Parliamentary Briefing

Care Bill: Report Stage, House of Commons

The Nuffield Trust is an authoritative and independent source of evidence-based health service research and policy analysis. We aim to promote informed debate on health and social care policy in the UK.

The Nuffield Trust has provided in-depth briefing and analysis at each stage of the Care Bill, focusing on issues of social care reform, hospital oversight, and the hospital failure regime. This short briefing focuses on the key Report Stage issues of funding for social care, and new powers for Trust Special Administrators. Our other relevant publications include:

- Care Bill: Second Reading, House of Commons. This earlier briefing covers the Bill in more depth, including issues around ratings and the way regulators can deal with failing hospital trusts.
- Got a problem? Call 118. Our interim Chief Executive, Andy McKeon, blogs on Clause 118 (now 119).
- Evaluating integrated and community-based care: How do we know what works? This paper summarises over 30 evaluations of projects focused on people in care homes or receiving treatment in communities where they live. These projects typically aimed to take pressure off hospitals, but the research found that unplanned emergency admissions were not significantly reduced in the short run. We suggest that if success is possible it might take much longer than expected.
- Hospital and social care use by older people in England. This graph shows some evidence that use of care homes might help older people stay out of hospital.
- Health Committee Inquiry Submission: public expenditure. This evidence paper warns about the difficult financial situation facing hospital trusts.

Funding for social care [New Clause 9]

Key facts on funding for social care

- Currently, older people need to meet two tests to get state help paying for personal care. First there is a **needs test**: their problems must be severe enough to qualify for help. The threshold here is set by local authorities based on a four-point scale. Then there is a **means test**, set by central government: older people must have assets below a certain threshold (currently £23,250) to get help to live in care or nursing homes.
- Local government spending in England has been affected by the deficit reduction plan: it is set to fall by nearly 30 per cent between 2008 and 2015, according to the Joseph Rowntree Foundation. As the largest area of local authority expenditure, social care has accounted for a large proportion of the resulting cuts.
- Councils have responded in part by raising the needs test thresholds they use. The vast majority already use the second-highest threshold ("substantial need"), and some now use the highest ("critical need"). This allows them to save money by no longer having to support people whose needs are not the most severe. Many older people who need help washing or dressing, and would have received care from local authorities before, now only get care if they can fund it from their savings or it is provided by family members.
- Last year, 320,000 fewer people received care funded by local authorities compared to 2010 (according to the London School of Economics). The Nuffield Trust will soon publish work showing especially large reductions for day and home care.
- The Care Bill will mean more people qualify on the means test. It raises the asset threshold to £118,000, and introduces a headline private spending cap of £72,000. However, the Bill will not relax the needs test. The criteria for how severely people must need care to receive help paying for it will be set nationally. The Government intends to set them relatively high, so that many people who would have received publicly funded care before 2010 will remain ineligible.
- New Clause 9 introduces an annual report on whether social care funding is sufficient, produced by the "Joint Care and Support Reform Programme Board" including representatives of the Department of Health, councils and social services directors. It is backed by groups including the Local Government Association, many charities, and several care home companies.
- The intention of this clause is to explore the issues above, and to question whether there is enough money for high quality social care to be provided to new people included in the means test under the Bill. The report would also look at any knock-on costs of a restrictive eligibility policy on the NHS and social care further down the line.

Nuffield Trust position

There is cause for serious concern around the funding of social care. MPs need to ask what is happening to the many older people who have significant personal care needs, but who no longer receive local authority help. Are they paying for care themselves, relying on family members taking more time to care, or going without help altogether? Each of these three might have troubling consequences for the older people themselves, their family, the economy, and the health service.

In making the case for looking again at social care spending, though, MPs should be very careful about relying on the idea that higher funding would ease pressure on the NHS. There are some studies suggesting that intensive support in care homes may reduce hospital

admissions, including the Nuffield Trust work linked to above. However, it is not clear that supporting people to stay in their *own* homes automatically reduces hospital use, and the evidence for projects aimed at reducing admissions overall is patchy.

The Nuffield Trust has evaluated more than 30 initiatives in out-of-hospital care, usually looking at whether they have really had an impact on costs or service use in hospitals (also linked above). In the short term, we have found little sign that projects led by community or social care have achieved cost-effectiveness by keeping people out of hospital. Where programmes like this do seem to have worked in other countries, the effect has taken several years to filter through: success may require the courage to invest in the short term for results much later.

Because of these issues, MPs should look very closely at the key social care funding policy which will come in before the Care Bill takes effect, the Better Care Fund. This is a compulsory pooled £3.8 billion fund for local authorities and Clinical Commissioning Groups to use together. It will top-slice around £2 billion from the NHS budget to support social care services and improve co-ordination between sectors.

