Rotherham Metropolitan Borough Council

Review of Continuing Healthcare in Rotherham

Joint report of the Health and Improving Lives Select Commissions

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Review Group

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1. Executive Summary

Continuing Healthcare (CHC) is a complex and highly sensitive area which affects people at a very vulnerable stage in their lives. Because of the complex nature and a history of legal challenges to decisions in relation to funding Continuing Healthcare, a national eligibility criteria and processes were introduced in 2009, in the National Framework for NHS Continuing Healthcare and Funded Nursing Care.

In Rotherham, spend on CHC is lower than that of surrounding and statistical neighbours. Anecdotal concerns have also been raised in relation to the service user experience of the CHC process and time taken to receive a decision. Scrutiny Members were concerned about this level of spending locally and the impact this was likely having on service users as well as Local Authority budgets, and subsequently where Local Authority social care resources may be being inappropriately directed.

A sub group of members and co-optees from the Health and Improving Lives Select Commissions agreed to look into continuing Healthcare in Rotherham; what the current picture was in relation to spend on CHC in comparison with other areas, how processes in relation to assessments and decision making were being implemented and gathering views and experiences from service users, to establish reasons for this lower spend locally and produce a set of recommendations for improving this service for Rotherham people.

1.1 Summary of Key Findings

There has been some positive engagement between the two organisations (local authority and NHS) to address some of the strategic issues faced locally in relation to budgets and procedures, although Members agree this needs to be developed further.

In Rotherham, the lower spend on CHC means that Adult Social Care spend is higher than it would be if the CHC spend was either at average levels, or in line with the levels of health inequalities in the borough.

Interviews with professionals raised a number of issues and concerns mainly around the process of assessments and decision making, including the CHC panel. It is clear that although the processes are being adhered to, there are inconsistencies in the way they are implemented and it is not clear that the processes are being correctly applied to get the right decisions, resulting in delays and creating a negative experience for the service user. There also appears to be a lack of transparency in the process which, along with the gap between expected level of funding and demographics, suggests there is a serious issue in Rotherham.

LINk Rotherham were asked to undertake a study to gather the views and experiences of service users. What was gathered from this activity clearly reflects the issues in relation to inconsistencies in implementing processes for assessments and decision making, which was having a negative impact on the service user. The response rate from this study was disappointingly low, and Members feel strongly that agreement needs to be made jointly between the NHS and Local Authority to ensure that experiences of customers can be properly and sensitively gathered in future, to support service improvements.

1.2 Summary of Recommendations

The review-group agreed a set of recommendations under 5 themes. A summary of the recommendations is provided below:

1. Assessments: To consider options for ensuring that CHC and social care assessments are undertaken together and for increasing the use of step up/step down units as a setting to undertake assessments

2. Training: To refresh the CHC training package, to incorporate some local case studies and opportunities for feedback to relevant workers

3. Written Protocols: To agree protocols for:

- Clarifying who should be the lead worker for individual cases
- Clarifying the backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist
- Agreeing an appropriate joint 'exit strategy' for people moving from high level of care to lower level
- Agreeing appropriate ways for engaging with customers to gather their views and experiences

4. Joint Working: To put in place joint strategic liaison meetings and regular MDT meetings to improve joint working and communication across agencies and look at ways of sharing good practice between services

5. Panels and Appeals: To ensure appropriate representation on CHC and Dispute panels to enable expert knowledge and independence, and ensure information in relation to the appeals process is routinely given to service users

2. Original concerns – why Scrutiny wanted to look at this issue

It was brought to the attention of members that spend on CHC in Rotherham was lower than that of surrounding and statistical neighbours. There have also been anecdotal concerns raised and evidence from social workers case files, in relation to the service user experience of the CHC process and time taken to receive a decision.

Scrutiny members were keen to unpick what the reasons may be for the lower spend on CHC locally, particularly looking at the way in which the national framework was being implemented across Rotherham and any issues with the process. Members were keen to look at how any issues could be addressed, ensuring a good working relationship between the local authority and NHS. Members also wanted to explore the concerns in relation to service user experience and establish whether the process could be done better or differently to improve this.

