



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board



Meeting Date	16th July 2019	Agenda Item	5.1
Report Title	Continuing Health Care Deep Dive Exercise Report		
Report Author	Jason Crawl, Unit Nurse Director		
Report Sponsor	Lynne Hamilton Director of Finance		
Presented by	Jason Crawl		
Freedom of Information	Open		
Purpose of the Report	To provide the Board with an Update on the Deep Dive exercise undertaken in partnership with MHLD Unit around adult Continuing Health Care (CHC) funding.		
Key Issues	<ul style="list-style-type: none"> • Both MHLD and PCS have been requested to undertake a Deep Dive exercise by the Finance and Performance Committee • Demand for CHC funding has increased • More complex cases are being seen by the service • Increasing cost impact to CHC budget 		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
		✓	
Recommendations	<p>The Unit Board is recommended to:</p> <ol style="list-style-type: none"> 1) Note the findings of the report. 2) Strengthen the Unit Scrutiny Panel so it is in line with MHLD to include a Finance Rep and the Unit Director / Deputy 3) Reintroduce high cost scrutiny panels to PCS Unit 4) Work with another Unit to undertake a Peer Review 		

Continuing Health Care Deep Dive Exercise Report

1. INTRODUCTION

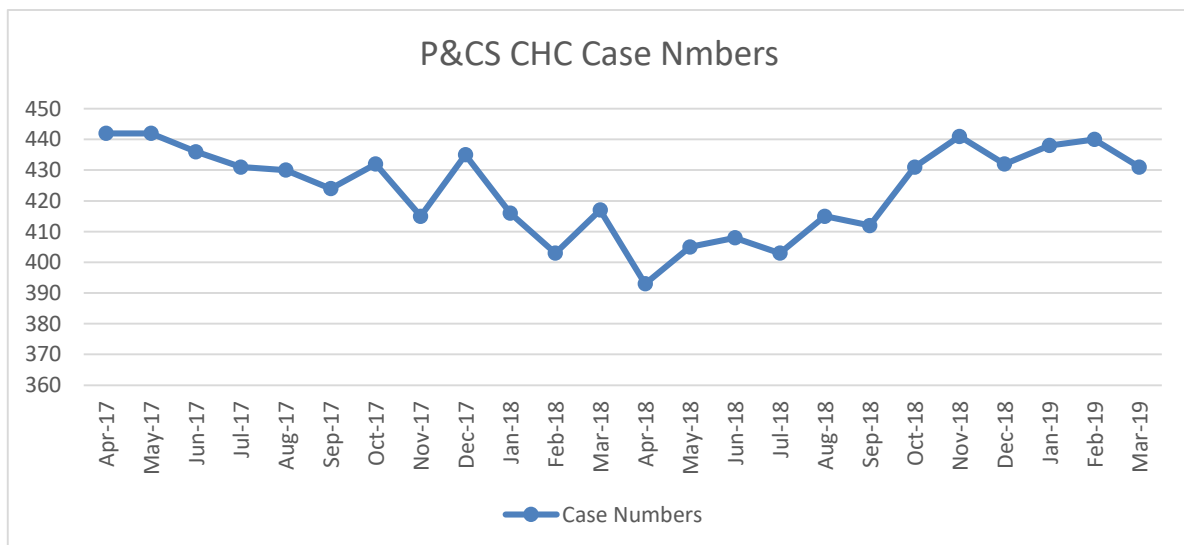
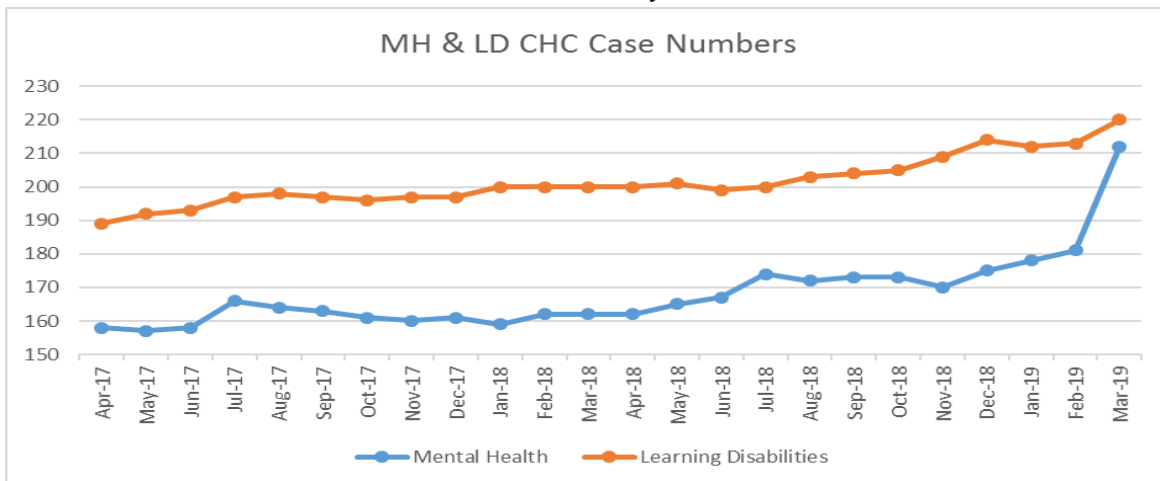
Due to the increasing cost associated with adult continuing care funding the Finance and Performance Committee have requested a review of arrangements for management of Continuing Care.

This report aims to provide an update of the findings from the 'Deep Dive' review undertaken into the provision of Adult Continuing Health Care across Mental Health and Learning Disabilities and the Primary and Community Services Delivery Units.

2. BACKGROUND

Number of CHC Cases

The presentation of cases and costs show two different pictures for MHL and PCS as shown in the charts below for last financial year.



Comparison of Cases over £1000 per week (non standard) 2018/2019

Total Summary as of 30.06.18	
Criteria	Count of Criteria
Adult Mental Health	3
Adult Palliative Care	15
Children	2
Community Based/Home Care Support	21
Elderly Mentally Ill Nursing Home	99
Equipment	3
General Nursing	167
Learning Disability	1
Grand Total	311

Total Summary as of 30.06.19	
Criteria	Count of Criteria
Adult Mental Health	4
Adult Palliative Care	21
Children	10
Community Based/Home Care Support	35
Elderly Mentally Ill Nursing Home	96
Equipment	2
General Nursing	197
Learning Disability	1
Grand Total	366

Neath as of 30.06.18	
Criteria	Count of Criteria
Adult Mental Health	1
Adult Palliative Care	8
Children	2
Community Based/Home Care Support	7
Elderly Mentally Ill Nursing Home	10
General Nursing	65
Learning Disability	1
Grand Total	94

NPT as of 30.06.19	
Criteria	Count of Criteria
Adult Mental Health	2
Adult Palliative Care	7
Children	4
Community Based/Home Care Support	9
Elderly Mentally Ill Nursing Home	11
General Nursing	73
Learning Disability	0
Grand Total	106

Swansea as of 30.06.18	
Criteria	Count of Criteria
Adult Mental Health	2
Adult Palliative Care	7
Community Based/Home Care Support	14
Elderly Mentally Ill Nursing Home	89
Equipment	3
General Nursing	102
Grand Total	217

