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NEW NATIONAL FRAMEWORK

FOR CONTINUING HEALTH CARE

1. Changing needs

Typically, CHC funding levels are set at the outset of a placement and are rarely (if ever) reviewed. There is often a degree of arbitrariness around the setting of the fee and an inability to force the NHS to reassess its contribution where care needs have increased.

The new framework gives providers significant new opportunities to ensure that, where care needs have changed and the level of service required has increased, a reassessment of the care needs takes place and the costs payable for those services are increased to match the increased level of services being provided or required. The new framework not only requires CCGs to review at least once every 12 months (an obligation which applies to local authorities in respect of care assessments in any event) but also at any time when there has been an increase in the care needs. This is not about financial eligibility but the assessment of care needs and clearly a provider is going to be best placed to identify any changes in care needs that do require enhanced services to be commissioned at a greater cost to meet those requirements.

Circumstances in which pressure needs to be applied to the NHS to ensure new assessments are undertaken may require providers to work closely with the families of their customers (or the customers themselves where they have capacity), so that the appropriate obligations are drawn to the attention of the health body and appropriate action taken if they fail to respond. Criticism of local authorities for their failures to carry out assessments correctly or in a timely manner over the past few years has been a notable feature of the work of the Local Government and Social Care Ombudsman. This is likely to be replicated in terms of health service complaints.

Where providers have supplied CHC services for several years at the same fee rate (but the patients' needs have changed), this should prompt a request for reassessment. Providers should take the opportunity to identify the current costs of providing the care services required. If current needs can only be met by paying more, then that should be addressed and payments increased.

A new, positive duty is imposed on providers to keep accurate records to assist in the assessment and review processes and doing so will allow providers to take the initiative in suggesting to CCGs the need for reassessment where, even without the support of the individual and their family, they believe it to be necessary.

2. Disputes between commissioners

Providers will be familiar with the problem of there being no obvious recourse when commissioners are arguing about responsibility between themselves. The framework does not wholly remove this risk and recent case law has given the NHS in particular, the opportunity to avoid paying for services, particularly where individuals change GP from one area to another which, as the case law implies, changes the funding obligation.

There are often significant disputes between local authorities and CCGs concerning funding issues and the recharging for services between them, which providers simply need to avoid getting involved in. The one point of principle that is worth noting is that any threat to stop existing funding, before new funding is in place from another part of the system, should be resisted and challenged robustly even through the courts (who are likely to be very sympathetic to the provider's position). More difficult are circumstances where services have yet to be commissioned, particularly where there is a private payer or an individual who has been paying privately but their funding is running out. This may also coincide with a change in needs which triggers the potential for CHC funding because families will look more closely at CHC where there is a threat to a person's entitlement to live in a particular setting.

Providers need to continue to be vigilant about these arrangements, particularly where placements are made by local authorities on behalf of individuals paying privately. It pays to have a clear understanding with the

local authorities about such things as deferred payment arrangements and the consequences of the individual running out of funds, before the deferred payment arrangements are crystallised. Local authorities are not slow to take advantage of the uncertainties and lack of knowledge on the part of providers or individuals and robust systems are required at the point of taking on new residents in such circumstances, to ensure that they understand the position. The provider also needs to ensure it is protected against those local authorities who will use uncertainty to take advantage of them.

3. Payment for private health services

Although the principle that health services should be provided free at the point of delivery remains true, the new framework does provide some useful clarification about the circumstances in which additional payments can be made by individuals looking to pay privately to enhance their health care.

The setting of arbitrary (and low) limits on what the NHS will pay for a CHC-funded nursing home or care home placement, has led to the practice of supplementary contracts being offered to private individuals otherwise in receipt of CHC, so that they can acquire additional services or have more choice around the quality of their services. This can include such things as the size or nature of the room being occupied, the quality of the menu offered or additional non-health related services being made available, among others.

Some health bodies have threatened providers with action over such contracts and sought to outlaw them on the basis that health care services should be free, but many have recognised that such an approach can reduce their costs overall. As CHC is not means tested it will inevitably be the case that there will be a significant number of recipients of CHC who have the money to pay such "top-ups".

The new framework reiterates that it is the responsibility of CCGs to meet the costs of all assessed health and wellbeing needs in full but does go further in describing those services which might not be based on health and wellbeing and therefore could be paid for privately. The new framework includes by way of example the choice of larger or better situated rooms in which additional services contracts can be entered into. This change clearly gives providers greater scope to enter into contracts for additional services. It is also an area likely to be reviewed in the CMA's final guidance on customer contracts.

4. The duty to pay the costs of care

The new framework states that the fees paid should be based on the "CCG's knowledge of the costs of services … in the locality where they are to be provided." The provision of accurate and up-to-date information regarding the costs of services and how those costs have changed in line with such things as national minimum wage, as well as the state of the local employment market, should be information which every provider is able to make available to their CCGs. The CCG's own data is likely to be patchy if it exists at all and if a CCG is presented with information based on actual market data, it can be very difficult for it to be ignored.

When discussing higher cost care packages, matching assessed needs to services becomes more important and the new framework clearly indicates that there should not be any arbitrary fee rates being set. The fee rates required by specialist providers is a feature that would need to be considered when deciding on the level of payment being offered, in order to meet the assessed needs. Whilst this does not match the more detailed approach set out in the Care Act and the statutory guidance which accompanies it, there is clearly a greater emphasis on matching specialist services to assessed needs.

The obligations of CCGs when considering moving someone from an existing, more expensive placement, to a cheaper one elsewhere are different to those set out in the Care Act guidance but CCGs must consider and make decisions in close liaison with the individuals concerned, their families and the existing provider as well as the local authority. The CCG must put the reasons for

relevance where an individual who is settled in accommodation becomes eligible for CHC funding and CCGs should not be using arbitrary fee levels to base decisions on where someone should be moved to.

A similar line is taken regarding the obligations on CCGs to fund CHC in an individual's own home. There is a specific provision which states that CCGs can take comparative costs into account but cannot set an arbitrary limit on the value of care / nursing home packages where it does not represent a personalised or accurate approach of the cost of meeting the assessed needs of the individual.

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It is not possible in this briefing to discuss all the detailed changes that have been made, but we hope that the above summary of the impact that the most important changes in CHC funding will have on providers, will be of assistance. If you have any questions on this briefing, CHC or care funding in general, please feel free to contact either John Wearing or Emma Watt.

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