

Public Accounts Committee

Oral evidence: Personal budgets in social care, HC 911

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Members present: Meg Hillier (Chair), Mr Richard Bacon, Caroline Flint, Mr Stewart Jackson, Nigel Mills, David Mowat, Stephen Phillips, John Pugh, Karin Smyth

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, and Aileen Murphie, Director, National Audit Office, and Richard Brown, Treasury Officer of Accounts, HM Treasury, were in attendance.

Witnesses: Nadra Ahmed OBE, Executive Chairman, National Care Association, Elliot Dunster, interim Group Head of Public Affairs, Policy and Research, Scope, David Pearson, Corporate Director of Adult Social Care, Health and Public Protection and Deputy Chief Executive, Nottingham County Council, and Immediate Past President, Association of Directors of Adult Social Care and Richard Lyle, Programme Director Community and Partnerships and Deputy Operations Director, NHS Bristol Clinical Commissioning Group, gave evidence.

Q1 Chair: Good afternoon, everybody. Welcome to the Public Accounts Committee on 13 April 2016. We are here to look at personalised commissioning in adult social care on the back of a National Audit Office Report on the subject. We will be looking at the implementation of the Care Act and how well it is going. As a Committee we are looking at value for money for the taxpayer, which is, yes, the value for the pound but also the effectiveness and efficiency of systems.

This has been going for a while in social care, but it is still early days in health. It does not need to be said that adult social care is vital for vulnerable people and their carers, and we know that it is a challenging agenda. That is the policy. It is not our job to discuss whether it is the right policy; we are here to see how well it is working. We are very aware that this is all being done against a backdrop of budget cuts, with the King's Fund finding some startling figures, which I have just mislaid, on the level of cuts coming in social care. Obviously, that might make a difference to how this may be implemented, and we want to find out today whether it does.

We have a pre-panel of witnesses representing people on the frontline who are or receiving personalised budgets are not, or who will be receiving them; some of those people will be managing

their own care, too, so there is a mixture. We want to know how well they are faring and any worries and issues that you have. The civil servants will be appearing in front of us, and we want an honest reflection of where things are now and of what problems are coming down the line that will need to be addressed to make sure that this policy is delivered effectively. Of course, there has been some experience in social care, as I mentioned, and we want to make sure that the Department of Health is on top of that.

We have four witnesses in the pre-panel. David Pearson is the corporate director of adult social care, health and public protection and the deputy chief executive—what a long title you have, Mr Pearson—at Nottinghamshire County Council, but he is also the immediate past president of the Association of Directors of Adult Social Services. You come multiply qualified, Mr Pearson. Elliot Dunster is the interim group head of public affairs, policy and research at Scope. We have Nadra Ahmed from the National Care Association, where she is the executive chairman. Finally, Richard Lyle is the programme director, community and partnerships, and the deputy operations director of the NHS Bristol clinical commissioning group. Welcome to you all. We aim for this session to last about 40 minutes, so I will ask you to be reasonably brief in your answers to our questions. I am afraid that I will cut you short if you are going a little bit long, because we need to get through the business today.

To kick off, I will ask you all what you think are the main benefits that personalised social care will bring to service users. Do you have any particular concerns right now that you would like to flag up to us?

David Pearson: Thank you very much for inviting me. There was very widespread support over the period of the implementation of personalised commissioning in adult social care from those people who are responsible for commissioning the services, from the providers of the services and, most important, from users and carers themselves. That is no better exemplified than by the very wide ranging partnership called Think Local Act Personal, funded by the Department of Health, which has helped to lead this transformation.

On the benefits I have seen personally and across the sector for particular people, it is not too fine a point to say that it has transformed many people's lives. I want to make the point that personalisation is not just about personal budgets. I know the National Audit Office made that point. It is about a system as exemplified by the Care Act that is founded on good advice and information, preventive services, re-ablement, personal budgets and building that community capacity. I will quote the POET Survey, which showed that 80% of 4,000 people who were surveyed in 2014 thought it made a significant difference to the quality of their care and the quality of their lives.

In Nottinghamshire, we did some joint work with the Alzheimer's Society. I also saw this being deployed with benefit to people with fairly significant needs who lack capacity, with carers helping to keep people at home without a doubt longer than they otherwise would have done with that extra control.

In terms of the issues raised by the National Audit Office, one is clearly funding and money. Is this a cost-saving exercise? Can it save money and what has been the impact of the last few years? Our budget survey which was published last July—

Q2 Chair: That is the county council?

David Pearson: No, this is the ADASS budget survey published last July indicated that if you take into account the demographic changes in our society, the fact that we are gloriously all living longer, and that is fantastic, the implications are that we need more care and support to manage some of these long-term conditions. Over the previous five years there had been a £4.6 billion, 31% reduction. Some of that is cash and some is the impact of the increase in the number of younger adults needing care and older adults. If there is £6.3 billion on community services, it would be unrealistic to assume that that budget is not to be looked at and savings are not to be made. That clearly has to be the case, which is why you see the dichotomy between the view of the directors and the view of the Department of Health, as reported.

Directors, along with their staff and providers are trying to balance giving that choice control and making sure there is an appropriate market that is sustainable but at a rate that the public purse can afford, given that needs are rising and funding in overall terms is reducing. That is the fundamental dilemma that we have. Our view is that, although there has been some funding through the social care precept, and there will be further funding through the local government Better Care Fund settlement from 2017-18, the overwhelming demographic demand and the costs of things like the living wage and other policy developments outstrip the funding that is coming in.

Chair: Thank you, Mr Pearson. Mr Dunster, what is Scope's perspective?

Elliot Dunster: We echo a lot of what David has just said. I would start by saying that disabled people have been on a long journey towards getting personalisation in social care services. That was not always the case. The consensus that has been described around personalised services and the goals and outcomes that disabled people want to achieve is really welcome, but for disabled people in particular it is really important to remember that one third of adult social care users are working-age disabled people and about half the local authority spend on adult social care is also for working-age disabled people. That is really important, because often the conversations can be around the care for older people, the demographics and the glorious fact that we are all living longer, but disabled people are living longer than ever before.

Q3 Chair: Can you give us an example of people in that category for whom you think it is making a difference and how?

Elliot Dunster: Yes. We have done an extensive piece of research around disabled people's experiences of care, which the NAO picked up on in their Report. The single biggest factor that drove personalisation—the one thing that people said made a difference to them getting personalised social care support—was access to personal budgets. Six in 10 people who said they had choice control over their care said that was because of having a personal budget. What is more, people who said they did not have choice control identified that having a personal budget in the future would help them to get there. It was by far the biggest thing that drove personalisation.

Q4 Chair: This is the good bit. What about the challenges?

Elliot Dunster: There are three things. David has touched on the funding. It is really important that we start with an individual's goals—that the care plan is worked out with someone and then the package of support is designed around that. That is what we are starting with. Lots of people who have come to us saying that their package does not buy them the support they need,

particularly over time. I am sure you will ask more questions about that and I have much more detail.

The second thing is the market—ensuring that once you have money in a personal budget, particularly in direct payments, that individual can buy the support that they need and that it is actually available where they live. The third thing is about the support to take on a personal budget in the form of a direct payment. Lots of disabled people tell us that they would love to have control over their support and would love to have that direct payment, but they need the support to become an employer—to manage sick pay, pensions, increases in the minimum wage and things like that.

They are the big challenges and it is certainly the case that the funding environment overall is the big driver for lots of that.

Chair: Okay. We may want to come back to you, particularly on some of the clients that you support because there are particular issues there.

Nadra Ahmed: I predominantly represent small to medium-sized providers in all different parts of social care. For us, the personalisation agenda was an issue. When it was introduced, we felt a little bit as though we had been delivering personalised services as providers. Responsible providers had been doing it for a while, especially when you look at care planning to ensure the needs of individuals are met, but we understand the challenges of people who want to have the control and support—the choice control stuff.

Those people who do it are enabled to do it properly through a process that is not hastily done. One issue we had was that there was some undue haste in implementation, with people trying really hard to get it done quickly, so there were some early failings. Some of our providers were telling us that people who had been unable to live independently were actually walking their way back to the care service they had been in. That was challenging for us because they did not feel supported. Having come from a sort of family environment with learning disability services, they did not feel they had that support any more.

For me, the messages are really around the consistency. This is great for people who are enabled to do it and have the mental capacity to do it. With older people's services, certainly in residential care homes, it is not something that has hit our radar, but certainly with some of our LD services and home care services, we are seeing that this is out there.

The consistency element is really important but part of that will run around the sustainability that David spoke about. There is a real issue out there for us with staffing because we have a massive recruitment and retention problem. The support mechanisms that are out there for people who are receiving this service can very easily be broken down and that is where we see the challenges in all of this.

Chair: Thank you. Richard Lyle?

Richard Lyle: The health service is at a much earlier stage in terms of personalised budgets, direct payments and so on. I would separate out the benefits for the service user, which I would be very upbeat on. I think every case that I have been involved in has had a positive outcome, certainly around choice control—things like deciding when you go on holiday, which we all take for granted. Those are very simple and innovative things. It has been a bit more complicated for organisations.

There have been quite a lot of blocks and barriers such as finding the right workforce and supplier of services.

Often we work with people who do not have capacity, have limited capacity or need other people to support them to make choices, so getting the right support is difficult. There is also quite a challenge for staff. Most of us would accept improving respiratory function through the use of a physiotherapist, but some people might be a bit more challenged if we said, "Buy the person a trampoline and allow them to bounce up and down." That is one of the things we have done. You can imagine that the challenge is that people sometimes apply judgmental approaches to things. It has been difficult. You end up with lots of moving parts. We have been piloting working with local authorities around jointly funded work. You then get into the issue that the NHS is free at the point of delivery whereas social care is means-tested. It is things that you need to work through; it is not reasons not to do it. It just means that it is maybe a little bit slower and more staff-intensive than you first imagined.

Q5 Chair: As you say, it is early days in health. What do you think the particular risks are in health? You touched on it there but could you expand on that a bit?

Richard Lyle: Probably the thing that has been most challenging for me is changing people's attitudes. There is a different approach to risk in health, particularly clinical risk. We have had to be much more open-minded about our approach to risk. There is what I said earlier about people making judgments about whether something is valid or not. I think there are some concerns about resource implications. We have managed them so far on small numbers of people. When you expand it, say, to everybody who has a long-term condition, it would be more difficult.

Q6 Chair: With all of you I wanted to touch on safeguarding and risk. We were reflecting earlier that more care is provided in domiciliary settings than in residential care. There is always potential risk—I am sure Nadra Ahmed will have something to say about that and the challenges for organisations. With this approach of personalised care, do you think there is going to be more risk? How do you think we need to deal with it? Is the system working in terms of safeguarding? Perhaps we could start with Nadra Ahmed because you represent the care association and then David Pearson.

Nadra Ahmed: Working with safeguarding?

Q7 Chair: Yes. Does it make it work better or worse? Are there any particular issues around personalising care?

Nadra Ahmed: We cannot be risk averse. When people have made a choice that they want to control the way that they live, we have to risk-manage that. I think there will be potential. I know of cases in the service where I am involved: two young girls went out and took that option, then gave their addresses and phone numbers to somebody in a pub. It was just lucky that we were continuing to support those girls at that time, because the chaps came and started knocking on the door. Issues like that that will be out there and we cannot eliminate them, so we have to respect the fact that people have made the choice to do that. That is why, in order to mitigate some of that risk, we have to be very clear about the actions we take to mitigate the risk around very vulnerable

people. We have to remember that. Some of the people who are making those choices are very vulnerable and remain vulnerable whether they are within a setting or outside.

Q8 Chair: Mr Pearson, give us a council point of view.

David Pearson: Yes, very quickly. There is no evidence that this leads to a higher incidence of safeguarding procedures compared with regulated settings. Clearly, when it was being introduced there was a concern about lack of regulation—that family, friends and neighbours doing the work would lead to more. That has not been the case. One thing that local authorities need to do is check out who are the people who are helping the people to support them, particularly after 2009 when for people who lacked mental capacity we had to appoint a suitable person to ensure that that person is indeed suitable.

