

Government response to the House of Commons Health Committee Report on Social Care

(Fourteenth Report of
Session 2010-12)



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Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

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Introduction

1. On 8 February 2012, the House of Commons Health Committee published *Social Care: Fourteenth Report of Session 2010–12* (HC 1583–II). The report followed an inquiry by the Health Committee which received evidence from the Minister of State for Care Services along with other witnesses, including the Local Government Group, Age UK and the Alzheimer’s Society.
2. The Government has carefully considered the Committee’s report in deciding its approach to reform. In line with the Committee’s recommendation, the Care and Support White Paper, the progress report on funding reform and the Government’s response to the Law Commission published on 11 June 2012 constitute the full Government response to the Health Committee report.
3. The long-term plans Government has set out provide the framework for transforming care and support, which will put people, not institutions or services, at the forefront of care and support.
4. Everyone – Government, local authorities, the NHS, care users and their families, care providers, care workers, and communities – will need to work together to make this vision a reality.
5. This accompanying document to the Care and Support White Paper responds to each recommendation and conclusion. These are grouped by theme, setting out the actions being taken forward. The Committee’s conclusions and recommendations have been listed and numbered at appendix A and correspond to the numbers at the beginning of each section.

Government response to the Committee's conclusions and recommendations

Integration

Summary of the Committee's recommendations 2 – 6, 8 – 13 and 20

- Multiple funding streams and commissioners can lead to service fragmentation.
 - The policy objective should be to deliver joined-up, integrated services that deliver the best outcomes for people in the most efficient way.
 - Integration can deliver real benefits to service users but progress achieved over the years has been limited and continues to be disappointing.
 - A fully integrated approach to commissioning is needed but localities should decide on the approach best suited to their circumstances.
 - The Government should enable health and wellbeing boards to develop integrated commissioning budgets.
 - A duty should be placed on commissioning organisations to create a single commissioning process with a single accounting officer for older people's services. The expenditure on older people's services across NHS, social care, housing and welfare should be rebalanced.
6. Whilst the Government welcomes the Committee's focus on older people, the ambition of improving the quality of care and outcomes through better integration should be for the benefit of all, not just one section of society. The Government agrees that there is currently wide variation in how well health and care services join up around the needs of service users, and we are determined to support improvements in this area with even greater pace and urgency.
 7. The new commissioning arrangements contained in the Health and Social Care Act 2012, along with the reforms in the Care and Support White Paper, will put in place a stronger yet flexible legal framework to support and encourage integration. This includes clear legal duties on the NHS Commissioning Board, clinical commissioning groups (CCGs) and health and wellbeing boards to promote integrated care. The new public health responsibilities for local government mean there is greater scope for focusing earlier on preventing illness and reducing the need for care and support services. This new framework will 'deliver joined up, integrated services that deliver the best outcomes for people in the most efficient way', as the Committee suggests.
 8. Health and wellbeing boards will provide the forum for local system leadership to join up health and care services, as well as wider services such as housing, in order

to better meet the needs of service users and their families. The engagement, *Caring for our future*, and the NHS Future Forum, underlined the significant potential for the new arrangements to deliver real change, and for health and wellbeing boards to be 'a crucible for integration'. The Care and Support White Paper further reinforces the strategic importance of health and wellbeing boards to join up health and care. In bringing together elected councillors, patient and public representatives, and commissioners from across the health, public health and care system, the boards will be able to work as system leaders, enabling resources to be invested in the most effective way possible to improve services and outcomes. They must produce and publish Joint Strategic Needs Assessments (JSNAs) and a Joint Health and Wellbeing Strategy (JHWS) that sets out how they will work together, with their communities, in order to meet local needs and priorities. Together, local partners can identify local priorities and take the difficult decisions about them to improve the health and wellbeing outcomes for their local population.

