April 2009

Overview and Scrutiny Committee

Report of the Scrutiny Standing Review of NHS Finances

Members of the Standing Review

Councillors

Cllr Margaret Davine (Chairman)
Cllr Vina Mithani
Cllr Rekha Shah
Cllr Stanley Sheinwald

Cllr Myra Michael
Cllr Jean Lammiman

Co-optees

Avani Modasia, Age Concern Harrow
Janet Smith, Mind in Harrow
Julian Maw, PPI, Harrow PCT
Ruth Coman, Harrow Resident

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CHAIRMAN'S INTRODUCTION & ACKNOWLEDGEMENTS

The standing review of NHS finances was established in July 2006 in response to the significant financial difficulties being experienced by local health providers. These difficulties were having a serious impact on the council's finances and also on the well-being of local people. Investigation of the financial crisis had originally been undertaken by the Adult Health and Social Care scrutiny sub committee but as the severity of the crisis began to unfold, it became increasingly difficult to investigate the financial performance of the local trusts as a part of the normal business of the sub committee. It was therefore agreed to set up the standing review. The terms of reference of the review are attached as Appendix One.

Colleagues from Harrow Primary Care Trust, North West London Hospitals NHS Trust and the Council's Adults and Housing Directorate have met with the standing review on a regular basis and have been able to provide us with detailed explanations of the financial position being encountered and their respective proposals for recovery. We are very grateful to Fiona Wise and Mary Wells current and previous (respectively), Chief Executives of NW London Hospitals Trust, and Sarah Crowther and Andrew Morgan, current and previous (respectively) Chief Executives, Harrow PCT, for the time they and their officers have given to the review. We would also like to thank Paul Najsarek and Penny Furness Smith, current and previous (respectively) Corporate Directors of Adults services.

The review was originally chaired by Cllr Myra Michael, then Chairman of the Adult Health and Social Care scrutiny sub committee until her resignation from scrutiny in July 2007. I should like to place on record, the group's gratitude to her for her commitment to the improvement of healthcare for the residents of the borough and to acknowledge her expertise in this area.

We were also joined in our deliberations by a number of community experts, who brought a real understanding of the impact of the financial difficulties on the lives of some of our vulnerable residents. I would like to thank:

- Ruth Coman. Harrow resident
- Julian Maw, PPI Forum, Harrow PCT
- Avani Modasia, Chief Executive of Age Concern Harrow
- Janet Smith, Mind in Harrow

I would also like to thank the health professionals who have given us their advice in this very technical area and thus enabled us to unravel some of the issues precipitating the difficulties locally In particular we would like to thank:

- Joy Tweed, Centre for Public Scrutiny
- Paul McKevitt, Healthcare Commission
- Adewale Kadiri, Healthcare Commission
- David Poland, Audit Commission

Whilst the group remains concerned regarding the financial performance of, in particular, the NW London Hospital Trust, we are more confident that there is greater communication between local organisations and a greater understanding of the impact that recovery plans have on residents. Whilst it is important for the books to balance, it is also important that the impact on our most vulnerable citizens is minimised. It is the standing reviews opinion that only with increased communication can this be achieved.

In order to ensure that performance is monitored in future, our primary recommendation is that the Performance and Finance scrutiny sub committee continues to monitor and challenge the financial performance of our health partners.

Cllr Margaret Davine
Chairman Standing Scrutiny Review of NHS Finances

RECOMMENDATIONS

The Standing Scrutiny Review of NHS Finances makes the following recommendations:

- *We strongly recommend that the Performance and Finance sub committee and the adult health and social care scrutiny lead councilors continue to monitor the financial performance of the PCT and the NW London Hospitals Trust*

- *We urge the PCT, the council and the hospital trust to ensure that communication continues to improve and that joint planning becomes more than just a phrase bandied about to get through inspections*.

