NCF Briefing: Health and Care Bill – Final Stages

This is an updated version of the National Care Forum's (NCF) briefing on the Health and Care Bill following the completion of the Third Reading in the House of Lords. The list of amendments by the House of Lords to the Bill can be found here. The amendments made by the House of Lords will be considered by the House of Commons on 30.3.22 and possibly 31.3.22.

This briefing is based upon the feedback of our membership, conversations with the NHS and DHSC teams implementing ICSs and the debates in the Houses of Parliament. The House of Lords has made a number of significant changes to the Health and Care Bill, many of which we support and would urge MPs to support. We have also included our thoughts on a number of other aspects of the bill which were not amended during the parliamentary process but which we feel need addressing.

Who we are

The National Care Forum brings together over 160 of the UK's leading social care organisations, representing large numbers of care providers, offering thousands of services across the country, **which are not-for-profit** and always at the heart of community provision. Collectively, these organisations deliver more than £2.3 billion of social care support to more than 218,000 people in over 8,200 settings. The NCF membership body collectively employs more than 117,000 colleagues.

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Our Position

Our aim is to ensure that adult social care – both the providers of it and people drawing upon it – have a much better presence in the legislation and any subsequent guidance, as well as better influence within the new Integrated Care System (ICS) landscape as a whole. The Bill has been disappointingly silent on social care, despite being framed as seeking to better join up health & care at a local level for better population outcomes. Some of the amendments made by the House of Lords to the Bill attempt to fix these oversights, but issues with the legislation remain.

We are concerned that the legislation, even in its amended form, will fail to properly deliver the ambition of better integration, and is in danger of entrenching in legislation an unequal relationship between adult social care and the NHS, where the latter always has priority. This danger has been reinforced by the publication of the Integration White Paper which has conflated Local Authorities with social care and other local partners. It neglects crucial system partners: social care providers. Together, the Health and Care Bill, Integration White Paper and Adult Social Care White Paper, make ICSs the lynchpin of the entire reform agenda – particularly at 'Place' level – but crucially do not give social care (or those accessing social care) a voice in the new systems. The power remains with NHS and LA commissioners.

It remains our view that:

1. Local authorities cannot fully represent the voice of social care on their own.
2. Many people receive social care support in their local area in order to live their lives to the full. Social care providers have a unique insight into population health and wellbeing, essential for strategic planning, as a result.
3. Historic workforce shortages in social care have a significant impact on population health and wellbeing, as well as contributing to pressures on the NHS. Amendments to introduce a level of workforce forecasting and planning are much needed and welcome but can only ever be the beginning. We need a dedicated plan for social care.
4. There are significant levels of unmet need due to a lack of investment and workforce planning in social care. Integration must not become a substitute for adequate funding.

We noted with disappointment the repeated references to 'permissiveness' throughout the debates in both Houses of Parliament as a reason not to have some basic requirements for representation from social care in the Integrated Care Partnerships (ICPs), Integrated Care Boards (ICBs) and other bodies at lower levels of the ICSs.

Debates around the membership of Integrated Care Boards and Integrated Care Partnerships in the House of Commons were unfortunately stuck on the issue of private sector involvement due to a number of MPs apparently interpreting the Bill as an 'NHS Privatisation Bill'. Let us be clear, in our view this Bill should not be seen as an attempt to privatise the NHS. It is also worth noting in the debates about the Bill that key NHS Primary Care services, such as GPs and Dental Surgeries are technically private sector. A representative of Primary Care will sit on the ICB, why not also a representative from Social Care?

In the Lords, debates about membership of ICBs centred on mental health parity with physical health and we welcome the inclusion of an amendment to add a member with mental experience and knowledge to the ICBs in light of this.

Nevertheless, social care will not have an opportunity to bring its innovation, problem solving, insight and value to the table if the system does not have mechanisms to guarantee representation. Current governance arrangements mean that representatives from social care are in danger of being frozen out of the key strategic planning partnerships. Only in those areas where there are already good working relationships will a permissive approach work. Many other areas will simply carry on the status quo. In our view, some level of prescription is actually needed to enable culture change and ensure that all organisations work together for the benefit of people accessing services in a system. **Social care providers are not just a set of commissioned services** – they are key and equal partners and need to be at the heart of the strategic planning for local health & care systems. At this point, the legislation is not going to change but we would call on parliamentarians to push the government to ensure that any guidance makes it clear that there is an expectation to ensure there is appropriate social care representation at every level of the ICSs.

