TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15 MAY 2013

CONTINUING HEALTH CARE AND WHOLE SYSTEM APPROACH

REPORT OF ASSISTANT DIRECTOR – SOCIAL CARE SPECIALIST

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The report highlights the issues arising from a change in application of national Continuing Healthcare criteria by the PCT in 2009 which have impacted detrimentally on local people both directly and through displacing over £8m costs onto the Council already subject to Government funding cuts of 27%.

2. FOR INFORMATION OR DECISION

2.1 Decision and information

3. RECOMMENDATIONS

3.1 Board Members consider the information set out in the report.

3.2 Board Members recommend that within 3 months Officers of the Council and CCG develop a jointly agreed approach to CHC funding decisions alongside a sustainable financial agreement for both organisations.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	Do these proposals contribute to a specific HWB Priority	
	Yes	To improve the health & wellbeing of our communities and address health inequalities
	Will the proposals impact on specific groups of people?	
	Yes	CHC is of relevance to people of all ages (18 and above), who have

		significant care needs resulting from a primary health care needs and their immediate family
TARGET COMPLETION/DELIVERY DATE	*N/A*	
FINANCIAL/VALUE FOR MONEY IMPACT	Yes	Detail of the financial implications of the change in application of Continuing Healthcare Criteria are contained in the body of the report. The financial impact to the Council is an ongoing budget pressure of over £8.0m. This has grown in impact since 2009/10 and reached this ongoing level in 2011/12. There has been some one off funding from the PCT for 2011/12 and 2012/13 to partially offset the impact plus agreement to use £2m national NHS allocations to local government for the same purpose in both years. These funds should have been available for service improvements and protection of existing social care services against the pressures on Council grant funding. Instead they have been utilised to meet part of the local NHS cost shift. In 2012/13 the combined one off local and national NHS funding used to cover around £8.5m NHS costs shifted onto the Council was around £4.8m leaving £3.7m to be funded by the Council. Discussions around 2013/14 and beyond are continuing with a minimum £2.4m contribution by the CCG proposed for this year only at present.
LEGAL ISSUES	Yes	See legal comment, attachment 1
EQUALITY & DIVERSITY	Yes	
IMPACT ON SPECIFIC WARDS	No	
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 A report on the 22 September 2011 to the shadow Health and Wellbeing Board highlighted the concerns of the Council in respect to a number of actions within the NHS that were creating financial pressures for the Council, in particular in respect of continuing health care. Through the Shropshire Health economy's QIPP plan it had been noted (though there was no formal consultation with the Council) that there was an intention to make over £6million savings in the Continuing Health Care (CHC) budget between 2011/12 and 2014/15 with an assumption that £2.3 million of this was attributable to NHS T&W. In the end this target was vastly overachieved by the PCT and used partly to cross subsidise the failure to deliver other QIPP targets and partly to allocate additional funds to the hospital trust.

5.2 T&W Council had recognised in 2009 that numbers of people locally, receiving NHS CHC funding to meet all their care needs was significantly above the national average and therefore the Council agreed to increase its community care budget to achieve a more equitable balance between CHC and council funded community care. However at the time of writing the first report there were concerns that the reduction in the numbers of people receiving CHC funding was reducing at a rate that was much higher than anticipated. Not only was this impacting on the Council's budget, but Officers were concerned that some individuals may be denied a legal right to free NHS care where they had a primary health need and therefore the Council may be acting illegally by providing such care.

5.3 A person should be considered to have a primary health need when the nursing or other health services they require, when considered in their totality, are:
"(a) where that person is, or is to be, accommodated in a care home, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or
(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide".

5.4 The Council had been raising concerns with the PCT Board since June 2010 but with continued lack of progress, The Council's Managing Director wrote to the Chief Executive of the West Mercia Cluster asking for mediation at a higher level (see attachment 2). This letter pointed out that the cost transfer to the Council was now over £8million and still expected to rise given the approach. An update report to the shadow Health and Wellbeing Board on the 14 December 2011, informed members of the escalating situation.

5.5 As a result of discussions with Eamonn Kelly and his resulting concerns over the actions of the PCT, agreement was reached in January 2012 to pass one off funds of £3million to the Council from the Cluster in respect of 2011/12

