

Health and Care Bill

Member Briefing session, 1 April 2022



Essex County Council

What we'll cover today

- Health and Care Bill reforms:
 - NHS reforms and new integrated care systems
 - New adult social care inspection regime
 - Changes to social care charging
- Implications
- Questions

Health and Care Bill



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Why is the Government making changes?

Improve population
health

Improve quality of
services

Improve local
accountability

Promote
collaboration

Remove barriers to
integration

Reduce
bureaucracy

Creating integrated care systems

An integrated care system is essentially about how the NHS will work with other partners such as councils and voluntary and community sector to plan, commission and deliver services – these will become statutory entities from July 2022.

An ICS will have 4 core purposes:

- i. improving outcomes in population health and healthcare;
- ii. tackling inequalities in outcomes, experience and access;
- iii. enhancing productivity and value for money; and
- iv. contributing to broader social and economic development.

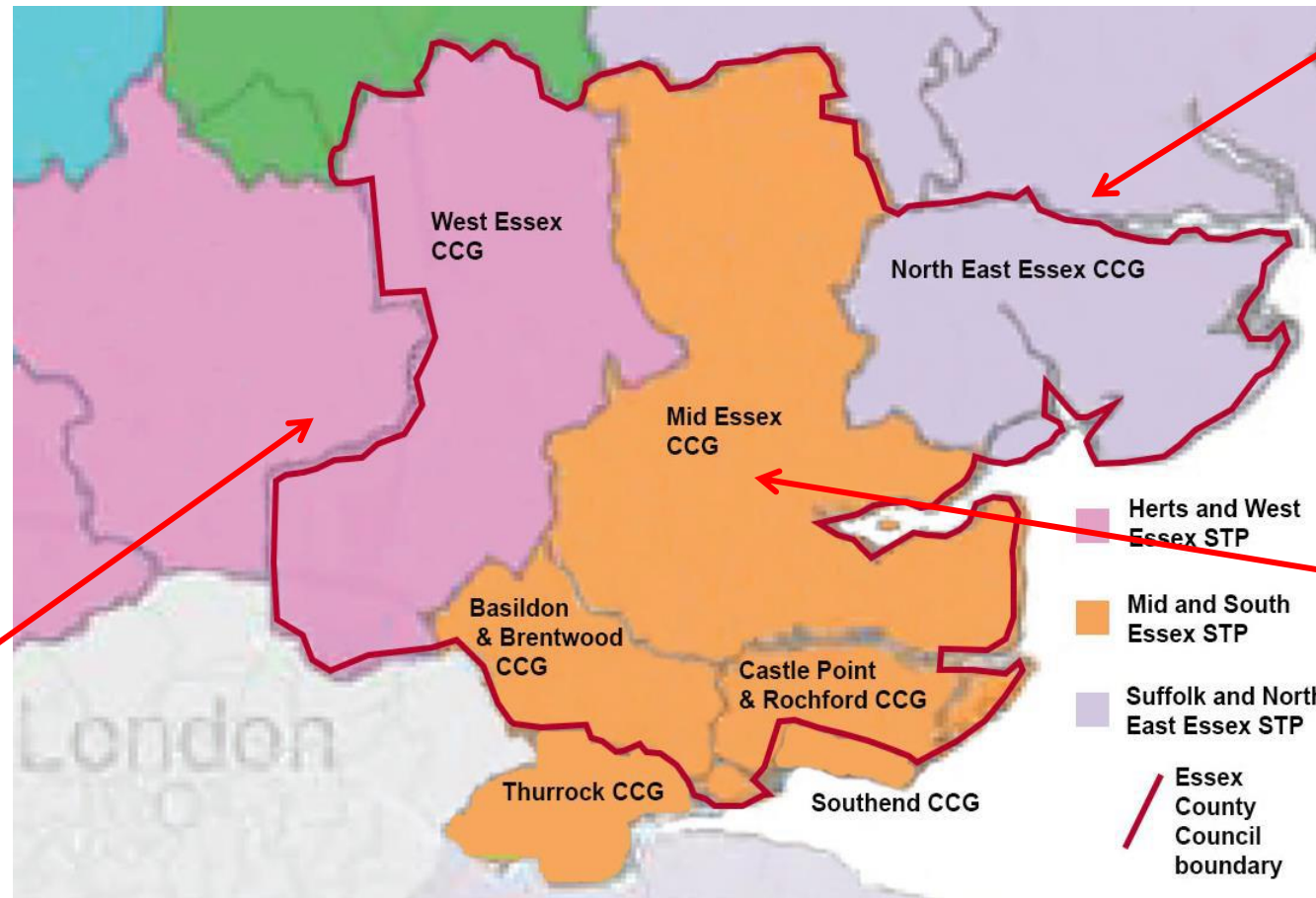
Councils and communities have key roles

The majority of health outcomes are a result of non-health services. It is “the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of life” that largely determine health outcomes (World Health Organisation) – often called the wider determinants of health



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Essex is in three integrated care systems



Hertfordshire & West
Essex Sustainability
