



NHS continuing healthcare

Detailing what NHS organisations need to know and do

Key points

- From April 2013, CCGs will be legally responsible for commissioning and assessing patients for eligibility for CHC.
- The challenge is to ensure a smooth transition to commissioning by CCGs, retaining skills within the system, and providing more personalisation for patients.
- Collaborative working with providers from all sectors will be essential.
- By April 2013, CCGs will need to have received assurance on models of delivery and how they will fulfil their CHC statutory duties.
- Commissioning support offers to CCGs need to consider assessments, care management, benchmarking performance and training and development, amongst other issues.

NHS continuing healthcare (CHC) is care and support provided to adults aged 18 or over, that is arranged and funded solely by the NHS, and is therefore free at the point of delivery. It covers health, personal care and accommodation (if that is part of the overall need). It may take the form of a care home placement or a package of care and support in the individual's own home or elsewhere. In essence, the NHS funds all the assessed health and social care needs.

From 1 April 2013, the legal requirements on primary care trusts to undertake the assessment process for CHC will transfer to clinical commissioning groups (CCGs). The current role of strategic health authorities to run independent review panels (and undertake support and monitoring of consistent access) will transfer to the NHS Commissioning Board.

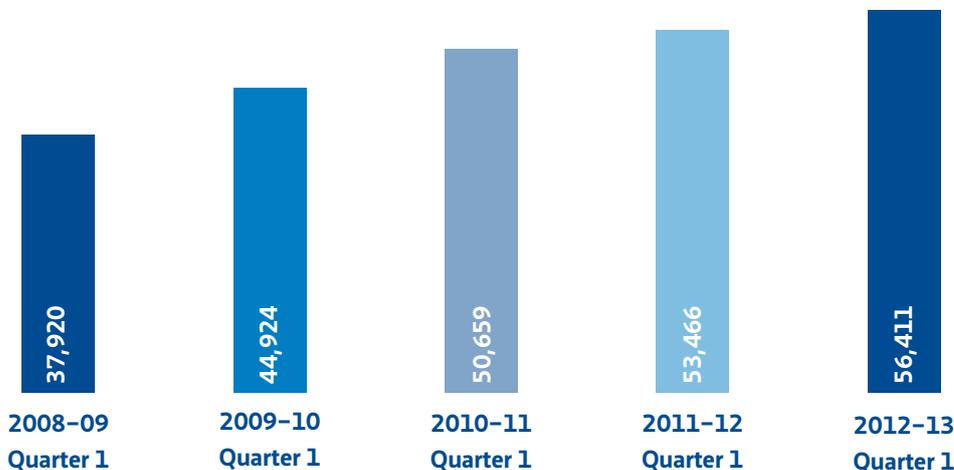
This *Briefing* outlines for commissioners and providers the challenges and opportunities they will need to consider as the responsibilities change for assessing eligibility for and commissioning CHC.

Background

A key principle of CHC is that eligibility is not dependent on where (in England) you live. Assessment for CHC has to follow the prescribed national process, set out in the *National framework for NHS continuing healthcare and NHS-funded nursing care*.¹

To monitor this process, the Department of Health collects and publishes data on the number of people receiving CHC on a quarterly basis. Since 2007 there has been a marked increase in access (see Figure 1). It is important to note that the number of people seeking CHC

Figure 1. People receiving NHS continuing healthcare in England (2008–12)



Source: Department of Health

may vary as a result of other local NHS provision, as well as the local demographics of the population.

At present, around 56,000 people receive CHC, costing approximately £2.5 billion a year. All of these people (apart from those fast-tracked due to a rapidly deteriorating condition that may be entering a terminal phase) will have been carefully assessed and determined by the NHS to have care and support needs that are intense, complex and/or unpredictable, or to have needs that are clearly beyond the remit of local authority social services to provide. Therefore, the costs of individual packages are often high. With demographic changes it is anticipated that this figure will continue to rise.

