

CHPI briefing on the Care Bill

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About CHPI

The Centre for Health and the Public Interest is a new, independent health and social care policy think-tank established in 2013. It aims to disseminate research to policy makers, health experts and the media and inform the public, setting out a view of health and social care policy in the UK in keeping with the founding principles of the NHS. So far the Centre has published reports on healthcare fraud in the new NHS, lessons from social care markets in England, health and social care integration,; personal budgets, mental health services, and pandemic flu preparedness.

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Introduction

1. The CHPI's analysis of the prospects for healthcare fraud in the new NHS and the lessons from social care markets in England, both published in 2013, identified 3 specific aspects of the Care Bill which require further consideration as the Bill is debated in the House of Commons. These are the Clauses within the Bill which seek to deal with particular aspects of market failure in health and social care:

- Preventing 15-minute care slots for recipients of home care services, and dealing with the lack of training and poor terms and conditions of social care workers (Clause 5);
- Dealing with the failure of a major provider of residential or domiciliary care - the "market oversight" powers granted to CQC (Clauses 49 – 58);
- Dealing with providers providing "false or misleading information" to regulators and the NHS – an opportunity to deal with the likely rise in health care fraud in the new NHS market (Clauses 90 -92).

Clauses designed to prevent "15-minute care slots" and to improve the terms and conditions of the social care workforce. (Clause 5)

2. In 2013 the Leonard Cheshire foundation found that a significant number of people in receipt of local authority-funded home care services were receiving their care in 15-minute slots. Concerns were also raised during the debate on the Bill in the House of Lords about care workers working without proper training. Social care workers often receive pay below the minimum wage and a significant proportion – more than half of all home care workers, according to Skills for Care – are operating on 'zero hours contracts'¹. The estimated 1.4 million care workers in England are unregulated by any professional body and, according to Skills for Care, fewer than half have completed a basic NVQ2 level qualification. Thirty per cent have apparently not completed any basic induction training. Many of these issues and other aspects of the operation of social care markets were covered in CHPI's 2013 report on social care markets².

3. During the consideration of the Bill in the Lords the government tabled two amendments to the duties imposed on local authorities when commissioning social care services in order to address these aspects of market failure:

Clause 5 (2) (f) was introduced to deal with zero contract hours and poor training and conditions for care workers. This places a duty on local authorities to have regard to:

"() the importance of fostering a workforce whose members are able to ensure the delivery of high quality services (because, for example, they have relevant skills and appropriate working conditions)."

Clause 5 (4) was introduced to deal with the issue of 15-minute care slots. This places the following duty on local authorities:

“() In arranging for the provision by persons other than it of services for meeting care and support needs, a local authority must have regard to the importance of promoting the well-being of adults in its area with needs for care and support and the well-being of carers in its area.”

4. By introducing these legal duties on local authorities when commissioning social care the government considers that many of the negative consequences of the social care market which have arisen over the past 2 decades will be addressed.

5. However, these provisions seek to deal with the poor commissioning practices of local authorities, rather than the practices of care providers themselves. Whilst the Bill does not currently specify that the Care Quality Commission will be able to review whether local authorities are meeting these duties, there were suggestions by the government spokesperson in the Lords (Earl Howe) that CQC will have the powers to conduct “thematic reviews” of local authority commissioning practices³. If so the CQC would, amongst its many other responsibilities, be required to assess whether local authorities are contracting for care services which are in 15-minute slots or whether care workers are being paid below minimum wage or on zero-hours contracts or are not receiving adequate training.

Issues for further consideration:

6. It has been noted that one of the main reasons why local authorities are commissioning care in 15-minute slots and from providers who pay the minimum wage and below is because of the reductions in their budgets – local authorities have reduced their care budgets by £2.68 billion over the past 3 years, despite rising need⁴.