- *We recommend that all proposals for change in health and social care provision are subject to risk analysis, health impact assessment and consultation in order to ensure that the potential for local people to 'fall through the gaps' in provision are identified and addressed.*

- *We recommend that the Overview and Scrutiny committee invites the chairman of Harrow LINk to become a non-voting co-optee on the committee and also that the chairman is invited to quarterly briefings of the Adult Health and Social Care lead scrutiny members.*

- *We recommend that the working party supporting the council's representatives on the JOSC should seek reassurances on both the financial capacity of the NW London Hospital Trust to sustain the addition of the regional stroke centre and on the robustness of the strategic planning for the hospital overall should the bid be successful whilst preparing submissions to the JOSC.*

- *We recommend to the Adult Health and Social Care management group of the Harrow Strategic Partnership that their work includes consideration of innovative means of delivering services jointly to local people.*

BACKGROUND

During 2006, Harrow Primary Care Trust began to address the severe financial difficulties it was facing and it became apparent that their recovery proposals would have a significant impact upon the council. In order to reduce the cost of its continuing care budget, which provides residents experiencing primarily health related difficulties with free NHS services, the PCT had undertaken a detailed, case-by-case assessment of those residents receiving free services. This had resulted in the reclassification of a number as social care cases which meant that the care was no longer free and the council's social care services would therefore need to pick up the costs of looking after these vulnerable residents. This transfer of costs to the council then resulted in some serious budget difficulties for the council itself and meant that the council was also forced to make some very difficult funding decisions. As local organisations facing financial difficulties focussed their resources only on the most acute cases, the gaps between organisations increased as did the potential for people to fall through these gaps.

Scrutiny councillors became aware of a number of very distressing cases which saw severely ill residents being denied some of the services upon which they had previously depended. The councillors were also aware that very little communication was taking place between the different agencies and that, in the rush to balance budgets, very little thought was being given to the potential impact of funding changes on users of service themselves. A number of meetings of the Adult Health and Social Care scrutiny sub committee received information regarding the PCT's recovery proposals but there was insufficient time to consider this on the normal committee agenda. The Standing Review of NHS Finances was established in July 2006 to redress this accountability deficit and to safeguard the health and well-being of vulnerable residents. The review group met on a monthly basis and held 13 meetings at which detailed explanations of health and social care recovery proposals were discussed and challenged. The group also undertook a specific piece of work with carers in an attempt to understand how the organisational changes were impacting on residents. The report of the carers' case study is attached as Appendix Two. The case studies findings were further investigated during round table discussion with officers from within the council and partners from health organisations and carers' representatives. The minutes of this meeting are attached as Appendix Three.

The Health and Social Care Act 2001 is the statute from which local authority scrutiny committees derive their power to hold local health care providers to account. The early experience of the implementation of this power was somewhat resisted by health colleagues, who did not appreciate the powers of local councillors and thus whilst willing to attend committee meetings to present basic information on their financial performance, they were not so keen to provide the detail later requested by the review group. Indeed it has been interesting to review early correspondence with the previous Chief Executives of the PCT and hospital trust who were unclear as to the rights of the group. This lack of communication has characterised the relationship between the partners and is returned to later, at this point suffice to say, that scrutiny's desire to understand the difficulties, to lobby on behalf of local people and to broker a clearer relationship between significant local organisations was not immediately welcomed. Nonetheless, the group has persisted in its task and has been able to ask the difficult questions and broker the relationships required. It is worth noting that whilst Harrow chose to work in this way, a number of other London local authorities were considering a more litigious approach to solving their problems. We are glad that our deliberations have contributed to a more harmonious resolution.

The review period has been characterised, and probably complicated by staffing issues in all of the organisations. The Chief Executive of the PCT changed, as did a number of the senior management team at the PCT. The Chief Executive of the NW London Hospital Trust also changed, as did the Corporate Director for Adult and Housing Services at the council. The changes, it has to be noted have been generally positive and have resulted in a new focus and commitment to improvement between the different organisations. It is beyond doubt that these managerial difficulties will not have helped the resolution of the financial situation and we commend the new approach and positive attitudes that have resulted from the changes. However, we still perceive a level of reticence to acknowledge the rights of scrutiny to challenge performance and we hope that the various officers can appreciate the importance of an openness to challenge and the benefits this can bring for local people.

The standing review methodology adopted by the project has meant that the more in-depth consideration of a particular topic, has not been a feature of our deliberations, though the investigation of the impact of change on carers did make a significant contribution to our understanding of the situation. More, the role

of the standing review has been to continually monitor activity and to hold health and social care providers to account for the delivery of their respective recovery plans.

