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

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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

Data analysis & Local Interviews

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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

The review was asked to consider:

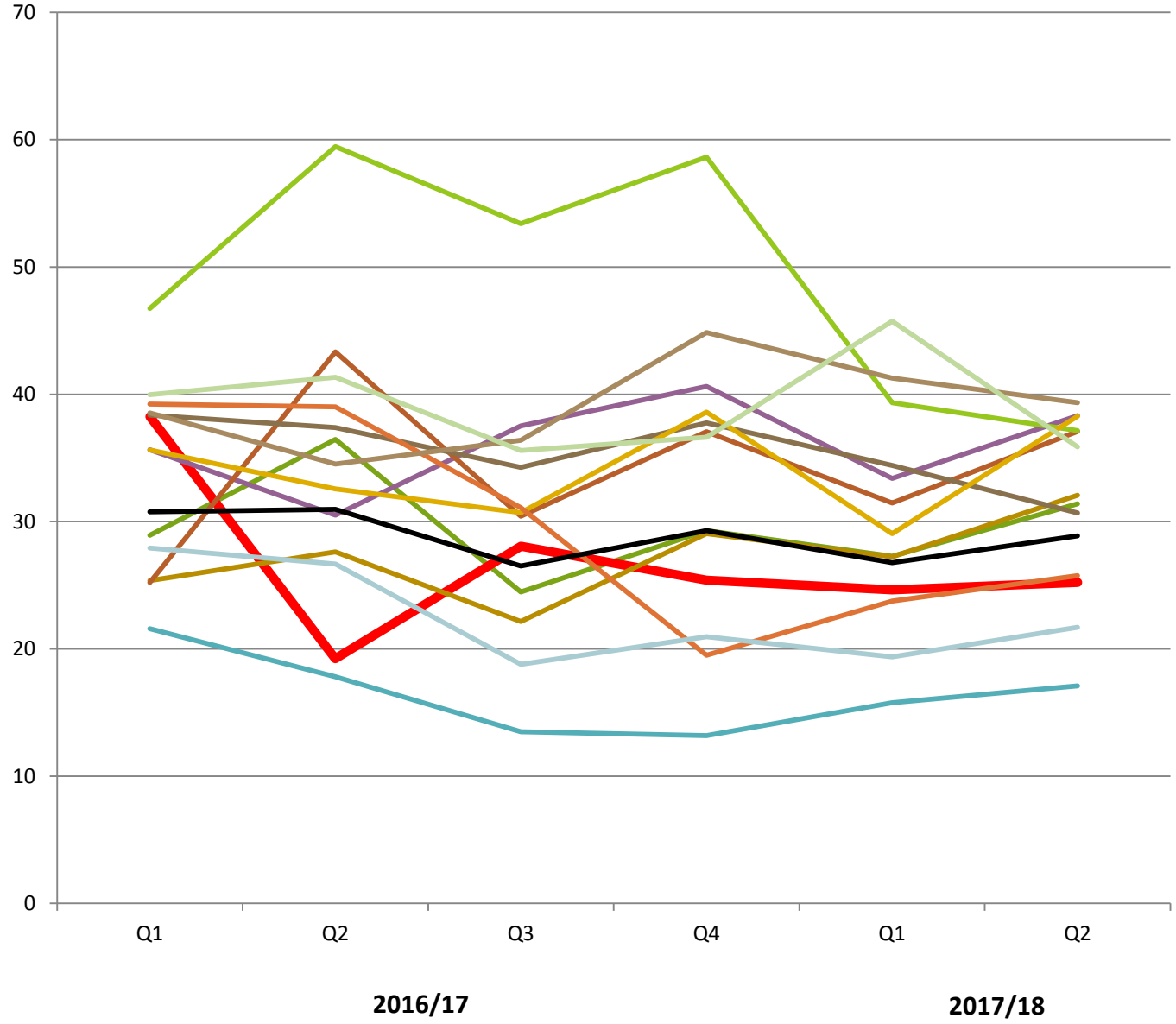
- Checklist activity
- Newly eligible CHC patients
- Total CHC numbers
- FNC vs CHC
- Overall CHC financial picture
- Relationships across the system
- Positive practice
- Challenges that have arisen

