NHS
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 – 6th December 2018

Continuing Healthcare in Central and West Norfolk

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1. Introduction and Background

This report provides an update on changes to Continuing Healthcare (CHC) service delivery that have occurred since the Norwich CCG, South Norfolk CCG, North Norfolk CCG and West Norfolk CCG formed the Norfolk Continuing Care Partnership (NCCP) to deliver services in November 2017.

The report includes contextual information regarding the caseload of CHC patients, progress against the 28 day assessment target and an analysis of complaints activity for the period February to October 2018. Information regarding cessation of CHC or Funded Nursing Care (FNC) and Discharge to Assess Pathways has been provided where available to NCCP.

NHOSC previously raised a series of issues in relation to CHC service delivery in May 2017 and progress against each area is outlined in the report.

A brief overview of the changes that have resulted from the publication and implementation of a revised National Framework for Continuing Healthcare and NHS-funded Nursing Care (October, 2018) has also been included to demonstrate how central and West Norfolk has adapted practice to accommodate new requirements.

Information has also been provided on the CHC Fast Track pathway as requested by NHOSC.

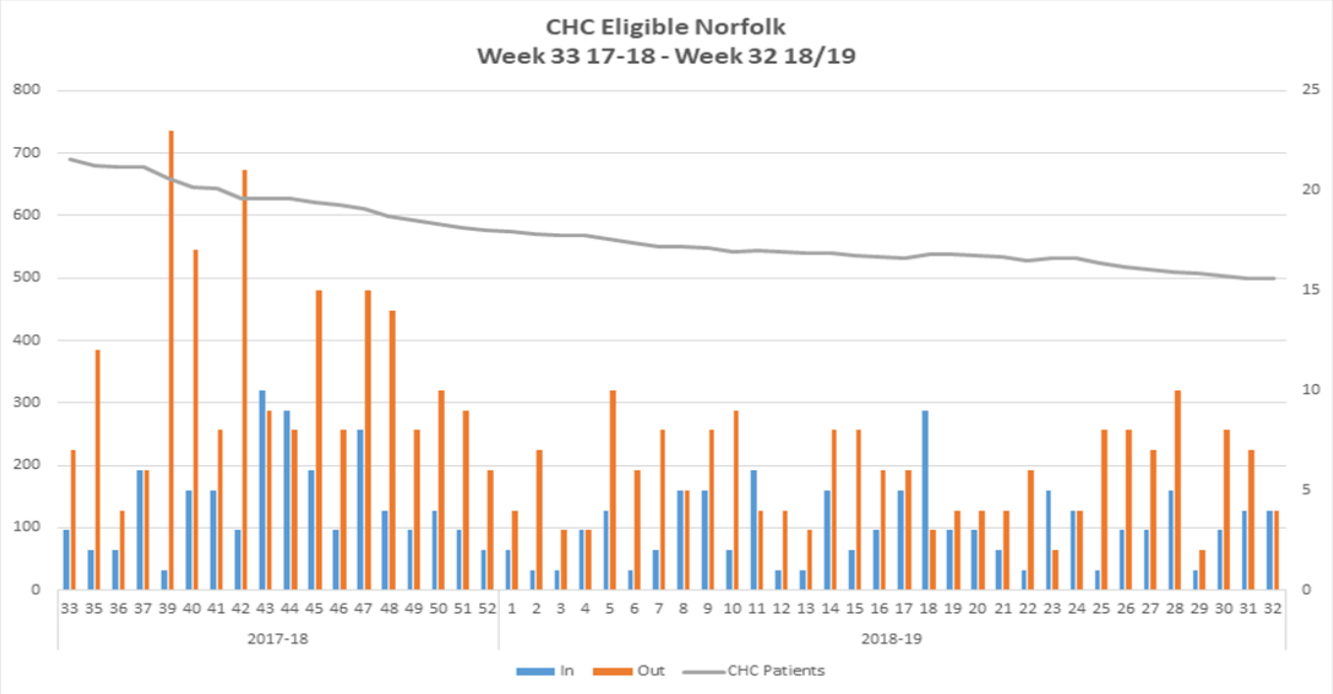
2. General Contextual Information

2.2 Trend in Residential / Domiciliary Care Packages for CHC Patients

	2015/16				2016/17				2017/18				2018/19			
	Q1		Q2		Q1		Q2		Q1		Q2		Q1		Q2	
	Res	Dom	Res	Dom	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%	66%	34%	67%	33%
Norwich CCG	75%	25%	75%	25%	74%	26%	73%	27%	54%	46%	71%	29%	67%	33%	67%	33%
South Norfolk CCG	68%	32%	69%	31%	66%	34%	66%	34%	63%	37%	72%	28%	63%	37%	62%	38%
West Norfolk CCG	68%	32%	53%	47%	63%	37%	62%	38%	55%	45%	68%	32%	69%	31%	64%	36%
All CCGs	**71%**	**29%**	**68%**	**32%**	**69%**	**31%**	**68%**	**32%**	**59%**	**41%**	**70%**	**30%**	**66%**	**34%**	**65%**	**35%**

The table above indicates the percentage split of location of care provided to CHC patients over the past 4 years. Quarter 1 and 2 data has been presented for consistency. The data indicates that the percentage of patients receiving care in their own home has marginally increased over the 4 year period.

2.3 Trend in the numbers of patients eligible to receive CHC in the past 12 months



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.

2.4 Progress Against the CHC 28 Day Assessment Target During 2018

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
All CCGs	No. Referrals completed <=28 days	14	18	49	28	41	30	47	36	43	56
	No. Referrals completed	30	49	56	32	46	31	50	40	43	59
	%	47	37	88	88	89	97	94	90	100	95

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
North	No. Referrals completed <=28 days	7	9	13	6	6	8	12	6	12	15
	No. Referrals completed	12	14	14	7	7	8	13	7	12	16
	%	58	64	93	86	86	100	92	86	100	94
Norwich	No. Referrals completed <=28 days	3	3	13	6	9	14	7	13	8	14
	No. Referrals completed	4	12	18	6	9	14	7	15	8	15
	%	75	25	72	100	100	100	100	87	100	93
South	No. Referrals completed <=28 days	4	5	18	10	18	4	21	5	12	16
	No. Referrals completed	9	13	18	12	20	4	21	5	12	17
	%	44	38	100	83	90	100	100	100	100	94
West	No. Referrals completed <=28 days	0	1	5	6	8	4	7	12	11	8
	No. Referrals completed	5	10	6	7	10	5	9	13	11	8
	%	0	10	83	86	80	80	78	92	100	100

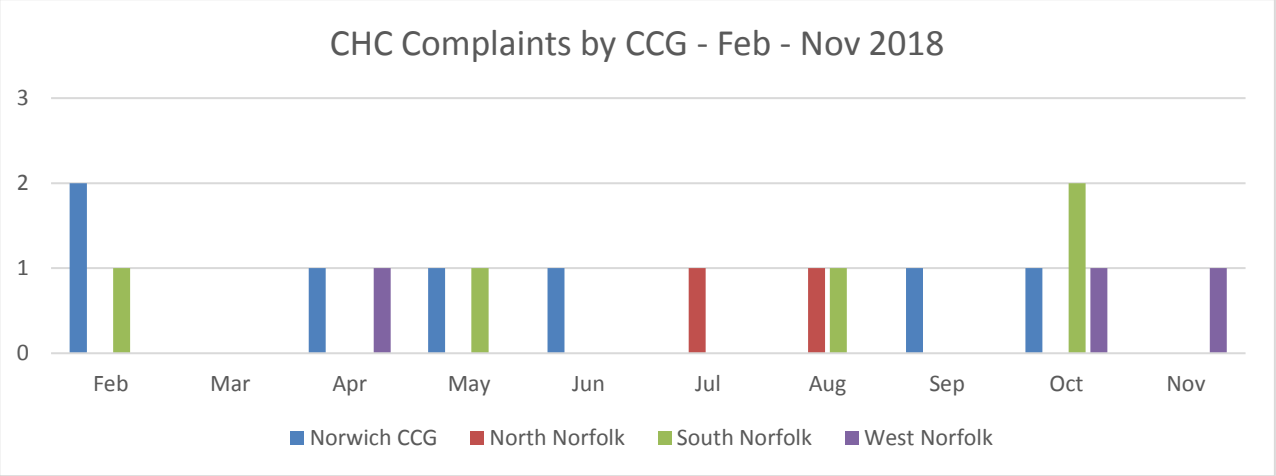
2.5 CHC Complaints Information and Analysis

NCCP has an established complaints system that ensures all complaints are initially seen by a senior member of the team 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.

