NHS
North Cumbria
Clinical Commissioning Group

North Cumbria CCG Continuing Healthcare Annual Report 2018-2019

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Table of Contents:

1. Purpose and Scope:

The purpose of this report is to provide the System Partnership Quality Assurance Committee with a year-end position for 2018-19 in respect of "Continuing Healthcare" and its associated processes in North Cumbria. In North Cumbria our overarching aim is to provide a positive eligibility assessment experience for all clients referred to NHS Continuing Healthcare. North Cumbria CCG (NCCCG) and North East Commissioning Support Unit (NECSU) staff work with partners to ensure the care commissioned is personalised, good quality and fair for all.

2. Definitions:

2.1 **NHS Continuing Healthcare (CHC):** means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a ''primary health need". Care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered, or on the type of service delivery (National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care *October 2018: Revised).*

2.2 **NHS-Funded Nursing Care (FNC):** is the funding provided by the NHS to nursing homes in order to support the provision of nursing care by a registered nurse. Since 2007 NHS-funded nursing care has been based on a single band rate. In all cases individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS-funded nursing care.

2.3 **Shared/Joint Package of Care (between NHS and LA):** Individuals who need ongoing care/support may require services arranged by CCGs and/or LAs. CCGs and LAs therefore have a responsibility to ensure that the assessment of eligibility for care/support and its provision take place in a timely and consistent manner. 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.

3. Financial Context:

3.1 **Budget Setting:** Budget setting for "CHC" is always a challenge given that it is often based upon the previous year outturn, which doesn't reflect the demographic changes in North Cumbria or recognise the ageing population, the increasing number of children with complex needs who are transitioning into adult services and/or the increase in public expectations. Similarly, It doesn't take into account the significant increase in CHC packages in an individual's own home, or the high cost cases coming through in relation to complex clients. The anticipated

inflationary increases are applied together with known increases e.g. FNC national increases 2% in 2018/19, living wage increases etc.

3.2 **National Benchmarking:** During 2018/2019 NC CCG was an outlier in relation to CHC eligibility. Although the CCG has moved to mid- table for eligibility we remain an outlier for the cost of packages of care

4. Current Assurance and Activity Position in North Cumbria:

4.1 **NHSE Assurance Indicators**: North Cumbria Clinical Commissioning Group is measured nationally defined compliance metrics. These are:

4.1.1 Number of DSTs completed within Acute Services

'Quality Premium: CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.''

At the beginning of April 2017 CCGs nationwide were required to reduce the number of Decision Support Tools (DSTs) carried out in an acute setting. This NHSE directive is in line with National Framework's guidance, and is intended to facilitate the completion of assessments in the right place and at the right time for the patient. That is, when the patient has returned to their optimum in terms of health and/or has an appropriate care package/placement established.

In October 2018, the Discharge Pathways Framework was launched by NC CCG in collaboration with both North of England Commissioning Support and Local Authority Colleagues. This framework was designed so that patients identified as medically fit could be discharged, with an appropriate package of interim funded care, in order to have a full DST assessment within 14 days (from discharge).

Whilst the reported figure for DSTs completed in acute services has consistently been 0% (against an expected NHSE trajectory of 15%) for the final quarter, there are inevitable impacts for the CHC core team, and the wider system, due the displacement of this work from acute services to the CCG. Historically, these assessments would not be undertaken by the CHC core team, and as such this increase in workload represents a considerable pressure on capacity, and therefore the CHC team's ability to meet other key compliance targets.

As at 31 March 2019 the total number of referrals received for patients following pathways was **31.** Of this number, the following breakdown is apparent:

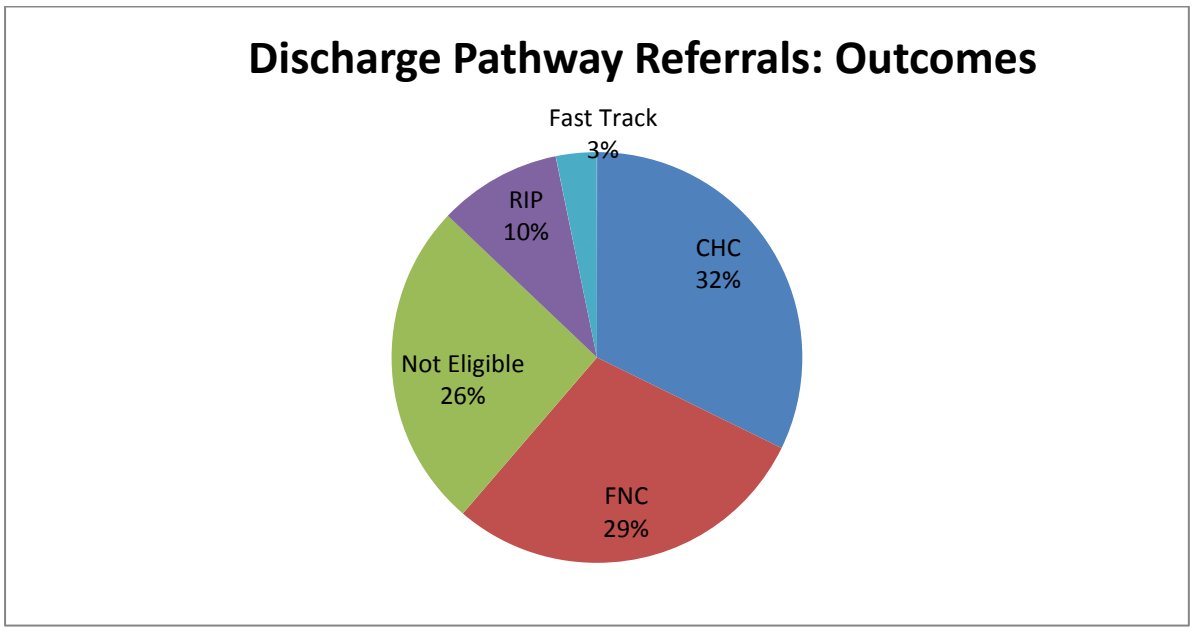
24 Patients were discharged to a new nursing home placement
2 Patients were discharged to their own home, with an existing package of care
5 Patients were discharged to their own home, but required a new package of care