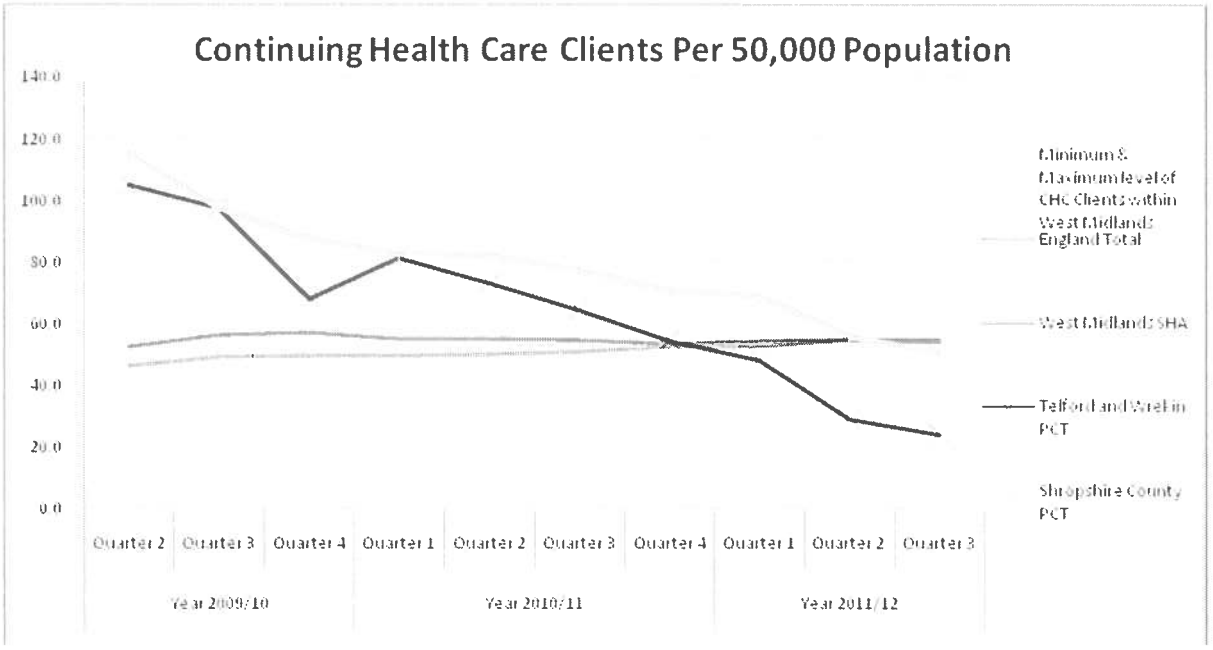
and agreement to our use of the "Lansley" money passported across to the Council to offset part of the shortfall hitting the Council in that year as well. It was also agreed to set the PCT budget for CHC in 2012/13 at a level "proportionate to average levels of CHC support". In effect this meant that the CHC budget was set at £6.5m even though the spend in 2011/12 was only £3.8m and still falling. This positively meant that £2.7m would be transferred to the Council which together with £2.1m Lansley money would offset £4.8m of the £8m plus impact on Council budgets in 2012/13. However using the Lansley money in this way means it was not available via the Council as a contribution to whole system development and integration initiatives.

5.6 For 2013/14, when T&W CCG take over responsibility for CHC from the PCT/West Mercia Cluster there is a proposal to replicate the transfer of one off funding from the CCG at a slightly reduced level of £2.4m but no ongoing arrangement for future years and currently no resolution of the concerns about the ongoing CHC decision making which has now passed to the CCG.

5.7 Officers of the Council and CCG are now in discussions with officers from NHS England to arrange externally facilitated sessions to find a mutually acceptable approach for day to day operation of the CHC process. This will require both sets of officers to approach this work with open minds if we are to resolve the situation in the interests of our local people.

5.8 The numbers of people receiving CHC funding has continued to reduce throughout this period as people have been reviewed and a decision made that they are no longer eligible, even though their situation and needs have not changed (or have deteriorated in some cases).
At the same time very few new people are agreed to be eligible and ill people in receipt do die. **The dramatic decrease in the numbers of people in T&W receiving CHC funding compared with the national and regional averages is shown in a table (see attachment 3) and the graph below. The latest NHS information available to the Council from mid 2012/13 shows that in the period 2009/10 to mid 2012/13 the numbers of people in receipt of funding locally has dropped from 100 to 17.4 cases per 50,000 population- a cut of just under 83%, while the West Midlands average has risen from 51 to 58 and the national average has increased from 44.2 to 57 leaving support for local people at only 30% of the national and regional averages.**

Graph 1: Comparative Funding Rates for Continuing Healthcare Funding



5.9 Locally in the last year there have been other developments too:

5.10 T&W Health and Social Care Scrutiny became involved, stimulated by an individual appeal and complaint, where the family had sought support from one of our Councillors. The Scrutiny Report is on today's agenda for consideration

5.11 Within the Council, our Assessment and Case Management staff have become totally disillusioned with the local CHC process, feel their assessments are not valued and there is no point in referring people into the system. We now recognise that we need to provide our staff with more training, knowledge, skills and support to overcome this. To achieve this we have agreed (having looked at models in place elsewhere) to recruit 2 CHC specialist workers who will support this training process, support colleagues in completing and pro-actively promoting their part of the assessment process as well as undertaking assessments in situations where we feel the need to challenge and dispute the local CHC decision. One Officer has been in place for 2 months now and a second will be in place shortly.

5.12 Our local MP became involved last summer and wanted to raise the issue in Parliament, see attachment 4. Following discussion he agreed not to do this on the basis that we were hopeful of resolving this locally. With little progress having been made it may be hard to delay this happening now, particularly given the findings of the Scrutiny Review which is also on the Board's agenda today.

5.13 An illustration of where the PCT approach has brought us is that recently we discovered (we should have identified this much earlier and thereby

avoided there being an issue) that 2 people who had been taken off CHC funding, were in fact placed in private hospitals by the PCT but without alternative NHS funding. Our staff concerned about not removing care packages from vulnerable people continued to fund the placements, without establishing the nature of the placement. There is no statutory basis for a LA to fund hospital placements. The PCT prior to their abolition did agree to reimburse the Council in these particular cases.

5.14 Nationally the CHC National Framework was reviewed and updated at the end of 2012 to take account of the changes brought about by the Health and Social Care Act 2012 and in particular the passing of CHC commissioning responsibilities to CCGs and the CHC independent appeals process to NHS England. There were no significant changes to the eligibility criteria. Locally the Team responsible for CHC decision making has transferred into T&W CCG and their lead officer has reviewed the local operational framework, to update it accordingly. National guidance states the local framework should be agreed with the local authority. On the 20 April, the Council wrote to the CCG making it clear that we could not sign up to the framework without significant changes to bring it in line with the national framework and evidence that the approach which currently unduly restricts the number of people deemed eligible for CHC funding is adjusted. Subsequently the CCG have positively decided to use the content of the National Framework as their local position statement but the Council still need to see an increase in local CHC funded activity.

