PAPER B

Purpose: For Decision

ISLE of WIGHT COUNCIL

Committee report

Committee	**CABINET**
Date	**14 MARCH 2019**
Title	**INTEGRATION OF CONTINUING HEALTHCARE**
Report of	**CABINET MEMBER FOR ADULT SOCIAL CARE & PUBLIC HEALTH**

EXECUTIVE SUMMARY

1. This report provides an overview of NHS Continuing Healthcare ('CHC') and the proposals to integrate this health function with the Councils Adult Social Care Commissioning to create a single team better placed to serve the Islands residents with a joined up health and social care pathway. The report provides an update in terms of the actions taken to date and seeks approval to include the existing CHC budget within the pooled budget of the Better Care Fund Section 75 agreement ('BCF S.75') from 1 April 2019.

BACKGROUND

2. CHC is a package of care for people, aged 18 plus, who are assessed as having significant ongoing healthcare needs. It is arranged and funded by the NHS. In essence if a person receives care in their own home and is eligible for CHC the NHS covers the cost of the support needed from health professionals and the cost of personal care which can include help with washing and getting dressed, If a person is a resident of a care home or nursing home the NHS pays the persons care home fees. Unlike adult social care funding CHC is not means tested an is free at the point of need however there is a clear legislative framework which is applied to determine if a person is eligible for funding through a formal assessment.

3. Nationally CHC spend increased in excess of 7% year on year. In 2017 NHS England put in place a national CHC Service Improvement Programme in answer to this increased spend and a Parliamentary Audit Committee report

which identified the lack of standardisation in application of the National Framework for NHS Continuing Healthcare and Funded Nursing Care.

4. Against this national backdrop the Isle of Wight Clinical Commissioning Group ('IOW CCG') commissioned a service review of CHC in 2017. The review identified significant risks relating the capacity and skills relating CHC.

5. In addition the review also looked at the arrangements in place for Specialist Placements. Specialist Placements provide support for people who require specialist help to meet their complex needs. This can include provision of care and support in specialist environments which can be very costly and can be some distance from the person normal place of residence. The review also found that there was a lack of specialist mental health and neuro-rehabilitation skill and knowledge within the IOW CCG and in response in May 2018 the IOW CCG transferred the operational function of Specialist Placements to West Hampshire CCG.

6. In addition in February 2018 the IOW CCG brought the CHC assessment function back into the IOW CCG team from the Isle of Wight NHS Trust ('the Trust'). This was to improve the quality of assessment, decision making and case management and to ensure compliance with the National Framework for Continuing Healthcare and Funded Nursing Care ('FNC').

7. As part of this transfer of CHC functions from the Trust to the IOW CCG a full resource and capacity analysis was undertaken, and a service restructure put in place. To date the increased staffing structure to meet the activity requirements (previously commissioned from the Trust) has been put in place by the IOW CCG. Recruitment to the new structure has been problematic. To address the recruitment challenges the CHC department have been supported by a contract with an external provider to deliver the required number of CHC assessments and reviews so as to maintain the appropriate level of service delivery. The leadership role of Head of CHC has been vacant as this is a particularly difficult post to recruit (the budget for the vacant post has been being used to ensure that the transformation of the service is complete and that there is operational resilience).

8. The CHC department has had to address significant backlogs transferred back to the service by the Trust due to the underperformance identified in the service review.

9. In addition to the issues identified as part of the CHC provision there has also been a stretch on the limited health and social care resource with practitioners in health and social care often in conflict regarding attribution of health funding, with this resulting in ongoing disputes and lack of parity for those we serve. This

approach has distracted practitioners in health and social care with a perceived lack of transparency and conflict hindering the teams from ensuring that health funding is accessible at the point of need. It has also prevented the development of an integrated and skilled workforce with the ability to allocate health and social care appropriately and fairly.

10. The different approaches of commissioning from health and social care have historically resulted in a challenging and uncertain market place and this has hindered clear planning based on population need.

11. As part of the CHC review undertaken in 2017 a full options appraisal was undertaken as to the service model and delivery system and five key options were considered.

12. The two options identified in the options appraisal in 2017 as the highest scoring and the best fit with the two key service models for the CCG were that of:
    a. Integration of the service with the Local Authority
    b. The hosting of the service by a CCG partner within the local Sustainability and Transformation Plan ('STP') area.

