Haringey Council

NOTICE OF MEETING

Scrutiny Review – Access to Services for Older People

MONDAY, 4TH FEBRUARY, 2008 at 13:00 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, LONDON N22 8LE.

MEMBERS: Councillors Bull (Chair), Adamou, Alexander and Wilson

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

The Chair will consider the admission of any late items of urgent business. (Late items will be considered under the agenda item where they appear. New items will be dealt with at Item 11 below).

3. DECLARATIONS OF INTEREST

A Member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to the meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A Member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a Member of the public, with knowledge of the relevant facts, would reasonably regard as so significant that it is likely to prejudice the Member's judgement of the public interest and if this interest affects their financial position or the financial positions of a person or body as described in paragraph 8 of the Code of Conduct and/or if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. HARINGEY COUNCIL OLDER PEOPLE'S SERVICE (PAGES 1 - 10)

To look at the Internal and External Spend analysis and the number of service users supported by Haringey Older People Service.

5. HARINGEY TEACHING PRIMARY CARE TRUST OLDER PEOPLE SERVICE (PAGES 11 - 12)

To look at the HTPCT annual spend analysis.

6. CABINET MEMBER FOR ADULT SOCIAL CARE

To hear from Cllr Harris

7. ACCESS PATHWAYS PROJECT

To hear from the Access Pathways Project Manager on the work being undertaken in relation to Older People's Services.

8. THE NATIONAL FRAMEWORK FOR NHS CONTINUING HEALTHCARE AND NHS-FUNDED NURSING CARE (PAGES 13 - 52)

To hear a briefing on the Continuing Healthcare Framework and its implementation in Haringey

9. HARINGEY FORUM FOR OLDER PEOPLE

To hear from Haringey Forum for Older People.

10. MINUTES FROM PREVIOUS MEETINGS (PAGES 53 - 74)

To approve the minutes of the meetings held on 15th October 2007 and 19th November 2007 and the notes from the informal meeting of 17th December 2007.

11. NEW ITEMS OF URGENT BUSINESS

12. DATE OF NEXT MEETING

Monday 25th February 2008
13:00-15:30
Civic Centre

Yuniea Semambo
Head of Members Services
225 River Park House
Wood Green N22 4HQ

Melanie Ponomarenko
Scrutiny Research Officer
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2005/06	Gross Total Expenditure including capital charges			INCOME				
Service	Own provision (including joint arrangements)	Provision by others	Total Expenditure	Client Contributions	Joint Arrangements	Other Income	Total Income	NET TOTAL COST
OLDER PEOPLE (AGED 65 OR OVER) INCLUDING OLDER MENTALLY ILL								
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Assessment and care management	3,626	14	3,641	4	119	32	155	3,486
Nursing care placements		3,354	3,354	1,059	-50	0	1,008	2,346
Residential care placements	7,332	6,003	13,335	3,007	995	0	4,003	9,332
Supported and other accommodation	183	0	183	0	0	0	0	182
Direct payments		377	377	16	0	0	16	360
Home care	5,572	4,163	9,735	761	337	0	1,098	8,637
Day care	2,244	525	2,769	130	1	0	131	2,638
Equipment and adaptations	0	0	0	0	0	0	0	0
Meals	238	604	842	279	0	0	280	562
Other services to older people	233	729	962	428	-501	0	-73	1,035
TOTAL OLDER PEOPLE excluding Supporting People	**19,428**	**15,768**	**35,196**	**5,684**	**902**	**32**	**6,618**	**28,578**
Supporting People	5,280	0	5,280	14	0	0	14	5,266
TOTAL OLDER PEOPLE including Supporting People	**24,708**	**15,768**	**40,476**	**5,698**	**902**	**32**	**6,632**	**33,844**

2006/07	Gross Total Expenditure including capital charges			INCOME				
Service	Own provision (including joint arrangements)	Provision by others	Total Expenditure	Client Contributions	Joint Arrangements	Other Income	Total Income	NET TOTAL COST
OLDER PEOPLE (AGED 65 OR OVER) INCLUDING OLDER MENTALLY ILL								
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Assessment and care management	6,740	0	6,740	12	4	47	64	6,677
Nursing care placements	0	3,083	3,083	1,042	-485	622	1,178	1,905
Residential care placements	4,272	7,097	11,447	2,835	0	54	2,889	8,558
Supported and other accommodation	145	0	145	0	0	142	143	3
Direct payments	0	452	452	28	0	0	29	424
Home care	3,685	4,440	8,126	1,053	0	130	1,182	6,943
Day care	1,840	593	2,466	119	0	46	166	2,301
Equipment and adaptations	0	0	0	0	0	0	0	0
Meals	100	616	717	280	0	0	280	437
Other services to older people	222	1,414	1,636	417	-63	0	355	1,282
TOTAL OLDER PEOPLE excluding Supporting People	**17,005**	**17,696**	**34,814**	**5,787**	**-543**	**1,042**	**6,285**	**28,529**
Supporting People	5,852	0	5,852	0	0	0	0	5,852
TOTAL OLDER PEOPLE including Supporting People	**22,857**	**17,696**	**40,666**	**5,787**	**-543**	**1,042**	**6,285**	**34,381**

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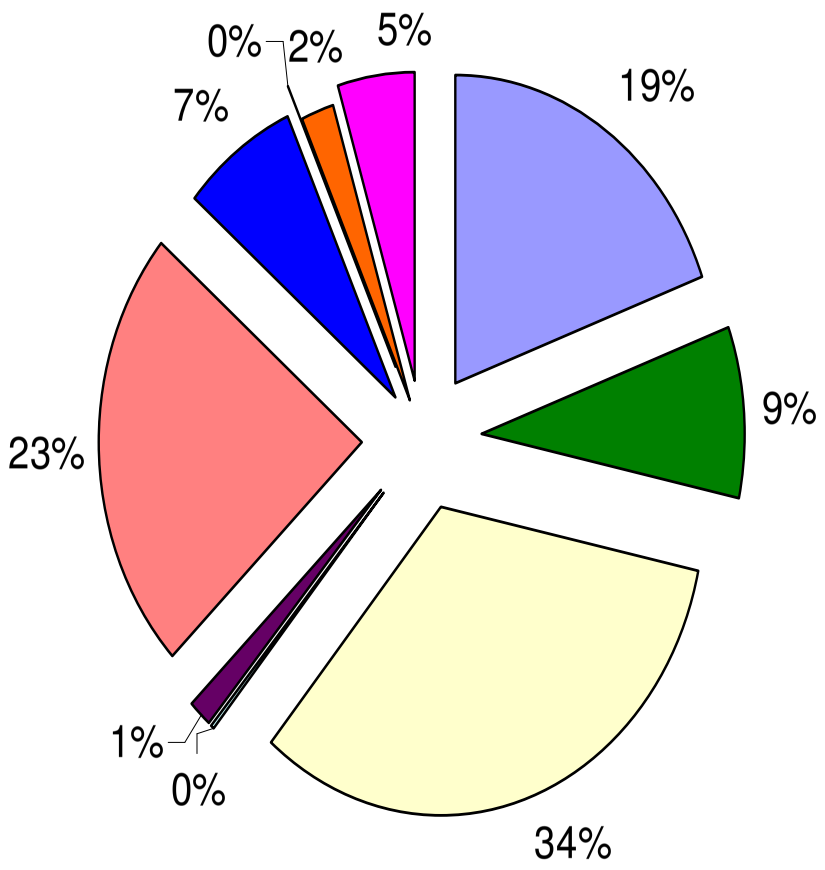
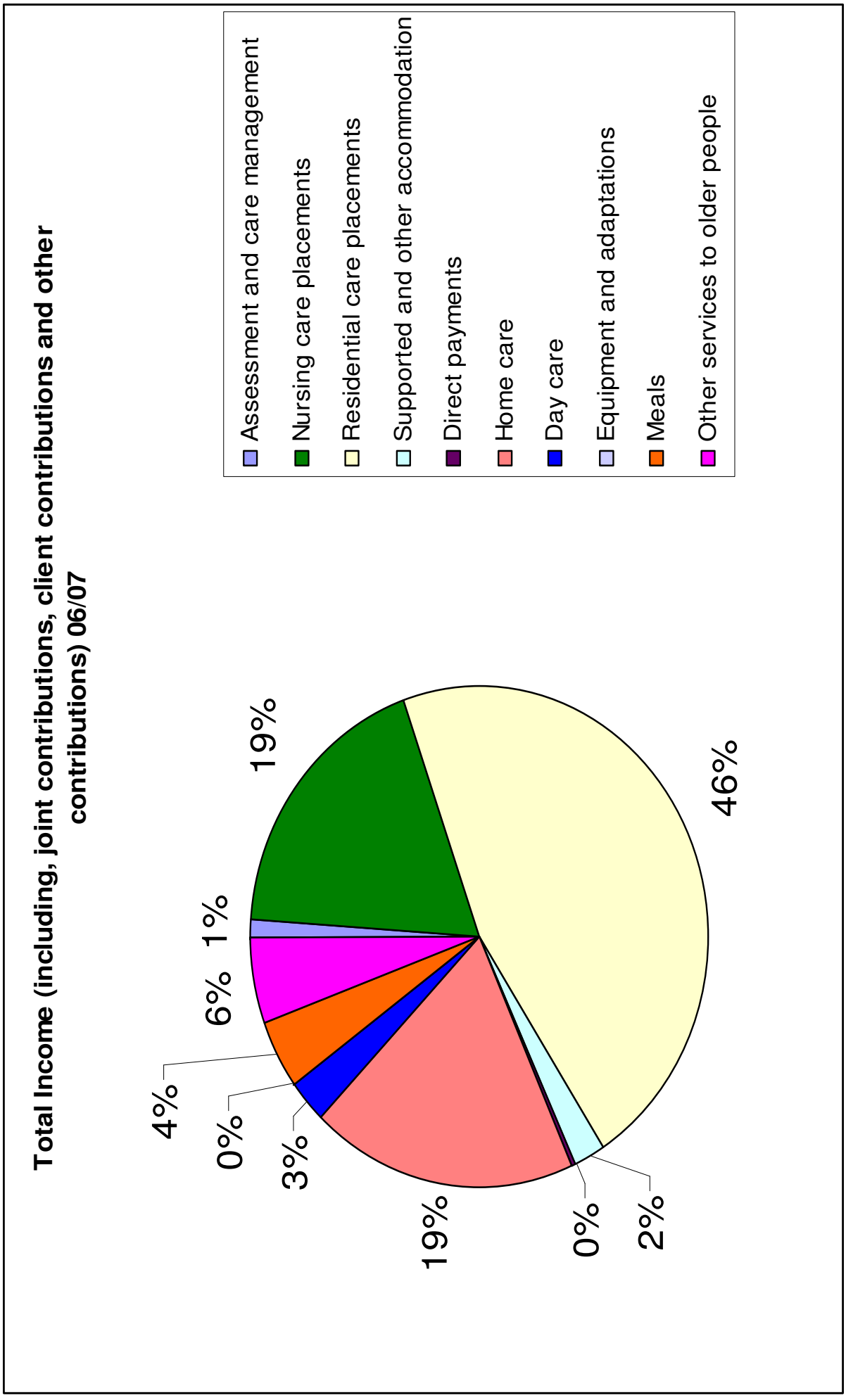
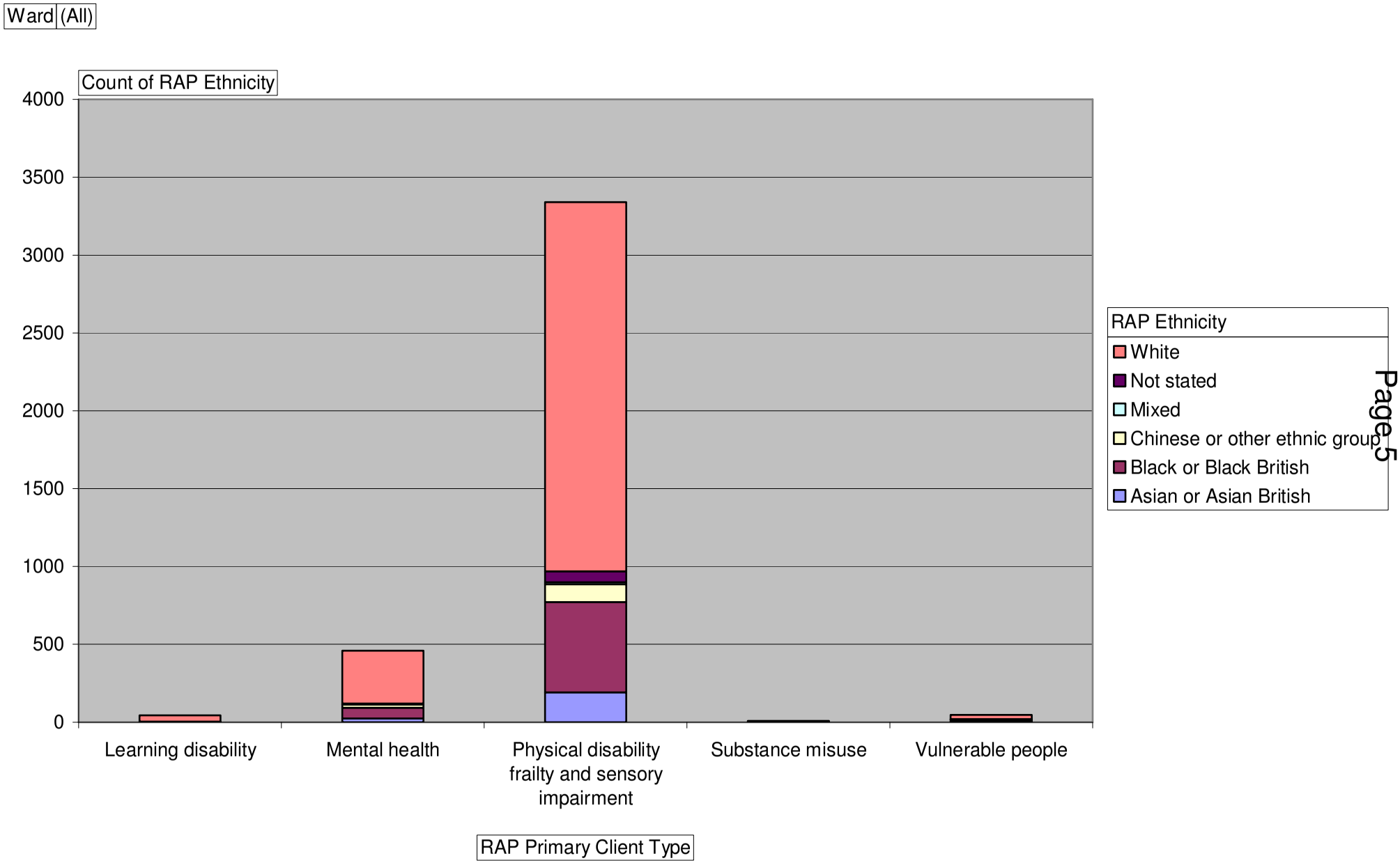
Gross total expenditure including capital charges (own provision and provision by others, excluding Supporting People) 06/07