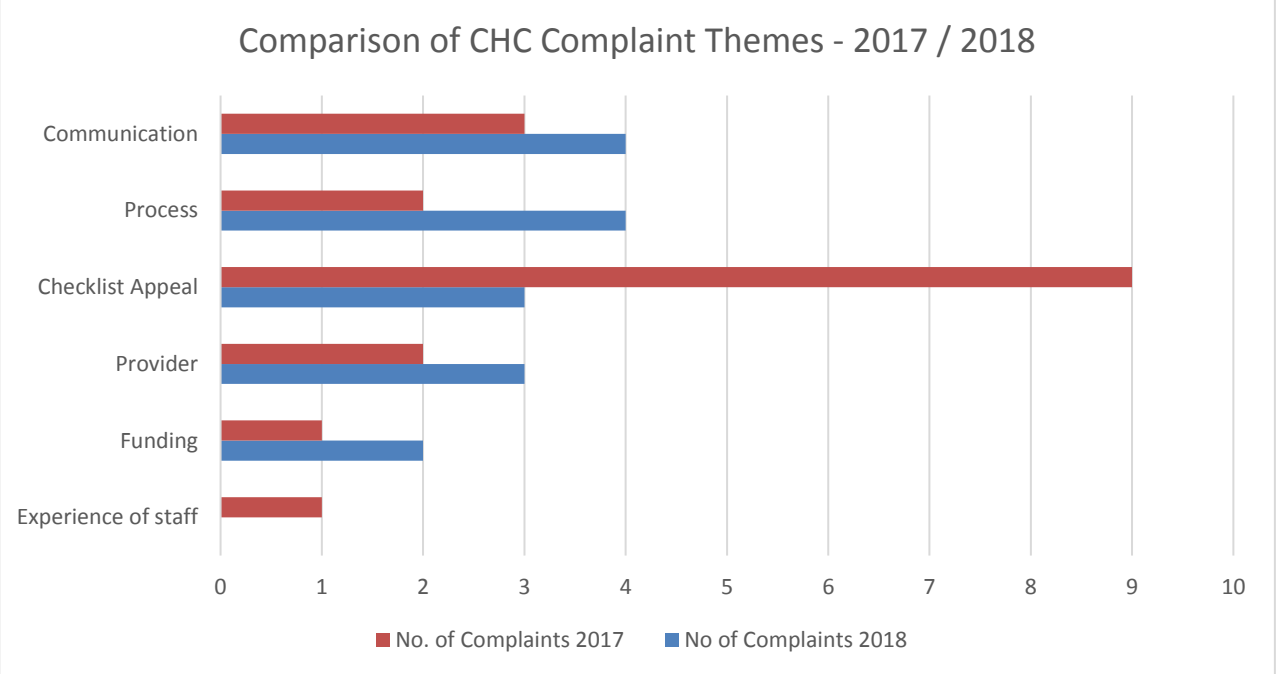
2.5.1 The required timescale for answering complaints is 25 working days from the date the complaint has been received, to the date the final response has been sent. For CHC complaints that were concluded in the nine months from February – November 2018 all except one received a final response within 25 days.

During this period the requirement to acknowledge each complaint within three-working days was met in 94% of cases.

2.5.2 CHC complaints activity has been split by CCG as follows;



2.5.3 Thematic analysis and comparison of complaints



The chart above shows a thematic analysis of complaints received during February and November 2018. Complaints received during 2017 have been included as a baseline.

2.6. Capacity of the Assessment Service

CHC Practitioners are responsible for undertaking CHC assessments for new referrals, undertaking reviews for existing patients and case managing a cohort of patients so capacity for each element is variable depending on demand across the service.

2.6.1 Caseload Numbers

A Case Management model has been introduced. CHC Practitioners have been allocated a caseload of patients including a case mix of individuals receiving care in different care environments. Caseloads have been set to ensure that every patient in receipt of continuing healthcare has a named case manager.

CHC Practitioners have been allocated a caseload of around 30 patients (current average 27 patients per clinician). The specialist Complex Case Managers manage patients with greater variance in their care requirements and have on average 12 cases per clinician. Resilience is provided through a system of Lead and Support clinicians, from supernumerary team leaders and other clinicians within NCCP.

2.6.2 Staff Vacancy Levels – CHC Clinicians

NCCP have 2 whole time clinical vacancies but have been highly successful in recent recruitment drives. Both posts have been offered to successful candidates and staff are due to start in post during December 2018 and January 2019.

The senior Clinical Team Lead and Clinical Service Manager positions have substantive members of staff in post and have experienced stability since service transition to NCCP.

3 Norfolk Health and Overview Scrutiny Committee (NHOSC) – NCCP Progress Update Since Feb 2018

	NHOSC Recommendation	CCG Progress Update (see also the HealthWatch Norfolk Report)
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	**UPDATE - November 2018** The suite of standard template letters have been amended in conjunction with Healthwatch to ensure the tone and content of written communication reaches a high standard is clear and easily understood. Service Leaflets have been produced to assist with information giving and to support verbal communications. The proposed CCG information giving audit will commence late in 2018 as part of phase 3 of service transition.

	decisions including funding decisions	
1.	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*** **UPDATE - November 2018** Information regarding Continuing Healthcare 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. ***People to be well informed of the services available*** **UPDATE – November 2018** General information about services are available from leaflets. More detailed bespoke information is tailored to need by the CHC clinical staff who are undertaking that patient's assessment. Healthwatch Norfolk are assisting in reviewing service leaflets using the expertise of their volunteers. A revised program of integrated training is due to commence in November 2018 to raise professionals' awareness about Continuing Healthcare funding and referral routes. Training will be aimed at social care, community healthcare and mental health teams to improve knowledge and assist with signposting to appropriate services. ***Expectations to be managed*** **UPDATE – November 2018** The NCCP senior management team have linked with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to how processes were explained. A draft patient feedback questionnaire has been developed in conjunction with Healthwatch. The process for distribution, collection, recording and analysis is being finalised and a pilot is due to commence shortly. Complaints have been monitored formally on a monthly basis with a written paper being submitted to the NCCP Operational Management Group and to the CCG Directors of Nursing and Quality via the Clinical Quality review Group. All complaints are reviewed by the senior management team within the NCCP. This senior involvement enables the organisation 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	**UPDATE – November 2018** Patients undergoing CHC assessment have access to an independent mental capacity advocate (IMCA) where required, in accordance with the Mental Capacity

	services for people involved in the CHC assessment process and those in receipt of CHC so that their views are fully expressed and understood	Act (2005). Independent advice is freely available via Beacon and NCCP signpost patients and their representatives to this service in every written communication. Where a patient with capacity 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. NCCP have implemented a model of case management which allocates each patient a named CHC Practitioner. The CHC Practitioner will work with the patient and their representatives throughout the assessment process to provide continuity and ensure personalisation of the process. Following award of CHC funding this relationship continues, to ensure care provision is tailored to clinical need and provided in a way which respects individual circumstances and preferences.
2.	CCGs to undertake more proactive quality monitoring to check that CHC patients are receiving a service that meets their needs	**UPDATE – November 2018** NCCP has designated Quality Assurance Leads. These members of staff maintain close links with the Norfolk County Council 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. 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. Where a care provider may be identified as having issues with care quality a proactive set of welfare checks is undertaken for all NHS funded patients receiving care from that provider. A case management approach has been established to provide a named CHC Practitioner for each CHC patient. The purpose of the case management approach is to provide a personalised care package for each patient with support from a senior registered nurse who is knowledgeable about their case. Each CHC Practitioner is also aligned to specific care providers to develop positive relationships and provide consistent support and oversight to commissioned care packages.
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	**UPDATE – November 2018** Healthwatch Norfolk have provided advice on the appraisal and selection of suitable methods for gathering patient and families CHC experiences. A draft patient feedback questionnaire has been developed in conjunction with Healthwatch. The process for distribution, collection, recording and analysis is being finalised and a pilot is due to commence shortly. NCCP have ensured that there are a variety of accessible alternative feedback mechanisms including generic feedback email addresses which are checked several times each day and a manned Single Point of Access telephone service.
4.	CCGs to work in close partnership with social care	**UPDATE – November 2018**

