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Notice of Meeting

Health Scrutiny Panel

Tuesday, 4 December, 2012 at 6.30pm

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Friday, 23 November 2012

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact David Lowe/ Charlene Myers on (01635) 519817 / (01635) 51969
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West Berkshire
COUNCIL

To: Councillors Howard Bairstow, Dominic Boeck, Sheila Ellison, Carol Jackson-Doerge, Tony Linden, Alan Macro, Gwen Mason (Vice-Chairman) and Quentin Webb (Chairman)

Also to: Jan Evans and Charlene Myers (Strategic Suppport Officer)

Substitutes: Councillors George Chandler, Roger Hunneman, Andrew Rowles and Julian Swift-Hook

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Agenda

Part I

		Page No.
1	**Apologies for Absence** To receive apologies for inability to attend meeting (if any).	
2	**Minutes of Previous Meeting** To approve as a correct record for the minutes of the meeting of the Panel held on 19 June 2012.	1 - 6
3	**Declarations of Interest** To receive any Declarations of Interest from Members.	
4	**Urgent Items** *Purpose: For the Chairman to draw to the Panel's attention any urgent items for consideration.*	
5	**Findings of the Independent review of Continuing Healthcare** *Purpose: to receive the findings of the independent review of Continuing Healthcare in West Berkshire and to consider the next steps.*	7 - 92
6	**Dignity and Nutrition in Local Hospitals.** *Purpose: to receive an update from the West Berkshire LINk (HealthWatch) on progress of the patient survey of dignity and nutrition standards at the Royal Berkshire Hospital.*	Verbal Report
7	**Work Programme** To consider and prioritise the items on the work programme.	93 - 96
8	**Next meeting date**	

Andy Day

West Berkshire COUNCIL

Head of Strategic Support

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West Berkshire
COUNCIL

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON TUESDAY, 19 JUNE 2012

Councillors Present: Howard Bairstow, Sheila Ellison, Carol Jackson-Doerge, Tony Linden, Gwen Mason (Vice-Chairman) and Quentin Webb (Chairman)

Also Present: June Graves (Head of Care Commissioning, Housing & Safeguarding), Kate Green (Public), Jenny Legge, Tony Lloyd (Chairmain of the West Berkshire Local Involvement Network (LINk)) and Mark Robson (Director of Operations for Networked Care)

Apologies for inability to attend the meeting: Councillor Dominic Boeck, Edward Donald and Councillor Alan Macro

Councillor(s) Absent:

PART I

3. Apologies for Absence

Apologies were received from Dominic Boeck, Alan Macro and Councillor Hunneman. Mark Robson substituted for Edward Donald.

4. Minutes of Previous Meeting

The Minutes of the meeting held on 27 March 2012 were approved as a true and correct record and signed by the Chairman, subject to the inclusion of the following amendments:

Page 1, point 5 and page 3, point 6: It was noted by Councillor Tony Linden that 'mason' should have a capital letter and read 'Mason'.

Page 1, point 5 and page 3, point 6: Councillor Gwen Mason commented that 'a member of the West Berkshire Disability Alliance' should read 'an associate member of the West Berkshire Disability Alliance'.

Page 2, 2nd paragraph: Councillor Mason noted that 'Apri2' should read 'April'.

The Minutes of the meeting held on 10 May 2012 were approved as a true and correct record and signed by the Chairman.

5. Declarations of Interest

There were no declarations of interest received.

6. Actions from Previous Minutes

The results of the NHS Continuing Health Care Programme were still awaited.

No further actions were brought forward.

7. Urgent Items

No urgent items were reported.

8. Dignity and Nutrition - Hospitals

Councillor Quentin Webb expressed concern over Royal Berkshire Hospital's (RBH) reluctance to take part in the patient survey operated by LINks and that the panel would like to understand the reasoning behind RBH's position.

Tony Lloyd drew the groups attention to his discussions with Dr. Lindsey Barker (Group Director, Networked Care) and Sharon Herring (Operations Manager) at RBH and informed the panel that there was now an agreement to run a survey for 500 people across the hospital. The questionnaire was being formatted to make it RBH specific and would cover patients aged 65 and over as they were discharged from any ward. It was not, therefore, West Berkshire specific. However, he assured the meeting that independent surveys generally gather more honest answers. The aim was to begin the survey at the hospital in July 2012. He noted that this was the first time there had been a partnership between LINks and Royal Berkshire Hospital

The Chairman applauded and thanked Royal Berkshire Hospital for its participation in this endeavour.

In response to Councillor Webb's query regarding RBH's earlier position, Mark Robson commented that he had no personal knowledge of any previous decisions, but as the trust had been undergoing a major restructuring, it was possible the survey had been overlooked in the transferring of responsibilities necessitated by this process. However, following discussions with Tony Lloyd and the agreement on wording; he confirmed that the trust was content to take part in LINks consultation and felt it would dovetail into their own continuous survey.

Councillor Webb enquired as to Mark Robson's role within the newly restructured Royal Berkshire Hospital. Mark Robson informed the meeting that his role was Director of Operation for Networked Care and was line-managed by Dr. Lindsey Barker. He advised the meeting that the trust was clinically led with managerial support and was organised into 3 Care groups:

1. Urgent Care
2. Planned Care
3. Networked Care

His group dealt with long term specialities and his role was to provide support in order to ensure targets were achieved and for quality assurance. Each Care group had a board which was chaired by a clinical director.

The Chairman asked Mark Robson if the areas of dignity and nutrition would fall under his control. Mark Robson confirmed that this concerned all the Care Groups and he would be taking the lead in public / patient involvement. He explained that, in addition to the continuous survey, the hospital consults with patients via the Meridian online system which matches the statutory National Picker Institute survey. RBH endeavoured to ensure a consistent approach in its consultations and his experience had shown that useful variants of opinion emerged from different surveys.

Councillor Webb enquired if LINks had seen copies of the current questionnaires. Tony Lloyd responded that they had been offered sight of Meridian results, but had not yet received them.

Councillor Webb expressed his relief that RBH's position had changed and asked how the consultation would be progressed. Mark Robson advised that a covering letter from RBH should be attached so as to authenticate the questionnaire and garner a better response rate from patients

The Chairman asked whether the survey would be completed at discharge or follow-up. Mark Robson noted that the national consultation was postal, and suggested it would be more effective if the questionnaire was explained to the patient by a member of staff at the point of discharge.

Councillor Webb conjectured that as the survey was anonymous, patients would not be pressurised into completing the form and a follow up for patients who had not completed the questionnaire could not take place. Mark Robson confirmed the results were anonymous, but that a second mailing could still take place. This would increase the response rate.

Councillor Webb enquired if this would be a stand alone consultation or if there would be a follow up survey after, for example, three or six months. Tony Lloyd confirmed that it had been envisaged as a stand alone event, unless there was some discrepancy with the results. Mark Robson ventured that should the consultation reveal patients were generally unhappy with a certain aspect of the care they received, RBH would look into changing their practices and follow up on this change. Tony Lloyd concluded that Edward Donald had commented that should there be any further problems encountered by the panel with RBH, he would be happy to intervene on their behalf.

Kate Greene enquired if the survey would be delivered directly to a disabled patient or with the help of their carer. Mark Robson suggested that ideally it would be directly to the patient, unless a carer was required. Kate Green commented that some patients may not understand what is being asked of them and this may skew the results. Tony Lloyd explained to the panel that the aim was to have 20 responses from each ward and therefore it would be more effective to distribute the surveys whilst the patient was on the ward where their special needs were understood, rather than in the discharge lounge. Mark Robson agreed that the details of the delivery of the survey would need careful thought.

Councillor Tony Linden raised a general question following an article in the GP magazine regarding the restriction of access to care such as knee and hip operations. He expressed his concern that care rationing would occur in West Berkshire. Mark Robson confirmed that RBH was governed by the NHS constitution and he had no personal knowledge of any restrictions; people were treated in turn, on their clinical need.

June Graves remarked that, as patients were already asked to complete two surveys, an additional consultation might lead to survey fatigue. She queried whether the information LINks required could be gathered by expanding an existing questionnaire. Mark Robson informed the meeting that this would be problematic as the national survey was very prescriptive in its approach and the results were not returned directly to the hospital. The Meridian survey was completed by pressing coloured buttons on a key pad and was by its nature more quantitative than qualitative.

Councillor Carol Jackson-Doerge expressed her concern regarding how the consultation would be delivered to those patients with a learning disability. She suggested this might be solved by having a nominated person on each ward who was trained in special needs. Mark Robson observed that as the consultation would take place on the ward prior to discharge; the ward staff would be aware of the needs of the patient and carer. Councillor Jackson-Doerge asked if specific training would be given regarding the delivery of the survey. Mark Robson confirmed that guidelines would be explained to the staff as to the number of patients etc, to ensure a consistent approach across the trust.

Councillor Gwen Mason requested clarification as to the timeframe of the consultation. Tony Lloyd confirmed that he intended to commence the distribution of questionnaires in July and the results should therefore be available in late September. Mark Robson

asserted that the survey would need to take place either in July or September as the National Picker Institute survey was carried out in August.

Kate Greene drew the panels attention to the case of one of her clients, who had been distressed during their time in care due to a number of transfers and the confusion this caused them. Mark Robson apologised for the distress caused to this patient and explained that the intention of the trust was to return the patient to their base ward whenever possible to avoid the confusion caused by transfers. The Disability Coordinator would be aware of any patient who may need additional help. The trust was endeavouring to improve its service to those with a disability and to educate staff more fully in how to care for patients with learning disabilities and dementia.

In response to questioning from Councillor Howard Bairstow, Mark Robson explained that 96 -100 patients were discharged a day and they were all asked to complete the more generic questions of the Meridian online survey. They were also asked to complete specific questionnaires to inform RBH on how to improve individual services.

Councillor Bairstow speculated that if a patient had special needs it should be prominently displayed in the their notes, in order to inform those caring for them that they might become distressed and confused. Mark Robson assured the meeting that this information was included in the clinical notes and the Learning Disability Coordinator liaises with staff when a special needs patient is on the ward.

Councillor Mason enquired if the Community Hospital in Newbury was being included in the survey as it was part of RBH. Mark Robson clarified the situation stating that the Community Hospital was not part of the bed-stock and therefore not relevant in this case. Councillor Mason concluded that she was content the communication problem with RBH had been an isolated occurrence and thanked Mark Robson for his contribution.

Tony Lloyd asked if the RBH doctors were going on strike. Mark Robson commented that only routine operations could be cancelled; it was not legal to postpone urgent or cancer operations. It was expected that there would be minimal disturbance, however doctors had been canvassed so an estimation of numbers could be made. Any disruption will be recorded, as will the impact on patient care.

9. Anti-Child Poverty Strategy

Julia Waldman introduced her report to show how the local issues related to the national picture She explained that this was a high level strategy that aimed to be achieved in 2020. Her experience had shown that this was challenging target. West Berkshire was in a good position in relative performance to other councils. However, the results of actions taken now would not be seen for many years. In the short term the council would endeavour to alleviate and change child / family poverty with the intention that as an adult they would not live in poverty. National guidance is being reviewed. The Coalition Government wanted to re-frame, by autumn, the building blocks put in place by the previous party to reflect their own objectives, which would make it more difficult to compare data over time. Changes at national level would in-turn impact on local level work-streams.

Councillor Mason asked if national indicators were still being collected. Julia Walkman replied that some were still being collected and that the Government was looking to change the definition of NI 116, which would present a challenge in terms of comparative data. She commented that it was positive that this group had taken on responsibility for this concern. Child poverty was connected to health issues and was part of the NHS outcomes. Since she had written the report Child Poverty had been embedded in the Strategy Framework in Berkshire wide health services.

In response to questioning by Councillor Mason, Julia Waldman made the following points

- Benchmarking with other unitary authorities: the framework was Berkshire wide, and therefore there was a synergy around early health.
- Page 16, point 1.7 – annual reporting: The affect of any actions would not be seen for approximately three years. She hoped that when Public Health entered the authority they would take on the responsibility for data capture as there was little resource within the Council.
- Page 16, point 1.8: as Council resources are stretched and areas overlap with Public Health and Child Poverty, the inclusion of Public Health with in West Berkshire Council was a positive step .
- Statutory duties will be carried out. However, minimal central support remained in the service and there was a demand to maintain early help provision

Tony Lloyd asked if there was a correlation between child poverty and subsequent criminality in later life; thereby a reduction in poverty was a reduction in crime. Julia Waldman advised that there was a whole suite of risk factors, with child poverty being only one of them. There was also a correlation between out-of work parents and a higher level of accidents to children in their care. She concluded that she was grateful for the support of this group and the Child Poverty Action Group had produced an interesting report which showed a range of ideas of what had worked in the past and what hadn't (see attached).

Councillor Jackson-Doerge suggested that the JSNA for children had helped to ensure this subject stayed a high priority.

Councillor Webb commended the quality of the report and recognised that many events had been planned for the near future. He asked that the outcome of this work be reported back to the meeting. Julia Waldman concurred with this request and suggested that it might be useful to coordinate the dates of this meeting with the CYP task group. She concluded that with the current economic climate, poverty would continue to rise in, however it should then improve.

10. Health and Wellbeing Board Update

June Graves introduced her report which showed the history behind the creation of the Health and Wellbeing Board (HWB) and an update on its progress.

Councillor Webb enquired if the HWB was replicating what had gone before. June Graves stated that it was a new development and was something very positive. There had been good attendance by clinical commissioning groups and she believed it had established its authority. However there were similarities with the Primary Care Trust (PCT) and it would be interesting to see how it developed further. The Government had acknowledged that there would be a transitional period until the CCG (Care Commissioning Group) formed a view of itself.

The Chairman asked if the board would be reactive or proactive. June Graves answered that it would mainly be proactive but would also be reactive. It was currently establishing itself, but had gained good attendance and commitment, with a completed draft strategy. In the course of a year it had gone from nothing to having a draft strategy prepared. West Berkshire was comparable to other Councils and had made good progress. As the CCGs took their commissioning plans, there might be a challenging period for the board. Health services coming into the local authority might find the democratic aspect challenging.

Tony Lloyd concurred that HWB meetings would be held in public and therefore doctors might have to justify their decisions.

June Graves further discussed the work needed for transition at chief executive level. The model was being developed for Public Health delivering on a Berkshire wide level. Nick Carter and Andy Day were working hard to encourage everyone to sign up; however it was necessary to address staffing issues through a consultation exercise in order to comply with statutory time-frames and enable staff to consider their future.

Councillor Jackson-Doerge inquired whether the consultation document would be led by the Council or PCT. She felt it should be a joint piece of work owned by the Local Authority; however Public Health might have resources that could be utilised.

June commented that there was speculation regarding secondary legislation falling under section 102, which she would support.

