Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 25 February 2016**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Mr A Dearnley	Norfolk County Council
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Ms S Bogelein	Ms L Grahame	Norwich City Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr N Smith	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mrs S Matthews	Mr R Richmond	Breckland District Council
Mrs M Stone	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council

Mrs S Young	Vacancy	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 3 December 2015. (Page 5)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter.

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role

- that of another public body of which you are a member to a greater extent than others in your ward.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4.		**To receive any items of business which the Chairman decides should be considered as a matter of urgency**		
5.		**Chairman's announcements**		
6.	**10.10 – 10.45**	**NHS South Norfolk Clinical Commissioning Group – changes to policies and services in 2015-16**	(Page	23)
		Representatives of NHS South Norfolk Clinical Commissioning Group will answer members' questions.		
7.	**10.45 – 11.30**	**CCG commissioning intentions and plans for 2016-17**	(Page	29)
		Appendix A – Healthwatch letter to CCGs	(Page	33)
		Appendix B – CCG's report (Norwich, North Norfolk, South Norfolk and West Norfolk)	(Page	35)
	11.30 – 11.40	**Break at the Chairman's discretion**		
8.	**11.40 – 12.15**	**Continuing healthcare**	(Page	57)
		Appendix 1 – Letter from Equal Lives	(Page	61)
		Appendix 2 – CCGs' response to Equal Lives	(Page	64)
		Appendix 3 – CCGs' report	(Page	67)
9.	**12.15 – 12.30**	**Children's mental health services in Norfolk**	(Page	158)
		To agree areas and issues for future scrutiny		
10.	**12.30 – 12.40**	**Forward work programme**	(Page	162)
Glossary of Terms and Abbreviations			(Page	164)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 16 February 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 3 December 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Mrs S Matthews	Breckland District Council
Mrs M Stone	Norfolk County Council

Substitute Member Present:
Mrs M Fairhead for Mrs S Weymouth, Great Yarmouth Borough Council
Ms L Grahame for Ms S Bogelein, Norwich City Council
Mrs M Wilkinson for Mr B Bremner, Norfolk County Council

Also Present:

Dr Louise Smith	Director of Public Health, Norfolk County Council
Dr Martin Hawkings	Consultant in Public Health, Norfolk County Council
Jonathan Stanley	Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council and Clinical Commissioning Groups
Clive Rennie	Assistant Director of Commissioning Mental Health and Learning Disabilities, NHS and Norfolk County Council
Denise Clark	Interim Head of Specialised Mental Health (East of England), NHS England Specialised Commissioning
Andy Goff	Improvement and Development Manager, Norfolk and Suffolk NHS Foundation Trust
Dr Catherine Thomas	CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust
Dr Sara Ramirez-Overend	CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust
Dr Kiran Chitale	CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust
Dan Mobbs	Chief Executive of MAP (one of the providers of tier 2 child and adolescent mental health services in Norfolk, as part of the Point 1 consortium)
Andrew Fox	Deputy Director of Operations at the James Paget University Hospitals NHS Foundation Trust
Dr Kneale Metcalf	Consultant Physician, Norfolk and Norwich University Hospitals NHS Foundation Trust

Candy Jeffries	Cardiovascular Strategic Clinical Network Manager (East of England), NHS England
Dr Mazhar Zaidi	Stroke and Orthogeriatrics Consultant and Divisional Director for the Emergency Division, James Paget University Hospitals NHS Foundation Trust
Colin and Joyce Bell	Members of the Public
Deborah Wooler	Head of Specialist Rehabilitation, Norfolk Community Health & Care NHS Trust
Manjari Mull	Stroke Services Manager, Norfolk and Norwich Hospital
James Joyce	County Councillor and Chairman of Children's Services Committee, Norfolk County Council
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1. Apologies for Absence

Apologies for absence were received from Ms S Bogelein, Norwich City Council, Mr B Bremner, Norfolk County Council, Mrs A Claussen-Reynolds, North Norfolk District Council, Mrs S Young, Borough Council of King's Lynn and West Norfolk and Mrs S Weymouth , Great Yarmouth Borough Council

2. Minutes

The minutes of the previous meeting held on 15 October 2015 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements: NHS Workforce Planning in Norfolk – response from Ben Gummer MP, Parliamentary Under Secretary of State for Care Quality

5.1 The Chairman referred to a letter from Ben Gummer MP, Parliamentary Under Secretary of State for Care Quality, in response to the Committee's letter to the Secretary of State for Health, regarding NHS workforce planning in Norfolk. Copies of the letter had been emailed to Members before the meeting and were laid on the table in the Committee room for information.

5.2 The Committee agreed that the Chairman and Mrs Stone (the Chairman of the Scrutiny Task and Finish Group) should be co-signatories to a letter to Simon Stevens, Chief Executive of NHS England, about the key issues of concern to Members, namely, Service Increment Funding for Teaching (SIFT) and the importance of speeding up the progress towards a fair share of funding for Norwich Medical School.

6 **Children's Mental Health Services in Norfolk**

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to the issues and concerns raised in the terms of reference for scrutiny of children's mental health services that were agreed by the Committee in September 2015. The report provided the Committee with an opportunity to discuss Norfolk's Local Transformation Plan for children and young people's mental health with the commissioners and providers of such services.

6.2 The Committee received evidence from Dr L Smith, Director of Public Health, Norfolk County Council, Dr Martin Hawkings, Consultant in Public Health, Norfolk County Council, Jonathan Stanley, Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council and Clinical Commissioning Groups, Clive Rennie, Assistant Director of Commissioning Mental Health and Learning Disabilities, NHS and Norfolk County Council, Denise Clark, Interim Head of Specialised Mental Health (East of England), NHS England Specialised Commissioning, Andy Goff, Improvement and Development Manager, Norfolk and Suffolk NHS Foundation Trust, Dr Catherine Thomas, CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust, Dr Sara Ramirez-Overend, CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust, Dr Kiran Chitale, CAMHS Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust, Dan Mobbs, Chief Executive of MAP (one of the providers of tier 2 child and adolescent mental health services in Norfolk, as part of the Point 1 consortium), Andrew Fox, Deputy Director of Operations at the James Paget University Hospitals NHS Foundation Trust.

6.3 In his introductory remarks, the Chairman said that Child and Adolescent Mental Health Services (CAMHS) were jointly commissioned by the NHS Clinical Commissioning Groups and Norfolk County Council Children's Services using pooled funds. The services were provided by NHS and voluntary sector organisations. In a joint commissioning situation it was impossible to scrutinise the health service in isolation from the local authority service and the CAMHS commissioners worked across both organisations. If there were to be any recommendations from the NHOSC then they would be reported to Children's Services Committee as well as to the relevant NHS organisations.

6.4 The Committee received a short presentation by Dr Martin Hawkings on the numbers and spread of children's mental health needs throughout Norfolk.

6.5 In the course of discussion the following key points were made:

- The witnesses said that one in ten children and young people needed support or treatment for mental health problems. These problems ranged from short spells of depression or anxiety through to severe and persistent conditions that could isolate, disrupt and frighten those who experienced them.
- Mental health problems in young people could result in lower educational attainment and were strongly associated with behaviours that posed a serious risk to health, such as social isolation, eating disorders, self-harm and criminal activity.
- In Norwich and Great Yarmouth, a higher than average percentage of children and young people with mental health issues entered the youth justice system. Norwich and Great Yarmouth also had a higher than

average number of recorded cases of self-harm amongst children and young people.

- Dr Martin Hawkings was asked to provide details about how the level of self-harm amongst children in deprived areas of Norfolk (particularly Great Yarmouth) compared to the levels in similar areas of deprivation nation-wide.
- The witnesses said that many adult mental health problems were present before the age of 18.
- Early intervention avoided young people falling into crisis and avoided expensive and longer term interventions in adulthood. Continued support throughout teenage years, and into the early 20s, avoided a sudden fall off in support on reaching adulthood.
- Child and Adolescent Mental Health Services (CAMHS) were making a number of fundamental changes in how mental health services were delivered, moving away from a system defined in terms of the services provided by public and voluntary organisations (the 'tiered' model described in the report) towards a system that was built around a more co-ordinated approach to meeting the needs of children, young people and their families generally.
- For instance, steps were being taken to embed Tier 3 teams in children's centres. Three dedicated teams had been set up in children's centres in King's Lynn, Great Yarmouth and Norwich.
- The Committee was informed that children's centres, schools, school health services, youth centres, primary care and District Councils all had their own important roles to play in providing a means of delivering mental health promotion and prevention activities, and worked best on mental health issues when they operated together on a whole-system basis.
- In Norfolk as a whole there was a 25% year on year increase in the number of children with eating disorders. The CAMHS staff visited schools to work alongside teachers and school staff to tackle this issue.
- It was pointed out by a Member that Norwich City Council had introduced a "Street Champions" Scheme that would be able to provide assistance to CAMHS in identifying and promoting ways to tackle mental health issues in the City.
- The witnesses said that for a number of years the rising number of referrals accompanied with the squeeze on budgets had led to increasing delays for treatment.
- The award of an extra £1.9m per year of Government funding to develop local provision for children and young people with mental health needs In Norfolk and Waveney was seen by the witnesses as a positive step forward. They said a large amount of this new money would be invested directly into bolstering the care pathway for children and young people, providing additional support to the Police on mental health issues and in meeting the costs of recruiting and employing additional CAMHS staff, and providing for the training of more "home grown" staff.
- The Point 1 service was commissioned to provide a "maximum average" of 6 sessions of support per client. This meant that some children and young people received significantly more than 6 sessions. The witnesses said that in services where there were no limits on the number of sessions, clients on average had 8 sessions.
- The witnesses said that there was evidence to show that most young children and their families favoured a "family centred" approach to meeting mental health needs and supported the initiatives, such as the "Think Family" and the local "Compass Outreach" programmes that were mentioned in the report. However, for some of the hard to reach young

people in their late teens a one to one service might be considered more appropriate.

- The availability of public transport and travelling distances were important issues for parents and carers who had to go outside of their immediate area to get the kind of specialist services for their children that they needed.
- Members stressed the importance of regular mental health assessments for "Looked After" Children who needed them.
- The witnesses estimated that only 25% of children with mental health issues were issued with a Statement of Special Educational Needs.
- The witnesses added that Norfolk as a whole was ahead of the average for most of the performance benchmarks and targets for children with mental health needs that were mentioned in the report. For instance, the waiting time in Norfolk for first treatment was estimated at 8 weeks which compared with a national target of 18 weeks and waiting times of up to a year in other parts of the country.
- The witnesses said that it was difficult to put in place meaningful long term performance targets for children's mental health services when many of the leading causes of mental health were linked to family breakdowns and social problems in society generally. However, significant further improvements in CAMHS services should be clearly visible in the next two years.

6.4 The Committee **agreed** to carry out a further assessment of the progress of children's mental health services at a future meeting. Members' were asked to raise any outstanding issues of concern on this subject that they might wish to raise at a future meeting to Maureen Orr so that they could be considered for inclusion in the forward work programme when the Committee next meets in February 2015.

7 **Stroke Services in Norfolk**

7.1 The Norfolk and Waveney Stroke Network (the Network) updated Members on developments in stroke services following the recommendations made by the Committee in July 2014. The Network's progress report drew together updates from all the organisations to which the Committee had originally made recommendations.

7.2 The Committee received evidence from Dr Kneale Metcalf, Consultant Physician, Norfolk and Norwich University Hospitals NHS Foundation Trust, Candy Jeffries, Cardiovascular Strategic Clinical Network Manager (East of England), NHS England, Dr Mazhar Zaidi, Stroke and Orthogeriatrics Consultant and Divisional Director for the Emergency Division, James Paget University Hospitals NHS Foundation Trust. The Committee also heard from Colin and Joyce Bell, members of the public.

7.3 In the course of discussion the following key points were made:

- The witnesses from the Norfolk and Waveney Stroke Network (the Network) updated Members' on the progress made in stroke care since this issue was last reported to the Committee in November 2014.
- The witnesses said that the position of clinical lead was shared between consultants in the Network and that the acute hospitals were benefiting from a coordinated approach to best practice.
- The Network was continuing to work with EEAST on the number and location of ambulance bases in Norfolk. The travelling times to the hyper

acute stroke units remained below expectations in some areas of north and south Norfolk.

- The ageing population was likely to increase the numbers of people living with a disability arising from stroke.
- The ages of those who were being treated for stroke had continued to fall and it was not uncommon for people aged in their 50s to require assistance.
- The Committee was informed that the James Paget University Hospitals NHS Trust (JPH) had advertised nationally to increase numbers of stroke specialist consultants and nurses in its service and continued to experience significant recruitment difficulties. The recruitment process had, however, identified two potential candidates for senior stroke positions at the JPH who were due to complete their training shortly.
- The Committee was pleased to hear that the NNUH had 6 stroke specialist consultants and 5 specialist registrars.
- Further details as to numbers of specialist stroke staffing and numbers of rehabilitation beds throughout Norfolk could be found at Appendix A to these minutes (this revises the figures that Members received before the meeting).
- Overall, the stroke services at the NNUH and at the JPH were in a better position now than they were in 12 months ago.
- At the present time, 13 stroke patients at the NNUH were waiting for transfer of care or discharge outside of the hospital. Discharge from the hospital was led by a specialist stroke support team.
- Witnesses considered that delays in processing of patients, particularly for entitlement to Continuing Health Care, were a more significant part of the problem than the availability of intermediate care beds. Great Yarmouth and Waveney CCG had commissioned 7 beds where patients could wait for assessment.
- With regard to improving specialist stroke cover, a dedicated stroke consultant was available at the NNUH at weekends. This was considered a significant improvement since the issue was last been reported to the Committee.
- The witnesses said that more in-depth analysis was required of the data that the Sentinel Stroke National Audit Programme (SSNAP) was generating in relation to stroke services in Norfolk.
- The Cardiovascular Strategic Clinical Network Manager (East of England) said that the National Clinical Director for Stroke had been visiting hospitals in Norfolk and would be looking at ways to support links between them.
- Mrs Bell, a member of the public, spoke about the difficulties stroke carers within the family could experience in getting the right kind of stroke support to be able to provide care at home and how stroke related issues could lead to depression, mental health issues and family breakdowns. She also emphasised the importance of making it easy for people to be referred back into the rehabilitative service if necessary.

7.4 The Committee **agreed** :

1. To note the recommendations of the Review of Stroke Rehabilitation report to the Norfolk and Waveney Stroke Network, commissioners and providers.

2. To ask for a further update from Norfolk and Waveney Stroke Network at a future meeting.

8. Forward work programme

8.1 The forward programme was **agreed** with the following additions:-

For the meeting on 25 February 2015

CCG commissioning intentions for 2016-17 (the three central Norfolk CCGs and West Norfolk CCG)

Continuing Health Care in Norfolk – to examine the new processes with the three central Norfolk CCGs and West Norfolk CCG.

Children's mental health services in Norfolk – when the Committee should undertake further scrutiny and the issues that should be scrutinised. Members were asked to send details of the issues they wished to examine further to Maureen Orr, Democratic Support and Scrutiny Team Manager.

For a future date – to be arranged

An update from Norfolk and Waveney Stroke Network on progress with stroke services.

8.2 Members who had any other items which they wished to have considered for inclusion in the forward work programme were asked to contact Maureen Orr, Democratic Support and Scrutiny Team Manager in the first instance.

Chairman

The meeting concluded at 12.05 pm

JPH Stroke Unit Specialist staffing

For 5 HASU beds (monitored) and 25 ASU/rehab beds

		WTE posts	WTE in post (including agency and Locum)	Bank/Agency/Locum cover	Comments
Medical	Cons	3.1	3.1	(I of these is agency locum)	
	Spr	1	1		
	Sho	(3 WTE rotating junior doctors on stroke unit, non specialist)			not dedicated to stroke, shared with OPM
Nursing	Band 8A	0			
	Band 7	3	3		
	Band 6	8.45	8.45		
	Band 5	26.25	17.61	0.51	
Unqualified	Band 4	0	0		Generic worker role
	Band 3	0	0		Generic worker role
	Band 2	19.71	15.41		
OT	Band 8A	0	0		
	Band 7	1	1		
	Band 6	1	1		
	Band 5	1	1		
	Band 4	0.89	0.89		
	Band 3	0	0		
Physio	Band 8A	0.9	0.9		
	Band 7	1	1		
	Band 6	1	1		
	Band 5	1	1		
	Band 4	0.89	0.89		
	Band 2	0.74	0.74		
SaLT	Band 8A				
	Band 7	0.2	0.2		1 wte band 5 covering mat leave fixed term contract

	Band 6	0.9	0.9		
	Band 5	1	1		
	Band 4	0	0		
	Band 3	0	0		
Dietetics	Band 8A	0	0		
	Band 7	0	0		
	Band 6	0	0		
	Band 5	0.3	0.3		
Psychology	Band 8A	0	0		
	Band 4	0	0		

ESD team Average caseload 22 patients

OT				
	Band 7	1	0	(vacancy out to advert)
	Band 6	1	1	
	Band 5	0	0	
	Band 4	1.4	1.4	
	Band 3	0	0	
Physio	Band 8A	0	0	
	Band 7	1	1	
	Band 6	1	1	
	Band 5	0	0	
	Band 4	1.4	1.4	
	Band 2	0	0	
SaLT	Band 8A			
	Band 7	0.5	0.5	
	Band 6	0	0	
	Band 5	0	0	
Nursing	Band 6	0.5	0.5	
	Band 5	0	0	

QEH Stroke Unit Specialist staffing

Total bed base is 28

		WTE posts	WTE in post (including agency and Locum)	Bank/Agency/Locum cover	Comments
Medical	Cons	4	4	1	
	Spr	2	2		
	Sho	4	4	1	
Nursing	Band 8A	1	1		
	Band 7				
	Band 6	12	10		
	Band 5	19	16		
Unqualified	Band 4	1	1		
	Band 3	5	5		
	Band 2	15	15	2	
OT	Band 8A	0	0		
	Band 7	1.6	1.6		
	Band 6	3	3		
	Band 5	2	2		
	Band 4	2.72	2.72	OT & PT Assistant	
	Band 3	0	0		
Physio	Band 8A	0	0		
	Band 7	2.2	2.2		
	Band 6	2	2		
	Band 5	1	1		
	Band 4	0	0		
	Band 3	2.52	2.52	OT & PT Assistant	
SaLT	Band 8A	0.1WTE	0.1WTE		
	Band 7	3.0 WTE	3.0 WTE.From 08/04/16 2.64WTE		1 wte band 5 covering mat leave fixed term contract

	Band 6				
	Band 5	0.9WTE	0.9 WTE.From 1/02/16 1.0WTE		
	Band 4	1.0WTE	1.0WTE		
	Band 3	0	0		
Deitetics	Band 8A	0.5	0.5		
	Band 7		0.75		
	Band 6				
	Band 5	0.3	0.3		
Psychology	Band 8A	0.2	0.2		
	Band 4	0.2	0.2		

NNUH Stroke Unit Specialist staffing

For 12 HASU beds (monitored) and 38 ASU beds

		WTE posts	WTE in post (including agency and Locum)	Bank/Agency/Locum cover	Comments
Medical	Cons	6.2	6.2	1 of these is a locum	
	Spr	5	5		
	Sho	3	3		not dedicated to stroke, shared with OPM
Nursing	Band 8A	0.5	0.5		
	Band 7	2	2		
	Band 6	14.44	12.64		Vacancy filled - waiting for staff to start
	Band 5	41.26	36.04		Out to advert
Unqualified	Band 4	4	3		
	Band 3	0.8	1		
	Band 2	34.27	28.7		
OT	Band 8A	0.58	0.58		
	Band 7	1	1		
	Band 6	2.2	2.2		
	Band 5	2	2		
	Band 4	0	0		
	Band 3	0.5	0.5		
Physio	Band 8A	0.2	0.2		
	Band 7	0.6	0.6		
	Band 6	2.41	2.41		
	Band 5	2	2		
	Band 4	0	0		
	Band 3	1.41	1.41		
	Band 2	1.31	1.31		

SaLT	Band 8A				1 wte band 5 covering mat leave fixed term contract
	Band 7	1.3	1.3		This is temporary
	Band 6	1	1		
	Band 5	1	1		
	Band 4	0	0		
	Band 3	0	0		
Deitetics	Band 8A	0	0		
	Band 7	0	0		
	Band 6	0.6	0.6		
	Band 5	0	0		
Psychology	Band 8A	0.8	0.8		shared across pathway Beech, ESD and Acute stroke services
	Band 4	1	1		Maternity leave cover being arranged.

Central Norfolk Stroke Reahabilitation Unit (NNUH commision from NCHC)

For 24 Rehab beds

		WTE posts	WTE in post (including agency and Locum)	Bank/Agency/Locum cover	Comments
Medical	Cons				3 times a week ward round from consultants at NNUH
	Spr				
	Sho	1	1		1 CMT doctor is available, this is managed by NNUH.
Nursing	Band 8A				
	Band 7	1	1		
	Band 6	2	2		
	Band 5	14.58	13.13	Bank and agency utilised as per safer staffing	
Unqualified	Band 4	0	0		
	Band 3	0	0		
	Band 2	19.54	17.2	Bank and agency utilised as per safer staffing	
OT	Band 8A	0	0		
	Band 7	0.66	0.66		
	Band 6	1.48	1.48		
	Band 5	2	2		
	Band 4	4.08	4.08		Generic therapy role shared within therapy team
	Band 3	0	0		
Physio	Band 8A	0	0		
	Band 7	1	0.8		1 day of research not back filled
	Band 6	1	1		on mat leave backfilled with band 5 wte
	Band 5	2	2		
	Band 4	as above	as above		

	Band 3	0	0		
SaLT	Band 8A	0	0		
	Band 7	0.8	0.8		
	Band 6	0	0		
	Band 5	1	1		5/6 developmental post
	Band 4	as above	as above		
	Band 3	0	0		
Deitetics	Band 8A	0	0		
	Band 7	0.3	0.3		
	Band 6	0.4	0.4		
	Band 5	0	0		
Psychology	Band 8A	0.8	0.8		shared across pathway Beech, ESD and Acute stroke services
	Band 4	1	1		Maternity leave cover being arranged.

ESD Service for Central Norfolk (NNUH commission from NCHC)

Covering North Norfolk, Norwich and South Norfolk

		WTE posts	WTE in post (including agency and Locum)	Bank/Agency/Locum cover	Comments
Medical	Cons				3 times a week consultants from NNUH available for advise at ESD
	Spr	0	0		
	Sho	0	0		
Nursing	Band 8A				
	Band 7	1.91	1.91		
	Band 6	1.64	1.64		
	Band 5	1.54	1.54		
Unqualified	Band 4	3	3		Generic worker role
	Band 3	7.6	7.6		Generic worker role
	Band 2	0	0		
OT	Band 8A	0	0		
	Band 7	0.64	0.64		
	Band 6	0.6	6		
	Band 5	2	2		
	Band 4	as above	as above		
	Band 3	as above	as above		
Physio	Band 8A	0	0		
	Band 7	0.64	0.64		
	Band 6	1	1		
	Band 5	2	2		
	Band 4	as above	as above		
	Band 3	as above	as above		
SaLT	Band 8A	0	0		
	Band 7	0.8	0.08		1 wte band 5 covering mat leave fixed term contract
	Band 6	0	0		

	Band 5	1	1		
	Band 4	as above	as above		
	Band 3	as above	as above		
Deitetics	Band 8A	0	0		
	Band 7	0	0		
	Band 6	0	0		
	Band 5	0	0		
Psychology	Band 8A	0.8	0.8		shared across pathway Beech, ESD and Acute stroke services
	Band 4	1	1		Maternity leave cover being arranged.

South Norfolk Clinical Commissioning Group – changes to policies and services in 2015-16

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

An opportunity for the Committee to discuss the way in which South Norfolk Clinical Commissioning Group proposed changes to policies and services for in-year implementation in 2015-16.

1. Background

1.1 In January 2016 South Norfolk Clinical Commissioning Group (SNCCG) reported to its Governing Body that its forecasted deficit for 2015-16 was £6,645k, which was in line with the financial plan it submitted to NHS England in May 2015. In November 2015 it reported there was also a risk of an additional potential overspend of £1.3m if Quality Innovation Productivity and Prevention (QIPP) savings were not delivered and if unplanned activity rose above predicted levels. In January 2016 that potential additional overspend had reduced to £910k.

1.2 In the third quarter of 2015-16 the CCG brought forward a number of proposals for changes to policy and services. Norfolk Health Overview and Scrutiny (NHOSC) members were notified about these changes via the NHOSC Briefing, where possible, but notice periods were increasingly short towards the end of 2015. It seemed clear that the proposals, or at least the timescales in which they were brought forward, were being driven by the need to make in-year cost savings.

1.3 The former Chief Officer and Chief Finance Officer had both left the CCG in mid 2015 and interims were in place. The interim Chief Officer left just before Christmas and a new permanent Chief Executive Officer took up post on 27th January 2016.

2. Proposed changes

2.1 Decommissioning of intermediate care beds

2.1.1 Towards the end of November 2015 SNCCG proposed to serve notice on (decommission) 9 intermediate care beds; 6 at All Hallows Hospital, Ditchingham and 3 at Lincoln House Nursing Home, Swanton Morley. These beds were block purchased, which means that they were paid for whether they were in use or not. The CCG wished to cancel this arrangement and move to spot purchase arrangements, whereby it

would ‘buy’ intermediate care beds as and when needed. The block purchase of the 9 beds was to end on 22 December 2015.

2.1.2 Brief details of this proposal were sent to the Democratic Support and Scrutiny Team Manager on 11 December. These details and an explanation of subsequent events were included in 14 January NHOSC Briefing.

2.1.3 In mid-December All Hallows was informed that the block purchase arrangement could continue until 7 January 2016 and just before Christmas the CCG and All Hallows announced that the beds would not be decommissioned before April 2016. Agreement was also reached with Lincoln House for its beds to remain open up to April 2016.

2.1.3 The CCG intends to re-procure intermediate care in its area from April 2016. It has explained that over the past three years the length of time that patients stay in the majority of intermediate care beds has reduced from around 30 days to 18 days. This has, in effect, increased bed capacity. The CCG wants the non-NHS providers of intermediate care to adopt the model of shorter lengths of stay and this will be reflected in the re-procurement process. It has also made clear that it does not consider the re-procurement process will result in a substantial change to service that would require consultation with NHOSC.

2.1.4 A Prior Information Notice (PIN) will be published in mid February and a market engagement day for potential providers will be held in the first week of March. After it sees the response from providers and is confident that the re-procurement will proceed, the CCG intends to have a 2 – 3 week window where the public can give feedback on the plans. As part of the public engagement process the CCG will:-

- Explain what it is doing – short term measures with long term aims
- Ask for feedback on current bed capacity
- Ask for feedback on what it is proposing
- Discuss some possible options for a reconfigured intermediate care bed / community care model in South Norfolk.

2.1.5 Possible options for a reconfigured intermediate care bed / community care model in South Norfolk will be set out during the public engagement process so that people understand the context of the re-procurement process and are made aware that further changes may be coming in the future. The CCG is not proposing to implement any of these options in April 2016. It has given assurance that it would consult on any such proposals at a later date.

2.1.6 The proposal to decommission block purchased beds at All Hallows and Lincoln House in advance of the re-procurement process appears to have been driven by the need to make immediate financial savings in 2015-16.

2.2 **Clinical evidence review prior to operations (including for second cataract operations)**

2.2.1 The press reported on 9 December 2015 that SNCCG had written to GPs to inform them that 31 surgeries for patients on the CCG's Prior Approval List, including second eye cataract operations, would now be automatically rejected unless clinicians could demonstrate that an exception should be made. From 1 December 2015 applications for patients' second eye cataract operations were only to be decided by the Individual Funding Request (IFR) panel.

2.2.2 There was no advance notification of the policy change so NHOSC members did not get the opportunity to look at the details and consider whether or not the proposal was likely to lead to a substantial variation to service for which consultation with the committee would be appropriate.

2.2.3 After Christmas the CCG confirmed that the policy change had been amended and clarified for GPs. Applications for second eye cataract operations would not go to IFR panel, but a new clinical evidence review stage would be included in the Prior Approval process. The CCG also gave assurance that the process would take no longer than 48 hours from start to finish and there would be no detrimental impact on the 18 week referral to treatment pathway.

2.2.4 In a further development in January, the CCG indicated that the change to process would now be taken forward as a project with North Norfolk CCG and Public Health England. The plan was to look at the hip and knee pathway first and then to expand to other procedures. The CCG was also planning to engage with the acute hospitals on changes to process.