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

Local Picture

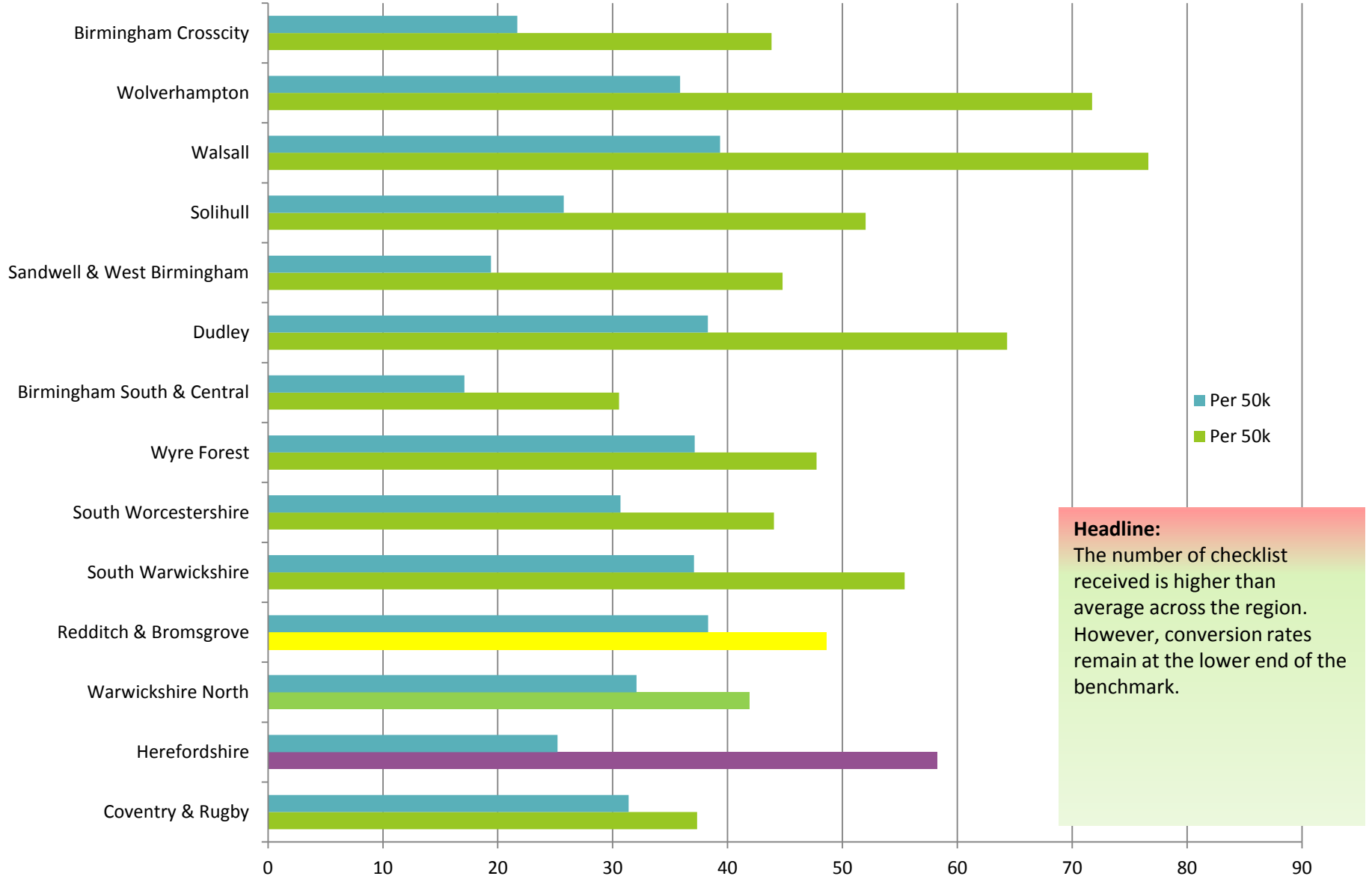
CHC newly eligible cases (per 50k of population) - Regional



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.