Initial discussions with the portfolio holder for Adult Social Care and local authority Director of Health and Wellbeing helped the review-group understand the challenges faced locally and agree the scope and key lines of enquiry for the review. These discussions highlighted to members that there had been some positive engagement between the two organisations (local authority and NHS), and positive dialogue between the Strategic Director of Neighbourhoods and Adult Services and the Chief Operating Officer of NHS Rotherham/Clinical Commissioning Group (CCG). In

addition there had been some sharing of expertise around commissioning which has resulted in commissioned services providing improved value for money.

However there were still considered to be delays experienced in the timing of assessments, and consequently delays in people accessing CHC which can have a negative and in some cases significant impact on customers.

Despite the council and NHS using, in some cases, the same services in the community, there are times when the transfer of an individuals care from local authority or from self funding care to CHC funding is not smooth, resulting in distress and disruption for the customer. The apparent 'underfunding' of CHC within Rotherham compared to others in the region, also results in increased pressure on council budgets.

2.1 Scope of Review

The review-group agreed the scope for the review, which was to include:

- Gathering benchmarking information against South Yorkshire authorities and statistical neighbours to establish the Rotherham position overall
- Reviewing the current arrangements in relation to the national framework, and identify areas of improvement and any non-compliance
- Examining the current role of the CHC Panel and how decisions are taken
- Examining the service user experience, building on anecdotal concerns in relation to experience of the CHC process and timings of assessments and decisions
- Developing conclusions and recommendations based on the evidence that is collected

To achieve these objectives the following actions were undertaken by the review group and supporting officers:

- Desk-top review of relevant reports, publications and gathering data and information from other local authorities to provide benchmarking
- Comparison of Department of Health published figures
- Use of the LINk to help gather views and experiences of local people
- Meeting with representatives of Adult Social Services
- Meeting with relevant NHS representatives
- Meeting with the Chair of the Continuing Healthcare Panel

3. Legislative and Policy Context

CHC is a complex and highly sensitive area which can affect people at a very vulnerable stage of their lives. CHC and NHS-Funded Nursing Care (FNC) refer to services that are funded by the NHS due to a persons health related needs. CHC is where the NHS fund 100% of care and FNC is where the NHS funds the nursing element of a care package. In these cases the accommodation (board and lodging) costs are either paid in full or in-part by the service user and/or by the Local Authority. Responsibility for CHC assessments and decisions in relation to NHS funded services were previously with the local Primary Care Trust (NHS Rotherham), however this responsibility has now transferred to the local Clinical Commissioning Group (CCG).

People who are not eligible for NHS funded care will have their needs assessed to establish whether they receive social care services from the Council. NHS funded care differs from Local Authority care in that NHS care is free at the point of delivery but Local Authority care is means tested.

CHC and FNC differ from many NHS services in that there are specific eligibility criteria and assessment/decision-making processes set out in legislation that must be followed. This reflects a history of legal challenges and Health Service Ombudsman investigations that led to a single national eligibility criteria and processes being introduced in 2007, and then revised in 2009, via the National Framework for NHS CHC and FNC. Since the introduction of the National Framework there have been no successful legal challenges to CHC.

Where a person has long-term health and social care needs, *and* their primary needs (their main needs) are health needs, the NHS is responsible for meeting both the health and social care needs via the provision of CHC. This can be offered in any setting including care homes and a person's own home. In many cases the providers are the same as used by Rotherham social care services.

Where a person is not entitled to CHC but their care plan identifies that they need a placement in nursing care accommodation, the NHS pays a fixed rate contribution towards the cost of support from a registered nurse via FNC. Local Authority social care and/or the individual themselves pay the remaining costs, depending upon the person's means. There are three national tools which are required to use in making decisions on eligibility for CHC – these being:

1. ***NHS Continuing Healthcare Checklist*** – initial checklist used by workers (social work/nurses etc) which triggers the need for a full assessment
2. ***Decision-Support Tool (DST)*** – tool completed by a multi-disciplinary team to establish whether the individual should be in receipt of CHC; their recommendation then goes to the eligibility panel for ratification
3. ***Fast Track Pathway Tool*** – is a rapid assessment process (fast track) – with a quick reference guide for use by all workers when a quick decision is required, where a person's health maybe quickly deteriorating

Responsibility for making decisions on CHC eligibility is with multidisciplinary teams (MDTs) of health and social care professionals, who carry out the assessment and make the recommendation on eligibility. The NHS CHC panel is expected to accept MDT recommendations in all but exceptional circumstances and are required to consult with the relevant Local Authority before making an eligibility decision (including before making a decision to end CHC eligibility).