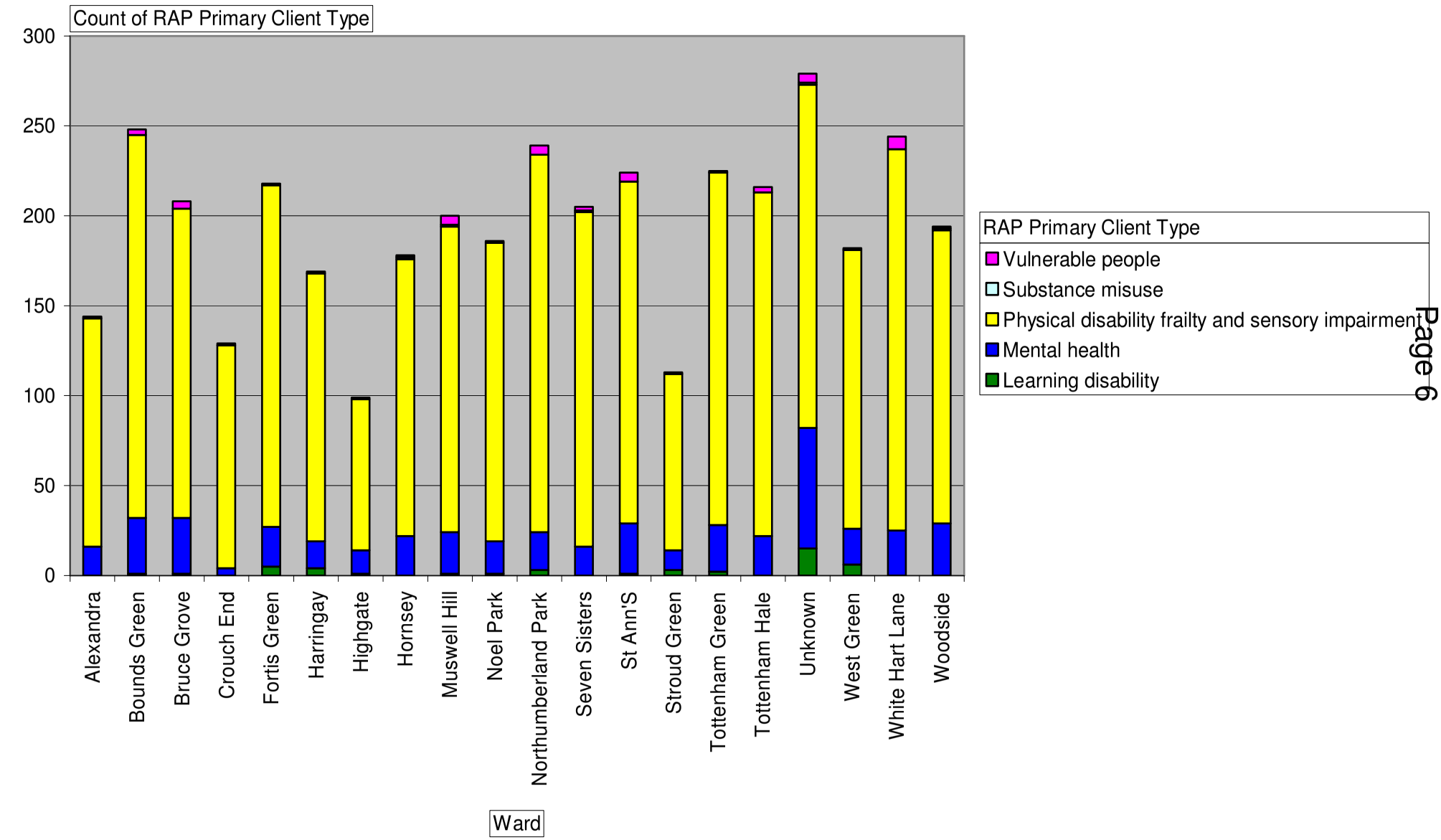


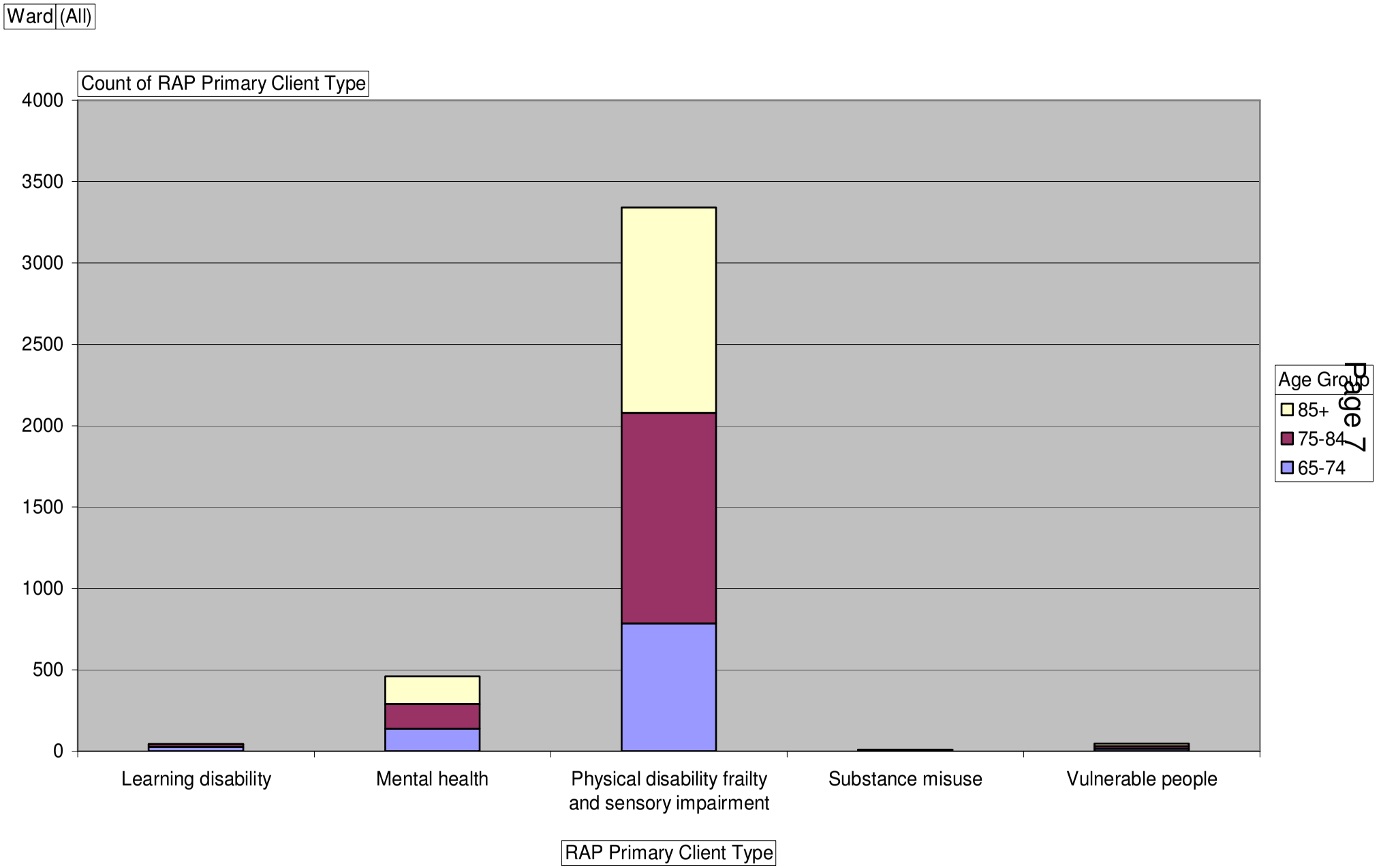
- Assessment and care management
- Nursing care placements
- Residential care placements
- Supported and other accommodation
- Direct payments
- Home care
- Day care
- Equipment and adaptations
- Meals
- Other services to older people


Total Income (including, joint contributions, client contributions and other contributions) 06/07
Assessment and care management
Nursing care placements
Residential care placements
Supported and other accommodation
Direct payments
Home care
Day care
Equipment and adaptations
Meals
Other services to older people
1%
19%
46%
2%
0%
19%
3%
0%
4%
6%


Ward (All)
Count of RAP Ethnicity
4000
3500
3000
2500
2000
1500
1000
500
0
Learning disability
Mental health
Physical disability frailty and sensory impairment
Substance misuse
Vulnerable people
RAP Primary Client Type
RAP Ethnicity
White
Not stated
Mixed
Chinese or other ethnic group
Black or Black British
Asian or Asian British

RAP Ethnicity (All)




Ward (All)
Count of RAP Primary Client Type
4000
3500
3000
2500
2000
1500
1000
500
0
Learning disability
Mental health
Physical disability frailty and sensory impairment
Substance misuse
Vulnerable people
RAP Primary Client Type
Age Group
85+
75-84
65-74

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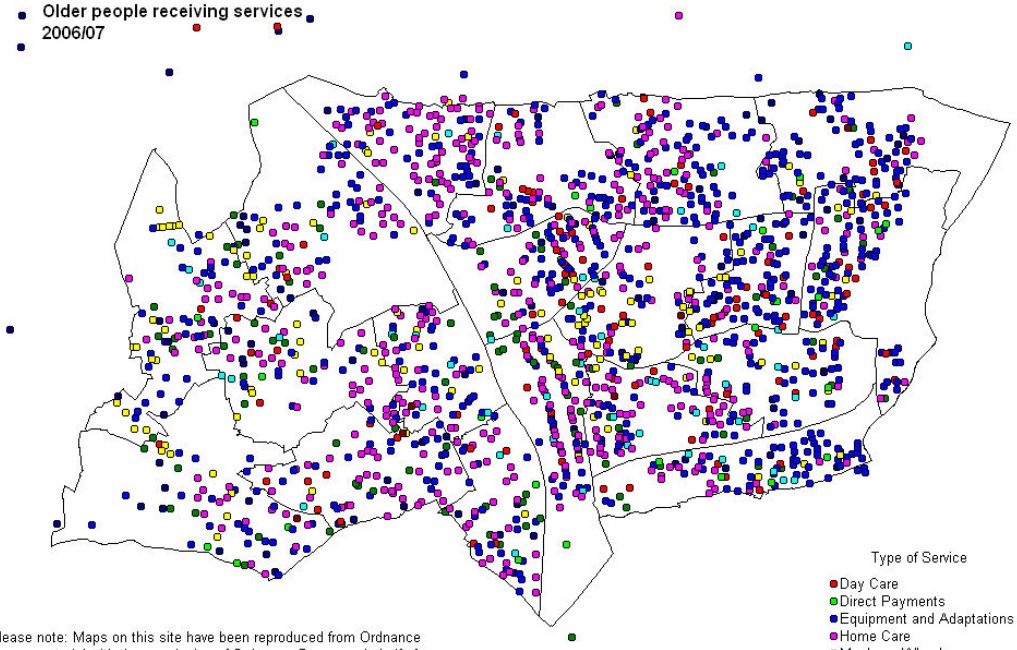

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Haringey NHS
Teaching Primary Care Trust

Total service Budgets

Total Budget Per Service

Service	Organisation	Commissioning Arrangements	Budget £
NMUH (Therapies)	NMUH	SLA- NMUH/ Providerside	**2,243,159**
Integrated Community Therapy Team (Rehab)	HTPCT	Direct provision	**711,738**
Section 31 Pooled Budget Projects	HTPCT/ LBH/NMUH/ WH	Through WSCP	**322,887**
Greentrees	HTPCT	Direct provision	**1,831,222**
HICES	LBH/ HTPCT	Direct provision	**357,245**
Community matrons	HTPCT	Direct provision	**238,090** (5.4 wte)
Case managers	HTPCT	Direct provision	**636,000** (15.0WTE)
Community matron assistants	HTPCT	Direct provision	**108,000** (4.0WTE)
District Nursing	HTPCT	Direct provision	**1,905,930** (55.55 wte)
Handy Person Project	HTPCT	SLA-Age Concern	**19,129**
Active Age	HTPCT	SLA-Age Concern	**32,611**
Expert Patient Programme	HTPCT	Direct provision	**51,103**
DESMOND Programme	HTPCT	Direct provision	**27,260**
Total			**8,056,907**

Estimated Budget Per Service- Prevention

Service	% Proportion on Prevention per Service	Budget £
NMUH (Therapies)	80	1,794,527
Integrated Community Therapy Team (Rehab)	90	640,564
Section 31 Pooled Budget Projects	50	161,443
Greentrees	80	1,464,977
HICES	75	
Community matrons	90	214,281
Case managers	75	477,000
Community matron assistants	75	81,000
District Nursing	70	933,906
Handy Person project	100	19,129
Active Age	100	32,611
Expert Patient Programme	25	12,775
DESMOND Programme	25	6,815
Total		5,891,602

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

Executive summary

1. The national framework

This sets out the principles and processes of the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care. We will also issue Directions in time for an implementation date of 1 October 2007. Until that date, we are encouraging Strategic Health Authorities (SHAs), Local Authorities (LAs), Primary Care Trusts (PCTs) and NHS Trusts to use the Framework and associated tools to prepare for implementation.

2. Legal framework

We set out the main responsibilities for the NHS and LAs that are in primary legislation, and explain the influence of key court cases. The Coughlan judgment examined the responsibilities of NHS and LAs, particularly in the provision of nursing care. The Grogan judgment examined the interaction between NHS continuing healthcare and NHS-funded nursing care.

3. Primary health need

We describe how the phrase a 'primary health need' has developed and how this idea helps to make the decision about when someone should receive NHS continuing healthcare.