7. Even if the CQC is granted the powers to assess how local authorities commission social care it is unclear whether this will prevent the practices from occurring. Often requirements such as those contained within Clause 5 have little or no impact beyond their declaratory intent. For example, under the Health and Social Care Act 2008 the Care Quality Commission had the duty “to protect and promote the health, safety and welfare of people who use health and social care services.” With the general purpose of encouraging “the improvement of health and social care services”. It is unclear whether this has led to increased protection for users of health and social care services since the CQC was established and these duties were imposed on it.

8. The proposed amendments from the government do nothing to address the structural problems with the care market, namely that there is an inherent tendency within competitive markets of this nature for workforce costs to be driven down as low as possible in order for providers to make a profit. In addition, low-cost provision and the rationing of care to “15-minute slots” allow local authorities to provide care to as many people as possible within constrained budgets, so there is a strong incentive for these practices to continue whilst

resources are tight. Indeed local authorities' obligations to meet the care needs of their resident population are made clearer under Clauses 18 -20 of the Bill.

9. Therefore it is unclear how imposing a "statutory duty" on local authorities, even if this could be effectively enforced, would deal with the underlying structural problems in social care markets and the reductions in the social care budgets for local authorities. Nonetheless the government is of the view that the current Clause 5 "would make it very difficult for local authorities to commission services in 15-minute slots where doing so undermines the quality of those services."⁵ Further questions should be raised about how this would operate in practice.

'Provider Failure' and Market Oversight Clauses 49 – 58

10. The Market Oversight regime proposed in the Bill empowers the Care Quality Commission to assess the financial sustainability of large providers of social care services. Where the CQC has concerns about the financial sustainability of a large provider the Bill provides the CQC with powers to require that a plan is put in place to deal with any issues of financial sustainability and to require an independent person to carry out a review of the business. The CQC must also inform a local authority if it considers that a care service in its area is likely to go out of business.

11. In addition, under these provisions of the Bill a duty is imposed on local authorities to meet the needs of any adult whose needs were being met by a registered care provider (a care home or a domiciliary care provider) which has gone out of business.

Issues for further consideration:

12. These provisions were included in the Bill as a response to the collapse of the Southern Cross care home chain in 2011, which put the care homes of some 31,000 people at risk of closing.

13. The government's own impact assessment assumes that 6 large providers will collapse over the next 10 years, potentially affecting 19,000 people⁶. The government is also concerned about the financing arrangements of a number of the larger care providers. In the impact assessment the government describes those corporate providers backed by private equity as being "highly leveraged and with highly complex capital structures" and also that "We are aware that many providers are carrying substantial debt, which are often structured in complex arrangements and the subject of covenant restrictions. Some of these debts will need to be refinanced over the next few years and, given the current circumstances in the wider economy, this will be challenging". It also acknowledges the risks due to consolidation; in terms of places in residential care, for example, the top twenty providers account for around 28% of the market.

14. Although no government-funded research has been carried out on the effects of care home closures on care home residents, two studies show that rapid closure has a significantly negative impact on care home residents – many of those who are transferred to new care homes die, whilst others suffer from increased “restlessness”⁷.

15. Moreover when private care homes are fending off financial collapse the quality of the care that they provide to residents diminishes – the facilities deteriorate, staffing levels are reduced and additional ‘services’ for residents such as outings or entertainment are cut back⁸.

16. However, despite the magnitude of the potential problem there is no provision within the current version of the Bill for the Government or the CQC to do anything to prevent the collapse of a major care homes business – it simply puts in place a financial surveillance system which will be undertaken by the Care Quality Commission, so that local authorities are forewarned of any financial difficulties which a major care provider may find itself in. The duty imposed on local authorities to look after those who were in receipt of care provider in effect provides a legal ‘backstop’ to deal with a major provider collapse, although it is assumed that local authorities would undertake this role anyway.

