



Health Committee

Oral evidence: Public expenditure on health and social care, HC 679

Tuesday 18 November 2014

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Written evidence from witnesses:

- [NHS Confederation](#)

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Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Andrew George, Robert Jenrick, Barbara Keeley, Charlotte Leslie, Andrew Percy, Mr Virendra Sharma, David Tredinnick,
Valerie Vaz

Questions 299 -395

Witness: **Dame Kate Barker CBE**, Chair, Commission on the Future of Health and Social Care in England, gave evidence.

Q299 Chair: Welcome, Dame Kate. Thank you very much for coming to give evidence today. For the benefit of people listening, would you introduce yourself and give some background to the review?

Dame Kate Barker: Certainly. Thank you for giving me that opportunity and for giving me the opportunity to come.

For those of you who do not know me, I am primarily a business economist. The King's Fund asked me to conduct this commission independently of the King's Fund, so our conclusions are not necessarily those that the Fund is signed up to. I led the commission but it had other people on it, many of whom know rather more about health than I do, and it was very enjoyable. I am glad to have the opportunity to make that clear because I am not here to speak for the King's Fund; I am here to speak for the commission. We finished our work in September and since then we have been decommissioned.

Q300 Chair: Thank you. Overall, were you pleased with the response from the King's Fund to your commission?

Dame Kate Barker: I am really sorry, but I did not hear.

Q301 Chair: Were you pleased with the response from the King's Fund to the commission?

Dame Kate Barker: Yes. That is not surprising because, although it was independent, if we had come up with something they really did not like we would have had an argument about it at an earlier stage. I am saying this because you will be aware that they are taking forward several strands of work from it and I am not involved with taking it forward.

Chair: Thank you. I will hand over to Andrew George.

Q302 Andrew George: Hello, Dame Kate. You say you are a business economist. Is there anything we can draw from that to conclude why you felt that a single commissioner and a single budget would be most appropriate for the provision of health and social care? In other words, is it for good economic and business efficiency reasons, or can you also point to improvements in equality as well?

Chair: Before you start, Dame Kate, could I ask you to speak up because the acoustics are a little difficult?

Dame Kate Barker: Yes, I thought that likewise. I will do my best. I do not think my background as a business economist had anything particularly to do with that recommendation. You rightly ask whether it is about efficiency or about equality—

Andrew George: Quality, sorry.

Dame Kate Barker: About quality, okay. In that case, the point of the single commissioner is about both. I say this because of two things that we came across in doing the report. I have not had very much personal involvement with the social care system for a time, but I was quite distressed, as I am sure you would imagine, by the stories that you uncover once you start to talk about it. The reason for wanting to have a single commissioner was simply to ensure that there is proper integration of the two systems and that you do not have people lingering in hospital because there is no real incentive on the social care people to find a way to bring them out, or people, in the case of one of the experts by experience that we used, who stayed in hospital while there was a lively discussion about who should pay for their home adaptations. That kind of thing is not helpful either to the efficiency of the system or to the happiness of the person concerned. For both those reasons, I would support a single commissioner.

One thing you might say—and I am conscious of this in the reading and the submissions we had—is that a number of local authorities are finding much better ways of working together without necessarily having a single commissioner. That is great, but I still think that a single commissioner would achieve a sort of clarity around the patient because it is partly about quality.

I would put the two together—I do not think they are conflicting—and I notice you had some evidence last week in which somebody made the same point. It is not at all clear, if you look where integration has happened, that it throws off lots of money necessarily, but it does provide the opportunity to offer the patient better quality, more certainty and fewer assessments—all the kinds of things you would want if you were the individual concerned.

Q303 Andrew George: If you bring these two systems together—and you were saying that there are circumstances where it is possible for integration to happen even though the budgets and the commissioning are not a single body—have you drawn a conclusion that you can sustain that integration if the personalities change? In other words, do you think that in order to have lasting integration you need to have a single budget and a single commissioner? Do you think that is absolutely essential now?

Dame Kate Barker: Ultimately, that is what the commission concluded. I am interested that you raise the point about sustainability. I would probably come back more to the point about the ability to deal with the question of whether something is paid for or not. In a sense, even when things are brought together, because of the very different nature of entitlements in health and social care, things will still have to get labelled a little bit, and in some senses I am sure there are issues about how budgeting works. You can cut through a lot of that by moving to a single commissioner. I had not thought of it, but your point that it would be a more durable arrangement, because it would be more clearly set up, is also probably correct.

Q304 Andrew George: In terms of being able to distinguish between those parts of health or social care that are paid for by the state and those that may or may not be paid for by the individual, do you think that having a single budget with a single commissioner will make that distinction easier to explain to the recipients of that care and their families?

Dame Kate Barker: If you look at the whole report, one thing, in a way, that we were keen to do was to try—particularly for people who have greater needs—to move away from having to label something as health or social care, because people would have greater entitlement to a package of care that was paid for by the state. I do not think you can work that all the way down. That would be an unreasonable and quite a high burden on the taxpayer, particularly in these rather difficult times. But the more we are able to think of people's care in a single way and offer them a range of care, or a personal budget that they can choose between pieces of care without having to worry about, "Is this health or social care?", the easier it will be for people to get what they want and to get the right value out of the system. I am not sure that quite meets your question.

Q305 Andrew George: Let me put it in a different way. Some people—perhaps the cynics or those of a more cynical dimension—have suggested that further integration will drive the private sector, which currently, for example, provides, through nursing home care, greater levels of acute services that previously were only provided by the acute and, indeed, community hospitals, and allow that slippery slope of more and more aspects of health and social care being taken on by the private purse rather than by the state. Do you think it is possible to define where the limits of the state-funded care and support are and that you can make that durable for the future?

Dame Kate Barker: I want to be absolutely clear what you are asking me. You are asking me about what is funded—not about the nature of the people providing it.

Q306 Andrew George: No. Let us ignore that because, if you are saying that there is a single commissioner with a single budget, I am hoping that that level of distinction about

who is providing it is less important. It is whether it falls on the private individual to fund that care.

Dame Kate Barker: The difficulty here in the sense of whether it is durable is, of course, that any change you make is only going to be durable for as long as the politicians are in power and the people think it is appropriate and want to go on paying for it. If I am really honest, what strikes me about the present situation, and I am sure you will hear this from the people who are coming to give you evidence later this afternoon, is that the present pressure, both on the health and local authority budgets, leaves people in need of adult social care—and we know there are many fewer people receiving support today—at tremendous risk of getting squeezed out of the system at both ends. I would hope that the point of bringing it together, making clearer what people’s entitlement to an overall package of care was, and in a sense ring-fencing it so that it is not possible for local authorities to say, “Actually, we would rather do something else with the money,” is that this particularly vulnerable group of people would get better protection than I feel, in a sense, they have had over the past couple of decades.

Q307 Andrew George: Finally, who do you think will be best placed to be the integrated single commissioning body? Is the CCG closest to the model, or the health and wellbeing board, or do you think it should be democratised and entirely handed over to the local authority?

Dame Kate Barker: I do not think it should be entirely handed over to the local authority. Not to have the present CCGs playing a role in that would not be helpful. It is a very natural thing—and a lot of people commented on this following the commission’s report—to think that health and wellbeing boards would, in some sense, be the natural people to pick this up. On the whole, the commission—and most of the commissioners had more experience of the health and wellbeing boards than I have personally—felt that the health and wellbeing boards’ state of development was not such that they would be ready to take this on and that they would need some reform. I am not a great expert in how that would be done. I would say that health and wellbeing boards have the potential to become those bodies, but they are perhaps not there today, and, even as a very non-clinical expert—and I certainly am not a clinical expert—it would be odd not to have proper clinical expertise on those bodies.

Q308 Robert Jenrick: Dame Kate, good afternoon. Can I ask a follow-up question? You said that combining health and social care might cost in the region of £3 billion or that a figure in that sort of region might need to be found. For the benefit of people watching at home maybe, could you explain what the driver of that cost is and is there any way to reduce that, given that, in some respects, it is counterintuitive that if you combine services you should drive up the costs rather than find efficiencies?

Dame Kate Barker: That was not in fact what the report said. The reason for the additional costs was the report’s proposal that entitlement to state-funded social care should be extended to people with a lower level of need than is common today. As you will appreciate, people’s ability to access social care has been moved up, so most councils now only give funded care to people who are at the most needy end of the spectrum. Our proposal was that people at the next stage down—I always get confused between critical

and substantial—should also be entitled to care, and that is where the cost comes from. The cost does not come from integration. We made no assumption about either savings or additional costs from integration. You are quite right that one's natural sense is that you would get cost benefits from integration, but, as I tried to express it, my view—and I think the view of the commission—is that it was more appropriate to think of integration as something that would deliver a better quality to the patient.

I want to stress this in a way because, having introduced myself as a business economist, the thing that we tried to keep in our minds right through the work on this report—and that is why having the group of experts by experience was so important—was the patients, their carers and families, and how to try and get a system that would work better for them. That is what you hope you would get out of integration and the hope that you would be able to provide better quality, because we know there are concerns about quality—though not in all social care—and the shortness of visits. If there were efficiencies, our strong view would be that we would prefer to see that moving into better quality care.

Q309 Valerie Vaz: Dame Kate, my questions are about clarification on the report and some background information. First, are you aware that the NHS Confederation has said that health and social care commissioners already have the ability to pool their budgets? Did you look at that when you drew up your report?

Dame Kate Barker: Yes, we did look at it. As I have said, there are examples of cases where people have pooled their budgets. That is very helpful, but it does not completely solve the problem because the entitlements of individuals to one type of care or another still will run across means testing. One of the reasons for wanting to take more people out of means testing was that it will make single commissioning and pooling of budgets a much easier and better process. I am certainly aware that people have been pooling budgets, and I have to say that is great, but something you are always very concerned about when you write a report is that you do not stop good practice. I hope that, as they think about how we move towards the kind of system that we recommend, people will build on a lot of the good practice that is already occurring today. Absolutely I agree you can pool budgets but, if entitlement and means testing are still different, it is hard to make that work as smoothly as perhaps one would like. I have to say that, even under our system, it would not work perfectly unless you made everything free. Indeed, even with the NHS, where we think of everything as being free, of course being ill often costs you money.

Q310 Valerie Vaz: That is partly what I was going to pick up. An idea that occurred to me was rather than pool the health budget—and I will come on to why I ask that question—was maybe to give local authorities the money directly so that everyone is not means tested; everyone can have the ability to have their critical needs assessed free. Maybe it is better to give them money rather than have another structural position that you are advocating with the single commissioner.

Dame Kate Barker: I can see the case for that and that would be one way of doing it, although you would still want it to be ring-fenced. The question then is whether you would get over the business of people squabbling about who pays for what, which—or so it seems to me—is always very unhelpful. I have been struck—I articulated this a little bit in

answer to an earlier question—by the institutional resistance to some of these proposals. It is not just about institutional resistance to another reorganisation—which nobody wants and is one of the reasons why we do not think this would happen very quickly—but that the local authorities do not want this money ring-fenced because they would like to be able to pluck it away a little bit, and the health service do not want it ring-fenced in case they also lose a little bit of influence over some of their budget. That is why I come back to saying we tried to think about how it works from the patient's point of view and not how it works from the interests of these organisations.

Q311 Valerie Vaz: That leads me on to the other aspect—the provider aspect. Did you look at the effect this kind of proposal would have on the hospitals, bearing in mind that social services is about a particular group of people but yet the hospitals have to provide for a wide range of people that do not come under adult social care? We are talking about pooling budgets when they have a much wider remit. For example, there would be implications on training the next doctors, and so on, in different specialties. Did you look at what this would do to hospitals?

Dame Kate Barker: We did think about that. The proposal is not that the acute hospitals would necessarily come under this banner. I do not think you would want to have acute care in hospitals sitting in this pooled budget. This is much more about community hospitals and the work on health prevention—the kind of work that is done closer to the patients. I would not see the people who are involved in deciding on resources for, say, health surgery going into that. But the point you raise about training is a good one, not necessarily so much about medical staff but about the training of the kind of work force, if you had a pooled budget, that you would want to go out and deliver services because they would be delivering a much more integrated package and might need to be rather different from some of the people who deliver the care today.