Swansea as of 30.06.19	
Criteria	Count of Criteria
Adult Mental Health	2
Adult Palliative Care	14
Children	6
Community Based/Home Care Support	26
Elderly Mentally Ill Nursing Home	85
Equipment	2
General Nursing	124
Learning Disability	1
Grand Total	260

The overall spend for MHL D from April 2017/2018 to March 2018/19 increased by £2.3 m and is expected to increase by a further 2.4m in 2019/20. The overall increase in spending for the same period in PCS is £1.3m and is expected to increase by a further £2.2m in 2019/20

Category	Total 2017/18 £m	Qtr 1 2018/19 £m	Qtr 2 2018/19 £m	Qtr 3 2018/19 £m	Qtr 4 2018/19 £m	Total 2018/19 £m	Forecast 2019/20 £m
MH&LD CHC	27.1	6.6	6.9	7.2	8.7	29.4	31.8
P&CS CHC	20.3	4.9	5.5	5.8	5.4	21.6	23.8
FNC	9.1	2.4	2.4	2.3	2.6	9.7	10.1
Paeds	1.2	0.3	0.3	0.3	0.3	1.2	1.2
Total	57.7	14.2	15.1	15.6	17.0	61.9	66.9

2019/20 Month 4 position

	Annual Budget	Budget to Date	Actual to Date	Variance
PCS	£16,855,590	£4,215,058	£4,686,702	£471,644
MHL D	£18,499,367	£4,268,507	£5,869,635	£1,601,128

The month 4 position shows a significant challenge for 2019/20.

There is a national All Wales CHC Work stream lead by Albert Heaney. In light of the new framework expected in 2020 and the increasing challenges for all Health Boards in containing costs the current National Work stream will be developing into a National Complex Care Work stream.

3. DEEP DIVE REVIEW METHODOLOGY

The Deep Dive aimed to review the following:

1. Current processes and arrangements used in each Unit
2. Experiences from Teams
3. Financial position

The team uses improvement tools available via the health Boards Quality Improvement Portal were utilised as part of the review.

http://abmshare/sites/HROPS/sit/_layouts/15/start.aspx#/SitePages/Home.aspx

A cross Unit review team have been established consisting of:

- UND for PCS (Chair)
- Finance management Business Partner for MHL D and PCS
- Head of Complex Care PCS
- Head of Complex Care MHL D
- Head of Nursing PCS
- Head of Nursing MHL D

The review consisted of the following:

- One workshop utilising brainstorming approach
- Review of data
- Process Mapping
- Process Descriptors
- Review of Case notes
- Follow up meeting

Tools used as part of the review form the appendices of the report.

4. DEEP DIVE FINDINGS

The review has made a number of findings which have been entered into a table relevant to each question.

Review Findings Table

No	Review Area	Finding
1	Documentation Quality Check	<ul style="list-style-type: none"> ➤ A review of 10 sets of records found the documentation to be correctly filed, clear, appropriate and of a high standard. Notes reflected the historical filing arrangements used in the team areas (SCC,NPT and BCBC). ➤ Since 1st April 2019 all PCS Complex Care notes are entered onto the National Continuing Care Database and the team have moved to a paper light documentation system.
2	CHC Process Arrangements	<ul style="list-style-type: none"> ➤ There are two separate teams. One in MHLD and one in PCS ➤ Both MHLD and PCS have clear process arrangements which involved a local panel and a scrutiny panel. ➤ PCS Scrutiny Panel has a full clinical focus, chaired by head of Nursing and does not bring finance business support into the meeting. MHLD is chaired by medical Director and does have business support attending the meeting. ➤ All cases are reviewed by a specialist member of the team, summarised and presented at scrutiny panel. ➤ There is high cost form which summarises the case but there is no High cost panel process which is used in other Health Boards to review cases over £200,000 ➤ MHLD Scrutiny Panel is chaired by Unit Director and has Finance Business Partner. PCS is chaired by Head of Nursing and does not have the Business Partner Present. This did not appear to impact decisions but does have a lower level of Unit Scrutiny. ➤ PCS introduced a standardised process in 2017 when it reorganised the county teams under one structure. This resulted in improved consistency and increased right sizing of cases leading to a gradual reduction in activity/spend until April 2018. ➤ MHLD have introduced the same process

		<p>from April 2018</p> <ul style="list-style-type: none"> ➤ Reviews of cases are undertaken by both Units. Higher cost cases were reviewed more frequently. The aim of the review is to check governance and also appropriate levels of funding. PCS review rate varied between 85% and 100%. MHLD varied between 55% and 100%. Both units rates were impacted by staff sickness.
3	Partnership working	<ul style="list-style-type: none"> ➤ Limited progress on Pooled Budget arrangements with Local Authorities. ➤ There are two established Care Home Forums, attended by the health Board. ➤ PCS HoN chairs the Care Home Sub Group as part of regional working. ➤ There appears to be a concerted approach appeal all CHC Decisions from Local authorities. ➤ Reports of Social Workers who attended DST meeting, agreeing the FNC or residential care position in the DST then after leaving the meeting promptly logging an appeal and refusing to sign the documentation. ➤ All Patients in Acute Hospital beds who have a LD are referred by on Authority for a DST when NHS staff are clear no rationale exists (this was also picked up at DTOC validation in May). LD is in it self not a health need! ➤ Social workers at DST, for example making an agreed finding only to change their minds a week or two later after discussing with their manager. ➤ Staff advising they are no longer authorised around CHC/DST and have to refer upwards ➤ Although the Units have never had to keep figures, for PCS it was rare to have an appeal and last year there maybe 3-4 a year. At the moment it is reported that there is around 1 appeal a week in Swansea. ➤ When funding a package of care for fast track end of life care the PCS Unit has to commission care from the Council Domiciliary in house Care Teams (when core or private agencies are not available). For one Authority it is £18 per hour as they will give a discretionary rate for the NHS partner. However another authority will charge £46.34 and will not offer a discretionary rate

		for the NHS partner. This creates cost containment issues for the Unit.
4	National Context	<ul style="list-style-type: none"> ➤ Weekly rate increases were applied in quarter two in relation to 2018/19 CHC Uplift and FNC Judicial Review uplift for P&CS CHC. These were backdated to April and funded by the Health Board. ➤ The Health Board is liable for additional backdated and ongoing costs in relation to the FNC Judicial Review. This is due to a further challenge on the historic FNC rate rebasing exercise carried out in 2014 covering calculations by Laing & Buisson. This along with the agreed 2018/19 inflationary uplift results in an additional increase in the FNC rate of £3.61 per package per week.
5	Local context	<ul style="list-style-type: none"> ➤ Changes to core service long stay NHS inpatient older people mental health beds requires more patients to receive long term care in the community. ➤ PCS has seen an increase in the need to place patients with complex behaviours in Nursing Homes at a higher cost where previously these patients would have had provision from NHS Core Services. ➤ There are areas of dispute between PCS and MHLD where core service beds are empty and available but the admission criteria excluded patients whose needs cannot be met in Non Specialist EMI Care Homes. This requires PCS to fund higher cost specialist beds. ➤ Funding disputes can exist between partners and Units resulting in patients staying in hospital until a resolution is agreed. ➤ Over the last few years the rising number of registrant vacancies experienced in the NHS has been mirrored in the Care Home Sector, this is not an exclusive issue for the SBUHB and is replicated across Wales. ➤ The impact of the paucity of registrants available to the care home sector has meant on occasions that a provider who has previously offered nursing beds has had no

