MIDDLESBROUGH COUNCIL

AGENDA ITEM 9

OVERVIEW AND SCRUTINY BOARD

CONTINUING HEALTHCARE (CHC) PROVISION
TO ENSURE THE HEALTH ECONOMY FUNDS HEALTH NEEDS
FINAL REPORT OF THE SOCIAL CARE AND ADULT SERVICES SCRUTINY PANEL

27 MAY 2014

PURPOSE OF THE REPORT

1. To present the findings of the Social Care and Adult Services Scrutiny Panel's review of Continuing Healthcare (CHC) Provision – To Ensure the Health Economy Funds Health Needs.

BACKGROUND

2. NHS Continuing Healthcare (CHC) is the name given to a package of ongoing care and support which is arranged and funded solely by the NHS where an individual has been found to have a 'primary health need'.

3. Prior to 1 April 2013, NHS Primary Care Trusts (PCTs) which were largely administrative bodies, were responsible for commissioning primary, community and secondary health services from providers. A decision was taken to abolish PCTs in 2013 and these were replaced by Clinical Commissioning Groups (CCGs), set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. The South Tees CCG is responsible for providing services in Middlesbrough and Redcar & Cleveland.

4. National guidance in relation to the role of CCG's with regard to the NHS CHC process specifies that CCG's have a statutory responsibility for determining whether an individual is eligible for NHS funded care (including CHC).

5. In recent years, there has been concern that Middlesbrough's NHS CHC rates are not as high as they should be, both nationally and regionally. As a consequence, the scrutiny panel's aim was to investigate what strategies/measures have been implemented to address previously reported inconsistencies in NHS CHC application and improve/develop working practices.

TERMS OF REFERENCE OF THE SCRUTINY INVESTIGATION

6. The scrutiny panel concentrated its investigation on the following terms of reference:

   a) To examine Continuing Healthcare (CHC) principles, processes and practices.

   b) To identify the CHC responsibilities and duties of:

      - the Local Authority
      - the South Tees Clinical Commissioning Group (CCG)
      - the North of England Commissioning Support Unit (NECS)

   c) To establish Middlesbrough's CHC rates and receive relevant data and statistics.

d) To determine measures and strategies that could be implemented in order to improve Middlesbrough's CHC rates and develop current working practices.

METHODS OF INVESTIGATION

7. The scrutiny panel investigated this topic over the course of 4 meetings held on 23 January, 20 February, 13 March and 3 April 2014. A Scrutiny Support Officer from Legal and Democratic Services co-ordinated and arranged the submission of written and oral evidence and arranged witnesses for the investigation. Meetings administration, including preparation of agenda and minutes, was undertaken by a Governance Officer from Legal and Democratic Services.

8. A record of discussions at scrutiny panel meetings, including agenda, minutes and reports, is available from the Council's Egenda committee management system, which can be accessed via the Council's website at www.middlesbrough.gov.uk.

9. This report has been compiled on the basis of information submitted to the scrutiny panel by the Council's Department of Wellbeing, Care and Learning; the North of England Commissioning Support Unit (NECS) and the South Tees Clinical Commissioning Group (CCG).

MEMBERSHIP OF THE PANEL

10. The membership of the scrutiny panel was as detailed below:

    Councillors P Purvis (Chair), F McIntyre (Vice-Chair), E Dryden, N Hussain, D G Loughborough, T Mawston, M Saunders and J A Walker.

THE SCRUTINY PANEL'S FINDINGS

11. The scrutiny panel's findings in respect of each of the terms of reference are set out below:

TERM OF REFERENCE: TO EXAMINE CONTINUING HEALTHCARE (CHC) PRINCIPLES, PROCESSES AND PRACTICES.

<u>What is NHS Continuing Healthcare (CHC)?</u>

12. The Council's Executive Director of Wellbeing, Care and Learning and the Head of Assessment and Care Management provided information on the main issues surrounding NHS Continuing Healthcare (CHC), with regards to the National Framework.

13. Members were advised that the NHS CHC is the name given to a package of ongoing care and support which is arranged and funded solely by the NHS, where an individual has been found to have a 'primary health need'.

14. The scrutiny panel heard that eligibility for NHS CHC places no limits on the settings in which the package of support can be offered or on the type of service delivery.

15. It was conveyed that such care is provided to an individual aged 18 or above, to meet the needs that have arisen as a result of disability, accident or illness.

16. Members were told that, unlike the help and support, provided by Social Services, for which a financial charge may be made (depending on a person's income or savings), NHS CHC is free at the point of delivery. In all CHC cases, the NHS funds the assessed health and social care needs.

What is the National Framework?

17. It was noted that the National Framework sets out the principles and processes for NHS CHC.

18. The scrutiny panel was advised that the purpose of the National Framework is to provide for fair and consistent access to NHS funding across England, regardless of location, so that individuals with similar needs should have an equal likelihood of getting all their health and nursing care provided free of charge.

Eligibility

19. The scrutiny panel noted that eligibility for NHS CHC is based on an individual's assessed level of health need and is not dependent on diagnosis, disease or condition.

20. Members were advised that in order to assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the NHS Act 2006, and to distinguish between those and the services that local authorities may provide, the Secretary of State developed the concept of a 'primary health need'.

21. It was conveyed that 'primary health need' assists in deciding when the NHS is responsible for meeting an individual's assessed health and social care needs as part of the overall duties under the NHS Act 2006 to provide 'services and facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness'.[1]

What is a primary health need?

22. Whether someone has a 'primary health need' is assessed by looking at all of the individual's care needs and relating them to four key indicators:

    - Nature – this describes the characteristics and type of the individual's needs and the overall effect these needs have on the individual, including the type of interventions required to manage those needs.

    - Complexity – this is about how the individual's needs present and interact and the level of skill required to monitor symptoms, treat the condition and/or manage the care.

    - Intensity – this is the extent and severity of the individual's needs and the support needed to meet them, which includes the need for sustained/ongoing care.

    - Unpredictability – this is about how hard it is to predict changes in an individual's needs that might create challenges in managing them, including the risks to the individual's health if adequate and timely care is not provided.[2]

The Assessment Process

23. Officers from the North of England Commissioning Support Unit (NECS) provided the scrutiny panel with information on the NHS CHC assessment process.

24. Members were advised that assessments are undertaken by a multi-agency team in line with the NHS Framework's core values and principles. The multi-agency team consists of Social Workers, Community Nurses, Hospital Nurses, Consultants and GPs who all contribute to the assessment process.

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[1] Department of Health – National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care (2012)
[2] Department of Health – NHS Continuing Healthcare and NHS-Funded Nursing Care – Public Information Leaflet (2013)

25. It was noted that the whole decision-making process is 'person-centred'. This means putting the individual and their views, about their needs and the care and support required, at the centre of the process. It also means making sure the individual plays a full role in the assessment and decision-making process.

26. It was emphasised that the individual is the main priority throughout the NHS CHC process and it is important that the individual receives the type of care that is most suitable to their health needs.

27. It was stressed that access to assessment, care provision and support should be fair, consistent and free from discrimination.