and Transformation
Partnership
(population 1.6 million)

Suffolk & North East
Essex Integrated
Care System
(population 1 million)

Mid & South
Essex Strategic
Transformation
Partnership
(population 1.2 million)

Key parts of an integrated care system (ICS)

An ICS comprises two main statutory components:

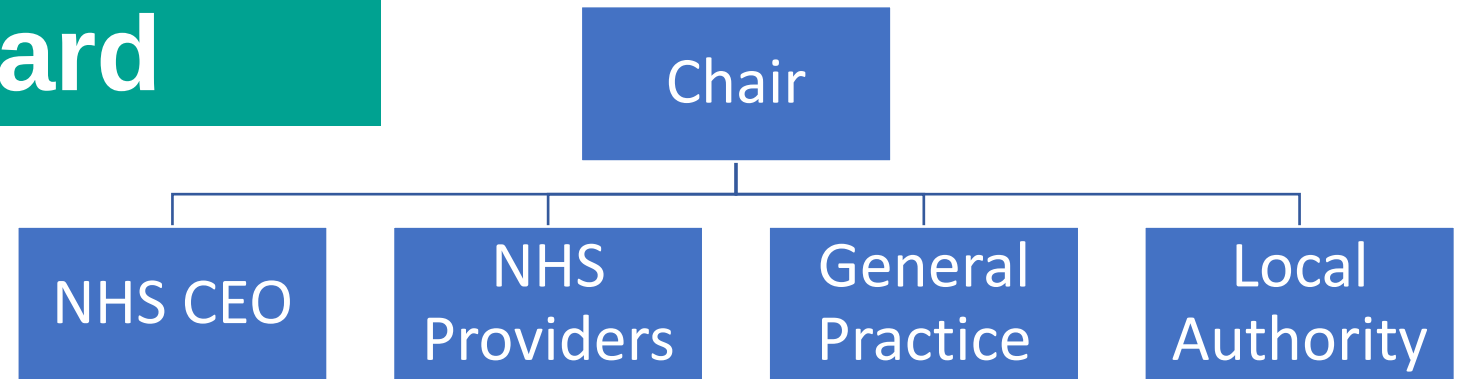
NHS Integrated Care Board (ICBs) – these will be responsible for day-to-day running of the NHS in its area and will be responsible for arranging for the provision of services for their population, which will typically be +1 million. They will be responsible for commissioning acute hospital services, primary care services, community health and mental health services, as well as dental, ambulance and nursing. They will hold and allocate the NHS budget for their area. They will replace existing clinical commissioning groups and be based on larger geographies.

The Government expect ICBs to delegate down to, and empower, local place-based partnerships – typically covering a population of 250-500k.

The Integrated Care Partnership Board (ICP) – this will be a new statutory joint committee between an NHS ICB and the respective upper tier local authorities in the area of the ICB. It must set a Health and Care Strategy for its area covering adults and children's social care, public health and NHS services. The NHS ICB must have regard to this plan.

The ICB and ICP must also link with, and have regards to, relevant strategies and plans of health and wellbeing boards, which will remain a statutory duty of upper tier authorities.

