Norfolk Health Overview and Scrutiny Committee
6 December 2018
Item no 6

Continuing Healthcare

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

A report on the management of NHS continuing healthcare by Norfolk Continuing Care Partnership for the four Clinical Commissioning Groups (CCGs) in central and west Norfolk and by Great Yarmouth and Waveney CCG for its area.

1. Purpose of today's meeting

1.1 The focus areas for today's meeting are:-

(a) An update on the management of continuing healthcare (CHC) in Norfolk.

(b) Norfolk Continuing Care Partnership's (NCCP) progress on issues previously raised by Norfolk Health Overview and Scrutiny Committee. (These related only to the service in the central and west Norfolk area).

(c) Examination of how local systems are changing to take account of the *Revised National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, October 2018.*

(d) Examination of how the fast track CHC system operates in Norfolk.

1.2 NCCP and Great Yarmouth & Waveney CCG have been asked to provide the following information for the areas they cover:-

- General contextual information:-
    - Numbers currently receiving CHC (residential and domiciliary).
    - Trend in the numbers of patients eligible to receive CHC in the past 12 months.
    - Compliance against the 28 day assessment target in the past year (showing the trend month by month).
    - Numbers of complaints & themes since Feb 2018.
    - Capacity of the assessment service (caseload numbers and staff capacity, including info on staff vacancy levels).
    - Numbers of people that have had their CHC or Funded Nursing Care withdrawn since NCCP have been completing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.

- Information about the Discharge to Assess pathways at each of the three acute hospitals in Norfolk (NCCP to provide info for the N&N and QEH; GY&W CCG for the JPH), including:-

    - Description of the pathway at each of the 3 hospitals
    - Numbers accessing the pathway at each hospital
    - Numbers assessed and declined at each hospital
    - Numbers converted to eligible / not eligible for CHC after the Discharge to Assess pathway period.
    - Number of beds used for Discharge to Assess in relation to each of the three hospital areas.

- Fast track:-

    - The number of fast track awards year by year for the past 5 years.
    - The average duration of Fast Track award funding.
    - The proportion of fast track patients placed within 3 days of referral
    - Numbers of fast track patients that plateau and require ongoing care and who this is provided by.

- A breakdown of CHC and fast track considerations and eligibility by CCG area and compared to national benchmarking.

- Numbers of CHC checklists completed.

- 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.

- 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).

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

- Update on issues previously raised by NHOSC (**for NCCP only**)

    - Outcome of NCCP's work with Healthwatch Norfolk to improve communication with patients / families

    - Whether it has been possible to introduce real-time feedback from service users

NCCP's report for the central and west Norfolk area is attached at **Appendix A**.

Great Yarmouth and Waveney (GY&W) CCG's report for its area is attached at **Appendix B**.

Representatives from NCCP, GY&W CCG and Norwich CCG (representing central & west Norfolk) will attend NHOSC to answer Members' questions.

1.3 Healthwatch Norfolk has been working with NCCP to improve NHS continuing healthcare communication with patients and families in the central and west Norfolk area. A paper outlining this work is attached at **Appendix C**. A representative from Healthwatch will attend to present the paper and answer any questions that may arise.

2. Background

2.1 The continuing healthcare assessment process

2.1.1 Patients who are assessed as being eligible for continuing healthcare receive healthcare funded by the NHS (i.e. free at the point of use) on an ongoing basis, dependent on subsequent eligibility reviews.

The National Audit Office (NAO) report '*Investigation into NHS continuing healthcare funding*', published on 5 July 2017, included a diagram that clearly and simply illustrated the CHC assessment process (see Diagram 1 overleaf - the numbers shown are for the whole of England in 2015-16).

The full NAO report, which covered issues including the length of the assessment process, access to funding, the cost, variation in access to CHC funding and oversight and monitoring of access, is available on their website:-