13. As a result of the options appraisal in 2017 it was agreed to progress the option of an Isle of Wight Integrated Model based upon the strategic aspirations and plans for integration of services to provide best value, safe, stable, sustainable seamless service to the residents of the Isle of Wight.

14. The key functions of CHC and FNC considered as part of the integrated service were agreed to include:
    a. CHC and FNC Assessments and reviews
    b. Assessment and management of Personal Health Budgets ('PHB's')
    c. Decision making processes
    d. Commissioning and procurement functions
    e. Finance and payments functions
    f. Maintenance of service data and NHS England benchmarking reporting
    g. Management of CHC Appeals and Disputes processes including Independent Review Panel with NHS England

15. Over the past year the CHC transformation programme has been undertaken supported by Crisante Consulting which has delivered:
    a. National Framework Compliance and best practice models,
    b. The transfer of the service back from the Trust,
    c. The clearing of the backlog of assessments,
    d. The restructure of the service and recruitment to a new CHC structure
    e. The delivery of joint health and social CHC training events
    f. Development of standard operating policies and procedures

g. The improvement of data quality and integrity.

16. In June 2018 an NHS England STP wide initiative undertaken by Delloites reviewed and scored the transformation journey and outcomes against the national CHC Maturity Matrix. The outcome of the STP Maturity Matrix review identified that the Isle of Wight has made significant progress improving CHC over the last 12-18 months. However, there are still areas of CHC on the Island that are not operating at optimal levels. In particular; market management, brokerage and Persona Health Budget's.

17. The NHS CHC Service Improvement Programme commissioned a Quality, Innovation, Productivity and Prevention programme (QIPP) opportunity review to be undertaken by Deloittes to identify through a process of benchmarking nationally the opportunity for each CCG to maximise CHC savings. QIPP is in essence a broad national policy agenda rather than a single, definable policy. There are a number of national work streams within QIPP designed to support the NHS to improve care and lower costs. These range from improving commissioning of care for patients with long-term conditions, to improving how organisations are run, staffed and supplied. The specific changes required to meet the QIPP are left for local providers and commissioners to identify and implement.

18. For the Isle of Wight the QIPP in relation to CHC savings identified an opportunity of £1.337 Million in savings for 2018/19. To deliver the identified QIPP the CCG agreed a 'spend to save' QIPP investment of £81,600 for 2018/2019 to achieve a savings opportunity of £623,738. The key enabler for the delivery of the QIPP programme was that of commissioning support to deliver fit for purpose specifications, contractual terms and conditions and market management and development to provide best value services to CHC eligible patients. This work has been delayed by contractual issues, with work only really gathering traction in October 2018; this has had an impact on the opportunity for a full year effect QIPP which will largely remain undelivered. As a result of the failure to deliver the QIPP for 2018/2019 the budget has been rebased for 2019/2020 so that the under delivery of savings is not transferred into the new financial year.

19. Since 1 January 2019 the CHC service has been integrated with Adult Social Care under the management of the Assistant Director of Commissioning and Partnerships with the current Strategic Commissioning Manager within the Commissioning and Partnerships Team adding the Head of CHC to her function (with the pay differential being funded by the CCG). This methodology provides a number of advantages.