Integrated Care Board



Key points:

- Integrated care board (ICBs) will take on the **NHS planning functions** previously held by clinical commissioning groups (CCGs)
- ICB will produce a **five-year plan** (updated annually) for how NHS services will be delivered to meet local needs.
- In developing this plan and carrying out their work, the ICB must have regard to their partner **ICP's integrated care strategy** and be **informed by the joint health and wellbeing strategies** published by the health and wellbeing boards in their area.
- Statutory function as of 1 July 2022

• ICB Membership:

- Chair
- CEO and representatives from NHS providers
- General Practice
- Local authority member responsible for social care services in ICS area – ECC will have a rep on each ICB
- Other – as determined by local area

[Kings Fund](#)

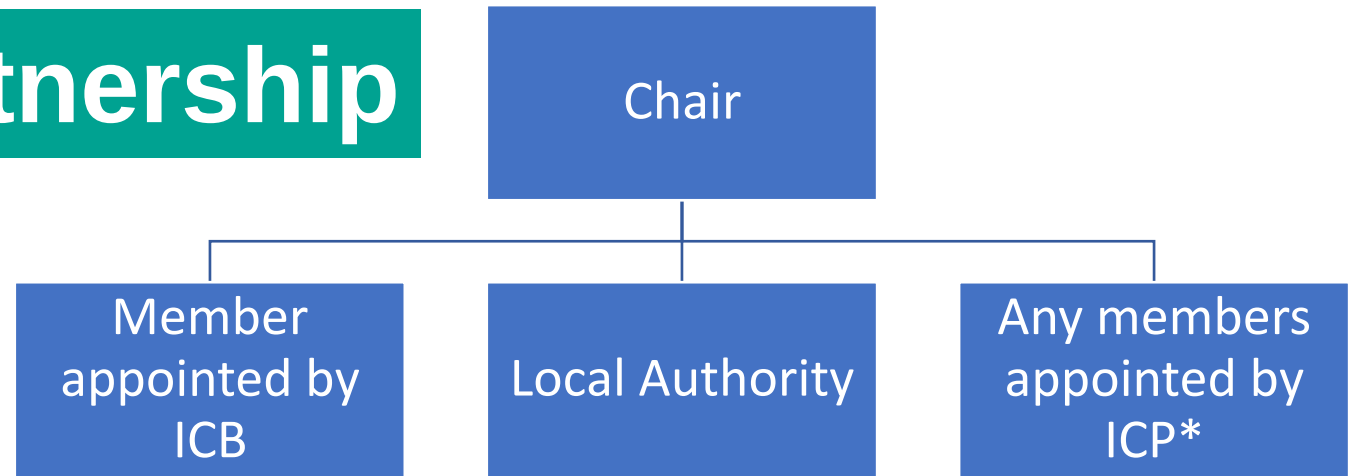
[NHS England](#)

Place-based partnerships

Integrated Care Boards are encouraged and expected to delegate decision-making and budgets to place-based partnerships. Several governance models have been set out for place-based partnerships (below) and the recent Integration White Paper (February 2022) has signalled an expectation that councils and NHS set out clarity on their local governance model by April 2023 for how they could take forward Option 4, as well as how local places will have a single accountable leader (the latter is being consulted on by govt and has raised concerns from councils and NHS)

Option	Description
1 Consultative forum	Advisory role – decisions of ICB should be informed by the consultative forum
2 Individual executive	Statutory bodies agree to delegate functions to individual members of staff to exercise delegated functions. They can convene a committee to support them with membership from across partnership.
3 Committee of a statutory body	A committee with delegated authority to make decisions about the use of resources. TOR set by the ICB and agreed to by HCP Board.
4 Joint Committee	A committee established between ICB and statutory providers. ICB agrees to delegate to the committee.
5 Lead provider	One statutory organisation manages resources and delivery at place level under a contract with ICB and / or Local Authority.

Integrated Care Partnership



Key points:

- will operate as a **statutory committee**, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care
- Responsible for developing an **integrated care strategy**, which sets out how the wider health needs of the local population will be met - must involve the local Healthwatch, the VCSE sector, and people and communities living in the area.
- ICPs will not directly commission services.

