READING BOROUGH COUNCIL

REPORT BY HEAD OF LEGAL AND DEMOCRATIC SERVICES

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE**		
DATE:	**12 JULY 2017**	**AGENDA ITEM:**	**7**
TITLE:	**SCRUTINY REVIEW – CONTINUING HEALTHCARE FUNDING**		
LEAD COUNCILLOR:	**COUNCILLOR EDEN**	**PORTFOLIO:**	**ADULT SOCIAL CARE**
SERVICE:	**LEGAL & DEMOCRATIC SERVICES**	**WARDS:**	**BOROUGHWIDE**
LEAD OFFICERS:	**RICHARD WOODFORD** **SIMON HILL**	**TEL:**	**0118 9372332 / 9372303**
JOB TITLE:	**PRINCIPAL COMMITTEE ADMINISTRATORS (SCRUTINY)**	**E-MAIL:**	**Richard.woodford@reading.gov.uk** **Simon.Hill@reading.gov.uk**

1. EXECUTIVE SUMMARY

1.1 The task and finish group appointed at the 3 February 2016 ACE Committee meeting have completed their review of Continuing Healthcare Funding. Their report is attached at Appendix 1 and includes a number of recommendations.

2. RECOMMENDED ACTION

2.1 That the Committee receive the report of the Continuing Healthcare Funding scrutiny review task and finish group.

3. BACKGROUND

3.1 At the ACE Committee meeting that took place on 3 February 2016 it was agreed that Councillors Hoskin, Gavin and Stanford-Beale be appointed to a task and finish group to conduct a review of Continuing Healthcare Funding.

4. THE REVIEW

4.1 To carry out the review a series of four evidence gathering sessions were held as follows:

- 27 July 2016 – meeting to consider the report by Wokingham Borough Council detailing concerns about CHC

- 13 September and 15 December 2016 – meetings with Cathy Winfield, Chief Officer North West Reading, South Reading, Newbury and District and Wokingham Clinical Commissioning Groups (CCGs)

- 23 March 2017 – meeting with Paula Johnston, Acting Service Manager, Older and Physically Disabled People, Reading Borough Council.

5. REPORT AND RECOMMENDATIONS

5.1 The group have drawn up a number of conclusions based on their evidence gathering sessions and have made a number of recommendations which have been grouped together under the following headings in Section 5 of the report:

- Benchmarking
- Joint Action Plan
- Future Reporting
- Provision of CHC for Children and Young People

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 The review of Continuing Health Care contributes to the strategic aim to promote equality, social inclusion and a safe and healthy environment for all.

6.2 The Council is committed to:

- Ensuring that all vulnerable residents are protected and cared for;
- Enabling people to live independently, and also providing support when needed to families;
- Changing the Council's service offer to ensure core services are delivered within a reduced budget so that the Council is financially sustainable and can continue to deliver services across the town.

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 Any community engagement as part of the scrutiny review was considered.

8. EQUALITY IMPACT ASSESSMENT

8.1 Implementation of the policy impacts on those with long term health needs and those at the end of their life. the very low level of funding of CHC from CCG would seem to indicate that there may be some patients who may not be getting specialist healthcare that they need or are being charged for care services when in another post code they would be seen to be eligible for free care

9. LEGAL IMPLICATIONS

9.1 National Framework for NHS Continuing Health Care and NHS Funded Nursing Care November 2012 (revised) provides the legislative framework for the provision on Continuing Health Care and NHS Funded Nursing Care.

10. FINANCIAL IMPLICATIONS

10.1 From a revenue point of view Reading has the lowest level of eligible recipients of CHC in England. This potentially highlights that the Council may be providing funding for clients that actually should be receiving CHC and therefore having a detrimental impact on the current financial position.

11. BACKGROUND PAPERS

11.1 National Framework for NHS Continuing Health Care and NHS Funded Nursing Care November 2012 (revised):

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf

11.2 ACE Committee 3 February 2016 - Minutes and report.

Adult Social Care, Children's Services and Education Committee

Scrutiny Review – Continuing Health Care Funding

Report by Task and Finish Group

Membership:

Councillor Graeme Hoskin (Chair)
Councillors Gavin and Stanford-Beale

Terms of Reference:

To investigate the reasons for the significantly lower than average level of Continuing Health Care (CHC) and NHS-funded Nursing Care funding in Reading, and the impact this has on individuals and the local authority.

