The Commissioning of Hospice Care in England in 2013/14

May 2013

Background

Between March and May 2013, Help the Hospices undertook a survey among its member hospices in England to establish what arrangements were being put in place with Clinical Commissioning Groups for the 2013/14 financial year.

The survey included both adult and children's hospices in England, and achieved a response rate of 78 per cent (127 out of 163 English hospices).

This summary report identifies key findings based on the quantitative feedback from the survey results, and includes examples from qualitative feedback. We have also included recommendations that we believe could help to improve the commissioning of hospice care.

Summary of findings

Progress in agreeing arrangements for 2013/14

The survey was undertaken over a number of weeks, and circumstances will have changed. At the time of responding to the survey, 80 per cent of hospices reported that they did not have signed agreements in place with one or more commissioner.

However, hospices (n=25) responding to the survey in May (long after arrangements for 2013/14 should have been in place) reported that while 70 per cent had agreed funding levels with their commissioners, only 16 per cent had signed an agreement.

The delay in confirming commissioning arrangements for 2013/14 has caused some hospices real difficulties.

> Following the survey, one hospice contacted us to say that *"as a result of the local CCGs failing to pay their invoices on time we have had to sell investments worth £500k to meet the demands of our payroll for this month".*

The complexity of commissioning arrangements for hospice care

Historically, hospices have frequently worked with more than one NHS commissioner, and this has been particularly true for children's hospices.

In the new configuration, the commissioning arrangements for hospices are becoming more complex. 38 per cent of hospices responding to the survey said that they are working with three or more statutory commissioners and a quarter are engaging with four or more commissioners. There are, however, examples of good practice with CCGs collaborating on the commissioning of palliative and end of life care.

"CCGs have nominated a lead commissioner at Federation level so we only deal with one point of contact."

Many hospices are managing a range of different contractual and service delivery arrangements. Almost a fifth of respondents reported that they have three or more different forms of agreements with statutory commissioners (involving a mix of service level agreements, block contracts, spot contracts, grants and NHS Contracts).

"We are currently commissioned by 8 PCTs – of which 5 have agreed funding for the next financial year with the remaining 3 still to confirm".

"[It is] a real mess…with patients really being commissioned on a postcode lottery"

The quality of commissioning

Hospices reported several examples of poor commissioning practice. For example, a number reported that their commissioners were only proposing six month agreements, and others reported that they were given inappropriately short timescales to respond to proposed arrangements for 2013/14.

"Inexperienced commissioners are defaulting to a heavily transactional commissioning process."

The use of the NHS Contract

Increasingly hospices are being asked to agree to the use of the NHS Contract. Almost half of respondents have signed or been invited to sign an NHS Contract, with three quarters of these running for one year or less. Only 15 per cent of hospices responding that have signed an NHS Contract said that their contract was for the recommended three-year period.

This means increasing complexity for hospices, moving to a different contractual arrangement (covering only a proportion of service costs) with limited return in terms of security of funding.

Many respondents commented on the inappropriate nature of the NHS Contract to commission hospice care, citing the challenges of removing inappropriate clauses of the mandated content, and the difficulties arising from using the contract in situations in which the NHS is only part funding, or making a contribution towards, the costs of care provided by the hospice.

"we're using a shortened version of the standard contract and have negotiated out some of the more ridiculous elements such as a requirement to contact the CCG about any publicity/media coverage we undertake".

"At the moment [an] NHS standard contract is being proposed but it covers ALL [of the hospice's] provision for only 2/7th of the cost so we will not sign. We would prefer a co-commission agreement."

Alternative commissioning arrangements

A number of hospices reported that they are using alternative commissioning arrangements with the local NHS. In some locations, the hospices concerned had worked with the NHS to agree a 'co-commissioning agreement' which better reflected the partnership between the hospice (as a major funder as well as a provider of care) and the NHS.

Other hospices have attempted to talk to their commissioners about alternative arrangements, but with limited success.

"I have raised with both CCGs the potential alternatives to the NHS contract, provided examples etc. CCG1 say that all of the SHA are using the contract and only NHS organisations can have SLAs – they are not appropriate for the voluntary sector. CCG2 said that with their reduced management levy they cannot afford the time to develop or use an alternative to their off-the-shelf NHS contract"

"For at least 7 years we had a very good and simple 3 year SLA followed by another 3 year SLA that was extended a further year; it was only 25 pages long. The Chief Executive of the PCT was very happy to sign it because, as he said, 'I like this because it does what it says on the tin'."