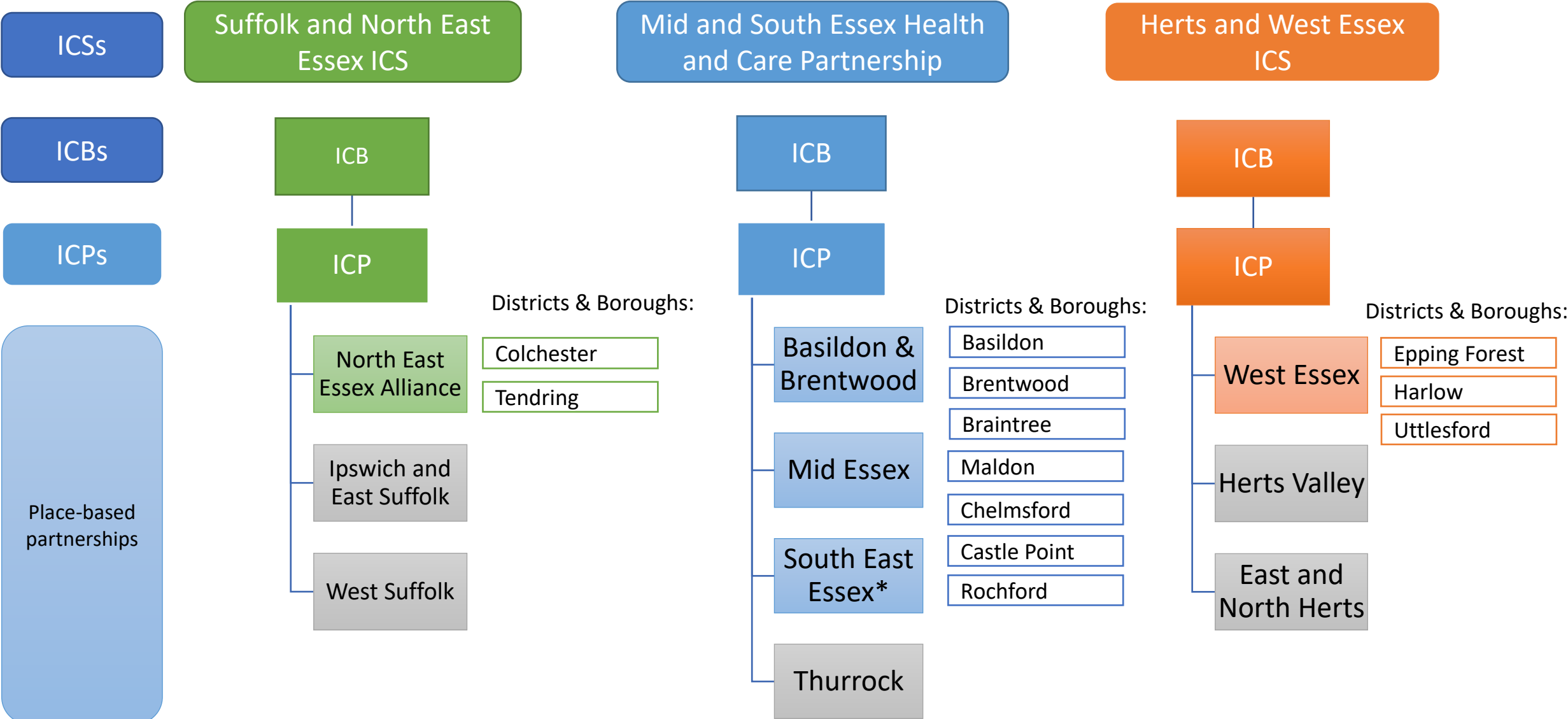
Membership:

- HWBs
- Other statutory organisations e.g district/boroughs, HealthWatch
- Voluntary, Community and Social Enterprise (VCSE) sector partners
- Social care providers
- Organisations with a relevant wider interest, such as employers, housing and education providers and the criminal justice system (Including courts, probation, and prison services)

[Kings Fund](#)

[NHS England](#)

