# Telford and Wrekin Clinical Commissioning Group

**Health and Adult Care Scrutiny Committee**

**25th March 2013**

**Scope for the Work on Continuing Healthcare Funding**

The Scrutiny Committee have reviewed the questions regarding CHC funding following the evidence they have received. The Members are concerned about the effect of the reduction in CHC funding for the following reasons:

- There has been no evidence that the overall needs of people assessed for CHC funding has reduced.

  CCG Response

  Eligibility for NHS CHC is based on the needs of the individual and the level of need to be assessed as a 'primary health need' – this fundamental criteria has not changed since the publication of the first National Framework NHS Continuing Health Care and NHS Funded Nursing Care in 2007 (and associated Directions) Subsequent revisions in 2009 and 2012 have served only to codify the application of this criteria to ensure consistency of approach across all PCTs/CCGs in England.

- Patients and their families do not understand the CHC assessment process and the implications of the decisions that are made.

  CCG Response

  It is accepted that the concept of 'primary health need' is complex, however the PCT/CCG ensures that all cases referred to the PCT/CCG following initial screening (NHS CHC Checklist) and for those who require full multi-disciplinary team (MDT) assessment (NHS CHC Decision Support Tool) are informed verbally and in writing of the process. This is in full compliance with the National Framework, Directions, Practice Guidance and the Mental Capacity Act (2005). In so doing, the 'implications' of the process are made clear in that the assessment process and establishment of eligibility is to determine who is responsible for funding the cost of care required to meet assessed needs – either the NHS, which is free at the point of need or the Local Authority who have the power to means test for eligibility for state funded care.

- The rate of change in CHC funding has resulted in Telford and Wrekin moving from one of the highest funded areas to one of the lowest funding areas within the space of a few years. While the rate of funding varies between authorities the overall trend

has been an increase in funding and the number of individuals receiving CHC funding.

CCG Response

Since the inception of the national benchmarking process in 2009 it has been accepted by the project managers that there are a number of limitations to the validity of the data. As a consequence every data out-put carries the following 'Health Warning'

***'HEALTH WARNING' ON DATA:***
*Data rankings are for information only and form a **starting point** to try and understand how Funded Care is delivered regionally and nationally. Grey rankings identify outliers (i.e. those that are either high or low in comparison to other PCTs in their region or nationally) but other factors need to be taken into consideration when viewing the data including (but not limited to) variations between geographical areas and market costs, differences between PCTs in terms of their internal processes, and other local services which may impact on PCTs' levels of Funded Care'*

In accordance with the locally agreed Action Plan (Jan 2010) the PCT has invested a significant amount of resources to ensure that budgets are properly aligned to spend. This has resulted in areas that remain the commissioning responsibility of the PCT/CCG, but had historically erroneously been aligned to the NHS CHC budget to be re-provided under the correct budget heading. An example of this is patients detained under the Mental Health Act (1983) or individuals whose care should have been the commissioning responsibility of the Specialised Commissioning Service.

- The decisions made which have resulted in the reduction in the level of CHC funding has compromised the level of care that can be provided. Members are particularly concerned about individuals who are determined to be ineligible for both CHC funding and means tested local authority funded care.

CCG Response

Eligibility for NHS CHC is based on the needs of the individual and the MDT recommendation to the PCT/CCG that a 'primary health need' has been established.

Individuals who need on-going care/support may require services arranged by CCGs and/or Local Authorities (LAs). CCGs and LAs therefore have a responsibility to ensure that the assessment of eligibility for care/support and its provision take place in a timely and consistent manner. If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part-funding the package of support. Where a package of support is commissioned or funded by both an LA and a CCG, this is known as a 'joint package' of care. A joint package of care

could include NHS-funded nursing care and other NHS services that are beyond the powers of a LA to meet. Joint packages of care may be provided in a nursing or residential care home, or in a person's own home.

Undoubtedly, some people will not be eligible for support because their needs do not meet the council's eligibility criteria. In reaching such conclusions, the council should have satisfied itself that the person's needs would not significantly worsen or increase in the foreseeable future because of a lack of help, and thereby compromise key aspects of independence and/or well-being, including involvement in employment, training and education and parenting responsibilities[1].

- There are wider implications for the health and social care economy:
    - A reduction in the availability / choice of care for people of Telford and Wrekin. The continued reduction of CHC funding may result in the closure of care homes or these services being commissioned by CCGs who fund CHC funding at a higher rate.

      CCG Response

      There is no evidence to suggest that that the availability of nursing home placements has reduced in the Telford and Wrekin area since 2009.

      There are 650 nursing home beds for older people available in and around the immediate borders of Telford and Wrekin Council. It is unknown to the PCT/CCG what proportion of these available beds are commissioned fully or in part by Telford and Wrekin Council in comparison with self funding residents. It is however likely that the national emphasis on social care being delivered in an individual's own home for as long as possible before considering residential care has impacted on the overall proportion.