Secondly, some of these things are hidden, which makes reviewing people's circumstances absolutely crucial. Again, that is a resource-intensive process to be done at least once a year, or more frequently in certain circumstances.

Finally, there is an advantage in having an early discussion with people who have capacity and their families about what the risks are in sharing that risk. Life is a risk. If I climb up a mountain I might fall off it. Having choice control is a risk but it is a risk worth taking, if you have a better outcome and better quality of life.

Q9 Chair: You mentioned outcomes; the Report is clear that the Department cannot yet be clear about the beneficial outcomes of personalisation. You might all want to contribute on what you think could be done so that that is better measured.

David Pearson: Shall I start? I think that we as an association absolutely welcome continued research and evaluation in this area. It is groundbreaking, both nationally and internationally. I was personally asked to go and speak to the national conference for older people about personalisation because they are embarking on this journey. We are well ahead of many other countries in the world. We need to be careful about it. There is some evidence; there is the POET survey, and we ran with TLAP a personalisation survey of all authorities and got an 83% response rate on the benefits. More research and more evidence, perhaps sponsored by the Department of Health, would be very welcome.

Q10 Chair: I suppose one of the challenges, especially as we move into health—Richard Lyle may want to come in on this—is this: how can we prove actual outcomes in terms of health if we cannot measure them? The Department will be answering this later. What could be done to enable that to be captured better? We hear anecdotes about people having a dog to help get them out of the house and manage their mental health condition better, perhaps, or improve their physical health. How is that captured? How do you manage to capture that when we are dealing with so many micro examples?

David Pearson: You need high-level information. We have the adult social care outcomes framework, in which we do an annual survey of people's satisfaction. At a time when social care has

been under enormous pressure, those satisfaction levels have remained at around 90% of people being mostly satisfied or satisfied. That is a lot to do with the personalisation agenda, which has mitigated some of those other issues. That is one thing.

Secondly, there is more granular research, such as an extension of the POET survey. That survey is on a scale, but it is about asking people more granular questions about the quality of their lives and their response to personalisation. Some of the ASCOF survey does that, and it asks questions about wellbeing. It is probably a good model, but we could extend it.

Elliot Dunster: I would just like to pick up on David's point about the adult social care outcomes framework. At the moment, we have different outcomes frameworks for health, public health and social care. There is something else going on in personalisation in health around integration. It is really important that those two things do not develop in silos. We think having one single outcomes framework across those areas would drive much better practice for disabled people by driving independent living, because you would stop thinking about which health intervention is going to fix this person's problem, and which social care intervention is going to keep this person living independently. You start thinking about the systems and structures working together properly.

The Better Care fund is helpful as a mechanism for driving integrated care and support, but it lacks some measures around independent living for disabled people. If that was strengthened a bit, we would see benefits in the personalisation agenda, too, because you would start to drive social care outcomes that are about disabled people living independently. Those are perhaps around working and volunteering—things like that.

This comes back to the point on risk, which I underline. That point is important for Scope. Disabled people also like to take risk. That is part of living a full and independent life. The social care system should enable people to take a risk and be supported. That is something slightly different from taking risk on as an employer. If you have lived in an institutional care setting for a long time and you are suddenly given control over the direct payment of a personal budget, that may be extremely challenging. I have an example here; someone said: "When directly employing you need support to deal with disciplinary measures—I felt I had to let someone back into my home even when they had tried to be violent towards my husband because I had no support". That is an example of the risk, but there is a tension here. That person still needs to take a risk over their life, but the tension is in how they work with the local authority to get the right support and guidance so that the right action can be taken.

Q11 John Pugh: What about a scenario where you have a problematic family that is receiving adult social care? Perhaps they have a very young child or a baby. It is a question of looking at not just the commissioner's personal desires and inclinations, but the wider social picture, in which the risks fall not on the person taking them, but maybe on someone that they are looking after. I am thinking of the recent very sad case of a child killed by their mother. In that scenario, how do we deal with that sort of risk, given that the assumption is that the individual is competent and capable of running a personal—

Elliot Dunster: I am speaking from my experience working with disabled people. I think that the case you are referring to is slightly different, but I do think it is about the care planning process, too: ensuring that the risks are properly identified through the care planning process, and ensuring that if they are identified, the appropriate action is taken in a slightly different format.

Q12 John Pugh: How should the system deal with someone who needs care but is probably incapable, for a variety of reasons, of making good decisions for themselves?

David Pearson: We have to be satisfied on two fronts. First, we have to be satisfied that a direct payment will work in any given circumstances. We can refuse to make a direct payment available. The personal budget can be managed.

Q13 John Pugh: That gives an element of control, does it not?

David Pearson: Yes, it gives an element of control. Indeed, if we think that the suitable person is not suitable, in terms of lacking mental capacity, we would say, "That is not an appropriate person to do this for these reasons." There have been judicial proceedings involved in these things where local authorities have stood their ground.

Q14 John Pugh: Can I stop you there? I didn't say I had a case where somebody lacked personal capacity; it was where we thought they were going to make extremely bad decisions that would impact on a vulnerable person.

David Pearson: Yes, that is part of the judgment about whether the direct payment will meet their needs and whether we have evidence that it will. The issue of the child care case is slightly different. Although personal budgets can apply to children, they tend not to apply to children in care settings or under a child protection order, as in the case that you were quoting. The key point is that we have the discretion or the responsibility to make a judgment that the arrangements are satisfactory.

Q15 Chair: We were talking about outcomes just now. I would like to hear from Richard Lyle how you think the Department could be looking more at outcome measurement.

Richard Lyle: I think there would be different outcome measures for different groups of people. One group of people we are looking at are people who are chaotic users of drugs and alcohol who use lots of services. An outcome for us would be a reduction in what we might see as a misuse of services—in attendance at accident and emergency, and so on—and appropriate use of support.

There is a theme within this around personalisation, which is about care co-ordination. The personalisation bit is about getting the right inputs to the person. If the person does not get the right inputs, they will try to find the right inputs, and that is why many people bounce around lots of different services. I think there are different measures. For the health service, use of other health services would be a good measure.

Q16 Chair: Do you set those measures locally? Are you beginning to have a measurement in Bristol for that group, for example, or maybe for health outcomes? If somebody has type 2 diabetes or obesity is getting their budgets personalised, and chooses a trampoline, do you then measure whether their cardio has improved, or they have lost weight or whatever?

Richard Lyle: It is early days for long-term conditions. The people who we are currently seeing tend to have multiple disabilities, learning disabilities, things like that. A lot of what is reported is probably about how the person and the family are feeling about services.

Q17 Chair: So it is all very anecdotal at this point.

Richard Lyle: Sometimes the reduction in the requirement for us to intervene and reorganise or change services would be a good outcome—the fact that they are happy with what they have got.

Q18 Chair: So it is still a bit difficult to pin down, I think it is fair to say. Mr Pearson, you touched on the issue of local authorities sometimes managing the personalised care for somebody. We have also seen from the Report that that means that sometimes the local authority takes off a slice to do that management. Does the association set any guidelines for what it would be reasonable to take off as, effectively, a management fee? With budgets being squeezed, I can see that if you are responsible for social services as a cabinet member or director, it must be a great temptation to look at how you are balancing your money and whether you are carving off enough to cover the costs—or maybe more than cover them. Is there any guidance that you want to provide on that?

David Pearson: The principle in the Care Act is that the funding that we give must be sufficient to meet people's needs and to ensure that, where necessary, there is brokerage to help people co-ordinate it. Where people do not want to be responsible for the accounts or the payments to particular staff, they can be handled by a third party. All those things have to apply, so typically local authorities will make available an amount for that purpose.

As for the personal budgets managed by local authorities, that is a matter of choice for the person concerned. The Report seemed to indicate, on funding, that we might only give the amount that we would give for our own services. Again, I think the carrot is quite clear. You have to be reliant on the market conditions to make sure there is sufficient funding. The answer to your question is that we do say that there is an amount that should be creamed off. The amount for the infrastructure to make it happen—the payroll has to be paid for, whether you are in local authority managed care or it is a direct payment—has to be made available. Otherwise, it is making sure that there is sufficient funding available.

Chair: It seems that is quite a wide open thing. Does anyone have anything to add to that before I bring in David Mowat?

Q19 David Mowat: One thing that the NAO Report says is that savings are expected in this area from the local authorities, but not the Department. I wonder whether personalised care makes it easier to make savings than it would be if it care were not personalised, or is it neutral? Does the very fact that it has not been personalised make it easier to control?

David Pearson: We think that overall it is neutral. I would agree with the Department of Health's view that it is not in itself a mechanism for making savings, although there are some areas where direct payment and the use of personal assistants is less expensive, because clearly, if somebody is employing somebody on an individual basis to be their personal assistant, you are not

having to pay the organisational overheads of, say, a home care agency. Typically, the amount that would be given for that would be less, but it depends on the person's needs.

The savings that local authorities have tended to make around this is in the way in which services are commissioned to get the best value for money. That is about trying to create the market conditions. If you make available modern assistive technology, such as telecare, that would clearly reduce the amount of care costs that you might need to pay, or the person might need to pay out of their direct payment. A classic example of that is ensuring that you have assistive technology that notifies people if someone has woken up and might be wandering, so that care staff who might be looking after a number of people are not sitting and waiting for the person to wake up. That is the sort of example. It is about finding innovative ways of saving the funding.

Q20 David Mowat: But that is, in a sense, about a more effective way of delivering the service, rather than making a saving.

David Pearson: It does make a saving, because you might not be paying waking night staff.

Q21 David Mowat: My original question was, does the fact that more care is being personalised make it easier, harder or neutral, in terms of making cuts?

David Pearson: It is, overall, neutral because you will find things both ways.

Q22 David Mowat: So it is not a relevant consideration to the personalisation debate. I understand that it matters, but the personalisation debate is not part of that, in a sense.

David Pearson: No. You can find creative ways of making packages that can be more cost-effective, but it depends on the needs of the individual. It is very much an individual thing. Some, with choice, might cost a bit more.

Q23 David Mowat: Yes. Do your colleagues have anything to say on that?

Elliot Dunster: Yes, I have a few things on that. We agree with the NAO Report that, if you cut someone's personal budget, it will be less effective. That sounds quite obvious, but it is an important starting point. At the beginning, Chair, you talked about the Committee looking for value for money in public services, and not just at the level of expenditure. What we find with personal budgets is that if you enable disabled people to direct the support that they need, you get very good value for money and outcomes.

Q24 Chair: Have you got any research or surveys you can point us to on that? That would be very helpful.

Elliot Dunster: I can certainly submit that in written evidence to the Committee, of course; no problem. For us, the starting point has to be the care planning. That process is critical. You have to start with the goals that the individual wants to achieve. We are fortunate that the Care Act

describes that really well. The very first section of the Care Act describes the wellbeing principle, which is really ambitious about the types of support that disabled and older people should expect to receive.

Q25 Chair: Ambitious but difficult to measure.

Elliot Dunster: Very difficult to measure, but it can be done; lots of authorities are doing it, and it makes a huge difference to people's lives. The care planning process has to start with the disabled person and what they want to achieve in their life, and then the funding has to be able to deliver it.

You will get better outcomes if disabled people, rather than someone else, have the ability to say where that money is spent. I have a great example of that here; someone said: "I used to have individual personal assistants, but now I use some of my budget to pay for a dedicated organisation who are helping me to volunteer and hopefully set up as a self-employed cleaner for a couple of hours a week under their supervision. I could end up self-employed."

That is a really good example of where the outcomes from someone's care package will radically improve their life and drive better value for money than someone just passively receiving the care that they are given.

Q26 David Mowat: One of the things that strikes me about this is that if I were in receipt of social care, the very fact that I was in control of it would make me happier—even, arguably, if I was getting "less" care, if you see what I'm saying—because somehow I know what I am doing and can control it. In terms of how that works on the ground, is that something that you see?