11. Health Scrutiny Panel Work Programme

The following amendments to the work plan were proposed and accepted (see revised programme attached):

- OSMC/11/125 - Day Centres

The Chairman suggested this item be deleted. Councillor Mason agreed as no feedback regarding gaps in service had been received and there were no Officers available to take responsibility for this subject. She expressed her concern regarding the impact of a reduced service on those in rural areas.

- OSMC/11/105 - Dignity and Nutrition – Hospitals

June Graves informed the meeting that Nigel Owen was no longer an Officer at West Berkshire Council. The Chairman proposed that LINks should report back to the panel on the results of the consultation taking place this summer.

OSMC/11/106 - Update on the Health and Wellbeing Board

June Graves noted that Teresa Bell was no longer at West Berkshire Council

- OSMC/11/119 - Continuing Healthcare (CHC)

Councillor Webb commented that the panel was still awaiting the results of this review.

- OSMC/12/122 – Home Care

June Graves advised that this item was being addressed by the ASC Efficiency Programme and agreed to arrange a meeting with Councillor Webb to discuss what elements would be of interest to Scrutiny.

- OSMC/12/124 - The effect of health service reorganisation

Tony Lloyd noted that West Berkshire Community hospital was the only ‘local provision’. The Chairman agreed to readdress this item.

(The meeting commenced at 6.30 pm and closed at 7.55 pm)

CHAIRMAN ………………………………………….

Date of Signature ………………………………………….

Agenda Item 5

Title of Report:	Continuing Health care in West Berkshire
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	4 December 2012

Purpose of Report: **To introduce the findings of the Independent review of Continuing Health care in West Berkshire in order to allow members to conduct scrutiny.**

Recommended Action: **To note the report.**

Resource Management Working Group Chairman	
Name & Telephone No.:	Councillor Quentin Webb – Tel (01635)
E-mail Address:	qwebb@westberks.gov.uk

Contact Officer Details	
Name:	Charlene Myers
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1. Introduction

1.1 Members were concerned that patients in Berkshire receive some of the lowest levels of Continuing Healthcare funding when compared to other Primary Care Trusts nationally.

1.2 The Health Scrutiny Panel investigated this issue at its meeting on 17th January 2012 and invited Charles Waddicor (Chief Executive, NHS Berkshire) to attend and present the Primary Care Trust perspective.

1.3 Since the meeting in January, the South Central Health Authority conducted an Independent Review of Continuing Healthcare in West Berkshire. This report is attached at Appendix A & B.

1.4 Both Jan Evans (Head of Adult Social Care) and Marion Andrew – Evans (Interim Director of Nursing in NHS Berkshire) are invited to review the recommendations and discuss the method by which they will be taken forward.

2. Recommendations

2.1 Members are asked to consider the Independent Review findings and recommendations, assessing the extent to which the NHS CHC framework and the allocation of funding to those with the most complex residents' needs is being applied, considering any further action as appropriate.

Appendices

Appendix A - CHC Independent Review
Appendix B - Action Plan

Consultees

Local Stakeholders:

Officers Consulted: Scrutiny and Partnerships Manager

Trade Union: N/A

South of England

Review of NHS Continuing Healthcare Processes in Berkshire

Date: May/June 2012

South West Strategic Health Authority

Report on the Review of NHS Continuing Healthcare Processes and Procedures in Berkshire

Paper of the findings of the review undertaken by Eileen Roberts, Jill Smith and Jo Dexter	
Authors	Jill Smith, Eileen Roberts and Jo Dexter
Responsible Persons	Olga Senior – on behalf of the Strategic Health Authority Margaret Goldie – on behalf of Local Authorities in Berkshire Marion Andrews-Evans on behalf of the two Primary Care Trusts
Main Aim of Review	To report on the review of processes and practice relating to NHS Continuing Healthcare in Berkshire with suggestions for improvement

Executive Summary

The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was launched in 2007 and revised in October 2009. This external review of processes and procedures in Berkshire was requested by both the Primary Care Trusts and the six Local Authorities as some difficulties with regard to processes and procedures between the authorities had arisen.

The report analyses activity and cost data against national benchmarking figures which provides a context for the review, appraises the processes and procedures in Berkshire against the standards of the National Framework, summarises the findings and makes recommendations for change.

NHS Berkshire and the Local Authorities have worked hard to deliver the requirements of the National Framework for Continuing Healthcare. Whilst areas of good practice exist, the review outlines several areas where improvement should be focused particularly in the first few months following this report. The reviewers accept that there are a large number of recommendations include in this review at a time of major change within the NHS structures and suggest that the main areas requiring urgent attention include:

- The Strategic Health Authority requires assurance that the Primary Care Trust is operating within the legal framework and guidance around the Fast Track Pathway Tool;
- Improvements in Joint working between the NHS and the six local authorities at all levels;
- The approval of an Operational Policy which makes all procedures clear will smooth the whole process and procedure and allow for better working relationships;
- Further work is required on the draft dispute resolution policy between the NHS and Local Authorities to put into place a signed and agreed policy as required in the NHS Continuing Healthcare Responsibilities/Directions;
- Further work is required to resolve the current polarised view on the use of the NHS CHC Checklist Tool and information requirements to accompany the tool, in order to avoid delayed discharges from the acute setting and ensure a patient centred approach.

Regarding the other recommendations contained within this report, priorities need to be agreed at a senior level to ensure a smooth handover to local Clinical Commissioning Groups in the future.

South West Strategic Health Authority

Review of the NHS Continuing Healthcare Processes and Procedures in Berkshire

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Section 1

Introduction

This section sets out the key components of the National Framework for NHS Continuing Healthcare and the responsibilities for the Strategic Health Authority, Primary Care Trusts and Local Authorities outlined therein.

1. Introduction

The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care

1.1 ‘Continuing care’ is care provided over an extended period of time, to a person aged 18 or over, to meet physical or mental health needs that have arisen as a result of disability, accident or illness. ‘NHS Continuing Healthcare’ is a package of continuing care that is arranged and solely funded by the NHS.

1.2 In June 2007, the Department of Health published the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care, after a lengthy formal consultation period. This Framework was supported by national decision-making tools and a standard process of assessment of the needs of individuals, and by a national training programme. The Framework meant that instead of each of the 28 Strategic Health Authorities in England having its own rules, tools and processes for determining eligibility for NHS Continuing Healthcare there was one national approach. The Department of Health committed to review the Framework following its implementation in 2007.

1.3 In October 2009, the revised National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care was launched along with revision of the three national tools (Fast Track Pathway, Checklist and Decision Support Tool) and clarification on the expected approaches to the completion of them.

1.4 The guidance was underpinned by the NHS Continuing Healthcare (Responsibilities) Directions 2009 laid down by the Secretary of State for Health. These Directions came into force on 1 October 2009 and apply to every Strategic Health Authority, Primary Care Trust and social services authority in England. These set out the:-

- Duties of Primary Care Trusts – determining eligibility for NHS Continuing Healthcare;
- Duties of Primary Care Trusts and social services authorities: joint working;
- Duties of Strategic Health Authorities around reviews of decisions,

1.5 Relevant Department of Health policy documents are listed in Appendix 2.

1.6 A refresh of the National Framework and associated guidance is currently underway in preparation for the new architecture in the NHS. It should be noted that there will be no change to the eligibility threshold for NHS Continuing Healthcare, the purpose of the refresh is to add more clarity to the processes.

Strategic Health Authority responsibilities

1.7 The revised Framework confirmed that Strategic Health Authorities are responsible for the following in relation to NHS Continuing Healthcare:

- co-ordinating the Independent Review process which is instigated when there is an appeal about the procedures followed or decision reached by a Primary Care Trust;
- strategic leadership, organisational and workforce development;
- ensuring local systems operate effectively and deliver improved performance;
- holding Primary Care Trusts accountable for their responsibilities.

Primary Care Trust responsibilities

1.8 The range of Primary Care Trust NHS Continuing Healthcare responsibilities include:

- ensuring consistency in the application of the national policy on eligibility for NHS continuing healthcare;
- promoting awareness of NHS continuing healthcare;
- implementing and maintaining good practice;
- ensuring that quality standards are met and sustained;
- providing training and development opportunities for practitioners;
- identifying and acting on issues arising in the provision of NHS continuing healthcare; and
- commissioning NHS Continuing Healthcare on a strategic and individual basis (within the context of World Class Commissioning).

Local Authority responsibilities

1.9 The range of Local Authority NHS Continuing Healthcare responsibilities include:

- ensuring assessment of eligibility of continuing healthcare takes place in a timely manner;
- notifying the relevant PCT if, in carrying out an assessment it is apparent that a person's needs may fall under the National Health Service Act 2006;
- ensuring a person's needs are not of a nature beyond which a LA could be expected to provide;
- promoting awareness of NHS continuing healthcare;
- implementing and maintaining good practice;
- ensuring that quality standards are met and sustained;
- providing training and development opportunities for practitioners.

Operational issues

1.10 As well as clarifying the roles and responsibilities of Strategic Health Authorities and Primary Care Trusts, the revised Framework (2009) provided clarification and guidance on a number of other issues, listed below:

- The threshold of eligibility for NHS Continuing Healthcare did not change but more detailed guidance (including use of the three tools) was provided. The current refresh of the Framework will not change the threshold of eligibility but provide more clarity;

- Use of the national Fast Track Pathway Tool was made mandatory in the NHS Continuing Healthcare (Responsibilities) Directions 2009. Where the Fast Track Pathway Tool is used, NHS Continuing Healthcare must be awarded until the Primary Care Trust has completed a full assessment of needs;

- An individual must be involved (and given support to do so where needed) throughout the eligibility process. Decisions must be given in writing;

- Consent of the individual to be assessed must be explicitly obtained. The need to apply the Mental Capacity Act throughout has been highlighted in the revised National Framework;

- NHS Continuing Healthcare decision-making should usually take no more than 28 days from receipt of a completed Checklist (or where no checklist is used, other notification of potential eligibility for NHS Continuing Healthcare). The NHS Continuing Healthcare Refunds Guidance was published by the Department of Health in March 2010. The guidance states in 6b "where a Primary Care Trust has unjustifiably taken longer than 28 days to reach a decision, the Primary Care Trust should refund to the individual or the Local Authority the costs of the service from Day 29";

- Primary Care Trusts are recommended to consider providing interim support (in own home, care home, intermediate care) until the patient has stabilised sufficiently to be able to make an NHS Continuing Healthcare decision on basis of likely long term needs;

- The Framework highlights that those in receipt of NHS Continuing Healthcare continue to be entitled to all services available to other patients of their Primary Care Trust (including community nursing, joint equipment services etc) and all other relevant policies;

- Primary Care Trusts should have protocols explicitly setting out the responsibilities of each relevant local NHS organisation and the Local Authority in relation to NHS continuing healthcare;

- Clarity is provided concerning the children/adult NHS continuing healthcare transition policy;

- Primary Care Trusts are encouraged to commission NHS Continuing Healthcare using models that maximise personalisation and individual control. The role of Personal Health Budgets is highlighted.

Health and Social Care Bill 2011

1.11 The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

- As a result of the passage of this Bill, the current Primary Care Trust statutory responsibilities will transfer to Clinical Commissioning Groups and the SHA statutory responsibilities will transfer to the NHS Commissioning Board but the detail of how this will work in practice is yet to be determined.

Section 2

Review of NHS Continuing Healthcare Processes and Procedures in Berkshire

This section sets out the methodology followed in undertaking the review of NHS Continuing Healthcare Processes and Procedures in Berkshire.

2. Approach to the Review

2.1 This external review of processes and procedures in Berkshire was commissioned by the Strategic Health Authority alongside both the Primary Care Trusts and the six Local Authorities as difficulties with regard to processes and procedures between the authorities had arisen together with questions regarding practice arising from the benchmarking data.

2.2 The review was divided into four stages:-

Planning Stage

- Initial meeting with the Local Authorities representative;
- Initial meeting with the Primary Care Trust representatives;
- Agreement of the Terms of Reference of the review (Appendix 1);

Stocktake of Processes and Procedures

- Questionnaires were designed, one for the Primary Care Trust and one for the Local Authorities in order to gather information relating to NHS Continuing Healthcare processes and procedures in Berkshire;
- The purpose of the review was to ensure compliance with the National Framework and the Responsibilities/Directions, and to provide assurance on the quality and consistency of practice across the two Primary Care Trusts (East Berkshire and West Berkshire) and the six local authority areas. It also provided a platform for the external reviewers to understand how the whole system worked, its strengths and potential areas for improvement;
- The questionnaire covered the following topics:-
  - ∗ compliance with the National Framework;
  - ∗ timescales;
  - ∗ retrospective cases;
  - ∗ capacity;
  - ∗ operational policy;
  - ∗ patient centred;
  - ∗ management of appeals, complaints and disputes;
  - ∗ training;
  - ∗ quality assurance/ standards;

* joint working;
* networking / best practice;
* information and activity;
* transitions.

Interviews with Staff and Validation of Files

- These were undertaken on 30 and 31 May 2012 in order to validate areas of underperformance or dispute as well as areas of good practice. The interviews were undertaken by Eileen Roberts and Jill Smith;
- At the same time Mrs Jo Dexter, registered nurse and former clinical lead for NHS Continuing Healthcare in Gloucestershire, undertook the review of 20 case files;
- The six local authorities prepared two files obtaining an audit of cases relating to NHS Continuing Healthcare from their perspective.

Presentation of Initial Findings

- A meeting with senior staff was planned in order to present the initial findings of the review together with initial recommendations;
- At the time of this report, further actions and timescales are yet to be defined.

2.3 The review also considered the activity and expenditure performance of the organisations in Berkshire in relation to NHS Continuing Healthcare; this report also considers this data in Section 3.

Section 3

2012 Benchmarking Position of Berkshire Primary Care Trust for NHS Continuing Healthcare

This section sets out the activity and financial information relating to NHS Continuing Healthcare in Berkshire for 2011/12.

3. NHS Continuing Healthcare 2011/12 Benchmarking Position in Berkshire

3.1 NHS Continuing Healthcare funding must be available to all people who are eligible.

3.2 There is significant work that can be done by Primary Care Trusts and Local Authorities to ensure that where eligibility is determined the best quality service is made available to individuals at the most cost effective price for the organisation.

3.3 Quarterly benchmarking on NHS Funded Care, which includes NHS Continuing Healthcare, is produced by a nationally funded project team based at NHS North Somerset and has been in place nationally for the past three years.

3.4 The data is analysed by weighted population. This is based on the crude populations adjusted according to the relative need (age, health status) for healthcare and the unavoidable geographical differences in the cost of providing healthcare.

Activity

3.5 Before drilling down into the statistics for East and West Berkshire it is helpful to look at the broader context, both nationally and regionally. Table 1 shows the regional activity per 10,000 weighted population by region in 2011/12. It shows the number of people receiving Continuing Healthcare.