      All care commissioned by the PCT/CCG under NHS CHC or NHS FNC arrangements is subject to the provider's agreement to adhere to the provisions within the NHS Standard contract. The PCT/CCG works in partnership with Shropshire Partners in Care (SPIC) to agree the service specification within the contract where there is a clear emphasis on quality of service provision. All individual patient care costs are agreed on the basis of need, there is no 'cap' to this figure and the funding level alters in accordance with any change in the individuals care needs.

[1] Under section entitled 'Assisting individuals not eligible for social care support', *Prioritising Need* (2010).**Note:**FACS was superseded by *Prioritising Need* in February 2010. It built on the reform programme set out in *Putting People First* - promoting personalised support through the ability to exercise choice.

- There will be an impact on the hospital discharge process if appropriate NHS funded care is not provided in the community.

  CCG Response

  There are no delays to hospital discharge due solely to the requirements for assessment under NHS CHC arrangements. It is locally acknowledged that the National Framework states that assessment for eligibility for NHS CHC whilst in acute care setting does not always provide an accurate reflection of on-going needs[2]. Local arrangements therefore provide for the following assessment and discharge pathways:

  1. **NHS CHC Fast-track** to support expedient safe discharge home with automatic eligibility for NHS CHC funded care for patients at end of life. In all cases the PCT/CCG arranges discharge and provision of care in the community within a maximum of 48 hours of receipt of NHS CHC Fast-track referral.

  2. **NHS CHC eligibility** recommended by MDT with full assessment process being undertaken in the acute setting.

  3. Discharge to the care of the **Rehabilitation and Reablement Team**. The Rehabilitation and Reablement service is jointly funded by the PCT and the Local Authority via a section 256 agreement (of the NHS Act 2006)

     The team is managed by the Local Authority led Home from Hospital Team and is used to support safe and expedient discharge for those patients who have been assessed as having rehab and/or reablement needs. The local arrangement between acute services, the PCT/CCG and the Local Authority is that when a patient is referred to the Rehabilitation and Reablement service, that service will refer an individual for an NHS CHC Checklist to be completed when they are in the community and when they have been discharged from the Rehabilitation and Reablement service. Such a referral would only be made if the individual had on-going needs that indicated such an assessment was required.

[2]National Framework (2012)Para 64 Part 1'It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs'.

4. Discharge under **interim arrangement** which is fully funded by the PCT/CCG. This is used where an individual has been assessed as medically fit for discharge and they have not been assessed as having rehabilitation and reablement needs but their on-going needs on discharge remain unclear. The completion of the NHS CHC Checklist is deferred until the on-going needs have become clearer and if indicated a full MDT assessment for eligibility for NHS CHC is undertaken. The PCT/CCG remains responsible for funding the full cost of care until the outcome of the MDT assessment is known or the NHS CHC Checklist does not indicate a need for full assessment.

5. Discharge to the care of the **Local Authority**. This is used when there are no rehab and reablement needs and the on-going needs are clear so the NHS CHC Checklist is completed by ward staff.

- There has been a transfer of costs to the Local Authority – this is not sustainable and if this continues could result in the raising of the eligibility criteria for adult care.[3]

**CCG Response**

**Current Position:**

Eligibility for NHS CHC is based on establishing a 'primary health need' in relation to individual assessed needs.

The usual rule is that the NHS provides healthcare free of charge to the user regardless of means, but does not provide social care services. Local authorities are funded by the state to provide social care (a means tested service). Subject to two **exceptions**, it is ultra vires for the NHS to fund social care because these are **not** healthcare services under section 3 of the NHS Act 2006. The **first** exception is where a patient is accommodated in an **NHS hospital**. In-patients are provided with accommodation, meals and such elements of social care as they require during a stay in hospital.

The **second** exception is NHS CHC eligibility which developed to cover cases where there was highly intensive medical support for a patient **outside** the hospital setting. The "border" as to when the NHS provided such care was set by NHS CHC eligibility criteria which were an exercise of the Secretary of State's discretion under s3(1)(e)

[3] *Fair Access to Care Services* ("*FACS*"), issued by the Secretary of State for Health under section 7(1) of the Local Authority Social Services Act 1970.In setting eligibility criteria councils have to take account of their resources, local expectations and local costs. *FACS* explains that councils should take account of agreements with the NHS and other agencies (paragraph 18) and consult users, carers and others (paragraph 20). Paragraph 12 of *FACS* has a specific reference to human rights and discrimination law, noting that when drawing up eligibility criteria for adult social care, councils should have regard to the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, the Human Rights Act 1998, and the Race Relations (Amendment) Act 2000. Paragraphs 28 to 41 of *FACS* set out, with reference to other publications, general but detailed principles of assessment. Paragraphs 42 to 46 outline how eligibility for an individual should be determined following assessment.

of the NHS Act 2006 (and predecessor Acts). NHS CHC is thus a highly **limited** exception to the usual rule because it is a set of circumstances where the NHS meets the social care costs of a patient who is not accommodated in an NHS hospital. However, regardless of the intensity or complexity of an individual's care needs, a person will **only** be assessed as eligible for NHS CHC if those care needs can properly be described as leading to a "primary need" for healthcare.

