Norfolk Continuing Care Partnership

Managing Continuing Care services on behalf of the NHS Clinical Commissioning Groups in central and west Norfolk

Report for Norfolk Health and Scrutiny Committee – 22nd February 2018

Continuing Healthcare in Norfolk

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1. Introduction and Background

This report provides an update on the Continuing Healthcare (CHC) service delivery work conducted by the Norwich CCG, South Norfolk CCG, North Norfolk CCG and West Norfolk CCG over the past year. The report includes information on significant changes that have occurred in the way the service is managed and the transition from an 'arm's length' delivery mechanism to an in-house, CCG partnership, hosted by Norwich CCG. The report also updates against the recommendations made by the Norfolk Health and Overview Scrutiny Committee (NHOSC) in February 2017.

1.2 On 23rd February 2017, Norfolk Health Overview and Scrutiny Committee (NHOSC) received a presentation from Rachael Peacock, Jeanette Patterson, Nikki Cocks and Rob Jakeman on behalf of the four CCGs, Norwich, North Norfolk, South Norfolk and West Norfolk. The presentation provided an annual update of the progress and impact since April 2016 of implementing local policy, guidance and procedure documents for delivering NHS CHC to patients who have been assessed as eligible under the National Framework for NHS Continuing Healthcare (Department of Health, 2012). In response to the presentation, NHOSC made a series of 5 recommendations and a subsequent action plan from the CCGs was submitted to NHOSC on 15th May 2017.

1.3 The CCGs have also been requested to provide additional contextual quantitative and qualitative information regarding CHC service provision to NHOSC in regards to;

- Numbers of complaints and any trends in subject matter
- Waiting times for CHC cases to be considered by the CCRPs
- Consistency of decision-making and service delivery across the four Complex Case Review Panels (CCRPs)
- The settings in which patients receive CHC care (i.e. has there been an increase / decrease in those who receive it in a residential care home / their own home)
- Trend in the overall numbers receiving CHC
- The need for a 'safety net' on occasions where the agency delivering healthcare fails to deliver for whatever reason (to enable patients cared for at home to remain at home in those situations).

2. CHC Service Transition

2.1 Between June and October 2016 the CCGs carried out a review of CHC to look at the service and alternative models for future delivery. This work sought to understand the current service, the weaknesses and barriers experienced, the inter-relationships of CHC within the Norfolk health and social care system and the impact of this. This included collating best practice and lessons learned from across the Norfolk system and others, while exploring evidence to support moving to an alternative model and culminating in a case for change.

2.2 The CCGs recognised that the outsourced service model was limited to the basic components of the CHC framework and provided a transactional service in the main. The service required significant commissioning management resource and oversight and required four sets of duplicated processes, discussions and ways of doing business between CCGs and the Commissioning Support Unit (CSU).

2.3 A key consideration for the service transition was the achievement of strategic priorities (Appendix 1) which included the ambition to reduce duplication, unwarranted variation and ensure positive change within the health and social care system to benefit patients and service users. By working together and using the STP footprint, CCGs sought to develop integration opportunities, flexibility to make operational changes and to deliver efficiency and value for money initiatives.

2.4 The benefits of this new model of working are many, including improved development and progression opportunities for staff underpinned by recruitment, retention and succession planning; greater capacity in the team to deliver a high quality assessment and care coordination service; strong and stable management to drive forward innovation and the strategic priorities; and value for money. Better links with existing CCG projects will line up and maximise cross working potential especially in areas such as quality monitoring in the domiciliary care area. An opportunity to streamline work currently duplicated in different CCGs and in Norfolk County Council (NCC) was also acknowledged. It was felt that patient experience could be improved and market development and assurance enhanced.

2.5 The proposed model for CHC in Norfolk is based on a 'lift and shift' approach of the current staffing and structure in the CSU. It was essential to avoid any loss of staff and no redundancies or redeployments were necessary in the service transition. This initial starting point will be enhanced by a stronger management team, additional clinical roles, and a greater support infrastructure including HR and training and audit roles. This is underpinned by a governance structure that recognises both the provider and commissioner aspects of an in-housed CHC service.

2.6 The proposed partnership model is providing a foundation for future integrated working. The governance structure for the Norfolk Continuing Care Partnership includes a Strategic Board with Director level membership from all 5 CCGs and NCC.

2.7 The service transitioned on the 1st November 2017 and the Norfolk Continuing Care Partnership (NCCP) was formed. The transition is the first of a series of phases (see Appendix 2) and allows for the service to transition and stabilise and for the newly appointed leadership team to become established. During this phase ongoing recruitment is taking place to fortify key areas of the service.

2.8 In the next phase of the work (see Appendix B) other concurrent related projects run by individual CCGs as part of the Quality, Innovation, Productivity and Prevention (QIPP) agenda will become part of the 'Business as Usual' (BAU) work of the NCCP business unit. Opportunities for closer working with NCC will be identified and explored in line with the strategic priorities of the service.

3. Progress Update on Norfolk Health and Overview Scrutiny Committee Recommendations - 23.2.2017

	NHOSC Recommendation	CCG Response
1.	a) The CCGs address the findings in the Healthwatch Norfolk survey - Improvement to both verbal and written communication of the different stages of the process, the outcome of each stage, and the notification of decisions including funding decisions	***Improvement in verbal communication*** **INITIAL RESPONSE – MAY 2017** The CCGs have agreed to fund an education and development post to work with staff to improve their knowledge, skills and competency in relation to Continuing Health Care. Staff development will include focusing on communication and information sharing. Through use of their 'Feedback Centre', Healthwatch Norfolk will assist the CCGs in gathering patient and families' feedback on verbal communication with patients and families who have experienced the CHC pathway, to assess any improvements. **UPDATE – FEBRUARY 2018** Provision has been made for two full time educational posts within the NCCP business unit. The job descriptions have been developed and recruitment is underway. A meeting has been scheduled with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to both verbal communication by members of NCCP staff. ***Improvement in written communication*** - ***Regarding stages of the process*** - ***Outcome of each stage*** - ***Notification of decisions (including funding decision)*** **INITIAL RESPONSE – MAY 2017** Using the expertise of their volunteers, Healthwatch Norfolk will assist in reviewing a sample of anonymised CHC letters and processes for informing patients to check tone and content. The CCGs will conduct an audit of information giving to ensure clear notification is given at each stage and in a timely way. **UPDATE - FEBRUARY 2018** The suite of standard template letters used by NELCSU will be amended in conjunction with Healthwatch to ensure the tone and