OBSERVATIONS

Interim findings

In March 2007, the standing review reported its interim findings to the Overview and Scrutiny committee. These included:

Budget analysis and monitoring

The review was satisfied that, in the main, the most appropriate budget areas were being targeted and that financial monitoring appears more robust than in the past. The group agreed to continue to monitor the delivery of the turnaround plans, in particular to monitor the impact on local people.

Developing a Partnership Response – Continuing care

A key area of concern and indeed a driver for the establishment of the standing review was the PCT's adjustment in the continuing care criteria which resulted in significant numbers of residents, previously eligible for free NHS care no longer being entitled to this care. The care needs of these vulnerable residents were passed to the council's Community Care service and this transfer of costs resulted in significant financial difficulties for the council. The significant impact on the council's finances cannot be underestimated and the impact of our own resultant budget cuts must still be monitored.

The review group heard that the council and health partners had managed to keep lines of communication open during this very difficult time and indeed, had begun to work on identifying future solutions to difficult budget situations and assessing the risk presented by this *collectively*. The use of the Health and Social Care Integration Board was identified as a critical component in this future work.

Developing a Partnership Response – PCT/NW London Hospitals NHS Trust

The interim report noted that, not only was the impact of the PCT's turnaround plan been felt by the council. The hospital trust faced a similarly difficult financial situation and the group was concerned to note that components of the recovery plan of one seem to have a negative impact on the recovery plan of the other. For example, the PCT proposed resolution of some of its difficulties by reducing activity commissioned via the hospital trust, which in turn proposes to reduce its financial difficulty by increasing activity. This continues to be an issue and one which may well be beyond the control of any of the local organisations.

Regional/national response

A number of PCTs across London and indeed the UK had faced significant budget difficulties and these had a similar impact on respective local councils as they did in Harrow. In many circumstances, PCTs seemed to be powerless to respond to evidence of the impact of their turnaround plans as NHS London or the DoH insisted that all possible action was taken to meet the 'break even duty'. In many ways this pointed to the need for a more fundamental examination of NHS funding arrangements than could be facilitated on a single-borough basis and suggested more generalised regional lobbying activity may have been appropriate. The group thus agreed not just to challenge the delivery of the respective turnaround plans locally but also to use evidence of the impact of these turnaround plans gathered during the challenge process for submission on a more regional basis. To this end the group proposed two pieces of work:

- The impact of the NHS (and subsequent council) funding difficulties on the lives of people caring for vulnerable friends or relatives and the people they care for
- The impact of budget reductions on the capacity of GPs to deliver some of the community based facilities central to the Government's future health agenda.

The report of the impact of funding cuts on carers was undertaken during the summer of 2007. Unfortunately, it was not possible to undertake the piece of work with GPs, despite numerous attempts to engage with them, no communication could be arranged on mutually acceptable terms.

Overall findings and observations

Since its initial report, the group continued to meet and to monitor the performance of the local health organisations and their engagement with the council's own services for vulnerable residents. This regular monitoring was also mirrored in other partnership forums in particular the Health and Social Care integration board of the Harrow Strategic Partnership (HSP). The group members welcome this increased dialogue but remain concerned on a number of levels. Our overall observations at the completion of the project are:

- Increased monitoring has been implemented and is welcome
- Increased communication between the key organisations has been implemented and is welcome however still some concern re joint planning
- There is still only limited comprehension/investigation of the impact of budget cuts on residents
- The group remains concerned about the financial status of the NW London Hospital Trust
- Strategic planning - Healthcare for London requires further embedding.
- There is need for more fundamental consideration of how services are configured and delivered – both internally and between agencies

Increased monitoring

The standing review of NHS finance was the first real opportunity the council had to undertake a detailed investigation of the financial performance of Harrow PCT and NW London Hospital Trust. It did this in the context of the impact that the deteriorating financial position being experienced by the PCT was having on the council's own finances and it did so at a time when the levels of hostility between the council and the PCT were at a height – it is to the credit of both organisations that lines of communication remained as constructive as they did.

