



House of Commons  
Health Committee

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**Social Care**

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**Fourteenth Report of Session 2010–12**

***Volume I***

*Volume I: Report, together with formal minutes*

*Volume II: Oral and written evidence*

*Additional written evidence is contained in Volume III, available on the Committee website at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom)*

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## The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom).

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

### Committee staff

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<sup>1</sup> Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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## Summary

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Many people will, at some point in their lives, require care and support either from family and friends, or from the formal care sector. It comes as a great shock to many people that whilst the care and treatment provided by the NHS is free, care services (like help with washing or preparing food at home), are means tested and many people will have to pay for them.

The NHS, social care and social housing are most frequently used by older people, and these older people often have several needs at the same time; a need for NHS care from their GP and a specialist for a long-term condition like diabetes, a need for help with washing, dressing or getting around that is often provided by their council, and a need for housing that keeps them warm and well.

The best test of such complex services is whether they work well together from the point of view of the older person, or whether they provide care and support in the most effective and efficient means possible, from the point of view of the public purse. The Committee has come to the view that these separate systems are inefficient and lead to poorer outcomes for older people. Indeed, trying to define NHS care and social care as two separate and distinct things will only make matters worse for older people.

We have spoken with people who use and work in the services of Care Trusts, some of the most integrated organisations in the country, and heard evidence that integration can prevent hospital admissions and support the independence of older people. Such organisations do this better, at least in part, because they have a single pot of money from different sources to deploy in the manner that best meets people's needs. Although the Government has "signed-up" to the idea of integration, little action has taken place to date. The Committee does not believe that the proposals in the Health and Social Care Bill will simplify this process.

The Committee recommends that, whilst integration is not an end in itself that it can be a very powerful tool to improve outcomes for older people and people with disabilities and long-term conditions. To that end, each area should establish a single commissioner who will bring together the different pots of money that are spent on older people. This single commissioner could then best decide how this resource should be deployed in order to improve outcomes for older people. A similar task needs to happen at the national level, with the Government coordinating policy and regularly rebalancing spending across health, housing and care services. The Government should also develop a single outcomes framework for older people to replace the three overlapping but confusing frameworks that currently exist.

In order to achieve the level of integration that is required, a number of steps need to be taken. The Government must face the issue of the existing "funding gap" in social care services i.e. the gap between the number of people who need care (and the level of their care need) versus the amount of money that is currently in the system to deal with their needs, The Government will also need to outline its proposals for responding to the Dilnot Commission on how the individual contribution to their care costs can be made in a

manner that is fair and equitable. It is essential, however, that services are shaped by the objective of providing high quality and efficient care delivery, and the funding structures are fitted around that objective, not vice versa.

The millions of informal carers in England must also get a better deal. Despite the clear case for supporting carers to continue to care, the majority are not being identified, assessed or offered support. The Committee is clear that a new offer needs to be made to older people. A new, integrated legal framework is required which supports integration of health, social care and other services around the needs of the individual.

# 1 Introduction

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1. The purpose of our inquiry has been to consider the issues facing the future of social care, and to make recommendations for consideration by the Government in advance of publication of its White Paper on social care and update on funding. Although this report will particularly focus on those people aged 65 and older, many of our recommendations are equally relevant to services for younger people who have a disability, and other people who have long-term conditions.

2. A high proportion of people require care and support at some point in their lives. Whilst families, neighbours, friends and informal, unpaid carers are the main providers of this care, many people will also need to turn to the formal social care system.<sup>2</sup> Unlike the services provided by the NHS, which are largely provided free at the point of need, social care services are subject to a means test and many people will be expected to pay for some or all of their care and support. This comes as a shock to many. It also serves to sustain the artificial distinction between health and social care services, making joined-up, integrated care more difficult to achieve.

3. A well-funded, fully integrated system of care, support, health, housing and other services is essential, not just to provide high quality support for individuals, carers and families, but also to provide good value to the exchequer and the tax payer. The aim of establishing such an integrated system has long been an objective of successive governments. The existing, fragmented systems are both difficult to use and expensive to provide, and funding for them (which comes from a multiplicity of sources, including local and national government spending programmes as well as private sources) is coming under increasing pressure from England's ageing population. The quality of services delivered and the outcomes achieved are highly variable.

**4. This report will highlight several significant issues that the Committee has identified from the substantial body of evidence received during our inquiry. Our aim is to paint a picture of how a fully integrated system could be achieved with more efficient use of resources and the improved outcomes that it could deliver. The Committee recommends that the Government respond to the issues we have raised in its forthcoming White Paper and its proposed bill as well as in its progress report on funding reform. The Committee plans to revisit social care in the light of these documents, with a view to reviewing the progress that has been made.**

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2 In 2010–11 there were 1.15 million people using the care and support system provided by councils in England, and 2.12 million contacts from potential new clients, The NHS Information Centre for Health and Social Care, *Community Care Statistics: Social Services Activity, England 2010–11*, provisional release, p 3

## 2 The fragmentation of services and commissioning

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### The consequences of fragmentation

5. When thinking about the structure and delivery of health and social care services it is important to have clearly in mind the “typical” service user. This individual is often, wrongly, characterised as a normally healthy adult who relies on the health and care system to provide an episode of care which allows them to resume a normal, healthy life. Such patients, like all patients, are of course important, and the system must meet their needs. But estimates suggest they constitute a small proportion of all hospital activity. The main focus of this report is the needs of those individuals often, but not only elderly people, who suffer from long term and chronic conditions and who need coordinated packages of care to allow them to lead fulfilling lives. It is important to remember that it is these individuals who constitute the “typical” users of services—accounting for 29 per cent of the population, but 50 per cent of all GP appointments and 70 per cent of all inpatient bed days.<sup>3</sup>

6. The statistics relating to adult social care underline this point. Some 51 per cent of people receiving state-funded personal social services are over the age of 65 years,<sup>4</sup> three quarters of adults in residential care are aged 65 and over, and 91 per cent of people in nursing care are aged 65 and over.<sup>5</sup>

7. The NHS Confederation told us that the main job of acute hospitals now is looking after older people:

People with long-term conditions are major users of the NHS. Greater life expectancy means patients can typically have several long-term conditions. One of the most challenging of these is dementia. 70% of acute hospital beds are occupied by older people, 20% of acute beds are occupied by people with dementia and 75% of residents of care homes have dementia.<sup>6</sup>

8. David Orr from the National Housing Federation also made the case that older people are the principal “customers” of Housing Associations when he told us that:

Something like half of all housing association tenancies are now held by people who are 60 or over.<sup>7</sup>

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3 “Ten things you need to know about long term conditions”, Department of Health website, [www.dh.gov.uk](http://www.dh.gov.uk)

4 The NHS Information Centre for Health and Social Care, *Community Care Statistics: Grant Funded Services for Adults, England 2010–11*, 2011 p 6

5 The NHS Information Centre for Health and Social Care, *Community Care Statistics: 2009–10: Social Services Activity Report, England*, 2010, p 4

6 Ev 200

7 Q 498

9. Many older people have multiple needs across this spectrum of services. The Nuffield Council on Bioethics expressed this in their evidence to the Committee, using the example of dementia:

[...] after a diagnosis of dementia, people will still need help in accessing what is inevitably a fragmented support system, given the wide range of health and social services which people with dementia and their families may potentially use.<sup>8</sup>

10. The evidence is therefore clear—many older people, and those with disabilities and long-term conditions need to access different health, social care, housing and other services, often simultaneously. Unfortunately the evidence is also clear that these services are fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them. Indeed, on our visits to Torbay and Blackburn with Darwen the Committee heard evidence that before integration it was commonplace for multiple assessments of older people to take place. The result is that assessments are duplicated, opportunities to provide necessary help are not taken and the condition of individual patients deteriorates in many cases where this did not need to happen. Apart from a few notable exceptions, the provision of services to individuals takes place in unconnected silos—by the NHS, by local authorities and by the voluntary and independent sectors. The BMA told us that because of England’s ageing population and increasing levels of long-term conditions “there are dangers in creating fragmented services that separate their management from others within the system”.<sup>9</sup>

11. This “silo” mentality among service providers is reinforced by fragmentation of commissioning budgets. Instead of looking at their services from the perspective of the user, and challenging providers to deliver “joined-up”, efficient services, the development of separate commissioning budgets for health, social care, housing and other services has tended to entrench the fragmentation of services. Responsibilities lie across several different organisations, from Primary Care Trusts, to local authorities and individual citizens. The Committee does not believe that the proposals in the Health and Social Care Bill will simplify this process. **Many older people, people with disabilities and those with long-term conditions need to access a wide range of services, from the NHS through to housing services and care and support. Their experience of these services is often fragmented. The Committee believes that there is a link between the fact that people experience fragmented services and the fact that there are multiple funding streams and multiple commissioners of the services that they use.**

## Defining social care

12. At the heart of this fragmentation lies a key issue—the distinction that has been drawn between what is health care (commissioned and largely delivered by the NHS), and what is social care (mainly commissioned by local authorities and individuals, and provided by many different sources). This distinction, much discussed but little understood, arises from a succession of political compromises stretching back to the 1920s.

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8 Ev 174

9 Ev 183

13. The latest attempt to define the concept of social care comes from the Law Commission’s recent report on reforming the law governing adult social care. Although the existing law does not establish a clear definition of social care, the Commission sets out the existing definition of social care as:

Adult social care means the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support.<sup>10</sup>

This definition goes on to establish the settings in which social care is provided.

14. Furthermore, the Law Commission is clear that social care is currently defined “largely by reference to what services are not being provided by other organisations under different legislation”.<sup>11</sup> Its proposals for the future lie in not defining social care but in identifying a single “unifying purpose” around which social care should be organised—the “well-being principle”. This approach would establish in law that “the overarching purpose of adult social care is to promote or contribute to the well-being of the individual”.<sup>12</sup> A further checklist of issues that decision-makers would need to take into account would also be in the statute including involving users in decision-making, safeguarding adults from abuse or neglect and finding the least restrictive solution to any problems.<sup>13</sup>

15. During their evidence to us the Law Commission further clarified this issue and underlined the difficulty in clearly defining what social care is. They stated that:

The second issue is that we decided, quite early on in the report, that it would not be possible to define adult social care. We could only define its purpose, which is what the well-being principle aims to do. A lot of what adult social care currently provides is what other organisations do not provide—health services that are not provided by the NHS or housing services that are not provided by housing. In that sense, it was important for us to keep a very dynamic definition of the purposes of adult social care that did not exclude those sorts of matters at the margins.<sup>14</sup>

When asked if what they were defining is the obligation to fill in the gaps other people are not providing, the Commission told us “That is right”.<sup>15</sup>

**16. The Committee found the evidence provided by the Law Commission instructive. Faced with the challenge of providing a coherent definition of social care the Commission clearly felt it was building on sand. The Committee was not surprised that the Commission found it impossible to express 80 years of political compromises as a coherent legal principle.**

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10 The Law Commission, *Adult Social Care*, HC 941, para. 1.5

11 *Ibid.* para. 4.15

12 The Law Commission, *Adult Social Care*, HC 941 para 4.16

13 *Ibid.* Recommendation 5

14 Q 295

15 Q 296

17. In fact, in the Committee's view, the Law Commission's attempt to define social care underlines the central problem. The overarching aim of social care as defined by them, to "promote or contribute to the well-being of the individual", could just as easily be applied to health care or housing services. The conclusion we draw from this is that attempts to draw a distinction between these services and social care will fail because such distinctions are artificial and unhelpful, and because they directly contradict the policy objective. This objective is the same whether it is seen from the point of view of service user preference, objective outcome measurement or cost efficiency. It is to deliver a joined-up, integrated service that aims to deliver the best outcomes for the patient and in the most efficient manner possible. If that is the objective—and the Committee found that it is an objective shared between users, staff and policy makers—it seems perverse to attempt to build integrated service delivery on a fragmented commissioning system.