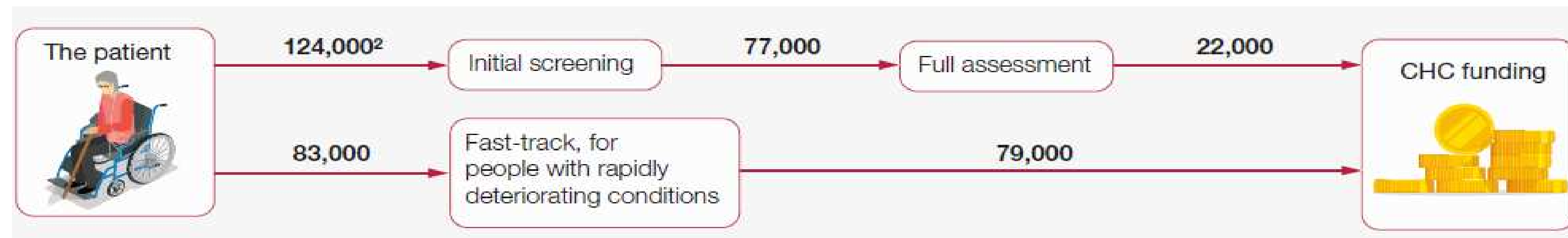
https://www.nao.org.uk/wp-content/uploads/2017/07/Investigation-into-NHS-continuing-healthcare-funding-1.pdf

The NAO investigation found that in 2015-16 there was significant variation between CCGs in eligibility for CHC funding that could not be fully explained by the demographics of the population:-

- The number of people that received, or were assessed as eligible for, funding ranged from 28 to 356 people per 50,000 population in different CCG areas.
- The estimated proportion of people that were referred for fast track, or who were identified as needing a full assessment, and subsequently assessed as eligible ranged from 41% to 86%, excluding the 5% of CCGs with the lowest and highest percentages.

The CHC process

For most people the assessment process for CHC funding involves two stages



NHS England recognises that the current assessment process raises people's expectations about whether they will receive funding and does not make best use of assessment staff

Notes

1 All numbers and percentages are for 2015-16 unless stated otherwise. Numbers for the CHC process are rounded to the nearest 1,000.

2 These figures are estimates.

Source: National Audit Office

2.2 The Discharge to Assess (D2A) process

2.2.1 Since 2016 NHS England (NHSE) has encouraged the establishment of Discharge to Assess pathways. In 2017-18 and 2018-19 there have been financial incentives for CCGs to carry out 85% of CHC assessments outside hospital[1].

Discharge to Assess is defined in the Quick Guide on NHSE's website as follows:-

'Where people who are clinically optimised[2] and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

People on the D2A pathway are NHS funded, i.e. care is free to the patient) until:-

(a) they are assessed as eligible for NHS CHC, i.e. care continues in the longer-term, funded by the NHS and free to the patient

(b) or not eligible for NHS CHC, i.e. care continues but is self-funded by the patient or paid for by social care on a limited means tested basis.

The Quick Guide to D2A is available through the following link:-
https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

2.2.2 The Quick Guide does not specify how a decision on who is eligible for the D2A pathway should be made but it is clearly an important decision, which may affect the longer-term future for the patient and their family.

Each of the three acute hospitals in Norfolk have introduced their own version of a Discharge to Assess pathway and have their own systems for deciding eligibility based on questions about the patient's condition. The decisions are made by both health and social care staff at the hospitals.

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[1] Source - the National Audit Office (NAO) report '*Investigation into NHS continuing healthcare funding*', 5 July 2017. The financial incentive is awarded through the quality premium programme, which rewards CCGs for improvements to the quality of the services that they commission.

[2] Clinically optimised is described as the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge' 'medically optimised.' NHS England (2015).
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

The reports at Appendix A and B set out the details of the three D2A pathways.

2.3 **Management of CHC in Norfolk**

2.3.1 On 1 November 2017 Norwich, North Norfolk, South Norfolk and West Norfolk CCGs established an in-house partnership, Norfolk Continuing Care Partnership (NCCP), to manage CHC in their areas. Great Yarmouth and Waveney CCG was not part of that arrangement and manages CHC in its own area in-house.

2.3.2 NCCP is hosted by Norwich CCG, which has established an Operational Management Group to oversee its operational activities.

2.3.3 The governance structure for NCCP includes a Strategic Board with director level membership from all five CCGs and Norfolk County Council.

2.4 **Local efficiency savings in NHS CHC**

2.4.1 During the period of financial constraint which has affected all public services in the past decade, the NHS has operated a 'Quality, Innovation, Productivity and Prevention (QIPP)' challenge. This involves setting QIPP targets for savings to be delivered via specific improvements in service or ways of working.

2.4.2 According to figures published in reports to their Governing Bodies, the five local CCGs were planning for QIPP or efficiency savings of approximately £3.7m in in continuing care in 2018-19. The overall budget for the continuing care service across the five is approximately £65.2m. The latest report to the Governing Bodies show that up to October 2018 they have achieved more savings than expected (off-set against some other areas of activity where savings are not being realised at the expected level).

