

Health and Social Care Committee

Oral evidence: Adult Social Care Reform: The Cost of Inaction, HC 368

Wednesday 5 March 2025

Ordered by the House of Commons to be published on 5 March 2025.

Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; and Gregory Stafford.

Questions 118 to 214

Witnesses

I: Hugh Evans, Executive Director of Adult and Communities, Bristol City Council; Councillor David Fothergill, Chairman, LGA Community Wellbeing Board; Melanie Williams, ADASS, President.

II: Dr Anu Singh, Chair, Black Country ICB; Dr Birju Bartoli, Chief Executive, Northumbria Healthcare Foundation Trust; Isabel Lawicka, Director of Policy and Strategy, NHS Providers.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]



Examination of witnesses

Witnesses: Hugh Evans, Councillor David Fothergill and Melanie Williams.

Q118 **Chair:** Good morning, everyone. Welcome to this session of the Health and Social Care Select Committee. This is a hearing in our inquiry into the cost of inaction in adult social care. It is our delight to have two illustrious panels for us to question this morning to get to the bottom of some of these numbers.

For the benefit of the Committee and those watching, may I ask the first panel to introduce themselves and what they do?

David Fothergill: I am Councillor David Fothergill. I am a councillor in Somerset, which was at the end of a very difficult train line this morning, and the chair of the Community Wellbeing Board at the LGA. I am also a deputy chair of the LGA.

Melanie Williams: Good morning. I am Melanie Williams. I am an executive director of adult social care in Nottinghamshire and I am also ADASS president.

Hugh Evans: Good morning. My name is Hugh Evans and I am executive director for adults and communities at Bristol City Council. I am also the statutory DASS for Bristol City Council.

Chair: Thank you so much for being with us this morning.

Q119 **Danny Beales:** I want to start by asking in quite a general sense about the funding challenge, which I am sure will be familiar territory for all of you. Just generally, what impact are you seeing from the current funding constraints around social care? What is that meaning for your ability to deliver adult social care?

Melanie Williams: If we think about the impact of it, it is useful to think about four lines of inquiry in terms of reform. The first is about our ability to transform models of care. We are thinking about improving people's outcomes through greater choice, control and self-determination. Secondly, there is the impact on workforce, which is about our ability to reward, recognise, pay, develop and promote our staff. Thirdly, there is a bit about our interface and integration importantly but not solely with the NHS. It is also thinking about housing and DWP, for example. Lastly, there is something about who pays and people's contribution to care.

I am sure you have had some evidence on the financial challenge in local government, but I can make reference to what ADASS thinks our overspends are, if that is helpful. In terms of those four lines of inquiry, the impact on local government finance means we cannot invest in models of care in the way that we would like. We are very focused on in-year results. We cannot invest into people's outcomes because whatever we do has to have an in-year effect.



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If I think about a model of care that needs reform, preparation for adulthood is a really good place to start. If we invest in younger people to move into adulthood successfully, you need to make an investment in that service now for a financial return in five years' time. If you do not invest, you know you will have that cost pressure in the future. None the less, you need the resources to be able to do that. Council resources are focused so much on the immediate: mental health detention, adult safeguarding and supporting people with urgent packages of support. That is where councils' money is going. I am sure David will refer to that as well. We are not able to invest in those models of care.

Clearly, we also have financial constraints. If we are thinking about how we reform our market and our care providers, that will also take investment. We do that through fee strategies, provider relationships and joint workforce developments. Those are the kinds of activity that local government undertakes. In order to invest in provider fees for them to reward their workforce again requires investment. Most councils are currently negotiating fee strategies with their partners that are either at a minimum amount of cost, slightly above cost or below cost. It is really tight for councils at the moment. That means we cannot develop the sorts of provision and quality of provision that we might want to see in councils.

Thinking about integration and relationships, our partners are also under financial challenge. If we think about the pressures on the NHS, one example would be joint spaces, where we discharge people with mental health issues, learning disabilities or autism from acute care and support people to avoid crisis by using things such as jointly funded packages of care and continuing healthcare. Those budgets are really tight and challenging for both local government and the NHS. Because of that, we spend a lot of time debating about who pays, rather than having a conversation about how, in the longer term, we can invest in people's outcomes to enable better health and wellbeing.

Lastly, we have not resolved issues about who pays for care. What is the relationship between local and central funding in adult social care? Do we expect individuals to pay for their own care? We know some of the issues about the cap and the floor. That means people are struggling to meet their contributions to care, particularly for working-age adults. There is a lot of poverty for older adults too, along with carer stress. Those are some of the consequences of local government financial pressures, if that is helpful as a summary.

David Fothergill: We have to recognise that adult social care is more or less half the budget of local authorities. If you add it up with children's social care, it is well over 70% of budgets. That leaves very little for the remaining services, which many of your residents and my residents depend upon, including roads, libraries and things like that. There is a lot of pressure on us.



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You also have to look at the amount of funding that has been taken out of local authorities over the last 15 years. We estimate that we have made savings of about £24 billion. We have made a lot of savings to be able to meet the pressures, but we currently estimate that there is a funding gap for local authorities, the vast majority of which comes from social care, of £1.9 billion next year, £4 billion the year after, then £6 billion the year after and £8.4 billion the year after that. Over the course of the next four years, we estimate that there is a funding gap of over £20 billion in local government.

Clearly, by taking out cost from the cost base, we have been able to meet our current demands, but we are reaching a point where it is becoming really difficult. You have to add on to that the increase in national minimum wage, the living wage. We all fully support that, but it has an impact and it has to be paid for. You also have to add on to that the national insurance contribution. We have received about £500 million as compensation for that, but our costs are about £750 million. That is adding further and further pressure.

What is the impact of social care at the moment? It is really putting local government under a lot of pressure, which means all the other services we provide are becoming at risk, most importantly prevention. The amount of money we spend on prevention is now falling. It was 8% last year; this year is 7%. That does not help for the future.

Q120 Danny Beales: My colleagues are going to pick up the issues around prevention and other council services. Finishing up on council budget pressures, do you have a sense of any regional differences or differences between type of council? Is it uniform pressure? Is it falling in certain parts of the country more or less? Is the ability to respond to these pressures greater in certain areas or not?

David Fothergill: The problem is less about the authorities and more about the council tax base. More and more funding is now expected through council tax as opposed to directly from local government. Therefore, it heavily relies upon local authorities to increase their council tax.

If you operate on a low council tax base, it means there is additional pressure. For example, if you raise it by 1% in Somerset you get £2 million; if you raise it by 1% in Hampshire, I am sure it is more like £14 or £15 million. The impact is all about the council tax base.

The only other thing to say is that last year 15 local authorities applied for emergency funding support. This year I believe it is 34. It is getting more difficult. There is a wide range of authorities within that, including unitaries, counties and metropolitans.

Q121 Danny Beales: Do you have a sense of how many of those applying for emergency support are driven by social care pressure?

David Fothergill: Most of them are driven by social care pressure.



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Q122 Danny Beales: In terms of finances more broadly, do you have a sense of how many are approaching section 114 notices or considering that actively because of social care pressures?

David Fothergill: I cannot give you an exact number, but anecdotally the number is certainly increasing. The number of local authorities that talk about it seems to be increasing each year.

I can speak for my own authority, Somerset. We have declared an emergency financial crisis. That is purely based upon social care pressures.

Q123 Danny Beales: What impact does that have? When there is pressure to access emergency exceptional funding or take a section 114 notice, what impact does that having on adult social care and the council?

David Fothergill: If you go for a 114, you lose control of the council. Somebody else comes in and runs it for you and makes all the difficult decisions, as I am sure others around the table know. Section 114 has to be the last call.

Taking the emergency financial support is really just kicking the can down the road. You still have to resolve the fundamentals. That is what we are not doing: resolving the fundamentals.

Q124 Danny Beales: Do you have a sense of how many councils are relying on their reserves to plug some of the gaps that Melanie and you touched upon?

David Fothergill: The better question would be how many are not relying upon their reserves because the vast majority are.

Q125 Paulette Hamilton: Good morning, all. I will start by saying that local councils—I have worked in one for many years—run over 136 local services. Two-thirds of that, as you so eloquently said, David, comes from children and adult social care. Many of these services are classed as non-statutory, which—I have to be honest—used to drive me mad. These are services such as libraries, museums and youth services, which many of you know can take a council over the edge with local people.

My first question is to Hugh and David. What are the trade-offs that councils are having to make between social care and other services?

Hugh Evans: Just to echo what my colleagues have said, the cost of adult social care is rising at a much higher rate than the stable funding sources that are coming into councils. Almost regardless of the ability to raise revenue through council tax or the precept, in the end it is still not sufficient to meet the increased cost of adult social care.

That has certainly happened in Bristol. Spending has outpaced local government funding, which means we have had to make savings. Numerically, just as background, the overall proportion of Bristol's revenue budget that is committed to adult and children's social care,



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which is what you were talking about, has increased by nearly 20% between 2017-18 and 2023-24 from 56% of total revenue spent to 75%. The knock-on implications for the non-statutory services you are referring to are quite profound. Even with increased numbers of pounds in actual terms, in real terms spending power has decreased quite significantly.

Q126 Paulette Hamilton: To bring you back to the substantive point—I know your authority well; my mentor came from your authority—what exactly are you having to give up so you can carry on with adult and children’s social care? What services are you having to reduce or let go of in an authority like yours, which has been run exceptionally well?

Hugh Evans: Thank you.

Paulette Hamilton: It’s the truth.

Hugh Evans: Within adult social care and children’s social care, we are having to emphasise, as Melanie said, survival within the year. We are having to emphasise the bare minimum of statutory services in order to fulfil our duties under the Care Act. Beyond that, any investment from the social services perspective in the excellent potential preventative work that can be done through the voluntary and community sector and partnership work with the NHS is diminished. It either stops or really slows down. That is the first point.

Secondly—we see this in the deterioration of other public services and the public space—transport, adult learning, housing, education, environmental, green spaces and community cohesion have all had to take budget decreases as a product of the overall imperative to meet our basic statutory duties.