2.2.5 It remains to be seen if fewer patients will receive the treatments and procedures that are on the Prior Approval and Non-Routine treatments and procedures list as a result of this project, or if the threshold of need that triggers a referral to secondary care in these cases will be greater than at present.

When it was looking to introduce a clinical evidence review stage to the process for approval of referrals for second eye cataract operations, the CCG said it did not expect a significant change in the numbers going forward for surgery.

2.2.6 Members received details in the NHOSC Briefing 14 January 2016 about the situation regarding changes in the Prior Approval process.

2.3 **Restriction on hearing aids for adults with mild hearing loss**

2.3.1 On 23 November 2015 the CCG provided information for NHOSC about its proposal to revise criteria regarding eligibility for hearing aids for adults, restricting the issue of hearing aids to patients with a hearing loss measured as mild. The information was included in the NHOSC Briefing, 3 December 2015.

2.3.2 The CCG held a public consultation from 9 November to 15 January 2016, using its website and one public meeting.

2.3.3 The original proposal was to apply the eligibility restrictions only to adults over the age of 50, which the CCG estimated would affect approximately 700 people per annum and save in excess of £177,000. During the consultation period the CCG decided to extend the proposal to all adults with mild hearing loss. This was due to direct feedback which suggested that to limit the restriction to adults over 50 was discriminatory. In taking the decision to extend the threshold, the CCG further extended the consultation period to accommodate for the revision.

2.3.4 On 26 January 2016 the CCG Governing Body decided to not to restrict audiology services for people with mild hearing loss for the time being. This was due partly to the feedback received from local people, clinicians and patient groups during the public consultation. The CCG has decided to await the publication of a national Commissioning Framework for Hearing Services, which is due in April 2016. NHS England is currently working on the Framework with input from several organisations including Action on Hearing Loss and the National Community Hearing Association. It will provide model service specification, contracts etc. and enable CCGs to follow good practice and reduce costs.

2.3.5 Other CCGs in England that have already considered restricting the funding of hearing aids include North Staffordshire, South Staffordshire, Mid Essex, Devon and Cornwall. North Staffordshire brought its policy into force in October 2015.

2.4 **Reduction in IVF provision**

2.4.1 South Norfolk CCG provided information for the NHOSC Briefing 15 October 2015 on its proposal to restrict IVF (in vitro fertilisation; level 3 Specialist Fertility Services) provision from 1 January 2016 to the following exceptional circumstances:-

- Patients undergoing cancer treatments/chemotherapy
- Patients who have a disease or condition requiring a medical or surgical treatment that has a significant likelihood of making them infertile
- Couples who meet current eligibility criteria in which the male partner has a chronic viral infection where there is high risk of viral transmission to the female partner and potentially any unborn child (such as HIV or Hepatitis C), would also be offered ICSI (intra-cytoplasmic sperm injection).

2.4.2 The CCG ran an on-line public consultation between 16 October and 13 November 2015 and on 24 November 2015 the Governing Body approved the proposed restrictions.

2.4.3 National Institute for Health and Clinical Excellence (NICE) guidance suggests that the NHS should offer patients 3 cycles of IVF. Most CCGs

do not offer 3 cycles but South Norfolk has become one of very few in England to offer none, except for patients in exceptional circumstances. Norwich, North Norfolk and West Norfolk CCGs offer 2 cycles for women under the age of 40 and 1 cycle for those aged between 40 and 42. Great Yarmouth and Waveney CCG offers 3 cycles, with a maximum maternal age of 42.

2.4.4 South Norfolk CCG estimates that in future just 5 couples per annum will receive NHS funded Level 3 Specialist Fertility Services and the saving will be approximately £188,068 per annum.

2.5 **Withdrawal of prescriptions for gluten-free products**

2.5.1 The CCG provided information for the NHOSC Briefing 15 October 2015 on its proposal to withdraw prescriptions for gluten-free products. North Norfolk CCG became the first CCG in England to take this step in July 2015 and now South Norfolk, Norwich and West Norfolk have followed suit, although West Norfolk continues to allow prescriptions for under 18s, which the others do not. Great Yarmouth and Waveney CCG continues to allow prescription of gluten-free products to children and adults but limits the amount.

2.5.2 South Norfolk CCG estimated that 350 people would be affected by the change and the cost saving would be £150,000 per annum.

3. Purpose of today's meeting

3.1 Members of NHOSC were aware of South Norfolk CCG's financial situation and aware of their own responsibility to consider financial sustainability when considering the CCG's proposals for change. No objections were raised by the committee to the proposals of which members were notified in the October and December NHOSC Briefings.

3.2 However, concerns grew about the way in which the CCG was bringing proposals forward one at a time with no opportunity for NHOSC or members of the public to assess how overall NHS provision in South Norfolk was changing.

3.3 The concerns were compounded during December when news about restrictions on second eye cataract operations appeared in the press before any notification to NHOSC and when All Hallows hospital warned of possible closure as an unintended consequence of South Norfolk CCG's decision to decommission block purchased beds.

3.4 The Chairman and Vice Chairman of NHOSC agreed that South Norfolk CCG should be invited to today's meeting to discuss its handling of proposals for in-year changes in the second half of 2015-16. The new Chief Officer, the Clinical Chair and the Chief Operating Officer will attend today's meeting to answer members' questions.

4. Suggested approach

4.1 Members may wish to focus on the following areas:-

(a) It has appeared as though some of the changes listed in section 2 of this report were brought forward sooner than the CCG may have ideally wished, in order to mitigate immediate financial pressures. How can the CCG avoid a similar situation arising in 2016-17?

(b) What are the CCG's comments about equality of access to NHS services following the introduction of policies in South Norfolk that are more restrictive than in neighbouring CCG areas?

(c) There is a Joint Committee for commissioning across the North Norfolk, Norwich and South Norfolk CCGs but the CCGs have acted differently in the face of financial pressures. Would merger of the three CCGs be a better option for economic sustainability and equitable delivery of NHS services across central Norfolk?

(d) Before proposing the de-commissioning of block purchased intermediate care beds at short notice, did the CCG fully investigate and understand the potential effect on the providers and the possible knock-on effects on the wider health and social care system (in terms of delayed discharges from the acute hospitals)?

(e) Can the CCG assure NHOSC that it will in future give early notification of proposals for changes that members may consider to be substantial, so that there is time for consultation with the committee if members wish it?

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Clinical Commissioning Groups – commissioning intentions and plans for services in 2016-17

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

NHS North Norfolk, South Norfolk, West Norfolk and Norwich Clinical Commissioning Groups (CCGs) will present commissioning intentions and plans for services in 2016-17.

1. Background

1.1 On 3 December 2015 Norfolk Health Overview and Scrutiny Committee (NHOSC) agreed to add 'CCG commissioning intentions for 2016-17' to its agenda for 25 February 2016.

1.2 The subject was raised because of concerns that in some areas proposals for changes to policy and services in 2015-16 had come forward one at a time, sometimes with short consultation periods. This was particularly the case in the South Norfolk CCG area, which faced a significant financial deficit in 2015-16. There was no opportunity for NHOSC, or the public, to consider the overall effect of these proposed changes or to have a say on the competing priorities faced by the CCGs.

The in-year changes and proposed changes in the South Norfolk CCG area are the subject of a separate report on today's agenda.

1.3 The introduction of local CCG commissioning was intended to allow NHS services to be better tailored to local needs but 2015-16 has seen some notable differences emerge between CCG areas in Norfolk and departures from usual NHS practice in the rest of England. For instance:-

(a) Prescribing of gluten free foods

In July 2015 North Norfolk CCG was the first CCG in England to stop the prescribing of gluten free products. Norwich, South Norfolk and West Norfolk CCGs followed suit, but West Norfolk decided to continue prescriptions for under 18s, which the other CCGs did not. Great Yarmouth and Waveney CCG continues to allow prescription of gluten free products to children and adults, but limits the amounts.

(b) IVF

Great Yarmouth and Waveney CCG funds 3 cycles, North Norfolk, Norwich and West Norfolk CCGs fund 2 cycles and from January 2016 South Norfolk CCG funds none, except in certain exceptional circumstances. NICE guidance suggests 3 cycles; most CCGs in England do not provide 3 but very few provide as little as South Norfolk.

1.4 In early January 2016 Healthwatch Norfolk wrote to all the CCGs in Norfolk seeking reassurance as to the methodology and governance arrangements in place to ensure that service users, carers and their families are fully engaged and consulted in instances where initial reviews conclude that a service may need to be reduced or stopped completely. Healthwatch's letter is attached at Appendix A. The CCGs' responses are attached at Appendix 2 to Appendix B.

1.5 On 4 November 2015 all the Norfolk CCGs presented their 2016-17 commissioning intentions to Norfolk Health and Wellbeing Board (HWB), which found them to be broadly in line with the longer term goals and priorities of the Joint Health and Wellbeing Strategy. The HWB also agreed that in future it would like the opportunity to input at an earlier stage of the annual planning cycle.

1.6 New NHS planning guidance 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21' was published by NHS England on 22 December 2015:- https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

It asks for 'every health and care system to come together to create its own ambitious blueprint for accelerating its implementation of the Forward View' and to produce two separate but interconnected plans:-

1. A new local health and care system 'Sustainability and Transformation Plan (STP)' to cover the period from October 2016 to March 2021; and
2. A plan by organisation for 2016-17. This will need to reflect the emerging STP.

The STP should cover integration with local authority services 'including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies'. NHS England expects STPs to be submitted in June 2016 and they will be subject to formal assessment in July.

The Norfolk and Waveney area will be covered by a single STP.

2. Purpose of today's meeting

2.1 The purpose of today's meeting is not to repeat the HWB's examination of how the 2016-17 CCG commissioning plans will help to deliver the

priorities and goals of the Norfolk Health and Wellbeing Strategy but to focus on the following areas:-

(a) What do the commissioning intentions and plans mean in terms of changes to services 'on the ground' in 2016-17?

(b) How will the CCGs bring forward proposals for changes to services in 2016-17; jointly or as single CCG areas?

(c) How do the CCGs intend to engage and consult with the public and with NHOSC about proposals for significant changes?

(d) Do the CCGs work together to avoid health inequalities as a result of commissioning decisions across Norfolk?

(e) Do the CCGs take account of the responses to eachothers' consultations when making decisions on similar policy matters?

(f) Can CCGs look again at their decisions taking into account the reasons for different conclusions reached by neighbouring CCGs on the same policy matters?

(g) What is the assurance that the planned Quality Innovation Productivity and Prevention measures for 2016-17 (or other cost saving measures) will be delivered so additional in-year changes to deliver savings will not be required?

2.2 Representatives from the three central Norfolk CCGs and West Norfolk CCG have been invited to attend today. Great Yarmouth and Waveney (GY&W) CCG has not been asked to attend because the Great Yarmouth and Waveney Joint Health Scrutiny Committee, which includes health scrutiny councillors from Norfolk and Suffolk, conducts overview and scrutiny of health services in its area. GY&W CCG conducted an extensive 'Shape of the System' consultation in 2015-16, which was commended by the Joint Health Scrutiny Committee.

2.3 The four CCGs have been asked to report on their intentions for 2016-17 and in particular on:-

(a) Plans for service changes
(b) The timescales for bringing forward proposals for changes
(c) Plans for engagement with patient groups and other stakeholders and for consultation with the public.
(d) Plans for consultation with NHOSC on proposals for substantial changes.
(e) Planned Quality Innovation Productivity and Prevention (QIPP) savings and the level of assurance that they will be achieved.
(f) The outturn from 2015-16 QIPP plans and the predicted overall financial situation of the CCGs at the end of the year, and what effect this will have on 2016-17 planning.

The CCGs' report is attached at Appendix B.

3. Suggested approach

3.1 After the CCGs have presented their report, NHOSC may wish to discuss the questions set out in paragraph 2.1.

3.2 The Committee may also wish to ask the CCGs for their comments on the Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals NHS Foundation Trust, Queen Elizabeth Hospital NHS Foundation Trust and Norfolk Community Health and Care NHS Trust's intentions to form a Provider Partnership, and what effect the move may have on their commissioning intentions.

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healthwatch Norfolk

4 January 2016

To: Chief Officers CCG
Cc: Andrea Patman, NHSE

Firstly I would like to wish you all a Happy New Year.

As we begin a year that will undoubtedly prove challenging within the health and social care sector I am writing to request information on the criteria used in your decision-making.

We fully appreciate and welcome any proposals by your CCG to review the current range of services being commissioned. We endorse any such reviews as being important to ensure that the services are fit for purpose, reflect the local needs appropriately and provide value for money. This is particularly important during a time of potential funding cuts by central government.

However the reason for my letter is to seek reassurance as to the methodology and governance arrangements in place to ensure that service users, carers and their families are fully engaged and consulted in those instances where your initial review has concluded that the service may need to be reduced or to be stopped completely.

As you are aware, our role as a consumer champion is to ensure that the views and experiences of service users is taken into account when considering the commissioning and provision of health and social care provision in Norfolk.

Therefore I would be grateful if you could respond to my request for the following information:

1. Confirmation as to which services have been or will be reviewed for possible amendment to their continuation. If we are made aware of any proposed changes to commissioned services, Healthwatch Norfolk is able to provide you with details of any service user feedback we have entered into our information database.

2. Evidence of the decision making criteria and governance arrangements in place that are used by the CCG Governing Body when making any decision to amend the commissioning of current or future services.

3. Evidence of the consultation process that ensures all residents of Norfolk have an opportunity to comment on the proposed changes to services being commissioned by your CCG.

4. Evidence that an Impact Equality Assessment is undertaken as part of the final decision making process.

As an example, we note that South Norfolk CCG is proposing to amend the current options available for second cataract surgery and we are seeking evidence that the impact of this on patients has been fully assessed. We note that the RNIB has expressed concern about the impact of such a decision on the balance of patients. Therefore we believe it is paramount that the CCG is able to respond to any such feedback with the appropriate evidence to support its decision.
I look forward to hearing from you within the 20 working day statutory timeline applicable to requests for information from Healthwatch organisations.

Kind regards

Alex Stewart
Chief Executive

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Norfolk Health Overview and Scrutiny Committee
25 February 2016
Item no 7 **Appendix B**

Clinical Commissioning Groups – Commissioning intentions and plans for services in 2016-17

Response on behalf of North Norfolk, South Norfolk, West Norfolk and Norwich CCG's

1. Background and Purpose

The Norfolk HOSC have invited the Norfolk CCGs to share with them commissioning plans for 2016/17 and in particular plans for major service changes which may require significant public engagement with stakeholders including the HOSC itself. This is of course in the context of the most challenging financial context for health and other public services which require significant savings to be made in a relatively short timeframe.

There is also a concern about the extent to which CCGs can and do make differential commissioning decisions within Norfolk or nationally.

The purpose of this paper therefore is to provide HOSC members with a high level overview of CCG's plans for 2016/17, the processes by which the CCGs work together where appropriate, and each CCGs commitment to and delivery of community engagement in those plans.

This paper covers North Norfolk, South Norfolk, West Norfolk and Norwich CCGs as directed by HOSC. It is noted that there is a separate agenda item on South Norfolk CCG's plans.

2. General Comments

The Health and Social Care Act (2012) created 209 Clinical Commissioning Groups across England as new commissioning organisations led by local clinicians – predominately GPs elected by their peers - and with a mandate to engage with and reflect the needs of their local communities. At the same time Members will be aware that the squeeze on public expenditure over the last few years and the foreseeable future has meant that all CCGs and other public sector bodies have had to make unprecedented levels of savings which involve at times difficult and contentious decisions.

It is unsurprising therefore that CCGs in Norfolk and beyond do agree different priorities in some areas which reflect the differences in populations, and affordability. The covering paper prepared by Democratic Support and Scrutiny Team Manager identifies some examples of such. The CCGs strongly believe that each of these

decisions are carefully and legitimately reached by their Governing Bodies, following appropriate dialogue with a range of stakeholders. It is also worth noting that differential access to services, such as IVF, are not new to the NHS. There is a significant history of predecessor commissioning organisations also having different policy thresholds in a number of areas.

It is also the case however that in many areas the Norfolk CCGs, and increasingly Norfolk County Council, work formally in partnership to common service standards, policies and contracts. Examples of this include:

- All CCGs have to commission services to meet NHS Constitutional standards around such issues as the 4 hour A&E wait, 18 week referral to treatment for elective care, a range of cancer standards, and from April 2016, 2 new access standards for mental health.

- Collaborative contracts for County/Region wide services such as 111/Out of Hours Primary Care (North Norfolk, South Norfolk, West Norfolk, and Norwich CCGs), Emergency Ambulance services (19 CCGs across the East of England), and acute secondary and mental health care (North Norfolk, South Norfolk, and Norwich CCGs)

- A common set of Continuing Health Care Policies and assessment processes across North Norfolk, South Norfolk, West Norfolk and Norwich CCGs.

- Common policies and panels for considering Individual Funding Requests for services outside of those normally funded by the NHS.

- Common policies and teams for Adult and Children's Safeguarding across all Norfolk CCGs, including Great Yarmouth and Waveney CCG.

- Since September 2015, North Norfolk, South Norfolk and Norwich CCGs have with Norfolk County Council established a Joint Commissioning Committee to oversee the operation of joint commissioning across the 3 CCGs on issues of common interest such as those areas set out above. The JCC operates as a formal committee of the CCGs' Governing Bodies with minutes and actions reported back to the individual Governing Bodies.

- NHS England and NHS Improvement (the regulator for Foundation/NHS Trusts) published planning guidance in December for 2016/17 and beyond. ("*Delivering the Forward View: NHS Shared Planning Guidance 2016/17-2020/21"*). A key part of that guidance requires communities of CCGs, NHS providers and local authorities to work together to produce Sustainability and Transformation Plans (STPs) for local health and care systems "at scale" in order to identify how services will need to be reorganised in order to work within available resources. Local NHS bodies have agreed that the footprint for this work in Norfolk will be the entirety of both Norfolk and Waveney, reflecting patient flows from the later area into the James Paget Hospital and other providers. This plan is due for submission by the end of June and is likely to

lead to further service changes as yet unidentified which local health bodies are committed to engage HOSC and stakeholders in.

3. Specific Questions for CCGs.

HOSC have asked CCGs to address a set of specific questions set out in Paragraphs 2.1 and 2.3 of the cover paper which are addressed below.

(a) What do the commissioning intentions and plans mean in terms of changes to services 'on the ground' in 2016-17?

Each CCG presented their Commissioning Intentions to the Norfolk Health and Well Being Board on 4 November 2015. The detailed plans are available to HOSC Members at:-
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/346/Committee/39/Default.aspx
151104 HWB Agenda, pages 34 – 61.

Appendix 1 sets out the high level QIPP plans for each CCG and in the case of the Central Norfolk CCGs, their joint plan. In general terms there is significant alignment between the CCG plans including QIPP. Common themes include:

- Schemes to improve urgent care pathways so as to reduce costs and duplication of effort
- Whole pathway reviews of major disease areas such as diabetes, and stroke
- Reviews of referral/treatment thresholds for NHS intervention in line with best practice
- KPI's to drive increased efficiency through acute hospital care such as measures to optimise the level of Outpatient follow up appointments
- Continued efficiencies in Primary and Secondary Care Prescribing Budgets, including maximisation of generic (non branded) drugs, and reviewing the availability of certain drugs on the NHS which are available for over the counter purchase.
- Continued management of high cost, long term care packages so as to ensure best value

(b) How will the CCGs bring forward proposals for changes to services in 2016-17; jointly or as single CCG areas?

This depends entirely on the issue. Where the change is unique to one area, such as a treatment access threshold, then it is the responsibility of the individual CCG to carry out the appropriate engagement and consultation with stakeholders.

Where however changes are common to one or more CCG or it is a service provided on a countywide/system basis then common sense dictates that CCGs will work together with HOSC and other stakeholders.

(c) How do the CCGs intend to engage and consult with the public and with NHOSC about proposals for significant changes?

CCGs have found it very helpful to have early informal engagement with HOSC, normally through the Democratic Support and Scrutiny Team Manager, to test out ideas about service changes and the required degree of engagement. It may be helpful to formalise this into a regular meeting in 2016.

(d) Do the CCGs work together to avoid health inequalities as a result of commissioning decisions across Norfolk

All CCGs are committed to working towards reducing health inequalities within the populations they are responsible for. This however does not extend to a countywide mandate. CCG resource allocations from NHS England are reflective of relative health outcomes and other population health measures, which inter alia, reflect health inequalities.

(e) Do the CCGs take account of the responses to each other's' consultations when making decisions on similar policy matters?

Yes. CCGs routinely share initiatives and take into account responses to neighbouring CCG consultations. By way of example North Norfolk CCG are currently reviewing the introduction of a minimum threshold for NHS funded hearing aids and are closely following the outcome of the current consultation being carried out by South Norfolk CCG.

(f) Can CCGs look again at their decisions taking into account different conclusions reached by neighbouring CCGs on the same policy matters?

Yes. See comment above. CCGs also network with colleagues across the wider NHS on key issues**.**

(g) What is the assurance that the planned Quality Innovation Productivity and Prevention measures for 2016-17 (or other cost saving measures) will be delivered so additional in-year changes to deliver savings will not be required?

Given the very challenging financial position set out below delivery of QIPP plans are essential to the sustainability of local NHS services. However, all plans, however robust, carry risk and therefore it more than probable that additional in year savings schemes will need to be developed. It is also likely, as highlighted above, that the STP will identify further necessary service changes.

The four CCGs have been asked to report on their intentions for 2016-17 and in particular on:-

(a) Plans for service changes

Any significant and material changes will be subject to informal discussion with HOSC as set out above. This will determine the appropriate and proportionate level of engagement/consultation.

(b) The timescales for bringing forward proposals for changes.

Appendix 1 includes start dates for each of the initiatives.

(c) Plans for engagement with patient groups and other stakeholders and for consultation with the public.

Each CCG has its own arrangements for engagement with patient groups and other stakeholders. Each CCG recently responded to Healthwatch following a similar enquiry. The individual responses from CCGs are included at Appendix 2.

(d) Plans for consultation with NHOSC on proposals for substantial changes.
See response to Point (a).

(e) Planned Quality Innovation Productivity and Prevention (QIPP) savings and the level of assurance that they will be achieved.

Each CCG has established robust Programme Management arrangements so as to minimise risk of under delivery. There is clearly though inherent risks to delivery with such challenging savings targets.

(f) The outturn from 2015-16 QIPP plans and the predicted overall financial situation of the CCGs at the end of the year, and what effect this will have on 2016-17 planning.

The table below sets out the forecast QIPP delivery and financial out turns for each CCG for 2015/16, though it should be noted that these are based on Month 9 figures and are therefore subject to significant risk in Quarter 4. The table also shows the forecast QIPP requirement for each CCG in 2016/17 given their financial allocations and underlying financial positions. Again these are likely to change as a result of the ongoing planning process and contract negotiation round with providers for 2016/17.

Table1: CCG Forecast and QIPP and Financial Out turns 2015 -16, and Forecast QIPP requirements 2016-17

CCG	2015 -2016				2016-17	
	Forecast QIPP Delivery		Forecast Year- end position (at mth 9) Surplus / (Deficit)		Forecast QIPP Requirement	
North Norfolk	£7.7m	3.4 %	£0.4m	0.2%	£9.2m	4%
Norwich	£6.4m	2.7%	£3.4m	1.4%	£9.7m	3.95%
South Norfolk	£5.6m	2.1 %	(£6.6m)	(2.5%)	£13m	4.8%
West Norfolk	£5.5m	2.4%	£2.3m	1.0%	£10.0m	4%

Note: NHSE Business rules require CCG's to achieve a surplus equivalent to 1% of turnover.

Sue Crossman	**Antek Lejk**	**Jo Smithson**	**Mark Taylor**
Chief Officer West Norfolk CCG	Chief Officer South Norfolk CCG	Chief Officer Norwich CCG	Chief Officer North Norfolk CCG

Appendices

1. CCG Commissioning/QIPP Plans 2016/17
2. CCG Responses to Chief Executive, Healthwatch Norfolk

    - North Norfolk CCG.
    - Norwich CCG.
    - South Norfolk CCG.
    - West Norfolk CCG.

Central Norfolk CCG Joint Workplan

Programme Area	Scheme	South Norfolk CCG	North Norfolk CCG	Norwich CCG	Timescale for Delivery
Non-Elective	**NNUHFT Front Door Reconfiguration** - Review of current Urgent Care Centre and Emergency Clinics.	Yes	Yes	Yes	Apr-16
	Pre Hospital Improvement Board - to reduce ambulance conveyance into hospital	Yes	Yes	Yes	Various
	Re-procurement of Norwich Walk-In-Centre (WiC)	Yes	Yes	Yes	Sep-16
	Local tariff review for very short length of stay and reduced tarif for Clinical Decision Unit	Yes	Yes	Yes	Apr-16
	Paediatric Admissions - review tariff for short stay admissions	Yes	Yes	Yes	Apr-16
	Paediatric Admissions - pathway review, to include both acute service pathway, primary care referals and community teams	Yes	Yes	Yes	Oct-16
Elective	**Diabetes Service Review**	Yes	Yes	Yes	Oct-16
	Review of Maternity Services	Yes	Yes	Yes	National Programme
	Ophthalmology Pathways & Thresholds review (Excluding Wet AMD Lucentis usage)	Yes	Yes	Yes	Apr-16
	Review of Stroke Services and Pathways	Yes	Yes	Yes	Review Oct-16 Live Apr-17
	Acute Clinical Thresholds/Ratios - 1st/ Out Patient Appointments and Follow Up Appointments	Yes	Yes	Yes	Apr-16
	Suitable admission ratio to be agreed - A&E to admission to a hospital bed	Yes	Yes	Yes	Apr-16
	Excess Bed Days - to reduce delayed transfers of care from hospital	Yes	Yes	Yes	Apr-16
	High Cost Drugs - strengthen local guidelines for use of specific high cost hospital drugs	Yes	Yes	Yes	Apr-16
	Audiology Thresholds - For hearing loss	Yes	Yes	Yes	Apr-16

Mental Health	**Re-basing of Norfolk Suffolk Mental Health Foundation Trust contract**	Yes	Yes	Yes	Apr-16
	Transforming Care (implementing Winterbourne Review)	Yes	Yes	Yes	Rolling
	Implement national standard for First Episode Psychosis	Yes	Yes	Yes	National Programme
	Review of CRHT/Acute/Community Teams	Yes	Yes	Yes	Apr-16
	Implement new Child & Adolescent Mental Health Services (CAMHS) including Eating Disorders	Yes	Yes	Yes	Apr-16
	Review use of Section 136 Suites	Yes	Yes	Yes	In Year
Children, Maternity & Young People	**Review ASD Pathways for Children & Young People**	Yes	Yes	Yes	TBC
	Looked After Children Service Model Review	Yes	Yes	Yes	Apr-16
	Short Breaks - Review current commissioning arrangements	Yes	Yes	Yes	Apr-16
Other	**Norfolk & Norwich University Hospital Foundation Trust (NNUH)** - Local Price Review	Yes	Yes	Yes	Apr-16
	7 Day Working - implementation	Yes	Yes	Yes	Apr-16

Local CCG Workplans 2016/17

North Norfolk CCG

Programme Area	Scheme	Timescale for Delivery
Non-Elective	**Crisis Response Team -** Design and development of CRT to wrap emergency care around patients who at risk of a hospital admission	TBC
	COPD Admissions - reduce the number of COPD related admissions via practice upskilling in case management and medicines management	Apr-16
	Community IV Therapy Service - Introduction of a community IV service to provide greater coverage on a localised footing for this service	Jun-16
	Community Beds for Discharge to Assess - in-patient bed stock to enable faster discharge from an acute bed and a quicker return home for patients	TBC
	Community Beds to Chairs - rethink of our current bed usage and use of community assets to enable conversion of beds to chairs to provide greater service composition in a community setting	TBC
	Decommission NANSA -sleep counselling	Apr-16

