

Communities and Local Government Committee

Oral evidence: Adult Social Care, HC 47

Monday 30 January 2017

Ordered by the House of Commons to be published on 1 February 2017.

[Watch the meeting](#)

Members present: Mr Clive Betts (Chair); Bob Blackman; Helen Hayes; Kevin Hollinrake; David Mackintosh; Melanie Onn; Mr Mark Prisk; Mary Robinson.

Questions 360 - 428

Witnesses

Mr Marcus Jones MP, Minister for Local Government, Department for Communities and Local Government; David Mowat MP, Minister for Communities, Health and Care, Department of Health; and Penny Mordaunt MP, Minister for Disabled People, Health and Work, Department for Work and Pensions.

Examination of Witnesses

Witnesses: Mr Marcus Jones MP, David Mowat MP and Penny Mordaunt MP.

Q360 **Chair:** Ministers, thank you very much indeed for coming to be with us this afternoon for the final evidence session in our inquiry into the financial sustainability of social care and the quality of the care provided. You are all most welcome. To begin with, I would ask members of the Committee to put on record any relevant interests that they have. I am a vice-president of the Local Government Association.

David Mackintosh: I am a Northamptonshire county councillor.

Helen Hayes: I employ a local councillor in my parliamentary team.

Chair: Okay, those are our interests. Thank you for coming, Ministers. Marcus, you have been with us on a number of occasions before—our most regular Minister, I think. You have no doubt told your colleagues, David and Penny—you are most welcome—how terrifying an experience it is to come before us; you have forewarned them of what to expect. If we could get under way then, it is an obvious question, given all the evidence we have had: is social care in crisis, in this country, at present?

Mr Jones: It is not the be-all-and-end-all in terms of social care, but finance is obviously a much discussed topic in relation to social care. If I could just set out a little, Chair, what the Government are doing to assist with the finances of social care: across the Parliament or at the spending review, we identified that social care was a priority for the Government and for DLGG, and we therefore undertook to put up to an additional £3.5 billion into social care. That comprises £2 billion from the adult social care precept in the additional council tax flexibilities that we have given councils and £1.5 billion from the improved Better Care fund. Together with that, we have also since identified an additional £240 million this year as a social care grant to local authorities. We have also given further flexibility around the precept, which could enable councils to realise an additional £900 million in the next two years.

I hope that that sets out the intent of the Government in regard to funding social care. No doubt my colleagues will want to elaborate on that aspect. The other thing I would like to say is that we accept that money is not the only game in town, in this sense. We are requiring all areas to bring health and social care together by the end of this decade, to make sure that we are providing the most comprehensive service we can for people in the community.

Chair: I am not sure whether that was a yes or a no—a “probably not”, I think.

David Mowat: In the Chamber, I have said that the social care system is under stress and that is the word that I would rather use than the wording that you chose. I think it is more accurate.

The second point I would make is that it is not accurate to say that there is one social care system in this country. There is a massive disparity in different locations, between different local authorities and different health authorities as well. To answer that question intelligently, you need to look at each of those.

As an example, 42% of local authorities increased their adult social care budget last year in real terms and 20% increased it by more than 5% in real terms. But others did not; I accept that there are difficulties in many places, but there is a huge disparity of performance. That is how I would answer you.

Q361 **Chair:** We will come to those issues and the particulars of funding as we go through our questions. One of the things that comes out as well is the extent to which Government are joined up at the top, as well as further down, at local level. All three of you are here with us today, sat at the same table, answering our questions. Presumably you have been together, locked away in a room with officials, being briefed on what we are likely to ask you; but how often, as a matter of course, do you get together as Ministers from the different Departments to talk through these issues?

Penny Mordaunt: It is not just the Ministers sat here; it is other Ministers from these Departments. From my perspective, the Work and Health Unit has been a game changer, and that is not just looking at the disability employment gap and the employability issues; it is wider than that. It is about accessibility, which is obviously Marcus's department. There are a lot of dealings with that.

It is also business. Many of the solutions to the issues that you are looking at in this inquiry are led by disabled entrepreneurs, if we could just scale some of those things. Then there is social care as well. In terms of the liaison between our Departments, it happens on a daily basis. At a ministerial level for me, we are talking to Ministers in other Departments probably a couple of times a week.

Q362 **Chair:** Is that with your colleagues here?

Penny Mordaunt: Yes, and other colleagues. In Health, I deal with Nicola Blackwood most regularly. Yes, it is very frequent.

Q363 **Chair:** I have one or two specific questions about joined-up government. If there is that degree of connection between Government Departments and thinking through issues on a cross-departmental basis, how did you manage to make such a mess of the supported housing regime when you announced the changes to how it was going to be funded? DCLG, apparently, did not have a clue what was happening when they suddenly saw much of their new provision disappearing with a decision made by DWP.

Mr Jones: I would not say that DCLG did not know what was happening.

Chair: You were responsible as well then, were you?

Mr Jones: There were clearly concerns raised about how that was being provided. To be fair, it was a small part of the supported housing sector. The Government decided to undertake a review in terms of supported housing, how it was provided and how it would be funded. What I can say to you, talking about how often Ministers meet, is that I, the Housing and Planning Minister and Ministers from the DWP have met regularly on that particular issue and continue to do so, as we work to bring forward a sustainable solution for supported housing.

Q364 **Chair:** It was not the best example of thinking through the impact of a policy across Government, was it? You would not say it was your finest hour, would you, Minister?

Penny Mordaunt: Perhaps it would be helpful to explain to the Committee that I do not look after housing for DWP, and I have not been involved in these meetings directly, so I cannot comment on their frequency. Just for the record, the Minister for Employment is the lead on fuller working lives. There are other DWP Ministers who will have been involved in these conversations but, from my perspective on the areas that I look after, I have a particular cross-Government role.

I have a role in every Government Department, through my responsibility for disability, which is now a Minister of State job—it used to be at PUS level—and that has been extremely helpful. I have not had any issues with getting into Departments and plugging into their agenda to try to shape it for the people I am now working for.

Q365 **Chair:** Let us just explore one other area, to see how far you discuss issues that go across. One of the things that came out when we met a number of people receiving care was the continuing healthcare arrangements, where some individuals get their care paid for by the health service but, if you do not get that, depending on your personal resources, you may well pay for the healthcare yourself, which often means paying the local authority for a service or paying the funding to a health provider.

How far does that sort of issue get discussed across Departments? It is incredibly confusing at local level for people receiving care, but it looks as though there is no thinking across Government Departments about that sort of issue.

David Mowat: I was thinking about that. It is a complex issue, because it means that effectively the same individual can have some care paid for by the NHS and some care paid for by the local authority. It is not always clear exactly why that is. It is to do with the difference between illness, frailty and all the rest of it.

To be honest with you, though, the actual policy position is quite clear. What matters in that instance is whether or not the people who are making those decisions are working together on the ground. The answer to that is that in some places they are and in some places they are not. It is not particularly a policy thing.

We may disagree with the policy, in terms of having it split in that way between two Departments, in a sense. The whole Better Care fund and integration are trying to achieve a solution in which there is no big wall between the individuals making those decisions. In an ideal world, that would be the case. That is how I would answer that particular point.

Chair: It can be very nice in policy, but not if people do not understand it.

David Mowat: That is true. All I am saying is that for me and Marcus to discuss that every day is frankly a lot less useful than the people in Sheffield Council and the relevant CCGs discussing that every day and working together with each other. You have to differentiate, when you are looking at joined-up government, between what Ministers have to do—

Q366 **Chair:** What they might say is that the task you are giving them on the ground to do joined-up working is pretty complicated and difficult.

David Mowat: I can accept that. I think that is true in this case. Any organisation structure will throw up that sort of thing, from time to time. All I am saying is that that is where it matters that we get integration and

a continuous dialogue, because that is where the interface with people takes place.

Chair: We will come on to that issue later.

Q367 **Mr Prisk:** One of the recurring themes coming out of other evidence that we have heard, both written and indeed oral, has been the concern about the level of and the growth in unmet need. Could I ask what you as Ministers, and therefore your Departments, have done to find out, to understand and to measure that unmet need for social care? What actually happens to those people?

This is something that all of us see on a constituency basis in surgeries. What are you doing to understand where that lies and what the implications are? Perhaps I had better start with Mr Jones, because obviously that starts there, and then I am sure the health service will have a different view.

Mr Jones: The Care Act clearly puts obligations on local authorities to assess the need of an individual, to make sure that that individual is getting the care that they need. If there is a significant impact on the wellbeing of that individual because they are not getting that care, the particular local authority in question should be providing that service to the individual. The local authority, in any particular case, cannot tighten those criteria. They could expand on those criteria and be more generous if they wanted to, but they certainly should not be tightening those criteria.

