The evaluation of an innovative Continuing Health Care pathway in West Norfolk

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Partnership organisations participating include:

healthwatch Norfolk

The Queen Elizabeth Hospital
King’s Lynn
NHS Foundation Trust

Norfolk County Council

NHS West Norfolk
Clinical Commissioning Group

NEL Commissioning Support Unit
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1. Introduction

The subject of this study is NHS Continuing Health Care (CHC), which is the name given to a package of care that is arranged and funded by the NHS when a person aged 18 or over is identified as having a “primary health need.” The National CHC Framework, a complicated area of health policy requiring professionals to interpret a detailed matrix of criteria refined by legal tests developed through case law, determines what constitutes a primary health need. People considered under the National CHC Framework have some of the most complex, unpredictable and variable health and social care needs and this naturally has a significant impact on them and their families. In addition to this, they are required to undergo a lengthy and detailed assessment process to determine whether their needs are ‘health’ or ‘social’ related, which can be extremely stressful.

The particular focus of this study is the impact of the CHC assessment process, both on the individual’s experience of care and on the health and social economy. It is well established that CHC is the subject of high numbers of complaints to the NHS and an area of care with rising costs to the state due to the ageing population. There is a wide body of research into the costs of care for the increasingly elderly UK population and the pressure this will create for both health and social care in the next decade. Some reports, such as the Barker Report, have made recommendations about how to fund this care but at present, there is no fundamental change in the NHS and Social Care funding mechanism proposed, so there is a need for local health and care economies to come up with cost-effective solutions that meet the increasing care needs of their population.

Research on the specific topic of CHC assessment is sparse and it is an area of political sensitivity, being the subject of numerous legal challenges to the NHS where patients and families have appealed against the outcome of their assessment. A multitude of NHS information guides are available online as well as literature offering support such as appeals advice from various private and voluntary agencies and this has proliferated over the last few years. Complaints and NHS Ombudsmen appeals often relate to CHC, with families reporting dissatisfaction with their experience of the assessment process. This has had an impact on the development of the NHS Guidance on the subject, with several reviews and revisions of the CHC Framework over the last decade.

CHC can be simplistically defined as a two-stage process: the assessment of needs and arrangement of a care package if the assessment leads to a positive eligibility decision. The CHC assessment process can take place in an acute hospital prior to discharge, a community
facility or where people reside. National policy places a duty on Trusts providing care to determine whether people need CHC support, however, there is emerging evidence indicating that a hospital is not an appropriate place to carry out CHC assessments. It is recognised in the National CHC Framework that conducting the CHC assessment in hospital at a time when patients often have the potential for significant recovery, makes it an unreliable measure of on-going support needs. It also puts a delay in the discharge process, for a group of patients that are vulnerable to hospital complications when they should be moved to a more appropriate setting to complete their rehabilitation.

This is an area of continuous exploration and many pilots have been carried out to improve the discharge assessment process. These types of initiatives are under the umbrella term ‘discharge to assess’ for projects that aim to speed up early hospital discharge, and more precisely for CHC ‘placement without prejudice’. The evidence as to whether these initiatives work is mixed, partly due to the heterogeneity in measuring outcomes, with variability in methodological rigour and the quality of data processes in place. Many of these schemes come under the national ‘Integration Pioneer’ programme, established by NHS England to generate and test grass-roots innovative schemes that enhance integrated care. West Norfolk is one the Integration Pioneer sites and the project has been actively supported by the national Integration Pioneer team.

This study aims to find a more efficient and economically viable hospital discharge CHC assessment pathway, leading to satisfactory outcomes for patients, families and all related parties involved in the process. The intervention tested has 3 elements; the ‘5Q Care Test’, a new CHC pathway and an integrated checklist and full CHC assessment post-discharge. In this context, the hypothesis tested by West Norfolk is ‘Is the new CHC intervention cost-effective and does it lead to improved outcomes for family and patients?’ This study seeks to answer the hypothesis postulated by using a mixed-method approach. Quantitative techniques are used to test the economic viability of the intervention while qualitative research methods are used to determine whether the outcomes for patients and their families are met.

2. Legislative framework and literature available

2.1 National policy

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care was first published in June 2007 and became mandatory from 1 October 2007. Instead of different areas having their own rules for determining eligibility, the National Framework introduced a national approach for the NHS in England, with a common process and national “tools” to support decision making. The Secretary of State issued Directions requiring NHS bodies and local authorities to comply with key aspects of the new policy. The
revised National framework for NHS continuing healthcare and NHS funded nursing care was created by the Health and Social Care Act 2012, effective from 1 April 2013. The Care Act 2014 (formerly contained with the National Assistance Act 1948) and the NHS Act 2006 determine the boundary between health and social care. There is an overlap of duties here, as both the local authority and NHS have responsibilities to accommodate people who are ill and disabled.

Following the transfer of responsibility for NHS continuing healthcare to clinical commissioning groups (CCGs) in April 2013, The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, set out CCG and NHS England duties in this area. In Part 6, Regulation 21(12) states that in carrying out duties CCGs and NHS England must have regard to the National Framework, which means they are under a legal obligation to follow the Framework unless they have a good reason not to.

2.2 Legal considerations in funding care

The ‘Coughlan Case’ in 1999 established that people should receive NHS funded care providing their needs could not reasonably be expected to be provided in a social care setting and the test for this was proving ‘primary health need’. It also tested the right in that case to receive free care for life, which was deemed a ‘legitimate expectation’ following the ‘promise’ made to Ms Coughlan.

Whilst the statutory guidance ‘Delayed Discharge (Continuing Care) Directions 2013’ pertaining to the NHS Act 2006, places a duty on Trusts to conduct the CHC assessment, it does not stipulate what kind of Trust, nor where the assessment should be carried out and as previously stated, there is a wide body of evidence that hospital is not the appropriate setting for CHC assessments. This is also quite clearly supported by the National CHC Framework. However, the Care Act 2014 has some specific instructions. This is detailed in Schedule 3 of the Act and the associated regulations — ‘The Care and Support (Discharge of Hospital Patients) Regulations 2014’.

The Regulations state that:

“Before issuing an assessment notice, (to social care) the NHS body must have also completed any assessment of the potential Continuing Health Care needs of the patient and if applicable made a decision on what services the NHS will be providing”.

In West Norfolk, following the introduction of the new pathway, the Local Authority has been accepting the newly developed care dependency assessment as reasonable evidence that the patient was suitable for discharge into social care. There have been no formal challenges made since the introduction of this pathway in January 2016, by patients,
families or the Local Authority. It is important to note that a Local Authority can only lawfully provide health services, if those services are:

1. Merely incidental and ancillary to the provision of accommodation which the local authority is already under a duty to provide;
2. of a nature, which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide;
3. otherwise authorised by a delegation of functions arrangement under Section 75 of the National Health Service Act 2006

2.3 Assessment consistency and fairness

There is a scarcity of literature on the effectiveness of the CHC assessment process. This could be due in part to the highly litigious nature of some appeals, with case law setting precedence when challenges were made to negative decisions. In 2014, Dame Kate Barker was commissioned by the King’s Fund to review the issues of inequality in funding for health and social care and to explore mechanisms to address this. The findings of the final report included:

- **A lack of alignment in entitlements to health and social care.** The NHS remains largely free at the point of use. Social care is both heavily needs- and means-tested. As these entitlements stand they create inequalities that the commission believes are profoundly unjust.

- **A lack of alignment in funding streams.** The NHS, broadly speaking, is paid for out of general taxation and operates within a ring-fenced budget. Social care is paid for either privately or from non-ring-fenced local authority budgets. Councils retain considerable discretion over how much is actually spent. Who pays for what is a source of constant friction between the NHS and social care, with enormous and distressing impacts on the patients, users and carers caught between the two.

- **A lack of alignment in organisation,** with health and social care commissioned separately.

To tackle these three structural flaws, the report argued that England needs to move over time to a single, ring-fenced budget for health and social care that is singly commissioned. National statistics on CHC provide a picture of high variability and some information regarding the costs. Table 1 below provides some representative figures.
Table 1: CHC numbers and spend

<table>
<thead>
<tr>
<th>Nationally:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 77,000 referrals for standard CHC consideration each year and 83,000 ‘Fast Track’ referrals</td>
</tr>
<tr>
<td>• 62,000 people in receipt of CHC on any given day (including through Fast Track) but during year many more receive CHC for a period of time</td>
</tr>
<tr>
<td>• 33% (just under) average conversion rate from positive checklist to CHC eligibility</td>
</tr>
<tr>
<td>• 52,000 (conservatively) CHC assessments undertaken per year which do not result in eligibility</td>
</tr>
<tr>
<td>• 16 fold reported variation in eligibility rates per 50,000 population</td>
</tr>
<tr>
<td>• £2.5 – £3b = Annual national CHC spend</td>
</tr>
<tr>
<td>• 448 appeals considered by NHSE in 2015/16 of which 122 (27%) resulted in eligibility for at least some period of care</td>
</tr>
</tbody>
</table>

(NHS England CHC design event, June 2016)

This illustration of less than a third of the appeals to NHS England being upheld and the huge variation in eligibility rates across England clearly highlights a problem associated with reliable, consistent application of the process. The ‘Failing to Care’ report from the All Parliamentary Group on Parkinson’s found that:

“All of the health and social care professionals we spoke to admitted the system is so complex they have difficulty following the correct process”

“In 21 per cent of cases examined, there were clear examples of existing national guidance not being followed either in the length of assessment or in how the decision is made, with no repercussions for breaching these guidelines”

The report made robust recommendations to NHS England to improve the quality, fairness and transparency of the entire CHC process.