Q127 Paulette Hamilton: David, I know what we went through at the LGA. Even though we are on totally opposite sides of the scale, you work really hard. I thank you for all the work you did while we were at the LGA.

David Fothergill: That is very kind.

Paulette Hamilton: What are your thoughts? Can I declare an interest? I know David and Melanie really well. I will start with David. I was married to you, was I not, David?

David Fothergill: What?

Chair: We have strayed into too much information.

Q128 Paulette Hamilton: David, I will go over to you. We will go back to normal.

David Fothergill: The interesting part of that question is the statutory services. We have 700 statutory requirements upon us, but a lot of those statutory requirements are not clearly defined in law. The library service is a statutory service, but what is a library service? Those are the debates that are going on in county halls and city halls across the country.



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There are lots of examples where money is having to be taken out of valuable services to fund social care because that is the only thing to do. One example would be rights of way, which is really important, particularly in rural areas. Rights of way, maintenance, registration and things like that have been taken out of planning, community cohesion and various welfare matters.

On the other side of the coin, we can only raise money in one of three ways. We can only raise it through council tax; business rates, which is quite difficult to influence year on year; and fees and charges. A lot of councils are putting up their fees and charges quite dramatically because that is one of the few ways we can use to help fund the other services. There is a pincer movement on us at the moment.

Q129 Paulette Hamilton: My follow-on question is around public perception. How are local councils getting across the issues around using additional council tax and other revenue to bridge the gap? What is being done within local councils about this feeling that the public have that the services are absolutely dire and not in the place they need to be? What is being done in that space?

David Fothergill: Locally, each of local authorities will approach this in a different way. They will have a different way of communicating with their residents, whether that is through letters about the council tax increases or whatever.

There is a lack of understanding about social care amongst the public. A recent survey showed that something like 28% of people believe social care is fully funded through the NHS. I have been to thousands of council meetings and parish council meetings. Very few members of the public talk to me about social care. They talk to me about potholes, waste collection and things like that.

Within the social care sector, our profile is not high enough. It is not talked about enough. Therefore, people do not understand the true cost. We all need to do far more work to change the perception of people. Social care is only important for most people when you need it.

Q130 Paulette Hamilton: Just before I move on, David, how much of the cost of this extra funding is being passed through on to council tax, if you were to put a percentage?

David Fothergill: Mel might be able to help me there. By the time you add on things such as the living wage and national insurance, we are talking about several million pounds. I am sure Mel has more precise figures.

Q131 Paulette Hamilton: Mel, could you answer that bit of the question?

Melanie Williams: ADASS modelled that only 25% of the cost pressure on councils from the living wage and national insurance contributions was met by the increase in the social care grant. The Department of Health



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and Social Care announced that the social care grant was being increased to meet council pressures in the adult social care market, but we modelled that it was about 25% of the cost.

That is the total amount passed to councils, but bear in mind that the social care grant funds both adult and children's services. Locally, it may well have been used in a whole range of ways. There will be local variation. For some councils, it would be more or less than that because of how the social care grant is divided.

Hugh Evans: As David said at the beginning, a 1% council tax increase in Bristol generally amounts to just over £2 million. With the 4.99% increase—the 2.99% increase and 2% for the precept—that gives us something just shy of £10 million or £11 million.

We have estimated, by the same LGA reckoning, the overall cost of the employers' national insurance and the national minimum/living wage increases for care providers at about 8%. We think that will cost Bristol care providers around £17 million.

Even just in adult social care, just with the care provision elements of adult social care, regardless of children's or any of the other areas, the amount that is required for that particular issue is almost double what we would retrieve in the context of extra council tax.

It is worth noting—we have done recent surveying—that there is quite a poor public perception of government, local and otherwise, as I am sure everybody knows. This is the "Britain is not working" perception. In our context, there is support—it is just over 50%—for the council tax increases that we have proposed, but amongst the poorer sections of the community there certainly is not support for it, and there is less support for the social care precept than there is for mainstream council tax.

That is a product of exactly the situation that David described. The majority of people do not have a learning disabled or physically disabled family member. Four out of five people do not need recourse to adult social care in their older years. Social services is not really a major factor in those people's lives. Potholes, bins, parks and things like that are more important to them. It is a big argument to win that social services should take more money from overall budgets.

Q132 **Jen Craft:** I am mainly covering prevention, but, before we move on to that, I just wanted to follow up on the last comment that you made. What kind of impact does that have on the perceptions of people who use adult social care services? If people are being asked to pay an increase either through a precept or through council tax, do you have any reflections on how people view people who use those services, if they are not a direct user themselves?

Hugh Evans: I cannot really comment with any great knowledge on that. The people who use services are very grateful for them. When services



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work well, they work well for people. Are you talking about it in the context of people using all the resources and other people being resentful?

Q133 Jen Craft: I am just wondering about disabled adults of working age. If someone is being asked to pay an extra amount in your council tax and they and their family members are not covered by adult social care, does that increase the perception about where the money is going?

Hugh Evans: In our recent consultation, there was marginally but meaningfully less support for increasing the social care precept part of council tax. That shows that people are not necessarily as supportive of social services as they are of other services.

Q134 Jen Craft: I have one interesting follow-up to the end of that. In pre-reading I noticed a comment—I think it might have been from you, David—about the democratic deficit. Just 4% of people are receiving a large amount of the funding. I am just wondering whether that is part of the perception from people on the ground: “I pay X amount of council tax, but I am not seeing a return in investment”.

David Fothergill: People do not make that jump. They know they are paying more council tax and they are seeing fewer services, but they do not work that out. There is a gap there. They have not worked out that it is because social care costs have gone up so much. Perhaps this comes back to Paulette’s question: should we play more of a role in explaining to people? That is probably right.

Increasingly, we are spending more of our funds on a smaller proportion of the population, if you look at those that are drawing on the services.

Q135 Jen Craft: I will move on to prevention. There is a really good argument for prevention. Everyone in the room understands prevention is better than cure, particularly in adult social care. How are the continuing funding pressures that all councils are under affecting your ability to invest in and deliver prevention services?

My local authority is subject to a section 114 order. They are restricted in terms of what they can provide that is not statutory. When you are under fairly strict financial limitations, there is a temptation to pick at non-statutory services. How is that affecting your ability to deliver prevention? What does that look like in the short and medium term?

Melanie Williams: I will give you the national perspective and then maybe Hugh can give you a local one. Prevention is a duty under the Care Act. As a statutory director, I do have a duty to prevent, reduce and delay adult social care need. In the ADASS survey this year, only half of directors were confident they would meet that duty to any great degree. Most were confident that they were not going to meet that prevention duty.



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As I mentioned in my intro, we have a very in-year focus. It is all about managing the restrictions now and, in all honesty, trying to work with somebody in a way that minimises their draw upon adult social care and the cost.

As David said, we are spending more and more on individual people. We are finding that 20% of care is more costly than it was last year. In Nottinghamshire, we support 13,000 people, but a very small proportion of people generate most of that spend. It is not unusual for a package of support for an adult or a child with mental health, learning disability or autism who is leaving hospital to cost £10,000 or £20,000 a week. The more cost we are facing, the less we are able to invest in prevent, reduce and delay.

The services that come within that in Nottinghamshire are things that I run in adult social care, such as reablement services, enablement and day opportunities. Those services rely on being able to support people to access libraries, parks and green spaces. There is a direct link between the two.

Not only are we not able to invest as much directly in those prevention services, even those that have an immediate impact on need, but we are also less likely to be able to support someone to access other facilities out there because of the financial constraint.

Adult safeguarding has increased. Most councils have seen 20% more referrals for adult safeguard over the last three years. That is a result of the quality of care—we are seeing that as one of the drivers—carer stress and financial abuse. In times of financial challenge and a high cost of living, it is not unexpected that some people will take the opportunity to abuse others financially. We are also seeing an incredible increase in mental health detentions. Most councils have seen a 25% increase in activity over the last three years.

We are spending more time doing urgent and immediate work. As David said, most councils are financially challenged. As a leader, you are spending your time doing financial work and trying to manage the budget. As an operational leader, you are spending your time leading these urgent services.

As a consequence, we are in this spiral of focusing on today and we are not able to think about what might be a really brilliant wellbeing service to support older people with loneliness. That would be an example of the types of services that we are not able to invest in or develop at the moment.

Q136 Jen Craft: How do you get out of it?

Melanie Williams: There are a number of things. A multi-year financial settlement is one of the obvious ones so our section 151 officers can take a longer-term view rather than just think about the in-year position.



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There is clearly the case for looking at how we fund care and support and what we think a good life should look like and how we support that, particularly around older adults. Older adults get a slightly better deal from adult social care than working-age adults.

The obvious point would be about resolving local government finance, but that is a bit of a wish at the moment, is it not? To me, the obvious thing would be to think about a fair funding settlement for local government.

Q137 Jen Craft: Just before we move on, what benefits are local authorities failing to deliver for people who receive adult social care because you are not able to invest in prevention services as much as you would like? Are local authorities failing to deliver for people who are in the adult social care system due to not being able to invest in prevention services?

Hugh Evans: The most desirable benefit would be all of the benefits that one gets from the fabric of a healthy society. With supportive communities and asset-based community development, we would be building on community assets to support people to enjoy, benefit from and gain good health from their community context.

We do quite a lot of investment in public health in Bristol. We have a community impact fund, which is fiercely protected, and we make longer-term community investments. The problem with the adult social care end of things is the short-term nature of funding sources. One-year funding precludes proper investment.

As an example of something good in Bristol, Age UK is leading a consortium of our community anchors: Wellspring, BS3, Southmead Development Trust and Knowle West Health Park. That is through the discharge grant and the better care fund. It is always year on year, so you never know, towards the end of the year you are in, whether you are going to be able to continue it. We have transfer of care hubs. When people are coming out of hospital, they can be diverted to a community solution. We now have a front door to our adult social care, so people can speak to a representative from Age UK right at the outset.