The table below shows the CHC conversion rates as at the 31 March 2019:

Discharge Pathway Referrals: Eligibility Conversion Rates	
Referrals Received	31
Discounted before assessment*	3
Eligible	19
Not Eligible	9
Conversion rate	61% *(eligible for CHC funding)*

*Either RIPd before, or shortly after discharge.

Of these numbers, the following breakdown is apparent:



Of the total number of referrals received, the average days funded under the discharge pathway framework was **30** for 2018/19. This number is outside of the 14 day funding agreement, and illustrates that the new demand on capacity has been considerable. Ongoing reviews of the pathway framework, together with close monitoring will both aim to reduce the time taken to assess from point of discharge and increase the effectiveness of the process.

In this sense, the CCG/NECSs' continued, collaborative working with both Local Authority Acute and Hospitals' colleagues serve to enhance the effectiveness and efficiency of the Pathways Framework. To date, this collaborative work has included some focused multi-organizational training sessions, which have been helpful in developing knowledge around the CHC assessment process. Continually improving working relationships with colleagues across the health and care system has also resulted in improved communication and effective joint planning around discharge, which ultimately impacts and facilitates a higher level of end-to end service and patient experience in a positive way. This work will continue to be emphasized as we move into the new financial year.

4.1.2 Percentage of referrals completed within 28 days

''Quarterly Premium: CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility).

The table below shows the number of referrals received by the CHC core team, across North Cumbria, by quarter and year end.

New Referrals					
CHC Category	**Q1**	**Q2**	**Q3**	**Q4**	**Year-end totals**
New referrals received	119	121	104	98	**442**

There have been 442 new referrals for CHC/positive checklists received within the financial year 2018/19. These are shown in terms of completion rate in the trajectory below:

80% of referrals completed within 28 days												
NHSE traget	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trajectory %					65%	67%	70%	72%	75%	77%	60%	65%
Actual			76%	58%	65%	63%	31%	62%	60%	61%	55%	49%
RAG rating												

Focused measurement and reporting in relation to this compliance target began in July 2018, giving a baseline of 58%. In the months that followed the expected trajectory increased gradually, with the expectation of continued compliance and a consistent completion rate 80% or more. However, despite a positive beginning, the trajectory shows that this compliance target has not been met. That considered, there are a number of factors which have clearly impacted the CHC core team's ability to achieve this target.

In April 2018, some 86 positive checklist referrals were received at CHC, relating to learning disability clients, based in the community. These referrals became the responsibility of the core CHC core team due to a change in service level agreement between the CCG and Community Learning Disability Teams (CLDTs). This backlog placed considerable pressure on the CHC team which at that point in time, owing to budgetary constraints, was only able to allocate one whole-time equivalent health professional to respond to the workload. Unfortunately, this resulted in the vast majority of these cases breaching the 28 day deadline (many by more than 12 weeks – see 4.1.3, below). This meant that at the point when 28 day monitoring became a focused aim, the CHC team had a number of cases which were already out of date. This meant that their completion would always negatively impact this target (i.e. if 4 cases are completed, and two are already beyond 28 days, then the compliance target will automatically equal 50% completion within 28 days).

A key theme to emerge at the completion of this backlog was that a number of the total referrals were either inappropriate, or not based in comprehensive assessment/evidence. In an effort to embed some wider learning from this, new best practice guidance was implemented where CHC now ask (where at all possible) that initial CHC screening is undertaken jointly as part of an MDT meeting. This has approach has proven effective in enhancing joint-working and in helping to clarify the CHC process, reducing the number of unnecessary referrals that are received.

In order to help address this increase in workload, the CCG employed 2.4 WTE extra clinical staff . These nurses have been working in close collaboration with the existing CHC Core team and have particularly focused on addressing learning disability backlog.