Changes in the levels of statutory funding

For those that had had their levels of statutory funding confirmed by their commissioners, 60 per cent reported that their funding was being frozen for 2013/14. 18 per cent reported that their funding for this year was being reduced. Many hospices reported that their levels of statutory funding had been frozen for a number of years, representing significant cuts in funding in real terms.

"[There] has been no change [in funding] for FIVE years!!"

The level of priority being given to palliative and end of life care locally

A majority of respondents (74 per cent) described the level of priority being given to palliative and end of life care by commissioners as medium or high, although many described variation among different CCGs that they are working with.

"Commissioners are prioritising generalist palliative care (ie via GPs) rather than specialist (ie via hospices)."

"[They] talk about it being a priority but have not even appointed a lead GP within the CCG!"

In contrast, only 37 per cent of respondents said that palliative and end of life care as a medium or high priority for their Health & Wellbeing Boards, with a further 32 per cent reporting that it was either a low priority or simply not on the Health & Wellbeing Board agenda.

"We spoke to their chair of the HWB but he said he had bigger challenges to address"

"We have 3 Health and Wellbeing Boards in our catchment. [End of life care is] only a named priority in one of them."

Recommendations

1. **There should be improved coordination among local CCGs on the commissioning of lower volume services such as hospice care.**

   The administrative cost for hospices engaging with multiple commissioners, often with a variety of arrangements, is considerable. Encouraging CCGs to collaborate, for example through lead commissioner arrangements, would help to improve efficiency and support the better strategic planning of local hospice and palliative care services.

2. **The NHS Contract should be reviewed and adapted to ensure that it is appropriate and relevant for the commissioning of hospice care.**

   The NHS Contract is an inappropriate tool where the NHS is only making a contribution towards the costs of care, and where the service specification does not set out specific services or volumes. The development of a national framework for the commissioning of hospice care in such circumstances would improve commissioning practice and reduce complex contract variation negotiations.

3. **Commissioners should be reminded of the flexibility at their disposal to make appropriate commissioning arrangements for hospices.**

   In previous years, the guidance to commissioners on the use of the NHS Contract has reminded them that they have considerable flexibility when making arrangements with charities such as hospices, and that the NHS Contract is not always appropriate to be used with charities. This is not present in the current guidance to commissioners, and should be reinstated. This would help to promote innovation and strengthen partnerships between the NHS and local hospices, such as through the use of co-commissioning arrangements.

4. **Commissioners should ensure that the levels of funding for hospice care reflect local need, and recognise that hospices are often the major local funders, as well as providers, of hospice and palliative care.**

   The erosion of funding for hospice care, either through direct reduction or the freezing of funding levels, directly impacts on the ability of hospices to meet local needs. Encouraging commissioners to focus on needs not budgets would help hospices and the NHS work together to meet the growing demand for palliative care, and would help to maximise the impact of the considerable charitable resources raised and spent locally.

5. **Multi-year contracts and arrangements should be put in place as soon as possible.**

   Short terms arrangements of one year or less undermine the ability of hospices to plan for the future. Commissioners should be encouraged to introduce multiple year arrangements as quickly as possible. This would help to ensure the sustainability of the hospice movement and give hospices the confidence to invest in service developments and improvements.

6. **There should be better collaboration between commissioners of health and social care.**

   This is particularly important for children's hospices who work closely with commissioners from the NHS and local councils, but also for adult services as they seek to deliver better integrated care.

For further information

For more information about the results of the survey, please contact Karen Lynch, Policy Implementation Manager at k.lynch@helpthehospices.org.uk, or by calling 020 7520 8200

Appendix 1 Analysis

In response to the survey, after excluding duplicate and partial responses, we received 127 responses giving a response rate of 78 per cent.

We have removed 'Don't know' and uncompleted responses from a number of the graphs included here. Where this has been done the graphs include the number of respondents to allow comparison.