	Private providers - Review of private provider activity and costs	Apr-16
	Palliative Care - new service model	Jun-16
	Reduce Emergency Admissions from Care Homes - Work with Care Homes to upskill and reduce avoidable admissions for patients	Apr-16
Elective	**Primary Care Variation -** reduce variation in referrals to acute from primary care	Apr-16
	Procedures of Limited Clinical Value - application of agreed clinical protocols and pathways	Apr-16
	Review of Opthalmology (Cromer) - Contractual rebasing	Apr-16
	Review of Audiology (Cromer) - Convert current activity to Any Qualified Provider contract	Apr-16
	Community Based Out Patient Appointments - Conversion of O/P appts to a community setting	TBC
	Day Case without Procedure Code - Contractual rebasing	Apr-16
	Unwell Neonates - Contractual rebasing	Apr-16
Community	**Better Care Fund -** Agreement of future funding from CCGs	Apr-16
	MSK Physio Tender - Reprocurement of physiotherapy services	Oct-16
	Reprovision of Paediatric Speech and Language Service - Procurement benefit	Apr-16
	Integrated Community Equipment Store (ICES) - Recalls of equipment and better manage redistribution of equipment	Apr-16
Other	**Pathology Testing -** Only request tests in relation to the condition being investigated	Apr-16
	Acute Contract Management - ensuring correct payments for activity	Apr-16
	Small Schemes - Various other initiatives	Apr-16
	NHS Property Services - Rationalisation of property leases, estate usage etc.	Apr-16
	CHC - Package renew to ensure VfM	Apr-16
	Prescribing - Reducing annual uplift in prescribing by working with practices proactively to better manage prescribing variation	Apr-16
	NOACs - reduce prescription levels	Apr-16
	Commissioning Support Services - Review of value for money	Apr-16

South Norfolk CCG

Programme Area	Scheme	Timescale for Delivery
	Mental Health Conditions - Review the increase in admissions, and coding, of patients with primary diagnosis of mental health	Apr-16
	Social Care - Delayed Transfers Of Care	Apr-16
	Health Care - Delayed Transfers Of Care	Apr-16
	WSH, Ratios, Admissions and DTOCs	Apr-16
	Planned Procedures - not Carried Out	Apr-16
	Specialised Attribution - OP & APC	Apr-16
	Diagnostics - direct access pathways	Apr-16
	Pathology - Restrict / decommission pathology tests or 'bundles' of tests	Apr-16
Community	**Better Care Fund -** Agreement of future funding from CCGs	Apr-16
	MSK Physio Tender - Reprocurement of physiotherapy services	Oct-16
	Reprovision of Paediatric Speech and Language Service - Procurement benefit	Apr-16
	Integrated Community Equipment Store (ICES) - Recalls of equipment and better manage redistribution of equipment	Apr-16
	Continence - Renegotiate Continence service to reduce current spend	Apr-16
	Section 117s	Apr-16

	Patient Transport - eligibility	Apr-16
Children, Maternity & Young People	**IVF Level 3 Review**	Apr-16
	Vol Orgs - Review of current contracts	Apr-16
Other	**Pathology Testing -** Only request tests in relation to the condition being investigated	Apr-16
	Acute Contract Management - ensuring correct payments for activity	Apr-16
	CHC - Package restructuring and ensure VfM	Apr-16
	Prescribing - Reducing annual uplift in prescribing by working with practices proactively to better manage prescribing variation	Apr-16
	NOACs - reduce prescription levels	Apr-16
	Commissioning Support Services - Review of value for money	Apr-16

Norwich CCG

Programme Area	Scheme	Timescale for Delivery
	Decommission NANSA -sleep counselling	Apr-16
	Private providers - Review of private provider activity and costs	Apr-16
	Telederm - new service to be delivered across practices	Apr-16
	Community Heart Failure Nurse - new service reduced EMAs	TBC
	Palliative Care - new service model	Jun-16
	Ambulance Conveyances - manage growth in 14/15 down	Apr-16
	Respiratory - focus of practice variation work	TBC
	Reduce Emergency Admissions from Care Homes - Work with Care Homes to upskill and reduce avoidable admissions for patients	Apr-16
Elective	**Primary Care Variation -** reduce variation in referrals to acute from primary care	Apr-16
	Procedures of Limited Clinical Value - application of agreed clinical protocols and pathways	Apr-16
Community	**Better Care Fund -** Agreement of future funding from CCGs	Apr-16
	MSK Physio Tender - Reprocurement of physiotherapy services	Oct-16
	Reprovision of Paediatric Speech and Language Service - Procurement benefit	Apr-16
	Integrated Community Equipment Store (ICES) - Recalls of equipment and better manage redistribution of equipment	Apr-16
	Continence - Renegotiate Continence service to reduce current spend	Apr-16
Other	**High Cost Drugs -** gain share with acute provider in switching of bio similars etc.	Apr-16
	Pathology Testing - Only request tests in relation to the condition being investigated	Apr-16
	Acute Contract Management - ensuring correct payments for activity	Apr-16
	Small Schemes - Low value QIPP projects that are bundled into an over arching project	Apr-16
	NHS Property Services - Rationalisation of property leases, estate usage etc.	Apr-16
	CHC - Package restructuring and ensure VfM	Apr-16
	Prescribing - Reducing annual uplift in prescribing by working with practices proactively to better manage prescribing variation	Apr-16
	NOACs - reduce prescription levels	Apr-16
	Commissioning Support Services - Review of value for money	Apr-16

West Norfolk CCG

Programme Area	Scheme	Timescale for Delivery
	Palliative Care Contract - Reduce avoidable admissions	Apr-16

Non-Elective	**Reduce Emergency Admissions from Care Homes** - Care Home Matrons	Apr-16
	Rapid Assessment in Hospital	Apr-16
	Virtual Ward Enhancement / Rapid Response service	TBC
Elective	**Primary Care Variation -** reduce variation in referrals to acute from primary care	Apr-16
	Procedures of Limited Clinical Value - application of agreed clinical protocols and pathways on specified procedures	Apr-16
	Dermatology Review - Review of Dermatology pathway/services	TBC
	Pain Management - Pathway Redesign	TBC
Community	**Better Care Fund -** Agreement of future funding from CCGs	Apr-16
	Integrated Community Equipment Store (ICES) - Recalls of equipment to better manage equipment costs and redistribution of equipment	Apr-16
Mental Health	**QEH Psychology Provision**	Apr-16
Other	**High Cost Drugs -** gain share with acute provider in switching of bio similars etc.	Apr-16
	Pathology Testing - Only request tests in relation to the condition being investigated	Apr-16
	Acute Contract Management - Challenges to the acute provider	Apr-16
	CHC - Package restructuring and ensure VfM	Apr-16
	CHC - Review LD Packages of care and other Individual Patient Placements	Apr-16
	Prescribing - Reducing annual uplift in prescribing by working with practices proactively to better manage prescribing variation	Apr-16

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Alex Stewart
Chief Executive
Healthwatch Norfolk

25th January 2016

Dear Alex

Thank you for your letter dated 4 January regarding the CCG's approach to engaging patients, carers and the wider community in our commissioning work, specifically with regard to the need to achieve QIPP savings.

I have addressed the specific questions in your letter below but would like to preface that with some more general comments. North Norfolk CCG takes its responsibility to act for and behalf of its local population very seriously – we genuinely believe that we act as the stewards of NHS finances allocated to the area. It is local people to whom we are primarily accountable, not NHS England or any other body. As such the Governing Body made the decision early last year to be open and transparent about the size of the financial challenge facing the CCG, and the possible actions that we may have to take to deal with this. We have therefore specifically engaged the local community through the media, our public Governing Body meetings, and a Community Engagement Panel to pursue this. Whilst I am sure that we can always do this better – and would welcome any further insight or support Healthwatch can offer us – I feel that this approach is right one, and we now have a much more informed and realistic dialogue with the local community than ever before.

With regard to your specific questions:

1. **Confirmation as to which services have been or will be reviewed for possible amendment to their continuation**

   Essentially we have to review the entirety of our budget in order to deliver the level of savings which the current financial climate necessitates. For 2015/16, the CCG Executive including our 5 elected GP members reviewed our whole budget and generated a long list of potential areas for review.

   I attach a summary of our QIPP programme for 2015/16, and our 2016/17 plan. We would welcome any insight or information Healthwatch can provide on these areas.

2. **Evidence of the decision making criteria and governance arrangements in place that are used by the CCG Governing Body when making any decision to amend the commissioning of current or future services.**

   All of the CCG's commissioning decisions are led and informed by experienced local clinicians which we believe is the essential value of clinical commissioning as a model. Ideas tend to be generated by feedback from our Governing Body GP members, informed by national benchmark data, such as the Better Care Batter Value indicators published by NHS England, and on rare occasions, specifically commissioned external reviews.

   We do not use a formal rating or scoring system for such decisions but essentially we focus on minimising any adverse impact on patients relative to the size of any saving. It is the case of course that in many instances savings can be achieved which do not have any adverse impact and may actually improve services.

   Ideas are then always tested through our monthly Council of Members meetings with all member practices in order to test a broad swathe of clinical opinion and get formal practice sign up. During this early stage we take emerging ideas to our Community Engagement Panel for comment and shaping – which I have described in greater detail below. Issues of concern to local patients gathered through a variety of feedback channels, including Healthwatch, are also regularly discussed at our Patient Engagement, Safety and Quality Committee. This committee is attended by a CCG clinicians and staff and is chaired by a lay member who reports this discussion to the Governing Body.

   Following this and Governing Body ratification, plans are then moved into our formal QIPP Programme Management Process, where they are tracked and monitored internally by our Programme Management Office.

3. **Evidence of the consultation process that ensures all residents of Norfolk have an opportunity to comment on the proposed changes to services being commissioned by your CCG.**

   We established a Community Engagement Panel early in 2015/16 with the specific purpose of ensuring that we consult and engage with local community representatives on our QIPP Plans. We do not constrain the membership of the Panel specifically and welcome any legitimate interests but typically members include:
   - Practice Patient Groups
   - Other Patient and Carer representative organisations,
   - Local Authority members
   - Voluntary Sector organisations
   - Healthwatch

   The group is well supported and meets on a monthly basis and is attended by both the CCG Chairman and myself. I attach its Terms of Reference.
   We also of course engage with patient representatives on specific QIPP schemes and topics. Recent examples include:
   - Significant patient involvement in the procurement of IAPT/Wellbeing services
   - Patient representatives supporting our procurement of MSK Physiotherapy services
   - Focus groups to inform the development of the falls pathway and carers support

We have not as yet needed to engage in a formal public consultation though we would of course commit to doing so where an issue to merit it. We do meet frequently with the Maureen Orr,

Norfolk HOSC Support Officer so as to check out our thinking in this regard and allow HOSC Members the opportunity to comment if they believe an issue requires such formal process.

4. **Evidence that an Impact Equality Assessment is undertaken as part of the final decision making process.**

   Once a QIPP scheme is included in our Programme before going live there are a number of key gateways which all schemes have to pass; these include a Quality Impact Assessment undertaken by the Patient Experience, Safety and Quality Committee; an Equality Impact Assessment, and an Information Governance Assessment. All of these are pro actively checked and reported on by our QIPP PMO function.

   I hope that this note is helpful in understanding our processes. Whilst I am sure there is more we could do, I would like to re assure Healthwatch members of our commitment to fully engage and work with the local community in managing the challenging agenda we face, and we are very open to any further ideas and suggestions Healthwatch may have.

Yours sincerely

Mark Taylor
Chief Officer, NHS North Norfolk CCG

Attached via email:
QIPP Programme 15/16 & 16/17
CEP ToR

CC:
Dr Anoop Dhesi - Chairman, NHS North Norfolk CCG
Rebecca Champion - Engagement Manager, NHS North Norfolk CCG
James Leeming - Turnabout Director, NHS North Norfolk CCG

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25 January 2016

Dear Alex

Thank you for your letter of 4 January 2016 and Happy New Year!

Norwich CCG fully endorses the necessity to ensure that service users, carers and their families are fully engaged and consulted in all aspects of our work, especially for any services which may need to be reduced or stopped completely.

In answer to your specific points,

1. A part of the commissioning cycle, we set out our key commissioning intentions for 2016/17 at our September Governing Body in public http://www.norwichccg.nhs.uk/about-us/agendas-and-papers/governing-body-papers-2015/september-2015.These intentions reflect our 5 year strategic plan and 2 year operating plan and have been widely shared with all stakeholders and are published on our website. These intentions are informed by our key work programmes: Your Norwich, Healthy Norwich and the Primary Care Development programme, which are formally reported in public. We are currently developing our five year Sustainability and Transformation Plan (STP), in line with the new planning guidance, and we will consult fully on our new models of care work.

2. We employ clear decision making criteria for all our projects, with full business cases reviewed by our Executive Committee in detail to ensure appropriate governance of decision making. All business cases are all impact assessed. We also have a Clinical Reference Group chaired by Dr Chris Dent which considers all service changes from a clinical perspective.

3. As you know, Norwich CCG has a comprehensive programme of patient and public engagement, supported by our Engagement Manager, Laura McCartney-Gray and our Lay Member for Patient & Public Engagement, Irene Macdonald.

   We are now looking to recruit individual patients and representatives from the voluntary sector onto our Patient and Community Advisory Group. This group will advise us on improving our engagement approaches, consider proposals and identify areas which may of particular concern and champion the patient voice, particularly those who are seldom

heard. This group will work closely with our wider Community Involvement Panel which helps us with all our projects, lending experts by experience.

We invited Healthwatch to sit on our groups taking service changes and procurements forward; last year's procurement of the 111/Out of Hours service is an example where we also invited a panel of patients and carers to the bidders' day.

Recent changes to gluten free prescribing have been fully informed by Coeliac UK and the Norfolk and Norwich Coeliac Society and we have invited patients and carers of children who use the Short Break Service to a meeting to discuss all the options. No decision will be made by the CCG without their input.

4. All our projects, service changes and procurements have Equality Impact Assessments carried out at the initial stage and then at further stages if it is recognised that there could be impact on one or more of the protected characteristics. We have recently added a Quality Impact Assessment process to ensure all aspects of quality and patient safety are fully addressed.

I hope we have been able to reassure you of our commitment to have patient and public involvement and engagement at the heart of what we do at NHS Norwich CCG and believe this strengthens our planning, our decision making, and the services that we commission.

Yours sincerely

Jo Smithson
Chief Officer
NHS Norwich CCG

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Dear Alex,

Re your letter dated 4th January 2016.

Thank you for your correspondence and we also wish you and colleagues from Healthwatch a very Happy New Year.

We apologise for the delay in responding to you. As you know we personally met with you on the 22nd January 2015 to discuss the commissioning intentions of the CCG both in-year and into 2016/17. We found the meeting very productive and hope it went some way to alleviate any questions or concerns you have regarding both methodology and governance.

To answer the questions specifically raised:

1. Confirmation as to which services have been or will be reviewed for possible amendment to their continuation.

The following services or service lines are being/have been considered for possible amendment in 16/17:

Scheme	Status
Hearing Aid AQP	Following public consultation SNCCG will no longer be restricting hearing aids for people with mild to moderate hearing loss in 15/16. The CCG will look to renegotiate current tariff from 16/17 onwards.
NANSA sleep counselling	Contract due to expire on the 1st April 2017. No decision to renew due to failure of provider to demonstrate outcomes and benefit. Patients can access alternative sleep counselling services
Paediatric Speech and Language Therapy	Being re-commissioned due to failure of current provider to deliver targets.
MIND BME	Contract due to expire on the 1st April 2017. No decision to renew due to failure of provider to demonstrate outcomes and benefit. And due to duplication with new Primary Care Mental Health Service.
Independent bed procurement	Notice served and procurement commenced for all independently commissioned block beds in South Norfolk. This was due to an inequity of costs and provision. To complete April 2016.
MSK Physio and Orthopaedic triage	Notice served and procurement commenced due to failure of provider to consistently meeting targets, and an inequity of cost,

	access and provision in South Norfolk. To complete October 2016.
Integrated Equipment Store	To review prescribing access/thresholds to access products. To review catalogue range and pricing. Year on year has seen extensive growth in requests for equipment.
Continence	To review current spend on continence provision. Benchmarking suggests service is expensive.
Patient Transport Eligibility	To review current eligibility criteria for access. The CCG is still a high user of non-emergency patient transport and this is increasing year on year.

In addition and via contract negotiation/planning round discussions with principal providers, discussions are taking place regarding internal pathways and related pricing.

2. Evidence of the decision making criteria and governance arrangements in place that are used by the CCG Governing Body when making any decision to amend the commissioning of current or future services.

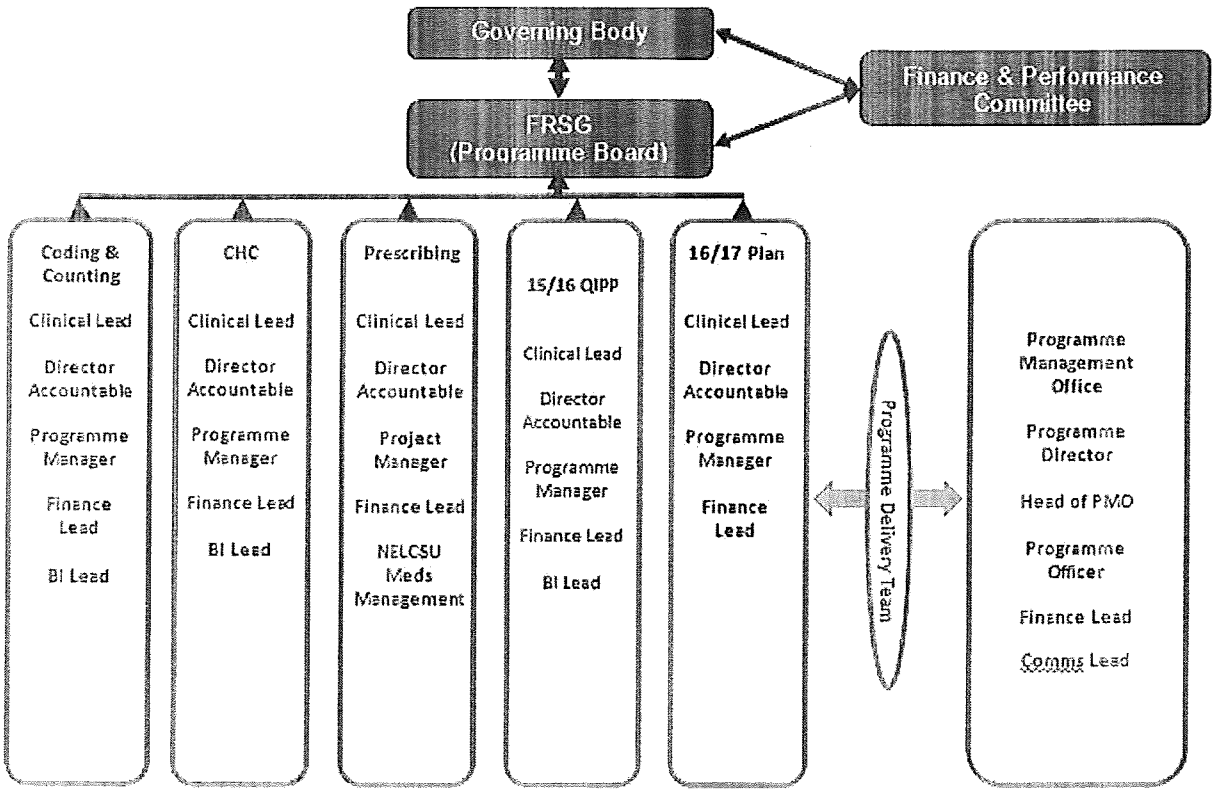
The SNCCG PMO oversees and assures the delivery of the 20 schemes comprising the CCGs 2015/16 QIPP work programme. Schemes are embedded and delivered within established commissioning programme portfolios (e.g. Acute) to drive and sustain a 'business as usual' approach to QIPP delivery. All programme areas report into the PMO and assurance is provided through a robust delivery structure comprised of:

- Weekly programme lead PMO meeting (including progress and delivery reporting)
- Weekly 15/16 delivery and 16/17 planning meetings by programme area
- Weekly Financial Recovery Steering Group meetings

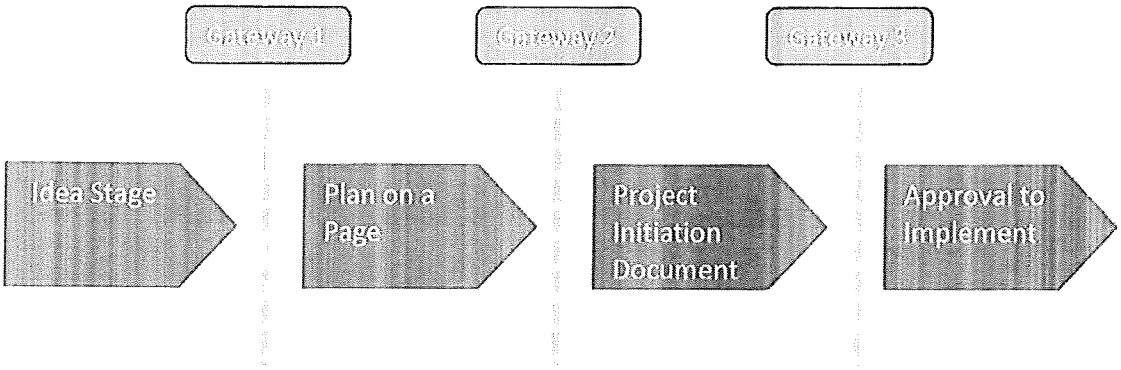
SNCCG has embedded a tailored approach to project and programme management based on industry standard best practice (PRINCE2 and MSP) methodologies. All programme leads report delivery progress on a weekly basis, supported by aligned finance and business intelligence leads, with high value/ complex change project leads providing weekly highlight reports to the PMO.

The PMO is fully embedded into SNCCGs governance framework and provides a critical role in assuring QIPP delivery. In addition to reporting to the CCGs Financial Recovery Steering Group, the PMO reports directly into both the Finance & Performance Committee and Governing Body, ensuring transparency and consistency of decision-making, communication, challenge and oversight.

Programme Governance and Assurance



Gateway Process & Project Checklist



PROGRAMME/PROJECT ASSURANCE CHECKLIST				
	Criteria	Assured	Partially assured	Not assured
1	Sponsor identified			
2	Steering group in place			
3	Baseline agreed			
4	Clear objectives with B/W/L			
5	Milestones and trajectory			
6	Financial plan agreed			
7	Comms plan			
8	QIA completed			
9	Impact on stakeholders /other projects identified			
10	Risks identified and mitigation in place			
11	Clinical engagement/ approval			
12	Plans agreed with provider and contracts reviewed			

3. Evidence of the consultation process that ensures all residents of Norfolk have an opportunity to comment on the proposed changes to services being commissioned by your CCG.

The CCG's approach to engagement and consultation through its commissioning cycle are articulated on pages 10-11 of its 'Communications and Engagement Strategy, 2014-16', which can be found here: http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/SNCCG%20Communications%20and%20Engagement%20Strategy%20FINAL.pdf

Since its inception, the CCG has focused on supporting and developing the capacity of its Patient Participation Groups, as they are pre-existing, mobilised patient and public forums that can provide local insight and intelligence. The CCG also maintains communication with a wide-reaching stakeholder audience.

Over the 2015-16 financial year, the CCG has engaged in a number of informing, engaging and consultation activities, either coordinated singularly or by working with colleagues at other CCGs.

NHS South Norfolk CCG consultations

The CCG has two recent examples of designing and delivering consultations to gather feedback on commissioning proposals – such as policies that would restrict access to hearing services for people with a diagnosed 'Mild' hearing loss, or for Level 3 Specialised Fertility Services.
Consultations went through the following stages:

- **Informing:** Outlining what the CCG was proposing in clear, concise language to a wide audience, including patients and public, clinicians, statutory and independent health providers, and the voluntary sector
- **Formally consulting:** Asking questions to gather specific feedback on the proposed policy, via written and electronic surveys, workshops and one-to-one meetings
- **Evaluation and Discussion:** Analysing the responses to the consultation, organising the information into themes and trends, and presenting this to the CCG's Governing Body for discussion
- **Feedback and Next Steps:** Communicating the Governing Body's decision and how it was reached, liaising with key stakeholders and everyone that responded to the consultation, and involving interested parties in the actions coming from the consultation

The CCG regularly involves Primary Care and wider health colleagues, patients and stakeholders in its decision making and discussions regarding commissioning, and uses a variety of methods with which to do so.

County / central Norfolk consultations and procurement

NHS South Norfolk CCG is an active partner in the commissioning, mobilisation and monitoring of services that cover the whole of Norfolk (or central Norfolk area).

This includes involving South Norfolk clinicians, Primary Care, patients and local stakeholders in the design, development and commissioning of the Wellbeing Service delivered by Norfolk and Suffolk NHS Foundation Trust, the Non-emergency Patient Transport service provided by ERS Ltd, and the 111 and Out of Hours service provided by IC24.

4. Evidence that an Impact Equality Assessment is undertaken as part of the final decision making process.

Impact assessments are completed via a 2 stage process and in keeping with the gateway process for all potential projects outlined above:

Stage One –initial assessment to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are commissioned and/or delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score. Quality is described in six areas, each of which must be assessed at stage 1. Where a potentially negative risk score is identified and is equal to or greater than (≥) 10 this indicates that a more detailed assessment is required in this area. All areas of quality risk scoring equal to or greater than 10 must go on to a detailed assessment.The stage one assessment screening tool will require judgement against the seven areas of risk. Each proposal will need to be assessed whether it will impact adversely on patients / staff / organisations.

Stage Two - where an adverse impact score greater than (≥) 10 is identified in any area a more detailed Impact Assessment is undertaken to determine the impact before a final recommendation is made to proceed.

The Quality Team will provide support to complete Stage One and will complete any that escalate to Stage Two in partnership with the relevant Clinical Lead

I hope that answers the questions raised in your letter and assures Healthwatch that the CCG has robust methodology and governance in place regarding its QIPP portfolio and wider commissioning intentions.

Please come back to me directly if you have any further questions.

Kind regards,

Jocelyn Pike – Chief Operating Officer

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Our Ref:

29 January 2016

Dear Alex

Re: Involving Patient and the Public in Service Changes

Thank you for your letter of 4th January 2016 seeking reassurance as to the methodology and governance arrangements in place to involve patients and the public in proposals to change services.

It goes without saying that we take seriously the statutory duty to involve patients and the public in service planning and proposals for change (Section 242 of the Health and Social Care Act 2006) and I trust you will agree that we have a strong track record in this regard.

Where we have made local changes to improve services, such as dementia and End of Life care, we have held meetings with users and carers, to involve them fully in the development.

We also have a Community Involvement Forum, with broad representation from a variety of user groups, and with whom we discuss future plans.

Healthwatch is also represented on our System Resilience Group and makes a valuable contribution to our strategic planning and oversight.

You will be aware that the West Norfolk health and care system, like many areas nationally, is under pressure and that we have been working with partners to ensure the long-term sustainability of services for local people. To date, our work has focussed on identifying the challenges and opportunities to do things differently and, last year, we published an evidence based 'Case for Change' which was accompanied by a comprehensive programme of patient and public engagement.

Over the coming months, we will be taking forward the 'Case for Change' with a view to developing a Sustainability and Transformation Plan (STP) by the end of June 2016. This Plan, as the name suggests, will need to set out the strategic direction for health and care services in West Norfolk and may include proposals for significant service redesign. In developing the STP, we will:

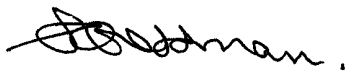
a) ensure patients and the public are involved in developing any proposals for service changes and we will, of course, continue to work with Healthwatch throughout this period;

b) set out and share our planning process and timeline for the period from February to June 2016 and beyond, incorporating governance arrangements, decision points and assessment criteria;
c) undertake impact equality assessments where required;
d) ensure that a formal consultation process takes place at the appropriate time, should the proposals contained in the STP require statutory consultation. Any formal consultation is likely to take place in autumn 2016, following the development of the STP.

I hope the above provides you with the reassurance you seek and please do not hesitate to get in touch with me, should you wish to discuss this further.

You can also contact Aidan Fallon, Interim Director of Strategy & Planning (01553 666934 aidan.fallon1@nhs.net), who is leading the development of the STP.

Yours sincerely



Dr Sue Crossman
Chief Officer
West Norfolk Clinical Commissioning Group

Continuing Healthcare

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

Examination of the new policy and guidance being introduced by Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups regarding provision of NHS Continuing Healthcare.

1. Background

1.1 On 28 May 2015 Norfolk Health Overview and Scrutiny Committee (NHOSC), received a presentation from North East London Commissioning Support Group (CSU) and NHS North Norfolk Clinical Commissioning Group (NN CCG) on behalf of the four CCGs, Norwich, North Norfolk, South Norfolk and West Norfolk, regarding work on a new comprehensive guide for how NHS Continuing Health Care is implemented in Norfolk. At that stage the CCGs were planning for a public consultation from June to September 2015, but there was still work to be done between the CCGs and with other NHS representatives and patient groups to define the proposed new guidelines and policy.

1.2 The CSU and NN CCG made it clear in May that their work would not touch on the National Framework for NHS Continuing Healthcare (CHC), which local CCGs are not in a position to change. The National Framework defines, for example:-

- How screening is undertaken to identify people who may be suitable for an assessment of eligibility for NHS CHC –"the Checklist"
- Processes for the assessment of eligibility undertaken through the completion of " the Decision Support Tool"
- Reviews of patients to ensure care continues to meet changing needs and that eligibility is reassessed at three months and then as a minimum annually
- How interfaces with joint funding arrangements should be applied.

