Welcome to the 5th NHS Continuing Healthcare Conference!

24th June 2025
Leonardo Hotel, Milton Keynes, Midsummer Boulevard, Milton Keynes, MK9 2HP

CONVENZIS TRAINING

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Chair Opening Address

James Crowe
Independent Chair for CHC
NHS Wales

Keynote Presentation

Helen Sands
Head of All-Age Continuing Care
Lincolnshire ICB

Paula Elding
Deputy Head of AACC
Lincolnshire ICB

Improving quality and efficiency within CHC

NHS
Lincolnshire
Integrated Care Board

Helen Sands And Paula Elding June 2025

Improving quality and efficiency within CHC

- Better outcomes for individuals
- Safer, patient centered care
- Optimizes Resources
- Reduce Costs

Fast Track Process

- 1.6 million overspent in Q3 24/25 due to a high levels of activity plus higher proportion of packages running >12 weeks than seen previously.

Caseload Type	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Ave.	% change
Fast Track (Active)	21/22	208	201	244	216	232	210	203	253	237	248	221	225	225	
Fast Track (Active)	22/23	228	239	258	247	237	250	260	275	243	262	344	299	262	16%
Fast Track (Active)	23/24	296	284	326	352	313	329	323	344	298	354	381	431	336	28%
Fast Track (Active)	24/25	441	410	374	344	271	291	244						339	1%

Number of Fast Tracks Open at 12 weeks

	Ave 23/24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
No. Fast Track referrals open at 12 weeks	62	83	92	107	143	119	110	77	48	29
- **No in Care Home**	34	48	63	73	76	72	76	45	24	12
- **No in Own Home**	28	35	29	34	67	47	34	32	24	17

What did we do

- Business case for additional staff – declined
- Back to the drawing board and agreed 3WTE Clinical and 1.5 admin for 6 months with a focus to clear backlog
- Made up from overtime and agency
- 470K decrease in expenditure on fast tracks in Q4 24/25

Open Fast tracks Q3/4

	Year	Nov	Dec	Jan	Feb	March
Fast-track active	21/22	253	237	248	221	225
Fast-track active	22/23	275	243	262	344	229
Fast-track active	23/24	344	298	354	381	431
Fast-track active	24/25	214	209	208	220	177

	Ave 23/24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
No. Fast Track referrals open at 12 weeks	62	29	14	14	14	16
- **No in Care Home**	34	12	6	10	8	7
- **No in Own Home**	28	17	8	4	6	9

That Was Just The Beginning

- Improved efficiency put how did reviewing and removing packages improve the quality for people
- Still receiving fast tracks for 28 hours with or without 7 nights
- Decommissioned the Palliative Care Coordination Centre
- Golden opportunity to do something different
- Moved to 7 day working
- Used back log work as a proof of concept
- Introduction of 3 x End of Life Case Managers

Improving quality and efficiency through effective case management

- Access to case manager 7 days a week
- Dedicated case manager and contact details
- Early phone call introduction
- Continuous review of package
- DST when optimised
- Improved Patient Flow
- Improved Training offer

Further opportunity

- Referrals remain high
- Early days with training offer opportunity to improve

Ave 23/24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
255	260	273	274	198	249	167	234	221	233	227	255	229	213
99	103	114	105	83	101	46	87	99	80	59	84	87	88
153	157	155	166	113	145	115	147	122	153	168	171	142	124
3	0	4	3	2	3	6	0	0	0	0	0	0	1
102	103	113	116	76	95	49	79	79	95	96	108	109	82
155	157	160	158	122	154	118	155	142	138	131	147	120	131

Thank you for Listening

Lincolnshire
Integrated Care Board

Any Questions

27/06/2025

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Panel Discussion

Helen Sands
Head of All-Age Continuing Care
Lincolnshire ICB

Deborah Jackson-Howarth
Associate Business Lead
ML CSU

Juliet Hammond
CHC Clinical Lead
NHS Frimley Integrated Care Board (ICB)

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Refreshments & Networking

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Chair Morning Reflection

James Crowe
Independent Chair for CHC
NHS Wales

Case Study

access
freedom to do more

Case Study

Brogan Archer
Digital Healthcare Consultant
The Access Group

access Health, Support and Care

Bridging the Gaps in CHC through improved Integration

PPL People Places Lives

access freedom to do more

Access Health, Support Care

Access Health, Support and Care the largest provider in the sector bringing together best-in-class technology to deliver integrated person-centred care.

About Access HSC

Putting the individual at the centre of everything is critical within the Health, Support and Care community.

We recognize that providers face increasing challenges to ensure they operate effectively while delivering high quality support.

Our ambition is to provide the widest eco-system of interconnected Health, Support and Care products across the care continuum …
.. so that our users have the 'Freedom to Make it Personal'

45+

NHS Trusts and Organisations using healthcare solutions

800+ industry experts, bringing over 30 years' experience in Health and Care technologies.

200+

Local authorities using our solutions

10+

ICB Customers using CHC and Social Prescribing

access

Access Continuing Healthcare System

PPL PHBs & Virtual Wallet | SPINE | Rio EPR | SystmOne | Mosaic / Liquid logic | Adam CHC

Access Intelligent Care Platform (Master Patient Record)

Referrals	Case Management	Patient Portal	Commissioning
Reporting	Invoicing	Provider Management	Digital Dictation
AI Ambient Technology	Social Prescribing	Call Monitoring	Tech enabled care

Access Intelligent Care Platform - Demo

PPL
People Places Lives

Introduction to Virtual Wallet

Samantha Hey

2025

PPL Introduction

Est: **'08**

Staff: **50**

Revenue: **£3m**

Who we are

WIGAN HQ

+ staff & clients nationwide

Who we serve

70 Public Sector Clients

Vendors / Providers **36,000**

£100m Transactions processed annually

Accreditations

Information Security Management ISO 27001 Certified

Quality Management ISO 9001 Certified System

CYBER ESSENTIALS CERTIFIED

NHS Approved Supplier

FCA FINANCIAL CONDUCT AUTHORITY

Crown Commercial Service Supplier

What we do

financial management

eMarketplaces

PA Recruitment tools

directories

online assessments

websites

payroll

Supported Accounts

Our partners

MARK BATES insurance

ACCESS GROUP case management

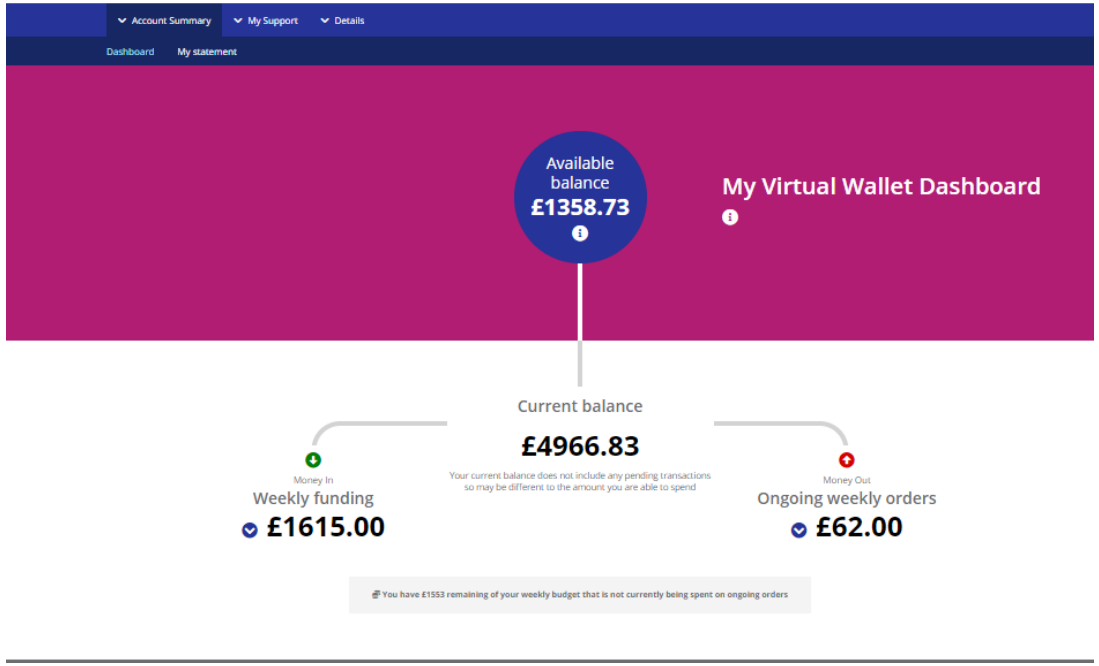
SELF DIRECTED FUTURES individual service funds

How does it work?

