

*Parliamentary Briefing*

# Care Bill: Second Reading, House of Commons

This briefing addresses the Care Bill in the form in which it will be read to the House of Commons on Monday 16<sup>th</sup> December 2013. It provides a brief summary and analysis of the parts of the Bill where the Nuffield Trust has particular expertise: social care funding reform, ratings for providers, management and accountability in the NHS, and the hospital trust failure regime. Key questions are given for each issue examined.

Key points

- The Care Bill paints an attractive picture of greater fairness, personalised care and services designed to achieve well-being. But it does so against a background of increasing pressure on local authority social care budgets, which have been cut by 7.5 per cent in real terms between 2010/11 and 2013/14. The number of older people receiving local authority funded social care services in the community has fallen from 958,000 to 714,000 between 2009/10 and 2012/13. Meanwhile, in 2011, 21 per cent of men aged over 65 and 31 per cent of women reported that they needed help with at least one activity of daily living, such as dressing or bathing, but received no help. There are legitimate concerns that, despite the bill's intentions, further cost-cutting will reduce the quality of care for vulnerable older people.
- The implementation of a cap for personal spending on care costs and a higher upper means test threshold for help with social care is a major step forwards. But the new spending which will support the new cap and means test threshold will only serve to substitute public for private spending. It will not provide extra care, and will not bridge the growing funding gap created by an ageing population and severe cuts to local authority budgets.
- An important development alongside these reforms will be the £3.8 billion "Integration Transformation Fund" announced by the Government for

2015-16. This will be a pooled budget between NHS and local authorities to support the principles in the Bill and improve coordination of services. Again, however, none of this is new money. It will be drawn from existing budgets and not add to the funds available for care.

- The controversial new powers for Trust Special Administrators, including the power to take action regarding an NHS Trust or Foundation Trust other than the one to which they were appointed, represent a centralisation of decision-making. MPs should consider what this says about where responsibility now lies in the NHS.
- Close scrutiny must be given to the potential that these powers will enable central bodies to curtail local debate over controversial reconfigurations involving closures, and to by-pass local commissioners and Health and Well-being Boards.
- The Duty of Candour is a positive step, but it will only contribute to a more open NHS if it is supported by a culture which is transparent and positive about feedback. There should be at least as much urgency about creating a culture of openness among national bodies. MPs should question why the duty will not apply to these bodies.
- There must be careful consideration of how the Care Quality Commission can develop to take on the task of financially monitoring large and specialist social care providers.
- The framework for the introduction of ratings for health and social care providers broadly reflects the recommendations of the Nuffield Trust Review, and we welcome its general principles. However, the value of a single rating for a trust or hospital is very limited – maternity has little in common with geriatric care. Greater emphasis should be placed on ratings for individual departments or services.
- It is important that the Care Quality Commission should be given time and space to develop a system of ratings in which the public and professionals can have full confidence.

## Part 1: social care funding and eligibility

A consensus exists among policymakers, across parties, that the current system of helping older people to pay for social care is unfair and unsustainable (Poole, 2009). The criteria for who gets help varies arbitrarily depending on place of residence. Furthermore, there is only a very limited element of risk pooling, which means that a minority of one in ten over-65s will face costs of over £100,000.

Meanwhile, pressure on funding is already intense, dominating forward projections for local authority budgets. Adult social care budgets have already been reduced by 7.5 per cent in real terms between 2010/11 and 2013/14 (Audit Commission 2013). The number of older people receiving local authority funded social care services in the community has fallen from 958,000 in 2009/10 to 714,000 in 2012/13 (Nuffield Trust, 2014, forthcoming).

Population ageing in the UK is set to accelerate, with almost one in four people likely to be over 65 by 2035. Many of these older people will need help with social care needs as they age. In 2011 21 per cent of men aged over 65 and 31 per cent of women reported that they needed help with at least one activity of daily living, such as dressing or bathing, but received no help. More money – private, public, or both – needs to enter the system in order to meet growing need (Commission on Funding of Care and Support, 2011).

The sections below set out:

- How needs-testing and means-testing are currently used in deciding who receives help paying for social care;
- Why this system is not sustainable;
- How need-testing and means-testing will operate under the provision of the Care Bill; and
- The potential limitations of these reforms.

