Overview & Scrutiny

Health in Hackney Scrutiny Commission

All Members of the Health in Scrutiny Commission are requested to attend the meeting of the Commission to be held as follows

Monday 5 December 2022

7.00 pm

Council Chamber, Hackney Town Hall, Mare Street, London E8 1EA

The press and public are welcome to join this meeting remotely via this link: https://youtu.be/dX6YNMOWTR0

Back up live stream link: https://www.youtube.com/watch?v=-vaSgkg3tPw

If you wish to attend please give notice and note the guidance below.

Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Mark Carroll
Chief Executive, London Borough of Hackney

Members: **Cllr Ben Hayhurst (Chair), Cllr Deniz Oguzkanli, Cllr Kam Adams, Cllr Grace Adebayo, Cllr Frank Baffour, Cllr Eluzer Goldberg, Cllr Sharon Patrick (Vice-Chair) and Cllr Ifraax Samatar**

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

ACCESS AND INFORMATION

Public Involvement and Recording

Public Attendance at the Town Hall for Meetings

Scrutiny meetings are held in public, rather than being public meetings. This means that whilst residents and press are welcome to attend, they can only ask questions at the discretion of the Chair. For further information relating to public access to information, please see Part 4 of the council's constitution, available at https://hackney.gov.uk/council-business or by contacting Governance Services (020 8356 3503)

Following the lifting of all Covid-19 restrictions by the Government and the Council updating its assessment of access to its buildings, the Town Hall is now open to the public and members of the public may attend meetings of the Council.

We recognise, however, that you may find it more convenient to observe the meeting via the live-stream facility, the link for which appears on the agenda front sheet.

We would ask that if you have either tested positive for Covid-19 or have any symptoms that you do not attend the meeting, but rather use the livestream facility. If this applies and you are attending the meeting to ask a question, make a deputation or present a petition then you may contact the Officer named at the beginning of the agenda and they will be able to make arrangements for the Chair of the meeting to ask the question, make the deputation or present the petition on your behalf.

The Council will continue to ensure that access to our meetings is in line with any Covid-19 restrictions that may be in force from time to time and also in line with public health advice. The latest general advice can be found here - https://hackney.gov.uk/coronavirus-support

Rights of Press and Public to Report on Meetings

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the

start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting.

Disruptive behaviour may include moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording Councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease, and all recording equipment must be removed from the meeting. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

Advice to Members on Declaring Interests

Advice to Members on Declaring Interests

Hackney Council's Code of Conduct applies to all Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- Director of Legal, Democratic and Electoral Services
- the Legal Adviser to the Committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the meeting when the item in which you have an interest is being discussed. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the meeting and participate in the

meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.

If you have other non-pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

ii. You may remain in the meeting, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission, or licence matter under consideration, you must leave the meeting unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the meeting whilst discussion of the item takes place, and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the meeting. Once you have finished making your representation, you must leave the meeting whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the meeting. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non-pecuniary interest.

Further Information

Advice can be obtained from Dawn Carter-McDonald, Director of Legal, Democratic and Electoral Services via email dawn.carter-mcdonald@hackney.gov.uk

Getting to the Town Hall

For a map of how to find the Town Hall, please visit the council's website http://www.hackney.gov.uk/contact-us.htm or contact the Overview and Scrutiny Officer using the details provided on the front cover of this agenda.

Accessibility

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall.

Induction loop facilities are available in the Assembly Halls and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Further Information about the Commission

If you would like any more information about the Scrutiny Commission, including the membership details, meeting dates and previous reviews, please visit the website or use this QR Code (accessible via phone or tablet 'app')

Health in Hackney Scrutiny Commission

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Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Integrated Delivery Plan for the City and Hackney Place Based Partnership**	Item No **4**

PURPOSE OF THE ITEM

At our 29 June meeting members received a detailed update on the development of the City and Hackney Placed Based Partnership which is the local end of NHS NEL, our Integrated Care System. Members also have had a training session on Place Based Partnership. The Director of Delivery flagged up that a Delivery Plan for this work was in train and the purpose of this item is to give consideration to that Plan.

OUTLINE

Attached please find a briefing paper '*Delivering the City and Hackney Partnership Strategy: The Integrated Delivery Plan'*.

Attending for this item will be:

Nina Griffith, Director of Delivery, City and Hackney Place Based Partnership
Helen Woodland, Group Director, Adults Health and Integration

ACTION

The Commission is requested to give consideration to the report and make any comments or recommendations as necessary.

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City and Hackney Place-based Partnership

Delivering the City and Hackney Partnership Strategy: The Integrated Delivery Plan

AUGUST 2022

Introduction

The City and Hackney partnership brings together health and social care organisations who have committed to work together to support improved outcomes and reduce inequalities for our local population. It is one of seven Place Based Partnerships ICS-implementation-guidance-on-thriving (england.nhs.uk) within the North East London Integrated Care System. The partnership is overseen by the City and Hackney Health and Care Board (formally the Integrated Care Partnership Board). The board is co-chaired by Councillor Kennedy from Hackney and Councillor Helen Fentimen from the City of London. We have agreed a set of strategic focus areas and developed an Integrated Delivery Plan that describes how we will deliver this strategy.

The attached pack includes:

- The strategic focus areas and how these were determined
- Some introductory narrative on the plan
- Our 'big ticket items' within the plan
- Next steps for the plan

Strategic Objectives

Sources of strategy themes which our place-based partnership must respond to

NEL ICS partnership priorities

Employment and workforce
To work together to create meaningful work opportunities for people in North East London

Long term conditions
To support everyone living with a long term condition in North East London to live a longer, healthier life

Children and Young People
To make North East London the best place to grow up

Mental Health
To improve the mental health and well being of the people of North East London

Local health and wellbeing strategic focus areas (Hackney and City of London separate strategies)

- **Improving mental health and preventing mental ill-health**
- **Increasing social connection**
- **Supporting greater financial wellbeing**

HW strategies currently being refreshed

NHS Long Term Plan chapters / aims

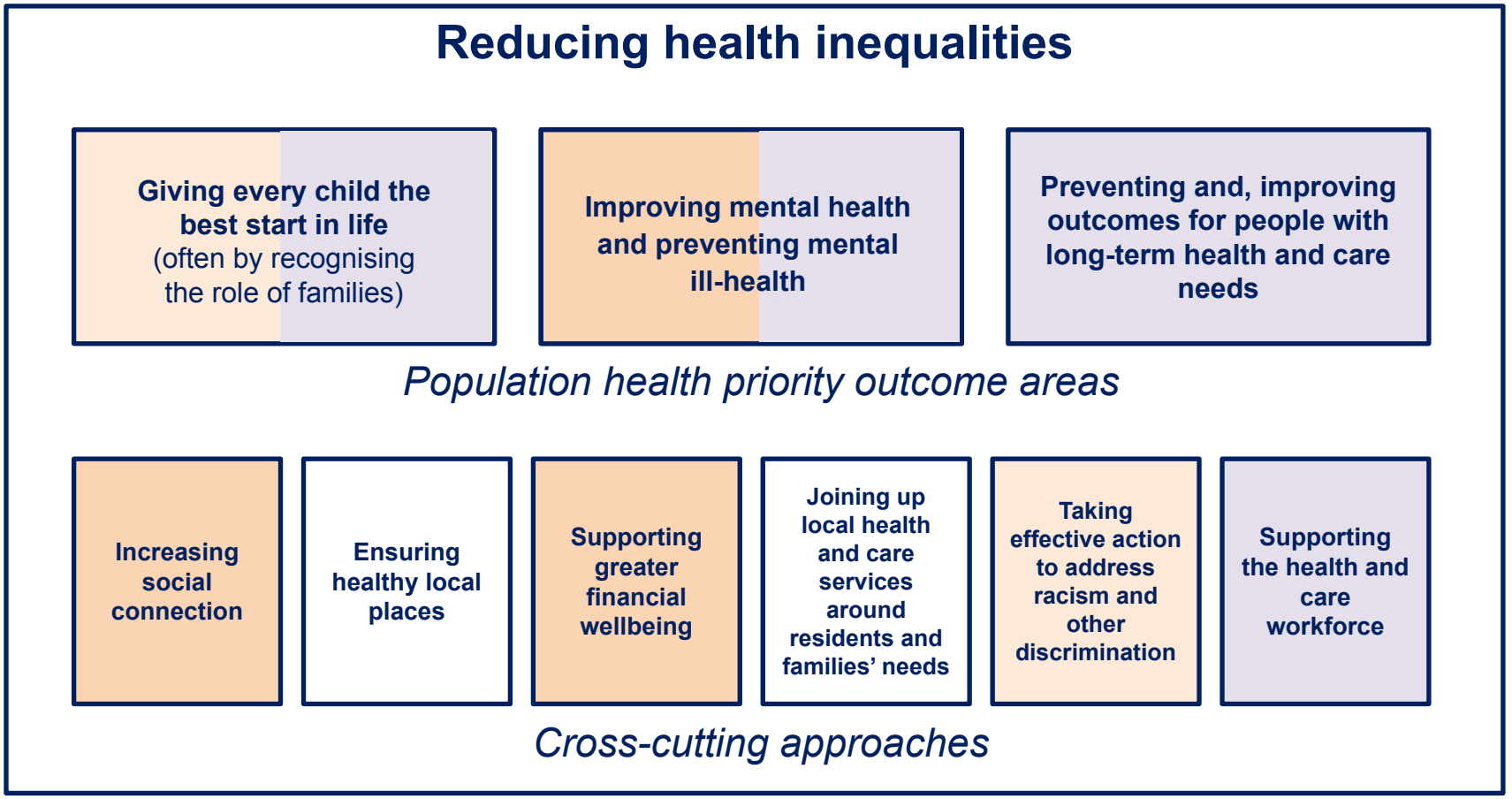
- A new service model for the 21st century
  - Boost **out of hospital care**
  - **Reduce pressure** on emergency hospital services
  - People get more control and more **personalised care**
  - Greater focus on **population health** and move to ICSs
- More NHS action on **prevention and health inequalities**
- Further progress on care quality and outcomes
  - **A strong start in life for CYP**
  - Better care for **major health conditions**
- **NHS staff** get the backing they need
- **Digitally enabled care** goes mainstream
- **Financial balance**, efficiencies and better use of investments

City and Hackney Borough-based Partnership Strategic Plan and Priorities

Local identified priority outcomes and delivery priorities in response to strategies

Outcomes	City and Hackney Outcomes Framework
SOCG	Integrated Delivery Priorities 2021/22

Strategic focus areas for the City and Hackney Place-based Partnership



=Hackney HWB focus area

= Hackney HWB specific 'lenses': (approaches to reducing health inequalities)

= NEL ICS four partnership priority areas

= reflecting LTP response / long term C&H partnership ambitions / Neighbourhoods Programme vision

Mapping place-based transformation programmes to population health focus areas

Population health strategic focus areas	Giving every child the best start in life	Improving mental health and preventing mental ill-health	Preventing and Improving outcomes for people with long-term health and care needs
Place-based partnership transformation programmes	Children, Young People, Maternity and Families	Mental Health and Learning Disability	People with long term health and care needs
	Neighbourhoods		

All programmes will address cross cutting themes:
Ensuring healthy local places
Joining up local health and care services around residents and families' needs
Increasing social connection
Supporting greater financial wellbeing
Taking effective action to address racism and other discrimination
Supporting the health and care workforce

The Integrated Delivery Plan - Background

The Integrated Delivery Plan

The Integrated delivery Plan is a two year, partnership plan that describes what we are doing together to achieve our strategic priorities. It does not describe the totality of the work underway within each of our organisations.

A focus on population health

All our work is aimed at improving the health of our local residents and reducing inequalities. The plan has been driven the population health needs of our residents - which we know from data and also from what we get told by residents. We have identified the key population health outcomes that we expect the plan to address.

Big Ticket items

The full plan describes a large amount of work across the partnership. Within it, we have identified a number of Big ticket Items – these are the areas where we expect to see the most transformation and where we need to work together to deliver.

Neighbourhoods

Neighbourhoods continues to be a strategic priority for City and Hackney. The programme is a key enabler for our model for out of hospital services, local resident and community engagement and addressing local health inequalities. We have described the specific work of the programme within the plan, however, it should also be seen as a broader cross-cutting approach that informs our approach to all of our strategic priorities.

Involving local residents in our work

- We are committed to involving local residents in our work because we believe that our communities are best placed to help shape solutions to local issues.
- We do this by working with local community and voluntary sector groups, Healthwatch branches, patient groups and individual residents.
- Residents have been, and will continue to be involved in a wide variety of ways – including through events and focus groups, surveys, by becoming community champions or public representatives.

The Integrated Delivery Plan - Big Ticket Items

Giving children and young people the best start in life - The Big Ticket Items

The big ticket items for this area include:

1. Children and Young People Emotional Health

We want to reduce the number of children and young people who experience a mental health crisis, and support people from specific communities with accessing mental health support and services. We will do this by prioritising prevention for children, young people and families, and continuing to make sure that children and young people's mental health services have sufficient resources to meet local needs.

The outcomes we expect our work to drive include:

- Reductions in crisis mental health presentations to emergency departments
- Improvements in mental health and wellbeing outcomes for specific communities

2. Children and Young People with Complex health needs, Special Educational Needs and Disabilities, including autism

We want to help more children achieve a good level of development, improved health and educational outcomes. We will do this by ensuring early support is available to children, young people and their families by the right services working closely together.

The outcomes we expect our work to drive include:

- An increase in the % of children achieving good level of development
- Improved health and educational outcomes for those at risk of exclusion
- Improved health and educational outcomes for those with complex needs, SEND and autism

3. Improving uptake of childhood immunisations and vaccinations

We want more children to have the best possible protection against illnesses like measles. This will help prevent future outbreaks of illness, ensure good level of development, and reduce the number of deaths in children under the age of 1.

The outcomes we expect our work to drive include:

- Increase immunisation coverage
- Increase % children achieving good level of development
- Increase in health of Looked After Children (LAC)
- Reduce infant mortality rate

Strategic Priority: Improving mental health and preventing mental ill-health -- The Big Ticket Items

The big ticket items for this area include:

1. **Providing integrated and personalised support to people with Serious Mental Illness (SMI):**

We want to help more people with a serious mental illness receive the right care and support that meet their personalised needs and improve their resilience as well as physical and mental health. We will do this by increasing the number of people with serious mental illness who receive a physical health check and have access to patient owned digital care plans and personal health budgets.

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The outcomes we expect our work to drive include:

- Improved physical health outcomes for people living with Serious Mental Illness
- 1,500 Personalised Patient Owned Digital Care Plans
- 400 personal health budgets, linked to personalised care plans
- Improvement in wellbeing for people with personal health budgets
- Reduction in SMI excess mortality

2. **Common Mental Health Problems**

We want to improve access to mental health services for people who are living with long term conditions, those experiencing economic hardship and people from Black Minority Ethnic heritage communities.

The outcomes we expect our work to drive include:

- Improved access to mental health services for people living with long term conditions
- Improved access to mental health services for black and minority ethnic populations

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

The big ticket items for this area include:

1. Stronger community support for people with long term health and care needs

Whenever it is appropriate to do so, we want to support people in crisis at home as a safe alternative to A&E. We will do this through the urgent community response services and our aim is that 90% of people referred to the services are seen within 2 hours.

We are introducing a new model of community based care called **Virtual Wards** whereby people can be safely cared for and monitored at home as an alternative to hospital admission. This will help people with long term health and care needs feel better supported in their own home, recover more quickly and avoid further crisis. This will also help people live independently for longer and have a better quality of life.

The outcomes we expect our work to drive include:

- Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach, therefore avoiding further crisis
- Recover more quickly from crisis / acute episode
- Making sure more people are able to live independently for longer
- An improved health-related quality of life for people with long term conditions

2. Homelessness and vulnerably housed

We want to reduce the number of people who are homeless or who are living in precarious housing situations. We also want to help more people make contact with health, social care and wider services, resulting improved health outcomes through things like increased vaccination rates.

The outcomes we expect our work to drive include:

- A reduction in the number of residents in vulnerable housing
- An improvement in the population
- vaccination rates
- An increased engagement with health, social care and wider services

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

The big ticket items for this area include:

3. Improving quality of care for people with Long Term Conditions

We want to help more people with long term conditions receive good quality care, as early as possible, **focusing on prevention**. We want people to have the same standard of care regardless of where they live and feel supported to manage their conditions. We will do this through continuing to work with local GP practices so that they can deliver high quality care for those who most need it. We also want to increase access to self-support programmes for people with long term conditions, recognising the expertise that people themselves and their communities have. This will lead to earlier diagnosis, improved health outcomes and reduced deaths from cardiovascular and respiratory illness.

The outcomes we expect our work to drive include:

- A reduction in premature mortality from cardiovascular and respiratory illness
- Improved blood pressure control in particular within black population
- Improved diabetes outcomes (Blood glucose, blood pressure and cholesterol)
- Accurate diagnosis of diseases to enable correct management and treatment in community – (avoid unnecessary hospital admissions)

4. Discharge

We are working together as a health and care partnership to ensure that when people are discharged from a service, this happens in a way that is safe, timely and effective.

The outcomes we expect our work to drive include:

- An improvement in health-related quality of life for people with long term conditions
- Making sure more people are able to live independently for longer

Helping us deliver: Our strategic enablers

To be able to realise delivery of all the work around our transformation areas, we have six strategic enablers. These strategic enablers are programmes that support the work that takes place to meet local health and care needs. Their purpose is to help us achieve our priorities around improving local health and wellbeing and preventing ill-health.

STRATEGIC ENABLER	PURPOSE
Population Health	Ensuring that health inequalities are considered in everything we do and that services are available and accessible to all City and Hackney residents.
Workforce	Ensuring that our health and care professionals are skilled, supported have opportunity to learn and develop, and that we have sufficient capacity to deliver services.
IT &Digital	Working with Transformation Programmes to develop digital tools and platforms that enable better information sharing and that both patients and workforce have access to good quality, real-time data.
Communications and Engagement	Keeping residents and workforce informed and involving local stakeholders in decision making in a meaningful way, making sure that our work is underpinned by what matters to people living in City and Hackney.
Voluntary and Community Sector	Ensuring that the local VCS are involved in decision making, shaping local services and solutions and that their skills and expertise are harnessed and recognised.
Estates and assets	Working to ensure that the buildings and other property we have as a local health and care system are fit for purpose and utilised in a way that benefits the local population.

Next steps:

- To work with the system enablers - digital, workforce, comms/engagement, population health hub - to ensure that they are supporting the partnership strategy and delivery of this plan - by end September
- To develop mechanisms to monitor delivery of the plan and associated risks. This will include short and medium term process and outcomes measures – by December
- To develop a resident and easy read friendly version that can be circulated more widely - by December
- To develop an outcomes framework that describes how the plan will drive longer term population health outcomes – by January

Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Adult Social Care Reforms: Fair cost of chare and sustainability**	Item No **5**

PURPOSE OF THE ITEM

To consider the national changes to Adult Social Care and how they are likely to impact on Hackney. This is one of a series of briefing items agreed with the Group Director. Issues of waiting times for assessments, provision of 'extra care', the staffing challenges, and housing services for the elderly, came up in the annual Scrutiny Survey both from residents and Members.

OUTLINE

Attached please find:

a) Report from Adult Services on *'Adult Social Are Reforms: Fair cost of care and sustainability'*
b) Briefing paper from the House of Commons Library on *Proposed reforms to adult social care (including cap on care costs)*. Author - David Foster.

The latter provides useful background and national context however it was written before the announcement by the Chancellor in the mini budget that the introduction of the, long awaited, Care Cap would again be postponed.

Attending for this item will be:
Zainab Jalil, Head of Commissioning, Business Support and Project, Adults Health and Integration Directorate
John Holden, Financial Advisor, Finance and Resources Directorate
Jenny Murphy, AD Adult Social Care and Public Health Commissioning, AHI
Georgina Diba, Director of Adult Social Care and Operations, AHI

ACTION
The Commission is requested to give consideration to the report and make any comments or recommendations as necessary.