Table 1: Activity per 10,000 weighted population by region

Region	Cumulative Activity 20011/12	Weighted Population	Cases per 10,000 Weighted Population 2011/12
South Central	**5,075**	**3,468,003**	**15**
South East Coast	10,203	4,152,379	25
South West	14,910	5,115,860	29
East Midlands	12,277	4,483,935	27
Yorkshire & Humber	16,755	5,170,212	32
West Midlands	14,159	5,624,297	25
North East	7,391	2,945,582	25
North West	14,752	7,702,579	19
London	15,935	8,114,958	19
East of England	12494	5,470,707	23
TOTAL	**123951**	**52,248,512**	**24**

3.6 This cluster analysis shows that overall South Central have the lowest number of people in receipt of NHS Continuing Healthcare per weighted population.

3.7 This could be for a variety of reasons. These may include that the population is not in need, there is insufficient information available to the public and clinicians concerning continuing healthcare, the processes are unclear or difficult, the threshold for eligibility is set too high and / or the Primary Care Trust is not adhering to the National Framework.

3.8 However it is necessary to see whether this should be applied to the whole cluster and where NHS Berkshire sits within the cluster which the next table shows.

Table 2: Cumulative NHS Continuing Healthcare activity in 2011/12 sorted by number of cases per 10,000 weighted population

Primary Care Trust	Cumulative Activity YTD 2011/12	Weighted Population	Cases per 10,000 Weighted Population 2011/12
Berkshire East	363	349349	10
Berkshire West	279	392859	7
Buckinghamshire	866	432557	20
Hampshire	1694	1153888	15
Isle of Wight	340	156005	22
Oxfordshire	613	530227	12
Portsmouth	566	206088	27
Southampton City	354	247031	14
TOTAL	**5,075**	**3,468,003**	**15**

3.9 Comparing the activity levels within South Central shows that both Berkshire East (10) and Berkshire West (7) have the lowest number of recipients of NHS Continuing Healthcare per 10,000 weighted population in the cluster (15), which is considerably lower than the national average of 24.

3.10 Berkshire East ranks 148 out 150 Primary Care Trusts in the country on this indicator and Berkshire West ranks 150 out of 150.

3.11 All activity nationally has increased over the last two years, including in Berkshire.

Expenditure

3.12 Activity converts into expenditure having differing impact on Primary Care Trust expenditure. The following table shows costs per 10,000 weighted population by region.

Table 3: Costs per 10,000 weighted population by region

Region	2011/12 Costs £'000	Population	Costs (£'000) per 10,000 Weighted Population 2009/10
South Central	**179,522**	**3,468,003**	**518**
South East Coast	209,371	4,152,379	504
South West	279,659	5,115,860	547
East Midlands	203,544	4,483,935	454
Yorkshire & Humber	299,886	5,170,212	580
West Midlands	288,264	5,624,297	513
North East	121,114	2,945,582	411
North West	270,568	7,702,579	351
London	358,526	8,114,958	442
East of England	209,612	5,470,707	383
TOTAL	2,420,066	52,248,512	463

3.13 Using the aggregated cluster analysis NHS South Central would be expected to record the lowest expenditure on Continuing Healthcare per 10,000 weighted population nationally, however the above table shows that expenditure in this area is the third highest nationally.

Table 4: Costs per 10,000 weighted population by organisation

Primary Care Trust	**Costs £'000 2011/12**	**Weighted Population**	**Costs (£'000) per 10,000 Weighted Population 2011/12**
Berkshire East	**22,607**	**349349**	**647**
Berkshire West	**13,258**	**392859**	**337**
Buckinghamshire	28,692	432557	663
Hampshire	67444	1153888	584
Isle of Wight	8468	156005	543
Oxfordshire	14515	530227	274
Portsmouth	10641	206088	516
Southampton City	13896	247031	563
TOTAL	**179522**	**3,468,003**	**518**

3.14 Table 4 shows there is wide variation in the costs per 10,000 weighted population across the organisations in South Central with Berkshire East being the second highest in the region and 22 out of 150 nationally. Berkshire West are second lowest regionally and 107 out of 150 nationally in what it spends on NHS Continuing Healthcare per 10,000 weighted population.

3.15 Table 5 sets out the position on numbers of referrals exceeding 28 days in 2011/12

No. of Referrals Exceeding 28 Days in Quarter 1112*	Q1	Q2	Q3	Q4	TOTAL 1112
Berkshire East	18	17	15	14	64
Berkshire West	8	19	6	17	50
TOTAL	**26**	**36**	**21**	**31**	**114**

*Referrals exceeding 28 days are counted according to the date the deadline is first exceeded (i.e. day 29)

E.g. an application which hits day 29 on 28th June in Q1 and is still not complete by 1 July in Q2 is only counted in Q1 NOT both Q1 & Q2

Following the review, the reviewers noted that from the Q1 benchmarking figures for 2012/13 Berkshire East reported 13 referrals >28 days and Berkshire West had 6 indicating a general improvement in comparison to previous quarters

Discussion

3.16 NHS Continuing Healthcare activity and cost is increasing nationally and regionally.

3.17 In further considering the Primary Care Trust analysis which takes into account the type of populations served by Primary Care Trusts; both Berkshire Primary Care Trusts are in the bottom three of Primary Care Trusts for numbers of people eligible for NHS Continuing Healthcare. However this is not reflected in the money spent on NHS Continuing Healthcare, particularly in Berkshire East.

3.18 NHS Berkshire data quality is judged as good nationally. However, even after accounting for some margin of error in the data quality and analysis, it does seem that NHS Berkshire is dealing with proportionately **less** cases that would be expected and that the costs of these cases are also **more** than would be expected.

3.19 It is recommended that more work is done by the Primary Care Trusts to review activity and to control costs relating to NHS Continuing Healthcare. In summary:

- NHS Berkshire does not appear to be achieving best value for money when purchasing care;
- All care packages, including high cost/value care packages should be regularly reviewed;
- The relationship with the Local Authority should be fostered to maximise joint working arrangements across health and social care. In particular this should focus on value for money and the cost of care, and providing the best quality of care for the individuals.

Number of referrals and conversion rate

3.20 The number of referrals, both Fast Track and non Fast Track, is collected under the benchmarking returns. Similarly, the conversion rate is collected for Fast Track and non Fast Track NHS Continuing Healthcare applications. Either of these factors might influence the variation in performance and further analysis is recommended.

Cost of care

3.21 The cost of the care funded under NHS Continuing Healthcare will be influenced by many factors including the nature of the market from which the care is purchased in individual areas. Analysing the type, cost and quality of care provided with NHS Continuing Healthcare funding is recommended. It is suggested that this is undertaken strategically alongside all six Local Authorities.

High cost cases

3.22 The benchmarking data shows aggregate costs under NHS Continuing Healthcare and therefore the cost of individual packages of care cannot be determined. However, exploring the position with regard to the level of high cost cases funded by NHS Berkshire could provide useful information.

Retrospective cases

3.23 Activity and cost information is collected in the benchmarking data relating to retrospective cases. Further work to better understand the influence of retrospective cases on activity and spend is recommended.

Number of appeals to the Primary Care Trust

3.24 The nature of the appeals processes within NHS Berkshire might influence activity. The audit showed that very few appeals take place in NHS Berkshire, possibly related to poor publicity and the fact that letters to applicants do not clearly set out the appeal process. Appeals would be expected to increase as the overall NHS Continuing Healthcare Processes including letters to applicants are improved and information to the public is improved.

Relationship between the NHS and the Local Authorities

3.25 The relationship with the Local Authority can have a significant influence on the performance of individual organisations in relation to NHS Continuing Healthcare.

3.26 Nationally, some organisations have fully integrated adult health and social care services. Others have very active Local Authorities who engage fully with the NHS Continuing Healthcare agenda putting pressure on the NHS to frequently assess and consider individuals for NHS Continuing Healthcare eligibility.

3.27 In NHS Berkshire relationships between the NHS and the Local Authorities appear to vary. There is a willingness to work together, however trust appears to have broken down overall with the NHS and one Local Authority often liaising through legal correspondence and practice emerging such as a Local Authority asking for a checklist to be completed for every hospital discharge.

3.28 The NHS and Local Authorities should work together in the best interest of the individual, regardless of funding or care outcome. Once achieved performance should improve for all partners.

Recommendations

3.29 In relation to the activity and cost information presented in this chapter, it is recommended that:

KR1	Primary Care Trusts and Local Authorities review all possible opportunities to improve activity and outcomes for patients and improve compliance with the National Framework;
KR2	NHS Berkshire is encouraged to maintain the quality of data returns under the benchmarking project;
KR3	NHS Berkshire and the six Local Authorities jointly and regularly meet to use the benchmarking data to monitor their performance both regionally and nationally;
KR4	The NHS Berkshire Board and the Local Authorities review the benchmarking data and consider the factors influencing the local performance on NHS Continuing Healthcare.
KR5	NHS South Central scrutinises the benchmarking data at a regional level and undertakes further analysis in relation to the issues listed above in support of all its Primary Care Trust areas, and ensures that best practice is shared.

Section 4

Assessment of NHS Continuing Healthcare Processes and Procedures in Berkshire

This section summarises the findings of the review of NHS Continuing Healthcare practice and process in Berkshire.

4. Assessment of NHS Continuing Healthcare Processes and Procedures

4.1 This section provides a summary of the key points derived from the questionnaires and interviews.

4.2 The section summarises the common themes identified under the topic areas explored within the questionnaires and interviews and gives key recommendations relating to them. The themes are based on the standards set out within National Framework for NHS Continuing Healthcare.

General Findings

4.3 From the evidence available it would appear that the Primary Care Trusts in Berkshire may not be acting within the Responsibilities/Directions as laid down by the Secretary of State for Health in relation to the Fast Track Pathway Tool. The Strategic Health Authority needs assurance that the Primary Care Trusts are complying with the Directions. Further information on this is set out from paragraph 4.29.

The key areas for improvement are:

4.4 There is an urgent need for a Local Operational Policy which is clear on all the procedures with regard to implementing the National Framework for NHS Continuing Healthcare. This is key to all areas particularly in ensuring consistency, undertaking training of staff, working relationships with the Local Authorities and transparency of process for the public and stakeholders.

4.5 Joint working between the Primary Care Trusts and the Local Authorities needs urgent attention with a patient-centred focus although there are some areas within Berkshire where good practice exists.

4.6 Timescales for assessment, decision making and review need to be addressed.

4.7 The Fast Track process appears to be misinterpreted and may not therefore always be working to the benefit of patients.

4.8 A draft dispute resolution process was received from NHS Berkshire, this urgently needs to be taken forward and agreed with all parties.

4.9 Staff training needs addressing at all levels in order to ensure consistency of application of the eligibility criteria and to promote understanding of all Continuing Healthcare processes. A Joint training programme involving the NHS and the Local Authorities needs to be established on a regular basis.

Compliance with the National Framework

Information for the Public:

4.10 Information regarding NHS Continuing Healthcare is available on the NHS Berkshire website and is conveyed through both health and social care

practitioners. There is a reliance on nationally available information, and there was little evidence of locally adapted materials.

4.11 All organisations (NHS and Local Authorities) were found to be using the mandatory Checklist, Decision Support Tool and Fast Track Pathway Tool.

Completion of the Checklist

4.12 Referrals are accepted via the Checklist from a variety of settings including acute sector, nursing homes, community and domiciliary care, including both NHS and Social Care Staff although this process is not used for fast track referrals. This means that Checklists are often completed by and accepted from staff who have not undertaken any recent training.

4.13 Checklists which are not accepted by the Primary Care Trust are those completed without sufficient evidence or where the evidence supplied does not support the banding applied. Checklists submitted without appropriate evidence can cause delays. There was some ambiguity regarding the information required with the checklist, and in some cases a lot of information was asked for which appeared unnecessary. Practice Guidance (Paragraph 6.9) states "the checklist is intended to be relatively quick and straightforward to complete."

4.14 Where the checklist is negative it is expected that the professional who had completed it would inform the individual/family of the outcome.

4.15 Where the checklist is accepted contact is made with the individual/family and appropriate professionals to confirm the assessment and request reports.

4.16 The importance of, and need to include the individual in the eligibility process was recognised by the organisations involved. However, all areas were struggling with achieving an appropriate level of input whilst ensuring the timeliness of decision making.

4.17 Consent appeared to be recorded appropriately by the NHS, being well documented and signed by the appropriate person (file audit). However there was some confusion regarding what information could be held by different organisations and what could be shared. The reviewers are aware that this confusion is not specific to Berkshire and clarity on the sharing of information would be welcomed nationally.

4.18 There was evidence to show that the Local Authority was not always seeking appropriate consent before completing checklists. There was evidence that the hospital staff involved in completing checklists felt that their professional judgements were ignored by the Local Authority whose staff were completing a second checklist with a different outcome in many cases and that Local Authorities were seeking to have a checklist completed for all individuals being discharged from hospital.

4.19 Following completion of the checklist, most organisations were experiencing some degree of problem with achieving high quality, timely multi-disciplinary

assessments. In particular, the engagement of Community Psychiatric Nurses and social workers in assessments were cited as problematic. Local Authorities felt that they were not always invited to the table and that timescales were unnecessarily lengthy.

4.20 The Department of Health Frequently Asked Questions published in November 2011 gives further information on checklisting and how it fits into the Delayed Discharge arrangements at 3.4 and 3.5. Organisations should take this into account when agreeing arrangements around checklisting. Section 7.1 of the Practice Guidance is also relevant.

4.21 The organisations appear to have a polarised view on when checklisting is required, and need to urgently reach a joint understanding and agreement on this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital

Decision Support Tool

4.22 The review highlighted a range of issues in relation to the completion of the Decision Support Tool.

4.23 From the interviews and file audit, the process for completion of the multi disciplinary assessment and Decision Support Tool appeared complex. In some areas the domains on the Decision Support Tool are not completed at this stage, with the professionals completing them separately afterwards. For example, on several files, the social services representative's comments had been written after the multi disciplinary meeting (East Berkshire in particular). Whilst this is acceptable it is not necessarily best practice and organisations should be mindful of the Practice Guidance Section 8.5 in terms of multi-disciplinary team assessments.

4.24 However, generally Decision Support Tools were well evidenced within the care domains, each individual's view noted and it was documented that discussion had taken place. From the file audit it seemed that some members of the multi-disciplinary team did not understand what evidence was needed to support the levels in each care domain, which showed a lack of understanding of the National Framework. This lack of knowledge could lead to inconsistency in decision-making, particularly at a local level.

4.25 The explanation as to how a recommendation for NHS Continuing Healthcare eligibility was made was not clearly documented in any of the Decision Support Tools. There was insufficient detail about the nature, intensity, unpredictability and complexity of a person's needs to explain why a person did or did not have a primary health need. This was evident in all the processes including lack of explanation in the panel minutes and in the letters to the applicants. This was consistent in the file audit and in the evidence given by the local authorities. See also sections 3.55 and 3.56 under training.

