NOTICE OF MEETING

NORTH CENTRAL LONDON SECTOR JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Contact: Robert Mack

Direct line: 020 8489 2921
E-mail: rob.mack@haringey.gov.uk

Monday 5 December 2011 10:00 a.m.
Barnet Town Hall, The Burroughs, Hendon NW4 4BG

Councillors: Maureen Braun and Alison Cornelius (L.B.Barnet), Peter Brayshaw and John Bryant (Vice Chair) (L.B.Camden), Alev Cazimoglu and Anne Marie Pearce (L.B.Enfield), Gideon Bull (Chair) and Dave Winskill (L.B.Haringey), Martin Klute and Alice Perry (L.B.Islington),

Support Officers: Sally Masson, Linda Leith, Robert Mack, Pete Moore and Shama Sutar-Smith

AGENDA

1. WELCOME AND APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST (PAGES 1 - 2)

Members of the Committee are invited to identify any personal or prejudicial interests relevant to items on the agenda. A definition of personal and prejudicial interests is attached.

4. MINUTES (PAGES 3 - 20)

To approve the minutes of the meetings of 31 October and 14 November 2011 (attached).

5. NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC) - TERMS OF REFERENCE (PAGES 21 - 24)

To note the current terms of reference for the JHOSC.

6. TRANSFORMING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) IN PATIENT SERVICES FOR YOUNG PEOPLE LIVING IN BARNET, ENFIELD AND HARINGEY (PAGES 25 - 36)

To consider further proposals to reconfigure in-patient CAMHS services for young people in Barnet, Enfield and Haringey.

7. QIPP PLAN - PERFORMANCE (PAGES 37 - 44)

To consider the latest performance figures for the QIPP Plan for North Central London.

8. QIPP PLAN - UNSCHEDULED CARE (PAGES 45 - 64)

To consider QIPP plans for unscheduled care.

9. CONTINUING CARE (PAGES 65 - 124)

To consider changes to the provision of NHS Continuing Healthcare (CHC) in NHS North Central London and the development of a single CHC policy across the cluster.

10. FUTURE WORK PLAN (PAGES 125 - 126)

To consider the JHOSC's future work plan.

23 November 2011

Agenda Item 3

DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF

What matters are being discussed at the meeting?

Do any relate to my interests whether already registered or not?

NO → You can participate in the meeting and vote

YES

Personal interest

Is a particular matter close to me?

Does it affect:

- me or my partner;
- my relatives or their partners;
- my friends or close associates;
- either me, my family or close associates:
  - job and business;
  - employers, firms you or they are a partner of and companies you or they are a Director of
  - or them to any position;
  - corporate bodies in which you or they have a shareholding of more than £25,000 (nominal value);
- my entries in the register of interests

more than it would affect the majority of people in the ward affected by the decision, or in the authority's area or constituency?

NO

NO

YES

You may have a **personal interest**

Declare your personal interest in the matter. You can remain in meeting, speak and vote unless the interest is also prejudicial; or
If your interest arises solely from your membership of, or position of control or management on any other public body or body to which you were nominated by the authority e.g. Governing Body, ALMO, you only need declare your personal interest if and when you speak on the matter, again providing it is not prejudicial.

Prejudicial interest

Does the matter affect your financial interests or relate to a licensing, planning or other regulatory matter; and
Would a member of the public (knowing the relevant facts) reasonably think that your personal interest was so significant that it would prejudice your judgement of public interest?

YES

You may have a **prejudicial interest**

YES

Do the public have speaking rights at the meeting?

YES

You should declare the interest but can remain in the meeting to speak. Once you have finished speaking (or the meeting decides you have finished - if earlier) you must withdraw from the meeting by leaving the room.

NO

You should declare the interest and withdraw from the meeting by leaving the room. You cannot speak or vote on the matter and must not seek to improperly influence the decision.

Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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MINUTES OF THE NORTH CENTRAL LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE HELD ON MONDAY 31 OCTOBER 2011 AT 10.00 AM IN THE COUNCIL CHAMBER, ENFIELD CIVIC CENTRE, SILVER STREET, ENFIELD, MIDDLESEX, EN1 3XA

Present: Councillors Gideon Bull (Chair) (L. B of Haringey), John Bryant (Vice Chair) (L.B. of Camden), Peter Brayshaw (L. B. of Camden), Alev Cazimoglu (L. B. of Enfield), Alison Cornelius (L. B. of Barnet), Martin Klute (L. B. of Islington), Graham Old (L.B. of Barnet), Anne Marie Pearce (L. B. of Enfield), Alice Perry (L. B. of Islington), Barry Rawlings (L. B. of Barnet) and Dave Winskill) (L. B. of Haringey).

Officers: Rob Mack (L. B. of Haringey), Mike Ahuja (L. B. of Enfield), Sue Cripps (L. B. of Enfield), Sally Masson (L. B. of Barnet) and Peter Moore (L. B. of Islington).

Also present: Martin Machray, Dr Douglas Russell, Sarah Thomson and Felicity Bull (NHS North Central London), Rachel Tyndall (NHS London), representatives of FERAA, Haringey LINKs, Save Chase Farm Group and Bush Hill Residents' Association and Councillor Patricia Ekechi (L. B. of Enfield) and local residents.

1. **WELCOME AND APOLOGIES FOR ABSENCE (Item 1)**

   The Chairman welcomed all those present to the meeting and in particular Councillor Alice Perry (L. B. of Islington) attending her first meeting of the Committee.

   An apology for absence was received from Councillor Maureen Braun (L. B. of Barnet) who was substituted by Councillor Barry Rawlings. Councillor Alison Cornelius (L. B. of Barnet) advised that Councillor Graham Old was also representing the L. B. of Barnet. It was noted that the terms of reference for the JHOSC stated that, in the event of there being a need for a vote, each borough was entitled to a single vote irrespective of the number of representatives it had at the meeting in question.

2. **URGENT BUSINESS (Item 2)**

   Donald Smith, a local resident, referred to an article in the Health Service Journal on Friday 28 October 2011 concerning a report from NHS London outlining significant shortfalls in consultant presence in labour wards; only four maternity units in London met consultant labour ward requirements. He suggested that a response was required at a later date. Martin Machray (Head of Communications and Engagement, NHS North Central London) advised that he had not seen the report but would be happy to discuss the contents at a future meeting.

   The Chairman suggested that this be considered as an item for discussion at a future meeting.

   RESOLVED that a report be submitted to a future meeting of the JHOSC regarding consultant presence in labour wards and responding to the issues raised in the Health Service Journal report.

3. **DECLARATIONS OF INTEREST (Item 3)**

Councillor Gideon Bull declared an interest that he was an employee at Moorfields Eye Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Peter Brayshaw declared an interest that he was a Governor at University College London Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alison Cornelius declared an interest that she was Assistant Chaplain at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alice Kerry declared an interest that she was an employee of the London School of Hygiene and Medicine, but did not consider it to be prejudicial in respect of the items on the agenda.

4. MINUTES (Item 4)

RESOLVED that the minutes of the meeting held on 19 September 2011 be agreed subject to the following:-

- the current spelling of Eric Karas (not Karac) from the Barnet, Enfield and Haringey Mental Health Trust; and
- deletion of 'had' after 'No staff' in paragraph 6 on page 3 (Transforming Child and Adolescent Mental Health Services - In-Patient Services for Young People living in Barnet, Enfield and Haringey).

5. NORTH CENTRAL LONDON PRIMARY CARE STRATEGY (Item 5)

An interim report had been circulated with the agenda on the Development of the North Central London Primary Care Strategy dated 7 October 2011.

The report detailed the background work being undertaken to develop the Primary Care Strategy the purpose of which was to further improve quality, capability and productivity in Primary Care. The strategy would define the medium and long-term goals, priorities, principles, investment criteria and performance expectations.

It was emphasised that this was an interim report and identified emerging themes. Consultation on the report was ongoing. The Committee questioned why NHS North Central London was introducing a top down report as this was only a temporary body lasting eighteen months.

Dr Douglas Russell (Medical Director, NHS North Central London) responded that universal, accessible high quality general practice supported by well developed primary care teams integrated with social care and the third sector was crucial in improving health service provision.

Kate Wilkinson (Save Chase Farm Group) stated that a Primary Care Strategy had already been agreed previously; she questioned why it was not possible to inherit the previous one.

Councillor Alev Cazimoglu stated that the problem was not the lack of a Strategy but the lack of funding in Enfield. She stressed that it was essential to know what Enfield would receive financially.

Dr Russell advised that this was a consultation paper which sought views. The Strategy would build on the current five borough-based primary care plans and determine how NHS North Central London and the successor organisations would invest in primary care in each of the five Boroughs over the coming years. He pointed out that 80% to 90%o of the public's experience of health care was in primary care and not hospitals. Sometimes, however, there were access difficulties and other factors such as GPs being dismissive which meant people attended local hospitals instead.

The aim of the strategy was to provide an effective service coupled with care and compassion. He added that patients needed to be at the centre of the consultation. It was necessary to ensure that GPs had the supporting services and that premises were fit for purpose, meeting minimum standards.

Dr Russell advised that in the North Central London area, 56% of income was spent on hospitals compared to 46% in the rest of London. The intention was that GPs would do as much as they could within Primary Care to avoid hospital admissions.

The Chairman questioned how this Strategy would be better than previous ones and as to whether GPs were supportive. Dr Russell responded that he had undertaken similar work in Tower Hamlets for a number of years and improved services there which were now recognised both nationally and internationally. He stated that it was necessary to have the support of clinicians and to listen to any scepticism and doubt and address such issues.

The Committee then questioned how the issue of poorly performing GPs would be addressed. Dr Russell said that GPs would have written personal development plans and have an annual appraisal of their performance with a qualified GP appraiser. GPs were required to apply for professional re-accreditation every five years. He emphasised that GPs did not have a contract for life – breach notices, remedial notices and even termination notices could be served on GPs. Care and compassion from GPs was essential. This started from a sense of vocation but would need nurturing by a culture of professionalism and continuing professional development and support, peer comparison and personal reflection.

Councillor Alice Perry questioned where resources would be provided from. Dr Douglas Russell responded that too much was being spent in hospital care even though GP referrals were going down (except North Middlesex and Chase Farm where they were increasing). Therefore it was necessary to have first class GP and Primary Care services.

Councillor Alev Cazimoglu advised that there was a Working Group in Enfield looking at why residents sometimes went to local hospitals rather than visit GPs. She pointed out that primary care in Enfield was significantly underfunded (£70m

for the current year). Without the necessary investment in primary care, the over reliance on acute care could not be addressed successfully. She added that she was concerned that spending on acute care could be even higher in 2012/13. Appropriate primary care needed to be in place before any reconfiguration on local hospitals took place.

Councillor Cazimoglu referred to a letter from MIND in Enfield which indicated that they were currently undertaking almost 3,000 counselling sessions per year with residents. The service was currently under treat due to budget cuts by NHS Enfield. She questioned who would be delivering this in the future.

Dr. Russell responded that it was vital to engage with the Councils and the public in the consultation with a view to reducing the numbers attending hospitals and not GPs. This involved engaging the five Boards to reduce hospital spend and increase primary care funding. He added that the support of local authorities for primary care was very important. He stated that it was hoped that some non-recurrent money could be made available if the benefits could be clearly demonstrated and it was supported by a clear plan on how improvements would be implemented.

The Chairman referred to problems of obesity especially among children and people's lifestyles, e.g. smoking or alcohol. Furthermore, the continuing lack of green spaces meant little or no exercise was being taken. Similarly, poor standards of housing were closely linked with poor health.

Councillor Anne Marie Pearce advised that Enfield Council's Planning Department had been asked to give careful consideration as to whether applications for take-aways should be approved near schools.

Martin Machray referred to the divide between health and wealth and the work of Professor Sir Michael Marmot which dealt with tackling health and well being and needed to be understood in relation to a range of factors that interacted in complex ways. These factors included material circumstances, e.g. whether one lived in a decent house with enough money to live healthily; social cohesion, whether one lived in a safe neighbourhood without fear of crime; psychosocial factors such as whether good support from family and friends was available; behaviours – whether one smoked, ate healthily or took exercise.

Similar work had been undertaken by The King's Fund, the UK health charity that shapes NHS policy and practice.

Councillor John Bryant observed that the report indicated that there appeared to be more registered patients in Camden and Islington that the actual population. The Chairman referred to 'ghost patients' – patients who were registered but no longer lived in the area. Dr. Russell responded that there was always a mismatch on such figures; this was because people did not always register with GPs and some only registered when sick.

Local authority population figures were based on various statistics including electoral registers and the National Census which was undertaken every ten

years. Currently people registering with GPs needed to show passports and evidence of where they were living. It was planned that in the future people could also register in Council offices. Dr Russell advised that there was a regular trawl through those registered with GPs to remove 'ghost patients'.

Kate Wilkinson referred to the 15% increase in referrals to the acute sector and hospital services being removed. This coupled with cuts to the voluntary sector had exacerbated the situation. She stated that any monies from the sale of land at Chase Farm should be ring-fenced to address the shortage of Primary Care.

Dr Russell advised that no monies would be ring-fenced. It was necessary to reduce expenditure on hospitals and increase Primary Care. He pointed out that most health expenditure was in the last two years of a patient's life. Under the Strategy, Patient at Risk (PAR) would be used in assessing people's illnesses. He added that new ways of working would make a difference to the quality of life.

In response to further questions from the Committee on poor performing GPs, Dr Russell stated that the voice of patients was fundamental to the Clinical Commissioning Groups.

Donald Smith expressed concern as to the lack of GP provision on new estates being built on former NHS land in N18. He stressed the need to commission a GP surgery whilst it was still NHS land. Dr Russell stated that the NHS Planning Sector and the Local Authority Planning Department could liaise on this matter.

John Jewson, FERAA, referred to the lack of GPs particularly in Enfield and the need for their assessment. He also referred to the limited time GPs could spend with patients and the need to send them to hospitals for x-rays.

Liz Henthorn, a local resident, urged that support services be provided for stroke victims. Councillor Anne Marie Pearce advised that a Stroke Navigator had recently been appointed.

Ivy Beard, a Broxbourne resident, questioned where the financial resources would come from. She stated that south Hertfordshire no longer funded the urgent care centres with a doctor present; it was just a nurse-driven facility whereby nurses diagnosed patients. This was why residents from Broxbourne went to Chase Farm A & E and why it was essential to keep Chase Farm Hospital open.

Councillor David Winskill stressed the need to ensure that Dr. Russell's project and initiatives should continue after the Clinical Commissioning Groups supersede the NCL cluster in 2013. He suggested that the Chairman write to NHS London to seek clarification on how the project would continue and its momentum sustained..

RESOLVED: That a letter be sent on behalf of the Committee to NHS London to seek clarification on how the strategic role in developing and monitoring the quality of primary care currently undertaken by NHS North Central London would continue after its demise.

Members then considered the report by Grant Thornton 'Independent Business Review of Camidoc Ltd'

Councillor Winskill requested detailed information on the finances of Camidoc, the Board's involvement and whether minutes of various meetings were available. It was noted that in 2009/10, £30,000 of pension contributions were used as working capital. Similarly, it was understood that national insurance deductions had not been made. He suggested a separate meeting with NHS North Central London to address this. This was supported by Councillor John Bryant.

Martin Machray agreed that it would be useful to have a working session to address this issue in a structured way.

RESOLVED:
1. That a letter be sent on behalf of the Committee to NHS North Central London outlining the further information that it wishes to receive in respect of the financial issues that led to the demise of Camidoc.

2. That a meeting of representatives of representatives of the health scrutiny committees of host boroughs be arranged to discuss the concerns expressed by the Committee with regard to Camidoc.

6. <u>BARNET, ENFIELD AND HARINGEY CLINICAL STRATEGY (Item 6)</u>

The Secretary of State's letter dated 12 September 2011, regarding the Independent Review Panel's (IRP) recommendations and decision on the Barnet, Enfield and Haringey Clinical Strategy, along with the IRP's recommendation to the Secretary of State was circulated with the agenda.

The Chairman stated the next Committee meeting to be held on 14 November 2011, would be examining the plans for implementation.

Councillor Alev Cazimoglu stated that Enfield's position remained the same and, as such, was opposed to any reconfiguration. The Council was not convinced that a case had been made to reconfigure Chase Farm Hospital and was of the view that the shortfall of £70m in funding for primary care had not been addressed. She added that advice was being sought for judicial review and this had been a cross-party decision.

Mike Ahuja advised that an underfunding case could be provided to the Committee.

Councillor Anne Marie Pearce wished to ensure that any monies from Chase Farm be ring-fenced and used for Primary Care purposes.

Ivy Beard, a Broxbourne resident fully supported Enfield's concerns on the retention of Chase Farm and the need for other services. She added that the borough had been hugely underfunded which had a knock-on effect on walk-in centres etc. The residents of Broxbourne and Cheshunt valued the Consultant Lead 24-hour A&E at Chase Farm Hospital.

Donald Smith advised that since 2003, promises had been made to improve transport to hospitals within the Borough of Enfield, however, nothing had happened and the situation was getting worse. He questioned whether NHS London had considered this problem and would assist in improving access to the services.

The Chairman expressed fundamental concern that if the Clinical Strategy was not implemented, the effect it would have on North Middlesex Hospital.

The Committee agreed to discuss the various issues at the next meeting on 14 November 2011, which was specifically to deal with the Barnet, Enfield and Haringey Clinical Strategy.

RESOLVED that the Chairman circulate the proposed agenda for the special meeting of 14 November 2011 for comments from other Councillors.

7. STRATEGIC AND QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION PLAN (QIPP) (Item 7)

Liz Wise, Quality, Innovation, Productivity and Prevention Director, NHS North Central London gave a presentation on the Commissioning Strategy and QIPP Plan for 2012/13 – 2014/15.

The objective of the presentation was to share the process and progress of the Plan and to provide an opportunity for the Committee to reflect on the priorities in the Plan. One cluster plan was required by the Strategic Health Authority; this was needed by the end of November 2011.

The population of the area involved was relatively young, deprived and diverse and 31% was from Black and Minority Ethnic Groups. The current population of 1.34m was expected to grow to 1.45m over the next decade.

A copy of the presentation is attached.

In response to questions from the Committee, Liz Wise advised:

- guidance was sought from NICE as to whether to carry out certain treatments;
- currently £11m was spent annually unnecessarily on medical treatments that did not work or did not work well;
- there were major concerns over child obesity;
- consultants employed to consider the financial gap of £80m were present in the summer of 2011 and noted short-comings on plans which had since been addressed;
- no monies would be passed directly from one PCT to another;

- lifestyle factors were often linked to deprivation and were important sources of inequalities and poorer health outcomes;
- considerable changes were underway in services dealing with mental health;
- there was a need to focus on interventions, e.g. diabetes awareness within particular communities; and
- those with long-term conditions and frail would be looked after in the community.

Martin Machray stated that with a cosmopolitan population, there was often social isolation and low esteem. Average life expectancy was highest in Barnet and lowest in Islington.

Councillor Alison Cornelius detailed work undertaken in Barnet to address obesity which involved the whole family and getting people to diet.

RESOLVED:

1. That any further comments on the QIPP Plan be sent to Liz Wise as soon as possible.

2. That further discussion focussing specifically on outcomes of QIPP programmes be arranged for future meetings of the Committee.

8. CANCER MODEL OF CARE (Item 8)

Rachel Tyndall, (Chief Executive Officer, NHS London) gave a presentation on implementing the Model of Care for Cancer.