20. The advantages of the integration are as follows:

a. A fully integrated local approach.
b. The opportunity to develop shared goals between the NHS and the Local Authority
c. An integrated team that is able to focus on the best outcomes and quality provision for individuals.
d. A joint brokerage service would reduce resource replication/duplication of effort when trying to identify vacancies or broker care packages. Brokerage in the Council is currently undertaken by the Single Point of Commissioning Team ('SPOC') and as part of Living Well the Council have also commissioned People Matter IW to provide some Brokerage services for people who fund their own care or who have personal budgets. This supports the CCG in creating choice for people in how they can secure a provider to meet their needs.
e. Significant QIPP opportunities to deliver the QIPP delivery plan 2018/2019 to 2019/2020, including opportunities for the CCG and the Council to work together to:
f. Increase joint commissioning and market management. The Council currently undertake significant market engagement and market management
g. Co-production of the Market Position Statement provides real opportunity for market shaping and development.
h. Improve contracting arrangements with providers, based on the pooling of expertise
i. Have sensible discussions about the limits of care and how to ensure CHC packages are only funded in response to a demonstrable health need
j. The development and roll out of an extensive Personal Health Budgets offering for CHC building upon the Councils direct payments offer. The Council is recognised as being GOOD at the management of Direct Payment Personal Budgets. The council has commissioned a pre-paid card scheme to improve audit and access to funding for people but alongside this has developed ICT systems to support its delivery. This Council's ICT developments have been recognised nationally by the banking industry and are shaping the way other authorities administer personal budgets. This integration of CHC would enable Personal Health Budgets to benefit from the same systems and processes and could result in faster implementation of this key health priority.
k. Financial, payments and contracting functions to be managed by the Local Authority. This creates real system advantages as providers will hold one contract with the council and the CCG. There can be no confusion of terms and obligations which makes holding providers to account in terms of quality and service delivery much easier.
l. Alignment with the current FNC payments service hosted by the Council

m. Ensuring engagement in assessment process by the Local Authority
n. Joint health and social care service goals and KPIs meeting the NHS England 28 day assessment period and Discharge to Assess agenda.
o. Offers organisational efficiency in management support and integration resources
p. Delivery of a joint commissioning strategy between Health and Social Care with the IOW independent provider market.

21. The challenges of the integration are as follows:
    a. Integration process itself. Integrating health and social care teams has been known to be difficult due to the different organisational cultures and embedded ways of working
    b. Capacity – the current integrated team is currently working at capacity
    c. The potential for lack of clarity around new integrated team structure and implementation of the same
    d. System move to place-based commissioning – lack of clarity around intention and timescales
    e. The need for clear and robust governance structure
    f. The need for clear and robust quality assurance process
    g. The need to ensure clinical governance within CHC team is appropriate and sustainable
    h. Agreeing the Pooled budget, and processes to ensure appropriate assessment and application of the CHC Framework

STRATEGIC CONTEXT

22. This proposal is linked to the Corporate Plan 2017-20 in so far as the integration of health and social care contributes directly to outcomes for wellbeing by supporting people to take responsibility for their own health and wellbeing and ensuring that vulnerable people are supported and protected. The proposal furthers the integration of adult social care and health and will contribute directly to the delivery of the Care Close to Home strategy.

SERVICE/DECISION SPECIFIC PARAGRAPH

23. It is essential that in order to ensure the success of the proposed integration robust governance and quality assurance processes are put in place. There will need to be clear oversight of the integrated approach and of the decision making process. The CHC Transformation board, which meets monthly, will be changed to be a Partnership Programme Board, attended by the Interim Managing Director of the CCG and the Director of Adult Social Care.

24. In addition it is proposed that the quarterly NHSE Assurance report will ensure that there is benchmarked reporting of performance.

25. Further quality assurance will be provided by an independent organisation who will undertake quarterly external audit (which will need to be commissioned) of decision making (10% of CHC and Fast-track decisions) and an annual external review using the NHS England Maturity Matrix for CHC to demonstrate ongoing service improvement.

26. Two recent reports on NHS CHC have thrown into sharp relief areas of concern nationally about the quality of CHC services across England and patient experience of those who access CHC funding. Key areas of concern include:
    a. Variation in access to CHC
    b. Inconsistency in decision making with huge variation in eligibility rates for CHC
    c. The assessment process did not follow National Guidance
    d. The process took too long and was subject to delays
    e. Poor communication with individuals and their families
    f. Complaints and appeals mishandled
    g. The process is a burden of individuals and their families

27. NHS England has already embarked on a programme of improvement for CHC and in addition has revised the National Framework for CHC taking account of feedback from individuals and representative groups. This revision has also reflected changes in the Care Act 2014 and the drive to ensure that the majority of CHC assessments should occur outside of an acute hospital.

28. The Council and the CCG, as part of creating an integrated service delivery model, has put in place a comprehensive assurance framework to allow CHC to continue to improve and achieve these levels of maturity. More importantly the assurance framework offers assurance that the service meets the requirements of the revised National Framework for CHC 2018. In addition it enables assurance to be given that the service is improving improvement against targets that are reported on monthly and quarterly to NHS England. It must be noted that at the same time as improving the quality and performance of the service, increasing demand and significant budgetary pressures must also be managed. The assurance framework provides the opportunity for oversight of this too.