4.26 The Practice Guidance reiterates the position that only in exceptional circumstances should the recommendation of the multi disciplinary team provided on the Decision Support Tool not be accepted by the organisation.

In the cases reviewed and in the file audit when a multi disciplinary recommendation for NHS Continuing Healthcare was not accepted by the Primary Care Panel, the reasons for this were not given, either in the minutes of the meeting or the letter to the families, and it was not clear whether cases were referred back to the multi-disciplinary teams for further work if the evidence did not match the recommendation made by the MDT.

4.27 From the file audit, the decisions appeared to be based on clinical need; however it was difficult to ascertain if they were consistent across and within the two Primary Care Trust areas. No audit of consistency had taken place.

4.28 Panel arrangements were different across the two Primary Care Trust areas, although plans were in place to bring the Panels in line with each other. The same Panels consider multi-disciplinary assessments and decision support tools as well as act as Appeal Panels.

Fast Track Processes

4.29 Fast Track procedures appeared clear in some areas and not so clear in others.

4.30 NHS Continuing Healthcare (Responsibilities) Directions 2009 at paragraph 2 and the Practice Guidance paragraph 5.9 make it clear that a Primary Care Trust must accept and action the Fast Track Pathway Tool immediately where the Tool has been properly completed in accordance with the criteria.

4.31 Hospital discharge staff appeared clear about the required processes with regard to fast track procedures and stated that it worked well most of the time.

4.32 Evidence was found where the Primary Care Trust had not agreed Fast Track Pathway Tools immediately and it was not clear what further information was required by the Primary Care Trust resulting in delay for clients with several cases found where disputes still existed after patients had died.

4.33 There was also evidence to show that on completion of the Fast Track Tool where eligibility is determined, patients did not always receive funding until a full assessment had been made. This is not in line with the Directions.

4.34 The position is very clear in the Directions and National Framework that the sole requirement for a finding of eligibility under the Fast Track Pathway Tool is for a clinician to have reached a positive decision that (a) the patient has a primary health need arising from rapid deterioration and (b) that it may be entering a terminal phase. Completion of the Fast Track Pathway Tool is the mechanism for the clinician to evidence his/her decision. Once the Primary Care Trust has received an appropriately completed Fast Track Pathway Tool then the Primary Care Trust must put into place Continuing Healthcare funding without delay.

4.35 Where the clinician has confirmed in the Fast Track Pathway Tool that the patient has met the two requirements set out above then the Primary Care Trust does not have the discretion to overturn a clinician’s decision or turn

down a Fast Track Pathway Tool without a full multi-disciplinary assessment being carried out. Further the Primary Care Trust must not delay putting in place the arrangements in order to carry out a multi-disciplinary assessment.

4.36 If there is significant concern by the Primary Care Trust that the clinician is acting inappropriately then the Primary Care Trust should speak immediately to the clinician and ask the clinician to confirm that he/she considers the patient meets the two requirements. Only if the clinician decides to withdraw the application can the Primary Care Trust not approve the eligibility for Continuing Healthcare.

4.37 The reviewers are aware that a number of Primary Care Trusts are experiencing significant problems with the use of the Fast Track process by some clinicians, for which there is a training need. However, legislation and guidance clearly confirms that the Primary Care Trust does not have discretion to refuse a Fast Track Pathway Tool where it is fully completed. Further, it cannot require additional documentation to be filled in by the practitioner in order for Continuing Healthcare funding to be awarded.

A Fast-track Pathway Protocol should form part of the overall Operational Policy for Continuing Healthcare.

3.38 ***Appeal/Review Panel arrangements***

NHS Berkshire undertook very few Appeals relating to their eligibility decisions. When an Appeal was requested, it was heard at the same Panel as cases at the first stage. Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable. There was no evidence of cases being reviewed by people who had not been previously involved. There was no evidence of a local resolution policy or processes. The PCTs may wish to consider adopting the local resolution process in place in the South West, a copy of which is attached at Appendix 5.

4.39 The Primary Care Trust did have terms of reference in place for both Appeal Panels and other Panels. Whilst adequate these require revising to reflect current guidance. They were unclear as to the role of the Local Authority as well as to the expectations of Panel members and of the Applicants. Letters to applicants informing them that they were not eligible for NHS Continuing Healthcare did not clearly inform the applicant of their right to appeal/apply for a review of the decision and how to do this, and there was no signposting to advocacy services.

Key recommendations relating to Compliance with the National Framework:

KR6	All organisations in Berkshire should ensure they have clear arrangements for the timely review of Fast Track applications. This should ensure that the relevant staff are clear on how to complete the fast track tool in line with the National Framework.

KR7	NHS Continuing Healthcare funding must be available to patients once a positive Fast Track Tool has been completed. This funding should be available until a person is assessed as no longer eligible.
KR8	All organisations should consider how to engage clients and their representatives appropriately at all stages in the process including information on how to appeal and to agree a local resolution process which could form part of the operational policy.
KR9	All organisations should ensure consent for assessment is explicitly obtained at the appropriate stages and is clearly recorded.
KR10	All organisations need to reach an agreed understanding and appropriate use of the checklist tool when individuals are in hospital. They should pay particular attention to this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital Clarity is also required regarding information required with checklist is required, keeping this as simple as possible.
KR11	The process for completion of the multi-disciplinary assessment and Decision Support Tool must be consistent, transparent and clear. It should include the views of both NHS and local authority organisations and any dissent should be recorded.
KR12	When a multi-disciplinary team recommendation is not accepted by the Panel a full rationale and explanation must be given (or the case referred back to the MDT for further work/additional evidence)
KR13	Decisions regarding a person's eligibility for NHS Continuing Healthcare must be clearly distinct from decisions regarding the approval and funding of care packages and/or Funded Nursing Care.
KR14	Eligibility decisions should be based on the four key indicators of primary health need which should be supported by the Decision Support Tool. A clear rationale should be given on all the relevant documentation.
KR15	The right to Appeal and how to do so must be transparent to applicants during each part of the process.
KR16	It is recommended that Appeals are held as a separate process to regular decision making Panels
KR17	The Primary Care Trust should set up a resolution process prior to an applicant progressing to Independent Review.

Timescales

4.40 The NHS Continuing Healthcare Refunds Guidance (March 2010) places the priority on the NHS to be prompt in its decision making regarding NHS Continuing Healthcare eligibility. When a PCT makes a decision that a person is eligible for NHS Continuing Healthcare and it has unjustifiably taken the PCT longer than 28 days to reach a decision, the PCT should, in appropriate circumstances, refund to the individual or the LA, the costs of the services from Day 29.

4.41 The data from the National Benchmarking relating to numbers of referral exceeding 28 days in 2011/12 is set out in Section 3.

4.42 At the time of the review, the recent announcement of the cut off dates for retrospective cases did not appear to have been communicated to the public. However this was later confirmed to have taken place.

4.43 The Primary Care Trust should also ensure that the new timescales for appeal from 1 April 2012, as published by the Department of Health are now incorporated into their processes and correspondence.

4.44 A letter was sent from Olga Senior to all Primary Care Trust cluster Chief Executives and copied to Continuing Healthcare staff across NHS South of England on 29 May 2012 highlighting these two announcements and the requirement for Primary Care Trusts to have arrangements in place to deal with any potential increased workload. Primary Care Trusts will need to demonstrate to the Strategic Health Authority that the exercise has been communicated within their areas and the data on numbers of applications and number of reviews undertaken will be collected and published within the national benchmarking figures.

Key recommendations relating to achieving timescales:

KR18	The Primary Care Trust must ensure that there are arrangements in place for achieving timely eligibility decisions alongside the six local authorities. This includes ensuring that fast track referrals are dealt with in a timely way.
KR19	New regulations must be communicated to the public and to staff in a systematic and timely way. The Primary Care Trust must ensure that there is a process in place to achieve this, and that capacity of teams to meet this need is addressed. Numbers of retrospective cases received will be collected in the national benchmarking figures

Retrospective cases

4.45 Dealing with cases that require the consideration of eligibility for a retrospective period can put significant pressure on organisations both in terms of capacity and financial resources.

4.46 All Primary Care Trusts are currently experiencing increasing numbers of requests for retrospective reviews following the announcement by the Department of Health of deadlines for individuals to request such reviews and these need to be factored in to capacity planning.

Key recommendations relating to Retrospective cases:

KR20	The backlog of retrospective cases needs to be given clear priority and resources allocated appropriately.
KR21	It is recommended that the Primary Care Trust assesses the potential for both activity and finance in this area and plans accordingly over the next twelve months.
KR22	The recent announcement with regard to retrospective cases needs to be communicated effectively to both the public and to staff in all agencies. A national communication toolkit was made available to all Primary Care Trusts together with a comprehensive nationally agreed retrospective review policy for Primary Care Trusts to follow or adapt locally.

Capacity

4.47 The capacity and structure of the NHS Continuing Healthcare teams appeared light.

4.48 There appeared to be limited capacity to undertake reviews and these were behind schedule. Timely reviews are necessary to ensure best patient care and to ensure appropriate use of resources.

4.49 The NHS Berkshire Continuing Healthcare lead has recently suggested a new structure for NHS Continuing Healthcare teams across Berkshire, bringing the two former Primary Care Trust teams together.

Key recommendations relating to Capacity:

KR23	NHS Continuing Healthcare is a significant risk area for NHS Berkshire. Senior managers need to be assured of the processes and procedures within their organisation. This includes assessing that sufficient capacity at the right level is available to undertake the work required as well as maximising and sharing resources across East and West Berkshire.
KR24	Any new structure in relation to NHS Continuing Healthcare should be based on needs not on the present numbers and grades of staff available. The structure must be fit for the future with particular reference to Clinical Commissioning Groups/Commissioning Support Services.

KR25	Evidence suggests that resources in Berkshire are low for both NHC Continuing Healthcare work and Funded Nursing Care. It is suggested that further benchmarking takes place to ensure that assessment teams are adequately resourced to achieve the necessary assessment and review requirements.
KR26	Local Authorities must ensure that they have sufficient staff to be part of multi disciplinary teams and be available to attend members of Primary Care Trust Panels/joint decision making processes and Appeal Panels. This should be within a co-ordinated approach across all of the Local Authorities.

Operational Policy

4.50 There was no operational policy in place for NHS Continuing Healthcare.

4.51 Overall the processes and procedures in place lacked transparency and seemed time consuming.

4.52 The reviewers were informed that an operational policy was currently being drafted but were not able to see a draft at the time of review.

Key recommendations relating to Operational Policy:

KR27	A clear concise operational policy, taking account of the NHS Continuing Healthcare (Responsibilities) Directions 2009 and the principles laid out in the NHS Continuing Healthcare framework, which is drafted in consultation with relevant partner agencies, and in particular the local authorities is required as a matter of urgency for ratification by the Primary Care Trust Board (suggested timescale within four weeks – to be agreed in action plan). This must include terms of reference for relevant Panels.
KR28	A local dispute resolution policy must be agreed with the six local authorities urgently (suggested timescale within two months – to be agreed in action plan).
KR29	The Primary Care Trust must make the operational policy available on their website.

Patient Centred

4.53 The Framework makes it clear that the whole process of the assessment and decision making should be “patient centred” (Practice Guidance Para 2.3).

This is necessary in a number of ways including good, clear information, inclusive assessment processes and local resolution opportunities.

4.54 There were examples of the client and/or their representatives being present at assessments and the completion of the Decision Support Tool. Applicants did not appear to attend panels, and appeal numbers were unusually low.

4.55 Letters to the applicants/their representatives were not clear and did not give good explanations of the rationale for decisions neither did they clearly explain what a person could do next if they were not satisfied with the decision.

Key recommendations relating to Patient Centred:

KR30	Local and regularly updated information should be available on the website and also in paper format if required.
KR31	The operational policy should clearly set out how applicants are systematically involved in all processes including assessment, decision making and appeal panels as applicable.
KR32	Opportunity for local resolution meetings should be offered to patients and families as a way of explaining the processes and reasons for the decisions made.
KR33	All letters should be revised to ensure that they convey appropriate information, are user friendly in plain English and include the reasons for decisions made as well as identifying the next steps for appeal or complaint. It is suggested that NHS Berkshire contacts one or two other areas for examples of letters used.

Management of appeals, complaints and disputes

4.56 NHS Berkshire lacked clearly defined local review processes which included how complaints, appeals and disputes are managed.

4.57 Appeals are heard through the regular Primary Care Trust Panels and not separated. There was no evidence to demonstrate that applicants/families were involved with these or how often appeal panels were held. However the reviewers were told that Appeals were not requested frequently.

4.58 Local resolution is considered an important aspect in the management of appeals. There was no local resolution policy or process identified.

4.59 It is essential that NHS Berkshire had an up to date local dispute policy which is agreed with partner organisations. This has been started but not finalised at present.

Key recommendations relating to Management of appeals, complaints and disputes:

KR34	NHS Berkshire should ensure all those with the potential to request a review of the decision of eligibility for NHS Continuing Healthcare are made aware of how this can happen and the related timescale. That all applicants must know about their right to appeal.
KR35	Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable.
KR36	All decision makers on panels should contribute fully to the decision making processes at Panels with any differences in opinion noted.
KR37	Letters following the Appeal Panel should be clear and give good explanations for decision made. They should also be clear about the next steps in line with the local resolution process and right to request an independent review of the decision once all local resolution processes have been exhausted.
KR38	All organisations should ensure they agree and have in place an up to date local dispute policy agreed between NHS Berkshire and the six local authorities.
KR39	Information should be clear regarding what can be appealed and what should be dealt with through local complaint processes.

Training

4.60 Primary Care Trusts and Local Authorities are required under the National Framework to provide training and development opportunities for practitioners. It is also important for organisations to invest in NHS Continuing Healthcare awareness training and in training of any professional who may be required to complete the checklist, Decision Support Tool or Fast Track tool to ensure understanding and that the appropriate quality is achieved.

4.61 The training of those completing the Decision Support Tool is implicit in the quality of the recommendation being made by the multi disciplinary team. This includes both NHS and local authority staff.

4.62 There were some areas of poor practice with regard to the application of the Decision Support Tool and four key indicators of a primary health need. For example if a person was fed through a “PEG” it was thought that they were automatically eligible for NHS Continuing Healthcare; there was also a view (particularly in the Local Authorities) that if someone had a terminal illness they were automatically entitled to Fast Track funding, and that PCTs should fund all end of life care. There were also examples of misapplication of the

Decision Support Tool domain criteria by staff across the board, except for the NHS Continuing Healthcare Nurses who appeared to have a good grasp of its application.