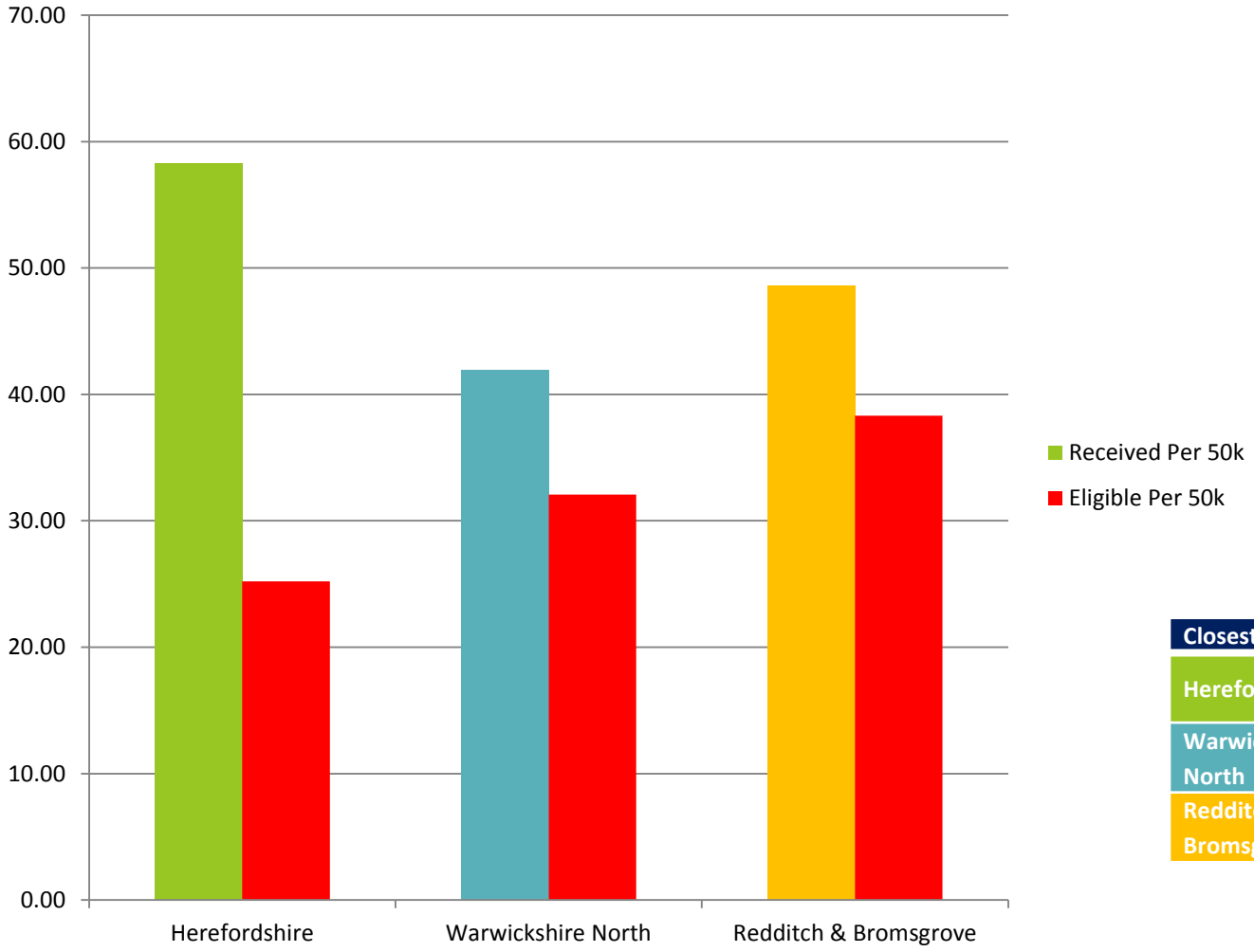
- Coventry & Rugby
- Herefordshire
- Warwickshire North
- Redditch & Bromsgrove
- South Warwickshire
- South Worcestershire
- Wyre Forest
- Birmingham South & Central
- Dudley
- Solihull
- Walsall
- Wolverhampton
- Birmingham Crosscity
- West Midlands

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



Headline:
The number of checklist received is higher than average across the region. However, conversion rates remain at the lower end of the benchmark.