28. The NHS Framework also contains a set of tools aimed at providing support to practitioners.

NHS CHC Checklist

29. Members were advised that the first step for most individuals is the screening process, using the NHS CHC Checklist – unless it is deemed appropriate for the Fast Track Tool. This checklist is an initial screening tool to determine whether a person requires a full assessment for NHS CHC. The checklist does not indicate whether an individual is eligible for NHS CHC, only whether they require full assessment.

Decision Support Tool (DST)

30. The scrutiny panel was advised that the Decision Support Tool (DST) is used following a comprehensive multidisciplinary assessment of an individual's health and social care needs and the desired outcomes for that individual. The assessment provides an accurate reflection of current need. The multidisciplinary assessment that informs the completion of the DST draws on those health and social care professionals who have direct knowledge of the individual and their needs. It also makes use of existing specialist assessments and should make referrals for other specialist assessments whenever that is appropriate. The DST is not an assessment in itself; it is a way of applying evidence in a single, practical format. The evidence and decision-making process should be accurate and fully recorded.

31. It was highlighted that assessments are based on individual needs, and budgets and finance do not play a part in any decisions on the care package required.

32. The individual and their relatives are included in the assessment process.

33. Members were advised that guidance states that as far as reasonably practicable, the CCG should consult with the relevant local authority before making a decision about an individual's eligibility for NHS CHC.

34. The DST is designed to ensure that the full range of factors that have a bearing on an individual's eligibility are taken into account in reaching the decision, irrespective of the client group or diagnosis.

35. The tool provides practitioners with a framework to bring together and record various needs in 12 'care domains'. The care domains are:

    1. Behaviour.
    2. Cognition.
    3. Psychological and emotional needs.
    4. Communication.

5. Mobility.
6. Nutrition – food and drink.
7. Continence.
8. Skin (including tissue viability).
9. Breathing.
10. Drug therapies and medication: symptom control.
11. Altered states of consciousness.
12. Other significant care needs.

36. The completion of the tool should result in an overall picture of the individual's needs that captures their nature, and their complexity, intensity and/or unpredictability.

Fast Track Tool

37. The scrutiny panel noted that if an urgent package of care is required due to a rapidly deteriorating condition which may be entering a terminal phase, then the Fast Track Tool will be used instead of the DST.

38. Members were advised that the Fast Track Tool should be completed by the appropriate Clinician, who should give reasons why the person meets the criteria required for the fast-tracking decision. 'Appropriate Clinicians' are those who are responsible for the individual's diagnosis, treatment or care and are medical practitioners or registered nurses.

39. The Clinician will have an appropriate level of knowledge or experience of the type of health needs.

40. Where a recommendation is made for an urgent package of care via the fast-track process, this will be accepted and actioned immediately.

Assessments in Hospital

41. It was conveyed to the scrutiny panel that when an individual is being assessed whilst in hospital, their Consultant, Nurse or Social Worker and if appropriate, their carer will also be involved. Where an individual is admitted to hospital, before utilising the Design Support Tool (DST), the individual is subject to a screening process carried out by the nursing staff using the NHS CHC Checklist; unless the individual has a deteriorating condition and in that case the Fast Track Tool will be used. Fast Track assessments are usually, but not always, undertaken in hospital. Where an individual has a terminal pathway they will be fast tracked.

42. As part of the DST, assessors can prioritise hospitals or book hospital slots.

Reviews

43. In response to a query with regard to the number of individuals that have been in receipt of NHS CHC and have proceeded to make a full recovery, the scrutiny panel was advised that it is very rare that an individual who is eligible for NHS CHC recovers sufficiently to no longer require NHS CHC. In a few cases after intensive rehabilitation this might be the case, however, these cases are very rare.

44. In response to a query with regard to in what circumstances a decision would be made to cease providing an individual with NHS CHC, Members were advised that a joint decision would be taken following an assessment involving the health and local authority social care teams. If an individual is assessed as still requiring NHS CHC, funding would continue.

TERM OF REFERENCE: TO IDENTIFY THE CHC RESPONSIBILITIES AND DUTIES OF:

THE LOCAL AUTHORITY, THE SOUTH TEES CLINICAL COMMISSIONING GROUP (CCG) AND THE NORTH OF ENGLAND COMMISSIONING SUPPORT UNIT (NECS)

45. Jean Fruend, Executive Nurse from the South Tees Clinical Commissioning Group (CCG) advised the scrutiny panel that prior to 1 April 2013, NHS Primary Care Trusts (PCT's) which were largely administrative bodies, were responsible for commissioning primary, community and secondary health services from providers. A national decision was taken to abolish PCT's in 2013 and these were replaced by Clinical Commissioning Groups (CCGs), which were established by the Health and Social Care Act 2012 to commission the delivery of NHS services in England. The South Tees CCG is responsible for commissioning services in Middlesbrough and Redcar & Cleveland. NECS is responsible for commissioning services on behalf of a number of CCGs in different localities across the north of England, including Cumbria, Northumberland, Tyneside, Durham and Darlington and the Tees Valley.

46. The South Tees CCG consists of GPs (with 3 sitting on the Executive Committee) and a mixture of clinicians and managers and it is considered that the mix of professionals produces better outcomes in terms of commissioning services.

47. The CCG work very closely with NECS who undertake a large percentage of the day to day work of the CCG. Although NECS are assisting with the commissioning of services on behalf of the CCG; all decisions with regard to commissioning taken by NECS have to be ratified by the relevant CCG.

The Local Authority (LA) Responsibilities

48. The Council's Head of Assessment and Care Management advised the scrutiny panel that where cases are brought to the attention of Adult Social Care, there is a requirement to provide advice and assistance with regards to individual cases as far as reasonably practicable. If a local authority has carried out a community care assessment, it should, as far as is reasonably practicable, use the information obtained from it when providing assistance.

49. The scrutiny panel advised that the involvement of the Local Authority in the assessment process helps to streamline the process of care planning and makes decision-making more effective and consistent.

50. Responsibilities include:

- Making staff available, where practicable, to be part of multi-disciplinary assessments.
- Contributing to Community Care Panels which consider eligibility.
- Making staff available to undertake joint reviews.
- Work jointly in the planning and commissioning of care/support for individuals deemed to be eligible for NHS CHC.

The South Tees Clinical Commissioning Groups (CCGs) Responsibilities

51. The Executive Nurse from the South Tees CCG provided the scrutiny panel with information with regard to the role of the CCG and its responsibilities, duties and strategies in respect of the delivery of NHS CHC.

52. Members were advised that the aim of the CCG is to optimise services and ensure that where possible there is consistency in the types of services available and the delivery of those services. It was acknowledged that there are local variations in respect of the types of services available, however, the aim of the CCG is to ensure that all the services that are delivered are economical, efficient and effective.

53. Members were advised that the national guidance in relation to the role of CCG's with regard to the NHS CHC process specifies that CCG's have a statutory responsibility for determining whether an individual is eligible for NHS funded care (including CHC) where an individual is found to have a primary health need. Guidance also specifies that accountability for deciding on an individual's eligibility cannot be delegated. The scrutiny panel heard that the National Framework is designed to ensure that decision-making is equitable and fair and it is important for CCG's to ensure that their Standard Operational Procedure (SPO) is in line with the National Framework.