9. This puts health and wellbeing boards, along with the JSNAs and the JHWSs, at the heart of the commissioning cycle and creates the vehicle in which to develop a 'single' joined up commissioning process as the Committee suggests. The Government therefore does not share the view that an additional duty to create a single commissioning process with a single accounting officer for older people's services is required, or that commissioning responsibilities divided between different bodies will undermine the ability of the system to deliver truly integrated services. However, over the coming months we will pursue the development of contracts covering all health and social care needs for older people, including preventative services.
10. The Government recognises that integrated commissioning budgets can be a positive step towards delivering better integrated care. As part of the new arrangements, the NHS Commissioning Board and health and wellbeing boards have a duty to promote the use of joint budget arrangements between CCGs and local authorities where it would benefit patients, service users and carers. The Government expects these bodies to maximise the use of joint budget arrangements where it would benefit patients, service users and carers. Commissioners will be held to account for commissioning high-quality services with good outcomes, many of which will only be achieved if services are designed and delivered in an integrated way.
11. Whilst the Government shares the view that achieving more integrated care requires commissioners to work together effectively, providers play an equally important role, as it is the provision of services, not commissioning, that individuals experience directly. We know from the excellent examples of integrated care across the country that a relentless focus on service users' needs is paramount.
12. Through reform, the Government will encourage greater flexibility for providers of health, housing and social care to work across the systems, stimulating new and innovative models of integrated provision that better respond to people's needs. Under the Health and Social Care Act 2012, the healthcare regulator Monitor has new duties to enable integration where it will benefit patients and service users. The Department of Health is working with Monitor to clarify the rules on choice, competition and integration for the benefit of patients and service users.
13. In future, service users and carers will increasingly make their own decisions about the services they receive and will direct those services to work closely together to meet their needs. As personal health budgets are extended beyond the pilot sites, subject to the current evaluation, people will be able to combine them with social care personal budgets in order to make the most of the support they are entitled to, and to design integrated services that work around their needs and preferences. Empowering people to choose from different providers, who might offer different ways of meeting their needs and

goals, will help to improve the quality of care and ensure that it is responsive to people's needs.

14. Later in 2012, the Government will publish a framework, co-produced with partners across the new health and care system, that will outline the progress made on integration and the plans that the system has to remove barriers to integrated care. Some of the areas the work will consider are:
- measuring people's experience of integrated care;
 - sharing tools and innovations that promote integrated care;
 - aligning incentives; and
 - developing models of coordinated care for older people.

Summary of the Committee's recommendations 14 and 15

- Care Trusts can be effective models of integration and the Government should retain them as an option for localities.

15. The Government agrees that Care Trusts are an important way for NHS bodies and local authorities to work together to improve outcomes and experience for people using services. It is up to local bodies to determine whether the Care Trust model is appropriate for their circumstances.
16. Through the Health and Social Care Act 2012, the Government has amended legislation to support the Care Trust model in the reformed system and for new ones to form. The changes make it possible for Foundation Trusts or CCGs and local authorities to form Care Trusts in future, if that is what they decide locally as the best way to meet the needs of their local populations.

Summary of the Committee's recommendation 30

- A new integrated legal framework is needed to support integrated care for people.

17. The Government agrees with the Committee's principle that the legal framework should support integration of services, and must not create artificial barriers or disincentives for organisations to work together. This is at the heart of the Health and Social Care Act 2012. The Government will build on this and modernise the legal framework for care and support, using the recommendations of the Law Commission as the basis.
18. The Government has published the draft Care and Support Bill for pre-legislative scrutiny. The Government wants to work with experts in care and support, including people who use services, to get the legal framework right. This will provide a further opportunity to engage on the detail of the new legal framework to ensure it is integrated across care and support, health and wider support services such as housing. The provisions include:
- new statutory principles which embed the promotion of individual wellbeing as the driving force behind care and support. These will be supported by duties to promote cooperation and integration between local partners to improve the way organisations work together;
 - general duties on local authorities to provide information and advice, and to shape the market for care and support providers;
 - the default position in law to be that everyone, including carers, should have a personal budget as part of their care and support plan, and a right to ask for this to be made as a direct payment; and
 - a new statutory framework for adult safeguarding, setting out the responsibilities of local authorities and their partners, and creating Safeguarding Adults Boards in every area.

Summary of the Committee's recommendation 16

- Alignment between the three outcomes frameworks is disappointing. The Government should adopt a single health and social care outcomes framework for older people.