Q312 Valerie Vaz: But do you accept that it could have an impact on acute hospitals? Not every area has community hospitals, does it?

Dame Kate Barker: It could have an impact on part of the acute hospitals, yes.

Q313 Valerie Vaz: What was your conclusion?

Dame Kate Barker: You would hope that the conclusion would be that you would not have so many beds in acute hospitals taken up by people who have not yet been moved out into the community. That would be my expectation.

Valerie Vaz: Thank you very much.

Q314 Andrew Percy: We are all of the same mind in terms of the need for greater integration, but it is very brave of you to target winter fuel payments in your commission; I do not know whether many politicians will be lining up behind that particular one, but it is an interesting read all the same.

The Five Year Forward View came out recently. How do your recommendations tie in with that? We heard from Mr Stevens only a couple of weeks ago of the potential of a £30 billion annual gap by 2021. Obviously, a single budget where you are adding social care in makes a significant impact financially, and you have talked about national insurance increases, diverting winter fuel payments and various other tax and charging changes. How does your commission's report tie in with the models that are outlined in the Five Year Forward View?

Dame Kate Barker: The Five Year Forward View did not talk all that much about social care, although it did talk about integration more generally. I have become aware that lack of integration in the health service is not just about the division between health and social care; it is also about the division between particular practices. In that sense, it ties in with the Five Year Forward View quite well, a sort of general move towards something that might strike one as obvious, which is trying to be more organised around individuals. I recognise that that is one of those things that trips off the tongue and is probably rather harder to do in practice, but if you are really asking in terms of funding—

Q315 Andrew Percy: Financially.

Dame Kate Barker: The fact is that the money that we would want to find to give people better entitlements to social care would be additional to the money that Simon Stevens has talked about. If you were to ask me as an economist whether I feel this is a very serious funding challenge for the UK and for politicians at the next election, yes, absolutely, I do. Although there has been quite a lot of discussion about—and other people have put forward thoughts for—funding, none of them thus far seem to be adequate to the scale of the challenge that, between Simon Stevens and me, we have produced. As you will be aware, Simon Stevens's challenge itself assumes a very good level of productivity in the health service, which, by the way, is absolutely right. It is, of course, important that the health service looks at how it can improve its productivity, but we know that is not easy. International experience suggests that the NHS as we have it is reasonably efficient.

Q316 Andrew Percy: You are clear, from your commission's report, that this gap cannot be funded without tax rises, are you not?

Dame Kate Barker: I find it very difficult to see, particularly with regard to social care. You may say, "Can't we use technology?" Of course, if you can use technology to help you, that is great. But if I look at the cut-backs since 2010, where the councils have been obliged, as I commented earlier, to change the criteria by which they have given adult social care, it is hard not to draw the conclusion that, if you want to push that back again, you are going to have to put more money into the system even when you have done integration. It may sound incredibly sanctimonious, but this seems to me to be a very profound challenge for all of us today. We are still going through a period of economic difficulty, slow growth and fiscal deficit. Simultaneously, we have an ageing population and technological advances in the health service, which, as Simon Stevens very clearly pointed out, means there are increasing demands on the service and there are only three things you can do. You either provide a worse service; you find a way of providing it startlingly more efficiently than you have ever managed to do before; or you raise more

taxes. I am sure that, in fact, what we will do is a little bit of all three, but none of it is particularly cheerful.

Q317 Andrew Percy: Some local authorities are not changing their criteria—including mine, which has not had to and has put more money into social care. However, you will have seen the bidding war that is going on at present with regard to the general election, which I am told is happening in five months' time. There is a bidding war and figures are being bandied around. Have you done any assessment of how serious those figures are in addressing the challenge, the gap and then the greater gap there will be if we go for full integration and a single budget? How adequate do you think those are, and how honest do you think the parties are really being with the public with regard to addressing the scale of the problem, which everybody seems to know about but everyone comes up with £1 billion or £2 billion here and there and they think that will buy the electorate off?

Dame Kate Barker: I need to say that I focus very much on the social care end; I am not such an expert on health care. I have already said very clearly that I do not think the kind of social care that the commission would want to see could be met without extra spending. I have talked about that. I have not done any detailed work myself on the health service challenge, but in order to produce the report we did look at the basic figures that John Appleby, who I know came to see you last week, has produced for the King's Fund. They are not very different from the numbers that other people produced that suggest that rising demand and the lack of ability to continue to save money in the health service by keeping wages down in order to keep staff quality up will get much more difficult. It is very difficult to dissent from the view that to deliver the present standard of health care to an ageing population with rising expectations of what they get from their health service will not be possible out of the current budget. That seems to me very clear.

If you are inviting me to say whether £1 billion or £2 billion will fix it, my answer is I very much doubt it will. The question will be, is that what we want to do, and then we will not quite have the advances in medicine that we could have, or people will have to wait longer to see doctors, or all the other things that we worry about? In some sense, that is the choice. It is a choice that the public faces. The great thing about the NHS Five Year Forward View, although I have not done detailed work on it, was that in some sense it articulated that choice rather well.

Q318 Mr Sharma: After the next election, if the incoming Government looks to adopt your proposals, what do you consider to be the key recommendations that would have to be implemented to make a significant difference?

Dame Kate Barker: When I think about these proposals, in a way they fall for me into two parts. One is the proposal that there is a simpler pathway through the present maze of health and social care so that people find it easier to know what they are entitled to and how they will be funded at different stages, which will be helped by having a single commissioning body. The other is a proposal that the whole system is funded more generously. Both of them will make a big difference, although they will make different differences to different people; there will be winners and losers from the two. Perhaps surprisingly, given that, in a way, this was about entitlements and funding, the important

thing for me is the simpler pathway, the single commissioner and the better articulation to individuals of how they might move through the system as they age and ail.

Q319 Barbara Keeley: As a point of clarification, when we have been talking about the commission's recommendations around the NHS services being funded largely free and social care chargeable, did you look at any differences in continuing care? For instance, I understand my local authority funds five times the number of continuing care cases that the NHS does in an adjoining authority. That is another source of difference, is it not? Were you looking at that sort of issue?

Dame Kate Barker: We do talk about continuing care in the report and noted in fact these tremendous differences, and the very large legal bills that are sometimes run up by people's legal challenges to continuing care. One of the reasons that we wanted to move the bar down for where people qualified for getting everything free was to try and remove that misery and cliff edge of continuing care; it seems to me to be a very unhelpful thing for people to encounter at what must already be a very distressing stage of whatever condition they have and it is easy to see some of that as cynical.

However, I should say that one of the things we propose in the review, which is that people who have qualified for continuing care should have to continue to meet their residential costs, would actually make continuing care slightly more expensive. More people would get more things free, but some people—not people who are already in continuing care but people who are moved into continuing care—would be made worse off to that extent. It is never very easy to move money around without creating losers.

Q320 Barbara Keeley: No. In terms of the commission's proposals, implementing them in full, you say, would take a decade. Do you think there are staging posts in that 10 years that one can see, or is it difficult to envisage those at the moment?

Dame Kate Barker: I find it slightly difficult to talk about. I know it is one of the things that the King's Fund wants to do more work on. There are two reasons for staging. The one that I find really frustrating is the fiscal difficulties that I have already referred to. In that context, having talked about the choices that face politicians at the next election, I was not particularly encouraged to see that the CBI, my former employers, last week—I think a majority of the businessmen—said that they would like to see the ring fence removed from the NHS, which suggests to me that they have not quite gripped where the discussion lies. I say that because it demonstrates how difficult it will be to have this more adequate funding that we are talking about. I am going to answer your question properly in a moment, but I want to make this point because it is an important point to me.

If we have an ageing population, with far more people in it with conditions such as dementia, we are going to have to look after them; we are going to have to pay for them. The proposition on this is whether you pay for them across the population or leave most of the burden with the families of those who are better off. That is a perfectly sensible question for politicians to take a view on. You will see that the commission has taken a view on it. In the sense that they have to be paid for anyway, increasing tax for everybody but releasing the burden on some people probably does not make that much difference to the economy. In that sense, we might not worry about it but it might still be a slightly

disruptive thing to do at the moment; it might be challenging, given that we already have plenty of other challenges in the public finances.

In terms of organisation, I am absolutely not an expert on the organisation of the NHS and local authorities. I am keenly aware of the fact that the NHS has just been through one reorganisation and there is some reorganisation implicit in the Five Year Forward View. So to introduce another reorganisation very quickly I do not think would be very helpful.

I am also interested in the idea that came out of one of the earlier questions about trying to build on what is there now. To drive ahead with a sudden reorganisation would not be quite right. The reason it would take time is that you might want to pilot things in some areas before you moved ahead, but I do not have enormously worked-through views about exactly how I would stage it. Both the financing and the desire to make sure you have the right form of organisation are reasons for being a little bit hesitant. Scotland, of course, has been doing some of this already; so there are presumably some things we could learn from looking at their experiences.

Q321 Barbara Keeley: On the £3 billion of funding that might be made available to fund the changes that you propose, there are some illustrations of how current funding could be redirected at a time when increased funding is unlikely, and we have already touched on winter fuel allowance being one of those. Do you see the redirection, where there are elements in that which might or might not be politically palatable, as just a pragmatic solution, or do you think the whole £3 billion is absolutely fundamental? Does it have to be that much to make the single commissioner and budget model work?

Dame Kate Barker: No, it absolutely does not have to be that much if you are not going to change entitlements. You are then still in the business—the complexity and cost—of means testing people, so I do not think you would quite deliver as much for the patients. But of course politicians can choose to face up to the difficult choices. Nowhere that you raise tax is going to be popular; we would be kidding ourselves if we thought it was. The reason that we made the particular proposals—and we set the rationale out in the report—was the perception that today’s pensioner population, relatively, are quite well off for a pensioned population, not everybody. I would be a foolish person to believe that every pensioner was well off, but, relatively, they are reasonably well off. I am part of a couple that gets the winter fuel payments; I absolutely do not require it and will be giving it to the Surviving Winter fund. When we have had a time of such difficult austerity, the fact that some of these pensioner benefits have been untouched seems to me odd, but that is personal. I am not a politician and it is the politicians who will have to make these difficult choices. Plenty of difficult choices have been made by politicians in the last few years.

Q322 Barbara Keeley: The £3 billion is essential if you want to change to that new model.

Dame Kate Barker: It would be essential to produce the improvement in entitlements that the commission has argued for. We did argue for that—again, I do not want to sound sanctimonious—on moral grounds, on the grounds that it felt to us fundamentally unjust that people who are unfortunate enough to have dementia or Parkinson’s, where they have very high needs for things that are classified as social, should have to meet a so much

greater share of the costs that fall on them than people who have an expensive cancer. That sounds really terrible, and I know it sounds—

Barbara Keeley: I understand.

Dame Kate Barker: I know it is a terrible way to put it, but that is why we made that decision.

Q323 Chair: Thank you. Can I return to a point you made earlier that the costs would be there anyway and that it is just a case of sharing it differently so that the burden does not fall on individuals but the state? Did you take into account the number of people where that is not actually happening because they are choosing to go without? Those who are self-funders very often do not spend the money at all; they are just going without any social care, running into difficulties and requiring earlier admissions to hospital. Is that something that you factored into your review?

Dame Kate Barker: Yes, although in some sense the fact that people run into difficulties is part of the reason why you might want to provide them with a package of care that would help them.

Chair: Yes.

Dame Kate Barker: The point I am making is that in a civilised society you would like to think that people who needed this kind of care would have decent access to it. One of the critiques of the report that has been put to me by other groups is that even saying that people with moderate needs do not get as much free care is not sufficient, because moderate needs are still relatively acute. Although we have tried to tackle the moral problem, we certainly have not completely resolved it. Yes, self-funders who decide to do without could, frankly, still decide that.