Q368 **Mr Prisk:** The reality for many is that they have seen their numbers drop substantially. We have heard from several but, if I just take Newcastle, it argued that, if you look at 2010-11 and the period that it was reporting on, it was supporting 9,780 people through social care; today it is 5,200. It reflects the wider pattern that we have heard from people, which is that, whatever the requirements are, the reality is that they are not just able to meet that demand.

David Mowat: I saw the Age UK evidence that they gave you of 1 million and all the rest of it. I was not aware of the Newcastle figures. How I would answer it is like this. As Mr Jones said, there is a Care Act and the Care Act clearly stipulates who must get care. It takes away the postcode lottery.

For there to be a significant unmet need out there, either one of two things must be happening. Local authorities are not implementing the Care Act in the way that it was intended or expected to be, or the criteria in the Care Act are wrong, such that there would therefore be a lot of people who are not picked up in it. I do not think there is any evidence that either of those two things is in place. I will say that at the start.

When the Care Act came in, it was scrutinised a great deal in terms of the criteria for that. In general, the evidence that I have seen from local authorities is that the Care Act requires them to do more assessments,

not fewer. You would expect it to be in the other direction if that was the issue, so I do not think it is to do with the criteria in the Care Act.

The other possibility is that local authorities are somehow not implementing it in an effective, common or consistent way. The evidence that they have given back to the Department, in terms of the stock-take, is that that is not the case. Now, I am not saying that there are no issues with it.

The question that then arises is: what is the unmet need that is talked about? The only answer that I can give you on that, and I have reflected on this quite a lot, is that a large amount of it was in respect of what you might call services that were previously non-statutory and may have been withdrawn, to an extent. They are things like meals on wheels and things that would not necessarily be picked up by a Care Act assessment. Age UK has not provided an analysis of what it thinks that number is.

I just repeat the point: for there to be a significant unmet need, either the Care Act and the criteria in it are wrong, because we know those assessments are happening, or somehow the councils are not doing what they should be doing in the Care Act. I do not think either of those things are happening.

Q369 Mr Prisk: We have some statistics from NHS Digital's annual report on community care about the fall in the number of people actually receiving care. Is the Department looking at those?

David Mowat: There are essentially two sorts of care, in terms of the Care Act: domiciliary or care home care. The numbers of care home places are pretty much the same today as they were 10 years ago. Now, that is in the context of rising demand, I accept. Nevertheless, the actual numbers are almost identical. In terms of domiciliary care, there is a lot of evidence that there is a lot more domiciliary care going on than there was 10 years ago. Facts on that are quite hard to get, because a large number are self-funded, as opposed to being funded by the Government.

One of the indicators about how much care is going on would be the number of people working in care. We know that, since 2010, that has gone up by about 150,000 in terms of full-time jobs within the care system. That does not indicate that there has been a great fall-off in the way that you have said, but it is true that the proportion of people in care homes is lower and there was an increase of those in domiciliary. There are lots of reasons for that but, in general, I think it is a good thing.

Q370 Mr Prisk: From Work and Pensions point of view, clearly there is a knock-on impact on your budgets, let alone on anything else.

Penny Mordaunt: I would briefly mention four things that are trying to get us focused on really understanding the unmet need, which have happened in the last six months.

The first is that, when we are looking at what services and support we need to develop, we are focused on those very local numbers. Rather

than have some abstract formula for the disability employment gap, in most cases we have the data at constituency level for the numbers of people with learning disabilities and numbers of people with various impairments, so that we understand what we are producing has the reach that it needs.

I know you are primarily concerned with adult but, unless we also get children right, we will not be doing our jobs properly, so we have set up a children's and young person's forum, which sits in the Department for Work and Pensions, to give their issues a higher profile. That is plugged into networks across the country, campaign organisations and so forth, so again we can pick up issues really quickly, whether in education or social care.

We are doing work on extra costs, to complement work Scope and others are doing on that, to really understand what people are spending their money on and where they are having to plug gaps and compensate. The other thing we are doing and should be able to introduce shortly is real-time feedback on our systems. Service user representatives were doing this digitally across the country and across therapy areas.

If we are not getting something from another part of the system—quite often it is not necessarily something across the whole board or wrong with the whole system; it might be something going on in a particular local authority or one of our local offices—we can pick it up in real time and we are not having to wait for a colleague to give us a pile of case work and say, "What is going on in my area?". Those are four examples of where we are trying to get focused on what the actual local need is.

Q371 Mr Prisk: Simon Stevens said, "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". From a ministerial point of view, probably most relevantly for Mr Mowat, to what extent do you feel that the pressures on the NHS are directly attributable to the problems in social care?

David Mowat: Simon Stevens was talking about delayed transfers of care, which have increased in the last 18 months. Interestingly, they have stabilised in the last couple of months, but they certainly increased in the 18 months prior to that. That is across the system as a whole.

The first caveat I would give is that there was an extraordinary disparity in delayed transfers of care between different local authorities. I was looking at the figures today for the four worst local authorities versus the four best. The disparity is a factor of 40 in terms of the impact of that.

Nevertheless, they have gone up over the system as a whole, and there is an impact from that in terms of NHS beds. Broadly speaking, the impact on NHS beds is from the steady-state delayed transfers of care. It is a bit like unemployment: you cannot get it beneath a certain number, which is about 3%, and it has gone up to about 5% over that 18-month period that has just happened. Of that increase, 2% of extra

beds, about a third is due to delayed transfers of care caused by social care changes, which is therefore about two-thirds of 1%. There has been an increase in the number of beds that are not usable for other things, across the whole system, by about two-thirds of 1% in that last 18-month period.

Now, hospitals work on very tight margins and tight figures, so that is still quite a lot of beds—several hundred beds, probably equivalent to a hospital or so. Whether it is decisive or not is for you to judge, in terms of how you take a view on it, but, for me, as a Minister looking at this, the thing that we really need to get a better understanding of is why that factor of 40 exists, because it is out of all comparison in terms of budget pressures and those types of things. In my mind, that is where we need to start with this, as well as, in due course and when the time is right, having more funding. Understanding why that factor of 40 exists is terribly important in terms of NHS pressures and all that goes with that.

Q372 **Mr Prisk:** Are you and Mr Jones going to get those worst performers and best performers in, to look at where the gap is?

David Mowat: Our role is, to be positive about it, to try to encourage best performance. There is a lot to it. There are people in the NHS whose full-time job is to do this, and there are people in local government whose full-time job is to get this right. That sort of discrepancy is quite spectacular, frankly. I was at a hospital last week, which was discharging to four different councils, because that is quite a common feature of how this is organised. I was listening to the team dealing with the discharge on what is called the frailty ward, and one of the big factors that they had to discuss was whether it was council A, council B, council C or council D because, frankly, their job was quite different, depending on the arrangements that that council had and how it did its work.

What I am describing is clearly a suboptimal process, if you have a consultant with his team trying to get people back home, having to deal with that. It is very difficult, like I said at the start of this, to say that there is one big system here. We have multiple systems and multiple people who need to do their jobs well.

Mr Jones: The role that we have, as you know, Mr Prisk, is to operate on the basis that local government is directly elected to serve the local people it represents on a local level. What we seek to do as a Department, working with the Department of Health, is to work with local authorities in terms of improvements through the LGA, ADASS and other organisations to try to improve the performance in local authority areas.

As Mr Mowat quite clearly said, there is a huge variation between the best and the worst-performing areas in this sense. The disparity is not reflected in the difference that each particular area has in funding. There is certainly a lot more work we need to do in this area and, as I say, we are working with the various organisations that our Department funds in

some cases, such as the LGA, to bring forward further improvement to the way in which local government operates and provides services.

Mr Prisk: If the disparity is that great, then obviously there is an opportunity there for you, as Departments, to politely or otherwise raise the standards.

Q373 **David Mackintosh:** Are the funding commitments in the provisional local government finance settlement enough? In that context, what are your thoughts on Surrey County Council wanting to raise its council tax by 15%?

Mr Jones: In terms of Surrey, as you know, Mr Mackintosh, the Government operate on the basis that local authorities can work to referendum principles. This year, the referendum principle for council tax increases is 2%. In relation to adult social care, there is an additional 3% that local authorities can achieve through that, so effectively a particular area has to operate to a maximum of 5% increase in council tax or go to its local area with a referendum.

Now, Surrey is well within its rights to go to its local electorate to see if they think that the council should be spending that additional money on the particular services that Surrey is going to set out to its local population. It will be up to the people of Surrey to confirm whether they are happy to provide more money to that particular local authority or not.