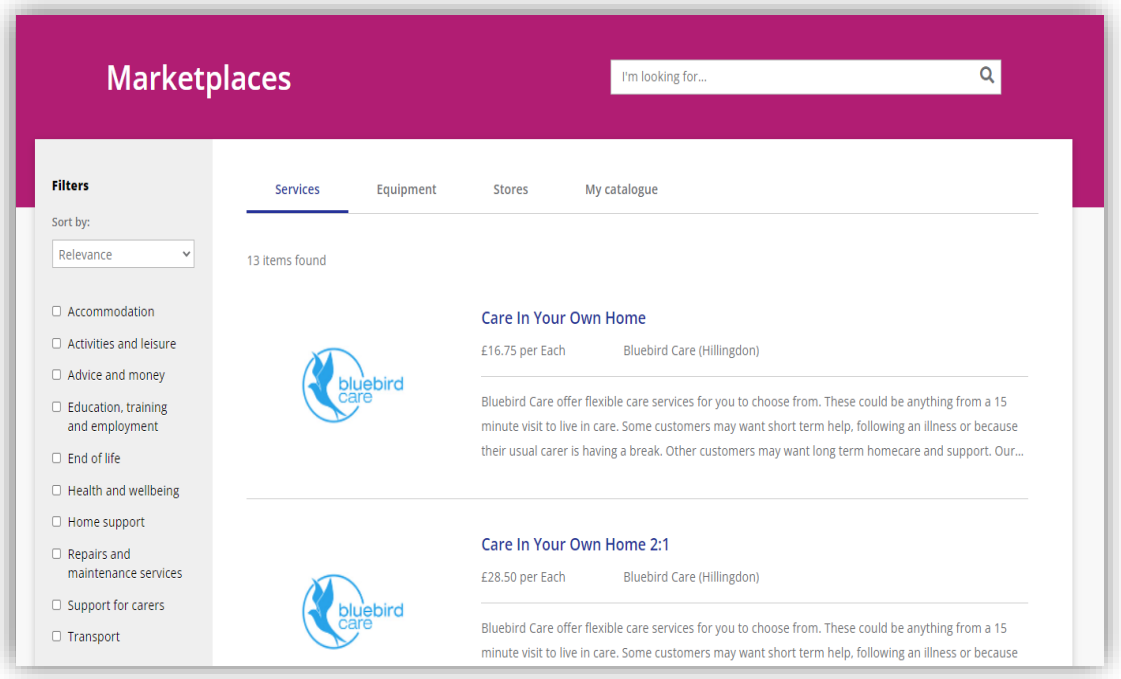
The solution can be adapted for any personal budget - from small one-off grants to complex personal health budgets. There are three common steps for every user:

PHB Holder's benefit

Auto budget management – no paperwork

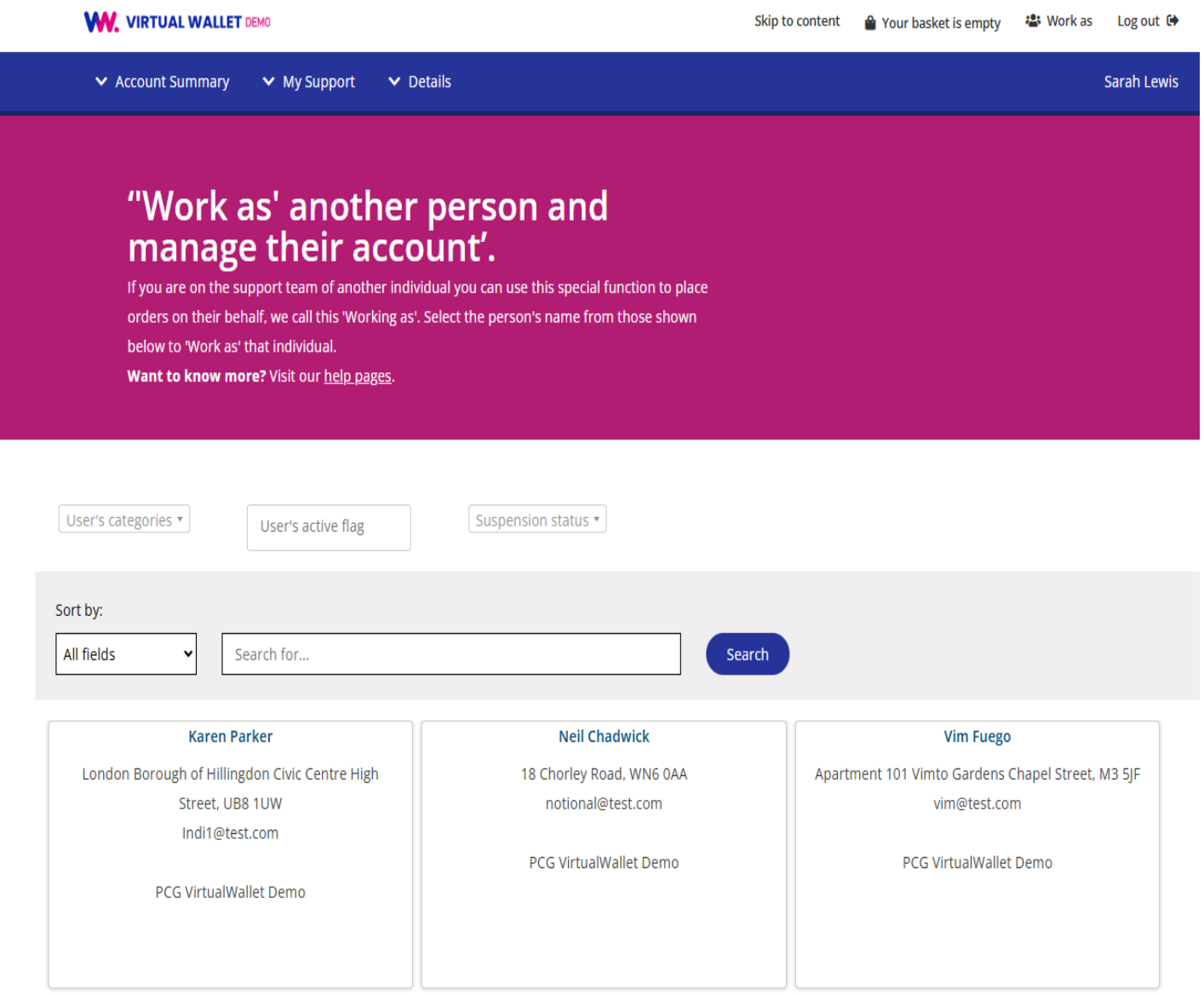


Easily book care and support from a regionalised emarketplace

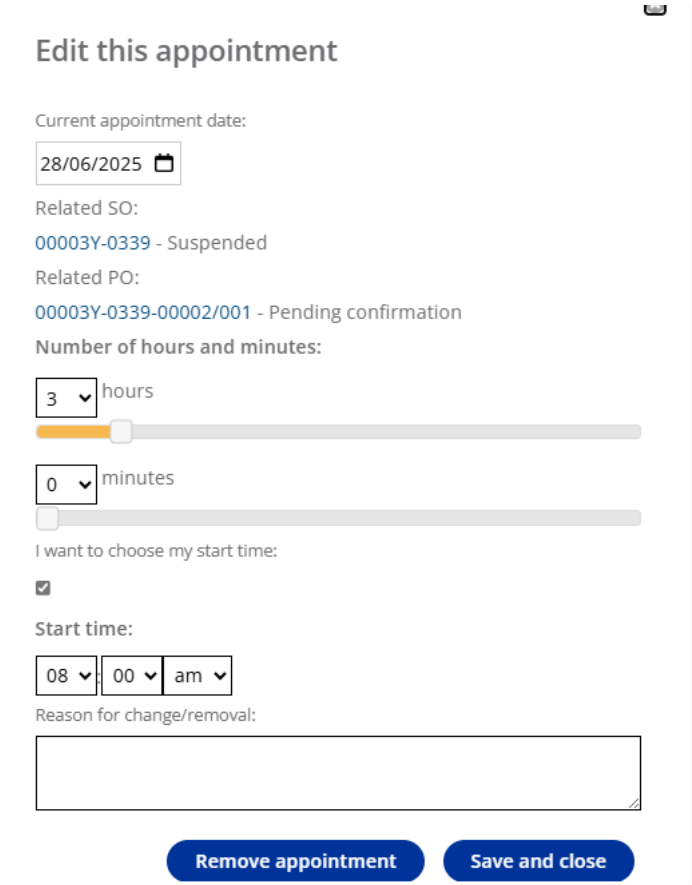


NHS professional's benefits

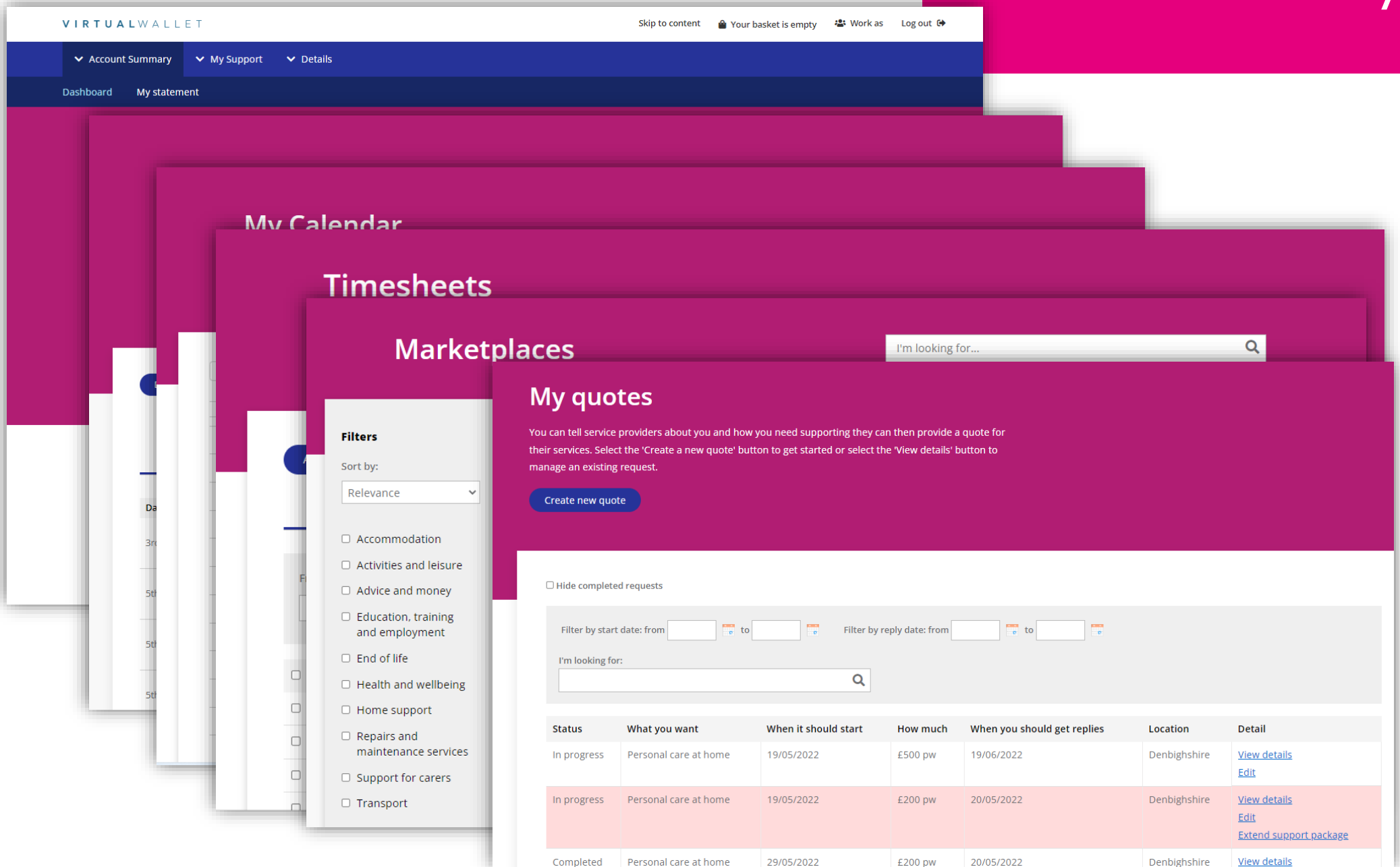
Can 'work as' patient



Can edit and cancel bookings



Key Features



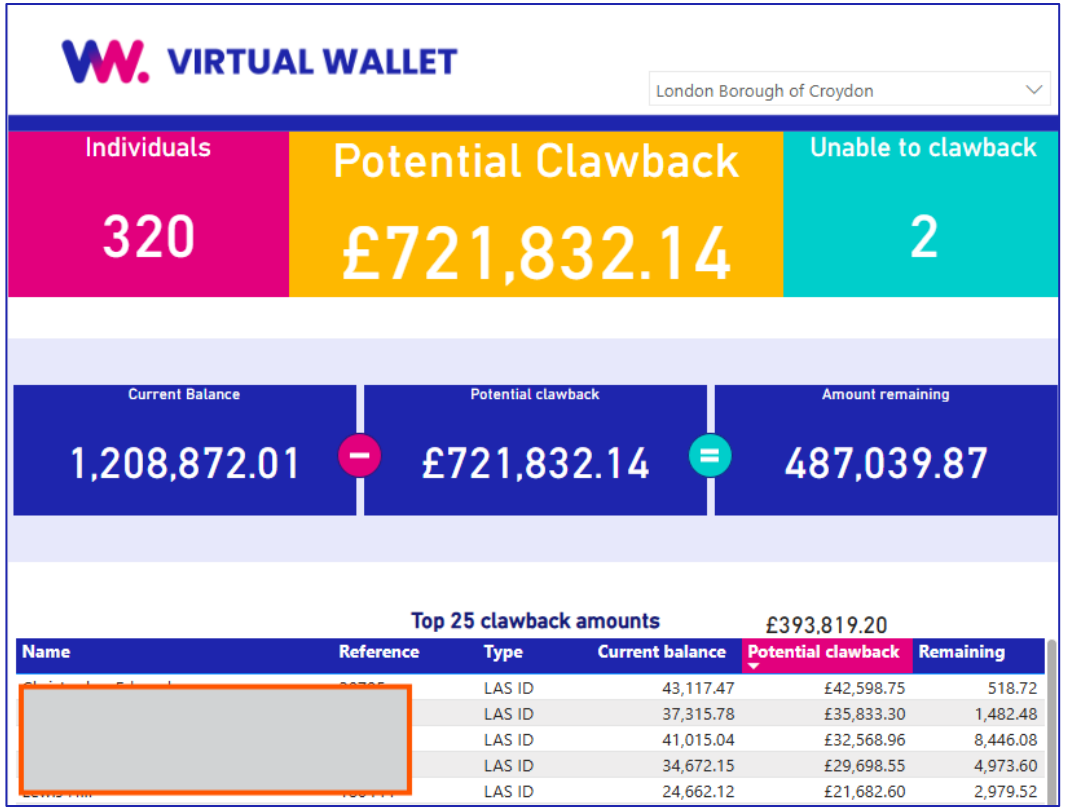
Reporting

A suite of Power BI reports providing professionals with visibility as to what care and support their citizens are selecting.

Type	Overview
KPI Dashboard	A summary of all activity in an easy-to-read format
Financial Management	Detailed transactional reports that can be interrogated and filtered - e.g. current balance of each individual, potential clawbacks, etc
Alert Reports	Identify matters (based upon business rules) for further review and investigation – e.g. inactive accounts, underspend, large transaction volume or values
Care & Support Insights	Care provision trends and activity reports, including care providers and PAs

Clawbacks - Process

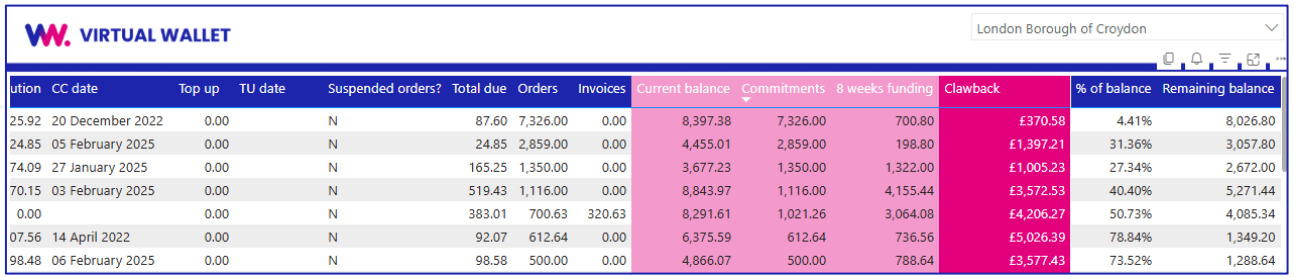
The ‘headline’ report shows the potential clawback (based on agreed parameters) and the top 25 individuals *(personal information redacted here)*:



Name	Reference	Type	Current balance	Potential clawback	Remaining
[redacted]		LAS ID	43,117.47	£42,598.75	518.72
		LAS ID	37,315.78	£35,833.30	1,482.48
		LAS ID	41,015.04	£32,568.96	8,446.08
		LAS ID	34,672.15	£29,698.55	4,973.60
		LAS ID	24,662.12	£21,682.60	2,979.52

This report is indicating that of the £1.2m currently held in Virtual Wallet, there is a potential clawback of £0.7m.