The challenge

Commissioning CHC has been considered to be a niche area, run by those with specialist knowledge. The challenge is to ensure a smooth transition to

commissioning by CCGs, retaining knowledge and skills within the system, and providing more personalisation for patients. The introduction from April 2014 of personal budgets for patients eligible for CHC will test whether this opportunity has been utilised.

The process

In order for someone to receive CHC they have to be assessed according to a nationally prescribed, structured decision-making process to determine whether they have a 'primary health need'. This is set out in the national framework, which must be followed in order to comply with the law.

The question of who funds ongoing care for people with significant nursing/healthcare needs has been legally contested since the 1990s and has been the subject of court judgments and Parliamentary and Health Service Ombudsman scrutiny. Following a critical Ombudsman report in

2003, the NHS had to identify thousands of individuals who had been wrongly denied CHC and reimburse care costs, sometimes going back to 1996.

Decisions around eligibility for CHC are particularly subject to legal challenge. 'No win, no fee' legal firms regard CHC as 'good business' and it is increasingly common (but unnecessary) for patients to bring legal representation to assessments.

The national framework ensures there is fairness and equity; a consistent application of the eligibility for 'free' ongoing NHS care; value for money; effective care pathways; and compliance with the law.

Individuals can be considered for CHC through a number of different routes or care pathways. These include on discharge from hospital, following rehabilitation or intermediate care, through a referral from social services or self-referral.

Currently, specialist teams are employed to discharge responsibilities around CHC. It is a skilled and complex area of work that involves not only the clinical expertise required to support the assessment process, but also the skills to work with individuals and families at a very difficult time. These teams work in a complicated and occasionally contentious area of law. They have to deal sensitively with families who may contest the decision if the individual is assessed as not eligible for CHC, as there may be significant financial consequences for the individual and their family.

Key issues for commissioners to consider

- By April 2013, CCGs will need to have specified and secured the delivery of CHC statutory duties.
- Collaborative working with providers, including care homes, and local authorities will be essential.
- CCGs need to ensure that processes are legally compliant.
- CCGs will need to work collaboratively across neighbouring areas to share financial risks and achieve economies of scale regarding assessment and commissioning.

The process in seven steps

Step 1: An individual is identified as in need of assessment for CHC, usually through use of the nationally prescribed 'checklist' screening tool. All reasonable steps should be taken to ensure that an assessment of eligibility for CHC is carried out in all cases where it appears that there may be a need for such care.

Step 2: A case coordinator must be identified to oversee the multi-disciplinary team assessment process. A team, in this context, is at least two professionals, preferably one from healthcare and one from social care, but otherwise from two different healthcare professions. All relevant assessment reports are gathered to inform the decision-making process.

Step 3: The multi-disciplinary team uses the assessment information to complete a decision support tool. This has 12 'domains' and records an overview of the individual's needs. The team uses this information to make a recommendation as to whether the individual has a 'primary health need', i.e. whether or not they are eligible for CHC.

Step 4: The commissioner checks and verifies the team's recommendation. Only in exceptional circumstances, and for clearly articulated reasons, should the recommendation not be followed.

Step 5: If the individual is eligible for CHC, the commissioner arranges and funds the care placement or home support package to meet all the assessed health and social care needs.

Step 6: The commissioner is responsible for ensuring that there is ongoing case management and that the care arrangements are regularly reviewed, including whether the individual is still eligible for CHC. If it appears that they may no longer be eligible, a multi-disciplinary team must complete a new decision support tool and make a recommendation regarding ongoing eligibility.

Step 7: If the individual does not agree with the eligibility decision they can appeal.

Responsibilities of commissioners in the new system

CHC is at the interface between health and social care provision. Collaborative working with providers from all sectors, including care homes, will be essential, particularly as demand continues to rise.

Successful delivery of CHC relies on close working with local authority adult social care services. Therefore, co-terminosity with the local authority can be very helpful.

To ensure a smooth transition from April 2013, local health economies will have to develop models for the future delivery of the range of functions connected with CHC. It will be essential that CCGs are aware of the need to provide or commission a service that has the detailed clinical, pathway and system knowledge and skills required to ensure that processes are legally compliant, and that packages of care deliver quality and value for money.