		content of written communication reaches a high standard is clear and easily understood. The proposed CCG information giving audit will commence late in 2018 as part of phase 3 of service transition
	b) CCGs to ensure people are well-informed about what they might be eligible for and what services are available, without raising expectations	***People are well informed about what they might be eligible for*** **INITIAL RESPONSE - MAY 2017** CCGs will ensure that their websites contain links to relevant national leaflets about the CHC assessment process and local information detailing what is/is not funded via CHC. **UPDATE - FEBRUARY 2018** The change to NCCP is published on each CCGs website with a downloadable information sheet and contact details CCG websites contain links to a CHC easy read version of the local guidance. Both the easy read and standard versions of the patient guide to CHC services set out the processes for assessment of eligibility for NHS CHC Funding and include details of what may and may not be funded by the NHS. NHS CHC Contracting Policy is available on each website (this includes reference to the way the CCRP functions. The Norfolk policy is due to be updated to reflect the significant changes that have occurred). Links are available on the each of the CCG websites to signpost patients to national NHS guidance https://www.nhs.uk/conditions/social-care-and-support/nhs-continuing-care/? ***People to be well informed of the services available*** **INITIAL RESPONSE - MAY 2017** General information about services will be available from leaflets. More detailed bespoke information will be tailored to need by the CHC clinical staff who are undertaking that patient's assessment. Healthwatch Norfolk will assist in reviewing national and local information on eligibility for CHC and CHC content of CCGs websites using the expertise of their volunteers. **UPDATE – FEBRUARY 2018**

		General information about services remains available as before. The national NHS website contains information on CHC assessments and links to the National Framework documents. More detailed information is tailored by the CHC clinical staff who are undertaking that patient's assessment. A National Strategic Improvement Programme was launched by the Department of Health in January 2017 and is expected to run for a period of 2 years. This national program of work is expected to include a review of the mandated documents within National Framework for Continuing Healthcare such as the CHC Checklist. Any changes to policy at a national level will need to be locally implemented and guidance for CCGs may change over the next 12 months. Should local policy change as a result of national directives, all CCG and NCCP guidance will be altered to comply and details will be published on the NCCP page of the CCG websites. ***Expectations to be managed*** **INITIAL RESPONSE – MAY 2017** The CCGs will assess the impact of information giving on managing patient expectation through monitoring of patient feedback and complaints. **UPDATE – FEBRUARY 2018** Following the CHC service transition and stabilisation period the NCCP senior management team will link with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to how processes were explained. Complaints are monitored formally on a monthly basis with a Key Performance Indicator linked to this service measure and a written paper being submitted to the Operational Management Group which is chaired by a Non-Executive Director. The Operational Management Group is the forum whereby the member CCGs receive assurance on the various aspects of service delivery. All complaints are initially received by the Head of Adult CHC and all response letters are signed off by the Director of Integrated Continuing Care. In this way the senior management team within the NCCP are aware on a continued basis of all complaints received and of the outcomes. This senior involvement enables the NCCP business unit to actively learn from processing complaints and to implement service adaptations in response to feedback where necessary.

	c) CCGs to consider whether to commission more advocacy services for people involved in the CHC assessment process and those in receipt of CHC so that their views are fully expressed and understood	***Consider commissioning more advocacy services for*** - ***those being assessed*** - ***those in receipt of CHC*** ***so that patient views are fully expressed and understood*** **INITIAL RESPONSE – MAY 2017** Advocacy is available for patients that lack capacity and do not have alternative suitable representation. All healthcare professionals involved in a patient's care advocate for the patient and are responsible for making 'Best Interest' decisions where necessary. The CHC nurse assigned to a case will ensure patient views are expressed, understood and upheld wherever possible. The CCGs intend to implement a model of case management to ensure patients are reviewed regularly by staff that are familiar with their case, and receive a package of care review to ensure the care delivered meets the patients' assessed clinical needs. **UPDATE – FEBRUARY 2018** CHC patients going through assessment have access to an independent mental capacity advocate (IMCA) where required in accordance with the Mental Capacity Act (2005). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. Where a patient has capacity to make decisions of their own has an assessment for CHC, every effort is made by nursing and social care staff to support the patient and their family to understand the proceedings and their options at each stage. This is part of the role of every member of health and social care staff. During 2018 NCCP intend to implement a model of working which ensures patients receive a package of care review regularly by staff familiar with their case, to ensure the care delivered meets the patients' assessed clinical needs.
2.	CCGs to undertake more proactive quality monitoring to check that CHC patients are	***Proactive quality monitoring to ensure CHC patients receive a service that meets their needs*** **INITIAL RESPONSE – MAY 2017** A review process for all eligible patients is set out in the National Framework for NHS Continuing Healthcare and NHS Funded

	receiving a service that meets their needs	Nursing Care. This requires a three month review for all newly eligible patients to ensure that health care needs are being met and that patients continue to meet the eligibility threshold for NHS funded care. Following this, annual eligibility reviews are undertaken and the clinician undertaking the assessment will specifically assess the package of care in place and any change in care requirement. The CCGs intend to implement a model of case management to ensure patients are reviewed regularly by staff that are familiar with their case, and receive a package of care that meets their assessed clinical needs. Whilst all patients should have access to a designated CHC clinician the CCGs acknowledge that patients with highly complex or labile health care needs will be prioritised. The planned model of case management will link clinicians to groups of health care providers in order to build and maintain proactive working relationships that provide an opportunity to monitor standards through regular contact. **UPDATE – FEBRUARY 2018** The contracting department within NCCP maintains links with care providers and undertakes routine quality monitoring (see example in Appendix 3). A series of provider forums are scheduled to take place during 2018 to improve these links. Each of these forums will have a specific focus to improve quality of care e.g. Business Continuity Planning. NCCP has senior nurses that are designated Quality Assurance Leads. These members of staff maintain close links with the NCC Quality team and share information about care providers. Where issues arise, the Quality Assurance Leads work with care providers to implement action plans to address care deficits and improve quality. Where a care provider may be identified as having issues with care quality a proactive set of welfare checks would be undertaken for all CHC funded patients receiving care from that provider. All CQC reports for Nursing, Residential and Domiciliary care providers with CHC funded patients are closely monitored and shared with NCCP team members and CCG recipients to promote an awareness of quality issues across the care providers in Norfolk. The Quality Assurance Leads attend briefing sessions with the CHC clinical teams to promote the exchange of information and to gather soft intelligence from nursing staff that can be used to identify trends. Recruitment is underway to enhance the clinical team with stronger leadership and additional clinical posts. The additional nursing