ICS structures which include Essex County Council



* Includes Southend-on-Sea

Implications for NHS

1. Current NHS commissioning structures will be abolished. Ensure you are familiar with the new arrangements in your area. New websites and branding, for example, are being developed or updated for each system and expected to launch 1 July.
2. There will be new appointments to leadership roles in the local NHS. Most CCG staff will transfer to the new integrated care board organisations.
3. Budgets need to be managed and allocated from ICB level, delegating as much as possible to places. Some services – such as acute services – will likely be commissioned at an ICB level rather than at place (currently CCG) level
4. NHS needs to set out its new governance framework – what decisions will be taken at ICB level and what decisions will be taken elsewhere?
5. NHS will need to harmonise key policies across their geography to ensure consistency e.g access policies; safeguarding policies; complaints policies; Continuing Health Care (CHC) approaches; quality
6. NHS providers required to be part of “collaboratives” and these could get delegated powers over budgets, strategy and prioritisation. Work underway on Southend, Essex and Thurrock mental health collaborative
7. Changes to NHS provider selection regime to simplify some procurement rules. This can apply to “mixed procurements” with social care.

Designate appointments

Hertfordshire and West Essex

Integrated Care Board

Chair of NHS ICB: Paul Burstow

CEO of NHS ICB: Jane Halpin

Integrated Care Partnership

Chair: Cllr Richard Roberts (Herts CC)

Mid and South Essex

Integrated Care Board

Chair of NHS ICB: Prof Mike Thorne

CEO of NHS ICB: Anthony McKeever

Integrated Care Partnership

Chair: Prof Thorne
Vice-Chairs: Essex, Southend and Thurrock health and wellbeing board chairs

Suffolk and NE Essex

Integrated Care Board

Chair of NHS ICB: Prof Will Pope

CEO of NHS ICB: Ed Garrett

Integrated Care Partnership

Co-Chairs: Prof Pope, Cllr John Spence (ECC) and Cllr Reid (Suffolk CC)

Implications for local government

1. County Council and district/boroughs to be engaged via:
 - Essex Health and Wellbeing Board – set Vision and ambitions for Essex population and high level strategy. Setting the purpose of the ‘Why’
 - Integrated Care Partnership Boards (x 3) – these will set plans for improving Health and Care for their geographies. Setting out the ‘What’
 - Local place-based partnerships (x 5) – these will integrate work on the ground. Taking forth the ‘How’
2. Councils have opportunity to be more involved in NHS planning at all levels and an opportunity to shape plans and priorities
3. ECC will need to refresh legal agreements and existing pooled funds (Better Care Fund) with CCGs and transfer them to the new NHS entities
4. Role of HOSC remains unchanged but there may be a need for future joint meetings of HOSC
5. Essex Health and Wellbeing Board refreshing its membership and terms of reference

Assurance and inspection



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Health and Care Bill assurance regime

Care Quality Commission (CQC) to have a role looking at local areas and systems

- A role for CQC in reviewing Integrated Care Systems
- New duty for CQC to assess how local authorities are meeting their social care duties under part 1 of the Care Act (this covers a range of things but for simplicity, includes:
 - Promote wellbeing
 - Prevent, reduce, delay onset of care needs
 - Assessments of care needs
 - Meeting care needs
 - Financial charging and personal budgets
 - Safeguarding
 - Provider failure
 - Market oversight

CQC will rate integrated care systems

Leadership

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Governance and assurance
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability
- Workforce Equality, Diversity & Inclusion

Integration

- Safe systems, pathways and transitions
- Care provision, integration & continuity
- How staff, teams and services work together

