



ALL PARTY PARLIAMENTARY GROUPS

Primary Care & Public Health

And

Social Care

Report of Joint Inquiry on:

**White Paper: *Our health, our care, our say -
a new direction for community services***

November 2006

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1. Introduction

The All Party Group on Primary Care and Public Health and the All Party Group on Social Care launched a joint inquiry into key aspects of the new White Paper *Our health, our care, our say – a new direction for community services*. We wanted to explore the proposals presented in this important document inviting written and oral evidence on specific areas in the White Paper to cover issues of both health and social care.

There are good reasons for bringing together public health, primary and social care in a single White Paper, since many people are users of both primary and social care services, and many aspects of social care impact greatly on maintaining good public health. The Government is looking to create a patient-led service, providing services that are user-centred, responsive, flexible, open to challenge, accountable to communities and constantly improving. Indeed, the White Paper outlines some radical changes which, once implemented, will totally transform health and social care services. Giving people more choice and control, moving towards a more integrated approach, changing the culture towards prevention of ill health and promoting well-being, as well as shifting NHS resources from secondary to primary care will all require robust systems in place and a thorough implementation plan if they are to happen.

Fulfilling the expectations of the new White Paper will mean major reforms and expansion of community and social care services. These policies prompted a series of questions about how they will become reality. As part of the inquiry experts in health and social care were invited to

submit evidence focusing on three main areas in the White Paper; funding, decision making and integration, (see annex 1 for a list of organisations that contributed to the inquiry by giving evidence). Specific questions were asked around these three significant areas:

Funding

- How can implementation of the White Paper be funded? Could sufficient funding come from existing work streams in both health and social care, or will some new money be needed?
- How will the funding be sustained, when new resources will be scarcer after a period of relative growth in health and to a lesser extent social care spending?
- What are the links to the recommendations of the Wanless report on costs and funding of social care for older people, including how much individuals should provide for their own care?
- How will the charging policies in social care be reconciled with health care which it is said will remain “free at the point of need”?

Decision-making

- The White Paper proposes a shift of spending from acute services to prevention including more self-care. Who will be responsible for making decisions to ensure this happens?
- How will accountability work in the new system? How will services address the risks and consequences of professional self-protection and multi-disciplinary teamwork blurring roles?
- How can professionals ensure increased say for service users over what happens to them?
- How can service users influence professionals to ensure a collaborative approach to decision making?
- How can we shift from the precautionary principle, prevalent in the NHS and parts of social care, to a much more flexible approach to risk and opportunity?

Integration

- How can we achieve better integration between health and social care, and how will cultural differences be overcome?
- How should PCTs and Local Authorities work together to provide the new kinds of services?
- How can the social care input into strategy development at the DH be strengthened, and how can the Cabinet Office enhance integration across government?
- How can government achieve policy and service coordination beyond health and social care, and include DfES, DWP, DCMS, ODPM to bring in housing, benefits, work and training, leisure and culture?

The following pages of this report describes the summary of written and oral evidence received during the inquiry

2. Summary of evidence

On the whole the oral and written evidence received during the inquiry was very positive about the content of the White Paper especially the commitment to provide much stronger collaboration between health and social care agencies. The following focus was particularly welcome: the emphasis on funding mechanisms to give users more control and the ability to shape more personalised services; the need to focus efforts on outcomes; and the recognition of the need to support informal carers.

There were, however, a number of concerns around certain issues and a feeling that some elements in the White Paper had not been given due prominence. One area that was felt to be largely overlooked was the interface between patients and health professionals. Modernising the health professional's role to engage patients involving them in treatment decisions, encouraging them to see each other as partners should be a priority in primary care. It is

necessary that health professionals recognise their responsibility to promote health literacy, support self care and self management and involve patients in treatment decisions. A fundamental change in the culture of care is necessary without which, the White Paper will have limited chance of success.

Social care funding was also a high priority during the inquiry. There is an existing unmet need, and, as demographics change, that need will increase – therefore requiring greater investment. Evidence includes the resource-driven raising of eligibility criteria to exclude more people from access to services, Department of Health figures showing a continued decline in numbers receiving domiciliary care when the proportion of very old people in the population continues to grow, and damage to the health of caring relatives because of the lack of respite services. “Invest to save” funding will be required to facilitate the changes required. Existing work streams cannot contain the known demographic pressures over the next 10-20 years.

Sir Derek Wanless gave evidence about his latest report on social care and considered that the Government should monitor changing demographics in order to ascertain what route funding could take. He gave examples of charging systems: 1) free personal care 2) a partnership model where people are entitled to a basic level of care free and after that the state and the individual pay 50/50. The partnership model could be adapted but at the heart of the system there would be an entitlement to care as in free personal care. This was a long term issue that he felt would be better dealt with in two elections’ time when there would have been a better idea of the demographics in England. As well as the long term issue he felt there was also a crucial short term need as far as social care funding is concerned. If nothing is done about funding now then the system will continue to reverse, the need will continue to grow and the funding base will not keep pace with the demographic change. A sensible long term debate on the funding of social care is necessary but the important short term message is about what needs to be done now about the funding and organisation of care.

Commissioning of services required improvement. Voluntary sector providers were particularly concerned about full-cost recovery funding. They believed that many PCTs are still not paying a fair price for services despite the August 2006 deadline imposed on all government departments by HM Treasury

Direct Payments and Individual Budgets were welcomed, but it was recognised that appropriate support systems need to be in place to make them effective.

Social care service users see changes in policy, professional and organisational cultures and attitudes as essential to improve involvement, which is too often a tokenistic exercise.

We begin by highlighting the concerns and proposals of those organisations and individuals that provided evidence during the enquiry. The Groups reached their own conclusions and recommendations based on this evidence at the end of the report.

3. Highlights from evidence on funding

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| 3.1 | How can implementation of the White Paper be funded? Could sufficient funding come from existing work streams in both health and social care, or will some new money be needed? |
| 3.2 | How will the funding be sustained, when new resources will be scarcer after a period of relative growth in health and to a lesser extent social care spending? |

- 3.3 What are the links to the recommendations of the Wanless report on costs and funding of social care for older people, including how much individuals should provide for their own care?
- 3.4 How will the charging policies in social care be reconciled with health care which it is said will remain “free at the point of need”?

There is an assumption in the White Paper that money will be saved by reducing the amount of care performed in the (expensive) acute sector which will allow the health system to refocus itself on primary care, preventing for example expensive admissions by ‘frequent users’ and other groups that could be helped to better manage their condition and avoid emergency admissions. Integrating health and social care delivery is expected to improve efficiency. Although this may be the case once systems are in place, for services to shift from secondary to primary care in the first place, a significant increase in facilities and community staff will be necessary which will of course require funding.

Even with new and exciting ways of delivering social care, there will still need to be an increase in resources to support growing numbers of people with a learning disability, and particularly those with profound and multiple learning disabilities. Bridging funding will also be required to pay for old and new services in the transition phase. We want the DH to make a convincing case for extra resources as part of the Comprehensive Spending Review.

The development of new services inevitably means that older services are closing. It is this period of transition that will prove to be a difficult time, particularly within the context of wider NHS budget cuts. It is essential that a transition fund is established for the purpose of making the changes to services with as little disruption as possible to the care and treatment that service users and carers need.

The one contributor who thought that funding levels were adequate, still argued that a radical change was required in how existing funding is used.

- 3.1 *How can implementation of the White Paper be funded? Could sufficient funding come from existing work streams in both health and social care, or will some new money be needed?*

Funding the reforms suggested in the White Paper was clearly an issue of great concern to those providing evidence, especially the PCTs, and actual ideas on funding the implementation of the White Paper were limited. Concerns around funding were submitted as well as suggestions of how monies from existing work streams can be used. There were also examples of where new money would be necessary.

Concerns: The key points made by contributors were:

- Many current NHS estates are not designed for “one stop” range of multi professional facilities. There could be rationalisation of estates between community, primary care and social services since current funding streams for capital developments are complicated and take time.
- Payment by Results (PBR) means that there is an incentive to reduce hospital admissions although a period of ‘pump priming’ of community services and self care initiatives will be required until anticipated savings made in secondary care under PBR will be available.
- Some felt that Foundation Trusts and Payments by Results are likely to make shifting resources from secondary to primary and community care even more challenging.
- If additional money is provided there will be genuine concern that this will be used for deficits. Many PCTs are using *choosing health* monies towards deficits and this has created mistrust with local authority colleagues.