3. The CHC pathway prior to the intervention

The CHC process typically involves two phases: the assessment of the patient’s primary health needs and the arrangement of a care package if the assessment leads to a positive eligibility decision. The CHC assessment process in turn also follows a two-stage process: a checklist is carried out to see if the patient qualifies for a full assessment, followed by a full CHC assessment if the checklist indicates that an assessment is appropriate.

Historically, there have been inherent anomalies in the interpretation and application of the CHC assessment process that result in subjective decision-making, which raises expectations for the people receiving care and sometimes has to be reversed at the first review after three months, thereby creating high numbers of appeals and complaints. It is well established that hospital stays can be harmful to frail elderly people in terms of loss of motor skills, cognitive impairment and risk of falls and infections. If the protracted and lengthy assessment for CHC eligibility takes place in an acute setting, the journey and the outcomes for the patients are likely to be suboptimal, resulting in patients and families...
experiencing often considerable delays to hospital discharge, waiting for information about where they will be cared for and who will be paying for the care and this had been causing considerable distress in some patients in West Norfolk. Guidance in the National CHC Framework\(^1\) states (page 24):

“It is difficult to make an accurate assessment of an individual’s needs while they are in an acute services environment.”

“In such situations, assessment of eligibility for NHS continuing healthcare should usually be deferred until an accurate assessment of future needs can be made.”

Across the county of Norfolk approximately 953 people are eligible for NHS continuing healthcare at any one time, currently costing approximately £55,227,848 per annum. This is a disproportionately high cost for the population size and is due in part to the higher than England average of elderly people. West Norfolk CCG has a registered population of 170,270 people, with a rapidly ageing population (the second highest population of people over 65 of any CCG in England), estimated to experience an 8% growth in the next 5 years (ONS, 2012\(^14\)). West Norfolk recorded a total of 209 people currently CHC eligible during the last week of 2015, just before the new CHC pathway was introduced.

As the main provider of acute services in the West Norfolk area, The Queen Elizabeth Hospital (QEH) provides approximately 450 overnight beds and 115 day beds. During the calendar year 2015 there were 300 patients who had a CHC checklist in the QEH. In this study we followed the journey of patients from West Norfolk CCG, and contrasted it with ‘the intervention’ or new pathway. During the fiscal year 2015/16, the QEH reported 83,300 discharges. Up to the 31\(^{st}\) December 2015, CHC assessments were conducted in the hospital following a standard assessment pathway, which involved health and social staff working together to complete the necessary assessment documentation and holding a meeting with the family before making a recommendation for CHC funding or not, as illustrated in Figure 1.

**Figure 1: NHS CHC previous acute trust pathway**

<table>
<thead>
<tr>
<th>In-patient awaiting CHC checklist</th>
<th>CHC assessment, MDT recommendation, decision eligible, agree placement</th>
<th>Discharge into CHC care with 3 months review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 0-3</td>
<td>Day 3-5 (max 28 days)</td>
<td>Day 95 review eligibility</td>
</tr>
</tbody>
</table>

In the above pathway, patients are discharged from hospital as CHC eligible and are provided with a CHC care package with an NHS commitment of funding until the first review at 3 months. In this case, any of those patients who might have been prematurely awarded
CHC because they had not completed their recovery, cannot be re-assessed until 3 months and at this point if they become ineligible, there is considerable disruption for patients and families. The decision-making tree associated with this pathway is illustrated in the flow diagram in Figure 2 below.

**Figure 2: Patients with complex care needs decision-tree**

- Could NHS services enable further improvements in health or functioning that might alter outcome of eligibility decision?
  - Yes: Provide NHS re-ablement or other service to achieve optimum health
  - No: Complete checklist, or go straight to full CHC assessment

**Checklist positive Possible CHC eligibility**
- MDT assessment and recommendation to CCG
  - Yes: Care planning - consider whether need for joint LA/NHS package or placement, including Funded Nursing Care
  - No: Regular 3 month then annual reviews of needs and package

**Checklist negative, Social Services referral**
- Care planning - consider whether need for joint LA/NHS package or placement, including Funded Nursing Care
  - Yes: NHS care planning and fully funded provision
  - No: Social Services or self-funded care

**Care planning - consider whether need for joint LA/NHS package or placement, including Funded Nursing Care**
- No: Jointly funded care
4. The hypothesis justifying the intervention

The hypothesis driving the West Norfolk intervention was that removing the CHC assessment (and checklist) totally from the acute hospital, and doing it once the patient has settled in the community having reached their optimum recovery from the acute period of illness, will translate into the following benefits:

I. Quicker discharge from hospital, thereby reducing risks associated with hospital admissions such as infections and falls and improved hospital operational flow, measured by reduced ‘excess bed days’;
II. A more reliable indication of long term care needs, that efficiently filters those patients who do not need a checklist. Thus long term health care needs are reflected more accurately.
III. A reduction in CHC cases due to improved recovery and independence as discharge fore-shortened the motor and cognitive skills decline associated with hospital admission in the elderly;
IV. A significant reduction in bureaucracy and workload for discharge nursing teams;
V. A higher satisfaction level among patients and families of the CHC assessment process.

The hypothesis therefore postulated that there would be an improved patient experience of hospital discharge as well as economic benefits to the health and social system.

Ethical approval was not sought for this study as it comes under the category of a small local service evaluation and therefore an application to the research ethics committee is not required. The intervention was universal, no patients were selected as ‘in’ or ‘out’ of the pathway and the study was simply an audit or evaluation comparing the evidence before and after the change.

4.1 Distinction between ‘Nursing’ and ‘Care’

Currently NHS nursing is free, social care is mean-tested. During the early exploratory work in this study, there was much debate between health and social care partners about the distinction between nursing and care needs. Frustration was expressed about the difficulty in defining this and the CHC checklist is most commonly used when there is any doubt. However, this often results in an over-zealous use of the checklist, which then commits staff to a statutory pathway which includes a full CHC assessment. The high rate of negative CHC eligibility following a positive checklist (90% in West Norfolk before the study), illustrates that people were inappropriately entering the pathway. A discussion about how to assist health and social care practitioners in judging who should have a CHC checklist was therefore initiated and explored at a ‘co-design’ event held in November 2015.
The following statements were tested during the design phase:

1. The difference in personal care provided by a social care worker and a health care assistant relates mainly to their care model of ‘promoting independence’ versus ‘treating’, as opposed to their qualifications and skills.
2. Therefore, if care can be met by either of these care workers, the patients could be said to have the same level of need.
3. ‘Care’ (as opposed to ‘nursing’) is that which could be given by a competent relative at home, with some instruction and support.
4. Patients who need the constant attendance and frequent intervention of a registered nurse, in excess of that provided by the periodic community nursing service, need ‘nursing care’.
5. ‘Nursing’ is that which could not reasonably be expected to be given by a relative because it involves making judgements, interventions and decisions based on nursing knowledge that a lay person could not be expected to have.
6. This includes mental health distress and extreme behaviour.
7. Where families need extra hours of care and support, but that care is at a level they could provide if there were a wide enough family network to cover, it is not ‘nursing’.

4.2 Outcomes

Having debated these statements fully in a multi-organisational forum, there was agreement that they were valid and provided a basis to assist judgement about which people should have a CHC checklist. As a result, a new dependency test called the ‘5Q Care Test’ was developed, whereby people’s needs are classified as ‘nursing’ or ‘care’ (see appendix 1).

It is important to state that this test does not in any way replace the CHC checklist or CHC assessment and does not alter patients’ rights to request a CHC assessment due to a change in their needs. The test was developed to assist practitioners to make a judgement about whether it is appropriate to initiate these assessments at a given point in time.

5. The intervention

5.1. The new CHC pathway from January 1st 2016

Following the ‘co-design’ event in November 2015, materials were collaboratively developed and approved by a joint health and social care committee. These included a care dependency test, a new pathway for hospital discharge and information for staff, patients and care homes. The hospital discharge liaison nurses ceased all CHC assessments and focussed on placing patients into appropriate community care following application of the new ‘5Q Care Test’.

This provided two routes out of hospital:
a) ‘5Q Care Test’ determines the patient has social care needs on discharge, which could be met at home or in a residential care home – hospital raises an assessment notice and discharge notice to social care. Any nursing needs can be met by the community nursing service.

b) ‘5Q Care Test’ determines the patient has nursing care needs which cannot be met by Social Services plus community nursing – patient discharged to an NHS funded community care setting appropriate to their level of need.

A CHC assessment is then conducted within 28 days following discharge, if deemed appropriate when the patient has reached optimal recovery.

- Theoretically, by 28 days post-discharge the full CHC assessments will more accurately predict on-going care needs, thereby avoiding the disappointment experienced by patients and families when a 3 month package is ended once the patient’s condition has improved.