54. The CCGs have lead responsibility for NHS Continuing Healthcare in their locality. This includes:

- Ensuring consistency in the application of policy on eligibility for NHS CHC.
- Promoting awareness of NHS CHC and ensuring clients and families understand the processes and decisions involved.
- Implementing and ensuring good practice, including facilitation of advocacy where appropriate.
- Ensuring the quality standards are met and maintained.
- Providing training and development opportunities for practitioners.
- Identifying and acting on issues arising from the implementation of NHS CHC.

55. The CCGs are also required to consult (so far as is reasonably practicable) with the relevant Social Services department before making a decision on a person's eligibility for NHS CHC.

The North of England Commissioning Support Unit (NECS) Responsibilities

56. Locality Managers and the Senior Commissioning Manager from NECS explained to Members that in the South Tees CCG area, the assessment and commissioning function is undertaken by NECS.

57. In order to satisfy the CCGs core responsibilities, the NECS CHC Team:

- **Ensure consistency in the application of policy on eligibility for NHS CHC** by:

    - Monitoring patterns of eligibility decision-making by nurse assessors – individual managers verify each DST.

    - Holding joint local panel meetings between health and local authorities. The local panel meets on a weekly basis. The local panel looks at the jointly funded care packages as well as the quality of the decision making process and works to ensure the consistency of decisions. The panel consists of the Head of Assessment and Care Management, a Social Worker, a Community Nurse and a representative from NECS (North of England Commissioning Support). The panel examines the paperwork produced and either endorses the recommendation or queries it. There are times when the panel debates as to whether the case should be health funded rather than Council funded. The most debate usually concerns individuals who have complex learning disabilities because it is difficult to assess their abilities, behaviour, cognition and mobility.

    - Holding Tees Disputes meetings, which comprise of representation from CHC team and the 4 Teesside local authorities. The meetings provide the opportunity to resolve disputes with regard to eligibility for NHS CHC which has not been agreed at a local panel and to share information in relation to complex cases. It also provides the opportunity for peer review and the development and application

of a consistent decision-making criteria. Very few cases have been referred so far and it appears that the assessment system is working well (only 2 cases have been disputed in last 2 years, with one upheld). The scrutiny panel was asked to note that all evidence used in the assessment process is catalogued to ensure that in cases of disputes, the rationale behind the decision can be examined.

- Holding interagency group meetings. The interagency group involves the four local authorities across the Tees Valley area meeting on a 6 weekly basis. The group works to ensure that the national guidelines and policy in relation to NHS CHC is implemented correctly. Work also involves discussing local implementation/operation of the National CHC Framework and agreeing consistent approaches across the Tees Valley. In addition, the group looks at local policies, procedures and referrals in respect of NHS CHC and is constantly working to review and refine procedures.

- Any decisions with regard to eligibility for NHS CHC are ratified by the CCG.

- The Standard Operating Procedure is subject to internal auditing procedures.

- Having an appeals process.

- Providing NHS CHC joint training that's offered to both health and social care staff.

- The completion of a Rapid Process Improvement Workshop (RPIW) which is currently being rolled out in the Middlesbrough and Redcar & Cleveland area.

- 6 weekly peer audits for nursing assessors involved in assessing eligibility for NHS CHC are carried out by clinical supervisors.

- Management carrying out monthly audits of practice on 10 cases, on a monthly basis.

- Developing consistent protocols around completion of the DST – Weekly nurse assessors and monthly team meetings are held with a view to developing consistent protocols with regard to the completion of the DST.

- Working with staff to disseminate learning and identify development issues - feedback during nurse assessors meetings, individual sign offs, one-to-one supervision.

- Awareness sessions for staff in local hospitals.

- The dissemination of information leaflets to individuals, carers and family members.

- The provision of effective equality, diversity and human rights training and development.

- The requirement of staff to complete mandatory on-line modular training and attend appropriate training courses relevant to their role.

In the majority of cases, the CCG accepts the decision of the assessors but they do, on occasion, request further information before verifying a decision.

- **Promote awareness of NHS CHC** by:

    - Staff providing leaflets to individuals, carers and family members at the DST stage.

    - Training being available for all health and social care staff.

- **Implementing and maintaining good practice** by:

    - Sharing and implementing good practice - The CHC Managers participate in the CHC Leads meeting, the Regional Transformation meetings and the CHC Durham/Tees joint team meetings.

- **Ensuring that quality standards are met and sustained** by:

    - Management monitoring and review.

    - Audits.

    - Complaints.

    - Local Panel and Tees Disputes meetings.

- **Providing training and development opportunities for practitioners** by:

    - Delivery of NHS CHC training. Independent Training has recently been commissioned at Wynyard and is open to all staff from health and social care and this includes community hospitals and acute hospitals.

    - Availability of a CHC e-learning programme.

    - Delivery of staff inductions.

- **Identifying and acting on issues arising in the provision of NHS CHC** by:

    - Responding to, and learning from, complaints.

    - Holding disputes meetings.

    - Appeals. The scrutiny panel was advised that there have been very few challenges to the outcomes of assessments and there have been very few successful appeals. A national exercise which involved looking back over a number of years at the individuals that could have qualified for NHS CHC, but were refused, had been carried out and very few cases were found where an incorrect decision regarding eligibility to NHS CHC had been made.

    - Root cause analysis. A root cause analysis is also carried out for each complaint to assess if procedures need to be amended.

58. Reference was made to the CHC Fast Track process where consultants are given the power to decide on CHC eligibility without having to complete the full DST checklist. In these cases, NECS will facilitate a package of care for the individual with immediate effect based on the individual’s health condition and medical requirements.

TERM OF REFERENCE: TO ESTABLISH MIDDLESBROUGH’S CHC RATES AND RECEIVE RELEVANT DATA AND STATISTICS

Middlesbrough's position regarding CHC

59. Table 1 provides 2012/13 statistical information provided by South Tees CCG which illustrates that in terms of spend per 1,000 weighted population, Middlesbrough was ranked 2nd lowest of the four Tees Valley authorities.

Table 1

Key areas of spend	Hartlepool 2012/13	Stockton 2012/13	Middlesbrough 2012/13	Redcar & Cleveland 2012/13
Weighted Population (April 2013)	106,928	193,252	167,687	150,324
CHC Spend (2012/13 outturn)	£9,110,646	£12,470,242	£10,123,922	£6,128,510
Spend per 1,000 weighted population	85,204	64,528	60,374	40,769
Community Hospitals (2012/13 outturn)			£2,170,004	£5,750,246
Spend per 1,000 weighted population			12,941	38,252
Community Nursing inc Pallative Care (2012/13 outturn)	£4,098,559	£3,428,922	£5,943,957	£5,890,176
Spend per 1,000 weighted population	38,330	17,743	35,447	39,183
Specialist MH/LD Package of Care	£1,904,556	£3,428,922	£3,153,001	£2,748,563
Spend per 1,000 weighted population	17,812	17,743	18,803	18,284
Total	**£15,113,761**	**£19,328,086**	**£21,390,884**	**£20,517,495**
Spend per 1,000 weighted population	**141,345**	**100,015**	**127,564**	**136,488**