19. The Government believes in better health and social care outcomes for all. In order to promote local transparency and decision-making as part of the coalition Government's commitment to a new era of localism, the Department of Health has developed outcomes frameworks. The different delivery and accountability mechanisms for the NHS, public health, and adult social care made it important to develop three separate outcomes frameworks and mean that we will not be able to have a single framework in future. However, the Government takes seriously the need to align the three outcomes frameworks. Each of the frameworks describes how it is moving towards better alignment and the Government will continue to look at how this aim can be achieved as it refreshes the three frameworks in Autumn 2012.

Social care funding

Summary of the Committee's recommendations 7, 8 and 19

- The additional resource invested in social care by the Government is welcomed but it meets only additional demand and does not close the gap on unmet need.
- Social care funding pressures are causing reductions in service levels.
- Stronger focus on integrated services is needed to realise the efficiency savings required by the NHS and social care.
- The efficiency savings required by the NHS and social care require a full rethink of the way services are commissioned and provided. 'Salami-slicing' is not an option.

20. The Government welcomes the Committee's acknowledgement of our efforts to support the adult social care system in a tough economic climate and challenging local government settlement. In the Spending Review, the Government prioritised adult social care by allocating an additional £7.2 billion over four years to 2014-15 to support local authorities in delivering social care.

21. This additional resource means that there is funding available to protect people's access to care and support and deliver new approaches to improve quality and outcomes, provided local authorities have a rigorous focus on efficiency. Whilst the Government is aware that this requires significant efficiencies to be delivered, evidence from the Association of Directors of Adults Social Services (ADASS) budget survey (May 2011) suggests that authorities are meeting the challenge, and Demos' *Coping with the cuts* demonstrates that forward-thinking authorities are realising efficiencies by redesigning their services.¹ As a result, they are often able to offer better provision to service users and carers within their local populations.

22. Local authorities make the decisions about local priorities and budget setting. However, the Government is confident that the additional £7.2 billion funding is enough to protect people's access to, and level of, care – a view that was broadly corroborated by the King's Fund.² Where councils have chosen to tighten eligibility, they should be held to account by local people for this decision.

23. The Government is clear that the Spending Review settlement for social care sought to protect access to care, meaning that any potential funding gap was closed and eligibility thresholds did not need to rise. However, it was not expected to fund the level of unmet need that the Government inherited and in this sense a needs gap remains.

1 *Coping with the Cuts* – Demos, September 2011.

2 *Social Care Funding and the NHS: An Impending Crisis*, Kings Fund, March 2011.

24. On the issue of ‘salami slicing’, cutting a proportion of all budgets indiscriminately, the Government has written to the Committee on this in its response to the Committee’s previous report.³ The Government agrees that service redesign will play a significant role in helping the NHS and local authorities to deliver improvements, productivity and achieving efficiency. However, change needs to be locally led so that services meet the needs of local people.
25. To support this, the Government has set out investment through the NHS, to promote joint commissioning and development of re-ablement, post-discharge support and intermediate care services, as admission to and discharge from hospital involve both partners. Over the Spending Review period, a total of £3.8 billion will be transferred from the NHS, rather than the £2 billion referenced by the Committee. A further demonstration of this commitment came in January 2012, when the Government made an extra £150 million available to prevent unnecessary delays in hospital discharge.
26. On top of the resources announced at the Spending Review, the health system will transfer an additional £100 million and £200 million in 2013-14 and 2014-15 respectively to bolster joint working between health and social care further, and develop more innovative services that can support people to maintain their independence at home.

The Dilnot Commission

Summary of the Committee’s recommendations 22 and 23

- A ‘Dilnot’ style capped cost funding model is an important element but not the whole answer of the total funding model.
- Government should accept the principle of capped costs in the progress report on funding and indicate where cap level should be set.
- The Committee supports a contribution to living costs.

