

Housing, Communities and Local Government Committee

Health and Social Care Committee

Oral evidence: Long term funding of adult social care, HC 768

Tuesday 24 April 2018

Watch the meeting

Ordered by the House of Commons to be published on 24 April 2018.

Members present:

Housing, Communities and Local Government Committee: Mr Clive Betts (Chair); Helen Hayes; Kevin Hollinrake; Andrew Lewer; Jo Platt; Mr Mark Prisk; Liz Twist.

Health and Social Care Committee: Dr Sarah Wollaston; Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Diana Johnson; Andrew Selous; Derek Thomas; Martin Vickers; Dr Paul Williams.

Questions 62 - 174

Witnesses

I: Douglas Cooper, Project Director, Competition and Markets Authority; Professor Martin Green OBE, Chief Executive, Care England; Andrea Sutcliffe CBE, Chief Inspector of Adult Social Care, Care Quality Commission; and Jules Constantinou, President-elect, Institute and Faculty of Actuaries.

II: Sarah Pickup, Deputy Chief Executive, Local Government Association; and John Jackson, Co-Lead, Resources Policy Network, Association of Directors of Adult Social Care.

III: Simon Stevens, Chief Executive, NHS England.

Examination of witnesses

Witnesses: Douglas Cooper, Professor Martin Green OBE, Andrea Sutcliffe CBE and Jules Constantinou.



HOUSE OF COMMONS

Q62 **Chair:** Good afternoon and welcome to you all to this inquiry into the long-term funding of social care. It is a joint inquiry of the Housing, Communities and Local Government Committee and the Health and Social Care Committee, which is a mouthful in itself before we even start, but thank you very much for coming this afternoon.

Before we come to you, I will ask members of the Committee to put on record any particular interests they have that may be deemed relevant to this inquiry. I am the vice-president of the Local Government Association. Would anyone else like to put anything on the record that may be relevant?

Kevin Hollinrake: I employ a councillor in my office.

Jo Platt: I employ two councillors in my constituency office.

Dr Cameron: My husband is a councillor.

Q63 **Chair:** Thank you very much for that. As witnesses—and thank you very much for coming this afternoon—could you go down the table and say who you are and the organisation you represent here today? That would be helpful to the Committee.

Jules Constantinou: Thank you. I am Jules Constantinou. I am the president-elect of the Institute and Faculty of Actuaries. We are a professional body with expertise in demography, finance and long-term risk.

Andrea Sutcliffe: I am Andrea Sutcliffe. I am the chief inspector of adult social care at the Care Quality Commission, which regulates health and social care services in England.

Professor Green: I am Martin Green. I am the chief executive of Care England, a representative body for care providers, both charitable and private. We look after services for older people, people with learning disabilities, and some brain injury and mental health services.

Douglas Cooper: I am Douglas Cooper from the Competition and Markets Authority. I was project director of our market study into provision of care home services for the elderly.

Q64 **Chair:** Thank you very much. I am sorry we are so far away from you down there. One problem with this room is that we set out enough tables in case everyone turns up and we cannot change the configuration very quickly, so, apologies, but we are connected to you as far as we can be.

May I say at the beginning that, if you agree with what somebody else has already said, you can just say, "I agree"? You do not have to do what politicians do and repeat it over again for a second time. I will ask the first question. Clearly there are current challenges facing care providers. Could you say what you think they are, in essence, and how they may differ between the different services that are provided and the different clientele for whom the services are being provided?



HOUSE OF COMMONS

Professor Green: As a representative of care providers, there are several issues, of which funding is a major one, but I want to start with the issue of workforce. It is becoming increasingly difficult to recruit and retain specialist workers, particularly to nursing posts, but also to get more baseline care workers. It has increasingly become a problem, and if you look at the level of churn in the sector, which is running at about 30% to 35%, we see this as a major challenge for us. Of course, it links to funding, and one of our challenges around that is the underfunding of social care in local authorities.

I do not think that local authorities do not want to give the money—they do not have the money. The Better Care Fund will be reducing, and the money that has gone into things like precept and some of the extra money has not necessarily reached the frontline, which is partly because of the greater pressures on local authorities in the numbers of people who require care and support, but also because we are starting from a very low base in terms of the funding position.

Andrea Sutcliffe: From the Care Quality Commission's point of view, the key issue is the fact that quality is variable. Four out of the five services that we have rated in adult social care are good, which is fantastic, and 2% are outstanding; but it means that one out of five services are not good enough, which includes 2% of services that are inadequate, so people cannot rely upon good-quality care at a time when they most need it, which I am sure is a worry to us all.

The variability that we see is across very many dimensions. We see variability in the key questions that we ask. When we ask whether the service is caring, we rate that very highly, and I think that is testament to the amazing dedication and commitment of staff working in adult social care services who really do want to give of their best and treat people with dignity and respect; but we worry on those questions that we ask around safety and leadership. Those are the two areas that we rate the least well when we look at individual services.

When we look at services, community services such as Shared Lives rate very well under our regime, of which 88% are good or outstanding, but the real worry for us in the type of service is nursing homes. That is difficult from two perspectives. First, 26% of them require improvement and 3% are inadequate, and those are the services being provided to people in the most vulnerable of circumstances with the highest needs.

We see variability by region. The services in the east of England are generally better; the services in Yorkshire and Humber are at the other end of the scale, and there is a gradation in between.

We also see a real concern about services sustaining their good rating and those services that we have rated as "requires improvement" struggling to improve. We have seen that inadequate services, in general, will improve after we have rated them as "inadequate," although about 18% stay at that level and we have to take further action. But those



HOUSE OF COMMONS

rated as “requires improvement” do not improve at that rate, and we have been going back to good services, I have to say largely in response to people identifying risk there, but we see about 20% of services deteriorating to “requires improvement” and 3% deteriorating to “inadequate.” My worry about that is that there are changes and pressures in adult social care that impact on people’s ability to improve and to sustain that good performance that we have previously seen.

As to what we think is causing all that, Martin has already mentioned two of the key areas. Resources are undoubtedly a factor. There have been increased costs and increased demand in the complexity of care needs that people have, and funding has not kept pace with that. That is one reason why in the “State of Care” in 2016, and then again in 2017, the Care Quality Commission said that we felt that adult social care was approaching a tipping point and that it remained precarious. That remains our concern now.

Staffing, as Martin has quite rightly said, is a particular concern, with high levels of turnover and vacancies, which means that there is a reliance on agency staff. Nursing is a particular issue and we see a lack of good-quality training. The real problem around all of that is the impact that it has on people who are using services. I know from my own family’s experience that the continuity of care of the people who come into your own home is so very important. If you have turnover, if you have agency staff, you are not going to be getting that. Equally, if you are not training and developing them so that you have a skilled and capable workforce, the very acute demands and needs that people have—for example, in nursing homes—are not going to be met in a safe way. I could probably go on, but I will stop there.

Q65 Chair: One issue around nursing homes, as I understand it, is that qualified nurses in that environment get paid less than a person with the same qualification in the NHS.

Andrea Sutcliffe: One issue that we have been looking at when we have been doing the local system reviews that are currently under way is what is happening to the workforce in a local area across health and social care. You are quite right that there is a real struggle to recruit and retain nursing staff in adult social care for all sorts of reasons. Terms and conditions, to which you quite rightly allude, is one, but there is also an issue about the support that they get, and the training and development that they might have is better in the health service than it tends to be in adult social care.

Sad to say, there is also a stigma attached to working in adult social care as opposed to working in the NHS. We regard nurses in the NHS as angels and are very positive about that, and I have heard stories from people who are working in nursing homes that they feel disregarded and as if they are second-class citizens. It is absolutely not the case, but it obviously has an impact on recruitment and retention, and how valued they feel.



Q66 Chair: What came out of the CMA study for me was that the fees paid to residential homes might be just enough to keep the home ticking over, but not enough, even in the medium term, for necessary improvements and developments. Looking slightly further ahead than the current situation, is that something about which you have particular concerns?

Douglas Cooper: That is right, Chair. We looked largely at care homes and nursing homes for the over-65s in our financial analysis, which was partly motivated by the CQC's concerns over tipping point and industry talking to us about their concerns about sustainability.

Looking at the current situation, based on financial performance in recent years, while in the main the industry is able to cover its operating costs, we found there was quite a substantial divide between those care homes that are able to concentrate on self-funders and those that more reliant upon local authority-funded residents. In the case of local authority funding, typically the fee rates being paid were, we estimate, some 10% or so below the long-term sustainable rates that are necessary to provide care home operators with the incentive and ability to modernise and to meet essential maintenance, let alone to think about any expansion of capacity to meet growing demand going forward.

The other element is that the great majority of care homes run a mixed model of local authority-funded and self-funded residents, and there is a very significant disparity in the fee rates that are paid. That presents effectively a cross-subsidy that masks the underfunding experienced on the local authority side. Those price differentials can be very large—for large operators around 41%—and that leads us to question whether this is sustainable in the long run. Will it not mean that, where care homes have the opportunity, they will increasingly specialise in serving only self-funders? It is a higher revenue stream and they can provide better value for money if they do not need to cross-subsidise.

We are already seeing that reflected in investment. There is very little investment going into care homes in areas that are primarily dependent upon local authority-funded residents.

Professor Green: That has also seen a pattern of development. In some areas where there are very few self-funders, services are not keeping pace with need and no new services are being developed; so, this is a real challenge.

To pick up on Andrea's point about training and development, the Government spend £3,615 per person per employee in the NHS on training, and they spend £16 per person in social care. If you look at the disparity between those two elements in a system that we are told is going to be integrated, there needs to be a review of those disparities of training and development moneys.

Q67 Chair: Picking up on the point about the quality of the care provided, if some care homes are providing services that are inadequate, you might



think, all right, people can go somewhere else, but that is not the case, is it, very often, particularly for people who are paid for by the local authority? They may just be told, "That is where you are going." It is almost, "Take it or leave it" in some of those circumstances, is it not?

Andrea Sutcliffe: As to the services that we see that are inadequate, you would not want somebody that you loved to be living there. In terms of what we can do about that, we absolutely are expecting those services to improve. That is something that they can work on themselves, with the providers, if they are part of a group, with the support that they get from their quality teams as well, but it is also something that the local authorities need to be working on with services around sustaining a good-quality market capacity. There are a variety of efforts across the country, including working with the health service, to improve services in inadequate care homes that we see.

There is a difficulty in moving people. We have sometimes had to do this because there are circumstances that are just so bad that we know that people are at real risk of harm and neglect, and we will move them, but it is the last thing on earth that we want to do because of the detrimental impact that it has on people's health and wellbeing.

You are quite right that, in areas where there is limited choice, it may well not be feasible for people to move to another service that is rated good because there is not one available, or, if there is, there is a very significant waiting list for it. There are some places across the country—and we see this data from our registration of new services—where we know there is a gap in the amount of services that need to be available, which will mean that people might have to move much further away, which is again no good for them and for their friends and family who want to visit them.

Q68 **Liz Twist:** I would like to ask about market shaping and commissioning, starting with Mr Green and Mr Cooper. In your view, how well do local authorities fulfil their market shaping and commissioning duties at present?

Douglas Cooper: We reviewed 20 local authorities' actions on market shaping and their market position statements, and spoke to a large number of other local authorities. A few prepare multi-year strategic plans and a few undertake forecasting of care needs, but in the main we found that the information and plans that were prepared were insufficient to provide the kind of information that commercial providers—the sector—needed to plan ahead and make decisions and investments on that basis.

We recognise the problems that local authorities face in terms of current levels of funding, uncertainty about future funding and their need to ensure that they concentrate on delivery of care at the moment. We worry that this provides a short-term focus on them, when we think there is definitely a need for longer-term planning and co-operation with the



sector in order to ensure that the sector can develop, invest and innovate as care needs expand and change in the coming years.

Professor Green: I would agree with all that Douglas has said there, particularly the issue about innovation. One challenge is that these plans often talk about needing more of the same rather than thinking about how we do things differently. It has been very helpful that the Care Quality Commission has been doing reviews of the whole of the system and looking at some of the issues around commissioning. Certainly, that is something that needs to happen. Commissioning is such an important part of the system that it should be called to account just as provision is called to account.

Q69 **Liz Twist:** Thank you. In your view, would those activities benefit from greater regulation and oversight?

Professor Green: I definitely think they would. We need to have greater regulation and oversight. Also, the plans need to be very much more future-thinking and future-proofing. We need to see creativity and innovation in the plans because that will send some really clear messages to the market about how they develop services.

For example, I would like to see issues in there about not only the numbers of services required but also encouraging people to embrace technology, to think differently about how they use services, to link sometimes care services to a range of other facilities that might be needed in local areas.

There are some big opportunities through this process of market shaping, but they are being lost because it is only focusing on one aspect, which is about the care and how much is needed in the future, rather than thinking holistically about community needs and where care can fit into those needs around the people, if they are in residential care, who they are supporting directly, but also what their role might be in facilitating support to local people in local communities who might have care and support needs.

