The Commissioning of Hospice Care in England in 2014/15

July 2014
Executive summary

Hospices are quite unique among providers of health and social care – contributing as they do so significantly to the funding and provision of palliative and end of life care. Local charities provide the vast majority of hospice care within the UK, caring for around 360,000 patients and family members each year.

As well as being key providers of local palliative care, hospices are significant funders of care services – with independent charitable hospices spending over £900M per year in the UK to provide care to those who need it. Hospices work hard to be recognised as partners with the statutory sector in addressing local health needs.

To gather a picture of how the new NHS commissioning arrangements, formally established in April 2013, are impacting on hospice services locally we undertook a survey of member hospice in England in April/May 2014.

We found a significant proportion of hospices are experiencing frozen or reduced funding, increasing complexity of commissioning arrangements and overall an absence of proportionality in the contractual arrangements being required by many NHS commissioners. These factors are impacting on services to patients, their carers and communities in some instances. The variability of funding for palliative and end of life care evident from our survey is something intended to be addressed by the outcome of the Palliative Care Funding programme being led by NHS England. We hope that the results from this survey will help in setting some of the context of the forthcoming work to plan and deliver a new funding regime for palliative and end of life care.

Our survey found:

- **Increasing complexity in the commissioning environment for hospices**: a third of hospices are now working with four or more commissioners; at the extreme one hospice reported having 25 statutory funding arrangements with 15 different commissioning bodies.

- **Ongoing uncertainty around the sustainability of statutory funding**: in April/May 2014 only 15% of hospices had a signed agreement in place with their local NHS commissioners. Fewer than a third of NHS standard contracts are running for more than 12 months, and less than a half of all types of agreements with the NHS have secured funding for more than a year.

- **Continuing funding cuts and frozen budgets for many hospices**: half of hospices have had their NHS statutory funding either cut or frozen for 2014/15 largely due to financial restrictions on NHS commissioners.

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3. Includes standard contracts, block contracts, spot contract agreements, service level agreements and grant arrangements.
Impact on services: more than half of hospices surveyed reported an increase in staff time taken up or additional costs incurred in responding to NHS commissioning or contracting requirements. An increase in costs and the uncertainty of funding is impacting on services to patients, with some hospices reporting reductions in some services, keeping staff vacancies open longer to make savings or halting service expansions and innovations.

Relationships with commissioners: in many instances relationships with commissioners are improving, nevertheless more than two out of five hospices expect the future of NHS commissioning to get worse (or much worse).

Priority for care: while the majority of hospices feel that their local Clinical Commissioning Groups (CCGs) have palliative and end of life care as a medium or high priority, almost a quarter feel that it is a low priority or not on the CCGs’ agendas. Even more worryingly less than a third of hospices surveyed described palliative and end of life care as a high or medium priority for their Health and Wellbeing Boards. With 36% of hospices surveyed feeling that it is a low priority or not on Health and Wellbeing Boards’ agenda.

Lost opportunities to work in partnership: while a significant majority of hospices surveyed reported being engaged with local CCGs, only a third were able to engage with Health and Wellbeing Boards, and only 31% with local authority commissioners. Hospices described working with CCGs in a number of ways, but also reported CCGs being less positive about working with hospices as co-funding partners.

Background

Between April and May 2014, Help the Hospices undertook a survey among member hospices in England to gather a picture of how the new NHS commissioning arrangements, formally established in April 2013, are impacting on the commissioning and contracting of services locally.

The survey included both adults and children’s hospices in England and achieved a response rate of 70% (114 out of 163 English hospices).

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

A similar survey was carried out among members in England in March to May 2013. The survey in 2013 achieved a response rate of 78% (127 out of 163 English hospices, including children’s and adults’ services). In some areas we draw comparisons between the results of the two surveys to show the direction of travel.
Our findings

The complexity of commissioning arrangements for hospice care

Working with more than one NHS commissioning body is not a new phenomenon for hospices. Children’s hospices in particular cover a wide geographical area, frequently bringing them into the catchment area of several commissioners. However, the NHS commissioning environment for hospices has become even more fragmented following the formal establishment of clinical commissioning groups (CCGs) in April 2013. Children’s hospices face added complexity in children’s palliative care services being commissioned through both local and national commissioning arrangements.