In addition to the above, weekly huddle/focus sessions were introduced which has been effective in the following two ways: 1) allowing improved analysis of decisions made on a week-by-week basis, and: 2) facilitating more effective monitoring and allocation of incoming referrals in a timely and proactive way. By looking at completed cases on a week-by-week bases, cases completed within timeframe can be tracked, and outcomes then accurately reflected in the figures that are provided to NHSE. Conversely, this analysis also serves to highlight cases which were not completed within the timeframe; by taking an in-depth view of these cases, any obstacles in the process that prevented them from being completed within 28 days have been identified. This learning is then utilised in our pro-active allocation planning, with the expected result that the 'lessons learned' helps to mitigate further target breaches.

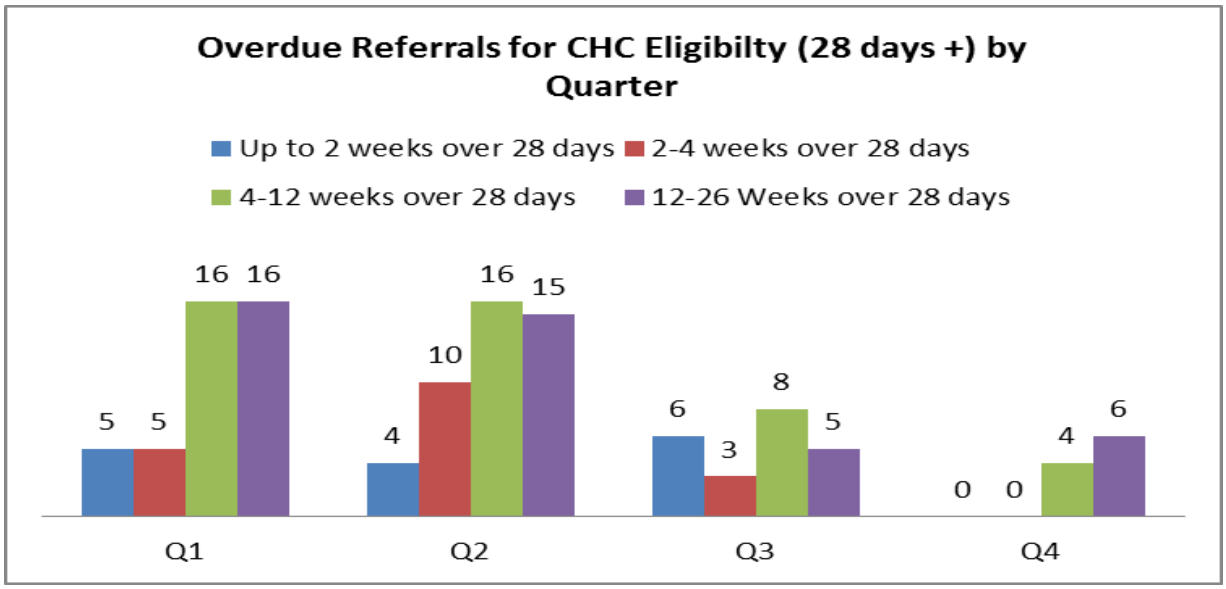
Finally, as part of our strategy to ensure that new referrals do not exceed 28 days, a new system has been introduced whereby the case manager is made explicitly aware of relevant deadlines via our Broadcare system, as soon as the case is allocated. This deadline is then monitored closely by the business support team, via the weekly huddle process; in order to ensure any potential for delay is mitigated/required support is given at the earliest opportunity. Close working with our colleagues in the community has been essential in ensuring that they are supported to complete assessments by the CHC Core team wherever needed. The CHC panel procedure has also been amended to respond more effectively to pressing deadlines with ad-hoc panel dates arranged around assessment demand.

4.1.3 Number of incomplete referrals that exceed 28 days

The table below highlights the numbers of referrals that exceeded 28 days at each quarter end. These are also then given as a total number, by category across the financial year.

Outstanding Referrals over 28 days					
CHC Category	**Q1**	**Q2**	**Q3**	**Q4**	**Year-end totals**
Up to 2 weeks over 28 days	5	4	6	0	**15**

2-4 weeks over 28 days	5	10	3	0	**18**
4-12 weeks over 28 days	16	16	8	4	**44**
12-26 Weeks over 28 days	16	15	5	6	**42**
26+ Weeks over 28 days	40	44	19	5	**108**



As previously outlined many of the backdated cases highlighted in the above originate from an earlier backlog, which could not be addressed immediately due to a lack of capacity within the CHC core team. The table clearly outlines a significant reduction in the numbers of long waiting cases, which is due to a sustained focus by the CHC core team.

Whilst this reduction is undoubtedly positive, it is worth pointing out that previously the CCG has only been required to report on cases which are either completed within 28 days, or which remain incomplete beyond 12 weeks. What this reporting standard has overlooked is the breakdown and pressure of those cases which have existed between these two time-points. In example, for at the end of quarter 2, there were some 14 cases which were out of date by more than 28 days but less than 12 weeks which (because they did not directly impact a compliance target which was under close monitoring) may have taken lesser importance, but have nonetheless represented a significant pressure.