The ‘detail’ reports show the calculations for each individual:



ution	CC date	Top up	TU date	Suspended orders?	Total due	Orders	Invoices	Current balance	Commitments	8 weeks funding	Clawback	% of balance	Remaining balance
25.92	20 December 2022	0.00		N	87.60	7,326.00	0.00	8,397.38	7,326.00	700.80	£370.58	4.41%	8,026.80
24.85	05 February 2025	0.00		N	24.85	2,859.00	0.00	4,455.01	2,859.00	198.80	£1,397.21	31.36%	3,057.80
74.09	27 January 2025	0.00		N	165.25	1,350.00	0.00	3,677.23	1,350.00	1,322.00	£1,005.23	27.34%	2,672.00
70.15	03 February 2025	0.00		N	519.43	1,116.00	0.00	8,843.97	1,116.00	4,155.44	£3,572.53	40.40%	5,271.44
0.00		0.00		N	383.01	700.63	320.63	8,291.61	1,021.26	3,064.08	£4,206.27	50.73%	4,085.34
07.56	14 April 2022	0.00		N	92.07	612.64	0.00	6,375.59	612.64	736.56	£5,026.39	78.84%	1,349.20
98.48	06 February 2025	0.00		N	98.58	500.00	0.00	4,866.07	500.00	788.64	£3,577.43	73.52%	1,288.64

The calculation is taking account of client contributions due, existing spending commitments, future funding and the default assumption of how much should be retained in the account *(8 weeks in this example).*

Access anywhere, anytime

Co-produced

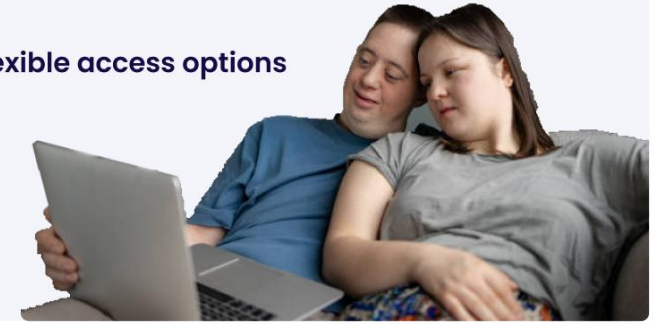
Secure

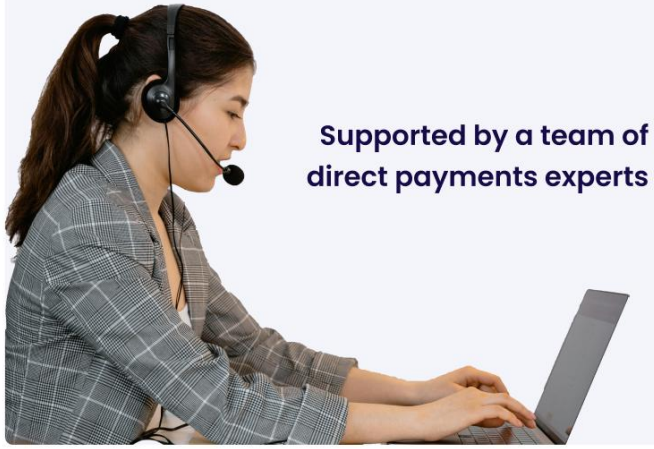
Paperless

You are in control

VIRTUAL WALLET

Flexible access options

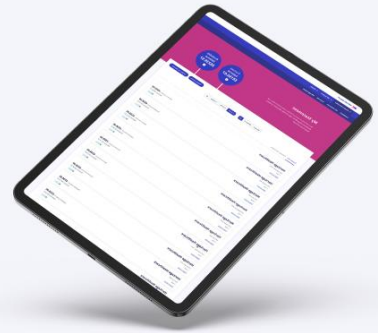




Supported by a team of direct payments experts

Trusted by councils and the NHS

Automated payments



Easy to use

access

Thank you

access

PPL
People Places Lives

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Case Study

ieg4

Case Study

Matt Culpin
Product Director
IEG4

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Fireside Interview

Deborah Jackson-Howarth
Associate Business Lead
ML CSU
Contact: djackson-howarth@uclan.ac.uk

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Case Study

MultiHealth SPECIALISTS

miaa

Case Study

Ken Jones
Director of Delivery – Finance & Corporate Performance
MIAA

Joyce Bowler
Clinical Director
MultiHealth Specialists

The Power of Partnerships

Multi Health Specialists and MIAA

miaa
Trusted Assurance & Solutions

MultiHealth
SPECIALISTS

Who are we : MIAA

Established NHS Organisation

- A not-for-profit organisation working exclusively within the public sector with 35 years of experience.
- Part of the NHS and supporting over 100 NHS & Other Public Sector organisations with governance, risk, finance, digital assurance, and transformation.

Specialists in Integrated Health & Care Systems

- Proven expertise in supporting Integrated Care Boards (ICBs) and wider system partners to deliver safe, compliant services.

Trusted for Assurance & Insight

- Works at both strategic and operational levels to identify risks, provide insight, and support system resilience.

Enabler of Collaborative Change

- Brings together clinical, operational, and corporate functions across NHS and care systems to deliver meaningful impact change and efficiencies.

miaa
Trusted Assurance & Solutions

Who are we : Multi Health Specialists

Established, Clinically-Led

Founded and led by experienced senior clinicians and operational leaders.

Specialists in All Age Continuing Care (AACC)

Deep expertise in Continuing Healthcare (CHC), Joint Funded care, Mental Health, and Complex Care.

Integrated, End-to-End Support

Clinical reviews, operational delivery, commissioning advice, governance, training, and service transformation.

Trusted by , ICBs, and Local Authorities nationally

Focused on Quality, Compliance & Sustainability

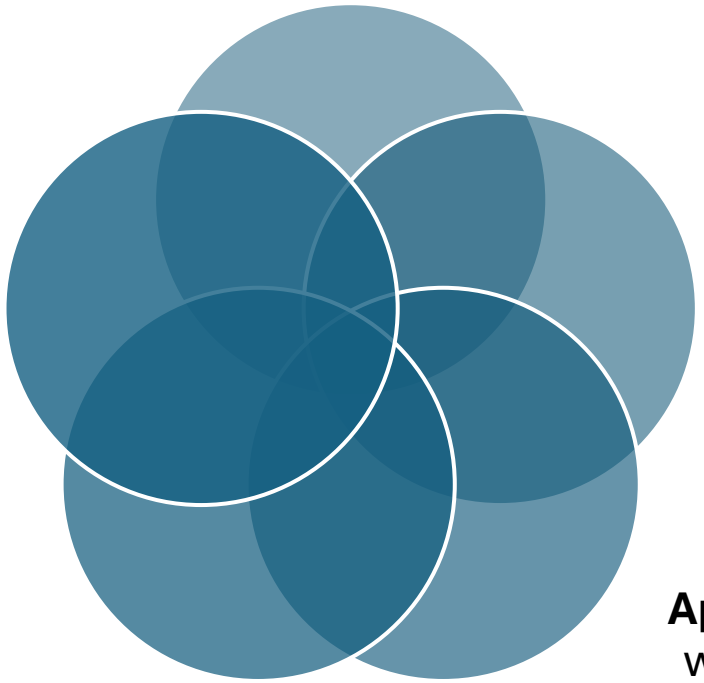
Framework-aligned delivery with patient outcomes and system impact at the core.

MultiHealth SPECIALISTS

First Partnership

7+ Years of Partnership: MHS Ltd (clinical & operational delivery) and MIAA (governance, finance & PMO).

Scalable Success: Robust governance enabled sustainable outcomes—project has been extended and continues to deliver value.



Project Focus: Supporting a North West ICB to address significant CHC case review backlogs.

Proven Impact: 1,100+ patients receiving safe, appropriate care. £12.6M in recurrent savings for the ICB.

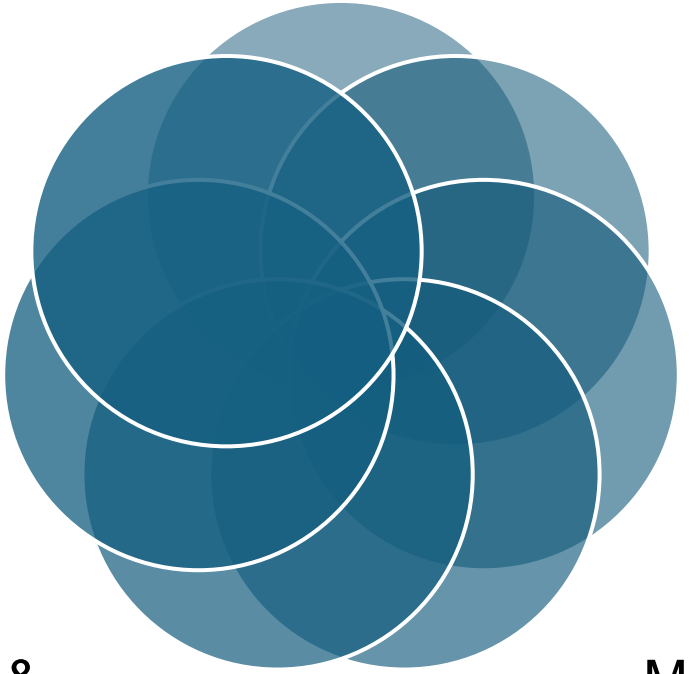
Collaborative Approach: System-wide coordination across health and care partners.

Second Partnership

Lancashire & South Cumbria ICB

GPs & Community NHS Teams

Four Local Authorities



Numerous Nursing Home & community care providers

MIAA (Finance & Corporate Performance team)

*Midlands & Lancashire Commissioning Support Unit

Multi Health Specialists Ltd (Clinical and Operational Team)

Mobilisation: Setting the Foundation for Success

Mobilisation meetings

Key partners brought together
Clarify project objectives and individual roles.
Agree on processes and collaborative working
Build a shared understanding and commitment

Critical

- Establishing trust and engagement.
- Creating strong working relationships
- Laying the groundwork for sustained joint delivery and shared outcomes.