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ADULT SOCIAL CARE REFORMS:

FAIR COST OF CARE + MARKET SUSTAINABILITY

Presentation for Scrutiny
05 Dec 2022

Zainab Jalil Head of Commissioning, Business Support and Projects
John Holden Financial Advisor, Finance & Resources Directorate

Adult Social Care: The Hackney Picture

- In 2018, the population of Hackney was 279,994 of which 210,624 were over 20 years old.
- In 2020/21, approx 3600 adults accessed ASC services, just ~1.7% of the adult population. However, this accounts for ~30% of the overall Council spend.
- It is estimated 1,900 people accessing ASC services were aged over 65, and 1,600 aged between 18 – 64.
- On 1 Oct 2020*, 482 people were in care home placements (68% of which were out of borough), and 1248 received home care support.
- According to the last Census, 19,300 residents identified as a carer. There are currently 2,828 carers registered, and ASC supported 1,535 carers during 2019/20.
- The growth in all age population between 2016 and 2020 was on average 1.13% but the growth in the number of people receiving care was on average 6.14% in the same period.

https://hackney.gov.uk/statistics-evidence-plans-and-strategies

*complete and accurate data prior to the cyber attack

Summary of reforms

Charging Reforms

Changes in how people are expected to contribute to their care costs:

- The introduction of new upper and lower capital limits
- The unfreezing of the Minimum Income Guarantee and the Personal Expenses Allowance
- The introduction of a standardised notional Daily Living Cost

The Cap - delayed now until at least 2025

No person has to pay more than £86k towards care costs.

From Oct. 2023 the LA will help you 'meter' towards the cap, accounting for any money you spend on care

The LA will assess your needs and let you know how much they would be prepared to pay for your care, and this is the max. you can meter.

You can pay for increased provision of any kind, but this will not count towards your £86k.

Fair Cost of Care - covered in this presentation

Anyone will have the right to ask for their LA to commission their care, whoever will then be funding it. (also delayed)

The local authority is also expected to do development work to ensure that their local care market is stable + well funded to reduce fragility.

This slide deck will look at the work we did to prepare for this.

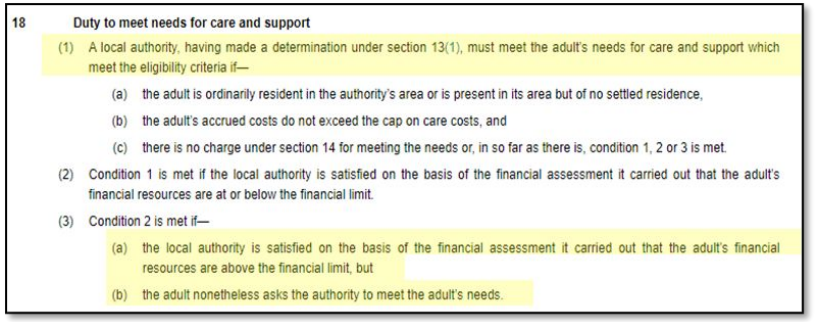
Why is the Fair Cost of Care needed?

Section 18(3) of the Care Act will be enacted from October 2023

- This gives everyone the right to ask the local authority to commission their care on their behalf

This gives them the right to local authority commissioned services, and local authority rates of care

- Though still paying for themselves if deemed a self funder



18 Duty to meet needs for care and support

(1) A local authority, having made a determination under section 13(1), must meet the adult's needs for care and support which meet the eligibility criteria if—

(a) the adult is ordinarily resident in the authority's area or is present in its area but of no settled residence,

(b) the adult's accrued costs do not exceed the cap on care costs, and

(c) there is no charge under section 14 for meeting the needs or, in so far as there is, condition 1, 2 or 3 is met.

(2) Condition 1 is met if the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are at or below the financial limit.

(3) Condition 2 is met if—

(a) the local authority is satisfied on the basis of the financial assessment it carried out that the adult's financial resources are above the financial limit, but

(b) the adult nonetheless asks the authority to meet the adult's needs.

Currently, on average, self funders pay 40% more for the same care than the local authority

- This provides significant cross-subsidy to the provider

At current fee rates, provider viability is threatened by loss of the cross subsidy, due to:

1. More people being local authority funded (partially or fully) due to the extended means test
2. More people being local authority commissioned through utilising 18(3)

Reforms will "enable all local authorities to move towards paying providers a fair rate for care"

- Through Market sustainability and fair cost of care fund 2022 to 2023

National Breakdown of ASC reform funding prior to budget statement

Charging Reforms: Any funding has been postponed - until at least 25/26

Market Sustainability:
LBH received £948k in 22/23
Original plans to continue funding in 23/24 and 24/25 is now uncertain

Table 2: Breakdown of the £5.4 billion package for reform

£3.6 billion	**£2.2 billion**	2022–23: **£0**	Reform charging system through cap and means test
		2023–24: **£800 million**	
		2024–25: £1.4 billion	
	£1.36 billion	2022–23: **£162 million**	Enable local authorities to move towards paying providers a fair cost of care
		2023–24: **£600 million**	
		2024–25: **£600 million**	
£1.7	At least	Workforce training, qualifications, and wellbeing	

Funding following Budget statement - Nov - 22

The funding to deliver ASC reforms will be repurposed,

Fair Cost of Care

- Maintain current levels of Fair Cost of Care funding for local authorities for the next two years (£162 million per year), given fee uplifts will already have been agreed for year one of the Fund on this basis
- underpayment within the sector is only one issue being faced.
- Repurpose with a ringfenced fund of £400 million in 2023-24, rising to £680 million in 2024-25 - will support local authorities to continue to move towards paying a more sustainable rate for care – while balancing this with wider objectives to support capacity and discharge.

Source: Letter from the Minister for Care and Mental Health to the Chair

WHAT WERE THE REQUIREMENTS?

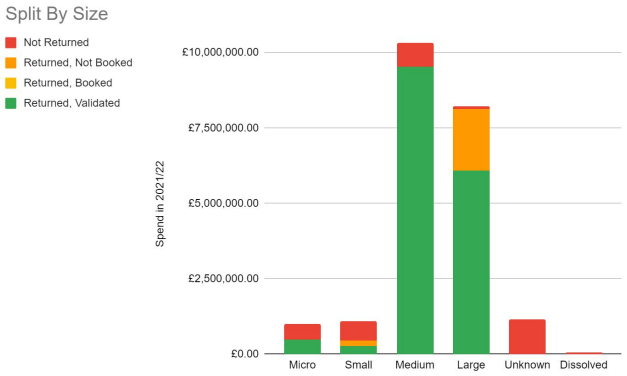
		What do we have to do?		*Who is leading from the Council?*	*How is the Annex submitted?*
Fair Cost of Care & Market Sustain-ability exercise	**Annex A**	**FCoC rates**	Hourly rate for 18+ homecare providers	John Holden	Submitted via DHSC portal 14 October, not published
			Weekly rate for residential and nursing homes, enhanced and not enhanced, with a Hackney postcode		
		Spend report	How we are allocating the 2022/3 grant on implementation and provider uplifts		
	Annex B	**FCoC Approach report**	For homecare and care home providers: • How did we engage them? • What were their responses and feelings towards the exercise? • What challenges did we face? • How did we approach return on investment/operations? • What were the rates (from Annex A)?	Mark Watson	Submitted via DHSC portal 14 October, published in October or November - Waiting for notification
	Annex C	**Market Sustainability Plan**	What problems affect the sustainability of the care market?	Mark Watson	Submitted via DHSE portal 14 October, published after 2023/4 budgets finalised in February
			What is the impact of future market changes, including self funding reform?		
			How will Hackney address these issues, including using FCoC grants?		

SUMMARY OF RETURNS

18+ Homecare

We invited all of our homecare providers to calculate their costs using the LGA-provided toolkit. Twenty one out of the sixty nine providers engaged with the exercise, representing 85% of the value of contracts with homecare providers.

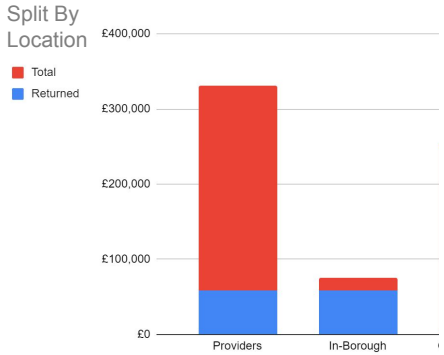
We wanted to ensure that we are supporting our Framework providers, as well as hearing from smaller providers that we want to help to grow. Below shows that we hit our target of engaging >50% of the providers in each size category.



65+ Care Homes

There are seven care home providers with a Hackney postcode and all seven were invited to complete the exercise via the iEse Care Cubed tool. Four out of the seven have completed the return and engaged with the exercise, which accounts for more than 80% of care home spend within the borough.

Due to the low number of care homes in Hackney, over 70% of our care home beds are based outside of the borough. We worked closely with the North East London network to align our approaches and compare our rates.



SUMMARY OF THE ANNEXES

Please note: these draft figures have now been submitted to DHSC

Annexes A + B – FCoC rates

Homecare:

- Response rate: 31% by volume, 85% by spend
- FCoC median cost per hour -the draft rate is significantly higher than current rates being paid and would require significant additional funding to achieve it; the draft rates have been submitted to DHSC for review
- Comparison to what we currently pay:approx 21% more than current rates

Moving to FCoC across all homecare providers immediately, assuming the same volume, would cost an additional **£5.5m** per year.

Care Homes:

- Response rate: 57% by in-borough volume, 75% of in-borough spend
- Similarly to homecare, the draft rates generated by the exercise are significantly higher than current rates; the draft rates have been submitted to DHSC for review
- Comparison to what we currently pay: 33% more than current rates

We currently spend £16.8m per year on both in-borough and out-of-borough care homes. To determine the full cost impact requires knowledge of the agreed FCOC for all host authorities. The aim is to collect this data from North East London and derive a NEL rate.

Annex C – Market Sustainability Plan

Current sustainability:

- The main area for worry is within our care home market. The biggest sustainability risk here is the fee rate gap to costs of care. Providers reported not being able to make a profit and cost uncertainty
- Within the homecare market, the workforce supply is the biggest sustainability risk but this is seen as a dynamic market, where new entrants with varied offerings are entering the market

The impact of reform and other market changes:

- Proportion of care home self-funders in Hackney is low within London and nationally at 13%. For homecare this ranges between 7-50%.
- There is wider Council work in how we design our commissioning framework, affordable housing, renewable energy and employment services to support a stable market

Our commitments:

- To continue to insist that the providers we use are paying their staff London Living Wage and to uplift our rates in line with this (inflationary policy)
- We are focussing on keeping small businesses growing through some centralised workforce development including passporting of qualifications
- Supporting green sustainability
- n.b. this is all dependent on grant availability, of which there is a lack of clarity on future amount and apportionment

NEW Providers feedback

Risks to sustainability	Detail of risk	Analysis to investigate this
Recruitment and retention – capacity	• Where turnover and vacancy rates are high, providers may have to close due to lack of capacity and therefore lack of business	• How many providers take up what proportion of care hours? • How long are wait lists for dom care/how many are on a brokerage list waiting for package starts?
Recruitment and retention – wages	• LLW doesn't make the role attractive given the reputation of the sector, when people could work e.g. in a cinema for the same	• Do providers who pay above LLW have less of a problem with turnover?
Recruitment and retention – travel time	• Some staff are paid for travel, others aren't. If a visit is only 30mins the cost of return travel can be half the wage earned	• Do providers who pay for travel have lower turnover/vacancies?
Recruitment and retention – head office staff	• When care staff already being just paid LLW, when income is squeezed have to cut HO • HO staff have to be on call 24/7 so sometimes their pay > carers	
Recruitment and retention – niche providers	• Niche markets are difficult to staff, there is also a lack of awareness among social workers of their existence	
Recruitment and retention – sparse hours	• 0 hour contracts and spread out hours rather than block shifts mean carers aren't guaranteed work and income	
Recruitment and retention – progression	• Lack of progression in smaller providers and in providers without clear L&D plans or progression plans	• Do providers who invest more in training have better CQC ratings?
Growth of small providers limited by volumes and fees	• As smaller providers aim to grow, unless they can secure regular contracts, current volume and fees don't support them	• At what volume would smaller providers be able to break even?
Capacity is strained because of unnecessary DH packages	• Providers are incentivised to recommend DH packages, reducing the independence of the user and absorbing care hours that could be used for someone else	
Not making a surplus	• High costs and squeezed income means providers are struggling to make a surplus • This makes the business endeavour not worth it and discourages new providers	
Fuel prices	• Increases (300%) cut into surplus	
Increased need of users	• More frail or higher sickness • Requires either more staff or more skilled staff which is costly	• How has demand increased by size of care package? • What is the increase in co-morbidity?
LA picking up payments for users who have met their cap	• Providers subsidise LA users with private fees. Once the cap is introduced and private user fees move to the LA rate, income will drop	

NEW NEL comparison - comparing draft figures from North East London

Home Care

- Each local authority had the choice of what modelling to use. Hackney used the standard modelling tool issued by central government to support benchmarking.
- That modelling shows that for home care we are able to have rates that are not at the higher end across NEL.

Care Homes

- Hackney's rates for care homes are currently showing as higher in the NEL comparisons.
- This may in part be due to having fewer returns/providers for care home submissions. The care homes are also organised differently - e.g. (charity, private, etc)
- More work on this is needed to understand differences and comparisons. We will also compare rates with other inner london authorities.
- The funding from government is unlikely to match the cost of care rates generated by the toolkits.
- Our comms hase been clear, we can only implement this if we get the grant from the government.

Market Sustainability - cost of care - is it affordable?

Key statements from guidance on cost of care (FCoC) exercise:

*"LAs will now also need to **have regard to** data obtained through the FCoC process, and its own CoC report. In doing so, LAs will need to decide on the weight to put on that information."*

*"**start making** genuine progress towards more sustainable fee rates, where they are not already doing so".*

"Local authorities should scrutinise cost outliers, in collaboration with the provider, and consider where they should be removed."

*"In practice we will expect actual fees to be **informed by** the FCoC …"*

*"some LAs will reach the FCoC in this Spending Review period, whereas others are on a longer journey and will not. Our policy expectation is therefore that you make **as much progress as possible,** be based on sound judgement, evidence, and through a negotiation process"*

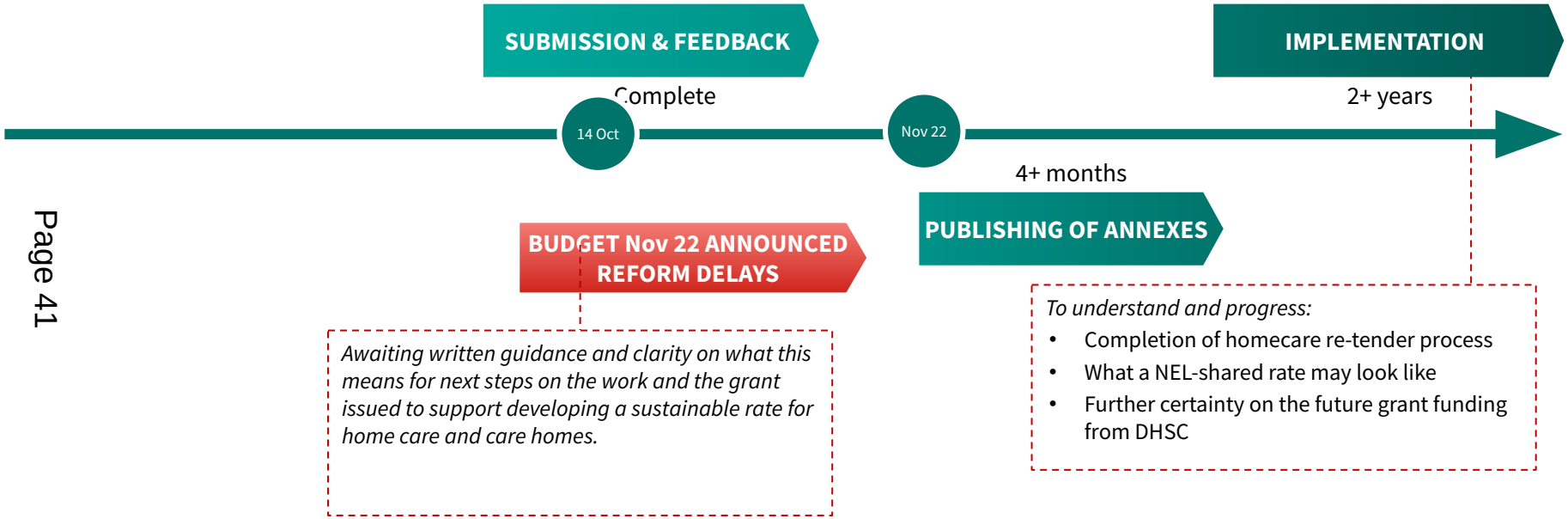
Direction of travel was to **move towards** the rate and the rate must **have regard** to the cost of care exercise.

Conclusion: we do not need to immediately pay providers the results of their cost of care returns but instead: (a) explain how we have derived our rate considering the returns, (b) how we are moving towards it and also (c) what our standard inflation strategy is

How we are planning to spend this year's grant?

Fair Cost of Care and Market Sustainability Grant 2022-23. Enter your grant amount below in pounds.	**(1) Spending associated with fee increases for 18+ domiciliary care (including domiciliary care providers who operate in extra care settings), £**	Biggest sustainability challenge for 18+ homecare	**(2) Spending associated with fee increases for 65+ care home places without nursing, £**	Biggest sustainability challenge for 65+ care home places without nursing	**(3) Spending associated with fee increases for 65+ care home places with nursing, £**	Biggest sustainability challenge for 65+ care home places with nursing	**(4) Spending associated with internal resourcing for implementation activities, £**	Number of annual FTEs	Short description of spend	**(5) Spending associated with external resourcing for implementation activities, £**	Short description of spend2	**Percentage of spending that is not on fee rates, % auto populated**
£948,377	£529,911 (Cost of LLW for providers, In year increases and balance estimated at 0.42p per hour for framework providers)	Workforce supply	£53,372	Fee rate gap to costs of care	£128,000 (LLW in borough and who provided data)	Fee rate gap to costs of care	£142,094	1.872	Project officers to support internal capacity	£95,000	External consultancy to provide additional assurance over process and provide additional capacity. Communications with providers.	25.00%

NEXT STEPS


SUBMISSION & FEEDBACK
Complete
14 Oct
Nov 22
IMPLEMENTATION
2+ years
4+ months
PUBLISHING OF ANNEXES
BUDGET Nov 22 ANNOUNCED REFORM DELAYS
Awaiting written guidance and clarity on what this means for next steps on the work and the grant issued to support developing a sustainable rate for home care and care homes.
To understand and progress:
• Completion of homecare re-tender process
• What a NEL-shared rate may look like
• Further certainty on the future grant funding from DHSC

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House of Commons Library

By David Foster
3 October 2022

Proposed reforms to adult social care (including cap on care costs)

Summary

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Contents

Summary

In September 2021, the Government set out plans to reform adult social care in England (PDF). £5.4 billion be used to fund the reforms over the next three years:

- £3.6 billion will be used to reform how people pay for social care. This includes £1.4 billion to help local authorities move towards paying a "fair cost of care" to providers.
- £1.7 billion will be used to support wider system reform.

The funding was initially planned to come from the new Health and Social Care Levy, but in September 2022 the Chancellor announced the levy will be cancelled. The new Health Secretary has, however, said funding for social care will remain unchanged.

The briefing focuses on the proposed reforms to how social care is paid for. Section five provides brief information on the plans for wider reform.

Cap on care costs

From October 2023, the Government plans to introduce **a new £86,000 cap** on the amount anyone in England will have to spend on their personal care over their lifetime. The cap will apply irrespective of a person's age or income. The legislative framework for a cap is already provided by the Care Act 2014, but the relevant provisions are not currently in force.

Only money spent on **meeting a person's personal care needs** will count towards the cap. Spending on daily living costs (commonly referred to as "hotel costs" in a care home) is not included. The Government has said daily living costs will be set at a notional level of £200 per week at 2021/22 prices.