Almost half (45%) of all hospices surveyed said that they are working with three or more commissioning bodies; while almost a third (32%) of hospices reported working with four or more commissioners. These figures represent an increasingly complex picture – our 2013 survey found 38% of hospices working with three or more commissioners and a quarter engaging with four or more commissioners.

The scale of this complexity varies across the sector:

- hospices providing adult services reported working with up to 12 commissioners
- children’s hospices said that they are working with up to 24 different commissioners.

"In previous years [one CCG] coordinated [two others]. Now we have to deal with total 4 CCGs. This multiplies meeting and reporting demands, especially on senior staff.”

In addition to the number of commissioners, there is further complexity in the number and range of arrangements hospices are working with. Almost two-fifths (37%) of hospices surveyed have three or more statutory funding agreements, and more than a quarter have four or more agreements in place (involving a mix of service level agreements, block contracts, spot contracts, grants and NHS Standard Contracts).

This has been a further area of increasing complexity for hospices: in our 2013 survey almost a fifth of respondents reported three or more different forms of agreements.

This year, one hospice reported having 25 funding agreements in place with a total of 15 statutory commissioning bodies.

For children’s hospices the uncertainty of funding can be further heightened by a focus on spot purchasing of services.
"The majority of statutory funding received by [the hospice] is in respect of young adults (to age 35) for whom contributions are negotiated on a case-by-case basis. These may relate to a "per bed-night" tariff for the individual for a specified number of nights over the year, or may be episode specific. Agreements may be in writing but relatively few are in the form of an SLA/contract."

Sustainability of funding
At the time of responding only 15 percent of hospices surveyed had formal signed agreements in place with their statutory funders for 2014/15. A further third of hospices (32%) reported that they had not yet agreed funding levels with one or more of their NHS commissioners.

"Some CCGs we work with do not have formal agreements and have indicated they are not willing to enter into these at the moment, so purchase ad hoc services."

Hospices surveyed reported that less than a third (31%) of NHS standard contracts covered a period of more than 12 months. Similarly commissioners using service level agreements or grant agreements were consistently issuing agreements for 12 months, or less. Fewer than half of hospices surveyed (48%) reported having any form of statutory funding agreement that ran for more than 12 months.

The quality of commissioning
In some instances hospices are experiencing improving relationships with their NHS commissioners. 18 per cent of hospices surveyed saying that they felt commissioning relationships with NHS commissioners were better or much better.

"[W]e have retained our CCG commissioner over a number of years which has been extremely helpful."

"I am very happy with current commissioning arrangements. We have a close supportive working relationship with our CCG."

"All engagement is positive and enables the Hospice to influence the EOLC [end of life care] strategy in [the locality] and ensure that our strategy is aligned with the city."

However, almost a quarter of hospices (23 percent) felt that relationships were worse or much worse. Hospices also expressed a degree of uncertainty about the future, with 41% of hospices surveyed stating that they saw the future of NHS commissioning getting worse or much worse.
Areas of concern highlighted by some hospices surveyed included:

- lack of understanding by some commissioners (and procurement professionals within Commissioning Support Units) of the legal and regulatory position of hospices as independent local charities
- inappropriate application of the NHS standard contract where the NHS is making only a contribution to service costs
- application of national policy directives without apparent due consideration of proportionality

"Contracts [...] have overly restrictive elements.... These are wholly understandable where the state is commissioning 100% funded service, but where it is co-commissioning with the hospice as a major contributor, the legal obligations are overly restrictive, unfair potentially, and a possible threat to independence if they were enforced - our CCG says they won’t [enforce them] even though they could legally if/when we sign."

"Significant changes in personnel due to re-structuring. Very difficult to meet and discuss and to find somebody who understands the essence of Hospice care and the charitable status and our contributions to services (i.e. no service is fully NHS commissioned)."

"CCGs have greater demands on their time organising failing acute contracts, therefore, late or no discussion regarding Hospice contracts. Commissioners then applying national conditions on to our contracts which are only a contribution to the full cost of the service."

The use of the NHS Standard Contract

The use of the NHS Standard Contract remains an area of concern for many hospices. Almost half of hospices surveyed (48%) reported having at least one NHS standard contract in place. In some instances locally commissioners did not seem to be aware of guidance from NHS England that the NHS Standard Contract is not necessarily appropriate in certain circumstances and that commissioners locally may decide to follow an alternative approach.

Hospices reported the use of the NHS standard contract remains, in many instances, inappropriate.