Oversight Group

Lancashire & South Cumbria ICB
Midlands & Lancashire CSU
MIAA and Multi Health Specialists Ltd
Local Authority partners

Group function

- Maintained strategic oversight.
- Met fortnightly to monitor progress, manage risk, and make joint decisions.
- Reviewed assurances provided by a supporting Operational Group.

Key Challenges at Mobilisation

- System Access & Data
- Building Relationships
- Information Governance
- Stakeholder Engagement
- Workforce Constraints
- Data Quality
- Primary Care Input
- Urgency vs Capacity

Operational Delivery & Governance

Operational Group Leadership

- MHS led a weekly cross-Local Authority Operational Group.
- Focused on resolving day-to-day issues and escalating unresolved matters to the Oversight Group.

Data-Driven Delivery

- Meetings structured around KPIs and supported by weekly activity and finance reports.
- Clear visibility of performance, progress, and blockages.

Robust Risk Management

- Live risk log maintained, reviewed by both governance groups.
- Enabled timely escalation and resolution of key risks such as workforce capacity and data integrity.

Strong Governance Culture

- Described by partners as “the right people in the room.”
- Collaborative decision-making environment fostered trust and accountability.

Planned Project Closure

- Agreed transition of complex cases to ICB BAU teams.
- Defined cut-off for case management responsibilities.

Project Outcomes & Impact

1,100+ Patient Reviews Completed	• Ensured care was clinically appropriate, safe, and aligned to current needs.
Improved Quality of Care	• Tangible enhancements in service delivery for vulnerable individuals. • Informed redesign of local services across the ICB footprint.
Sustainable Change	• Learning embedded into Business as Usual (BAU) operations. • Influenced commissioning decisions and long-term care planning.
Significant Financial Impact	• Over **£20 million** in recurrent savings. • Many care packages adjusted where needs had changed, improving value for money.
System Learning	• Frameworks for review, governance, and escalation now being applied in other localities and project extensions.

Collaboration, Recognition & Legacy

Model	A cross-system success story demonstrating what integrated working is possible through trust, pace, and shared purpose. A real effective partnership.
Award-Winning	🏆 Winner: **HFMA Collaboration Award 2024** 🏅 Shortlisted: **Public Finance Collaboration & Innovation Award 2024**
Blueprint	A replicable future model for effective collaboration between ICBs, Local Authorities, and system partners.
Patient-Focused	Quality, safety, and compliance with the National CHC Framework embedded at every stage.
Governance	Collaboration, shared values and accountability acted as the golden thread across delivery.

Expanding Our Partnerships Across the North West & Beyond

From Lancashire & South Cumbria...

- Successful delivery and ongoing impact across CHC, Joint Funded, and Complex Care pathways.

...To Cheshire & Merseyside

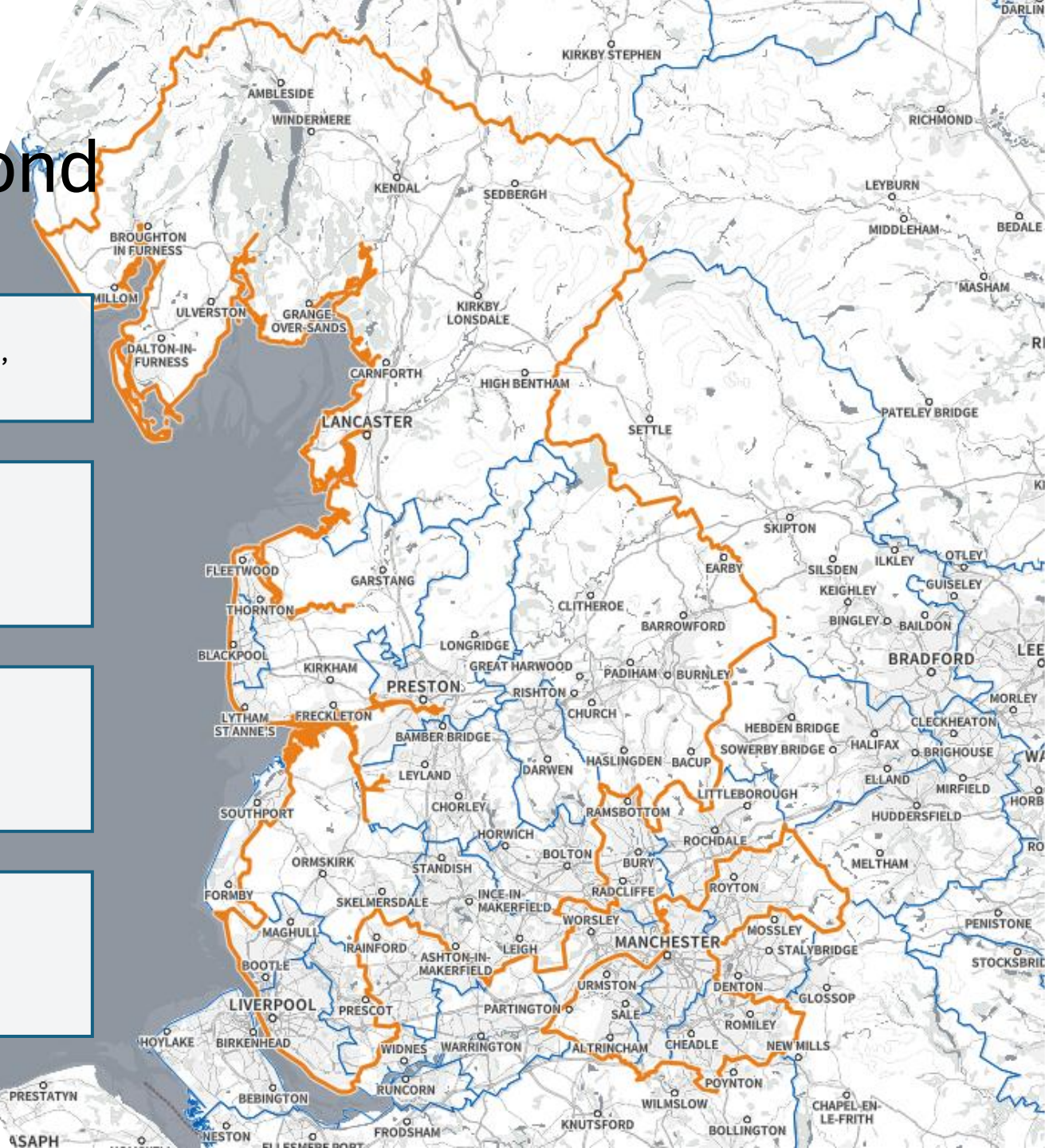
- Now supporting localities in Sefton and Liverpool through targeted reviews and governance-strengthening work.
- Delivering Section 117 and mental health commissioning support.

...And Greater Manchester

- Working with all 10 place-based localities on a strategic commissioning model for individually funded packages.
- Focus on AACC, sustainability, and market shaping.

Unified, Scalable Approach

- Consistent frameworks adapted to local needs.
- Embedding best practice, improving quality, and delivering financial impact.



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Lunch & Networking

Chair Afternoon Reflection

James Crowe
Independent Chair for CHC
NHS Wales

ONVENZIS

Case Study

cornerstone

Friction points and flow: humanising the CHC pathway

June 2025

Vivien Ziwocha, Chief Operating Officer

Dorothy Lain, General Manager – Marula Lodge

Leanne Parmenter, Head of Business Development

The Resident Journey Through Continuing Healthcare (CHC)

The journey through CHC funding and placement can be an incredibly stressful time for the person at the centre, their family and support network.

Often, CHC processes are triggered following a period of exacerbated ill health or crisis, which in itself can be an incredibly emotional and emotive time. Whilst the focus in that moment is on supporting the person to be as well as they can be, the focus on hospital discharge shifts to a financial and process based discussion around the person.

When does CHC become relevant in a resident journey?

For our residents:

- On discharge from hospital as part of a D2A pathway (intended only for up to 12 weeks) followed by a CHC review and decision for ongoing funding
- CHC funding may already in place following eligibility assessment for another care setting
- Joint funding with social care where there is both and a health and social care element to the persons needs. This can change over time following assessment of the persons current needs

Regardless of the funding stream, at Cornerstone, our intention is to offer a safe space to call home whether only for a short time or longer term. To do this we *focus on the person as a human, not as a diagnosis or set of needs*.

Why does it matter?

CHC is more than funding—it's about people and ensuring their complex needs are met.

It is to everyone's benefit that we improve the flow of the process, reducing the friction points and creating a seamless process for decision making, provision of great care and a safe, secure transition to a new home for a person.

Where engagement and collaboration is limited, there is often greater opportunity for friction points which often result in moving to a process over human approach.

Improving the flow of the journey not only eases the administration burden but eases the pressure for families and residents and enables the focus to be on providing the good care needed for the person.

Our goal: a human-centred, collaborative, and transparent process

The CHC process

1. Referral from ICB for a resident ready for hospital discharge (D2A Pathway), admission from home or other care setting (where needs have changed or placement broken down)

2. Provider conducts assessment – family engaged early

3. Admission into care home – clinical records begin

4. Preparation for CHC review (typically around 12 weeks)

5. Multidisciplinary meeting with CHC, Social Worker, Family

6. Decision and funding pathway agreed

7. Ongoing review and clarity on long-term plan

Case Study: Mrs X – Navigating CHC post-discharge

Background:
Mrs X, an 84-year-old woman with advanced dementia, experienced a deterioration in her health and presentation leading to hospital admission from her home. The ICB initiated a referral for post-discharge care under the Discharge to Assess (D2A) Pathway.