Elliot Dunster: Certainly, a huge benefit of an individual having a direct payment or personal budget is that they feel they have choice and control, and it makes a huge difference to how people feel about their lives. It is also about flexibility: deciding when you need the support, not being put to bed at 6 o'clock, and saying, "On a Thursday I really like to watch 'Question Time', so can you come round a bit later?".

Q27 Chair: Glad to know that there's interest.

Elliot Dunster: That was for the Committee's benefit.

Q28 Chair: Surely they are watching reruns of Public Accounts Committee sittings.

Elliot Dunster: I very much hope so. That flexibility that someone can have in their care package is really important.

Nadra Ahmed: Just to add to that, it is about empowering them. That is why people feel so happy about having that choice and control and having that budget. We always have to be mindful that the support mechanisms are there if they need them. That is the thing that drives us, because it is picking up the pieces afterwards. If we have got comprehensive care plans in place, which enable people to know where they can turn if there is an issue in their home environment or whatever, that

makes it much easier. The empowering of people to remain independent for as long as they possibly can has got to be a good thing. It has got to be where we go. That is all about personalisation. That can also happen in care settings, which is a whole different topic, but it has got to be good because we empower people.

Q29 David Mowat: I think it was Mr Pearson who said earlier that the UK leads the world in this area and that others have not taken it up yet. Why is that? If it is, as you have described, such a good thing, why are we alone?

David Pearson: There are other countries that have taken it up. We have probably been one of the leading ones in the world on this. I think it is because it is quite a difficult thing to do. If we think about the health service, notwithstanding the work that has taken place in Bristol, it has taken quite a number of years to get to a relatively small number of people. It has taken the best part of 15 years. Permission to provide direct payments under statute came in 2001, so it has taken a long time to get to this stage. It is a difficult thing to get right for all the reasons that are implied in your questions.

Chair: I am going to move on to Karin Smyth, but I had better warn you that I also want to touch on the market providers. I give Nadra Ahmed a little warning that we are going to talk about that. Finally, we will need a couple of quick points from each of you that you think we should ask the Government Departments that come in front of us next.

Q30 Karin Smyth: I was going to come in on the market. The Report is quite clear that this depends on a fairly thriving market both for care and voluntary sector and other organisations, particularly in relation to what Mr Dunster said. Richard Lyle talked about that a bit in terms of health. Can you give us your thoughts on your role in supporting or developing that market and the Department's role, and how you see that happening?

Chair: Perhaps we should start with Nadra Ahmed, as you are the market representative.

Nadra Ahmed: Do you mean the development of the personalisation agenda or the care market?

Q31 Chair: The care market. The people who provide this.

Nadra Ahmed: It will not have escaped anybody's notice that there is a crisis looming, if it has not already arrived. There is a challenge. A survey we did quite recently indicated that of the 100 people we polled who were care providers, 72% of them told us that they were not sure that they would still be in the market in two years' time.

The challenge is substantial and that is quite scary. Part of it is to do with the national living wage, but not all of it, because people are quite happy to be able to pay it. Of course, we have had underinvestment in the sector for such a long time through the commissioning process that we are now at this point. I always want to be as positive as I can. We have to look at the demographics and know that we are going to need more care, not less. I think we have got to look at the market in a more dynamic way and ensure that we have got a mix of solutions for people, so that if people want to stay at home, they can.

I visited somewhere quite recently and was absolutely astonished that somebody had built care suites. He is doing really very well, but he is now looking not at going to the local authority for a contract, but at using housing benefit and all those other things to make up the money he needs to run that service. We have to look at different ways of planning social care.

Q32 Karin Smyth: Whose job do you see that as?

Nadra Ahmed: I think it has to be collective. I think the provider sector has a major role in it. The bit of the sector that I represent is 78%, which is the small to medium-sized businesses. We all get very concentrated on the corporate services because we are all worried about another Southern Cross, but we have to think about how we make a vibrant local economy, because we know that in the economy we're employers and we're buyers in little villages—we are making sure that that happens.

We have major issues around recruitment, which is a real problem. If I was asked what the single most difficult problem for providers was at this moment in time, I would say that I have just come away from meeting 40 registered managers in Kent and they told me that they cannot get staff. That is really difficult. How do we create that image in social care that makes people want to come to us? Why are we not saying in schools that it is a career option? Why is it the last thing that people think about? "Well, you can't do anything else, so why don't you think about a social care qualification?" I really want to try to motivate that and make it happen.

Local authorities do have a major role in helping with this mapping, and the CQC has a role as well so that we don't have the scandals and the constant conversations about poor care. We have to be looking at what good care is and try to use those models.

Richard Lyle: As a commissioner, I think it is about nurturing the market and listening to what people tell you on things like length of contract and paying people a fair amount for the work you expect. It is about giving them access to services that statutory services have—things like training and other support are really important so that you do not create duplicate overheads. It is about trying to share your strategy with people so that they can respond to it, because a lot of the time it feels very boom and bust. At the moment, we have a real shortage, but at other times there has been an over-supply in different types of care. It is about being open and honest with your local suppliers about where you are going and what you need, and trying to nurture that.

Q33 Chair: The NAO Report is very clear: in paragraph 3.16 on page 44, it highlights the fact that the Department "is the national steward of the market for care providers". I have to say that in some ways that is quite a big ask for Whitehall, but someone has to be the national steward of it. David Pearson, what could the Department be doing better? Presumably, the challenges that Nadra Ahmed outlined are your problems as a county council too.

David Pearson: Yes. It is not just the Department of Health; the whole of Government need to make sure that there is sufficient money in the system to provide the kind of high-quality market we would all be proud of. We spend about 2% of public expenditure on social care, and that has been going down as needs have been rising. There is an issue with making sure that there is enough money in the system to pay staff appropriately.

The national market position statement that the Department intends to publish is a good move in terms of setting out the stall for how things can be stimulated, and it chimes well with local authorities' responsibility to develop their own market position statements, which should also be about trying to stimulate new and innovative ways of providing care. For example, in my authority we used a voluntary third-sector organisation to help to stimulate 67 new micro-social enterprises, which were delivering care and support through the employment of personal assistants and other kinds of innovative care. We need that scaled up across the country so that there is more choice control.

There are things around housing solutions as well, because people's choice control can be severely limited by the accommodation they are in. It fits with the whole national agenda about making sure we have the right kind of housing for people at the right times in their lives. We have lots of older people living in unsuitable housing, while we have younger families in this country who do not have the right housing. We need a strategy that takes account of our changing demographics.

Q34 Chair: Quite a lot of asks there.

David Pearson: Lots. I could go on.

Q35 Chair: I am sure they are listening and taking all that on board. Elliot Dunster?

Elliot Dunster: A lot of changes have happened to the support that disabled people get to live independently—things like the Independent Living Fund being transferred to local authorities. About 19,000 social care users get that additional support to live independently. One thing that Scope recommended to your colleagues on the Health Committee was to do an inquiry into how independent living is working for disabled people. That inquiry could take in personal budgets and direct payments, as well as things like the broader personalisation agenda, the integration agenda that I talked about and the housing points that David rightly identified.

There is a lot happening that is impacting on the market for social care at the moment, particularly for disabled adults. We think that Select Committees have a role in looking at that as well, because we are seeing more and more responsibility given to local government, but disabled people also expect central Government to take some steering control over the care and support they receive. We have the Care Act, which is really brilliant, and we are very supportive of it, but, as you said earlier, the challenge is delivering it. We want to see what impact it is having on disabled people's independence.

Q36 Chair: Nadra Ahmed, what do you think Government could do? You gave us some hints earlier, but what would be your couple of asks from Government?

Nadra Ahmed: We have to recognise the importance of social care. It should not be an afterthought. I always worry about why we have a Health Department with social care sitting within it; if we are talking about an integrated agenda, it should be the Health and Social Care Department to reflect that. That is just a silly thing, but it is important to me, because I think social care is the infrastructure that very often props up health, and we are not recognised for it. I sit and listen every time the Health Secretary—or a shadow Health Secretary, or anyone—makes a speech, and very rarely is there a mention of social care, unless it is really focused. It is always about health. I think we

need that recognition. That is important. We also need to talk about how the commissioning process is working, and about buying good care.

Q37 Chair: You say we need to talk about it; what would you do about it?

Nadra Ahmed: Let's be absolutely honest and put it on the table: we are told privately by a lot of commissioners, "We know we should be paying you more, but we haven't got the money." Let's have that honest discussion and that debate about the money, and then the Treasury needs to reflect that and how it moves forward. Some of it is about integration and how some of that money can come through; the training money is really important, because if we could get appropriately trained staff, we could share that. It would be a really quick win if we could get the training agenda sorted out so that we had local authorities, the providers and health working together to get the right people trained up to deliver the services. The winners would be the service users, because they would have a consistent service.

Q38 Chair: Once, when I was doing a double care package for two relatives, I counted the agencies we were dealing with and I lost count when I got to 13, so I take your point on that one. Richard Lyle, what would you ask from Government?

Richard Lyle: I think it is about recognising that most care now takes place outside hospital; it takes place in the community, broadly within the burden of social care. There is an issue around how that is funded. Secondly, anything that can be done to recruit, retain and train the workforce—we are completely dependent on a good, stable workforce to deliver any health or social care programme. That is becoming a really acute problem at the moment; all our plans always stop when we try to recruit and retain the workforce.

Q39 John Pugh: There is a further question on that. The Chair has just mentioned 13 providers. If you are in the northern part of Northumbria, or somewhere like that, you do not have that level of choice. In other words, the market will exist in different places for different people. Are there any strong trends coming out where, for example, people in isolated, rural communities are not benefiting in the same way as people in urban environments, where you can imagine that there are a lot of providers, and people can choose and differentiate between them?

Richard Lyle: I represent an urban environment, but the peripheral areas—the more rural areas around Bristol, where I am—do have that problem. It means, for instance, that it takes longer to get a package of care when somebody is leaving hospital.

Q40 John Pugh: Possibly you just drive out with the services you provide. Am I right in thinking that?

Richard Lyle: That is one of the services we provide.

Q41 John Pugh: There simply might not be a service in certain areas.

Richard Lyle: No. Often people will gravitate to the city to receive those services, which creates different problems. But I certainly think that, for older people or frail people who live in rural communities, it is a massive problem. Again, it is the recruitment and retention of the workforce that are very difficult: they push up the cost of providing those services and reduce the choice. But then you have the other benefits of living in a non-urban environment.

Chair: A very final word from David Pearson.

David Pearson: I have two quick points on that. Richard has made the point that it is clearly more expensive to provide in more rural areas. For one thing, travel time is a factor, as well as recruiting and retaining staff. One of the solutions to the joined-up issue you referred to in terms of organisations, particularly from a commissioning point of view, is to make sure that we have integrated health and social care personal budgets. If we think about the debate about health and social care, the simplest way of doing it is integrating it around the individual with one sum of money.

Q42 Chair: Okay. Well, I think the Departments have some challenges laid out for them there. Thank you for your clear evidence. You are very welcome to stay for our second panel session, which will probably be about an hour and a half. Our transcript of the whole hearing will be published in the next couple of days, straight to the website. Obviously, we will send you a copy, and our report will be out some time in May, at the rate we are publishing our reports. We will obviously get you a copy of that as well. Mr Dunster, you are going to send us the survey in the next week or so. We will write to you about that as well.

Examination of Witnesses

Witnesses: Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, Department of Health, Tamara Finkelstein, Chief Operating Officer and DG for Group Operations, Department of Health, and Graham Duncan, Deputy Director, Care and Reform, Department for Communities and Local Government, gave evidence.

Q43 Chair: Welcome to our second panel this afternoon. We have in front of us—this is his first appearance—Graham Duncan, the Deputy Director for Care and Reform at the Department for Communities and Local Government. Tamara Finkelstein—again, I think this is your first appearance before us, Tamara— is the Chief Operating Officer and Director General for Group Operations at the Department of Health. Jon Rouse, who has been a reasonably regular visitor to us, is also from the Department of Health, where he is Director General for Social Care, Local Government and Care Partnerships.

Before we start, I want to be clear: Tamara Finkelstein, I think you are about to be appointed the accounting officer, on an interim basis, for the Department.

Tamara Finkelstein: That is correct.