Q324 Chair: Did you make an assessment during the course of the commission about the level of unmet need, that is to say, self-funders who are going without?

Dame Kate Barker: I am not sure we did, but I recognise this is a point because it runs the risk that you would find, as I think they did in Scotland, that demand rises more rapidly than you expect when you make something free.

Q325 Chair: Indeed, that is one of the reasons it is thought that integration of health and social care does not save money because you are better at identifying unmet need.

Dame Kate Barker: Yes, that is right. In a sense, that was partly what I was driving at when I said I thought it was much more likely you would get some quality improvement rather than that you would get money out of it. Frankly, I do think this is a problem. You might have to tackle this by careful designation of the packages. I am in favour—although perhaps if I had more experience of health I would be less in favour—of personal budgets.

Q326 Chair: So you do not overrun on costs.

Dame Kate Barker: If you use personal financial budgets, you then do have a way to control the financial burden that falls on you, but I am conscious of the fact that there is probably unmet need today and that people are not getting the care that they need.

Chair: Did you want to follow up on that particular point?

Q327 Robert Jenrick: How much of the £3 billion figure is an assessment of unmet need, or are you saying that your review did not make a full assessment of how costs might rise when these services become available? The £3 billion might be just a baseline and, in fact, there might be considerably more than that on top.

Dame Kate Barker: My sense is that the way in which it was calculated—because it was on the numbers of people who would meet that kind of standard of need—probably did, broadly, take account of unmet need. But there is always the risk that when you make something free you will find suddenly that there are rather more people than you expected who wish to access it.

Q328 Chair: Thank you. I have a question to ask you about hypothecation, with your economist's hat on. I find that is a very popular prospect when I talk to people at public meetings—they like the idea of paying a health service tax—and yet you rule out hypothecation. Could you set out, for all those people who think it is a good idea, why it does not work in practice? That would be helpful.

Dame Kate Barker: The first thing I would say is that this was one of the livelier debates we had on the commission. We did have lively debates and I would be failing Julian Le Grand in particular if I did not say that he was more enthusiastic about hypothecation than the rest of the commission. Why in the end did we come out against it? We found it quite difficult to think of a way in which we might make it work. We all remember that during the time when Gordon Brown was Chancellor there was an increase in national insurance to pay for a higher share of money going into the health service. Now, several years later, we are still paying the higher national insurance, but it is impossible to track the counter-factual of whether that extra money is still going into the health service after all the austerity and everything that has been shuffled around, because the money has gone into the Treasury and the money is fungible. The problem is that you can say, “We were going to spend x on the health service, but next year we will raise national insurance by whatever and spend y.” But five years down the line, all that really gets lost and the money could quite well move off into other things, not because anybody is cynical about it but just because other Departments also have their spending priorities.

The way you could get around that would be to say that we are going to be really clear about this so that everything we raise in terms of particular taxes will go on the health service. The problems with that are twofold. One is that the taxes you would have to dedicate to it would be incredibly significant taxes; the whole of income tax, for example, might be one thing. The second thing very obviously is that the take of any tax, such as income tax, does not go up and down in any way that is related to the needs of the population for health. Those are the reasons why we really found hypothecation difficult.

That does not mean that I would have any problem with saying, after the next election—and I heard you all telling me about winter fuel payments—“We are going to means test winter fuel payments in future because we want to fund a better social care system.” That is fine, but it is not really hypothecation in a strict sense. It is perfectly fine to say we are doing this for the next couple of years because we want to do that—that is great; but it is not really strict hypothecation where you tie a particular stream of money to a particular thing. The way in which you might most obviously think of it, because it is not so difficult, is, for example, to say you were going to spend the whole of the road fund tax on roads, nothing more and nothing less. That would be perfectly possible. It might mean that roads are a bit better one year and a bit worse another. Health is not quite like that and that is why I personally would find hypothecation difficult. However, revealing my prejudices, I do also share the Treasury’s general prejudice against hypothecation because, of course, the more you hypothecate, the less ability you have to make sensible decisions.

Chair: Thank you for setting that out.

Q329 David Tredinnick: Thank you very much; good afternoon. The commission proposes “an independent official body making regular assessments of the health and social care needs of the country, and of the spending needed to meet those.” How would you see such a body working in practice, please?

Dame Kate Barker: The proposal for this came out of the lengthy discussion we had about hypothecation. There was a sense that, if you did not have hypothecation and clarity about what was needed, there was not, as it were, anything to hold people’s feet to the fire to make sure that we were funding this properly. In a way, it was a slightly compromised proposal. I would see this body as being independent. I would not see it as making the decisions. In the end, decisions need to be taken by politicians. What I would see this body doing across health and social care, rather as Simon Stevens did for health care, is setting out very clearly what they thought the choices were between funding and entitlements and what you might get out of it, for the politicians then to take a decision. Somebody asked the question about whether I thought the bidding war was quoting the right figures. I thought the Five Year Forward View went quite a long way towards saying, “You are all talking about £1 billion or £2 billion, but we think the figure is nearer £8 billion.”

Q330 David Tredinnick: You said earlier on that some of these decisions are for politicians and yet this proposal would mean the Government giving up control over a large area of public spending, would it not?

Dame Kate Barker: No, not at all. This body would make recommendations and it would say—having looked in more detail than we were able to at the productivity potential of the health service—what it felt might be the consequences of different quantities of funding. It would still absolutely be for Government to make a choice along that bound, but it would mean that, instead of the Department of Health telling us, “It is all fine; we can fund it out of this,” you would have an independent body that said, “We are not sure that is right.” It would absolutely not mean politicians giving up control.

Q331 David Tredinnick: Is this proposal very different from NHS England's role for health? In other words, would you see NHS England becoming "NHS & Social Care England"?

Dame Kate Barker: That would be a possibility. I do not think it is very different from NHS England's role in that sense. I would see it as a body that set out clearly an expert view on what we might get for different levels of funding.

David Tredinnick: Thank you.

Q332 Chair: Do any other members of the Committee have follow-up questions on this? If not, can I ask a final question? How hopeful are you that these recommendations will be taken forward?

Dame Kate Barker: I am very hopeful that we will see moves towards integration after the next election. It seems a very popular idea. I am, bluntly, less hopeful that we will see the better funding for social care, but I am hopeful that by putting adult social care very clearly on the agenda, drawing attention to the inequality that exists because of the differences in the system today, that we will help to protect what, as I have already said, I would regard as a very vulnerable group. I would hope, however, that as the economy recovers further—and I really do hope it recovers further—we would start to be able to look to be more generous towards this group. Families really do struggle and it is fundamentally unjust. Indeed, as the commission argues, had the nature of disease and ageing been in 1948 what it is today, we would not have had the separation between health and social care.

Q333 Chair: Thank you. I have one last point. During the passage of the Care Bill we looked at free social care at the end of life. I noticed that your initial recommendation at least was that we should look at providing critical care free. Did you look at evidence around the cost benefits to the whole system of providing free social care at the end of life, in terms of avoiding the need for more expensive hospital admissions? Quite apart from the argument about giving people much more control over where they want to be at the end of their life, did you see good, clear evidence about cost benefits as well, or again was it about having better clinical care and more compassionate care at the end of life?

Dame Kate Barker: I have to say that I did not look at the evidence on that. I have nothing to add to that, I am afraid.

Q334 Chair: Thank you very much, Dame Kate, for coming today.

Dame Kate Barker: Thank you for giving me the opportunity.

Witnesses: **Rob Webster**, Chief Executive, NHS Confederation, **Carolyn Downs**, Chief Executive, Local Government Association, and **David Pearson**, President, Association of Directors of Adult Social Services, gave evidence.

Q335 Chair: Welcome to our second panel. Before we start, we are expecting a Division at about four o'clock, so apologies in advance that we will have to take a quick pause there.

Could you introduce yourselves to those who are following this debate, perhaps starting with Rob Webster?

Rob Webster: Hi, everyone. I am Rob Webster. I am the chief executive of the NHS Confederation.

Carolyn Downs: I am Carolyn Downs. I am chief executive of the Local Government Association.

David Pearson: I am David Pearson. I am president of the Association of Directors of Adult Social Services and corporate director, adult social care, health and public protection with Nottinghamshire county council.

Q336 Chair: You are all very welcome. Thank you for coming today. Could I start off with a question to Rob Webster? The NHS Confederation is not usually given to emotive language, but you start off in your submission saying it would be unthinkable for you to “provide a submission without raising serious alarm about the current state of NHS finances” and go on to set out the financial challenge. Could you perhaps set out for the Committee how serious are the funding problems of the NHS and social care overall in this financial year and how they compare with previous years of financial challenge?

Rob Webster: Certainly; thank you. We use those words advisedly on the back of previous submissions where we always try to be measured, consistent and fact based. The position in the NHS this year is one of deterioration on the finances. We are seeing increasing numbers of trusts in deficit and forecasting to be in deficit; we are seeing increasing numbers of CCGs forecasting to be in deficit; we are seeing a decrease in confidence in managing the financial position for this year and into the medium term. We are getting to a point where many of the indicators on the finances are going in the wrong direction, which leads us to the conclusion that we are at a bit of a tipping point in the NHS at the moment. On the back of four years and a whole Parliament of significant efficiency gains in the NHS, where we should be applauding the service for making the largest ever efficiency gains that it has made, increasing productivity and maintaining quality, we are now at a point where those efficiency savings, around doing the same thing but doing it quicker or cheaper, are running out and we need to move to a position in the medium term where we can change the way we deliver care so that we can have a service that is better, simpler, more cost-effective and more sustainable.

Q337 Chair: In your evidence you use the expression, “We think the NHS has now reached a point at which finances could collapse quickly.” Could you set out what you mean by the consequences of that collapse and how quickly? How do you see that panning out?

Rob Webster: At the moment we are seeing that there is a year-on-year requirement to meet demand that is growing at at least 4% and we have had flat-term increases in growth.

We have been at a point where the NHS is able to deliver efficiencies, but in the future a more realistic view would be between 2% and 3% efficiency. That means that a couple of billion pounds a year would materialise as a gap. What you then start to see over the next year—exacerbated by changes in the way in which we use funds, with moves to the Better Care Fund and other things, which we support—is more providers and more CCGs getting into deficit. That gets us into a spiral of focusing on maintaining the existing service rather than moving to delivering a different kind of service. We lay out in the submission what we think the answers to that are in terms of more secure longer-term funding, some transitional resources and so on.

Q338 Chair: What do you see as being the consequences if that does not happen?

Rob Webster: We know that it is always helpful to maintain good financial discipline so that you can focus on quality. We must maintain a focus on quality in the delivery of services. Once we get into financial ill discipline, we have to start making choices, and most of our members would say that the choices they make are always based on maintaining safety and ensuring that clinical effectiveness is secure. But what you start to see, potentially, are reductions in the experience that people have. You might see an extension of waits, a delay in the availability of treatments or you might start to see people thinking about which treatments they offer routinely. Those are the sorts of choices that people get into.

There is a choice to be made, though. The NHS Confederation in its 2015 challenge, which we are signed up to by the Local Government Association and 19 other organisations beside ourselves, sets out an ambition that says over the next five years we can have a sustainable NHS that is free at the point of use if we invest in it, support the transformation of it and if we get behind it. The subsequent Five Year Forward View by NHS England reinforced that, with many of the same messages and asks that we had of national bodies being repeated in the Forward View. This is why we are saying we are at a tipping point because we can either focus on the short term, which would mean a bit of crisis management, or we can focus on sorting out the short term and the medium term at the same time. If we do not do both together, we could be in a fairly parlous state.

Chair: Thank you. Over to Virendra.

Q339 Mr Sharma: How realistic is it to expect that the NHS will be able to achieve efficiencies and reorganisation to the degree set out in the Forward View in the period of 2020-21?

