Nuffield Trust Parliamentary Briefing

Care Bill: House of Lords Consideration of Amendments

The Care Bill is returning to the House of Lords in May 2014, for consideration of amendments from the Commons. This briefing from the Nuffield Trust, a leading health policy think tank, looks at the changes within our area of expertise which need the most intensive scrutiny by Peers. These are the new Part Four, which lays out the legislative basis for the Better Care Fund, and the amendments to the controversial clause 118 (clause 119 under Commons changes), dealing with the Special Administration process for NHS trusts. Key points include:

- The decision to make the Better Care Fund (worth £3.8 billion) available to joint health and social care projects from 2015/16 is an important step to enable better joined-up care for patients. However, this is not new money, and is largely redirected from the NHS. This has the potential to create serious financial risks for health services if Better Care Fund projects do not generate savings in the short run.
- Within the tight time frame laid out, projects under the Better Care Fund are unlikely to accomplish many of its key goals. In particular, they will not reduce emergency hospital admissions on the scale suggested. Factors behind the rise in emergency admissions are complex, and many have more to do with the NHS itself, rather than social care. Evaluation of integrated or community projects shows most have a very limited impact on reducing emergency admissions in the short run.
- Even where reductions are possible, the savings generated in hospitals will be a fraction of the money the Better Care Fund has taken out. The

implications of this may be an increasing number of hospital trusts facing financial failure.

- There have already been substantial cuts to social care services for older adults especially, and local authorities have mostly been targeting limited resources on those people with the most acute needs. Given the scale of the funding crisis in social care, there is a risk that the Better Care Fund could be absorbed into the social care funding gap, rather than invested in preventive services that might enable people to remain independent for longer.
- We do not believe the process laid out in Clause 118 is the right way to change services at financially healthy hospitals. The special administration process was designed for rare situations where financial problems at a hospital threatened services, and a rapid intervention was needed to safeguard patient care. A longer consultation process, with more public engagement, remains the most appropriate way to change hospital services on a regional level.

The Better Care Fund

The Better Care Fund provided for by the new Part Four of the Bill is an ambitious policy intended to support better joint working between NHS bodies and the local authorities which fund public social care. The fund will be set aside from the financial year starting April 2015, and will contain a total of at least £3.8bn, made up of £1.1bn of funds which the NHS already transfers to social care; £800 million of funds previously intended for capital investment and for social care related services like breaks for carers paid for by the NHS; and £1.9bn of funds which have simply been 'top sliced' from Clinical Commissioning Group (CCG) budgets for hospital, mental and community healthcare.

Local authorities and CCGs are responsible for agreeing plans to use this money, which Part Four will allow NHS England to ringfence and reroute to projects which meet Better Care Fund conditions. National conditions include joint plans; protection for social care services; seven-day support for patients leaving hospital or at risk of entering it; use of the NHS number across health and social care; and use of one accountable professional. Local Better Care Fund projects will be judged against national metrics including the rate of admissions to residential and care homes; reducing delays in transferring patients from hospitals to social care; and reducing avoidable emergency hospital admissions. Reports suggest councils and CCGs have already chosen to pool over £5bn, even more money than NHS England initially planned.

The Nuffield Trust believes that a long-term journey towards joint working of health and social care is necessary. Patients should get care wherever, whenever and however is most efficient and effective in promoting their wellbeing, without regards to institutional limits. Some changes through the Better Care Fund – in particular, better sharing of information - will drive real progress towards this. Overall, though, we have serious concerns about the Better Care Fund as it is currently planned. We urge Peers to look carefully at the assumptions on which it rests, and the risks it creates at a time of intense financial strain for the health service.

Implications for social care

Cuts to local authority funding have been steep, and social care budgets for all adults have been reduced. The cuts to services for older people have been significant, and fewer older adults now receive state-funded social care than in 2010. Councils have implemented these reductions by raising their eligibility thresholds for help: many people whose needs would once have been severe enough

to qualify for state-funded assistance now rely on family or private resources for their care. People who receive care in the community tend to have less acute needs than those in care or nursing home. As a result the number of people getting these services from local authorities has fallen sharply. For example, day care provision is down by 35 per cent. A recent Nuffield Trust and Health Foundation report laid out these cuts in full.

One of the national conditions for the way in which the Better Care Fund is used is that social care services must be 'protected'. Although the exact interpretation of this will take place locally, it implies that a large proportion of the money transferred to social care will serve to offset the ongoing cuts to existing services.

In itself, this is welcome – although as discussed below there is no reason that more provision of social care services will automatically reduce pressure on NHS services. However, as cuts to adult social care spending since the beginning of deficit reduction so far have been estimated at £2.8bn, it is very unlikely that new Better Care Fund transfers, even if they exceed the initial £1.9bn, will restore adult social care provision to the levels of 2010. Meanwhile, rationing by eligibility will continue to focus these services on the very neediest. While there are obvious and good reasons for this as a policy, it does not represent a way of using social care which is focused on prevention. Voluntary and family carers provide most care, and will have stepped in where public funding has been reduced. Providing targeted support to them is an example of how local authorities can act strategically to maximise their ability to help people. But with local authorities still facing rising demand and very difficult decisions on who to fund, they may struggle to spare any funding to support people before they develop the most critical needs.

Implications for health care finances

The introduction of the Better Care Fund is likely to intensify the problems with financial sustainability currently facing NHS and foundation trusts. These bodies, which provide mental, community, hospital and ambulance care, are seeing their financial positions deteriorate. Reports from oversight bodies showed that trusts overall were running at a deficit, for the first time since 2006/7.

