2015/6 National Tariff Payment System: National Prices Methodology Discussion Paper. A response from Care England

1.1 Care England, a registered charity, is the leading representative body for independent care services in England. Working on behalf of small, medium and large providers, Care England speaks with a single unified voice for both members and the whole care sector. Our membership includes organisations of varying types and sizes, amongst them single care homes, small local groups, national providers and not-for-profit organisations and associations. Between them they provide a variety of services for older people and those with long term conditions, learning disabilities or mental health problems.

1.2 Care England welcomes the opportunity to respond to this consultation and will focus on locally determined prices where there is no national tariff for continuing healthcare (CHC). Independent care homes provide care for people commissioned by CCGs using CHC funding. There are 57,000 people receiving CHC in England at a cost of around £2bn per annum.

1.3 Care homes are social care registered services but provide many services for CCGs including CHC, intermediate care, rehabilitation, mental health and learning disability services for example. Care homes are also commissioned by Local Authorities and self-funders and so represent complex funding environments. Many are small and it is important to remember that care homes are people's homes.

1.4 Care homes are seeing decreased lengths of stay down from an average 600 days to 200 days as a result of higher eligibility thresholds and people therefore being far more dependent on entering a care home. Particularly for CHC residents the care home will need to be able to respond to high clinical and social care needs, while ensuring a person is helped to live an independent life with dignity.

1.5 This is a sector that is dominated by people costs (most providers' staff costs are about 65% - 80% of total costs).Good, well paid, trained and empathetic carers are vital to ensuring the dignity of people living in care settings yet many staff are on a pay rate not hugely above national minimum wage and constantly reducing fees from statutory commissioners are making it more and more difficult to retain staff and ensure regular training and support for what are very responsible roles.

Consultation

What would you like to see from NHS England and Monitor to be confident that we are being transparent, evidence-based and consultative, and that we have assessed the impact of our proposals for the 2015/16 tariff?

2.1 In order for us to be confident in this regard, more could be done to promote mutual learning between care homes and CCGs and indeed NHS England and Monitor and the representative bodies for independent social care providers such as care homes and homecare providers. The general lack of understanding works to the detriment of positive contracting and working relationships especially between care homes and CCGs.

2.2 The lack of understanding can be seen in the continued references to either the NHS or healthcare exclusively, which neglects the role of social care and the providers who offer services that fall under this area. For instance, when discussing 'largely static commissioning budgets', this paper only makes reference to the NHS, without noting the funding pressures that the social care sector has experienced in the recent past, which have been far greater than those experienced by health.

2.3 This is worrying in the sense that local authority cuts of around 26% to adult social care, have resulted in many providers making the maximum number of efficiency savings possible over the last four years. Consequently, whilst NHS Foundation Trusts may be able to absorb a seemingly modest efficiency factor, it is almost certain that social care providers will not be – thus placing the sustainability of the social care market at risk.

2.4 We therefore welcome the comprehensive consultative approach that Monitor is taking in setting the efficiency factor in 2015/6, but caution that in setting such a figure, the organisation must consult with the social care providers who offer CCG commissioned services. We also welcome the fact that Monitor has started the consultation process early for the setting of the 2015/6 tariff and therefore hope that feedback – especially that of often ignored independent providers – can be taken into account.

Do you agree that admitted patient currencies in 2015/16 tariff should be based on the 2011/12 Reference Cost design, rather than the 2010/11 design?

2.5 We have no comment to make.

Do you agree with our preferred option of modelling national prices from updated cost data, rather than using a rollover? Please note that the decision must be consistent with the choice of currency design.

2.6 A model based on updated cost data, which discriminates between the size of different organisations when setting prices would be both preferable and more equitable.

Do you agree with our preferred option of developing the DH PbR 2013/14 model, rather than constructing a new model?

2.7 We have no comment to make.

Do you agree with our preferred option for updating the model inputs?

2.8 Yes, as it would enable a fairer and more consistent system.

What evidence would you want us to use in future years to be confident in our estimation of differential efficiency factors? Given current information constraints, do you agree with our preferred approach of estimating a single efficiency factor for 2015/16, based on data from the acute sector?

2.9 In the consultation document, Monitor mentions that the setting of an efficiency factor will continue even in 'the absence of tight funding constraints'. As mentioned in our response to the first consultation question, some providers have already made the maximum number of efficiency savings reasonably possible to continue running a safe service and should be rewarded for this. Moreover, commissioners should be looking to take advantage of these better value providers, rather than relying upon the use of incumbent ones, who may even be more expensive.

2.10 On page 10 of the consultation document, it is noted that one of Monitor's duties is to act with a view 'to preventing anti-competitive behaviour in the provision of NHS services which is against the interests of patients'. If Monitor decides to set a national efficiency factor, it will be going against this duty in the sense that social care providers will be asked to make disproportionate savings on top of those that they have already been required to make and this will therefore impair commissioners' duties to treat providers equally.

2.11 As we noted in our response last year, a continuous efficiency factor will undermine confidence and stifle innovation. If providers know that they will face a real-terms reduction in income year-on-year, regardless of how efficient their services are, existing providers will be discouraged from innovating to improve services and cut costs, whilst potential providers may be discouraged from entering the market at all.

2.12 If homes that provide CCG funded services such as CHC are discouraged from doing so, this will be bad news for the taxpayer as individuals who use such services, will be forced to rely upon more expensive, less personalised and arguably less efficient services.

2.13 Basing the factor solely on the data obtained from the acute sector would also go against the guiding principle espoused in the consultation document, which is to make more intelligent use of data. As a health and social care regulator, if Monitor is modelling its efficiency factor on the basis of only one of these areas, it is not making intelligent use of data and we would therefore not be in favour of either a single efficiency factor, or one based just upon the acute sector.

What might be the causes and drivers of leakage? What are the forms in which leakage might occur?

2.14 We have no comment to make.

Conclusion

3.1 The decision for too many providers will unfortunately be to no longer care for CHC funded residents as they will not be able to give the level of service required at the fees proposed and the residents will likely end up back in hospital at a far higher cost to the tax payer. Other smaller homes e.g. specialist LD homes where a large proportion of care is funded by the NHS are gradually being squeezed out of business.

3.2 Judicial reviews brought by care homes against local authorities have been won by providers as the judge said that the LA had to take notice of the true costs of care, and the impact on individuals of reducing fees had not been considered by the council. There are important lessons for CCGs from the

judicial reviews and its principles which are based on Building Capacity and Partnership in care and also apply to the NHS as a commissioner.