29. The framework to assure quality in CHC has been developed across 3 domains. The first two are identified in the National Framework and specify the key quality standards for CHC. The third outlines what needs to be in place to ensure a quality service can be achieved:
    a. Assessment and Decision Making
    b. Care Planning and Commissioning packages of care
    c. Enablers

30. A draft paper identifying the key quality assurance framework model is currently under development (Appendix 1), when fully implemented this will provide assurance upon the delivery of CHC by the integrated service delivery model.

CONSULTATION

31. There is no statutory requirement for consultation however the Council and the CCG have engaged with the primary stakeholders in relation to this proposal including the Trust and independent sector providers

FINANCIAL/BUDGET IMPLICATIONS

32. There is a requirement for the council and the CCG to have a pooled fund to support integrated commissioning and provision. This has been a requirement for a number of years and provides a vehicle for the two organisations to pool funding to achieve better outcomes and integration.

33. The Better Care Fund Section 75 Agreement ('BCF S.75') is the existing pooled budget between the Council and the CCG and it is proposal that the current BCF S.75, which is currently being revised and update, is used to create the pooled fund for CHC from 1 April 2019. The BCF S.75 already consists of a fund made up of contributions from both organisations to deliver agreed health and social care outcomes.

34. The IOW CCG allocation for CHC this financial year 2018/2019 was identified as follows:

Area	**£**
Continuing Care Older Persons MH over 65	2,424,089
Continuing Care Physical Disabilities over 65	2,235,913
Continuing Care fast Track EOL	852,956
Continuing Care LD Adult over 65	155,177
Personal Budgets Adult	1,782,921
Continuing Care TQ21 Contract	173,519
Funded Nursing Care	2,573,077
Transitional Funding (FWP)	393,928
Continuing Care Older Persons MH under 65	6,668
Continuing Care LD Adult under 65	1,742,562
Continuing Care Physical Disabilities Under 65	1,927,894
Joint Funded Adult	59,189
Child Continuing Care	798,101
BCF - Carers (Supports Personal Budgets)	295,656
TOTAL CONTINUING CARE SERVICES	**15,421,649**

35. Budget growth in the past 3 years has been as follows:
    a. 2016/17 - the plans provided for 6.6% to cover both the growth and uplift in 2016/17 (approx. 2% to cover growth after fee uplift)

b. 2017/18 - the plans provided for 6.5% to cover both the growth and uplift in 2017/18 (approx. 1-2% to cover growth after fee uplift)
c. 2018/19 - 7.2% based on Deloitte's national modelling

36. Modelling is in progress in relation to the proposed budget build for 2019/2020 and it is envisaged that the budget will be uplifted by a similar sum to reflect increase costs (provider fees) and demographic growth. It is anticipated that there will be a rebase of the budgets based on the people currently eligible for CHC due to the material changes that can occur in year with part year effects on client numbers and package prices. The budget for 2019/2020 will also need to factor in the CHC QIPP expectations for 2019/2020 which has been identified as being £908,215.

37. In addition to the service, the budget in relation to staffing has been identified as being £621,362.

38. Further funding is provided to cover legal fees as this is a heavily litigious area. This has been:
    a. 2015/16 £31,625.04 (incl VAT)
    b. 2016/17 £56,283.79 (incl VAT)
    c. 2017/18 £18,029.42 (incl VAT)

39. The BCF S.75 will set out the arrangements for financial risk sharing between the council and the CCG should the CHC budget overspend or underspend. It is likely, as has been the case in previous years, within the BCF S.75 that each organisation is responsible for any overspends and underspends relating to its own functions; therefore the BCF S.75 will not increase the financial risk to either organisation. This is subject to further discussion with finance colleagues however a recent meeting it was agreed that the CCG will continue to hold financial responsibility for this budget and that there will, at this initial stage of integration be no risk share in relation to the overspend or underspend on CHC. Any change to this position would need to be agreed between the organisations at a later date. The upcoming BCF S.75 finance meeting will endorse this position and ensure that it is reflected in the legal agreement.