The cap will not apply retrospectively (ie costs accrued before October 2023 will not count towards the cap).

Health and Care Act 2022

In November 2021, the Government announced it would seek to amend the Care Act 2014 so that any money paid by a local authority towards meeting a person's eligible care needs **will not count** towards the cap. A clause to this effect was added to the Health and Care Bill at report stage in the Commons.

The proposed change proved controversial and was the subject of disagreement between the Commons and the Lords during the Bill's passage through Parliament. However, the change was included in the agreed final version of the Bill, which received Royal Assent on 28 April 2022.

Changes to the social care means test

From October 2023, the Government proposes to make the means test for accessing local authority funding support **more generous.** The upper capital limit (the threshold above which somebody is not eligible for local authority support) will increase from £23,250 to £100,000. The lower capital limit (the threshold below which somebody does not have to contribute towards their care costs from their capital) will increase from £14,250 to £20,000.

Fair cost of care reforms

Local authorities can use their position as a large purchaser of social care to obtain lower fee rates from care providers, which can be less than the cost of providing the care. To compensate, providers often attempt to cross-subsidise by charging more to people who fund their own care. The Government says this leads to market failure and has announced two measures to address the issue:

- Provisions in the Care Act 2014 (section 18(3)) will be brought fully into force enabling self-funders to ask their local authority to arrange their care in a care home for them so that they can benefit from lower rates.
- £1.4 billion will be provided to local authorities over the next three years to support them to increase the rates they pay to providers where necessary (move towards paying a "fair cost of care").

Following a consultation, the Government announced the reform will be implemented in stages from October 2023 to April 2025 at the latest.

Analysis of charging reforms

The Government says the proposed charging reforms will mean "people will no longer face unpredictable or unlimited care costs". It estimates the proportion of older people in care receiving support from the state will increase from around half to around two-thirds as a result of the reforms.

The Government estimates the annual cost of the reforms, including the "fair cost of care", start relatively low (£1.42 billion in 2023/24) but increase to an estimated £4.74 billion by 2031/32 (in 2021/22 prices).

The proposals have been broadly welcomed by stakeholders, but it's also been suggested they may "not live up to their marketing" and that the cap will "help relatively few people."

Concerns have also been raised about whether funding for the reforms is sufficient, particularly for the fair cost of care, and it has been questioned whether local authorities have the workforce capacity to implement them successfully.

One of the main areas of controversy has been the amendment to the Care Act 2014, under which a local authority's contribution will not count towards the cap on care costs. Stakeholders have highlighted the change will mostly affect those with modest levels of wealth and in lower wealth regions. However, the Government says the change makes the reforms fairer and that the savings created have allowed the proposals to be made more generous in other areas.

1 Introduction

1.1 Paying for adult social care

There is no national government budget for adult social care in England. Instead, publicly funded social care is mostly financed through local government revenue. This is made up of central government funding from the local government finance settlement, combined with locally raised revenue from business rates, council tax and income from fees and charges. Individual local authorities then determine how much is allocated to social care.

In recent years, the Government has also provided additional ring-fenced funding to local authorities for adult social care.

Local authority support with care costs

Broadly, whether a person is eligible for local authority funding support towards their adult social care costs depends on how much capital they have:

- Care home residents with more than £23,250 (**the upper capital limit**) are not eligible for local authority funding.
- Care home residents with capital between £14,250 (**the lower capital limit**) and £23,250 are eligible for funding support but must contribute a "tariff income" of £1 per week for every £250 they have above the lower limit towards the cost of their care.[1]
- Care home residents with capital below £14,250 are eligible for funding support and are not charged any "tariff income".[2]

While the capital limits are rigid for care home residents, local authorities can set higher (but not lower) limits for people receiving care in other settings (such as their own home).

The value of a person's main or only home is disregarded as capital when they are receiving care outside of a care home. For care home residents, their home can be counted as capital, but in certain circumstances it must be

1 Or part of £250. For example, somebody with £300 over the limit would contribute £2 in tariff income.

2 The Care and Support (Charging and Assessment of Resources) Regulations 2014 (SI 2014/2672), paras 12 & 25; DHSC, Care and Support Statutory Guidance, last updated 21 April 2021, Annex A, paras 24-7.

disregarded (eg, if the home has been continuously occupied by the person's partner since before they went into a care home).[3]

Income contributions

If someone receives local authority funding, they are still required to contribute their income towards the cost of their care, subject to any disregards (eg, income from earnings does not have to be contributed).

Individuals must, however, be allowed to retain a certain amount of income each week for personal expenses and (if applicable) household bills.

Further information on the current system of paying for social care in England is available in the Library briefing: Paying for adult social care in England.[4]

1.2 Funding pressures

Adult social care funding has been under pressure for several years.[5] Estimates of the 'funding gap' vary according to the data used and the assumptions made.

In its October 2020 report on adult social care funding and workforce (PDF), the Health and Social Care Committee included different organisations' estimates of the adult social care funding gap. The estimates, which did not account for additional costs created by the Covid-19 pandemic, ranged from £1.4 billion to £12.2 billion per year.[6]

In February 2021, the Health Foundation published projections of how much funding might be needed based on four scenarios up to 2030/31:

1. To meet future demand
2. To meet future demand and improve access to care
3. To meet future demand and pay more for care
4. To meet future demand, improve access to care and pay more for care.

Estimates for the additional funding required by 2024/25 ranged from £2.5 billion (scenario 1) to £9.3 billion (scenario 4).[7]

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3 Care Act 2014; The Care and Support (Charging and Assessment of Resources) Regulations 2014 (SI 2014/2672); The Care and Support (Miscellaneous Amendments) Regulations 2015 (SI 2015/644); DHSC, Care and Support Statutory Guidance, last updated 27 January 2022.

4 CBP01911, Paying for adult social care in England, 27 August 2021.

5 LGiU, LGIU MJ State of Local Government Finance Survey 2020, 5 February 2020.

6 Health and Social Care Committee, Social care: funding and workforce, HC 206 2019-21, pp13-15.

7 Health Foundation, Social care funding gap: Our estimates of what it would cost to stabilise and improve adult social care in England, 11 February 2021.

In October 2021, the Health Foundation published updated projections for scenarios 2 (stabilisation) and 4 (recovery) over the next three years. The report estimated funding would need to be approximately 25% (£4.8bn for stabilisation) to 50% (£9.3bn for recovery) higher in real terms by 2024/25 compared to 2021/22. The report noted the projections were prepared before the Government's September 2021 announcement on social care funding (see section 2). However, it said they are "a benchmark to compare those announcements against".[8]

In its August 2022 report on the long-term funding of adult social care, the Levelling Up, Housing and Communities Committee said the evidence it received highlighted the estimates of the Health and Social Care Committee and the Health Foundation as "being credible".[9]

Effects of funding pressures

It's argued that funding pressures in adult social care contribute to a range of issues, including:

- **People not having their care needs met**. Analysis by Age UK in September 2022 estimated 2.6 million people over the age of 50 are living with some form of unmet care need in England.[10] Based on a survey carried out in April 2022, the Association of Directors of Adult Social Services (ADASS) estimated around 300,000 people were waiting for a care assessment.[11]

- People not eligible for local authority support can face potentially **"catastrophic" care costs** of over £100,000.[12] The Government has estimated around one in seven adults aged 65 face such lifetime costs (excluding "hotel" costs in care homes).[13] The median lifetime cost of care for over 65s is around £22,000.[14]

- **High levels of unpaid care**, with carers not always able to access the support they need.[15]

- The **financial sustainability of care providers**. In its Spring Survey 2021, published in July 2021, the ADASS said 77% of local authorities were

8 Health Foundation, Health and social care funding projections 2021, October 2021.

9 Levelling Up, Housing and Communities Committee, Long-term funding of adult social care (PDF), 4 August 2022, HC 19 2022-23, para 28.

10 Age UK, Incoming PM needs to act fast, says Care and Support Alliance, as new analysis finds 2.6m aged 50+ now have some unmet need for social care, 2 September 2022.

11 ADASS, ADASS survey waiting for care, 4 August 2022.

12 'Alarming' rise in level of unmet care and support needs', Community Care, 16 February 2017.

13 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 78.

14 DHSC, Adult social care charging reform: impact assessment, January 2022, para 4; DHSC, Operational guidance to implement a lifetime cap on care costs, 14 March 2022. "Hotel" costs refers to daily living costs for people in care homes;

15 DHSC, Evidence review for Adult Social Care Reform (2MB, PDF), December 2021, pp24-45.

concerned about the financial sustainability of some of their care home providers, with 19% concerned about most of their providers.[16]

- **Impact on health services**, including delayed hospital discharges and unnecessary attendances at A&E.[17]

- **Workforce pressures.** Skills for Care estimates there were 165,000 vacancies in 2021/22, with the number of vacant posts increasing by 52% since 2020/21.[18] Further information is available in the Library briefing on the adult social care workforce in England.[19]

Further information on adult social care funding, including funding pressures and effects, is available in the Library briefing: Adult Social Care Funding (England).[20]

1.3 What reforms have been proposed before?

Reforming adult social care, including how people pay for care, has been an issue for successive governments and several reform proposals have been made.

The Dilnot Commission

In July 2011, the Commission on the Funding of Care and Support, chaired by Sir Andrew Dilnot, published its report Fairer Care Funding (PDF). This is particularly relevant to the current proposals. The Commission's recommendations for reform included:

- **A cap of £35,000 on the contribution people aged over 65 would be expected to make towards their personal care costs over their lifetime**. After reaching the cap, individuals would be eligible for full state support. Different caps were proposed for adults aged under 65, including a zero cap for anybody entering adulthood with care and support needs.

- **Increasing the upper capital limit to £100,000 for care home residents.** Anyone with capital above this would not receive local authority financial support towards their care. The cap for people receiving care outside a care home would be unchanged.

16 ADASS, Spring Survey 2021, July 2021, pp7 & 22.

17 Institute for Fiscal Studies, Long-term care spending and hospital use among the older population in England, 7 December 2020; NHS England Delayed transfers of care data.

18 Skills for Care, The size and structure of the adult social care sector and workforce in England, July 2022.

19 Commons Library briefing CBP-9615, Adult social care workforce in England.

20 CBP7903, Adult Social Care Funding (England), 11 December 2020.

- **A standard rate for services other than personal care provided in a care home** (such as accommodation and food). The Commission recommended this should be in the range of £7,000 to £10,000 a year.[21]

The Coalition Government accepted the Commission's proposals in principle, but altered the parameters for the cap and the means-test as well as some of the detailed policy behind the cap. This included:

- **The level of the cap on personal care costs**. The Government proposed a higher cap (£72,000) that would apply to all adults (there would not be lower caps for younger adults).[22]

- **What spending counts towards the cap**. The Dilnot Commission said every pound a person spent on social care should count. In contrast, the Government proposed it should be every pound that would have been spent if a local authority had been paying for the care (a local authority may spend less for equivalent care).[23]

The Government initially set an implementation date of April 2016 and the Care Act 2014 provided the legislative framework for a cap on care charges.[24] However, implementation was delayed until April 2020 and then effectively indefinitely postponed.[25]

In 2017, the then Government said it would publish its proposals for adult social care funding in a green paper.[26] However, the paper was delayed several times and had not been published by the time Boris Johnson became Prime Minister in July 2019.

Further information on past proposals for reform, including the Dilnot Commission, is available in the Library briefing: Social care: Government reviews and policy proposals for paying for care since 1997 (England).[27]

Developments between July 2019 and September 2021

The Conservative Party's 2019 general election manifesto said a Conservative Government would seek a cross-party consensus on how to reform paying for

21 Commission on Funding of Care and Support, Fairer Care Funding, July 2011, pp5–6, 21, 28, 35 and 76.

22 HM Treasury, Budget 2013, 2012–13 HC 1033, p57, para 1.195 and HC Deb 20 March 2013 c941; Department of Health, The Care Act 2014 – Consultation on draft regulations and guidance to implement the cap on care costs and policy proposals for a new appeals system for care and support, February 2015, p38, para 3.15.

23 Department of Health, Caring for our future: progress report on funding reform, Cm 8381, July 2012, p22; Department of Health, Caring for our future – How the care and support funding reforms will work, archived webpage. Section 3.2 below provides more information on how this works.

24 Care Act 2014, section 15.

25 HLWS135 17 July 2015; HC Deb 7 December 2017 c1235.

26 HL Deb 21 June 2017 c6.

27 CBP8000, Social care: Government reviews and policy proposals for paying for care since 1997 (England), 23 October 2017.

adult social care. It said a prerequisite of the proposals would be that "no one needing care has to sell their home to pay for it."[28]

In January 2020, the Prime Minister said the Government would bring forward a plan "this year" and would "get it done within this Parliament."[29] The Government subsequently said it would not be possible to meet this timetable because of the Covid-19 pandemic.[30]

At the Spending Review 2020, the Government said it was "committed to sustainable improvement of the adult social care system and will bring forward proposals next year [2021]".[31] This position was reiterated at the Queen's Speech in May 2021.[32]

Further information is available in the Library briefing: Reform of adult social care funding: developments since July 2019 (England).[33]

28 Conservative and Unionist Party, Get Brexit Done – Unleash Britain's Potential, November 2019, p12.
29 BBC, The Big Interviews: Boris Johnson on BBC Breakfast, (at 16 minutes 25 seconds), 14 January 2020.
30 PQ 64976, 2 July 2020; PQ 59766, 22 June 2020.
31 HM Treasury, Spending Review 2020, November 2020, para 4.10.
32 Prime Minister's Office, Queen's Speech 2021: background briefing notes, 11 May 2021.
33 CBP8001, Reform of adult social care funding: developments since July 2019 (England), 12 May 2021.

2 The Health and Social Care Levy

In a statement to the House on 7 September 2021, the then Prime Minister, Boris Johnson, announced plans to substantially increase funding for health and social care over the next three years (2022/23 to 2024/25), to be funded by a new tax, the Health and Social Care Levy.[34]

The levy was to be introduced in two stages:

- In **2022/23:** the rate of primary Class 1 National Insurance contributions (NICs) for employees charged on their earnings, the rate of secondary Class 1 NICs for employers charged on their employees' earnings, and the rate of Class 4 NICs for the self-employed charged on their trading profits, increased by 1.25 percentage points.
- In **2023/24:** a separate levy set at 1.25% was to be introduced, replacing the temporary increase in NICs rates. People in employment who are over State Pension age would also have to pay the levy. Currently, pensioners are not liable to pay NICs on any earnings they receive from employment.

The funds from the Health and Social Care Levy were to be ringfenced for investment in health and social care.

The Health and Social Care Levy Act 2022, which provided for the temporary increase in NICs rates for 2022/23 and the introduction of the new levy from 2023/24, received Royal Assent on 20 October 2021. Further information is available in the Library briefing: Health and Social Care Levy Bill 2021-22.[35]

Cancelling of the Levy

On 22 September 2022, the Chancellor, Kwasi Kwarteng, announced the 1.25 percentage point rise in NICs rates would be reversed from 6 November 2022. In addition, he said, the Health and Social Care Levy would be cancelled.[36] To give effect to these changes the Health and Social Care Levy (Repeal) Bill 2022-23 was introduced the same day.[37] Further information is available in the Library briefing on the Health and Social Care Levy.[38]

34 HC Deb 7 September 2021, cc153-181.
35 Commons Library briefing CBP-9310, Health and Social Care Levy Bill 2021-22.
36 HM Treasury, National Insurance increase reversed, 22 September 2022.
37 Parliament.uk, Health and Social Care Levy (Repeal) Bill 2022-23.
38 Commons Library briefing, Health and Social Care Levy.

2.1 Funding for social care

It was planned that £5.4 billion of revenue from the Health and Social Care Levy would be used to support adult social care reform in England over the next three years (2022/23 to 2024/25).[39] This was made up of:

- £3.6 billion to reform how people pay for adult social care, including **introducing a cap on care costs and making the means test for accessing local authority funding support more generous**. (sections 3 and 4 provide information on these reforms).
- £1.7 billion to support **wider system reform** (section five provides more information).[40]

The Health Secretary, Thérèse Coffey, has said the planned spending on social care will remain unchanged despite plans to reverse the increase to National Insurance rates and cancel the Health and Social Care Levy. On 7 September 2022 she said:

> Instead of having, in effect, a ring-fenced levy, we will be funding [health and social care changes] out of general taxation so the investment going to health and social care will stay exactly the same.[41]

Similarly, a Government policy paper published on 22 September 2022, Our plan for patients, said the Government would "work with local government to deliver the 'cap and means test' reforms by October 2023, learning from the 6 trailblazer local authorities starting early in 2023".[42]

39 HM Treasury, Autumn Budget and Spending Review 2021, HC 822, October 2021, para 4.8.
40 HM Treasury, Autumn Budget and Spending Review 2021, HC 822, October 2021, para 4.8.
41 Therese Coffey says health and social care spending will stay 'exactly the same', Independent, 7 September 2022.
42 DHSC, Our plan for patients, 22 September 2022.

3 Reforming how people pay for care

This section explains the Government's proposed reforms to how adult social care is paid for. The plans were originally set out in the September 2021 policy paper: Build Back Better: Our Plan for Health and Social Care.[43]

As noted in section two above, the reforms will be supported by £3.6 billion of funding over the next three years (2022/23 to 2024/25).[44]

3.1 Cap on care costs

From October 2023, the Government plans to introduce **a new £86,000 cap** on the amount anyone in England will have to spend on their personal care over their lifetime. The cap will apply irrespective of a person's age or income.[45]

When somebody reaches the cap on care costs the local authority will pay for their eligible care and support needs. The person will still be responsible for paying daily living costs (see below).[46]

As set out in section 1.3 (pages 11-12), a cap on care costs was a central recommendation of the 2011 Dilnot Commission and the Care Act 2014 provides the legislative framework for the introduction of a cap.

On 4 March 2022, the Government published a consultation on draft operational guidance setting out how the cap on care costs will operate in practice. The consultation closed on 1 April and the Government responded on 7 July 2022.[47] The following sections provide a brief summary of how the Government has said the cap will work.

What spending counts towards the cap?

The amount somebody pays for their social care will not necessarily be the amount that is counted towards the cap. Instead, if a person is paying for their own care, the amount counted towards the cap will be the amount **it would have cost the local authority** if it had been meeting the person's

43 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021.
44 HM Treasury, Autumn Budget and Spending Review 2021, HC 822, October 2021, para 4.8.
45 Prime Minister's Office, PM statement to the House of Commons on health and social care: 7 September 2021, 7 September 2021.
46 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.11.
47 DHSC, Operational guidance to implement a lifetime cap on care costs, last accessed 21 September 2022.

eligible care needs (those needs that meet national eligibility criteria set by regulations).[48] The Government says this "ensures the new system does not unfairly advantage those who can afford to pay more for their care and want to do so to reach the cap quicker."[49]

Care needs met by an informal carer do not count as eligible needs and so will not count towards the cap.[50] Support provided under legislation other than the Care Act 2014 (eg, NHS continuing healthcare and NHS funded nursing care) will also not count towards the cap.[51]

The introduction of a cap means many self-funders who do not currently have any contact with their local authority will be brought into the care system. This is because the local authority will have to set out how much it would be spending if it were paying for the person's care (an independent personal budget) and maintain a 'care account' to keep track of a person's progress towards the cap.[52] Further information on independent personal budgets and care accounts is provided in chapters two and three, respectively, of the Government's draft operational guidance.[53]

A person may choose to make additional payments on top of the amount the local authority would pay towards meeting their eligible needs (top-up fees) – for example to secure a premium room in a care home. For those receiving local authority funding support, top-up payments are usually made by a third party (eg a family member) and there are only limited circumstances where the person can pay the top-up themselves (first-party top-ups).[54]

The Government has said it will change the regulations[55] to allow everyone receiving local authority support to make top-up payments themselves if they wish. Any top-up fees paid will not count towards the cap on care charges and will remain payable after the cap is reached.[56]

Amendment to the Care Act framework

Under the framework for a cap on care costs as originally provided by the Care Act 2014, where a local authority contributes towards the cost of

48 Care Act 2014, section 15(2); The Care and Support (Eligibility Criteria) Regulations 2015 (SI 2015/313); DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.2.