It is not enough. We cannot do enough to develop that community capacity that is going to be properly beneficial for people.

Melanie Williams: As a good example of that, for older adults we would be really focused on providing the minimal amount of support in their homes. They may take a direct payment, and we will be looking at the minimum that they would require to stay relatively well. We would not necessarily be able to invest in them having friendships or being able to get out and about more. Somebody will probably be receiving basic personal care, the bare minimum, rather than what is needed for an older adult to enjoy a great quality of life as they age. There is rationing over time, if you like, because we are focusing on the most immediate need.



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David Fothergill: Can I just come back to prevention? Prevention is one of the ways out of this. We all know that, but it is about finding a way to implement it. As I said before, last year councils spent 7% on prevention whereas in the year before it was 8.2%. It is a falling amount.

At the LGA, we think there are six things that could be done to help advance prevention. Some of them are funding-linked, I have to say. First, there has to be a recognition of the pathfinders that are working on prevention. We have a whole host of local authorities that we can mention that are doing that. It is about taking that work and scaling it up to ensure there is some prevention work.

Secondly, we need to take down some of the barriers to working with our partners to ensure that prevention work is delivered. In line with that, there were some really good recommendations in the Hewitt review about prevention, which we think need to be picked up and taken forward.

We also think the way that supported housing is funded needs a review. That would help us to work on prevention and keep people independent for longer. The other one is about the workforce strategy. If we had the right workforce strategy with the right skills, we could spend a lot more on prevention.

Prevention is something that we all talk about, but it gets less and less attention and less and less funding. The suicide prevention fund, which was withdrawn from local authorities last year, was doing some great work. We are now in a very exposed area. Prevention is great, but it does need funding.

Q138 **Gregory Stafford:** Apologies for being late. My questions are around the better care fund. ADASS has said that previously political direction led to the better care fund being prioritised to ease pressures on the NHS, especially on discharge. Will the recent reforms to the better care fund effectively address the issues that it is trying to solve and shift the focus back towards the prevention end?

Hugh Evans: Yes, in theory. I have worked with a few councils on their better care funds. As they are stratified layers of activity that have been put in over the years, a lot of the funding within the better care fund is established long-term based budget-orientated funding for councils and other organisations. There is not necessarily the flexibility within it to do huge amounts with the majority of it.

What I will say is that it, in the context of the potential for developing around the three shifts to community, prevention and digital and in the context of developing neighbourhood teams, the consolidation of the discharge fund and other such things into the better care fund as flexible funding might be useful in order to create some community capacity, which would help us to alleviate pressure on the acute sector.



There is some excellent work going on through the LGA. I am involved—I know a number of us are—in the communities of practice around the future of prevention, which is looking at reablement services and how they can be developed into a much more coherent community offer that has as its central focus keeping people out of hospitals and keeping them safe at home. Accident and emergency is not the place to go if carer breakdown is your issue.

What I will say—I would like to get this point in—is that there are some anachronistic financial mechanisms, such as continuing health care, which I know the DHSC is looking at, and section 117 aftercare, that have no place in these new community ideas around neighbourhood-focused community teams or, as we call them, integrated locality teams. We have been working on them for quite a while. I have been working on integrated care for 25 years. Let us face it: the lack of reform is demonstrated by the lack of progress we have probably made.

Q139 Chair: We will be coming back to this point more substantially.

Hugh Evans: In regard to continuing health care, it would make the world a much better place—we would be able to collaborate and do a lot more—if we could avoid having difficult conversations about money all the time.

Melanie Williams: The better care fund was set up some time ago now, probably 10 years ago. It was my job at the time to be setting it up. We had a real spirit. It was Sir David Nicholson. It was about getting upstream. In 2015, 2016 and 2017, there were dramatic reductions to local government budgets and the BCF was deliberately repurposed nationally to protect adult social care.

The elements that have come in since are predominantly around hospital discharge. Locally and nationally, that has been used really well to increase social care capacity to support hospital discharge, particularly around home care reablement-type services and services such as the Red Cross, which can go in and help somebody for 72 hours if they do not need ongoing social care support. Those services are really important, both the base budget care packages and those.

I see very little slack to reinvest that into neighbourhood health. Neighbourhood health is absolutely where we need to go, but the BCF does not have any particular flexibility or scope in it to make that shift.

On neighbourhood health, I would agree with Hugh. Intermediate care is really where we should be focusing in our relationship with the NHS. We should be working around primary care and supporting people to avoid needing crisis support. That is where social care is best placed: supporting people in a crisis and supporting their family to cope, where possible.



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Intermediate care is not just for older people. It can also be support for somebody with mental health issues to avoid hospital or somebody with a learning disability or autism who may be at risk of needing admission to an assessment treatment unit, where we know the outcomes are really poor. Investing in that community capacity is certainly the right policy direction. I just doubt, as ADASS does, that there is any flex in the BCF to make that important shift in investment.

Q140 Gregory Stafford: Just before I come to Councillor Fothergill, just so I am clear, you are saying that the rhetoric from the Government is not matching up with the reality on the ground, i.e. the better care fund will not make any difference to front-end prevention. Is that what you are saying?

Melanie Williams: Most local areas have reviewed the BCF annually. There is a perception that local areas do not review it or know what is in it. I have been in Nottinghamshire for a while, but I have been in other places too. We review the resources in the BCF very actively to look at investment. It underpins community health services, reablement services and social care services. That is where the money is going. There is not necessarily a lot of free unallocated resource to invest. As Hugh and I have described, the discharge element of the funding is already invested again in Home First-type services.

Hugh Evans: Can I just note that the Age UK initiative that we were talking about is a commitment of less than 0.5% of the Bristol BCF? It really is not major.

David Fothergill: I defer to my colleagues. They have a far better understanding of the BCF and they have given you a full answer.

Q141 Gregory Stafford: Councillor Fothergill, the better care fund is a pooled resource. It is intended to encourage integrated working between the NHS and local authorities. Within that context, what else needs to happen to ensure more integrated working at system level to reduce adult social care pressures? I know that is a huge topic, but within the stuff that we have been talking about—the discharge end and the prevention end—what else needs to be done?

David Fothergill: Our view is that the integrated care boards, where they work well, work very well. There is some good sharing of resources and some good sharing of finances. There are examples across the country where they are not working so well. It is a bit of a tapestry. There needs to be more review of that.

The review of them by the Hewitt review again needs to be picked up. We need to come back to it and say, "How could we improve?" Councils, local authorities and the NHS absolutely need to be working very closely together, but there is one very big difference: the NHS can keep overspending, but local councils cannot overspend in the year. We always



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have to come in balanced. For local authorities, there will always be a pressure on achieving their budget.

Melanie Williams: Leadership at place is absolutely essential, as David said. You need that leadership from the integrated care board and the integrated care system to focus on neighbourhood health and prevention, but, equally, there is a reality about the pressure our colleagues in the NHS are under. There are some really good examples where all parts of the place are involved in that.

The prevention fund—David has mentioned the Hewitt review—was a really useful model, but, again, it is not a mandatory fund. There is an option for areas to disinvest that elsewhere to meet financial pressures, particularly when they are under national scrutiny for their financial control.

Hugh has referenced the interface areas. That is not just in terms of where we deliver services together. There is a huge amount of emphasis put on hospital discharge, but the amount of people who benefit from that is disproportionate compared to those who need us to work in an integrated way. Services such as intermediate care and the relationship with community health services are funded through section 117 and the CHC. They are outdated and they cause dispute and conflict locally. Those will be the areas where there is rightful reform and change.

Hugh Evans: To reiterate the point, the BCF has the potential to be a developmental funding mechanism, but the other funding mechanisms through which the NHS and local authority partnerships are organised—continuing health care and section 117 aftercare—preclude good partnership arrangements. They prevent good development of joint systems.

In Bristol, North Somerset and South Gloucestershire ICB, we have an excellent partnership. We work really well together. The three chief executives of the three councils sit on the integrated care board, which is quite unusual and a very positive thing that we are proud of. At the same time, the perennial issues around other joint funding mechanisms always thwart our best intentions for proper system partnership. Reform of all the funding around health and care would be beneficial in order that we could do that more effectively.

Q142 **Chair:** How?

Hugh Evans: Some people talk about it in the context of a national care service, but it would be a mechanism for the development of budget pools that were broader than just acute sector pressures in urgent and emergency care. There would be pooled budgets for the pressures of long-staying people in mental health hospitals, for example, or the pressures when it comes to supporting younger adults. There is an increasing incidence of younger adults with high-level needs who have to



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resort to very expensive care packages that we should be paying for jointly. At the moment, the system is organised around local solutions.

At the end of it, you have some basic guidance, but you have to make local solutions. Local solutions equals debate and potential stasis when it comes to financial matters.

Gregory Stafford: We do not have time to go into that in any more detail, but, with your permission, Chair, we would welcome any views on that in writing, because it is a really important issue.

Chair: Indeed. Yes, please.

Q143 **Josh Fenton-Glynn:** I too am a recovering cabinet member for social care. The budget spent on working-age adults has increased by a third since 2020. David, could you perhaps give us an idea of what is driving that?

David Fothergill: The good news is that people living with a disability are living longer. The downside for them and for local authorities is that they are living longer with more complex needs, as people get older and into maturity more. Those complex needs are therefore driving additional cost within the social care sector.

Q144 **Josh Fenton-Glynn:** Just to drill down on that, there has been a one-third increase in four years. In my old authority, it is about 50% of spend. It is getting close to that in most places. It cannot just be people living longer. Is something else driving that cost?

David Fothergill: Mel might be able to give us some insight into that.

Melanie Williams: There was a County Councils Network report published on this last autumn. It was not just about county councils. They used national data. That report clearly identifies some of the drivers of that costs. It is a really brilliant report.

Certainly, both that report and the experience of ADASS and locally highlights the group of people we support that are titled nationally Building the Right Support (Transforming Care). This group is a very small number of people, predominantly with learning disability and autism but also an element of mental health, who are either avoiding admission to or, importantly, stepping down from NHS long-stay hospitals, often high or medium secure. Typically, they have spent a lot of time in segregation or isolation and they have complex forensic backgrounds.