Douglas Cooper: I very much agree with Professor Green's comments. In our market study we made recommendations for oversight. We thought this was important to create a credible commitment to the future of social care in order to provide transparency in information and engagement with providers. Also, we felt that local authorities' ability to plan for the future was highly variable. Obviously, some are very small and maybe not in a position to engage with the potential for innovation, questioning what types of care are appropriate and how best to provide it. We thought in that respect that oversight that was also able to give guidance and information to local authorities would be very helpful.

Andrea Sutcliffe: I will pick up on the basis of the role that the Care Quality Commission is playing, as Martin has alluded to that. We were asked last year by the Secretaries of State for Health, as it was then, and



HOUSE OF COMMONS

Health and Social Care now, and Communities and Local Government, as it was then, and Housing, Communities and Local Government now, to look at 20 systems across the country, looking in particular at the way older people were experiencing their journey through health and social care at points of need.

As Martin has said, that has enabled us to look at the system as a whole, which has included looking at commissioning and looking at the role of local authorities working with the NHS around market shaping. We have seen areas that have been very positive about wanting to do that and thinking about that imaginatively, but we have seen that that, too, is variable and that many of those plans are not as well developed as we would like them to be.

I have been trying to encourage us to look at this on the basis of what the local authorities and the systems are doing to think about capacity now and into the future. Are we making sure that we are looking at quality, ensuring that it is not just places, but places that we would be happy for anybody we love to use, particularly making sure that we are looking at the workforce strategy in a market-shaping way and thinking through how that can be encouraged at a local level?

As Martin quite rightly says, we are looking at innovation and making sure that we create plans that can look to the future and enable people to invest in some of the things that may help them to be more cost-effective and efficient in the future, which will help to sustain everything going forward. We have found looking at the system as a whole incredibly useful, because it is not just about what local authorities do; it is also about what the local NHS does in partnership, and in partnership with the local providers.

Q70 Liz Twist: It sounds as if what you are all saying is that we should not just be looking at the cost but at the quality and the wider field of social care, not just splitting it into residential or home care.

Andrea Sutcliffe: I would absolutely agree with you on that. As our written evidence submission to the Committee made clear, it is very important to have the conversation about funding and how that funding is going to materialise, but we cannot have that conversation without thinking through what it is going to be spent on and how it is going to be spent.

For my money, that has to be thinking about what are the needs that people have in their local communities and in the specific services, but also how we ensure that that is a service that meets their needs and aspirations, because we do not want people to be fearful of using adult social care services. We want them to see that as a positive thing that will help them to live the life that they want to live.

Professor Green: It has to be very much focused on that positive approach that enables people to be as independent as possible, and



HOUSE OF COMMONS

services should be focused on that and maintaining people at the highest level of independence they can possibly have. It needs to be a preventive strategy as well as a service strategy. People need lives, not a series of services.

Liz Twist: Can I turn now to the impact on the care market?

Chair: Before you do, Liz, Sarah wants to come in with a follow-up point.

Q71 **Dr Wollaston:** Do you mind if I come in with a supplementary? We absolutely recognise and welcome your points about the need to innovate and the workforce, but, particularly in areas that have lower levels of people who are able to self-fund, how much is funding completely the limiting factor on this?

Professor Green: It is a combination of things. Funding is a really limiting factor, but partly, as well, the limitation comes from the low funding and the fact that people are running to stand still, so they do not have the headspace to think differently and to think creatively. If you have a local authority that does not have a dynamic and creative plan, if you are running to stand still because your resources are poor and you cannot attract the right level of staff, it does not give you the opportunity to think creatively, and it also does not give you opportunity to focus, as Andrea said, on the quality. What happens is that people focus on the process of delivering a service and not the outcome to the service user. We need to shift our agenda to looking at the outcome to the service user and monitoring the outcome rather than a series of processes.

Q72 **Dr Wollaston:** Andrea, is the CQC going to be much more explicit in future where you feel there are quality issues that are simply because there is not an adequate or realistic level of funding? We have already heard it is 10% below what it is realistic to provide the service for.

Andrea Sutcliffe: We look at services on quality regardless of the funding behind them. Very many services will operate a mixture, so they will have a mixture of people who are self-funding and those who are funded by the public purse, be that local authorities or, indeed, the NHS, which obviously happens in some nursing homes as well. What is important from our point of view is that we call out the quality regardless of the funding issue. What I am certainly not going to be doing is expecting our inspectors to mediate their assessment or their expectations of services because of funding.

Q73 **Dr Wollaston:** No, I do not mean it that way round. What I mean is, are you going to be quite explicit where you think it is not feasible or realistic to recruit, train, retain and provide all the things that we want around innovation, where the level of funding is simply not adequate to do that?

Andrea Sutcliffe: When we look at services, we are not specifically looking at the funding they are getting, what the contracts are and how they are arranged in that way.



HOUSE OF COMMONS

There are two things I would say, though. First, we have been explicit in the "State of Care" in 2016 and in the "State of Care" in 2017 in drawing the conclusion that there were pressures in adult social care; that funding was indeed having an impact on that in the ways that Martin has described in terms of lack of headroom for people to develop services, but also around the levels of unmet need that there are. We see that particularly in the local system reviews where there is less of a focus on what can be done to prevent people falling into crisis and enabling them to have the life that they want to live. So, we have identified in a number of ways where we think funding is an issue, and both the chief executive David Behan and I are on record as saying that we think there should be more money.

Chair: Kevin has a follow-up on the same point.

Q74 **Kevin Hollinrake:** I think, Ms Sutcliffe, you said that as well as looking at the funding solution we also need to look at the provision, the diversity and the quality, to make sure it meets people's needs, which I entirely agree with, but doesn't one thing follow another? When we went out to Germany in the DCLG Select Committee inquiry, we saw a very sustainable system over there, with a high diversity in the range of provision, both in terms of family provision and third-party provision because there is enough money in the system. Is that not the sequence of events that really will provide the solution?

Andrea Sutcliffe: It absolutely has an impact, and I am not wanting to undermine that point at all. It is also about how people use the money, though. We see four out of five services being good, so there are an awful lot of places that get this right. They get it right because they have invested in the past and established a good foundation for the care that they are providing now, and they are investing in their workforce and supporting their staff to be capable and confident in the difficult job that they need to do. But we are seeing a real squeeze on the resources that are available.

The fact that a very significant number of people working in adult social care work at the lowest level of the national living wage is something that is concerning in attracting in really good people. The sort of job we are asking people to do is not easy; it needs to be recognised, valued and rewarded. Those are the sorts of things that we need to be thinking about as well. It is not just the pounds, pennies and pence; it is what we do with it as well.

Q75 **Liz Twist:** I would like to return to the issue of the impact of self-funders. What would you say, Mr Green and Mr Cooper, is the impact on the care market of providers' reliance on self-funders topping up?

Professor Green: My view is that we are starting to see it in terms of the development of services. They are being developed in areas where there is a self-funder market that will sustain those services. We are seeing attrition of services in areas where there are lower levels of



HOUSE OF COMMONS

self-funders. It also has an impact as to the sheer lack of resources in any particular service, particularly a mixed service, because you have to deliver to Andrea's quality standards, and the less money you have to do that, it is more difficult to achieve the quality required.

The biggest impact is going to be seen in the way services are developed, and if you look at the pattern of development you see pockets of the country that are predominantly publicly funded where services are closing or very run down because they have not had capital investment. In other parts of the country, you see lots of new services developing to meet demand from self-funders and to meet the demographic change demand. So, I think there is a big challenge there.

Douglas Cooper: Absolutely. I agree with that. The impact will vary across the country. For a lot of care providers, there is limited opportunity to turn to self-funders, reflecting local demographics, and changes will take time. However, the situation going forward is about the investment in modernisation, that you could potentially get a split of the market into a healthy self-funded sector and declining quality and capacity within the local authority-focused sector. At the moment the sector is getting by in part because the fee differential point is not that well understood by the public and not appreciated until they are in care. That situation is unlikely to be fully sustainable, and then we will see providers increasingly responding to that in where they invest going forward.

Q76 **Liz Twist:** Mr Green, you were talking about differentials in different areas. Do you see regional variations appearing where there are greater numbers of self-funders?

Professor Green: Yes, and it is often linked to the property market and the equity that people have in their properties. I am from the north of England. There are places there where a house is not worth the amount of money that would enable you to pay for your own care at a reasonable rate, whereas those of us who now live in the south-east of England are in a much happier position. We are starting to see those sorts of differences in the pattern of development. I think Douglas is right: if we are not careful, we will sleep-walk into a two-tier system. Andrea made a point that this is about trying to provide the best services for citizens who require them, rather than seeing a differentiation between those who can afford quality and those who cannot.

Q77 **Liz Twist:** Thank you. I would like to go on now to navigating the care system. How easy is it for families and service users to navigate the care system in terms of finding care and understanding how it is paid for, and in accessing different funding sources as well? Could you tell us about that, please?

Andrea Sutcliffe: We all want to do that one.



HOUSE OF COMMONS

Professor Green: With another hat on, I am a trustee of a charity called Independent Age, and we see a lot of people who are going through this process. It is incredibly complicated. In fact, I went through this process for my own father and it was incredibly complex, and I thought I was in the know.

The other challenge is that people are doing this at a time of crisis and at a time when there is very little time to make decisions. The other thing is that, sometimes, the system is not helpful in that it does not give people all the information, and people are sometimes given part of the story about what they should expect from the system. So, there is a lot of what might be described as subtle rationing by the fact that information is not given quite fully to people.

It is a major challenge to get both clear and accessible information, and to ensure that everybody starts with having all the information. Of course, you are trying to do that at a time when you are in a crisis. You might be told you have to go into a care home and, "By the way, we need your hospital bed in two days' time."

Andrea Sutcliffe: I would agree with Martin in the sense that it is difficult to navigate this system, particularly if you have both health and social care needs, and that is what impacts on people who traditionally are using adult social care services. They are moving between the different systems.

As Martin has already said—I know from my own personal experience and from talking to colleagues—we are working in health and adult social care, and we find it difficult for our family members, so what on earth must it be like for people who do not have the benefit of that insight? What I see in a professional capacity are families and people using services who are bewildered by the system.

One reason why that is so is because we do not talk about adult social care in advance. People do not think about it; they do not think it is going to be for them and they do not prepare for it. It comes as a great surprise that it is means-tested, for example. Very often, they are coming into the adult social care system at a point of crisis; either their long-term carer has died or is no longer able to support them, or they themselves have had a worsening of their condition that requires additional care. You need clear, reliable information at that point.

In a recent survey of people who had made decisions around choosing care services, over 70% of them said it was the most stressful decision that they had ever made in their lives. I completely understand why that is. As Martin says, one really important thing is that we have good-quality information for them. At the Care Quality Commission, we are inspecting individual services and rating them with a very clear indication of what we think the quality of care is and what we have recommended within those services. I know that that is helpful to people, but I think across the system there is an awful lot more that we can do.



HOUSE OF COMMONS

Douglas Cooper: We undertook two qualitative consumer surveys to find out about people's experience of going into care and helping relatives into care, and I agree entirely with the points that have been raised. There is no single clear source of information for people to turn to. There is some very good information out there provided by charities such as Independent Age and Age UK, by local authorities and some of the care providers, but people who have no experience of care and who do not understand the system simply do not know where to look and rapidly become completely overwhelmed by sources of information, and so often have to rely on very partial, ill-informed social network information or by turning to potential care providers.

Local authorities should be people's first port of call, and some local authorities do provide very clear information. For others, it is varied and very difficult to access, and self-funders particularly may feel that they are being deterred from pursuing their rights for needs assessments and guidance.

Liz Twist: Mr Green, can I pick up on—

Chair: Before we move on, I am getting conscious of the time now and we have other panels to come in. When answering questions, can you start to focus not on what is wrong with the system now but what could be done to change it for the future to make it better? I think Lisa has a supplementary to come in on the last point.

Q78 **Dr Cameron:** I am very interested in what you say. I have recent experience of constituents' parents becoming very unwell, being unable to live independently, and the constituents having to move them into their own home to look after them. There seems to be a real difficulty in services transitioning, particularly from one local authority to another—some care providers are recognised by one and not the other—and families have to navigate myriad things in the system. Could something be done to improve that for their families and their experience?

Chair: Briefly, if we could.

Professor Green: The Care Act was supposed to be giving us portability, but, in a very decentralised system, the challenge is to get people to understand that they should be connecting with each other. Also, everything should be focused on the person needing care and the system should wrap itself around the person, not the other way round.

Q79 **Liz Twist:** Looking to the future, is the answer to have better systems to provide information for services and families, or is it to change the system?

Professor Green: Both.

Andrea Sutcliffe: We certainly need to provide better information. We need to provide information that responds to people's needs at the point that they seek to access services, but I particularly think that we need to



do something a lot earlier. We need to talk about adult social care and we need to share the system with people. Whatever the system is, it needs to be explained to people much earlier. They need to understand what the potential pressures on them personally are going to be in terms of their financial arrangements and the information that they need to have access to, and we need to be encouraging that discourse in the way that obviously this inquiry is helping to do as well.

Chair: We will move on to the future now.

Q80 **Dr Williams:** I have two questions to ask. The first is about workforce and the second is about funding.