1. Introduction

The Task and Finish group were commissioned as a Councillor Task and Finish Group to carry out this scrutiny review at a meeting of the Adult Social Care, Children's Services and Education Committee (ACE) on 2 February 2016. The Committee received a report on Continuing Health Care Funding which stated that in 2012 a review had been carried out by the Department of Health that had noted that Berkshire had the lowest level of eligible recipients of CHC in England, with the East ranking 148 out of the then 150 Primary Care Trusts, and the West, the Clinical Commissioning Group (CCG) for Reading, ranking 150 out of 150. As a result, and in light of the concerns noted at the time, actions were set to ensure that this data was collated on activity and scrutinised by the CCG (regionally) and together with each local authority in order to identify the factors affecting performance. Data for quarter one of 2015/16 had been analysed and had shown that the West of Berkshire and the East of Berkshire had the lowest number of CHC packages of care, with South Reading CCG area being the lowest.

2. Background

NHS CHC is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. It is aimed at meeting needs that have arisen as a result of disability, accident or illness and includes those at the End of Life. Eligibility for NHS CHC places no limits on the type of service delivery or on the settings in which the package of support can be offered, for example:

- In the home – The NHS will pay for healthcare such as services from a community nurse or specialist therapist, and personal care, such as help with bathing, dressing and laundry;
- In a Care Home – As well as healthcare and personal care, the NHS will pay for care home fees, including board and accommodation.

NHS CHC and NHS Funded Nursing Care (FNC) is free for residents who meet the criteria, in the same way as access to all other health care support via the NHS.

NHS FNC is the funding provided by the NHS to Care Homes providing nursing to support the provision of nursing care by a registered nurse.

To be eligible a person must be over 18 and have substantial and ongoing care needs, they must also have been assessed as having a 'primary health need', this means that their main or primary need for care has to relate to their health. Eligibility does not depend on:

- A specific health condition, illness or diagnosis;
- Who provides the care;
- Where the care is provided.

CHC is not means tested and therefore an individual who is in receipt does not have to pay a contribution towards their care, unlike local authority funded care, which is means tested, via the national guidance on contributions towards the cost of Care Home placements; Care and Support Charging and Financial Assessment Framework.

In Reading, along with its two neighbouring authorities, the level of provision for NHS funded CHC is significantly lower than average. This has an adverse impact on the Council's ability to ensure the financial sustainability of the Council as the Council is paying a larger proportion of high care placements than other local authorities.

In 2012 a review carried out by the Department of Health noted that Berkshire had the lowest level of eligible recipients of CHC in England, with the East ranking 148 out of the then 150 Primary Care Trusts and the West ranking 150 out of 150. As a result, and in light of the concerns noted at the time, actions were set to ensure that this data was collated on activity and that it be scrutinised regularly by the CCG (regionally) and together with each local authority in order to identify the factors affecting performance. Data for the first quarter of 2015/16 had been analysed and showed the following for Berkshire:

Organisation	Patients Newly Eligible per 50k GP patient size list aged 18+	Patients Currently Eligible per 50k GP patient size list, 18+
NHS England Average	27.50	68.42
NHS England South Central	18.24	40.89
NHS Bracknell & Ascot (East Berks)	11.40	35.28
NHS Windsor & Maidenhead (East Berks)	7.69	39.65
NHS Slough (East Berks)	5.83	26.46

NHS Newbury & District (West Berks)	11.60	22.09
NHS South Reading (West Berks)	2.74	11.41
NHS North & West Reading (West Berks)	8.26	21.24
NHS Wokingham (West Berks)	4.06	15.82

In order to address the issue since 2010 the Council had funded a post to actively pursue the application of CHC. However, take up of CHC continued to remain low and officers had been in contact with neighbouring authorities in the West of Berkshire to compare uptake and found that Wokingham Borough Council in particular had had a greater success rate achieving £2m of CHC funding as at the end of December 2015. The Council therefore entered an agreement for Wokingham to oversee a team of CHC workers as part of an 'invest to save' proposal, with the plan that the Council would be able to support individuals to achieve CHC. This was put in place from January 2016.