Q44 Chair: But you are not quite the accounting officer right at this moment.

Tamara Finkelstein: I am the interim accounting officer.

Q45 Chair: So who is in charge at the moment? I suppose that is my simple question.

Tamara Finkelstein: I am the interim accounting officer until our new permanent secretary starts.

Q46 Chair: Until Chris Wormald starts.

Tamara Finkelstein: Yes.

Q47 Chair: Do we have a date?

Tamara Finkelstein: We don't have that quite yet, but it is likely to be in a very short time.

Chair: Well, welcome to the important role of being accounting officer at the Department of Health for the time that you are doing it. We had an interesting first session. I have outlined some of our concerns arising from the NAO Report at the beginning, so I will not repeat those. We expect this session to last about an hour and a half. If you can keep your answers to the point, it will help us. I will cut you short if you are going on a bit; the same goes for Committee members.

We have big challenges financially. The King's Fund estimates that there will be a funding gap of between £2.8 billion and £3.5 billion by 2020, even if all councils implement the new 2% council tax precept, so there is a challenging backdrop to introducing a major and—as you will pick up from the Committee—largely welcomed change to how care is delivered. How confident are you that it can be fully implemented with the state of local authority budgets? Perhaps I can start with Tamara.

Tamara Finkelstein: Thank you very much for having us. We welcome the Report, which gives such a good exploration of personal budgets, and in particular the conclusion that they can improve the quality of life and experience of care. That is why the Government have personalisation at the heart of the Care Act. We particularly welcome the helpful steers around the need to build up evidence and learn from what works. We hope to do that, building on our strong record of working with the sector.

Q48 Chair: We will come back to you on the evidence of what works.

Tamara Finkelstein: You asked a question about how we do this. Clearly, it has been a challenging financial environment for local government in previous years, and it continues to be so. As part of the spending review, there is additional money through the ability to raise a precept for social care on the council tax, and additional money through the Better Care fund will give up to £3.5 billion by 2020. That is to recognise the need for funding in social care. The environment is still really challenging, but we have seen local government able to, relatively, protect social care and a commitment—

Q49 Chair: Up to now?

Tamara Finkelstein: Up to now, and welcoming the kind of initiative that personalisation enables.

Q50 Chair: Given that your two Departments are the stewards of this whole programme, as co-sponsors of the Care Act, and given that further cuts are coming down the line for social care, what conversations are you having within Whitehall to make sure that this is not going to be put at risk because of the challenges financially? It is a major change, a major agenda. As we have heard, it has been going since 2001 for social services; now, it is moving to health. It is really transformational for people, but it could go badly wrong if the resource is not in place, so how are you going to make sure that the budget that is set centrally will not have a detrimental effect and basically stop this policy in its tracks?

Tamara Finkelstein: We played that role during the spending review, in terms of providing the information about some of the pressures that social care faces, and that lay behind some of the additional money provided as part of the spending review settlement. But in this period, we are very much working with ADASS, the LGA and the sector on trying to make the best use of the money that we have and delivering the transformation. Local authorities have transformed services over the previous period, and are looking to do so going forward, and to deliver some of these transformational changes that we are supporting through our work with the sector and some of the guidance and support that we are providing.

Q51 Chair: Mr Duncan, you are very expert in this area, we know, and your Department obviously deals with local authorities on a regular basis. They are being squeezed pretty hard, and more squeeze is coming down the line. Even the 2% council tax precept is differential in different areas. Are you convinced that it is possible to continue to deliver the agenda on personalised care and personalised budgets with that spending challenge coming down the line?

Graham Duncan: As Tamara said, I don't think anyone pretends that it is not a financial challenge, particularly in the next two years, for local authorities. We spent a lot of time, in particular with the Department of Health and with the Treasury, in the run-up to the spending review thinking about what the evidence was on cost pressures, including, actually, following on from the National Audit Office's work on the financial sustainability of individual local authorities—how that would play out differentially around the country. So we recognise that this is not just about how it works in England-wide aggregate; it's about how it affects different areas.

Q52 Chair: On that, which types of local authority are struggling the most and how do you support them?

Graham Duncan: What I was going to say was that the spending review was not the end of the story. When we announced the local government finance settlement, which distributes Government funding to local authorities, the next phase was, "What are the decisions that we need to advise Ministers to make there, to make sure that we have recognised the differential impact?" We specifically recognised in the advice we gave to Ministers the pressures on adult social care. That is why, if you look at our figures for the local government finance settlement, councils that provide

adult and indeed children's social services have smaller reductions than other local authorities. That was specifically based on the work that we did about where the cost pressures were. The social care precept, of course, helps councils differentially, depending on how much they can raise from council tax. That is why we have proposed that when we put out the extra Better Care fund money to councils, we will use a methodology that effectively mirrors that, and recognises that different ability to raise money from council tax.

Q53 Chair: Can you name any authorities that are struggling and say why? Is it the demographic? Is it their management of their budget? Is it a bit of both?

Graham Duncan: Interestingly enough, our experience is that it's not always the things that you might expect. If you looked at a spread of figures on a spreadsheet, that might tell you one story, but often it is down to the leadership capacity of the council and relationships within that leadership. That makes it that much more complicated to try to make sure that you are understanding where the impacts will fall, but remember that councils have, by law, to set a balanced budget. That makes it that much more complicated to try to make sure that you are understanding where the impacts will fall, but remember that councils have, by law, to set a balanced budget. The challenge is often about the leadership of the council, rather than just what the numbers tell you.

Q54 Chair: But if a local authority does not have enough money to meet the increasing direct payment budgets, what happens? The Care Act is really clear about sufficient support. Who bails them out—which of you?

Graham Duncan: We wouldn't expect them to get to that position, because they have to set a balanced budget.

Q55 Chair: And be legally within the Care Act. It might not be possible to square that circle.

Graham Duncan: All I would say is that we put in an awful lot of work, particularly the Department of Health, in advance of the spending review looking at cost pressures, looking at the sources of funding that are available and looking at the scope for doing things differently. The spending review settlement reflects that. Probably there has never been a spending review document in history that has so many mentions of adult social care. That in itself signals how seriously the Government takes it. I do not think within Government it is a Cinderella service any more. It is well recognised across Government that social care is very important, that there are these pressures and that we need to take it seriously.

Q56 Chair: We will come to you shortly, Jon Rouse, but I want to talk a bit about the market for care providers. We will go into this a bit more further along. One particular area that I want to focus on at the moment is the fees that local authorities pay. We heard from the care providers earlier that there is a challenge there. "Let's be honest," she said, "and put it on the table: we're not paying you enough and we know that, but no one says this publicly." Tamara Finkelstein, do you think that there is a problem about how much money local authorities are—you know, now that

they are screwing down their budgets—giving in individual payments to care providers, and is that going to cause a crisis down the line?

Tamara Finkelstein: There certainly is a challenge for the care market in terms of limited financial circumstances and demand. We do quite a lot in the Department in terms of assessing those risks, understanding that market and helping to play back to local authorities what the provider needs are in an area and to understand some of the demands. We try to support them in the work that they do in terms of shaping the market and supporting that market.

Q57 Chair: So you will know, in each local area, what the market rate would need to be for that provider to continue to survive as a provider with a set fee.

Tamara Finkelstein: We have developed that intelligence. Jon can probably fill in a bit more of the detail on that. We are looking at how we can provide more of that information as part of our role as the steward of the system that you spoke about earlier by ensuring that we are providing some of the information that is needed, the data that is needed and some of the guidance on how to do it, as well as trying to ensure that there is the kind of diversity in the market that is key for the personalisation agenda and supporting that stability or security in the market.

Q58 Chair: Jon Rouse, do you want to pick up on this?

Jon Rouse: The starting point for us is the statutory duty in the Care Act that every local authority has to do its own market shaping and market statement. They have a responsibility for making sure that there is a sustainable market and a diversity of providers. At the heart of that is paying a fair price for care.

Actually, since the spending review, I have written personally to all the local authority directors, chief executives and treasurers to remind them of what the statutory guidance says, while also recognising the toughness of the financial conditions and settlement that they are operating in. Clearly, having given them the ability to raise the additional money through the precept, we want to make sure that it is being spent on social care. That can take a number of forms, but one is making sure that they are meeting the duty in terms of a sustainable local market.

Q59 Chair: One of the challenges that we all worry about all the time is that, because of the screwing down of budgets by local authorities—Mr Duncan may want to come in on this as well—the private purchaser of a service is often charged more to backfill the gap. Although we are here to look at taxpayers' money, we are also looking at the efficacy of the system. It does not seem a very good system if that is what it is relying on. Ultimately, it still costs the taxpayer when the individual user runs out of money. Is that something that you look at when you are writing to treasurers and chief executives? Is that something that is in your mind too?

Jon Rouse: It is certainly in our mind. I don't know if this is helpful, but as a Department, what we basically do at a locality level is continuously look at a range of indicators, which are telling us what is going on within that locality. We would be looking at the levels of activity that were being commissioned for different age groups and seeing whether that is what we would expect against the level of need that we can see in the area. We would be looking at the CQC ratings of the providers in that area. Have they got a high number of "requires improvements" and "inadequates", which

suggests there may be a problem in terms of commissioning or price of care? There is a constant job of triangulation in working out where there may be difficulties in any given locality.

Q60 Karin Smyth: Just to pick up on the reference from Mr Duncan on the challenges between the Care Act and the policy, figure 15 in the Report talks about the examples of savings mechanisms that are available and are happening locally. Given that discussion, would you look at which of those the local authority might be doing, and have a view on which of those savings mechanisms would be most appropriate to a locality? I think, Mr Rouse, that is what you are saying.

Jon Rouse: I don't think we would go into that level of detail with a locality. There is something about the Department not trying to replicate the statutory responsibilities and accountabilities that rightly fall to the local authority as a democratically elected body. What we are interested in, in total and in different areas of the country, is whether they are consistently meeting their statutory duty, which David Pearson set out very clearly in the last session: personal budgets have got to meet the individual's needs and their statement of reasonable preferences, in terms of how those needs are met.

Q61 Karin Smyth: On that, if a local authority sets its standard at a lower rate—that first example there—would you see, then, that the concern for the survival of that market in that local authority is very much at the local level? Is the responsibility for the market and the success of that market at the local level?

Jon Rouse: Not necessarily, because it would depend on the reasons why. If they were doing it as a crude piece of cost-cutting, then clearly that may raise questions about what the state of the local market is. They may have worked this through in a very rational way and it may be a reasonable efficiency saving—for example, about the way that transport is being procured. It may well be that individuals and their families can procure specialist transport more cheaply than through a local authority commissioned contract with big overheads in it. It would very much depend on what the reasons are and why the direct payment was at a lower level than the normal budget.

Q62 John Pugh: Can I just follow through on that? Local authorities in the past used to be responsible for delivering a quality service and be tasked when they didn't. You have moved the goalposts slightly—well, not slightly. The Government have moved the goalposts by suggesting that they are also responsible for having a buoyant market of alternative provision in the area. If it turns out in your dialogue with a local authority that there is actually a problem in that market being there, perhaps because of high wage costs, or low wage payments by the local authority that do not match with high housing costs and stuff like that, so that you have a problematic area where the market is not really working very well—it may be a rural area or an affluent, suburban area—do you reflect that in the payment you then make to the local authority for the provision of social services?

Jon Rouse: Do you want to answer that, Graham, for the local authority formula?

Graham Duncan: You will be very familiar, at least in general terms, with the complex formulae that we use to try and reflect needs and—

Q63 John Pugh: I was hoping that the complex formulae would take this into account.

Graham Duncan: They do, but not directly. We do not have a bit in the formula that is about wage costs, which would fluctuate anyway. There is an adult social care formula and that, as well as the formula as a whole, takes into account different costs in different parts of the country. We spend quite a lot of the time trying to get that right. For instance, we think about what extra costs there might be for local government services generally in rural areas compared with urban areas, and the formula takes that into account. In fact, in the settlement we have just published, we have put extra money into the settlement for rural services for that sort of reason.