		capacity will be required to work towards a case management / care coordination approach that enables clinicians to be aligned to care providers to develop links and provide consistent support.
3.	CCGs to arrange for a more widely accessible survey of the experiences of CHC patients and families / carers, i.e. using a wider variety of methods than the previous survey, which was on-line, internet based	***Gather information on the experiences of CHC patients, families and carer*** **INITIAL RESPONSE – MAY 2017** Healthwatch Norfolk have agreed to support CCGs with advice on the appraisal and selection of suitable methods for gathering patient and families CHC experiences, taking into account the following: • An estimation that 75% of Norfolk households are 'on-line' • The survey sample is predominantly comprised of family members/carers, as representatives of the person receiving CHC • Evidence from a 2016 paper-based, postal CHC survey with SAE's in the West Norfolk locality produced a *NIL return rate* • In 2016, telephone interviews were the preferred means of contact for family carers • Use of social media platforms is increasing • Word of mouth and face-to-face survey promotion (i.e. by trusted clinicians, practitioners, nursing home care staff and VCS support workers) is proven to be very effective **UPDATE – FEBRUARY 2018** A meeting is scheduled with Healthwatch to progress this work and explore mechanisms to seek patient / relatives feedback with regard to both verbal communication by members of NCCP staff.
4.	CCGs to work in close partnership with social care and other relevant agencies including service user groups to ensure planning for an effective safety-net service for CHC patients on occasions when their usual provider is unable to deliver	***CCGs work in partnership with*** - ***NCC*** - ***Other relevant agencies*** - ***Service user groups*** **INITIAL RESPONSE – MAY 2017** CCGs are working with NCC to ensure the existing urgent social care service is able to meet the needs of CHC patients. NCC have agreed to monitor the incidence of CHC patient requests for urgent social care intervention for a 1 month period to determine the demand profile and ability to meet demand for safety netting. CCGs will work with NCC to identify other relevant agencies and routes to access temporary support for patients where appropriate e.g. Marie Curie, Red Cross, Royal Voluntary Service.

		Contingency plans are already built into care plans with those patients in receipt of Personal Health Budgets. CCGs will ensure that contingency arrangements and designated funding are in place to enable patients in receipt of a Personal Health Budget to plan for and mitigate potential problems associated with short term care breakdown. The Continuing Healthcare Brokerage team will be available Mon-Friday to support with longer term disruption in care delivery and to offer alternative options via commissioned care where necessary. **UPDATE – FEBRUARY 2018** The managers of the Norfolk First Response Service (NFS) were approached to discuss the issues of safety netting for CHC patients. Service Lead Denise Forder was not aware that this was a significant issue and agreed to assist with an audit of CHC activity in Spring 2017. An audit of the Swifts / Night Owls service took place during April and May 2017. It appears that requests for support from the NCC Swifts and Night Owls service does come from patients eligible for CHC funded care. However, these amount to a small number (1 per month) and are predominantly newly eligible Fast Track patients who are awaiting a CHC funded package to be arranged and rely on NFS / Swifts / Night Owls for a short period whilst suitable care is sourced. The senior management team of NCCP are working with CCGs to support development of care services and ensure CHC funded patients are able to access all mainstream services and sources of support in accordance with National Framework. This includes commissioning of mainstream end of life NHS services and block procurement options from third sector organisations such as Marie Curie. ***Ensure planning for an effective safety net service for CHC patients should the usual provider be unable to deliver*** **INITIAL RESPONSE – MAY 2017** Care plans should be in place for all patients in receipt of Continuing Health care in line with the best practice requirements outlined in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care. These care plans record both the care required and patients' preferences to provide guidance and direction for care givers. These documents enable continuity of care provision for patients that may require an episode of care from an alternative care giver. The CCGs will audit the quality and availability of care plans from a range of providers to provide assurance with regard to the effectiveness of these documents.

		The CCGs will seek specific feedback regarding experiences of alternative care provision as part of the patient survey planned. **UPDATE – FEBRUARY 2018** Care Plan audits form part of the NCCP routine Quality visits in nursing homes and are a CQC requirement for all registered care providers. (See Appendix C for an excerpt from the Care Plan audit). NCCP Quality Assurance Leads plan have started work to conduct assurance visits for domiciliary care providers and will be extending this work during 2018. A meeting is scheduled with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to alternative or respite care provision where this has been required.
5.	CCGs work to speed up the process between referral and assessment for CHC eligibility so that the average waiting time in each of the 4 CCG areas reduces to meet the 28 day standard	***Speed up referral to assessment (meet 28 day target)*** **INITIAL RESPONSE – MAY 2017** The CCGs have measures in place to record reasons for delays in assessments. However, it is acknowledged that the existing process is restricted by IT functionality and does not support accurate categorisation of reasons for delays. An alternative process is required with additional training for staff to enable more accurate reporting. Accurate data availability will enable implementation of targeted interventions to reduce delays. The CCGs are planning to in-house their CHC service within a single CCG led business unit. Investment into the clinical team is planned which will reduce assessment delays attributed to resource availability. The business unit will enable better standardisation of processes and reduce unwarranted variation between different areas of the county. **UPDATE – FEBRUARY 2018** A significant amount of work has taken place to improve performance in this area. The monitoring and reporting processes have been reviewed and NHS England request monthly and quarterly reports on the CCG performance against the 28 day assessment standard. An audit of delayed cases was undertaken in September 2017 for all 4 CCGs in the Partnership. The audit identified contributory delays and a number of internal and external factors including administrative delays, unnecessary steps in the process, lack of social work or CHC

nurse availability, delays writing up cases, varied eligibility ratification processes, lack of tracking for deferred cases.