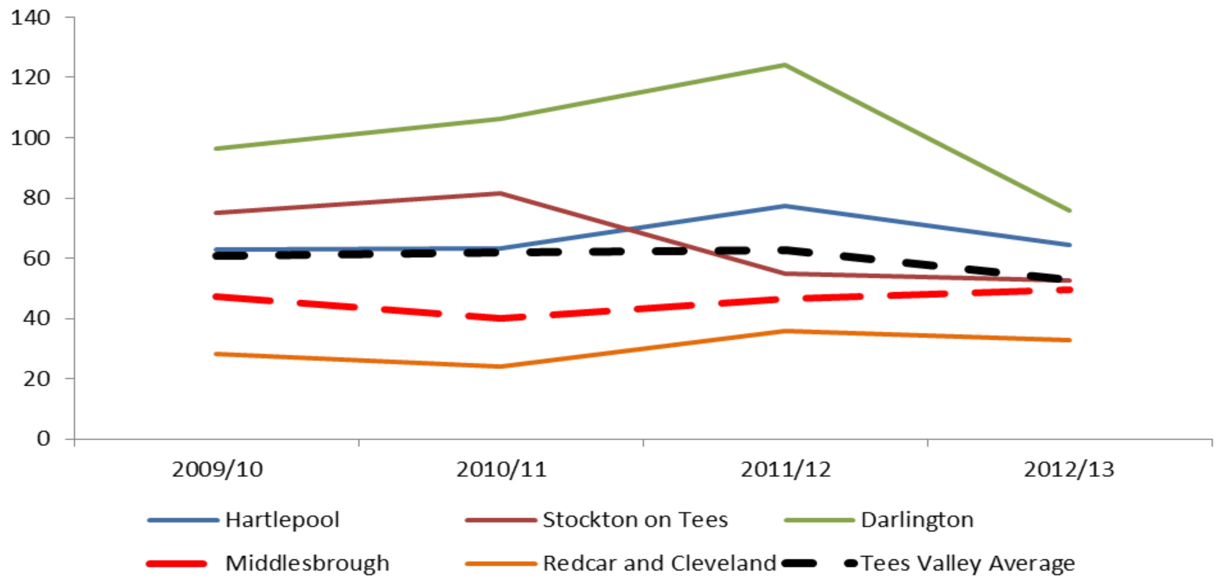
Table 2

Locality	Population data	Quarter 4	Rate per 100,000 Population
Redcar and Cleveland PCT	139,494	115	82.44
Stockton-On-Tees PCT	189,141	205	108.38
Middlesbrough PCT	138,434	153	110.52
Hartlepool PCT	91,137	104	114.11
North East SHA	2,555,708	4,555	178.23

60. The Department of Health publishes data on the number of people receiving NHS CHC on a quarterly basis as a way of monitoring the process.

61. Table 2 shows figures from the last quarter in 2012/13. The table shows the 4 authorities bottom of the North East region in terms of NHS CHC rates. It demonstrates that all 4 local authorities remain the bottom four performers in the North East and below the North East average for NHS CHC, with Middlesbrough being third from bottom.

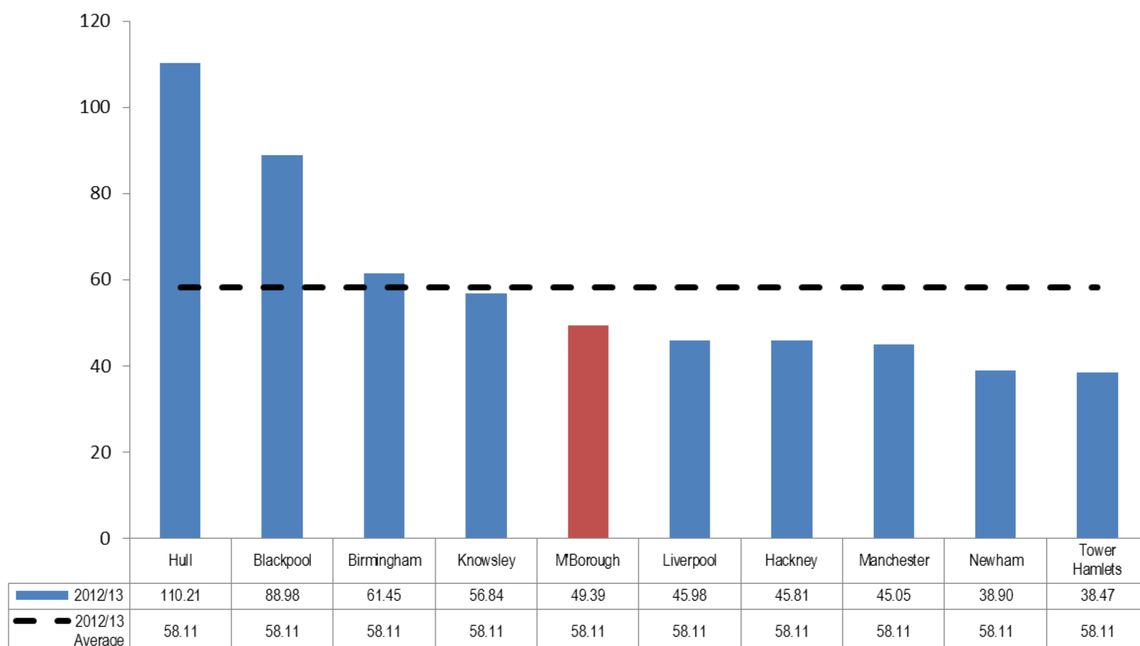
Graph 1



62. Graph 1 demonstrates that Middlesbrough is the only Tees Valley authority to have continually improved NHS CHC awards since 2010/11.

63. This graph also shows that the differences in NHS CHC cases between Tees Authorities is narrowing from a 2010 position.