### Needs-testing for public support with social care: how it works now

Each individual local authority is responsible for setting a threshold of need to determine who might receive public support in paying for social care. Local authorities use the Fair Access to Care Services (FACS) framework to define levels of need. Introduced in 2003, this has four bands: “Critical”, “Substantial”, “Moderate” and “Low” (see box 1).

#### Box 1: Eligibility for social care

The Fair Access to Care Services (FACS) framework for assessment was implemented in England in 2003. Its aim was to establish a more consistent national framework for assessing eligibility for social care. Critically, it did not seek to achieve a position where individuals with similar needs receive similar services across the country, as it was acknowledged that councils would take account of their local resources. The eligibility framework is graded into four bands, which describe the seriousness of the risk to independence or other consequences if needs are not addressed. The four bands are as follows:

- **Critical** – when life or health is threatened and/or vital social or work roles cannot be maintained, and/or serious abuse/neglect will occur.
- **Substantial** – the majority of care routines cannot be carried out, many social or work roles cannot be maintained, or abuse/neglect may occur.
- **Moderate** – several care routines cannot be carried out, and/or several social or work roles cannot be maintained.
- **Low** – one or two care routines cannot be carried out, and/or one or two social or work roles cannot be maintained.

Department of Health, 2002; 2010c

Local interpretation of these bands, as well as local discretion in choosing which bands serves as the eligibility threshold, has led to wide variations in access to local authority funded social care for people across England. A 2011 survey found that 82% of councils used the “Substantial” or “Critical” bands. This was an increase from 62% in 2005/6, with financial pressure likely to have been the primary cause of the change (ADASS, 2011; CSCI, 2008). As some councils still use the “Low” band, regional inequality in access is severe.

This trend towards setting higher needs thresholds has been driven by funding pressures on local authority budgets and rising demand from an aging population, causing local authorities to raise their threshold for eligibility to “substantial” or “critical” levels of need.

This has meant that more people are falling outside the system of public support when they are assessed as having “moderate” needs, even if they might have very limited financial resources to support themselves. Recent research showing that 31% of over-65s facing difficulties dressing and bathing received no help from any source is consistent with this (Vlachantoni, 2011).

The Government has announced that in 2015-16, £3.8 billion will be taken from a range of social care and NHS budgets to fund joint work programmes between the NHS and social care (the “Integration Transformation Fund”). One goal of this is to provide “protection for social care services” (LGA & NHS England, 2013). The ITF represents an understanding that social care spending reductions are taking place on a scale which risks increasing pressure on the NHS, as the conditions of people whose needs are not met worsen.

However, clear evidence of success in reducing emergency demand for hospital treatment by investing in social care has not yet been demonstrated. There is therefore a limit to how much of this funding can be used to support residential and home care for the elderly. Any substantial re-allocation of NHS budgets towards social care will mean a real terms cut for the health service. Yet the NHS already seems unlikely to meet the unprecedented savings targets it must meet to continue to meet demand even with a flat budget.

### **Means-testing for public support with social care: how it works now**

For those whose physical needs are assessed by local authorities through the FACS system as potentially eligible for public support, whether they get any funding depends on a subsequent assessment of their financial means. Under current law and regulations, eligibility criteria for financial support according to means are set centrally. Individuals who own more than £23,250 in assets are responsible for the full cost of social care, even if their physical needs have been assessed as being above the threshold set by the local authority. If the social care the adult requires is in their own home, then the value of their home is not counted towards this level: if they require residential care, then house value is included in this figure.

Between £23,250 and a lower asset threshold, now £14,250, eligible individuals are supported by their local authority on a sliding scale. For residential care, income which would pay for everyday living, for example from a pension, is used to pay full “living costs” – charges for accommodation, food and other essentials.

Assets including housing may still be used to make a contribution to pay for care itself, and to living expenses if the individual’s income is not sufficient to cover them. Below the lower threshold, assets are disregarded and the state contributes everything an eligible individual cannot pay from their income in residential care, and will provide free care if the individual lives at home.