4.63 There were also examples noted on two occasions where a nurse had completed a checklist in the acute sector and there was no need to refer on to the NHS Continuing Healthcare team, the social worker then filled in a further checklist, increased the domain levels and sent it to the team. Good training and joint working and understanding of each other perspectives will help to alleviate such incidents. There was another example, this time from a Local Authority where a Continuing Healthcare Nurse Assessor had agreed an A in the breathing domain, but downgraded other domains already stated by the acute sector so that there was no need to complete a Decision Support Tool, this is outside of the national guidance and legal framework.

4.64 Some staff interviewed had had minimal training and many had learnt on the job. At the time of the review there was no ongoing training taking place and no joint training with the local authorities planned.

Key recommendations relating to Training:

KR40	NHS Berkshire and the six local authorities should invest in a suitable training strategy/programme which covers the training needs of each level of staff i.e. whether they complete the checklist, undertake fast track assessments, represent the local authority or are a continuing healthcare assessor or manager.
KR41	Training should be joint and meet the needs of both the NHS and the six local authorities. Urgent training is required at all levels, and should follow shortly after the agreement of the operational policy. It is suggested that external facilitation and training is procured in the first instance.
KR42	The training strategy and policy should be explicit within the operational policy or at least referred to within that document.

Quality Assurance/ standards

4.65 NHS Continuing Healthcare is a significant resource commitment for organisations and as such should have a profile at a senior level to ensure appropriate scrutiny and strategic leadership.

4.66 The responsibility for NHS Continuing Healthcare sits at Director level in the Primary Care Trust and at senior management / assistant director level within the local authorities.

4.67 Evidence of Board level reporting was disappointing, with NHS Continuing Healthcare being mentioned in risk registers only within the Primary Care

Trust although it had been discussed at the occasional local authority scrutiny committee. No formal report on activity, costs or risks was found.

Key recommendations relating to Quality Assurance/ standards:

KR43	Executive Directors should be appropriately briefed and engaged across the field of NHS Continuing Healthcare and should provide strategic direction where required.
KR 44	Appropriate Directors within the local authorities should also be properly briefed regarding NHS Continuing Healthcare and its associated risks.
KR 45	NHS Continuing Healthcare performance should be presented as a separate item at Board meetings at least annually and also to the local health scrutiny committees. Ideally this should be the same joint report across the area.

Joint working

4.68 In some Local Authority areas staff on the ground reported good practical working relationships with Local Authority colleagues to achieve the best possible service for individual patients. However there were concerns that this was not evidenced in all areas and not always supported by efforts to engage at a senior and more strategic level.

4.69 Generally there was no evidence of a "can do" culture in either health or social services correspondence, with both resorting to their legal position rather than liaising to plan a way forward.

4.70 All eight organisations were aware of the need to have constructive working relationships across the health and social care boundary, although evidence suggested that this had broken down, hence difficulties and disputes arising.

4.71 The difficulties reported included:

- The engagement of some Local Authorities in the assessment and review process;
- Local Authority staff not feeling an equal part of the decision making processes either in assessments or at panels;
- One Local Authority insisting that the checklist is completed for all patients being discharged from hospital whether appropriate or not;
- The lack of an operational policy and dispute resolution process;
- The number of legal exchanges between the NHS and the local authorities (West Berkshire in particular) has decreased trust between the agencies and exacerbated a breakdown in relationships;

- View from Local Authorities that the Primary Care Trust is delaying discharge and view from the Primary Care Trust that Local Authorities do everything they can to put obstacles in the way;

- Staff from all organisations operating to own organisational pressures rather than being customer/patient centred and applying the National Framework objectively.

The reviewers were made aware that the NHS has made a proposal to the Local Authorities that in order to free up beds and reduce delayed discharges, the Local Authority fund people to go to care homes and that a full assessment can then be undertaken as to who should fund the individual's care. Should the individual meet the CHC criteria the Primary Care Trust will then pick up all the costs from day of discharge and refund the Local Authority. It was not clear to the reviewers why the Local Authority would not accept this proposal and this should be explored further.

Key recommendations relating to Joint working:

KR46	All organisations should be mindful of their responsibilities in relation to NHS Continuing Healthcare as set out in the introduction to this document – 1.6, 1.7 and 1.8.
KR47	All organisations should prioritise the building and maintenance of constructive strategic and operational working relationships across Berkshire, particularly between the NHS and the six local authorities. This should be led by appropriate senior individuals. Regular joint meetings should take place on at least a monthly basis in the first instance at both strategic and operational levels.
KR48	Assessment and review is the joint responsibility of health and social care and organisations should work collaboratively to ensure this is achieved.
KR49	Brokerage and/or advocacy services should be considered, and where possible currently available services used to support patients in their NHS Continuing Healthcare applications.
KR50	NHS Berkshire should ensure that partner organisations and in particular the mental health trust recognise the importance of NHS Continuing Healthcare assessments and make staff available as required by the National Framework.

Networking / Best Practice

4.72 It was unclear what networking arrangements existed across NHS Berkshire to enable problem solving and sharing good practice and arrangements should tie in with the wider South Central networking arrangements. Ideally this should include NHS and Local Authority representation. Due to a lack of

networking it has been difficult for the teams to learn from best practice, share ideas and innovation.

Key recommendations relating to Networking / Best Practice:

KR51	NHS Berkshire should look outwardly as well as locally to glean ideas and develop practice.
KR52	NHS Berkshire and the six local authorities should consider setting up a local operational group that meets regularly to discuss issues relating to NHS Continuing Healthcare processes and procedures.

Information and activity

4.73 NHS Berkshire appears to have a sound recording and financial management system.

4.74 Section 3 of this report discusses in detail issues relating to the benchmarking data which is collected nationally. NHS Berkshire submits data into this national data collection exercise, however does not appear to have outwardly questioned its position nationally and this does not appear to have been discussed at Board level.

4.75 NHS Berkshire was aware of the need to ensure data confidentiality. However some of the systems that they had employed to obtain data were laborious. For example they required original signed copies of assessments and would not accept them by email. The reviewers also noted that the Primary Care Trust did not always take a note of telephone calls from applicants and record these as contacts. These processes should be reviewed.

Key recommendations relating to Information and activity:

KR53	NHS Berkshire should scrutinise performance on the national benchmarking measures and to share this information with their Board and local authorities. This should include both activity and finance and further understanding of why NHS Berkshire is one of the lowest in the country in terms of numbers of people receiving NHS Continuing Healthcare yet costs are high in comparison to numbers.
KR54	NHS Berkshire should continually assure themselves of the quality of their data relating to NHS Continuing Healthcare performance.
KR55	NHS Berkshire should undertake comprehensive forecasting taking account of all relevant factors including a provision for retrospective cases and the transition of children into adult services. This will enable realistic budgets to be set for NHS Continuing Healthcare.

Transition

4.76 There is a separate Framework which covers the policy context for the assessment of need and provision of care for children and young people. The Framework for Children and Young People relates to Continuing Care rather than NHS Continuing Healthcare and this reflects the different organisational arrangements expected for the care of children and young people. As with adult NHS Continuing Healthcare however, Primary Care Trusts are responsible for leading the continuing care process for children and young people.

4.77 The Children and Young People's Framework states that 'all Primary Care Trusts should ensure that they are actively involved in the strategic development and oversight of their local transition planning processes with their partners, and that their representation includes those who understand and can represent adult NHS continuing healthcare. Primary Care Trusts should also ensure that adult NHS continuing healthcare is appropriately represented in all transition planning meetings regarding individual young people wherever the individual's needs suggest that there may be potential eligibility'.

4.78 Clear expectations for the NHS are included starting with the identification of children for whom adult NHS Continuing Healthcare may be required at age 14. By the age of 17, an individual's eligibility for adult NHS continuing healthcare should be decided in principle by the relevant PCT in order that, where applicable, effective packages of care can be commissioned in time for the individual reaching adulthood on their 18th birthday.

4.79 NHS Berkshire has an identified nurse who leads on transition from the adult team. This is good practice.

Key recommendations relating to Transition:

KR56	A Transitions agreement should be part of or referred to in the overall NHS Continuing Healthcare Operational Policy.
KR57	NHS Berkshire must ensure the identification of children for whom adult NHS Continuing Healthcare may be required at age 14 and planning organised accordingly. This includes customer centred planning as well as ascertaining resource implications.

Section 5

Summary of Key Findings and Recommendations

This section sets out the key findings and recommendations

5. Summary of key findings and recommendations

5.1 The review has highlighted areas that will require addressing which have also been explained in section 3 (3.3 to 3.9) of this report.

5.2 From the evidence available it would appear that NHS Berkshire may not be acting within the Directions as laid down by the Secretary of State for Health around the Fast Track Pathway Tool. This means that they could be acting outside of the legal framework for NHS Continuing Healthcare.

5.3 The three major areas that require urgent attention are:

- The Strategic Health Authority requires assurance that the Primary Care Trust is operating with the legal framework and guidance around the Fast Track Pathway Tool;

- The need for an Operational Policy which is clear on all the procedures with regard to implementing the National Framework for Continuing Healthcare. This is key to all areas particularly in ensuring consistency, undertaking training of staff, relationships with the Local Authorities and transparency of process for the public;

- Joint working with the six local authorities. All partners must work together with the patient at the centre and find ways of achieving this at all levels. This should help to eliminate delays, eliminate frustration experienced by both NHS and Local Authority practitioners, stop the need for legal correspondence and for arbitrary practices such as requiring checklists to be completed for all patients and frequent requests for additional information before acceptance of checklists;

- The joint approval of an Operational Policy which makes this clear will smooth the whole process and procedure and allow for better working relationships.

- Checklisting out of hospital.

5.4 Other important areas to address include:

- Timescales for assessment and resolution need to be addressed urgently.

- The dispute resolution process and policy requires revision and agreement.

- Staff training needs addressing at all levels in order to ensure consistency of understanding of and the application of the eligibility criteria and to promote understanding of all processes. Joint training needs to be established on a regular basis.

5.5 A full list of all recommendations is provided at Appendix 4.

Section 6

Next Steps and Summary of Actions

6. Next steps and summary of actions

6.1 NHS Berkshire in partnership with the six Local Authorities is now required to produce an action plan setting out how the issues in each organisation will be addressed including appropriate implementation timescales. These should be submitted to NHS South of England by (timescale to be agreed).

6.2 The action plans submitted will be monitored by NHS South of England.

6.3 It is recommended that NHS Berkshire and the six local authorities regularly review the actions between them and brief their executives/Board as applicable.

6.4 Each organisation puts in place a regular review of the benchmarking data and audits and assesses progress accordingly.

Appendices

Appendix 1	**Terms of Reference**
Appendix 2	**Key Department of Health policy documents relating to NHS Continuing Healthcare**
Appendix 3	**Issues for Executive Leads / Operational Leads Networks to consider**
Appendix 4	**Key Recommendations Arising from the Review – to form basis for action plan**
Appendix 5	**Local Resolution Process**

Appendix 1

Terms of Reference

CONTINUING HEALTHCARE REVIEW

NHS BERKSHIRE /WEST BERKSHIRE COUNCIL (on behalf of all six Local Authorities)

FEBRUARY 2012

Terms of Reference

1. To review the application of Continuing Healthcare Policies by NHS Berkshire across the six local authority areas, including any specific NHS Ombudsman guidelines currently used to inform local decision making.

2. To review the way in which the Directions, National Framework and Practice Guidance are being implemented by NHS Berkshire; review current local operational policies and procedures, and to determine the extent to which these are compliant with the national requirements.

3. To review how the application of the test for Primary health Need is being applied, with specific reference to the eligibility criteria for NHS CHC, the use of the Decision Support Tool, and whether the Framework and National Practice Guidance are being interpreted correctly.

4. To review the work of the CHC Panels, specifically in relation to timeliness of decision making and communication of outcomes, and the relationship between MDT recommendations and Panel decisions.

Background material

1. Review of existing written procedures in place across Berkshire.

2. Review of the advice and guidance provided to CHC Leads, and to Panel members, by NHS Berkshire.

3. Review of written evidence relating to specific cases where there has been dispute provided by the six Councils.

Activities

1. Agree ToR etc with NHS Berkshire, and WBC on behalf of the 6 Councils.
2. Meet with staff from NHS Berkshire.
3. Meet with staff from West Berkshire Council, and representatives of the other 5 Berkshire Councils (this is likely to be one meeting only).
4. Agree timescales for the Review and reporting back arrangements.

5. Agree who receives the report and how it can be shared.

6. Agree how any recommendations are to be implemented, and the timescales for these.

7. Agree how outcomes will be monitored.

Appendix 2

Key Department of Health policy documents relating to NHS Continuing Healthcare

This appendix lists the key policy documents relevant to NHS Continuing Healthcare

Key Department of Health policy documents relating to NHS Continuing Healthcare

Document	Date of publication
NHS Continuing Healthcare Frequently Asked Questions	November 2011
Directions on the National Health Service Acts 1977 and 2006 published in 2009	30 April 2010
NHS continuing healthcare practice guidance	1 April 2010
NHS continuing healthcare: refunds guidance	30 March 2010
National Framework for Children and Young People's Continuing Care	25 March 2010
NHS funded-nursing care practice guide (revised) 2009	30 September 2009
The NHS Continuing Healthcare (Responsibilities) Directions 2009	29 September 2009
The national framework for NHS continuing healthcare and NHS-funded nursing care – July 2009 (revised)	22 July 2009
The Delayed Discharges (Continuing Care) Directions 2007	30 August 2007
The National Health Service (Nursing Care in Residential Accommodation) (England) Directions 2007	30 August 2007
NHS continuing healthcare: Continuing care redress	14 March 2007

Appendix 3

Issues for Executives Leads / Operational Leads across NHS Berkshire and Berkshire Local Authorities to Consider

This sets out issues for NHS Berkshire and the six Berkshire Local Authorities to consider

Issues for NHS Berkshire and the six Local Authorities to consider

In addition to the key recommendations this appendix summarises key issues for consideration. Key to success will be how organisations work together in partnership and a workable operational policy.

Assessment and review

- Skill mixes within assessment teams – including the release of specialist input, for example, MH, LD or other areas, for example, social worker, occupational therapist.
- Interim arrangements to avoid assessing in hospital
- Achieving good multi disciplinary team assessments
- Specialist input into reviews – sharing resources across areas
- Understanding case management requirements to help inform resource requirements for reviews

Panels/decisions

- Audit and/or peer review of eligibility decisions on a regular basis in order to ensure the correct application of the criteria and consistency across the whole area.
- This should include audit of DSTs on a regular basis as well as Panel decisions.
- Clarity of Appeal Panels, who attends and who are the decision makers

Training

- Pooling training resources across the health and social care community to enable relevant, joint training. This should include all six Local Authorities.
- Pooling of training ideas and resources across a wider area e.g. South Central region and/or NHS South
- Learning from national and regional good practice.