As to workforce, we have already heard you, Martin, say it is increasingly difficult to get workers. Andrea, you have talked about the need for local workforce strategies, and you have mentioned pay as well. I visited a local care home as part of National Care Home Open Day at the weekend and heard for myself from staff about their issues around being valued and having low pay.

With estimates of the increase in workforce that we need to deal with the changes in demographics of somewhere around half a million extra workers, or even more, what do we need to do to make sure that that expansion in the workforce takes place?

Professor Green: First, we need to set social care in the same space as the NHS. It needs to be seen as a career. There needs to be parity of esteem across the system. We are constantly being talked about in relation to integration and yet we have this vastly disproportionate amount of investment in training and development. We also need to acknowledge that, with those significant increases in workforce that are required, we are not necessarily going to be able to do things in the same way that we are currently doing them, so we need to start working smarter, not harder.

We need to embrace technology. It has been used in the past to beat people over the head because they were two minutes late going into their domiciliary care visit, but we need to use technology as a way to enable people to live better and to be more flexible in how they draw down services.

There are a lot of things that need to be done, but the start point needs to be in the integration debate to have a clear policy that is about the health and social care workforce. It is not helpful when we are told on one day that we have a health and social care workforce, and on the next we are told there is going to be a pay increase for the NHS staff and for nobody else. The rhetoric needs to match the practice, or people need to stop talking about integration.

Andrea Sutcliffe: I think there are four key strategies. The first is that we have to be clear about how we are going to attract people. We have already made the points about valuing people, understanding and



recognising the really important and difficult job that they do; paying those people appropriately; and promoting adult social care as a vibrant place that people can work. Thank you so much for visiting a care home on Care Home Open Day. That is one way that we can connect care homes and adult social care services with the local community so that it is not something that is hidden behind a hedge that people don't know about.

Secondly, we have to make sure that we recruit the right people. We need to make sure that we recruit people who really do want to care, people who have the innate values that would be the sorts of people that we would want our loved ones to be supported by.

As Martin has already said earlier in this session, learning and development is absolutely crucial in enabling people to have the skills and the confidence to cope with people who have dementia, for example. We know that their needs are going to increase and it will become more difficult over time. We have to make sure that people have that training and support.

We also have to kill off the idea that there is no career progression in adult social care: there is. Three of my deputy chief inspectors started off working as care assistants in the dim and distant past. A variety of people have done that.

Last but not least on the health and social care workforce point, Health Education England put out a workforce strategy a few months ago. The consultation on that has concluded. We welcomed the fact that it was there, but we wanted the "and social care workforce" bit of it to be a bit more meaningful. For example, having a health and social care workforce strategy that included a chapter that said how to make the NHS the employer of choice kind of disregards "What does that mean for adult social care?" So, we have to think about this in the round and not just add "and social care" as an afterthought.

Q81 Dr Williams: Are there any other comments? That is excellent. Thank you very much.

My second question is about money. The broad question is, how much does good care cost? How much more funding is the sector likely to need in the long term, and how can we make sure that that funding reaches the providers on the frontline?

Professor Green: One thing we should acknowledge is that there is a great differentiation between older people's care and younger adults' care. If you look at the unit cost of that, there are significant differences. We need to start from the basis of saying what it costs to provide good-quality care, which is about giving people a life. If you look at some of the learning disabilities services, they certainly are able to do that because they are much better resourced. I think there is a paucity of



HOUSE OF COMMONS

ambition sometimes in services for older people, which tend to be more process-focused rather than delivering a very good-quality life.

If you benchmark the costs of delivery in, let us say, younger adult services compared with older people services, you are looking at probably about £1,000-plus a week difference, if not more, so these are significant differences.

If you look at the benchmark—and I am sure Douglas has more stats on this—around the cost of quality care as a private payer, it can be anything from about £1,800 to £2,400 a week in terms of the delivery of good-quality care that enables you to have a personalised offering.

Douglas Cooper: On average, self-funders will pay round about £44,000 per year. For local authority-funded, that would be typically 40% less. We think that the long-term sustainable rates for the provision of care as it is need to be at least 10% higher just to cover full costs. If we look at those homes that are most at risk of being unable to survive or to invest—those who are most reliant on local authority funding—we estimate that at around £300 million a year if money was paid directly in the fee rates that those homes received, and that is just to hold still. It makes no allowance for improvements in services, changes in costs, increases in need or whatever.

In order to provide a full cost of care by local authorities for a mixed care home so that they are not relying on cross-subsidy, we are talking about £1 billion to £1.1 billion per year. Again, this is just to hold still.

The problems particularly pronounced are in relation to growth in need. Choices will need to be made about how care can best be provided, but demand for care home spaces is likely to grow between 1.5% and 4% a year. I am sorry—I have forgotten my final point.

Andrea Sutcliffe: From our point of view, we looked at the assessments that others have made of this. You will have had evidence from a variety of different people. The Local Government Association and the National Audit Office have done work on this. It certainly looks as if many of those estimates of additional funding that is required are around the £2 billion-plus mark in terms of the long-term future.

The second bit of your question, which is how you make sure that funding gets to the frontline, is a really important one. That links to our earlier conversation that this has to be about improvement; it has to be about quality; it has to be about that money being invested in a way that impacts on people.

In many places across the country, local authorities are having good conversations with their local providers. As Martin says, that is happening in an atmosphere where they really are strapped in terms of the resources that are available, but those are the conversations that need to happen. Providers need to have those conversations in a mature way with



HOUSE OF COMMONS

their local authorities, and local authorities need to be able to have that conversation to be clear about what it is that they are expecting people to use that money for and then hold the providers to account for it.

- Q82 Dr Williams:** It sounds as if there is a contradiction, though, because the providers on the one hand are being asked perhaps to pay staff more, to recruit people of higher quality, but, on the other hand, they need to produce care at the cheapest possible rate for the local authority. How do we square that circle?

Professor Green: The only way to square that circle is to put more money in the system and be really clear about the quality outcomes that you want. Certainly, if you look at the cost increases that have come through to care, the vast majority of them have been induced by Government policies. The living wage, which we are all very supportive of, is absolutely great, as is the auto-enrolment of pensions and the shift of resources from the regulator being funded by Government to those who are being regulated. All these things are added costs. One thing we have to do is that forensic analysis of what you need to deliver a sustainable, high-quality service where you can invest in the future as well.

Part of the challenge is that there has been all this overlay of Government adding expenditure, but there has not been commensurate support for extra money coming into the system. There has been a bit, but it has not been reaching the frontline, which is another challenge.

- Q83 Andrew Selous:** Do you have any proper labour market information on what you need to pay care staff in every region of the country in order to get the quality workforce that we need, given that people have a choice and do not have to come and work in care?

Professor Green: There is the minimum dataset that is produced by Skills for Care, but we do not have what it costs to deliver quality and a sustainable workforce, because it will be very different in different areas and I don't think there is that data around.

- Q84 Andrew Selous:** Don't you think there should be?

Professor Green: Definitely.

Andrea Sutcliffe: I do not think that data is around. Skills for Care, as Martin has said, provides a huge amount of information for us. The National Audit Office review of the workforce strategy for adult social care is really insightful as well, but we do not have the answer to the question that you ask.

The other thing I would say is that there are some very specific local circumstances that impact on this. For example, one of the local system reviews that we did was in Trafford. When the big supermarkets and the big mall up there expand, there is a real pressure on the local workforce



because people can go and earn as much, if not more, doing that sort of job as opposed to staying in the care system.

In the south of England, you have real pressures because of the cost of housing. Again, the cost of travel is an issue in having people available to work in the centre of London, where people live and need to have adult social care support.

Q85 Andrew Selous: I understand that, but I am sorry—time is tight. I just put it to you: you need to gather this information on a micro-level and you need to present it to Government urgently so that we know what we need to pay to attract people into care. That is the point I am making.

Professor Green: You could benchmark it against what you have to pay to attract people into the NHS, for example. There is data available from the NHS. We should see the NHS and the social care workforce as being pretty much the same because what they do is pretty much the same. It would be very interesting to benchmark how many people left the NHS to go and work in Aldi in Stafford compared with how many people left social care. What you will see is that the very big differential in the payment has translated into the fact that one is seen as a career and the other is not.

Andrea Sutcliffe: The challenge you are setting is absolutely the right challenge, and the joining together of the Local Government Association, the Association of Directors of Adult Social Services, whose representatives will be speaking to you in a minute, and the providers is really important for them to have that kind of coherent view of what we need to take this forward.

Q86 Kevin Hollinrake: These questions are primarily for Mr Constantinou, if I may. How much, typically, are people who fund their own care having to pay to do that—self-funders?

Jules Constantinou: We did a little bit of work on this in our study commissioned by Independent Age in looking at the cap. The reason for the study was that a tariff cap as proposed in the Care Act and by Sir Andrew Dilnot's Commission was difficult to understand; it was not that simple. With a cap of £72,000 in the Care Act, people would have to spend up to £140,000 of their own money before they hit the cap.

Our work looked at an all-encompassing cap based on statistics and models that were available in the market at the time but not independently researched. We found that an all-inclusive cap of £100,000 roughly equated to a care home stay of about three years. Four in 10 people going into care aged 85 would probably hit that cap. Our statistics and models would seem to indicate that 1% of people could live in a care home for up to 10 years, which would double or triple the amount that we are talking about there. I think about 20% of people probably would be in care homes for five years. It is not a uniform distribution of cost.



HOUSE OF COMMONS

The average cost that we have depicted is pushed higher, because the median cost would probably be maybe 20% or 25% lower than that.

Q87 Kevin Hollinrake: We talk about catastrophic care costs. At what level would you set that as being catastrophic, and what is not? You said four out of 10 people who enter care hit the threshold of £100,000. Is that what you said?

Jules Constantinou: Correct, yes.

Q88 Kevin Hollinrake: Is that how you might define that level?

Jules Constantinou: Yes. It is almost framing the question in terms of what people believe a reasonable stay in a care home might be. Sir Andrew's recommendation was the three-year average, and so the model we built corresponded to that. I am not sure that £100,000 would be necessarily deemed to be completely catastrophic.

Q89 Kevin Hollinrake: It depends where you start from, I guess.

Jules Constantinou: Yes.

Q90 Kevin Hollinrake: When we talk about catastrophic costs, most of us insure against catastrophic costs in our life, so why can't we in the UK? Why hasn't the insurance industry come through in the UK and provided products that would solve those problems?

Jules Constantinou: That is a complex question. It is not as simple as it seems. I will give you a little bit of history. In the middle 1990s to early 2000s there were products that were pure insurance, typically sold from a target market perspective to people around their retirement, from age 55 to age 70. That seemed to be the sweet spot from a sales perspective. But the mathematics starts to prove a little difficult.

If we assume costs of £100,000—the number that we spoke about previously—the common wisdom or statistics that come out is that at age 65 one in four males would go into care, which basically means that four males each need to pay £25,000 for this £100,000 cover to be put in place, and that almost is not commercially viable. In the current environment, in a defined contribution space where people's funds are not that big, it is a large amount of money to give away.

The insurance industry has responded, and we have a product called an immediate needs annuity. What that does is this. If you are the unlucky one, then you need to buy the insurance at the point that you need to go into care and that product provides tail risk. It provides the catastrophic risk. If you are that 1% that is going to stay in a care home for 10 years, that policy provides you with the protection that you need. I think the pension freedoms themselves will enable people to have more flexibility in how they live their retirements from 65 to possibly going into care. As I say, not everybody will go into care. The equity release market has grown, so last year I think they were about £3 billion—



HOUSE OF COMMONS

- Q91 **Kevin Hollinrake:** But, focusing on insurance, the immediate needs is about today. Mostly, insurance pools risk, does it not, among all of us and looks into the distance?

Jules Constantinou: Correct.

- Q92 **Kevin Hollinrake:** Why has that market not formed? This is the principle behind the Dilnot Commission, of course. That model was supposed to allow a situation where risk could be pooled and products would come to deliver solutions. Why did that not happen?

Jules Constantinou: It goes back to the way I described the history of the example. First, in that 1990s to 2000 period, only about 45,000 policies were sold, which is a travesty. This market is actually an advised market, so there is not really any demand from the public and there is no demand for advisers for these products. In the context of a voluntary insurance market there is not a market there.

- Q93 **Kevin Hollinrake:** Would a mandatory solution solve that problem? There would be a widespread demand and therefore the market solutions would develop.

Jules Constantinou: A mandated solution will create a greater amount of awareness from the public to say, "This is the deal between you and the state. This mandated system, where you will be paying an additional amount of funding, is meant to be a pooling."

The issue that you have with a mandated system, if you compare it with motor insurance, is that we only mandate people who own motor vehicles to buy that, whereas in care we are now mandating the whole population for the fact that very few are going to go into care.

- Q94 **Kevin Hollinrake:** Yes, but you might buy motor vehicle insurance and never crash or not perhaps suffer a terrible crash, but it pools the risk among all of us. Is that not the point behind the insurance and where the premiums are?