This system has been justifiably criticised on several grounds. There is no element of “risk pooling” between individuals, meaning that the costs of care fall overwhelmingly on a minority who require several years of residential care: in 2009/10, one in ten older people was projected to pay more than £100,000 for care. The means test thresholds are well below the average price of housing (£165,586 across the UK as of April 2013 [Nationwide, 2013]), meaning that a significant proportion of those requiring social care have to sell their homes during their lifetimes to pay for care. In 2011, it was calculated that those with a median value of assets would face a total depletion of over 80% where they faced residential care costs of £150,000. The difficulty in predicting these costs has been pointed to as a disincentive for people to save in preparation for possible social care needs (Charlesworth and Thorlby, 2012: Commission on Funding of Care and Support, 2011).

### Needs-testing for public support with social care: how it will work under the Bill

Clause 13 of the Bill replaces the current system of individual local authorities setting the threshold which determines eligibility for help with social care according to need. Under its provisions, central regulations will specify what levels of need (or combination of needs) will be eligible for public support. The Government has said that these regulations will be announced following the 2013 Spending Round (DH, 2013a).

This is a major step towards a fairer system which allocates social care resources on a nationally consistent basis, rather than varying by place of residence. Effectively, control over the level of the threshold for eligibility will be centralised.

But everything hinges on the generosity of this new national definition of eligible need. The Joint Committee considering the Draft Care and Support Bill received evidence from a number of sources arguing that regulations should consider setting a national eligibility threshold approximately at the level of the FACS “Moderate” band (see above). These included written evidence from the Care and Support Alliance, Carers UK, and the England and Wales Law Society and the Voluntary Organisations Disability Group. These groups warned that individuals currently assessed as having a “moderate” level of need were often at risk of social isolation, with needs which could substantially reduce their quality of life if unmet and potentially result in more severe care and support needs developing which may be avoidable (Joint Committee, 2013).

However, given that local authorities are mostly and increasingly using the “substantial” band of need and continue to face considerable financial pressure, it seems unlikely that a national threshold could be set at a similar level to “moderate” without the need for a further substantial increase in spending, beyond what has been budgeted for implementing the cap and increased assets threshold (see below). The 2011 White Paper *Caring for our future: reforming care and support* noted the pressures facing local authorities and suggested that the national threshold would be similar to the “substantial” band (DH, 2012). Under current circumstances, this would result in 18% of local authority areas setting higher thresholds, with 4% setting lower thresholds.

Given this, it is important that consideration of the Bill includes an examination of how those who fall below the national threshold will be supported, and the knock on effects of no state support on health and social care in the future for a group of people whose needs are likely to deteriorate gradually, especially if no investment is made in prevention schemes. It is also important that local authorities apply the national eligibility criteria in a comparable and consistent way, as previous research has shown that there can be substantial variability in how local authorities understand and apply the current eligibility system (Fernandez and Snell 2011). Clause 1 of the Bill gives a general duty to local authorities to promote individual well-being through actions taken under the Bill’s care and support provisions. This includes a duty to have regard to the importance of preventing care needs from arising, and reducing all care and support needs individuals may have. It will be important

to establish the extent to which this is likely to include the support of individuals whose needs fall below the eligibility threshold.

### Key questions

- **Is there confidence that older people with moderate social care needs, who are likely to continue to receive no help paying for care, will be able to find and receive any support they might need?**
- **What are the likely “knock on effects” of a national decision not to give financial support to those with moderate care needs, including the costs to individuals, their carers, social services, and health services in future? How will these be monitored?**

### Means-testing for public support with social care: how it will work under the Bill

In July 2010, the Care and Support Commission led by Andrew Dilnot was tasked with making recommendations primarily addressing the issue of funding social care through a “partnership between state and individual”. In July 2011, the Commission presented its report, including a series of recommendations, to the Secretary of State (Commission on Funding of Care and Support, 2011). Those recommendations form the basis for the measures introduced in clauses 14 to 17 of the Care Bill.