5.15 On the 12 March 2013 our Director of Adult and Community Services wrote to Graham Urwin, Director of the Shropshire & Staffordshire Area Team of NHS England to ensure he was aware of the history of CHC in T&W Wrekin. The letter (see attachment 5) outlined most of the points above and expressed concern about the impact CHC practices in T&W could have on relationships with the new CCG and the potential repercussions for the whole health and care economy if not resolved soon.

5.16 Board members will be aware of the pressures in the health and care economy at a time when the Council's funding is being reduced by 27% in cash terms alone (now rising to 33%) with further pressures ahead. Health initiatives to make changes across the health economy through a Shropshire Compact to reduce costs and improve people's experiences, particularly in the acute sector, will inevitably involve an element of switching costs out of the acute sector and into community settings. The Council are supportive of these policy initiatives.
We believe we are a critical stakeholder in the "whole system" and without our

involvement such changes will be severely restricted. However our ability to support these initiatives will entirely depend on appropriate resource switching across the health economy into the care system. Our current experience of CHC and the resulting budget implications for the Council do not bode well and make it very difficult for the Council to support the changes. Our relationships with the PCT and now CCG have otherwise been very positive and we hope that we can find an agreeable way forward to both organisations, before relationships are damaged and put at risk the strategic approach we all agree with.

5.17 Interestingly, across the country there is an increasing trend to Local Authorities being commissioned to deliver CHC functions by their respective CCGs, with evidence where this can be agreed, that it results in a significant reduction in the tensions that are inherent at the interface between CHC and Council funded community care, given the current legal position.

6. IMPACT ASSESSMENT – ADDITIONAL INFORMATION

N/A

7. PREVIOUS MINUTES

5.1 Health and Wellbeing Board members were first informed about the local position in a report prepared by the Council for the shadow Board meeting on the 22 September 2011.

5.2 A short update to the Board was provided at the next meeting of the shadow Board on 14 December 2011

6. BACKGROUND PAPERS

6.1 National Framework for NHS Continuing Health care and NHS Nursing Care - November (2012) – Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127199/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf.pdf

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CHC Report Legal Comment

On 28 November 2012, the Department of Health announced that the National Framework for NHS Continuing Health Care and NHS Funded Nursing Care had been updated. This sets outs the how eligibility for funding should be determined and replaces the previous version of the National Framework published in July 2009

The Framework was revised to reflect changes introduced by the Health and Social Care Act 2012 relating to the new NHS framework and structures and came into effect from 1 April 2013

In addition to the amendments made to the Framework itself, the supporting tools have been updated and The NHS Continuing Healthcare (Responsibilities of Social Services Authorities) Directions 2013 also came into force on 1st April 2013.

https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

As set out in the Framework at paragraphs 18 to 29 , the relevant legislation does not use or define the expressions 'continuing care', 'NHS continuing healthcare' or 'primary health need'.

Section 1 of the National Health Service Act 2006 (the 2006 Act) (as amended by the 2012 Act) requires the Secretary of State to continue the promotion of a comprehensive health service, designed to secure improvement:

a) in the physical and mental health of the people of England; and
b) in the prevention, diagnosis and treatment of illness.

Section 1A of the 2006 Act requires the Secretary of State to exercise these functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with:

(a) the prevention, diagnosis or treatment of illness, or
(b) the protection or improvement of public health

Section 1H of the 2006 Act establishes the National Health Service Commissioning Board ("the Board") , an independent body which will hold CCGs to account for the quality of services they commission, the outcomes they achieved for patients and for their financial performance. The Board also has the power to intervene where there is evidence that CCGs are failing or are likely to fail to fulfil their functions. The specific functions of the Board are set out in the 2006 Act.

The Board is subject to the duty to promote the comprehensive health service (other than in respect of those services falling within the public health functions of the Secretary of State or local authorities).

Section 3 of the 2006 Act requires CCGs to provide a range of services, to such an extent as they consider necessary to meet all reasonable requirements. These services

must include, amongst other categories, 'such other services or facilities for the prevention of illness, the care of persons suffering from illness, and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service' (section 3 (1)(e) of the 2006 Act).

The Secretary of State for Health remains accountable for the NHS and the amendments to the 2006 Act do not change the Secretary of State's core duty to promote a comprehensive health service, which dates back to the1946 NHS Act . The Secretary of State must bear this duty in mind whenever he exercises any of his functions.

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

If an NHS body is assessing a person's needs (whether or not potential eligibility for NHS continuing healthcare has been identified) and the assessment indicates a potential need for community care services that may fall within an LA's responsibilities, it should notify the LA of this in order for the LA to fulfil its responsibilities.

Section 21(8) of the National Assistance Act 1948 states that nothing in section 21 authorises or requires an LA to make any provision that is authorised or required to be provided under the 2006 Act. This was considered by the Court of Appeal in the *Coughlan,* case where it was held that an LA is excluded from providing services if the NHS has, in fact, decided to provide those services.

Section 21 should not be regarded as preventing a local authority from providing any health services. The subsection's prohibitive effect is limited to those health services which have been authorised or required to be provided under the 2006 Act. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the 2006 Act it was not necessary for the NHS to provide.

LAs also have the function of providing welfare services under section 29 of the National Assistance Act 1948 (which includes functions under section 2 of the Chronically Sick and Disabled Persons Act 1970). Section 29(6)(b) of the National Assistance Act 1948 only prohibits LAs from providing such services under section 29 as are 'required' to be provided under the 2006 Act and so excludes only those services that must, as a matter of law, be provided under the 2006 Act.

Section 49 of the Health and Social Care Act 2001 prohibits LAs from providing, or arranging for the provision of, nursing care by a registered nurse in connection with the provision by them of community care services. 'Nursing care by a registered nurse' is defined as 'services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse'.