Hospices surveyed reported little over half of NHS standard contracts contained a service specification that closely reflected the services delivered. Further, in many instances the funding provided did not fully fund the specified services – meaning hospices being required to deliver services under the contract for which they do not receive funding: charitable funds effectively subsidising contractual agreements.
"[We have] not signed but [the CCG] clearly want us to sign the NHS contract for the first time. This is the hospice specific and community element of the contract. Apparently (according to them) the clause related to co-commissioning arrangements meaning that NHS contracts do not need to be signed is no longer relevant!"

"NHS Standard Contracts are in place but this is still just a contribution to our services (and not necessarily applicable for commissioning arrangements). Our NHS standard contracts still only funds small contributions and are NOT based on payments by results."

"[T]he ongoing problem is that the service specification (and the contract document) applies to all of our services, despite the commissioners only funding approximately 30% of our clinical costs."

Nevertheless, in some instances hospices agreed that a standard contract was applicable and appropriate, for example where commissioners are fully-funding a service with a clear specification for delivery.

"We have a 3 year NHS contract and we are very happy with this."

**Alternative commissioning arrangements**

In some areas hospices and commissioners have been working together to develop partnering arrangements and to develop ‘co-commissioning agreements’ that better reflect the relationship between the NHS and hospices as major funders of care. A small but growing number of hospices reported entering into co-commissioning agreements with their NHS commissioners: in 2013 5 hospices reported such agreements; this increased to 8 hospices in 2014.

"We now have a joint collaboration agreement with our local health Trust which is jointly commissioned by the CCG."

"[Commissioning arrangements by statutory bodies have improved as a result of] a combination of successfully introducing a significant new service model into the locality that was part voluntary funded and putting a proactive co-commissioning proposal to them that fit with their overall strategy for the locality. We are also now in regular dialogue with the Local Authority commissioners for the first time and have been involved in their commissioning strategy development on the back of our NHS co-commissioner status."
Hospices as partners
Hospices reported working with a range of partners within their communities to develop and deliver care to those who need it.

"We work in partnership with 2 NHS trusts through a service contract whereby we fund a nurse to work in the children’s community team."

Our survey found a significant majority of hospices surveyed (83%) are engaged with their local CCGs. In contrast only a third of hospices surveyed (34%) reported currently being engaged with their local Health and Wellbeing Boards, and less than a third (31%) reported being engaged with local authority commissioners. Hospices were looking to address these differences – with a further 30% reporting that they were planning to engage with HWBs and 20% planning to engage with local authority commissioners.

"Engagement has been generally very positive and the groups have been welcoming of a more proactive approach from the hospice. We have consciously sought to align our strategy where possible with that of these organisations. The LETB is proving a difficult nut to crack and has no voluntary sector input at all at the moment. We are working well with the local GP provider organisation and in 14/15 will be co-delivering an end of life care local enhanced service with them. We are also discussing joint bids for other work that is likely to go to tender in late 14/15, early 15/16."

"[...] we set up a Palliative Care Partnership (PCP) with our Community Palliative Care team (CPCT) in April 2013. This involves our Hospice at Home service now working under a joint contract with the local Trust who employ the CPCT. The impact has been positive."

However, pressures on both hospices and other aspects of the health and social care system have created challenging circumstances in many localities.

"Arrangements with LA’s have got worse because their funding is being cut so much and they will try to avoid paying for say step down nights, because we are too expensive, and then there is no care package at home that is appropriate, so we end up providing an emergency bed and huge upheaval, rather than planned care, and they have to pay in the end anyway."

Some hospices reported missed opportunities for effective partnership working.

"When we have tried to commission services [the CCG] keeps changing the goal posts and paperwork until we give up due to time spent on nothing. 4 years running we spent trying to commission [a specific service] to no avail. They stated they would not fund it as it was not cost effective enough. It costs £35,000 to run per year and saved the NHS over £300,000 last year. Not sure how cost effective they want us to be!"
Changes in the level of statutory funding

Half of hospices surveyed reported that their funding has been frozen or reduced for this year. A further 18% expect a similar position when their funding is finally agreed.

“CCG have stated a 11-12% decrease in funding over the next two years across all providers in [the locality]. They have inherited significant debts from the PCT which they say mean they have to make cuts. We have argued that we should not be treated in the same way as fully funded NHS providers but to no avail.”

The reduction in funding ranged from 0.9% to as much as 20% of a hospice’s overall statutory funding. One hospice reported expecting a reduction in funding of £100,000.