During its final meetings, the review group received evidence from the PCT that it anticipated break even at the end of the financial year 2007/08. The PCT's annual report for 2007/08 confirmed that not only had the organization broken even but it had also paid off all of its accumulated debts from previous years having successfully delivered its 2-year turnaround plan. This is indeed excellent news for local people and the review group offers its congratulations to staff at the PCT for this achievement., However, in the light of the considerable impact upon health and social care performance that the PCT's financial situation can have, it is critical that this remains closely monitored. Whilst we are more confident in the financial competence of the organisation, ***we strongly recommend that the Performance and Finance sub committee and the adult health and care scrutiny leads continue to monitor the financial performance of the PCT***

With regard to the NW London Hospital Trust, the group was advised that the financial position was less certain and that the year end position for 2007/08 was by no means secure. The Trust in fact delivered a £1m surplus at year end but this was set against the need to repay the loan received in respect of the historic debt of £24m. Our concerns therefore remain. The trust, whilst able to deliver in year savings – demonstrating its increased financial awareness – still retains its historic debt. Again, therefore, ***we strongly recommend that the Performance and Finance sub committee and the adult health and care scrutiny leads keep the performance of the NW London Hospital Trust under review.***

With regard to services delivered by the Council's Adult and Housing Services directorate, we are impressed with the work that has been undertaken by the service to understand its weaknesses and to devise solutions to some of the serious financial drivers that have threatened to devastate the delivery of services to local people. The Transformation Programme Plan is beginning to deliver significant improvements. We also thank the director of this service for his willingness to engage with scrutiny in the delivery and monitoring of the Transformation Programme Plan.

Increased communication

It is clear to us that times have changed and the dire position that local organisations found themselves in, resulting in the establishment of the standing review is no longer the case. There is a tangible improvement in the relationship between the council and the PCT in terms of the commitment to service delivery and service improvement. A strengthened Harrow Strategic Partnership and the impetus being felt locally by the implementation of the Comprehensive Area Assessment make it clear that all organisations that have a role to play in improving the lives of local people must now work together to

that stated aim. The HSP Harrow Chief Executives and the Adult and Social Care management group offer real opportunity for communication and planning. However, whilst these opportunities exist and indeed, joint planning is emerging in more than just words, our investigations have left us with concerns.

During the round table discussion of the outcomes from our carers' case study, it became apparent to us that the engagement of the PCT was nominal in the development of the 'Joint Carers' Strategy'. Similarly, during discussions with officers, it was also revealed that resource limitations had meant that the involvement of the PCT in the Joint Needs Assessment had been limited. We would reiterate our plea for communication between organisations: if we are to avoid similar difficulties in future, increased communication is crucial, there is nothing to be gained from the council and its health partners failing to work together to both join up service delivery and at the same time maximise the effective use of resources. In this instance therefore. ***we would also urge the PCT, the council and the hospital trust to ensure that communication continues to improve and that joint planning becomes more than just a phrase bandied about to get through inspections***.

In this context, we also restate the concerns raised in our interim report regarding the impact of the recovery proposals of one organsation on the recovery proposals of another. We received evidence from all parties of changes in tariff payments, inappropriate coding of charges and over performance and the differential impact of these on individual organisations. It is clear that this is a significant issue and one which probably warrants national resolution. However, in the absence of this we would reiterate our comments on the need for real and continuous communication between the council and health partners, only if this communication is effective can we avoid the difficulties that emerged in our recent past and only through this communication will we be able to identify mutually acceptable solutions which minimise impact upon our residents.

Limited comprehension of the impact of budget cuts on residents

As stated earlier, the main process that has been adopted by the standing review has been to challenge and consider reports from the health and social care partners on their financial performance. However, this has to be more than a simple case of balancing the books and the review undertook to investigate the extent to which the real impact of budget cuts was being considered by the organisations. The detailed findings of the carers' case study and the outcome of the 'round table' discussions on these findings are appended to this report, but we would reiterate the concerns expressed in that report that suggest that only limited attention is being paid to the impact of change on service users.