Social care providers need to be recognised as leaders in integration, and, as we are seeing very acutely in some areas, the effective functioning of the NHS and health system in local areas is hugely dependent on a robust, sustainable social care sector.

Below we have given our view on some the clauses which have been amended by the Lords, as well as some clauses which were previously amended by the Commons and others which we are disappointed were not amended. All clauses and page numbers below relate to the Bill as it looked when it **first entered the House of Lords.**

Clause 21 - Integrated Care Partnerships and strategies

Clause 21, page 28-31

This clause establishes Integrated Care Partnerships. It **was not** amended by the House of Lords.

NCF View

As stated above, we were disappointed that serious debate was not given in either House to ensure that representatives from adult social care providers were included in the ICS structures. Significant numbers of people will be receiving social care support in any given area, therefore social care needs representation to reflect the importance of its role in the lives of the population of the area as well as the insights brought from a social care perspective. Guaranteed representation will help change a culture in many areas where social care providers are not listened to or consulted. At the very least there must be an expectation in any formal guidance and in CQC's regulatory framework that ICPs contain social care representation beyond that of the Local Authority.

We also feel that the duty 'to have regard to assessments and strategies' should have been strengthened so that the integrated care strategies created by Integrated Care Partnership are not simply disregarded by saying existing strategies 'are sufficient'.

Schedule 2 – Membership of Integrated Care Boards

Pages 136-142

Schedule 2 contains information about the constitutions of ICBs, including information about the membership and how members are appointed. Each ICB must have a Chair, a Chief executive and at least three other members to include:

- one member nominated jointly by the NHS trusts and NHS foundation trusts
- one member nominated jointly by persons who provide primary medical services
- one member nominated jointly by the Local Authorities whose areas coincide with, or include the whole or any part of, the ICB area

We note, and welcome, the Lords' amendment to ensure a further member *'with expertise and knowledge of mental health in the integrated care board's area'.*

NCF View

We would like to see social care representation beyond that of the LA commissioner. We note that primary care services will be represented, which will include GPs, dentists, etc. – all private providers to the NHS. In order for social care to be acknowledged and listened to, social care providers need a similar level of representation at the top of the system. We would ask local systems to consider this when establishing their ICBs. The inclusion of mental health experience is welcome and we would point out that many social care providers provide support that is instrumental to the people's mental health.

Clause 26 – Care Quality Commission reviews etc of integrated care system

Clause 26, page 37-38

Clause 26 was added during the Commons' Committee Stage and is a welcome recognition of the need to regulate and review the ICS as a whole system, rather than just its component parts. This answers one of the key asks we presented to MPs. The Adult Social Care White Paper chapter on Local Authorities contains more detail about what this might look like but we await further detail from CQC. The Clause requires CQC to publish a report on each ICS area with some form of 'indicator' measuring how it is performing. We assume this will be similar to a 'rating system' currently in place for other parts of the system. It would be left to CQC to determine how frequently to inspect. The reviews would focus on how well the ICBs, ICPs, LAs, NHS Providers, Social Care, VCSE and other system partners are working together to further integration in the delivery of integrated services. We would hope that these reviews would also add another incentive for ICBs and LAs to ensure there is representation on the ICPs from a diverse range of key stakeholders, including social care providers. This clause should be considered in conjunction with clauses 137, 138 and 139.

Clause 35 - Report on assessing and meeting workforce needs

Clause 35, page 42

The House of Lords has introduced a very welcome amendment to this clause, which replaces lines 14 to 19 of page 42 with:

"The Secretary of State must, at least once every two years, lay a report before Parliament describing the system in place for assessing and meeting the workforce needs of the health, social care and public health services in England.

(2) This report must include—

(a) an independently verified assessment of health, social care and public health workforce numbers, current at the time of publication, and the projected workforce supply for the following five, ten and 20 years; and

(b) an independently verified assessment of future health, social care and public health workforce numbers based on the projected health and care needs of the population for the following five, ten and 20 years, taking account of the Office for Budget Responsibility long-term fiscal projections.

(3) NHS England and Health Education England must assist in the preparation of a report under this section.

(4) The organisations listed in subsection (3) must consult health and care employers, providers, trade unions, Royal Colleges, universities and any other persons deemed necessary for the preparation of this report, taking full account of workforce intelligence, evidence and plans provided by local organisations and partners of integrated care boards."