The balance between LA and NHS responsibilities with respect to continuing care has been the subject of key court judgments , which are summarised in paragraphs 30 to 32 and Annexes B and C of the Framework , namely *R v North and East Devon Health Authority, ex parte Coughlan (1999)* and *R v Bexley NHS Trust, ex parte Grogan (2006)*

To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the 2006 Act, and to distinguish between those and the services that LAs may provide under section 21 of the National Assistance Act 1948, the Secretary of State has developed the concept of a 'primary health need'. Where a person has been assessed to have a 'primary health need', they are eligible for NHS continuing healthcare. Deciding this involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's assessed health and social care needs – including accommodation, if that is part of the overall need.

The Framework sets out the requirements for review and is clear that neither the NHS nor an LA should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement.

If agreement between the LA and NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved. There is a separate disputes procedure for when the individual disagrees with the decision. Both procedures are set out in paragraphs 145 – 165 and Annex F of the Framework.

CCGs and LAs in each local area should agree a local disputes resolution process to resolve cases where there is a dispute between them about eligibility for NHS continuing healthcare, about the apportionment of funding in joint funded care/support packages, or about the operation of refunds guidance (Annex F). Disputes should not delay the provision of the care package, and the protocol should make clear how funding will be provided pending resolution of the dispute. Where disputes relate to LAs and CCGs in different geographical areas, the disputes resolution process of the responsible CCG should normally be used.

The National Health Service Commissioning Board/ CCGs and Las should have clear jointly agreed local processes for resolving any disputes that arise between them on the issues covered in the Framework guidance. The Standing Rules Regulations and Directions to LAs require the Board or CCGs and LAs to have an agreed local process for resolving disputes between them on issues relating to eligibility for NHS continuing healthcare and for the NHS elements of joint packages. The Board, CCGs and LAs could extend the remit of their local disputes process to include disputes over refunds. It is

important that it should include an identified mechanism for final resolution, such as referring the case to another CCG and LA and agreeing to accept their recommendation. Where an individual disputes the Board's or a CCG's decision on whether to provide redress to them, or disputes the amount of redress payable, this should be considered by the Board or CCG through the NHS complaints process

The Framework at Annex G: Local NHS Continuing Healthcare Protocols provides a best practice guide for what to include when drawing up and updating local protocols and procedures regarding NHS continuing healthcare.

Telford & Wrekin
COUNCIL

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Your Ref:		**Our Ref:**		**Date:**	24 November 2011

Dear Eamonn

Re: Continuing Health Care Funding

It is with regret that I must raise with you a very urgent issue of great concern to this Council in the hope that you will take some action to help resolve an issue that, otherwise will potentially undermine the Council's financial position and the local health and care economy.

I have been aware for some time of the issues for the Council created by the local PCT's changed approach to funding of Continuing Health Care (CHC) as part of the NHS QIPP agenda. While the issues of the knock-on impacts for the Council and consequences for our ability to play our part in the local health and care economy have been raised regularly at the PCT Board for over 18 months now, we have tried to approach this positively in order to sustain the good partnership working between PCT and Council which has been built up in our local area and the changes that we are all looking to make to service delivery. Telford and Wrekin Council has a long and proud track record of partnership working and this is demonstrated through the way that we have supported the recent proposed reconfiguration of acute services and also the way that we have sought to work with the PCT – without seeking to make a major issue out of this with members, scrutiny, MPs, the media etc – in relation to its changing approach to CHCs. However our wish to try to work through this issue with the PCT has now placed us in a totally untenable position as the PCT's proposed further disinvestment in CHC continues and accelerates the transfer of costs to the local council at an unsustainable level for us.

The Council has to meet grant cuts of 27% in cash terms alone from mid 2010 through to 2014/15 which after taking account of inflation and service pressures is nearer to 40% in real terms. We carry low balances and the front end loading of severe grant cuts in a settlement only announced mid December last year meant much of those had to be deployed as part of the current year's budget while savings programmes already planned had a chance to deliver. Current Government policy also effectively deprives councils from any recourse to council tax increases. Thus as we are and have been for some years delivering all the efficiency savings and increased charges we can, including a second wholesale restructuring of the Council in 2 years, any additional burdens inevitably result in extra service cuts now at a time when the economic situation actually increases the demands on our services.

We appreciate the NHS also finds itself with significant savings to make and will naturally look at areas of higher spend /lower priority to disinvest in, but this ought to take some account of the

consequences for other parts of the health and care economy in making a judgement on the degree and pace of adjustment. The PCT set itself a target of saving £1.8m in 2010/11 for CHC costs and actually delivered savings of around £4m (of which £0.5m was then helpfully returned to the Council as a one-off), the balance of over achievement was then used to pass additional funding to SaTH to help meet its ongoing financial overspend issues. For 2011/12, the PCT then set itself a target of a further £2m savings and by September was flagging an over-achievement of around £1.4m to date, but latest full year projections in November show a £4m (200%) overachievement and this is again being used to switch additional funding to the hospital trust plus meeting all other PCT overspend areas. While these savings may look relatively 'easy' on paper for the NHS to realise, the reality on the ground here is very different and will get much worse.

The Council has previously set aside additional ongoing funding of around £1.5m from its savings for transferred CHCs and is also utilising £2m additional NHS funding transferred to the Council as part of the Lansley money to promote integrated health & care working. This should have been sufficient to meet the PCT's cumulative budget savings target given some element of self-funding in CHC cases, however the disinvestment/cost transfer has just carried on accelerating. The additional in-year pressure to the Council has been largely absorbed so far by use of one-off funding, contingencies and programmed in-year savings made early in other services. However these will not be available in 2012/13 and thus the continual and rapid rise in CHC costs being shifted to the Council is not sustainable in our current budget strategy for 2012/13. Taking account of the full year impacts in 2012/13 of decisions to date and further CHC investment we have already set aside for that year from our own funds, we estimate a further shortfall of at least £3m in our current overall deficit projections for which no funding is now projected and we are due to launch our overall budget strategy for consultation in papers to be issued mid December.

