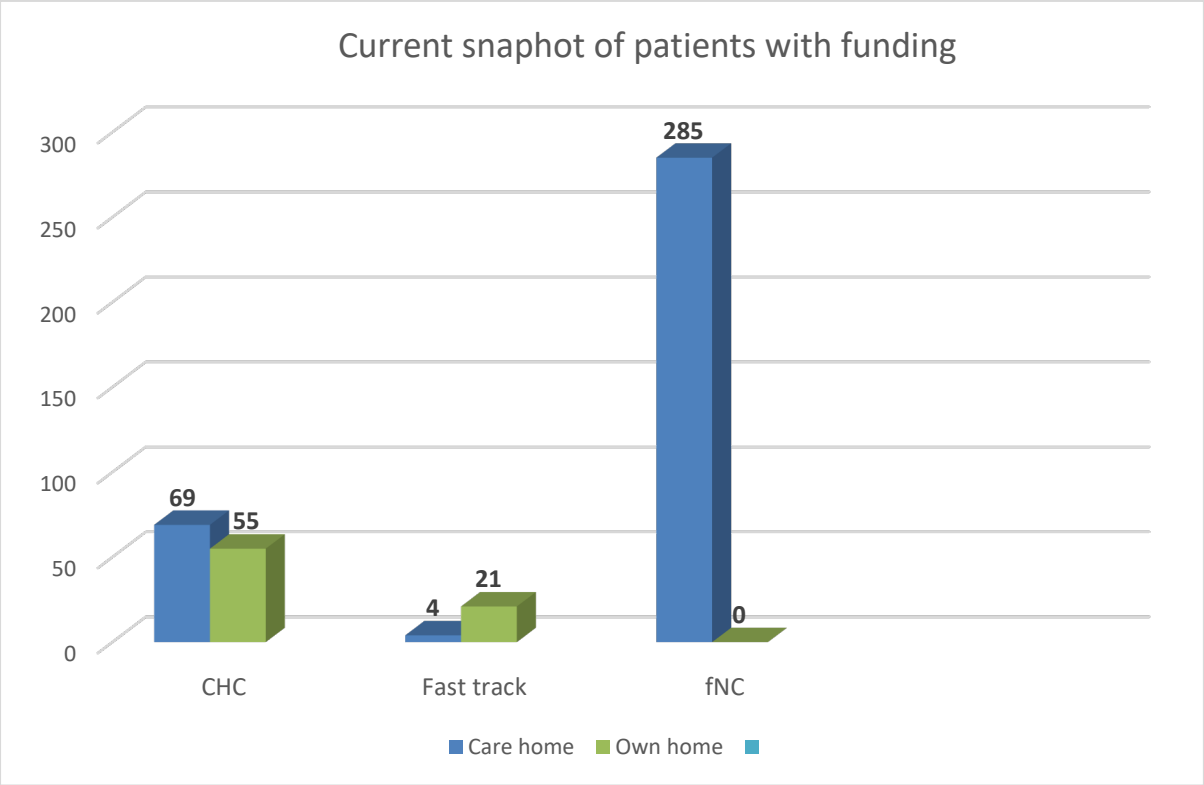
Great Yarmouth and Waveney Clinical Commissioning Group

Norfolk Health Overview and Scrutiny Committee
NHS Continuing Healthcare
Appendix B – NHS Great Yarmouth and Waveney Clinical Commissioning Group

General contextual information:
Numbers currently receiving NHS Continuing Healthcare CHC (residential and domiciliary) as at 09 November 2018:
NHS Great Yarmouth and Waveney Clinical Commissioning Group (NHS GYW CCG)



Trend in the numbers of patients eligible to receive CHC in the past 12 months NHS GYW CCG:

Month	Newly eligible for CHC in month	Individuals in month eligible for CHC
November 2017	6	183
December 2017	5	183
January 2018	3	175
February 2018	2	170
March 2018	3	161
April 2018	6	156
May 2018	5	161
June 2018	5	152
July 2018	7	145
August 2018	0	141
September 2018	3	134
October 2018	4	129

Compliance against the 28 day assessment target in the past year (showing the trend month by month).