Jules Constantinou: Correct. That is the fundamental premise behind insurance, and we got to the point where we were saying a voluntary market would be difficult. A mandated market would create greater awareness and greater demand for that type of product. Is that the solution in an environment where, if we think about it holistically, we would prefer people to accumulate more funds until they get to the point of retirement and then almost have the flexibility to use those funds depending on their lifestyle and needs going forward? I could not guarantee that a mandated solution would necessarily be the correct answer.

- Q95 **Kevin Hollinrake:** So you are not keen on a mandated solution. That is how it has worked in Germany and Japan of course; it is a mandated solution, is it not?



Jules Constantinou: Correct. The thing about Germany and Japan—and I will talk about Germany because my knowledge of that market is better—is that that mandated solution is in no way a 100% solution. The understanding is that this is only a part solution. The German mandated solution only pays a quarter or a third of the costs that people might incur when going into care, and there is a market in top-ups and private, which Sir Andrew also alluded to in his evidence to you. Maybe that is the potential. Once we have established what the baseline is we can move on.

The other thing, thinking about it from an awareness-creating perspective and what have you, is that people seem to focus just on the means-tested elements of social care funding, yet, if you look at the non-means tested elements, there is attendance allowance, funded nursing care and the state pension, which, when all packaged together in a positive message, would maybe cover up to 40% of what people might spend in social care going forward.

Q96 **Mr Prisk:** Following on, if I can, on insurance, with the Dilnot Commission notion of putting a cap in so that people knew that after a certain point the state would step in, would that be the trigger that would make an insurance market in this field realistic, in your view?

Jules Constantinou: Not necessarily. I think there was a survey done of insurers asking this question and they were ambivalent as to whether there was or was not a cap in place. They did not see that as the reason why there has not been an insurance solution presented.

Q97 **Mr Prisk:** What is the principal reason why they feel the market is not viable?

Jules Constantinou: It is a demand question, as I explained earlier, and my colleagues on the panel talked about it earlier. People are reticent to discuss what it might feel like if you are going into care. Is it something that is going to happen to you? Do you want to talk to your children about that? It is not something that people easily plan for. The view from an insurance industry perspective is that there needs to be a greater awareness of what the deal is. People need to understand that they will be funding their own care if they have sufficient assets, on top of, I guess, national insurance and their local taxes that they pay anyway.

Q98 **Mr Prisk:** Just briefly, realistically, what alternatives are there to the insurance market? People have touched on equity release, and annuity has been mentioned in a particular aspect. In your view, which of these could prove a realistic alternative to insurers?

Jules Constantinou: I think all of them. The reason I say that is that we have not had an insurance market for the best part of 20 years, or ever, you might say, and yet when people get to the crisis point that my colleagues described they then look at all the assets. They look to see what they have as home equity; they look to see what they receive as benefits from the state; they look at their private pensions; they consider



HOUSE OF COMMONS

their other savings; they consider what support they can get both from a physical support and a financial support perspective from their families. They put that whole package together. So, the product that you were talking about will enable them to access some of those resources and funding more efficiently.

Equity release enables you to release equity in your home without having to sell it. That is a form of insurance because your equity release provider is making an assessment of how long you are going to live in advancing you an amount of money. The flexibility that people will have within their pensions will enable them to possibly buy an annuity, as described, which provides you with a regular income. The immediate needs annuity that I described at the point of care is available to protect you against catastrophic costs, although within the Dilnot model the state is prepared to take that on. Therefore, I almost see it as, "What does good advice look like to people and how can they use the products that are available today to manage their way forward?"

Q99 **Mr Prisk:** So, having a range of choices available rather than one answer is your preference.

Jules Constantinou: Correct. That deals with the individuality of each person's situation.

Chair: Thank you all very much for coming to give evidence to us this afternoon.

Examination of witnesses

Witnesses: Sarah Pickup and John Jackson.

Q100 **Chair:** Thank you both very much for coming this afternoon. Can you say who you are and the organisations that you represent to start off with?

Sarah Pickup: I am Sarah Pickup, deputy chief executive at the Local Government Association.

John Jackson: Good afternoon. I am John Jackson, one of the two resources policy leads for the Association of Directors of Adult Social Services, which is generally shortened to ADASS.

Chair: Thank you for coming. Sarah.

Q101 **Dr Wollaston:** Thank you both for coming. I am not sure whether you sat in on the previous panel.

Sarah Pickup: We did.

Q102 **Dr Wollaston:** You will have heard the challenges that they set out, so I do not feel that we need to go over that ground. I would ask you both to reflect on what you have heard from them about the challenges and how you intend to respond to those challenges. Could you also comment on how much extra funding you feel is needed in order to do so?



Sarah Pickup: Shall I begin?

Dr Wollaston: Yes, please; thank you, Sarah.

Sarah Pickup: We did hear the challenges in the previous panel. We missed the very beginning because of the incident at the front door. I would like to start with the Care Act and say that it is a good basis for setting out what we are all aspiring to do for people. There was talk about quality, innovation and focusing on wellbeing and prevention. All those things are the aspirations of the Care Act. There is an intention to focus on wellbeing and a duty indeed around prevention.

It was also mentioned that social care is about supporting people to live a life, not just to survive, and we absolutely agree with that.

The challenges we face are those of rising demand, increasing costs and reducing funding. I think there was mixed opinion on the panel, but I do not think that means that there is no innovation in the system. I do not think that means that there are not new services coming forward. If I think back 10 or 15 years, things such as extra care housing, housing-related support and enablement homecare did not exist. They are now mainstream. We could probably do with more extra care housing and more for different care groups, but they were not there, and it is innovation that those things are now there and widespread, and delivering efficiency and better lives for people.

Looking forward, one reason we are in this difficult situation is the rising demographic demand, not just in older adults but for younger working-age adults as well and the increasing costs in a context where funding to councils has been reducing, and, although inflation has been low, certainly in the costs of care with things such as the national living wage, it has been going up.

A £6 billion gap has been bridged in adult social care since 2010, and we estimate at the Local Government Association—I think this was referred to earlier—that a further £2.2 billion gap will open up by 2019-20. That includes our assessment of what is needed at a very basic level to make the market more sustainable, so some of the things that Martin and the person from the CMA were talking about. We think it will be £1.3 billion. Our assessment of that cost is based on the UK Homecare Association minimum rate for home care and looking at LaingBuisson floor rate for care homes.

We do not always agree with all the providers about how much should be paid for care and what the level of profit should be, but we accept that there is a level below which you cannot go, that you have to allow providers to have a return and that you have to be able to pay the staff appropriately. That £1.3 billion we think is needed here and now—indeed, it was needed last year and the year before—to make the market more sustainable, and then, moving forward, a further gap, despite the recent funding, opens up of about £900 million in 2019-20, and then it will



HOUSE OF COMMONS

escalate from there.

Q103 **Dr Wollaston:** Sarah, can I take you back to some of these numbers because a lot of them are quoted without end points and exactly what we are referring to. You are saying the sector needs £1.3 billion here and now.

Sarah Pickup: Per year.

Q104 **Dr Wollaston:** But then what are you estimating will be the total gap that will have opened up by 2020 for both adult and young adult social care?

Sarah Pickup: I am estimating £2.2 billion, including the £1.3 billion.

Q105 **Dr Wollaston:** So it is £2.2 billion in total.

Sarah Pickup: It is £2.2 billion in total per annum by 2019-20, but then you have demography and inflationary pressures rising from there, demography running at about £400 million per year.

Q106 **Dr Wollaston:** Thank you for clarifying that. Did you have some points you wanted to go on to make? I am sorry if I interrupted you.

Sarah Pickup: Those particular figures are about addressing the very basic issues of demographic growth, inflation, the national living wage and the provider market stability—the basics of keeping the same care going. They do not address unmet need. They do not address funding investment in prevention and early intervention, which we really need if we want to cap those costs in a different way from the other kind of cap in the future—we want to prevent needs arising—and they do not address the additional pressures of things like the sleep-in ruling that happened recently.

Q107 **Dr Wollaston:** That is what I was going to come on to next. There are a lot of people expressing grave concern about the sleep-in issue. Do you want to comment on that now and also on how much—

Sarah Pickup: It is a huge issue. It is one that rests with providers. Some of those providers are councils, but that needs to be picked up by commissioners, particularly going forward. Maybe in the short term there are things providers can do, but they will not be able to sustain their provision if they have to pay without increases in fee. So it falls back to fee levels. For providers, the biggest issue is the potential backdated pay, which amounts to millions of pounds and certainly has been quoted in the recent Allied Healthcare case as one of their big financial pressures.

Q108 **Dr Wollaston:** It keeps being kicked down the road. When do you think is the actual crunch point at which we will start to see providers collapse as a result?

Sarah Pickup: It depends on what you mean by collapse. It is like a council collapsing, isn't it? We have a provider here now going into a voluntary arrangement because it cannot meet its debts. Those debts



HOUSE OF COMMONS

include that potential liability around sleep-ins. I do not think those are the foremost of the debts that they are having to face. There are providers up and down the country handing back contracts. In 2016-17, 123 councils had 48 home care contracts and 54 residential contracts that ceased trading in the previous six months, and 43 contracts and 11 residential contracts were handed back. So, the contracts being handed back—

Q109 **Dr Wollaston:** It is happening already.

Sarah Pickup: It is happening already. That is what I meant, yes, in short.

Q110 **Dr Wollaston:** What I meant was in terms of this particular issue, when do you—

Sarah Pickup: Of sleep-ins?

Dr Wollaston: Yes. When do you think it will be?

Sarah Pickup: I think Mencap put that case better than any others, and I do not have the full details of their case with me.

Q111 **Dr Wollaston:** Okay. We will refer to their evidence.

Sarah Pickup: That would be what we would want to look at. We would happily provide that for you. We are working with them.

Q112 **Dr Wollaston:** Thank you. It is just an issue of concern, so, if you want to provide separate written feedback, you can do that.

Sarah Pickup: We are happy to do that.

Q113 **Dr Wollaston:** John, did you want to come in on this?

John Jackson: Yes. I just wanted to say a couple of things to build on what Sarah has said. The first is that the debate is often about older people. The evidence we have now is that the greatest pressures are in relation to younger adults. We do an annual survey of directors; there is a lot of coverage of this and it is in the public domain. The demographic pressures now of younger adults are quite significantly greater than they are for older people. That is what local authorities are reporting on the ground. It is about £400 million a year, as Sarah mentioned. It is £157 million for older people and £243 million for younger adults. It is really important that we see the issue of sustainability about younger adults as well as older people.

I would also refer to the LGA's submission where there is a reference to the spending figures that are on NHS Digital, which shows that spending now on younger adults is nearly as much nationally as it is for older people. There is a big issue about younger adults and the pressures in that area.



HOUSE OF COMMONS

Secondly, looking forward in terms of the financial challenges, ADASS's position—and we have only done some very initial work on this—is that by 2030 you can see the need to spend on adult social care doubling. Local authorities currently spend net, after income, about £14 billion a year, so that could double. That is the challenge. That includes the £2 billion that Sarah has talked about.

It also makes some assumptions that a state-funded insurance scheme such as that recommended by Sir Andrew Dilnot would be implemented. But the bulk of the costs are about what is happening now and about trying to make that work better for people and in a way that will be sustainable.

Q114 Andrew Selous: I have a quick question for Sarah. As to the £2.2 billion gap by 2019-20 rising at £400 million a year, is that on the current rates of pay, which are leading to a 35% churn in staff, or is that based on the rates of pay that you really need to pay to attract the right quality workforce that you then retain?

Sarah Pickup: The £2.2 billion is the bare minimum to keep the current system going, not without change, but, basically, it is not factoring in higher pay rates, more spend on prevention and not delivering you the ideal system.

Q115 Andrew Selous: What is the actual figure if we are going to pay people at a rate to attract the quality we need and keep those people in the system? Do you have a figure for what we would need to do it properly, as it were?

Sarah Pickup: John can pick that up. I might come back to it.

John Jackson: The figure I came out with, which is obviously a much bigger figure, assumes, for example, that the impact of inflation in any one year is the same as demography, so it is about 3%. I do not think that is a particularly wild assumption given that the long-term inflation rate is about 2.5% and you would expect inflation in the care sector to be marginally bigger. I suspect Martin, if he was here, would be arguing for a higher figure. If you build that in, the demography in inflation challenge, in terms of how much you spend in cash terms on adult social care, is £800 million pounds per year extra, and that is £8 billion from 2020 to 2030.

The second element is that we have made some quick assumptions about what might happen in terms of improving wages of care workers. If we take 29%—and I think MPs will recognise why I have chosen the 29% figure, because it was what the lowest paid NHS staff got in the most recent pay award—then you are probably talking about £3 billion more. I am not convinced that it would necessarily fix all the issues that you were being presented with earlier on, but we have to accept—

Q116 Andrew Selous: I am sorry. You are losing me a bit on the same question as Sarah. We have had plus £800 million per year and then plus



HOUSE OF COMMONS

£3 billion. So, is it plus £3.8 billion a year?

John Jackson: No, I am sorry. I will just go through it in a slightly different way. You start with the £2 billion a year that we need by 2020 to which Sarah referred. Then I am saying the pressures every year are an extra £800 million. In the first year it is £800 million and the second year it is £1.6 billion. After 10 years that totals £8 billion extra that you need to spend a year by 2030.