Also in this context, we did not receive any evidence to suggest that the recovery plans of either organisation has been subject to health impact assessment. Though we have clearly moved on from the very difficult situation which warranted the recovery planning process, we are concerned that decisions are still being made without real reference to the impact on service users. To this end, we would emphasise the importance of an early appreciation of the impact on service delivery and indeed on Northwick Park hospitals application for regional stroke specialist hospital status of the proposed redundancies at NW London Hospital Trust. Health and social care providers must be absolutely clear about the impact their proposals are having generally on the health of residents but also they must be able to identify if their proposals have an unintentionally adverse impact on specific groups of our residents which result in increasing rather than decreasing health inequalities. ***We recommend that all proposals for change in health and social care provision are subject to risk analysis, health impact assessment and consultation.***

Since the completion of the review's work, the Harrow Local Involvement Network (LINk) has been established with a brief to monitor, investigate and comment upon the performance of local health and social care services. This body offers an important opportunity for both the council and health partners to consult and engage with local people about service performance and the impact of changes to these services. The standing review welcomes the establishment of the Harrow LINk and, in order to consolidate its position in the borough, ***we recommend that the Overview and Scrutiny committee invites the chairman of the LINk to become a non-voting co-optee on the committee and also that the chairman is invited to quarterly briefings of the Adult Health and Social Care lead scrutiny members.***

Financial status of the NW London Hospital Trust
The NW London Hospital Trust's historic debt of £24m, though put aside, still appears to be creating significant difficulties for the organisation. Whilst the trust hopes to deliver an-in year surplus, it is still required to repay this significant sum of money and to this end has devised a 5-year delivery plan. As mentioned above, 2007/08 did see the trust return a modest surplus and pay the initial instalment on its £24m DH loan. However, as the Chief Executive of the trust has advised, much of the savings already identified are non-recurrent e.g. the disposal of assets which would suggest the need for more fundamental service reconfiguration as a key part of the efficiency process. During discussions, we have also learned of proposed reduction of 270 posts at the trust. In discussions with the Chief Executive, we have not been able to ascertain what the impact of these ongoing financial difficulties will be on the performance of the hospital and thus on the lives of local people. ***We recommend therefore that the financial performance of the trust is monitored by the Performance and Finance sub committee and that in particular, the Adult Health and Social Care leads seek reassurances that risk analysis and health impact assessments accompany any proposed reductions in service***.

Strategic planning and the response to Healthcare for London proposals
One of the early observations of the group had been the need for greater co-ordination regarding the provision of services on a regional basis. The proposals in Lord Darzi's report 'Healthcare for London – A Framework for Action' augured a welcome improvement in the strategic planning of health provision across the capital, which had been sorely lacking in the past. We would hope that the implementation of the Healthcare for London proposals can deliver a more strategic approach to the delivery of health services across London. Negotiations are currently underway on the future delivery of both stroke and major trauma services and Northwick Park hospital has applied to become a regional stroke centre under these proposals. The council is participating fully in the pan London negotiations via the Joint Overview and Scrutiny committee that are considering these proposals. The council's JOSC representatives and the associated working group will continue to monitor this and to ensure the needs of local people are paramount in the discussions.

However, we remain concerned, given the financial concerns identified above, about the local impact of the trust's application to become a regional stroke centre or indeed whether or not a trust experiencing financial difficulties has the capacity to offer the stroke service whilst maintaining the other wide ranging functions of an acute hospital. On balance therefore, we remain, unconvinced of the robustness of decision-making in relation to local health provision. Whilst we would welcome the additional investment in the trust that the development of stroke provision at Northwick Park hospital would generate, we seek assurances on both the financial capacity of the organisation to sustain this and on the robustness of the strategic planning for the hospital overall should the bid be successful. ***We recommend that the working party supporting the council's representatives on the JOSC keeps this in mind whilst preparing submissions to the JOSC.***

Fundamental reconfiguration
In the early phase of the review, we received information regarding innovations such as GPs with special interest (GPSIs) which suggested that more fundamental consideration of structures and processes was underway in health. We also received evidence from other PCTs about the ways in which funding difficulties could be turned around – through more fundamental analysis of service provision. At the time we commended this approach to the PCT and we would hope that where it is appropriate and practical, the best practice of other bodies is now being referenced. However, In particular, in relation to our discussions with regard to the need for improvements under the continuing care issue, we were surprised to hear that there are no real proposals in relation to schemes such as intermediate treatment – the prevention of admission to hospital and the acceleration of discharge from hospital through the use of intensive community/home care services. Similarly, we feel that the NW London Hospital Trusts 'Cost Improvement Programme' also reflects a more piecemeal approach to cost reduction.