	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	Care plans should be in place for all patients in receipt of Continuing Healthcare in line with the CQC requirements and the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (2018). Care plans should 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. NCCP review the quality and availability of care plans as part of our case management approach and will work with providers to ensure the effectiveness of these documents. Specific contingency plans are built into care plans for those patients in receipt of Personal Health Budgets to enable patients to plan for and mitigate potential problems associated with short term care breakdown. The Continuing Healthcare Brokerage team is available Mon-Friday to support with longer term disruption in care delivery and to offer alternative options via commissioned care where necessary. Better links and relationships with providers is helping to identify issues with care delivery much earlier so that alternative arrangements can be put in place proactively where care disruption is anticipated. During the severe weather experienced in March 2018, NCCP enacted its own Business Continuity Plan. Key services were maintained throughout the period and care disruption was minimal. Links via the Emergency Resilience and Preparedness personnel, Winter Planning and Silver Call systems enabled close contact with providers, identification of areas of concern and enabled private providers to access wider NHS resources to maintain care provision e.g. the voluntary 4x4 Service. The learning from the major incident debrief was used at a Provider Forum event in late spring 2018 to assist Providers in development of their own business continuity plans. NCCP have actively participated in ongoing resilience planning for winter 2018 and have put additional resource in place to support care sourcing. Part of NCCPs remit is to identify and escalate commissioning gaps to CCG partners to improve provision of health services in Norfolk. Close links with the CCGs ensures up to date knowledge of mainstream commissioned NHS services, such as Hospice at Home and Virtual Wards, and increases in social care provision such as additional capacity for the Swifts / Night Owls service.
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	**UPDATE – November 2018** A significant amount of work has taken place to improve performance in this area. 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 progress cases more efficiently. The CCGs have delegated responsibility for verification of cases to NCCP and Eligibility Verification Meetings are run 4 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.

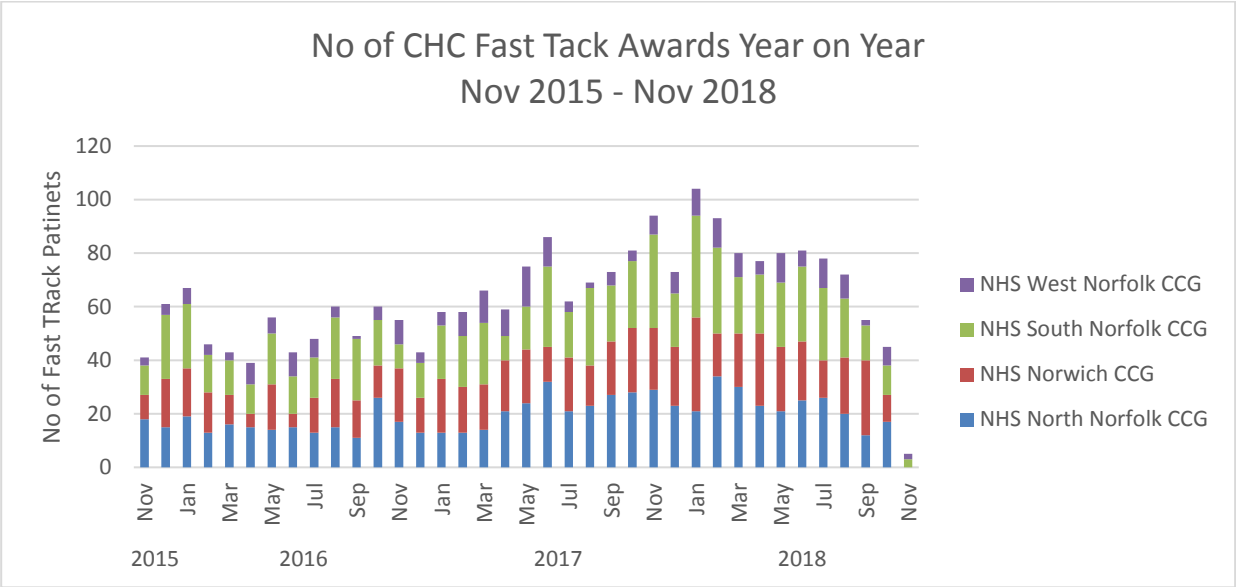
		NCCP and NCC are working cooperatively to address issues related to staff availability to undertake assessments within the required timescale. CCGs have consistently achieved 80% compliance against the 28 day assessment target since April 2018.

4. Additional Information Requested by NHOSC

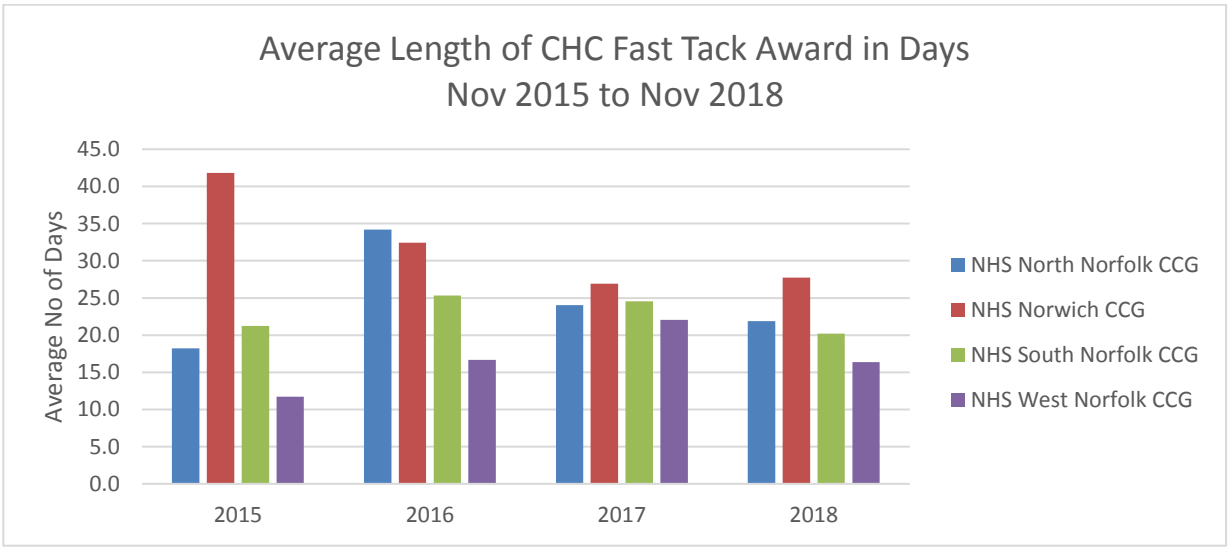
4.1 CHC Fast Track

CHC Fast Track referrals are managed by a small team within central and West Norfolk. These nurses follow each patient from referral, through the assessment and care sourcing process and support their care delivery through the end of life period. They provide continuity and support for patients with oversight of care packages and have the ability to adjust care provision in a timely manner to respond to changes in patient need.

