

Health and Care Bill

Committee Stage Briefing (Lords)

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Introduction

The pandemic has had an adverse effect on older people's physical and mental health. While many older people were already dealing with significant health challenges before the pandemic, a combination of lockdowns, social distancing measures, loss of routine and support – as well as limited access to services to manage pre-existing or newly emerging health conditions – means millions of older people have seen their health decline.

Around a quarter of older people – 4 million – are now living in more physical pain than they did before the pandemic, while around 4.3 million older people now can't walk as far. Just over half of older people – 8.7 million - feel less confident to go to a hospital appointment than they did at the start of the pandemic and around 6 million older people feel less confident to go to their GP surgery.

It is likely that the implications of the pandemic on older people's health and care needs will be long lasting, and without the right support could be irreversible. More than ever before older people will need timely access to high-quality health and social care.

We welcome the ambitions in the Bill to improve health and care for all through increased integration, joined-up planning, and prevention. To improve the health and social care for older people the Bill needs to deliver truly integrated working across health services, public health and social care. The Bill's ambitions cannot be delivered without a clear workforce plan across health and social care, support to unpaid carers and a clear plan for addressing health inequalities. The impact of the pandemic has not been felt equally, with older people among the groups that have disproportionately suffered throughout the last 22 months. Some of this impact comes from a legacy of age discrimination and unequal access to care. We expect existing statutory bodies covered by the Bill to comprehensively demonstrate their adherence to their duties under the Equality Act 2010.

The Covid-19 pandemic laid bare the deep systemic inadequacies of the current social care system which has had catastrophic consequences for millions of older people, families and carers. While we are pleased that the Government has announced action on social care reform, for millions of older and disabled people who need care now it will be many years before they may benefit from the proposed reforms.

Age UK is very disappointed with the Government's announced change to the care cap. Clause 140 (Cap On Care Costs For Charging Purposes) was not given the opportunity to be scrutinised in the Commons Bill Committee, therefore we are hopeful that Peers will give Clause 140 the due consideration, scrutiny and debate required at Committee Stage. Clause 140 significantly waters down the Government's plan for a cap on catastrophic care costs and does so in a way that protects only the better off, contrary to the Government's 'levelling up' agenda. This follows the Government failing to give social care the financial settlement it needed at the spending review and admitting that most of the money raised by the National Insurance Health and Care levy would go to the NHS. We hope Peers will vote to remove Clause 140 from the Bill.

Integrated Care Boards: Functions - Clause 19

The Bill outlines explicit duties across a number of domains including collaboration, joint working and quality improvement. There must be a commitment to developing and maintaining clear, measurable standards for delivering these duties.

For patient and public involvement, this would be an important way of setting clear expectations and goals for people and local groups who are giving their time for service development and scrutiny.

To further strengthen the voice of patients and the public, we believe there is scope to extend the expertise sought under the “duty to obtain appropriate advice” (Clause 19, 14Z38). Currently the duty covers seeking medical/clinical and public health expertise. We believe this should be amended to include an additional category covering those with expertise in receiving care and managing health conditions. This would recognise that patients, researchers and local groups with expertise in living with and managing care needs have an equal contribution as medical professionals. This would help to overcome historic attitudes that can see patient/user involvement as an add-on to service development and oversight rather than a fundamental part of healthcare.

The duty to collaborate must not become a tick-box exercise. The Health and Social Care Act 2012 had provisions for aligning strategies across the work of CCGs and local authorities, but we are not convinced this had a meaningful effect on the care and services delivered.

Age UK want to see:

- *The value of the voluntary sector’s involvement in the development of healthy communities raised to ensure this informs the debate on the formation of both the Integrated Care Boards and Integrated Care partnerships.*
- *The Government amend the “duty to obtain appropriate advice” so that groups and people with expertise in the experience of living with long-term conditions and receiving care are properly represented in local services, planning and scrutiny.*

Secretary of State’s Functions: reporting on assessing and meeting workforce needs - Clause 35

The Secretary of State for Health and Social Care should, at minimum, have a duty to publish a biennial report on the health and social care workforce.

We also believe bolder and more significant changes could be made by introducing robust accreditation of care workers working in CQC registered services. This could be achieved through a formal register of care workers.

We are disappointed that the Bill simply requires the Secretary of State to report on the healthcare workforce and does not set out proposals to tackle the immediate shortfall or a long-term strategy to address serious and persistent shortages in the social care workforce. Future success of Integrated Care Systems relies upon robust workforce planning across health and social care and effective collaboration with Local Authorities and providers.

Age UK supports the proposed amendment (Amendment 10 to Clause 35) put down by Baroness Cumberlege, Lord Stevens, Lord Hunt of Kings Heath and Baroness Brinton with the support of over 90 health organisations amending Clause 35 to strengthen workforce planning, requiring the Secretary of State to publish independent assessments of current and future workforce numbers every 2 years. We were pleased to see cross party support for this amendment in the Commons and are hopeful this proposal will receive widespread support in the Lords.