The local work was focused on producing an open and transparent guide and policy for delivering NHS CHC to patients who have been assessed as eligible for it under the national framework. The aim of the guide was to ensure fairness and equity in provision of CHC across the four CCG areas.

1.3 In July 2015 members received information from the CSU in the NHOSC Briefing that rather than moving to consultation at that stage, they and the CCGs had decided to undertake a further period of three to four months development work on the proposed guidance and policy, after which they would decide whether it was necessary to proceed to full public consultation. At that stage they hoped that Great Yarmouth and Waveney CCG would also adopt the new guidance and policy.

1.4 In the October NHOSC Briefing members were informed that following discussions between the four CCGs and engagement with stakeholders, the CCGs and CSU considered that their intentions for local CHC policy did not amount to substantial variation for which consultation with NHOSC would be required. They did not intend to set a financial threshold above which CHC patients would not be funded to receive care in their own homes. They would continue with the practice of case-by-case decisions based on individual circumstances but handled in a more systematic way than in the past, by standardising the guidance for Complex Case Review Panels (CCRPs).

1.5 The CSU and CCGs had spoken with representatives of Equal Lives, Norwich Independent Living, Opening Doors, Norfolk Carers, Norfolk Older People's Strategic Partnership, Making it Real, Alzheimer's Society and Headway. Healthwatch Norfolk was also involved. The CCGs and CSU had concluded that a CCRP would undertake thorough consideration of cases where there was a more than 5% cost difference in the options of care being considered (see paragraph 1.8 below). They were recommending agreement of a standard list of services which NHS CHC packages would fund and those which they would not. In October 2015 the list was under development in discussion with social services and was to be shared with stakeholders for discussion and feedback.

1.6 The CSU and CCGs were also working on proposed standardised domains which CCRPs would consider when making decisions about individual packages of care for patients who were eligible for NHS CHC.

1.7 The CSU and CCGs said that there would be opportunities for stakeholders to be involved in their ongoing work on the planned local guide to NHS CHC to ensure it is accessible to all and that they intended to put the new arrangements into effect from 1 January 2016. The new policy has, however, not yet been implemented for the reasons set out in the CCG's report at Appendix D, section 5.

1.8 The CCGs have also decided that when the new policy is implemented, which they anticipate will be in April 2016, the CCRPs and CSU will initially consider all cases in line with the standardised domains (see paragraph 1.6 above), not just those cases where there is more than a 5% cost difference in the options of care being considered.

1.9 NHS Great Yarmouth and Waveney CCG (GY&W CCG) does not intend to adopt the same policy and guidance as the other four CCGs in Norfolk. It will support the provision of a clinically safe and sustainable package of CHC to an individual in their own home where the anticipated cost to the

CCG of such a package does not exceed the anticipated cost of suitable provision for that individual in a care home by more than 40%. In the event of a need to deviate from this policy, a panel would be convened to discuss the request.

2. Purpose of today's meeting

2.1 On 30 November 2015 the Chief Executive Officer of Equal Lives and a continuing healthcare service user sent a joint letter to the chairman of NHOSC raising concerns about the new CHC policy and asking the committee to examine particularly the training of panel members, the application of principles and progress towards creating a suitable 'safety net' service for people who receive CHC.

2.2 Bearing in mind that Equal Lives had been involved in the CSU and CCGs' development of the new policy and guidance and that it is an organisation representing the interests of disabled people who may use the service, NHOSC agreed on 3 December 2015 to ask representatives of the CCGs and CSU to attend today's meeting to discuss progress with the new policy and guidance and the concerns that have been raised.

2.3 A copy of Equal Lives' letter is attached at Appendix 1. The letter was forwarded to the CSU and a representative of the CCGs, who provided a response on 22 December 2015; copy attached at Appendix 2.

2.4 The CCGs and CSU have been asked to report to NHOSC with:-

(a) An update on the development of the guidance and the implementation of the new policy.
(b) A copy of the new guidance.
(c) A copy of the standard list of services.
(d) Details of the training given to Complex Case Review Panel (CCRP) staff and CHC staff on the new policy and guidance.
(e) Details of how the CCGs and CSU took account of stakeholder's feedback on the standard list of services and guidance
(f) The timetable for undertaking analysis of the impact of CCRPs' decisions in 2016.

The CCGs and CSU's report is attached at Appendix 3.

2.5 Representatives of the CCGs will attend today's meeting and the Chief Executive Officer of Equal Lives and the service user who submitted the letter at Appendix A have asked to speak to the committee.

3. Suggested approach

3.1 The committee may wish to discuss the following areas:-

(a) How will the CCGs ensure consistent decision making between the four separate Complex Case Review Panels (CCRPs) in the four CCG areas?

(b) What is the reason for having four separate CCRPs rather than one covering the whole county?

(c) The CCGs no longer intend to set 5% cost variance as the trigger point for consideration of a case by a CCRP when they implement the new policy. Does this mean that all cases will need to be considered by a CCRP? If not, how will it be decided which cases go to CCRPs and which do not?

(d) What is the likely waiting time for cases to be considered by CCRPs?

(e) What are the CCGs' comments on the difference between their new policy and Great Yarmouth and Waveney CCG's policy, where review panels are triggered by a 40% cost variance between options for care?

(f) Given the complex nature of CHC patients' needs, is it likely that those who are cared for at home by CHC funded providers, or via carers directly employed by the patient under a Personal Health Budget arrangement, are at high risk of admission to hospital or a nursing home bed on occasions when the agency delivering their healthcare fails to deliver? What more can be done to ensure a 'safety net' to deliver the appropriate level of care in such situations so that patients can remain in their usual home setting?

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

Mr Michael Carttiss

Chair, Health Overview and Scrutiny Committee

Norfolk County Council

30 November 2015

Dear Mr Carttiss

Re: Continuing Healthcare Care (CHC) policy – health overview and scrutiny committee

Having had discussions with Amanda Cousins and meetings that included few if any continuing healthcare users we are writing with you to share our concern about the outcome of the review of CHC.

The four CCG's have now decided on a unified approach. An area of particular concern to us is the proposals to refer any home care packages that cost more than 5% above an equivalent residential package to a panel. We believe this proposal will potentially open the CCGs up to legal challenge under the Equalities Act 2010, Article 8, Respect for your Private and Family Life and the Care Act 2014/Local Authority Act 1972, as our understanding is, you are not allowed to 'fetter discretion' in this way.

We are also very aware that costs vary in different areas of the county. This could introduce a postcode lottery. Also If residential care were to be found cheaper than home care this could force people into institutions – a retrograde step that is also against Government and Norfolk County Council policy.

It is difficult to apply a standardised approach in many cases because the nature of people using CHC is that they have a degree of complexity and unpredictability that will cause each case to be very different in any particular situation or time.

To ameliorate this problem, Amanda stressed that the panel members and CCG CHC staff would be trained in the following aspects:

– Human rights legislation

– 'I' statements

– The Harwood, care and support charter

We have considerable concerns that each CCG panel and CCG will experience difficulty in keeping the focus on patient care without rigorous application of these principles. To give an example, Norfolk County Council became signatories of the Harwood, care and support charter in 2013 but Norfolk's first response and social work staff still fail to use the Charter card correctly. And in a recent meeting in West Norfolk a social services member of staff made a general (and in our view, prejudiced) comment to NHS staff that disabled people were 'milking the system'.

The proposal is to commence reviewing cases in January and we have not been invited to assist with any training. We were also told that a booklet of guidelines would be co-produced and we have not had any input or knowledge of the contents.

Also during our discussions with Amanda about who people should contact if they are unable to identify and purchase suitable services, it was clear to us all that there is no identified 24/7 safety net service. This will clearly drive people to use hospital or residential solutions, even when this is very much against their wishes. It also leaves people in potentially abusive situations without a clear route to find alternatives.

It is our belief that the correct use of the Harwood Charter card by health and social services could provide a unified contact point/safety net service.

We understand that the issue will not be brought back to the health overview and scrutiny committee on 2 December as previously agreed, but will monitor the arrangements at a later date.

We would be grateful if the committee would consider our concerns as we believe these proposals are about 'salami slicing' cuts rather than a genuine attempt to improve patient care. It would also be useful if the committee could examine the training of panel members, the application of the principles, and progress towards creating a suitable safety net.

Yours sincerely,

Caroline Fairless – Price

CHC user

Mark Harrison

CEO, Equal Lives

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Maureen Orr
Democratic Support and Scrutiny Team Manager
Norfolk County Council
Martineau Lane;
Norwich;
NR1 2DH

22nd December 2015

Dear Maureen,

Thank you for sharing the attached letter Re: Continuing Health Care (CHC) policy – Health Overview and Scrutiny Committee. As Coordinating Commissioners for CHC, Norwich CCG would like to acknowledge receipt of this and respond to the points raised. We have given consideration to the main points made in the letter and reviewed the draft policy and supporting guidance documents to ensure we have addressed these.

Please see below a summary of the main concerns outlined in the letter (in bold) and our response to each.

- **The proposals to refer any home care packages that cost more than 5% above an equivalent residential package to a panel.**

  This is not the proposal going forward in the policy. The proposal is that a CCG Complex Case Review Panel (CCRP) will ensure that where there is more than 5% difference between options for care being considered, a panel will make the decision in relation to a number of domains.

  The domains to be considered in reaching a decision will include patient preference, relevant legislation, best practice and reasonableness.

- **The fact that costs vary in different areas of the county.**

  We have standard NHS Contracts in place across the four CCGs which have the same cost bandings. This approach is intended to bring costs in line and minimise variations across the county.

- **That panel members and CCG CHC staff would be trained in human rights legislation, "I" statements, the Harwood Care and Support Charter.**

Training to aid the panel members and CCG CHC staff will be developed in January 2016. Supporting material has been drafted to support a standardised decision-making approach using a number of domains on which to base decisions.

- **That panel members and the CCG will experience difficulty in keeping the focus on patient care without rigorous application of the principles enshrined by the human rights legislation, "I" statements, the Harwood Care and Support Charter.**

  The chair of the CCRPs will be a clinician or Quality Lead to maintain the emphasis on patient care. The Terms of Reference for the CCRP will reflect a focus on the patient and his/her care.

- **A booklet of guidelines would be co-produced and the letter writers allege not to have had any input or knowledge of the contents**

  Stakeholders were engaged in a series of workshops and events to discuss and agree the headings for the guide for patients, as well as inclusion of the human rights legislation, "I" statements, the Harwood Care and Support Charter. Consulted groups included Norwich Older Peoples Forum, Equal Lives, Opening Doors, Alzheimer's Norfolk, Norfolk Older Peoples Strategic Partnership and a champion for the Harwood Charter. The document reflects these points and further circulation is planned prior to the document being finalised.

- **A recent meeting in West Norfolk where a social services member of staff made a general and in their view prejudiced comment to NHS staff that disabled people were 'milking the system'.**

  We thank the stakeholders for bringing this to our attention. This is a deplorable stance and not one that is shared by the CCGs. We expect to challenge such views wherever they are expressed and would advise that this feedback be escalated to Harold Bodmer.

- **The proposal is about 'salami slicing' cuts rather than a genuine attempt to improve patient care.**
  The policy sets out the principles that the CCGs will apply in commissioning NHS CHC effectively and efficiently. The content represents policy strands that CCGs had developed to ensure:
    - that patients' assessed NHS CHC needs will be met by the NHS

- appropriate patient care is delivered
- that patients are safeguarded
- that patients will not pay for NHS services at the point of delivery
- that decisions about clinically-appropriate care provision for patients are made in a consistent way that is patient centred and conforms to legislative requirements
- that NHS funds are allocated and utilised responsibly

We hope that this gives an acceptable response to the issues raised and provides sufficient detail and perspective. The programme of work that is currently underway to improve our processes around the management of NHS Continuing Health Care is both structured and inclusive with the genuine central objective of improving care delivery in this area.

I would be pleased to offer any further information if required and will continue to coordinate the response from the CCGs.

Yours sincerely

Rachael

Rachael Peacock
Head of Continuing Care
NHS Norwich Clinical Commissioning Group

Telephone; 01603 613325
Rachael.peacock@nhs.net

c.c. Chief Officers; NHS Norwich CCG, NHS North Norfolk CCG, NHS South Norfolk CCG, NHS West Norfolk CCG

Quality Leads; NHS Norwich CCG, NHS North Norfolk CCG, NHS South Norfolk CCG, NHS West Norfolk CCG

Rosa Juarez - Continuing Care QIPP Project Manager (Central and West CCGs)

Max Bennett – NEL CSU Communications Manager

CCGs and CSU Report to NHOSC

1. Introduction

1.1. This report is the culmination of work conducted by the NHS Continuing Healthcare (NHS CHC) Policy Workstream and members of the Continuing Care QIPP Operational Group from Norwich CCG, South Norfolk CCG, North Norfolk CCG and West Norfolk CCG. The following documents were produced:

- NHS CHC Policy
- Procedures regarding CHC for NHS Staff
- Guide for patients and carers

Copies of these documents are included in the Appendix (see appendices A, B and C).

1.2. CCG Governing Bodies for Norwich CCG, South Norfolk CCG and West Norfolk CCG approved these documents in January 2016. North Norfolk CCG approved the overarching policy in October 2015 and are due to review the Procedures for staff and Guide for Patients and Carers on the 23rd February 2016. CCGs are seeking to implement the policy from 1st April 2016.

2. NHS CHC Policy

2.1. This is policy document brings together the previous policy for the Mobilisation of NHS CHC care home contracts and the previous additional services policy. This also includes the standardised process for the Complex Cases Review Panel (CCRP) decision making which North Norfolk CCG, Norwich CCG, South Norfolk CCG and West Norfolk CCG approved in 2015 through their Governing Body meetings.

2.2. The approval and application of the CHC Policy by all four CCGs will ensure a consistent approach for all patients and providers of NHS CHC across the four CCGs.

3. Procedures regarding CHC for NHS Staff

3.1. This sets out the procedures for NHS staff in relation to the areas covered in the NHS CHC Policy. It includes referral guidelines for external services, support and standard operating processes. It is intended that these are in sufficient detail to be implemented.

4. Guide for patients and carers

4.1. This is a Guide to NHS CHC in central and West Norfolk for patients, carers and families. It includes areas of frequently asked questions and all aspects of the NHS CHC Policy in a way that is easily accessible for patients, carers and families.

5. Implementation of the NHS CHC Policy

5.1. As North Norfolk CCG has yet to approve the documents formally, CCGs have decided to delay implementation of the NHS CHC Policy until all CCGs have formally approved it. This is anticipated to be April 2016.

5.2. Additionally, it was intended that the NHS CHC Policy would include information from the expected release of the next version of the CHC National Framework. This guidance was expected in December 2015 but was delayed and is now expected in April 2016. CCGs plan to conduct an internal review of the NHS CHC Policy once the DoH guidance is received. This is expected to take place between May and June 2016.

5.3. The NHS CHC Policy establishes norms in respect of when a CCRP will convene to review a care package and what services NHS CHC should and should not fund. In planning the implementation of the NHS CHC Policy, CCGs have decided to defer the implementation of the following aspect of the "Standard Decision Making Framework and Governance Arrangements for CCGs When Commissioning and Reviewing NHS CHC Packages" until further review:

- "A CCRP will ensure all domains are considered at the point where there is a more than 5% difference in the options for care being considered".

5.4. This is due to the fact that CCGs have agreed that the application of the domains is best practice and requested that CCRPs and the CSU apply these in all cases, regardless of whether there is a 5% difference in the options for care being considered. As such, the operational enactment of the 5% difference will not be implemented until CCGs evaluate the application of the policy and whether this criteria is still required. However CCGs remain committed to whilst always ensuring that patients receive high quality care, the value for money of care packages has also to be taken into account given the need to balance the interests of patients in receipt of NHS CHC with the wider community.

5.5. Each CCG is required by law to have their own arrangements for decision making for patients they are responsible for. However, CCGs will ensure

consistent decision making between the separate CCRPs in the four CCGs areas by ensuring that:

- The NHS CHC Policy is implemented once all CCGs have approved the policy
- CCRPs have adapted, approved and adhere to the Terms of Reference that have been developed collaboratively (see appendix D).
- CCRPs have and consult the Guidance Sheet for Consideration of Human Rights in Complex Case Review Panel Decision Making (see appendix E)
- The standardised template developed to support CCRPs in considering the five domains in all cases is used (see Appendix F).
- Appropriate training opportunities are offered and attended by CCRP members and CSU staff.

6. Evaluation of the Standardised Process for CCRP Decision Making

6.1. As the standardised process for the CCRP decision making introduces new arrangements for CCRPs, CCGs have committed to evaluating the impact of these changes. The evaluation will analyse the impact of CCRPs' use of the standardised decision making framework. The evaluation is expected to commence in September 2016. This is to allow the NHS CHC Policy a period of 6 months of mobilisation. Healthwatch have been approached to undertake the evaluation and provide a quote. The timescales for the evaluation will be agreed with Healthwatch and the final report will be submitted to CCG Governing Bodies.

7. Training for CCRP staff and CHC CSU Staff

7.1. A training session for CCRP members from all CCGs was held on 1st February 2016. This covered the NHS CHC Policy, Staff Procedures, Patient Guide, Harwood Charter and Operating Model "I" Statements (see Appendix G for the full presentation[1], Appendix H for the attendance log and Appendix I details of the evaluation completed).

7.2. Additional training is available online and has been recommended for CCRP members from all CCGs in relation to equality, disability and human rights (including the panel chairman).

[1] Note to NHOSC – Appendix G (44 page document) has not been included with agenda papers for NHOSC but is available on request from the Democratic Support and Scrutiny Team Manager

7.3. The CSU has provided a training plan for their staff detailing how the information from the Policy, Guides and CCRP domains will be cascaded (please see Appendix J).
7.4. The CCGs have shared the presentation training materials (PowerPoint and evaluation) with the CSU to support them in this process.

8. Stakeholder Feedback on the Standard List of Services and Guidance

8.1. Between July and October 2015, CCGs embarked on a series of meetings and workshops with stakeholders to discuss and identify concerns, key issues and to test thinking and proposals regarding NHS CHC. Additionally, a feedback workshop was held on the 29th October to communicate proposals to those who had been engaging in reviewing proposals for NHS CHC (see Appendix K for a list of all organisations engaged with in producing the Guide for patients and carers). Stakeholders were also given an opportunity to provide feedback on the Guide for patients to NHS CHC at the end of December 2015.
8.2. CCGs are committed to taking account of stakeholder's feedback and ensuring that our approach to NHS CHC is effectively communicated to the public and our staff. It is anticipated that stakeholders and patients will be contacted for feedback during the evaluation planned for September 2016.
8.3. CCGs will also seek to ensure that the Standard List of Services (found in both Appendices B and C) are effectively aligned with Norfolk County Council's list of services funded by a personal budget.

9. Safety Netting for Patients Receiving CHC Funded Care

9.1. The CHC Policy and other documents produced do not specifically address the issue of safety netting but the points raised have been considered with interest.
9.2. NHS CHC is a funding stream to support NHS long term care provision rather than a service to deliver care.
9.3. Services are purchased from private providers in Nursing and Residential Care settings, by Domiciliary Care agencies and more recently via carers directly employed by an individual under a Personal Health Budget arrangement.
9.4. Nursing and Residential Care providers and Domiciliary Care agencies have a responsibility to provide care but also to have plans in place covering contingency arrangements for sickness etc. This presents a more problematic scenario for those individuals that may employ their own carers.
9.5. Individuals in receipt of 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, social care services are able to respond to unplanned situations on a short term basis for people in need of responsive social care support. This includes individuals in receipt of CHC funding.

9.6. We will continue to explore opportunities to strengthen the integrated approach between patients, their carers & families, the NHS and social services, to ensure care is delivered where needed regardless of funding stream.

10. Appendices

Ref	Document title
A	NHS CHC Policy
B	Central and West Norfolk Procedures for Staff on NHS CHC V10
C	Central and West Norfolk Guide to NHS CHC for patients V 20
D	Draft CCRP Terms of Reference (to be amended by each CCG as appropriate)
E	Guidance Sheet for Consideration of Human Rights in Complex Case Review Panel Decision Making
F	Decision Making Template for CCRP
G	Powerpoint presentation for CCRP and CSU training on NHS CHC Policy, Staff Procedures, Patient Guide, Harwood Charter and Operating Model "I" Statements **Note to NHOSC – this 44 page document has not been included with agenda papers for NHOSC on 25 February 2016 but is available on request from the Democratic Support and Scrutiny Team Manager**
H	Attendance log of CCRP training session on NHS CHC Policy, Staff Procedures, Patient Guide, Harwood Charter and Operating Model "I" Statements
I	Details of the evaluation of training completed by CCRP members
J	CSU Training Plan for Staff
K	List of organisations engaged with in producing the Guide for patients and carers

Appendix A

the Clinical Commissioning Groups
for North Norfolk, South Norfolk
Norwich and West Norfolk

POLICY WITH REGARD TO NHS CHC CONTRACTS FOR CARE HOMES WITH NURSING AND RESIDENTIAL CARE HOMES

Version: 12

Date: 05/01/2016

Release: Draft

Document Location

The source of the document will be found at:

Policy NHS CHC Contracts for Nursing & Residential.docx

Revision History

Revision date	Author	Version	Summary of Changes	Changes marked
11/08/2014		1	Original mobilisation policy draft	
10/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	2	Review of mobilisation policy draft with regards to best interests sections and inclusion of joint CCG panel section. Document renamed to be the basis of a central policy for CHC Contracts with regard to nursing and residential care. Table of contents added.	As described
11/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	3	Added in Additional Services policy section and supporting documents as appendices (Version AC/ Anglia CSU July 2014).	As described
25/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	4	Inclusion of standardised decision making framework for CCRPs.	Tracked changes
30/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	5	Changes following meeting on 27/11/2015 on exceptionality (section 4.1). Addition of introduction for whole document.	Tracked changes
01/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	6	Changes made in meeting to review Additional Services and Standardised decision-making framework sections.	Tracked changes
07/12/2015	Tim Curtis, NHS Norwich CCG Communications	7	Formatting and general changes for consistency.	
09/12/2015	Howard Stanley, Safeguarding	8	Changes made to safeguarding elements within Additional Services section.	

14/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	9	Amendment to Additional Services section as agreed with Sarah Taylor, Rachael Peacock, Mark Payne and Paul Martin on 11/12/2015. Changes to wording under standardised governance and decision-making to reflect JCC paper signed off.	
16/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	10	Review with Laura McCartney-Gray, Engagement Manager, Norwich CCG	
30/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	11	Addition of appendices I and J.	
05/01/2016	Rosa Juarez, Continuing Care QIPP Project Manager, NCCG	12	Addition of Appendix J with changes as agreed on 04/01/2016	

Approvals

This document requires the following approvals:

Name	**Title**	**Date of Issue**	**Approved/ Rejected**	**Version**
	JCC	19/01/2016		12
	North Norfolk CCG Governing Body	26/01/2016		12
	South Norfolk CCG Governing Body	26/01/2016		12
	Norwich CCG Governing Body	26/01/2016		12
	West Norfolk CCG Governing Body	28/01/2016		12

TABLE OF CONTENTS

1. INTRODUCTION AND PURPOSE OF THIS POLICY

This Policy sets out the principles that the NHS Norwich Clinical Commissioning Group (CCG), NHS North Norfolk CCG, NHS South Norfolk CCG, and NHS West Norfolk CCG will apply in commissioning NHS Continuing Healthcare (NHS CHC). As such, this policy relates to care commissioned by:

- NHS Norwich CCG
- NHS North Norfolk CCG
- NHS South Norfolk CCG
- NHS West Norfolk CCG

This Policy is applicable to both new and existing patients eligible for NHS Continuing Healthcare. This Policy applies once an individual has received a comprehensive, multidisciplinary assessment of his/her care and support needs and the outcome shows that s/he has a primary health need and is therefore eligible for NHS Continuing Healthcare funding.

The content of the Policy represents policy strands that CCGs had developed within a guide. This is to ensure appropriate patient care and is in line with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised) ("the Framework"). It has been developed to provide a common understanding of the CCGs' commitments with respect to NHS CHC.

This policy ensures that:

- the patient's assessed NHS CHC needs will be met by the NHS
- patients will not pay for NHS services at the point of delivery
- patients are safeguarded

2. CONTRACTUAL ARRANGEMENTS AND PATIENT PLACEMENT

2.1. INTRODUCTION

This section outlines the approach being taken by CCGs in Norfolk to ensure continuity of care for patients eligible for NHS Continuing Healthcare (NHS CHC) as they introduce a new contractual model for care homes. This policy will apply to residential care homes but not to home care provision. For the purposes of clarity and consistency, references in this document to "care homes" includes both care homes with nursing and residential care homes.

This policy has been drafted in order to address a number of scenarios for which both CCGs and the Commissioning Support Unit require an agreed approach that can be implemented by the CSU contracts team.

Key principles:

- CCGs will only place patients with providers with whom they hold a contract for the provision of NHS CHC and which meets the quality and patient safety standards within that contract.
- Policies will seek to ensure that existing NHS CHC patients, insofar as possible, are not moved between providers or their historically-provided NHS funded care disrupted.
- Patients will be informed, prior to check-listing, of the contractual status of their current care provider. If the care provider does not hold an NHS contract and does not wish to hold one, for the provision of NHS CHC, options for alternative settings will be discussed with the patient and their families.
- Those providers that do not wish to provide NHS CHC will be enabled over time to withdraw from the market in a managed way.
- Where a patient lacks capacity to make decisions about their future care options, a best-interest meeting will be called and contractual options available considered.

For providers that have signed the new contract for provision of NHS CHC the contracts will be mobilised as normal. This will provide continuity of care for existing NHS CHC patients and choice for new patients seeking placements funded by NHS CHC. The quality standards within the new contracts will ensure that the CCGs can hold providers to account for the quality of care they provide and ensure that the most complex and vulnerable patients are well cared for.

2.2. SCENARIO PLANNING FOR PROVIDERS WHO NO LONGER WISH TO PROVIDE NHS CONTINUING HEALTHCARE AND PROVIDERS WHO ARE OUT OF AREA

Two scenarios have been identified for which a policy is needed:

- An approach with regard to existing care homes that are no longer choosing to provide NHS Continuing Healthcare under contract to the NHS with regard to:
    - Existing long standing NHS funded patients
    - Residents of non-contracted care homes thinking about the implications of being assessed for NHS CHC.
    - Newly eligible patients

- An approach with regard to provision of NHS CHC funded care outside the CCGs' areas.

2.3. CARE HOMES THAT ARE CHOOSING TO NO LONGER HOLD A CONTRACT FOR THE PROVISION OF NHS CHC

Providers that choose **not** to continue to hold a contract with the NHS for the provision of NHS CHC will not be made available on the choice menu for new NHS CHC funded placements.

2.4. WITH REGARD TO EXISTING NHS CHC FUNDED PATIENTS ALREADY ON NAMED PATIENT CONTRACTS WITHIN THESE CARE HOME SETTINGS, AT THE POINT AT WHICH THE CURRENT CONTRACT CEASES, OR FOR WHOM A DATE IS TO BE AGREED FOR THE IMPLEMENTATION OF THIS POLICY THE PROCESS WILL BE:

- Patients may choose to remain within a care home which is no longer willing to hold a contract for provision for NHS CHC. Where this is the case a discussion will be held with the provider. Those patients who wish to stay will be documented as a list of NHS CHC residents on a Named Patient document where the CSU/ CCG will endeavour to secure continuing placements for any existing NHS CHC patients at their current contracted prices. Such providers with named-patient arrangements will be reviewed annually, as a minimum. CCGs will still need to ensure that minimum CQC standards of care are reached and that there are no patient concerns or complaints about the standards of care being provided. The provider will still be required to deliver the care requirements of the NHS CHC package.

- Without a formal NHS CHC contract in place CCGs have few levers to apply to ensure actions are taken to improve care overall but any concerns would be communicated to the CQC; NHS funded patients may wish to reconsider their ongoing placement with that provider. Providers who do not hold an NHS Contract for NHS CHC will still be required to deliver a degree of reporting and will still be required to meet CQC standards for Care Homes.

- Individual patients who choose to remain in homes that do not wish to continue with an NHS contract for NHS CHC will be individually and clinically reviewed in line with normal NHS CHC patient review schedules for contracted providers. This can be monthly to annual reviews dependant on clinical need.