NHS GYW CCG has been compliant with the minimum data set of 80% of new full considerations for CHC being completed within 28 days:

October 2017	96%
November 2017	100%
December 2017	100%
January 2018	95%
February 2018	95%
March 2018	91%
April 2018	81%
May 2018	91%
June 2018	100%
July 2018	100%
August 2018	89%
September 2018	100%
October 2018	95%

There has been a strong commitment by both Norfolk and Suffolk County Councils and NHS GYW CCG to complete all new full considerations for CHC within 28 days of referral date. In the months whereby 100% has not been achieved this has been because of individual/representative choice or social worker/CHC Nurse availability (including staff sickness, inclement weather etc.). Consistently achieving the 28 day assessment target is a priority for NHS GYW CCG as it lends itself to timely, quality assessments that lead to an improved individual/representative experience of the service that we deliver.

Numbers of complaints and themes since Feb 2018.

Complaints relating to Previously Unassessed Periods of Care: On 21 January 2018, NHS GYW CCG received 25 cases back from North East London Commissioning Support Unit (NEL CSU). These were retrospectively assessed by NEL CSU. Letters of complaint to NHS GYW CCG were in relation to lack of progress and lack of communication associated with furthering the appeals process. Five complaints since February 2018 have been received – all from Claims companies.

Complaints related to assessment process: Since February 2018, NHS GYW CCG has received two complaints about the assessment process – one from an individual and one from their MP. The complainant was dissatisfied that a Decision Support Tool (DST) would be held without separating the roles of Lead Co-ordinator and health Multidisciplinary Team Member. The complainants were informed that the National Framework for NHS Continuing Healthcare permits this arrangement.

Complaints related to commissioning of care: Since February 2018, three complaints have been received by NHS GYW CCG about CHC commissioning. Two complaints were from a representative dissatisfied with the care commissioned for a CHC eligible individual. This complaint was resolved by commissioning a new provider for the individual. Third complaint was from a jointly funded individual and their representatives about their commissioned care; a meeting was held with senior NHS GYW CCG staff to discuss the issues arising.

Capacity of the assessment service (caseload numbers and staff capacity, including info on staff vacancy levels).
The team model is an end to end service. This means that a CHC Nurse will commence and complete the CHC journey with an individual from Checklist through to DST and then case management and review, if the individual is eligible to receive CHC. Therefore caseloads reflect this model of working and are deliberately low (currently up to 20 CHC eligible cases per CHC nurse) to allow for a good standard of case management (care planning, evaluation and review). In addition to this, each CHC nurse is responsible for a geographical area centred round a care home with nursing.

The CHC nurse will also be responsible for all NHS-funded Nursing Care (NHS-fNC) activity associated with this care home (up to 60 beds) and will also be allocated all Checklists associated with other care homes and residential addresses that are received within their geographical area. Relationship building to support care homes and care home quality reviews are all the responsibility of caseload holders. Currently the team employs seven CHC nurses (one of whom is currently on maternity leave) in this function of the team. An additional nurse has been recruited to commence in post January 2019. There are currently no active vacancies within the team. Staff retention is good.

Numbers of people that have had their CHC or Funded Nursing Care withdrawn since NCCP have been completing the reviews and the numbers where exceptional decisions have been made to continue funding despite no longer being eligible.

Since October 2017, 12 individuals have been found to be no longer eligible to receive CHC. No exceptional decisions have been made to continue funding after CHC has been withdrawn.

Since October 2017, 0 individuals have been found to no longer be eligible for NHS-fNC.

It is the expectation of NHS England that as numbers of individuals in nursing home beds receiving CHC level off, the numbers of residents in these care homes receiving NHS-fNC will increase. This has been the reality for NHS GYW CCG since 2014-15 and demonstrates responsiveness to changing needs of individuals and partnership working with social care colleagues.

Information about the Discharge to Assess pathways at each of the three acute hospitals in Norfolk (NCCP to provide info for the NNUH and QEH; GYW CCG for the JPUH), including:-

In January 2018, NHS GYW CCG introduced Discharge to Assess (D2A) for individuals assessed to require complex discharge planning – also known locally across the health and social care system as Pathway 3.

Two NHS GYW CCG CHC nurses in-reach permanently into JPUH and are co-located with their social care colleagues.

The D2A model was developed to focus upon the maturity of the relationships between CCG and social care colleagues. It was judged by health and social care leaders that there is sufficient level of trust and mutual respect for professionals to have a 'conversation' about the best pathway for an individual patient on leaving hospital. The conversation model puts the person at the centre, aims to discharge the individual to a location in which they will be able to remain, does not falsely raise public expectations of on-going health funding post discharge and aims to ensure that the care commissioned on discharge will meet needs.

The pathway was designed to continue to reflect health/social care discharges that took place prior to the commencement of the D2A model.

