August 2007

Overview and Scrutiny Committee

Report of the Standing Scrutiny Review of NHS Finances

Carers Case Study

DRAFT REPORT

Members of the Standing Review Group
Councillors:
Cllr Myra Michael, Chairman
Cllr Margaret Davine, Vice Chairman
Cllr Jean Lammiman (until May 2007)
Cllr Rekha Shah
Cllr Stanley Sheinwald

Community co-optees:
Ruth Coman
Julian Maw, Harrow PCT Patient and Public Involvement in Health Forum
Avani Modasia, Age Concern Harrow
Janet Smith, Mind in Harrow

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Chairman's introduction

This report on carers is a case study undertaken as part of the Overview and Scrutiny Committee's Standing Scrutiny Review of NHS Finances. The purpose of the case study was to investigate the impact that changes in NHS and local authority budgets are having on carers and the person they are caring for.

The key function of the Standing Review has been to monitor the financial difficulties being experienced by NHS partners by meeting with chief officers of the council, Harrow Primary Care Trust (PCT) and the North West London Hospitals Trust. These meetings provided us with an insight into how local financial pressures are being addressed, but we could not help but be concerned about how the impact of key resource decisions on patients and carers have been assessed.

The evidence we received from carers has painted a challenging picture. We have heard a number of disquieting stories from carers, including from an 84 year old carer contemplating returning to work to fund care for his wife. Taken together with evidence from the Commission for Social Care Inspection (CSCI) on best practice, these individual anecdotes point toward much larger strategic questions concerning the planning and delivery of services, partnership working and value for money. We believe that by working together organisations can mitigate some of the troubling impacts of cuts on local people.

Acknowledgements
The Standing Review group would like to thank Michel Syrett for his paper on *Carers Resource Needs*, which informed our preparations for the carers' conference. We would like to thank Mike Coker and Sue Springthorpe for their contributions of advice and evidence to the review.

Finally we would like to thank all of the carers who provided us with evidence. We recognise that caring for a relative or friend can be a time-consuming activity and are very appreciative of the time carers have given up to share their views with us.

Councillor Myra Michael
Chairman, Standing Scrutiny Review of NHS Finances

Methodology

The scope of the Standing Scrutiny Review of NHS Finances is attached to this report as Appendix A. Paragraph thirteen of the scope identifies a number of proposed case studies. During the Standing Review's deliberations, it was decided that considering the experience of carers would provide the most useful means of assessing the impact of the financial challenges.

Carers Conference – A Life Beyond Caring
The main evidence directly from carers was gathered through a one-hour focus group convened as part of the council's carers' conference (arranged by adult social care) entitled 'A Life Beyond Caring'. The event was held on 24 April at Pinner Village Hall.

The overall purpose of the conference was to raise awareness of national developments on carers' issues and the vision for delivery of local adult social care services, as well as informing the development of new local multi-agency carers' strategy.

In the first section of our focus group, carers were asked to think about their needs. The areas of need identified as prompts for discussion were 'my rights as a carer', 'getting the right information and support', 'getting support from other people', 'time to be me', and 'my emotional needs'. Carers were encouraged to review and add to this list.

In the second section of the exercise, carers were encouraged to think about changes that they had noticed over the last eighteen months. It was possible to identify some areas where there had been changes, but there were also comments made about the quality of services, which were also captured.

Other opportunities for carers
We also sought to ensure that carers had other means of contacting the Standing Review, other than through the conference. We published details of our work on the council's website and encouraged carers to contact us with their views. We are also grateful to Carers Support Harrow and Harrow Crossroads who also communicated with carers about this piece of work.

Additional evidence
Evidence from carers was supplemented by evidence gathered through a desktop research exercise of best practice.

The group is also grateful for a paper from Michel Syrett on *Carers Resource Needs*, which informed the development of the focus group structure and materials.

Executive summary

National evidence on support to carers demonstrates many challenges, which are reflected locally. This case study has highlighted the importance of carers to the wider wellbeing of the community and has illustrated how recent changes are impacting on carers' ability to cope. Losing support, such as a few hours of respite care or support from a care worker, has a major impact and may make all the difference to a carer's willingness to continue caring. Providing support such as respite is considerably cheaper than an extended stay in hospital or care home provision, so it is becoming clear that greater co-ordination between the agencies could potentially save the PCT, hospitals trust and council large sums. Money spent supporting carers has been demonstrated to us to be money well spent.

