NHS
South Tyneside
Clinical Commissioning Group

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☒ Official
☐ Sensitive: Commercial
☐ Official Sensitive: Personal

MEETING TITLE:	**GOVERNING BODY MEETING (PUBLIC)**	**DATE: 22.03.18**
REPORT TITLE:	**CONTINUING HEALTHCARE UPDATE**	**AGENDA ITEM: 2017/124** **ENCLOSURE: 10**
LEAD DIRECTOR / REPORT SPONSOR:	Matt Brown, Director of Operations Matt.brown2@nhs.net 0191 283 1903	
REPORT AUTHOR:	Sarah Golightly, Integrated Commissioning Lead Sarah.Golightly@southtyneside.gov.uk 0191 283 1903	
REPORT SUMMARY / RECOMMENDATIONS:	This paper is intended to summarise the current position for the CCG around management of Continuing Healthcare (CHC) and progress against a series of recommendations that were made to Executive Committee in November 2017. Of the two key national metrics around CHC, South Tyneside CCG historically has very good performance in one (a high proportion of assessments taking place outside hospital), but very poor performance in the other (a low proportion of assessments taking place within 28 days). South Tyneside CCG has a high rate of Fast Tracks, CHC referrals, individuals assessed as eligible for CHC and consequently a very high level of expenditure on CHC. Expenditure on FNC and joint packages are low. This is a consequence of an expensive and fragmented CHC system with a series of perverse incentives and a culture of poor working relationships, entrenched positions, low levels of trust and a distinct lack of ownership. To address this, a series of recommendations was approved by Executive Committee, around: • Commissioned Services • Partnership Working • Operational Management • Internal Accountability and Performance Management Progress has been made against these areas : **Commissioned Services** 1. Notice has been served on the elements of CHC provided by NECS. These included financial management of invoices, some case management, some brokerage, some appeals and disputes, representation, queries, panel organisation and quality assurance of the documentation. 2. An approach to take those elements (and associated resource) into the Joint Commissioning Unit (JCU) has been developed for commencement of implementation from 1st April 2018, including an opportunity to shadow across the agencies. 3. Work is underway with Sunderland CCG and the STFT nurse assessment service to ensure clear expectations across all partners. **Partnership Working** 4. Early outline discussion has been held about the need to formalise arrangements for commissioning joint packages and these will be developed following the completion of the transfer of services to JCU.	

	Operational Management 5. In February 2018, Executive Committee gave approval to a CHC Policy on Healthcare Packages, for implementation and publication in August 2018. The proposed date was set as August 2018, to allow key supporting work to be put in place, including new processes, market development, training, communication and costing methodology. 6. A series of process and operational improvements have been implemented, including: a. Alternative process in place for decision authorisation, which removes the need for a weekly panel, but allows for disputes and queries to be managed at this allotted times b. New delivery model has been developed for the fast track process, by front-line staff. This is being tested initially in one of the integrated hubs and being very much driven in conjunction with South Tyneside Foundation Trust community team c. Dispute process drafted and with stakeholders for comment d. Interim appeal process commissioned whilst longer term solution developed 7. The CCG has sought active participation in the national NHS Continuing Healthcare Strategic Improvement Programme, aiming to be at the forefront of learning from other areas, although there has been relatively little to share from this to date. **Internal Accountability and Performance Management** 8. Internal accountability has been clarified in line with the Operational Scheme of Delegation. 9. The CHC Steering Group is becoming well established and will support the change programme. 10. Dedicated analytical capacity will be introduced through the JCU, using the resource released from NECS, to ensure high-quality strategic management information and to facilitate operational grip. 11. Internal reporting arrangements have been revised so that strategic performance report and exceptions will be received at Executive Committee, with oversight of operational management information at the CHC Steering Group. Exceptions and themes relating to the quality of care for individuals will continue to be received at Quality and Patient Safety Committee. To give an indication of some of the early impact of these changes, performance against the 28-day assessment target has improved significantly from 18% in Q2 to 77% in Q3 (January and February only). Governing Body is asked to note the report, progress made and work ongoing.	
FINANCIAL IMPLICATIONS / RISKS	Continuing Healthcare (CHC) expenditure is at a high level for South Tyneside CCG and the update reported in this paper includes work to address that, ensuring better value for the taxpayer and the South Tyneside Pound.	
EQUALITY IMPACT ASSESSMENT (EIA) COMPLETED Following the launch of the revised EIA documents on 1 March 2016 EIAs must be completed as follows: An EIA should be undertaken at the start of the development for **a new proposed service, policy or process** to assess likely impacts and provide further insight as to what will be required to implement it effectively. The EIA form and associated documents can be found on the CCG's intranet or through NECS Equality and Diversity Team Has an Equality Impact Assessment been completed using the equality impact documents	**NO** ☒ If no please specify the reason why: Not applicable, report does not make any proposals - it is for information only.	**YES** ☐ If yes please attach a copy of the completed assessment to the back of your report

ensuring that no persons are adversely affected as required by the Equality Act 2010 *(Please check the relevant box by double clicking on the box and selecting "checked" under the default value heading – only one box should be checked.)* **If you are unsure if the report requires an EIA or for any further guidance please contact:** **NECSU.Equality@nhs.net**		
QUALITY IMPACT ASSESSMENT COMPLETED Following the implementation of the STCCG Quality Strategy (September 2015) it has been agreed that a QIA should be undertaken for a new proposed service, policy or process or any changes to current services which may have an impact on quality or experience Has a Quality Impact Assessment been completed using the quality impact assessment tool ensuring that they have demonstrated the potential quality and safety impact?	**NO** ☒ If no please specify the reason why: Not applicable, report does not make any proposals - it is for information only.	**YES** ☐ If yes please complete the below Quality Impact Assessment and submit with your report STCCG Quality Impact Assessment 2

PURPOSE OF REPORT:	**For Information**	**For Approval To Note**	**For Decision**
	☒	☐	☐

RISK REGISTER Is the report subject matter included on the CCG Risk Register	**NO** ☐ **YES** ☒ If yes please confirm the risk register has been updated in accordance with the content of this report: **Updated** ☒ **Not Update** ☐	If not updated please specify the reason:
SPONSORING LEAD DIRECTOR APPROVAL: Has the Lead Director approved the paper (proof of approval must be retained for audit purposes)	**YES** ☒ **NO** ☐	Papers without Lead Director approval will be withdrawn from the agenda

1. Executive Summary

This paper is intended to summarise the current position for the CCG around management of Continuing Healthcare (CHC) and progress against a series of recommendations that were made to Executive Committee in November 2017.