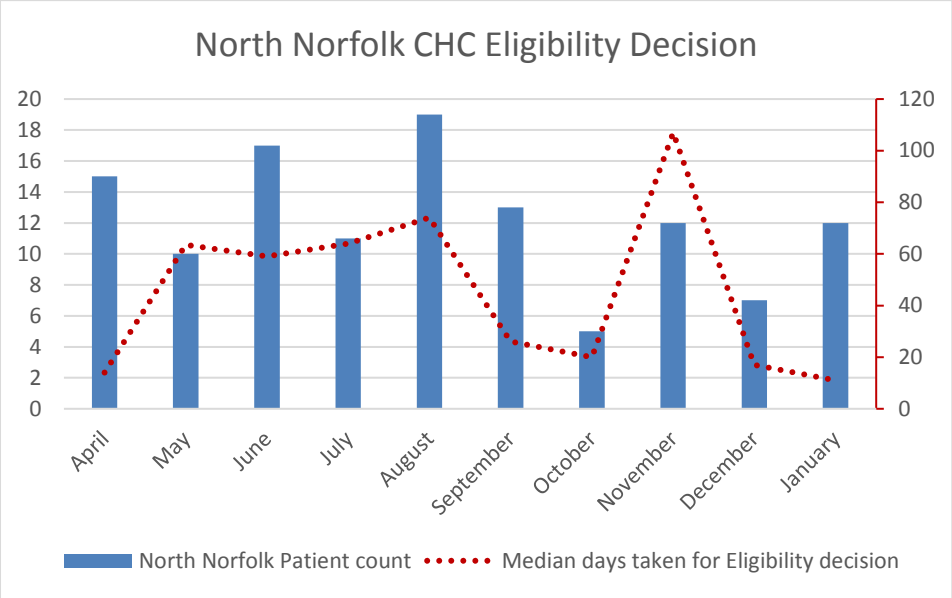
Additional enhanced leadership within NCCP has enabled Clinical Service Managers to have a smaller span of control and better oversight of staff. They are able to utilise data to monitor flow of cases, identify delays and backlogs and support administrators and clinicians to process cases more efficiently.

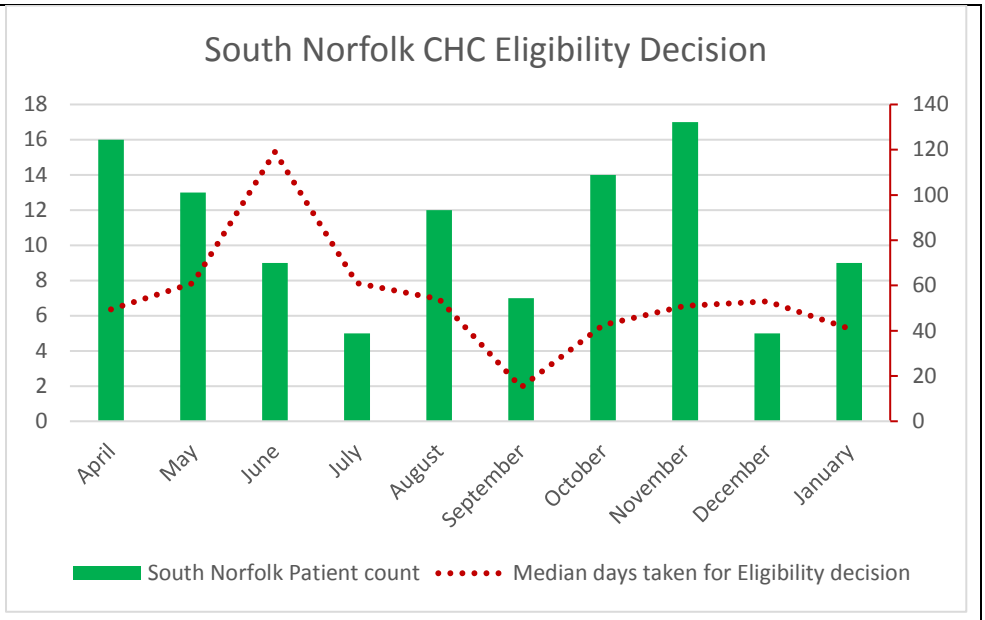
The CCGs have delegated responsibility for ratification of cases to NCCP and Eligibility Ratification Meetings are run 3 times each week. Very senior clinicians provide quality assurance and peer review recommendations ensuring they have been made based on relevant evidence and in accordance with the National Framework. A single central process eradicates unnecessary stages in the process, reduces variability across CCGs and contributes to improving the standard of assessments. Where it is necessary to defer a decision these are quickly and robustly followed up by a named member of staff and a log used to track progress towards resolution.

NCCP and NCC are working closely to address issues related to staff availability and both orgnaisations are recruiting additional staff to ensure there is sufficient capacity to undertake assessments within the required timescale.

CCGs are expected to achieve an 80% compliance against the 28 day assessment target by end of March 2018.

The graphs below show the median number of days taken, by month. The small number of cases can cause large fluctuations. The left axis shows patient numbers and the right shows the median number of days.




South Norfolk CHC Eligibility Decision
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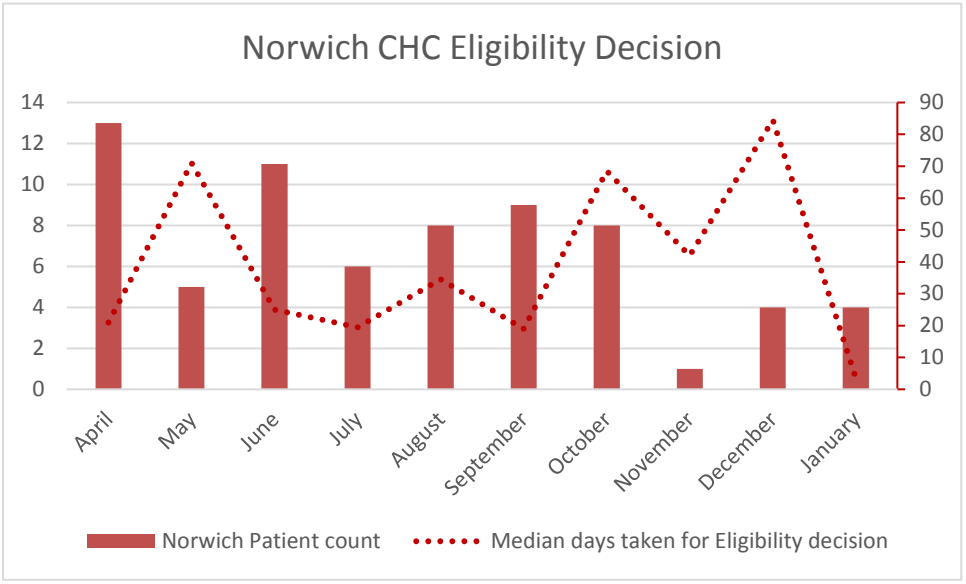
South Norfolk Patient count
Median days taken for Eligibility decision