Patient experience

- Audit tools to monitor and improve quality of patient experience from referral to outcome.
- Improving the Patient experience.
- Examples of good patient literature.

- Examples of good correspondence.

Quality assurance

- One page KPI sheet / dashboard
- Quality assurance checklist pre-eligibility

Information and activity

- Understand growth areas for future referrals to help in planning both in terms of assessment and review

Appendix 4

Key Recommendations arising from the review

This appendix provides a list of the key recommendations from the review which should be used to form an action plan.

Key Recommendations arising from the review

KR1	Primary Care Trusts and Local Authorities review all possible opportunities to improve activity and outcomes for patients and improve compliance with the National Framework;
KR2	NHS Berkshire is encouraged to maintain the quality of data returns under the benchmarking project;
KR3	NHS Berkshire and the six Local Authorities jointly and regularly meet to use the benchmarking data to monitor their performance both regionally and nationally;
KR4	The NHS Berkshire Board and the Local Authorities review the benchmarking data and consider the factors influencing the local performance on NHS Continuing Healthcare.
KR5	NHS South Central scrutinises the benchmarking data at a regional level and undertakes further analysis in relation to the issues listed above in support of all its Primary Care Trust areas, and ensures that best practice is shared.
	Compliance with the National Framework
KR6	All organisations in Berkshire should ensure they have clear arrangements for the timely review of Fast Track applications. This should ensure that the relevant staff are clear on how to complete the fast track tool in line with the National Framework.
KR7	NHS Continuing Healthcare funding must be available to patients once a positive Fast Track Tool has been completed. This funding should be available until a person is assessed as no longer eligible.
KR8	All organisations should consider how to engage clients and their representatives appropriately at all stages in the process including information on how to appeal and to agree a local resolution process which could form part of the operational policy.
KR9	All organisations should ensure consent for assessment is explicitly obtained at the appropriate stages and is clearly recorded.
KR10	All organisations need to reach an agreed understanding and appropriate use of the checklist tool when individuals are in hospital. They should pay particular attention to this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital Clarity is also required regarding information required with checklist is required, keeping this as simple as possible.
KR11	The process for completion of the multi-disciplinary assessment and Decision Support Tool must be consistent, transparent and clear. It should include the views of both NHS and local authority organisations and any dissent should be recorded.

KR12	When a multi-disciplinary team recommendation is not accepted by the Panel a full rationale and explanation must be given (or the case referred back to the MDT for further work/additional evidence)
KR13	Decisions regarding a person's eligibility for NHS Continuing Healthcare must be clearly distinct from decisions regarding the approval and funding of care packages and/or Funded Nursing Care.
KR14	Eligibility decisions should be based on the four key indicators of primary health need which should be supported by the Decision Support Tool. A clear rationale should be given on all the relevant documentation.
KR15	The right to Appeal and how to do so must be transparent to applicants during each part of the process.
KR16	It is recommended that Appeals are held as a separate process to regular decision making Panels
KR17	The Primary Care Trust should set up a resolution process prior to an applicant progressing to Independent Review.
	Timescales
KR18	The Primary Care Trust must ensure that there are arrangements in place for achieving timely eligibility decisions alongside the six local authorities. This includes ensuring that fast track referrals are dealt with in a timely way.
KR19	New regulations must be communicated to the public and to staff in a systematic and timely way. The Primary Care Trust must ensure that there is a process in place to achieve this, and that capacity of teams to meet this need is addressed. Numbers of retrospective cases received will be collected in the national benchmarking figures
	Retrospective Cases
KR20	The backlog of retrospective cases needs to be given clear priority and resources allocated appropriately.
KR21	It is recommended that the Primary Care Trust assesses the potential for both activity and finance in this area and plans accordingly over the next twelve months.
KR22	The recent announcement with regard to retrospective cases needs to be communicated effectively to both the public and to staff in all agencies. A national communication toolkit was made available to all Primary Care Trusts together with a comprehensive nationally agreed retrospective review policy for Primary Care Trusts to follow or adapt locally.
	Capacity
KR23	NHS Continuing Healthcare is a significant risk area for NHS Berkshire. Senior managers need to be assured of the processes and procedures within their organisation. This includes assessing that sufficient capacity at the right level is available to undertake the work required as well as maximising and sharing resources across East and West Berkshire.

KR24	Any new structure in relation to NHS Continuing Healthcare should be based on needs not on the present numbers and grades of staff available. The structure must be fit for the future with particular reference to Clinical Commissioning Groups/Commissioning Support Services.
KR25	Evidence suggests that resources in Berkshire are low for both NHC Continuing Healthcare work and Funded Nursing Care. It is suggested that further benchmarking takes place to ensure that assessment teams are adequately resourced to achieve the necessary assessment and review requirements.
KR26	Local Authorities must ensure that they have sufficient staff to be part of multi disciplinary teams and be available to attend members of Primary Care Trust Panels/joint decision making processes and Appeal Panels. This should be within a co-ordinated approach across all of the Local Authorities.
	Operational Policy
KR27	A clear concise operational policy, taking account of the NSH Continuing Healthcare (Responsibilities) Directions 2009 and the principles laid out in the NHS Continuing Healthcare framework, which is drafted in consultation with relevant partner agencies, and in particular the local authorities is required as a matter of URGENCY. This must be completed within four weeks of the publication of this report for ratification by the Primary Care Trust Board. This must include terms of reference for relevant Panels.
KR28	A local dispute resolution policy must be agreed with the six local authorities urgently i.e. within two months of this report.
KR29	The Primary Care Trust must make the operational policy available on their website.
	Patient Centred
KR30	Local and regularly updated information should be available on the website and also in paper format if required.
KR31	Applicants should systematically be involved in all assessments including Decision Support Tools, and should be invited to Appeal Panels as applicable.
KR32	Opportunity for local resolution meetings should be offered to patients and families as a way of explaining the processes and reasons for the decisions made.
KR33	All letters should be revised to ensure that they convey appropriate information, are user friendly in plain English and include the reasons for decisions made as well as identifying the next steps for appeal or complaint. It is suggested that NHS Berkshire contacts one or two other areas for examples of letters used.
	Management of appeals, complaints and disputes
KR34	NHS Berkshire should ensure all those with the potential to request a review of the decision of eligibility for NHS Continuing Healthcare are made aware of how this can happen and the related timescale.

	That all applicants must know about their right to appeal.
KR35	Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable.
KR36	All decision makers on panels should contribute fully to the decision making processes at Panels with any differences in opinion noted.
KR37	Letters following the Appeal Panel should be clear and give good explanations for decision made. They should also be clear about the next steps in line with the local resolution process and right to request an independent review of the decision once all local resolution processes have been exhausted.
KR38	All organisations should ensure they agree and have in place an up to date local dispute policy agreed between NHS Berkshire and the six local authorities.
KR39	Information should be clear regarding what can be appealed and what should be dealt with through local complaint processes.
	Training
KR40	NHS Berkshire and the six local authorities should invest in a suitable training strategy/programme which covers the training needs of each level of staff i.e. whether they complete the checklist, undertake fast track assessments, represent the local authority or are a continuing healthcare assessor or manager.
KR41	Training should be joint and meet the needs of both the NHS and the six local authorities. Urgent training is required at all levels, and should follow shortly after the agreement of the operational policy. It is suggested that external facilitation and training is procured in the first instance.
KR42	The training strategy and policy should be explicit within the operational policy or at least referred to within that document.
	Quality assurance/standards
KR43	Executive Directors should be appropriately briefed and engaged across the field of NHS Continuing Healthcare and should provide strategic direction where required.
KR 44	Appropriate Directors within the local authorities should also be properly briefed regarding NHS Continuing Healthcare and its associated risks.
KR 45	NHS Continuing Healthcare performance should be presented as a separate item at Board meetings at least annually and also to the local health scrutiny committees. Ideally this should be the same joint report across the area.
	Joint working
KR46	All organisations should be mindful of their responsibilities in relation to NHS Continuing Healthcare as set out in the introduction to this document – 1.6, 1.7 and 1.8.
KR47	All organisations should prioritise the building and maintenance of constructive strategic and operational working relationships across Berkshire, particularly between the NHS and the six local authorities. This should be led by appropriate senior individuals. Regular joint

	meetings should take place on at least a monthly basis in the first instance at both strategic and operational levels.
KR48	Assessment and review is the joint responsibility of health and social care and organisations should work collaboratively to ensure this is achieved.
KR49	Brokerage and/or advocacy services should be considered, and where possible currently available services used to support patients in their NHS Continuing Healthcare applications.
KR50	NHS Berkshire should ensure that partner organisations and in particular the mental health trust recognise the importance of NHS Continuing Healthcare assessments and make staff available as required by the National Framework.
	Networking/Best Practice
KR51	NHS Berkshire should look outwardly as well as locally to glean ideas and develop practice.
KR52	NHS Berkshire and the six local authorities should consider setting up a local operational group that meets regularly to discuss issues relating to NHS Continuing Healthcare processes and procedures.
	Information and activity
KR53	NHS Berkshire should scrutinise performance on the national benchmarking measures and to share this information with their Board and local authorities. This should include both activity and finance and further understanding of why NHS Berkshire is the lowest in the country in terms of numbers of people receiving NHS Continuing Healthcare yet costs are high in comparison to numbers.
KR54	NHS Berkshire should continually assure themselves of the quality of their data relating to NHS Continuing Healthcare performance.
KR55	NHS Berkshire should undertake comprehensive forecasting taking account of all relevant factors including a provision for retrospective cases and the transition of children into adult services. This will enable realistic budgets to be set for NHS Continuing Healthcare.
	Transition
KR56	A Transitions agreement should be part of or referred to in the overall NHS Continuing Healthcare Operational Policy.
KR57	NHS Berkshire must ensure the identification of children for whom adult NHS Continuing Healthcare may be required at age 14 and planning organised accordingly. This includes customer centred planning as well as ascertaining resource implications.

Appendix 5

Outline Local Resolution Process for Appeals from Individuals Regarding Eligibility for Continuing Healthcare

NHS South West

SOUTH WEST STRATEGIC HEALTH AUTHORITY

Outline Local Resolution Process for Appeals from Individuals Regarding Eligibility for Continuing Healthcare

Updated May 2012 to reflect the new timescales introduced by the Department of Health applicable from 1 April 2012

1.0 Background

1.1 NHS Continuing Healthcare is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing healthcare needs that satisfy the criteria for the funding. You can receive Continuing Healthcare in any setting, including your own home or a care home. NHS Continuing Healthcare is free, unlike help from Social Services, for which a financial charge may be made depending on your income and savings.

1.2 When it is identified that an individual may have ongoing healthcare needs, he or she should be assessed by appropriate professionals to consider eligibility for Continuing Healthcare using the tools provided within the National Framework for Continuing Healthcare and NHS Funded Nursing Care issued by the Department of Health.

1.3 The National Framework sets out in detail the process for considering a person for Continuing Healthcare funding, including the principles and legal framework about eligibility.

1.4 In summary, to qualify for Continuing Healthcare an individual must have a Primary Health Need. Professionals will use the available evidence and assessment material to look at the totality of the individual's needs to agree whether or not the individual has a primary health need. There are three different tools available within the National Framework to aid decision making.

I. The Fast Track Pathway Tool - is used to gain immediate access to NHS Continuing Healthcare funding where an individual needs an urgent package of care.

II. The Checklist tool – is a screening tool used to help practitioners identify individuals who may need a referral for a full consideration of eligibility for NHS Continuing Healthcare funding.

III. The Decision Support Tool (DST) – is used when the checklist indicates that the person may be eligible for Continuing Healthcare, or if the professionals decide this without using the Checklist. A multi-disciplinary assessment should be used by the multi-disciplinary team (MDT) to complete a DST. The multi-disciplinary team should use the DST to decide whether or not to recommend the person has a primary health need and is therefore entitled to full NHS Continuing Healthcare funding.

The recommendation is then passed to the Primary Care Trust (PCT) for approval.

1.5 When an individual or (if appropriate) their representative does not agree with the decision about eligibility for Continuing Healthcare funding, the PCT should try to resolve the matter. This document sets out below the process to be followed if this happens. The timescales set out in this document are a guide of what to expect (but there may be exceptions depending on the circumstances of each case).

1.6 The process will not be the same when an individual or their representative asks for a retrospective review.

2.0 What happens if a person does not agree with the outcome of the Checklist?

2.1 When a Checklist is completed, a copy of it should be given to the individual or (where appropriate) their representative in a timely manner. The Checklist should include enough information to understand how the decision was made. If the Checklist indicates that a full consideration for Continuing Healthcare is not required, then the individual does have the right to request a review of the decision if they disagree with it. Details of who to contact at the PCT should be included with the Checklist.

2.2 The PCT should give such requests due consideration, taking account of all the information available, including additional information from the individual or his or her carer or representative. The PCT may decide to arrange for a full multi-disciplinary assessment and DST to be completed if there is evidence to suggest it should. If not, then a clear and written response should be given to the individual or their representative, as soon as possible *(within 28 days)*. The response should also give details of the individual's rights under the NHS complaints procedure. There is no right to request an independent review of a negative checklist decision by a Primary Care Trust.

3.0 Local Review Process – what happens when an individual or their representative does not agree with the decision on the DST?

3.1 All individuals who have been considered for Continuing Healthcare using the DST should be sent a decision letter by the PCT explaining the decision. The letter should be sent *within 28 days of the decision being reached* and should include the contact details of the named officer at the PCT to call if they disagree with the decision or would like more information. The individual has a time limit of no later than **six months** from the date that the notification of the eligibility decision is given to request a review of that decision (i.e. to appeal to the PCT).

3.2 If the individual (or representative) contacts the PCT about the decision, and the matter cannot be resolved during the phone call, then the PCT should provide details of the named coordinator who will be the point of contact for the duration of the local review process.

3.3 Some individuals may need support to understand or challenge a decision made about their continuing healthcare needs. The PCT should ensure that they are made aware of local advocacy and other services that may be able to offer advice and support. Individuals should also be advised of local Independent Complaints Advocacy Service (ICAS) arrangements.

3.4 From this point forward in this document 'the individual or (if appropriate) their representative' will be referred to as 'the applicant'.

3.5 The named coordinator at the PCT should offer to meet with the applicant or arrange a telephone call, whichever the applicant prefers. The date and time of the meeting or booked call should be confirmed in writing with a copy of the PCT's published Local Resolution Process. *The meeting or booked call should take place within 28 days of receiving the call*.

3.6 If the applicant is not satisfied by the end of the discussion in the meeting or by the end of the booked call, the PCT will need to gather and scrutinise additional evidence appropriate to the case to take account of any specific concerns raised by the applicant. The new evidence and DST should be considered by a PCT Panel. In this document, we will refer to this Panel as a Local Review Panel (LRP). The Local Review Panel membership should be different to the original decision makers where practicable, however it is accepted this is not always possible. The applicant should always be invited to attend the Local Review Panel.