- There is little planning or funding to meet the needs of young people with profound and multiple learning disability who are coming through transition.
- There will be an increased requirement for treating mild to moderate depression and stress.
- The No.10 Strategy Unit report *Improving the Life Chances of Disabled People* is also excellent, but funding to deliver is inadequate.
- The proposals in the White Paper fail to provide sufficient financial incentives and opportunities for GPs and other providers to enter deprived areas, meaning that, unless this is addressed, the worst-off members of our society will continue to receive a second rate service.
- NHS life-check may be useful for some patients but there is a concern that they will largely appeal to the 'worried well'. Prevention should also focus on those patients who are most at risk and initiatives that target under-privileged areas are likely to be more effective in tackling ill-health and helping to lessen health inequalities.

Proposals: The key points made by contributors were:

- Provide pump priming of community services prior to anticipated savings as a result of Payment by Results (PBR)
- Provide extra funding for double-running costs, additional investment in staff for retraining, recruitment, reassigning, etc; change management transaction costs including planning, commissioning and delivering new services; and additional IT and recording requirements tracking people across disparate services.
- Establish a target for the shift in resources from health to social care and financial stability in health and social care system in order to secure robust arrangements to satisfy both NHS and local government.
- Develop greater capacity in the system, greater investment, and improved access training in the workforce – this is important as the workforce need to plan for new roles. Options for Excellence could outline a constructive way forward to achieve this.
- Increase the level of Carers' Allowance, and remove the regulation that bars people from continuing to access this benefit when they reach retirement age
- Allow Direct Payments to be used to pay family carers.
- Ensure full implementation of Standard One of the National Service Framework for Mental Health, which aims to ensure that health and social services promote mental health and reduce discrimination and social exclusion.
- Areas with significant health inequalities will require growth as well as efficiency savings.
- Areas which are under-doctored will require funding for additional doctors and other health professionals.

3.2 *How will the funding be sustained, when new resources will be scarcer after a period of relative growth in health and to a lesser extent social care spending?*

The NHS has benefited from above inflation funding increases over the past two years. The challenge is now to improve productivity and efficiency. The sustainability of services depends on improved productivity, supported by improved technology, information systems and organisational infrastructure. By working in partnership with social care, some of these efficiencies can be delivered through the sharing of care, support services and streamlined regulatory processes. The full implementation of tariff or other standardised funding mechanisms will enable sustainability of funding for community services. However, sustainability will also be affected by the pace of implementation and the ability to fit local priorities meaningfully alongside national targets. Local health and social care communities must be allowed to plan in a way which fits local health needs, funding considerations and commissioning requirements.

Proposals: The key points made by contributors were

Continued funding for expanded and more comprehensive community care services will rely on:

- Efficiency savings gained from more integrated health and social care teams, including shared 'back office' and support functions across health organisations and social care.
- A clear mechanism for reinvesting savings from fewer contacts with acute hospitals (under PBR) into community services. This mechanism will need to link to Practice Based Commissioning (PBC) and development plans of GP practices.
- The development of a clear and explicit framework for entitlement to health and social care.
- A rebalancing of NHS and local authority funding (eg it is estimated that 20% of NHS funding savings immediately impact on social care budget)
- A more measured pace of change within the NHS, especially in achieving financial balance rather than the current position in many cases on unplanned, unpredicted and non-strategic opportunistic financial and service cuts.
- Redirecting savings and benefits in other parts of the government agenda to social care. Government needs to assess the full value of reconfigured services so that it makes fiscal sense to maintain them.
- A target for the shift in resources from health to social care and financial stability in health and social care system to secure robust arrangements to satisfy both NHS and local government.
- Joint commissioning and joint appointments, integrated services and pooled budgets which should all provide opportunities for reduction of duplication in service, cost efficiencies and better value for money.
- Local Area Agreements (LAAs) as a vehicle to secure high level agreements and deliver better performance and outcomes for individuals.
- Suitable housing and assistive technology which are central to preventative strategies. Supporting People is being reduced and while there is a ring fenced grant for assistive technology in 2006/07, its use on large scale will require further up-front investment.
- Ensuring that resources must not be taken from those with complex needs in order to fund more preventative services.
- Joint commissioning and joint appointments, integrated services and pooled budgets which provide opportunities for reduction of duplication in service, cost efficiencies and better value for money.
- Evaluating the effectiveness of areas of major expenditure (eg training)
- Link schemes for people to save for their retirement and their long-term care needs, and develop the tax regime to create stronger incentives for people to provide early for their future care needs
- Providing more flexibility in funding packages and more advocacy and support for people to take up direct payments
- Developing better integration between health and social care and the residential care sector field to enable the sector to be supported to develop residential units into Community Health and Support Centre
- Improving LA commissioning. Councils need:
 - to commission services for all those living within their boundaries, including those who pay for their own care and those whose voice is not heard
 - capacity to evaluate need is the starting-point for developing a responsive commissioning strategy
 - to make better use of user-led or user-managed services, and social enterprise services.
 - develop strategic commissioning that recognises it is better to support people in the community rather than waiting until a crisis (more expensive) service is required

- commissioning guidance that makes it clear that an allowance needs to be provided to allow for adequate provision for the training of care workers.
- Extending quality and outcomes framework, but the information needs to be used for commissioning at practice level and larger populations.
- Ensuring that councils track and respond to changes in individual preferences as a result of Direct Payments and Individual Budgets.
- Providing adequate resources to support Direct Payments and Individual Budgets equally across all local authorities.
- Enabling people with experience of mental health problems to become part of the mental health workforce for service provision – if there is greater flexibility in the way benefits and work can be combined then they can make a greater contribution, work can contribute to their recovery and reduce their overall whole system cost.
- Joint commissioning of carers support by health and social care
- Giving carers access to services, information and choices will help many to carry on caring safely and with their own health and well-being intact. Carers request relatively cheap kinds of support to carry on caring, so investing in their well-being is cost effective.
- Enabling the voluntary sector could offer alternatives to hospital, such as crisis intervention services or assertive outreach provision to enable service users to remain at home.
- Extending the parameters of existing “health” funding to embrace social care, such as Personal Medical Services, health and social care services – this could join up and be more effective at meeting the holistic needs of local populations. This proposed funding shift will need to be supported by a government directive to extend the range of suitable providers to incorporate Third sector organisations.

Good practice: The best councils:

- Work well with local economic development and regeneration services, as well as small service providers.
- Work with their partners in PCTs and Hospitals and in Mental Health Trusts.
- Engage providers at an early stage in service planning
- Recognise that providers need medium-term financial security on which to base their business planning
- Have sound procurement strategies that understand that quality outcomes are associated with good staff, and that agencies need to pay their staff properly and offer decent terms and conditions
- Find ways that use the knowledge and experience of providers to develop quality services without compromising public procurement policies or excluding them tendering for business
- Give sufficient support to local agencies, e.g. access to training

Concerns: The key points made by contributors were:

- Practice Based Commissioning could lead to the prevalence of medical models over more holistic social care approaches.
- Spot commissioning of social care services at the minimum cost is not supporting the development of the sort of market that could deliver on the intent of ‘Our health, our care, our say’.
- Local authorities often use their purchasing power to buy care at the lowest price per hour through block and spot contracts. This disadvantages homecare providers who struggle to implement hourly pay rates that will attract workers.
- Price-driven purchasing also runs the risk of compromising quality and reduce the choices open to self-funding users and direct payment recipients.
- Inappropriate commissioning of care in units as short as 15 minute visits often limits careworker to meeting anything but immediate physical needs.

- Independent providers remain concerned that in practice the value of Direct Payments does not always reflect the equivalent cost of care that would be purchased through statutory provision, reducing service user's choice and purchasing power.
- It is disabled children and adults, and older people and their carers who carry the real cost of the funding inadequacies and imbalances, and this undermines the credibility and delivery of positive government policies.

3.3 *What are the links to the recommendations of the Wanless report on costs and funding of social care for older people, including how much individuals should provide for their own care?*

The original Wanless report, was based upon two assumptions: there would be new ways of working and improved self care; after four years there still appears to be no evidence of this happening. Wanless did not envisage a large amount of money being spent on choice, plurality, a framework for competition and payment by results. Choice and provision according to wants can even increase unnecessary costs and health inequalities and prevent sensible prioritising of scarce resources.

The development of information and support for self care is an essential part of the White Paper. A balance must be struck between central and personal funding so that health inequalities are not widened further as the more disadvantaged stop using services on the basis of cost. The Wanless proposal to raise the baseline level of social care funded by Local Authorities is very much supported, although it would require high levels of added central funding. There are health benefits through having an improved and consistent range of social care services, particularly 24 hour home care and respite for carers. Similarly a move away from the two fold eligibility for social care, on both the grounds of ability to pay and social care needs would enable greater service integration and create a system which is less confusing for users and more geared to the delivery of universal health and wellbeing services.