Q64 John Pugh: So when you get the market assessments and you have tested it, that somehow or other impacts on fees, back to the formula?

Graham Duncan: I am saying not directly.

John Pugh: Not directly.

Graham Duncan: But the sort of underlying costs, which the market assessment would take into account, also feed into the formula.

Q65 Chair: I am struggling on who's accountable. If a market goes wrong locally and providers fail because the council is screwing down the costs—maybe it is forced to; maybe it chooses to; or maybe a bit of both—is it the council that is responsible for the failure because it should have flagged it up earlier and tried to do something about it, or is it the Department? It is quite a long way from Whitehall to a small local provider.

Jon Rouse: That's absolutely right. That's why we structured our whole relationship with local government—both collectively and on an individual level—on a relationship basis. This isn't just about wielding a big stick and sending in inspectors. The reasons why something goes wrong in any part of this market will be multifarious.

I recently spent a day with the senior team of a southern county. They are really struggling at the moment with delayed transfers of care and with accessing domiciliary care. It is true that they've done a few things and got a few things wrong on their procurement strategy—they've been very honest about that—but their fundamental problem was the fact that they were almost at full employment. In a way, that is a nice problem to have, but they are really struggling to access domiciliary care workers among their providers and to accommodate them, as somebody already said. There's no point in wielding a big stick in those circumstances. It's about working with them to see what creative solutions you can generate to source new supplies of labour into that area to provide home care.

Q66 Chair: Sorry, how do you do that? I have a constituent—at least one—who travels from Hackney to Cornwall, where she spends three to three and a half weeks of every month living in a residential setting to provide care. She then comes back to live in her home—most of the time she is not in her home—in Hackney. Is that a solution?

Jon Rouse: There may be something about widening your net of providers, so that providers from, say, London can set up a labour supply into that county. But there's also something about—

Q67 Chair: You talked about the problems with the housing. Where do people like that live?

Jon Rouse: It's very difficult. There are no easy solutions to that. The other route is to get people who wouldn't otherwise have chosen to work in the care market to come in. A crucial group for that is young people. There is also the use of apprenticeships. We had 93,000 new start apprenticeships in social care last year, which we are very proud of. Clearly, there is an opportunity to—

Q68 Chair: Clearly, there is a geographical issue. Having 93,000 apprenticeships is fine, but they might all be in an area where there is a glut of young social carers, whereas in other areas you've got none. In practical terms, can you lay out for us, on that example, how they will get people in to provide the care?

Jon Rouse: There's no single approach that will solve this completely. There is a number of things that, in that case, they are going to have to do. The first is that they are going to have to diversify the number of providers that they source from, because they won't solve all of this themselves and they need more providers who are out in the market trying to recruit staff and bring them into that county. The second is to have your own workforce development strategy, which is partly about young people. It may be about attracting people who are towards the end of their career and are willing to come in and work part time, and about how you create flexible options for them. It is partly about your retention strategy. There is high churn in this sector. There is no single solution; it is something you have got to keep working away at in the current circumstances in which we find ourselves.

Q69 Chair: We are going to come back to this. I want to make one last point before I pass over to Karin Smyth. Again, it is about the distance from Whitehall to the local provider. If you've got someone who receives a personal budget—they may manage it themselves or not—how do you know whether it is working? What mechanisms of accountability have you got in place, so you can be assured in Whitehall that the policy is working and that the individual is getting the care that they are supposed to be getting through their personalised budget?

Tamara Finkelstein: The responsibility for providing that care lies with the local authority. That feels like the right place for it to lie.

Chair: So how do you know—

Tamara Finkelstein: And it is part of the legal framework. In some ways, the legal framework provides a stronger framework within which people receive care than an administrative framework. We obviously have a strong inspection framework through the CQC. They inspect various providers of care, so that is provided as well. The fact is that the responsibilities lie locally.

Q70 Chair: Maybe Jon Rouse touched on this a bit, but where would your early warning systems come if something is going badly wrong? I could read out a raft of examples we have picked up through the media and internet trawling. What would flag that there is a problem in a local authority in this area?

Of course, it is the only free budget left, and there are cuts coming down the line as well. Going back to that financial stress, it is going to be a real squeeze and a real pressure. What will alert you to a problem? In the end, it is the individual user who will lose out if it is not working.

Jon Rouse: We have a set of signal indicators and we could send those to you, which might be helpful, so you can see the things that we are actually looking at. The quality of provision in an area is a really good indicator. If you have a pattern of lots of homes and domiciliary care providers that are getting “requires improvement” or “inadequate”, that has to tell you something about what is going on with local commissioning and the stresses on that system, because there is a reason.

Q71 Chair: With respect, even if they are all brilliant, the individual user might not be getting their personalised care. That is the point I am driving at. How would you know?

Jon Rouse: I was going to go through a list of indicators but let me skip straight to that. There are indicators around personalisation. One is the levels of direct payments for different groups. If you have got a very low level of use of direct payments, I would have some anxieties. From 2014-15, the NAO has helped us and that is something that it has since recognised in the Report. We are starting to break down our outcomes data by the type of support that somebody is receiving. If they are receiving a local authority managed personal budget or a direct payment or a provider-curated independent service fund, we will be able to see for any given locality—local authority—what is the quality of experience of care according to the type of support that they are receiving. We have been able to do that only from 2014-15.

Q72 Chair: I will leave that there for now. Aileen Murphie, do you want to come in?

Aileen Murphie: I think that is a very welcome development and it takes the outcomes framework forward to another stage, so we can link outcomes to the way that the money is actually delivered.

Chair: We will come on to outcomes right now with Karin Smyth and will come back to budgets later.

Q73 Karin Smyth: Just before we do that, can I come back to Mr Rouse on what was just said about support for the workforce, which is very welcome? To be clear, do you see that as your role? You talked about “we” and that it needs doing and so on. I just want to be clear.

Jon Rouse: We are drawing up a fresh social care workforce strategy. In that overall stewardship role that is described in the NAO Report, we certainly have an oversight in terms of trying to ensure that there is the right supply of workforce. That is about all levels: care assistants, registered managers, nurses and allied health professionals, and also access to pharmacy and primary care. Because not all of those are within the gift of providers and local authorities. It is a constant challenge in the current market and under current financial constraints. Yes, with each of

those groups, we are striving to work with providers and local authorities to ensure that there is sufficient capacity.

Karin Smyth: We want to move on to outcomes.

Chair: I warn you that we expect events.

Q74 Karin Smyth: If we start with the opening sections, paragraphs 9, 10 and 11 in the key findings do highlight the lack of outcomes. Perhaps you could give us your view before we go for the vote on those three paragraphs and what you want to say. Then perhaps we can pick up on some of the detail when we come back from the vote.

Jon Rouse: We think it is a fair cop, up to point. I think that is the way we would describe it. I will say what I mean. Basically, post the Care Act, there is a need for some deeper research to be able to demonstrate at local authority level, as opposed to just at user level, whether or not there is a positive impact on outcomes from personal budgets and the different ways of receiving personal budgets and personalisation overall.

In October, we issued a commission or an ask from research providers to tell us how we are doing in terms of Care Act implementation. They have all put in their proposals, and we will announce the results of those bids next month. Because we see personalisation as absolutely the heart and core of the Care Act, clearly one of the things we will commission research on is that very question.

The reason why I think it is only in part a fair cop is because we have not been idle. First, in terms of the POET survey, although it is at the individual user level, it is a rich source of data; it is a sample of 4,000 people. From that, we can derive a lot of information about what works for people and what perhaps does not work for people in terms of personalisation. Also—I don't know whether the NAO have access to this or not—we have undertaken at least six different qualitative studies since 2007 on different groups in terms of their experience of personal budgets and personalisation. That is rich—they are all rich—with information about the experience of personal budgets and what works and what does not work, and we have built that into our policy development in recent years.

Q75 Karin Smyth: Mr Duncan, do you want to add anything?

Graham Duncan: No, this is very much a Department of Health research area. We benefit from the results and we are involved in shaping the research paths.

Q76 Karin Smyth: Do you want to say anything about the link between what local authorities might be looking at in terms of those outcomes and the Department—if they are doing local work in terms of their outcomes and how that looks?

Graham Duncan: Yes, so, definitely, there is a whole strand of work where individual local authorities look at the impact of their service options. In fact, I had a conversation with the Association of Directors of Public Health earlier this week, and we discussed the experience of moving from the health service into local government. Interestingly, I don't know whether other people would back this up, but one of the reflections they had was that local authorities are very

focused on trying to work out—especially nowadays—the impact of the money they spend in different ways, because with less money, you have to be sharper at making sure that you make the impact with the interventions you spend it on.

Tamara Finkelstein: The new adult social care datasets give us that richness by local authority. That is where we get that richness of data.

Amyas Morse: I am curious and interested in your lead indicators. I have a couple of questions. When you look at your heat maps of those areas where it looks like the lead indicators are troubling, is there any geographic distribution of those? Secondly, if you find yourself in a position where an authority is starting to develop more and more concerning indicators and they do not have much resource available, what happens then?

Jon Rouse: The first thing is that it is surprisingly difficult to discern patterns, which brings us back to the point made earlier about the overarching question of leadership and historic decisions and so on. If there is any sort of pattern or bias, I would say that some of the smaller mets and some of the unitaries are probably the ones finding life quite difficult right now. But there again, there is not an even pattern, because some smaller mets have got really tight budget constraints, but are doing extraordinarily good work in terms of transforming their services and still maintaining a really high-quality offer.

In terms of your second question, we have a ladder of escalation. As a starting point, if we did have concerns about a local authority, we would go and talk to them at a pretty senior level to try and get a mutual understanding of what is happening and how high a level of risk it is in reality. We would hear their story and what their mitigation strategies are. From there, we would probably then ask ADASS and the Local Government Association whether they would be prepared to work with that authority through some sort of peer support mechanism, maybe putting in somebody very experienced—an external senior—particularly if there was a gap in leadership at that point.

Ultimately, we have recourse to statutory powers—both ourselves and DCLG—and the starting point would be to use our section 48 powers to ask the Care Quality Commission to go in and inspect and do a detailed report for the Secretary of State. I am pleased that, up to now, we have not reached that point in the escalation ladder. That does not mean we never will, but the more this can be resolved through relationships, the better.

Q77 David Mowat: Do you see evidence of local authorities using the indicators to compare themselves to peer authorities to see what they are doing better and not doing better? That is the power of it if that was happening, rather than you doing that.

Jon Rouse: I think local government has got a really good track record in terms of using comparative data. I think a lot of it came in the early 2000s, when we had the local area agreements and you had an indicator set, and you would compare yourself with other authorities. Certainly, I did when I was a chief executive, and so from that built up a whole relationship around peer review and peer relationships. So I think the answer is yes, they definitely use the adult social care outcomes framework; they definitely use our efficiency tool to look at their relative value for money with each other. So, yes, I think for the most part, with a few exceptions, they do use comparative data.

Q78 Karin Smyth: I crossed off some of my questions, because you very helpfully moved us on a little bit, but I think it would be worth exploring figure 5, and I might ask the National Audit Office to guide us through there. In terms of what you have said, and the work that you are doing—and I appreciate that you are going to be reporting—I think it would be helpful for the hearing to perhaps flesh out a little bit your views on what the National Audit Office have given us here, in terms of the indicators and columns that they have put through. Is that the sort of direction you are working in? Do you think those indicators are reasonable, in figure 5?

Jon Rouse: They are all indicators that we would recognise. We might choose to add to them in terms of maybe drawing out one or two more, but I thought this was a very sensible set of outcomes. What was interesting for me, when I read them, was how many of them are also relevant to our broader integration framework; in terms of the work of the better care fund, for example, you will be using, to a significant extent, some of the very same indicators, like detox and the proportion of older people still at home 91 days after hospital discharge. They are the same indicators we would be using to answer those questions, too.

Q79 Karin Smyth: You will have heard in the pre-panel discussion that that was suggested—that actually the multiplicity of indicators is not always helpful—although one of our panel experts did also say, for different client groups, you would want different outcome measures.

