National Care Forum Submission to the Consultation on the Health and Care White Paper – March 2021

Who are we?

The National Care Forum (NCF) is the membership organisation for not-for-profit organisations in the care and support sector. NCF supports its 130 members to improve social care provision and enhance the quality of life, choice, control and wellbeing of people who use care services. We are the voice of the not-for-profit care and support sector.

1. Context

1.1. Our response has been shaped by input from our membership. We have responded to the sections of the white paper directly relevant to adult social care as well as those we feel will have an impact on the shape of any future reform or collaboration with health and local government partners.

1.2. The Committee asks about three important topics:

- will the proposals deliver integrated health & care services?
- the extent to which the White Paper delivers the necessary long-term plans for social care and the health and social care workforce
- and the proposals to confer additional powers on the Secretary of State for Health and Social Care

1.3. Our submission considers each of these points in some detail, but of course, the key point to make about the entire white paper is that it contains very little of substance in relation to the long-term reform of social care and the plans for properly funded, long-term investment in the whole social care system. It really was a missed opportunity to start to share the government's thinking and plans for social care, while at the same time, committing to a significant overhaul and restructure of the systems within the NHS which will inevitably absorb time, effort and resources at the expense of the long-term reform needed for social care.

1.4. The ambition outlined in the white paper to shift towards a new model of collaboration, partnership and integration is welcome as we have long argued for the importance of equity and parity between health and social care. However, we are concerned that the reform proposals focussed on the health system will constrain the integration possibilities between health and care. Without clear vision and detail for the combined reform of the NHS, Public Health and Adult Social Care alongside one another, the white paper's health will limit the potential and scope of future reform in both social care and public health, and ultimately prevent the creation of a system which looks at the holistic wellbeing, care and health of individuals. In particular, once the Integrated Care System model as presented in the White Paper is in legislation the bandwidth for the meaningful reform of social care will be significantly narrowed.

1.5. In summary, it was disappointing to find that the white paper was hugely focussed on health, with a real lack of substance in relation to social care and the people who use care and health services. It only talks about care in relation to those who have health needs. This will limit the potential for a preventative agenda, as health outcomes will be prioritised. It is also striking to see the complete absence of anything related to housing.

Summary of NCF Response

2. Will the proposals deliver integrated health & care services?

2.1. The ambitions for the ICS model have to be welcomed – who would not support the aims of improving population health and healthcare; tackling unequal outcomes and access; enhancing productivity and value for money; and helping the NHS to support broader social and economic development? The ICS model presents opportunities to join up health and care to bring it closer to the communities and people that need it and improve collaboration between all the partners and providers involved in making that happen. However, at present, the focus of activity, the governance proposals, the ICS model and the ambition in the white paper are far too health focussed and miss two key elements of the wider local health and care system – that of the organisations that design, create and provide social care and those who use it or will need to use it. See section 5 below.

2.2. The white paper does not say much about the commissioning of social care services in the new ICSs but does attempt to create more collaborative arrangements between health providers and health commissioners when suggesting collaborative commissioning and joint committee arrangements. Social care providers and those who need care and support should be at the ICS top table alongside Local Authorities (LAs) and NHS contracting authorities to design the services that they want to offer/ want to use. This needs to be written clearly and firmly into the governance arrangements to give a meaningful voice to providers, those who receive care and their families. This must include both self-funded and publicly funded recipients of care, and the providers who provide it, otherwise there will be a significant underestimation of need, and services will inevitably be procured that do not fully deliver what is required. All too often, LAs and CCGs begin to procure services based on affordability alone rather than first seeking to understand what the needs and preferences are of those in their area. This often also ignores those who self-fund their own care. This needs to change. See sections 7 and 8 below.

2.3. The proposals to introduce a new duty for CQC to assess LA's delivery of their adult social care duties is very welcome and long overdue but more detail is needed on what exactly this will involve in both the white paper and CQC's new strategy. There is a real opportunity here for the CQC to use its overarching regulatory power to ensure that the wider health and care system in localities is meeting the needs of the people and

communities they serve in terms of both the quality and choice of services available and in terms of the quality of commissioning practice. See section 12 below.