Norwich CHC Eligibility Decision
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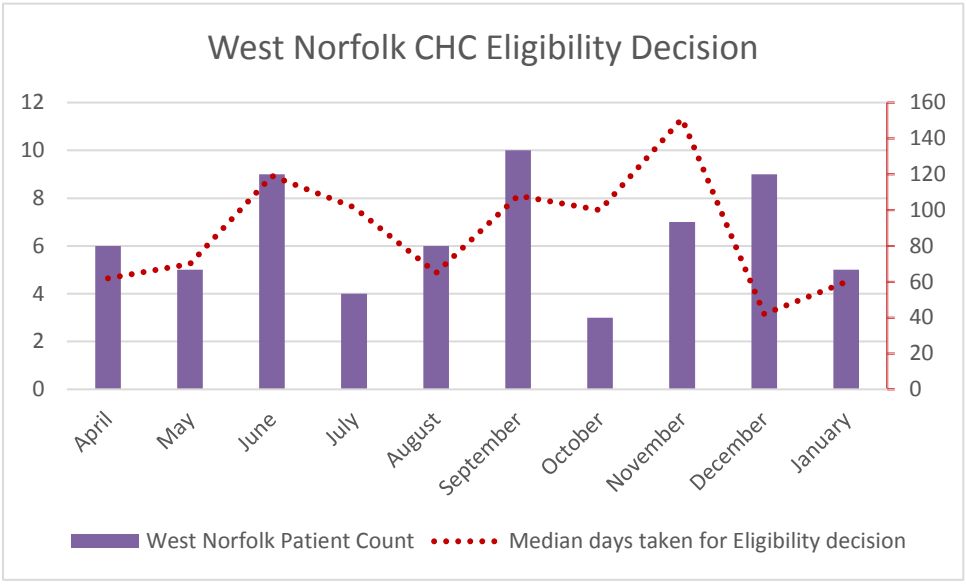
Norwich Patient count
Median days taken for Eligibility decision


West Norfolk CHC Eligibility Decision
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120
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40
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0
April
May
June
July
August
September
October
November
December
January
West Norfolk Patient Count
Median days taken for Eligibility decision

4. Contextual Data for CHC Service Delivery;

The Norfolk Health and Overview Scrutiny Committee requested NCCP to provide some additional data to provide some context and quality markers for service delivery.

4.1 CHC complaints and trends Feb 2017- Feb 2018

NCCP has continued with and refined an existing system that ensures all complaints are initially seen by a senior clinician to determine the required handling process. This is because many elements of correspondence are formal 'appeals' to the outcome of the CHC assessment process rather than complaints. CHC appeals are not classified as complaints because they are a formal part of the CHC decision making and follow a process set out in the NHS National Framework for Continuing Healthcare.

The complaints handling system includes early liaison with the complainant to ensure their wishes are understood and clarified to allow the correct process to be followed e.g. where an appeal may also include some elements of dissatisfaction with service delivery and may therefore need to be handled simultaneously via both the appeal and complaints pathways. In addition, some enquiries had previously been handled through the complaints process, rather than through a Patient Advice and Liaison Service (PALS) type of approach. This has also since been remedied and staff will routinely respond quickly, in person, to patient concerns offering a face to face meeting to discuss and address issues wherever possible.

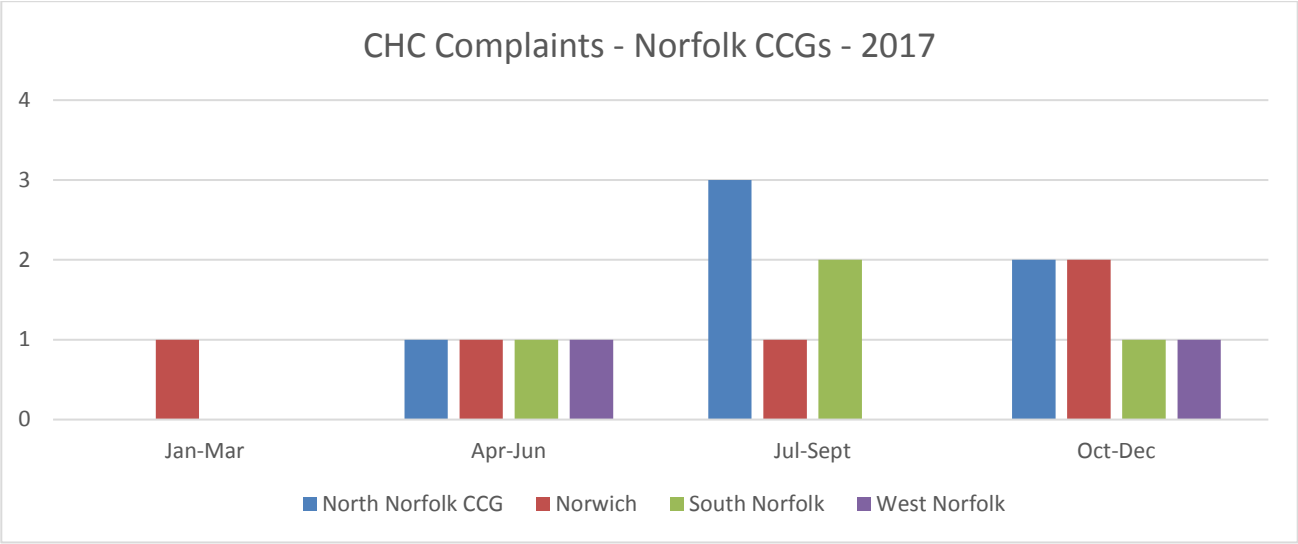
4.1.1 Categorisation of complaints was changed between 2015-16 and 2016-17 following a review which identified that historically CHC appeals were being incorrectly handled as complaints. The number of complaints reported in previous years was therefore artificially inflated. The categorisation also differentiated cases/complaints where the Member of Parliament (MP) writes to raise concerns on behalf of his/her constituent. Correspondence from MPs are handled separately because NHS complaints handling legislation does not apply to MP cases / complaints.

4.1.2 The required timescale for answering complaints is 25 working days from the date the complaint has been received, to the date the final response has been sent. However it may occasionally be necessary to agree an extension to this 25 day deadline with the complainant where a case is particularly complex, multifactorial or requires information from an external source e.g. a care home provider. Where a case has been completed within an agreed extension period this is still deemed to have been completed 'within the required timescale'.

For all CHC cases that were concluded in the six months from July – December 2017, the average time between the case being received and the final response sent was 26.20 days, and the average time between case received and case closed fully was 27.67 days.

For July to December, the requirement to acknowledge each complaint within three-working days was met in 95% of cases; only one case fell outside this mark and this was due to a communication error. A total of 94% of cases were also handled within the agreed timescale for response, with one case falling outside this requirement.