49 DHSC, Operational guidance to implement a lifetime cap on care costs, 7 July 2022.

50 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.21.

51 DHSC, Operational guidance to implement a lifetime cap on care costs, 14 March 2022.

52 Care Act 2014, section 28; DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, paras 1.7-1.8 & 1.31-1.34.

53 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022.

54 For further information see the Library briefing, Paying for adult social care in England, section 2.4; DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.9.

55 The Care and Support and After-care (Choice of Accommodation) Regulations 2014, SI 2014/2670.

56 HM Government, Adult social care charging reform: further details, 17 November 2021.

meeting a person's eligible care needs, this spending would count towards the cap (in addition to any contribution made by the individual).[57]

However, in November 2021 the Government announced it would amend the Care Act so that only the amount **that the individual contributes** towards meeting their eligible needs will count towards the cap and not any local authority contributions.[58]

The Government estimated the change would save around £900 million a year from 2027/28 (the point when the additional cost to the state of the cap on care costs will stabilise).[59]

Health and Care Bill

The proposed change proved controversial (see section 4.4 below) and was the subject of disagreement between the House of Commons and the House of Lords during the passage of the Health and Care Bill:

- On 18 November 2021, the Government tabled a New Clause to the Health and Care Bill for consideration on Report (PDF) providing for the change to the Care Act framework.[60] On 22 November 2021, the new clause was approved by the Commons following a division.[61]
- At Report Stage in the Lords, peers agreed an amendment removing the Government's new clause from the Bill.[62]
- On 30 March 2022, the Commons disagreed with the Lords amendment removing the clause from the Bill (ie, the proposed change to the Care Act framework was re-inserted into the Bill). Further technical amendments were agreed regarding how the cap will operate.[63]

On 5 April 2022, the Lords insisted on their amendment removing the clause from the Bill and agreed an amendment which would provide the Secretary of State with the power to make regulations amending the Care Act 2014 with regards to how people progress towards the cap on care costs. The amendment additionally provided:

- The regulations must ensure costs incurred by a local authority in meeting a person's eligible needs are included.
- The regulations may not be made unless the results of the trailblazer pilots (see pages 22-23 below) have been evaluated and the Secretary of State has published a further general impact assessment "covering

57 Care Act 2014, section 15.
58 HCWS399, 17 November 2021; HM Government, Adult social care charging reform: further details, 17 November 2021.
59 DHSC, Adult social care charging reform: analysis, 19 November 2021.
60 Health and Care Bill Notices of Amendments as at 19 November 2019 (699KB PDF), NC49, pp9-11.
61 HC Deb 22 November 2021, cc108-c156.
62 HL Deb 7 March 2022, cc1168-1185.
63 HC Deb 30 March 2022, cc939-953.

distributional regional analysis, regional eligibility, and the effect of the care cap on disabled adults under 40."

- The regulations must ensure that no charges are imposed on any adult aged under 40 with a disability.[64]

On 25 April, the Commons disagreed with the Lords amendment (ie, the proposed change to the Care Act framework was re-inserted into the Bill along with the previously agreed technical amendments).[65]

On 26 April, the Lords voted not to insist on its amendment and thus agreed to the Bill including the clause amending the Care Act framework.[66]

The Bill received Royal Assent on 28 April 2022.

Daily living costs

Only money spent on meeting a person's personal care needs will count towards the cap; for those living in a care home, daily living costs (or what are commonly referred to as "hotel costs") **will not** count towards the cap.[67] Similarly, a care home resident who has reached the cap will still be required to pay their daily living costs (subject to the means test).[68]

The Government has said daily living costs will be set at a national notional level equivalent to £200 per week in 2021/22 prices.[69] The Government's impact assessment said this means daily living costs "will be affordable to people on average incomes so they do not have to continue to use their assets after reaching the cap."[70]

Costs accrued before October 2023

From October 2023, anyone assessed by a local authority as having eligible care and support needs, either new or existing social care users, will begin to progress towards the cap. The Government has said local authorities will "need to work to identify people who currently meet their eligible needs themselves, to ensure that they can begin progressing towards the cap from the point it comes into effect."[71]

64 HL Deb 5 April 2022, cc1985-2002 & c2035-2039 (motion G1).
65 HC Deb 25 April 2022, cc525-546.
66 HL Deb 26 April 2022, cc219-243 (motion D)
67 Care Act 2014, section 15(6); HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, paras 38-40.
68 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.12.
69 HM Government, Adult social care charging reform: further details, 17 November 2021; DHSC, Operational guidance to implement a lifetime cap on care costs, 14 March 2022.
70 DHSC, Adult social care charging reform: impact assessment, January 2022, para 40.
71 HM Government, Adult social care charging reform: further details, 17 November 2021.

Costs accrued before October 2023, however, will **not count towards the cap (it is not retrospective).**[72] During the Lords committee stage debate on the Health and Care Bill, the Minister, Lord Kamall, said it was "unfeasible" to retrospectively introduce the cap for everyone currently in the care system, and to include their care costs during their lifetimes in the cap calculation.[73]

If a person has to wait for an assessment, their progress towards the cap will be backdated to when the individual contacted the local authority or the authority first identified them (but not earlier than October 2023).[74]

People receiving care in other countries of the UK

If a local authority in England arranges for a person to receive residential care in another country of the UK, and the person remains ordinarily resident in England, the person will progress towards the cap based on the cost to the English local authority of meeting the person's needs. However, if a person living in England arranges their own residential care in another country of the UK, they would usually become ordinarily resident in that country and will not progress towards the cap.

Similarly, if a local authority in another country of the UK arranges for a person to receive residential care in England, and the person will not be ordinarily resident in England, they will not progress towards the cap. However, a person from another part of the UK who arranges their own residential care in England will usually become ordinarily resident in England and will progress towards the cap.[75]

Adjustments to the cap parameters

The level of the cap will be adjusted annually in line with average earnings.[76] Where the level of the cap is adjusted, a person's progress towards it, in terms of accrued costs as a percentage of the cap, will be maintained. For example, if a person is 50% towards the cap when the level of the cap is changed, adjustments will be made to ensure that the person's progress remains at 50%.[77]

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72 Care Act 2014, section 15(5); DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.15.

73 HL Deb 31 January 2021, c753.

74 DHSC, Implementing the cap on care costs: draft operational guidance (PDF), 4 March 2022, para 2.22.

75 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, paras 1.40-1.41.

76 Care Act 2014, section 16(1); DHSC, Adult social care charging reform: impact assessment, January 2022, para 37.

77 DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, paras 1.48-1.49.

Under the Care Act 2014, the Secretary of State is required to conduct a review on the operation of the cap every five years. This will include, for example, the level of daily living costs.[78]

Legislative implementation

The legislation for a cap on care costs is already included in the Care Act 2014 and the Build Back Better policy document said the cap will be implemented using this legislation.[79] However, as discussed above (pages 17-19), the Government has amended this framework via the Health and Care Act 2022.

Primary legislation related to the cap will be commenced and the level of the cap and daily living costs will be set through statutory instrument subject to the affirmative procedure.[80]

As set out above, on 4 March 2022, the Government published a consultation on draft operational guidance setting out how the cap on care costs will operate in practice. The consultation document provided further information on the regulatory changes required to implement the reforms. The Government responded to the consultation on 7 July 2022 and published a revised version of the operational guidance. The guidance will become part of the Care and Support Statutory Guidance in October 2023.[81]

Local authority implementation

The March 2022 consultation also sought views on draft guidance to support local authorities with preparing for implementation of the reforms.[82]

The Government responded to the consultation on 15 June 2022.[83] While responses to the consultation were "supportive of the policy principles and aims of the reforms", they raised issues in a number of areas, including:

- **Implementation timescales**: some respondents suggested a phased approach and "a significant number of local authorities" raised concerns about building IT capability within the timescales. The Government's response recognised "the challenging timescale for implementation" and said it was working with trailblazer and pathfinder local authorities (see page 22 below) to develop implementation plans.

78 Care Act 2014, section 71; DHSC, Implementing the cap on care costs: draft operational guidance, 4 March 2022, para 1.48.

79 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 38.

80 Care Act 2014, sections 15(4) & 125(4)(b); DHSC, Adult social care charging reform: impact assessment, January 2022, para 94.

81 DHSC, Operational guidance to implement a lifetime cap on care costs, 7 July 2022.

82 DHSC, Supporting local preparation: draft guidance, 14 March 2022.

83 DHSC, Charging reform: government response to the consultation on 'supporting local preparation' guidance, 7 July 2022.

- **Funding**: concerns were raised that funding for the reforms would be insufficient. In response, the Government said the impact assessment on the reforms, which included funding, had "been through extensive peer review on several occasions."

- **Workforce capacity**: many respondents highlighted the reforms will require a significant increase in the workforce in the context of existing recruitment and retention difficulties. The Government's response highlighted the funding being provided for implementation but recognised "this alone will not overcome the challenge, and local authorities will need to deploy a range of initiatives to implement the charging reform."

- **Communications**: respondents called for a national approach to raise awareness and communicate the reforms. The Government said it recognised this need and that there would be national communications through the Transforming Social Care campaign website, social media and other media channels.[84]

A revised version of the guidance on local implementation was published as a new chapter 23 of the Care and Support Statutory Guidance at the same time as the consultation response.[85]

Among other things, the guidance suggests local authorities may conduct needs and financial assessments of self-funders who are seeking to access the cap (or who are newly captured by the more generous means test) from April 2023 onwards to help manage the demand for assessments. If an individual is assessed early, they will still not being accruing towards the cap until October 2023.[86]

Alongside the consultation response on 15 June 2022, the Government published details of initial implementation funding allocations for the 2022/23 financial year.[87]

Trailblazer local authorities

Six "trailblazer" local authorities – Wolverhampton, Blackpool, Cheshire East, Newham, North Yorkshire and Oxfordshire – will implement the charging reforms from January 2023 ahead of national rollout in October 2023. The

84 DHSC, Charging reform: government response to the consultation on 'supporting local preparation' guidance, 7 July 2022.

85 DHSC, Care and Support Statutory Guidance, 2 September 2022, Chapter 23: Charging reform: guidance on supporting local preparation.

86 DHSC, Care and Support Statutory Guidance, 2 September 2022, Chapter 23: Charging reform: guidance on supporting local preparation, paras 23.20-23.23.

87 DHSC, Adult social care charging reform: implementation support funding grant determination 2022 to 2023, 15 June 2022.

Government has said the areas were selected "to ensure a cross section of communities are represented."[88]

Details of funding for the trailblazer local authorities was announced by the Government on 15 June 2022.[89]

3.2 Changes to the social care means test

From October 2023, the Government proposes to make the following changes to the capital means test:

- Increase the **upper capital limit** (the threshold above which somebody is not eligible for local authority support towards their care costs) from £23,250 to £100,000.
- Increase the **lower capital limit** (the threshold below which somebody does not have to contribute towards their care costs from their capital) from £14,250 to £20,000.
- If somebody has capital between £20,000 and £100,000 they will be charged a "tariff income" of £1 per week for every £250 in capital they have between the lower and upper thresholds. This mirrors the current system.[90]

These limits will apply to those in residential care and to those receiving care in other settings (eg, in their own home).[91]

3.3 Fair cost of care reforms

Background

Local authorities can use their position as a large purchaser of social care to obtain lower fee rates from care providers, which can be less than the cost of providing care. Government modelling estimates 70% of local authorities pay below a "fair cost of care."

88 DHSC, Operational guidance to implement a lifetime cap on care costs, 14 March 2022; DHSC, Local Authorities announced as trailblazers for social care charging reform, 25 March 2022; DHSC, Oxfordshire joins as sixth trailblazer for charging reform, 25 July 2022.

89 DHSC, Adult social care charging reform: early assessment and trailblazer support funding grant determination 2022 to 2023, 15 June 2022.

90 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, paras 41-44; HM Government, Adult social care charging reform: further details, 17 November 2021.

91 HM Government, Adult social care charging reform: further details, 17 November 2021.

The Government says this is leading to market failure, with care providers "having low resilience to cope with changes such as fluctuations in demand, cost increases, and other factors such as worker shortages."[92]

It can also lead to providers attempting to cross-subsidise, with the result that self-funders often pay more for equivalent care than people funded by the local authority. In 2017, the Competition and Markets Authority estimated a self-funder will on average pay 40% more than a local authority funded person in the same care home.[93]

The Government is proposing two related measures aimed at addressing these issues:

- Enabling self-funders to access local authority fee rates.
- Providing funding to local authorities so that they can increase the rates they pay for care (move towards paying a "fair cost of care").

Enabling people to access local authority fee rates

The Government has said it will bring section 18(3) of the Care Act 2014 fully into force so that self-funders can ask their local authority to arrange their care in a care home to "find better value".[94] Currently, self-funders can only do this if they receive care outside of a care home.[95]

An article in Community Care explained:

> Currently, self-funders pay significantly greater sums for care than those funded by councils or the NHS (under continuing healthcare).
>
> However, the government said [on 7 September 2021] it would also implement section 18(3) of the Care Act 2014 in full, requiring councils to arrange care in a care home for those self-funders with eligible needs who request that they do so.
>
> This is designed to enable councils to take account of their bulk purchasing power to secure lower rates for self-funders; as a result, the costs paid by self-funders and the state should converge, meaning self-funders' care accounts should reflect what they actually pay." [96]

92 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 266; DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021.

93 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 265-6.

94 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 40. For more information on the current position, see Care Act 2014, section 18(3); Department of Health and Social Care, Care and Support Statutory Guidance, last updated 27 August 2021, Annex A, paras 41-43.

95 Care Act 2014, section 18(3); Care Act 2014 (Commencement No. 4) Order 2015/993, paragraph 3.

96 Community Care, Government resurrects cap on care costs plan four years after ditching it, 7 September 2021.

The Government says this will help address the difference in fee rates charged to some self-funders.[97] It will also, the Government says, protect the integrity of the cap on care costs by ensuring people progress towards the cap at the rate they are paying for care (ie the local authority rate).[98]

Fair cost of care

Allowing self-funders to access local authority fee rates will mean some care providers will have to reduce their reliance on using self-funders to subsidise state-funded care. The Government has said where this happens, "local authorities will need to ensure their market can be sustained and fee rates are sustainable."[99]

The Government said it will provide an additional £1.36 billion over the next three years – referred to as the Market Sustainability and Fair Cost of Care Fund – to help enable local authorities to increase the rates they pay to care providers where necessary (move towards paying a "fair cost of care"). £162 million will be allocated in 2022/23 and £600 million in both 2023/24 and 2024/25. The funding is part of the £3.6 billion allocated for social care charging reforms.[100]

The Government expects local authorities to conduct a cost of care exercise to determine sustainable rates and identify how close they are to them. The additional funding should then be used "to genuinely increase fee rates, as appropriate to local circumstances."[101] The actual change in fee rates in an individual local authority will "vary according to their starting point, local market circumstances and local pressures."[102]

Further information was provided in a policy paper published in December 2021: Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023 and in a written ministerial statement.[103]

On 24 March 2022, the Government published guidance on the use of the funding in 2022/23. Among other things, this set out that local authorities must submit the following to the Department of Health and Social Care by October 2022 as a condition of future funding:

- cost of care exercises for 65+ care homes and 18+ domiciliary care

97 DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021.
98 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 267.
99 DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021.
100 DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021.
101 DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021.
102 PQ108454 [Home Care Services: Finance], 27 January 2022.
103 DHSC, Market Sustainability and Fair Cost of Care Fund: purpose and conditions 2022 to 2023, 16 December 2021; HCWS509 [Adult Social Care Funding and Reform], 16 December 2021.

- a provisional market sustainability plan, using the cost of care exercise as a key input to identify risks in the local market, with particular consideration given to the further commencement of Section 18(3) of the Care Act 2014 (which is currently in force only for domiciliary care) – a final plan will be submitted in February 2023.

- a spend report detailing how funding allocated for 2022 to 2023 is being spent in line with the fund's purpose.[104]

The guidance said local authorities must spend no more than 25 per cent of the funding for 2022/23 on implementation costs. Authorities are expected to use at least 75 per cent of the funding to increase fee rates paid to providers of 65+ care homes and 18+ domiciliary care.[105]

An article published by the Nuffield Trust in June 2022 provides further information on the proposed "fair cost of care" reforms, which it described as "arguably more significant to how the social care system operates than the cap on care costs."[106]

Implementation

Many responses to the Government's consultation on operational guidance for implementing the cap on care costs (see section 3.1 above, page 21) raised concerns about the impact of fully implementing section 18(3) of the Care Act (ie, allowing self-funders to ask the local authority to arrange their care in a care home for them). These included concerns over funding, and the impact on local authorities' administrative workload and workforce requirements.

In its response to the consultation, the Government argued the issues raised by the respondents were "underpinned and exacerbated" by the uncertainty around how many people will choose to use section 18(3). "Concerns around funding, workforce, administrative pressures and the timing of introduction are all significantly increased", it said, "in a scenario in which many self-funders simultaneously choose to use section 18(3) in October 2023."

In light of this, the response said, the Government planned to introduce section 18(3) via a transitional period:

- From October 2023, self-funders who enter a care home for the first time will be able to use section 18(3).

104 DHSC, Market sustainability and fair cost of care fund 2022 to 2023: guidance, 24 March 2022; DHSC, Care providers to receive fairer costs for providing care, 24 March 2022.

105 DHSC, Care providers to receive fairer costs for providing care, 24 March 2022.

106 Nuffield Trust, Fair cost of care: what is it and will it fix the problems in the social care provider market?, 15 June 2022.

- Self-funders who are already in a care home in October 2023 will gain access to section 18(3) at the end of the transition period. This will be no later than April 2025 and earlier "if the market can sustain full rollout."[107]

The transitional period will be reviewed after one year (October 2024).[108]

3.4 Other changes

The Government announced other changes to the adult social care charging framework. These include:

- From April 2022, the **amount of income** a person must be allowed to retain after contributing towards their care costs (the Personal Expenses Allowance for care home residents and the Minimum Income Guarantee for people receiving care in other settings) increased in line with inflation (3%).[109] The rate of the Personal Expenses Allowance had not increased since 2015/16 and the rate of the Minimum Income Guarantee had not increased since 2016/17.[110]

- The Government will review the system of **Deferred Payment Agreements** to "provide more flexibility." A Deferred Payment Agreement is essentially a loan given by a local authority, which is usually secured against the value of a person's property. The intention is to allow a person to delay paying their care costs to avoid having to sell their home in their lifetime to pay for residential care.[111]

107 DHSC, Charging reform: government response to the consultation on 'implementing the cap on care costs' operational guidance, 7 July 2022; HC Deb 7 July 2022, cc73-4WS.

108 DHSC, Charging reform: government response to the consultation on 'implementing the cap on care costs' operational guidance, 7 July 2022.

109 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 45.

110 CBP8005, Adult Social Care: Means-test parameters since 1997, 11 June 2021.

111 For further information, see CBP1911, Paying for adult social care in England, 27 August 2021.

4 Analysis of charging reforms

4.1 Comparison with Dilnot Commission proposals

In evidence to the Treasury Committee on 18 November 2021, Sir Andrew Dilnot identified areas where the Government's proposals are more generous than those recommended by the Dilnot Commission in 2011:

- The Government's proposals increase the upper capital limit for everybody, including those receiving care in their own home. The Dilnot Commission recommended a lower capital limit for those receiving care in their own home.[112]
- The Government is proposing setting daily living costs at a lower notional level than proposed in 2015.[113]

However, he also highlighted areas where the Government's proposals are less generous than recommended by the Commission:

- The Dilnot Commission recommended a £0 cap for people entering adulthood with a care need (ie they would make no contribution towards their personal care). The cap would then increase in steps for those aged over 45. Under the Government's proposals, the £86,000 cap will apply to all adults irrespective of age.[114]
- The increase to the upper capital limit for those in residential care is less in real terms than recommended by the Dilnot Commission.[115]
- The level of the cap on care costs is higher than recommended by the Commission.[116]

112 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q308.
113 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q308.
114 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q307.
115 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q308.
116 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q308-309.