I am also suggesting that if you want to improve care workers' wages—and we would strongly support that—then you need quite a significant injection of money direct to those care workers. If you were to put up wages by 29%—and I have chosen 29% because that is what the lowest-paid staff in the recent NHS settlement are going to get—then that will probably cost about £3 billion a year. I have to say that this is quite rough and ready; it is not scientific. There is an argument for having a much more scientific piece of work, but I would be very surprised if they came up with a figure that was significantly different from doubling the spending on adult social care, and that is just to let the current system carry on as it is now.

Q117 **Kevin Hollinrake:** Mr Jackson, you are talking about it doubling by 2030—an extra £14 billion by 2030. Currently, council funding principally, from the way things look at the moment, which is going to cover this area too, is from business rates and council tax. How suitable is that in terms of meeting that need for extra resources?

John Jackson: There are a number of things that I would say. I think we would both say that we very much strongly value the place of adult social care. It is not to argue against closer integration with health, but the value of it being within local government is that it links to other important services, which are all about supporting people to live in their own communities. So it is part of the prevention agenda. Housing is the best example, but, frankly, there is a range of other local government services—

Q118 **Kevin Hollinrake:** We are talking about the funding here—matching the funding with the need.

John Jackson: I do understand that point, but I want to make the point about the place, because, if it is in the place, there is then the question of how you fund local government. The reason why there have been lots of savings made in adult social care is because the funding of local government has been cut more than any other part of the public sector, and that is a consequence. I am sure for members of the Housing, Communities and Local Government Select Committee you are very familiar with that as an issue. That is part of the problem. You have to have a solution for local government that funds local government properly if you are also going to be able to fund adult social care properly. That is the first thing.



HOUSE OF COMMONS

The second issue, which I think is what you were getting at, is, how well does the actual system of funding local government work? There is undoubtedly a potential mismatch—and I think you said this yesterday—between need and resources. The reality is that, if you have an area that is growing, then what you will have probably there is a relatively young population, more houses so you have more council tax income, and more businesses being created so you may have more potential business rate income. I know they are pooled, but it is not necessarily the case that you will have a lot more older people, who are one of the two main causes of need to spend on adult social care.

Q119 **Kevin Hollinrake:** A mismatch, yes.

Sarah Pickup: Could I add to that? There clearly is an issue about who can raise the most council tax and where is the most need, but we all know that local government finance has to be redistributed in order to deal with that anyway. Council tax and the business rate have the benefits of being a stable tax base, and we also have to think about the fact that most of adult social care is funded from those two sources at the moment. With the addition of fees and charges, £2.7 billion is paid by people themselves as their contribution towards care, and relatively little is now paid by central Government because grant bases have reduced. So the core of funding is from these sources.

If, as in one of your Committee's reports yesterday, business rates retention at 75% were allowed to be retained to help fund local government pressures, or indeed, as we would argue, at 100%, then that would go a significant way towards helping fund the challenges in adult social care. But redistribution would be critical to that. So, the fair-funding review needs to pick up not only the redistribution of business rates to match need but also—and this is being worked on because we are doing joint work on it—needs to pick up the issue of the council tax and how to take the ability to raise council tax into account.

For me, with kind of a finance and a social care background and working on both those areas of work at the moment, linking those two pieces of work together is critical, but it is not necessarily the case that rises in business rates will match the rising demand for adult social care, thinking about children's services and so on as well. So, it seems to me that there could still be a place for a Government grant in this system. If you had still some retained grant in the system or new fiscal devolution, that is probably another story, but you could go for new fiscal devolution. If you do not want too much radical change, you could say you need to retain grants because grants would allow you to equalise without quite so much redistribution of the locally raised income.

Q120 **Kevin Hollinrake:** You picked up on our report saying, basically, that there is some extra money in the system and it should be kept by local authorities to try to plug this gap, but how does that fit with the longer-term need? Mr Jackson, for example, talked about doubling of the funding requirement by 2030. Have you extrapolated potential growth in business



rates and is it going to match that doubling by 2030?

Sarah Pickup: First, my gut reaction is I doubt it. We are doing some more sophisticated work than that. We are doing some modelling up to 2025. We tend to think in spending review periods and so on. We are going to be starting with some of the very high-level figures I gave you such as maintaining the status quo, building in what we anticipate the funding changes to be, along with what we expect the demand changes to be, and looking at where we get to in terms of gap.

I have to say that John's very high figure, which I endorse in terms of the need, could be mitigated to some extent if the sources of funding were able to be raised by inflation, as most other services are allowed to raise their income to match costs. The capping of council tax alongside the cutting of grants has had a really significant impact. Councils have had no levers to raise more money with the rising demand. If you look at fees and charges, there is very little more you could extract from citizens' income to pay for their care. The charging regimes in most councils now take pretty much every penny you have spare. If you are in a care home and you are reliant on state funding, you probably have pocket money. It is called pocket money and it is not good for people's dignity in the long run, is it?

Q121 **Kevin Hollinrake:** You mentioned before about the work that is going on in terms of distribution and the fairer funding review. How co-ordinated is that with the other element of this, which is the social care Green Paper? Are those two things coming together?

Sarah Pickup: Not as much as I would like them to. It is one thing that I raise in all the meetings about both. It is really critical that they do, because, whatever funding we get for adult social care—and there appears to be a commitment that we need more funding, source to be identified—it needs to be distributed through whatever formula is devised through the fair funding formula. It needs to sit alongside the council tax business rates and, if we retain a means-tested system, the means-tested component of that system.

The thing is that, looking at the Green Paper, whatever is designed has to fit in—unless it is a whole new system and you throw all the existing funding mechanisms away—with what is there now. I think it would be very hard to say we will not fund any adult social care from the council tax or business rates, because that is what quite a lot of council tax and business rates is spent on.

Q122 **Kevin Hollinrake:** Do you have anything to add to that, Mr Jackson, or are you on the same page?

John Jackson: No, I do not have anything to add.

Q123 **Kevin Hollinrake:** Neither of you mentioned—and I do not think it is in the figures, although it may be—phase 2 of the Care Act 2014, which would put a huge financial burden on local authorities because of the



HOUSE OF COMMONS

different means-testing arrangement. What are your thoughts on that? Is that included in your forecast or not?

John Jackson: Let us be clear. First, there was an estimate given of the implementation of that element of the Care Act at the time, because there was a document published by the Department of Health, and we were working together collectively, on the implementation of that particular aspect. Their estimate was that the costs would be £2 billion. That was in the relatively short term, so within five years. If you roll it on, the expectation would be higher. Certainly, some local authorities were concerned, particularly the ones who are most significantly affected because that tended to be the areas with a lot of self-funders, that the costs were understated and it could be significant.

Q124 **Kevin Hollinrake:** I think it was an estimate of £6 billion costs over five years. I think the LGA—

Sarah Pickup: Yes. I think it was £2 billion rising to £6 billion.

Q125 **Kevin Hollinrake:** I think the LGA estimates £6 billion costs for the policy over five years, but, anyway, it is a lot of money either way.

John Jackson: It was a lot of money. Even though we were doing a lot of detailed work in a genuinely open way with the Department of Health, I would say that there is a need for more work to be done, and also it is dependent on how and what exactly might be implemented. The principles that were outlined in the commission's report were good principles, but there is the argument about where you set the cap and what you do about thresholds.

It was dealing with two issues. One was about people who had a relatively large sum of money having a cap on the amount of care they might receive, but the other issue that Sir Andrew was very concerned about was the inequity that somebody who might have bought their council house or who might have a house that was worth only £100,000, or even less in some parts of the country, would end up using up most of that to pay for their care. There was a suggestion that the threshold at which you start to pay towards your care ought to be significantly increased to, say, £100,000. There were two issues that needed to be addressed. There is an awful lot more work that would need to be done to cost up what the implementation would be in the light of whatever might be implemented.

Q126 **Kevin Hollinrake:** That was the reason why the LGA wanted to delay the introduction, Sarah, was it?

Sarah Pickup: We felt that if there were £2 billion available—that would have been an early period cost—it would be better spent providing more care in the current care system, because that was going to reduce the catastrophic costs for individuals who, while it was hard for them, were able to pay for their care, and you could spend that £2 billion providing care for people who did not have resources to pay for it. It was really



HOUSE OF COMMONS

about deferring to the point when resources were available to properly fund the core system.

We absolutely agree that catastrophic costs need to be tackled, but, in considering how social care should be funded in the future, there could be other ways to avoid catastrophic costs. You have mentioned some of them yourself in terms of risk pooling, which is different from capping risk, because in effect in the Dilnot proposals the state caps the risk and has to spend state money capping the risks for individuals who need care because the burden of the cost of care, beyond that which is paid for by the taxpayer, is met only by the people who need the care and there is no contribution from the people who do not. Therefore, we are not doing what you said and pooling the risk as we would with motor or home insurance or as we do for the NHS through taxation.

Kevin Hollinrake: That is very useful; thank you very much.

Q127 **Mr Prisk:** The central essay question of this inquiry is how we fund social care in the future. What is your answer to that question?

Sarah Pickup: Shall I start? It is clear that substantial new funding is needed. It needs to be sustainable, so whatever source is chosen needs to be sustainable. In the view of the LGA, it needs to be affordable and progressive and needs to look at national risk sharing.

The LGA's view is that all options should be on the table: taxation, insurance and non-means-tested benefits. All the sources that have been identified by the many inquiries should be on the table.

Q128 **Mr Prisk:** Does that mean that they should all be part of the answer or that you are not taking a view on which one is the answer?

Sarah Pickup: No. It means that they should all be considered, and, in my view—I should be clear that this is my view, not an LGA view—any solution is going to be a combined solution. The problem we have had in the past when different parties have come up with a proposal for one thing or for something else is that it has been seen in isolation. I think any solution to this problem is going to be a package. There is going to be a mix of things off that list, so you will probably still have council tax and business rates in there, you might still have some grant and you may have an insurance. You have to work out how it fits together, particularly in light of the complexity of the system we have. On the surface it has to be penetrable by the public, but underneath we have to work out how those things fit together.

I know that you asked the question earlier about how we should fund the increase for the NHS and social care, but, on the whole, people do not say, "Where shall we get the money from for the NHS?" They assume it will come from taxation, whereas with social care the people who run the services are asked, "Where do you think we should get the money from?" You tend not to ask Simon Stevens, "Where shall we get the money from?" You ask him, "How much do you need?" and, "No, you can't have



HOUSE OF COMMONS

it," but you do not say, "Shall we change means-tested benefits to fund the NHS?" It is a different approach to the two services, which are so often seen together, and I think that was referred to in the previous session as well.

Q129 Mr Prisk: From that, I take it that you would prefer to see the vast majority of social care funding coming from the taxation system, in whatever form—and it may be a variety of forms. What role do individual contributions have in that, if any?

John Jackson: First, ADASS's position is the same as the LGA's, which is that we do not want to rule out any means of options for funding. All the options need to be on the table because, frankly, we need a solution to this. This is a problem that has been around for at least 20 years and we have not sorted it. We do need a solution. That is, I think, the first plea.

Secondly, in terms of the pressures that I outlined earlier on, you can see them falling into two camps. Potentially, that may open up some options about funding, because part of it is about older people and the pressures there are with older people. Certainly, Sir Andrew Dilnot in his evidence talked about changing taxation in relation to older people. That may possibly be an argument for funding that part of it.

However, the issue about younger adults is that those are people who have, broadly, no resources to pay for their care, because most people who go through the adult social care system have had that disability from either birth or as a young person. There is a different solution there, and it seems to me that that is very similar to the whole question about how we fund the NHS in those circumstances.

Q130 Mr Prisk: What about older people, because obviously that is where the discussion is about individual contributions and the balance between how the funding comes from tax and how it comes from families?

John Jackson: We need to be frank. Even quite poor people pay an awful lot for their care. As Sarah has referred to, if you are an older person on a state pension, you have nearly the whole of your pension taken off you and you are left with £20 a week or something like that in a care home. If you are living at home, getting home care and you have something more than the state pension, you will contribute towards the costs of your care. They are quite significant sums for people in terms of their income. For the people who are currently paying through the state system, it is very difficult to argue that they should be paying more at that point in time.

There is a separate issue about whether you go down some sort of mandatory insurance scheme, which would expect people when they are younger to be paying it, but that raises a whole range of questions about where the greatest financial burdens are currently in society.

Q131 Mr Prisk: You have mentioned that council tax may have a part to play in this. Some have argued for a hypothecated individual tax—a national



HOUSE OF COMMONS

insurance version of maybe the current one or an amendment to that. What is your view about whether that is the answer, or is it both of your views that there is no single solution to this and it has to be a blend of existing taxes?

Sarah Pickup: I think it has to be a blend unless you were going to say that we are going to completely change the way we fund the whole system. We are tending to look at how we are going to meet the future pressures, assuming that the current funding remains in place. You change the shape of local government if you say we are not going to fund it from council tax and business rates at all in the future. Whether a tax is hypothecated or not is, in a sense, a decision for the Government. What we need is appropriate funding.