3.7 PCTs may wish to appoint an Independent Chair to the LRP, although this is not a requirement or - to add an additional level of independence - may ask another South West PCT to look at the decision. This should not be allowed to cause undue delay. If the PCT does choose to send the case to another PCT for an independent decision, the originating PCT must be prepared to accept the decision made by the independent PCT. The applicant should be invited to attend the Panel whatever approach is taken, with adequate notice being given to the applicant and enough time allocated at the LRP for the applicant's full involvement with the discussion.

3.8 The decision of the Local Review Panel should be given to the applicant without delay. Applicants will usually be asked to leave prior to the Panel's deliberations and therefore would not find out the decision of the Panel on the same day. However the PCT should notify the applicant of the decision in writing, which includes a detailed rationale for how the decision was made. *The letter should be sent within 28 days of the date of the Panel.* The letter from the PCT should give details of how to request a review by NHS South West's Independent Review Panel if they remain dissatisfied.

3.9 Unless there are exceptional circumstances the PCT should complete the review/appeal process within three months of the receipt of the request.

PCTs are asked to be mindful of Annex A. This sets out the essential parts of the process to complete at a local level before a case is referred to NHS South West.

4.0 Independent Review Panel

4.1 NHS South West is the Strategic Health Authority for the South West and is responsible for appointing Independent Chairs and Panel members to consider requests by individuals for an Independent Review.

4.2 Applicants should contact NHS South West to request the Independent Review *within* ***six months*** *of the date of the PCT's decision letter* unless there are exceptional circumstances. NHS South West should acknowledge this request *within one week of receipt of the letter.*

4.4 Included with the acknowledgment letter from NHS South West will be a Public Information Leaflet [1] explaining the role of the Panel and how the process works and a questionnaire (unless one has already been completed) which asks for some additional information about why the applicant is requesting an independent review of the Primary Care Trust decision.

4.5 If the applicant's request for a review is appropriate and accepted by NHS South West, papers will be requested from the PCT, with a view to the Review Meeting taking place *within three months of the date of receipt of the request for the independent review.* In order to achieve the three month deadline, it is important that PCTs have already gathered and scrutinised all appropriate additional evidence at their local review panel.

4.6 If, for whatever reason, it proves impossible to arrange the Review Meeting within three months of the PCT's Local Review Panel, NHS South West may need to ask the PCT to refresh the assessment of the individual, and re-visit the decision about eligibility for Continuing Healthcare funding.

4.7 The Independent Chair allocated by NHS South West for the Review Meeting will "preview" the file, to ensure that the case is ready for the Review Meeting. In the event of there being flaws in the local process which would or could affect the fair and comprehensive consideration of the individual's needs, the case may be sent back to the PCT or questions may be put to the PCT.

4.8 It should be noted that the Independent Review Panel has a limited remit and is not able to consider any legal challenges to either the eligibility criteria or the responsibilities of the NHS. There is no role for legal professionals at the independent review panel and therefore any costs incurred by individuals will not be reimbursed by the NHS. Legal professionals can attend Panels in an advocacy role.

4.9 The remit of the Independent Review Panel is to:-

- Consider the process followed by the PCT in coming to a decision about eligibility for NHS Continuing Healthcare and to:
- Look at whether the PCT properly applied the eligibility criteria for NHS Continuing Healthcare.

[1] NHS Strategic Health Authorities Independent Review Panels – Public Information

Annex A

Tasks to be completed by the PCT prior to referring a case to NHS South West for Independent Review

All reasonable attempts should be made to resolve a dispute at local level by the PCT. PCTs in the South West are asked to observe the process above and whilst it is accepted that each PCT may have a slightly different method of local resolution, the basic principles within the National Framework must be included.

In order not to waste time, or misdirect individuals, PCTs should check the list of tasks below. If any of the tasks have not been completed then the PCT should do more to strengthen the local process before they advise the applicant to request an Independent Review.

1. Has there been a comprehensive multi-disciplinary assessment of the individual's heath and social care needs?
2. Was the DST completed by an appropriately constituted MDT and does it include a proper recommendation?
3. Was the recommendation of the MDT accepted by the PCT?
4. Was the individual or their representative given the opportunity to be involved at all stages of the process
5. Has adequate local resolution taken place which includes:
    a. Offer of a face to face meeting with the individual or their representative (the applicant) or telephone call if preferred
    b. Consideration of the concerns raised by the applicant
    c. Gathering and scrutiny of any additional evidence relevant to the case
    d. Referral to a Local Review Panel at which the applicant should be invited to attend
    e. A comprehensive letter sent to the applicant which explained in detail the reasons for the Local Review Panel's decision

Eileen Roberts
NHS Continuing Healthcare Manager
NHS South of England
22 May 2012

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NHS BERKSHIRE

CONTINUING HEALTHCARE

ACTION PLAN

Executive summary – Urgent Recommendations

1) The Strategic Health Authority requires assurance that the Primary Care Trust is operating within the legal framework and guidance around the Fast Track Pathway Tool

No.	Recommendation	Action	Responsible Lead	Completion Date
KR6	All organisations in Berkshire should ensure they have clear arrangements for the timely review of Fast Track applications. This should ensure that the relevant staff are clear on how to complete the fast track tool in line with the National Framework.	• PCT to review correct CHC Nursing structure to include a fast-track team. • Undertake additional training and awareness sessions for provider staff who work in relevant fields. e.g. Specialist Palliative care nurses, District/Community Nursing, Consultants in Care of the Elderly, Oncology, Palliative Care etc and General Practitioners. • Priority for training will be given to clinical staff working in specialist fields which have high referral rates to fast-track. • Local Authority specialist CHC practitioners to be included in this training for the purpose of consistency.	M. Andrews-Evans / E. Rushton	
KR7	NHS Continuing Healthcare funding must be available to patients once a positive Fast Track Tool has been completed by a registered clinician. This funding should be available until a person is assessed as no longer eligible.	• PCT to check that funding is available to fast-track patients. • UAs each to provide a senior named contact in relation to fast-track • Fast Track assessments initiated and completed by registered clinician will be responded to immediately by CHC staff.	E. Rushton	

		• PCT and UAs to undertake a joint audit of cases where the fast-track assessment was rejected to assess the outcome for the patients as a shared learning activity. • The U.A.'s to review their practise in respect of fast tracking based on the feedback in the Review Report.	Retrospective review to September 11 2012	

2) Improvements in Joint working between the NHS and the six local authorities at all levels

KR48	All organisations should prioritise the building and maintenance of constructive strategic and operational working relationships across Berkshire, particularly between the NHS and the six local authorities. This should be led by appropriate senior individuals. Regular joint meetings should take place on at least a monthly basis in the first instance at both strategic and operational levels.	• Regular monthly meetings will be arranged between assistant Directors to exchange ideas and discuss issues relevant to all. This will follow on from the joint development of the operations policy and will review and oversee its implementation. • Meetings to be co-ordinated by PCT / CCGs. • Organisations to agree the definition of reablement in relation to daily living activities and rehabilitation potential where health needs can be proactively lessened before long term care commences. This will be included in the operational policy	ALL UAs and PCT / CCGs M.Andrews-Evans / CCG leads E. Rushton / J.Evans	

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3) **The approval of an Operational Policy which makes all procedures clear will smooth the whole process and procedure and allow for better working relationships**

KR27	A clear concise operational policy, taking account of the NHS Continuing Healthcare (Responsibilities) Directions 2009 and the principles laid out in the NHS Continuing Healthcare framework, which is drafted in consultation with relevant partner agencies, and in particular the local authorities is required as a matter of urgency for ratification by the Primary Care Trust Board (suggested timescale within four weeks – to be agreed in action plan). This must include terms of reference for relevant Panels.	• Three identified Assistant Directors (1 East UA, 1 West UA & PCT) will be facilitated to develop a joint operational policy. Samples will be provided by review team as a template for the group to follow. • The PCT & 6 UAs will jointly agree and implement the operational policy. • PCT and 6 UAs will consult with legal services to ensure compliant with legislation.	M. Goldie / M. Andrews-Evans Jill Smith ALL UAs and PCT /CCGs ALL UAs and PCT /CCGs	1st October 2012 30th November 2012 30th November 2012

4) **Further work is required on the draft dispute resolution policy between the NHS and Local Authorities to put into place a signed and agreed policy as required in the NHS Continuing Healthcare Responsibilities/Directions**

KR28	A local dispute resolution policy must be agreed with the six local authorities urgently (suggested timescale within two months – to be agreed in action plan).	• Disputes policy will be considered by the Assistant Director's group. • Joint policies working well in other areas will be used to inform policy development. • Final Document to be ratified by	M.Goldie / M. Andrews-Evans All UAs & PCT / CCGs	1st November 2012 14th December

		PCT and 6 UAs and implemented.		2012

5) **Further work is required to resolve the current polarised view on the use of the NHS CHC Checklist Tool and information requirements to accompany the tool, in order to avoid delayed discharges from the acute setting and ensure a patient centred approach**

KR10	All organisations need to reach an agreed understanding and appropriate use of the checklist tool when individuals are in hospital. They should pay particular attention to this with particular reference to Section 6 of the Practice Guidance and appropriate arrangements when individuals are in hospital
	
	Clarity is also required regarding information required with checklist is required, keeping this as simple as possible.
		• A facilitated meeting with PCT / WBC to consider disputed cases.
		
		• Learning from this exercise use experience to inform future practice; e.g.
		  • Quality and quantity of information required to ensure checklist is not rejected.
		  • All organisations to make appropriate use of CHC checklist tool whether in hospital, care home or own home
		
		• Facilitated meeting with PCT/WBC and RBH to jointly consider the appropriate use of the checklist.
			E. Rushton / J.Evans
			
			ALL ADs in UAs & PCT
			
			AD PCT / AD WBC / Discharge Nurses RBH
				17th August 2012
				
				On-going
				
				23rd August 2012

		• To prepare a set of guidelines for nurses on how to complete the checklist. To be agreed by UAs / PCTs and NHS Providers • U.A.'s to review their practise in respect of check listing based on the feedback in the Review Report and Reviewers. • Guidelines to be incorporated in operational policy. • Agreement re: interim funding of care to be achieved to release acute bed whilst CHC / long-term care assessment processes are completed.	AD PCT & AD WBC UAs AD PCT & AD WBC PCT/ UA ADs	1st October 2012 1st October 2012 1st October 2012 On-going

Summary of Remaining Actions

Activity and Cost

No.	Recommendation	Action	Responsible Lead	Completed By
KR1	Primary Care Trusts and Local Authorities review all possible opportunities to improve activity and outcomes for patients and improve compliance with the National Framework;	To develop, agree and implement a robust: • Operational Policy • Disputes Policy • Review the feasibility of interim NHS funded beds for CHC patients after 4 weeks in a hospital	M. Goldie / M. Andrews-Evans PCT / CCGs	1st October 1st November November 2012
KR2	NHS Berkshire is encouraged to maintain the quality of data returns under the benchmarking project;	To appoint an analyst to establish and maintain a database for the 7 CCGs and prepare monthly reports to CCG AOs.	E. Rushton	1st December
KR3	NHS Berkshire and the six Local Authorities jointly and regularly meet to use the benchmarking data to monitor their performance both regionally and nationally;	From 1st October CCGs will establish a system for meeting with UAs to consider CHC / FACS information together To provide CCG lead contact details to Directors of Social Services.	CCG AOs – Cathy Winfield & Alan Webb / UA DSSs Marion Andrews-Evans	1st October 2012 September 2012
KR4	The NHS Berkshire Board and the Local Authorities review the benchmarking data and consider the factors influencing the local performance on NHS Continuing Healthcare.	Joint meeting with CCGs / UAs to consider benchmarking and develop joint strategic intentions to improve provision and access to long-term care.	CCG AOs - Cathy Winfield & Alan Webb UA DSSs	1st December 2012
KR5	NHS South Central scrutinises the benchmarking data at a regional level and undertakes further analysis in relation to the issues listed above in support of all its Primary Care Trust areas, and	Action by SHA and subsequently the LAT		

	ensures that best practice is shared.			

Compliance with the National Framework

KR8	All organisations should consider how to engage clients and their representatives appropriately at all stages in the process including information on how to appeal and to agree a local resolution process which could form part of the operational policy.	To undertake a review of patient /carer engagement processes and information provided. To include in operational policy.	E. Rushton & PCT Communications team E.Rushton	1st October
KR9	All organisations should ensure consent for assessment is explicitly obtained at the appropriate stages and is clearly recorded.	• All referrals made to CHC will be checked to ensure a consent form is attached to the documentation and feedback provided to the provider and UA. • UA Social Workers to get signed consent forms prior to undertaking the checklist assessments. • UA Social Workers to complete MCA decision specific to consent to CHC application should applicant's lack of capacity be an issue on this point.	E. Rushton UA Directors of Social Services UA Directors of Social Services	1st September 2012 On-going On-going
KR11	The process for completion of the multi-disciplinary assessment and Decision Support Tool must be consistent, transparent and clear. It should include the views of both NHS and local authority organisations and any dissent should be recorded.	• An Independent audit of documentation will take place to assess the robustness of documentation and actions will be agreed if necessary. Methodology and scope for audit to be agreed.	E. Rushton / UAs	1st December 2012

		• The guidance that moves a criteria to a higher scoring on the DST where there are dissensions between agencies and supported by the necessary documentary evidence will be included in the operational policy • PCT to clarify role of CHC Nurse Assessor as distinct from CHC Co-ordinator at MDTs .	E. Rushton	October 2012
KR12	When a multi-disciplinary team recommendation is not accepted by the Panel a full rationale and explanation must be given (or the case referred back to the MDT for further work/additional evidence)	• CCGs / PCT will review how the panels operate and consider whether the use of an independent chair is appropriate. • Panel meetings and decisions made will have minutes which are distributed to panel members as a record. • Terms of Reference of Panel to be agreed to be included in operational policy. • PCT will write to all applicants with outcome and reasons for rejection within 2 weeks of that Panel.	E. Rushton E.Rushton	1st December 2012 1st December 2012
KR13	Decisions regarding a person's eligibility for NHS Continuing Healthcare must be clearly distinct from decisions regarding the approval and funding of care packages and/or Funded Nursing Care.	CHC Checklists will always be completed prior to the Nurse assessment for FNC. CHC Nurses will be reminded of this requirement.	E. Rushton	1st September 2012
KR14	Eligibility decisions should be based on the four key indicators of primary health need which should be	An audit of documentation will be undertaken to ensure compliance with the	E. Rushton	1st December 2012

	supported by the Decision Support Tool. A clear rationale should be given on all the relevant documentation.	four key indicators and rational is provided in the documentation.		
KR15	The right to Appeal and how to do so must be transparent to applicants during each part of the process.	Letters to patients / carers will be reviewed to ensure appeals process is transparent.	E. Rushton	1st October 2012
KR16	It is recommended that Appeals are held as a separate process to regular decision making Panels	• As an interim arrangement the appeals panel for East and West will manage appeals for each other to ensure independence. There will be a different chair for the two panels • A review will be undertaken with the CCGs to determine future appeal arrangements.	E. Rushton CCG AOs – Cathy Winfield & Alan Webb	August 2012 January 2013
KR17	The Primary Care Trust should set up a resolution process prior to an applicant progressing to Independent Review.	A resolution process will be included within the operational policy, including instructions on how they will be organised.	ADs Group	1st October 2012