4. Core values and principles

We set out the main things to remember when assessing somebody and deciding whether they should receive NHS continuing healthcare. The individual, the effect their needs have on them, and how they would prefer to be supported, should be kept at the heart of the process. Access to assessment and provision should be fair, consistent and free from discrimination

5. Eligibility considerations

At the heart of this document is the process for deciding whether someone is eligible for NHS continuing healthcare or NHS-funded nursing care. Assessments should be carried out by a multi-disciplinary team in line with the core values and principles section and taking into account other existing guidance.

6. Links to other policies

We point to other areas of law and policy that may be relevant to this framework, especially around mental health.

7. Care planning and provision

The PCT should identify and arrange all services required to meet the needs of all individuals who qualify for NHS continuing healthcare, and for the health care part of a joint-care package. We set out the key principles in both cases.

8. Review

Regular reviews should be carried out, no later than three months following the initial decision, and then at least once a year after that. Some people will need more frequent reviews. We describe this in more detail.

9. Dispute resolution

If there is a disagreement about a decision, or about who pays for necessary care, the PCT's "local resolution" process will usually be the first step. We also describe the other possible steps, if this does not provide a satisfactory solution, or if the person wants to complain separately using the relevant complaints procedure.

10. Governance

Both PCTs and SHAs have roles in overseeing the process, as they do in other areas, and we indicate this in this final part.

The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

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

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning / Performance	Finance
Clinical	**Social Care / Partnership Working**

Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	8427
Title	The National Framework for NHS Continuing Healthcare and NHS funded Nursing Care		
Author	Social Care Policy and Innovation (System Reform)		
Publication Date	26 Jun 2007		
Target Audience	PCT CEs, SHA CEs, Directors of Adult SSs, Lead officials for continuing care in SHAs and PCTs and Councils with Social Services responsibility		
Circulation List	Lead officials for Continuing care in SHAs & PCTs and Councils with Social Services responsibility		
Description	This document sets out the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care. We will also issue Directions in time for an implementation date of 1 October 2007. Until that date, we are encouraging Local Authorities and NHS bodies to work together to prepare for implementation.		
Cross Ref	Consultation on a national framework for NHs continuing healthcare and NHS funded nursing care in England		
Superseded Docs	HSC2001/15 and LAC2001(18) NHS and local councils responsibilities NHS Continuing Care: action following the Grogan judgement (2006)		
Action Required	N/A		
Timing	**N/A**		
Contact Details	Andrew Palethorpe Social Care Policy & Innovation (System Reform) 8E28 Quarry House Quarry Hill, Leeds LS2 7UE 0113 254 6468		
For Recipient's Use			

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Executive summary

1. **The National Framework.** This sets out the principles and processes of the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care. We will also issue Directions in time for an implementation date of 1 October 2007. Until that date, we are encouraging Strategic Health Authorities (SHAs), Local Authorities (LAs), Primary Care Trusts (PCTs) and NHS Trusts to use the Framework and associated tools to prepare for implementation.

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3. **Primary Health Need.** We describe how the phrase a 'primary health need' has developed and how this idea helps to make the decision about when someone should receive NHS Continuing Healthcare.

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5. **Eligibility Considerations.** At the heart of this document is the process for deciding whether someone is eligible for NHS Continuing Healthcare or NHS-funded Nursing Care. Assessments should be carried out by a multi-disciplinary team in line with the Core Values and Principles section and taking into account other existing guidance.

6. **Links to other policies.** We point to other areas of law and policy that may be relevant to this Framework, especially around Mental Health.

7. **Care planning and provision.** The PCT should identify and arrange all services required to meet the needs of all individuals who qualify for NHS Continuing Healthcare, and for the health care part of a joint-care package. We set out the key principles in both cases.

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Contents

The National Framework

Summary

1. This guidance sets out the principles and process of the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care. It concentrates mainly on the process for establishing eligibility for NHS Continuing Healthcare and principles of care planning and dispute resolution relevant to that process, rather than specifying every aspect of planning NHS Continuing Healthcare. Directions under the National Health Service Act 2006 and the Local Authority Social Services Act 1970 in relation to the National Framework will be issued in October 2007. Until that time, this guidance and associated tools can be regarded as good practice and used to prepare for implementation. In this interim period, we would encourage the efforts of Strategic Health Authorities (SHAs), Local Authorities (LAs), Primary Care Trusts (PCTs) and NHS Trusts to move towards practice that more closely reflects the processes set out here.

Action

2. PCTs should consider how the principles and process in this guidance relate to what is currently in place and prepare to align their processes with this guidance.

3. SHAs should help facilitate this process. The obligations of SHAs to operate review panels (directions 4 to 8 of the Continuing Care (National Health Service Responsibilities) Directions 2004 as modified by the Continuing Care (National Health Service Responsibilities) Modification Directions 2006) continue.

4. NHS Trusts will wish to consider those sections of this guidance which are relevant with a view to reviewing current review and discharge processes.

5. LAs should read this guidance and consider how their current practice fits with the responsibilities outlined below.

6. NHS bodies and LAs are encouraged to work together in a partnership approach when reviewing existing processes.

Background

7. “Continuing care” means care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as the result of disability, accident or illness. “NHS Continuing Healthcare” means a package of continuing care arranged and funded solely by the NHS. The actual services provided as part of that package should be seen in the wider context of best practice and service development for each client group.

8. An individual who needs “continuing care” may require services from NHS bodies and/or from LAs. Both NHS bodies and LAs therefore have responsibilities to ensure that the

assessment of eligibility for, and provision of, continuing care takes place in a timely and consistent fashion. If a person does not qualify for NHS Continuing Healthcare, the NHS may still have a responsibility to effectively contribute to that person's health needs. This is sometimes known as a "joint package" of continuing care (set out in paragraphs 78-81 below). The most obvious way in which this is provided is by means of the Registered Nursing Care Contribution, in a care home setting, but there are many other models.

9. In December 2004, we announced our intention to develop a National Framework to improve consistency of approach in relation to, and ease of understanding of, NHS Continuing Healthcare. The White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services*, published in January 2006, reaffirmed this formal commitment to develop a National Framework and to simplify the interaction between NHS Continuing Healthcare and NHS-funded Nursing Care.

10. The major changes proposed in the draft National Framework, published for a three month consultation on 19 June 2006, were:
    a. Instead of each of the 28 SHAs in England having its own rules, tools and processes for determining eligibility for NHS Continuing Healthcare, there should be one national approach on determining eligibility, with a common process and national tools to support decision making, for the NHS in England.
    b. Rather than having a separate nursing determination to assess an individual's need for registered nursing care in a nursing home, and which places recipients into three bands, there should be one single band for NHS-funded Nursing Care in a nursing home. The determination of eligibility for NHS-funded Nursing Care should be integrated into the same framework as eligibility determination and care planning for NHS Continuing Healthcare.

11. This guidance is based on statutory responsibilities, case law, input from the Health Service Ombudsman, and responses received in the consultation (please refer to the response, published alongside this document). It sets out a process for the NHS, working together with LA partners wherever possible, to assess health needs, decide on eligibility for NHS Continuing Healthcare, and provide that care. It is to be read in conjunction with the national tools to support decision-making: the "Decision Support Tool", and the "Fast Track" and "Checklist" tools. Separate user notes, to clarify how to apply the tools, are attached to the tools themselves.

12. This guidance cancels the following previous guidance and circulars:-
    - HSC2001/15 and LAC2001(18): Continuing Care: NHS and local councils' responsibilities
    - NHS Continuing Care: action following the Grogan judgment (2006)

13. From 1 October 2007, the following previous guidance and circulars are cancelled:
    - HSC 2001/17 and LAC(2001)26: Guidance on free nursing care in nursing homes
    - NHS Funded Nursing Care: Practice Guide & Workbook
    - HSC2003/006 and LAC(2003)7: Guidance on NHS funded nursing care

14. The current, three-tiered system of NHS-funded Nursing Care funding remains in place until 30 September 2007. Directions will be issued in due course which will cancel the current system and introduce a single band, operational from 1 October 2007.

15. This document will be reviewed on 30 September 2008.

Legal framework

Legislation

16. Primary legislation governing the health service does not use the expressions "continuing care", "NHS Continuing Healthcare" or "primary health need". However, section 1 of the National Health Service Act 2006 requires the Secretary of State to continue the promotion in England of a comprehensive health service, designed to secure improvement in (i) the physical and mental health of the people of England and (ii) the prevention, diagnosis and treatment of illness[1]. Furthermore, the Secretary of State is under a duty to provide services for "the care of persons suffering from illness" throughout England to such extent as she considers necessary to meet all reasonable requirements (section 3, particularly section 3(1)(e) of the National Health Service Act 2006). This includes accommodation for the purposes of health services provided under that Act. SHAs and PCTs (amongst others) carry out this function on behalf of the Secretary of State. What is appropriate to be provided as part of the health service therefore has to be considered in the light of the overall purpose of the health service to improve physical or mental health or prevent, diagnose or treat illness.

17. Each LA is under a duty to assess any person who appears to it to be in need of community care services (section 47 of the National Health Service and Community Care Act 1990). Community Care services can include residential accommodation for persons who by reason of age, illness or disability are in need of care and attention which is not otherwise available to them (section 21 of the National Assistance Act 1948) as well as domiciliary and community-based services enabling people to continue to live in the community. The LA, having regard to the result of that assessment, must then decide whether the person's needs call for the provision of community care services. The LA must also notify the relevant PCT if, in carrying out the assessment, it becomes apparent to the authority that the person has needs which may fall under the National Health Service Act 2006, and invite them to assist in the making of the assessment (see section 47(3)(a) of the National Health Service and Community Care Act 1990).

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

19. Section 49 of the Health and Social Care Act 2001 prohibits LAs from providing, or arranging for the provision of, nursing care by a registered nurse in connection with the provision by them of community care services. "Nursing care by a registered nurse" is defined as "services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care other than any

[1] "Illness" is defined in the NHS Act 2006 as including any injury or disability requiring medical or dental treatment or nursing

services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse".

20. Deciding on the balance between LA and PCT responsibilities with respect to continuing care has been the subject of key court judgments.

Case law

21. The decision of the Court of Appeal in *R v North and East Devon Health Authority ex parte Coughlan [1999]* considered the responsibilities of health authorities and LAs' social service provision, in particular the limits on the provision of nursing care (in a broad sense, i.e. not just registered nursing) by LAs. This case was decided before the enactment of section 49 of the Health and Social Care Act 2001. The key points from this judgment are set out at Annex B. The Court referred to a very general indication of the limit of LA provision in the context of a person living in residential accommodation, saying that if the nursing services are:-
    i. merely incidental or ancillary to the provision of the accommodation which a LA is under a duty to provide pursuant to section 21; and
    ii. of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide,

    then they can be provided under section 21 of the National Assistance Act 1948.

22. After the enactment of the Health and Social Care Act 2001, care from a registered nurse cannot be provided by the LA as part of community care services. Nevertheless, the extent of care supported by the registered nursing care contribution is still to be considered as "incidental and ancillary" in the sense described in *Coughlan*. The interaction between NHS Continuing Healthcare and NHS funded Nursing Care was further considered by the High Court in *R v. Bexley NHS Trust, ex parte Grogan [2006]*. The key points from this judgment are set out at Annex C.

Primary health need

23. To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006, and to distinguish between those and the services which LAs may provide under section 21 of the National Assistance Act 1948, the Secretary of State has developed the concept of "a primary health need". Where a person's primary need is a health need, the NHS is regarded as responsible for providing for all their needs, including accommodation, if that is part of the overall need, and so they are eligible for NHS Continuing Healthcare. The decision as to whether this is the case should look at the totality of the relevant needs.

24. There should be no gap in the provision of care, such that people might be in a situation where neither the NHS nor (subject to the person meeting the relevant means test) the relevant LA, separately or together, will fund care. Therefore, the "primary health need" test should be applied so that a decision of ineligibility for NHS Continuing Healthcare is possible only where, taken as a whole, the nursing or other health services required by the individual:

i. are no more than incidental or ancillary to the provision of accommodation which LA Social Services are under a duty to provide; and
ii. are not of a nature beyond which a LA whose primary responsibility is to provide Social Services could be expected to provide.

25. There are certain limitations to this test, which was originally indicated in *Coughlan*: neither the PCT nor the LA can unilaterally dictate what the other agency should provide, and the *Coughlan* judgment itself focused only on general and registered nursing needs.

26. Instead, a practical approach to eligibility is necessary, which will apply to a range of different circumstances, including situations in which the "incidental or ancillary" test is not applicable. This will include, for example, cases where people are cared for at home, or currently fund their own care in a care home. Certain characteristics of need, and their impact on the care required to manage them, may help determine whether the "quality" or "quantity" of care required is more than the limits of LAs' responsibilities as outlined in *Coughlan*:

- Nature: the type of needs, and the overall effect of those needs on the individual, including the type ("quality") of interventions required to manage them;
- Intensity: both the extent ("quantity") and severity (degree) of the needs, including the need for sustained care ("continuity");
- Complexity: how the needs arise and interact to increase the skill needed to monitor and manage the care;
- Unpredictability: the degree to which needs fluctuate, creating difficulty in managing needs; and the level of risk to the person's health if adequate and timely care is not provided.

Each of these characteristics may, in combination or alone, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs.

27. One or more of these characteristics may well apply for those people approaching the end of their lives. There may also be circumstances where an individual not previously awarded NHS Continuing Healthcare on the basis of need does have a rapidly deteriorating condition, which may be entering a terminal phase. They may need NHS Continuing Healthcare funding to enable their needs to be urgently met (e.g. to allow them to go home to die or to allow appropriate end-of-life support to be put in place). This would also be a primary health need because of the rate of the deterioration. Good practice in end-of-life care is currently supported through the End-of Life Care Programme[2]. The national End-of Life Care strategy will be published at the end of this year[3].

28. To minimise variation in interpretation of these principles and to inform consistent decision-making, we have developed the national Decision Support Tool in conjunction with stakeholders. The Decision Support Tool supports practitioners in obtaining a full picture of needs and by indicating a level of need which could constitute a primary health need. The Decision Support Tool, combined with practitioners' own experience and professional judgement, should therefore enable them to apply the primary health need test in practice in a way which is consistent with the limits on what can lawfully be provided by a LA, in accordance with the *Coughlan* and *Grogan* judgments.

29. Further details about the Decision Support Tool, and its application, are set out below (paragraphs 56-61) and in the notes accompanying the tools. Before using the Decision Support Tool, practitioners should ensure that they have obtained evidence from all the necessary assessments (comprehensive and specialist), in line with the core values and principles outlined here.