Over 13,000 people die from cancer in London each year, with more than half of these under 75 years of age. The number of cancer cases in London was expected to increase as the population ages and continued to grow.

It was necessary to diagnose as quickly as possible and work to improve care and ensure equitable access to specialist, GPs, hospitals and healthcare professionals.

Cancer experts from a range of specialities had reviewed London's cancer services and published the case for change in December 2009, demonstrating the need for improving the capital's cancer services. A range of people were engaged between August and November 2010, on the proposed model of care, which had received widespread support.

In January 2011, the NHS in London began the implementation of the proposed Model of Care.

The case for change document made a series of compelling arguments for changing cancer services in London. The case for change highlights that:-

- later diagnosis had been a major factor in causing poorer relative survival rates;

- there were some areas of excellence in London but inequalities existed in access to and outcomes from care;
- treatment and care should therefore be standardised across London;
- specialist surgery should be centralised but common treatments should be localised where possible; and
- comprehensive pathways should be commissioned so that organisational boundaries were not a barrier.

It was noted that Professor Sir Mike Richards (National Cancer Director) had endorsed the case for change and had said that maintaining the status quo was not good enough – to provide world-class services across the whole of London and to address the existing inequalities between London Primary Care Trusts required radical change.

A copy of Rachel Tyndall's presentation is attached.

RESOLVED: that the cancer model of care and the implementation programme be welcomed.

9. FUTURE WORK PLAN (item 9)

Members considered the Work Plan for future meetings of the Committee.

14 November 2011 at Haringey

This would be a special meeting to consider the issue of the Barnet, Enfield and Haringey Clinical Strategy. The Chairman advised that he had sent an email to Councillors setting out the key issues and looked for feedback to his suggested agenda. Briefly these key issues were:

1. at what stage is the implementation process?
2. have the four tests for service change been met?
3. how has the transition process been affected by reductions in management capacity and the current financial challenges and what measures have been taken to mitigate these?
4. does the commitment from the PCTs to move services only when there is an established capacity and all facilities are in place at the designated hospitals still stand?
5. what progress has been made in addressing the transport issues?
6. what safeguards are in place to ensure that there is sufficient capacity to cope with demand for:
   - maternity services so that hospitals are not forced to turn women away: and
   - A&E services
7. what progress has been made in implementing the planned developments in primary and community care necessary to support the changes in the strategy and, in particular, the provision of additional health centres and urgent care facilities?
8. how will all local NHS trusts remain financially sustainable and, in particular, able to fulfil the demands of being foundation trusts and meeting PFI payments?

9. how will commissioners seek to engage with patients and the public in order to ensure that their views are considered and to build confidence in the new arrangements?

The Chairman stated that the public would be welcome at this meeting.

Councillor Dave Winskill suggested that Hertfordshire County Council be invited to attend this meeting particularly on the issue of reconfiguration of Chase Farm Hospital.

RESOLVED that representatives from Hertfordshire County Council be invited to attend this meeting.

5 December 2011 at Barnet
Items for this meeting:

- Transforming Child and Adolescent Mental Health Services (CAMHS) – In-patient Services for Young People living in Barnet, Enfield and Haringey;
- QIPP Performance – outcome issues to be included;
- Urgent Care;
- Vascular surgery; and
- Future Work Plan.

16 January 2012 at Camden
Item for this meeting:

Primary Health Strategy.

27 February 2012 at Islington
To be determined.

10. ANY OTHER BUSINESS

The Chairman wished to record the thanks and appreciation of the Committee to Dr Douglas Russell for his really helpful contributions at the meeting and looked forward to hearing more from him at future meetings.

RESOLVED that the Committee record its thanks and appreciation to Dr Douglas Russell for his very helpful contributions to the meeting.

……. **…….**
Chairman **Date**

MJE/JHO&SC21.10.11

North Central London Joint Health Overview and Scrutiny Committee
14 November 2011

Minutes of the special meeting of the Joint Health Scrutiny Committee held at the Civic Centre, High Road, Wood Green, N22 8LE on 14 November 2011 at 10.00am.

Present: **Councillors:** Alison Cornelius and Barry Rawlings (LB Barnet), John Bryant (Vice Chair) (LB Camden), Alev Cazimoglu and Anne Marie Pearce (LB Enfield) Gideon Bull (Chair) and Dave Winskill (LB Haringey) Alice Perry (LB Islington)

Also in attendance; Mark Easton (Barnet and Chase Farm Hospitals), Claire Panniker (North Middlesex University Hospital), John Goulston (NHS London), Nick Lossef, Dr. Doug Russell, Jill Shattock and Caroline Taylor (NHS North Central London), Rob Mack (L.B.Haringey), Peter Moore (L.B.Islington), Sue Cripps (L.B. Enfield) and Sally Masson (L.B. Barnet)

1 WELCOME AND APOLOGIES FOR ABSENCE (Item 1)

The Chair welcomed all those present to the meeting.

Apologies for absence were received from Councillors Maureen Braun (L. B. of Barnet) who was substituted by Councillor Barry Rawlings, Councillor Peter Brayshaw (L. B. of Camden) and Councillor Martin Klute (L. B. of Islington).

2 URGENT BUSINESS (Item 2)

None.

3 DECLARATIONS OF INTEREST (Item 3)

Councillor Gideon Bull declared an interest that he was an employee at Moorfields Eye Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alison Cornelius declared an interest that she was Assistant Chaplain at Barnet Hospital, but did not consider it to be prejudicial in respect of the items on the agenda.

Councillor Alice Perry declared an interest that she was an employee of the London School of Hygiene and Medicine, but did not consider it to be prejudicial in respect of the items on the agenda.

4 BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY - FEASIBILITY STUDY (Item 4)

The Committee received a presentation from John Goulston of NHS London. He reported that, in July, the Independent Reconfiguration Panel (IRP) had submitted its recommendations to the Secretary of State for Health. It had recommended that BEH Clinical Strategy should be implemented. However, representations were made to the IRP which suggested that the needs of Enfield residents might be better served by splitting up Barnet and Chase Farm NHS Trust and creating a new trust comprising of the North Middlesex and Chase Farm hospitals.

In September, the Secretary of State announced that he had accepted the IRP's recommendations. In doing this, he also directed NHS London to work with Barnet and Chase Farm and North Middlesex University Hospital (NMUH) NHS trusts to assess the feasibility of de-merging Barnet Hospital from Chase Farm hospital and merging Chase Farm hospital with NMUH. NHS London were requested to report back to him on the results of this by 16 December.

The feasibility work was only considering organisational issues and service reconfiguration was not within its scope. It as looking at the needs of residents of Barnet, Enfield and Haringey and not just Enfield.

Three criterion were being used to assess the options. The structure recommended should:

- Support the implementation of the BEH clinical strategy;
- Ensure the financial viability of NHS trusts and their progress towards Foundation Trust (FT) status whilst not destabilising the progress of other NHS trusts' progress towards FT status; and
- Be deliverable within the current legal and policy framework

Assessments would be undertaken on the following possible structures:
- The status quo;
- The merger of Chase Farm and North Middlesex with Barnet hospital as a stand alone trust.

Feedback had been obtained that the following other options should also be considered if the two main options proved not to be viable:
- The acquisition of any of the three hospitals by another organisation
- The inclusion of local community services in Barnet and Enfield
- The merger of all three hospitals to create a combined trust.

This process would include an assessment of the potential risks and benefits. Engagement was a key part of the feasibility work and NHS London was working closely with a range of stakeholders including elected representatives, patients and the public.

The Chair expressed concern that the exercise was being described as feasibility on Enfield hospitals as the hospitals in question served residents from a number of London boroughs local authority areas as well as south Hertfordshire. In addition, it could be considered that previous mergers had contributed to the financial challenge that had made the reconfigurations necessary. Councillor Winskill questioned whether small district general hospitals were likely to continue to be viable in the current climate with more and more services being transferred to hyper acutes.

Mr Goulston stated that it was accepted that the hospitals served a wider range of residents than just those in Enfield. However, the reference to just Enfield had come from the Secretary of State's direction. NHS London were nevertheless looking more widely. A full financial appraisal was being undertaken on all of the options. Part of this involved considering what would be a fair and equitable split in finances between the respective bodies. The work would include consideration whether Barnet would be viable as a stand alone trust. It would not be the smallest stand alone trust in existence as Hillingdon Hospital was also small and there was nothing intrinsically unviable about small trusts.

Councillor Cazimoglu expressed that further reconfiguration could affect the chances of trusts gaining Foundation Trust (FT) status which was the overriding priority at the moment. It was also possible that joining all three hospitals together could lead to further consolidation of services on different sites. Mr Goulston stated that FT status was the end point. Trusts had to demonstrate ongoing viability as part of this. The modelling process was based over ten years and on the implementation of the Clinical Strategy.

It was noted that NHS London was funding the feasibility study. The work was mainly being undertaken by senior staff with some limited assistance from external consultants. The models that were being developed were based on commissioner expectations and included, amongst other things, the shift to primary care and productivity gains.

Claire Panniker, the Chief Executive of the North Middlesex University Hospital (NMUH), reported that the crucial issue for the trust was that the Clinical Strategy was implemented quickly. In the absence of this, it would start to feel the impact in 2012/13 when it would be forecasting a deficit. At the time that the Public Finance Initiative (PFI) deal for the construction of new buildings was signed in 2007, the scheme had been affordable. This was prior to formal consultation on the Clinical Strategy. Since this time, two issues had arisen:
- Care closer to home had grown rapidly
- The economic climate had changed and there was now a squeeze on tariffs.

In 2008, the trust had obtained additional investment as it decided that the PFI should be upsized during construction so that there were enough beds to accommodate the additional activity that implementation of the Clinical Strategy would generate. NMUH would no longer be financially viable if the Clinical Strategy did not proceed.

Mr Goulston stated that the modelling was assuming a reduction in tariff of 1.5 % for the next 5 years and current levels of activity. In respect of the attainment of FT status, the current timetables for both of the trust would still apply if there was no merger. In the event of a merger, the new trust would have to be

running for a year before it could apply for FT status in order to provide the necessary track record. If a merger was agreed, it could possibly be implemented in 2013.

A resident asked what would happen to patients from south Hertfordshire after the reconfiguration. Mark Easton (Chief Executive of Barnet and Chase Farm Hospitals) reported that the vast majority of patients from South Hertfordshire would continue to use Chase Farm as most services would stay on the site. Although Barnet and Chase Farm had made a financial surplus in each of the last few years, there was nevertheless a historical deficit that needed to be addressed.

It was noted that the view of Enfield MPs was that a single acute trust covering the borough would fit in with the commissioning group and local authority structure and facilitate partnership working. Dr. Nick Lossef (Clinical Director NHS North Central London) reported that there had been some discussion between clinicians across the trusts in question. Clinical services needed to be supported by the organisational structure and not vice versa. As a result of this, a high level document had been produced by medical directors that gave a consensus view on the options.

Donald Smith, a local resident, highlighted the fact that NHS community services in Enfield were now undertaken by Barnet, Enfield and Haringey Mental Health Trust (BEH MHT) and their role therefore also needed to be considered as part of the feasibility study. There was a lack of community provision in Enfield. Although the issue of co-terminosity with Enfield commissioning group had been one of the drivers for the exercise, this ignored the needs of Haringey whose residents were major users of NMUH.

Caroline Taylor (Chief Executive of NHS North Central London) stated that if BEH MHT had been considered as part of the feasibility exercise, it could impact upon it and there was no desire to cause instability on other organisations. If a merger took place between Chase Farm and NMUH, it would have substantial dealings with not just two but four commissioning groups.

Mr Goulston reported that the costs of the feasibility study were mainly the time and effort of officers. The actual cost was approximately £100,000. Organisational change would have a cost should it be agreed. Amongst other things, a new board would need to be set up. This was likely to be in the region of £1.5 million in total.

RESOLVED:

1. That concern be expressed that the cost of the feasibility exercise is being funded by NHS London rather than the Secretary of State for Health.

2. That the views of local clinicians are fully considered as part of the feasibility exercise and the input of medical directors, as expressed in their collective response to the feasibility study, be shared with the Committee.

5. BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY – IMPLEMENTATION (Item 5):

Caroline Taylor (Chief Executive of NHS North Central London) reported that, in October 2010, the Clinical Review Panel had advised that the clinical case for change was still relevant, and if anything had increased in the past few years. There was a need to improve health outcomes and reduce health inequalities by:

- Improving primary and community care to deliver care closer to home and support people with long term conditions
- Improving the quality and sustainability of hospital services

In reference to transport, a working group had been set up and had looked at both patient and public transport facilities. It had also considered the role of the voluntary sector in providing transport. The group had reported in May 2010. A group would be set up to take the recommendations forward. The report would be shared with the Committee.

Dr. Douglas Russell (Director of Primary Care, NHS North Central London) stated that it was acknowledged that progress with improving primary care was not as great as it should be and that he had

been brought in to facilitate change. The focus was on improving clinical quality and outcomes. There were clear benefits from better primary care, such as improved patient satisfaction levels, greater financial sustainability and better outcomes. The primary care strategy for the cluster would be submitted to the NCL board in January. There was a determination to bring in changes.

There were between 3 and 4 million patient consultations in primary care each year. The vast majority of interactions contacts were undertaken in a caring way by dedicated staff but some were very disappointing in quality. Considerable improvements had been made in Barnet and around 85% of patients were now saying that they were satisfied with services. Edgware Community Hospital was an excellent facility and Finchley Memorial Hospital was to be developed soon. New services were also being developed outside of hospital as part of the QIPP programme. Future developments would involve a full range of services being networked amongst groups of GP's. This would also enable diseases to be diagnosed earlier. Patients often had more than one condition and were increasingly having them for longer. Primary care required generalists who were multi skilled. Clinicians also needed to be able to share medical records easily and work in new ways.

Councillor Cornelius stated that the development of Finchley Memorial was crucial. It was noted that:
- A relatively small range of services were currently provided in the community in Barnet.
- The number of GP referrals from Barnet was going down. This was often with the support of hospital consultants.

Committee Members felt that assurances needed to be provided that real change was taking place and not merely isolated outreach sessions being provided in the community. Dr Russell stated that transformational change was planned. The sharing of records was fundamental as this would facilitate integrated working between teams. Work needed to be undertaken on how services could work together in the best way. This would help to reduce duplication and would also involve social care. There would also be integration with specialists and it was hoped that it would be possible to tap into their expertise without patients always needed to travel to see them. He had managed to implement considerable improvements in primary care in Tower Hamlets where sustained improvement had been made.

Dr Russell stated that there was much work to be done to improve primary care in Enfield. Recent policies had been overly focussed on buildings rather than services. They wished to explore opportunities for joint working with the local authority as part of developing services. A high percentage of patients used urgent care services due to frustration at not being able to easily access primary care services and it was intended to address the causes of this.

The Chair stated that the Clinical Strategy had required that primary care be improved before changes were implemented. Councillor Pearce stated that promises had been made that no services would be taken away before new services were in place to replace them and that this could include a need for some "double running" of services.

Ms Taylor stated that there had been improvements across the three boroughs but more had been achieved so far in Barnet and Haringey than in Enfield. However, there were specific plans to make improvements in Enfield. These included developments at Ordnance Rd and Highmead.. There were three possible sources of investment to improve primary care:
- Non recurrent funding which could be prioritised for primary care
- Joining up IT. A bid for capital funding had been made for this.
- Investing with money from savings made elsewhere.

However, the funding position across the three boroughs concerned was challenging.

Dr Russell stated that the expenditure required to implement the changes would be in the millions for each borough. There would be some double running of services over the next year. The funding was required for a number of issues including the provision of web based information services and additional clinical staff. This did not all need to be funded by new money. Ms Taylor stated that she understood the scepticism of many people. It was not possible to specific about sources of funding at this stage but the Committee would no doubt be wishing to monitor progress on a regular basis. The strengthening of primary care would help to address the deficit that there currently was at NHS Enfield.

Dr Russell outlined the improvements to primary care that had also been implemented in Haringey. The Chair commented that the new clinic at Lordship Lane was very good and that residents were pleased with it. However, there were issues with some primary care accommodation. Dr Russell commented that there was an expectation that all primary care services should be located by practitioners in appropriate buildings. There were a range of arrangements in place with some practices being owner occupied. PCT assets were in the process of being transferred to majority users and this process would be completed by the end of the financial year.

Concern was expressed that some surgeries were still using 0845 or 0844 telephone numbers which could be expensive for residents who only had access to mobile phones. Dr Russell stated that there were contractual issues that needed to be resolved. Responsibility for these was likely to transfer to the NHS Commissioning Board. Some patient experiences were not acceptable and contracts needed to delivered appropriately.

Dr Russell stated that access to services in the community would be different to that provided within hospital settings. There was no wish to remove specialists from hospitals. The emphasis would be on using them where they were most needed. This would enable them to undertake longer consultations with the patients who particularly needed their expertise. Ms Panniker commented that acute trusts recognised the cost implications of their work and were agreeable to targeting resources where they were most needed. Specialists from NMUH were being used to deliver clinics in the local community.

Councillor Bryant commented that the majority of NHS spending in Camden was now on primary care. However, it had taken 10 years for the changes to fully implemented. The current NHS structure was only likely to last a further 18 months and it would be challenging to implement the changes necessary within this short time frame. Dr Russell commented that there was a correlation between the proportion of expenditure made by NHS Camden and its healthy budgetary position. Primary care consultations were considerably cheaper than acute care and also led to better outcomes and improved patient satisfaction levels. The most challenging of the changes was getting clinicians and services to work together more effectively but good progress was being made in gaining their support. He was confident that considerable progress could be made in a year and a half. The experience from Tower Hamlets was that transformation could be very rapid.

A South Hertfordshire resident commented that urgent care centres in Hertfordshire were no longer running. Ms Taylor gave assurance that there would be liaison with South Hertfordshire to ensure that services complemented each other. A Councillor from Broxbourne District Council reported that the urgent care centres had not closed but were now operating as minor injury units. Severe problems in residents being able to register with a GP had been highlighted and the District Council was engaging consultants to look at the issue.

Mark Easton (Chief Executive of Barnet and Chase Farm Hospitals) outlined progress that had been made in developing Barnet and Chase Farm hospitals. Whilst Barnet would focus on emergency, maternity and paediatric care, Chase Farm would cover planned care. An additional maternity ward would be provided to deal with increased demand for maternity services. The additional maternity capacity would be available from 2014. There would also be additional capacity at NMUH. £15 million would be spent on remodelling Chase Farm. This would be funded by a loan from the strategic health authority for which a business case was currently being developed. £20 million would be spent on Barnet and this would involve remodelling A&E including provision for paediatrics. ITU would also be expanded. There would also be an additional CT scanner. The cost of the remodelling would be offset by the possible sale of derelict land on the site. The trust would have to demonstrate to the strategic health authority that it could afford the loan.

It was noted that diagnostics would still be provided at Chase Farm. In the event of an emergency, residents from South Hertfordshire would probably be taken to Harlow once the changes at Chase Farm had been fully implemented as this would then be the nearest alternative A&E. Ms Taylor agreed to provide the Committee with information on additional provision for ambulance vehicles that might be necessary for the implementation of the strategy.

Mr Easton stated that no land sales were yet planned for the Chase Farm site. Any proceeds from land sales would be re-invested in services by the trust although no guarantee of this could be given as this would need to be agreed by NHS London as the trust had not yet gained FT status.