Of the two key national metrics around CHC, South Tyneside CCG historically has very good performance in one (a high proportion of assessments taking place outside hospital), but very poor performance in the other (a low proportion of assessments taking place within 28 days).

South Tyneside CCG has a high rate of Fast Tracks, CHC referrals, individuals assessed as eligible for CHC and consequently a very high level of expenditure on CHC. Expenditure on FNC and joint packages are low.

This is a consequence of an expensive and fragmented CHC system with a series of perverse incentives and a culture of poor working relationships, entrenched positions, low levels of trust and a distinct lack of ownership.

To address this, a series of recommendations was approved by Executive Committee, around:

- Commissioned Services
- Partnership Working
- Operational Management
- Internal Accountability and Performance Management

Progress has been made against these areas :

Commissioned Services

12. Notice has been served on the elements of CHC provided by NECS. These included financial management of invoices, some case management, some brokerage, some appeals and disputes, representation, queries, panel organisation and quality assurance of the documentation.
13. An approach to take those elements (and associated resource) into the Joint Commissioning Unit (JCU) has been developed for commencement of implementation from 1st April 2018, including an opportunity to shadow across the agencies.
14. Work is underway with Sunderland CCG and the STFT nurse assessment service to ensure clear expectations across all partners.

Partnership Working

15. Early outline discussion has been held about the need to formalise arrangements for commissioning joint packages and these will be developed following the completion of the transfer of services to JCU.

Operational Management

16. In February 2018, Executive Committee gave approval to a CHC Policy on Healthcare Packages, for implementation and publication in August 2018. The proposed date was set as August 2018, to allow key supporting work to be put in place, including new processes, market development, training, communication and costing methodology.
17. A series of process and operational improvements have been implemented, including:
    a. Alternative process in place for decision authorisation, which removes the need for a weekly panel, but allows for disputes and queries to be managed at this allotted times
    b. New delivery model has been developed for the fast track process, by front-line staff. This is being tested initially in one of the integrated hubs and being very much driven in conjunction with South Tyneside Foundation Trust community team
    c. Dispute process drafted and with stakeholders for comment
    d. Interim appeal process commissioned whilst longer term solution developed
18. The CCG has sought active participation in the national NHS Continuing Healthcare Strategic Improvement Programme, aiming to be at the forefront of learning from other areas, although there has been relatively little to share from this to date.

Internal Accountability and Performance Management

19. Internal accountability has been clarified in line with the Operational Scheme of Delegation.
20. The CHC Steering Group is becoming well established and will support the change programme.
21. Dedicated analytical capacity will be introduced through the JCU, using the resource released from NECS, to ensure high-quality strategic management information and to facilitate operational grip.
22. Internal reporting arrangements have been revised so that strategic performance report and exceptions will be received at Executive Committee, with oversight of operational management information at the CHC Steering Group. Exceptions and themes relating to the quality of care for individuals will continue to be received at Quality and Patient Safety Committee.

To give an indication of some of the early impact of these changes, performance against the 28-day assessment target has improved significantly from 18% in Q2 to 77% in Q3 (January and February only).

Governing Body is asked to note the report, progress made and work ongoing.

2. Purpose of Paper

This paper is intended to summarise the current position for the CCG around management of Continuing Healthcare (CHC) and progress against a series of recommendations that were made to Executive Committee in November 2017.

3. What is CHC?

Let us start with first principles to ensure that there is clear, shared understanding within the CCG. The National Audit Office published the findings of an investigation into NHS CHC funding in July 2017 (National Audit Office, 2017), which set out some useful clarifications to supplement the National Framework (Department of Health, 2012).

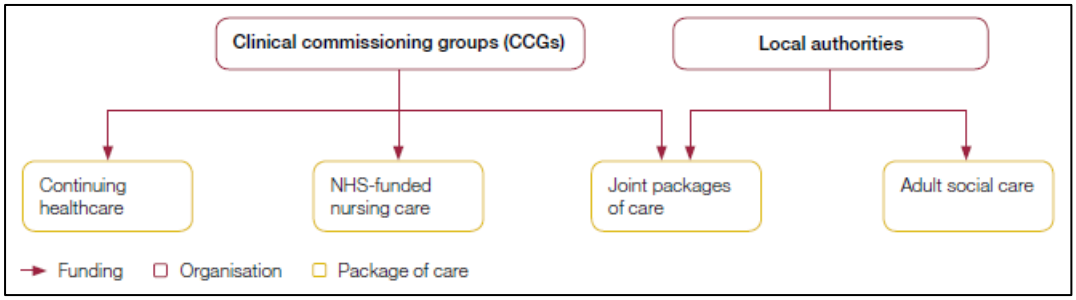
"NHS continuing healthcare (CHC) is a package of care, usually provided outside of hospital, for individuals aged 18 years and older who have been assessed as having a 'primary health need'. People who are assessed for CHC funding include some of the most vulnerable in society. Some are reaching the end of their lives, or have long-term conditions as a result of a disability, accident or illness.

If someone is assessed as eligible for CHC funding, the NHS funds the full package of health and social care. For example, if a patient is eligible for CHC in their own home, the NHS will pay for healthcare costs (such as services from a community nurse or specialist therapist) and for associated social care costs (such as personal care and help with bathing). In a care home, the NHS also pays for people's care home fees, including board and accommodation.