## 3 Integrating around older people

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### The case for integration

18. Despite its importance, the integration of health and social care services has been a matter of debate for decades. As the King's Fund told us:

Integrated care has been a recurrent goal of public policy under successive governments for more than 40 years.<sup>16</sup>

The Committee notes that there are some recurring themes from the history of integrating health and social care. Numerous research reports and policy papers have been published on this matter, signposting the value of integration, and our predecessor Health Committees inquired into this issue in 1999 and again in 2010.<sup>17</sup> For instance, 50 years ago to the month:

[...] a Circular was sent to local authorities highlighting a section of the [*ten year*] plan that described the development of hospital services 'as complementary to the expected development of the services for prevention and care in the community and a continued expansion of those services has been assumed in the assessment of hospital provision to be aimed at' (cited by Sumner and Smith 1969 p.43). Accordingly, local authorities were asked to produce plans for developing their health and welfare services over the same ten year period.<sup>18</sup>

Our predecessor Committee took evidence on the historical context of integration:

There was growing concern in the 1960s about the lack of co-ordination of health and social services. This led to the appointment of the Seebohm Committee on Local Authority and Allied Personal Social Services which reported in 1968 commenting that 'Although for many years it has been part of national policy to enable as many old people as possible to stay in their own homes, the development of the domiciliary services which are necessary if this has to be achieved has been slow', partly due to the shortage of appropriately trained social workers. It recommended new, unified social services departments to assess local needs and resources and plan accordingly, taking account of and supporting the contributions of independent organizations, relatives and neighbours. The report stated: 'Services for old people in their own homes will not be adequately developed unless greater attention is paid to supporting the families who in turn support them...If old people are to remain in the community, support and assistance must often be directed to the whole family of which they are members'.<sup>19</sup>

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16 Ev 153

17 Health Committee, First Report of Session 1998–99, *The Relationship between Health and Social Services*, HC 74–I, Health Committee, Third Report of Session 2009–10, *Social Care*, HC 21–I

18 Wistow, G. 2012 (in press) 'Still a fine mess...?' *Journal of Integrated Care*, 2012

19 Health Committee, Third Report of Session 2009–10, *Social Care*, HC 21–I, Ev 148–153

As noted in a forthcoming article on the issue of integration, once the decision had been made to separate health (NHS) and local authority (social care) provision and commissioning in the 1970s, plans were drawn up to facilitate greater collaboration:

This exercise led to a number of statutory provisions, some of which remain in force today. The package included requirements for each authority to make its respective professional services freely available to the other and forbade them from directly employing staff from professions allocated to the other. In addition, on the grounds that collaboration was ‘too important to be left to be left to good administrative practice’, it proposed that health and local authorities should work under a statutory duty to collaborate through a statutory Joint Consultative Committee (JCC).<sup>20</sup>

19. We also note the provisions of the National Health Service Act 1977 which went on to develop further the role of the JCC to advise the Area Health Authorities and local authorities on the performance of their duties, and “on the planning and operation of services of common concern”.<sup>21</sup> This “bridging” function will be reincarnated in the different form of the Health and Wellbeing Board. **The Committee is struck that despite repeated attempts to “bridge” the gap between the NHS and social care, that, aside from a few notable exceptions, little by way of integration has been achieved over this 40 year period.**

20. The King’s Fund told us about the successes that had been achieved through integration in Torbay Care Trust in Devon:

Torbay’s Integrated Care Project (Thistlethwaite 2011) has highlighted low rates of emergency admissions, emergency bed day use and discharges into residential care compared with other areas in the South West.<sup>22</sup>

On our visit to Torbay the Committee also heard examples of people being assessed quickly, risks identified and equipment, aids and adaptations being made available to people in very short timescales.

21. David Orr from the National Housing Federation gave us an example of integrated housing options reducing costs from health and social care and improving outcomes for older people:

We gave a very small example in our written evidence of Havebury Housing Partnership, which has come to an arrangement with a local hospital about discharge. They provide a flat, at a cost of £150 a week, which stops someone potentially having to stay in hospital while the discharge programme is properly set in place, at a cost of £2,800 a week [...] There is research evidence of the value of having a warm and secure home, in terms of reducing demand on the health service. There is research evidence about the impact of the supporting people funding, for

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20 Wistow, G. 2012 (in press) ‘Still a fine mess...?’ Journal of Integrated Care, 2012

21 National Health Service Act 1977, Section 21

22 Ev 153

example: £1.6 billion generating £3.4 billion of savings, and many of those savings are in health.<sup>23</sup>

22. In a report on integrated care, Turning Point outlined the potential economic savings from integrating a range of health, housing and social care services. They found that integration created efficiencies and savings, with early intervention services potentially saving the NHS up to £2.65 for every £1 spent.<sup>24</sup> The consequences of not integrating are no less stark. As the recent report from the King's Fund and the Nuffield Trust states, "Without integration, all aspects of care can suffer. Patients can get lost in the system, needed services fail to be delivered or are delayed or duplicated, the quality of the care experience declines, and the potential for cost-effectiveness diminishes (Kodner and Spreuwenberg 2002)".<sup>25</sup>

23. The Government's vision for adult social care emphasises that there are clear benefits from integrated health and social care.<sup>26</sup> The Health and Social Care Bill places the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy at the heart of joint working between health and social care, alongside the new duties to promote joint working.<sup>27</sup> The Government has stated that it will:

[...] identify and remove barriers to collaboration and to pooling or alignment of budgets across health and social care and bring together funding streams for employment support and consider the barriers to market entry for micro and small social enterprises, user led organisations and charities, and the proposed role for Monitor to play in market shaping.<sup>28</sup>

Integration is clearly not an end in itself. Rather, it is an essential tool to improve outcomes for individuals and communities.

24. In recognition of the need to achieve four per cent efficiency gains in the NHS over four years which equates to £20 billion in savings, the Department of Health initiated the Quality, Innovation, Prevention and Productivity challenge (QIPP),<sup>29</sup> which this Committee refers to as the "Nicholson Challenge", after the Chief Executive of the NHS/Chief Executive of the NHS Commissioning Board Authority Sir David Nicholson. A recently published joint report by the King's Fund and the Nuffield Trust has stated that "moving towards a new model of integrated care will help to create the foundations for

23 QQ 500–1

24 Turning Point, *Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care*, 2010

25 The King's Fund and the Nuffield Trust, *Integrated Care for patients and populations: improving outcomes by working together*, 5 January 2012.

26 Department of Health, *A Vision for Adult Social Care; Capable Communities and Active Citizens*, 16 November 2010, p 23

27 Explanatory Notes to the Health and Social Care Bill, [HL Bill 92]

28 Department of Health, *A Vision for Adult Social Care; Capable Communities and Active Citizens*, 16 November 2010

29 QIPP is defined by the Department of Health as "a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector and will improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014–15, which will be reinvested in frontline care."

sustainable delivery against the Quality, Innovation, Prevention and Productivity challenge in the longer term”.<sup>30</sup> They went on to state that:

Put simply, integrated care should become the main business for health and social care.<sup>31</sup>

25. This Committee has previously recommended that the delivery of the Nicholson Challenge requires fundamental changes to the way health and care services are delivered.<sup>32</sup> However, during our Public Expenditure inquiry the Audit Commission told us that their “analysis of adult social services efficiencies in 2009–10, and those planned for 2010–11, shows that integration and working more closely with the NHS was one of the least common ways of achieving savings”.<sup>33</sup>

26. The Committee is concerned that whilst integration is vital to the financial sustainability and quality standards of the health and care system, some evidence suggests that current pressures are encouraging organisations to adopt a defensive stance which is undermining delivery of the objective of integration. In evidence to the Committee, the NHS Confederation has stated that:

[...] members of our Mental Health Network already report growing numbers of local authorities withdrawing from integrated older people’s and other adult services. We are concerned that as financial problems become more profound, it will become harder for individual organisations to look outwards and invest in cross organisational collaborations that deliver more efficient, more integrated, better patient care.<sup>34</sup>

More generally, there is also a growing body of evidence that the quality of services delivered, in particular, to elderly people is being undermined by defensive institutional responses to current pressures. A recent inspection of acute hospitals by the Care Quality Commission found that twenty per cent of the establishments inspected failed to meet basic standards for dignity and nutrition.<sup>35</sup> Too many people are being admitted to hospital from entirely preventable causes. For example, we know that the NHS spends £600 million on treating injuries from falls and other preventable accidents at home.<sup>36</sup>

**27. Integration between the NHS and social care systems has been the explicit policy objective of successive Governments. It is not an end in itself, but can deliver real benefits to people who use multiple services across the health and care systems. It is also an essential tool in delivering quality and efficiency in the public sector. This Government has recently restated its commitment to integration in its acceptance of**

30 The King’s Fund and the Nuffield Trust, *Integrated Care for patients and populations: improving outcomes by working together*, 5 January 2012.

31 *Ibid.*

32 Health Committee, Thirteenth Report of Session 2010–12, *Public Expenditure*, HC 1499–I, para. 9

33 Health Committee, Thirteenth Report of Session 2010–12, *Public Expenditure*, HC 1499–I, Ev 56

34 Ev 198

35 Care Quality Commission, *Dignity and Nutrition for Older People*, October 2011

36 The NHS Future Forum, *Integration*, 10 January 2012, p 12

**the Future Forum recommendations on this issue.<sup>37</sup> The Committee welcomes Government support for this objective but is concerned that progress continues to be disappointing.**

28. The potential consequences for the individual of a continuing failure to integrate both commissioning and provision are clear—disjointed care, more hospital admissions, later discharge and poorer outcomes. The consequences for the health and social care systems are no less stark—as we stated earlier in this report, the NHS will fail to deliver on the Nicholson Challenge unless it achieves greater integration between health and social care. The King’s Fund, the Local Government Association and others have told us that the NHS and social care systems are facing unprecedented pressures, particularly from the impact of an ageing population.<sup>38</sup> During our public expenditure inquiry, Sir David Nicholson told the Committee that:

If an acute hospital thinks they can carry on as they are and, in a sense, salami-slice their service through efficiencies, it will not work for them. They will have more and more difficulty. They increasingly need to look at how they integrate with health and social care and to think about what sort of organisation they are going to be.<sup>39</sup>

29. Pursuing the “salami-slicing” of services, coupled with a failure to improve quality and efficiency through integration, will have very serious consequences for standards in both health and social care.

**30. Delivery of the Nicholson Challenge (four per cent efficiency savings in the NHS over four years) requires a fundamental rethink in how health and social care services are commissioned and provided. As Sir David Nicholson told us, NHS organisations that “salami-slice” services and fail to integrate with housing and social care could have very serious consequences for standards in both health and social care.**

### **The case for a single commissioner**

31. Support for service integration that has been expressed consistently over many years by successive governments; the Committee has therefore sought views about why progress has been so disappointing.