Proposals: The key points made by contributors were:

- A balance between central and personal funding is necessary to prevent further inequalities
- Improving the range of social care services would increase health benefits
- The charging system for social care should be reviewed.
- A fairer system of charging people for social care services is needed, a public debate on funding for social care might reveal alternative solutions and make the public more aware of why social care services must be paid for by individuals

Many believe that current levels of social care funding services are inadequate and the cost of providing care has risen at well above the rate of inflation. There is concern that increased Government funding for adult social care has consistently been diverted away from older people's services. The result is that increases in funding for older people's services have been barely sufficient to cover the increased demands arising both from changing demography and from policies such as the reduction of delays in hospital discharge.

The White Paper is consistent with Wanless, which provides realistic cost estimates for simply maintaining current levels of support in the context of demographic growth, and offers one model for new cost-sharing arrangements between the individual and the state. Because of the increase in home ownership, growing numbers of people are already funding their own care (estimates of a third of those in residential care). There is a need for further examination of the options for people to make more provision for their care needs earlier in their working lives.

Many patient groups believe the means-testing system for social care is both complex and intrusive. The further integration of health and social care is important but the current system demands that they are ultimately separated in order to establish whether or what the person should be charged for.

A fairer system of charging people for social care services is needed, a public debate on funding for social care might reveal alternative solutions and make the public more aware of why social care services must be paid for by individuals

Social care service users support the Wanless view that social care will require more funding for the future.

Many contributors believed that the provision of all personal care services free of charge continues to be the best way forward. A fairer decision might then be made about the extent to which 'hotel costs' should be met by the state or individuals.

Sir Derek Wanless made the point that free personal care is a more equitable way forward for those who require services throughout life, and will go some way towards addressing the fact that disabled people are far more likely to live in poverty than non-disabled people.

3.4 How will the charging policies in social care be reconciled with health care which is said will remain "free at the point of need"?

With the integration of health and social care teams it will be increasingly difficult for front line workers to explain different policies regarding charging. There could also be organisational problems that relate to boundaries between the two sectors. There is scope for some costs to be saved and services made more seamless, but funding is key. As long as there remains an incentive for health services to shift costs there will be disharmony between the two sectors. Clear information will be required on a national and local level and a focussed public education campaign would help to assist front line workers.

Charging policies for mental health services should be based on a system to incentivise the most effective provision. Adult social care should be free at the point of need. Complex charging systems are inappropriate for those who cannot work and those who do work contribute most effectively through the normal tax system.

The current charging policies are confusing and give rise to inequity between areas, conditions and individual circumstances. There should be a full Government-led review to take into account changes in the way that health and social care are now delivered, and with the aim of introducing clearer and fairer national criteria. The Secretary of Stat has now acknowledged that the present means-testing regime is unsustainable.

Some differences in charging policies for health and social care are likely to remain a given, and hence restrict the development of integrated health and social care commissioning and service provision. They are also reflected in the tendency for cost-shunting at the boundaries between health and social care. There will be helpful lessons from the Scottish experience once the final report has been produced at the end of 2006 of introducing "free personal care". Moves to promote more self care in health may also colour the picture.

Proposals: The key points made by contributors were:

- Charging policies will cause problems in integrating health and social care teams and so clear national and local level information must be provided to help front line workers.

- Charging policies for mental health services should be based on a system to incentivise the most effective provision.
- There should be a full Government-led review to take into account changes in the way that health and social care are now delivered, and with the aim of introducing clearer and fairer national criteria

4. *Highlights from evidence on decision-making*

- 4.1 The White Paper proposes a shift of spending from acute services to prevention including more self-care. Who will be responsible for making decisions to ensure this happens?
- 4.2 How will accountability work in the new system? How will services address the risks and consequences of professional self-protection and multi-disciplinary teamwork blurring roles?
- 4.3 How can professionals ensure increased say for service users over what happens to them?
- 4.4 How can service users influence professionals to ensure a collaborative approach to decision making?
- 4.5 How can we shift from the precautionary principle, prevalent in the NHS and parts of social care, to a much more flexible approach to risk and opportunity?

Commenting on prevention Derek Wanless insisted that changing lifestyles is as effective as providing treatment. His early reports looked at long term projections primarily taking into account preventative measures in order to solve fundamental funding problems in the health system – long term. He also looked at the short term projections and budgeted for both. The long term programme of prevention, lifestyle change and integration (the “fully engaged scenario”) has not yet happened, four years after the report was published. This is because the budget for this programme has been squeezed in order to concentrate on short term delivery focussing on structural changes, even though the long term programme would have been the cheaper option. Sir Derek felt that the “fully engaged scenario” would be more difficult to execute now than in 2001, although it isn’t too late. In his opinion cultural change was more important even than structural change, by this he meant that the culture needed is one where people think more about prevention to enable individuals to take greater responsibility for themselves and engage both the public and health professionals to work in a different way.

Changing the culture is very much a long term need and continuing with this focus, Derek Wanless is adamant that Government should be continually monitoring demographics to calculate the long term impact of the sort of society that we have got and the way in which our society is going to require services. Since the economy is growing at 2.5% a year there is the capacity to solve these problems.

Inter-dependence as a concept is important for our individual and collective wellbeing and can be fostered in such a way to enhance and not compromise self determination and freedom of choice.

There are those who wish to control every aspect of their service through individualised budgets, and those who wish to be assisted to exercise some control, and those who want neither.

Proposals: The key points made by contributors were:

- The long term programme for health should be given more importance, especially finding ways of implementing the “fully engaged scenario” in order to change the culture from one of dependency

- Government should be applying mechanisms to continually monitor demographics in England to be prepared for future health eventualities for our society
- Outcome-focused targets will help to make the radical changes proposed in the White Paper into reality. Resources should be allocated to develop clearer outcome-based targets for measuring the performance of health and social care providers. Users and carers should be involved in helping to develop these measures.
- While individuals' rights should remain paramount, it must be recognised the welfare of a patient and that of the family member caring for them are often indivisible, so a whole-family approach should be taken to assessing the personal health and social care needs of both.
- It is important the decisions are made as close to the ground as possible by assessment teams including individuals needing services as well as professionals from health, social services, the voluntary sector and including advocacy and self-help organisations. True joint commissioning needs to join up all the relevant agenda's including housing and transport issues which are often not considered. It is also vital there are good step-up and step-down facilities to ensure that people can seamlessly access services according to their changing circumstances.

4.1 *The White Paper proposes a shift of spending from acute services to prevention including more self care. Who will be making decisions to ensure this happens?*

In theory this is the role of the PCTs and general practices. Research shows that general practitioners and other primary care staff have been slow to grasp the nettle of self care in their own clinical practice. Consequently, it seems unlikely that those leading commissioning will be able to shift the attitudes and practices of their colleagues unless additional incentives to do so are built into the system. Incentives are needed to change entrenched practice patterns to help switch the culture of dependency to one of prevention. These incentives should be built into professional education, clinical governance, performance assessment, appraisal and revalidation. Systematic feedback from patients can also be a part of these procedures which is something government is advocating with the recent policy document "Stronger Local Voice" (July 2006).

Previous undertakings to make the shift from acute services have not been delivered, and the risk is that in a period of reduced growth it will be even more difficult to make these changes stick. Strong political commitment will be required at ministerial level to secure the shift of spending, backed up with effective performance management measures to ensure delivery. There is also a need to educate the public, local politicians and people using services about the benefits of community support and prevention measures, and to increase incentives for self-care and early identification of health and care problems.

Proposals: The key points made by contributors were:

- A fully joined up approach should be embraced by PCTs and Social Services. The PCTs commissioning decisions will be influenced by the plans of GPs under Practice Based Commissioning and so a shift of spending will be informed by the needs of the population, the evidence of effectiveness, cost effectiveness and efficiency of preventative actions. This shift requires:
 - The development of robust methodology to define 'preventative spending'
 - PBC and commissioning in general needs urgent development and should be a top priority for the DH since it is being viewed as the brake on elective providers' oversupply and the main lever for moving money into community settings to develop new services (lack of direction may be the reason for GPs not yet embracing PBC)
 - A mechanism within the commissioning processes at local level to redirect savings achieved under PBR to reinvest in preventive activities

- A culture and ethos where, in the development of new models of care, all feasible preventive actions are prioritised for investment alongside treatment and care options
- Clear direction from central government to Health and Local Authorities; there has generally been a poor record of success in simply “encouraging” this change from commissioners;
- The establishment of single, local bodies with clear remit and control of pooled budgets;
- Ring-fenced grants to commissioners aimed at specific preventative / self-care services, funded where appropriate from existing budgets
- Local public services board/s local strategic partnerships should be evolved into the accountable bodies for joint outcomes, with LAAs as the statement of joint objectives and the Director of Adult services as the lead executive officer responsible for planning and implementation.
- Local Public Service Boards (LPSBs) should be responsible for making decisions that ensure the shift of spending from acute services to prevention, including more self care.
- Further work is needed to better organise services around particular groups of service users with complex needs. It also makes no sense to duplicate referrals and assessment processes when, with cross-training, one person could deliver a package of care. Resources must be allowed to shift between the health and social care where responsibility also shifts.