3. The extent to which the White Paper delivers the necessary long-term plans for social care and the health and social care workforce

3.1. The White Paper contains very little of substance in relation to the long-term reform of social care and the plans for properly funded, long-term investment in the whole social care system. It really was a missed opportunity to start to share the government's thinking and plans for social care, while at the same time, committing to a significant overhaul and restructure of the systems within the NHS which will inevitably absorb time, effort and resources at the expense of the long-term reform needed for social care. See section 6 below.

3.2. The White paper is also entirely silent on the very important issue of the social care workforce. See section 9 below for our suggestions.

3.3. The forthcoming Data Strategy for Health and Care must be co-created with social care providers as well as users of care and support services. The proposals in the white paper certainly identify the problems in term of consistent and accessible data for social care, but a better solution is needed. It isn't enough for DHSC to simply centralise data collection. Care must also be taken to recognise the different 'data philosophies' in social care and the NHS. See section 10 below.

4. The proposals to confer additional powers on the Secretary of State for Health and Social Care

4.1 We note the proposals to extend the Secretary of State's existing power to directly pay not-for-profit health and care providers to all care providers. This is presumably informed by the challenges during the pandemic of directing funding to the frontline of social care and the limitations experienced by having to channel money via LAs. We welcome the proposals but note that the paper is silent on the wider challenge, which is the reform of social care and resolving the systemic problems that exist in current funding and commissioning of social care. See section 12 below.

4.2 And we note the extension of other powers, which include:

- Giving the Secretary of State for Health and Social Care more intervention powers with respect to relevant functions of NHS England.
- A more flexible mandate for NHS England, which will make it easier for the Secretary of State to set objectives for the body.
- A provision to allow the Secretary of State to intervene in local service reconfiguration changes where required

5. Integrated Care Systems (ICSs) - seeking to integrate health and care

5.1. The ambitions for the ICS model have to be welcomed – who would not support the aims of improving population health and healthcare; tackling unequal outcomes and access; enhancing productivity and value for money; and helping the NHS to support broader social and economic development? The ICS model presents opportunities to join up health and care to bring it closer to the communities and people that need it and improve collaboration between all the partners and providers involved in making that happen. However, at present, the focus of activity, the governance proposals, the ICS model and the ambition in the white paper are far too health focussed and miss two key elements of the wider local health and care system – those who use it or will need to use it and those organisations that design, create and provide social care.

5.2. The Health and Care White Paper seems to conflate the role of Local Authorities (LAs) and the role of the adult social care sector, suggesting that they are one and the same and that the formal representation of LAs in the governance arrangements of the ICS NHS Board and the ICS Health and Care Partnership means that the diverse views of social care will be represented. It is important to remind the government that the social care sector is much more diverse than LAs – the conflation of the commissioners of adult social care with those actually providing and receiving care and support is a common, but important, mistake.

5.3. The focus of LAs is often on serving those in need of publicly funded care, but their wider market shaping duties do mean that they should also be working collaboratively with other partners to encourage and facilitate the whole market in their area for care, support and related services and market – including those who fund their own care. Sadly, this is often less of a focus for LAs. LAs certainly cannot adequately represent the breadth of provider provision and the voices of all those receiving care and support. The current model will skew the representation of social care towards the views of the commissioners. The recent consultation on the governance arrangement for ICSs did not offer much comfort for the voluntary, not-for-profit adult social care sector and the people they serve since neither of them include any formal role or meaningful voice for the sector in the decision-making processes. Only the statutory organisations of the NHS and LAs currently have a clear role. Consequently, there is the risk that LA and health commissioners will agree to arrangements, or services, which are undeliverable, ineffective, or inappropriate, based on the funding constraints of the LA, or NHS, rather than being tailored to the needs of those receiving care and support. It is important to get this right because LA's have significant duties in shaping local social care markets.

5.4. We welcome a more clearly defined role for social care within the governance arrangements of the ICS NHS Body. It is essential that the voice of social care is strengthened in the ICS model. The governance must be broader than just the LA and

NHS bodies. As it stands, the ICS NHS Body is a consolidation of CCG commissioning powers focused on integrating health providers, with input from LA commissioners. As is the problem with the wider white paper, the focus is too often on how social care can facilitate the objectives of the NHS, rather than how health and care work together to improve the outcomes and experience of those receiving care and support. Indeed, the goals of the ICS NHS Body (5.7 of the white paper) and the Triple Aim (5.17 & 5.18 of the white paper) are all centred on health provision, resource management and health outcomes. There is nothing about social care. Social care must be seen as an equal partner in the ICS model - not merely as the handmaiden to the priorities of the NHS[1].