There is cause for particular concern in the ambitious figures for reducing emergency admissions which have been put forward by NHS England in relation to Better Care Fund plans. Firstly, as set out below, these will almost certainly not be realised. Secondly, they suggest that there will be a particular emphasis on taking funding out of the acute trusts that run hospitals. According to the government oversight bodies, Monitor and the NHS Trust Development Authority, these already have the weakest financial positions of any type of trust.

Unlike local authorities, hospitals do not have the power to ration care by eligibility. This means that given the limited prospects for a reduction in the demand for urgent care, they are likely to face the obligation to treat the same number of patients as before, with significantly lower budgets. This could have troubling implications for their finances, and for pressure on waiting times in A&E and elsewhere.

The prospects for reducing emergency admissions:

NHS England has estimated that the implementation of the Better Care Fund will require a reduction in emergency admissions of 15 per cent. They assume that investment in projects combining social and other kinds of non-hospital care will enable far more patients to be cared for in these settings. The evidence suggests that this kind of substitution will not happen on the scale they have suggested in either the short or medium term.

The Nuffield Trust has evaluated more than 30 integrated care programmes, many of which had reducing urgent hospital admissions as a key goal. We have found little evidence of cost-effective reductions in hospital admissions from such initiatives. This is partly as a result of commissioners

being impatient for change in too short a timescale, and partly due to the initiatives themselves often not being well designed to fit in with other services. Where evidence exists from other countries, the reductions have taken three to five years to secure – far beyond the single year of the Better Care Fund in full operation that CCGs will have to balance their budgets. Successful integrated care initiatives rely on local understanding and trust, gradual changes to the way that organisations and professionals actually work, and time to fit their objectives into a framework that makes sense in the wider system.

The total proportion of all emergency admissions which could in any way be prevented by joint projects with local authority-funded social care is almost certainly much less than 15%. It should also be remembered that significant reductions in hospital staff and ward capacity would be needed before money could actually be taken out. Yet major investment outside hospital might need to be seen *before* the NHS begins a lengthy process of closing or downgrading services in certain areas. This raises the prospect of a period of time with overlapping 'double costs', which seems impossible in the current financial climate.

2. Changes to the powers of Trust Special Administrators

Special administration occurs when an NHS trust is effectively declared bankrupt by the Secretary of State or by the Foundation Trust regulator, Monitor. It is designed for exceptional circumstances, and has only been used twice. A Trust Special Administrator (TSA) consults patients, staff and commissioners to develop a set of recommendations, which may involve closing, downgrading or moving services. The Secretary of State (with Monitor in the case of Foundation Trusts) decides whether or not to approve them.

Last year, the South London Healthcare Trust Special Administrator recommended that the best way to balance services on a sound long-term footing across South London was to downgrade some wards at its financially healthy neighbour, Lewisham Healthcare Trust. The TSA was largely supported by the Secretary of State. This caused huge local controversy, and the High Court ultimately decided that the TSA and the Secretary of State did not have these powers. Clause 118 (or 119 if all Commons amendments are accepted) reverses this. It would specifically allow TSAs to recommend changes not only to the trust in special administration, but also to any other trusts where changes are "necessary" and "consequential" for their plans at the original trust.

Our concerns

The understanding of how the NHS works at a local level which forms the rationale for these changes is fundamentally right. Hospitals struggle financially, not just when there are failures in productivity or management, but when the wider system, which determines their funding and has a huge impact on the care they are asked to provide, is not matching supply to demand. Any realistic way to deal with their problems will mean looking at where money and patients go across a wider region.

Instead, our concerns are about the way changes to services would be made under this clause, and what this would mean for the relationship between NHS leaders, professionals and the public. There has long been a distinction between two different processes for changing hospital services. Closing or downgrading parts of a hospital in crisis could be done quickly under special administration, to reflect the urgency of finding a solution for patients. Regional or national programmes to close or downgrade parts of financially healthy hospitals, however, were a far slower process. They were usually led by regional or national NHS bodies over the long term, advised by professional bodies, involving consultation with patients, local people, and clinical staff. This distinction reflected the democratic and practical case for working hard to make sure staff and patients understood and, as far as possible, supported the way that their local NHS was to work.

The justification for curtailing the public engagement process in the case of a failing hospital is that it is for the public's own good: there is an urgent need to safeguard their care. This does not apply to the patients of a financially sound hospital, and yet under clause 118 they would have even less right to consultation than patients of a hospital in special administration. We would recommend that the normal service change consultation process should continue to be used for any changes to the neighbours of failing trusts.

Amendments 41 and 43A

Commons amendment 41 extends consultation rights to staff, commissioners, and local authorities at any other trust for which a TSA makes recommended changes. It is right that both staff and commissioners should be involved in any such decision. However, two key groups left unrepresented here are patients and the local public. Yet they are in many ways the most powerful groups in any local NHS system facing dramatic change, and arguably the groups with the strongest case for being consulted.

Amendment 43A, put before the House of Lords by Baroness Finlay of Llandaff, imposes a duty on TSAs to seek the continuation of services at affected trusts at a level decided by commissioners. This would probably act to discourage any use of special administration for major regional service change. 43A would also allow commissioners for trusts which would potentially be affected by a TSA's recommendations to open a consultation with patients and the public.

While this amendment would be a step forwards towards a more thorough and inclusive process, reflecting the duties of CCGs in securing services for their local populations, it still does not give patients or the public an automatic role in decisions. Nor does it guarantee a timescale long enough to ensure that the complex and always controversial process of large-scale service change is done properly.

evidence for
better health care

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