Continuing Healthcare - Process

The process to obtain CHC funding has a number of stages which are as follows:

1. Initial Assessment – The process starts with the 'Checklist' Assessment that looks at 11 aspects of health. The Checklist can be carried out by one person, such as a social worker, GP or Care Home Manager, but they must understand the process and be familiar with the individual's needs. The Checklist does not determine eligibility it simply indicates whether or not there should be a full assessment.

2. Full Assessment – At this point a form called the 'Decision Support Tool' (DST) is completed by a Multidisciplinary Team (MDT), not just one person. A social worker or other local authority representative must be involved at this stage. The team's assessment will consider needs under the following headings:

    - Behaviour;
    - Cognition (understanding);
    - Communication;
    - Psychological/emotional needs;
    - Mobility;
    - Nutrition;
    - Continence;
    - Skin (including wounds and ulcers);
    - Breathing;
    - Symptom control through drug therapies and medication;

- Altered stated of consciousness;
- Other significant needs.

These needs are then given a weighting marked "priority", "severe", "high", "moderate" or "no needs". The MDT will consider:

- What help is needed;
- How complex the needs are;
- How intense of severe the needs can be;
- How unpredictable the needs are, including any risks to the person's health if the right care isn't provided at the right time.

If the person has at least one priority need, or severe needs in at least two areas they should be eligible for CHC. They may also be eligible if they have a severe need in one area plus a number of other needs or a number of high or moderate needs, depending on their nature, intensity, complexity or unpredictability. In all cases the overall need and interactions between needs will be taken into account, together with evidence from risk assessments. The assessment should also take into account the individual's views and the views of any carers.

3. Award of Funding – If the person is found to be eligible for CHC after the Full Assessment they are said to have a Primary Health Need. Funding will be awarded by the NHS to cover care costs including social care costs, such as accommodation in a care home. Funding is backdated to day 29 after the original Checklist was received by the NHS and a further funding review will then take place in three months and after that on an annual basis.

   A decision about eligibility for funding should normally be made by the CCG within 28 days of them receiving a completed Checklist or request for a Full Assessment. If the decision is made that the person is eligible but it takes longer than 28 days to reach the decision and the delay is unjustifiable any care costs from the 29th day until the date of the decision should be refunded.

4. Appeal Process – If the individual was found to be ineligible at the DST stage a Continuing Care appeal can be submitted via the local NHS. A Local Dispute Resolution Meeting may be offered first and if the decision of ineligible is upheld an Independent Review Panel can be requested and will take place at regional level. If the person is then found to be eligible funding will be awarded and backdated to shortly after the Checklist. Alternatively, if the person is confirmed to be ineligible for funding at the Review they can approach the Health Ombudsman.

3. Scope

The review began with a scoping meeting on 27 July 2016 where it was decided that the focus of the review would be to seek to:

- Analyse the differences between the level of CHC funding in Reading and other local authorities, in particular the Council's comparator group;
- Consider the extent to which the national guidance for CHC and NHS Funded Nursing Care funding decisions is being applied in Reading, by comparing local policies and procedures against the national guidance and practice in similar areas;
- Examine and summarise the impact of current local policies and procedures on individuals and the local authority;
- Make recommendations to ACE Committee for any actions which should be taken to ensure that the national CHC guidance is applied in an effective and equitable way.

It was decided that the review would consider the process for making decisions on CHC funding and would not look at CHC within the wider Health & Social Care integration agenda or in relation to transition to/from other services and care plans.

4. Findings

4.1 Evidence Gathering Session 1 – Report by Wokingham Borough Council: Concerns about CHC

At the scoping meeting on 27 July 2016 a report that had been produced by WBC officers was considered. The report outlined the issues and concerns that WBC officers involved in CHC work had about the CCGs implementation of the CHC National Framework. The report was later developed into an action plan jointly with the CCG to address the issues. The issues raised in the report have now mostly been addressed (see 4.1).

