# Partial Public Sector Regulatory Impact Assessment

## TITLE: The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England

## Purpose and intended effect

### Objective

1. To publish a single integrated framework which sets out national policy on eligibility for and assessment of NHS Continuing Healthcare and NHS-funded Nursing Care in England. The National Framework will act to remove the 'postcode lottery' of current arrangements and promote fair and consistent access to NHS funding, which is simpler to understand and administer.

### Background

2. Following the movement of long-term care patients from acute hospitals into the community in the mid-1990s, the Department of Health drew up central policy on how the care would be funded for those whose needs made them the ongoing responsibility of the NHS. This policy was brought together in Health Service Guideline (HSG) (95)8 "*NHS responsibilities for meeting continuing health care needs"*, which listed "continuing in-patient care under specialist supervision in hospital or in a nursing home" and "specialist health care support to people in nursing homes" amongst other NHS responsibilities. It required the then Health Authorities (approximately 100) to develop local eligibility criteria which set out clearly the criteria which would be used as the basis, in individual cases, for decisions about the need for NHS funded care.

3. Following the *Coughlan* judgment in July 1999, the Department of Health issued a Health Service Circular (HSC1999/180) on 11 August 1999, which set out actions that health and local authorities should take to satisfy themselves that their criteria and policies for full NHS responsibility were in line with the judgment.

4. In March 1999 "With Respect to Old Age – a report by the Royal Commission on Long Term Care" was published. This recognised that there was a large group (approximately 120,000 at that time) of nursing home residents, who were not entitled to full funding by the NHS but who were receiving the services of a registered nurse. That these individuals were personally funding the provision of registered nursing care which in any other setting would be provided free of charge was an anomaly, and the Royal Commission recommended such charges for nursing care provided in nursing homes be abolished.

5. The Government responded to the Royal Commission in July 2000 by making the commitment that "We will make nursing care available free under the NHS to everyone in a care home who needs it. In the future the NHS will meet the costs of registered nurse time spent on providing, delegating or supervising care in any setting".

6. Section 49 of the Health and Social Care Act 2001, which was granted Royal Assent in May 2001, separated out the services of the registered nurse, as they are defined in the legislation, from the rest of the care which could be provided by social services in a nursing home. By removing the existing ambiguity, whereby both NHS and local authorities could provide these services, the intention was to make it plain that care provided by a registered nurse was now the NHS's responsibility.

7. The Department of Health also published Health Service Circular HSC2001/15 "Continuing Care: NHS and local councils' responsibilities" on 28 June 2001. This consolidated guidance on NHS Continuing Healthcare, including clarifying that local eligibility criteria for NHS Continuing Healthcare should be based on the nature, or complexity, or intensity, or unpredictability of a person's health care needs. It asked the NHS and local councils to agree together how they would meet their population's care needs in the light of this guidance and the impending change in the provision of care from a registered nurse following implementation of section 49 of the Health and Social Care Act 2001. It also updated advice on a number of aspects in the light of changes in the organisation and processes of the NHS since the previous 1995 and 1999 guidance.

8. In August 2002, the Department required the Strategic Health Authorities to bring together the various sets of criteria across their area into a single set and asked them to provide a legal opinion that these revised criteria were compliant with the *Coughlan* judgment. SHAs formulated criteria for their area in the light of local legal advice and against the framework of the guidance issued in 2001. This review and alignment was completed throughout England by autumn 2003. The "Continuing Care National Health Service Responsibilities Directions 2004" clarified the SHAs' responsibilities for continuing care.

9. Following criticism of the uneven provision of NHS Continuing Healthcare, work was announced in December 2004 to develop a National Framework to improve the clarity and consistency of policy, making it clear that this should include the interface with NHS funded nursing care.

10. Subsequent legal judgments, such as the *Grogan* case in January 2006, have continued to expose difficulties in the interpretation and application of local eligibility criteria and processes.

## Rationale for Government Intervention

11. The Government recognises that there continues to be confusion over Continuing Care policies and their application – as highlighted by various reports, studies and legal judgments. The current arrangements (in which each SHA sets their own processes on the basis of central guidance) have led to the perception of a 'postcode lottery' in which the

provision of NHS Continuing Healthcare is seen by some as inconsistent when viewed comparatively across the country. Variation also leads to a disproportionate amount of resources invested in disputes with individuals, other NHS bodies and Local Authorities.

12. Critical reports, negative media coverage and the outcome of legal cases have contributed to raising the profile of Continuing Care policy, and may have led to a greater willingness to challenge funding decisions, including through the courts.

13. The consequence of not acting would allow the situation to continue, which would be destabilising and waste resources.