- Under the Government's proposals, only an individual's contribution will count towards the cap, and not any contribution from the local authority (see section 4.4 below for further commentary on this).[117]

Although he raised some concerns with the Government's proposals, Sir Andrew emphasised they were a big improvement on the current system:

> [The Government's proposals] still takes us to a much better place than where we are at the moment. The cap is less generous than I wanted it to be. The upper cap is a bit lower. Nonetheless, it moves us from a world where we are now, where this is an entirely means-tested regime that exposes the whole population to catastrophic costs, to, for the first time, a national risk pool for social care. These things are to be noted and welcomed. The particular way in which they are being done, and particularly what was announced yesterday [the proposed amendment to the Care Act], is less than the best way.[118]

A table setting out how the Government's proposals differ from those consulted on in 2015 is available on page 11 of the joint report by the Institute for Fiscal Studies and the Health Foundation: Does the cap fit? Analysing the government's proposed amendment to the English social care charging system (PDF).[119]

During the Lords Committee stage on the Health and Care Bill, an amendment was discussed which would have set a zero cap for people who enter the care system at or under the age of 40. The amendment was not moved. The Minister, Lord Kamall, said the Government's proposals did not include different caps for different ages because it was "considered unfair."[120]

As discussed in section 3.3 above, on 5 April 2022, the Lords agreed an amendment to the Bill which would prevent a local authority from charging a disabled person aged under 40 for meeting their eligible care needs.[121] This amendment was rejected by the Commons and was not included in the final agreed version of the Bill.[122]

4.2 Government analysis of impact on care users

The September 2021 Build Back Better policy paper said the proposed cap on personal care charges will mean "people will no longer face unpredictable or unlimited care costs". It added that "everybody will benefit from the certainty

117 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q309.

118 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q329.

119 IFS, Does the cap fit? Analysing the government's proposed amendment to the English social care charging system (PDF), February 2022, p11.

120 HL Deb 31 January 2021, cc735-753; UK Parliament, Baroness Bull's amendment In Clause 140 (234), last accessed 8 February 2022.

121 HL Deb 5 April 2022, cc1985-2002 & c2035-2039 (motion G1).

122 HC Deb 25 April 2022, cc525-546; HL Deb 26 April 2022, cc219-243 (motion D).

and security that if they or their loved ones need personal care, they will no longer face unpredictable and unlimited costs."[123] The Government's impact assessment on the reforms, published in January 2022, estimated the monetary value of these 'peace of mind benefits' to be around £1 billion a year by 2027/28.[124]

The impact assessment said the main objective of the reforms is "to address the risk individuals face due to unlimited care costs." It added the proposals "also aim to increase the protection of those with lower wealth and incomes who fall under the means test."[125]

Older adults

Analysis published by the Government in November 2021 estimated that, given 2021/22 demand, around 90,000 additional older adults would be receiving state support due to the proposed reforms (around 360,000 received support under the current system). Of this, around 30,000 would be benefiting from the more generous means test only, and 60,000 would be benefiting from the cap (or cap and means test). The proportion of older adults in care receiving support from the state would increase from around half to around two-thirds. The analysis added that "no one will be worse off, and some will be better off".[126]

The Government's impact assessment shows that up to the end of 2025/26, very few people will benefit from the cap (as it will take time to reach it); the main additional beneficiaries of state support in the early years will be those getting support through the more generous means test. By 2031/32 around 115,000 additional older adults would be receiving state support with their care costs because of the proposed reforms. Of this, 74,000 would have reached the cap on care costs.[127]

The impact assessment projected that, under the reformed system, spending on the least wealthy 20% of older adults (those with less than around £71,000 of assets) in 2021/22 would be around £4.42 billion compared to £4.24 billion under an unreformed system. Spend on the wealthiest 20% would be £0.5 billion compared to £0.05 billion.[128]

The assessment noted that, while the additional spending on the cap on care costs "goes towards those in high wealth groups" the "overall system remains progressive." It added that the more generous means test provides protection for those at lower levels of wealth.[129]

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123 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, paras 38 & 44.

124 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 376-382.

125 DHSC, Adult social care charging reform: impact assessment, January 2022, para 61.

126 DHSC, Adult social care charging reform: analysis, 19 November 2021, p3.

127 DHSC, Adult social care charging reform: impact assessment, January 2022, para 141.

128 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 456-458.

129 DHSC, Adult social care charging reform: impact assessment, January 2022, para 141.

Younger adults

In 2020/21, approximately 256,000 adults aged under 65 received long-term care compared to around 360,000 older adults. The Government has estimated that for 2020/21 around 90% of care users aged 18-64 are already state supported, compared to 55% of care users aged over 65.[130]

The Government's impact assessment estimated that by 2031/32 around 21,200 additional adults aged under 65 would be receiving state support under a reformed system. The assessment estimated that, on average, users that are partially state funded are less likely to hit the cap by 2031/32 as their contribution to their care is low. However, they may benefit from the more generous means test.[131]

Regional variation

The Government's impact assessment said people "are either more or less likely to benefit from reforms based on their income and wealth and care journeys, rather than where they live." It added:

> ...while on average there will be variation between regions in terms of how they will be [sic] benefit from the different aspects of the reform, there will be considerable variation within regions. Comparably less wealthy regions will likely have fewer users benefiting from the cap, whilst having more users benefit from the more generous means test, than comparably wealthier regions.[132]

While noting detailed regional analysis is restricted by a lack of data, the assessment drew some inferences based on how care fee rates and wealth and income profiles vary by region:

- Regions with higher fee rates are likely to have more users hitting the cap on care costs. Areas in the south of England generally have higher fee rates than the north. However, there is also substantial variation within regions.[133]

- Median house prices in 2021/22 varied from £141,000 in the North East to £479,000 in London. Homeowners in northern regions are more likely to get state support from the more generous means test, while homeowners in London are much less likely to get state support until they hit the cap (assuming their house is not disregarded).[134]

130 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 232.
131 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 233-238.
132 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 233-238.
133 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 464-471.
134 DHSC, Adult social care charging reform: impact assessment, January 2022, para 472.

Impact on individual care users

How someone receiving social care will be affected by the proposed reforms depends on their individual circumstances, including their starting wealth, their income, how long they need care for and their care fees.

The Government has published an interactive asset depletion chart, which can be used to show what percentage of a person's starting wealth will have depleted at a given point during their time receiving care under the current system, the proposed reformed system, and the reforms proposed in 2015. The analysis is based on the following assumptions:

- The individual has a weekly income (excluding disregarded income) of £239 (DHSC's estimate of the median income of over 65s in England).
- The individual pays the average weekly fee rate for older adult users in residential care of £683.

The level of asset depletion varies depending on a person's starting wealth and how long they spend in care. Based on somebody spending 97-weeks in care, for example (the median length people spend in residential care), the analysis shows:

- Under the current system, asset depletion peaks for an individual who started with £65,000 of wealth, depleting 65% of their assets over this time.
- Under the reformed system, a person with £65,000 starting wealth would deplete 22% of their assets.

The Government's impact assessment also gave a breakdown of spend from a person's income and assets, and state funding, for a 97-week period in care based on different levels of starting wealth.[135]

A person's stating wealth will also have a big impact on how long it takes them to reach the cap on care costs. Assuming daily living costs of £200 a week, care fees of £683 a week and weekly income of £230, the Government's impact assessment estimated it would take somebody with £100,000 of starting wealth 13 years and nine months to reach the cap. In this time, they would receive £260,000 of state support. On the other hand, somebody with £200,000 of starting wealth would reach the cap in three years and six months and would receive no support over this time.[136]

This example demonstrates the impact of not counting the local authority's contribution towards the cap (amendment to the Care Act). Without the amendment, the people in the example would reach the cap at the same time.

[135] DHSC, Adult social care charging reform: impact assessment, January 2022, para 460.
[136] DHSC, Adult social care charging reform: impact assessment, January 2022, para 106.

The Government has estimated around 13% of older adults who enter a care home are there for five years or more; 2% are there for 10 years or longer.[137]

Further analysis is provided on pages 30 to 36 of the impact assessment.

4.3 Stakeholder commentary on impact on care users

The proposed reforms were broadly welcomed in stakeholders' initial responses. The Resolution Foundation, for example, said they were "an overdue socialisation of the risk we all face of high care costs" and the Nuffield Trust said the changes "will be a relief to tens of thousands of people."[138] ADASS similarly said the reforms feel "like a significant step forward" and the Local Government Association (LGA) said they are "an important first step toward changing the way social care is funded and will help to reduce the burden of costs on people."[139]

The Resolution Foundation, however, raised the potential risk that the reforms will not live up to their marketing, with some people still needing to "give the local authority a significant stake in their home to pay for social care." The plans are also, it said, "significantly less generous" than those proposed by the Dilnot Commission.[140] The Foundation also outlined the differential impact across English regions, with the cap offering more support to families in the South and the more generous means test impacting favourably in lower wealth regions.[141]

In its initial response, the King's Fund said the changes to the means test are "very welcome and will bring thousands more people into the publicly funded system". It added, however, that while the cap on care costs will protect people from very high costs, it "will help relatively few people".[142]

In May 2022, the King's Fund published an assessment of the Government's progress in addressing eight key problems in social care. While it assessed the Government as making good progress on means testing (7/10), progress

137 DHSC, Adult social care charging reform: analysis, 19 November 2021, p3.

138 Resolution Foundation, Nationally Insured? New taxes and new spending to address key Department for Health and Social Care priorities, 8 September 2021, p2.; Nuffield Trust, Care providers, care users and workers will feel short-changed by proposed health and social care levy and reform, 7 September 2021.

139 Association of Directors of Adult Social Services, Prime Minister Announces Adult Social Care Reform Plans & Funding, 7 September 2021.; Local Government Association, LGA responds to social care funding announcement, 7 September 2021.

140 Resolution Foundation, Nationally Insured? New taxes and new spending to address key Department for Health and Social Care priorities, 8 September 2021, pp9-11.

141 Resolution Foundation, Nationally Insured? New taxes and new spending to address key Department for Health and Social Care priorities, 8 September 2021, pp9-11.

142 King's Fund, The King's Fund responds to the announcement of a health and social care levy, 7 September 2021.

on preventing catastrophic costs was rated as "disappointing" (5/10) and the effectiveness of tackling unmet need was assessed as "very limited" (2/10). On addressing market fragility, the King's Fund highlighted the highly unpredictable nature of the "fair cost of care" reforms and said it was too soon to judge its effectiveness.[143]

The Health Foundation welcomed the proposed cap on care costs as "a positive and bold step forward" which will give people "greater certainty about the future costs they need to plan for and help reduce the care cost lottery." It also highlighted, however, that those with modest means still risk losing a high proportion of their wealth:

> With the cap set at £86k, most people will be protected from catastrophic care costs, but those with modest assets and high care needs will still risk losing a high proportion of their wealth in future. For example, an individual whose house is valued at £125k still risks losing almost half of their housing wealth whereas a cap set at £50k would have enabled them to retain two thirds. By comparison, a person with a house valued at £500k risks losing less than a fifth of their housing wealth.[144]

Age UK and the Care and Support Alliance said the £86,000 cap gives "much needed certainty" and removes "the fear of care bills spiralling to infinity, though at that level it will help fewer people than many had hoped." It added: "A more generous means test is arguably the more significant announcement for most and will result in greater numbers receiving at least some financial help."[145]

The Institute of Public Policy Research said the proposed reforms are "a clear improvement on the current system" and "will save the family homes of many and help tackle unmet need." It added, however, that the system "still falls short of putting social care on the same basis as other care provided by the NHS – free to all at the point of need."[146]

4.4 Costs and funding of charging reforms

The Government's impact assessment estimates the proposed charging reforms, including the "fair cost of care", will cost around £23.25 billon (in 2021/22 prices) in total by 2031/32. The annual costs start low (£1.42 billion in 2023/24) but increase to an estimated £4.74 billion by 2031/32.

143 King's Fund, Reform of adult social care: some progress, but nowhere near enough, 10 May 2022.
144 Health Foundation, Social care cap a bold step forward but funding won't 'fix' social care or tackle the NHS backlog, 7 September 2021.
145 Age UK, Age UK & CSA response to PM's Social Care reform announcement, 7 September 2021.
146 IPPR, Social care plan 'a clear improvement' on current system but leaves key problems unresolved, says IPPR, 7 September 2021.

A table on page seven of the impact assessment provides a breakdown of the costs.[147]

The Government says the announced £3.6 billion of funding over the next three years covers the cost to local authorities of implementing the proposed reforms. If costs "differ significantly from projections", the Government will "work closely with local authorities to address this, including through national guidance, supporting appropriate local level mitigations, and by agreeing necessary updates to distribution mechanisms."[148]

On 8 August 2022, the Government published a consultation on the distribution of funding to support the charging reforms in 2023/24. The consultation closed on 23 September and the Government is yet to respond.[149]

The cap and more generous means test

The cap on care costs and the more generous means test are estimated to cost around £0.57 billion in 2023/24, rising to £2.68 billion in 2027/28 and £3.60 billion in 2031/32. Costs start low as most people will not reach the cap for several years after implementation. Costs from the cap are observed from 2026/27 and the system reaches a steady state roughly four years after implementation (in 2027/28).

Increased costs from 2027/28 are driven by a projected increase in demand and increases in the estimated costs of care.[150] The costs for younger adults are substantially lower than for older adults as there are currently fewer younger adults funding their own care.[151]

There is also estimated to be a saving arising out of a reduction in benefits paid by the Department for Work and Pensions. This is because care home residents in receipt of local authority support are not eligible for Attendance Allowance, the care component of Disability Living Allowance or the daily living component of Personal Independence Payment, and the reforms are expected to lead to an increase in the number of care home residents in receipt of state support. The impact assessment estimated the saving from this to be around £0.23 billion in 2027/28 and £0.27 billion in 2031/32.[152]

The impact assessment noted the reforms will likely lead to an increase in administration costs for local authorities as they will have to conduct assessments for self-funders so they can begin progressing towards the cap. It estimated the additional cost of assessments for older adults to be between £150 million and £170 million a year between 2024/25 and 2031/32.[153] The extra

147 DHSC, Adult social care charging reform: impact assessment, January 2022, p7, table 1.
148 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 46.
149 DHSC, Adult social care charging reform: distribution of funding 2023 to 2024, 8 August 2022.
150 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 133-140.
151 DHSC, Adult social care charging reform: impact assessment, January 2022, para 227.
152 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 354-361.
153 DHSC, Adult social care charging reform: impact assessment, January 2022, p44, table 12.

costs of assessments for younger adults are estimated to be between £10 million and £12 million a year.[154]

The implementation costs of the reforms include funding for early assessments and planning and preparation costs. The Government estimates these costs to be £34 million in 2022/23 and £168 million in 2023/24.[155]

Concerns around funding and implementation

As noted in section 3.1 above (pages 21-22), responses to the Government's consultation on local implementation were supportive of the principle and aims of the reforms. However, they also raised a number of areas of concern, including around workforce capacity, funding, and implementation timescales. Insufficient supply of workforce was the most common concern raised.[156]

A report published by the County Councils Network in May 2022 estimated the costs of the charging reforms in the nine years from when they are introduced to 2032 could be a minimum of £10bn higher than currently estimated. The analysis also estimated 4,300 more social work staff and 700 more financial assessors will be required to carry out additional assessments, reviews and case management. The report suggested there is significant regional variation in the impact of the reforms.[157]

In a survey by the Local Government Association (LGA) in June 2022, 98% of responding councils said they were not confident that funding for the reforms will be sufficient. Three quarters of responding councils said they were also not confident of having the workforce capacity to deliver the reforms.[158]

On 5 August 2022, the LGA called on the Government to delay implementation of the cap on care costs, changes to the means test and section 18(3) of the Care Act to April 2024. It said councils had "serious concerns over the deliverability of…reforms within the current climate and to the current timescale, with many concerned that crucial council services may be negatively impacted to afford the reforms."[159]

LUHC Committee report on social care funding

In its August 2022 report on the long-term funding of adult social care, the Levelling Up, Housing and Communities Committee said it had received concerns about the practicability of implementing all the charging reforms at

154 DHSC, Adult social care charging reform: impact assessment, January 2022, p61, table 23.

155 DHSC, Adult social care charging reform: impact assessment, January 2022, para 263.

156 DHSC, Charging reform: government response to the consultation on 'supporting local preparation' guidance, 7 July 2022; Social worker shortages sector's biggest concern in delivering cap on care costs, Community Care, 17 June 2022.

157 County Councils Network, Preparing for reform, May 2022, pp4-6.

158 LGA, Not enough money for adult social care reforms, say 98 per cent of councils in LGA survey, 27 June 2022.

159 LGA, Evidence of immediate pressures to social care growing, 5 August 2022. Delay cap on care costs, council heads urge government, Community Care, 5 August 2022.

same time, and whether the funding is adequate, particularly for the fair cost of care.[160]

The report said the Government's decision to stagger the rollout of section 18(3) (see section 3.3 above, pages 26-27) "may help to avert the worst-case scenario in terms of local authority capacity pressures and market sustainability." It recommended, however, that the Government should re-evaluate the combined impact of the charging reforms and should regularly monitor take-up and update its models accordingly. It added that the Government should provide further funding to local authorities if necessary.

The Committee also expressed concern about the additional assessments which local authorities will have to carry out and that proposed workarounds will place additional strain on those requesting care and care workers.[161]

4.5 Amendment to Care Act

As set out in section 3.2 above (pages 17-19), the Government has amended the Care Act 2014 so that only the amount an individual contributes towards their eligible care costs (and not any local authority contribution) will count towards the cap on care costs.[162] This change has been one of the most contentious elements of the reform proposals.

Government rationale

The Government said it was introducing the change to ensure the reforms "are clear and reduce complexity."[163] It has also argued the change makes the proposed reforms fairer. For example, the impact assessment said:

> ...two people starting with the same level of wealth and contributing the same amount towards their eligible care needs each week will hit the cap at the same time; under the previous formulation they could reach the cap at very different times, depending on the level that the LA was contributing towards the cost of their care. People with modest means are primarily supported through the more generous means testing regime, which makes it very unlikely they will deplete a large proportion of their assets rather than the cap.[164]

During the Lords Report Stage on the Health and Care Bill, Lord Kamall, Parliamentary Under-Secretary at the Department of Health and Social Care,

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160 Levelling Up, Housing and Communities Committee, Long-term funding of adult social care (PDF), 4 August 2022, HC 19 2022/23, para 50.

161 Levelling Up, Housing and Communities Committee, Long-term funding of adult social care (PDF), 4 August 2022, HC 19 2022/23, paras59-64.

162 HCWS399, 17 November 2021; HM Government, Adult social care charging reform: further details, 17 November 2021.

163 HM Government, Adult social care charging reform: further details, 17 November 2021; HCWS399, 17 November 2021.

164 DHSC, Adult social care charging reform: impact assessment, January 2022, para 40; see also DHSC, Operational guidance to implement a lifetime cap on care costs, 14 March 2022.

said basing progress towards the cap on both individual and local authority contributions to care costs was both "unfair" and "considered unaffordable." In this context, he suggested previous proposals for reform hadn't been implemented because of affordability.[165]

The Government has said savings from the change (estimated to be around £900 million by 2027/28) have allowed it to be more generous in other areas compared to the proposals consulted on in 2015. This includes:

- To make the notional daily living charge lower (£200 a week compared to £258 in today's prices under the 2015 proposals). The Government estimates this will cost an additional £600 million a year.