- Individual applications from non-contracted providers for inflationary uplifts will be considered by the CCGs whose patients are placed. These are unlikely if placements are above normal NHS CHC base rates.

- Existing NHS CHC Patients in non-contracted homes will be informed of the non-contractual status on review. Patients will be offered the option to move if they wish to and the options can be explored with them. In exceptional circumstances, where patients wish to stay in a non-contracted care home, and this is in the best interests of the patient, discussions with that care provider will be held to see if they will accept continuation of that patient's care provision under named patient arrangements.

- The intention is to reduce activity in non-contracted care providers as patients move, become no longer eligible or come to the end of their lives. This provides a managed transition for providers who wish to withdraw from NHS provision of NHS CHC. The CSU clinical teams have lists issued at regular intervals to ensure they know which care homes are signed up to an NHS Contract for the provision of NHS CHC and those that are not.

- Homes can seek to discharge a resident who is entitled to NHS CHC where they do not wish to continue to provide NHS CHC. In these cases all steps will be taken to support that patient and their family to find alternative provision. Patients may be under pressure to refuse NHS CHC funding and continue to self-fund. Staff need to be aware of this and ensure that patients are given all the advice and support they need to make the right decision for them.

2.5. WITH REGARD TO RESIDENTS IN NON-CONTRACTED CARE HOMES

Patients within non-contracted care homes should be given access to information on the potential outcomes of an eligibility assessment prior to check listing. Patients need to accept that unless an exceptional case can be made (e.g. patient is in end stage care or there is limited alternative provision available) they will be required to move to a contracted NHS CHC provider.

If the patient wishes to stay in a care home which does not provide contracted NHS CHC services, then the patient may choose to decline the checklist completion and the assessment of eligibility for NHS CHC funding and continue to self-fund or be funded by the Local Authority. Where patients choose not to proceed with a checklist and potential eligibility assessment this should be documented and signed off by the patient and the Local Authority

informed if LA funded care is being provided. This can be reviewed by the patient at any time in the future and they can ask to be moved to a NHS CHC contracted care home at a later point in time and funded by the NHS from the point they move. Patients would be given personal contact details for the CSU clinical team and their CCG in case they wish to review.

2.6. WITH REGARD TO PATIENTS IN NON-CONTRACTED CARE SETTING WHO BECOME NEWLY ELIGIBLE FOR NHS CHC

The following process would be followed:

- The provider would be asked again if they wish to take up an NHS standard contract for the provision of care to patients eligible for NHS CHC.

If the provider declines then the following steps are followed:

- The patient is given a choice of homes in the area that provide NHS CHC under contract, from which to choose a new care setting. Once the patient has chosen their preferred option to move then the CSU NHS CHC team will facilitate this with communications to both the sending and receiving providers. If a chosen provider has no bed available then arrangements will need to be agreed to meet the costs of care while the patient is awaiting the move.

Note: It is a patient's right to be assessed for NHS Continuing Healthcare funding eligibility and, if eligible, they have a right to have their care funded by the NHS. However it is not compulsory to take up the assessment, funding and provision on offer if a patient chooses not to. From time to time patients do seek not to pursue NHS CHC as they may wish to continue in accommodation than the NHS is not able to afford or contract for. A small number of care homes have contracted for the provision of NHS CHC but will be able to apply to offer patients options for additional services to meet wishes (not health needs). This may be attractive to some patients looking to move from wholly non-contracted providers (see "Additional Services policy" which is currently in development).

If the patient declines to move when the provider has refused to accept an NHS Standard Contract, a CCG joint panel may be convened to discuss a way forward. This will ensure due process has been followed, offer a peer review opportunity, explore options available and inform future policy development. Each CCG will nominate a representative to attend. The panel will be advisory. Decisions will remain the responsibility of the funding CCG. Meetings will be held as required and formally documented.

There will be rare and exceptional cases where the NHS CHC clinical team may, as a result of a best interest meeting, propose that a patient needs to stay in a particular setting (e.g. terminal phase of end of life care or where alternative provision is unavailable). Such cases will be presented to the appropriate CCG for a decision accompanied with relevant risk assessments.

2.7. PATIENTS IN "OUT OF AREA" CARE HOMES

A number of patients are currently cared for close to family in other parts of the country but funded by Norfolk CCGs.

Occasionally, patients may be placed out of county where specific clinical needs cannot be met locally. CCGs are involved in decisions about out of area placements where the patient requires a specialist placement. These will be reviewed annually to ensure needs continue to be met appropriately.

Norfolk has historically offered this option in exceptional circumstances and these contracts have been inherited as long standing arrangements or agreed by CCGs as short term arrangements for terminal phase of end of life care and undertaken on a non-contracted activity (NCA) basis for the benefit of families.

It is proposed going forward that:

- These contracts be managed on a named patient basis as "non-contracted activity".

  Provider's ongoing CQC registration would be monitored annually as a minimum via the national CQC website. The CSU is not currently resourced to physically visit the majority of NHS CHC patients placed out of area. Whilst teams may notify the local CCG of the presence of a Norfolk patient, many receiving areas are not set up to do anything with this information. The home in that area will register the patient with the local GP practice, enabling them to access local NHS services.

- Where a care home out of area is put under special measures or is closing, the Local Authority will generally contact all residents within that home. They will also contact those agencies that are funding care to notify them of the situation and the plan of action. Moves to alternative provision are normally handled in discussions with families, patients and commissioners by the Local Authority where the care home exists.

Example: This occurred in a care home in Lincolnshire where a care home closed and the residents were relocated in discussions with the patient, family, NEL CSU and the relevant CCG. The patient moved to a care home not far from the original setting in Lincolnshire at the same cost envelope.

- A placement with an out of area provider would be made based on an extended Individual Case Arrangement (ICA) which requires the provider to:
  - Notify of any admission to hospital or death of the patient within 48 hours.
  - Notify commissioner of any safeguarding or results of best interest meeting with regard to our patient.
  - Notify commissioner of any complaints received from the patient and / or family and their response.
  - Invoice the correct CCG for the agreed amount monthly.

- Pricing would be at the local CCG rate for the area in which the care setting sits. This is historically and nationally what CCGs currently do. This enables each CCG area to maintain reasonable market stability even if it means that more is paid for placements in an area which has agreed higher than Norfolk weekly rates for NHS CHC patients or conversely the cost may be less if they have local rates than in Norfolk.

- Families would be encouraged to let the CCG/ CSU in Norfolk know of any concerns regarding care home quality or problems as soon as possible so that discussions can be held with local services and registration bodies/ CQC. Contact information for their local commissioners would be provided.

Note: This out of area definition will apply to Great Yarmouth Nursing homes and residential homes that do not hold a contract with North Norfolk CCG, South Norfolk CCG, Norwich CCG, or West Norfolk CCG.

3. ADDITIONAL SERVICES CONTRACTS BETWEEN CARE PROVIDERS AND PATIENTS (AND/OR THEIR REPRESENTATIVES)

3.1. INTRODUCTION

This section has been developed to ensure that CCGs have a consistent and transparent approach to patients who wish to purchase additional services (over and above their assessed needs under NHS Continuing Healthcare. This is also intended to safeguard patients against unforeseen additional costs.

Additional Services, in this section refers to services which a patient who eligible for NHS CHC may choose to purchase directly from a Provider. These optional additional services must be over and above those identified as required to meet their Continuing Healthcare assessed needs. For clarity, this is distinct from social care arrangements which allow “top-ups”.

The relevant CCG will only provide and fund those services that are identified in an individual’s Complex Case Review Panel (CCRP) approved care plan and for which it has statutory responsibility.

3.2. ARRANGEMENTS FOR PATIENTS CHOOSING TO PAY FOR ADDITIONAL SERVICES

Patients may wish to make separate arrangements for additional services (such as aromatherapy, private garden area, manicures, sole use facilities which represent ‘wants’ not ‘needs’). Current case law supports this concept as acceptable. These additional services should be arranged and contracted for separately from the NHS contracts for NHS CHC services.

Patients are advised to inform CCGs in the first instance when they request additional services from a Provider. This is required to ensure patients are not paying for services to meet an assessed need.

Admissions into NHS CHC-funded care for nursing care, residential care or domiciliary care packages with a Provider are not conditional on a patient or their family entering additional services contracts.

Patients who cease any previously agreed additional services payment or contract should not be required to move to another nursing or residential care home following cessation of their contract for additional services. This does not exclude movement within a nursing home or residential care home.

An example of this would be where a nursing or residential care home has a luxury wing with rooms which have sole use private garden at a higher price than the NHS contracted rate. Under this arrangement, the NHS will pay the appropriate contracted rate and the patient will take out an additional service contract directly with the Provider for the sole use garden area on the understanding that if they become unable to pay for their the additional services then they would be moved to the standard NHS level of room within the same home.

The CCG does not accept liability for any failure by patients or families to pay for additional services, or upon cessation (either by the patient or Provider) of the additional services contract.

Patients must be made aware of the arrangement and consequences of cessation of their additional services contract by the Provider from the outset. This should be communicated in a professional, timely and transparent manner.

The commissioners will make an appropriate referral (e.g. to Adult Safeguarding, CQC, counter-fraud) if a provider is found to be charging for additional services and either:

- the services are not in place
- the amount of the charges outweighs the additional services being provided
- fraud or abuse is suspected

3.3. INFORMATION FOR PATIENTS, FAMILIES AND CARERS

Information explaining additional services must be clearly written and shared with patients and carers by the Provider. Patients and/or their representatives are required to sign to confirm that they understand and accept their private contractual arrangements regarding additional services and the consequences of cancelling any additional services payment agreement between themselves and the provider.

Failure of the Provider to communicate the nature, content and terms of the contractual arrangement to patients and/or their representatives, will result in CCGs/CSU making an appropriate referral as above.

4. STANDARD DECISION MAKING FRAMEWORK AND GOVERNANCE ARRANGEMENTS FOR CCGS WHEN COMMISSIONING AND REVIEWING NHS CHC PACKAGES

This section has been developed to provide a common understanding of the CCGs' commitments with respect to the funding of packages of care to meet an NHS CHC eligible individual's assessed health and associated social care needs.

This section is intended to assist the CCGs standardise the quality and consistency of care, and make decisions about clinically-appropriate care provision for individuals in a consistent way.

CCGs have identified the need for a clearly articulated policy regarding the commissioning and review of NHS CHC care packages. The key aim is to inform robust and consistent commissioning decision making by the CCGs using a locally developed standardised decision-making framework. This section relates to a standardisation of decision making on care packages for patients who are eligible for NHS CHC across all CCGs. Standardising governance arrangements will support CCGs in their oversight and decision making with regard to funding of individual NHS CHC packages of care.

The following norms are established in respect of when a CCG Complex Case Review Panel (CCRP) will convene to review a care package and what services NHS CHC should and should not fund:

- A CCRP will ensure all domains are considered at the point where there is a more than 5% difference in the options for care being considered
- Agreement of standard list of services which CHC packages will fund, and those which they won't (standard list of services on page 14 of Appendix I).

The following are standard domains that CCG CCRP's will take into consideration when making decisions regarding individual packages of care for patients eligible for NHS CHC:

- Patients' needs and the outcomes they wish to obtain from their care
- Patient and family preferences and views
- The Human Rights Act and any other Disability Rights legislation (see Appendix J)
- Clinical and safeguarding risks and patients/ families views on these. (Patient view would apply where a patient fully understands risks in the choices they would like to make but still wishes to take those risks.)

- The price and affordability of the various options for the provision of care in light of the need to ensure equitable use of limited NHS resources.
- Due to geographical gaps in some care services, panels will have to take into account the availability of services and choices for patients as this is a limiting factor for many. Reviews of current provision are taking into account current gaps in services in order to support commissioners to fill these.

Decisions regarding the setting of personal health budgets will be treated in the same way.

All existing NHS CHC patients will go through a review process, either at 3 months post eligibility decision, or annually. At that point for any home care packages in excess of the 5% of the equivalent Care Home package, a CCG CCPR will be convened to review the package of care taking into account the domains set out above. The CCRPs will be cognisant of the 5% figure but also required to take all of the other factors set out above in agreeing a care package, and reflect any exceptionality in circumstances.

This approach will be clearer for patients and families, result in CCGs having a more consistent approach, allow CCGs flexibility to reflect the unique nature of care packages and individual needs and ensure CCGs treat all patients fairly and comply with the law.

5. EXCEPTIONAL CIRCUMSTANCES

In exceptional cases, the relevant CCG, having regard to the individual's assessed health and associated social care needs, may be prepared to consider funding a package of care where the anticipated cost to the CCG is more than it would usually expect to pay; or elements of the care package are not usually funded from NHS CHC budgets.

The Commissioner recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources. Exceptionality will be determined by the relevant CCG on a case by case basis. The grounds for and appropriateness of exceptionality will be determined by the merits of each case by the Commissioner.

Exceptionality may include (but it not limited to):

- the provision of a care package to an individual who has an advanced, progressive, incurable illness;
- those cases in which consideration must be given to address the particular cultural and/or communication needs of the individual;

- those cases in which consideration must be given to address the particular clinical and/or physiological needs of the patient and/or the risks associated with meeting their needs
- those cases in which an individual in an existing out of area placement becomes eligible for NHS Continuing Healthcare and wishes to continue to be accommodated out of area.

In addition the CCGs recognise that there will be cases in which, as a consequence of the nature of the needs of the individual in that particular case, it may be necessary to fund a higher cost package of care for a limited period of time (for example, in cases where a high/intense level of staffing needs to be put in place to set up the care package). In such cases the CCG may be prepared to consider funding the higher cost package of care for a limited period of time.

6. REVIEW OF THIS POLICY

NHS Norwich CCG, as the coordinating commissioner, owns this policy. The policy sections will be reviewed as set out below. However, each time a section is reviewed, the full document must be reviewed to ensure consistency.

Section 1: Contractual Arrangements and Patient Placement

This section is to be reviewed in the first instance, by the CCG joint panel in six months on the basis that all parties will have more experience of working with patients and providers to see if this policy is working. Out of area placement arrangements will be reviewed as part of a wider discussion between CCGs and CSU regarding all patients placed out of area and how we can better monitor at a distance or resource the travelling.

Section 2: Additional Services contracts between care providers and patients (or families) for patients in receipt of NHS Continuing Healthcare

REVIEW OF THIS SECTION WILL BE ANNUAL OR ON RECEIPT OF RELEVANT ADDITIONAL CASE LAW OR GUIDANCE.

Section 3: Standard Decision Making Framework and Governance Arrangements for CCGs when commissioning and reviewing NHS CHC packages

Review of this section will be within 6 months of January 2016. This will submitted to HOSC and CCGs' GB meetings.

7. APPENDICES

NOTE TO NHOSC:–
Appendices A-H in the list below have not been included with the report to NHOSC on 25 February 2016 but are available on request from the Head of Continuing Care NHS Norwich CCG.
Appendix I has been included as Appendix C to Appendix 3 of the report to NHOSC
Appendix J has been included as Appendix E to Appendix 3 of the report to NHOSC

Reference	Document title	
1. Contractual Arrangements and Patient Placement		
A	Flow Chart	
B	Contract Offer Letter 1	
C	Contract Offer Letter 2	
D	Checklist Waiver	
E	Assessment Waiver	
Section 2: Additional Services contracts between care providers and patients (or families) for patients in receipt of NHS Continuing Healthcare		
F	Mills and Reeve summary	
G	Contract Variation	
H	List of Additional Services	
Section 3: Standard Decision Making Framework and Governance Arrangements for CCGs when commissioning and reviewing CHC packages		
I	Central and West Norfolk Procedures for Staff on NHS CHC V10	
J	Guidance Sheet for Consideration of Human Rights in Complex Case Review Panel Decision Making	

DRAFT

Central and West Norfolk CCG Procedures for NHS Staff in relation to NHS Continuing Healthcare

Version: 10

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Co-authors: Sarah Taylor, West Norfolk CCG; Rachael Peacock, Norwich CCG; Mark Taylor, North Norfolk CCG; Anne Borrows, South Norfolk CCG; Rosa Juarez, central and West Norfolk CCGs; Ceri Jackson, NEL CSU; Paul Martin, NEL CSU

Date: 30/12/2015

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The source of the document will be found at this location –

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Date	Author	Summary of Changes	Changes marked
03/09/2015	Rosa Juarez, Continuing Care QIPP Project Manager	First draft	n/a
04/09/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Added AC's draft for sections 1.1, 2.3, 3.1, 3.3, 3.4, 3.8. General formatting changes.	
10/09/2015	Amanda Cousins and Rosa Juarez	Added 1.3, 1.4, 2.2, 3.5, 4.3, 5.2, and 5.3. Proof-reading of draft sections for grammar and formatting.	
12/10/2015	Amanda Cousins,		Version 2
29/10/2015	Rosa Juarez, Continuing Care QIPP Project Manager	General formatting and correction of typos.	Version 3
30/0/2015	Amanda Cousins	Addition of sections	Version 4
6/11/2015	Changes following meeting between Amanda Cousins and Ceri Jackson	Changes to the guide to what NHS pays for and some simpler headings	Version 5
25/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Following Amanda Cousins' update and discussion, this will form the basis of the procedures document for staff to mirror the guide for patients but include further detail (referral guidelines for external services, support and standard operating processes). Addition of latest table on services	Version 1

		funded by CHC/mainstream.	
26/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Renamed document and edited briefly for new audience in preparation for review by Sarah Taylor, Oliver Cruickshank, Rebecca Champion, Ceri Jackson, Paul Martin and Amanda Cousins on 27/11/2015	Version 2
02/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Review of document with Paul Martin, NEL CSU with regard to structure, formatting and appropriateness of content for NHS staff.	Version 3
03/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	General formatting, consistent use of acronyms and addition of hyperlinks.	Version 4
09/12/2015	Howard Stanley, Senior Nurse Adult Safeguarding (Prevent, Domestic Abuse and Mental Capacity Act) North Norfolk CCG (on behalf of Norfolk and Waveney CCG's)	Review of additional services section.	Version 5
10/12/2015	Ceri Jackson, Clinical Services manager (CSM) Adult CHC NEL Commissioning Support Unit	Review of whole document	Version 6
11/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Review of document by Mark Payne, Sarah Taylor, Paul Martin and Rachael Peacock	Version 7
14/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Addition of Ceri's sections as emailed. Addition of Howard Stanley's new section on Mental	Version 8

		Capacity Act, DoLs and safeguarding adults.	
16/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Review of document with Laura McCartney-Gray. Changes made to acronyms. Added complaints contact and appendices.	Version 9
30/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Changes to reflect most up to date table and wording on PHBs as per patient guide.	Version 10

Approvals

This document requires the following approvals.

Name	Signature	Title	Date	Version
Amanda Cousins		AD DITC, NEL CSU	30/12/2015	Version 20
Mark Taylor		SRO, North Norfolk CCG		

Contents

1. Introduction to NHS Continuing Healthcare

1.1. What is the purpose of this document?

The purpose of this Guide is to provide information for NHS staff about the provision of NHS Continuing Healthcare (NHS CHC) in Central and West Norfolk. This relates to NHS CHC for adults only.

Providing this information will help NHS staff understand the complexities of the national and local processes, as well as the limitations that might apply.

This document is organised in the form of frequently asked questions. It is designed so that you can print off specific sections that you may be interested in.

This information will be kept up to date so that staff will be more informed and have the opportunity to gain a better understanding of the procedures and processes that apply. This Guide will also provide links to other more detailed guidance for those who wish to access it.

1.2. What is NHS CHC?

NHS continuing healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over to meet needs that have arisen as a result of disability, accident or illness.

NHS CHC can be provided in a range of settings; from care in your own home, nursing homes, supported living, group home arrangements or in specialist care units. Care arrangements for NHS CHC are managed via the NHS CHC Brokerage Team or through a Personal Health Budget, subject to formal approval by CCGs.

Prior to considering referral into the NHS CHC pathway, NHS staff are advised to consider all other mainstream service options that may be appropriate for patients. These may include, but are not limited to:

- Local authority Social Services
- Volunteer organisations
- Assistive technology

The Department of Health has produced a public information leaflet on NHS Continuing Healthcare and NHS-funded Nursing Care:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193700/NHS_CHC_Public_Information_Leaflet_Final.pdf

1.3. What frameworks govern NHS Continuing Healthcare and NHS-Funded Nursing Care?

The two key documents that NHS staff should have a relevant understanding of in relation to NHS Continuing Healthcare for adults are:

- The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf*

- *NHS England Operating Model* for NHS Continuing Healthcare: https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf

The Association of Directors of Adult Social Services (ADASS) has produced three documents to support health professionals to understand the principles and implementation of the National Framework for NHS CHC.

1. Guide for Health and Social Care practitioners:

https://www.england.nhs.uk/wp-content/uploads/2015/04/guide-hlth-socl-care-practnrs.pdf

2. Explaining the NHS Continuing Healthcare process:

https://www.england.nhs.uk/wp-content/uploads/2015/04/chc-process-publc-guid-practnr.pdf

3. Quick Reference Guide to the National Framework:

https://www.england.nhs.uk/wp-content/uploads/2015/04/qck-ref-guid-chc-nat-framwrk.pdf

1.4. What do NHS Staff need to be aware of in relation to NHS CHC?

1.4.1. The Harwood Care and Support Charter

The Charter sets out principles for how care providers should work to ensure people are at the centre of their care. Being a Charter signatory demonstrates to people using services that an organisation or individual is committed to ensuring people who receive care and support services in Norfolk have the high quality services that they want.

The Harwood Care and Support Charter was produced with input from people who receive care and support services, carers and representatives from organisations providing care and support in Norfolk.

Signatories to the Charter are committed to:

- listening to people and responding to their needs;
- treating people with respect, dignity and courtesy;
- making sure people are not left unsupported;
- telling people how much services cost and how to access financial assistance;
- making sure staff are properly trained and Police checked;
- reporting back to commissioners where things work well or could be developed to better meet needs.

1.4.2. NMC Code of Conduct

The Code presents the professional standards that nurses and midwives must uphold in order to be registered to practise in the UK.

Effective from 31 March 2015, this Code reflects the world in which we live and work today, and changing roles and expectations of nurses and midwives. It is structured around four themes – prioritise people, practise effectively, preserve safety and promote professionalism and trust. Developed in collaboration with many who care about good nursing and midwifery, the Code can be used by nurses and midwives as a way of reinforcing their professionalism. Failure to comply with the Code may bring their fitness to practise into question.

Further information available at: http://www.nmc.org.uk/standards/code/

1.4.3. Safeguarding Adults

Safeguarding is preventing the physical, emotional, sexual, psychological and financial abuse of adults who have care and support needs, and acting quickly when abuse is suspected. It can also include neglect, domestic violence, modern slavery, organisational or discriminatory abuse. Norfolk County Council Adult Social Services is the lead agency for Safeguarding Adults.

Within Norfolk, all referrals should be made to 0344 800 8020, which is a 24 hour number.

If the patient is receiving care outside of Norfolk, then a Safeguarding referral can be by contacting the County Council for that area.

It is the professional responsibility of all those involved in co-ordinating and providing an individual's care, to play an active part in safeguarding them from harm or abuse.

1.4.4. Capacity Assessments under the Mental Health Act

The patient's mental capacity must be established at key points in the NHS CHC process, taking in to account that capacity is both time and decision specific. As such, capacity should be considered when seeking consent to undertake relevant stages of the assessment, including capacity to refuse or deny access to records held by other agencies. Additionally, a patient may not have capacity to make decisions with regard to how their care needs can be met,

The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. The initial assumption will be that adults have capacity to make all or some decisions, unless it is shown that they cannot. The MCA clarifies the rights and duties of the workers and carers, including how to act and make decisions on behalf of adults who may lack mental capacity.

Where the health professional involved in facilitating the NHS CHC assessment or arranging the package of care suspects the individual may not have the Mental Capacity to accept, refuse or choose amongst options, it is their responsibility to undertake a mental capacity assessment, in accordance with the Mental Capacity Act 2005 and the National Framework for NHS CHC.

Where a patient lacking capacity has no family or friends to support the decision making process, a suitable person from the Independent Mental Capacity Advocate (IMCA) service or a suitable person from other local advocacy services, should support when:

- A decision is being made about serious medical treatment, or a long term change in accommodation
- The patient lacks capacity to make that decision
- The patient does not have friends or family with whom the decision maker feels is appropriate to consult with about the decision.

In a situation where the patient lacks capacity to make a decision, it is the responsibility of the health professional to make and document a best interest's decision. This should consider all of the options that would be available to the patient if they had capacity and should take in to account the views of those advocating on the patient's behalf, along with others involved in the delivery and planning of their care. In some situations where the decision is significant or challenged, it may be appropriate to undertake this within a best interests meeting.

1.5. Deprivation of Liberty

In some cases, a best interests decision may be made to provide a package of care that restricts the patient's freedom to come and go unsupervised (continuous supervision) or where physical barriers are in place to prevent them leaving their care setting (locked doors/bed rails). Where this restriction arises it could be considered to be a Deprivation of Liberty and as such, will require authorisation

through the relevant routes. When a patient's needs are met in a CQC registered domicile (Hospital, Nursing Home, Residential Home) it is the responsibility of the provider to make DoLS applications via the local authority. However, in cases where a patient is being deprived of their liberty in a non-CQC registered domicile (supported living/own home), it is the responsibility of those arranging the care to make application to the Court of Protection.

1.6. How is eligibility for NHS CHC established and reviewed?

The initial checklist assessment can be completed by a nurse, doctor, other healthcare professional or social worker. Patients should be told that they are being assessed and have their informed consent obtained.

Depending on the outcome of the checklist, patients will be told that they don't meet the criteria for a full assessment of NHS Continuing Healthcare and are therefore not eligible for a full assessment, or will be referred for a full assessment of eligibility. Being referred for a full assessment doesn't necessarily mean that a patient will be eligible for NHS Continuing Healthcare. The purpose of the checklist is to enable anyone who might be eligible to have the opportunity for a full assessment.

The professional(s) completing the checklist should record written reasons for their decision, and sign and date the checklist. Patients should be given a copy of the completed checklist. You can download a blank copy of the NHS continuing healthcare checklist from GOV.UK (PDF, 168kb).

Full assessments for NHS continuing healthcare are undertaken by a "multi-disciplinary" team (MDT) made up of a minimum of two health or care professionals who are already involved in a patient's care. Patients should be informed about who is coordinating the NHS CHC assessment.

The team's assessment will consider patients' needs under the following headings:

- behaviour
- cognition (understanding)
- communication
- psychological/emotional needs
- mobility
- nutrition (food and drink)
- continence
- skin (including wounds and ulcers)
- breathing
- symptom control through drug therapies and medication

- altered states of consciousness
- other significant needs

These needs are then given a weighting marked "priority", "severe", "high", "moderate", "low" or "no needs".

The multi-disciplinary team will consider:

- what help is needed
- how complex these needs are
- how intense or severe these needs can be
- how unpredictable they are, including any risks to the person's health if the right care isn't provided at the right time

If the patient has at least one priority need, or severe needs in at least two areas, they should be eligible for NHS Continuing Healthcare. Patients may also be eligible if they have a severe need in one area plus a number of other needs, or a number of high or moderate needs, depending on their nature, intensity, complexity or unpredictability.

In all cases, the overall need, and interactions between needs, will be taken into account, together with evidence from risk assessments, in deciding whether NHS CHC should be provided.

The assessment should take into account the patient's views and the views of their carers. Patients should be sent a copy of the decision documents, along with clear reasons for the decision.

You can download a blank copy of the NHS continuing healthcare decision support tool from GOV.UK.

Eligibility will be reviewed at 3 and 12 months following establishment of eligibility for NHS CHC, as a minimum. These reviews ensure that the care package remains relevant to the patient and meets their assessed needs. There is a possibility that patients will be found ineligible.

Potential outcomes following ineligibility for NHS CHC may include eligibility for NHS-funded Nursing Care being established, which could make a contribution towards meeting a health need in a residential care setting. If patients are found ineligible for either NHS CHC or NHS-funded Nursing Care, they will be referred to the local authority.

Patients who wish to appeal the decision should contact the Appeals Department at the contact details outlined in "How can patients appeal the eligibility decision?".

1.7. Is there an NHS CHC pathway for patients with 'a rapidly deteriorating condition which may be entering a terminal phase'?

In these circumstances an 'appropriate clinician' may complete a Fast Track Pathway Tool. Once completed, the documentation will be sent to the NHS CHC Clinical Team for immediate review and action if eligible. This will include the clinical information required to arrange the appropriate placement/package of support as soon as possible (usually within 48 hours).

1.8. How are NHS staff involved in the decision-making process for patient care?

NHS Staff will be involved through requests for input into the MDT process. This could be in the form of attendance to the MDT meeting or submission of a report. NHS Staff should only be involved in a patient's MDT if they are knowledgeable about the patient or have undertaken an assessment of that patient's needs. NHS Staff should also have undertaken relevant and appropriate training on NHS CHC.