- For people who are discharged to social care support and subsequently trigger a CHC assessment within 28 days and are found to be eligible, the NHS agrees to back-pay the family or Social Services for the month after discharge. If they become eligible at a later date, they will be treated as any Social Care placement that develops CHC eligibility.

The pathway is illustrated in Figure 3 below.

**Figure 3: NHS CHC new acute pathway**

There are 3 key elements to the intervention;

1. The ‘5Q Care Test’ which reliably predicts whether a patient is likely to need a checklist.
2. A new decision-making pathway, which separates ‘health’ (those who are likely to need a checklist) into fully funded NHS care and ‘social’ (those who are not likely to need a checklist) who will be supported by Social Services.
3. A comprehensive, multi-disciplinary CHC checklist conducted in the community setting by the CHC assessor along with a social worker, the care provider, the patient and family. If the checklist is positive, the evidence is used to populate the full ‘DST’ framework to complete a full CHC assessment, with all parties involved and agreeing the recommendation.
The new CHC hospital discharge decision-making tree which supports this pathway is illustrated in the flowchart at Figure 4.

**Figure 4: West Norfolk Complex Care needs discharge decision making tree**

- **5Q Care Test – Does the patient have complex substantial nursing needs?**
  - **No**
    - MDT agrees social care referral – documented in patient record
  - **Yes**
    - Discharge plan for nursing care to support optimal recovery

- **Social care package, (means tested) either re-ablement at home or in residential care with GP and community nurse input**

- **CHC checklist can be undertaken at any time if patient appears to have continuing complex care needs**

- **CHC Checklist and full assessment if indicated**
  - Regular 3 month then annual reviews of needs and package
  - Eligible – **NHS CHC funding awarded**

- **Not eligible for NHS CHC, considered for NHS ‘Funded Nursing Care’ and means-tested to contribute to care costs**

- **NHS fully funded appropriate community care for up to 28 days to allow recovery before assessment of long term needs**
5.2 Evaluation framework

The process for evaluating the study was designed to ensure accurate capturing of data to produce robust evidence of improved patient experience and economic benefit, in order to test the hypothesis. There were two types of data collected for this purpose; quantitative and qualitative. A health economist developed the purpose-built analytical framework and requested appropriate data from both health and social care partners.

5.3 Information governance

Patients were tracked by the practitioners who cared for them, thus avoiding issues of inappropriately sharing patient identifiable information and maintaining confidentiality. When data was requested for analysis, it was only necessary to identify the numbers who entered each arm of the new pathway and what happened to them, not who they were. Patients were identified as having been on the new pathway only at the point of inviting them to provide feedback on their experience.

6. Quantitative evaluation

6.1 Data and data sources

For the purpose of this study, a baseline analysis was conducted that aimed to capture the relevant variables needed to assess the pathway before the intervention took place. The terms ‘intervention’ and ‘new pathway’ are interchangeable in this context and refer to the CHC new acute pathway implemented in West Norfolk CCG. To compute the baseline variables three data sources were used: hospital monthly aggregated figures collected by nurses on check-listed and assessed patients, CHC data extracts from Broad Care (NHS CHC database) at patient level to track eligibility outcomes and costs, and hospital level ‘secondary user services’ (SUS) data to estimate excess bed days average costs. The period used for the baseline was January 2015 to July 2015, and the initial number of patients captured in the baseline was 178. These patients were considered suitable for a CHC checklist during their acute episode, thus marking the entry point to the pre-intervention CHC acute pathway.

In order to assess the cost-effectiveness of the intervention, two data sets were generated containing data fields which permitted the calculation of key variables. The first data set was populated by acute nurses and has been designed to capture events occurring to patients who had an acute episode and were considered suitable for a ‘5Q care test’. The second data set was populated by the CHC nurse assessor and aimed to capture events once patients were deemed as having ‘nursing needs’. A third data set was provided by Social Services teams to capture events associated to new intervention when patients took the ‘care needs’ route. The period of data collection was January 2016 to July 2016, and the initial number of patients captured was 195, i.e. those who had 5Q care test during their acute episode, and the entry point to the new CHC acute pathway.
Additional intelligence needed (e.g. such as survival estimates after CHC eligibility in an acute setting) to feed the pathway model specifically designed to evaluate the cost-effectiveness of the interventions was provided by the Commissioning Support Unit (CSU) CHC and Social Services analytic teams. Data to calculate estimated excess bed days average costs was provided by QEH analysts. The analysis was conducted only for West Norfolk CCG patients who were included in the new pathway for the period January to July 2016. Data flows were quality assured and validated during the data analysis phase to ensure the reliability of outputs.

6.2 Methodology

In order to determine the cost-effectiveness of the intervention for those patients registered in West Norfolk CCG who entered the new pathway via hospital admission, a probabilistic model following a beta distribution was constructed. A beta distribution allows the modelling of events that are constrained to take place within an interval defined by a minimum and a maximum value. The Beta probability density function for $X \sim \text{Beta} (\alpha, \beta)$ is given by:

$$f(X) = \frac{X^{\alpha-1}(1-X)^{\beta-1}}{B(\alpha, \beta)}$$

Where $B(\alpha, \beta)$ is the beta function with parameters $\alpha$ and $\beta$ given by,

$$B[\alpha, \beta] = \int_{0}^{1} X^{\alpha-1}(1-X)^{\beta-1} \, dX$$

Where $\alpha$ and $\beta$ are positive shape parameters and $X$ is a random variable between 0 and 1.

This probabilistic model takes the shape of a decision tree; the branches of the tree represent the flow of patients in each path. The decision tree maps all possible alternative flows and includes computations for the probability of events occurring at each chance node. The variables of the model are the parameter estimates from a probabilistic beta distribution calculated for the new and the old pathway captured in this study. The parameters are likely estimates that populate the chance nodes of the decision tree following a probabilistic distribution. Analytic techniques were used to calculate the parameters using the data sets previously described, as shown in Table 2.
Table 2: Intervention and pre-intervention parameters and chance nodes

<table>
<thead>
<tr>
<th>Pathways node</th>
<th>Description</th>
<th>Patients in chance node</th>
<th>Data parameter Alfa</th>
<th>Data parameter Beta</th>
<th>Parameter 1</th>
<th>Parameter 2</th>
<th>Pathway location of parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Node pn1</td>
<td>5O care test to health needs</td>
<td>195</td>
<td>34</td>
<td>161</td>
<td>17.4%</td>
<td>82.6%</td>
<td>pn1 = leading to pn2 and (1-pn2)</td>
</tr>
<tr>
<td>Node pn2</td>
<td>Checklist to full assessment</td>
<td>34</td>
<td>14</td>
<td>20</td>
<td>41.2%</td>
<td>58.8%</td>
<td>pn2 = leader to pn3 and (1-pn3)</td>
</tr>
<tr>
<td>Node pn3</td>
<td>Assessment to positive decision</td>
<td>14</td>
<td>2</td>
<td>12</td>
<td>14.3%</td>
<td>85.7%</td>
<td>pn3 = leading to b1</td>
</tr>
<tr>
<td>Node pn4</td>
<td>Die while waiting</td>
<td>20</td>
<td>17</td>
<td>3</td>
<td>85.6%</td>
<td>14.4%</td>
<td>pn4 = leading to pn5 and (1-pn5)</td>
</tr>
<tr>
<td>Node pn5</td>
<td>Die while waiting in NH</td>
<td>17</td>
<td>11</td>
<td>6</td>
<td>64.7%</td>
<td>35.3%</td>
<td>pn5 = leading to b3</td>
</tr>
<tr>
<td>Node pn6</td>
<td>SC die while in hosp</td>
<td>161</td>
<td>15</td>
<td>8</td>
<td>95.6%</td>
<td>4.4%</td>
<td>pn6 = leading to pn3 and (1-pn7)</td>
</tr>
<tr>
<td>Node pn7</td>
<td>SC funded package</td>
<td>153</td>
<td>78</td>
<td>75</td>
<td>51.6%</td>
<td>49.4%</td>
<td>pn7 = leading to pn6 and (1-pn8)</td>
</tr>
<tr>
<td>Node pn8</td>
<td>In caseload after 2 months</td>
<td>78</td>
<td>59</td>
<td>28</td>
<td>64.1%</td>
<td>35.9%</td>
<td>pn8 = leading to b6</td>
</tr>
</tbody>
</table>

Pre-intervention parameters and chance nodes (old pathway)

<table>
<thead>
<tr>
<th>Pathways node</th>
<th>Description</th>
<th>Patients in chance node</th>
<th>Data parameter Alfa</th>
<th>Data parameter Beta</th>
<th>Parameter 1</th>
<th>Parameter 2</th>
<th>Pathway location of parameter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Node po1</td>
<td>Checklist to health needs</td>
<td>178</td>
<td>57</td>
<td>121</td>
<td>32.6%</td>
<td>67.4%</td>
<td>po1 = leading to po2 and (1-po2)</td>
</tr>
<tr>
<td>Node po2</td>
<td>Checklist to health</td>
<td>57</td>
<td>42</td>
<td>15</td>
<td>73.7%</td>
<td>26.3%</td>
<td>po2 = leading to po3</td>
</tr>
<tr>
<td>Node po3</td>
<td>Health to eligibility</td>
<td>42</td>
<td>16</td>
<td>26</td>
<td>38.1%</td>
<td>61.9%</td>
<td>po3 = leading to b10</td>
</tr>
</tbody>
</table>

Note: The table shows the number of patients included for the computation of the parameters in each chance node that populates the decision tree. For example, node pn1 shows the probability estimate of having a ‘nursing care need’ for those patients entering the new pathway (34 out of 195). Node 1-pn1 represents the probability estimate of having a ‘social care need’ (161 out of 195). All other chance nodes have been calculated in the same manner.