Claire Panniker (Chief Executive, NMUH) outlined recent developments to NMUH. It received roughly half its patients from Enfield and half from Haringey. There were no significant patient flows from elsewhere. Its services were focussed on dealing with emergencies. It was fully Care Quality Commission (CQC) complaint and had received very positive feedback from recent inspections. The new hospital buildings had been opened in June 2011 and most of the site now contained state of the art facilities. Two thirds of patients for services that were to be reconfigured as part of the Clinical Strategy who would previously have been dealt with at Chase Farm before implementation would now be treated at NMUH. Action was being taken to ensure that the necessary developments to facilities and the work force were made. A business case was being developed and this would be used to develop 120 extra adult inpatient beds, including extra women's and children's beds, a Paediatric Assessment Unit, a new building to provide consultant-led maternity care at all levels, a larger special care baby unit, two new operating theatres and a women's out patients and additional inpatient ward. This was scheduled to be implemented by 2013. There would also be an increase in the number of A&E consultants. This would enable extended consultant cover to be provided in A&E.

The Chair commented that NMUH had made considerable progress in recent years. It had not been well regarded by residents and there was evidence that this perception was now changing. Councillor Cazimoglu commented that the hospital covered a deprived area and it did not need additional pressure placed on it. Councillor Pearce stated that although the hospital had improved immensely, transport remained a major issue and it was particularly inaccessible form the west of Enfield.

Ms Panniker responded that the hospital could not stay as it currently was as its financial position would deteriorate. Whilst the transport issue could not be underestimated, the vast majority of patients would continue to receive services in the same settings as before. It would be mainly people who were very unwell who would be affected by the change and they were comparatively small in number. The majority of patients currently treated at Chase Farm would continue to be treated there or at locations even closer to their home.

A Haringey resident asked how the needs of migrant and refugee communities would be addressed within the modelling. Many people from these communities were not registered with a GP. Dr Russell stated that there should be no excuse for not being able to access primary care. There were a number of GP practices that were very experienced at dealing with some communities. Ms Panniker reported that the urgent care model that was in place at NMUH enabled patients to register with GPs when they attended.

Mr Easton commented that very few clinicians only worked on one hospital site so any reduction in the services provided at one location would have limited impact on attracting and retaining staff. The feasibility exercise nevertheless needed to look at recruitment and retention issues. The uncertainty about the future of Chase Farm was having an effect on the ability of the trust to recruit. Changes in A&E provision had taken place in London in recent years with some areas of activity being specialised and not provided at every centre e.g. major trauma and stroke. As a result of this, Chase Farm was already no longer a major A&E department.

The Chair thanked NHS officers from all the trusts in attendance for their assistance. He was of the view that considerable work was required to reassure the local community about the future long term arrangements. The Committee would consider future arrangements for monitoring the implementation of the strategy, including the involvement of Hertfordshire County Council, once the potential judicial review issue had been resolved. It was essential that significant investment was placed into primary care in Enfield and that improvements were implemented speedily.

RESOLVED:

1. That the Committee consider further the arrangements for monitoring the implementation of the BEH Clinical Strategy, including the potential involvement of Hertfordshire County Council, once the issue of the potential judicial review by Enfield Council has been resolved.

2. That NHS North Central London be requested to share the report of the Transport Working Group on transport issues arising from the implementation of the BEH Clinical Strategy with the Committee.

3. That NHS North Central London be requested to provide information to the Committee on the additional number of ambulance vehicles that would be provided as part of the implementation of the strategy.

FINISH:
The meeting closed at 13:15 p.m.

CHAIR:

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

5 December 2011

JHOSC Terms of Reference

1. Introduction

1.1 This report outlines the current agreed scope, terms of reference and procedural arrangements for the JHOSC.

2. Recommendation

2.1 Members are requested to note the report

3. Terms of Reference and Scope for the JHOSC

3.1 In January 2010, Chairs of health scrutiny committees in the north central London sector agreed to set up a JHOSC to engage with the NHS on the North Central London Service and Organisation Review, which was set up by the NHS to consider sector wide options for reconfiguring acute care. The proposals arising from this would have had wide ranging implications for health services across the sector and undoubtedly constituted a "substantial variation", thus requiring formal consultation and the establishment of a JHOSC.

3.2 The principle of the establishment of the JHOSC and the terms of reference were agreed by each Council prior to the 2010 local government elections. Following the local government elections, appointments to the JHOSC were made by each of the constituent Councils. The number of representatives per borough (two) was also agreed prior to the local government elections

3.3 Following the general election the review process was suspended in the light of a change of policy by the incoming coalition government. In the meantime, NHS North Central London was established formally and took on a more significant role than was envisaged when it was originally set up as a sector wide commissioning agency. Significant numbers of key strategic commissioning decisions began to be taken at sector level rather then by individual PCTs. In addition, NHS North Central London became the transitionary body for the switch to GP led commissioning.

3.4 The JHOSC met informally on 2 August 2010 and considered how to respond to the changing circumstances. It agreed to broaden the scope of the JHOSC so that it had a standing role in scrutinising strategic sector wide issues through regular engagement with NHS North Central London. In addition, it would also consider any proposals involving significant reconfiguration of services across the sector. Finally, it would also have a role, where appropriate, in responding to any proposals for changes to specialised

services where there are comparatively small numbers of patients in each borough and commissioning was undertaken on a cross borough basis.

3.5 As a result of this, the revised terms of reference were agreed by each participating authority. These were as follows:

"1. To engage with NHS North Central London on strategic sector wide issues in respect of the commissioning of health services across the area of Barnet, Camden, Enfield, Haringey and Islington; and

2. To scrutinise and respond to stakeholder engagement, the consultation process and final decision in respect of any sector wide proposals for reconfiguration of specific services in the light of what is in the best interests of the delivery of a spectrum of health services across the area of, taking account of:

- The adequacy of the consultation being carried out by the health bodies including the extent to which patients and the public have been consulted and their views have been taken into account

- The impact on the residents of those areas of the reconfiguration proposals, as set out in the consultation document

- To assess whether the proposals will deliver sustainable service improvement

- To assess whether the proposed changes address existing health care inequalities and not lead to other inequalities

- The impact on patients and carers of the different options, and if appropriate, which option should be taken forward

- How the patient and carer experience and outcomes and their health and well-being can be maximised whichever option is selected

- Whether to use the joint powers of the local authorities to refer either the consultation or final decision in respect of the North Central London Service and Organisation Review to the Secretary of State for Health.

3. The joint committee will work independently of both the Executive and health scrutiny committees of its parent authorities, although evidence collected by individual health scrutiny committees may be submitted as evidence to the joint committee and considered at its discretion.

4. To maintain impartiality, during the period of its operation Members of the Joint Committee will refrain from association with any campaigns either in favour or against any of the reconfiguration proposals. This will not preclude the Executives or other individual members of each authority from participating in such activities.

5. The joint committee will aim work together in a spirit of co-operation, striving to work to a consensual view to the benefit of local people"

3.6 The agreed terms of reference were not intended to reduce the power of individual health scrutiny committees to engage with their PCT on local issues. NHS North Central London indicated that they would continue to work with individual PCTs to support them in engaging with local health scrutiny committees.

4. Procedural Arrangements

4.1 In terms of the procedural arrangements, the following was agreed:

Quorum

- The quorum for the JHOSC is one Member from four of the participating authorities. In the event of a meeting being inquorate, it can still proceed on an informal basis if the purpose of the meeting is merely to gather evidence. However, any decision making is precluded.

Voting Rights

- Due to the need for recommendations and reports to reflect the views of *all* authorities involved in the process, one vote per authority was agreed as more appropriate then each individual Members being given a vote. It is nevertheless to be emphasised that decisions by the joint committee should be reached by consensus rather than a vote. Every effort should therefore have been made to reach agreement before a vote is taken.

Dissent and Minority Reporting

- It was recognised that issues that emerge during the work of the JHOSC may be contentious and there therefore might be instances where there are differences of opinion between participating boroughs. The influence of the JHOSC will nevertheless be dependent on it being able to find a consensus. Some joint committees have had provision for minority reports but these powers can, if used, severely undermine the committee's influence. Whilst such provision can be made for the JHOSC, it is agreed that use of it is only made as a last resort and following efforts to find a compromise.

Writing Reports and Recommendations

- The responsibility for drafting recommendations and reports for the JHOSC is shared amongst participating authorities. It is recognised that this may be challenging due to the possibility of there being conflicting interests amongst participating authorities but in the current financial climate it is unlikely that it will be possible to fund any external assistance except in exceptional circumstances.

Policy and Research Support and Legal Advice to the Joint Committee

- This is jointly provided by all of the participating authorities. Each authority is responsible for supporting its own representatives whilst advice and guidance to the JHOSC will be provided, as required, through liaison between relevant authorities. Consideration could be given by the JHOSC, in due course, to the provision of external independent advice and guidance, should it be felt necessary. This could be of benefit if it enables the joint committee to more effectively challenge the NHS and may be of particular assistance in addressing issues of a more technical nature, where lack if specific knowledge could put the joint committee at a disadvantage.

Administration

- Clerking responsibilities are shared between participating Councils, with the borough hosting a particular meeting also providing the clerk.

Frequency and location of meetings

- Meetings rotate between participating authorities for reasons of equity and access.

Servicing costs

- In the current financial climate, it is unlikely that it will be possible to meet any costs arising from the work of the JHOSC except on an exceptional basis. Any such financial commitments will need to be agreed beforehand and the cost split between the participating authorities.

Transforming Child and Adolescent Services for Young People Living in Barnet, Enfield and Haringey

Report for the Joint Overview and Scrutiny Committee

NHS North Central London

5th December 2011

1.0 Statement of Intent

The NHS in Barnet, Enfield and Haringey, working with their partners in the Local Authorities and with a range of stakeholders including children and young people, are looking to further improve the way that local CAMHS is configured and delivered for adolescents with severe and complex mental health needs.

The proposed changes, set out in this document, are part of a continuous focus on quality, improvement, productivity and prevention across all health services, and in particular responds to the National CAMHS Review which was published in 2008. The work of the commissioners and their local provider, Barnet, Enfield and Haringey Mental Health Trust, has focused on benchmarking local performance against national data, reviewing published best practice, addressing spend and cost at a time of reduced budgets and seeking to redesign a total pathway to improve outcomes and meet the individual needs of young people and their families.

The report to the PCTs' Joint Boards meeting of 1 December makes recommendations for changes to enable the implementation of the new clinical model with enhanced community team support and there is an agreed timetable for the production of the business case for this service redesign project, which commissioners are working with Barnet, Enfield and Haringey Mental Health Trust to develop and implement in a joint planning partnership.

2.0 Proposal History

The joint Overview and Scrutiny Committee has received reports on this transformation project in July 2011 and September 2011. On each occasion the committee has raised a number of significant concerns and has recommended that these be addressed prior to submission to the Joint Boards of NHS North Central London for consideration.

This paper responds to the issues raised by the committee with particular reference to the:

- clinical evidence base underpinning the proposals
- delivery of a clear pathway
- local consultation and its impact on the redesign process

- Implementation planning

3.0 Good practice in CAMHS Care Pathways

Recent national research has recommended that CAMHS works most efficiently and effectively for young people when it is able to offer intensive community focused services at times of need, which provide 'wrap around' support for young people in their own environment (Green and Worrall, 2008, Kurtz, 2009 and Sergeant et al., 2010). This intensive community support bridges the gap between mainstream community mental health care and inpatient/residential services, providing more individualised options along a continuum of care.

Studies into the outcomes for young people with severe and complex mental health needs indicate that because there is so much variability in the home and school environment of each child there is not a "gold standard" of evidence upon which to decide which model is best for which group of young people (Green and Worrall-Davies, 2008). However, reviews of the field have concluded that a spectrum of intensive services should be offered. For example, Sergeant et al (2010) discuss the benefits of recent interest in "stepped care" models offering inpatient, day-patient and intensive outpatient programmes more pragmatically and flexibly.

Literature reviews into improving outcomes for adolescents indicate that care pathways should seek to minimise the length of any inpatient stay and to support a carefully graded transition back to the young person's community through enhanced services, minimising disruption to home and school environments. In addition, such services can tailor treatment components to the needs of each individual and family, and are well placed to assess risk and provide the required level of intensity of treatment. This view is echoed by Green and Worrall-Davies (2008), who conclude that

"In an ideal future there would be a set of flexible and complementary platforms for the delivery of intensive care for acute and complex disorders."

4.0 Benchmarking

When comparing data collected nationally on CAMHS (national CAMHS data mapping exercise 2007/8) there is evidence that Barnet, Enfield and Haringey spend a significantly higher proportion of funding on hospital or residential care for young people. Locally 35% of the current £17million investment in CAMHS is spent on inpatient services, in comparison to 26% in comparable areas (groupings based on issues including deprivation). Therefore the current structure of provision in less likely to prevent young people being

required to break contact with their community (family, friends, education etc) and more likely to require a long inpatient stay.

5.0 Local Models of Care

Within the wider north London health and social care system, commissioners and their provider partners have been working to address gaps in provision. For example, in Camden and Islington there has been a significant restructure of the inpatient provision and an investment in an intensive community team to support individuals and their families. The model has led to a reduction in admissions and length of stay in inpatient care, and an increased offer to young people and their families in the community.

Within Enfield commissioners have piloted an intensive community model of care which, following a year of operation can positively and clearly demonstrate that intensive or enhanced support in the community can prevent admission and reduce the length of stay in inpatient care. The Alliance Model has provided excellent local data about what can be achieved by investing in additional community care and bridging the gap between community and inpatient provision.

6.0 Evidence Base

There appears to be a good evidence base to demonstrate that adolescents with severe and complex mental health need benefit from:

- Enhanced community support which can be flexible in working with them as individuals, and with their families, in the community
- Inpatient care that works with, or is integrated with, enhanced community teams working with young people for short periods of time and supporting rapid discharge

The evidence does not indicate whether inpatient units have to be geographically located in close proximity to enhanced community teams, but it might be assumed that this has basic advantages in terms of communication and relationship development.

Measuring outcomes for young people with complex needs can be challenging, however, a reduction in the number and length of inpatient stays is an excellent proxy measure for a system that is supporting people well in the less restrictive platforms of care.

7.0 Stakeholder Views

The NHS in Barnet, Enfield and Haringey, having assessed the clinical evidence base, with good knowledge of the current local gaps in provision for

adolescents, and knowledge of the reducing level of referrals to the current inpatient units proposed the following:

- To develop enhanced community teams in each borough
- To close the Northgate inpatient unit, with its model of care based on longer lengths of stay
- To commission New Beginning to provide a greater breadth of inpatient care locally (including seeking to meet the needs of some young people closer to home rather than in out of borough placements)

The proposals aimed to reshape service provision to improve outcomes and also responded to the need to provide services more efficiently and produce savings to be returned to the PCTs. The proposals relating to the first two bullet points aimed to deliver a £550,000 saving across NHS Barnet, Enfield and Haringey.

This proposal was presented in formal consultation. The learning from this consultation was presented in the 29 September Board report and is set out in the supporting papers for this document.

Views of Young People:

There was a good response to the consultation from young people, both from those who use tier 3 clinic based care currently and those who are or have been inpatients.

There was a significant level of support for the development of enhanced community teams, where most young people commented on the benefit of accessing support more regularly and in a range of environments (i.e. not just within formal clinics) at times of need. However, for a significant minority of young people, particularly those who had experienced care in the unit, the closure of the Northgate Unit was a real concern, as was a proposal to integrate therapeutic care in a crisis unit such as New Beginning.

The temporary closure of Northgate to admissions, agreed prior to the consultation, seemed to indicate that stakeholder views were not being considered and that decisions had already been made. However, the restriction on referrals was the result of two factors;

- A decision to ensure that no young person would have to be moved part way through a treatment package, which in the Northgate model of care was approximately 9 months, if the consultation was supported
- A requirement to decant the building in order to refurbish specific areas.

Other stakeholder views

In line with the views of young people, the consultation indicated strong support for enhanced community teams from other stakeholders including local authority and mental health partners. However, the inpatient solution continued to give a level of concern, particularly that the closure of Northgate and the remodelling of New Beginning would lead to an increase, rather than a reduction of young people being admitted to out of area placements. In addition, concerns were expressed about the continued disjointed nature of the care pathway with young people being referred on and reassessed by different parts of the system (clinic based care, enhanced teams and inpatient units).

Responding to stakeholder views

The commissioners have responded to these views and with Barnet, Enfield and Haringey Mental Health Trust have developed a care pathway that builds further on the clinical evidence base to develop therapeutic care across community and inpatient services. In addition, the new model of care gives a greater focus to the inpatient requirements and proposes, not a simply a remodelled New Beginning but a unit that can meet the needs not only of clients traditionally seen in the two current units, but also young people currently based in out of area placements.

The new version of the clinical model still requires the closure of Northgate and it is acknowledged that some young people will continue to feel this is not in the best interest of adolescents. However, basing planning decisions on the recommendation that lengths of stay in inpatient care should be reduced in order to improve outcomes, it seeks to provide a range of therapeutic options across community and inpatient care. In addition, the inpatient provision proposed in the new model will remain on the Edgware Community Hospital in the Northgate building.

The NHS in Barnet, Enfield and Haringey have established a focus group with young people to continue to shape the development of CAMHS services and any changes in care for adolescents with severe and complex needs. This group is planned as an ongoing group and will be in regular contact with commissioners to guide implementation.

8.0 A new model of care

NHS Barnet, Enfield and Haringey have developed a new commissioning framework for CAMHS for adolescents (aged 12-18) with severe and complex mental health needs which will include:

- Clinic based multidisciplinary care (the current tier 3)
- Enhanced therapeutic care that should ensure that even the most complex of mental health needs can be met in the community

- A model of care that ensures that if a young person does require inpatient admission they continue their contact with the enhanced therapy they had been receiving in order to facilitate appropriate transfer back to the community
- Inpatient provision that supports high dependency and acute care for a wider range of young people including those with specialist needs (learning disabilities and forensics)

In terms of key performance indicators the commissioning framework will seek:

- Overall reduction length of stay in inpatient care
- Reduction in admissions
- Reduction in out of area admissions in crisis
- Improved client satisfaction
- Improved HONOSC scores (measure of mental wellness)

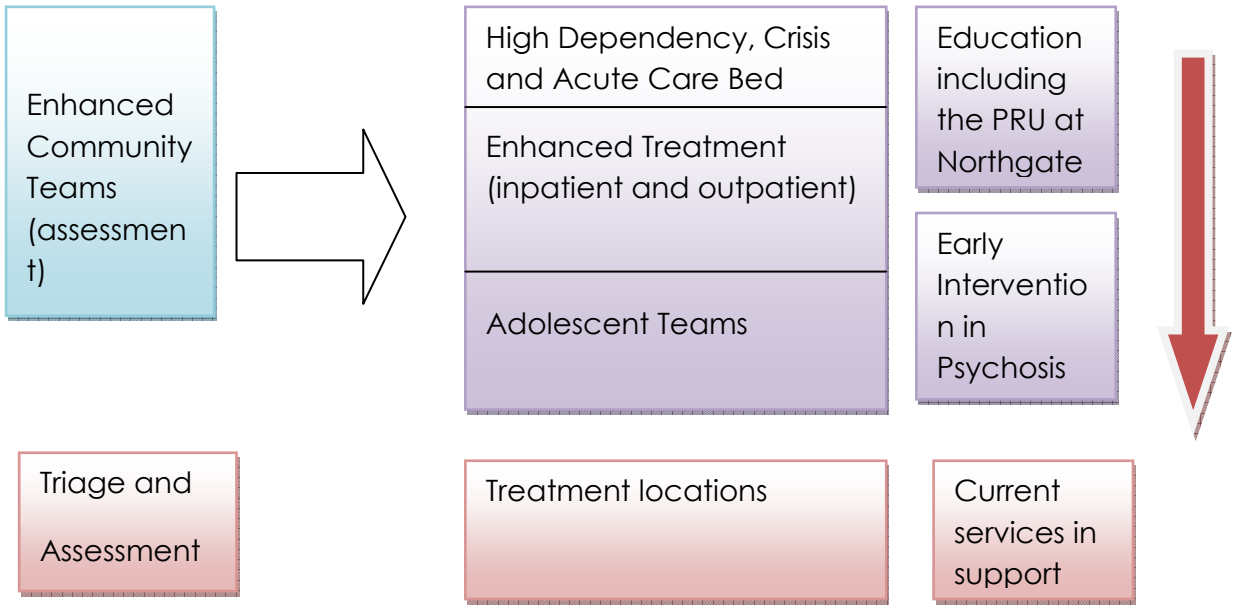
Barnet, Enfield and Haringey Mental Health Trust proposal

The provider has developed a clinical model to respond to this brief.