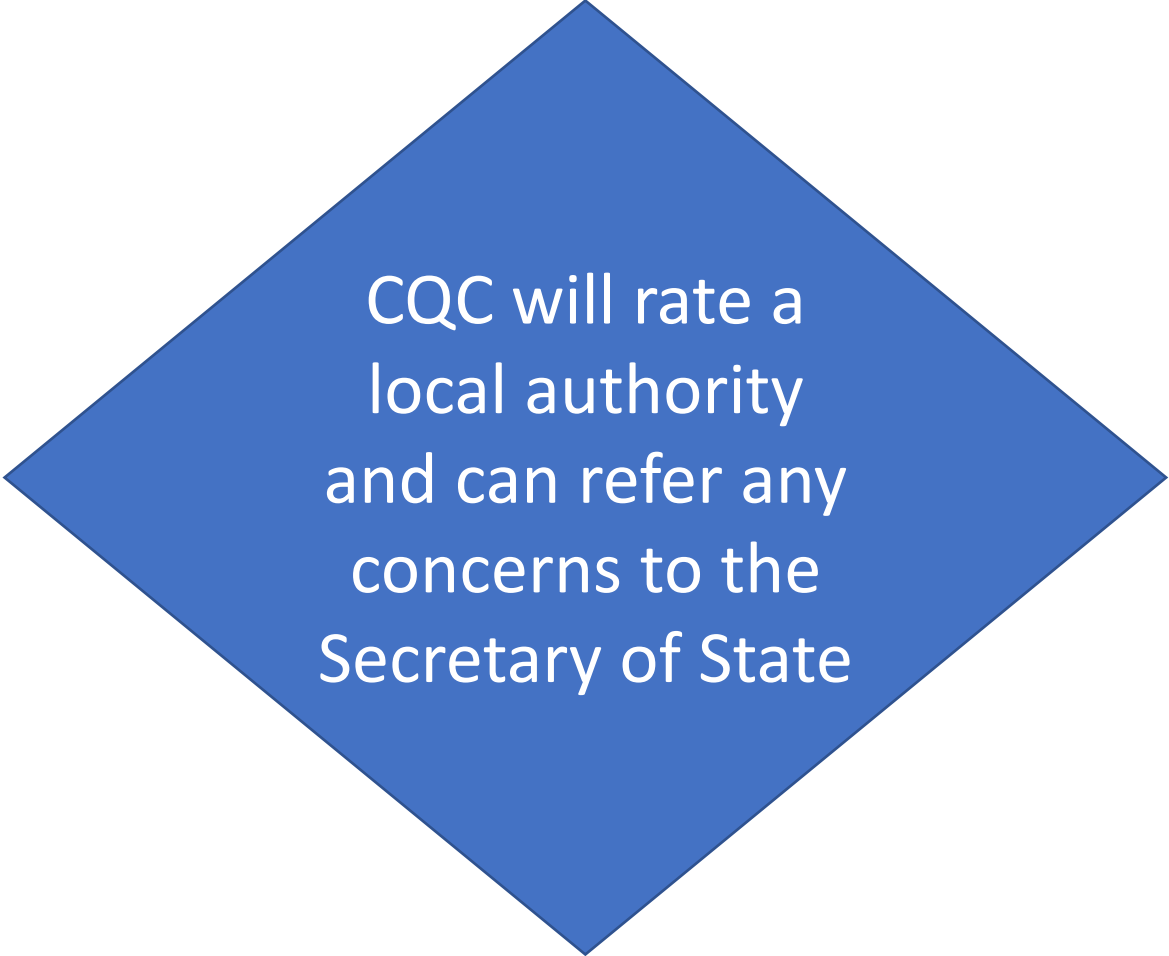
Quality and Safety

- Learning culture
- Supporting people to live healthier lives
- Safe and effective staffing
- Safeguarding
- Equity in access
- Equity in experiences and outcomes

CQC will inspect local authorities

Initial focus of Local Authorities will be across four key themes:

1. Working with people
2. Providing support
3. Ensuring safety
4. Leadership and workforce



CQC will rate a
local authority
and can refer any
concerns to the
Secretary of State

CQC will inspect local authorities

Theme 1: Working with people

- Assessing needs
- Supporting people to live healthier lives

Theme 2: Providing support

- Care provision, Integration, and continuity
- Partnerships and communities

Theme 3: Ensuring safety

- Safe systems, pathways and transitions
- Safeguarding

Theme 4: Leadership and workforce

- Capable, compassionate and inclusive leaders
- Learning, improvement and innovation
- Workforce equality, diversity and inclusion

CQC evidence for assessments

- People's experience
- Feedback from partners
- Feedback from staff and leaders
- Observation
- Processes
- Outcomes and performance data