4.2 Evidence Gathering Sessions 2 and 3 – Meeting with Cathy Winfield, Chief Officer North West Reading, South Reading, Newbury and District and Wokingham CCGs

The Task and Finish Group met next with Cathy Winfield, Chief Officer North West Reading, South Reading, Newbury and District and Wokingham CCGs, on two occasions on 13 September and 15 December 2016.

At the meeting on 13 September 2016 Cathy Winfield gave a presentation on CHC funding and why it was lower in Reading than elsewhere. The presentation made a number of points including the following:

- Areas with a high elderly population had a high level of CHC spend whereas relatively healthy and prosperous areas with low numbers of elderly people had a lower spend. Low numbers of nursing home beds would also be a factor;

- A local Operational and Dispute Policy had been agreed by the CCGs and local authorities, this had followed a legal review;

- A jointly commissioned review of seven cases had taken place and the eligibility decisions had been upheld in every case;

- The CHC function would be reviewed as part of the national CCG Assurance Framework;

- The CCG had requested Eileen Roberts, Head of NHSE South, to review their operational policy and to check that it was compliant with the national framework;

- Reading CHC expenditure had increased by 2.6% from £6.08m in 2015/16 to a forecast of £6.24m for 2016/17;

- The CCG would report to the Council on CHC activity and spend on a monthly basis for transparency;

- The CHC team would be strengthened by seconding a social worker into the team to speed up joint assessment and to ensure the social care prospective was taken into account.

The Task and Finish Group met again with Cathy Winfield on 15 December 2016 who gave a presentation providing the Group with an update on CHC and presented a Joint Action Plan (attached to this report). The main points raised at this presentation were as follows:

- Good progress had been made and joint working had been strengthened at operational level;

- It was clear that the process had needed strengthening, was not user friendly and some 'myth busting' about current practice was required as well as some misunderstandings about eligibility that needed to be addressed;

- An Action Plan had been put together and was waiting to be signed off, although some of the actions were already being implemented;

- A reporting format had been developed in order to be more transparent and an oversight group would be set up to provide assurance to senior leadership and Councillors;

- Work needed to be done on benchmarking to agree a reasonable cohort of other authorities to benchmark against;

- CCG expenditure was increasing with a proposed overspend in north and west Reading of £651k and £335k for south Reading;

- Nationally there was concern in NHS England about the wide variation spend from one area to another and national strategic improvement programme had been set up designed to address variations in processes and expenditure;

- Work had started on producing CHC Activity Reports for both south Reading and north and west Reading;

- An Action Plan had been produced and the Task and Finish Group were presented with the highlights.

4.3 Evidence Gathering Session 4 – Meeting with Acting Service Manager, Older and Physically Disabled People, Reading Borough Council

The Task and Finish Group met with Paula Johnston, Acting Service Manager, Older and Physically Disabled People, on 23 March 2017 and discussed the issues that had been raised in the report by Wokingham Borough Council that had been considered by the Task and Finish Group at their first meeting in July 2016.

Paula told the Group that some of the issues in the WBC report were outstanding and gave an update on some of these issues. The process for applying for CHC funding could still be lengthy and the number of people who had successfully obtained CHC funding remained low. There had been some internal process issues in Adult Social Care which meant that while progress in developing expertise in this area had been made it had been slower than hoped.

Action Plan Outcomes

- The implementation of a new Best Interests form to evidence the individual's consent to the process. This had not been evidenced consistently and checklists were being returned by the CCG. Where there were any minor technical issues with the recording of consent the CHC process would continue while this was rectified. The effectiveness of this was due to be reviewed in July 2017.

- Joint mechanisms were now in place between the CCG and the LA for aspects of the process such as deciding whether a checklist should be returned due to a lack of information, and whether a significant change in need had occurred triggering further assessment. Regular meetings had been held to identify shared learning and training needs.

- The CCG and LAs had begun to work jointly on cases where process issues appear to have influenced the outcome, on a planned and phased basis. 12 cases were initially identified with more added recently. Meetings were scheduled to discuss and progress these, to share learning and to identify training needs.

- The CCG was now accepting referrals which had been completed by professionals who had not completed the CCG CHC training if they had been countersigned by a professional who had. These referrals were previously being rejected, but the completion of the CCG training was not a requirement of the CHC National Framework.