The above cases have been addressed alongside business as usual referrals. As described in the above, the focus on completing referrals under 28 days, whilst also focussing on those that exceeded by up to 12 weeks has placed considerable demand on our capacity to complete the other long waiting cases (those beyond 12 weeks).

The completion of these cases within April should mean that we are able to achieve the 28 day quality premium by the end of quarter 1, and maintain it as we move into the new reporting year.

4.1.4 Number of new patients eligible for standard CHC (by quarter and year end)

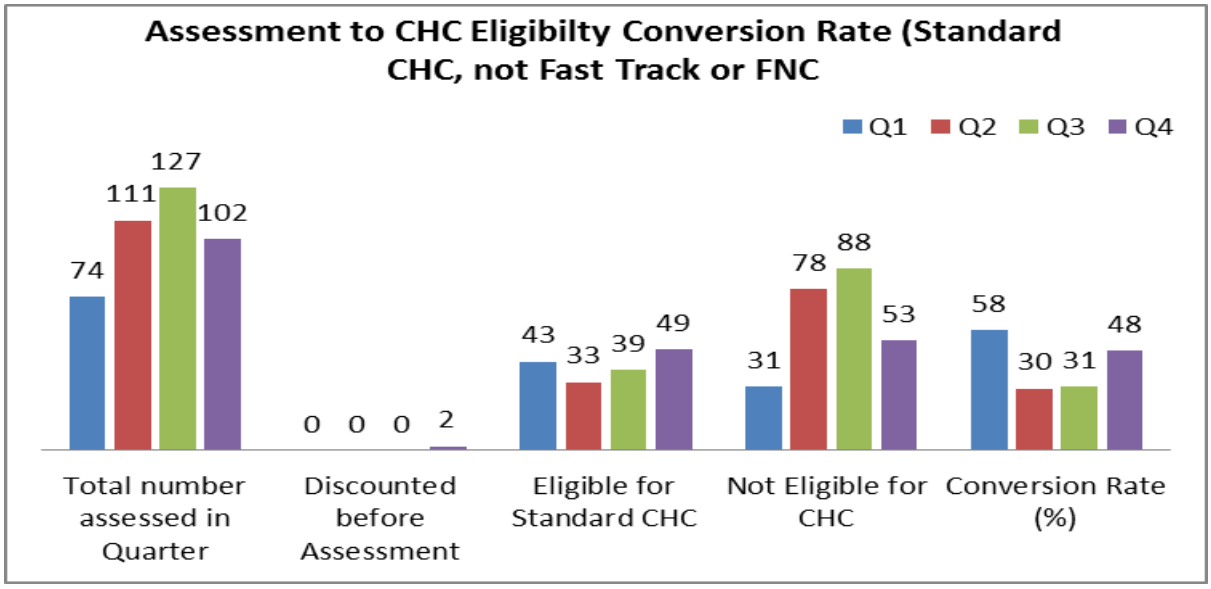
The table below shows the number of assessments completed (and eligibility conversion rates) by both quarterly and year-end position (excluding fast track),

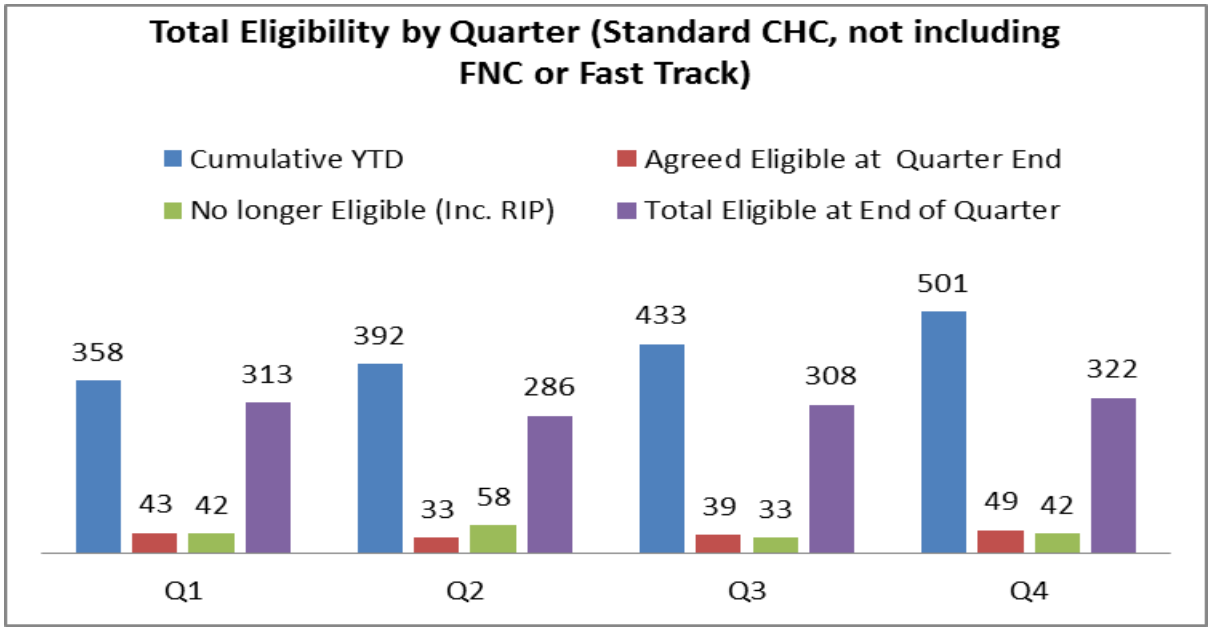
CHC Eligibility Conversion Snapshot: Quarterly Conversion totals (by total assessments carried out)					
CHC Category	**Q1**	**Q2**	**Q3**	**Q4**	**Year-end totals**
Total number assessed in quarter	74	111	127	102	**414**
Discounted before assessment	0	0	0	2*	**2**
Eligible for CHC	43	33	39	49	**164**
Not eligible for CHC	31	78	88	53	**250**
Conversion rate %	58%	30%	31%	48%	**39%**

