Communities and Local Government Committee

Oral evidence: Adult Social Care, HC 47

Wednesday 14 December 2016

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Watch the meeting

Members present: Mr Clive Betts (Chair); Rushanara Ali; Helen Hayes; David Mackintosh; Melanie Onn; Mary Robinson.

Questions 254 - 286

Examination of witnesses

Stephen Dorrell, Chair, NHS Confederation; and Simon Stevens, Chief Executive, NHS England.

Q254 **Chair:** Good afternoon and welcome to this evidence session of the inquiry into the financial sustainability of social care, which seems quite appropriate, given the media interest that has suddenly been aroused in the last few days about this issue. Thank you both very much for coming. As Committee members, we will put on record any interests we may have in this matter. I am a vice-president of the Local Government Association.

David Mackintosh: I am a Northamptonshire county councillor.

Helen Hayes: I employee a councillor in my staff team.

Chair: Thank you both very much for coming in this afternoon. Perhaps for our record, if you could say who are and the organisation you are representing, that would be a good start. Thank you.

***Simon Stevens*:** I am Simon Stevens. I am the chief executive of NHS England.

***Stephen Dorrell*:** I am Stephen Dorrell. I am the chair of the NHS Confederation and, by way of declarations of interest, could I also declare an interest as chair of LaingBuisson?

Q255 **Chair:** Thank you very much for that. As I say, the whole issue of social care funding has been in the news very much, and probably quite rightly, in the last few days. Where it did not appear was in the Autumn Statement. Did that surprise you? Was that a serious omission?

***Simon Stevens*:** I have been clear for some time now that, from the point of the view of the NHS, given the pressures that have clearly been building in social care, it would make sense, were extra funding to become available, that it should in the first instance go to social care. The question of whether or not that flexibility exists is a matter for the Government. However, unusually as the chief executive of NHS England, back in June I said that that was our point of view. I am pleased that, to some extent, that has become the new orthodoxy in the following six months. Now we have moved from denial of the fact that there is an issue to acknowledgement of the fact that there is an issue. We need to move from acknowledgement to action.

***Stephen Dorrell*:** Simon Stevens made that statement at the confed conference last summer and regularly quoted it. It is important that that has now been heard. It is also important to recognise that, while the announcement that has been speculated about today is a step in that direction, one of the other pieces of advice that the confed gave to the Government ahead of the Autumn Statement—and we were disappointed that it was not reflected in the Autumn Statement—is that the new money proposed from the improved better care fund later in this Parliament should have been part of a package to carry through what Simon described as targeted assistance to social care. It is nonsense to talk about NHS funding and social care funding as though they are separate issues. They are one and the same issue and need to be seen as such.

Q256 **Chair:** In terms of that general debate, do you think there is still an imbalance in expectation, thoughts and planning between expenditure for health and for social care?

***Stephen Dorrell*:** As I have said, it is a mistake to see the two as separate issues. They are clearly separate budgets in the way that our national accounts are drawn up, but in terms of the impact on services delivered in a locality, the tendency in recent years has been to protect or to prioritise NHS funding at the expense of funding for other local services, and it should hardly be a surprise to find that if you do that the demand for NHS services grows. The NHS is used to meet demand that is more properly met elsewhere in the network of public services: in social care, in social housing and in the other public services in a place. That is why it is important that the linkages between funding for local public services generally and social care in particular are seen as integral to the funding of the National Health Service.

Q257 **Rushanara Ali:** Mr Dorrell, would you say that the Government have then been short-sighted in the way that they have implemented these funding formulae over the last few years? Is that a trend that you have seen over successive Governments, or is there a particular departure over the last few years?

***Stephen Dorrell*:** It has been a very long-term characteristic of British politics that it is easier to justify tax increases or spending commitments when linked to the National Health Service than to other services. That is

why I stress every time I talk about this issue that it is incoherent to talk about the NHS separated from the full range of local public services. The image that I quite often use is that the NHS cannot be a city on the hill. It has to come down from the hill and be part of the range of public services delivered in a place.

Q258 **David Mackintosh:** We know that there have been reduced social care budgets and I just wonder how this is affecting the NHS.

***Simon Stevens*:** The most obvious measure of stress in the system is the number of older people who are stuck in hospital when they, their families and their nurses and doctors know it would be better for them to be looked after back at home or, indeed, in an appropriately high-quality care home. The number of formally measured delayed days for which people find themselves languishing in hospital has doubled over the last three years from about 110,000 days a month of delayed care to over 200,000. That is the equivalent of having about 6,500 of our 101,000 hospital beds out of action.

That is not just a problem for the people who are in those hospital beds; it also has a knock-on effect on the ability of people, when they come into A and E departments and need emergency hospital admission, to be treated quickly. Part of the reason why hospitals are struggling with the A and E four-hour goal is the difficulty of finding hospital beds for patients who then need to be admitted.

The system is gumming up, and there is a phrase to describe this, "Amdahl's law", which was first developed for computing. It says that, over time, the bit of a system that is working least well will come to determine the performance of the overall system. To give a non-health example, that is one of the reasons why, if you go on a plane ride for less than 2,000 miles, it will take you longer to get to the airport, get checked in and get your bags back at the other end than it will to actually do the flight. Flying has got better, but airports and congestion have not. Similarly, what we are seeing in the NHS is that, as the delays on the home care, the care homes and the social care piece expand, that is having an impact on the ability of hospitals to do their job.

***Stephen Dorrell*:** Can I reinforce that? It is not only a question of delayed discharges. It is also the people who present at the front door of the hospital, as a result of failure to deliver proper home care services in particular. Home care services and support within care homes have been particularly hard hit by the issue we are talking about: social care funding and social care planning. It is about having care plans that support people before they need hospital services, as well as the ability to discharge them.