- A process was in place for resolving differences in professional opinion about the evidence in a CHC checklist, which it had not yet been necessary to implement.

- The CCG no longer closed down a referral after 28 days if insufficient evidence had been submitted, and a process was in place for the CCG or the LA to actively pursue this evidence.

- The CCG and LA had agreed that the intention of the CHC National Framework was that a meaningful and joint discussion should be held in relation to eligibility. The CCG included the views of all relevant parties giving them equal weight.

- The CCG and LA had reviewed the dispute process, adjusted the timescale and confirmed that it was consistent with other CCG dispute processes in the South. Ongoing actions working towards completion included the following:

    - An agreed process to ensure that the Multi-disciplinary team meeting robustly collected both verbal and written evidence when completing assessments. There had been disagreement between the CCG and LA about whether this had happened in all cases.

    - The CCG and the LA would produce a leaflet for staff and guidance for members of the public to inform their participation in CHC assessment meetings.

    - The CCG and the LA would review the documentation for individuals in relation to appeals to ensure that it was accessible, in plain English and included signposting to advocacy.

    - E-learning and jointly delivered training for staff would be made available.

    - The local authorities would be provided with quarterly benchmarking data provided by the CCG.

    - The CCG and the LA would jointly agree to draft a form of words for communication to staff regarding appropriate use of fast track process and relevance of CHC at end of life.

- Joint transition (from child to adult) protocols would be agreed between the CCG and the LAs.

5. Conclusions and Recommendations

Benchmarking

The Benchmarking data had yet to be obtained so that comparison and analysis of the differences between the level of CHC funding in Reading and comparator Local Authorities could be carried out.

Recommendation:

(1) That benchmarking data is obtained on a three monthly basis from the CCG as agreed;

Joint Action Plan

Issues were identified by WBC in relation to the application of the national guidance for CHC, an action plan had been implemented and local practice and procedures had been developed.

Recommendation:

(2) That the joint Action Plan be implemented as agreed and reviewed by the CCG and local authority on a monthly basis;

Future Reporting

In order to continue to monitor the position it is also recommended that progress reports be submitted to future meetings of the Adult, Social Care and Children's Services Committee.

Recommendation

(3) That the Adult Social Care, Children's Services and Education Committee receive a report at its meeting of 12 December 2017 detailing progress in delivering the Action Plan with an explanation if any actions have not been achieved or only partially achieved;

(4) That as part of the report for 12 December 2017 the most recent data on the provision of CHC is included to allow comparison with the data in section 2 of this report;

Provision of CHC for Children and Young People

Following this review of CHC funding for adults the Task and Finish Group would like a review to be carried out on the process of allocation of CHC for children and young people.

Recommendation

(5) That a review of the provision of CHC for children and young people is commissioned in consultation with the Lead councillors for Children's Services and for Health, to report back to a future meeting of the Adult Social Care, Children's Services and Education Committee.

Jointly Agreed Action Plan

Ref.	Issue:	Action taken:	Assigned to:	Date to be completed:
1	**CHECKLISTS AND CONSENT**			
1a	Agree to accept Social Services consent forms provided these sufficiently cover CHC	CHC Service and L.A. have agreed: SS consent not suitable. ER & JG agreed new simplified BI consent - start 1st Jan 2017	ER/JG	START 1ST Jan 2017 then on-going. Review effectiveness – 6 months – July 2017
1b	Look at how it might be possible to move the CHC process forward whilst written consent is finalised.	CHC Service and L.A. have agreed: • to begin process whilst consent is resolved – admin staff in place. • Liaise with L.A. team where appropriate • Full compliant consent must be in place before the MDT takes place	ER/JG	START November 2016 then on-going. Review – 6 months

Ref.	Issue:	Action taken:	Assigned to:	Date to be completed:
1c	Have mechanism between CCG and LA to agree whether checklist should be returned and any learning from this	**CHC Service and L.A. have agreed:** • Checklist over banded but screens in – checklist accepted – letter to referrer to highlight over banding. • Checklist over banded but does not screen in or outcome unclear - T/C to referrer – follow up with letter. • Learning to be collated at regular CHC and L.A. meetings – addressed via training	ER/JG	START NOVEMBER 2016 then on-going. Review – 6 months Training to be addressed later in action plan.