In terms of the overall envelope of funding, we have been very clear in the Department, since the spending review, that adult social care is a priority. With the adult social care precept, as I said before, there is additional flexibility over the next two years for councils to go up to a 3% increase in that sense, with the improved Better Care fund, which totals up to £1.5 billion in 2019-20, and with the additional £240 million that is being put into adult social care this year. There is a package there, dedicated to social care, in the region of up to £7.2 billion, which is significant additional funding to that which has been available to date.

David Mowat: Can I just add a little bit to that? One of the things I said at the start of this is that there is not one market for adult social care; there are many. The Surrey thing is an example of that. Surrey has a specific issue in terms of a large number of adults with learning disabilities, working age social care.

One of the interesting things about this debate is that we always focus on older people, whereas a third of the costs are to do with people with autism and significant learning disabilities. I would just add to what my colleague has said by saying that, if you were to speak to the Surrey people, they would say that they have a specific issue in respect of that and that is what is driving that particular issue.

The only thing I would add to what my colleague has said on the overall funding level is that there is a real-terms increase during the course of this Parliament. That is a fact. People could argue about whether the point we are starting from is too high or too low, but there is a real-terms

increase. It was somewhat back-loaded; the announcement that came before Christmas made it less back-loaded. One would expect some of the pressures to alleviate over that period. In Surrey's case, as I say, I think you will find there are specific issues around working-age adults requiring social care.

Q374 David Mackintosh: Given the variations in council tax revenue around the country, do you think it is sustainable to carry on paying for social care through local taxation?

Mr Jones: At the moment, I would say that the full extent of the cost of social care is not completely met through local taxation. There is currently a Government grant, in that sense. There is currently an amount raised through the business rate, which is local taxation, and there are also user charges that contribute to the cost of social care. Council tax is effectively one part of that.

There seems to be some sort of narrative where it is a bad thing for taxation to be collected locally and, somehow, if the Government provide the money there is an implication that it is not necessarily coming from taxation. There is the point that, whether it is collected locally or nationally, it is taxpayers' money in either case, and that is therefore a cost to people as individuals. The way in which the majority of adult social care is funded enables local people, through raising local taxation, to support the care needs of local people.

David Mowat: The Better Care fund is a large chunk of how this is being funded now, in terms of the increment. A lot of that is not raised locally.

Q375 David Mackintosh: The Better Care fund and the precept are both short-term funding mechanisms. Is some thought being given to what can be looked at longer term?

Mr Jones: We are not in a position to go beyond the next spending review in that sense, which is generally when these matters would be determined. The Government and particularly the Prime Minister have been very clear that we need to make sure that we have sustainability, in terms of funding for adult social care in the medium term, but particularly in the longer term, bearing in mind that we have a population that is generally getting older, which we have to support.

The Government are constantly looking at ways in which we support social care going forward. In terms of any direct comments that I can make about that, it would be very difficult to do pending the next comprehensive spending review.

David Mowat: We do know that we are different from other countries, in this regard, across Europe. The Barker review and various reviews have looked at this, and a solution has never really been found. Different countries do different things, in terms of social insurance and long-term saving schemes that are protected around this. In this country, we have not chosen to do any of those yet.

Q376 Bob Blackman: On a slightly related factor, I commend for your attention a rather excellent report that was published today from the All-Party Parliamentary Group on Smoking and Health, which demonstrates with medical evidence that those people who smoke are twice as likely to require social care in older age, because of the diseases that they are likely to suffer from. Indeed, over the last three years, the evidence demonstrates that the costs to local authorities have increased quite dramatically, as a result of having to care for people with smoking-related diseases.

The problem is that, at the same time, local authorities are now cutting their services to assist people to give up smoking, so a short-term measure to save money will potentially lead to a long-term issue—I know we are going to come on to long-term funding in a minute—of having to find more money for adult social care. I guess this falls between two Departments, but surely there is something we can do to get local authorities to understand the implications of these short-term measures that will have long-term implications.

Mr Jones: First of all, Mr Blackman, I have read very briefly a news bulletin I saw about the report that you have referred to, but I have not looked at it in any detail, so cannot make significant comment in that sense. No doubt David will say more about the public health budget, but local authorities have a public health budget that is effectively ring-fenced. Within that, they are able to make decisions as individual local authorities in regard to the level of funding they give to various things.

If there is very strong evidence to back up what you are saying, Mr Blackman, that will be a consideration as we go forward that local authorities have to make, as to whether they think that spending in this area would be prioritised over spending in another area to help the situation further down the track.

David Mowat: I am sure everybody agrees that, if we were to have less smoking, the costs first of all to the NHS—and possibly that is the bigger number—would be significantly lower, never mind social care. People's lives would be enhanced significantly. There is an open door regarding that. If your point therefore is that it is obvious we should be spending more money on "stop smoking" campaigns, that is a judgment as to how effectively we are spending the money that the public health people are spending already. I completely agree that smoking, like obesity, has implications in terms of social care and particularly in terms of health.

Q377 Bob Blackman: I am glad to hear you say that. When are we going to see the long-promised tobacco control plan from your Department?

David Mowat: We discussed this in the debate and I said at the time that it was not my portfolio. The answer I gave you at that time was "shortly", and I am afraid I have only been briefed to give the same answer. I will try to get back to you. I will write to you on that, if it is not shortly.

Penny Mordaunt: Can I just add something, because I think it is an important piece of work? The Chief Medical Officer at DWP is doing some pioneering work with Health, in terms of sharing records for people who may have had transplants and very large numbers of records for people with mental health conditions, and then we are tracking those individuals through the benefit system.

The long-awaited sharing of that information and then using it to make good policy is well under way. The legal and ethical issues that have previously put it in the "too tough" in-tray are cracked now, so that work is going on, which I think will be a big help.

Q378 **Chair:** I do not know whether "shortly" is quicker than "soon", which is when we are going to get the housing work, David. Nevertheless, we will move on to ask about this problem of different areas being able to raise substantially different amounts of money, through the precept, which is an obvious fact. Those that can raise the most money do not necessarily have the most pressing problems.

The Government have chosen to allocate the new homes bonus money through a social care grant, which has a formula basis for it, but you could have chosen to allocate it through the Better Care fund formula, which would have skewed the money directly to authorities that have the least ability to raise money through the precept. Why did you not do that?

Mr Jones: The improved Better Care fund is £105 million this year, £825 million the following year and £1.5 billion the year after that. It is effectively geared to reflect places where the council tax base is not as significant as in other places and, therefore, that reflects the support being given in that sense.

In relation to the £240 million being provided this year, which is a far lower figure compared to the amount in the improved Better Care fund, it has been distributed using the relative needs formula, but it is a social care grant as such. It is a short-term measure to support the places where there are the greatest challenges at present. That is why that grant has been distributed in that way this year, as a short-term measure.

As we go forward, obviously the cumulative effect of the adult social care precept will ameliorate the situation for the places with the larger council tax bases, by which time the more significant money from the improved Better Care fund will be benefiting the places that have smaller council tax bases.

Q379 **Chair:** You could have chosen to put the new homes bonus money to local authorities on the same formula as the Better Care fund, could you not, which then would have put more money directly into those authorities with the least ability to raise money through the precept? You could have chosen to do it that way.

Mr Jones: It could have been done that way. As I say, we chose to do it the way we did to smooth out the situation in this current year, where there are a lot of local authorities that may have had larger council tax bases, but saw very little, if any, effect from the improved Better Care fund. It was to smooth out the effects.

Q380 **Chair:** Nobody is getting money from the Better Care fund this year, because it is back-loaded, is it not?

Mr Jones: This year, they are. It is £105 million.

Chair: That still does not really answer why you chose to go one way, rather the other, but there we are. We will move on.

Q381 **Kevin Hollinrake:** Marcus Jones, local authorities are funded based upon what some people would say is an outdated means of assessing need. The previous Secretary of State and the current one are proposing a revision to that assessment and a review of whether the needs assessment is fit for purpose. Where are we with that?

Mr Jones: You make a very good point, in that there are a significant number of local authorities that have made representations to the Department about the needs assessment, which was last looked at thoroughly over 10 years ago. There is concern being put forward that, in many places, the demographic has changed significantly within that time and the current needs formula, in the view of those areas, does not reflect the current demographic situation that we have.

A call for evidence in relation to the fair funding review that we are doing was put out last summer. We now have all that information back. We are going to respond to that piece of work very shortly. Once we have responded to that, we are then going to bring forward a further consultation to keep that piece of work moving with some pace, with a view then to the fair funding formula and the new formula coming into effect at the same time as the 100% business rates retention system, for which we are currently bringing legislation through the House.