5.5. Experience of the Lansley reforms tells us that the integration of NHS organisations into the new ICS models is likely to take priority over the integration of the wider system. By the time CCGs are absorbed into the new system and primary care rearranged, along with the organisational politics that will engender, plus then the inclusion of LAs within that system, we wonder about the capacity, vision and appetite to truly involve social care? The voice of social care is needed at ICS NHS Body level in order to prevent resource and strategic decisions which do not prioritise the long-term care and support needs of a local population. The integrated care system in Manchester which first took form in 2015 took several years before even GPs were fully involved and social care is still only being represented by many NHS or LA representatives[2].

5.6. The ICS Health and Care Partnerships are clearly designed to address the concerns raised above and encourage wider system integration. However, it is not entirely clear how much influence these will have. 6.19 of the white paper states 'Each ICS NHS Body and local authority would have to have regard to' the plan developed by the partnership… but 'it would not impose arrangements that are binding on either party'. The voices of those receiving care and support, and social care providers are already marginalised in the current arrangements – these new arrangements do not propose anything that would radically change that. We would suggest that the governance surrounding the ICS Health and Care Partnerships need strengthened and the goals of the ICS NHS Body made more ambitious. Currently the goals do not address the holistic wellbeing of a population and their long-term care and support needs – the overall ICS model is a key opportunity to create meaningful collaboration with social care and other local partners and the people it serves.

5.7. There is overlap in the roles of the ICS Health and Care Partnerships and the existing Health and Wellbeing Boards. The rationale for keeping both is not entirely clear, nor is the relationship between the two, particularly as both the ICS Health and Care Partnership and ICS NHS Body must 'have regard to Health and Wellbeing Board plans' (white paper 5.101). It would be helpful to understand better how it is envisaged that they will work together to improve the outcomes and experience of people who use

[1] https://blogs.lse.ac.uk/politicsandpolicy/nhs-white-paper/
[2] https://www.gmhsc.org.uk/about-devolution/partnership-agreements/

care and health services.

5.8. The effectiveness and representative nature of the plans developed by ICS Health and Care Partnerships depends on who is part of the partnership. As stated above the ICS model proposed here does not give a formal role to adult social care providers and those who receive care and support. We understand the desire to avoid being overly prescriptive in legislation about who would be expected to sit on such partnerships in order to encourage local relationships and flexibility. Nevertheless, total localism without some mandated national structure seems likely to bring a postcode lottery of quality and effectiveness. We suggest a standard national framework and model for the membership of ICSs that mandates the involvement of the voluntary, not-for-profit adult social care sector and the people they serve which gives them a clear role in decision-making, governance and accountability. Without this safeguard, there will be a patchwork of local arrangements that will not support the ambition of the ICSs to meet the needs of their population properly in terms of care as well as health.

5.9. We would suggest that the following need to be considered when formulating governance arrangements and guidelines for the ICS Health and Care Partnerships[3]:

- Create a defined and funded role for local care associations and provider forums in the partnerships
- Create a defined role for the various residents and relatives' associations
- Intentionally seek out the voices of marginalised people who may not belong to one of these associations on a periodic basis – such as Personal Assistants or unpaid carers.
- If there are no established groupings, there may be the need to invest time and resource, alongside LA partners, to support providers to come together into an association.
- Work with the ten national associations, which make up the Care Provider Alliance which can offer support and advice at a strategic level, each bringing a particular focus and expertise to different parts of the sector.

5.10. The balance between localism and centralism is a difficult one to strike. Throughout the pandemic, we have seen the best of localism, usually where relationships across social care, health and local authorities are already strong, and we have seen the worst of it, with silo working and multiple barriers to ensuring people get the very best care where and when they need it. ICSs must build on the best and prevent the worst and be held publicly accountable for both.