This suggested to us that there has been no real strategic analysis of some of the fundamental issues that have resulted in the financial difficulties being experienced by the trust and PCT or of the potential solutions to these problems. We feel that the scope for delivering the level of savings required is beyond the piece-meal approach taken by our partners, and indeed by the council itself. With the onset of more intense joint service delivery and of the significant changes associated with the personalisation of care agenda, we would suggest this is an ideal time to undertake a fundamental analysis of service provision

and delivery across all agencies in order to investigate the potential of more innovative means of service delivery. ***We therefore recommend to the Adult Health and Social Care management group that their work includes consideration of innovative means of delivering services jointly to local people.***

CONCLUSION

Times have changed, the regulatory processes under which the performance of all local agencies is measured have been refined and we are now more than ever before required to ensure that we work together and that we put people at the centre of our planning. The standing review of NHS finances has spent a long time considering why things went so badly wrong, and it is our conclusion that local service providers, both council and health, didn't communicate and didn't put people at the centre of the planning processes. The new regime changes all of that and we will stand or fall in relation to how well we can demonstrate we have improved and now genuinely engage with each other and with service users. The review group acknowledges that things have improved, but just how much so is not clear, we feel there is still a way to go but we hope that just by asking the questions the standing review has helped our colleagues in the authority and in the health service to make steps in the right direction.

I commend this report to you, in the spirit of positive and productive partnership working.

Cllr Margaret Davine
On behalf of members of the Standing Review of NHS Finances

APPENDIX ONE

STANDING SCRUTINY REVIEW OF NHS FINANCES - DRAFT 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 Chris Noyce 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 MANAGER**	Chief Executive Harrow PCT 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/ CONSTRAINTS**	Availability of experts advisor to the review group
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 [ ] When *Interim report [√] When March 2007* *Quarterly updates [√] When from March 2007* *Final report [√] When March 2008 (approx)* To Portfolio Holder [ ] When To CMT [√] When June 2008 To Cabinet [√] When June 2008
21	**FOLLOW UP ARRANGEMENTS (proposals)**	Regular reports to O&S

APPENDIX TWO

August 2007

Overview and Scrutiny Committee

Report of the Standing Scrutiny Review of NHS Finances

Carers Case Study

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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Version 5 – 13/09/07
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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

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[3] Ibid. Paragraph 7.12.

councils to provide services across north west London – adopting a regional approach – should be considered.

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:

[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.

> 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 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

[7] Ibid. Paragraph 7.24.

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 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.

[8] Ibid. Paragraph 7.95

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 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.

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

- 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.

[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

[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

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 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 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.

[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

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 MANAGER**	Chief Executive Harrow PCT Chief Executive NW London Hospitals NHS Trust

STANDING SCRUTINY REVIEW OF NHS FINANCES

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/ CONSTRAINTS**	Availability of experts advisor to the review group
16	**SECTION 17**	None

	IMPLICATIONS	
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	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
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.	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	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	TS	Identified officer/ member/ group to action	Info	P/ship (Y/N)	Action taken (6 months or 1 year)	Measure of success
share with carers. Changes in service provision should also be better communicated.						
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 Preventio n 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.

APPENDIX THREE

Panel members: Cllr Margaret Davine (Chairman); Cllr Rekha Shah; Julian Maw; Cllr Vina Mithani; Janet Smith, Mind in Harrow.

Apologies: Ruth Coman, Avani Modesia, Age Concern Harrow; Councillor Stanley Sheinwald

Officers: Jasvinder Perihar, Senior Professional – Well-being and Carers' Strategy, Harrow Council; Jonathan Tymms, Director of Finance, Harrow PCT; Mark Bamlett, Harrow PCT; Heather Smith, Scrutiny Officer, Harrow Council (notes)

1. **Welcome**
   The Chairman invited everyone to introduce themselves and welcomed Mike Coker (Harrow Carers), Ann Freeman (Rethink) and Sue Springthorpe (Harrow Crossroads) to the meeting.

2. **Introduction from the Chairman**
   The Chairman outlined the purpose of the challenge panel, convened by the Standing Review of NHS Finances, which was to receive a presentation on the new Carers Strategy and to investigate progress made on the recommendations made by the group in its carers' case study.