“Honest clarity [needed] regarding the reintroduction of inflationary uplifts for hospices and voluntary sector support organisations. We really cannot survive in a market where pay inflation exists for staff in the NHS (which it does) and private sector, whilst our own staff can be offered nothing because the contracts on which we survive provide no inflationary uplifts. This needs to be addressed with urgency or our organisations will fail.”

“Almost all of our CCGs had applied the 4% national deflator to our previous contract values, despite them only funding a small proportion of our service delivery costs. This continues to impact on our service.”

61% of hospices surveyed cited financial restrictions on NHS commissioners or standstill budgets as the reason for the funding freeze or cuts.

Impact on services

A combination of the increased costs of the changing commissioning environment and the uncertainty of funding and ongoing frozen/reduced funding is having an impact on services to patients.

Hospices reported negative impacts on a variety of services including inpatient and home care services.

More than half of hospices surveyed (53%) reported an increase in staff time or costs taken up in responding to commissioning or contracting requirements. One hospice found the demands so extensive that it has recruited to a new full-time commissioning post - incurring an additional cost of £45,000 per annum.

"We have halted development and expansion of our 24 hour advice line due to reduction in funding. Increased risk to inpatient services due to reduction in funding and loss of opportunity to improve and develop services such as 24 hour advice line.”
"Less funding available has meant lower staffing and savings being made by, for example, keeping vacancies open longer. For hospice at home this has meant that there are fewer appointment slots available. For inpatients, inpatient staffing levels have been below the optimum level, which has meant we have been reliant on agency staff to cover sickness and holidays, and also it is harder for the inpatient staff to enable patients with higher needs to fully participate in all the activities available at the hospice. We have also found that previously free ambulance transport to and from the hospice has been withdrawn (we have to pay £300 per trip) and we have recently discovered that we are also being treated as non-priority, so patients with urgent deterioration have to be taken to hospital instead of the hospice. Some patients with high needs who need stretcher transport cannot attend timed hospice outpatient appointments and activities."

"No funding contribution offered for weekend admissions, which we can no longer fund from our own resources. Otherwise no impact on day to day operations at present, but community services under threat in the future and the lack of dialogue will inhibit future strategy development and innovation."

As well as a direct impact on the day to day work of hospices, a number of hospices reported that funding uncertainty was stopping innovation as a result of the reduced ability to plan strategically.

The priority given to palliative and end of life care locally
The majority of hospices surveyed (65%) described the level of priority being given to palliative and end of life care by their clinical commissioning groups as high or medium priority. But almost a quarter (23%) felt it was a low priority or not on their commissioner’s agenda.

In contrast, less than a third (29%) of hospices surveyed described palliative and end of life care as a high or medium priority for their Health and Wellbeing Boards. With 36% of hospices surveyed feeling that it was a low priority or not on the Health and Wellbeing Boards’ agenda.

This perception was reflected in the level of engagement with the new structures. 71% of hospices surveyed reported their CCGs having end of life care leads. And 68% of hospices surveyed reported that palliative and end of life care was reflected in CCG commissioning intentions.

However, only 14% of hospices surveyed reported their HWB having an end of life care lead; with 27% of hospices reporting local JSNA’s including palliative and end of life care, and only 14% reporting a perception that local Joint Health and Wellbeing strategies include palliative and end of life care.

However the picture is varied between CCGs in different localities: a fact highlighted by respondents.
“Very mixed [picture] across the patch with so many different CCG’s and Boards (38 in total). However only a rare few have EOL for adults or children as a priority.”

“Wide variety [of priority] again across the area. Most JSNAs do not include children with disabilities or palliative care needs. Where it is mentioned in strategies, it largely relates to adults and is linked to long term condition management.”

“[Palliative and end of life care is not on the CCG’s agenda.] They have disbanded our End of Life Care team.”

“Through positive action to attend meetings and networking. Generally responsive, but dominance of acute hospital, GPs and care providers tends to place hospice lower in the pecking order as far as commissioners are concerned.”

“Engagement has been generally very positive and the groups have been welcoming of a more proactive approach from the hospice.”
Recommendations

We recommend that:

1. **NHS and other statutory commissioners should seek to engage with hospices as key local partners in understanding and working to meet the needs of local communities.**

   Particularly in the face of ongoing financial pressures statutory bodies cannot hope to meet the health and social care needs of local communities on their own. Hospices bring a unique combination of expertise, innovation, local engagement and resources to the partnership table. Their experience in partnership working to provide person-centred, co-ordinated care can help to make the best use of resources across sectors.