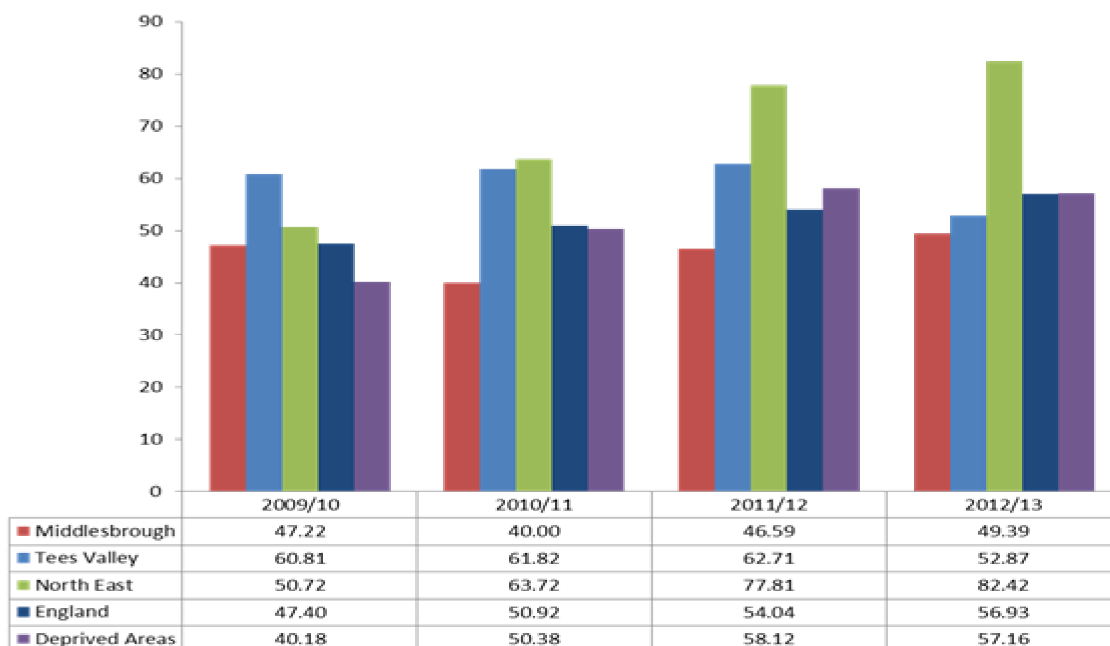
Graph 2



	Hull	Blackpool	Birmingham	Knowsley	MBorough	Liverpool	Hackney	Manchester	Newham	Tower Hamlets
2012/13	110.21	88.98	61.45	56.84	49.39	45.98	45.81	45.05	38.90	38.47
2012/13 Average	58.11	58.11	58.11	58.11	58.11	58.11	58.11	58.11	58.11	58.11

64. Graph 2 shows Middlesbrough's performance in 2012/13 against other local authorities in the top ten deprived areas chart, and places Middlesbrough more or less in the middle of this group.

Graph 3



	2009/10	2010/11	2011/12	2012/13
Middlesbrough	47.22	40.00	46.59	49.39
Tees Valley	60.81	61.82	62.71	52.87
North East	50.72	63.72	77.81	82.42
England	47.40	50.92	54.04	56.93
Deprived Areas	40.18	50.38	58.12	57.16

65. Graph 3 shows that from 2009/10 Middlesbrough has remained below the North East average, below the England average, and below the deprived areas average with regards to NHS CHC cases.

66. The Council's Head of Assessment and Care Management explained that the analysis of NHS CHC activity data, shows that whilst Middlesbrough has improved in obtaining NHS CHC since 2010-2011, there is still work to be done to raise rates compared to North East and England averages.

67. It was also explained that one of the reasons why Middlesbrough's performance has improved is because the Local Authority has been pro-active in taking the lead in assessing people. However, lower rates of NHS CHC could impact on the Local Authority because it could potentially be funding care costs that should be the responsibility of the NHS. This could also impact on Middlesbrough residents who are potentially contributing towards care costs which should be free at the point of delivery.

TERM OF REFERENCE: TO DETERMINE MEASURES AND STRATEGIES THAT COULD BE IMPLEMENTED IN ORDER TO IMPROVE MIDDLESBROUGH'S CHC RATES AND DEVELOP CURRENT WORKING PRACTICES.

Development of current working practices

68. Jean Fruend, Executive Nurse from the South Tees CCG and Lou Okello, Senior Commissioning Manager from NECS advised the scrutiny panel that in July 2012 a paper was presented to Tees Valley Chief Executives which outlined a number of issues and

concerns surrounding NHS CHC services and the relationship between the CHC team and their social care colleagues.

69. Concerns were raised with regard to the Tees local authorities being the bottom four authorities in the North East in terms of NHS CHC provision. This was picked up by the PCT at the time and a series of workstreams initiated, involving representation across Tees, to improve consistency of application across the locality.

70. It is acknowledged by all stakeholders that NHS CHC is a service area that is complex and often challenging due to decisions having a direct impact on organisational resources; however, the overriding principle that has governed the work that has been undertaken, is that the needs of individuals and their families/carers is paramount and overrides all organisational considerations.

71. In July 2012 there were a number of process issues within the NHS CHC service and these are detailed below:

- Inconsistency in relation to processes and the application of criteria between the CHC team and the four respective local authorities.
- Perceived lack of progress within the PCT (as it was in July 2012) to address internal issues.
- Relationships between CHC team members and local authority colleagues were not always conducive to partnership working.

72. The three areas described above have in the main been addressed. Information is detailed at paragraph 57 which highlights the practices that have been developed to address these concerns.

73. Members were informed that an area that remains challenging for all stakeholders is around the continued perception that the CHC Framework is not consistently applied across the four local authorities within Tees.

74. The scrutiny panel were advised that one of the actions identified by the local authority Chief Executives in 2012 to address this issue was the development of a Tees-wide panel. The CHC Stakeholder Group, which now meets on a 6-weekly basis, was tasked with establishing this panel. This group is attended by senior representatives from all partner organisations and following much debate around the practicality of such a proposal, a decision was recently taken not to proceed with this development.

75. It was conveyed that this decision was reached having regard to the practicalities of all partner organisations being present for what would have amounted to a full day meeting with particular concerns around best use of time and information sharing. The decision was further informed by feedback from local authority colleagues who now feel that the local panels are largely working well and that relationships between CHC team members and social care colleagues have improved considerably over the last 16 months. The group therefore decided that local panels would continue as they are at present.

76. Members noted that the stakeholder group did, however, agree that a Disputes Panel should be set up with representatives from the CHC team and all four local authorities – more information on these meetings is detailed at paragraph 57. The meetings provide a forum to objectively resolve disputes and share complex cases, offering an opportunity for peer review and the development and application of consistent decision making criteria.

77. Work has been on-going across Tees for some time as a consequence to address the inconsistencies in NHS CHC application, and improve working practices. Middlesbrough has been closely involved in working groups taking deliberations forward.

78. Within Adult Social Care, a strategy has been implemented to improve the Council's performance including specialist training to support staff involved in the assessment processes and deliberations.

79. The scrutiny panel was advised that all those involved in the NHS CHC process have a professional obligation to the person they are caring for to optimise their care and to encourage the individual to help themselves to be more independent. Members were advised that NECS acknowledges the requirement for everybody that is involved in the NHS CHC process to be fully trained as the responsibility for the delivery of NHS CHC rests with the CCG. Training has been provided on completing the DST checklist, the process for making referrals and recognising when a referral should be made to all those involved in the CHC process. The take up of training in the hospital setting has been very good and those that receive the training also offer peer support and training to other colleagues.

80. The Senior Commissioning Manager from NECS commented that the Fast Track Pathway Tool is operating very well. However, Members were advised that it is important for the hospital-based staff to take up the training. Ongoing training with regard to the importance of completing the checklist is being carried out in hospital settings.

81. The scrutiny panel was advised that the take-up of training is discussed regularly in the inter-agency meeting and any gaps in training provision are identified.

Is there a need to increase the uptake of NHS CHC in Middlesbrough?

Evidence: The North of England Commissioning Support Unit (NECS) and the South Tees Clinical Commissioning Group (CCG)

82. Locality Managers and the Senior Commissioning Manager from NECS and the Executive Nurse from the South Tees CCG provided the scrutiny panel with possible reasons for Middlesbrough's NHS CHC rates remaining below the North East average and below the England average.

Community-Based Services

83. NECS conveyed that reasons include Middlesbrough's residents having access to a broad range of services. These services are listed below:

- One community hospital (Carter Bequest).
- One hospice (Teesside Hospice).
- 24 hour District Nurse Team.
- Intermediate care Services (MICC).
- Discharge to assess bed provision in Belle Vue care home.
- Marie Curie service.
- MacMillan service.