As local authority and health boundaries become harmonised geographically then this strategic / commissioning partnership will be responsible and accountable for ensuring the White Paper ambitions are delivered at a local level. This partnership could be expected to lead extended LSPs and actively involve main third sector providers, such as the voluntary sector and other key strategic partners, such as the police, within the local area.

4.2 How will accountability work in the new system? How will services address the risks and consequences of professional self-protection and multi-disciplinary teamwork blurring roles?

Accountability for providing health and social care lies with the PCT Board and Local Authority respectively. It will be necessary to streamline accountability arrangements in future in order to realise the potential of integrated working. New governance arrangements and powers of devolving decision making will be necessary.

For the White Paper objectives, such as the creation of personalised, individualised solutions, to be achieved it will be necessary to strengthen the accountability of professionals and teams to the people using their services. New models of professionalism will be needed, based on partnership working and power-sharing with service users, access to knowledge and involvement in decisions. Blurring of roles may be beneficial in terms of increasing flexibility of service response and improving the experience of service users. This does not have to be at the expense of quality professional practice.

Proposals: The key points made by contributors were:

- Streamline accountability arrangements for the PCT Board and Local Authority to realise the potential of integration.
- Strengthen existing systems, for example, Local Strategic Partnerships, to be accountable for joint agreements.
- Audit current care pathways to identify where they work well and where they don't and which health professional is involved.
- Health professionals should be trained on how to make patients more accountable for their own health

- Patient feedback should be used to provide an opportunity to measure progress and set targets for improvement at institutional, departmental, team and individual levels
- Develop a common system of accountability incorporating:
 - Maximum openness and sharing between care providers, with the agreement of the service user where possible
 - Patient, carer and community safety should be paramount
 - Deliberate or negligent withholding of information relevant to risk assessment should be severely penalised
 - Information sharing and accountability processes should included in external audit
 - Clarity as to which agency or individual is responsible for what, with a named individual responsible for co-ordination of information and decision making
- Ensure carer's views and role should be taken into account in risk assessment.
- Have clarity about roles and where professional's responsibilities and accountabilities sit within multi-disciplinary working, develop trust between the different professional roles and eradicate the blame culture.

Individual staff will retain their respective professional accountability. Organisations participating in the delivery of integrated health and social care services will be required by commissioners to meet clear government set standards of care delivered by suitably trained staff.

There is a potential for role blurring to occur when commissioned providers are contracting out to other organisations, e.g. in Practice Based Commissioning (PBC) GP's could "buy in" counselling services. However, if commissioning arrangements between purchasers and those contracted in to provide "extended" health and social care services become mandatory and transparent, then service specifications and targets against funding outcomes will be explicit and part of the local SLA contracts. If service boundaries are clear then professional boundaries will follow.

The model of the Practice Manager in GP surgeries or the Services Manager in acute settings are good examples of the need for key individuals to manage the operational aspects of the multidisciplinary business, allowing the clinicians and care providers to deliver quality provision at the coalface.

As local commissioning becomes clearer, and partnerships more effective this will set the tone for clarity at delivery level. The role of assessment and inspection and general accountability will then be shunted back to services.

4.3 How can professionals ensure increased say for service users over what happens to them?

Patients can play a distinct role in their own care by diagnosing and treating minor ailments, self-limiting conditions and by preventing occurrence or recurrence of disease or harm, by selecting the most appropriate form of treatment for acute conditions in partnership with health professionals, and by actively managing chronic diseases. Recognising these roles and seeking to strengthen them is fundamental to securing a more patient-centred approach to healthcare delivery, the central aim of the NHS Plan for England in 2000. A growing body of evidence demonstrates that patient engagement in treatment decisions and in managing their own healthcare can lead to more appropriate and cost-effective utilisation of health services and better health outcomes (Coulter & Ellins 2006). The key to greater patient engagement lies in building health literacy and ensuring that health professionals help patients to help themselves. This means a cultural change for health professionals and patients to change the way they think about their roles. Patients should no longer be seen simply as hapless victims of ill-health with

a duty to follow doctors' orders. Instead their right to make autonomous choices must be understood and facilitated by health professionals.

Patients need to understand the limits of medical care and the uncertainties surrounding the effectiveness and outcomes of most interventions. They must be actively encouraged to use health services appropriately and responsibly.

Proposals: The key points made by contributors were:

- A cultural change for health professionals and patients is needed in order to change the way they think about their roles
- The public should be educated into using health services responsibly with a campaign to inform them about the limits of medical care and the uncertainties involved in medical interventions
- Training is necessary to help health professionals engage patients into taking responsibility for themselves, to promote healthy behaviour
- A comprehensive engagement strategy should be compiled to assist professionals, patients and policy makers in ensuring a responsible society
- Ownership of the assessment process and their records by the service user rather than the professional is crucial and wherever possible self-assessment should be encouraged.
- There will need to be a plan to embed the skills and knowledge that underpin effective preventative work in the training regimes for all types of social care workers.
- Developing a model of accountability of the worker to their employer, and to the GSCC, service users and the public, provides a sound basic framework that could be developed for the new types of service organisations.

Areas where further steps could be taken to develop closer user involvement include:

- Service users being directly involved in planning and commissioning processes;
- Transparent individual initial assessments and reviews agreed with service users;
- Strict monitoring of failure to meet those assessments, fed back into planning and commissioning.

This needs to be reinforced by processes which make clear that risks which result from different responses are understood and accepted by service users, carers, families and the local community

The increased involvement of service users in assessing services should be further developed with resources for training, support and empowerment. A clear budget element should be built in to all tender processes to enable service user involvement.

There should be an audit cycle covering all aspects of the service where feedback from all stakeholders is fed into service assessment, provision, staff awareness and practice.

All professionals should be covered by a code similar to the GSCC Code of Practice requires Social Care Workers, supported by their Employers Code.

There are still basic barriers that need to be overcome: information and communication needs to be more accessible; the knowledge and attitudes of frontline staff (eg reception and medical staff) still causes concern; inflexible systems such as appointment systems that depend on someone being able to use the telephone; physical access barriers.

Solutions to these barriers include:

- Making resources available to ensure that existing health strategies are implemented, particularly NSFs

- Better consultation with disabled people
- It should be obligatory for PCTs to ensure that all front line staff attend disability equality training
- Healthcare Commission should monitor PCTs on their success in addressing barriers to access.

Independent local service user controlled organisations need to be supported, as recommended in the government report, Improving The Life Chances Of Disabled People (2005)

Many social care service users want more training and capacity building themselves (provided by experienced service users) in order to be involved more effectively.

More support is needed for user involvement in research and user research to strengthen social care's evidence base.

Leadership and management competence needs investment starting at induction to management and supervision and then continued through the full range of responsibilities.

The sector will need to develop skills in decision-making that both acknowledges and supports the participation of carers.

Training needs to focus professionals' attention on how they would want their own health and care needs to be met and then translate this into their own practice.

Social care has a longer tradition of working in partnership with service users than health care and this needs to be built in to models of multi-disciplinary working.

Commissioners need to engage with their local communities differently, and involve them in the planning, design and delivery of service.

Community engagement programmes can also provide a pool of potential health and social care workers from the local community,

Voluntary sector providers are uniquely placed to reach out to some of the most excluded people in our society.

The Healthcare Commission could also work alongside the voluntary sector to develop accessible information about mainstream health checks

Direct payments and individualised budgets:

- Service users value direct payments and we can expect the same picture to develop with individualised/personal budgets. More attention needs to be paid to developing infrastructures in association with service users and their organisations to ensure that individualised support schemes and budgets represent a cost-effective, durable and accessible alternative to traditional service systems.
- Individualised budgets should be introduced prior to 2012 so that they can be offered as a genuine alternative to direct payments for people who do not want the burden of managing a direct payment themselves.
- There is a risk that a big push on direct payments before individual budgets are in place will unnecessarily distort the market place and make it difficult for commissioners and service providers to plan for future provision.
- The notion of care brokers is a mechanism which will support service users to have increased say and access to the information.