RECOMMENDATION 1

- We recommend that communication between all agencies be improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.

RECOMMENDATION 2

- We recommend that partners come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.

RECOMMENDATION 3

- Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.

RECOMMENDATION 4

- We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Further work should be undertaken to reach those who do not recognise themselves carers. Changes in service provision should also be better communicated.

RECOMMENDATION 5

- We recommend that the forthcoming multi-agency carers strategy set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.

Appendix B of this report sets out how scrutiny will monitor progress against the recommendations.

Context

Who are carers?
The Commission for Social Care Inspection (CSCI) describes carers as follows:

> "Carers are not paid. They are people who look after a spouse, relative or friend who needs support because of a physical or learning disability, illness or mental ill health. Most people will be carers at some point in their lives. Many people do not want to be defined by their caring role and will not associate themselves with the description of 'carer'."[1]

Table 1: National statistics on carers[2]

- Over a lifetime, 7 out of 10 women will be carers, and nearly 6 out of 10 men.
- 4.7 million people over the age of 18 are carers in England.
- There is a turnover in the population of carers. In any one year, 301,000 adults in the UK become carers.
- 70% of the people cared for are over 65.
- 1.5 million carers in England provide over 20 hours of care per week. 985,000 provide over 50 hours of care per week.
- 1.5 million carers combine full-time paid employment with unpaid care. 58% of these working carers are men.
- People from Bangladeshi and Pakistani ethnic groups are more likely to be carers than those from other ethnic groups, taking account differences in age structure.
- 471,000 carers reported they were in poor health (2001 census). Of these, 30% were aged 65-plus.

There are approximately 20,550 carers in Harrow. Approximately 2,000 are in contact with the local authority, primarily through social care provision.

Table 2: Carers in Harrow

- 1 in 10 people in Harrow are carers (Census 2001).
- 72% provide 1-19 hours of care.
- 12% provide 20-49 hours of care.
- 17% provide 50 or more hours of care.
- 3,000 carers provide 50 hours or more of care.
- There are 634 young carers aged 5-17 years; 84% provide 1-19 hours, 9% 20 - 49 hours, and 7% 50 hours or more hours of care.
- 100 young carers provide 20 hours or more of care.

[1] CSCI (2006). *The State of Social Care in England 2005-06*. Accessed 28 February 2007. p. 85 http://www.csci.org.uk/about_csci/publications/the_state_of_social_care_in.aspx
[2] Ibid.

Findings

Introduction
The Commission for Social Care Inspection's (CSCI) report on *The state of social care in England 2005-06* included a review of councils' progress in adopting a strategic approach to supporting carers and meeting their needs. This section of the report is divided into thematic areas. Within each area there is information on the national picture derived from the CSCI research and a section on local findings.

Developing services strategically
Nationally, against CSCI criteria about a fifth of councils could be considered to have adopted a strategic approach to meeting carers' needs. A strategic approach would include:

- A multi-agency carers' strategy.
- An identified social services lead on carers.
- A corporate approach within the council, displaying a shared ownership of the carers' agenda.
- A strategy based on local profiling to map numbers and needs of carers, including carers in work, black and minority ethnic carers and young carers.
- Proactive initiatives and good practice going beyond the basic legal requirement of taking carers' employment, education, training, and leisure needs into account in the carers' assessment. For example, the provision of flexible, reliable and emergency cover which enables carers to take part in chosen activities; imaginative ways of increasing paid employment opportunities for carers.
- Innovative carers' services and use of direct payments.
- Carer engagement in commissioning, service development and evaluation and workforce training.
- Outreach activity beyond traditional social service networks to ensure equal opportunity and equity.[3]

Locally, we are pleased to note that a multi-agency strategy is under development in Harrow, and that there is a lead officer for carers, the Prevention and Carers Strategy Manager. The current inter-agency strategy (between Harrow PCT and Harrow Council) maps a range of demographic information on carers; as the Harrow Vitality Profiles evolve, we hope that further scope for developing the mapping of carers is strengthened and includes data from a range of agencies.

At the conference carers commented that:

"Services need to join up including their budgets"

"[There is] poor partnership between health and social care teams"

Carers are well aware of the lack of co-ordination between services. One group of carers had concerns about the level of provision in Harrow and also commented that working with other councils to provide services across north west London – adopting a regional approach – should be considered.