84. It was conveyed that if individuals are referred to any of the services above, then there will be no need for a referral for a DST. The panel was asked to note that these alternative community services are funded by South Tees CCG.

85. Members were advised that other areas do not always have access to such a broad range of community-based services which often provide an alternative to NHS CHC. It was commented for instance that in the Durham area, individual's choices were being increased by putting in place other alternatives to NHS CHC.

86. In relation to a query with regard to how the community services were funded, Members were advised that some of the services such as Marie Curie Services, the hospices and Macmillan Nurses were in receipt of charitable donations. These community services can also be procured by NECS using health funding to establish contracts with the local authorities to provide the services.

Community Hospitals

87. The use of community hospitals has the effect of reducing in some cases the amount of people who require assessments for NHS CHC. The scrutiny panel was advised that patients who are admitted to a community hospital for rehabilitation have longer to recover and at the point of discharge from the community hospital, may not require referral for NHS CHC. The community care beds provide patients with the opportunity to recover outside an acute hospital setting. In cases, where a patient is discharged straight to the home, from an acute hospital setting after an acute episode of care, there is a higher likelihood that these individuals would meet the NHS CHC criteria.

88. Access to community hospital beds is via Consultant or General Practitioner (GP). The 4 community hospitals within Redcar and Middlesbrough:

- Have circa 132 beds available (Redcar and Cleveland 88 and Middlesbrough 44).
- Provide rehabilitation and palliative care.

89. In response to a query with regard to the difference between NHS CHC and Community Services; the scrutiny panel was advised that a referral to a community hospital is usually made at the point of discharge; it is a health referral to a community setting. If, however, the individual deteriorates once they have been discharged to a community hospital they could still be referred for an assessment for NHS CHC. The scrutiny panel was advised that NECS are confident that everybody who has been referred for, and is entitled to receive, NHS CHC is receiving it.

90. The scrutiny panel were provided with an example, it was highlighted that in the case of a person that lived alone but who has suffered a stroke, the individual may initially be admitted to an acute hospital to receive clot busting drugs to dissolve the clot but they may still be unsteady on their legs. The individual may eventually be discharged to a community hospital where they will receive intensive physiotherapy and will still be under the care of a consultant. At the point of discharge from the community hospital a first assessment will be carried out to see if the individual qualifies for NHS CHC. If the individual does qualify for NHS CHC they will receive the appropriate care and a review will be carried out after three months to determine if the patient was still eligible for NHS CHC and to check if the package of care is still meeting the needs of the patient. It was emphasised that patients are advised that at any time during the three month period a referral for a reassessment / review could be triggered.

91. A Member raised a query with regard to the increased demands on community-based facilities as a result of winter pressures and what alternatives could be put in place. The scrutiny panel was advised that the CCG's Urgent Care Work Stream focusses on winter pressures, hospital discharges and the reduction of hospital admissions following problems experienced in the previous year when the weather had been particularly poor. NECS are also able to commission spot purchases and access bed places from another facility if there is an increased demand for places. Individuals occupying acute beds who requires respite care rather than acute care are discharged to the appropriate care home or community facility.

92. NECS recognised that a reasonable level of capacity needs to be available. The scrutiny panel was advised that the South Tees NHS Foundation Trust has commissioned sixteen

Time to Think Beds at the Belle Vue Care Home on a pilot basis, however, it is anticipated that this capacity will increase in the future. It was commented that the introduction of this facility removes the immediate pressure on families and the individual to make life changing decisions about long term/short term care in a short space of time. The outcome of the pilot will be considered when determining which kinds of care provision need to be commissioned. The scrutiny panel was advised that there has been some excellent work carried out in relation to reablement and it was acknowledged that the arrangements with the Belle Vue Care Home need to be consolidated and formalised.

Palliative Care

93. The Palliative Care Service initially provided support to people within Redcar and Cleveland, however, approximately five years ago the service expanded and now also provides a service to Middlesbrough residents.

94. Members were informed that access to this service is via the district nursing service and therefore the criteria for NHS CHC is not applied, and the number of people supported by this service is not included in the CHC data return.

95. The scrutiny panel noted that if this service is not available there would be a need to commission the support required for people with palliative needs from the independent sector and in this instance there would be a requirement to apply the NHS CHC criteria.

96. The palliative care beds within the community hospitals provide palliative treatment and end of life care. Access to these beds is via GP and therefore there is no requirement to apply the NHS CHC criteria. In the absence of the palliative care beds the person will have their care provided within a nursing home. To access care within the independent sector the NHS CHC processes will need to be applied.

Marie Curie Service

97. It was conveyed that the contract for the Marie Curie service was changed four years ago to allow the service to be provided to people with non-cancer related illnesses. Again, to access this service there is no requirement to apply the NHS CHC process as this is arranged via the district nursing service.

District Nursing

98. Members were advised that in the South of Tees area if it is recognised that a person may need some support for a health task, this can be addressed by the district nursing service. In these instances the NHS CHC process is not applied, even if the person is end of life, therefore, these individuals will not be counted in the NHS CHC data return.

99. If it is recognised that if a person has support needs that are not related to district nursing tasks then the NHS CHC process is applied and a package of care is commissioned from an independent provider and these individuals would be counted in the NHS CHC data return.

Variation across South Tees CCG and Hartlepool and Stockton-on-Tees (HaST)

100. It was conveyed to the scrutiny panel that whilst there is variation across South Tees CCG and Hartlepool and Stockton-on-Tees (HaST) CCG (see table 1 and 2), these figures need to be interpreted with caution as there are a number of variables that impact upon these rates, e.g. the three community hospitals within Redcar & Cleveland and Middlesbrough. Whilst the majority of the beds provide rehabilitation, each community hospital also provides a palliative care service.

Funding

101. In response to a query with regard to whether individuals in receipt of community services would have to pay for their care, it was emphasised that as long as the individual meets the eligibility criteria for NHS CHC, all community services will be funded by the NHS. It was highlighted that a referral for NHS CHC can be made at any stage of an individual's illness, even if an individual is receiving treatment in their own home.

102. It was commented that initially an individual might not be poorly enough to meet the NHS CHC criteria and may have been managing with social care or community health services. It was pointed out, however, that at any point during a individual's care, even if the care is being provided by the District Nurse or the Marie Curie Nurse; an individual could be referred for an assessment for NHS CHC; if the person caring for the individual considers that the individual's illness is at a stage where they require more health care intervention.

103. It was clarified that social care services are means tested and an individual who did not automatically qualify for funding would have to pay for the care they receive. Individuals who qualify for funding can either choose which type of care they want to access through their personal budget or any care provided will be funded by the Local Authority's Adult Social Care. It was clarified that once an individual is classed as being eligible for NHS CHC, the NHS will pay for the full cost of that individual's care, including any social care and health care costs. It was clarified that the individual will receive any treatment free of charge from the point of referral.

Conclusion

104. The Senior Commissioning Manager advised that NECS did not have any aspirations to increase the uptake of NHS CHC as in her view; if an individual is eligible for NHS CHC they will receive it.