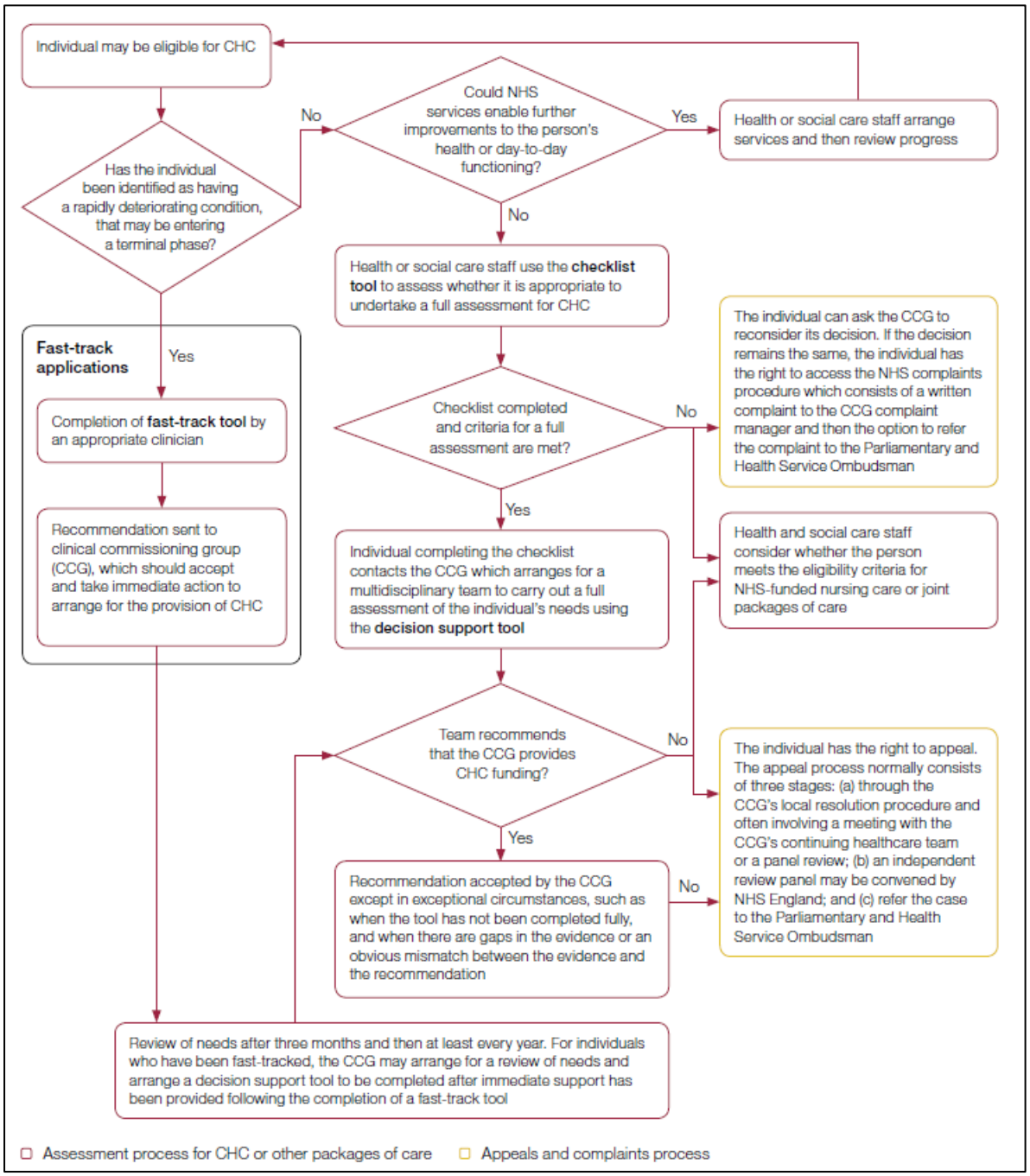
If someone is assessed as not eligible for CHC, they may still be entitled to other health and social care services, such as NHS-funded nursing care or social care services funded by the local authority. However, social care services are means-tested, meaning the person may have to pay a charge depending on their income, savings and capital assets. For NHS-funded nursing care (FNC), the NHS pays a flat-rate contribution towards the cost of the person's nursing care (a standard rate of £155 a week in 2017‑18). In 2015-16, the average cost of providing care to each person was £19,190 for CHC, compared with £3,305 for NHS-funded nursing care and £9,944 for social care." (National Audit Office, 2017, p. 12)

"If a person does not qualify for NHS continuing healthcare, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both an LA and a CCG, this is known as a 'joint package' of care. A joint package of care could include NHS-funded nursing care and other NHS services that are beyond the powers of a LA to meet. The joint package could also involve the CCG and the LA both contributing to the cost of the care package, or the CCG commissioning part of the package. Joint packages of care may be provided in a nursing or residential care home, or in a person's own home." (Department of Health, 2012, p. 10)

The following depicts the different funding streams (National Audit Office, 2017, p. 13):



The following sets out the high-level CHC assessment process (National Audit Office, 2017, p. 16):



4. Where are we now?

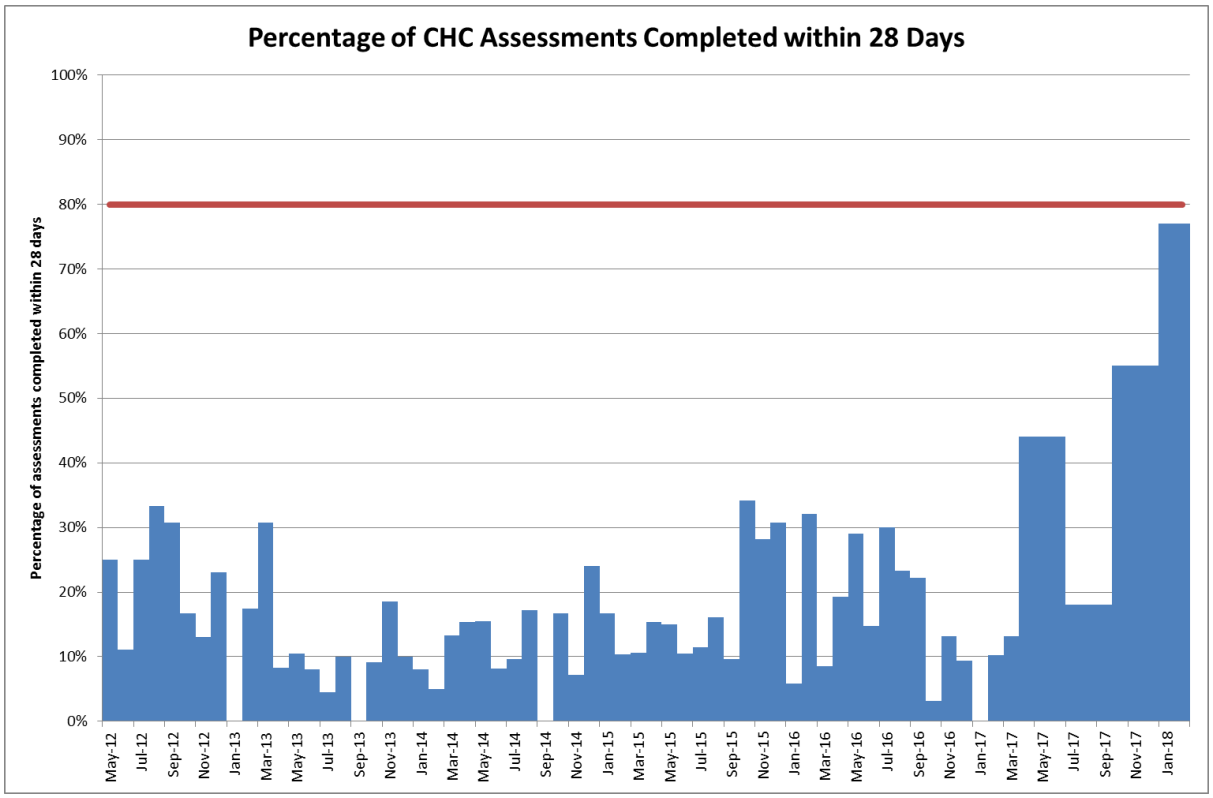
Let us start by clearly establishing the relative performance of the South Tyneside CHC system.