[3] Ibid. Paragraph 7.12.

Having considered best practice from CSCI and IDeA[4] we were struck by the way in which evidence we had received from individual carers pointed to much larger strategic questions of value for money, the planning and delivery of services and partnership working by the council, the PCT and the hospitals trust. However, it is not clear that such considerations feature in the planning of services and decision-making about the allocation of scarce resources. Whilst we are pleased to learn that the PCT and hospitals trust financial positions have considerably improved, we are worried that there seems to have been only limited attempts to assess the impact of the financial decisions on service delivery. We would expect this consultation process to extend beyond discussions with health professionals and to include patients and their carers.

The PCT has advised us that they have engaged in a series of consultations with the public on health services and the next consultation is planned for 24 September. The PCT will offer further opportunities to engage with residents later this year with regard to the proposed consultation on the service models set out in the Healthcare for London report.

It was concerning that both the hospitals trust and the PCT perceived that they had not been formally consulted on the proposed changes outlined in the council's Fair Access to Care Services consultation. While the council can evidence the provision of the consultation document to both trusts it appears that organisational change may have impacted on the effectiveness of communications with the trusts. We welcome the Chief Executive of North West London Hospitals trust's desire to facilitate joint meetings to address some of the initial challenges relating to patients with hospital stays beyond 14 days. Given that there are new chief executives at the council and hospitals trust and a future new chief executive to be appointed at the PCT, we strongly urge the three organisations to take the opportunity to form new working relationships at the strategic level, which can then be cemented at operational level.

RECOMMENDATION 1: We recommend that communication between all agencies be improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.

Developing services in partnership – financial arrangements

Whilst 37% of councils reported to CSCI that they were engaged in collaborative working with health partners, 25% of councils reported that PCT restructuring or NHS financial pressures, or difficulties establishing collaboration with GPs had had an impact on the ability to deliver on their vision for 2006-07.[5] Forty-six percent of councils report that financial constraints have impacted on the delivery of support to carers; CSCI found that strategic approaches to managing the pressure were not apparent in all councils.[6]

We are acutely aware of the financial pressures facing the council, hospitals trust and PCT. We accept that this places pressure on partners but we also feel that this provides all the more incentive for partners to come together to identify ways to improve efficiencies. The following example, reported to us by a voluntary sector organisation, clearly illustrates considerations including the timeliness and appropriateness of provision as well as value for money:

> *A couple ended up in separate care homes because the cared-for, a man with dementia, wandered off while the carer was out receiving dialysis. The couple had not received assessment and support quickly enough. Had respite care been provided, the carer*

[4] Improvement and Development Agency. Carers self assessment tool available at www.beacons.idea.gov.uk
[5] CSCI (2006). *The State of Social Care in England 2005-06*. Paragraphs 7.21 – 7.22.
[6] Ibid. Paragraphs 7.28 – 7.29.

could have attended dialysis without leaving her husband unattended and at risk because of his dementia.

The implication of this example is that the cost of providing residential care for a week for the couple (never mind an ongoing period) could have funded many weeks of respite provision to help the couple to remain in their own home.

RECOMMENDATION 2: We recommend that partners come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.

Developing services in partnership – working with the voluntary sector

The Commission for Social Care Inspection (CSCI) reports that whilst councils have commissioned services from the voluntary sector, there was concern that "councils report they are unsure as to how, precisely, the funds made available for carers' services are being spent, how many people are accessing the services and what the outcomes are for carers of the services commissioned."[7]

Locally there is clearly a range of support available to carers from voluntary providers. Carers who are actually able to access support such as respite were extremely positive about the impact of that provision on their well-being and quality of life.

Table 3: Background: Harrow Crossroads

Harrow Crossroads is one of 200 Crossroads schemes run across the country to provide high quality respite care for carers. In Harrow carers are offered three hour sessions, every week, which are often used by the carer to enable them to undertake their own medical appointments, collecting prescriptions or other practical tasks. Harrow Crossroads' work has a preventative emphasis, as it enables carers to look after their own well being, as well as that of the person they care for, and helps people remain in their own homes.

Staff are trained to a level above that of domiciliary care workers. Respite is provided by the same individual every visit to allow relationships to be developed. Crossroads is rated as 'excellent' by CSCI and has achieved Investors in People status.