105. It was highlighted that the tool used to assess eligibility for NHS CHC; the Design Support Tool (DST) is the same model used for the whole of the UK. The scrutiny panel was advised that if a referral is received which suggested that a person might qualify for NHS CHC; they would receive a full assessment carried out by a multi-disciplinary team.

106. The CCG's Executive Nurse advised the scrutiny panel that when the amount of money spent on referring individuals to community hospitals and community services is taken into account; the spend per 1,000 weighted population (see table 1) is comparable to the other local authorities as many individuals receive rehabilitation and respite rather than NHS CHC. As a consequence, the view of the South Tees CCG is that it is difficult to actively increase referral rates as individuals are assessed on need and having been in a community hospital or community service; needs may subsequently reduce so that the individual may not require a referral to the CHC team.

107. It was commented that if the figures for those who were in receipt of NHS CHC nationally were examined, they would reveal that many of those individuals that had qualified for NHS CHC were nearing the end of their life. As a consequence these individuals would be receiving care from organisations such as Marie Curie Services and Macmillan Nurses. The provision of these services allowed individuals more flexibility in dealing with their illness such as the chance to be treated in their own home.

Retrospective Case Review

108. The NHS CHC service is currently undertaking a comprehensive restitution exercise.

- South Tees CCG has received 394 initial restitution queries and has to date reviewed 132 of these. Out of the 132 reviews that have been carried out only 1 has been approved as having been eligible for NHS CHC, 9 cases are still being appealed (4 at local review and 5 with NHS England).

- HaST CCG has received 339 initial restitution queries and has to date reviewed 111 of these. Out of the 111 reviews that have been carried out to date only 3 have been approved as having been eligible for NHS CHC, only 5 cases are being appealed at local review.

109. Members were advised that this further demonstrates that the CHC team has been applying the framework in an appropriate and consistent manner.

Evidence: The Local Authority

110. The Council's Head of Assessment and Care Management and the Interim Head of Community Care provided a response to the evidence submitted by NECS with regards to Middlesbrough's NHS CHC rates.

111. It was conveyed to the scrutiny panel that there had been some concern for a couple of years that Middlesbrough Council's achievement of NHS CHC rates were not as high as they should be, both nationally and regionally. The Head of Assessment and Care Management advised that initially concerns had been raised about the level of people in receipt of NHS CHC because of statistical information which is more than 12 months out of date and because of the gap between the level of NHS CHC take-up in Middlesbrough and other North East authorities.

Funding

112. The Interim Head of Community Care pointed out that some of the services described by the NECS staff as being alternatives to NHS CHC (such as the Community Nursing Service or Marie Curie Services) could well be in place alongside services from Adult Social Care, which are chargeable services to the individual.

113. Members were advised that if an individual is therefore not considered against NHS CHC criteria, or considered not eligible for NHS CHC funding, because of the provision of one of these "alternative" services, then the individual will be charged for the social care component when potentially the NHS should be paying for them.

114. It was suggested that this emphasised the need to consider NHS CHC as a question of eligibility first and foremost with considerations around provision following afterwards.

Eligibility Concerns

115. It was commented that the issue is not about raising levels of NHS CHC; it is in relation to concerns with regard to eligibility. It had been suggested by NECS that if an individual accessed one of the community services there would be no requirement to carry out a DST.

116. The scrutiny panel was advised that the NHS in the form of the Clinician or person responsible for the individual's care, has a duty to consider when planning for the person to be discharged from hospital to decide whether or not a person requires to be considered against NHS CHC criteria. The guidance states that if a checklist is used for this purpose then it must be the nationally established CHC checklist. If the checklist is not used then the Clinician must have authority to make the decision in another way delegated from the

CCG but it is not clear that such a delegation is formally in place. It is also presumably the case that all such cases have to be documented.

117. The Interim Head of Community Care questioned whether the checklist procedure is used in every appropriate case or whether it is only linked to cases where a social work referral is being made. He commented that individual's should still have a formal decision recorded as to whether they require to be considered against the criteria or not, even if further assessment is not indicated.

118. The scrutiny panel was advised that given the degree of deprivation and physical ill health in the town, it is reasonable to assume that there should be higher levels of NHS CHC than currently experienced when considered against other areas with high levels of ill-health and deprivation. It was commented that it would be a major concern, if insufficient individuals were being considered against the eligibility criteria. It was highlighted that individuals are required to be assessed before community services are provided.

Awareness

119. It was highlighted that individuals and families are not always aware of the availability of NHS CHC and it was confirmed that it is the CCG's responsibility to raise awareness of the support available. Members suggested that a single point of contact would be useful for individuals wishing to access NHS CHC.

120. A Member commented that she had received feedback from some members of the public that families of some individuals felt that sometimes intervention in the form of NHS CHC or community services did not happen at the right time.

Obtaining Statistics and Data

121. It was conveyed to Members that difficulties have been experienced in obtaining data from 2012/2013 to the present, from the CCG, in order to ascertain whether improvements in CHC have continued following the development of the CCG and the NHS CHC management being contracted to North East Commissioning Support Unit (NECS).

ADDITIONAL INFORMATION

122. In the course of the Scrutiny Panel's investigations, information came to light which, while not directly covered by the terms of reference, is relevant to the work of the panel on this topic. This related to:

The Better Care Fund

123. Reference was made to the Better Care Fund which will make available £3.8 billion to local services across England to provide integrated working between health and social care services around the needs of individuals.

124. The scrutiny panel was advised that there has been huge cuts in funding for Adult Social Care and the Government is aiming to ensure that health and social care work better together as it is perceived by some that organisational barriers exist.

125. The ultimate aim of the Better Care Fund is that money from both health and social care will be pooled together to provide a range of services including reablement and complex care services. A formal agreement will be signed between the groups which will set out a framework for the delivery of the service and the expected outcomes.

126. The hospital-based Social Workers currently work five days a week; however the community based Social Workers work five days a week but with emergency twenty four hour and week-end cover provided by the Stockton-based Emergency Duty Team. It was highlighted that as part of the introduction of the Better Care Fund, the issue of extended working hours will be explored. It was noted, however, that even if the working hours of Social Workers were to be extended, they would still be reliant on services provided by other clinicians and services who did not currently work seven days a week to be able to discharge individuals.

127. The Interim Head of Community Care advised the scrutiny panel that in a recent CCG Urgent Work Stream meeting, the work of the hospital based social work service was described as "excellent" by a senior manager from the hospital.

128. A Member queried whether individuals were not being discharged on a week-end because other clinicians were unavailable on weekends. It was highlighted that the introduction of the Better Care Fund will facilitate better joint working. The Head of Assessment and Care Management advised that if all the facilities and staff were in place, more individuals would be discharged on a week-end. A Member commented that week-end discharges would be likely to benefit families as they would not be required to take time off from work.

129. It was acknowledged that following the introduction of the Better Care Fund, the health authority and social care services will need to establish joint performance indicators which will need to be agreed by NHS England.

CONCLUSIONS

130. Based on the evidence given throughout the investigation the panel concluded that:

NHS Continuing Healthcare (CHC)

a) NHS Continuing Healthcare (CHC) is a name given to a package of ongoing care and support provided to adults aged 18 or over, which is arranged and funded solely by the NHS where an individual is found to have a ‘primary health need’. In essence, the NHS funds all health and social care needs.

b) All health and social care professionals have an obligation to the person they are caring for, to optimise their care and encourage the individual to help themselves to become more independent. If the person caring for the individual is of the view that the individual's illness is at a stage where they require more health care intervention, then they have a duty to consider whether the individual is eligible for NHS CHC.