That group of adults is increasing in number, particularly as these people are being recognised in the justice system as having disabilities. We are supporting people to avoid admission, but there is a trend where people are transferring from prison into that group. They are a very costly group to support safely in a community setting. That can cost us £10,000 or



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£20,000 a week. As Hugh said, we jointly support that group, but that is one of the drivers.

There is another group of young people transitioning from the SEND system often with a mental health admission. This is where somebody has been living quite successfully with adults and managing through school for a while. Adult social care will not have particularly been aware of them. They will then be admitted through the health system. We might still not be working together, but then the situation will rapidly escalate and the person will require a very intensive package of support. When they come back either to children's or adult services, again, it is a very costly package of care. That is another driver of the cost.

The other element that we are seeing is about providers managing risk. David has touched on the workforce strategy that we need. We know the quality of care is really variable around the country. Providers are struggling to recruit and train people. Working in some of these settings is really challenging. I used to love it, but for some people it is really difficult. You need really good training; you need good support; and you need to be able to pay. Some of that is increasing the providers' costs as well.

Q145 Josh Fenton-Glynn: Just to pull that apart, I am aware from my experience that a working-age adult's placement is usually more expensive than an older person's placement. You are saying that that specific cost is going up exponentially as well because we cannot recruit into those roles. Is that correct?

Melanie Williams: It is partly the recruitment, but, touching on some of the feedback that David gave, we are now supporting people to live nearer to home when 10 years ago they would have been in an NHS institution or hospital. We are supporting people, which is brilliant news. That is what we want as a society, but we ought to recognise that doing those bespoke packages of support for people that require specific accommodation to be repurposed or built and a specific care team recruited is really intensive and costly work. You have both of those factors.

Q146 Josh Fenton-Glynn: Domiciliary care in this instance is more expensive than residential care.

Melanie Williams: Yes.

Q147 Josh Fenton-Glynn: Moving on, in my drafted question I said, "A report by the County Councils Network says", because I had read it in preparation. One thing that it makes clear is that there is a bit of a gap where people are falling through some of these holes when they leave. You mentioned this earlier in terms of what we are not paying for in prevention. As people leave the children's social care system, they are not being picked up by the adult social care system. Why are they falling through? What can be done to do a better job on that?



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Melanie Williams: Where a younger person has a lifelong disability and is well known by councils, in the main, that movement through life is supported quite well. Adults and children's social care work together. Children's social care is not involved in every young person that has a disability, particularly neurodiversity.

There will be occasions where somebody is working really well in the special educational needs system and attending school, but the risk of them needing adult social care is not quite identified in that way. The school may be thinking, "Okay, they are going to transition to university or college quite successfully". For a family supporting a 17 or 18-year-old, the needs are quite different. It is at that point that families will sometimes fall into crisis and challenge. That is where people often fall through the net. Trying to work out whether someone will need adult social care in those circumstances is a bit of a guess. The council, as a social care team, children's and adult, would not necessarily be working with that family.

Hugh, I do not know what you see in Bristol.

Hugh Evans: I would like to draw attention to Bristol's relatively young population, especially for one of the core cities. You are talking about care leavers or people who, one way or the other, might have experienced quite significant trauma in their childhoods or backgrounds.

Those people may have received children's social care in one way or the other, but they are not children with disabilities and may not be people who would immediately, as they become 18, have recourse to adult social services. They may very much struggle in adult life and be much more prone to the kinds of disadvantages or multiple disadvantages that can result in drug and alcohol use, homelessness or involvement in the criminal justice system in one way or the other. These are people who are generally at risk of lifestyles that are less than organised and less stable.

Somewhere down the line, some of those people do have recourse to adult social care services. When they do, especially when there are issues around people challenging services, et cetera, some of those services can be really quite costly. In the past, there were things such as the Supporting People programme and the independent living fund. Those were geared up specifically to support people in those kinds of circumstances.

Again, this is one of those things where, in an ideal world, we could be much more trauma-informed and much more capable of supporting people who are having difficulties in life early on to prevent them having recourse to these complex packages of services that are not very well co-ordinated and probably quite costly.

Melanie Williams: We often do not have an adult early support offer through transitional safeguarding. If we are thinking about prevention, it



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would be really key to think about how we could invest in that more collectively.

Q148 Josh Fenton-Glynn: I just had a flashback to an unsuccessful campaign that I ran to save the independent living fund.

Moving on, the subject of this inquiry is the cost of inaction. You have hinted at it there, but I wonder whether you could make a bit clearer for us what the cost of inaction is in cases such as this, where people are falling through the gaps and not getting that continued support and therefore they are more likely to end up either taking part in harmful behaviours, as Hugh just outlined, or simply needing a greater deal of support rather than being transitioned and supported into meaningful activity, be that work or otherwise.

I wonder whether you could talk about what the cost of inaction is in terms of the greater level of need; their parents, carers and so forth needing more services themselves; and finally the cost of them not working and not being supported to have meaningful activity.

David Fothergill: I will have a go. What you have just described is another way of saying prevention. It is about getting in there early and doing the work that needs to be done. If we do not do that, the cost escalates later.

The cost of inaction is not only a cost to the individuals, who are living with a situation or a condition that will become more complex; there is also a cost to the councils. If the local authorities do not take action earlier, that leads to the financial pressures we have talked about. There is a cost on the workforce because it means we require a more skilled workforce and we do not have the workforce strategy that we need. We also clearly need additional employees to come into that role.

There is also a cost on society generally. We are seeing more complex cases, which are not being resolved earlier and therefore are leading to greater strains on the councils.

Q149 Chair: Do we have any numbers to go with those buckets?

David Fothergill: No.

Q150 Chair: You can write to us if you want.

David Fothergill: I will write to you.

Chair: We are really keen on the numbers as much as we are the buckets.

Q151 Ben Coleman: I have one quick question. You talked about the need for multi-year settlements. In the local government finance policy statement 2025-26, the Government have set out their intention to move to multi-year settlements from 2026-27. How helpful will this be?

David Fothergill: It is incredibly helpful.



Hugh Evans: It will be very helpful.

David Fothergill: We have called for it for years, probably for the last decade. We welcome it. It gives us visibility. We do not commission services on a year-by-year basis; we commission services on a several-year basis. It gives us the visibility and security to maximise the power we are being given. It is very welcome.

Q152 **Ben Coleman:** How important is it that the same thing happens in the NHS? Will the lack of it in the NHS inhibit you from making full use of the multi-year settlements for local government?

Melanie Williams: Yes. I would look at things like the better care fund. The planning guidance for that often comes out very late. Anybody who has chaired a health and wellbeing board could give evidence on that. It is really important that those are aligned or else there will be a disincentive to those points of integration.

Yes, we definitely need to think about how those planning cycles align. They do not at the moment. The NHS planning cycle is different to the local government planning cycle.

Chair: That brings us to the end of panel 1. Thank you very much, Huw, Melanie and David, for your evidence.

Examination of witnesses

Witnesses: Dr Bartoli, Isabel Lawicka and Dr Singh.

Q153 **Chair:** Panel 2, thank you so much for being with us. As with panel 1, if you would not mind, please say who you are and what you do.

Dr Singh: I am Anu Singh. I am privileged to be with my NHS colleagues, but I chair, as has already been trailed, an integrated care board, which is much more than just the NHS. It is local government; it is working with communities; it is working really closely at place. I am the chair of the Black Country ICB and I also work with a number of other ICBs.

Dr Bartoli: Hello, I am Birju Bartoli. I am the chief executive of Northumbria Healthcare Trust, which is an acute and community integrated provider trust in the north-east.

Isabel Lawicka: I am Isabel Lawicka. I am the director of policy and strategy at NHS Providers. We represent all NHS trusts and foundation trusts in England. That covers services across acute, community, mental health and ambulance.

Q154 **Andrew George:** It is nice to meet you all. The County Councils Network and the NHS Confederation have both produced reports and commentary about delayed discharges from hospital and have found that the vast



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majority of delayed discharges are in fact unnecessary admissions in the first place. If you speak to the clinicians who are admitting those who come through emergency departments into hospitals, they will say that you can only know for sure whether a patient was admitted inappropriately in retrospect.

Are those reports from the NHS Confederation and the County Councils Network just being wise in retrospect? Are the clinicians right that they need to take a precautionary approach, or are they just being overly risk-averse?

Dr Bartoli: I talk from the perspective of Northumbria Healthcare Trust. We have been fortunate to have a number of different routes that have evolved to prevent admission where we can. Admission to a hospital bed is the last resort. Either we turn people around as much as we can from the emergency department or our ambulatory same-day emergency care unit. That unit tries to put some very senior clinicians up front to take those risks that you allude to, rather than leaving it to a more junior workforce.

In our experience, a small number of people, relative to the number of admissions that we have, come under the banner of a social sort rather than being acutely unwell. For my organisation, the majority are people who need to be in hospital. Because of the nature of our model of care, in which we have very senior clinicians up front in the patient's journey, the delivery of risk is far less than there may be in other models of care.

Isabel Lawicka: If we are thinking about delayed discharges and avoidable admissions, both of them are complex issues with multiple factors going on. We know there is a link between having what we would like to see, which is a more stable and well-funded social care system, and being able to get people the right care in the right place at the right time.

At the moment, that principle of right care, right place and right time is difficult to achieve in all cases. That is where we see a really clear link showing up in terms of delayed discharges at the back door of the hospital and avoidable admissions at the start. I can go into a bit more detail on that.

Chair: We are going to come back to avoidable admissions specifically later.

Q155 **Andrew George:** We will come back to that, yes. I just wanted to get some clarity. No one is arguing for the wrong care in the wrong place at the wrong time. I would be interested to know whether there is any substance to that rather platitudinous statement, if you do not mind.

Isabel Lawicka: Social care in action is a barrier to being able to achieve that at the moment. That is the link that I would make.