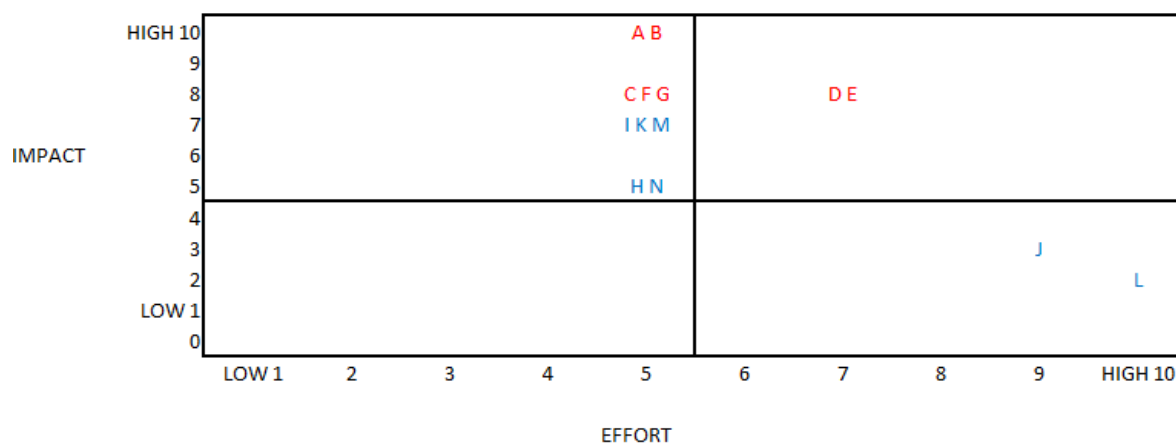
		<p>choice but to de register those specific categories, over the last two years this has led to a reduction of 37 nursing care beds across the SBHB region.</p> <ul style="list-style-type: none"> ➤ The bed pool for nursing and dual registered care homes in SBUHB is circa 1,211. The Sector are a fundamental element of the patient flow system and to all intents and purposes they are providing what were previously deemed “long stay elderly care beds” and more usually dementia beds.
6	Financial	<ul style="list-style-type: none"> ➤ PCS cost increases are attributed to a small number of high cost placements or packages of care. For conditions such as MND/MS/Huntington Chorea ➤ PCS cost increases are attributed to increased number of fast Track patients whose needs cannot be met through core community services, or agency services and have to be funded through Local Authority In-house Domiciliary care Services which have variable rate. ➤ PCS set the CHC rate as a cost made from the FNC contribution and the cost of the higher Residential bed in the local area. ➤ MHLD use an agreed brokerage and commissioning framework and have individual itemised funding plans which reflects the complexity of cases.

Action Priority Matrix Tool

No Red MHLD Blue PCS	Activity	Impact (0-10)	Effort (0-10)
A	Repatriation of rehabilitation patients to the Gwelfor Unit at Cefn Coed. There was under capacity in Gwelfor relating to women in the Unit so this has now been developed into a male only service. We have placed the remaining 2 women in external residential services and repatriated 6 expensive male placements.	10	5
B	Modernisation of womens services. There are no low secure services for women. There is some unused capacity currently for men in Taith Newydd. Taith Newydd consists of 2 units and the plan is to find alternative placements for a number of the men and repatriate expensive female placements into one of the units and develop this unit for women.	10	5
C	Implementation of locality scrutiny panel in addition to the joint complex case panels with the local authorities that were already in place. This puts some of the ownership of CHC out to locality with opportunity for challenge and identifying other internal solutions and provision.	8	5
D	West Glamorgan review of cases, this is a right sizing review continued from 2018-19 but with additional resource from an ICF bid. This will enable the review of 40 MH cases and 40 LD cases. The cases for review have been agreed with the commissioning team.	8	7
E	CHC Team development from I2S bid. The team will be strengthened to provide more integration with locality teams and additional capacity for review and right sizing.	8	7
F	Transfer of new and existing patients to RSL placements. The Health Board is working collaboratively with the local authorities and there is a joint accommodation group. The first development is due in Neath Port Talbot and there is capacity here to take HB patients. This is a level of care that is not currently available and will meet	8	5

	some unmet level of care.		
G	Containment of CHC inflation. There is inflation at 3% included in the Unit forecast but the starting point for agreeing uplifts with providers for 2019-20 has been set at 2%	8	5
H	Scope most efficient delivery of joint and palliative packages of care with SPICE, MCN	5	5
I	Working with Hospital to Home Project to promote more support to patients earlier in their Admission Stay	7	5
J	Undertake a review of all High Cost Packages in external placements	3	9
K	Reinstate High Cost Panel procedures for PCS and have finance at the PCS Scrutiny meeting	7	5
L	Scope the develop locally achievable alternatives to high cost packages through use of NHS inpatient beds	2	10
M	Review all CHC home based packages of care	7	5
N	Share and compare plan with CHC managers from other NHS Organisations through a Health Board Peer review Process	5	5

Action Priority Matrix



5. DISCUSSION

The review found that cost rise was likely to be associated with:

- Higher number of more complex cases which required higher care cost
- Care home Market costs increasing to meet higher delivery costs associated with case complexity and also use of agency staff.
- Reduce care home bed availability leading to higher costs
- Core community and long term care bed provision has been maximised or has changed criteria
- One Local Authority does not provide discretionary rate for domiciliary care services to the Health Board
- Increase appeals raised by Local Authorities
- Increased demand to provide more care in the community
- Population increase
- Changes to National FNC Rate

The degree of assurance for achieving financial recovery differed between the units with MHL D appearing to have a wider range of opportunities than PCS. This is reflected in the different stages of the improvement journeys being undertaken by both Units.

PCS Unit has already delivered significant savings against the 2017 baseline through implementing stricture and standardised processes. Whilst MHL D implemented these changes from November 2018 and it is anticipated that this work will bring further benefit.

The MHL D Unit improvement [plan has identified key actions against costs as indicated below:

Other mitigating actions	£	Risk
Implementation of Locality Scrutiny Panels	200,000	High
Western Bay review of complex cases	200,000	Medium
CHC Team development from I2S	450,000	High
Transfer of patients to new RSL placements	50,000	High
Containment of CHC inflation	100,000	Medium

The PCS Unit improvement plan needs to develop a closer relationship between its improvement plan and financial recovery and would benefit from strengthening presence at scrutiny panel.

