HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Care for adults in England, HC 1118

Wednesday 26 March 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon, Jackie Doyle-Price, Mr Stewart Jackson, Fiona Mactaggart, Austin Mitchell, Ian Swales, Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, National Audit Office, Gabrielle Cohen, Assistant Auditor General, National Audit Office, Laura Brackwell, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Dr David Bennett, Chair and Chief Executive, Monitor, and Una O'Brien, Permanent Secretary, Department of Health, gave evidence.

Q1 Chair: Welcome. Thank you. We are very grateful to you all for coming. Just to remind you, this first session is short and focused. What we want from you, as representatives of your organisations, is what you think the key issues are in this area. We are coming at it early on in the development of a new policy. What are the key issues that you think we should interrogate the accounting officers on when they give their evidence? We are picking your brains; that is what we are after. Who wants to start? Do you, Caroline Abrahams?

Caroline Abrahams: Okay, I will have a go. Age UK has been running a campaign for some years now called Care in Crisis. That does what it says on the tin. That encapsulates our view of the state of the social care system as regards older people. Not everything is terrible. There is some good local practice. There are hundreds of thousands of well-meaning, well-intentioned people on the front line who go the extra mile in order to do their best to provide good care to older people, and there is some good care for older people. The main problem about social care that is worth thinking about is that trying to meet the demand is a bit like running up an escalator the wrong way. The demand for social care is going up all the time because the people who mostly need it, who are older people and adults with disabilities, are two groups in society that are growing all the time. We need to see the amount of money going into social care keeping pace with that, and it absolutely has not.

It is important to look at this a little bit further back in history. If we look at the amount of money that has gone into social care, it has at best plateaued, at least from 2005

and 2010. From 2010 onwards, the amount of money going into social care has reduced. The overall result of that is completely consistent across the piece. A number of reports have said that; the one that we produced a couple of weeks ago did. The National Audit Office Report said something similar, and so did work that the Care and Support Alliance has done. What they show is local authorities trying to spread the treacle ever thinner, and the end results are that we are seeing charges going up and the number of older people, for example, who receive state care going down. That is not because there are less of them, or they do not want as much. It is because, by various means to do with eligibility and so on, they are not able to access the system.

Credit where credit is due: we as an organisation very much like lots in the Care Bill. There are a lot of good things in it, and the Government deserve real credit for bringing it forward, but our big concern is that it will be underfunded. That would be a great shame, because there are lots of good things there that could make life better for older people and disabled people. Our concern is that without the money, those things will not come about.

Q2 Chair: Let's go across the panel, and then I will open it up to questions. Sandie Keene.

Sandie Keene: From a local government perspective, in adult social care services, we have been saving money consistently for the past five to seven years. In the past three years alone, we have taken out £2.68 billion from local authority social care budgets to either reinvest or meet the growing need. The demographic trends have been well articulated; the number of older people is growing. We also have serious concerns about the number of under-65 people who are in need of care and support, particularly very disabled young people who are living longer with more serious disabilities. There are some really serious demographic problems which we estimate are at least 3% per year.

Q3 Chair: 3% more each year?

Sandie Keene: The impact of the demographic trends and inflation is just under 3%.

Q4 Chair: And inflation?

Sandie Keene: Yes. Just under 3%—2.9%.

Q5 Chair: You are sure that is counting inflation?

Sandie Keene: There is a real-terms cut in social care budgets, which has been articulated in the National Audit Office Report. One of the ways local government has been doing this—this is also articulated in the Report—is very much around efficiency changes. We have done that through procurement. We have been reducing costs—and prices, very often—and moving services from local government to the independent and voluntary sector for less cost. We have been increasing prevention services, but we have also been providing more personalised approaches for individuals.

We have also been stopping services. As for the impact of that on individuals, we are now a very low wage economy, and there are almost weekly reports in the press about people not getting the services they require. There has been a lot of attention on 15-minute calls this year, and on providers paying below the minimum wage in many instances.

In terms of budget reductions, local authorities have in fact been trying to preserve adult social care services. In many instances, adult social care is getting a larger slice of a smaller budget. Percentages are increasing slightly. For example, we have seen 9.4% total service reductions in local authorities; that compares with 7.5% in adult social care services. We have also seen a transfer of NHS budgets to local authorities of £859 million, of which 32% was used to avoid cuts and only 18% to provide new services.

That leads on to one of the solutions suggested: the Better Care Fund, which is the mandatory pooling of budgets between ourselves and the health service for the year 2015-16. We are positive about the potential for that; we believe in the direction of integrated services. However, we are very concerned that that does not represent new money; it is about how you spend existing money in the NHS. Its original intention was to protect adult social care services, but we can only protect adult social care services through that fund if we save money in order to spend it, and that money has to come out of the acute sector. The history of actually getting money out of the acute sector in order to spend it differently is not a good one. There is a lot of ambition and good work, but there are high risks as regards the achievability of delivering what is expected from that fund. We believe that it is the right way to go, but we are very cautious about the risks. We believe that health and wellbeing boards have a critical role to play in helping local communities to redesign and redistribute services.

Q6 Nick Smith: Do you have any good examples of where the acute sector has dipped into its pocket and helped out?

Sandie Keene: One example I can give locally in Leeds is where the acute sector has supported the whole system to develop our information systems. It has developed a platform from which we have developed an integrated care record, integrating primary care, community care in the health service, the acute sector and the local authority. There are examples of how the acute sector can contribute to the total, but I think that the industrialised scale of the evidence is not there. There are examples of good practice that can happen—hospitals reaching out and working differently, saving money through reduced hospital admissions and indeed rapid delayed transfers—but the scale that is required to address the problems in adult social care funding has yet to be proven.

Moving on from that—this is linked to the Better Care Fund—one of the concerns is that the fund has within it £135 million, which is earmarked to be spent on the new burdens of the Care Bill. That is not new money, because it is already being spent in the health service; we have to save it in order to be able to spend it on the new burdens of the Care Bill, so that puts an additional pressure on adult social care finance. We are very positive about the policy direction of the Care Bill, and about the rights and entitlements that it gives to individuals who need care, and in particular to carers, but we are very much concerned about the proper identification of the financial burdens, in terms of implementing the legislation, which is shortly to be passed. We are working constructively with the Department of Health, but we believe that the final amount of money has not been identified properly.

We are also concerned about the implementation costs—for example, the £335 million that has been identified as a potential cost. Many local authority treasurers would say that part of that money was already top-sliced by the extra £1 billion of savings required for local authorities for 2015-16.

In summary, a lot of good work is going on, in terms of not just the care that is being delivered but the policy intentions for the future. Nevertheless, we are concerned, as we were at the beginning of the year, that the prospects are fairly bleak for the long-term sustainability of adult social care services. Despite the many best endeavours of Whitehall, we are not sure that the long-term sustainability has actually been addressed, or will be addressed. The risks associated with the Better Care Fund and the Care Bill must be seen in the context of the size of the problem we are dealing with.

Q7 Mr Bacon: What would you do to make it more sustainable?

Sandie Keene: We would try to extend some of the time scales for the expectations of the delivery of adult health and social care integration. We would like to see the additional burdens of the Care Bill funded separately, rather than as part of the Better Care Fund, and we would want there to be—we are working with the Department of Health on this—a fully transparent identification of the costs, because there is currently a divergence of view.

Q8 Mr Bacon: The first point is about cutting up the cake—the money. Everyone knows that there is no money, and there is not going to be any more. The second point is about clarity. Will you give me an example of where there is no clarity about costs and you would wish to see more clarity?

Sandie Keene: At this moment in time, the costs of the carers' eligibility and assessment processes that will be part of the Care Bill. At this stage, it is very difficult to be able fully to anticipate how many carers will come forward for assessment. For example, in my authority in Leeds, we are in touch with 12,000 carers. From the work that has been done nationally, we believe that there are actually 70,000 carers in Leeds. We know from the recent surveys of carers that if the total value of informal carers caring for their loved ones for more than 50 hours a week was translated into a budget for routine home care services, that would take up three times the current total expenditure on adult social care services in Leeds.

Now, we would not for a minute suggest that every carer will come forward for that amount of service, but my point is that there are a lot of unknowns in the implementation of the Bill, and we must have some overall assurances as to what the fall-back position is in the event of more people coming forward with their entitlements than we can currently accommodate.

Q9 Nick Smith: Why do you think you have 70,000 carers, rather than the 10,000 you have on your books in Leeds? That is a big difference—700%.

Sandie Keene: No, as an organisation we are currently in touch with 12,000 carers, but we know that there are 70,000 in Leeds in total. The balance of people are caring without any contact with adult social care services at all, because they are doing it informally, within their family, for their loved ones. The Care Bill means that there will be an entitlement for carers to come forward for an assessment of their needs and, indeed, an entitlement to have those needs met in part by the public purse, and that will put a new burden of duty on local authorities to provide that level of care.

Q10 Mr Jackson: Not surprisingly, in a very charming and roundabout way you are making a plea for more money. You used quite an interesting euphemism, saying that we need to look at a challenge separately; that is a new way of asking for more money. On a serious point, would you not have a stronger case to make to central Government if it was not the case that not all local authorities are enabling the public to scrutinise their work through adult care performance information? A significant minority of local authorities are not publishing the data, so it is difficult to look holistically across the whole country at the demographic challenges. That is the first question. The second question is on something that comes through in the Report as well, and I would be interested in your response. Why are carers relatively less satisfied with the service they get from local authorities, in terms of the feedback that they give and that is collated?

Sandie Keene: First, in relation to publicity, the Report talks about the sector-led improvement initiative and the publication of local accounts. All information about local authorities is publicly available through the Health and Social Care Information Centre, and many local authorities publish information through their scrutiny and other reports. It is not necessarily just through local accounts that that information is available; other mechanisms include scrutiny, ordinary performance reports and financial accounting in terms of the success or otherwise of financial sustainability. We, as an association, encourage all local authorities to publish local accounts. This is in its infancy; it is a relatively early programme, in terms of sector-led improvement, and we are feeding back to local authorities and encouraging best practice, so we absolutely take that point.

Q11 Mr Jackson: But you need more clarity. There are so many players in this very complex area, and we only have to look at the beginning of the Report to see how complex it is. The diagram on page 6 looks like the periodic table—adult social care, health services, housing, leisure and well-being, and welfare and benefits. To expect stakeholders to keep up to speed on a scrutiny committee or commission in a large metropolitan district council like Leeds city council, let alone a small unitary authority such as mine, is quite difficult. It is quite an unfair question to ask you, but do you not think that DCLG should insist that there is openness, transparency and consistency in the presentation of those data?

Sandie Keene: I cannot speak for DCLG, but the Local Government Association and ADASS would encourage, as a principle, transparency and openness, and would very much want to support that. I would also like to say that I am not just here requesting more money, because I think there are issues we need to address within the Better Care Fund, not just about the supply side of how health and social care work together, but on the demand side, in terms of working with the public on the options that are available: using services differently,

encouraging people to have regard to their own self-care and self-management, and supporting preventive services. There are other things that we are doing. The evidence that ADASS would bring forward is from all our budget surveys, our surveys of members and our knowledge of what we have already been doing, and also the limitations on what is left for us to do to continue to save money. That is why we believe it is a wider subject that requires addressing.

Q12 Mr Jackson: Is there a tension between acute care and adult social care in local authorities? Obviously, in delivering services that have been commissioned by a clinical commissioning group, there is a capitation issue, because it is per-capita funding. In a sense, some acute hospitals are not that worried if they cannot keep people in hospital, because when they are at the margins of deficits, as is my local hospital, that few hundred thousand or million pounds is quite important, whereas local authorities do not want people discharged too quickly because they take full responsibility in the same way. Is there something that needs to be done to reconcile that?

