Continuing Healthcare (CHC)
Cluster Analysis and Workforce

NHS Continuing Healthcare
Strategic Improvement Programme

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The Team Today

#hello my name is...

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Programme Aim and Goals

The Continuing Healthcare Strategic Improvement Programme looking to provide fair access to NHS CHC in a way which ensures:

1. Better outcomes
2. Better Experience
3. Better use of resources

The Programme goals are to:

• Reduce variation in patient and carer experience in quality, timeliness and speed of assessment, eligibility decisions and appeal processes.
• Establish national standards of practice and outcome expectations.
• Ensure the best possible package commissioning is in place.
• Achieve the spending review target of reducing growth in CHC expenditure, through standardisation and adoption of best practice.
• Ensure that assessments occur at the right time and place, and reduce the number of full assessments for CHC in acute settings.
• Influence national policy framework and care market oversight
• Strengthen alignment between NHS England work programmes which have a CHC component, such as Personalisation and Choice.

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Today’s presentation

• This presentation will focus on two key aspects of current work in the CHC Strategic Improvement Programme and NHS England’s CHC Business Unit.

• Andy Tookey will discuss the methodology that is being used to understand and investigate variation in CCG eligibility and expenditure rates.

• Toby Hewlett will then talk about the workforce challenge in CHC, and the workforce projects that SIP is currently delivering.
Business Need

• NHS England has a responsibility to monitor assurance and compliance with the National Framework for NHS Continuing Healthcare.

• There is an ongoing requirement from the Public Accounts Committee to answer questions around and understand variation in eligibility and expenditure rates.

• Clustering CCGs with similar demographics provides a meaningful starting point to do this.

• This approach improves on the previous methodology which simply looked at national or regional comparisons without taking demographic factors into account.

• Reducing variation in eligibility and expenditure will demonstrate a consistent application of the CHC National Framework, and support the NHS Efficiency Plan.
Clustering Methodology

• The application of ‘k-means clustering’ was used by Deloitte as part of the QIPP ‘CHC At Scale’ project.

• Preliminary clusters were produced for the 2016/17 structure of 209 CCGs, grouping CCGs based on similar characteristics:
  
  o Demographics
  
  o Socioeconomics
  
  o Disease
  
  o Deprivation

• The same methodology has now been applied with the latest available data to generate clusters for the 2018/19 structure of 195 CCGs.

• By grouping together similar CCG we address the variation in eligibility and expenditure rates attributed to demographics – any variation within a cluster is largely attributed to other factors.

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• For each CCG in a cluster the eligibility rate for standard CHC is compared, and CCGs outside the 5th and 95th percentile are identified.
• A set of assurance prompts has been developed to help CCGs and local performance managers investigate and understand what may be driving high or low eligibility.

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Standardising the Output

The individual → Process → Output

Strategy and national guidance → Organisational Structure
Standardising the Output

Training Competency Framework

Revision of the NF

Delivery Model ICP

Digital CHC
Workforce planning
Commissioning structures

Output
Continuing Care Workforce Data

• Inform understanding of what the national Continuing Care workforce looks like: different staff structures, skill and staff group mix.
• CCGs record Continuing Care Workforce costs on the Assessment & Support cost centre in ISFE. Assessment & Support is defined as:

  CCG expenditure on the function of assessing and arranging the care of all types of Continuing Care and NHS-funded Nursing Care (FNC) clients.

Includes in-house & outsourced functions

• CCGs nationally reported expenditure of £162m on workforce costs for 2017/18.
• This equates to 3.6% of the total spend on Continuing Care.
• However, there are some concerns about the quality of data: for 17/18, seven CCGs reported nil expenditure. Similar potential data quality issues were evident in 18/19 financial plan data.
Workforce Projects

- Competency Framework
  - To define the skills and knowledge required to carry out CHC processes

- Training toolkit
  - To standardise the training given to those carrying out CHC processes

- Workforce planning toolkit
  - To support CCGs and Local Authorities in building sustainable teams

- Delivery Model
  - Online resource sharing best practice, standardised document templates and pathways
Programme Benefits

Better Outcomes
- Consistent application of national framework via joint working with ADASS, Third Sector Collaborative, CHC Connect, Improvement Community WebEx sessions and Delivery Workshop events.
- Better safety, effectiveness and timeliness of CHC process through delivery of Workforce Modelling Toolkit.
- Clearly defined commissioning processes available via Delivery Model Website.

Better Experience
- Improved CHC experience for staff, patients, family and friends through CHC training (e-learning) and Competency framework.
- CHC specialised website for information on CHC Process Map, Best Practice Case Studies, Patient Video Clips.
- Prompt patient-centred brokerage.

Better use of Resources
- Reduction in reliance on using spot contracts by using e-brokerage and utilising Digital CHC Specification Model.
- Increased standardisation and compliance with NHSE contracting guidance.
- Improved financial reporting and analysis to focus on reduction of unwarranted variation.

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