The Commission recommended that for those adults whose needs were deemed eligible for publicly funded social care (see above), there should be a cap on the total amount that they might have to pay themselves. Once this cap had been reached, all their care would be funded by the state. For over-65s, they recommended this cap be set at between £25,000 and £50,000. They also advocated an increase in the upper limit of the asset threshold for state support in funding residential care should be raised to £100,000.

Clause 15 lays down the legislative basis for a cap to be established, to limit the financial burden on individuals whose needs are deemed eligible for support. It prevents local authorities from charging for carrying out their duties to provide care when asked (specified in Clause 18) once total charges exceed the cap. The Government has announced that the level of this cap will be initially set at £72,000 in 2016/17 (House of Commons, 2013a). Clause 16 gives the Secretary of State powers to adjust this in line with inflation or income growth.

Spending on social care by individuals will be counted at the rate which would be paid by the local authority – so if an individual chooses to pay above council rates for premium care, the extra money paid will not be included. The cap only applies to the costs of care, not for example the full costs of living in a care home. Spending on living costs will not count towards the cap.

Clause 17 sets out how local authorities will carry out financial assessments of assets to determine who is eligible for local authority help in paying for care. The level of the upper and lower capital limits will be set by later regulations: the Government has announced that the upper limit will be raised to £118,000 (House of Commons, 2013a).

These funding reforms are a positive step towards a fairer system, using the state to pool the risk of severe asset depletion faced by over-65s entering social care by setting a cap. They will help to give older people greater peace of mind about the costs of social care. It is hoped that this greater certainty may facilitate the growth of a private insurance market, and encourage more people to save for the costs of care in the knowledge that they will not see their assets massively diminished by costs from long-term social care which are outside their control.

However, it should be noted that because the reforms protect assets using public money, the cap will be of greater benefit to the wealthiest, who have most to lose under an uncapped system. There is also a possibility that new forms of regional inequality will be created due to the wide variation in average house price that exists in English local areas: analysis should be carried out to determine the extent of this.

The cap and increased threshold for the means test will reduce the risk of catastrophic costs to some individuals. The Government has committed to fund the reforms fully (DH, 2013b), and this is welcome and appropriate. But these reforms do not address the more fundamental problem of funding social care needs adequately, particularly given that many people will still not qualify for state support. It is important that there is a funding settlement which enables local authorities to meet their duties to fund social care of appropriate quality to those who need it and at the same time invest in measures to prevent people from deteriorating to the point that they need more expensive social care. This is key to ensuring that the new duties under Clause 1 to promote wellbeing, and to have regard to preventing and reducing need, can be implemented to real effect.

As discussed above, there is a consensus that local authority budgets for current duties to provide social care support are already underfunded, and that there is a growing gap between the reduction in funding and the increase in demand. A recent survey of adult social care directors at English councils found that their average target savings for 2013 were 6.3% (The King's Fund, 2013).

Although scope for increased efficiency exists, it is unlikely that it could account for savings on this scale (Charlesworth & Thorlby, 2012). Reflecting this, around half of adult social care directors told the same survey that the quality of care they commissioned had worsened in the last year, while over a third anticipated having to reduce services. There is a possibility of the situation reaching crisis point, at least in certain areas, well ahead of the implementation of the reforms included in the Bill. It is important that these facts are fully taken into account by the Government leading up to the social care funding settlement due to be announced as part of the June 2013 Spending Round.

Earlier work by the Nuffield Trust has shown that the decade from 2003/4 to 2009/10, a period of increasing funding for the NHS saw the health budget grow around twice as fast as the social care budget. Since 2010 sharp reductions in spending on social care for older adults have come alongside a ring-fenced budget for the NHS. In 2012, taking into account pensions and welfare, just 6% of total Government spending on older adults went towards meeting social care needs (Charlesworth & Thorlby, 2012).

It is not clear that this is an optimal balance, particularly given that there is evidence that reductions in social care funding for over 65s have been associated with increased pressure on other services, for example accident and emergency departments, primary care and inpatient care (NHS Confederation, 2012). The Government's decision in the 2010 Spending Review to move £1 billion over three years from the NHS budget to support social care was a welcome recognition of this, but political leaders should give further careful thought to the appropriate balance of future spending and strengthen the evidence to support these funding decisions.