Q259 **David Mackintosh:** How significant a pressure on the NHS is the cost of delayed discharge or delayed transfers of care and non-elective admissions?

***Simon Stevens*:** The National Audit Office did a piece of work looking specifically at delayed transfers of care and put a gross price tag of

£820 million on the so-called DTOCs, but that is probably an underestimate, given that there are many other people who are not counted formally into that definition. There are some moving parts around how much of that is different bits of the health service not connecting properly versus the interactions with social care.

When you get under the skin of it, it is pretty clear that, although perhaps only 40% of the delayed discharges are formally recorded in the stats as being a hospital trying to get social care for its patients, the majority of the delays are attributable to that, because the elements that are recorded as being NHS-related delays are often continuing healthcare, which in turn is about getting home care or transfer to care homes. We are clear that it is in the zone of £500 million to £1 billion simply for the blocked beds. There are many other knock-on consequences for individuals in other parts of the health service as well.

Q260 **David Mackintosh:** Besides just money, what else could be done to address that?

***Simon Stevens*:** There are a number of things in terms of shared assessments of the needs that a person has, making sure that you have so-called "trusted assessor" models, so that a nurse or a physio is doing that, not just for the community health services but for all the local authorities, and they agree to share the assessment that is undertaken.

It makes a big difference if you do the assessment of somebody's ongoing needs when they are actually back at home or getting some form of rehabilitative support than if you make that self-same assessment when they are on a hospital medical ward. You can see more easily what support people need in order to get the degree of independence back.

Changes are also needed to the speed at which the services respond for these assessments, including Saturdays, Sundays and public holidays. There are processes that can be got right, and some parts of the country, having got those processes joined up, have seen significant improvements, despite the funding pressures that we have described.

However, just to give you a couple of data points, two thirds of hospital in-patient beds are used by people over 65 years old—if you go round a typical hospital ward, of course it is older patients—of whom more than one quarter have dementia. For every hospital bed, there are more than four care home beds. The interdependency between care homes and hospitals, and the extent to which what hospitals are doing is looking after older people, is laid bare by those facts.

Q261 **Mary Robinson:** Looking at that interdependency between care and hospitals, when it comes down to delayed transfers and non-elective admissions, is it mainly down to the NHS, down to social care or both? Where does it lie?

***Simon Stevens*:** There are processes that the NHS can improve on, particularly the relationship between what the hospitals and the community health services are doing. However, if you look at the

numbers, the majority of delayed discharges are linked to the availability of social care services.

***Stephen Dorrell*:** If I can re-emphasise the point I made a moment ago, it is about discharges, but it is also about supporting people so that they do not need to present to hospital in the first place. The reduction in the number of home care packages available through local authorities' social care departments I believe to be a significant root cause of the rising demand trend, both of hospital admissions and of people presenting in GP surgeries.

We discuss this too often, in my view, as an economic issue. Your question is quite rightly about how we would save and how many pounds are involved. We need to remember this is about people's lives. The whole purpose of social care and the National Health Service is to enable people to lead lives that are as normal, fulfilling and enjoyable as possible, given their circumstances. When we do not provide the support that fulfils that and allows that to happen, we are failing them as citizens as well as wasting their money.

Q262 **Mary Robinson:** You mentioned the increasing demand, of course, and we recognise that there is that increasing demand there. The other side is the supply. How is the increase in closures of care homes and other care providers failing to support the NHS in this?

***Stephen Dorrell*:** First of all, there is clear evidence of declining capacity, particularly in home care. I emphasise that to the Committee. In terms of social care, there is a tendency to think about residential care, but supporting people in their own home and providing packages that are more than 15-minute slots is an important element of the deterioration of the quality of social care. There is also evidence of reduced bed-space capacity in residential care.

It is the CQC that said earlier this autumn that it is both a question of capacity and a question of quality. Its "State of Care" report described a developing tipping point in social care. There is a great tendency for people to talk about an impending crisis. We have all been asked the question by journalists: "Is this a crisis". Actually, what happens when there are spending pressures, in particular on social care, is a gradual deterioration. We should take particular note of the CQC's report, which reported across the range of social care services an approaching tipping point.

Q263 **Mary Robinson:** Of course we have the holy grail, which is that people do not need to be in hospital or care homes. In terms of perhaps the pressures that would be put on adult social care, is the NHS doing enough or can it do more to improve the health of people, particularly those with dementia, so that they are not needing to access that care as quickly?

***Simon Stevens*:** Your point on dementia is of course a really significant one, because we now know that many dementias are in fact preventable. There are no effective cures for dementia, despite enormous amounts of

money being spent worldwide, particularly in the life sciences industry. Over the last 10 years, 99.6% of clinical trials for new dementia cures have failed. However, at the preventive end of the spectrum, the good news is that, if we make the same lifestyle changes that are good for our hearts, it turns out they are good for our heads We have seen a reduction in the incidence of dementia for men by 41% since 1990.

That means that, instead of having 250,000 of new cases of dementia a year, we have 210,000. That is 40,000 people a year not getting dementia a year as a result of improvements in their blood pressure, the extent to which they are exercising, eating right, drinking sensibly and not smoking. Those broader preventive improvements in population health, which have also produced a 42% reduction in your likelihood of having a heart attack or stroke before you are 75, turn out to be good for dementia as well.

Q264 **Mary Robinson:** This is not the whole answer; I know that. However, is there more to be done on this? People would be quite relieved if they thought the focus was going to be on keeping people healthier, out of hospital and out of care homes.