At a national level, the standard NHS CHC assessment conversion rate was 24%. The table shows that the total eligibility rate for CHC was considerably higher than this average for 2018/19. That said, as previously explained, there were an increased number of referrals for CHC eligibility during the year, which may have translated into increased eligibility for North Cumbria. This suggestion/pattern is supported by the quarter-end information above, where eligibility is considerably higher for the first and last quarters of the year. A considerable focus was placed on backlog/long waiting cases during these quarters and this may well explain the peaks in eligibility rate.

This area will be closely reviewed based on accurate comparator data, and presented within the first executive summary at the end of quarter 1.

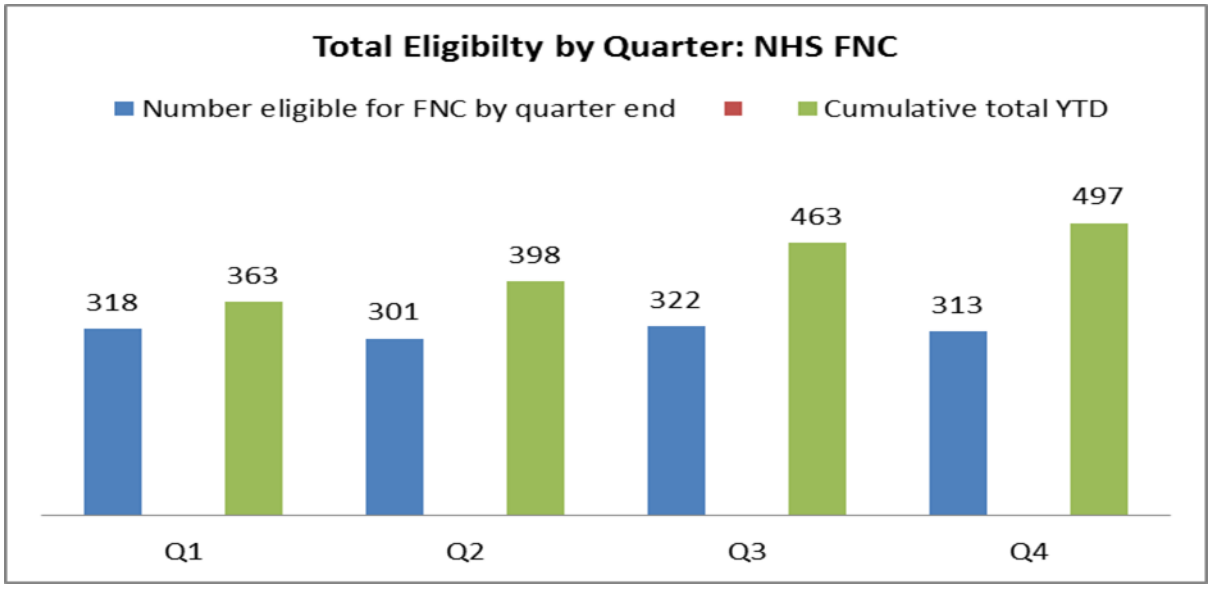
Further information for 2018/19 is given in the graphs below.





NHS Funded Nursing Care

The graph below shows the number of patients eligible for CHC FNC at each quarter end and the cumulative number of new eligibility at the years end.



The table above shows that there was an increase of 134 newly eligible FNC patients between April 2018 and March 2019. However, the numbers reported for FNC eligibility by quarter appear to be static over the financial year. This offset is likely to be due to the fact that patients will have either deceased or fallen out of eligibility criteria. It may also be that some of this number have shown an increase in need and therefore have converted to fully funded CHC. One further explanation for this static pattern may be the fact that there is a limit on bed capacity across the region, and it may be that beds have been consistently filled to capacity across the year. The introduction of the health and care system's 'capacity tracker' may offer more clear information around this point in future reports.