[2] http://www.endoflifecare.nhs.uk/eolc/Tools/
[3] http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Endoflifecare/index.htm

Core values and Principles

30. The process of assessment and decision-making should be person-centred. This means placing the individual, their perception of their support needs and their preferred models of support at the heart of the assessment and care-planning process. The individual's wishes and expectations as to how and where the care will be delivered should be documented and taken into account, along with the risks of different types of provision and fairness of access to resources, when deciding how their needs will be met.

31. Access to both assessment and provision should be fair and consistent. There should be no discrimination on the grounds of race, disability, gender, age, sexual orientation, religion or belief, or type of health need (for example whether the need is physical or mental). PCTs are responsible for ensuring that discrimination does not occur by means of effective auditing (please see the section on Governance below).

32. Assessments, and the consideration of eligibility for, and delivery of, NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that the person who is undergoing an assessment and their family and/or carers understand the process, and receive advice and information to enable them to participate in informed decisions about their future care. Decisions and rationales relating to eligibility should be transparent from the outset: for individuals, carers, family, and staff.

33. As with any examination or treatment, the individual's informed consent[4] should be obtained before the process of determining eligibility for NHS Continuing Healthcare begins. If there is a concern that the individual may not have capacity to give their consent, this should be determined in accordance the Mental Capacity Act 2005 and the associated code of practice, which, for the purposes relevant to this guidance, is in force from October 2007.[5] In fulfilling the requirements of the Mental Capacity Act 2005, PCTs may also need to consider the appointment of an independent mental capacity advocate in certain circumstances especially when deciding on long-term care provision: again, further guidance can be found in the code of practice.

34. Any person may elect a family member or other person (who should be independent of LA or NHS body) to advocate on their behalf. Even where this is not the case, the views and knowledge of family members may be taken into account, where consent has been given to seek these views.

35. PCTs and LAs should bear in mind that a carer providing regular and substantial care has a right to an assessment of their needs as a carer (Carers and Disabled Children's Act 2000 as amended by the Carers (Equal Opportunities) Act 2004).

36. 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.

[4] Further guidance on consent can be found at www.dh.gov.uk/consent.
[5] http://www.opsi.gov.uk/acts/en2005/ukpgaen_20050009_en_cop.pdf

37. NHS Continuing Healthcare may be provided by PCTs in any setting (including, but not limited to, a care home, hospice or the person's own home). Eligibility for NHS Continuing Healthcare is therefore not determined or influenced by either the setting where the care is provided nor by the characteristics of the person who delivers the care. The decision-making rationale should not marginalise a need because it is successfully managed: well-managed needs are still needs. Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need will this have a bearing on NHS Continuing Healthcare eligibility.

38. Financial issues should not be considered as part of the decision about an individual's eligibility for NHS Continuing Healthcare, and it is important that the process of considering and deciding eligibility does not delay treatment or appropriate care being put in place.

39. Establishing that an individual's primary need is a health need requires a clear, reasoned decision based on evidence of needs from a comprehensive assessment framework. The evidence and the decision making process should be accurately and fully recorded. A number of models are already in place, for example:
i. Single Assessment Process (SAP) for Older People (extends to other care groups in some regions)
ii. Care Programme Approach (CPA) for Mental Health patients
iii. Person-Centred Plans for Learning Disability
These will be developed into a common assessment framework following on from the White Paper: Our Health, Our Care, Our Say: A New Direction for Community Services.

40. A person carrying out an assessment for NHS Continuing Healthcare should always consider whether there is further potential for rehabilitation and regaining independence, and how the outcome of any treatments or medication may affect ongoing needs.

41. The risks and benefits to the individual of a change of location or support (including funding) should be considered carefully before any move or change is confirmed. Neither the PCT nor LA should unilaterally withdraw from funding an existing package without appropriate reassessment and identification of the body responsible for funding.

42. The reasons given for a decision on eligibility should not be based on:
– the setting of care,
– the ability of the care provider to manage care,
– the use (or not) of NHS employed staff to provide care,
– the need for/presence of 'specialist staff ' in care delivery,
– the existence of other NHS-funded care, or
– any other input-related (rather than needs-related) rationale.

43. The NHS's responsibility to provide or commission care (including NHS Continuing Healthcare) is not indefinite as needs might change. This should be made clear to the individual and their family. Regular reviews are built into the process to ensure that the care package continues to meet the person's needs.

Eligibility Considerations: Process

44. Figure 1 illustrates the process of determining eligibility for NHS Continuing Healthcare.

45. Occasionally, individuals with a rapidly deteriorating condition, which may be entering a terminal phase, will require "fast-tracking" for immediate provision of NHS Continuing Healthcare because they need an urgent package of care. In this case, the "Fast Track Pathway" tool may be used by a senior clinician such as a ward sister, consultant or a GP to outline the reasons for the fast-tracking decision. This may be supported by a prognosis if available, but strict time limits are not relevant for end-of life cases and should not be imposed: it is the responsibility of the assessor to make a decision based on the relevant facts of the case. If possible and appropriate, the initial fast-tracking decision should be followed by a full assessment of need. Careful decision making is essential, to avoid undue distress that might result from a person moving in and out of NHS Continuing Healthcare eligibility within a very short period of time.

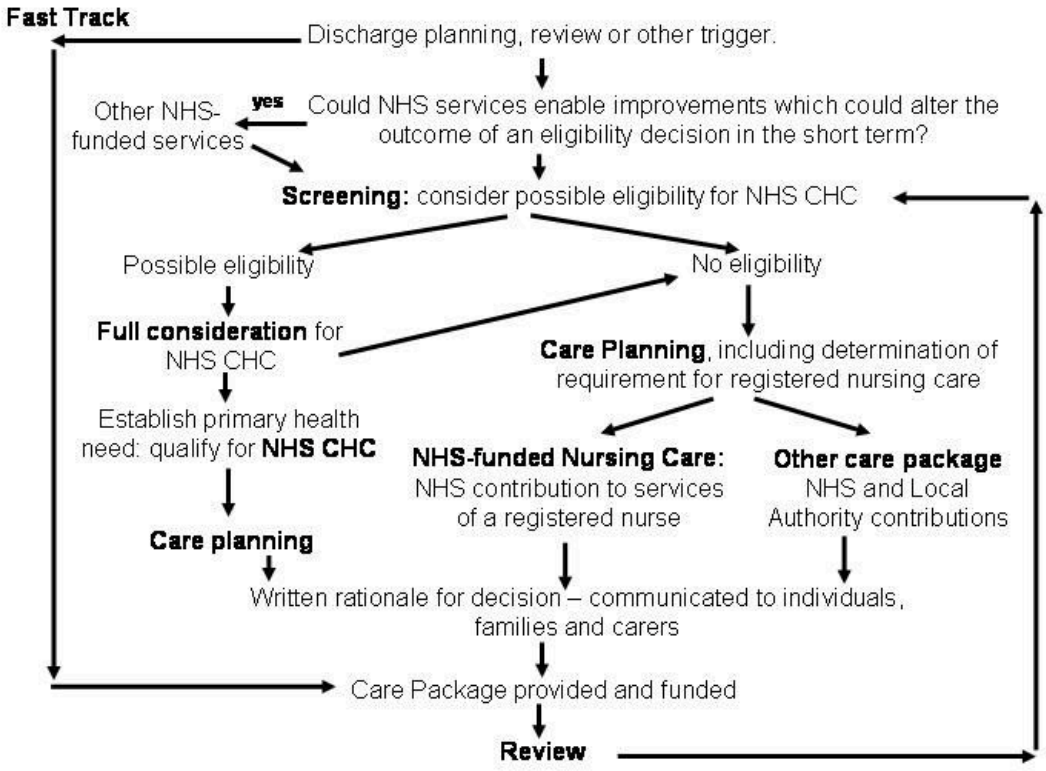

Figure 1. Overall process for determining eligibility for NHS Continuing Healthcare (CHC) and NHS funded Nursing Care. Please see main text for explanation.

46. The first step in the process for most people to the system will be a screening process, using the NHS Continuing Healthcare Needs Checklist. The purpose of the Checklist is to encourage proportionate assessments, so that resources are directed towards those people who are most likely to be eligible for NHS Continuing Healthcare, and ensure that a rationale is provided for all decisions regarding eligibility.

Before applying the Checklist, it is necessary to ensure that the individual, and their representative where appropriate, understand that the Checklist does not indicate the likelihood that the individual will be found to be eligible for NHS Continuing Healthcare. The threshold at this stage has been set deliberately low, to ensure that all those who require a full consideration of their needs do get this opportunity.

47. A nurse, doctor, other qualified healthcare professional, or social worker could apply the Checklist to refer individuals for a full consideration of eligibility for NHS Continuing Healthcare from either a community or hospital setting. Whoever applies the checklist will need to be familiar with, and have regard to, the content and principles of this guidance and the Decision Support tool (see paragraphs 55-60).

48. In a hospital setting, before an NHS body gives notice of a individual's case to a social services authority, it "must carry out such an assessment as it considers appropriate of the individual's need for continuing care, in consultation, where it considers it appropriate, with the relevant social services authority" (the Delayed Discharges (Continuing Care) Directions 2004). This is to comply with its duty under section 2(2) of the Community Care (Delayed Discharges etc) Act 2003.

49. Assessments in acute settings can sometimes poorly represent an individual's capacity to maximise their potential. To help avoid this problem but to ensure that unnecessary stays on acute wards are avoided, it should be considered whether further NHS-funded therapy and/or rehabilitation might make a difference to the potential of the individual in the following few months, and if so, transfer the patient to the appropriate NHS service. Where NHS-funded care, other than on an acute ward, is the next appropriate step after hospital treatment, this does not trigger the responsibilities under the Community Care (Delayed Discharges etc) Act 2003.

50. If the Checklist is used at the point of discharge from hospital, and indicates either

i. a need for a full eligibility consideration, or
ii. an inconclusive result,

a decision should be made, and recorded, to undertake a full consideration of eligibility once all treatment and rehabilitation has been completed. This full consideration should be completed in the most appropriate setting, whether it is another NHS institution, the individual's home, or other care setting. In the interim, the PCT retains responsibility for funding appropriate care.

51. In many cases, whether in a hospital or community setting, a full consideration of NHS Continuing Healthcare will be inappropriate. If the outcome of the screening assessment is that a referral for a full consideration for NHS Continuing Healthcare is unnecessary, this decision, together with the reasons for it, should be communicated clearly to the individual, and their carers or representatives where appropriate. They may still request a full assessment from the PCT, and the PCT should give this request due consideration, taking into account all the information available including additional information from the individual or carer. Care planning for those individuals with ongoing needs, including the consideration of need for registered nursing care, will still be necessary (see the section on care planning, below).

52. If the outcome of the screening assessment is that a referral for a full consideration for NHS Continuing Healthcare is necessary, the result and the reasons for it should be

communicated clearly to the individual, and their carers or representatives where appropriate, as soon as reasonably practicable. In line with the assessment models mentioned above, once an individual has been referred for a full consideration for NHS Continuing Healthcare, an individual, or individuals should be identified by the PCT to co-ordinate the process. This role will involve taking responsibility for the whole process until the decision about funding has been made and a care plan has been written.

53. A comprehensive, multidisciplinary assessment of an individual's care needs, including all relevant specialist and non-specialist assessments, should be carried out by a multidisciplinary team in line with the Core Values and Principles outlined above, and other existing guidance, particularly about the Single Assessment Process[6], Care-Programme Approach (under review[7]) and Person-Centred Planning[8].

54. Involving social services colleagues as well as health professionals in the assessment process will streamline the process of care planning and make decision making more effective and consistent. Some form of joint working could be made mandatory in future by virtue of directions under the National Health Service Act 2006 and section 7A of the Local Authority Social Services Act 1970. As with assessments which they are carrying out individually[9], LAs should not allow an individual's financial circumstances to affect a decision to participate in a joint assessment.

55. Wherever possible, the person coordinating the assessment process and eligibility consideration will liaise with the multidisciplinary team members themselves to complete the Decision Support Tool, matching, as far as possible, the individual's level of need with the description that most closely relates to their specific needs. As a general principle, LAs should work with PCTs to complete the tool wherever possible. As set out above, consideration is being given to appropriate Directions to both PCTs and LAs to require joint working in this area.

56. The Decision Support Tool is designed to ensure that the full range of factors which have a bearing on an individual's eligibility are taken into account in making this decision. The tool provides practitioners with a framework to bring together and record the various needs in eleven 'care domains', or generic areas of need. The domains are sub-divided into statements of need representing low, moderate, high, severe or priority levels of need, depending on the domain. The care domains are:

1. Behaviour
2. Cognition
3. Communication
4. Psychological/Emotional Needs
5. Mobility
6. Nutrition – Food & Drink
7. Continence
8. Skin (including tissue viability)
9. Breathing
10. Drug Therapies & Medication: Symptom Control
11. Altered States of Consciousness

[6] http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Socialcare/Singleassessmentprocess/index.htm
[7] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_063354
[8] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4098013
[9] LAC(2002)13 - Fair Access to Care Services – Guidance on Eligibility Criteria for Adult Social Care.

57. The result of completing the tool should be an overall picture of the individual's needs, which captures their nature, and their complexity, intensity and/or unpredictability and thus the quality and/or quantity (including continuity) of care required to meet the individuals' needs. Figure 2 indicates how the domains in the Decision Support Tool can illustrate the complexity, intensity and unpredictability of needs. The overall picture, and the descriptors within the domains themselves, also relate to the nature of needs.

