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# NHS continuing healthcare: Effective commissioning approaches



NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

# Introduction

NHS continuing healthcare (CHC) is a package of care funded by the NHS for individuals who have a 'primary health need'. Clinical Commissioning Groups (CCGs) commission and case manage this process, and are statutorily accountable for the delivery of CHC in local areas.

# Why is this a priority area for CCGs and the NHS?

## Increasing cost and expected savings

CHC accounts for 4.9 per cent of the total NHS budget. There was a 16 per cent increase in spending on CHC between 2013–14 and 2015–16 (NAO, 2017). Much of this is spent on delivering an assessment and screening process where only 18 per cent of those assessed are found to be eligible, (NAO, 2017). There is further additional spend on legal advice and support in response to appeals. NHS England expects delivery of £855 million worth of savings by 2020/21 from reducing administration assessment costs and the overall cost of CHC provision.

## Variation and opportunity

There is significant variation between CCGs in both the number and proportion of people assessed as eligible for CHC that cannot be explained by local demographics or core services alone. For example, the range in estimated proportion of people that were referred and subsequently assessed as eligible, excluding the 5 per cent of CCGs with the lowest and highest percentages, was 41–86 per cent. This suggests that there are considerable opportunities to deliver improvements and efficiencies. Within CCGs the percentage of the local budget that is spent on CHC varies from 2.1–10.4 per cent.

## Meeting the needs of the local population

An ageing population and an increasing number of people living with multiple co-morbidities means that CHC is a priority for the populations that CCGs serve. Improvements in processes ensure that individual patient needs are met and that where individuals are eligible for receipt of CHC they receive this in a timely manner. The Continuing Healthcare Alliance report *Continuing to care? Is NHS continuing healthcare supporting the people who need it in England?* outlines some of the issues that patients experience in accessing CHC funding.

This document outlines key learning points from those CCGs that have achieved significant efficiency savings and improvements for patients in the provision of CHC in their local area, and the national support that NHS England and others can provide to support local decision-making. The document was informed by a series of interviews with leaders in high performing CCGs and a roundtable with representatives from CCGs, the Association of Directors of Adult Social Services (ADASS), the Continuing Healthcare Alliance and NHS England.

## Continuing healthcare assessment process

- Patients are screened to determine if they should be assessed for CHC through a nationally prescribed checklist, and an equity monitoring form is completed (Department of Health 2012, 2013).
- A nationally prescribed decision support tool (DST) is completed to determine if an individual is eligible (Department of Health, 2016). This is a complex process where the applicant is assessed against 12 domains each subdivided into up to six statements of needs.
- The decision is checked and verified by a commissioner lead and only in exceptional circumstances is the recommendation not followed, for example when the quality of the care package does not meet the care needs of the individual.
- If the individual is eligible for CHC the commissioner arranges and funds the care placement.
- Individuals with a rapidly deteriorating condition that may be entering a terminal phase may require a fast track to CHC, so that they can immediately receive CHC.
- The commissioner is responsible for ensuring that there is ongoing case management and regular reviews of CHC.
- If the individual does not agree with the eligibility decision they can follow a resolution and appeals process which can include an independent review undertaken by NHS England outside of the CCG.

## Six national actions to support local delivery

Alongside adoption of best practice approaches from CCG colleagues, there are six actions that can be taken by national organisations to support local delivery:

### 1 Recognise and value the CHC workforce

The role of the CCG CHC nurse assessors has been stretched to encompass a range of tasks, while lacking the national recognition or support afforded to other sectors of the nursing profession. With responsibility for the effective delivery and management of nearly 5 per cent of the NHS budget there is a need to ensure that this workforce is effectively supported. The Royal College of Nursing should recognise this as a distinct role undertaken by a nurse and provide appropriate collegiate support. NHS England should seek to define the scope of the role, the skills required and the potential structures of local teams building on best practice approaches in local areas. This should also include support for the current workforce through the development of a CHC specialist forum or network. There must also be clarity on the special class status for CHC nurses.

### 2 Develop a clear national CHC narrative

CCGs want to ensure that patients eligible for CHC are appropriately identified in a timely way; however, thresholds in the checklist are calibrated at a relatively low level, which results in many referrals going through to the CCG that are subsequently unsuccessful. It is estimated that only about 18 per cent of checklist screenings in 2015–16 led to the individual being assessed as eligible for CHC (NAO 2017). CCGs reported that conversion rates from checklist to eligibility as ranging from 13–40 per cent. Referrals from checklist screening raise patient and family expectations and can result in complaints when referrals, assessed appropriately and legally, are unsuccessful. NHS England should therefore work pro-actively to communicate effectively with patients, families and members of the public when CHC funding will be available and when it will not via a national information campaign.