2.5 **Previous reports to NHOSC**

2.5.1 On 28 May 2015 NHOSC received a presentation about proposed changes to CHC local implementation policy in the Norwich, North Norfolk, South Norfolk and West Norfolk CCG areas. At that stage North East London Commissioning Support Unit (CSU) was managing delivery of CHC.

2.5.2 The four CCGs emphasised that they were not proposing and had not made any changes to the National Framework for NHS Continuing Healthcare, which is set at national level and not within the power of local CCGs 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 as appropriate
- How interfaces with joint funding arrangements should be applied.

The four CCGs' proposals were aimed at achieving an open and transparent approach to delivering NHS CHC with fairness and equity across their area and comprehensive, helpful documents for the patients and public explaining everything there was to know about NHS CHC in central and west Norfolk.

2.5.3 NHOSC was interested in the outcome of the new policy and processes in terms of its impact on patients and the local health and social care system. The committee received update reports from the four CCGs and the CSU on 25 February 2016 and 23 February 2017.

In February 2017 NHOSC made five recommendations to the four CCGs concerning:-

- communication with patients and families regarding the CHC process (including advocacy for those who need it)
- proactive quality monitoring of CHC
- widely accessible surveying of patients & families experience of CHC
- partnership working with relevant agencies to ensure planning for an effective safety-net service for CHC patients on occasions when their usual provider is unable to deliver
- speeding up the process between referral and assessment for CHC eligibility to meet the 28 day standard.

The Healthwatch Norfolk paper at Appendix C shows good progress by NCCP on the communication, quality monitoring and surveying points.

2.5.4 The last report to NHOSC was on 22 February 2018 by which stage NCCP had taken over day-to-day management of CHC from North East London CSU (with a 'lift and shift' of staff from the CSU). The report included details of the CCGs' & NCCP's responses to the committee's Feb 2017 recommendations, an update on progress and details of the strategic priorities and development phases for NCCP's management of the CHC service. The report is available on the County Council website via the following link:-
NHOSC 22 Feb 2018 Continuing Healthcare (see Reports, 7 App B)

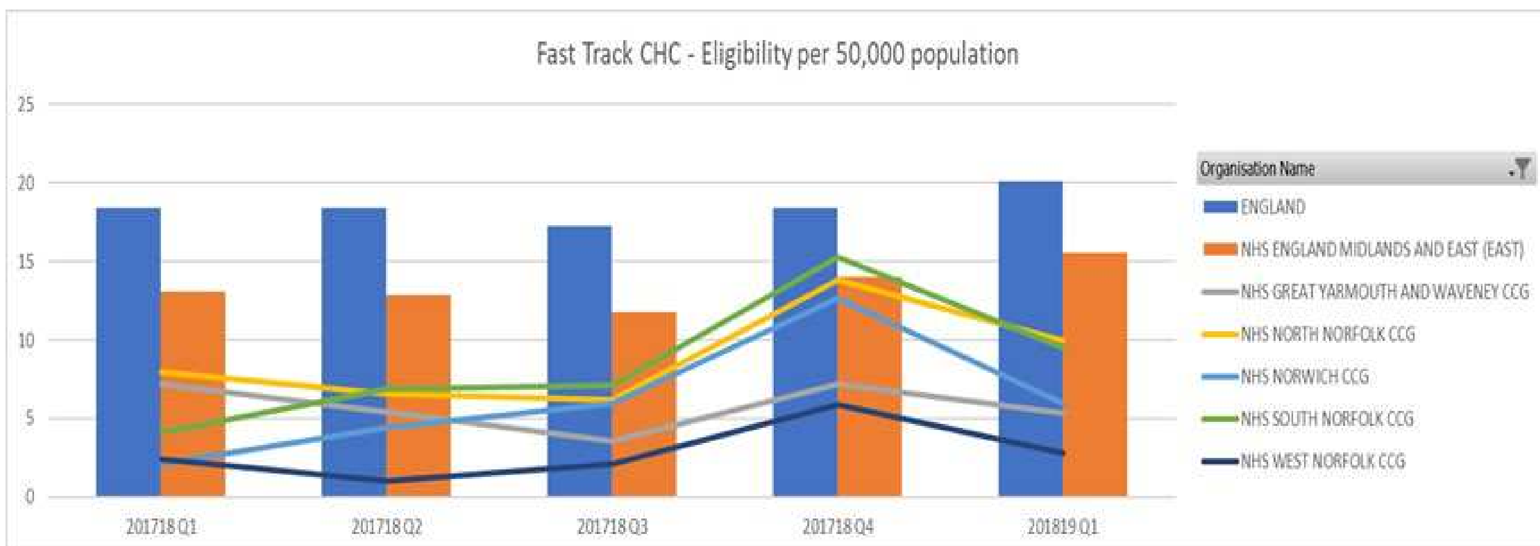
2.5.5 On 18 October 2018 NHOSC received a report on 'Access to palliative and end of life care in Norfolk' which touched on the CHC fast track process in relation to patients approaching the end of their life. It was noted that the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* says that '*Individuals with a rapidly deteriorating condition that may be entering a terminal phase may*