[3] Adapted from initial thinking around Sustainability and Transformation Partnerships https://careprovideralliance.org.uk/assets/pdfs/cpa_publication_on_stp_engagement_170915.pdf

5.11. The care sector has, in recent years, provided its thinking in relation to Sustainability and Transformation Partnerships (STPs), the fore runners to ICSs[4]. The four key principles highlighted remain as valid now for ICSs as they were then for STPs and we would strongly urge the government to apply them to the ICS model and governance arrangements:

- Guidance to ICSs should highlight the need for them to engage proactively with the independent and voluntary adult social care sector; and that a formal expectation that they will do so should be created. The proposals in this white paper go some way towards this but there needs to be more than simply a requirement by the ICS NHS Body to 'give regard'.
- Funding should be made available, either centrally or from individual ICSs, to support the engagement of the independent and voluntary adult social care sector at an ICS level
- There should be a progress dashboard for ICS should include indicators of the performance of adult social care services in the ICS area; and of how well health and adult social care services are working together; and of whether the ICS has engaged with the independent and voluntary adult social care sector
- The CPA should be funded by the Department of Health and Social Care to maintain a national overview and coordinating role

6. Long-term reform of social care – entirely absent from the White paper

6.1. The White Paper contains very little of substance in relation to the long-term reform of social care and the plans for properly funded, long-term investment in the whole social care system. It really was a missed opportunity to start to share the government's thinking and plans for social care, while at the same time, committing to a significant overhaul and restructure of the systems within the NHS which will inevitably absorb time, effort and resources at the expense of the long-term reform needed for social care. The White paper is also entirely silent on the very important issue of the social care workforce. We would like to see both investment in social care and investment in the social care workforce front and centre of the government's reform plans.

7. Invest in Adult Social Care to ensure it has sustainable funding and contributes to economic recovery

7.1. The social care system immediately needs additional funding of at least £7bn per year in England to simply stand still and deal with demographic changes, the fallout of the pandemic, uplift staff pay with the National Minimum wage and to protect those facing catastrophic social care costs.[5] Longer-term, significantly more per year is

[4] This was produced in 2018 by the Care Provider Alliance which brings together the 10 main national associations which represent independent and voluntary adult social care providers in England. https://careprovideralliance.org.uk/assets/pdfs/cpa_select_committee_submission_180118_final.pdf.

[5] As pointed out by H&SC – Social Care: Funding and Workforce report 2020

required to create a social care system that is sustainable, accessible to everyone that needs it, provides the best care possible and removes the perverse 'cross-subsidy' for private funders created by the underfunding of publicly funded care packages. We need a system that enables people to live to their full potential and contribute fully to their communities and wider society.

7.2. So far, the government has fallen woefully short in addressing current funding pressures. The government increased funding to social care by £1bn per annum (split between adult and children's social care) following the December 2019 General Election[6]. An additional £1bn was promised as part of the Spending Review in November 2020 but only £300m of this was being funded by central government and was again split between adult and children's social care. The remaining £700m is to be raised by Local Authorities increasing the social care precept.[7]

7.3. This a fundamentally ineffective and unfair way to fund social care because poorer areas have more people eligible for publicly funded care but less capacity to raise money for it. Further emergency injections of cash into the system through the various iterations of the Infection Control Fund as well as the Rapid Testing Fund and the Workforce Capacity Fund while a welcome sticking plaster, do not offer a sustainable solution to the funding pressures. We are disappointed to see that adult social care was completely absent from this year's Budget. Urgent action is required to address this.

7.4. Investment in Adult Social Care will bring many benefits for society beyond improved care for those who need it. In 2018, Skills For Care found that the economic benefit of the care sector in England alone was £38.5bn[8]. Social care is very much a local enterprise, providing local employment in local areas, bringing the economic benefit of local wages spent in local shops and businesses, supporting local supply chains and paying local taxes. It is time for government policy to recognise social care as a vital contributor to the economy.

8. Recognising and addressing the ongoing challenges

8.1. The increasing pressure on LA budgets has resulted in a reduction in spending per person on adult social care services by around 12% in real terms between 2010/11 and 2018/19 (taking into account an ageing population)[9]. This is resulting in a postcode lottery in terms of access to care and choice of care as LAs grapple with their funding pressures.