The recent Future Forum report on integration states that services must be integrated “around the individual”.<sup>40</sup> However, the current system has multiple commissioners and multiple funding streams. The policy has been to tolerate separate services and seek to build bridges between them. Given the failure of that approach, a single commissioner should now be established to create integrated services.

**32. The evidence presented to us leads us to the conclusion that when commissioning responsibilities are divided between different bodies, the effect is to undermine the ability of the system to deliver truly integrated services. Each commissioner is**

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37 Department of Health, *Government Response to the NHS Future Forum’s Second Report*, 10 January 2012

38 See SC 19, SC 66 for example

39 Health Committee, Thirteenth Report of Session 2010–12, *Public Expenditure*, HC 1499–I, Q 121

40 The NHS Future Forum, *Integration*, 10 January 2012, p 3

**inevitably subject to different pressures and priorities, with the result that it becomes impossible to focus on the key objective, which must be to integrate services around the individual.**

33. During the course of its inquiry the Committee has visited a number of locations in the north-west of England (Lancashire County Council, Blackburn with Darwen Care Trust Plus and Cumbria County Council and Clinical Commissioning Group) and Torbay Care Trust in Devon. This and other evidence we received about integrated organisations demonstrated that integrated commissioning had clear advantages in the delivery of better outcomes.

34. The Committee believes, however, that it is the policy objective rather than the precise institutional framework which is important. It is wary of recommending a single structural solution—particularly in the light of the very slow progress which has been made with service integration over a long period. It agrees with the King’s Fund which told us that:

A more ambitious approach is required. This should avoid an over-prescription by central government, with the emphasis instead on developing financial, performance and outcome frameworks that create incentives to integrate care.<sup>41</sup>

35. The Association of Directors of Adult Social Services reinforced this approach in their evidence to us:

[...] any integration must be bottom up rather than purely just England –wide prescribed structural reform. The dynamic of localised commissioning provides the vehicle for real integration which is referenced against a localised JSNA and articulated as a local Health and Wellbeing Strategy, subject to local democratic scrutiny and endorsement.<sup>42</sup>

**36. In the Committee’s view the key is that real progress towards integrated care must begin with a clear commitment to create a fully integrated approach to commissioning. The precise model will depend on local circumstances. Integration could take place around a local authority or a clinical commissioning group.**

37. In an earlier report this Committee was critical of the creation of Health and Wellbeing Boards (HWBs), arguing that they represented an unnecessary cost and complication in the NHS commissioning process.<sup>43</sup> However, the NHS Future Forum report of June 2011 argued the case for strengthened Health and Wellbeing Boards, suggesting that:

[...] health and wellbeing boards’ role should be strengthened. They should agree commissioning plans, be able to refer concerns about commissioning consortia’s commissioning plans to the NHS Commissioning Board and contribute to their annual assessment.<sup>44</sup>

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41 Ev 153

42 Ev 196

43 Health Committee, *Commissioning : Further Issues*, HC 796, para. 48

44 NHS Future Forum, *Recommendations to Government*, 11 June 2011, p 27

38. The Committee also recognises that many local authorities have welcomed the establishment of HWBs, believing that they provide an opportunity for greater local engagement in the commissioning process for healthcare.

39. We note, however, that the Government has not encouraged the development of the HWB as the holder of a single integrated budget. The Committee believes this could be a lost opportunity. In those areas where good working relationships have been established between NHS and social service partners, HWBs would seem to represent an obvious starting point for a radically strengthened commitment to integrated health and social care commissioning. The Committee would strongly urge that if the HWB is to be developed in this way, its membership and scope should be extended to include social housing.

**40. The NHS Future Forum recommended that Health and Wellbeing Boards should agree commissioning plans and refer these plans to the NHS Commissioning Board where they have concerns. Enabling HWBs to develop integrated commissioning budgets would be a positive first step towards integration and the Committee recommends that the Government re-examines this issue.**

**41. The Committee does not, however, support the imposition of a single statutory framework for the achievement of the objective of service integration. It proposes, instead, that the Government should place a duty on the existing commissioning structures (including the proposed new NHS structures) to create a single commissioning process, with a single accounting officer, for older people's health, care and housing services in their area. This pooling of resources will encompass the Government's contribution (in the form of the budgets and grants it makes to support local health, housing and care services), the local authority contribution (from national and local sources) and the contribution of individuals (from charges for social care services).**

**42. A single commissioner will have multiple lines of financial accountability, including to the NHS Commissioning Board, local authorities and service users. Central Government, NHS bodies and local authorities will need to establish robust procedures to ensure effective financial accountability.**

**43. The holder of a single commissioning budget will also need to demonstrate proper local democratic accountability for its decisions. The Committee sees the development of the Health and Wellbeing Board, as an agency of the local authority, as a means of achieving this objective.**

## Care Trusts

44. Provisions in the Health and Social Care Bill will establish Clinical Commissioning Groups and the NHS Commissioning Board as the commissioning bodies for NHS services throughout England. Care Trusts will no longer be able to commission health services on behalf of their populations as this function will principally pass to local Clinical Commissioning Groups and the NHS Commissioning Board. Some existing Care Trusts clearly believe this development will threaten the service integration they have been able to achieve. The Committee welcomes the Government statement that PCTs and local authorities ensure that succession plans are in place for existing joint commissioning

arrangements,<sup>45</sup> but is concerned that some Care Trusts still feel that the progress they have made is at risk.

45. On our visit to Torbay Care Trust, for example, the Committee heard that, while the integration of social care and community health was being maintained, the local authority felt that the effectiveness of the Care Trust had been diminished by the transfer of NHS commissioning to the PCT cluster.

46. When the Committee questioned the Minister of State for Care Services about the future of these highly integrated organisations, he told us:

I think that they proved to be an interesting experiment, but as an experiment they did not really get out of the lab. One of the problems with the care trust model is that it did not lead to any significant transformation across the service. I think they can teach us lessons about how you can orientate organisations around people. The interesting thing about visiting Torbay was their model of saying, “How do we get this organisation to change the way it works? We have to think about Mrs Smith.” That is their sort of way of mobilising that. It was not just the structure; it was about the culture and behaviours within the organisation. Those are the lessons I take away from my visit to Torbay.<sup>46</sup>

47. Although Care Trusts have not been widely rolled out across the country, the benefits that they are capable of realising are significant, both for those who use their services and for their local care economies. Torbay Care Trust supplied us with data showing that it had been able to achieve real benefits for local people. The average length of stay in hospital is low, they have few delayed discharges and there is rapid access to equipment and services that keep people out of hospital.<sup>47</sup> The Committee believes that these achievements are the result of positive cultures and behaviours that have been able to take root within a flexible organisational structure. This structure allows resources from different funding streams to be deployed in the most effective means possible, across permeable budgetary boundaries. The challenges of doing this in a system that is not integrated are outlined in the findings of the Partnerships for Older People Programme (which was commissioned by the Department of Health and states):

Moving monies around the health and social care system was a huge challenge, and proved an insurmountable one where budgets were the responsibility of more than one organisation. For instance, monies could be moved from residential care budgets to home care budgets within a local authority, but a claim for monies by a local authority from either primary or secondary health care budgets did not prove possible.<sup>48</sup>

**48. The Care Trusts that exist in England are, generally speaking, the most integrated health and social care organisations. Alongside the provision of services to people,**

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45 Department of Health, *Government Response to the NHS Future Forum's Second Report*, 10 January 2012

46 Q 577

47 See Annex for data

48 Personal Social Services Research Unit, *National Evaluation of Partnerships for Older People Projects: Executive Summary*, 18 January 2010

some Care Trusts also combine parts of the health and social commissioning budgets into one statutory body.<sup>49</sup> The experiences of Torbay, Blackburn with Darwen and other integrated organisations suggests that the cause of integrating services around the individual can be best served by integrated funding streams and integrating commissioning.

49. The Committee notes that the Minister of State for Care Services sees Care Trusts as “an experiment that [...] did not really get out of the lab” and that he argues it is not the organisational form of Care Trusts that makes a difference but the behaviours within the organisation. Nevertheless there is clear evidence that some Care Trusts have made progress with the integration of services and the Committee recommends that the Government should allow communities to have the option of retaining Care Trusts as commissioners of health, housing and social care.

### Integrating outcomes

50. In 2011 the Department of Health published a social care outcomes framework, which includes process targets and outcome measures through which social care commissioners will be held to account, and which will support local comparison and benchmarking.<sup>50</sup> In terms of integration, the framework seeks to overlap with two other outcomes frameworks, one for the NHS and the other for public health:

The first version of the ASCOF [adult social care outcomes framework] provides a strong basis for further alignment with the other frameworks, as they are finalised and implemented. Whilst there are few areas in which social care outcome measures are replicated exactly with other frameworks (the impact of reablement on supporting people to stay at home, and delayed transfers of care being the examples), there are several other areas in which the outcomes focus is complementary, for instance in relation to quality of life for people using services and carers. There are also a number of placeholders which offer an opportunity for alignment and joined development of measures.<sup>51</sup>

51. The new NHS Outcomes Framework and indicator set are the means through which the NHS Commissioning Board will be held to account for what it achieves in the NHS.<sup>52</sup> It seeks to recognise the complexity of measuring outcomes across separate health and social care systems:

In terms of adult social care, the NHS Outcomes Framework continues to include outcome indicators which complement or replicate indicators in the Adult Social Care Outcomes Framework. The complementarity between the NHS and adult social care is often different in nature from that between NHS care and public health. Better outcomes will often be delivered through contemporaneous integration of service provision, including particularly for those with long-term conditions. Again, it is

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49 The Audit Commission, *Means to an end. Joint financing of health and social care*, October 2009

50 Department of Health, *Transparency in Outcomes: A Framework for Quality in Adult Social Care*, 31 March 2012

51 *Ibid.* para 2.46

52 Department of Health, *The NHS Outcomes Framework for 2012–13*, 9 December 2011

likely that greater alignment between these two frameworks can be achieved over time.<sup>53</sup>

52. The NHS Outcomes Framework goes on to state that “We hope [*our emphasis*] that this clearer focus on alignment, collaboration and integration at a national level will cascade down to the local level.”<sup>54</sup> The Committee does not share the Government’s view that the outcomes frameworks for the NHS, public health and social care are sufficiently aligned at national level, nor that the degree of alignment will “cascade” down to local level. When asked if there should be a single outcomes framework for older people, encompassing the NHS, wellbeing, social care and housing, the Minister replied:

When you come to grapple with how you boil those down into one document without making it more confusing, we concluded that having three that do overlap in terms of mental health and frailty is the best way to incentivise different parts of the system to work collaboratively, where working together is an essential part of achieving their own outcomes and assisting others to achieve theirs [...] We won’t have a single one [outcomes framework] because we think there are still discrete elements of social care, and the model that is there as part of social care, that are different from the health service.<sup>55</sup>

**53. The new outcomes frameworks for the NHS, public health and social care systems are crucial as they will become the primary means through which the Government will establish whether services are delivering better outcomes for the public. In the context of integrated service provision and integrated commissioning, the degree of alignment between these frameworks looks disappointing. We are particularly concerned that the Government merely “hopes” that national alignment “will cascade down to local level”. It follows from the recommendations of this report that the Committee recommends that the Government move quickly to adopt a single outcomes framework for health and social care for elderly people and that it will abandon the attempt to create artificial distinctions between health, social care and social housing.**

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53 Department of Health, *The NHS Outcomes Framework for 2012–13*, 9 December 2011, para. 1.19

54 Department of Health, *The NHS Outcomes Framework for 2012–13*, 9 December 2011, para.1.20

55 QQ 572–3

## 4 Funding and staffing an integrated system

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### A social care system in crisis?

