Integrated health and social care evidence reviews

What works in managing demand for Continuing Healthcare packages?

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CordisBright

As an independent evaluator of seven NHS Vanguard projects, we are sharing key learnings relevant to replicating success in integrated health and social care.

Here we look at Continuing Healthcare (CHC) packages, sharing insights on best practice in managing demand for CHC based on our review of the literature[1] and exploring examples of demand management practice in local areas.

Please get in touch with our Head of Research, Dr Stephen Boxford, for more detail or to continue the conversation.

1 About Continuing Healthcare packages

1.1 What is a Continuing Healthcare (CHC) package?

A Continuing Healthcare (CHC) package is an ongoing package of free health and social care support arranged and funded by the NHS for adults with a primary health need (NHS 2018). A primary health need is any health need resulting from accident, illness, or disability that means that an adult requires health and social care support. The package of care can be delivered as a care home placement or as care in the individual's own home.

1.2 What does best practice look like in CHC delivery?

NHS England states that good CHC practice must be aligned with the principles of the 6Cs (NHSE 2015):

- **Care**: accurately identifying care needs;
- **Compassion**: treating package users and their families with empathy, respect and dignity;
- **Competence**: assessments should be good quality;
- **Communication**: information should be understandable and accessible;

[1] If you would like details on the methodology used for the literature review, or a full bibliography, please get in touch with the Cordis Bright research team: info@cordisbright.co.uk

- **Courage**: NHS staff should have the courage to deliver innovative, personalised care;
- **Commitment**: NHS staff should be committed to delivering a person-centred approach.

1.3 Who is eligible?

Eligibility for a CHC package is determined based on the individual's assessed health needs rather than diagnosed conditions. Assessments consider the nature, intensity, complexity, and unpredictability of the individual's health need and needs are re-assessed at least once a year. Needs assessments are administered by Clinical Commissioning Groups (CCGs) and involve two stages: the national Checklist, and the Decision Support Tool (DST) (NHSE 2015).

1.4 What is the current demand for CHC package provision?

NHS England estimated that around 60,000 adults were in receipt of CHC at any one time in 2015 (NHSE 2015). However, demand is growing. The 2017 National Audit Office (NAO) investigation into NHS CHC funding found that the number of people eligible had grown by an average of 6.4% each year since 2012 (NAO 2017). In 2015/16 almost 160,000 people were assessed as eligible for CHC funding that year.

The investigation also found that spending on CHC packages had increased by 16% between 2013-14 and 2015-16, and that CHC packages accounted for about 4% of CCGs' total spending in 2015-16 (NAO 2017). NHS England's estimates suggest that spending on CHC, NHS-funded nursing care and assessment costs will increase from £3,607 million in 2015-16 to £5,247 million in 2020-21 (NAO 2017).

There is therefore significant pressure on CHC providers to manage the demand for CHC efficiently. Despite rising demand, NHS England would like CCGs to make £855 million of savings on CHC and NHS-funded nursing care by 2020-21 (NAO 2017).

2 Best practice in managing demand for CHC packages

2.1 Overview

While data and evaluations of CHC provision in England and Wales are limited (APPGP 2013), there are a small number of evaluations at the local and national level that provide evidence regarding five key themes for best practice in managing demand for CHC. We summarise these themes below.

Moving the CHC assessment into the community: CCGs reviewed here have taken the approach of moving the CHC assessment into the community in order to increase the speed of inpatient discharge, thereby reducing inpatient functional decline and lessening the demand for CHC provision.

Standardising eligibility frameworks: The National Audit Office has suggested that standardising staff interpretation of the CHC eligibility framework may help to manage demand for CHC.

Amalgamation and resource sharing: CCGs and Health Authorities reviewed here have sought to manage demand for CHC packages by bundling packages by geographical area, sharing resources between Primary Care Teams, and improving collaboration and information sharing.

Ensuring effective joint working between health and social care: Foundation Trusts and Strategic Health Authorities reviewed here used end to end ownership models to improve joint working between health and social care teams, and thereby manage CHC packages more efficiently.

Upskilling assessment teams: Two CCGs reviewed here are providing additional training to their assessment teams to ensure that the right people receive CHC packages at the right time.

In the following sections we discuss each of these themes and their evidence base, along with relevant case studies.

2.2 Moving CHC assessment into the community

Why is this needed?

Lengthy inpatient stays can exacerbate functional decline among patients, driving up the need for post-discharge CHC packages. Accordingly, some CCGs have sought to manage the demand for CHC packages by intervening to reduce the length of patient stays in hospital.