If patients are assessed to require the health pathway on discharge, NHS GYW CCG will fund the individual's care on discharge for 28 days. Within the 28 days a full DST will be completed. If the individual is eligible to receive CHC health funding continues. If the individual is not eligible to receive CHC funding, health funding ceases on day 28 post discharge.

All pathway 3 individuals are followed up post-discharge:

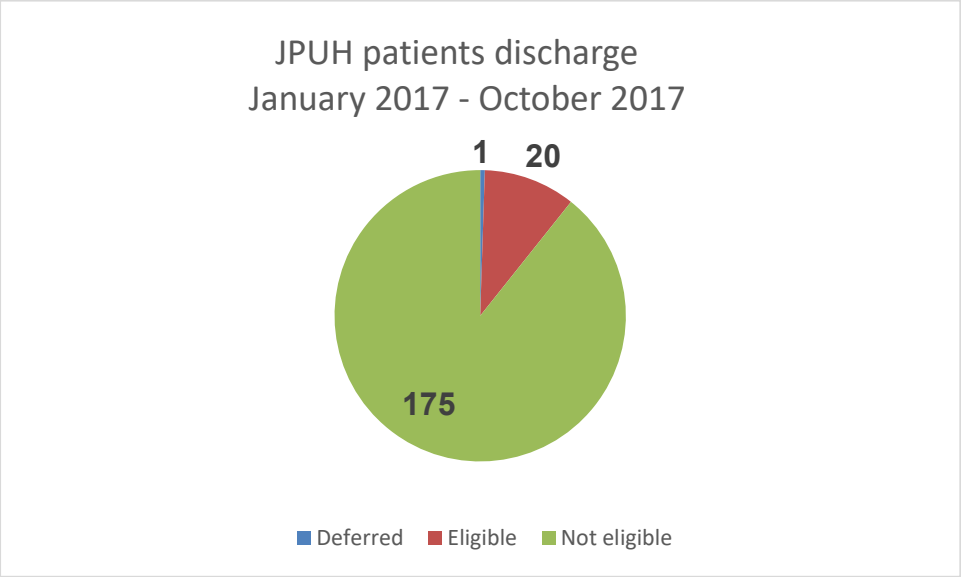
CCG follow-up post discharge	**Local Authority follow up post discharge**
Discharged on health pathway	Individuals discharged with social care funding
Discharged as a self-funder (alerted by social care colleagues)	
Discharged to a care home with nursing	

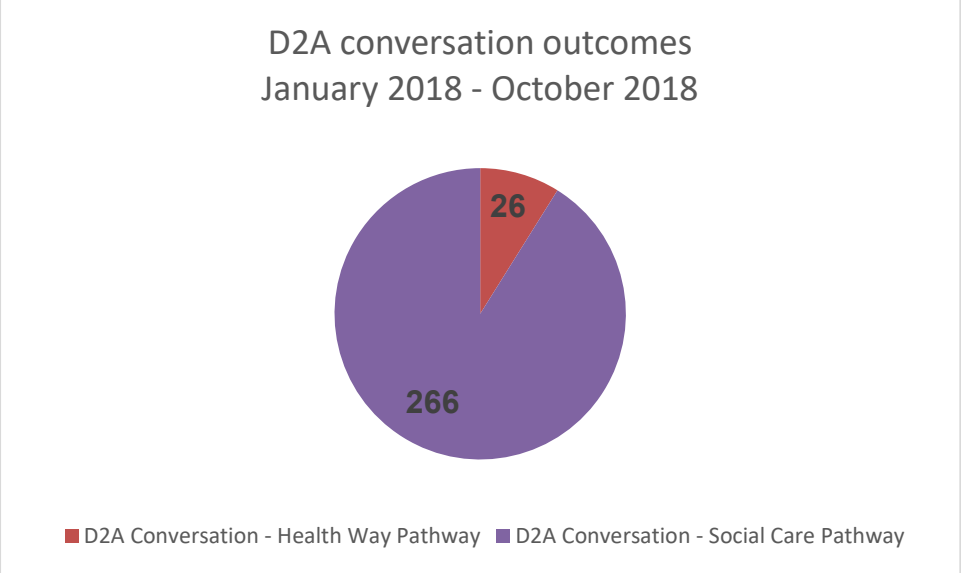
There is no financial risk to social care/individual as any individual followed up after discharge from hospital who is found at review to be eligible for CHC will be reimbursed back to the date of discharge from hospital – thus far this has applied to four individuals (Norfolk = 3).