The PCT's Board report in November on its financial position brought some clarity to the CHC position in terms of historic CHC spend trends plus outlining a possible strategy. Given the PCT policy changed around Autumn 2009 and therefore was already impacting on 2009/10 spend, this shows a net cash disinvestment by the PCT of around £8m to date - a cut of some 55%, though an extrapolation of the 3 years' growth up to 2009/10 would indicate a far higher potential real terms cost shift towards the Council and cut of nearer 70% over the last 2 years. At present taking account of projected full year impacts into 2012/13 we estimate at least £8m CHC costs will effectively have been transferred to the Council by next year even if no more cases are reviewed from now. We have no ongoing funding for £3m of this and the availability of the £2m NHS funding beyond 2012/13 must be in doubt which will make the position even worse.

Our ability to support the local health and care economy is therefore going to be reduced which is concerning given the Government priority of greater health and care integration and the NHS need for Council support to deliver QIPP savings. It is clearly in everyone's interests to support the acute hospitals and avoid bed-blocking, however, if because of the scale of these funding pressures we are unable to fund some of our community-based care services at their current levels, then this will inevitably have a financial and operational impact for NHS resources. To stress, we want to avoid this situation, but the position, without any change in policy/implementation regarding CHCs, is one that should concern us all greatly.

We have regularly flagged for over 18 months with the PCT Board the impact of overachieving their budget strategy targets which is switching funding away from the preventative, community based services we provide and into the acute sector – the complete opposite of current Government strategy and generally accepted good practice. The issue was raised in more detail through a paper to Health & Wellbeing Board in September. While we appreciate the need for some measured and phased reduction in CHC spend by the PCT it has been too far, too fast without consideration of the wider impact and in our view has at the margin resulted in individual decisions which are concerning. It has also put a considerable strain on working relations in front line services in some cases which impacts on our vulnerable clients.

As mentioned, we welcome the presentation of a strategy in the latest Board monitoring papers but would wish to discuss the applicability of the target of average spend when arguably ours is not an average position locally with no community hospitals/very limited intermediate care provision, particularly significant long term health issues in our more deprived areas and some concern around CHC spend classification consistency between PCTs.

As I said at the beginning it is with real and genuine regret that I find myself having to write such a letter. I know Paul Clifford is meeting with Leigh Griffin and Mike Innes to discuss this issue next week and, given the urgency of resolving this before our budget process, I would be grateful if we could then meet the following week – w/c 5th December - so I can then advise our Cabinet of the next steps. Apologies for requesting a meeting at such notice when I know how big your workload is handling all the NHS change agenda across the West Mercia area but this has reached a critical point for us. To this end, both Paul and I are very happy to travel down to Worcester to see you and will look to re-schedule pre-arranged meetings in our diaries to ensure that a meeting can be held and we can look to find a satisfactory resolution to this very difficult situation.

Yours sincerely

Richard Partington
Interim Chief Executive

cc: Leigh Griffin, Managing Director, Shropshire & Telford PCT
Mike Innes, Chair, Telford & Wrekin Clinical Commissioning Group

Summary of NHS Continuing Health care data – taken from the Department of Health data on numbers of individuals in receipt of NHS continuing healthcare 2009/10 to date, by PCTs in England

Full data can be accessed by the following link http://www.dh.gov.uk/health/2013/01/nhs-continuing-healthcare/

PCT	2009/10								2010/11								2011/12							
	Qtr1		Qtr2		Qtr3		Qtr4		Qtr1		Qtr2		Qtr3		Qtr4		Qtr1		Qtr2		Qtr3		Qtr4	
	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop	People	Per 50k pop
England Total	45k	44.2	47k	46.4	50k	49.3	50k	49.7	50k	49.9	51k	50.3	51k	51	53k	52.5	53k	52.7	55k	54.7	54k	54	55k	54.8
T&W PCT	324	100	341	105	317	97.9	221	68.3	264	81.5	237	73.2	209	64.5	177	54.7	156	48.2	94	29	78	24.1	64	19.8
West Mids SHA	5.4k	51	5.6k	52.7	6k	56.3	6.1k	57.2	5.9k	55	5.9k	55.2	5.8k	54.6	5.7k	53.5	5.8k	54.3	5.8k	54.6	5.8k	54.7	5.9k	55.5

12/13			
Qtr1		Qtr 2	
People	Per 50k pop	People	Per 50k pop
56k	55.6	57.6	
70	21.6	56	17.4
6.173k	57.5	6.175	

The data shows that T&W PCT moved from being the 5th highest ranked PCT for CHC funded people per 50,000 population at Qtr 1- 2009/10 to the 14 lowest by Qtr 2 – 2011/12 and 4th lowest by Qtr 4 – 2011/12. By the end of Qtr 2 2012/13 the number of people receiving CHC funding fell to a new low and 14 fewer than the previous quarter suggesting that people are still leaving the system at a faster rate than new people are accepted into the system, at a time when nationally figures are still on the increase

These trends have resulted in the financial impact on the Council as set out in the attached paper.