54. In its terms of reference for this inquiry the Committee sought to focus its attention on the future funding systems for social care in England. During the inquiry, however, the Committee has concluded that the issues involved in social care funding should be seen as part of the wider issue of funding for the health and care system as a whole. No one, including the Government, has sought to persuade us that it is either desirable or possible to fund future care needs on the basis of the current structure of care.

55. This set of circumstances creates two key issues. Most immediately—are current funding arrangements sufficient to meet care needs while a more integrated model of care is put in place? Secondly—do current plans suggest that the move to a more integrated model of care will be fast enough to meet the needs placed upon the care system within the resources available?

56. The Government recognised the immediate issue in its Spending Review when it announced an unprecedented transfer of funds from health into social care, something that this Committee very much supports. The Department of Health evidence has set out the position in detail:

In the Spending Review, the Government allocated an additional £2 billion per annum by 2014/15 to support adult social care which, together with an ambitious programme of efficiency, it believes will enable local authorities to maintain the current level of service provision. This assessment has been corroborated by the King's Fund. Its publication on social care budgets following the Spending Review showed that the settlement would be sufficient if local authorities made efficiency savings of around 3.5% per annum in adult social care. The Department agrees broadly with this analysis.<sup>56</sup>

57. The report of the Commission on Funding of Care and Support (the Dilnot Commission) is instructive. Published after the Spending Review<sup>57</sup> (which outlined the transfer of £2 billion in additional resources to social care from the NHS) the Commission stated that:

We consider that the current social care system is inadequately funded. People are not receiving the care and support that they need and the quality of services is likely to suffer as a result. We recognise that there is a shortage of precise data on the extent to which needs are currently met, but we do know that social care expenditure on

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56 Ev 222

57 The report of the Dilnot Commission was published on 4 July 2011 whereas the Government's spending review of the Department of Health was published on 20 October 2010

older people has not kept pace with the increase in demand. Over the last four years demand has outstripped expenditure by around 9%.<sup>58</sup>

58. Many witnesses to our inquiry have restated that a crisis in funding exists within social care. The Local Government Association has stated that “[...] the current system is underfunded and has been for many years. The demand is growing and, therefore, that gap is growing. That is a case the Local Government Association, and indeed others, have been making for a long time”.<sup>59</sup> The Association of Directors of Adult Social Services went on to tell the Committee that:

[...] The gap has never been disputed. The gap exists [...] What we try and do is avert the collapse of social care by constantly trying to re-examine what we do in the absence of the reform and resources that we have clearly asked for, for some time.<sup>60</sup>

59. The Government cites the King’s Fund in support of its viewpoint that the existing level of funding for social care is adequate, should local authorities make the efficiency savings required of them. The King’s Fund’s evidence to us however paints a slightly different picture, calling these efficiency savings “very ambitious”:

The squeeze on local authority budgets over the next four years will see a widening gap between needs and resources. As we indicated in our evidence to the Committee’s previous inquiry into public expenditure, despite the additional £2 billion announced in the Spending Review and the best intentions of local authorities to protect social care, a funding gap of at least £1.2 billion could open up by 2014 unless all councils can achieve unprecedented efficiency savings. Since then, the ADASS budget survey shows that there will be almost £1 billion less in adult social services budgets this year, of which councils aim to recover £681 million from efficiency savings. This is a very ambitious target when taking account of efficiencies already achieved in recent years.<sup>61</sup>

60. When we spoke to the Minister of State for Care Services about the funding gap he argued that there is no funding gap and no funding crisis in social care:

The point I am making is that there is no gap. There is no gap in the current spending review period on the basis of the moneys that we are putting in plus efficiency gains through local authorities redesigning services [...] We don’t accept the position that there is a gap. We have closed that gap in the spending review.<sup>62</sup>

61. The King’s Fund has estimated that in 2012 approximately 890,000 service users with some care needs are not receiving any service, and that this will reach 1 million people by 2016.<sup>63</sup> The Minister did not accept this figure:

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58 The Commission on Funding of Care and Support, *Fairer Care Funding. The report of the Commission on Funding of Care and Support*, July 2011, p 14

59 Q 126

60 Q 164

61 Ev 152

62 Q 544

63 King’s Fund, *Securing Good Care for More People*, 11 December 2010, p 49

On the issue of unmet need, I am yet to find any agreement among academics on a definition of unmet need. Even the personal social services research unit says that it is a very hard area to navigate and come to any firm conclusions on.<sup>64</sup>

62. The Local Government Association publicly responded to this statement by saying that:

It is deeply worrying that despite the best efforts of councils, leading charities and the government's own experts, the message that we are facing a financial crisis still doesn't seem to be getting through.<sup>65</sup>

63. In supplementary written evidence after the Minister's appearance the Department of Health told us:

The Department acknowledges that there is unmet need but also that the scale of this is difficult to precisely define and measure. The eligibility framework seeks to support councils in prioritising funding on those with the highest need. Government is clear that everyone who thinks they may be in need of care and support is entitled to an assessment, and if this assessment concludes that services are required to meet the person's assessed needs and the person qualifies under the means-test, services must be provided.<sup>66</sup>

64. The Department of Health says that additional funding made available to social care in the spending review (through two streams: one from the NHS for social care which also benefits healthcare, and one to local authorities through the general formula grant) will by 2014–15 provide an extra £2 billion a year for social care compared to pre-2010 expenditure, amounting to £7.2 billion in total over the four year period (see table below). It says that this, together with the up to 3.5% a year efficiency savings that local authorities are being asked to make, means that there is no funding gap for social care:

£bn	2011/12	2012/13	2013/14	2014/15
New DH grant funding for social care (rolled into formula grant – non ring fenced)	0.53	0.93	1.0	1.0
NHS Funding to support social care	0.8	0.9	1.1	1.0
• Of which: Reablement	0.15	0.3	0.3	0.3
• PCT transfers 11/12 and 12/13	0.65	0.62	-	-
• Other- mechanism for 13/14 and 14/15 to be confirmed	-	-	0.8	0.7

Source: Department of Health

65. Against this, the LGA told us that, in 2011–12, “the [social care] service's budget has already been reduced by nearly £1 billion”.<sup>67</sup> Age UK said that:

64 Q 544

65 “No funding crisis in social care says Minister”, *The Guardian*, 17 January 2012

66 Ev 223, page 2.

67 Ev 189, para 15.b.iii.

Councils have reduced their spending on older people's social care by £671 million in real terms in the year between 2010–11 and 2011–12. This is a decrease of over 8 per cent [...] Even after adding the £330 million transferred from PCTs to the amount spent by local authorities, the overall effect is still a real decrease in spending on older people's social care of £341 million or around 4.5 per cent.<sup>68</sup>

**66. As the Committee reported in its recent report on Public Expenditure, there is clear evidence of resource pressures on social care authorities. The Committee welcomes the Government's commitment of an additional £2 billion per annum to social care by 2014–15, but recognises that even this substantial additional commitment is only sufficient to meet additional demand if social care authorities are able to deliver an unprecedented efficiency gain of 3.5 per cent per annum throughout the spending review period and does not allow for any progress in responding to unmet need.**

67. The quality of social care is also an issue that has been raised with the Committee. Regardless of whether there is sufficient funding in social care, evidence suggests that there are also problems with the quality of some social care services. High quality social care is important. As Scope told us in their evidence:

The receipt of high quality social care can often make the difference between a disabled person being able to work or not, and can have a huge impact on their ability to contribute to the economy and engage in society.<sup>69</sup>

68. Despite its importance, some people are in receipt of a variable level of service quality. Age UK told us that:

The whole area of quality, both in care homes and domiciliary care, is key. There are huge issues around the funding of care being in crisis, but there is a deeper and hidden crisis around the quality of care.<sup>70</sup>

The Alzheimer's Society shared one particular example of poor quality domiciliary care that risked having a negative impact on the life of the service user:

I was talking to one domiciliary care provider who said that they refused to book sessions of less than 30 minutes for their private clients but on local authority-funded care they are booking 15 minute visits, which, of course, for somebody with dementia is often worse than useless. You have barely got through the door and you are expected to dress, feed and look after the personal needs of somebody in 15 minutes. You cannot do it. There is a need to expose the failures of the system in order to get change.<sup>71</sup>

69. Despite national guidance on the matter there continues to be a highly variable approach to assessment. Local Authorities have the discretion to determine which needs are "eligible needs", i.e. which level of need will qualify a person to receive care and

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68 Age UK, *Care in Crisis 2012*, 30 January 2012, page 1.

69 SC 78

70 Q 78

71 Q 74

support. Since 2003, eligibility has been assessed by councils according to a set of four standard threshold criteria (critical, substantial, moderate and low), laid down in mandatory Fair Access to Care Services (FACS) guidance.<sup>72</sup> Definitions of moderate, substantial and critical can vary across Local Authority boundaries, and can depend on who is undertaking the assessment. As Jeremy Hughes, Chief Executive of the Alzheimer's Society told the Committee:

There is an example I was reading recently of somebody who has spent six months and gone through three re-assessments with a different outcome each time, thinking, "But my needs have not changed. How can this be?" There is an enormous amount of confusion and a need for that universal understanding of what quality is and what the assessment is.<sup>73</sup>

70. The Care Quality Commission told us that "for those that fund their own care, navigating the system, finding the right information, in the right place at the right time to help them choose a service can be a very difficult process."<sup>74</sup> Hanover Housing, the National Housing Federation and others described to us the variable quality in the housing options available to older people.

71. The Government recognises the importance of this issue. The National Institute for Health and Clinical Excellence will be tasked with developing quality standards for social care. The Government's vision for social care emphasises more information, a greater focus on outcomes, driving forward personalisation and greater choice and competition as the way forward.<sup>75</sup> The Minister of State told us that the Government will pursue this issue further in its forthcoming White Paper on social care:

[...] how we make sure that people can, through greater choice and awareness of what the options are to meet their care needs, also help, through those choices, to drive improvements in quality. That quality will be a very big part of what we will set out in the White Paper.<sup>76</sup>

72. The evidence suggests that some people are paying for poor quality housing and services. Despite this, Parkinson's UK told us:

There is little detail on the Department's promise to look at a citizen's right to challenge poor quality services and lack of choice.<sup>77</sup>

**73. The weight of evidence that we have received suggests that social care funding pressures are causing reductions in service levels which are leading to diminished quality of life for elderly people, and increased demand for NHS services. Although the transfer of £2 billion from health to social care is welcome, it is not sufficient to maintain adequate levels of service quality and efficiency.**

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72 Social Care Institute for Excellence, *Facts about FACS 2010*, April 2010

73 Q 94

74 SC 62

75 Department of Health, *A Vision for Adult Social Care; Capable Communities and Active Citizens*, 16 November 2010

76 Q 635

77 Ev 153

74. As it reported in its recent report on Public Expenditure, the Committee believes that the levels of efficiency gain which have been planned by the Government will not be achieved unless there are fundamental changes in the way care is delivered. In particular the Committee believes that successful delivery of the Government's plans requires a dramatic strengthening of its commitment to deliver more integrated services.