Figure 1 – Progress in statutory funding agreements for 2013/14

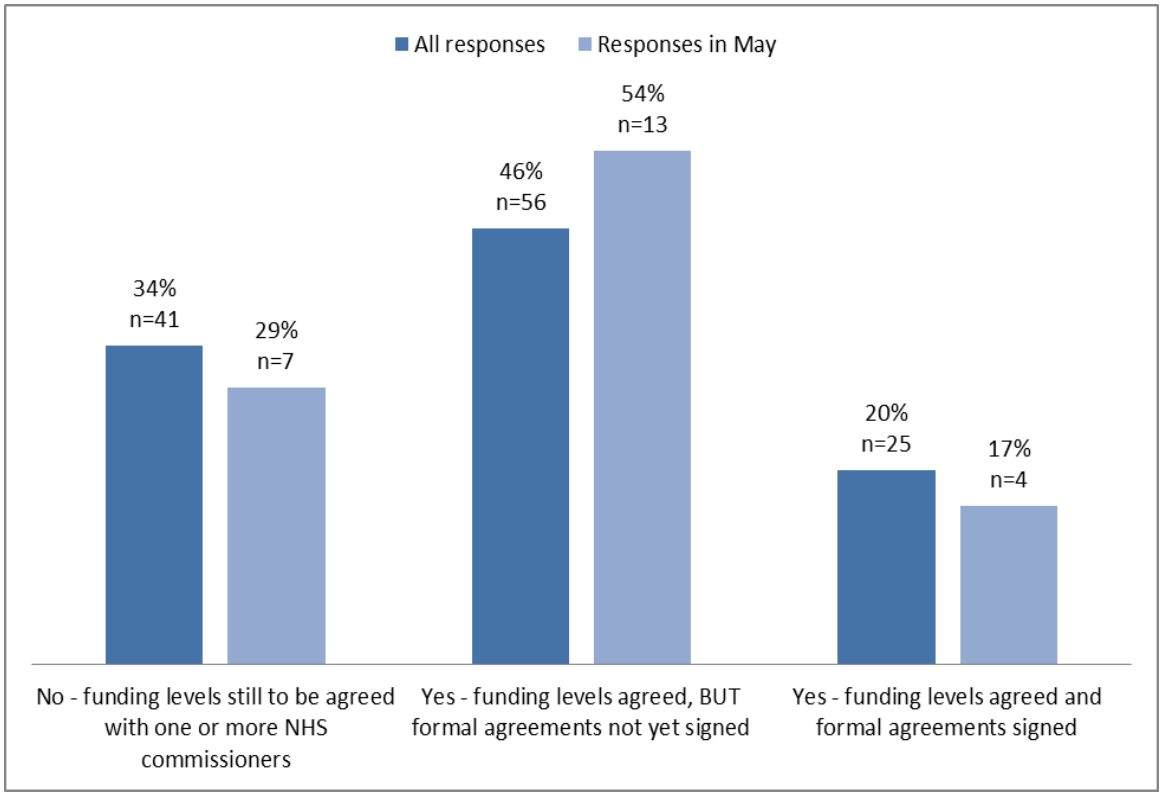

Figure 2 – Number of statutory commissioners, by hospice

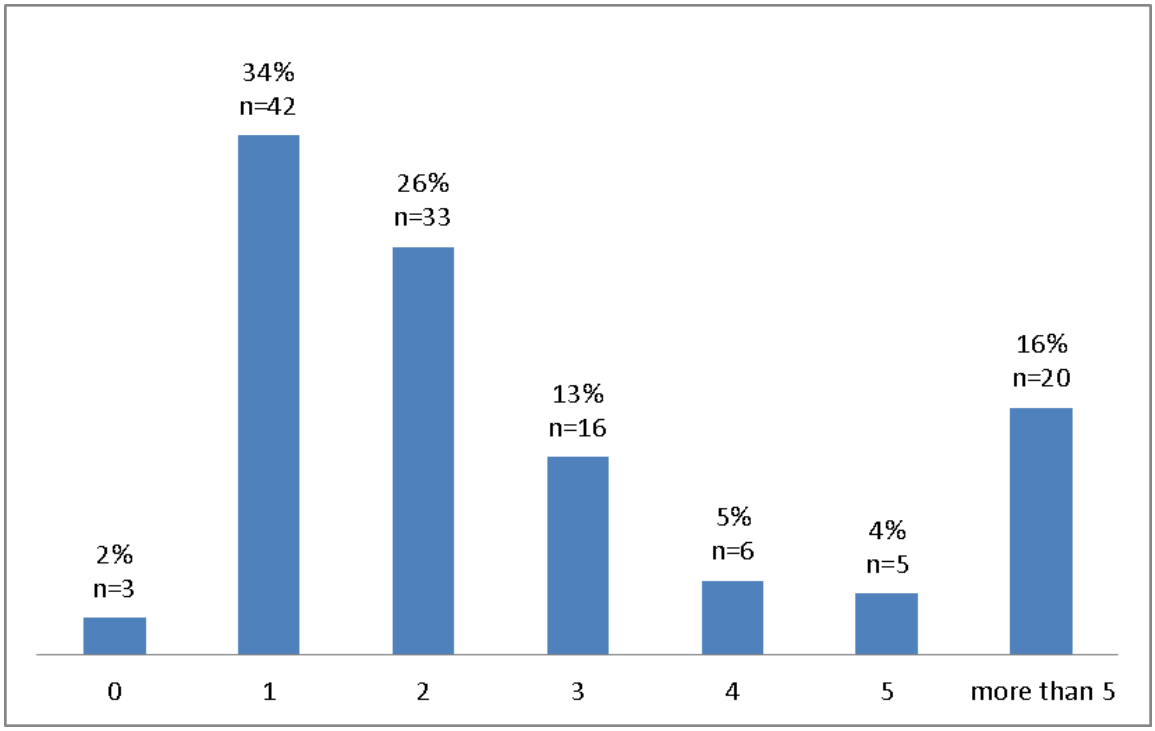