Referral & Assessment
ICB referred Mrs X for assessment by Marula Lodge post-discharge as her home-based care was no longer able to meet Mrs X needs safely.
Marula Lodge carried out an initial clinical assessment within 48 hours of referral involving the family actively from the outset and shared the written assessment and offer letter (weekly fees) with referrer.

Approval
The referring ICB approving the funding for a D2A pathway and agreed on admission, a date to complete the CHC review to assess eligibility for ongoing funding.

Care Home Integration
Mrs X settled into the care home. A clear clinical record was established to capture needs and interventions from Day 1.

CHC Review
At the 12-week mark, detailed reports and care evidence were compiled in readiness for the CHC review. A collaborative meeting was held including CHC representatives, a social worker, and Mrs X's family. All perspectives were documented and considered.

Decision Reached
Mrs X was found eligible for CHC funding. A fully funded care package was agreed with regular monitoring protocols and her placement continued at Marula Lodge where she content and settled. Her family were grateful for the support throughout the process and a positive relationship has been maintained.

Long-Term Planning
Follow-up reviews were scheduled to ensure care remains appropriate, with clarity for the family on future planning and support.

Optimising a successful journey

Success factors

- Early and ongoing family involvement
- Clear milestones (e.g. 12-week review agreement)
- Strong documentation from day one
- Positive, collaborative and informed MDT discussions
- Shared understanding of resident needs and goals

Friction points

- Confusion around frameworks, eligibility, responsibilities and communication
- Lack of consistent review timelines
- Good care interpreted as ‘reduced need’
- Delayed decisions impacting financial planning
- Limited family understanding of CHC criteria
- Funding decisions (social care/private) where CHC is not awarded

Humanising the CHC process

- **Reframe funding conversations around the person;** start the discussion with the person, their wishes and preferences
- **Ensure the family voice is central, not peripheral;** support the family to understand the process, how it works, what is needed and most importantly give them time to think about their loved ones wishes
- **Acknowledge emotional energy as well as clinical data;** this can tell us so much more about the person, their triggers, frustrations and things that make their heart sing!
- **Enable transparency between provider and commissioner;** remember we are here for the same purpose and all bring something to providing the best possible quality of life for the people we care for
- **Recognise and record the human journey, not just the symptoms;** understand what has led to needing CHC
- **Consider our professional language;** does it sound caring or person-centred. How do we reflect our best intentions in our language e.g. “placement breakdown.”

Call to action!

For Commissioners:

Standardise D2A milestones and review timelines.

For Providers:

Empower teams with knowledge of CHC domains and documentation needs.

For the System:

Enable shared access to digital records (e.g. GP Connect).

For all parties:

To keep challenging ourselves to humanise the process and decision making.

Continuing Healthcare should reflect the continuity of care, the complexity of need, and the humanity behind the funding.

Thank you.

We welcome your reflections and questions.

cornerstone

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Keynote Presentation

Rachel Hutchings
Fellow
Nuffield Trust

Access and variation in NHS Continuing Healthcare

Emerging findings

NHS Continuing Healthcare conference – 24th June 2025

Rachel Hutchings - Nuffield Trust

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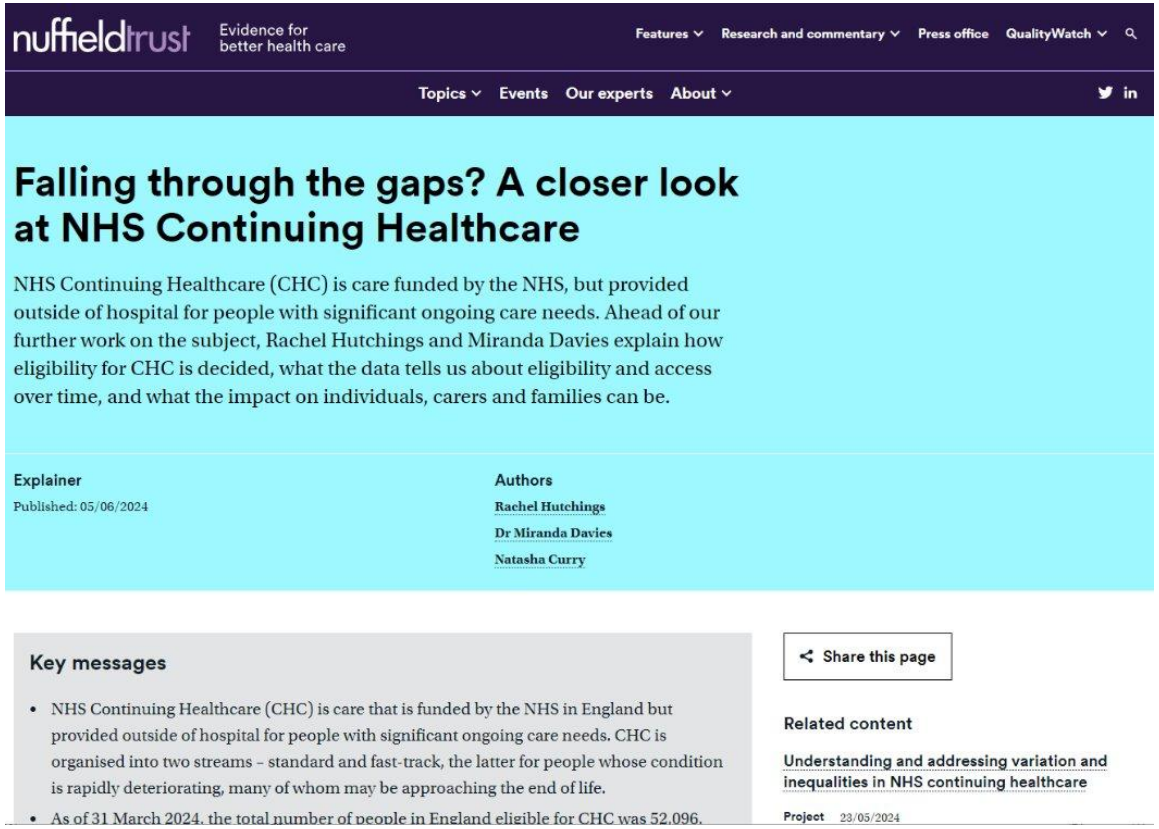
Our work on NHS CHC

Published explainer

- Conversations with stakeholders
- Reviewing previous reports and investigations
- Analysis of publicly available NHS England data



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About the research

A mixed-methods project exploring inequalities and variation in CHC

Aims were to understand:

- factors affecting variation
- the relationship between CHC and patient/local characteristics
- actions local systems are taking to address variation
- implications for the health and social care system

Methods: Freedom of Information requests to NHS England and Integrated Care Boards, **interviews** with people working in ICBs and local authorities, **focus groups** with care providers, **analysis** of local data, **lived experience** input, **stakeholder engagement** and a **policy workshop.**