Jon Rouse: I think it is like a Venn diagram, really. I am not sure about the wisdom of actually completely merging the three outcomes frameworks; but I think what you do want is a cluster of indicators that are in the middle of that Venn diagram, that are relevant to NHS social care and public health, that allows you to have a holistic view of how a local system is working.

Q80 Karin Smyth: So who do you think will be measuring? Who is going to be doing the measuring of those outcomes? How is that going to work in practice? I appreciate you are going to report to us, but if you can give us an idea of your thinking.

Jon Rouse: We already capture and measure these outcomes. We utilise them in our work in terms of developing policy, and we publish a lot of these outcomes in different ways, to hold a mirror back out to the system.

Tamara Finkelstein: It is also something which we use internally to look at how we are doing against all of our work. We use the outcomes framework with our own departmental—

Q81 Karin Smyth: Do you? But some of this is very new for some client groups, for looking at not just the processes or the outputs but actually looking at what people would define as outcome. We heard earlier that we are leading the thinking on some of this. So we all appreciate some of it is new and needs refining. How quickly do you think you would be sending that to us?

Jon Rouse: There are two different things here. I think I will send you the signal indicators we are using to look at vulnerability in the system, and then I think there is the broader capturing of outcomes that let you know how a system is performing for the users. What we have tried to do, really, over the last two to three years, across NHS and social care and public health, is increase our transparency around performance. Now if you go on to NHS Choices, not only do you find a whole myriad of NHS indicators by individual trust and clinical commissioning group, but also social care

indicators as well, by commissioner and provider. So you can go on there and look up any care home and it will come up with indicators, the most recent inspection report—and we will continue to add to that transparency.

Q82 Chair: The outcome data is poor. You talk about all of that but how do you really know it is working, and how will you in future? What mechanism are you going to set up to make sure that when we have you back in a year, two years, three years' time, you can say, "Well, this is what it is actually achieving for the user"? It is important to check that money is going down the line, that something is being spent and that the providers are doing their job, but what about whether it is actually delivering outcomes for the individual user? How are you going to be measuring that?

Jon Rouse: There are two dimensions to this. We probably mentioned both of them previously, but now let's bring them together. The first is the changes we have made to the adult social care outcomes framework, which means that we can now look at outcomes, experience, quality of life, satisfaction et cetera by the type of social care support you are receiving.

Q83 Chair: But what about health outcomes? Although all those are important, if in the end if it is a health issue people are not getting better or if it is a social care issue they are not getting something that they need—*[Interruption.]* I will leave that question hanging—how you measure that. We will aim to be back within 10 minutes. I think we are in separate Lobbies so it should be quite quick.

Sitting suspended for a Division in the House.

On resuming—

Chair: We are now quorate again. Sorry about that, but that's democracy in action. I will pass to Karin Smyth, who is going to continue with the line of questioning.

Q84 Karin Smyth: I think you said you were going to come back to us on figure 5 and so on.

Jon Rouse: In order to answer this properly, I will leave social care personalisation for the moment and come back to it and talk first about the journey we have been on with personal health budgets. I will then bring the two things together, to answer your question.

In 2009, we set up the first pilots on personal health budgets. That process ran through to 2012, with an evaluation which found that, overall, they did represent positive value for money, but not because they had an impact on the biomarkers of your illness or disease—it wasn't that you got better. What it did demonstrate very well was that you had less unplanned admissions and there was less need to use acute services, so there was something about the fact that you had greater personal choice and control and you were able to maintain yourself in your independent life better with the support you were able to procure.

Off the back of that, and bringing in social care, NHS England have now created an integrated personal commissioning programme. They are testing that now in nine areas and looking at four different cohorts: children and young people with long-term conditions and chronic illnesses; working-age adults with the same combination; people with higher end learning disabilities and

higher level needs as a result of that; and people with chronic mental illness. That programme only got under way in April 2015; it will last for three years, and there will be a full evaluation of it. What we are testing, which was your question, is the impact on outcomes of having integrated personal budgets—social care and health together, with control across those cohorts' needs.

Q85 Mr Jackson: Apologies if this has been raised, and apologies for being late—I had a meeting with the Secretary of State. There was a debate yesterday in Westminster Hall about supported housing and the impact that the reduction in rent and local housing allowance might have. My question is a factual one. This is very much a cross-departmental issue that will have an impact on, for example, the Home Office and the Department of Health. Are you feeding into that review between DCLG and DWP? Do you have any observations on that? It is slightly off topic.

Jon Rouse: It is related, without any question, because an individual's ability to meet their housing needs has to be considered alongside health and care. You cannot divorce it in any way. DCLG are represented here today, but from a Department of Health perspective, we are very much involved in the review that has been announced, and DCLG were very purposeful in inviting us and DWP to the table to get involved.

We are concerned. Our questioning is really around two things. One is making sure that over the medium term the decisions taken, particularly around local housing allowance, do not place a significant additional burden on social care. The second important dimension is avoiding an undue period of uncertainty that could slow down the number of starts in terms of supported housing provision.

We completely understand the landscape in which these judgments are being made. There are very many things to balance and weigh here, which is why it is absolutely right that we have a review process and we have had the delay of a year in terms of introducing the local housing allowance side, but we will be playing in these questions about impact on health and social care.

Q86 Mr Jackson: Notwithstanding the fact that the discretionary housing payments are not a viable long-term solution, in my opinion, and—you are quite right—there is some evidence that future planning is going to be affected by this, are you doing an audit of the impact of the uncertainty, in lieu of the review being concluded, in terms of the specific impact on people with special needs, for instance—a generic title?

Graham Duncan: The review is in two stages. We had a call for evidence or information to gather as much of that as we could, and that is a basis for saying, "Okay, in what way should supported housing be funded and supported in the future?" We are going a bit wider than, "Should we have a local housing allowance cap?" That sort of triggered it, but it is worth just stepping back and saying, "Well, this is a really important sector. How do we fund it? How does this element feed in, but what are the other elements? How do we make sure that the right source of funding is funding the right thing—what should the local housing allowance be funding and what should other parts of the state system be funding?"

Q87 Mr Jackson: The Committee knows that my bugbear is lack of Treasury engagement in the long-term holistic planning of housing in order to have proper link-up and co-ordination between adult social care—well, all social care—and acute hospital care.

Chair: I have to say, Mr Jackson, that that is not just your view; it is pretty much a Committee view—cross-party.

Mr Jackson: If only the Treasury were to look again, perhaps even at tax breaks for those partners that wanted to construct new extra care facilities and so on, it would really have a long-term impact on the cost. That is for another day, though.

Graham Duncan: It is relevant, though.

Mr Jackson: It is worth putting it on the record.

Chair: I refer you to our session on right to buy, when we discussed some of these issues.

Q88 Karin Smyth: I am just going to bring us back to figure 5 and outcomes before we move on to other people, because we all think this is a really important policy and it is not going to change; there is going to be more of it. We have heard from Health about how it is going to be rolled out for other diseases, which I am sure is something that we will want to look at. If I can summarise, you said that what the National Audit Office said is partly a fair cop; then you gave us a number of qualitative surveys that you are doing and also said that you felt the indicators in figure 5 were helpful, and you talked about bringing some things together but not all. I will just refer to the National Audit Office. Could you give us any comment about what you have seen and what you have not seen? I have not seen all those surveys, so I bow to your knowledge on this.

Aileen Murphie: As I said, the linking up of how the money is paid and the outcomes is really welcome. That is very helpful. On POET, we were not critical of the survey or all that; we were saying that we would like to see the number of authorities taking part much extended and consistency over time. It would be useful to know whether the Department has plans to try to encourage more than 24 to take part. Lastly, we have not seen the qualitative reviews that the Department has done, nor have we seen the signal indicators and heat mapping that Jon Rouse referred to, which sound very helpful indeed. If we were going to take a view on those, it would be very helpful if we could see them.

Sir Amyas Morse: Just to add to that, it might be quite helpful for the Committee in considering the balance of its Report to have seen your indicators very quickly before we actually do the Report. Otherwise, would we or would we not be talking to you about the need for forward indicators and recommending that in the Report? That will depend on our understanding, perhaps, or the Committee's understanding of what you have in place. It really would be most helpful—I mean that in a positive way—if we could see it really quickly, as the Committee might feel able to take a view on that either way and support what you are saying rather than ask you to do something about it that you are already doing.

Q89 Chair: The Comptroller and Auditor General raises an important point. We were concerned about this in preparation, but you have given us some reassurance, Mr Rouse. It is always

going to be coming; that is the nature of the way that we work, a bit, as well as the way you work. But if what you say is coming, we are really interested to know exactly how that is going to work.

Jon Rouse: We can certainly share those.

Chair: I want our recommendations to be live, real and impactful, not talking about something that you are already going to do but building on that.

Karin Smyth: It will be very helpful for being able to mark that against the outcomes, which are more difficult for Health as we heard in our pre-panel. The final thing—the NAO has mentioned this—is that our speaker from Scope did ask for the extension of POET and thought that that would be really helpful. I re-emphasise that that was a request from them in the pre-panel.

Q90 Caroline Flint: I wanted to go back to the information you mentioned a bit earlier, Mr Rouse, about moving towards integrated social care and health, or health and social care. As I have been listening to the evidence and looking at the Report, I jotted down that we have personal social care budgets and personal health budgets. On top of that, I added the movement from DLA to PIPs because, in their own regard they also are providing for people to live independently and buy in services. Adding to that, in my own area I have had to deal with some cases around the independent living fund being transferred to local authority areas. You could throw mobility allowance into that as well.

My question is really about integration, which is what I am interested in. It seems that it could be the same people—not exclusively—applying for all these different types of budget, and the difference is between one and another is quite grey. How do you see this coming together? First, for the person using the budgets, it might make it easier; secondly, it might help with finding savings in terms of efficiency and avoiding duplication; and thirdly, it might also help the market in terms of generating a sense of clarity about how these areas are developing and therefore the providers that will be needed to provide those services. I would really like to hear a bit more about that. Why are we not just pooling all these together now?

Jon Rouse: There is no question that there is an evolving landscape in terms of individuals, particularly those with complex needs and long-term conditions, receiving different pots of resource, which at the present time have certain fences around them. Some of those fences exist for good reasons—to ensure that there is fair allocation for the particular set of needs.

My personal view is that, as we move forward, the devolution agenda provides us with an opportunity to work with some localities on how you better join these things up with individuals and how you curate services to allow people to use those budgets in combination in new ways. It seems to me that the devolution conversation is as good as any for beginning to work some of that through and to test and pilot different approaches with some trusted localities.

Q91 Caroline Flint: In the meantime, given that we do not have that cohesion and integration, how will you ensure that the issuing of personal health budgets is not duplicating, and in that sense not using the money wisely, set against people getting their social care budgets?

Jon Rouse: You could argue that that question pertains regardless of whether you have personal budgets. You will have a continuing health care assessment being done in terms of the

individual's health needs and you will have a social care assessment being done in terms of their social care needs, regardless of whether or not they have turned into personal budgets. The real question is how we move towards integrated assessments and single care plans, from which a personal budget can flow. Certainly, at the heart of the Better Care fund and whatever we move forward with from 2017 onwards in terms of the spending review commitment around integration, will have to be this commitment to join up the assessment processes and the care planning so that individuals experience one process, not two parallel processes.

Q92 Caroline Flint: What about PIPs, mobility allowance and other things that are all there, quite rightly, to help support people with those extra costs that they have as a result of their health or disability?

Jon Rouse: There may be further opportunities there. It is an evolving landscape. There is something about not running before we can walk: our first priority is to get the health and care systems properly joined up in terms of co-ordinated care around the individual; then, as I said a few moments ago, there may be a possibility of using a devolution dialogue to test out some wider approaches within a few localities.

Q93 Chair: I want to come back to this issue of the care market. Jon Rouse, you talked earlier about a number of measures that you are trying to bring in, but who is ultimately responsible for making sure that the training and pipeline is there for good-quality social care workers? Is that the Department of Health? Is that you? Where does the buck stop?

