From the Lord Prior of Brampton
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Department of Health

The Rt. Hon Lord Hunt of Kings Heath
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Dear Philip,

I said that I would write to you following the debate on 24 November about the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2015, to answer your question whether the current eligibility criteria for NHS-funded nursing care are being observed properly by the NHS and not being reinterpreted.

The Department has in place a National Framework[1] which sets out the principles and processes for NHS Continuing Healthcare (NHS CHC) and NHS-funded Nursing care (NHS-FNC).

NHS CHC is a package of ongoing health and social care arranged and funded solely by the NHS where an individual has been found to have a 'primary health need' as set out in the National Framework.

NHS-FNC is the funding provided by the NHS to care homes that provide nursing, to support the provision of nursing care by a registered nurse for those assessed as eligible. The NHS makes a flat rate contribution to the care home in respect of all individuals who are eligible for nursing care, whether or not their care is paid for by their local authority or self-funded. This is currently £112.00 per week. You may wish to note that the Department has recently commissioned an external review of this rate which is now underway.

As you know, a fundamental principle of the NHS is that NHS services are free at the point of delivery (except in limited circumstances), regardless of an individual's financial circumstances. The National Framework sets out that the final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of a decision-making panel.

[1] *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (November 2012 revised)

CCGs, working in partnership with local authorities, are responsible for eligibility assessments and decisions and the commissioning of care to meet the identified needs. This should be based on a multidisciplinary assessment of need, preferably involving both CCGs and local authorities so that an individual's health and social care needs can be identified and met appropriately by each organisation. A registered nurse should be involved in identifying and documenting the registered nursing needs during assessments for both NHS CHC and NHS-FNC.

NHS England has a role to be assured of CCGs' compliance with the National Framework and the Department has worked closely with them on the development of the NHS England *NHS Continuing Healthcare Operating Model and Assurance Framework.* The final version of this tool was published on 31st March 2015.

The Operating Model and Assurance Framework sets out the strategic importance of NHS CHC as a vehicle for delivering long term care; improving the patient and staff experience; the statutory responsibilities of CCGs and NHS England, and the support and assurance role of the NHS England regional teams. This tool will be used to hold CCGs to account for delivering against the National Framework in terms of the assessment process and the quality of packages of care.

I should also like to expand on the risks of perverse incentives in waiting time standards. As you know, Sir Bruce Keogh recommended moving to the single (incomplete pathway) RTT standard, on the grounds that "within this confusing set of standards there are in-built perverse incentives… The admitted and no-admitted standards penalise hospitals for treating patients that have waited longer than 18 weeks standard".

The focus on the achievement of the completed pathway standards that 90% of inpatients and 95% of outpatients should be treated within 18 weeks potentially incentivised the treatment of short waiters at the expense of those who had waited a long time – as once patients had been waiting longer than 18 weeks there was actually a perverse incentive not to treat them because the performance standards could still be achieved by treating other (pre-18 week) patients first.

As the NHS Standard Contract included financial sanctions for failure to meet the standards, the risk of being sanctioned for doing the right thing in treating their long waiters could lead to could lead to 'quota management', admitting only one person who had waited over 18 weeks

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for each nine who had waited under 18 weeks. This practice of treating patients out of order potentially cuts across clinical decision making.

In 2012, the incomplete pathway standard was introduced to ensure that those waiting longer than 18 weeks are not forgotten about and that they are treated as quickly as possible, but the continued emphasis on the completed pathway standards meant scope for poor behaviour remained. A sole focus on the incomplete pathway standard is intended to address that.

As I outlined in the debate, we will guard against new forms of poor behaviour developing as an unintended consequence of this change. An example would be the possibility of admitted patients waiting longer, as providers could manage their performance against the incomplete standard by concentrating on non-admitted patients, who tend to be less complex and therefore easier and less costly to start treating in a shorter time frame. To maintain transparency and safeguard against these changes having unintended consequences, the collection of information on completed admitted and non-admitted pathways will continue alongside the information on incomplete pathways. NHS England has also added to the data that will be collected and published, (collecting the number of clock starts in the month and the number of decisions to admit). This will enable better understanding of the waiting list dynamic, robust monitoring by system regulators to ensure patients are being treated fairly, and enable us to identify and address any unforeseen perverse behaviours.

I hope this clarifies all outstanding matters. I will copy this letter to Lord Lansley and place it in the library.

Yours

DAVID PRIOR