***Simon Stevens*:** That is obviously a huge part of what we have to do across the board. As I have just said, we have really positive trends on what is called cardiovascular health, and that in part is linked to big improvements in smoking rates. Even in the last five years, we have seen a reduction in the number of adults smoking from 8 million to 7 million. That 1 million smoker reduction is huge in terms of the benefits we are going to see playing out over the next five and 10 years. We need to carry on that trend. We want to get it down to 13% or thereabouts, from 17.5%. That is going to help us with the cancer improvements we want to see, as well as dementia and heart disease.

The countervailing risk is around obesity, and there are also pressures in the local authority-funded preventive health services. Although I know we are talking about adult social care today, since we are talking about prevention, we must pay attention to the fact that we do not want a reduction in smoking cessation services, alcohol and drug treatment services and sexual health services, because they quite quickly show up, then, as extra avoidable illness and demand into the National Health Service.

Q265 **Mary Robinson:** Have any projections been made on this?

***Stephen Dorrell*:** I just wanted to re-emphasise the point that has been made to me by many health service leaders over the last few months. For all kinds of reasons that we will come on to talk about, there is a developing relationship, and should be a developing relationship, between the NHS and local authorities in particular areas. However, the trust element within the health service is undermined when local authorities are not being seen to make an investment as a partner in the prevention public health services.

To the point that Simon was just making about the trends and the effect of the trends in cardiovascular disease, making those linkages, drawing them out to local communities and understanding which interventions are effective and which ones are not is as much an issue for local authorities as it is for the National Health Service. It is an area where the developing understanding between the NHS and local authorities is very important. However, it requires changed behaviours on both sides.

Melanie Onn: I have a couple of supplementaries. I have to jump in on the point you just made about the frustration on the part of the NHS that councils and local authorities are not seen to be playing their part by putting funding in the right place. My local authority has had a cut of about 70% of its budget. It has not had protection for the budget. It has just wrestled back some public health funding to support drug and alcohol services that have been reduced by 40%. My local authority area has one of the highest rates of drink-related illness and drug-related illness in the country, which is nothing to be proud of.

What you said exemplifies some of the struggles at a local level. I know we will move on to the STPs later, but there is a polarisation of position. There is protectionism going on within the organisations, and a lack of trust that either health or local authorities fully understand all the needs of all the communities. That is a big challenge. I would be interested to hear your views on that.

Mr Stevens mentioned the issue of assessors earlier. I wonder if there are particular issues with the availability of appropriate assessors prior to discharge, and whether there are sufficient numbers to ensure that discharge can be undertaken in a speedy way that does not cause unnecessary delays. Also, to the point you made, Mr Dorrell, about a reduction in home care packages or home care—I wonder whether a reduction in district nursing perhaps comes into that as well—are there any measurements that compare the impact of those cuts to that side of social care with delayed discharge? Can you easily say, "This percentage is due to delayed discharge and this percentage is due to reductions in home care availabilities"?

***Stephen Dorrell*:** I certainly do not have figures that allow me to draw out how much of it is coming out of home care or the relative impact of different forms of service reduction. It is an area that would merit additional work. There are no figures I can quote to you that are retained in my head. Can I come back to your earlier question? I want to emphasise that, when I said what I did—which I feel very strongly about—namely that the local authorities and National Health Service in each locality need to develop a different relationship with each other in order to address both prevention and early intervention, as well as the discharge points that Simon was making earlier, I was not seeking to suggest that any of this was easy. I absolutely understand that it is not easy.

Simon and I were talking earlier in the week about how there have been statements to the press in different localities, from both the health

service and from local authorities, that could be interpreted as old behaviours reasserting themselves. It is important, going forward into the new year, that those behaviours are discouraged and that we emphasise the importance of, as I was saying earlier, those responsible for the full range of local services, certainly including social care but including housing, public health services and other local services.

The example I quite often quote is library services. It is not immediately obvious that a library is connected to health, but if you remove or reduce library services, it has the effect of reducing places where people can meet. It increases the dangers of isolation, which leads into the kind of issues that we were talking about earlier. Public services are joined up and, when they fail, the result too often is increased and avoidable demand on the National Health Service.

Q266 **Chair:** Simon Stevens, you talked about the problems of delayed discharge. No. 10's lobby briefing yesterday said that a lot of the problem is down to local authorities not managing their resources very well. Some local authorities are better at this than others, of course. There is a range of performers. However, is it your understanding and your view that, even if the worst local authorities up their game and perform as well as the best, there will still be a need for extra resources in social care?

***Simon Stevens*:** Yes. Both things are true. It is right to say that, for any given level of resource, there is a spread of performance in the pressure of delayed discharge and joint working across the country. Come what may, we should do something about that. Even having sorted that out, if we have a widening gap between the availability of social care and the rising number of frail old people, that is going to show up as extra pressure on them, their families, carers and of course the NHS.

Let's just remember that we have another 1 million people turning 75 by the end of this Parliament compared with the beginning of it. We are not in a steady-state situation, which is a really good thing, by the way. That is a consequence of the fact that life expectancy in this country is going up by five hours a day. If nothing else, in the hour or so we will have spent together today, you will each have gained 12.5 minutes of life. That is the gift of the National Health Service to this Committee.

Chair: Thank you. You can come again.

***Stephen Dorrell*:** Many years ago, as Health Secretary, I used to say that you live two years longer under the Tories, which was then true, but you now live longer still as a result of Governments that have come since.

Q267 **Chair:** We will think about that one as well. Stephen, you avoided the word "crisis" and you talked about tipping points. Is it your view that, if money is not put into the system very soon, we will tip over into a crisis?