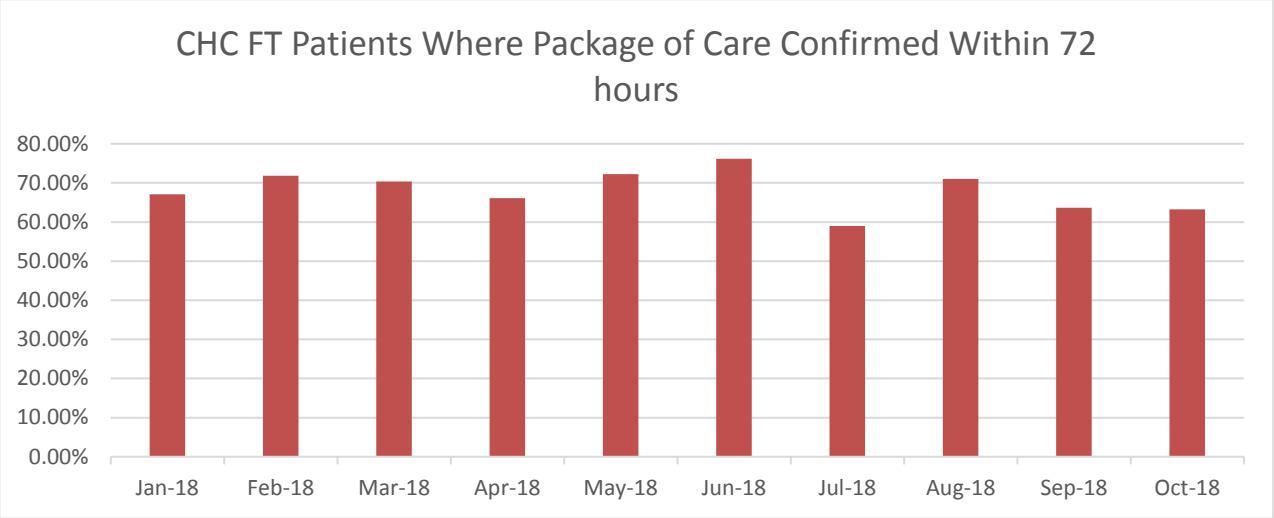
4.1.1 CHC Fast Track Awards by CCG



4.1.2 Average duration (in days) of CHC Fast Track funding over the last 3 years.



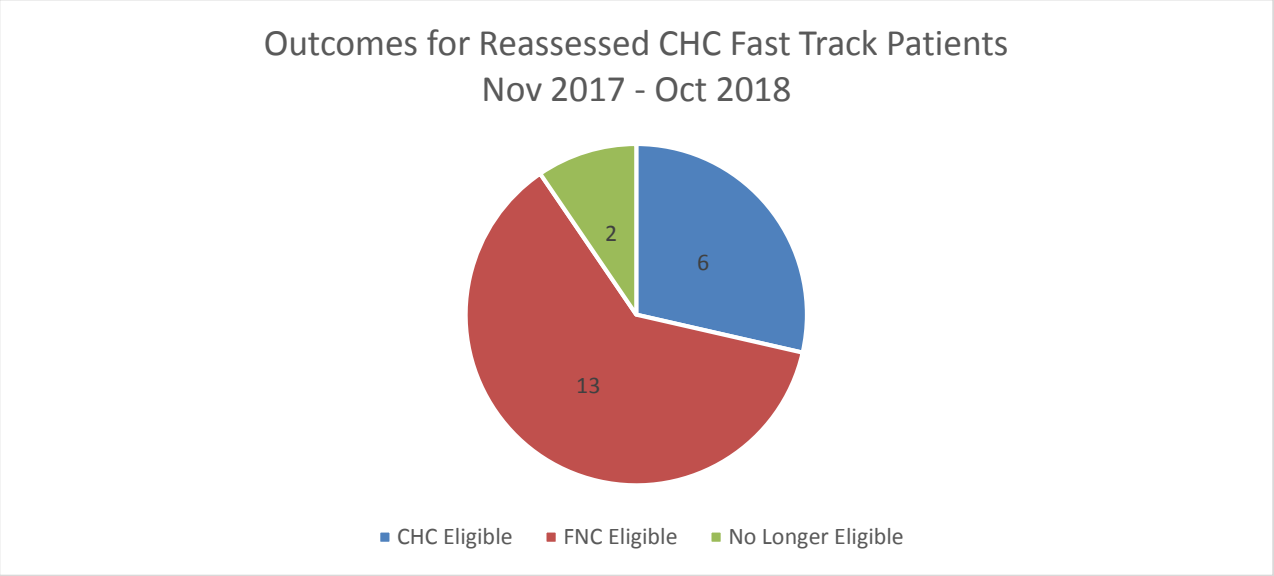
4.1.3 The proportion of CHC Fast Track patients placed within 3 days of referral



Provider capacity remains a nationwide concern and these concerns are mirrored within Norfolk. NCCP are currently working to implement an electronic bed management system to facilitate rapid sourcing of nursing home placements. From 1st October 2018 the National Framework care arranging guidance for patients eligible for CHC Fast Track placement has reduced to 48 hours.

NCCP are exploring alternative mechanisms of sourcing care to provide reliable access to services over the peak winter months and will commission blocks of domiciliary and nursing home care provision from January 2019. NCCP work closely with mainstream NHS commissioned services such as the local Hospice at Home team to ensure we can support timely discharge from hospital and provide the best collaborative service possible to the people of Norfolk.

4.1.4 Number of CHC Fast Track patients that plateau and require ongoing care and who this is provided by



Where a patient who is in receipt of CHC Fast Track experiences a plateau in their condition they may undergo a reassessment of eligibility for CHC. In the cases where this has occurred between November 2017 and October 2018, 90.5% of patients have remained eligible for some form of

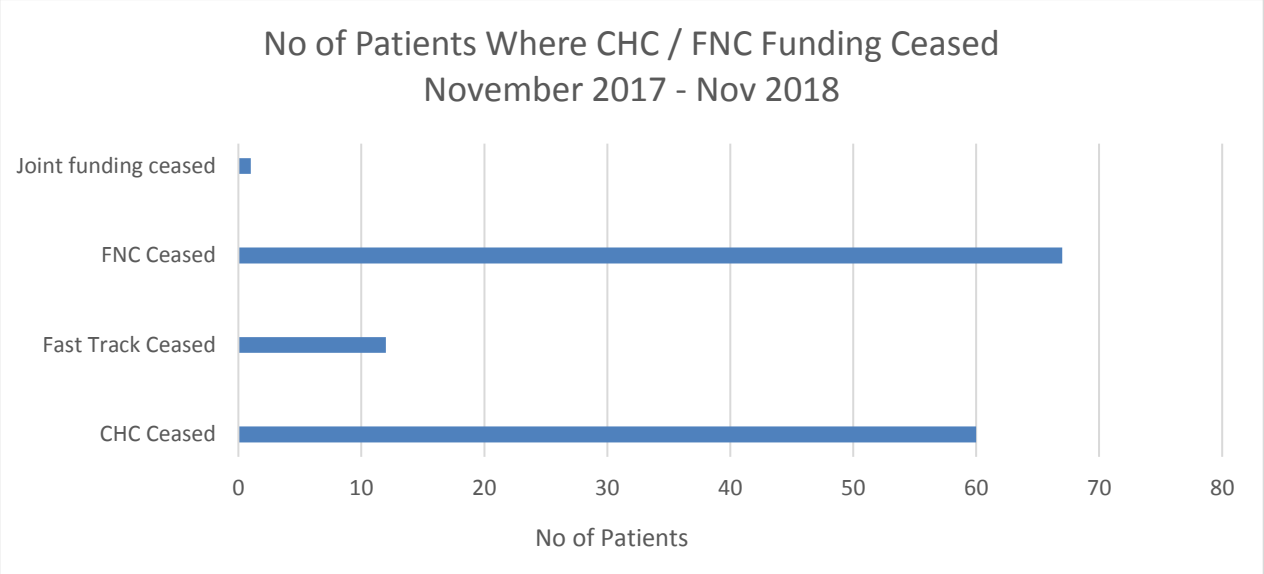
NHS funded care. For the remaining two patients who were not eligible, this was because their assessed health needs could be met through mainstream NHS services such as district nursing and specialist palliative care services.

4.2 Cessation of FNC / CHC Funding

All patients that are no longer eligible for full CHC or Fast Track CHC are referred to Norfolk County Council (NCC) Adult Social Services for assessment of eligibility for social care support in line with the requirements of the Care Act (2014). The NHS National Framework for Continuing Healthcare (2018) clearly sets out that 'no services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place'.

NCCP uphold this element of the Framework vigorously and work closely with NCC to ensure social care representation within the assessing multidisciplinary team wherever possible. When responsibility for a patient moves between one funding body and another, clear processes have been put in place, agreed notice periods are observed and information on the changes are provided to the patient in a timely way.