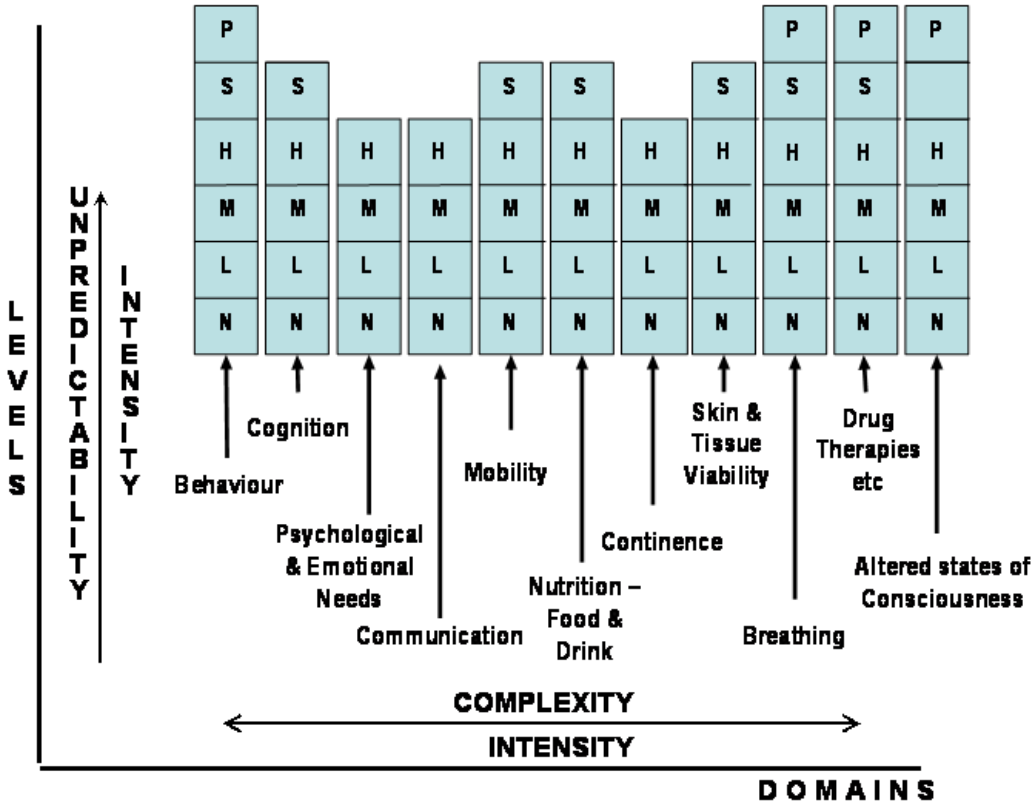

Figure 2. How the domains in the Decision Support Tool help to build up a picture of complexity, intensity and unpredictability. The letters N, L, M, H, S and P refer to No, Low, Moderate, High, Severe and Priority levels within the eleven care domains.

58. There may be circumstances, on a case-by-case basis, where an individual may have particular needs which are not easily categorised by the care domains described here. In this situation, it is the responsibility of the assessors to determine and record the extent and type of this need, and take that need into account when deciding whether a person has a primary health need according to paragraphs 24-30.

59. As described in the Decision Support Tool, the multidisciplinary team should use it to set out the evidence to allow them to consider not just the overall needs, but also the interaction between the needs, and evidence from relevant risk assessments. Although the tool supports the process of determining eligibility, and ensures consistent and comprehensive consideration of an individual's needs, it cannot directly determine eligibility. Indicative guidelines as to a threshold are set out in the tool (for example, if one area of need is at priority level, then this demonstrates a primary health need) but

these are not to be viewed prescriptively. Professional judgement should be exercised in all cases to ensure that the individual's overall level of need is correctly determined.

60. Once the multidisciplinary team has reached agreement, they should make a recommendation about eligibility to the PCT.

61. PCTs should be aware of cases which have indicated circumstances where a finding of eligibility for NHS Continuing Healthcare should have been made, and where the same outcome would be expected if the same facts were being considered in an assessment for NHS Continuing Healthcare under the National Framework (e.g. *Coughlan*, and those in the Health Service Ombudsman's report NHS funding for long term care of older and disabled people). However, they should be wary of trying to extrapolate generalisations about eligibility for NHS Continuing Healthcare from the limited information they may have about those cases. There is no substitute for a careful and detailed assessment of the needs of the individual whose eligibility is in question.

62. Many PCTs use a panel to ensure consistency and quality of decision-making. Processes which are already in place, have suitable governance and are working well do not need to be altered. However, panels should not be used as gate-keeping function nor as a financial monitor. Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed. A decision to overturn the recommendation should never be made by one person acting unilaterally. Because the final eligibility decision should be independent of budgetary constraints, finance officers should not be part of a decision-making panel.

63. The time between referral for a full consideration of need and communication of the funding decision to the individual, and their carers or representative where appropriate, should not exceed two weeks in most cases. However, if the referral has taken place and NHS care is still ongoing, the process may take longer. When there are valid and unavoidable reasons for the process taking longer, time scales should be clearly communicated to the person and their carers.

Links to other policies

Links to Mental Health legislation

64. PCTs and LAs should be familiar with relevant sections of the Mental Health Act 1983.

65. Under section 117, PCTs and LAs have a duty to provide after-care services for individuals who have been detained under certain provisions of the Mental Health Act 1983 until such time as they are satisfied that the person is no longer in need of such services. Section 117 is a free-standing duty and PCTs and LAs have been advised to have in place local policies detailing their respective responsibilities[10].

66. There are no powers to charge for services provided under section 117, regardless of whether they are provided by the NHS or LAs. Accordingly, the question of whether services should be "free" NHS services rather than potentially charged-for social services does not arise. It is not therefore necessary to assess eligibility for NHS Continuing Healthcare if all the services in question are to be provided as after-care under section 117.

67. However, a person in receipt of after-care services under section 117 may also have needs for continuing care which are not related to their mental disorder and which may therefore not fall within the scope of section 117. An obvious example would be a person who was already receiving continuing care in relation to physical health problems before being detained under the 1983 Act and whose physical health problems remain on discharge. Where such needs exist, it may be necessary to carry out a consideration for NHS Continuing Healthcare.

Bournewood

68. The Mental Health Bill, currently going through Parliament[11], contains provisions in response to the ECHR case of HL v UK in October 2004 ("the Bournewood judgment"). This would introduce new procedures into the Mental Capacity Act 2005 that will apply to a person who lacks capacity and who needs to be deprived of their liberty in a care home or hospital in their own best interests in order to receive necessary care or treatment. The fact that a person who lacks capacity does need to be deprived of his or her liberty in these circumstances does not affect the assessment of whether the person is eligible for NHS Continuing Healthcare. Therefore, the same process outlined above to determine eligibility for NHS Continuing Healthcare should be undertaken Pending the enactment of the provisions in the Bill, PCTs should be aware of existing guidance published in December 2004[12].

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[10] HSC 2000/003 and LAC (2000)3: After-care under the Mental Health Act 1983: section 117 after-care services.

[11] http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Mentalhealth/DH_073490

[12] Advice on the Decision of the European Court of Human Rights in the Care of HL v UK (The Bournewood Case) - Gateway Reference 4269.

Other existing commitments to NHS funded care

69. There may be other circumstances, aside from a PCT's responsibilities for NHS Continuing Healthcare and under the Mental Health Act 1983, when the NHS will be expected to take responsibility for a person's long term care. An example might be people with learning disabilities, where there may be an existing commitment to fund ongoing care to individuals following the closure of long stay hospitals or campuses. These responsibilities arise independently of the PCT's responsibility to provide continuing care and there should not be any assumption that these responsibilities equate to eligibility for continuing care or vice versa.

Links to Children's Policy

70. This guidance does not cover under 18s (children). Whilst similar principles and values apply, there are different legislative drivers for younger people's services, including their need for education, and guidance on this topic is currently under consideration.

71. However, regulations[13] state that a child in receipt of Children's Continuing Care should be reassessed for their eligibility for Adult NHS Continuing Healthcare, and that until they have been assessed, the current package of care should be maintained. It is therefore in the child/young person's and the PCT and LA's interests to monitor those recipients of continuing care who are aged 16 or 17, to ensure continuity of care provision (not necessarily funding) once the individual reaches 18. The transition from childhood to adulthood is thus a trigger for a full review (see section on Reviews, below).

13 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073109

Care planning and provision

72. Whether a person is eligible for NHS Continuing Healthcare or not, if he has ongoing care needs, the care planning process decides on how to best meet those needs.

73. It is the responsibility of the PCT to identify, commission and contract for all services required to meet the needs of all such individuals who qualify for NHS Continuing Healthcare, and for the health care part of a joint care package (see Care planning for other Care packages, below).

74. To enable efficient commissioning, it may be appropriate for LAs to share information and databases in order to assist PCTs with their commissioning responsibilities. NHS-funded care can be commissioned from the full range of providers. NHS commissioning includes an ongoing case management role in addition to regular reviews. PCTs should try and have a strategic rather than a case-by-case approach to fulfilling their commissioning responsibilities, and be aware of the principles of the draft Commissioning Framework for Health and Wellbeing, published for consultation earlier this year[14].

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Care planning for NHS Continuing Healthcare

75. Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the PCT thinks is appropriate for the individual's needs. Although the PCT is not bound by the views of the LA as to what services the individual needs, the LA's assessment under section 47 of the National Health Service and Community Care Act 1990 or contribution to a joint assessment will be important in identifying the individual's needs and in some cases the options for meeting them.

76. The LA is, however, not prevented from providing services, as it sees fit. Indeed in some cases, there may have to be individual arrangements reached between LAs and PCTs with respect to the provision of services. This may be particularly relevant where the person is to be cared for in a community setting.

77. NHS services cannot be provided as part of an Individual Budget or through Direct Payments, and *Our Health, Our Care, Our Say: A New Direction for Community Services* makes it clear that these will not be extended to NHS healthcare in the near future. This means that when an individual begins to receive NHS Continuing Healthcare they may experience a loss of control over their care which they had previously exercised through Direct Payments or similar. It should be emphasised that PCTs can commission to maximise continuity of care, i.e. to maintain a similar package of care to that already in place, and in determining whether to maintain an existing package, the PCT should take into account the individual's preferences wherever possible.

Care planning for other care packages

[14] http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_072622

78. Where a person is not found to be eligible for NHS Continuing Healthcare, they may receive a package of health and social care (rather than being fully funded by the NHS). As part of the care planning process, the NHS determines its responsibility for the services required from a registered nurse in a care home providing nursing care, which the LA cannot provide, according to Section 49 of the Health and Social Care Act 2001. Please see Annex D for further information.

79. Additional health services apart from registered nursing may also be funded by the NHS if these are agreed as part of a care plan. The range of services which the NHS is expected to arrange and fund includes but is not limited to:

- Primary health care
- Assessment involving doctors and registered nurses
- Rehabilitation and recovery (where this forms part of an overall package of NHS care as distinct from intermediate care)
- Respite health care
- Community health services
- Specialist health care support
- Palliative care

80. According to each LA's *Fair Access to Care* criteria, they will be responsible for providing such social care, including personal care, as can lawfully be provided following the *Coughlan* limits set out in paragraph 22 (see also Annex B).

81. With respect to other types of joint packages, the extent to which each service should provide care is for NHS and LA partners to agree. LAs can provide some health services. Section 21(8) of the National Assistance Act 1948 states that nothing in section 21 authorises or requires a LA to make any provision authorised or required to be provided under the NHS Act 2006 (formerly the NHS Act 1977). This was considered by the Court of Appeal in *Coughlan*:

> *"[Section 21] should not be regarded as preventing a local authority from providing any health services. The subsection's prohibitive effect is limited to those health services which, in fact, have been authorised or required to be provided under the 1977 Act. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the 1977 Act it was not necessary for the NHS to provide."*

Review

82. If the NHS is providing any part of the care, a case review should be undertaken to reassess care needs and eligibility for NHS Continuing Healthcare and to ensure those needs are being met no later than three months following the initial assessment (including those who did not receive a full consideration for NHS Continuing Healthcare eligibility following application of the Checklist), and then as a minimum standard on an annual basis. This also ensures that full NHS responsibility can be reconsidered at review, if the person did not meet the eligibility criteria for full funding at the first assessment. Some cases will require a more frequent case review in line with clinical judgement and changing needs. There is also the right to request a review if a individual or their representative considers that the wrong decision was made (please refer also to the paragraphs on dispute resolution).

83. When reviewing the need for NHS funded nursing care, potential eligibility for NHS Continuing Healthcare should always be considered and a full assessment carried out where necessary. Using the Checklist should enable proportionate assessments.

84. The outcome of the case review will determine whether the individual's needs have changed, which will then determine whether the package of care may need to be revised or the funding responsibilities altered. The outcome of a review does not necessarily indicate the same outcome should have been reached with a previous assessment, provided that the previous assessment was properly carried out and the decision taken on the basis of that assessment was based on sound reasoning.

85. From October 2007, all individuals entering the system will be assessed using the National Framework and Decision Support Tool. Routine reviews (paragraph 82), should also be carried out in this way.

86. If a person was assessed as not needing NHS Continuing Healthcare under a previous system, and when reassessed under the National Framework is found to be eligible for NHS Continuing Healthcare, assuming that the previous decision under the old system was properly taken (i.e. the criteria at the time were lawful, the criteria were properly applied, there are sound reasons for the decision taken and the process was properly documented), that should not entitle the person to be reimbursed from the date they were previously refused NHS Continuing Healthcare. However, if their needs have not changed, it should be considered whether their funding should be back-dated to the implementation date of the National Framework.

87. Neither the NHS nor LAs should unilaterally withdraw from an existing funding arrangement without a joint reassessment of the individual and without first consulting one another and the individual about the proposed change of arrangement. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If joint agreement cannot be reached upon the proposed change, the local disputes procedures (see below) should be invoked and current funding arrangements should remain in place until the dispute has been resolved.

88. In reviewing decisions made before implementation of the Framework, PCTs should use the most relevant, lawful criteria. These may therefore be pre-National Framework criteria, as long as they are *Coughlan*- and *Grogan*-"compliant".

Dispute resolution

Challenges to individual decisions

89. Under direction 3(2) of the Continuing Care (National Health Service Responsibilities) Directions 2004, PCTs are responsible for informing the individual as to the circumstances and manner in which he may apply for a review of the decision about a person's need for Continuing Healthcare: it is intended to make Directions with a similar content to continue the review procedures on and after 1 October 2007 at which point the 2004 Directions will be revoked.

90. Primary Care Trusts should deal promptly with any request to review decisions about eligibility for either NHS Continuing Healthcare or NHS-funded Nursing Care. The PCT's local resolution process will be the usual first step, unless it will add unnecessary delay in resolution. This process will usually take the form of a PCT review panel, though local procedures may be adapted to include reference to the review panel of a neighbouring PCT to provide greater patient confidence in the impartiality in decision-making.

91. Once local procedures have been exhausted, the case should be referred to the SHA's Independent Review Panel (IRP) (details in Annex E), who will consider the case and make a recommendation to the PCT (currently directions 4-8 of the Continuing Care (National Health Service Responsibilities) Directions 2004. The panel's key task is to assess whether the PCT has correctly applied the National Framework for NHS Continuing Healthcare or NHS-funded Nursing Care, and has followed the processes set out in this guidance. Based upon its review of the circumstances surrounding the case, the IRP can then make a recommendation on the validity of the PCT's decision.