Q382 **Kevin Hollinrake:** You have the LGA with the technical working group looking at this as well. This Committee suggested a completely independent perspective on this. What we have seen so far is that the current way of distributing monies is very complex, to say the least, and probably needs a completely fresh look at it. Do you think that is what we will get from the LGA technical working group, or will we put something else in place to make sure we have the right system, moving forward?

Mr Jones: In terms of the depth of the review, we are currently considering how far it will go, bearing in mind the responses we have had to our call to evidence. You quite rightly identify that there is a technical working group, with which the LGA is involved. There are people from across local government involved with that, representing all the various interests, so county areas, metropolitan areas, unitary councils and so forth, together with the mixture of urban, rural and all the various

geographical differences that you would expect to see. That is where we are.

As I say, we are currently considering the extent to which the review will be made, but I think he will know that my right hon. Friend the Secretary of State has been very clear that he wants to make sure the needs formula reflects the situation as it is now and not as things were 10 years ago. I think I can give a pretty good indication that we are looking very carefully and pretty deeply at how the funding formula will work, going forward.

Q383 Kevin Hollinrake: You are probably aware that this Committee itself is looking at this and is going to do a shadow inquiry on it. Presumably the evidence and the recommendations we make would be something that you are keen to look at.

Mr Jones: I would like to say, looking at the Chair, that we always take into account the views of this Committee. There is a very recent example of us doing that with the Homelessness Reduction Bill brought forward by Mr Blackman, where this very Committee has been involved with the legislation and taken it forward from the first iteration of the Bill. The Government have taken up a number of things within that that this Select Committee suggested. I can certainly say that we will obviously be listening carefully to the views of the Committee.

Q384 Melanie Onn: We have heard some evidence, and I am sure you are already aware of the figures, which shows that we are expecting by 2035 to see a rise of nearly 50% in the numbers of people who are aged over 65, going up from 9.7 million to 14.5 million. The number of disabled people over the age of 65 is going up by 65%. We have also heard from Norfolk County Council about the increased demand for adult social care in the last five years, which has gone up by some 46%.

I wonder how you plan to fund social care to keep pace with those growing numbers, and younger disabled people and the increasing complexity of their needs. Has any consideration been given to the fact that not only are we going to have an increase in the number of over-65s, but the people who traditionally have cared for them—their children—are also getting older, and living longer and have their own health needs?

David Mowat: There are several points there. One of them you alluded to at the end: the area of informal caring. There are now 6 million people in this country with some kind of caring responsibilities. Of those, perhaps 200,000 are under 18, so there is a whole cohort of people who are almost bypassed by this discussion, as well as the 1.6 million full-time carers.

Part of the solution is properly bringing those informal carers into some kind of system. We have a carers strategy that is about to come out, to try to give more recognition to that and to help them get back into the workplace. If people are doing more than 10 hours of care a week, that begins to affect their ability to hold down a job at the same time, and

that is all to do with how employers deal with them and all that goes around that, so there is a chunk of activity around that.

I think your wider question is: care demand is increasing right across the board; how are we going to deal with that? In terms of the funding currently allocated, the spending review is all that we have. If your point is that this is going to become a bigger and a higher proportion of our country's GDP over time, it is certainly right. In terms of how we deal with that and the different mechanisms available, it is an open question. I do not think we have a final answer to that.

When you look at the total amount of GDP that we spend on care, it is again a slightly difficult number to get up, because it is private versus Government spend, but in terms of the Government spend we know that we spend more than some countries like Germany and Canada, which we would consider to be comparator economies. There is absolutely no question that the total amount of GDP that we spend on adult social care, including working-age social care of people with autism and disabilities, will increase. There is absolutely no question about that.

Q385 **Melanie Onn:** Are you having discussions with the Treasury about how this can be properly planned for?

David Mowat: There are discussions with the Treasury all of the time. In terms of this spending round, we have set out what the plan is and Mr Jones have gone over that in some detail.

Q386 **Melanie Onn:** Have you set out these figures to the Treasury to explain how pressing this need is going to become?

David Mowat: There is nobody here from the Treasury, but I do not think that anybody from the Treasury, were they here, would disagree with the conclusion that, over a period of time, the amount of money our society spends on care is going to increase. That is not a very dramatic conclusion; it is clearly true.

You then get into what the options are for how we deal with that in the medium term, which is a bigger, wider question. There have been lots of reviews on that. I mentioned earlier that the Barker review looked at different options and how different countries do this. We are unusual in Europe in that we do not have a social insurance system or long-term savings scheme and all that goes with that, but there are options out there.

Q387 **Melanie Onn:** Is that something that you would propose?

David Mowat: I personally am of the view that that is something that would only make a difference in the very long term, given that we are starting from where we are now, but there are other people looking at that. It is a cross-Government thing; it is not a health matter really.

Your basic point that this is a very rapidly growing sector of our economy is true. We are going to end up spending at a higher proportion of our GDP in the future than we do now; that is also true.

One of the biggest areas that struck me going round is this one of learning disabilities. This is a very good thing: the life expectancy of people with learning disabilities and severe autism has gone up massively, even in the last decade. These people are very expensive in terms of care, which creates a challenge rather like you have set out.

Melanie Onn: I am conscious of the time, so I will leave it at that.

Q388 **Chair:** I will just pick up a couple of points. Taking it forward then, in the medium term, local authority finance is going to change. We had the debate the other day about business rate retention, which the Committee has supported in principle. There is this discussion about what the extra money that is available in business rates compared to the current grant, which is somewhere between £12 billion and £13 billion, should be spent on. The LGA has given evidence to the Select Committee that, before we look at new things for councils to take responsibility for, we ought to begin by properly funding social care as a start. Would the Government be in support of that approach?

Mr Jones: There are a few things I would say to that. First, in bringing forward the business rates retention system, the Government have been very clear on this from the outset. The Government see that as a fiscally neutral exercise. Therefore, additional money going to local government would be to provide additional services.

That said, Mr Betts, you will have seen in the call for evidence we conducted around the additional responsibilities that Government may devolve to local authorities a suggestion that the Better Care fund could be devolved as an additional responsibility that would be funded through business rates retention. At the moment, we have not made any firm decisions in that regard, but I can say to you that we will be coming forward very shortly with an initial response to the call for evidence that was made.

Q389 **Chair:** Will that include the LGA's idea that some of the pressures of social care might well be ones that that money is used for?

Mr Jones: As Mr Mowat said earlier, we have set out our position into the medium term in relation to the funding for social care. That said, beyond there, when we get to the point where we are looking at the devolution of this system, it will no doubt be bound up in the discussions around the next comprehensive spending review, at which point those things will obviously be debated within Government and a determination made.

Q390 **Chair:** One of the other points made to us, which seems an entirely reasonable one, given the increasing demand for adult social care, which we have all accepted exists and is going to continue, is that it is likely to grow faster than the council's business rate income. In the long term, you have a tax going up by a certain amount and demand for the major budget on which local authorities spend their money, adult social care, going up faster. Is that not a slightly unstable situation in the long term? You will have to think through how you are going to deal with it.

Mr Jones: I do not want to predetermine the additional burdens that may be put on local government for the additional business rate income that they are going to receive, so that is really a hypothetical question at the moment. However, I would say that, as you know, when the Government expect and mandate local authorities to provide additional services, there is generally a new burdens assessment that has to take place at the time.

Q391 **Chair:** New burdens tend to give local authorities a new responsibility to do something that they not currently doing, not simply to find more money for a growing demand for a service that they already are providing. I did not think new burdens were covered by simply an increasing demand for social care.

Mr Jones: Taking the point that you are making, Chair, we are coming back to the situation of the next comprehensive spending review and work that is going on across Government to assess what the future demand on social care will be.

Q392 **Chair:** I am glad the Government were thinking about the problem anyway, which everyone could see coming down the road. To go to the slightly longer term, I was interested in what David Mowat was saying about the review. We all want to see a review into the longer term and how it should be done. There might be slight differences about it, but do you have any ideas of a timescale for that? That is the first question: when are we going to see something from the Cabinet review? Do we know?

David Mowat: The answer first of all is that a piece of work is going on. I think the Prime Minister said that to the Liaison Committee and set that out. In effect, I am going to give a very vague answer; there is always work going on in this area.

Since I have been in the Department of Health, about six months, we have been looking at options around this. The Cabinet Office is as well, as you have just said. In due course, that will come forward with some ideas that will inform policy. I do not know what the timescales are. I am not sure timescales are being set in that regard, so I cannot be more helpful than that, in terms of where they are with it.

Q393 **Chair:** Can we know anything about the nature of the review? Is it blue-sky thinking? Are all options there? Is it looking both at what Government should be paying, as we said before, but also what private individuals should be paying? We went to Germany and looked at their very different model, their social insurance model. Are all the options being looked at as part of this review?