A full understanding of the relationship between social care use and health service use is seriously hampered by poor data: it is not currently possible to track social care users across health services in national data sets, and almost nothing is known about people who fund their own care. We would encourage the government to enable much better integration of health and social care data sets and ensure that data about the health and wellbeing of self-funders and carers is also collected.

### **Key questions**

- **What will the implications be for access to, and the quality of social care services of continued reductions in local authority care spending before these reforms?**
- **What will the implications be for social care access and quality of the continued pressure on local authority care spending which is likely even after these reforms?**
- **Will these reforms ensure that the proportion of all public spending on older people which goes to social care is the right balance to maximise wellbeing and efficiency? If so what is the evidence for this right balance?**

## Part 2: care standards, provider failure, and Duty of Candour

### Single provider failure regime

Beyond the particular expansion of powers discussed above, clauses 81 to 84 of the Bill introduce a new, unified system for dealing with hospital trusts which are failing to maintain standards of quality, governance or finance. This would replace the current system where Monitor, which regulates the finances and governance of Foundation Trusts, the NHS Trust Development Authority (NTDA) which regulates the finances and governance of NHS Trusts, and the CQC which regulates quality each have different and separate processes to address failure (DH, 2013e).

Under the current system, Monitor has powers to place Foundation Trusts into special administration for financial or, in theory, clinical reasons, after consulting with the Secretary of State and other bodies. It must first send in a Contingency Planning Team to see whether financial problems can be solved and to draw up plans to continue care provision for the local population if the trust ceases to operate.

The Secretary of State has powers to place NHS Trusts into special administration in consultation with the NTDA. In both cases, Trust Special Administrators are then appointed to determine the future of the services provided by the trust. Special administration powers over Foundation Trusts and NHS Trusts have recently been applied in the high-profile cases of Mid Staffordshire NHS Foundation Trust and South London Healthcare NHS Trust (Harrison and Dixon, 2012: Monitor, 2013: House of Commons, 2013b).

The CQC's powers are more straightforward: it can simply declare providers or particular services within providers to be in breach of their registration conditions, and close them down. The Government has argued that the lack of intermediate stages, other than issuing warning notices, to ensure the continuation of care and explore options for the future of services contributes to a perception that this is in reality unlikely to happen to a hospital trust (DH, 2013e).

In his inquiry into the systemic failings at Mid Staffordshire hospital, Robert Francis QC suggested that Monitor, being primarily a financial regulator, had not given concerns about quality of care as much weight as concern about the financial health of the Foundation Trust. Meanwhile, he concluded that the Healthcare Commission, CQC's predecessor, had not been able to persuade Monitor to give its investigation into quality failures full backing (Francis, 2013).

The changes laid out in the Bill aim to remove these discrepancies and create an integrated system for dealing with failures of quality in hospital trusts. The intention is for there to be a "single version of the truth" when it comes to identifying failures in quality – that the Care Quality Commission will put together information on quality arising from ratings and its inspection activities with financial and governance information from Monitor and the NHS Trust Development Authority (NTDA) in an overall rating.

In order to ensure that these bodies work smoothly together, it is intended that there will be “one agreed national definition of quality consistent with the NHS Mandate and NHS Outcomes Framework”.

There are reasons to be cautious about the ease with which such a definition can be drawn up. Quality of care is multifaceted, and the types of providers and services highly varied. It may not be possible to come to a national definition or 'single version of the truth' unless it is relatively general and therefore risks being less valuable and impactful. There may be more consensus about the criteria for failure at whole institution or corporate level, but this will be much rarer than clinical failure in part of a provider, for example within a specific hospital department. Having a high level “single version of the truth” may mask instances of poor quality care in part of a provider, and clearly thought needs to be given for how a more granular picture of quality can best be portrayed to the public.

The new Quality Surveillance Groups, which share information and quality aspirations between different bodies at a local level, may be better positioned to provide nuanced views of quality, based on the most up to date information available. But unless care is taken, the views of the Quality Surveillance Groups may be at odds with an official ‘rating’ of the whole institution.