Rob Webster: There is a pretty good degree of consensus around what is achievable for the NHS coming out of think-tanks—people that you have had here giving evidence—and the Five Year Forward View in terms of being able to deliver, say, 2% or 3% efficiencies if we look at transformational change rather than doing the same things cheaper and cheaper. If we have a structural reorganisation, that will divert attention from that. We would suggest that the administration of health care, CCGs, health and wellbeing boards and previously PCTs, is something that we have obsessed about too much in this country. We have had many reorganisations of the administrative structures. We need to look at how we change the way we deliver care, and a reorganisation around the way we deliver care is

essential to meet the 21st century needs of patients, which are more about older people, people with long-term conditions and ongoing needs, which are integrated with social care too. If we get behind the consensus that exists clinically, managerially and, I think, politically around what needs to happen, back local leaders to make the changes and do not impose a reorganisation of the administrative systems, we have a chance of both delivering high quality care and achieving the efficiency savings. The Five Year Forward View and our view, as set out in the evidence, is that, unless you put a bit of real-terms growth in on a recurrent basis, there will be a gap between the efficiency that is achievable and the demand on the service. It is also likely that we will require a bit of money to pump-prime change or pay for double running, which I think the Committee recognised in its work on long-term condition management.

So we are asking for three things to happen. The first is to recognise that there is a bit of a hole at the moment in terms of the NHS finances. The number of trusts in deficit and the systems in deficit suggest that we are running a service we cannot afford, so you have to fill that hole. If you can fill that hole, that then gives you a platform to do two further things—to make money available over a longer period to give certainty to manage the change. The third thing is to make some genuine ring-fenced resource available to pay for the changes around double running.

Chair: Thank you. Andrew wants to come in unless you have a follow-up point, Virendra.

Q340 Andrew Percy: I am interested in the double running costs. On our one and only foray out of the country, we went to Denmark some time ago. Obviously we heard of the transformation there, where they closed a third of the hospitals and really invested in social care. It has always struck me that when we talk about change everybody signs up to it, but you do not need to be a rocket scientist to work out that you cannot just move seamlessly from one to the other. Have you done an assessment of what you think the cost is of double running and for how long you think that has to be absorbed—over what period?

Rob Webster: The starting point for us was to make good on the commitment that the policy suggests needs to be in place now. The expectation is that commissioners should put aside 2% of their running costs non-recurrently to pay for changes, which accounts for about £2 billion-worth of investment. The reality is, in many places, that that money does not exist; it goes into mainstream delivery. That is a good starting point.

There is work going on that we are supporting and committed to with the King's Fund and the Nuffield Trust to say, "How much do you need and when would you spend it?" We commend the Five Year Forward View for saying we need to look at how a transformation fund would work. This is an area that needs more of a focus. You will see that in our submission we suggest an independent body, much like Kate Barker has suggested, comes into place, which gives an independent view of how much is required and when, because there will be decisions to be made about when you allocate and when you use transitional funding on the basis of when change can happen. That is our position at the moment. Let us make good for a couple of years the resources that are supposed to be in place for the

policy that exists, but we are really open to looking at the evidence around what is going to be most effective on that.

Q341 Andrew Percy: You think £2 billion is a reasonable starting point.

Rob Webster: It is a reasonable starting point.

Q342 Andrew Percy: For how long?

Rob Webster: For two years.

Andrew Percy: Over two years.

Q343 Charlotte Leslie: NHS England's Five Year Forward View suggests a £30 billion funding gap by the end of the decade without significant change. The LGA says that social care faces a funding gap of £4.3 billion by the end of the decade, which is comparable in extent with the funding gap for health, which is 28% of the NHS budget. What will be the consequences for the health and social care systems if the combination of funding, efficiencies and reorganisation does not succeed in closing those gaps?

Rob Webster: From a health perspective—and I will let Carolyn and colleagues give you a local government view—if we believe the demands that are upon us are real, and there is a pretty strong consensus that they are, then somebody has to meet the costs somewhere. There is a planned way of approaching this and there is a chaotic and crisis-driven way of approaching it.

If we end up with a significant gap between what is affordable and what we need to deliver, then we have three choices. The first is that you cut the service that is available—you curtail the offer and say, “The NHS only delivers this much.” The second is you say that people need to wait longer for treatment. The problem with that is it gives you a one-off benefit because the demands are still there; you just leave them for a bit longer. The third is to introduce charging. In a survey of our members, they said that they suspected that their lack of confidence in the future funding availability led them to believe that those things may become a reality, with charging being the least likely to happen. If we do not have a conversation with the public about two things—for me, they are how much we put in and what the service looks like as a consequence, because it needs to fundamentally change in terms of care delivery—then we cannot make the changes and we will not have the resources. In doing those things, we need to have a conversation with the public about what choices you want to make about what we prioritise. Do you want to say something about local government?

Carolyn Downs: In terms of local government spending and the gap, that gap you have just mentioned is just in relation to adult social care and there is a much larger gap for local government as a whole. We would argue that adult social care needs to be protected as a budget going forward because, if it is not, the impact on the NHS will be even greater. So we would definitely wish to argue that adult social care budgets should receive protection.

However, if they do not, and if the cuts at the level that we anticipate continue in adult social care, councils will have clear choices. Those choices will be whether to continue to relatively protect social services budgets, which has happened. For example, if you look at council budgets, the budgets for planning and development have been reduced by 45%, whereas adult social care budgets have effectively reduced by 26%. Councils can make those choices as to which budgets they themselves choose to protect. However, particularly in those councils that have really high-level demand demographic growth as well and county councils which do not have the wider budgets to the same extent as unitary authorities, I genuinely think that what will happen is that services will be restricted. Efficiencies have been delivered now in adult social care and councils, so we will be starting down the route, much more so, of service reduction. On that basis, our budgets will eventually end up getting determined in the courts as people bring forward judicial reviews to challenge—

Charlotte Leslie: That is a nice cheap way.

Carolyn Downs: —the decisions that councils make. That would be a really unfortunate place for both Parliament and local government to be in.

Q344 Charlotte Leslie: I am going to relate to you something that a GP said to me when I was talking to her, and as gatekeepers of much of the NHS system GPs are interesting. She said, “If politicians grow up and don’t hurl abuse at each other when they come up with interesting ideas about how to safeguard the NHS for the next 50 years,”—“if that happened,” she said—“the NHS may be able to meet ‘free at the point of need.’ But,” she said, “I don’t think we are ever going to be able to meet it ‘free at the point of people’s demands’ because the two things are different.” We have talked a lot about supply side reform when we have talked about reorganisation. To what extent do you think demand side change is, first, necessary and, secondly, possible?

David Pearson: Can I contribute here? In terms of social care, there has been an incredible amount of creativity and innovation over the last four years in response to that austerity, which is why satisfaction levels with social care services have remained relatively high despite the reductions. There has been creative use of personal budgets, use of assistive technology, better advice and information, some better support for carers in places like Bristol, integrated commissioning in some areas with the health service that have helped with that, and also the work with enablement in some authorities, such as Leeds, Sandwell and Nottingham, where there has been work with the voluntary sector to help to meet that demand and need, and delay the need for care and support. However, with the doubling of the number of over 85s in this country, and something that is not often talked about, which is the increased number of people of working age—adults—with disabilities, there is good research that shows there is likely to be a 25% increase in the need for social care between now and 2026 for people with learning disabilities. We often talk about this in terms of the older people context, but we have to understand that there is a number of working age adults who rely on social care services.

In terms of the view about that, there has been a lot of work to manage it and there is more that can be done. The Care Act places a statutory duty on local authorities—and that needs to be done across housing and health—for prevention and early intervention strategies.

The scale of the demographic change means that, even if you do that, the graph gets deflated but it will not meet the funding gap that we have.

In terms of the Directors of Adult Social Services, when we completed our budget survey in July we were very concerned that the quality of life and the quality of care may go down. It may be difficult in future, if we do not do something, to meet the demands placed upon social care through the NHS. We have already heard about the possibility for legal challenge. There is a mix of measures that are required here. As Dame Kate Barker said earlier, it is implausible—I think she said previously—that those mixtures of measures do not include some investment from the state in increasing the spend on health and care. It would be unlikely to be successful otherwise.

Carolyn Downs: I would wish as well to support the point that Rob made earlier about the absolute essential need for a national campaign, working with the public directly about changing behaviour, so therefore changing demand, and the essential changes that will be needed in health service provision and health and social care provision. Without that, we are really going to struggle because every time there is a change then, obviously, the public react to that defensively.

Q345 Charlotte Leslie: But there is also, and I would value your thoughts on this, the story that a colleague of mine who is a GP—but also other GPs have made the point and it is illustrated by this—sees an 85-year-old chap with crushing chest pain who comes in and says, “I’m terribly sorry for taking up your time, doctor,” and then someone perhaps of my generation or younger who comes in in their pyjamas, which does happen, and says, “I have a sore throat. What are you going to do about it?” That change in stoicism, expectation and sense of entitlement is a very intangible change, but it has very tangible consequences on demands on our system. Is that something that you think should be included in a national conversation, not in a judgmental way but in an exploratory and explanatory way?

Carolyn Downs: Absolutely

David Pearson: Absolutely.

Rob Webster: I would posit it in a slightly different way. The 2015 challenge manifesto that we produced talked about two significant changes in this sphere. The first is to really focus on prevention and to keep people as well as possible for as long as possible. There is an incredibly strong role for cross-Government consensus on the environment, housing education and employment.

Q346 Charlotte Leslie: And physical activity.

Rob Webster: Yes, physical activity, which then plays out with local government in that the place where you live will determine how long you live and how well you are. Let us focus on that.

The second thing we should say is let us support people who have a long-term condition—18 million now and 19 million soon—to look after themselves, which they do for 9,000 hours a year already. What we do is waste their assets. People can look after themselves pretty well and there is a huge cohort of people who want support to look after themselves

better. As you look at the number of long-term conditions people have, it is still the case that many people want to have supported self-care. What we are calling for—and what was very strongly endorsed at the annual Self Care Conference last week—is a national sector-led programme that asks, “How are we harnessing this energy? How are we changing the conversation with patients? How are we reflecting on the fact that you can’t be cured of being a child, of having diabetes or being old? We just need to have a different relationship with you.” If we harness that energy—Simon Stevens talks about harnessing the renewable energy of communities—we won’t waste it. For everybody who we may think is inappropriately accessing care, there are lots of people who could take control, but we need to make sure that we give them the opportunity, which requires us to change the way we deliver service, the attitudes that we have, the way that the service work force is organised and so on.

David Pearson: May I add to that? The conversation with the public about expectations is absolutely crucial. There are a number of components to that, though. There has to be readily available advice and information about people’s difficulties, because people will go to the easiest port of call, which, for too long, has perhaps been accident and emergency departments.

The major cost for the NHS now is that 70% of the budget is being spent on mainly older people with long-term conditions, so we do need to shift the balance of resources into that community provision. That is where the transformation fund, and the issues that you have discussed previously, comes into play to ensure that that shift is made, but also at a local level to join up services across not only health and care but housing, the voluntary sector and other local organisations, which is why it is so important that this is locally set to some clear national parameters about performance outcomes, the policy priorities and making sure that the levers are aligned to make sure that those changes can happen. Of course every developed country in the world is seeking to make these changes, so we are not new in that and we can refer to other examples, but those are the sorts of ingredients that seem to us to be absolutely essential.

Q347 Charlotte Leslie: One of the very frustrating things about being a politician is that in politics—unlike in any other walk of life, where if you have a really huge problem to solve you should be free to ask any questions; it may be that for the question you ask the answer is no, but you should be free to ask—there are so many areas that we cannot talk about in terms of solutions for the NHS so that we are not exploring where those possible answers might even take us. Do you think there is a need for a political amnesty, for us all to make an oath that we are not going to misrepresent and chuck stones at anyone who comes up, as Norman Warner did, with some alternative models for how we might do this? Do you think that would be a useful manifesto pledge for all three political parties? Is that nodding?

