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Communities and Local
Government Committee

Adult social care

Ninth Report of Session 2016–17

*Report, together with formal minutes relating
to the report*

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Communities and Local Government Committee

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Committee staff

The current staff of the Committee are Mark Etherton (Clerk), Tamsin Maddock (Second Clerk), Craig Bowdery (Committee Specialist), Nick Taylor (Committee Specialist), Tony Catinella (Senior Committee Assistant), Eldon Gallagher (Committee Support Assistant), Gary Calder (Media Officer) and Alexander Gore (Media Officer).

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Executive Summary

Key facts

- Fewer than one in twelve Directors of Adult Social Care are fully confident that their local authority will be able to meet its statutory duties in 2017–18 (Paragraph 13)
- 28% of care services are inadequate or require improvement (Paragraph 18)
- Some councils pay £2.24 an hour for residential care (Paragraph 42)
- 96% of people paying for their own care pay on average 43% more than state funded residents in the same home for the same room and the same level of care (Paragraph 53)
- The turnover rate for nurses working in social care is 35.9% (Paragraph 78)
- 47.8% of care workers leave within a year of starting (Paragraph 78)
- The median hourly pay for a care worker is £7.40 (Paragraph 80)
- 160,000 to 220,000 care workers in England are paid below the national minimum wage (Paragraph 81)
- 49% of home care workers are on zero hour contracts, compared with 2.9% of the workforce nationally (Paragraph 85)
- 27% of care workers received no dementia training and 24% of those who administer medication were not trained to do so (Paragraph 86)
- Between 2010–11 and 2013–14, the number of unpaid carers increased by 16.5%, while the general population grew by 6.2% (Paragraph 102)
- In Leicester, although 30,000 people identified themselves as a carer in the 2011 Census, only 2,200 carers were in contact with the council (Paragraph 107)
- One in five unpaid carers providing 50 hours or more of care each week receives no practical support from the local authority (Paragraph 110)

This report should be read with [Adult social care: a Pre-Budget Report](#). Taken together these reports describe the funding pressures on adult social care and their very serious consequences, and make the case for immediate extra funding. In addition, this report explores progress on integration of health and social care services and innovation in the provision of social care. We also set out what needs to happen to ensure that social care is funded sustainably in the medium and long terms.

The impact of funding pressures on adult social care

We believe that inadequate funding very seriously affects the quantity and quality of care that is being provided to people, the National Health Service, care providers, the

care market, the way that care is commissioned and the workforce and unpaid carers. We examine the evidence in paragraphs 8 to 119, and conclude that constraints on funding have led to:

- Councils providing care and support to fewer people and concentrating it on those with the highest needs.
- Care becoming the minimum required for a person to get through the day.
- A deterioration in the overall quality of care, which is likely to continue.
- Increases in the number of delayed discharges from hospital and in emergency admissions, related to councils increasingly directing their resources towards services for people with higher levels of need rather than preventative services.
- Serious threats to care providers' financial viability, which mean providers failing, exiting the market and handing back contracts for provision of care services.
- Reliance by care providers on their privately paying clients to subsidise local authority funded clients by paying higher costs for the same care.
- Increase in demand, problems with supply and significant shortages in the workforce, which have affected the stability of the care market.
- The undermining of councils' abilities to fulfil their duties to shape the care market in order to provide diverse and high quality care for all people in their area.
- The pursuit of low fees becoming the driving factor in commissioning for many councils, undermining their relationships with care providers.
- Severe challenges in the care workforce, manifested in high vacancy and turnover rates, which result from low pay not reflecting the amount or importance of the work involved, poor employment terms and conditions, lack of training and lack of opportunities for career progression.
- Increasing reliance on unpaid carers, who are providing more hours of higher level care as councils have reduced the amount of care they provide.
- Councils being unable to fulfil their statutory duties to identify, assess and meet carers' needs for support, which has consequences for carers' health and well-being and their ability to stay in work.

This is why, in our Pre-Budget Report, we recommended that **extra funding (in the form of the £1.5 billion 2019–20 tranche of the improved Better Care Fund) should be made immediately available to meet the shortfall in 2017–18** and that the **Government should commit to closing the adult social care funding shortfall for the years to 2019–20, in line with the amount that the National Audit Office estimates is needed**. While we welcome the Government's commitment to provide an additional £2 billion for social care over the next three years, this falls short of the amount we believe is required to close the funding gap.

We recognise that increased funding alone is not the solution, and make a range of other recommendations (which are set out in full at the end of this report) for action. Our key recommendations concern care commissioning, monitoring of care services, and the workforce:

Care commissioning

Councils are required to facilitate and promote high quality care, personalised care and support for all people in their local area, including self-funders, through their market shaping and commissioning activities. We found that funding pressures are undermining the relationships between councils and providers, thus affecting councils' ability to work with them to shape the market. Funding pressures have similarly affected the commissioning process for both councils and providers, with the pursuit of low fees becoming the driving factor in commissioning for some councils. We also heard evidence from providers about poor commissioning practice, unfair contracts and depleted commissioning teams.

- **The Care Quality Commission (CQC) should oversee the market shaping, commissioning and procurement activities of councils.**
- **A standard process both for assessing the costs of care, taking into account local variations in wage rates, and for setting fair prices that reflect costs, would help guide local authorities in setting fees.**

Monitoring

The evidence we heard suggested that not all councils routinely monitor the care services they procure to ensure that they are sufficient to meet people's needs, or are of a high enough quality and adequately resourced, for example to pay for care workers' travel time and 'sleep ins'.

- **Councils should annually audit the services they commission, should regularly carry out spot checks to ensure that people are actually receiving the care they require and ensure that providers are paying staff the national minimum wage, covering care workers' travel time, travel costs and 'sleep ins'. The CQC should oversee councils' monitoring arrangements.**

The workforce

The high vacancy and turnover rates, particularly among nurses in social care, point to severe challenges in the social care workforce. We heard that a range of factors contributed to these. These included low pay not reflecting the amount or importance of the work involved, low status, poor terms and conditions, and lack of training opportunities and career progression.

- **The Government, working with the Local Government Association, should publish a care workers' charter, which would set out what care workers can expect from their employer on wage levels, employment terms and conditions, training and career development.**

- **To ensure a high quality and sustainable workforce which keeps pace with demographic change, the status of care work must be improved. Better pay, commensurate with skills and responsibilities, and better terms and conditions, including pensions, will be part of this, as will the development of a strong career structure—from apprenticeship to registered nurse—and centrally delivered training with national standards and qualifications, similar to the NHS Knowledge and Skills Framework.**

Organisation of health and social care services

The complexity of the social care system and its interaction with the NHS and other services, such as housing and benefits, is very clear. The evidence we received highlighted the Disabled Facilities Grant as an example of how the structure of the system hindered service delivery, and we look at this in detail in paragraphs 122 to 124. Integration of health and social care services aims to reduce complexity by streamlining services, as well as improving people's outcomes and achieve efficiencies.

Integration: closer working between health and social care

We believe that integration of health and social care has great potential and that it is the right direction of travel, given the increasing demand for services and the need to improve patients' experiences and ensure they are at the centre of how care is organised. However, we found that:

- The time needed for such large-scale changes to take place is significant—we heard that it could take up to ten years to achieve the necessary cultural and system changes;
- Progress, which is dependent on good local relationships between health and social care, varies across the country;
- There were various barriers to integration—including organisational differences between the NHS and local government; different payment systems; different regulatory, performance and outcome frameworks; workforce challenges and lack of funding for social care; and
- There is little evidence on the benefits of integration, both in terms of patient outcomes and efficiency savings.

We therefore recommend that the Government be more realistic in its expectations for integration and that it addresses the barriers to integration by, for example, setting out a strategy with Skills for Care and Health Education England, for aligning the health and social care workforces.

We believe that the inclusion of local councils in planning for integration will result in integration of more services, such as housing, benefits and public health services, leading to better experiences and outcomes for people who use them. **We recommend therefore that decisions on pooling health and social care budgets should be made**

locally and that local government should be involved in the commissioning of local health services to ensure that decisions about local health services are informed by local needs and existing local public services.

Innovation

We approached innovation in the light of the other evidence we heard about funding pressures, demographic change and the difficulties presented by the structure of the system. We found that funding constraints and demographic pressures are acting as a driver for some councils to innovate and change the way they deliver care. However, due to budget pressures, most councils are in panic mode and are not ready to rethink the way they do things. **We recommend that the Government should create an innovation fund to encourage and give councils the capacity to consider how innovative approaches could be applied in their local area, including alternative models of care, such as the Shared Lives scheme.**

Future funding

We believe that serious consideration must be given to how social care will be funded once reforms to local government finance have taken effect (i.e. 2019–20 and beyond) and in the much longer term (from 2030), taking into account current demographic trends.

2019–20 onwards

From 2019–20, local government will retain 100% of business rates, leading to a rise in its funding levels by £12–13 million, the transfer of additional responsibilities to ensure the reforms are fiscally neutral and the ending of Revenue Support Grant (RSG). In our Pre-Budget report, we presented estimates ranging from £1.1 billion to £2.6 billion for the funding gap in social care by 2019–20 and requested that the National Audit Office make an independent determination of the shortfall.

Once RSG has been phased out, councils' main sources of discretionary funding will be council tax and business rates. Much of the evidence we received highlighted the fact that, growth in council tax and business rates income was unlikely to match demand for social care, particularly in deprived areas with higher levels of need. We recommend that:

- **Local government should be allowed to use some of the additional revenue that results from 100% retention of business rates, according to need, to close any funding shortfall in social care in 2019–20, before being allocated new responsibilities.**
- **Given that council tax and business rate income will not meet current and future demand for social care, funding should be made available for adult social care via a central government grant linked to need and rising demand.**

A long-term solution

We believe that, after successive attempts at reform and in the context of ever-increasing demographic pressures on the system, there is an urgent need for a review of how to fund social care in the long term. The evidence we received suggested that, to ensure success, it would need to be inclusive and attract wide public backing, and our visit to Germany showed that cross-party political support, which was key to securing their reforms, is vital. We also heard that the review must be ambitious and consider taking funding from a wide range of sources, including how each of us contributes towards the cost of our own care.

We welcome the Government's announcement of a Green Paper on the long-term funding of social care. We recommend that it:

- **Involves political parties across the spectrum, together with the social care sector and the wider public, in the process of reaching a solution.**
- **Proceeds on the basis that 'all options are on the table' and considers taking funding from a wide range of sources, including hypothecating national taxation (income tax, National Insurance Contributions, asset taxes, inheritance tax) and all age-related expenditure (the state pension, including the funding for the triple lock pension guarantee, winter fuel allowance, concessionary bus fares, free prescriptions and, indirectly, TV licences). The Green Paper should also look at the role of local taxes in funding social care, as well as how individuals should make financial contributions to the costs of their care.**
- **Takes into account the range of uses for which social care funding is required. Over the course of this inquiry, we have identified these as including:**
 - **Care and support, including meeting people's needs for care and support; preventative care and early intervention; and assessments for carers, leading to the provision of support for carers.**
 - **Payment of fees to providers, which contribute to: the wages of the care workforce, as well as holiday, sickness, pension and travel costs; their training, qualifications and career development, including measures to enhance the status of the care workforce; and meeting providers' business costs and generating profit to invest in their capital assets and the workforce.**

Conclusion

The Government needs to take three urgent steps with regards to the funding of social care: address the funding pressures being felt now; ensure that funding for social care is linked to need and rising demand following the reforms to local government finance; and, based on cross-party and public support, find a lasting way of funding social care sustainably in the long-term. Recognising that increased funding alone is not the only solution, we also make a range of other recommendations for action, namely on care

commissioning, monitoring of care services, and the workforce. We will review the scope of the Green Paper when it is published later this year and consider whether a further inquiry into any of the issues it raises is needed.

1 Introduction

1. Over the course of our inquiry on adult social care we heard extensive evidence about the financial pressures affecting adult social care: we therefore published a report before the Budget on 8 March which focused on funding and called on the Government to bring forward the £1.5 billion promised for 2019–20 to 2017–18 and to make a commitment to closing the funding gap for the rest of the Parliament.¹ We also asked the National Audit Office to make an estimate of that funding gap.

2. We welcome the Chancellor's commitment in the Spring Budget to provide an additional £2 billion for social care over the next three years.² However, the £1 billion that will be provided in 2017–18 falls short of the amount we believe is needed to close the funding gap in that year and to provide adequate relief from what the evidence we have received shows to be a crisis in the funding of social care. We continue to believe that, on the basis of the National Audit Office's determination of the level of funding required, the Government should commit to closing the funding gap for the years to 2019–20. We also welcome the announcement of a Green Paper on the long-term funding of social care³ but believe that it should be taken forward on a cross-party basis and include key bodies in the sector to ensure that the work results in a lasting solution that is supported across the political spectrum.

3. In this final report, we bring together evidence to show the very serious consequences that the levels of funding for social care in recent years have had on:

- The quantity and quality of the care people receive;
- The NHS;
- Care providers;
- The care market and care commissioning;
- The workforce; and
- Carers.

We also identify the difficulties arising from the structure of the system and, in this context, examine the progress on closer working between health and social care services. We also explore innovation in the provision of social care and, finally, we look at how social care will be funded once reforms to local government finance have taken effect (2019–20 and beyond) and in the much longer term (from 2030) taking into account current demographic trends.

1 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

2 HM Treasury, [Spring Budget 2017](#) (March 2017), p 47

3 HM Treasury, [Spring Budget 2017](#) (March 2017), p 47

Our inquiry

4. As we noted in the report that we published before the Spring Budget, this has been our longest inquiry this Parliament.⁴ The length and depth of our investigations reflected both the importance of social care for some of the most vulnerable people in our society and the carers who support them, and also the repeated and mounting concerns of the sector about the state of social care finances and the consequences for people who receive services and for the NHS. We set out to hear from as many stakeholders as possible and took evidence from 41 witnesses over eight evidence sessions and received over 200 written submissions.

5. We were particularly conscious of the importance of hearing from people who receive council-funded social care and from unpaid carers and wanted as many people on the ‘frontline’ to take part in our inquiry as possible. As well as taking formal evidence from people in receipt of social care—Isaac Samuels, Anna Severwright and Larry Gardiner—and carers—Margaret Dangoor, Lana Harber and Christine Euman—we gathered informal evidence through an online forum and spoke to service users and carers at a roundtable event in Westminster. In addition, the Channel 4 Dispatches team gave us a showing of their documentary on home care and answered our questions about the findings of their investigation.⁵ We are very grateful to the many people who took part in our inquiry and to our special advisers, Caroline Glendinning, Professor Emerita of Social Policy at the University of York, and Raphael Wittenberg, Associate Professorial Research Fellow at the Personal Social Services Research Unit at the London School of Economics and Political Science.

4 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

5 Channel 4 Dispatches, [Britain's Pensioner Care Scandal](#) (April 2016)

2 The impact of funding pressures on the adult social care system

6. In the report we published before the Spring Budget, we examined the reasons for the funding pressures on the adult social care system and looked at how councils had coped with those pressures by redesigning services and making other efficiency savings.⁶ We came to the conclusion that the Chancellor should provide immediate additional funding for social care and commit to closing the funding gap for the rest of the Parliament. In this chapter, we bring together evidence to show the very serious consequences that constrained social care funding has had on: the quantity and quality of the care people receive; the NHS; care providers; the care market and care commissioning; the workforce and carers.

7. The social care sector is affected by the demographic pressure of a growing and ageing population with increasingly complex care needs.⁷ According to the National Audit Office (NAO), while the overall adult population grew by 10% between 2001 and 2011, the number of people aged over 65 grew by 11% and the number aged over 85 grew by 24%.⁸ As adults are living longer, their care needs are increasing and, in addition, more people with disabilities and complex health conditions are living longer.⁹

Care received

8. Where a local authority has assessed a person as having needs for care and support, the Care Act 2014 requires that it must meet those needs.¹⁰ However, the evidence we received, which we examine below, suggested that an increasing proportion of people with care and support needs were getting no care at all (unmet need) and that those who did receive care were not getting enough (undermet need). The service users and unpaid carers who took part in our roundtable said that funding pressures on councils were visible in the form of service reductions, including closures of day care centres, and were resulting in increased reliance on families and carers.

Unmet need

9. As a result of changes in councils' data reporting requirements, it is not possible to compare how the numbers of people receiving care have changed year-on-year over recent years. However, we know that the number of people receiving care from local authorities fell by 25% (427,000) between 2009–10 and 2013–14 and that there was a further fall of 2% (19,000) between 2014–15 and 2015–16.¹¹

6 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

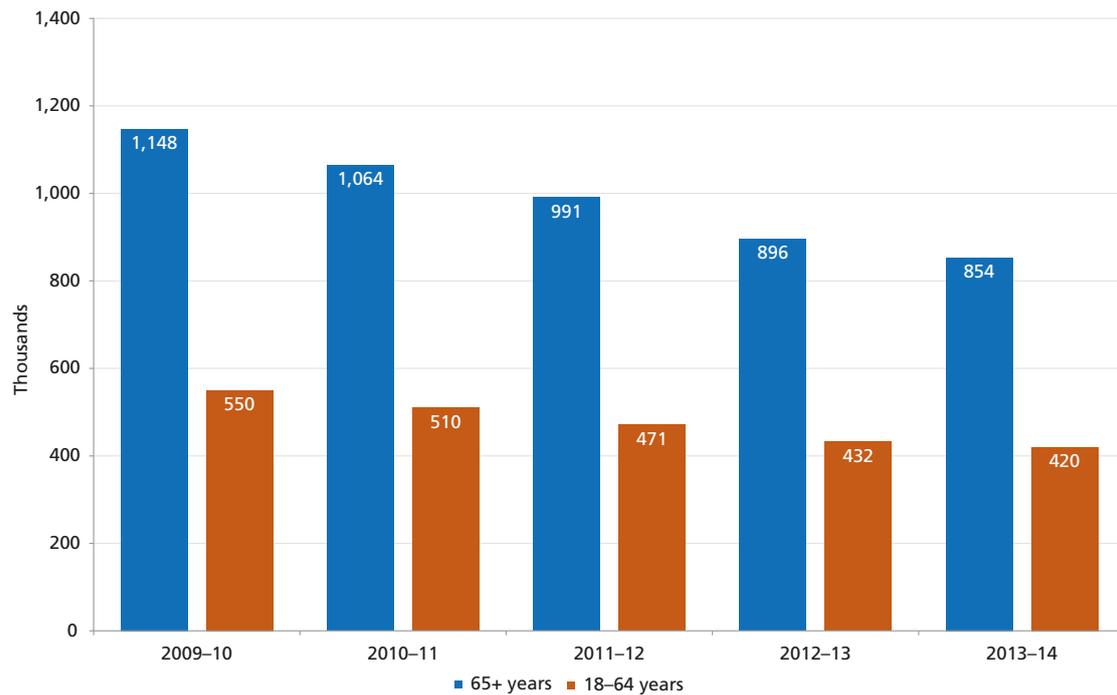
7 House of Commons Library, [Population: social indicators page](#), 7 November 2016

8 National Audit Office, [Adult social care in England: overview](#), 13 March 2014, HC 1102

9 Qq4–5, 387

10 Care Act 2014, [section 18](#)

11 NHS Digital, Community Care Statistics, Social Services Activity, England (2009–10 to 2015–16)

Figure 1: Number of people receiving local authority funded social care, 2009–10 to 2013–14

Age UK said that the number of older people receiving social care had fallen from 1.2 million in 2005–6 to 850,000 in 2013–14, despite the rising numbers of older people in the population.¹² This is confirmed by what we heard from councils. Jon Rouse, Chief Officer of Greater Manchester Health and Social Care Partnership, said that, over the last seven years, there had been a “20%-plus reduction in the number of people in residential and nursing care in Greater Manchester, and a 25% reduction in the number receiving domiciliary care”,¹³ and Newcastle City Council and the London Borough of Havering also said they had reduced the number of people to whom they were providing care.¹⁴

10. From April 2015, a national minimum threshold for eligibility for care was introduced.¹⁵ This means that councils are required to provide care and support for people whose needs have a “significant impact on their wellbeing”. Our witnesses from Newcastle and Haringey councils said their organisations had reduced the number of people they cared for not only by promoting independence and being flexible with support but also by “strict adherence to the eligibility criteria”.¹⁶ José-Luis Fernández, Deputy Director of the Personal Social Services Research Unit at the London School of Economics and Political Science (LSE), observed that the “system’s concentration on people with very high needs is associated with a significant drop in the resources available”.¹⁷ One of the carers who attended our roundtable said that, while supervising her mother’s care, she had witnessed how funding was driving decision-making about eligibility for care and that this was forcing people out of the system.

12 Age UK ([SOC151](#))

13 [Q219](#)

14 [Qq88](#), [93](#)

15 The Care and Support (Eligibility Criteria) Regulations 2015, [section 2](#)

16 [Q93](#)

17 [Q4](#)

Under-met need

11. Age UK said that levels of “under-met” need were rising and that, in 2015:

The number of older people who had difficulty undertaking activities of daily living (such as getting dressed, washed and eating) and instrumental activities of daily living (including managing medication, cooking or shopping for essential items) and who did not receive adequate help exceeded one million for the first time.¹⁸

The organisation has since updated this figure to 1.2 million.¹⁹ Vicky McDermott, Chair of the Care and Support Alliance, said that her organisation was in contact with people who had been affected, including an older person who was sleeping in their wheelchair having had their home visits reduced to one a day.²⁰ We heard similar accounts from other people who received council-funded social care. A contributor to our online forum said:

Having disabilities, I am already at a disadvantage in general, but requiring the equipment and support I do daily from the moment I wake up til the moment I go to bed every day and at night means what I require is expensive. I realise there are cutbacks, but being told during numerous assessments throughout my life that there is “no money” for what I require is deeply worrying and demoralising.

Another contributor to the forum said:

Currently I pay my self-employed, tax paying etc carer/personal assistants (PA) the sum of £10 per hour. My local council has just undertaken my annual review, cut my hours by 10% and reduced the hourly rate to £7.35 per hour this is worrying. I need 2 people to take me out, been outside 4 times this year so far. My PAs have now said they will be leaving in September, they cannot afford to work.