92. The IRP will seek information from the patient's family or carer, and appropriate professional advice from relevant staff involved with the case (hospital, community health and social services staff, the patient's GP).

93. The key principles for the IRP, and indeed for any dispute resolution process for NHS Continuing Healthcare are:

- Gathering and scrutiny of all available and appropriate evidence, whether written or oral, including that from the GP, hospital (nursing, medical, mental health, therapies etc), community nursing services, care home provider, Social Services records etc, as well as any information submitted by the individual concerned.
- Compilation of a robust and accurate identification of the care needs.
- Audit of attempts to gather any records said not to be available.
- Involvement of individual/carer as far as possible, including the opportunity for individuals to input information at all stages.
- There should be a full record of deliberations at all review panels.
- Clear and evidenced written decisions to the individual setting out rationale for the panel's decision on their eligibility for NHS Continuing Healthcare on the basis of their needs only. This should include appropriate rationale related to this guidance. The rationale should not be based on:
  - the inputs currently being provided rather than the care needs,
  - the setting of care,
  - the ability of the care provider to manage care,

– the use (or not) of NHS employed staff to provide care,
– the need for/presence of 'specialist staff ' in care delivery,
– the existence of other NHS-funded care, or
– any other input-related (rather than needs-related) rationale.

• Consistency between the panel deliberations and the recommendation/decision letter.

94. The panel's IRP's role is advisory, but. the decisions of the IRP should be accepted in all but exceptional circumstances by the PCT.

95. If the original decision is upheld and there is still a challenge, the case should currently be referred to the Healthcare Commission. It should be noted that the Government has announced its intention to merge the Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission by 2009 and, as part of the merger, to review the functions of the new regulatory body. The role of the Healthcare Commission – or rather its successor body – in relation to NHS Continuing Healthcare disputes may therefore change. Where the criteria for such a referral are satisfied, a complaint may finally be made to the Health Service Commissioner (Ombudsman).

96. The individual's rights under the existing NHS and Social Services Complaints procedures, and their existing right to refer the case to the Health Service Commissioner, remain unaltered by the panel arrangements.

97. The White Paper, *Our Health, Our Care, our Say: a new direction for community services* contained a commitment to establish a comprehensive single complaints system across health and social care. A formal, three-month public consultation on proposals for reform of the NHS and social care complaints procedures was launched on 18 June 2007. As part of these reforms, it will be considered whether the dispute resolution procedures for NHS Continuing Healthcare should align with other NHS complaints within the same complaints procedure. Until the new procedures come into effect, SHAs should deal quickly with any request to review decisions about eligibility for either NHS Continuing Healthcare or NHS funded nursing care.

Disputes regarding the responsible body

98. For cases where there is a dispute between NHS bodies, or between LA and PCT about responsibility, the bodies should put in place a local dispute resolution process, which proceeds in a robust and timely manner. Disputes should not delay the provision of the care package and the protocol should make clear how funding will be handled during the dispute. The process could operate in a similar way to the panels established under the Community Care (Delayed Discharges etc) Act 2003, and similar panels may be implemented by Directions at a future date.

Governance

99. Both PCTs and SHAs have roles is establishing and maintaining governance arrangements for NHS Continuing Healthcare eligibility considerations and commissioning, as they do in other areas (please refer to existing guidelines about the roles of PCTs and SHAs[15]).

100. PCTs are responsible for:
i. Ensuring consistency in the application of the national policy on eligibility for NHS Continuing Healthcare,
ii. Promoting awareness of NHS Continuing Healthcare,
iii. Implementing and maintaining good practice,
iv. Ensuring quality standards are met and sustained,
v. Providing training and development opportunities for practitioners,
vi. Identifying and acting on issues arising in the provision of NHS Continuing Healthcare, and;
vii. Informing commissioning arrangements, both on a strategic and individual basis.

101. PCTs may therefore find it helpful have in place a system to record the assessments undertaken and their outcomes, and the costs of NHS Continuing Healthcare packages. This will help PCTs commission care more efficiently and to ensure that the data fed back to the Department and SHA is accurate and consistent.

102. SHA functions include providing strategic leadership and organisational and workforce development, and ensuring local systems operate effectively and deliver improved performance. SHAs, rather than the Department directly, hold PCTs accountable. SHAs should therefore engage with PCTs to ensure that they discharge these functions, for which they are accountable to the Department.

15 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4134649.

Annex A: Glossary

Assessment
A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.

Care
Support provided to individuals to enable them to live as independently as possible, including anything done to help a person live with ill health, disability, physical frailty or a learning difficulty and to participate as fully as possible in social activities. This encompasses health and social care.

Care co-ordination
The process of coordinating the tasks needed to enable a person to live independently. This will involve the individual, their family and carers, health and social care workers, and any additional support network.

Care coordinator
A person who coordinates the assessment and care planning process where a person needs complex and/or multiple services to support them. Care co-ordinators are usually the central point of contact with the individual.

Care package
A combination of services designed to meet an individual's assessed needs.

Care planning
A process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved.

Care plan
A document recording the reason why services are being provided and the outcome that they are seeking to achieve;

Carer
Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid.

Cognition
The higher mental processes of the brain and the mind, including memory, thinking, judgement, calculation, visual spatial skills and so on.

End of Life Care
Care which helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

Multidisciplinary
Multidisciplinary refers to when professionals from different disciplines - such as social work, nursing, occupational therapy, work together.

Multidisciplinary assessment
Multidisciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.

Multidisciplinary team
A team of at least two professionals, usually from both health and social care backgrounds.

NHS Continuing Healthcare
A complete package of ongoing care arranged and funded solely by the NHS, where it has been assessed that the individual's primary need is a health need. It can be provided in any setting. In a person's own home, it means that the NHS funds all the care that is required to meet their assessed health needs. In care homes, it means that the NHS also makes a contract with the care home and pays the full fees for the person's accommodation as well as all their care.

Palliative care
The active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.

Registered Nurse
A nurse registered with the Nursing and Midwifery Council.

Rehabilitation
A programme of therapy and re-enablement designed to maximise independence and minimise the effects of disability.

Social care
Social care refers to the wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships *Our Health, Our Care, our Say: a new direction for community services*, paragraph 1.29). It is provided by statutory and independent organisations and can be commissioned by a LA's Social Services Department on a means-tested basis, in a variety of settings.

Social services
Social services are provided by 150 LAs in England through their Social Services Departments. Individually and in partnership with other agencies they provide a wide range of care and support for people who are deemed to be in need.

Specialist assessment
An assessment undertaken by a clinician or other professional who specialises in a branch of medicine or care e.g. stroke, cardiac care, bereavement counselling.

Annex B: The Coughlan judgment

R v. North and East Devon Health Authority ex parte Pamela Coughlan

Pamela Coughlan was seriously injured in a road traffic accident in 1971. Until 1993 she received NHS care in Newcourt Hospital. When the Exeter Health Authority wished to close that hospital and to move Miss Coughlan and other individuals to a new NHS facility at Mardon House the individuals were promised that Mardon House would be their home for life. In October 1998, the successor Health Authority (North and East Devon Health Authority) decided to withdraw services from Mardon House, to close that facility, and to transfer the care of Miss Coughlan and other disabled individuals to LA Social Services. Miss Coughlan and the other residents did not wish to move out of Mardon House and argued that the decision to close it was a breach of the promise that it would be their home for life and was therefore unlawful.

The arguments on the closure of Mardon House raised other legal points about the respective responsibilities of the Health Service and of Social Services for nursing care. The Court of Appeal's judgement on this aspect has heavily influenced the development of continuing care policies and the National Framework. The key points in this regard are as follows:-

1. The NHS does not have sole responsibility for all nursing care. LAs can provide nursing services under section 21 of the National Assistance Act as long as the nursing care services are capable of being properly classified as part of the social services' responsibilities

2. No precise legal line can be drawn between those nursing services which are and those which are not capable of being provided by a LA: the distinction between those services which can and cannot be provided by a LA is one of degree which will depend on a careful appraisal of the facts of an individual case

3. As a very general indication as to the limit of LA provision, if the nursing services are:-
    i. merely incidental or ancillary to the provision of the accommodation which a LA is under a duty to provide pursuant to section 21; and
    ii. of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide,

    they can be provided under section 21 of the National Assistance Act 1948.

4. By virtue of section 21(8) of the National Assistance Act a LA is also excluded from providing services where the NHS has in fact decided to provide those services

5. The services that can appropriately be treated as responsibilities of a LA under section 21 may evolve with the changing standards of society

6. Where a person's primary need is a health need, the responsibility is that of the NHS, even when the individual has been placed in a home by a LA

7. An assessment of whether a person has a primary health need should involve consideration not only the nature and quality of the services required but also the quantity or continuity of such services

8. The Secretary of State's duty under section 3 of (what is now) the National Health Service Act 2006 is limited to providing the services identified to the extent that she considers necessary to meet all reasonable requirements: in exercising her judgement the Secretary of State is entitled to take into account the resources available to her and the demands on those resources

9. In respect of Ms Coughlan, her needs were clearly of a scale beyond the scope of LA services.

Annex C: The Grogan judgment

R v. Bexley NHS Care Trust ex parte Grogan

Maureen Grogan had multiple sclerosis, dependent oedema with the risk of ulcers breaking out, is doubly incontinent, is a wheelchair user requiring two people for transfer, and has some cognitive impairment. After the death of her husband her health deteriorated, she had a number of falls and was following an admission to hospital with a dislocated shoulder, it was decided that she was unable to live independently and she was transferred directly to a care home providing nursing care. Subsequent assessments indicated that Mrs Grogan's condition was such that she did not qualify for fully funded NHS Continuing Healthcare. She was initially determined to be in the medium band of NHS-funded nursing care, and remained in this band with the exception of one determination which placed her in the high band from April to October 2004. Mrs Grogan argued that the decision to deny her full NHS funding was unlawful, since the eligibility criteria put in place by South East London SHA were contrary to the judgment in the *Coughlan* case. She also submitted that the level of nursing needs identified in the RNCC medium and high bandings (in which she had been placed) indicated a primary need for health care which should be met by the NHS.

The Court concluded that in assessing whether Mrs Grogan was entitled to NHS Continuing Healthcare, the Care Trust did not have in place or apply criteria which properly identified the test or approach to be followed in deciding whether her primary need was a health need. The Trust's decision that Mrs Grogan did not qualify for NHS Continuing Healthcare was set aside and the question of her entitlement to NHS Continuing Healthcare was remitted to the Trust for further consideration. There was no finding, or other indication, that Mrs Grogan in fact met the criteria for NHS Continuing Healthcare.

Annex D: Determining the need for registered nursing care.

1. There are currently two stages to a decision about registered nursing care: assessment of need sufficient to make a decision about the requirement for registered nursing care in a nursing home, and a determination of which "band" should apply.

2. In all cases, the decision about eligibility for NHS Continuing Healthcare should precede the decision about the need for registered nursing care (refer HSC 2003/006). In most cases, therefore, the individual will already have had a consideration for NHS Continuing Healthcare, which will provide sufficient information to judge the need for registered nursing care in a nursing home. In certain circumstances, an individual who has been found not to be eligible for NHS Continuing Healthcare at the Checklist stage may still need to be considered for registered nursing care. In these cases, it may, therefore, be appropriate to use elements of the Single Assessment Process or similar process, to ensure that the decisions reached are proportionate, reasoned and recorded.

3. From October 2007, when the single band is implemented through Directions, the outcome of this process should provide the PCT with sufficient information to establish a contract with the care home in respect of registered nursing services, and will trigger the PCT's responsibility to fund the care from a registered nurse through a single rate of payment. Until then, once it has been decided that the individual requires a placement in a care home providing nursing care to manage their needs, but their primary need is not a health need, the determination of which "band" should apply will still be necessary.

4. Until October 2007, PCTs should be very clear that the criteria used for assessment for high band RNCC are clearly distinct from those for NHS Continuing Healthcare. It may be helpful to benchmark the need for care, monitoring and review by the registered nurse against the **average** nurse involvement (i.e. provision of care or the planning, supervision or delegation of care) in care homes providing nursing care, on which the funding linked to the medium band is based.

5. To the extent that the descriptions of the high band and of the medium band in the "workbook" (*NHS Funded Nursing Care: Practice Guide and Workbook*) use similar wording to the criteria for NHS Continuing Healthcare, and might appear to describe a need for nursing care beyond that which could be deemed incidental and ancillary, they should be disregarded. The workbook will be reviewed before implementation of the single band.

6. The RNCC bandings are not relevant to, and should not influence, the assessment of a person's eligibility for fully funded NHS Continuing Healthcare; in particular, there should be no concept that the nursing needs contained within the bandings represent a further criterion which has an impact on fully funded NHS Continuing Healthcare (National Health Service (Nursing Care in Residential Accommodation) (England) Directions 2001, paragraphs 3(2) and 5(2)).

Annex E: Independent Review Panel procedures

The purpose and scope of review panels

1. The purpose of the SHA Independent review procedure is:
   - to check that proper procedures have been followed in reaching decisions about the need for continuing NHS health care and the NHS services contributing to continuing health and social care;
   - to consider the application of the eligibility criterion for NHS Continuing Healthcare to the facts of an individual case.

   A review should not proceed if it is discovered that the individual has not previously received a comprehensive assessment of needs.

2. The review procedure does **not** apply where individuals or their families and any carer wish to challenge:
   - the content of the eligibility criteria
   - the type and location of any offer of NHS funded continuing care services;
   - the content of any alternative care package which they have been offered;
   - their treatment or any other aspect of the services they are receiving or have received (this would properly be dealt with through the complaints procedure).

3. Individuals and their carer or representative where appropriate should be given clear information about the review procedure, the situations it does and does not cover and how it operates locally (paragraphs 90-98 in the main text). Advocates should be provided where this will support the individual through the review process.

4. It is particularly important that before a panel is convened, all appropriate steps have been taken by the SHA in discussion with the relevant PCT or Trust to resolve the case informally. Each organisation should have a named contact who is the first port of call for queries from partner organisations.

5. If the case cannot be resolved by local resolution, the individual or their carer or representative may ask the appropriate SHA (i.e. the SHA in whose area the decision-making PCT is situated) to review the decision that the individual's needs do not meet the eligibility criteria for continuing care. The normal expectation is that the SHA in reaching a view will seek advice from an independent panel, the IRP. Before doing so it should ensure that none of the conditions listed at paragraph 2 of this annex apply.