### Rebalancing public sector spending

75. The Commission on Funding Care and Support (known as the Dilnot Commission), citing Department of Health and Department of Work and Pensions figures, estimates that just under £150 billion is spent on services and welfare/disability benefits to older people in England. In his evidence to us, Andrew Dilnot broke this number down further:

One of the earliest pieces of analysis that we asked our colleagues on the secretariat to do was to draw us a chart [...] which shows how much public spending in England there is on older people. It shows that total spending is about £145 billion a year: nearly £3,000 for every man, woman and child in England is spent on an older person. Of that, more than half is social security benefits, principally the state social security pension, but also housing benefit, pension credits and so on; £50 billion is the NHS; and just £8 billion is social care.<sup>78</sup>

Andrew Dilnot went on to state that this distribution of resources is sub-optimal:

It is pretty clear to us that, if you started with a bar that was £145 billion high, you would not draw the lines in that position, particularly the distinction with this very small amount of separate money spent on social care and the much larger amount spent on healthcare [...] our strong sense was that the balance is not right and there is inefficiency and reduced welfare as a result of that split between social care and the NHS. Because of the way the systems work at the moment—the lack of pooled budgets and of working together—there is a barrier to getting sensible allocation of resource across the piece. We need to tackle that. We think it is essential, and certainly something to be looked at.<sup>79</sup>

76. We noted earlier the Dilnot Commission's conclusion that the social care system is 'inadequately funded.'<sup>80</sup> Andrew Dilnot was also clear that the separate funding streams for health, social care and welfare mean that resources are allocated in an inefficient way. At a time of scarce resources and rising demand the Committee believes that this structural inefficiency, which has been recognised for decades, can no longer be ducked. Too much is spent treating preventable injuries like falls, which can have a catastrophic impact on the lives of older people, some of whom may never regain independence again. If we are to create a sustainable, high quality support system for older people, commissioners need to rebalance the entire expenditure on services for older people across the NHS, social care, housing and welfare. This will be a process, rather than an

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78 Q 387

79 *Ibid.*

80 Paragraph 52

**event; the purpose of creating integrated commissioners, is to create agents within the system who have both the ability and the incentive to drive the necessary process of fundamental change in service provision.**

## Personalisation

77. Personal budgets (one element of the personalisation agenda) allow individuals to have direct control over how their care needs are met. Following an assessment, an individual can be allocated an indicative budget that could be made available to them to meet those needs. Individuals are given the choice of an account held and managed by a local authority, a direct cash payment in lieu of services or a mixture of both. We saw evidence of how this new culture of personal budgets works in practice during our visit to Torbay where a number of patients had opted for previously unavailable treatments such as acupuncture.

78. The Committee is well aware of the support which has been expressed for the growing personalisation of social care by both the previous Government and the current Government, as well as by many service users, and it is sympathetic to these responses. It is also, however, concerned that some of the implications of growing personalisation of social care budgets need to be further examined.

79. A growing number of people are having their care needs quantified and converted into a sum of money through a resource allocation system (RAS). This creates a scenario in which people's needs could be assessed less personally and could develop into an entitlement-based system which awards them a specific cash amount under a process more akin to social security than social care. On the pitfalls of this system in respect of social security support for residential care in the 1970s and 1980s, particularly cost control, Jenny Owen from Essex County Council told us:

The costs were running away and it became the responsibility of the local authority, and then we had FACS, that gate-keeper. But now what we have is all the questions you were asking about portability and whether you can have a consistent system. That is the tension that you are describing.<sup>81</sup>

**80. While the Committee remains sympathetic to the cause of greater personalisation, it believes the Government needs to be clear-sighted about the likely impact of personalisation on total demand for social care—and therefore on social care budgets. This is an issue to which the Committee will return.**

## Social care workforce

81. The Committee also notes that a new offer needs to be made to the social care workforce. This large group of dedicated staff work exceptionally hard for the people that they care for. Often they do this under difficult circumstances and for low, sometimes minimum wage. The Minister acknowledged this when he told us that:

Can I start with the first point, which was an unfair press, by acknowledging that an awful lot of people—the vast majority—who work in our care work force do a fantastic job? They are dedicated and compassionate and should be applauded for that. We tend to focus on the shocking and appalling.<sup>82</sup>

82. Like all services, social care depends on a skilled, motivated workforce. It is reasonable to assume that with demand for social care rising as the population ages that we will also see a rise in the numbers of people working in social care services. Such staff need and deserve the respect of the communities in which they work in order to ensure that services can recruit the right people at the right time.

83. In our previous report on the Nursing and Midwifery Council, the Committee examined the issues surrounding the registration of healthcare assistants and support workers, and recommended that they be subject to statutory regulation.<sup>83</sup> The boundaries of the social care workforce clearly extend far beyond these two groups, and there is a case for ensuring that there are clear professional standards and a means for holding people to account when these are repeatedly not met.

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82 Q 559

83 Health Committee, Seventh report of the session 2010–12, Annual accountability hearing with the Nursing and Midwifery Council, HC 1428

## 5 The Dilnot Commission

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84. The Dilnot Commission set out to establish how the future system of funding social care could be made to be sustainable and resilient, fairer for individuals, families and society, value for money and as clear and simple as possible.<sup>84</sup>

85. The key recommendations of the Commission's report concern the introduction of a series of caps on the contributions required from individuals to the cost their own social care. They recommend a cap of between £25,000 and £50,000 (£35,000 is suggested) on the amount that any individual has to pay for their care, after which the state would bear the costs. They also recommend that this capped figure would not include costs associated with accommodation, food and other living costs, but that these should be subject to a separate cap of between £7,000 and £10,000 per year.<sup>85</sup>

86. Dilnot also recommends the implementation of better needs assessment processes, portability of assessment, and better assessment and services for informal carers; he argues that the current means test threshold should be raised from £23,250 to £100,000, that eligibility for care should be standardised across England, and that people should be able to defer payment until their home is sold as part of their estate; finally he recommends that a new information and advice strategy is required.<sup>86</sup>

87. The Committee has found that there is a broad consensus in favour of implementing the main findings of the Dilnot report. Gillian Manthorpe, Director of the Social Care Workforce Research Unit at King's College, London told us:

Dilnot represents an opportunity to move this into its next phase, even if it is not yet the entire answer, because we do not have public confidence, at the moment, in the social care system. We certainly do not have a good understanding of what social care offers, how it is funded and what implications there are for families [...] The Dilnot report gives us the best analysis we have had, probably, for a very long time. There is a risk of giving it the thumbs down and saying, "No. It has to go into the long grass," but that would be a very poor outcome.<sup>87</sup>

Richard Humphries from the King's Fund agreed, stating that:

The almost unanimous support given to Dilnot's recommendations suggests we are on the cusp of not a total solution, as colleagues have alluded to, but at least a way forward, a way through it.<sup>88</sup>

**88. The capped cost model proposed by the Dilnot Commission represents an important element of the total funding model, but it is not the whole answer. The**

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84 The Commission on Funding of Care and Support, *Fairer Care Funding. The report of the Commission on Funding of Care and Support*, July 2011

85 *Ibid.*

86 *Ibid.*

87 Q 2

88 Q 7

Committee recommends that in its forthcoming “progress report on funding”, the Government should accept the principle of capped costs and outline proposals on where the cap should be set.

89. Dilnot also recommends that there should be a separate cap on living costs of between £7,000 and £10,000 per annum. We support this and recommend that the Government accepts it.

90. The Committee believes it is important that the future shape of social care is not dominated by a debate about the technical details of funding. It is essential that services are shaped by the objective of high quality and efficient care delivery, and the funding structures are fitted around that objective, not vice versa. It is, however, unsurprising that there is a focus on funding issues given the current financial stress on the care system.

91. Although the Committee supports the implementation of the main recommendations of Dilnot, it believes the narrow terms of reference given to the Commission meant that the more fundamental issues about the need for a more integrated care model were only addressed in passing by Dilnot.

### Capping care costs

92. The Committee also believes some fine-tuning of the capping proposals is required. The charges levied for social care, and assessment of social care need are determined in part by local authorities. At the moment this leads to variations in access to, and charges for, social care. These variations are in themselves not necessarily a problem as they may simply reflect local variations in labour costs or assessment practices. However a problem may exist when the proposed national cap on care costs for the individual is transposed over a local system of assessment and pricing.

93. The system proposed by the Dilnot Commission would require some means of assessing the care needs of all persons who present to a local authority and then “metering” care so that each local authority can establish when the individual has or will reach the level of the cap.<sup>89</sup> The Committee is concerned that this could create a situation where two people with identical care needs, but who live in different local authority areas, could reach the cap at different times.

94. The care meter could also disadvantage people who live in areas where property prices are depressed, especially if a higher level cap is introduced. Some recent media stories have suggested that the level of the cap on care costs would be set at £60,000 as opposed to between £35,000 and £50,000 suggested by the Dilnot Commission.<sup>90</sup> A £60,000 cap would clearly represent a larger proportion of the housing value of those people living in those parts of England where a house can be bought for £60,000 or less.

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89 The Commission on Funding of Care and Support, *Fairer Care Funding. Volume 2, Analysis and Evidence Supporting the Recommendations of the Commission*, July 2011

90 For example see “Social care crisis needs reform now, says report author”, *The Mirror*, 18 January 2012

95. It has been suggested to the Committee that some of the disadvantages of the cap expressed as a cash sum could be addressed if the cap was expressed as a period of time. The Committee understands that the Dilnot Commission considered this approach and rejected it on the grounds that it would make the actual cost of the individual's contribution dependent on the acuity of their care needs during the period involved.

96. The Committee recommends that the Government should look again at the principle of expressing the cap on care costs in terms of the length of time that people fund their social care for themselves in its progress report on funding, ensuring the equivalence of care standards before and after the cap is reached. Further work however is required to address unintended anomalies caused by regional variations in housing values and the difference between domiciliary and residential care costs.