We also heard that care was not being increased at the rate that people’s needs were growing. One witness, Anna Severwright, told us that, although her hours had been increased at her last review, she felt that the deterioration in her condition meant that she should have had a bigger increase.²¹

12. We were therefore not surprised to hear witnesses say that they felt that the care they received did not promote their wellbeing²² as required by the Care Act 2014.²³ Larry Gardiner said that his care package was “simply written to keep me hydrated—fed and watered—and hygienic”²⁴ and other people we spoke to said the system had become focused on “functionality”, or washing and dressing, with no regard to combatting isolation and loneliness. Scope said that their 2015 research into the experiences of 500 working-aged disabled people had shown that more people were receiving the “basics of care” and

18 Age UK ([SOC151](#))

19 Age UK, [1.2m older people don't get the social care they need](#), 17 November 2016

20 [Q14](#)

21 [Q296](#)

22 [Qq299–302](#)

23 Care Act 2014, [section 1](#)

24 [Q302](#) [Larry Gardiner]

fewer people were receiving support to meet their “wider needs and aspirations”, such as employment, education and training.²⁵ Anna Severwright said that her main worry was not about her quality of life but what was going to happen to her care in the future.²⁶

13. The Health Minister, David Mowat, told us that councils were fulfilling their duties under the Care Act and that Age UK’s figures related to “services that were previously non-statutory and may have been withdrawn [...] things like meals on wheels”.²⁷ Age UK has however since written to the Committee to explain that their figures were based on statutory services and reflected the number of people they have estimated to have a need for social care which is not being met. Sector organisations have also warned that councils are facing difficulties in meeting their statutory duties. The Association of Directors of Adult Social Care (ADASS) said that only 8% of Directors were fully confident of being able to deliver all of their statutory duties this year, 2017–18.²⁸ The Local Government Association has said that reductions in care will “constitute a failure to meet both the spirit of the Care Act and its statutory duties” and that, as a result, councils are likely to face an increase in judicial reviews.²⁹

14. Councils are coping with reduced budgets by providing care and support to fewer people and concentrating it on those with the highest needs. They are also reducing care provided to the minimum required for a person to get through the day, and are not promoting wellbeing nor increasing care in accordance with need. Many councils are therefore potentially in the position of being unable to comply with their Care Act duties and may therefore face legal challenges. It is alarming that fewer than one in twelve Directors of Adult Social Care are confident that their local authority will be able to meet its statutory duties in 2017–18.

15. José-Luis Fernández of the LSE said, however, that it should not be assumed that, because councils were providing less care, people’s needs were going unmet: “you become a self-payer, or you get some unpaid care, or you go without”.³⁰ He added that “it was very difficult to find those people with social care needs outside of the system”.³¹ Councils are, however, required to consider how to identify unmet need in their area but, according to ADASS, only 34% have monitoring arrangements in place.³² The evidence we received indicated that unpaid carers were having to step in to meet shortfalls in the care provided by councils; for example, Isaac Samuels told us that he had mitigated the shortfall in the care the council provided with unpaid care from friends and family.³³ We also heard evidence that reductions in services were placing pressure on hospitals through rising emergency admissions and delayed transfers of care. We explore these issues later on in this report at paragraphs 28 to 41.

16. Little is known about what happens to people who are not receiving any or enough care, and whether they are paying themselves, relying on carers or coping alone. Data on delayed transfers of care and emergency admissions suggest that unmet need is

25 Scope ([SOC052](#))

26 [Q298](#)

27 [Q368](#)

28 Association of Directors of Adult Social Care ([SOC134](#))

29 Local Government Association, [Submission to the Spring 2017 Budget](#), 20 January 2017

30 [Q14](#)

31 [Qq14](#), [Q14](#)

32 Association of Directors of Adult Social Care ([SOC134](#))

33 [Q296](#)

placing significant pressure on the NHS. We are disappointed that so few councils have monitoring arrangements in place to identify unmet need. Without such arrangements, it will be impossible to understand the scale of unmet need. *We therefore urge all councils to consider how to identify unmet need and to put arrangements in place for this. This will help to build up a national picture of unmet need and inform overall funding decisions.*

Quality

17. Professor Keith Moultrie, Director of the Institute for Public Care, described the approach to assessing the quality of care and support:

It has to look at people's satisfaction and the happiness that people have in services; it has to have some minimum standards about the kind of services, how frequent, reliable and regular services are, and the skills of the people involved; it has to set standards around the quality of the work people are actually doing. It has to have a combination of those and a focus on outcomes.³⁴

We believe that it has been possible to build up an overall picture of quality by looking at inspection results and other indicators, alongside the evidence we heard from people who receive social care, councils and care providers. We explore how care commissioning and the workforce affect quality in later sections of this report.

18. The Care Quality Commission (CQC), the care regulator, published its assessment of the state of care in England in 2015–16 in October 2016.³⁵ This is the second of such reports, following the introduction of a new ratings system in 2014. The CQC found that in 2015–16 “despite some variation, overall quality remains good”, with 1% of adult social care services rated outstanding, 71% good, 26% ‘requires improvement’ and 2% inadequate. While these results are an improvement on 2014–15 when the CQC rated 1% of services outstanding, 59% good, 33% ‘requires improvement’ and 7% inadequate,³⁶ we note that more than a quarter of care services (28%) are rated as requiring improvement or inadequate.

19. According to the CQC, there was variation in terms of service type; they found that nursing homes were the “biggest concern”, with 1% rated outstanding, 58% good, 37% ‘requires improvement’ and 4% inadequate.³⁷ Sir David Behan, the Chief Executive of the Care Quality Commission, said that the workforce was key to this:

The people in nursing homes are very old and both physically and intellectually frail, and therefore the levels of skill and numbers of people required to make sure that they are clean, hydrated and fed is a key issue. If you look at what we reflect in our reports, very often in care and nursing homes for the very elderly, it will be about the adequacy of staff and their care.³⁸

34 [Q139](#)

35 Care Quality Commission, [The State of health care and adult social care in England 2015–16](#) (October 2016)

36 Care Quality Commission, [The State of health care and adult social care in England 2014–15](#) (October 2015)

37 Care Quality Commission, [The State of health care and adult social care in England 2015–16](#) (October 2016)

38 [Q108](#)

Furthermore, the CQC found that smaller nursing and residential homes³⁹ performed better overall: they believed this was because caring for small numbers of people made it easier to respond to people's needs and deliver person-centred care. Extra-large home care agencies (250 plus staff) performed the worst, with 7% rated inadequate.

20. The Director of Resources at Newcastle City Council, Tony Kirkham, said he thought the quality of their services was still good⁴⁰ and Cllr Noble, the Spokesman for Health and Social Care at the County Councils Network, said he did not accept that councils were commissioning care of lower quality because there was less money in the system.⁴¹ However, Cllr Arthur, Cabinet Member for Finance and Health at the London Borough of Haringey, did think that quality of provision had reduced⁴² and a group of councils in the East of England said that there were signs that financial and recruitment pressures were affecting the quality of care:

In Essex, a consistent number of providers cause ongoing concern and there have been significant service failures in the past 18 months. 14 provider contracts for care services have been terminated since November 2014 due to poor quality. Norfolk has seen a reduction in the overall quality of care, with less residential care providers (59.6%) achieving Good CQC inspection ratings compared to the average for England (68.1%).⁴³

Furthermore, the Association of Directors of Adult Social Care said that 82% of Directors of Adult Social Care had reported that more providers already faced quality challenges as a result of the savings being made to social care budgets.⁴⁴

21. The providers we heard from were concerned about maintaining quality in the face of pressure from councils to reduce fees. For example, Humberside Independent Care Association said that “the practice of always choosing the cheapest provider forces quality down”.⁴⁵ Some providers said they preferred to provide no care at all than poor quality care at reduced fee levels. Mandy Abbey, who runs a care agency, told us she was “being put under enormous pressure to cut care to the point where quality of care and quality of lives are hugely impacted on”, which she refused to do.⁴⁶ This was also the case for much larger providers, like Four Seasons Healthcare.⁴⁷ Providers were, however, doing whatever they could to continue providing quality care, often to the detriment of their business. Andrew Dykes, the Chairman of Exalon Autonomy Group, a care provider for adults with learning disabilities, said that they had kept the quality of care up by “extend[ing] bank terms and reduc[ing] management overheads as far as possible” and by being fortunate in having low staff turnover.⁴⁸

39 For nursing and residential homes, small comprises 1 to 10 beds.

40 [Q95](#)

41 [Q95](#)

42 [Q93](#)

43 Cambridgeshire County Council, Essex County Council, Hertfordshire County Council, Norfolk County Council, Suffolk County Council, Southend Council and Thurrock Council ([SOC195](#))

44 Association of Directors of Adult Social Care ([SOC134](#))

45 Humberside Independent Care Association ([SOC143](#))

46 Mandy Abbey ([SOC36](#))

47 [Q150](#)

48 [Q150](#)

22. An important indicator of quality is how satisfied care users are with the services they receive. According to the Personal Social Services Adult Social Care Survey, only 3.6% of people in England were dissatisfied with their publicly-funded care in 2015–16.⁴⁹ Richard Humphries of The King’s Fund pointed out the limitations of such surveys: “there is a danger, particularly with older people, that gratitude and relief is not necessary the same as satisfaction”.⁵⁰

23. The Personal Social Services Adult Social Care Survey results contrast with the rising number of complaints to the Local Government Ombudsman (LGO) about adult social care. Since 2014–15, the number of complaints received about independent providers has increased by 19% and the number of complaints and enquiries about care arranged privately with independent providers increased by 21%.⁵¹ Most complaints were about residential and home care, of which 58% and 65% respectively were upheld after a detailed investigation. We note that the LGO and the CQC work together closely, sharing information received through complaints to inform regulatory action.

24. The Channel 4 Dispatches documentary, *Britain’s Pensioner Care Scandal*, gave us an insight into what poor care looks like and its repercussions.⁵² Through secret filming and undercover reporting, the programme highlighted serious concerns about the standard of home care provided to older people in Haringey. Ray James, whose mother’s care was filmed, told us about the impact that poor care had had on his mother’s physical and mental health and the distress that this had caused to both of them. The Relatives and Residents Association, whose evidence was based on what the relatives of people receiving care had told them, said that the quality of service had been adversely affected by cuts to social care budgets.⁵³ Carers also had concerns about quality; for example, Independent Age said that some were having to refuse respite care because of this and that those who did accept it felt “unease and worry that [it] would not be adequate”.⁵⁴

25. The evidence from the three witnesses who receive social care suggested that the way the system was set up affected the quality of their care overall. Isaac Samuels said that the care he received was not joined up and that, as a result, the burden of coordinating it fell to him.⁵⁵ Larry Gardiner described the difficulties he had had in moving from one local authority area to another and having to be reassessed for care.⁵⁶ Asked whether she had choice and control over her care, Anna Severwright said:

There are choices, as long as it fits within the system or within their boxes. I feel like my life is a unique journey that doesn’t fit into any boxes, and nobody else has ever done it before, so my care needs to be truly unique. I would like it to be that somebody comes out and says, “So what is your life about?” and then, “How do we fit the care to that?” and not, “Okay, this is what we do.” Often—usually—they are used to working with more elderly people.⁵⁷

49 NHS Digital, *Personal Social Services Adult Social Care Survey 2015–16* (September 2016)

50 [Q14](#)

51 Local Government Ombudsman, *Review of Adult Social Care Complaints 2015/16* (November 2016)

52 Channel 4 Dispatches, *Britain’s Pensioner Care Scandal* (April 2016)

53 Relatives and Residents Association ([SOC168](#))

54 Independent Age ([SOC67](#))

55 [Q298](#)

56 [Q298](#)

57 [Q301](#)

We also heard about the difficulties witnesses had had with securing funding for home adaptations through the Disabled Facilities Grant and explore this issue in paragraphs 122 to 124.

26. The CQC's 2015–16 report concluded that, although adult social care services have been able to maintain quality, sustainability was a concern.⁵⁸ They cited the facts that a quarter of services did not improve after receiving an inadequate rating last year, that half of services rated as 'requires improvement' which were re-inspected had not improved and that, in 8% of cases, care had become inadequate. The concerns providers expressed about maintaining quality (discussed at paragraph 21) echo the CQC's findings, as did 95% of Directors of Adult Social Care responding to ADASS' Budget Survey 2016 who thought that more providers will face quality challenges in the future.⁵⁹

27. The number of complaints about social care to the Local Government Ombudsman is high, and rising, and the Care Quality Commission found that, in 2015–16, 28% of care homes required improvement or were inadequate, with some types of services, such as nursing homes, significantly worse rated. Councils are becoming concerned about quality of care, and care providers, and the Care Quality Commission are concerned about its sustainability. We share their concerns and fear that overall quality of care is likely to continue to deteriorate, unless sufficient funding is provided.

Pressure on the NHS

28. When we asked the Chief Executive of NHS England, Simon Stevens, how the pressures on social care budgets were affecting the NHS, he said:

The most obvious measure of stress in the system is the number of older people who are stuck in hospital when they, their families and their nurses and doctors know it would be better for them to be looked after back at home or, indeed, in an appropriately high-quality care home.⁶⁰

Stephen Dorrell, Chair of the NHS Confederation, added that there was also pressure from "the people who present at the front door of the hospital, as a result of failure to deliver home care services [which] have been particularly hard hit by [...] social care funding".⁶¹ These are known as 'emergency admissions'.

Delayed transfers of care

29. According to NHS Guidance, a delayed transfer of care occurs when a patient has been deemed ready to depart from acute or non-acute care and is still occupying a bed.⁶² The number of delayed transfers of care are recorded at the end of each month, alongside the reason for the delay and whether the delay was attributable to the NHS, the local authority or to both organisations. The reasons are: awaiting completion of an assessment; awaiting public funding; awaiting further non-acute NHS care; awaiting residential home

58 Care Quality Commission, *The State of health care and adult social care in England 2015–16* (October 2016)

59 Association of Directors of Adult Social Care ([SOC134](#))

60 [Q258](#)

61 [Q258](#)

62 [NHS England, Monthly Delayed Transfer of Care Situation Reports: Definitions and Guidance](#) (updated October 2015)

placement or availability; awaiting nursing home placement or availability; awaiting care package in own home; awaiting community equipment and adaptations; patient or family choice; disputes; and housing.

30. The National Audit Office's (NAO) report, *Discharging older patients from hospital*, found that there had been a 31% increase in bed days taken up by patients with a delayed transfer between 2013 and 2015, but that the NHS was spending around £820 million a year treating older patients who no longer needed to be in hospital.⁶³ Furthermore, they noted that delayed transfers have detrimental effects on patients, affecting their morale, mobility and increasing their risk of obtaining a hospital-acquired infection.

31. The most recent data on delayed transfers covers December 2016, when there were 195,300 total delayed days; 56.2% of which were attributable to the NHS, 36.0% to social care (compared to 32.2% in December 2015) and the remaining 7.9% to both NHS and social care.⁶⁴ Despite this data, the extent to which social care was responsible for delays was disputed. While Mark Lloyd, Chief Executive of the Local Government Association, emphasised that only a third of delayed transfers were due to the social care system,⁶⁵ Simon Stevens, on the other hand, said:

When you get under the skin of it, it is pretty clear that, although perhaps only 40% of the delayed discharges are formally recorded in the stats as being a hospital trying to get social care for its patients, the majority of the delays are attributable to that, because the elements that are recorded as being NHS-related delays are often continuing healthcare, which in turn is about getting home care or transfer to care homes.⁶⁶

32. The Health Minister, David Mowat, said that there was “extraordinary disparity in delayed transfers of care between different local authorities” and that the disparity between the four worst and the four best was a “factor of forty”.⁶⁷ He illustrated this by saying that on a recent visit to a hospital:

I was listening to the team dealing with the discharge on what is called the frailty ward, and one of the big factors that they had to discuss was whether it was council A, council B, council C or council D because, frankly, their job was quite different, depending on the arrangements that that council had and how it did its work.⁶⁸

The top and bottom ten authorities for average daily rate of delayed transfers in 2015–16 is shown in the table below:

63 National Audit Office, *Discharging older patients from hospital*, 26 May 2016, HC 18

64 NHS Digital, *Monthly delayed transfers of care data, England* (December 2016)

65 [Q212](#)

66 [Q259](#)

67 [Q371](#)

68 [Q372](#)

Table 1: Delayed transfers of care per 1,000 population aged 65+, local authorities (2016)

Highest rates		Lowest rates	
Local authority	Delayed transfers of care per 100,000 population aged 65+	Local authority	Delayed transfers of care per 100,000 population aged 65+
Southampton	313	Barnsley	12
Cumbria	299	County Durham	12
Manchester	261	North Tyneside	12
Trafford	256	Northumberland	12
City of Bristol	255	Wakefield	10
Reading	239	Darlington	10
Birmingham	236	Peterborough	10
Tameside	230	Newcastle upon Tyne	9
Hackney	220	Sunderland	7
Wolverhampton	203	City of London	0

Source: NHS England [Delayed Transfers of Care reports](#); ONS [mid-year population estimates](#) 2015

33. **The balance of responsibility between NHS and local authority social care for delayed discharges is not clear and councils' performance in relation to delayed discharges appears to vary across the country. This suggests the causes are many, complex and based on local circumstances, which closer working between councils and NHS partners and sharing best practice may help to alleviate in the medium to long term.**

34. The Health and Local Government Ministers both denied that the pressures on the NHS were due to funding pressures on social care.⁶⁹ Marcus Jones, Local Government Minister, said that the variation in councils' performance on delayed discharges was not reflected in the amount of funding they had and that more integrated working was needed instead (we explore integration issues in paragraphs 37 to 39).⁷⁰ However, Simon Stevens of NHS England told us that even if all councils performed well at managing delayed discharges, there would still be a need for extra resources in social care.⁷¹

35. The NAO found that "Rising demand for services, combined with restricted or reduced funding, is putting pressure on the capacity of local health and social care systems",⁷² and that lack of community workforce and bed capacity, stemming from commissioners under pressure keeping fees as low as possible and, in turn, putting pressure on providers, were significant causes of delays. Indeed, the NHS data show that the main reason for social care delays was lack of home care (36.9% of all social care delays).⁷³ In addition, in its report on *Winter Pressures in Accident and Emergency Departments*, our colleagues on the Health Committee concluded that adult social care was underfunded and that this was having an impact on the NHS.⁷⁴

69 [Q371](#)

70 [Q372](#)

71 [Q266](#)

72 National Audit Office, *Discharging older patients from hospital*, 26 May 2016, HC 18

73 NHS Digital, *Monthly delayed transfers of care data, England* (December 2016)

74 Health Committee, Third Report of Session 2016–17, *Winter Pressures in Accident and Emergency Departments*, HC 277

36. Even given the complexities of organisational responsibility for delayed discharges, we believe that inadequate social care funding has a very significant impact on the speed of discharges from hospital. Reductions in spending on adult social care, leading to pressure on providers and the care market and difficulties in recruiting and training staff, have led to an increase in the number of delayed discharges attributable to social care and an increase in emergency admissions of older people. *The Government should provide extra funding to increase social care provision in order to relieve pressure on the NHS, as recommended by the Health Committee in its report of October 2016 on Winter pressures in accident and emergency departments.*

Closer working to reduce delays

37. Simon Stevens of NHS England was clear that some councils performed better than others, saying there were “processes that can be got right, and some parts of the country, having got those processes joined up, have seen significant improvements”.⁷⁵ He believed that shared assessments and quick response by services to assessments had a role to play in this. Tim Hammond, the Chief Executive of Four Seasons Healthcare, one of the largest residential care providers in England, said that he could point to parts of the country where the systems were slowly becoming more joined up:

Last winter, when usually the pressures are greatest, we had around 400 winter bed contracts, as I will call them, if that makes any sense to you; they are often called step-up and step-down. If an older person has a problem at home, often the only solution for them is to go to hospital, but, actually, they could go into a care home, have skilled care for a few days or weeks before being discharged to their home. Step-down is more common. This relates to your discharge point. It is about getting people out of hospital much more quickly, freeing up the system. It is of course much better for the patient, who might just need a few days or weeks. We had around 400 of those contracts last winter versus roughly 200 the winter before. [...] there are circa 50,000 empty beds in the care home sector in total. I think the NHS only has about 100,000 beds in total. The opportunity for the care home sector to really play a role in helping the NHS is very real.⁷⁶

We also heard about a similar project in Somerset where 18 reablement beds in one of Somerset Care’s nursing homes had been purchased by Yeovil District Hospital, into which suitable patients were being transferred, thereby freeing up hospital beds. The average length of stay was 11 days, during which patients received intensive NHS-funded physiotherapy and occupational therapy, leading to 95% of patients in the ‘reablement beds’ being discharged home and 42% having reduced support needs. The price per bed paid by the NHS of £750 per week was lower than the actual costs of care estimated at £850–900 per week.

38. Evidence from the Department for Communities and Local Government and the Department for Health described the ongoing work on improving performance, including sharing best practice and work with the NHS and local government to speed up and streamline processes, for example by promoting new models of care such as discharge

75 [Q260](#)

76 [Q157](#)

to assess and trusted assessor models.⁷⁷ The two Departments said that to access the Better Care Fund (BCF) every area has to agree a local action plan and target on delayed discharges. We note, however, the NAO's recent findings that the BCF did not achieve this target in 2015–16 and that, although local areas had planned to reduce delays compared with 2014–15 by 293,000 days in total saving £90 million, the number of delayed days increased by 185,000, costing a total of £146 million more than planned.⁷⁸

39. There are many ongoing projects aimed at reducing delayed discharges and emergency admissions through closer working between the NHS and social care. Because of local circumstances and practices, what works in one area may not be successful in another, and it takes time for new processes to become embedded. The Government, working with the Local Government Association, should increase efforts to share examples of best practice, including the use of reablement beds.

Emergency admissions

40. Stephen Dorrell, Chair of the NHS Confederation, believed that the lack of availability of home care was a “significant root cause of the rising demand trend, both of hospital admissions and of people presenting in GP surgeries”.⁷⁹ Emergency admissions are unplanned, short-notice admissions to hospital via Accident and Emergency (A&E). The numbers of emergency admissions are rising; in 2016, the number of emergency admissions was 4.5% higher than in 2015, with an average of 500 extra admissions each day and 17% higher than in 2011.⁸⁰ The NAO concluded that this was caused by demographic change; the increasing number of elderly people with one or more long-term conditions were more likely to need urgent care, go to an A&E department and be admitted once there.⁸¹ Despite the focus of the Care Act 2014 on prevention and early intervention, we heard that councils were providing less preventative care, which could also be a factor in the increasing number of emergency admissions. ADASS said:

As budgets reduce further in real terms, it is becoming harder and harder for councils to manage the tension between prioritising statutory duties towards those with the greatest needs and investing in services that will prevent and reduce future needs. As a result of this tension, this year [2016–17] councils will be spending 4% less on prevention than last year.⁸²

Carers and care users at our roundtable observed that councils were now not spending money on prevention and early intervention, even on low cost items like ramps and grab rails, despite the obvious longer-term financial benefits. The Local Government Association highlighted that the in-year cut in public health funding of £200 million had further increased the challenge to councils in investing in prevention and early intervention.⁸³

41. There are also concerns about the impact of social care budget pressures on the ‘front door’ of hospitals—emergency admissions. We are concerned that budget pressures are driving many councils increasingly to direct resources towards services

77 Department of Health and Department for Communities and Local Government ([SOC216](#))

78 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

79 [Q258](#)

80 House of Commons Library Briefing, [NHS Indicators: England](#) (February 2017)

81 National Audit Office, [Emergency admissions to hospital: managing the demand](#), 31 October 2013, HC 739

82 Association of Directors of Adult Social Care ([SOC134](#))

83 Local Government Association ([SOC075](#))

for people with higher levels of needs, rather than towards prevention. Extra funding would enable councils to provide preventative services for people with lower levels of need, which is likely to reduce demand for higher-intensity, higher-cost services later on. The need for preventative services should be included in future estimates of funding needs.