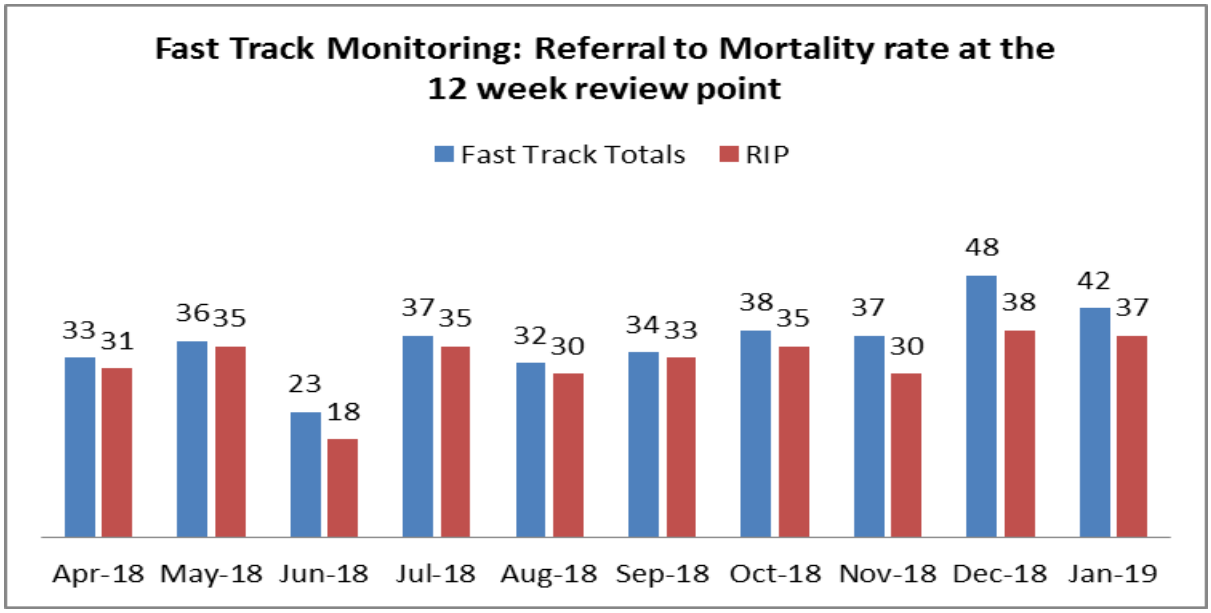
Unfortunately, given the comparatively recent implementation of the Broadcare System (the database used to hold records on all clients referred for CHC), conversion information is not readily available or understood. Further comparator information is due to be available by, and presented within the first executive summary (due at the end of quarter 1 of 2019/20).

4.1.5 Fast Track Referral Conversion

Fast Track Activity:

''Fast track'' funding is usually agreed when a person has a rapidly deteriorating health condition, which may be entering a terminal phase. The person may need NHS Continuing Healthcare urgently to ensure that their health needs are met (e.g. to provide appropriate end of life support, either in their own home or in an appropriate care setting). As it would be unusual for a fast track funding to continue beyond 12 weeks, a comprehensive review is required to take place at this stage to determine an up to date care position for those who remain alive and in receipt of care.

The graph below provides the year-to-date fast track activity for April 2018 – January 2019.

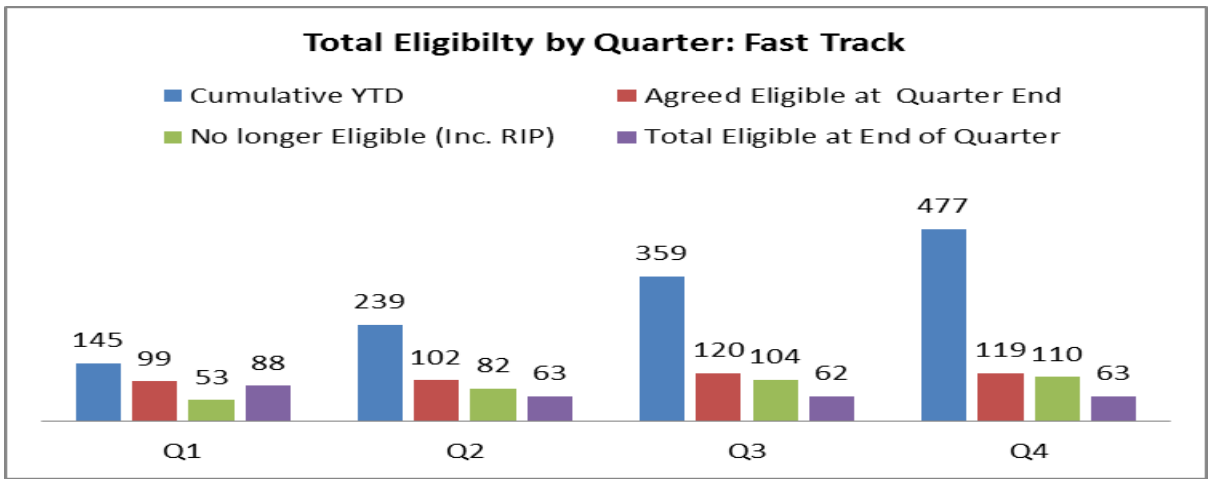


The Fast Track assessment conversion rate was 100% at both local and national level, meaning the NC CCG was complaint within this area.