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Dr Singh: May I respond to that? What we have outlined, and certainly what we picked up in the previous panel, is that at the moment we are all players in a system that is forced to manage risk rather than help people to be where they need to be.

One of the drivers of that is the fact that the system and how people navigate through the system is underfunded at every single point of the system. In order to be safe—these are some of our most vulnerable people—we have to take decisions that prioritise safety.

You can look at any part of our system. If you look at general practice, lists have grown by over 20% in the last decade. You could look at same-day emergency care, which my colleagues have been talking about. People are coming into A&E. They are coming into a place where they feel safe. We are trying, through transformation, to make sure we do not admit them unnecessarily, but sometimes we absolutely have to in order to make sure they are safe.

Transformation is in place, but it is still limited and it cannot deal with the volume of underfunding across all points of the system.

Q156 **Andrew George:** I was just trying to get to the bottom of what you felt about these reports, which are claiming that admissions to hospital through emergency departments, the majority in some cases, are unnecessary or avoidable. One can understand that there is a case for a strong emphasis on prevention, preventing those episodes happening in the first place. When it comes to making the clinical decision about an admission, you are saying that the claims of unnecessary admissions are exaggerated.

Dr Bartoli: If you have senior clinicians making the decisions as early as possible, they are less likely to be avoidable admissions. If you have a more junior workforce, they are arguably going to be more risk-averse and you are more likely to get avoidable admissions.

If we flip the question slightly and talk about avoidable attendance to the emergency department, my colleague talked about the pressure on primary care and the elective pathway. Those pressures can have an impact. Because people are not getting operations as quickly as they might need to, they are turning what would be a planned procedure into an emergency presentation. Similarly, because of the pressure that primary care is under, if someone cannot get to see their GP, they may turn up at the emergency department instead.

Q157 **Andrew George:** Can I turn back to the other end of the scale, as it were, the discharge process? Certainly from my own local authority in Cornwall, the statistics that we can interrogate suggest that around a quarter of all discharges are delayed as a result of not being able to identify a sufficient social care package. The remainder either have a primary health need that needs to be met in the community or elsewhere or there is a combination of the two.



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Do each of you, from your different perspectives, find the same? The current conventional wisdom is that it is entirely down to social care, but in fact it is more complex than that. Is that a fair point?

Isabel Lawicka: I will kick off with the national perspective. If we are thinking about delayed discharge, we are automatically thinking about the issue of patient flow across the whole system and all the different parts working together so people can get to the place they need to be. If one bit of that is not working well, it causes challenges, which is what we are seeing in terms of the social care element.

Q158 **Chair:** Have you ever quantified it? What we are really interested in is those numbers.

Isabel Lawicka: As you have talked about, Andrew, there will be a local understanding about what is happening locally. I do not have a breakdown.

Q159 **Chair:** Anu has a number. Do you have a number?

Dr Singh: Let me go to my hospital colleague and then I will give you my system number.

Dr Bartoli: From a trust point of view, I need to put this in context. As an organisation, we have spent a long time working collectively with the chief execs of our two councils to build really strong relationships. We are at the end of the spectrum where we have delayed discharges, but they are relatively smaller than perhaps what might be found elsewhere. These numbers are based on that. For calendar year 2024, delayed discharges were just over 25,000 bed days. That equates to a cost of £8.9 million to the hospital. I can send the breakdown of that to you separately afterwards.

Chair: That would be very helpful.

Dr Bartoli: You can see the impact that would have, as my colleague Isabella has said, on patient flow as a consequence. Those figures are bed days. If you equate that impact down to patient numbers, actual ward numbers, that impact on flow can be seen.

Q160 **Chair:** The figure of 25,000 bed days is not just those who are in beds waiting to be discharged. Is that the total number of people through the entire system who are waiting unnecessarily, across the whole of the flow of the hospital, or is that just the end number?

Dr Bartoli: That is when they are medically fit for discharge and ready to go.

Q161 **Chair:** That is just the end number. You have not quantified all the other delays that happen in the hospital for all the other wards that are affected. You do not have that.



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Dr Bartoli: This is everybody who is medically fit for discharge and is waiting. It is the time they wait before they are discharged.

Q162 **Andrew George:** They are in a position of no criteria to reside. It depends on whether you have these statistics on the basis of a pathway analysis and where the budget flow needs to be found. In other words, is it the social care budget or is it primarily a primary care need, either for continuing care or other healthcare?

Dr Bartoli: It will be a mixture.

Q163 **Andrew George:** Yes, exactly. It is about what that mixture is. I am just trying to get an indication of a more global figure. I am sure Cornwall is probably reflective of the country as a whole. Is that fair? Is that reflected in your own areas?

Isabel Lawicka: If I think about January 2025 as a snapshot to help give a bit of context, on a typical day we had an average of around 23,000 patients who were not discharged.

If you are looking at the difference between acute and community settings, in acute settings nearly three in five patients, at the end of a typical day, were not able to be discharged when they were medically ready to be discharged. That was at nearly a two-year high in January. We know this is a problem, and it is getting worse. If you look at the community equivalent, it is four in five patients at the end of a day. It has been at that level for about two years. We have seen that as a trend, and it is a worry.

As Birju said, there will be complex reasons for the reasons behind that. We know social care is one part of it, but there are things within hospitals, such as discharge processes, et cetera, that are also important.

Q164 **Chair:** How much is social care a part of it?

Isabel Lawicka: I will write to you on that, if that is possible, because I think NHS England have done a breakdown. I would want to get the most recent figure for you, if that is okay.

Q165 **Andrew George:** The last one we see is from 2023, is it not?

Isabel Lawicka: Yes, that is the last one that I have, actually. I probably do not have an up-to-date figure on that beyond that.

Dr Singh: We have some more topical regional data, but, before I share that, I wanted to emphasise the context a little bit.

Building on what our colleagues from the first panel said, it can be unhelpful to look at social care as the alleviation for delayed discharge. That forces us all to have very tactical and crisis-based conversations.

Although it is incredibly helpful to look at pathway problems and discharge problems—those are problems that we are looking at, as



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systems, because we know that pooled budgets and bringing teams together can help to solve them—if that is all we are looking at in terms of our partnerships, we are just going backwards. There is something about not talking about social care as a solution to discharge.

Having said that, I will share a little bit of what we have found, but hopefully in a really positive way. I am really hopeful about this review. It could dramatically change the stagnation that we have been suffering for decades now.

Q166 Andrew George: When you say “the review”, you mean the Casey review?

Dr Singh: Yes. The NHS is really gripping the three shifts. This is where local authorities have been for a long time: embracing prevention and looking at neighbourhood health. It could be really monumental if we help local government to throw off some of the shackles and the underfunding.

The thing about discharge is that it can work really well if you have integrated teams working really well together at place. You cannot have that if local government does not have the headspace or the staff to put into those integrated discharge teams.

In the Black Country, we have four amazing councils that are part of the integrated care board and the integrated care partnership. If I take one of them, Walsall, for many years we have been looking at how we can repurpose the BCF and target it at those who are medically fit. We first started to track the data in 2020. By putting a single budget and a single team together and targeting discharge, we have moved from above average to well below average and kept that on trajectory for the last four years. That is data we can certainly send you.

Chair: Yes, please.

Andrew George: That would be helpful.

Dr Singh: Where we have less mature partnerships, we can look at delayed discharges and attribute them to delays in perhaps finding social care solutions. Across our other three places, the data shows that about 11,000 delays are attributable to social care. That is not the total delays that Birju was talking about. These are the ones that we have been able to look at more scientifically, which equates to 31 permanent beds being taken out at a cost of £7 million.

Q167 Andrew George: What proportion of delayed discharges is that, though?

Dr Singh: I do not have that data, but it will be similar to what Birju was talking about. It will be a much larger percentage, and then you are able to look into the smaller figures.

Q168 Andrew George: Finally, on the point about integration, Councillor



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Fothergill suggested that there is a tapestry of success and failure, if you like, across the country as a whole. I do not know whether that is reflected in what you are saying in terms of how integrated that process has been, effectively. It sounds very good in the Black Country.

With regard to the pressure on hospital beds, I remember that the NHS Confederation produced, in my view, an infamous report about 20 years ago called *Why we need fewer hospital beds*. The percentage of occupied beds is in the high 90s. I suppose this is a question to Birju. Surely we should be working towards a percentage in the mid-80s to avoid these pressures of crisis management and the dysfunctionality of the admission and particularly the discharge process?

Dr Bartoli: You are right. We are at our optimum when we are around 85%; we can afford to go up to 90%. If you go over that, you really start to feel that flow pressure.

To be mindful, some of those bed base numbers—again, this will depend on individual models—will incorporate elective beds, beds for planned operations. As an organisation, our planned bed base for those planned operations is really very small because clinically things have evolved and we can now do things much quicker than we used to with day-case operations, for example.

We have done some modelling internally. Using ONS figures, in a do-nothing scenario, both clinically, from an NHS model point of view, and in respect of delayed discharge, by 2040 our organisation would need an additional 242 beds.

Chair: Wow!

Q169 **Andrew George:** What proportion is that?

Dr Bartoli: I currently have one hospital that is a specialist emergency care hospital. It is another one of those that we would have to build.

Q170 **Chair:** How much would that cost?

Dr Bartoli: We built that one 10 years ago. It was about £100 million. From a capital point of view, it is not affordable. From a workforce point of view, it is not affordable, and the people do not exist.

Q171 **Chair:** I am interested in this, because the do-nothing scenario is exactly what this inquiry is about.

Dr Bartoli: This is the do-nothing scenario. Although it is not all about social care and delayed discharges, it is about how we change that clinical model.

Q172 **Andrew George:** What proportion increase is the 242 on top of what you already have? That is what I am trying to understand, because 242 means nothing unless—

Dr Bartoli: It is about a quarter of my bed base again.



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Q173 **Andrew George:** That is fine, thank you. It would be a 25% increase in 10 years.

Dr Bartoli: Yes. This is in an organisation that uses its beds pretty efficiently.