From the point of view of a number of voluntary sector organisations that provided us with evidence, there is potential for extending services currently provided. This finding appears to fit with the view expressed by carers through our focus groups that the voluntary sector is key in making linkages between services and filling gaps, and that there is more that could be done. Given the limited level of investment in supporting carers, the quality of outcomes achieved appears to us to represent value for money.

Yet in the context of the current cuts, one respondent also commented that the council needed to be honest with the sector and to explain how it should relate to the cuts. One voluntary sector chair commented that "there is one pot of money and therefore it makes sense for organisations to work closely together."

Harrow Crossroads has a service level agreement (SLA) with the council and the Primary Care Trust. The SLA sets out the level of funding Harrow Crossroads receives from the council for a set number of hours of respite care. In addition to this, the SLA provides for Harrow Crossroads to be reimbursed for additional hours of respite care that are provided over and above the

[7] Ibid. Paragraph 7.24.

agreed hours. Harrow Crossroads has reported having been encouraged to exceed the targets and to provide additional care (including training and recruiting staff), but we were advised that the council has decided not to reimburse them for the additional care that has already been provided. We received evidence at one of our meetings that it would not represent good practice for an SLA to be open-ended and that there was a need to work within resource constraints. We would encourage all partners to ensure that future arrangements for commissioning accord with best practice and that there is a clear understanding of responsibilities on all sides.

We heard from voluntary sector partners that the shift to contracting for services has meant that organisations are no longer receiving support for core functions, yet the voluntary sector needs infrastructure to run the services that providers are looking to contract. The Harrow Compact (the Harrow Code of Practice on Funding and Procurement) partly addresses this in that partners are expected to recognise that "it is legitimate for voluntary and community organisations to include the relevant overhead cost in their estimates for providing a particular service, and where a full service is funded apply the full cost recovery principle". However, it does not appear that negotiations over provision are this sophisticated. Voluntary sector partners felt that capacity building is not addressed and that overall strategy for bringing the voluntary sector into public service delivery is unclear.

Additionally, the carers' grant is no longer ring-fenced and local reductions have served to increase uncertainty in the sector. Local concerns reflect CSCI's view that many voluntary organisations have significant concerns about the security of their funding – particular when, as in Harrow, PCT and council budgets are under pressure.[8] Whilst the Harrow Compact speaks of respecting the independence of the sector and also encouraging the sector to "diversify its funding base", without a clear framework within which to operate it is unclear whether this is a realistic prospect.

RECOMMENDATION 3: Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.

Routes for carers into services and support

Sixty-three percent of councils reported to CSCI that they have been raising awareness and providing information to carers though it is not clear how successful this has been.[9] Fifty-nine percent of councils report that they provide training for staff in providing assessments, and 52% provide assessment tools.[10] Seventeen percent of councils have appointed specialist staff. Evidence from Beacon councils suggests that a strong working relationship between social services and GP surgeries improve the chances of effective referrals for assessment and services.[11]

When inspecting services for adults with a learning disability in eleven authorities, CSCI found that only 46% of carers reported that they that they had been told about their entitlement to an assessment of their needs.[12] We are concerned that locally, out of the sixty carers in

[8] Ibid. Paragraph 7.95
[9] Ibid. Paragraph 7.36 – 7.37
[10] Ibid. Paragraph 7.42
[11] Ibid. Paragraph 7.38
[12] Ibid. Paragraph 7.40

attendance at the conference only one had ever had their own needs assessed, though we acknowledge that this information must be put in the context of the overall numbers of carers in Harrow that have received assessment in accordance with the council's reporting to CSCI. In any case, as the carers assessment is considered to be the route through which carers' immediate and wider needs are assessed this is an area of concern. Carers commented that:

"If you don't know what you're entitled to you can't ask for it"

"Assessment of needs [are] practically non-existent"

Carers need to have confidence in assessment, especially in the context of tightened funding and eligibility criteria.