6. Each SHA should designate an individual to maintain the review procedure and collect information for the IRP. Clear and timely communication is very important. Each SHA needs to identify clear timeframes for the process which should be made explicit, especially to individuals and carers.

7. The SHA does have the right to decide in any individual case not to convene a panel. It is expected that such decisions will be confined to those cases where the individual falls well outside the eligibility criteria or where the case is very clearly not

appropriate for the panel to consider. Before taking a decision the SHA should seek the advice of the chairman of the panel, who may require independent clinical advice. In all cases where a decision not to convene an IRP is made, the SHA should give the individual, their family or carer a full written explanation of the basis of its decision, together with a reminder of their rights under the NHS complaints procedure.

8. While this review procedure is being conducted, the PCT should continue to fund appropriate care Any existing care package, whether hospital care or community health services, should not be withdrawn under any circumstances until the outcome of the review is known.

Establishment of review panels

9. Every SHA should maintain a standing panel, according to their responsibilities under any relevant Directions (currently the Continuing Care (National Health Service Responsibilities) Directions 2004 but a new set of Directions will revoke and replace these from October 2007).

10. The chair should be selected by the SHA following an open recruitment process. The person chosen should have a clear understanding of the IRP's purpose and be able to communicate this to the individual, their family and any carers concerned. On the basis of the evidence received and the advice given at the panel, the chair should be able to determine whether eligibility criteria have been correctly applied. Chairs should have the capacity to make balanced decisions in sometimes difficult circumstances, whilst taking a sympathetic view of the concerns of individuals, their family and any carers.

11. Selection of the right person as Chair, who is capable of securing the confidence of all parties, will be a crucial factor in the success of the panel. Current non-executive Directors of SHAs, PCTs or council members should not be considered, but people who have formerly held such a position are eligible for consideration. SHAs are strongly advised to involve lay people in the selection process.

12. The appointment of representatives of PCTs and local council(s) will be on the basis of the nomination of those organisations. They should take account of the professional and other skills which will be relevant to the work of the panel.

13. Authorities should make arrangements to appoint an alternative Chair and members to cover absences, or to make a reciprocal arrangement for cover with a neighbouring authority. The Chair and members of the panel should receive reasonable expenses.

Operation of the panels

14. The designated SHA individual (paragraph 6 of this annex) is responsible for preparing information for the panel. The panel should have access to any existing documentation which is relevant, including the details of the individual's original assessment. They should also have access to the views of key parties involved in

the case including the individual, his or her family and any carer, health and social services staff, and any other relevant bodies or individuals. It will be open to key parties to put their views in writing or to attend.

15. An individual may have a representative present to speak on his or her behalf if they choose, or are unable or have difficulty in presenting their own views. This role may be undertaken by a relative or carer or advocate acting on the individual's behalf. The IRP should be satisfied that any person acting on behalf of the individual accurately represents their views and that their interests or wishes should not conflict with those of the individual. The IRP should respect confidentiality at all times.

16. The IRP will require access to independent clinical advice which should take account of the range of medical, nursing and therapy needs involved in each case. Such arrangements should avoid any obvious conflicts of interest between the individual clinician(s) giving the advice and the organisation(s) from which the individual has been receiving care.

17. The role of the clinical advisers is to advise the IRP on the original clinical judgements and on how those judgements relate to the National Framework. It does not have a role to provide a second opinion on the clinical diagnosis, management or prognosis of the individual.

18. The members of the IRP should meet to consider individual cases. They may wish to invite the clinical adviser(s) and the PCT Continuing care lead, or, if appropriate, the person they have nominated to take the views of the parties concerned, to attend their meetings. They should ensure that the panel has access to all the information it will require and to the views of all parties..

19. If a SHA decides, in very exceptional circumstances, to reject an IRP recommendation in an individual case, it should put in writing to the individual and to the Chairman of the panel its reasons for doing so.

20. In all cases the SHA should communicate in writing to the individual the outcome of the review, with reasons. All relevant parties (Trust, PCT, consultant, GP and other clinician(s)) should also receive this information.

Access to Services for Older People
Panel Meeting
15th October 2007

Present: Cllr Bull (Chair), Cllr Adamou, Cllr Alexander, Cllr Wilson, Celia Bower (OP Forum), Alex McTeare (PCT), Robert Edmonds (Age Concern), Tom Brown, John Haffenden, Verlyn Cowell, Chris Henderson, Maureen Dewar, Lloyda Fanusie,

Agenda Item	Notes	Action
Apologies	Zeedy Thompson Hazel Griffiths Manuela Toporowska	
Urgent Business	None	
Declarations of Interest	None	
Scope and Terms of Reference	Inclusion of Black and Minority Ethnic communities and geographic equity is welcome, discussion as to whether inclusion of gender balance in services should also be looked at. Agreed that the review will remain open minded and flexible throughout to allow for other areas to be incorporated where appropriate.	

Older People's Service Presentation	Tom Brown, Acting Assistant Director for Adults, Adult, Culture and Community Services (ACCS) Directorate spoke about the Older Peoples Service and the pathways taken by those accessing the service. Anyone over the age of 65years who is deemed as vulnerable is eligible for an assessment of need. Referrals generally come from other professionals and members of a person's family with the first point of contact being either the Initial Contact Team or the Stuart Crescent Health Centre. Assessment is then made as to whether Social Services is the most appropriate place (as opposed to health or the Department for Work and Pensions) and also ascertain the urgency of the person's situation. If it is found that Social Services is the appropriate place then the complexity and urgency of the case is and whether intervention from for example the Voluntary sector is more appropriate. The service endeavours to complete an assessment within 28days. This assessment includes detailed discussions with relevant parties, judgements on risk and a persons needs in relation to all aspects of their life are looked at and the four bandings of the Fair Access to Care Services (FACS) applied. Aim to try and reach a consensus with a person as to the best course of action. Haringey operates within the Substantial and Critical bandings of FACS). Unless there is clear urgency the case then goes to the Commissioning Panel in order to consider the allocation of services. The impact of providing or not providing a service is considered here. Both in-house and external providers are approached to see whether any of the	

	low level needs can be met. A review is undertaken after 6-8 weeks and then approximately once a year. If the person's needs are more complex then contact is more regular. If a person's situation changes then contact is more frequent. This is often brought to light by a person's carer or someone at a centre the person attends e.g. a day centre. A Higher Needs Panel also exists. This panel is a multi-disciplinary, multi-agency group where people's needs are assessed as to whether they meet the NHS Continuing Care Criteria for funding. This is where the need is deemed to be primarily health. Ideal outcome = Independence. Carers The assessment also takes into consideration the Carers needs. Noted that carers provide a valuable service which saves a lot of money. **Discussion Points** Funding The only external funding that is received is from government grants. Examples of this are the Carers Grant and the Access and Systems Capacity Grant. At present these are ring-fenced grants. Discussion as to whether it is possible to find out how many people present at Critical and Substantial. This will be investigated and will report back to the panel. Most authorities have a Commissioning Panel. Advantages of this include:	Tom Brown/Melanie Ponomarenko

	Equity and consistency of decision making. ➢ Objectivity when looking at cases. ➢ Ensures that all options have been looked at. ➢ Ensures that the quality of assessment is high as it acts as a check on the process. Approximately 50% of those coming into contact with the service are filtered out before assessment. Discussion surrounding what happens to these and as to whether they are borderline eligible for services, also whether they would be likely to come back to the service at a later date should their situation deteriorate. Analysis is not always possible due to resources. Noted that health and social services jointly need to improve the management of people will lower levels of need in order to prevent them from moving into the higher level needs areas. The Social Care workforce in Haringey does reflect the diversity of the borough, this has been officially audited. There are also good links in place with faith groups and voluntary agencies which are able to reach the harder to reach groups. There are budgetary issues in the service. It is impossible to predict how many people will come into the services within a year, at the same time there is set budget for the service. Budget monitoring takes place on a regular basis, however due to the statutory requirement to provide a service to those who meet eligibility criteria there is a frequent overspend. An overview of the Access Pathways Project, currently taking place in Adult, Culture and Community Services was given by John Haffenden (Assistant Director, Commissioning and Strategy):	

	Current routes into services are complicated and do need to be simplified. The end vision of the project is for universal services to be accessed by all, this includes those will lower level needs who are not eligible for a social care package. Emphasis is on preventative services. Current work includes looking at what is being done across each of the services in the ACCS Directorate and where the access points are. Service directories are being looked at. The Older Peoples service has a directory; it would be useful if every Councillor had a copy of this for when they are speaking to residents. Voluntary and community organisations will also be included and an aim is to ensure that the staff working in the Directorate will know what services are provided here. Noted that Melanie Ponomarenko has joined to Project Board so that the review and the project share information.	Tom Brown
Draft Review Timetable	Panel Members attendance at a Commissioning Panel meeting to be arranged asap. This will be Members only. Cabinet Member for Adult Social Care and Well-being to be invited to speak at a Panel meeting. Commissioners and Providers to be invited to panel meeting.	Melanie Ponomarenko Melanie Ponomarenko Melanie Ponomarenko

	Coordination of a list of places for panel to visit to be drawn up and scheduled in. Consideration to be given to the panel members having lunch at age concern to enable them to talk to people there.	Melanie Ponomarenko Melanie Ponomarenko
Date of Next Meeting	19th November 2007 10:00-12:00	
New Items of Urgent Business	None	

Scrutiny Review - Access to Services for Older People
Panel Meeting
19th November 2007

Councillors present: Cllr Bull (Chair), Cllr Adamou,

Others attending: Robert Edmonds (Age Concern), Andy Briggs, Diana Edmonds, Delia Thomas, Melanie Ponomarenko, Douglas Maitland-Jones

Agenda Item	Subject/decision
1.	Cllr Alexander Cllr Wilson Manuela Toporowska (Haringey Forum for Older People)
2.	**Urgent Business** None
3.	**Declarations of Interest** None
4.	**Minutes** Carried forward to next meeting
5.	**Overview and Feedback from Commissioning Panel** Carried forward to next meeting
6.	**Libraries** Diana Edmonds (Assistant Director Culture, Libraries and Learning) gave evidence and answered questions on the work currently undertaken by the Libraries services. There are significant pockets of libraries usage by Older People throughout the borough. For example, Tottenham, Coombes Croft, Highgate and Muswell Hill. It is important that facilities in libraries are 'easy' for Older People e.g. accessible, toilet facilities, chairs the correct height. Older People's capabilities are taken on board when ordering stock, for example large print and cassettes.

IT training courses take place in all libraries. IT is an important aspect of many Older People's lives as it can be used for social interaction, staying in contact with family, doing on-line shopping etc. Prevents Older People from being isolated. There are large keyboards to assist.

Special Services include a mobile library for those who are housebound. Information on these people is kept on a database and referrals come through Adult Services and by self referral. Once a person has been referred they are visited by a staff member to discuss their requirements, they are then visited once a month with new material.

Noted that this service could link up with Meals on Wheels who are aware of housebound people, and also by visiting day centres to increase awareness of the service.

Information and learning include 'Happy Heart days'. These are sessions which aim to help people keep mobile.

Good relationship with Age Concern, who can book courses for Older People.

Drop-ins, coffee mornings and other social interaction settings are being encouraged.

Link with the Access Pathways Project currently being undertaken in Adult, Culture and Community Services.

Newspapers are supplied taking into consideration the desires of the local community, for example Cypriot papers. Books are also supplied in community languages.

Discussion points

Libraries are more than providers of books; they are also a good contact point with residents in the borough.

Noted that libraries are also an access to warmth for older people. This is especially the case in some areas of the west of the borough, for example Highgate, where older people are often equity rich and cash poor.

Diana Edmonds will speak to teams at the Haringey Teaching Primary Care Trust to ensure that they know what services are provided.

Not all libraries are currently accessible for older people, for example Highgate does not have accessible toilets.

	There is currently no written 'plan' in place to link libraries with the wider well-being agenda. There are currently two well-being suites (Marcus Garvey and Wood Green Library). These run sessions such as Massage where residents are also taught massage techniques linked to their well-being. Noted that aspects of life-long learning could be improved. **Action points** What are the numbers of Older People that use the services provided by libraries?
7.	**Leisure Services** Andy Briggs (Head of Sports and Leisure Services) gave evidence and answered questions on the work undertaken by Leisure Services. Issues in raising the usage of Leisure centres by Older People: There is a perception by Older People that Leisure Centres are for younger people. Raising awareness and breaking down the barriers. For example, people understanding what they can access. Transport issues Confidence, in that older people can find going to a leisure centre daunting. The Active Card is only used by 5% of the over 65yrs of age population across the borough. There is a perception that parking is not free for those using Tottenham Green, this is not the case. Those over the age of 65yrs also get a free parking notice with their Active Cards. All facilities are Disability Discrimination Act (DDA) compliant. There are hoists in place to assist people getting into pools, also areas with no steps and women only sessions. There are specific sessions provided for older people and there are sessions which are free of charge. Not all sessions are conducted within the Leisure Centres. This year the service began to go out to the Community. For example into Care Homes. These include Cranwood, Red House and

	Broadwater Farm, where one hour sessions take place each week to raise awareness of the benefits of keeping active and also to promote movement. These are conducted by the services fitness instructors, attended by 5-8 people and feedback received is good. The service would like to build on this but the funding is not available at present. Scope for greater link up between leisure and libraries in the homes visited. The gym at Tottenham Green is used by a high number of people who are 50 years of age and above. For as many people who use the gym there are likely to be as many again who do not necessarily have the confidence to attend. This is also a barrier which needs to be overcome. The service acknowledges that they have further work to do, for example at Park Lane and White Hart Lane centres. Provision will be developed in 2008. There is a GP referral scheme in place with 9 surgeries on board. (this is funded through the Neighbourhood Renewal Fund and is a joint venture with the TPCT). This scheme consists of referrals for a 12 week cardiac programme with incentives included to encourage the person to continue using the gym afterwards. Staff are trained from within the NRF money and the aim is to keep these staff at the centres. This is a scheme that the service would like to develop further including the possibility of extending it to other areas. For example to include the sessions at the New River Sports Centre for people who have had a stroke. There are also free walking programmes in place. **Points of discussion** Noted that services available at Tottenham Green Leisure centre sound excellent. There are more services here in comparison to other centres due to size and demand (there is a greater demand for services in Tottenham Green and if the service is able to provide those required then they do). At the same time the service believes that the infrastructure in Tottenham Green Leisure Centre needs investment. The Business Development Manager is also the Champion for Older People in the service.

