TELFORD & WREKIN COUNCIL

HEALTH & WELLBEING BOARD – 15th MAY 2013

TITLE – SCRUTINY REVIEW OF CONTINUING HEALTHCARE IN TELFORD AND WREKIN

REPORT OF – HEALTH AND ADULT CARE SCRUTINY COMMITTEE

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1 The Scrutiny Committee have made a series of recommendations set out in the report attached that if implemented will improve the Continuing Healthcare (CHC) assessment process. A fair assessment process will ensure that all patients assessed for CHC funding will have their needs appropriately assessed to determine both health and social care needs and address the funding issues for the Council's Adult Care budget.

2. FOR INFORMATION OR DECISION

2.2 This report is for Decision

3. RECOMMENDATIONS

3.1 The Health and Wellbeing Board:

3.2 Consider the Scrutiny report and recommendations and agree to provide a response to a future meeting of the Health and Adult Care Scrutiny Committee.

3.3 Agree to monitor the level of CHC funding, the number of jointly funded care packages made following a CHC assessment and the total funding contributions by partner organisations on a quarterly basis as set out in recommendation 21 in the Scrutiny Report.

4. SUMMARY IMPACT ASSESSMENT

<table>
<tr><td rowspan="4">COMMUNITY IMPACT</td><td colspan="2">Do these proposals contribute to a specific HWB Priority</td></tr>
<tr><td>Yes</td><td>Improve: emotional health and wellbeing of borough residents

Improve :unpaid carers health and wellbeing

Support :people with specific health needs to live independently for as long as possible

Support :people with dementia</td></tr>
<tr><td colspan="2">Will the proposals impact on specific groups of people?</td></tr>
<tr><td>Yes</td><td>The report has a direct impact for patients who are assessed for CHC funding and their families.</td></tr>
<tr><td>TARGET COMPLETION/DELIVERY DATE</td><td colspan="2">Response from Health and Wellbeing Board to be presented to a future meeting of the Health and Adult Care Scrutiny Committee</td></tr>
<tr><td>FINANCIAL/VALUE FOR MONEY IMPACT</td><td>Yes</td><td>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</td></tr>
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		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	The Health and Social Care Act 2012 and the National Health Service Act 2006 (as amended) and Regulations made under the Acts make provision for local authority scrutiny of health services and include a power to refer matters to the Secretary of State. The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care governs the approach that should be taken by bodies in relation to CHC and refers to protocols being established between relevant bodies.
EQUALITY & DIVERSITY	Yes	The Scrutiny report identifies the difference in level of CHC funding between different PCT areas across the West Midlands.
IMPACT ON SPECIFIC WARDS	No	
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	The Scrutiny Committee have received evidence from individuals, Age UK Shropshire, Telford and Wrekin Advocacy Service
OTHER IMPACTS, RISKS & OPPORTUNITIES	Yes	The Scrutiny Report has set out how the Committee will measure if the recommendations have been effectively implemented and the further recommendations the Committee will make if the issues regarding CHC are not resolved.

PART B) – ADDITIONAL INFORMATION

5. INFORMATION

5.1 The Scrutiny Report and Recommendations are attached.

6.0 IMPACT ASSESSMENT – ADDITIONAL INFORMATION

6.1 The effect of the reduction of CHC funding is set out in the main report.

7.0 PREVIOUS MINUTES

7.1 HACSC- 42

8.0 BACKGROUND PAPERS

8.1 Report prepared by Fiona Bottrill, Scrutiny Group Specialist, Telephone: 01952 383113

Health & Adult Care Scrutiny Committee

Scrutiny Review of Continuing Healthcare in Telford and Wrekin

April 2013

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Chair's Foreword

I have been involved in Health Scrutiny since it started in 2003 (and in the Shadow Health Scrutiny arrangements for 2 years prior to this) and believe that this is one of the most significant pieces of work that the Health & Adult Care Scrutiny Committee in Telford and Wrekin has undertaken.

I also believe that this Scrutiny Review is particularly timely as the new Telford and Wrekin Clinical Commissioning Group (CCG) has recently taken formal responsibility for the commissioning of many local health services. The system of assessment for Continuing Healthcare (CHC) funding that is criticised in this report has been inherited from the Primary Care Trust. I am pleased to report that my most recent discussions with the CCG regarding CHC have been very positive, and I am confident that this report will provide the basis for future improvements in the CHC process.

Whilst the issue of Continuing Healthcare cannot be separated from funding, the Committee's primary concern has been that the people of Telford and Wrekin should get the level of healthcare based on their need and that this should be consistent with the level of healthcare provided in other areas. As a new organisation the CCG has the opportunity to make the changes necessary to make a real difference for some of the most vulnerable patients and their families. However, the other inescapable finding of this review is that the issue of Continuing Healthcare cannot be seen in isolation from other parts of the health and social care system. The solutions to the problems identified in this report must be resolved through partnership working that puts the patient at the centre – not funding.

This has been a challenging piece of work and it is the first time that the CCG has been involved in a Scrutiny Review and also the first time the Council's new Health and Wellbeing Board will be involved in responding to Scrutiny recommendations. I welcome the approach taken by the CCG in recent discussions and I believe that this establishes a good working relationship with our new NHS colleagues based on the principles of good scrutiny:

- Providing constructive "critical friend" challenge.
- Amplifying the voices and concerns of the public.
- Led by independent people who take responsibility for their role.
- Driving improvement in public services

The Scrutiny Committee is independent of the Local Authority Executive and while a Cabinet Member and Local Authority officers have given evidence to the Committee, we have seen this in the wider context of all the evidence received. The independence of the Committee is greatly enhanced by the Co-opted Members of the Committee who have participated fully in this review. The recommendations in this report were agreed unanimously.

I want to thank everyone who contributed to this review – but especially Mr. S Wood and Mrs. M. Wood, Shropshire Partners in Care, Lightmoor View Nursing Home and Age UK Shropshire, Telford and Wrekin who provided compelling evidence to the Committee of how the CHC assessment process affects patients and their families.

Cllr. Derek White

Chair Telford & Wrekin Health & Adult Care Scrutiny Committee

About Scrutiny

Local Authorities were given the power to scrutinise local health services in 2003. The Health and Social Care Act 2012 reinforced the role of Health Scrutiny Committees setting out their power to review and scrutinise matters relating to the planning, provision and operation of the health services in their area.

The Centre for Public Scrutiny promotes 4 principles of good scrutiny. Scrutiny should be:

- Providing constructive "critical friend" challenge.
- Amplifying the voices and concerns of the public.
- Led by independent people who take responsibility for their role.
- Driving improvement in public services

In Telford & Wrekin, the Health & Adult Care Scrutiny Committee carries out the Health Scrutiny function. The Committee can undertake reviews into local services and is a statutory consultee where the NHS proposes substantial variation or development in services. The legislation and guidance sets out that scrutiny should not be an adversarial process but where a substantial change has been made to NHS services and the Health Scrutiny Committee has not been consulted, the consultation has not been adequate or the Committee believes that the outcome of the consultation is not in the interest of the local health service, the Committee can refer the matter to the Secretary of State for Health. This power of referral should only be used if all other options have been explored to resolve the issue locally.

The Members of the Health and Adult Care Scrutiny Committee are:

Cllr. Derek White (Chair)
Cllr. Veronica Fletcher
Cllr. Jackie Loveridge
Cllr. Adrian Meredith
Cllr. John Minor
Cllr. Roy Picken
Cllr. Jacqui Seymour
Cllr. Chris Turley

Co-optees:
Dilys Davis
Jean Gulliver
Cllr. Ralph Perkins
Richard Shaw

About Continuing Healthcare (CHC)

Continuing Care means care provided over an extended period of time to a person aged 18 or over, to meet physical or mental health needs arising from disability, accident or illness.

Historically, responsibility for continuing care rested either with the NHS when the person was in a hospital setting or with Local Authorities when they were in their own home or in residential or nursing home care.

However, with the closure of many long stay hospitals (specialist hospitals for people with a learning disability or mental health need, geriatric hospitals, cottage hospitals, etc.), and reducing stays in general hospitals, this division of responsibility based on the location of the person in need became increasingly problematical. Emerging concerns were that some funding arrangements may be ultra vires if the NHS or Local Authorities were funding care that was outside their statutory roles. There were also concerns about :

- Cost shunting of NHS responsibilities to Local Authorities
- Cost shunting of some (community care services are means tested and many people pay a contribution towards the total cost of their care) or all (where a person is financially assessed as being wholly responsible for funding their community care services as a "self-funder") of the costs to the individual

This led in 1995 to the Department of Health (DoH) setting out guidance for the first time for the NHS in respect of people with long-term or end of life care needs who were no longer receiving their care in hospital. From 1996 each Health Authority (with responsibility subsequently passed to Primary Care Trusts (PCTs)) were required to have criteria (locally developed) defining when the NHS would be wholly responsible for all elements of a person's care and treatment needs even though they were no longer receiving this care and treatment in a hospital setting.

Over time an increasing number of people were deemed to meet these local criteria and therefore had all of their care and treatment costs funded by the NHS, with no personal contribution. However there was significant variation across the country.

Whilst this was a step forward many legal challenges and judgements followed, ultimately resulting in the Department of Health announcing in 2004 that it was commissioning the development of a national consistent approach to funding NHS Continuing Healthcare.

One further positive development was recognition for people in nursing homes (not residential care homes) whose care was either funded by Local Authorities (together with a personal contribution) or wholly funded by the individual, that an element of their care should be the responsibility of the NHS. This led to the introduction of the right to "free nursing care" in a nursing home, which meant that the NHS would pay a proportion of the nursing home fee for all individuals as NHS-funded Nursing Care. The standard rate for 2013 is set at £109.79 a week. This applied to each nursing home resident whether or not they had also been assessed as meeting CHC criteria.

In 2007 the first national framework for NHS CHC and NHS-funded Nursing Care was published followed by a revised framework in July 2009. The Department of Health issued a further revised framework in November 2012 and this is the document that the Committee has used in this review. The framework tried to bring more consistency to the determination of eligibility for NHS funded CHC by applying a "primary health need" test to determine the nursing or other health services

required by the individual. The term 'primary health need' does not appear, nor is it defined, in primary legislation, although it is referred to in the Standing Rules where it sets out that 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".

The Local Authority can only meet nursing/healthcare needs when, taken as a whole, the nursing or other health services required by the individual are below this level. If the individual's nursing/healthcare needs, when taken in their totality, are beyond the lawful power of the Local Authority to meet, then they have a 'primary health need'.

The process to determine if a person has a primary health care need and is therefore eligible for CHC funding is made through the CHC assessment process which involves a two stage assessment. An initial Check List is completed by a qualified healthcare professional or social worker to establish whether an individual needs a full assessment of eligibility. If the outcome of this initial Check List is that the person should have a full assessment, it is the responsibility of the Primary Care Trust (PCT) / Clinical commissioning Group (CCG) to work with other relevant professionals as a multi-disciplinary team (MDT). The MDT will make a recommendation to the PCT / CCG which will decide if the patient is eligible for CHC funding.