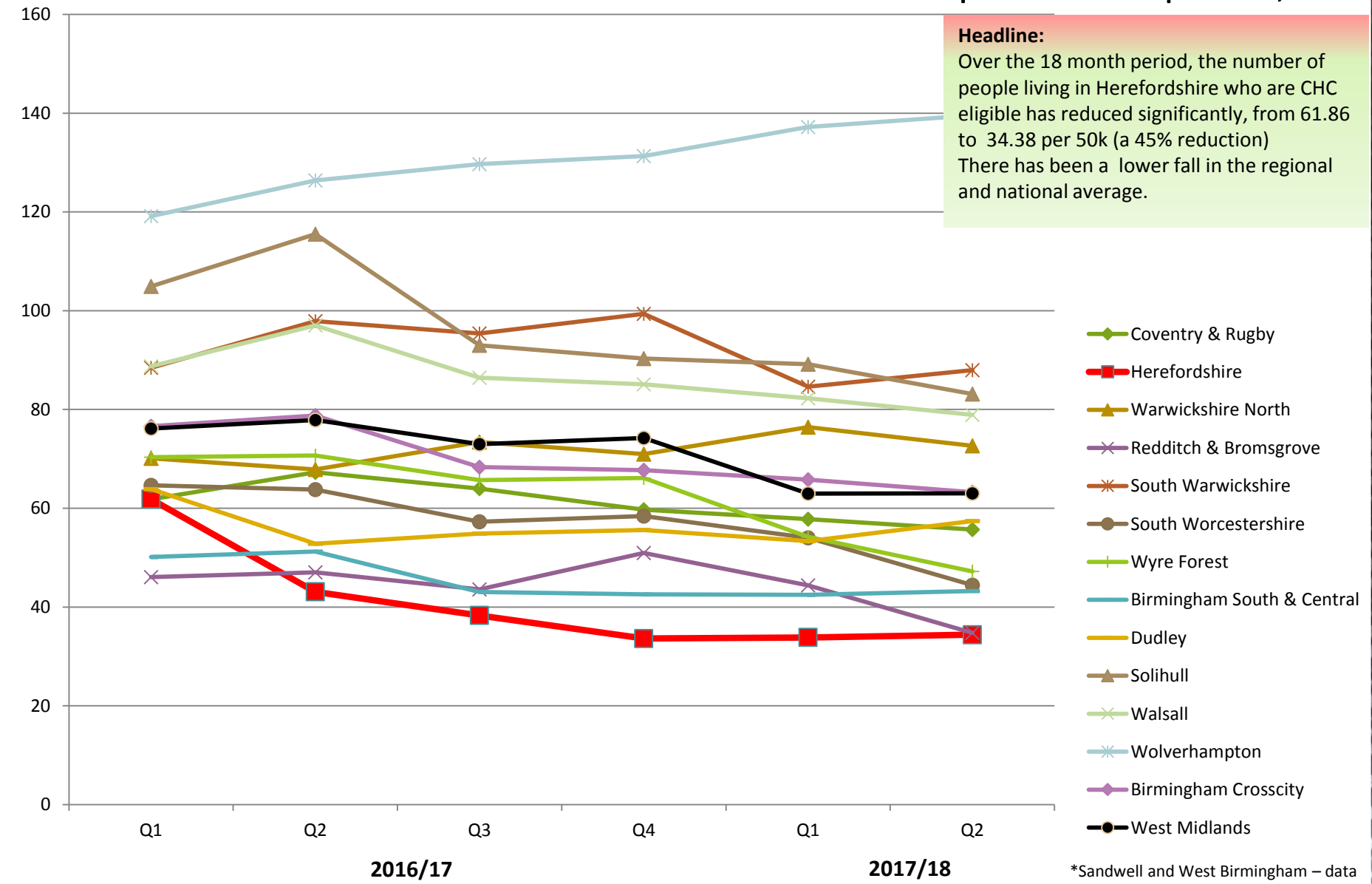
Checklists Received Per 50k Converted to CHC (Q2 17/18)
Closest CCG neighbours by population