David Mowat: I have seen the terms of reference, but I have not been involved with the project. I would think that they are looking at all options. We know that we are going to implement Dilnot coming down the line. It is how that happens as well, in respect of all of these other types of things too.

I have mentioned the Barker review, which looked at how we might attack this problem in terms of the various options. You have options like national insurance, taxation, treatment of houses, business rates and those types of things. I would expect them to be looking at all of that, in some regard.

Q394 **Chair:** Is Dilnot definitely going ahead?

David Mowat: Yes.

Chair: Not everyone in local government seems to be that convinced when you talk to them.

David Mowat: I think there are options about how it is implemented, but the policy is clear.

Q395 **Helen Hayes:** Just to follow up that last question before I move on to some other questions, surely looking at the very significant question of the future funding for social care requires engagement, collaboration and involvement with organisations and individuals across the sector and indeed the public. Why have the Government not published the terms of reference for such a significant review and do you have plans to do so?

David Mowat: As I say, none of the Ministers here are responsible for doing the piece of work that is going on now, but there is a lot of engagement across the sector, in terms of all of these types of things, and indeed in the public. As your colleague said, there is no doubt that demand is increasing—as the Chair said, at possibly a faster rate than business rates. We have to find a way of dealing with that. There are a lot of interwoven issues here.

One of them is for us to start thinking as a society about how we deal with the care of our own parents. One thing that has always struck me as I have been doing this role is that nobody ever questions the fact that we look after our children. That is obvious and nobody ever says that that is a caring responsibility; it is just what you do.

I think some of that logic and some of the way that we think about that, in terms of the volume of numbers that we are seeing coming down the track, will impinge on the way that we start thinking about how we look after our parents. In a way, it is a similar responsibility in terms of our lifecycle.

Q396 **Helen Hayes:** It just seems surprising that all of that is not being funnelled into a formal statement of the terms of the review, but we will move on. We have seen and heard significant evidence in the course of this inquiry that social care providers across the country are under significant financial pressure. Many of them are closing and many are choosing to hand their contracts back to the local authority. What are you doing to help providers mitigate the financial and quality risks that they face?

David Mowat: First of all, there is churn in any market. That can sound a very complacent thing, but it is not meant to be that. We often hear

about care homes closing, and they do close, but new ones come up as well. I made the point at the start that the number of care home beds that we have now is the same as it was 10 years ago. Similarly, there is churn in domiciliary. I would start by saying that you would expect some of that to happen.

However, your specific question was what we are doing to protect a major supplier going out of business. The formal way that we do that is that the CQC has a role, in terms of the top 50 care-home suppliers; that is the biggest 50. It monitors them pretty rigorously and carefully, and it reports to Ministers on that process with its observations and the extent to which it is seeing problems, and sometimes it can be quite proactive in hands-on management of that. There is that responsibility that the CQC exercises, in terms of that financial thing.

The other part of this is that the Care Act gives a statutory duty to local authorities to build and develop their own marketplace. If they were here, they would say that they need money to do that, and enough money to do that. Nevertheless, they have that statutory duty and they do market assessments. I think they have all done a market assessment. We have a hub that enables those to be compared. That is part of it as well, so it is a double approach, in terms of how that should be done.

Q397 Helen Hayes: On the number of care-home beds, the CQC has said that the total number of beds available in care homes fell between 2010 and 2016—a fall of 19,490 over that period. That is of concern. There is clearly a mismatch between that and your statement that the number of beds is the same.

David Mowat: No, the total number of beds is the same. What they may have been referring to is that there has been an increase in the number of self-funded beds, so funded by the public versus funded by a local authority. As a point of fact, the number of beds in 2010 and 2015 is the same.

Q398 Helen Hayes: They are talking about the number of available beds.

Mr Jones: The point as well is that there may be fewer care homes in number, but there are more beds within the care homes.

David Mowat: You said beds, did you not?

Helen Hayes: Yes.

Mr Jones: There are more beds, and therefore that backs up a point Mr Mowat made in terms of the number of beds being the same.

Q399 Helen Hayes: There is the question about numbers, which there seems to be some debate about, in terms of total numbers. There is also a question about the distribution of those beds and whether they are available in the places that need them. There is then a question about what happens in an individual local authority area when a care home closes or a provider hands back the contract.

In one of the local authorities that I represent, we had a situation where a care home closed because it did not have the capacity within the organisation to make the improvements that were required by the CQC. There was no assistance provided to the local authority in terms of rehousing those residents. The care home was not bought by another provider and did not reopen, and there was a net loss of capacity, so what is the support that should be available to a local authority from the Government in a situation where a contract fails in that way?

David Mowat: That is an interesting question, is it not? The local authority has the responsibility for shaping that market. If it was a very serious thing, with a big care-home supplier, the Government would need to get involved in that. It is a question, though, as to the extent to which the local authority has this responsibility and the Government should be checking to make sure it is being done right.

This applies to many things in the Care Act, actually. There is a question as to what the Government should do versus what the local authority, which is accountable to its electors and its scrutiny committee, should do. I do not have an answer as to what is right and what is wrong. I know that, in the way that it is being done now, that is a local authority responsibility.

Q400 **Helen Hayes:** Could you unpack what you mean by the phrase, "The local authority has the responsibility for shaping the market"? The local authority has the responsibility for delivering the care that is needed for its residents with the funding that is available to it from the Government, but I am unsure as to what you mean by "shaping the market".

David Mowat: The Care Act gives them the responsibility, as well as for that, for ensuring there is a market in their patch for care, so they have the responsibility not just for actually arranging it. The intention of that is that they should be thinking, when they are commissioning, more widely necessarily than perhaps just the next contract—always getting the cheapest deal and that sort of thing. That is their responsibility.

To be fair, if they were here, they would say they are under such financial pressure. That is tough, and I understand that. That is the trade-off. The Care Act gives them that responsibility, and they have done a thing called the market assessment, which you can see on their website. They should be evaluating their market and looking at risks, just like the sort of thing that you mention. I am not saying that it always works smoothly, but that is the way that it is structured.

Q401 **Helen Hayes:** The evidence that we have seen in the course of this inquiry would indicate that the level of resourcing available to local authorities is so stretched that there is market failure occurring in many areas of the country, where providers are going into liquidation or choosing to hand back their contracts because the money is not available, and that, it seems to me, is beyond the responsibility of the local authority.

David Mowat: Yes, you are right. The question would be how that would manifest itself. One of the issues about care is that there is a risk of it being not a major problem but lots of little problems, and therefore it is a slightly hidden problem, in a way that perhaps waiting lists on the NHS are not.

The question is about how that situation would manifest itself. In that situation, I would expect that the CQC evaluations on care homes would be going down, because they cannot maintain quality. That is not happening. Another measure might be the satisfaction of care-home users, which is actually very high. It is surprisingly high; I was looking at it this morning. That is not happening.

The other thing is that we ask the LGA to do what is called a stock-take of implementation of the Care Act. There are various questions on that, and the most recent one of those was published in November of last year. I think 99% of local authorities said they were happy that they had implemented the Care Act. They did see financial pressures into next year, but in terms of this year or the current status 70% of them said that they were resourced enough to deal with it.

I am trying to walk a tightrope here: I do not want to sound complacent, other than to say that some of those indicators, which you would expect to be indicating "red", are not yet. That is not to say that there are not a lot of people out there—the Chairman used the word "crisis"; I accept the word "strain"—saying the system is under strain, and a lot of people are doing remarkable things in it. I do not see the carte blanche problems in the way that you have suggested.

Q402 **Helen Hayes:** We have also seen evidence in the course of this inquiry that increasingly providers are using the funding provided by privately paying clients to subsidise the cost of those residents funded by local authority care. Indeed, from my own constituency I have examples of voluntary-sector providers saying that they are subsidising out of their charitable reserves the costs of local authority care that local authorities are unable to pay for the clients that they fund. Is that situation right?

David Mowat: Two separate things are occurring. The first is the issue of cross-subsidy, which has been in the press and all the rest of it. There are two areas where that could be happening: one is care homes and one is domiciliary. Generally, it is about the care home thing.

The way I would answer that is to say that, if a local authority is able to bulk-buy a large proportion of beds and give bulk contracts, it is possible that it is able to negotiate a considerably cheaper price for that than an individual will be able to have in terms of something else. It is a little bit like I could be going on an easyJet flight and the person next to me on the flight has paid a completely different amount for that seat because the supplier has dealt with it in a different way. There is a part of that.

The other thing with care homes is that a large proportion of their costs are fixed, so what matters if you are running a care home is getting

enough capacity in there, which perhaps the local authorities are giving them, that they cover their fixed costs, and then that is very valuable to them, because they know that they can stay in business.