8.2. These funding pressures inevitably puts the focus on the those with the most acute need for care, reducing the ability to enable preventative care and an earlier offer of

[6] The Conservative Party Manifesto December 2019 – Pg 12.
[7] Spending Review November 2020
[8] https://www.skillsforcare.org.uk/About/News/News-Archive/Contribute-38-billion-to-English-economy.aspx
[9] https://www.health.org.uk/publications/long-reads/health-and-social-care-funding

help and support to those for it may well prolong independence and delay the increasing acuity of need.

8.3. The current funding and commissioning of social care presents real challenges to the individuals who need to use care and support services and their families. The focus of LA and CCG commissioning practice has, for many years, been to drive down the price of care, using things like Dynamic Purchasing Systems for bidding to provide packages of care, which restricts choice and puts huge pressure on the quality of care available. They encourage a race to the bottom in terms of cost and quality of care. In our view, they should **never** be used in the procurement of care services. This commodification of social care has done little to support a truly person-centred approach based on the needs, wants and circumstances of those who need it most. The proposals in the white paper do nothing to fix this.

8.4. The current funding system also puts huge burden on those who need care and support and are able to pay for their own care and support under the current means testing arrangements. It is perceived to be fundamentally unfair and creates a huge uncertainty and anxiety about the future costs people may incur and creates a complex system around costs of care at precisely the time when care is needed urgently, often as a result of a crisis. Unlike in the NHS, whether people receive help from the state depends not just on their level of need but also on their wealth. For those who need care and have assets worth more than £23,250, they will have to pay for it, and this includes the value of their house if they have one and if they need to choose a care home to meet their needs. So, while some older people will live the rest of their lives without needing social care, a significant minority – those with intense care needs extending over many years – may face hundreds of thousands of pounds in costs.

8.5. This is exacerbated by the unofficial 'cross subsidy' effect faced by many people who have to cover the costs of their own care as the state's commissioning approach is driving down the fees that the state pays for those who cannot afford to pay for their own care, which is resulting in an increase in costs for those who can. Analysis from the Kings Fund[10] highlights that '*this cross subsidy can be significant: on average, a* self-funder's place costs around 40 per cent more than one paid for by the local authority'[11].

8.6. Long-term funding reform must enable a fair price for care for all those who need to buy it. It must include the key essential components of providing high quality care that supports peoples' wellbeing and choice and also appropriately recognises and rewards the workforce that deliver it. It is essential that funding reform delivers a fair system which meets the needs and expectations of the millions of people who need to rely on it and one which rewards properly the 1.5m who work in social care.

[10] https://www.kingsfund.org.uk/projects/positions/adult-social-care-funding-and-eligibility
[11] https://www.nao.org.uk/report/adult-social-care-at-a-glance/

9. Invest in the workforce to create a professionally skilled workforce, properly valued, better paid, with more training and development.

9.1. Investing in social care also means investing in the workforce. This will bring a range of strong economic and quality benefits as well as enabling social care employers to pay social care workers what they are actually worth.

9.2. Great care needs great people to provide it. Investment is essential to create a dedicated, fully funded People Plan for Social Care that complements and augments the NHS People Plan. We need to develop a clear career progression, better recognise and value staff, invest in their training and support, and introduce professionalisation and registration where this is appropriate. This will improve our ability to recruit and retain high quality, skilled social care staff with the right values and our ability to grow innovative models of support, as well as to develop and recruit a workforce that reflects and understand the needs of communities being served.

9.3. The pandemic has shone a spotlight on the social care workforce vis-à-vis the NHS workforce. Both are comparable in terms of numbers (social care is slightly bigger) but the former is much less supported, rewarded and recognised. This needs to change.

10. Maximising the power of data in social care - the Data Strategy for Health and Care must be co-created with social care providers as well as users of care and support services

10.1. The first wave of the pandemic highlighted just how little data central government and local government held about adult social care – and in particular those who self-fund their care. In response, DHSC adopted the Capacity Tracker and various local authorities created their own equivalents, all seeking to collect data from, care homes at first, and now the wider adult social care sector, in order to inform the response to COVID-19.

10.2. The white paper seeks to build on the Capacity Tracker on this by consolidating and centralising data collection from adult social care providers for DHSC and other parts of the health and social care system. The proposals in the white paper certainly identify the problems in term of consistent and accessible data for social care, but we must learn from the issues with the Capacity Tracker and find a better long-term solution is needed. It isn't enough for DHSC to simply centralise data collection. Care must also be taken to recognise the different 'data philosophies' in social care and the NHS. The sorts of data desired by NHS commissioners and clinicians will be very different to that desired by LA commissioners and social care providers – we need to ensure that the correct data is being captured.