Carers commented that carers' support (e.g. Harrow Carers group, MENCAP, HAD) has developed over the last couple of years, which helps to fill gaps in information and support in other services. It was commented that this activity developed infrastructure. Carers groups were able to fill gaps left by social care, in particular by working with GPs. Speaking of support to carers:

"[It is] Very helpful to have those contacts and to have emotional support"

GPs were referred to by many carers particularly in terms of providing information and support and as signposts to other organisations and services. Views on the level of support available from GPs varied widely. Carers Support Harrow provides literature to GPs, including information on support available, including from other organisations such as Harrow Crossroads. The reaction of a PCT representative at one of our meetings was that GPs engaged with carers in their capacity as patients, not in their role as carers. At a recent event for mental health carers it appeared that not all GPs keep records of carers, however it is a positive development that there are efforts to require GPs to do, in accordance with best practice.[13] The PCT has advised that:

- Practice managers in Harrow meet on a regular basis and carer support representatives attend these meetings to discuss issues.
- Under the Quality and Outcomes Framework (QoF),[14] GPs are required to maintain a Carers Register.
- Under the QoF, and in relation to palliative care, GPs are required to review plans with carers.
- Many practices have a carers representative and recruit carers.
- GPs are required to have in place systems to identify carers for onward referral to social services where there are particular needs that require addressing.

We are very aware that many carers often would not describe themselves as such, treating the care and support that they provide as an extension of their role as spouse, partner, family member or friend. We therefore strongly support all efforts to reach these 'unidentified' carers.

[13] A member of the PCT's Professional Executive Committee (PEC) commented at a recent mental health carers' event that she intended to work to ensure that carers were properly recorded by GPs.

[14] The Quality and Outcomes Framework (QoF) is part of the contract primary care trusts (PCTs) have with GPs. It is nationally negotiated and rewards best practice and improved quality of services (source: Department of Health A-Z glossary).

RECOMMENDATION 4: We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Further work should be undertaken to reach those who do not recognise themselves carers. Changes in service provision should also be better communicated.

Supporting carers to care

Nationally, CSCI reports that there is a wide range of performance in provision of services to carers but even those rated 'very good' have a low baseline of 12% of carers receiving support in their own right.[15] Access to breaks for carers varies considerably. The use of direct payments for the full potential range of support to carers is limited.

Looking at diversity and equal opportunities, CSCI reports that assisting carers to continue or return to work is a high priority for councils but that only 35% say they are taking proactive steps.[16] The voluntary sector, often funded by councils, plays a significant role in supporting carers to have their own lives. The report also highlights the importance of supporting young carers as services for adults and children divide.[17]

The national picture highlights that there is a long way to go. Locally, when asked about changes to the level of support received, carers reported a number of recent changes, listed in Table 4.

Table 4: Changes identified by carers in the support that they receive

- Lack of flexibility – for example a GP ladies morning was moved to an evening; no flexibility for those who can't leave the person they are caring for unattended.
- Lack of planning for discharge, including lack of training for the carer
- Lack of interface between continuing care/social services and lack of information about the new reassessment.
- Lack of assessment of carers' own needs.
- Respite care is valued enormously by those who can access it.
- There is not enough respite during day/night.
- Carers did not know who would fit the criteria for respite care. Others felt the quality of assessment for requirements for respite care was poor.
- Less respite care available now. Respite that is available is more expensive and difficult to get hold of.

Locally, the impact of major statutory consultations being undertaken by the council at the time of the focus groups should not be underestimated. Some of the feedback illustrated great anxiety about the future. For example, one carer wanted information about the impact of the proposed changes to the criteria for who qualifies for social care services on direct payments. Strategy for direct payments was not clear to some of the carers attending the conference and there appeared to be a lack of awareness of what direct payments could be used for. There is clear potential to develop direct payments and to develop innovative approaches to providing support to carers, for example in helping carers cope with emergencies. However, direct payments require a change in culture and approach; it is not clear that this has been articulated at this stage or that this is shared by all partners. For example, there was willingness but uncertainty among some voluntary organisations about what it might mean for providers and

[15] CSCI (2006). *The State of Social Care in England 2005-06*. Paragraph 7.60
[16] Ibid. Paragraph 7.83
[17] Ibid. Paragraph 7.99

service users. Strategy for direct payments could be developed as part of the multi-agency strategy and related to the 'self-directed care' initiatives.