To give you the context from my area of the world, the number of people over the age of 75 is increasing quite dramatically. The growth in population is in people over the age of 75 and over the age of 85. That will have an impact on social care in the north-east.

Dr Singh: Just to build on that, I absolutely agree. One of the challenges that we are facing across the NHS, working in partnership with communities and local government, is about how you prevent that from happening. How do we not wander into the do-nothing scenario? We already have some good direction of travel around that, which is about neighbourhoods.

Q174 **Chair:** The operational guidance says that you have to.

Dr Singh: Yes, we are moving into prevention through different ways of supporting and preventing escalation of need.

This is not just about direct social care, but, as we heard from the previous panel, the thing that will make the NHS have to make those tough choices is growing acuity. The escalation of need is not just the demographics; it is that people are getting more ill and frailer.

As we just heard from local government, we are not able to prioritise things like voluntary and community sector investment. Those are organisations that could support our population. By the time the demography hits us all, they are frailer than they need to be and they have fewer options than they could have. We are almost wandering into a scenario where we are having to build these fifth lanes on the motorway. The root cause of it all, which we should be addressing, are those wider determinants of health. Local authorities are not able to address those because they are forced into crisis management through targeted social care.

Chair: We are now very definitely straying into my set of questions.

Dr Singh: I am sorry.

Q175 **Chair:** No, it is fantastic and predicted. We have focused a bit on the hospital side of it and now we really want to drill down on the community bit and the integration between the two. To carry on with you, Anu, you have set out what the challenge is, but how do we now deepen those partnerships? What do we need to do specifically?

Dr Singh: We are incentivised, are we not? You heard this from the previous panel. We are incentivised to think about our bit of the world, not the system. There has been a lot of rhetoric around thinking system and integrated care boards. Many partnerships through decades



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previously have encouraged us to think system, but none of the incentives has flowed that way.

Q176 **Chair:** What would be a good example of an incentive that would work to get people to think that way?

Dr Singh: Number one would be if funding were joined up across different Government Departments and we were able to take a multi-year prevention-based lens.

Q177 **Chair:** What we are talking about there is a pot that is shared and you are all equally responsible for it. Is that what we are saying, in layman's terms?

Dr Singh: Yes, exactly that. In layman's terms, we heard about the delays that can happen and the tense partnerships that can be developed through CHC and 117 conversations.

What we absolutely know works are pooled budgets at place. We know that communities, the voluntary community sector and our health partners in those community services understand what matters to the community. This is not what is the matter with them, but what matters to them to keep them well. You are able to spread the jam much thicker. At our end of the world, we are having to spread it so thinly because we are not addressing the escalation of need. That is number one.

We are just not encouraged to think in that way by our regulators, by the performance stats that we are reporting or by personal accountability.

Q178 **Chair:** There is a lot of talk about the regulators currently. What could the regulators do differently to encourage this kind of thinking?

Dr Singh: I defer to my CEO colleague, who I know will be in daily conversations about metrics that are all about today. They are very rarely about the medium term or in a few years' time.

Dr Bartoli: On metrics, the element of having a shared consequence is really important. With my local authority colleagues, we both have a vested interest in our local communities. We have slightly different lenses, potentially, but we both want what is right for those individuals.

If we take something like delayed discharge as an example, there could be a pot of money and we say, "This is a baseline that the hospital has. This is the baseline of packages that the local authority delivers. Let us see a measurable shift in that". There could be a consequence if there is not a measurable shift, if money has jointly been put in.

Q179 **Chair:** In that case, would a stick perhaps work better than a carrot? What kind of consequence would work in that situation?

Dr Bartoli: There is something about being responsible back to the public.



Chair: You mean accountability measures.

Dr Bartoli: Yes, accountability measures. I will probably never be thanked for saying this, but we cannot just keep spending money without there being something about asking, "If it does not work, how do we stop it?" If you had to pull it back, would you think differently? At the minute, we give and there is no taking back. You might think twice about doing something if you had to give it back if it did not work.

There are areas across the country, some of which the panel spoke about previously, that have some very good working relationships with local authority colleagues and that can say, "Let us try something that is a little bit different". They both have a will and a vested interest in trying to make a difference because they are part of their local community. They can say, "If we did this, what could we show from both a numbers point of view and an outcomes point of view for the local population?"

Q180 **Chair:** May I just come back on the specific point about safety? Anu, you were talking about how we have a system that is just focused on safety.

I recently did a ride-along with Oxford University's ambulatory team, which both diverts at the discharge end and works with South Central Ambulance Service to stop people coming in in the first place. They try to tout for business within the ED. People come to the ED, but they find that the clinicians have a very safety-first view. They think that safe care can only be delivered inside a hospital. They have got quite frustrated.

The clinicians themselves need to be reassured by the system as a whole that there are other ways of doing this, with really quite complex and amazing kit in people's own homes, which can deliver such enormous benefits, not least in terms of cost to the hospital. That is why the hospital is funding it: it can see that it is helping not just quality of care but also the cost of care.

Birju, does that ring true with your experience of this? Is there a job to do with the workforce to get them to look at this differently? It is a very different way of working as compared to how they have been.

Dr Bartoli: Yes, that is almost an in-built experiment within our organisation because we are an acute and community integrated trust. Our community teams have spent a lot of time with our acute colleagues demonstrating to them what they can do in the community. There is sometimes a misconception, exactly as you have said, that everything has to happen in the hospital. No, there is an awful lot that we can do. There is an awful lot of risk that both primary care and our community colleagues hold in the community.

As an organisation, we have invested in virtual wards and hospital at home. Traditionally, there are patients who we would support on respiratory wards with respiratory kit. We now do that at home. We have a respiratory hospital at home service. As others can see, they gain faith that we can do some of this at home.



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There is a lot of stuff that we used to do in hospital that we now do out in the community, such as the delivery of IV antibiotics. That always used to be a hospital activity. We now do that either through ambulatory care or in people's own homes.

There will always be a cost-benefit to that. Because part of our patch has quite a rural geography, that is not always as efficient from a financial point of view in terms of the number of people who the community staff can see on any given day. However, there is definitely a shift in terms of what clinicians feel they can do in hospital versus what can be done out in the community.

Q181 **Chair:** How easy is it to get into the local care homes? The advanced clinician who I was with was desperate to get into care homes and to start there by helping them to see that, when things get tricky and they are worried about safety, the first port of call might not be the ED; they might find another way in via their service. Do you have a good relationship with your care homes locally?

Dr Bartoli: We do. A lot of that has been built over time. It was built during Covid in particular. There were some strong relationships with infection control teams, et cetera.

Q182 **Chair:** Is that still there? A lot of places say that that has gone.

Dr Bartoli: The relationships are still there. We need to rebuild and re-educate, because of the turnover of staff, in terms of what options are available. We have community matrons, for example, who work out in the community and in those nursing homes but feed back into the organisation.

We also have something called a single point of access service, which is a number that anybody out in the community can ring and then be directed or navigate to the right part of the system.

Q183 **Chair:** That is separate from 111.

Dr Bartoli: It is separate from 111. Linked to that is something called the two-hour urgent community response. For example, if a care home rings that number, we can say, "We will send somebody out to see you within two hours", rather than sending that patient into hospital. Is that very well utilised? It is a work in progress.

Q184 **Chair:** A lot of these are nascent around the country, it would seem. I just want to come to Isabel because I know you had some things you wanted to say about integration.

Isabel Lawicka: I was just going to come in on what Anu and Biju referred to in terms of thinking about the ingredients for successful integration and improving that. As you said, it is nascent in some areas. It is going really well in other areas, but we need to have the ingredients for success there.



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Colleagues have pointed to a couple of things there. First, that multi-year focus is really important. A lot of it comes back to relationships, as Birju said. It takes time to build that trust.

Q185 **Chair:** Do you need local leadership?

Isabel Lawicka: Yes, you need local leadership. You need time to build those relationships and see that multi-year picture so you know what you have to work with. You need to have a decent amount of time to be able to build something together in partnership, see the results through and improve it. Adopting a continuous improvement approach to keep improving is really important. At the moment—the previous panel talked about this as well—the difficulty is that we do not have that multi-year focus. That is a challenge.

There are loads of good examples across the country where we know it is working really well. In South Warwickshire, for example, they have a joint funding arrangement across the ICB, the trust and the county council that supports people with domiciliary care and therapy at home. That is the type of example where we see some of those levers that people can pull on, such as the joint funding that Anu mentioned, but it has taken time to build those relationships over a number of years and really get that to a solid place. That is something we need to have in mind as we are thinking about the solutions as well.

Q186 **Chair:** Anu, can I ask you about the role of the ICB in navigating the community? In some parts of the country we have big trusts, which hold all the money and very often a lot of the power, and then there are these more disparate groups. In terms of the roles that ICBs can play, from where you sit, how well is this working? What could we be doing better? Thinking about the cost of inaction, what is not happening because it is not quite working well? I am also really keen to hear about that.

Dr Singh: In the Black Country, like Birju, our four trusts are acute and community. The problem that some other ICBs might have we do not experience in the Black Country, which is why we feel that we are quite advanced in terms of our place models. We know that getting it right at place is an essential ingredient to the solution.

I was really pleased that Birju talked about the clinical appetite. For me, the biggest shift has to be in boldness of ambition. As a health system, we are tinkering around the edges of transformation and trying to fix the model that we have when what we need is a fundamentally different care model. We kind of know that.

The new policy drivers are helping us move to that new care model. Some areas, such as the Black Country, have had that belief for a long time and are now almost able to see the fruits of it. For example, we have built a brand-new hospital. We would really welcome the Committee to come and have a look at that model. It is a model that is almost unique, in that it has a lesser bed base.



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We know the future of care is not in big shiny hospitals. They have to be for those acute episodes where people most need to be in hospital. Instead, we have invested differently in community. At the same time as that was being built—

Q187 **Chair:** Where did the money for that come from?

Dr Singh: It was part of the national programme. The real key ingredient was the clinicians having the appetite and the bravery to say, “The community-based model is the one we are going to go to”. I was blown away by that. Our clinicians were forcing us, almost, as system leaders, saying, “Come on. Put your money where your mouth is”.