The multi-disciplinary assessment is based on 12 domains, scored on a 6-point scale from "no need" through to "priority" – though not all domains attract the higher ratings.

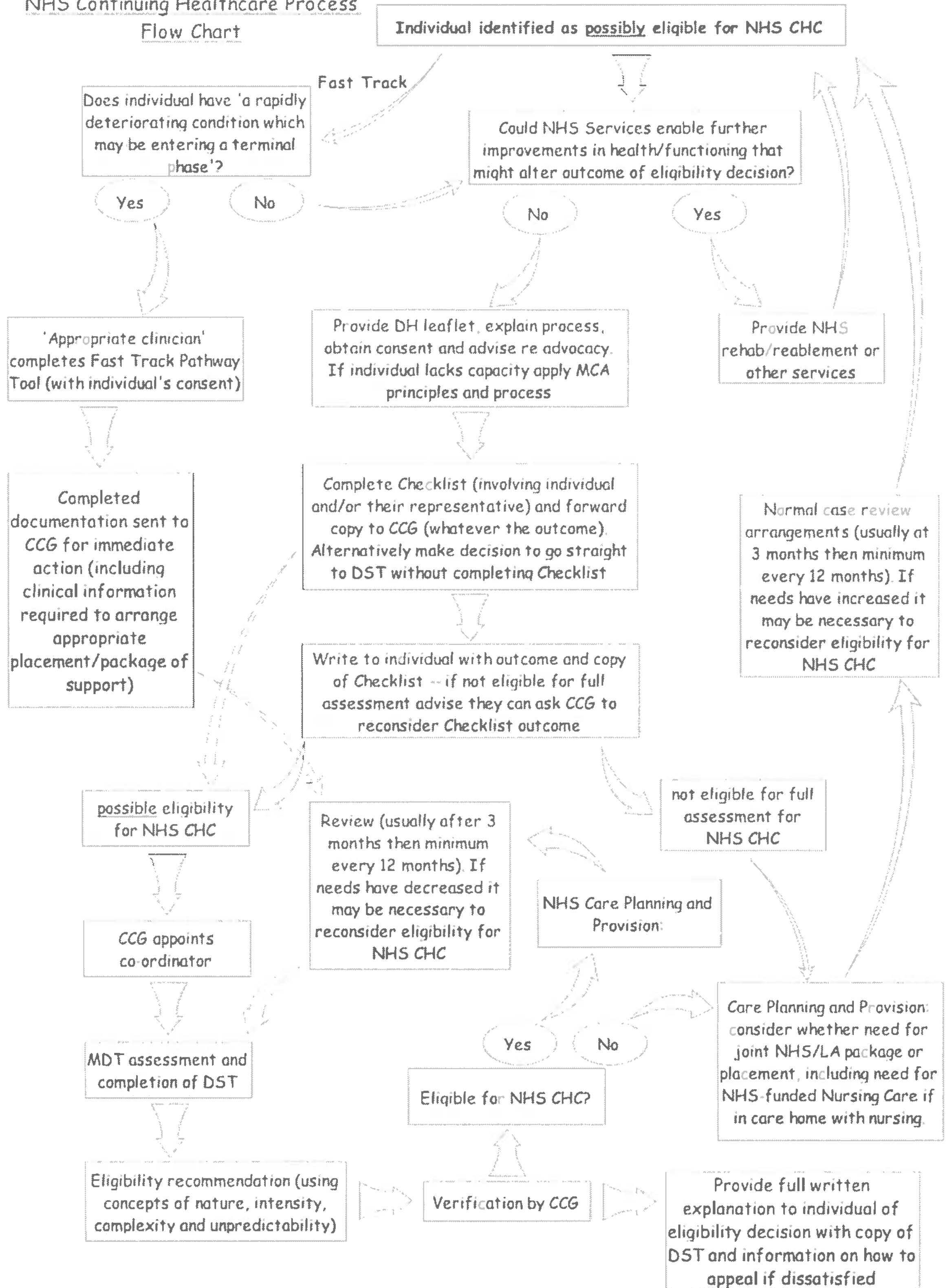
The 2012 Decision Support Tool (DST) Guidance states that a clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains. Where there is:

- one domain recorded as severe, together with needs in a number of other domains, or
- a number of domains with high and/or moderate needs.

This may also, depending on the combination of needs, indicate a primary health need and therefore careful consideration needs to be given to the eligibility decision and clear reasons recorded if the decision is that the person does not have a primary health need. In all cases, the overall need, the interactions between needs in different care domains, and the evidence from risk assessments should be taken into account in deciding whether a recommendation of eligibility for NHS Continuing Healthcare should be made. It is not possible to equate a number of incidences of one level with a number of incidences of another level, as in, for example 'two moderates equal one high'. The judgement whether someone has a primary health need must be based on what the evidence indicates about the nature and/or complexity and/or intensity and/or unpredictability of the individual's needs. Multi-Disciplinary Teams are reminded of the need to consider the limits of Local Authority responsibility when making a Primary Health Need recommendation.

The Flow Chart below, from the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care sets out the CHC assessment process.


NHS Continuing Healthcare Process Flow Chart
Individual identified as possibly eligible for NHS CHC
Fast Track
Does individual have 'a rapidly deteriorating condition which may be entering a terminal phase'?
Yes
No
Could NHS Services enable further improvements in health/functioning that might alter outcome of eligibility decision?
No
Yes
'Appropriate clinician' completes Fast Track Pathway Tool (with individual's consent)
Provide DH leaflet, explain process, obtain consent and advise re advocacy. If individual lacks capacity apply MCA principles and process
Provide NHS rehab/reablement or other services
Completed documentation sent to CCG for immediate action (including clinical information required to arrange appropriate placement/package of support)
Complete Checklist (involving individual and/or their representative) and forward copy to CCG (whatever the outcome). Alternatively make decision to go straight to DST without completing Checklist
Normal case review arrangements (usually at 3 months then minimum every 12 months). If needs have increased it may be necessary to reconsider eligibility for NHS CHC
Write to individual with outcome and copy of Checklist – if not eligible for full assessment advise they can ask CCG to reconsider Checklist outcome
not eligible for full assessment for NHS CHC
possible eligibility for NHS CHC
Review (usually after 3 months then minimum every 12 months). If needs have decreased it may be necessary to reconsider eligibility for NHS CHC
NHS Care Planning and Provision
CCG appoints co-ordinator
Care Planning and Provision: consider whether need for joint NHS/LA package or placement, including need for NHS-funded Nursing Care if in care home with nursing.
Yes
No
MDT assessment and completion of DST
Eligible for NHS CHC?
Eligibility recommendation (using concepts of nature, intensity, complexity and unpredictability)
Verification by CCG
Provide full written explanation to individual of eligibility decision with copy of DST and information on how to appeal if dissatisfied

The current Framework from the Department of Health Continuing Healthcare and NHS-funded Nursing Care is available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127199/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf.pdf

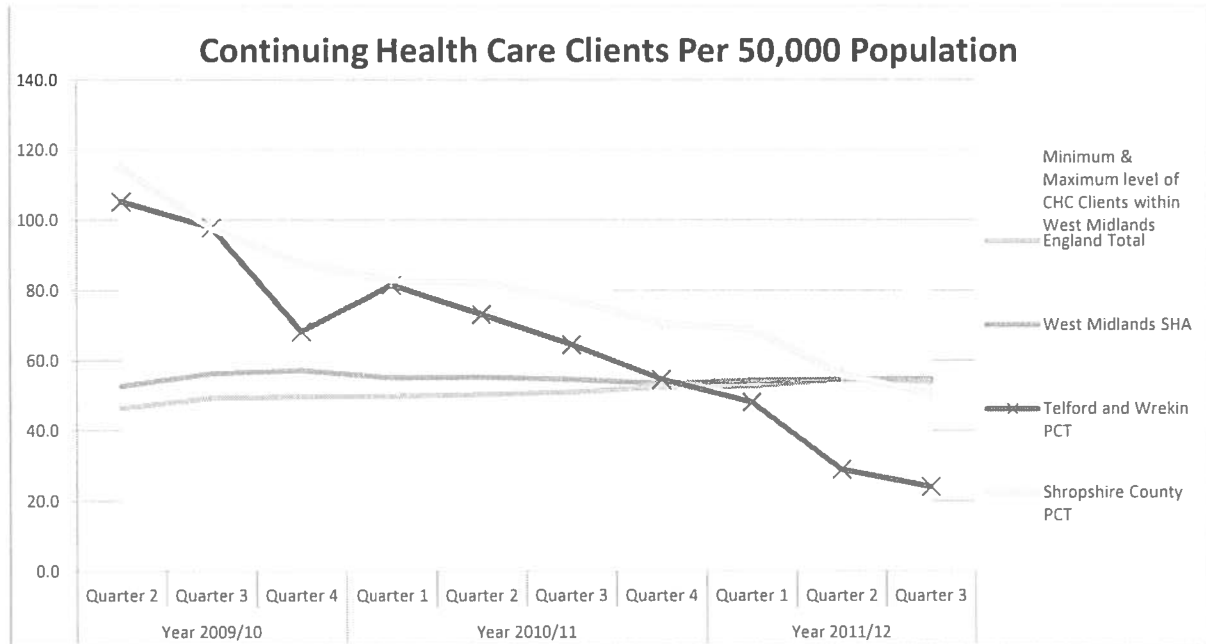
The Committee also received a copy of the House of Commons Library 2011 briefing on NHS Continuing Healthcare which provided a useful summary. This has been attached as Appendix 1. (It should be noted that this has not been updated since the 2012 Framework and so references are still made to PCTs)

Continuing Healthcare (CHC) Funding in Telford and Wrekin

During 2009 it was recognised that the rate of CHC funding in Telford and Wrekin was above the national and regional averages and though on a par with the rest of Shropshire, Telford and Wrekin PCT was the 5th highest funder of over 150 PCTs. It was expected that there would be some reduction in CHC funding in Telford and Wrekin to bring the rate more in line with other areas. However it was reported to the Committee by Telford & Wrekin Council that there had been a 73% cut in PCT spend on CHC from £13.9m in 2009/10 to £3.8m in 2011/12 in cash terms alone and still falling. Therefore, the total reduction in CHC funding over this period has been £10.1 million – around £8.5m is placing an additional burden on the Council's budgets - with the balance falling directly on local people who 'self fund'. During this period the regional and national average rate for CHC funding increased. The figures reported by the CCG showed a reduction in CHC funding from £13.7m in 2009/10 to £4.4m in 2011/12.

Graph 1 below shows the rate of change in CHC funding in Telford and Wrekin compared to the regional range, the regional and national average and the funding rate in Shropshire based on the Department of Health CHC data. It is noticeable that while the funding rate in Shropshire was higher than the rate in Telford in 2009 this has decreased but is now only slightly below the regional and national rates. The total reduction of CHC funding in Telford and Wrekin does not take into account inflation costs and demographic increases.