- Individualised budgets should include funding for brokerage support to enable people to manage their individual budgets. There needs to be effective evaluation to ensure that service users are getting the support they require and that harder to reach groups are being targeted.

4.4 *How can service users influence professionals to ensure a collaborative approach to decision making?*

Outdated professional attitudes are preventing patients from playing the active role that most want and that could greatly increase the efficiency and effectiveness of healthcare. Patients should be encouraged to raise their expectations of involvement and to express their preferences more vocally. It is also the role of patients' groups to encourage their members to take more responsibility for their health.

Participation needs to be realistic, not tokenistic, and may require services and professionals to adjust their ways of working to hear and respond to users' perspectives. Models such as direct payments give people much greater say over what happens to them, and organisational and political blocks to increasing numbers on direct payments need to be tackled. Increasing access to information for people using services will help to promote collaborative working with professionals, and may enable more people to make their own arrangements for support.

The relationship between Patient and Public Involvement (PPI) Forums (**soon to be known as LINKs - Local Involvement Networks**), PCTs and Council Scrutiny Committees to allow a broader focus on patient's views needs to be nurtured to allow the public's and the patient's views to influence, for example, Practice Based Commissioning. There is a risk, however, that too broad a geographical remit for the functions of the PPI and CSC could make an effective relationship with commissioners difficult to manage.

PCTs might find it useful to view PPI Forums as the patients advocate and a member of a partnership between the NHS and the public. Working in this way can allow a genuine understanding to be developed among the PCTs medical staff, management and public representatives.

The White Paper does not offer the same transfer of decision making in the NHS as in social care. A strengthened health scrutiny function should be extended to practice based commissioning in order to review patient journeys within and across sectors.

The potentially revolutionary change in the White Paper is the shift of control over decision making to service users, through the introduction of Individual Budgets. This will create a challenge for commissioners and providers. For commissioners this front end activity and very intensive and the procurement activity that it generates is much more difficult to aggregate.

Proposals: The key points made by contributors were:

- PPI Forums should be seen as the patients' advocate working in a partnership between the NHS and the public
- Patient groups should help to encourage their members into taking more responsibility in their own health
- PPI Forums, PCTs and CSCs should ensure that the patient voice is heard and make a difference in directing new health programmes and initiatives
- Issues around the cross over between Direct Payments and Individual Budgets and continuing care will need to be resolved.
- Care staff should be expected to have accessed training in Values Based Practice.

- Values Based Practice is the theory and skills-base for clinical decision making where legitimately different, but potentially conflicting values are in play. This work is built around 10 principles. Prof Fulford and Kim Woodbridge have produced a practical workbook: *Whose values?* published by the Sainsbury Centre.
- Values are particularly important in the field of mental health with its complex interplay of issues around trust, power, responsibility, risk, and safety, duty of care and service user empowerment.
- Carers should also be involved in the process. The inducement for GPs to identify carers in the nGMS contract should be raised to a meaningful level.
- Each PCT and GP practice should be required to nominate a carers champion. Local services inspection could play a key role in ensuring that resources are adequate.
- The proposed NHS “Life Check” needs to include specific questions about caring responsibilities and be available to people of all ages. The proposed Personal Health and Social Care Plans should take into account the presence and needs of any carer and should also be available to carers themselves.
- Service users have to be provided with accurate and appropriate information and allowed time to learn about how systems work. All parties need to fully understand the collaborative approach and this will have to be demonstrated through outcomes, particularly when there are areas of disagreement or constraints to be managed. Professionals will have to truly collaborate.
- Health and social care commissioning could include a set of outcomes for providers based on service user collaboration and involvement. Providers could be required to evidence how they have enabled service users to engage in decisions connected to their own health and social care.

Once planning and budget cycles for the NHS and local authorities are aligned, all extended LSP’s will be expected to include “listening” initiatives in their strategic plans.

4.5 *How can we shift from the precautionary principle, prevalent in the NHS and parts of social care, to a much more flexible approach to risk and opportunity?*

Professionals (and politicians) have to be persuaded that traditional paternalistic practice styles undermine people’s confidence in their ability to look after themselves. In addition to the potential for achieving greater efficiencies in resource use, encouraging patients to take more control when they are ill could also prove to be an effective tool for improving public health. Replacing paternalism with a partnership approach can help to enhance a sense of self-efficacy. Helping patients to help themselves with the more serious illnesses as well as giving them the confidence to deal with their own minor illnesses themselves. Boosting patients’ ability to cope with the effects of disease could encourage them to take more responsibility for reducing risk factors and preventing ill-health. This is the best way to meet health and behavioural targets, as well as ensuring that the demand for healthcare resources is manageable. It will also empower the patient and help with self esteem.

This is partly a question of mind-set and an increased acceptance of the rights of individuals to take decisions on matters affecting their lives including risk-taking. It also reflects organisational and system rigidities, such as the influence of insurers on the procedures of home care agencies, which need to be surfaced and confronted. The development of more skilled and creative commissioning should help create a climate in which service providers are expected to maximise people’s opportunities for ordinary lives, not minimise their risks through excessive caution and intrusion. A stronger commitment to human and civil rights in the provision of social care would reinforce this message.

For there to be a safe transfer of control – and risk – to service users, there must be a safer and more assured environment for them to exercise their choices, with LAs providing clearer strategic direction and less fragmentation of infrastructures.

Proposals: The key points made by contributors were:

- Choice requires over capacity and this needs to be integrated into the system.
- There needs to be a discussion around joint performance monitoring and the consequences for future.
- Services must be planned around users and not structures. The providers also need to be involved in proceedings at all stages.
- Individual budgets should be well resourced, transparent and flexible, and for people with a learning disability to be properly empowered through effective support.
- Identify good practice and roll this out. Eradicate the blame culture and cultivate a learning culture. Form partnerships including service users signing up to managing their own risks. Move the emphasis away from Performance Indicators and targets that can inadvertently skew people's attention from the real outcomes. Successful risk management needs to be more publicly celebrated and shared to demonstrate what works.

Risk management currently focuses too heavily on protecting the workforce rather than enabling service users to take more control of their lives. However, risk assessments will continue to be a crucial part of all assessment processes and a balance will need to be struck in relation to enabling risk with support and information and ensuring appropriate protection for those who need it.

Whilst there is a need to balance risks for professionals and individuals, people living in an institutionalised setting are often assessed according to the level of challenges they present in that environment, but changing that environment may reduce the need for support.

Individuals will need to have sufficient information to make informed decisions about levels of risk, the current levels of risk that they face and the risks that they are prepared to take on.

5. *Highlights from evidence on integration*

- 5.1 How can we achieve better integration between health and social care, and how will cultural differences be overcome?
- 5.2 How should PCTs and Local Authorities work together to provide the new kinds of services?
- 5.3 How can the social care input into strategy development at the DH be strengthened, and how can the Cabinet Office enhance integration across government?
- 5.4 How can government achieve policy and service coordination beyond health and social care, and include DfES, DWP, DCMS, ODPM to bring in housing, benefits, work and training, leisure and culture.

A number of actions will be required to overcome barriers to integrated working: the development of shared posts (joint appointments); a bottom-up approach to re-examining prevention and treatment care pathways whereby job roles are identified from the tasks required; work with Higher Education Institutions; engaging clinicians in service review and development.

There is also a risk of a greater divide developing between providers of unscheduled care and chronic disease management. New nursing roles need to be clearly connected and there is a need for primary care health teams to be further developed, or as is the case in many parts of

the country, reinstated. There is a critical role for GPs working in collectives through PBC in developing strong care networks. Clinical leadership is also required to fulfil the ambitions of reform.

Proposals: The key points made by contributors were:

- Develop shared posts to help with the integration between health and social care
- Good clinical leadership in order to implement reform, ensure successful integration and direct health and social care policy

5.1 How can we achieve better integration between health and social care, and how will cultural differences be overcome?

Health and Social care services come from entirely separate financial and statutory systems that reinforce differences in both funding and culture. Integration of services is extremely difficult to achieve with these differences: when is a bed bath a health bath or a social bath? As far as the public is concerned the social care bath is means tested and the health care bath is free. Cultural issues can be overcome where local relationships between professionals are encouraged and work well. Even here though, working practices in pay and conditions are different in the NHS from Local Authorities; and education and professional development is very different for nurses and social workers.