There have been no complaints associated with the D2A pathway since it was implemented. The model has proved popular with health and social care professionals and has since been adapted for use at Norfolk and Norwich University Hospital.

Numbers accessing the pathway at each hospital
James Paget University Hospital (JPUH)

In order to put current data into context, the numbers accessing the full CHC process (that is Checklist and DST) in JPUH in the same period in 2017 are illustrated below:





Breakdown by County Council:

LA	Health pathway	Local Authority pathway
Norfolk	12 (46%)	147 (55%)
Suffolk	14 (54%)	119 (45%)

Numbers converted to eligible / not eligible for CHC after the Discharge to Assess pathway period.

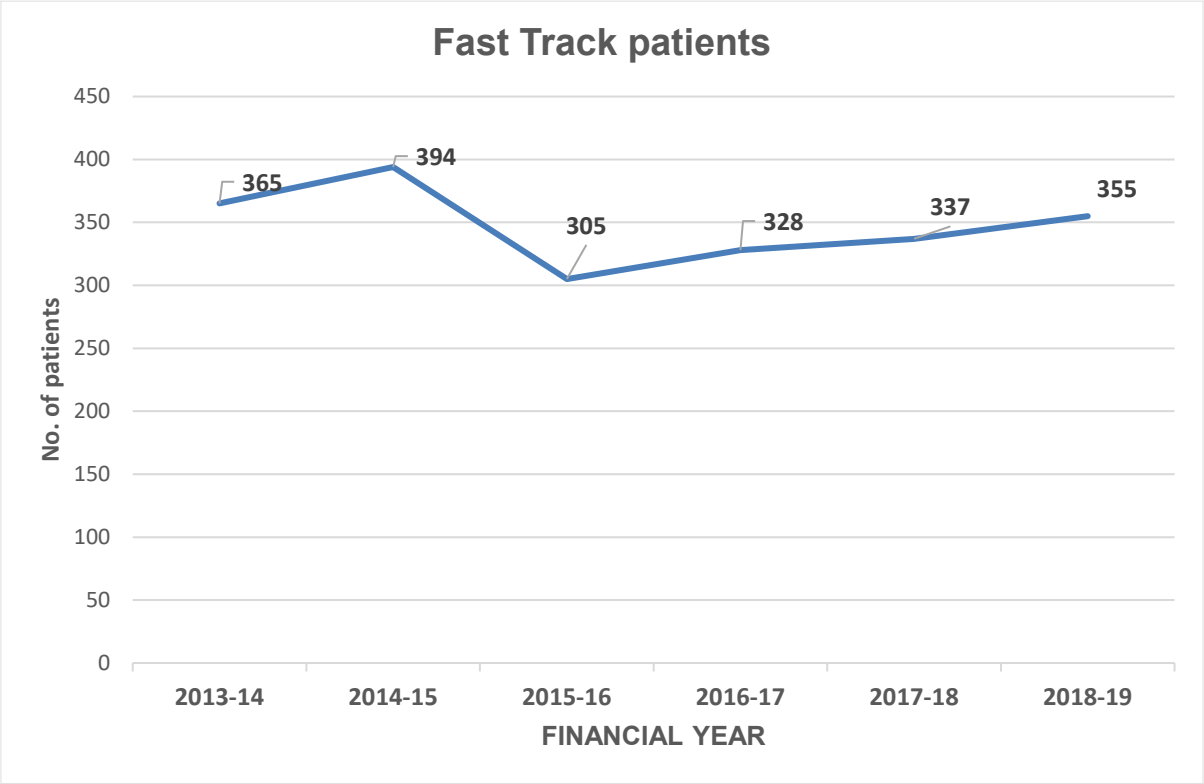
NHS GYW CCG health pathway status after 28 days:

Status	**Number of individuals (N = Norfolk)**
Health funding continues (CHC eligible)	7 N = 2
Health funding ceases (not CHC eligible)	12 N = 7
Joint care	1 N = 0
Patient deceased	6 N = 3

Number of beds used for Discharge to Assess in relation to each of the three hospital areas.
Of the 26 individuals accessing health funding on discharge from JPUH, 24 transferred to a care home bed on discharge from hospital.

Of the 266 individuals discharged from JPUH without health funding, 240 transferred to a care home bed on discharge from hospital, (10% returned home).

Fast Track:-
The number of Fast Track awards year by year for the past five years.



