

# Briefing

## THE CARE BILL SECOND READING IN THE HOUSE OF COMMONS MONDAY 16 DECEMBER 2013

### Summary

The King's Fund welcomes the Care Bill as an important stepping stone to wider reform of care and support. By modernising the legal framework for social care and implementing the recommendations of the Dilnot Commission on social care funding, it will significantly improve the way the current system operates and protect people from the catastrophic costs associated with long-term residential care.

However, the Bill alone will not solve the social care funding challenge, nor will it deliver the change needed to meet future health and social care needs. With the NHS and social care facing profound challenges, fundamental change is needed. Central to this is a more ambitious approach to aligning health and social care resources around the needs of patients and service-users. This is why The King's Fund has established an independent commission to explore whether, and if so how, the NHS and social care system should be brought closer together.

The Bill also includes measures to take forward some of the commitments set out in the government's response to the Francis report into the failures of care at Mid Staffordshire NHS Foundation Trust. Implementing the changes in response to the Francis report will require a culture change right across the NHS and will take place against a backdrop of severe financial pressure. In doing so, it will be important to recognise that regulation can only ever be a third line of defence against poor care – primary responsibility for the quality of care lies with frontline staff and hospital boards.

Our views on some of the key issues relating to the Bill are summarised below.

- We welcome the new duty on local authorities in the Bill and the other steps taken recently by the government to promote integrated care – this needs to be followed by much greater urgency at a local level to deliver integrated care at scale and pace.
- The creation of the Better Care Fund provides an opportunity to drive forward integrated care but will significantly increase financial pressures on NHS organisations.
- The introduction of a cap on the costs of care and the decision to implement the other recommendations in the Dilnot report is an important milestone and will protect people from some of the worst iniquities of the current system, but will not solve the social care funding challenge.
- We welcome the new regime set out in the Bill for managing provider failure and overseeing the social care market – this is a sensible response to the risk of business failure and the consequences of this for vulnerable service-users.
- While we support the extension of the trust special administration regime to cover failures in the quality of care, we are concerned that amendments added to the Bill in the House of Lords potentially create a back door route to service reconfiguration without public consultation or commissioner support.

- While we support the government's commitment to make more information available about the quality of services, a single aggregate performance rating for hospitals is too blunt an instrument and risks misleading patients by masking variation in the quality of different services.

## **Background**

The current social care system is inadequate, unfair and unsustainable, imposing significant human costs on service-users, their families and carers. The combination of unremitting financial and demographic pressures is undermining the Bill's aim of putting social care on a stable footing. The Winterbourne View scandal and recent concerns about the length of some home visits to provide people with care and support have also heightened concerns about the quality of social care.

2013/14 is the fourth consecutive year that local authorities have reduced social care budgets, with a planned reduction of £795 million contributing to a cumulative reduction of £2.68 billion over the past three years. Although councils have a strong track record of delivering efficiency savings, it is clear that their room for manoeuvre is now severely limited, with £104 million of this year's savings coming from the direct withdrawal of services. 87 per cent of councils now only respond to needs classified as substantial or critical under the Fair Access to Care (FACS) criteria.<sup>1</sup> The decision in the 2013 Spending Round to impose a further reduction in grant funding of 10 per cent in 2015/16 will add to these pressures.

As a result, the number of older people receiving publicly funded services has fallen by 26 per cent since 2009/10, with an equivalent reduction of 21 per cent among working age adults over the same period. Given the overriding imperative to provide care closer to home and reduce the need for residential care and hospital admissions, it is particularly worrying that the largest reduction has been in the use of community-based services, such as home care (down 25 per cent), compared to nursing home care (down 4 per cent) and residential care (down 1.7 per cent).

Looking further ahead, the prospects look even more challenging. Projections suggest that the number of people aged over 85 will almost double by 2030, with an additional 600,000 older people developing significant care needs over this period. The number of working age people with disabilities and long-term conditions needing care will also increase as life expectancy for this group continues to rise. Against this backdrop, it is not surprising that the House of Lords Select Committee on Public Service and Demographic Change concluded that the social care system faces a crisis.<sup>2</sup>

Our views on the key issues relating to the Bill are set out in more detail below.

## **Integrated care**

Clause 3 of the Bill places a new duty on local authorities to promote integrated care, mirroring the duties on NHS bodies in the Health and Social Care Act 2012. Delivering integrated care is essential to meet the needs of an ageing population and improve services for the growing number of people with long-term conditions. It offers significant opportunities, both to improve patient outcomes and experience, and to make more efficient use of resources by reducing waste, duplication and fragmentation.

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<sup>1</sup> *ADASS Budget Survey 2013*; Association of Directors of Adult Social Services, 2013

<sup>2</sup> *Ready for Ageing?* Select Committee on Public Service and Demographic Change, House of Lords, 2013

We therefore welcome the new duty in the Bill and the amendment made in the House of Lords to ensure that housing is seen as a health-related service for these purposes. Alongside the establishment of 14 new pioneer areas to lead the way in developing integrated care, the publication of a 'shared commitment' signed by a number of national bodies and the creation of the Better Care Fund (see below), this signals a much stronger political commitment to delivering integrated care.

