HEALTH SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON

TUESDAY, 17TH JANUARY 2012

Councillors Present: Councillors Howard Bairstow, Dominic Boeck, Sheila Ellison, Tony Linden, Gwen Mason (Vice-Chairman), Quentin Webb (Chairman) and George Chandler.

Also Present: Councillor Joe Mooney, Mr Charles Waddicor (NHS Berkshire), Ms Helen Mackenzie (NHS Berkshire), Margaret Goldie (Corporate Director), Janet Golder (Continuing Healthcare Specialist Worker), Dr Abid Irfan (Newbury & District Clinical Commissioning Group), Samantha Ward (South Central Strategic Health Authority), Junes Graves (Head of Social Care Commissioning & Housing), Leigh Hogan (Team Leader, Legal Services), Alison Coles, (Solicitor), Keith Ulyatt (Public Relations Manager) and Jo Naylor (Principal Policy Officer).

18. Apologies

Apologies were received from Councillors Jackson Doerge and Macro. Councillor Chandler substituted for Councillor Jackson-Doerge.

19. Minutes of the previous meeting.

The minutes of the meeting held on the 4th October, 2011 were agreed as a true and correct record and signed by the Chairman.

20. Declarations of Interest

Councillor Mason declared a personal interest in Agenda Item 4. She reported that as her interest was personal and non-prejudicial she determined to remain to take part in the debate and vote on the matter.

21. Scrutiny Review of NHS Continuing Healthcare

(Councillor Mason declared a personal interest in Agenda Item 4 by virtue of the fact that she was an Associate Member of the West Berkshire Disability Alliance and Independent Living Network. As her interest was personal and not prejudicial she was permitted to take part in the debate and vote on the matter).

The Chairman then invited Mr Charles Waddicor (Chief Executive of NHS Berkshire) to describe if there were any particular reasons why West Berkshire would have less equitable access to NHS Continuing Healthcare (CHC) compared to elsewhere in the country.

Mr Waddicor said his general belief was that the Primary Care Trust (PCT) was doing more than fine with a complex set of directions and guidance. He explained the guidance sometimes conflicted with the directions and in these instances the Primary Care Trust (PCT) would follow the directions as these were the law.

Berkshire West PCT was the lowest funded PCT in the country. The level of funding was based on a Government calculation that takes into account the healthcare needs of the population. He explained that as a consequence he would have expected to see expenditure at the lower end across all services.

He reported that in terms of actual expenditure on CHC the PCT was 126 out of 150 PCTs nationally. He explained that on a prima facie case there was not any evidence which showed the rules had not been applied fairly in West Berkshire.

He explained that the directions were derived from the Acts of Parliament and these had the basis of law. The PCT considered the guidance but during times

when the guidance conflicted with the directions the PCT would ultimately follow the directions.

Mr Waddicor responded to the nine questions published at Item 4, Appendix B (reprinted as headings below).

How does the PCT explain the inconsistency in approach whereby only 3.3 per 10,000 patients received Continuing Healthcare funding in the NHS Berkshire area, when as many as 29.3 people per 10,000 received funding in other parts of the country?

Mr Waddicor explained that whilst the Berkshire West PCT area was 150 out of 150 in terms of Government funding for healthcare that actual expenditure on CHC was ranked as 126 out of 150 PCTs for these funding awards.

He could not comment on how other PCTs applied the rules and regulations but he was not aware of major differences around the country. He added there was not any national formula for calculating CHC spend.

Councillor Boeck asked Mr Waddicor about the perception of medical practitioners that health care needs were not being met and that fewer patients received CHC in West Berkshire than elsewhere in the country.

Mr Waddicor responded by saying the PCT would deny they were not meeting healthcare needs where the evidence demonstrated they should have been. He would not accept this assertion. He said that as the PCT as the lowest funded body in the country it would be expected to spend at that level otherwise the organisation would have been in financial difficulty.

He explained that even though the numbers were lower the PCT spend more than they should on CHC and he did not see the evidence for any assertion that needs were not being met.

What budget build process has been taken and has there been a policy decision taken around the Continuing Healthcare budget to bring down budget spends? What has been the expenditure on Continuing Healthcare over the last 5 years?

The budget build process was based on expenditure from the previous years and made allowances for inflation. This would also include an assessment as to whether growth was required based on changes to the legislation or demographical changes. Mr Waddicor said he categorically guaranteed there was not any requirement for the CHC Team to deliver cost savings.

Mr Waddicor explained that complete data was not available over 5 years only for the last 4 years. Over this time, records showed that broadly the expenditure had remained the same.