***Stephen Dorrell*:** I was seeking to emphasise that I do not believe there is a day when this will tip off the edge of a cliff in social care. It is

important to understand the reason for that. It has been relatively easy to see a deterioration in the quality and range of services, and the differences are felt by individuals and their families but do not lead to a spectacular crisis. That is part of the problem of winning this argument in the public space. If you take the range and quality of services delivered three years ago and the range and quality of services delivered today, there is a significant deterioration. The people who bear the brunt of that are the people and their families who suffer that deterioration.

Q268 **Helen Hayes:** Integration now seems to be received wisdom. There is a broad consensus that the integration of health and social care is where we need to be heading. It certainly was not several years ago. Can integration alone solve the funding pressures on the NHS and social care? Can you comment on the key dimensions of integration that would need to be delivered? There is a whole spectrum of views about what integration means. The most tricky bit, it seems to me, is the question of integrating budgets, who has responsibility for spending decisions and how that follows through, where there is perhaps not as much consensus as there is on the broader question of integration in principle.

***Simon Stevens*:** In answer to your first question—will integration alone, however defined, sort out the funding pressures—the answer, of course, is no. I have said for a while now that simply putting together two leaky buckets does not produce a watertight funding solution for health and care. No, it will not, but that does not mean that we should not be doing it. Then, having got past the headlines, you have to define the terms. What do we actually mean by this and who should be the decision-makers about the basis on which it happens?

In my view at least, given the different funding streams that support adult social care, of which there are at least five—central Government grant, local authorities' own funds, personal contributions that people have to make, elements that come from the National Health Service, transfers from the benefits system—the notion that you could glob it together with £107 billion of the NHS England national budget and think that you would get something that is workable is not a viable proposition.

In my opinion, the right place to make decisions about where and how budget pooling should occur is locally, and those decisions are most likely to be made responsibly if they are decisions between consenting adults in different parts of the country. That is what we have begun to see with the better care fund, which has not been by any means a perfect programme but nevertheless, compared with a minimum requirement that £3.8 billion worth of budgets would be pooled, people have chosen to pool £5.9 billion. That tells you that, with good will and mutual support, people will make those kinds of judgments.

Some parts of the country have gone a lot further, and one would be nervous about mandating that that would occur if there is no security about what the floor level of contribution will be for adult social care. Otherwise, the risk is that resources that Parliament has voted for the

National Health Service end up being used for other pressures, outwith the vote that was intended for the NHS.

***Stephen Dorrell*:** I wanted to develop that argument and to make a point about the role of local government in this process to this Committee. It is a rather historical point but an important one. We have had lots of party-political debate for over a quarter of a century on purchaser-provider, commissioner-provider and all that within the health service. I was there on the day that the original purchaser-provider split was introduced in 1990. One of the arguments I had then with Ken Clarke was about the removal of local government from the commissioner process.

I was always personally in favour of removing local government representatives from the provider side of the NHS as it developed in those days. I was opposed then and am even more strongly opposed now to the idea that we should make decisions about the shape of local health services divorced from the decisions made by local government for the rest of public services. It was a mistake when purchaser-provider was originally introduced to remove local government from that purchaser, commissioner, planner—or whatever word you want to use—process.

To answer your question, "What does integration mean?", it certainly does not just mean this, but reintroducing local accountability and local political engagement into decisions about the shape of public services and the use of money across budgets seems to be an important part of the answer to your question.

Q269 **Helen Hayes:** At the moment, we have local authorities facing a continual series of Hobson's choices about services that should not be having to compete with each other. However, exactly as you describe, libraries are competing with public health and adult social care is competing with children's services. There is not enough money to go round and cuts are taking place across the country. The NHS is facing a similar set of pressures to its budget.

What is the mechanism that creates the environment in which people work together to decide on the most sensible, cost-effective way to spend the money for individual patients, which delivers the best outcomes for them and the most efficient use of public services? At the moment, professionals across the NHS and social care are, for rational and proper reasons, seeking to hang on to the money that they have because they can see it shrinking before their eyes.

***Simon Stevens*:** We have examples of local authorities and local parts of the NHS that have begun doing that and are doing it well. If you think about, say, Plymouth, the social care and community health staff have been combined into a single provider organisation. If you think about Sheffield, it has gone much further on budget pooling than any of the minimums that were required. If you think about what is happening

across Greater Manchester, with the "Devo Manc" proposition that the NHS is playing a very active role in, we are seeing progress there.

In specific places like Salford and Tameside, the local authority is transferring social care staff to the employment of the hospital, and I have agreed the appointment of a local authority chief exec as the accountable officer of the CCG. You have different models arising in different parts of the country.

My strong belief is that, if we were to try to mandate a single model in every part of the country, we would definitely get it wrong. This gives you lowest common denominator solutions and means you are unable to take account of where the talent and leadership sit in different communities. In some cases, the local hospital is very strong and the local authority leadership is MIA, and vice versa in other parts of the country. That is the real-world reality, however much we might prefer it was not.

Helen Hayes: It might be called a top-down reorganisation.

***Simon Stevens*:** That is another thing I would be opposed to. That is a secondary reason for adopting that stance.

***Stephen Dorrell*:** I would specifically endorse what Simon has just said. I wholeheartedly agree with it.

Q270 **Melanie Onn:** On the process of drawing up STPs, do you think that the way it has been done to produce the plans that we have seen has properly taken account of the needs in terms of adult social care and involved the views of local authorities sufficiently up to this point?

***Simon Stevens*:** What are STPs? STPs are an answer to the fact that, as is clearly illustrated by the conversation that we have been having for the last half an hour, you cannot expect individual councils, hospitals, mental health services, GP practices or patient groups to sort out their own issues without having a conversation with their partners. STPs, if nothing else, are a structured way of driving those kinds of shared conversations and taking a view that extends beyond the cut and thrust of this year, next year and the year after. That is stage one, which is STPs as a space where proposals can be debated.