We have to bear in mind that the progressive component of funding adult social care is people paying their tax, their national insurance and their council tax. People are contributing towards what the state pays, but, if you reach the point of needing care, two people may have paid in the same amount all their lives, and, if one gets dementia and the other does not, the person with dementia can get to that catastrophic costs threshold and the other person does not. They have all contributed equally up to that point, all other things being equal.

If we are only ever saying that the state has so much money and the rest of the money has to come from the people who need care, then, as I said, we take pretty much all the people's income that they have. The Dilnot proposals enhance the taper, which would allow people to keep more savings, so if they are implemented that would allow them to keep more and reduce the income as well as the cost of the cap.

The only other place to go if an individual is going to fund and you are not going to spread the burden through risk pooling is properties. Properties are already taken into account for residential care but not for domiciliary care. Clearly, any of that would have to be subject to deferred payments and it caused a furore when it was in the manifesto. But that is why I say the one thing that comes up on its own that is not part of a bundled solution inevitably says, "Oh, that is a really bad thing because..." but you need to look right across the piece.

John Jackson: It is probably worth saying that, currently, adult social care is now funded in a very blended way, to use Sarah's phrase, because the total gross spending on adult social care is about £20 billion. Of that, £14 billion comes from local authorities as net cost, which is ultimately paid for by the council tax, business rates and by the relatively small sum that is general grant. In addition to that, some is funded from the old Better Care Fund scheme, which is effectively income from the NHS, and some is funded from the amount that people pay—the £2.7 billion that Sarah was referring to earlier.

In terms of newer funding sources, we have the precept, which is a ring-fenced hypothecated tax, you could argue, and we also have the



improved Better Care Fund, which is effectively a ring-fenced grant. So, we have a blended system at the moment, which we are living with but is not sustainable in the longer run. We need something better that is more sustainable but is also able to be blended in the future.

- Q132 Derek Thomas:** I want to try a bit of blue-sky thinking and am looking at the culture of who should pay for the NHS, which is obviously taxation, and who should pay for social care. If we were to say, okay, fine, we will just include social care and the NHS in general taxation and collect that, however much it needs to be, would you see that as developing or achieving the integration that we all long for? Would it get rid of all sorts of complications around assessments, inequalities and variations in care? If we are committed to integration, should we put the whole thing together and fund it centrally by collecting maybe more significant taxes? Would that potentially provide better value for money and more sustainable services in the long run?

Sarah Pickup: First, it would simplify how the system works together if one was not means-tested and the other was, but that does not mean the source of funding has to be the same. You could still have locally raised taxes combined with grants. Historically, until recent times, a significant proportion of local authority income was grant. It has declined since austerity and the locally raised income has risen. The barriers that you have are not because of the source of funding; they are because of the means-testing. Removing means-testing probably would facilitate integration because you would not have to work out which bit is social care and which is health.

In terms of integration, where you really want integration and probably more joint commissioning is around community, social and primary care, providing the care that people have in the places where they live, supporting them through their lives, their wellbeing and preventing them escalating into those acute trusts, which is a different sort of service.

Social care is more like community and primary care—there to help people through their lives, to help them live a life and to help with their wellbeing. The acute care is episodic, and the objective should be to have your episodic care, return to your community and be supported there. Bringing the funding together in a pooled budget way around those community-based services would be very sensible. I still do not think they all have to have the same source of funding. They just have to have the same freedoms in terms of what you can do with it. I think that the risk of bundling it all in together is the same as the risk of bundling all the health service funding in together. The money drifts up towards the acute, and the investment that is really needed in community and primary is lost.

- Q133 Mr Bradshaw:** We are never going to achieve the proper integrated service that we want if we keep fighting these turf war battles among local government, the NHS and your different political cultures, your different levels of localism and local accountability. If you were not a local



HOUSE OF COMMONS

government person, given everything else you have said, would it not make more sense, as Derek has suggested, to have a nationally funded system that is equitable, across the country and completely integrated?

John Jackson: Okay, we are both local government people and we believe in local government. The first thing I would say is that there is a huge issue about democratic accountability. While the NHS is ultimately accountable to Parliament, at a local level, most local councillors would be very critical about the extent to which they would see themselves having an ability to have a local say, and there have been various things to try to address that.

Secondly, if you talk to people who need care, they are not really interested in pooling budgets, organisational change or joint commissioning—all those sorts of things—because, frankly, they do not understand them because they are seen as management jargon. They are really interested in the way that the GP, the physiotherapist, the social worker and the care worker—if they do have to go into acute hospital—talk to each other in a way that does not cause problems rather than causing loads of frustrations. That is the issue.

The other thing is that it is not appropriate to think that the NHS does not have local variation, because it has significant local variation. To some extent that is inevitable in a large organisation that is dealing with millions of people and millions of different episodes.

Sarah Pickup: In a way, it is almost the opposite to what we need. Even in Jeremy Hunt's recent announcements and those of the NHSE around taking integration from the person-centred point of view and the personalisation pilots that are being put in place, we need to integrate around the person. That happens in a place, so we need place-based, person-centred and population-focused services, not something that is driven from a building in London or even from buildings in regions. I think you bring those services better together in local places and you get closer to what the citizens need and want.

Q134 **Mr Bradshaw:** Can I clarify that, in your joint support for a “nothing off the table, risk-sharing solution,” you would not exclude a posthumous levy on people's estates as part of that?

Sarah Pickup: By definition, saying everything should be on the table means that it should be on the table. You can call it a posthumous levy, inheritance tax or deferred insurance. Deferred payments are okay for residential care. Everybody has accepted that. Indeed, we have been criticised for not doing enough of them, so what about deferred payments for other things?

Chair: We are moving on to the integration points.

Q135 **Helen Hayes:** Slightly changing the order of my questions, I want to pick up on Ben's questioning around integration of health and social care budgets. I completely take the points you were making about



HOUSE OF COMMONS

place-based integration, but, fundamentally, if you have a combination of different organisations responsible for different budgets and cost pressures in each of those budgets, you get a situation where there are cliff edges around the picking up of responsibility by different organisations. I can certainly recall one constituent whose mother was in palliative care funded under continuing healthcare by the NHS, who lived longer than expected, and then her family was told very suddenly that it was not the NHS's responsibility to care for her any more, which created an incredibly difficult situation.

I want to ask again about integration of budgets, and, if your inference is that that type of integration is not appropriate, how do you get the smooth, place-based, person-centred care, when fundamentally there are different organisations responsible for the money?

John Jackson: I understand the issue, but the example you have given is an example of poor practice locally. There is no doubt about it. What you were hearing earlier on was examples of poor practice. That is not necessarily what is happening in all areas, because the decision about who gets continuing healthcare is a decision for the NHS. Local government can be involved as part of the process but the decision sits with the NHS. That is an NHS decision. In those circumstances, there is a consequence potentially for both the individual concerned but also for the local authority, because they have to pick it up if the person does not have the means to pay.

A non-integrated system is one where one part of the system makes a decision that puts costs on to other people without considering the consequences of that. That is a poor system, and that is a poor decision by the people who are making those decisions.

Integrated working could be very much about people understanding the consequences for other organisations of what happens, so you have the right sort of relationships going on. It would be wrong to have a single organisation, for example, that just ignores part of the issues to do it. It seems to me that some of the discussions that have been in the public domain of the NHS for the last five years have been about parts of the NHS, such as mental health, saying, "We have been neglected."

Sarah Pickup: You do not have to do big national integration to pool budgets together. Pooling budgets locally can achieve that. There is a separate issue about continuing healthcare because it does not make sense, particularly in a care home setting, where one minute you are paying for your full care and the next you are paying for nothing, when maybe a compromise would be to pay for your room and board, and then your care is treated differently. There is an issue about the costs of accommodation and care that perhaps would merit looking at.

We should also remember that there is integration around the country of older people services but particularly in mental health. I worked in an area where we integrated mental health services in 2001. There was



integrated working before, but we pooled the budgets, pooled the commissioning and pooled the provision. Over time—I worked in that authority for a further 15 years after that was done—that was sustained, but we got to the point where, when you had to work out which bit of funding was which, it was quite hard because the teams became integrated and they multitasked. We set up an agreement that said, “Okay, if someone has to reduce their budget, what is the process?” If you want to reduce your budget, you would have to say what you are not going to buy any more and what the implications will be. You have to have methods for that, but I think that is critical and you can make it work.

Q136 Helen Hayes: What impact are sustainability and transformation partnerships having, and what impact will they have, on the current problems in the social care sector?

John Jackson: In our annual budget survey we ask for a fair bit of information about that and the latest one will be coming out in a couple of months’ time, so I am going back to what came out last year from directors. Nearly all directors—something like 96%—said they could not see any direct financial benefit for adult social care coming out of STPs. Equally, though—and this is the more positive side—two thirds of them said they could not see any costs coming out.

We also asked questions about whether people were considering the workforce issues, which was one thing you touched on in your earlier session. Again, I think there are some areas for development. This is a new development. STPs as a concept in which the NHS is taking a more local approach to planning and thinking about how to move resources around is certainly something ADASS would want to strongly support, but there is some way to go because it is a different way of operation for the NHS.

The challenge comes back to how you stop spending so much on acute care, which has been the area where most of the investment in the NHS in the past 10 years has gone, and you spend more on community-based services, whether that is social care, primary care or community health services, which is the point that Sarah was making earlier.

Sarah Pickup: I think that STPs are the right thing in principle—the place-based approach is what I have just been talking about—and in fact in the NHS there needs to be more delegated decision making at a local level, because, often, what happens is that good local partnership is undone by a top-down approach. Places such as Manchester show that, with the right players and the right relationships, you can make it work, but it is almost despite the system rather than because of it. Even in Manchester, the integration is around the health and wellbeing board areas. They are pulling it together, but the integration is different in each health and wellbeing board area. I think we forget about health and wellbeing boards. They are the only statutory body around integration. If



HOUSE OF COMMONS

they had been properly empowered in the first place, we might have got a more placed-based approach at a more local level sooner.

Q137 Helen Hayes: Is it your view across the country that local authorities have the right level of role or not enough within the STP process? What is your take on that, very briefly?

Sarah Pickup: It is really good in some places, it is okay in others, but a lot of council chief executives and leaders are still telling us that they are insufficiently engaged; and there is a tendency to revert to dealing with the here and present issue, which might be financial deficits or potential projected deficits, particularly in trusts. For all the plans and talk about primary community, and the need for all those services to be in place, there is much less focus on that than on restructuring and financial challenges.

Q138 Diana Johnson: I want to ask a question about continuing healthcare and the challenges facing that budget. I want to ask your view on this. There is a proposal that £855 million can come out of that budget through efficiency savings by 2021. In the evidence to the Public Accounts Committee earlier this year, NHS England said that could be done through adapting best practice, speeding up assessments and using better care management systems. Do you think that is realistic in light of what you have said about the growing population that needs this budget?

John Jackson: In my experience, there are two ways that the NHS can make savings in the continuing healthcare budget. One is to look at whether you could get the care provided in a less expensive way. In some parts of the country, for example, the local authority commissions the continuing healthcare placement and often pays less than the NHS. In those circumstances, that seems to me an entirely legitimate efficiency saving. It has an impact on providers, because, if they are getting more income, then that worsens their financial position. Providing there is a fair rate paid, that is potentially an area where you could make savings.

The second genuine efficiency saving is that there may be ways of supporting people in a less expensive way, changing the care setting in one way compared with another, because some settings are less expensive than others but maybe the needs will be met.

Where I think there is a problem—it is only in some areas of the country; I would not say it is anywhere near the majority of areas—is where you have inadequate relationships locally between the local authority, or local authorities, and the NHS and clinical commissioning groups, and there is a decision that says, “We think we are being quite lenient in the way we interpret the continuing healthcare rules and we are going to tighten them up.” That means that fewer people get continuing healthcare and that effectively shunts the cost on to either the individual or the local authority, or both. I am not really answering your question because “I do not know” is the answer to it, but I think a degree of scepticism is not unreasonable.



Q139 Martin Vickers: Could I bring housing into the discussion, because it is clearly important that we integrate not just health and social care but the housing element as well? What progress do you think is being made?

Sarah Pickup: There is variable progress. You are more likely to see integration around social care and housing than you are around housing and health, but there are exceptions. There is definitely evidence that things like extra care housing can save money for the NHS. In East Sussex, for example, they have calculated that extra care housing saves over £1,000 per person per year. There is other evidence like that, but it is not just about extra care housing; it is about adaptations, handy-person services, assistive technology and supported housing. There is any number of ways in which housing can support people to live a life, which is the most important thing, but that make really good use of resources.

Some of the best examples at the most expensive end of care are from the people with the most complex needs in the learning disability world. Certainly, I remember going to visit a young man who had come out of a secure establishment and was now living in his own flat with a very extensive care team around him but had moved from out of the area back to near his family. This was costing less and he was living a life he wanted to live. He was doing some volunteering, he was about to go on holiday when we went to visit, and he had lost 6 stone by going to Weight Watchers with his mum. That cost less and delivered better. Having the kind of housing that supports those sorts of care plans as well as to support older people was critical to that.