require 'fast tracking' for immediate provision of NHS continuing healthcare' (page 63, paragraph 217).

However, the terms 'rapidly deteriorating' and 'terminal phase' were open to interpretation. A patient with a prognosis of six weeks to live, but who was currently stable and not presently 'rapidly deteriorating' could be considered ineligible for a fast-track decision on NHS continuing healthcare. Such a patient could be discharged to a nursing home on a social care or self-funded basis with the understanding that a fast-track assessment for NHS continuing healthcare could happen when the patient was 'rapidly deteriorating' and 'entering a terminal phase'. In practice such assessments rarely happened.

The committee received Graph 1[3] below, which showed that significantly fewer people per 50,000 population are assessed as eligible for fast track continuing healthcare in Norfolk than is the case in England as a whole, or in the NHS England Midlands and East (East) region.

Graph 1 – Eligibility for Fast Track CHC in Norfolk



NHOSC Members asked for further information about the management of fast track CHC across the whole county.

2.6 **The national framework**

2.6.1 A revised *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* was introduced in October 2018 and is available via the following link:- https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

[3] Graph 1 is based on data extracted from NHS England's *NHS Continuing Healthcare and NHS-Funded Nursing Care* statistics https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/2018-19/

NHS Continuing Healthcare (CHC) aims to meet the cost of a patient's care in full. NHS Funded Nursing Care (FNC) makes a contribution towards care provided by a registered nurse for people who live in a nursing care home. FNC is intended to acknowledge the fact that the cost of an NHS District Nurse is not required as the patient's nursing needs are met by the nurse in the home rather than a District Nurse attending as they would if the patient was in their own home or a residential home.

2.6.2 Beacon, an independent social enterprise company with profits donated to charity to fund older people's services, has summarised the main differences between the new framework and the previous version as follows:-

- The Framework has been updated to reflect the implementation of the Care Act 2014**.** As such, it makes clear that **the eligibility criteria must be applied to everyone equally, regardless of where they receive their care**. This removes the opportunity for interpreting the criteria differently for people who receive care at home. The Framework's new wording removes this double standard, which is welcome news for patients whose needs can be met in their own home.

- **The definition of a social care need has been updated** in alignment with the Care Act 2014, making it clearer and narrower. This should make it easier to make the important distinction of when a care need is 'social' or 'health', and to judge whether the health needs of the patient are more than incidental or ancillary to their social care needs and therefore count as 'primary health needs'.

- Guidance on **the nature of annual CHC reviews has been significantly improved**, which is excellent news for patients and their families. There is now a clear focus on reviews being primarily to check that the patient's care package is working well, not on reviewing eligibility. Eligibility should only be reviewed if the CCG can demonstrate that the needs have substantially changed. Where eligibility reviews are carried out, they must – like the first full assessment – involve a multidisciplinary team and use the Decision Support Tool.

- There is now welcome **clarity on top-ups** (when the CCG does not meet the full cost of care so the patient or their family pays the excess). The update makes it clear that it is the responsibility of CCGs to meet assessed health and wellbeing needs in full. It also provides guidance around the very limited circumstances in which patients can legitimately pay a top-up, i.e. for non-needs-based services such as hairdressing.

- The **make-up of the multidisciplinary team has been clarified**, with very helpful guidance clarifying that the assessment co-

ordinator (often referred to as the 'nurse assessor') must not dominate proceedings. Instead the whole process must be multidisciplinary throughout.

- The **description of the remit of CCG verification of eligibility decisions has been improved,** reiterating that **'**Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed' and that verification should not replace proper multidisciplinary panel assessment.

- The Framework **strengthens the guidance around CCGs' commissioning responsibilities** in an attempt to deal with the spread of worrying 'settings of care' policies. These policies cap funding for people who want to live in their own home, and can have the effect of forcing people to move into a care home or live with inadequate care provision. The Framework outlines the rights of individuals to have their assessed health and social care needs fully met by the CCG, taking into account the person's preferences and without unreasonable restrictions being in place.