We now want to intensify the engagement, particularly with communities, with staff across the health service and, indeed, with local councils, and turn those proposals into concrete plans. Come the spring, those plans need to have a governing partnership, involving councils and all parts of the NHS, to actually put them into action. What we are doing, in effect, is a workaround to a pretty fragmented set of accountabilities that exist throughout the system, avoiding a top-down administrative reorganisation and making the best of the circumstances we have in terms of shared purpose and a common agenda locally.

Is that working perfectly everywhere? Is there a magic wand that could have been waved sixth months ago and all would be tickety-boo? Of

course not. That is just not the real world. People are making good faith efforts to advance, and in most places that is what is actually happening.

Q271 **Melanie Onn:** You think it is already happening.

***Simon Stevens*:** Happening—present continuous.

***Stephen Dorrell*:** I have some personal experience of this because I was, for the initial convening period, the independent chair of the STP process in Birmingham and Solihull. Like all the other 43 STPs, there was good and bad in what we were doing. One of the good things we did was that, having prepared the original plan, we concluded that accountability, which is an important theme this afternoon, required that the STPs should have as its chair not somebody from outside but the leader of Solihull Borough Council, one of the two local authorities actively involved in the process.

The development of that STP to something that could be carried out and change the way services are delivered, in particular outside hospital, is a challenge on which work is very much in process. I am clear that the STP process is a route map towards the kind of world we have been describing. Has it been a perfect process in Birmingham and Solihull or anywhere else? The answer is no.

Q272 **Rushanara Ali:** I will have to ask some speedy questions, so I am just going to chuck them at you quickly. Mr Stevens, you said that the better care fund has attracted more than expected: £5.9 billion. How effective do you feel it has been in supporting integration, if you want to add any points to that? Is it being used to meet the shortfall in adult social care services? Should the funding be brought forward?

I have two additional questions, which are about disability-free ageing and the gender divide as well as the region divide. What contingency planning and preparation is being made in terms of social care looking to the future? What assessments have you made about the EU migration issue and care providers? What implications will the decisions that we take over the coming years about migration have for the supply of labour in the NHS, as well as in social care?

***Simon Stevens*:** Five quick questions, five quick answers: has the better care fund been effective? It certainly has stabilised what would otherwise have been greater pressures in adult social care—no doubt about it. If you look at the measures of integration that we set out—some of the process things that people had to get right, seven-day availability of discharge services, shared use of the NHS number and various things to lock together the way care has been delivered—we have seen some pretty substantial improvements during the life of the better care fund.

However, I do not think the better care fund per se is the be-all and end-all. It was a pragmatic response to a particular set of challenges. By itself, it does not negate the need for a more profound rethinking of the way in which adult social care is financed and delivered in this country. I would be happy, if you want to ask a sixth question in a moment, to

speculate a little on where that should be. That is the first answer. The second question was—

***Stephen Dorrell*:** Is it funding existing services?

***Simon Stevens*:** It has certainly been funding existing social care services. It has not been creating new ones. It has been offsetting what would otherwise have been a greater reduction in social care. We have seen 400,000 or 500,000 fewer people getting publicly funded social care in the course of the last Parliament.

Q273 **Rushanara Ali:** Should it be brought forward?

***Simon Stevens*:** We need additional funding in adult social care. That is a potential mechanism for doing it. You ask about disability-free ageing and the gender and regional gap. One important point is that the male to female life expectancy gap is narrowing, which is going to help with that.

To your last question on EU free movement, we have 135,000 health and social care staff from the rest of the EU. I have said that it would be very important that we provide good reassurances about their continuing role in the country.

Sitting suspended for a Division in the House.

On resuming—

Q274 **Rushanara Ali:** I did not catch the answer on disability-related ageing, the gender gap, the regional divide and what preparation the NHS is making. What should we be doing more generally about that? How concerned are you?

***Simon Stevens*:** On the gender gap, the life expectancy difference between men and women is of course one of the great health inequalities of our time. Fortunately that has narrowed; it is now one third less than what it was in 1981 and is likely to continue to narrow. That is a positive. It is not because women are getting less healthy; it is because men are catching up. In terms of disability-related pressures, obviously part of what has to happen with the social care services is making sure that we have home care adaptations and so on, being very practical about it, to enable people to live in their home as long as possible, rather than finding themselves confronted with the choice of having to go into a care home, if that is not what they want or need. Was there a particular point you were getting at, Rushanara?

Q275 **Rushanara Ali:** It was just in terms of the disparities. We have disparities between regions as it is on other indicators. This is yet another one. We talked earlier about local government finance cuts and all the things that you have heard from colleagues about the effects. How concerned are you about that and how much does that exacerbate the health inequalities looking forward? You take a very strategic, long-term view. I just wonder whether you are doing that with this and whether you are concerned. Is it something we should not be so

concerned about because it will work itself out?

***Simon Stevens*:** There are different layers to this. There is the whole debate about what is called the "compression of morbidity". In other words, as we get older, are we enjoying our extra years of life as healthy years of life or is the period of time with various illnesses just stretching? A number of things can be done about that. One thing we have to get right is what I would call "mutual aid" between the local NHS and the local social care services. We know that, with effective rehabilitation services and home care, you can reduce the proportion of people who need to go into a care home. Obviously, for those that are publicly funded, that is a big pressure point for councils. There is quite a big variation around the country in the likelihood that the same person with the same need will find themselves having to go into a care home, as against being able to be looked after and supported at home.