4.1 Quality Premium Measures

In terms of the efficiency and effectiveness of CHC processes, there are two core measures to be delivered, each of which is worth 8.5% of the CCG Quality Premium for 2017/18. The measures are:

1. In more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision must be made by the CCG within 28 days from receipt of the Checklist.
2. Less than 15% of all full NHS CHC assessments must take place in an acute hospital setting.

Unfortunately, South Tyneside CCG has historically been well off the mark in terms of performance against the first (28-day assessment) measure, amongst the worst in the country. However, the changes outlined in this paper, mostly since November 2017 have had a significant positive impact.

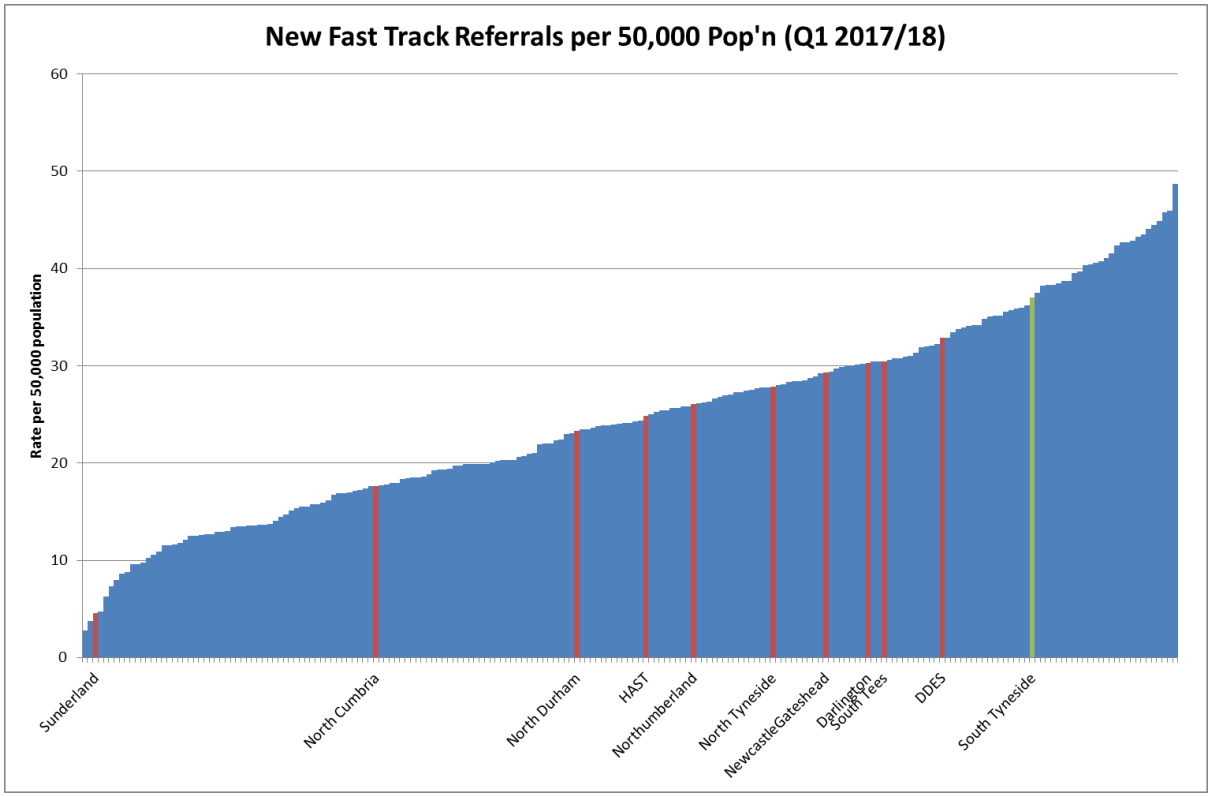


In terms of the second measure, South Tyneside CCG is amongst the best in the country.

4.2 Fast Tracks

The Fast Track process does not require a full assessment and is intended for individuals with rapidly deteriorating conditions who may be nearing the end of their life.

In terms of new fast tracks, South Tyneside has a referral rate within the highest 20 CCGs in the country. The Fast Track referral rate for South Tyneside is around a third higher than North Tyneside CCG and is eight times that of Sunderland CCG (the nearest socioeconomic comparators).