	Issue rose that transport is also an issue for usage of facilities as is the timing of some of the services. For example, Aqua-cise is in the afternoons which are now during hours of darkness. Up to 50% of those using services are means tested/have concessionary prices. There is awareness that the subsidy needs to be reduced on the part of the council. There needs to be a move towards 'the ability to pay' so that those who really do need the help to pay only have to pay a nominal amount or nothing at all. Partnership working Greater investment in prevention is needed; the government needs to lead the way on this. The GP referral scheme is a good example of partnership working and this can be built on further. Noted that Broadwater Lodge has an accessible bus which is not used to full capacity. There is a possibility that this is the case with other buses across the Council. The idea that this could be used more flexibly was suggested. For example could it be coordinated by the use of a database or timetable? This could then be used to assist people accessing universal services. A defined well-being plan should be developed including looking at provision gaps. Where external funding can be applied for the service applies for it. There is a possibility of a link up between the 'Health for Haringey' projects and Leisure Services. 'Health for Haringey' projects have received funding from the Big Lottery Fund and are supporting 82 organisations in the community at present. This funding was acquired by Age Concern jointly with the TPCT. **Action point** What is the profile of those who use the Leisure Centres?
8.	**Voluntary Sector** The panel received evidence from Robert Edmonds, Director, Age Concern Haringey.

Age Concern receives 60% of its funding from Statutory services including the TPCT and Adult Services. Other funding streams include Neighbourhood Renewal Fund and the Big Lottery Fund.

Age Concern Haringey has 22 staff members and 100 volunteers.

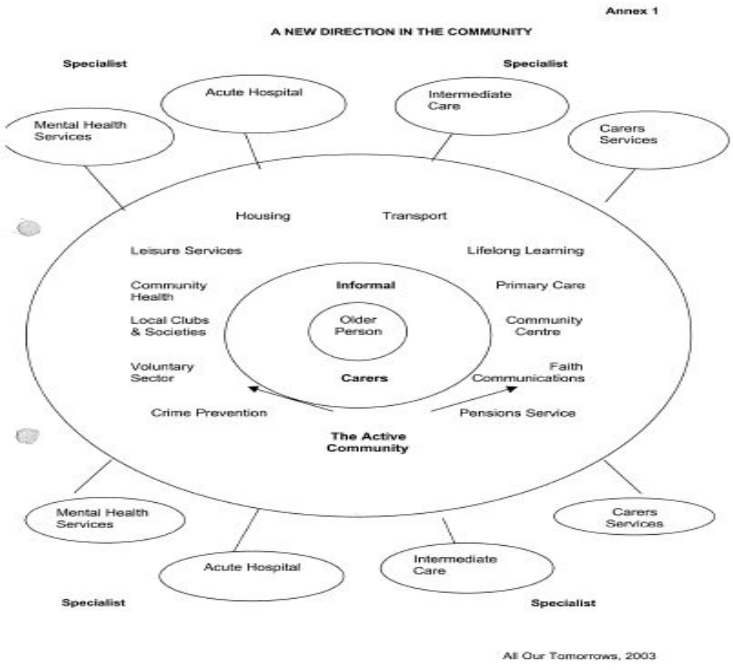
An Age Concern DVD was shown illustrating the impact that joined up services can have on an older person's life.

There is a belief that Haringey is making progress at a strategic level and that it is about joining up the dots.

The well-being and preventative approaches are to be welcomed. However there are concerns that the 1% increase announced for Social Care in the Comprehensive Spending review is not in keeping with inflation.

Advantages of the voluntary and community sector organisations include the fact that people are aware of other people's activity. For example, they are likely to notice when someone who regularly attends a day centre does not arrive.

Reference to Annex 1 in 'All Our Tomorrows' policy document. A New Direction in the Community model which places Older People at the centre.



	Felt that more could be done across the partnership in terms of helping publicise services. For example Haringey Council advertises four drop in centres in the borough, where in reality there are more than fifteen available for people to attend. Why are they not being jointly advertised? Issue that Older People are still not necessarily being seen as participating citizens. Reference to the Projects for Older People Projects funding from the Department of Health, noted that this will be ring fenced but details were not available at this time. There are potentially great benefits to be gained by the Befriending Service. 68 people are currently involved in this. Benefits also include: A reduction in the risk of isolation An increase in a person's confidence The benefits can often take 6-8 months before they begin to take effect. Belief that Haringey needs a number of Older People champions across the services to enable the desired vision to be achieved. There is a need to bear in mind day opportunities, especially culturally specific ones like the Cypriot Centre and the Irish Centre, when considering the funding associated with Local Area Agreements. This will be a challenge. Noted that HAVCO (Haringey Association of Voluntary and Community Organisations) has a Well-being Theme group which involves between 30-40 organisations. This is a useful avenue for networking and for consultation. There needs to be a shift in the way that older people are involved in the commissioning of services. Older people should be consulted on which services should be commissioned. Older People need to be asked 'How can I help you to get involved?' This would enable Older People to continue to feel that they have a roe in society. They would be contributing to the services that they are receiving. Important to note that front-line staff are key to the inclusion of Older People. It is these people who can identify when someone would benefit from services.

	Belief that there needs to be greater linkage across the services and across the agencies. Also that there should be triggers in place which would help to identify when a person could benefit from services. **Points of discussion** Noted that any service is as only as good as their staff. For example it is vital that Social Workers are aware of what services are available as they have direct access to people. This includes people who are in the low and medium bandings of the eligibility criteria of the Fair Access to Care Services Criteria.
9.	**New Items of Urgent Business** **None**
10.	**Date of next meeting** Monday 17th December 2007 11:30-14:00

Scrutiny Review - Access to Services for Older People notes
Panel Meeting
17th December 2007

Councillors present: Cllr Bull (Chair),

Others attending: Robert Edmonds (Age Concern), Delia Thomas (Teaching Primary Care Trust), Jane Havergal, Celia Bower, Zeedy Thompson, Manuela Toporowska (Haringey Forum for Older People), Lauritz Hansen-Bay, Matthew Pelling, Tom Brown, Chris Henderson, Trevor Cripps, Melanie Ponomarenko

Agenda Item	Subject/decision
1.	Cllr Alexander Cllr Wilson Cllr Adamou Llyoda Fanusie
2.	**Urgent Business** None
3.	**Declarations of Interest** None
4.	**Minutes** Carried forward to next meeting `
5.	**Older People's Services Resources** There have been large changes in those aged 65 years of age and over in recent years. For example, there has been an increase in the number of 'older older' people, especially in the 85 years of age plus population. Amongst the 85 years there is an increased prevalence of cognitive impairments. This will undoubtedly put pressure on statutory services. Those present were taken through a number of projections for Haringey which were sourced from the Projecting Older People Population Information system (POPPI). POPPI has been developed by the Institute of Public Care for the Care Services Efficiency Delivery Programme designed to help explore the possible impact that demography and certain conditions may have on populations aged 65 and over. Office of National

	Statistics (ONS) data is used for this projections and it is important to note that there are differences in these projections when put alongside the Greater London Authority (GLA) projections. However, ONS statistics are used to determine local authority budget allocations. Haringey's over 65 years population is expected to increase by almost 2,000 over the next 17years with those over 85 years expected to increase by 600 over the same period. Along side these it is also projected that there will be an increase in the number of; ➢ people receiving community based services; ➢ people helped to live at home; ➢ households receiving intensive home care; ➢ people projected to have dementia; ➢ people unable to manage at least one self-care activity on their own; ➢ people unable to manage at least one domestic task on their own. All of the above will put increased pressures on the older people's service budget. Resources are tied up in the acute end of services. Preventative services for older people receive approximately 5% (£937,000) of resources for the service as a whole. 2% (£417,000) of this is on drop-in centres. There are investment proposals in the forthcoming budget for older people's services. With regards to efficiency savings the service is looking at ways of providing services more efficiently whilst not compromising the quality or level of service and where possible improving these. An example of this is the Community Transport System where vehicles that are linked to centres, and may be left unused for periods of time are being centrally coordinated and therefore able to provide a more flexible service to more groups. (Noted that this needs to be widely publicised to address user concerns) The Community Transport System will train drivers from groups who wish to hire the vehicles. There is still an East/West divide with a 10 year difference in the East of the borough – people in the east of the borough are more likely to get the same type of illness as people in the west of the borough, but ten years earlier.

	Points of Discussion There are concerns about the issues surrounding census data for Haringey, including the projections. This is due to a number of reasons including the high transience amongst the population and the 'hidden population'. This is noted as an area that Haringey needs to focus attention on before the next census to ensure that the government recognises the true Haringey population and is able to resource accordingly. <u>Basic Foot care</u> At the Age Concern Annual Meeting at least half of the approximately 180 attendees raised basic foot care as an issue. This includes simple tasks such as cutting toe nails. Concern raised that if the 90 attendees with basic foot care issues is representative of the older people population in Haringey then this signifies a significant problem. Noted that Foot care is a NHS responsibility and that due to financial pressures this has been a service which has been reduced. There are four drop-in centres in Haringey which will cut older people's toe nails, this is being funded by the social care budget and not the TPCT. Noted that this is also a preventative measure as long toe nails can cause falls. Noted that there is a view that the TPCT should at least contribute to this cost. Age Concern has been running a campaign called 'Feet for Purpose' since August 2007. It is hoped that this is something that will be included in the Joint Strategic Needs Assessment. A Member of the Haringey Forum for Older People and Muswell Hill & Highgate Pensioners Action Group has written to the TPCT requesting information about foot care services available in the borough.
6.	**Teaching Primary Care Trust Resources** Due to the absence of Alex McTeare, Tom Brown took the attendees through the figures provided by the TPCT. Noted that the definition of prevention may not be the same for the TPCT as for Haringey Council.
7.	**Partnership working**

	There is a good partnership working relationship between front line workers. For example, Social Workers, Occupational Therapists and Nurses. However, the partnership working has not been quite as good on a more formalised basis. For example, Joint Appointments. There are currently no joint appointments in Older People Services, however this is something that is being discussed. There is a desire to work towards a joint commissioning unit for improved service delivery. There are currently two pooled budget arrangements between the TPCT and Haringey. One of which is the Prevention Enabling Team which provides a range of services including Physiotherapy, Occupational Therapy and Domiciliary Care. This service identifies and intervenes in cases to prevent people going into hospital and works to enable independence. It is accessed via the home care service and receives a number of referrals from people who have gone to A&E but who do not need to be admitted to hospital. The service receives forty plus referrals a month. An area for improvement is the joint working between Community Matrons and the Assessment and Care Management Teams, especially with regards to a more joined up system for identifying people in need of intervention. Another area for improvement is in budgeting, it is hoped that in the next financial year this will have greatly improved but both parties need to be wary of pushing budgetary pressures onto each other.
8.	**Supporting People** The Supporting People Programme is funded by Central Government and managed in partnership between Haringey Council, Probation and Haringey Teaching Primary Care Trust. There are two main areas that Supporting People is responsible for: 1 – Supported Housing for example Sheltered Housing for older people. This is different from residential and Nursing Care. 2 – Support services for example support workers who visit people in their own homes to provide support. The support they are offered includes benefit help (for example advocating on behalf of the client), money management (for example

budgeting and managing arrears). This service is about people's independence and is very different from domiciliary home care.

The emphasis is about enabling people to ultimately do things for themselves, however the issue can be slightly different for older people.

Supporting People provides a robust monitoring framework for providers. For example:

- Health and safety
- Complaints procedures
- Managing of support planning
- Performance Indicators

The programme currently receives £20,000,000 of funding annually. This is, at present, ring-fenced.

- This supports approximately 19 client groups, including older people, people suffering from domestic violence and the community alarm service.

The average age for a person entering sheltered housing is going up. It is now people aged 75 years and above that are entering whereas it was previously those aged 65 years and above.

Supporting People undertook a needs mapping exercise approximately 18 months ago. The information showed that there is a need to consider alternate types of provision, for example Extra Care Sheltered Housing. It also showed that there would be a need for 300 units of extra care over the next 10-15years in Haringey.

Supporting People also funds the Sixty Plus scheme, which is a support service.

This service is accessible over the telephone and anyone can refer someone to the service. For example, self referral, neighbour, councillors, doctors.

The scheme offers a support worker who sets outcomes with the older person, if after these outcomes are met further ones are identified then support will continue.

Supporting People is monitored through the Partnership Board and also through the Haringey Association Voluntary Community Organisations (HAVCO).

The Audit Commission recently praised the Supporting People Programme for its strong governance arrangements.

The Council does not have powers to inspect schemes that it is

not funding or where there is no contract in place (there is no statutory framework in place).

Do Older People know this?

<u>Extra Care Sheltered Housing</u>

Becoming increasingly popular.

Buildings are adapted, for example corridors are wide enough for wheel chair users.

There is overall a higher level of facilities than in normal sheltered housing. This can include hydro pools, rehabilitation rooms and assisted bathing facilities.

There is a 24/7 support service plus care services e.g. domiciliary care.

Extra Care Sheltered Housing can bridge the gap between supported housing and residential care or even provide an alternative to residential care.

There are currently two new Extra Care schemes going through the Planning Committee stages in Haringey:

1 – A site on Hornsey Lane has been acquired by One Housing Group for a 40 unit scheme. Subject to approval this site will be up and running in 2-3 years.

2 – A site has been acquired by Hill Homes in Highgate Village.

Both schemes are working with the Council and with Occupational Therapy.

Points of discussion

Discussion around the possibility of going from owner occupation to extra care sheltered housing. This is currently unclear in areas, for example, those with substantial capital assets.

The Urban Environment Directorate have set up a Project Board to look at the issues raised in the Supporting People Needs mapping exercise. Part of this will be to look at accessibility; including from owner occupation. It will also consider Older People Lease projects.

Discussion around the reality of an older person having to sell their home in order to get the level of care needed. The Council can only sell a person's home if the decision is taken that the older person needs long term care.

Anything over £20,000 is payable.

If the client has, for example, £5,000 in the bank a £250,000 home and a pension then a charge would be placed on the person's home until it is sold.

Noted that Supported Housing operates a different financial regime.

9.	**Feedback from the Older People's Commissioning Panel** Deferred
10.	**Date of next meeting** TBC

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