The flipside or reciprocal of that is that we know, if you get better support for people in care homes, you can substantially reduce their risk of being admitted to hospital as an emergency. In places like Sutton, Airedale and Gateshead, we have been funding what we call care home vanguards to expand the GP support, the pharmacy support, the senior nurse and practitioner support in care homes. That is having big benefits in terms of hospitalisation rates. In a sense, what you are getting at is a specific instance of a more general theme, which is that there are these interface services, which, if we get them right, will both reduce pressure on the NHS and reduce pressure on social care.

***Stephen Dorrell*:** Can I offer a suggestion? The Committee may think that there is a developing role for local government here. The consequence of public health becoming the responsibility of local government is that they are also responsible for measuring some of these health variations and inequalities. It becomes part of the responsibility of local authorities to compare the life experience of people in their area with the life experience of people in similar areas elsewhere in the country and even, I would argue, outside this country, from places with a similar demographic.

The questions you are asking ought to be the normal business for a local authority: to ask itself whether the range of services it is directly responsible for and responsible for engaging with, in the form of the National Health Service, are delivering outcomes to its citizens that compare favourably or unfavourably with equivalent localities. There will be some metrics that are favourable and others that are unfavourable.

Q276 **Rushanara Ali:** Do you feel that the Government should report to Parliament on that at a national level?

***Stephen Dorrell*:** I have had the conversation with Public Health England because that it is something that Public Health England should be encouraging public health as a discipline to do. It certainly should come from the centre. However, it is something where, if there is a bottom-up demand for it and it is coming both ways, it is more likely to happen.

Can I also comment on the EU migration issue? Simon made the point about the existing employees in particular working in the National Health Service. There are two further points I would like to underline to the Committee. First, in the social care workforce, there are all the issues that are often commented on regarding the NHS, about the extent to which it relies on staff from outside the UK, both within the EU and beyond the EU. That is true in spades in social care. In particular in the south of the country, the stability of continued provision of social care services is to a significant extent dependent not just on the existing migrant, non-UK workforce but on future access to that workforce looking beyond the point of Brexit.

That is to look at it from the point of numbers. It is also important to emphasise the cultural question that, in my view, the NHS has always been enriched by the fact that it has welcomed as members of staff people from overseas, and that NHS employees have gone to work overseas. While we would certainly want to ensure that we have proper commitment to training and career paths for people who want to work in health and care in the UK, if that is developed into wanting self-sufficiency and closed frontiers, that would be the same thing as professional isolation, which is something that would undermine the quality of care delivered to UK citizens.

Q277 **Rushanara Ali:** I have one question related to this. What are your migration projections or labour force projections for social care, looking ahead with the ageing population?

***Stephen Dorrell*:** The labour force requirement is a function of rising demand in productivity. You can look for ways of delivering services more productively, and such opportunities exist through technology and other things, but we have to ensure that we can staff those services. We know as a matter of fact that the only way we can staff them at the moment is by relying to a significant extent on people coming from overseas.

***Simon Stevens*:** I would just add that we have some opportunities to improve the lot of people working in social care. One of the ways we are going to do that is through the increase in the national minimum wage, which will in turn put pressure on the cost structures of social care; nevertheless, there is clearly a strong logic for doing that. We have about 1 million care assistants working across health and social care, and about half a million registered nurses. One of the things we are committed to doing is creating more ladders of opportunity for people from care assistant jobs into the new nursing associate role, and then from the nursing associate role into being a registered nurse.

That ability, on an apprenticeship basis, so you can still be working and earning and nevertheless building your career, is one of the ways in which we can make the care assistant role important, not only week in, week out, but as a career path that leads to advancement. We have a paradox in this country. Because of the way that we have capped nurse training places, which is linked to the lumpiness of the public funding for

our training slots, we turn away thousands of people each year who would like to train to be nurses at just the same time as we are desperately trying to increase the number of nurses we are able to employ. Changing the nurse training arrangements, introducing the apprenticeship model and the new nursing associate grade are going to benefit not only the NHS but the care sector as well.

Q278 **Rushanara Ali:** Does that mitigate the need for migration, whether from within the EU or beyond, going forward?

***Simon Stevens*:** Are you talking about the NHS now or social care?

Rushanara Ali: Both.

***Simon Stevens*:** Between one third and 40% of doctors in the NHS have trained internationally. That said, as far as doctors are concerned, we have an advantage relative to the average of the OECD in that fewer of our doctors are in the 55-plus retirement age than is the case in many other countries. We need to expand the number of doctors we are training here, given the circumstances you describe. That is why the long-term gain that we will get from another 1,500 medical school places, which are going to be introduced from the year after next, 2018, is important. Just for comparison, we have about 6,000 places in England at the moment, and another 1,500 on top of that is a 25% expansion. That is a long-term gain; it will be a decade or more. However, it is absolutely a step in the right direction towards improving our ability to be more self-sufficient.

There are some things that are very short-term. The demand for and the employment of care assistants operates on a much shorter cycle than does predicting how many cardiologists or GPs we will need in 12 or 15 years' time.

Q279 **Chair:** Can I come back to the sixth question, then, that you alluded to? I think, Simon, you were at the Lords Committee the other day.

***Simon Stevens*:** Yesterday.

Chair: Yesterday. It was about the longer-term funding possibilities for social care. By chance, some Committee members were in Berlin talking to our German colleagues about their system. I appreciate they have a different overall system in terms of an insurance model, which has gone way back, for employment, pensions and the health service there. They were really putting another leg into an existing system. You were talking the other day about bringing an insurance element into the funding of social care. Could we simply introduce that into our system in the UK, without disrupting the funding of all the related services at the same time?

***Simon Stevens*:** Could I unpack that a bit? In terms of the German system, I think they introduced their long-term care insurance in 1995 but it has antecedents that go back to 1883, when Bismarck became the first politician in Europe to think that having politicians involved in the financing of health services would be good for people and good for

politics. They have been at their particular funding mechanism for a long time. As it happens, when you look at what people in Germany say about care co-ordination differences, gaps and hand-offs between different bits of the system, and what people in this country say, there is not an enormous difference.