### 3 Address workload pressures

Given the nursing and social care resource required to assess individuals, NHS England must develop a pre-checklist process to manage the number of claims that proceed to assessment. The number of referrals found ineligible and subsequent appeals and complaints was found to place significant resource and emotional strain on patients and CHC teams (each assessment was reported to take at least 25 hours of nursing time), and results in backlogs. This can result in delays for those patients who are eligible for CHC.

### 4 Develop national guidance that supports local process

There are several areas where NHS England can provide national guidance or adjust current process that would support the effective delivery of CHC processes locally and reduce variation. These include:

- Incentivise assessment following an acute phase rather than a specified setting in recognition of the fact that individuals can be in an acute phase in hospitals, community beds and/or at home. Incentives should be based on a specific number assessed for a CCG on an individual basis, rather than a standard percentage. This will address unintended consequences of incentivising assessment in specific settings.
- Develop a consistent national approach to assessing care package costs, and national specifications for care homes and domiciliary care packages. There is currently considerable variability in charges to CCGs and services delivered.
- Clarify the process around responsible commissioner arrangements for out-of-area placements and develop a process for dispute

resolution. Our members find it challenging to provide ongoing case management at distance; some placements can be hundreds of miles away leading to a lack of robust oversight and coordination of care provision, with only yearly reviews being undertaken. This can lead to a more difficult relationship with individuals and families as the CHC team can lack up-to-date knowledge of the individual's care needs and there is a lack of clarity of responsibilities between the commissioning and local CCGs.

## 5 Establish a national process for sharing legal advice where appropriate between CCGs

Currently CCGs seek legal advice to clarify elements of the process and for specific individual cases. This creates a significant cost pressure for CCGs and has led to inconsistency, as local legal firms can give differing advice and often seek to support the CCGs proposed approaches to policies and individual cases rather than offering robust challenge. NHS England should encourage sharing of legal advice where appropriate between CCGs, and establish a central publicly available repository of endorsed approaches.

## 6 Establish a policy feedback forum to ensure effective links with the reality of delivery on the ground

The NHS Continuing Healthcare National Policy Advisory Group provides consistent advice and guidance on policy areas and is a valuable forum for raising issues and ideas. The Department of Health should develop clear links between CCGs and this group, ensuring that information is shared on a two-way basis through the establishment of a formal policy feedback forum. The NHSCC should lead the establishment of this forum, which should include patient representatives, and hold an annual meeting of CHC leads to facilitate sharing of best practice. NHS England should test policy proposals with this group and seek their advice in the development of any future national guidance.

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Members identified ten characteristics that improve the overall process of CHC delivery for patients and CCGs in local areas.

## CCG leadership prioritising CHC

**"CHC is viewed as an integral part of the CCG's provision of care with the aim of providing proactive and ongoing case management of CHC patients. The team has a clear emphasis on quality and a personal approach to CHC. The CCG views CHC as inextricably linked to the nurse leadership and improving quality agenda."**

Where CHC teams have the full support of senior leadership within the CCG, with either direct reporting or close links to the chief nurse and quality directorate, they are more likely to feel integrated within the CCG and core services, continually seek to improve the patient experience and effectiveness of CHC, and contribute more widely to the quality agenda. Consideration must be given to the maintenance of the executive nursing role in the evolving commissioning system and the link with delivery of quality services, especially given that this is such an increasing cost for CCGs. However, ownership for effective delivery must be CCG-wide, rather than seen as the sole responsibility of the executive nurse.

Where CHC works well there is often a balanced approach to the inter-related delivery principles underpinning CHC. There are several core delivery principles that should underpin CHC including meeting individual patient need, delivering quality and well managed care, ensuring positive relationships with individuals, families and providers, safety, compassionate working practices, provision of patient choice and equity, and cost effectiveness.