The pandemic has highlighted the immense dedication and compassion of many care staff and how valuable they are to our society. Yet despite being a vital and skilled role, social care is not generally viewed as a professional career and social care workers have been consistently underpaid and undervalued. We agree with the Care Quality Commission (CQC). They are clear in their recent State of Care report (Oct 2021) that a new deal for care must consider the professionalisation of the workforce. We also agree with the Government in its social care White Paper, *People at the Heart of Care*, committing to ensuring that “those working in social care feel recognised, rewarded and are equipped with the right skills and knowledge”.

Many of the proposals in the White Paper are welcome, however we do not believe they go far enough. We believe instead that some form of professional register of care workers could help to raise the status of those working in social care. Age UK sees registration as a first step towards professionalising the care workforce. England is the only nation in the UK without a professional register of this kind. Such a register would apply to people who work in CQC registered services only, therefore excluding Personal Assistants for whom a more informal approach is considered by disability groups to be more appropriate.

Successful implementation of the register would lay the foundations for professionalising the workforce which is increasingly asked to support people with complex health conditions, with limited clinical support or oversight. A register would give care providers a framework for recognising an individual’s experience and training, enable care workers to be part of a formally recognised group, and enable the Government and others to communicate with all care workers in England when needed. For example, administering the current requirement to vaccinate health and care workers would be aided by the existence of a workforce register.

Registration of social care workers would provide reassurance to older people in receipt of care and their loved ones, and over time would help to demonstrate that care workers meet an agreed national set of standards for their professional skills. It also has the potential to develop opportunities for career progression and improved pay and conditions. Investment in the workforce and parity with health care is essential if recruitment and retention is to be achieved.

The proposals in the White Paper, *People at the Heart of Care*, appear to share many of these aims. However, if every element of accreditation is ultimately voluntary, as proposed, the Government risks leaving little incentive to providers who are already struggling to maintain the right skills and experience in their staff. This in turns risks entrenching a two-tier system where the most qualified staff with a more comprehensive skills “passport” are only attracted to higher cost settings or services. Instead, a registered care workforce would be the first step towards improving terms and conditions for care workers and lay the foundations for achieving the Government’s own ambitions.

Age UK want to:

- *Encourage the Government to accept amendments to ensure a biennial report on both the health and social care workforce.*
- *Encourage the Government to bring forward proposals to register the care workforce working in CQC registered services as a first step towards the professionalisation of care workers.*

Secretary of State's Functions - Clause 38

We accept that there may be exceptional circumstances in which the Secretary of State could intervene in local decisions on services. However, local decision-makers and planners, including communities, must have clarity on what these circumstances are and what steps they can take to reduce the risk that these powers will be used.

There already exists a provision in the Bill (Clause 19, 14Z50) for Integrated Care Boards to produce plans with specific reference to its duties to, among other things, quality improvement and public involvement. As such, failure to demonstrate these duties either in planning or performance management of the ICS could form reasonable grounds for the Secretary of State to intervene. Likewise, the Integrated Care Board, using the standards proposed above, would have a reasonable framework to minimise interference from the Secretary of State.

We believe the Secretary of State for Health and Social Care must be accountable to Parliament and the public in the delivery of a comprehensive health and care service. However, local decision-makers, and communities playing a meaningful role in planning and oversight of services, should have confidence that their role and contribution takes precedence as the default.

Age UK want to see:

- *Assurance that new powers for the Secretary of State to direct NHS England and intervene in local decisions will only be used in exceptional circumstances. To this end, a clear framework for such an intervention must be in place and should include mediation through the general duties of Integrated Care Boards.*

Hospital Discharge – Clause 80

The discharge to assess model must be matched with funding for community health and care services, clear statutory guidance that includes standards on accountability and safeguards, and respect and deference to patient and family choice. As a step in a permanent change to how hospital discharge works, it cannot ultimately succeed without full reform of the social care system.

Discharge to assess describes an approach by which people leaving hospital have their onward needs assessed and care planned in the place they are living or recovering. For most people, this will be their own home but will also include both short and long stay care homes. We support the discharge

to assess approach. It can speed discharge from hospital and provide a more realistic assessment of need that captures both the environment they will be living in and their wider support needs.

Clause 80 will remove the requirement for local authorities to carry out a social care assessment before someone is discharged from hospital. In the right hands, this can allow flexibility in how discharge is managed and ensure that the onward provision of care is tailored to best meet that person's needs. However, without the right services in the community, people and families experiencing discharge to assess risk being left without adequate support and lacking even the safety net of being in hospital.

In the past, some older people have told us that being "discharged to assess" just felt like they were being shunted out of hospital. We need to ensure the effective monitoring of patients' journeys post discharge, including recording and reviewing outcomes from care. We believe people going through discharge should have a clear timetable for receiving care in the community, which could include maximum waiting times for an assessment and subsequent receipt of care. This assessment should be coordinated across both health and social care but is focused on what will best support that person's immediate recovery and rehabilitation.