Graph 1: Comparative Funding Rates for Continuing Healthcare Funding



The CCG informed the Committee that the Department of Health data comes with a 'Health Warning' which makes it difficult to use to compare the level of funding between different areas. However, any inconsistencies in data between authorities would not affect the accuracy of the reduction of CHC funding in Telford and Wrekin. The Committee made it clear at the meeting with the CCG that their concerns about CHC in Telford and Wrekin were not based on the statistical data alone - the data served as a further indicator of the problems identified by other people who had given evidence. A statistical analysis of the rate of change between quarters for the past 3 years demonstrated that over this time period, the change in Telford and Wrekin is significantly different to national and West Midlands trends. (The full analysis is set out in Appendix 2.)

Following the meeting with the CCG the Members asked for clarification regarding the number of people in Telford and Wrekin who are assessed as eligible for CHC funding and their age profile. This was towards the end of the scrutiny review and the CCG was unable to provide clarification before this report was produced. Table 1 below summarises the data that the Committee has considered. The Committee understands that Department of Health data is based per 50,000 population and that the number of people who receive CHC funding every quarter will not equal the total annual number of people who are assessed each year – but the Committee found it difficult to reconcile the two sets of figures and requested a further explanation.

Table 1: Data from the Department of Health and Telford and Wrekin CCG regarding CHC

	2009/10				2010/11				2011/12				2012/13
DoH Data*	Q1 100.1	Q2 105.3	Q3 97.9	Q4 68.3	Q1 81.5	Q2 73.2	Q3 64.5	Q4 54.7	Q1 48.2	Q2 29.0	Q3 24.1	Q4 N/A	Q1-4 N/A
CCG Data**	185				99				127				101

*Number of people receiving CHC funding per 50,000 population

**Number of people assessed as eligible for CHC funding

It may be the case that the local data provided by the CCG includes figures for young people under 18 who receive funding through a separate CHC funding stream who would not be included in the Department of Health data.

The PCT / CCG has made some arrangements to transfer one off funds to the Local Authority to mitigate the ongoing £8.5m financial impact of the reduction in CHC funding but there is no ongoing funding transfer commitment. This included:

- Agreement to use £2m per annum 'NHS 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 to the Council. This is not ongoing funding.

- £3m one off PCT funds to cover part of the Council's overspend in 2011/12. £2.7m in 2012/13 and an estimated figure of £2.4m in 2013/14 (the actual figure will be based on how much the CCG actually spend in 2013/14 against what would be the per capita national average relating to Telford and Wrekin).

The Committee have been informed by Local Authority officers that discussions with the CCG have been ongoing regarding CHC, and both the Strategic Health Authority and the National Commissioning Board have been involved in these discussions as was the PCT Cluster. At the time of writing this report the Local Authority and CCG are planning a workshop which will be externally facilitated.

Scrutiny Review of Continuing Healthcare (CHC)

The issue of CHC funding was brought to the attention of the Health & Adult Care Scrutiny Committee through a number of routes:

- It had been reported to Cabinet and the Budget & Finance Scrutiny Committee that that over a period of about 3 years the level of funding from the PCT had reduced and this was having an impact on the adult care budget
- It was reported by adult care services that there were concerns about the CHC assessment process and the impact the reduction in funding had on the adult care budget
- A letter from Shropshire Partners in Care which raised concerns about the effect of the reduction in the level of CHC funding on patients, their family and care homes
- A ward Member raised concerns about the CHC process following the experience of a family in his ward.

Following these concerns the Health & Adult Care Scrutiny Committee included the issue of Continuing Healthcare in the work programme. It is not the role of the Scrutiny Committee to consider the quality of individual assessments – but the Committee has gathered evidence which has provided an overview of the CHC process.

Prior to the review, the Chair of the Health & Adult Care Scrutiny Committee wrote to the CCG highlighting the scale of the change in CHC which had resulted in a substantial change in service. The letter also asked for details of any consultation and impact assessments carried out regarding the change in the local interpretation of the CHC framework. The response from the Chief Operating Officer of the CCG to these questions was "Whilst I appreciate that the level of reduction in spending on CHC is extremely significant, I would not agree that this forms a substantial variation in service as changes have been brought about as a result of changes in national policy in the revised framework. In that respect therefore there was no requirement for a consultation, nor indeed a requirement for an impact assessment. I am sure however that as this was a national policy change, then consultation should have taken place at a national level." (Letter from CCG Chief Operating Officer to Chair of the Health & Adult Care Scrutiny Committee, 10th September 2012.)

There were a number of issues that the Committee would like to have considered in more detail but this would have taken more time and based on the strength of the evidence received the Committee concluded that it was more important to ensure that the CCG was presented with the report and recommendations and therefore given the opportunity to take action sooner rather than later. Where the Committee felt it was appropriate, recommendations have been included that request further work is carried out by the relevant organisations to investigate the issues the Committee did not pursue.

Evidence Received

Mr. Steve Wood and Mrs. Marion Wood

Shropshire Partners in Care

Lightmoor View Nursing Home

Age UK, Shropshire, Telford and Wrekin

Telford and Wrekin CCG: Chair, Chief Operating Officer and Executive Lead and Quality, Nursing and Safety

Shrewsbury and Telford Hospital Trust: Deputy Chief Nurse, Discharge Liaison Nurse, Princess Royal Hospital

Shropshire Community Health Trust: Nurse Consultant

Telford & Wrekin Council: Cabinet Member, Resources & Service Delivery; Assistant Director, Care & Support; Assistant Director, Social Care Specialist; Two Service Delivery Managers from Adult Care & Support; Continuing Healthcare Team Leader.

Issues Identified by the Committee

Effect on Individuals and their Families

One of the Committee's primary concerns is that the local interpretation and application of the national CHC framework results in an unfair assessment process and that some patients are receiving care that is not adequately meeting their needs.

The Committee have spent a great deal of time understanding the CHC assessment process and recognise that making an assessment of health and social needs is complex. However, the Committee felt very strongly that every effort must be made to explain the process and the consequences of the decisions that will be made to patients and family/carers so that they can understand and contribute to the process and challenge where they feel necessary. From the evidence that the Committee received many patients who are assessed for CHC funding will be very frail and some will be receiving end of life care. The Committee asked the local NHS organisations how patients' mental capacity is assessed and how the professionals involved in the CHC process decide if and how to involve family in the assessment process. The answers provided by NHS organisations stated that their procedures were in line with legislation and good practice. However the evidence from care homes, Local Authority officers, Age UK Shropshire, Telford and Wrekin and a family who had been through the CHC assessment process highlights that people are often very confused by the assessment process and do not understand the implications of the decisions that will be made. It was suggested by a family who had been through

a CHC assessment process that each patient and their family should be provided with a full guide setting out the CHC process, how this fits with the hospital discharge process and clearly sets out the implications of the decisions regarding CHC for the patient and their family. The Committee did consider this proposal when making the recommendations in this report. However the Committee recognise that people who are assessed for CHC will have different conditions and live in different environments and it would be impossible to produce a single document that would cover all eventualities for all patients. The Committee has therefore focussed on the need for advocacy services that would provide advice and support based on individual needs.

The Committee understands that difficult decisions have to be made regarding CHC and that in some instances patients or their family will not be happy with the outcome of a fair assessment on the basis that it has not produced the outcome they would like. However, the principles of good care as set out in the Francis Inquiry should relate not only to direct medical and nursing care for patients but also to the supporting systems and processes within the healthcare system. The effectiveness of the CHC must also demonstrate the values of "Caring, Compassionate and Considerate Nursing". The Committee wants to ensure that this caring culture is established at all levels of staff in the CHC team. The Francis Report highlights the role of leaders modelling these vaules and the Committee wants to ensure this, and that CCG managers lead by example. The National Framework is clear that the "individual, their perception of their support needs, and their preferred models of support [is] at the heart of the assessment and care planning process." (p.17)

The Committee received evidence that the Council's policy has been that if the NHS is not meeting the cost of care through CHC funding or joint packages of care and the person is eligible for Local Authority funded care then the Council has covered the cost of this care. However, the Committee was informed by care homes that the contracted local authority rate and the NHS-funded Nursing Care do not cover the full cost of some patients' nursing health care needs. In such cases, the patient or their family would be asked to make a 'top up' payment. The Committee was impressed with the dedication and level of care provided by the nursing homes to the extent that in some cases the care home had provided the higher level of care needed without receiving the additional payment where this was not possible. It was stressed that it would always be a last resort for patients to be moved to a different care home which charged lower fees. The Committee was concerned that any move for a frail patient can be traumatic and detrimental to their health and in some cases terminal. Members were also concerned that where a care home charges lower fees this would probably result in less qualified staff providing the care and the home would therefore be less able to meet the needs of patients with complex physical and mental health needs or there will be fewer staff to complete essential tasks.

The Committee was also greatly concerned about the consequences of the CHC process for people who are not eligible for Local Authority funded care. The Committee was informed that where an individual has capital of over approximately

£23,500 they will have to cover the costs of the care themselves i.e. they are self-funding. Based on demographics, Telford and Wrekin does not have a high proportion of people who are self-funding – but as some people who self-fund do not contact the Local Authority but arrange their own care, it is difficult to estimate the numbers involved. Shropshire Partners in Care provided some data based on 26 care providers in Telford and Wrekin which showed that of the 164 self-funding residents, 16.5 % were eligible for CHC funding, 32.9% were not eligible for CHC funding and 50.6% had not been assessed for CHC funding. This data does not provide a comprehensive analysis of people who fund their own care in the borough – but it does illustrate that there are a number of patients who are not funded by the Local Authority who have been through the CHC process. These individuals and their families will be coping with illness which in itself is stressful but in addition will also be trying to understand the complexities of health and social care funding perhaps without any independent advice or advocacy. The Committee is extremely concerned that there are individuals and families who are paying for their own care needs who have not been assessed fairly throughout the CHC process.

When asked about this, the CCG responded that irrespective of where the funding comes from the care received by individuals should of the required level. This does not take account of the fact that the standard contracted rate for Local Authority care is between about £364 and £424 per week, which even with the additional £109.79 NHS-funded Nursing Care does not cover the cost to the nursing home of providing the level of nursing led care of around £800 per week. There are cases where the Council does pay a higher rate and this contributes to the pressures on the adult care budget.

Patients and Families Understanding of and Involvement in the Continuing Healthcare (CHC) Process

A strong theme that came throughout the review was that patients and their families do not understand what the CHC assessment process is, what the implications of the decisions are or how they can appeal these decisions. The Committee has concerns that families are not involved appropriately in either the Initial Check List or the Full Assessment.

More seriously, Members were also informed that there had been occasions during the assessment meetings when a member of the CHC Team had informed family members that the family should not worry about the outcome of the assessment because if the person was not eligible for CHC funding the Local Authority would pay. The Committee objects most strongly that this message is given to families when they are very vulnerable and may not be aware that Local Authority care is means tested and a 'top up' payment may be required.