CHC is fundamentally a 'whole system' issue which can only operate successfully if Local Authorities and the NHS work in partnership. CHC and Local Authority social care assessments consider very similar issues.

3.1 NHS Reforms

Launched on 20 July 2010, the Commission on Funding of Care and Support was an independent body tasked by Government with reviewing the funding system for care and support in England. Their report (Fairer Funding for All, July 2011) identified that different funding streams between the NHS and social care can create barriers for people and can sometimes seem unfair, such as in the instance of Continuing

Healthcare. The Commission recommended that NHS Continuing Healthcare should be given a much firmer statutory footing.

The publication of the Draft Care and Support Bill (2012) demonstrates the Government's response to the recommendations made by the Commission. A series of clauses are included in the Bill which relate to cooperation between the local authority and NHS when undertaking assessments for Continuing Healthcare, a requirement of the Secretary of State to make regulations about how an assessment is carried out, to provide clarity and ensure consistent practice (for instance, an assessment for NHS Continuing Healthcare), and the part local authorities must play in assessments to establish whether a person is entitled to Continuing Healthcare.

N.B. At the time of this report being published, the Bill and associated proposals and legislation were being consulted on nationally.

4. Findings

4.1 Local Position

Desk-based research gathered information and data on the total numbers of people receiving CHC from 2009 onwards. This data shows how Rotherham compares with other South Yorkshire local authorities and Rotherham's statistical neighbours. There was an increase in total numbers receiving CHC in 2011/12 compared with 2009/10 and 2010/11, which may be in part due to the implementation of the revised National Framework in October 2009 which brought into practice national eligibility criteria.

In 2011/12 768 people received CHC in Rotherham (compared with 411 in 2009/10 and 644 in 2010/11), costing £11.709. On average 425 people received FNC in the same period at a cost of £1.5m.

Whilst the spend per head of population has increased in the last year, Rotherham's ranking in relation to spend on CHC has dropped from 8th to 10th out of the 15 local authority areas in Yorkshire and Humberside. Overall the ranking has reduced and Rotherham is still below the average spend per head of population, in an area of poor health and low life expectancy, there are some key areas of spending variation:

- older people with dementia – Rotherham is still at less than half the regional average
- people with physical disability- Rotherham is a third below the regional average
- people with a learning disability – Rotherham spend has deteriorated and is 13% below the regional average

Data for the financial year 2011/12 shows that the majority of spend on CHC in Rotherham was on Learning Disability under 65s, which was 30.5% of the total CHC budget, whereas this represents only 5% of the total number of people receiving CHC; demonstrating the high cost of learning disability care packages. In the same year, spend on Physical Disabilities age 65 plus was 30% of the total budget with the total number of people receiving CHC in this year at 28%. Spend on Mental Health age 65 plus was 15% of the total budget, which was 28% of the total number of people and Physical Disabilities under 65s was 14% of the budget with the total number of people receiving CHC in this year at only 4%. Spend in relation to the Fast Track process was at only 6.5% of the total budget; however this group

represents the highest number of people receiving CHC, at 50.5%, which is due to the nature of the care packages through Fast Track, as they are often people at the end of their life.

In Rotherham, this means that Adult Social Care spend is higher than it would be if the CHC spend was either at average levels (or at a level in accordance with the level of health inequalities in the community). This has been recognised within budget setting processes, and an estimate of £4.5m is included in the adult social care budget to reflect additional CHC funding that the local authority will attempt to secure through negotiations with the CCG over the next 3 years.

4.2 What Professionals Told Us

The review-group interviewed a number of professionals in relation to CHC; these included social care representatives from the Local Authority, a representative from the Clinical Commissioning Group and the CHC Panel Chair.

The key lines of enquiry were as follows:

- *How effective is the multi-disciplinary assessment process?*
- *How are decision made? Can decisions be challenged? And how would challenges be dealt with?*
- *Are there any ways in which the current arrangements could be improved?*

The outcomes of this interview have been collated into themes and outlined below:

Theme 1. Decision Making

Decisions are made at the point of assessment by the multi-disciplinary team (MDT). The MDT looks at the evidence and makes recommendations as to whether they are eligible for CHC or not and this decision goes to panel for ratification. It is <u>not</u> the role of the panel to disagree with decisions, <u>but to ratify them</u> and ensure the appropriate information and evidence is available. If it is felt there is not enough evidence, the panel will send the case back to the MDT to gather further information.