Table 5: Changes reported by carers - a range of reduced services for the cared-for

- Homeopathic treatment no longer funded.
- Treatment at the Maudsley hospital no longer available.
- Reduction in agency time from 20 minutes to 10 minutes.
- Wiseworks under threat of closure*
- Merger of Amner Lodge and Orme Lodge (NHS)
- Reduced funding for epilepsy outreach nurses is being reduced. Lack of clarity about when the changes will occur and who is responsible.
- Admiral nurses team that supports carers of people with dementia cut from two to one.
- Physiotherapy cut back generally. Rehabilitation physiotherapy after a stroke is given for a limited period only.
- Delays in accessing physiotherapist [teenager, mental health]. Referrals not followed up.
- Delays in accessing occupational therapy equipment.
- Reduction in the hours of care that people are receiving in their own homes. Rationale for reducing the number of visits from three to two or two to one not given.
- Residential placement for learning disabilities cut by the PCT and not picked up by social services.
- Lack of provision for dental care for people with a learning disability (using general anaesthetic for diagnosis) and long waits at Northwick Park.
- Lack of training for staff to help people with a learning disability – for example helping distressed patients cope with waiting rooms, taking blood.

* Note: Cabinet has since decided not to re-provide the Wiseworks service and a value for money review is underway (18 January 2007 Cabinet (Special), Minute 159 refers).

The importance of breaks to Harrow carers has already been highlighted in the report. It is important to note that Harrow Crossroads reported to us that they have a waiting list of 50 carers; though the organisation has the capacity to support 202 carers per week at the time we gathered evidence the organisation was only able to give services to 152 (it is worth noting that the council is aware of 3,000 carers who provide 50 hours or more of care). Harrow Crossroads reported they were:

- Unable to provide support to more than one client per household - for example, respite cannot be provided for two twins with autism because of the costs involved in providing two carers.
- Unable to provide overnight respite - Crossroads is only able to provide overnight respite to one client because a nine-hour session involves three funded slots.
- Unable to provide support in crisis situations - in the past Crossroads has been able to provide additional support to carers in crisis situations; there are now no resources for providing 'duplicate' support

Harrow Crossroads is considering offering private respite provision in order to continue offering a service. That the Government is providing additional funds for emergency respite[18] is an

[18] Department of Health. Emergency respite care: Determination of funding additional to the Carers' Grant for 2007-08, and guidelines to local authorities.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076717

incentive to begin to address carers' concerns about coping with emergencies. However, national developments and priorities need to be set in the context of local needs and resources.

The role of other types of provision such as day centres and specific activities in providing breaks for carers should not be underestimated; one carer commented that the Wealdstone Centre has been excellent in providing three days per week of voluntary work for her daughter, increasing her confidence and also provided respite for the carer.

RECOMMENDATION 5: We recommend that the forthcoming multi-agency carers strategy set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.

Conclusions

Final thoughts

We have set our findings in the context of the national picture because we are aware that support to carers is an evolving and challenging area – Harrow is not alone in facing a demanding financial climate.

Nationally, CSCI reports that there are some positive examples of services being developed to meet carers' needs. However, progress is limited and patchy given the number of carers in England. Emphasis is placed on supporting carers in their caring role rather than on promoting equal opportunities (for example remaining in employment or returning to work). There is a lack of multi-agency strategic planning, which is even more important given the tight constraints facing health and social care.[19] Support to the voluntary sector to build capacity is likely to be an increasingly important element of multi-agency strategy.

Locally there are major pressures ahead in developing support to carers in the context of restricted and tightening budgets. Yet there is undoubtedly a need for all partners – including carers themselves – to the see bigger picture from each other's perspective in terms of working in partnership to produce better outcomes. For many carers, caring is a highly charged role – it is unsurprising and understandable that carers react strongly to what is often a difficult and unnatural situation. Yet the odds are that most of us will become a carer at some stage in our lives. A key question for Harrow is the extent to which carers bear the cost of tightened eligibility criteria for support. Whilst it cannot be quantified, CSCI suggests that carers provide care and support in the absence of formal services, which in turn implies that an even greater burden will fall on them if criteria are tightened.[20]

Caring is highly charged and there is a need for providers to recognise what people are feeling and why, and to overcome the high emotion of the situation by listening. At a recent mental health carers' event a consultant psychologist commented to that he could not give a single example where carer input had not improved patient outcomes. Whilst it may be easier to exude positive values in the context of sufficient resourcing (the mental health trust has recently attained foundation status), we would hope this supportive attitude spreads across health and social care providers locally.