6. RECOMMENDATIONS

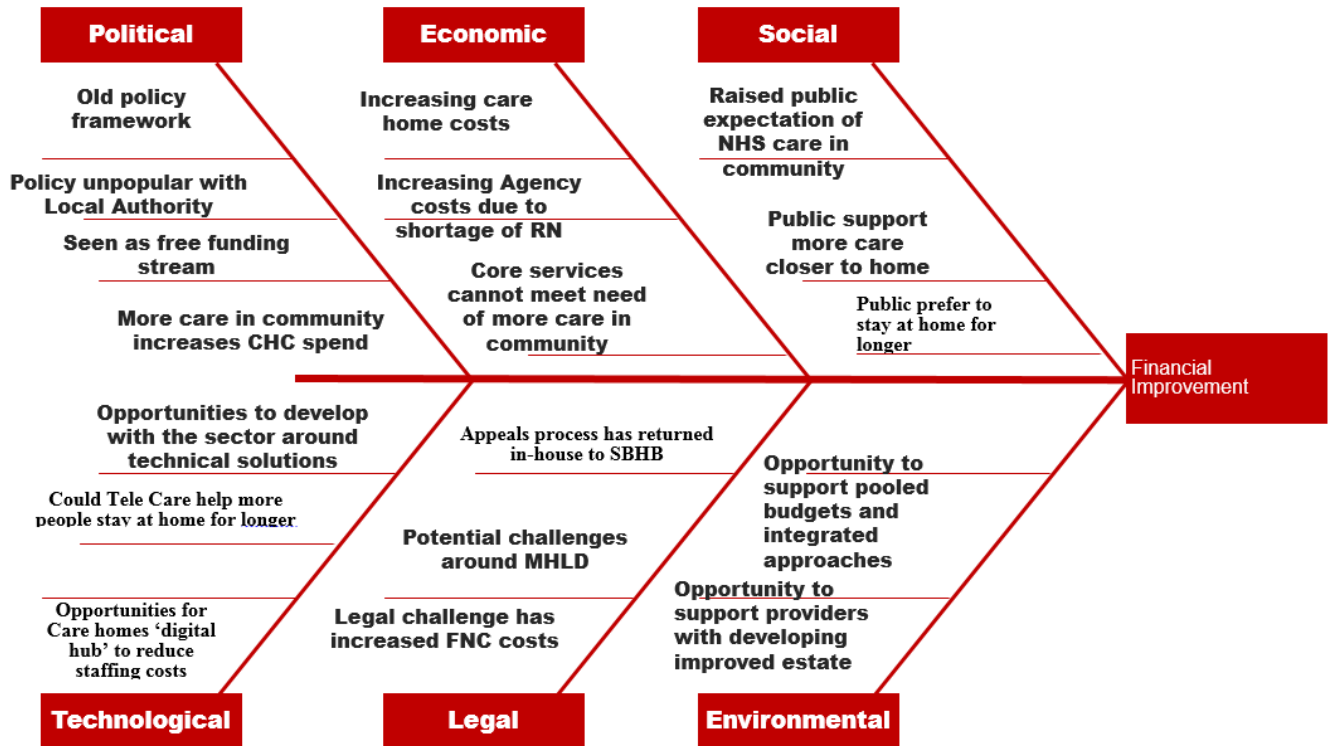
The Unit Board is recommended to:

- 1) Note the findings of the report.
- 2) Strengthen the Unit Scrutiny Panel so it is in line with MHL D to include a Finance Rep and the Unit Director / Deputy
- 3) Reintroduce high cost scrutiny panels to PCS Unit
- 4) Work with another Health Board to undertake a Peer Review
- 5) Work with All Wales Complex care Team and Public Health Wales to assess complex care needs against deprivation and population growth

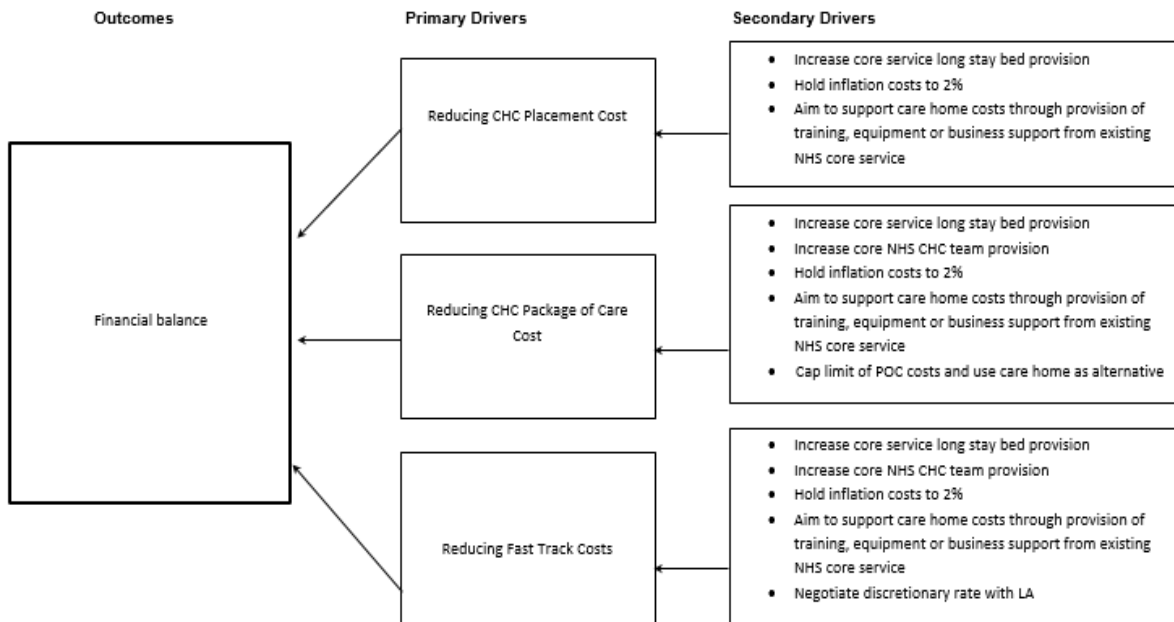
Governance and Assurance										
Link to corporate objectives (please ✓)	Promoting and enabling healthier communities		Delivering excellent patient outcomes, experience and access		Demonstrating value and sustainability		Securing a fully engaged skilled workforce		Embedding effective governance and partnerships	
			✓		✓					
Link to Health and Care Standards (please ✓)	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources			
	✓	✓	✓	✓	✓	✓	✓			
Quality, Safety and Patient Experience										
Paper supports										
Financial Implications										
Paper provides summary, spreadsheets and outline of issues										
Legal Implications (including equality and diversity assessment)										
Paper references legal position										
Staffing Implications										
Paper identified staffing issues										
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)										
Nil, referenced										
Report History										
Appendices										
<ol style="list-style-type: none"> 1) Workshop Review and Actions 2) MH&LD Adult Funding Process Flow Chart 3) Primary Care & Community Services Adult Funding Process 4) Changes to MHL D OPMHS Bed Provision 5) Freedom of Information Request (June 2019) 6) Financial Reports 7) Population Statistics 										