The decision tree is formed by many branches, which reflect patient flow estimates. For each branch, the average unit cost was calculated and then multiplied by the number of patient estimates to obtain the total cost. The total costs of all branches was added to calculate either the health or social care cost corresponding to the old and new pathway, i.e. the key outputs of the model. Table 3 shows the average unit cost for each branch of the model. A partial visualisation of how the model works in practice is captured in Figure 5.

Table 3: Pathway costs

<table>
<thead>
<tr>
<th>Pathway branch</th>
<th>Avg. excess bed cost</th>
<th>Avg. nursing bed cost</th>
<th>Avg. CHC care Package</th>
<th>FNC</th>
<th>Av. Social Care cost</th>
<th>Readmission</th>
<th>Avg. unit cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branch 1 - CHC eligible</td>
<td>£ 1,482</td>
<td>£ 2,224</td>
<td>£ 29,386</td>
<td></td>
<td></td>
<td></td>
<td>£ 33,092</td>
</tr>
<tr>
<td>Branch 2 - CHC not eligible</td>
<td>£ 1,482</td>
<td>£ 2,224</td>
<td>£ 4,167</td>
<td></td>
<td></td>
<td></td>
<td>£ 7,873</td>
</tr>
<tr>
<td>Branch 3 - Die in nursing home</td>
<td>£ 1,482</td>
<td>£ 1,088</td>
<td>£ 1,482</td>
<td></td>
<td></td>
<td></td>
<td>£ 2,570</td>
</tr>
<tr>
<td>Branch 4 - Die in hospital</td>
<td>£ 1,482</td>
<td>£ 1,482</td>
<td>£ 1,633</td>
<td></td>
<td></td>
<td>£ 2,700</td>
<td>£ 5,815</td>
</tr>
<tr>
<td>Branch 5 - Readmission</td>
<td>£ 1,482</td>
<td>£ 1,633</td>
<td>£ 2,700</td>
<td></td>
<td></td>
<td></td>
<td>£ 5,815</td>
</tr>
<tr>
<td>Branch 6 - Funded SC long</td>
<td>£ 1,482</td>
<td>£ 3,616</td>
<td>£ 17,628</td>
<td></td>
<td></td>
<td></td>
<td>£ 17,628</td>
</tr>
<tr>
<td>Branch 7 - Funded SC short</td>
<td>£ 4,232</td>
<td>£ 3,616</td>
<td>£ 3,616</td>
<td></td>
<td></td>
<td></td>
<td>£ 3,616</td>
</tr>
</tbody>
</table>

Note: The table shows the average cost per patient of each branch in the decision tree. For example, for patients in branch 1 (those who are CHC eligible) the cost computation is the sum of the different cost elements: the average excess bed days in hospital, the average nursing bed cost while being assess, and the CHC package estimate while being in the CHC caseload. The sum in this case is £33,092 per patient.
Figure 5: Partial visualisation of how the model works (example of one bootstrapping estimate)

Note: This figure is a graphical representation of how the model works in practice. Parameters and number of patients are included, as well as output estimates and the unit costs in each branch. The Monte Carlo simulation captures 1,000 output estimates from this model and from those computations the cost difference between the old and the new pathway is calculated.

Branches 1 to 5 in the new pathway are the ‘health outputs’ and branches 6 to 9 are ‘social care outputs’. The branch terminations have been colour coded, where red denotes a health branch and blue a social care branch. The old pathway follows the same format, however, note that it does not include costs or pathway branches associated to social care flows, as the baseline data was not available. This is discussed further in the limitations section.

The model outputs fed a Monte Carlo simulation which generates 1,000 bootstrapping estimates (resampling), computed using a macro in an excel spread-sheet. The results were
used to calculate the cost difference between the new and old pathway. This is a method that explicitly and quantitatively represents uncertainty, i.e. the result of this type of analysis based on inputs represented by probability distributions (Beta in this case) is in itself a probability distribution. The statistical significance of the difference was calculated using a pool variance t-test.

The computation of health costs included three key elements that directly impact on the cost-effectiveness of the intervention: hospital costs (excess bed days and readmissions), post-discharge costs (nursing home fees) during intervention and CHC package or FNC costs. Social care cost components only included the cost of social care packages. Resources used to conduct the intervention have been excluded from the analysis. Estimated death rates in the old pathway occurring while individuals were waiting for checklist or assessments were derived from detailed data obtained in the new pathway as previous records only reflected individuals who had a checklist (note that some patients died while waiting for a checklist) and assessed patients that had an eligibility output.

### 6.3 Results

Evidence from the analysis suggests that there is a £562k statistically significant ($p < .001$) cost difference between the old and the new pathway favouring the intervention. This figure reflects the health cost difference for the period January to July (note the study is ongoing) incurred from patients entering the intervention via QEH admission, 178 in the old pathway and 195 in the new pathway. The average cost estimate for the old and new pathways are £781K and £219k respectively. The major component leading to the cost difference was given by the substantial decrease in CHC positive eligibility decisions since patients were quickly referred to suitable services as a result of the intervention.

Zero Delay Transfers of Care due to CHC funding decisions were reported in this period as well as reductions in excess bed days (which have been included in the cost component of the pathway as average costs estimates per patient), thus relieving operational hospital pressures that translated into system operational efficiencies. A reported 81% reduction of checklists, from 178 to 34, was also noted.

Additional analysis has been conducted to estimate the probabilities associated to cost difference estimates from the model, as illustrated in Figure 6. This is an important feature of the evaluation as it describes the probability range associated to cost savings when the parameters of the model take different values, the worst cost saving scenario is around £300k and the best cost saving is £850k with probabilities of 0.98 and 0.05 respectively. This could serve as a guide when making inferences to other health economies. The curve in Figure 6 shows that, for example, a cost difference of £300k favouring the new pathway has a 0.98 probability of occurrence, whilst a cost difference of £500k favouring the new pathway has an associated probability of 0.66. Probability parameters are positive, with
values between zero and one. Inferences concerning system effects in other health economies testing this intervention should be carried out at hospital level for the purpose of facilitating comparability. This will be further explained in the replicability.

Figure 6: Curve showing associated probabilities of cost differences between the old and new pathway occurring

![Probability curve](image)

Note: This figure shows the probabilities associated to difference cost differences between both pathways. For example, the probability estimate of the new pathway generating a saving of £450k is 0.79.

The average Social Care costs associated to the intervention has been estimated to be £983k based on information provided by Social Services. Due to the lack of baseline data, which Social Services had been unable to provide, it was not possible to calculate the cost of the old pathway; however, finance scrutiny and activity data comparisons between the same months in 2015 suggests that the intervention did not have an adversely material impact on social care costs. Table 4 details the monthly referrals for social care packages in 2015 compared to the intervention period in 2016.

Table 4: West Norfolk Social Care referrals
The social care components of the pathway are modelled in branches 6 to 9 of the analytical framework and, as before, reflect costs estimates associated to patient flows. Note that a substantial number of people died while in hospital or shortly after a funding allocation has been agreed; nodes pn6 and pn7 reflect those proportions. This is to be expected for this cohort of patients but had not been tracked previously.

Some descriptive statistics obtained after running the simulation are shown in Figure 7. These figures reflect social care costs linked to the implementation of the new pathway and may serve as a reference for future decision making in relation to this intervention. The level of precision around the ‘point estimate’ is determined by the confidence interval. The picture shows that the confidence interval is small, which means the likely social care costs of implementing this pathway will be close to this value. The key determinants of social care costs are given by the parameter estimate of people who are in the caseload and the life expectancy of those people in the case load as a high proportion seem to die within a short period after assessment. The standard deviation and standard error are measures of dispersion, and useful to assess how far the data points are from the mean value. The confidence level, also called margin of error, shows the likelihood that the result from a sample is close to the number one would get if the whole population had been queried. These descriptive statistics provide a likely expectation of results for other studies that may be conducted.

**Figure 7: Descriptive statistics of Social Care data and pictorial representation of confidence intervals**

<table>
<thead>
<tr>
<th>Social Care statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>Standard Error</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Standard Deviation</td>
</tr>
<tr>
<td>Sample Variance</td>
</tr>
<tr>
<td>Range</td>
</tr>
<tr>
<td>Minimum</td>
</tr>
<tr>
<td>Maximum</td>
</tr>
<tr>
<td>Count</td>
</tr>
<tr>
<td>Confidence Level (95.0%)</td>
</tr>
</tbody>
</table>
7. Qualitative evaluation

Qualitative data were collected through interviews. It was important to ascertain the experience of those administering the new CHC pathway and those who were undergoing it, in order to determine whether there were any perceived negative effects that should be considered along with the quantitative results. Since the original reason for reforming the pathway came from negative feedback from families and staff, it was important to document any impact, positive or negative, that the new pathway might have. Stakeholder and user experience contributes to service quality improvement and is a key component when evaluating a quality improvement initiative. Therefore West Norfolk CCG wished to capture the views and experiences of patients, family carers and health and social care professional regarding the intervention pathway and invited Healthwatch Norfolk to do so on their behalf, to ensure impartiality and to give staff freedom to express their views without reserve. Some of these staff had been in their role before the pathway commenced, others had not. All staff were free to refuse to take part and the results would be presented in an aggregated anonymous format, to reduce the likelihood of attribution of remarks to an individual.