The piece of evidence that I cite to substantiate that claim is the annual survey done by the Commonwealth Fund of what people in 11 countries think about care. It has just last month published its 2016 survey, which included asking people in Germany and people in Britain whether they had had problems with care co-ordination. You can probably see that Germany and the UK were the two best performing of the 11 industrialised countries that they asked. 19% of people in each country said they had a care co-ordination problem, which is rather better than the Netherlands, Canada, Switzerland, France, Sweden, Norway or the US. Similarly, when you ask the same question on hospital discharge planning, it suggests that we are at the better end of the range.

That is not satisfactory. It is not good enough that one in five or one in four people have had a problem. The first part of the answer is to say that the German model is obviously built out of their long-standing financing arrangements, and the financing mechanism by itself does not appear, from the point of view of the individual, to have produced something that is dramatically better than what we have, although it is better than many other countries in Europe.

Be that as it may, what should our approach be, looking out over the next five years or so? In my opinion we have to take three steps on three different timelines. First of all, in the here and now, we have to deal with the widening social care funding pressures in 2017, 2018, 2019 and beyond. There is a set of tactical things that can be done, of which the suggested changes that are being discussed today are a part, but not necessarily the final word.

Secondly, we have to advance over the next three or four years on the health and social care integration agenda that we were discussing, through different ways in different parts of the country. That by itself, for reasons I said, I do not believe answers the strategic question about the future of social care.

Thirdly, it seems to me that we need a big set of changes and a new national consensus on a new deal for retirement security for people in this country. In my opinion, you cannot answer the social care funding system question just by looking at the relationship with the NHS. You have to look at the full range of services and needs that people have in retirement. The reason that we should move from thinking about a triple lock for pensions to, instead, a triple guarantee on retirement security, which would include income but also being able to stay in your own home where that makes sense and getting the care you need, including social care, is that it represents an expansion in the offer to retirees. It is not about taking things away.

It is important that this debate is understood as a benefit for people of retirement age, not simply a debate about intergenerational fairness. What I mean by that is that there is no point in saying to our parents, "Yes, you have a free bus pass", if they are not able to leave the house because they do not have the availability of home help. There is no point in saying we are putting all the available increases into triple lock pensions, including for much better off pensioners, if it then means you have 14% or 15% of pensioners still living in poverty and not able to get the social care they need. We have to have a single conversation about the new social contract for older people, and we have to make it easier for older people themselves to take back control in terms of how those funds are used for their own services, rather than partitioning them up in ways that other people have decided.

***Stephen Dorrell*:** I agree with the first two stages of what Simon said, and I particularly strongly agree with the third stage. It is not the same as the commission on the future funding of health and care services that Norman Lamb, Alan Milburn and I have been talking about all year, but it is in the same territory. We were referring earlier to the extent to which the growth of demand on NHS services comes from the elderly population. It is addressing a very similar set of issues.

The creation of a space where this is an opportunity, on an explicitly political, cross-party basis, for the kind of dialogue that Simon has described seems to me to be an urgent national requirement. It is important to emphasise that it does not take these questions "out of politics". We have all heard people say, "This is above politics". It is creating a framework for a debate where the political debate can focus on real choices rather than slogans and substitutes for choices.

Q280 **Chair:** One of the striking things in Germany was that there was cross-party agreement. They had had the agreement in 1995 and, indeed, they are now building on it with a cross-party agreement. Coming back to the point you made, Simon, we do not have the German model, so you cannot recreate it necessarily, but you mentioned the word "insurance" in your comments to the Lords. Given we have to get some extra money into the system somehow, are you seeing some sort of social insurance contribution as being an element in trying to reform or remodel the offer for older people?

***Simon Stevens*:** If you think about today's 30 year-olds, 40 year-olds and 50 year-olds, the first question is: what are the mechanisms that we need in order to save for our old age, individually and collectively as generational cohorts? A social insurance mechanism is one way of hypothecating and making transparent to people that that is what you are doing. However, the point I made yesterday in the House of Lords Committee was that, based on the international experience, if you do that as a voluntary private insurance mechanism, it is prone to market failure. If you are going to try to use some form of supplementary risk pooling over and above general taxation, that needs to be on a social insurance or a mandatory basis.

The most recent country to fail on the voluntary front was President Obama's United States. Obamacare had an add-on, which had been advocated for by the late Senator Ted Kennedy, where you could voluntarily opt in to a long-term care insurance piece. Of course, it became immediately obvious that that was going to actuarially fail, because the people who opted in were the people who needed the services and therefore you did not have a risk pool. The insurance point was that it has to be a collective endeavour if it is going to be insurance. That means it cannot just be left to the workings of voluntary insurance in the way that life insurance or, to some extent, supplementary pensions work. That is people looking out over 10, 20 or 30 years, building up savings in the same way as you might with pensions or the idea of care ISAs that have been advanced. For the here and now, that is no use because we do not have 20 or 30 years to build up a pre-funded system. Then the question is: how much of the extra that is needed should come from everybody and how much should come from redistribution between funding streams that are going to be supporting older people over the next five or 10 years?

That is where I get to the triple guarantee notion, in that you have attendance allowance, pension flows, housing wealth and other sources of spending that probably need to be considered in the round. Otherwise, as the OBR has pointed out, the opportunity cost will be further pressure on services and transfers for poor, working-age adults and for children. Because of the success of reducing pensioner poverty over the last 25 years, we now have a situation where twice the proportion of children are living in poverty in this country compared with older people, and we cannot exacerbate that situation.