Whilst there is no legal lower limit to what the NHS can provide, there is a legal upper limit to nursing and healthcare that can be provided by local authorities. This is a complex area of law and there is no simple authoritative definition of what is beyond the responsibility of the local authority. The powers and duties of local authorities are a matter of Statute and case law, including the Coughlan Judgment.

However, local authorities can and do commission care in care homes (with or without nursing) where needs to be met include elements of 'general nursing' provided by healthcare assistants or care assistants. A local authority can fund this 'nursing care' provided it is both incidental and ancillary to the individual's accommodation and of a nature that a local authority can be expected to provide.

There is therefore no direct correlation to the financial impact of NHS CHC eligibility decisions as the legislative framework applicable to each statutory organisation is manifestly different.

**Future Proposals**:

The *Caring for our Future* White Paper was published in July 2012, alongside the Government response to the Law Commission report and the draft *Care and Support Bill*. The White Paper set out Government proposals to "deliver a re-engineered care and support system that shifts resources towards prevention and early intervention."

The White Paper's proposals include the introduction of a national minimum eligibility threshold for care, to be implemented by 2015; legislating to ensure portability of assessments; piloting the use of direct payments in residential care; legislating to give people an entitlement to personal budgets; improving mechanisms for the early identification of carers and legislating to provide carers with an entitlement to support; and legislating to introduce Local Safeguarding Adult Boards.

There have been a number of judicial reviews relating to Local Authorities raising eligibility criteria (FACS) to critical[4] only, most notably Birmingham City Council in

[4] FACSexplains in paragraph 16 that, for the purposes of the eligibility framework, a person's needs are *"critical"* when life is, or will be, threatened; and/or significant health problems have developed or will develop; and/or there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or serious abuse or neglect has occurred or will occur; and/or there is, or will be, an inability to carry out vital personal care or domestic routines; and/or vital involvement in work, education or learning cannot or will not be sustained; and/or vital social support systems and relationships cannot or will not be sustained; and/or vital family and other social roles and responsibilities cannot or will not be undertaken.

2011[5]Included in the judgement was a review of the evidence that changing eligibility may not deliver savings in the long run, noting that :

*"limiting access through raising eligibility criteria has only a modest and short-term effect on expenditure"*
And
*"raising eligibility thresholds without putting in place adequate preventative strategies often leads to a short-term dip in the number of people eligible...followed soon after by a longer-term rise."*

**CCG – Information Requests before Meeting on the 25th March**

Please provide data on the following per year from 2009-13

- Number of initial check lists completed and the number of referrals for full assessments

- Number of full assessments carried out

| 2009/2010 | 2010/2011 | 2011/2012 | 2012/2013 |
|---|---|---|---|
| 408 | 239 | 412 | 253 |

- Number of people assessed as eligible for CHC funding

| 2009/2010 | 2010/2011 | 2011/2012 | 2012/2013 |
|---|---|---|---|
| 185 | 99 | 127 | 101 |

- Number of reassessments and the outcome of these re- assessments

  This information is not routinely captured. The National Framework and associated Directions[6] require all PCTs to reassesses on-going eligibility for NHS CHC/NHS FNC 12 weeks after the initial recommendation is made by the MDT and accepted by the PCT/CCG and then, as a minimum, annually thereafter[7].

- Number of appeals / review of CHC funding decisions and the outcomes of these appeals /reviews

[5] [2011] EWHC 1147

[6] The NHS Continuing Care (Responsibilities) Directions 2009 ("the Responsibilities Directions") require PCTs to take **reasonable steps** to ensure that an assessment of eligibility for NHS CHC is carried out:"where it appears to the Trust that that there may be a need for such care or an individual who is receiving NHS CHC may no longer be eligible for such care.

[7] The Directions impose a statutory **duty** on the PCT to carry out an assessment. The PCT only needs to be **aware** of the existence of the individual and to have information that "may" lead to suggest a need for CHC or a variation in the care services before coming under a specific duty to carry out a CHC assessment. The duty to carry out an assessment can arise whether there is a request by the patient or not. The wording of the duty is substantially the same as the duty on a local authority to carry out an assessment of an individual's entitlement to community care services under section 47 of the NHS and Community Care Act 1990.

CCG Response

All individual referrals to NHS Telford and Wrekin for initial assessments or review for eligibility for NHS Continuing Healthcare are subject to a multi-disciplinary team approach and in all cases this includes social care representation. The multi-disciplinary team members make a recommendation to the PCT in regard to eligibility for NHS Continuing Healthcare based on the assessed needs of the individual and in consultation with the individual and/or patient representative. The National Framework requires PCT's to accept the recommendation of the multi-disciplinary team in "all but exceptional circumstances". NHS Telford and Wrekin have accepted all recommendations made and there is no second tier "scrutiny panel" stage between the MDT recommendation and the PCT accepting this.