Q188 **Chair:** What level of clinicians were driving this? Are these the ones who sit around your board?

Dr Singh: It was MMUH, the Midland Met. I have heard the medical director speak many times about getting in there, corralling the community of clinicians and care professionals of every facet, getting people excited about a different model of care and trusting in it.

To your point, Birju, clinicians are trained to be risk-averse. There is something about delivery of care rather than the co-production of care, which again is a big shift for the NHS. We are on the way, but we are nowhere near there in terms of co-producing care with patients, carers and communities themselves.

The big shift for us was investing in community provision along with our local authority and our community sector, to make sure that the front door pathway into the new-build hospital was not overwhelmed. We believe in the new model. We believe in neighbourhood health.

Q189 **Chair:** Was the hospital leading in it?

Dr Singh: Yes. That is one example. I do work on a number of ICBs. I work across south-east London as well with six boroughs, with some really big organisations, such as Guy’s and St Thomas’, King’s and SLaM. Just this last week, I have been closely involved with something called the Living Well Network Alliance in Lambeth. SLaM is a big mental health provider, but it has the humility to work very closely in partnership, through many pooled arrangements, with the voluntary and community sector and the local authority to look at investing differently in prevention and making sure that the whole pathway design is thought through, rather than only looking at managing exacerbations or moving people to different settings.

It is possible to do, but it takes bravery, time and, as you have said, relationships over many years.

Q190 **Chair:** I am hearing lots of good things about, as you say, the value of individuals deciding this is a priority, therefore driving the system to make this a priority and it then happening. The problem with that is, if we



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are trying to do this across the entire country, at some point we need to quantify and codify what the secret sauce was. Having good people in place is not enough. We have to do more.

If you were to try to distil it, as we are thinking about parts of the country that perhaps are scared to do this, have not done this or feel they do not have the money to do this, what would that be, if that is not too difficult a question? I am happy to throw that to everybody.

Dr Singh: If I may just come back, a few years ago we did not have clarity around the policy drivers. It is not just the Darzi report.

Q191 **Chair:** This is the drive from Government themselves.

Dr Singh: Yes. People feel safer; they feel more comfortable. Very recently, the latest planning round in the NHS has come out, along with a model for neighbourhood health. We have not had that in the past. Some of the things that are coming out as expectations from Government are incredibly helpful.

The key ingredient has to be looking over the medium to long term, perhaps across a life course of a few years, along with our partners rather than as different organisations.

Q192 **Chair:** We need clear direction from Government and long-term settlement. Birju, do you want to add anything else?

Dr Bartoli: There is something about knowing what your local area needs. There is a general view of, "Yes, let us move care into the community". That is probably felt by all acute trusts now, whether they are integrated or not. Gone are the days of wanting to suck everything into—

Q193 **Chair:** Would client-level data help with that?

Dr Bartoli: We talk about neighbourhoods and we probably all mean something slightly different. If we are talking about shifting care into the community or moving to a neighbourhood model, we need to be clear on what we mean and what we are going to do. We need to know how to scale that up enough to say, "I am going to move X, which was being delivered in hospital, out into the community, so the resource needs to go alongside that". We all talk about that in a slightly different way.

In my area, I am working with both of my councils at the moment on mapping this out. I am trying to understand, between health, social care and primary care, what already exists and what the need is within whichever locality.

Q194 **Chair:** This is really the nub of it. As a hospital CEO, if the money was going to be taken from you and given to the community, even if you could see it was the right thing to do, your bottom line would decrease. Would you do that?



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Dr Bartoli: Yes, if I do not need it anymore because I have moved that element of care, it is only right that the money follows with.

There is a balance between thinking about the here and now, which is about the money and shifting the care in the people who already exist, and thinking about the future. This was the point I made earlier. It also prevents the future cost of having to build more hospital wards, et cetera. It is not just the here and now.

The trick is how to get almost the double running cost around what to do in the meantime while the next model is being grown and developed.

Q195 **Chair:** If you have no extra money, how do you do that?

Dr Bartoli: That is the challenge.

Chair: You do not have an answer.

Dr Bartoli: I do not.

Isabel Lawicka: Just building on what my colleagues have said, we are seeing green shoots. The policy framework is bringing in that focus on the shift to prevention and community, but we need to be realistic. It will take time.

In terms of your question around what will help, we need a nationally aligned framework for both health and social care and we need to make sure both of those are pointing towards integration, working well and getting the ingredients right. The 10 Year Health Plan is in progress. It is great that that has a 10-year focus, because that points to what Birju was saying about how it is going to take time to shift the resources to where they need to be.

The Casey review is also coming up. There is a really important point for me there around the alignment between those two pieces of work. They will be doing things slightly in parallel, but they need to be working together and looking at the different pieces.

We have seen some green shoots this year in the planning guidance, as Anu said. We need that to shift over time as well, so the three shifts are really built into what all services in the NHS are being tasked with doing over a one-year-plus period. In the medium to long term, that absolutely needs to be the focus.

I was also thinking about data and digital as well. Digital transformation is really key part of—

Q196 **Chair:** What about it?

Isabel Lawicka: The examples that we have seen work really well. Lots of them have come up today. As Birju said, some people are really able to use local data to understand what is going on and what their local



communities need. We know that digital transformation would help with that in terms of being able to really—

Q197 **Chair:** Which bit of digital transformation? It is a big umbrella. Can you drill down into what exactly you would like to see that would help this?

Isabel Lawicka: One example would be ensuring that the health and care partners locally are able to invest in really understanding their data around health inequalities, for example, so they know what the needs of the local population are and they can put in place things that are going to help with demand over time.

Chair: That does not exist already.

Isabel Lawicka: Not enough of it, I would say.

Q198 **Jen Craft:** I am going to touch on the better care fund and how that is utilised in terms of preventative community work. We have picked up on some concerns that the better care fund has been prioritised on short-term issues affecting hospitals rather than being used for the community prevention work that stops people from needing to access acute care in the first place or keeps them in hospital for longer.

If you were able to completely redesign the system, how would you spend better care fund money to relieve some of the funding pressure on local authorities? What areas of prevention are crying out to have some of that money spent there?

Dr Singh: The learning from the BCF is absolutely part of the solution going forward. Part of the answer is about understanding what else social care is doing that does not need us to use the BCF to backfill some of the preventative work. Assuming that we have a different settlement for social care and assuming that does not suck money, as it sometimes does out, of public health or other wider determinants work, we can look at the BCF as a tool for that joint interface around intermediate care. Yes, absolutely.

At the moment, you are right. Because of the crisis management we are in, almost all the BCFs are tilted at getting flow fixed, which is not the right thing to do. It absolutely needs to be focused on strengths-based, community-led investment to help communities be more resilient so they do not have escalations of care.

We have an example—I talked about the Walsall example—of really strong partnerships, but, because of the funding issue, there had to be a decommissioning of falls prevention services. The data tells its own story. It was absolutely high-achieving, but the number of presentations through a fall has now gone exponentially the other way. We can track that to the lack of a falls prevention service.

There is something about not seeing the BCF in isolation as a fix-it fund. We need to think about what needs to be around the BCF in terms of



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community support, basic prevention and public health. Then you can together, as a health and wellbeing board, target your BCF locally at the things you need to. It cannot be a national solution, but the things around it need to be in place.

Q199 Jen Craft: Again, that relies on local leadership being in place. How can Government, at the centre, incentivise local boards to take the action you have just outlined?

Dr Singh: A number of the funds that were put into the BCF recently have been around discharge. They have been around winter. That is a message in itself. If Government want to have locally empowered leaders with agency that can tilt into what their communities most need, we probably need to be giving money without conditions or reporting attached to it. We need to give localities a bit more freedom to use that investment.

For example, I work in certain areas where it is absolutely critical that we do something about black maternal health. It is absolutely critical. Locally, we need to be able to tilt our spend into that kind of preventative work. We need to work with the voluntary and community sector and trusted advisers to help shift that terrifying data.

Lots of our money is tied up in different streams and is linked to very specific reporting that we might have to do around UEC, elective reform and discharge. That means that, as local systems, whether you are at ICB level, place level, neighbourhood level or MDT level, you are caught up in conversations that perhaps you would not want to be.

Q200 Jen Craft: I am probably going slightly off-piste from what I have written down here, but you have just said something that is incredibly interesting. You said that you have to do something on black maternal health. Leaving aside the moral imperative, you have data that shows there are worse health outcomes for that particular group. You say “have to”. Are you being driven to do this either from the centre or the oversight of your board? Is this a local priority that you have identified?

Dr Singh: It is a local priority. It is one in four maternal deaths. That is the data we are dealing with. We know we have to do it. In the Birmingham and Solihull ICB system—there are slightly different drivers—the levels of neonatal mortality are some of the most shocking across Europe. We know we have to tilt in and do something slightly different with our funding.

Chair: I am going to have to draw us back to the topic. I am sorry, guys. The Committee is very interested in this. Perhaps watch this space.

Dr Singh: It is about local freedoms. It is about having the local freedom to spend and tilt in on prevention.

Q201 Jen Craft: My question was about where you are getting the pressure from. The local ability to identify and take action is probably the key thing



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there.

Just to very quickly touch on another large funding basis, we have heard concerns from local authorities that there are ever increasing and stricter criteria on entitlement to continuing healthcare, which is, in turn, having a knock-on effect on local authorities' social care budgets and potentially leading them to having to pick up more complex cases than they would have done in the past. Is this a concern that you share? If you do, how do you see that reaching a resolution there?

Isabel Lawicka: I can give a national picture, but there will be important local examples. The problems that you have highlighted are a symptom of demand not being met overall. That is where it is so important to be thinking about the stability of the system overall, and a lack of action storing up further problems. I would see those issues as a symptom of the broader instability and lack of funding in the system, but there will probably be local examples.