During 2007-08 the PCT funded £13.8m of the NHS costs for CHC with a further £3.8m of jointly funded care costs or £17.7m for Berkshire West PCT area overall.

During 2010-11 the NHS funding for CHC was £13.4m. This figure was only £400k different from the total for 2007-08 and when the joint funding for cases was included (just over £3m) the total annual expenditure was reported as £16.5m. This showed that the total figures were only £1.2 million pounds lower in 2010-11 compared to the budget figures from 2007-08.

Mr Waddicor noted that there had been a significant reduction in the NHS funding for certain client groups most notably for those with Learning Disabilities. A series of reviews undertaken in 2008-09 had shown the PCT was incorrectly funding certain individuals and he explained this might be the reason

for the reduction in expenditure which was seen. He reported that there was not any evidence of significant change over the last 5 years.

How many individuals were in receipt of Continuing Healthcare funding, year on year, and what are the implications for West Berkshire Council?

Mr Waddicor explained the figures were for the Berkshire West PCT area as a whole. During the 2007-08 the NHS funded 378 people (for NHS and joint CHC costs) compared to the financial year 2010-11 when 465 individuals received funding which demonstrated that the PCT was funding more people in 2010-11. He reported that the process was not about reducing costs but ensuring the proper assessment of individuals' needs.

How many applications are submitted for Continuing Healthcare funding and how many of these are successfully awarded funding each year?

Mr Waddicor explained that he does not have the complete picture but he supplied figures for 2009-10 and 2010-11 for the number of new requests for CHC assessments. In the Berkshire West area 128 applications were granted during 2009-10 which represented 68% of all applications received. Whilst in 2010-11 it was reported that 123 assessments were awarded funding this equated to 63% of all applications received.

On what grounds can the NHS Continuing Healthcare Checklist be declined?

Ms Helen Mackenzie (Deputy Chief Executive, NHS Berkshire) responded by explaining that the directions indicated that the CHC checklist can be used as a screening tool to inform the decision as to whether a full assessment was required.

The PCT had been alerted to the fact there had been issues around the return of inappropriately completed checklists. She referred to national Ombudsman reports which instructed PCTs that checklists needed to be completed in full to provide sufficient evidence for an informed decision and to document the rationale behind any decision.

She mentioned that the PCT undertook a proportionate approach to ensure resources were directed to those who were most likely to be eligible for CHC funding. There was not any requirement to complete the checklist.

Under the directives and framework the PCT applied their expertise and knowledge in determining when to complete a full assessment and providing an explanation for the cases that fail to progress to a full assessment.

How many NHS Continuing Healthcare Checklists are received and how many go on to have a full assessment completed?

Mr Waddicor apologised that the PCT did not record data in such a way that would have allowed him to answer this question. The stored records only reported on the assessments received as opposed to checklists received and this response had already been provided to answer Question 4, Appendix B.

For those patients that require "Fast Track" care due to the urgency of their needs, and where the form is appropriately completed by a clinician, how many of these have been declined Continuing Healthcare funding and on what grounds have these decisions been made?

Mr Waddicor explained that although a patient might apply for a "Fast Track" assessment this did not mean they had any automatic entitlement to funding. Only a clinician can apply for a "Fast Track" assessment and should the criteria be met the PCT would provide funding in these cases.

He added that a patient with a terminal illness does not have an automatic right to CHC funding as the NHS provided a whole range of other services that are free at the point of delivery which could meet their needs.

Were all types of patient (e.g. End of Life, Learning Disabilities, those with complex needs) equally eligible for Continuing Healthcare funding?

Mr Waddicor reported that all types of patients were indeed eligible for CHC funding and there was not any discrimination between the groups, however he explained that there was not any automatic entitlement to funding either. He described that the needs of the individual would be considered and a decision made on entitlement in a similar way to Adult Social Care funding awards.

How many cases that were assessed for Continuing Healthcare funding took longer than the 28-day statutory time period to determine the application?

Mr Waddicor explained that delays in determining the applications might occur for a variety of reasons; there were often family requests, delays awaiting medical reports or difficulties finding a suitable time to meet which could result a longer time period than might ordinarily have been expected.

During 2010-11 there were 48 out of 123 applications that took longer than the statutory 28-day requirement.

The Chairman asked how many assessments had not been done and whether patients were being denied access to the full assessment. Mr Waddicor acknowledged that sometimes the necessary paperwork was not completed properly and this was the cause of returned assessments.

Councillor Linden described how other local authority areas also received low levels of healthcare funding but remained able to fulfil their necessary obligations. He was concerned that the figure of £400k (reduction of NHS CHC in 2010-11) showed an overall funding reduction despite continuing demand for CHC funding.