Jon Rouse: I think we have an overall stewardship responsibility for the social care workforce, in the same way as we have for the health workforce. It is clearly a different type of relationship and a lot of it we broker through the relevant sector skills council, Skills for Care. We finance Skills for Care and then hold them accountable for the resources we give them for putting in place a whole series of programmes, but clearly there are also needs—nursing is a very good example—where we need a relationship with Health Education England that takes into account the needs of the social care workforce as well as the NHS workforce and we are commissioning against that whole background. In terms of an overall stewardship role for the sustainability of the social care market, yes it is—

Q94 Chair: In terms of the overall stewardship role, you have different grades of people working in a domiciliary setting, from care assistants to community social workers and district nurses, but often without the overlap of necessary skills. For example, a care assistant may not be able to give a simple injection or provide simple medication, depending on their skill level. It might be rather a big thing, unnecessarily to bring in a district nurse for something like that if you could have the care workers graded up and trained up to do it. Where in the planning does the decision about skill mix come? Is that through you? Is it through Health Education England? You have already named a few bodies and we always get worried in this Committee when lots of different organisations are mentioned. Who is making sure that that mix is there, supporting providers and ensuring that they can afford to employ those people?

Jon Rouse: Obviously, at the level of the individual care service, it is for the provider to work out the mix they need to meet the provision that they are making.

Q95 Chair: Let me stop you there. If you are a care provider with a budget that is being funded largely by local authority budgets, which will be screwed right down, you are not going to be employing the equivalent of a district nurse in your organisation if you can employ care workers and then buy the district nursing through the health service. We have talked a lot about integration today, but there isn't really integration there. Under the current structure you will have the social care provider providing the social care providers while nursing, certainly in a domiciliary setting, will more or less be provided by the NHS. Am I right?

Jon Rouse: Up to a point, but the social care sector employs a very significant number of nurses indeed. I am just searching for a figure.

Q96 Chair: For domiciliary settings?

Jon Rouse: For mainly residential and high nursing home settings. To a lesser extent, within—

Q97 Chair: Although not every personalised budget is outside a residential care setting, the majority will be—the whole point is about independence. So who is thinking, across that mix, about whether the grades are right? You talk about the sector skills council—fair enough, I am sure that has a role—but what is the paradigm for the future of the social care sector from the Department of Health's point of view and how are you going to get there?

Jon Rouse: That is why we are pulling together a workforce strategy. In terms of who is playing into that, as well as the relevant arm's length bodies that I have mentioned, it is the key care provider representative organisations, the Local Government Association and ADASS who are all contributing to the development of that strategy. Then it does break down into its constituent parts.

One of the points that you have just raised, which is the fact that too often there is a gap between care assistant up to clinical member of staff, is absolutely right. We also want to provide care assistants with a bit of a career structure that gives them another reason to come into the social care sector. One of the things we are working with HEE on is the potential development of a nurse associate, or a grade of member of staff between care assistant and fully qualified nurse, to be able to take on some of those responsibilities, but also to provide another pathway for those care assistants.

Q98 Chair: In terms of this debate about personalised budgets, the Department has very clearly set out, according to the NAO Report, that you are not expecting savings, and we are going to touch a bit more on that in a moment, but would you see those intermediate individuals being cheaper than a district nurse or more expensive than a care assistant? In terms of the balance, would it more expensive or less expensive to have those individuals? Have you done an analysis of the potential costs?

Tamara Finkelstein: The expectation will be somewhere in between. That is the kind of path on which you would like to set care workers.

Chair: When you do the workforce planning, is someone doing that modelling about how many of those individuals you would need and what cost savings or costs there would be? For some people, it would be more expensive, but for other people—perhaps with expensive district nursing or whatever that they don't need—it might be cheaper.

Q99 David Mowat: I have difficulty understanding how you can be doing workforce planning, given some of the comments that you have made. These people are employed by third parties, predominantly if not entirely. You say you have a stewardship responsibility for them, but that is a wide word; it can mean lots of things. You are doing a strategy and looking at grading and all the rest of it. I wonder how you get traction sitting in Whitehall doing that, when there are hundreds of companies out there who employ all these people, presumably, and are responsible for their retention and development and all that goes with that. You implied it was similar to what you do for the health sector, but it seems to me to be quite different, because the NHS employs most if not all of those people. It is quite a different set-up.

Jon Rouse: What I think I said is that at the service level, it was the responsibility of the individual care provider in terms of the skills mix and how they employ. But if you are a care provider and you do not have access to the right number of nurses because they simply don't exist, you have a problem. Where we have a responsibility as Government, working with the sector skills council and the industry, is ensuring as much as we can that there is a sufficient supply of the relevant labour with the right skills. Remember that most of these providers are very small enterprises. They do not necessarily have the ability in terms of training and development of nurses and other skilled members of the workforce.

Q100 David Mowat: Yes, but you are not accountable for that, are you? If you were accountable for that and they ran out of those people, somebody would knock on your door and say, "You've done a bad job."

Jon Rouse: I didn't use the word accountable. I said we were stewards. I used a different word.

Q101 Chair: Who is accountable?

David Mowat: That is what I am struggling with a little bit here. The set-up, as I understand it, is that there are market signals. Basically, budgets are given out and are being spent by people in getting the care that they want—that seems a good approach—and the market picks that up, hopefully staffs it, and people go into that industry. That is nothing to do with you?

Jon Rouse: We can help to create the conditions where that is less or more likely to happen by working with the industry and the sector skills bodies.

Q102 David Mowat: Just as an example, you say you are doing workforce planning for the industry. Does every company within the industry know that you are doing that and look at it and say, "Well, that is interesting. That will really help us."?

Jon Rouse: I hope not because, to be honest, if I was a small domiciliary care or care home provider, I would probably have more useful and important things to do in terms of running my micro-service.

Q103 David Mowat: So this workforce plan that you do—if it is not being used by the people who employ the workforce, who is it being used by?

Jon Rouse: The relationship is such that when that individual care home provider or domiciliary care service, without knowing anything about what we are doing, comes to recruit a nurse, a care assistant, care co-ordinator or other posts, the actions that we have been taking with the industry and the sector skills council will have given them a better prospect of being able to recruit that member of staff and retain them at the right price with the right skills.

Tamara Finkelstein: We do it in other bits as well. For example, we use sector skills councils in things like early years, where many of the settings will not necessarily be state settings but we have a responsibility to try to ensure the right kind of supply.

Q104 David Mowat: If, for example, your workforce plan says that we are 5,000 nurses or care nurses short in three years' time and therefore we have to go out and train them, or whatever we have to do to get them, what is your accountability regarding that? Do you have to go and put that plan into place and make sure those 5,000 people happen?

Jon Rouse: It may not be quite as exact as that, but it would require us to take action, and indeed that is exactly what we have done. We have a nursing workforce group that the industry, HEE and the Royal College of Nursing sit on, and that is one of the reasons why we are increasing the number of nurses that are being trained at the present time—an extra 40,000 for the NHS and social care by 2020. That is why nurses are on the shortage occupation list.

Chair: The training places went down three years ago.

Q105 David Mowat: I do not want to spend too much time on this, but let's say that you put into a plan to get 5,000 nurses. You are doing that somewhat in an abstract way, because the people that employ the nurses don't know that you are doing it.

Jon Rouse: They do at a representative level in terms of the industry bodies.

Q106 David Mowat: Okay, some of them might, but what if you were wrong; what if it turned out you needed only 2,000 nurses? How does that work through in terms of your accountability and all the rest of it?

Jon Rouse: Well, this is not an exact science, is it? If we ended up, across the NHS and social care, with a surplus of nurses, those individuals would either have to find something else to do or would work abroad—whatever that combination might be. I have to say that at the present time we are grappling with the opposite problem.

Q107 Caroline Flint: I think this is a hugely difficult task you have set yourself, because we have had evidence before about shortages of nurses in the more traditional settings. There is also the issue that ultimately it is public money used for training nurses and the private sector is not necessarily making a contribution to it. Some might say it is a further privatisation of the NHS. But I would like to come back to care assistants—those people who in the main are the ones going out to people's homes and providing services.

We heard in the witness previous session about the difficulties of recruitment. I am not saying it is fair, but there is an image of the people who are doing this sort of work. They are often on zero-hours contracts. They are having to go to people's homes—multiple homes—and I never have a sense of where within that the downtime is for those workers to come together, not just for training and development but maybe to address some of the stressful situations they are dealing with. I wonder where that fits in with all this. Do the direct payments have enough within them to pay for the providers to be able to cover the costs of that part of those workers' working week? That seems to me, in terms of the publicity, a huge disincentive for people to think about coming into this sector, because they can feel pretty isolated and alone. At the same time, where is the incentive for the providers to provide that? Don't get me wrong—I am sure some are providing it, but how does this fit together not only to encourage people to be recruited, but to retain the workforce?

Jon Rouse: It is an important part of retention and you are right to raise it. In terms of a fair fee rate at local authority level in relation to a provider, that should take into account those reasonable additional costs of employing that individual when they are not actually providing care. That includes travel time and it includes training and development and whatever you fit within that definition. It is not necessarily the job of the Department of Health to police that, but that is one reason why I wrote to all local authorities, post the local government settlement, to remind them of their responsibilities in terms of the statutory guidance and a sustainable market and the reflection of that in fee rates, because it points to this broader landscape: how do you not only recruit but then retain staff in these provider organisations?

Q108 Mr Jackson: There is a vicious circle though, because if you have a relatively less prosperous area where the local authority—usually a unitary authority or county council—has a reputation of paying on the low side in terms of tariff and fees, people will not want to go there; that will be much more difficult. Therefore, you will have a vicious circle of inability to recruit and retain people. Do you see your role at all as giving practical assistance or suggestions to deal with that—for instance, collaborative working between a poorer local authority and two more prosperous local authorities?

Jon Rouse: We have certainly done two key things. One is that we have provided a lot of guidance on how to go about this market shaping—tools, review mechanisms and goodness knows what else—and as I said earlier we have facilitated peer support mechanisms using colleagues at the Local Government Association and ADASS. Indeed, every region, through ADASS and the LGA, has a very experienced adviser to support local areas in terms of the way they are undertaking their responsibilities.

Q109 Mr Jackson: Peterborough is traditionally a low-fee authority. I recently went to a specialist care home in my constituency for adults with learning difficulties. The difficulty they have

in recruiting the right people is acute because of that traditional low fee compared with, say, Cambridgeshire or Lincolnshire, neighbouring authorities, where it is higher.

Jon Rouse: That is interesting.

Q110 Chair: The variation between authorities is interesting. Six authorities have fewer than 50% of their long-term users with personal budgets at the end of 2014-15: Bromley, at 10.2%, is the lowest, which is interesting, being very low; then come Somerset, Stoke-on-Trent, Manchester, the Isles of Scilly and Trafford. The other outlier there is Somerset, at 23.8%. Do you have any thoughts about why they are so low? There are 12 authorities—I will not go through them all—that have 100% of their long-term community care users with personal budgets. Do you know why Bromley and Somerset, which are two quite different areas, have such a low level? Does anyone want to comment on that?

Jon Rouse: I would say a couple of things about this. First, I remind everyone that under the Care Act it is 100% from now on, so in a personal budget—

Chair: It is supposed to be, yes.

Jon Rouse: Yes, and that will be something that we have to monitor and evaluate. That comes on to the second thing that I want to say, which is: be a little bit careful about those individual local authority statistics, because with those who are reporting 100%, I would really want to test whether they were all genuine personalised budgets that are really about personal choice and control, or was it simply that they had gone through an administrative mechanism to set up a separate personal account in their treasury management system. The truth is that it would be on a wider spectrum. It may just be that the likes of Somerset, which is a local authority with many positive characteristics, are being particularly rigorous in their definitions of what constitutes a personal budget.

Q111 Chair: That is interesting, because this is from the Health and Social Care Information Centre, which has been a focus of this Committee in the past. When we are talking about outcome measurement, it is interesting because I had exactly the same concern when I looked at that, because it is a mysteriously neat number. We can submit this as evidence—the NAO dug this out for us. Do you think that there is an issue about how the information centre is actually collecting that data, or is it down to local authority data quality? Is there something that can be done to cleanse the data?