We conclude with a telling summary from CSCI's report:

> "At the heart of this picture on the state of support to carers, there are major tensions for councils in their policies to support carers. They are charged with improving efficiency and targeting resources effectively and are consequently restricting eligibility to services. But at the same time they are looking to support carers, recognising the risk that without support many carers own health and well-being may suffer and they, too, will need help in their own right. The danger, as ever, is that carers are only seen as a 'resource' and some carers continue to be socially excluded and barred from the opportunities others would expect."[21]

[19] Ibid. Paragraph 7.102 – 7.103
[20] Ibid. Paragraph 7.52 – 7.54
[21] Ibid. Paragraph 7.106

Times are tough but agencies must be honest with each other and more importantly with those voluntary organisations that provide a critical support service to vulnerable residents. Without this, local agencies would be required to make a much greater financial contribution.

Appendix A: Standing Scrutiny Review of NHS Finances - Scope

1	**SUBJECT**	Review of the financial recovery proposals of NW London NHS Trust and Harrow PCT, the strategic consequences and the impact on Harrow residents
2	**COMMITTEE**	Overview and Scrutiny Committee
3	**REVIEW GROUP**	Councillor Myra Michael – Chairman Councillor Margaret Davine – Vice Chairman Councillor Jean Lammiman, Chairman Overview and Scrutiny Committee Councillor Rekha Shah Councillor Stanley Sheinwald
4	**AIMS, OBJECTIVES & OUTCOMES**	The Standing Scrutiny Review of NHS Financial Performance will consider the financial performance and consequent strategic direction of the Harrow PCT and NW London Hospitals Trust and investigate the impact of the financial deficits and related recovery plans on the quality of life and well being of Harrow residents by: • reviewing the effectiveness of respective financial recovery plans; • receiving regular financial updates from the respective Chief Executives on the delivery of these plans; • considering strategic proposals of the trusts • gathering evidence of the specific experiences of local people; and • investigating the impact of financial difficulties at the interface between health and social care The Standing Review will support local health providers to return to financial balance. The Standing Review will report its proceedings to the Overview and Scrutiny Committee
5	**MEASURES OF SUCCESS OF REVIEW**	• Comments from review endorsed by health providers • Impact of financial deficit minimised • Indicators suggest Trusts returning to balance
6	**SCOPE**	• Analysis of the trusts' financial position • Challenge of the proposed recovery plans – how robust are they? Have the real source(s) of financial difficulty been identified and effective solutions identified? • Investigation of the strategic proposals resulting from the financial position. Are they viable? Will they deliver the sustainable financial savings needed? • Investigation of the impact of the recovery plans and associated strategic proposals on the well being of local residents.
7	**SERVICE PRIORITIES (Corporate/Dept)**	Making Harrow safe, sound and supportive Tackling waste and giving real value for money
8	**REVIEW SPONSOR**	Jill Rothwell
9	**ACCOUNTABLE**	Chief Executive Harrow PCT

	MANAGER	Chief Executive NW London Hospitals NHS Trust
10	**SUPPORT OFFICER**	Lynne McAdam
11	**ADMINISTRATIVE SUPPORT**	Review administrator
12	**EXTERNAL INPUT**	Review group members to include: • CfPS expert advisor • Community experts • Expert patients/PPI • Group Manager People First Finance • Director Community Care • Director Children's Services Advisers • Health Care Commission Witnesses to include: • Chief Executives and financial directors – NW London Hospital NHS Trust, Harrow PCT • Director of recovery • NHS auditors • Other NHS Trusts • Other boroughs dealing with NHS deficits
13	**METHODOLOGY**	Background to Health Service financial systems – desk top research and expert briefings Written and oral evidence of • NHS policy and financial framework • Financial situation • Recovery plan and health impact assessment • Methodology for development of recovery plan • Strategic proposals – NWP and CMH hospital reconfiguration Challenge of evidence presented: • Robustness of recovery plan • Alternative approaches to restoring financial balance • Comparison with other health providers? • Expert witnesses – auditors opinion of recovery plan? Audit Commission Regular monitoring and update of financial information Case studies: Impact of recovery proposals and resultant reconfigurations on quality of life of local residents – care pathway analysis – separate specific scopes to be provided. • NW London Hospitals Trust reconfiguration • School Nursing • Domiciliary Care
14	**EQUALITY IMPLICATIONS**	Changes in the availability of health service may have a disproportionate impact upon the health and well being of the more vulnerable, elderly, less mobile members of the community or those whose first language is not English
15	**ASSUMPTIONS/**	Availability of experts advisor to the review group