- To set a higher upper capital limit for those in domiciliary care (£100,000 compared to £32,000 in 2023 prices under the 2015 proposals). The Government estimates this will cost an additional £200 million a year.[166]

The Government's impact assessment considered the reform proposals as a whole and did not assess the impact of the proposed amendment in isolation.[167]

Stakeholder concerns

The change has proved controversial among stakeholders. The King's Fund, for example, said it was "disappointing" and means "people who need the most protection from catastrophically high care costs – those with low to moderate levels of wealth – will get less protection than wealthier people."[168] Noting the cap was already more beneficial to those in the south of England, Torsten Bell, Chief Executive of the Resolution Foundation, said the change is a "big problem for those in the north/midlands".[169]

In its January 2022 report on the Autumn Budget and Spending Review 2021, the Treasury Committee welcomed the Government's proposed reforms, but expressed concern about the impact of the proposed change to the Care Act on people with wealth between £20,000 and £106,000. It said:

> Even if people within this cohort do not as individuals end up needing care, they are still exposed to far greater financial risk of having to contribute £86,000 of their own money in full than would have been the case under the provisions of the Care Act 2014. It is regrettable that a such a large cohort of people are still exposed to the possibility of incurring these high costs, which

165 HL Deb 7 March 2022, c1177-1178. Similar arguments were made by Edward Argar in the Commons on 25 April 2022: HC Deb 25 April 2022, c525-6.

166 DHSC, Adult social care charging reform: analysis, 19 November 2021.

167 IFS, Does the cap fit? Analysing the government's proposed amendment to the English social care charging system (PDF), February 2022, p6.

168 King's Fund, The King's Fund responds to social care cap change, 19 November 2021.

169 Torsten Bell, Twitter, 18 November 2021, available from: https://twitter.com/TorstenBell/status/1461336910547329030; Torsten Bell, Twitter, 18 November, available from: https://twitter.com/TorstenBell/status/1461037495328686083.

> make up a large proportion of their assets. Compared to the original Dilnot proposals, this will be regressive.[170]

As discussed in section 3.1 (pages 18-19) the proposed change also faced opposition during proceedings on the Health and Care Bill. For example, during Lords Report Stage on the Bill, Baroness Wheeler, who put forward the amendment removing the relevant clause from the Bill, argued the Care Act framework reflected a "carefully crafted…cross-party agreement" and the Government's proposed change was "a last-minute, hastily scraped together, ill-though-out mishmash…".[171]

IFS and Health Foundation report

On 7 February 2022, the Institute for Fiscal Studies (IFS) and the Health Foundation published a joint report on the impact of the proposed amendment to the Care Act. The report said the change "would impact most strongly those older people with modest levels of wealth." It added:

> Those with wealth, including their home, of around £75,000 to £150,000 would face the biggest loss of protection as a result of the amendment. The result is that someone with around £110,000 in assets could lose 78% of their total wealth even after the cap is in place, while someone with £500,000 could use up only 17%.

The report said "those in the North East, Yorkshire and the Midlands, where wealth tends to be lower, would see the biggest erosion of their protection against large care costs."

The report's other findings included:

- Those who receive means-tested support will have to contribute to their own care costs for longer before they reach the cap.
- Someone with £106,000 of assets and an annual income of £11,800 would contribute £76,000, or 71% of their assets, compared to £44,000, or 41% of their assets under the existing Care Act framework.
- The greatest impact will be on the second quintile of wealth distribution (those in households with wealth per person of between £83,000 and £183,000). There is a negligible effect on the wealthiest 40% (those with assets over £298,000).
- The proposed amendment would not substantially change the number of people at risk of having to use their housing wealth to pay for care, as most receiving means-tested support would have to draw on housing wealth (if they have any) under the reforms even without the amendment.

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170 Treasury Committee, Autumn Budget and Spending Review 2021, HC 825 2021/22, 27 January 2022, para 107.

171 HL Deb 7 March 2022, c1169.

- Working age adults with modest income could be significantly affected as a result of it taking years longer to reach the cap.[172]

4.6 Fair cost of care reforms

As set out above (pages 25-27), the Government's reforms include plans to enable self-funders to "find better value care" by asking their local authority to arrange their care for them (fully implementing section 18(3) of the Care Act 2014). At the same time, local authorities will be expected to move towards paying a "fair cost of care."

It's been suggested the ability of providers to charge self-funders more is what keeps them viable. As a report by care market specialists LaingBuisson explains, "it is the combination of fees from different funding sources [self-pay fees (typically high), council-paid fees (typically low) and NHS-paid fees (intermediate), plus third-party top-ups] which makes the sector as a whole viable." The report adds: "the sector as a whole is currently operating at average fees which are close to operating costs plus a reasonable return on secondary assets, pulled down by low state-paid fees and pulled up by high self-pay fees."[173]

This means changes to the fees paid by self-funders could potentially affect care providers' financial models if not mitigated by increased local authority fees.[174] In evidence to the Treasury Committee on 18 November 2021, Sally Warren, Director of Policy at the King's Fund, explained:

> ...section 18(3) of the Care Act allows self-funders to ask the local authority to access care at the local authority rate. It is an attempt to remove the cross-subsidy, which has been growing over the last decade. If you get that wrong in removing the cross-subsidy by not setting the Government rate high enough, that could see very high levels of instability for providers, and you could see providers removing themselves from the market. In that case, the only option you may be left with would be for local authorities to step in, definitely in the short term and possibly in the long term, to provide care.[175]

The Government's impact assessment highlighted uncertainty over how far the positive effect of the fair cost of care reform (as local authorities increase the rates they pay) will mitigate the effects of allowing self-funders to pay the local authority rate:

> The extent to which this happens will vary by provider and region and depend on several of the market conditions listed earlier (e.g. number of self-funders,

172 Institute for Fiscal Studies, Government's proposed amendment to social care cap puts more people at risk of catastrophic care costs, particularly those in the North East, Yorkshire & the Humber and the Midlands, 7 February 2022.

173 LaingBuisson, Care Homes for Older People: UK Market Report, December 2019, p105.

174 Guardian, UK care homes say funding shake-up threatens their viability, 8 September 2021.

175 Treasury Committee, Oral evidence, Autumn Budget and Spending Review 2021, HC 825, 18 November 2021, Q343.

> fee rate differentials, uptake etc).[...] whilst the overall impact on providers is currently uncertain, we will take steps to engage with local authorities and identify how different types of providers are affected.[176]

An article published by the Nuffield Trust in June 2022 said that, while the primary ambition of the reform has been largely welcomed, concerns have been raised about the risks in three main areas:

1. Will councils and providers be able to agree a "fair" rate?
2. Is funding sufficient for councils to increase fees to ensure providers can operate without the cross subsidy?
3. Will councils have sufficient capability and capacity to implement and administer the new system?

The article suggested the fair cost of care policy is "a bold element of the reform package that offers an opportunity to set the market for social care on a more stable footing." It added, however, that it will only be successful if the risks can be managed and if the funding is sufficient.[177]

In its July 2022 report on the health and social care workforce, the Health and Social Care Committee also said the fair cost of care reforms "must not be used as an excuse to reinforce the low pay which is endemic in the sector."[178]

Costs of implementing a 'fair cost of care'

The Government's impact assessment noted substantial uncertainty around the cost of implementing a fair cost of care, as this will depend on the outcomes of the cost of care exercises conducted by local authorities. The assessment's central cost estimate is that the reform will cost around £556 million in 2023/24, increasing to £726 million by 2031/32.[179]

If local authorities move towards a fair cost of care (ie they increase the fees they pay for care) this will mean people will progress to the cap on care charges more quickly. The Government estimates this will cost between £300 and £363 million a year between 2026/27 and 2031/32.[180]

It is also planned that local authorities will use funding for fair costs of care to build their capacity and capability to manage their local care markets. The Government estimates this will cost between £36 million and £43 million a year.[181]

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176 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 285-309.
177 Nuffield Trust, Fair cost of care: what is it and will it fix the problems in the social care provider market?, 15 June 2022.
178 Health and Social Care Committee, Workforce: recruitment, training and retention in health and social care, 25 July 2022, HC 115 2022/23, para 186.
179 DHSC, Adult social care charging reform: impact assessment, January 2022, p86, table 40.
180 HSC, Adult social care charging reform: impact assessment, January 2022, paras 334-336.
181 DHSC, Adult social care charging reform: impact assessment, January 2022, paras 328-329.

LaingBuisson report (March 2022)

A report by care market specialists LaingBuisson, commissioned by the County Councils Network and published in March 2022, suggested the Government had underestimated the cost of implementing the fair cost of care reforms. It said this "could cause severe sustainability risk to care markets across the country." Under its central estimate, the report said funding for the reform would have to be increased by £854 million a year for residential and nursing homes to prevent "widespread market instability." It added that even if funding was raised to this level "some care economies would still face financial significant pressures."[182]

The report said the financial impact of the reforms "will vary widely from provider to provider". It explained:

> Care homes operate in discrete geographies, with particular care offers (residential care, nursing care, residential dementia care and nursing dementia care being the core categories), and with varying degrees of self-funder and local authority revenues. The combinations of these characteristics will affect how they are impacted.[183]

In response to the report, the LGA raised concerns about the "significant underfunding of the Government's reform proposals" and said this also poses a risk to the financial viability of some councils.[184]

The report was also referenced by a "significant number of respondents" to the Government's consultation on local implementation of the charging reforms (see section 3.1 above, pages 21-23). In its response, the Government argued its modelling had "been through extensive peer review on several occasions." It added that the Government would "continue to work with local authorities and providers to monitor market changes, and determine appropriate grant conditions, guidance, and distribution mechanisms, ahead of allocating money for 2023 to 2024."[185]

4.7 Other options considered

The Government's impact assessment set out a range of other reform options which were considered but not taken forward as they "fail[ed] to meet the overarching policy objective of providing individuals with protection against

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182 LaingBuisson, Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care (PDF), March 2022, pp4-9; County Councils Network, New analysis warns government has 'seriously underestimated' the costs of adult social care charging reforms, 18 March 2022.

183 LaingBuisson, Impact Assessment of the Implementation of Section 18(3) of The Care Act 2014 and Fair Cost of Care (PDF), March 2022, p7.

184 Local Government Association, LGA responds to County Councils Network and LaingBuisson report, 18 March 2022.

185 DHSC, Supporting local preparation: draft guidance, 14 March 2022.

unpredictable and unlimited care costs." The options, and the reasons for their rejection, included (but were not limited to):

- **Full social insurance**: would require a much larger increase in public expenditure and would leave little scope for future flexibility in costs.
- **Free personal care instead of a cap on care costs (as in Scotland):** would provide a degree of universal protection for everyone but would "not provide protection from unpredictable and unlimited costs for those with long care journeys."

Variations on the proposed reforms which were considered included:

- **Cap on total weekly expenditure (as in Wales)**: ruled out as not effective at protecting those with long care journeys from high and unpredictable care costs.
- **Regional cap based on relative levels of wealth**: not thought to be viable and levels of wealth vary substantially within regions.
- **A time-based cap**: would introduce less regional inequality but would increase inequalities between people with different intensities of care.
- **Cap based on percentage of wealth**: would require local authorities to assess the value of everybody's assets not just those at the means test thresholds so would create a high administrative burden.[186]

[186] DHSC, Adult social care charging reform: impact assessment, January 2022, paras 54-55.

5 Wider system reform and funding

5.1 Wider system reform

Of the £5.4 billion to be provided to adult social care in England over the next three years, £1.7 billion will be used to support wider system reform.[187]

Further information on the reform proposals was provided in a White Paper published on 1 December 2021: People at the Heart of Care: adult social care reform white paper.[188]

The White Paper set out a range of specific funding commitments over the next three years, including:

- At least £300 million to integrate housing into health and care strategies.
- At least £150 million "to drive greater adoption of technology and achieve widespread digitisation across social care".
- At least £500 million to support the adult social care workforce, so that it has "the right training and qualifications, and feel recognised and valued for their skills and commitment."
- Up to £25 million to "kick start a change in the services provided to unpaid carers."
- £30 million to "help local areas innovate around the support and care they provide in new and different ways."
- At least £5 million to "pilot new ways to help people understand and access the care and support available."
- More than £70 million to "increase the support offer across adult social care to improve the delivery of care and support services."[189]

[187] HM Treasury, Autumn Budget and Spending Review 2021, HC 822, October 2021, para 4.8; HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, para 49.

[188] DHSC, People at the Heart of Care: adult social care reform white paper, 1 December 2021.

[189] DHSC, People at the Heart of Care: adult social care reform white paper, 1 December 2021, p8. Further information on what the £500 million of workforce funding will be used for was provided in a blog by Deborah Sturdy, Chief Nurse for Adult Social Care in England.

Further information on the £500 million of workforce funding was provided in a press release published by the Department of Health and Social Care on 5 April 2022: £500 million to develop the adult social care workforce.[190]

On 21 February 2022, the Government published an impact statement (PDF) explaining the rationale and potential effects of the proposals for system reform set out in the White Paper.[191]

5.2 Core funding for adult social care

Regarding broader core funding for adult social care, the September 2021 Build Back Better policy paper said:

> The Government will ensure Local Authorities have access to sustainable funding for core budgets at the Spending Review. We expect demographic and unit cost pressures will be met through Council Tax, social care precept, and long-term efficiencies; the overall level of Local Government funding, including Council Tax and social care precept, will be determined in the round at the Spending Review in the normal way.[192]

Autumn Budget and Spending Review 2021

At the Autumn Budget and Spending Review 2021, the Government said local authorities would be provided with £1.6 billion of new grant funding in each of the next three years, on top of the £5.4 billion to implement social care reform. The Government said this funding, which will not be ring-fenced for adult social care, will ensure "the government can reform social care, increase investment in supporting vulnerable children and enable local authorities to continue to provide the other local services that people rely on." It added the settlement for local authorities comprised an estimated real-terms increase of 3% a year in core spending power.[193]

In a written ministerial statement setting out details of the Local Government Finance Settlement for 2022/23, the Secretary of State, Michael Gove, confirmed the social care grant (for children's and adult social care) would be increased by £636 million. He added that this, together with a £63 million inflationary uplift to the improved Better Care Fund and deferred adult social care precept flexibilities of up to 3% from last year's settlement, "forms a package of additional resource, specifically for social care, potentially worth over £1 billion."[194]

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190 DHSC, £500 million to develop the adult social care workforce, 5 April 2022.

191 DHSC, Impact Statement: Adult Social Care System Reform (PDF), February 2022.

192 HM Government, Build Back Better: Our plan for health and social care, CP 506, September 2021, paras 47-56.

193 HM Treasury, Autumn Budget and Spending Review 2021, HC 822, October 2021, paras 2.30-2.31.

194 HCWS597 [Local Government Finance Settlement for England: 2022-23], 7 February 2022.

Further information on the broader funding of adult social care is available in the Library briefing: Adult Social Care Funding (England).

5.3 Commentary

Much of the initial commentary on the proposed reforms announced in September 2021 focused on the wider funding of adult social care and, in particular, if this is sufficient to address the wider issues in the sector. The Nuffield Trust, for example, said the £5.4 billion allocated to social care from the Health and Social Care Levy would "only go some of the way to stabilise a dire situation and leaves little for meaningful change".[195] The King's Fund similarly argued the funding will be "inadequate…to bring about meaningful change in areas such as workforce, access and quality."[196]

A number of stakeholders raised similar concerns following the Autumn Budget and Spending Review 2021, and following publication of the December White Paper.[197]

For example, while welcoming the "increases of 3% across all local government services" set out at the Spending Review, the Nuffield Trust said "they are not enough to address the disastrous situation in social care."[198] ADASS also expressed disappointment that "the Chancellor failed to recognise the crisis in social care that is already upon us and will now only deepen this winter". It added the additional £1.6 billion in grant funding "will do little more than meet the costs of the rise in the national living wage for care workers from next April."[199]

The LGA welcomed the December White Paper as setting out "a positive vision for the future of adult social care", but said:

> We need to balance the aspirations and expectations set out in this paper against the wider reality of the funding backdrop against which councils and care providers are operating, which is insufficient to meet current and rising demand. While councils share the Government's ambition and want nothing more than to deliver it, they will need a substantially bigger share of the new Health and Social Care Levy for that to happen.
>
> Addressing unmet and under-met need, tackling rising pressures, retaining hard working care staff, and investing more in prevention are all areas which need investment now, if we are to significantly bolster core services. This is the

[195] Nuffield Trust, Care providers, care users and workers will feel short-changed by proposed health and social care levy and reform, 7 September 2021.

[196] King's Fund, The King's Fund responds to the announcement of a health and social care levy, 7 September 2021.

[197] For example, see King's Fund, The social care White Paper: not wrong, just not moving far enough in the right direction, 2 December 2021.

[198] Nuffield Trust, Spending Review leaves social care the poor relation and facing uncertainty, 27 October 2021.

[199] ADASS, ADASS Responds to the Spending Review 2021, 27 October 2021.

> essential platform which is needed to fully realise the long-term positive vision set out in this white paper.
>
> Unless these can be urgently addressed as an immediate priority, any long-term proposals for social care – including those in the white paper backed by funding to kick-start change and innovation – will be set up to fail because core services themselves will not be available or sustainable. Without such investment, public expectations will be unfairly raised.[200]

ADASS similarly said the White Paper "sets out strong values and principles and has great ambition." It added, however, that "the sums identified so far can be no more than pump-priming" and there is "much more funding to find."[201]

In response to the White Paper, the Health Foundation said:

> Beyond the money to cover the new cap on care costs, just £1.7bn of extra funding from the health and care levy will go towards the social care system over the next three years. This will do nothing to tackle the high levels of unmet need, persistent workforce shortages and recruitment difficulties, and the precarious position facing many care providers. To meet these challenges, we estimate that additional funding of around £7.6bn in 2022/23 is needed, rising to £9.0bn in 2024/25, over and above that provided for in the Spending Review.[202]

200 LGA, LGA responds to adult social care reform white paper, 1 December 2021.

201 ADASS, ADASS Press Release: ADASS Responds to Social Care White Paper.

202 Health Foundation, New vision for social care will feel like hollow words without the money to deliver it, 1 December 2021.

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Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Implementation of Liberty Protection Safeguarding**	Item No **6**

PURPOSE OF THE ITEM

In the past the Commission has considered briefings on the DoLS (Deprivation of Liberty Safeguards). These are a set of safeguards designed to protect cared-for people who are deprived of their liberty or lack the mental capacity to consent to their arrangements. In a significant national development that system is now being replaced with *Liberty Protection Safeguards* (LPS). This item is to explain the changes and the impact it will have on the Council and on service users.

OUTLINE

Attached please find:

a) Note from Adult Services on *'LPS implementation"*
b) Presentation from Adult Services on '*Liberty Protection Safeguards'*.

Attending for this item will be:

Dr Godfred Boahen, Principal Social Worker, Adult Services, AHI
Georgina Diba, Director of Adult Social Care and Operations, AHI

ACTION

The Commission is requested to give consideration to the report and make any comments or recommendations as necessary.

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Liberty Protection Safeguards Implementation cover sheet

Health in Hackney Scrutiny Commission, 5 December 2022

What are the Liberty Protection Safeguards?

The Liberty Protection Safeguards, known as LPS, are a set of safeguards designed to protect cared-for people who:

- Are deprived of their liberty[1]
- Lack the mental capacity to consent to their arrangements

They will replace the previous Deprivation of Liberty Safeguards (DoLS) system and expand this system in several key respects:

- LPS applies in community and domestic settings as well as hospitals and care homes
- The local authority is no longer the only body that can authorise a deprivation of liberty
- LPS applies to 16 and 17 year olds as well as 18s and over

Safeguards are essential in these scenarios because they protect people's Article 5 right to liberty given by the European Convention on Human Rights. Article 5 provides that your right to liberty and security of the person cannot be denied apart from in certain circumstances and in accordance with a procedure in law. LPS is the legal procedure we must follow when we believe a deprivation of liberty is in a person's best interests to keep them safe and provide care, and they cannot consent to this arrangement.

An LPS authorisation will confirm that the relevant procedures have been followed to ensure that a deprivation of liberty is legal and does not stand in contradiction to a person's human rights which apply universally.

In 2022 the Government published the draft Code of Practice for the Mental Capacity (Amendment) Act, 2019 which set out how LPS would operate. The draft code was open to consultation. The Government has not published its response to this consultation yet, or revealed any resulting changes to the Code of Practice. The information in this briefing is therefore subject to change, should amendments be made to LPS via the Code.

When will they be implemented?

We don't yet know when LPS will be implemented. The last firmly established date set out by the government was April 2022. However, implementation requires at least a six month lead in, during which training courses and other resources will be available.

What are the main impacts for Hackney?