This project was part-funded by the Nuffield Foundation

Shifting picture: trends and variation in CHC assessments and eligibility

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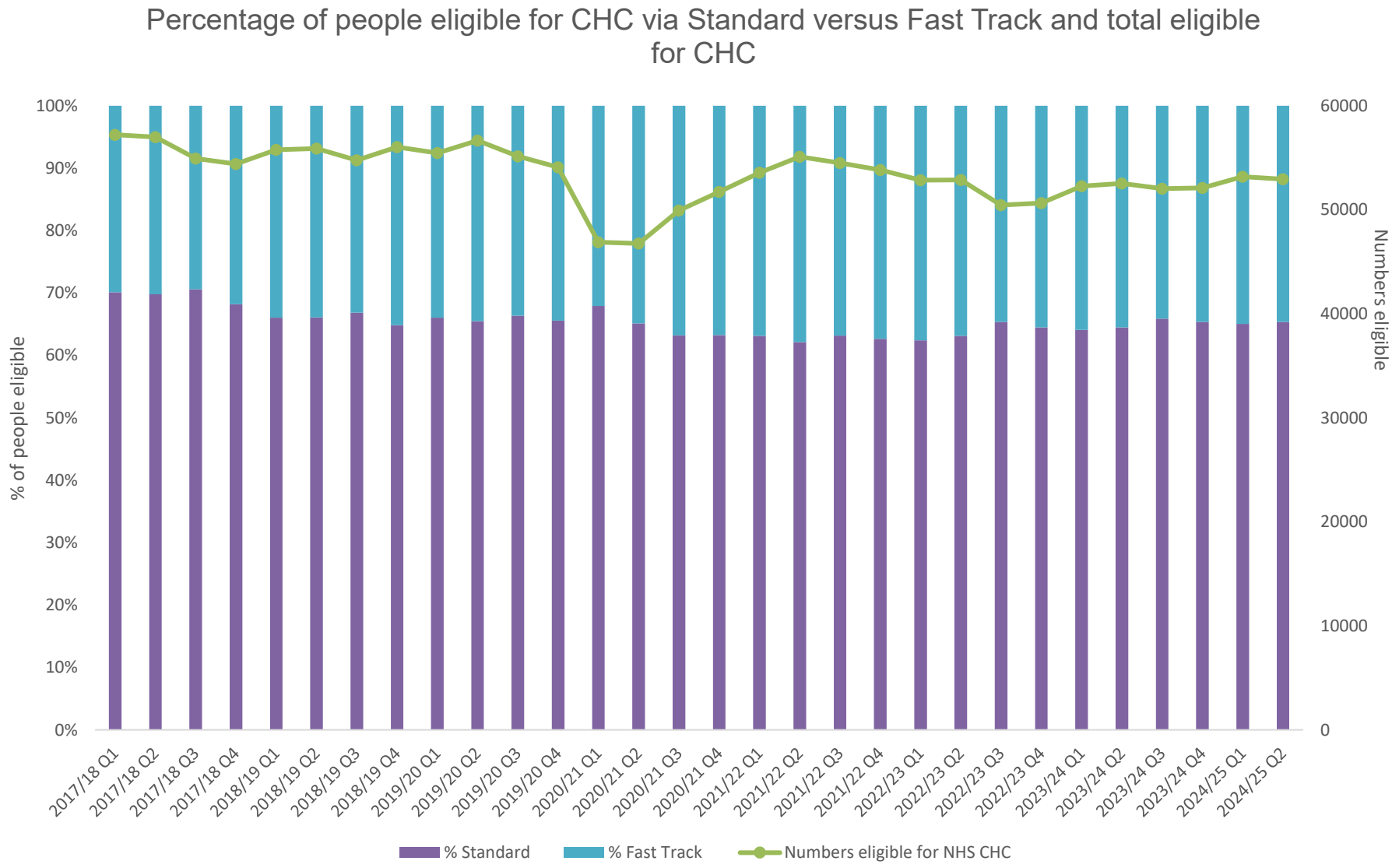
Eligibility for CHC has decreased



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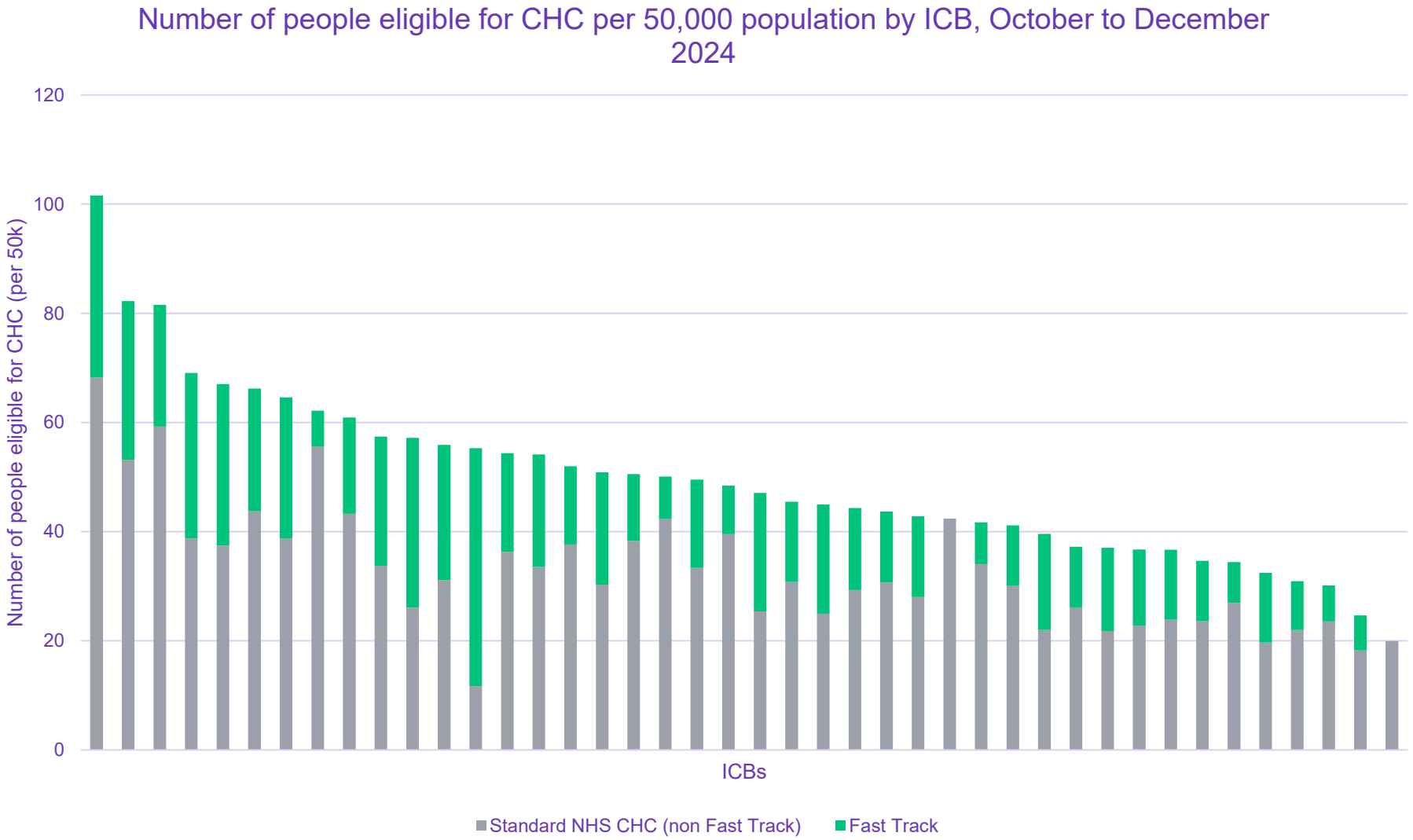
Eligibility varies across the country



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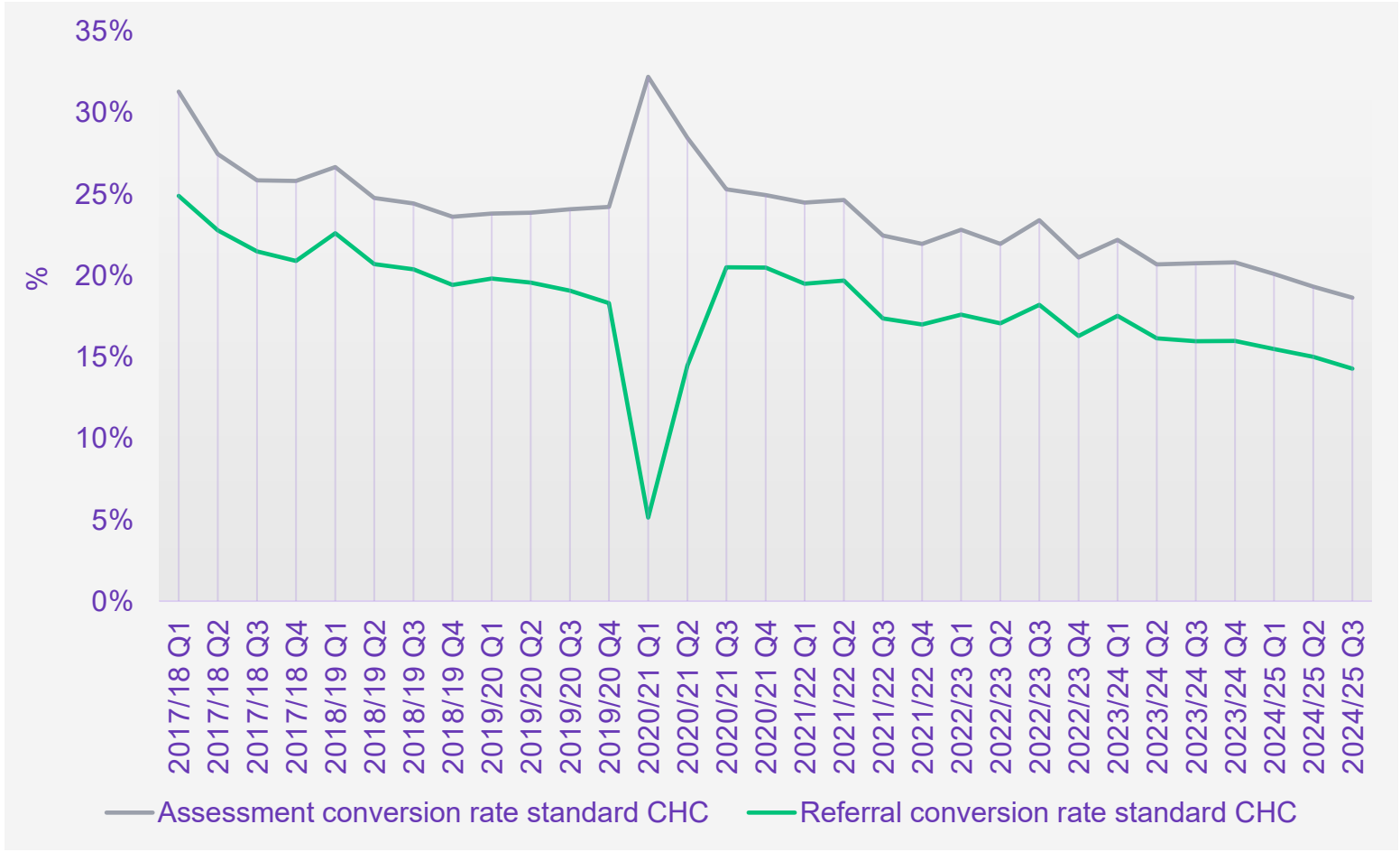
The proportion of people assessed as eligible has decreased



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Luck of the draw? Features and drivers of variation

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What is driving variation?