4.2.1 Number of patients where CHC / FNC funding has ceased



4.2.2 Number of patients where exceptional decisions have been made to continue funding despite no longer being eligible

Under the National Health Service Commissioning Board and Clinical Groups Regulations (2012) and NHS National Framework for Continuing Healthcare (2012, 2018) the CCG remains responsible for contributing to identified health needs regardless of eligibility for Continuing Health Care. Where patients are no longer eligible for CHC or FNC, the CCG ensures that patients are considered for alternative funding, either by mainstream NHS commissioned services such as community nursing, or by part funding an individual package of support as a joint package of care.

4.3 Discharge to Assess (D2A) Pathways

The 2018 version of the National Framework for Continuing Healthcare and NHS-funded Nursing Care sets out a requirement for CCGs to ensure that eligibility for NHS Continuing Healthcare is considered after discharge from hospital wherever possible. This enables a period of recovery and optimisation of health potential and enables assessment to take place in care environment where the person's ongoing needs should be clearer.

NCCP provide an oversight function to the central Norfolk D2A pathway but have limited involvement in the West Norfolk D2A Pathway from the Queen Elizabeth Hospital (QEH).

4.3.1 Discharge to Assess (D2A) Pathway at the Norfolk and Norwich University Hospital (NNUH)

The D2A Pathway at the NNUH has undergone a 12 month pilot and is in the process of transition to a business as usual model. Norwich, North Norfolk and South Norfolk CCGs have collaborated with Norfolk County Council and the NNUH to establish and deliver the pathway.

Patients with complex health needs may be considered for the D2A Pathway using a screening tool. This enables a multiprofessional approach to select the most appropriate discharge pathway for each individual patient. Where a patient has ongoing care needs that require consideration for CHC they will enter the D2A pathway and be supported to leave hospital into an NHS funded care placement either in their own home with a package of care, or to a nursing home environment.

A team of nurses and therapists visit regularly to provide support to enable each patient to reach their health optimum.

A full CHC assessment is undertaken with the patient and their representatives at the most appropriate point. Designated social workers are assigned to support the pathway, participate in all assessments and provide social care expertise and onward support to those patients that may not be eligible for CHC.

4.3.2 Discharge to Assess (D2A) Pathway at the Queen Elizabeth Hospital, Kings Lynn (QEH)

The Discharge to Assess Pathway from the QEH has been running since 2016 as a collaboration between QEH, NCC, and West Norfolk CCG. The pathway is currently under review with overarching leadership and management provided by West Norfolk CCG.

Patients are selected for the D2A pathway by specialist Discharge Coordinators at the QEH hospital and offered a supported placement in their own home or a care home environment. Patients are reviewed by a D2A case manager and referred to NCCP for assessment for CHC when they have reached their health optimum. As with central Norfolk, designated social workers are assigned to support the pathway, participate in all assessments and provide social care expertise and onward support to those patients that may not be eligible for CHC.

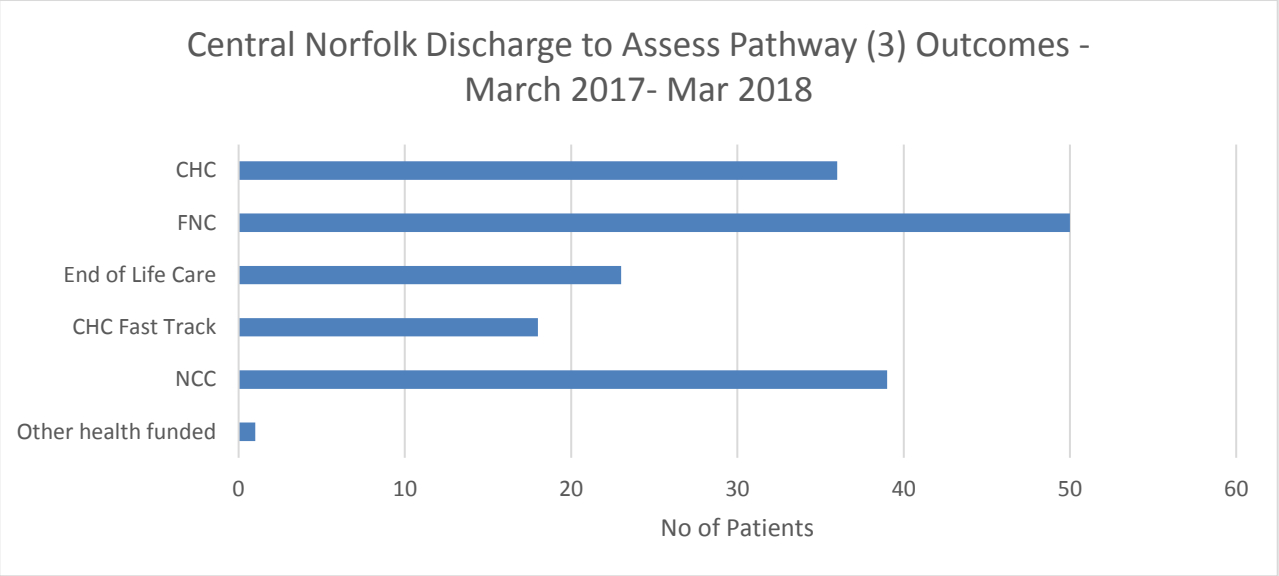
4.3.3 Number of patients assessed and declined at each hospital

For central Norfolk, the D2A end of year report (March 2017 - March 2018) stated that 1442 Discharge to Assess referrals were received by the discharge team at the Norfolk and Norwich University Hospital. Of these, 167 patients were identified as appropriate for the pathway. This equates to 11.6% of all 5Q Care Test's (D2A screening tool) completed.

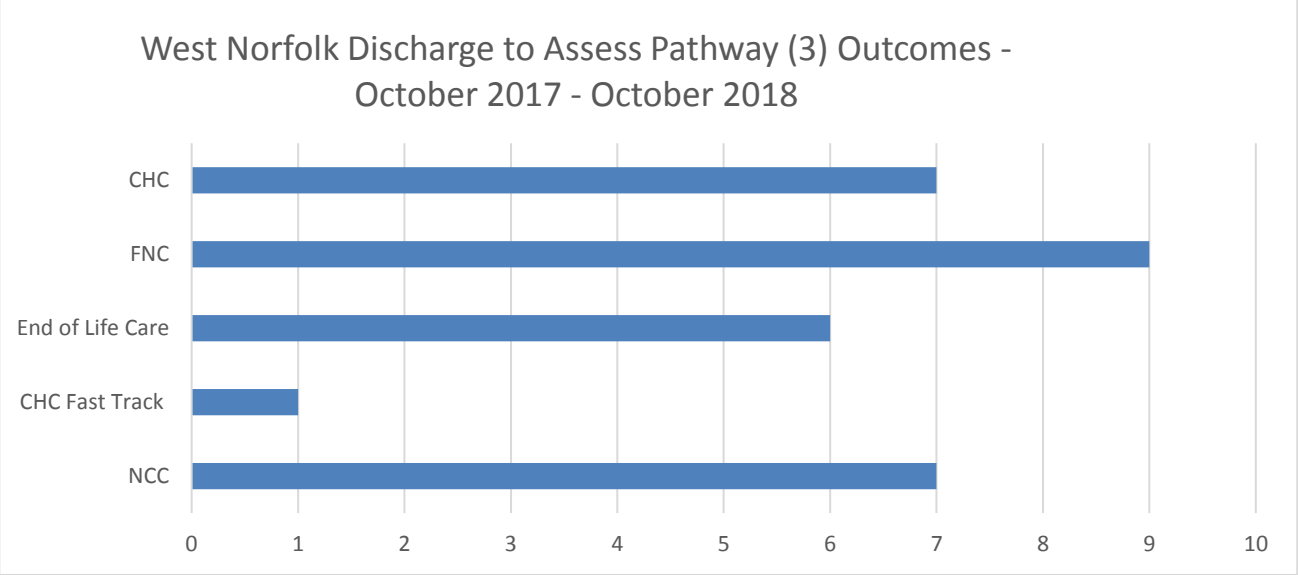
During the 12 month period from March 2017 – March 2018 on the QEH D2A pathway 482 5Q D2A referrals were received. Of these, 91 were identified as appropriate for the pathway which equates to 18.88%.