Care providers

42. The funding pressures on social care budgets have led to councils either freezing the fees they pay to care providers or only providing small yearly uplifts. LaingBuisson, care market analysts, estimated that, across care homes in the UK, baseline fees fell by a cumulative 6% in real terms between 2010–11 and 2015–16.⁸⁴ The evidence we received from councils supported this: for example, Cllr Noble, Spokesman for Health and Social Care at the County Councils Network, said that his council, Suffolk, had not increased the fees paid to providers for four or five years⁸⁵ and Lancashire County Council said their providers had received small or no fee uplifts since 2011.⁸⁶ Professor Martin Green, Chief Executive of Care England, highlighted how low residential care fees currently are:

In some areas the fee levels are quite staggeringly low. For example, in places like Sheffield, £377 per week for residential care translates into £2.24 per hour. Consider the level of dependency of people in care services, 80% of whom have some form of dementia.⁸⁷

Colin Angell, Policy and Campaigns Director at the UK Homecare Association, said that his organisation had calculated a minimum price for home care at £16.70 per hour but had found that the weighted average price for home care in England was £2 per hour less, which “providers were working absolute miracles to accommodate”.⁸⁸ The Registered Nursing Home Association said:

A typical shire County will pay a nursing home circa £560 per patient per week, that’s £80 per night. For that fee the nursing home is expected to provide 24 hour nursing care, accommodation, food, laundry etc. etc. It is no more than one expects to pay in a large budget hotel chain, and a lot less than it costs to stay at a better hotel, but the service provided is considerably different and the staffing numbers required in nursing homes is considerably greater.⁸⁹

Cost pressures

43. Care providers highlighted that little or no fee increases meant they were having to absorb costs increases themselves. The main costs arose from providers’ responsibilities as employers and included: the Apprenticeship Levy;⁹⁰ statutory holiday;⁹¹ statutory

84 LaingBuisson, Care of Older People—UK Market Report, 27th edition, 2015

85 [Q98](#)

86 Lancashire County Council ([SOC141](#))

87 [Q149](#)

88 [Q149](#)

89 Registered Nursing Home Association ([SOC99](#))

90 Humberside Independent Care Association ([SOC143](#)), Coverage Care Services ([SOC016](#)), Brendoncare Foundation ([SOC053](#)), Heritage Care Group ([SOC065](#))

91 Kent Integrated Care Alliance ([SOC020](#)), Care Association Alliance ([SOC027](#)), Eden Futures ([SOC157](#))

pensions⁹² and recruitment costs;⁹³ training and development;⁹⁴ paying for care workers' travel and sleep-in time;⁹⁵ and, most significantly, the introduction of the National Living Wage (NLW).⁹⁶ They also frequently cited the registration fees they were required to pay to the Care Quality Commission.⁹⁷

44. Ray James, Immediate Past President of the Association of Directors of Adult Social Care (ADASS), set out the overall cost of wages in 2015–16:

Our survey this year showed that the living wage probably cost about £520 million in the first year. In addition, there were some other costs from ensuring full compliance with one or two other pieces of legislation, making sure travelling time was paid for, ensuring sleeping nights were being appropriately remunerated and things of that nature. That probably took the bill for providers for council-funded cases up to about £600 million in the year.⁹⁸

ADASS reported that the introduction of the NLW had “driven a very rapid increase in fees paid to providers in 2016–17”, with 82% of councils increasing fees, 42% increasing fees by over 3% and one third increasing home care providers' fees by 5%.⁹⁹ It is not clear whether this was also linked to the introduction of the social care precept.

45. However, care providers said that councils were not passing on the money raised by the precept via fee uplifts; for example, Four Seasons Healthcare said that, although all but eight councils raised the precept in 2015–16, only around half of the 80 councils in England who commission their services “recognised the NLW cost pressures and passed on appropriate fee rises”.¹⁰⁰ In our pre-Budget report, we concluded that the precept would not raise enough to cover the increasing costs of the NLW.¹⁰¹

46. With regards to sleep in shifts, the common approach across the care sector has been to pay a flat rate for a sleep in shift, rather than an hourly rate, which can result in care workers being paid below the national minimum wage. However, recent court judgements have come to different positions on the approach that should be taken to paying for sleep in shifts, which some of the providers who submitted evidence to our inquiry said was causing them significant financial uncertainty.¹⁰² The Health Minister, David Mowat, did not confirm the approach, but said that providers “could be held liable for minimum wage violations going back six years” and described the costs as “enormous”. The HMRC, however, appears to have changed its approach and now considers that every hour of the

92 Kent Integrated Care Alliance ([SOC020](#)), Eden Futures ([SOC157](#))

93 Q148, Humberside Independent Care Association ([SOC143](#))

94 Q148, Eden Futures ([SOC157](#)), Home Group ([SOC126](#))

95 Eden Futures ([SOC157](#)), United Response ([SOC115](#)), Camphill Village Trust ([SOC049](#)), Heritage Care Group ([SOC065](#)),

96 Care Association Alliance ([SOC027](#)), Camphill Village Trust ([SOC049](#))

97 Brendoncare Foundation ([SOC053](#)), Heritage Care Group ([SOC065](#)), Eden Futures ([SOC157](#)), St Ronan's Care Home ([SOC166](#))

98 [Q62](#)

99 Association of Directors of Adult Social Care ([SOC134](#))

100 Four Seasons Healthcare ([SOC219](#))

101 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

102 Camphill Village Trust ([SOC049](#)), United Response ([SOC115](#)), Hft ([SOC119](#))

sleep-in counts for National Minimum Wage purposes.¹⁰³ *The Government should take steps to resolve this uncertainty and confirm the approach to paying for sleep in shifts. Furthermore, the Government should, with the HMRC, find a solution to the payment of back pay for sleep ins which avoids severe financial consequences on care providers.*

Income and profit

47. Care providers use income and profit, among other things, to service debts and mortgages, invest in training staff, fund additional activities for residents, and pay for routine upgrades of the physical estate. In the context of rising costs and stagnant fees, the Care Quality Commission's (CQC) finding that providers were finding it difficult to make a profit is not surprising. They found that providers which were reliant on local authorities for more than half of their income made on average "28% less profit per bed compared with all providers" and that "the profit margin for domiciliary care providers has continued to fall".¹⁰⁴ Care providers suggested that councils did not appreciate that providers needed to make profits; for example, care providers who were members of the Lancashire Care Association said that some councils "struggle to understand the business environment (especially around the sensitive issues of 'profit' and the important role of banks)" and others simply "prefer not to".¹⁰⁵ Kent Integrated Care Alliance said that the council with which it contracted had made an assumption about profit when setting a guide price for fees on the basis of insufficient and questionable data.¹⁰⁶ A care provider responding to a survey by the Care Association Alliance said their council had made it clear that they "do not pay fees to providers so that they can make profits". The provider made the observation in response that "without profits there can be NO future for this industry and certainly no reinvestment".¹⁰⁷

Financial viability

48. This accumulation of pressures is posing a threat to providers' financial viability, leading to providers failing, deciding to exit the market or hand back council contracts. ADASS said that 80% of Directors of Adult Social Care had reported that their providers were facing financial difficulties and that, in the six months to June 2016, provider failure had affected at least 65% of councils.¹⁰⁸ Some of the councils that we took evidence from had experienced this; for example, Lancashire County Council said that they had experienced "unprecedented numbers" of residential, nursing and home care provider failures since April 2015.¹⁰⁹ In October 2016, the CQC reported that, since 2010, there had been a 12% reduction in the number of residential (non-nursing) care homes, along with an 8% decrease in total beds—from 255,289 to 235,799.¹¹⁰

103 Anthony Collins Solicitors Newsroom, [HMRC—changing their approach to sleep-ins?](#), 16 November 2016 and Anthony Collins Solicitors Newsroom, [HMRC and sleep-ins](#), 20 February 2017

104 Care Quality Commission, [The State of health care and adult social care in England 2015–16](#) (October 2016)

105 Lancashire Care Association ([SOC044](#))

106 Kent Integrated Care Alliance ([SOC020](#))

107 Care Association Alliance ([SOC027](#))

108 Association of Directors of Adult Social Care ([SOC134](#))

109 Lancashire County Council ([SOC141](#))

110 Care Quality Commission, [The State of health care and adult social care in England 2015–16](#) (October 2016)

49. Some providers are handing back contracts to local authorities: Janice Dane, Assistant Director of Early Help and Prevention at Norfolk County Council, said this happened ‘periodically’ in her area.¹¹¹ ADASS reported that, of the 151 councils that had responded to their survey, 59 had had home care and 32 had had residential and nursing care contracts handed back in the 6 months to June 2016.¹¹² In Norfolk County Council’s case, a home care provider and a nursing provider were handing back contracts because they were unable to make sufficient profit and because the nursing provider was “struggling to get the right staff”.¹¹³ As discussed at paragraph 21, providers are also handing back contracts if they feel unable to maintain quality of care.

50. In addition, we heard that some providers were not taking contracts on in the first place.¹¹⁴ The UK Homecare Association surveyed the UK home care market in 2014–15 and found that 50% of providers who responded had decided not to bid for tenders on the basis of price.¹¹⁵ Vicky McDermott, the Chair of the Care and Support Alliance, observed that “The concern is the people at the end of it who are left without that care. Often those people are very vulnerable”.¹¹⁶ We wholeheartedly agree. **Relocation and changes in the continuity of care have significant consequences for people’s health and wellbeing and cause great concern to families and carers.**

51. **Care providers are on the receiving end of reductions in spending on adult social care, with councils having exerted significant downwards pressure on their fees in recent years. At the same time, they face cost pressures from the National Living Wage, auto-enrolment in work place pensions, Care Quality Commission registration fees, the Apprenticeship Levy, paying hourly rates for ‘sleep ins’ and recruitment and retention costs from high staff turnover. While the National Living Wage has the welcome effect of raising low wages in the care sector, it is adding substantially to the financial pressures faced by providers. Providers are reporting that councils are not passing on the money raised by the precept as fee uplifts to cover the costs of the National Living Wage. *Central government should take responsibility for funding the costs to local authorities linked to care of initiatives such as the National Living Wage.***

52. **This accumulation of pressures poses a serious threat to providers’ financial viability and providers are failing, exiting the market and handing back contracts. The consequence of this for people’s care is extremely serious, and the reduction in capacity is causing delayed transfers of care. Providers’ profit margins have reduced which affects their ability to invest in the workforce and their capital assets, and deters new entrants to the market. *Councils should take into account the fact that providers use profit for these reasons, as should a future review of the long-term funding of social care.***

Self-funders and cross-subsidisation

53. Care providers regularly top up or ‘cross-subsidise’ local authority fees with fees from people who pay for their own care, or ‘self-funders’. Several care providers had been advised by councils that they should subsidise the council’s fees by charging higher rates for private

111 [Qq105–106](#)

112 Association of Directors of Adult Social Care ([SOC134](#))

113 [Qq105–106](#)

114 [Q130](#)

115 UK Homecare Association ([SOC173](#))

116 [Q41](#)

clients. Kent Integrated Care Alliance said their members were told that “they should look to make profits from the privately funded service users”¹¹⁷ and Brunelcare had been told their private rates “should be raised in order to subsidise the socially funded provision”.¹¹⁸ Research commissioned by the County Councils Network found that providers were seeking a growing proportion of their business from self-funders and that, in 96% of cases in a large scale sample across England, self-funders paid more than state funded residents in the same home for the same room and the same level of care.¹¹⁹ They also found that the quantum of cross-subsidy was substantial, with an average 43% premium on private payers. David Behan of the Care Quality Commission observed that cross-subsidisation depended on the wealth of the area, giving the example that an authority like Cleveland would have far fewer self-funders than West Sussex.¹²⁰ United Response, a provider of services for adults with learning disabilities, made the point that “there are virtually no self-funders among our clients, so we cannot ‘cross-subsidise’ with private fees”.¹²¹

54. We do not believe it is acceptable for self-funders to pay higher costs for the same care in order to subsidise the costs of local authority funded clients. This is polarising the market, with providers in more affluent areas more able to cross-subsidise their fees than those in poorer areas.

The care market

55. The market for care and support in England comprises many smaller local markets characterised by variations in wealth and geography;¹²² it is also notable in that within local markets councils are ‘super-’¹²³ or ‘monopsony’¹²⁴ purchasers of care. Various factors contribute to the overall stability of the care market. Professor Keith Moultrie, Director of the Institute for Public Care, explained that these included “demand and supply roughly being equal over time, good information on which people can base decisions about purchasing or securing services, and entry and exit to the market”.¹²⁵ The CQC has described the care market as “fragile”, which their Chief Executive, David Behan, explained was due to increasing demand; declining supply; quality concerns; and providers failing, exiting the market and handing back contracts.¹²⁶ He highlighted declining supply, particularly in nursing beds, as a significant issue, particularly in the context of increasing demand. Paul Simic, the Chief Executive of the Lancashire Care Association, said the market was at a “tipping point” which he attributed to funding, issues around quality, oversight and, most particularly, the workforce.¹²⁷ We note, however, that the majority of providers are providing good quality care and that the Care Quality Commission concluded in 2015–16 that “overall quality remains good”, with 1% of adult social care services rated outstanding and 71% rated good.¹²⁸

117 Kent Integrated Care Alliance ([SOC020](#))

118 Brunelcare ([SOC088](#))

119 County Councils Network ([SOC204](#))

120 [Q127](#)

121 United Response ([SOC115](#))

122 [Q113](#)

123 Lancashire Care Association ([SOC044](#))

124 HFT ([SOC119](#)), Lancashire Care Association ([SOC044](#)), Registered Nursing Home Association ([SOC099](#))

125 [Q104](#)

126 [Q104](#)

127 [Q105](#)

128 Care Quality Commission, [The State of health care and adult social care in England 2015–16](#) (October 2016)

56. We have already explored many of the factors outlined above in the preceding sections and will go on to look at the issues affecting the workforce in paragraphs 77 to 100. **The care market is in a fragile state. Contributory factors are increasing demand, together with problems of supply, financial pressure causing providers to fail, exit the market and hand back contracts, a significant workforce shortage, deteriorating quality and increasing and unsustainable reliance on self-funders.**

Market shaping and commissioning

57. The Care Act 2014 places a duty on local authorities to facilitate and promote a diverse and high quality market for care and support services, including prevention services, for all people in their local area, regardless of who arranges and pays for those services.¹²⁹ It is important to note that councils are now responsible for the whole of the care market, including care purchased by self-funders (it is estimated that 43% of residents of independent care homes fund the entire cost of their care, which rises to 57% if those ‘topping up’ local authority funding with private funds are included).¹³⁰

58. We heard this new duty described by Professor Moultrie as a huge shift in what is expected of local authorities, requiring them to maintain business and market intelligence and commercial awareness.¹³¹ Market shaping and commissioning are closely related and are both essential to ensuring appropriate local supply and quality of care. The guidance which accompanies the Care Act states:

High-quality, personalised care and support can only be achieved where there is a vibrant, responsive market of service providers. The role of the local authority is critical to achieving this, both through the actions it takes to commission services directly to meet needs and the broader understanding of and interactions it undertakes with, the wider market, for the benefit of all local people and communities.¹³²

59. This guidance also sets out the principles and steps that councils are expected to follow in shaping the market and commissioning. The principles include focusing on outcomes and wellbeing; promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support and supporting sustainability. The steps councils are expected to follow include engaging with providers and local communities and securing supply in the market and assuring its quality through contracting.

Market shaping

60. We heard that best practice in market shaping involved the creation of “longer-term partnerships and relationships with providers that can build in security and minimise risk of breakdown within the market”.¹³³ Norfolk County Council said that they invest

129 Care Act 2014, [section 5](#)

130 LaingBuisson 2013a, cited in The King’s Fund, [Paying for Social Care: Beyond Dilnot](#) (May 2013)

131 [Q113](#)

132 Department of Health, Care and support statutory guidance, [para 4.1](#)

133 [Q113](#)

a lot of time and effort into market shaping: “We have a comprehensive market position statement [...] annual care conferences and local provider forums”.¹³⁴ ADASS South Eastern Region described:

Work[ing] closely with providers to ensure the market responds to emerging need, required service developments and changing practice. This is achieved through contract review process, ongoing discussion, events and workshops, joint work and mechanisms such as the production of Market Position statements.¹³⁵

61. However, a survey of councils by the Local Government Association (LGA) suggested that not all felt able to shape the market; only 15% of councils who responded felt that they “understand and can fully shape their markets to deliver choice, diversity and quality” and 81% felt that they could only “partially influence” the market.¹³⁶ The LGA said that many cited funding pressures, the National Living Wage and recruitment and retention as prohibiting factors. We also heard that councils’ ability to shape the market was linked to the number of self-funders in an area: where an area had a high number of self-funders, the council’s ability to influence the market was limited as providers were not dependent on local authority funded clients: the reverse was the case in areas with few self-funders.¹³⁷ The County Councils Network said there was evidence of a “two-tier’ polarised market, with providers seeking an ever increasing proportion of their business from higher fee paying ‘self-funders’, locking out local authorities from accessing segments of their local market”.¹³⁸

62. Care providers were often critical of councils’ market shaping practices; for example, Surrey Care Association said that, in its area, market shaping was “underdeveloped and ineffective”¹³⁹ and Martha Trust said:

Our feeling is that behind the façade of consultation there lies no substance and the authority has already made its own decision ahead of the consultation. Market oversight is patchy. Authorities have some knowledge of local markets but communication within and between teams in their structure can be less than perfect. Market development initiatives in general appear at first sight to be inclusive but in practice the motivation is self-centred on the part of local authorities with, in reality, little regard for the opinions, needs or ethos of providers.¹⁴⁰

In addition, the lack¹⁴¹ or poor quality¹⁴² of market position statements was often noted. Care England said:

Largely, these do not account for the impact of cuts to social care, nor do they explain where savings will be made. While they demand a lot from

134 Norfolk County Council ([SOC103](#))

135 Association of Directors of Adult Social Care South East Region ([SOC171](#)). See also West Berkshire County Council ([SOC162](#)) and St Helens Council ([SOC014](#))

136 Local Government Association ([SOC75](#))

137 Lancashire County Council ([SOC141](#))

138 County Councils Network ([SOC204](#))

139 Surrey Care Association ([SOC091](#))

140 Martha Trust ([SOC057](#))

141 Surrey Care Association ([SOC091](#)), Lancashire Care Association ([SOC044](#))

142 Jewish Care ([SOC061](#))

providers, they rarely outline gaps in the market, the impact of staff shortages, a long view of changing demography, or propose concrete solutions. Few offer any analysis of local workforce needs.¹⁴³

A separate LGA survey of providers in February 2016 found that 68% of providers had regular contact with their local authority through a provider forum or equivalent and around 50% said that discussions with councils on commissioning priorities and plans were “very or fairly effective”.¹⁴⁴ We heard that the funding pressures experienced by councils, and in particular the impact this has had on fees, were a direct challenge to relationships with providers and councils’ ability to fulfil their market shaping duties.¹⁴⁵ Heritage Care Group said that:

Our experience, given the constraints on local authority budgets, is that there is a tension between the strategic planning aspirations detailed in market positioning statements and acute funding pressures forcing Authorities into short term cost management approaches.¹⁴⁶

63. Councils are statutorily responsible for shaping the care market to provide diverse and high quality care for all people in their local area, including self-funders. Successful market shaping by councils involves local engagement and developing trusted relationships and regular dialogue between providers, service users and other partners. However, funding pressures are undermining the relationships between councils and providers, thus affecting councils’ ability to work with them to shape the market. Councils should be reminded that their market shaping responsibilities extend to and include oversight of the financial viability of their local providers.

Commissioning and procurement

64. As nearly all care services are procured from the independent sector, commissioning is a very significant part of the care system. Care Act guidance sets out the wider implications that commissioning has for quality of care and the workforce:

[Local authorities should] assure themselves and have evidence that contract terms, conditions and fee levels for care and support services are appropriate to provide the delivery of the agreed care packages with agreed quality of care. This should support and promote the wellbeing of people who receive care and support, and allow for the service provider ability to meet statutory obligations to pay at least the national minimum wage and provide effective training and development of staff. It should also allow retention of staff commensurate with delivering services to the agreed quality, and encourage innovation and improvement.¹⁴⁷

Despite this significant role, the evidence suggested that the standard of commissioning ranged very widely,¹⁴⁸ and a significant proportion of the evidence we received indicated that, in some areas, commissioning practices were poor. For example, a survey by the

143 Care England ([SOC098](#))

144 Local Government Association ([SOC75](#))

145 [Q113](#)

146 Heritage Care Group ([SOC065](#))

147 Department of Health, Care and support statutory guidance, [para 4.31](#)

148 [Q44](#), National Care Forum ([SOC114](#)), Humberside Independent Care Association ([SOC143](#))

Care Association Alliance reflected this: 58% of its members that responded rated their authorities as either ‘poor’ or ‘extremely poor’ at commissioning and only 10% rated them as ‘good’.¹⁴⁹ We note evidence that churn in council staff has made it difficult to maintain provider-commissioner relationships¹⁵⁰ and led to loss of commissioning skills.¹⁵¹

Provider-commissioner relationships

65. Deteriorating relationships between providers and councils were hindering commissioning as well as market shaping. According to Avenues Group, “lack of communication and collaboration” was a “barrier to effective commissioning”.¹⁵² Other providers said that councils conducted their commissioning in a hostile manner. Surrey Care Association said that the council’s contact with providers was “procurement-led” and “directive, harsh and commercial in its approach”¹⁵³ and Martha Trust said commissioning practices were “not just tough and a search for value” but “inflexible, out of touch, unrealistic and defensive”.¹⁵⁴ Humberside Independent Care Association said:

One local authority chose not to hold consultation meetings with providers regarding rates for 2016–17 and reached their decision based on discussions with other local authorities and the available budget. Other local authorities did not make it easy for providers by refusing to share their pricing mechanism without pressure from providers.¹⁵⁵

Fees

66. The Care Association Alliance said that the most negative interactions between providers and commissioners revolve around fees,¹⁵⁶ which is perhaps unsurprising given that, in response to funding pressures, councils have either frozen fees or are providing small yearly uplifts (see paragraph 42). We heard that lowering fees had become a driving factor in commissioning for some councils, with some using ‘e-auctions’ in which the lowest bidder won the contract.¹⁵⁷ This is contrary to Care Act guidance that fee levels should be appropriate to deliver quality care and allow providers to pay staff at least the national minimum wage and provide training and development. We heard that councils were increasingly taking a “price first, quality second approach”¹⁵⁸ and Brunelcare said that “over the last five years the balance between quality and price has shifted from 70:30 to 50:50” leading to them deciding to withdraw from several bids.¹⁵⁹ Professor Green, Chief Executive of Care England, told us that:

149 Care Association Alliance ([SOC027](#))

150 [Q151](#)

151 Surrey Care Association ([SOC091](#)), Oxfordshire, Care England ([SOC098](#))

152 Avenues Group ([SOC059](#))

153 Surrey Care Association ([SOC091](#)). See also Humberside Independent Care Association ([SOC143](#))

154 Martha Trust ([SOC057](#))

155 Humberside Independent Care Association ([SOC143](#))

156 Care Association Alliance ([SOC027](#))

157 Registered Nursing Home Association ([SOC099](#))

158 Avenues Group ([SOC059](#))

159 Brunelcare ([SOC088](#))

There is a misnomer in talking about negotiations with local authorities. The vast majority of local authorities have a set budget and the negotiation is about going down from a figure, not identifying what the true costs of care are.¹⁶⁰

On the other hand, there was evidence that some providers were placing low fee bids which, in some cases, were financially unsustainable and led to them handing back the contract.¹⁶¹ Janice Dane of Norfolk County Council said, however, that her council would not accept the lowest price and would question whether low prices covered care workers' travel time.¹⁶²

67. The Care Act guidance suggests that, to guide fee setting, authorities should have reference to three costs of care models: UK Homecare Association Minimum Price for Homecare,¹⁶³ the LaingBuisson Fair Price toolkit¹⁶⁴ and the ADASS Paying for Care calculator.¹⁶⁵ Essex Independent Care Association said that, in collaboration with other providers, it had carried out a costs of care exercise and that:

The costed models produced figures which were well in excess of those currently being paid by the local authority. Both domiciliary care and residential care providers have been informed by the local authority that their budgets do not allow for the costed models to be adopted and they can only pay what their budgets permit.¹⁶⁶

However, Lancashire Care Association said that developing a fair price model had been a positive development for its local care market,¹⁶⁷ and Tim Hammond, the Chief Executive of Four Seasons Healthcare, said it would be helpful to have an agreed, transparent method of working out the costs of care across the whole country.¹⁶⁸

68. Funding pressures have similarly affected the commissioning relationship between councils and providers. The pursuit of low fees has become the driving factor in commissioning for some councils, despite Care Act guidance that they should be appropriate to deliver quality care and allow providers to properly remunerate and train staff. A standard process for assessing the costs of care, which takes into account local variations in wage rates, and setting fair prices that reflect costs, would help guide local authorities. It should focus on key services such as residential care for older people and home care, be designed by an independent body and agreed by provider representatives and councils through the Local Government Association, the Association of Directors of Adult Social Care, and the Department of Health.