Figure 3 – Number of different forms of statutory funding arrangements, by hospice

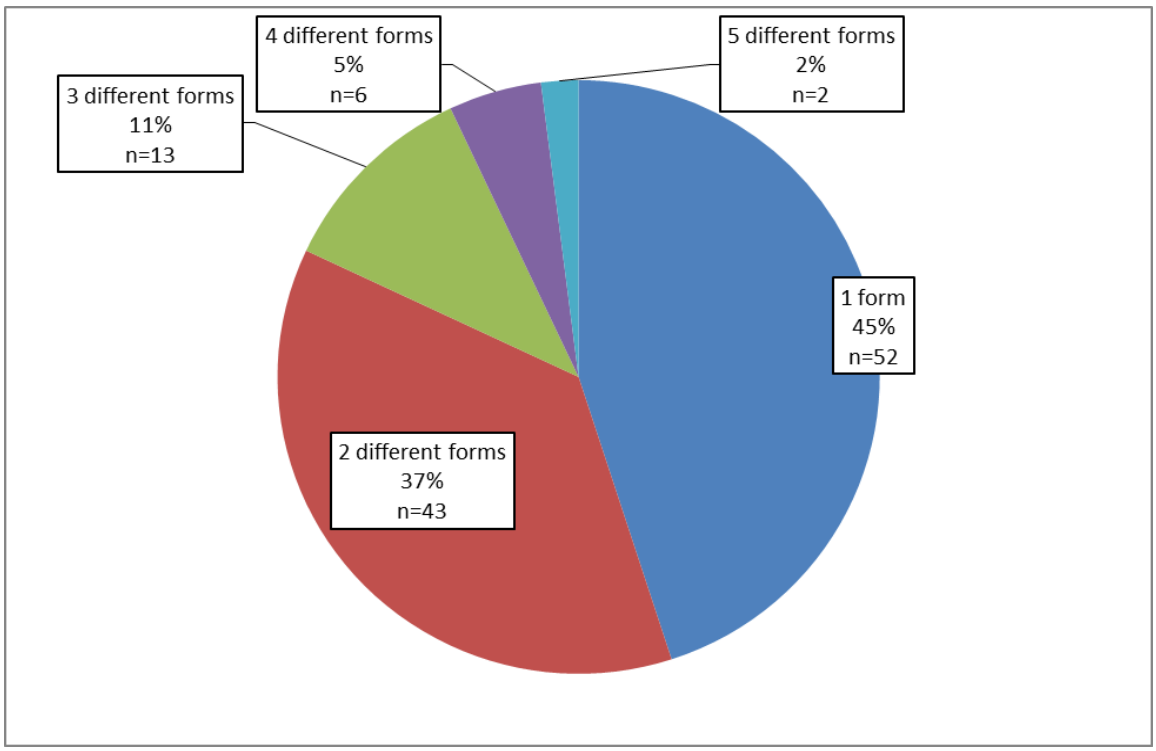

Figure 4 - Forms of funding agreements proposed by statutory commissioners 2013/14