CCGs will need to work collaboratively to ensure compliance with the law, share financial risks around high-cost packages of care and achieve economies of scale around the assessment and commissioning processes.

The key CCG responsibilities are:

- assessment of a person's needs and subsequent review, as set out in the national framework
- identification of a case coordinator

Case study. Commissioning CHC in-house

East Coast Community Healthcare CIC (ECCH) provides a range of community health services for a population of 230,000. Nearly 90 per cent of their services are commissioned by Health East CIC, the clinical commissioning group for Great Yarmouth and Waveney.

Before 2010, NHS Great Yarmouth and Waveney outsourced their commissioning of CHC to other primary care trusts (PCTs). However, the rising numbers of eligible patients and associated increasing costs and waiting lists led to a decision to take the commissioning back in-house. The assessment and decision-making services were provided by their own community services. The team was expanded and, in addition, a learning disability nurse specialist was appointed to assess those whose primary diagnosis was one of learning disability. The service separated from the PCT and became a social enterprise in 2011.

In 2011/12 Great Yarmouth and Waveney had the highest number of eligible patients per population at 83.5/50,000 (East of England average was 45.9). Demand continues to rise, with an increase of 41 per cent between the first quarter of 2011 and 2012.

Involving patients

Patient involvement is crucial ('no decision about me without me') and allows the patient to ask questions about the process and eligibility. Although this may take longer, it means they rarely need to revisit the reasons given for the decision made.

Once the checklist has identified that a full assessment needs to be made, the case is allocated to a specialised nurse assessor. The patient remains at the centre of the process and time is taken to ensure that they have a full understanding of the process.

Working with local authorities

The local county councils work closely with the team and everyone assessed has social care representation from the outset.

Getting it right first time

Decisions that find a person not eligible for CHC are being increasingly challenged by patients, often through legal companies. Robust processes by ECCH have ensured that only two 'no' decisions have gone to the Independent Review Panel and both were upheld.

Assessment setting

ECCH are working with James Paget University Hospital, on a project that enables patients to leave the hospital to have their assessment for CHC in a more appropriate setting. Patients have a choice of local care homes to which they can be transferred while waiting for their assessment. The care is paid by the commissioner but at social service rates. This can save up to £200 per week per patient. In addition, if the patient is not eligible for CHC then there is no financial reason for the patient to move again.

Statutory duties

As a social enterprise ECCH is not legally regarded as an NHS organisation. However, statute requires that decision-making for CHC eligibility is made by an NHS organisation. To date, secondment arrangements with NHS Norfolk and Suffolk have allowed the processes to continue, but the future is uncertain with the demise of PCTs in April 2013.

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- decision-making on eligibility, engaging families and managing disputes
- commissioning the care and support package (including the possibility of a personal health budget) in line with procurement, choice and competition rules
- case management and reviews of complex cases
- governance and system management to ensure legal compliance.

Models for delivery

Potential delivery models might include:

- assessment teams based in an NHS provider body or social enterprise – provided legislation is amended to enable this
- assessment and commissioning functions in a commissioning support offer
- assessment and/or commissioning jointly or within adult social care
- delivery through closer integration of provision with NHS community services and alignment with support for people with long-term conditions, including through the role of community matrons
- utilising the role of health and wellbeing boards in relation to governance and system management.

What do commissioners need to do now?

By April 2013, CCGs will need to have specified and secured the delivery of CHC statutory duties for:

- assessment of individuals
- decision-making on eligibility
- commissioning the care and support package
- case management and appropriate governance
- system management to ensure legal and policy compliance.

By April 2013, CCGs will need to have received assurance that those delivering the above have:

- the required clinical skills and knowledge
- an understanding of, and clear responsibilities, for delivering the correct CHC processes
- knowledge of the legal framework in which they will operate
- an understanding of social care and the provision of personalised care and support
- an understanding and knowledge of the local independent care sector.