Date	Notes	Actions	Lead	Complete
	puts pressure on the nursing team. RE spoke about documentation when this happens.			
20 June 2019	Impact on Decisions e.g. Tonna Bed Closures: <ul style="list-style-type: none"> LTC is no longer in MH now short term. Explanation from KG after patient have been admitted / assessments and working with the patient on their needs. 			
20 June 2019	Review Admission Criteria for LT MH Beds: <ul style="list-style-type: none"> Suggestion of working smarter with contractor for (x) number of beds. Complex needs beds cost from £800 to £2400+ per week. Need to decide what typr of bed and cost would be the most appropriate for the patients. 	<ul style="list-style-type: none"> Query how do we address the levels of cost for the various beds. 		August 2019
20 June 2019	Changes to Community Services & Funding: <ul style="list-style-type: none"> KG not clear about disaggregation if we should be discussing as previously everything with a MH tag was managed. <p>Have we lost things with changes of Locality / Units to be able to give older people services even in MH.</p>	<ul style="list-style-type: none"> KG was asked to draft something on this topic. 	KG	Complete
20 June 2019	Explore Breakdown of Packages across FNC/CHC and associated costs: <ul style="list-style-type: none"> RB gave explanation + LA + Nursing Homes. FNC has been higher as their base rate has been set higher. LA to keep track – lack of capacity. In NPT there are more people at Home on Packages of Care. With FNC you can have DN’s calling at home. More requests for people to come home with various patients at different stages of sickness and all need care. Domiciliary care and MH NPT – struggled with EMI beds. Documentation to be provided. We have lost nursing bed due to nursing at home. Good managers needed and nursing care and safeguarding issues. Large turnover and impact on staff and morale, 	<ul style="list-style-type: none"> DF to be asked to look at this and draft something on this issue 	DF	Complete

Date	Notes	Actions	Lead	Complete
	<p>need to be mindful.</p> <ul style="list-style-type: none"> • CHC patient – how do we reconcile – loss of beds and need for more nurses. 			
20 June 2019	<p>Explore opportunities to small number of beds at higher CHC rate to encourage choice of Care Home:</p> <ul style="list-style-type: none"> • Explore how man beds we have and what type of care. NPT base rate, is there psychology input. What % in NPT. Look at beds and occupancy with examples between base rate and funded. The committee would need an understanding of what can be done to manage costs down. • How do we take this forward with LA. Strategy is that people wish to stay in their home. Care Homes may become the last option. More requests for 1:1 care which is becoming more difficult and expensive. LTA scrutinises all costs and with mapping we could describe this as well. Stepping down cost can be £1k cheaper. • Commissioning appropriately with LA/HB combination and conversation if patient pays. • D/N have to oversee the commissioning of all care – carers who work with the D/N Team – Palliative Care. 	<ul style="list-style-type: none"> • DF to be asked to sort out by end end of week commencing 24th June. Follow-up meeting to be organised for beginning of July 	DF	August 2019



Reducing CHC Cost



APPENDIX 2

MH&LD Adult Funding Process Flow Chart

The purpose of this document is to assist clinical staff in preparing a potential referral for funding by the Swansea Bay UHB MH&LD Delivery Unit

It should be used in conjunction with the attached Flow Chart and is relevant to all types of purchased care, support and bespoke specialist equipment. This may range from small packages of domiciliary care right through to complex and intensive Residential or Independent hospital placements.

This document will need to be read in conjunction with relevant documents such as...

Terms of Reference for Locality Scrutiny Panels

ToR Complex Case Panel

Continuing Health Care Framework (2014)

DST trigger tool

CHC Dispute Process

MH&LD Joint Funding Arrangements with Local authority Partners

Stage 1 PREPARATION what needs to be funded and why?

The Care Co-ordinator and MDT (all health professionals involved in the patient's care) are fundamental to deciding and recommending that an individual requires any element of health funding. This is achieved by detailed assessment of the individual's health care needs and will need to be evidenced by up to date professional documentation that has been gathered in advance. This documentation may include...

CTP's and Care Plans

Risk assessments (e.g HCR 20)

Professional reports (psychiatry, psychology, OT, SALT, dietetics, nursing reports, SBT, Social

Work reports etc.

Positive Behavioural Support (PBS) plans

Best Interest decisions and Capacity assessments

Legal Documentation (MHR Tribunal reports, CoP directions)

Evidence available to support funding eligibility CHC eligibility, Section 117 eligibility etc.

Prior to any decision to submit a funding referral it is imperative that all potential 'in house' options have been scrupulously considered. Careful thought should be considered as to whether all or part of the individual's needs can be met by '**core health or Local Authority services**'. These should be pursued in the first instance and systematically ruled out (or in) and evidence of consideration provided. Examples may include....

: Hospital based Open Rehabilitation, Locked Rehabilitation and Low Secure units (N.B. currently there is no female specific Locked Rehabilitation or Low Secure facility within the Health Board). These are achieved by submitting a SPAM referral to Rehabilitation and Recovery Services.

: SRS Provision

: Community based health care such as CPN support, HCSW support, Assertive Outreach Service.

: Primary care support such as Community Nursing visits for physical health interventions.

: Community based Learning Disability support such LDIST and SBT.

: Local authority residential and respite care (core)

: Local Authority day services (core)

It is prudent for an experienced member of the MDT such as Team Manager or Ward Manager to supervise and support members of their team in understanding the commissioning process through clinical supervision, peer supervision and PADR. This will assist in reducing delays and identifying barriers to meeting the individual's placement needs.

Continuing Health Care applications (only)

Once a DST has been appropriately triggered (requested) and evidence gathered to support a decision regarding Primary Health Need, the completed DST form, additional supporting documentation and MDT recommendation should be forwarded as soon as possible to the MH&LD Commissioning Team. This would usually be scrutinised within 14 days and the outcome communicated back to the Care Co-ordinator (or referrer) the outcome will be either.....

That the decision regarding a Primary Health Need (PHN) is ratified

Or

That the decision cannot currently be ratified due to either a failure to follow process or a lack of detailed evidence to support the decision. An opportunity(s) to provide any additional evidence will be afforded.

N.B **All DST decisions** should be scrutinised and submitted regardless of whether a PHN is identified.

Stage 2, MAKING A REFERRAL

Once it has been confirmed at MDT level that an individual's needs are above and beyond what 'core' services can deliver and that a funding request is required this should be completed by the Care Co-ordinator or nominated professional in collaboration with relevant others using the appropriate documentation.

Brokerage Form for all new placement requests such as Residential Care, Nursing Home care. Detailed justification for the individual support hours will be required.

FIRM document for changes to current package of care, increased hours, domiciliary care, Supported Living, environmental adaptations and specialist equipment requests. For additional support requests, evidence should be provided that the hours are necessary.

Specialist Hospital request for Locked Rehabilitation, Low Secure Unit or specialist hospital placement.

All referrals should be submitted to the MH&LD Commissioning Team via rosemarie.williams2@wales.nhs.uk

Stage 3 Commissioning Team QA Scrutiny

Referrals received will be allocated to the respective Case Manager in the Commissioning Team weekly meeting.

The process of scrutiny will commence at this stage and the Case Manager will complete a Scrutiny Checklist form on **every occasion**. This document will assist the Case manager to ensure a consistent approach is applied.

The Case Manager will identify the route by which the placement/support/equipment will be identified or sourced, some of this may require consultation with the Care Co-ordinator/MDT and may include....

CCAPS Framework

West Glamorgan (formally Western Bay) Brokerage process

Local Authority Framework (e.g. Supported Living, Closer 2 Home)

Awareness of local Supported Living Scheme voids/vacancies (e.g. Robense House)

Individual Spot Contract for 'Off Framework' providers.