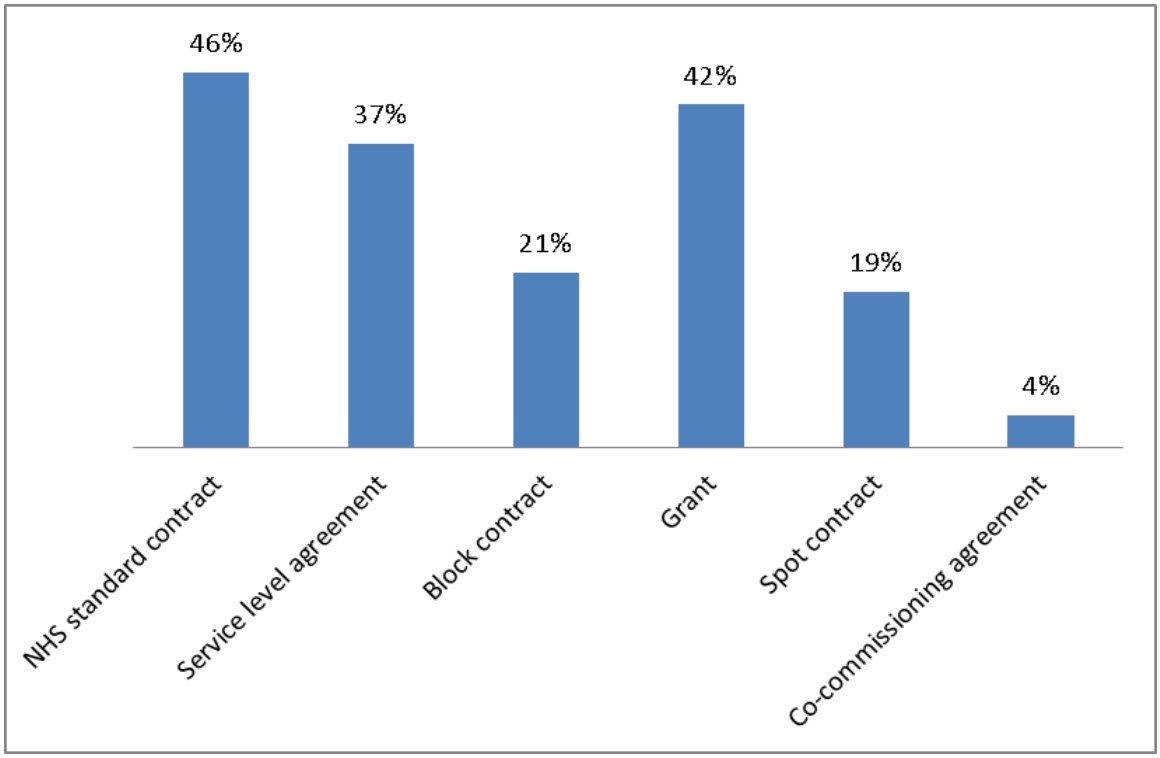

Figure 5 – Length of NHS contracts

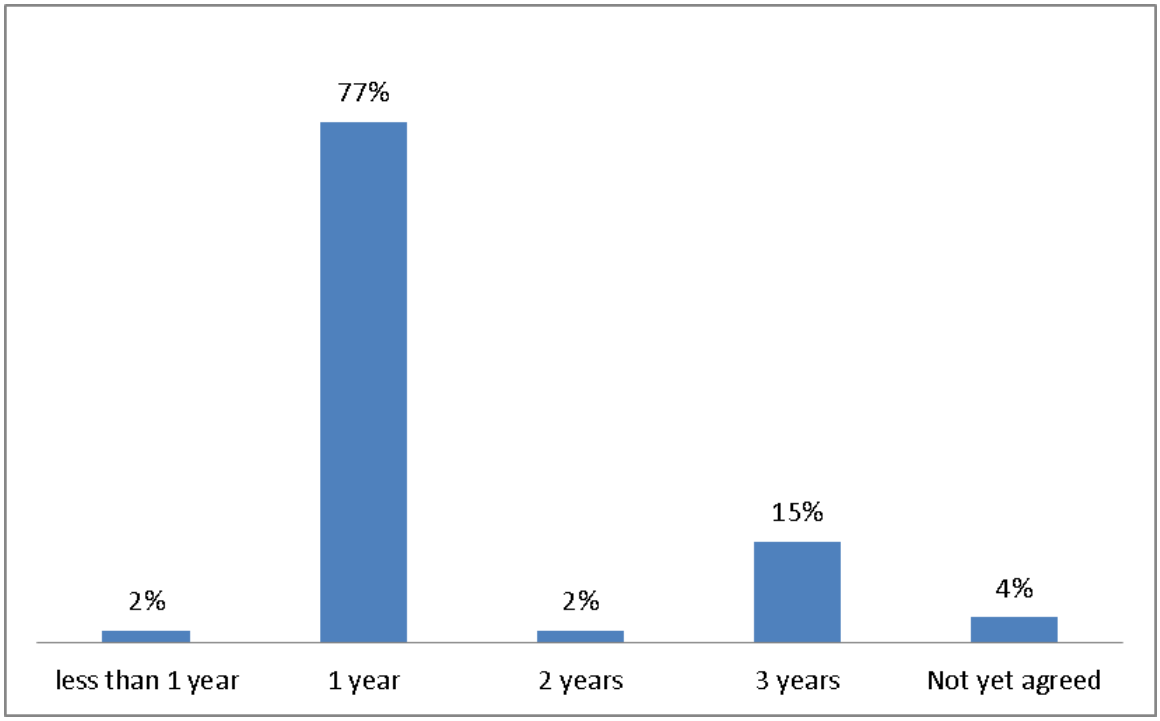

Figure 6 – Changes in funding from