The decision will be based on factual, contemporaneous information (i.e. up to date and within 3 months) and recorded within the DST.

1.9. How will the decision about eligibility be made and communicated to patients and relevant NHS staff?

The recommendation for eligibility or ineligibility will be made by the MDT and communicated verbally at the time the DST is completed. An MDT should not leave a meeting with a patient without informing them of what the recommendation is. Following the conclusion of the MDT, the recommendation is submitted for ratification (agreement or approval) to the relevant CCG.

Following ratification of a decision for eligibility or ineligibility, the patient will receive a letter informing them of the decision and a copy of the DST. This letter should include details of what happens next for patients and their families; it also provides contact details. If a patient is found to be ineligible for NHS CHC, this will be communicated formally to the local authority.

1.10. What does the NHS CHC funding cover?

Patients who are eligible for NHS CHC have complex needs that can be met from a wide variety of services (NHS, local authority and Voluntary Sector). The following

table outlines a list of services and describes whether they are available from NHS mainstream services or NHS CHC budgets.

In order to ensure equity of provision and fair use of resources, careful consideration has been given to what can be included within a package of care for a patient who is eligible for NHS CHC.

The following table is a guide to what can be funded by NHS CHC and what can be provided from mainstream NHS services. Please note: for a Personal Health Budget, the table below will be used to calculate the value of that PHB. Once the value has been established, the individual will have choice and control over choosing services to meet their health need, subject to agreement with the CCG and ensuring existing services are fully utilised. This is clarified further in section 2.5.

Service	Is this service available within mainstream NHS provision?	Is this service available within an NHS CHC budget?	Referral Guidance
Domiciliary care	No	Yes. Available from locally contracted providers.	Contact NHS CHC Brokerage Team.
Planned care to replace informal care provision	No	Yes – if identified following care review	Referrals can be made to local authority for a carers assessment. Referrals can also be made to NHS CHC Brokerage Team for care review if circumstances change.
Additional unplanned care to replace informal care provision	Yes – short term urgent support is available via Local Authority.	No – except in exceptional circumstances.	Referrals can be made to local authority
Carer advice and befriending services	No	No	Referrals can be made to local authority and information is available on the Norfolk County Council website. The Carers Agency Partnership has a helpline and website.

Physiotherapy	Yes	No – except in exceptional circumstances.	In exceptional circumstances CHC funding may be used to train a family or paid carer to undertake certain activities such as passive movements and exercises to help to maintain function and relieve pain.
Occupational Therapy	Yes	No	Referrals should be made to mainstream OT services.
Speech and Language Therapy	Yes	No	Referrals should be made to mainstream SALT and Dysphagia Services.
Podiatry	Yes	No	Referrals should be made to mainstream podiatry services.
Advocacy	Yes	No	Refer to mainstream Advocacy services.
Transport	Yes, but only to and from medical or clinical appointments if a person meets the eligibility criteria for the transport.	No – except in exceptional circumstances.	If family are unable to support, referrals should be made to NHS mainstream transport services, local authority transport services, DWP, voluntary and community sector. NHS CHC cannot be used to purchase vehicles.
Assistive technology - smart house technology and safety equipment	Yes	No	Referrals to Norfolk Community Health and Care or local authority Social Services.
Standard Equipment (including pressure care)	Yes	No	Referrals to Integrated Community Equipment Services (ICES).
Bespoke equipment (including pressure care)	No	Yes	Referrals to NHS CHC Brokerage Team.
Respiratory support equipment (e.g. ventilators)	No	Yes	Referrals to NHS CHC Brokerage Team.

Wheelchairs and seating systems including electric and outdoor chairs	Yes	No	Referrals to Wheelchair Service.
Equipment for leisure and social activities (e.g. swimming gear or horse riding boots).	No	No	Patients will self-fund or pay for rental of equipment.
Day services	No	Yes	Referral to local authority Social Services.
Computers, laptops, Wi-Fi and Broadband	No	No – except exceptional circumstances	Referral to NHS CHC Brokerage Team. If considered, rental from third party only.
Major adaptions to housing and environment	No	No	Referral to local authority District Councils.
Specialist foods and fluids	Yes - if provided on prescription.	No	Referral to GP.
Hearing and low vision services	Yes	No	Referrals can be made to specialist services.
Gardening, domestic and window cleaning	No	No	Referrals to local voluntary organisations.
Path clearance to aid access	No	No - except in exceptional circumstances	Referrals to NHS CHC Brokerage Team.
Falls assessments	Yes	No	Referral to mainstream services.
Palliative care and end of life services	Yes	Yes	Referral to NHC CHC Brokerage Team.
Continence services	Yes	No	Referral to mainstream services.

1.11. What are the arrangements for patients choosing to pay for additional services?

NHS CHC funding is only available to cover the care required to meet a patient's assessed needs.

Patients may wish to make separate arrangements for additional services directly with the provider (such as aromatherapy, private garden area, manicures, sole use facilities which represent 'wants' not 'needs') and current case law supports this concept as acceptable. These additional services should be arranged and contracted for separately from the NHS contracts for NHS CHC services.

Admissions into NHS CHC-funded care for nursing care, residential care or domiciliary care packages with a Provider are not conditional on a patient or their family entering additional services contracts.

Where patients are considering entering into arrangements for additional services, it is advisable that they contact the NHS CHC Brokerage Team for advice (e.g. a nursing home may request a financial contribution for laundry costs which should be included within the NHS CHC care package).

2. Planning and Commissioning of NHS CHC

2.1. How is a patient's care planned once they are assessed as eligible for NHS CHC?

Once a patient's eligibility for NHS CHC is established, a care package to meet each individual patient's needs has be agreed. The planning of the patient's care will be based on the documentation received from the MDT professionals. An Individual Case Arrangement (ICA) form will be used to identify the patient's needs, list and mitigate risks and detail care delivery.

The NHS CHC Brokerage Team is responsible for coordinating the planning of a patient's care. They will engage with the patient, their family and/or representatives as well as health professionals in considering the options for the provision of services to meet a patient's assessed needs. The focus of the planning is to secure improved outcomes for the individual.

The NHS CHC Clinical NHS CHC team can provide information on:

- Lists of care providers with NHS CHC contracts
- Nursing home information with regard to CQC compliance
- Day services
- Local voluntary schemes and support in local communities
- Equipment and NHS wheelchairs

If patients are currently in receipt of local authority funded care and become eligible for NHS CHC, the NHS CHC team will do their best to facilitate continuity of care. There may be issues which make this difficult (e.g. the service provider may not be willing to sign an NHS contract). If this happens the NHS CHC team will work with the patient to seek alternative services to meet their individual needs.

2.2. How are decisions about the funding of patients' care packages made?

Once the NHS CHC Brokerage Team have recommended a package of care to meet a patient's assessed needs, and an ICA form has been completed, this will be presented to the relevant CCG's Complex Case Review Panel (CCRP). The CCRP meets on a regular basis to approve the care to be offered under NHS CHC to meet each individual patient's needs.

Some norms have been established in respect of when a CCG Complex Case Review Panel (CCRP) will convene to review a care package and what services NHS CHC should and shouldn't fund. Specifically:

- A CCRP will ensure all domains are considered at the point where there is a more than 5% difference in the options for care being considered
- Secondly a standard list of services which NHS CHC packages will fund, and those which they won't.

CCRPs will take the following domains into consideration when making these decisions:

- Patients' needs and the outcomes which they wish to achieve from their care
- Patient and family preferences and views on the choices available
- The Human Rights Act and any other Disability Rights legislation
- Clinical and safeguarding risks and patients'/families views on these (Patient view would apply where a patient fully understands the risks in the choices they would like to make but still wish to take those risks).
- The price and affordability of the various options for the provision of care in light of the need to ensure equitable use of limited NHS resources.
- Panels will have to take into account the availability of services and choices for patients as this is a limiting factor for many. Reviews of current provision are taking into account current gaps in services CCGs are looking to try to fill.

The following evidence base will be compiled by NHS CHC Clinicians to aid CCRP members in considering the domains listed above:

- Care plans
- Risk assessments
- Assessments tools (e.g. Waterlow Score, MUST, falls risk, behaviour charts)
- Brokerage form
- CCRP form
- Individual Case Arrangement

CCRPs will be focused on patient care. Both CCRP members and NHS CHC staff will be knowledgeable of the following:

- Human Rights Act 1998
- Disability Rights legislation
- Equality Act 2010

- The UN Convention on disability rights
- The Harwood Care and Support Charter
- Part A “I” statements from the NHS England Operating Model for NHS Continuing Healthcare

Please see the appendix for the links to each of these.

2.3. Are there any limiting factors with regard to patient’s care packages?

The NHS CHC Brokerage Team can only arrange NHS CHC care packages with Providers who have signed up to NHS Standard Contracts and who have available capacity. Despite this, there may be occasions when the NHS CHC team are unable to arrange care packages with these providers. This may be due to:

- Concerns regarding the quality of care
- Safeguarding concerns
- The provider is unable to safely deliver the care required to meet the patient’s needs
- The provider does not have capacity or coverage in the area
- Financial dispute

2.4. What is a personal health budget?

A personal health budget is a monetary allocation to an individual patient to support their identified health and wellbeing needs. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

Personal health budgets work in a similar way to the social services-funded personal budgets that many people are already using to manage and pay for their social care.

Together with the NHS CHC Clinical team, patients or their representatives will develop a care plan that sets out their personal health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how they are going to spend it. Personal health budgets can be used to pay for a wide range of items and services, including day services, personal care and equipment.

2.5. What can a patient spend their PHB on?

- There is no “set menu” of services a PHB can be spent on, as each person is unique.
- However, each PHB-holder will need to ensure they have used their PHB to meet the identified care needs of the CHC-eligible person. This means if a person was identified as needing a certain number of hours a day for care, it would be expected the PHB would be used to meet that care.

- PHBs do encourage innovation and choice, and this could include using the PHB for services and activities. If this is the case, the PHB-holder will need to explain the benefit to the person's health, and this will need to be agreed by the relevant CCG.
- A PHB may not be used for equipment without first checking with the relevant OT and with the Integrated Community Equipment Service, as this is something which has already been funded.
- A PHB may be used for transport to activities, provided the PHB-holder can demonstrate the benefit to the health of the person. PHBs will not be used to cover the maintenance / insurance of a vehicle. It is suggested any transport costs are allocated a sum of money which will then be reviewed.
- PHBs cannot be used for the daily cost of living – this includes food, utility bills (unless in exceptional circumstances e.g. live-in carers), and cleaning / gardening services
- PHBs should be used to provide full insurance cover, costs of being an employer (including pensions) and support as needed.

2.6. Is there a process for out of area placements?

CCGs will consider individual requests for commissioning care outside of area as part of the CCRP decision making process outlined in 2.2. In exceptional circumstances such as for end of life care, CCGs can consider placements out-of-area. However, CCGs cannot fund care outside of the UK.

If patients move to another county, their responsible CCG will remain the same. Reviews of eligibility are arranged by the NHS CHC teams with the relevant CCG.

2.7. Can family members continue to provide care as part of a patient's NHS CHC care package?

Families and friends who are actively involved in the provision of care are very much part of the care planning and delivery. Care plans start with the care that the family are able and willing to provide.

Training and equipment can be provided to support carers in the safe provision of care.

If families are providing elements of care, they need to agree the care plan, approve it and be clear about who to notify if they are suddenly unable to provide it.

3. Reviewing care and eligibility for NHS CHC funding

3.1. What happens if the patient's needs change?

Should family members, carers or other health professionals believe the care package is no longer relevant to the patient or does not meet their assessed needs, they should contact the NHS CHC Team and request a review of the package of care as soon as possible.

3.2. What happens if upon review, the patient is found to be ineligible for NHS CHC funding?

The process for reviewing a patient's care is in line with the National Framework; all patients who are eligible for NHS CHC are reviewed, as a minimum, three months following initial eligibility and thereafter at least annually. The process for defining ineligibility is exactly the same as the process for agreeing eligibility (as outlined in 1.5).

If a patient is found to be ineligible for NHS CHC there are four possible outcomes:

3.2.1. Care and support no longer required

If a patient is found to be ineligible for NHS CHC, funding for care will cease 28 days following the date of ineligibility.

3.2.2. Care and support is required and patients self-funds

If the local authority decide that the patient will transfer to self-funding for their ongoing care, responsibility for meeting these costs will be transferred within 28 days following the date of ineligibility. Patients or named individuals with power of attorney will be notified of this in writing and given a contact point for any individual queries.

3.2.3. Care and support is required and patient is eligible for NHS-funded Nursing Care

For patients who still have a health need, they may be eligible for NHS-funded nursing care. This provides a nationally agreed contribution to the funding of care needs and is paid directly to the nursing home. NHS-funded nursing care is administrated by the local authority. For enquires about NHS-Funded Nursing care please use contact details below:

NHS Funded Nursing Care

Room 614

Sixth Floor

County Hall

Martineau Lane

Norwich

NR1 2SQ

3.2.4. Care and support is required and patient is eligible for local authority funding

For patients transferring to social services support, the assessment of a patient's ongoing needs will be completed by the local authority within 28 days. For enquiries contact:

Adult Community Care- Norfolk County Council

Norfolk Care First

Tel: 0344 800 8020

3.2.5. How can patients appeal the eligibility decision?

Regardless of the possible outcome, patients who wish to appeal the decision should contact the Appeals Department at the contact details shown below.

If patients wish to lodge an appeal they will need to submit their reasons for disagreeing with the decision. This should contain new or previously unseen evidence. An appeal must be lodged within 6 months of notification of the eligibility decision, in line with the National Framework.

If a member of NHS Staff is supporting a patient through the appeals process, they should refer the patient to the "Central and West Norfolk CCGs Guide to NHS Adult Continuing Healthcare", which contains a detailed description of the process.

Appeals Department

NEL CSU

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

4. Providing feedback and getting in touch

4.1. How can NHS Staff provide feedback on their experience of services and help to improve them?

If staff want to tell us about NHS CHC services which have not met their expectations, they can contact the NHS CHC Team via the Single Point of Access e-mail:

ANGLIACSU.CHCClinicalTeam@nhs.net

Staff are also able to:

- Escalate via line manager
- Escalate to Safeguarding
- Escalate to the patient's CCG
- Escalate to NHS England

4.2. How do patients complain if they are not happy with their care or experience of the NHS CHC pathway?

Patients can contact the NEL CSU Complaints Team directly via:

nelcsu.angliacomplaints@nhs.net

The CSU Complaints Team will log the complaint and send a letter acknowledging its receipt within 2 working days. An investigation will then take place and on (or before) working day 25, the person will be sent a letter detailing the outcome.

NHS Staff may be contacted for input during the investigation to ensure that the Investigation Officer has a full picture of the complaint.

4.3. What should NHS Staff do if they have further questions?

E-Learning for NHS CHC

NHS England, in conjunction with the Association of Directors of Adult Social Services (ADASS) have launched an electronic training tool for all those involved in assessment and decision making around NHS CHC.

The tool, fully endorsed by the Department of Health, was developed by staff working within this complex policy area from the NHS, Adult Social Care and patient representative groups.

The tool is free to use and is designed to be intuitive and flexible so that health and social care staff can easily register and undertake training at a time and place that suits them. The tool will support local training programmes and support the work undertaken by all CCGs to ensure that there is consistency and legal compliance in the assessment and decision making processes for NHS Continuing Healthcare.

For NHS Staff, the E-Learning tool is available at:

http://www.e-lfh.org.uk/projects/nhscontinuinghealthcare/

For Local Authority Staff, the E-Learning tool is available at:

http://nhscontinuinghealthcare.e-lfh.org.uk

For enquiries about NHS Continuing Healthcare please contact:

Continuing Healthcare Department

NELCSU

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

Email: ANGLIACSU.CHCClinicalTeam@nhs.net

Tel: 01603 257 243

For enquiries regarding Retrospective Claims please contact:

Retrospective Continuing Healthcare Department

NELCSU

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

Email: ANGLIACSU.RetrospectiveClaims@nhs.net

Tel: 01603 257 284

Appendix	Document title	Document source
1	NHS CHC Information Sheet	
2	The Human Rights Act 1998	http://www.legislation.gov.uk/ukpga/1998/42/contents
3	Further information on Disability Rights	https://www.gov.uk/rights-disabled-person/overview
4	Equality Act 2010	http://www.legislation.gov.uk/ukpga/2010/15/contents
5	The UN Convention on disability rights	http://www.un.org/disabilities/convention/conventionfull.shtml
6	The Harwood Care and Support Charter	http://www.norfolk.gov.uk/view/NCC117232
7	Part A - “I” statements from the NHS England Operating Model for NHS Continuing Healthcare	https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf

Appeals

What to submit if you want to Appeal:

If you wish to lodge an appeal you will need to be able to submit your reasons why you do not agree with the not eligible decision, with any new or previously unseen evidence to support your statement. An appeal must be lodged *within 6 months* of notification of the eligibility decision, in line with the National Framework.

The Appeals process:

To begin the process you should write to:
CHC Quality Assurance Manager
Lakeside 400
Old Chapel Way
Broadland Business Park,
Norwich
NR7 0WG

On receipt of your appeal, you will be sent a copy of the full assessment documents for your information and you will be asked to submit your rationale along with your evidence to be returned *within 28 days**.

Your rationale will be forwarded to the Multi Disciplinary Team (MDT) members who carried out the MDT meeting requesting their feedback. You will be sent a copy of their responses to your rationale. The Lead Appeals and Retrospective Assessor will then carry out a peer review on the assessment and the assessment process and produce a report of their findings, a copy of which will be forwarded to you.

If, on receipt of the peer review, you disagree with the findings, you will be offered to attend a meeting with the Peer Reviewer as part of our local resolution process. If, you are still dissatisfied, you have the option of requesting that your case is heard by the Independent Review Panel (IRP) details of which will be sent to you at this time.

We aim to complete the appeal process within *3 months** of receipt of an appeal.

**in some situations there may be good evidence for extending this timeframe.*

NEL CSU Anglia Contacts

Continuing Healthcare Department
Continuing Healthcare
Lakeside 400
Old Chapel Way
Broadland Business Park
Thorpe St Andrew
Norwich
NR7 0WG
Email: ANGLIACSU.CHCClinicalTeam@nhs.net
Tel: 01603 257 243

Retrospective Continuing Healthcare Department
Retrospective Continuing Healthcare
Lakeside 400
Old Chapel Way
Broadland Business Park
Thorpe St Andrew
Norwich
NR7 0WG
Email: ANGLIACSU.RetrospectiveClaims@nhs.net
Tel: 01603 257 284

Appeals Department
Appeals Department
Lakeside 400
Old Chapel Way
Broadland Business Park
Thorpe St Andrew
Norwich
NR7 0WG

Adult Community Care- Norfolk County Council
Norfolk Care First
Tel: 0344 800 8020

NHS Funded Nursing Care
NHS Funded Nursing Care
Room 614
Sixth Floor
County Hall
Martineau Lane
Norwich
NR1 2SQ
Tel: 01603 224 127

Continuing Healthcare

This factsheet explains what NHS Continuing Healthcare (CHC) is, the process for deciding whether you are eligible to receive funding and what to do if you would like to challenge a not eligible decision. It also explains what NHS Funded Nursing Care (FNC) is.

This factsheet also explains what a Retrospective Claim for previously paid care fees is, how a Retrospective Claim is taken forward, and what to do if you would like to Appeal an eligibility decision. We will also provide you with the correct contact details should you need to get in touch with us.

NEL Commissioning Support Unit

NHS Continuing Healthcare

What is NHS Continuing Healthcare?

NHS Continuing Healthcare is the name given to a package of care which is arranged and funded solely by the NHS for individuals, over the age of 18, outside of hospital who have on-going health care needs which constitutes a Primary Health Need.

What happens if I'm found eligible?

If you are entitled to NHS Continuing Healthcare, the Clinical Commissioning Group will discuss options with you as to how your care and support needs will best be provided for and managed and your preferred setting in which to do that (e.g. at home or in a care home) and which organisation/s will be responsible for meeting your needs. When deciding on how your needs are met, your wishes and expectations of how and where the care is delivered should be documented and taken into account, however we cannot guarantee that these will be able to be accommodated.

What happens if I'm found not eligible?

If you disagree with a decision not to proceed to full assessment of eligibility for NHS Continuing Healthcare, you can ask the Clinical Commissioning Group to reconsider the decision. This should be done in writing, and the rationale for appealing the decision should be given. This should then be submitted within 6 months, in accordance with the National Framework. You should include any areas of the Checklist or Decision Support Tool that you disagree with, or any processes which you feel may not have been completed satisfactorily.

NHS Funded Nursing Care

What is NHS Funded Nursing Care?

By Law, local authorities cannot provide registered nursing care. For individuals in care homes with nursing needs, registered nurses are usually employed by the care home itself and, in order to fund this nursing care, the NHS makes a payment direct to the care home. This is called NHS Funded Nursing Care and is a standard rate contribution towards the cost of providing registered nursing care for those individuals who are eligible. Registered nursing care can involve many different aspects of care. It can include direct nursing tasks as well as the planning, supervision and monitoring of nursing and healthcare tasks meet your needs.

Who is eligible for NHS Funded Nursing Care?

You should receive NHS Funded Nursing Care if:

- You are resident within a care home that is registered to provide nursing care; and
- You do not qualify for NHS Continuing Healthcare but have been assessed as requiring the services of a registered nurse.

In all cases individuals should be considered for eligibility for NHC Continuing Healthcare before a decision is reached about the need for NHS Funded Nursing Care. Consequently most individuals will not need to have a separate assessment for NHS Funded Nursing Care if they have already had a full multidisciplinary assessment for NHS Continuing Healthcare as this process will give sufficient information to judge the need for NHS Funded Nursing Care. However if you are not happy with the decision regarding NHS Funded Nursing Care, you can ask the CCG for the decision to be reviewed.

If you are eligible for NHS Funded Nursing Care the NHS will arrange for the payment to be made directly to the care home and this payment should be reflected in the care home fee actually charged to you. This is applicable when the individual is funding their own placement.

NEL Commissioning Support Unit

What is a Retrospective Claim?

In some cases, people have paid for their own care, when they would have been entitled to help from the NHS to meet these costs.

In March 2012 the Department of Health announced a new process for identifying people who should have had help from the NHS. Anyone who had been having care between April 2004 and March 2012 and had not been previously assessed for Continuing Healthcare could apply for their needs during that period to be looked at retrospectively. The final deadline for these applications was 31st March 2013.

Retrospective Claims

How will my Retrospective Claim be handled?

Retrospective claims go through an almost identical process as other Continuing Healthcare claims. An initial review of the facts of the case will be completed using the documentation that you will be asked to provide when registering your claim. If there has been no evidence of maladministration, the retrospective team will be in contact to explain why they will not be taking the case forward.

If following the initial review, evidence of maladministration is found, the retrospective team will request a variety of records from a number of different sources, including care homes, hospitals or social services, in order to enable a checklist to be completed. As with a current Continuing Healthcare assessment, the checklist will indicate either referral for a full Decision Support Tool, or the case will be screened out as not eligible.

If the retrospective checklist indicates that a full Decision Support Tool should be completed, further records may be required in order to complete the Decision Support Tool robustly. The nurse assessor will contact you for any additional comments which you feel may be relevant for them to complete the Decision Support Tool. The nurse will then complete the Decision Support Tool using the contemporaneous evidence that has been compiled, and will reach a decision on retrospective eligibility.

Central and West Norfolk Guide to NHS Adult Continuing Healthcare for patients and their carers

Version: 20 (Final)

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6/11/2015	Changes following meeting between Amanda Cousins and Ceri Jackson	Changes to the guide to what NHS pays for and some simpler headings	Version 5
09/11/2015	Changes made by Group reviewing document.	Plain English, clarifications.	Version 6
11/11/2015	Changes made by Peter Whitney	Went through the PHB sections (3.6) and have amended the text to reflect what happens in Norfolk. What was originally on there was the text from NHS Choices, so I have updated it.	Version 7

26/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Addition of draft glossary of terms, appendices and links to national guidance. General re-wording to clarify just for patients/carers/families (i.e. not staff).	Version 8
30/11/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Refinement of glossary of terms	Version 9
03/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Changes made with Max Bennett	Version 10
07/12/2015	Max Bennett, Communications NEL CSU	Changes made with Max Bennett	Version 11
09/12/2015	Howard Stanley, Senior Nurse Adult Safeguarding (Prevent, Domestic Abuse and Mental Capacity Act) North Norfolk CCG (on behalf of Norfolk and Waveney CCG's)	Changes to additional services section.	Version 12
10/12/2015	Max Bennett, Communications NEL CSU	Number of changes to entire document.	Version 13
14/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Change to additional services section in line with discussions with Mark Payne, Sarah Taylor, Rachael Peacock and Paul Martin on 11/12/2015. Additions on safeguarding adults from Howard Stanley	Version 14
15/12/2015	Tim Curtis, Communications, Norwich CCG	Making language / paragraphs simpler. Removing as far as possible references to CCGs and NEL CSU because a) this is all rather confusing and b) for longevity.	Version 15
16/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Review of document with Laura McCartney-Gray,	Version 16

		Engagement Manager, Norwich CCG. Addition of all contact details, complaints contact and appendices.	
18/12/2015	Rosa Juarez, Continuing Care QIPP Project Manager	Added list of organisations engaged with as an appendix. Added more definitions to glossary as per meeting with Laura McCartney-Gray. Added exceptionality paragraph at the end of section 1.8	Version 17
22/12/2015	Anne Borrows and Mark Payne, SNCCG and NNCCG	1.9 Respite revision	Version 18
23/12/2015	Peter Witney, PHB Team Manager NHS NEL CSU	Added in PHB elements	Version 19
30/12/2015	Rosa Juarez, Amanda Cousins and Max Bennett	Changes to PHB elements general language. Addition of revised table elements.	Version 20

Approvals

This document requires the following approvals.

Name	**Title**	**Date of Issue**	**Approved/ Rejected**	**Version**
	JCC	19/01/2016		20
	North Norfolk CCG Governing Body	26/01/2016		20
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	Norwich CCG Governing Body	26/01/2016		20
	West Norfolk CCG Governing Body	28/01/2016		20

Contents

1. Introduction to NHS Continuing Healthcare for Adults

1.1. Purpose of the Guide

This guide contains information for patients, carers and families about NHS Continuing Healthcare (NHS CHC) in Norfolk (excluding Great Yarmouth and Waveney.). This is the area covered by the NHS Clinical Commissioning Groups (CCGs) for Norwich, North Norfolk, South Norfolk and West Norfolk.

This information should help patients, their carers and families to understand the national and local NHS CHC processes, as well the choices available to them.

The guide comprises a number of frequently asked questions regarding NHS CHC and the answers to these. It also provides signposting to more detailed guidance.

1.2. What is NHS Continuing Healthcare?

NHS CHC is the name given to a package of care for adults aged 18 or over, which is arranged and funded solely by the NHS.

In order to receive NHS CHC funding, a person has to be assessed according to a legally-prescribed decision-making process to determine whether they have a 'primary health need'.

A person can receive NHS CHC in a variety of settings, including their own home or a care home. NHS CHC is free, unlike support provided by local authorities for which a financial charge may be made depending on income and savings.

If a person is eligible for NHS CHC, this means that the NHS will pay for their healthcare and associated social care needs.

There are two national documents that patients and their carers or families may wish to consult for further information. These are:

1. The NHS National Framework for Continuing Healthcare and NHS-Funded Nursing Care: defines the way that eligibility is assessed and established. This ensures fair and consistent access to NHS funding across England, so that people eligible for NHS CHC and with similar needs have an equal likelihood of getting all of their health and social care provided by the NHS. This is available via the GOV.UK website at:

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

2. **The NHS England Operating Model for NHS Continuing Healthcare:** sets out the strategic importance of NHS CHC and the arrangements for NHS England to be assured that CCGs are complying with the National Framework. This is available at:

https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf

1.3. What is the process for deciding whether a person is eligible for NHS Continuing Healthcare?

To be eligible for NHS CHC, a person must have a 'primary health need'. This means their need for care is primarily due to their health needs and is determined by a team of healthcare professionals (known as a multi-disciplinary team). A primary health need is not dependent on a particular disease, diagnosis or condition, nor on who provides the care or where that care is provided.

Once eligible for NHS CHC, a person's care will be funded by the NHS. This is subject to regular reviews, and, if a person's care needs change, the funding arrangements for their care package may also change.