Longer hospital stays have been linked to increased levels of functional decline, particularly among elderly patients (see Hoogerduijn et al. 2007 and Wilson et al 2012). An increase in functional decline has clear implications for patients' care needs post-

discharge, increasing patients' dependency, and increasing healthcare costs and the likelihood they will need a nursing home placement (Hoogerduijn et al. 2007). Reducing the duration of in-patient stays may therefore help to reduce the level of functional decline that occurs within the hospital setting, and ultimately help to manage CHC demand. In the long term, this might include implementing interventions to prevent in-hospital functional decline (Agmom et al. 2017). In the short term, this might involve intervening to reduce the frequency and duration of in-patient stays, particularly non-elective in-patient stays.

Waiting for a CHC assessment is a common cause of delayed discharge from hospital[2], and therefore moving the CHC assessment out of the hospital and into the community is one way to reduce length of stay and help limit CHC demand.

Moreover, the NHS England Operating Model for CHC acknowledges that acute hospital settings may not be the best place to undertake a full CHC assessment in any case; rather, the *"wide range of community, rehabilitation, reablement and intermediate care services locally can help ensure that individuals are assessed for NHS Continuing Healthcare at a time when their longer-term needs are clearer"* (NHSE 2015). Moving CHC assessments into the community is therefore in line with NHS guidance.

What is being done?

As mentioned above, some CCGs are reforming their approach to CHC by changing the location and timing of assessments.

Figure 1 outlines West Norfolk CCG's approach, which reduced inpatient stay duration and reduced demand for CHC packages (Healthwatch Norfolk 2016).

[2] We know the absence of a continuing care plan is a major cause of prolonged hospital stays. NHS data on Delayed Transfers of Care for July 2017 highlight patients awaiting further non-acute care (29.2% of all NHS delays in transfer of care) and patients awaiting care packages in their own home (35% of social care delays in transfer of care) as two of the primary drivers of delays in transfers of care (Government Statistical Service 2017). Discharges can also be delayed if patients are waiting in an in-patient setting for a CHC package assessment.

Figure 1: The West Norfolk CCG approach

Component	Description
Issue	With a comparatively large elderly population, Norfolk's CHC package costs in 2015 were £55,227,848, disproportionate to the county's population size.
Intervention	The CCG's 'Innovative Continuing Health Care Pathway' changed timing and location for CHC assessments. Assessments took place in the community once patients had settled and reached optimum recovery from their illness, instead of taking place while the patient was still in hospital.
Aims	The intervention aimed to improve patients' experiences of leaving hospital and deliver a more cost-effective service. It also aimed to reduce the length of inpatient stays and, in turn, reduce demand for CHC packages.
Evidence	An evaluation was conducted in November 2016 involving mixed methods analysis of cost differences, and patient and health care professionals' views.
Findings	Overall, the evaluation found increasing the speed of discharge from inpatient settings was effective in managing demand for CHC packages. It found evidence for improved patient outcomes and reduced health costs. Health care staff interviewed thought the intervention had led to a reduction in CHC cases "due to improved recovery and independence".

Source: The evaluation of an innovative CHC pathway in West Norfolk (Healthwatch Norfolk 2016)

2.3 Ensuring consistency in the interpretation of eligibility frameworks

Why is this needed?

The number of individuals assessed as eligible for a CHC package varies across CCGs. The National Audit Office reports that the number of individuals deemed eligible in 2015-16 ranged from 28 to 356 people per 50,000 population. It concludes that such variation cannot be explained by demographic factors alone and proposes that differences in the interpretation of the national eligibility framework across CCGs may partly explain the variation (NAO 2017). These findings imply that there may be scope for managing CHC demand through re-considering how CHC eligibility criteria are interpreted and reassess patients accordingly (see examples below).

However, this approach should be treated with caution. CHC eligibility criteria are already criticised as too narrow, with many people who should be found eligible being denied CHC packages according to the Continuing Healthcare Alliance (2016). This finding is supported by the Parliamentary Health Service Ombudsman (reported in APPGP 2013):

> *"Only a minority of people are successful in claiming NHS funding for their continuing care needs … it is clear that most people's care needs are not being met by NHS continuing care funding."*

Continuing to Care, a report from Parkinson's UK and the Continuing Healthcare Alliance also emphasizes that cuts to social care support, restricted welfare benefits, and the removal of the Independent Living Fund have increased the importance of CHC packages

for people with long term care needs, who now more than ever lack alternative sources of funding for their care (Continuing Healthcare Alliance 2016).