Although NHS Telford and Wrekin has a relatively low incidence of appeals (locally – 10 over 2010-2013 – none overturned) or at Independent Review Panel – 2 over 2010-13 – none overturned) in order to gain assurance of the robustness multi-disciplinary team recommendations and consequently the acceptance of the PCT of these recommendations, senior officers from Telford and Wrekin Council requested a peer review of 45 cases. In all cases the individuals had their care and support previously funded by NHS Telford and Wrekin under NHS Continuing Healthcare arrangements, but had been assessed, on review, as no longer eligible. The selection of the 45 cases was made by the Telford and Wrekin Council members and terms of reference were jointly agreed between senior officers of Telford and Wrekin Council and NHS Telford and Wrekin.

The key objectives of the peer review, which was undertaken on the 27th and 28th June 2012 were agreed as:

1. Determine if the process followed by the PCT was in accordance with the National Framework, NHS Continuing Healthcare and NHS Funded Nursing Care (2009) i.e. that there was a properly constituted MDT and that there is evidence of patient/advocate involvement.
2. Determine if the MDT recommendation of ineligibility for NHS Continuing Healthcare was correct based on the evidence gathered within the DST
3. Determine if there are any elements of the care needs, as identified within the DST and/or the care plans (as provided by Telford and Wrekin Council) that are not provided within ordinary NHS primary and secondary care services and are potentially beyond the lawful competencies of a social care authority i.e. should be funded by the NHS.

The full minute of the findings of the peer review have been approved by peer review panel members and has been made available to senior officers of Telford and Wrekin Council, but for reasons of patient confidentiality and in accordance with the Data Protection Act, the full minute will not be made available as a public document.

The summary findings and general observations of the peer review panel are however provided for your information and are as follows:

a) The panel noted that there was clear evidence of a properly constituted MDT approach in all cases where a full assessment for NHS CHC was completed. There was also

clear evidence of patient/family/advocate in each case. The Panel referenced the National Guidance noting that the final decision on whether an individual fulfils the criteria rests with the PCT. The Panel further noted that the national guidance requires that, based on the professional views of the MDT, the NHS Continuing Healthcare Coordinator makes a recommendation to the PCT and it is expected that in most cases this recommendation will be accepted. The panel therefore felt that the MDT member's professional judgment should have been accepted by both statutory organizations.

b) The panel commented that, on the whole, the assessment process was very good and demonstrated a comprehensive, multidisciplinary and patient centered approach. It was recognized however, that some of the cases dated back to 2010 and there had been a process of "evolution" in terms of the how the final MDT recommendation was worded and in some cases reference to whether a "primary health need" had been established (or not) could have been clearer. To support this view the panel suggested that within the body of the DSTs, each section should be completed using the structure as set out in the national DST. This would ask the MDT to describe the needs for the individual and then provide the evidence that informs/supports this. Following this structure for each domain and in the MDT meeting/discussions would ensure the need was identified and would help clarity of discussion.

c) The panel noted that there was one case where, with the benefit of visibility of events following the assessment period, there appeared to be evidence of deterioration. It was noted, however, that no new referral or (laterally) Fasttrack was received by the PCT. Although the reasons why are unclear, if found to be a communication or training issue, the Panel recommended that this would need to be addressed.

d) The panel noted the number of cases (13) that were subject to s117 aftercare and suggested that given the clear guidance within the National Framework (NHS CHC) regarding the relationship between s117 and NHS CHC there needs to be agreement between the PCT and the LA as to how to manage future cases. The panel noted that none of the cases presented should have, in their view, previously been funded under NHS CHC arrangements.

e) The panel also noted 2 cases were clearly undergoing rehabilitation. In these cases, as the national guidance makes clear, there was no requirement to assess for NHS CHC until the rehabilitation care plan was complete. The Panel referenced the national guidance which notes specifically that "Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect on-going needs".

f) The panel also noted 4 cases where the care provision had remained fully funded by the NHS, so were unclear on what basis the cases were presented for peer review.

g) In addition the Panel felt that there were a significant number of cases that had been previously funded by the PCT under NHS CHC arrangements that had a level of needs unlikely to have met the Checklist threshold, so were unclear of the basis that agreed historical eligibility for NHS CHC. The Panel considered the inclusion of these cases was not a good use of their time and, far more importantly, has taken assessment time away from people who need it.

Please provide information about decisions taken to change the local interpretation of National Guidance on CHC funding and any impact assessment that was carried out regarding this decision. Was this decision taken by the Board or officers?

CCG Response

There have been no decisions made to change the local interpretation of the national criteria. The PCT/CCG is required as a matter of law to follow the Directions and to use the national tools (The NHS CHC Checklist, NHS CHC Decision Support Tool, NHS CHC Fast-track Tool)

Please provide copies of any Board reports that have considered or made reference to the reduction in the number of patients considered eligible for CHC funding and the consequent reduction in funding.