Carolyn Downs: It would be useful but unlikely.

Q348 Charlotte Leslie: Let us see if we can change that.

David Pearson: We are in awe.

Rob Webster: I do not think there are enough solutions around to ignore any of them.

Charlotte Leslie: Absolutely; thank you.

Q349 Barbara Keeley: To add to Charlotte mentioning the debate on inactivity and activity this morning, you said people cannot be cured of diabetes, but we could avoid diabetes if we had a more active population. It has struck me when we have discussed it here that we are in the silly situation, as with the cuts to social care, that the body that can maybe do the most about this—local government—has had such enormous cuts. To expect new activity and new initiatives around physical activity to emerge from that situation is tricky. We are already pushing on social care, but clearly there are things such as avoidable deaths, illness from cancer and avoidable diabetes that we should be taking more seriously. Perhaps, in terms of ADASS, this whole thing about public health spending 33% of its budget on anti-smoking measures and 3% on physical activity needs to be redressed.

Coming back to our Committee's questions, the NHS Confederation argues in favour of a 10-year funding settlement for the NHS and for an "Office for Budgetary Responsibility in Health" to support and provide evidence for such a settlement. Could you tell us what advantages you think a 10-year settlement would bring? Is that realistic, given that you are also pointing out the situation we are in at the moment? Ten years would be two or more Parliaments, with all of the bidding war that you get into in the months running up to a general election. Would it be meaningful to even think that you had a 10-year settlement, when no Parliament can bind a future Parliament, and these decisions are always made quite close to the election when you are going out to ask the public what they want, if you like—what they see as a priority and what they want to spend money on.

Rob Webster: There is a degree of consensus among the think-tanks and local leaders around having longer-term settlements. The position we find ourselves in now—and I attended all of the party conferences personally—is that we have some sort of idea of what the spending commitments would be of the political parties over the next Parliament through various comments that have been made, but I do not think there is any agreement or understanding, first, of what they really mean and, secondly, whether it is sufficient. One thing the Five Year Forward View did pretty well was to give some scenarios about what might happen, which you can put alongside the Barker commission, the work of the Health Foundation, the Nuffield Trust and the King's Fund and others. But what we do not have is an independent body that says, "If you look at the demographic trends of this country, we have a doubling of over 85-year-olds; we have a system that looks like this; there is learning from elsewhere," and that says, "The pressures on the system over the next decade look like this." Wanless started to do this. "So the pressures over the next decade look like this. The position currently in the service and the opportunities for improvements on the evidence base would suggest that the investment in health care, through the public purse, needs to look like this. It needs to be matched by reforms which will deliver efficiencies of...", and that requires some choices.

With a fixed-term Parliament of five years, I think you can then say, "Okay, we will consider in advance of the election what our commitment would be to that." You could make a five-year commitment to that and make an assessment of what the next Parliament might be against that 10-year settlement. All of those conversations could take place in public with public involvement and public debate about the analysis, the assumptions and the choices.

Having worked in the Department of Health for a number of years previously and having been in the spending review team, I know how it works out. There is lots of great debate and fantastic analysis, but it is all done in Richmond House, in the Treasury and in No. 10. If we are faced with some serious financial challenges and a tight fiscal position, should we not be saying to the public, through an independent body, “Here are some choices we can make based on the best evidence and the facts available”? You would still have Parliament making the decisions, but you would be able to do that in a way that gave the NHS some certainty so that back in the field people could do what they are trying to do now, which is do long-term deals that risk share and manage the transition from hospital out towards more integrated hospital and acute or hospital and acute community services. At the moment we already do long-term commitments with things like the pharmaceutical industry, which last more than a Parliament to give them certainty. So does not the NHS deserve the same?

Q350 Barbara Keeley: But is it realistic—can it be meaningful—when there is the bidding war that you get before a general election, and the fact that, whatever political parties say, they cannot bind a different Parliament, which may be run by a different party that has different priorities? Is it sensible? What could you rely on there when everything could change?

Rob Webster: It is about ambition and commitment. You can make a firm commitment for a fixed-term Parliament and you can make—

Q351 Barbara Keeley: But not beyond that; that is the point I am making.

Rob Webster: But you can have a recognition of a share of GDP that you might expect.

Q352 Barbara Keeley: But it would change, would it not? If things change, if there is a different Government elected, they would potentially have different priorities, particularly now where we have a coalition Government and the splits between parties. I am asking how meaningful it is to be asking for things. It is a bit like asking for a 10-year weather forecast, isn't it? It may not be sensible.

David Pearson: I would say it is advisory. It is rather like the Monetary Policy Committee. In relation to that, it is up to the Government to decide what its actual financial policy is, but it helps both to have the expertise applied to a particular issue—and these issues are complex—and to shine a light on them, which informs that policy direction, or whatever Government. In a way, perhaps at the moment we have a mismatch as a nation between our expectations of the health and care system, the growing need and demand, and our collective understanding of that and what the implications are. Anything that helps to exemplify that must lead to a better public debate and a better set of political decision making.

Carolyn Downs: On the point of longer-term budgets, we have a very strong view that local government should get a five-year settlement to cover the period of the Parliament. I understand the issue about longer-term projections, which are really important, but just that five years will definitely enable us to plan ahead. If you are trying to achieve

significant change, it does allow you to front-load your funding to enable change that may achieve savings further down the line. We support the concept of the Better Care Fund—and I say the concept—but we are clear that that should have been a five-year programme and had up-front funding to ease the transition and the impact on acute care. Then it would have really been able to take off in an innovative and locally-led way.

Q353 Chair: Can I clarify a point that, Mr Webster, you referred to earlier when you were talking about the consequences? You talked about cuts to availability, waiting for longer and introducing charging. It is an area that the public are quite concerned about. Have the NHS Confederation identified any areas where there have been new charges or top-ups? Has there been an extension of charging or top-ups at present? Have you seen any evidence of that?

Rob Webster: No, because—

Q354 Chair: As Charlotte was mentioning, do you think we should have everything open for discussion? Is that something the NHS Confederation would welcome? We have heard other witnesses telling us that top-ups do not raise as much as people think they will and that we should not go down that route. Is that the view of the Confederation?

Rob Webster: We need to look at the debate. We do not support charging, but we do require people to make decisions based on evidence, choices and analysis. We did some work in 2011-12 about tough choices in the financial environment we were in—“What would you do, what is the evidence around charging and how effective it is? What is the evidence around waiting? What is the evidence around rationing?”—because some of those things might be material choices that you have to make if there are not sufficient resources. We should never discount a consideration of the effectiveness of the ways we do things because of political sensitivities, but we should allow politicians to make the final decision around what they think is appropriate based on a public debate. If we think that there may be better ways of applying charges—I know that some people believe the way we apply prescription charges, car parking charges and dental charges is not fair, and there are all sorts of things we could do—

Q355 Chair: The Barker commission specifically looks at changing prescription charges. You do not abolish them; you make more people have to pay them but at a lower amount. Is that something you have looked at as the Confederation?

Rob Webster: No.

Q356 Chair: To reiterate, you have not seen any evidence of new charges or top-ups at present.

Rob Webster: No.

Q357 Andrew Percy: I am interested in the public debate and trying to tie politicians into agreeing over a long period of time, which is delightful but probably unlikely. I asked Simon Stevens when he came before us the question about whether or not it is time to have a royal commission, which is one way of trying to bind the parties in. Simon Stevens's response was not to support that, his evidence being that there had been royal commissions in the past. What do the panellists think about whether it is time we had a royal commission? I find this whole bidding war unsavoury and, basically, all politicians are misleading the public about the scale of problems facing the NHS for a few cheap votes and all the rest of it. Is it time we had a royal commission in which the parties sign up to that and sign up, so far as they can, to be bound by the consequences of that around the future funding of the NHS?

Rob Webster: My worry about that is pace. If we have a worsening financial position and we are running services in a way we cannot afford now, a royal commission would take a significant period of time to conclude. The timing would then be interesting about recommendations and the parliamentary cycle. People can be braver earlier in the political cycle, and if brave choices need to be made they should be made earlier.

Q358 Chair: Did anyone have a final point before we have to dash down to the Division lobbies?

Carolyn Downs: I would like to support that point in terms of time and pace. Adult social care funding is in crisis now and we cannot wait for it to be fixed.

Q359 Chair: You feel it would just take too long. Is that your view as well?

David Pearson: I absolutely agree with those comments.

Chair: That is a very good point at which to break because we are moving on to another group of questions. Thank you very much for answering that concisely.

Sitting suspended for a Division in the House.

On resuming—

Chair: Apologies for the long delay. It puts into perspective why we need electronic voting, but I digress. Thank you. We will come back to start on integration of health and social care with David.

Q360 David Tredinnick: Chair, as a gentle introduction, having had this enforced break, I was reflecting, having served here for something like 28 years, on how much time I had spent in Divisions and it would be a very long time. I do remember serving on another Committee—the Channel Tunnel Rail Link Bill—which sat for long enough to walk from

here to Madrid at a leisurely pace. So we do spend quite a lot of time doing various things here.

I wanted to ask you, moving on—after what I hope was a fairly light-hearted introduction—to talk about integration from another angle. We pretty much have a consensus that there should be greater integration of health and social care services, and the commission that Kate Barker chaired, whom we saw earlier on, has advocated moving to a single, ring-fenced budget. Do you agree with these proposals? Mr Webster, you look anxious to answer.

Rob Webster: No, I was wondering if someone else wanted to answer first. In the places where we serve populations, we should look at what care people need and we should do that together. My concern about being too prescriptive about the structures through which we do that is that we start to focus on the structures and not the needs. We would very strongly advocate—and did so in our *All together NOW!* joint publication—that there needs to be a joint settlement for health and care over a five-year period; that that needs to be considered jointly at a local level in terms of how that is spent; and that you should do that in ways that preserve and support relationships so that people can focus on what people need, which is joined-up care.

Carolyn Downs: We are entirely in that same place as well, perhaps more in relation to Kate Barker's larger and wider proposals. We absolutely support the need for more money into both health and social care. There needs to be a really high-level conversation with the public about health and social care and how they are funded going forward. We would not want to dismiss out of hand her proposals about how to get more money into health and social care, but that needs to be a conversation directly with the public around the issue of a public information campaign as well.

We are very supportive of the idea of a single budget for health and social care. We would like to see it over a five-year period, as Rob has said, and we would want to see a transformation fund that sits alongside that. We understand that local government does not like ring-fenced budgets because we feel it definitely restricts local discretion. However, if the proposals that are on the table are for such a significant level of additional funding into social care, then that is something that local government needs to be very mature about and discuss and consider going forward. We have always had a real dislike of ring-fenced budgets. On that point about ring-fencing, if you look at the level of funding over the four years of austerity that have gone into social care, both for children and adults, those budgets, while not ring-fenced, have been significantly protected.

David Pearson: As an additional contribution to that, I totally agree with the points that have been made around not seeking structural solutions. Also, in terms of aligning, or a single budget, I cannot see this divorced from the assessment of how much it needs to be, given the need for transformation change and integration and what that can deliver in savings. But, as Simon Stevens has coined the phrase, joining two leaky buckets together does not necessarily make them watertight, so there is an overarching issue about how much is in the pot.

The second issue is about the local oversight of that. I totally agree that we do not need structural solutions, but the role perhaps of something like the health and wellbeing board, with teeth, could be a way of bringing services together without changing those structures.

Finally, the announcement on 4 September between NHS England, the LGA, ourselves and Think Local Act Personal about integrated personal commissioning about perhaps joining up individual personal budgets around the needs of people who have substantial numbers of long-term conditions—possibly around 3 million people in this country—could be something that, if we can see a way through that, could break down a lot of the barriers automatically between them.

Q361 David Tredinnick: When you say “see a way through”—

David Pearson: It would help to ensure integration around people’s needs in a very effective way.