2. **Commissioners should ensure that the levels of funding for hospice care reflect local need.**

   The erosion of funding through ongoing freezing or cuts directly impacts on the ability of hospices to meet local needs. A focus by commissioners on the needs within communities and how best to meet those needs would help hospices and the NHS work together to address the growing need for palliative care.

3. **NHS commissioners should seek to improve co-ordination of the commissioning of lower volume services such as hospice care.**

   Engaging with multiple commissioning bodies, often with a variety of different commissioning and contracting arrangements is costly and requires significant resourcing by hospices. Collaborative arrangements between commissioners and hospices can help to improve efficiency for both providers of palliative and end of life care services, and for commissioners. Initiatives encouraging joint commissioning between health and social care sectors are important as hospices seek to deliver better integrated care. Nevertheless greater joint working can also happen outside of specific projects such as the Better Care Fund.

4. **Multi-year contracts and other funding arrangements, and earlier confirmation of funding, should be put in place as soon as possible.**

   Instability of funding impacts adversely on hospices’ ability to plan strategically and on confidence to make decisions about longer term investment. Commissioners should be encouraged to introduce multiple year arrangements, and to confirm funding agreements as early as possible in the commissioning cycle to help secure sustainability and give hospices the confidence to invest further in developing services.
5. **Commissioners should apply proportionate and intelligent practice to make appropriate commissioning arrangements for hospice care**

The complexity of commissioning arrangements, fragmentation of funding and the demands involved, which are often disproportionate to the funding received by hospices, have an impact on the services provided to patients, family members and local communities. Commissioners should be better supported in considering and implementing the most appropriate commissioning approach for their local needs.

The wider use of arrangements such as co-commissioning agreements would help promote innovation and strengthen partnership working between the NHS and local hospices.

6. **Guidance to commissioners on the flexibility available to them when making funding and contracting arrangements with hospices should be strengthened.**

Guidance from NHS England in relation to the NHS Standard Contract for 2014/15 specifically reminds commissioners that the contract is not always appropriate to be used where services are only partially funded. Nevertheless not all commissioners appear to be aware of this guidance. Strengthening of the guidance and further dissemination to commissioners and to Commissioning Support Units would help ensure commissioners are adopting appropriate arrangements in practice.

7. **The NHS Standard Contract should be further developed to more accurately reflect the true relationship between commissioners and hospices.**

The NHS Standard Contract for 2014/15 and associated guidance introduced a specific version of the contract for hospice services. This development is warmly welcomed as it has begun to reflect a more proportionate approach to this contractual relationship. Nevertheless the hospice contract retains elements which are neither applicable nor appropriate for hospices. Further development of the contract would help ensure an accurate reflection of the true relationship between commissioners and hospices.
Appendix 1 Analysis

Figure 1: Progress in statutory funding agreements for 2014/15

- No response: 6%
- No - funding levels still to be agreed with one or more NHS commissioners: 32%
- Yes - funding levels agreed and formal agreements signed: 15%
- Yes - funding levels agreed, BUT formal agreements not yet signed: 47%

Figure 2: Number of statutory commissioners, by hospice

- 0: 4% (n=4)
- 1: 28% (n=32)
- 2: 24% (n=27)
- 3: 12% (n=14)
- 4: 11% (n=13)
- 5: 6% (n=7)
- More than 5: 15% (n=17)
Figure 3: Number of statutory arrangements, by hospice

Figure 4: Change in funding levels from 2013/14
Figure 5: Perceived priority for palliative and end of life care

![Bar chart showing the perceived priority for palliative and end of life care. The chart shows the percentage of NHS commissioners and Health and Wellbeing Boards (H&W) for high priority, medium priority, low priority, not on their agenda, don’t know, and unreported.]

Figure 6: View of NHS commissioning in the future

![Pie chart showing the view of NHS commissioning in the future. The chart indicates the percentage of responses for seeing things getting better, much better, staying the same, getting worse, much worse, and not sure.]

- See things getting better: 15%
- See things getting much better: 2%
- See things staying the same: 18%
- See things getting worse: 37%
- See things getting much worse: 4%
- Not sure: 14%
- Unreported: 10%