Issues for commissioning support to consider

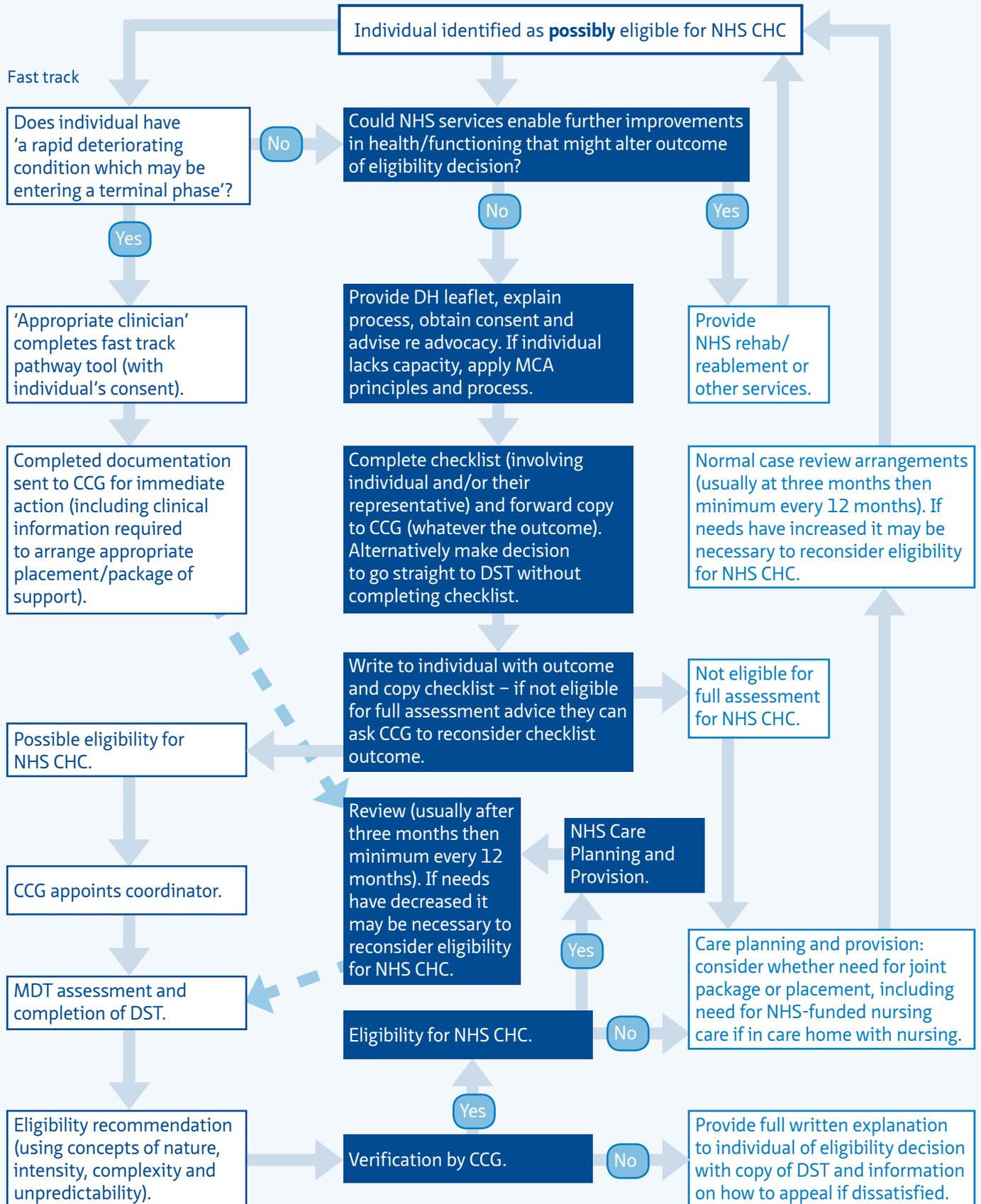
Commissioning support offers to CCGs need to reflect a whole system approach to CHC and the importance of partnership working with local authority social care. These offers need to consider the issues outlined below.