Mr Waddicor mentioned there was a substantial reduction in NHS funding in CHC from the assessment of adults with learning disabilities (LD) during 2008-09 which contributed to a significant reduction in expenditure. He explained that he had shown that the PCT was supporting more people with CHC needs now than compared to several years ago. He had to apply the rules equitably across the area and he did not see any evidence that people in West Berkshire were disadvantaged compared to other parts of Berkshire. The PCT was the lowest funded in the country and lower expenditure across all services would be expected.

The Chairman asked Mr Waddicor to explain the reason for the difference between local authority areas and whether this might indicate a stricter application of the guidance.

Mr Waddicor said he could not comment on the situation in other areas. He repeated how an organisation that was the lowest funded in the country based on a calculation of healthcare needs would have been expected to spend accordingly.

The Chairman asked whether there were cases where the PCT should be responsible for providing the funding and that perhaps the low figures of those receiving CHC indicated the local authority might be paying for some of these individuals instead.

Mr Waddicor mentioned a difficult session two years ago where the Council had felt strongly that the PCT was making the wrong decisions in relation to the

assessment of those with Learning Disabilities (LD). He recollected that when the disputed cases went to arbitration the PCT won every single one of those cases. Therefore he did not see the evidence that the PCT had applied things incorrectly or inappropriately.

In other parts of the South Central SHA region there was wider variation in the figures for numbers accessing CHC funding which might suggest different stringency and application of the rules. For Berkshire West the rules had been applied consistently and there was not any reduction to funding.

The Chairman asked how differences of opinion in relation to CHC funding cases would be resolved and what dispute resolution process was followed.

Ms Mackenzie responded by confirming that there was not any dispute procedure currently in place. However, consultation was underway on a draft procedure with the Berkshire local authorities. She acknowledged the importance of formalising this procedure.

The Chairman enquired whether the draft document covered the creation of a Committee of officers to determine decisions and whether an independent panel for the resolution of disputes would be established.

Ms Mackenzie described how a suggestion had been made for managing the disputes process as part of the draft procedure which was currently the subject of consultation.

Councillor Mooney reported his surprise that Mr Waddicor could not supply the specific figures for the West Berkshire local authority area. He expressed his concern there had been a 20% increase in the numbers receiving CHC funding yet there was reduced expenditure on CHC overall, per person per annum. He was concerned that West Berkshire Council might be covering end of life care costs particularly on occasions when a patient made a request to die in their own home.

Mr Waddicor responded by explaining that the PCT did pay for some terminally ill patients who were being treated at home. He explained that just because an individual was terminally ill this does not give an individual an automatic entitlement to funding. He reiterated that during 2007-08 the PCT funded 378 individuals and that during 2010-11 this figure was higher with 465 individuals receiving funded. He did not see that there was any evidence for the concerns that had been raised.

Councillor Mooney also asked why data could not be analysed by local authority area or by postcode. Ms Sam Ward (South Central Strategic Health Authority (SHA)) responded by explaining that the published Department of Health figures and benchmarking data for CHC funding could only be extracted by PCT area. There was not any ability to collate the data by local authority area.

The Chairman asked whether this data on CHC applicants could be collected and analysed by different means in the future.

Mr Waddicor responded by explaining how he would not ask for this to be done, due to the huge organisational pressures that the PCT was facing at this time. He reported that in the future the local authority would be in receipt of CHC assessments and might wish to conduct retrospective reviews.

Councillor Mason asked whether “Fast Track” applications can be denied if a clinician had made the funding request and whether “Fast Track” applications were possible from all types of patients.

Ms Mackenzie clarified that “Fast Track” related to a separate funding stream which can only be requested by a clinician. She explained that a “Fast Track” application could be made in situations when there is a primary need for health care and this was a completely separate process from the 28-day statutory deadline for CHC assessment requests. A “Fast Track” assessment form would still be returned if this was not completed satisfactorily.

Dr Abid Irfan (Newbury & District Clinical Commissioning Group Chairman) said that from April 2013 the Clinical Commissioning Groups would have the responsibility for managing the budget for CHC funding. He reported that the PCT process appeared to have been consistent from the figures he had seen and suggested however in the future better record management of the data was advisable. He added that the guidance suggested decisions over “Fast Track” applications should be made within 48 hours and he reassured Members that from the data he had seen this had happened in the vast majority of all cases.

Councillor Boeck asked about the management tools and PCT measurements which were used which might give reassurances that the needs of patients’ were being met.

Ms Mackenzie explained that the assessment process gave the PCT this information and also by following the expectations as outlined in the directions and guidance.