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

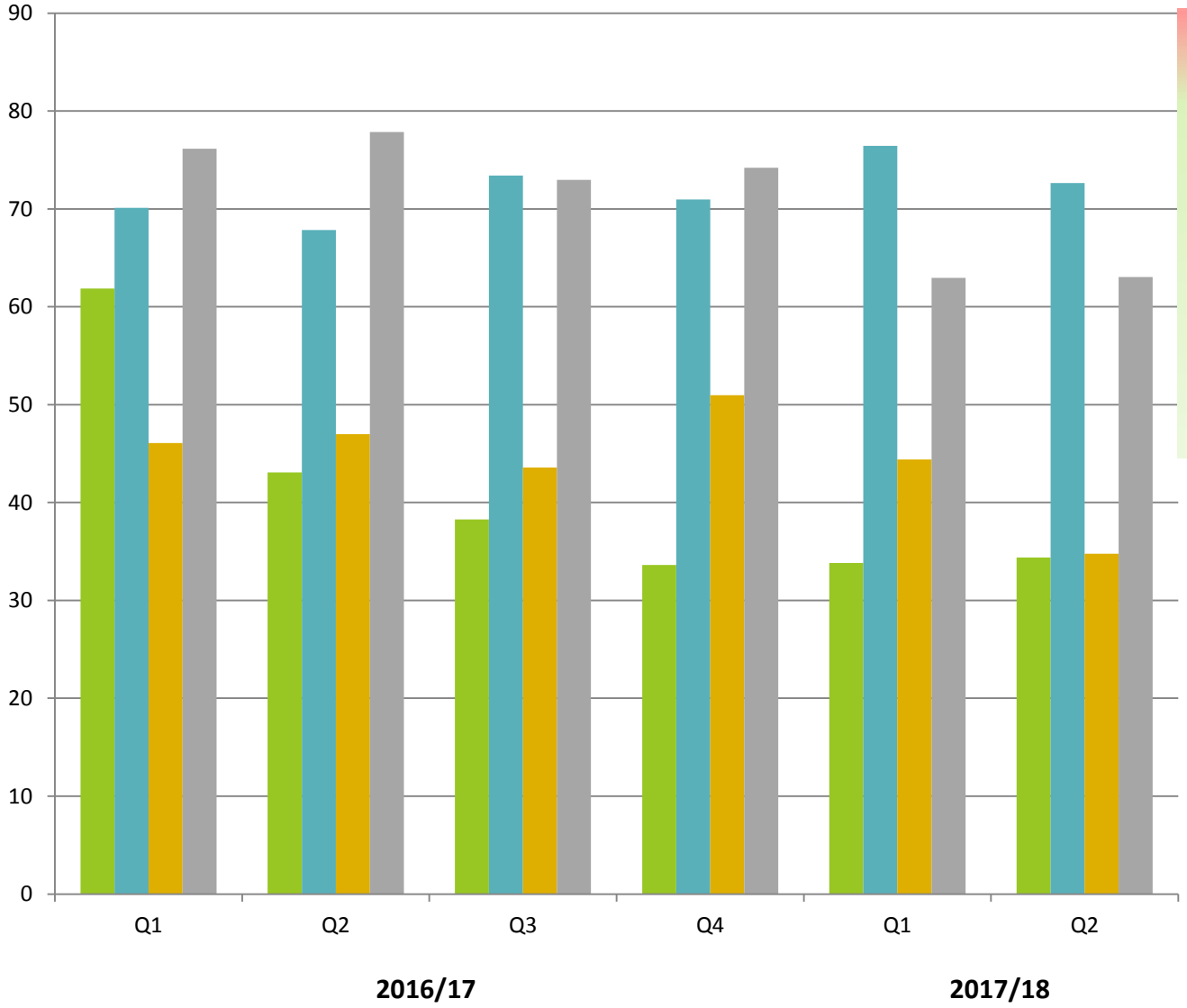
Individuals eligible for NHS CHC (Standard NHS CHC and Fast Track) at quarter end per 50,000



Headline:
Over the 18 month period, the number of people living in Herefordshire who are CHC eligible has reduced significantly, from 61.86 to 34.38 per 50k (a 45% reduction)
There has been a lower fall in the regional and national average.

*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.