The trust see a real opportunity to provide an integrated model of care and move away from the delivery of separate teams, or tiers of provision. Therefore clinic based care will be integrated with the enhanced community teams, who in turn will work with the young person within the inpatient unit on any given admission. Rather than separating inpatient provision into different units, there will be the resources available in a single unit to meet; high dependency, crisis, acute and treatment needs. A young person will need different inputs during an admission and this care will be flexed around them, without them needing to move unit or bed, in addition they will retain their enhanced community team key worker who will ensure the young person has a clear discharge plan on admission, facilitating appropriate transfer to the community when clinically ready. The therapeutic community previously established in units such as Northgate will not be replicated in the new model however learning from the Northgate model will be incorporated and group work will be provided across the inpatient unit and the community.

The trust refer to the model as a ‘gravity model,’ with the key worker clearly based in the community, they will work with the young person to achieve the least restrictive environment for care at any given time, but with quick access to enhanced community input or to inpatient beds when required. By establishing the enhanced community team as the main assessment and key worker provision, there will be a reduction in assessments that young people require and the key worker will act as the navigator through various platforms of care, including inpatient.

Diagram 1.



The enhanced community teams for each borough, based in the community would work with young people to determine the level of care required at any given time and to hold and manage the young person's care plan.

Impact

The comprehensive model of care proposed draws heavily on experience in other care environments including eating disorders, personality disorders and forensic provision in adult services and some specialist adolescent services. The model is designed for optimum efficiency where the enhanced community teams are able to work with the young person in a local inpatient unit, but would also work if a young person needed an out of area admission where the key worker would manage regular contact with the provider to facilitate a discharge plan (This is achieved in the Alliance Model).

The model draws on good practice and is innovative where the enhanced community team in this model remain a constant for the young person as their care needs flex and change until such a time that they are discharged back to clinic based care or no longer need CAMHS services.

Education

London Borough of Barnet has stated that it intends to maintain the PRU on the Northgate site. It has excellent results and is the preferred education model identified by the mental health provider to support the inpatient clinical model. Discussions with Enfield and Haringey Local Authorities are on-going in relation to the model of education they wish to purchase for their young people. These have been positive to date with a commitment from each LA to ensure each child has a clear education plan and to establish more robust planning and oversight of these through local Complex Care panels. It is noted though, that changes to length of stay for treatment may also change each LA's requirements for the type and extent of support required from Barnet PRU. This will need planning on a case by case basis and the NHS can only support discussions in this area, advising on potential impact of the new model on expected lengths of stay. The commissioners and BEHMHT will continue to work with the Local Authorities to ensure that young people achieve the greatest benefit from any inpatient stay.

9.0 Developing a financially affordable case

The Barnet, Enfield and Haringey Mental Health Trust proposal relies on a restructuring of provision across:

- Parts of tier 3 services (specifically adolescent teams which are part of the multi-disciplinary clinic based teams joint funded with the Local Authorities)
- Local Inpatient Units (Northgate and New Beginning)
- Out of Area Inpatient Units

In the next phase of the business planning process therefore we must ensure the further engagement of local authorities to agree changes, if any are required, in commissioning arrangements for adolescent clinic based care. There is currently work being undertaken by the commissioners and provider to jointly review cases placed in out of borough units to ensure that their clinical needs can be met in the model of care that has been designed by the trust. This is a complex process and is essential in ensuring that sufficient NHS resource can be redirected from out of area providers to fund a local provision.

The business case must demonstrate financial affordability for both the Trust and commissioners particularly from the re-provision of inpatient beds in the locality rather than in high cost out of area placements.

10.0 Enablers

The commissioners and provider are agreed that it is increasingly important to take the recommended decisions to end the extended period of uncertainty

during which the Northgate Unit is closed to admissions and alternative provision is being made in existing community teams and, if necessary, out of area placements. Whilst the details relating to the business case are jointly assessed, a number of inter-dependent and enabling actions need to take place which should be seen as facilitative steps towards the new model of care. The enablers for the new model of care are:

- The closure of the Northgate Unit – this can be achieved swiftly as the unit is not currently accepting referrals and will release £1.2 million (pro rata) to facilitate system change
- The reinvestment of £650,000 (and the current Enfield Alliance resource of £125,000) in enhanced community teams across the three boroughs – this will ensure that policies and procedures can be developed and the triage, assessment and key worker model can be piloted
- Release of £550,000 back to the NHS as part of the QIPP plan

It is acknowledged that during this period of change adolescents with severe and complex needs may require an inpatient admission. This will be facilitated through commissioners purchasing placements, either at New Beginnings (which will accommodate some non-crisis admissions if the environment is considered appropriate, as well as continuing to take all crisis admissions) or from other NHS and private provision in other boroughs: Simmons House, The Bourne, SLAM and Brookside. These placements will be funded separately by commissioners. The initial enhanced community teams will work with these young people and with the unit where they are admitted to achieve a clinically appropriate admission and length of stay, and to facilitate discharge. It is acknowledged that building links with units out of area has a number of challenges which is why it is important to work with units who share a philosophy about the importance of minimising a break in contact for young people with their communities.

11.0 Managing Risk

The safety of young people is a key issue for the commissioners and provider and both agree that the new model does deliver a system of care that can support adolescents with severe and complex needs. The implementation of the enablers is a positive step change as part of the implementation of the full care pathway and model of care on approval of the business case. The commissioners and provider agree that the enablers will bring new challenges but they will also reduce the risks that were inherent in the previous system. They will also support learning which will be beneficial when the inpatient element of the new model of care is established. It is acknowledged that it will be important to work closely with a small number of NHS inpatient units to support the establishment of relationships and good communication.

Although no system can eliminate all risk, the proposals offer an appropriate and effective approach to risk management.

12.0 Implementation

The proposals to redesign CAMHS provision for adolescents with severe and complex mental health needs has been developed over time and has received significant comment from stakeholders. Key to providing stakeholder confidence about the new model of care is ensuring a clear implementation plan.

The commissioners and provider propose the following sequencing to ensure this major service redesign can be achieved. Both parties are seeking quick implementation to ensure that the highest quality care is available for young people and that savings can be released appropriately.

Key actions and milestones are listed below:

- Closure of Northgate Unit by December 2011
- Development of Enhanced Community Teams in each borough from January 2012
- Completion of Business Case by January 2012
- Review of Business Case by appropriate bodies by February 2012
- Consultation with New Beginning staff to facilitate move to new inpatient unit by March 2011
- Implementation of new inpatient model from April 2012
- Extension of enhanced teams across community and inpatient provision from April 2012

The following recommendations are therefore being made to the Joint Boards' meeting on 1 December 2011:

The Joint Boards are asked to DELEGATE authority to the Chair and Chief Executive to consider any further views of the Joint Health Overview and Scrutiny Committee on 5 December 2011 and, if appropriate:

- APPROVE the establishment of enhanced community teams in each Borough as part of a clear care pathway for adolescents (12-18) requiring intensive CAMHS support
- APPROVE the closure of the Northgate Inpatient Unit as an enabler to the implementation of a new care pathway
- NOTE the provision of inpatient care for adolescents previously admitted to Northgate at New Beginnings and other NHS and private providers (Simmons House, The Bourne, SLAM and Brookside) and the plan to deliver a remodelled inpatient unit on the Edgware Community Hospital site as part of the new model of care
- AGREE to receive the business case being jointly developed with Barnet, Enfield and Haringey Mental Health Trust, which is subject to QIPP review, to ensure a new inpatient unit provides effective crisis

care and on-going treatment and reduces out of area admissions, operating as an integral element of care pathways coordinated by enhanced community teams delivering specialist therapy services.

As previously stated the young people's focus group (with representation from across CAMHS) will be central to ensuring that implementation is managed to best meet the needs of current and future service users. This group will meet with planners on a monthly basis and provide regular input via various media including e-mail etc. on an on-going basis.

13.0 Conclusion

The NHS in Barnet, Enfield and Haringey are committed to improving the quality of care for adolescents with severe and complex mental health needs. The commissioning PCTs are looking to achieve a range of enhanced care and support in the community for young people in line with best practice guidance. In addition, a local inpatient solution is sought that provides clinically appropriate care and reduces the risks currently being held by the provider in operating two units at significantly less than full capacity.

There is an acknowledgement that through investing in enhanced community teams, commissioners are seeking to reduce inpatient care provision and costs. However, if a clinically and financially sustainable business case can be agreed both the commissioner and the local provider are keen to develop a single inpatient unit that can not only support young people who have previously met the New Beginning and Northgate admission criteria but also some of those currently sent out to other providers across London.

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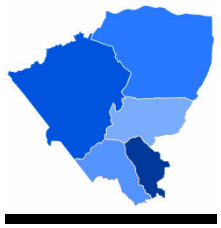
NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: QIPP Performance Update	
REPORT OF: Liz Wise Director of QIPP NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** Monday 5th Decemeber
SUMMARY OF REPORT: An update on QIPP performance. CONTACT OFFICER: Lorraine Robjant Associate Director Service Transformation NHS North Central London	
RECOMMENDATIONS: To note the update.	
Liz Wise Director of QIPP **DATE: 21st November 2011**	



NHS
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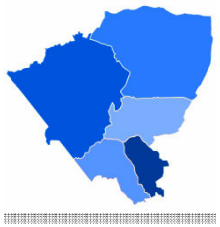
QIPP Performance

Liz Wise
Director of QIPP
NHS North Central London



QIPP Performance

Performance at October (month 07)

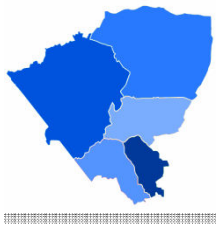
- ❑ Plan £137 million
- ❑ Forecast outturn £118 million

Additional QIPP identified – £15.3 million

- ❑ Medicines management challenges high cost drugs
- ❑ Borough prescribing efficiencies
- ❑ Acute data challenge
- ❑ Primary care
- ❑ Borough initiatives

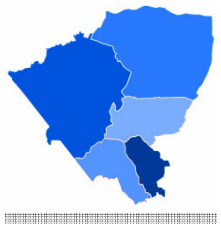
Risk Assessment of Forecast Outturn

123 red rated projects	• Value of £12m (10%)
101 amber rated projects	• Value of £22m (19%)
241 green rated projects	• Value of £84m (71%)



Delivering Operational Excellence

- 2012/13 contracting process
- Claims management
- Medicines management
- Unscheduled Care
- Mental Health
- Continuing Care
- Community / integrated care



Developing the High Performing Organisation

- Clinical leadership
- Performance management
- Organisational development

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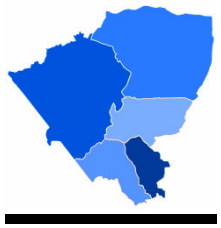
NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: Unscheduled Care	
REPORT OF: Aimee Fairbairns Associate Director Unscheduled Care	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** Monday 5th Decemeber
SUMMARY OF REPORT: 1. Unscheduled Care QIPP workstream 2. NHS 111 national programme CONTACT OFFICER: Aimee Fairbairns Associate Director Unscheduled Care NHS North Central London	
RECOMMENDATIONS: To note and comment on Unscheduled care, and implementation of NHS 111 national programme within North Central London.	
Aimee Fairburns Associate Director Unscheduled Care **DATE: 21st November 2011**	



NHS
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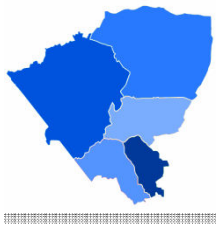
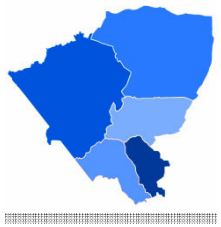
Unscheduled Care

Liz Wise
Director of QIPP
NHS North Central London



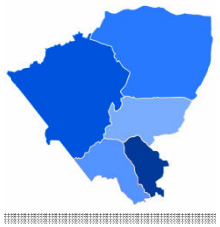
Unscheduled Care

- Vision and strategy
- Whole system approach, ensuring;
- Right Care, Right Time, Right Place
- Shifting unscheduled care to planned care
- Improving patient experience and outcome
- Sustainable



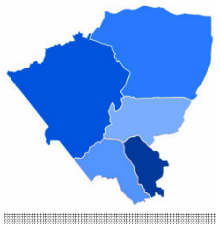
Aim

- To transform unscheduled care by development and commissioning of integrated services
- These will be efficient and robust, and address increasing levels of unplanned secondary care through the enhancement of integrated working between GP practices, out of hours services, unscheduled care provision, community services and social care
- This will take into account good practice from within NCL, across London and from other parts of the NHS
- The national priority to establish a single point of access is a key element



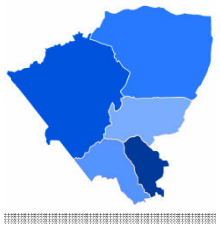
Initiatives

- NHS 111 (NCL implementation date 01/01/13)
- Urgent Care Centres (range of pilots and models)
- Appropriate Care Pathways (LAS)



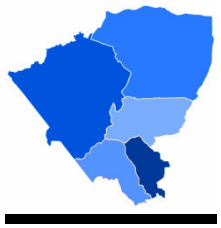
Key interfaces and enablers (whole system)

- Primary Care Strategy
- Care closer to home
- Community Services
- Mental Health services
- Admission avoidance initiatives
- Social Care



Urgent Care Centres

- Co-location with A&E to deliver: right care, right place, first time
- Primary care clinical expertise
- Internal and external benefits
- Whittington, Royal Free, Chase Farm, North Middlesex University Hospital, UCLH
- Evaluation and monitoring of benefits, quality and value for money



NHS

North Central London

NHS 111 Pilot

Background

Research shows the public find it difficult to access NHS services. People are confused about what services are available to meet their urgent healthcare needs and how those services should be accessed, especially outside normal working hours. Therefore people will often default to A&E or 999 when other services might better suit their needs.

Following successful implementation of four national NHS 111 pilot sites the Department of Health and NHS are committed to the national roll-out of the NHS 111 Service.

NHS 111 is supported by the **public, British Medical Association, Royal College of General Practitioners, Royal College of Physicians,** all **SHAs** and London's **clusters**. **London Ambulance Service, NHS Direct** and **GP out of hours providers** are positively engaged in London's pilot areas.

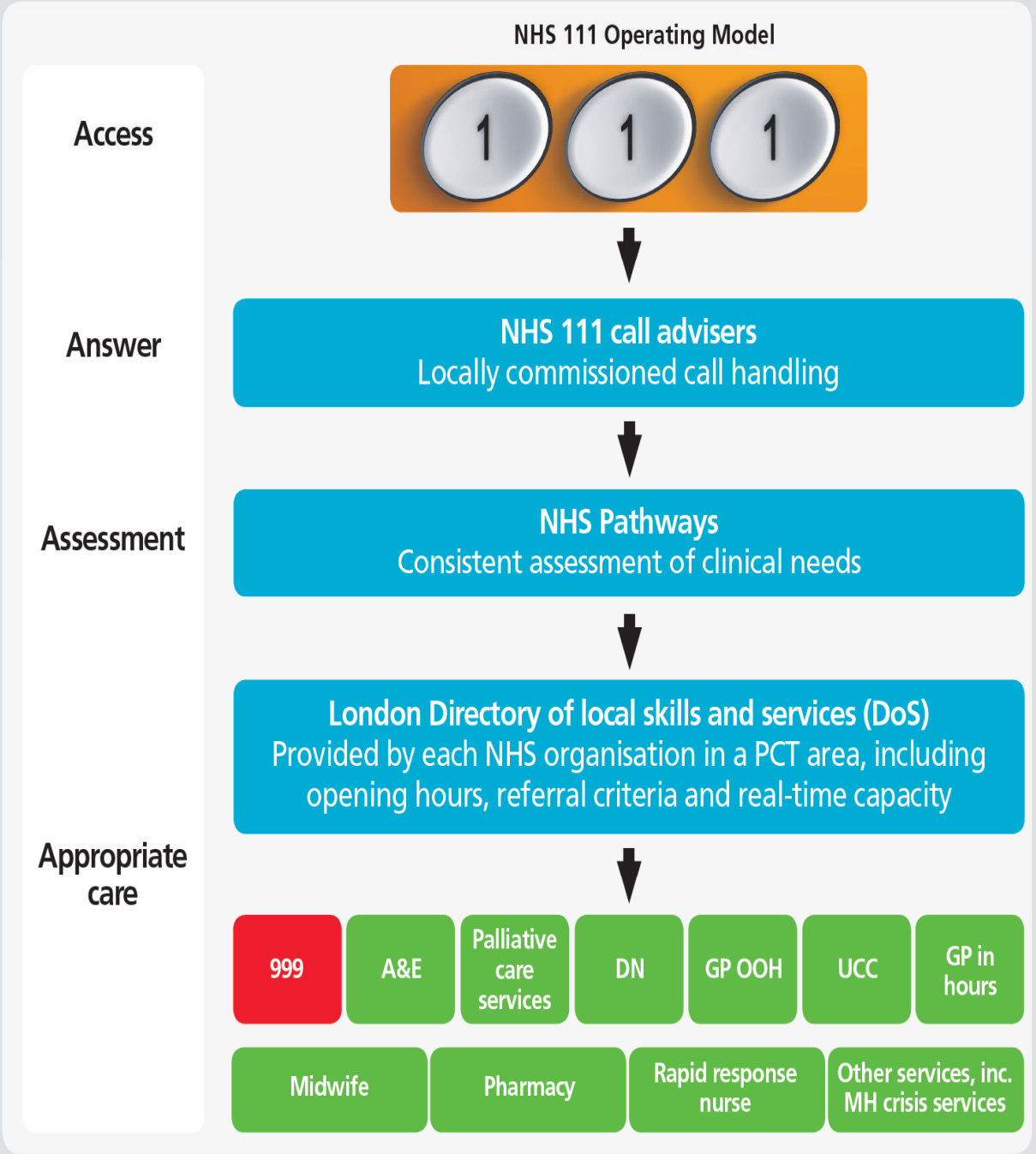
Underpinning the success of London's 111 service and its contribution to improving urgent care access is the significant effort by commissioners and providers to populate the Directory of Services, which uniquely for London includes **mental health crisis services** and the **End of Life Care register**.