For patients and families, experiences are especially pertinent at four decision points (stages) on the intervention pathway:
For the purposes of inviting CHC patients, services users and families to participate in giving feedback, Healthwatch Norfolk created a patient pack containing:

- A letter of introduction from Dr Sue Crossman, Chief Officer of West Norfolk CCG asking patients and/or their family members and carers if they would share their experiences of the CHC care pathway (see Appendix 2)
- An information sheet explaining the purpose of the evaluation and voluntary nature of participation and a consent form (see Appendix 3a & 3b)
- A leaflet about Healthwatch Norfolk
- A stamped, addressed envelope for returning the consent form

In order to maintain the confidentiality of CHC patients and their next-of-kin, the assistance of the CHC Team of the NEL CSU and the Hospital Social Work Team at the Queen Elizabeth Hospital was sought in identifying the next-of-kin of those patients recently discharged from the hospital on the new, intervention CHC pathway. Ready-prepared, postage-paid, patient packs were delivered to the NEL CSU CHC team and hospital social work team in the Queen Elizabeth Hospital King’s Lynn, where the teams added the names and addresses of individuals and posted the packs out.

Those individuals wishing to give feedback were requested to complete and return a consent form, giving their name and their preferred means for Healthwatch Norfolk to make contact with them (e.g. by telephone, post, email etc.). Therefore, the identities of individuals concerned remained unknown to Healthwatch Norfolk unless a consent form was returned. Upon receiving a consent form, the patient’s next-of-kin were contacted according to their preference as indicated and a suitably convenient date arranged for an interview.

West Norfolk CCG proposed a brief list of questions aligned to the four key decision points on the CHC intervention pathway as set out in Figure 1. These questions asked patients and/or their families about:

- the experience of leaving the hospital
- satisfaction with the care received after discharge
- the Continuing Healthcare Assessment
- what happened next

After gaining consent, the interview was digitally recorded and a clean verbatim transcript prepared.

The initial scope of the qualitative evaluation was widened to incorporate gathering views and experiences from health, social care and care home professionals involved in patient care on the intervention pathway. We were given a list of health and social care
professionals involved in the development of the intervention pathway by the West Norfolk CCG and the NEL CSU supplied a list of care homes that had recently accepted CHC patients on the new pathway. West Norfolk CCG proposed questions (please see Appendix 4) to be asked of health care, social care professionals and the managers of care homes that covered:

a) understanding the reasons for making the change to the CHC pathway
b) how well the new pathway has addressed previous issues
c) opportunities to influence the pathway
d) the expressed experience of patients and families on the pathway
e) strengths and weaknesses of the new pathway
f) further improvements that could be made

Health and care were contacted and a suitably convenient date arranged for a telephone interview to take place. Notes detailing the responses of staff were recorded during the interview using a standard template constructed from the question guide (Appendix 4).

7.1 Results

7.1.1 CHC patients, service users and family members

The CHC Assessors and hospital based social workers sent 26 patient packs by post on behalf of Healthwatch from which two responses were received. One telephone interview with the next-of-kin of a person on the CHC health pathway was conducted and transcribed to a clean verbatim text. A second response received indicated that the next-of-kin declined to be interviewed as they felt they could not adequately represent the patient. No further consent forms were received from patients or family members.

Healthwatch chose not to include the one interview in the evaluation; this is not in any way to diminish the importance of this individual’s experience but it could not be viewed as a representative experience of 26 patients (or families). The exclusion is purely to avoid bias. The experience of this family member is a valuable piece of service feedback that can be anonymised and reported through the usual Healthwatch Norfolk and WN CCG channels.

7.1.2 Health care, social care and care home professionals

In total, 12 health, social care and care home professionals were interviewed between September and November 2016. This was after the early quantitative results had been shared within the team.
a) Reasons for change

In the hospital settings, respondents gave the following as their understanding for the reason behind making the change to the intervention pathway:

- addressing the length of patient stay in hospital (reducing length of stay and associated costs)
- amount of time taken to conduct a full assessment i.e. 10 clinical hours plus completion of 80-90 pages of paperwork (lengthy process which impacts upon the ability to discharge an otherwise medically fit patient and consumes capacity for clinical care)
- previous system was time consuming and cumbersome
- amount of precise/exacting evidence required to be collated to support the assessment
- increasing accuracy of evidence/reducing artificiality of evidence based upon a hospital environment as opposed to a more ‘normal’ home or community environment
- reducing the length of stay in patients with high dependency for whom a hospital bed/ward is not their best interests

b) Addressing the need for change

Respondents were asked how well they thought the intervention pathway was addressing the need for change. We were given the following examples:

- Removes the requirement to conduct the full assessment of a patient whilst they are in a hospital environment
- Reduces the artificiality of evidence (which is temporarily influenced by the hospital environment)
- Enables the patient to be assessed in a more ‘normalised’ setting
- Frees up more time for ward staff and the discharge planning team
- Decreasing the overall length of stay
- Hard to manage patient and their families expectation of future care/CHC
- In the ward environment, interaction with families could be difficult and confrontational at times

“to enable the NHS continuing healthcare assessment to take place outside of the hospital within 28 days to allow the patient to stabilise and to free up the hospital bed and the assessment time (previously conducted by the discharge planning team)”

“this isn’t about not having Continuing Healthcare, this is about not having the assessment in hospital”
- Removes the possibility that the patient could become unwell again during the period of assessment with a subsequent impact/influence on the assessment process
- Reduces the likelihood of assessing a patient demonstrating challenging behaviours as a result of an acute infection affecting their cognitive ability
- Addresses the need to find a non-prejudicial environment for assessment to take place
- For very ill patients nearing end of life, fewer deaths take place in the hospital care setting (many patients express a wish to die at home)
- The hospital-based assessment intensified the likelihood the process would develop into a disagreement over ‘who is paying for care?’
- Fewer instances where patient’s families are confronted with the potential scenario of paying for care e.g. up to £800 a week whilst simultaneously having to deal with the pressure to discharge the patient to a more appropriate care setting

c) Influencing development of the pathway

The development of the pathway is seen as an example of change management and some individuals are quicker to embrace change than others. There has been some resistance to the new pathway but this is described as improving recently. It is difficult, however, to qualify a general view of adoption of the interview pathway; as some describe a feeling of acceptance and others a feeling of resignation.

The hospital discharge team were the most enthusiastic about the intervention pathway, describing regular and meaningful opportunities to engage in the development of the new pathway. For this team, from the onset, they have been able to comment on and shape the new pathway using their clinical knowledge and professional experience of the discharge process and assessment of a patient’s needs. Others had been afforded the opportunity to comment on and to develop particular aspects of the new pathway such as the setting for assessment. Some individuals – predominantly those in care home and social care services - said that they had received regular updates and/or had been involved in regular meetings with the project team but felt they had not been able to influence aspects of the pathway as it developed. Social care professionals described being regularly involved with project meetings and having the opportunity to raise queries and concerns which were listened to and thoroughly challenged and at times, agreed. On a practical level, some of the points agreed were not well communicated to all professionals involved in the CHC pathway and consequently were lost.
### d) Perceived strengths and weaknesses of the new pathway

<table>
<thead>
<tr>
<th>Intervention pathway</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Adheres to guidance on CHC – CHC assessment is best done in the patient’s ‘normal’ i.e. home environment</em></td>
<td><em>Criteria too rigid, excluding complex individuals who do not have nursing needs</em></td>
</tr>
<tr>
<td><em>Reduces patient’s length of stay – average length of stay is much shorter</em></td>
<td><em>People with severe dementia but without a nursing need may be disproportionately affected even in the early stages of the new pathway, as these individuals do not meet the criteria used</em></td>
</tr>
<tr>
<td><em>Quicker transfer of patient to more appropriate care setting which meets their needs i.e. high dependency</em></td>
<td><em>Restricts the opportunity to raise concerns/query the appropriateness of a 28 day residential care package for individuals whose needs are too complex to be met in a residential care setting causing an avoidable delay in hospital discharge</em></td>
</tr>
<tr>
<td><em>Patients can be discharged within 2-3 days</em></td>
<td><em>Introduced a new effect of screening out some individuals who would usually have benefitted from health funding on discharge. Most notably, those individuals with complex mental health needs or behavioural difficulties who are difficult to accommodate</em></td>
</tr>
<tr>
<td><em>Patients are discharged into an assessing environment</em></td>
<td><em>Where individuals have not triggered the new pathway, their stay in hospital has often been lengthy as before</em></td>
</tr>
<tr>
<td><em>Speedier referral to social care</em></td>
<td><em>The social care staff report a significant increase in demand on their time</em></td>
</tr>
<tr>
<td><em>The new pathway allows people to attain optimum health before assessment</em></td>
<td><em>Removing the NHS CHC ‘checklist’ has also removed parity with other localities and with assessments undertaken in the community</em></td>
</tr>
</tbody>
</table>