The Full Assessment Process

The Committee has concluded that based on the evidence received the CHC Assessment process in Telford and Wrekin is fundamentally flawed. As part of the review the Committee considered the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and came to the conclusion that it is the local interpretation and implementation that is causing problems. The Committee commented that the November (2012) revised Framework addresses many of the issues identified in the scrutiny review and Members found the Practice Guidance section of the document particularly helpful.

The Committee concluded that the CCG has not adequately explained why the local interpretation of the Framework has resulted in the reduction in CHC funding from £13.7m to £4.4m between 2009/10 and 2012/13 (CCG figures) while the regional and national trend has seen an increase in CHC funding. In the evidence presented by the CCG to the Committee at the meeting on the 25th March 2013, it was stated that the "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 in NHS Continuing Healthcare and NHS Funded Nursing Care in 2007". The Committee was also informed that no decisions had been made to change the local interpretation of the national framework and the implementation of the Decision Support Tool. The Committee was not satisfied that the evidence presented by the CCG explained why such a dramatic change in CHC funding has occurred without a change in policy at some level within the organisation.

The Committee noted that the 2012 Guidance on the Decision Support Tool does make some changes to the indicative guidance in the Decision Support Tool that will lead to a clear recommendation of eligibility for CHC funding. Under the 2009 Framework the Decision Support Tool Guidance sets out that:

> "A clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:
>
> - A level of priority needs in any one of the four domains that carry this level.
>
> - A total of two or more incidences of identified severe needs across all care domains.
>
> If there is one domain recorded as severe, together with needs in a number of other domains, or a number of domains with high and/or moderate needs, This **may well** also indicate a primary health need."

However the 2012 Decision Support Tool Guidance sets out that a clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:

- A level of **priority** needs in any one of the four domains that carry this level.
- A total of two or more incidences of identified **severe** needs across all care domains. Where there is:
  - one domain recorded as severe, together with needs in a number of other domains, or
  - a number of domains with high and/or moderate needs.

The difference identified by the Committee is that whereas in the 2009 Decision Support Tool Guidance there is some ambiguity regarding the eligibility of patients who do not 'score' a priority need in any of the domains, the 2012 Decision Support Tool Guidance states clearly that patients who do not have any needs identified as a "Priority Need" can still be eligible for CHC funding under certain circumstances.

There are several issues that the Committee concluded were particularly problematic within the local approach to CHC assessments:

Multi-disciplinary Approach to the Full Assessment for Continuing Healthcare (CHC)

The Committee heard from a number of sources that the local CHC assessment process did not pay sufficient regard to the views of non-NHS professionals. This view was expressed by Local Authority officers, care homes and families who have been involved in the process. Both the framework documents issued by the Department of Health in 2009 and 2012 stress the importance of joint working between the PCT / CCG and other professionals "respecting each other's professional judgement, knowledge and experience and working together to obtain the best outcome for the individual" (NHS Continuing Healthcare Practice Guidance 2009). The 2012 Framework explains at length how the Multi-Disciplinary Team (MDT) should work and it is the view of the Committee that this guidance is not implemented locally in the spirit in which it is intended. The Committee was most concerned that staff from care homes reported that they were prevented from fully taking part in the Multi-Disciplinary Team meeting with the families. Local Authority staff reported that they are pressured by the CHC assessors into complying with the view of the PCT / CCG that the person being assessed is not eligible for CHC funding. The information presented to the Committee said that this has resulted in the social work staff becoming disillusioned with the CHC process and no longer challenging unfair decisions as it will not change the outcome. A significant piece of evidence on the quality of the CHC assessment process came from Shropshire

Partners in Care and the nursing homes which provide services commissioned through CHC funding from other PCT / CCG areas. The care homes reported that the process managed by other NHS areas valued the professional opinions of their staff and produced better care outcomes for the patients. It was reported that of all the NHS areas, the CHC assessment and re-assessment process managed by Telford and Wrekin PCT / CCG was the most difficult for the patients, their families and the care homes. The Committee was informed that the PCT had previously included a panel as part of the decision making process - however this ended some time ago and the CCG does not operate a panel. The Committee considered the advantages and disadvantages of a panel in the process including the additional resources and time to administer a panel and the check and balance that the panel can provide in a system.

The Committee received evidence that the PCT / CCG approach to the assessment was based entirely on the Decision Support Tool (DST). Nursing homes and Local Authority officers reported that when full assessments are carried out the CHC assessors do not take account of the holistic needs of the patient, (physical, mental cognitive and behavioural) in the setting they are in. This is contrary to the 2009 and 2012 Department of Health Frameworks which describe the "purpose of the DST is to help identify eligibility for NHS Continuing Healthcare; it is not designed as an assessment tool in its own right." (p.71). The CCG reported to the Committee that "all recommendations made to the PCT are made by a properly constituted MDT". However, this did not provide the assurance the Committee wanted that the views of all the professionals and carers are seen by the CCG as an essential part of the assessment process. The CCG provided information about a peer review of 45 CHC cases. However the Committee understands that this was a desk-based exercise based on the assessments managed by the PCT. It is the Committee's view that a desk-based exercise of a flawed assessment process will produce a flawed result. The peer review did not take into account all the necessary information and therefore does not provide assurance that in all cases the correct decision regarding CHC funding has been made.

The Committee has been informed that the working relationship between the CCG and the Local Authority in all other respects has been very positive and so the difficulties experienced by the Local Authority in relation to CHC cannot be seen as symptomatic of wider problems between the organisations. In fact the Local Authority had raised issues concerning CHC funding locally with the PCT / CCG and at a regional level with the Strategic Health Authority / National Commissioning Board. However the Local Authority had purposely not pursued a confrontational line with local NHS organisations which might be detrimental to wider partnership working. The Committee hopes that the CCG will take the opportunity now they have full and legal responsibility for the CHC process to listen and respond to the concerns expressed by the other organisations and individuals who have taken part in this review.

Other issues

The Committee is also concerned about the quality of the assessment forms used in Telford and Wrekin. The Department of Health Framework is clear that only the information set out in the framework document should be used as part of the CHC assessment to determine eligibility for CHC funding. However it was reported to Members that one section of the Telford and Wrekin Integrated Health Assessment used in hospital (which includes the Initial Check List) states within the Cognition Domain that "if a patient has suffered a CVA (stroke) and has not had previous cognitive issues do not refer to MH [mental health] team." Members are concerned that including this information on the form provides a poor basis for the assessment and is not good clinical practice as it is common for people who have survived a stroke to suffer depression or other mental health issues regardless of their previous mental health.

The Committee also investigated how the CHC process fits with other health and social care processes, for example hospital discharge. There was general consensus on the principle that if a patient is referred for a Full Assessment that this should take place in a setting where the patient has received enablement support and their condition has improved as far as can be expected. It was generally accepted that a patient is unlikely to reach this level while in hospital and therefore in most cases the Full Assessment should take place following hospital discharge and a period of enablement. (An exception to this is Fast Track assessments which are initiated while a patient is in hospital.) However this presents a potential funding issue as the NHS is required to fund post-hospital care for 6 weeks but it was reported by the Local Authority that on average it will take 16 weeks to complete the full assessment. When the Committee met with representatives from the Hospital Trust and Community Trust it was also raised that it would be helpful for NHS staff to have access to the assessment carried out by social workers so that they are aware of the social care support needs that have been identified and the care package that has been put in place for patients once they are discharged.

Due to time constraints the Committee did not explore the full extent of the use of Joint Packages of Care but on the basis of the evidence provided by the Local Authority it appears the majority of cases are funded wholly by the Local Authority or the NHS. The Department of Health Framework advises that "if an individual does not qualify for fully funded Continuing Healthcare the NHS may still have a responsibility to contribute to meeting that individual's health care needs" (p. 89). In addition the Framework sets out that "CCGs are reminded that joint funding will be appropriate where someone in a care home with nursing has nursing or other health needs that, whilst not constituting a primary healthcare need, are clearly above the level of needs intended to be covered by NHS-funded Nursing Care." (p. 91).

The Committee met with the officer recently appointed by the Local Authority to support front line social work staff to re-engage with the CHC process and challenge

where appropriate. The Committee was pleased to hear that this role will also include working with nursing care homes to ensure they have the necessary skills to demonstrate the level of nursing care required by their patients.

Re-Assessment

The problems with the assessment process were highlighted during discussions regarding the re-assessment process. The Committee understands that the Department of Health Framework sets out that "a case review should be undertaken no later than 3 months after the initial eligibility decision" (p. 40). However the evidence from the care homes and the Local Authority indicated that the re-assessment process is financially driven and used as a mechanism to withdraw CHC funding at the earliest opportunity. The Framework states clearly that "neither the NHS or LA should unilaterally withdraw from an existing funding arrangement without a joint re-assessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement......and current funding and care management responsibilities should remain in place until the dispute has been resolved" (p. 41). The evidence from the Local Authority is clear that this part of the framework is not implemented. The Committee asked for information on the number of re-assessments and the outcome of these re-assessments. When asked to provide this information the CCG responded that this data is not routinely captured.

Another major concern for the Committee with regard to the re-assessment process is the local interpretation of the Well Managed Need principle as set out in the Framework document (p. 61). Nursing care homes reported that it felt that they were being penalised for providing high quality care that stabilised a patient's condition or where the care resulted in a decrease in the symptoms but the underlying condition remained. The Framework states that the "decision making rationale should not marginalise a need just because it is successfully managed: well-managed needs are still needs." (p. 61). Nursing homes reported that the re-assessment process did not recognise that while the direct care may be provided by care staff that the patients' care plans are designed by qualified nursing staff who are on site 24 hours a day, 7 days a week. The nursing staff supervise the care and are the first point of contact if a non-nursing member of staff has concerns about a patient. The Committee debated at length the distinction between the roles of nursing and care staff and the changes in professional roles in recent years. During this discussion Members of the Committee made comparisons between care provided in hospital where care that would have previously been provided by qualified nursing staff is now provided by Healthcare Assistants. The Committee concluded that if this is the situation in a hospital setting, the same principles should apply in a nursing led care home setting. This view is confirmed in the Department of Health Framework which states that "Eligibility for NHS continuing healthcare is, therefore, not determined or

influenced either by the setting where the care is provided or by the characteristics of the person who delivers the care" (p21).

One of the major concerns expressed by the care homes was that the local interpretation and implementation of the re-assessment process was very difficult for families to understand. Nursing care homes reported that they can be placed in a difficult position where they do not agree with the outcome of the assessment but the family can come to the conclusion that the outcome of the assessment is because there has been a problem with the care provided. This is all happening at a time when the family is particularly vulnerable.

The issues regarding re-assessment were highlighted to the Committee when considering the cases of patients with dementia. When visiting a nursing home which specialised in dementia care, Members were informed that the proportion of patients who received CHC funding had reduced from 80% to 20% over the last 3 years, resulting from a higher threshold for new patients who are assessed for CHC and also patients who are re-assessed as no longer eligible for CHC funding.