Sandie Keene: There are some inherent tensions in the different funding models of the health service and the local authority. I believe that through the pioneer programme and through Monitor, there are different ways of looking at the financial flows in the health service. I think you are quite right that some of the incentives are not necessarily where we would want them to be, in terms of helping people to achieve outcomes for people to live in their own homes. As far as social care and the acute sector are concerned, we have worked as closely as we can together for a long time. The track record of social care has been that the percentages for delays for discharges, for example, have gone down from 33% to 27% over the last three or four years. We are working really hard to make sure that we can help, support and sustain the health service with the very acute needs.

The danger and the difficulty for adult social care services, however, is that in concentrating on the people who have serious, profound and intensive needs, some of the care for people with less intense needs is having to be forgone, so some of the care that we might have been able to provide for people who had lower-level needs cannot be prioritised any more.

Q13 Mr Jackson: It could be argued—to play devil's advocate—that the Better Care Fund is a direct transfer of revenue funding from the NHS to local government, and therefore can be used as a mechanism to keep people in local government care, where you can do preventive work, rather than in acute care, which is very expensive, and you may end up having to pick up the pieces of that, anyway.

Sandie Keene: If the money can be transferred to the local authority, it has to be saved first, because it is not new money. It has already been spent in the NHS. I quite agree with you, but the critical thing for the Better Care Fund is that we have to save it before we can spend it.

Q14 Chair: Is there any evidence at the moment that the cutback in resources is having an impact? If not, are you monitoring this for the future? Presumably, it is the preventive work that is going. You are being forced to spend more on people with acute needs, rather than on the preventive work. Are you doing that, and are you tracking that over time to see whether that means your expenditure on acute rises, because you are not catching people early enough?

Sandie Keene: The Audit Office has identified the fact that over time we have been concentrating on those with more intensive needs. We survey our directors every year in relation to the budget survey and the impact on local areas. At the beginning of the last financial year, 32% of our authorities said that the cuts made were impacting on a reduced care service, so 32% of local authorities had actually reduced care for the people in their care.

We also ask about perceptions of the impact on quality of life and quality of care. Fortunately, last year, a fairly low percentage of people thought that there was a negative impact, so only 7% of authorities felt that their budget decisions were having an impact on people's quality of life. What is of more concern is that when we asked them to speculate on what the impact was likely to be in two years' time, that rose to 18% of local authorities, so nearly a fifth of local authorities believed that the measures they were having to take were likely to have an impact on the quality of life of their residents.

Q15 Chair: Steve wants to come in, but I am conscious of the fact that we have not asked Emily to speak yet. Emily, what is your perspective?

Emily Holzhausen: Thank you. I will keep it brief. As my colleagues have said, there are some really good aspects of the Care Bill—hopefully, soon to be the Care Act—in terms of aspirations, well-being and what can be achieved, but as my colleagues and the NAO Report clearly set out, we are not squaring the circle as far as the demographics and the money going into the system are concerned. For the families that my organisation, Carers UK, represents, we are seeing the demographics going up. We are seeing assessments and the number of people provided with care going down, and we have a gap in between. What we are seeing in between is the numbers of carers who provide the heavier end of care—between 20 and 50 hours' care—going up. That is a rise of about 35%, which is of concern.

Chair: A 35% rise over what period?

Emily Holzhausen: Over the last 10 years. What is of concern is the impact of that. At 20 hours, if you are juggling work and care, that starts to bite on your ability to work. There are costs for health at work—for occupational health and for productivity at work—and we have started to measure those with some of the employers. At 50 hours, it becomes significant. You are twice as likely to be suffering ill health yourself—mental ill health and depression, as well as physical ill health—and you are significantly less likely to be in work. About 2.2 million people have given up work to care.

Q16 Chair: Two million have given work to care—over what period, again?

Emily Holzhausen: That was a YouGov poll, so it was not measured over a particular period. We don't know annual rates of giving up work to care.

I wanted to make a wider economic point, because it is easy to say, "Shouldn't families do more?" They are already doing an enormous amount, and this has a big impact in families, often very privately. We asked families what was happening to them, and they feel quite negative about the future. Some 52% of people expected their quality of life to be worse in the forthcoming year, 42% expected it to stay the same, and 6% expected it to get better.

I also want to pay tribute to the work that the NAO has done on the impact of welfare reform and seeing this in tandem with the implementation of the Care Bill or Act. Some of the changes will be—and indeed are already—very problematic for families. They will have an impact on social care budgets, particularly where you have people who have disabilities who have to be moved because of single room subsidies and their caring relationships all fall down as a result.

My point is, first, about economics and the wider economic impact—the receipts that the Treasury will not be receiving from additional tax and national insurance, or the additional costs being paid out in benefits. But secondly, it is that quite often, caring for a loved one is a private matter. These things are going on in families quite privately, but the level of care that families are bearing is of public concern. We need a solution and we need a solution fast. It would be a great shame if all the positive things in the Care Bill were not brought to bear for families and the people whom they care for simply because there is insufficient funding in the system.

Chair: Thank you. Steve, then Stewart.

Q17 Stephen Barclay: Ms Abrahams, you mentioned that there were pockets of innovation and good practice. Could you describe the best of those?

Caroline Abrahams: You might have seen in the newspapers and so forth reports about 15-minute care and things like that. We know, because of the factors that Sandie was talking about such as prices being driven down, that the living standards of people who provide front-line care are pretty poor. Often they are employed by private sector organisations, and they are not always paid for their transport costs. So they are essentially subsidising that. They are only paid for the time they are with people, so they might be trying to look after five or six people during the day and moving from one to the other. What we hear is very often that the individuals who are doing that are subsidising the money themselves. They are not making very much money out of it. They do absolutely everything they can within the time they have to provide the care that people need. That is one example, so in a sense the front-line staff who provide care are just as much victims of the underfunding as everybody else.

Q18 Stephen Barclay: But that is not best practice, surely, that they are having to subsidise?

Caroline Abrahams: No, but what I am saying is that in a way, I am surprised that the practice is as good as it is under the really difficult circumstances that people are working in.

Q19 Stephen Barclay: Sure. There are various pioneering projects that are going on, and I am trying to understand the variance in delivery, whether there are any areas performing better, for behavioural or other reasons, and whether we could socialise that innovation more elsewhere.

Caroline Abrahams: As the NAO Report points out, different local authority areas are in different places in the development of their policy and practice. This is definitely Sandie's business rather than mine, but they face different demographic challenges depending on, for example, how many older people there are. Or just a handful of very young, severely disabled adults can have a big impact on the budget because of the amount of care they need, so it is difficult to generalise from one area to another.

There are schemes such as those that my organisation runs which are about trying to form a team around an older person, and act as a broker and integrate care around them. But, at its heart, what social care is for many older people in particular is knowing that there is somebody who will be coming in in the morning to help you get out of bed, to help get your meals, to help you get dressed and who will come back again at lunchtime, or will then put you to bed in the evening, because you can't manage those things on your own. That is not really about innovation. That is a pretty simple thing, but it needs to be done consistently and well. That is the difficulty. There are people who struggle with very basic, ordinary things to do with daily living who at the moment cannot access the state care system because they are deemed not to have sufficient eligibility. They have been squeezed out because of the lack of funds.

Q20 Stephen Barclay: Would you be tracking, for example, whether people go into a house and someone else then goes into the same house that day for other things? Have you looked at the extent to which we can cut some of the travel out if one person going in carried out more functions in that household rather than sending in multiple people during the day?

Caroline Abrahams: It is true that sometimes very frail older people in particular might experience a number of people coming in during the day. But typically they will be different professionals doing different jobs, so some will be health professionals, for example.

Q21 Stephen Barclay: What I am trying to drive at is that, if you paid the person going in more and skilled them up more, there may be a saving. In a rural area in particular, travel is expensive and very time-consuming. Has an assessment been made—looking at what the cost would be from reduced turnover or paying them slightly more—of one person doing more in each household, but reducing the number of people going in and the travel times?

Caroline Abrahams: I don't know the answer to that, but we are talking at the moment about different sorts of professional groups. The social care work force is barely regarded as a professional work force, unfortunately. I am sure you are right that, if they received better training, they could do more. We know, for example, that there is much more evidence now that loneliness is a real health issue for older people and predisposes them to quite serious illness and admission to hospital. Because care staff on the front line are having to move around so fast, they are not able to provide that kind of companionship which, if you did a cost benefit analysis, you might find would pay back. That is emergent thinking at the moment.

Chair: Okay, Stewart, Fiona, Nick, then I am going to try to draw the session to a close and move on.

Q22 Mr Jackson: I think Mr Barclay makes a very good point. Duplication is something that we as constituency MPs are occasionally made aware of. If you had one or two people looking after elderly, frail people and co-ordinating all the agencies, that would be best practice.

I would like to ask one or two things very briefly. First, the absolute number of carers has risen significantly in the last five or six years. Informal carers now stand at 354,000, from 387,000. There has been a very significant spike in the last 10 years of young carers aged between five and 17. What is your view on how we support young carers and assist them as much as possible? Also, what are we doing about respite care? Again, Members of Parliament come across that as a very important issue for informal adult carers and for children who have huge burdens on their shoulders when they have to go to school and have an education.

I have two more very quick points. On the living wage in the care sector, how do you square that circle if you eventually move to the living wage, which might happen? How would that have an impact? The final point is a bit more long-term. Are the Government doing enough to facilitate the development of extra care facilities, for example, very sheltered housing for elderly people who would otherwise be under the auspices of acute care? I know they are different issues—

Chair: Let us bring Emily in first.

Emily Holzhausen: With young carers, we have had a lovely bit of co-ordinated legislation across two Government Departments and more, which is a joy to see. We have new provisions in the Care Bill which potentially give the leverage for extra services for parents who have disabilities to make sure that children are not taking on inappropriate responsibilities. Then we have the rights for young carers themselves, which are embedded in the Children and Families Act, and the responsibility for different departments within local authorities to work together and take a whole family approach.

The framework is there, which is excellent and a really good step forward. Of course, there is the issue of the overall funding envelope, which is the subject of discussion today, which is of concern. I would say that the rise that we are seeing is probably partly due to some of the funding issues that we are talking about and partly due to young carers getting more prominence, so people are recognising the issue more. Those statistics come from the

census, so it is a robust form of looking at numbers as well as some slightly different economic research that is being done.

On the subject of respite care, because I know that is something that you all get as MPs in your correspondence, and it is of huge importance, I want to broaden it out a bit to talk about breaks, really, because it is different for everybody. The amount of funding that will go into breaks, through the Better Care Fund—Sandie may have something to say about this—will go up to £130 million. The issue is whether it reaches people. Before, it has been a transfer from health to social care, and not all of that funding has come across. It varies between nothing, or 10%, to nigh on 100%, depending on relationships. At the end of the day, it is all public funding.

A number of different creative schemes have been used to utilise that funding, but we still come across examples. I was going to supply the Committee afterwards with a few personal stories, if I may, about some of the cuts that families have experienced. Families are still talking about having cuts to the breaks that they are getting, such as to overnight care. So people are not getting a full night's sleep at all when they are caring for a severely disabled person. Things like day care, which is sometimes seen as a really important break, are also being cut back on. There are some positives in that, some transfer issues, part of which is about relationships, but the overall funding envelope definitely remains an issue.

Chair: Sandie, can you keep it quite tight?

Sandie Keene: Duplication is at the heart of the Better Care Fund work; responsibilities for a lead professional, new multi-agency assessment processes and using time more effectively are absolutely at the heart of where we want to go. So that message is well heard and implemented.