***Stephen Dorrell*:** Can I make another contextual point? We are addressing the question of future funding of the third age, to use a slogan phrase, and the role of health and care services in that. Simon is seeking to describe a process that recognises that these are growing services, demand for these services will continue to grow and the population we serve expects that demand to be facilitated. If we continue to live in a world where this is constrained by the willingness of central Government to raise central taxation as the only source that facilitates that growth, we are denying ourselves the opportunity to deliver decent-quality care, support and life experience to people later in life. It is about facilitating growth of these services.

There is a tendency for people to look at the growth in expenditure on health and care services and say this is a growing national burden that cannot be afforded. Actually, no, it reflects the growing demand of all of us as citizens and our families for these services to be delivered in ways that meet our aspirations. If we put in place a set of political choices that artificially restrain our capacity to pay for those services and, therefore, presumably to pay for other services, we do ourselves no favours at all. It is Maslow's famous hierarchy of need. As we get richer, we should expect that a rising share of our rising income is spent on these services.

Q281 **Melanie Onn:** Do you think that there might already be enough money in the system, if we were to look hard enough? For example, I understand that there is around £242 million in unallocated business rates. Were that put into social care, would it significantly ease the burden currently faced by local authorities?

***Simon Stevens*:** I cannot comment on the business rates proposition specifically. However, it is worth recalling that the LGA, I think, has sized the current gap at around £1.3 billion. The Nuffield Trust, the Health Foundation and the King's Fund have sized the current gap at around £1.9 billion. Those are the orders of magnitude we are talking about.

***Stephen Dorrell*:** Your question, "Could we meet all the demand with the existing resource?", refers back to an earlier question from you. There will always be choices to be made. There will never be enough money in this or any other aspect of our lives for us not to make choices. However, if our choice is to deliver improving experience at the end of life and support for people to enjoy their lives and to deliver, in other words, the aspirations we are good at expressing in the political world, that requires a buoyant access to resources. On the one hand, we talk about improving quality of service. On the other, if you look at the future projections of spending on health and care services in the Government's spending plans, they project a declining share of national income on these services. Those two projections are at variance with each other.

Q282 **Rushanara Ali:** The Work and Pensions Committee suggested that the triple lock should be removed. Should the resources be redirected towards elder care, and would that go far enough? It is very difficult for any party to make the argument to remove it post-2020, but if the focus is on a model that could be really beneficial for older people and those who are caring for them, where there is a massive cost to the economy, is that an argument that could be built on? Is that essentially what you are saying?

***Simon Stevens*:** My point is that it should not be about taking things away from people. This should be about expanding the offer, giving older people more control and allowing them to take back control over the different funding pipes that at the moment are partitioned. We have a particular policy preference through the triple lock, which goes in one direction, at the same time as we are seeing this massive pressure rising in social care, which is leaving people trapped in their own homes and stuck in hospitals. That is a partitioning that, from the point of view of most older people, makes no sense. This is obviously a matter for Government, Parliament and national debate. My personal view is that it should be succeeded by this triple guarantee on income, yes, but also on housing security and access to care.

***Stephen Dorrell*:** What Simon is describing is a development or improvement of the triple lock.

Chair: That is a politician's answer.

***Simon Stevens*:** There is an important chart in the Work and Pensions Committee paper, which shows the opportunity in terms of the share of GDP between different constructions of the triple lock. The point is that, within that wedge, there is an opportunity to give retirees more control over how that wedge is deployed.

Q283 **Rushanara Ali:** One final thing on the council tax increases: what are your thoughts on them, and are they going to generate, as some have said, a postcode lottery? Is this just tinkering and passing the buck by national Government—more of the same—with a little bit of improvement where they can increase the precepts? Have you any reflection on that?

***Simon Stevens*:** It is figure 16 in the Work and Pensions Committee that I was referring to. You can see the different lines for different scenarios, and it is the gap between the lines that represents the opportunity. Speaking from the point of view of the National Health Service, given there are these funding pressures in social care, we would like to see every local authority using the flexibility that it has through the precept.

Chair: That is even more of a politician's answer.

***Simon Stevens*:** Why? 95% of authorities have done so far. It would be great if 100% would now do so.

Q284 **Chair:** There is a disparity.

***Simon Stevens*:** In terms of the tax distribution?

Chair: Yes.

***Simon Stevens*:** Absolutely. That is why the Department for Communities and Local Government made adjustments to the way in which other parts of the local government financing settlement would operate to reflect that last year. We have not seen this year's mechanism but, in terms of the distribution of any extra coming out of the BCF, it obviously should take account of the differential local fundraising powers.

Q285 **Rushanara Ali:** Have you made representations to them to do that for this year or going forward?

***Simon Stevens*:** I think they well understand that point.

Q286 **Chair:** I am not sure that they did alter the basis of the settlement to reflect the differential ability last year. The BCF was said to us to be the mechanism for how they were going to help poorer authorities that could not raise as much money, but the BCF does not come in quick enough.

***Simon Stevens*:** Not just the BCF, but in general. I am referring to the evidence that, I believe, DH and DCLG submitted to you, which sets out their point of view on that.

***Stephen Dorrell*:** Could I just be clear? I am pleased it has come up, even if it is at the end of the session. From an NHS Confederation point of view, the flexibility on the precept allows additional resource into the

system, and that is welcome, but it reinforces the need to look at the funding base for local authorities, because there is very clearly a distributional inequity. Relying on continued development of local taxation puts into sharper and sharper focus the need to look at the underlying equity of the distribution effect as between well-off authorities and less well-off authorities.

Chair: Thank you both very much for coming. I, and I am sure the other Committee members, found that was both informative and challenging to us, in thinking about what we are going to be recommending and mentioning in our report.