Overview

The NHS 111 service will make it easier for the public to access urgent healthcare and also drive improvements in the way in which the NHS delivers that care.

The easy to remember, free to call 111 number will clinically assess callers during their first contact and direct them to the right local service, first time.

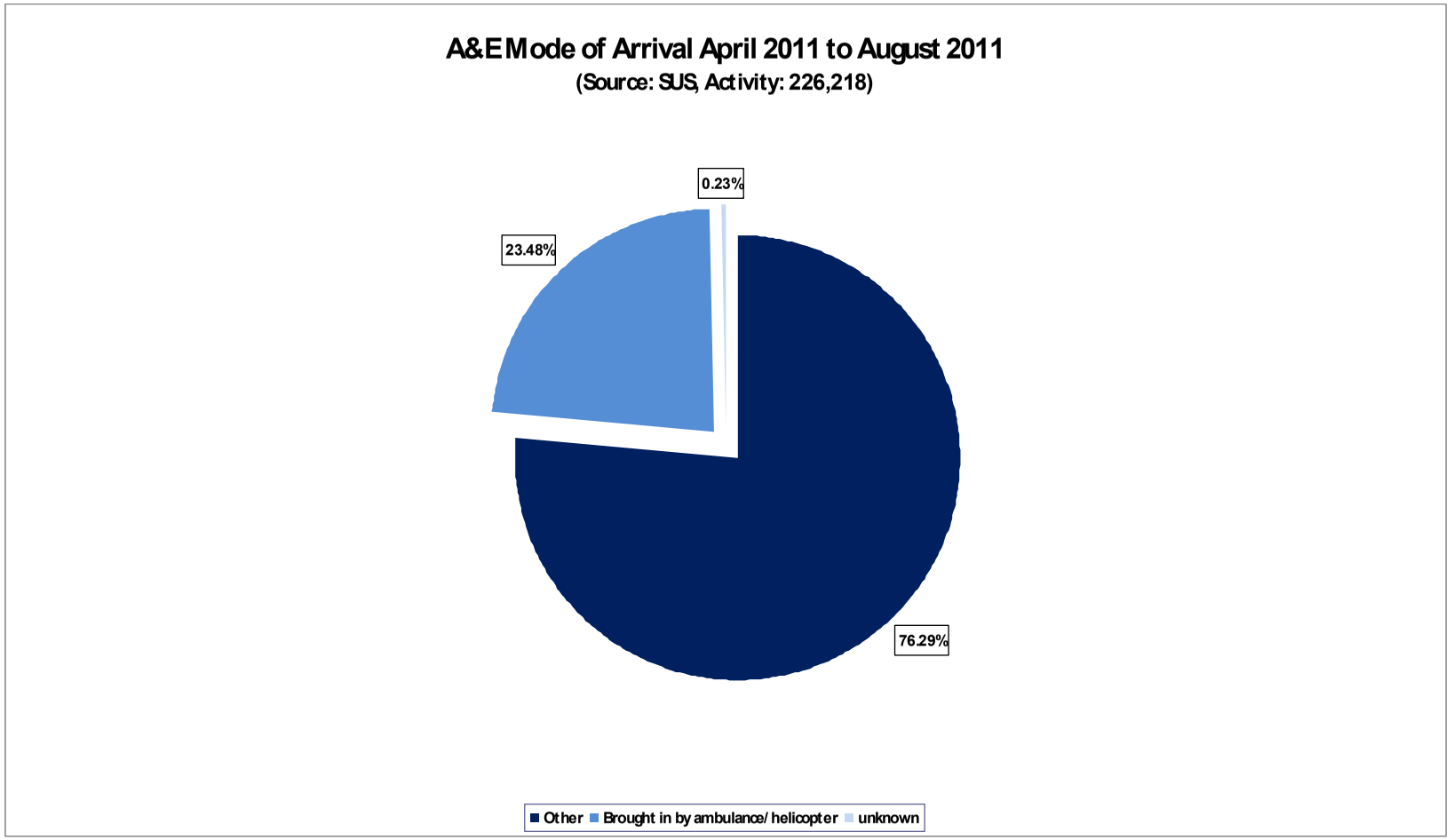
London is officially an NHS 111 pilot site with staged roll-out of NHS 111 services across the capital, achieving pan-London coverage by 2013, in-line with national roll-out.



Benefits

- Improve public access to appropriate unscheduled healthcare services;
- Increase the efficiency of the NHS by ensuring that people are able to quickly and easily access the healthcare services they need;
- Increase public satisfaction and confidence in the NHS;
- Enable the commissioning of effective and productive healthcare services that meet people's needs;
- Reduce non-emergency calls to 999, so London Ambulance Service can focus on real emergencies.

Mode of Arrival



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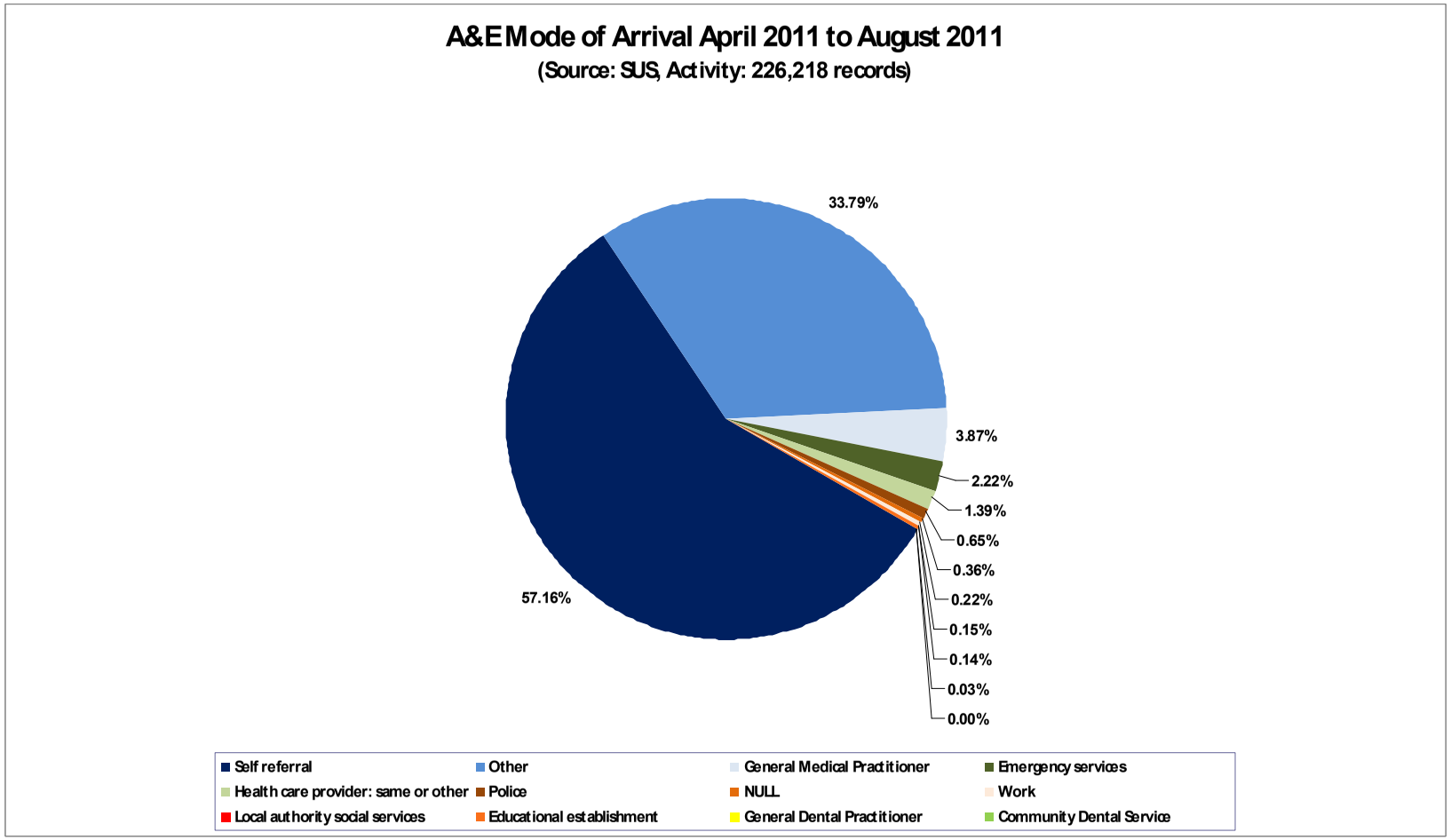
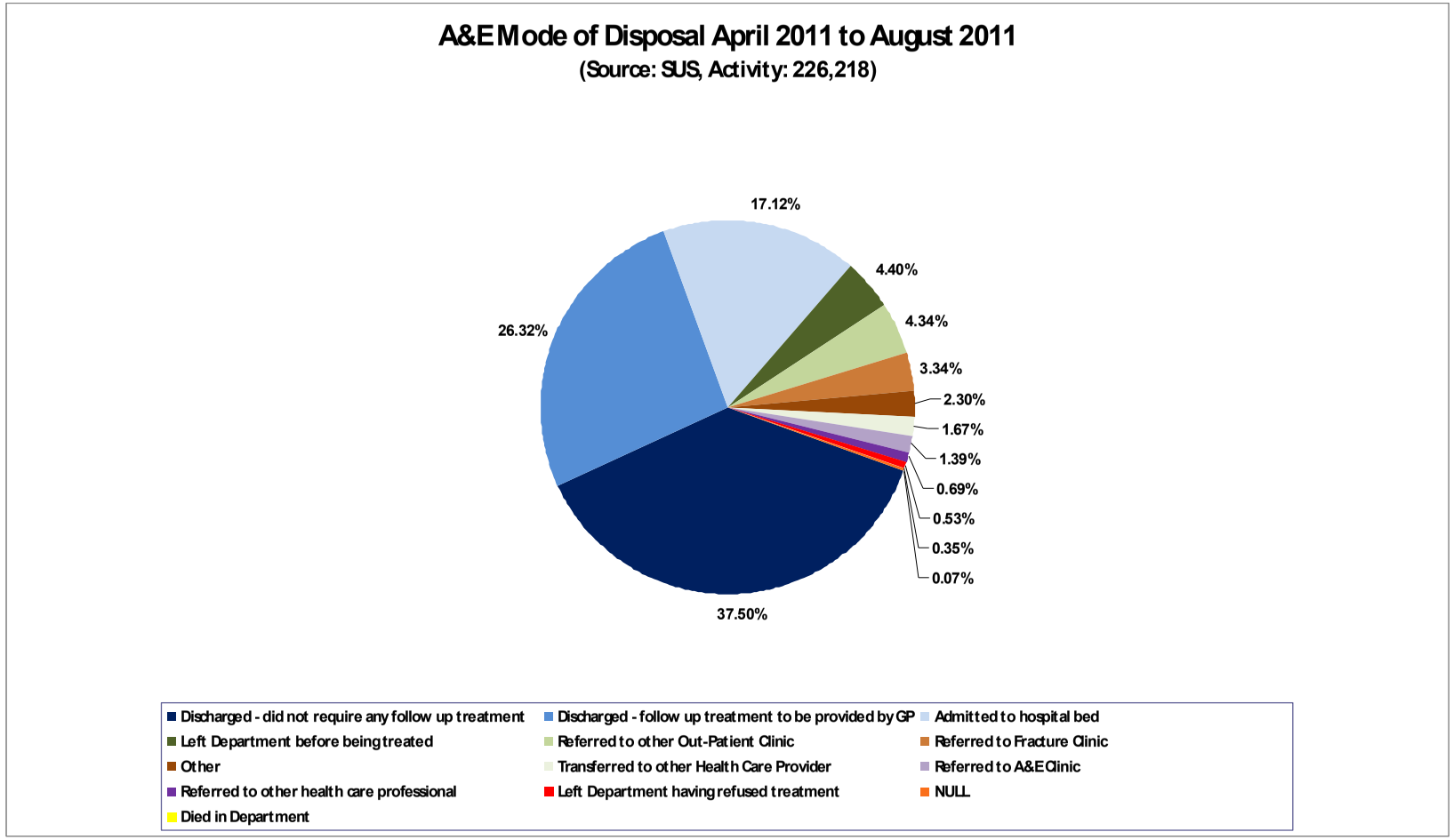
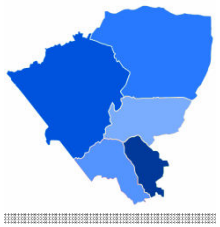
Mode of Referral



Discharged to?





HRG Codes

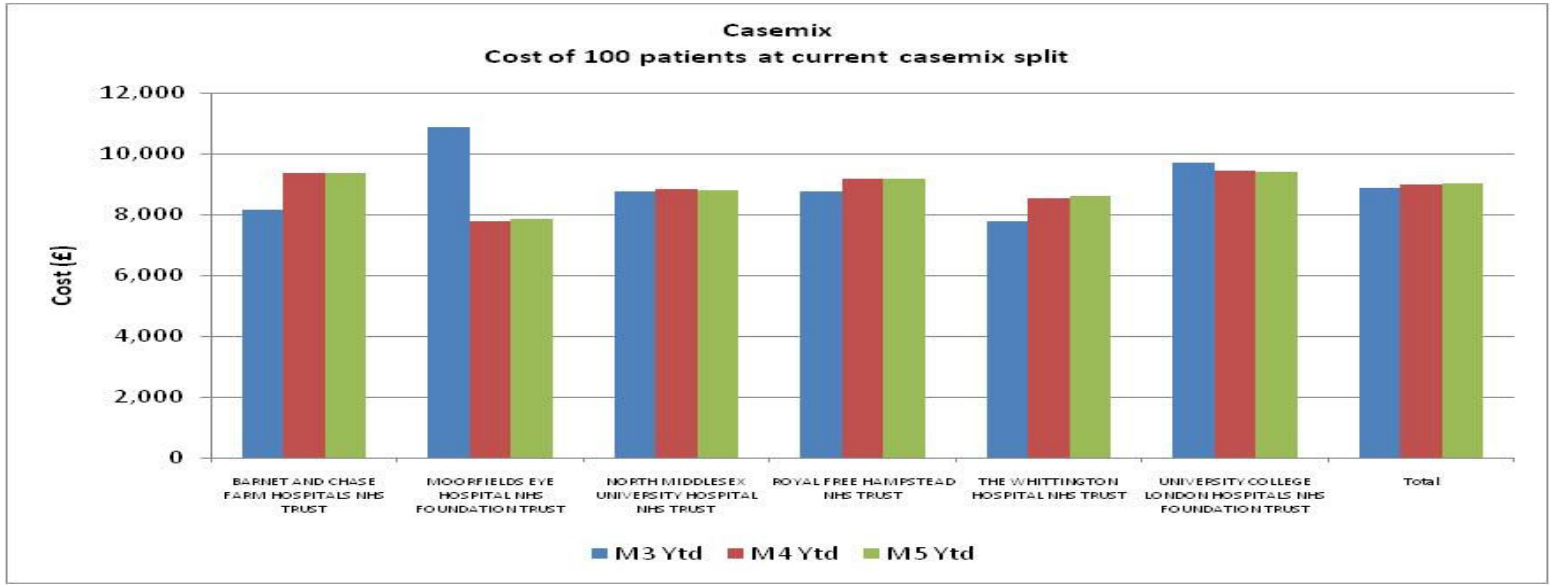
HRG code	HRG name	Band	A&E tariff (£)
VB01Z	Any investigation with category 5 treatment	1	183
VB02Z	Category 3 investigation with category 4 treatment	1	183
VB03Z	Category 3 investigation with category 1-3 treatment	2	133
VB04Z	Category 2 investigation with category 4 treatment	2	133
VB05Z	Category 2 investigation with category 3 treatment	2	133
VB06Z	Category 1 investigation with category 3-4 treatment	3	78
VB07Z	Category 2 investigation with category 2 treatment	4	110
VB08Z	Category 2 investigation with category 1 treatment	4	110
VB09Z	Category 1 investigation with category 1-2 treatment	3	78
VB10Z	Dental Care	5	52
VB11Z	No investigation with no significant treatment	5	52

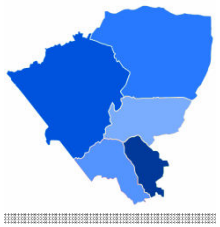
- For A&E there are 11 HRG codes across five bands which generate the tariff
- Commissioners also pay an additional Market Forces Factor
- Non-24 hour A&E units and MIUs are only eligible for the band five tariff
- Band one and two will be your more traditional blue light conveyances

Casemix

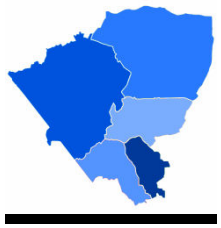
% activity by band April to June 2011

	BARNET AND CHASE FARM HOSPITALS NHS TRUST	MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	ROYAL FREE HAMPSTEAD NHS TRUST	THE WHITTINGTON HOSPITAL NHS TRUST	COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	Total
Band1	0.3	0.0	0.6	0.4	0.2	1.0	0.5
Band2	8.6	0.5	10.5	7.8	6.6	12.1	8.7
Band3	18.2	97.5	31.3	28.7	16.3	43.5	30.5
Band4	51.2	1.5	32.1	43.5	41.6	33.8	38.7
Band 5	21.5	0.0	25.4	19.6	35.3	9.6	21.5
No Payment	0.2	0.6	0.0	0.0	0.0	0.0	0.1
	100.0	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**





The report of the Primary Care Foundation *Primary Care and Emergency Departments* (commissioned by the DH) found that when a consistent definition of all attendances was applied, the proportion that could be classified as primary care - types regularly seen in general practice - was between 10% and 30%.



NHS
North Central London

Questions

Agenda Item 9

NHS
North Central London

NHS NORTH CENTRAL LONDON	**BOROUGHS** BARNET, CAMDEN, ENFIELD, HARINGEY, ISLINGTON **WARDS:** ALL
REPORT TITLE: NHS North Central London Continuing Health Care Policy	
REPORT OF: Kath McClinton Deputy Borough Director Islington Presence NHS North Central London	
FOR SUBMISSION TO: North Central London Joint Health Overview & Scrutiny Committee	**DATE:** Monday 5th Decemeber

SUMMARY OF REPORT:

Update on the changes to the provision of Continuing Healthcare in NHS North Central London (NHS NCL). We have identified a need for a single Continuing Healthcare policy across the sector. We are presenting the new policy.

The NCL policy was presented to and agreed by the NHS NCL Joint Boards on 29 September. It is based on current best practice models from across London.

The main difference between the new NCL policy and the existing frameworks is in how choice is balanced with best value for taxpayers' money; along with the most effective, fair and sustainable use of finite resources, as set out in the principles and values of the NHS Constitution.