The process for establishing if someone is eligible includes the following steps:

1. Referral for initial checklist

The purpose of the checklist is to decide whether a person should be given a full assessment for NHS CHC. A professional involved with a person's care may refer them for the initial checklist. A person can also make their own request to be referred.

The checklist can be completed by a nurse, doctor, other healthcare professional or social worker. People should be told that they are being assessed and be asked for their consent. Being referred for a full assessment does not necessarily mean that a person will be eligible for NHS CHC.

The professional(s) completing the checklist should record written reasons for their decision, and sign and date the checklist. The person whose needs are being assessed should be given a copy of the completed checklist. A blank copy of the NHS continuing healthcare checklist from GOV.UK (PDF, 168kb).

2. Full assessment for NHS CHC

Full assessments for NHS CHC are carried out by a "multi-disciplinary" team, made up of a minimum of two health or care professionals who are already involved in a person's care. A person should be told who is coordinating their assessment.

The team's assessment will consider a person's needs under the following headings:

- behaviour
- cognition (understanding)

- communication
- psychological/emotional needs
- mobility
- nutrition (food and drink)
- continence
- skin (including wounds and ulcers)
- breathing
- symptom control through drug therapies and medication
- altered states of consciousness
- other significant needs

The team will consider:

- what help is needed
- how complex these needs are
- how intense or severe these needs can be
- how unpredictable they are, including any risks to the person's health if the right care is not provided at the right time

The assessment should take into account a person's own views and the views of any carers. The person being assessed should be given a copy of the decision documents, along with clear reasons for the decision.

A blank copy of the NHS continuing healthcare decision support tool is available from GOV.UK: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

1.4. What happens if a person becomes eligible for NHS CHC while in receipt of self-funded or local authority-funded care?

If a person is already resident in a nursing home or residential care home (either self-funded or local authority-funded), they will be told before the checklist stage whether their home has an NHS Standard Contract.

The relevant NHS Clinical Commissioning Group will only arrange care packages with homes that have a valid Standard Contract for NHS CHC.

If the person wishes to stay in a care home which does not provide contracted NHS CHC services, they may choose to decline the checklist completion and the assessment of eligibility for NHS CHC. These patients will continue to self-fund or will be funded by the local authority.

If a person already receives local authority-funded care and becomes eligible for NHS CHC, the NHS CHC team will do its best to facilitate continuity of care. There may be issues which make this difficult, for example: the provider may not being willing to sign an NHS Standard Contract. If this happens, the NHS CHC team will explain what alternative services are available to meet a person's needs.

1.5. What arrangements are in place for palliative and end-of-life care?

There is an NHS CHC pathway for patients with a rapidly deteriorating condition which may be entering a terminal phase. In these circumstances, a health professional may consider it is appropriate to complete a Fast Track Pathway Tool. Once completed, the documentation will be sent to the NHS CHC Clinical Team for immediate action. This will include the clinical information required to arrange the appropriate placement/package of support as soon as possible (usually within 48 hours).

1.6. How does a person appeal if they not deemed eligible for NHS CHC?

If a person wants to appeal, they will need to submit the reasons why they do not agree with the decision, along with any new or previously unseen evidence to support their statement. An appeal must be lodged *within 6 months* of notification of the eligibility decision, in line with the National Framework. The aim is to complete the appeal process within *3 months** of receipt of an appeal. The NHS will not fund a person's care package during the appeals process. To begin the process the person appealing should write to:

<u>Appeals Department</u>

NEL CSU

Lakeside 400

Old Chapel Way

Broadland Business Park,

Norwich

NR7 0WG

Further information on appeals is available in the NHS CHC Information Sheet (Appendix 2).

1.7. What can a person expect in the planning and commissioning of their care?

Once eligibility for NHS CHC is established, a care package to meet their needs is agreed. Care planning will be based on the documentation received from the multi-disciplinary team.

The NHS CHC Brokerage Team is responsible for coordinating the planning of a patient's care. They will engage with the person, their family and/or representatives, as well as health professionals, and draw up options for providing services that meet the person's needs. Options are dependent on what services are available in local areas.

In the following circumstances, it may be appropriate for NHS CHC services in the person's own home to be withdrawn and provided in a different setting:

- the situation presents a risk of danger, violence, or harassment of staff who are delivering the care package;
- the NHS considers that the level of clinical and/or safeguarding risk to the individual has become unacceptable and cannot be safely managed;
- the clinical risks of providing care in a specific environment are considered too high – a full risk assessment must be made covering all the assessed needs and reflecting the proposed environment in which the care is to be provided. A person can choose to accept clinical risks but if the cost of managing that risk is too high, the NHS in certain circumstances may not agree to fund this option;
- the person who wishes to receive care at home does not have a full understanding of the risks and possible consequences. In these circumstances a 'best interest' meeting may be convened or a mental health capacity assessment made;
- the organisations contracted to provide safe care cannot do so ;
- the patient's primary care team feels it cannot provide adequate medical cover.
- the family/person with whom the person normally lives feel they cannot cope. If action by family members or friends is needed to provide elements of care or to manage risks, they must also agree to the care plan. An example of this would be the care of a patient with behavioural difficulties as a result of brain trauma who needs to be cared for in a quiet environment where activities are highly structured. This cannot be provided by some families within the family home so the risk is that the person's health will deteriorate and the care plan at home will fail;
- actions to minimise risks will include those that must be taken by the person in receipt of care or their family – an example of this is where a person with severe breathing difficulties is returning to a family home where relatives

smoke. Relatives need to agree to refrain from smoking, and the risks need to be explained to the patient if they choose to receive care in that environment.

1.8. How are decisions about the funding of a person's care package made?

Once a person's eligibility for NHS CHC is established, a care package has to be agreed. The person and their family will be involved with other health professionals in considering available options.

Complex Case Review Panels (CCRPs) make decisions about the care to be offered under NHS CHC to meet a person's needs. In agreeing the funding for a person's care, they will take into account:

- A person's needs and the outcomes which they wish to achieve from their care
- Preferences expressed by a person and/or their family, and their views on the choices available
- The Human Rights Act and any other Disability Rights legislation
- Clinical and safeguarding risks and the views of a person and/or their family on these. (A person's own personal view would apply where they fully understand risks in the choices they would like to make but still wish to take those risks.)
- The price and affordability of the various options for providing care, in light of the need to ensure equitable use of NHS resources.

Also

- Panels will have to take into account the availability of services and choices as this may be an important factor.

CCRPs and NHS CHC staff will be knowledgeable of the following:

- Human Rights Act 1998
- Disability Rights legislation
- Equality Act 2010
- The UN Convention on disability rights
- The Harwood Care and Support Charter
- Part A "I" statements from the NHS England Operating Model for NHS Continuing Healthcare

Please see the appendix for the links to each of these.

In exceptional cases, the NHS may be prepared to consider funding a package of care where the anticipated cost is more than the NHS would usually expect to pay; or elements of the care package are not usually funded from NHS CHC budgets.

The NHS recognises that exceptional circumstances may require exceptional consideration but will retain its obligation to make best use of NHS resources.

Exceptionality will be determined by the relevant CCG on a case by case basis. The grounds for and appropriateness of exceptionality will be determined by the merits of each case by the Commissioner.

1.9. What does NHS CHC funding cover?

If a person is eligible for NHS CHC, the NHS will pay to provide their healthcare (e.g. services from a community nurse or specialist therapist) and associated social care needs (e.g. personal care and domestic tasks, help with bathing, dressing, food preparation and shopping) in their own home.

For a person in a care home, the NHS also pays care home fees, including board and accommodation.

The Brokerage Team can only arrange NHS CHC care packages with providers that have signed up to NHS Standard Contracts. Despite this, there may be occasions when the team is unable to arrange care packages with contracted providers. This may be due to:

- Concerns regarding the quality of care
- Concerns regarding safeguarding
- The provider is unable to safely deliver the care required to meet the person's needs
- The provider is unable to deliver the care required in a person's geographical location
- Financial dispute

To ensure that everyone is treated equally and NHS resources are used fairly and efficiently, careful consideration has been given to what can be provided from NHS CHC. The following table is a guide to what can be funded by NHS CHC and what can be provided from mainstream NHS services. Please note: for a Personal Health Budget, the table below will be used to calculate the value of that PHB. Once the value has been established, the individual will have choice and control over choosing services to meet their health need, subject to agreement with the CCG and ensuring existing services are fully utilised. This is clarified further in section 2.

Service	Is this service available within mainstream NHS provision?	Is this service available within an NHS CHC budget?
Domiciliary care	No	Yes. Available from locally contracted providers.
Planned care to replace informal care provision	No	Yes – if identified following care review

Additional unplanned care to replace informal care provision	Yes – short term urgent support is available via Local Authority.	No – except in exceptional circumstances.
Carer advice and befriending services	No	No
Physiotherapy	Yes	No – except in exceptional circumstances.
Occupational Therapy	Yes	No
Speech and Language Therapy	Yes	No
Podiatry	Yes	No
Advocacy	Yes	No
Transport	Yes, but only to and from medical or clinical appointments if a person meets the eligibility criteria for the transport.	No – except in exceptional circumstances.
Assistive technology - smart house technology and safety equipment	Yes	No
Standard Equipment (including pressure care)	Yes	No
Bespoke equipment (including pressure care)	No	Yes
Respiratory support equipment (e.g. ventilators)	No	Yes
Wheelchairs and seating systems including electric and outdoor chairs	Yes	No
Equipment for leisure and social activities (e.g. swimming gear or horse riding boots).	No	No
Day services	No	Yes
Computers, laptops, Wi-Fi and Broadband	No	No – except exceptional circumstances
Major adaptions to housing and environment	No	No
Specialist foods and fluids	Yes - if provided on prescription.	No

Hearing and low vision services	Yes	No
Gardening, domestic and window cleaning	No	No
Path clearance to aid access	No	No - except in exceptional circumstances
Falls assessments	Yes	No
Palliative care and end of life services	Yes	Yes
Continence services	Yes	No

In exceptional cases, the NHS may be prepared to consider funding a package of care where the anticipated cost is more than it would usually expect to pay; or where elements of the care package are not usually funded from NHS CHC.

1.10. After the NHS has defined a person 'needs', how do they commission additional private services for things they 'want'?

NHS CHC funding is only available to cover the care required to meet a person's assessed needs. People who wish to make separate arrangements for additional services (such as aromatherapy, a private garden area, manicures etc.), can arrange and pay for these separately.

A person who wants to take up this option is advised to inform the people drawing up the care package before making any arrangements, to ensure they do not end up paying for services that NHS CHC funding already covers (i.e. services that meet an assessed need).

Admissions into NHS CHC-funded care for nursing care, residential care or domiciliary care packages with a provider are not conditional on a person or their family entering additional services contracts.

If a person or their family has any concerns about a provider's request for payments for additional services, please contact the Single Point of Access via e-mail:

ANGLIACSU.CHCClinicalTeam@nhs.net

1.11. How can a person plan activities to promote their physical and mental health?

People will be encouraged to think about ways of improving their physical and mental wellbeing but it is also important to take into consideration the carer support needed to help them throughout the day. People will be supported to undertake a range of hobbies such as swimming or horse riding for the disabled. The hours required for a carer to help people access these activities will be covered by NHS CHC funding.

Older people living in their own homes will be encouraged to participate in local community activities. If living alone, they will also be encouraged to get involved in local befriending schemes to reduce social isolation. Care planning needs to identify the activities which are most enjoyed by an older person.

Example:

Mr B lives alone and needs support to help him with mobility and his personal care. He loves to do crosswords, read the local paper, and going to a local bridge club. In planning his care, consideration is given to making sure he always has a good supply of large-print crosswords, a daily newspaper is brought to him by his carer, and his carer is funded to take him to the local bridge club once a month.

1.12. What is the process for out-of-area placements?

A number of people are cared for close to their families in other parts of the country. These people are still funded by their local NHS.

In exceptional cases, care packages outside Norfolk may also be arranged where specific clinical needs cannot be met locally.

Individual requests for commissioning care in another area will be considered as part of the CCRP decision-making process outlined in “How are decisions about the funding of a person’s care package made?”. In certain circumstances, such as for end-of-life care, placements can be considered in Scotland and Northern Ireland but not outside the UK.

If patients move to another county, their local NHS will remain responsible for their care and reviews of eligibility are in cooperation with the local NHS team in the area they live in.

Families and carers are encouraged to inform the NHS CHC Clinical Team at NEL CSU if there are any concerns about the out-of-area care home as soon as possible. This will enable discussions to be held with the relevant local services and registration bodies.

1.13. What is the process if family or friends are providing care as part of a person’s care package?

Families and friends who are actively involved in the provision of care are very much part of the care planning process. Care plans start with the care that family or friends are able and willing to provide.

Training and equipment can be provided to support carers in the safe provision of care. If families or friends are providing elements of care, they need to agree the care plan and be clear about who to notify if they are suddenly unable to provide it.

2. Personal Health Budgets

2.1. What is a Personal Health Budget?

A Personal Health Budget (PHB) is a sum of money provided to support a person's identified health and wellbeing needs.

PHBs are being introduced to help people manage their care in a way that suits them. The aim is to give people with long-term conditions and disabilities greater choice and control over the healthcare and support they receive.

A PHB is planned and agreed between the person and the NHS.

People can use PHBs to pay for a wide range of items and services (for example, employ their own care staff or pay for items which can be funded by NHS CHC).

2.2. Who can have a Personal Health Budget and how does this work?

Anyone who is eligible for NHS CHC, has not gone through the Fast Track Pathway, and is living in their own home, is eligible for a PHB. This includes both adults and children.

An assessment is made to determine the care they need and the NHS can then provide a sum of money to meet their assessed needs.

Once a budget has been approved, the person will need to complete a support plan which explains how they intend to use the funding to meet their assessed care needs. A PHB support officer will be able to help with this. Once completed, the support plan will be checked and signed by the NHS.

A start date will be agreed and the person will need to complete a care plan. This document will tell carers what they need to do to meet the person's needs. This will help in reviewing their care and CHC eligibility.

2.3. What is the difference between a Personal Health Budget (PHB), a Personal Budget, an Individual Budget and a Direct Payment?

- A PHB is for healthcare and is delivered by the NHS. To be eligible for a PHB you need to meet the criteria above.
- A Personal Budget is delivered by Norfolk County Council and is for social care only. If a person is eligible for NHS CHC they will not be able to have both a Personal Budget and a PHB.
- An Individual Budget is another term for a Personal Budget.
- A Direct Payment is one way of receiving funding. This means the money is paid into an account solely for a PHB (or for a Personal Budget) and can be used to employ carers.

2.4. What can a person spend their PHB on?

- There is no "set menu" of services a PHB can be spent on, as each person is unique.
- However, each PHB-holder will need to ensure they have used their PHB to meet the identified care needs of the CHC-eligible person. This means if a person was identified as needing a certain number of hours a day for care, it would be expected the PHB would be used to meet that care.
- PHBs do encourage innovation and choice, and this could include using the PHB for services and activities. If this is the case, the PHB-holder will need to explain the benefit to the person's health, and this will need to be agreed by the relevant CCG.
- A PHB may not be used for equipment without first checking with the relevant OT and with the Integrated Community Equipment Service, as this is something which has already been funded.
- A PHB may be used for transport to activities, provided the PHB-holder can demonstrate the benefit to the health of the person. PHBs will not be used to cover the maintenance / insurance of a vehicle. It is suggested any transport costs are allocated a sum of money which will then be reviewed.
- PHBs cannot be used for the daily cost of living – this includes food, utility bills (unless in exceptional circumstances e.g. live-in carers), and cleaning / gardening services
- PHBs should be used to provide full insurance cover, costs of being an employer (including pensions) and support as needed.

3. Reviewing care and eligibility for NHS CHC funding

3.1. How is a person's care and eligibility be reviewed?

A person's eligibility for NHS CHC is assessed three months after they are found eligible and at least once a year afterwards.

For people whose needs may change quickly, the review programme may be more regular than this, to ensure they receive the right care. These reviews may also assess ongoing eligibility.

If relatives, carers or other health professionals believe a care package is no longer meeting a person's assessed needs, they can contact the NHS CHC Team and request a review.

3.2. What happens, if upon review, a person is deemed not eligible for NHS CHC funding?

The process for reviewing care is in line with the National Framework. Anyone eligible for NHS CHC is reviewed after three months and thereafter at least once a year. The process for defining ineligibility is exactly the same as the process for agreeing eligibility (as described in "What is the process for knowing whether a person is eligible for NHS Continuing Healthcare?". This is dependent on a person's needs and how their condition changes.

If a person is found ineligible for NHS CHC, there are four possible outcomes:

1. **Care and support is no longer required**

2. **Care and support is required and the person opts to self-fund**

If a person is not eligible for social care (which is means-tested), they will need to meet the costs of their own care. Responsibility for meeting these costs will be transferred to them within 28 days of the date they are assessed as ineligible for NHS CHC. The person, or a named representative with power of attorney, will be notified of this in writing and given contact details. Mainstream NHS healthcare services will still be available to them.

3. **Care and support is required and the person is eligible for NHS-funded nursing care**

For enquires about NHS-funded nursing care (for people found ineligible for NHS CHC) please contact:

NHS Funded Nursing Care

Norfolk County Council

Room 614

Sixth Floor

County Hall

Martineau Lane

Norwich

NR1 2SQ

4. Care and support is required and the person is eligible for local authority-funding

If a person is ineligible for NHS CHC funding, a referral will be made to Norfolk County Council social services requesting an assessment. Social services then has 28 days in which to complete the assessment of the person's needs.

The NHS CHC Team will explain the process and liaise with social services in an effort to ensure continuity of care. If a person employs their own staff as part of a PHB, carers can be made redundant or transferred to a PB.

For enquiries about a person's care if they are found ineligible for NHS CHC, please contact:

Adult Community Care- Norfolk County Council

Norfolk Care First

Tel: 0344 800 8020

Anyone who wishes to appeal against ineligibility should contact the Appeals Department using the contact details set out under "How does a person appeal if they are found to be ineligible for NHS CHC?". The NHS will not fund a person's care package during the appeals process.

4.1. What are the arrangements for people transferring to local authority funding or self-funding?

For people transferring to social services support (which is means-tested), the assessment of ongoing needs will be completed by Norfolk County Council social services within 28 days.

If a person chooses to self-fund their own care, they will be asked to meet these costs within 28 days of being notified that they are ineligible for NHS CHC. Anyone affected, or their named representative with power of attorney, will be notified of this in writing and will be given contact details.

5. Assurance, Providing Feedback and Getting in Touch

5.1. How can people give feedback on their experience of NHS CHC services and help to improve provision?

It is important that people who receive NHS CHC and carers are able to let us know about their experiences. This helps us to improve services.

If a person or their carer wishes to provide feedback about a service which is not working well, they can write to or email if they prefer. Comments are also welcomed from people who have not been able to find a service in their local area which might be of benefit to them.

Harwood Charter

- CCGs in North Norfolk, South Norfolk, West Norfolk and Norwich have signed up to the Harwood Charter (see appendix 2) and monitor all providers that have also signed it.
- CCGs and NHS CHC clinical teams offer patients the option of using the charter cards if they feel this gives them greater confidence in voicing their needs and giving feedback on services.

5.2. How do people complain if they are not happy with their care or the options available to them?

People can contact the NEL CSU Complaints Team directly via:
nelcsu.angliacomplaints@nhs.net

The CSU Complaints Team will log the complaint and send a letter acknowledging its receipt within 2 working days. An investigation will then take place and on (or before) working day 25, the person will be sent a letter detailing the outcome.

People can also contact the Care Quality Commission (CQC) at their England based National Customer Service Centre:

Telephone: 03000 616161

Fax: 03000 616171

People can also write to the CQC at:

CQC National Customer Service Centre

Citygate, Gallowgate

Newcastle upon Tyne

NE1 4PA

5.3. What can people do if they have concerns about a person's safety?

Safeguarding is preventing the physical, emotional, sexual, psychological and financial abuse of adults who have care and support needs, and acting quickly when abuse is suspected. It can also include neglect, domestic violence, modern slavery, organisational or discriminatory abuse. Norfolk County Council Adult Social Services is the lead agency for safeguarding adults.

Within Norfolk, all referrals should be made to 0344 800 8020, which is a 24 hour number.

If the patient is receiving care outside of Norfolk, then a safeguarding referral can be made by contacting the County Council for that area.

If you feel an individual in receipt of NHS CHC is at risk of harm and abuse, you can also contact the NHS CHC team for help and support in dealing with your concern.

5.4. What should patients or their families do if they have further questions?

Carers can be referred to the local authority for a carer's assessment. Norfolk County Council has responsibility for these in Norfolk. You can contact Norfolk County Council via:

E-mail

information@norfolk.gov.uk

Telephone

0344 800 8020 (Monday to Friday 9am - 5pm)

Fax - 0344 800 8012 (Monday to Friday 9am – 5pm)

Text message - 07767 647670 (Monday to Friday 9am - 4.45pm)

Post

Norfolk County Council

County Hall

Martineau Lane

Norwich

Norfolk

NR1 2DH

For enquiries about NHS Continuing Healthcare please contact:

Continuing Healthcare Department

NEL CSU

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

Email: ANGLIACSU.CHCClinicalTeam@nhs.net

Tel: 01603 257 243

For enquiries regarding Retrospective Claims please contact:

Retrospective Continuing Healthcare Department

NEL CSU

Lakeside 400

Old Chapel Way

Broadland Business Park

Thorpe St Andrew

Norwich

NR7 0WG

Email: ANGLIACSU.RetrospectiveClaims@nhs.net

Tel: 01603 257 284

Appendices

Ref	Document title	Location
1	Glossary of Terms	
2	NHS CHC Information Sheet	**Note to NHOSC – available as an appendix to Appendix B of this report.**
3	The Harwood Care and Support Charter	http://www.norfolk.gov.uk/view/NCC117232
4	Part A - "I" statements from the NHS England Operating Model for NHS Continuing Healthcare	https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf
5	CHC Public Information Leaflet	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193700/NHS_CHC_Public_Information_Leaflet_Final.pdf
6	List of organisations engaged with in producing this guide	Stakeholder meetings\2015.12.18 List of organisations engaged with.docx **Note to NHOSC – the list of organisations engaged with is available at Appendix K to the report to NHOSC, 25 Feb 2016**
7	The Human Rights Act 1998	http://www.legislation.gov.uk/ukpga/1998/42/contents
8	Further information on Disability Rights	https://www.gov.uk/rights-disabled-person/overview
9	Equality Act 2010	http://www.legislation.gov.uk/ukpga/2010/15/contents
10	The UN Convention on disability rights	http://www.un.org/disabilities/convention/conventionfull.shtml
11		

Appendix 1 Glossary of Terms

These definitions describe various terms used in this document. This glossary is a developing document and we will be working with partners to refine, update, and develop this over the coming year.

Term	Definition
NHS CHC Brokerage Team	Refers to the NHS CHC team
Best interest meeting	A formal best interests meeting is likely to be required where the decisions facing the patient are complex and cannot be easily made by the decision-maker and immediate colleagues. There may be a range of options and issues that require the considered input of a number of different staff as well as those with a personal and/or legal interest in the needs of the person lacking mental capacity. Making sense of these issues and options can only be properly covered and addressed through holding such a meeting, and clearly recording the discussions.
Carer	Someone who provides unpaid support to family or friends who cannot manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. Source: Carers Trust
Care Package	A combination of support and services designed to meet an individual's assessed health and associated social care needs.
Care Plan	A document recording the reason why support and services are being provided, what they are and the outcomes that they seek.
Care Planning	A process based on assessment of an person's needs that involves working with them to identify the level and type of support to meet his/her assessed health and associated social care needs, and the objectives and potential outcomes that can be achieved.
CCGs (Clinical Commissioning Groups)	Refers to NHS North Norfolk Clinical Commissioning Group, NHS South Norfolk Clinical Commissioning Group, NHS West Norfolk Clinical Commissioning Group, and NHS Norwich Clinical Commissioning Group.

Term	Definition
Commissioning	The process used to secure the best quality and best value care for local people. This involves planning and procuring services for the local population, translating people's aspirations and needs into services that: • Deliver the best possible health and well-being outcomes, including promoting equality; • Provide the best possible health and social care provision; and • Achieve the above with the best use of available resources.
Complex Case Review Panel	A panel which meets on a regular basis to consider, review and/or approve the care to be offered under NHS CHC to meet each individual patient's needs.
NHS Continuing Healthcare	A package of ongoing care that is arranged and funded solely by the NHS for a person who has been found to have a primary health need. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. Source: National Framework for NHS Funded Nursing Care
Direct payments	One way of managing a Personal Health Budget (PHB) where money is given directly to a person or their representative for the management of their NHS care. This option became legal on 1 August 2013 and is in addition to the pre-existing legal options for managing a PHB – by the NHS, or through a third party. Personal budgets for social care needs via local authorities have been available in the same format since 1997
Home Care	Care provided in a patient's own home.
Local Authority	In this guide, refers to Norfolk County Council.
Long-term conditions (LTCs)	Illnesses that people live with for a long time and that currently cannot be cured, such as diabetes, heart disease, dementia and asthma.
NEL Commissioning Support Unit (NEL CSU)	NEL CSU is an NHS body which provides NHS CHC services to patients in Norfolk and other areas.
NHS Standard Contract	A standard contract mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

Term	Definition
Multi-disciplinary team	A team composed of members from different healthcare professions with specialised skills and expertise. The members work together to make treatment recommendations that facilitate quality patient care.
Patient Experience	A term used for individual and collective feedback. (1) A person's feedback about their experiences of care or a service e.g. whether they understood the information they were given, their views on the cleanliness of the hospital where they were treated. (2) A combination of all the intelligence held about what patients experience in services, drawing on a range of sources including complaints, compliments, and reporting of incidents and serious incidents.
Person-centred care	Person-centred care takes patients and their families as the starting point of all decisions. Patients are equal partners with health professionals in planning, developing and assessing care to ensure it is most appropriate to their needs. It involves putting patients and their families at the heart of all decisions and requires a different kind of interaction between patients and healthcare professionals.
Personal Health budgets	A personal health budget is an amount of money to support an individual's identified healthcare and wellbeing needs, planned and agreed between them, or their representative, and their local NHS team. At the centre of a personal health budget is a care plan. The plan sets out the individual's health and wellbeing needs, the health outcomes they want to achieve, the amount of money in the budget and how they are going to spend it. Personal health budgets can be used to pay for a wide range of items and services, including therapies, personal care and equipment. This allows individuals to have more choice and control over the health services and care they receive. For more information please visit the NHS England website.
Primary Care	Health care provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment.

Term	Definition
Representative	Any family member, friend or unpaid carer who is supporting the individual, as well as anyone acting in a more formal capacity (e.g. welfare deputy or power of attorney, or any organisation representing the individual). Where an individual has capacity, s/he must give consent for any representative to act on his/her behalf.

NHS
North Norfolk
Clinical Commissioning Group

Complex Case Review Panel

Terms of Reference

1 Introduction

The Complex Case Review Panel (CCRP) has been established by INSERT NAME CCG to provide a system that supports discussion, consideration and agreement relating to the complex care requirements of individuals for whom the CCG have the responsibility to fund a reasonable and safe care arrangement to meet their care needs as identified within the National Framework for NHS Continuing Healthcare 2014.

CCRP responsibilities include the consideration of clinical and financial accountability, quality and safety implications: they explicitly do not include the consideration of a person's eligibility.

The CCG will take ownership of the decision-making for the commitment of costs associated with all packages of care, where cases have been presented to the Panel. The decisions and understanding of the composition of Individual Care Packages may influence the strategic direction of the CCG's commissioning strategy for future provision of all services associated through mainstream contracts and integrated commissioning with local authorities.

2 Objectives

- To enable the CCG to discharge its responsibilities in relation to Continuing Healthcare and the complex care arrangements of individuals eligible under the CHC framework 2014.
- To ensure that the most effective care choices are offered to individuals based upon quality, equality, safety and value for money
- To provide an auditable governance process around managing CHC care arrangements, its financial allocation and the collaborative arrangements between the CCG and NELCSU.
- To identify service provision and potential gaps in commissioned services to inform future commissioning and strategic planning.

3 Function of the Panel

The Panel will consider the following routinely:

- all new proposed care arrangements of a very complex nature that require in principal agreements for options of support that could be offered to individual patients in order to best meet their care needs;

- all new care arrangements and recommended changes to existing care arrangements with a higher level of complexity; typically this will capture those care packages with a cost higher than £667 per week (Band A equivalent for Care Homes);

- care arrangements to meet Fast-Track referrals: this will be undertaken retrospectively in order to prevent delay in the provision of urgent care and support;

- proposed Personal Health Budget plans;

- proposed shared funding arrangements (i.e. shared care with Norfolk County Council (NCC); and

- all CHC care arrangements and eligibility recommendations for children.