Charging reforms



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Key changes

- The Government has announced major changes to social care funding, which will be implemented from October 2023 – this will be a major reform requiring lots of work and creating lots of uncertainties for adult social care and for ECC
- The big changes are:
 - A more generous means-test which will mean more people will be eligible for ECC to fund their care, rather than have to fund their own care
 - A cap on eligible care costs of £86,000 – after which, the council will be expected to fund care
 - A new right for private self-funders to ask ECC to arrange their care for them at better rates
 - A duty on ECC to implement and operate “care accounts” so that a person’s care costs can be tracked to ensure they can see how far from the “cap” they are
- The Government has announced a new Health and Care Levy of 1.25% on national insurance to fund the reforms (£5.4bn for social care over 3 years) – there is concern that the Government has under-estimated the cost of the reform and the challenges of preparing for implementation by October 2023.
- Consultation on operational guidance for reforms closes 1 April

Government case study 1

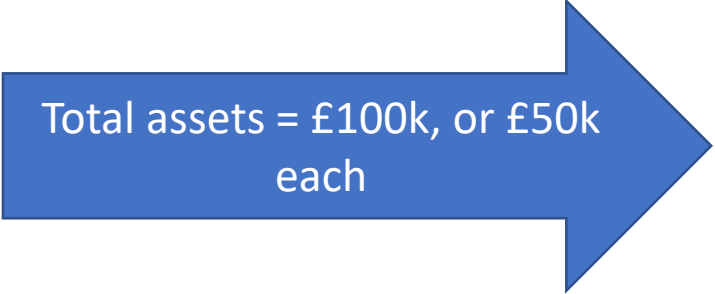
Case study: Mary and Bob

Mary is a pensioner living in Burnley with her husband, Bob. Together, they own a home worth £90,000 and have joint savings of £10,000. They both worked hard throughout their lives, planned carefully for their retirement and have a joint weekly income from pensions of £470. Mary has dementia and receives care in their home, but Bob is her main carer. Sadly, after a year Bob suffers a severe stroke and both Bob and Mary need to enter residential care.

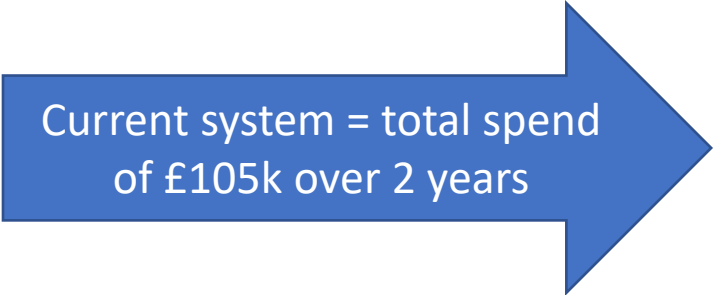
Under the current system, if they both stayed in residential care for 2 years, Mary and Bob would have spent around £105,000 in total towards their care. They wouldn't have got any state support until right at the end when they individually reached the UCL of £23,250, which would be based on half of their shared assets. They would be left with around £43,000 in assets between them.

Under the new system, once they both enter a care home, they immediately become eligible for some state support due to each of their £50,000 share of their wealth being below the new £100,000 UCL. Under the new system, they spend £68,000 in total for their care from their income and assets.

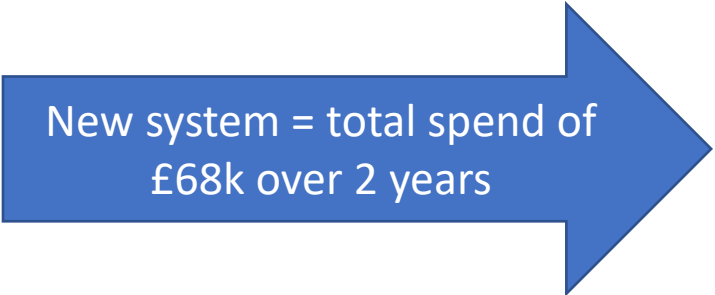
Over their combined care journeys, Mary and Bob save £37,000 from their assets and their income in the new system compared to the current system.