4.1.3 Broken down by quarter, CHC complaints were received as follows:

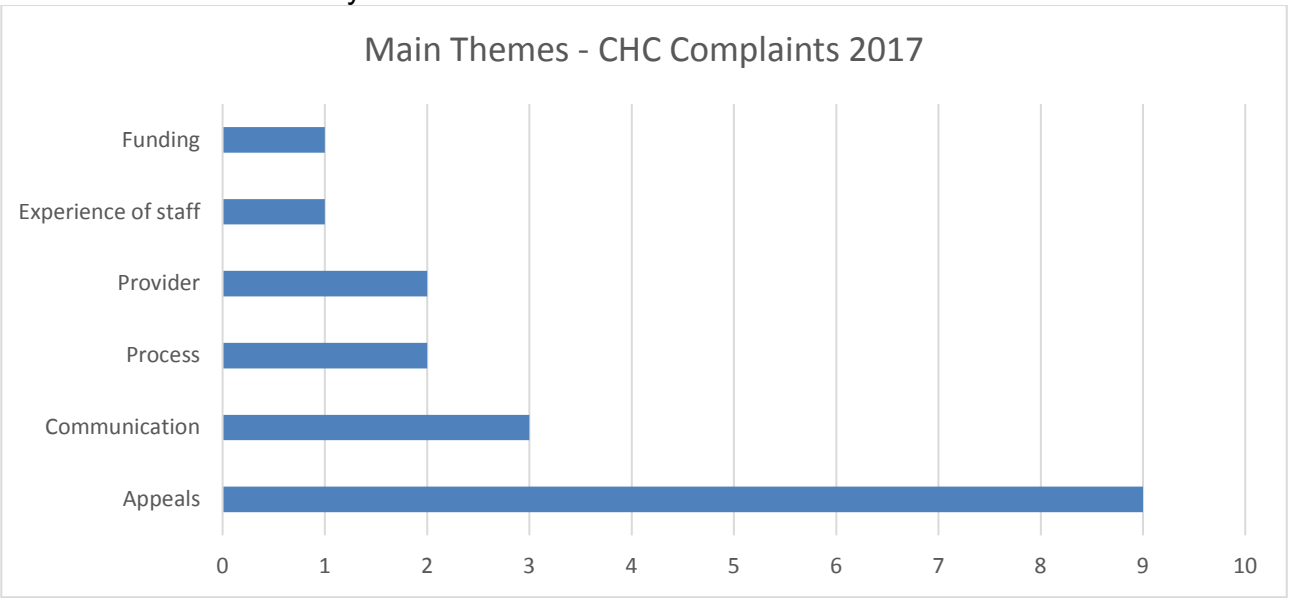


As a comparator, the Quarter 1 complaints table previously submitted to NHOSC in February 2017 has been updated with recent figures to indicate activity over the past 3 years.

Number of complaint and type of outcome
[Quarter 1 Comparison, 2015-2016, 2016-2017, 2017-2018]

Column1	Quarter 1 2015-2016	Quarter 1 2016-2017	Quarter 1 2017-2018
April	1	4	2
May	2	3	0
June	6	0	2
Total	**9**	**7**	**4**
Outcome			
Upheld	1	6	4
Partially	4	0	0
Not upheld	4	0	0
Ongoing	0	1	0

4.1.4 Thematic analysis



The chart above shows a thematic analysis of complaints received during 2017.

The thematic analysis indicates that complaints over the last 12 months predominantly relate to delays in process or communication in relation to Appeals claims (9).

In the second largest category, three complaints were received around communication, one in Quarter 1 and two in Quarter 2. In two cases relatives did not feel that information they provided at the point of CHC assessment had been taken into account, and in one case, information around care provision was not considered adequate by a patient's relatives.

In addition to the above, 8 MP complaints were received during 2017. Five of these were related to funding, 1 was related to the outcome of the CHC Assessment, 1 was related to the family experience of the process, 1 was related to a care home and a family's dissatisfaction with the care provided. Of these complaints, 2 were fully upheld and 1 was partially upheld. Where complaints were upheld there is evidence of a change in process and learning within the CHC team in response to the issues raised.

4.1.5 From April 2018 North and South Norfolk CCGs will be hosting the corporate complaints service on behalf of themselves, Norwich CCG and West Norfolk CCG, to bring greater consistency to the processes for receiving, handling and responding to complaints across central and West Norfolk. As NCCP is a CCG hosted service, all CHC complaints will be included in this arrangement. The CCGs plan to provide their complaints service 'in house' to enable closer monitoring of themes and trends and to have greater responsibility for liaising with complainants and MPs to address issues arising.

4.2 Consistency of decision-making across the four Complex Case Review Panels (CCRPs)

Prior to November 2017 each CCG ran its own Complex Case Review Panel with staff from each respective CCG involved in decision making. With the formation of a Partnership each CCG has delegated authority to NCCP to run their Complex Case Review Panels as a single central process. Four panels are run each week. This has

improved consistency in decision making and reduced variation across the CCGs because decisions are made by a small number of highly experienced clinical staff.

4.3 Waiting times for CHC cases to be considered by the CCRPs

NCCP does not collect data around waiting times for sign off of cases at the Complex Case Review Panel. This is because panels run very frequently and this is not a significant cause for delay of a care package commencing. Care packages can commence ahead of the paperwork where necessary and would be authorised by a member of the NCCP senior management team to minimise delays.

4.4 The settings in which patients receive CHC care

NHOSC invited the CCGs to comment on whether there has there been an increase / decrease in those who receive NHS CHC funded care in a residential care home or in their own home.

The CHC data below indicates the split between residential care home packages and domiciliary care packages has been provided for Q1 and Q2 to enable comparison over the previous 3 years.

	2015/16				2016/17				2017/18			
	Q1		Q2		Q1		Q2		Q1		Q2	
	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom
North Norfolk CCG	75%	25%	75%	25%	73%	27%	71%	29%	62%	38%	68%	32%
Norwich CCG	75%	25%	75%	25%	74%	26%	73%	27%	54%	46%	71%	29%
South Norfolk CCG	68%	32%	69%	31%	66%	34%	66%	34%	63%	37%	72%	28%
West Norfolk CCG	68%	32%	53%	47%	63%	37%	62%	38%	55%	45%	68%	32%
All CCGs	**71%**	**29%**	**68%**	**32%**	**69%**	**31%**	**68%**	**32%**	**59%**	**41%**	**70%**	**30%**

Table 2. Spread (%) of patients between residential or domiciliary NHS continuing healthcare settings by CCG

The data indicates that there has been fluctuation but no significant overall change in the percentage split of patients that receive care in a domiciliary setting compared to a residential setting over the last 3 years.