The introduction of LPS will bring changes to the health and social care system, both in terms of procedures and practice. The key areas of change, some of which are Hackney-specific and some of which are general, are outlined in the presentation.

[1] The Supreme Court Judgement of 2014 (Cheshire West and Chester Council vs. P) defined the acid test for a deprivation of liberty as the person being 'subject to continuous supervision and control' and 'not free to leave'. The new Code of Practice for the MCA, which sets out how LPS will work, interprets a DoL more loosely in its scenario exercises, but this is contradictory to case law and guidance is subject to change following publishing of the results of the consultation.

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Liberty Protection Safeguards: Briefing to Health in Hackney Scrutiny Commission

5 December 2022

Background to the Liberty Protection Safeguards

The purpose of the LPS

- LPS replaces the Deprivation of Liberty Safeguards (DoLS) but the purpose remains the same
- The system that protects a person's Article 5 human right
- The system that provides the legal safeguards for this: assessments, duty to consult and right to appeal

What is changing?

- Expansion of settings
- Expansion of 'Responsible Bodies'
- Inclusion of 16 and 17 year olds

The context of implementation

The national context

- Ongoing delays to implementation
- Uncertainty about LPS implementation date
- Workforce and funding challenges

Areas of impact for Hackney

- Workforce demand
- Cross-organisational integration
- Systems design
- Legal compliance
- Social work practice

What our data tells us

We estimate that around 35% of LPS applications will be complex or contested. These cases will require input from an Approved Mental Capacity Professional (AMCP).

Around 900 DoLS applications are made each year in Hackney. We expect this number will slightly increase because there are more settings and more eligible age groups.

In the first year of LPS LBH will transfer all DoLS authorisations to LPS. After that the renewal responsibility will be held by the relevant Responsible Body.

After Year 1, the number of LPS applications should decrease, as cases get processed by their relevant Responsible Body.

Principles and methodology

- Recognise the unique demography of Hackney
- Co-produce the approach where possible
- Take a whole systems approach
- Take a human rights and person-centred approach
- Foster high quality, professional practice

Next steps

January-March

- Workshops with providers, residents and advocacy groups
- Plan, commission and deliver first phase of the training programme
- Confirm model for LPS in Hackney and plan internal pathways
- Mosaic development

Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Refresh of Mayor of London's Six Tests for health service reconfiguration - FOR NOTING**	Item No **7**

PURPOSE OF THE ITEM

To note a letter to the Chair from the Mayor of London's Senior Health Advisor on the refresh of the Mayor of London's Six Tests relating to health service reconfigurations.

OUTLINE

Introduced in 2017, the tests have played an important role in challenging the NHS to ensure that any major changes to our hospitals and other health services result in the best quality of care for all Londoners. Since the Covid-19 pandemic, several reports have highlighted the disproportionate impact the pandemic has had on people from global majority backgrounds and this has led to the refresh of the Tests. Scrutiny committees have been invited to consider these as they carry out their scrutiny work.

Attached please find copy of letter from Dr Tom Coffey OBE, Senior Health Advisor to the Mayor of London to the London JHOSC Chairs.

ACTION

The Commission is requested to NOTE the information.

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Cllr Ben Hayhurst and Jarlath O'Connell
Inner North East London

Date: 8 November 2022

Dear JHOSC Chairs

The Mayor's Six Tests – refresh

I wanted to alert you to changes that we have made to the Mayor's Six Tests. I've been pleased to see that the tests, introduced in 2017, have continued to play an important role in challenging the NHS to ensure that any major changes to our hospitals and other health services result in the best quality of care for all Londoners. Since the Covid-19 pandemic, several reports have highlighted the disproportionate impact the pandemic has had on people from Black and minority ethnic backgrounds. Many of these reports have also shown that this has only served to exacerbate health inequalities across London and the UK as whole.

The Mayor of London responded to this by commissioning a report from the Nuffield Trust at the beginning of the year. The report has taken an in-depth look at the available evidence and highlights the ways in which the Health Inequalities strand of the Mayor's Six Tests (HI Test), could be strengthened to better address disparities in access to, experiences of, and outcomes from healthcare services across our city. The report also recognises recent changes to the health and care system such as those introduced by the new Health and Care Act 2022, as well as other approaches the NHS has put in place to tackle ethnic disparities in healthcare. Leveraging the provisions of these new approaches, the report proposes a number of recommendations that have informed the Mayor's revisions to the HI test.

The Mayor's revisions to the HI test have been set out in his response to the report and has been sent to colleagues in the NHS. The revised HI test includes an additional supplementary question that highlights the role of the NHS as an anchor institution. In view of the ongoing cost-of-living crisis, the Mayor recognises that the NHS can play a significant role in addressing wider of determinants of health, such as employment and as a significant procurer of goods and services. The NHS is a major employer in local communities, and by procuring locally, can enhance the local economy. The NHS is

already participating fully in the Mayor's Academies Programme, which will help Londoners to get the support they need to reskill to access good jobs and skills opportunities. The programme will target support to people from the most disadvantaged groups, who have been disproportionately affected by Covid, into entry level jobs as a first step towards a new career.

Beyond tackling health inequalities, the Mayor's response also sets out changes to the Hospital Beds strand of the Six Tests. The revised beds test recognises new opportunities afforded through the use of digital healthcare and sets out conditions that the NHS will want to reflect on when deciding on the number of beds to include in a healthcare facility. The Mayor has made these changes to ensure that London's healthcare facilities are built to an excellent standard. The changes will also ensure that our hospitals and care facilities are adequately equipped to deal with large scale health emergencies such as pandemics, while also being able to provide the best quality of care for all Londoners at all times.

I'm grateful to all those colleagues in the NHS who have actively contributed to this work. I hope the changes will be welcomed by those working on major services changes across London's health system. I believe the refreshed six tests will serve to champion improvements in the delivery of health and care services for all Londoners going forward.

Yours sincerely

T Coffey

Dr Tom Coffey OBE
Senior Health Advisor to the Mayor of London
GREATER**LONDON**AUTHORITY
City Hall, Kamal Chunchie Way, London E16 1ZE
Mobile: 07971167731

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Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Minutes of the previous meeting**	Item No **8**

OUTLINE

Attached please find the draft minutes of the meeting held on 16 November 2022.

Matters Arising from 16 Nov

Action at 4.4b

ACTION:	*CE of Homerton Healthcare to provide high level breakdown by category of funding which City and Hackney CCG received and spent in its final year. This is to assist discussions at both HiH and INEL on comparing financial flows.*

This is in progress and related information will be presented at INEL.

Action at 4.4e

ACTION:	*CE of Homerton Helathcare to provide breakdown of the elective care waiting list by category.*

This is awaited.

Action at 4.4f

ACTION:	*CE of Homerton Healthcare to provide an update on the progress of the plan to redevelop St Leonards Hospital site. Item to be scheduled once there is sufficient progress to report.*

This will be added to the work programme.

Action at 5.11

ACTION:	*The Chair to write to the CE of NHS NEL to progress the issues arising from this discussion.*

This is in progress.

ACTION
The Commission is requested to agree the minutes and note the matters arising.

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Hackney

London Borough of Hackney
Health in Hackney Scrutiny Commission
Municipal Year: 2022/23
Date of Meeting: Wed, 16 November 2022 at 7.00pm

Minutes of the proceedings of the Health in Hackney Scrutiny Commission at Council Chamber, Hackney Town Hall, Mare Street, London E8 1EA

Chair	**Councillor Ben Hayhurst**
Cllrs in attendance	**Cllr Kam Adams, Cllr Frank Baffour, Cllr Eluzer Goldberg, Cllr Deniz Oguzkanli and Cllr Sharon Patrick (Vice Chair)**
Cllrs joining remotely	**Cllr Grace Adebayo**
Cllr apologies	**Cllr Ifraax Samatar**
Council officers in attendance	**Nina Griffith, Director of Delivery, City and Hackney Place Based Partnership** **Andrew Trathen, Consultant in Public Health**
Other people in attendance	**Louise Ashley, Chief Executive, Homerton Healthcare** **Richard Bull, Primary Care Commissioning, NHS NEL** **Tam Bekele, Secretary, East London and City Local Dentistry Committee (LDC)** **Dr Dewald Fourie, Dentist, Chair, East London and City LDC** **Siobhan Harper, Transition Director Primary Care, NHS NEL** **Cllr Chris Kennedy, Cabinet Member Health, Adult Social Care, Voluntary Sector and Culture** **Dr Reza Manbajood, Dentist, Treasurer, East London & City LDC** **Breeda McManus, Chief Nurse and Director of Governance, Homerton Healthcare** **Catherine Perez Phillips, Deputy Director of Operations, Healthwatch Hackney** **Dr Mark Rickets, NEL ICB Member for Primary Care** **Cllr Claudia Turbet-Delof, Member Champion for Mental Health** **Jeremy Wallman, Head of Primary Care Commissioning, Dentistry, Optometry, Pharmacy, NHS England London**
Members of the public	34 views
YouTube link	**The meeting can be viewed at:** **https://www.youtube.com/watch?v=M6KZ82RHcwE**
Officer Contact:	**Jarlath O'Connell, Overview and Scrutiny Officer** jarlath.oconnell@hackney.gov.uk; 020 8356 3309

Councillor Ben Hayhurst in the Chair

1 Apologies for absence

1.1 Apologies for absence were received from Cllr Samatar, Dr Stephanie Coughlin, Dr Sandra Husbands, Dr Kirsten Brown, Caroline Millar, Janet McMillan and Helen Woodland.

1.2 The Chair welcomed Louise Ashley and Breeda McManus to their first meeting of the Commission.

2 Urgent items/order of business

2.1 There were no urgent items and order of business was as per the agenda.

3 Declarations of interest

3.1 There were none.

4 Discussion with new Leader of NEL ICS City and Hackney Place Based Partnership

4.1 The Chair welcomed:
Louise Ashley (**LA)**, Chief Executive, Homerton Healthcare and new Place Based Leader for City and Hackney Place Based Partnership.
Breeda McManus (**BM**), Chief Nurse and Director of Governance, Homerton Healthcare
Nina Griffith (**NG**), Director of Delivery, City & Hackney Place Based System

He welcomed Louise and Breeda to their first meeting of HiH and stated that the purpose of this item was to question the recently appointed CE of our largest acute trust Homerton Healthcare and the Place Based Leader for the City and Hackney Place Base Partnership, which is part of NEL ICS.

4.2 Members gave consideration to a background report: *North East London Integrated Care System & City and Hackney Place Based Partnership*

4.3 LA thanked Members for the welcome and gave a verbal update the key points of which were noted:

(a) Background as general nurse, paediatric nurse, health visitor, then chief nurse in many places, spending the past 4 years as CE of Dartford and Gravesend Trust. Worked in Homerton previously and set up their Starlight Paediatric Services Unit.
(b) The ground work that's gone into integrating health and care in City and Hackney has put in it a very good place and is way ahead of comparators.
(c) Having the Mayor on the ICB and Cllr Kennedy as Chair of the City and Hackney Health and Care Partnership Board, both providing a strong voice for

the borough, shows a commitment to joint working which is not present in other places.

(d) Conscious that there continues to be a nervousness locally about Barts and fears that the Homerton could not survive on its own but there are excellent working relationships between the two trusts already in place and the good work in integrating care is down to this.

(e) Understand the concerns about finance flows pre vs post ICS and noted that the ICS is working on a financial strategy but this work moves slowly.

(f) She and her Chair, Sir John Gieve, continuously point out that others can learn from C&H and so removing the resource from us to level up elsewhere, where there weren't similar levels of investment say in primary care in the past,is not the way to go. She has excellent working relationships with both Marie Gabriel and Zina Etheridge.

(g) It looks like there will be some sort of return to Payment by Results after two years of block contracts (due to pandemic). There will be money to place based commissioning for development work and there will be transformation monies also..

(h) Currently no appetite to devolve all commissioning and monies down to Place level and while that might sound like an attractive option it would only distract us from some of the development work we need to do in the Neighbourhoods for example. They do not want lots of additional work thrown down from the ICB without the resources to deal with it.

(i) On the elective backlog at the Homerton itself, most elective work had to be stopped during the pandemic and so they have about 25k on waiting lists now. Prior to Covid it was about 19k. Some of that increase is down to various coding changes.

(j) Their 18wk wait rate is still 4500 and this hangs heavily· However nobody at Homerton is on the 104 wks or 78 wk wait unlike in other parts of NEL. Homerton does have 72 patients who have waited a year and this is not good enough. They are steadily working through them and remain one of the best performing in London..

4.4 Members asked detailed questions and in the responses the following was noted:

(a) The Chair asked, notwithstanding the Acutes beng directly commissioned from the ICS for certain activity, would the bulk of the money which used to be spent by the CCGs remain at Place or be kept at the ICS level. LA replied that some would still come down to place; there has been a top slice of that across NEL for transformation i.e. developments that will then be allocated out to areas. It is still unclear, she added but there won't be a reduction in what City and Hackney receives but some of the development funding might be directed to other areas which may be further behind.

(b) The Chair stressed that there was a need to protect Hackney's interests and there need to be absolute transparency and if money flows were essentially

being diverted to other areas then this can't just be done at ICS level without proper, accountability, scrutiny or knowledge adding that he appreciated that Outer NEL has older population and that there are counterbalancing arguments but there needs to be transparency about these money flows.

ACTION:	**CE of Homerton Healthcare to provide high level breakdown by category of funding which City and Hackney CCG received and spent in its final year. This is to assist discussions at both HiH and INEL on comparing financial flows.**

(c) A Member asked about the relationship between Barts and the Homerton, the latter not having a seat on ICB board. LA replied that Homerton Healthcare protects itself by being high performing and that Hackney is miles ahead on the way we do integrated health and social care and on the development of the Neighbourhoods. She added she has a very close working relationship with Shane DeGaris the CE of Barts Health and he has no interest in consuming the Homerton. The focus needs to be on patients and the population and we need to get the best deal for residents and the Homertron has excellent relationships with the specialist services at Barts and indeed it could not provide what they provide and they do it really well.

(d) The Chair asked about the impact of the advent of the Acute Provider Collaborative on the Homerton. LA replied she was the Deputy Chair of the APC and that feeds into the Population Health and Care Cttee which feeds into the ICB. The APC has worksteams on children maternity etc and all feed into APC board and work on things across the system such as elective and emergency care. A lot of the focus has been on other trusts currently because of ambulance waiting times and A&E performance in the wider system. She added that while the Homerton does not have a seat on the IBC the Mayor does and that Shane DeGaris represents Acute Providers on it, not just Barts. Sir John Gieve (Homerton Healthcare Chair) also chairs the APC Board.

(e) A member asked of the 25k on elective waiting list what percentage are classified as urgent or life saving treatments. LA explained how in urgent care patients are classified into 4 categories (P1 to P4). P1 refers to life threatening cases and they get top priority obviously.

ACTION:	**CE of Homerton Helathcare to provide breakdown of the elective care waiting list by category.**

(f) A Member asked if the 8 Neighbourhoods have the resources required to meet their priorities and for an update on the St Leonards redevelopment plan. LA replied that the 8 Neighbourhoods aligned to PCNs have some

development funding but there is never enough to do what they want to do. They are exploring closer working relationships including with academia to support their work and of course each Neighbourhood has different needs and this also needs to be factored in. On St Leonards she stated that they had been offered the opportunity to take over the site which is currently owned by NHS PropCo and there is a way for this transfer to be arranged but before that can happen very many assessments that need to be done to ensure they can do it. She added that if they just took over St Leonard's currently there is no money to support it being re-developed and that is not acceptable. So there have been assessments of land values et t and looking at similar hospital developments where parts of the land need to be sold to pay for the hospital redevelopment. She added that it was a bid they'd like to develop but they have to get it right and it will take time to complete all these assessments. She commented that If she had the capital funding to do this tomorrow she would. She undertook to keep Members updated.

ACTION:	**CE of Homerton Healthcare to provide an update on the progress of the plan to redevelop St Leonards Hospital site. Item to be scheduled once there is sufficient progress to report.**

4.5 The Chair thanked LA and colleagues for their attendance and asked if LA could return at the appropriate time with an update on the St Leonard's development and if the officers could assist with providing a comparison of the budget flows for City and Hackney pre and post the ICS.

RESOLVED:	**That the report and discussion be noted.**

5 NHS Dentistry in Hackney - Panel Discussion

5.1 The Chair stated that the purpose of this discussion was to hear from the commissioners, local dentists, Public Health and Healthwatch about the current provision of dentistry and oral health services in Hackney as there had been concerns from a number of quarters about the service and in particular access and cost and the challenges facing the providers working with an outdated contract and pricing system. He added that commissioning of dentists would soon be devolved from NHSE London to the sub region - NHS North East London, and so this provided an opportunity to improve the services and make them more locally accountable and responsive. He added that unfortunately that the Dr Stephanie Coughlin the Clinical Lead for City and Hackney Place Based System who had championed the need for this item was now unable to be present but her overview of the current commissioning landscape would be provided by Andrew Trathen one of the

Council's Consultants in Public Health. He was representing the Director of Public Health who was ill and unable to be present.

5.2 He welcomed to the following contributors, comprising current and future commissioners, local dentists and Public Health

Jeremy Wallman (**JW**), Head of Primary Care Commissioning, Dentistry, Optometry, Pharmacy, NHS England London

Richard Bull (**RB**), Primary Care Commissioning, NHS NEL
Siobhan Harper (**SH**), Transition Director Primary Care, NHS NEL

Tam Bekele (**TB**), Secretary, East London and City Local Dentistry Committee (LDC)
Dr Dewald Fourie (**DW**), Dentist, Chair, East London and City LDC
Dr Reza Manbajood (**RM)**, Dentist, Treasurer, East London & City LDC

Cllr Chris Kennedy (**CK**), Cabinet Member Health, Adult Social Care, Voluntary Sector and Culture, Hackney Council
Andrew Trathen (**AT**), Consultant in Public Health, Hackney Council

And the following who also contributed to the discussion:

Catherine Perez Phillips (**CP**), Deputy Director of Operations, Healthwatch Hackney
Dr Mark Rickets (**MR**), NEL ICB Member for Primary Care
Cllr Claudia Turbet-Delof (**CT**), Member Champion for Mental Health

5.3 Members gave consideration to the following background briefing notes:

5a - Background note setting out the context
5b - Data sheet from the current commissioner - NHS England London
5c - Note from the sub region NHS North East London Primary Care Team
5d - Note from NHS NEL 'Roadmap to Recovery of Dental Services the next 5 years'
5e - Note from Public Health on Hackney and City Oral Health Prevention and Promotion Service
5f - Report from Healthwatch Hackney 'Access to dental care in Hackney – when, where, how' from January 2022.

5.4 Cllr Kennedy (Cabinet) and Andrew Trathen (Public Health Consultant) standing in for the Director of Public Health introduced the briefing paper and gave an overview of the commissioning landscape for dentistry in Hackney. AT summarised the situation with the 2006 contract and how the payment system operates, how dentists receive business rate reductions and on the Public Health needs assessment which identified that oral health particularly for children in Hackney is poor. A key concern is that access rates for children during the pandemic had dropped 14%. He explained what Kent Community Health Trust provides in Hackney and the work on prevention in schools and

the focus on the Orthodox Jewish community where there was a particular need.

5.5 Tam Bekele (Secretary of East London and Local Dentistry Committee) introduced his presentation. The key focus was Access issues and the significant problems caused by the current national contract. The contact value of it was determined in 2004-5 when dental uptake was low and the rates were not based on a proper needs assessment. The 2006 contract which followed and is still in place also abolished catchment areas and patients can now come from anywhere. He added that we have a diverse population, some without a culture of visiting the dentist regularly. The key issue is that payment is based on UDAs (unit of dental activity) and rates have in no way kept up with costs and the system militates against ongoing or preventative work as the number of UDAs are capped and once a Practice reaches its allocated maximum it has to stop offering service as it won't get paid for any of the additional work.