The living wage is a major issue depending on which part of the country you are in. The payment for care, not surprisingly, is less in the north-east, the north-west and Yorkshire and Humber. So the cost of moving to a living wage in those areas will be significantly more than in other areas of the country, and that will need to be accommodated and considered.

Q23 Chair: Hang on. The Report talks about nearly a quarter of a million being paid below the national minimum wage. We haven't even got there yet.

Sandie Keene: Yes, but in terms of the total amount per hour that local authorities are paying, there is a north-south divide in terms of the unit cost per hour.

Q24 Chair: How come you—not you personally, but local authorities—are paying people below the living wage? The NAO found that it was 220,000, to be absolutely right.

Mr Jackson: What would you pay someone in Leeds as a care assistant on an hourly rate?

Sandie Keene: In terms of us as a provider of services, I don't know the exact amount—

Q25 Chair: You know what you pay to the private sector.

Sandie Keene: We pay the private sector £13 an hour.

Chair: £13 an hour?

Sandie Keene: Yes.

Mr Bacon: That is what you pay to them?

Sandie Keene: Yes.

Q26 Chair: And what do they get paid? Why does that come down?

Sandie Keene: We have done a survey with our providers—

Chair: Goodness.

Sandie Keene —particularly in relation to the national attention to minimum wage. We have discussed it with our providers. Some of our providers pay living wage, and some of them pay minimum wage.

Q27 Chair: And some pay under the minimum wage?

Sandie Keene: We are not aware of any providers in Leeds who pay below minimum wage, having discussed it with all of our providers. It depends so much on what the on-costs are that people pay, what their back-office costs are—

Q28 Mr Bacon: Can I just be clear? When you say you pay £13 an hour, that is to the provider. The provider then takes that money and pays the carer a wage by the hour, which will be £5 or £6, or whatever it is. So they are keeping £6 or £7 each hour. That is right, isn't it?

Sandie Keene: Depending on what they pay their carers and depending on whether they have weekend hours or other hours.

Q29 Mr Bacon: Let us say there were 30 hours in a week. Then for one employee of that provider—let us take the example of £6 being lopped off—you are looking at £180 lopped off for, as it were, the administration for that one employee per week. That is right, isn't it, if you take the example of 30 hours?

Sandie Keene: If you follow that argument, yes.

Mr Bacon: It's not a case of following that argument, it's a case of just doing the arithmetic. I want to be clear that we are talking about the same thing.

Sandie Keene: We are talking about the same thing.

Q30 Mr Bacon: So in four weeks, it would be £720 that they are lopping off for each employee.

Sandie Keene: Yes. The UKHCA—

Q31 Mr Bacon: Why haven't you negotiated a discount?

Sandie Keene: Because the UKHCA reckons that with the costs of training—

Q32 Chair: UKHCA?

Sandie Keene: Sorry, the United Kingdom Homecare Association, which represents providers of care. We are talking about a number of factors: travel time, training, equipment—

Chair: Training?

Q33 Mr Bacon: You are not paying them for travel time, in many cases.

Sandie Keene: But that is not in every case. I think the UKHCA figure is that £15.61 per hour would be required to give a good home care service. Clearly within the local authorities up and down this country, there is a variety of costs that are paid and a variety of wage economies in terms of the north and south. We are under serious pressure from the providers that we do not pay enough for them to be able to—

Q34 Chair: Do you know what their profit margin is? Have you got an open account so you know what their profit margin is?

Sandie Keene: Every one is different.

Q35 Chair: I know, so do you know what they all are?

Sandie Keene: What the model for the UKHCA recommends is 30%—

Q36 Chair: Do you know yours? The ones you are responsible for in Leeds?

Sandie Keene: I personally do not know every instance.

Q37 Chair: Does your department know, do your people know the profit margin?

Sandie Keene: Not in every instance, no. What we are currently—

Q38 Mr Bacon: Do you know the profit margin in any examples?

Sandie Keene: We know the profit margin in our care home sector, because we have done a piece of work with them as to the true cost of care. What we are doing now is with an open-book accounting process.

Q39 Mr Bacon: What about the carers who are peripatetic—not the care homes, the domiciliary carers?

Sandie Keene: These are the ones that I am saying I don't know the examples.

Q40 Mr Bacon: You don't know the profit margin at all?

Sandie Keene: What we are currently doing—

Mr Bacon: Sorry, can I just be clear? You are saying you don't know the profit margins of your supplier.

Sandie Keene: What I am saying is that at this moment in time we are in discussion with them about establishing a true and fair cost of care.

Q41 Mr Bacon: You don't know it already?

Sandie Keene: They don't have to tell us.

Q42 Mr Bacon: Of course they don't have to, but then you don't have to buy their services. This is extraordinary—it is £15.61. If we take our putative carer who is getting £6 an hour, that leaves £9.61 on every single hour that is going to the provider. Multiply that by 30 hours and 52 weeks and you get £14,991 that is coming from you to the provider and is not going to the carer who is providing the petrol themselves out of their own money. Whatever is coming out of that £14,991, it sounds like it is often not petrol. What is it all going on?

Sandie Keene: The fact of the matter is that not all carers get a blanket amount for every part of their working day.

Q43 Mr Bacon: Ms Keene, if I could just be clear and stick to the question, I am not talking about what the carers are getting. I am talking about what the carers are not getting. You have just given a putative example of one carer, £6 an hour, 30 hours a week, which sounds plausible. I am talking about the £14,991 in a 52-week year that is not going to them. What is happening to that? Can you tell us?

Sandie Keene: What the providers would say and what I would say is that it is going on running their business, their management, managing their work force—

Q44 Mr Bacon: What percentage goes on training? What percentage goes on administration? What percentage goes on fuel for managers? Do you know the breakdown?

Sandie Keene: I can forward to you the UKHCA report—I do not have it with me at this moment in time.

Q45 Mr Jackson: It might be helpful if we asked the NAO to draw out the comments it made in the Report, which I think were that, generally speaking, the market was as competitive as could be expected. Perhaps it might want to make further reference to that.

Aileen Murphie: It is a very fragmented market, with lots of small providers everywhere, which does not help in terms of economies of scale and that kind of thing. In terms of what people are being paid, paragraph 2.20 of the Report says that up to an estimated 220,000 people are being paid less than the minimum wage and the median pay was £7.90. So out of the £13 or whatever, they are getting £7.90. The rest will be going on NI, tax, profit, admin.

Chair: I shouldn't think there's much tax there.

I am going to speed this up a bit. Let's go Fiona and then Nick, and then Amyas wanted to come in.

Amyas Morse: No, it's okay—what I was going to talk about has been covered.

Chair: Okay. Fiona, Nick, then we are going to move to the main session, because we have a vote coming.

Q46 Fiona Mactaggart: One of the things the Report says is that personal budget holders found that the system of personal budgets gave quality in terms of the care that they had. An issue has been raised with me in relation to a constituent who had a successful award of continuing care funding. Her daughter, who is her main carer and has power of attorney, was kept completely in the dark and continues to be kept in the dark about why various provisions are deemed not suitable. Is it usual for carers to be excluded from some of these decisions and what do you believe is the consequence of excluding them?

Emily Holzhausen: The consequence of excluding people is quite straightforward. If you are looking after somebody 24 hours a day, seven days a week and you know that person

personally, there is a false economy, isn't there? We train nurses and doctors to be experts and that is what families become. Quite often, families know the person best and they know the condition best, so it is a false economy to do so, especially if they have power of attorney and they act in the best interests; there are legal provisions around that. We found that practice is variable about what is deemed unsuitable. There are times when some practice is really prescriptive about what you can buy and who you can buy from in terms of direct payments. That is not the intention of guidance; it is supposed to be much more open than that. Some authorities are quite keen on having a very, very clear audit trail—every last receipt, every accounting process.

What is interesting with the families we have looked at is that on the whole, 65% feel that it is a better service through a direct payment to the family, but that still leaves a large chunk who say, "The same" or "Worse". We have seen a slight drop of a percentage in how good people find them. That is about the increased administration that families have to take on as a result. The other issue is the flat rate. The local authority is purchasing at the same rate and that rate is passed on to the family, but the family cannot buy that on the open market, so either you drop the level of care that you are able to purchase or you have to subsidise. Again, I have examples of where people have gone both ways and made those decisions. Going forward, we would like to see a few changes around that policy. We will be recommending that to Government.

Q47 Nick Smith: I have a constituent, a young man, who hurt himself in a rugby match last year. He is now disabled from the neck down. He has had a terrible problem getting his new life together. I have a multi-agency meeting to talk to a variety of people this coming Friday. A caseworker originally wrote to five people saying, "This looks terrible. Why aren't you pulling your act together?" It now looks as though there are going to be 17 people at this multi-agency team meeting on Friday for me to go through my constituent's problems and work out whether there is some sort of fresh-start action plan for him.

Miss Keene, you talked about the need for lead professionals and that being somewhere you wanted to go. Because 17 people are going to be there, it is obviously very complex and it is going to be expensive, but the effect on this young man's family—him and his wife—has been terrible since he had the accident. What can be done so that some sort of baton holder can take responsibility for helping this couple build a new life? It is a really bad example, but I would not be surprised if it occurs all over. What would you do to improve things for that young man and others?

Sandie Keene: Simply a lead professional—somebody who holds the baton, as you say. Within the Better Care Fund and the legislation, GPs are being encouraged to take that role to be able to co-ordinate the care arrangements. For someone who has had a sudden—

Q48 Nick Smith: Can I interrupt? It is a really difficult thing to ask the GP—to pull together the Department for Work and Pensions, housing, the council and a range of service providers. You are lucky if you can get 15 minutes with your GP. Expecting a GP to do that sort of networking and co-ordination feels like a big ask.

Sandie Keene: I agree with you, but we must ensure it is done so that whoever takes the lead can account and report to the GP for their health needs. In terms of the other elements of how life fits together, clearly local authorities, through the social care services, and the health services need to work together. But as you say, a range of different professionals come in with different accountabilities. If there was a way of being able to accommodate those resources together and work across Government or across Departments, that would be helpful, but at the moment those opportunities do not exist.

Q49 Meg Hillier: I have been in the position of doing that co-ordination, and I know it was hard work, but there was no one else to do it. There is no one in the care system—no social worker—who will jump in and do that level of co-ordination. If there are 17 care providers—in my case, I was dealing with 13, including the podiatrist and all the rest—it would not be beyond the wit of the system to name one person in each group to lead for the individual, and spread it around. Surely that is possible, and it doesn't require a lot of Government action. With respect to people, I recognise the challenges. Everyone wants the Government to do something about this, but a lot of it is down to the professionalism of the staff on the front line, the agencies that manage them and the authorities that commission them.

Sandie Keene: Forgive me, I thought I had said that. There is someone who is accountable for somebody's care needs, and the new legislation determines it to be the GP. It is not for the GP to do it, but they must be sure who will do it. It can be whoever is the most appropriate lead professional within the organisation.

Q50 Meg Hillier: Practically, how will the GP monitor that that happens? Say among the group in Mr Smith's case there is an occupational therapist who becomes the lead for whatever reason. What purchase does the GP have over the OT? Nothing. They do not have any line management responsibility or contractual responsibility.

Sandie Keene: No part of the system has responsibility over other parts. That is why your point about how we co-operate and work together is the most important thing.

Q51 Chair: Right. I think we're looking at a troubled families initiative here.