The Case Manager will gather and scrutinise all supporting documentation and costings in preparation for the Locality Scrutiny Panel.

When appropriate * Brokerage forms will be sent out for potential providers by the Case Manager.

The Case Manager will scrutinise Brokerage responses, including proposed Care Plans, detailed costings and discuss with referrer, this may inform decision regarding preferred placement.

Stage 4 Locality Scrutiny Panel

The agenda for the Locality Scrutiny Panel will be informed by the Commissioning Team Case Managers in collaboration with the respective Locality Manager.

Membership of the panel will include...Head of Nursing, Locality Manager, Service Managers (Health and LA) Clinical Leads, Case Managers and Care Co-ordinators/Responsible Clinicians.

The agenda will include....

For cases that have been initially scrutinised by the Commissioning Team and potential placements identified, these will be formally presented to the Panel by the Care Co-ordinator or nominated other. The decision to recommend submission to Complex Case Panel will be made and recorded in the minutes.

For cases that are unable to be progressed due to lack of evidence, delays or process issues. An action plan will be identified and recorded alongside those responsible for addressing any issues.

Case Managers may identify potential delays to progress and need not wait for the Scrutiny Panel to highlight and address with the relevant professionals.

Stage 5 Locality Complex Case Panel

Membership of the Locality Complex Panel will include...

Service Director

Medical Director

Locality Manager

Senior Finance Partner

Head of Nursing

Commissioning Team Case Managers and Service Manager

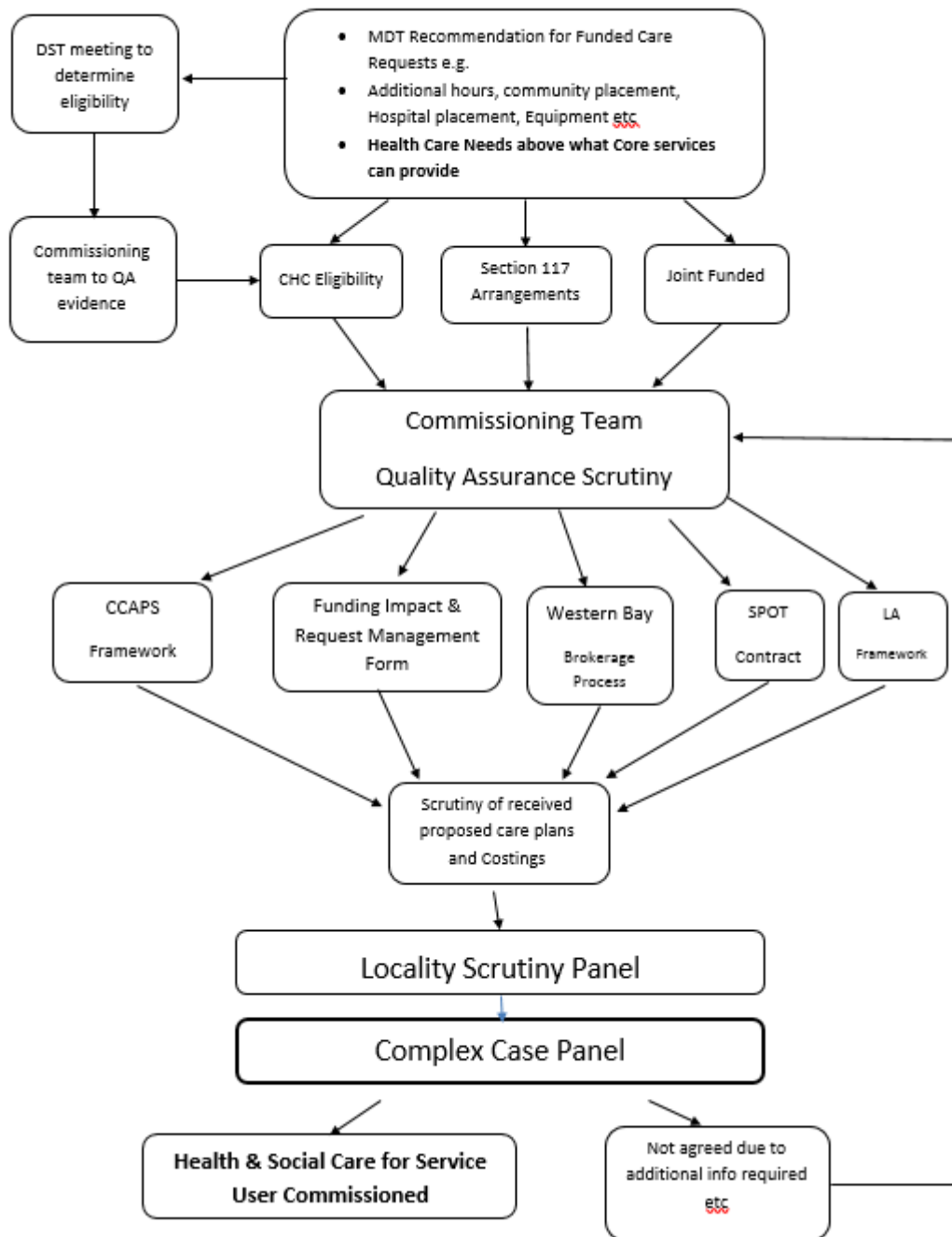
Relevant heads of profession

Local Authority representation

Complex Case Panel will meet monthly, here Case Managers will provide Chief Executive Sign-off Reports (CESO) and/or FIRM document for presentation and ratification of funding agreement.

The outcome of Panel decision will be made in writing by the Case Manager to the relevant professionals.

Mental Health and Learning Disabilities Delivery Unit CHC Process Chart



APPENDIX 3

Primary Care & Community Services Adult Funding Process

The purpose of this document is to assist clinical staff in preparing a potential referral for funding by the PC&CS Delivery Unit.

This process should be used in conjunction with the attached Flow Chart and is relevant to all types of purchased care, support and bespoke specialist equipment. This may range from small packages of domiciliary care right through to complex care home placements.

Stage 1- Preparation what needs to be funded and why?

The Care Co-ordinator and MDT (all health professionals involved in the patient's care) are fundamental to deciding and recommending that an individual requires any element of health funding. This is achieved by detailed assessment of the individual's health care needs and will need to be evidenced by recent professional documentation that has been gathered in advance of the Multi -Disciplinary Meeting. This documentation may include...

Care Plans

Risk assessments

Professional reports (for example; - psychiatry, psychology, OT, SALT, physiotherapy, dietetics, nursing reports, Social Work reports)

Positive Behavioural Support (PBS) plans

Best Interest decisions and capacity assessments

Evidence available to support funding eligibility

It is prudent for an experienced member of the MDT such as Team Manager or Ward Manager to supervise and support members of their team in understanding the commissioning process through clinical supervision, peer supervision and PADR. This will assist in reducing delays and identifying barriers to meeting the individual's placement needs.

Continuing Health Care applications (only)

Once a DST has been appropriately triggered (requested) and evidence gathered to support a decision regarding Primary Health Need, the completed DST form, additional supporting documentation and MDT recommendation should be forwarded as soon as possible to the relevant Long Term Care Team. This would usually be scrutinised and presented at Complex Care Panel within 7 days and the outcome communicated back to the Care Co-ordinator (or referrer) the outcome will be either.....