Members were aware that dementia is a progressive illness and while the symptoms can be managed there is no cure. While the review was carried out a report from the Care Quality Commission highlighted the scale of the problem of dementia - 80% of people living in care homes have a form of dementia or severe memory problems and that this will increase as the aging population increases. The Census figures for 2011 showed that since 2001 the population aged between 65 - 84 years of age increased by 22.2% and the population aged over 85 grew by 27.3%. The Members recognise that not all patients with dementia would be identified as having a 'primary health need' but were very concerned about dementia patients who were re-assessed as no longer having a primary health need and therefore would not continue to receive CHC funding to provide the level of nursing care they require. The Department of Health Framework is clear that "only where the successful management of a healthcare need has been permanently reduced or removed an on going need, such that the active management of this need is reduced or no longer required, will this have a bearing on the NHS continuing healthcare eligibility." (p21).

Appeals and Reviews

The Committee received compelling evidence from a senior Member of the Council who has supported a family through the CHC appeals process that this suffered from all the problems that marred the assessment process. The appeals process was not explained to the family, the CHC staff had undue influence during the appeal meeting and the letter informing the family of the outcome of the appeal did not come from the Chair of the Panel but from the CHC Team. The Committee was extremely concerned that, if a Councillor who is familiar with the processes and systems within

the public sector was confused by the CHC appeals process, families who are in a vulnerable position appealing a decision on behalf of a family member will be overwhelmed by this experience and denied the opportunity of a fair appeal.

The Committee was particularly concerned for patients and families who have been assessed as not eligible for CHC funding and do not meet the criteria for Local Authority funding. The particular concern was that these individuals and families may be going through an appeals process without independent support or advocacy.

The Committee was informed toward the end of the Review that the CCG removes CHC funding if a patient is re-assessed as not eligible for CHC funding even if the patient or their family dispute this decision. The Committee were informed that this is not in line with the Framework.

Effect on Local Authority Adult Care Services, Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust, Care/Nursing Homes and Domiciliary Care Services

The consequences of the CHC process in Telford and Wrekin is not just an issue between the CCG and the Local Authority. There are consequences for individuals and their families as set out above and also for the wider health and social care system. The change in the assessment process locally has directly resulted in additional costs to the Council of around £8 million. If the current approach to the CHC assessment process continues, it is likely that the financial burden this places on the Local Authority adult care budget will result in the Council having to raise the level of eligibility for care to critical. In practice this would mean that people whose care needs are assessed as substantial and are currently receiving care funded by the Local Authority would no longer receive this funding and would have to fund their care themselves. The impact of the transfer of these costs must be seen in the broader context of the savings that all areas of the Council must make as part of the austerity measures, equivalent to a real term cut of £40m to the Council's budget. The average reduction in funding for Government departments over the 4 year period of the Comprehensive Spending Review is 8.3% - the average reduction in Local Government funding is 27% rising to 33% after recent government announcements. The CCG has recognised that the reduction in funding is an issue and has transferred one-off funding to the Local Authority on an annual basis during 2011/12 and this agreement has continued for 2012/13 to make up some of the pressure that the reduction in CHC funding has created on the adult care budget. While there is verbal assurance from the CCG to carry on this arrangement, there will be a growing risk of challenge from their auditors.

As well as the financial implications for the Local Authority the Committee was concerned about the morale and wellbeing of Local Authority staff involved in the CHC assessment process. An indication of the break down in the working

relationship between the PCT / CCG and Local Authority reported to the Committee is that social work staff feel bullied, that their professional opinion is not valued and as a consequence many have disengaged from the CHC process. They have 'given up' challenging decisions that they do not agree with as they feel this will not make any difference to the outcome.

It was reported to the Committee that the reduction in funding for nursing care homes will mean that some nursing care homes in Telford and Wrekin may close and that more places at nursing care homes that continue to provide services could be commissioned by other CCGs. The consequence of both of these outcomes would be a reduction in the availability and choice of nursing care in the borough.

The implications set out above will have a direct effect on the Hospital Trust through an increase in demand for acute services and delay in hospital discharge. The Hospital Trust is under great pressure and has recently announced that non-emergency operations and outpatient appointments were cancelled on one day in order that the Trust could ensure safe emergency services. There are financial consequences for the CCG if the Hospital Trust is not able to resolve these capacity and patient flow issues.

The Committee was not able within the time constraints of the review to explore the views of domiciliary care providers on CHC. The Committee recognises that in many cases, care staff who visit people in their homes can regularly identify deterioration in a patient's condition – but the Committee received evidence that they are not always aware of how to raise these concerns. The Committee discussed the need to ensure that domiciliary care providers and their care staff are engaged in the CHC process so that they can contact the relevant professionals to request and contribute to an Initial Check List. Care staff should also be able to contribute to the Full Assessment.

Conclusion

The CHC assessment process is fundamentally flawed resulting in the situation that people in Telford and Wrekin are less likely than people in other areas of the West Midlands to receive CHC funding. This has consequences for the level of nursing care they will receive and may have financial implications for the patient and their family. As previously highlighted, a statistical analysis has demonstrated that over the last 3 years the change in Telford and Wrekin is significantly different to national and West Midlands trends.

Given that the CCG set out in the evidence presented to the Committee that the fundamental criteria for CHC funding has not changed since the publication of the first CHC National Framework in 2007, the Committee has concluded that the CCG has not adequately addressed the following points:

- If the eligibility for CHC is determined on the level of a patient's need – a reduction in funding of 73% and rising should be the result of a reduction in the overall level of need. This reduction in the level of need has not been demonstrated by the CCG and the Committee does not accept that the flawed assessment process can be used to justify this reduction.
- Why the rate of change of CHC funding has been so much greater compared to other areas while regional and national average rates have increased.
- How such a change in the interpretation of the Decision Support Tool has been made and without a decision being made and recorded at some level in the PCT.

The Committee has also concluded that the extent of the change in CHC funding in Telford and Wrekin constitutes a substantial variation in the provision of this service as set out in the Regulations of the Health and Social Care Act 2012. It was explained in the introduction to this report that the PCT did not undertake any consultation on the local interpretation of the Framework issued by the Department of Health in 2009. The Committee sincerely hopes that the CCG will consider the issues identified in this report and implement the first stage recommendations set out below. The Committee has concluded that these consequences are so serious and so far reaching, that if the CCG is not prepared to accept and implement the recommendations of this report without an explanation that is accepted by the Committee, that it is in the best interest of the local health service and the people of Telford and Wrekin that there is a full public consultation on the future provision of CHC in the borough.

If a consultation is undertaken, the Committee has also concluded that while the CCG, as the commissioning body, will be responsible for the consultation, the Terms of Reference for the consultation must be agreed by the Health & Wellbeing Board in consultation with Shropshire Partners in Care and Age UK Shropshire, Telford and Wrekin and other advocacy services involved in supporting patients and families during the CHC process. In order to demonstrate that the CCG is taking an open minded approach to the consultation it is important that, while the CHC and Complex Care Team contribute to this consultation, it is managed, the responses analysed and the report written by an independent body.

It is the expectation of the Committee that if this consultation is carried out that this will produce an outcome that best meets patient needs and is supported by the organisations involved in the CHC process. However, in the event that the CCG does not agree to carry out the consultation as described or that the consultation does not satisfactorily resolve the issues identified in this report, the Health & Adult Care Scrutiny Committee retain the right to refer this matter to the Secretary of State for Health.

Recommendations

The Committee has made a series of recommendations that are set out in the three stages below. The Committee is aware that the issue of CHC in Telford and Wrekin has not been resolved despite attempts by the Local Authority to raise its concerns. The Committee needs to ensure that this report sets out clearly what its expectations are of a successful CHC process, how they will measure this and what action they will take if the issues identified in this report are not resolved.

While the recommendations are directed at the different organisations involved in the CHC process, the report will be presented to the CCG Board and the Health & Wellbeing Board. The Health & Wellbeing Board will have a role in co-ordinating the response to the recommendations and monitoring implementation. The Scrutiny Committee will hold the Health & Wellbeing Board to account for its role in resolving the issues regarding CHC.

First Stage Recommendations

The Scrutiny Committee Recommend that:	**Made to**	**How the Scrutiny Committee will Measure that this has been successfully implemented**
Involving patients and Family 1. The CCG put systems in place to ensure that all patients and their families are appropriately involved in the assessment process. The CCG must ensure that the assessment is patient centred and that the assessment is carried out in a caring and compassionate manner in line with the Francis Report.	CCG	CCG to seek and analyse the patients' and families' experience of CHC. One option that has been suggested is that patient and their family are encouraged to use the patient options website to provide feedback. However, the Committee are of the view that other methods of feedback must also be developed for people who do not or cannot use the internet. The feedback should include specific questions on the assessment process rather than the quality of care. The Committee recognise

		that in some instances patients or their family will not provide positive feedback on the basis of the outcome of the assessment – not the quality of the assessment. This must be recognised in any audit or evaluation of the CHC process.
Advocacy 2. All patients who are assessed using the Initial Check List and their families should be given written information about independent advice and advocacy services with specialist knowledge of CHC BEFORE the checklist is initiated. The information should provide the contact details for the advocacy services. 3. This advocacy service must be adequately resourced to respond in a timely manner and provide the necessary support to individuals and their families throughout the CHC process. The Committee recommend that the CCG contribute toward the cost of this service in line with the National Framework Practice Guidance (p.98)	CCG AGE UK and other CHC advocacy services CCG LA	There is an increase in the uptake of advocacy by patients and their family Part of the contract with the organisation(s) providing the advocacy service is that they will provide quarterly report to the CCG, Health and Wellbeing Board and the Health and Adult Care Scrutiny Committee on the advocacy work provided and the views of patients and their families of the CHC process.
Multi-Disciplinary Team Working 4. The Multi-disciplinary working can only be delivered through a successful partnership approach both at organisational level and practitioner level where all the people involved in the care of an individual feel that their views are valued. The views of all	CCG LA SaTH Community Health Trust Domiciliary Care	The DST will provide a record of the contribution of the range of professionals and carers and how their views are taken into account.

professionals in the MDT must be evidenced in the decision making process.	Providers (Other organisations as set out p. 74 of the National Framework)	
5. All the organisations involved in the care of an individual being assessed for CHC must be included in the Personal Details section of the DST (p. 53 of the draft Operational Arrangement Document). All these organisations must be contacted to provide evidence for the assessment including mental health services.	CCG	This will be evidenced in the completed Decision Support Tool
6. Joint training is undertaken (including role play) ensuring that all professionals from the different organisations involved in CHC understand the full implications of the decisions that are made from the perspective of the patient, their colleagues from other organisations and the implications for wider health and social care economy.	CCG LA SaTH CT SPIC Advocacy organisations	Attendance and feedback from training provided
7. Domiciliary care providers and their care staff are involved in this training so that they can engage in the CHC process to contact the relevant professionals to request and contribute to a check list and contribute towards the Full Assessment.	CCG LA Domiciliary Care Providers	Attendance and feedback from training provided
Initial Checklist 8. The CCG record and monitor the number of people who have an Initial Check List and the outcome of this i.e.	CCG LA SaTH	Robust data collected and monitored.