The revisions to the Framework in 2009 required all PCT's to "consider how the principles and processes in the revised guidance relate to what is currently in place, and should align their processes accordingly. They should also consider where NHS continuing healthcare responsibilities require clearer arrangements to be made with provider organizations, and should ensure that these are built into commissioning processes".

In addition, Local Authorities were required to "consider this guidance and review whether their current practice fits with the responsibilities outlined (within)"

As a consequence of these requirements the Lead Commissioner, NHS CHC completed an evaluation of the decision making processes in relation to the assessment of NHS CHC eligibility that were in place at that time and concluded that they were not compliant with the Directions (2009). A Board paper was compiled outlining the concerns; this included an action plan for improvement. The presentation of this paper to Board was delayed to enable full consultation with Telford and Wrekin Council, but was subsequently presented and endorsed by the Board in January 2010. The Board paper is embedded in this document for ease of reference.

NHS TW -BOARD REPORT FORMAT - C

The delivery of the Action Plan was completed under the direction of a Joint Commissioning Partnership Group that was established for this purpose and was known as the Joint

Strategic Steering Group, NHS CHC This group, which up until recently met on a monthly basis, has senior PCT and local authority representation (Karen Kalinowski, Paul Taylor, Richard Smith) and independent advocacy provided by Age UK and is chaired by a PCT Non-Executive Director. Minutes of each meeting were approved and circulated to all group members. A copy of the Terms of Reference which were agreed at PCT Board in April 2010 is embedded in this document for ease of reference.

NHS TW -BOARD REPORT JSSG ToR Ap

Please provide copies of Telford and Wrekin policies and procedures in place regarding the CHC assessment and re-assessment process.

The local approach, which is fully compliant with the National Framework NHS CHC (Revisions 2009) and associated Directions and Good Practice guidance, is laid down in the Joint Operating Procedure, NHS CHC which was developed and agreed under the direction of the Joint Strategic Steering Group as part of the improvement plan. The most recent version of the Joint Operational Arrangements is embedded in this document for ease of reference. The amendments, which are currently out to consultation with LA colleagues, reflect the minimal changes to the revised National Framework (2012) and the transfer of responsibility for NHS CHC from the PCT to the CCG that comes into effect on April 1st 2013.

NHS CHC and NHS FNC Operational Arra

All individual referrals to NHS Telford and Wrekin for initial assessments or review for eligibility for NHS Continuing Healthcare are subject to a multi-disciplinary team approach and in all cases this includes social care assessment and representation[8]. The multi-disciplinary team members make a recommendation to the PCT in regard to eligibility for NHS Continuing Healthcare based on the assessed needs of the individual and in consultation with the individual and/or patient representative. The National Guidance requires PCT's to accept the recommendation of the multi-disciplinary team in "all but exceptional circumstances". NHS Telford and Wrekin has accepted all recommendations made and there is no second tier "scrutiny panel" stage between the MDT recommendation and the PCT decision to accept.

Please provide information on the total amount of CHC funding per year over the last 4 years

| 2009/2010 | 2010/2011 | 2011/2012 | 2012/2013 |
|---|---|---|---|

[8]Paragraph 73 of the National Framework NHS Continuing Healthcare and NHS Funded Nursing Care (Revisions) 2009 notes that "The involvement of LA colleagues as well as health professionals in the assessment process will streamline the process of care planning and will make decision making more effective and consistent. Directions require that, as far as is reasonably practicable, PCTs should consult with the relevant LA before making any decision about an individual's eligibility for NHS continuing healthcare. If an LA is consulted, there is a requirement for it to provide advice and assistance to the PCT, as far as is reasonably practicable. If an LA has carried out a community care assessment, it should, as far as is reasonably practicable, use the information obtained from it when providing advice and assistance to the PCT. LAs should also advise PCTs of any information they have on changed needs since the community care assessment was completed. As with any assessments that they carry out, LAs should not allow an individual's financial circumstances to affect its decision to participate in a joint assessment".

| | | | | |
|---|---|---|---|---|
| NHS CHC | £13.7m | £10.9m | £4.4m | £2.4m (FOT) |
| NHS FNC | £1.38m | £1.36m | £1.57m | £1.73m (FOT) |
| Specialist Placements | | | | £1.85m (FOT) |
| | | **Total** (2012/13) | | **£5.98m** (FOT) |

**Lines of Inquiry for Meeting on 25th March**

How has the PCT / CCG communicated the change in the full assessment process to staff and partner organisations?

There has been no change in the full assessment process. The MDT approach is a requirement of the Directions (2009) and the Practice Guidance (2010) in recognition that this will provide relevant, accurate and up-to-date information about an individual's health and social care needs. The role of the MDT members is to complete their own professional assessment of need and then in collaboration with professional assessments provided by other MDT members apply professional judgment to decide what this information signifies in relation to those needs as described within the NHS CHC Decision Support Tool (DST). Both professional assessment and judgment are therefore required.