I would be disturbed if there was a consistent approach to a cross-subsidy in the way that you have said. Having said that, these contracts are all between third parties and suppliers, which it is not necessarily for the Government to intervene in.

Q403 Kevin Hollinrake: Talking about commissioning in the local authorities, are you comfortable with the way local authorities are setting about meeting their responsibilities in terms of market-shaping?

David Mowat: Do you mean market-shaping or commissioning?

Kevin Hollinrake: Both.

David Mowat: Let me take commissioning first of all. This gets us into the area of integration. The evidence is that there are a great deal of different approaches that go on out there, and that we do not fully understand why so many people do so many things so differently.

I started earlier by talking about delayed transfers of care and factors of 20, 30 or 40 between councils that are doing this effectively and councils that are not. I was at a council recently; it was St Helens, which is not a particularly affluent area. I was very struck by the fact that, when I asked a person whether they worked for the local authority or the CCG, they said, "Both". They had a boss in each, and everybody in their organisation acted as though they were in both the CCG and the local authority. That performance translates into a place that has virtually no delayed transfers of care, which struck me as being very strong. In other places, I am pretty sure that is not the case.

Q404 Kevin Hollinrake: How would we develop a situation where it is more consistent? Should the CQC have a role in overseeing commissioning bodies, for example?

David Mowat: That is an open question. I would be interested to know what your Committee thinks in terms of whether the CQC should be evaluating local authorities in the same way as it evaluates CCGs and others, such as care homes. At the moment, we do not do that. The logic of that, I suppose, is that the local authority is accountable to its electors, and therefore the Government should not impose something on that. I do not think that is cast in stone, and I would be interested to know what your Committee thought about that.

Mr Jones: On that point, there is the very important situation of the Better Care fund and the type of practice that Mr Mowat mentioned in St Helens, where they are getting to the point where the integration between social care and health is such that it is having a very positive effect. Through the Better Care fund, we can try to bring places up to the standard of the best, and try to roll that good practice out across the country, which is critical.

Q405 **Kevin Hollinrake:** It is interesting. The Select Committee met the makers of a *Dispatches* programme, and we watched a particular programme that illustrated some deficiencies in the domiciliary care provided by one of the agencies that this local authority had commissioned, which was very disturbing. It begs the question of why the local authority was not auditing the work of the body it commissioned to do that work, for example. Is that something you are looking at to provide some guidance or oversight to the local authorities?

David Mowat: I am not sure which *Dispatches* programme you are referring to, but 1.65 million people work in social care. It is quite a hard job—I am not sure it is a job that I could do—and some of them, from time to time, will do the wrong thing. That is just going to happen, whatever evaluation system we have through the CQC and all that goes with it.

Q406 **Kevin Hollinrake:** It was not unsafe. It was just cutting corners, taking liberties and not adhering to the service standards that they were committed to.

David Mowat: The structure in place to monitor that is the CQC inspection regime, which applies to domiciliary care. We know that when it finds something that is either “inadequate” or “requires improvement”, there is a process by which that is sorted out. If it is “requires improvement” and stays “requires improvement”, it begs the question as to whether they should be closing.

Mr Jones: In that sense, local authorities are under an obligation to monitor contracts that they let, and make sure that they are getting the requisite standards that they are employing whatever contractor it is to provide.

Q407 **Kevin Hollinrake:** In this case, it clearly was not happening, and nor were they monitoring the contractor. Therefore, should there be some statutory obligation to do that, to make sure that this is happening on a routine basis, to make sure the standards stay high? That is the key question.

Mr Jones: That is something that I will certainly take away with me today. I am more than willing to write back to the Committee in regard to the particular point you have made.

Q408 **Kevin Hollinrake:** Can I just make another point? We have had some evidence to the Committee about intentional community and Shared Lives. There is a community called Botton Village, just outside my constituency, which is an inspirational place where people with learning difficulties live alongside co-workers. They would say it is a much more efficient and cost-effective way to provide gainful employment and a way to live for people with those kinds of challenges. Is it something that we are looking to promote as a different solution to some of the problems that you highlighted earlier, Mr Mowat?

David Mowat: Funnily enough, I have my list of points that I would like to make to the Committee if I get the chance, and on it is one of the

frustrating things about something like Shared Lives, which is a brilliant idea. It is a very similar concept to fostering, is it not? It is cost-effective and it creates a quality of life that is difficult to emulate in other situations.

The question we get to is why everybody is not doing it. That is a little bit like the same question about delayed transfers of care and integration. I visited, as you obviously have as well, a Shared Lives location, and the particular council that that was at was Merton Council; it does it a lot. However, other councils, similar councils around, do not do it. There is an inconsistency of approach out there.

From the centre, all we can do is try to make sure that people know about the best practice, encourage and hope that those decisions are made. Those councils that do not do it are missing a trick.

Q409 Kevin Hollinrake: Talking to the residents and the parents of residents, they feel that not only did it not fit, but that we need to tick boxes in this world, such as safeguarding, financial accountability and all these things, and it did not seem to be easy to tick those boxes with something like Shared Lives. Does it fit within the frameworks that we put in place?

David Mowat: Shared lives is growing pretty quickly across the patch. I do not know about the boxes that it ticks and does not, but all I can say is what I have seen, and my understanding is that Shared Lives organisations are growing, and they are trying to promulgate them and do more.

It seems to me to be very clear that it is one of the solutions, particularly for the people with severe learning disabilities and autism, making them live in the community in a meaningful way, so it is a great solution.

Penny Mordaunt: Can I just add my perspective? We are looking at two of the biggest obstacles to good things happening. I mentioned at the start that there are a lot of solutions and enterprises that have been set up by disabled people themselves, which are brilliant but are not being taken up or not being rolled out at the speed that you would like.

We are identifying the themes behind that. Some of it is around councils perhaps not feeling that they can take the risk, so they will signpost someone, to give you an example, to Gumtree to find a carer, because that is okay, but if they recommend this wonderful service that pairs you with a carer they feel they might be taking on a risk.

One of the strands of work that we are doing is looking at how we can support disabled entrepreneurs but also entrepreneurs who are coming up with these sorts of solutions, so we are working with the Department for Business to look at how we can identify what those myths and obstacles are.

The other obstacle, particularly around employment, is an individual's productivity. I know this is an issue you are particularly interested in—things like a therapeutic wage and so forth. We are doing a piece of work

looking particularly at those with very high needs and severe learning disabilities, about potentially scoping out an employer subsidy that would enable us to pay, say, the living wage and then enable that person to not get the whole thing that they do with Shared Lives but a large chunk of it.

We are dealing with productivity and those myths around bureaucracy and risk.

Kevin Hollinrake: That is very interesting. Thank you very much.

Q410 **Chair:** Could I raise one point about the oversight of the whole business? Clearly, in the end, you have care workers going to the homes of quite vulnerable people on a one-to-one basis, and the public want to know that they are safe. I raised at the last session a case that had come up in my own constituency, where Mr Malcolm Pitcher had complained about his elderly mother being abused by a care worker.

The local authority quite rightly said that the worker should not work unsupervised with vulnerable people. The company ignored that. A safeguarding panel was set up. The local authority found the worker guilty of emotional and verbal abuse against this elderly lady who has since died. The local authority said that this individual should not work in future with vulnerable people, elderly people or young children. The company, Comfort Care, has completely ignored it and said that they are the employer and they are going to carry on, and he is now out there working with vulnerable elderly people. Who should have an oversight to stop that sort of thing from happening?

David Mowat: There is a fitness test but it does not apply to individual carers; it applies to directors and managers. That is clear. In that instance, I am a bit surprised. Was there police involvement?

Chair: I think it has gone to the police now, yes. I do not think the police have acted yet, but it has gone to the police.

David Mowat: If there was a police involvement and it resulted in even a caution or some kind of criminal record in respect of that, I would be very surprised if, subsequently, that person was employable in a care home. That would be unacceptable to me. It is something that you would expect their recruitment standards and the CQC inspection of that to pick up.

Chair: So CQC could be—

David Mowat: Yes. One of the things they look at is the processes around that. The thing is, of course, that CQC inspections are not every day, but I would expect them to pick that up. It rather depends how forcefully the council made that point. The council does not have to commission from a care home that continues employing that person, so there is that market response. I suppose they could move him to some other part of the country. I do not know.

Q411 **Chair:** So there is a role for the CQC, a role for the police and a role for

the local authority.

David Mowat: Yes. In the instance that you said, it sounded like it could almost be a police matter, the way you put it.

Mr Jones: It also comes back to the monitoring of contracts. When a local authority lets a contract, there will certainly be parameters within which that contract should work. You would expect local authorities to be using that particular issue, making sure people are fit and proper to work with vulnerable people, as part of the criteria of that contract.