how many of these are referred for a Full Assessment.	CT	
9. All staff who carry out the Initial Check List must be appropriately qualified professionals and have had training on how to carry out the assessment, what information to provide to patients and their families and how to promote the advocacy support that is available. The information provided to patients should include health care and financial implications for patients and their families in the event of the range of outcomes of the assessment process.	CCG SaTH	All staff who complete the Initial Check List receive training that includes the full CHC process, the need to ensure patients and their families are informed of and involved in the process, how the CHC process fits with other health and social care processes, the consequences of the possible outcomes of the assessment process and the advocacy services that are available.
10. The CCG should work with the hospital Trust to review the Integrated Health Assessment Form which incorporates the CHC Checklist to ensure that all information is clinically appropriate – of specific concern is the current instruction that patients who have not had previous cognitive impairment and have suffered a stroke must not be referred to mental health services	CCG SaTH	The CCG and SaTH undertake a review of the Integrated Health Assessment.
Assessment Process 11. That as part of the agreement of the Operational Arrangements document the CCG, Local Authority and other partners agree to a local protocol on the interpretation of the revised Decision Support Tool guidance on the eligibility of patients who do not have a Priority Need but do have needs that meet indicative guidance set out on p.14 and 15 of	CCG LA SaTH SPIC Age UK and other advocacy services	The local protocol is agreed and set out in the Operational Arrangement document

the revised guidance. 12. The CCG should work with partner organisations including the Local Authority, SPIC, the Community Health Trust, the Hospital Trust, Age UK and other advocacy services to establish a panel that will consider the MDT assessment and make recommendations to the CCG regarding CHC eligibility. The terms of reference and operation of the panel should be reviewed annually to ensure that it is adding value to the process. 13. The CCG and Local Authority work together to agree a dispute process as set out in the National Framework (p. 136) and jointly monitor the number and outcome of the assessments disputed by the Local Authority	 CCG LA SaTH SPIC Age UK and other advocacy services CCG LA	 That the Terms of Reference for the Panel are agreed by consensus and the Panel is operational within 3 months of the CCG receiving this report. As a measure of the level of engagement by local authority staff the Committee would expect a robust multi-disciplinary relationship between the CCG and Local authority to result in an increase in the number of disputed cases. If managed properly this should not be seen as a failing in the CHC process but an effective check and balance in the system.
Re-Assessment Process 14. As part of the Operational Arrangements document the CCG must include information on the re-assessment process. This must include a local policy on the interpretation of the principle of well managed needs as set out in the 2012 Department of Health Framework (p. 61) agreed by the CCG, Local Authority, Community Health Trust, SaTH, SPIC and the local advocacy services.	 CCG LA CT SaTH SPIC Age UK and other advocacy organisation	 Inclusion of an agreed policy and procedures in the Operational Arrangements document.

Review / Appeal Process 15. The CCG records and monitors the number of appeals / review and their outcomes.	 CCG	 Robust data is collected
16. All patients and their family / representatives should be offered independent advice and advocacy before and during the appeal / review process. Patients should also be made aware of independent legal advice available e.g. free 15 minute appointments with a solicitor through Age UK and other specialist legal advice.	CCG Age UK and other advocacy services	An increase in the number of people seeking and using advocacy services in relation to CHC.
17. The CCG ensures that it is adhering to the Framework when the patient or their family dispute the outcome of a re-assessment where funding is withdrawn.	CCG	Assurance that the review/ appeal process is carried out as set out within the Framework.
18. The Membership of the appeal panel should reflect the good practice established by the regional appeal panel (previously at the SHA) which included an independent chair. All communication from the Panel should come from the independent Chair.	CCG	The CCG review the terms of reference and procedures for the Appeal / Review Panel.
Funding 19. The Committee has not made any specific recommendations regarding the level of CHC funding as the funding inequality is a product of the failings in the CHC assessment process.		 If the previous recommendations are fully implemented the Committee expects that the level of CHC funding in Telford and Wrekin will move to the regional and national average.
20. The CCG and Local Authority work together to explore the option of Joint Funding Packages for patients	CCG LA	Assessment of the potential benefits of Joint Packages of Care

who are not eligible for CHC in line with the National Framework 21. The Committee does however recommend that the number of CHC cases, the level of funding and the number of jointly funded care packages made following a CHC assessment and the total funding contributions by partner organisations is reported quarterly to the Health and Wellbeing Board.	 CCG LA HWB	 Monitoring reports to the Health and Wellbeing Board
Other Issues		
22. The Local Authority should ensure that any staff who report bullying or harassment are appropriately supported – this should include policies and procedures to cover partnership arrangements.	LA	The Council ensures that all managers working in partnership arrangements are aware of the Council's policies. If there are patterns or trends that are identified these should be raised with the relevant Director.
23. In line with the Framework (p. 21) should the Initial Check List or full assessment identify a carer they should be informed of their right to a carer's assessment and advised to contact the Local Authority or, with their permission, refer them for this purpose.	CCG LA CT SaTH	Increase in number of Carers Assessments and support to carers for people who have been through the CHC assessment process
24. Further work is carried out to clarify the number of patients assessed as eligible for CHC funding and receiving CHC funding and the age profile of people receiving CHC funding.	CCG	The CCG provide this information to the Scrutiny Committee and the Health and Wellbeing Board in the response to this report and recommendations.
25. The Operational Procedure Document that was presented to the Scrutiny Committee is an opportunity for the CCG to have genuine dialogue with partner organisations. The committee recommend that the concerns expressed by the local	CCG LA SPIC Age UK and other advocacy organisations	The operation procedure document for CHC is agreed in partnership by all the key organisations involved in the CHC process.

authority regarding this document are taken into account and that SPIC and Age UK and other advocacy organisations are also given the opportunity to comment on the Operational Procedures for CHC.		

CCG – Clinical Commissioning Group, LA – Local Authority, SaTH – Shrewsbury and Telford Hospital NHS Trust, SPIC – Shropshire Partners in Care, CT – Shropshire Community Health NHS Trust.

Second Stage Recommendation

If the CCG does not agree to implement the recommendations set out in this report or if they are agreed but do not achieve the measures of success set out above without adequate explanation, the Committee recommends that the CCG undertake a public consultation on Continuing Healthcare. As the Commissioning body the CCG would be responsible for this consultation – but because of the implications for other organisations the Committee recommends that the Terms of Reference should be agreed by the Health & Wellbeing Board in consultation with Shropshire Partners in Care, Age UK and other advocacy organisations . The Committee recognises the role of the National Commissioning Board and that as a member of the Health & Wellbeing Board they will be involved in this process. The consultation should be managed by an independent body and the CHC and Complex Care Teams would have a role in responding to the consultation.

Third Stage Recommendation

As a last resort, the Committee recommends that if in response to the second stage recommendations above the CCG does not undertake the consultation as described or that in the view of the Scrutiny Committee the outcome of the consultation is not in the interest of the local health service, the Committee retains the right to refer the matter to the Secretary of State for Health.

NHS Continuing Healthcare in England

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Section: Social Policy

NHS continuing healthcare means a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs that have arisen because of disability, accident or illness. Eligibility decisions for NHS continuing healthcare rest on whether someone's need for care is primarily due to health needs. For example, people who are eligible may have complex medical conditions that require highly specialised nursing support. This note is intended to help Members respond to queries from constituents about eligibility to NHS continuing healthcare.

As services provided by the NHS are free whereas those arranged by local authority social services are means tested, the outcome of any decision as to who has responsibility for providing care can have significant financial consequences for the individual concerned.

Since the early 1990s, the Parliamentary and Health Service Ombudsman has investigated a large number of complaints about local criteria used for making decisions about eligibility for NHS continuing healthcare. The legality of individual eligibility decisions has also been challenged in the courts on a number of occasions. In 2007 the Department of Health issued a *National Framework for NHS Continuing Healthcare*, to try and improve the consistency of approach taken by local NHS bodies, by providing a common framework for decision making and the resolution of disputes. A separate Library note, *Background to the National Framework for NHS Continuing Healthcare* (SN04643) is intended to help Members to understand the background to the introduction of the Framework through an account of the preceding guidance and case law.

The key Department of Health documents, and briefings from other organisations, are listed at the end of this note. The Department of Health guidance should be consulted for a fuller account of the rules and duties that apply to NHS bodies (currently primary care trusts (PCTs) are responsible for determining eligibility for NHS continuing healthcare but, subject to the passage of the *Health and Social Care Bill*, formal responsibility will transfer to Clinical Commissioning Groups in 2013).

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1 What is NHS Continuing Healthcare?

NHS continuing healthcare is a package of care provided outside hospital, arranged and funded solely by the NHS, for people with ongoing healthcare needs. Services may be provided in any setting including, but not limited to, a residential care home, nursing home, hospice or a person's own home. The *National Framework for NHS Continuing Healthcare* (the National Framework)[1] uses the term NHS continuing healthcare to describe the situation where the NHS takes full responsibility for ongoing, sometimes long-term, care.

Primary legislation governing the health service does not explicitly define the duty of the NHS to provide continuing healthcare. It is from the broader requirements to provide a health service under sections 1 to 3 of the *NHS Act 2006* that the duty is derived. The Secretary of State has issued instructions, known as Directions, to the NHS that specify what sections 2 and 3 of the *NHS Act 2006* mean for PCTs when they determine eligibility for NHS continuing healthcare.[2]

The National Framework explains that the actual services provided as part of that package should be tailored to meet the specific health and social care needs of the individual, and should be seen in the wider context of best practice and service development for each "client group". Eligibility for NHS continuing health care is not based on having a specific medical condition and eligibility places no limits on the settings in which the package of support can be offered or on the type of service delivery.

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[1] Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-funded nursing care (revised July 2009)*

[2] Regulation 1, *The NHS Continuing Healthcare (Responsibilities) Directions 2009.*

There is thus no specific set of services that must constitute NHS continuing healthcare. Services will depend on the needs of the individual in question and, whatever the services may be, people in receipt of NHS continuing healthcare continue to be entitled, like other people, to the usual range of NHS primary, community, and secondary care, and other NHS services.[3]

Someone may have a package of support provided or funded by both the NHS and the local authority, this is known as a 'joint package' of continuing care. Local authority social services have duties to provide welfare services, for example, residential accommodation "for people who, by reason of age, illness or disability, are in need of care and attention that is not otherwise available to them."[4]

How that division of responsibility is made between the NHS and local social services has been a major point of contention over the years and has repercussions for the respective expenditure of the NHS and the local social services authority. For individual patients it can mean the difference between a service that is provided free (if it is the responsibility of the NHS) and one that is means-tested (if it is the responsibility of the local authority).