Caroline Abrahams: I was just going to say that Age UK is trialling an integrated care pathway to do that for older people. We are doing it in Cornwall—it won a health award last year—and we want to replicate it across the country. We work alongside the GP, who remains clinically accountable, but an Age UK member of staff acts as a broker and draws together people from the statutory sector. Because we are talking about frail, older people, often what they want is not just medical help and social care but companionship or something fixed in the house, so we sort all that out. We find that that is a good way to work with the grain of it. So far, £1 saves £4.14. We want to use a social impact model to make it work. There are variations on the theme across the country, but ours is one of the most developed.

Chair: Why don't you write to us about that? I am going to close it now. Can any of you provide us with any information on whether you have the cost base of your contracts with domiciliary care?

Mr Jackson: They could write about the extra care facilities.

Chair: And the extra care facilities, which nobody talked about. Okay, we have overrun. We are going to have a vote, but let's do the changeover. I hope that my members will be five minutes in the vote, otherwise we will be here all night. Thank you very much indeed. That was very helpful.

Examination of Witnesses

Witnesses: **Sir Bob Kerslake**, Permanent Secretary, Department for Communities and Local Government, **Helen Edwards**, Deputy Permanent Secretary and Director General for Localism, DCLG, and **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health, gave evidence.

Q52 Chair: I am going to start with paragraph 3 in the summary of the Report, where it says "The government wants to continue reducing public spending while maintaining spending on care and support, and improving outcomes for adults, as need for care rises." That is the policy. Is it deliverable?

Sir Bob Kerslake: I think it is deliverable, but it is very challenging. That is what I would say, Chair; and we do not yet know the full way in which you need to achieve it.

Q53 Chair: What indications have you had that it is moving in the right direction? I do not want to bore people; we had a report this morning from Nuffield. We have had endless reading from Age UK and everybody, demonstrating an inevitable reduction in the number of services and probably in the cost of those services. I am sure we will come back to private providers. So what makes you think, in that context, that you can sit here and tell us you can deliver this in the time frame that the Government has set?

Sir Bob Kerslake: As I said, I think it is challenging but deliverable, for these reasons: first of all, I think what we find when we look across authorities is there is a huge variation in how much things cost, actually, per unit of delivery, whether that is in the community or residential care; and not all of that can be explained by local circumstances. So I think there is still some work that can be done to strengthen commissioning, to get a more consistent approach to getting best value through the commissioning process. So that is one thing.

I think the second thing I would pick out is—and I would emphasise this is far from a proven position yet—there are some really good examples up and down the country of people innovating and doing things differently to improve the experience for the user of the service, or the receiver of the service, and reduce the cost. A lot of work was done through the pilots

that we had—the community budget pilots last year—that showed that the system, with everybody's best intent, is still quite fragmented, and people experience what we heard earlier, with lack of clarity on who is taking responsibility for somebody in the round.

The lead professional model is being piloted in a number of places as we speak. I heard today of Cheshire West and Chester, where they are following a model of a lead professional. There is early evidence—I would say it is early and we are not there completely—that it is making a difference, and pointing to the way in which you can make the system both more effective and more efficient. I will stop there, because I think you have now got a vote.

Chair: I will come back to you on that because there is a challenge with your localism agenda. You might think about that. If some local authorities' costs are higher, how can you, with your usual mantra, tell us that you are going to get them down?

Sitting suspended for a Division in the House.

On resuming—

Q54 Chair: Let's go. We will stick with this theme, then I will bring in Stewart. Sir Bob, you said to us that it is challenging, but deliverable. I would come back to you on two things. First, you said "If everyone gets to the best," but your policy, particularly in DCLG, is not to interfere and to tell local authorities what to do, so I do not know how you can square that circle. Second is the time frame really, because it is yet another of these areas in which there will be no quarrel with the intent of the Act; the danger is that you will raise expectations among a whole lot of carers and individuals about their rights, and you simply cannot deliver. I think that that is what this Committee would want to avoid: we are not trying to intervene about the policy, but the deliverability. It is localism, timetable and an honest view of whether, when we get to 2015 or 2016, you will be able to deliver in that time frame.

Sir Bob Kerslake: I will go through all those points, and I am keen to bring in Helen and Jon on this, in particular to flesh out the points about variability in costs and efficiency across the country. On your first point, about localism, we are doing quite a lot here to shape or nudge—call it what you want—local authorities towards improving the way that they do things and, more particularly, the whole health and care system in places.

I mentioned the community budget pilots earlier; they told us a lot about what needed to change. For example, the tri-borough authorities did an interesting piece of work about the experience of users in the health and care system, which told us a lot about what we needed to change. I would say it has proved the concept and told us that if we change the way things work, there is potential to save money and improve quality.

The second thing that we are doing is a lot of work on sectoral improvement, which we have sought to do through the Local Government Association. That is one of the things that funding goes into the LGA to do—to work with the sector to peer review and peer challenge to improve the quality of operations. The third thing is the Better Care Fund itself,

which I see as a catalytic fund. It has clearly been set up to put in new money in return for local places changing the way in which they run things.

Q55 Chair: What new money? It is not new money, let's all accept that. It is a redirecting of resources.

Sir Bob Kerslake: I will rephrase that. It is pooled money across the health and care system, but it is new money towards the agenda of integration. That might be a better way of putting it. It is a way of catalysing change in places, and I think that that is very powerful.

The last bit of it is that, as you yourself have said, the financial imperatives on local authorities are very considerable, so the driver to change is very strong indeed. Jon and Helen will speak for themselves, but I do not pick up, up and down the country, any lack of will or intent to transform. The task is to help them to do it.

On your last point, about timetable, we have set some time scales for the delivery of the Better Care Fund, which starts from 1 April 2015, but I am not expecting that every part of the country will have transformed its system by April 2015. What we would want to see is measurable progress in the direction that we have set. That is why we are putting £1 billion into, in effect, an incentive scheme to make changes. So this is not going to happen overnight. I would hope that we will accelerate the process through the Better Care Fund—that is critical—but I suspect that this will be a process of change that will go on for a number of years.

Q56 Chair: May we have a reality check on this? I am sorry about this, Sir Bob, but according to the stuff that Nuffield put out today, which I assume you have seen, a quarter of a million fewer older people received publicly funded community services in financial year 2012-13 compared with 2009-10; that is a 26% drop. Home and day care spending by councils fell by 23% over the same period. The number of older people receiving home-delivered meals has more than halved since 2009-10, falling by 59%. Around 42% of people received lower intensity care over the same period, with the focus on people with greater need. Transfers of money from the NHS to adult social care have more than doubled since 2009-10. This suggests that cuts in social care services could have been even more drastic. This is the reality check. Of course we need change, and we will come on to how you can encourage that and work on that, but I want a real reality check about what is deliverable, given the financial imperative that will be there whatever happens in 2015.

Sir Bob Kerslake: I think we are very clear about what the reality is on the ground. All three of us go out regularly to talk to local authorities about the issues they are facing. I cannot validate the Nuffield figures; they came out today.

Q57 Chair: You can rely on Nuffield. They are not a leftie think-tank.

Sir Bob Kerslake: I am not making any comment about the accuracy or otherwise. I am just saying, as you would say, that it is not possible to validate late data. My point is that

we will use the data in the NAO Report, which show a real-terms reduction of 8% over three years. We recognise that that is what has happened. We also recognise that there has been a reduction in what might be called the lower end of care over the period. In fact, it has gone on for a decade now. We are not unaware of these challenges to the system.

What we can say is that, as the Report says, there has been an improvement on delayed discharge, and we know that satisfaction levels with the service are high. So there are some positives here against some very challenging figures as well. We believe that with the right actions and the right leadership, it is possible to transform health and care services to improve outcomes with the funding that is available

Jon Rouse: I will start with the issue of variability. First, local government have done tremendously well in this area over the last few years in terms of driving efficiency. That is widely recognised. Clearly, their ability to stay within their means over the next few years while still providing a reasonable quality service is dependent on their finding further efficiencies. We took their assumption for 2015-16, which was that they could find another 3% in that year. The reason why we have some optimism that, at least through to 2015-16, they can continue to find that level of efficiencies is the degree of variation in their costs at the moment.

Q58 Chair: They don't understand their costs. I bet you don't, either. I don't think anybody understands their costs. That is what we established in the pre-hearing.

Jon Rouse: Let me talk about the variability first and then the structure of the costs. In terms of variability, there are two ways you can look at this, and both are helpful. First, you take the cost per older adult—the cost of providing older adult services against the older population; it is a straight ratio, and you take out other externalities that might explain difference. Then you put authorities into their statistically similar groups—authorities that have similar characteristics. I will give you a few examples.

Bristol spends, we calculate, £1,604 per head of older population. That is £150 a head more than any of its statistical neighbours. Bristol scores very well on outcomes, and we should recognise that, and they do tremendous work on carers, but that is a big differential. In another example, Warrington spends £1,232 a head, which is £100 a head more than any of its statistical neighbours. There are outliers in each group and a number of authorities that are well above the median in terms of costs. We need to really get underneath that and understand what those differences are, and through mechanisms that we have with ADASS and LGA we need to try and support those authorities to see if there are ways of reducing their costs structure.

You mentioned the unit costs in domiciliary care, and it might be worth highlighting the variation there. The costs in each authority varied from around £10 per hour up to above £20 an hour. Again, even if you take statistically similar authorities, such as Gloucestershire and Dorset, there is as much as £7 or £8 a head difference in terms of what those authorities are paying. There is a number of things we can do. One is transparency—just hold up a mirror and say, "What's going on?"

Q59 Mr Bacon: Sorry, £7 to £8 an hour difference?

Jon Rouse: Yes. Some of that might be explained by different case loads or different levels of complexity, but across a whole county you would not expect it to be that different.

So there is transparency, and then I think it is about providing support, help and assistance and working through how you can transfer best practice from one area into another area. Of course, you can pay too low. There will come a threshold—it will be different in different localities—where it does start to impact on the quality of care.

Q60 Chair: Well it is already, isn't it? One of the pretty shocking statistics in the Report is that up to 220,000 domiciliary staff are being paid below minimum wage.

Sir Bob Kerslake: I think we should just be clear on this minimum wage point. It is unacceptable for providers to pay below minimum wage. It is against the law. If local authorities find that this is the case, they should challenge them and ask whether they should still be providers for them. They should certainly be referred to HMRC. This is absolutely clear-cut.

Q61 Chair: It depends how you define it, doesn't it? I know somebody who does this work. This person works in London and they get paid only for the quarter of an hour that they are with the elderly. They do not have a car so they travel by bus. It takes half an hour to get from client A to client B, for which they do not get paid. It seems to me that that is outrageous. They are on minimum wage. It is outrageous.

Sir Bob Kerslake: We agree with you. It should be tackled. I think it is worth talking about the efficiency issue as well.

Helen Edwards: To add to the point about whether there are resources in the system that could be used more effectively, the whole point of the integration argument is that we know that resources are not used effectively at the moment. People tend to be passed from pillar to post; they see different professionals. It does not work for them and it certainly does not represent good value for money.

The other thing we see, and I think it was a figure in the Report, is that about 20% of emergency admissions to hospital could and should be avoided because people are getting treatment and care that they could get in the community. This goes to the point about timing as well. Trying to integrate services is not new for health and local authorities; the best have been at this for some time. In the areas where they have been working at this, we have begun to see some falls in emergency admissions. I am thinking of the West London Alliance, the group of six local authorities, which have seen quite a significant drop. In Wigan, they have seen a drop, and in Tameside, too. If you join things up better, are able to look at different models of care, try to get upstream of the problem and look at how you can prevent people coming into the acute system and allow people to live independently for longer, there are savings to be had. As Sir Bob said, the objective of the Better Care Fund is to accelerate the work that is already going on, to give it real impetus and to see if we can reap more efficiencies and savings as well as preserve services.