An interesting statistic is that 9.5 million older people live in 43% of all homes, so if we do not look at housing we are missing a trick. I have lots of examples on this. I have some documents that I can leave with the Committee with lots of examples of good practice because there is not enough time to go through them all.

John Jackson: Can I add to that and come up with maybe a couple of suggestions for you to consider? Sarah has already referred to the transformation in extra care housing. There is a lot more to do there, but, in practice, we have gone from a position where, certainly in the middle of the last decade, there was very little extra care housing and the quality was quite poor, to one where we now have a lot more and we are beginning to see some experimental things done, such as extra care housing for people with dementia, for which, historically, the only solution for somebody with very complex needs was for them to go into a care home. There are real advantages.

The other thing we want to stress, from the personal point of view, is a very clear, positive view that people feel they are retaining their own home; it might be a different home, but they are retaining their own home. It is a different experience from being even in a well-run care home.



Secondly, there is a huge issue about older people. Sarah has just given you the statistics—the numbers. The reality is that we have a lot of older people living in their family homes and very much enjoying it, but there is a real question that, at some point in time, they are going to become harder to manage and there is more likelihood of things going wrong because of stairs and so forth. The whole question of having a housing strategy, which is thinking about what older people want, and not a question of forcing or nannying people, or anything like that, but giving some choices to older people as they age, is not only positive for social care but almost certainly positive for the housing market because it will free up some of the larger properties that families, for example, need to move into.

The planning authorities should be required to have a housing plan for older people generally, which would cover the issue of retirement housing that I am talking about, and a plan for supported living for both younger adults and older adults. There should be a requirement for the planning authority to develop that and for that to be agreed by the health and wellbeing board.

Q140 Martin Vickers: Sarah, I could see you nodding at that, so you feel that this specialist housing plan should be a routine part of the social care offer.

Sarah Pickup: Whether or not it needs to be a separate plan, housing plans need to accommodate. In our housing commission, which reported recently, and I am sure you have seen it, the report has a whole chapter particularly on housing and the ageing population, and it has some good examples in it. It is not so much that housing should be part of the social care offer. It should be if you need different housing, but we ought to use the social care offer to enable you to stay in your own home or to provide you with a different new home if you cannot stay in the one that you have lived in before. That could be about adaptations or assistive technology helping you to stay in your home, but certainly if people need to move it should not be that the only place you can go is a care home.

One development I am most proud of from when I was a director was dementia extra care housing set up and built on PCT land by a housing association, managed by a housing association with the care commissioned by the council. That got people out of secure settings, enabled them to live a life and enabled some couples to stay together.

Q141 Martin Vickers: Finally, I have one point of clarity. We have knocked around a lot of figures—all in the billions—this afternoon. I take it that the housing element is not included in those figures and we are talking about an additional cost here.

John Jackson: I am not sure it is necessarily. People who want to develop homes or housing for older people, whether that is specialist housing or things like retirement homes—the sort of offering you get from McCarthy & Stone or something like that—are not encouraged in



terms of their developments. That may be because the profit in terms of development may not be quite as great as putting up a modern housing estate with a lot of two, three or four-bedroom houses on them. So, there may be a cost in terms of whether developers will necessarily go ahead. That is a slightly broader planning issue. I do not think there is necessarily an issue for subsidy, because you have to bear mind for older people that about 80% of people aged 65 own their own homes.

For me, there is an issue about the offer we are making that encourages people who already own their own home to move into an alternative home, which might release some capital for them that might help with some of the funding of their generic needs, not necessarily care needs. If they get too old to clean, if they had a little bit of extra money, could that pay for somebody to help with the cleaning or things like that? It is a slightly different model and it is about how we prepare as a society to support people as we get older.

Chair: We probably are going to have to draw things to a close. Sarah, you can have literally two sentences.

Sarah Pickup: We must not forget working-age adults and the link to the benefits system. There was a pause in development of supported housing for working-age adults when there was doubt on the rent caps that would be placed on it.

Chair: Okay. As to the point about local plans having a particular plan for housing for older people, that was one of the recommendations of our Select Committee report that was produced a few months ago. Thank you both very much for coming to give evidence this afternoon.

Examination of witness

Witness: Simon Stevens.

Q142 **Chair:** We have tried to alter the configuration of the room, as I said earlier, but it takes two hours to do it, so we decided not to keep you another two hours while we did that. Thank you very much for coming. We have met you before, but, just for the record, can you please say who you are and what is your position? That would be helpful.

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

Chair: Thank you. Jo Platt is to begin.

Q143 **Jo Platt:** What are the challenges facing the social care system from a local government and NHS perspective, and how do these challenges vary in different parts of the country depending on the age of the service user?

Simon Stevens: You have heard from previous panels many of the elements that are causing concern. Fundamentally, there is an undersupply of social care for a range of groups of people who need it,



HOUSE OF COMMONS

both working-age adults and older adults. Secondly, the way the system works is arguably unfair and is certainly hard to navigate. Thirdly, as a result, public satisfaction with social care, as reported in the recent British Social Attitudes survey, is in fact a negative 18%, so the public itself is concerned for those reasons.

Q144 Jo Platt: Do you see variations around the country as well, with different pressures? Are there regional variations, for example?

Simon Stevens: There are regional variations in the availability of publicly funded social care relative to assessed need, and, on some measures, by organisations such as the Institute for Fiscal Studies, perhaps only about a quarter of the difference in need explains the differences in spending. There are some genuine questions to be answered there.

Fundamentally, this is about the experience that vulnerable and frail people have of care services, and, if we want to make this real and poignant, there is no better way of illustrating that than tonight's "Hospital" programme on the BBC. That gets right to the heart of the pressures and the dilemma facing the teams and the patients at Nottingham University Hospital where, on the day of filming, there were 220 patients across the hospital who were medically fit and ready to go home. This programme tells the story of what it feels like as a patient and as a family member not able to get the social care and support that you need when you are ready to go home.

Q145 Jo Platt: Do you see a difference in the age groups as well? The previous panels have mentioned that it is not just older people. It is also obviously younger people who need social care. Is that having an impact on the NHS?

Simon Stevens: Yes. Good progress is being made on joining up the health and care support that people with learning disabilities need, and we have a major programme of reducing the reliance on institutional care for a group of people who have been stuck in often outmoded facilities. Ever since the Winterbourne View care scandal, there has been a big programme to reduce the number of people who are confined to that outmoded support. That is a joint health and local authority endeavour on the health services for people who have been stuck in health facilities for a long period of time, with funding dowers to allow local authorities to create alternatives to admission.

In respect of other groups, such as people with severe and enduring mental health problems, there is good work to join up the opportunity for people to take a personal budget, and there is an important consultation under way at the moment on extending that offer to a wider group of people. But, fundamentally, the pressures are really being experienced for frail, older people, and, as we are an ageing country, that shows up in the support that people have in their own homes, in the availability of high-quality care home places where people need it, and in the fact that



HOUSE OF COMMONS

today, of the 100,000 hospital beds across England, about 18,000 people have been stuck in hospital for more than 21 days. A lot of that is attributable to difficulties getting discharged and the social care support that people need. That is the equivalent of having 36 of our acute hospitals out of action.

Q146 Jo Platt: How much extra funding is needed in the short term to tackle these challenges, and have recent Government commitments of funding for social care helped to ease pressures?

Simon Stevens: Recent funding has clearly helped ease what would otherwise have been far greater pressures, and indeed I was very explicit in arguing 18 to 24 months ago about the importance of ensuring that social care received additional funding, which it did. Various estimates have been made as to what the likely increase in funding will be over the next 10 or 20 years by the King's Fund, the Health Foundation, the Nuffield Trust and others.

The interesting point is that, although in percentage terms one of the figures that has been talked about is a 4.4% real-terms increase annually, in absolute pound notes that is a relatively modest increase. On the estimates that have been produced by the Personal Social Services Research Unit, it only equates to about £1 billion in real terms extra each year, which, on average, amounts to about £7 million per council.

This is not an impossible problem to solve, but that is holding current eligibility and current modes of provision. If we want to do more than that, then we have to get into the conversation about what that would look like and how it should be paid for.

Q147 Jo Platt: Obviously you said you championed an increase in social care, which is fantastic to hear. Do you think NHS trusts locally are advocating that? Is it something on which they agree with you?

Simon Stevens: I think across the health service people see this. People would be supportive of local authorities using the revenue flexibilities that they have now been given, but there is also a recognition that the history of social care is that this has always been a mixed-funding model, so there is also a personal responsibility and a mixed set of funding streams that produce the combined care service. We have to think about the comprehensive range of options here and not just one particular funding source.

Q148 Jo Platt: In the local authority that I represent, again funding for early intervention and prevention packages, for example, is not necessarily supported by the local NHS trust. I am not saying that it does not support them, because of course it does, and it agrees that that is the way we could go, but money is so tight at the moment that it seems to be a little bit of a battle.

Simon Stevens: Let us be clear about it. Given that there has been a pull-back in the availability of public resources, the national eligibility



HOUSE OF COMMONS

criteria require a focus on what used to be called substantial needs. That means that some of that preventive or upstream work is not being funded in the way it previously would have been. However, I do not think that the NHS makes any apology for arguing that most acutely ill and unwell people are, when times are tight, where we have to put particular attention.

Frankly, we have seen the benefits of that. We argued last year that it was very important that right across the country there was a combined health and social care focus on reducing delayed transfers of care. As a result, we have turned the tide and reduced by 1,700 beds the number of delayed transfers of care this February compared with last February. That would not have happened if that had just been an entirely laissez-faire process.

Q149 Mr Prisk: You have talked about the case of Nottingham, and that is very alive and will be acute for many viewers this evening. Do you see a wide variance between different hospital areas and their social services? Are there particularly bad areas that you are seeing as head of the national service, and why are the variances there?

Simon Stevens: There are variances, which is one reason why the targets that were set for individual areas, both for the health service and local authorities, reflected that differential starting point and set a more ambitious expectation for those areas that were starting from further behind. Some of this is about the availability of the local care services, the availability of domiciliary care and the viability of the care home sector. You probably had evidence earlier in the session on some of those topics as well.

Just as there is in the NHS, there is variation across social care, and that gives us an opportunity. However, there are particular issues around weekend working, in community health services and in social care support, care home support and particularly home care and adaptations and assessments for old people. One thing that we would be very keen to see as part of an investment and reform package in social care would be a particular focus on ensuring that people can get the social care they need on a Friday night, a Saturday and a Sunday, and not just a Monday to Friday, because that will then help patients and citizens get the support seven days a week that they clearly need.

Q150 Kevin Hollinrake: In terms of the overall quantum required in the longer term, I think you said about £1 billion a year.

Simon Stevens: That is an estimate.

Q151 Kevin Hollinrake: I won't hold you to it.

Simon Stevens: I am not saying that is the final word on the topic, but in real terms.

Q152 Kevin Hollinrake: That matches the expectations from our previous



HOUSE OF COMMONS

witnesses too. That would work out roughly to an extra, say, £14 billion by 2030 or something. You said that is only £7 million for each local authority, but I guess then you are talking about probably an extra nearly £100 million a year for each local authority by 2030. Would that be a fair estimate of where you think we will be?

Simon Stevens: I am not sure that all of that will necessarily be funded through the local authority route. That is obviously something that your two Committees will be considering. It is part of the debate that Parliament needs to have.

Q153 **Kevin Hollinrake:** But the overall quantum is about right.

Simon Stevens: Yes, it is, on a per authority area, but clearly there are constraints on the rate of growth in council tax and in business rate retention. To state the obvious, it is important to remember that, for every pound of local authority adult social care spending, another £2 is being made available through the benefits system, through attendance allowance and other DWP arrangements, and then on top of that there is the funding that the health service is transferring.

On top of that, there is the contribution made through the means-tested or the self-pay system. We have to look at that in the round, and there are obviously big questions around intergenerational fairness as to what is the right way of raising resources, particularly given the relatively advantaged position of my parents' generation relative to my children's generation when it comes to what is, I think, about £1.5 trillion-worth of accumulated housing wealth held by retirees.

Q154 **Kevin Hollinrake:** Is that to maintain the service we are providing today or is that the kind of service we would like to provide in the next 14 years? Many people would say the social care system is not providing the level of service we require today.

Simon Stevens: The figure I quoted from these third-party sources is simply to sustain what we have, taking account of our growing, ageing population, and not to expand the offer on a like-for-like basis. That would be a further question.

Q155 **Kevin Hollinrake:** We have a blank canvass opportunity here; we have two Select Committees coming together with a completely open mind.

Simon Stevens: Right.

Q156 **Kevin Hollinrake:** Yes, absolutely. You have the opportunity to tell us how you think the service should be funded in the future.

Simon Stevens: From the point of view of the vulnerable and frail people that we are particularly focused on in the NHS, priority no. 1 has to be to expand the amount and availability of social care as against redistributing the financing burden between individuals, desirable as that might be. An answer that is simply a redivision of who pays what for the current level of social care is not really going to future-proof either the



HOUSE OF COMMONS

social care services or, indeed, the health service looking out over the next five or 10 years.