- Need and demographics
- Local structures and processes
- Commissioning and the care market
- Awareness and understanding
- Relationships, integration and accountability
- Resources and system capacity

What is driving variation?

Need and demographics	• **Age and local area characteristics:** deprivation and rurality, prevalence of different conditions
Local structures and processes	• **CHC at a local level**: different approaches to CHC teams, assessments, commissioning and case management
Commissioning and the care market	• **Commissioning**: policies around what care will be funded (e.g. use of panels, working with local authorities) • **Setting fees and rates**: consistency with local authorities, approaches to market shaping, unrealistic costs • **Care market**: out of area placements, availability of specialist placements, fragility

What is driving variation?

Awareness and understanding	• **Public awareness**: awareness and knowledge, need for advocates, visibility • **Staff awareness, experience and training**: approach of individuals in multidisciplinary team (MDT), variable training, inappropriate constitution of MDT • **Application of the National framework**: subject to interpretation, local practices, variable training
Relationships, integration and accountability	• **Interaction with local services**: approaches to referrals, existence of specialist services, variation in fast-track, discharge and end-of-life care • **Relationships and integration:** variable relationships and ways of working, communication, joint posts or practices, bellwether for wider integration efforts • **Accountability**: limited assurance over ICB approach, different approaches locally to oversight and quality assurance
Resources and system capacity	• **Organisational capacity**: backlogs, staffing shortages • **Financial context**: of individual ICBs/ local authorities but also the wider context, cost-shunting

“I think it's a disparity, I think it's the type of illnesses. I think it's definitely about where it's given. I don't think we get enough referrals for people who are already in nursing care. And residential care, that doesn't seem very fair to me at all.”

Focus group participant

Examples of good practice

Assessments and eligibility	• **Outreach and public information**: leaflets, assigning staff members to different care settings, dedicated public information posts • **Training** for CHC teams, providers, social care and NHS staff • Good and **holistic assessments** involving people with knowledge and understanding of person and their needs • Improved **recruitment** and **retention**
Commissioning and providing care	• **Commissioning** policies to improve consistency and transparency in decision-making • **Collaborative** approaches to market-shaping, developing provider frameworks and embedding requirements on quality
Integration and accountability	• **Joint working/ commissioning** approaches or posts with local authorities • Close working **partnership** between LA/ ICB and providers • Effective **communication** and approach to dispute resolution

"So what they're doing is that the nurse is always visible, present and they can link a face to the service... So it's about raising the profile in that particular area of what CHC is…"

Interview participant

Recommendations

Training	• Develop practical co-produced training on the National Framework, including how it applies to individuals with conditions such as dementia and learning disabilities • Ensure CHC assessments are conducted in line with the requirements of the National Framework
Data	• Proactively capture data and information on demographics and access to CHC assessments and eligibility. Particular action is required to address gaps in understanding about ethnicity. • Use the information provided in the NHS CHC Patient Level Dataset to monitor access to CHC to identify gaps and regularly report CHC eligibility by at a minimum, age, gender and ethnicity to proactively monitor and address potential inequalities
Good practice	• Explore opportunities to spread good practice, share learning and encourage improvement and consistency

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Keynote Presentation

Amy Heard
Clinical Manager – Personalised Healthcare Commissioning - LLR
NHS Midlands and Lancashire Commissioning Support Unit

ML
A care system support organisation

NHS

Tailoring CHC assessments for neurodivergent individuals through personalised approaches and specialised training.

Amy Heard- ML Personalised Healthcare Commissioning- LLR

Introduction:

Within this presentation we are going to look at:

How the CHC process can be tailored to meet the needs of adults with a diagnosis of Learning Disability and/or Autism.

How can the Personalised Commissioning Team support the wider MDT in ensuring individuals reach their full potential.

A case study to show how the process can support positively

CHC Framework:

The same CHC framework, checklist and DST tool is used for all adults.

The Gov.uk website has and easy read booklet that can be downloaded and printed to explain what CHC is and the process: https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care-easy-read

Prior to the DST:

All DST's must be completed by the most appropriate nurse with the relevant background and training.

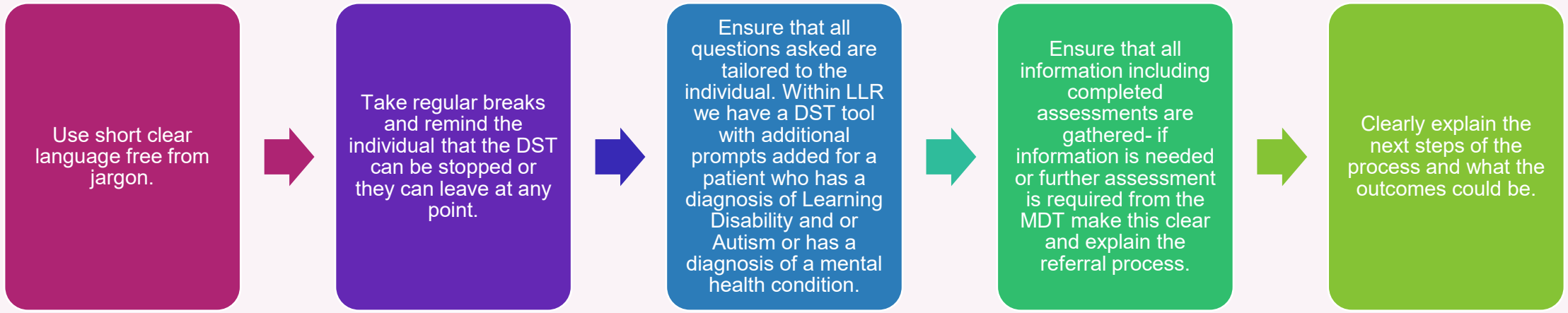
Reasonable adjustments should be made to support the individual to attend if they wish to.

Ensure that they have representation from a family member or friend if possible.

Gather as much information as possible from wider professionals including assessments and PBS plan.

Invite all relevant care providers, MDT, Education, LA.

During the DST:



After the DST:

Work closely with the patient, family and MDT to ensure the best care.

Discuss care and support options and the most appropriate level and type of care for the patient.

Make any outstanding referrals to the MDT.

Make any necessary referrals for COP DOLS.

Attend relevant MDT or MAM meetings.

Discuss transition into new services, how this can be done, who needs to be involved etc.

Care and Support:

- Appropriate level of care and support is identified.
- Work collaboratively with the patient, MDT, Adult Social Care and the care provider to ensure that the care package sourced is suitable to meet the patients needs.
- Assessment is to be completed by the care provider.
- All care plans and risk assessments must be individualised and person centred ensuring all needs including sensory needs are met. All care plans must be least restrictive.
- Care providers will work together with the patient and family to ensure that the patient is working towards independence in order to reach their full potential.

Personal Health Budgets:

- Personal health budgets are required for all patients eligible for Continuing Health Care who live in their own home, with families or in supported living.

- PHB's offer flexibility, choice and control of patient care.

- Care packages are person centered, and patient led.

- Outcomes are set for the individual and care team to work towards.

- Training and contingency plans are completed.

How the PHC Team support the wider MDT:

- Ensure all referrals are made to the wider MDT
- MCA, Best Interest and COP DOLS
- MAM Meetings
- Safeguarding Referrals
- MDT Meetings
- Primary and Acute Liaison Nurses
- PHB- Relevant training for PA's
- Care provider and Level of Care
- Be Open, Honest and Transparent

Referrals

Referrals to Community Learning Disability Team can be made directly by the Personalised Commissioning Team or Adult Social Care.

Referrals to the Autism Service can be made by the Personalised Commissioning Team, however for the referral to be made the individual must be supported by a Consultant Psychiatrist or Psychologist.

A referral to Psychiatry or Psychology can be made by the Community LD Team or GP. Clinicians within the Personalised Commissioning Team are not able to make this referral directly.

Case Study:

- Polly (P) has a diagnosis of Mild Learning Disability, Autism, Emotionally Unstable Personality Disorder, Anxiety and ADHD.
- Polly had a DST completed prior to turning 18 and was CHC funded from her 18th Birthday.
- Polly has worked closely with the MDT to be able to achieve her outcomes on her PHB and has been able to move back home with her family.

Any Questions

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Panel Discussion

Mrs Kate Smith
Service Manager/CHC Lead
Hampshire County Council

Dr Tiritega Mawaka
Interim Director AACC
NHS Sussex

Alex Smith
CHC Lead
Rochdale Council

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Food, Drinks & Networking