NCF View

We support this amendment and would ask MPs to back it as well. This amendment would require the Government to publish independently verified assessments every two years of the current and future workforce numbers required for NHS, Social Care and Public Health to deliver care to the population in England, based on the economic projections made by the Office for Budget Responsibility, projected demographic changes, the prevalence of different health conditions and the likely impact of technology. This will be a major step forward towards a comprehensive people plan for adult social care, which is joined up with NHS workforce planning. Adult social care has not had a dedicated workforce plan since 2009. Until this happens, we will continue to see workforce shortages and crises periodically over the coming months and years.

We note that the government's Integration White Paper also fails to tackle the need for a dedicated social care workforce plan. This is not something that can be planned or fixed from Place level. It is a nationwide systemic issue. This amendment puts us on the right track.

Clause 80 + New Clause after - Hospital patients with care and support needs: repeals etc

Clause 80, page 70

This clause appears to have been introduced as part of the move towards Discharge to Assess and Home First, aiming to get those admitted to hospital back to their own homes before any decisions on long-term care arrangements are made. While we support the principles behind Discharge to Assess, we are concerned that simply repealing these pieces of legislation will have unintended

consequences, particularly as it involves repealing duties in relation to the requirement for a needs assessments before discharge from hospital in the Care Act.

The House of Lords has listened to some of our concerns and has introduced a new clause after Clause 80 to protect carers:

*"**Carers and safe discharge from hospital***
(1) This section applies where—

(a) a person ("the patient") is a qualifying hospital patient at a hospital, and
(b) the responsible NHS body considers that it is unlikely to be safe to discharge the patient from hospital unless care provided by one or more carers is available to the patient.

(2) It is the duty of the responsible NHS body to—

(a) consult the patient about their preferences regarding their care following discharge from hospital, and
(b) take reasonable steps to identify and consult any carer or potential carer of the patient about to be discharged.

(3) The NHS body must consult any carer or potential carer identified under subsection (2) to ascertain—

(a) whether the carer is able, and is likely to continue to be able, to provide care for the patient needing care, and
(b) whether the carer is willing, and is likely to continue to be willing,

to do so.
(4) Having consulted the carer, the NHS body must cooperate with the local authority in relation to their duties under the Care Act 2014, the Health and Care Act 2006 and the Children Act 1989.

(5) For the purposes of this section—

(a) a "qualifying hospital patient" means a person being accommodated at—

(i) a health service hospital, or
(ii) an independent hospital in pursuance of arrangements made by an NHS body,
who is receiving (or who has received or is expected to receive) care.

(b) a "carer" means any person, including any child under the age of 18, who provides or intends to provide care in respect of a patient to whom the NHS may provide services, but a person is not to be regarded as a carer if they provide or intend to provide care under or by virtue of a contract, or as voluntary work."

NCF View

We support this amendment as it adds safeguards around the proposals in Clause 80. However, we are still concerned about unintended consequences from Clause 80:

First, not everyone admitted to hospital for the first time will be able to go home – they may develop high needs suddenly or have been missed earlier in the system. The aim to move people home before they get an assessment in this scenario will not work and might result in multiple moves for people with high needs.

Second, if we want Home First and Discharge to Assess to work, we must ensure that community health teams and social care teams are sufficiently resourced and flexible to provide care when needed and that any needs assessment takes place as soon as possible after the individual is discharged. There is a danger that the removal of an assessment prior to discharge will result in less priority to undertake the assessment once someone has left hospital – for someone needing support to remain in their own home, this is concerning and puts pressure on families and unpaid carers (something the government's own impact report acknowledges). We must ensure that there is a person-centred approach, which involves the individual in deciding what their care will look like.

Third, the current workforce crisis in social care will make it very hard to meet the ambitions of Home First and Discharge to Assess. It is clear that these policy ambitions simply cannot be delivered without a shared endeavour to tackle the workforce pressures that care providers are facing and the long waits for assessments for individuals. Families and unpaid carers will struggle if an assessment takes months.

Long-term strategic planning is needed about the funding of community and social services and the recruitment to roles currently in short supply.