### Financial products

97. One other element of the Dilnot proposals is the potential stimulation of the market in financial products that people could use to fund their contribution towards their care needs. The Dilnot Commission report is clear that no major financial services providers offer pre-funded insurance against social care costs making it difficult for people to plan for the financial consequences of having a care need later in life.<sup>91</sup> The Strategic Society Centre told us that the pre-funded insurance market for social care is unlikely to grow under the Dilnot proposals:

[...] it does not expect a pre-funded insurance market to grow in response to its recommendations or in response to the capped-cost model. It talks about different sorts of financial products, but in terms of pre-funded insurance, which is one of the key financial products people have often talked about in relation to long-term care and the potential for such a market, it is very specific in saying it does not expect that market to develop to any significant degree in response to the capped-cost model.<sup>92</sup>

This was reiterated by the Association of British Insurers who told us that:

[...] it is unlikely you will find pre-funded products developing. It is difficult enough to get people to save sufficient for their pensions without thinking of saving for a product which they may not need for 40 or 50 years.<sup>93</sup>

98. There are some specific products that are taken out when people have a care need, such as equity release and immediate-needs annuities, that may grow if the cap on care costs were implemented. Immediate needs annuities (INAs) are a type of insurance product that individuals purchase at the point of entering residential care. In return for a significant up-front payment, the annuity will pay out a regular income until a person dies, covering all (or most of) their care fees. In return for the lump-sum premium, individuals purchasing INAs obtain protection against the possibility that they will survive for a very long-time in residential care, and therefore spend all or most of their wealth. However, Chris Horlick

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91 The Commission on Funding of Care and Support, *Fairer Care Funding. The report of the Commission on Funding of Care and Support*, July 2011 p39

92 Q 323

93 Q 325

from Partnership Assurance (a provider of financial products in this sector) told us that the immediate needs annuities market is small and that “I do not think the Dilnot model in any way would attract fresh money in”.<sup>94</sup>

99. Equity release products aim to support individuals in retirement to access part of the value of their home. They have been identified by Dilnot and others as a potential source of income for older people, particularly in the context of historically high rates of home-ownership and house price inflation experienced over the last decade. The Committee has heard however that these products are relatively novel and have not yet been widely taken up. As Professor Martin Knapp told the Committee:

I also agree [...] about the equity release model. To me, it feels like the more attractive and viable approach. It has not been any more successful in getting off the ground than long-term care insurance until recently, but I understand there are some experiments under way, and perhaps we can learn from those.<sup>95</sup>

100. In contrast to the relative pessimism of the financial services industry, Andrew Dilnot gave a much more upbeat assessment of the likely market for financial products in the future:

I have no doubt at all, having spoken to the really big players in the financial services sector at the highest and most senior level throughout this, that there is enthusiasm for getting into this market. The financial services strand of the Department of Health’s consultation on this has already published some of its developing findings. It says things like, “There is strong support for capping care costs:—This would provide a major opportunity for behaviour change,” and, “It would facilitate a range of financial products.” That is across the financial services sector as a whole

[...] Our view is that there would be very significant development in two areas, mainly housing-related and pension-related, because those are the two big assets that people build up. For many people, once a cap is in place they will simply treat the funding up to the cap as part of their general asset accumulation strategy. They will want to build up some assets that they might use to help out one of their children, go on a long holiday, build an extension or do the things they have wanted to do. Rather than wanting an insurance product, it will be part of their lifetime savings strategy. They might then spend that money through either equity release from their house or by a policy that was related to their pension.<sup>96</sup>

**101. The Government should clarify the likely market for pre-funded insurance, equity release, and immediate needs annuities, as well for pension-related and other products. It should also articulate how it will work with the industry to stimulate the market for these products.**

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94 Q 324

95 Q 2

96 Q 444

## 6 The needs of carers

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### The demography of caring

102. Most people who need care rely on family members, friends and neighbours i.e. informal care. Some estimates place the number of informal carers in the UK at 6.4 million; the NHS Information Centre for Health and Social Care estimates that 12 per cent of people aged 16 or over in England in 2009–10 were looking after or giving special help to a sick, disabled or elderly person.<sup>97</sup>

103. Some 60 per cent of informal carers in England are women (as are 63 per cent of those cared-for) and the majority of carers are over the age of 45. Around 1.7 million adults in England are the sole carer for their main cared-for person.<sup>98</sup> Carers performed a wide variety of tasks for the person they mainly cared for. They were most likely to provide practical help (such as preparing meals, shopping and doing the laundry) keep an eye on the person they cared for, keeping them company or taking them out.<sup>99</sup>

104. Identification of carers continues to be a major issue. Many people do not readily identify themselves as a carer, as Liz Fenton from the Princess Royal Trust for Carers told the Committee:

People who care for only a few hours a week, who might actually be making all the difference, may not identify themselves as carers. The biggest problem that we have in our sector is that people see themselves as doing something that is a normal part of family life, and not as carers. They may be the 62% who are carrying on quite happily. It becomes about making sure that people recognise, when they need support, that they are carers and that they can get the support that they are entitled to from being a carer. That is a major problem: to get people to identify themselves, let alone other professionals to help identify them.<sup>100</sup>

105. The Government has taken a number of actions on identification of carers. The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme that rewards GP practices for, amongst other things, identifying carers on a carers register and referring them to the local authority for assessment.<sup>101</sup> The Princess Royal Trust for Carers has stated that take up for this QOF indicator has been quite high (though this does not mean that all carers have been identified).<sup>102</sup> Carers UK, the Princess Royal Trust for Carers and the Royal College of General Practitioners have also been awarded funding from the Department of Health to look at using carer and GP ambassadors to support early identification of carers on GP lists.<sup>103</sup>

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97 NHS Information Centre, *Survey of Carers in Households 2009–10*, December 2010

98 *Ibid.*

99 *Ibid.*

100 Q 469

101 NHS Information Centre, *Quality and Outcomes Framework Achievement Data 2010–11*

102 Princess Royal Trust for Carers, *Good Practice in Strategic Development*, 2010

103 Carers UK, *New programme to improve GP support to carers*, [www.carersuk.org](http://www.carersuk.org)

## The impact of caring on carers

106. Overall 62 per cent of carers felt that their own general health is good, while fewer than one in ten (8 per cent) felt their health is bad. Around half of carers in the Carers Survey stated that their health had been affected because of the care they provide. A third of carers reported feeling tired, 29 per cent felt stressed, and 42 per cent said their personal relationships, social life or leisure time had been affected because of the assistance they provided.<sup>104</sup>

107. Some 26 per cent of working age carers felt that their caring responsibilities had affected their ability to take up or stay in employment. Flexibility in working hours was the most important thing that would help carers who wanted to work to take up paid employment. However, awareness of the right to request flexible working from an employer was low.<sup>105</sup> When we asked the Minister of State for Care Services about the right to request flexible working, he told us:

In terms of flexible working, the conversations are with BIS and my colleague Edward Davey, who has been leading on the consultations around extending the rights to request flexible working, meaning that there is an opportunity to widen the numbers of carers who currently have access to flexible working in the future. Good progress is being made there.<sup>106</sup>

## Supporting carers

108. The willingness of informal carers to engage with their friends and family members should be recognised and respected by the Government and the rest of the community. In return for the care that they deliver, the Government is committed to identifying carers and their needs. The cross-Government Carers Strategy identifies four key priorities:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages;
- enabling those with caring responsibilities to fulfil their educational and employment potential;
- personalised support both for carers and those they support, enabling them to have a family and community life; and
- supporting carers to remain mentally and physically well.<sup>107</sup>

109. Despite these commitments, the NHS Information Centre Carers Survey found that only 6 per cent of identified carers were offered a carer's assessment in 2010–11.<sup>108</sup> Some 67

104 *Ibid.*

105 *Ibid.*

106 Q 662

107 HM Government, *Recognised, Valued and Supported: The Next Steps for the Carer's Strategy*, November 2010

108 *Ibid.*

per cent of carers who had been assessed said they had received a service of some kind as a result of the assessment. The most common services were equipment such as mobility aids (26 per cent), services for the person they care for (22 per cent) an assessment of the person they care for (21 per cent) and information about benefits (20 per cent).<sup>109</sup>

110. The most recent figures from the NHS Information Centre show that the numbers of carers being assessed has dropped by 3 per cent between 2009–10 and 2010–11. The numbers of carers receiving a service has also declined, by 2 per cent over the same period. There has also been a 9 per cent decrease in the number of carers receiving a carer-specific service. The number of carers receiving “information only” has risen by 7 per cent.<sup>110</sup>

111. When we asked the Minister of State for Care Services about the fall in the numbers of assessments and services for carers, he told us:

I am certainly not satisfied and expect both the NHS and social services to do more [...] I certainly agree that there is an awful lot more that we need to do, and we will set that out in the White Paper. There are a number of things we are doing, and the strategy that we have set out provides that.<sup>111</sup>

**112. The Committee welcomes the Government’s recognition of the importance of support for informal carers and carers’ assessments. The Committee is however concerned that the effectiveness of the policy is too often undermined by the failure of GPs, social workers and others to identify carers. The Committee believes the Government needs to find new and more effective ways to identify carers in order to ensure that their needs are properly assessed and met.**

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109 *Ibid.*

110 NHS Information Centre, *Community Care Statistic: Social Services Activity 2010–11*, provisional release

111 QQ 659–660

## 7 A new offer for older people

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113. As part of a commitment to a single integrated commissioner for older people, the Committee would like to see the Government make a new offer to older people. As the Department of Health told us:

The state of current adult social care legislation has been roundly criticised as opaque, complex and anachronistic. Over 60 years, a patchwork of legislation has grown and evolved, with more added from time to time to mould the framework to different policy objectives, but without any substantial reform. There are now around 30 different pieces of legislation which relate to adult social care, with the base statute still the 1948 National Assistance Act.<sup>112</sup>

114. This legal tangle not only makes social care difficult to administer for professionals—it makes it almost impossible for service users and carers to navigate. The Committee also believes that, in addition to reform of the law, reform of the way this is communicated with the public is also essential. The Local Government Association told us:

With a range of assessments, means and needs tests, charges, eligibility and interactions with other systems (such as health and benefits) the adult social care system is incredibly confusing for the individual. And as legislation has developed piecemeal over time it is also often confusing for practitioners, with different aspects of adult social care codified in primary legislation, statutory instruments or set out in guidance. This level of complexity in the current system is unsustainable for the future.<sup>113</sup>

In their evidence to us, Age UK stated that:

A clear and consistent legislative framework is vital if older people and carers are to be able to speak out and challenge inadequate care.<sup>114</sup>

**115. The Committee supports the need for reform of the law governing social care, but is clear that this cannot take place in isolation from the law governing health, housing and welfare services. It believes that a new, integrated legal framework is required which supports integration of care around the needs of the individual, with a focus on driving forward quality and improving outcomes.**

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112 Ev 134

113 Ev 189

114 Ev 148

# Conclusions and recommendations

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## Introduction

1. This report will highlight several significant issues that the Committee has identified from the substantial body of evidence received during our inquiry. Our aim is to paint a picture of how a fully integrated system could be achieved with more efficient use of resources and the improved outcomes that it could deliver. The Committee recommends that the Government respond to the issues we have raised in its forthcoming White Paper and its proposed bill as well as in its progress report on funding reform. The Committee plans to revisit social care in the light of these documents, with a view to reviewing the progress that has been made. (Paragraph 4)

## The consequences of fragmentation

2. Many older people, people with disabilities and those with long-term conditions need to access a wide range of services, from the NHS through to housing services and care and support. Their experience of these services is often fragmented. The Committee believes that there is a link between the fact that people experience fragmented services and the fact that there are multiple funding streams and multiple commissioners of the services that they use. (Paragraph 11)

## Defining social care

3. The Committee found the evidence provided by the Law Commission instructive. Faced with the challenge of providing a coherent definition of social care the Commission clearly felt it was building on sand. The Committee was not surprised that the Commission found it impossible to express 80 years of political compromises as a coherent legal principle. (Paragraph 16)
4. In fact, in the Committee's view, the Law Commission's attempt to define social care underlines the central problem. The overarching aim of social care as defined by them, to "promote or contribute to the well-being of the individual", could just as easily be applied to health care or housing services. The conclusion we draw from this is that attempts to draw a distinction between these services and social care will fail because such distinctions are artificial and unhelpful, and because they directly contradict the policy objective. This objective is the same whether it is seen from the point of view of service user preference, objective outcome measurement or cost efficiency. It is to deliver a joined-up, integrated service that aims to deliver the best outcomes for the patient and in the most efficient manner possible. If that is the objective—and the Committee found that it is an objective shared between users, staff and policy makers—it seems perverse to attempt to build integrated service delivery on a fragmented commissioning system. (Paragraph 17)