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
2	**RE-REFERRALS AT CHECKLIST STAGE**			
2a	Agree that if someone has had a DST they should only have another full assessment where there is a relevant and evidenced change in need – agree mechanism between health and social care to discuss these cases before a decision is made to either reject or agree to a new full assessment.	<u>CHC Service and L.A. have agreed as per the slide and:</u> • Cases to be discussed at fortnightly meetings (or by phone if urgent) between CHC and L.A. (Senior level) • Discussion with CHC, outlining the changes, before checklist. If progressing complete checklist jointly. • Learning to be collated at regular CHC and L.A. meetings – addressed via training	ER/JG	START – as required. Review – 6 months Training to be addressed later in action plan.
2b	Wherever possible agree to jointly complete the Checklist in such situations.	AGREED AS ABOVE		
2c	Agree also to work jointly on cases where process issues clearly seem to have influenced the outcome – on a planned and phased basis.	<u>CHC Service and L.A. have commenced this work:</u> • 12 cases identified to date – 5 RBC, 7 WBC: • Query – whether there are any more cases • Learning to be collated at regular CHC and L.A. meetings – addressed via training	ER/JG	START October 2016 – then ongoing Training to be addressed later in action plan.

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
3	**REFERRALS FROM LA WHEN INDIVIDUAL IS IN AN ACUTE HOSPITAL SETTING**			
3a	It has already been agreed that referrals from social care staff in hospital will be accepted			COMPLETED – October 16
3b	Cathy will check that the IG issues around LA accessing records in hospital are being addressed.	RBH have confirmed that L.A. staff can access the relevant records to enable them to checklist where appropriate.	CW	COMPLETED – October 16
3c	If checklists are disputed between hospital staff and LA these will be escalated to CHC team	**CHC Service and L.A. have agreed:** • Tri-partite (L.A.CHC and Acute) completion of these checklists. • Learning to be collated at regular CHC and L.A. meetings – addressed via training	ER/JG	START – as required – then on-going Training to be addressed later in action plan.

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
4	**CO-ORDINATION OF CASES AFTER 28 DAYS**			
4a	The CCG no longer operates a 28 day close down but we agree the need for a mechanism between health and social care to address situations where there are difficulties obtaining necessary information between positive checklist and DST	**CHC Service and L.A. have agreed:** • CHC evidence letter offers assistance in evidence provision • Each letter followed up with T/C • CHC Service to consider arranging to collect records • Where LA funded, LA can chase for records	ER/JG	START – November 2016 – then on-going
4	**CO-ORDINATION OF CASES AFTER 28 DAYS**			
4a	The CCG no longer operates a 28 day close down but we agree the need for a mechanism between health and social care to address situations where there are difficulties obtaining necessary information between positive checklist and DST	**CHC Service and L.A. have agreed:** • CHC evidence letter offers assistance in evidence provision • Each letter followed up with T/C • CHC Service to consider arranging to collect records • Where LA funded, LA can chase for records	ER/JG	START – November 2016 – then on-going

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
5	**ELIGIBILITY DECISION MAKING BEFORE MDT**			
5a	CCG agree that prior work should not include prejudging domain weightings and recommendation	**CHC Service to address this:** • QA process before draft DST is circulated • Draft evidence summaries to be clear they are based on written evidence received to date. • It is possible these will change following MDT discussion – to be monitored if issues arise	ER/JG	START – November 2016 then ongoing
5c	Intent of Framework is for a meaningful discussion at MDT about correct weightings and recommendation	**CHC Service and L.A. both agree this principle to be addressed through nos 6 – 9 in this action plan**		