We agree in principle with Baroness Wheeler's amendment to require a social care assessment at discharge or no longer than two weeks after leaving hospital. However, this should be in service of achieving a full coordinated assessment that covers all health and social care needs

The future success of discharge to assess, therefore, is dependent on investment in services in the community and clear lines of responsibility for onward care when someone leaves the hospital, whether they are discharged into their own home or a residential setting. This must include support and respect for patient and family choice. People should not feel pressured into being discharged somewhere that doesn't work for them in the longer term just to achieve the goals of the programme. Incorporating their preferences and wishes, and what works for their family, should be enshrined in discharge to assess models.

Age UK want to see:

- *Assurances on the standards envisaged in the proposed statutory guidance for discharge to assess. These should include clear standards on accountability and safeguarding, respect for patient and family choice and should consider minimum service requirements, including maximum waiting times for assessment in the community.*
- *Discharge support adequately funded and focused on meeting patient goals from care.*

Collection of information about adult social care - Clause 85

We welcome the ambitions set out in the White Paper, *People at the Heart of Care*, to expand and enhance data collection in adult social care. The new powers included in the Bill to help achieve this must include a presumption of transparency so any new collections are published by default.

We strongly support the Bill's provisions giving the Secretary of State new powers to improve and expand data collection to address the systematic lack of understanding about the social care sector.

There is a lack of data about older people who fund their care, we agree with the Government that this is an important issue to correct.

Publishing these data sets is vital to enabling health and social care organisations to understand and monitor issues facing the social care system. This should also include organisations that scrutinise the sector on behalf of service users and for people and families making choices about where to receive their care. We expect data sets to be collected and published by NHS Digital.

Age UK want to see:

- *Assurances that the Secretary of State for Health and Social Care will make all data collected available via NHS Digital, as outlined in the explanatory notes.*

Cap On Care Costs For Charging Purposes- Clause 140

We are extremely disappointed that the Government are attempting to make this last-minute change, the impact of which will be very significant for those with longer care journeys, and people with modest income and assets.

The Government pledged to reform the social care system, which is overdue, but while we were supportive of the professed objective to protect individuals and families against catastrophic care costs, Clause 140 has the effect of significantly watering down the original proposals at the expense of people who have built up some assets over their working life but are by no means well off.

As originally envisaged, the amounts accrued towards the £86,000 cap on care costs were based on the actual cost of someone's care (within the limits of the budget set by the local authority). Wealthier individuals would be expected to pay the full cost up until the point they reached the cap, however people of more modest means would receive help towards their costs once their assets dropped below the £100,000 upper means test threshold. As a result, individuals with identical care needs would reach the cap after the same period, however, those on lower incomes and with more modest assets would have spent less out of pocket. The interaction between the cap and extended means test was intended to ensure the system was fair and provided vital extra protection for people who would otherwise still stand to lose most of their assets under the cap.

Clause 140 makes amendments to the Care Act 2014, meaning the amounts accrued towards the £86,000 cap are based solely on an individual's out of pocket contribution. As a result, everyone will be expected to make the full £86,000 cash contribution towards their costs regardless of their means. Although individuals will still qualify for means-tested financial support if their assets fall below £100,000, in practice, this will no longer act to protect people with more modest means and will simply see them contributing over a longer period.

Overall, the effect of this proposed amendment is that those with modest assets of between £106,000 and £186,000 in value will hardly be better off at all under the new scheme. This Clause would also be extremely unfair to those who have no assets and a modest income. It is clear that these changes have the potential to save the Government hundreds of millions of pounds, but at the expense of those on low incomes, with modest assets and living in parts of the country where houses values are lower.

Age UK opposes Clause 140 of the Bill. We support Baroness Wheeler, Baroness Surbiton and Lord Warner's intention to oppose Clause 140.

Age UK want to see

- *The Government withdraw Clause 140, and for all care costs incurred, whether by the adult or Local Authority to accrue towards the £86,000 cap.*

Human Rights – strengthening the rights of care home residents to receive visitors

The pandemic has cruelly exposed how easy it has been to cut care home residents off from their loved ones and how hard it has been for any one person to challenge the rules imposed on them. Families have been separated from their loved ones for very long periods. This separation has often been disproportionate to the current pandemic risk or has been imposed across all residents with no assessment of the risk of a proposed activity. Being isolated from family and friends is intrinsically harmful, and evidence of the extreme anguish this has caused to so many older people has been widely reported. Last April, when we surveyed our supporters, we found that when people were able to resume contact with their loved ones in care settings:

- **40% of people told us their loved one's physical health had got noticeably worse**
- **50% of people told us their loved one's mental health had got noticeably worse**

Many care providers have faced a very difficult set of circumstances during the pandemic with lack of easy access to testing, concerns about staffing and constantly having to judge the risk the pandemic represented to their residents. However, we believe that too often the rights of care home residents to engage with and be supported by their family and friends has been infringed.

Care home residents must receive better legal protections so they and their families can understand and apply their rights to enable them to live well and with dignity.

Age UK want to see

- *That the vital visits between care home residents and their loved ones have strong and enforceable protections.*
- *The Joint Committee on Human Rights has proposed [a new Statutory Instrument](#) to be laid as a regulation under the Health and Social Care Act 2008. We believe the adoption of this SI would help to rebalance the rights of care home residents to receive visitors and the duties of residential care providers to keep people safe.*

Get in touch with us

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