What is being done?

Some CCGs have explored reassessments for patients to determine whether some are ineligible for CHC. For example, Somerset CCG estimated that removing newly ineligible patients would save £522,000 in 2016/17 (Somerset CCG 2016). That said, NHS England standards for CHCs state that *"no services or funding should be unilaterally withdrawn unless a full joint health and local authority assessment has been carried out and alternative funding arrangements have been put in place, taking individual's preferences into account"* (NHSE 2015). If service users are re-categorised as ineligible for CHC, alternative funding would still need to be secured for their care.

Comparing approaches to CHC eligibility assessment and delivery across CCGs may tell us more about how different interpretations of national eligibility criteria affect demand. In Figure 2 we compare Salford CCG, which has one of the highest proportions of registered GP patients deemed eligible (233 per 50,000), with Tower Hamlets CCG, which has one of the lowest (17 per 50,000) (see NHS RightCare 2016b and 2016a respectively).

Figure 2: Comparing approaches to CHC eligibility assessment and delivery

CHC operating policy/practice	Salford CCG CHC (233 eligible per 50,000)	Tower Hamlets CCG CHC (17 eligible per 50,000)
Local Operational Policy	Yes – used alongside national framework.	No – uses the national framework.
Local eligibility criteria	Yes - Needs are: complex, intensive, or unstable; deteriorating rapidly; require regular supervision by NHS staff; long-term or terminal conditions.	No – uses the national framework.
Referrals received	Fewer referrals than would be expected given its population.	Fewer referrals than expected given its population.
Referrals deemed eligible for CHC	Lower than average proportion of cases agreed eligible given the number of referrals.	Higher than average proportion of cases agreed eligible given the number of referrals.
Oversight	Salford CCG scrutinizes assessment of MDT, and makes final decision on eligibility. Review Panel determines correct application of eligibility criteria.	Working with CSU to ensure quality and provision of CHC providers, developing a quality framework for CHC.
Frequency of Reviews	3 months after first assessment, and at least every 12 months thereafter.	3 months after first assessment, and at least every 12 months thereafter.
Identified Areas for Improvement	Dispute resolution policy.	Continue to monitor quality of CHC providers.

Source: Commissioning for Value Long term conditions pack: NHS Tower Hamlets CCG (2016a) and NHS Salford CCG (2016b).

Despite the difference in demand, both CCGs receive fewer referrals than would be expected given their population. Additionally, Tower Hamlets, with one of the lowest rates of CHC packages per 50,000 registered GP patients, deems a higher than average percentage of its referrals to be eligible for CHC. In contrast, Salford deems a lower than average percentage of its referrals to be eligible for CHC. This suggests that the differences in demand are not overtly linked to referral or assessment processes in these cases.

It is possible that the difference may lie in the challenges that Salford has experienced around dispute resolution, in particular resolving cases where CHC has been denied. It may be that more people deemed ineligible for CHC packages in Salford subsequently see these decisions overturned.

It is also worth noting that while Salford has developed a localised framework for CHC assessment, Tower Hamlets continues to work with a broader national framework, which may affect the CCGs decisions around eligibility.

2.4 Amalgamation and resource sharing

Why is this needed?

A number of CCGs, Trusts, and Strategic Health Authorities have sought to manage the demand for CHC by sharing resources across different sectors of the organisation, or by amalgamating the packages of care that they provide.

What is being done?

For example, the South West Strategic Health Authority identified the capacity of its CHC team as a significant risk area it could address by maximising resource sharing (NHS South of England 2012). A similar approach has been taken in Somerset, where the CCG conducted a small pilot that involved bundling packages of CHC care across multiple patients based on their geographical location (Somerset CCG 2016) (see Figure 3 below).

There is also a range of existing initiatives aimed at cultivating resource and information sharing around CHC, such as the Continuing Healthcare Network. This network shares best practice examples and supports local areas to meet their goals for CHC provision. Charities including Marie Cure, Parkinson's UK, and Alzheimer's Society provide condition-specific guidance to the network for CHC assessments.

Figure 3: The Somerset CCG approach to package amalgamation and resource sharing

Component	Description
Intervention	Bundling packages of care across multiple patients based on their geographical location.
Evidence	Pilot study – evaluation methods unknown.
Findings	The pilot study found delivery of CHC packages was more efficient under this approach and enabling more previously unmet need to be met.