2 The National Framework

2.1 Publication

The *National Framework for NHS Continuing Healthcare* was published in June 2007[5] and became mandatory from 1 October 2007. Instead of each Strategic Health Authority (SHA) having its own rules for determining eligibility, the National Framework introduced a national approach for the NHS in England, with a common process and national "tools" to support decision making.[6] The Secretary of State issued Directions requiring PCTs, SHAs and local authorities to comply with key aspects of the new policy. The relevant Directions, as updated in 2009, are:

- *NHS Act 2006, Local Authority Social Services Act 1970: The NHS Continuing Healthcare (Responsibilities) Directions 2009*

The following Directions also contain relevant provisions:

- *The Delayed Discharges (Continuing Care) Directions 2009*
- *The National Health Service (Nursing Care in Residential Accommodation) (Amendment) (England) Directions 2009*

As well as dealing with the arrangements for NHS continuing healthcare, the National Framework simplified the arrangements for *NHS-funded nursing care* (that is, care provided by a registered nurse in a nursing home for someone not otherwise funded by the NHS - sometimes known as the Registered Nursing Care Contribution). The National Framework made clear that in all cases, individuals should be considered for eligibility for NHS continuing healthcare before a decision is reached about the need for NHS-funded nursing care.

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[3] The National Framework paragraph 107.

[4] The basic legal framework governing the social services is summarised on pages 6 and 7 of the National Framework, which also describes the legal framework governing the NHS.

[5] Written Ministerial Statement : HC Deb 26 June 2007 20-21WS and Department of Health Press Notice, "Streamlining the system for NHS continuing care," 26 June 2007:

[6] See the final page of the note for a list of the current associated documents.

Following a Government commitment to review the National Framework after one year, a revised Framework was published in July 2009. The revised document says that the main change concerns fast track treatment for people with a rapidly deteriorating condition entering a terminal phase. If an appropriate clinician considers a person to have a *primary health need* arising from such a situation and has given a completed *Fast Track Pathway Tool* to the PCT, that PCT is required to determine that the person is eligible for *NHS continuing healthcare*, until such time as a full assessment is completed using the standard *Decision Support Tool*. The revised document also includes some changes to processes, for example, in relation to obtaining a review of an initial screening decision, but the main basis of eligibility was not changed.

2.2 Who is eligible? The *primary health need* test

The central criterion for receipt of NHS continuing healthcare, set out in the National Framework, is whether a person's primary need is a health need:

> Where a person's primary need is a health need, they are eligible for continuing NHS healthcare. Deciding whether this is the case 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 needs – including accommodation, if that is part of the overall need.[7]

The Framework document expands on this, saying that as there should be no gap in the provision of care, the *primary health need* test is partly dependent on the limits of a local authority's responsibilities. This, it says, means that the test should be applied in such a way that a decision of <u>ineligibility</u> is only possible where, taken as a whole, the nursing or other health services required by the individual satisfy the definition of what a local social services authority might provide, as established by the *Coughlan* judgement[8]. In other words, a decision of ineligibility is only possible where the health services:

> a) are no more than incidental or ancillary to the provision of accommodation which LA social services are, or would be but for a person's means, under a duty to provide; and
>
> b) are not of a nature beyond which an LA whose primary responsibility it is to provide social services could be expected to provide.

The National Framework adds that there are limitations to this test as neither the PCT or local authority social services can dictate what the other agency should provide. In addition, the *Coughlan* judgment itself, on which the criterion was based, focused only on general and registered nursing needs. A practical approach to eligibility was therefore required, including situations in which the 'incidental or ancillary' test was not applicable because, for example, the person would be cared for in their own home.

Certain characteristics of need – and their impact on the care required to manage them - might help determine whether the 'quality' or 'quantity' of health services required was more than the limits of a local authority's responsibilities. These characteristics are listed in the National Framework as:

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[7] National Framework, paragraph 25

[8] The significance of the *Coughlan* judgement is explained in a separate Library note, *Background to the National Framework for NHS Continuing Healthcare* (SNSP.....). The impact of the judgement is also summarised in Annex B of the National Framework.

Nature: This describes the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.

Intensity: This relates both to the extent ('quantity') and severity ('degree') of the needs and to the support required to meet them, including the need for sustained/ongoing care ('continuity').

Complexity: This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/ or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.

Unpredictability: This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the person's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.[9]

Each of these characteristics may, alone or in combination, demonstrate a *primary health need*. In order to minimise variation in the interpretation of these characteristics, the Department of Health has published a Decision Support Tool, which is outlined in the section on *Assessment Process* below).

As well as describing the characteristics on which eligibility should be based, the Framework includes a section on what **not** to base eligibility. It lists the following examples:

- the person's diagnosis;
- the setting of care;
- the ability of the care provider to manage care;
- the use (or not) of NHS- employed staff to provide care;
- the need for/presence of 'specialist staff' in care delivery;
- the fact that a need is well managed;
- the existence of other NHS-funded care; or
- any other input-related (rather than needs-related) rationale.

In addition, the Framework says that the possibility of deterioration should generally be taken into account. In particular, where an individual has a rapidly deteriorating condition that may be entering a terminal phase, this would be a *primary health need* because of the rate of deterioration. The Department of Health has published a Fast Track Tool to help decide eligibility where this may be the case (see section on *Assessment Process* below).

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[9] The National Framework page 10.

2.3 Assessment Process

Getting an assessment

The NHS choices website provides advice about getting an assessment for NHS continuing healthcare. It says:

> PCTs are responsible for assessing eligibility for NHS Continuing Healthcare and NHS-funded Nursing Care, as well as ensuring that the national eligibility criteria are used consistently. They also identify, arrange and fund all the services required to meet your needs:
>
> - if you qualify for NHS Continuing Healthcare, or
> - for the healthcare part of a joint care package.
>
> The PCT for your area can provide more information on the eligibility criteria and assessment process. If you think you have care needs that should be assessed, or if someone you care for has needs that you think should be assessed, you should contact your PCT.
>
> You can get contact details for PCTs by calling NHS Direct on 0845 4647 or visiting the NHS Choices website. When you contact your PCT, ask to speak to the co-ordinator for NHS Continuing Healthcare.[10]

The Directions specify circumstances where eligibility must be considered and place a general duty on PCTs to take reasonable steps to ensure that an assessment of eligibility is carried out in all cases where it appears to the PCT that there may be a need for *NHS continuing healthcare*. A couple of specific circumstances where an assessment should be carried out are set out below (these are not the only ones mentioned).

- When patients are discharged from hospital: where the NHS is intending to refers someone to social services for help with social care needs, it should first carry out an assessment for NHS continuing healthcare.
- Before any decision is made by the NHS to make a registered nursing care contribution when a person goes into a care home that provides nursing care.

The National Framework sets out principles and values that should be applied to the process of assessment, for example, obtaining the patient's consent, what happens when the patient does not have capacity to consent, and making patients aware of advocacy services that might be available. The Framework then describes the process of establishing eligibility, much of which is covered in the Directions to PCTs, which also contain requirements for local authorities to co-operate in the procedure.

If the NHS is commissioning, funding or providing any part of the care, a case review should be undertaken no later than three months after the initial eligibility decision, in order to reassess care needs and eligibility for NHS continuing healthcare, and to ensure that those needs are being met. Reviews should then take place annually, as a minimum. These reviews are separate from the dispute resolution reviews described in part 3 of this note.

Screening: *The Checklist*

The first step for most people is a screening process where a nurse, doctor other qualified healthcare professional or social worker applies the *Checklist* to see if the individual needs a

[10] *NHS Choices website: What is NHS continuing healthcare?*

full assessment of eligibility.[11] Whatever the outcome of the *Checklist* process, the decision, including the reasons why the decision was reached, should be communicated clearly and in writing to the individual and (where appropriate) their representative.

Where the outcome is not to proceed to a full assessment of eligibility, the written decision should also contain details of the individual's right to ask the PCT to reconsider the decision. The PCT should give such requests due consideration and provide a clear, written response as soon as is reasonably practicable. The response should also give details of the individual's rights under the NHS complaints procedure.

Full Assessment: *The Decision Support Tool*

If the person has passed the screening test, the next step is a full assessment (in some cases an individual may be referred directly for a full assessment, in which case the full assessment would be the first stage). The assessment should be carried out by a multidisciplinary team and, irrespective of the setting, the PCT has responsibility for coordinating the process until a decision is reached.

The aim is to capture the nature, complexity intensity and/or unpredictability of a person's needs (see section 2.2 on the *primary health need* test above). In order to do this, the *Decision Support Tool*[12] provides a framework for recording the person's needs in 12 generic areas. The 12 areas are: behaviour, cognition, psychological and emotional needs, communication, mobility, nutrition (food and drink), continence, skin (including tissue viability), breathing, drug therapies and medication (symptom control), altered states of consciousness, other significant care needs. For each domain, the assessment records: low, moderate, high.

However, the *Decision Support Tool* is not an assessment in itself; it is meant to be a way of applying the *primary health need test* by bringing together evidence in a single format in order to improve consistency and evidenced-based decision. It is not intended to directly determine eligibility and "Professional judgment should be exercised in all cases to ensure that the individual's overall level of need is correctly determined."

Once the multidisciplinary team has reached agreement, it should make a recommendation to the PCT on eligibility. Only in exceptional circumstances and for clearly articulated reasons, should the PCT reject the multidisciplinary team's recommendation and a decision not to accept the recommendation should never be made by one person acting unilaterally.

The Framework says that many PCTs use a panel to ensure consistency and quality of decision making but that a panel should not fulfil a gate-keeping function. Nor should it be used as a financial monitor.

The time between the *Checklist* (or other notification of potential eligibility) being received by the PCT and the funding decision should, in most cases, not exceed 28 days. In acute settings it may be appropriate for it took take much less than this. When there are valid and unavoidable reasons for the process taking longer, timescales should be clearly communicated to the person, and (where appropriate) their carers and/or representatives.

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[11] *Healthcare Checklist (September 2009)*
[12] *Decision Support Tool (September 2009)*

Terminal Care: *The Fast Track Pathway Tool*

The *Fast Track Pathway Tool*[13] is designed for assessing individual who need urgent attention because they have a rapidly deteriorating condition that may be entering a terminal phase with an increasing level of dependency. The Tool needs to be completed by an "appropriate clinician" who should give the reasons why the person meets the conditions required for the fast-tracking decision.

The 'appropriate clinician' is defined as someone who is, pursuant to the *NHS Act 2006*, responsible for an individual's diagnosis, treatment or care and who are medical practitioners (such as consultants, registrars or GPs) or registered nurses. Clinicians should have an appropriate level of knowledge or experience of the type of health needs, so that they are able to comment reasonably on the situation. They can be clinicians employed in voluntary and independent sector organisations that have a specialist role in end of life needs (for example, hospices), provided that they are offering services pursuant to the *NHS Act 2006.*

Where a recommendation is made for an urgent package of care via the fast-track process, this should be accepted and actioned immediately by PCTs. The framework says that it is not appropriate for individuals to experience delay in the delivery of their care package while disputes over the use of the *Fast Track Pathway Tool* are resolved. As mentioned in section 2.1, this is one of the areas where there has been a change since the first version of the National Framework was published in 2007.