**“the new pathway makes it easier to ask the question ‘can this person’s care needs be managed in the community?’ ”**

### e) Further improvements

Some staff thought that the pathway appeared to be working well and could not articulate any further refinement needed at this stage. A majority felt that that there was a need to educate the public about CHC and was were doubtful of the quality and accuracy of publicly-available information on ‘entitlement to CHC’. As this can be so variable, it leads to raised expectations in patient’s family members e.g. families find information on the AgeUK website, medical legal advice websites etc. which they interpret as telling them their relative has an entitlement to CHC, as opposed to the entitlement to a CHC assessment.
Some felt that the pathway needed further refinement and to the extent of a complete redesign with the full involvement of Norfolk County Council, in order to ensure equity of access to a care pathway for all people with complex needs. Such a redesign would need to be truly undertaken in partnership between health and social care rather than presented as an initiative that was going to happen no matter what. Some thoughts that it would be helpful to reinstate the NHS CHC checklist to provide some parity with other localities and with assessments undertaken in the community, as this can lead to inequity of access and service provision for patients purely depending on where they live.

Care home staff, as a group, expressed some dissatisfaction with the existing financial and contractual arrangements for the intervention CHC pathway. One care home manager described the brevity of stay for one resident admitted to the care home for an anticipated 28-day stay that, due to a speedy assessment, fell to a 5-day stay. Another said they wanted to support the initiative more than they had done so to date but were holding back until a more tightly-specified contract was in place.

In view of the number of older people with dementia, the intervention pathway could be reviewed in respect of how well it meets their needs (or not). Some staff said that the needs of patients deemed to be ‘fast-track’ have not always been fully considered and that their needs could be looked by an alternative member of the hospital team.

f) Expressed experience of patients and families

There were mixed views and observations on the expressed experience of patients and families.

In the hospital setting, patients and families appear to have accepted the new pathway in that the assessment no longer takes place in hospital. The expressed experience of families whose loved ones were on the intervention pathway was described as having improved. Previously, discussions with family members regarding CHC for a patient would be influenced by the length and complexity of the CHC assessment when conducted in the acute setting alongside the urgency of having to arrive at a decision and arrange an appropriate discharge with the right kind of care. We were told that the number of incidents involving family members becoming upset, angry and confronting staff about the outcome of a CHC assessment had reduced. Fewer family members were having to make rushed decisions about long term care for the patient before the patient left the ward environment and subsequently, there was reduced pressure to find money very quickly for those who were not eligible for funded care.

Some staff thought some older people in particular retain a particular view of the NHS providing convalescent care, however, this type of care is now offered in other, community settings e.g. at home, in care homes. The nature of convalescence care has changed but in
general the public’s understanding of it has not yet caught up the reality of care delivery. Some families carry out a lot of their research into CHC and a proportion have high expectations of an entitlement to CHC (sometimes conflating an entitlement to assessment with an entitlement to CHC).

Other staff who have been involved in attending assessments of ‘28 day’ health-funded care packages said that patients and their families describe a limited understanding of the pathway up until the point of the full NHS continuing healthcare assessment meeting. The families of patients who have the ‘28 day’ health-funded beds are often not informed that they can appeal against a decision, if the outcome is not for the award of NHS continuing healthcare. This is feedback from social workers who have attended to carry out the assessments in the ‘28 day’ health funded beds.

8. Discussion

The quantitative results of this study suggest that the West Norfolk Continuing Health Care hospital discharge pathway has improved patient outcomes, reduced health costs and facilitated hospital discharge without affecting patients’ rights under the NHS CHC Framework and without any adverse impact on social services demand. The financial impact is statistically significant, demonstrating with a high degree of confidence that the savings are due directly to the intervention. This may be of interest to other health and social economies wishing to scrutinise the efficiency and quality of their CHC pathways.

The qualitative results suggest mixed views from participants about the intervention and this seemed partially related to whether they were health or social care staff. Health staff perceived there were benefits to patients as posed in the hypothesis, namely

I. Quicker discharge from hospital, thereby reducing risks associated with hospital admissions such as infections and falls and improved hospital operational flow, measured by reduced ‘excess bed days’;

II. A more reliable indication of long term care needs, that efficiently filters those patients who do not need a checklist. Thus long term health care needs are reflected more accurately.

III. A reduction in CHC cases due to improved recovery and independence as discharge fore-shortened the motor and cognitive skills decline associated with hospital admission in the elderly;

IV. A significant reduction in bureaucracy and workload for discharge nursing teams;

V. A higher satisfaction level among patients and families of the CHC assessment process.

These perceptions were only partially shared by social care staff, who cited negative aspects to the pathway that were not entirely clear as there was no documented evidence relating
to their concerns. On balance, the intervention achieved the goals set out but latterly, there was a negative response from social care staff to the emerging data and the pathway process which had been previously working smoothly and with good collaboration from all parties. There were no complaints at all received by health and social care relating to CHC during the study period.

Introduction of the new pathway in West Norfolk was challenging, with significant preparatory work in shaping the proposal, airing practitioners’ concerns, amending the pathway and clarifying duties and responsibilities, to ensure that all partners were comfortable that the pathway was compliant with the National Framework and their own organisation’s requirements. If not pro-actively managed, this had the potential to derail the whole pathway from the outset and therefore reduce the benefits to the patient and system as a whole. This is unsurprising, as the CHC assessment is extremely complex and practitioners are often anxious about understanding and accurately adhering to the Framework. The fact that historically there have been so many legal challenges to CHC assessment decisions is likely to have a compounding effect. However, once established, all partners were in agreement that the pathway demonstrated significant benefits for patients, the workforce and the economy. Regular meetings were conducted with staff involved in the implementation of the pathway. The meeting facilitated troubleshooting, making the required adjustments to the new pathway where people expressed their views and provided continuous feedback on progress. This forum also discussed particular cases and provided solutions to complex situations.

8.1 Social Services perspective
Social Services colleagues were engaged with the design and development of this study from the outset. Crucially, there was a consensus at the November co-design event that the previous CHC process did not support patients to achieve optimal outcomes and that there were significant drawbacks across the health and social care system in effectiveness and efficiency. There was therefore a shared willingness to think differently and vitally, senior support to adopt the approach set out in this study in alignment with the Council’s Promoting Independence Strategy. This view extended to local management and operational colleagues who have participated in fortnightly project meetings throughout the course of the study.

Nonetheless, the significant changes introduced through this study have presented several challenges to practitioners. Concerns were raised by Social Services during the exploratory phase, that the proposed pathway might adversely affect people’s rights to a CHC checklist and therefore their opportunity to receive CHC funding. This was fully discussed in relation to the National Framework, best interests of patients, local flexibility and trust between hospital-based health and social teams. In practice, there is always a cohort of patients who will be discharged to social care who do not have a CHC checklist carried out because it is
clear their needs relate to social care only. The more complex a patient’s needs are, the more difficult it becomes to make this judgement and there will be a group for whom a CHC checklist provides a means of assessing this. However, as discussed earlier, when conducted in hospital this judgement is frequently misleading, resulting in a positive checklist but an ineligible outcome to the full CHC assessment. The new intervention therefore attempted to determine which group of patients fall into this category and to identify their needs accurately using an alternative judgement support process that did not inappropriately place patients on a statutory CHC assessment pathway. It was thus agreed that the intervention did not affect the patient’s right to a checklist it just delayed any checklists until after discharge. The outcome of this was an agreement between health and social care to introduce the new pathway, accept the ‘5Q Care Test’ as a filter to discharge patients to the appropriate care setting to meet their immediate needs and to examine very carefully any potential negative impact on patients and families rights at any point in the pathway. This was discussed at the fortnightly review meeting with front-line practitioners and senior health and social care managers, where anonymous individual cases were reviewed and the social work team were consistently reassured that any patient on the ‘social pathway’ could trigger a checklist at any time if those providing their care felt it was appropriate.

Other concerns expressed by Social Services colleagues included the transfer of CHC assessments to the community setting, as these had to be covered by the hospital social work team. Although the number of hospital assessments had been significantly reduced (approximately 15 full CHC assessments and MDT meetings plus paperwork per month), the social work team did not perceive the same reduction in work pressure as the discharge nursing team. The reasons for this are not clear but it remains an important perception that influenced the way the new pathway was viewed by different practitioners. Since the new pathway was introduced, there are approximately 5 CHC check-lists and full assessments (conducted at the same time) per month carried out in the community setting. The Social Services management team are currently looking at how to redeploy team resources to cover these within the community team rather than asking the hospital team to out-reach and this should ease the burden on the hospital team.