## Collaboration with social care

**"Many CCGs are moving towards closer working with social care around CHC. This is a result of increasing recognition of the opportunities to provide a better experience for patients and to achieve cost efficiencies through pooling resources, reducing duplication, and ensuring that the most suitable and cost-effective packages can be identified."**

CCGs reported that the approach local authorities take to working with health colleagues to support individuals strongly influences the CHC process. Where there has been effective collaboration around CHC and joint packages of care, CCGs reported that there were often existing good relationships, trust between organisations and clear senior leadership. This takes both time and commitment to establish and it is only through working collaboratively that long term cost disputes can be resolved.

Joint working at an operational level, with leadership that supports these arrangements, is essential to provide a better experience for patients and achieve cost efficiencies. This includes streamlining assessments across health and social care, having clear contact points for individuals, pooling resources, reducing administrative duplication, brokering care packages, and joint ongoing case management.

### Joint packages of care

If an individual does not legally qualify for CHC, the NHS may still have a responsibility to contribute to that person's health needs either by directly providing services or by part funding the package of support. Where a package of support is provided by both the local authority and NHS, this is known as a 'joint package of care'.

The funding split of joint packages for individuals can be a potential point of tension between health and social care, as well as with individuals and families. Openness, transparency, consistency, evidence based decision making, empathy and clear communication are essential for effective determination of joint packages of care. The most effective approach may be a fully integrated model and pooled budget, although most health and social care budgets are separate with policies to agree funding splits for individual patients. These policies should be developed collaboratively by the CCG and local authority and ratified through appropriate governance structures.

Joint packages of care work well when there are positive and mature relationships between health and social care and when there is trust and delegated authority for lead nurses and social workers to decide on the package for individuals (usually below a certain cost level), often with the more easily identifiable health and social care cost components allocated accordingly and then the remaining component costs split equally between health and social care. A process for senior review and sign-off of all joint high-cost packages for individuals ensures that care needs are met, that all options for care provision have been explored and there is increased consistency across the local area. This can also form the basis for the development of effective relationships, for example, one CCG found benefit in the CCG chief nurse and social care director reviewing and quality assuring decisions regarding eligibility and cost-splits for each case at the start of implementation. Then, as the system became more established and trust developed, the authority to make decisions on funding splits was delegated to the CHC team and social care colleagues, with senior review of more complex cases or cases over an agreed threshold.

## Joint commissioning

Whereas joint packages of care are for individuals, joint commissioning arrangements are the broader systems and processes underpinning the purchase of care packages. Some CCGs are adopting a form of joint health and social care brokerage for commissioning care home places and domiciliary care to ensure price comparability – asking providers to tender for care packages, which are not specifically identified as coming from health or social care, and having a single shared health and social care system to purchase the final care packages.

Some CCGs have also worked with local authorities to commission domiciliary care on a locality basis to streamline provision. This involves a tender for a single 'prime' provider to contract for a specified number of guaranteed monthly hours. The prime provider is one that covers a set geography and either develops a workforce with the capacity to meet demand and/or holds contractual relationships with smaller providers and sub-contracts to them. This has been most successful when there is assurance that the prime provider is able to effectively engage and co-ordinate subcontractors and when implementation is undertaken during a relatively low demand and high capacity period.

## Ongoing case management

**"The CHC nurses are viewed as end to end case managers, in which acting as a CHC nurse assessor is just one component of their role."**

The national framework outlines that there must be "ongoing case management", that can be undertaken as a yearly review and reassessment. However, where there is more regular contact and effective case management there is more likely to be effective assurance that care packages meet patient needs, more robust contract and provider management, and improved communication and relationships with individuals, families and providers.

Several CCGs have adopted a 'tiered approach' to CHC reviews as opposed to full assessments on an annual basis. The 'tiered approach' works well when coupled with ongoing case management of the individual and their care package, so that there is regular contact with individuals and families and an in-depth understanding of changes in situation and conditions. The 'tiered approach' is based on a determination of complexity and likelihood of changing care needs – where conditions are non-improving and well-managed there is a lower tier assessment through desk and phone based collation of evidence and reassessment. The next tier is assessment by a CHC nurse for less complex cases that are unlikely to have changed, and then through to full MDT reviews for those cases that are likely to require changes to eligibility or care packages. This ensures more effective use of health and social care resources and more appropriate reassessment. However, this approach only works if CHC is viewed as a core CCG service and individuals are connected into mainstream services that can highlight significant changes if needed.