CONTACT OFFICER:
George Howard
Senior Joint Commissioning Manager for Mental Health and Continuing Health Care
Islington Presence
NHS North Central London

RECOMMENDATIONS: The Committee is asked to comment on the NCL Continuing Healthcare Policy

Kath McClinton
Deputy Borough Director

DATE: 24th October 2011

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North Central London

CONTINUING HEALTHCARE POLICY
September 2011

Version	2.1
Approved by	Caroline Taylor
Date approved	Version 2.0 approved by the NCL Joint Board on 30 September 2011
Author	Sarah McIlwaine
Name of responsible committee	NHS North Central London Board
Date issued	15th September 2011
Date for review	March 2013
Target audience	NHC NCL commissioning, Whittington Health Continuing Healthcare Team, Patients, Public

North Central London

Document Control

Location:

Preparation:

Action	Name	Date
Prepared by:	Sarah McIlwaine	July 2011

Release

Version	Date Released	Change Notice	Pages Affected	Remarks
2.0	15 September 2011	NA	NA	None – baselined release
2.1	30 September 2011	NA	4, 6, 9	Insertion of clauses to clarify that: • assessments will take into account non-clinical factors • PCTs cannot allow patients to contribute financially to the core package of care.

North Central London

Contents

1. Introduction

This policy describes the way in which the five Primary Care Trusts (PCTs) in NHS North Central London (NCL) will make provision for the care of people who have been assessed as eligible for fully funded NHS continuing care. The term 'continuing care' is used in this policy as an abbreviation for 'fully funded NHS continuing care'.

Most patients who require continuing care will receive it in a specialised environment. The treatments, care and equipment required to meet complex, intense and unpredictable health needs often depend on highly trained professionals for safe delivery, management and clinical supervision. Specialised care, particularly for people with complex disabilities may only be provided in specialist nursing home or hospital settings, and may be distant from the patient's ordinary place of residence. Placements may be very costly.

These factors mean that there is likely to be limited choice of a safe and affordable package of care.

PCTs hold the responsibility to promote a comprehensive health service on behalf of the Secretary of State and to not exceed its financial allocations. It is expected to take account of patient choice, but must do so in the context of those two responsibilities.

In the light of these constraints, NCL has developed and agreed this policy to guide decision making on the provision of continuing care, in a manner that reflects the choice and preferences of individuals but balances the need for the PCT to commission care that is safe and effective and makes best use of the resources available to the PCT.

The policy sets out to ensure that decisions will:

- be robust, fair, consistent and transparent,
- be based on the objective assessment of the patient's clinical need, safety and best interests,
- will have regard for the safety and appropriateness of care packages to those
- involved in care delivery
- will involve the individual and their family or advocate where possible and appropriate,
- take into account the need for the PCT to allocate its financial resources in the most cost effective way,
- support choice to the extent possible in the light of the above factors
- be consistent with the principles and values of the NHS Constitution
- take into account an individual's needs for both their health and their wellbeing

This policy and NCL's Continuing Care Guidelines (Appendix A) form NCL's continuing care framework. Both documents should be read in conjunction with:

- The National Eligibility Criteria for NHS Continuing Care (2007 and 2009)
- National framework on Continuing Healthcare and NHS funded nursing care
- PCT Health and Safety Policies
- PCT Policy and Procedure for Safeguarding Adults
- The NHS Constitution
- NCL's Continuing Care Appeals Policy

2. Context

Where a PCT has assessed an individual and found that the person's primary need is a health need then that individual will qualify for continuing care. Continuing care describes a package of on-going care arranged and funded solely by the NHS. Where an individual is eligible, the NHS is responsible for providing for the individual's assessed care needs.

The PCT is required to secure and fund a continuing care package to meet the reasonable needs of patients as assessed by the relevant professionals. Such needs will be identified through the multi disciplinary assessment.

There is no duty on the PCT to provide a specific package of care although the PCT will take individual choice into account when arranging a suitable package.

3. The Provision of Continuing Care

Continuing care is generally provided in a range of nursing home settings. These are established and managed specifically for the purpose of providing multi-disciplinary interventions in an environment designed to promote safety, dignity and choice within the constraints of the patient's condition. These may include a registered nursing home or hospice. These settings have high levels of expertise in the successful management of complex or unusual physical and mental health care, and employ staff trained, managed and supervised in specialist interventions. They provide care significantly beyond the degree of complexity which can generally be managed safely in community settings. The most appropriate placement may not always be in the patient's borough of residence.

NCL's Continuing Care Guidelines, September 2011 (Appendix A) describes the process of assessing continuing care eligibility in detail. When the decision on eligibility is agreed, the care manager, in conjunction with the residential brokerage team, will identify establishments which are capable of meeting the assessed needs and which are in a position to provide a place within a reasonable space of time.

The PCT aims to offer individuals a choice of care packages which meet an individual's assessed needs. This assessment takes into account their needs for both their health and their general wellbeing.

If more than one suitable establishment or care package is available, or where there is a request for a care package which is not usually commissioned by the PCT, the total costs of each package will be identified and assessed for overall cost effectiveness by the care management team and commissioners.

While there is no set upper limit on expenditure, the expectation is that placements will not be agreed where costs exceed 10% over the most cost effective package that has been assessed as able to meet an individual's needs.

This is the most effective, fair and sustainable use of finite resources, as set out in the principles and values of the NHS Constitution. PCTs hold the responsibility to promote a comprehensive health service on behalf of the Secretary of State and to not exceed its financial allocations. It is expected to take account of patient choice, but must do so in the context of those two responsibilities.

Any assessment of need will include a review of the psychological and personal care needs and the impact on home and family life as well as the individual's healthcare needs.

Where a care package requested by an individual is not the most cost effective, the PCT, taking into account the considerations set out below, may agree to fund such a package of care in exceptional circumstances:

- Circumstances of overall placement/ package
- Clinical need
- Psychological need
- Risk
- Patient preference

- Available alternatives
- Overall cost to PCT

A discussion will take place between the care manager and the patient and family on the respective merits of the alternatives. Where the patient and family preference is consistent with the most cost effective package, the placement will be negotiated and the arrangements made and reviewed by the care management team.

If placement at home is more cost effective than in an establishment setting, it will only be agreed with the consent of the patient and family or advocate.

Where an individual is found eligible for continuing care whilst in acute NHS care or in a placement funded by the NHS, the individual or family must seek prior approval from the PCT for any change in the care package location unless they intend to pay for the full care privately. In the event that the placement is not one of the packages offered by the PCT, the PCT will consider the proposed placement in accordance with this policy. For the avoidance of doubt, a patient will not be treated on a different basis to another NHS patient because the individual previously received privately funded treatment.

An individual may appeal the decision in writing within 28 days through the Continuing Healthcare lead, as outlined in NCL's Continuing Care Guidelines Appeals Policy (within Appendix A).

4. Capacity to Make the Decision

The PCT will support an individual in making the decision as to where they wish to live. However, if concerns remain that an individual does not have the mental capacity to make the decision as to where they live, a mental capacity assessment will be undertaken.

Where the individual lacks capacity to make the decision on where to live and there is no Lasting Power of Attorney which extends to healthcare decisions then the PCT is under a duty to act in accordance with the individual's best interests in accordance with the Mental Capacity Act. The PCT will take the decision on the basis of consideration of the best interests of the individual taking into consideration the views of the family/carers. The PCT will need to consider whether there is a requirement for a deprivation of liberty authorisation.

Where the individual does not have the capacity to understand the particular decision then the PCT will consider whether it is appropriate to involve an independent advocate if the PCT considers that there is no one else willing and able to be consulted or that appointing an independent advocate will benefit the individual.

Where a personal welfare deputy has been appointed by the Court of Protection under the Mental Capacity Act or a Lasting Power of Attorney with powers extending to healthcare decisions has been appointed then the PCT will consult with that person and obtain a decision from the appointed person on the preferred care option.

5. Top Up

The PCT is only obliged to provide services that meet the assessed needs and reasonable requirements of an individual. A patient has the right to decline NHS services and make their own private arrangements.

Where an individual is found eligible for continuing care, the PCT must provide any services that it is required to provide, free of charge. In the context of care home placements this will be limited to the cost of providing accommodation, care and support necessary to meet the assessed needs of the patient. For 'care at home' packages this will be the cost of providing the services to meet the assessed needs of the individual. The package of care which the PCT has assessed as being reasonably required to meet the individual's needs is known as the core package.

Where an individual wishes to augment any NHS funded care package to meet their personal preferences they are at liberty to do so. However, this is provided that it does not constitute a subsidy to the core package of care identified by the PCT. The PCT is responsible for the core package and must not allow the individual to contribute to it.

Joint funding arrangements are not lawful and any additional private care must be delivered separately from NHS care. The invoices for any extra services must be dealt with directly by the individual and show the service/item that the payment relates to so that it can be clearly seen that payment is not subsidising the PCT's core package.

As a general rule individuals can purchase services or equipment where these are optional, non-essential items which an individual has chosen (but was not obliged) to receive and are not items which are necessary to meet the individual's assessed needs. Examples include private hairdressers or a personal television.

6. Review of Continuing Care Support

The PCT is routinely reviewing packages of care and as a result all reviews will comply with the policy.

All individuals will have their care reviewed within the first three months of its start. Subsequent to any review, including this first, all patients must be reviewed at least once every twelve months thereafter, or sooner if their care needs indicate that this is necessary.

Individuals with palliative care needs will have their care reviewed more frequently in response to their medical condition.

The review may result in either an increase or a decrease in support offered and will be based on the assessed need of the individual at that time. Reviews will include input from the individual, their family and in the case of those who lack capacity, their advocate also.

Where the individual is in receipt of a home support package and the assessment determines the need for a higher level of support the criteria set out in Section 7, below, will apply. This may result in care being offered from a nursing home, hospital or hospice, whichever best meets the criteria overall.

Decisions on proposed changes of placement on financial grounds only would be made at Director level.

The individual's condition may have improved or stabilized to such an extent that they no longer meet the criteria for NHS fully funded continuing care. Consequently, the individual may be referred to the Local Authority who will assess their needs against the Fair Access to Care criteria. This may mean that the individual will be charged for all or part of their ongoing care. Where possible, transition to Local Authority care will be managed by agreement between the respective authorities.

An individual may appeal the decision in writing within 28 days through the Continuing Healthcare lead, as described in NCL's Continuing Care Guidelines Appeals Policy (Appendix A).

7. Continuing Care in a Care Home Placement

The PCT aims to offer individuals a reasonable choice of care homes and care providers. The PCT will provide information to individuals/representatives about the choice of care homes so that they are able to make an informed choice.

An individual has the right to decline NHS funding and make private arrangements. For the avoidance of doubt, in the event that an individual has been assessed and found to be eligible for continuing care they will no longer be able to receive funding from the Local Authority towards their care even if they decline NHS funding.

Where, immediately prior to being found eligible for continuing care, an individual is residing in a care home which is not one of the PCT's preferred providers and that individual does not wish to move, the PCT will undertake a clinical assessment of the individual to consider the clinical or psychological risk of a move to an alternative placement.

In exceptional circumstances, including where there is a high risk in moving the individual, the PCT will consider whether it is appropriate to commission a package outside of the PCT's preferred providers. In this instance, the PCT will consider:

- the cost of the package;
- the Care Quality Commission's assessed standard;
- the appropriateness of the package;
- the clinical assessment of the individual's needs;
- the risk any the change to the individual's health;
- the likely length of the proposed package;
- and the psychological needs of the individual in determining whether the PCT will continue to commission care at the care home.

In the event that the PCT commissions care in a home that is not normally commissioned by the PCT, the appropriateness of the placement will be reviewed at the initial and any subsequent reviews.

Where an individual is in hospital at the point that he/she is found eligible for continuing care then he/she will not be considered to be resident in a care home.
This will be the case even if prior to the admission to hospital the individual was resident in a care home.

The PCT will not normally fund a placement where the requested care home is not the most suitable place for the provision of care and the care package can only be provided safely or resiliently at the current home with additional staffing at significant extra cost to the PCT.

If the individual or their family/representative indicates that they are unwilling to accept any of the placements offered by the PCT then the PCT shall issue a final offer letter setting out the options available. If the PCT does not receive confirmation that the individual has accepted one of the placements within 14 days then the PCT will write to the individual confirming that the NHS funding has been turned down and NHS funding will cease from 28 days after the date of this notice.

Where the individual or their family/representative choose to turn down continuing care funding, they will not be able to access local authority funding for the care and will need to make private arrangements.

If after receipt of a letter from the PCT, stating that funding has been turned down, the individual or their representatives want to access NHS services, they remain entitled to do so and can re-enter the continuing care process.

8. Continuing Care at Home

Given the complexity of continuing care cases, it would be unusual for the PCT to provide NHS continuing care to an individual in their own home. The PCT only supports the use of 'care at home' packages where appropriate and recognises the importance of patient choice. However, there may be situations where the PCT cannot provide the individual's choice of having a 'care at home' package either because of the cost or risks associated with the package. The PCT considers that packages which require a high level of input may be more appropriately and safely met in another care setting.

The PCT's duty to fund services does not extend to funding for the wide variety of different, non-health and non-personal care related services that may be necessary to maintain the patient in their home environment. Should the PCT identify that such basic needs are not going to be (or have not been) properly met, the PCT may find that a 'care at home' is not or no longer appropriate.

Whether a particular service should be provided by the PCT will depend on the review by the PCT of whether that particular service is required in order to meet that individual's personal or health care needs.

NCL will only consider the provision of continuing care at home in the following circumstances:

- Care can be delivered safely to the individual and without undue risk to the individual, the staff or other resident members of the household. The safety will be determined by professional assessment of risk which will include the availability of equipment, the environment and appropriately trained carers to deliver care whenever it is required;
- The acceptance by the individual, the PCT and each person involved in the individual's care of any risks relating to the care package.
- The patient's General Practitioner's opinion on the suitability of the package and confirmation that he/she agrees to provide primary medical support
- The opinion of a secondary care, specialist clinician, will be taken into account
- It is the individuals informed and preferred choice.
- The suitability, accessibility and availability of alternative arrangements
- The extent of a patient's needs
- Where the total cost of providing care is within 10% of the equivalent cost of a placement in an establishment.
- The cost of providing the package of choice
- The cost (or range of costs) of the care package(s) identified by the PCT as suitable to meet the individual's assessed care needs.
- The psychological, social and physical impact on the individual
- The individual's human rights and the rights of their family and/or carers including the right of respect for home and family life.
- The willingness and ability of family members or friends to provide elements of care where this is a necessary / desirable part of the care plan and the agreement of those persons to the care plan.

If the service user has capacity to make an informed decision and still wishes to be cared for at home, the following conditions apply:

- A full risk assessment must be made covering all the assessed needs and reflecting the proposed environment in which the care is to be provided.
- the individual agrees to receive care at home with a full understanding of the risks and possible consequences.
- the organisation with responsibility for providing the care agrees to accept the risks to their staff of managing the care package.
- the patient's primary care team agrees to provide clinical supervision of the care package, accepting the risks, which will need to be made explicit on a case by case basis.
- If action by family members or friends is needed to provide elements of care they must also agree to the care plan.
- actions to be taken to minimize risk will include those that must be taken by the individual or their family.
- any objections from other members of the household are taken into consideration.
- costs are expected to fall within 10% of an equivalent care although there is no set tariff placement and the assessed needs to be met within the cost are itemized within the care plan
- care is provided by an organisation or individual under a formal agreement and meeting standards acceptable to NHS commissioners; at this time it is not possible to make payments to individual patients or their families to purchase their care directly.

If a service user does not have the mental capacity to make an informed choice and is placing themselves at risk by indicating choice of a care package at home a mental capacity assessment will be undertaken. An independent advocate will be offered to support the user in this process, under the provisions of the Mental Capacity Act 2005.

If the service user does not have the capacity to make an informed choice the PCT will deliver the safest and most cost effective care available based on an assessment of best interests and in conjunction with any advocate, close family member or other person who should be consulted under the terms of the Capacity Act.
An individual may appeal the decision in writing within 28 days through the Continuing Healthcare lead as described in NCL's Continuing Care Guidelines Appeals Policy (Appendix A).

9. Assessments for Continuing Care at Home

In order to establish whether it is appropriate to fund a 'care at home' package, the PCT will undertake a number of assessments prior to agreeing to any package.

Safety of the package will be determined by a formal assessment of risk, undertaken by appropriately qualified professionals. The risk assessment will include the availability of equipment, the appropriateness of the physical environment and availability of appropriately trained carers and/or staff to deliver care whenever it is required.

The resilience of the package will be assessed and contingency arrangements will need to be put in place for each component of the package in case any component of the package fails.

Environmental Risk Assessment

The risk assessment must consider all risks that could potentially cause harm to the individual, any family and the staff. Where an identified risk to the care providers or the individual can be minimised through actions by the individual or his/her family and/or carers, those individuals must agree to comply with the steps required to minimise such identified risk. Where the individual requires any particular equipment then this must be able to be suitably accommodated within the home.

The PCT is not responsible for any alterations required to a property to enable a home care package to be provided. For the avoidance of doubt, where an individual or representative has made alterations to the home but the PCT has declined to fund the package, the PCT will not provide any compensation for those alterations. Included in the risk assessment will be a robust Safeguarding Adult assessment in order to assess whether there are any actual or potential risks to the individual.

Clinical Assessment

When considering whether a package of care is suitable, the PCT will undertake a clinical assessment of the patient's needs and the extent to which that clinician considers that the proposed 'care at home' package meets those needs. The clinical assessment will consider the benefits of a 'care at home' package against the benefits of a care home placement.

A nurse and the individual's GP will be asked to consider the proposed arrangements in order to determine whether it is the most appropriate care package. This will include current and likely future clinical needs and psychological needs. Where part of the package is based on care being provided by a family carer(s) it will also include consideration of how needs will be met in the event that the carer is temporarily unable to provide the care.

Staffing Assessment

The PCT will assess the care need and the input required by the individual to meet those needs. The PCT shall consider the qualification of any required staff and the sustainable availability of appropriately qualified staff including appropriate contingency arrangements.

The PCT has a duty to its staff to assess any potential harm and take steps to prevent it. This covers both physical risks and any potential psychological risks that may arise. The PCT's Health and Safety policies and procedures will apply.
This includes manual handling policies and lone worker policies.

The individual (or representatives) are responsible for ensuring that the environment is safe for the provision of the care package. Where the safety assessment identifies a potential risk associated with the home, the individual is responsible for remedying that. The individual (or representatives) are also responsible for ensuring that the environment is appropriate for the provision of the care package by staff. This includes ensuring staff are able to have access to toilet, bathroom and kitchen areas and such areas are kept in a clean state and ensuring that staff are treated with dignity and respect.

10. Memorandum of Understanding for 'care at home'

Where the PCT agrees to fund a ‘care at home’ package the individual (if appropriate) and/or representatives will be required to enter into a Memorandum of Understanding ("Memorandum") confirming that they accept the terms on which any care is provided.

This Memorandum (Appendix B) will set out what the PCT will provide and what the individual and representatives have agreed to provide.

This Memorandum will also confirm that the individual and representatives understand that the care package is agreed on the basis of the assessed health and personal care needs and the required input at the date of the Memorandum. Where the cost of meeting the assessed care needs increases for any reason, the individual and representatives acknowledge that it may no longer be appropriate for the PCT to provide and they will work with the PCT to agree an alternative care package.

The Memorandum will set out the agreed alternative arrangements should the care package break down.

11. Termination of a 'Care at Home' Package

In any circumstance where the PCT considers that the safety of its staff or its agents/contractors are at risk it shall take such action as it considers appropriate in order to remove that risk. Where this relates to the conduct of the individual or the home environment it shall request that the individual/representatives take the necessary action to remove the risk.