10.3. There is important research work going on in the DACHA study[12] which aims to create a minimum data set for care homes. It aims a) to establish what data need to be in place to support research, service development and uptake of innovation in care homes and b) to synthesise existing evidence and data sources with care home generated resident data to deliver a minimum data set (MDS) that is usable and authoritative for different user groups (residents, relatives, business, practitioners, academics, regulators and commissioners). Both the government and the Select Committee need to understand that this important work is underway and the data strategy needs to be informed by it.

10.4. We need more robust data collection and analysis which involves both social care providers and those accessing care. Improved data collection requires resource and a focus on the right data at the right time with a rounded analysis. Social care has been locked out of that during the pandemic with the Capacity Tracker data which is supplied by the sector being unavailable to us. This is a real opportunity to build a shared view of what data matters and for us all to use it to improve what we do and create more informed procurement and commissioning practices. We need an approach which engages the whole sector in a specific locality, including those using care services now (both self-funders and publicly funded) and those who may need to use it in the future and their families.

10.5. The forthcoming Data Strategy for Health and Care must be co-created with social care providers as well as users of care and support services.

11. Discharge to Assess and the Better Care Fund

11.1. We note the proposals to place a legal framework for a 'Discharge to Assess' model, whereby NHS continuing healthcare (CHC) and NHS Funded Nursing Care (FNC) assessments, and Care Act assessments, can take place after an individual has been discharged from acute care. This will replace the existing legal requirement for all assessments to take place prior to discharge.

11.2. Experience shows however, that the most important ingredient in successful Discharge to Assess models are good levels of funding to support this process, real choice for the individuals concerned and a strong, collaborative relationships between commissioners and care providers. The emphasis must be on person-centred care and choice. In our view, the quality of the discharge process is the most important as aspect of the model.

[12] Developing research resources and minimum data set for Care Homes' Adoption and use (DACHA). It is a collaboration between the Universities of Hertfordshire, Cambridge, East Anglia, Newcastle, Leeds, Nottingham, Kent, Exeter, Glasgow; The Health Foundation; and the National Care Forum; led by Professor Claire Goodman, University of Hertfordshire (Chief Investigator). https://arc-eoe.nihr.ac.uk/research-implementation/research-themes/ageing-and-multi-morbidity/amm01-developing-resources-and

12. CQC Duty to assess LAs and additional powers to Secretary of State

12.1 The proposal to introduce a new duty for CQC to assess LA's delivery of their adult social care duties is very welcome and long overdue and we look forward to more detail on what exactly this will involve. Better assurance and oversight of the way LAs commission and fund social care is important, especially in the context of the CQC draft strategy, which proposes a greater focus of regulation to improve people's care by looking at how well health and care systems are working and how they're acting to reduce inequalities. It is, of course, important that the CQC, and this white paper, recognise and understand the extent to which providers actually have the necessary powers to effect change in this regard. We note the proposal also that the Secretary of State takes the power to intervene where, following assessment under the new CQC duty, it is considered that a local authority is failing to meet their duties.

12.2 We note the proposals to extend the Secretary of State's existing power to directly pay not-for-profit health and care providers to all care providers. This is presumably informed by the challenges during the pandemic of directing funding to the frontline of social care and the limitations experienced by having to channel money via LAs. We welcome the proposals but note that, of course, that the paper is silent on the wider challenge, which is the wider reform of social care and resolving the systemic problems that exist in current funding and commissioning of social care.

12.3 And we note the extension of other powers, which include:

- Giving the Secretary of State for Health and Social Care more intervention powers with respect to relevant functions of NHS England.
- A more flexible mandate for NHS England, which will make it easier for the Secretary of State to set objectives for the body.
- A provision to allow the Secretary of State to intervene in local service reconfiguration changes where required

For further information or a conversation, please contact:

Liz Jones, Policy Director Liz.Jones@nationalcareforum.org.uk

Nathan Jones, Senior Policy, Research and Projects Officer:
Nathan.Jones@nationalcareforum.org.uk