Q362 David Tredinnick: I want to ask about personal budgets a little bit further down the road in a minute or two. How difficult do you think it will be to bring together different eligibility and co-funding rules, and what do you think the costs will be? We have had some figures bandied around. It seems to me pretty obvious that, if you are going to do away with means testing, there is going to be a huge increase in cost, and I mean social; it is completely different funding, is it not? Health and social care are funded in a completely different way at the moment.

Carolyn Downs: Yes.

David Pearson: Yes.

Q363 David Tredinnick: How difficult is it to do this? What do you think?

Rob Webster: At the moment local leaders take a positive decision to work together for the benefit of local people. In some places they share the risk around that. They try and design services in ways that will meet their needs, recognising that there will be an element of means and needs assessment, and there will be an element of payment potentially for some part of that care. It would be better if the rules allowed for that work to be developed in ways that were simpler and supported those local leaders, and there are a number of things that could improve that around how people are held to account and what the outcomes are expected to be. You do not necessarily need to get away with needs assessment in taking forward those proposals. That is one of the choices that needs to be debated with the public and comes back to this issue of, “What do you want to invest in? Do you want to invest in care, in health, or health and care together? If you do that, how much money do you have? How much does it save in simplifying the system by making it more efficient, and what is the gap?” All of these issues are packaged together in a future system that we have not yet designed. It is clear that there is a need for a significant amount of activity through local relationships, good intentions and local commissioning to make this work.

Q364 David Tredinnick: You would see significant savings down the road through the amalgamation of the two services, would you?

Rob Webster: There is limited evidence on this. If you look at the submissions we have had from people like the Health Foundation and the King’s Fund, they point to the

evidence base. It is clear that we have multiple assessments and multiple services supporting single individuals, and there must be some element of double running or duplication there. As one of the questions from one of the members of the Committee mentioned earlier, at the moment there is a bit of unmet need too, probably. These things all have to be taken into consideration when we are thinking about how services are developed, what the costs would be, what the impact is and what the overall mechanisms are. But at the moment we do not have an alignment between the policy intent, the funding mechanisms, the incentives and the delivery. Until we have that, I do not think we will have the kind of integration that we want.

David Pearson: If I can add briefly to that, as Rob said, the research evidence around savings is mixed, but the savings do not come necessarily from joining up structures or pooling budgets per se. It is about applying that to, for example, the 30% to 40% of older people in hospital, where consistently the research evidence says that if there are better community-based services they could be cared for in an alternative place.

In relation to your point about eligibility and the differences between health and care, clearly we have just had the Care Act with the national eligibility criteria and, although these things are complications in the local systems, they are not insurmountable in terms of joining up the services. It is like information sharing and all the other barriers that there are: they are things to be overcome and worked with at a local level.

Q365 David Tredinnick: The Health and Social Care Act has facilitated that through health and wellbeing boards and clinical commissioning groups. I sit on the local board in Hinckley in my area and I am very impressed with the way the different services are working together; you have a sense that both sides are delighted to have been put into an alchemical vessel where they can work it through.

What do you think has been learned from initiatives such as care trusts, integrated care pioneers and the Better Care Fund? Ms Downs, you are smiling wryly, so maybe you are wondering about where that question is coming from.

Carolyn Downs: I can certainly talk about the Better Care Fund and I sponsor an integrated pioneer as well. In relation to the Better Care Fund, this is a concept that we would all warmly endorse. We definitely endorse the bringing together and the integration as a concept. It was rather unfortunate that in the agreement it was for one year only, which is starting from April next year. I genuinely think that the placing of the £3.8 billion in both spending power for health and local government has done absolutely nothing to help the whole process. That has been a real block.

The policy around the Better Care Fund changed halfway through the process, effectively, of putting the plans together. The issue of a £1 billion-worth of savings that were required to the NHS when we started the whole process of the Better Care Fund was perceived as a performance element that was £1 billion-worth of benefit to the NHS. That change in the whole policy intention of the Better Care Fund was deeply unhelpful, and it became a discussion in local places not so much about integration and better outcomes for patients or residents, but a competitive process as opposed to a collaborative one. It became a very transactional discussion about which budgets fit where, as opposed to a transformational discussion. Nevertheless, and as a result of that, it has slowed down the process, and some

councils would definitely say that it has set the process of integration backwards because it has not allowed local relationships to flourish on the basis of a mutually agreed understanding of what needs to happen in that community as opposed to a more top-down process imposed from Whitehall.

In relation to the Better Care Fund there are a lot of lessons that can be learned. It needs to be agreed over the course of a much longer period; it needs to have a transformation fund sitting alongside it; there needs to be a far greater level of local discretion, and let local leadership, through health and wellbeing boards, determine the type of integration as opposed to it being imposed from Whitehall.

Having said that—I am sorry this is a bit of a rant—£5.3 billion has been pooled over and above the £3.8 billion; 64 health and wellbeing board areas have pooled more than was required of them. Savings of over half a billion have been identified in the process and the overwhelming majority of plans have been approved. Actually, there are good outcomes that are coming from the plans in benefits to residents in all our communities. The concept is good and I personally think it will be beneficial in the communities, but the process has been too top-down.

David Pearson: Just to add to that, the lessons from the Better Care Fund emphasise, when embarking on a transformational programme of this nature, how important are the national policy parameters—the performance requirements and aligning the levers to make sure that those changes can be made at a national level—and then enabling the local health and wellbeing boards and organisations to get on with it. From a social care point of view, we were disappointed that the performance requirements for social care got relegated in the redesign, but I suppose, taking the next step, we need to make sure that, in terms of that policy performance and those levers being aligned, there is flexibility about how local areas implement it, because there are differences between places such as Wigan and Nottinghamshire just in terms of size, scale, rurality and all those things, which need to be taken into account by local clinicians, politicians and communities designing the future together.

Rob Webster: The other thing I would add to that is that everybody agrees with the intention behind it and the principles are good. Giving the health and wellbeing boards some teeth and a decision to make was a really powerful thing to do for health and wellbeing boards. The lack of engagement of providers was a significant issue throughout the process, and it is still the case, I think, that a fifth of providers signed the plans off with caveats or reservations, which demonstrates a lack of maturity of the system at the moment. We must make sure that we are learning the lessons from the process so far, because all of us would agree that the actors around the table are going to be instrumental in thinking about a different future.

Q366 David Tredinnick: Following on from that, much of the discussion focuses on commissioning bodies, but what role do you think the providers should have? We have not heard so much about the providers. Do you have a view on that?

Rob Webster: It is all about the providers. We have to start from a position of understanding that commissioners do not deliver any care directly. We are asking, in total, 1.4 million health staff, 1 million social care staff, 3 million volunteers and 6 million or 7

million carers to work differently in the future. Embracing and engaging the staff around the different model of care, the different way they are going to engage with families and the different way they are going to work with each other—the cultural aspects of that—are instrumental in the success of any integration in the future. That integrated provision, backed by an integrated single view around commissioning, is incredibly important; so providers have to be engaged and their insights and understanding harnessed in coming up with the potential solutions.

Carolyn Downs: As to some of the integrated pioneers, their health and wellbeing boards are specifically working with the providers directly as a mechanism to get a quicker and deeper level of change. There are different ways of doing that. Some health and wellbeing boards have the providers sitting on the health and wellbeing board. That was not prescribed in legislation, but places are doing it. Personally, I think that is a really good idea. Other health and wellbeing boards are working on the basis that they have sub-committees where the providers are fully involved in discussions that impact on the services they provide. We have to work on the basis that health and wellbeing boards have to engage directly with providers to make sure that that buy-in is there, otherwise we are not going to get the level of change that we need going forward.

David Pearson: Can I add, from a practical point of view, that my own authority, Nottinghamshire, is a fast-track Better Care Fund area with six clinical commissioning groups, seven district councils and three acute trusts? We would not have been a fast-track area had it not been for the engagement of the providers in the change plans that we were making because they are absolutely crucial to the delivery. They sat on the sub-area of transformation boards in each of our areas and helped co-design those processes.

Q367 David Tredinnick: Let us go back and pick up a point we were on earlier to talk about personal budgets for a minute but also to link it to patient choice and the recommendations in the Five Year Forward View. What role will personal budgets play in the integration of health and social care? What lessons do you think can be learned from the experience of personal budgets for social care?

David Pearson: We now have 80% of people in social care on a personal budget, and in some authorities it is higher. In my own, it is over 90%, and it is only not 100% because there are some people who are not in the system long enough—because they have been reabled—to receive a personal budget. In Nottinghamshire, 46% are on a direct payment and so directly receive the funding to help organise their care.

That can be helped by other organisations. I have seen some very interesting joint work with the Alzheimer's disease Society about using things like direct payments for people with advanced dementia, which have made a significant difference in keeping people at home for longer, utilising the carers and helping the informal carers—the family—to shape and co-ordinate that care in a way that helps to put them in control of what can be quite a bewildering situation. That can have a profound effect, but, clearly, if we can shape together the health and social care budgets, then a lot of the joins that people have to overcome to receive their care and the multiple telling of stories about getting the service would be, potentially, significantly helped in terms of joining up the services.

Q368 David Tredinnick: I looked at some of the trials of personal budgets and they were extraordinary because they were breaking new ground in several ways. First of all, it was empowering the patient.

David Pearson: Exactly.

Q369 David Tredinnick: Secondly, it was empowering the carer, who very often—in some cases, maybe not very often—was able to go back out to work because of the change. Thirdly, it gave extraordinary choice to the patients in what they were able to choose as treatments. I have mentioned before in the Committee that I can think of some of the less conventional therapies that have been chosen, such as tai chi, yoga, mindfulness and piano therapy. Patients could choose whatever they like and were not told that these therapies had to have double-blind, placebo-controlled trials to authenticate them. They were told to go and get them. The last point is that these personal budgets have reduced costs. All the time we are hearing about demands for more money and very little about reducing costs, and I would put it to you that giving patients and their carers more choice is improving the services and reducing the cost.

David Pearson: If I could come back on that—and other colleagues might want to contribute—I hope it was clear in my earlier submission that Directors of Adult Social Services and local authority councils have taken very seriously the responsibility of managing austerity by reducing costs. We do recognise our financial responsibilities and take those very seriously.

In relation to your analysis, I would entirely support it. Clearly, the social care experience tells us that we need to make sure that the support planning around the use of the personal budgets is good, to make sure that the moneys from the public purse are used for the most effective treatments and approaches as well as the choice. So there is a balance here. If we are talking about something that is absolutely known to be evidence based, a good sort of service or treatment in delivering outcomes, it is quite important that we make those available and encourage people to use them. The choice, the control and some degree of saving is absolutely right, but, rather like integration, it is not the silver bullet for all of our financial challenges.

David Tredinnick: I am suggesting to you that, if we are really going to go down the route of patient choice, “the NHS will take decisive steps to break down the barriers in how care is provided”—I am quoting from the Five Year Forward View—and people will have “far greater control of their own care”. There are recommendations running to a whole page on empowering patients—“more to support people to manage their own health”. Then it says: “A third step is to increase the direct control patients have over care that is provided for them.” I also chair the All-Party Parliamentary Group for Integrated Healthcare, the old Complementary and Alternative Medicine group, and a lot of people out there are asking for what you might call ancillary services. Some of them have taken quite a beating over the years, and I am thinking in particular of the homeopaths. However, the homeopathic doctors have been regulated by Act of Parliament since 1950, and the Society of Homeopaths, which are the non-doctor homeopaths, have just been taken under the wing of the Professional Standards Authority—about 1,000 of them, from memory. The acupuncturists, the largest society—

Chair: Do you have a question to ask?

Q370 David Tredinnick: I have; thank you, Chair. The British Acupuncture Council has also been taken under the wing of the Professional Standards Authority. A lot of these treatments are less expensive. I am suggesting to you, “Is there not a third leg on the stool here?” You can have your integration of health and social care, but you cannot really have patient choice, as aspired to by the two Secretaries of State—the current and the last one—and these reports, unless you broaden the range of treatments available, as demonstrated by the way patients have been choosing services in the personal budgets.