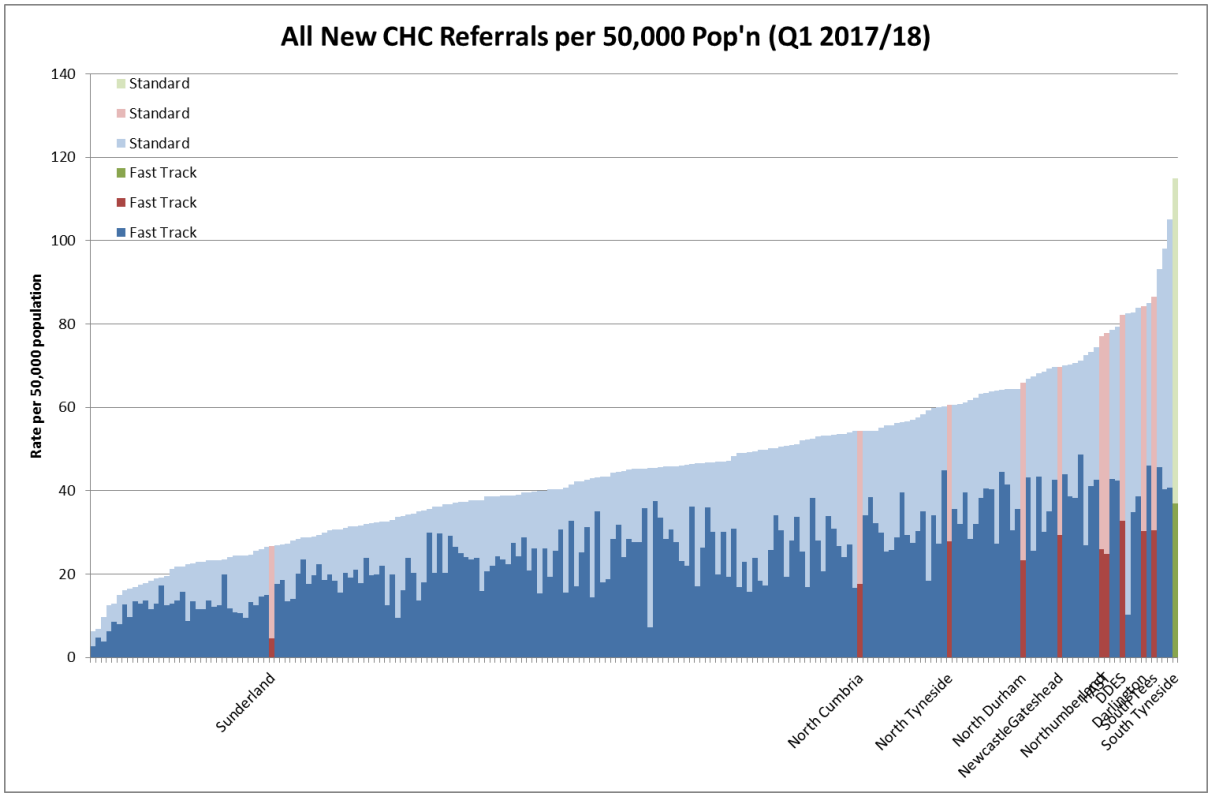
It is felt likely that the high Fast Track referral rate reflects a number of issues:

- Lack of understanding about the options available for patients on the end of life pathway
- Lack of education and feedback for clinicians on the Fast Track process
- A misperception that Fast Track is needed to enable rapid discharge from hospital
- Perverse incentives to circumvent other funding routes
- Weak CHC control systems

4.3 CHC Referrals and Eligibility

According to Q1 2017/18 data, South Tyneside CCG has the highest rate of CHC referrals (per capita) in the country. In particular, in addition to a high Fast Track referral rate, South Tyneside CCG has the second highest rate of standard (i.e. non-Fast Track) CHC referrals in the country.

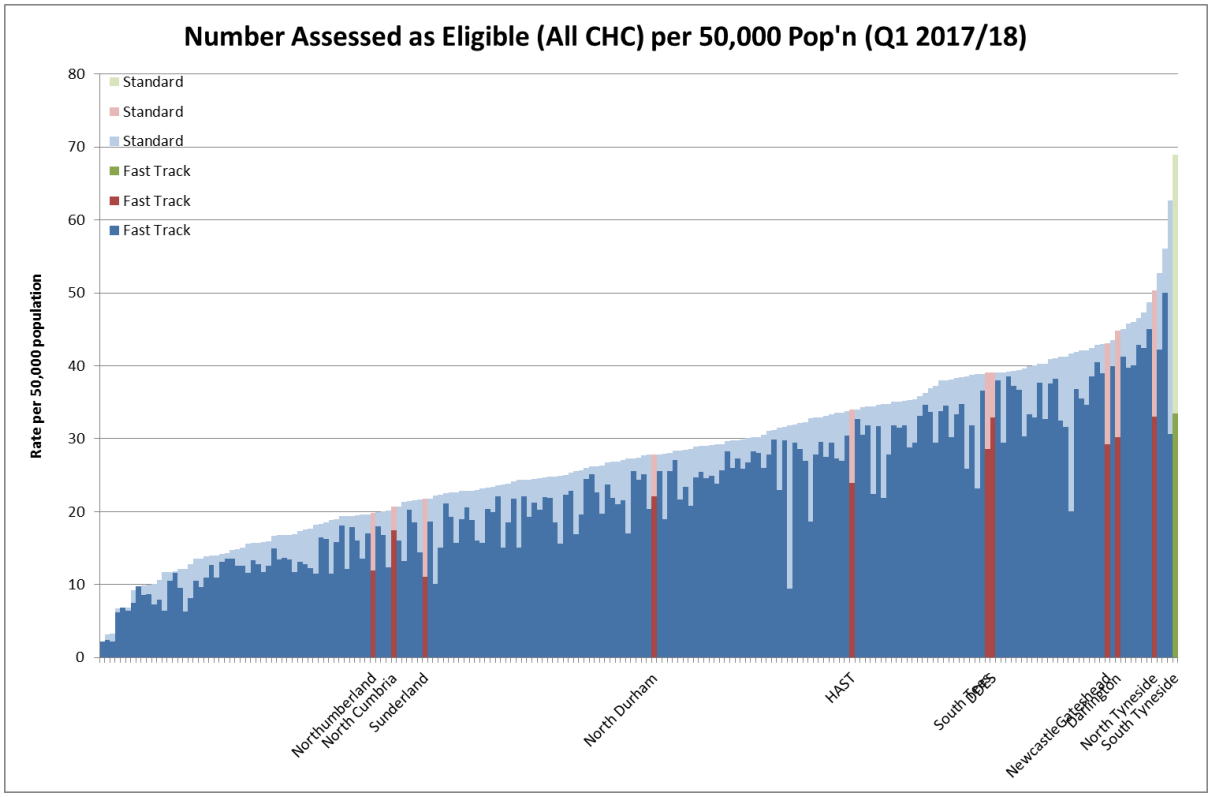
Although this data reflects just one quarter, the same is true over the data available for the previous year also, that South Tyneside CCG has amongst the very highest rates of CHC referrals.



For the conversion rate, which is the proportion of CHC referrals that are assessed as eligible, South Tyneside CCG is somewhat, but not exorbitantly, above national and regional averages, with around half of referrals being assessed as eligible.

However, this is misleading, as the CCGs with high conversion rates tend to have much lower referral rates, indicating a system that is much more tightly controlled, with greater understanding and clarity about eligibility.