	CONSTRAINTS	
16	**SECTION 17 IMPLICATIONS**	None
17	**TIMESCALE**	18 months – 2 years
18	**RESOURCE COMMIMTENTS**	Service Manager Scrutiny
19	**REPORT AUTHOR**	Service Manager Scrutiny
20	**REPORTING ARRANGEMENTS**	Outline of formal reporting process: To accountable managers [ ] When January 2007 To O&S: • *Interim report* [√] *When March 2007/September 2007* • *Quarterly updates* [√] *When from March 2007* • *Final report* [√] *When March 2008 (approx)* To Portfolio Holder [ ] When *September 2007/March 2008* To CMT [√] When June 2008 To Cabinet [√] When June 2008
21	**FOLLOW UP ARRANGEMENTS (proposals)**	Regular reports to O&S

Appendix B: Recommendations Matrix

The aim of this matrix is to allow Members to monitor the implementation of the recommendations they are making.

Prioritisation: (TS)	Requiring action immediately:	S
	Requiring action in medium term:	M
	Requiring action in long term:	L
Incorporated information: (Info)	Evidence received from officers	O
	Evidence received from best practice	BP
	Evidence received from local people	LP
	Evidence received from voluntary groups	VG

Recommendation	TS	Identified officer/ member/ group to action	Info	P/ship (Y/N)	Action taken (6 months or 1 year)	Measure of success
RECOMMENDATION 1 • We recommend that communication between all agencies be greatly improved, as there is significant potential for fostering stronger relationships between the council, PCT and hospitals trust.	S	- Council - Harrow PCT - North West London Hospitals Trust	BP O	Y		Now – 6 months: Partners can demonstrate closer working and discussion on major issues and have established relevant joint bodies. For example organisations can show that they consult each other early on (e.g. service reconfiguration). Work with carers should also be a feature of this dialogue.
RECOMMENDATION 2 • We recommend that partners to come together to seek innovative solutions that provide timely and appropriate services for carer and cared-for as well as delivering opportunities to make the best use of limited resources.	M/L	- Council - Harrow PCT - North West London Hospitals Trust	BP LP VG	Y		6 months – 2 years: Evidence of joint working to address 'tricky issues' (see recommendation 1). For example regular inter-agency meetings to address stays in hospital of over 14 days. This should be both at operational and strategic levels.

Recommendation	TS	Identified officer/ member/ group to action	Info	P/ship (Y/N)	Action taken (6 months or 1 year)	Measure of success
RECOMMENDATION 3 • Given the important role of the voluntary sector in mitigating the effects of cuts and making linkages between services we recommend that the overall strategy for engaging the voluntary sector in public service delivery be clarified. That there are plans to refresh the Harrow Compact offers a valuable opportunity to do this and to secure Harrow Strategic Partnership commitment to an improved way of working.	M/L	- HSP - Council (Strategy and Improvement; Community and cultural services)	BP VG	Y		1 year: Revised Harrow Compact. 1-2 years: Improved rating of perception of joint working with partners.
RECOMMENDATION 4 • We recommend that routes for carers into services and support be strengthened, for example by ensuring all GPs and other primary care providers have knowledge and information to share with carers. Changes in service provision should also be better communicated.	L	- Council (Carers Prevention and Strategy Manager) - PCT	BP VG LP	Y		1-2 years: PCT can demonstrate that it is working with GPs to identify carers and that GPs are engaging with the requirements of the QoF. 1-2 years: Relevant elements of the multi-agency strategy (see recommendation 5) contain appropriate performance measures in order to track improvement.
RECOMMENDATION 5 • We recommend that the forthcoming multi-agency carers strategy to set out the context for partnership working and set out clear deliverable and SMART priorities for carers in Harrow. The strategy should also address major policy developments and opportunities such as direct payments.	L	- Carers Prevention and Strategy Manager - PCT - NW London Hospitals Trust - Relevant voluntary Groups	BP LP	Y		1-2 years: Multi-agency strategy developed and 'owned' across partners. 1-2 years: Clear priorities established with associated performance measures against which robust information can be provided.