The mechanism for failure laid out in the Bill has three stages. Firstly, CQC will be able to issue a warning notice to hospital (or other types of) provider boards when it identifies inadequate standards of care. This will give a fixed period of time for them to improve, during which Monitor or the NTDA will use their powers to impose new conditions on the provider, potentially including the suspension or removal of their boards. Monitor is granted these powers in this situation under clause 82 of the Bill. The NTDA is already able to issue new conditions, and the escalation process they will use under the single provider failure regime is laid out in the recent 2013 Accountability Framework for NHS Trust Boards (NTDA, 2013). If at the end of the period CQC concludes that improvement has not been satisfactory it may require Monitor to appoint a Special Administrator, or request that the Secretary of State do so.

In our response to the 2013 Francis inquiry, the Nuffield Trust called for CQC and Monitor to work together more closely, but recommended against transferring Monitor’s responsibilities to the CQC (Nuffield Trust, 2013). We welcome these steps in that direction.

However, it is equally important that the two bodies work together closely outside this particular process, sharing information and developing a culture of co-operation. Because Monitor will remain generally focused on finance and governance, while CQC will remain focused on quality, it will be important for joint work that, as far as possible, criteria are clearly set out in advance.

In the case of a Foundation Trust, Monitor will now play an important role throughout the process of intervention where a provider is failing on quality. In issuing new licence conditions with the specific goal of improving quality where it has fallen below acceptable standards, Monitor will need to be confident in dealing with clinical quality and other aspects of patient care, and in time have confidence in the judgements of the CQC in this regard. Until such time that Monitor can depend upon the CQC, there is a need for clarity as to which organisation is responsible for ensuring that these issues are dealt with.

Clauses 54 to 58 of the Bill give the CQC further responsibilities relating to the finances of the largest social care providers – those which are defined as “too large to replace” and which could therefore cause serious harm to users if they collapsed financially. The criteria defining these will be laid out in regulations from the Secretary of State, taking into account size, market dominance and specialism. CQC must aim to ensure that they do not interrupt care due to financial failure by ordering them to

develop sustainability plans, and, optionally, ordering an independent business review. It has new powers to demand information from these care providers, and a duty to inform local authorities if it suspects they are at risk so that contingency plans can be made (DH, 2013d).

While these changes are welcome, it could be questioned whether CQC has the financial expertise to carry out these roles over and above Monitor. There is a risk that the new responsibilities could distract focus from the organisation's central concern, quality, and that failure to carry them out adequately might undermine credibility as CQC takes on a broader role through ratings. Just as Monitor may relinquish some of its activities to assess quality of care as CQC developed, so in time CQC might relinquish to Monitor financial oversight of large care providers.

### **Key questions**

- **How will nationally agreed quality standards reflect the diversity and complexity of services without being too vague or high level? Will Monitor and the NHS Trust Development Authority be supported in sharing information and developing links with the CQC outside of, and in preparation for, the single failure regime?**
- **Who is responsible for ensuring that these bodies are well prepared for joint working and are actually working together effectively?**
- **Is the CQC well suited to a financial oversight role with respect to large or specialised social care providers?**
- **Is Monitor well suited to take on a quality oversight role for hospitals subject to warning notices?**

### **New powers for Trust Special Administrators**

Clause 118 of the Bill contains important changes to the role of Trust Special Administrators (TSAs), whose crucial role in the failure regime is discussed above. It provides statutory backing for TSAs to formally recommend action at trusts other than those for which they have been appointed, as long as the activities of a neighbouring trust would be "necessary for and consequential on" the process of dealing with a failing trust (House of Commons, 2013c).

Effectively, this would reverse the implications of the recent High Court ruling regarding Lewisham Hospital. The court judged here that that the Secretary of State did not have powers to implement service reductions at Lewisham on the recommendation of a TSA at the neighbouring South London Healthcare NHS Trust. However, Clause 118 also has the potential to apply to cases even broader than this, making it possible for the failure regime to serve as a mechanism for "reconfiguring" services across entire regions – a process which is often controversial where it involves the closure and centralization of certain hospital services.