MP BRIEFING 29/8/12: CONTINUING HEALTH CARE

Continuing Health Care (CHC) funding eligibility is decided by the PCT after considering health and care information and is intended to fund the health and care needs of those clients whose primary need is for health care, though this can be supported in a community setting rather than acute hospital. Revised national guidance to be applied in deciding on CHC eligibility was issued in 2009 to bring greater uniformity in its application across the country. At that point spend per head of population by the T&W PCT for this area, though on a par with the rest of Shropshire, did appear to be high compared with other areas of the country -5th highest out of over 150 PCTs- so some adjustment was potentially to be expected .
Since then existing cases already in receipt of CHC have been reassessed by the PCT even though their needs have not changed, and the majority assessed have had CHC withdrawn which means the costs then fall on the individual if they are 'self funders' under social care criteria, or in most cases the costs then default to the council. The impact has been:

- A decision making process driven largely by PCT cost saving needs
- A 73% cut in PCT spend on CHC from £13.9 in 2009/10 to £3.8m last year...and falling. This is in cash terms only and thus ignores demographic trends (new cases) and inflation. In the 3 years leading up to 2009/10 spend was increasing at 18% pa on average-taking that into account the cut is over 80% in the space of 2 years
- PCT savings targets for CHC of £3.8m over the 2 years have been exceeded by 165%. The in year overachievement in savings has been used to give additional funding to SaTH thus in the overall Health and Care economy switching funding away from preventative, community based services into acute-the complete opposite of stated intentions from the Health Secretary
- PCT spend is now 4th lowest per capita in the country, lowest in the West Midlands and half that of Shropshire
- PCT spend is now only 55% of that as far back as 2005/06 in cash terms alone ie without building in inflation and demographic increases
- Social workers feel worn down by a CHC process and approach by the PCT team they describe as generally bullying and dismissive of their input where decisions appeared already made before their input was considered – relations otherwise with the PCT and now CCG are good and this is the sole area of conflict
- Around £8m of the PCT cost savings have hit the Council...on top of the Government's 28% funding cuts – this nearly doubles the cuts to be made by social care. It leaves us in the position of considering consulting shortly on explaining this impact and how it means we must now raise our care assessment criteria to critical for next year unless an ongoing solution can be found. This risks judicial reviews and we would join only a handful of councils nationally having to take this step so far.

The issue has been raised with the PCT for over 2 years now with no ongoing resolution, but discussions with the PCT Cluster Chief Exec in January 2012

around the impact on the Council's financial position and services,put in place a temporary solution for 11/12 and 12/13 only, on top of using £3.4m ongoing of the Council's own funding created from service cuts across the Council:

- Use of £2m pa 'Lansley money' from the national £1bn intended largely for investment in services to reduce future pressures on acute services but instead used to offset part of this cost switch from the PCT
- £3m one off PCT funds to cover the balance of the Council overspend in 11/12
- A one year agreement to set the PCT budget for 12/13 CHC at the national per capita average of £6.5m compared with 11/12 outturn of £3.8m and transfer any unused balance to the Council.
- An external review of the PCT's application of the criteria for CHC assessments. Despite our stated reservations, this was arranged to be carried out as a paper based exercise only, which found on the basis of the information originally included for consideration the decisions chosen for review were ok. Our view, stated at the time, is that this exercise was severely limited by being solely paper based as the papers can only reflect the outcome of the PCT driven DST discussion and not the application of the criteria to the individual which could only be properly achieved by an actual reassessment of a sample of individuals.

This arrangement with the PCT cluster has safeguarded the Council's position this year but there is still no ongoing solution in place and responsibility for resolving a situation created by the PCT this has been passed to the CCG. The PCT pledge to spend up to national average by transferring unused budgets to the Council is for this year only and while there is verbal assurance from the CCG to carry on this arrangement, there will be a growing risk of challenge from their auditors. There are also no 13/14 allocations available yet of any Lansley money, thus neither of these funding sources is sustainable and the Council potentially faces an additional funding shortfall of around £5m for 2013/14 or 2014/15. This will mean additional service cuts including raising care criteria…all of which will be counterproductive for keeping out/getting people out of hospital. Hence our concern all along with an adjustment applied too far and too fast with no consideration of the overall health and care position for the area and its people…..the complete opposite of the integrated approach promoted by the Secretary of State. This outlines the overall impact on the Council and the health and care economy…at a more detailed level there are local people who are being affected both in terms of care and support as well as financially.

a co-operative council

Telford & Wrekin COUNCIL

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Your Ref: **Our Ref:** **Date:** 12th March 2013

Dear Graham,

Continuing Health Care in Telford and Wrekin

Further to our brief discussion at Cluster Board regarding the unresolved issues around the PCT's approach on CHC, I am setting out the local position from the Council's perspective.
There was a change in approach to the application of CHC criteria by the PCT from October 2009 which was not discussed with the Council or assessed for impact. We agree that CHC spend in 2009, though on a par with the rest of Shropshire, did appear to be high compared with other areas of the country – 5th highest out of 152 PCTs and thus warranted some review and adjustment. However we completely disagree with the speed and extent of change which has cut PCT supported cases by 83% (see attached table of NHS data) taking T&W PCT to lowest spender in the West Midlands, one of the 3-4 lowest in the whole country . T&W now provides less than half the level of support given by Shropshire PCT even though that has also declined (and they have a community hospital network as well to handle NHS responsibilities post acute settings)

Since 2009/10 CHC spend has fallen from £13.9m to £3.8m in 2011/12 in cash terms alone ie without allowing for inflation or demographic increasesand continues to fall. While some has fallen on local people who are 'self funders', over £8m NHS spend has been shunted onto the Council-a massive impact on top of 27% government grant cuts to local government. CHC spend by the PCT in 2011/12 is only 55% of what was incurred as far back as 2005/06-again without any adjustment for inflation or demography.