A joint training event was held in September 2010 that was open to all health and social care professionals involved in the NHS CHC decision making process and also included representation from the independent sector and advocacy services. Although there were 50 representatives present from the LA, there were no representatives above team manager level.

This initial 'launch' event has been followed up with a programme of training events for the Acute and Community Trusts and GPs. The training events are provided on an on-going basis as 'group' training sessions and as individual training opportunities.

Telford and Wrekin Council held a training event in December 2011 led by Prof Clements, Cardiff Law School.

How has the PCT/CCG ensured that the changes in the interpretation of the CHC Guidance still ensures that there is a multi-disciplinary approach to decisions made about CHC funding?

There have been no changes in interpretation of CHC Guidance the PCT has been following national directives. All recommendations made to the PCT are made by a properly constituted MDT.

'Multidisciplinary team' (MDT) has many meanings but in the context of NHS Continuing Healthcare the Standing Rules Regulations define a 'multidisciplinary team' as:
'(i) two professionals who are from different healthcare professions, or

(ii) One professional who is from a healthcare profession and one person who is responsible for assessing individuals for community care services under section 47 of the National Health Service and Community Care Act 1990'[9].

NHS Telford and Wrekin have always considered a properly constituted MDT to include a social care professional.

How is the CHC assessment process managed to ensure that it fits with the wider health and social care economy e.g. the hospital discharge process?

Fully responded to on page 3

What training have staff had in undertaking the full assessments using the multi disciplinary assessment tool?

Fully responded to on page 11

What policies and procedures do you have in place to ensure that family are involved appropriately in the full assessment process for Continuing Healthcare funding? What happens of family do not live close to the patient?

As with all professional assessments consent is gained from the individual before proceeding. A comprehensive consent form is included in the NHS CHC Checklist document and the individual is asked if they wish to have a family member present. This is recorded in the documentation.

With the individuals consent or where appropriate in compliance with the Mental Capacity Act (2005) every effort is made to ensure that a family member is involved appropriately with the full assessment process. If the family member can attend the MDT meeting this invitation is extended and the meeting convened as far as possible to enable their attendance. If the family member cannot attend their views are sourced prior to the MDT convening and a draft of the NHS Decision Support Tool forwarded to them for their comment prior to the MDT finally agreeing the recommendation to the PCT/CCG.

Whilst the individual and/or their representative should be fully involved in the process and be given every opportunity to contribute to the MDT discussion, the formal membership of the MDT consists of the practitioners involved. However, concerns expressed by individuals and representatives [are] fully considered by [the MDT by] reviewing the evidence provided. If areas of disagreement remain these are recorded in the relevant parts of the DST[10].

What procedures do you have in place to ensure the full assessment is completed properly if the patient and /or their family does not have the capacity to give consent or is very frail / vulnerable?

[9] National Framework (2012) Para 30.1 Part 2
[10] National Framework (2012) Para 36.1 Part 2

As with all professional assessments if the person does not have capacity and there is no family member available, a best interest assessment to proceed is made. This is clearly documented in the consent section of the NHS CHC Checklist document and this is compliant with the Mental Capacity Act 2005. Where appropriate, referral to advocacy services or IMCA are made[11].

Although the individual professional assessments of need are completed based on the observed presenting needs of the individual, supporting information such as information provided by the patient themselves, any significant person in their lives, their GP and where applicable care home/agency records are also evaluated and are expected to be included in the assessment. This is in line with usual assessment processes.

As there is an MDT approach there is a multi-professional evaluation of need.

What evidence do you have of how family members are involved in the full assessment process?

It is clearly documented in the consent process and in the completion of the assessment documentation.

How do you ensure that patients and their family are informed about the reasons for carrying out the full assessment and what the result means?

In line with the National Framework each referral is screened for potential eligibility for NHS CHC by the completion of a NHS CHC Checklist[12]. The NHS CHC Checklist is completed by whoever is making the referral i.e. a District Nurse or a staff nurse in a ward setting[13]

[11] Mental Capacity Act 2005 and associated code of practice requires practitioners to comply with the 5 main principles of the Act:

- **A presumption of capacity:** Every adult has the right to make his or her own decisions and must be presumed to have capacity to do so, unless it is proved otherwise.
- **Individuals being supported to make their own decisions:** A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- **Unwise decisions:** Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- **Best interests:** An act done or decision made under the Act for or on behalf of a person who lacks capacity must be in their best interests.
- **Least restrictive option:** Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.
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[12] It is noted within paragraphs 60-62 of the National Framework, NHS CHC Revisions (2009) that "The purpose of the Checklist is to encourage proportionate assessments, so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare, and to ensure that a rationale is provided for all decisions regarding eligibility. Before the Checklist is applied, it is necessary to ensure that the individual and (where appropriate) their representative understand that the Checklist does not indicate a likelihood that the individual will be eligible for NHS continuing healthcare – only that they are entitled to **consideration** for eligibility. The threshold at this stage of the process has intentionally been set low, in order to ensure that all those who require a full consideration of their needs have this opportunity."