4.3.4 Number of patients eligible / not eligible for CHC after D2A pathway

Of the 167 patients placed on the D2A pathway in 17/18, 62% (no. 104) received some form of ongoing health funding with 22% (no. 36) of patients becoming eligible for CHC funding.



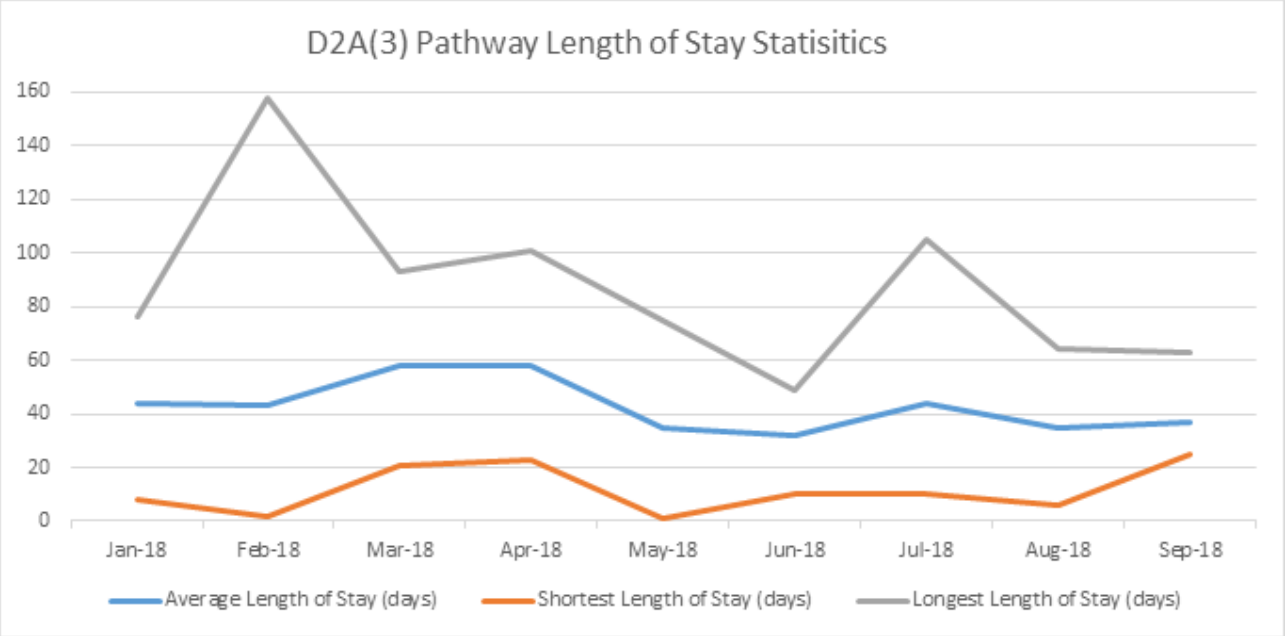
NCCP have provided information regarding the outcome of D2A patients who were referred to NCCP for assessment however this is not representative of the whole cohort of patients that accessed this pathway.



4.3.5 Number of beds used for D2A in relation to each of the 3 hospital areas

Beds are commissioned on a spot purchase basis for the central and West Norfolk D2A pathways and bed usage is variable. Concurrent usage has decreased over time as the average length of stay has stabilised. Employment of social workers specifically to support the D2A pathways has had a

significant impact in reducing bottle necks in the assessment process in central Norfolk since February 2018.



D2A Pathway Length of Stay Statistics for the central Norfolk D2A pathway.

4.4 Statistical Benchmarking of CHC and FT Consideration and Eligibility by CCG Area

CHC data is collated and submitted to NHS England on a quarterly basis of behalf of the CCG Partners. This enables NHS England to provide benchmarking data regarding individual CCG variance and national averages. The full statistical data sets can be accessed via the following link;

https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/.

5.4.1 Quarter 1 and 2 CHC Data for Central and West Norfolk CCGs, With National, Regional and Sub-regional Comparative Rates

To determine the eligibility rate per 50K population, the GP patient list size for patients aged 18 or above at the end of each quarter, is used. National, regional and sub-regional comparative rates are included within the tables but a more sophisticated 'cluster' based methodology has been developed by NHSE for benchmarking purposes.

Comparison of the Quarter 1 and 2 data sets indicates that the central and West Norfolk CCGs experience variability in conversion rates despite centralised processes. The numbers assessed as eligible are becoming more consistent locally, but remain lower than regional and national levels.

Quarter 1 Data for NCCP CCGs

NHS Continuing Healthcare Quarterly Figures
CCG Q1 2018-19 Data Collection
09 August 2018
NHS CHC Data Team
england.chcdata@nhs.net

	Number of new referrals (not including PUPoCs)				Number of referrals completed (including discounted referrals)		Number assessed as eligible		Assessment Conversion Rate (% newly eligible cases of total cases assessed)	
	Standard NHS CHC (non Fast Track)		Fast Track		Within 28 Days (Standard NHS	% within 28 Days (Standard NHS CHC)	Standard NHS CHC (non Fast Track)	Fast Track	Standard NHS CHC (non Fast Track)	Fast Track
Organisation	**Total**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Total**
ENGLAND - 195 CCGs	**18,853**	**20.10**	**23,575**	**25.13**	**14.15**	**67%**	**4.76**	**23.25**	**27%**	**100%**
MIDLANDS AND EAST OF ENGLAND REGION - 59 CCGs	**6,059**	**21.40**	**7,436**	**26.27**	**15.69**	**69%**	**6.01**	**24.68**	**30%**	**100%**
NHS ENGLAND MIDLANDS AND EAST (EAST) - 14 CCGs	**1,152**	**16.86**	**1,588**	**23.24**	**11.80**	**72%**	**3.76**	**21.37**	**26%**	**100%**
NHS NORTH NORFOLK CCG	33	11.36	84	28.90	6.88	91%	0.69	24.09	10%	100%
NHS NORWICH CCG	43	11.11	88	22.74	7.75	100%	1.29	19.90	17%	100%
NHS SOUTH NORFOLK CCG	50	13.56	93	25.21	8.68	89%	2.17	21.69	22%	100%
NHS WEST NORFOLK CCG	33	11.42	25	8.65	6.58	83%	3.11	7.96	39%	100%

Quarter 2 Data for NCCP CCGs

NHS Continuing Healthcare Quarterly Figures
CCG Q2 2018-19 Data Collection
08 November 2018
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	Number of new referrals (not including PUPoCs)				Number of referrals completed (including discounted referrals)		Number assessed as eligible		Assessment Conversion Rate (% newly eligible cases of total cases assessed)	
	Standard NHS CHC (non Fast Track)		Fast Track		Within 28 Days (Standard NHS CHC)	% within 28 Days (Standard NHS	Standard NHS CHC (non Fast Track)	Fast Track	Standard NHS CHC (non Fast Track)	Fast Track
Organisation	**Total**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Total**
ENGLAND - 195 CCGs	**18,763**	**19.84**	**23,748**	**25.12**	**14.72**	**71%**	**4.28**	**23.94**	**25%**	**100%**
MIDLANDS AND EAST OF ENGLAND REGION - 59 CCGs	**6,106**	**21.49**	**7,452**	**26.23**	**16.76**	**76%**	**4.86**	**24.88**	**26%**	**100%**
NHS ENGLAND MIDLANDS AND EAST (EAST) - 14 CCGs	**1,154**	**16.85**	**1,552**	**22.66**	**12.06**	**63%**	**4.40**	**21.81**	**26%**	**100%**
NHS NORTH NORFOLK CCG	47	16.14	73	25.06	9.96	91%	1.72	22.66	16%	100%
NHS NORWICH CCG	37	9.49	85	21.80	8.72	92%	2.82	20.01	31%	100%
NHS SOUTH NORFOLK CCG	45	12.16	78	21.07	12.43	100%	2.16	19.45	19%	100%
NHS WEST NORFOLK CCG	45	15.55	26	8.99	12.79	90%	2.42	8.99	17%	100%