Total assets = £100k, or £50k each



Current system = total spend of £105k over 2 years



New system = total spend of £68k over 2 years

Government case study 2

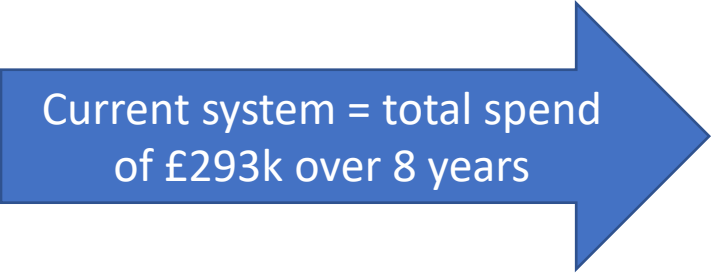
Case study: Yusuf

Yusuf is in his late 70s. He has lived on his own since his wife died from cancer 10 years ago. When she died, he downsized from their family home in Hastings to a smaller property worth £180,000. As a result, he has £70,000 in savings. Yusuf develops dementia, can no longer cope at home and needs to move into residential care. His underlying health is good and he ultimately spends 8 years living at the residential home. Yusuf's care home costs £700 per week.

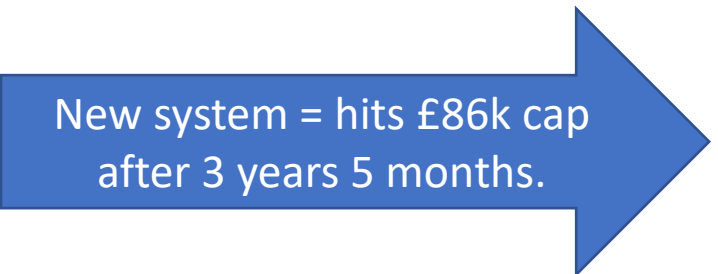
Under the current system, Yusuf would spend about £293,000 on his care from his assets and his income, and as a result only have £35,000 left in assets. This does not factor in any additional income he may receive from state benefits, such as Attendance Allowance, which he may be entitled to.

Under the new system, Yusuf hits the £86,000 cap after 3 years and 5 months. He no longer needs to contribute for his personal care from either his assets or his income. Beyond this, he will only have to contribute towards daily living costs. He is now left with £152,000, or 61% of his original assets.

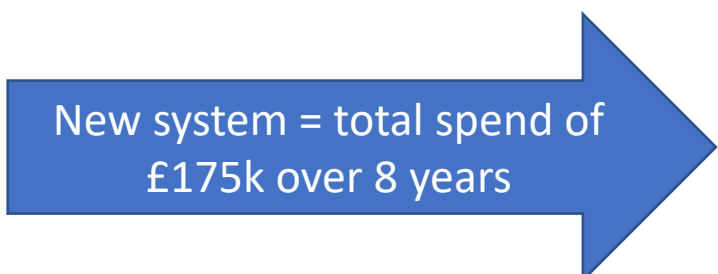
Over his whole care journey, Yusuf spends £118,000 less than under the current system.



Current system = total spend of £293k over 8 years



New system = hits £86k cap after 3 years 5 months.



New system = total spend of £175k over 8 years

Implications

1. A cap of £86,000 on eligible costs will protect people against unlimited costs but not all costs are eligible. Costs accrued before October 2023 will not count towards the cap.
2. Local authority contributions towards care will not count towards the cap. This has (and remains as of 31/03) subject to parliamentary debate and finalisation.
3. The cap will not cover daily living costs such as rent, food and utility bills, which will remain the responsibility of individuals. These will be set at a national, notional amount of £200 per week in 21/22 prices – or £10,400 per year. This applies to people in care homes.
4. Any “top-ups” to fees paid (for example, to secure more premium room and furnishings) will not count towards the cap.
5. More people will be eligible for council-funded support because of the new, higher, upper capital limit of £100,000 (increased from the current £23,250). People with less than £100,000 of chargeable assets will never contribute more than 20% of these assets per year. This will reduce council income from service user contributions.
6. Private funders have the right to approach councils to arrange fees at rates paid by local authorities (typically lower rates). This will lead to increased demand on the Council’s social care workforce and could also affect provider income.
7. Councils need to have systems in place that can operate ‘care accounts’ from October 2023. There are concerns from local government this is not achievable. A small number of pilot authorities will test it in early 2023.

Questions



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