27. We agree with the Committee that a Dilnot style capped cost model is not the whole answer of the total funding model. The Commission was asked to consider how best to share the costs of care between individuals and state.
28. Alongside this document, we are also publishing a progress report on funding reform. This sets out the Government’s support for the principles on which the capped cost model is based. Protecting people against very high care costs provides peace of mind and enables them to plan and prepare for their future care needs. The Government agrees that the principles of the Commission’s model would be the right basis for any new funding model – financial protection through capped costs and an extended means test.
29. Whilst we support the principles of the approach recommended by the Commission, and it is our intention to base a new funding model on them if a way to pay for this can be found, there remain a number of important questions and trade-offs about how those principles could be applied to any reformed system. Given the size of the structural deficit and the economic situation we face, we are unable to commit to introducing the new system at this stage. The Government will work with stakeholders and the Opposition to consider the various options for what shape a reformed system could take, based

³ *Government Response to the House of Commons Health Committee Report on Public Expenditure (13th Report of Session 2010–12)*.

on the principles of the Commission's model, in more detail before coming to a final view on reforming the system in the next Spending Review.

30. Some of the key questions about how to apply the principles include:

- the level of cap: some people have argued for a cap within the range suggested by Dilnot, and others have argued that a higher cap would deliver similar peace of mind benefits. This question also includes how the cap rises over time, what is and isn't counted in the cap, and the contribution to general living costs that people are expected to make; and
- who should benefit: many commentators have suggested that those who benefit most from reform should be asked to meet the cost of reform. One way of doing this is through a voluntary or opt-in funding system, where people have a choice to pay a specified amount to receive financial protection from the state.

31. The Government will explore these issues further, alongside others as set out in detail in the progress report, engaging with stakeholders to ensure we are in the right place to make final views in the next Spending Review. We welcome and strongly encourage stakeholders to contribute to the debate and bring forward their own ideas about applying these principles.

32. The introduction of living costs into residential care was recommended by the Commission as part of the capped cost offer. This was to reflect the costs incurred when someone receives domiciliary care. Someone living at home has to pay living costs, such as their light, heat and food. The Commission felt it was fair to introduce a contribution to living costs for people in residential care and the Government acknowledges the support of the Committee for this.

33. The Commission also made a number of recommendations where we have made further progress, both through the White Paper, and as part of the draft Care and

Support Bill, published today. This includes introducing a universal deferred payments guarantee from April 2015, national minimum eligibility for services, work to ensure services are designed around the individual, giving carers a statutory footing in law and ensuring integration between health and social care.

Summary of the Committee's recommendation 25

- The narrow terms of reference of the Dilnot Commission meant that integration was only addressed in passing.

34. Integration, as the Committee notes, was not within the remit of the Dilnot Commission. However, the Dilnot Commission was supportive of a move towards more integrated services. The Care and Support White Paper sets out the Government's plans to drive greater integration in the system, building on the framework set out in the Health and Social Care Act and the Future Forum recommendations, which Government accepted in full.

35. We have shown our commitment to integration already, setting an explicit objective for the NHS on integration in the draft Mandate for the Commissioning Board, published on the 4th of July.

Summary of the Committee's recommendations 26 and 27

- Government should revisit the principle of expressing the 'cap' in terms of the length of time people fund their care and support.

36. As stated, the Government has agreed that the principles of a capped cost system are right, and it is our intention to base a new funding model on them if a way to pay for this can be found. We are now considering the best application of these principles and the implications for costs. The *Caring for our future* engagement highlighted a series of areas that partners thought we should consider, such as the level of the cap, what it is based on

and how it is calculated. We will look to our stakeholders to continue to help us to develop our understanding of the model, to suggest how best to implement the principles of the model.

Summary of the Committee's recommendation 28

- Government needs to clarify the likely market for pre-funded insurance and other related products and how it will work with the industry to stimulate the market for these products.

37. Through the *Caring for our future* engagement, we worked with representatives to understand the impact of funding reform on financial services. They supported the use of a cap and could see the potential for financial products, both before and after the cap. The Government understands that the market could also provide a range of products such as pre-funded insurance, immediate needs annuities, equity release and disability linked annuities. The market for pre-funded insurance might be small compared to other products.
38. In making its recommendations, the Dilnot Commission recognised the role of financial services and their products.
39. In response to the Commission's recommendation, the Government will set up an expert working group with financial services and other related parties. The group will explore how the sector as a whole can contribute, and make links with pensions, benefits, wider services and specialist financial advice to ensure the offer is comprehensive.
40. The Commission and some sections of the financial services sector felt that the tax treatment of disability-linked annuities was unclear. The Government has taken this feedback on. HMRC has worked with the Association of British Insurers to clarify the rules and will publish an update to its guidance on the HMRC website by September.