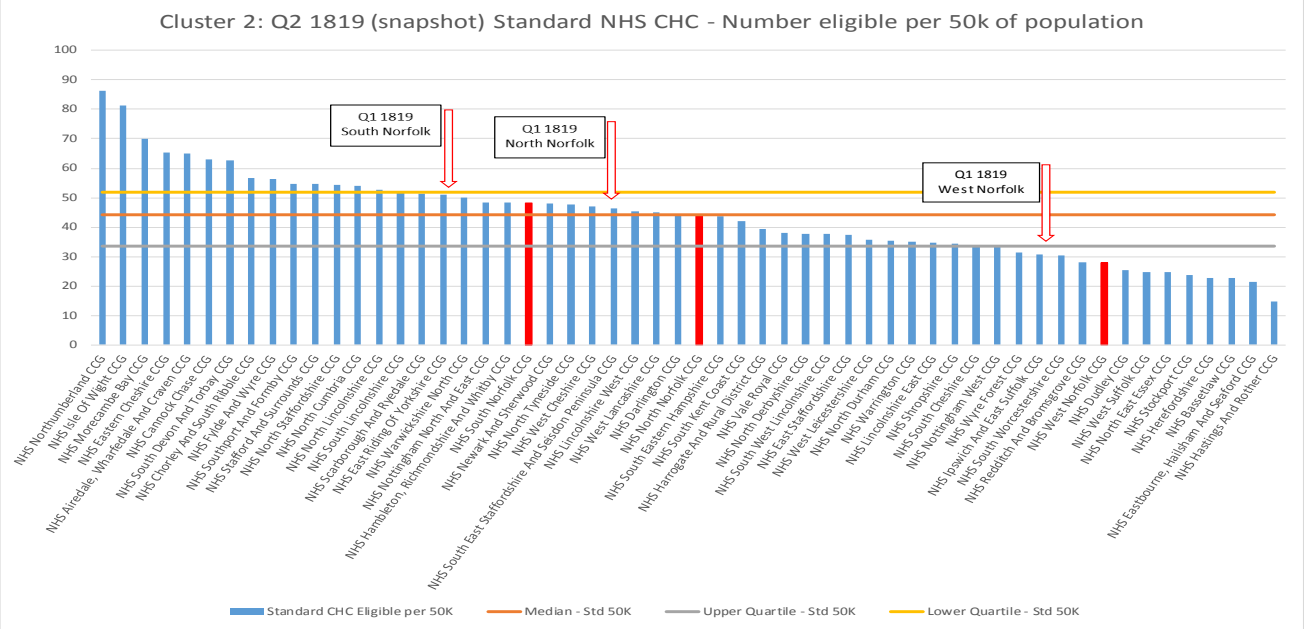
It is believed that the significantly lower number of CHC Fast Track referrals in West Norfolk is due to the existence of other commissioned End of Life services which can be accessed without the need for completion of a Fast Track referral.

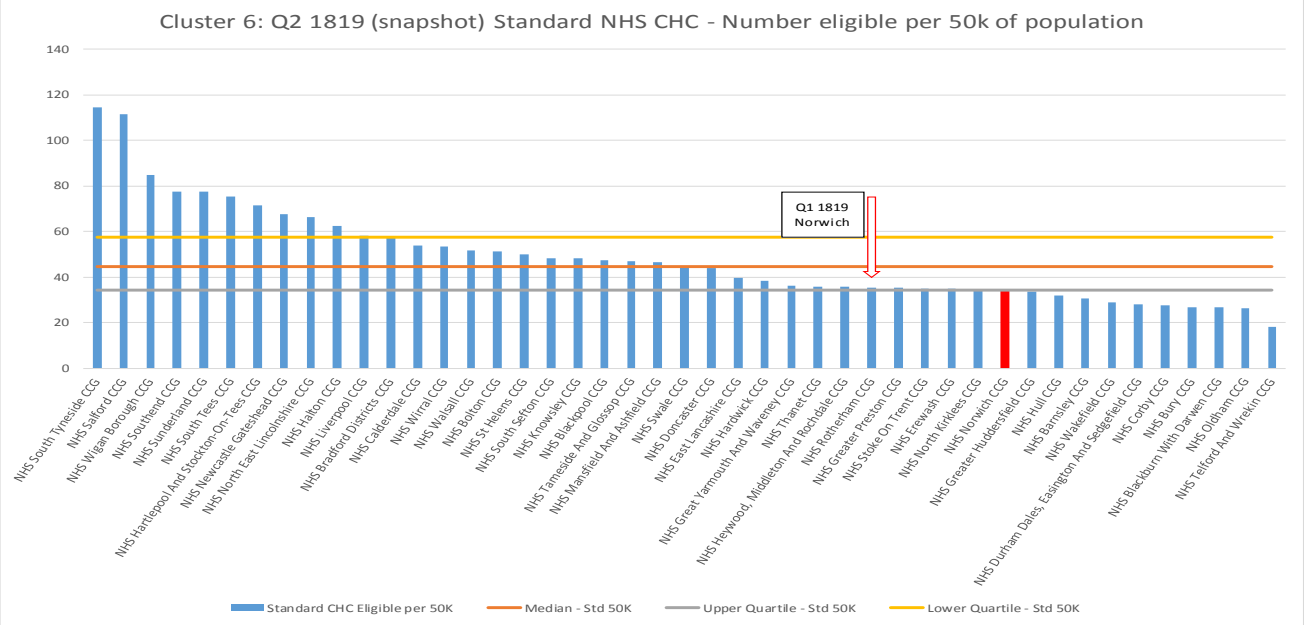
4.4.2 NHS England Cluster Benchmarking

In 2017/18, NHSE developed a 'cluster' benchmarking methodology to interrogate CHC data. NHSE identified comparable CCGs based on a number of factors including, rural population; deprivation; proportion of population aged over 65; ethnic diversity and various disease prevalence. North Norfolk CCG, South Norfolk CCG and West Norfolk CCG are included within Cluster 2, while Norwich CCG is included within Cluster 6.

This methodology was developed further for 2018/19 and is now used by NHS England as part of individual CCG assurance by identifying CCGs, with comparable populations, who have either a high or low incidence of CHC eligibility.

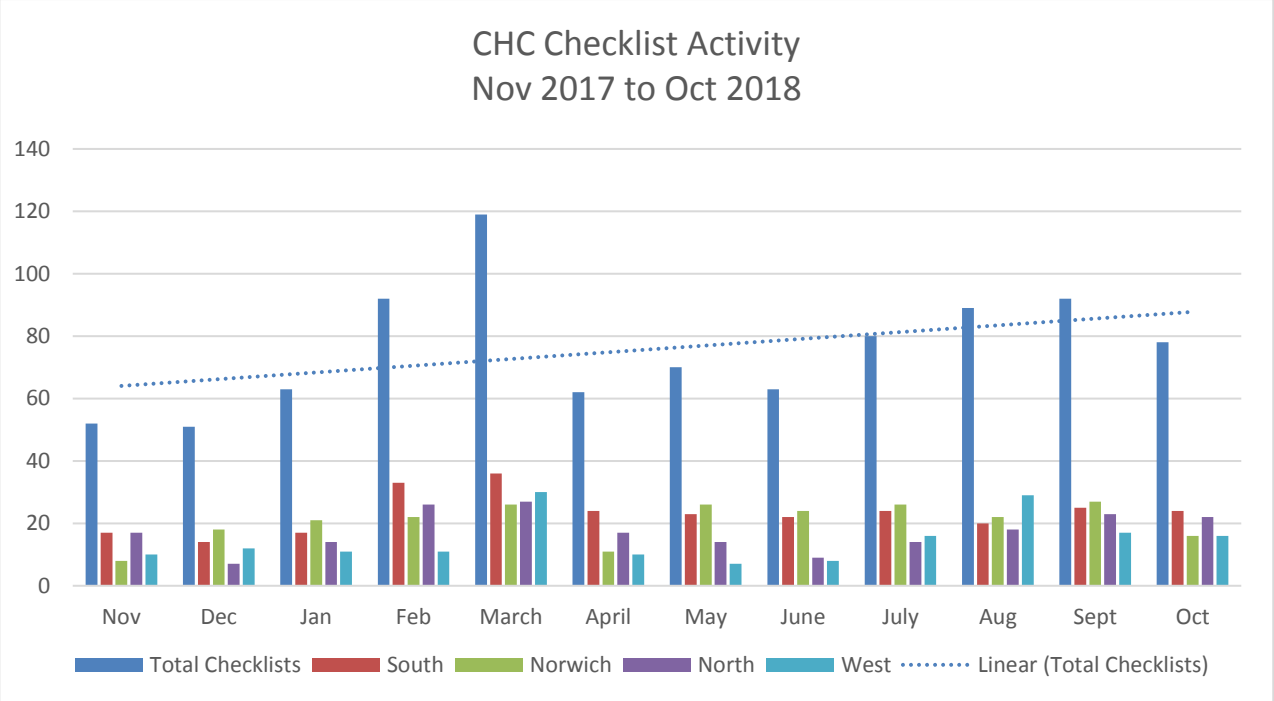
As at the end of Q2 2018/19, the position of the Norfolk CCGs within these cluster groupings was as set out in the chart on the following page. The charts identify how each CCG's CHC eligibility numbers compare with similar CCGs, and how their position in the cluster group has changed between Q1 2018/19 (end of June) and Q2 2018/19 (end of Sept).