The decisions that the MDT make include:

- Full CHC funding – NHS pays in full the costs of care
- Nursing component – NHS pays a set amount towards the nursing care element of a person's care package (the individual/local authority pays the rest)

There is a written process for making decisions; however a number of issues have been raised:

- Social workers are not in a position where they can admit someone into a home without a Decision Support Tool (DST) being completed; this can result in people waiting in hospital until the DST has been done by the MDT, which is often delayed
- It is not always possible to get a timely response from district nurses to complete assessments
- If this happens at a weekend, there can be huge delays in getting a person admitted to a home, as they will not do this without a DST being completed
- It was felt there should be an element of trust involved; if a social worker felt a person needed a nursing unit at the weekend then it would be an issue as a DST would have to be completed, if the person was placed somewhere pending a DST

being completed on the Monday, if CHC was not agreed, It was felt that NHS would not be prepared to pay that nursing cost which was an issue for the Local Authority and more flexibility and common sense was needed from the CCG;

- There needed to be a solution to this so that a person could be admitted over the weekend based on a checklist only, then a full DST could be done after the weekend. Agreement is needed that NHS would fund this package regardless of the decision
- There are a number of contacts from district nurses with a request for an assessment to be completed, without a fast track or checklist being completed initially, which can delay the full assessment
- It is felt that the process is in place, but lines of clear accountability were not felt to be there - the lead worker for each case is described as the 'person who knows them best' which is felt to be unclear and standard guidelines for this would be beneficial
- Although the 'process' is in place, every case is different which suggests there needs to be localised protocols agreed and clear guidance for what to do in specific situations
- There were felt to be inconsistencies in relation to the autonomy of MDTs, with a view that decisions needed to be based on need not finance

Hospital / A&E Issues

Issues were raised in relation to acute Accident and Emergency (A&E) assessments and discharge processes:

- Staff within A&E were currently <u>not</u> completing DSTs and they should be doing this; the process should be that ward staff should complete the check list/DST first to assess for CHC and rule out if necessary before the social worker goes in to complete a social care assessment
- There is a view that there needs to be greater partnership working for discharge planning to avoid delays
- It was felt customers did not always understand this process and what was happening in the hospital setting was not always clear

There were also concerns in relation to occasions when a hospital-based social worker assesses for one need and a few days later there may be more or different issues/needs, and a CHC assessment may need to be completed. It was felt that step up/step down services (where a person goes into a small unit for intensive intervention for a period of time) was beneficial, as the person can then be re-assessed as to where they need to be. Step up/step down units were also felt to be much better places to complete the DST if needed.

Learning Disability services

Learning disabilities have a fairly static populous; with people who are very familiar to services and the processes in relation to assessments. It was also suggested that because learning disabilities services was a joint service; with workers co-located, it made the process much easier and issues could be dealt with quickly.

The CHC service run a dedicated Learning Disability (LD) Panel, which has on it two senior LD service managers representing the service. An LD expert from out of the area was brought in to facilitate, educate and support this panel for a period of over 18 months. Despite this, concerns were raised in relation to the lack of

understanding of specific learning disability services issues on the CHC panel, which could sometimes make ratifying decisions difficult. It was noted that this was improving, but more work and training may be required.

Theme 2. The role of panel and appeals process

There were felt to be inconsistencies with the MDT decision being ratified by the panel. It is felt that where the MDT has made a recommendation which has been challenged and overturned by the panel, the decision was no longer that of the MDT but of the panel, which was not the correct process.

The ratification panel is in place to ensure consistency, but if eligibility decisions were being overturned due to inconsistency in the completion of the DST, then this suggests a need to provide feedback to people completing assessments to ensure they are completing them correctly.

It was noted that there was an open invitation for the Local Authority to attend panel meetings, but to date no-one had been attending and this needed to be addressed.

Appeals

If the decision was taken that the person was not eligible for CHC, individuals and/or families have a right to appeal. Appeals can take up to 14 days if a local issue, or a few months if referred to the Strategic Health Authority.

