording re: H@H – how many cases are diverted away from CHC and what is the ongoing impact	This will be monitored as part of contact monitoring KPI at monthly contact meetings with Hospice at Home	HCCG	September 18
CCG to investigate reasons for reduced CHC eligibility (bottom quartile) whilst population trends place the county in the top quartile of +65s and top third of +85s	Review of processes by regional team using KLOE re eligibility Review of current processes to ensure alignment with new national framework All contested DST to have peer review	HCCG	October 18

DRAFT

Incorporate a person centred approach to CHC package planning (July 2017 Skills for Health – Framework) in order to remove concerns when service users move to full CCG package care	Review of current processes to ensure alignment with new national framework Review of operational policies.	HCCG	October 18
Independent desktop reviews of contested DSTs and of a set number each quarter (dip sampling) ▪ This will ensure that there is agreement between both parties re: application of the guidance	All contested DST to have peer review Additional set number of DSTs to have quarterly review Disputes policy and process agreed	HCCG	Complete Complete September 18
Joint DST workshops for joint learning and a consistent approach	Update training to be provided to all HCCG CHC and LA staff		September 18
Note takers/ admin who can independently minute key meetings (example: safeguarding)	Administration support in place	HCCG	Complete
Continue the good work re: reducing acute setting assessment and remove CHC screening from hospitals Develop a local tool to decide health or social care pathways out of hospital (Norfolk 5Qs?)	This practice is in place and further opportunities to enhance will be explored Review Norfolk 5Q in partnership with STP CHC approach	HCCG HCCG	Complete October 18

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▪ Clarity around what an acute setting is in Herefordshire – e.g. community hospitals	This work is also linked to evolving joint work allied to D2A pathway development		
Regular commissioning reviews of high cost packages (also for CHC funded packages) that focus on the package rather than eligibility (as per new CHC guidance) **Training** Training for key ASC staff who attend MDT meetings ▪ Non clinical CHC Guidance (social work perspective) ▪ Joint training re: DST to be provided by agreed trainers ▪ Joint training re: Outcomes and Person Centred Care	Jointly agreed revisions to operational process regarding reviews of high cost packages of care in line with the new National Framework LA and HCCG to agreed joint training with an agreed provider	HCCG/LA	October 18
Management of the CHC team and pathway to sit within the CCG	CHC Team management already transferred to CCG as of May 2018	May 18	Complete

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(rather than CSU) to offer a more localised approach to CHC and to package management and to address some of the perceptions around the local CHC team ▪ It has been made clear in the new guidance that where CHC processes are outsourced to Commissioning Support Units, CCGs remain responsible for all decisions of eligibility. It would make sense for the team to sit within the CCG for this reason.			
CCG to test cases where FNC has been awarded with regard to complexity to ensure confidence with regard to high numbers of FNC eligibility and to take a joint approach with HCC on scope and findings	Review of the process that is in place for the ongoing review patients in receipt of FNC	HCCG	October 18

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Review the understanding of "managed need" across the organisations (with independent support) to reach a common understanding	Update training to be provided to all HCCG CHC and LA staff with a jointly agreed training provider	HCCG/LA	September 18
Review the understanding of "double scoring" within domains (with independent support) to reach a common understanding ▪ Primary Health Need is about whether the totality of a person's health needs are more than incidental or ancillary to their social care needs – regardless of whether arbitrary thresholds are met.	Update training to be provided to all HCCG CHC and LA staff with a jointly agreed training provider	HCCG/LA	September 18

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APPENDIX 3

Herefordshire CCG benchmark against recognised statistical neighbours CHC Eligibility by 50k Population

Number per 50k

160
140
120
100
80
60
40
20
0

Quarter 1 - 2016/17
Quarter 2 - 2016/17
Quarter 3 - 2016/17
Quarter 4 - 2016/17
Quarter 1 - 2017/18
Quarter 2 - 2017/18
Quarter 3 - 2017/18
Quarter 4 - 2017/18
Quarter 1 - 2018/19

- ENGLAND
- NHS AIREDALE, WHARFEDALE AND CRAVEN CCG
- NHS BASSETLAW CCG
- NHS CANNOCK CHASE CCG
- NHS CHORLEY AND SOUTH RIBBLE CCG
- NHS DARLINGTON CCG
- NHS DUDLEY CCG
- NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG
- NHS EAST RIDING OF YORKSHIRE CCG
- NHS EASTBOURNE, HAILSHAM AND SEAFORD CCG
- NHS EREWASH CCG
- NHS FYLDE AND WYRE CCG
- NHS GREAT YARMOUTH AND WAVENEY CCG
- NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG
- NHS HARDWICK CCG
- NHS HASTINGS AND ROTHER CCG
- NHS HEREFORDSHIRE CCG
- NHS ISLE OF WIGHT CCG
- NHS LINCOLNSHIRE EAST CCG
- NHS LINCOLNSHIRE WEST CCG
- NHS MORECAMBE BAY CCG
- NHS NEWARK AND SHERWOOD CCG
- NHS NORTH CUMBRIA CCG
- NHS NORTH DERBYSHIRE CCG
- NHS NORTH DURHAM CCG
- NHS NORTH EAST ESSEX CCG
- NHS NORTH LINCOLNSHIRE CCG
- NHS NORTH NORFOLK CCG
- NHS NORTH SOMERSET CCG
- NHS NORTH STAFFORDSHIRE CCG
- NHS NORTH TYNESIDE CCG
- NHS NORTHUMBERLAND CCG
- NHS NOTTINGHAM WEST CCG
- NHS SCARBOROUGH AND RYEDALE CCG
- NHS SHROPSHIRE CCG
- NHS SOUTH DEVON AND TORBAY CCG
- NHS SOUTH KENT COAST CCG
- NHS SOUTH LINCOLNSHIRE CCG
- NHS SOUTH WEST LINCOLNSHIRE CCG
- NHS SOUTHPORT AND FORMBY CCG
- NHS VALE ROYAL CCG
- NHS WEST LANCASHIRE CCG
- NHS WEST NORFOLK CCG
- NHS WYRE FOREST CCG