Our concerns have been raised regularly at PCT Board since June 2010 and because of lack of action, led to this being raised with Eamonn Kelly in November 2011-letter from Richard Partington attached.The letter sets out the key issues but is obviously based on the data at that point in time.As a result of discussions with Eamonn who was concerned with the scale of what had happened and the impact on the Council's Adult Care budget, there was an agreement to pass one off funds of £3m across to the Council in respect of 2011/12 and agreement to our use of the 'Lansley' money passported across to the Council to offset part of the shortfall in that year as well.It was also agreed to set the PCT budget for CHC in 2012/13 at a level 'proportionate to average national levels of CHC support' Thus a budget of £6.5m was set although spend outturn in 2011/12 was only £3.8m and still falling, and this will cover an agreement to transfer £2.7m across to the Council -and again with use of the £2.1m Lansley money together they will offset £4.8m of the £8m+ impact on Council budgets. For 13/14 there is a proposal to replicate the transfer of one off funding from the CCG at a slightly reduced level-£2.4m, however there is currently no progress on resolving the concerns with the ongoing CHC decision making within the PCT/CCG which was one of the elements of the agreement with Eamonn back in January 2012.

Given the continued difficulties and her own concerns with our PCT on this issue, Rachel Holynska, Deputy Director for People,Communities and Local Government at Midlands and East has for some time been trying to facilitate further discussion on the matter. Through Rachel it was suggested that facilitators for a joint CCG/Council workshop could be Jim Ledgwidge (consultant with Social care background) and Su Fitzgerald (Health background) as they have taken part in joint training events on CHC regionally and nationally. We were in agreement but the CCG would not accept Su Fitzgerald as the named health facilitator. We flagged this with Rachel who discussed the position with Corinne Taylor, Regional CHC lead and there was a proposal for Corinne instead to take the NHS part in the workshop but we understand she may not be the lead beyond March 31st so haven't yet put this forward to the CCG.

Locally there have been other developments.

- The Health and Social Care Scrutiny Committee have been undertaking a review of the local CHC position, stimulated in particular by an individual appeal and complaint, where the family were supported at their request by one of our Councillors. They are nearing the completion of their review and I understand in finalising their conclusions are considering whether to refer the matter to the Secretary of State on the basis that what has happened constitutes a major change in local NHS policy and as such should have been referred to Scrutiny before implementation.

- Within the Council, our Assessment and Case Management staff have become totally disillusioned with the local CHC process, feel their assessments are not valued, and there is no point in referring people into the system. We now recognise that we need to provide our staff with more training, knowledge and skills to overcome this but have also decided (as per models in place elsewhere) to recruit 2 CHC specialist workers who will support this training process, but also support colleagues in attending panels as well as undertaking assessments in situations where we feel we need to challenge and dispute the local CHC decision. They will be in place by April.

- Our local MP Dave Wright has become involved –see briefing note from last August -and wanted to raise the issue in the House when it came back from the summer recess. We managed to put that on hold saying we were still trying to resolve this locally but we have made no progress since then and would find it hard to justify delaying him again, particularly with the Scrutiny Review under way.Dave has asked for another briefing this month.

- Since 2009/10 T&W PCT support for CHC cases has fallen from 100 to 17.4 cases per 50,000 population while the West Midlands average has risen from 51 to 58 and national average has gone from 44.2 to 57 highlighting why both the 2009 and current positions are outliers in opposite directions.

- The local approach is still reviewing existing cases to remove even more people from CHC (there's only 56 left!!) on top of very few new ones being allowed.It also results in issues such as we now find ourselves funding 2 people in private hospitals with no NHS support at all-clearly wrong for us but symptomatic of an approach where in contrast to the PCT, our staff are concerned not to remove care packages from vulnerable people and thus want to avoid people getting caught between the 2 organisations and suffering as a result.

- An update on CHC will be going to our Health & Wellbeing Board in May and under the new arrangements then on to full council.

- An initiative driven by the 2 local CCGs to make changes across the health economy through a Shropshire compact saving costs and improving people's experiences will inevitably involve an element of switching costs out of the acute sector and into community settings. Our ability to support these initiatives will entirely depend on resource switching across the health and care economy to follow consequent organisational impacts given our financial position, and our continuing and disturbing CHC experience will inevitably colour our approach and level of trust.

Our relationships with the PCT and now CCG have been very positive in all but this area and we haven't wanted to damage this ,but due to that concern and the actions of one team in the PCT we are left in an untenable financial position ongoing which will have repercussions for the whole health and care economy locally if not resolved soon.

Yours sincerely

Paul Clifford
Director, Adult and Community Services

Telford & Wrekin Health and Well Being Board
15th May 2013

NHS Continuing Healthcare (CHC)

1.0 Introduction

This report details the Telford and Wrekin Clinical Commissioning Group's (CCG) position in relation to the application of the National Framework for Continuing Healthcare (2012) and the legal framework in which it is required to operate.

As a new organisation, the CCG is keen to ensure all services it commissions for the population of Telford and Wrekin are provided equitably, consistently and in accordance with national NHS directives and guidance. Failure by the CCG to comply with national guidance could lead to judicial review.

CHC is an emotive issue and a nationally devised, prescriptive process must be followed by CCGs in their consideration of each individual's case. (The National Framework for Continuing Healthcare 2012 and Practice Guidance 2012).

It must be remembered that this is an individual process for each person and decisions are made on an individual basis depending on the level of assessed need. The ratification of these decisions is for the NHS organisation to determine.

The NHS can only support funding where the individual has a primary need for healthcare. In simple terms, the process involves a holistic view of an individual's overall needs to determine their health needs and their need for personal and social care. (Personal care is washing, dressing, mobility and moving, nutrition, elimination needs, maintaining a safe environment, providing some psychological support.) If health care is the primary need then the NHS is required to fund the entirety of the individual's package of care , whether this is in a nursing or residential home or in their own home.