Source: Continuing Healthcare Progress Report, Somerset CCG (2016)

2.5 Ensuring effective joint working between health and social care

Why is it needed?

A review of NHS continuing healthcare procedures in Berkshire found major issues with joint working between its health and social care teams that contributed to inefficient working practices around CHC assessment (NHS South of England 2012). For example, one local authority was assessing all patients at discharge, regardless of perceived needs and disputes around patient eligibility for care.

What is being done?

Some Foundation Trusts and Strategic Health Authorities identified in our review were using end-to-end ownership models to improve joint working between health and social care teams and manage CHC packages more efficiently. For example, Central Manchester University Hospitals (CMUH) NHS Foundation Trust piloted a model of CHC assessment involving a dedicated CHC co-ordinator, which has been linked to decreased assessment times and improved patient experience (CMUH 2012). See Figure 4 for more detail.

Figure 4: The CMUH NHS Foundation Trust approach to ensuring effective joint working

Component	Description
Intervention	An end-to-end ownership model involving dedicated CHC coordinators whose role is to: • ensure timely collection of assessments alongside treatment and discharge processes; • relay information to the multi-disciplinary team, commissioners; and • support patients to understand the process. The model was based on a model implemented by Stockport PCT.
Evidence	Pilot study – evaluation methods unknown.
Findings	• **Reduction in length of stay.** Although few CHC assessments were conducted as part of the Manchester pilot study, it found assessment and discharge times were reduced by 18-19 days. • **Potential cost savings.** The Trust estimated in 2012 that reducing all assessment and discharge times by 18-19 days would save £570,000 per year. The estimated cost of implementing a management team to scale up the pilot was £104,000.

Source: Integrated Care – Scaling Up the Intermediate Care Pilots for Sustainable Change, Central Manchester University Hospitals NHS Foundation Trust (2012)

2.6 Upskilling assessment teams

Why is this needed?

There is evidence to suggest that there is a lack of knowledge and expertise among professionals undertaking CHC assessments. The 2013 report from the All Party Parliamentary Group on Parkinson's found that 59% of CHC assessments did not involve

professionals with condition-specific knowledge or specialist expertise, and that this led to funding decisions that were *"inaccurate and incorrect"* (APPGP 2013). The report also noted that all the health and social care professionals interviewed admitted to having difficulty following the correct processes given the complexity of the CHC system.

Ensuring that assessment teams are equipped with specialist knowledge of particular conditions, and of the assessment system in general, may help to ensure that the right people receive CHC packages at the right time.

What is being done?

Our review identified two examples of CCGs that have provided additional training to their CHC assessment teams so as to ensure the right people receive CHC packages at the right time. However in neither case has an evaluation yet been completed, therefore no evidence on the impact of these approaches is available.

- Surrey Downs CCG made changes to their CHC operational policy in 2016 (Surrey Downs CCG 2017). These changes include:
    - All Decision Support Tools (DSTs) are now quality checked by senior clinicians.
    - Social care practitioners are now required to be present for the completion of the DST and must be part of Multi-disciplinary Teams.
- Hillingdon CCG created an 'Integrated Appraisal Team' in 2015 to conduct CHC assessments and upskill hospital staff about CHC processes (Hillingdon CCG 2015). The team was intended to provide the following benefits:
    - Provide access to assessments seven days per week, thereby reducing avoidable delays in discharge.
    - Improve use and allocation of resources.
    - Reduce duplication and silo working.

A note on the role of Personal Healthcare Budgets in managing CHC demand

Personal Healthcare Budgets (PHBs) enable adults who are eligible for continuing healthcare to take a more substantial role in allocating the money spent on meeting their needs. Individuals may receive direct payments for their healthcare or participate in a discussion around their needs and how money can be spent (NHS England 2017).

Thus far, there is little conclusive evidence to indicate that PHBs facilitate the cost-effective management of CHC packages. For example:

- The 2012 evaluation of the PHB pilot programme found there to be no statistically significant difference in costs between PHB and control groups, after accounting for baseline differences (Forder et al. 2012).

- Likewise, a review of global PHB provision, including the UK, found there to be little evidence to suggest whether (and to what degree) PHB programmes are cost-effective (Wirrmann Gadsby 2013). The same review did identify an English study of ten local authorities which estimated PHB costs to be 10% lower than comparable traditional services, however this study did not include PHB start up and delivery costs (Leadbeater et al. 2008 in Wirrmann Gadsby 2013).