Q62 Chair: The problem with that argument is that I was around when the same argument was used when we introduced community care. It was going to save a whole load of money. It was going to be absolutely wonderful, but actually, it never saved a penny. What you are fighting against here is the demography as well. You have a mix. First, you have a theology that tells you, integrate it and you will save money—let's wait and see if that translates into actual practice. Secondly, the demography is against you. All my experience from the community care experiment in the '80s is that it never actually saved money. We ought to learn from those things.

Helen Edwards: We should learn the lessons of that.

Q63 Mr Jackson: Do you think that there is an element of moral hazard in the bias against self-funders? The Report says self-funders were spending £10 billion a year in 2010-11, the last year for which data have been collected. They do not have the capacity to block book and deliver economies of scale in the same way that local authorities and other commissioners do. Are they effectively subsidising those who are under the auspices of local authorities? There is a bit of moral hazard there, because they have the money built up. Local authorities generally have not built up any money. Therefore, how do you get that balance right?

Sir Bob Kerslake: This is referred to in the NAO Report. It is a valid issue to raise. The Care Bill will certainly help with this. Jon, do you want to say a bit more about that?

Jon Rouse: It is a really pertinent question. The first thing to say is that we don't know whether cross-subsidy is going on at present, and if there is, how much. It may be, and it is likely, that to a certain extent some self-funders are paying a quality premium as well, in terms of a better quality of product.

Q64 Chair: Let's ask the NAO. Why did you put it in?

Aileen Murphie: Because a significant amount of care is being bought with that £10 billion.

Q65 Chair: But why did you put in the assertion that there appears to be cross-subsidy?

Aileen Murphie: Because that is what it looks like.

Q66 Mr Jackson: You cannot prove that it does not happen.

Aileen Murphie: Providers told us that. We had evidence for it, that is why we put it in.

Amyas Morse: You have positive statements from providers that in some cases at least they are cross-subsidising.

Q67 Chair: Either there is evidence or there is not evidence. That is what I am driving at.

Jon Rouse: How shall we put this? There is anecdotal evidence in that providers say that. When I speak to directors of adult social services, some say there is and some say there is not. In some ways it comes back to the question Mr Bacon asked earlier about really understanding as a local authority what is your true cost of care and are you paying it—not too much and not too little.

There may or may not be some cross-subsidy within the system, but the good thing is that the Care Bill will make that much more transparent, because each self-funder will come into a relationship, if they wish to, with the care system, in terms of opening a care account and starting to progress towards their cap. If they want to, they can ask the local authority to organise the care on their behalf, which potentially could bring them into the local authority's pricing mechanism. That should really begin to expose whether cross-subsidy is going on. We would expect to see some level of market response if there is.

Amyas Morse: Thinking about it from a business point of view just for a second, let's visualise ourselves as one of these homes. You have x number of beds and you are getting your guaranteed volume by doing stuff that is local authority funded. You fill up on that and know that it is at a controlled price; then you fill up on private self-funders at a higher price. Is it not inevitable, looking at your accounts, however you describe it, that there is going to be cross-subsidy, because you have a set of accounts for the business that contain the two sources of income and they are not kept segregated? It cannot be a realistic proposition to say that there is no cross-subsidy.

Sir Bob Kerslake: Let's be clear about what Jon said. He did not say that there is no possibility that this is happening. What he is saying is that we do not have good data that tell us the extent of it or the nature of it. The truth is that the market for those who are self-funding is more competitive in some parts of the country than in others, so people will very quickly get to know what the charges are and make decisions. We want maximum transparency so that they do not have to work hard to find those figures.

Amyas Morse: I totally agree with that. Forgive me Chair, I have one more point. In the absence of good data, which, after all, is pretty pervasive in a lot of the areas we are talking about, would you not think it right to make a prudent, mid-range assumption rather than an optimistic one of whatever proposition you are arguing?

Jon Rouse: I think it comes back to what Mr Bacon was arguing earlier, which is the importance of local authorities themselves understanding what the true cost of care is and negotiating on that basis, including a reasonable profit margin.

Q68 Mr Jackson: That is my next question. Although the report is generally quite positive—our witnesses earlier made reference to this—everyone says that things could be

better: we could reduce duplication or have fewer case conferences where we have 17 people coming along. How do you improve contract management? On the one hand, Sir Bob, you quite laudably say, "Well, we don't want to micromanage what every local authority does," but at the heart of this is the contractor and client relationship. How do you encourage local authorities to improve that in order to keep front-line services at their optimum without using, say, the stick of the Treasury saying, "If you don't do it, we'll cut your funding."? It is a self-fulfilling prophecy.

Sir Bob Kerslake: Two or three points: first, I want to echo what Jon said. I think local government has done a huge amount to manage these financial restraints and done it very well. The NAO Report points to the fact that a significant amount—I think a quarter—of the savings have come through tighter commissioning. I think the ways you can help the sector are the things I spoke about earlier: the work with the LGA, sector improvement, finding the best people and getting them working together on how to improve collectively. Peer review is a very powerful model as well. Jon touched on transparency. The more transparent the information is, the more likely it is that one authority will say, "Well why are we paying more?" At the moment we are not transparent enough. If we can work with the sector to get that data out there—

Q69 Mr Jackson: There are more examples, such as Worcestershire, where the whole portfolio of stakeholders is working together.

Sir Bob Kerslake: On the last point about where I think the drivers for change will come, we touched earlier on the £3.8 billion being pooled. It now has to be, if you like, released by agreement with the health and wellbeing board and the partners working together. Given that the money has come through reductions in the overall money for the NHS, I would expect all the players at local level to be testing whether the money is being used and whether the commissioning good enough. I think it will drive better collaboration at the local level and better commissioning as well.

Q70 Mr Jackson: That is my next question—you keep teeing me up, Sir Bob. We are a great tag team. I do not think I saw anything in the Report about something that is quite dear to my heart: palliative care. That is quite important. It is a separate issue. I just wonder what your thoughts are on that. Obviously that is a very sensitive area and a very cost-intensive area. With the prevalence of cancers, and as people get older and have other neurological conditions, it is becoming very important for local authorities.

Sir Bob Kerslake: You are absolutely right. It is both sensitive and very important. In my experience, they are often quite reliant on money they raise through fundraising.

Jon Rouse: You know the background to this, which is the move away from the Liverpool care pathway. We are into a review of palliative care at the present time. What is interesting about it is that the more we get into it, the more it becomes clear that the same principles of integration that apply in terms of the rest of the Better Care Fund also apply in terms of palliative care. That means putting the individual and their family and their carers at the heart of the decision making and the planning, ensuring that there is a lead professional who co-ordinates what is going to happen, when it happens and how it should happen. One

significant outstanding issue from a social care perspective, which came up prominently during the Care Bill, is around the cost of social care at the end of life and whether it should be means-tested. We have pledged to review that. I think the Government would like to be in a position where that would not be the case but we are just working through the affordability and what that would mean at the present time.

Q71 Chair: But you do not even fund the hospice movement, do you? No public money goes into that.

Mr Jackson: Clinical commissioning groups do, but substantially the funding stream is from the voluntary charitable sector.

Sir Bob Kerslake: My experience is exactly that.

Mr Jackson: Certainly capital.

Sir Bob Kerslake: Yes. A large part of it comes from voluntary donations.

Q72 Mr Jackson: Can I make a capital appeal for the new Sue Ryder hospice in Peterborough?

A number of key points occurred to me. One thing that comes out of the Report, apart from the lack of data collection by some local authorities which is unhelpful, not least to both your Departments, is this question: is anyone actually plotting demographic trends on a regional or local authority level to assist local authorities to draw up strategic plans for dealing with older people in particular, but also younger adults, who are living longer, as we know—20 or 30 years ago they died quite young—and children and young people who are in receipt of this care. That is my first question.

Linked to that, which we did not have time to ask the previous witnesses about, is the question of extra care housing. It is an important aspect of keeping people out of acute care. It is good for them, I would argue, and good for the taxpayer. Are we joining up the dots for tax policy and planning policy and adaptations to try to get more of those facilities built for the growing population? I know that they are big issues, but they are quite important.

Sir Bob Kerslake: I will say a few words about extra care and then colleagues will fill in the detail. On the first point, the health and wellbeing boards are required to produce strategic needs assessments and those will heavily rely on demographic data. Of course, the public health role is being transferred into local authorities—in my experience, that was often where that demographic analysis was. So I think at local level there is a way in which data is collected, analysed and forms the foundation for the health and care plan for the area over time. That is getting well established now.

Your point about extra care is entirely fair. There is a limited amount of funding going into extra care through—

Mr Jackson: The HCA.

Sir Bob Kerslake: The HCA. Whether there is more that we can do to encourage extra care is certainly worth exploring. As you know, it is typically more expensive to provide, but it is growing and it certainly provides a level of care, in my experience, which is very high indeed. I am happy to give you a separate note on what some of the issues are.

Mr Jackson: That would be very helpful. Thank you.

Helen Edwards: On the housing point, in terms of the £3.8 billion pot, a number of local authorities are pooling other funds as well. In some areas, some of their housing funds are coming into that pot. So they are seeing an opportunity to bring other forms of public money to the table to give a more joined-up response. I think Sheffield, significantly, has something like £40 million through the Better Care Fund but is pooling something like £180 million all told. So we hope that this can act as a catalyst to the better joining up of public money on a more ambitious scale than we have seen.

Q73 Mr Jackson: My last question. Reference was made earlier to and we had a discussion about respite care, which is very important, and obviously the Care Bill is an important piece of legislation. How will you monitor the efficacy or otherwise of local authorities' policies for respite care? We discussed young carers earlier, but we also need to think about older carers. As people are living to 85 or 90 these days, they are likely to have children in their 60s and 70s themselves who are potentially unwell, quite stressed and so on. How will you monitor the impact of respite care?

Jon Rouse: In the 2010 spending review, we put the money in for carers' breaks through the NHS: that was £400 million over that period. But we have decided that, for 2015-16, we will put it in the Better Care Fund. That gives us a number of advantages. One is that it means that local areas have to think about how meeting those needs for carers fits with the overall package of care, so it is not just something in isolation. The second is that each of those plans requires ministerial approval. It is quite unusual these days for such a decision to have that level of sign-off, but we deliberately wanted that because of the level of transformation we were expecting, and Ministers agreed to that.

One of the criteria in the guidance we have put out to health and wellbeing boards is that they must be explicit about what the fund will do for carers and carers' breaks. That is one of the things that we will be looking at, and are looking at now, in terms of analysing the draft plans and whether they are going to do what they need to do for carers.

Q74 Chair: Are you signing them off before they spend?

Jon Rouse: There is a decision as to whether that plan is sufficiently robust and meets the conditions that we have set.

Q75 Chair: And if you say no, they cannot spend?

Jon Rouse: If they say no—

Q76 Chair: If you say no, sorry.

Jon Rouse: If Ministers say no, they will effectively go into a remedial process with NHS England and the Local Government Association, with a degree of oversight from ourselves, to put that plan right. Remember, we have got until April 2015 to do that.

Sir Bob Kerslake: That is the key point. We have started early and the plans are essentially being looked at now, so the process allows us to improve the quality over time, well ahead of 1 April 2015.

Q77 Chair: And none of that money can be spent on bin collection?

Helen Edwards: There is quite a lot of conditionality set around this fund.

Q78 Chair: Is it ring-fenced?

Helen Edwards: No, but we have set national conditions and local metrics as well.

Q79 Chair: So what happens? What does that mean? Give us the nitty-gritty.