3. **The Carers' Strategy**
   Jasvinder Perihar gave a presentation on the strategy. The previous strategy ran until 2008, so the decision was taken to hold an event in April 2007 in order to begin to identify priorities for the new strategy. It was originally intended that the new carers' strategy would also reflect the new national strategy for carers, which was due to be published in December; it was, however, still awaited.

   There was a desire for the new strategy to adopt a multi-agency approach (also a recommendation from the Carers' case study). To date Harrow Primary Care Trust (PCT) representation at the Carers Partnership Group has been patchy, though two new nominees have been made by the PCT very recently. As part of the development of the strategy national and local policy was mapped. The strategy relies on data on carers from the 2001 census and the Harrow Carers register. Current local service provision was also mapped in order to identify gaps. The strategy adopts the priorities set out in *Our health, our care, our say: a new direction for community services*[22], with an action plan that outlines how the priorities will be addressed in the first year. The Harrow Mental Health Services Action Plan for Carers (2007-10) and Young Carers Action Plan (2008-09) are appended.

   The strategy was now subject to endorsement from the partnership groups including the older person's reference group, the mental health task group, learning disability task group (and Mencap) and HAD (as there is no physical disability group. Carers would be given the opportunity to comment in carers' week. The chairman suggested that the Partnership with Older People (POP) panel should also be considered.

   Jonathan Tymms alluded to previous financial constraints and that in the past carers had not been a priority, or received detailed focus. The PCT's new operating plan and the more

[22] Department of Health (2006) http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm

tranquil financial position for the PCT meant that carers' needs had been recognised; funds had been put aside for the voluntary sector to apply for additional grants and in the next few weeks voluntary sector groups would be approached and invited to apply. An open day was also planned to offer groups the opportunity to visit and to discuss the application criteria. Joint funding was also being explored.

Sue Springthorpe reported that Crossroads had begun discussions with the PCT with regard to a new respite care contract. She commented that the organisation had not recovered from the loss of the contribution that the former health authority had made to core costs (£42k) and the organisation currently expected to have no reserves by 2009. The organisation's current SLA with the council stated that there would be no guaranteed funding beyond the life of the SLA because of moves to direct payments. While Crossroads embraced the concept of direct payments this statement did not seem to reflect that it would take a longer period to introduce direct payments and that in any case they would not suit all users who would still seek a service from organisations such as Crossroads. Crossroads is looking at the possibility of offering a private service in a different format. There had been no advice from the council on future developments or how it could work with Crossroads in setting up direct payments projects.

Comments from the panel on the strategy were as follows:

- The demographic information about Harrow carers could be more strongly reflected in the strategy. The strategy should seek to set the scene for Harrow nearer the beginning of the document.
- In the light of the information received by the panel about the level of consultation undertaken and the role of outreach workers in the development of the strategy by providing direct feedback from carers, the panel was of the view that this should also be more strongly reflected in the strategy. The strategy did not currently give itself credit for that activity and this would also help it to better convey how national priorities have been married with local need.
- There is still a lack of clarity for the voluntary sector, particularly in terms of future policy developments. There were also issues in terms of groups being given sufficient notice of changes and having time to reflect changes in the planning cycle of the business. The short term nature of grants was also alluded to. The chairman alluded to the scrutiny review of delivering a strengthened voluntary sector and the linkages with the findings of this panel.
- With regard to the previous recommendations from the group's case study, panel members were pleased that the multi-agency strategy has begun to be developed but that there was clearly further work to be done in relation to developing effective partnership working and future monitoring of progress. The challenges in terms of measuring meaningful outcomes from the strategy as opposed to outputs were noted.
- The panel welcomed the proposed launch of the strategy and suggested ways of offering a wider range of carers to see the strategy before final sign-off. Circulating the executive summary via Harrow Carers' mailing list was suggested as well as the council website and magazine.

4. **Concluding remarks, next steps**
   Given that the standing review was now drawing to a close, the chairman requested that future progress on delivering the carers' strategy and recommendations from the carers' case study be reported to the Overview and Scrutiny Committee.

Heather Smith, 9 June 2008