statutory sources 2012/13 to 2013/14

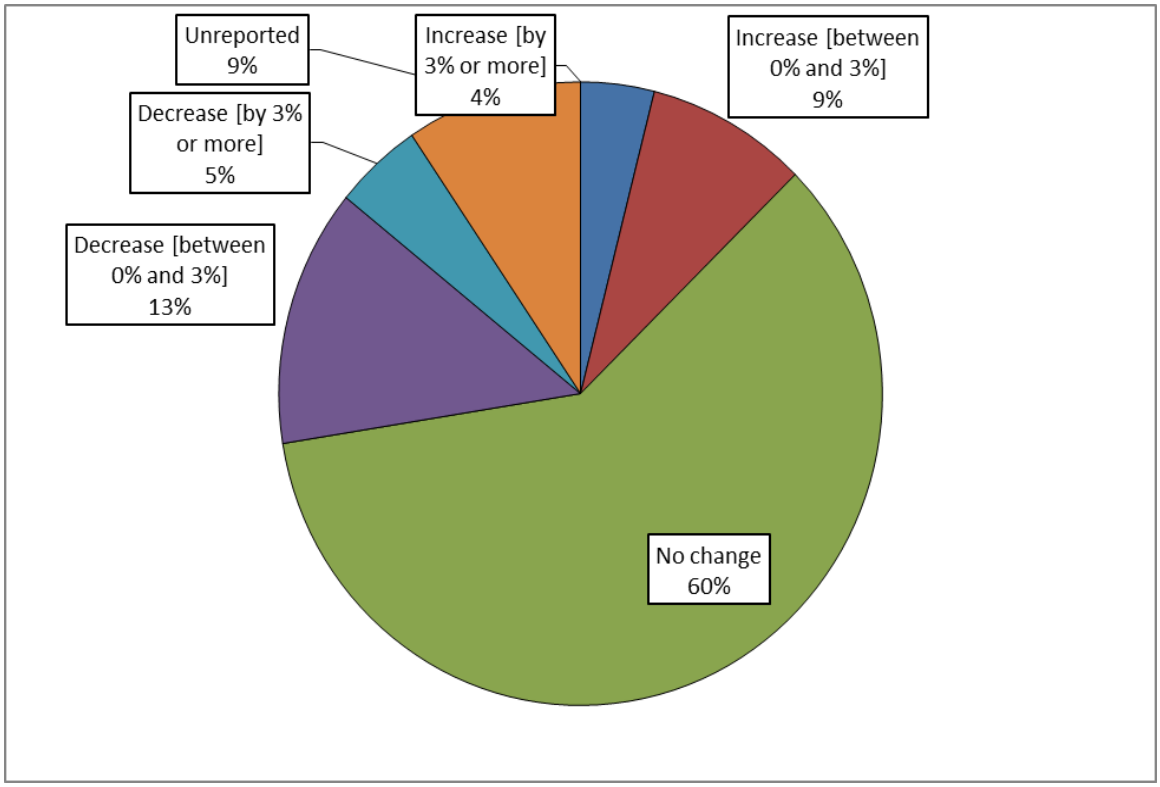

Figure 7 – Perception of palliative and end of life care as a priority for CCGs