Helen Edwards: In terms of the plan—the assurance processes—it has got to be signed off locally. We have got to be clear that it is a joint plan, that it will safeguard adult social care, that the acute sector has been involved and that the impact on the acute sector has been looked at. There is an assurance process, then an assessment by NHS England and the LGA, the local authorities. They then send it up to an advisory board that Jon and I chair, where we again try to make sure that the plans are ambitious enough and that they are spending on the right kind of things. Then we recommend to Ministers that they sign off the plans. But of course a good bit of the money has to be earned through payment by results, so there is £1 billion that is conditional on areas making good progress against some of the national conditions, particularly things like unplanned admissions and delayed discharges, so it gets paid in April 2015 and another tranche in October 2015, depending on the progress that has been made. That is quite a lot of oversight. That is the point.

Q80 Chair: Why don't you just ring-fence it? Either it can be spent on bin collection or it can't. Be honest and open, Sir Bob.

Sir Bob Kerslake: I think we are being very honest and open. First of all, if you think about it for a minute, if you ring-fenced this extra money on better care, we are not ring-fencing the substantive part of the money, which is the £17 billion they are spending on the main care programme. It would be a completely fictitious ring fence to ring-fence their share of the £2 billion when you have left the whole sum un-ring-fenced. It is much better, as Helen described, to say, "You will get your share of the £2 billion if we see that you have conscious plans to protect care levels." It is a much more effective way of influencing the money.

Secondly, look at what has actually happened in local authorities. They have seen something like a 29% reduction in real terms on their grant. Their spending power fell by 14% over this period. They have, in relative terms, substantially protected adult care. They have worked incredibly hard to avoid reductions in adult care, so the suggestion that they have willingly moved money out of adult care to other places is just not borne out by the facts.

Q81 Nick Smith: There are three things I want to touch on. Mr Rouse, in Blaenau Gwent in south Wales, there is a very good project trying to stop frail elderly people having falls. It is good preventive work. What evidence do you have that preventive work like that works and reduces an individual's need for care or reduces the costs of that care? It all sounds great and I am really pleased to say that we have more able older people in Blaenau Gwent but I have not really seen the data.

Jon Rouse: It is a really good question. Being honest, we have good data in some areas of preventive intervention but it is not good enough in others. We did a piece of work a couple of years ago through the School for Social Care Research where we did a deep dive into 11 authorities and asked, "What are your main preventive interventions?" They came out with three. By far the most significant was reablement and enablement. It is stopping people having accidents and going into crisis in the first place. If they do get into crisis, it is getting them back into independent living as quickly as we are able to, within their capabilities. The second one was around telecare and telehealth. The third was around what we might call low-level community support, the sorts of things that Sandie does brilliantly in Leeds. Our evidence on the first, reablement, is really good and very positive. The evidence consistently shows that over 50% of people are able to sustain independent living following reablement interventions. Some authorities do even better than that and it definitely saves money. Reablement is very positive, but on the other two areas, I would say that our evidence is pretty weak, if I am being honest. We need to invest in better research in those two areas.

Q82 Nick Smith: Sir Bob Kerslake was talking about cost reductions for local authorities, but some of us remember what happened a few years ago with Southern Cross and other big residential care providers. I am interested in your concerns about the financial sustainability of those private sector care providers, given that local authorities are driving down costs.

Sir Bob Kerslake: Can I quickly deal with Southern Cross? The issues with Southern Cross were not to do with the fee levels they were paying; it was do with the financial structure. They are the only recent case of any major provider that has got into that sort of difficulty and it was entirely to do with how they ran the financial structure of selling the assets and then leasing them back. It is fair to say, Jon, that you monitor the five biggest providers on a regular basis and that more providers have come into the sector than have left.

Q83 Chair: Are any at risk?

Jon Rouse: At the present time, no.

Q84 Meg Hillier: Of the five biggest?

Jon Rouse: Of the five biggest. We also do some more general monitoring of the medium to bigger sides of the market in terms of trying to identify the risks. As you would expect, quite a lot of this work goes on behind closed doors. There was a period after Southern Cross where we did need to get into quite deep dialogue with one or two providers, but it feels, particularly over the past 18 months, that conditions have eased, particularly around debt structure and servicing debt. Obviously, where they own assets, those assets are for the most part going up in value. That does not mean that we are in any way complacent, and we are heading towards 1 April 2015, which is when the Care Quality Commission will take on this responsibility with a proper statutory underpinning, whereby they will be able to require information and data from the top 40 or 50 providers and take early action if necessary.

I want to make one more point. It does all sound quite heavy in terms of market intervention, but our purpose, which will be the same for the CQC, is not in any way to shore up the market. Our interest is safeguarding the individuals in their homes in terms of receiving care and ensuring continuity of provision. That is why we are doing it. It is not about trying to fix or support what is a market sector.

Q85 Nick Smith: And how are you ensuring that the users are getting quality services even though fees are being squeezed? How are you testing that?

Jon Rouse: Partly, it has to be said, on the back of what happened at Mid Staffordshire and Winterbourne View. We have, as you know, completely overhauled the Care Quality Commission and its inspections and ratings process and, again, there is statutory underpinning for that in the Care Bill. The new inspection regime under the new chief inspector, Andrea Sutcliffe, is starting to roll out this summer with a really clear rating system for all providers.

Sir Bob Kerslake: And I think the NAO Report talks about the annual reviews and the findings there about—

Chair: Can I just—

Nick Smith: I have one final question.

Q86 Chair: I am coming back to you. I just have two questions on that issue.

First, I read in the *Health Service Journal* that the CQC—I do not know whether this is true—do not have the skills to deliver their market oversight. Why on earth are we giving it to them if they do not have the skills to do it?

Secondly, what is your failure regime? You are monitoring, but what do you do if you get another—I cannot remember the name. Four Seasons Health Care was one that was at risk when we looked at it.

Jon Rouse: Shall I deal with both of those? In terms of the skills, the *HSJ* is right that the CQC do not have the skills now because they have not needed them, but they have until April 2015 to put those skills in place. I am confident that they will do so, and we are working very closely with them to ensure that that happens.

Why were they the right body? What we felt trumped any other consideration was their depth of knowledge of the care sector and the strength of the relationships with providers and commissioners at local authorities that they already have through the inspection framework. You can have a statutory underpinning, but a lot of this is based on trust, relationships and sharing information. Yes, you need the financial analytical skills to examine ratios and be able to interpret them, but a lot of this comes down to the quality of relationships. In terms of intervention, without going into the detail of what the statute says, what it comes down to is that they have the powers to ensure there is continuity of care for individuals within that situation, working very closely with the local authorities as commissioners.

Q87 Nick Smith: I wanted to touch on some safeguarding issues. Safeguarding vulnerable adults from abuse and neglect is still a major issue. Between 2011 and 2013, safeguarding referrals by local authorities went up by 13%. Do you think that reflects increased awareness of abuse in the sector, overstretched resources, pressures in the system or something else? What is going on here? Is it some national phenomenon?

Jon Rouse: I think it is a mix, if I am being honest. First, there is increased awareness in the system. Remember that, in the whole context of adult safeguarding, the system is much newer than it is for children. It is only now, in the Care Bill, that we are putting that properly on to a statutory footing for the first time, giving adult safeguarding boards the status that they should have. I think there is also an increasing awareness among the public about what is right and wrong and how you can actually refer concerns to the safeguarding system. So this is partly about the system growing up and there is a lot there about increasing awareness.

Having said that, 43% of those safeguarding referrals were either substantiated or partly substantiated last year. That is clearly far too many. Therefore across the system—national Government, local government, providers—we have a lot of work to do in terms of how we bring the principles of the Francis report and embed them within the social care sector as well.

Q88 Nick Smith: What do you think we can do, or you can do, to help families of people in residential homes, who suspect there is an issue or have concerns, to raise those concerns and draw attention to neglect or abuse that they think may be there?

Jon Rouse: I think it is families and staff, so both. If you think about Winterbourne View, it was an ex-staff member who actually whistleblew there and raised the alarm. So it could come from either place. I think the CQC have a very significant role here. They have their whistleblowing helpline now. I know that the number of calls to that helpline has gone up tenfold in the last year and a half or so. Then it is about making sure that those sorts of arrangements are replicated at the local level as well.

If I could just give you an example of best practice on this: I visited Nottinghamshire a few weeks ago and their multi-agency safeguarding hub. When I say that, you will probably think children. Actually, in Nottinghamshire they have a single MASH that covers both children and adults. It is a fantastic idea, because it allows you in many of those cases to take a family perspective. An issue around safeguarding one part of the family may have knock-on effects and implications on other generations. I was really impressed with that.

Helen Edwards: I hope that trusts are also strengthening their whistleblowing policies. Every trust has them and I think a lot of trusts are asking themselves: "Why are people using the CQC and not the whistleblowing policies that are actually in the trust?" It is not that they have not been in place, but they have not been used. So there is a huge amount of work going on to make sure that this issue is taken much more seriously and that the systems work.

Sir Bob Kerslake: The user ratings, as the NAO Report says, are low as well. I think there is potential there to do more.

Q89 Meg Hillier: I want also to touch on the quality aspect. I know that you have answered this to a certain extent, Mr Rouse, but I want to ask again about the CQC. I remember the days two regimes ago when, pioneered by the council that the Chair used to lead, an independent inspection regime was embedded in a different section of the council. That meant you had local knowledge and a lot of local gossip and stuff that you could pick up because of that very embedded local team. Plus, local councillors, who were pretty cheap, frankly, could look at inspection ports very regularly. Again, that local knowledge was really important. I know that things are changing at the CQC, but we were unimpressed when we last looked at its ability to deal with some of these areas. Why have you gone for that route? Is it because that is the body that is there? Sir Bob, you represent local authorities in Government, in a sense. Given their local knowledge and understanding and the fact that they have to deliver this, why not let local authorities have a role?

Sir Bob Kerslake: In the inspection process? It is interesting, because I recall those times when it was done that way. To be frank with you, I am not convinced that it was better. Even though there was local knowledge, I do not know that there was enough separation to get the rigour of the inspection process right. Given the change in the market, with a much higher proportion now being through the independent and private sector, there is a lot more sense in having—you will get a lot more consistency and professionalism through it—a distinct inspectorate process through the CQC. That is my view. That does not mean that local authorities should not be involved. They should give feedback if they have issues and concerns. Having seen both systems, however, I believe that it is the right way to go. Jon, do you want to add anything?

Jon Rouse: Yes. If my ex-director of adult social services from when I was a local authority chief exec was here, she would be laughing at this point, because I used to argue regularly that inspections should be done at the local level, but I have genuinely changed my view. The reason why is that I have learned that there is an inherent conflict of interest in having the commissioner also as the inspector. Let us say that the inspector goes into a local area and finds a pattern within providers of poor quality of care. That points back to the commissioner, because there must be something going on in how the local authority is

commissioning those services. If that commissioner is also the inspector, will they really hold themselves to account for their influence on that system? There is a pretty strong case for a separation.

Q90 Meg Hillier: I suppose it depends. In the case that I was talking about, a separate bit of the council did it. They were embedded in a different department and given clear political direction to be brutally honest. We have heard about relatives in a residential setting, but let us say that you are a councillor picking stuff up through your local knowledge, and the CQC seems quite distant and passes it on. It is that local accountability that is not so readily there. How do you ensure that that happens in the model? Is there any room for flexibility as you move forward?

Jon Rouse: I think there are other mechanisms that can be used at the local level to supplement and support the work of the Care Quality Commission, and there are two in particular. One is HealthWatch. If you have a really strong HealthWatch in the area, they have powers to do thematic reviews, shine a light on the system and represent the care user's and the carer's voice, and that is powerful. The second, linked, mechanism is the role of scrutiny and overview. Scrutiny and overview is taking some of those CQC inspection reports and asking the hard questions about what is going on in local commissioning.