Where a review identifies, or the PCT otherwise becomes aware that an action to reduce an identified risk to either the people involved providing care to the individual or to the individual has not been observed and such failure may put those individuals providing care at risk or may significantly increase the cost of the package then the PCT will take the necessary steps to protect the individual and staff involved with a view to ensuring the safety of all concerned. Harassment or bullying of care workers by the individual, carers or family members will not be accepted and the PCT will take any action considered necessary to protect their staff and contractors.

Where safety of the individual and/or those people involved in providing care is likely to be compromised without such action and the individual or representative does not take the required action then the PCT may write formally to the individual. Where there is a threat to the safety of PCT Staff or agents then the PCT retains the right to take any action it considers necessary to remove the threat including the immediate withdrawal of the care provision.

Where the individual is in receipt of a home care package and an assessment determines that this is no longer appropriate for any reason (including increase in care needs, inability for family to provide agreed care or identified risk) then an alternative package will be discussed and agreed. If the individual declines to accept alternative suitable provision, the PCT may write formally to the individual, giving no less than 28 days notice for alternative arrangements to be put in place by the individual.

North Central London

Appendix A

Continuing Healthcare Guidelines September 2011

Version 1.0

North Central London

Document Control

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Release

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NHS
North Central London

Contents

Glossary

Continuing Healthcare Assessor – A collective named assigned by Islington PCT for anyone who co-ordinates the assessments carried out by the Multi-disciplinary team and who completes the London Decision Support Tool

Continuing Healthcare Manager – A collective name assigned by Islington PCT for anyone who is the allocated co-ordinating manager responsible for a patients CHC package after a decision has been made following Complex needs panel that a patient is eligible for NHS CHC.

Fully Funded NHS Continuing Healthcare – A care package which is to be completely funded by the NHS. This will include payments by the NHS for care not normally associated with the NHS. I.e. payment for a carer to do shopping, cleaning. The term continuing care (CHC) is used for Fully Funded NHS Continuing Healthcare.

Domains- The National Framework for NHS CHC uses 11 domains to assess eligibility for NHS CHC. They are behaviour, cognition, psychological and emotional, communication, drugs and therapies, nutrition, altered states of consciousness, skin, continence, mobility and breathing.

North Central London

1. Introduction

This document provides information to all practitioners involved in the process of NHS Continuing Healthcare (CHC) to understand their responsibilities in relation to NHS CHC within the North Central London (NCL) Primary Care Trusts (PCTs).

CHC is every practitioner's responsibility and it is important for everyone to be involved in the process in order that appropriate patients are recognized as meeting the eligibility criteria for NHS CHC with the intention that they receive both the necessary care and appropriate financial support.

These guidelines provide information on the process from identifying a patient who may be eligible for CHC through to managing a CHC package of care.

Some individuals may be eligible for either a joint funding arrangement between their PCT and their borough's social services. NCL has developed guidance for these Joint Funding arrangements (Please see protocols for joint funding for Young Physically Disabled (YPD) and Adults and Older People).

The guidelines may also be read by patients or representatives to support understanding of the process.

These guidelines should be read in conjunction with the Department of Health's *National Framework for Continuing Healthcare and NHS-funded Nursing Care* (revised 2009) Gateway reference: 11509, and with NCL's CHC Policy (September 2011).

2. Background

NHS CHC has been evolving since 1994 when the Health Services Ombudsman published a report on a case in Leeds entitled, 'Failure to provide long term NHS care for a brain-damaged patient' (Reid, 1994).

In July 1999, the Court of Appeal judged in the Coughlan case (DOH, 2007) that funding responsibility was dependant on the legal limit of what could lawfully be provided by a Local Authority (i.e. health care that is merely incidental or ancillary to the provision of accommodation).

In March 2001 the Department of Health issued a National Framework for Older People which referred to the provision of free nursing care in nursing homes but didn't include guidance on CHC. By June 2001 the Department of Health provided guidance on funding responsibilities and laid out 3 categories; NHS, shared responsibility and social services, (DOH 2001).

By 2003 North Central Sector Strategic Health Authority (NCL SHA) developed their own Eligibility Criteria NHS CHC, as did all other SHAs across the country. However over the next three to four years there was a strong push for a National Framework for NHS CHC to eliminate the postcode lottery that had developed. The Grogan Judgement assists the process to move forward, DOH, 2007.

On 1st October 2007, the National Framework for NHS CHC and NHS Funded Nursing Care was implemented after two to three years of consultation. With the introduction of the new framework came national tools to standardise the approach to CHC.

In 2009 the National Framework for NHS CHC and NHS-funded Nursing Care was revised. The revisions clarify the decision making and funding process and explain more clearly the types and levels of need that staff look for and record when they assess needs, complete the tools used to support decision-making and ultimately make a recommendation about eligibility.

Best practice guidance was issued in March 2010 and provides a practical explanation of how the Framework should operate on a day-to-day basis and gives examples of good practice.

NCL will commission CHC in a manner which reflects the choice and preferences of individuals but balances the need for the PCT to commission care that is safe and effective and makes best use of resources. Therefore, in circumstances where the quality rating of a care home is poor and the PCT cannot commission care in the home at that time, the Trust will work with individuals.

These guidelines should be read in conjunction with:

- National Framework on Continuing Healthcare and NHS funded nursing care (Revised July 2009)
- PCT Health and Safety Policies
- PCT Policy and Procedure for Safeguarding Adults

- The NHS Constitution
- NCL Continuing Care Policy (September 2011)

3. The Responsible Commissioner

The PCTs in NCL are responsible for those patients who have an NCL General Practitioner (GP) at the time of assessment even if they do not reside in NCL. If those patients have been placed out of borough, the PCT will be responsible either until death or until they no longer meet the criteria for NHS CHC, (DOH, 2006). However if a patient independently moves out of the borough without the assistance of the PCT then they become the responsibility of the receiving borough.

Therefore if a patient is placed in NCL PCT by another Local Authority (LA), registers with an NCL PCT GP, and after three months meets the criteria for NHS CHC, then they will be the responsibility of the NCL PCT. The reverse is true of those placed by NCL LA into another borough.

4. The Continuing Healthcare Team

Experts in CHC are available in PCTs and provider services to guide and assist patients, their carers and practitioners involved in the process.

The CHC team might involve:

- **A Commissioner** – The Head of Joint Commissioning is responsible for commissioning CHC packages for older people and people with physical disabilities. She/he will have overall responsibility for the purchase of care
- **A Continuing Healthcare Lead** – Who is responsible for the overall management of CHC processes in Islington PCT. She/he is responsible for managing the CHC team and developing CHC nursing services across Islington. She/he will have overall responsibility for the safety and appropriateness of nursing care.
- **A Continuing Healthcare Community Matron** – Who is responsible for providing guidance and support to all professionals both within the community and secondary care as well as co-workers in Social Services. She/he is also responsible for the care management of :-
    - Complex CHC packages in the community
    - All CHC packages in care homes both within Islington and outside of the borough

  She/he is not responsible for the care management of the under 65s with mental health problems or those with learning disabilities.
- **A Continuing Healthcare Specialist Nurse** – Who supports the CHC Community matron and holds his/her own caseload. She/he is also responsible for maintain the training and assessment of formal carers in packages of care within the home setting.
- **A Funded Nursing Care Assessor** – Who is responsible for assessing and reviewing all residents in Nursing Homes for Funded Nurse Contributions. She/he presents any patient to panel who meets the threshold for a full CHC assessment. She/he provides cover for the CHC Community Matron in his/her absence.
- **A CHC Administrator** – Who is responsible for coordinating papers and taking minutes for the weekly complex care panel and informing both family and care managers of the outcome of the panel. She/he also provides administration to the CHC team.
- **A Brokerage Manager** – Who is responsible for finding appropriate nursing home placements to meet the needs for those agreed for NHS CHC in liaison with the CHC Community Matron. She/he is also responsible for negotiating the cost of a placement and finalizing a Service level agreement with providers.

5. Who is eligible for a full CHC Assessment?

Eligibility for NHS continuing healthcare is based on an individual's assessed health needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility for NHS continuing healthcare.

Any patient in any setting is entitled to a full CHC assessment if CHC assessors or patients themselves consider that needs may be sufficiently complex to warrant a full assessment. *The National Framework for CHC*,(DOH, 2009) provides a 'Check List' for CHC assessors (see Suffix 2). This check list, as with all assessments in the CHC process should always be completed in conjunction with the patient and/or their relative or carer.

The aim of this tool is to support a decision as to whether a full CHC assessment is required, or not. A variety of staff, in a variety of settings, could refer individuals for a full consideration of NHS CHC eligibility. For example, the tool could form part of the discharge pathway from hospital, a GP or a nurse could use it in an individual's home, and Social Services workers could use it when carrying out a review for Community Care. This list is not exhaustive, and in some cases it may be appropriate for more than one person to be involved in the assessment process.

How to use this tool
Descriptions of need should be compared to the needs of the patient and boxes ticked as appropriate. All the descriptions should be considered. If the patient's need meets or exceeds the description given, tick the box in the first column (column A). If there is need in some or all of these areas, but the level of need falls just below that described in the main statement, tick the box in the second column (column B). If the patient clearly does not meet the described need, tick the box in column C.

A full consideration of eligibility is required if there are:

- Two or more ticks in column A.
- Five or more ticks in column B; or one tick in A and four in B.
- One tick in column A in one of the boxes marked with an asterisk (ie, the domains which carry a priority level in the Decision Support Tool), with any number of ticks in the other two columns.

There may also be circumstances where a full consideration for NHS CHC is necessary even though the patient does not apparently meet the indicated threshold.

Regardless of whether the patient requires a full CHC assessment, the rationale for the decision, the CHC assessor's signature and the date the Checklist was completed, should be recorded and kept in the patient records. The patient and/or carer should be informed of the decision (written if appropriate). The CHC assessor should explain to the patient and/or their carer that if they feel dissatisfied with the decision not to complete a full CHC assessment, it may be more appropriate to carry out a full CHC assessment. This may prevent an appeal at a later stage.

6. Which CHC Assessor is responsible for coordinating an assessment?

A process chart (Suffix 1) is provided to ensure clarity for CHC assessors with regards responsibility for taking a patient through initial assessments to identify CHC eligibility. Patients can be identified for a full CHC assessment in a number of settings; Acute hospitals, the community or in care homes. Some of these patients will already have allocated social workers and/or district nursing staff. In these instances it is these staff members who will be responsible for completing the full CHC assessment by collating information provided by professionals involved, the patient, and/or their carer. These CHC Assessors will be required to visit the patient in hospital or their current place of residence in order to gain a clear understanding of the needs of the patient.

CHC Training should be provided on a quarterly basis to educate staff about the process familiarize themselves with policy and provide an opportunity for staff to familiarise themselves with the relevant documents.

Some patients will not yet be known to services. If they are in hospital, the ward staff will be responsible for coordinating the assessment. If they are in care homes, either the residential review team social workers or the CHC nurse will be the responsible assessor.

In mapping out responsibilities in this way Islington PCT endeavours to prevent gaps or duplication of the process.

7. A Full Continuing Healthcare Assessment

For those patients who meet the threshold of the check list, a full assessment is required to ascertain if a patient has a primary health need and therefore meets the criteria for NHS CHC.

The appropriate CHC assessor is responsible for co-ordinating a Multi-Disciplinary Team (MDT) approach. The person responsible is highlighted in Suffix 1. It is the responsibility of this person to gather assessment information from all MDT staff involved with this patient. A health clinician is responsible for completing London Health Needs Assessment (HNA) but additional reports may be collected in order to gather an overall assessment of the patient. A social work assessment should also be submitted. Once the assessment of needs is completed the MDT should then complete an assessment of CHC eligibility. Eligibility is assessed using the National Decision Support Tool (DST). The MDT is then required to make a recommendation to the PCT as to whether the individual is eligible, including the reasons for making this recommendation.

When completing the DST, it is essential to involve both the patient and their relatives/carers in the assessment process. CHC is a complex process and good patient, relative and carer involvement throughout the process improves satisfaction and prevents undue appeals at a later stage.

A public information leaflet can be found in on the following website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079515

Each CHC assessor will supply patients and/or relatives and carers with this booklet to guide them through the process as well as a copy of The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing care (see below):
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

Capacity to make the decision
A mental capacity assessment should always be carried out for the DST. Capacity should always depend on the decision being made at that time. A major placement or treatment decision may accompany the assessment for CHC; if the patient lacks capacity to make such a decision and does not have a relative to act in their best interests, an Independent Mental Capacity Advocate (IMCA) may be required.

Patients requiring rehabilitation
Patients who are deemed to require a period of rehabilitation to meet their potential and have not completed this rehabilitation should not be presented for a CHC assessment until the full potential has been reached. The panel will always check if this has been fully explored. If not, they will reject the case until further rehabilitation has taken place.

ALL reports including the DST should be sent to the CHC administrator. The administrator will ensure that all papers have been submitted correctly and will book a slot on the CHC panel. If eligibility is clear, and the patient is ready to be discharged, an out of panel

ratification can take place. In these circumstances the administrator will forward all documentation to the CHC Lead for approval

8. The Complex Needs Panel

The role of the Panel is to ratify recommendations made by the MDTs. Only cases that are for Older People and Young People with Physical Disabilities are seen at this panel. Learning disabilities and Adult Mental Health have separate panels.

The Complex Needs Panel might consists of the following representatives:

- A Consultant Geriatrician
- A Consultant Psychiatrist for Older Age
- A member of the Community Rehabilitation Team
- A Social Service manager
- A Senior Nurse from the PCT
- An Administrator to take minutes

CHC assessors will present their cases to the Panel and provide any additional information. Relatives, and/or Carers are encouraged to attend the Panel meeting.

The Panel will ratify the eligibility decision made by the MDT using evidence provided and discussing each domain individually. Usually the Panel will ratify immediately, however in some circumstances insufficient evidence may mean the case will be deferred to gain further evidence. Normally delays in decision making should not affect the patient's discharge or search for a suitable placement.

At the end of Panel it is the responsibility of the CHC Administrator to add all new patients agreed for fully funded NHS CHC on the CHC datbase. The CHC administrator is also responsible for updating all relevant data on this database as it arises.

If the MDT recommends that an individual does not meet the eligibility criteria, the patient's case should be presented to a separate Community Panel. It is the responsibility of the patient's care manager to present the case to the Community Panel. However the administrator of the Complex Panel will be required to forward documentation regarding the decision along with an explanation to the Community Panel in the afternoon.

A process chart outlining the responsibilities of all individuals involved following the panel is outlined in Suffix 2.

9. Fast Track

Some patients whose condition is deteriorating very rapidly may need to have a fast track assessment in order to agree CHC to enable them to be discharged from hospital and die at home. The CHC Lead can agree CHC outside of the Panel.

The care manager should contact the Chair to warn them of the imminent fast track tool given the importance and speed with which the patient will need to be agreed for CHC.

10. Communication of the Decision

Minutes from the Panel regarding a specific patient are distributed by the CHC administrator to the CHC Assessor and CHC Manager if different, providing information on the overall decision as well as an explanation of the reasons for the decision. A letter is also sent to the patient and/or relatives/cares as appropriate with details of the panel's decision.

Patients and or their relatives/carers are informed to write to follow the PCT's complaints procedure if they would like to appeal the decision. A copy of Islington The PCT's complaints procedure is sent with the letter to the patient and/or relatives/cares.

11. Appeals Process

Please Suffix 3 for guidance on appeals.

If patients and relatives are involved in the process at the beginning appeals are less likely to occur.

12. Approval of CHC Packages at Home or in a Nursing Home

PCTs should seek to find suitable placements and packages of care to meet the needs of patients who meet NHS CHC funding. Placements and packages are required to be cost effective and take into account the patient's/carers personal preferences. (See Suffix 1 for a process map).

Placements in Nursing Homes
Placements to nursing homes both within NCL are the responsibility of the individual PCT Brokerage Managers. In liaison with the CHC Community Matron, the Brokerage Manager will find a placement suitable for the needs of the patient and agreeable to both patient and relatives/carers. Once a suitable placement is found, the Care Home manager completes a pre-admission assessment of the patient to verify they are able to meet the patient's needs. The Brokerage Manager requests a breakdown of the fees from the provider along with a total fee and forwards to the CHC Community Matron.

Users Service Information
The CHC Community Matron then completes a Users Service Information form (USI) which outlines the total cost of the proposed placement. Packages or placements under £1,000 per week are agreed by the CHC Community Matron and those over £1,000 need the approval of the CHC Lead.

When the placement fees are agreed by the Assistant Director for Adults and Older People, the Brokerage Manager sends the home manager a Service Level Agreement (SLA) to sign and returns it to the Brokerage manager. The Assistant Director for Adults and Older People then signs the SLA which is finally sent back to the care home manager along with instructions to send invoices to the Assistant Management Accountant in IPCT.

CHC Packages at Home

If the placement is in the patient's own home, a suitable care package is proposed by the CHC manager (usually a district nurse).

Users Service Information
The CHC manager completes a USI form which is authorised by the CHC Community Matron and forwarded to The Assistant Director for Adults and Older People for approval. Further discussions may be required with the CHC Community Matron and the Assistant Director for Adults and Older People to reach an agreement. Once it has been approved the Assistant Director for Adults and Older People sends it to Finance.

USIs are completed for ALL patients who receive CHC packages at home whether they require funding from the CHC budget or not. Eg. if a patient receives Marie Curie, Night Sitter or Carelink the indicative cost of this is highlighted in the USI to enable the true cost of CHC to be established.

13. CHC Managers role for patients who meet NHS CHC

Refer to the suffixes
CHC Assessors representing the MDT's recommendation to the complex needs panel may be Social Workers or hospital staff. If an individual meets eligibility for NHS CHC they will always be care managed by health care managers. District Nurses will care-manage all palliative care patients and the CHC Community Matron and her team care manages all other cases.

CHC managers are responsible for agreeing a care package to meet the patient's needs in the most appropriate care setting. Placements for all patients are dependent on a safe care package. Risk assessments may be required for patients who would like to remain at home but where care needs are very complex. Please refer to Commissioning Policy

Once the patient is established in the appropriate care setting, it is the responsibility of the CHC manager to complete an initial review within 3 months or earlier, as required. Statutory reviews should then be completed yearly following this unless the condition of the patient changes.

Cases may need to be re- presented to panel if their needs improve. They may not at this point be entitled to fully funded NHS CHC. Typical examples are young physical disabilities whose needs tend to settle once in a stable environment.