Procurement: tendering, contracting

69. As in any procurement process, care providers are expected to bid for care services contracts. Some providers were critical of the tendering process, saying that it was a slow

160 [Q151](#)

161 [Q44](#). See also Brunelcare ([SOC088](#))

162 [Q117](#)

163 UK Homecare Association, [A Minimum Price for Homecare](#) (September 2015)

164 LaingBuisson, [Care Cost Benchmarks](#), Seventh Edition (2015–16)

165 ADASS, [Paying for Care calculator](#)

166 Essex Independent Care Association ([SOC147](#))

167 Lancashire Care Association ([SOC044](#))

168 [Q151](#)

and costly exercise. Several tendering processes that Brunelcare had taken part in had been delayed and eventually extended to two years, over which time they estimated the costs of their input had amounted to £51,000.¹⁶⁹ They also said that tenders were increasingly cost rather than quality focused and that recently one had been “very onerous and probably beyond the capacity of many small providers”. Similarly, Lancashire Care Association argued that substantial resources are wasted in “overly complex and burdensome tendering processes”.¹⁷⁰ Concerns were also raised about delays in re-tendering, leading to short-term rollovers of contracts which inhibit providers’ financial planning.¹⁷¹ Providers also said that councils were using tendering and commissioning processes as a way of monitoring providers for quality and safeguarding, duplicating the work of the CQC and adding to existing regulation.¹⁷²

70. Professor Moultrie of the IPC said that the type of contracts used by councils to commission care “minimise[d] transaction costs”, enabling councils and providers to “spend more time on outcomes”.¹⁷³ Some providers, however, felt contracts were aimed at ease of commissioning and efficiencies, rather than ensuring quality of care or a diverse market unfair.¹⁷⁴ Others felt that contract terms were unfair, but said that they were often not in a position to argue. For example, Exalon Autonomy Group said:

[Learning disability] residential placements are usually agreed using a framework agreement between the provider and the local authority. These agreements are drafted by the [local authority], and are non-negotiable—it is a case of “take it or leave it”, leaving the provider with no choice if it wants to continue in business. In our experience such agreements give the local authority carte blanche with regard to fee uplifts (or even reductions) and are woefully deficient in providing for dispute resolution when it comes to fees.¹⁷⁵

We also heard that some councils were using per-minute billing or ‘banding’ for home care contracts. Colin Angell, Policy and Campaigns Director at the UK Home Care Association, said this meant that “You might work 25 minutes, but because it was not 30 minutes, the authority would round the time down to 15 minutes of pay”.¹⁷⁶

71. When we asked whether it would be possible for councils to contract on the basis of outcomes and quality rather than price, José-Luis Fernández, Deputy Director of the Personal Social Services Research Unit at the LSE, said that there was a lot of interest in the issue but that it was very difficult.¹⁷⁷ Janice Dane of Norfolk County Council explained why:

In terms of contracts, outcomes are hard. It is far easier to buy chunks of time and tasks than it is to work with outcomes. That is an area in which

169 Brunelcare ([SOC088](#))

170 Lancashire Care Association ([SOC044](#))

171 Brunelcare ([SOC088](#)), Heritage Care ([SOC065](#))

172 Lancashire Care Association ([SOC044](#)), [Q151](#), Brendoncare Foundation ([SOC053](#))

173 [Q132](#)

174 Q324 [Heather Wakefield], Save Autism Services Haringey ([SOC093](#)), Care Association Alliance ([SOC027](#)), Brunelcare ([SOC088](#))

175 Exalon Autonomy Group ([SOC125](#))

176 [Q148](#)

177 [Q46](#)

we are trying to improve, but it becomes very difficult to know when those outcomes have been achieved, who decides that and how to trigger the payment.¹⁷⁸

The Botton Village Families Group had experienced changes in the way the care was provided to their relatives which greatly concerned them and, as a result, suggested the Department issue guidance on the Care Act and other relevant legislation to ensure quality in provider-commissioner contracts.¹⁷⁹

Oversight

72. Our witnesses agreed with calls from provider bodies for oversight of local authority commissioning.¹⁸⁰ Professor Green, Chief Executive of Care England, said he had:

Advocated an oversight role for a long time, because it is about the only bit of the system that is not accountable to anybody for its performance [...] Every stage at which there is a requirement to do something, the rest of the system is locked down, quite rightly, by someone with oversight. The local authorities are not in that space. There is a real problem about not having that element of the system properly monitored for outcomes and performances.¹⁸¹

73. As nearly all care services are procured by local authorities from the independent sector, commissioning is a very important part of the system. There was significant evidence from providers about poor practice, unfair contracts and depleted commissioning teams. The market shaping, commissioning and procurement activities of councils are the only part of the system which are unregulated, yet they have a direct impact on the quality and diversity of care people receive and the sustainability of the sector. The Care Quality Commission's remit should be extended to include oversight of these activities, as well as the extent to which councils comply with the fair costs of care in their negotiations and contractual relationships with providers. It should also work with the sector to produce best practice template contracts for the provision of care services. The Department of Health should also review the guidance on commissioning which accompanies the Care Act 2014.

Monitoring and quality assurance

74. The councils often described the quality assurance arrangements they had in place to monitor the services they had commissioned.¹⁸² However, the undercover investigation undertaken by the Channel Four Dispatches programme demonstrated that such arrangements were far from infallible. Their investigation revealed that home care workers in Haringey were being paid below the national minimum wage, despite Care Act guidance saying that councils should assure themselves that the minimum wage was

178 [Q133](#)

179 Botton Village Families Group ([SOC179](#))

180 Care Association Alliance ([SOC027](#)), Humberside Independent Care Association ([SOC143](#)), Kent Integrated Care Alliance ([SOC062](#)), Lancashire Care Association ([SOC044](#))

181 [Q153](#)

182 Leicester City Council ([SOC150](#)), Isle of Wight Council ([SOC109](#)) and Liverpool City Council ([SOC127](#))

paid.¹⁸³ Heather Wakefield, National Secretary for Local Government at UNISON, said that a survey of councils by her organisation had found that around 70% did not monitor contracts to ensure payment of the national minimum wage and quality of care.¹⁸⁴

75. The evidence we have heard suggests that not all councils routinely monitor the care services they procure to ensure that they are sufficient to meet people’s needs, and are of a high enough quality and adequately resourced, for example to pay for care workers’ travel time and ‘sleep ins’. Councils should undertake annual auditing of the services they commission and the Care Quality Commission’s extended remit should also oversee councils’ arrangements for monitoring the care services they have purchased and the effectiveness of that monitoring.

76. The Channel Four Dispatches programme further highlighted the difference between the care councils were commissioning and the actual delivery of it. Their investigation, which included secret filming and freedom of information requests to councils, found large numbers of late, missed and truncated home care visits and errors in administering medicines. We heard evidence about the increasing potential for councils, carers and relatives to use digital technology, which we explore in paragraph 146, to verify that care has been delivered.¹⁸⁵ **Councils should regularly carry out ‘spot checks’ to ensure that people are actually receiving the care they require and be alert to new technological developments in this area.**

Workforce

77. A substantial proportion of the social care workforce consists of people who have worked as care workers for many years. According to Skills for Care’s dataset, workers had, on average, eight years of experience in the sector and around 70% of the workforce had been working in the sector for at least three years.¹⁸⁶

78. As discussed in paragraph 17, the size, calibre of the workforce and, linked to this, the standard of their employment, is key to ensuring quality of care; as Sharon Allen, Chief Executive of Skills for Care, said, “to provide genuinely person-centred care and support, you have to treat your workforce in a person-centred way as well”.¹⁸⁷ An adequate workforce is also essential to meeting demand for social care in the coming years and it is estimated that another 275,000 people will be needed to work in the sector by 2025.¹⁸⁸ However, in 2015, 6.8% of roles (84,000 jobs) were vacant and the turnover rate for all directly employed staff working in social care was 27.3% and 35.9% among nurses working in social care.¹⁸⁹ A large proportion of staff turnover is a result of people leaving the sector soon after joining (47.8% of care workers left within a year of starting).¹⁹⁰ This points to severe challenges in maintaining staffing levels and we explore the evidence for this in

183 Channel 4 Dispatches, [Britain’s Pensioner Care Scandal](#) (April 2016)

184 [Q350](#)

185 [Q229](#)

186 Skills for Care, [The state of the adult social care sector and workforce in England](#) (September 2016)

187 [Q324](#)

188 [Q311](#)

189 Skills for Care, [The state of the adult social care sector and workforce in England](#) (September 2016)

190 Skills for Care, [The state of the adult social care sector and workforce in England](#) (September 2016)

the paragraphs below. In addition, we heard concerns that, as 7% of the overall social care workforce is from the EU, rising to 10% in the South East and 12% in London,¹⁹¹ the recruitment and retention challenge may increase.¹⁹²

Key challenges

Recognition and status

79. Our witnesses were concerned by the lack of recognition afforded to care work.¹⁹³ Sharon Allen of Skills for Care said:

One of the most important things we can do is to address the image, the profile and the status [...] I am often frustrated to hear people conflate low pay with low skill and low value. Most people working in adult social care are undertaking very skilled roles and they need high skills and personal attributes and high levels of resilience to be able to do what they do.¹⁹⁴

This was also a common theme among the care workers who posted comments on our online forum, one of whom said “it is more often or not a job of last resort, rather than a job of choice [...] we are not respected, valued or recognised”. Another said that there needed to be a national campaign valuing the work that care workers do.

Pay and conditions

80. Care workers’ pay is very low and payment of sick pay¹⁹⁵ and pensions¹⁹⁶ is not universal. Skills for Care collects employment data for the sector, including the yearly and hourly rates of pay. The current full time median annual pay and median hourly rates are:

Table 2: Full time median annual pay and median hourly rates, 2016–17

Role	Median annual pay	Median hourly rate
Registered manager	£30,031.51	£13.45
Registered nurse	£26,936.25	£14.01
Social worker	£31,257.98	£17.57
Senior care worker	£17,387.06	£8.20
Care worker	£14,085.00	£7.40

Skills for Care: [National Minimum Dataset—Social Care](#)

Skills for Care provided further data to the Committee showing that care worker pay decreased in real terms by around 6% between 2009 and 2016, suggesting that the impact of the funding pressures of social care budgets passed from councils to provider fees and onto staff wages. A care worker who contributed to our online forum said:

191 Skills for Care, *The state of the adult social care sector and workforce in England* (September 2016)

192 National Care Forum ([SOC114](#)), Oxfordshire Association of Care Providers ([SOC092](#)), Royal College of Nursing ([SOC081](#))

193 Mandy Abbey ([SOC036](#)), Kent Integrated Care Alliance ([SOC062](#)), [Q156](#)

194 [Q327](#)

195 [Q323](#)

196 [Q337](#)

We have bills to pay and families of our own to look after. Our pay packets do not reflect the valuable and NECESSARY contribution we make to society. I do love my job but with it comes responsibility, unsociable working hours, & loads of training and working towards qualifications. We are undervalued ... And often overlooked.

Despite static or declining wages, the complexity of the work had increased. Colin Angell, Policy and Campaigns Director at the UK Home Care Association, said home care workers were becoming more like district nurses and undertaking tasks not previously expected of them”.¹⁹⁷ Witnesses observed that the low rates of pay and challenging nature of the work meant that people often preferred to work for the same pay in less stressful jobs in retail or leisure.¹⁹⁸

Non-payment of the national minimum wage

81. Pay levels are also affected by the practice of only paying care workers for the time they spend with clients, and not the time spent travelling between clients, handovers, training or ‘on-call’ hours in home care and residential care. The National Audit Office has estimated that as many as 160,000 to 220,000 care workers in England are paid below the national minimum wage because of the practice of only paying for ‘contact’ hours.¹⁹⁹ A survey of councils by UNISON found that only 35% of councils in England make it a contractual condition that their home care providers pay their workers for travel time.²⁰⁰ A care worker who contributed to our online forum said:

I love what I do but to be paid the hours I am actually in uniform and at work instead of just for the calls I do would be lovely. I don’t know many other jobs that you work 14 hour split shifts but only earn 10 hours money. [...] I do roughly 12,000 miles a year for work ... that’s a set of tyres.

82. UNISON has created an ‘Ethical Care Charter’ aimed at improving standards the home care sector. It has been adopted by 26 councils which have committed to ensuring that there is continuity of care, ending 15 minute visits for personal care, paying staff a living wage and ensuring that they are paid for their travel time. The union reported that some of the councils that have adopted it have experienced improved recruitment and retention rates and staff morale leading to better services and outcomes for the people receiving care.²⁰¹

The National Living Wage

83. While all our witnesses welcomed the intention behind the National Living Wage (NLW), we heard evidence that the practical consequences of the rise in pay were challenging for providers. Firstly, in that it is not being reflected in the fees paid by councils to providers (which we explored in paragraph 42) and, secondly, that it made it more difficult for employers to differentiate between staff levels. Sharon Allen, Chief Executive of Skills for Care, summed up the situation:

197 Q145. See also Mandy Abbey (SOC036)

198 Surrey Care Association (SOC033), Norfolk County Council (SOC103), Home of Comfort for Invalids (SOC106), North West Region Association of Directors of Adult Social Care (SOC139)

199 National Audit Office, *Adult social care in England: overview*, 13 March 2014, HC 1102

200 UNISON (SOC025)

201 UNISON (SOC025)

Everybody supports raising up the pay of the lowest-paid workers. People would like to pay their staff more but they can only afford to pay what is in the commission, and then the differential to then move up to being a team leader, a senior or a registered manager becomes less attractive because the national living wage is driving up the entry pay.²⁰²

Similarly, the Voluntary Organisations Disability Group said it had “flatten[ed] out the differential that many providers have sought to achieve to make social care an attractive career of choice.²⁰³ For providers, this would be an increasing concern as the NLW rises over the coming years.²⁰⁴ In addition, we heard that, having equalised pay across a broader range of employers, the NLW had increased the competition for staff with other sectors, where, as we highlighted earlier, the work may be less stressful.²⁰⁵

84. We heard that the NLW would not make a difference to the challenges of recruiting and retaining a high calibre workforce, capable of the demanding work involved²⁰⁶ and that it was “not enough to be commensurate with the skills and responsibilities required”.²⁰⁷

Working conditions

85. We were also told that working patterns, as well as wages, directly affected care workers’ job satisfaction and the quality of care they provided.²⁰⁸ According to Skills for Care, 24% of care workers (315,000 people) were recorded as being on zero hour contracts in 2015, compared with 2.9% of the workforce nationally.²⁰⁹ Home care had the highest proportion (49%) of workers on zero hour contracts. While some witnesses thought that flexible working arrangements could suit some workers,²¹⁰ others believed that these contracts hindered recruitment and retention²¹¹ and quality and continuity of care.²¹² A contributor to the online forum who had previously worked on a zero hour contract said that, now they had a full-time contract, they were enjoying their work a lot more. Sharon Allen of Skills for Care said that the key issue was whether care workers were offered genuine choice in the matter.²¹³

Training and development

86. No qualifications are required for work in social care, which makes the provision of training for care workers important. A survey of a thousand care workers conducted by UNISON in 2015 found that 27% had received no dementia training and that, of those that administer medication, 24% had received no training.²¹⁴ Heather Wakefield of UNISON said “there isn’t a sense that this is a job you can go into and really develop your skills.

202 [Q314](#)

203 Voluntary Organisations Disability Group ([SOC043](#))

204 Camphill Village Trust ([SOC049](#))

205 [Q315](#) See also [Q42](#)

206 Kent Integrated Care Alliance ([SOC062](#))

207 [Q315](#) See also [Q42](#)

208 [Q156](#)

209 Skills for Care, *The state of the adult social care sector and workforce in England* (September 2016)

210 [Q156](#)

211 UNISON ([SOC025](#))

212 [Q324](#)

213 [Q325](#)

214 UNISON, *UNISON’s homecare training survey report* (undated)

People do it by looking at a video or just learning on the job”.²¹⁵ The Cavendish Review found in July 2013 that “Training is neither sufficiently consistent, nor sufficiently well supervised, to guarantee the safety of all patients and users in health and social care”.²¹⁶ We also note that the undercover reporter in the Channel 4 Dispatches documentary was allowed to pay home visits to clients alone after only three days of shadowing.

87. We heard that more than 70% of councils do not include an element for training in the fees they pay to providers,²¹⁷ despite the statutory guidance that councils should assure themselves that fee levels should provide for “effective training and development of staff”. Providers said that lack of funding was affecting their ability to recruit, train and pay staff to a level that would meet the increased level of needs of their clients.²¹⁸ Clare Jacobs, Employment Relations Advisor at the Royal College of Nursing (RCN), identified the further challenge that:

Most social care is provided by smaller providers, which on the basis of economies of scale just do not have the resources to put in a training and development package or to employ people to do training and development. You have lots and lots of small providers, and it is not something that is centrally funded or provided, so there is a huge training and development gap in the market.²¹⁹

The Department for Health funds a Workforce Development Fund from which providers can claim for the costs of learning and development, but we heard that this was heavily over-subscribed and not used by all organisations.²²⁰

Nursing in social care

88. The challenges facing the care workforce appeared to be more acute for nursing in social care. Skills for Care’s data revealed that, despite a rise of 3% in 2012, the number of nurses working in the adult social care sector decreased by 4% between 2011 and 2015, reducing from 49,000 to 47,000.²²¹ The vacancy rate of registered nurses was high, at 9.2%, an average of 4,300 vacancies at any one time, and the annual turnover rate was also high, at 35.9%.

89. Providers described struggling to recruit the number of nurses they needed,²²² with some having consistently high numbers of vacancies²²³ and some waiting up to two years to fill them.²²⁴ Guild Care said that, as a result, they had had to rely on agency nurses at a cost of one third more per hour than their employed nurses.²²⁵ This situation may be contributing to the decline in the number of nursing beds across the country as nursing homes either exit the market or convert to care homes.²²⁶ Janice Dane, Assistant Director

215 [Q327](#)

216 The Cavendish Review, *An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings* (July 2013)

217 [Q327](#)

218 Home Group ([SOC126](#)), Eden Futures ([SOC157](#))

219 [Q327](#)

220 [Q343](#)

221 Skills for Care, *The state of the adult social care sector and workforce in England* (September 2016)

222 Guild Care ([SOC073](#))

223 MHA ([SOC117](#))

224 Care England ([SOC098](#))

225 Guild Care ([SOC073](#))

226 [Q108](#)

of Early Help and Prevention at Norfolk County Council, said that, in the last 16 months, there had been a reduction in nursing beds in seven different homes from which her council commissioned care: this was equivalent to a 5% reduction in the beds available.²²⁷

90. In 2015, registered nurses were paid a mean annual salary of £25,000,²²⁸ which is within the NHS' 'band five rate', above which there are 8 further pay bands. While social care nurses earn significantly more than care workers, they earn less than their counterparts in the NHS and do not have access to the other opportunities that working in the NHS affords, such as the NHS pension and career progression.²²⁹ As a result, providers said it was difficult to compete with the NHS for staff and that they were losing staff to the NHS.²³⁰

91. Clare Jacobs of the RCN highlighted the importance of the role of social care nurses with the workforce: "Nursing has unique knowledge, skills and professional accountability to assess clients adequately, and manage and evaluate their care".²³¹ Furthermore, there was an increasing need for nurses in social care as demand and the complexity of people's care needs increases.²³²

92. The workforce is essential to quality of care. High vacancy and turnover rates point to severe challenges. A range of factors are responsible, including low pay not commensurate with the level of work involved, low status, poor terms and conditions, and lack of training opportunities and career progression. Vacancy and turnover rates are particularly high among social care nurses, who understandably prefer the better pay and conditions and career development in the NHS.

93. Non-payment of the national minimum wage is widespread as a result of providers failing to pay care workers for their travel time, travel costs and 'sleep in' shifts. *When commissioning care, councils must ensure that providers pay enough to comply with the national minimum wage and to cover care workers' travel time and costs and 'sleep ins'. Contracts between councils and providers should stipulate this and councils should regularly monitor compliance.*

94. *The Government, working with the Local Government Association, should publish a care workers' charter, drawing upon UNISON's Ethical Care Charter, which sets out what care workers can expect from their employer. Employers should be expected to demonstrate their commitment to supporting and developing care workers.*

95. The National Living Wage, although welcome in a low paid sector, will not be sufficient to bring pay into line with skills and responsibilities or to improve vacancy and turnover rates. It has increased competition from less stressful jobs in other sectors and made it challenging for providers to differentiate pay between staff levels. Provision of additional funding for social care would enable providers to pay staff wages above the National Living Wage and provide staff with training. *The Government*

227 [Q128](#)

228 Skills for Care, [The state of the adult social care sector and workforce in England](#) (September 2016)

229 National Care Forum ([SOC114](#)), [Q340](#)

230 Guild Care ([SOC073](#)), Lancashire Care Association ([SOC044](#))

231 [Q344](#)

232 [Q108](#)

should request that Skills for Care, in discussion with unions and providers, conducts research to determine what level of wage is needed to sustain the workforce and attract new entrants.