Response to appeals could involve a further assessment being completed by a 'new' MDT or a peer review (another local authority area looking at it e.g. Sheffield or Barnsley). If there was still no agreement it would go to the Strategic Health Authority for an independent review panel.

The CHC manager informed that out of approximately 600-700 patients currently in the system in Rotherham, there are 5 appeals, with an average of 20 appeals per year.

There was concern that the appeal process was not independent in the first instance, as appeals were sent solely to the CHC manager as the 'dispute panel' to make decisions on the appropriate next steps.

There was also concern that the appeal process was not always followed properly, because it was not always understood by workers and individuals/families. Information leaflets for the public are available, but it is not clear how often these were being given out by the person responsible for completing the assessment.

'Scrutiny' of assessments

It was noted that the panel sends completed assessments to be scrutinised by the service deputy, they may make the decision that there was a lack of evidence, and send back to the author. In this instance, once the author has obtained the evidence required, it goes back to the service deputy and if they are happy, back to CHC panel again to ratify.

There were concerns that this process can significantly delay decisions, as they have to be sent by Safe Haven fax (secure fax system)/secure post/or hand delivered. Files cannot be sent electronically due to confidentiality.

Social Services Panel

If the decision was taken by the MDT that no eligibility for CHC was evident, the case would be put to the Social Services panel to make a decision regarding eligibility for social care services.

There have been instances when the social services panel disagrees with the decision taken not to fund CHC and requests this goes back to the CHC panel. If it goes back to CHC panel and still not enough evidence at this stage it can go for a peer review. If there was still no decision and there was dispute between the Local Authority and NHS, that can't be resolved at local level (through peer review / or a new MDT), the case would go to both Directors for a decision to be made; this would always be seen as a last resort, as a decision by a multi disciplinary panel, which included Local Authority representatives would save time and be more transparent.

Learning disability appeals

There were times when complex learning disability packages of support/care were put in place through CHC funding. When the package was then reassessed 6 months on, it may be that the person no longer presented the same difficulties because of the support being provided, however if the support was taken away these difficulties could re-occur and would require CHC again.

It was suggested that this situation could be extremely difficult to provide evidence of need, for example with autism and complex learning disability needs. If support was put in place, it could divert and recognise issues before they arose, resulting in an overall improvement in an individual's behaviour.

There was concern that different interpretation of 'managed' need between the panel and learning disability services was apparent, which made decisions difficult to understand by the panel.

Theme 3. Training

It was noted that there was a rolling programme of training in relation to the assessment process for all agencies, and it was noted that there had been good attendance on training to date, however some concerns were raised:

- There was concern that training had not changed since 2009, when the revised framework was implemented, and workers were anxious about this
- There was felt to be inconsistencies and variation in how assessments (using the Decision Support Tool) were completed depending on who completed the tool (e.g. district nurse/social workers) which suggested a possible training need
- It was suggested that anyone responsible for carrying out assessments would benefit from case studies being built into the training programme to enable workers to understand where things may be being done incorrectly.
- It was also suggested that individual workers should be given feedback on their assessments, to help review and understand the process and where they may be

going wrong (for example, where the CHC panel sends a case back for further information as it was felt incomplete)

It was noted that case studies were included in training, but only on a case by case basis and that feedback was not given to every contributor.

Further Comments

There needed to be greater communication and partnership working across all agencies and services. It was noted that there were new MDT meetings established, which should improve partnership working, but it was crucial that these continued and were prioritised as far as possible.

There were also concerns with capacity issues on both sides (NHS and Local Authority) which was a huge issue for all involved and consideration needed to be given to this by strategic leads in both organisations.

The joint service centre (based in Maltby) was seen to be a good example of partnership working and there needed to be consideration given to how shared learning from this could be used across the board.

4.3 What Service Users Told Us

The review-group asked LINkrotherham to undertake a study on their behalf to look at the experience of service users in relation to CHC.

This study took place between July and August 2012 with the following key lines of enquiry:

- *Experiences of continuing healthcare; including assessments, decision making, and length of time from first contact to receiving the decision*
- *What would make individuals' experiences better*
- *Do service users understand the process of assessments and decision making*

LINkrotherham developed a CHC survey which was sent to specific voluntary/community sector groups with a relevant user base (i.e. experience of continuing healthcare). It was explained in a covering letter that the purpose of the review was to gather information and evidence of the current arrangements in place locally in relation to the assessment process, the role of the CHC panel and service user experiences of the CHC system in Rotherham.