That the decision regarding a Primary Health Need (PHN) is ratified

Or

That the decision cannot currently be ratified due to either a failure to follow process or a lack of detailed evidence to support the decision. An opportunity(s) to provide any additional evidence will be afforded.

Panel outcomes are confirmed by letter and /or email within 2 days of panel, for those individuals where a placement has been identified the ward will be notified on the day of panel.

Fast Track submissions are scrutinised and agreed within one hour of receipt providing all relevant information is contained in the documentation.

If a nursing home placement has been identified for an individual or there are any other extenuating circumstances cases, CHC and FNC funding will be agreed outside of the panel process.

Weekly Scrutiny Group Meeting

This is a weekly meeting held prior to the Complex Care Panel, where all FNC and CHC funding applications are scrutinised to ensure process has been followed and all relevant information is available to ratify FNC funding. CHC cases are forwarded on to the Complex Care Panel for further decision making in relation to funding and commissioning decisions.

Complex Care Panel

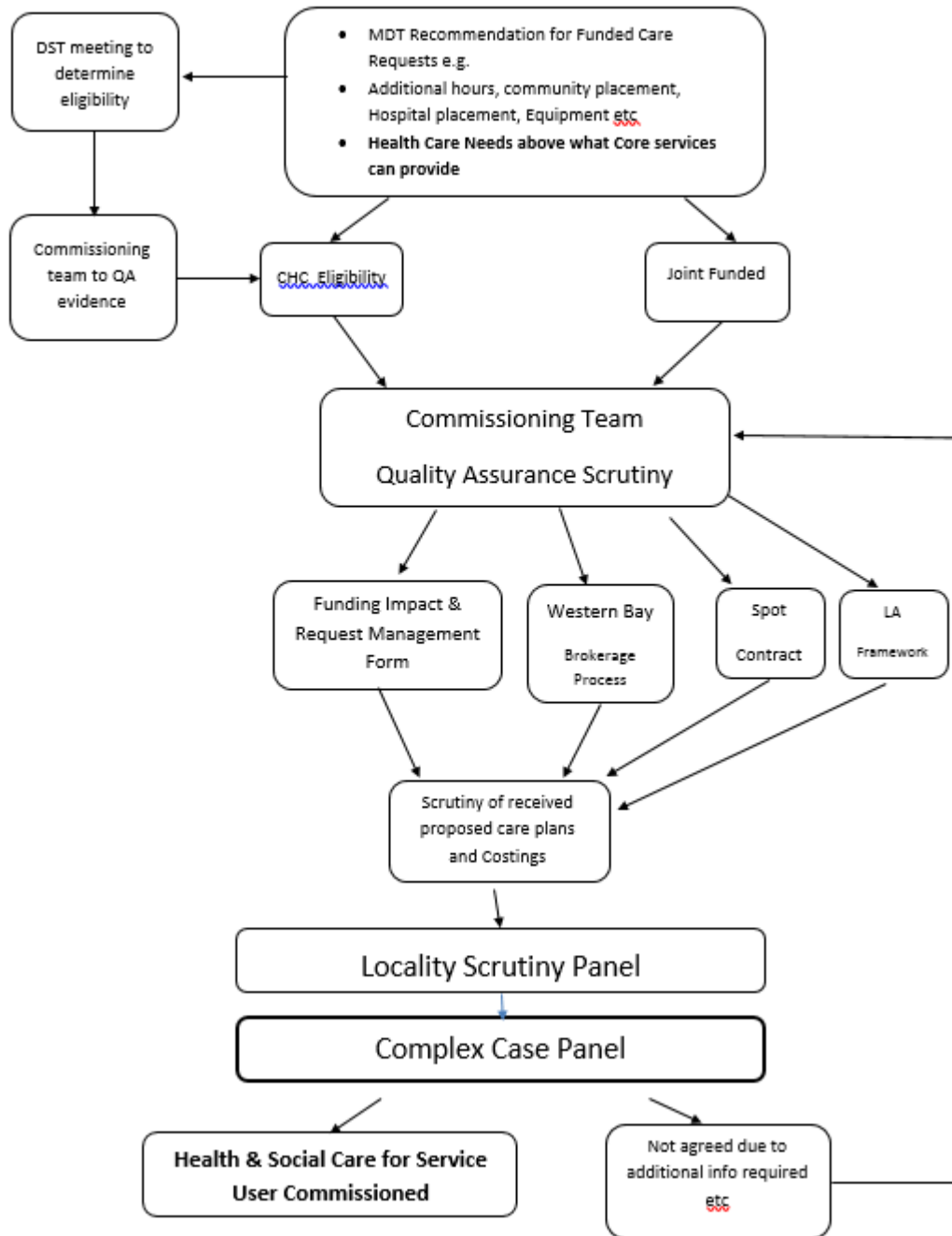
The agenda for the Complex Care Panel will be informed by the Long Term Care Team Managers.

Membership of the panel includes...Head of Nursing, Head of Long Term Care, Locality Managers, Case Managers, Care Co-ordinators and Responsible Clinicians as appropriate.

The agenda will include....

CHC or other complex cases that have been initially scrutinised by the weekly Scrutiny Group will be formally presented to the Panel by the Care Co-ordinator or nominated other. For cases that are unable to be progressed due to lack of evidence, delays or process issues, these will be discussed and actions will be identified and recorded. The case will return to panel when the actions have been completed.

Primary Care and Community Services Delivery Unit CHC / FNC Process Chart



APPENDIX 4

Changes to MHL D OPMHS Bed Provision

There have been no changes to the admission or discharge criteria relating to the access to the beds in the older peoples mental health services. The key criteria for admission is that they have a primary healthcare need as tested out through DST as part of the CHC framework.

The classification of the beds is assessment and intermediate care, the term long term care is just for the purpose of the NHS benchmarking working. With regard to the benchmarking and the FDU Efficiency Framework there is an ongoing piece of work around CHC for inclusion within the efficiency framework. The Finance Team are involved in this work and initial submission of findings is by 15 July.

The hospital psychiatric liaison team will review patients suitable for admission, patients will initially be admitted to assessment beds and then on to an intermediate care bed. Patients are then reviewed for discharge on a quarterly basis and where there is no longer a healthcare need they will be discharged as appropriate, home or some other care placement.

Although there has been a reduction in the number of OPMHS beds with the closure of the Tonna Suites there are continually 25 to 30 beds at any time. There needs to be some further work to understand if the empty beds are the assessment beds or the intermediate care beds notwithstanding there has been some reclassification of beds from assessment to intermediate care.