Although these are very important goals, the impact on NHS finances will be severe. The health service is very unlikely to see any savings from social care investment within a single year, let alone enough savings to offset the loss to its budget. Studies from bodies like Monitor already show trusts are slipping behind on key financial targets, and the extra loss of funding could potentially mean that more rationing of healthcare is necessary, and that more hospitals are at risk of closure or losing some services.

Finally, MPs should look at the big picture of the Care Bill's changes, and of spending on older people. We firmly support the introduction of the spending cap and higher asset threshold – they will end the unfairness of an unfortunate minority paying huge amounts for residential or nursing care. But by using extra funding to relax the means test instead of the needs test, this policy overall favours the wealthy with severe needs over poorer people whose needs are not as serious. There are good arguments on both sides about whether this is the best use of extra money in social care.

Across government, the Nuffield Trust, along with many other bodies, has pointed out the contrast between continued high spending on universal benefits for relatively well-off pensioners, and deep cuts to social care funding for those who need help. The IFS has calculated that a spending cap on social care for older people could be fully funded, at the much lower level suggested by the Dilnot Commission, by stopping winter fuel payments and free TV licences for better off pensioners. This would allow some of the currently planned funding to be used in lowering the needs test, allowing people to get help before they develop the most serious needs.

New Powers for Special Administrators [Clause 119]

Key facts on Special Administration reform

- Special Administration, introduced in 2009, happens 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, at South London Healthcare Trust in 2012 and at Mid Staffordshire Foundation Trust in 2013.
- A Trust Special Administrator (TSA) is appointed to make recommendations to keep NHS services going in the area. They must consult patients, staff and commissioners on these 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 Jeremy Hunt. 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 119 will ensure that the TSA, with the backing of the Secretary of State and Monitor if necessary, does have these powers. TSAs will be able 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.
- The introduction of this Clause created considerable controversy at Second Reading and Committee stage. In response, it was amended so that TSAs would have to publicly seek the written views of the staff, commissioners and managers of non-failing trusts.

Nuffield Trust position

Any realistic way to deal with the problems of effectively bankrupt hospitals will mean looking at where patients and money go across a wider region. But there are good reasons for the widespread concern that has greeted Clause 119.

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, and reflected the need to have multiple stages of conversation with patients, local people, and clinical staff.

Clause 119 sets in stone that the faster, less engaged process can be extended to make wider changes in hospitals. Trust Special Administrators, where approved by Monitor and the Secretary of State, can close or downgrade wards in financially healthy hospitals in less than a year, without the usual forms of patient engagement.

We welcome the amendments at committee stage, but although these expand engagement with staff and commissioners, they do not give patients and the public anything close to the opportunities to be heard which they have had in earlier widespread changes. The justification for curtailing the public engagement process in the case of a failing hospital is that it is for their 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 119 they 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.

Provider Ratings [Clause 90]

Key facts on provider ratings:

- Quality ratings for providers were not part of the Francis Inquiry's recommendations. However, the Nuffield Trust was asked by the Government last year to review this idea, and our conclusions fed into a system now being developed by the Care Quality Commission (CQC).

- The new Chief Inspectors of social care, general practice and hospitals will lead the rating process, which will be available to the public both for whole organisations and particular services.
- CQC has adopted more targeted inspections already in preparation for its new role, and is currently developing its first wave of ratings "in shadow form" awaiting legal authority.
- Clause 90 gives CQC the formal power to carry out and publish these ratings.

Nuffield Trust position:

Hospitals are made up of different wards, divisions and professional teams. Pockets of excellent and unacceptable care can exist anywhere – the Government and CQC's proposals rightly recognise that this means there must be separate ratings for different services inside hospitals. Alongside this, though, there will also be single ratings for whole hospitals. There is a danger that publicising these might either fail to highlight areas of failure, or fail to highlight areas where patients can receive the best care available.

The Nuffield Trust originally advised that because of this complexity, the hospital rating system should be given longer to develop than social care and general practice ratings. The decision to start with hospitals first, on a very short time frame, means CQC and the Government need to be cautious about relying on them as perfect reflections of quality. Given the intense media, political and public interest which will follow published assessments, there is a risk that the whole system of ratings might be discredited by a high-visibility early case where an assessment seems to get it wrong.

The more targeted inspections that have been adopted are a welcome step forward, and the Chief Inspectors are credible figures to develop this system. However, more time is needed for CQC to perfect surveillance activities so that it can spot more failures in real time, or before they happen.

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