Dr Singh: It probably is an ICB issue. The tension that you draw our attention to is a fundamental one around the system being set up in an unhelpful way. We are pitted to have difficult conversations with our local authority colleagues, which we do not want to have. Our relationships are not such that we should be having these conversations.

We talk all day and set up our own local governance structures around partnership, pooling, understanding each other's drivers, and leaning into population health management, which is what we want to do, and yet the way that the funding is set up nationally, especially around 117 and CHC, means that we do have to have those conversations about who pays. If you have read the lengthy guidance from NHS England, which is called *Who Pays?* it is a question mark. We are always worrying about that question mark—who pays?

Q202 **Chair:** If the budget was pooled, which you were suggesting earlier might be one of the changes that would help, the quantum of the budget does not increase, so how does not having the difficult conversations fix this?

Dr Singh: As was trailed earlier, local authorities have a statutory duty to set a balanced budget. Some of that drives behaviours in local authorities, where you have to make your limited piece of string fit. Some things will become not complicated, but sources of contention, because you do not want to have to spend that money, even though perhaps the arrangements around a package of care are best suited to one agency and not the other. You are driven to save money.

Similarly, in the NHS, having to work within your control total means that you want to present your budget as close to coming in as you possibly can. You are forced to have conversations such as, "Where does that cost truly sit?" That is not a conversation that benefits the people at the heart of either of those funding streams. We know that, and we are always trying to make sure that any debate or discussion does not impact care in any way, but it is an unnecessarily fraught piece of work.



Q203 Ben Coleman: This is a good moment to come in and pick these points up. We have been talking a lot about the challenges facing social care, and you are talking about the challenges of having two different organisations, as it were—the NHS organisation and the local authority organisation—involved in this. With regard to the challenges in social care and local authorities that we have already talked about, how are they affecting, or how will they affect, your ability to deliver the NHS's three shifts in terms of inter-community, digital and prevention?

Dr Singh: I will start off with a strategic piece and where I started the conversation. We are not able to have strategic conversations. We are having crisis-based conversations around points of service intervention—what services can we and can we not put in place? The fundamental issue for the NHS is the rising acuity. You get less needy populations if they are happy, if they are supported well, if they are walking down streets that are safe and if their housing is good.

What I have seen in almost all the local authorities that I have worked with in the last decade or so is that pulling away from those universal services that make people safe and well. Just look at some of the data around damp in homes and exacerbations for our most vulnerable, from children to older people.

Some of that tension that local authorities are feeling because of the underfunding of social care not only has a knock-on effect on those vulnerable people who are entitled to those social care packages, or our delayed transfers, but the NHS will feel this for decades to come. We are having to deal with people whose multiple long-term conditions are not supported in a timely way, because your social care budget is so inadequate that we are not able to invest in public health in the way that we should around smoking, obesity and healthy lifestyles.

The data tells us that, in terms of contributing to a healthy lifestyle, only 20% is NHS services. 40% is absolutely healthy behaviours. You then have the wider environment, and then housing and things such as that. We know that the condition that social care is in is giving the NHS, if you think of it in parochial terms, a long-term problem. We will never, ever have the investment to deal with the acuity that is growing and coming our way.

Dr Bartoli: Health and social care are inextricably linked. We have to do this together. That shift of hospital to community and sickness to prevention is not a health thing. It is not a social care thing. We have to find a way of how we combine those. The challenge that we all have is that this is going to take time. Sickness to prevention, just based on what you heard earlier on and what you hear now, is not a one, two or three-year fix. We are talking about a much longer period of time.

The hospital to community shift is really interesting. We could be bold and brave enough to say, "Let us just take the leap of faith". I would say this, but, if there is some bridging or some double running costs that



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could be put in to say, "What is the art of the possible here?", that is something that we should look to move more quickly on.

Within that, as with all of these things, there has to be a win-win for health and for social care. There will be things in the community that will help deliver some of the needs of the NHS that only social care can do, and it will be their statutory responsibility to do that. NHS needs to back off and stop thinking that it can fix everything. Leave that skill set to our councils.

Q204 **Ben Coleman:** What do you mean? What is NHS doing at the moment that would be interfering with social care unnecessarily?

Dr Bartoli: It is not per se, but rather than the NHS thinking that it has to fix everything out in the community, it needs to say that the things that are relevant for housing, for example, are a local authority issue. Why is the NHS necessarily commenting on that? The local authority knows what it needs to do.

Q205 **Ben Coleman:** Forgive me for challenging you a little bit on that, but is the NHS not commenting on the fact that, for example, too many homes are riddled with damp, which is causing problems for children throughout their lives and, ultimately, for hospitals? Is it not reasonable for the NHS to comment on that if we are trying to reduce and prevent the problems?

Dr Bartoli: Sorry, I should correct myself there. It is to comment, but not necessarily to do. The fixing of that housing issue is a local authority issue, and they are working in my patch. They are looking at and working on that. It will have a benefit, ultimately, for the NHS.

Similarly, in a way, there will be things in the community that the NHS can do from a pure health point of view that they need to focus on. Then there will no doubt be a subset in there that either one can lead on, where, as long as somebody is doing it, it does not matter who. When I talk about health and social care being inextricably linked, that is what I mean. The fix of the wider community is something that we all have to do together.

Isabel Lawicka: The interconnected nature of the two is really key here, as well as thinking about the demand picture. If we look at research that the Health Foundation has done fairly recently, there will be 2.4 million more people living with a major illness by 2040, so we have to be thinking about the three shifts in that context as well, in terms of being able to address demand and what that future demand is going to look like, so that we have done the three shifts by the time that that demand is escalating.

There is sometimes a risk of focusing on quite narrow policy priorities. We all know that elective care waiting lists are absolutely crucial to address, but, if we are looking at that only in a silo, not really looking at the issues that we started talking about in terms of patient flow, delayed discharge, the knock-on effect on bed base, avoidable admissions, et cetera, and not



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looking at the whole picture, there is a risk that we focus on that one thing but do not see the interconnected nature of all of that working together. That is the important part.

Q206 Ben Coleman: We talked about the lack of social care provision, which could have an impact on the NHS, and the need to reform social care. In my experience—as Josh said, I am one of these other people who has the scars on my back from being a cabinet member for health and social care for a long time—the NHS often does not, as we talked about earlier, understand social care. How could the NHS reform to interact more effectively with adult social care? What is the cost of the NHS not grasping this and not reforming to interact better with adult social care? Birju, I can see you smiling away, so why do you not start?

Dr Bartoli: I alluded to cost earlier on. We have to change. We have an ageing population. A colleague here has already talked about the rise in acuity now. We no longer see some of the less acute presentations that we used to see. In terms of the numbers, I have already alluded to what that would mean by 2040 in terms of a hospital service if we did not do something different.

Helpfully, when I talk about figures such as that internally, that is a real driver for a lot of our clinicians in terms of trying to say, “We absolutely have to now almost tip the model on its head and say, ‘If we were about to do a complete turn, what would that look like?’” That is a work in progress around exploration.

Sorry, I cannot remember the second part of your question.

Q207 Ben Coleman: The main point was what the NHS needs to do to reform itself so that it would interact better with adult social care, and what the cost will be if it does not do that.

Dr Bartoli: The cost is what I have said. How we reform is in the three shifts that have been said nationally. We have talked for a long time; I would say over the past 10 or 20 years, or as long as I have been in the NHS.

Q208 Ben Coleman: Is it just reforming in terms of the three shifts? Is there a mental shift that needs to take place in the NHS?

Dr Bartoli: It is both. We have talked about moving care more into the community for the past 10 or 15 years. Arguably, you might say that the external environment is right for it now, whereas it might not have been previously. Because of the pressure within the NHS now, the mind shift is absolutely there, and we should harness that mind shift now.

Dr Singh: You are absolutely right about the mental shift. The three shifts are absolutely right, as are the policy drivers, and we are doing it. One of the biggest things that we need to get right is the boldness to buy something different. In commissioning terms, commissioners such as



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integrated care boards need to buy preventative services. That is what we need to do. The buck is really here.

Q209 **Chair:** Do you have the skills to do that?

Dr Singh: Yes, absolutely. Going back to your data point, the data tells us that, if you were to take a population health approach and model the lack of certain interventions on things such as growing hypertension, COPD or whatever it might be, they are the things that are swamping our system. Something like 70% of spend is on long-term conditions and their presentations, or more than that.

Q210 **Ben Coleman:** Who would the commissioners be in this context?

Dr Singh: They would be the integrated care boards.

Q211 **Ben Coleman:** What about hospitals themselves commissioning preventative services?

Dr Singh: The world of the commissioner-provider split has long gone, so boards are now working with all partners in the system.

Q212 **Ben Coleman:** Why would hospitals not want to spend the money on prevention locally and get a much more formal role in that, given the knock-on positive impact for them?

Dr Singh: They are commissioned to deliver certain things that are acute.

Q213 **Ben Coleman:** So we need to change that.

Dr Singh: Yes.

Q214 **Ben Coleman:** If we did change that, are hospitals better placed than ICBs to do this, or are ICBs better placed than hospitals, in an ideal world?

Dr Singh: If you go back to where we want to be, which is population health improvement, and if hospital leaders are the right people to be talking to local authorities and communities, they need to be the right people. At the moment, in terms of having a leadership cadre that brings together clinicians, hospital leaders, local authority leaders, community leaders and the voluntary and community sector to focus on population health in the medium to short term, that is what the ICBs are set up to do.

Dr Bartoli: I was just going to comment on hospitals' role in that as well. Locally, we have something called making every contact count. It is a public health element of prevention. There is an evidence base that suggests, rightly are wrongly, that, when a clinician says to you, "You now must stop smoking because this is going to happen to you", the person is more likely to listen, rather than just when somebody else has been saying it, or they have been watching the adverts, et cetera. The same could go for alcohol or for whatever else, particularly when they



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have had an acute clinical episode. We use that almost as an opportunity to educate when patients are in front of us. It was just a comment in terms of what hospital services can do here and now with regard to that prevention agenda.

Chair: Thank you very much, all of you. That brings us to the end of our session.