4.5 Contingency care arrangements – ('safety net' to prevent admission to alternative care environment)

NHOSC asked NCCP to comment specifically about contingency care arrangements to avoid admission to an alternative care environment. NCCP work closely with patients and their families to listen to and respect their preferences and to support patients to

receive care safely in their preferred environment wherever possible. The NCCP Brokerage team has designated clinicians who are able to support care arranging using access to the most appropriate provider to meet patient's assessed clinical need. The need for robust contingency care arrangements runs throughout the organisation and measures have been put in place in the following areas;

4.5.1 Contracting;

- CCG contracts include a section about care provision, continuity and duty of care
- Contracts have been amended to support the Inclusion of 'golden hours' for domiciliary care providers that allows periods of additional uplifted care to acknowledge fluctuation in care needs at times
- Additional services policy allows temporary unauthorised uplift in care homes over weekends to enable providers to adjust care according to clinical need

4.5.2 Brokerage

- CHC Brokerage will work with patients, relatives and providers to source alternative care or offer temporary respite placements when notified that care needs are not being met. This includes linking with mainstream NHS services if private sector care provision is not available e.g. Care at Home Team.
- CHC clinicians work with families to offer regular domiciliary respite care in their own home, especially where family members are regular caregivers. This serves as a backup contingency plan also to develop familiarity with a range of care givers (policy under development to harmonise with NCC respite care provision).

4.5.3 Bespoke solutions

- PHB patients are provided with funds and support to prepare localised contingency arrangements relevant to their circumstances. This does not exclude PHB holders from accessing all other safety net options, but provides additional flexibility for those that would prefer to put their own contingency arrangements in place.
- Many agencies will train additional carers especially where care is particularly complex and requires a high degree of carer training to deliver care e.g. patients dependent on ventilatory support at home. These are generally packages of care where 24 hours 1:1 care is required, by staff specifically trained to operate ventilatory devices. NCCP authorises additional funding to support this contingency measure where clinically indicated.

4.5.4 Individuals in receipt of NHS CHC funded care have exactly the same rights as all other citizens under the Care Act including access to care in times of emergency. The NHS fund an array of care services round the clock for those in need of medical or nursing care in urgent situations. In a similar way the social care services provide round the clock, responsive services for those in need of urgent, short term, social care support. This includes individuals in receipt of NHS CHC funding. In addition to the local contingency measures put in place by NCCP, patients in receipt of NHS CHC funding continue to have access to;

Mainstream NHS services

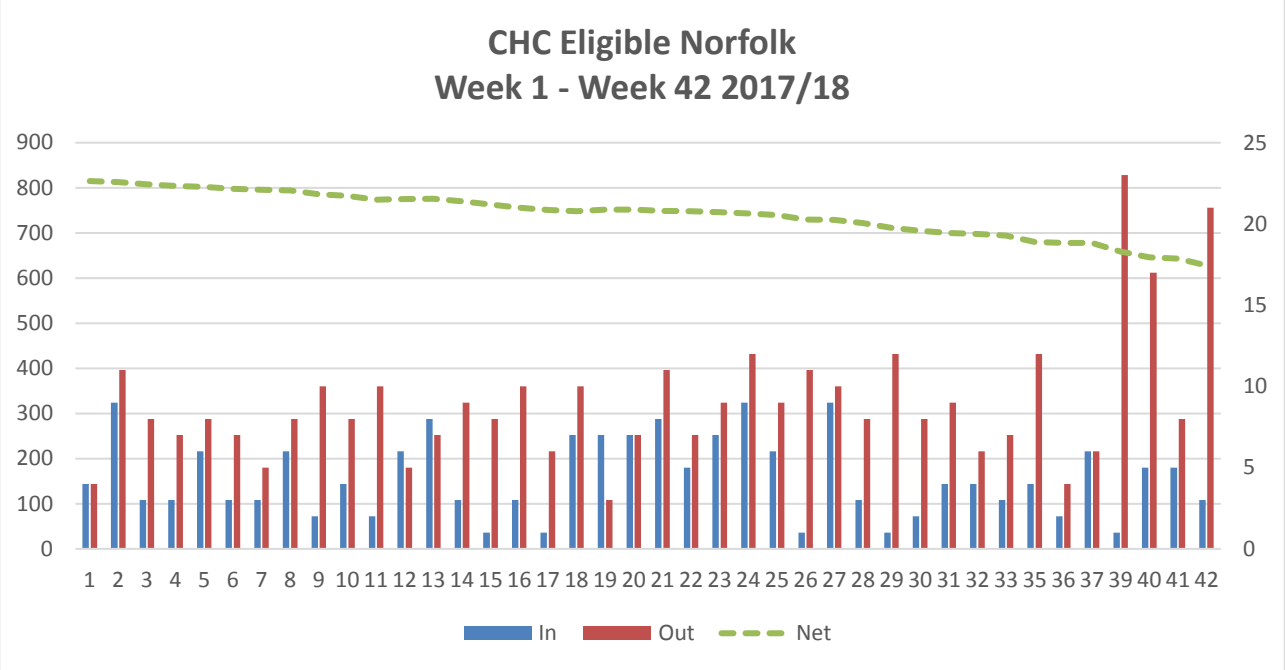
- The national mainstream NHS safety net for health can be accessed 24 hours a day via telephone to 111, Out of Hours Doctors, Community Nursing Teams, Virtual Ward teams, Ambulance services, Walk-In and Urgent Care Centres, and as a last resort A&E.

Mainstream Social Care services

- A mainstream safety net for social care can be accessed through NCC Swifts / Night Owls (which is partially NHS funded) to deliver urgent social care to patients in their own home and prevent deterioration in physical wellbeing.
- Safeguarding services via the Multi Agency Safeguarding Hub
- Learning Disability Crisis Intervention Team
- Duty Social Work teams for Children

4.6 Trend in the overall numbers receiving CHC

The number of patients eligible to receive CHC funded care has decreased over the last 12 months.



This is due to a number of factors including additional CCG investment in re-ablement and convalescent pathways which help patients leave hospital earlier and promote recovery prior to assessment for long term care needs, in line with the NHS National Framework for CHC.

Weeks 39 – 40 show a significant increase in the number of patients no longer eligible for CHC funding and may be attributed to the seasonal increase in end of life care over the winter period.

National work focused on improving consistency in decision making and clarifying eligibility considerations has also contributed to improving processes and application of the National Framework in Norfolk.