## Options

14. There are several broad options, as expressed below;

    i. Option 1 – Do not act.

    ii. Option 2 – Establish a National Framework to replace existing guidance and promote identical rules and processes across England. The National Framework will use the existing legal framework to set out the national policy on eligibility and assessment for NHS Continuing Healthcare. The Framework will also reform the provision of NHS-funded Nursing Care.

    iii. Option 3 – Remove the boundary between health and social care so that funding for both health and social services is provided free at the point of delivery by the body responsible.

## Costs and Benefits

### Sectors and Groups Affected

15. The proposals affect the 376,000 Older People in care homes, approximately 147,000 of whom currently receive some level of NHS funding towards their care. All adult social care providers will be affected by changes to Continuing Care provision: care homes (around 23,000, the vast majority of which are independent), domiciliary care agencies (over 4,000) and nurse agencies (about 900), as well as Local Authorities' Social Services Departments. The NHS currently funds about 21,000 people through NHS Continuing Healthcare.

### Benefits

16. Option 1: There are no potential benefits in pursuing this option. Changes in NHS structure will mean that organisational responsibilities will change, so there will be disruption to local continuing care policies even with a 'no change' option.

17. Option 2: By publishing a national policy on eligibility for full NHS funding, the current perceived problems surrounding fairness and consistency of interpretation will be alleviated.

The National Framework will also reduce any potential for misapplication of policy by providing a 'best practice' assessment framework which mirrors the overall policy.

18. The establishment of a policy consistent with the legal precedents will minimise the risk of future legal cases to be brought against individual SHAs, Local Authorities or the Department.

19. Reforms to the policy on NHS-funded Nursing Care, which are intended to be implemented nationally, will greatly reduce the administrative burden on front line staff which is entailed by the current banding system. Eligibility for this form of funding will be determined as part of the care planning process, meaning that no separate determination of the 'banding' of registered nursing needs is required. One PCT has estimated that the cost of NHS staff time to administer the current system equates to four times what is actually paid in terms of funding nursing care. On this basis, one might reasonably expect savings which equate to £20-50m in terms of nursing and administrative time. There will also be savings for care homes and/or Local Authorities who no longer have to reconcile varying nursing payments.

20. Calculation of the suggested amount of the new single band payment for NHS-funded Nursing Care will initially be set so as to be cost-neutral across the NHS on the basis of current spending.

21. Option 3: The existing separation between health and social care provision is a legal one, with the most obvious manifestation to the individual being that the NHS is free at the point of provision and social care is means-tested. In many cases, the NHS and Local Authorities are already forming strategic joint-working partnerships. The removal of the divide between universal and free healthcare and means-tested social care would bring about a realignment of care services which would reduce confusion and misunderstanding for frontline staff and individuals.

22. This option would necessitate primary legislation and it would reduce the practical significance of legal cases such as the *Coughlan* judgment. The implications of such reform would extend far beyond the scope of NHS Continuing Healthcare.

## Costs

23. Option 1: As described previously, the current situation has resulted in criticism, adverse media coverage and increases the potential for disputes. A lack of direct action, or a delay in that action, will only allow the situation to intensify.

24. Option 2: Eligibility policies for NHS Continuing Healthcare vary between SHAs in England. Implementing a national approach would, therefore, have differing effects, and net costs, based on these regional divergences.

25. National policy on NHS Continuing Healthcare is set out in the National Framework. When the National Framework is operational, PCTs will be required to determine a person's need for NHS Continuing Healthcare by reference to the assessment process set out in the framework. The PCT must go on to provide, or arrange for the provision of, such services

(including accommodation) as it considers appropriate in light of that assessment. The assessment process stipulated in Directions will be underpinned by Departmental guidance. This guidance will detail when a person's care should fall to the NHS (i.e. when the person's primary need is a health need), and what services should normally be provided (the full package of care, i.e. NHS Continuing Healthcare). The following costs are estimates based on all NHS bodies adopting the National Framework.

26. Over the whole of England, if the National Framework proposals on NHS Continuing Healthcare were to be adopted, it is likely that additional costs to the NHS would amount to £110m over the first year, on the basis of interim estimates. This cost is largely unavoidable, since legal judgments are already clarifying where the boundary of NHS responsibility lies, and shifting the balance between NHS and Local Authority provision on a local level. Initial estimates suggest that changes already occurring as a result of these judgments and improved local processes could account for an additional £70m, approximately, across England; so reducing the net cost to £40-45m. Within this cost are local variations reflecting the current inconsistent provision of NHS Continuing Healthcare across England as a whole.

27. The costs of implementation include a cost shift from Local Authority budgets, where Social Services have funded in the past individuals who may in future become eligible for NHS funding.