Another issue related to the transfer of care for those patients who had a negative CHC eligibility following their assessment and were in a Care Home which charges fees in excess of the current Social Services standard rates. This issue, which is not confined to this study, is being addressed via the development of a community flowchart process that incorporates some flexibility in the timescales for funding transfer to ensure this is managed appropriately and safely for the patient. This is also a feature of many ‘Discharge to Assess’ schemes elsewhere in the country, where patients are placed in a Care Home after discharge but need to move somewhere else after their CHC assessment.
During the period of this study, after the new pathway had been running for several months, there was a change in the social worker management hierarchy at hospital, locality and director level. This undoubtedly had an impact on the project as the new managers had not been part of the original co-design and did not therefore have the same level of engagement and confidence in the practical application of the new pathway. This resulted in concerns being raised and escalated through the social services management at a late stage in the pilot period and a subsequent deterioration in the cooperation and trust between health and social care colleagues. The learning from this is that new members of staff should be thoroughly inducted to the pathway, with the opportunity to work through their concerns in the same way that the originating team had done, otherwise their concerns are likely to grow. Nonetheless, there remains a strong commitment from Social Services, at senior and operational levels, in the principles that underpin the changes that have been introduced through the study. The consequences of the differences around health and social care perceptions needs to be viewed in the overall context of the positive impact of the intervention and the fact that there were no CHC complaints received by either health or social services during the study period.

8.2 Practical considerations

The ‘5Q Care Test’ pathway effectively de-couples the CHC process from hospital discharge, relying on nurses and social workers to assess patients and place them in a care setting that best suits their needs on discharge. At any time during this process, they can have a checklist if those providing the care feel it is appropriate.

The National Framework offers conflicting advice by recommending doing the CHC assessment after discharge as well as recommending doing the checklist in hospital, which creates the imperative to complete the full CHC assessment process within 28 days. If the checklist is conducted in hospital, due to its sensitivity, a large proportion of those with a positive checklist will end up in a nursing care setting with the false hope of CHC funding. This is not a good outcome for patients.

8.3 Comparison with conventional 'Discharge to Assess' schemes

These schemes typically move a whole cohort of 'positive' CHC check-listed patients from the acute setting to a care home to have the full CHC assessment\textsuperscript{16,17,18,19}. While this facilitates early hospital discharge, it does not reduce inappropriate checklists nor manage patient and family expectations. ‘Home First’ is a national initiative, recommended in the newly published Emergency Care Improvement Guidance from NHS England\textsuperscript{20} to discharge people directly home, providing the care they need immediately and conducting longer term care assessments from home. This philosophy aligns well with the West Norfolk CHC pathway and indeed ‘home’ is one of the categories of the health route in the pathway. Practically, most of the patients in the pathway are assessed as needing residential care due to the intensity of their needs but ‘home’ is always the first consideration.
8.4 Limitations of the West Norfolk pathway

The main limitation of this study is the small size of the cohort. Despite the sensitivity of the analytical tool used, the pathway should be tested in larger population groups. To this end, discussions are underway with neighbouring CCGs as well as the national Integration Pioneer sites, to explore testing the pathway in these additional areas. Some of the limiting factors found to affect the effective running of the pathway in West Norfolk included:

1. CHC assessors and social workers have to be flexible enough and have capacity to do the assessments in the community. This is off-set by the reduction in time previously spent doing them in hospital, so staff could be redeployed or investment in teams moved.
2. Community resources have to be adequate to support early discharge and this is a national priority as part of the emergency care improvement plan, supporting 'Home First' and rapid response admission avoidance.
3. Availability of baseline social care data is essential to provide accurate, attributable evidence of any impact of the pathway on activity and finance. To do this, the pathway requires prior information on Social Services hospital discharges, to be able to compare the size, costs and outcomes for this group post-intervention. This data was not routinely collected by Social Services in West Norfolk prior to the study.
4. Some of the patients in the hospital in this study came from neighbouring County Council areas. Their differing levels of willingness to accept the ‘5Q Care Test’ as a notice for discharge posed a problem which had to be addressed.

8.5 Key ingredients for replicability

If the introduction of this pathway is to be considered in other geographical areas, the following key elements should be addressed ahead of introducing the pathway.

a) Early and comprehensive stakeholder and public involvement to achieve a shared understanding of the problems and a collective energy for change
b) Clinical teams trained in the application of the ‘5Q care test’
c) Good coordination of patient transitions between settings
d) Senior sponsorship and clinical champions
e) Analytic capacity and data sharing mechanisms
f) Robust project management in place

To facilitate the estimation of potential financial savings associated with introducing the model, Table 5 illustrates the expected savings per 10,000 hospital discharges.
Table 5: Study comparators for replicability

<table>
<thead>
<tr>
<th>Marker per 10,000 population</th>
<th>Hospital discharges &gt;60 years old</th>
<th>5Q test</th>
<th>Checklist</th>
<th>CHC eligible</th>
<th>Expected Health savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Norfolk CCG patients</td>
<td>18500</td>
<td>195</td>
<td>34</td>
<td>2</td>
<td>£562,000</td>
</tr>
<tr>
<td>Marker per 10,000 population</td>
<td>10000</td>
<td>105</td>
<td>18</td>
<td>1</td>
<td>£303,784</td>
</tr>
</tbody>
</table>

Table 4 shows the key markers of the study associated with efficiency savings. For every 10,000 acute discharges of people 60 years old and over, the expectation is that around 105 5Q tests will be conducted leading to 18 checklists and one CHC eligible patient. These figures are approximate estimates and a range of values may be expected if the acute CHC new pathway is replicated in other health economies. Sensitivity analysis associated with efficiencies when the coefficients vary should be included in a wider study.

Whilst the preparatory work for introducing the pathway in West Norfolk was considerable, this included the conception and co-design of the scheme and this would clearly not be necessary in another health and social system. However, in order to maximise the success of the pathway, whole-system involvement in exploring and implementing the scheme is essential.

9. Conclusion and recommendation

Evidence from this study suggests that the introduction of the new CHC pathway is cost-effective and has improved outcomes for family and patients. The hypothesis posed has been supported namely that removing the CHC checklists and assessments from the hospital setting, replacing them with a test which filters those that should have a CHC assessment into a health funded pathway, and conducting the assessment in the community once people have regained optimum recovery produced benefits in terms of patient experience and cost-efficiencies. No complaints were received by either health or social care related to CHC during the study period.

The results from this local study may be replicated in other health and care economies wishing to address quality and economic problems in their CHC service and this would provide further data about the effectiveness of the model. The economic impact analysis
framework described in the study provides a range of financial savings with a probability value that may be applied to different settings.

Careful preparation, stakeholder engagement and collection of high quality data for establishing a baseline and capturing any impact specific to the intervention are all essential to successful implementation of such an initiative and the learning from this study provides some insight into the importance of addressing these.

The recommendations from this study are:

1. The reliability of the 5Q Care Test in determining accurately which patients should have a CHC check-list should be tested in a wider population and in the community setting
2. The benefits demonstrated in this study need confirming in different health and social care economies
3. Community capacity to undertake CHC assessments should be enhanced to allow for the transfer of this function out of hospitals
4. Health and Social Care partners should negotiate the terms of any similar pilot with a written Memorandum of Understanding to ensure all parties fully understand and agree to the process, particularly including collecting high quality data.
References

7. All party parliamentary group (2014) Failing to Care; https://www.parkinsons.org.uk/sites/default/files/failingtocare_appgfullreport.pdf accessed 15.9.16


Appendix 1

Care and Nursing needs assessment – ‘5Q Care Test’

Continuing Health Care (CHC) assessments are no longer carried out in hospital. There is still a need to
determine whether patients who are ready for discharge have ‘care’ or ‘nursing’ needs in order to provide the
appropriate health or social care support. This assessment tool is to be used to support the decision and must
be approved by the Discharge Planning Nurse Lead.

(1) Could the patient’s care be given by a competent relative at home, with some instruction and support?
YES/NO

Describe your evidence for this:

(2) Could the patient’s care be provided in a residential care home with community nursing support?
YES/NO

Describe your evidence for this:

(3) Is intervention from a nurse needed because the care required by the patient involves making judgements
and decisions based on **clinical knowledge** that a carer could not be expected to have?
YES/NO

Describe your evidence for this:
(4) Is close supervision by a nurse needed due to the risk of patient harm if not provided? (This includes severe mental distress and extreme behaviour.)

YES/NO

Describe your evidence for this:

(5) Is a nurse is required to supervise, train and delegate the care of a patient, whilst maintaining accountability for the delivery of that care by a person they deem competent?

YES/NO

Describe your evidence for this:

Can care be met by social care with community nursing support? YES/NO

If YES, refer to social work team

If NO, refer to an NHS service below

<table>
<thead>
<tr>
<th>Referral made to:</th>
<th>Social work team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Virtual Ward (home)</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Unit</td>
</tr>
<tr>
<td></td>
<td>Community Hospital Bed</td>
</tr>
<tr>
<td></td>
<td>Nursing Home</td>
</tr>
</tbody>
</table>

Location:

Confirm patient/family has been informed that NHS funding is for 28 days only unless CHC eligible?

Patient and Family information leaflet given and discussed YES/NO

Next of Kin: NAME CONTACT TEL. NO.