Sir Bob Kerslake: Can I just add two points to that? One is that in the end the local authorities are the commissioners. If they pick up consistent feedback about the quality of the provider, they have the ultimate power to stop using that provider. They have quite a lot of local influence. The second point is that if the system was set up in the way that you described and you could be absolutely confident that that conflict of interest would not happen, I would go along with you, but I am afraid that that is not the case. You cannot take the risk that a local authority will give it the necessary separation.

Q91 Meg Hillier: I hear what you are saying. While we have talked a lot about residential care, what about the domiciliary setting? If you look at in part 2 of the Report, on page 47 at paragraphs 2.31 onwards, it says: "72 per cent met all essential standards of care. However, 27 per cent (3,241 locations) required an action plan for improvement." That was locations, so presumably the care agency has inspected.

We need to ensure that someone in their home is not getting bad care. There is a real difficulty and there is no easy answer, but how much have you thought about that in what you are looking to do? The new vetting and barring arrangements at the DBS, as it is now called, should pick things up, but it will not necessarily do so if that older person does not complain or the relative does not see it. There could be some bad abuse going on that is not picked up. It is difficult to answer, but what is the plan? It is not clear that this measure will resolve it.

Jon Rouse: That is a really good question. There are inherent risks in any system of care that is personalised and based in people's homes. Successive Governments have been very strong proponents, quite rightly, of increased personalisation and people being able to control their budget to employ their own PAs and so on, but that clearly makes for a more fragmented system and more inherent risk that things might go wrong.

I therefore think there are two things that you can do. One is to be absolutely clear about the registration of domiciliary care agencies and about the way they are inspected: there are certain fundamental standards that cannot be breached, and if evidence is found that they are breached, the consequences will be very serious. That is what we are now doing with the new CQC regime. The second thing is to try to get more transparency into the system, which is why we are introducing the duty of candour, which will go across into social care, too. There will therefore be corporate responsibility—when you know that something has gone wrong, you have to say so and be transparent. Those are two very important safeguards that we are introducing.

Q92 Meg Hillier: Going back to the issue of costs, how much can local authorities take into account the calibre, training and professionalism of the people who are delivering on the front line? If you are dealing with, say, a learning-disabled adult, it is very challenging to get information about what might or might not be going on. A lot of older people just don't want to be bothered to complain because they feel a bit ground down and humiliated by lots of little, minor things that can add up.

Jon Rouse: There are two levels to this. One is the role of the registered manager. Registered managers are absolutely pivotal to the quality of care, both in organising domiciliary care and particularly within a care home or similar setting, and within that subset, particularly where you have high levels of vulnerability. The CQC gains a level of assurance because, first, there is a registered manager in place and the setting isn't without a registered manager for any length of time and, secondly, that individual has the right level of training, attitude and approach. That is very important.

Secondly, there is the broader care work force, particularly care assistants. Following Camilla Cavendish's report, we are going to be rolling out the care certificate across the sector to ensure that there is at least a minimum standard of competence.

Q93 Meg Hillier: Okay, thanks. I have a couple of very quick things. On the GP issue, we have heard about the lead professional being the GP. What do GPs earn from this? I do not know the language, but what incentive fee do they get for every person for whom they are the lead?

Jon Rouse: I haven't got the exact numbers, so if you want them, I'll have to give you a note.

Q94 Chair: Are they going to get extra money for it, then? Is that the way the system is going to work?

Jon Rouse: No, not quite. I will explain, but I do not have the exact numbers, so if you want them, I'll have to give you a note. Essentially, we have done a deal whereby we take away roughly a third of their QOF indicators, which are boxes they have to tick for the procedures they have carried out or things they have met, and we have taken the money that

they would have got for doing that QOF activity. Instead, we are giving the money to them for being a named accountable GP for the top 2% of the population.

Q95 Meg Hillier: So it just evens out?

Jon Rouse: I haven't got the exact numbers, because I didn't expect to be asked about it.

Chair: Wrap it up, Meg.

Meg Hillier: I think Sir Bob wants to come in, and then I have one final, very tight point.

Sir Bob Kerslake: On GPs, Jon is right that there has been a redistribution of work rather than more money. I have actually been to GP practices where they are doing this integrated approach, and they are doing it not because they are being paid more—the approach predated the deal—but because they see the potential of a collaborative approach across agencies.

Q96 Chair: Oh, Sir Bob, I wish that was true. The best GPs in my constituency cannot see it.

Sir Bob Kerslake: I can't talk about your GPs, but I can happily take you to the place where they are doing this of their own volition because of the way they see it working.

Q97 Meg Hillier: So the vision is that they will all do it of their own volition. Fantastic.

I have a final quick point, because I know the Chair is itching to move on. Data sharing comes up as one of the challenges in the work in figure 18. What progress is there on that? How much will have to be spent on IT systems to sort it out?

Sir Bob Kerslake: One of the provisions we will want to see in the plans is how they are going to improve data sharing between the agencies at local level. As part of getting the money, we will want to see a strengthening in what they are doing on data sharing. I am sure there will be some IT issues here, but from all my experience and talking to people on the ground, most of it is about culture, processes and attitudes. You can do a huge amount here. I don't think myself—I am happy to be corrected by either Helen or Jon—that this is about big investment in IT systems. Much of it can be done by simple, practical collaboration at the local level.

Q98 Meg Hillier: And will you make sure that best practice is shared, because it would be silly to reinvent the wheel?

Helen Edwards: We will. We really do want to ensure that best practice is shared across the piece. This agreement that the NHS number will be the identifier—we are not approaching this on the basis that there will need to be huge investment. But what we have said is that where people are coming across genuine barriers at the local level—whether it is to do with data sharing, contracting or anything like that—then we will look at it at the national level to see whether there are things we can do to make things work better on the ground. But we are not looking at huge investment.

Chair: Right, let's have Fiona, then Amyas and then Nick, and then I want to begin to draw things to a close. I have a couple of issues that haven't been covered.

Q99 Fiona Mactaggart: Jon, you are enthusiastic about the evidence about re-ablement services. One of my concerns is that the focus of most re-ablement services is on physical disability and doesn't include mental disability, mental illness and social isolation, which is very significant for this care group. Have you done any studies about the value and the importance of that?

Jon Rouse: I don't know whether there are any studies, but I know it is true.

Q100 Fiona Mactaggart: So how are you going to make sure that, within the care packages and the preventative mechanisms that people are offered, there is an appropriate focus on that issue? Scope, for example, have suggested to us that there is not.

Jon Rouse: There is a formal and informal level to this. Let us just deal with the formal first. First of all, there is an unwanted and unacceptable under-representation of older people receiving access to psychological therapies. The percentage is about 5%, and if you think about the proportion of over-65s in the population, that cannot be right. Let us think about why. Some of that is a generational thing, to a certain extent, about talking about mental health. So we have work to do to break down stigma, particularly around that generation. Secondly, it is about where those individuals would be most comfortable receiving those services. My instincts are that they would probably be more comfortable in a primary care context, in terms of their relationship with their GP, than necessarily being referred to a specialist centre. So there is some work we can do about embedding older people's psychological therapeutic interventions within primary care. That is the first thing to say.

At a more informal level, it is about how you break down isolation and loneliness. I cannot do better than to talk about Sandie's brilliant neighbourhood team structure in Leeds. They have broken the city up into 37 neighbourhoods. Each one has a voluntary sector organisation, or a social enterprise that works as part of the team with the professionals doing the joined-up care. So it is not just about the occupational therapist or the physio going into the home; it is about saying, "Did you know that Ethel has just come out of St James's? She's back on her feet but she's struggling. Could we as the voluntary organisation make sure we go in three days out of the next five, just spend an hour with her, chat to her and make sure she is okay?" We need to ensure that in each place that sort of informal infrastructure is in place as well. There are lots of good examples around the country. Cornwall is doing some

fantastic work which is another pioneer, particularly in Newquay and Penwith. I am aware of some very good work in Cumbria as well.

Helen Edwards: We heard this morning about the work going on in White City, a befriending scheme from local people in the community for isolated older people. It is heavily correlated with health problems. It is something that local people are prepared to invest time and energy in doing, if someone will take the trouble to organise it. Again, this was another social enterprise bringing this together.

Q101 Fiona Mactaggart: I am slightly surprised that none of you has mentioned the importance of family there. It is the family that the ill person is most likely to have contact with. Surely making sure that you support family carers more effectively is one of the ways to deal with this issue? That brings me to my constituent who is currently in an acute mental hospital. It is a very expensive bed. She has been assessed as being eligible for continuing care funding. Her daughter is being—I think this is the politest way to say it—squeezed out and kept in the dark, not knowing what is going on. Every time she finds a care home that she thinks, and that the care home thinks, is appropriate for mum, she is pushed away and told, "That won't do." The people who are deciding it have offered mum a dementia home, which is not a sensible place for her, as she is not in the least bit demented. She is isolated and mentally ill, and does need support and help. My constituent's daughter actually believes that this system is designed to keep families in the dark. I hope that she is wrong, but that is absolutely what she believes. She thinks that the decision support tool is being kept away from her; she feels almost as though her mum would not have got any support if she had not had an articulate, bossy daughter. She is getting some support, but not what she needs. Why is this still happening today, because it seems to me that this system is the closest one to the new territory that we are looking at?

Sir Bob Kerslake: From what you have described, it feels like the antithesis of what we are trying to achieve here—

Fiona Mactaggart: Exactly.

Sir Bob Kerslake: It is difficult to go into detail unless we know more, but that is clearly not what we are trying to create in the new system, when we have one.

Q102 Fiona Mactaggart: I understand that, but what I suppose I am saying is that in a system that is like the new system—as I understand it, continuing care assessment is the closest thing that already exists to the new system—families are feeling squeezed out and they certainly do not have a transparent system. Whatever else you might think about the decisions, it is not in the least bit transparent for the family. How are making sure that your new system will be transparent, so that someone who has power of attorney and who is the person who loves the patient more than anyone else is actually included in the decision making?

Sir Bob Kerslake: I suppose part of that is about what ways people have of redress and complaint. Jon, do you want to say a bit about this?

Jon Rouse: Yes. There is also complexity when you have got an individual who is receiving what we call tier 4 services, because they are in all probability commissioned by NHS England, rather than locally by the clinical commissioning group. What you are trying to do is take someone from that setting and place them back into a community setting with the right support, and there are barriers that might be to do with the right housing and the right care package. One of the things that the Better Care Fund and the integrated model should help with is that they should cause NHS England, through its local area team, to need to come to the table to be involved in that care co-ordination and to make sure that the transition takes place well. It is exactly the same issue that we had with Winterbourne View, with assessment and treatment centres. It is making sure that those transitions from acute services, which are commissioned through a national infrastructure, connect properly with the local level.

Q103 Fiona Mactaggart: How are you making sure that the people who love the patient most are involved in this decision making? What are you doing to make sure that that happens, because I do not think that I see it?

Sir Bob Kerslake: What you are describing is working to the convenience of the system, rather than the family. I think there have to be very clear pathways for people to complain if they think that they are not getting the right result.

Q104 Fiona Mactaggart: I agree with you about complaint, but what I am trying to do is to avoid complaints by asking how you involve the family carer in the decisions that are being made about someone. Is that not critical? If they feel involved—if they are engaged in this—then you can make things work together.

Sir Bob Kerslake: We can all trade anecdotes, but my sense is that that happens in the vast majority of cases. The question is what you do with the ones where it does not happen.