People taking part in the survey were informed that their feedback would be anonymised and used for the sole purpose of the scrutiny review. They were also advised that it would not make any change to the outcome of CHC assessments that had already been carried out, but the findings of the overall consultation may help others.

Surveys were completed by applicants, carers and jointly by applicants and carers. The age range of applicants ranged from 17 to over 85 years old and the majority of respondents were female. Not all respondents answered all of the questions.

Survey Responses

Text in quotation marks is verbatim from the survey responses.

Assessments

In response to how assessments were undertaken, the majority of respondents stated that the assessment was clear, with a few suggesting they did not understand the process and felt needs had not been addressed appropriately. However, there were a number of comments in relation to communication and perception of the process:

“Decision seemed already to be made; seemed unwilling to discuss areas of disagreement, although these were recorded, we were told”.

“Clear enough but marred by changes to the evidence required to support statements made by care staff about individual's needs - not a bad thing to need more evidence, but no communication of this need.”

“Views of carers and family recorded by assessor, but assessor's own perception (having met the resident very few times) guided setting of levels. Not seen as a positive experience by family (although I am speaking for them, obviously)”.

Decision Making

In response to a question concerning views and experiences of the decision making process, there was a wide range of responses with one respondent stating that it was “ok”, another stating “the decision was made quite quick” whilst another respondent stated that it “seems unfair to have a decision making panel that has no learning disability representation on it. Specialist knowledge required to accurately assess the complex needs of the resident we care for”.

There was a wide range of responses with respect to the length of time from first contact to receiving the decision which ranged from receiving a response within a month’s time, another within 6 months, one respondent stating that they “don’t know how long it’s going to take” and one respondent stating that they were “basically told on the day that CHC would not be received; officially informed 4 weeks later”.

The majority of respondents stated they understood the process of assessment and decision making and felt it was explained clearly. However one respondent commented “was not too sure what is going to happen, felt things were not clear enough” and another commented “When they came to do the assessment did not understand how they are going to process assessment”. Whilst another respondent commented “The evidence required for this assessment was completely different to past experiences”.

When asked what would improve people’s experience of CHC, respondents felt they “would like things to progress a lot quicker. Because the need is urgent.” And felt “More consistency between assessments.” was needed.

There was however a number of comments in relation to the need to explain the decision making and appeals process much better: “No appeal process explained. Not happy with the decision made.”

A number of people also felt that the decision had already been made prior to assessment, with one respondent commenting “Left with feeling of inconsistency and decision already made (another agenda?). On reflection the greater requirement in terms of evidence asked for etc, is not a bad thing, but not being forewarned about changes in style of assessment was not helpful, making it difficult to support statements made at the time.” Another respondent also felt that “Clearer, early communication of changes to guidelines regarding evidence [was] required to support individual assessments.”.

Review-group Response to Customer Study

The responses reflect the concerns in relation to inconsistencies raised by professionals. With a mix of people feeling the process was explained and some who felt it wasn’t clear enough. For those who felt the process was unclear and that they had not received appropriate, timely information, this has to be seen as a failure of the CHC service and needs to be addressed as a priority. Some individuals also felt unhappy with the way the assessment took place and the decision making process which, if explained, may help people understand the decision; particularly if the decision was not to fund CHC. A number of people also felt that the decision had already been made, regardless of the evidence being gathered, which may be due to a lack of understanding of the process and the way in which decisions were made.

The comment made in relation to a lack of specialist knowledge on CHC panels is a powerful observation. This reflects the concerns raised by professionals with regards to no learning disability service expertise on the CHC panel, which has resulted in a lack of understanding of the complex care needs of this population, and subsequently the wrong decisions potentially being made.

The review-group feel there needs to be a joint discussion between agencies in relation to how best to obtain qualitative data on customer experience in the future, not only for this group of people, but for any person where their experience and views would benefit health services in the future.

5. Conclusions

The information gathered by the review-group suggests that although processes are there, in line with the National Framework, there are inconsistencies in the way in which these are being followed across all agencies and services in Rotherham. The total number of panels in place, inconsistencies in the process and a lack of independent review and customer focus on this issue are clearly the main reasons for delays being experienced, financial discrepancies and negative service user experience. CHC is dealing with an incredibly vulnerable group and the failure to prioritise this issue will be seen by Scrutiny Members as unforgivable.