Quality

Summary of the Committee's recommendation 24

- Services should be shaped around high quality, and reform of the care and support system should not be dominated by the debate on funding.

41. Making quality the guiding principle for adult social care and equipping the workforce to meet this challenge is a priority. The Care and Support White Paper is clear that high quality must be the foundation of the care and support system.
42. A key component is enabling people to access easily understood, comparative information about the quality of care. The reforms will enable people to choose a care provider that best helps them to meet their goals as well as enable providers to distinguish themselves to potential customers and to build their reputations.

Personalisation

Summary of the Committee's recommendation 21

- The Government needs to be clear-sighted about the likely impact of personalisation on total demand for social care and social care budgets.

43. People should have control over the services they use. Whether a person funds their own care or receives a personal budget, the Government wants people to have genuine choice and control over the services they buy and receive. This is a radical shift of power into the hands of people using services.
44. The principle of personalisation, where people are in control of their care and support, is at the heart of our vision for a reformed care and support system. Reports from the Audit Commission have suggested that personalisation is more likely to lead to better

value for money from improved outcomes, which can be achieved at the same or lower cost.⁴

45. The Government will take the radical step to enshrine the concept of 'personalisation' in law. This will embed the principle of personalised care, through a focus on people's wellbeing and outcomes, including the control over their day-to-day lives. It will guide the way that local authorities, care providers and care workers deliver care and support. People can also drive up the quality of care by being in charge of their budget, and that is why we have announced that we will expand direct payments in residential care to a small number of areas to test this approach.
46. The Government notes that the Committee intends to return to the issue of personalisation at a later date.

Supporting carers

Summary of the Committee's recommendation 29

- Whilst progress has been made, more is required to support carers and for carers to be identified early.

47. Carers of all ages make a vital contribution, and the Government has taken strong action to support them. However, more is needed to help identify and support carers. The Government will change the law so that carers are given clear legal entitlements to assessment and support. Carers should be

treated as equals and not as an extension of the person they care for.

48. Helping those with caring responsibilities to identify themselves as carers is a priority area for action in *Recognised, valued and supported: next steps for the Carers Strategy* (November 2010). The Government is supporting a number of initiatives to help people with significant caring responsibilities to identify themselves as carers so that they can access timely information, advice and support. In particular, the Government is providing funding to the Royal College of General Practitioners and national carers' organisations to undertake a programme of initiatives aimed at raising awareness among GPs and others working in primary healthcare. The Government will work with and through the Royal Colleges, to build on these developments with professionals working in acute and community healthcare.
49. In June 2012, the Government in conjunction with Employers for Carers held a summit to consider how employers can encourage and support those who take on caring responsibilities to identify themselves as carers.
50. Respite care is highly valued by carers and that is why the Government has provided additional funding of £400 million to the NHS between 2011 and 2015 for carers' breaks. The 2012-13 NHS Operating Framework sets out clear obligations on Primary Care Trust clusters alongside local authorities to deliver improvements for carers.

⁴ Audit Commission reports *Improving Value For Money in Adult Social Care*, June 2011, and *Financial Management of Personal Budgets*, October 2010, said that whilst personal budgets were unlikely to produce significant cash savings, satisfaction and outcomes were improved. Overall, 'personal budgets offered improved outcomes for a similar or slightly reduced spend'. In addition, *Improving Value For Money in Adult Social Care* stated 36 per cent of councils cited personalisation as a driver of better value for money in 2009-10. This rises to 45 per cent for 2010-11. Better value came mostly from improved outcomes, not savings.

Appendix A: The Committee's conclusions and recommendations

1. 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)
10. The NHS Future Forum recommended that Health and Wellbeing Boards (HWBs) 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)

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)
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)



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