Mr Waddicor said data showing a wide variation in expenditure or in numbers over a period of time might have highlighted there was an issue. However, the PCT has not had any evidence of complaints or situations where their processes have been challenged or overturned in a court of law.

Councillor Boeck asked Mr Waddicor how the PCT is convinced that the 3.3 per 10,000 population figure demonstrated all the need was being met.

Mr Waddicor said he did not know specifically but the evidence suggested that overall the PCT was correct in their approach as the numbers were consistent, the policy had not been altered and the expenditure was consistent.

Ms Ward (South Central SHA) mentioned how the SHA was the organisation responsible for the next stage review and the Independent Review Panel. She explained she would have expected to see a significant number of complaints regarding the PCT decisions if there had been a problem.

The Chairman invited Ms Janet Golder (WBC Continuing Healthcare Specialist Worker) to give her view. She explained that more needed to be done in terms of providing more evidence-based analysis. She felt the low numbers awarded funding were a reflection of the low numbers of applications that were processed through to completion and consequently the absence of any referrals to the IRP. She explained that the process was further hampered by the absence of any dispute resolution procedure.

Ms Golder said the critical issue remained the actual number of completed CHC applications that were progressed to completion. The PCT had given numerous reasons why current applications were delayed and had not been processed, some of which had now been outstanding for several months. The Council officers had been challenging the PCT on cases where they believed the individual had an entitlement to CHC funding.

Councillor Boeck stated that a quarter of all applications for CHC funding fall outside the timeframe for determining applications and one-third do not actually receive this funding was evidence enough that the process needed investigating more thoroughly.

Councillor Bairstow requested the need for better data management so the PCT would know exactly how many applications were received, refused and the outcome of every application.

Mr Waddicor responded by saying that even by gathering data it might not fully explain the picture about meeting needs. He reiterated he did not see any evidence that the PCT was applying the rules in a stricter or more lenient fashion than other PCTs. He explained that he felt the consistency of approach was a good indicator. The SHA had not received considerably more appeals from the PCT's decisions and he does not see numerous Ombudsman complaints.

Mr Waddicor reminded the Panel Members that this was not a PCT that wanted to work in opposition to the Council. Ms Mackenzie emphasised that although there were different viewpoints it was important to agree a way forward.

Councillor Mooney reported that it was not lawful for local authorities to provide, fund or charge for care which should be provided by a PCT.

Mr Waddicor felt he had already answered this question and was confident that he was applying the regulations and guidance appropriately.

The Chairman summed up the discussion and explained this was the beginning of the Review on this subject. He said that the dispute resolution and the consultation process needed to be explored further. He welcomed the roundtable meeting between the PCT and Council officers as a useful way forward. He explained that there would be a further meeting of WBC officers once the written submission from Mr Waddicor and the benchmarking data from the South Central SHA had been received.

RESOLVED that:

(i) NHS Berkshire should formalise a dispute resolution process as a critical part of the fairness and equality of determining Continuing Healthcare funding across Berkshire.

(ii) An independent appeals panel should be established to arbitrate on cases where there is disagreement between the local authority and NHS Berkshire on Continuing Healthcare (CHC) awards.

(iii) There should be further investigation into the process of Continuing Healthcare (CHC) applications to establish the impact on West Berkshire residents.

(iv) NHS Berkshire should supply a written submission for the questions listed at Item 4, Appendix B.

(v) The South Central Strategic Health Authority (SHA) should supply benchmarking data to help support the Scrutiny Review with comparator data on Continuing Healthcare (CHC) awards.

22. Health Scrutiny Work Programme

Members considered the existing Work Programme for the Municipal Year 2011/12. Ms Naylor reported that the Day Centre scrutiny had not yet taken part due to a lack of resource and explained that the request would need to be considered and re-prioritised with all other work programme items.

Tony Lloyd (West Berkshire Local Involvement Network (LINk) Chairman) reported on the Review of "Dignity and Nutrition in Hospitals". He explained the difficulties encountered in the dispatch of questionnaires to those patients that had been treated in hospital over the last 12 months. He had been in contact with Crossroads and the Princess Carers' Trust to get their assistance. There

was a 20% response rate to the questionnaire which had been circulated and this included scope for some qualitative feedback. Some of the comments received showed some concerns to be followed up however overall the majority of the feedback was very positive about care within Berkshire's hospitals.

It was confirmed that the update on outcomes following the "Six Lives" Report had previously been considered by the Health Scrutiny Panel in October and there was no further work underway.

RESOLVED that:

(i) the "Six Lives" Report and "GP Commissioning" be removed as items from the Health Scrutiny Panel work programme.

The meeting commenced at 6.30pm and closed at 8.15pm.