South Tyneside CCG has an unusual combination of an extremely high referral rate and a relatively high conversion rate. The consequence of that is that South Tyneside CCG has the highest rate (in terms of the number per capita) of individuals assessed as eligible for CHC in the country.

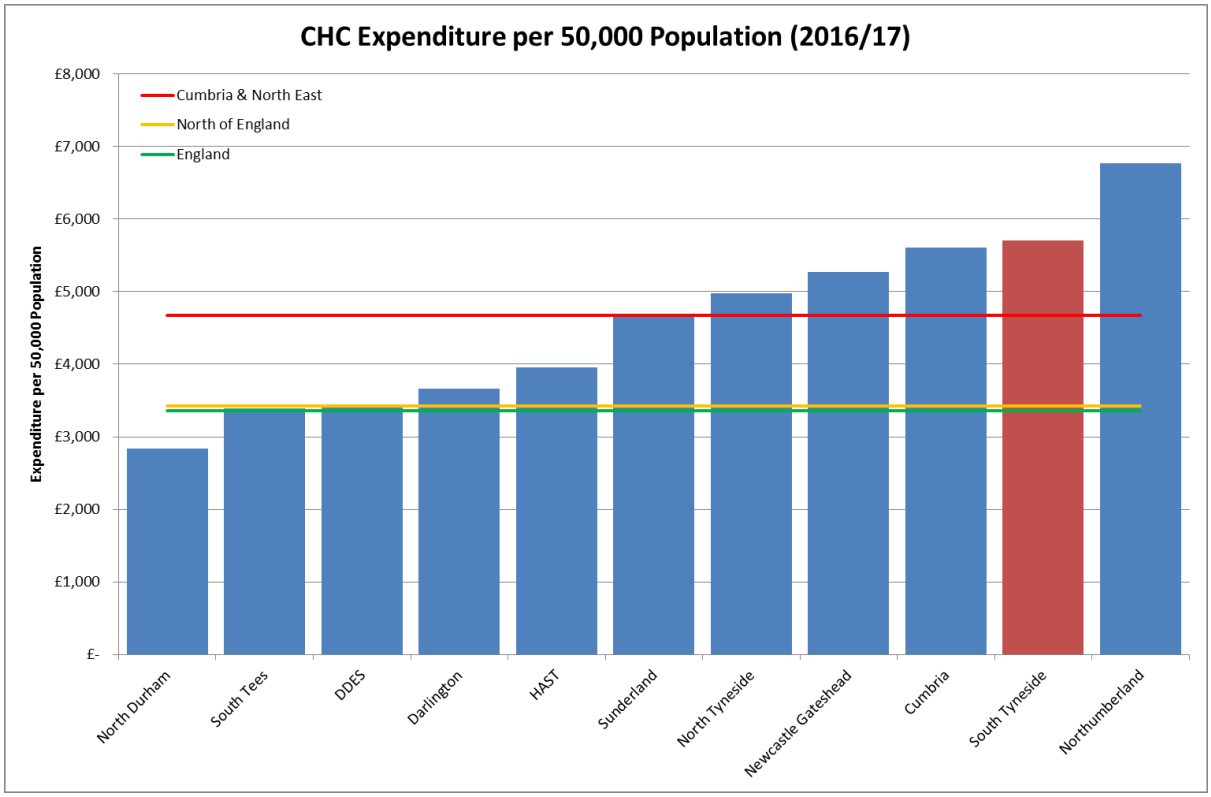


At this point, it is worth reflecting on the conclusions drawn by the National Audit Office "*that the variation cannot be fully explained by local demographics or other factors it has considered so far. This suggests that there may be differences in the way CCGs and local authorities are interpreting the national framework to assess whether people are eligible for CHC due to the complexity of this framework"* (National Audit Office, 2017, p. 11).

It is highly unlikely that the high rate of CHC eligible individuals is due to a difference in factors in the underlying population, for example relative to Sunderland. In other words, the reason that South Tyneside CCG has a very high rate of CHC eligibility, and therefore expenditure, is something to do with the processes, systems and behaviours that exist locally.

4.4 Expenditure

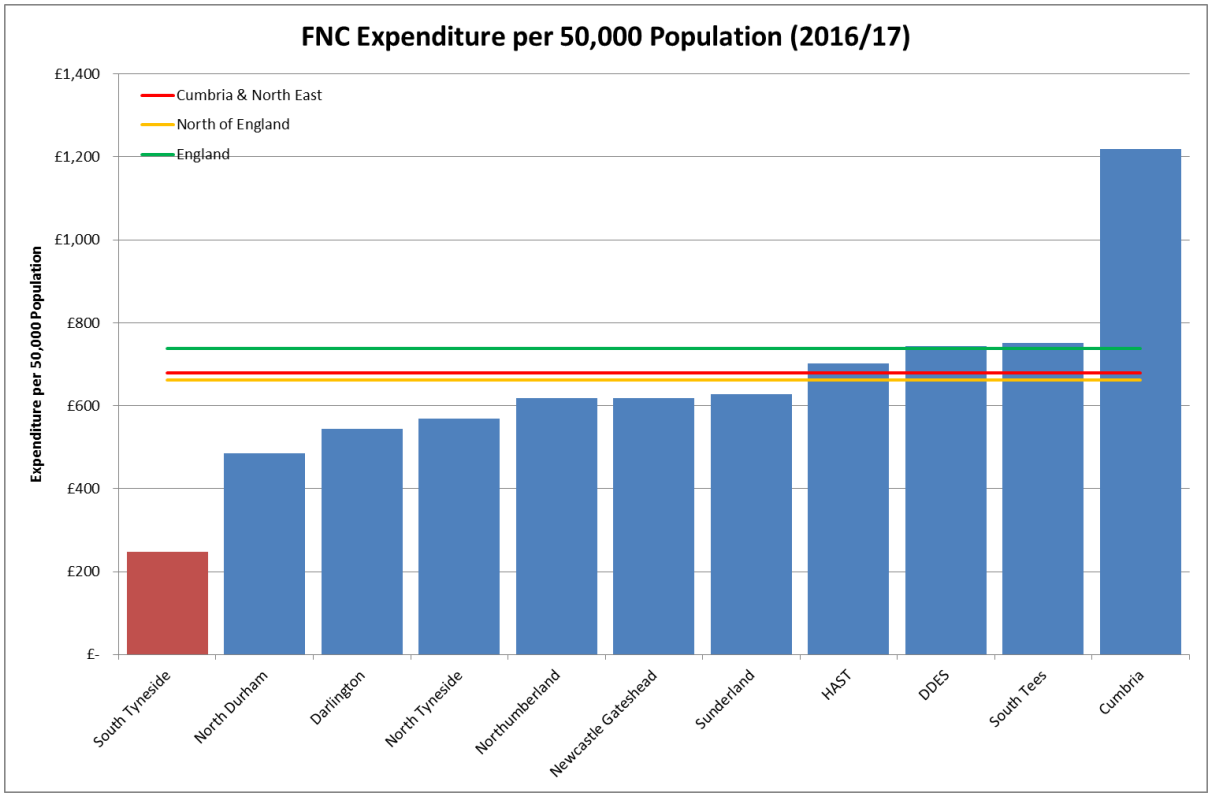
CHC expenditure has increased dramatically over recent years, and South Tyneside CCG has the second highest expenditure on CHC (per capita) in Cumbria and the North East, considerably higher than our comparator CCGs (Sunderland and North Tyneside). In addition, expenditure in Cumbria and the North East (per capita) was around 50% higher than in the rest of the country.