Q412 **David Mackintosh:** In terms of the workforce in social care, we have heard lots of people talk to us about the problems they have in recruiting and the high turnover rates. I just wondered what you are doing to improve prospects for care workers in order to reduce vacancy and turnover rates, to attract the additional staff needed for the coming years, and in particular to talk about the training and development needs.

David Mowat: Without sounding trite about it, one of the things we have done is increased the minimum wage, which has had a big impact on this sector. Something like 900,000 people are likely to be affected. I realise that is not a whole solution, but there is a particular issue with this sector in terms of turnover. There are rates of 25% or 30%, particularly in domiciliary. There is also an issue about zero-hours contracts, again in terms of domiciliary.

We have a recruitment and retention strategy, which the Department of Health has published, looking at turnover, vacancies and retention. One thing that is quite important here is this care certificate that has come in post the Cavendish review; we are starting to try to increase the professionalism of the role.

When I have been to really good care providers, they have often talked about the fact that they offer a career structure within it of different grades, so you start off at a certain grade and you move up. We have to get away from the tendency that sometimes is out there of people thinking, "I will do care because I do not have a job at the moment." This is a career, and it is something that is going to grow. Like I say, there are 1.6 million people in full-time caring roles, and frankly it is underpaid.

Q413 **Kevin Hollinrake:** One thing that came to the inquiry's attention was that domiciliary care workers do not get paid travel time between different visits, which I found quite astounding. They visit one person's home, travel to another and they do not get paid the travel time between the two.

David Mowat: No, they do. The minimum wage legislation says that they should, and they do. If that is the case, it is a minimum wage violation. If the result of that would be below the minimum wage, then that is illegal and should be followed up with HMRC.

Q414 **Kevin Hollinrake:** Okay. You would expect, then, a local authority, if it was aware of that issue and had given a contract to someone who was

not applying that—

David Mowat: The only caveat would be if their rate is such that it is above the minimum wage, if you see what I mean. If you pay someone £20 an hour when they are working and then they have the travel at their cost, that would be different, but the overall day, including travel time, cannot be less than the minimum wage. That would be a violation of the minimum wage.

The other minimum wage issue that has come up latterly, which is quite a serious issue, is the issue of minimum wage on sleepovers, which is potentially costing charities and carers. There is an unexpected cost—and frankly it is unexpected in terms of our costing—of about £200 million.

As you know, there was a court case around sleepovers in which the law was clarified in a way that the Government did not expect it to be clarified. Now, potentially, charities, and indeed individuals who have personal budgets, can be held liable for minimum wage violations going back six years. The potential cost is enormous, and that is quite serious.

Q415 **Kevin Hollinrake:** Penny Mordaunt, we definitely took evidence from witnesses and from the *Newsnight* programme that employers were taking that approach and not paying travel time. Is that something that DWP might take forward and look at?

Penny Mordaunt: If there were violations of meeting those thresholds, that is certainly something that would be looked at. My remit is not looking at those issues, so I have not directly been involved with those discussions.

Q416 **Kevin Hollinrake:** Violations of the minimum wage regulations would be DWP.

Penny Mordaunt: The Minister for Employment would certainly be looking at that.

David Mowat: HMRC as well.

Penny Mordaunt: Yes, it is primarily HMRC but the Minister for Employment would also be looking at that.

Mr Jones: If I can just add to that, Mr Hollinrake, in terms of local authorities employing companies I would expect that local authorities would not endorse the type of practice that you have mentioned in relation to the national living wage or the minimum wage. I know that in our discussions with the LGA, it has always been very clear about the obligations of increasing the national living wage—the extra cost that that would put on the sector and the implication of that. I do not think anyone within local government would set out to see people effectively not paid the legal amount that they are due for the services that they provide to a particular employer.

Q417 **Helen Hayes:** I want to turn now to the question of carers, who play an

absolutely vital role in delivering care across the country. First of all, I want to ask, Penny Mordaunt, what you are doing to help unpaid carers combine their caring responsibilities with work.

Penny Mordaunt: There are a number of pieces of work going on at the moment, as well as the carers' strategy that will sit with my colleagues in Health. We are looking at what more we can do for carers, both those in receipt of carer's allowance but also other informal carers, in the Health and Work Green Paper.

In addition to that, this is going to be a major theme of the fuller working lives strategy, which I can say will be published, judging by the terminology used so far, imminently. My colleague has looked at all the factors that are affecting that individual: someone who may not be in receipt of any support, not only, in many cases, with multiple caring responsibilities, but who may also be a single parent, may be in poor health themselves, considering the age that they might be, with various other complex issues and potentially on low income.

As well as support for that individual, the Minister for Employment has been looking at disincentives or blockages in the system that might mean that they have less chance, for example, of becoming more financially resilient, because they are penalised if they are earning more or doing more hours, as they will lose money elsewhere in the system.

We are trying to take this holistic approach, so the fuller working lives strategy and the Green Paper, in particular, are the vehicles through which DWP is looking at this.

Q418 **Helen Hayes:** Are you looking at the earning limit on the carer's allowance as a particular barrier to work?

Penny Mordaunt: Yes. There is the earning allowance and there is the amount itself. Clearly, just raising the amount, unless we do something else in the system, will not benefit an individual because it will affect means-tested benefits. However, the logic of raising the work allowance is there for all to see, so it is a live and ongoing issue. We have made some changes to that, but it is one thing that we will continue to look at. There are very many other things that someone in that situation will need in order to either stay economically active or, if their caring responsibilities end, be able to pick up a career that they want to do.

Q419 **Helen Hayes:** Do you think there is a case for raising the level of the carer's allowance, in order to reflect the contribution that unpaid carers make to our system and the fact that the system simply could not cope without them? Whether we call it stress or we call it a crisis, it is already absolutely straining to cope and in many instances not coping. It could not cope at all without unpaid carers. Do you think there is a case to be made for acknowledging that more?

Penny Mordaunt: You cannot put a price on what they do. It is priceless. You are absolutely right that, if they were not doing it, the consequences would be grave indeed. This is why we need to consult on

these issues and, even though we are not directly responsible for carers, why we have made it a part of the Health and Work Green Paper, because we need to really understand some of the knock-on costs to the public purse of not properly supporting these individuals.

The consultation finishes on 17 February, and we will obviously wait to see what people are recommending to us, but there are all sorts of ways in which we can support carers, through local services and through other very practical support, which might be to individuals more valuable than further cash. As I say, if we are going to increase either work allowance or carer's allowance in future years, we have to make sure that it is delivering a benefit to somebody and there is not another bit of the system that is hoovering it back.

Q420 Helen Hayes: We have heard quite a bit of evidence anecdotally from carers who have found the process of getting an assessment under the Care Act very unsatisfactory. We had a workshop session here with lots of carers. One woman there, who cares for her husband who has Alzheimer's, told me that her carer's assessment had been undertaken when she was sitting in the car in the rain, over the phone, while she was in tears, in a desperate state, and the person on the other end of the phone told her very quickly that there was no support that could be provided to her.

That sounds like an absolutely terrible experience, but there is evidence that there is a situation where increasingly local authorities cannot meet their obligations under the Care Act. I just wonder to what extent you are satisfied, as a team of Ministers, that councils are fulfilling their duties in assessing carers' needs for support.

Mr Jones: There are clear obligations set out in the Care Act. Obviously it is a Department of Health policy area, but in regard to local government, I am sure we, as Ministers, would all expect, in the way in which local government operates its services, that type of situation not to occur, because it sounds less than satisfactory.

In terms of DCLG, we do not have a direct role in setting policy in that regard, but certainly I can say to you that, with any work that the Department for Health is doing in regard to this, we will certainly assist where we can, in particular using our links through organisations like the LGA to make sure that we are disseminating best practice and getting the outcomes across the country that we need.

Q421 Helen Hayes: Have you undertaken any review of the new burdens under the Care Act, and the extent to which local authorities are able to meet them with the resources available to them?

Mr Jones: As I understand it—and I will need to come back to the Committee on this—there are a number of new burdens assessments and I think that is one of them, but I will come back to provide clarity.

David Mowat: We need to distinguish in this area between individual cases—the individual case that you just gave sounded awful; it is difficult

to say whether that is just somebody not doing their job or is a systematic issue—and whether councils are systematically unable and underfunded in order to do this duty that they have.

First of all, it is true that the guidance does not say, “You must do an assessment within X days”. It uses words like “reasonable”. My understanding is that when people complain about the time taken for an assessment, it eventually would go to an ombudsman. The ombudsman would regard anything over four to six weeks as being unreasonable, and that would be a ground for a complaint to be upheld.