### The CHC case coordinator role

Some CCGs are beginning to implement a robust case management approach to CHC, based around local joint working with core services and social care. Where this works well, CHC case coordinators provide an end to end service based on a geographical area through ongoing management of a case load of individuals throughout the process: from the checklist referral; eligibility decision making; booking care; and then through to ongoing monitoring of care packages. They establish care packages within existing services where possible, but if this is unsuitable then they would also commission care if required. Where this has been introduced the case coordinator is a generally employed at Agenda for Change Band 4 and is part of an integrated health and social care neighbourhood team, linking to nursing staff when care needs change. They can also be allocated to specific care homes providing a point of contact for that home enabling ongoing relationship and contract management and ongoing checks to identify good practice as well as flag areas of concern.

The CHC coordinator role also provides CHC teams with more fulfilling roles, as they stay closely involved and work with patients, families and providers to monitor and adjust packages of care to meet patient needs and expected outcomes. This can improve recruitment and retention for CHC assessment roles which is an ongoing challenge for CCGs.

## Developing positive relationships with families

**"At the point of undertaking the checklist, it can be an incredibly emotive time for the patient and their family – maintaining compassion, empathy and clear communication to manage expectations is critical."**

A positive relationship with patients and families is crucial to effective delivery of CHC. Positive relationships and communication enables issues to be resolved rapidly and prevents an escalation of problems and complaints. There is considerable value in maintaining a consistent point of contact for the public and to signpost those who are ineligible to mainstream services and patient organisations.

This can only be achieved by the development of a confident, professional, stable and empowered workforce that is able to manage expectations and be assured in their approach. Some CCGs have found benefit from providing a rolling programme of monthly joint NHS and local authority training sessions on CHC. These have improved the appropriate use of the checklist and reduced inappropriate submissions, as well as promoting staff awareness of the need for consistent communication to patients and families about CHC to manage expectations. A named CHC contact for each GP practice has also been found to reduce inappropriate referrals and increase understanding.

CCGs have developed dedicated teams to address initial complaints from individuals following a failed assessment. They undertake a reappraisal of the evidence of the ineligibility decision if cases are particularly complex. Informal resolution has worked well where there is a clear emphasis on preventing escalation and a compassionate approach is adopted. The engagement of front-line clinicians in developing an understanding of the overarching eligibility criteria to ensure that realistic discussions regarding eligibility are undertaken in the first instance has been shown to reduce the number of ineligible claims and is especially effective when led by the senior team in the CCG.

## Controlling processes and defining appropriate metrics and measures locally

**"We have worked to get tight control over the process with weekly control room meetings with key CHC staff which offers fifty-two opportunities to get it right. The meetings have ongoing short smart actions to continually improve the process."**

CCGs have found that CHC can be more efficient and effective when there is tight control of systems and processes and consistent leadership focused on improvement. CCGs have found retaining responsibility for CHC in-house resulted in better "grip" of the process and allowed for improvement in processes and data quality as well as future modelling and planning. Where the CHC assessment and review process was in a Commissioning Support Unit (CSU) there is a risk of fragmentation of the process – particularly as local authorities, providers and individuals find it difficult to determine the lead for CHC for a specific CCG.

CCGs reported that national statistics on CHC do not provide a useful or accurate platform to understand local CHC issues, and a more refined approach is required that does not rely on crude conclusions for what is a highly complex area. The effectiveness of approaches can only be determined through more refined assessments and understanding of local arrangements including benchmarking cases, individual feedback mechanisms and collation of patient stories, complaint rates, and resolution approaches and outcomes. Effective benchmarking across the system should act as an effective mechanism to ensure quality and consistency.

## Ensuring appropriate skill mix, capacity and capability

**"Reviewing the skill mix and delivering CHC at scale can release clinical time and result in a more supported process."**

CCGs are increasingly developing comprehensive CHC teams that comprise staff with the expertise and knowledge to complete assessments for the range of individuals requiring CHC funding. These specialist staff develop relationships with individuals and providers and extend their roles to support improvements in case management and service delivery. Many CCGs are also moving towards increasingly closer working with social care, supporting secondments of social workers to the CHC team or providing joint posts.

There are considerable benefits in operating a CHC team that covers a larger population, potentially across an STP footprint, rather than an individual CCG level. These include improved consistency and quality assurance across the area, effective peer support and review, access to greater administrative resource, enabling increasing specialisation of CHC roles, release of workforce efficiencies, opportunities to develop a CHC career pathway and the development of a team structure which empowers senior nurses to act as leaders of teams of case coordinators. There is also potential to release considerable administrative efficiencies by operating at a larger scale.

