Dr Sarah Wollaston (Totnes) (Con): Click here to watch Sarah live

I have good news: people in their 40s and 50s are at the pinnacle of evolution, according to Dr Bainbridge writing in the New Scientist. I do not think my children would agree with that assessment, but they would agree that they feel rather outnumbered. This is a cause for celebration, however, and we should note it in this House: it is a good thing that we are all living longer—after all, the alternative is very unattractive indeed. A man who reaches the age of 65 can now expect on average to live a further 18 years, and a woman at 65 can expect to live even longer to 85 and a half. We should welcome that on international women’s day. This is good news all round, therefore, but these extra years must be lived well. We should add to people’s years of life while also helping them live with independence and dignity.

I have the privilege of serving on the Health Committee, and I have also had the privilege of working for 24 years on the front line in the NHS. I have therefore met many carers, and also many people who, sadly, are suffering from dementia. Many Members have commented on that topic however, so I will not discuss it further now.

I want to focus on the Select Committee’s recommendations following our inquiry into social care. I acknowledge that, by 2014, an extra Â£2 billion a year will be spent on social care, and I welcome that investment. There is still an issue that needs to be addressed, however, and it transcends party politics.

As the King’s Fund and the Dilnot commission have made clear, demand is outstripping supply by 9% over the past four years and the Local Government Association and the Association of Directors of Adult Social Services have stated that this underfunding is a long-term problem. According to the King’s Fund, the funding gap could be as high as Â£1.2 billion by 2014. Also, about 890,000 older people in social care may have a need that is not being met. As the Select Committee heard, some councils are tightening their eligibility criteria, so that people who, sadly, are suffering from dementia are now being classed as having “moderate” needs. Other councils are setting a different benchmark, so they are funding only “substantial” needs, rather than both, as they might have done in the past. Obviously, the problem goes beyond the total spend. Government Members are taking a realistic attitude to our national debt, knowing that there are no blank cheques. However, we need to continue to increase our social care funding slightly, so that we can achieve what we want to achieve for our older people: dignity and independence.

It will not matter how much we spend unless we change how we spend it. One thing the Dilnot commission examined well was how we divide our spending. We know that we spend Â£145 billion a year on older people in England, about half of which goes on benefits, such as pensions, housing-related benefits and pension credits. Some Â£50 billion is spent on the NHS but only Â£8 billion goes towards social care. That balance is not right. If we were designing the system from scratch, we would not set the funding in that way. That structural problem has been recognised for decades, but the White Paper and the changes in the Health and Social Care Bill give us an opportunity to address it. I therefore ask the Minister to rebalance things by examining the Select Committee’s key recommendation, which was to deliver integrated health and social care, with a single commissioner or a commissioning
body, and to drive this joint working by also looking at pooling budgets.

Some wonderful examples of that approach are available, as we found when the Select Committee visited Blackburn with Darwen PCT and Torbay Care Trust. I am fortunate that the Torbay Care Trust covers much of my constituency, because it achieves real results: low average lengths of stay; rapid access to equipment, thus avoiding hospital admissions; and getting people out of hospital much quicker. The key to all that is recognising that keeping people independent in their own homes, rather than admitting them to expensive hospitals, saves money. As has been said, for every £1 we spend on integration, we save £2.65 for the health service—as is so often the case, the best care turns out to be the cheapest care.

I was disappointed to hear the Minister describe the care trust model as an experiment that never really got "out of the lab". I urge him to get back into the laboratory with care trusts, because this is good practice. They bring a positive culture on joint working, pooled budgets and putting patients first. In Torbay, they have considered an imaginary patient, "Mrs Smith", who has complex care needs and at every stage in the system they have designed everything around her, putting her needs first. That sometimes means sweeping away the silo working that we so often see. In many parts of the country, six different phone calls have to be made when dealing with a patient with complex care needs, and there are endless delays and frustrations, and repeated assessments, but Torbay has a care co-ordinator with a single number. We need to adopt that kind of working.

Paul Burstow: The hon. Lady is making an important set of contributions to this debate. That comment I made during the Health Committee's evidence session was very much born out of frustration—it is frustration that my hon. Friend the Member for Southport (John Pugh) has echoed. How we spread best practice and get it adopted is one of the key challenges in delivering more integrated health and social care, and it is one of the things we are going to address in the White Paper. The Select Committee's contribution to that process has been very helpful.

Dr Wollaston: I thank the Minister for that encouraging response. I am glad to hear him say that rolling out good practice is key to this. I ask him to consider the Select Committee's recommendation that the way that we can best drive that is by having a single outcomes framework. We are currently going to have outcomes frameworks for housing, for social care and for elderly people in health. Bringing those together would drive proper integration. Having a single commissioner for all these services would bring people together. If we do not have that, we risk carrying on as we are. When budgets are stretched, as we all accept they are, there is more of a tendency for organisations to say, "This money is for social care"; where spending the money would perhaps improve only health outcomes, there is less of an incentive to spend it. We should consider pooling the budgets, and having a single commissioner and a single outcomes framework. I am not saying that we should be too rigid in imposing how that is done, but we should set out what we expect. In addition, we should recognise how important housing is in this area. We should not leave it out of the equation when we consider how we help older people to continue to live independently.

Damian Collins (Folkestone and Hythe) (Con): Would my hon. Friend include more informal forms of care, such as referring patients who are socially excluded to local walking or singing groups where they can participate and be with other people? There are some good models of that in my constituency.

Dr Wollaston: I thank my hon. Friend for that intervention and agree with him absolutely. In the past couple of weeks, I have visited an organisation called Brixham Does Care in my
constituency as well as another, Saltstone Caring, and I am sure that we all have wonderful examples in our constituencies, sometimes involving social enterprises and sometimes charities.

I feel that one of the most encouraging things about the Health and Social Care Bill is that it will give commissioners the flexibility to draw in partners, because there is sometimes an assumption that only the NHS can deliver good care. The NHS remains at the core of good care and I trust that GPs will have the sense to commission integrated care pathways that do not fragment local services. I do not know a single GP who wants to privatise the health service or social care; GPs want the flexibility to bring all these elements together while having the good sense to protect their much valued local NHS services. I am very encouraged to see that there will now be a focus on integration, but I ask the Minister specifically to consider integrated care with a single commissioner, because the Committee felt that that would be the most encouraging way forward.

In conclusion, let me return to Dr Bainbridge in the New Scientist, who describes middle-aged people as

"the most impressive things yet produced by natural selection."

The Minister fits that bill perfectly and has a fantastic opportunity to achieve what we have been trying to achieve for 50 years: an integrated health and social care model. It can be done and I hope that he will look at the Health Committee's report and make it a reality.

Hansard