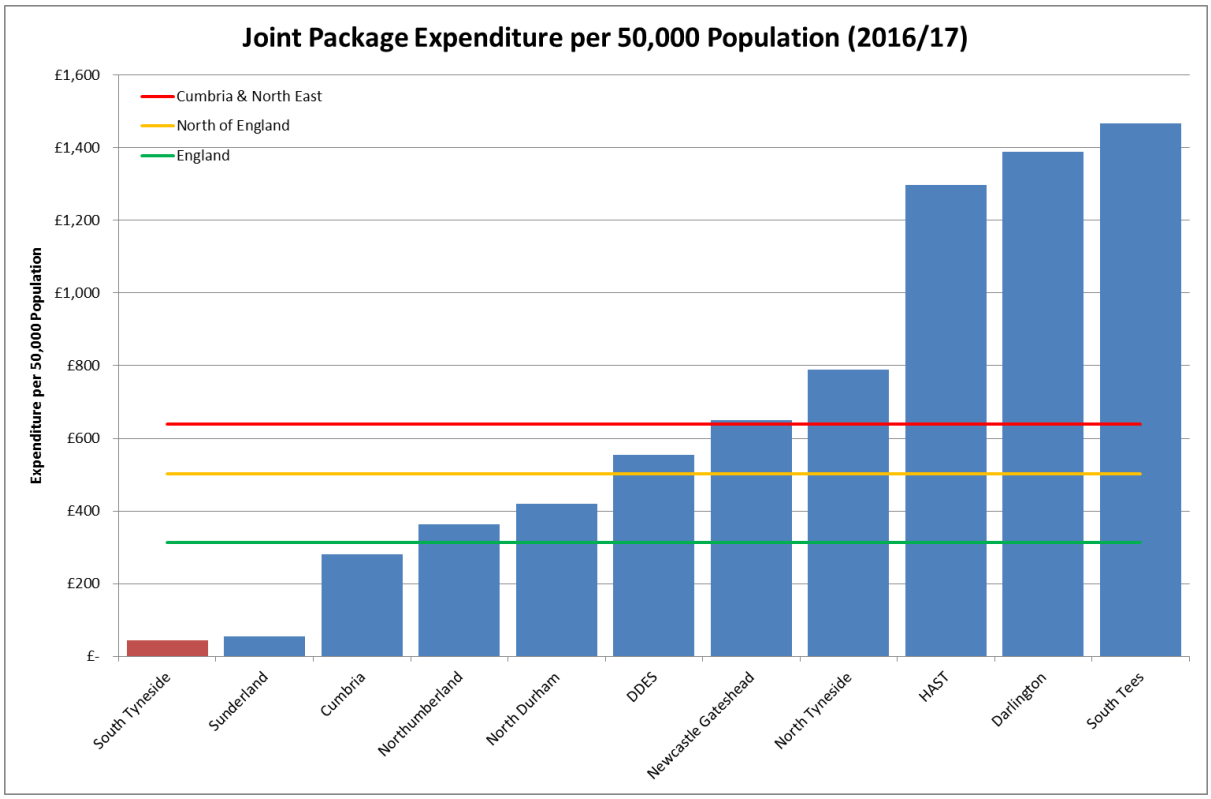


It is of particular interest that CHC expenditure is relatively high, whereas expenditure on both NHS-funded nursing care (FNC) and joint packages extremely low.

FNC is where the CCG pays a flat-rate contribution towards the cost of the person's nursing care (provided by a registered nurse for people who live in a nursing home), with the remainder of any costs through means-tested local authority payment, or self-funded.

Joint packages are where specific packages of support are commissioned or funded by both an LA and a CCG, and may be provided in a nursing home, residential home, or in the person's home.


FNC Expenditure per 50,000 Population (2016/17)
Expenditure per 50,000 Population
£1,400
£1,200
£1,000
£800
£600
£400
£200
£-
Cumbria & North East
North of England
England
South Tyneside
North Durham
Darlington
North Tyneside
Northumberland
Newcastle Gateshead
Sunderland
HAST
DDES
South Tees
Cumbria


Joint Package Expenditure per 50,000 Population (2016/17)
Expenditure per 50,000 Population
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£-
Cumbria & North East
North of England
England
South Tyneside
Sunderland
Cumbria
Northumberland
North Durham
DDES
Newcastle Gateshead
North Tyneside
HAST
Darlington
South Tees

5. Why is this?

5.1 Commissioned Services

The current structure of commissioned services is as follows:

Function	Provider
Nurse Assessment Same service also commissioned by Sunderland CCG	STFT
Case management and commissioning of care packages Procurement and commissioning of nursing home contracts and other contracts required for care packages provision, including quality framework	ST Council
CHC Commissioning support Arrangements Covers the provision of commissioning support for CHC and clinical oversight of certain types of packages eg Fast Track including case management and review and supporting services such as commissioning finance	NECS
Co-ordination Service for Some Fast Track packages	Marie Curie

The currently commissioned service is expensive and fragmented, with poor working relationships, low levels of trust and too many organisations involved. Over time, the fragmented system and lack of clear expectations have led to entrenched positions being developed across all organisations with a negative culture of blame and finger-pointing. There has been a void in terms of ownership and leadership. Furthermore, there are substantial gaps between organisations that have led to complaints and substantial costs being incurred.