Obviously, as you know, the Prime Minister announced at the Liaison Committee before Easter her support for the development of a 10-year plan now for the NHS, building on the five-year work that we have in train. For all of us in the NHS, it will be essential that, at least looking out of the first few years of that plan, the question of the availability of social care support is addressed. With hindsight, the fact that that was not done when the original NHS Five Year Forward View was advanced has turned out to be a source of additional pressure that has made it harder to do what needs to happen in the health service.

Q157 Kevin Hollinrake: You started off that answer by saying that you have to increase funds, so somebody has to put some extra money in. Who is that going to be? Is it going to be the individual, central Government or local government? What is your preference? You must have seen lots of different systems around the world and lots of different ideas on your travels. What do you think?

Simon Stevens: I hesitate to answer that kind invitation because in a sense—

Q158 Chair: Go on. We won't hold you to it, honestly.

Dr Wollaston: It won't go further than this room.

Simon Stevens: My personal point of view is that we cannot avoid the fact that, whether we like it or not, the founding deals for the national health service and for social care have been different. When we look at the question of whether working-age adults should see their taxes go up in an unbalanced way relative to the accumulated housing assets that our parents' generation have, that would be a difficult argument to win. The principle that, where people have resources, that needs to form part of the funding answer is almost bound to be part of a sustainable solution, given the implications otherwise for general taxation. But, frankly, that is straying way beyond my responsibilities to the national health service and it is Parliament's responsibility to answer these tricky questions, I suppose.

Q159 Kevin Hollinrake: Are you familiar with the German system of social insurance? They moved from a similar system of local government funding in 1995 when they moved to a pay-as-you-go scheme that allows small contributions to be made to allow pooling risk to take away the catastrophic cost. Is that something with which you are familiar, you have looked at or you have discounted?

Simon Stevens: No. I am somewhat familiar with that German system. You may have heard evidence earlier that of course that is still paying a minority of costs, so it may cap some elements of spending, but it is not a complete funding answer.



HOUSE OF COMMONS

There have been changes over time in the balance between national and local public funding, obviously, in this country too. The arrangements that were put in place after the Griffiths report on community care in the 1980s shifted funding responsibility for care home places from what had been an open-ended budget from the Department of Social Security—the DWP now—to the public funding that local authorities managed. In effect, the German system would to some extent be a move back towards a national scheme. To the extent that happened, it would mean that local authorities would really not be principal actors in shaping decisions about the way care works locally.

As a number of commentators have pointed out, there is a tension here between more localisation, including of local authority revenues, on the one hand, and, on the other hand, the desire to have greater national standardisation and public understanding of what you will get paid for by the state and what is your personal responsibility for social care. Those two things are potentially moving in different directions.

Q160 **Mr Bradshaw:** You have referred twice, Simon, to your parents' property assets.

Simon Stevens: They won't thank me for that, will they?

Q161 **Mr Bradshaw:** It makes me think that, in the balance of burden for a future long-term funding solution for social care, you recognise the pressures that working people are already under, and you would not want to rule out as part of the funding solution some sort of deferred payment on property assets. Is that correct?

Simon Stevens: That would be my personal view. We obviously have a mechanism that is not as widely used as it could be. The think-tank Reform recently laid out some of the variation that exists in the use of deferred payment agreements, and I think that is potentially part of an answer, yes.

There are other inconsistencies in the way in which fair judgments are made about the extent to which people themselves can contribute, and we have different ways of making that judgment for eligibility for care homes as against home helps and domiciliary care where your housing assets are not taken into account. The eligibility arrangements for attendance allowance, although they form part of the income for many folks in this category, are not aligned with the judgments that are being made around social care eligibility, and the judgments that are made around NHS continuing healthcare have a different set of eligibility criteria again where personal care costs are included.

So, we have very significant funding streams, each with different, arguably cross-cutting or contradictory eligibility criteria. Without in any way understating the complexity of a form of coherence or streamlining, that would appear to be important in any durable medium-term answer.

Q162 **Mr Bradshaw:** Does that mean that your view has changed from when



HOUSE OF COMMONS

the former Labour Government identified NI and an increase in NI as the way to help address the overall funding problems then, because of what has happened since, and would you not then favour a hypothecated tax or a hypothecated NI, as some people have been suggesting, as the prime solution to solving this long-term funding crisis?

Simon Stevens: Are you talking about the 2009 work?

Q163 **Mr Bradshaw:** No—whatever we did after the 2001 or 2005 election. I cannot remember, but it was when Labour wanted a penny on—

Simon Stevens: This was the response to the Commission on Long-Term Care.

Q164 **Mr Bradshaw:** No, when Labour put a penny on NI.

Simon Stevens: Sure, but that was for an increase in NHS funding rather than for social care.

Q165 **Mr Bradshaw:** Yes, so you would not favour the same fix for this.

Simon Stevens: I think all of these are potential mechanisms, and these are obviously decisions for the Government and for the Chancellor of the Exchequer. In the context of the question about how to have a sustainably funded national health service, connecting for the public the money they are paying with the service they are getting, finding a way of doing that—and there are various flavours of what that might look like—is very important, because people want to see a well-funded health service, but they also want to know that, if public resources are being used, that is where it is going and it is being used well without waste. That is part of the conversation on the NHS.

In the context of social care, obviously, it is a much more plural set of funding streams anyway.

Q166 **Chair:** I want to pick up on Ben's point there. You certainly mentioned intergenerational fairness and you raised this before with the Committee when you came to see us as well. You then went on to talk about the housing assets of the older generation and how you could then get some of those resources for people who actually need care. Are you also including in that intergenerational fairness maybe a tax generally on the assets of the older generation so that it is not just falling on the people who need care, but generally something that everyone contributes to who has assets of this kind?

Simon Stevens: I do not have a point of view on that. That is obviously one answer that some people have proposed. Taking a step back, the point here is that, right now, we have a system that has a very hard means test—as you know, £23,250, with a sliding arrangement between that and £14,250—and the fact is that most people do not understand that that is the status quo. Therefore, when you propose something better than that, but which is still not perfection, it is regarded as worse than the status quo rather than a significant incremental improvement.



HOUSE OF COMMONS

That is something that the Committees will be thinking about very hard, because, until people understand our legacy position, it will be harder to win an argument about what a better future needs to look like.

- Q167 **Chair:** You made the point that a significant source of new funding was found that came in—some sort of hypothecated tax. That might undermine the position of local government, being the prime drivers of provision of social care, but would it—because it might simply reinstate the revenue support grant funded by that means that existed a few years ago? Local authorities then were still the prime commissioners and leaders in terms of social care in their areas. Could that not fit together?

Simon Stevens: It depends how standardised a national formula or view there is as to what the adult social care spending should be.

- Q168 **Chair:** That is about provision rather than funding, which is slightly different.

Simon Stevens: There is a funding mechanism and then there is a discussion about how much variation in funding in quantum there should be in different parts of the country. If you look at, for example, what happened when schools' budgets were pulled out of local authority responsibilities—I guess in around 2005-2006, was it, but I defer to the Committee?—the net effect of that was that a lot of the discretion that had existed was then withdrawn from individual local authorities.

Given that adult social care is around a third of local authority spending over the parts that they control, if you were to nationalise that by saying, "Here is the fixed amount that has to be spent on each part of the country and here is the dedicated mechanism, be it a national insurance or a German social-insurance-style system and so on," you are removing some of the decisions that at the moment are the responsibility of local councils, which may be a good or a bad thing, but you just have to know what you are doing when you go into it.

- Q169 **Helen Hayes:** What impact are sustainability and transformation partnerships having on the social care sector? In particular, we had some comments from a previous panel that local authorities are not as engaged as they could and should be in the STP process consistently enough across the country. Could you comment on that as well?

Simon Stevens: Yes. The Health Committee had a hearing on this question around integration a few weeks ago and we discussed that. I would say, on average, the situation has improved quite significantly over the last 12 to 18 months, but within that kind of average improvement there is a range and there are some parts of the country where people are having very constructive conversations about the total resource, opportunity and the pressures in their system, and there are others where there are still antagonisms sometimes driven by difficult decisions that have to be made around the structure of local services. There is often a local political dynamic to that, and that is probably just inevitable given the way local politics plays out in some parts of country. It takes



HOUSE OF COMMONS

two to tango and both dance partners are getting closer to each other, but we are not yet ready for "Strictly."

Q170 Helen Hayes: Okay. In your view, should health and social care budgets be fully integrated, and, if so, at what scale geographically, and how should that integration take place?

Simon Stevens: In aggregate across England, I think my answer is no. The reason for that—as I said, actually, on the first day I came to do this job—is that putting two leaky funding buckets together does not make a watertight health and care service. If you are going to combine budgets, you have to either allow it to be voluntary for both parties to the agreement so that people can look into the whites of each other's eyes and make sure that one person's contribution is not being used to substitute what the other party should be bringing to the table, or you have to specify a floor level of contribution that each party has to bring to the table and then allow people to do more on top of that.

For various reasons, neither of those circumstances holds across all of social care and the health service across England. However, I would say three things. First, there are many parts of the country where they are now embarking on that journey, and in fact in some places they have several years of experience under their belt and they are seeing significant gains when they do it, but that is built on mutual trust. It is that kind of voluntary endeavour that is hard to mandate from sitting in my chair or that of a Government Department.

Secondly, it probably makes more sense for particular groups of individuals—such as people with learning disabilities, wheelchair users, or people with ongoing frail elderly care needs—where there may well be a strong case for doing it, but that is not quite the same as saying, as a general block of cash, all of social care spending and all of NHS spending should be pooled.

Thirdly, this is proving particularly successful in those places where it is the individuals themselves controlling the combined resources of the health service and social care through integrated personal commissioning—the personal health budget programme—and, there, people are making often different decisions than the statutory agencies would have made separately or together. We have more than 22,000 people now in England with those personal health budgets, and the consultation that we have just kicked off from now through to 8 June is offering to extend that as a right to everybody who has ongoing social care needs and is a long-term user with health needs, people with wheelchairs, people with mental health aftercare, armed forces veterans coming out of the armed forces with significant needs, people with learning disabilities and those with continuing healthcare. We are seeing real gains there.

In a nutshell, trying to mandate it when you do not have the requisite basis of trust locally would probably fail; trying to do it across the board



HOUSE OF COMMONS

rather than for particular client groups is probably folie de grandeur; and, wherever possible, empower individuals and families to make the integration decisions, because their decisions about what needs doing will often look different from the army of professionals with clipboards doing constant needs assessments, which is often part of the fragmentation problem rather than the join-up.

Q171 Helen Hayes: In that model, is there an issue about the quality of access to information that individuals have who are often vulnerable people and who often have a great deal to contend with in their personal lives? We do know about some of the problems around employment relationships under personal budgets and certainly I have examples from within my constituency of very good community organisations whose grant funding has been eroded as a consequence of funding being put into personal budgets, but they are not being recommissioned by people who are not aware of the range of choices available to them.

Simon Stevens: We have found these arrangements work most successfully where there is an advocacy organisation or a patient group working alongside the individual to help them to get that information and understand those choices, but it will sometimes be the case that people, when given the chance, will choose a different range of services than those that grant-makers or others might have decided a priori should be available, and that is the grit in the oyster.

Q172 Helen Hayes: Continuing healthcare funding seems to be an exemplar of one of the types of problem that can arise when there is not integration. We have had lots of evidence, not least from members' own experiences, of some of the cliff-edge, very difficult situations with which patients are faced as a consequence of continuing healthcare. Could you comment on continuing healthcare, the problems it presents and how you see its future planning out?

Simon Stevens: The spending by the NHS on continuing healthcare is of course continuing to go up, but there is wide variation in access despite the national eligibility framework, and so there is an opportunity to drive efficiency in the rate of growth, which is what we are seeking to do. We know that there are improvements from the point of view of the individual that could be made. If your assessment takes place in a hospital versus when you are back home, often different decisions and better decisions can be made.

Fundamentally, I suspect that, as to the money that is being spent on continuing healthcare alongside the money that is being transferred from the NHS budget to councils through the Better Care Fund alongside some of the adult social care spending itself, it would be better in a redesigned, integrated support system to think of that as part of the total pot rather than the way, historically, these different eligibilities and buckets have arisen.

Q173 Helen Hayes: Do you have information on how many continuing



healthcare decisions are contested across the country?

Simon Stevens: Yes. It is a pretty small proportion. I have previously discussed this with the Public Accounts Committee and I can send you the latest figures.

Q174 **Dr Wollaston:** Following up from that point, would you support the proposals from the Barker Commission that it is not such a cliff-edge, all-or-nothing situation and that we would be able to support more people if we slightly changed the way that that operated?

Simon Stevens: It is worth looking at, yes, because, in regard to what you said earlier, Sarah, on continuing healthcare, you have some programmes where personal care is paid for by the state, some where your housing assets are taken into account and some where they are not. We do not have a consistent way of matching your needs to your ability to make a personal financial contribution, and coherence across these different public-funded buckets would be advantageous from the point of view of an individual.

Dr Wollaston: So we should look at the whole thing.

Chair: That is absolutely spot on the button as we have a Division. Thank you very much indeed for coming to give evidence to the Committees today.

Simon Stevens: It was a pleasure, thank you.

Chair: Order. That brings us to the end of our public proceedings.