Given that the initial review date is set at 12 weeks from referral, the data shown in the table represents a retrospective view, based on quarterly reporting, which therefore gives an up to date position as at 31 January 2019. The total number of outstanding reviews at this date was 19, and the completions of these were given particular focus by the NECS clinical team, reducing this number to 9 at the end of the financial year.

Total Fast Track Eligibility by Quarter End

The table below shows total fast track eligibility figures by quarter end and year end position.



This reporting reflects NC CCGs ageing population and mortality rate. Both the number of fast tracks agreed and the number of fast tracks eligible at the end of each quarter appears to be relatively static, which would indicate no considerable increase in fast track referrals has taken place. In terms of the number of fast tracks who were no longer eligible, this number steadily increased toward the end of quarter 4. This reporting indicates the appropriateness of fast track referrals (in line with the expectation that patients will have deceased by the 12 week review point). At the end of the financial year, NC CCG had begun to explore the benefits to investing in in additional End of Life services (such as home care practitioners). This change should underline the emphasis of ensuring that patients are supported in a family/home environment, to die in their place of choice, and to relieve demand on capacity system-wide.

As the Broadcare database was only introduced late in 2017 accurate comparator information which maps fast track activity year –on-year is not available. That said, this is a metric that will be available moving forward and will help us to understand the relationship between fast track referrals and wider system pressures.

4.2 CCG/NECS Internal Measurement and Assurance Measures:

4.2.1 CHC Review Monitoring:

The table below shows outstanding reviews at 31st March 2018, with an up to date year-end position as at 30th April 2019.

31 March 2018	Outstanding	April 2019	Outstanding
FNC 3 Month Review	34	FNC 3 Month	19
FNC Annual Review	100	FNC Annual	30
CHC 3 Month Review	17	CHC 3 Month Review	23
CHC Annual Review	23	CHC Annual Review	17
Totals	174	Totals	89

As a result of the considerable backlogs, change in service level agreements and demand/capacity issues that were apparent during 2019/19, the CHC core reviews were unfortunately another area where a backlog occurred. Whilst there were still a total of 89 reviews outstanding at the end of quarter 4, the table shows a considerable improvement across the year.

These reviews continue to be managed within the CHC core team, in line with business as usual workload, and now follow the principles below:

Patients are reviewed by their case manager, who should ensure the following: a) that the patient remains eligible for funding provision under their current finding stream; b) that the current care package continues to meet assessed clinical needs in; c) a way which is both adequate and represents value for money, in line with NCCCG policy.

4.2.2 Periods of previously unassessed care (PoPUCs):

Claims for Previously Unassessed Periods of Care (PUPoC) refer to a specific request to consider eligibility for a past period of care, where there is evidence that the individual should have been assessed for eligibility for NHS CHC funding. PUPoCs may relate to either deceased or ongoing eligible cases.

On 15 March 2012, the Department of Health announced the introduction of deadlines for individuals to request an assessment of eligibility for CHC funding, for previously unassessed cases during the period 1 April 2004 - 31 March 2012.

As at 31 March 2019 there were 15 outstanding PoPUC cases for NC CCG, which are currently being addressed by a dedicated team within CHC.

4.2.3 CHC Panel and Ratification Procedure:

North Cumbria CCG and Cumbria County Council operate a joint panel which considers the recommendations for CHC eligibility that are made by a multidisciplinary team (MDT). There are weekly panels together with additional ad hoc panels (as required by system pressures) in order to expedite decision making. The panels functions to ensure that the recommendations from the MDTs are of a high clinical quality, and that these are supported by appropriate evidence to ensure consistency and equity.

In March 2019 the governance structure (Terms of Reference (ToR) which informs panel process was reviewed and amended by the CCG, in order to enhance its function. As at the end of March 2019, the CCG is satisfied that the decision making process around eligibility is robust; that patients who are assessed as eligible for CHC receive appropriate funding. Ongoing work is focused on ensuring that packages of care are procured and implemented in a timely fashion, and that these continue to be proportionate to assessed clinical need.

4.2.4 The 'CHAT' Tool

NHS England has a duty to perform an assessment of CCGs in order to be assured that they are carrying out their statutory duties. In addition, NHS England is committed to the trifold aim of better outcomes, better patient experience and better use of resources.

NHS England approached NC CCG during the launch of the CHAT v3 assurance tool in October 2018, with the offer to fund the implementation of a quality and compliance self-assessment tool designed to measure CCG compliance with the 'National Framework for NHS Continuing Healthcare and Funded Nursing Care (Revised 2018),

NHS England has three key NHS CHC assurance mechanisms:

- Assurance reporting on timeliness of assessment (using the Quality Premium metrics)

- Assurance reporting on eligibility rates (as a proxy for fairness of assessment of individuals)
- Assurance of CCG adherence to NHS CHC Standards (based on the National Framework)

The CHAT v3 sets out the proposals for further development of the third component, assurance of CCG adherence to NHS CHC Standards.