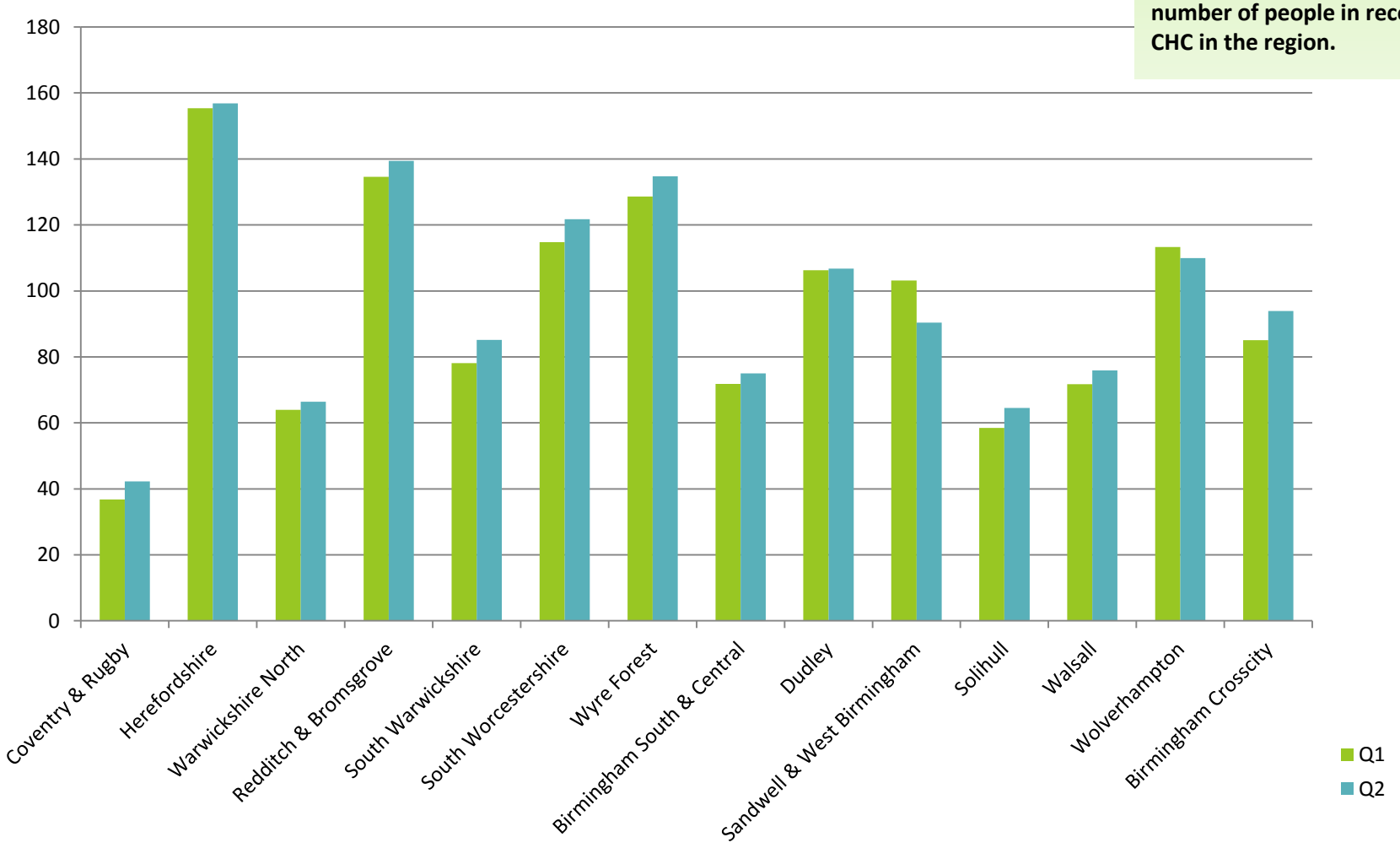
Over 18 months, it has seen the largest decrease in numbers and remains the CCG area with the lowest number of people eligible (per 50k) for CHC funding in the West Midlands Region.

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

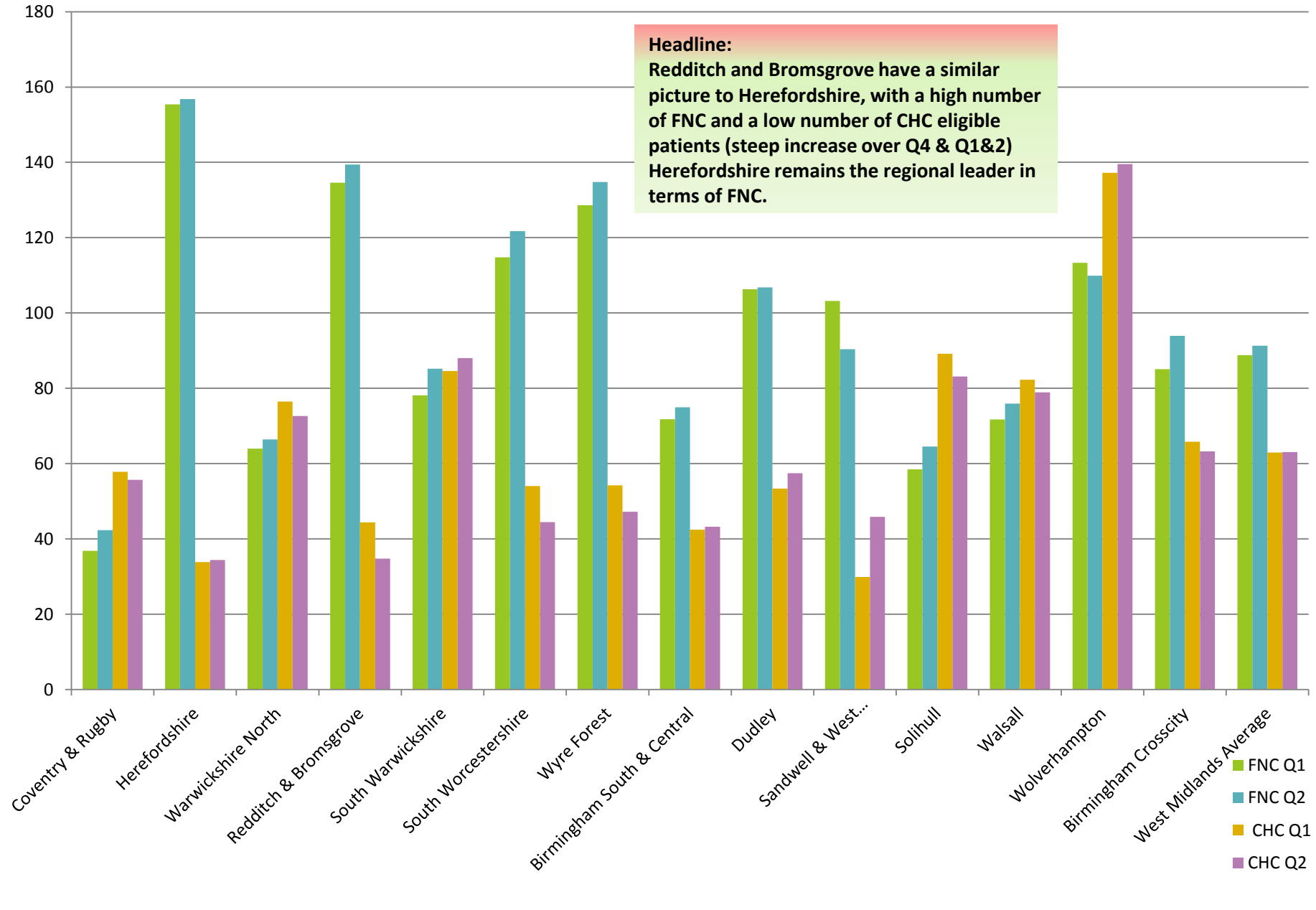
NHS Funded Nursing Care 2017/18 per 50k population- Regional