NHS CHC Rates

c) In 2012, it was felt that there was considerable variation in service provision across what is now the South Tees Clinical Commissioning Group (CCG) in comparison to other areas. This created an inconsistency in the number of individuals in receipt of NHS CHC. Statistics and data demonstrate that the four Tees authorities have the lowest levels of NHS CHC within the North East. Middlesbrough’s performance has improved in obtaining NHS CHC and the Local Authority has been proactive in assessing people. However, difficulties have been experienced in obtaining data and statistical information for 2013/14. Therefore, the scrutiny panel was unable to ascertain whether improvements in NHS CHC have continued following the development of the CCG and NHS CHC management being contracted to the North of England Commissioning Support Unit (NECS).

Reasons for Low NHS CHC Rates

d) The South Tees CCG and NECS sought to explain that the reason for Middlesbrough's low NHS CHC rates is the existence of the broad range of community-based services, such as community hospitals, palliative care, the Marie Curie service and district nursing. It was highlighted that with community-based services, individuals receive rehabilitation and respite, which often provide an alternative to NHS CHC. Other geographical areas do not always have access to such a broad range of services.

Local Authority Concerns

e) Some of the services described as being alternatives to NHS CHC (such as the district nursing and Marie Curie services) could well be in place alongside services from Adult Social Care, which are chargeable to the individual. If an individual is, therefore, not considered for NHS CHC, because of the provision of one of these "alternative" services, then the individual will be charged for the social care component, which potentially the NHS should be paying for. This can have major financial implications for individuals. It may also potentially impact on the Council, as the Local Authority may be paying the care costs for individuals who should be in receipt of NHS CHC funding.

Challenges

f) It is acknowledged by all stakeholders that NHS CHC is a service area that is quite challenging due to decisions having a direct impact on organisational resources; however, the overriding principle that should govern the NHS CHC process, is that the needs of the individuals and their families/carers is paramount and overrides all organisational considerations. Thus these decisions are not just about health or social care funding but about individuals' rights. The individual and their views, about their needs and the care and support required, should be at the centre of the process.

g) An area that remains challenging for all stakeholders is around the continued perception that the NHS CHC Framework is not applied consistently. Work is ongoing across the Tees to address the inconsistencies in NHS CHC application and improve current working practices.

Progress

h) Over the last 16 months, significant progress has been made with all partner organisations working to improve relationships and the consistent application of the NHS CHC Framework, the overriding principle being that people should receive the most appropriate care to meet their individual needs. Indeed, the CHC team is working very closely with local authority colleagues. Outcomes for patients have continued to improve as have the relationships between each of the agencies involved at both a strategic and operational level.

i) Communication between the CCG/NECS and the Local Authority has undoubtedly improved and there is a good working relationship in place between the organisations. However, further work is required to ensure all health and social care professionals have a clear understanding of procedures and the process would benefit from the development of a joint working protocol.

j) The Council has greater confidence now that its staff are robustly engaging in the assessment process. However, there is a need to ensure that health and social care professionals increase their knowledge and understanding and continue to gain confidence in this area.

Awareness

k) Individuals are not always aware of the availability of NHS CHC funding. It was highlighted that individuals, carers and family members are provided with leaflets at the Decision Support Tool stage. However, it is the view of the scrutiny panel that further work is required to ensure Middlesbrough residents are aware of NHS CHC and how to access it. The way in which information is disseminated needs to be reviewed. In addition to this, residents of Middlesbrough, and neighbouring authorities, would benefit from an advice and support service which offers a central point of contact. The purpose of the service should be to answer general enquiries, in addition to providing the necessary support throughout the process.

RECOMMENDATIONS

131. That the Social Care and Adult Services Scrutiny Panel recommends to the Executive:

a) That NECS provides the South Tees Health Scrutiny Joint Committee with up-to-date/current statistical information and data pertaining to NHS CHC rates. That statistics for 2013/14 be reported in the first instance and thereafter on a quarterly basis, providing the committee with an ability to monitor rates.

b) That NECS monitors the number of individuals who have an initial assessment and records outcomes, in addition to how many are referred for a full assessment.

c) That the inter-agency group develops a joint protocol for all health and social care professionals to assist in ensuring national guidelines and policy, in relation to NHS CHC, is implemented correctly and to ensure consistent approaches across the Tees Valley.

d) That NECS:
- Reviews the training package to include local case studies, examples of good practice and potential problems/issues that may be encountered.
- Regularly reviews the training package to ensure it is up-to-date and appropriate for different health professionals and social care professionals.
- Undertakes further work to actively encourage health and social care professionals to complete the training.

e) That NHS CHC training and completion of the e-learning programme is made mandatory for all of Middlesbrough's Adult Social Workers.

f) That NECS develops and manages an NHS CHC advice and support service. The service must offer specialist knowledge and must be adequately resourced to answer general enquiries, in addition to providing the necessary support throughout the process.

g) That the CCG and NECS undertake a review of how information is disseminated to the public and implement actions to raise awareness of the availability of NHS CHC and the support available. The scrutiny panel proposes that:
- Detailed NHS CHC information is made available on the CCG, NECS and South Tees Hospitals Foundation Trust websites.
- Leaflets are designed, distributed to, and displayed in local GP surgeries, health centres, hospitals and care homes. The leaflet should also be circulated to leading care associations, organisations and charities.
- Public information pertaining to NHS CHC provides details of the complaints procedures, appeals process, deadlines for making NHS CHC claims and contact details for advice and support.

h) That the Council website and documentation be updated to include information on the availability of NHS CHC and the support available.

i) That a forum be established, specifically for those in receipt of NHS CHC, whereby patients, families and carers can provide feedback and their views/opinions on the NHS CHC process to assist in establishing best practice and improving current working practices.

j) That, in six months' time, the CCG and NECS submit an update/progress report, on the implementation of the proposed recommendations, to the scrutiny panel.

ACKNOWLEDGEMENTS

132. The panel would like to thank the following people for their help with this review: -

Mike Robinson	Director of Wellbeing, Care and Learning, Middlesbrough Council
Colin Holt	Head of Assessment and Care Management, Middlesbrough Council
Erik Scollay	Interim Head for Community Care, Middlesbrough Council
Lou Okello	Senior Commissioning Manager, NECS
Yvonne Fagg	Locality Manager, NECS
Amanda Jones	Locality Manager, NECS
Joanne Dobson	Locality Manager, NECS
Jean Fruend	Executive Nurse, South Tees CCG

ACRONYMS

133. A-Z listing of common acronyms used in the report:

- CHC Continuing Healthcare
- CCG Clinical Commissioning Group
- DST Decision Support Tool
- NECS North of England Commissioning Support Unit
- NHS National Health Service

BACKGROUND PAPERS

134. The following evidence was consulted, or referred, to in preparing this report:

- Agenda papers and minutes of the Social Care and Adult Services Scrutiny Panel meetings held on 23 January, 20 February, 13 March and 3 April 2014.

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