Carolyn Downs: Yes, I think we would all agree with that, and we are all represented on a body working with NHS England directly specifically looking at the whole issue of integrated personalised care budgets. We are just starting. They are very clear that health needs to learn from local government in the work that we have done in that area. I would not underestimate how challenging it is going to be in bringing those wider health budgets into a personalised budget, but we are all committed to moving in that direction. I am not sure how significant the savings will be, although I accept there will be some savings. More important is whether there are better health outcomes for people as a result of using personalised budgets. Our experience would say, yes, there are better outcomes for people.

Rob Webster: That is one of the critical points. The evidence is really mixed on cost savings for personal budgets in health. What is proposed in the Five Year Forward View, in line with a well-designed experiment to see how personal budgets might work for people and recognising who they would work for and how and what the arrangements would need to be around them, is something we would welcome. We must not underestimate what we would require in terms of the information that is shared, information that is available for people to make choices that they want to make—a switch, I would say, towards outcome-based approaches rather than input based approaches to health care, particularly for people with long-term conditions. Many of these things are welcome but are part of the fundamental shift in the way that we think.

Sir John Oldham in his Whole Person Care Commission—another important piece of work—said there are three things that we need to think about together. One is supported self-care for people with long-term conditions; another is re-stratification, so that you are looking at how you segment your population; the third is integrating the services with the right information to support that. If you do not put those three things together, you do not get the kind of benefits that you need.

Q371 Chair: One of the things the NHS Confederation pointed out in evidence was that there seems to be more benefit from direct payments than managed personal budgets. Was that based on self-selected groups? In other words, is there evidence that people who want to manage direct payments are different from the group who do not? In other words, that may be what drives different outcomes. Is that something that you factored into that appraisal?

Rob Webster: I would have to look at the detail of that and come back to you if that is okay.

Q372 Chair: There are some people who simply would not manage direct payments. In other words, are they already going to be a group who are going to have worse outcomes? Anyway, I know that we have to move on probably to Barbara's group of questions. Do you want to add something as well?

David Pearson: There has been a recent survey—in fact there have been a few—on the social care experience in relation to direct payments of personal budgets. Clearly, some of the people with direct payments, because they are in a position to manage the money, are probably further on in the journey, if you like, than people perhaps who have a managed personal budget, but this has to be a choice. Compelling people to have a direct payment would not be advisable because that is not the responsibility that some people want. It has to be a mix of measures, I think.

Chair: Thank you. Barbara, I know you were getting on to the Better Care Fund.

Q373 Barbara Keeley: Going back to the Better Care Fund—we have touched on it, so perhaps we can go through some of these questions quickly, looking at the time we have—Carolyn has already made some points about it and we have touched on things such as the lack of involvement of providers. In terms of preparation and planning, the National Audit Office report on the Better Care Fund planning process said it was “an innovative idea but the quality of early preparation and planning did not match the scale of ambition.”

The first point is, do we accept that the planning process could have worked better? Clearly, it has needed a pause and a second round, but I think I am right in saying that David Pearson said that there was a sense in which you thought we should have just been allowed to get on with it in the local area. Clearly, getting on with it in some local areas just did not work. Could you go over again—and we do not have to repeat what we have already said—what can be learned from the way that CCGs and local authorities have worked together or not worked terribly well together on their plans for the Better Care Fund, and is the five months that is left after the end of October enough to prepare for the implementation? Can we have those two points first?

David Pearson: Shall I start? Carolyn has made the point that we have spent a year planning for something and we are now left with five months to get into the implementation. There is obviously a mismatch there between the time scales for both.

My point about getting on with it is that I fully accept and think it is desirable that there is an accountability to Parliament for the NHS, and, vicariously, for social care, and that the national policy priorities and performance are set out and agreed, and are clear at the outset. It was a complex budget because there were multiple existing uses for it, so we have had all the complications of that. It is in that context that we can get on with it. The lessons from the Better Care Fund are that those things were not necessarily clear at the first point and there was a desire to let a degree of localism run with this, which was one of the reasons why it was set up in the way that it was. The question there is as to being clear about those processes at the outset for the future.

We are where we are. I agree with my colleagues that it is a good concept and the right thing to do, but we do need to learn the lessons in terms of the future for this.

Rob Webster: There is something about maturity of the system in all of this. If we reflect for a moment on where organisations were during the planning of this—which was a quite sophisticated piece of work, where the evidence base nationally is mixed—we were asking a group of GPs, who have just come together, to create an organisation and a local authority, which has just been given some duties to do which it has not had before, to come together on something that has a national evidence base which is mixed, supported by a commissioning support unit that is in a bit of flux, to come up with a really credible plan. I suspect it would take some time to get to the point where the plans are as good as they would want them to be. There needs to be a bit of understanding around some of those factors and also recognition that there is some great work going on. People like NHS Clinical Commissioners are producing great examples where CCGs and local government are working together on integration all the time. The position we find ourselves in now is one where organisations are improving, health and wellbeing arrangements are better, and the commissioning is improving and will be even better in the future. There are lessons for national bodies and local organisations on all these things.

Carolyn Downs: Can I come back on the NAO report? If I was Bob Kerslake, I would also have refused to sign off the NAO report. It fundamentally misunderstands and misrepresents the process that was undertaken. The policy was a deliberately localist policy and it changed as the NHS budget crisis became more apparent. It is very easy, with hindsight, to look at the process that was set off and then say that the circumstances changed a few months in and, on that basis, we will criticise the original process that we set off on. That is a fundamental flaw in the report that the NAO have undertaken.

I would say in relation to central Government—both DH and CLG—that, when there was the concern about the NHS budgets, they responded very quickly to put in place a different planning process. It is not my job to defend Government—in fact quite the opposite—but on this occasion I feel that both CLG and DH did work on this with the right intentions and I do not agree with the NAO’s report at all.

Q374 Barbara Keeley: Okay. As to the final point on that about preparation and planning, we have already had a comment from Rob Webster about the lack of involvement of providers. I do not know if there is any more to say about that. Would that make a difference? It might be that you all think that at the stage we are at now, with this experience behind people, the GPs, the CCGs and the health and wellbeing boards would make a better fist of it next time. Can we be confident that providers would be more involved next time?

Rob Webster: They are already involved now and the Secretary of State wrote to all health and wellbeing boards recently, which we welcomed, to ask them to make sure that they were engaging providers, either directly asking them to sit on the board or through some other mechanism. The thing that the NHS learns from local government is that including people in the conversation and the engagement is critical if you want to go further. Having providers and commissioners working together on this will allow it to go further.

David Pearson: I agree with Mr Webster’s comments; they are absolutely right.

Q375 Barbara Keeley: The next point is about savings; it might be that you are equally critical about that. The Government's aim with the Better Care Fund was that the fund would provide £1 billion of savings to offset the contribution from the NHS budget. It is now estimated that those savings will be £314 million, so it is just a third. It is worth thinking about the implications of that shortfall. Have you any thoughts about what level of savings the Better Care Fund might produce and what will be the impact on the NHS? I know there are fears about this movement of funding and the effect on social care, if that is a worry too.

Carolyn Downs: So the 300 and something—

Q376 Barbara Keeley: £314 million is the current prediction.

Carolyn Downs: Is that related to A and E, because there are about a quarter of a billion pounds-worth of savings also to adult social care from the Better Care Fund? I would argue yet again that the £1 billion saving was always expressed originally as £1 billion-worth of value rather than saving to the NHS. The original plans that the NAO criticised came in with savings of—and they were—figures between £300 million and £700 million. I accept that is a very large variance, but nobody was allowed to test it and develop it. The fact that the savings now are precisely in the middle of £300 million to £700 million—at £500 million—is interesting. It would be useful for somebody to look at the outcomes in the plans and see whether any of the outcomes are going to be massively different from those that were originally submitted in February from those that have just been approved now. My view is that the outcomes are very much the same.

Q377 Barbara Keeley: To correct our brief then, you are saying that the savings are currently estimated at £500 million.

Carolyn Downs: That is my current information, yes.

Rob Webster: Can I say something on the savings and the impact on the NHS? We have seen an inexorable rise in non-elective admissions—emergency admissions—over the last few years. This year there has been another step change in terms of people walking through the door; A and E attendances so far this year are up 4% and ambulance journeys are up 6%. We then have to respond to that, and we see hospitals struggling to respond. If these plans are delivered and we see a 3% reduction in non-elective admissions and start to turn the curve, that helps stabilise the system, which has to be better. It is better for patients because they are not having a crisis that leads to an emergency admission and it is better for providers because the arrangements at the moment with the tariff are such that the hospital only gets a third of the cost of treating that patient anyway. If we can deliver this, we can see whole-system benefits and a 3% reduction in non-elective admissions, which can only be good for patients and the system.

David Pearson: I would simply add that in a very financially challenging situation, with the escalation in needs that we have described through this conversation, a rate of return of round about 10% on the total invested—because, although it is 3.8, it actually turns out to be 5.3 that is being pooled—in mainly one year is a very good outcome and probably in terms of ambition is commendable.

Q378 Barbara Keeley: I have a final point for David Pearson, I guess, mostly. I have a concern that there could be great confusion about where savings come from and if there are any at all, given that some local authorities, you will know, in terms of adult social care budgets, are this year making their eligibility change; mine is. This is the winter when we are going to be facing up to 1,000 people not having care packages which they would have had: either they have lost them or they will not qualify for them. I have a fear that they will almost entirely translate into A and E admissions. It seems odd that we are working hard to put together plans for that when, at the same time, this other factor creeps in over there. Obviously there is a transfer, but I fear it will come in too late from April 2015, when we have to get through a winter where people have lost their social care package.

David Pearson: Your point emphasises the need to look at this in the round in planning the budgets together. I would emphasise, though, that local government has given considerable priority to the pressures on the NHS. Although the overall absolute numbers of delayed transfers of care, for example, have gone up, the percentage attributable to social care has gone down from 33% to 26% of the total over the last few years at a time when we have been experiencing that austerity. That shows the degree to which local health and care communities have been working very hard together to redesign systems, to make sure that the pressures, as far as possible, are relieved on the hospital services in a context in which we are all running up the escalator the wrong way.

Rob Webster: If there is a discussion to be had—as all the Liberal Democrats have been suggesting—it points to the fact that we need to re-open the funding settlement for next year and think about the autumn statement. Winter will turn into spring and summer and we will have the pressures of next year. We need to think about my earlier point about what we are going to do in 2015-16 to make sure we have a sustainable service before we get into a period of transformation. It is really important that we get that right.

Q379 Chair: Does it seem strange to you that the Better Care Fund is only for one year? Would you like to see it extended further?

Carolyn Downs: Yes.

Rob Webster: On the basis of a good evaluation of what works and all the lessons that need to be learned from the position so far, we would welcome the position in the Five Year Forward View that there is a sense of a stock-take. But we have all agreed, I think, the principles of working together, having funding to do that. You could think of this as a transformation fund if it was new money and available in the way that we might want to see a transformation fund available.

Carolyn Downs: We would take a slightly different view from that. We are very clear, obviously, that it is important to have a stock-take and evaluate new areas of work. However, we genuinely think the Better Care Fund would have been far more successful and more ambitious if it had been planned over a five-year period rather than a one-year period. It would be really unfortunate if the Better Care Fund was stopped on the basis of something that was an imperfect start just because of the fact that it was curtailed to that one year from day one.

Q380 Chair: Thank you. One thing that we have heard in previous sessions of this Committee is that many councils were using the Better Care Fund to look at how they could fund provisions from the Care Act itself. How much does it concern you that you now have a gap—that you are not allowed to use it for certain aspects that were originally going to be earmarked?

Carolyn Downs: It is a matter of concern and we were really unhappy that the new moneys for the Care Act were put into the Better Care Fund because it is not money over which you have a huge amount of discretion.

Q381 Chair: And it is only one year.