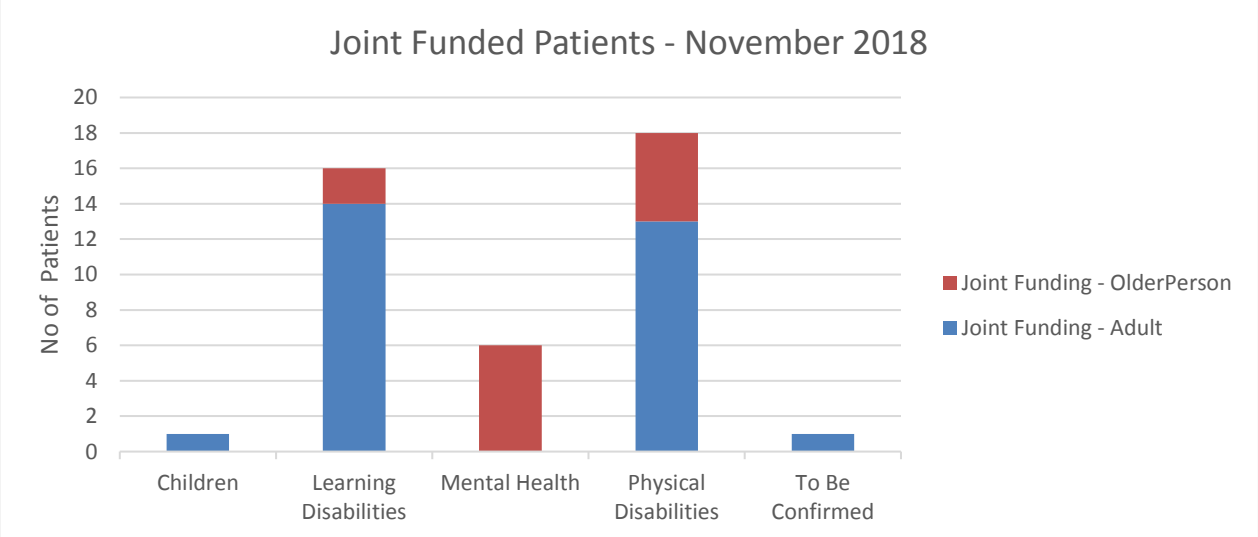
4.5 No of CHC Checklists Completed

The graph below shows the number of CHC Checklist referrals received by NCCP for the 12 months from service commencement in November 2017. The trend line indicates an overall increase in referrals.



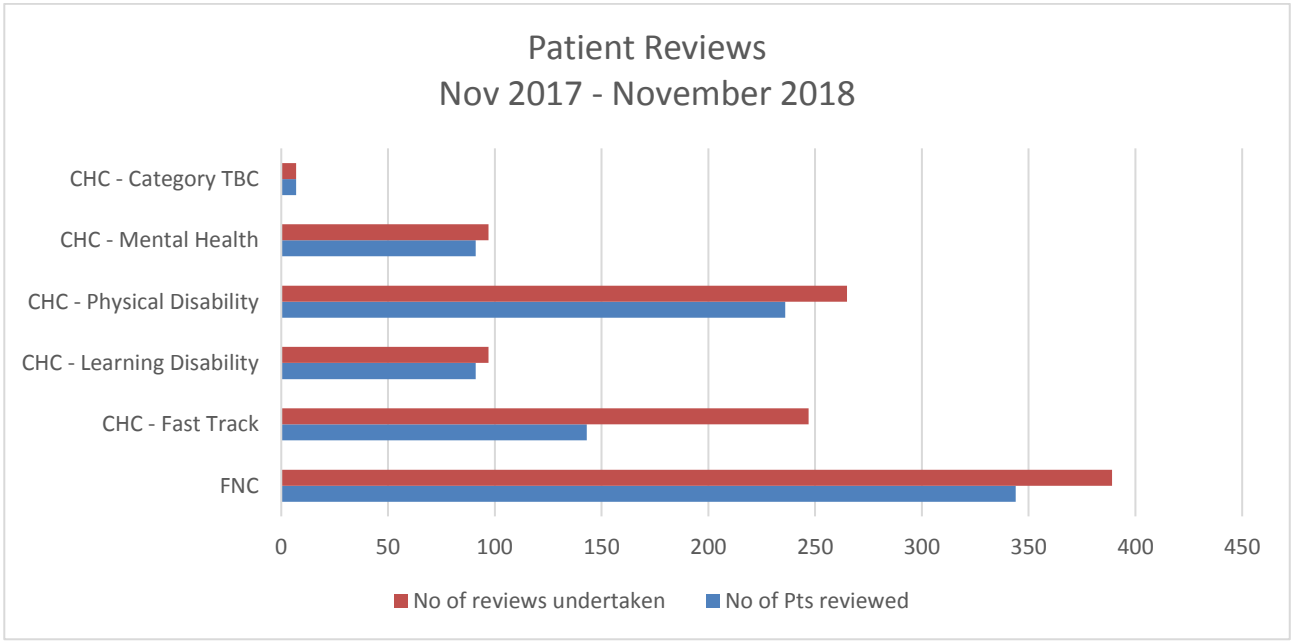
4.6 Shared Care Agreements

The current number of Joint Funded packages of care are indicated in the table below broken down into 'primary categories' as requested.



4.7 Reviews of Individual Packages of Care in 2018

The review activity undertaken by NCCP in the last 12 months is represented below according to patient category. The recording system used does not differentiate between eligibility and package of care reviews, but in practice every review will involve a package of care review to ensure patients clinically assessed needs are being met through the care provided.



4.8 Local System Changes to Reflect the Requirements of the Revised National Framework for Continuing Healthcare and NHS-funded Nursing Care (2018)

The Norfolk Continuing Care Partnership have undertaken significant preparation for the implementation of the new National Framework for Continuing Healthcare and NHS-funded Nursing Care (2018). The entire senior management team have attended training from a legal firm that specialises in CHC, to ensure that the nuance of the changes are well understood and accommodated at all levels within the organisation. A detailed action plan has been developed and implemented by key members of staff with activity carefully coordinated via a weekly steering group. The following measures have been put in place;

- All CHC clinical staff and specialist CHC Social Workers have attended NHSE training events, workshops and local updates to ensure readiness for practice.
- A series of additional role specific training sessions have been held for all staff within NCCP to facilitate an understanding of the changes to the National Framework and new ways of working.
- A case management model has been implemented and all patients have a named case manager allocated from 01.10. 2018.
- Websites and communication materials have been updated for all partner CCGs.
- The NCCP service KPIs have been updated to reflect new requirements (Fast Track patients placed within 48 hours).
- All mandated CHC documentation (CHC Checklist, Fast Track Tool, Decision Support Tool) has been updated and disseminated to stakeholders for use.

- The change in focus to undertake ‘care reviews’ rather than ‘eligibility reviews’ has been implemented and supported by a change in terminology, supporting documentation and reference points throughout the IT systems used by NCCP.

- An integrated training plan has been developed in collaboration with NCC colleagues and a joint CHC training programme is due to commence on a monthly basis from January 2019.

- The NCCP Appeals process is already in place with system for local resolution that is fully compliant with the new National Framework.