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
6	**CORRECT INVOLVEMENT OF MDT MEMBERS**			
6a	Accept Framework doesn't envisage a hierarchy of professionals within the MDT but also recognise need to develop trust between organisations – MDT members should be involved in 4 key indicator discussion and recommendations	**<u>CHC Service and L.A. agree:</u>** • Current practise records, in each domain, the views of Individuals and/or their representative **And** • All appropriate and relevant professionals are invited to the MDT. – This practice to continue. • In addition the CHC Service will ensure all professionals are present at and are in involved in the in 4 key indicator discussion and recommendations.	ER/JG	Current practice to continue.
6b	Can have useful learning from IRPs			
6c	Social Care reps for IRPs would be welcome	• Both JG and GG have put themselves forward to become IRP Panel members. • JG confirmed training session on 4/1 and they put forward dates they can be IRP members.	JG/GG	November 2016

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
6	**CORRECT INVOLVEMENT OF MDT MEMBERS**			
6a	Accept Framework doesn't envisage a hierarchy of professionals within the MDT but also recognise need to develop trust between organisations – MDT members should be involved in 4 key indicator discussion and recommendations	**<u>CHC Service and L.A. agree:</u>** • Current practise records, in each domain, the views of Individuals and/or their representative **And** • All appropriate and relevant professionals are invited to the MDT. – This practice to continue. • In addition the CHC Service will ensure all professionals are present at and are in involved in the in 4 key indicator discussion and recommendations.	ER/JG	Current practice to continue.
6b	Can have useful learning from IRPs			
6c	Social Care reps for IRPs would be welcome	• Both JG and GG have put themselves forward to become IRP Panel members. • JG confirmed training session on 4/1 and they put forward dates they can be IRP members.	JG/GG	November 2016

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
7	**EVIDENCE AT MDT STAGE**			
7a	Agree that the MDT does and should collect both verbal and written evidence through MDT process	AGREED and this is current practise in the CHC Service. **<u>CHC Service and L.A. agree:</u>** Both written and verbal evidence to be recorded accurately in the DST. Where verbal evidence is not supported by written evidence consider whether a behaviour or 72hrs intervention chart would support the proper assessment of the Individual's needs. Address where Professionals have not recognised or taken action where there is no recording of verbally reported needs. Where possible identify at checklist stage and ask for care interventions to be recorded prior to MDT. MDT to be clear what evidence the banding is based on.	ER/JG	Current practise to continue

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
7b	Agree importance of using professional skills to weigh up evidence in order to gain accurate picture of needs – including eliciting and weighing up evidence from family etc	AGREED as per 7a above		
7c	Agree need for clarity with providers (in contract and quality assurance) about need for good quality recording in order to substantiate statements about need	**CHC Service and L.A. agree:** • This issue to be raised formally with Providers by the relevant Commissioner.	ER/JG	On-going
7d	The issue of recorded evidence may relate to the need to improve professional practice – absence of written evidence is not necessarily evidence of absence of need	**CHC Service and L.A. agree:** • Both written and verbal evidence to be recorded accurately in the DST. • Where verbal evidence is not supported by written evidence consider whether a behaviour or 72hrs intervention chart would support the proper assessment of the Individual's needs. • Address where Professionals have not recognised or taken action where there is no recording of verbally reported needs.	ER/JG	On-going

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
8	**RECORDING INFORMATION ON DST**			
8a	Agree useful to pre-populate DST with information so long as this is shared with MDT members and is open to discussion and appropriate amendment at the MDT stage	AGREED and this is current practice in the CHC Service. • Current practise means pre -drafted information can be removed if inaccurate. • Discussion on all aspects of the DST and other information to be recorded.	ER	Current practise to continue
8b	Agree that record of MDT discussion needs to reflect where there are material disagreements	AGREED and this is current practice in the CHC Service • This applies to all aspects of the assessment, evidence, domain bandings, rationale and eligibility recommendation. • The L.A. to provide their notes of the meeting and if disagreement re content is subsequently raised, these can be reviewed. • Where there continues to be disagreement this will be discussed at the L.A./CHC meeting.	ER/JG	Current practise to continue
8c	Agree all MDT members should have opportunity to correct the record of what they said	AGREED and this is current practice in the CHC Service.		Current practise to continue