The standards are designed to:

- Support CCGs to understand their statutory duty with respect to NHS CHC
- Support CCGs to understand how they are performing with respect to the National Framework
- Support Regions/Directors of Commissioning Operation teams to target assurance conversations

The CHC team has fully invested in this process and was approaching full compliance at the end of the financial year. The CHAT tool operates on a RAG rating scheme, with NC CCG showing no RED ratings as at 31 March 2019.

5. Personal Health Budgets (PHBs)

North Cumbria CCG has seen 67 CHC patients in receipt of a Personal Health Budget up to March 2019.

The NHS recently shared its long -term aspiration that patients with long term conditions and/or disabilities should be given greater choice, flexibility and control over the health, care and support they receive. As part of this plan, there is a clear expectation that PHBs should become the default care offering to all patients by the end of the coming financial year. The benchmark figure across the whole of the North Cumbria Integrated Health and Care System has been set at 570 PHBs by the end of the April 2020.

The CCG, in close collaboration with NECS colleagues will continue to work closely with colleagues across the health and care system in its effort to reach this target.

Whilst it is understood that this number will not solely be comprised of CHC patients, the CCG have been working collaboration with NECS colleagues in order to develop both the local offer and governance structure/policy. These documents will both be public facing and will be published on the CCGs web page, in anticipation of the roll out of PHBs

6. Financial Risk and Mitigation

A considerable amount of work has been undertaken to understand both financial impact and financial risks relating to CHC. The NC CCG's financial management team work closely with CHC leads on a weekly basis.

The key areas of risk that have been identified are:

- Backdated cost relating to backlog cases and/or cases where there have been delays in the setting up of packages.
- Packages increases, where an increase is identified and implemented in the community, but the CCG is not made aware immediately
- A lack of clarity around existing and/or appropriate funding stream (i.e. the pooled fund)
- Increasing complexity of service demand, versus a lack in the local offer to meet this demand (the need to place out of county)
- Review frequency, in order to ensure that care provision is clinically appropriate and financially viable.
- Internal governance around key processes, such as 'High Cost Panel' (IFR).

In response to a number of these questions, a working group has been established which seeks to offer some explanation and form a narrative around the issues. In terms of the issues around governance, a full policy and standard operating procedures review was called for at the end of the financial year, which will be reported in terms of its findings and actions at the end of quarter 1 (2019/20).

7. Conclusion

This report highlights that 2018/19 has been a particularly challenging year for CHC.
That notwithstanding, as we move into 2019/20, there has been a significant amount of work done in relation to CHC, which should be acknowledged as an extremely positive step. As NC CCG and CHC move into the new financial year, it starts from the much stronger position of having positive, strengthened working relationships, increased understanding and visibility of the process around CHC, and improved compliance against system-wide targets.

8. The 'Look Forward'

As we move into the new financial year the CHC team, working in collaboration with colleagues across the health and care system, faces a number of key challenges. In order to address these, particular focus will center on continuing to develop and embed the processes needed to effectively manage the capacity that the system has/needs in order to respond demand.

In May 2019 the assurance reporting framework will change from the current method of returning monthly compliance figures and rationale by email submission, toward a revised system known as 'AIMS'. The Assurance and Improvement Management System (AIMS) has been developed by QUIQSOLUTIONS and NHS England to improve the timescale of the Quarterly Assurance Process. It is based upon the principle that once the quarter has finished the CCG will know how it is performing against the three key standards. This is in line with one of the CCGs internal assurance metrics:

''To ensure that quality standards are met and sustained, based on the consistent application of the national policy for CHC''.

AIMS will be shaped around the following evaluations, at each quarter end:

1. *As an average across the last quarter have less than 15% of all full NHS CHC assessments taken place in an acute hospital setting?*
2. *As an average across the last quarter did more than 80% of cases with a positive CHC Checklist receive an NHS CHC eligibility decision by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility)?*
3. *At quarter end, does the CCG have ZERO incomplete referrals that have exceeded 28 days in the 12-26-week category AND the over 26-week category?*

As outlined in the body of this report, there are clear strategies in place which address all of these objectives, and which aim to ensure that targets are met in a consistently compliant manner and enabling a positive eligibility assessment and review experience for all clients referred to NHS Continuing Healthcare . In addition to these assurances, as part of the CCGs internal quality assurance work, the CHC 2019/20 plan will focus on the following key areas:

In 2019/20 NC CCG will work to:-

1. Ensure the consistent application of the national policy on eligibility for CHC
2. Ensure compliance with the new National Framework (October 2018, revised)
3. Continue to promote awareness of CHC and Personal Health Budgets
4. Facilitate training and development opportunities across the system
5. Identify and act on issues within the provision of a CHC
6. Inform and influence commissioning arrangements, on both a strategic and individual basis.
7. Continue to review historic high cost packages to align commissioned services and ensure care packages are proportionate and based on patient need
8. Ongoing review of NC CCGs financial commitments to enable financial planning and trajectories

Key updates on our progress in all of these areas, as well as those key areas of compliance, will be reported quarterly to the System Partnership Quality Assurance Committee.