96. *The Government should encourage local authorities and their NHS partners to develop local joint strategies for recruitment and retention of social care nurses and to reduce competition between sectors for staff. Ensuring adequate nursing capacity in social care is essential if councils are to be able to support hospitals in the prompt discharge of patients.*

Care workers employed through direct payments

97. Social care users can opt to receive a direct (cash) payment so they can choose which services they purchase, which can include employing a personal assistant (PA). However, some of the direct payments recipients that we spoke to at our round table event said they had received no support from their local authority on recruiting and employing staff and consequently found the responsibility of being an employer a burden. Anna Severwright, who gave evidence to us, said:

There is not much support from my local authority if I have an issue with a PA; I am kind of left to sort it all myself. It has been a steep learning curve in how to be an employer, because I had never done that before.²³³

UNISON said that care workers employed in this way can find themselves in “a precarious position at work, with their employment rights often not properly observed”.²³⁴ Sharon Allen of Skills for Care said that support for individual employers and PAs had actually increased and that the challenge therefore was people often not realising they had become an employer.²³⁵ She said that more needed to be done to make people aware of this and then to direct them towards support. We agree. **Direct payments are a great opportunity for people to take control of and personalise their care. However, councils must ensure that people are comfortable with and able to take on the employment responsibilities that direct payments entail and guide people to sources of support and advice on being an employer.**

Improvement

98. We asked our witnesses what needed to be done to improve recruitment and retention in social care workforce, they had a number of suggestions linked to solving the challenges set out above. We heard that addressing the image, profile and status of the job was the key priority and that there was a “better story to tell” about the high level of skills and personal resilience needed to be a social care worker.²³⁶ Alongside this, there needed to be

233 [Q295](#)

234 UNISON ([SOC025](#))

235 [Q326](#)

236 [Q327](#)

a career structure which afforded care workers opportunities for progression (much like the NHS Knowledge and Skills Framework),²³⁷ better training,²³⁸ further investment in qualifications,²³⁹ and fairer pay, terms and working conditions.²⁴⁰

99. Simon Stevens, the Chief Executive of NHS England, outlined some recent positive developments:

One of the things we are committed to doing is creating more ladders of opportunity for people from care assistant jobs into the new nursing associate role, and then from the nursing associate role into being a registered nurse. That [...] is one of the ways in which we can make the care assistant role important, not only week in, week out, but as a career path that leads to advancement.²⁴¹

100. *The status of care work must be improved to ensure a high quality and sustainable workforce which keeps pace with demographic change. Better pay, commensurate with skills and responsibilities, and better terms and conditions, including pensions, will be part of this, as will the development of a strong career structure—from apprenticeship to registered nurse—and centrally delivered training with national standards and qualifications, similar to the NHS Knowledge and Skills Framework. The Department of Health should consider whether a national recruitment campaign, similar to Teach First or Step Up To Social Work, would be an appropriate mechanism to achieve this and whether care work should be designated a registered profession.*

Carers

101. Carers are entitled to assessments of their own needs for support, including those relating to education, employment and training, and to have those needs to be met. We explore the take-up of carer assessments at paragraphs 106 to 109 and the provision of support in paragraphs 110 to 114.

Increasing reliance on unpaid carers

102. Research by Carers UK found that, between 2010–11 and 2013–14, the number of unpaid carers had increased by 16.5% (compared to an increase in the general population of 6.2%), that the number of people providing 20–49 hours of care a week has increased by 43% since 2001 and that the number of people caring for fifty or more hours per week had increased by a third.²⁴² They attributed this to a decrease in the amount of care and support provided by councils in the context of increasing need (this issue is covered in paragraphs 8 to 16). This suggestion was supported by the evidence we received from people who receive social care²⁴³ and from the unpaid carers we took formal evidence from²⁴⁴ or spoke to at our informal roundtable.

237 [Q327](#)

238 [Q327](#)

239 [Q343](#)

240 [Q327](#) See also [Q277](#)

241 [Q277](#)

242 Carers UK ([SOC161](#))

243 [Q296](#)

244 [Q185](#)

103. Councils often acknowledged the important contribution made by carers; for example, ADASS North West said, without their “vast contribution”, the care system would “be bust”.²⁴⁵ Cllr Palmer, Lead Member for Adult Social Services at Leicester City Council, said that some families in his authority area were reporting that changes in care packages had led to an “increased level and scope of responsibility and pressure on unpaid carers and families” which he said was a real challenge to local government.²⁴⁶ In contrast, Surrey Care Association said their council’s “stated policy” was to use family, friends and community to provide unpaid care.²⁴⁷

104. At a time when the system’s reliance on unpaid carers is increasing, we heard that a “care gap” was emerging. Dr Linda Pickard, Associate Professorial Research Fellow at the LSE, said that:

[A] shortfall in intergenerational carers is projected to emerge in 2017 [...] and will grow rapidly from then onwards. The shortfall will amount to approximately 15,000 care providers in 2017, 50,000 in 2022, 105,000 in 2027 and 160,000 in 2032. The shortfall will mainly affect intergenerational care provided by children to their older parents.²⁴⁸

She explained that demographic change meant that “numbers of older people aged 85 and over in the UK are rising much faster than numbers in the younger generation aged 50 to 64”, while the number of ‘spouse carers’ was likely to keep pace with demand due to improvements in male mortality.²⁴⁹ Furthermore, carers are ageing; the number of carers over the age of 65 has risen by 35% since 2001, compared with a rise in the total number of carers of 11%.²⁵⁰ We note the challenge this poses to the Health Minister’s suggestion that society should start thinking more about the role of children in looking after their parents.²⁵¹

105. The social care system is heavily, and increasingly, reliant on unpaid carers. As councils have reduced the amount of care they supply, unpaid carers have stepped in to fill the gap, providing more hours of higher level care. However, demographic changes mean that a growing shortfall in intergenerational carers is projected, which poses a challenge to the suggestion that children may need to care more for their parents in future. It is clear that, unless social care receives more funding, the system will not have the capacity to fill the shortfall in the future.

Assessments of carers

106. The Care Act requires councils to identify, assess and meet a carer’s needs for support, if they are financially eligible, and in doing so have regard to whether they are in work, education or training or would like to be. While it was evident that councils take

245 North West Region Association of Directors of Adult Social Care ([SOC139](#)). See also Norfolk County Council ([SOC103](#))

246 [Q162](#)

247 Surrey Care Association ([SOC091](#))

248 [Q160](#)

249 [Q160](#)

250 Carers UK, [Facts about carers: policy briefing](#) (October 2015)

251 [Q395](#)

their duties towards carers seriously,²⁵² we heard that such duties presented challenges to councils, firstly, in terms of identifying carers and, secondly, in meeting the costs of carers' assessments.

107. Cllr Palmer of Leicester City Council said that, although 30,000 people had identified themselves as a carer in the 2011 Census, only 2,200 carers were in contact with the council.²⁵³ This was also the case for Lancashire County Council, which had only a "small proportion" of the carers identified in the 2011 Census on their database.²⁵⁴ We heard that the reasons for the difficulties in identifying carers could be cultural, apprehensiveness on the part of the carer as to what an assessment might entail or because they did not realise they were a carer.²⁵⁵

108. However, Peter Turner, Chief Executive of Carers First (Kent and Medway), said that councils had an incentive not to identify carers due to the cost implications,²⁵⁶ and we received evidence from councils highlighting the costs of carers' assessments and the added pressure this put on their social care budgets.²⁵⁷ Cllr Palmer said that, while his council did actively seek out carers for support:

If half of those 20,000-odd carers [...] came forward, and two-thirds of them were eligible for support, let me put it in absolutely straightforward terms: that would essentially bankrupt my local authority. It is as black and white as that. That presents a real tension and quandary. We do go out there and seek carers to come forward, to support them.²⁵⁸

109. Dr Pickard of the LSE said that research on carers' assessments had shown that managers and practitioners may be "rationing access to carers' assessments due to resource constraints" and that councils are tending to focus on assessing carers with the most intensive caring responsibilities or "virtually round-the-clock caring".²⁵⁹ Furthermore, Vicky McDermott, Chair of the Care and Support Alliance, said that carers were being told by their council, "If you have a couple of quid, we are not going to bother doing the assessment".²⁶⁰ Peter Turner said that the incentive to reduce the number of carers' assessments was "perverse" because carers were at the forefront of "keeping people out of hospital beds, residential care homes and GP surgeries".²⁶¹ Some of the carers who attended our roundtable event expressed concerns about the assessment process saying that they had found it be a box-ticking exercise and that council staff carrying out the assessment did not really listen to or empathise with them.

252 [Liverpool City Council \(SOC127\)](#)

253 [Q161](#)

254 [Lancashire County Council \(SOC141\)](#)

255 [Qq175](#), [Q191](#)

256 [Q188](#)

257 [London Borough of Camden \(SOC129\)](#), [Bristol City Council \(SOC132\)](#), [Lancashire County Council \(SOC141\)](#), [St Helen's Council \(SOC014\)](#)

258 [Q176](#)

259 [Q178](#)

260 [Q14](#)

261 [Q182](#)

Support

110. Support for carers takes various forms; equipment at home, such as help from care workers or ‘replacement’ or ‘respite’ care to enable the carer to have a break. There was significant evidence that support for carers was not readily available. For example, Carers UK said that 20% of carers who were providing 50 hours or more of care each week were receiving no practical support.²⁶² A Freedom of Information request to councils by Revitalise showed that, between April 2015 and April 2016, 42% had reduced their spending on respite care by an average of £900,000 each.²⁶³ Day centres are also an important way to provide respite for carers, but have been similarly affected by the funding pressures.²⁶⁴ Margaret Dangoor, who cares for her husband, who has advanced dementia, told us that:

Our caring cafe used to be held every Saturday. It is now every other week, and even then there are murmurings asking how they are going to keep it going, because of funding. These core services are really respite, because the person with dementia comes along with the carer, and then we have an opportunity to go into a little meeting on our own.²⁶⁵

Even where respite care was available, there were concerns about its quality. Independent Age said that some carers refused respite care because of its poor quality and that those who did accept it “felt a sense of unease and worry that [it] would not be adequate”.²⁶⁶ The Alzheimer’s Society’s helpline reported that:

[A lady] with dementia was supposed to go into respite for three weeks, but the care home didn’t understand her medication needs. The carer had to go in every day and ended up taking her home after a week and a half.²⁶⁷

111. Emily Holzhausen of Carers UK said that people were providing more care “without the kind of backup and support that they need in order to keep healthy and well”.²⁶⁸ Her organisation said that carers were suffering from physical injuries and mental ill-health, were less likely to be able to look after their own health and were likely to be socially isolated and depressed.²⁶⁹ A residential care provider told us the carers of people who are admitted to their home are often “at or near the point of exhaustion”.²⁷⁰ A contributor to our online forum said carers suffer with “stress, burnout, vitamin D deficits, back and muscle problems from lifting without support”.

112. In addition, we heard that caring could have a negative effect on a person’s ability to work, which is accentuated if the cared-for person receives no support services.²⁷¹ Carers UK’s 2016 State of Caring Survey found that half (49%) of carers who responded had given up work to care, 12% had retired early, 23% had reduced their working hours and 17% opted to take a less qualified job or turned down promotion.²⁷² One of the carers who contributed to our online forum said “I care for my mother and my aunt, try to keep

262 Carers UK, *State of Caring 2016* (May 2016)

263 Independent Age ([SOC067](#))

264 Brendoncare Foundation ([SOC053](#)), Jackie Luland ([SOC095](#))

265 [Q190](#)

266 Independent Age ([SOC067](#))

267 Alzheimer’s Society ([SOC070](#))

268 [Q163](#)

269 Carers UK ([SOC161](#))

270 Home of Comfort for Invalids ([SOC106](#))

271 [Q168](#)

272 Carers UK, *State of Caring 2016* (May 2016)

a part-time job too, and have a partner. Through my care role I have lost my house, full-time job, car, friends, quality of life, health”. Another said that to combine caring for her mother with work they had taken a less stressful job but with lower wages.

113. The Care Act requires councils to identify, assess and meet a carer’s needs for support, if they are financially eligible. However, councils said that the costs of assessing and supporting carers have significantly added to the pressure on their budgets. This places both local authorities and carers in a very difficult position.

114. Caring, particularly as it becomes more intensive, has serious consequences for a carer’s own physical and mental health. The support for carers which could prevent them from becoming unwell, such as respite care, is being reduced or is simply not on offer, despite duties in the Care Act which require councils to consider carers’ health and wellbeing and meet their needs for support. *Extra funding is needed to enable councils to fulfil their duties to assess and support carers and, in so doing, maintain their health and well-being, participation in education and employment and ability to continue caring.*

Caring and employment

115. Research by the LSE in 2012 indicates that the public expenditure costs of carers leaving employment in England are at least £1.3 billion a year based on lost tax revenues and the cost of Carers Allowance.²⁷³ Dr Pickard of the LSE said that there was evidence to show that carers were more likely to be in work if the person they looked after received care services, such as home help, home care, help from a personal assistant, day care, meals and short-term breaks or respite.²⁷⁴ In addition, we heard that having a “care friendly employer” who was supportive, flexible and understanding was important to a carer continuing in work but that recognition of carers in the workplace was “in the sphere childcare was in 20 years ago”.²⁷⁵

116. During its visit to Berlin, the Committee learnt about the *Pflegezeitgesetz* (the Caregiver Leave Act 2008) and the *Familienpflegezeitgesetz* (the Family Caregiver Leave Act 2012), which introduced a legal framework to reconcile the responsibilities of long-term caring and work. Depending on the size of the employer, this legislation allows carers to take short- (10 days) and longer-term (up to 24 months) periods of leave to care for a family member, on a full- or part-time basis. Carers are entitled to claim a wage compensation benefit (or ‘carer’s grant’) for the shortest-term period of leave and, for longer-term periods of leave, are entitled to financial support in the form of an interest-free loan from the Federal Office of Family Affairs and Civil Society Functions. In England, carers are entitled to request flexible working but have no dedicated employment rights.

117. Combining caring responsibilities with employment without extra support is particularly challenging. The Care Act requires councils to take carers’ work and education into account in the provision of support, yet many carers are having to leave work, which is detrimental to their longer-term financial security and a significant cost to the public purse. We look forward to progress on the Health and Work Green

273 National Institute for Health Research School for Social Care Research, [Overcoming barriers: Unpaid care and employment in England](#) (undated)

274 [Q168](#)

275 [Q170](#)

Paper and the Fuller Working Lives Strategy which the Minister indicated would look at how carers might be better supported to enter, stay in and return to work.²⁷⁶ As part of this the Government should consider whether the approach taken in Germany to carers' leave might be a basis for giving carers dedicated employment rights.

Carers Allowance

118. Financial support is also available to carers through the benefits system: Carers Allowance is £62.10 per week for providing at least 35 hours of care a week to someone in receipt of certain disability benefits. Carers cannot claim the benefit if they earn more than £110 a week (after deductions). Carers who contributed to our online forum were unhappy with the level of the benefit. One contributor said it “is an insult, and keeps people doing an amazing job poor and having to make choices about whether to heat or eat”. Another said “Since reaching 65, my Carers Allowance has reduced to just £34.50 a week, though I am [caring] for upwards of 100 hours a week”. Another said she was surprised to find that, even after taking a lower paid role to accommodate caring for her mother, Carers Allowance was means -tested. Independent Age said there was a “clear need for the government to review how it financially supports carers and recognises carers’ contributions through the social security system”.²⁷⁷ In light of this evidence, we were pleased that the Minister for Disabled People said that her Department was considering the earnings limit for Carers Allowance, that the “logic of raising [it] is there for all to see” and that the level of the benefit would be considered in the Health and Work Green Paper.²⁷⁸

119. Carers Allowance should be increased to reflect the increasing contribution that carers make to the social care system. In addition, the earnings limit should be higher and more flexible to enable carers to maintain some contact with the labour market.

276 [Q417](#)

277 Independent Age ([SOC067](#))

278 [Q418](#)

3 Organisation of health and social care services

120. Constituency casework concerning adult social care makes the complexity of the social care system, and its interaction with the NHS, very clear. At the outset of our inquiry, we asked witnesses whether it would be fair to describe the system as confusing: they all agreed.²⁷⁹ Richard Humphries, Assistant Director of Policy at The King’s Fund, told us that “If we set out to design a care and support system that was really difficult and hard for people to understand, we would be a world class leader”.²⁸⁰ The key reasons they gave were the number of agencies involved, the division of responsibilities between central and local government and between local government and the health service, the public and private split in the delivery of services and that fact that care may be publicly or privately funded.²⁸¹ Integration of health and social care services aims to improve this by streamlining services to reduce gaps in service delivery and prevent people from getting lost in the system, as well as achieving efficiencies.

121. We heard that people also struggled with how social care interacts with housing services and the benefit system.²⁸² Isaac Samuels, a social care user, said that he found himself having to be:

The person who pulls all the professionals together, the person who does all the research, the person who understands value for money, the person who is able to make a complaint. Where do I start just living my life? This is something that is supposed to help me, not make more work for me. I really struggle with the fact that housing talks a different language. No one wants to take responsibility; no one wants to be transparent.²⁸³

The evidence we received highlighted the Disabled Facilities Grant as an example of how the structure of the system hindered service delivery and we explore this below. In the rest of this chapter, we explore the progress being made on integration (paragraphs 127 to 141) and in the section headed ‘Innovation and alternative models of care’ look at ways of doing things differently within the existing system (paragraphs 142 to 155).

Disabled Facilities Grant

122. Disabled Facilities Grants (DFGs) are available to disabled people who need to make changes to their home to help them continue to live there, for example installing a stairlift or creating a downstairs bathroom. In 2014, the DFG became part of the Better Care Fund in line with its aims of joining up services to reduce hospital and care home admissions and enabling people to return from hospital more quickly. In recognition of the rising need for adaptations, funding for the DFG was increased in the 2015 Spending Review to £500 million by 2019–20.²⁸⁴

279 [Q2](#)

280 [Q2](#)

281 [Q2](#)

282 [Q2](#)

283 [Q306](#)

284 HM Treasury, [Spending Review and Autumn Statement 2015](#), (November 2015)

123. In two-tier authorities, the grant is administered by district councils, following an assessment and recommendation from a social care occupational therapist based at county level. In unitary authorities, the team that delivers the DFG is often managed separately from the occupational therapists and located in a different department. Foundations, the body tasked with improving the DFG programme, said that delivery needed to be better joined up with the provision of social care and its 2015 research found that only 30 of the 152 social care authorities could link DFG activity with their social care records.²⁸⁵ The Chartered Institute for Housing said that:

Anecdotally there is still variable involvement and integration of local housing authorities, particularly in two tier areas, in the development of health and wellbeing strategies and action plans to support the BCF. This is in spite of the fact that local housing authorities retain the statutory obligation in respect of DFGs.²⁸⁶

This division of responsibilities and lack of joined up working between district and county councils leads to delays. The main concern that our witnesses raised about the DFG was that it was a slow, costly and frustrating process.²⁸⁷ Anna Severwright said that she had waited more than three years to have a wet room installed, during which time she was unable to shower. She also said that she had no choice in the process: “You get no information at all. I really had to fight just to get told anything and to be able to make any kind of choices”.²⁸⁸ Isaac Samuels said that, in his experience, the Grant had resulted in a very costly adaptation which in the end did not meet his needs.²⁸⁹

124. *The Department for Communities and Local Government should review the operation of the Disabled Facilities Grant, and in particular the extent to which its administration and operation is hampered by the split in responsibility between district and county councils and between housing and social care departments in unitary authorities. The evidence we received suggested that beneficiaries found the process slow and cumbersome, had little say in the adaptations and doubted that it was always good value for money.*

Integration: closer working between health and social care

125. In our first report of this Parliament, on devolution, we concluded that health devolution and integration of health and social care, which in most cases is closer working between health and social care, had great potential. We continue to believe this is the right direction of travel, given the increasing demand for services as a result of demographic changes and, as we explored in paragraph 7 above, the need to improve patients’ experiences and ensure they are at the centre of how care is organised. The carers and service users who took part in our roundtable, who collectively and individually had many years’ experience of the system, commented on how they would like to see health and social care services better joined up. Many suggested that the GP should be the core of a coordinated system and that assessments should be shared between services and carried out by the member of staff who was most familiar with a person’s condition and needs.