North Central London

References

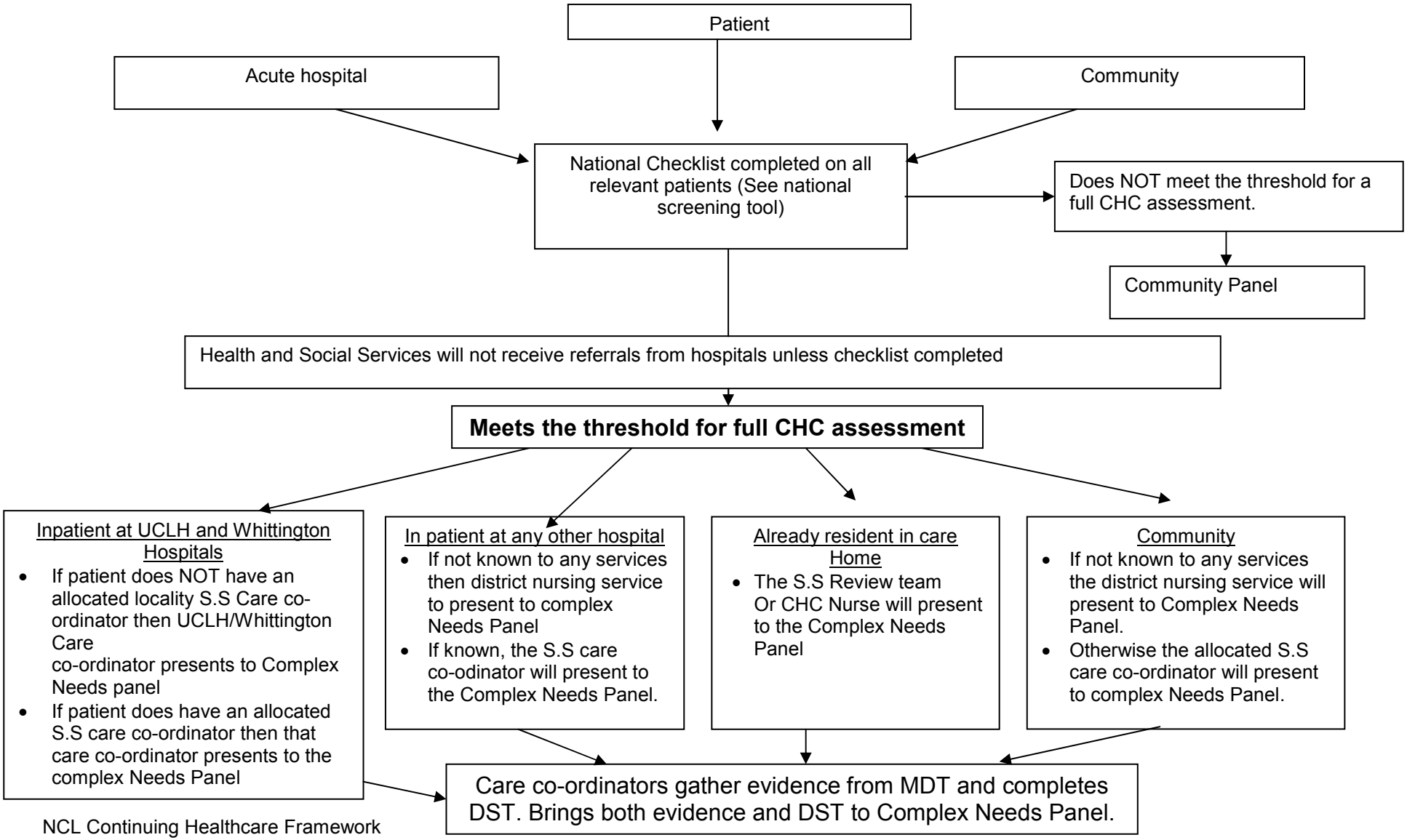
Reid, W, 1994: *Failure to provide long term NHS care for a brain-damaged patient* http://www.ombudsman.org.uk/improving_services/special_reports/hsc/care03/care03_rep.html

Department of Health, July 2009: *The National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288

Department of Health, 2001: *Continuing Healthcare: NHS and Local Council's responsibilities* (HSC 2001/015:LAC (Now superseded by the *National Framework for NHS Continuing Healthcare & NHS Funded Nursing Care*)

Department of Health, 2006: Revision: *Establishing the responsible commissioner: Guidance for PCT commissioners on the application of the legal framework on PCTs' secondary care commissioning responsibilities*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069634

Suffix 1: Older People and Young Physical Disabilities - CHC Process



North Central London

Suffix 2 - Protocol for CHC

From presentation to panel to provision of Continuing Healthcare

- Patient is presented to Complex Care Panel by the CHC assessment coordinator – Relatives to always be invited to panel

- Panel members go through paperwork presented, ask further questions to coordinator and ratify the patient needs using the National Framework for NHS Continuing Healthcare Criteria.
- Minutes of the panel discussions are taken.
- If the panel feels there is not enough information to ratify a decision, the case is deferred.

- The administrator will send to the **patient/family** a copy of the minutes including an explanation of the scoring, identifying the care coordinator along with covering letter explaining the panel's decision. A copy of the IPCT Complaints Procedure copy of the national framework criteria is also sent. If the decision is 'patient does not meet the CHC Criteria' and therefore the patient/family have the right to challenge/appeal.
- Minutes of the relevant patient is sent to the **care coordinator** of the case by administrator of the panel.
- The panel administrator enters the patient details on the CC data base.

Challenge:

- Patient follows the Complaints procedure.
- Complaint to be investigated by CHC Lead, following National Framework for CHC. Keeps accurate records and liaises either with SHA London or Ombudsman as necessary.
- CHC Lead liaises with Finance.

Meets CHC Criteria:

- Care coordinator receives panel minutes sent by Chair
- Patient receives a letter and the minutes informing him/her of the decision.

North Central London

CHC provision:

At home – Older People and Younger People Disabilities

These patients could be care managed by either

District Nursing/Generalist and specialist C Matrons

or

CC Community Matron.

District Nursing/Generalist and specialist C. Matrons care co-ordinators.

↓

Care co-ordinators provide the care with support from Marie Curie Nurses and Agency Nurses and Healthcare Assistants.

↓

A USI is completed and sent to CC C Matron for agreement along with a copy of the care plan. USI to include total the cost of the package, including Marie Curie, agency nursing and district nursing cost.

↓

USI sent to AD Adults.

↓

If a change in care package required a new USI is required and the process starts again.

↓

AD Adults to send UIS to Finance.

CC Community Matron
CC C Matron arranges a discharge planning meeting with patient and family.

↓

CC C Matron develops a plan of care and gets a costing from the agency and incorporates district nursing cost if appropriate.

↓

If District Nurses are included in the package then they are responsible for their care plan and the CC C Matron will co-ordinate the whole package.

↓

CC C Matron to complete a care management report and review weekly for first month.

↓

CC C Matron to agree care plan with AD Adults by sending him/her a USI

↓

AD Adults to send USI to Finance.

↓

If a change of care plan is required then new USI is required and agreement sought from AD adults again.

Key

CC C Matron – CHC Community Matron.
SLA – Service Level Agreement
USI – User Service Information

Nursing Homes – Older People and Younger People Disabilities

Social Worker informs family and gives details of the CC CMatron.

CC C Matron care manages these patients.

Nursing Homes
CC C Matron discusses with family location of Nursing Home – in Islington or out of borough.

↓

CC C Matron liaises with the Brokerage Manager with a detailed breakdown of patient's needs along with papers from panel.

↓

Brokerage Manager identifies a suitable home and links back with CC C Matron with details.

↓

CC C Matron contacts family and family visit the home.

↓

If the family rejects the home, CC C Matron will inform the Brokerage Manager who will find another suitable home.

↓

Nursing Home carries out a pre-admission assessment and provides the Brokerage Manager with a full breakdown of the costs.

↓

A breakdown of the costs to be sent to the AD adults for agreement.

↓

If the placement is not agreed by the home or AD Adults, the Brokerage Manager to identify another home.

↓

If the placement is agreed, Brokerage Manager to send home Service level agreement (SLA) for the home manager to complete and return to Brokerage Manager. This is then sent to AD adults for a signature and a signed copy is sent back to the home.

↓

AD Adults to send a breakdown of costs to finance.

Payment of Invoices

- Finance enters patient details in financial database, once an agreed SLA is received.
-
- Finance receives invoices, either for Nursing Homes or for CC at Home packages. Checks them against SLA. If correct, enters them on Finance Database and sends them to CHC Lead for authorisation and signing and then AD Borough commissioning. If invoices are incorrect, Finance sends them to provider advising them they are incorrect.

North Central London

Suffix 3 - Local Resolution Process for Disputes from Individuals Regarding Eligibility for Continuing Healthcare

1.0 Background

Fully Funded NHS CHC 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. The term 'continuing care' is used in this policy as an abbreviation for 'fully funded NHS continuing care'. 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.

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 CHC and NHS Funded Nursing Care issued by the Department of Health.

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.

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 care funding.

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

When an individual or (if appropriate) their representative does not agree with the decision about eligibility for continuing care funding, the PCT will aim 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.

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.

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. PCT contact details are included with the Checklist.

The PCT will 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 4 weeks). The response should also give details of the individual's rights under the NHS complaints procedure

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

The PCT will write to all individuals who have been considered for Continuing Healthcare using the DST will be sent a letter by the PCT explaining that the panel have ratified the recommendation. The letter will be sent within two weeks of the ratification process and will include the contact details of the named officer at The PCT, to write if they disagree with the decision or would like more information. The letter should ask them to write within two weeks.

If the individual (or representative) contacts the PCT about the decision, the PCT will provide details of the named coordinator who will be the point of contact for the duration of the local review process.

Some individuals may need support to understand or challenge a decision made about their continuing healthcare needs. The PCT will supply information of local advocacy and other services that may be able to offer advice and support within the response letter. Information will be included about the local Independent Complaints Advocacy Service (ICAS) arrangements.

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

The named coordinator at the PCT will 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 will be confirmed in writing with a copy of the PCT's published Local Resolution Process. The meeting will take place within two weeks from the meeting or telephone call.

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 the specific concerns raised by the applicant. The new evidence and DST should be considered by the 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 will always be invited to attend the Local Review Panel.

The PCT has a reciprocal agreement with a neighbouring PCT and will ask that they consider any new information and make a 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 PCT will 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.

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 will notify the applicant of the decision in writing, which includes a detailed rationale for how the decision was made. The letter will be sent within 2 weeks of the date of the Panel. The letter from the PCT will give details of how to request a review by NHS London's Independent Review Panel if they remain dissatisfied.

The PCT will ensure that, the essential parts of the process as set out in Annex A, are completed at a local level before a case is referred to NHS London.

4.0 Independent Review Panel

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

Applicants should contact NHS London to request the Independent Review within two weeks of the date of the PCT's decision letter unless there are exceptional circumstances. NHS London should acknowledge this request within one week of receipt of the letter.

Included with the acknowledgment letter 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 does not agree with the decision.

If the applicant's request for a review is appropriate and accepted by NHS London, papers will be requested from the PCT, with a view to the Review Meeting taking place within three

months of the date of the PCT's Local Review Panel. In order to achieve the three month deadline, it is important that the PCT gathers and scrutinises all appropriate additional evidence at their local review panel.

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

The Independent Chair allocated by NHS London 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.

Tasks to be completed by the The PCT prior to referring a case to NHS London for Independent Review

All reasonable attempts will be made to resolve a dispute at local level by The PCT. PCTs in London 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, the PCT will check the tasks listed below have been completed. If any of the tasks have not been completed then the PCT will review and 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

North Central London

Suffix 4 - Service User Information Form

This form should be completed for new Service Users (S/U) or to report changes any changes to a CHC package. Please send to Anne Conoulty, CHC Community Matron based at Hornsey Rise Health Centre

Patient's Last Name:

S/U First Name/s:

Date of Birth:

Patient's Address:

Name and Address of Next of Kin:

Provider Details:

Care Type:

Date of Start of Care:

Expected Length of Care Period:

Patient Diagnosis:

Care home charge rates:

Care Package details:

Shifts	Hours	Charge	Total Cost
Week Days			
Saturday			
Sunday			
Week Nights			
Bank hol			
Total weekly charge excluding Bank Hols			
Total annual charge including Bank hols			

Temporary variance to care package:

Name and designation of person completing form:

North Central London

Appendix B

Memorandum of Understanding for Continuing Healthcare At Home

THIS AGREEMENT is made **between**

(1) _____ **Primary Care Trust**, ("the **PCT**")
Located at: _____

(2) [Insert name of Individual] of [Insert Address] ("**you**" or "[Insert Name]);

(3) [Insert name of any carer who will be involved in the provision of the service] ("the Representative")

BACKGROUND

You/[Insert Name] have been assessed as eligible to receive NHS Continuing Healthcare funding and this Memorandum of Understanding sets out the agreement reached between the PCT in relation to the provision of your care.

[Insert name of patient] has been deemed not to have capacity to make the decision as to where they wish to receive care.] The [Representative] [you] has requested that you receive the care package at Home.

The PCT has agreed that a home care package is provided on the terms set out in this Memorandum of Understanding.

1 Provision of Care

1.1 The PCT has agreed to provide the Care Package as set out in your Care Plan which has been assessed to meet your current assessed care needs.

1.2 The Care Package will be provided at the following address ("Home"):
[Insert Address]

2 Review

2.1 The Care Package will be reviewed regularly by your care manager and the Continuing Health Care team. An initial review will take place within three months of the start of the package and at least once a year thereafter to see if your health needs are being met. Reviews will be undertaken more frequently if your needs or outcomes change substantially. You will be informed by either your Care Manager or Continuing Healthcare Nurse Adviser about the date of the review.

2.2 You or your Representative may request a review to be undertaken by the PCT if you think your care needs have changed or the care package is not meeting your assessed needs.

2.3 In the event that the assessed care needs have increased, the PCT will consider whether the care provision needs to change in order to meet those care needs. Where the care provision increases, the PCT will assess whether it remains appropriate for the care at home package to be provided. In doing so, the PCT will take the considerations set out in the PCT's Choice Policy and the cost of alternative care packages that would meet your assessed needs.

2.4 If you are assessed as no longer eligible for receipt of NHS Continuing Healthcare then the PCT will inform the Local Authority so that a joint assessment can be carried out.

3 Patient and Representative Obligations

3.1 You and your Representative agree to co-operate with a review of your needs.

3.2 You and your Representative acknowledge and recognise that if your care needs change then the PCT will need to re-assess the continued provision of the care at home package. If the PCT considers that the care package is no longer appropriate or cost effective then you agree to co-operate with the PCT in choosing and moving to alternative arrangements.

3.3 You and your Representative acknowledge that the PCT can issue a withdrawal of care notice if it considers that the provision of the care at home package is no longer appropriate. If you decide not to take up alternative package of care offered by the PCT then you will be considered to be refusing NHS funding.

3.4 You and your Representative agree to treat all care workers with dignity and respect and will take all the action that you and your Representative are required to do in the Risk Assessment.

3.5 You and your Representative will make sure that the care workers have the appropriate facilities so that they can provide your care. This includes clean and accessible bathroom and kitchen facilities.

3.6 You and your Representative acknowledge that the PCT will take any action it considers necessary in the event that it considers that there is a risk to the health or safety of any of its staff or agents including withdrawing the provision of care.

North Central London

I have read, understand and agree with the Memorandum of Understanding, the Care Plan and Risk Assessment attached.

Name of Individual receiving care:

…….....

Signed by: ……
Individual Receiving Care

Printed Name ……

Date…….....

Signed by: ……
Representative

Printed Name: ……
Representative

Date…….....

……Date……
Signed by PCT

Relevant Care Manager……Tel…….

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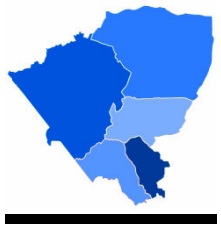
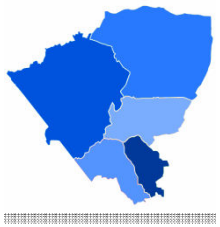


NHS
North Central London

NHS North Central London Adult NHS Continuing Healthcare Policy

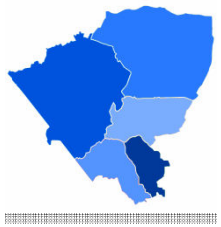
Kath McClinton
Deputy Borough Director
Head of Joint Commissioning Islington

www.ncl.nhs.uk



Introduction

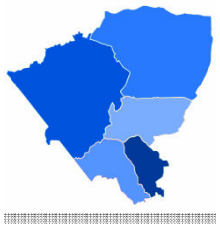
- What is NHS Continuing Healthcare?
- Who is Continuing Healthcare for?
- Continuing healthcare in NHS North Central London
- NHS North Central London policy



What is Continuing Healthcare?

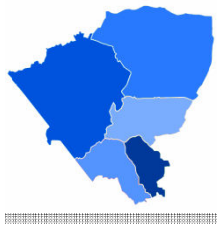
"a package of continuing care that is arranged and funded solely by the NHS"

- The complex nature of Continuing Healthcare means that there is likely to be limited choice of safe and affordable packages of care
- Eligibility is set out in a National Framework



Who is Continuing Healthcare for?

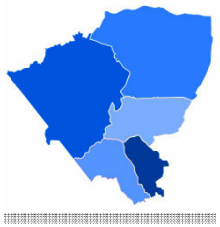
- The people who are eligible for Continuing Healthcare can have a range of complex health needs:
  - Physical frailty and mental health problems
  - Severe physical frailty
  - Mental health problems, both with and without behavioural difficulties
  - People who need ongoing, high level care until the end of their lives



Continuing healthcare in North Central London

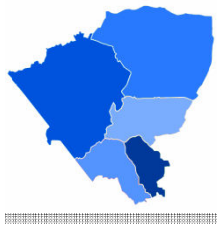
- NCL investment in 2011/12 is £91.7m
- Nationally there has been an exponential increase in expenditure
- NCL is managing a significant financial challenge

PCT	Budget
Barnet	£24,641,973
Camden	£17,880,279
Enfield	£19,355,867
Haringey	£19,293,192
Islington	£10,577,798
Total	£91,729,109



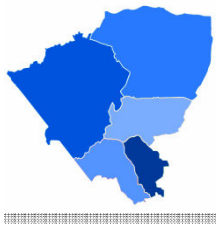
Developing an NHS NCL policy

- PCTs have responsibility to
    1. promote a comprehensive health service
    2. not to exceed financial allocations
- The NHS NCL policy will enable PCTs to take account of patient choice, but in the context of these two responsibilities
- NHS NCL also has an opportunity to ensure a consistent approach across 5 PCT areas



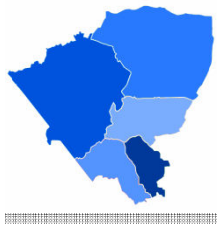
NHS NCL policy

- Individuals will, wherever possible, be offered a choice of care packages
- The policy provides a framework beneath which local protocols are being developed
- Choice is balanced with the most effective, fair and sustainable use of finite resources
- There is no set upper limit on expenditure
- The expectation is that placements will not be agreed where costs exceed 10% over the most cost-effective
- If the care package is not the most cost-effective the PCT will consider individual circumstances



People Currently Receiving Continuing Healthcare

- Regular reviews should be carried out involving the appropriate multidisciplinary professionals
- Some people will need more frequent reviews
- All reviews will be undertaken within the new policy
- Patients, with their families and carers, will be involved in and consulted on all decisions about their care and treatment
- Where transitions between services are necessary these will be as smooth as possible



Summary

- The number of people eligible for Continuing Healthcare under the national framework will continue to grow
- No impact on eligibility or creating pressures for Local Authorities
- Transparent framework that informs patients and carers of how choice is managed in relation to resources
- People who need Continuing Healthcare will continue to receive the medical care, and the comfort and dignity, they deserve

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Joint Health Overview and Scrutiny Committee (JHOSC) for North Central London Sector

31 October 2011

Future Work Plan

1. Introduction

1.1 This report outlines the work plan for future meetings of the JHOSC.

Monday 16 January – Camden

1.2 Items for this meeting are currently as follows:

1. Continuing Care

2. Future work plan

Future Meetings:

1.3 Further meetings of the Committee will take place as follows:

- *Monday 27 February - Islington*

1.4 Agenda items for these meetings will be agreed in due course.

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