The clause also lengthens the periods which TSAs will spend drawing up their draft report and consulting with stakeholders (HoC, 2013c). These increases – to 60 and 40 working days respectively – are a welcome recognition that it is likely to become even more important for stakeholders to be fully involved, and complex issues fully understood, in cases involving multiple trusts. However, these periods remain far shorter and fewer than those typically involved in reconfigurations, where decision-makers have usually felt the need to work over multiple years (NHS Specialist Services, 2012).

It also stipulates that before taking action with regard to another trust, the TSA must gain the support of that trust's commissioners. However, in the case of non-Foundation Trusts, the explanatory notes to the Bill make it clear that later regulations will lay out how a TSA reporting to the Secretary of State can seek support from the national commissioning body, NHS England, instead. The notes also state that guidance to be issued after the Bill will provide further options for

occasions when the TSA cannot gain support from either local or national commissioners (HoC, 2013c).

These changes have the broad support of the NHS Confederation and the Foundation Trust Network, the bodies representing English hospitals. They believe it will often be necessary to make changes at a sub-regional or wider level in order to sustain services (NHS Confederation & FTN, 2013). However, they have the potential to enable a considerable centralisation of control over changes to services, expanding the role of Monitor and the Secretary of State. There is a tension between this and the more decentralised vision of the health service which was intended under the Health and Social Care Act of 2012.

The Nuffield Trust has recently argued that the Act resulted in a more fragmented governance system for the NHS, with signs of increasing power moving towards the Secretary of State (McKeon, 2013). The abolition of Strategic Health Authorities means that there are now no strategic leadership bodies at a regional level. Clause 118 transfers an important regional decision-making role to central bodies, and should be seen in the context of the wider question of who holds power and accountability in the health service.

Reconfigurations involving hospital closures will continue to be highly controversial and politicised, as has recently been demonstrated in Lewisham and in North-West London among other areas. In some cases Clause 118 may require the Government and Monitor to choose whether to give their backing to recommendations from a TSA in the face of overwhelming local opposition. This may not be feasible unless a political consensus develops which will take far longer, and involve far more stakeholders, than the process set out in this bill.

### Key Questions

- **Can the Government provide more information on the secondary legislation which will lay out what happens when a Trust Special Administrator recommending changes across more than one trust is not supported by either local commissioners or NHS England?**
- **Are the Secretary of State and Monitor prepared to support large-scale reconfigurations, which will remain intensely political, under the powers granted in Clause 118?**
- **Does this clause suggest recognition of a gap at the regional leadership level, and is a greater role for central bodies envisioned at this level more broadly?**

### Duty of Candour

Clause 80 of the Bill provides for the introduction of a Duty of Candour on all health and social care providers through the conditions they must meet from the CQC. Recommended by the Public Inquiry into Stafford Hospital chaired by Robert Francis QC, this provision will mean that when certain incidents occur which have an impact on the safety of patients or service users, those patients or service users must be informed by the organisation responsible (HoC 2013c).

The Department of Health will consult on exactly what types of incidents will be covered under the new duty. The Francis inquiry suggested a similar duty to apply to individuals: the Government does not intend to implement this but has announced that it will work with professional regulators like the General Medical Council to introduce a duty of candour into codes of conduct (DH 2013f).

The duty will be backed by the consequences of breaching CQC conditions, which could result in an organisation losing the right to provide NHS-funded care. The Government has also announced that

it will consult on whether the NHS Litigation Authority would withdraw indemnity cover in legal cases relating to patient care where an NHS provider has not been candid (DH, 2013f).

The Duty of Candour could play a useful role in supporting the move towards an NHS which is more open and transparent, and which sees feedback as an opportunity to improve. Making this a reality, however, will require us to secure broader cultural change. Robert Francis QC described how attitudes to quality at Stafford Hospital were characterised by “fear of adverse repercussions”, a punitive culture which discouraged confronting problems and feedback from patients and staff.

The Trust Board held primary responsibility for what happened at Mid Staffordshire NHSFT, but the Inquiry concluded that their tendency to minimise the visibility of problems and prioritise a small set of financial and waiting time targets reflected a widespread issue across the NHS (Francis 2013). Today, pressure on NHS bodies to meet targets remains intense, and narrow measures of waiting times are still perceived by many leaders in the service to be the first priority of central bodies including the Department of Health and the NHS Trust Development Authority.