1.1The National Process

The national screening tool or checklist is completed by a suitably trained nurse or social care professional; this is usually a hospital or community nurse or social worker from the Local Authority. Referrals for the checklist process are also made by individuals or family members themselves or by nursing/ care home staff. This process determines whether an individual's level of assessed needs trigger the eligibility for a full continuing health care assessment. (N.B. There is a low national threshold set for eligibility for a full CHC assessment.)

The CHC assessment is carried out jointly by health and social care professionals (employed by the Local Authority) who make the recommendation in respect of eligibility for NHS funding to the CCG for ratification. The guidance states that the CCG should accept this recommendation in all but exceptional cases and in practice this is always the case at T&WCCG.

The CCG's appeal process is communicated to all claimants and their families with each outcome decision, should they wish to request a review of the decision. This process is rarely used in practice as the CCG and PCT before it receives a low number of appeals.

It is nationally recognised that the continuing healthcare process is complex and potentially confusing for individuals, usually at a time when they are most vulnerable, and as such the CCG's Complex Care Team, made up of expert nursing staff and social workers, will always help individuals and their families (where appropriate) to understand the process as much as possible.

The Board should note that the CCG, as a new organisation, has given a real commitment to work with the Local Authority (LA) and others to build effective working relationships. Furthermore, the CCG has agreed with the Chair of the Health and Adult Social Care Scrutiny Committee to address some of the recommendations that it is legally able to address, within their report.

2.0 Background

The CCG is aware that there have been tensions between the previous PCT and Telford and Wrekin Council in this area since 2009 in relation to funding.

The LA has maintained that the PCT changed its policy in relation to CHC at this time; however the PCT was merely applying the revised national guidance (as per the National Framework for Continuing Healthcare 2009) that gave a greater level of clarity to the eligibility decision making process aligned to the national criteria.

The CCG is clear that the National Framework for Continuing Healthcare (2012) is appropriately adhered to and implemented in the spirit for which it is intended.

The CCG has assurance of this via several mechanisms:

- An external peer review of cases selected by the Local Authority (LA) was carried out with jointly agreed terms of reference. The independent panel agreed the CCG decisions were in line with national procedure. The LA subsequently disagreed with the findings of this review.
- Review of challenged cases considered by the Independent Review Panel chaired by NHS Midlands and East resultantly upheld PCT decisions.
- Case referred to NHS Ombudsman's Office was not accepted for review.
- External audit of CHC carried out in August 2012 at the request of the PCT Board - outcome of this was "significant assurance" given.

3.0 Financial Impact

The national benchmarking of CHC across England commenced in 2009/2010.

At this time guidance to PCTs on data submission was unclear and PCTs did not readily have information in the required format to submit. This resulted in widely different data sets being submitted across the country. The resulting list of PCTs generated (to which the LA has consistently referred) does not compare "like with like" and as such is still published with a "health warning".

Since the start of the data collection in 2009/10 PCT/CCGs have refined the information they submit to show pure CHC funded cases- removing data related to other NHS funded care such as mental health and adult learning disability special placements and funding to support individuals following their detention under specific sections of the Mental Health Act. The funding of such cases continues to be met by the CCG but this is not reported in the nationally submitted data.

An example is evident in the increase of mental health specialist placement costs:

2009/2010	2010/2011	2011/2012	2012/2013
£1.356m	£1.744m	£1.724m	£1.85m (FOT)

This budgetary realignment is the reason why the national data has shown a reduction since 2009/10. This matter has been discussed on several occasions with the LA and latterly with HoSC members.

The CCG recognises that the Local Authority has financial constraints and to this end transitional support of £6million has been given by the PCT/CCG. It is recognised this can only be a temporary solution as this is not a statutory requirement of the CCG, indeed the CCG would be acting outside of its legal framework if it were to continue to fund social care; this funding could be used for other NHS services.

(It should be noted that the LA applies means testing processes before funding an individual's care whereas the NHS fully funds all care needs if eligible for CHC funding.)

Similarly, comparisons based on national data or even within the West Midlands are not easy to make, as each CCG will commission services that support individuals in a different way e.g. some areas fund 24/7 community nursing teams and have a resultantly low incidence of CHC in their population, whereas other CCGs commission different models of care for their population.

The CCG wish the Board to know that all outstanding financial issues raised by the LA with the former PCT have been resolved amicably and this includes the 2 cases cited by the LA in their report.

The health and social care economy pan Shropshire faces significant challenges in the coming years and it is imperative that the CCG and LA work effectively together to ensure the population is appropriately served.

4.0 Moving Forward

The CCG have given a commitment to work with the LA and its team to review:

- roles and responsibilities of both organisations,
- ways of working for both operational teams
- escalation processes in relation to CHC

Similarly, there is a commitment from the CCG to continue to work with provider organisations on training and education to ensure ongoing appropriate support is available to individuals and their families. The CCG will also be working with

its patient group, to identify any improvements to the advice and support currently in place.

In order that moving forward is successful the CCG requires a reciprocal level of commitment from the LA and their teams, as this will improve the understanding of the shared objectives and ensure both organisations teams understand the legal frameworks in placed upon them I their respective roles. By working together this should help to begin to demystify the CHC process helping individuals and their families understand the process more clearly.

. **Recommendations**

The Health and Well Being Board is asked to:

- fully consider the contents of this report from the CCG
- Note the CCG's commitment to work in partnership with the LA and other agencies to promote a greater understanding of roles, responsibilities and processes in relation to CHC.
- Seek assurance from the LA that it is willing to work constructively with the CCG to move forward for the benefit of the population of Telford and Wrekin

Christine Morris

Executive Nurse, Lead for Quality & Safety