## Developing an in-depth understanding of the framework and quality assurance

**"If CCGs followed the framework then a lot of variability would be avoided. There are instances where assessors are following the decision support tool, without referencing the Framework and legal context."**

Many challenges that CCGs experience around CHC could be prevented and resolved by ensuring that there is an in-depth understanding of the framework and robust evidence-based assessment of individuals' care needs. When a decision is made the assessor must have a detailed knowledge of the framework, case law and an in-depth experience of CHC to ensure consistent and fair application of the Framework. National support for the CHC workforce will act as a key enabler for the development of this understanding as will the retention of experienced individuals.

Peer support and review is viewed as a critical component in terms of ongoing quality assurance and sharing learning, as well as for supporting nurses following challenging cases and situations. Some CCGs undertake bi-yearly education and peer support away days, where they review case law, the framework and issues that have arisen in the locality. This can support increased consistency and mitigate the effects of isolation of CHC nurses. Other CCGs have a monthly peer review process where a nurse undertakes observation of another CHC nurse in the team, with feedback exchanged. A further approach has been the establishment of internal verification panels, where two or three CHC assessors review all the decision support tool assessments and evidence and decision-make collectively, this reduces the vulnerability of individual assessors and results in a clear and consistent CCG decision making approach. The non-eligible assessments are also reviewed, to ensure that these decisions are quality assured.

## Completing the checklist at the right point and monitor unintended consequences

**"Many CCGs are increasingly recognising the need to ensure that the checklist is initially used at the right point in the patient's recovery – after appropriate rehabilitation or reablement services."**

The checklist must be completed by someone with a clear understanding of the complexity and eligibility criteria for CHC as described in the decision support tool. Subsequent assessments after a positive checklist referral should be undertaken in a timely manner so that a care package can be put in place for individuals that are eligible. Completing the checklist after a period of rehabilitation is recognised as best practice. There are targets in place for CCGs to complete assessments in the community at the right point in a patient's recovery. However, these focus on setting and could be better focused on assessing after an "acute phase" – regardless of location (hospital, care homes or at home). CCGs should be mindful of the potential for unintended consequences in local relationships or patient experience if crude targets for completion are the focus of local CHC process.

## Rapid fast track validation

**"Dedicated CHC fast track nurses provide rapid validation to ensure that the appropriate referrals receive timely care and that cases requiring full CHC assessment are handed on. The fast track nurse aims to visit and assess all referrals within two days and then undertake rolling reviews to ensure that patients are receiving a care package that meets their needs."**

Some CCGs have a dedicated internal CHC nurse to provide rapid validation of fast track referrals, ensure that the appropriate referrals receive timely care and that cases requiring the full CHC assessment are appropriately managed. This validation function has been implemented in response to increasing referrals that have been submitted to by-pass the full CHC process.

## Exploring opportunities for strategic commissioning

**"CHC is an individual process and results in individual decisions based on that patient's clinical need. However, there are opportunities to improve the patient experience of CHC and the care delivered, as well as cost improvement, through robust analysis to determine patient cohorts and to commission and develop services to meet cohort needs – particularly for end of life care."**

CCGs are exploring new models of commissioning and delivery of services to populations, whilst maintaining assurance that individual assessed needs are met. They are also increasingly looking to integrate CHC more closely into core community services particularly where there is a concern that CHC is being used to fill service gaps in urgent care and end of life pathways. This is an inefficient approach to CHC, as it is based on a purchase of care package for individuals, whereas the analysis of population need, pathway design and purchase of services to meet cohort needs is more efficient.

Although CHC eligibility is based on a case by case assessment, there are opportunities, which will not be applicable in all cases, to improve the patient experience of CHC and the care delivered, through robust analysis and needs assessment to determine patient cohorts within CHC and to strategically commission and develop services to meet those cohort needs. For example, commissioning flexible frailty services and end of life care services in the community that can in-reach into other provider services – rather than spot purchase commissioning on a case by case basis for fast tracks. In one area, the fast track process has been embedded in the mainstream end of life care service, with palliative care experts undertaking the assessments for ratification within the CCG and providing care packages for individuals nearing the end of their life – this approach has led to more effective provision of services and a 50 per cent reduction in the number of fast tracks assessments in a year.

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If you would like to speak to NHS Clinical Commissioners about this report please email **office@nhscc.org**

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## Additional resources

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# Notes

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

**Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. We're building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.**

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