The Panel will also review and sign off of adult CHC eligibility and recommendations.

4 Membership

Members will be of sufficiently senior authority and clinical experience to fulfil the role of the panel. Membership will include:

- Head of Patient Safety & Clinical Quality (and/or nominated deputy);
- Individual Patient Pathway Manager;
- NEL CSU CHC Clinical Representative; and
- Any other relevant individual by invitation.

5 Quorum

A quorum will comprise a minimum of two members of the Panel, including Head of Patient Safety & Clinical Quality (and/or nominated deputy) and the NEL CSU CHC Clinical Representative.

6 Frequency of meetings

- The Panel shall meet on a weekly basis;
- Papers for the meeting shall be received 2 working days prior to the meeting
- Meetings may be held virtually at any time to support patients' best interests

7 Administration

NEL CSU will maintain comprehensive records of meetings; minutes and action logs will be provided to the CCG within 2 working days of a meeting.

8 Managing Conflicts of interest

Managing Conflicts of Interest will be the first standing agenda item following the receipt of apologies. The following statement will appear on the agenda, which the Chair of the Panel will read:

'The Chair and members of this meeting are reminded that if they have any pecuniary interest, direct or indirect, in any Patient case, contract, proposed contract or other matter which is the subject of consideration at this meeting, they must, as soon as practicable after the commencement of the meeting disclose that fact. Other than in relation to patient cases the holders of which may take part in the consideration and discussion of the matter but not any agreement arising, conflicted personnel will otherwise be precluded from participation in the agenda item of any kind.'

*Standards of Business Conduct Policy refers

9 Policy and best practice

The Panel has full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations and will apply best practice in all decision-making processes.

10 Conduct of the Panel

The Panel will conduct its business in accordance with national guidance; all relevant codes of conduct and good governance practice; and with the CCG's policy on Standards of Business Conduct which incorporates:

- The NHS Codes of Conduct and Accountability;
- Nolan Principles on Standards in Public Life;
- Standards for NHS Boards and CCG Governing Body Members;
- Code of Conduct for NHS Managers; and
- Standards of Business Conduct for NHS Staff.

In addition, the Panel will ensure the following standard domains are taken into consideration when making decisions regarding individual packages of care for patients eligible for NHS CHC:

- Patients' needs and the outcomes they wish to obtain from their care
- Patient and family preferences and views
- The Human Rights Act and any other Disability Rights legislation (see Appendix J)
- Clinical and safeguarding risks and patients/ families views on these. (Patient view would apply where a patient fully understands risks in the choices they would like to make but still wishes to take those risks.)
- The price and affordability of the various options for the provision of care in light of the need to ensure equitable use of limited NHS resources.
- Due to geographical gaps in some care services, panels will have to take into account the availability of services and choices for patients as this is a limiting factor for many. Reviews of current provision are taking into account current gaps in services in order to support commissioners to fill these.

Decisions regarding the setting of personal health budgets will be treated in the same way.

Guidance Sheet for Consideration of Human Rights in Complex Case Review Panel Decision Making

Human rights are universal rights inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion.

They guarantee the fundamental rights of each individual, representing moral and ethical principles.

They are often described as being underpinned by a simple framework of commonly recognised values – the so called 'FREDA' principles:

- **F**airness
- **R**espect
- **E**quality
- **D**ignity
- **A**utonomy

The Human Rights Act 1998 (also known as the HRA) came into force in the United Kingdom in October 2000. It is composed of a series of sections that have the effect of codifying the protections in the European Convention on Human Rights into UK law.

All public bodies (such as courts, police, local governments, hospitals, publicly funded schools, and others) and other bodies carrying out public functions have to comply with the Convention rights.

This means, among other things, that individuals can take human rights cases in domestic courts; they no longer have to go to Strasbourg to argue their case in the European Court of Human Rights (ECHR).

The courts themselves must also act compatibly with the ECHR, this includes the way they interpret the law in their decision-making.

Certain ECHR Articles protected by the Human Rights Act (HRA) are more likely to be relevant to people using NHS CHC services:

- The right to life (ECHR Article 2).

- Prohibition on inhuman or degrading treatment (Article 3).

- Right to liberty and security (Article 5) which includes freedom from unlawful detention.

- Right to respect for private and family life, home and correspondence (Article 8). This is a wide-ranging qualified right (see below) that also protects the right to respect for an individual's personal dignity, autonomy and social relationships.

- Right to peaceful enjoyment of possessions (Article 1 of Protocol 1).

- There are other ECHR Articles protected by the HRA which could also be relevant to home care or care home services in some situations:

- Freedom of thought, conscience and religion (Article 9).

- Freedom from discrimination on any ground in the enjoyment of other ECHR rights (Article 14). This is not a freestanding right – it must be used alongside another right under the ECHR.

The ECHR rights protected by the HRA fall into different categories. Some rights are 'absolute'; that is, they cannot be restricted in any circumstances, even in a national emergency, nor can they be balanced against the general public interest or the rights of others. Absolute rights include the right to life (Article 2) and freedom from torture and inhuman and degrading treatment (Article 3).

But many other ECHR rights are 'qualified'. This means that they can be restricted, provided this is justified by the wider public interest (such as national security or public safety) or the need to protect the rights or freedoms of others.

The restriction must be a **proportionate** response to a genuine social need and must have a basis in legal rules that are accessible and reasonably clear.

Article 8, the right to respect for private and family life, is an example of a qualified right. The requirement for proportionality is important. A proportionate response is one that is appropriate and not excessive in the circumstances. A straightforward way of thinking about this is that, when restricting human rights, public authorities must not use a sledgehammer to crack a nut. So panels need to think about proportionality and about reasonableness and what steps have been taken to reduce any risk of a loss of privacy and family life in the options for care being considered with the individual.

All aspects of the individual case must be considered when making decisions about the funding of long term care funded by the NHS.

If making a decision between funding care at home and care in a care setting the panel needs to take an overview overall and balance all the factors including importantly patient preferences and right to family life.

Panels may wish to also when making difficult and complex decisions to also recognise the potential risk of challenge under the HRA and seek to ensure that they have assessed the risk and their decision is on balance defendable.

Equality Act (previously the Disability Discrimination Act)

Provision of services elements of the Equality Act apply equally to all NHS services.
The spirit of the act is to ensure that people have equal access to services and to opportunity and that …

"A person must not, in the exercise of a public function that is not the provision of a service to the public or a section of the public, do anything that constitutes discrimination, harassment or victimisation."

Patients should always be enabled and encouraged to voice their views and preferences and be an active part of the care planning and monitoring process.

All services have a duty to make *reasonable adjustments* to ensure that services can be accessed in an equitable way this can relate to aspects such as physical access, information in an accessible form or additional support to access a service.

In planning care with patients consideration should be given to ensure equity of opportunity to enjoy family life, and support to enable them to live active and fulfilling lives within the resources available to them.

Further relevant information is provided in the Appendices.

Appendix	Document title	Document source
1	NHS CHC Information Sheet	**Note to NHOSC – available as an appendix to Appendix B of this report.**
2	The Human Rights Act 1998	http://www.legislation.gov.uk/ukpga/1998/42/contents
3	Further information on Disability Rights	https://www.gov.uk/rights-disabled-person/overview
4	Equality Act 2010	http://www.legislation.gov.uk/ukpga/2010/15/contents
5	The UN Convention on disability rights	http://www.un.org/disabilities/convention/conventionfull.shtml
6	The Harwood Care and Support Charter	http://www.norfolk.gov.uk/view/NCC117232
7	Part A - "I" statements from the NHS England Operating Model for NHS Continuing Healthcare	https://www.england.nhs.uk/wp-content/uploads/2015/03/ops-model-cont-hlthcr.pdf

Consideration of Domains in Complex Case Review Panel Decision Making

Domain	CRP Domain for decision making	How has this been considered / described?	Source of Supporting Evidence	Summary of Discussion points CCG CCRP
Domain 1 Patient Needs	What are the key assessed needs?	What key areas of need are identified in the evidence supplied to panel e.g. • Behavioural support • Complex feeding regime		
	What outcomes does the patient wish to achieve from their care?	Outcomes need to be clearly expressed within evidence e.g. • Patient states they wish to play as active a part in family life as possible		
Domain 2 Patient Preferences on Available Choices	What choices have been offered? What preferences and views have the patient and family expressed regarding the choices available?	The evidence submitted to panel needs to outline the choices that have been explored with the patient/family based on the market provision available.		
Domain 3 Clinical and Safeguarding Risks	Have any risks been presented in the evidence supplied? (list bullet points) If patient wishes to take risks have these been explained and patient signed to take those risks?	Evidence available with relevant risk assessments (clinical risks will be in the ICA) If required, crisis plan agreed with patient and family (to be available to CCRP on request)		
Domain	**CRP Domain for decision making**	**How has this been considered / described?**	**Source of Supporting Evidence**	**Summary of Discussion points CCG CCRP**

Domain 4 Equality, Disability and Human Rights	Have relevant Equality, Disability and Human Rights issues been acknowledged and addressed during CCRP decision making	Equal access to services Disability impact considered Human rights upheld Parenting or carer responsibilities considered Harwood Charter and 'I Statements' considered	Quality Impact Assessment *may* be required as supporting evidence in complex cases	
Domain 5 Reasonable Funding	Is the cost of funding the care reasonable? Is there a significant difference in price for care at home and comparative care home banding?	Cost of care at home = Comparative care home banding =		
Domain 6 Mainstream Services	Mainstream NHS or LA provision should be in place where required	CCRP members should consider whether aspects of a care package could be provided by NHS or LA services to avoid duplication of funding		

Attendance Log Sheet

1st February 2016

CCRP Training on NHS CHC Policy, Staff Procedures, Patient Guide, Harwood Charter and Operating Model "I" Statements

Lakeside 400, Room G5

To confirm your attendance on the day, please complete a row and sign.

11 STAFF ATTENDED - SIGNATURES REDACTED

Date	Time	Name	Signature
01/02/16	10:48	[redacted]	[redacted]
01/02/16	11:00.	[redacted]	[redacted]
01/02/16	11:00	[redacted]	
01/02/16	11-00	[redacted]	[redacted]
"	"	[redacted]	[redacted]
"	"	[redacted]	[redacted]
"	"	[redacted]	[redacted]
"	"	[redacted]	[redacted]
—	—	[redacted]	[redacted]
"	10·50	[redacted]	[redacted]
1:2.16	1100	[redacted]	[redacted]

CCRP Quiz on NHS CHC Policy, Staff Procedures, Patient Guide, Harwood Charter and Operating Model "I" Statements

*** 1. Which of the following is the "Policy with regard to NHS CHC Contracts for Care Homes with Nursing and Residential Care Homes" intended to achieve?**

- ○ Ensure appropriate patient care that is in line with the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)
- ○ Ensure appropriate patient care delivered without a common understanding of the CCGs' commitments with respect to NHS CHC
- ○ Ensure the policy is only applicable to new patients eligible for NHS CHC

*** 2. Which two of the following does the Policy do?**

- ☐ Improves the approach to decision making across CCGs giving inconsistency
- ☐ Protects patients by making 'Additional Services' payment arrangements clear
- ☐ Sets out expectations around contracting and patient placements

*** 3. What should patients be informed of prior to check-listing?**

- ○ Whether their families like the nursing or residential care home
- ○ The contractual status of their current care provider
- ○ Whether they have a choice of rooms

*** 4. Occasionally it is appropriate to place patients Out of Area. In these cases, which two of the following statements are true?**

- ☐ Agreed by all CCGs
- ☐ This would be on a Named Patient basis
- ☐ Agreed by the relevant CCG

*** 5. Scenario A: Mrs Andrews lives in a residential home and has deteriorating dementia. She has recently become CHC eligible. Mrs Andrews and her family express a preference to remain in the current residential home but it is not currently in contract. Which two of the following should have happened or needs to happen?**

- [ ] Mrs Andrews and the CHC Practitioner should not be aware of the contracted status of the home prior to the assessment taking place
- [ ] Mrs Andrews has the right to decline CHC funding if she wishes to remain resident in her existing home but would then need be required to self fund her care
- [ ] The CHC Practitioner should be aware of the contracted status of the home prior to the assessment taking place

*** 6. "Additional Services' is a covering term referring to:**

- ◯ Additional services that are added on to an ICA
- ◯ Additional services that the patient must purchase seperately in order to stay in the nursing home or residential care home
- ◯ Optional extras that patients may wish to purchase from their care home provider through a private arrangement.

*** 7. The Policy introduced a locally developed standardised decision making framework based on a set of 5 domains. Which of the following options represents these?**

- ◯ Clinical Need
  Patient and family views
  Equality, Disability and Human Rights Legislation
  Clinical risk
  Price and affordability
- ◯ Clinical Need and Required Outcomes of Care
  Patient and family views
  Equality, Disability and Human Rights Legislation
  Clinical risk / safeguarding issues
  Price and affordability
- ◯ Clinical Need
  Equality, Disability Legislation
  Human Rights Legislation
  Clinical risk
  Price and affordability

*** 8. In addition to the five domains, which other factors should CCRPs take into account?**

- ◯ Whether the residential home has entertainment facilities and wifi
- ◯ Service availability / Mainstream NHS Provision
- ◯ Whether the family can pay for the services themselves

*** 9. Which are the two most relevant sections of the European Court of Human Rights (ECHR) Legislation for NHS CHC?**

- ◯ Articles 8 and 14
- ◯ Articles 8 and 15
- ◯ Articles 1 and 5

*** 10. Which two of the following are principles of the The Harwood Care and Support Charter?**

- [ ] Listening to people and responding to their needs
- [ ] Treating people with respect, dignity and courtesy
- [ ] Making sure people are left unsupported

CHC Transformation High Level Training Plan

Action ID number	Action description	Action Owner	Start date	Completion date	Notes/Progress	BRAG
	Roll out of NHS Staff and Patient policies		**Workstream BRAG**			-
	Briefing note developed on the new policies and updating the SOPs to reflect them	Paul Martin	04/01/2016	15/01/2016		-
	Briefing note distributed to team leads of PHB, Childrens CC, Invoice Validation, Contracts and Finance Teams so that they	Paul Martin	18/01/2016	29/01/2016		
	Team meeting with each locality team which will discuss the new policy and how it impacts them, deliver training, talk through briefing note and answer questions	Ceri Jackson	18/01/2016	29/01/2016		-
	CHC Practitioner to hand the patient guide to each family at an initial assessment or MDT if they have not previously been present	Ceri Jackson	TBC		Awaiting sign off and confirmation of approval by JCC	-
	All staff to have read these policies and signed to say they have done so	Ceri Jackson	18/01/2016	29/01/2016		-
	Review impact of document on staff and processes	Ceri Jackson	29/04/2016	06/05/2016		-
						-
	Roll out of CCRP and Contract Related policies (as listed below)		**Workstream BRAG**			-
	*NHS CHC Contracts for Care Homes with Nursing and Residential Care					-
	*Additional Services Policy					-
	*Urgent Personal Interventions Process					-
						-
	Briefing note developed on the new policies and SOPs updated to reflect them	Paul Martin	04/01/2016	15/01/2016		-
	Briefing note on affect of the new policies on Brokerage Teams	Paul Martin	04/01/2016	15/01/2016		-
	Briefing note on affect of the new policies on Contract Teams	Tracey Ginn	04/01/2016	15/01/2016		
	Develop internal process and adjust 'pre-panel assurance form'	Maggie Warner	15/01/2016	18/01/2016	Support given from Paul Martin	
	Brokerage Team to undertake training on new process	Maggie Warner	25/01/2016	29/01/2016	Training materials being developed by Norwich CCG	-
	Clinical Teams to undertake training relating to their role	Ceri Jackson	18/01/2016	29/01/2016		-
	Contract Team to undertake training relating to their role	Tracey Ginn	18/01/2016	29/01/2016		-
	Set up CCRP representatives on Broadcare to allow access to panel information	Paul Martin	04/01/2016	29/01/2016		
	Review impact of document on staff and processes	Paul Martin	29/04/2016	06/05/2016		
						-

List of organisations engaged with in producing the central and West Norfolk Guide to NHS Adult Continuing Healthcare for patients and their carers

The following meetings were organised as part of the stakeholder engagement work for the CHC policy development workstream.

Where possible, the notes/minutes of these, as compiled by Max Bennett, have been attached. These were circulated following those meetings.

In addition, Amanda Cousins also had separate meetings with Mark Harrison and Caroline Fairless-Price to ensure that they were kept fully in the loop and provided them a further opportunity to make their views known. Amanda is able to provide the dates/details for those.

May 12 – Breckland Council offices, Dereham: briefing meeting for Norfolk Health and Overview Scrutiny Committee (HOSC) and Healthwatch Norfolk
Stakeholders attendees:
Councillor Michael Chenery (Norfolk HOSC member);
Maureen Orr (Norfolk HOSC scrutiny manager);
Ann Stephens (Enangement Manager, Healthwatch Norfolk)

June 1 – Breckland Council offices, Dereham: briefing meeting for key stakeholders
Stakeholder attendees:
Joy Stanley, Carers Council for Norfolk
Ian Hubbard, Opening Doors
Peter, Opening Doors advocate
June, Opening Doors advocate
Joyce Hopwood, chairman Norfolk Older People's Strategic Partnership
Mary Fisher, Making it Real Norfolk
Anne Biggar, Alzheimer's Society Norfolk
Ian Johnson, director Headway Norfolk
Joan Inglis, headway Headway, Norfolk – joan.inglis@headway-nw.org.uk
Mark Harrison, Equal Lives

August 6 – Breckland Council offices, Dereham: policy development workshop
Stakeholder attendees:
Anne Biggar, Alzheimer's Society Norfolk
Joy Stanley, Carers Council for Norfolk

August 20 – Lakeside 400: policy development workshop
Stakeholder attendees:
Mark Harrison, Equal Lives
Mary Fisher, Making it Real Norfolk
Caroline Fairless-Price, Norwich Independent Living

September 2 – Lakeside 400: policy development workshop
Stakeholder attendees:
Joyce Hopwood, chairman Norfolk Older People's Strategic Partnership

October 29 – Breckland Council offices, Dereham: stakeholder briefing/progress update

Stakeholder attendees:

Ian Hubbard, Opening Doors
Carole Andrews – Opening Doors advocate
Carol Barber – Opening Doors advocate
Joyce Hopwood, chairman Norfolk Older People's Strategic Partnership
Joy Stanley, Carers Council for Norfolk
Mark Johnston, Alzheimer's Society Norfolk

NOTE: Mark Harrison and Caroline Fairless-Price were both invited to this meeting; he failed to respond and she was unable to attend on this date.
However, it's worth checking with Amanda as she did meeting with separately Mark and Caroline and briefed them independently.

Children's Mental Health Services in Norfolk – areas for further scrutiny

Report from Maureen Orr, Democratic Support and Scrutiny Team Manager

This paper sets out the areas identified for further scrutiny by members of Norfolk Health Overview and Scrutiny Committee (NHOSC) following the Child and Adolescent Mental Health Services (CAMHS) commissioners and providers' attendance at committee on 3 December 2015.

1. Background

1.1 On 3 December 2015 NHOSC received a report from CAMHS commissioners addressing issues and concerns that were set out in scrutiny terms of reference agreed by the committee on 3 September 2015. NHOSC also received Norfolk and Waveney's Local Transformation Plan, which had recently attracted £1.9m per annum additional recurrent funding for CAMHS in Norfolk.

1.2 In addition the committee received background information from Public Health on levels of need, information from NHS England Specialised Commissioning about Tier 4 services and a paper from Healthwatch Norfolk about its research on young people's experience of the services in Norfolk.

1.3 During the meeting NHOSC decided that it would to return to the subject of Children's Mental Health Services in Norfolk at a future meeting. Members were asked to inform the Democratic Support and Scrutiny Team Manager of the areas and issues that they wished to scrutinise on that occasion. These were to be brought to today's meeting for discussion and approval by the committee, prior to the CAMHS commissioners and other relevant attendees being invited to attend a future meeting.

2.0 Areas for scrutiny

2.1 Members wish to look at both the implementation of the LTP, using the £1.9 million additional funding, and the evidence of outcomes achieved by the Plan. It therefore seems sensible for NHOSC to do this in two stages, with the first meeting focusing on LTP implementation issues and the second at a later date focusing on development of the services and outcomes achieved by the Plan.

2.2 The following have been raised as areas for scrutiny at each stage:-

Stage 1 – Implementation of the LTP

1. Has the £1.9 million additional funding promised for implementation of the LPT been received in full by the Clinical Commissioning Groups and fully allocated to services for children and adolescents' mental health?

2. Details of progress with recruitment of the additional staff identified in the LTP and skills training for others involved with mental health issues in universal settings:-
    a. How many and which type of staff have been employed using the transformation funding?
    b. What specific training is delivered to front line staff in schools and GP surgeries?

3. What is the LTP expected to deliver in terms of improved mental health support in schools and educating children in mental wellbeing?

4. Have the results of Healthwatch Norfolk's research on user experiences of tier 1-2 and tier 3 services (published in early 2016) been taken into account in the implementation of the LTP?

5. What was the outcome of the evaluation of Department for Education (DfE) funded work by the Benjamin Foundation linked to Compass Outreach / Compass Schools (this was raised at 3 December 2015 NHOSC meeting in the context of Looked After Children) and how does this affect implementation of the LTP?

6. How do drug and alcohol services (Matthew Project for under 18s; Norfolk Recovery Partnership for over 18s) link with CAMHS services as they develop in the LTP?

7. What are the current waiting times (at all tiers) for children's mental health services?

8. The LTP said that a range of key performance indicators (KPIs) would be developed. What KPIs are now in place, and what still needs to be agreed?

9. Self-harm - an area of special concern:-

    a. What services are available now (before full implementation of the LTP) to help children who have begun to self-harm and what additional service will the LTP put in place?
    b. What are the benchmarks regarding self-harm at the start of LTP implementation against which success of the Plan can be measured; e.g. numbers of children self-harming and types of self-harm (e.g. cutting, burning, overdose); numbers of attempted or successful suicide attempts; numbers of children attending A&E for self-harm on more than one occasion. Members have asked to see numbers 'before' implementation of the LTP.

10. Looked After Children – an area of special concern:-

    a. Is an assessment of mental health included in the initial health assessment for Looked After Children (LAC) and in subsequent annual assessments?
    b. Is there a process for linking the annual Strengths and Difficulties Questionnaire (SDQ) completed for each Looked After Child to the annual health assessments, so that mental health needs identified in the SDQ are picked up?
    c. If an annual health assessment or SDQ identifies a mental health need, does it automatically trigger action to meet the child's needs?
    d. How are mental health needs recorded through the annual health assessment and SDQ?
    e. Does the County Council, as corporate parent, oversee that the mental health needs of LAC are treated appropriately and at pace?

2.3 **Stage 2 – development of the services and early outcomes achieved by the LTP**

1. What are the current waiting times for children's mental health services (all tiers) and how have they been affected by the LTP?

2. What is the current performance against all of the KPIs in the LTP?

3. What has been the effect of the new Bank of staff for short notice deployment in a crisis (within 2 hours)?

4. What is the situation regarding staffing of the services? Has it been possible to recruit all the additional staff envisaged in the LTP and what is the situation regarding staff turnover?

5. Self harm – what is the current situation against the pre LTP benchmarks and national benchmarks?

6. Looked After Children – what is the current situation regarding delivery of Annual Health Assessments and Strengths and Difficulties Questionnaires, and linkage between the two?

Additional areas for scrutiny at stage 2 may be identified after the committee carries out the stage 1 scrutiny.

3. Action

3.1 NHOSC is asked to:-

(a) Approve the areas for scrutiny set out in paragraphs 2.2 and 2.3 above, or amend the list as appropriate.

(b) Decide on a date for the stage 1 scrutiny and stage 2 scrutiny. The following dates are proposed:-

Stage 1 – 21 July 2016
Stage 2 – after a full year of operation under the Local Transformation Plan changes (i.e. in April 2017)

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Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2016

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
14 Apr 2016	Service in A&E following attempted suicide or self-harm episodes - an update to the report presented in April 2015 by Norfolk and Suffolk NHS Foundation Trust and the three acute hospitals.	
26 May 2016		
21 July 2016	Children's mental health services in Norfolk – scrutiny of the implementation of the Local Transformation Plan	*Subject to agreement by NHOSC on 25 Feb 2016*
8 Sept 2016		

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for report to the Committee / items in the Briefing 2016

25 Feb 2015 (in the NHOSC Briefing) – Health Assessments for Looked After Children - an update to the piece in the October 2015 Briefing. Originally scheduled for 14 April 2016 NHOSC Briefing, this item was brought forward to 25 February 2015 Briefing at the request of members of NHOSC.

13 Oct 2016 – Ambulance Response Times and Turnaround Times in Norfolk – an update from East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and North Norfolk CCG (follow up to the reports in October 2015).

13 Oct 2016 – Stroke services in Norfolk – an update on progress with the 2014 NHOSC recommendations and the outcome of the Review of Stroke Rehabilitation in the Community, November 2015.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mr Bert Bremner (substitute Mrs M Stone)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Mrs S Bogelein)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Norfolk Health Overview and Scrutiny Committee 25 February 2016
Glossary of Terms and Abbreviations

ADASS	Association of Directors of Adult Social Services
APC	Admitted patient care
AQP	Any qualified provider
A&E	Accident And Emergency
AF	Atrial fibrillation – a heart condition that causes an irregular on often abnormally fast heart rate
AMD	Age related Macular Degeneration
ASD	Autistic spectrum disorders
BME	Black minority ethnic
CAMHS	Child And Adolescent Mental Health Services
CCG	Clinical commissioning group
CCRP	Complex Care Review Panel
CEO	Chief Executive Officer
CEP	Community Engagement Panel
CHC	Continuing Healthcare
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CRHT	Crisis Resolution Home Treatment
CRT	Crisis Response Team
CSU	Commissioning Support Unit
DfE	Department for Education
DoLS	Deprivation of Liberty Safeguards
DST	Decision support tool
DTOC	Delayed transfer of care
DWP	Department of Work and Pensions
ECHR	European Court of Human Rights
EMA	Emergency admissions
FRSG	Financial Recovery Steering Group
Five Year Forward View	Published by NHS England on 23 October 2014 the Five Year Forward View sets out a new shared vision for the future of the NHS based around the new models of care. It was developed by Health Education England, Public Health England, NHS Improvement (formerly Monitor and national Trust Development Authority), the Care Quality Commission and NHS England.
GB	Governing Body
GP	General Practitioner
GY&WCCG	Great Yarmouth And Waveney clinical commissioning group
HOSC	Health Overview and Scrutiny Committee
HRA	Human Rights Act 1998
HWB (H&WB)	Health And Wellbeing Board

IAPT	Improving Access to Psychological Therapies
ICA	Individual case arrangement
ICES	Integrated Community Equipment Stores
IFRP	Individual Funding Request Panel
IMCA	Independent Mental Capacity Advocate
IV	Intra venous
IVF	In-Vitro Fertilisation
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked After Children
LD	Learning difficulties / disabilities
LTP	Local Transformation Plan
MCA	Mental Capacity Act 2005
MDT	Multi-disciplinary team
MIND	A national association for mental health
MSK physio	Musculoskeletal physiotherapy
MSP	Managing Successful Programmes – a set of principles and process for managing a programme
NANSA	Norfolk and Norwich Scope Association – a local charity for people with disabilities in Norfolk
NCC	Norfolk County Council
NCCG	Norwich Clinical Commissioning Group
NEL CSU	North East London Commissioning Support Group
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
NNCCG	NHS North Norfolk Clinical Commissioning Group
NNUHFT	Norfolk and Norwich University Hospitals NHS Foundation Trust
NOAC	New oral anticoagulants – prescribed to help prevent stokes in people with atrial fibrillation (AF)
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OP	Outpatient
OPCC	Office of the police and crime commissioner
OT	Occupational therapy
PB	Personal budget
PHB	Personal health budget
PIN	Prior Information Notice
PMO	Programme Management Office
PRINCE2	A framework for managing projects

QIPP	Quality, Innovation, Productivity and Prevention: A DoH agenda, looking at health economy solutions to meet local financial challenges
RNIB	Royal National Institute of the Blind
SALT	Speech and language therapy
SDQ	Strengths and difficulties questionnaire
Section 136	The police can use section 136 of the Mental Health Act to take people to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and is in need of care.
SNCCG	South Norfolk clinical commissioning group
STP	Sustainability and Transformation Plan
TBC	To be confirmed
ToR	Terms of reference
VfM	Value for money
WiC	Walk-in centre
WSH	West Suffolk Hospital