As a consequence, steps have been taken to simplify the existing arrangements, increase the clarity of expectations and build ownership. In particular, we have taken specific lessons from North Tyneside CCG.

It was felt essential to take this service this in-house, to ensure that we are able to provide the level of leadership and grip that is required. Given that there is already infrastructure, systems and expertise to manage exactly this kind of service (and all packages of this kind) in the Joint Commissioning Unit (JCU), this seems the logical place to focus on.

The JCU is particularly sensible given that the most critical organisational relationship for the CCG around CHC is with South Tyneside Council, given that commissioning and management of care packages is their core business and also the perverse incentives that could otherwise exist in the system.

Therefore, the following is a summary of progress to date:

1. Notice has been served on the elements of CHC provided by NECS. These included financial management of invoices, some case management, some brokerage, some appeals and

disputes, representation, queries, panel organisation and quality assurance of the documentation.

2. An approach to take those elements (and associated resource) into the Joint Commissioning Unit (JCU) has been developed for implementation from 1st April 2018. Some shadowing will be necessary to ensure smooth transition.

The second critical relationship around CHC is with STFT, because of the role the commissioned nurse assessors play in determining eligibility, but also crucially because the vast majority of referrals into CHC (both Fast Track and non-Fast Track) are from STFT clinicians, either in the community or hospital.

From discussion with Sunderland CCG, it is felt that it may be possible to make significant progress with the service provided by the nurse assessment team to both CCGs, through a programme of joint work on expectations (particularly around the role that the individual nurse assessors play in eligibility decisions), training and leadership.

Therefore, the following is a summary of progress to date:

1. Work is underway with Sunderland CCG and the STFT nurse assessment service to ensure clear expectations across all partners.

5.2 Partnership Working

As mentioned above, the critical relationship for the CCG with regard to CHC is with South Tyneside Council. Without an extremely close arrangement between the two organisations, there is significant potential for there to be perverse incentives. The local agreement about the need to ensure the best for the South Tyneside Pound, under the alliancing principles is important for both organisations.

The work on CHC is intended to focus on how we ensure all individuals have their needs and support package assessed appropriately, as there is substantial financial waste to the taxpayer for both South Tyneside Council and the CCG at present.

To ensure a focus on individuals, rather than funding stream, and hence get the best for the South Tyneside Pound, it is particularly important that we change the incentives that exist in the system. In particular, it will be important to develop joint packages and explore pooled fund arrangements. Early discussion has been positive on both fronts.

Therefore, the following is a summary of progress to date:

1. Early outline discussion has been held about the need to formalise arrangements for commissioning joint packages and these will be developed following the completion of the transfer of services to JCU.
2. Early outline discussion has been held around the feasibility of developing a pooled budget arrangement and this will be developed following the completion of the transfer of services to JCU.

5.3 Operational Management

There are a series of operational issues that are predominantly driven by the lack of cohesion and clarity in the CHC system.

Of particular note, there is a distinct lack of clarity and training for referrers about end of life pathways, most notably about what the Fast Track process is, what it does and the other options that are available. In looking at the end of life pathway with front-line staff, it has become clear that there are issues with staff having to take "work arounds" to circumvent the present process, significant numbers of handoffs, disempowerment, high costs, lack of quality assurance and slow processes. This has a number of consequences, that individuals end up with packages that they don't need or want, that there is significant financial waste and that limited capacity is used for the wrong individuals.

There are a great number of issues related to the CHC process themselves, including the number of unnecessary steps, the flow of information, the reconciliation of lists and the tight management of all cases.

Further issues have existed in terms of the clarity of care package commissioning for South Tyneside residents, as opposed to other local areas.

There is significant work underway to address these, benefiting from structured support to facilitate and capture the range of agreed processes consistently through the JCU.

It should also be noted that new CHC framework has been published recently, for implementation in October 2018, and the implications are currently being worked through.

Therefore, the following is a summary of progress to date:

1. In February 2018, Executive Committee gave approval to a CHC Policy on Healthcare Packages, for implementation and publication in August 2018. The proposed date was set as August 2018, to allow key supporting work to be put in place, including new processes, market development, training, communication and costing methodology.
2. A series of process and operational improvements have been implemented, including:
    a. Alternative process in place for decision authorisation, which removes the need for a weekly panel, but allows for disputes and queries to be managed at this allotted times
    b. New delivery model has been developed for the fast track process, by front-line staff. This is being tested initially in one of the integrated hubs (Hebburn & Jarrow) and being very much driven in conjunction with South Tyneside Foundation Trust community team
    c. Dispute process drafted and with stakeholders for comment
    d. Interim appeal process commissioned whilst longer term solution developed

5.4 Internal Accountability and Performance Management

Although there are a number of issues to resolve in terms of commissioned service, partnership working and operational management, it is clear that there are also some internal matters to work through in terms of accountability, performance management and clarity.

It is of critical importance that the CCG has absolute clarity about the vision for CHC, but also about the mechanisms for internal management and the messages that we seek to give strategically.

Therefore, the following is a summary of progress to date:

1. Internal accountability has been clarified in line with the Operational Scheme of Delegation.
2. The CHC Steering Group is becoming well established and will support the change programme.

Also, there is a need to dramatically sharpen up the internal reporting and performance management of CHC. The volume of data available around CHC is substantial, but at present the level of management and operational information generated through that data is inadequate. This requires dedicated analytical support to ensure a firm grip on the key operational and strategic management information.

There is one management report received routinely within the CCG, which is at the Quality and Patient Safety Committee (QPSC). The QPSC report itself has been somewhat confused in its purpose. Furthermore, QPSC seems the wrong place to receive a report that, at least in theory, should be either an operational management paper or an overview of strategic performance and delivery.

The consequence of this is that it is too easy to be distracted by noise in the system, in terms of the urgent but less strategically important issues, rather than addressing the root causes of the poor CHC system.

Therefore, the following is a summary of progress to date:

1. Dedicated analytical capacity will be introduced through the JCU, using the resource released from NECS, to ensure high-quality strategic management information and to facilitate operational grip.
2. Internal reporting arrangements have been revised so that strategic performance report and exceptions will be received at Executive Committee, with oversight of operational management information at the CHC Steering Group. Exceptions and themes relating to the quality of care for individuals will continue to be received at Quality and Patient Safety Committee.

6. References

Department of Health. (2012). *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.*

National Audit Office. (2017). *Investigation into NHS continuing healthcare funding.*