However, progress locally remains variable. Anecdotal evidence indicates increasing interest in integrated care, with some parts of the country developing ambitious plans. However, our survey of health and wellbeing boards (HWBs) found that most have not identified integrated care as a priority – this highlights the need for them to take a much stronger lead in driving it forward locally.<sup>3</sup> There is also a pressing need to address the policy barriers that undermine the development of integrated care including the inflexibility of payment systems, the fragmentation of commissioning, the application of competition policy and the need for a single outcomes framework covering the NHS, social care and public health.

### **The Better Care Fund**

The 2013 Spending Round announced a new £3.8 billion Better Care Fund (formerly known as the Integration Transformation Fund) to create a single pooled budget for health and social care services. This will not comprise new money – £1.9 billion will come from allocations to clinical commissioning groups (CCGs), with the rest made up from a variety of existing funding streams. The money must be used to support adult social care services that have a health benefit and plans for spending it must be agreed locally by the CCG, local authority and HWB. Ministers have indicated that the government will table amendments to the Bill to place the Fund on a statutory footing.<sup>4</sup>

The creation of the Fund provides an opportunity to drive forward integrated care. However, it will result in an average reduction in funding for CCGs of approximately £10 million in addition to the money already transferred from the NHS to social care, adding significantly to pressures on NHS providers. Expectations about what it will achieve are high – national conditions that must be addressed in local plans include protecting social care services, relieving pressures on emergency care and ensuring seven-day working to support hospital discharge. Given this, it is critical that the Fund is used to support evidence-based initiatives that improve outcomes and provide good value for money. We will publish a guide in the new year to support CCGs, local authorities and HWBs in deciding how best to spend the money available to them.

### **Social care reform**

By modernising the legal framework for care and support, the Bill will significantly improve the way the current system operates. We particularly welcome the new duties on local authorities to promote wellbeing, prevention, and information and advice, including independent advocacy; the stronger framework for eligibility and assessment; and new rights for carers.

The Bill includes provisions to implement the Dilnot Commission's proposal to cap the costs of social care to the individual. This is an important milestone and a significant achievement in a daunting fiscal climate. Although the cap – which will be set at £72,000 from 2016 – is higher than the Dilnot Commission originally proposed, and will therefore help fewer people, the Bill provides for a five-yearly review, allowing future governments to lower it.

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<sup>3</sup> *Health and Wellbeing Boards: One year on*; The King's Fund, 2013

<sup>4</sup> *Health Service Journal*, 5 November 2013

The cap will protect people from the current lottery which leaves 1 in 10 people over 65 facing costs of £100,000 or more. Together with the increase to £123,000 in the upper threshold for receiving means-tested support, it should result in an additional 100,000 older people receiving public funding to help them meet their care costs. These will mainly be people with high care needs and modest assets. However, implementing the reforms will be challenging, with a high risk of confusion, complexity and complaints. Without a major public awareness campaign, there is a danger that many people may see the reforms as worse than the current system, rather than an improvement on it.

Implementing the Dilnot Commission's recommendations will not solve the social care funding challenge. As the Commission itself concluded '...the government must devote greater resources to the adult social care system. As well as funding for new reforms, additional public funding for the means-tested system is urgently required'.<sup>5</sup> The central challenge is to assess the total quantity of resources needed to ensure that people have access to the right level of support.

For many people it is eligibility for help, not protection from costs that is the primary issue. The Bill provides for the Secretary of State to set out the eligibility framework in regulations. Setting the national eligibility threshold at the moderate level would increase the number of people helped by 23 per cent. However, at an estimated cost of £2 billion, it is hard to see this happening in the current financial climate.

In the longer term, with the NHS and social care system facing fundamental challenges, it is time to re-examine whether the post-war settlement, which established largely separate systems for health and social care, remains fit for purpose. This is why we have established an independent commission, chaired by the economist Kate Barker, to explore whether, and if so how, the NHS and social care system should be brought closer together. The Commission will publish an interim report in the spring and a full report in the autumn.

### **Provider failure and market oversight in social care**

Private and voluntary providers now account for 92 per cent of all residential care and nursing home places,<sup>6</sup> with 89 per cent of home care hours outsourced by local authorities.<sup>7</sup> This reflects a long-term trend away from NHS and local authority provision which began in the 1980s. However, this has not been accompanied by adequate policy or regulation to protect individual care arrangements from the consequences of business failure.

In recent years, the sector has generally been stable and the number of business failures relatively small. However, as the case of Southern Cross illustrates, the emergence of very large national providers does raise the spectre of disruption and discontinuity in services for large numbers of vulnerable people. The ADASS budget survey indicated that more than half of directors of adult social services expect providers in their area to face financial difficulty over the next two years as a result of local authority budget savings. So the need for measures to protect service-users from business failure has never been greater.