It is important to recognise, and not gloss over, the different cultures, histories, constitutional arrangements, relationships with people using services, and funding levels of the NHS and social care. There are also cultural differences within social care (eg between statutory and private sectors) and the NHS (eg the GP and consultant contracts). Some of these differences can get in the way of effective partnership working and create gaps in understanding, practice and service provision. There are steps the Department can take, eg to develop integrated rather than separate performance assessment frameworks. At local level, the effect of cultural differences can be reduced if there is a clear focus on the individual and incentives to shape services to people's preferences and needs instead of fitting people into rigid services.

The nationally driven restructuring of PCT boundaries with Local Authorities may lead to better integration, although the disruption caused by this process will delay further implementation of integrated working. It is too soon to say whether the process will unsettle existing integration.

Integration may also be improved by encouraging the use of existing flexibilities through, for example, the use of related NHS targets. Now that PCTs are separating their provider arms from their commissioning functions, integration would be aided with the establishment of joint health and social care commissioning teams. Their role would be to commission a complete package of care for a given episode of illness. Cultural differences will be overcome with the establishment of joint management teams, a shared vision and targets and joint delivery teams with generic care staff. Work is required to align human resource issues (pay and conditions, pensions etc) between the NHS and Local Authorities, particularly when individuals move between organisations.

Genuine integration will only be achieved when we have a streamlined and integrated performance management framework. National and local government should agree a list of some thirty national outcomes which local government will take responsibility to deliver, with its LAA partners. These will be backed by locally-drawn targets and a new performance management regime, enabling the removal of national targets, performance indicators, specific grants, ring-fenced funding and financial bidding systems.

Proposals: The key points made by contributors were:

- Joint health and social care commissioning teams will be necessary to help with issues of integration
- Establishing joint management teams will overcome cultural differences and ensure a shared vision and targets
- Aligning human resource issues between NHS and Local Authorities will be necessary to allow smooth integration.
- Governance within local authorities and across the public sector will need to be developed.
- Social workers are keen to be an integral part of the more person, local and accessible service that the Government is seeking to establish.
- There needs to be clarity in the interface between national priorities and local control
- Better links are needed between Primary Care Trusts, Local Authorities and Strategic Health Authorities particularly to support joint planning and commissioning
- The commissioning capacity is very poor and needs strengthening
- We need to move to sector neutrality and start focusing on outcomes not who delivers them
- A better approach is needed to assessment and integration between health and social care assessment.
- Social care workers have something distinctive to bring to the mix – in particular the focus on the involvement of service users in planning provision can offer a powerful tool for ensuring that integrated services are flexible and effective.
- Joint work between the different regulators would be a powerful means of smoothing the way to effective integration.
- Social care needs a stronger voice at the most senior levels in the Department of Health. The very few Department of Health staff working on social care by comparison to the numbers working on the NHS is of real concern.
- CSR means that discussion about future funding of the social care sector will be vitally important – the vital case for social care must be put in those discussion and any local of capacity within the Department of Health will make this harder.
- Better alignment of job outlines and terms and conditions with clear progression structures. Parallel working, shadowing and more joint training and joint recording mechanisms. The complementary elements of health and social care need to be effectively demonstrated to people working in both sectors to encourage more joint working.
- Inspection could be a lever to achieve better joint working on commissioning.
- Local area agreements will be strengthened to develop them as a key mechanism for joint delivery between the NHS and social services.
- Two other levers include: practice based commissioning, which will extend and expand patient care closer to home and improve both access and responsiveness for patients, and payment by results with a tariff designed to stamp out perverse incentives to do more work in the acute sector, and allow different providers to be paid for different elements of treatment, will be crucial to delivering the White Paper.
- A new kind of delivery model, such as Connected Care, should be developed for people with complex needs living in deprived neighbourhoods. They would provide a single point of entry for a recognisable clear geographical area and its population, usually delivered on an estate basis. It integrates health and social care services as well as bringing in support across housing, employment, community safety and transport to provide a wide range of support that bring together universal services with targeted support for those with complex needs.
- Cultural differences need to be overcome. The new ethos of health and social care is that a person's role should be determined by their skills base, rather than their professional background or the title that is attached to the role. All staff needs to be much more solution-focused.
- A multi-disciplinary approach between health professionals, particularly in primary care, pharmacists and the voluntary sector is essential.

Concerns: The key points made by contributors were

- The approach to individuals and assessment by GPs, community nurses and social workers is entirely different.
- Despite recent changes to introduce more flexibility into partnership working, there will still be significant barriers to ensuring patients are cared for in the most suitable location for their needs. These include: different charging regimes as the interface between social and health care becomes blurred; different accountability requirements; different staff terms and conditions of service and health professionals current understanding of how social care works, its scope and interventions.

5.2 *How should PCTs and Local Authorities work together to provide the new kinds of services?*

The White Paper emphasises the policy shift towards prevention and away from reactive acute services. This will not merely involve a restructure of existing services, but will mean the creation of new services by new staff in new settings. The reality is that it will need both significant time and significant investment from both PCTs and Local Authorities.

There is also a need for effective profiling of communities and for PCTs and Local Authorities to concentrate on commissioning pathways of care. Public health has an important role to play in linking together commissioning strategies at local authority, PCT and PBC levels

Some of this is happening already through Local Strategic Partnerships, urban renewal programmes and multi-agency workforces. These could be formalised. The community strategy needs to include health on a more substantive basis. Public sector schemes need to be reviewed together and not in isolation with better use of Local Development Frameworks.

There is need and scope for investing in the development of much more skilled and sophisticated commissioning on the part of PCTs and local authorities, both in their separate roles and in joint working. Benefits can flow from working together on assessing needs at individual, locality and strategic levels, commissioning for outcomes, promoting person-centred solutions and services, encouraging innovation and flexibility, exchanging information and engaging with people using services. Not everything has to be done jointly, but as far as possible primary and social care provision should be complementary and well-coordinated, with clear protocols for joint working and incentives to apply resources flexibly to gain best value.

Proposals: The key points made by contributors were:

- Public sector schemes should be reviewed together with better use of Local Development Frameworks to ensure effective pathways of care are developed.
- New arrangements will have to be established based on integrated service user/patient pathways.
- Local partners need to agree the overarching strategic vision, rooted in local priorities. The LA and PCT will then work in partnership to delivery this vision which should be supported by integrated commissioning and quality assurance processes, joint workforce planning, and an effective, shared, local performance management framework.
- Coordination of regional groups, such as ADSS, CSIP and IDeA could be the answer to creating capacity. This is not a stepping stone to a regional structure but a pooling of resources.
- Social workers should be deployed in the places where a need for their service is likely to be first identified (eg A&E, health centres and schools). This would require either a significant

increase in established posts or a more traditional, generalist frontline social work role backed up by specialist practitioners.

- Frontline workers conditions should be improved. Successive restructuring of statutory services has seen the creation of more highly paid posts, rather than significant improvements in the working conditions of frontline workers.
- Outcome targets need to be set in key areas for both health and social care agencies.
- Monies used to promote pilot work should be adequate, and where successful their needs to be a drive to roll-out services across the country.
- There needs to be more systematic regulation, otherwise change will be patchy.
- National performance targets for adults with physical disabilities need to be a higher priority in order to impact on local targets.
- There is a need to develop more common standards in training in the health and social care sectors.
- The use of performance indicators that better align health and social care outcomes will help to focus individual organisations locally to work together to achieve common aims.
- Health and social services should co-publish their commissioning strategies and plans – this will enable assist providers to respond to local need.
- Providers and service users should be given opportunities to inform commissioning and service design.
- Service commissioners need to be encouraged and regulated to work together and to look beyond territorial boundaries in terms of professional roles and financial responsibility.
- Move away from punitive policies such as delayed discharge that pit organisations against each other and move instead to a system that rewards effective joint working.
- There should be nominated senior leads in both PCTs and in local authorities (a senior professional and a councillor) for work themes, including the theme of supporting carers. Explicit in all their roles should be the requirement to promote joint working.
- Local multi-agency “Change groups” should be set up – comprising representatives at a strategic level from each agency – to oversee change.
- For a combined response to meet some of the health and social care needs of the population, those commissioning services would need to identify concurrent funding streams for e.g. mental health support services and palliative home care – or even look to shared budgets with the Local Authority to commission social care for vulnerable groups.
- The role of social enterprise organisations should not be overlooked. Social enterprise organisations bring links with the community; a can do attitude; greater flexibility and the ability to deliver specialist services that target people often missed by statutory agencies.
- The Third Sector Commissioning Task Force will address the key barriers to a sound commercial relationship between the public and the third sector.
- New kinds of services can be delivered through APMS. APMS contracts could be the mechanism which enables PCTs and local authorities to work together, by including the voluntary sector as key provider of new kinds of services.
- The other routes such as General Medical Services (GMS), Personal Medical Services (PMS) which includes Specialist PMS, and Primary Care Trust Led Medical Services (PCTMS) could be keys to building the three way partnerships to health and social care delivery.