- It has been made clear that where CHC processes are outsourced to Commissioning Support Units, **CCGs remain responsible for all decisions of eligibility**.

- The obligations on CCGs in respect of **local resolution of appeals** have been improved. For example, the introduction of a two-step process whereby a first attempt at bespoke, collaborative and genuine resolution should be made by the CCG. If that does not answer the individual's concerns, the decision can be reconsidered by a panel.

More information is available on Beacon's website:-
http://www.beaconchc.co.uk/our-commentary-on-key-updates-to-the-nhs-chc-framework/

3. Suggested approach

3.1 After the CCG representatives have presented their report, the committee may wish to discuss the following areas:-

NCCP and Healthwatch Norfolk's work on communication with patients and families (central & west Norfolk only):-

(a) The Healthwatch Norfolk paper (Appendix C) refers to a workshop to be held on 29 November 2018 (after the publication date of these agenda papers) which will include information and discussion on alternative / respite care provision where appropriate. What were the actions arising from this workshop?

(b) One of the clear messages from the Healthwatch Norfolk paper is that there needs to be a 'communications boost' to raise

awareness and understanding about NHS CHC amongst the general public, and specifically what to expect, the process and where to get information and advice or advocacy. What more can be done in this respect?

Fast track CHC

(c) What is the explanation for Norfolk being significantly below the English and regional average in terms of numbers per 50,000 population assessed as being eligible for CHC fast-track?

(d) The National Framework states that in fast-track cases it is the 'appropriate clinician' who makes the decision on whether an individual who is both rapidly deteriorating and may be entering terminal phase has a primary health need, which denotes eligibility for CHC. An 'appropriate clinician' is defined as a person who is responsible for the diagnosis, treatment or care of the individual and a registered nurse or medical practitioner.

In each of Norfolk's hospitals is it an 'appropriate clinician' from the patient's care team who makes these decisions or is it a CHC nurse assessor who is not part of the patient's multi-disciplinary care team?

(e) In relation to referrals for fast track CHC are NCCP and GY&W CCG following the National Framework which states that 'Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed'?

Discharge to Assess (D2A)

(f) A relatively small proportion of patients who are referred for consideration for the D2A pathway are deemed eligible for the pathway (9.7% at JPUH; 11.6% at NNUH and 18.8% at QEH). Has the introduction D2A pathways at the three acute hospitals had the effect of reducing the numbers of patients who ultimately receive NHS CHC?

(g) In what proportion of cases do health and social care not agree on whether a patient is eligible for the D2A pathway? What is the longest period that a patient's discharge from hospital has been delayed in these circumstances?

(h) Since the introduction of the D2A pathways, to what extent are CHC initial screenings (checklist) and full assessments (decision support tool) still done in the 3 acute hospitals in Norfolk?

(i) If the decision is not to place a patient on a D2A pathway, is there a right of appeal against that decision?

(j) Where a patient has not been placed on the D2A pathway, how would they later arrange to have an assessment for CHC done in the community after they have been discharged and how long would it take for the assessment to be done?

Strategy, equity and the wider system

(k) The policy changes within the new National Framework would imply that more patients may qualify for NHS CHC. How does this square with local QIPP targets to reduce spending on it?

(l) With the announcement on 5 November 2018 that the five CCGs in Norfolk and Waveney will be moving towards a single management team, are there plans for management of CHC in the GY&W CCG area to be aligned with the rest of Norfolk?

(m) Healthwatch Norfolk's paper confirms the significant work that NCCP has done to improve and tailor NHS CHC literature for central and west Norfolk. Is a similar process needed for the Great Yarmouth and Waveney area?

(n) The NHS England CHC statistics, available to view via the link at paragraph 4.4 of NCCP's report (Appendix A), show that in the current year Great Yarmouth and Waveney CCG area has more than the regional average of patients assessed as eligible for NHS CHC (per 50,000 population) whereas every other CCG area in Norfolk has less than the regional average. How significant is the difference in local implementation of CHC between Great Yarmouth and Waveney and the rest of Norfolk?

(o) Has the Strategic Board (with director level membership from all five CCGs and Norfolk County Council), assessed the economic and practical effects of the new management of CHC in central and west Norfolk and the three Discharge to Assess pathways across the county on patients / families and on Norfolk County Council Adult Social Care?

4. Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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