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.

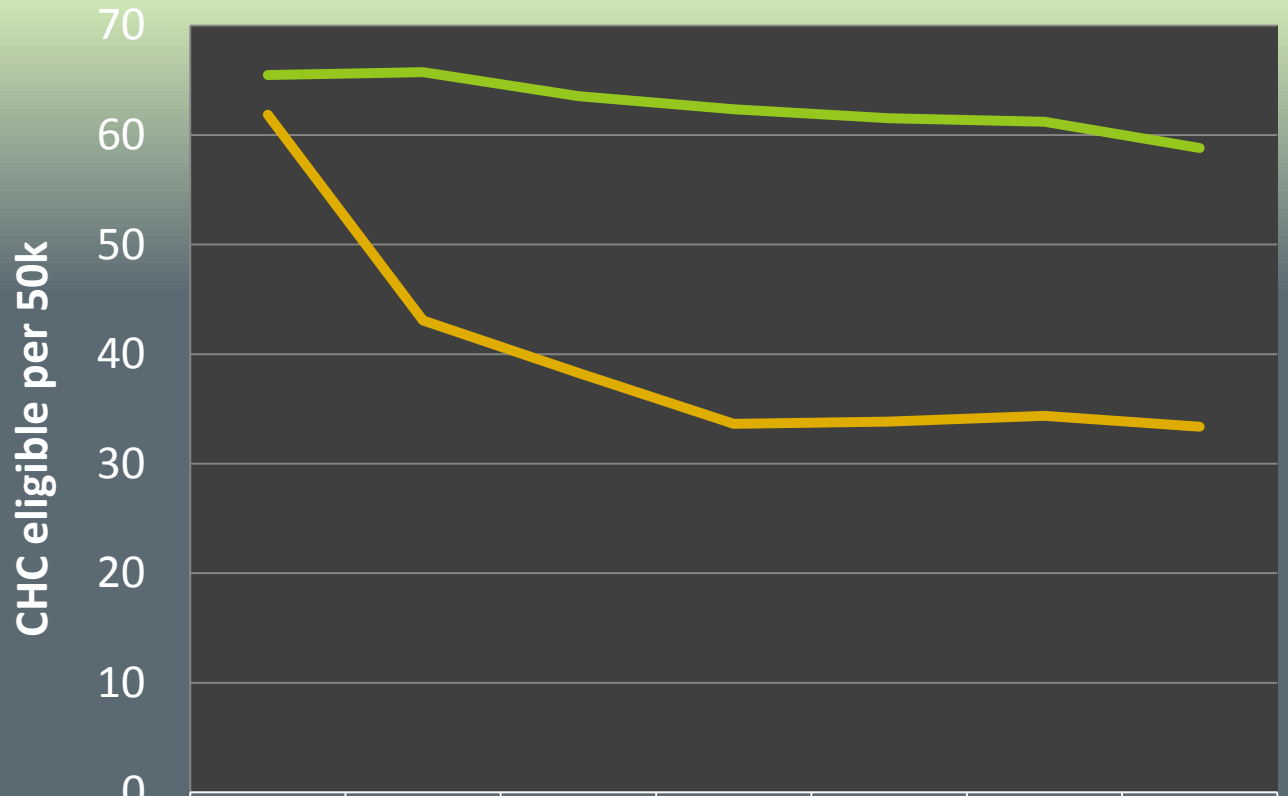


CHC vs FNC - Regional



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.