Clause 137 – Regulation of local authority functions relating to adult social care

Clause 137, page 112-113

This clause was introduced in the House of Commons and gives CQC the ability to regulate Local Authority (LA) functions relating to social care. In conjunction with clauses 138, 139 and 26, this is very welcome. We also welcome all that has been set out in the Adult Social Care White Paper on this new power.

NCF View

We welcome the regulation of Local Authority functions relating to social care – for too long the role of poor commissioning practice has not been recognised and the benefits of excellent commissioning practice have not been championed. We await further detail from CQC on what this might look like. The legislation suggests there would be a mechanism for CQC to inspect and issue a report and an indicator of performance – something akin to the rating system in place for providers.

We must also ensure the voice of the person receiving care and support and that of the provider of care and support are included in the process of assuring LA performance.

Clause 138 – Default powers of Secretary of State (SoS) in relation to adult social care

Clause 138 page 114-116

This clause was introduced during the Commons' Committee Stage and gives the SoS the power to intervene where LAs are failing to exercise their Care Act duties – we expect it will be the CQC which will determine this, see clauses 137 and 139.

This Clause allows the government to take control of a LA's adult social care duties but the exact approach will be laid out in the forthcoming Adult Social Care white paper. The SoS must give the LA concerned an opportunity to make representations about the measures to be taken.

NCF View

The powers in this clause give some teeth to the power of CQC to regulate LA functions relating to adult social care as outlined in clause 137 and are welcome. However, we need to see more detail on how this power will work in action and there are questions about accountability and the level of centralised powers this gives the Secretary of State. The powers outlined in this clause must be designed to meaningful improve the situation for social care providers and those that draw on their services in a LA area. We need detail on how this clause interacts with Clause 26 on the assurance of the entire ICS system.

Clause 139 – Care Quality Commission's powers in relation to local authority failings

Clause 139, page 116

This short clause was introduced in the Commons and amends the Health and Social Care Act 2008 to emphasise that elements of that act do not prevent CQC in publishing a report which specifies the respects in which CQC considers a LA to be failing, and recommendations for addressing this failure.

Clause 140 – Cap on care costs for charging purposes

Clause 140, pages 116-119

This clause would have made amendments to the Care Act 2014 which in turn would mean that the costs that accrue towards the cap on care costs are the costs incurred by an adult (at the LA rate) rather than the combined costs incurred by both the adult and the LA. This was an area of fraught debate in both Houses. The House of Lords has removed this clause in its entirety from the Bill.

NCF View

We support the House of Lords' removal of this clause from the Bill and would urge MPs to back its removal.

We support the removal of this controversial clause as it would have amended the Dilnot Cap as set out in the Care Act 2014 in a way that disadvantages those that most need the cap and enhanced means test, as well as changing the position the government announced in its Plan for Health and Social Care in September. Paragraph 38 on page 16 of that plan clearly states (emphasis mine):

"From October 2023, the Government will introduce a new £86,000 cap on the amount anyone in England will need to spend on their personal care over their lifetime. This will be a seismic change in

the way we pay for care and will deliver a core recommendation of the independent Dilnot Commission. ***It will be implemented using legislation already in place under the 2014 Care Act, which introduces the independent Dilnot Commission's social care charging reform****.* ***As a result of this new cap, people will no longer face unpredictable or unlimited care costs"***

There was no suggestion that the Care Act would be amended. Given the above, Clause 140 quite clearly changed the government's previous position. The government has published a more detailed document outlining the changes .

Providing the Commons passes this amendment, the government must now rewrite the draft operational guidance on a lifetime cap on care costs it has published which assumed that Clause 140 would become law.

There is also a fundamental problem not addressed by the Health and Care Bill or by the government's plan for health and social care. Not enough money is being put into the system. The Adult Social Care White Paper outlines how the money from the Health and Care Levy will be spent in social care over the next three years. £3.6bn is going to pay for the cap on care costs and £1.7bn is going on everything else. This is nowhere near enough to meaningfully improve capacity, meet unmet need, improve the quality of care received by people or improve the working conditions, retention and pay received by the workforce. Furthermore, the majority of the Health and Care Levy goes to the NHS (£36bn) **and not** to social care (£5.4bn) and there is no guarantee this will change after 3 years**.**

The debate around social care has become too narrowly focused on preventing people selling their homes. While this is important, we need to have a much wider, more ambitious vision of what social care means to people – of all ages and backgrounds – and work out how to fund that. The Adult Social Care White Paper goes some way towards this but parliamentary debate remains stuck.

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