285 Foundations ([SOC078](#))

286 Chartered Institute for Housing ([SOC041](#))

287 [Qq306-307](#)

288 [Q307](#)

289 [Q306](#)

126. Having visited Greater Manchester in October 2016 to learn about their work on health devolution, we were keen to hear from Jon Rouse, Chief Officer of the Greater Manchester Health and Social Care Partnership, about the progress made. He described the benefits an older person in Greater Manchester should see in the future as a result of integration:

They should be experiencing far more seamless and joined-up care than they experience today. Our starting point for that is to put the GP at the centre of that relationship again by really understanding their register and those who need help the most, and being equipped with all sorts of cool-off services that mean they can help to meet the needs of the people who have the greatest number of conditions or overall level of need. We do that by organising the other services around primary care. It means that we need social care services, physios, OTs and other allied health professionals, district nursing, but also services that go wider than traditional health and social care—some of our local welfare services and housing—to be much more joined up around that primary relationship between the GP and the individual. Ultimately, that is our vision for what that care should look and feel like by 2021.²⁹⁰

We note, however, that Greater Manchester is different to other areas, having had greater opportunity to pursue integration within the context of health devolution.²⁹¹

Progress

127. In her evidence to the Liaison Committee, the Prime Minister said that it was wrong to assume that the only solution to the challenges facing social care was funding and argued that there was a “medium-term job to be done” in improving delivery of social care through integration.²⁹² Given that the 2015 Spending Review set a target for full integration of local areas through the Better Care Fund for 2020,²⁹³ we take ‘medium-term’ to mean the next three years. The evidence we heard indicated that it would take longer than this since it was a slow process and that it could take up to ten years to achieve the necessary cultural and system changes.²⁹⁴ Professor Gerald Wistow, Visiting Professor in Social Policy at the LSE, said that the Government’s objective for integrated care in five years was unrealistic.²⁹⁵ In its recent report on health and social care integration, the National Audit Office (NAO) said that the Government’s expectations on the rate of progress of integration were “over-optimistic”.²⁹⁶

128. The evidence we received suggested that there are a wide range of locally-driven integration initiatives and projects in progress across the country, including joint

290 [Q189](#)

291 [Q211](#)

292 Liaison Committee, Oral evidence: The Prime Minister, HC 833 (20 December 2016), [Q117](#)

293 HM Treasury, [Spending Review and Autumn Statement 2015](#) (November 2015)

294 [Qq206–207](#)

295 [Q206](#)

296 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

commissioning,²⁹⁷ co-location and sharing IT systems,²⁹⁸ and providing a single point of contact for patients.²⁹⁹ Mark Lloyd, the Chief Executive of the Local Government Association (LGA), said:

The situation varies across the country. There are parts of the country where there is excellent good practice with councils and health bodies coming together to commission and deliver in a completely joined-up way. There are other parts of the country where the relationship is much less mature.³⁰⁰

He went on to say that the LGA was actively engaged in disseminating best practice in one area to another. The Prime Minister has also said that some parts of the country are doing integration of social care and health “very well and very innovatively” but that this was not universally the case.³⁰¹

Challenges

129. Professor Wistow of the LSE said that, despite the fact that there have been attempts to integrate health and social care for several decades, “we still have a very chequered record”.³⁰² The evidence pointed to various structural, cultural and financial challenges that have acted as barriers to closer working and impeded progress. These included personal relationships;³⁰³ organisational differences between the NHS and local government;³⁰⁴ different payment incentives;³⁰⁵ different regulatory, performance and outcome frameworks;³⁰⁶ information sharing;³⁰⁷ and workforce challenges.³⁰⁸ Furthermore, in our pre-Budget report, we highlighted evidence about the burdensome requirements and conditions which local areas needed to comply with in order to access the Better Care Fund and the NAO’s finding that this had disrupted integration work in some areas.³⁰⁹ In their recent report on health and social care integration, the NAO highlighted three “longstanding” barriers as misaligned financial incentives, workforce challenges and reticence over information-sharing. They concluded that Department of Health, DCLG and NHS England were not systematically addressing these barriers and needed to bring greater structure and discipline to their coordination of work in this area.³¹⁰

Workforce

130. Clare Jacobs, Employment Adviser at the Royal College of Nursing, said that integration posed challenges for the workforce because of differences between social care and NHS staff in standards, pay rates, terms and conditions, pensions and pension

297 London Borough of Haringey ([SOC159](#)), Liverpool City Council ([SOC127](#)), South East Strategic Leaders ([SOC172](#))

298 Isle of Wight Council ([SOC109](#))

299 London Borough of Newham ([SOC133](#))

300 [Q200](#)

301 Liaison Committee, Oral evidence: The Prime Minister, HC 833 (20 December 2016), [Q117](#)

302 [Q200](#)

303 [Q201](#)

304 [Q201](#)

305 [Q202](#)

306 [Q202](#)

307 [Q202](#)

308 [Qq351–353](#)

309 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

310 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

entitlement, career progression and skill development.³¹¹ (We explore the differences in pay and conditions between nurses in social care and NHS nurses in paragraphs 88 to 91.) The NAO said that their case studies had also shown that these differences, as well as recruitment and retention of staff, particularly in community and domiciliary care, were barriers to integrating and developing the workforce.³¹²

Social care funding

131. Lack of social care funding was also identified as a key barrier to integration.³¹³ Professor Wistow explained the effect this had on integration:

At the time that it is more important for organisations to work together, the very conditions that make it necessary for them to work together, such as resource scarcity, also drive them apart [...] the great incentives are to shunt the costs on to another organisation and argue about who is or is not responsible for particular parts of the care system.³¹⁴

Hull City Council described a similar situation at the local level, saying that funding pressures meant there was:

A significant risk that the agenda of one partner will dominate and direct resources to the detriment of the other partner. [...] Some of these negative effects are already being seen. Joint working initiatives involving specialist staff are being frustrated as budget cuts actively undermine relationships between the City Council and its NHS partners.³¹⁵

Jon Rouse, Chief Officer of the Greater Manchester Health and Social Care Partnership, said that in some areas (although not Manchester) NHS bodies were reluctant to “truly risk share with social care” because of concerns about social care cost pressures impacting on the NHS.³¹⁶ He also said that funding was needed to implement integration and that Greater Manchester had been given front-end loaded transformation resources, which had given them a “better chance than most” at integration.³¹⁷ We note the observation made by Sir Amyas Morse, Comptroller and Auditor General, that in the context of austerity, lack of joined-up decision-making and funding arrangements can give rise to “unforeseen conflicting objectives for local bodies; cost shunting between parts of connected systems; and ultimately risks of financial, or service, failure locally”.³¹⁸

Evaluation and outcomes

132. We heard that evaluation work on integration was continuing,³¹⁹ and that how integration was monitored and evaluated depended on its objectives, which might vary

311 [Qq351–353](#)

312 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

313 [Q202](#)

314 [Q202](#)

315 Hull City Council ([SOC048](#))

316 [Q219](#)

317 [Q202](#)

318 LSE British Politics and Policy blog, [When ‘more for less’ becomes ‘less for less’: the implications of central decision-making for the delivery of frontline services](#), February 2017

319 [Q212](#)

and related to a wide range of organisations.³²⁰ For example, Jon Rouse of the Greater Manchester Health and Social Care Partnership said that his organisation used a “balance scorecard” which contained metrics on levels of non-elective admissions; readmission rates back into hospital; the number of people who are dying in the place of their choice; delayed transfers of care; and people’s experiences of their GPs and primary care services; and their ability to get a GP appointment in good time.³²¹ However, reducing emergency admissions and delayed transfers of care have become the main performance indicators for integration and local areas are expected to set these, as well as reducing admissions to residential and care homes; and increasing the effectiveness of reablement, as targets for their use of the Better Care Fund.³²² The Government has highlighted the variation in local delayed transfers of care performance between councils as an indicator of local progress on integration.³²³

133. Given the scale of the changes and the barriers that we have identified, it may take some time before outcomes from integration are evident. The evidence that we heard on whether integration could improve patients’ experiences and outcomes was not strong,³²⁴ and we note the NAO’s recent finding that the Government has not yet established a robust evidence base to show that integration leads to better outcomes for patients.³²⁵ The evidence on whether integration could save money was clearer,³²⁶ but there was uncertainty over the amount that would be saved.³²⁷ Jon Rouse explained why it was difficult to gauge:

You have to shift care over time from acute and into the community. If you do not do that, it cannot save money. You do that by reducing demand for those services, which means that it is then safe to turn down some of that supply. You have to choose really carefully which of those services in which locations you turn down in terms of the supply. That is why it is so hard, because it has to lead to reduced costs within the acute system.³²⁸

He said that Greater Manchester was one of the “few places [that] have done systemic, placed-based integration over a long enough period of time to know whether that is true” and that, because of this, the combined authority’s progress was being followed nationally and internationally.³²⁹

134. *The Government should be more realistic in its expectations for integration. The time needed for such large scale changes to take place is significant and there is little evidence available yet on the benefits of integration, both in terms of patient outcomes and efficiency savings—the recent National Audit Office report on health and social care integration reflected this. Furthermore, progress, which is dependent on good local relationships between health and social care, varies across the country.*

320 [Q212](#)

321 [Q212](#)

322 Department of Health and Department for Communities and Local Government, [2016–17 Better Care Fund: policy framework](#) (January 2016)

323 HC Deb 11 January 2017 [c308](#)

324 [Q215](#)

325 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

326 [Q215](#) [Mark Lloyd]

327 [Q215](#)

328 [Q215](#)

329 [Q215](#)

135. *There are various barriers to integration which the Government must address. These include organisational differences between the NHS and local government; different payment incentives; different regulatory, performance and outcome frameworks; information sharing; workforce challenges and lack of funding for social care. Lack of social care funding is undermining integration, with reduced budgets causing tension between local partners.*

136. *The differences between the health and social care workforces in terms of culture, pay and conditions, career development and progression are stark. This presents a significant challenge to closer working, which is also inhibited in many local areas by difficulties in recruiting and retaining staff. The Government should acknowledge the challenge that this presents and with Skills for Care and Health Education England set out a strategy for aligning the two workforces.*

Accountability

137. One of the aspects of health and social care integration that we are particularly interested in is accountability; this is an issue which also arose during our inquiry last year on devolution. Then, we found that the Minister’s explanation as to how accountability for integrated health and social care services worked lacked clarity and concluded that:

Unless this is carefully considered, we risk both not having the flexibility to use budgets to reflect local priorities and facilitate joint working and replicating locally the silos that exist at national level.³³⁰

We therefore asked NHS witnesses in this inquiry who they thought should have responsibility for spending decisions from integrated budgets. We were reassured that Simons Stevens, Chief Executive of NHS England, said that “the right place to make decisions about where and how budget pooling should occur is locally”.³³¹ Stephen Dorrell, the Chair of the NHS Confederation, went on to make the further point, with which we wholeheartedly agree, that local accountability and political engagement in decisions about public services and the use of money across budgets are very important.³³² He went on to say that he was:

Strongly opposed now to the idea that we should make decisions about the shape of local health services divorced from the decisions made by local government for the rest of public services. It was a mistake when purchaser-provider was originally introduced to remove local government from that [...] process.³³³

One of the participants at our roundtable said that the current configuration meant that organisations could ‘pass the buck’ and therefore wanted to see a single integrated organisation with local accountability. Jon Rouse said that, because of the wider local political involvement in Greater Manchester’s integration plan, it has a much “richer population health approach” and covers work, health and early years.³³⁴

330 Communities and Local Government Committee, *Devolution: the next five years and beyond*, HC 396 (February 2016)

331 [Q268](#)

332 [Q268](#)

333 [Q268](#)

334 [Q223](#)

138. **Place-based planning on health and social care which has had input from local politicians is more likely to take into account other local services, such as housing, benefits and public health, and therefore result in wider integration of services and better outcomes for the people who use them. *Decisions on pooling health and social care budgets should be made locally. If this is not the case, there is a risk that local areas will not have the flexibility to use their budgets on local integration priorities and progress on integration will be impeded. Furthermore, we agree with Stephen Dorrell of the NHS Confederation that local government should be involved in the commissioning of local health services. This would further ensure that decisions about local health services are informed by the needs of the local population and the shape of existing local public services.***

Sustainability and Transformation Plans

139. Although local areas have been tasked with driving implementation, several integration-related initiatives have emanated from central government and NHS England. These include Health and Wellbeing Boards; New Care Models; Integrated Care Pioneers; and Sustainability and Transformation Plans (STPs). In addition, there is the Better Care Fund, which requires local areas to plan spending of a pooled budget for health and social care on integration. We heard that this rapid succession of policy developments had made it difficult for people to “find new ways of working and embed those ways of working before the next initiative comes along”.³³⁵

140. In December 2015, NHS England asked 44 STP areas across England to produce area-based plans for integration to 2021. Simons Stevens of NHS England highlighted the longer-term approach of STPs, saying that they were a “structured way of driving those kinds of shared conversations and taking a view beyond the cut and thrust of this year, the next year and the year after”.³³⁶ However, some councils were concerned by the involvement of local government in those ‘shared conversations’. South West England said that local authorities needed to be seen as “an equal partner in the STP process and not just a stakeholder”³³⁷ and Rutland County Council said that the STP guidance “does not go far enough in mandating the local authorities’ roles in the process. It is essential to the integration agenda that health and local authorities have an equal say in driving local plans”.³³⁸ Mark Lloyd, Chief Executive of the LGA, said that local government involvement would make “a big difference to solving the dilemmas that we face in social, health and wellbeing more generally”.³³⁹ The NAO concluded that, without full local authority engagement in the joint sustainability and transformation planning process, there is a risk that integration will become sidelined in the pursuit of NHS financial sustainability.³⁴⁰ We further note that the geography of the 44 STP footprints does not in all cases align with combined authority areas and, in some cases, councils are working with three STPs.³⁴¹

335 [Q206](#)

336 [Q270](#)

337 South West England ([SOC100](#))

338 Rutland County Council ([SOC138](#))

339 [Q222](#)

340 National Audit Office, [Health and social care integration](#), 8 February 2017, HC 1011

341 [Q224](#)

141. STPs are an important opportunity for places to take a longer-term approach to integrating health, social and other local services and, therefore, to be a success, local government should be an equal partner in planning. *The Government and NHS England should review the STP footprints with the aim of making them better aligned with local authority boundaries.*

Innovation and alternative forms of care

142. We took evidence on innovation towards the end of our inquiry and therefore approached it in the light of the other evidence we heard about funding pressures, demographic change and the difficulties presented by the structure of the system. We explored the extent to which councils were able to innovate given the funding pressures they faced; the use of digital technology; and innovation in the voluntary sector, focusing on the Shared Lives scheme.

143. Given the pressures on councils' adult social care budgets, we were interested to find out whether they were willing to invest in innovations. We heard that there were two different approaches; for some councils the funding constraints were a driver to innovation because they were looking for ways to save money by doing things differently, while others were in "panic mode"³⁴² and did not have the "space or resources to step back" and consider and try out innovations.³⁴³ Adaptive Technology Europe Ltd, which provides technology to commissioners, said that commissioners were a "constant barrier" to innovation and that, "bewildered" by the financial challenges they faced, they were reluctant to try out solutions which could lead to efficiencies.³⁴⁴ Karen Kibblewhite, Head of Commissioning Health and Wellbeing, Rutland County Council, said:

One of the lessons that we have learned in Rutland from looking at other authorities is that often, when people try to be really innovative, it is brilliant if it works, but if it does not then you can cause a lot more problems. At times when we have limited resources, it is quite difficult to run a twin-track approach, which is what you really need to do: to start the innovation, while keeping something else going on in the background just in case it does not work how you envisage.³⁴⁵

Alison Rogan, External Affairs Director at Tunstall Healthcare, said that increasing demand was also a key reason for councils pursuing innovations: "they have looked to the future and realised that they just cannot cope with the demographics".³⁴⁶

144. **Funding constraints and demographic pressures are acting as a driver for some councils to innovate and change the way they deliver care. However, due to budget pressures, most councils are in panic mode and are not ready to rethink the way they do things. *The Government should create an innovation fund to encourage and give councils the capacity to consider how innovative approaches could be applied in their local area.***

342 [Q238](#)

343 [Q238](#)

344 Adaptive Technology Europe Ltd ([SOC003](#))

345 [Q239](#)

346 [Q238](#)

Technology and digital

145. ‘Telecare’, assistive devices, such as smoke and carbon monoxide detectors, medication dispensers and help buttons, and ‘telehealth’, remote monitoring of conditions, are widely used in social care and have been available for many years.³⁴⁷ There is strong evidence to show that they help people to stay in their own home longer and reduce admissions to hospital³⁴⁸ and are therefore widely used by councils.³⁴⁹ Karen Kibblewhite of Rutland County Council said that her council had decided to use its Better Care Fund funding on assistive technology,³⁵⁰ and that it had provided reassurance and safety for some people which meant that they were “not reaching crises where they become eligible for social care services”.³⁵¹

146. We were interested in how the next generation of telecare and telehealth, apps and smart technology, could add to the care that people received and promote their independence and wellbeing. For example, Alison Rogan of Tunstall said that the technology her company provided could:

Liaise with all the agencies involved. We have very personal information about their data and their care provider, so we are able to co-ordinate that care, as long as we know about it. If somebody has not been into that home when we know they should have been, we know about it, through certain sensors in the home.³⁵²

According to The King’s Fund, the potential of this kind of technology in adult social care is “still far from fulfilled” and “digital therapies, online peer-to-peer support networks and smartphone apps to link people together around care needs are all emerging and deserve to be further explored”.³⁵³ However, we heard that the use of this technology very much depended on preference and abilities of the person involved and their carers, friends and family,³⁵⁴ as well as broadband coverage.³⁵⁵

147. Digital technology is also increasingly being used to share data between services. London Councils described how Sutton Council and its Clinical Commissioning Group use an ‘Integrated Digital Care Record’, accessible by acute, community health, mental health trust and adult social care professionals, to work more efficiently and improve patient care.³⁵⁶ They said that working in this way had reduced delays in the delivery of care and unplanned hospital admissions, and enabled quicker delivery of care and reduced clinical tests. We also heard that places were making increasing use of technology to share information to support commissioning. Karen Kibblewhite said that Rutland County Council had started to use the “Pi tracking tool” which would eventually allow

347 [Q227](#)

348 [Qq227, 230](#)

349 See, for example, Hull City Council ([SOC048](#)), Association of Directors of Adult Social Care South Eastern Region ([SOC171](#))

350 [Q232](#)

351 [Q234](#)

352 [Q229](#)

353 The King’s Fund and the Nuffield Trust ([SOC198](#))

354 [Q231](#)

355 [Q232](#)

356 London Councils ([SOC149](#))

them to track individuals through the health and social care systems and identify areas of need and gaps in provision which would, in turn, enable them to target resources more effectively and further integrate commissioning.³⁵⁷

148. Assistive technology is already helping people stay at home longer, reduce hospital admissions and coordinate care between different agencies, and smart technology will be an important part of improving care in the future. At the moment, however, very widespread use of digital technology is limited by the extent of broadband and 4G coverage. It also needs to be usable by and acceptable to service users and carers.

149. Councils are also starting to use digital data platforms which, by drawing together data from different sources, helps them track individuals' journeys through the health and social care system and target resources and commission more effectively.

150. The Department of Health, NHS England and the Local Government Association should explore how best to bring together centrally and regularly update information on innovation in the delivery of health and social care in local areas.

Alternative models of care

151. Alex Fox, the Chief Executive of Shared Lives, said that councils were more likely to innovate if they had strong links with local voluntary community and social enterprises and that the people who used services and their families were a source of new ideas and approaches.³⁵⁸ The need for closer working between councils and community groups, and involving service users in the design of services, was a theme of the discussions we had with service users and carers at our roundtable event.

152. The King's Fund said that community-based approaches to adult social care were a "vital development for people who want smaller scale, less transactional forms of care".³⁵⁹ The evidence suggested that councils were already employing this approach to delivering care; for example, Thurrock Council said that it had ten local area co-ordinators in the community identifying people in need of help and connecting them with "community-based interventions to ensure they can live a 'good life'".³⁶⁰ We took evidence on Shared Lives, a model of care in which an adult who needs support moves in with or regularly visits an approved Shared Lives carer, after they have been matched for compatibility.³⁶¹ There are 150 Shared Lives schemes in the UK, being used by 13,500 people with learning disabilities, people with mental health problems, older people, care leavers, young disabled adults aged 16 and 17, parents with learning disabilities and their children, people who misuse substances and offenders. Alex Fox of Shared Lives said that:

It is a model that does something really unusual in regulated social care. It combines what people find valuable and what they love about family and community with the resources, infrastructure and training of a CQC-regulated care service.³⁶²

357 [Q235](#)

358 [Qq239](#), [247](#)

359 The King's Fund and the Nuffield Trust ([SOC198](#))

360 Joint submission from Cambridgeshire County Council, Essex County Council, Hertfordshire County Council, Norfolk County Council, Suffolk County Council, Southend Council and Thurrock Council ([SOC195](#))

361 Shared Lives Plus ([SOC019](#))

362 [Q240](#)

153. We asked what would happen if the relationship between the people involved broke down and whether it might lead to vulnerable people going ‘off the radar’, but were told that there was lower turnover of people, fewer numbers of safeguarding alerts³⁶³ and that the Care Quality Commission’s inspection data showed that the safety was good.³⁶⁴ Alex Fox of Shared Lives argued that the scheme’s success depended upon properly resourcing and taking enough time over recruitment, approval and matching.³⁶⁵ The Health Minister, David Mowat, who had visited a Shared Lives scheme in Merton, said that the scheme was cost-effective, created “a quality of life that is difficult to emulate in other situations” and that more councils should be participating in Shared Lives.³⁶⁶ We note, however, that local demographics and need mean that not all innovations will be right for councils; for example, Karen Kibblewhite of Rutland said that, because Rutland was a small county, the costs of setting up the scheme would be high.³⁶⁷

154. Shared Lives appears to be an exciting innovation which enables care provision within family and community relationships. *The Government should commission a wide-scale evaluation on the outcomes and cost effectiveness of the scheme and, where appropriate, care commissioners should consider it as one of a range of available care options.*

155. We received a substantial amount of evidence about the benefits and cost effectiveness of another non-mainstream form of care, ‘intentional life-sharing communities’, in which adults with learning disabilities receive housing, support and day activities in community settings.³⁶⁸ The evidence revealed significant concerns among the families of adults in one such community, Botton Village, that funding pressures, commissioning practices and regulation posed a threat to the continuation of these communities. **We greatly sympathise with the families’ concerns, but are not well-placed to investigate or adjudicate the matter. But the amount of evidence we received on this one issue, and the strength of feeling expressed, exemplifies the reasons why it is essential to get the country’s social care system right in the short, medium and long terms.**

363 [Q241](#)

364 [Q245](#)

365 [Q246](#)

366 [Q408](#)

367 [Q247](#)

368 Botton Village Families Group ([SOC179](#)), Alliance for Camphill ([SOC124](#)), Camphill Families and Friends ([SOC076](#)), The Camphill Village Trust ([SOC049](#))

4 Future funding

2019–20 onwards

156. Reforms to local government finance are planned to come into effect in by 2020. From then on, local government will retain 100% of business rates, leading to a rise in its funding levels by an amount estimated at £12–13 billion, the transfer of additional responsibilities to ensure the reforms are fiscally neutral and the ending of Revenue Support Grant (RSG). The set-up of the new system will be underpinned by an updated assessment of local authority need, which will inform the amount of top-up and tariff assigned to each authority. We will be contributing to the ongoing work in this area with independent research later on this year.