SIGNED (ASSESSOR) PRINT NAME DATE

SIGNED (DISCHARGE PLANNING NURSE LEAD) PRINT NAME DATE
Appendix 2. Letter of invitation from West Norfolk CCG

King’s Court
Chapel Street
KING’S LYNNE
Norfolk
PE30 1EL
Telephone: 01553 666900
Email: contact.wnccg@nhs.net
www.westnorfolkccg.nhs.uk

Name of patients or next-of-kin
Address
NHS number
Date: August 2016

Dear

Gathering feedback on your experiences of care

You may remember the hospital discharge nurses and Continuing Healthcare assessor explaining that the care pathway for your discharge arrangements was introduced in January this year. The care pathway is being evaluated to see how patients and families are finding it.

An assessment for Continuing Healthcare used to be done before discharge from hospital. Now, the assessment is done after discharge from hospital. This was based on the recommendation that doing it this way gives a more reliable indication of people’s long term care needs. It also reduces delays to hospital discharge, meaning that patients get out into a suitable community facility more quickly to continue their recovery.

I have asked Healthwatch Norfolk, an independent champion for anyone using health and social care services, to gather some feedback from people on the pathway, on our behalf. Some more information is enclosed, telling you how you can share your experiences if you are happy to do so. This is entirely voluntary and your consent is needed for Healthwatch Norfolk to get in touch with you. Anything you chose to tell Healthwatch Norfolk will not affect the care you receive. Your experiences of care, and those of your family and friends, are important to us and will help us to measure the success of the Continuing Healthcare pathway.

Yours sincerely

Sue Crossman

DR SUE CROSSMAN
Chief Officer
Appendix 3.a Consent form for patients on the health care pathway

Patient feedback on the West Norfolk Continuing Healthcare pathway

Evaluation Lead: Dr Samantha Revill

Part 1: Information Sheet

About Healthwatch Norfolk

Healthwatch Norfolk is the independent consumer champion for anyone in Norfolk who uses health and social care services. Our role is to capture the views and experiences of local people and use this as evidence to influence the people and organisations who pay for and provide your health and social care.

About this evaluation

West Norfolk Clinical Commissioning Group has asked Healthwatch Norfolk to gather feedback from patients on the Continuing Healthcare (CHC) pathway. A slightly different care pathway for discharge arrangements was introduced in January 2016. The care pathway is being evaluated to see how patients and families are finding it.

An assessment for Continuing Healthcare used to be done before discharge from hospital. Now, the assessment is done after discharge from hospital. This was based on the recommendation that doing it this way gives a more reliable indication of people’s long-term care needs. It also reduces delays to hospital discharge, meaning that patients get out into a suitable community facility more quickly to continue their recovery.

Healthwatch Norfolk are asking if patients and their families would be willing to share their experiences of the care pathway. There are four parts of the care pathway we are keen to hear about. These are:

- your experience of leaving the hospital - how did it go?
- your satisfaction with the care you have received since - how is it?
- the Continuing Healthcare Assessment - was it clear and fair?
- what happened next?

About your participation

We are looking for patients and family members who are willing to talk to us about their experiences of the Continuing Healthcare pathway. The conversation will last about 15 - 20 minutes and it will be conducted at a time and place of your choosing. We will pay for any expenses.
You will be asked to give permission for the conversation to be recorded to help with later analysis. We aim to encourage all communities to take part in decision-making and influence the way that local health and social care services are planned and delivered. As a result, you may be asked some personal questions regarding your age, gender, ethnicity etc. You do not have to answer these questions if you do not want to.

We are required by law to protect your privacy. Your personal details will be confidential and will not be shared outside of Healthwatch Norfolk, unless we feel that it is necessary to prevent harm to you or others. All recordings and notes will be kept on a secured system and will be destroyed once the evaluation has been completed. We will provide a written report of our findings to West Norfolk Clinical Commissioning Group who will use it to help evaluate the new pathway. When this report is written you will remain anonymous and we will take great care to ensure that nobody will be able to use your story to identify you.

Participating in this evaluation is entirely voluntary. You may choose not to take part and you may change your mind at any time. Once the project is written, however, it will not be possible for you to withdraw your permission. You will not receive a reward for participating and your participation will not affect the quality of any care or support that you are currently receiving.

To go ahead, your permission for Healthwatch Norfolk to contact is required, along with your preferred means of being contacted e.g. by letter, telephone call or email. Please complete the Part 2. Consent Form that you will find overleaf and return it to Healthwatch Norfolk in the freepost envelope provided.

If you have any questions please contact Dr Samantha Revill or Stephanie Tuvey on 0808 168 9669 or by emailing sam.revill@healthwatchnorfolk.co.uk.
Part 2: Consent Form

Your initials and signature below mean that you have read the above information about this project and that you give permission for Healthwatch Norfolk to contact you using the contact information you provide.

Please initial each box

1. I have read the information provided.

2. I agree to Healthwatch Norfolk contacting me using the information I have provided.

________________________    ____________________       _____________________
Name of participant    Signature    Date

________________________    ____________________       _____________________
Name of carer/NOK    Signature    Date

Contacting you - please tick the one you prefer and give details:

<table>
<thead>
<tr>
<th>Letter by post</th>
<th>Telephone call</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Tel no:</td>
<td>Email address:</td>
</tr>
</tbody>
</table>

Please return this form to Healthwatch Norfolk using the FREEPOST envelope provided, thank you.

Healthwatch Norfolk
Suite 6, The Old Dairy, Elm Farm, Norwich Common, Wymondham, Norfolk, NR18 0SW
Registered Charity Number: 1153506
www.healthwatchnorfolk.co.uk
Appendix 3.b Consent form for people on the social care pathway

Your feedback on the West Norfolk Continuing Healthcare pathway

Evaluation Lead: Dr Samantha Revill

Part 1. Information Sheet

About Healthwatch Norfolk

Healthwatch Norfolk is the independent consumer champion for anyone in Norfolk who uses health and social care services. Our role is to capture the views and experiences of local people and use this as evidence to influence the people and organisations who pay for and provide your health and social care.

About this evaluation

West Norfolk Clinical Commissioning Group has asked Healthwatch Norfolk to gather feedback from patients on the Continuing Healthcare (CHC) pathway. A slightly different care pathway for discharge arrangements was introduced in January 2016. The care pathway is being evaluated to see how patients and families are finding it.

An assessment for Continuing Healthcare used to be done before discharge from hospital. Now, the assessment is done after discharge from hospital. This was based on the recommendation that doing it this way gives a more reliable indication of people’s long-term care needs. It also reduces delays to hospital discharge, meaning that patients get out into a suitable community facility more quickly to continue their recovery.

Healthwatch Norfolk are asking if people and their families would be willing to share their experiences of the care pathway. There are two parts of the care pathway we are keen to hear about. These are:

- your experience of leaving the hospital - how did it go?
- your satisfaction with the care you have received since - how is it?

About your participation

We are looking for people and their family members who are willing to talk to us about their recent experiences of the Continuing Healthcare pathway. The
The conversation will last about 15–20 minutes and it will be conducted at a time and place of your choosing. We will pay for any expenses.

You will be asked to give permission for the conversation to be recorded to help with later analysis. We aim to encourage all communities to take part in decision-making and influence the way that local health and social care services are planned and delivered. As a result, you may be asked some personal questions regarding your age, gender, ethnicity etc. You do not have to answer these questions if you do not want to.

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To go ahead, your permission for Healthwatch Norfolk to contact is required, along with your preferred means of being contacted e.g. by letter, telephone call or email. Please complete the Part 2. Consent Form that you will find overleaf and return it to Healthwatch Norfolk in the freepost envelope provided.

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Your initials and signature below mean that you have read the above information about this project and that you give permission for Healthwatch Norfolk to contact you using the contact information you provide.

Please initial each box

2. I have read the information provided.

2. I agree to Healthwatch Norfolk contacting me using the information I have provided.

________________________    ____________________       _____________________
Name of participant         Signature             Date

________________________    ____________________       _____________________
Name of carer/NOK           Signature             Date

Contacting you - please tick the one you prefer and give details:

<table>
<thead>
<tr>
<th>Letter by post</th>
<th>Telephone call</th>
<th>Email</th>
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</tr>
</tbody>
</table>

Address:          Tel no:          Email address:

Please return this form to Healthwatch Norfolk using the FREEPOST envelope provided, thank you

Healthwatch Norfolk
Suite 6, The Old Dairy, Elm Farm, Norwich Common, Wymondham, Norfolk, NR18 0SW
Registered Charity Number: 1153506
www.healthwatchnorfolk.co.uk
Appendix 3. Interview questions for patients, service users and next-of-kin

For those on the health and/or social care pathway:
   1. Please tell us about your experiences of leaving the hospital - how did it go?
   2. How would you describe your satisfaction with the care you have received since?

For those on the health pathway only:
   3. Please tell us about your continuing healthcare assessment - was it clear and fair?
   4. What happened next?
Appendix 4. Interview questions for health, social care and care professionals

1. What is your understanding of the reasons for making the change to the CHC pathway?
2. What is your view about how well the new pathway has addressed these issues?
3. How much opportunity have you had to comment on and influence the pathway?
4. In your contact with patients and families on the pathway, what has been their expressed experience?
5. What are the strengths and weaknesses of the new pathway?
6. What could we do to improve it further?