Carolyn Downs: Yes, exactly. We are very concerned about the level of funding for the Care Act per se, but one of the issues—and it comes back to a previous question about a single budget—is that there is a need for transparency around all these issues as to what money is being used for what. At the moment one lesson to be learned about the Better Care Fund is that it needs to be clean, new money that you are using rather than existing money from two very creaking systems. David will know more about the Care Act in particular, but I think we are very concerned about that issue.

Q382 Chair: On the subject of the Care Act—perhaps, David, you would not mind responding to this—obviously there has been the judgment in the Supreme Court on Deprivation of Liberty Safeguards and other aspects of it. Could you set out for the Committee what you feel currently is the position on the cost to councils—the extra costs, unfunded—of implementing the Care Act?

David Pearson: Yes. We carried out a survey of authorities—and 70% returned it within a week at the end of May—which showed a tenfold increase in the amount of referrals that come through for a best interests assessment by local government for people in residential nursing homes or hospitals, and a similar level of referral for community-based settings that would be referred through to the Court of Protection. That has a cost of at least £88 million extra on local government.

Q383 Chair: That is just following the Supreme Court judgment—just related to that aspect of it.

David Pearson: That is right, yes. Our view is that there are two things that need to happen. One is that there needs to be a very rapid consideration of the law. The Government have referred it to the Law Commission but we are concerned about the time scales for that, which could be two or three years, because in 1959 the Mental Health Act changed the jurisdiction of the courts for people detained under the mental health legislation to a professional judgment by GPs, approved doctors and approved mental health practitioners, and, 50 years on, for a different set of legislation, we are thinking this should be entirely under the jurisdiction of the court for people in community-based settings, which does seem a little at odds with the policy direction in terms of community-based care, plus the fact that for people who lack capacity, who have considerable needs, it could lead to a delay in the most appropriate placement of choice. If we think of people in hospital settings, people with a learning disability or mental health

issues, for example—and there have been all our concerns about Winterbourne View—it could delay the appropriate movement of people into less restrictive circumstances and community-based settings by that referral through to the court, as well as not being a very good use of public money. We would argue that there should be recourse to the courts where something is contested or there is a concern about an arrangement.

The second issue is, given the financial situation of local government and the fact that this escalation in work was not predicted by the original impact assessment carried out by the Government and is considerably in excess of what was envisaged in 2009 when this was introduced, that there is a responsibility on Government to fully fund what is in effect a new burden.

Chair: Thank you very much for clarifying that. David and Barbara, I do not know whether you feel some of your questions have already been answered earlier on in further questions.

Q384 David Tredinnick: I certainly do. I was going to ask a general question about the Better Care Fund link with the proposals in the Five Year Forward View. I do not know whether you want to comment on that if there is anything there that has not come up already.

Rob Webster: The other thing I would say is that we all believe that longer-term joint settlements that allow us to plan services that are joined up are essential for the future, and the Five Year Forward View sets out an intention to focus on prevention and on integrated services. It does not talk enough about social care for me in terms of the connections between what we do every day and the social care support that is required. We would want to strengthen that commitment, and the Better Care Fund is an example of working together.

Q385 David Tredinnick: Do you think there is enough scope for organisations to make innovations and test models when the current financial situation is alleged to be precarious?

Carolyn Downs: People are doing it all over the country; people are innovating and testing new models. Sometimes the burning platform pushes you together in a way that might not happen in times of plenty. My view is that, yes, people are doing it. One of the challenges to us all, both in the NHS and local government, is, if some places can do it really successfully, why can't everywhere? That is something that we really need to do in terms of sharing best practice and rolling it out across the country. That is definitely both for the NHS and indeed ourselves.

Q386 David Tredinnick: Finally, would you agree with me that, if you give patients more choice, it is inevitable that they will exercise it in a way that does not necessarily appeal to the existing establishment and that we may have to think out of our box if patients come back with new ideas that have not already been considered?

Carolyn Downs: It would be positive if patients were taking control over their own care and their destiny. That would be a real positive.

Rob Webster: We should always ask ourselves: why do we exist—

David Tredinnick: That is very philosophical.

Rob Webster: —as organisations, or as individuals and organisations? We do not exist to be organisations: we exist to deliver the best possible care and outcomes we can for people who live in England. It seems to me that, if people want something different, we need to listen. My worry is that the inverse care law persists and people who need the most care get less than they should. We need to find a way of ensuring that people who deserve better get better and we find ways for them to access care. I personally would like to remove any references ever to hard-to-reach groups—that we have created services that they find hard to access. At one end of the spectrum we need to make sure that people are informed and can make their own choices about the outcomes that they want for themselves, but we must not do that to the disbenefit of others who already get a bad deal.

David Pearson: My final contribution to that, as well as agreeing with my colleagues, would be to say that it is absolutely our experience in social care, and the first statutory responsibility to offer direct payments was as long ago as 2001. The cultural shift over that period of time, in thinking about what people say they want as a way of meeting their needs, has been a continuing journey. What you are saying is absolutely right; in fact it does challenge us, but it is right that, as Rob says, that is what we are here for.

Q387 David Tredinnick: Finally, in the Science and Technology Committee, on which I also have the honour to serve, we have looked at length at antimicrobial resistance—the resistance to antibiotics—something that has much exercised Dame Sally Davies, the chief medical officer. One of the sad things when we were looking at this was that there really are very few antibiotics down the road, if any, that are likely to come on stream soon that would be seen as general antibiotics such as penicillin or tetracycline, and there is a problem for the market there. If we do not have antibiotics, will it not make sense to make more use of well-established medical systems, such as herbal medicine and acupuncture, which have been around for thousands of years? Do you have a view on that?

Rob Webster: I think we should always focus the interventions we use on the evidence that is available and their efficacy. I am not an expert and I am not a clinician, so I could not comment on that.

Carolyn Downs: I cannot comment.

David Pearson: Neither can I.

David Tredinnick: Jolly good. Thank you, Chair.

Q388 Chair: I guess there is also the point you have to make about how you protect people from charlatans. That is also something that will be a challenge for local authorities and the NHS.

Rob Webster: Snake oil.

David Tredinnick: Absolutely.

Chair: Barbara, over to you.

Q389 Barbara Keeley: I have a quick question really. We touched on this and heard comments about the need for a transformation fund. How vital do you think it is to have additional funding to enable organisations to change care models? If they do not get it, will it completely hobble their ability to move ahead with transformation? It probably seems a bit of an obvious question really.

Rob Webster: Yes. I think everybody, from NHS England through to ourselves and the other 20 organisations that signed the 2015 challenge, which represents charities, patients, doctors, nurses and therapists, say we need a transformation fund. That is because we need to change the way we deliver care to make savings and to make it better. It is not to plug a gap—that is the vital thing—but to pump-prime that change, to pay for the clinical leadership or the professional leadership, to pay for the sump costs that might exist in buildings that we have now, for all the reasons that we know exist.

Carolyn Downs: Transformation is always going to be more successful if you invest to save as opposed to saving to invest, which is what we are doing through the Better Care Fund, unfortunately. We are very clear that a transformation fund is absolutely essential. If the money is not there in the system—because we have to be fully aware of the fact there is not much money around—then there are all the issues that one can think about in terms of longer-term settlements that allow you to take the savings from later and invest them at the start. That is a creative way of dealing with that.

David Pearson: I absolutely agree with my colleagues. It is my experience from many years in senior positions in local government that, if you are going to significantly change things that involve lots of major change programmes at local level, you do have to invest in order to pull out that money and make those changes with people, as well as providing a degree of safety in terms of the risks that you are taking in changing things to, in some cases, models that we have never tried before. We are in some cases in uncharted territory.

Q390 Chair: Thank you. I particularly like the quote that we should be investing to save rather than saving to invest, and pointing out why we need a transformation fund. Thank you for that.

Before we go, thank you, Mr Webster, for your response on page 11 to the call for evidence from this Committee about, as you put it, trying to end the “toxic debate” that gets in the way of discussing what the place of non-NHS providers can be. But, understandably, there is concern from the public. A few of the suggestions we have heard about that are to move to open-book accounting so that people can see how much profit taking there is, that there should be a greater use of ability to FOI private organisations for the part of that that is funded with public money, and also the issues about contribution to training. Do you think those are all ways forward to address some of these issues?

Rob Webster: The submission by the NHS Partners Network was incredibly interesting, was it not, and helpful in clarifying the actual contribution of the independent sector to the NHS? It showed some really strong performance in terms of waiting, staff perceptions, public perceptions and quality from the CQC. The benchmarks for all those things were strong. I do not think that those sorts of data are widely available enough. We have a set of providers who are required to meet the licence conditions of Monitor and to meet the quality standards of the CQC. If we were much more open about the standards that they do meet and achieve and the financial arrangements that they have, that would be welcome, and I think they would welcome it because the toxic debate that we get into fails patients. If services are available that patients can benefit from—and, as the Partners Network submission showed, people who live in deprived areas and in more affluent areas both benefit from this—then we should be making use of those services. So it is a yes; we need to find a mechanism for allowing it to happen.

Q391 Chair: Would you support making it possible to FOI organisations that are private-sector organisations or that part of them that are using public money? That is an issue for the public, is it not? There is a sense in which they feel that they are not allowed to ask the same questions or know what is being delivered. Would that be your suggestion of how we get round that?

Rob Webster: It is not where I would start. I would start with making publicly available the data that needs to be made available on all services, whether they are provided by charities or—

Q392 Chair: Yes, so that whoever provides them we have the same.

Rob Webster: Yes, so we have the same, so that when you look at the My NHS website it has the private providers alongside the NHS ones and all the data are the same.

Q393 Chair: So the same level of quality data is collected.

Rob Webster: Yes. What we end up with is a standard set of information that removes the need for FOI. If we believe that we need to go down the FOI route, it is because we do not think we are being told enough about what is happening. My personal preference would be to say that, if something is funded by the public, then maybe it needs to be FOI'able, but there is a general consensus that we just need to be much more open and transparent about the data on performance, the quality and finance from providers, whether they are from the independent sector, the NHS or charities.

Chair: Thank you.

David Pearson: Can I make a contribution on this? I am thinking of section 5 of the Care Act, which requires local authorities to be responsible for our diverse, sustainable and improving care market in the context of some of the issues that have been raised about commissioning in the context of budget reductions. It is clear to me, in the interpretation of that, particularly when reading the regulations, that local authorities absolutely have to understand the breakdown of the costs. The accountability to the public would be: is the

service of an appropriate quality and is the cost appropriate? In relation to the Care Act, it also talks about the work force being paid appropriately, given the minimum wage issues that we have had. That seems to be exactly in the same space, and, since we are talking this afternoon about joining up health and care, applying that principle to health and care services would seem to be a positive way forward to satisfy politicians and the public that we are delivering quality services that provide value for money through that public expenditure.

Q394 Chair: On that point about wages in the social care sector, do you feel you are making progress as a sector in paying people for time travelled between visits so that you are bringing people who are currently paid below the minimum wage towards a living wage? Do you think that is being addressed?

David Pearson: There are two things. Local authorities commission this externally from providers, so obviously we expect them to comply with the law, which is to pay the minimum wage for the hours and for the time travelled. We are very disappointed that that is not the case. Their argument in response is that we are not paying enough. That is why I am saying, and that is why the Care Act identifies, that we absolutely have to understand what those costs are so that we are paying enough. The current position is that some local authorities do identify the actual costs of care and others are still catching up with that. My point about the Care Act is that from next April it is my interpretation that that will become, in effect, the legal requirement. Therefore, progress will have to be made.

Q395 Chair: So you think councils will—

David Pearson: In relation to your living wage argument, we go back to the fact that, with a 26% reduction in budget as needs are rising, it is very difficult. Local authorities have looked to contracting in order to make some savings, so, clearly, there has been huge pressure on the system. It goes back to what is the appropriate cost for a quality level of market in social care, and we do have a very poorly paid work force for dealing with an increasing complexity of need.

Chair: Thank you. Do any of my colleagues have a final question to ask? No. Thank you very much for coming today.