Helen Edwards: I have a different hat, which I wear as a non-executive director of a mental health trust. What I do not understand is why that person has not got a care plan. They should have been fully part of putting such a plan together and it should have been shared with relatives. That case sounds like really bad practice. It is the kind of thing that, if the CQC is doing its job properly, it will pick up through inspection, but it is hard to understand, unless there is more to it than meets the eye about why that has happened. It sounds like very bad practice.

Q105 Fiona Mactaggart: It does to me. What I am really asking, I suppose, is how what you are putting in place can engage properly with the family carer to ensure that, instead of having to complain afterwards, they are involved from the start.

Sir Bob Kerslake: I absolutely get your point. If you are willing, maybe we should use this as a case study of the system not working. I am happy to do that.

Chair: I am trying to draw you to a close, so we can finish. Amyas?

Amyas Morse: May we just go back briefly? I appreciate that a lot of what we have been talking about—all very admirable direction of travel—is using resources more effectively and seeking to make everyone a winner. In part of our Report we are looking at this invincible onward march of demographics. How would you know when you needed to put more in? I know you should not say "give us more money" as a first plea, but how will you know when you need to put more money in the system because ingenuity is not going work any more to meet lack of capacity? I appreciate that you probably don't have the information now. Are you going to have that information at some point in the future?

Sir Bob Kerslake: I guess it works at different levels, Amyas. When we come to big events—let's say the next spending review in 2015—we will do the full analysis across the range of our Government services. We work incredibly closely with Health and we have regular joint boards. We share analysis. We will do in-depth work, and we have in effect joint teams working on these issues. So when we come to a big event—which is after all when these big decisions are made—

Amyas Morse: You will have the modelling in place for that?

Sir Bob Kerslake: We had better modelling in 2013. I think we will have better modelling again in 2015. I am particularly keen that we get more around the welfare side into the system, which is not as good as our working relationship with other teams.

Q106 Chair: I was going to say, because we had a session on PIPs—personal whatever they are—

Nick Smith: Personal independence payments.

Chair: And it was clear there that the cuts are going to hit just the group that you are going to have to provide adult social care for. There must be an impact. Somebody has got to monitor that and have a look at that.

Sir Bob Kerslake: Absolutely. One level is when we come to the big fiscal events like the spending review. That is one part of it, but on an ongoing basis we do assess the pressure in the system both at an aggregate level and locally in individual places. You have a set of indicators, Jon. We have a set of indicators. We can put the two together and see whether there are issues emerging in a particular area. That is how I would describe it.

Amyas Morse: Thank you.

Chair: Nick, a couple of questions, then I have three to clear us up.

Q107 Nick Smith: Thanks, Chair. At the start of the session I talked about the multi-agency meeting we are having this Friday regarding this young man who is severely disabled, with 17 people from different agencies. Since then, witnesses have talked about a single person, a sort of baton-holder, to help this young man and his family put their life together. We talked about it a bit more, and we have talked about getting the GP to have co-ordinating responsibilities. They are going to get a fee for it. However, I am not sure whether, if the GP

might be co-ordinating it but a different health professional or someone from the Department for Work and Pensions actually does the work, that will be recognised. Will they get a fee for that, or will there be savings in the system that mean that is covered off? How is that going to work?

Helen Edwards: There are a number of joint teams already in place. We are looking at joint working and we are hearing, as Bob said, from Cheshire West, where they have brought together joint teams from a range of services. If you have the joint team, it does not really matter which agency you nominate, because you want that co-ordination—although it would be good if it was relevant. I don't think we are looking at extra money for this. I think we are looking to see people changing ways of working so that they see this as part of their jobs.

Chair: It might be good to get the GP to do that without extra money too.

Q108 Nick Smith: But are GPs really the accountable people to make sure that works to plan? Is that clear?

Helen Edwards: They will be in the formal sense.

Q109 Nick Smith: Related to that, a couple of weeks ago we had the Troubled Families Unit in. They said that they have done this sort of thing with boutique answers to tricky problems in lots of places around the country, but it was all a little bit informal—it was not properly mapped out. I wondered if there is any chance that there could be one simple model around all of this, which you can all agree is the best way forward, which you can roll out and which has a reasonable chance of working, rather than reinventing the wheel.

Sir Bob Kerslake: This is a very important question, I think, because when we came to troubled families, we did have some practical experience of the family intervention programme and that particular lead professional model, which we could draw on for the model that we were promoting to local government. We are still developing the models in relation to integrated health and care, but we do have the 14 pioneer areas—

Nick Smith: How many?

Sir Bob Kerslake: Fourteen. We will, in my view, learn about which of the various ways we can approach this is the best way to do it, and therefore have a more consistent model that we can see applied across the country. This year, I think, will be a year when we learn about these issues through those pioneers.

Jon Rouse: That is absolutely right. Can I just ask—I think we may have misheard you—how old you said your individual was?

Sir Bob Kerslake: Was he 70 or 17?

Nick Smith: No, he is a young man—he is in his early 20s, and he is in Wales. I haven't had the session yet, so I didn't want to broadcast all of that, but my office sent a few e-mails out, and 17 people are now coming to that session.

Jon Rouse: Just very quickly—I know you are looking to draw things together—I think the key intervention in England going forward will be the integrated education, health and care plan, which was part of the Children and Families Bill. Any young person with special educational needs, up to the age of 25, will have a single plan with co-ordinated care, again, underpinned by statute.

Nick Smith: He hasn't got special educational needs, he is a young man who was a rugby player, and he got a back injury and is disabled from the neck down.

Sir Bob Kerslake: And he had 17 people involved.

Nick Smith: Yes, and six months after the case was brought up, it has still not really worked for him.

Sir Bob Kerslake: Okay.

Q110 Chair: I just want to ask you three questions. First, you are all talking about joining up at the local level through health and wellbeing boards. Why aren't you joining up at the centre? Why not have, for example, an adult social care funding council, or something that really joins you at the centre?

Sir Bob Kerslake: I think we are really joined up. You are shaking your head, but as I said earlier, we are joined at the strategic level and have regular joint board meetings on these big issues. We have effectively a joint team working on the new Better Care Fund, so that team is working across Departments in a collaborative way. I think we are joining up. We have not gone for a big structural change, and I do not think that is necessary, but in every practical sense we are doing this as a joint process.

Q111 Chair: Let me give you an example, Sir Bob. In the new fund, £2 billion is going in from Health, or whatever it is—£1.8 billion, isn't it? That is from the CCGs.

Jon Rouse: The whole of the money is going in from Health, with a small amount of disabled facilities grant, but—

Q112 Chair: The CCG money is £1.8 billion. The rest is existing budgets that you are just bringing together, isn't it?

Jon Rouse: You are right to say that the new money is around £2 billion.

Q113 Chair: It is the CCG money. Okay. But it still counts in your NHS budget, doesn't it?

Jon Rouse: It comes through the NHS budget, down into the pooled funds under section 75.

Q114 Chair: Okay. When I looked at the spending round 2013 documents, it showed up in the NHS budget, so the 0.1% real growth includes the money that is going to this. Then table 2.5, on the local government spending budget, shows that it is added in there. That is a cheat, bluntly. It is a double counting cheat. You are counting money twice, once as the money from Health and then again in local government spending. That sort of distortion of the figures—that is the kindest way of putting it—suggests to me that you would be much better just having one budget, really joined up, rather than pretending to local government that you are increasing the budget when it is actually already counted in the Health budget.

Sir Bob Kerslake: I don't think it is distortion, Chair. What we were trying to describe here was a pooled budget that is available to tackle a shared issue.

Q115 Chair: It is counted twice.

Sir Bob Kerslake: It will be a benefit to local government.

Chair: It may be a benefit to local government, but it is counted twice in the figures in the 2013 spending round documents.

Sir Bob Kerslake: You are talking about the spending power point, aren't you? That is not about where the funding is. Anyway, we will happily drop you a note on that.

Q116 Chair: Okay. I think it is a distortion, which is a bit unfair, and I think you would deal with it if you had a really joined-up system.

One other question. On page 36, at the right of figure 15 there is a whole list of potential problems that could throw your plans for getting more for less completely out of kilter. What I want to know is—if you look at all those things on the right—what have you got structurally? How are you working your way through these sorts of challenges?

Jon Rouse: From our perspective, we have two pieces of apparatus that are important. First, I have an adult social care oversight board that reports direct to the departmental board, where I bring together relevant officers in my own team, CQC and CLG. We look at the risks to the system and work out what mitigation actions we need to take. We take a short lead and a long-term perspective on that.

The second is about how we implement the care and support reform programme. It is a high-risk programme. We are quite open about that—it is an important programme and the Care Bill is a good Bill, but it is a complex implementation process. What we are doing there, which I am not sure has been done before, is that we have a single, completely joined-up programme management approach with the LGA and ADASS. There is one programme office staffed from all three organisations, which is doing the national implementation, the

writing of regulations and guidance, the funding elements and the local implementation together as one programme.

Sir Bob Kerslake: I will add one point, which I made earlier, and reinforce it. We regularly have joint board meetings where we review progress on these risks and progress on the programme.

Q117 Chair: The other thing—and I say this from my experience of trying to do the integration when we were doing Every Child Matters—is that if you look at figure 18, you have such different cultures between social care and health. There is a highly professional health capability and a very low-paid, poorly trained social care capability. Bringing those two professional capabilities together into an integrated service is hugely challenging. We read in the Report that over half of GPs say that their relationship with social care is poor or very poor. It is a massive mountain to climb. What are you trying to do to bring those very different cultures together?

Sir Bob Kerslake: I think I said right at the beginning of the session that this is a very challenging agenda that will not be achieved straightforwardly. Our judgment is that it is more likely to happen and will be more effective if it is led at local level by the key partners. We are building in funding to catalyse that and placing expectations on the key partners about how they work together and drive it.

Q118 Chair: My experience of this is that it is a massive educational and training cultural change. If you haven't got the money for it, it will fail, in the same way as quite a lot of the Every Child Matters agenda has not been pursued.

Sir Bob Kerslake: I would not for a moment say that this is not a big agenda. We have put money in to help it happen, but in the end, just as we found with Troubled Families, the best way we can get confidence about this is the fact that it is owned as an agenda by local authorities and it is in their interests and in their ambitions to make this happen. That is the most powerful way of doing this.

Q119 Chair: Finally, what keeps each of you awake at night on this one?

Jon Rouse: I'll tell you what keeps me awake at night: it is the reduction in the number of users, which is what the Nuffield Trust flagged up. If you are in the system and you are receiving care, the indicators are pretty good. Satisfaction levels are up and quality of life scores are up. There has not been any real reduction in provision for those who receive high-intensity care. That is okay. But some people are not in the system and, for whatever reason, are not receiving care packages. Do we know enough about what is happening to them? Do we really know whether these preventative services and lower level interventions are making a difference, maintaining their quality of life and enabling their health and well-being? I worry about the unknowns, and we need to do a lot more research in that area.

Helen Edwards: I suppose it is the scale of the challenge. There is such a lot resting on this, and ambition for it is very high. Our Ministers are investing a lot of their personal

time and energy in it. They want to create momentum behind it and create real change on the ground that makes a difference to people's lives. We all share that ambition. As we have discussed today, some of the challenges involved are pretty formidable so, playing back to you, will we be able to make it happen in the way we want to?

Sir Bob Kerslake: I will finish. If anyone has studied the numbers for beyond 2015, then if we think the last period has been challenging, we still have quite a long way to go. Getting to 2015 is not completion of the task. The challenges will continue and we will have to raise our game even further to deliver the figures that we see in those numbers.

Chair: Thank you.