Communication between agencies (NHS and Local Authority) was clearly improving, but Members feel that more work is needed to seriously address the issues in relation to processes and communication. If workers in all settings have a clear understanding of processes and there is a common approach across Rotherham to

implementing procedures, this would have a positive impact on customer experience, as well as ensuring resources were appropriately directed for all agencies. Training, addressing service change in relation to how assessments are undertaken, and having jointly agreed protocols for Rotherham have therefore been identified by the review-group as areas where significant improvements are needed.

In relation to Rotherham being below average for spend on CHC, addressing the issues with undertaking assessments and having agreed protocols for specific situations, including the funding of care packages which have been put in place over the weekend based on a checklist and ensuring specialist knowledge for all services on CHC panels, will go some way to improve the CHC spend locally. However Members feel there needs to be more open and honest discussions between both agencies to tackle this and therefore recommend that regular formal meetings are held between strategic leads to consider budget issues and issues in relation to transitions between funding streams and services, as well as informal MDT meetings to address more operational issues on the ground and improve communication between workers.

6. Recommendations

The review-group has agreed a set of recommendations under 5 specific themes to address the issues raised from both professionals and customers.

1. Assessments:

1a) To consider options for ensuring the CHC and social care assessments are undertaken together and develop an agreed protocol for how this should be delivered

1b) To consider options for utilising the use of step up/step down units much more widely, and enable assessments to be undertaken in this setting

2. Training:

2a) To refresh the CHC training package, ensuring it is up to date, appropriate for the different staff involved and rolled out to all relevant staff periodically

2b) To ensure the training package incorporates local case studies and opportunities for feedback to relevant workers on completing the assessment process to enable shared learning

3. Written Protocols:

3a) To clarify issues in relation to who should be the lead worker for individual cases and how to resolve disputes by producing written, agreed guidance for all to adhere to

3b) To put in place written agreement regarding the backdating of funding when a person is admitted to a nursing unit based on a fast track or checklist, pending a full DST being completed (protocols for weekends/holidays etc)

3c) To agree and put in place an appropriate joint ‘exit strategy’ for people moving from high level of care to lower level (within and across service providers)

3d) To agree joint protocols for engaging with service users to gather their experience and views for the purpose of service improvement

4. Joint Working

4a) To ensure the continuation of MDT meetings on a regular basis to improve joint working and communication across agencies

4b) To put in place joint strategic liaison meetings on a twice yearly basis, to allow for issues to be raised across agencies in an open and honest forum (including budget issues, transition planning and implementing the proposals within the Care and Support Bill)

4c) For the NHS and Local Authority to agree appropriate arrangements to consider discharge planning to avoid delays

4d) To consider options in relation to closer working across agencies, based on examples of good practice e.g Maltby Service Centre

5. Panels and Appeals

5a) To address concerns in relation to the lack of representation from the Local Authority at CHC panel meetings

5b) To ensure there is expert knowledge via an appropriate worker (such as a learning disabilities representative) on future CHC and Dispute Panels

5c) To review the current Dispute Panel, and take action to ensure this is an independent, multi-disciplinary panel which includes representation from the Local Authority

5d) To review the decision making process and look to streamline panels where possible to reduce delays and inconsistencies

5e) To ensure that all workers are routinely giving service users information leaflets and that the appeals process and their right to appeal is clearly explained at the beginning of the process

Reviewing Recommendations

6) For the Health Select Commission to receive a report from the CHC manager 6 months from the recommendations being approved, to ensure they are being implemented and making progress to improve this service in Rotherham.

7. Thanks

The review-group would like to thank the representatives from the local authority and NHS for their cooperation in undertaking this review.

Thanks are also given to LINk Rotherham for undertaking consultation with customers on behalf of the review-group, and to the customers, family members and carers who responded with their views and experiences.

8. Information Sources/References

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9. Contact

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10. Glossary of Terms

CHC Continuing Healthcare

CCG Clinical Commissioning Group

DST Decision Support Tool

FNC Funded Nursing Care

LINk Local Involvement Network

MDT Multi-disciplinary Team

NHS National Health Service