157. In our pre-Budget report we set out the estimates that we had received, which ranged from £1.1 billion to £2.6 billion, for the funding gap in adult social care by 2019–20 and have requested that the National Audit Office makes an independent determination of the funding shortfall.³⁶⁹ The Local Government Association is calling for newly retained business rates to be used to address the funding pressures on local government, particularly the social care funding gap, before any further responsibilities are considered.³⁷⁰ *We agree that local government should be allowed to use some of the additional business rates revenue, according to need, to close any adult social care funding shortfall that exists when 100% business rates retention comes into effect, before being allocated new responsibilities.*

158. After 2019–20, once RSG has been phased out, councils' main sources of discretionary funding will come from council tax and business rates. The Care and Support Alliance said that, as a result, the landscape for adult social care would “change fundamentally”. Much of the evidence highlighted the fact that, particularly in deprived areas with higher levels of need, growth in council tax and business rates income was unlikely to match demand for social care.³⁷¹ Ray James, Immediate Past President of the Association of Directors of Adult Social Care (ADASS), said:

As I look forward, given the relationship between deprivation and the need for social care—there is a really strong link between levels of disability and mental illness and the prevalence of [need], and also in terms of lone older households in deprived areas—it seems unlikely that local taxation alone could provide for that.³⁷²

James Lloyd, Associate Fellow at the Strategic Society Centre, said:

The link between social care and business rates in particular has never been clear to me. I am not really clear why we try to fund social care through

369 Communities and Local Government Committee, Eighth Report of Session 2016–17, [Adult social care: a pre-Budget report](#), HC 47

370 [Q69](#)

371 [Q66](#). See also [Q83](#), Hull City Council ([SOC048](#)), Bupa Ltd ([SOC097](#)), United Response ([SOC115](#)), Liverpool City Council ([SOC127](#)), Gateshead Council ([SOC146](#)), London Councils ([SOC149](#)), County Councils Network ([SOC204](#)), Care and Support Alliance ([SOC155](#)), Centre for Welfare Reform ([SOC164](#))

372 [Q75](#)

a locally administered tax that is now effectively part-hypothecated, plus business rates increasingly in the future. That feels like a very odd way of funding social care.³⁷³

In the interim report from our inquiry on business rates reforms, we also concluded that there is likely to be little or no correlation between changes in business rate revenue and changes in local authority needs.³⁷⁴ We further concluded that the reformed arrangements would most likely need to be supported by a system of grants for councils affected by increases in need. When we asked our witnesses whether they also thought this was the case, they agreed.³⁷⁵ Ray James of ADASS said that it was “undeniable that the total quantum required for social care will be greater”.³⁷⁶

159. Council tax and business rate income will not be commensurate with current and future local demand for adult social care. *The Government should report on what measures it intends to use to tackle the disparity that this will create. We recommend that funding should be made available for adult social care via a central government grant linked to need and rising demand. As further insurance against future shortfalls in funding, the Government should consider giving local authorities greater flexibility on the level at which they set council tax.*

A long-term solution

160. In our pre-Budget report on adult social care, we said that there was an urgent need for a review, ideally cross-party, of the provision and funding of social care in the long-term. We therefore welcomed the Chancellor’s announcement in the Spring Budget that, later this year, the Government will set out proposals for the long-term funding of adult social care in a green paper.³⁷⁷ We also welcomed the Health Minister’s acknowledgement that there was “absolutely no question” that the total amount of GDP that we spend on adult social care will increase.³⁷⁸

161. As we explored in paragraph 7, it is well evidenced that the demographic pressures on adult social care will continue to increase in the longer-term. Richard Humphries, Assistant Director of Social Care Policy at The King’s Fund, explained why the current system is unlikely to be able to deal with the challenges this presents:

If we go right back to the 1940s and the founding of the welfare state, what we now call social care was not an issue then very much because most people did not live long enough [...] What has happened in the 60-odd years since is this fundamental change in the nature of the needs that we need both our healthcare system and social care to meet. A lot of it is around the success of an ageing population [...] Our system has never really faced the question about what it needs to do differently to meet that. This is a fundamental step change in what we are asking the system to do.³⁷⁹

373 [Q69](#)

374 Communities and Local Government Committee, First Report of Session 2016–17, [100 per cent retention of business rates: issues for consideration](#), HC 241

375 [Q78](#)

376 [Q78](#)

377 HM Treasury, [Spring Budget 2017](#) (March 2017), p 47

378 [Q384](#)

379 [Q4](#)

The Personal Social Services Research Unit has projected that, to keep pace with demographic pressures and increases in the unit costs of care, public expenditure on care for older people would need to rise from around £6.9 billion (0.43% of GDP) in 2015 to £17.5 billion (0.69% of GDP) in 2035 at constant 2015 prices and that care for younger adults will rise from around £8.4 billion (0.53% of GDP) in 2015 to £18.4 billion (0.73% of GDP) in 2035 at constant 2015 prices.³⁸⁰ ***Expenditure on adult social care will need to rise as a proportion of total public expenditure.***

162. We note that there have been several unsuccessful attempts at reform in the past, although most concerned the balance of responsibility for funding care between the state and the individual rather than the overall level of resources for adult social care. During this time, the funding and demographic pressures have increased. Richard Humphries of The King’s Fund observed that “When Sutherland did his Royal Commission in 1999, the costs of his reforms were £1 billion. Today, we talk about a funding gap this year of £1 billion for social care”.³⁸¹ We further note that, in the last 30 years, most other countries—for example, Germany, France, Japan and the Netherlands—have ‘grasped the nettle’ and reformed how they fund care.³⁸² We therefore agree with Stephen Dorrell, Chair of the NHS Confederation, who said that a review had become “urgent”³⁸³ and with the LGA that “this is the last chance we have to get this right”.³⁸⁴

163. After successive attempts at reform and in the context of ever-increasing demographic pressures on the system, the need to find a way to fund social care for the long-term has now become urgent. *The solution needs to be implemented in the next spending round.*

164. The evidence we received suggested that the review would need to be inclusive. It needed to entail a “much bigger conversation as to how society should support the most vulnerable when they need care and support”;³⁸⁵ it needed to enable “transparent debate” about where the money comes from;³⁸⁶ and it needed to take place “politically on a cross-party basis”³⁸⁷ and reach a “national consensus”.³⁸⁸ During our visit to Germany, we heard that the introduction in 1994 of reforms to social care funding in the form of a mandatory system of long-term care insurance had been devised and agreed with cross-party political backing and that this had been essential to establishing a lasting solution which retained public support.

165. We heard a range of suggestions about where the money to fund social care should come from, and we have set these out in the points below. We highlight the fact that our witnesses emphasised the need to be ambitious; for example, Stephen Dorrell of the NHS Confederation said:

380 Personal Social Service Research Unit, [Projections of Demand for and Costs of Social Care for Older People and Younger Adults in England, 2015 to 2035](#) (September 2015)

381 [Q55](#)

382 [Q51](#)

383 [Q280](#)

384 Local Government Association, [Budget 2017: LGA responds to social care funding](#), 8 March 2017

385 [Q9](#)

386 [Q59](#)

387 [Q280](#)

388 [Q279](#)

If we put in place a set of political choices that artificially restrain our capacity to pay for those services and, therefore, presumably to pay for other services, we do ourselves no favours at all. It is Maslow’s famous hierarchy of need. As we get richer, we should expect that a rising share of our rising income is spent on these services.³⁸⁹

Our witnesses suggested funding would need to be drawn from a wide range of sources. James Lloyd of the Strategic Society Centre said:

There is no one solution to this. It is foolish to think that we can just flick a few switches over here—a national tax there, or maybe trim state pension expenditure—and that will solve it. There will probably have to be a suite of interventions and changes to fiscal policy.³⁹⁰

The sources of funding that our witnesses suggested a review should consider were:

- Hypothecated tax for social care, which would make tax increases more acceptable to the public.³⁹¹ These might include income tax, asset taxes and inheritance taxes.³⁹²
- Public expenditure on older people; for example, the state pension, including the age at which it is set and the formula that is used to uprate it.³⁹³
- Ending the triple lock pension guarantee.³⁹⁴
- A mandatory social insurance mechanism, publicly owned and administered, which must be differentiated from voluntary private insurance mechanisms which are prone to failure.³⁹⁵ This would be similar to schemes in Germany and Japan.

Simon Stevens, Chief Executive of NHS England, suggested that there should be a “new social contract for older people”,³⁹⁶ which would entail a move from the triple lock pension guarantee to a “triple guarantee on retirement security” which he said would:

Include income but also being able to stay in your own home, where that makes sense, and getting the care you need, including social care [...] it represents an expansion in the offer to retirees. It is not about taking things away.³⁹⁷

166. It is vital that political parties across the spectrum, together with the social care sector and the wider public, are involved in the process of reaching a solution. The importance of this was demonstrated by our visit to Germany, where decisions on

389 [Q280](#)

390 [Q74](#)

391 [Q70](#)

392 [Q71](#)

393 [Q72](#)

394 [Q282](#)

395 [Q280](#)

396 [Q279](#)

397 [Q279](#)

reforming social care funding were supported by a political consensus, trades unions and employers and therefore attracted wide public backing. *As a first step, political parties should agree to work together.*

167. *There then needs to be an open debate about where the money to fund social care should come from. The review must consider taking funding from a wide range of sources, including:*

- (1) *Hypothecating national taxation (income tax, National Insurance Contributions, asset taxes, inheritance tax) and, in particular, the feasibility of introducing compulsory social insurance on the German or Japanese model.*
- (2) *All age-related expenditure (the state pension, including the triple lock pension guarantee, winter fuel allowance, concessionary bus fares, free prescriptions and, indirectly, TV licences).*

*Although they are likely to remain an important part of funding adult social care, local taxes, which will not grow at the same rate as need, cannot be the main funding solution. We have already called for significant reforms to council tax in our report on fiscal devolution in the last parliament and reiterated these in the report we published last year, *Devolution: the next five years and beyond*.*

168. *As well as considering future sources of funding for social care, the review should also take into account the range of uses for which social care funding is required. Over the course of this inquiry, we have identified these as including:*

- *Care and support, including:*
 - *Meeting people’s needs for care and support;*
 - *Preventative care and early intervention; and*
 - *Assessments for carers, leading to the provision of support for carers.*
- *Payment of fees to providers, which contribute to:*
 - *The wages of the care workforce, as well as holiday, sickness, pension and travel costs;*
 - *Their training, qualifications and career development, including measures to enhance the status of the care workforce;*
 - *Meeting providers’ business costs and generating profit to invest in their capital assets and the workforce.*

Means-testing

169. In the Spending Review 2015, the Government reiterated its commitment to introducing Phase 2 of the Care Act 2014 in April 2020.³⁹⁸ This would introduce a cap of £72,000 for people aged 65 and over on the amount they will pay towards care and support, regardless of means, and an increase in the threshold, above which people start

398 HM Treasury, [Spending Review and Autumn Statement 2015](#) (November 2015)

to contribute to their residential care costs, to £118,000. *The review will therefore also need to consider whether to go ahead with implementation of Phase Two of the Care Act 2014, as well as, more broadly, whether people should be means tested and, if so, how they should contribute to the costs of their care. As part of this, it should also consider the different approaches to including the value of a person's home in the means test for residential and home care.*

170. While health care will remain free at the point of use, social care will remain needs- and means-tested. We note the challenge that this lack of alignment in entitlements to health and social care poses to integration.

5 Conclusion

171. We are conscious that in many places in this report we have called on the Government to provide more funds for social care. We have not done so lightly. The Parliamentary Under-Secretary of State for Community Health and Care did not agree that the social care system was in crisis—a term the Chief Executive of NHS England was happy to use—preferring to describe it as “under stress”. But it is clear from our inquiry that unless significant extra funds are provided in the short and medium terms, the social care system will be unable to cope with the demands placed upon it. Extra funding alone will not solve the problems that face us, but without it the other steps we have suggested will quite simply fail.

172. We welcome the Government’s announcement of a Green Paper on the long-term funding of social care later this year. We reiterate that, to ensure the work results in a lasting solution, it should be taken forward on a cross-party basis. We will review the scope of the Green Paper when it is published later this year and consider whether a further inquiry into any issues it raises is needed.

Conclusions and recommendations

The impact of funding pressures on the adult social care system

1. Councils are coping with reduced budgets by providing care and support to fewer people and concentrating it on those with the highest needs. They are also reducing care provided to the minimum required for a person to get through the day, and are not promoting wellbeing nor increasing care in accordance with need. Many councils are therefore potentially in the position of being unable to comply with their Care Act duties and may therefore face legal challenges. It is alarming that fewer than one in twelve Directors of Adult Social Care are confident that their local authority will be able to meet its statutory duties in 2017–18. (Paragraph 14)
2. Little is known about what happens to people who are not receiving any or enough care, and whether they are paying themselves, relying on carers or coping alone. Data on delayed transfers of care and emergency admissions suggest that unmet need is placing significant pressure on the NHS. We are disappointed that so few councils have monitoring arrangements in place to identify unmet need. Without such arrangements, it will be impossible to understand the scale of unmet need. We therefore urge all. *We therefore urge all councils to consider how to identify unmet need and to put arrangements in place for this. This will help to build up a national picture of unmet need and inform overall funding decisions.* (Paragraph 16)
3. The number of complaints about social care to the Local Government Ombudsman is high, and rising, and the Care Quality Commission found that, in 2015–16, 28% of care homes required improvement or were inadequate, with some types of services, such as nursing homes, significantly worse rated. Councils are becoming concerned about quality of care, and care providers, and the Care Quality Commission are concerned about its sustainability. We share their concerns and fear that overall quality of care is likely to continue to deteriorate, unless sufficient funding is provided. (Paragraph 27)
4. The balance of responsibility between NHS and local authority social care for delayed discharges is not clear and councils' performance in relation to delayed discharges appears to vary across the country. This suggests the causes are many, complex and based on local circumstances, which closer working between councils and NHS partners and sharing best practice may help to alleviate in the medium to long term. (Paragraph 33)
5. Even given the complexities of organisational responsibility for delayed discharges, we believe that inadequate social care funding has a very significant impact on the speed of discharges from hospital. Reductions in spending on adult social care, leading to pressure on providers and the care market and difficulties in recruiting and training staff, have led to an increase in the number of delayed discharges attributable to social care and an increase in emergency admissions of older people. The Government should provide extra funding to increase social care provision in order to relieve pressure on the NHS, as recommended by the Health Committee in its report of October 2016 on Winter pressures in accident and emergency departments. *The Government should provide extra funding to increase social care*

provision in order to relieve pressure on the NHS, as recommended by the Health Committee in its report of October 2016 on Winter pressures in accident and emergency departments (Paragraph 36)

6. There are many ongoing projects aimed at reducing delayed discharges and emergency admissions through closer working between the NHS and social care. Because of local circumstances and practices, what works in one area may not be as successful in another, and it takes time for new processes to become embedded. *The Government, working with the Local Government Association, should increase efforts to share examples of best practice, including the use of reablement beds.* (Paragraph 39)
7. There are also concerns about the impact of social care budget pressures on the ‘front door’ of hospitals—emergency admissions. We are concerned that budget pressures are driving many councils increasingly to direct resources towards services for people with higher levels of needs, rather than towards prevention. Extra funding would enable councils to provide preventative services for people with lower levels of need, which is likely to reduce demand for higher-intensity, higher-cost services later on. The need for preventative services should be included in future estimates of funding needs. (Paragraph 41)
8. *The Government should take steps to resolve the uncertainty over paying for sleep in shifts and confirm the approach to paying for sleep in shifts. Furthermore, the Government should, with the HMRC, find a solution to the payment of back pay for sleep ins which avoids severe financial consequences on care providers.* (Paragraph 46)
9. Relocation and changes in the continuity of care have significant consequences for people’s health and wellbeing and cause great concern to families and carers. (Paragraph 50)
10. Care providers are on the receiving end of reductions in spending on adult social care, with councils having exerted significant downwards pressure on their fees in recent years. At the same time, they face cost pressures from the National Living Wage, auto-enrolment in work place pensions, Care Quality Commission registration fees, the Apprenticeship Levy, paying hourly rates for ‘sleep ins’ and recruitment and retention costs from high staff turnover. While the National Living Wage has the welcome effect of raising low wages in the care sector, it is adding substantially to the financial pressures faced by providers. Providers are reporting that councils are not passing on the money raised by the precept as fee uplifts to cover the costs of the National Living Wage. *Central government should take responsibility for funding the costs to local authorities linked to care of initiatives such as the National Living Wage.* (Paragraph 51)
11. This accumulation of pressures poses a serious threat to providers’ financial viability and providers are failing, exiting the market and handing back contracts. The consequence of this for people’s care is extremely serious, and the reduction in capacity is causing delayed transfers of care. Providers’ profit margins have reduced which affects their ability to invest in the workforce and their capital assets, and deters new entrants to the market. *Councils should take into account the fact that providers use profit for these reasons, as should a future review of the long-term funding of social care.* (Paragraph 52)

12. We do not believe it is acceptable for self-funders to pay higher costs for the same care in order to subsidise the costs of local authority funded clients. This is polarising the market, with providers in more affluent areas more able to cross-subsidise their fees than those in poorer areas. (Paragraph 54)
13. The care market is in a fragile state. Contributory factors are increasing demand, together with problems of supply, financial pressure causing providers to fail, exit the market and hand back contracts, a significant workforce shortage, deteriorating quality and increasing and unsustainable reliance on self-funders. (Paragraph 56)
14. Councils are statutorily responsible for shaping the care market to provide diverse and high quality care for all people in their local area, including self-funders. Successful market shaping by councils involves local engagement and developing trusted relationships and regular dialogue between providers, service users and other partners. However, funding pressures are undermining the relationships between councils and providers, thus affecting councils' ability to work with them to shape the market. *Councils should be reminded that their market shaping responsibilities extend to and include oversight of the financial viability of their local providers.* (Paragraph 63)
15. Funding pressures have similarly affected the commissioning relationship between councils and providers. The pursuit of low fees has become the driving factor in commissioning for some councils, despite Care Act guidance that they should be appropriate to deliver quality care and allow providers to properly remunerate and train staff. *A standard process for assessing the costs of care, which takes into account local variations in wage rates, and setting fair prices that reflect costs, would help guide local authorities. It should focus on key services such as residential care for older people and home care, be designed by an independent body and agreed by provider representatives and councils through the Local Government Association, the Association of Directors of Adult Social Care, and the Department of Health.* (Paragraph 68)
16. As nearly all care services are procured by local authorities from the independent sector, commissioning is a very important part of the system. There was significant evidence from providers about poor practice, unfair contracts and depleted commissioning teams. The market shaping, commissioning and procurement activities of councils are the only part of the system which are unregulated, yet they have a direct impact on the quality and diversity of care people receive and the sustainability of the sector. *The Care Quality Commission's remit should be extended to include oversight of these activities, as well as the extent to which councils comply with the fair costs of care in their negotiations and contractual relationships with providers. It should also work with the sector to produce best practice template contracts for the provision of care services. The Department of Health should also review the guidance on commissioning which accompanies the Care Act 2014.* (Paragraph 73)
17. The evidence we have heard suggests that not all councils routinely monitor the care services they procure to ensure that they are sufficient to meet people's needs, and are of a high enough quality and adequately resourced, for example to pay for care workers' travel time and 'sleep ins'. Councils should undertake annual auditing of the services they commission and the Care Quality Commission's extended remit

should also oversee councils' arrangements for monitoring the care services they have purchased and the effectiveness of that monitoring. *Councils should undertake annual auditing of the services they commission and the Care Quality Commission's extended remit should also oversee councils' arrangements for monitoring the care services they have purchased and the effectiveness of that monitoring* (Paragraph 75)

18. *Councils should regularly carry out 'spot checks' to ensure that people are actually receiving the care they require and be alert to new technological developments in this area* (Paragraph 76)
19. The workforce is essential to quality of care. High vacancy and turnover rates point to severe challenges. A range of factors are responsible, including low pay not commensurate with the level of work involved, low status, poor terms and conditions, and lack of training opportunities and career progression. Vacancy and turnover rates are particularly high among social care nurses, who understandably prefer the better pay and conditions and career development in the NHS. (Paragraph 92)
20. Non-payment of the national minimum wage is widespread as a result of providers failing to pay care workers for their travel time, travel costs and 'sleep in' shifts. *When commissioning care, councils must ensure that providers pay enough to comply with the national minimum wage and to cover care workers' travel time and costs and 'sleep ins'. Contracts between councils and providers should stipulate this and councils should regularly monitor compliance.* (Paragraph 93)
21. *The Government, working with the Local Government Association, should publish a care workers' charter, drawing upon UNISON's Ethical Care Charter, which sets out what care workers can expect from their employer. Employers should be expected to demonstrate their commitment to supporting and developing care workers.* (Paragraph 94)
22. The National Living Wage, although welcome in a low paid sector, will not be sufficient to bring pay into line with skills and responsibilities or to improve vacancy and turnover rates. It has increased competition from less stressful jobs in other sectors and made it challenging for providers to differentiate pay between staff levels. Provision of additional funding for social care would enable providers to pay staff wages above the National Living Wage and provide staff with training. *The Government should request that Skills for Care, in discussion with unions and providers, conducts research to determine what level of wage is needed to sustain the workforce and attract new entrants.* (Paragraph 95)
23. *The Government should encourage local authorities and their NHS partners to develop local joint strategies for recruitment and retention of social care nurses and to reduce competition between sectors for staff.* Ensuring adequate nursing capacity in social care is essential if councils are to be able to support hospitals in the prompt discharge of patients. (Paragraph 96)
24. Direct payments are a great opportunity for people to take control of and personalise their care. *However, councils must ensure that people are comfortable with and able to take on the employment responsibilities that direct payments entail and guide people to sources of support and advice on being an employer.* (Paragraph 97)

25. *The status of care work must be improved to ensure a high quality and sustainable workforce which keeps pace with demographic change. Better pay, commensurate with skills and responsibilities, and better terms and conditions, including pensions, will be part of this, as will the development of a strong career structure—from apprenticeship to registered nurse—and centrally delivered training with national standards and qualifications, similar to the NHS Knowledge and Skills Framework. The Department of Health should consider whether a national recruitment campaign, similar to Teach First or Step Up To Social Work, would be an appropriate mechanism to achieve this and whether care work should be designated a registered profession. (Paragraph 100)*
26. The social care system is heavily, and increasingly, reliant on unpaid carers. As councils have reduced the amount of care they supply, unpaid carers have stepped in to fill the gap, providing more hours of higher level care. However, demographic changes mean that a growing shortfall in intergenerational carers is projected, which poses a challenge to the suggestion that children may need to care more for their parents in future. It is clear that, unless social care receives more funding, the system will not have the capacity to fill the shortfall in the future. (Paragraph 105)
27. The Care Act requires councils to identify, assess and meet a carer's needs for support, if they are financially eligible. However, councils said that the costs of assessing and supporting carers have significantly added to the pressure on their budgets. This places both local authorities and carers in a very difficult position. (Paragraph 113)
28. Caring, particularly as it becomes more intensive, has serious consequences for a carer's own physical and mental health. The support for carers which could prevent them from becoming unwell, such as respite care, is being reduced or is simply not on offer, despite duties in the Care Act which require councils to consider carers' health and wellbeing and meet their needs for support. *Extra funding is needed to enable councils to fulfil their duties to assess and support carers and, in so doing, maintain their health and well-being, participation in education and employment and ability to continue caring. (Paragraph 114)*
29. Combining caring responsibilities with employment without extra support is particularly challenging. The Care Act requires councils to take carers' work and education into account in the provision of support, yet many carers are having to leave work, which is detrimental to their longer-term financial security and a significant cost to the public purse. We look forward to progress on the Health and Work Green Paper and the Fuller Working Lives Strategy which the Minister indicated would look at how carers might be better supported to enter, stay in and return to work. *As part of this the Government should consider whether the approach taken in Germany to carers' leave might be a basis for giving carers dedicated employment rights. (Paragraph 117)*
30. *Carers Allowance should be increased to reflect the increasing contribution that carers make to the social care system. In addition, the earnings limit should be higher and more flexible to enable carers to maintain some contact with the labour market. (Paragraph 119)*

Organisation of health and social care services

31. *The Department for Communities and Local Government should review the operation of the Disabled Facilities Grant, and in particular the extent to which its administration and operation is hampered by the split in responsibility between district and county councils and between housing and social care departments in unitary authorities* The evidence we received suggested that beneficiaries found the process slow and cumbersome, had little say in the adaptations and doubted that it was always good value for money. (Paragraph 124)
32. *The Government should be more realistic in its expectations for integration.* The time needed for such large scale changes to take place is significant and there is little evidence available yet on the benefits of integration, both in terms of patient outcomes and efficiency savings—the recent National Audit Office report on health and social care integration reflected this. Furthermore, progress, which is dependent on good local relationships between health and social care, varies across the country. (Paragraph 134)
33. *There are various barriers to integration which the Government must address.* These include organisational differences between the NHS and local government; different payment incentives; different regulatory, performance and outcome frameworks; information sharing; workforce challenges and lack of funding for social care. Lack of social care funding is undermining integration, with reduced budgets causing tension between local partners. (Paragraph 135)
34. The differences between the health and social care workforces in terms of culture, pay and conditions, career development and progression are stark. This presents a significant challenge to closer working, which is also inhibited in many local areas by difficulties in recruiting and retaining staff. *The Government should acknowledge the challenge that this presents and with Skills for Care and Health Education England set out a strategy for aligning the two workforces.* (Paragraph 136)
35. Place-based planning on health and social care which has had input from local politicians is more likely to take into account other local services, such as housing, benefits and public health, and therefore result in wider integration of services and better outcomes for the people who use them. *Decisions on pooling health and social care budgets should be made locally. If this is not the case, there is a risk that local areas will not have the flexibility to use their budgets on local integration priorities and progress on integration will be impeded. Furthermore, we agree with Stephen Dorrell of the NHS Confederation that local government should be involved in the commissioning of local health services. This would further ensure that decisions about local health services are informed by the needs of the local population and the shape of existing local public services.* (Paragraph 138)
36. STPs are an important opportunity for places to take a longer-term approach to integrating health, social and other local services and, therefore, to be a success, local government should be an equal partner in planning. *The Government and NHS England should review the STP footprints with the aim of making them better aligned with local authority boundaries.* (Paragraph 141)