28. Those individuals who may become eligible for NHS Continuing Healthcare under the national arrangements will, for the most part, have previously occupied the 'high band' of NHS-funded Nursing Care. However, it is important to stress that individuals are not now, nor will they become, eligible for NHS Continuing Healthcare simply because they are or were in the high band; eligibility is based on an assessment of actual care needs. Though it is not possible at the current time to estimate the numbers of individuals this might represent, the overall costs will be reduced since these individuals would already have been in receipt of some NHS funding. Moreover, on becoming eligible for NHS Continuing Healthcare the individuals would lose their state benefits and allowances (for example, Attendance Allowance).

29. The proposals for creating a single banded payment for NHS-funded Nursing Care would, in terms of overall NHS funding provision, be structured in such a way as to be cost-neutral on the basis of the current spending. Following this principle, it is estimated that the single band payment would be in the region of £97 per week.

30. Introduction of the single band system poses the risk of financially disadvantaging those current 'high banders' in respect of whom the PCT contributes £133 per week towards their requirement for services from a registered nurse. To reduce this impact, PCTs will be required to ensure they continue to provide such registered nursing services as appears to them to be appropriate, and, in making such a decision, to have regard to the nursing care which the individual currently receives. This may lead to additional short-term costs in relation to the 20-25,000 individuals in this high band, although most individuals do not remain at this level of need for more than a year.

31. Option 3: The divide between health and social care has stood since 1948, and to dismantle that now would be a fundamental and costly restructuring of the welfare state. In the case of long-term care alone, this is estimated at £1.5bn per year, rising to £3bn per year by 2020. This estimate does not include other types of care, nor the cost of board and lodging, which NHS patients currently receive free of charge.

32. The prohibitive cost of removing the health/social care divide would not provide any new services, nor improve the quality of existing services, nor allocate additional funding to those services. The move would simply benefit those who can currently afford to fund their own social care through the Local Authority means-testing, and would provide no improvement for the least well off, whose care is already provided free of charge.

## Public Services Threshold Test

33. Criterion 1: *Is the total additional monetary cost more than £30m per annum to the NHS?*

    Although the total cost of the proposals cannot be reliably estimated at the current time, it is likely that the correct application of the legal framework of NHS responsibility for Continuing Care on a national basis will have a significant cost impact.

34. Criterion 2: *Is the policy likely to attract high levels of political or media interest?*

    The issue of funding for NHS Continuing Healthcare involves some of the most vulnerable people in society and has attracted significant media interest. In addition, both the Health Services Ombudsman and the Health Select Committee have called for a simple set of national criteria.

## Enforcement and Sanctions

35. The National Framework will be supported by Directions under the National Health Service Act 1977, and by Departmental Guidance.

36. Implementation will be supported by pressure from Local Authorities, the Health Service Ombudsman and the public.

37. Non-compliance would attract action by the Department to performance manage the implementation process, and would lead to criticism from the Healthcare Commission and the Health Service Ombudsman and the risk of legal challenge.

## Monitoring and Review

38. The Government will keep the operation of the National Framework under review and will ask SHAs to benchmark the processes of their PCTs to ensure consistency. A national training programme will also be set up in the introductory phase to deal with implementation issues and resolve questions arising so that the correct message are disseminated to the front line. Following this, the Department will continue to monitor the application of the National

Framework across the country, liaising with NHS bodies, Local Authorities and Inspectorates where relevant.

## Consultation

### Within Government

39. The Government's proposals are a response to various reports into Continuing Care funding, including those of the Health Select Committee, the Royal Commission and the Ombudsman. In preparing the current proposals, the Government has undertaken a period of pre-consultation with the NHS, the Association of Directors of Social Services and the Local Government Association.

### Public Consultation

40. Full public consultation on the proposals is planned to begin in June 2006 and last for three months. The public consultation process will offer the opportunity for all stakeholders and members of the public to contribute to clarification of the framework and guidance.

## Summary and Recommendation

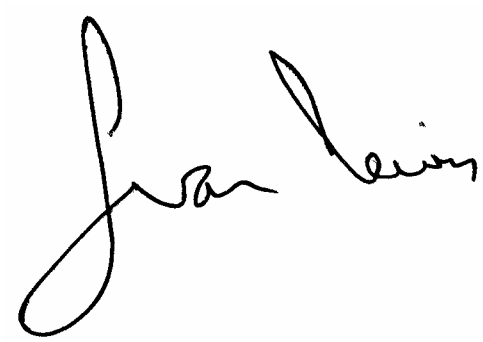
41. Of the options presented, only option 2 provides realisable benefits which are not outweighed by prohibitive cost. The proposed National Framework will provide a single and coherent set policy to access to NHS funding which, when adopted, will alleviate regional discrepancies and help to promote fair and consistent decision-making that is compliant with existing legal rulings.

42. The monetary costs of this option in terms of additional NHS spending can be offset by the general reduction of the administrative burden and dispute procedures. Moreover, providing a lawful framework will minimise the risk for future litigation.

## Declaration

43. *I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs.*

Signed by the responsible Minister



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Date……19 June 2006……

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