In terms of the extent that we monitor that process and others, the vehicle that has been used is the Care Act stock-take, which the LGA did for the Department. The data coming back from that, admittedly from local government departments, is that they were resourced—or currently are, although they have concerns into the future—enough to maintain their statutory duties under the Care Act, which, when it was brought in, just about everybody welcomed as a step forward in terms of consistency and all that that means.

Q422 Mary Robinson: When we have been talking to carers, it is clear that many of them do not start out to be carers; they slip into it and gradually take on more and more of a caring role. Many of them perhaps do not have full knowledge of their entitlements. There has been recent coverage around the carer’s pension credit and the lack of knowledge of it among a lot of people. Could more be done, or what more could be done, to help people know more about their entitlements, and perhaps help them identify earlier as being carers?

Penny Mordaunt: There are a number of things that we can do, and I am very conscious that, even if we have stellar help and great initiatives, unless they are really communicated and understood at the front line of our services, it is no good. We are strengthening our own internal communications on that and on some new initiatives that we are doing around social tariffs and all sorts of other things, making sure that they are going to be very well communicated and easy for people to pick up, understand and access.

The other thing that DWP has, when looking to understand people’s household outgoings and the income that we think they might need—we are doing much more of that, looking at those extra costs, particularly on disability—is a mechanism where we can take into account what might be happening at a local level.

When I speak to carers, one of the struggles that they have is keeping up with, for example, a local government consultation that might be going on on who is entitled to what, so we are ensuring that we have a mechanism to take these things into account when we are deciding national policies, and we are thinking about people’s outgoings and what they need to meet those outgoings.

The other thing of note on carers with regard to our benefits is, where the carer is the advocate for the person in receipt of those benefits, that we are giving the correct weight to the carer's voice. It is fair criticism that we may have historically viewed a healthcare professional as a more authoritative person as opposed to a carer when they are submitting evidence for someone getting a particular benefit. It is about ensuring that the carer's voice is receiving the weight it ought to when we are looking at those assessments. That is probably not central to your question, but that is the contribution DWP is making.

David Mowat: The other area that people might not wholly understand, as you say, because they drift into caring, is that of entitlement to a carer's assessment under the Care Act. We do know that more carer's assessments are being done. I do not have the figures, but I very much doubt that 6 million have been done. That is something that we need to keep emphasising, because that might provide them with non-financial support in terms of what they do, recognition and perhaps occasionally respite and things like that.

Q423 **Mary Robinson:** At a practical level, is this area of the pension credits really being pushed? Is there an awareness around it?

Penny Mordaunt: I would not say it is an isolated issue where awareness is particularly low. There is a general need to ensure that people are getting comprehensive information. Quite often, you will find that, in a peer support group or a patient group that also has carers involved in it, they have their own person who is looking at this or going out to find that information.

One thing that we have done, which came into effect in December, is to use the flexible support fund, which does a number of things. We have bolstered it, and it is delivered through our Jobcentre Plus offices. It is very easy to commission things from it and there is not masses of form filling-in.

We have made sure that we have some money, and we have also communicated to our front line—I have done that via a conference call with 600 individuals on it—that they can use that support fund to build the necessary links in those patient groups, peer support group and carer groups. We can pay for an individual, their time, to come in or for us to visit them to talk through what services we have. It may be directly with the patient or support groups; it may be with Age UK or another advocacy group.

We have tried to also use the health and work consultation to build a bit more of a network from our local Jobcentre Plus offices, which are the hub for a lot of this information being given out. We want to strengthen that, and we can check what is being commissioned via each office, so we know if they are building their networks. That to me is absolutely fundamental. We have to get into the carer groups, the patient groups and the peer support groups.

Q424 **Chair:** David Mowat, you talked about the German situation. When we went to Germany, we were slightly surprised that, when people are assessed as having a certain entitlement to funding for social care, they can as an alternative take a slightly reduced amount of money and pay their own family members to care instead. Is that something that has been looked at anywhere in the government reviews that have been going on?

David Mowat: I am not aware of it being looked at. I am aware that is what they do in Germany. It is an interesting model in terms of linking informal and formal care.

Q425 **Chair:** Finally, in terms of integration, Simon Stevens, when he came to give evidence, was saying that integration is good and should deliver better care for people and reduce costs, but it is not going to be the only solution. We also had quite a bit of evidence from Manchester, which is pioneering the way and trying to link health and social care, and from Hull and other councils, saying that lack of funding in social care was a barrier to getting genuine joint working relationships built up and developed. Is that something that is coming back to you as evidence?

David Mowat: Is the question about integration or devolution?

Chair: It is about integration, but obviously Manchester is doing it in a certain way; other areas are doing it in a different way.

David Mowat: The question with integration is: what are the manifestations and tangible results of integration? One of them is delayed transfers of care. Another one would be something at the front end in terms of A and E admissions. I do not know whether or not in Manchester they have enough money. The implication from what you just said is that they do not have enough money to change the way they do things.

Chair: That is what they said to us, yes.

David Mowat: I would just ask the question: why is that different in St Helens or Newcastle, both of which are demographically as tough as parts of Manchester, neither of which has delayed transfers of care of any kind, and which have taken a different approach to integration?

You always have to ask the question, in any particular situation, of whether or not it is to do with those relationships at that point in that place, or a systematic thing like Manchester implied. As I say, I do not know why somewhere like St Helens would be able to implement what looked to me to be pretty comprehensive integration, presumably with the same budgetary constraints that Manchester has.

The sort of thing that we are expecting people to be able to do, in terms of the back end, is to plan for discharge immediately, so the social workers and the teams are immediately looking to see when they approximately think they are going to be able to discharge, whether there will be implications for housing and adaptations, how they are going to do those assessments and whether there is an enablement thing.

One technique is trusted assessor, where all organisations accept that one person can do an assessment, or we have discharge to assess, where sometimes we have not done the assessment, we do not have the care package in place yet, we have not agreed all that stuff like continuing healthcare, but we are going to discharge anyway, do it at home and sort it all out later. Those sorts of things have been done by some councils and much less by others.

Similarly, at the front end, we hear about some councils in which people going into A and E are being streamed into GP practices, because they really should be going to a GP and there is a GP there. Some places are streaming you into a social care environment; they are saying, "You are going to A and E, but, actually, you have had a fall. You just need someone to sit with you and talk about what has happened. There is not an illness here. You just need time with somebody and it is a social care issue." That is done in some places and not in others.

There are a set of techniques there, and I do not accept that the degree to which they are being taken up is driven, in the way you just said, by budget.

- Q426 **Chair:** Further down the line, what has been said is that a lot more could be done out in the community. People probably did not need to go to hospital in the first place. We could spend more money on prevention, which they have agreed to do in Germany now, which we have almost stopped doing in terms of lower levels of social care needs funding. Is that not an issue where providing a bit more expenditure in social care at the beginning could save money in the NHS, but it does not happen because of the budget?

David Mowat: Mr Blackman's question about the cigarette thing was around that. Of course, the answer is yes. You have to look at things in the whole. I asked you if your question was about devolution or not. Sometimes—maybe not in Manchester—when you break it down in that way, it is an easier problem to solve. You can get all the people in a room together, in a sense, which is harder to do in a bigger environment. Devolution ought to make this easier, although I am not sure we have seen that yet being the case. There is some evidence in Scotland that they have been able to do things there by breaking it down in that way.

- Q427 **Chair:** Devolution is great, except can you really get devolved, co-ordinated systems of government when you have local authorities with their elected-representative structure and the Department of Health with its link back to the Secretary of State all the way? You have two very different governmental systems, have you not, which you are trying to put together?

David Mowat: I have not visited Manchester, so I am not aware of how well it is all going. I am just making a more general point that when you talk about the need for integration, working together, relationships and all of that, when you define a health economy in the way that they have done in Manchester, it seems to me that they have a higher chance of

success, and for that reason I would be in favour of it. That is not to say that they have achieved that; I do not know what they have achieved there yet.

Q428 **Mary Robinson:** In addition to what is happening in devolved areas like Manchester, and with the transformation funding that has gone into Manchester, I am not sure that it is the whole picture to say that things are working well there, because in terms of the locality working arrangements, they have recently put their strategy out—I think last week—on these areas. Is transformation funding to really push these ideas forward necessary across the board?

David Mowat: Yes, but Manchester would only have got, I imagine—Mr Jones will tell me if this is right—its share of the NHS transformation funding, and under a devolution settlement it would get its proportion of it, as indeed other people will when that happens. In terms of funding to make stuff happen, we are getting into STPs and that type of stuff as well, which is looking at a wider configuration and what the opportunities are, but yes, some seed funding to help make that happen is important.

Chair: Thank you, Ministers, for coming to give collective evidence to us this afternoon. It is very much appreciated.