Concerns: The key points made by contributors were:

The current approach to national procurement for primary care services for deprived areas appear to be narrowly focussed on the GMS elements of care, seeking merely to have these re-provided, without seeking to address the possibilities presented to adopt a completely new and fresh approach that brings funding streams together to commission truly holistic integrated services.

5.3 How can the social care input into strategy development at the DH be strengthened, and how can the Cabinet Office enhance integration across government?

The appointment of a minister for public health would be a stronger role if it were a cabinet position existing therefore outside the Department of Health. The minister would then have the freedom to concentrate solely on the public health agenda without it being overshadowed by a concern with health services and their performance. The public health minister role is an opportunity to co-ordinate public health activity across government departments.

The Cabinet Office needs to address some of the contradictions between different policy initiatives such as the confusion and complications inherent in the strategic commissioning of services and the move to personal budgets. Commissioning and contracting processes that facilitate personal commissioning by users should be established now.

The benefits will need to be clearly demonstrated to each department. It would be useful if providers and practitioners out on the ground are asked for information and examples of innovation that can then be shared across government and issues of transferability identified.

Organisations such as SCIE and CSIP obviously have a crucial role to play in enhancing integrations across government.

The appointment of the Director General for Social Care at Board level in DH is a crucial step forward, and should add a stronger voice to social care in contributing to strategic policy development and implementation. The post needs to be well supported by staff with the necessary levels of social care expertise, to fill the vacuum left by the removal of SSI staff, and must be able to access staff resources in other sections of the Department, particularly the Directorates for Workforce, Commissioning, Partnerships, R&D, Finance and EOR. Social care is a large and complex sector, with a bigger workforce than the NHS and a multiplicity of employers and providers. The Department needs to get better at engaging with its social care stakeholders, particularly people using services, the private and not for profit sectors, and front line staff. SCIE also has contributions to make in feeding in to DH the knowledge base for good practice and service improvement in social care, and working with the relevant regulation, training and improvement bodies to strengthen knowledge-based working.

Proposals: The key points made by contributors were:

- A minister for public health should be appointment and given a cabinet position. The public health minister can co-ordinate public health activity across government departments.
- Social care organisations such as SCIE and CSIP should be utilised to help enhance integrations across government

5.4 How can government achieve policy and service coordination beyond health and social care, and include DfES, DWP, DCMS, ODPM to bring in housing, benefits, work and training, leisure and culture?

There needs to be a single strategy approach between many of the government policy departments. Currently there are often conflicting policies that have then to be worked through at a service delivery level in terms of management and implications, because there may often be no change to targets and objectives that are required in terms of Departmental objectives. It would be useful to have a single plan that brings together the key objectives of each of these areas becoming a policy that is adopted across a number of areas. This would then require each of those departments to develop a strategy to deliver these objectives which could then be filtered down in respect of specific targets, including large targets. There should be strong communications and ownership of policies between Government departments delivering against

a common agenda. In practice just as we might ask a district nurse and a social worker on the frontline to be able to describe what their role is in achieving their organisations' objectives we should be able to do across each of the government departments. This will mean the health and social care agenda will allow culture differences to be overcome, action to address whether single organisations should be encouraged or developed should be considered as should the impact of widening the market.

This issue relates also to the question of Cabinet Office coordination. There is now a growing understanding that achieving the White Paper objectives of promoting independence and choice, tackling social exclusion, increasing wellbeing and improving life chances for children and adults is not just a matter of social care provision. Contributions and improvements are needed from a range of other services, including housing, education, training, employment, benefits, leisure, transport, regeneration and community development. Responsibility for policies and practice in these areas rests with a number of government departments, and their record on joined up strategies and initiatives is not good. Yet people using services make it clear that these other services often play a larger part in their lives and wellbeing than health or social care, and that the fragmentation of current provision makes for real difficulties and obstacles to their achieving a good quality of life. The development of a DH presence in the Government Regional Offices may be a vehicle for achieving a better coordinated approach, at least at the level of policy implementation and performance monitoring. Here again, SCIE is well placed to provide knowledge-based advice and support to the range of departments involved.

Local Area Agreements agreed with the ODPM is another opportunity to agree joint health policies across departments. Locally all these issues are joined up in the Local Strategic Partnership.

The Office of Disability Issues (ODI) can play a role in helping to integrate policies across Whitehall. The ODI, whilst based in the Department for Work and Pensions, has a cross-Governmental remit and is therefore ideally placed to work towards ensuring policy continuity throughout departments. If coherence across Whitehall can be achieved then coherence across local government is the next important step. Ensuring that the policy proposals from central government are successfully enacted at a local level should be addressed within a Local Government white paper, further highlighting the need for cross-departmental working at the genesis of social care policies.

Anticipated savings such as reducing the numbers on incapacity benefit and increasing the numbers in and returning to work will be realised outside the health and social care budgets and need to be at least partially transferred to health and social care to encourage the continued investment.

There are various requirements in legislation (particularly the Carers Equal Opportunities Act 2004) to promote co-operation between social care and other public services. Many local authorities have published carers' strategies, but far fewer PCTs have carers' strategies and there are still even fewer joint carers' strategies, which will be needed to implement the White Paper. A couple of local authorities have a joint assessment and working protocol between their children's and adults' services, which particularly benefits young carers by ensuring that adults' services enable disabled adults to find adequate professional support, rather than relying on their children for care (see model protocol at www.youngcarers.net/professionals).

Carers come into contact with all health and social care specialities and are affected by a range of other Departments. Therefore the Cabinet Office can ensure that all Government Policy documents which are relevant are proofed to be carer friendly. It is important that good practice guides to new legislation promote joint working. For example, when the Practice Guide is produced for Flexible Working within the Work and Families Bill for Carers, there should be a

reference to ensuring that a request for flexible working by a carer is assisted by appropriate support services for that carer under the Carers Equal Opportunities Act 2004.

'Our health, our care, our say' focuses on the development of community based services which respond to the needs of people who use services. This should also be the focus of health and social care organisations rather than expending energy on organisational integration.

Coordination can be achieved by demonstrating the benefits of doing so and the disadvantages of not doing so. Everyone has health and housing, social and employment needs, they cannot be viewed in isolation and as discrete from one another. For example there is so much evidence available about the impact of poor housing and homelessness on people's health. There are excellent examples in the voluntary sector of joining these agendas together and these need to be used to demonstrate the benefits for individuals and the wider preventive benefits of ensuring that everyone has all these elements of their lives appropriately met. This is actually at the heart of person centred approaches and if all policy and service provision was truly focused on the people requiring services this would become an automatic outcome.

Proposals: The key points made by contributors were:

- A single plan should be developed including key objectives across all departments for health and social care to become policy adopted by relevant departments.
- Strong communications and ownership of joint policies between Government departments delivering health and social care, perhaps using Local Area Agreements.
- A CLP sub group is being developed on health and wellbeing. This would be a way for Government to achieve policy and service coordination beyond health and social care.
- Ensuring that the policy proposals from central government are successfully enacted at a local level should be addressed within a Local Government white paper, further highlighting the need for cross-departmental working at the genesis of social care policies.
- Anticipated savings such as reducing the numbers on incapacity benefit and increasing the numbers in and returning to work will be realised outside the health and social care budgets and need to be at least partially transferred to health and social care to encourage the continued investment.
- Everyone has health and housing, social and employment needs, they cannot be viewed in isolation and as discrete from one another.

6. Conclusions and recommendations

The All Party Group on Primary Care and Public Health and the All Party Group on Social Care would like to take this opportunity to thank those who submitted evidence to the inquiry. Comments were very broad ranging and extremely helpful in compiling the joint report. Whilst the body of the report contains the views, including concerns and proposals made by those who gave evidence to the inquiry, the Groups would like to make it clear that these conclusions and recommendations are those jointly agreed by the two Groups.

1 - Conclusions

Funding

1.1 The Groups agree with the evidence presented by Sir Derek Wanless and others that current levels of funding are insufficient to meet present and predicted demographic pressures, in particular the growing numbers of the very old with high levels of disability.

1.2 The Groups agree that a reconfiguration of existing provision and resources will be necessary to achieve the increase in preventative health and social care services envisaged in the White Paper.

1.3 The Groups note that the level of charges for domiciliary social care is very unpopular with service users and acts as a deterrent from using such services for those with income above entitlement to free provision. This often leads to earlier use of more expensive institutional care.