The NHS Continuing Healthcare Good Practice Guidance (DH 2010) also notes at paragraph 6.9 that "The Checklist is intended to be relatively quick and straightforwardto complete. In the spirit of this, it is not necessary to submit detailed evidence along with the completed Checklist. However, the Checklist asks practitioners to record references to evidence that they have used to support the statements selected in each domain".

[13] NHS Continuing Healthcare Good Practice Guidance, DH 2012, paragraph 6.4 **Good practice notes: "**Checklists should not be completed too early in an individual's hospital stay; this could provide an inaccurate portrayal of their needs as the individual could potentially make further recovery. As far as possible the individual should be ready for safe discharge at the point that the Checklist is undertaken and sent to the PCT. It should therefore be completed at the point where wider post-discharge needs are also being assessed (although before issue of delayed discharge notices).If at any point after a Checklist has been sent to

following consent to proceed. In order to gain consent the assessing practitioner is required to explain the purpose of the assessment. The individual is also advised that the completed assessment will be passed to the NHS Complex Care team who on receipt write to the individual to advise of the outcome of the screening process and to provide a copy of the completed assessment & Checklist for their records. The individual also receives a copy of the DH Leaflet on NHS CHC and NHS FNC (if they do not have one already)


The NHS Complex Care Team also advise of next steps if the outcome of the Checklist is that the individual has a level of need that meets the requirement for full assessment, or of their right to request a review of the outcome of the NHS CHC Checklist if they do not.

If a safeguarding issue is identified as part of the full assessment process how is this managed?

The referring practitioner has a duty of care to raise a safeguarding issue through the appropriate channels if it is identified as part of the assessment process or at any other intervention with the patient.

Can you provide evidence that patients and their families are informed of the appeal process in they are found not to be eligible for CHC funding? How are people who are not eligible for Local Authority funding and therefore self funding supported through this process?

All individual are provided with an outcome letter following either initial screening or full assessment. In all cases the appeal process is clearly detailed. At no point in assessment process is there any knowledge of the individual's personal financial position.

Each LA is under a duty to assess any person who appears to it to be in need of community care services (section 47 of the National Health Service and Community Care Act 1990). Community care services may include residential accommodation for persons who, by reason of age, illness or disability are in need of care and attention that is not otherwise available to them (section 21 of the National Assistance Act 1948), as well as domiciliary and community-based services to enable people to continue to live in the community. The LA, having regard to the result of that assessment, must then decide whether the person's needs call for the provision of community care services. The LA must also notify the relevant CCG if, in carrying out the assessment, it becomes apparent to the authority that the person has needs which may fall under the 2006 Act, and invite the CCG to assist in making the

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the PCT the individual's needs change such that he/she requires further treatment, the completed Checklist will no longer be relevant and a new Checklist should be undertaken once the treatment has been completed. The PCT and the individual should be kept fully informed of the changed position. This process will enable the PCT to redirect their resources to where they are most urgently required".

assessment (see section 47(3) of the National Health Service and Community Care Act 1990).

These duties apply irrespective of the individuals financial means.

How does the re-assessment process take into account that when some health needs are managed well e.g. dementia this does mean that the need has reduced or no longer exists?

The NHS CHC Decision Support Tool (DST) is used for all adults who require assessment for NHS Continuing Healthcare, irrespective of their client group/diagnosis. The tool focuses on the individual's needs, not on their diagnosis. Directions require that the DST is used to inform the decision as to whether someone has a primary health need, and if they do they must be deemed eligible for NHS continuing healthcare.

The Framework provides that the decision-making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs. An example of this might occur in the context of the behaviour domain where an individual's support plan includes support/interventions to manage challenging behaviour, which is successful in that there are no recorded incidents which indicate a risk to themselves, others or property. In this situation, the individual may have needs that are well-managed and if so, these should be recorded and taken into account in the eligibility decision. In applying the principle of well-managed need, consideration should be given to the fact that specialist care-providers may not routinely produce detailed recording of the extent to which a need is managed. It may be necessary to ask the provider to complete a detailed 24/48 hour diary to demonstrate the nature and frequency of the needs and interventions, and their effectiveness.

Care should be taken when applying this principle. Sometimes needs may appear to be exacerbated because the individual is currently in an inappropriate environment rather than because they require a particular type or level of support – if they move to a different environment and their needs reduce this does not necessarily mean that the need is now 'well managed', the need may actually be reduced or no longer exist. For example, in an acute hospital setting, an individual might feel disoriented or have difficulty sleeping and consequently exhibit more challenging behaviour, but as soon as they are in a care home environment, or their own home, their behaviour may improve without requiring any particular support around these issues.

The fact that an individual has a well-managed need does not, of itself, mean that they are either eligible or not eligible for NHS continuing healthcare. However, well-managed needs should be considered as part of the eligibility decision-making process.[14]

What discussions have taken place with the Local Authority regarding the effects of CHC funding on Adult Care budget? How does the CCG work with the Local Authority to deliver Joint Care Packages?