## The case for integration

5. The Committee is struck that despite repeated attempts to “bridge” the gap between the NHS and social care, that, aside from a few notable exceptions, little by way of integration has been achieved over this 40 year period. (Paragraph 19)
6. Integration between the NHS and social care systems has been the explicit policy objective of successive Governments. It is not an end in itself, but can deliver real benefits to people who use multiple services across the health and care systems. It is also an essential tool in delivering quality and efficiency in the public sector. This Government has recently restated its commitment to integration in its acceptance of the Future Forum recommendations on this issue. The Committee welcomes Government support for this objective but is concerned that progress continues to be disappointing. (Paragraph 27)
7. Delivery of the Nicholson Challenge (four per cent efficiency savings in the NHS over four years) requires a fundamental rethink in how health and social care services are commissioned and provided. As Sir David Nicholson told us, NHS organisations that “salami-slice” services and fail to integrate with housing and social care could have very serious consequences for standards in both health and social care. (Paragraph 30)

## The case for a single commissioner

8. The evidence presented to us leads us to the conclusion that when commissioning responsibilities are divided between different bodies, the effect is to undermine the ability of the system to deliver truly integrated services. Each commissioner is inevitably subject to different pressures and priorities, with the result that it becomes impossible to focus on the key objective, which must be to integrate services around the individual. (Paragraph 32)
9. In the Committee’s view the key is that real progress towards integrated care must begin with a clear commitment to create a fully integrated approach to commissioning. The precise model will depend on local circumstances. Integration could take place around a local authority or a clinical commissioning group. (Paragraph 36)
10. The NHS Future Forum recommended that Health and Wellbeing Boards should agree commissioning plans and refer these plans to the NHS Commissioning Board where they have concerns. Enabling HWBs to develop integrated commissioning budgets would be a positive first step towards integration and the Committee recommends that the Government re-examines this issue. (Paragraph 40)
11. The Committee does not, however, support the imposition of a single statutory framework for the achievement of the objective of service integration. It proposes, instead, that the Government should place a duty on the existing commissioning structures (including the proposed new NHS structures) to create a single commissioning process, with a single accounting officer, for older people’s health, care and housing services in their area. This pooling of resources will encompass the Government’s contribution (in the form of the budgets and grants it makes to

support local health, housing and care services), the local authority contribution (from national and local sources) and the contribution of individuals (from charges for social care services). (Paragraph 41)

12. A single commissioner will have multiple lines of financial accountability, including to the NHS Commissioning Board, local authorities and service users. Central Government, NHS bodies and local authorities will need to establish robust procedures to ensure effective financial accountability. (Paragraph 42)
13. The holder of a single commissioning budget will also need to demonstrate proper local democratic accountability for its decisions. The Committee sees the development of the Health and Wellbeing Board, as an agency of the local authority, as a means of achieving this objective. (Paragraph 43)

### Care Trusts

14. The Care Trusts that exist in England are, generally speaking, the most integrated health and social care organisations. Alongside the provision of services to people, some Care Trusts also combine parts of the health and social commissioning budgets into one statutory body. (Paragraph 48)
15. The Committee notes that the Minister of State for Care Services sees Care Trusts as “an experiment that [...] did not really get out of the lab” and that he argues it is not the organisational form of Care Trusts that makes a difference but the behaviours within the organisation. Nevertheless there is clear evidence that some Care Trusts have made progress with the integration of services and the Committee recommends that the Government should allow communities to have the option of retaining Care Trusts as commissioners of health, housing and social care. (Paragraph 49)

### Integrating outcomes

16. The new outcomes frameworks for the NHS, public health and social care systems are crucial as they will become the primary means through which the Government will establish whether services are delivering better outcomes for the public. In the context of integrated service provision and integrated commissioning, the degree of alignment between these frameworks looks disappointing. We are particularly concerned that the Government merely “hopes” that national alignment “will cascade down to local level”. It follows from the recommendations of this report that the Committee recommends that the Government move quickly to adopt a single outcomes framework for health and social care for elderly people and that it will abandon the attempt to create artificial distinctions between health, social care and social housing. (Paragraph 53)

### A social care system in crisis?

17. As the Committee reported in its recent report on Public Expenditure, there is clear evidence of resource pressures on social care authorities. The Committee welcomes the Government’s commitment of an additional £2 billion per annum to social care by 2014–15, but recognises that even this substantial additional commitment is only

sufficient to meet additional demand if social care authorities are able to deliver an unprecedented efficiency gain of 3.5 per cent per annum throughout the spending review period and does not allow for any progress in responding to unmet need. (Paragraph 66)

18. The weight of evidence that we have received suggests that social care funding pressures are causing reductions in service levels which are leading to diminished quality of life for elderly people, and increased demand for NHS services. Although the transfer of £2 billion from health to social care is welcome, it is not sufficient to maintain adequate levels of service quality and efficiency. (Paragraph 73)
19. As it reported in its recent report on Public Expenditure, the Committee believes that the levels of efficiency gain which have been planned by the Government will not be achieved unless there are fundamental changes in the way care is delivered. In particular the Committee believes that successful delivery of the Government's plans requires a dramatic strengthening of its commitment to deliver more integrated services. (Paragraph 74)

### Rebalancing public sector spending

20. We noted earlier the Dilnot Commission's conclusion that the social care system is 'inadequately funded.' Andrew Dilnot was also clear that the separate funding streams for health, social care and welfare mean that resources are allocated in an inefficient way. At a time of scarce resources and rising demand the Committee believes that this structural inefficiency, which has been recognised for decades, can no longer be ducked. Too much is spent treating preventable injuries like falls, which can have a catastrophic impact on the lives of older people, some of whom may never regain independence again. If we are to create a sustainable, high quality support system for older people, commissioners need to rebalance the entire expenditure on services for older people across the NHS, social care, housing and welfare. This will be a process, rather than an event; the purpose of creating integrated commissioners, is to create agents within the system who have both the ability and the incentive to drive the necessary process of fundamental change in service provision. (Paragraph 76)

### Personalisation

21. While the Committee remains sympathetic to the cause of greater personalisation, it believes the Government needs to be clear-sighted about the likely impact of personalisation on total demand for social care —and therefore on social care budgets. This is an issue to which the Committee will return. (Paragraph 80)

### The Dilnot Commission

22. The capped cost model proposed by the Dilnot Commission represents an important element of the total funding model, but it is not the whole answer. The Committee recommends that in its forthcoming "progress report on funding", the Government should accept the principle of capped costs and outline proposals on where the cap should be set. (Paragraph 88)

23. Dilnot also recommends that there should be a separate cap on living costs of between £7,000 and £10,000 per annum. We support this and recommend that the Government accepts it. (Paragraph 89)
24. The Committee believes it is important that the future shape of social care is not dominated by a debate about the technical details of funding. It is essential that services are shaped by the objective of high quality and efficient care delivery, and the funding structures are fitted around that objective, not vice versa. It is, however, unsurprising that there is a focus on funding issues given the current financial stress on the care system. (Paragraph 90)
25. Although the Committee supports the implementation of the main recommendations of Dilnot, it believes the narrow terms of reference given to the Commission meant that the more fundamental issues about the need for a more integrated care model were only addressed in passing by Dilnot. (Paragraph 91)

### ***Capping care costs***

26. It has been suggested to the Committee that some of the disadvantages of the cap expressed as a cash sum could be addressed if the cap was expressed as a period of time. The Committee understands that the Dilnot Commission considered this approach and rejected it on the grounds that it would make the actual cost of the individual's contribution dependent on the acuity of their care needs during the period involved. (Paragraph 95)
27. The Committee recommends that the Government should look again at the principle of expressing the cap on care costs in terms of the length of time that people fund their social care for themselves in its progress report on funding, ensuring the equivalence of care standards before and after the cap is reached. Further work however is required to address unintended anomalies caused by regional variations in housing values and the difference between domiciliary and residential care costs. (Paragraph 96)

### ***Financial products***

28. The Government should clarify the likely market for pre-funded insurance, equity release, and immediate needs annuities, as well for pension-related and other products. It should also articulate how it will work with the industry to stimulate the market for these products. (Paragraph 101)

### ***Supporting carers***

29. The Committee welcomes the Government's recognition of the importance of support for informal carers and carers' assessments. The Committee is however concerned that the effectiveness of the policy is too often undermined by the failure of GPs, social workers and others to identify carers. The Committee believes the Government needs to find new and more effective ways to identify carers in order to ensure that their needs are properly assessed and met. (Paragraph 112)

30. The Committee supports the need for reform of the law governing social care, but is clear that this cannot take place in isolation from the law governing health, housing and welfare services. It believes that a new, integrated legal framework is required which supports integration of care around the needs of the individual, with a focus on driving forward quality and improving outcomes. (Paragraph 115)

## Annex

### Bed Day Usage per 1,000 pop Resulting from Emergency Admissions, patients aged 65 and over

Year	Bed days per 1000 population	
	Torbay CT	South West Region
2007/08	2004	2581
2008/09	2014	2815
2009/10	1895	2755

## Impact

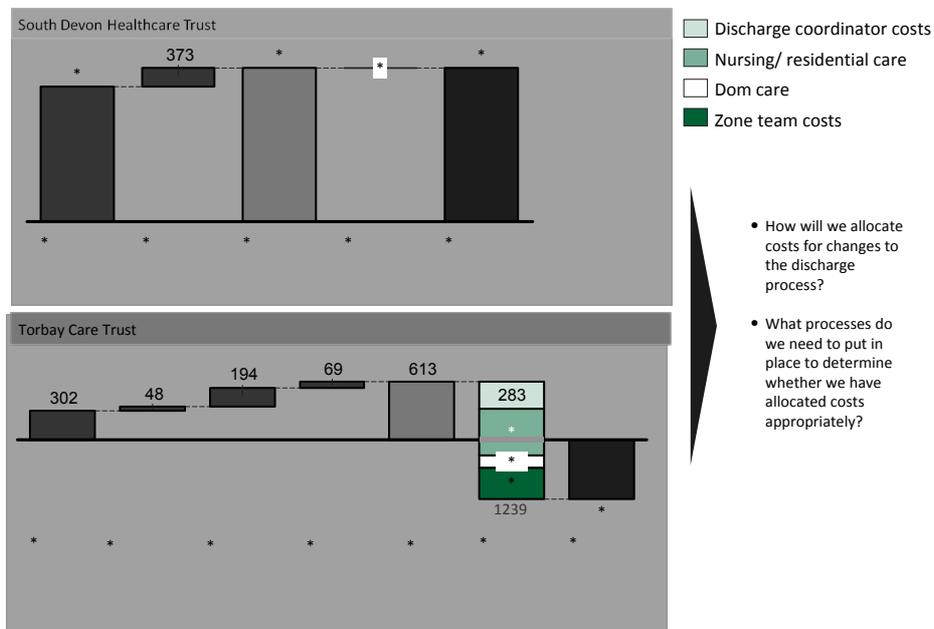
- Minimal delayed discharges from local DGH & fewest excess bed days in south west
- Lowest non-elective LOS in the southwest & 4th lowest in the country
- Lowest occupied bed days for >75s patients with 2+ admissions
- Acute beds reduced from 750 in 1998/99 to 517 in 2010/11
- Lowest rate of hospital deaths of any local authority in England at 44.60% - national figure of 58%
- I/C Access: 25% seen within 3½ hours; further 65% within 5 days. Rapid Equipment Service – average 62 mins.
- Res & nursing home long stay placements reduced by 487 since Feb '06 – from 1,298 to 811