Assessment of eligibility

This will need to include:

- the identification of individuals who require full assessment for CHC
- arrangements for assessment, including the identification of a 'coordinator' for each assessment
- systems and resources to complete assessments for eligibility within nationally prescribed timescales (normally within 28 days)
- administrative functions to ensure that information is gathered and stored securely and that correspondence with individuals is timely
- arrangements for dealing with 'fast track' referrals where a clinician authorises provision of CHC to individuals who have 'a rapidly deteriorating condition that may be entering a terminal phase'
- arrangements for conducting quarterly and annual reviews.

Figure 2. The statutory process to determine and review eligibility for CHC



Case management

It is important to consider how skilled and effective case management will be secured for those eligible for CHC. Case management includes ensuring a suitable care plan is in place; ensuring care/support meets needs and delivers intended outcomes; ensuring any non-NHS services which are part of the package are working effectively; monitoring the quality of care and responding to concerns; acting as a link person to coordinate services; ensuring changes in needs are addressed; reviewing regularly.

Benchmarking performance

Systems need to be established for collecting and analysing data on CHC assessments and eligibility decisions.

Arrangements need to be made to provide data on performance, to meet both local and Commissioning Board requirements.

Training and development

There needs to be a focus on training and development for all involved in the pathway, including hospital discharge and referral from social care.

Commissioning

There needs to be:

- close working and possibly joint commissioning with local authority social care
- relationship building with providers, including care homes and the independent sector
- commissioning care and support packages that may include the provision of a personal health budget

- financial and contract management that is proportionate and minimises bureaucracy.

Provision of legal advice

Arrangements need to be made for the provision of expert advice to frontline staff and managers regarding the correct implementation of the national framework and the interaction with other legislation. The determination of a 'responsible commissioner' could become more complex to determine once CCGs become the commissioners of CHC services.

Management of family and patient relationships

This will need to include:

- provision of clear information to individuals and their families
- arrangements to deal with complaints and appeals
- arrangements for the local resolution of disputes
- preparation of cases to be heard by an independent review panel
- preparation of cases to be heard by the Parliamentary and Health Service Ombudsman.

Arrangements for dispute resolution between agencies

Protocols are needed with relevant agencies, particularly the local authority, for resolving disputes about eligibility for CHC, joint funding arrangements and the implementation of the refunds guidance (where one agency has funded care that should have been funded by another agency). Protocols are also needed for dispute resolution with providers.

Confederation viewpoint

The number of people eligible for CHC is to likely increase due to demography, and the risks of not implementing CHC well are too great to ignore. It's previously been a 'niche' area of commissioning but needs to be mainstreamed and approached collaboratively with the local authority.

Personalisation is very important. That is not just about personal health budgets or direct payments but about really being 'person-centred' and giving people choice and control.

However, the inconsistency between fully funded NHS care, through CHC and means tested social care, can both confuse users and hamper the delivery of a comprehensive, integrated care package supporting care closer to home. For the Government's aspirations for integrated care to be realised, as detailed in our recent Briefing, *Papering over the cracks*,² we recommend the Government outlines the long-term costs of ensuring a personal health budget for all those who qualify for CHC and how CCGs will be able to facilitate risk pooling across larger geographical footprints.

For more details on the issues discussed in this *Briefing*, contact clare.gorman@nhsconfed.org

The NHS Confederation

The NHS Confederation represents all organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS.

We help the NHS to guarantee high standards of care for patients and best value for taxpayers by representing our members and working together with our health and social care partners.

We make sense of the whole health system, influence health policy and deliver industry-wide support functions for the NHS.

The Community Health Services Forum

The Community Health Services Forum, part of the NHS Confederation, represents organisations that provide community health. We:

- help the NHS and policy-makers understand the importance of community health services
- provide a strong voice for community health providers when influencing policy
- facilitate and share best practice in community health.

For more information, see www.nhsconfed.org/communityhealth

Acknowledgements

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References

- 1 Department of Health (2009), *The national framework for NHS continuing healthcare and NHS-funded nursing care – July 2009 (revised)*. Revised version expected to be published November 2012.
- 2 NHS Confederation (2012), *Papering over the cracks: the impact of social care funding on the NHS*.

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