[14] National Framework (2012) Paras 11.1-11.3 Part 2

There has been a long history of joint meetings in regard to NHS CHC with the most recent forum being the Joint Strategic Steering Group as referenced on page 10.

The National Benchmarking data has been available to the LA via direct email form the project manager and by access to the DH website.

Up until April 1st 2012 all PCT contracts for NHS CHC and NHS FNC were managed on the PCT's behalf by the LA under a SLA and re-charge arrangement. Full awareness on a case by case basis of variations in PCT spend for NHS CHC and NHS FNC was therefore provided.

The Integrated Care Group (The Group) is a joint meeting of Telford and Wrekin Primary Care Trust (NHS T&W) and Telford and Wrekin Council (T&WC). The Group meets to review individual cases where there is a multi-agency duty of care identified by Operational Staff (T&WC Assessment and Case Management/NHS Clinicians) in order to identify where there may be a need for additional care, services or interventions required, over and above usual commissioned services in order to meet identified needs. Decisions will be made within the legislative requirements and guidelines of respective organisations. Terms of reference are embedded as follows for ease of reference.

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What discussions have taken place with local health and social care providers about the implications for them on the changes to CHC funding?

Answered on page 3

How has the reduction in funding been managed? What have the savings been used for?

As the process to assess an individual for eligibility for NHS Continuing Healthcare is a need's led process which does not consider financial matters, the potential or actual total impact on the financial resources of the PCT is continually subject to variations in demand. This leads to variations in annual expenditure for NHS Continuing Healthcare. The PCT is subject to a legal process within which it can operate and make decisions relating to NHS CHC. The PCT complies with the National assessment process and its legal obligations in regard to resource allocation to provide for the health needs of the residents of Telford and Wrekin.

The Scrutiny Committee has received information on the national trends for CHC funding. How does the CCG explain the local reduction in funding compared to the regional trends?

Answered on page 1

How can the Council and CCG work together to resolve this funding issue?

As outlined in the Joint Strategic Steering Group terms of reference, which were approved by the PCT Board in April 2010, a key function of the Group was to "oversee and proactively seek to manage risk of any financial impact to partner organizations of the implementation of the National Framework and subsequently report back to PCT Board".

The PCT recognized that the approach to agreeing eligibility for NHS CHC prior to the implementation of the National Framework (2009) had led to an inconsistent and incorrect application of the criteria. This was further evidenced in the recent peer review of 45 cases that were selected by the Telford and Wrekin Council. There was an understanding that the correction of this situation could have a financial consequence to Telford and Wrekin Council as there was a likelihood that a proportion of the care costs previously held by the PCT would transfer to Council responsibilities.

In view of this a Section 256 (of the NHS Act 2006) transfer arrangements to the value of £3m was made in 2011/12 to support the local authority to deliver enhanced social care. This was over and above transfers of funds from the PCT to the Council to deliver rehab and reablement services.

There is a commitment to provide some transitional support in 2012/13 and the figure will be determined by end of year out-turn.

There was a requirement for both statutory organizations to ensure that the assessment process for considering individuals eligibility for NHS CHC was compliant with the Directions (2009) and National Framework NHS CHC and NHS FNC (2009).

There was a transparent and Board approved improvement plan put in place in January 2010 and the delivery of the plan was overseen by a Joint Steering Group which had senior management representation from both the PCT and the Council. A Joint Operational Procedure was developed, jointly agreed and has been in place since December 2010.

Recently there has been a locally agreed initiative to gain assurance about the operational interpretation of the national criteria and its application in respect of a range of cases selected by Telford and Wrekin Council. Although there has been some learning points gained, the overall conclusion of the peer review panel was that there was no evidence that the national criteria had been misapplied by the multi-disciplinary team members and that both NHS Telford and Wrekin and Telford and Wrekin Council were correct to accept the recommendations made in respect of the individual cases.

The potential financial impact of the corrective action required to ensure compliance with the Directions has been overseen and recognized by the Joint Strategic Steering Group and the PCT Board and significant financial support has been provided to Telford and Wrekin Council to ensure the on-going stability of the local health and social care economy.

Has the CCG considered the Department of Health National Framework for NHS CHC and NHS-funded Nursing Care November (2012)? How will this guidance be implemented locally? Will this result in any changes to local policy or practice regarding CHC funding?

The National Framework and associated Regulations come into effect on April 1st 2013. There is no alteration to the national criteria for eligibility for NHS CHC. The Joint Operational Arrangements document referenced on page 10 has been amended to reflect the minimal changes to the mandatory tools (NHS CHC Checklist, NHS CHC Decision Support Tool and NHS CHC Fast-track tool) and the transfer of responsibility for NHS CHC from the PCT to the CCG. This document is currently being reviewed by LA colleagues, prior to formal adoption on 1st April 2013.