Although the Duty of Candour is a clear statement of support for openness, MPs must be alert to the risks that inflexible, punishment-oriented performance management can push the other way as managers and care professionals are incentivised to conceal or downplay problems. There is a need for constant and careful scrutiny of the way in which NHS bodies are regulated and held to account, to make sure that pockets of negative culture are dealt with rather than supported by the wider system.

Given this, we question the apparent intention to apply the Duty of Candour only to providers, rather than to the regulators and commissioners who oversee them (House of Commons, 2013c). Firstly, this neglects the role of central bodies in ensuring an open system and their equal need to develop a clearer culture of admitting and confronting problems. Secondly, it risks sending a message to providers already under intense pressure that they have been particularly singled out as having a tendency towards a closed culture, perversely reinforcing the tendency to focus on fear of adverse repercussions instead of opportunities to improve.

### Key Questions

- **Does the Government recognise that the Duty of Candour can only be one contribution to the development of a more open NHS, and that rigid and punitive performance management carries the risk of undermining this change?**
- **Given this, is the decision not to extend the Duty of Candour to central bodies justified?**

### Assessment and Rating

In November 2012, the Nuffield Trust was asked by the Secretary of State to carry out a review into the possibility of rating providers of health and social care. We presented our report in March 2013, laying out the potential purposes, advantages and limitations of a ratings system, and suggesting principles regarding how it might best be implemented.

The provisions made in Clause 89 of the Care Bill provide the legislative backing for a process which broadly follows our recommendations (Dixon et al, 2013). Responsibility for carrying out assessments and reviews is given to the Care Quality Commission (CQC), the body responsible for making sure that health and social care providers maintain basic standards through inspection.

The clause provides for the Secretary of State to draw up regulations laying out exactly which services CQC will rate. These will be hospitals, GP practices, care homes, and domiciliary care services across both public and private sectors. (DH, 2013c). Clause 85, meanwhile, provides legislative backing for

the appointment of Chief Inspectors for hospitals, general practice, and social care. These have already been appointed by the CQC.

The Government's intention to use the three "Darzi domains" as a framework for selecting the quality indicators used in rating will provide a good basis for designing the system's inputs. These are effectiveness of treatment, patient or care user experience, and patient or care user safety.

As well as quality measurements, CQC will have the power to take account of indicators relating to the quality of governance and trust finances. While this breadth of input will help establish the key feature that ratings should be comprehensive, the Government and CQC must be alert to the possibility of aggregated ratings which reflect high general standards of care but conceal individual failures within organisations, or are simply unable to detect failures which are currently invisible to existing data collection systems. We welcome the intention to provide "dials" to allow a focus on individual specific areas of performance.

The Nuffield Trust Review noted that ratings can play an important role in informing patient choice and providing public assurance, among other roles (Dixon, 2013). This is particularly the case in social care, where we heard from both care users and providers that they felt that a reliable signal for quality was lacking (2013d).

For hospital trusts in particular, which operate across multiple sites and provide a range of complex services in different wards and units, it is important that service-level assessments are easy to find and understand, and that they make clear any limitations resulting from the fact that certain ward-level indicators are not yet available. This will be crucial for patient accessibility, and credibility amongst clinicians and the public (Dixon, 2013). There should be a commitment to making this process thoroughly robust before the activity of rating begins.

During the second half of 2013 CQC has already started to carry out inspections under a new framework designed for the purpose of drawing up ratings, as well as improving its previous function in guaranteeing basic levels of quality (CQC, 2013). Given this short time frame, CQC and the Government should see shadow and early full ratings as part of a longer-term sensible pathway to fully develop the ratings system over the next five years as information and data improves.

### Key questions

- **How are the Government and CQC ensuring that the system of assessment and ratings fully reflects the multiple domains and services within providers across which quality exists?**
- **Are the Government and CQC accept that best practice in inspection, alongside the best use of the information currently available, will not always be enough to detect serious failings in providers?**
- **How will the Government and CQC encourage public awareness of hospital ratings (including their important limitations in the first few years), and ensure that the system develops and retains credibility?**

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