40. In terms of accountability it is necessary for full information to be provided to NHS England and accordingly, within the scope of the existing BCF S.75, finance colleagues would set up separate cost centres within the Adult Social Care Budget so that the required information is readily available for both reporting and audit purposed.

LEGAL IMPLICATIONS

41. The development of the BCF S.75 is required in accordance with the Care Act 2014. It provides an ideal opportunity to progress the integrated health and social care agenda.

42. The BCF S.75 is the only mandatory policy to facilitate integration and brings together both health and social care funding.

43. A local authority has no lawful ability to commission or deliver Health services; the addition of the CHC function does not challenge this position and would not be a breach of the council's statutory obligations or authority.

EQUALITY AND DIVERSITY

44. The council as a public body is required to meet its statutory obligations under the Equality Act 2010 to have due regard to eliminate unlawful discrimination, promote equal opportunities between people from different groups and to foster good relations between people who share a protected characteristic and people who do not share it. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

45. Where required for each of the services under the BCF S.75 agreement equality impact assessments will be carried out in accordance with the council's obligations. This includes where the operation of CHC requires.

46. The integration of CHC with Adult Social Care wider functions has no negative impact on any protected characteristics.

PROPERTY IMPLICATIONS

47. There are no property implications. The CHC team will be located with the Adult Social Care Commissioning Team and this has formed part of scoping work undertaken as part of the relocation of Adult Social Care to County Hall.

OPTIONS

48. The council is limited in the options available to it in relation to CHC:

    a. Option 1 – Continue to operate separately and not to integrate the CHC function with Adult Social Care.
    b. Option 2 - That Cabinet notes the progress to date in relation to the integration of the CHC functions with Adult Social Care and agrees the inclusion of the CHC budget within the BCF S.75 from 1 April 2019.

RISK MANAGEMENT

49. In relation to CHC there are a number of key financial risks at this time. There are 7 cases currently awaiting a decision in relation to retrospective liability for CHC funding with an estimated total liability of £692,500 at this time. Determination in relation to these cases will be made by NHS England as part of their Independent Review Panel ('IRP') process. There is currently a backlog nationwide of these cases and it is likely that this will take in the region of 18 – 24 months to resolve.

50. Retrospective CHC cases present an additional risk. There is currently £395,000 left on the CCG balance sheet for provisions that was put into the ledger at the end of the last financial year. The provision was based on cases at the time that the CHC department had identified as presenting a risk of retrospective payments. In addition there is a further £516,000 that NHS England control (part of the CHC Risk Pool contribution), this relates to the outstanding 'Closing the Gap' cases (there are approximately 5 cases left locally that have been appealed). When these are agreed then the CCG reimburses the client the costs but then draws down on the money from the pool.

51. As identified earlier in this report there is a QIPP identified in relation to CHC. The QIPP will need to be delivered in 2019/2020 from the existing CHC budget. The sum of the QIPP to be realised is £908,215. In effect this will see the current CHC budget after uplift (to be determined) being reduced by £908,215 with those savings to be delivered in year. A QIPP of £1.337m was identified for the CHC budget in 2018/2019 but this has largely not been delivered, colleagues at the CCG have confirmed that the budget has been rebased and that there will be no requirement for the unmet QIPP for 2018/2019 to be delivered in 2019/2020 in addition. The CCG will contribute the full actual costs of the delivery of CHC, and ancillary costs, to the pooled budget and will bear the risk of the QIPP not being delivered.

EVALUATION

52. An integrated service within the Council is believed to provide both the best cost option and the best opportunity for strategic alignment. It fits well with the long term strategic plans of the IOW Health and Social Care integration agenda and provides greater opportunities for long term service sustainability and efficiencies. Perhaps more importantly it provides the opportunity to simplify the care pathway for those we serve and to achieve a better 'journey' though a complex part of the health and social care landscape for vulnerable people.

RECOMMENDATION

(a) Option 2 - That Cabinet notes the progress to date in relation to the integration of the CHC functions with Adult Social Care and agrees the inclusion of the CHC budget within the BCF S.75 from 1 April 2019

APPENDICES ATTACHED

53. Appendix 1 – CHC Quality Assurance Framework Model (Draft)

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