37. Funding constraints and demographic pressures are acting as a driver for some councils to innovate and change the way they deliver care. However, due to budget pressures, most councils are in panic mode and are not ready to rethink the way they do things. *The Government should create an innovation fund to encourage and give councils the capacity to consider how innovative approaches could be applied in their local area.* (Paragraph 144)
38. Assistive technology is already helping people stay at home longer, reduce hospital admissions and coordinate care between different agencies, and smart technology will be an important part of improving care in the future. At the moment, however, very widespread use of digital technology is limited by the extent of broadband and 4G coverage. It also needs to be usable by and acceptable to service users and carers. (Paragraph 148)
39. Councils are also starting to use digital data platforms which, by drawing together data from different sources, helps them track individuals' journeys through the health and social care system and target resources and commission more effectively. (Paragraph 149)
40. The Department of Health, NHS England and the Local Government Association should explore how best to bring together centrally and regularly update information on innovation in the delivery of health and social care in local areas. (Paragraph 150)
41. Shared Lives appears to be an exciting innovation which enables care provision within family and community relationships. *The Government should commission a wide-scale evaluation on the outcomes and cost effectiveness of the scheme and, where appropriate, care commissioners should consider it as one of a range of available care options.* (Paragraph 154)
42. We greatly sympathise with the families' concerns, but are not well-placed to investigate or adjudicate the matter. But the amount of evidence we received on this one issue, and the strength of feeling expressed, exemplifies the reasons why it is essential to get the country's social care system right in the short, medium and long terms. (Paragraph 155)

Future funding

43. *We agree that local government should be allowed to use some of the additional business rates revenue, according to need, to close any adult social care funding shortfall that exists when 100% business rates retention comes into effect, before being allocated new responsibilities.* (Paragraph 157)
44. Council tax and business rate income will not be commensurate with current and future local demand for adult social care. *The Government should report on what measures it intends to use to tackle the disparity that this will create. We recommend that funding should be made available for adult social care via a central government grant linked to need and rising demand. As further insurance against future shortfalls in funding, the Government should consider giving local authorities greater flexibility on the level at which they set council tax.* (Paragraph 159)

45. *Expenditure on adult social care will need to rise as a proportion of total public expenditure. (Paragraph 161)*
46. *After successive attempts at reform and in the context of ever-increasing demographic pressures on the system, the need to find a way to fund social care for the long-term has now become urgent. The solution needs to be implemented in the next spending round. (Paragraph 163)*
47. *It is vital that political parties across the spectrum, together with the social care sector and the wider public, are involved in the process of reaching a solution. The importance of this was demonstrated by our visit to Germany, where decisions on reforming social care funding were supported by a political consensus, trades unions and employers and therefore attracted wide public backing. As a first step, political parties should agree to work together. (Paragraph 166)*
48. *There then needs to be an open debate about where the money to fund social care should come from. The review must consider taking funding from a wide range of sources, including:*
1. *Hypothecating national taxation (income tax, National Insurance Contributions, asset taxes, inheritance tax) and, in particular, the feasibility of introducing compulsory social insurance, publicly owned and administrated, on the German or Japanese model.*
 2. *All age-related expenditure (the state pension, including the triple lock pension guarantee, winter fuel allowance, concessionary bus fares, free prescriptions and, indirectly, TV licences).*

*Although they are likely to remain an important part of funding adult social care, local taxes, which will not grow at the same rate as need, cannot be the main funding solution. We have already called for significant reforms to council tax in our report on fiscal devolution in the last parliament and reiterated these in the report we published last year, *Devolution: the next five years and beyond*. (Paragraph 167)*

49. *As well as considering future sources of funding for social care, the review should also take into account the range of uses for which social care funding is required. Over the course of this inquiry, we have identified these as including:*
- *Care and support, including:*
 - *Meeting people’s needs for care and support;*
 - *Preventative care and early intervention; and*
 - *Assessments for carers, leading to the provision of support for carers.*
 - *Payment of fees to providers, which contribute to:*
 - *The wages of the care workforce, as well as holiday, sickness, pension and travel costs;*
 - *Their training, qualifications and career development, including measures to enhance the status of the care workforce;*

- *Meeting providers' business costs and generating profit to invest in their capital assets and the workforce. (Paragraph 168)*
- 50. *The review will also need to consider whether to go ahead with implementation of Phase Two of the Care Act 2014, as well as, more broadly, whether people should be means tested and, if so, how they should contribute to the costs of their care. As part of this, it should also consider the different approaches to including the value of a person's home in the means test for residential and home care. (Paragraph 169)*
- 51. While health care will remain free at the point of use, social care will remain needs- and means-tested. We note the challenge that this lack of alignment in entitlements to health and social care poses to integration. (Paragraph 170)
- 52. We are conscious that in many places in this report we have called on the Government to provide more funds for social care. We have not done so lightly. The Parliamentary Under-Secretary of State for Community Health and Care did not agree that the social care system was in crisis—a term the Chief Executive of NHS England was happy to use—preferring to describe it as 'under stress'. But it is clear from our inquiry that unless significant extra funds are provided in the short and medium terms, the social care system will be unable to cope with the demands placed upon it. Extra funding alone will not solve the problems that face us, but without it the other steps we have suggested will quite simply fail. (Paragraph 171)
- 53. We welcome the Government's announcement of a Green Paper on the long-term funding of social care later this year. We reiterate that, to ensure the work results in a lasting solution, it should be taken forward on a cross-party basis. We will review the scope of the Green Paper when it is published later this year and consider whether a further inquiry into any issues it raises is needed. (Paragraph 172)

Formal Minutes

Monday 27 March 2017

Members present:

Mr Clive Betts, in the Chair

Bob Blackman	Mr Mark Prisk
Helen Hayes	Mary Robinson
Kevin Hollinrake	Alison Thewliss
David Mackintosh	

Draft Report (*Adult social care*) proposed by the Chair, brought up and read.

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

Paragraphs 1 to 172 read and agreed to.

Executive Summary agreed to.

Ordered, That the Executive Summary be made available as a separate document.

Resolved, That the Report be the Ninth Report of the Committee to the House.

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

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

[Adjourned until Tuesday 28 March at 3.30 p.m.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Monday 12 September 2016

Question number

Vicky McDermott, Chair, Care and Support Alliance, **Dr José-Luis Fernández**, Deputy Director, Personal Social Services Research Unit, LSE; and **Richard Humphries**, Assistant Director Policy, The King's Fund

[Q1–55](#)

Monday 10 October 2016

Ray James, Immediate Past President, Association of Directors of Adult Social Services, **James Lloyd**, Associate Fellow, the Strategic Society Centre, and **Sarah Pickup**, Deputy Chief Executive, Local Government Association

[Q56–78](#)

Councillor Jason Arthur, Cabinet Member for Finance and Health, Haringey Council, **Tony Kirkham**, Director of Resources, Newcastle City Council, and **Councillor Colin Noble**, Spokesman for Health and Social Care, County Councils Network

[Q79–101](#)

Wednesday 26 October 2016

David Behan, Chief Executive, Care Quality Commission, **Professor Keith Moultrie**, Director, Institute for Public Care, **Paul Simic**, Chief Executive, Lancashire Care Association, and **Janice Dane**, Assistant Director, Early Help and Prevention, Norfolk County Council

[Q102–144](#)

Professor Martin Green, Chief Executive, Care England, **Colin Angel**, Policy and Campaigns Director, UKHCA, **Andrew Dykes**, Chairman, Exalon Autonomy Group, and **Tim Hammond**, Chief Executive, Four Seasons Health Care

[Q145–158](#)

Wednesday 16 November 2016

Emily Holzhausen, Director of Policy and Public Affairs, Carers UK, **Cllr Rory Palmer**, Lead Member for Adult Social Care, Leicester City Council, **Dr Linda Pickard**, Associate Professorial Research Fellow, Personal Social Services Research Unit, London School of Economics

[Q159–182](#)

Peter Turner, Chief Executive, Carers First (Kent and Medway), **Margaret Dangoor**, carer and carer representative, **Lana Harber**, carer, **Christine Euman**, carer

[Q183–196](#)

Monday 28 November 2016

Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership, **Professor Gerald Wistow**, Visiting Professor in Social Policy, LSE, and **Mark Lloyd**, Chief Executive, Local Government Association

[Q197–225](#)

Alison Rogan, External Affairs Director, Tunstall Healthcare, **Karen Kibblewhite**, Head of Commissioning for Health and Wellbeing, Rutland County Council, and **Alex Fox**, Chief Executive, Shared Lives Plus

[Q226–253](#)

Wednesday 14 December 2016

Stephen Dorrell, Chair, NHS Confederation; and **Simon Stevens**, Chief Executive, NHS England

[Q254–286](#)

Monday 23 January 2017

Larry Gardiner, **Isaac Samuels**, and **Anna Severwright**

[Q287–309](#)

Heather Wakefield, National Secretary for Local Government, Unison, **Sharon Allen**, Chief Executive, Skills for Care, and **Clare Jacobs**, Employment Relations Adviser, Royal College of Nursing

[Q310–359](#)

Monday 30 January 2017

Mr Marcus Jones MP, Minister for Local Government, Department for Communities and Local Government, **David Mowat MP**, Minister for Communities, Health and Care, Department of Health, and **Penny Mordaunt MP**, Minister for Disabled People, Health and Work, Department for Work and Pensions

[Q360–428](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website. Further written evidence, originally submitted in confidence, will also be available on the website.

SOC numbers are generated by the evidence processing system and so may not be complete.

- 1 Action for M.E. ([SOC0074](#))
- 2 Action on Hearing Loss ([SOC0090](#))
- 3 Adaptive Technology Europe Limited (ATEL) ([SOC0003](#))
- 4 Age UK ([SOC0151](#))
- 5 Alzheimer's Society ([SOC0070](#))
- 6 Ambassador for Art's and Dyslexia Paul Milton ([SOC0102](#))
- 7 Ann Coffey ([SOC0028](#))
- 8 anon anon ([SOC0002](#))
- 9 Anson Care Services ([SOC0054](#))
- 10 Association of Directors of Adult Social Services (ADASS) ([SOC0134](#))
- 11 Association of Directors of Adult Social Services SE Region ([SOC0171](#))
- 12 BASW ([SOC0063](#))
- 13 Bedford Citizens Housing Association ([SOC0008](#))
- 14 Blackburn with Darwen Borough Council ([SOC0123](#))
- 15 brighterkind ([SOC0034](#))
- 16 Bristol City Council ([SOC0132](#))
- 17 Bristol Disability Equality Forum ([SOC0210](#))
- 18 British Healthcare Trades Association ([SOC0145](#))
- 19 British Medical Association ([SOC0046](#))
- 20 British Red Cross ([SOC0121](#))
- 21 Brunelcare ([SOC0088](#))
- 22 Bupa UK ([SOC0097](#))
- 23 BVFG (Botton Village Families Group) ([SOC0179](#))
- 24 Cambridgeshire County Council, Essex County Council, Hertfordshire County Council, Norfolk County Council, Suffolk County Council, Southend Council and Thurrock Council ([SOC0195](#))
- 25 Camphill Families and Friends ([SOC0076](#))
- 26 Care and Support Alliance ([SOC0155](#))
- 27 Care Association Alliance ([SOC0027](#))
- 28 Care England ([SOC0098](#))
- 29 Care Sector Innovations ([SOC0030](#))
- 30 Carers Trust ([SOC0104](#))
- 31 Carers UK ([SOC0161](#))

- 32 Catherine Emma Gibbons ([SOC0085](#))
- 33 Centre for Welfare Reform ([SOC0164](#))
- 34 Chartered Institute of Housing ([SOC0041](#))
- 35 Chartered Society of Physiotherapy ([SOC0105](#))
- 36 Choice Care Group ([SOC0113](#))
- 37 College of Occupational Therapists ([SOC0018](#))
- 38 Co-operatives UK ([SOC0160](#))
- 39 Cornwall partners in care ([SOC0120](#))
- 40 County Councils Network ([SOC0204](#))
- 41 County Councils Network ([SOC0223](#))
- 42 Coverage Care Services ([SOC0016](#))
- 43 Department for Communities and Local Government ([SOC0216](#))
- 44 Disability Rights UK ([SOC0080](#))
- 45 Down's Syndrome Association ([SOC0096](#))
- 46 Dr Elizabeth Guest ([SOC0005](#))
- 47 Dr Keith Blois ([SOC0056](#))
- 48 East Sussex County Council ([SOC0012](#))
- 49 Eden Futures ([SOC0157](#))
- 50 Elder ([SOC0197](#))
- 51 Essex Independent Care Association ([SOC0147](#))
- 52 Exalon Autonomy Group Limited ([SOC0125](#))
- 53 Fincch Ltd ([SOC0064](#))
- 54 Foundations ([SOC0078](#))
- 55 Four Seasons Health Care ([SOC0219](#))
- 56 Gateshead Council ([SOC0146](#))
- 57 Guild Care ([SOC0073](#))
- 58 Haringey Council ([SOC0159](#))
- 59 Headway—the brain injury association ([SOC0089](#))
- 60 Healthwatch Cambridgeshire ([SOC0101](#))
- 61 Healthwatch Essex ([SOC0152](#))
- 62 Heritage Care ([SOC0065](#))
- 63 Hft ([SOC0119](#))
- 64 Home Group ([SOC0126](#))
- 65 Home of Comfort for Invalids ([SOC0106](#))
- 66 Horizon Senior Care Ltd ([SOC0021](#))
- 67 Housing Learning and Improvement Network (LIN) ([SOC0009](#))
- 68 Hull City Council ([SOC0048](#))
- 69 Humberside Independent Care Association Ltd ([SOC0143](#))

- 70 Inclusion London ([SOC0011](#))
- 71 Independent Age ([SOC0067](#))
- 72 International Longevity Centre—UK ([SOC0066](#))
- 73 Isle of Wight Council ([SOC0109](#))
- 74 Jackie Luland ([SOC0095](#))
- 75 Jewish Care ([SOC0061](#))
- 76 Jon Glasby ([SOC0026](#))
- 77 Kent County Council ([SOC0035](#))
- 78 Kent Integrated Care Alliance ([SOC0020](#))
- 79 Kent Integrated Care Alliance ([SOC0062](#))
- 80 Kings' Fund ([SOC0222](#))
- 81 Knowsley Council ([SOC0142](#))
- 82 Lady Iveta Kurpniece ([SOC0039](#))
- 83 Lancashire Care Association Co. Ltd ([SOC0044](#))
- 84 Lancashire County Council ([SOC0141](#))
- 85 Later Life Ambitions ([SOC0110](#))
- 86 Learning Disability England ([SOC0136](#))
- 87 Learning Disability Voices ([SOC0140](#))
- 88 Leicester City Council ([SOC0150](#))
- 89 Leonard Cheshire Disability ([SOC0108](#))
- 90 Lifeways Group ([SOC0077](#))
- 91 Liverpool City Council ([SOC0127](#))
- 92 LivesthroughFriends CIC ([SOC0058](#))
- 93 Local Government Association ([SOC0075](#))
- 94 Local Government Ombudsman ([SOC0131](#))
- 95 London Borough of Camden ([SOC0129](#))
- 96 London Borough of Havering ([SOC0010](#))
- 97 London Borough of Newham ([SOC0133](#))
- 98 London Councils ([SOC0149](#))
- 99 London Fire and Emergency Planning Authority ([SOC0051](#))
- 100 Martha Trust ([SOC0057](#))
- 101 Mary Peedell ([SOC0185](#))
- 102 Merton Centre for Independent Living ([SOC0158](#))
- 103 MHA ([SOC0117](#))
- 104 Midland Heart Limited ([SOC0128](#))
- 105 Miss Fleur Perry ([SOC0165](#))
- 106 Motor Neurone Disease Association ([SOC0112](#))
- 107 Mr Clive Lewis ([SOC0038](#))

- 108 Mr Colin Slasberg ([SOC0212](#))
- 109 Mr Derek Peedell ([SOC0184](#))
- 110 Mr Duncan Cameron ([SOC0178](#))
- 111 Mr Max White ([SOC0186](#))
- 112 Mr Robin Sutton ([SOC0024](#))
- 113 Mr William Walker ([SOC0182](#))
- 114 Mrs Christine Dunlop ([SOC0190](#))
- 115 Mrs Diane Wall ([SOC0224](#))
- 116 Mrs Elizabeth Robertson ([SOC0181](#))
- 117 Mrs Fran Francis ([SOC0183](#))
- 118 Mrs Jane Caygill ([SOC0040](#))
- 119 Mrs Jenny Piercy ([SOC0177](#))
- 120 Mrs Kay Wilson ([SOC0180](#))
- 121 Mrs Mandy Abbey ([SOC0036](#))
- 122 Mrs Pippa Unwin ([SOC0187](#))
- 123 Mrs Rosemary Trustam ([SOC0094](#))
- 124 Mrs Sally Murray-Jones ([SOC0191](#))
- 125 Mrs Sue Hurst ([SOC0176](#))
- 126 Ms Heather Falconer ([SOC0169](#))
- 127 Ms Jayne Swallow ([SOC0206](#))
- 128 NAT (National AIDS Trust) ([SOC0163](#))
- 129 National Audit Office ([SOC0200](#))
- 130 National Care Forum ([SOC0114](#))
- 131 National Pensioners Convention ([SOC0205](#))
- 132 Newcastle City Council ([SOC0130](#))
- 133 NHS Confederation ([SOC0225](#))
- 134 NHSCC ([SOC0211](#))
- 135 Norfolk County Council ([SOC0103](#))
- 136 Northamptonshire County Council ([SOC0199](#))
- 137 Nottingham City Council ([SOC0072](#))
- 138 Nutricia: Advanced Medical Nutrition ([SOC0037](#))
- 139 NW ADASS ([SOC0139](#))
- 140 Oxfordshire Association of Care Providers CIC ([SOC0092](#))
- 141 Parkinson's UK ([SOC0060](#))
- 142 Precious Caring Limited ([SOC0045](#))
- 143 Prison Reform Trust ([SOC0086](#))
- 144 PSA Commission on Care ([SOC0220](#))
- 145 Real Life Options ([SOC0170](#))

- 146 Recovery Focus ([SOC0154](#))
- 147 Registered Nursing Home Association ([SOC0099](#))
- 148 ResPublica ([SOC0087](#))
- 149 Ribble Valley Citizens Advice Bureau ([SOC0004](#))
- 150 Richmond Mencap ([SOC0156](#))
- 151 RNIB (Royal National Institute of Blind People) ([SOC0137](#))
- 152 Rochdale Borough Council ([SOC0122](#))
- 153 Royal College of Nursing ([SOC0081](#))
- 154 Royal College of Psychiatrists ([SOC0174](#))
- 155 Royal College of Speech and Language Therapists ([SOC0071](#))
- 156 Rutland County Council ([SOC0138](#))
- 157 Save Autism Services Haringey ([SOC0093](#))
- 158 Scope ([SOC0052](#))
- 159 Sefton Council ([SOC0167](#))
- 160 Sense ([SOC0116](#))
- 161 Shaping Our Lives ([SOC0203](#))
- 162 Shared Lives Plus ([SOC0019](#))
- 163 SIGOMA ([SOC0079](#))
- 164 Silver Voices ([SOC0050](#))
- 165 Sir Stephen Bubb ([SOC0069](#))
- 166 Social Policy Research Unit, University of York ([SOC0218](#))
- 167 Solitaire Home Care Services ([SOC0006](#))
- 168 Somerset Care Ltd ([SOC0042](#))
- 169 Somerset Care ([SOC0226](#))
- 170 South East Strategic Leaders ([SOC0172](#))
- 171 South West England ([SOC0100](#))
- 172 Southern Healthcare ([SOC0135](#))
- 173 St Helens Council ([SOC0014](#))
- 174 St Ronans Care Home ([SOC0166](#))
- 175 Surrey Care Association ([SOC0033](#))
- 176 Surrey Care Association ([SOC0091](#))
- 177 Surrey County Council ([SOC0192](#))
- 178 techscheme ltd ([SOC0029](#))
- 179 The Abbeyfield Maidenhead Society Ltd ([SOC0032](#))
- 180 The Alliance for Camphill ([SOC0124](#))
- 181 The Avenues Group Trust ([SOC0059](#))
- 182 The Brendoncare Foundation ([SOC0053](#))
- 183 The Camphill Village Trust ([SOC0049](#))

- 184 The Co-operative Party ([SOC0217](#))
- 185 The Disabilities Trust ([SOC0107](#))
- 186 The Health Foundation ([SOC0153](#))
- 187 The King's Fund and the Nuffield Trust ([SOC0198](#))
- 188 The Relatives & Residents Association ([SOC0168](#))
- 189 The Salvation Army ([SOC0175](#))
- 190 Three Cs Support ([SOC0031](#))
- 191 Thurrock Coalition ([SOC0083](#))
- 192 Tunstall Healthcare ([SOC0023](#))
- 193 Turning Point ([SOC0148](#))
- 194 UNISON ([SOC0025](#))
- 195 United for All Ages ([SOC0084](#))
- 196 United Kingdom Homecare Association ([SOC0173](#))
- 197 United Response ([SOC0115](#))
- 198 Vanguard ([SOC0068](#))
- 199 VODG (Voluntary Organisations Disability Group) ([SOC0043](#))
- 200 West Berkshire Council ([SOC0162](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

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

Session 2016–17

First Report	100 per cent retention of business rates: issues for consideration	HC 241
Second Report	Pre-appointment hearing with the Government's preferred candidate for the post of Chair of the Homes and Communities Agency	HC 41
Third Report	Homelessness	HC 40
Fourth Report	Government interventions: the use of Commissioners in Rotherham Metropolitan Borough Council and the London Borough of Tower Hamlets	HC 42 (CM 9345)
Fifth Report	The draft Homelessness Reduction Bill	HC 635
Sixth Report	Pre-appointment hearing with the Government's preferred candidate for the post of Local Government Ombudsman	HC 737
First Special Report	Housing associations and the Right to Buy: Homes and Communities Agency response to the Committee's Second Report of Session 2015–16	HC 902
Seventh Report	Public Parks	HC 45
Eighth Report	Adult social care: a pre-Budget report	HC 47

Session 2015–16

First Report	Devolution: the next five years and beyond	HC 369
Second Report	Housing associations and the Right to Buy	HC 370
Third Report	Department for Communities and Local Government's consultation on national planning policy	HC 703
First Special Report	Child sexual exploitation in Rotherham: Ofsted and further government issues: Ofsted Response to the Committee's Ninth Report of Session 2014–15	HC 435
Second Special Report	Private rented sector: the evidence from banning letting agents' fees in Scotland: Government Response to the Committee's Eighth Report of Session 2014–15	HC 434