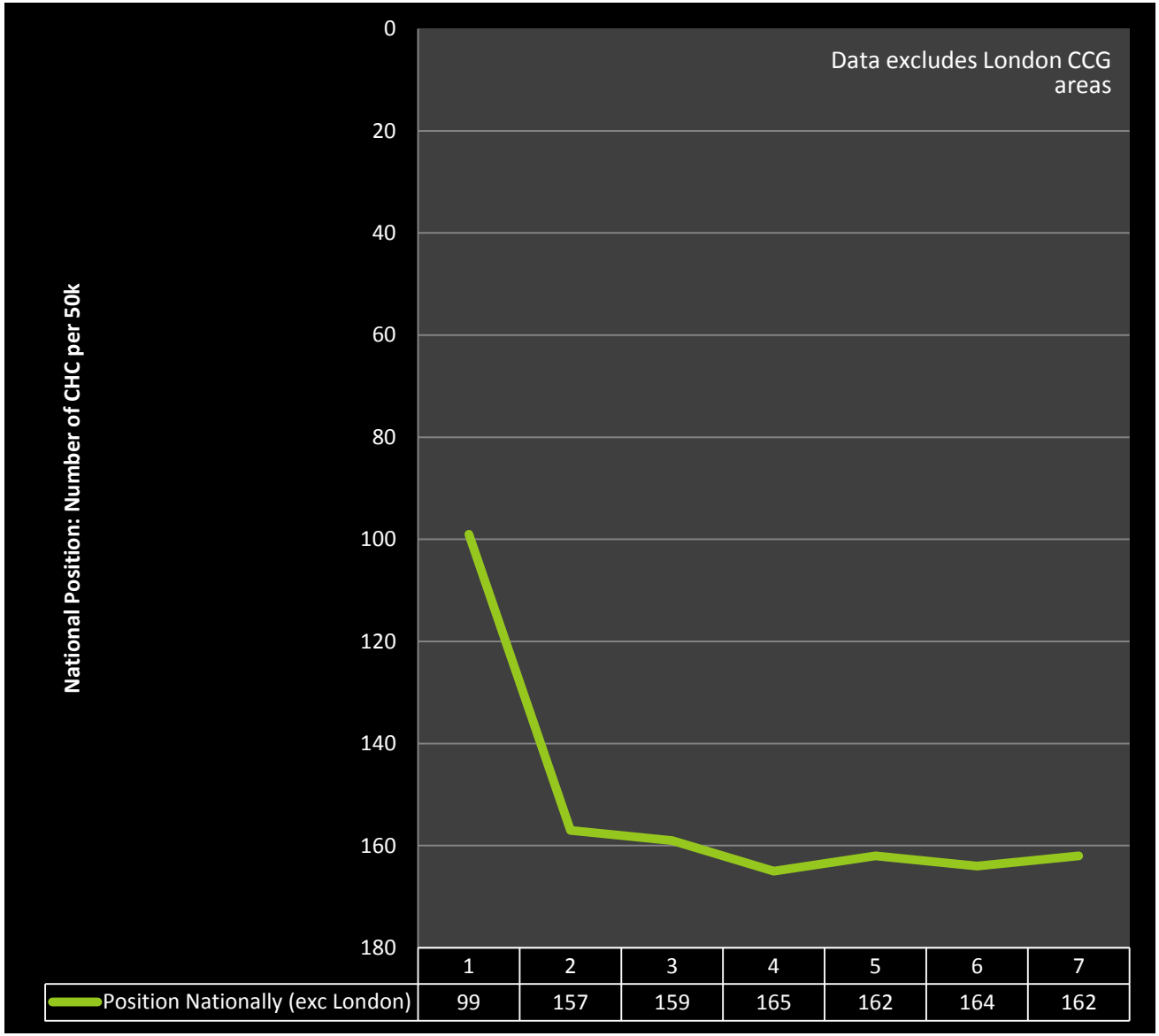


	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3
England - average per 50k	65.47	65.73	63.54	62.3	61.54	61.22	58.82
Hereford CHC per 50k of population	61.86	43.07	38.28	33.62	33.84	34.38	33.37

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) ***



* 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.