Jon Rouse: I think it is down to local authority reporting. In a sense, the discussion now moves on because in terms of meeting the administrative tests they all have to move to 100% under the Care Act. What I am going to be really interested in is the differences in terms of how many are using genuine direct payments and independent service funds, which we know from the research are more likely to result in a higher quality experience for the individual service users.

Q112 Chair: We also have one local authority—perhaps Aileen Murphie from the NAO can remind me which one—that had 700 providers.

Aileen Murphie: Seven hundred options in the way that they can provide against the needs in the care plan.

Chair: Can you remind me which local authority that was?

Aileen Murphie: It was the London Borough of Harrow.

Q113 Chair: Harrow has a wide range because it is using a lot of independent voluntary sector providers so that there can be choice—for instance, a befriending visit could be part of that package. In others, because the market has narrowed down—I am going back to this issue of the market—there is a lot less choice for people, so personalisation in some areas means a choice of this provider or that provider, broadly speaking, compared with the 700 that Harrow has managed to pull together. There is wide variation and we have talked a bit about how you share good practice, but given your role in making sure the market works, what are you doing to make sure that third-party providers are also supported to provide the wider choice for the individual user?

Jon Rouse: This has been written into the regulations and guidance under the Care Act, so in a sense the legal framework is in place to promote that diversity of provision. What we now need to see is that translated consistently across the country.

My personal view is that you can do that in two ways, and they are not necessarily mutually exclusive. There is the one that you have described, with the good example of Harrow, of really supporting, promoting and pointing people towards a really rich diversity of provision, and making sure that you are doing that for all cohorts—people with learning disabilities, mental health issues and so on. The other way of doing it is to work with your bigger providers to get them to provide a bigger choice of services themselves, so that you have choice within that individual provider relationship. The best areas will be doing both those things.

If I have a particular concern about a particular cohort at present, I would say it is about the diversity of the offer for working-age adults with learning disabilities. There are some very good practice examples—I would pick out Wigan as one—but there are too many areas that I go to where people with learning disabilities have personal budgets, and in many cases direct payments, but they and their carers, if there are any, find it difficult to put together a set of meaningful activities through the week because the local authority has not done enough to stimulate that range of services, particularly social enterprises, micro-businesses and voluntary sector opportunities that would give that individual and their carer that richness of experience. That is something we need to do more work on nationally and maybe issue some specific guidance around meeting the needs of those cohorts.

Q114 Chair: And I assume better good practice sharing, if Wigan are getting it right.

I wanted to touch again on the issue of savings versus outcomes. You said clearly that you do not expect savings. I know we have touched on this before but it is important to tease out whether there could be savings involved. I visited the second city of Denmark, where they are doing interesting work in this area, in particular telemedicine. They likewise talk about it being too early to assess whether there will be savings involved, but there are some very interesting models there that reduce the number of visits someone may need to make in a day, or they can be organised differently, focusing very much on the independence of the user.

If there are savings to be made in one area, how are you assessing that and whether there is an opportunity to ensure that that cohort—it may come down to cohorts—gets a really good service but you make savings that could be used for them or another cohort to provide more services? Is it just going round the system and savings are reinvested somewhere else—I don't suppose you use a financial term—or are you really expecting that there will be no savings at all?

Tamara Finkelstein: It might be worth clarifying our judgment around savings. We do not see personalisation in itself as being around driving savings. It is more than just a payment mechanism; it is that sense of organising care around people rather than around services. We don't see that as being in itself a source of savings, but especially since all local authorities will be passing their money through personal budgets and doing it in that way and looking for savings, they will be looking in the round at how they transform the way they do it, and personalisation will form a part of it. You can see ways in which individual cases will lead to savings. That is where we see savings could come from.

Q115 Chair: Okay. When you are doing the outcomes evaluation, will you be looking at these things? We talked earlier with Jon Rouse about commissioning specialist transport, for instance. I have come across examples in my constituency where a charity that was a separate trust at the time was commissioning taxis for schoolchildren at £85 a day. Frankly, if the person had been given some money they would have taken more of a risk by having a regular taxi firm with a regular driver, though perhaps not one who was police-checked in the same way, but for a lot less money. That is one obvious area. Are you looking at that when you are looking at outcomes?

Jon Rouse: We are. It is for individual local authorities to make their own judgments and decisions about where these efficiencies might lie. Our experience is that this works best when they do it with service users, so they get user groups set up, talk to the service users and carers and actually work this through together in terms of where there is an opportunity to use personalisation to drive out really obvious savings, like the one you described. There are two types of efficiency here. There are transactional efficiencies, exactly as you described. There are more allocative efficiencies around service transformation, just doing something in a completely different way from how you have done it historically.

A good example of that would be day care for people with dementia. You can have very expensive traditional services in a building that needs to be maintained. That might be right for a particular cohort, but I have visited examples—Derby is a good one—where they invested instead in peer social groups of carers and people with dementia and they just organise their own activities, putting together their own programme of different things they choose to do, using all sort of local provision—voluntary, private sector and public services. In doing so, they saved a significant amount of money and gave people a better quality of life and more choice. When you look at personalisation, if you are a local authority you will look at both those types of savings.

Q116 Chair: Another question I wanted to ask was about annual reassessments. I think it is written into the Act that they have to be done. Have you done a cost-benefit analysis? Some people have long-term conditions and an annual reassessment may be too frequent. It may be a cheap exercise or it might be quite costly to do annual reassessments. Is this something that is under review or are you wedded to annual reassessments? Have you done an evaluation yet? It is early days, but will you be doing an evaluation about how well that will work?

Jon Rouse: We haven't, but we will make sure we do so as part of the commission that I described earlier under the Care Act approach, because we should test that. At the moment, it is quite staccato in that you have an initial review after six months and then a review every 12 months after that. It may be that you can go for a more differential approach. The reason why we have put that in as we have was to protect the service user. It was to make sure that at the very least there would be a review every 12 months, so that if their needs changed the local authority would have to go through a process of reassessing those needs and potentially those of the carer as well. So that is why we did it. It was a back-stop mechanism, but it may turn out that we have been a little too rigid in terms of setting that.

Chair: Okay, because there could be a cost in bureaucracy.

Q117 Caroline Flint: On personal assistants, have you looked into how people with direct payments are meeting the national living wage for this group of workers?

Jon Rouse: That is a good question. One of the reasons why we require the employment of these individuals is partly to protect their rights and to ensure that there is an ability from an HMRC perspective potentially to monitor what is going on in their employment. That is why we do it. Have we done a specific piece of research on that question? No.

Q118 Chair: When we looked at local government new burdens, the national living wage was not considered to be a new burden because it applies equally to everybody, but we have heard from the sector that there are real problems about introducing that and national insurance contributions by employers, so will you be watching this? What advocacy do you make on behalf of the sector to the Treasury about the impact on this predominantly low-paid sector?

Jon Rouse: Broadly on the impacts on the sector, we meet the providers on a regular basis. They have their own taskforce and these are exactly the sorts of issues that they can raise and discuss with us, and there are cross-Department discussions around understanding those impacts.

Q119 Chair: Have you done an analysis of what the impact of the national living wage will be now that it has been implemented?

Jon Rouse: It was one of many factors that was taken into account during the spending review process.

Q120 Chair: So you are trying to tackle it through the spending review. But presumably you will be doing a post-hoc analysis in a year or so, when it has been bedded in for a year. When will you be looking at it again to see what the impact has been?

Jon Rouse: I do not have a precise answer to that. I don't think we have set a timeline for a further analysis and assessment of the actual impact of different cost burdens. I will take that question away.

Q121 Chair: We may reflect on that when we do our Report. I wanted to ask perhaps all of you, but certainly Tamara Finkelstein as you are the accounting officer, what you think are the top three or four challenges facing this programme as it rolls out. We asked at the beginning for honesty and candour. We know it is a challenging programme of work. It is really important to the people receiving it, as we heard clearly from our previous witnesses and as we know from our constituency work. What do you think are the four top challenges?

Tamara Finkelstein: We have covered a number of them. The financial constraints are clearly there. There are issues in terms of fragility in the care market and the recruitment and retention of the workforce. Those are things I would put at the top of the list, but colleagues might want to add to that.

Chair: That is for Mr Wormald's in-tray when he arrives at the Department of Health. All that is very helpful. Does anyone have any other questions?

Q122 Karin Smyth: Just one thing. We have not talked about older people particularly and the Report highlighting who does and does not pick up the service. I think it would be remiss of us not to highlight that there are particular problems there. Do you want to quickly add anything?

Jon Rouse: Three of the qualitative pieces of research that I described earlier are specifically on personal budgets and older people. We will make sure the National Audit Office has copies of those. A number of issues came out of those reports. I will just pick out two that I think are particularly pertinent. One is that the mindset of local authorities towards older people holding personal budgets can be unduly paternalistic. There is a different mindset for some of the working-age adults. That is not across all authorities; it is more of a tendency. That came out of the research.

Secondly, there is an issue about people with dementia, from a mental capacity perspective. There is an even more pronounced starting position of a person with dementia not holding a direct payment or actively using a personal budget, which needs to be challenged. For quite a period, particularly if there is care and support, there is absolutely no reason why an individual with the disease could not have more choice and control over the support that they receive.

Q123 Chair: Absolutely. I think the Comptroller and Auditor General has some questions.

Sir Amyas Morse: Two very quick things. First, I see that you are due to publish a draft national market position statement in the spring. Has spring sprung yet or not?

Jon Rouse: We knew you were going to ask that question.

Sir Amyas Morse: I'm sorry.

Chair: Spring in the civil service—when is that this year?

Sir Amyas Morse: Is it before the House rises for the summer?

Jon Rouse: I was tempted to ask whether it was Manchester or London, but I won't do that. The answer is that, with a number of stakeholders, we are working through the best form to produce this in. We are not convinced that a static, annual "this is our view of the world" is

necessarily the most helpful way of doing this. We are looking at whether it would be better to produce some sort of digital hub that could be updated on an ongoing basis. To answer your question simply, whatever we do, it will be done before summer recess. That's what we're aiming for.

Sir Amyas Morse: Thank you. To follow up on your very interesting remarks about trialling combined health and social care to see whether it produces better outcomes, supposing it does, what might you do about it?

Jon Rouse: Do you mean in terms of the integrated personal health—

Sir Amyas Morse: Yes. Supposing it produced either a negative correlation or a positive one, what will be the avenues open to you after that?

Jon Rouse: Okay. Maybe we will come back to this on another day. You have to answer that question within our overall framework on where we are taking the whole integration discussion. Ultimately, where we want to get to is utilisation of integrated personal budgets within a broad framework of joined-up provision.

Sir Amyas Morse: Do you mean joined-up health and social care?

Jon Rouse: Yes. We have a few examples at the moment of accountable care organisations in Northumberland, Salford, Torbay—I begin to run out after that. The ideal world would be to have organisations like that engaging with individuals on the provision of those integrated budgets. Who knows? Perhaps by 2019-20 that is the type of world we will be looking at in many more parts of the country.

Chair: Thank you very much for coming along to what for two of you was your debut hearing at the PAC. You can go back and tell the Department that there's not always blood on the carpet.

We think this is a really, really important area of work. We recognise that it is early days for the health side of it, and there is obviously a lot of practice to build on. We will be watching it very closely because, of course, if it goes wrong the impact on the individual is huge, and if it goes well it is transformational for those people. I do not doubt that you have that intention, but sometimes there is a distance between Whitehall and the user, and we are very focused on what happens for the user.

We are very concerned about the market, as you will have picked up. Again, there is quite a distance from Whitehall to the market. You gave us some reassurance there, Jon Rouse, but we will be watching that as well. I know that the NAO is doing a report coming up. When is the one you are doing on integrated care?

Aileen Murphie: It is for delivery halfway through 2016-17.

Chair: We will be coming back to this in around a year's time at the very least, so you can add that to Mr Wormald's to-do list as well. As ever, a transcript will be up on the website in the next couple of days. We will make sure you get a copy of that. Our Report will be out some time in May. Thank you very much indeed.

