Joint Committee on the Draft Care and Support Bill
Briefing note from The King's Fund - 8 January 2013

Introduction

1. The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

2. This note has been prepared for the Joint Committee ahead of its oral session on 9 January, where witnesses will include Richard Humphries, Senior Fellow for Social Care and Local Government at the Fund. It should not be considered a formal submission in line with the Committee's call for evidence in December. Our focus is not on the detail or wording of the draft Bill, but on how it fits into the wider policy landscape, particularly with regard to funding and integration issues.

Key points

3. We welcome the prospect of new legislation as a once-in-a-generation opportunity to establish a single modern statute and bank of statutory guidance. But it is important to recognise the limits of what can be achieved through legislation alone - this is particularly true of delivering integrated care.

4. We believe that many of the aspirations in the legislation will not be achieved without funding reform, including the implementation of the Dilnot proposals. This is particularly true of the clearer entitlements to care and support (clauses 17 and 18) and better support for carers (clause 19).

Integrated care

5. Despite growing high-level support for integrated care, a lack of urgency remains in its delivery. Clauses 4 to 6 of the draft Bill provide an opportunity to generate momentum towards better integrated care, as part of a wider package of reforms outlined in last year's White Paper *Caring for our Future*. It will be important that clause 6 in particular is consistent with the powers and duties to promote integration conferred on local authorities, clinical commissioning groups and the NHS Commissioning Board by the Health and Social Care Act 2012. However, our assessment of the evidence for integrated care shows that conferring legal powers on organisations is not sufficient for change to happen. Legal powers for joint commissioning and pooled budgets, for example, have existed for some time but few local authorities have used them.

6. Further changes are therefore needed to wider health and social care policy, to ensure that integration is hard-wired throughout the NHS. Our joint report with the Nuffield Trust last year outlined a number of practical priorities for action and barriers to developing integrated care at a national level (Goodwin *et al* 2012).

7. Too little progress has previously been made in prioritising these issues despite wider system reforms; although new ministerial team appointments, and the announcement last November of a series of large-scale integrated care

'experiments', have given us greater confidence. Much will depend on the integrated care delivery plan due to be published by the Department later this year. This should be the catalyst in moving integrated care from a subject for policy debate to making it happen at scale and pace across the country.

8. The use of pooled budgets (highlighted in clause 4) is another means of aligning resources, but currently these represent less than 5 per cent of total NHS and social care expenditure (Audit Commission 2009). However, adult social care commissioning actually contributes around 25 per cent of its budget towards these joint arrangements, whereas the NHS invests a lot less. The imbalance in investment between social care and health in joint commissioning presents a bigger challenge than that the overall total investment is small.

Funding reform

9. We welcome the aspiration of clauses 17 and 18 to provide a clear single route through which consistent entitlements to care and support can be established. But in order for these to be realised, there must be funding reform, including the implementation of the Dilnot proposals. Without this, there is a financial vacuum at the heart of the government's proposals.

10. We note recent media reports about implementing the Dilnot proposals. However, despite its commitment in the 'programme for government' to the urgency of funding reform, reiterated in its recent mid-term review, the government has still not produced a clear plan for how care should be funded or a timetable for how funding decisions will be considered.

11. It is critical that the momentum for change over the past 13 years – 2 independent commissions, 3 public consultations and now 3 White Papers – not be lost. The success of longevity and an ageing population mean that soaring care costs are inevitable and a no-cost option does not exist. The need to find a sustainable way of paying for care remains as urgent as ever.

12. The Dilnot report offers a credible and costed way forward on capped costs. Its recommended capped cost framework offers the prospect of a lasting settlement based on a partnership model in which costs are shared between individual and state in an open and transparent way – a principle we have long argued for.

13. These proposals to cap individual liability for the costs of care and to raise the upper threshold for the means test would represent a substantial improvement on the current system and ensure that people in every income group are better off. They would avoid disproportionate cost to the taxpayer, compared to the costs of providing free personal care, while protecting people from the worst excesses of the current system and the cliff edge of present means-testing arrangements.

14. There is also a broader economic case for investment. Any additional investment could create a significant employment multiplier effect and would support a strategy for economic growth. Further economic benefits could be expected from better social care support for carers and for people with disabilities who would be more likely to retain employment.

15. ***The Bill should be amended to make provision for the Secretary of State to issue regulations that would allow the Dilnot Commission's recommendations for a capped cost model to be implemented in full. While further work is required on the detail, this would avoid allow the government to proceed quickly after the forthcoming spending review.***

16. The current economic climate is not a reason for further delaying acceptance of the framework proposed by Dilnot. However, with the budget deficit in mind, there is potential for a phased introduction of the capped cost model, with the level of cap recalibrated as economic conditions improve.

References

Audit Commission (2009). *Means to an End: Joint financing across health and social care. Health national report.* London: Audit Commission.

Goodwin N, Perry C, Dixon A, Ham C, Smith J, Davies A, Rosen R, Dixon J (2012). *Integrated Care for Patients and Populations: Improving outcomes by working together*. A report to the Department of Health and the NHS Future Forum. London: The King's Fund and Nuffield Trust. Available at: www.kingsfund.org.uk/publications/integrated-care-patients-and-populations-improving-outcomes-working-together