Decision-making

1.4 The Groups strongly support the case for significantly increasing investment in prevention and community support services, and the evidence submitted to us suggests that this is what most people want.

1.5 The Groups believe a range of measures will be needed, including advocacy, brokerage and other participation, choice and control strategies, to ensure a stronger voice for people using services, particularly those with complex needs requiring a range of services from different sources

1.6 The Groups acknowledge that both the NHS and social care depend heavily on the huge amounts of support provided by caring families and friends, without which the statutory services would be overwhelmed, and consider current investment in carer support to be inadequate.

1.7 The Groups recognise that in developing a health and social care strategy for the long term Government should fully engage patients / clients in order to change the culture from one of dependency. This will require changing the role of health professionals so that they accept responsibility to provide health literacy, support self-care and self management and actively involve patients in treatment decisions.

1.8 The All-Party Groups note that it will be important to embrace a fully joined up approach by PCTs and social care agencies and acknowledge that PCTs' commissioning decisions will be influenced by the plans of GPs under Practice Based Commissioning. Any resultant shift in spending should be informed by the needs of the population, and evidence of the effectiveness, and efficiency of preventative actions.

Integration

1.9 The Groups recognise that the majority of working age and older people with physical, sensory, intellectual and mental health problems require support from both the NHS and social care, and need more flexible and joined-up responses and need help to negotiate an ever more complex system.

1.10 The All-Party Groups consider that closer coordination and integration of NHS, social care and wider local authority services will require better aligned priorities and more investment in infrastructure mechanisms and retraining, but should deliver increased service coverage and better value for money.

1.11 The Groups agree that new nursing roles need to be clearly connected and that there is a need for primary care health teams to be further developed, or as is the case in parts of the country, reinstated.

2 – Recommendations

Funding

2.1 The Comprehensive Spending Review (CSR) must acknowledge and make provision for the demographic pressures on Local Authority and NHS care and training budgets reflecting growing numbers of disabled children and young people with complex needs, adults with multiple disabilities suffering social exclusion, and the sharp rise in older people with combinations of physical, sensory and intellectual impairments.

2.2 The CSR should make provision for new money to address the issue of health inequalities and the need for training and development of the work force for their new role.

2.3 Government should take further steps to promote maximum flexibility in the use of resources, including wider opportunities for pooled budgets, greater financial and decision-making delegation to front-line staff and people using services, schemes to combine statutory and community resources, and safeguards against cost-shunting.

2.4 The rationale for and impact of charging for domiciliary care should be rigorously re-examined. A public debate on funding for social care might help to explore alternative solutions.

Decision-making

2.5 In order to embed decision making in primary health care, social care and preventative services, there must be an effective and efficient redirection of resources and the provision of special transitional funding to create new primary care facilities, retrain staff and build confidence in the restructuring among local communities before dramatically reconfiguring acute services.

2.6 The Groups recommend that the NHS computerised patient database should include health and social care information and this database should be made available to health and social care agencies in order to coordinate care where the patient is identifiable on a patient consent basis.

2.7 Government should introduce a mechanism within the commissioning process at local level to redirect savings achieved under PBR (Payment By Results) to reinvest in preventive activities enabling a culture and ethos where, in the development of new models of care, all feasible preventive actions are prioritised for investment alongside treatment and care options.

2.8 PCTs and social care agencies should ensure patient feedback is used to provide an opportunity to measure progress and set targets for improvement at institutional, departmental, team and individual levels.

2.9 Local Authorities and NHS Trusts should be required to publish their strategies, targets and results for effective user and carer participation in priority-setting and service development.

2.10 The Government must recognise and respond to the need for, and benefits of, increased support and respite provision for carers. The Government should set a national standard for the level of support that should be available to carers taking into account all the circumstances of the family.

Integration

2.11 The NHS and local authorities should designate a lead professional to coordinate responses for each person with complex needs and/ or requiring care and support from two or

more services. There should be available robust mechanisms to ensure a smooth transition from children services to adult services for those with complex needs, and as necessary from adult to elderly services.

2.12 The CSR should examine the costs and benefits of investment in coordination and integration mechanisms to make the fullest use of all available health, social care and community resources.

2.13 The public health agenda would be executed more effectively if the minister for public health were a cabinet position. The minister would then have the freedom to concentrate solely on the public health agenda since his role would be outside the Department of Health.

Annexes

7. Annex 1: All Party Group on Primary Care & Public Health Membership

Officers

Dr Howard Stoate (Co-chair)
Baroness Gardner of Parkes (Co-chair at the time of the inquiry)
Anne Milton (Co-chair)
Paul Burstow (Co-chair)
Stephen Hesford (Secretary)
Laura Moffat (Treasurer)
Baroness Masham of Ilton (Executive officer)

Members of Group

Baroness Eccles of Moulton
John Austin
Kevin Barron
Hazel Blears
Andy Burnham
Dr Vincent Cable
Baroness Cumberledge
Jim Dobbin
Clive Efford
Michael Fabricant
Paul Goggins
Dr Evan Harris
Baroness Hooper
Joan Humble
Lord Hunt of Wirral
Lynne Jones
Andrew Love
Baroness Pitkeathley
Lord Rea
Lord Rix
Helen Southworth
Gareth Thomas
Mark Todd
Sandra Gidley
Douglas Carswell
Rosie Cooper
Lynda Waltho
Barbara Keeley
Julia Goldsworthy

8. Annex 2: All Party Group on Social Care Membership

Officers

Joan Humble (Chair)

Paul Burstow (Co-chair)

Mark Pritchard (Co-chair)

Julie Morgan (Treasurer)

Anne Coffey (Secretary)

Members of Group

Liz Blackman

Peter Bottomley

David Burrowes

David T. C. Davies

Nadine Dorries

Evan Harris

Adam Holloway

Paul Holmes

Stewart Jackson

Tom Levitt

Stephen McCabe

Madeline Moon

Kali Mountford

Paddy Tipping

Betty Williams

9. Annex 3: Contributors of Written and Oral Evidence

Acevo (Third Sector Leaders)
Age Concern England
Association of Directors of Social Services (ADSS)
BASW (British Association of Social Workers)
Blackpool Primary Care Trust
BMA (British Medical Association)
Commission for Social Care Inspection (CSCI)
English Community Care Association
Faculty of Family Planning and Reproductive Health Care (RCOG)
Faculty of Public Health, (RCP)
General Social Care Council (GSCC)
Leonard Cheshire
Local Government Association (LGA)
Long-term Medical Conditions Alliance (LMCA)
The Medical Property Investment Fund
Mencap
Mental Health Providers Forum
NHS Confederation
The Picker Institute
The Princess Trust for Carers
PSNC (Pharmaceutical Services Negotiating Committee)
RCN (Royal College of Nursing)
Rethink
RCGP (Royal College of General Practitioners)
RCOG (Royal College of Obstetricians and Gynaecologists)
RCP (Royal College of Physicians)
RPSGB (Royal Pharmaceutical Society of Great Britain)
Salford Primary Care Trust
Scope
Shaping Our Lives
Skills for Care
Social Market Foundation (SMF)
St Anne's Community Services
Turning Point
United Kingdom Home Care Association (UKHCA)
Sir Derek Wanless

10 Annex 4: *Glossary*

A&E:	Accident & Emergency
ADSS:	The Association of Directors of Social Services
APMS:	Alternative Provider Medical Services
CSCs:	Council Scrutiny Committees
CSIP:	Care Services Improvement Partnership
CSR:	Comprehensive Spending Review
DCMS:	Department for Culture Media and Sport
DfES:	Department for Education and Skills
DH:	Department of Health
DWP:	Department for Work and Pensions
EOR:	Equal Opportunities Review
GMS:	General Medical Services
GP:	General Practitioner
GSCC:	General Social Care Council
IDeA:	Improvement and Development Agency for Local Government
LAAs:	Local Area Agreements
LAs:	Local Authorities
LiNKS	Local Involvement Networks (Former Patient and Public Involvement Forums)
LPSBs:	Local Public Service Boards
LSP's:	Local Strategic Partnerships
NHS:	National Health Service
NSFs:	National Service Frameworks
ODI:	Office for Disability Issues
ODPM:	Office of the Deputy Prime Minister
PBC:	Practice Based Commissioning
PBR:	Payment by Results
PCT:	Primary Care Trust
PCTMS:	Primary Care Trust Led Medical Services
PMS:	Personal Medical Services
PPI (Forums):	Patient and Public Involvement (Forums)
R&D:	Research & Development
SCIE:	Social Care Institute for Excellence
SLA:	Service Level Agreements
SSI:	Social Services Inspectorate