# Impact

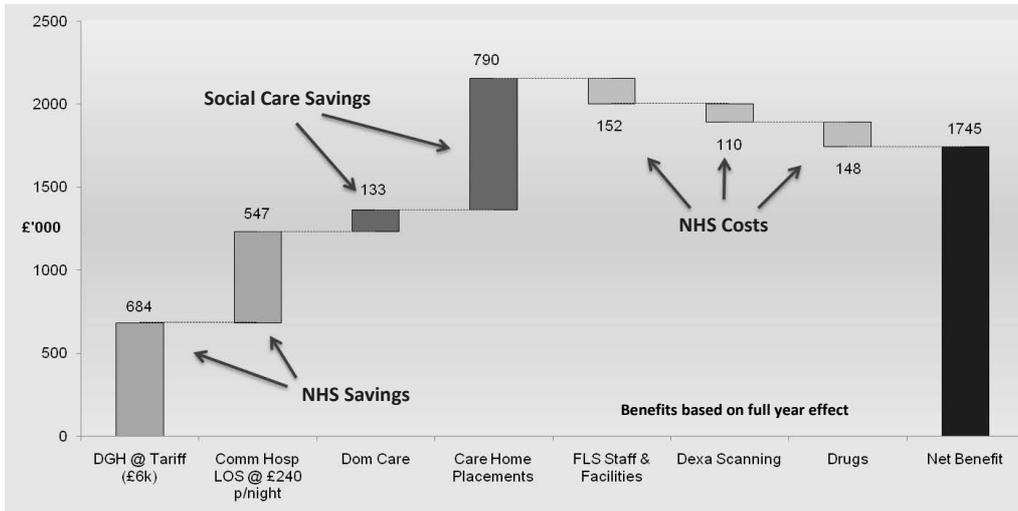
- Minimal delayed discharges from local DGH & fewest excess bed days in south west
- Lowest non-elective LOS in the southwest & 4th lowest in the country
- Lowest occupied bed days for >75s patients with 2+ admissions
- Acute beds reduced from 750 in 1998/99 to 528 in 2008/09
- Publicly funded residential & nursing home placements reduced by 30% over 5 years. Moved from 2<sup>nd</sup> highest to lowest decile of Local Authority's for age and need adjusted usage rates. High numbers supported at home.

## POTENTIAL FINANCIAL BENEFITS FOR A DISCHARGE PILOT ROLL-OUT

Base projection, £ thousands per annum



### POTENTIAL FINANCIAL BENEFITS FOR A FRACTURE LIAISON SERVICE (FLS)



**Annual financial benefits assume:**

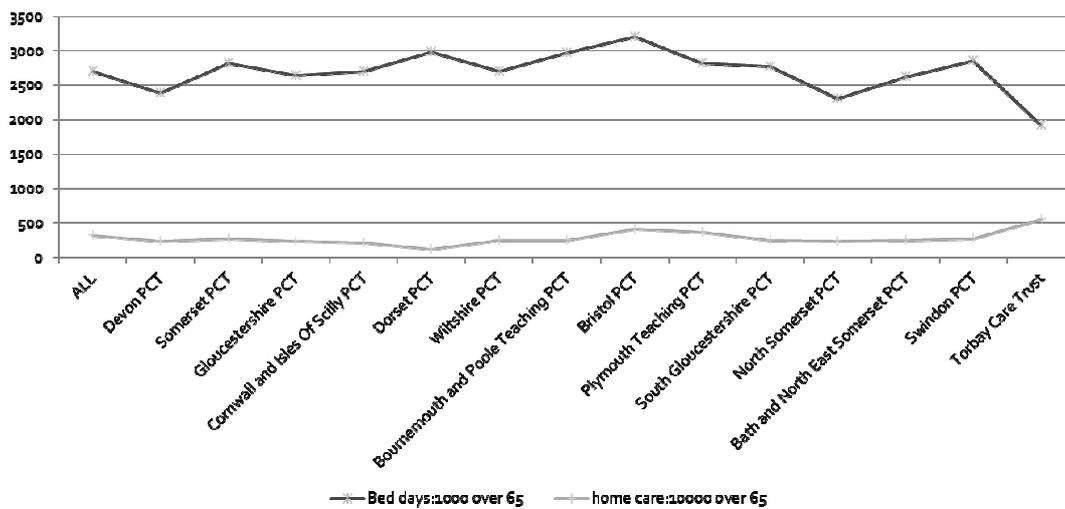
- On population of 62k >65s local DGH treats approx. 460 #NOFs p/a
- FLS saves 114 #NOF p/a, i.e. 25% of current #NOFs
- No account of savings made due to fewer minor/fragility falls
- 33% will no longer require care home placement (national research)
- 1/3<sup>rd</sup> of the 114 will not require a domiciliary care package (local research)



**Breakeven at:**

- 38 - 40 fewer #NOFs if only health savings taken into account, or at
- 12-15 patients if health and social care savings used

### Non-elective bed use per 1000 compared to numbers receiving a home care package (over 65)



## Quick check on assumptions (over 10 years)

Activity growth - 20%

Financial growth - Nil

Pay levels – 5–10%

Prescribing – 20%

Capital investment - limited

# Formal Minutes

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## Wednesday 1 February 2012

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper  
Andrew George  
Barbara Keeley  
Grahame M Morris  
Dr Daniel Poulter

Chris Skidmore  
David Tredinnick  
Valerie Vaz  
Dr Sarah Wollaston

Draft Report (*Social Care*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 115 read and agreed to.

Summary agreed to.

Annex agreed to.

*Resolved*, That the Report be the Fourteenth Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 7 February at 10.00 am

# Witnesses

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## Tuesday 25 October 2011

Page

**Julie Jones CBE**, Chief Executive, Social Care Institute for Excellence, **Martin Knapp, Director**, Personal Social Services Research Unit, London School of Economics, **Professor Gillian Manthorpe**, Director, Social Care Workforce Research Unit, King's College, London, and **Richard Humphries**, Senior Fellow, the King's Fund.

Ev 1

**Heléna Herklots**, Services Director, Age UK, **Jeremy Hughes**, Chief Executive, Alzheimer's Society and **Bruce Moore**, Chief Executive, Hanover Housing.

Ev 13

## Tuesday 8 November 2011

**Jo Webber**, Deputy Policy Director, NHS Confederation, **Peter Hay**, President of the Association of Directors of Adult Social Services (ADASS) and Strategic Director Adults and Communities, Birmingham City Council, and **Councillor David Rogers OBE**, Local Government Association (LGA).

Ev 24

**Mark Lobban**, Director of Strategic Commissioning, Families and Social Care, Kent County Council, **Helen Buckingham**, Director of Whole System Commissioning and Deputy Chief Executive, NHS Kent and Medway, **Sheila Bremner**, Chief Executive, North Essex NHS PCT Cluster, and **Jenny Owen CBE**, Deputy Chief Executive & Executive Director for Adult Social Services, Essex County Council.

Ev 37

## Tuesday 22 November 2011

**Frances Patterson QC**, Commissioner for Public Law, **Richard Percival**, Team Manager of the Public Law Team, and **Tim Spencer-Lane**, Lawyer, Public Law Team, Law Commission.

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**James Lloyd**, Director, Strategic Society Centre, **Chris Horlick**, Managing Director of Care, Partnership Assurance, **Nick Starling**, Director of General Insurance and Health, Association of British Insurers, and **Andrea Rozario**, Director General, SHIP Equity Release.

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## Tuesday 6 December 2011

**Andrew Dilnot CBE**, Chair, **Dame Jo Williams DBE**, Commissioner, and the **Rt Hon Lord Warner**, Commissioner, The Commission on Funding of Care and Support.

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## Tuesday 10 January 2012

**Liz Fenton**, Chief Executive, Princess Royal Trust for Carers, and **Emily Holzhausen**, Director of Policy and Public Affairs, Carers UK

Ev 87

**Dr James Mumford**, Senior Researcher, Centre for Social Justice, and **David Orr**, Chief Executive, National Housing Federation

Ev 97

## Tuesday 17 January 2012

**Paul Burstow MP**, Minister of State for Care Services, and **David Behan CBE**, Director General of Social Care, Local Government and Care Partnerships, Department of Health.

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2	Social Care Institute for Excellence	Ev 137
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5	Age UK	Ev 147
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7	Audit Commission	Ev 154
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26	National Housing Federation supplementary	Ev 227

## List of additional written evidence

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(published in Volume III on the Committee's website [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom))

1	FirstStop Advice for Older People
2	Dr Nigel Dudley LLM FRCP
3	English Community Care Association
4	Chartered Insurance Institute
5	British Red Cross
6	NICE
7	Joseph Rowntree Foundation
8	The Henry Spink Foundation
9	Keith Robinson, MA PhD

- 10 Monitor
- 11 Papworth Trust
- 12 Mencap
- 13 Wendy Regaard
- 14 Motor Neurone Disease Association
- 15 United Kingdom Homecare Association
- 16 National Pensioners Convention
- 17 Hampshire County Council
- 18 Royal College of Physicians
- 19 WRVS
- 20 Royal National Institute of Blind People and Action for Blind People
- 21 The Voluntary Organisations Disability Group
- 22 AKW Medi-Care Limited
- 23 Turning Point
- 24 Relatives and Residents Association
- 25 National AIDS Trust
- 26 Anchor Trust
- 27 Investment and Life Assurance Group Ltd
- 28 Professor Les Mayhew and Dr Ben Rickayzen, Cass Business School, London
- 29 Royal College of Nursing
- 30 Consumer Focus
- 31 the Care and Support Alliance
- 32 Learning Disability Coalition
- 33 Sense
- 34 My Care Umbrella
- 35 GMB
- 36 Bupa Care Homes
- 37 Independent Age
- 38 Ipsos MORI
- 39 Barchester Healthcare
- 40 National Centre for Independent Living, Disability Alliance and Radar
- 41 Stannah Lifts Holdings Ltd
- 42 Savitri Hensman
- 43 Mazars LLP, London
- 44 Gateshead Council
- 45 Action on Hearing Loss
- 46 Ideal Care Homes
- 47 Care UK
- 48 Care Quality Commission
- 49 The Institute and Faculty of Actuaries
- 50 Leon Smith, Nightingale Care Home
- 51 South East Strategic Leaders (SESL), South East Councils Adult Social Care Members (SECASC) and South East England Councils (SEEC)
- 52 MS Society
- 53 McCarthy & Stone

- 54 Sue Ryder
- 55 Citizens Advice
- 56 British Private Equity and Venture Capital Association
- 57 UNISON
- 58 Body Positive Cheshire & North Wales
- 59 Scope
- 60 University of East Anglia and London School of Economics

# List of Reports from the Committee during the current Parliament

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The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

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Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
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Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
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