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
9	**ACCEPTING MDT RECOMMENDATIONS**			
9a	Agree that where there is a disagreement over eligibility or where there are substantial concerns over an MDT recommendation the principles in the Framework will be followed in referring cases back to MDTs where required	AGREED and current practise • Where there is an agreed MDT recommendation – the case is ratified, by the CCG, without the need for Panel process. These cases can be returned to the MDT for additional work if the evidence does not support the bandings or recommendation. • CCG ratification process to identify where there are issues. • Where the MDT are not agreed in their recommendation , the case can be returned to the MDT if the DST requires more work or if the evidence supports the domain bandings but the recommendation is not agreed, be presented to Panel for an eligibility recommendation.	ER	Current practise to continue
9b	Agree to establish regular operational forum/group across health and social care to proactively discuss how to improve processes	Currently fortnightly meeting between ER/JG to take forward this plan and any other CHC issues arising.	ER/JG	Started October 2016 - ongoing

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
10	**DISCRIMINATION AT PANEL STAGE**			
10a	Agree that the Framework applies equally to adult client groups	AGREED		
11	**DELAYS IN RESPONDING TO LA DISPUTES**			
11a	View that this has been addressed, but interagency dispute policy to be revisited			
12	**INTERAGENCY DISPUTE POLICY**			
12a	Agree Jan and Liz to revisit interagency dispute arrangements, particularly in terms of timescales. Maybe consider independent chair arrangements.	• Interim discussion that timescales need to change particularly around timescale to first and second stages after the dispute is received. Currently 28 days to lodge the dispute and 10 days to first stage meeting. Change to 28 and 28. • Current process already allows for Independent Chair or Panel. • Agreed a shorter dispute notice with detail in the subsequent position statement	ER/JG	Discussion started – ongoing.
12b	Agree to look for any useful learning elsewhere	ER to contact other CHC Leads	ER	October 2016

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
13	**APPEALS BY INDIVIDUALS**			
13a	Agree that documentation for individual 'appeals' will be reviewed jointly to ensure they are user friendly, including appropriate language and signposting to advocacy	• Berkshire CHC Appeal leaflet already in use – to be reviewed with the L.A. • Advocacy Services in leaflets – Healthwatch and SEAP	ER/JG	2017
14	**TRAINING**			
14a	Agree that all relevant health and social care staff should undertake the E-learning	**CHC Service and L.A. agree:** • Currently being reviewed - To discuss with Jim Ledwidge when this may be available for use. • Consider developing on-line training ourselves	ER/JG ER to contact JL	2017
14b	Agree to jointly develop and jointly deliver a training programme	**CHC Service and L.A. agree:** • To explore the development of jointly delivered training in 2017 for date. JG like LA to jointly deliver the training. • ER to explore the possibility of an L.D. training event for the CHC and L.A Team.	ER/JG ER	2017 2017

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
15	**TENSIONS BETWEEN STAFF**			
15a	It is hoped that the other actions agreed will address this issue			
16	**BENCHMARKING DATA**			
16a	CCG happy to be open over benchmarking data	Template being developed for agreement	CW/GA/ER	December 2016
16b	Equally ASC happy to share their data	Template to be agreed	WF/SW/GW	December 2016
16c	Agree need to understand benchmarking position relative to other statistical neighbours – this to be monitored through the Joint CHC Oversight Group	Joint CHC Oversight Group to be established	GA/WF	START – January 2017

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
17	**END OF LIFE CARE**			
17a	Where a clinician is not using the Fast Track tool appropriately this will be escalated to the CCG	L.A. staff to be made aware through jointly agreed end of life letter	SW/WF/GA/CW/ ER	December 2016
17b	Agree to jointly draft a form of words for communication to staff about appropriate use of fast track process and relevance of CHC at end of life	RBC recent end of life letter to be reviewed and agreed	SW/WF/GA/CW/ ER	December 2016
17c	Vehicle for Implementation and Partnership Development	Joint CHC Oversight Group to be established	GA/WF	START – January 2017
17d	Agree need for joint transition (children to adults) planning protocols across whole system – Wendy to pick up with Judith		WF/JR	
17e	Gabrielle and Wendy to lead on joint plan going forward for CHC – co-opt others as required		GA/WF	

Ref.	Issue:	Action Taken:	Assigned to:	Date to be completed:
18	**AOB AND NEXT STEPS**			
18a	Agree to use GM and also recent EoL case as case studies for learning between organisations			