Ward Information				Total No. of Beds			
Locality	Area	Hospital	Ward	2015/16	2016/17	2017/18	2018/19
Bridgend	OPMHS	Glanrhyd	Ward 1 (Angelton Clinic)	12	12	12	0
Bridgend	OPMHS	Glanrhyd	Ward 2 (Angelton Clinic)	20	20	20	20
Bridgend	OPMHS	Glanrhyd	Ward 3 (Angleton Clinic)	10	10	10	10
Bridgend	OPMHS	POW/Glanrhyd	Ward 21/Ward 1 (Angleton Clinic)	18	14	14	12
Bridgend	OPMHS	POW	Ward 15	18	14	14	14
Sub Total				78	70	70	56
Neath/PT	OPMHS	Tonna	Suite 1	20	20	20	0
Neath/PT	OPMHS	Tonna	Suite 2	20	20	18	18
Neath/PT	OPMHS	Tonna	Suite 3	18	14	0	0
Neath/PT	OPMHS	Tonna	Suite 4	20	13	13	13
Neath/PT	OPMHS	Neath/PT	Ward G	20	20	20	20
Sub Total				98	87	71	51
Swansea	OPMHS	Cefn Coed	Onnen Ward (Ysbryd y Coed)	20	20	20	20
Swansea	OPMHS	Cefn Coed	Derwen Ward (Ysbryd y Coed)	20	20	20	20
Swansea	OPMHS	Cefn Coed	Celyn Ward (Ysbryd y Coed)	20	20	20	20
Sub Total				60	60	60	60
Total Beds included in Benchmarking Exercise				236	217	201	167
Total Beds within OPMHS Assessment/Older Adult (Benchmarking)				94	62	68	106
Total Beds within Longer Term (Benchmarking)				142	155	133	61

APPENDIX 5

Freedom of Information Request (June 2019)

1. What was the average time period in your health board in days/hours from the point at which a Fast Track CHC application is made to the care package being provided for the financial year 2018/19?

This is not recorded centrally. However we can tell you that applications are received electronically and treated as a priority in the Quality Assurance process. Once verbal approval has been given (within 1 hour of receipt), as soon as the referrer has been notified, and as long as care is available this process can be very timely, within a day in many cases. However there can be other factors which hold up this process, e.g. patient not medically fit for discharge, insufficient care package availability etc.

2. What was the average time period in days/hours from the point at which a Fast Track CHC application is approved to the care package being provided for the financial year 2018/19?

Fast Track applications are quality assured and a verbal decision is made within 1 hour of receipt of application. The referrer is notified of the decision and care packages can commence as soon as care is available and appropriate equipment (if required) in place.

3. During the financial year 2018/19, how many applications for fast track CHC did the health board receive?

399

4. During the financial year 2018/19, how many applications for fast track CHC were funded?

399

APPENDIX 6

Financial Reports



CHC FNC Cases.xlsx



CHC Spend MHL
16-17 - 18-19.xlsx

Appendix 7

Population Statistics

Source

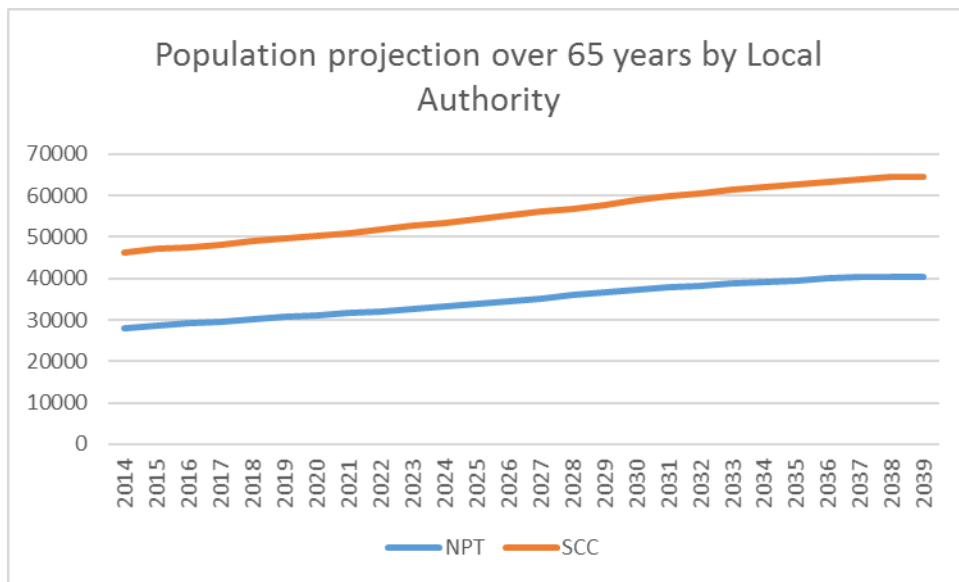
<https://gweddill.gov.wales/docs/statistics/2016/160929-local-authority-population-projections-2014-based-en.pdf>

2014-BASED POPULATION PROJECTIONS FOR LOCAL AUTHORITIES IN WALES

Local Authority	Projected Population, in thousands						
	2014	2019	2024	2029	2034	2039	2014-39 change (%)
Isle of Anglesey	70.2	70.2	70.1	69.7	69.1	68.3	-1.8 (-2.6%)
Gwynedd	122.3	124.0	126.2	128.5	130.6	132.6	+10.3 (+8.4%)
Conwy	116.3	117.0	117.9	118.5	118.6	118.2	+1.9 (+1.7%)
Denbighshire	94.8	95.7	96.7	97.3	97.4	97.3	+2.5 (+2.7%)
Flintshire	153.8	155.2	156.3	156.9	156.7	155.9	+2.1 (+1.3%)
Wrexham	136.7	139.8	142.8	145.5	147.9	150.0	+13.3 (+9.7%)
Powys	132.7	131.7	130.6	128.8	126.0	122.4	-10.3 (-7.7%)
Ceredigion	75.4	76.6	77.9	79.4	80.8	82.1	+6.6 (+8.8%)
Pembrokeshire	123.7	124.1	124.5	124.4	123.6	122.2	-1.4 (-1.2%)
Carmarthenshire	184.9	186.4	188.0	189.0	189.3	188.9	+4.0 (+2.2%)
Swansea	241.3	245.8	250.7	255.4	259.5	262.9	+21.6 (+9.0%)
Neath Port Talbot	140.5	141.5	142.5	143.1	143.1	142.7	+2.2 (+1.6%)
Bridgend	141.2	143.3	145.3	146.8	147.8	148.3	+7.0 (+5.0%)
Vale of Glamorgan	127.7	128.4	129.1	129.3	129.0	128.1	+0.5 (+0.4%)
Cardiff	354.3	370.3	388.2	407.0	425.9	444.7	+90.4 (+25.5%)
Rhondda Cynon Taf	236.9	238.9	241.5	243.7	245.3	246.5	+9.6 (+4.0%)
Merthyr Tydfil	59.1	59.3	59.3	59.2	58.7	58.1	-1.0 (-1.7%)
Caerphilly	179.9	181.3	182.5	183.0	182.8	181.9	+2.0 (+1.1%)
Blaenau Gwent	69.7	69.4	69.0	68.4	67.4	66.3	-3.4 (-4.9%)
Torfaen	91.6	92.1	92.5	92.5	92.0	91.2	-0.4 (-0.4%)
Monmouthshire	92.3	93.1	93.7	93.9	93.5	92.5	+0.1 (+0.1%)
Newport	146.8	149.2	152.0	154.5	156.6	158.5	+11.7 (+7.9%)

Source: Welsh Government, Local Authority Population Projections for Wales (2014-based), September 2016.

<https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2014-based/populationprojections-by-localauthority-variant-year>



98% of all PCS CHC patients are over 65 years.