The average duration of Fast Track award funding
The average duration of Fast Track award funding 12 month period November 2017 to October 2018 = 22 days

The proportion of fast track patients placed within three days of referral
This information is not currently an NHS England data set for collection. However NHS GYW CCG recognises the value of having this data readily available; this will be collected moving forward.

On receipt of a properly completed Fast Track referral the dedicated NHS GYW CCG Fast Track Nurse will begin to commission care. In most cases placements are currently exceeding three days due to individual/representative choice/the desire to view care homes when a care bed is required or lack of market capacity, especially in difficult rural areas for individuals requiring home care. When there is a lack of market capacity the Out of Hospital Team provided by East Coast Community Healthcare are engaged to provide care as an interim measure when capacity is available. Every effort to discharge the individual in a timely way is made whilst also maximising individual choice.

Numbers of Fast Track patients that plateau and require ongoing care and who this is provided by

Financial Year	Fast Track patient plateaus – DST – Eligible for CHC	Fast Track patient plateaus – DST – Not Eligible for CHC – referred to relevant local authority for on-going care
2015/2016	4	10
2016/2017	4	7
2017/2018	0	3
2017 to date	1	8

NHS GYW CCG are currently in the process of up-skilling JPUH ward staff to Fast Track patients who have a rapidly deteriorating condition that may be entering a terminal phase. Therefore it is expected that there may be a slight raise in the number of patients that plateau that go on to have a 'not eligible' decision for CHC. This is under continuous review and remedial steps are being taken when necessary regarding education and training.

A breakdown of CHC and Fast Track considerations and eligibility by CCG area and compared to national benchmarking

Data taken from published statistics Q2 2018-19 Year to Date			CHC	FAST TRACK	fNC
CCG Code	Organisation	Organisation Type	Per 50k	Per 50k	Per 50k
Q79	NHS England Midlands and East (East)	Regional Team	56.32	55.68	69.33
06M	NHS Great Yarmouth and Waveney CCG	CCG	59.00	55.16	102.67

Numbers of CHC checklists completed

Period - January 2018 to October 2018

Checklist Outcome	Norfolk	Suffolk
Negative	82	122
Positive	96	141
Grand Total	178	263

Numbers of shared care agreements between CCG and Norfolk County Council, broken down by Older People, Physical Disabilities, Learning Disabilities and Mental Health as a primary category

As at 26 November 2018, NHS GYW CCG jointly fund with Norfolk County Council the following care packages:

Category	CHC	Adult MH/LD	Total
Older People	0	0	0
Physical Disabilities	7		7
Learning Disability	1	12	14
Mental Health	1	42	43

Numbers of reviews of individual CHC packages of care completed in 2018 (i.e. to check the suitability of the CHC package in place, not primarily to re-assess eligibility).

In October 2018 the revised version of the National Framework for NHS Continuing Healthcare was implemented. For the first time reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.

Since October 2018, NHS Great Yarmouth & Waveney Clinical Commissioning Group has changed the way that data is collected about reviews undertaken. This data will be available to access early in 2019.

Changes in the local system to reflect the revised National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018

In order to prepare for the implementation of the revised National Framework for NHS Continuing Healthcare, October 2018 the following has been undertaken:

- NHS GYW CCG Local Resolution Policy has been agreed by the CCG's Clinical Executive Committee and is published on NHS GYW CCG's website - as per the National Framework for NHS Continuing Healthcare 2018 revised.
- Training programme for health and social care professionals – as of 24 November 2018 74 Norfolk and Suffolk health and social care staff have been trained regarding the changes to the Framework with more training sessions booked
- Revised CHC Tools have been shared with system partners

- NHS GYW CCG has developed commissioning care plans and review paperwork in order to comprehensively capture the quality and quantity of care required by an individual and how their needs will be met. This commissioning paperwork will be pivotal to demonstrate significant changes in an individual's presentation that result in a need to complete a further DST to individuals, their representatives and local authority colleagues. This paperwork has been positively received and is being adopted by NHS England as examples of on-going records that can be used when an individual is eligible to receive CHC
- The Disputes Policy currently in use by NHS GYW CCG, Suffolk CCGs and Suffolk County Council is being considered by Norfolk Continuing Care Partnership and Norfolk County Council to consider if it can be adapted for use across the entirety of Suffolk and Norfolk health and social care system
- Other changes, such as the verification of recommendations regarding CHC within 2 days of receipt by NHS GYW CCG, were already standard practice

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