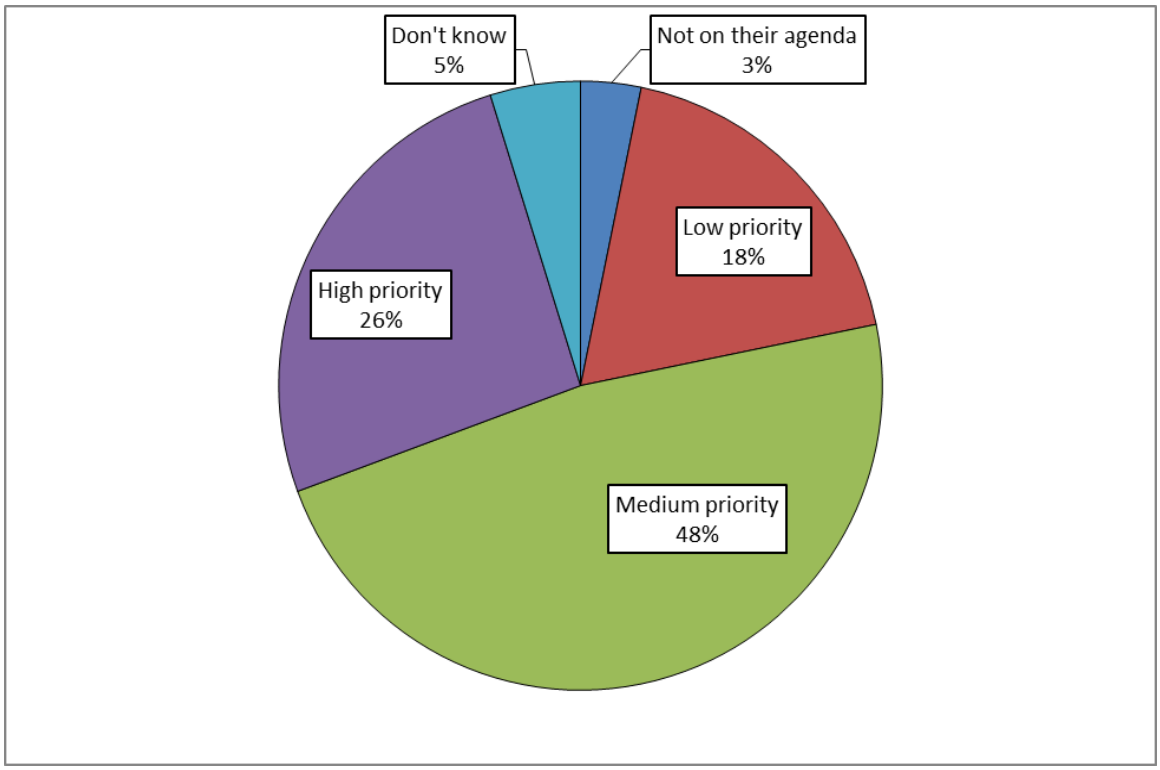

Figure 8 – Perception of priority of palliative and end of life care for Health and Wellbeing Boards