Timescales

KR18	The Primary Care Trust must ensure that there are arrangements in place for achieving timely eligibility decisions alongside the six local authorities. This includes ensuring that fast track referrals are dealt with in a timely way.	• Due to high volume of referrals additional nursing staff will be recruited to ensure the 28 day timescale is achieved. • Timescale for fast-track referrals will be monitored to ensure compliance and information provided monthly to CCGs / UAs.	E. Rushton / PCT AD HR E. Rushton	1st September and on-going 1st October and on-going
KR19	New regulations must be communicated to the public and to staff in a systematic and timely way. The Primary Care Trust must ensure that there is a	• Adverts will be placed in 4 local newspapers	E. Rushton / PCT Comms.	End August 2012

	process in place to achieve this, and that capacity of teams to meet this need is addressed. Numbers of retrospective cases received will be collected in the national benchmarking figures	• PCT will communicate with nursing Homes and GP surgeries information regarding the cut-off date for retrospective claims. • A log of all retrospective cases will be maintained.	E. Rushton / PCT Comms E. Rushton	Beginning September 2012 August 2012

Retrospective Cases

KR20	The backlog of retrospective cases needs to be given clear priority and resources allocated appropriately.	• The PCT will recruit additional staff to manage workload. Appointment of temporary nurses and admin staff will be considered in the short-term • Councils will notify the PCT before 30th September of any self-funding deceased individuals they are aware of who they consider may have been entitled to CHC retrospective funding.	E. Rushton / PCT HR	September 2012 On-going
KR21	It is recommended that the Primary Care Trust assesses the potential for both activity and finance in this area and plans accordingly over the next twelve months.	Financial risk assessment will be made by PCT to establish the potential liabilities for the PCT and CCGs. This information will be presented to the PCT Board and CCG Governing Bodies.	E. Rushton / J. Meek (PCT DoF)	27th November 2012
KR22	The recent announcement with regard to retrospective cases needs to be communicated effectively to both the public and to staff in all	A communication plan to be prepared and implemented.	E. Rushton / PCT Comms	August 2012

	agencies. A national communication toolkit was made available to all Primary Care Trusts together with a comprehensive nationally agreed retrospective review policy for Primary Care Trusts to follow or adapt locally.			

Capacity

KR23	NHS Continuing Healthcare is a significant risk area for NHS Berkshire. Senior managers need to be assured of the processes and procedures within their organisation. This includes assessing that sufficient capacity at the right level is available to undertake the work required as well as maximising and sharing resources across East and West Berkshire.	A review of staffing requirements will be undertaken and additional staff (nursing and Admin) will be recruited and identified.	E. Rushton / M. Andrews-Evans	September 2012
KR24	Any new structure in relation to NHS Continuing Healthcare should be based on needs not on the present numbers and grades of staff available. The structure must be fit for the future with particular reference to Clinical Commissioning Groups.	Discuss with the CCG federations (east & west) to ensure the staffing structure meets their requirements and enables joint working with UAs.	M. Andrews-Evans / CCG AOs	September 2012
KR25	Evidence suggests that resources in Berkshire are low for both NHC Continuing Healthcare work and Funded Nursing Care. It is suggested that further benchmarking takes place to ensure that assessment teams are adequately resourced to achieve the necessary assessment and review requirements.	As part of the staffing review benchmarking will be undertaken to inform the new staffing structure is fit for purpose.	E. Rushton	September 2012

KR26	Local Authorities must ensure that they have sufficient staff to be part of multi-disciplinary teams and be available to attend members of Primary Care Trust Panels/joint decision making processes and Appeal Panels. This should be within a co-ordinated approach across all of the Local Authorities.	6X UA Assistant Directors to agree how to resource MDTs and attend panels The feasibility of developing local communication systems between relevant UA and CHC staff will be explored.	J. Evans J.Evans/ E.Rushton	September 2012

Operational Policy

KR29	The Primary Care Trust must make the operational policy available on their website.	Once completed the operational policy will be available on the PCT and 7 CCG's websites and LAs website.	PCT Comms Lead LAs	November 2012

Patient Centred

KR30	Local and regularly updated information should be available on the website and also in paper format if required.	Information will be provided in various formats to the public that reflects people's entitlements and processes to be jointly agreed. The PCT staff in communications dept. will ensure the website is kept up to date and is user friendly. This will transfer to the CCGs later in the year ready for 1st April 2013	PCT Comms Lead	On-going
KR31	Applicants should systematically be involved in all assessments including Decision Support Tools, and should be invited to Appeal Panels as applicable.	An audit of documentation will be undertaken to ensure that this requirement is complied with.	E. Rushton	December 2012
KR32	Opportunity for local resolution meetings should be offered to patients and families as a way of explaining the processes and reasons for the decisions made.	This will form part of the operational policy. Resolution meetings will be offered to all patient / carers, which they will be supported to participate in.	E. Rushton	October 2012

KR33	All letters should be revised to ensure that they convey appropriate information, are user friendly in plain English and include the reasons for decisions as well as identifying the next steps for appeal or complaint. It is suggested that NHS Berkshire contacts other areas for examples of letters used.	A review of CHC letters will be undertaken. Sample letters will be obtained from other PCTs to inform the review. Revised standard letters will be prepared and available for use by the PCT and CCGs in the future.	E. Rushton	September 2012

Management of Appeals, Complaints and Disputes

KR35	Local Appeal/Review Panel membership should be different to the original decision makers wherever practicable.	• East and West panels will hear each other's appeals to ensure independence in the process. • This will be reviewed following establishment of the CCGs.	E. Rushton CCG AOs	August 2012 Spring 2013
KR36	All decision makers on panels should contribute fully to the decision making processes at Panels with any differences in opinion noted.	• Training will be provided to panel members to ensure they are cognisant of the process and support their input. • An independent chair will be used for specific cases as necessary. • See KR12	E. Rushton & Independent Trainer E. Rushton	September & on-going September & on-going
KR38	All organisations should ensure they agree and have in place an up to date local dispute policy agreed between NHS Berkshire and the six local authorities.	Disputes policy to be prepared by ADs group for agreement by the PCT (CCGs) and 6 UAs.	PCT & UA ADs	November 2012
KR39	Information should be clear regarding what can be appealed and what should be dealt with through local complaint processes.	Information leaflet / website information will be provided and checked for usability.	PCT Comms team	October 2012

Training

KR40	NHS Berkshire and the six local authorities should invest in a suitable training strategy/programme which covers the training needs of each level of staff	Following the development of the operational policy, training will be provided by an independent trainer to a joint team	PCT & UA ADs	November – December 2012

	i.e. whether they complete the checklist, undertake fast track assessments, represent the local authority or are a continuing healthcare assessor or manager.	from health and UAs. This will ensure common understanding of the policy, the process of assessment and decision-making and the use of the tools for assessment and documentation.		
KR41	Training should be joint and meet the needs of both the NHS and the six local authorities. Urgent training is required at all levels, and should follow shortly after the agreement of the operational policy. It is suggested that external facilitation and training is procured in the first instance.	See Above Need to ensure that newly recruited CHC nurses to be trained before they take up their role.	As Above	As Above
KR42	The training strategy and policy should be explicit within the operational policy or at least referred to within that document.	A joint training strategy will be developed led by the PCT training and development manager. This will ensure on-going training for operational staff.	PCT Training & Development manager	November 2012

Quality Assurance/Standards

KR43	Executive Directors should be appropriately briefed and engaged across the field of NHS Continuing Healthcare and should provide strategic direction where required.	A quarterly briefing will be provided to the Governing Body, containing both activity and financial information. Health Scrutiny and CCG Governing bodies to be provided with briefing on regular basis re: activity and financial information.	CCG AO CCG AO – Cathy Winfield & Alan Webb /LAs	January 2013 & on-going On-going
KR46	NHS Berkshire together with its Local Authority colleagues should jointly audit practice on a yearly basis. They are advised to contact other areas who may be able to share audit tools.	UAs and CCGs will agree a system of annual audit of CHC / long-term care to inform H&WB strategy and commissioning processes.	UAs	

Joint Working

KR49	Assessment and review is the joint responsibility of health and social care and organisations should work collaboratively to ensure this is achieved.	• As described in the CHC framework a review protocol will be agreed within the operational policy which will address the issue of a "well managed need". • The production of the operational policy will support joint working. • The appointment of joint posts will be explored and staff exchanges promoted	PCT/LAs PCT / CCGs / UAs	1st December 2012 On-going
KR50	Brokerage and/or advocacy services should be considered, and where possible currently available services used to support patients in their NHS Continuing Healthcare applications.	The PCT / CCGs will explore with the UAs a shared advocacy service. Looking at what services are currently available in the UAs and BHFT.	PCT / CCG / UAs / BHFT	Autumn 2012
KR51	NHS Berkshire should ensure that partner organisations and in particular the mental health trust recognise the importance of NHS Continuing Healthcare assessments and make staff available as required by the National Framework.	The PCT will raise this matter as part of the contract monitoring process with BHFT to ensure accessible, timely access to specialist advice when necessary.	PCT Mental Health Contract lead	September 2012

Networking/Best Practice

KR52	NHS Berkshire should look outwardly as well as locally to glean ideas and develop practice.	PCT and CCGs will attend and participate in the joint strategy group and leads meetings. Contact will be made with other CHCV departments to provide an exchange of ideas and benchmarking information.	PCT / CCG	On-going
KR53	NHS Berkshire and the six local authorities should consider setting up a local operational group that meets regularly to discuss issues relating to NHS Continuing Healthcare processes and procedures.	Local operational group to be established with the 3 ADs, which can be augmented with additional NHS / UA members as necessary.	PCT / UAs	September 2012

Information and Activity

KR54	NHS Berkshire should scrutinise performance on the national benchmarking measures and to share this information with their Board and local authorities. This should include both activity and finance and further understanding of why NHS Berkshire is the lowest in the country in terms of numbers of people receiving NHS Continuing Healthcare yet costs are high in comparison to numbers.	See KR2, KR3 & KR4		
KR55	NHS Berkshire should continually assure themselves of the quality of their data relating to NHS Continuing Healthcare performance.	CCGs / CSU will ensure systems are in place to periodically check the maintenance of data quality.	CCG AOs	January 2012 & On-going
KR56	CCGs and UAs should undertake comprehensive forecasting taking account of all relevant factors including a provision for retrospective cases and the transition of children into adult services. This will enable realistic budgets to be set for NHS Continuing Healthcare.	CCGs with the UAs through the use of the H&WB strategy, with the support of public health, will undertake an annual joint needs assessment of CHC and long-term care to influence the service planning, budget setting and delivery of community services.	CCGs / UAs	

Transition

KR57	A Transitions agreement should be part of or referred to in the overall NHS Continuing Healthcare Operational Policy.	Transition arrangements will form part of the operational policy.	ADs development group	October 2012
KR58	NHS Berkshire must ensure the identification of children for whom adult NHS Continuing Healthcare may be required at age 14 and planning organised accordingly. This includes customer centred planning as well as ascertaining resource implications.	A joint database will be established for children to ensure appropriate planning for future care requirements & timely assessments.	CCGs / UAs	March 2013

Agenda Item 7

Title of Report:	Health Scrutiny Panel Work Programme
Report to be considered by:	Health Scrutiny Panel
Date of Meeting:	4 December 2012

Purpose of Report: **To consider the completed work and the outstanding items on the work programme.**

Recommended Action: **To identify any work remains to be carried forward.**

Resource Management Working Group Chairman	
Name & Telephone No.:	Councillor Quentin Webb – Tel (01635)
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1. Introduction

1.1 Members are requested to consider the latest work programme attached at Appendix A. In addition, Members are asked to give consideration to future areas for scrutiny.

Appendices

Appendix A – Health Scrutiny Panel Work Programme

Consultees

Local Stakeholders:

Officers Consulted: Director for Community Services, Head of Adult Social Care, Head of Social Care Commissioning and Housing.

Trade Union: N/A

OVERVIEW & SCRUTINY MANAGEMENT COMMISSION WORK PROGRAMME 2012/13

Reference	Subject/purpose	Methodology	Expected outcome	Review Body	Dates	Lead Officer(s)/ Service Area	Portfolio Holder(s)	Status: In Progress Completed	Comments
OSMC/11/105	**Dignity and Nutrition – CQC Standards** To review the standards of dignity and nutrition in local hospitals - survey evidence to be provided by West Berkshire LINk (HealthWatch).	To survey and hold focus groups detailing information		HSP	Start: July 2011 End: March 2013	LINk, Age UK	Cllr Graham Jones	In Progress	Additional survey of the Royal Berkshire Hospital outpatients being undertaken in October 2012. Update from LINks required at March 2013 meeting.
OSMC/11/107	**Update on the Health Service in West Berkshire**	To update members on the changes to Health Service in West Berkshire	Monitoring item	HSP	Ongoing	Julie Curtis - Interim Director Joint Commissioning	Cllr Graham Jones	In Progress	Julie Curtis to be contacted about attendance at the next meeting.
OSMC/11/119	**Continuing Healthcare (CHC)** To examine the operation of the NHS CHC scheme in the NHS Berkshire West area	In meeting review		HSP	Start: Jan 2012 End: Dec 2012	Jan Evans – 2736 Adult Social Care	Cllr Graham Jones	In Progress	The findings of the Independent Review of CHC to be received at the December meeting.
OSMC/12/122	**Home Care** To understand and critically appraise the processes in place for the provision of Home Care.	TBD		HSP	Start: TBD End: TBD	Jan Evans–2736 Adult Social Care	Councillor Joe Mooney	To be scheduled	The remit of review work to be explored with June Graves/Jan Evans in October 2012.
OSMC/12/133	**PCT Quality Handover** To examine the PCT's arrangements for the handover of its quality responsibilities to Clinical Commissioning Groups	In meeting review.	Members satisfied with arrangements	HSP	Start: March 2013 End: March 2013	Sam Otoropec, PCT	Cllr Graham Jones		Presentation to be made at March 2013 meeting.

Key:

OSMC	Overview and Scrutiny Management Commission
RMWG	Resource Management Working Group
HSP	Health Scrutiny Panel

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