Closer working with NCC colleagues is helping to address cases which may have previously been on the borderline of CHC eligibility and has enabled a more consistent approach to considering those patients who would benefit from joint health and social care provision. Since the CHC service transition on 1st November 2017 a Joint Panel has been held fortnightly to enable closer working between NCC and NCCP.

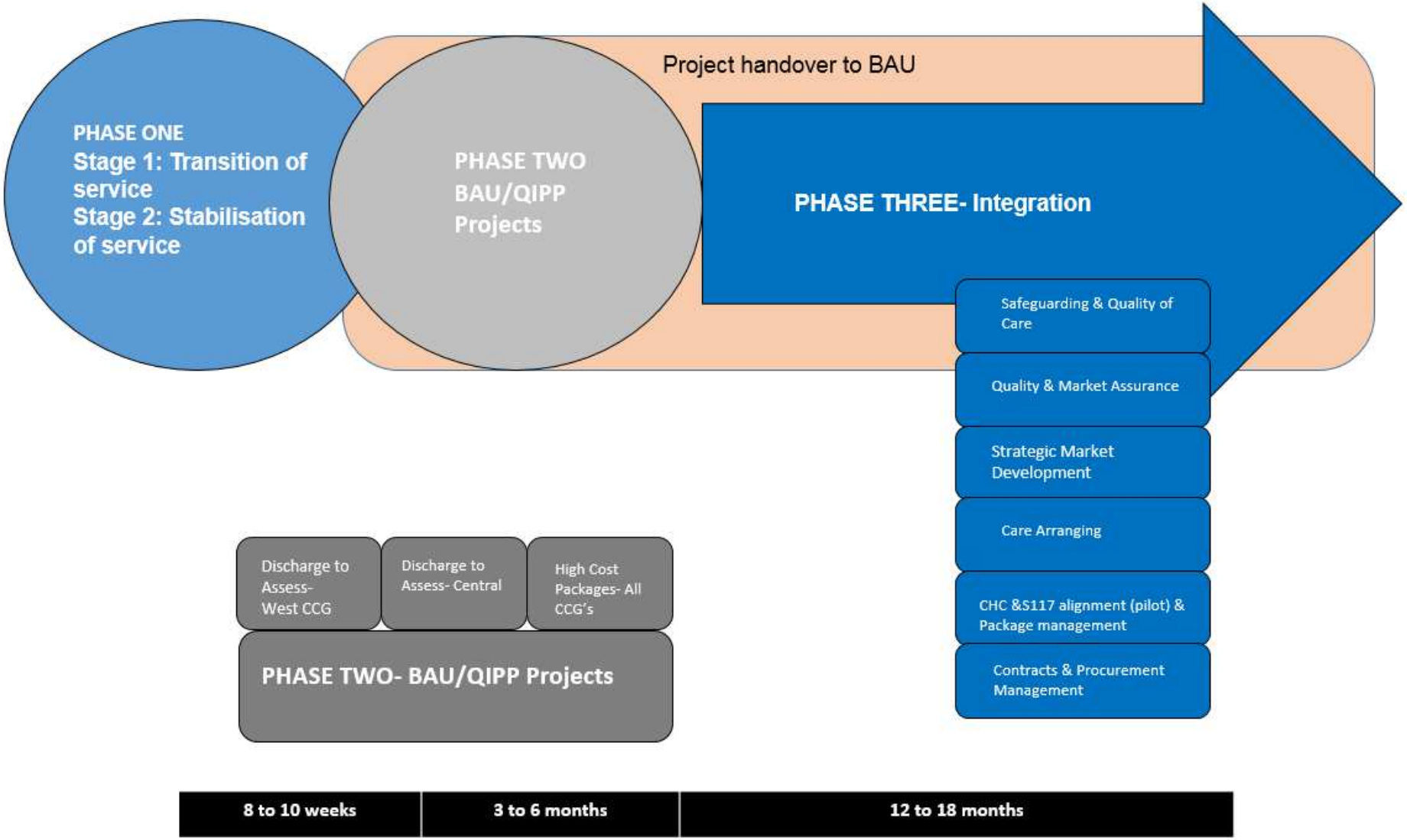
Appendices Document Title		Document location
1	NCCP Strategic Priorities	Attached
2	NCCP Developmental Phases	Attached
3	NCCP Quality Audit Tool – Provider Care Plans	Attached

Appendix 1 - Norfolk Continuing Care Partnership Strategic Priorities

How we will know we have achieved our ambition. How we will measure success. How we will contunie to measure how we are doing…….

Priority Area	Measures	Evidence/Outcomes
To reduce unwarranted variation across the county	Measure a Measure b Measure c	Centralised process for eligibility ratification Single Complex Case Review Panel for all cases Benchmarking against national standards
To improve experience and outcomes	Measure a Measure b Measure c	Active patient feedback mechanisms in place to monitor and learn from practice Virtual patient forum to provide interaction, support and advise System of peer review to share learning and drive improvement
To ensure the highest levels of patient safety and quality of care	Measure a Measure b	Individual Care Agreement in place for each patient specifically stating care requirements Contracts in place with all Nursing, Residential and Domiciliary Providers with quality assurance measures explicitly stated and monitored quarterly
To ensure value for money	Measure a Measure b Measure c	Package of care reviews undertaken regularly Quality Assurance mechanisms for both eligibility and provision of packages of care in line with CHC framework Reporting structures in place to monitor cost and benchmark both locally and nationally
To ensure exacting service standards for quality assurance and compliance	Measure a Measure b Measure c	Quality assurance of all care providers in liaison with social care partners Proactive Quality team working with providers to drive up standards All care providers to be in contract with the CCGs
To drive continuous improvement through the operational business while ensuring alignment with strategic aims including integration agenda	Measure a Measure b Measure c	Workforce development programme to link local and national improvement aims Process for review of strategic aims with staff via a robust appraisal process Competency framework developed and implemented Workforce strategy to develop and retain optimism staffing model making CHC a desirable career option

Appendix 2 - Norfolk Continuing Care Development Phases



Appendix 3 - Excerpt from NCCP Quality Audit Tool – Provider Care Plans

Documentation E4- How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?		
Are there risk assessments for the following? **care files reviewed:** 1 / 2 / 3 / 4		**Number of**
Are risk assessments/care / support plans regularly reviewed (at least monthly)?		
Are detailed care / support plans in place for above risk assessments?		
Is there depth and detail in the progress notes?		
Are care / support plans person centred?		
Are personal histories (Life stories), preferences recorded?		
If in use, are repositioning charts filled in correctly?		
Are the repositioning charts reflective of the care planned i.e. frequency?		