17. These are currently untested powers which have not been applied effectively in any other market, and it is not clear whether CQC has the ability or skills to take on such a role, partly due to the extremely complex nature of the financial arrangements underpinning the residential care home market, which according to Laing and Buisson is worth an estimated £12.4 billion in the UK⁹. Indeed, when questioned by the Health Committee about whether the CQC had the knowledge and skills to carry out such a role, the Chair of the CQC David Prior answered: “We do not have the financial skills that are required and it is highly unlikely that we would want to have them in house. These tend to be private equity companies with very complex capital structures. We will require external help to do that.”¹⁰

18. It is also unclear why a much more interventionist approach has been developed for providers of NHS care who get into financial difficulty, a role which will be undertaken by Monitor rather than the CQC. As Earl Howe noted in the debate on these clauses in the House of Lords, the purpose of the market oversight regime for social care providers ‘is to ensure that individuals continue to receive the services they depend upon during the failure of a provider’ whereas the proposed failure regime for providers of NHS care allows Monitor to ‘implement a special administration to take control of the provider’s affairs and directly manage the failure’¹¹. Yet the outcomes for patients and services users would not be substantially different.

19. Again, the clauses proposed by the government to manage, not prevent, a major provider collapse do nothing to deal with the structural aspects of the residential care home market which the government itself acknowledges is highly consolidated, highly leveraged and highly risky. It is unclear whether the same approach would be taken to similarly risky financial institutions providing acute hospital care and why the often older and more vulnerable people who are resident in these care homes should be more exposed to such risk.

False and misleading information (Clauses 90 – 92)

20. Clauses 90–92 of the Bill would make it an offence for providers of NHS care to provide false and misleading information in respect of information which they are required by law to provide. These provisions were introduced by the government following the publication of Robert Francis' report into Mid Staffordshire NHS Trust, where concerns were raised about the Trust providing accurate information to regulatory bodies.

21. Whilst these provisions are important in ensuring transparency and accountability in the provision of NHS care, they should also be considered as an important part of the tools available to government to deal with the potential for fraudulent behaviour in the new NHS market, which as the CHPI has pointed out is likely to increase as a result of the marketisation of NHS services¹². This was something that the government itself acknowledged in its impact assessment on these provisions, stating that “there are incentives for providers [of NHS care] to supply false or misleading information if otherwise it indicates their service quality is poor; e.g. to preserve its reputation and avoid consequences from regulators, commissioners and service users¹³”

22. Instances of providers of NHS care providing misleading information have already occurred in the new NHS market. The Public Accounts Committee recently investigated the provision of Out of Hours General Practice Services in Cornwall by Serco. The company, which held a contract worth an estimated £32m – were found by the National Audit Office to have altered performance data “with the result that the performance of the out-of-hours service reported to the primary care trust was overstated¹⁴”. They were found to have altered the performance data provided to the PCT on 252 occasions in 6 months in 2012, a fact which was only discovered after concerned Serco staff blew the whistle. In one instance, Serco falsely claimed that 100% of emergency callers received a face-to-face appointment within 60 minutes when in reality it was only 75%, falling short of the performance standard.

23. On the 22nd of April 2013 the Chair of the Public Accounts Committee branded Serco's behaviour as “lying and cheating”. She stated that she found it ‘disgraceful that Serco staff fiddled the figures on an astonishing 252 occasions between January and June 2012. This tampering presented a false, much rosier picture of its poor performance’ [...] She went on to say that ‘the PCT must be ready to penalise false reporting and services that fall short of essential standards¹⁵.’

24. Yet no sanction has been imposed on Serco for their behaviour and, other than a dent to its reputation, it has suffered no penalty.

25. In the context of Clauses 90-92 of the Care Bill it is important to note that the government only intends these provisions to apply to providers of secondary acute care (hospitals), so that they would not cover instances of fraudulent behaviour like that carried out by Serco or any other “Out of Hours” provider of NHS care, or any other provider of non-secondary care such as community services, which are currently being outsourced to the private sector¹⁶.

Issues for further consideration:

26. Given the absence of sanctions imposed on Serco for providing false and misleading information it is unclear why the government intends that Clauses 90 – 92 of the Bill should only apply to providers of NHS secondary acute care. As the Public Accounts Committee has found the opportunities for fraudulent behaviour apply across the new NHS market and consideration should be given to extending the coverage of these provisions to all providers of NHS care.

References

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