Clauses 49–58 of the Bill outline important new provisions which strengthen the role of local authorities in managing provider failure and give the Care Quality Commission new market oversight responsibilities. The extent to which these measures will be needed in practice will depend on how well local authorities discharge their new duty under Clause

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<sup>5</sup> *Fairer Care Funding*; The report of the Commission on Funding of Care and Support, 2011

<sup>6</sup> *Market Survey of Older People*; Laing and Buisson, 2013

<sup>7</sup> *Health Survey 2011*; Health and Social Care Information Centre, 2012

5 to promote the diversity and quality of services in the context of unprecedented financial pressures.

As new models of integrated care are developed, it is possible that some organisations – for example, a foundation trust that develops integrated social care services – will be subject to more than one failure regime. It will be essential that separate failure regimes do not create another obstacle to delivering integrated care.

### **Implementing the Francis report**

The Bill also includes measures to take forward some of the commitments set out in the government's response to the Francis report into the failures of care at Mid Staffordshire NHS Foundation Trust. Implementing the changes in response to the Francis report will be a long haul and will require a culture change right across the NHS. This will take place against the backdrop of severe financial pressure, with many NHS organisations already facing a difficult choice between whether to maintain quality of care or balance the books. In taking forward this agenda, it will be important to recognise that regulation can only ever be a third line of defence against poor care – primary responsibility for quality of care lies with frontline staff and hospital boards.

A regulation-making power to implement a new duty of candour on providers was added to the Bill at report stage in the House of Lords (Clause 80), strengthening the emphasis on transparency where safety incidents occur. Another regulation-making power was added to specify a body to set training standards for health care assistants and social care support workers (Clause 93). These standards will form the basis of the new certificate of care recommended by the Cavendish review, ensuring that health care assistants and social care support workers receive the support they need to provide high-quality, compassionate care.

### **The NHS failure regime**

Clauses 81–84 implement the commitment to develop a single failure regime, focused on quality as well as financial failure, set out in the government's response to the Francis report. The trust special administration process provides a clearer and more transparent way of dealing with financial failure than the previous practice of providing open-ended public subsidy. We support its extension to cover failures in quality – it is essential to increase the emphasis on tackling quality failure and ensure it is placed it on the same footing as financial failure.

The controversy earlier this year surrounding the temporary closure of the children's cardiac unit at Leeds General Infirmary highlights the difficulty in making decisions about failures in quality. As with financial failure, it will be important to focus on resolving quality issues before it becomes necessary to trigger the trust special administration process. With the new Chief Inspector of Hospitals responsible for triggering the process which is then led by Monitor, it will also be essential for the Care Quality Commission and Monitor to work closely together.

The government amended the Bill in the House of Lords to make it clear that a trust special administrator (TSA) can make recommendations about service changes in neighbouring trusts, not just the trust under their immediate jurisdiction. This follows the successful judicial review of the decision to downgrade the accident and emergency department at Lewisham hospital, recommended by the TSA as part of the reconfiguration of services in response to the failure of South London Healthcare Trust. The amendments (contained in Clause 118 of the Bill) also extend the time available to the TSA to make recommendations and clarify arrangements for public consultation and commissioner support.

We support the extension of the time limits for the trust special administration process – experience has already shown that the current timescales are inadequate. Clinical and financial problems often cross organisational boundaries, so we also support the principle that the TSA should be able to make recommendations affecting neighbouring trusts. However, by removing requirements to consult the public and secure the support of local commissioners in these circumstances, the amendments potentially open a backdoor route to service reconfiguration by enabling the Secretary of State to mandate change without the support of local commissioners or the public.

The trust special administration process provides a clearer and more transparent way of dealing with financial failure than the previous practice of providing open-ended public subsidy. However, it should only be used as a last resort. The emphasis should be on pre-emptive action and building a much deeper understanding of why trusts get into financial difficulties in the first place.

### **Performance ratings for providers**

Clause 89 amends the existing requirements on the Care Quality Commission in relation to its role in reviewing and assessing the performance of health and social care providers, paving the way for the new Ofsted-style ratings of hospitals and care homes announced in the government's response to the Francis report. The King's Fund welcomes the government's commitment to make more information available to the public about the quality of services and supports the use of comparative data as a driver of performance. However, a single aggregate performance rating for hospitals is too blunt an instrument.

The review of performance ratings commissioned by the Secretary of State from the Nuffield Trust was sceptical about the benefits of aggregate ratings for hospitals and clear that this would not help identify poor quality care.<sup>8</sup> Given the complexity of the services provided by hospitals, aggregate scores risk misleading patients by masking variation in the quality of different services. Rather than diverting resources to produce aggregate ratings, it would be far better to build on the welcome move to publish clinical outcomes by consultant for ten specialties by concentrating on making more information available at a service and specialty level.

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<sup>8</sup> *Rating Providers for Quality, a Policy Worth Pursuing?* Nuffield Trust, March 2013