5.6 Dr Dewald Fourie, local dentist, without growth being built into the contract the only way to grow is to see people privately. With the UDA system you get paid the same for 1 or 10 fillings, which is an issue particularly with new patients. No show appointments is another serious issue as this causes funding clawback from commissioners. Covid was also very difficult for the sector as they had to purchase air purifiers etc. He commented that patients think everything is on the national health and therefore must be free and it isn't. If you take on new patients, inevitably needing lots of fillings etc it takes up more time for the same pay.

5.7 Dr Reja Manbajood, local dentist explained that the current contract covers just about 50% of the population's needs. The contract itself is not functioning and small changes at the edges are not enough. Associate Dentists before 2006 earned £80K a year but their incomes have dropped. Many therefore choose to work privately and don't want to join the NHS because financially they are losing money. There hasn't been an uplift in 16 years yet all costs have risen such as electricity and rates of pay rightly demanded by dental nurses. A 20% uplift of contract this year would be required to solve the recruitment problem and thus enable practices to take on more patients.

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5.8 Jeremey Wallman (Commissioner for dentistry at NHSE London) introduced his briefing. He stated he was a longtime advocate for contract reform but commissioners have to play the hand they are dealt. The current contract doesn't work for patients or dentists, however the situation in London, although not great, is far better than in other regions. Dentistry, Optometry and Pharmacy are being delegated from NHSE London out to the ICBs from 1 April 2023 and his team who commission for all of London will be hosted by

NHS NEL from then. This was a very positive thing and they are aware that the need in NEL is greater than in many parts of London and he's pleased he'll be hosted by an organisation who understand dental commissioning. The contract as it stands won't change as it is enshrined in law and an Act of Parliament would be required to change it. In terms of what can be done he suggested that the move into ICS will allow them to drill down a bit more on population needs and look at issues from a borough perspective. He added they probably won't see new money but changes of structures should provide a level of flexibility and cross working with public health teams and local authorities which means that hopefully more can be achieved.

5.9 JW described how the urgent care infrastructure for dentistry was transformed during the pandemic and this remains and is being held up as an exemplar across the country. It works via NHS 111 but goes through to commissioned triage service and 40 urgent care hubs in London both in an out of hours so no patient in pain has to suffer. Most will be seen within 24 hrs as appropriate. Urgent Care delivery is for those who can't access a dental practice or choose not to. Even NHS charges are prohibitive to some people he added, He concluded that there was a sense of frustration as a commissioner re the contract as there are wider issues that need to be resolved.

5.10 Members asked detailed questions and in the Panel Discussion the following was noted:

(a) The Chair asked for the incoming commissioners' thoughts on how the system might be improved and enhanced. Siobhan Harper (NHS NEL Primary Care) described what would be involved in setting up working arrangements with the other 4 ICBs and how improvements can be owned at ICB level. Contracts worth c. £870m would be transferring across and a lot of due diligence work needs to happen. The Primary Care Team within NEL has a lot of experience working in this domain already and having Jeremy's team will give them a degree of advantage. They will need to think about lobbying in the right places where these systemic problems need to be addressed.

(b) Richard Bull (NHS NEL Primary Care) added that NHS NEL had put in a case to secure the dentistry team. He hoped they would utilise more of the Making Every Contact Count approach in primary care in pharmacies and working with the voluntary sector on equalities aspects. 'Change Please' programme who run a bus for street homeless will now have a dental service as part of that and this is just one example of what can be done.

(c) The Chair asked if NEL ICS would really be the local commissioner or just hosting the London commissioners. SH explained that it will become a deleaged function with a Memorandum of Understanding between NEL ICS and the other four ICSs in London. There were parallels with how GP services had been delegated locally while there is still a national contract but enhanced services are added and hopefully there will be development opportunities down the line.

(d) JW explained that the dismantling of the current NHSEL team is not possible. There are just 22 FTEs in the team and this is where the experience lies. They will deliver across London but be hosted by NEL ICS. Each ICS won't have its own bespoke function but they will build in a level of resilience within each ICS build on that. Over time they should build up a bigger resource to work round this.

(e) Members asked how the new contract will work and what will come out of it in the prevention work with older people and with children; also on the high incidence of delta caries in Orthodox communities and whether other communities were surveyed in a similar way and why Kent Community Healthcare is delivering a service in Hackney. AT expelled that the Orthodox Jewish data was bespoke data from that community and so led to the intervention. They needed to involve those who understood the issues within that community and this is why they secured the data. On KCH, they got the contract through open competition. They are experienced in delivering training, have a good academic base and a good track record, he added.

(f) Members expressed concern about both access to NHS dentists and then poor quality of personal care when they get one with one Member detailing poor personal service to children in particular. DF explained how the processes behind access to an NHS dentist works and how if a new patient is taken on then someone else potentially may lose out as there is a cap on UDAs and it can't be increased. New patients take more time as they need more attention because they most likely haven't had it. A normal check up is 30 mins but a new patient needing many fillings or root canal could take up 5 hrs. Retention of associate dentists and dental nurses to cover the work is a huge challenge.

(g) The Chair explained how the 2006 contract was based on an assumption of need then and pay not keeping up with inflation means a real term decrease. DF added that his practice has 12k UDAs and once that is filled they no longer get paid. Often taking on new patients would put a practice over its limit.

(h) The Chair asked JW about quality assurance stating that with GPs for example there is support to be had from a GP Confederation and if similar support could not be put in place for dentists in order to drive up quality and standards. JW explained that since 2006, and contrary to popular belief, there is no process of formal registration with an NHS dentist. As long as a dentist can deliver a service there is no obligation to take on new patients and the obligation to patients exists only for the duration of the specific treatment undertaken and that is it. On quality assurance he said there is thorough training and a formal complaints handling system to maintain professional standards. He commented that there is nothing in the current contract that actually rewards prevention work. A key flexibility in future hopefully will be working more closely with public health and local authority colleagues on these issues.

(i) Catherine Perez Phillips (Healthwatch Hackney) described the feedback they receive which is primarily on access and the problem of people having to phone round maybe 16 practices to get taken on. She added that when people do get seen the feedback they've had has been pretty positive with 83% being positive on quality and empathy. She questioned that it was not clear how these commissioning changes would improve access. JW replied

that there is an element of the unknown as they enter the new commissioning environment however it affords a level of flexibility to drill down a bit more on issues and there is a sizable budget involved and part of the challenge will be if they can re badge monies to focus on the more acute areas of need. SH added that there was a need to think more about ways of working and how to get under the skin of the issue and that having the team closer and having that overarching ambition to reduce inequalities will help. This could only be achieved by everyone coming together.

(j) A Member asked about the backlog of NHS patients not being seen and why dentists are doing more private work in this scenario. RM stated that the NHS and private work were separate things. Many cannot wait a long period and will try and get treatment privately when they can afford it. Providing comprehensive dental treatment for the whole population under this contract is not really possible because of the payment barriers. He added that prior to Brexit some EU dentists accepted the low rates in the UK but since then UK dentists generally will not. Dentists are not coming from other countries and there is an urgent need to recruit from abroad.

(k) The Chair asked if the recruitment issues were preventing practices from taking on new NHS patients. RM replied it was and gave the example that in 2011 he would receive 50 or 60 applications and now gets none.

(l) The Chair asked SH if a supplement could be given to help recruit dentists as has been done in the past to recruit GPs locally. RM commented that an uplift of 20% is needed to pay a higher UDA to dentists. SH added that in broad terms money is very tight now in the NHS and there is a recruitment crisis across all sectors of it.

(m) Cllr Turbet-Deloff (Mental Health Champion) commented on the severe impact of lack of dentistry on mental health forcing people to choose care over debt. She also presented statistics on the mental health of dentists themselves and expressed concern regarding the lack of a national screening campaign for oral cancers and asked if a local solution could be provided to this. TB replied that oral cancer rates in east London were comparatively high. He explained that dentists do provide cancer checks as a matter of course in treatment. DF confirmed that at every check up there should be hard tissue and soft tissue screening for oral cancers and it is always included. Cllr Turbet-Deloff commented however that recent BMJ research was showing that a third of dental practices did not appear to be completing these checks and could City and Hackney province reassurances on this. RM stated that every dentist knows they must do cancer checks. He added that locally they also have very effective referral pathways to hospital if potential cancers are found. He added however that because of the backlog fewer routine check ups were taking place and this could be a factor in rates for finding cancers early.

(n) SH replied on the mental health issues around dentistry and stated that in the new arrangements they hopefully would have the opportunity to build on this work. The KCH service at St Leonard's already works with those with learning disabilities and with mental health issues. She added that there does need to ber more lateral thinking on meeting patients' needs in a more holistic way and this must include services to those in mental health wards.

(o) Members asked at what point can the Council ensure that there is a fair review of this contract. JW replied that there is no quick answer and there was a long way off having a totally new contract. Some small changes had been

made as the BDA negotiates with DoH on behalf of the professions. They have to work with what they've got but olly a reformed dental contract will help and there needs to be concerned lobbying hopefully by ICS to achieve this.

(p) The Chair commented that, reading between the lines ,was it the case that the government doesn't want to redo it as it would only go one way in terms of costs. JW replied that reform of charging was just one aspect and there needed to be root and branch review in order to improve things.

(q) Members asked about the lottery in terms of accessing dental treatment and what can be done. JW reiterated that it was a big challenge but contract reform was crucial. He explained that access was much worse in other regions of England and we must put it in perspective while doing all we can to improve the situation in London.

(r) The Chair welcomed the 40 urgent care hubs. JW stated that they had set those up in direct response to the pandemic. There are 40 with a 24/7 delivery from a triage service and nowhere outside London has these. People can be fast tracked quickly. The Chair asked if the pathway was only via 111. He noted that there would likely be an issue over advertising the service adding that it was not completely understood that they exist but it is great that they are there. JW replied that demand was great and they would be stuck without them. RM added that his practice in Stoke Newington provided one of those hubs and without these it would have been much worse in London than outside.

(s) The Chair asked about dentistry appearing in the ICS Strategic Plan and the profile of it there. SH welcomed this point and undertook to take it back and she also thanked Cllr Turbet-Delof for raising the oral cancer issue which was important.

5.11 The Chair thanked all the contributors for their briefings and for their attendance and summed up by noting the political point on the need for lobbying. He added that in a year from the devolution he would like the Commissioners to return to report on progress.

ACTION:	**The Chair to write to the CE of NHS NEL to progress the issues arising from this discussion.**

RESOLVED:	**That the reports and discussion be noted.**

6 Minutes of the previous meeting

6.1 Members gave consideration to the draft minutes of the meetings held on 29 June 2022 and 21 September and the Matters Arising.

RESOLVED:	**That the minutes of the meetings held on 29 June and 21 September be agreed as a correct record and that the matters arising be noted.**

7 Health in Hackney Work Programme 2022/23

7.1 Members gave consideration to the draft work programme for 2022/23.

RESOLVED:	**That the Commission's rolling work programme for 2022/23 be noted.**

8 Any other business

8.1 There was none.

Hackney

Health in Hackney Scrutiny Commission 5th December 2022 **Work Programme for the Commission**	Item No **9**

OUTLINE

Attached please find the latest iteration of:

HiH work programme 2022/23
INEL work programme 2022/23

These are working documents and updated regularly.

ACTION

The Commission is requested to note the updated work programmes and make any amendments as necessary.

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Rolling Work Programme for Health in Hackney Scrutiny Commission 22/23

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name
29 June 2022	**Election of Chair and Vice Chair**				
deadline: 20 June	**Appointment of reps to INEL JHOSC**				
	The science on the health impacts of poor air quality: expert briefing	Briefing	Imperial College, Faculty of Medicine	Senior Lecturer in Public Health	Dr Ian Mudway
			Adults, Health and Integraton	Deputy Director of Public Health	Chris Lovitt
			Climate, Homes, Economy	Land Water Air Team Manager	Dave Trew
	City & Hackney ICP / Place based partnership	Briefing			Nina Griffith
	Response to draft Quality Accounts	For Noting only			
21 Sept 2022	**City & Hackney Safeguarding Adults Board Annual Report**	Annual item	CHSAB	Independent Chair	Dr Adi Cooper OBE
deadline: 12 Sept				Assistant Director, Quality Assurance, Safeguarding and Workforce Development	Georgina Diba
	Healthwatch Hackney Annual Report 21/22	Annual item	Healthwatch Hackney	Interim Chair	Lloyd French
				Deputy Director	Catherine Perez-Phillips
	New 'Integrated Mental Health Network' service	Briefing	Public Health	Director of Public Health	Dr Sandra Husbands
				Senior Public Health Specialist	Jennifer Millmore
	How Primary Care can optimise new ICS structures - GP Confed briefing	Verbal update	GP Confederation	Departing Chief Executive	Laura Sharpe
	New DHSC guidance on 'Health Overview and Scrutiny Principles'	For noting only		O&S Officer	
16 Nov 2022	**Q&A with new Place Based Leader for City and Hackney**	Briefing	Homerton Healthcare	Chief Executive (also Place Based Leader)	Louise Ashley
deadline: 7 Nov			Homerton Healthcare	Chief Nurse and Director of Governance	Breeda McManus
	Provision of NHS Dentistry in Hackney	Panel Discussion	NHS NEL	Clincial Director C&H and local GP	Dr Stephanie Couglin
			Public Health	Director of Public Health	Dr Sandra Husbands
			East London & City Local Dentistry Committee	Chair	Dr Dewald Fourie
			East London & City Local Dentistry Committee	Treasurer	Dr Reza Manbajood
			East London & City Local Dentistry Committee	Secretary	Tam Bekele
			NHSE London	Head of Primary Care Commissioning, Dentistry, Optometry and Pharmacy	Jeremy Wallman

			NHS NEL	Transition Director Primary Care	Siobhan Harper
			NHS NEL	Primary Care Commissioning	Richard Bull
5 Dec 2022	**Integrated Delivery Plan for the C&H Place Based Partnership**	Briefing	Adults, Health and Integration	Director of Delivery	Nina Griffith
deadline: 24 Nov				Group Director AHI	Helen Woodland
	Implementing new regime of 'Liberty protection safeguarding'	Briefing	Adults Health and Integration	Director of ASC and Operaitons	Georgina Diba
				Principal Social Worker	Dr Godfred Boahen
	Adult Social Care reforms fair cost of care and sustainability	Briefing		Director of ASC and Operations	Georgina Diba
				Head of Commissioning, Busine	Zainab Jalil
				Financial Advisor	John Holden
				AD ASC and PH Commissioning Development	Jenny Murphy
	Refresh of Mayor of London's Six Tests for service reconfigurations	Noting only			
12 Jan 2023	**Cabinet Member Question Time: Cllr Kennedy**	Annual CQT session	LBH	Cabinet Member for Health, ASC, Voluntary Sector and Culture	Cllr Chris Kennedy
deadline: 3 Jan					
	TBC				
8 Feb 2023	**Estates crisis in Primary Care**	Discussion			
deadline: 30 Jan					
	Language and cultural barriers in commissioning and delivery of mental health services				
	tbc				
15 Mar 2023	**Air quality - evidence base on the most affected areas and mitigation plans**				
deadline: 6 Mar	**Outputs from GP Confederation-PCNs Steering Group on futre of primary care**	Follow on from Sept 22	NHS NEL	Clincial Lead for Primary Care in City and Hackney and PCN Clinical Director	Dr Kirsten Brown
	Health and Wellbeing Strategy 2022-26 one year on	Update on outputs	Public Health	Director of Public Health	Dr Sandra Husbands
26 April 2023	**New Integrated Mental Health Network**	Follow on from Sept 22	Public Health	Senior Public Health Specialist	Jennifer Millmore
deadline:17 April					

ITEMS AGREED BUT NOT YET SCHEDULED

Possible date					
	Overview of capital build proposals in Adult Social Care	Briefing	Adult Services	Group Director Adults Health and Integration	Helen Woodland
				Director Adult Social Work and Operations	Ann McGale
Postponed from 1 May 2020	**Tackling Health Inequalities: the Marmot Review 10 Years On**	**SCRUTINY IN A DAY**	Public Health and others tbc	Director of Public Health	Dr Sandra Husbands
June/July 2023	**Air Quality Action Plan 2021-25- update on Implementation**		Climate, Homes, Economy	Land Water Air Team Manager	Dave Trew
			Adults, Health and Integraton	Consultant in Public Health	Jayne Taylor
	Consultation on Changes to Continuing Health Care - the Hackney perspective		Adults, Health and Integration		
			NHS NEL		
	In future items the Commission to test the performance of primary care in NEL against the principles set out in the The Fuller Report.		NHS NEL, PCNs and GP Confederation		
	New CQC inspection regime for Adult Social Care		Adults, Health and Integration		
	Redevelopment of St Leonard's Site		Homerton Healthcare	CE	Louise Ashley
April 24	**New commissioning arrangements for Dentistry one year on**		NHS NEL	Commissioner	Jeremy Wallman

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INEL JHOSC Rolling Work Programme for 22-23 as at 25 Nov

Date of meeting	Item	Type	Dept/Organisation(s)	Contributor Job Title	Contributor Name	Notes
	Municipal Year 2022/23					
25 Jul 2022	**Implementation of NEL ICS**	Briefing	NHS NEL	Independent Chair	Marie Gabriel CBE	
			NHS NEL	CEO	Zina Etheridge	
			NHS NEL	Chief Finance Officer	Henry Black	
	East London Health and Care Partnership updates inc.	Briefings	NHS NEL	CEO	Zina Etheridge	
	Trust updates and health updates		Barts Health/BHRUT	Group CFO	Hardev Virdee	
	Continuing Healthcare proposals		NHS NEL	Chief Nursing Officer	Diane Jones	
	Community Diagnostic Hubs		BHRUT/NEL ICS	Director of Strategy and Partnerships/ SRO for CDCs	Ann Hepworth	
	Operose and primary care issues		NHS NEL	Deputy Director Primary Care	Alison Goodlad	
			NHS NEL	Director Primary Care Transformation	William Cunningham-Davis	
			NHS NEL	Diagnostics Programme Director	Nicholas Wright	
	Whipps Cross redevelopment		Barts Health/BHRUT	Ralph Coulbeck	CE of Whipps Cross	
	Proposed changes to access to fertility treatment for people in NE London	Briefing	NHS NEL	Chief Nursing Officer	Diane Jones	
			NHS NEL	GP and Clinical Lead	Dr Anju Gupta	
19 Oct 2022	**NHS NEL Health Updates**	Briefing	NHS NEL	CEO	Zina Etheridge	
deadline 7 Oct	Trusts performance		Barts Health/BHRUT	Group CEO	Shane DeGaris	
	Winter planning and resilience		NHS NEL	CEO	Zina Etheridge	
			NHS NEL	Transformaton Director	Siobhan Harper	
	Vaccinations update - monkeypox and polio		NHS NEL	Chief Nursing Officer	Diane Jones	
	Developing ICS Strategy	Briefing	NHS NEL	CEO	Zina Etheridge	
	Acute Provider Collaborative - Developing Plans	Briefing	Barts Health/BHRUT	Group CEO	Shane DeGaris	
	Update on work of Whipps Cross JHOSC	Standing item	Chair of the Whipps Cross JHOSC		Cllr Richard Sweden	
15 Dec 2022	**NEL ICS Strategy (final)**	Briefing	NHS NEL	CEO	Zina Etheridge	
deadline 5 Dec	**NHS NEL Health Updates**	Briefing	Various		Shane DeGaris, Louise Ashley, Paul Calaminus	
	TBC Impact of ICS on local mental health commissioning landscape	Briefing	ELFT	CEO	Paul Calaminus	

	TBC Scheme of Delegation to Place Based Partnerships	Briefing	NHS NEL		Zina Etherdige, Henry Black	
	Update on work of Whipps Cross JHOSC	Standing item	Chair of the Whipps Cross JHOSC		Cllr Richard Sweden	
28 February 2023						
deadline 16 Feb						
	Update on work of Whipps Cross JHOSC	Standing item	Chair of the Whipps Cross JHOSC		Cllr Richard Sweden	
	ITEMS TO BE SCHEDULED					
	Monitoring new Assurance Framework for GP Practices	follow up from July 22				
	Continuing Healthcare Policy focusing on 'placements policy' or 'joint funding policy for adults'	follow up from July 22				
	NEL Estates Strategy	from 21/22				