2.4 Individual choice of care arrangement and limits on choice

The National Framework says that "the package to be provided is that which the PCT assesses is appropriate for the individual's needs".[14] However, practice guidance states that the PCT should take full account of the individual's own views of their needs and their preference as to how they should be met and that they "should be given as much choice as possible, particularly in the care planning process."[15]

PCTs have powers to offer personal health budgets for NHS continuing healthcare, either as a notional budget or a real budget held by a third party. Direct payments for NHS continuing healthcare can currently only be offered by PCTs that are pilot sites approved by the Secretary of State. In October 2011, Andrew Lansley announced that, subject to the evaluation of these pilots, by April 2014 everyone who is eligible for NHS continuing healthcare will have the right to ask for a personal health budget including a direct payment (although granting one would be at the discretion of the NHS commissioning body).[16]

The practice guidance provides some additional information about the limits that can be put on individual choice where, if followed, this would result in the PCT paying for a more expensive care arrangement, and the circumstances under which a PCT can decline to provide care in the preferred setting of the individual (see para 11.7). This section is set out below and notes that cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment:

> In many circumstances there will be a range of options for packages of support and their settings that will be appropriate for the individual's needs. The starting point for agreeing the package and the setting where NHS continuing healthcare services are to

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13 *Fast Track Pathway Tool for NHS continuing healthcare (September 2009)*
14 The National Framework, paragraph 100
15 *NHS continuing healthcare practice guidance* (April 2010)
16 Department of Health press release, 5 October 2011

be provided should be the individual's preferences. Individuals will not always be aware of the models of support that it is possible to deliver (for example, they may assume that it is only possible to receive support in a care home). Those involved in working with individuals to plan their future support should advise them of the options and the benefits and risks associated with each one. PCTs should be aware of the models of support offered by partners and by other PCTs and of evidence about their benefits and risks so that the options offered are maximised and that generalised assumptions are avoided.

In some situations a model of support preferred by the individual will be more expensive than other options. PCTs can take comparative costs and value for money into account when determining the model of support to be provided but should consider the following factors when doing so:

a) The cost comparison has to be on the basis of the genuine costs of alternative models. A comparison with the cost of supporting a person in a care home should be based on the actual costs that would be incurred in supporting a person with the specific needs in the case and not on an assumed standard care home cost.

b) Where a person prefers to be supported in their own home, the actual costs of doing this should be identified on the basis of the individual's assessed needs and agreed desired outcomes. For example, individuals can sometimes be described as needing 24-hour care when what is meant is that they need ready access to support and/or supervision. PCTs should consider whether models such as assistive technology could meet some of these needs. Where individuals are assessed as requiring nursing care, PCTs should identify whether their needs require the actual presence of a nurse at all times or whether the needs are for qualified nursing staff or specific tasks or to provide overall supervision. The willingness of family members to supplement support should also be taken into account, although no pressure should be put on them to offer such support.[27] PCTs should not make assumptions about any individual, group or community being available to care for family members.

c) Cost has to be balanced against other factors in the individual case, such as an individual's desire to continue to live in a family environment (see the Gunter case in box below).

Gunter Case

In the case of *Gunter vs. South Western Staffordshire PCT*, a severely disabled woman wished to continue living with her parents whereas the PCT's preference was for her to move into a care home. Whilst not reaching a final decision on the course of action to be taken, the court found that Article 8 of the European Convention of Human Rights had considerable weight in the decision to be made, that to remove her from her family home was an obvious interference with family life and so must be justified as proportionate. Cost could be taken into account but the improvement in the young woman's condition, the quality of life in her family environment and her express view that she did not want to move were all important factors which suggested that removing her from her home would require clear justification.[17]

The Alzheimer's Society notes that "the highest proportion of people receiving NHS continuing healthcare are in nursing homes and far fewer are awarded it while living at

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[17] *Ibid.*

home."[18] The practice guidance provides information on the respective responsibilities of PCTs and local authorities when a person is supported in their own home.[19]

3 Dispute resolution

The formal responsibility for informing individuals of the decision about eligibility for NHS continuing healthcare, and their right to request a review, lies with the Primary Care Trust (PCT). There are two possible levels at which a review of an eligibility decision (as distinct from a screening decision, for which see the section on the *Checklist* above) may take place:

- a local review process at PCT level; and
- a request to the Strategic Health Authority (SHA), which may then refer the matter to an Independent Review Panel.

If the Independent Review Panel upholds the original decision and there is still a challenge, the next stage is referral to the Health Service Ombudsman.

It is up to each PCT to agree a local review process, including timescales, which should be made publicly available and a copy should be sent to anybody who requests a review of a decision. The local review process may include referral of the case to another PCT for consideration or advice, in order to provide greater patient confidence in the impartiality of the decision making.

If a person has been unable to resolve the matter through any local dispute resolution procedure s/he may apply to the relevant SHA for an independent review of the decision if s/he is dissatisfied with:

a) the procedure followed by the PCT in reaching its decision as to the person's eligibility for NHS continuing healthcare; or

b) the application of the eligibility criteria for NHS continuing healthcare (i.e. the primary health need test).

Once local procedures have been exhausted, the case should be referred to the SHA's Independent Review Panel, which should consider the case and make a recommendation to the PCT. If using local processes would cause undue delay, the SHA has discretion to agree that the matter should proceed direct to an Independent Review without completion of the local process.

The Framework says that because Independent Review Panels have a scrutiny and reviewing role, it is not generally appropriate for any party to be legally represented at an IRP hearing although individuals may be represented by family, advocates, advice services and others in a similar role. It also says that although the role of the Independent Review Panel is advisory, its recommendations should be accepted by the PCT in all but exceptional circumstances.

The Framework sets out principles to be followed both locally and by Independent Review Panels (gathering of available evidence etc.). Annex E of the Framework provides further

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[18] *When does the NHS pay for care? Guidance on eligibility for NHS continuing healthcare funding in England*, Alzheimer's Society (2011).

[19] *NHS continuing healthcare practice guidance* (April 2010), paragraph 11.8

details of procedures to be followed in relation to Independent Review Panels. There are also provisions regarding disputes between PCTs and local authorities.

An individual's right under existing NHS complaints procedures and his or her existing right to refer a case to the Health Service Ombudsman is not affected by the Independent Review Panel procedures. In particular, where an individual is dissatisfied with issues other than the process followed or the application of the criteria, the Framework says that the matter should be considered via the complaints procedure.

4 Refunds guidance

NHS continuing healthcare: refunds guidance (March 2010) sets out the approaches to be taken by PCTs and local authorities when a decision is awaited on eligibility for NHS continuing healthcare or there is a dispute following a decision. It explains responsibilities for providing services during these periods and for refunding the costs of services provided.

If someone disputes a PCT's initial eligibility decision and this decision is revised following further consideration or as a result of a recommendation by an Independent Review Panel, the PCT should reimburse any costs incurred by the local authority or individual concerned. Ex-gratia payments from PCTs should aim to restore an individual's finances to the state they would have been in had the correct decision been made at the outset and to remedy any injustice or hardship as a result of the incorrect decision.

The period of reimbursement or ex-gratia payment should start from the date the initial PCT decision was made (or earlier if an unjustifiable delay has been acknowledged) until the date the revised decision comes into effect.

Disputes about PCT decisions on whether to provide reimbursement, or on the amount it intends to provide, can be addressed through the standard NHS complaints procedure.

5 Key guidance documents

The following Department of Health guidance, together with the Directions from the Secretary of State mentioned in the text of this note, should be consulted for a fuller account of the rules and duties of NHS bodies to provide NHS continuing healthcare.

- The National Framework for NHS Continuing Healthcare and NHS-funded nursing care (revised July 2009): This sets out principles and processes for establishing eligibility.
- Healthcare Checklist (September 2009): This is a screening tool to help establish who might need a full assessment of eligibility.
- Decision Support Tool (September 2009): This is a detailed questionnaire to help assess eligibility.
- Fast Track Pathway Tool for NHS continuing healthcare (September 2009): This is for urgent assessments of those with rapidly deteriorating, possibly terminal, conditions.
- NHS continuing healthcare practice guidance (April 2010): This provides a practical explanation of how the Framework should operate on a day-to-day basis and cites examples of good practice.

- Training materials for the revised National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (December 2009): These training materials have been developed to support local training on specific issues.

- NHS continuing healthcare: refunds guidance (March 2010): This sets out the approaches to be taken by PCTs and local authorities when a decision is awaited on eligibility for NHS continuing healthcare or there is a dispute following a decision. It explains responsibilities for providing services during these periods and for refunding the costs of services provided.

There are several introductory sources that constituents may find useful, for example:

- *NHS continuing healthcare and NHS-funded nursing care*, NHS public information booklet;

- NHS Choices website: *What is the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care?*;

- Age Concern factsheet 20, *NHS continuing healthcare and NHS-funded nursing care* (September 2010); and

- *When does the NHS pay for care? Guidance on eligibility for NHS continuing healthcare funding in England*, Alzheimer's Society (2011).

95% Confidence Interval

If Confidence intervals overlap, the samples are not significantly different.
Calculated using the Wilson method as recommended by Public Health Observatories

	2011/12 Quarter 3		
	Lower Level	Value	Upper Level
England	53.6	54.0	54.5
West Midlands	53.3	54.7	56.1
Telford & Wrekin	19.3	24.1	30.1

This table shows England and West midlands are not significantly different, but Telford & Wrekin is significantly different to both National and West Midlands.

Rate of Change

The rate of changes in CHC funding per 50,000 population has been analysed using the Mann-Whitney test. It covers the quarterly changes over the last 3 years (11 Quarters).
The Mann-Whitney U-value test has been used as the sample is less that 30.
The Mann-Whitney U-value test ranks the rate of change. If both samples are very similar you would expect the ranks below and above the middle value to be split 50:50 from both samples.
A 50:50 split is demonstrated in this test by a U-value of 50.

Rate of change between Quarters

	Year 2009/10				Year 2010/11				Year 2011/12		
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3
England		4.9	6.2	0.8	0.5	0.8	1.3	2.9	0.4	3.8	-1.2
West Midlands		3.3	6.8	1.6	-3.7	0.4	-1.1	-2.1	1.6	0.6	0.1
Telford & Wrekin		5.2	-7.0	-30.3	19.5	-10.2	-11.8	-15.3	-11.9	-39.7	-17.0

Using the data above gives a U value of 19.
The value is the same against England and West Midlands.
Using a Mann-Whitney look up table gives a critical value relevant for the sample size of how far away from 50 the value would need to be before being counted as significant.
In this instance the critical value is 27, meaning a number less than 27 is considered significant.

The rate of change of CHC clients over the last 3 years in Telford & Wrekin can therefore be considered as significantly different to National and West Midlands changes.

As the sample contains 20 measures a Z-score was also calculated at the same time as the U-value.
The Z-score was 2.3056 against both National and West Midlands.
Using a Z-score look up table this represents a p-value of 0.0209
A p-value less than 0.05 is considered significant, again demonstrating that Telford & Wrekin rate of change is statistically significantly different to both National and West Midland changes.