NHS Continuing Healthcare funding: anomalous, irregular, and often baffling

*The boundary between health and social care continues to be a major issue, and is especially stark around long-term care and NHS continuing healthcare. **Melanie Henwood** explores the issues raised by a new report from the National Audit Office and highlights the major anomalies around fully funded care for some people, and means tested social care for others.*

The National Audit Office (NAO) investigation into NHS continuing healthcare funding published on 5 July 2017 shines a light on the largely hidden and little-known operation of this area of long-term care. Amidst all the brouhaha around paying for care that surfaced during the general election campaign, mention of continuing healthcare was conspicuously absent, yet the interface between health and care is never sharper than where the two systems collide around long-term care.

Continuing healthcare (CHC) refers to a package of care that is arranged and fully funded by the NHS for people with significant, complex ongoing healthcare needs. As the NAO remarks, funding for such care "is a complex and highly sensitive area, which can affect some of the most vulnerable people in society and those that care for them."

Concerns about the operation, and inconsistencies, of CHC have been in evidence a considerable time. In a review I was commissioned to undertake for the Department of Health in 2004 I drew attention to ongoing problems that would still exist if national eligibility criteria were to be introduced (as they later were), not least because of the uncertainty about the boundary between health and social care that legal judgments had failed to resolve. The NHS Ombudsman has repeatedly revisited the issue of continuing care and drawn attention to the inconsistent and incorrect determination of eligibility for CHC in individual cases. The latest report from the NAO indicates that many of the familiar and long-standing criticisms of CHC eligibility continue to hold sway.

The issues around CHC are complex but the key considerations include the following:

- It's a lottery: the numbers of people eligible for CHC vary widely from 28 to 356 people per 50,000 population. This variation cannot be explained by demographic factors and "suggests that there may be differences in the way CCGs and local authorities are interpreting the national framework."
- A lot of people are assessed for CHC but relatively few are deemed eligible. NHS England estimates that 18% of initial screenings and 29% of people referred for full assessment are assessed as eligible for CHC.
- Other than the existence of a national framework there are few processes for ensuring consistency of

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eligibility decision-making either within or between CCGs.

- Delays in completing assessments and determinations of eligibility are common. The national framework states that eligibility should normally be determined within 28 days, but the NAO reports that about one third of full assessments took longer to complete in 2015-16 (with 10% of CCGs indicating that assessments took longer than 100 days). The knock-on effects of these timescales to delayed discharges (transfers of care) are obvious.
- The outcome of an assessment has major cost implications for patients and their families, local authorities, and clinical commissioning groups (CCGs). For people who are not deemed eligible, the costs of care will be transferred mainly to the social care system, and for people assessed as needing to pay some or all of those costs, these lie where they fall.
- Despite large numbers of people failing to meet eligibility criteria, CCGs face significant costs as they are legally obliged to pay the full costs of those who *are* eligible (estimated at 4% of all CCG expenditure). Nonetheless, CCGs are being required by NHS England to make £855 million in savings on CHC and NHS-funded nursing care by 2020-21.
- It is not known how many people appeal against unsuccessful CHC funding decisions. Although there are mechanisms for appeal, there is no central data collected on how these are used. It *is* known that cases that are reviewed can lead to different decisions. In 2003/04 the lack of consistency of eligibility decisions between Strategic Health Authorities (prior to national eligibility being introduced) led to a requirement for review and widespread restitution which refunded the costs of care when incorrect eligibility decisions had been made.

Eligibility for CHC is *not* about diagnosis (it does not, for example, cover everyone with dementia, or everyone with MS or Parkinson's). It *is* about someone's specific needs for healthcare, and particularly involves clinical judgements about the nature, intensity, complexity, and unpredictability of need. All of these dimensions are difficult to assess, complex to understand, and inevitably contain a highly subjective component. In any nursing home, people who are paying for their own care, who are funded through the local authority, or who are fully funded by the NHS, are often indistinguishable from one another in any common sense or lay understanding. It is little wonder that CHC is seen as unfair, arbitrary, and illogical – particularly by those people and their families who cannot understand why they do not fit eligibility criteria.

A great amount of resources and staff time are committed to undertaking assessments for CHC, and – in effect – policing the boundary between care and health. Given the significance of eligibility decisions, it is important that the question of eligibility is considered wherever relevant. The fact that large numbers of assessments are undertaken and find people ineligible is *not* necessarily an argument for fewer assessments, but for critical appraisal of *why* so few make it through the assessment, and *why* this is subject to so much variation. When patients are being considered for discharge from hospital, the first question in the discharge process is supposed to ask whether the person has been considered for CHC eligibility. This is an important check and safeguard that was intended to ensure that people's needs were properly assessed before major decisions about their care were made.

The NAO findings add to evidence built up over the last two decades and point once again to the anomalous, irregular, inconsistent, and often baffling operation of CHC eligibility determination, which is reflective of the wider fault line between two separate but parallel systems of eligibility and funding for health and care, and cannot be resolved in isolation from it. Any debate about the funding of long-term care, including the forthcoming promised Green Paper, will need to address this central dichotomy.

About the Author

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