HOUSE OF COMMONS

Levelling Up, Housing and Communities Committee

Oral evidence: Long-term funding of Adult Social Care, HC 35

Monday 25 April 2022

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Watch the meeting

Members present: Mr Clive Betts (Chair); Bob Blackman; Ian Byrne; Florence Eshalomi; Ben Everitt; Darren Henry; Kate Hollern; Andrew Lewer; Mohammad Yasin.

Questions 170 - 214

Witnesses

[I]: Sarah Pickup, Deputy Chief Executive, Local Government Association (LGA); Gavin Edwards, Senior National Officer for Social Care, UNISON; and Adrian Jenkins, Director, Pixel Financial Management Ltd.

Examination of witnesses

Witnesses: Sarah Pickup, Gavin Edwards and Adrian Jenkins.

Q170 **Chair:** Welcome, everyone, to this afternoon's session of the Levelling Up, Housing and Communities Select Committee. Our inquiry this afternoon is into the long-term funding of adult social care. We have one panel. I will come over to introduce the witnesses in just a second. First of all, I will ask Committee members to put on record any particular interest they may have that may be directly relevant to this inquiry. I am a vice president of the Local Government Association.

Mohammad Yasin: I am a member of the Bedford Town Deal Board.

Ian Byrne: I employ a councillor and my daughter is a councillor.

Florence Eshalomi: I am also vice chair of the Local Government Association.

Kate Hollern: I employ a councillor.

Bob Blackman: I am a vice president of the Local Government Association. I employ councillors in my office. My sister works in a care

home as a volunteer, and my late sister, who died recently, was a resident in a care home.

Andrew Lewer: Vice president of the LGA.

Darren Henry: I have family members in residential care.

Chair: Thank you for that. I will come over to our panel this afternoon. Thank you all very much for coming. I will just go down the table in that order if I can, Adrian Jenkins.

Adrian Jenkins: Hello, I am Adrian Jenkins. I am a director at Pixel Financial Management. We advise local authorities on funding and forecasting. We advise a wide cross-section of different types of authority. We also advise the county councils' network and rural services network.

Gavin Edwards: I am Gavin Edwards. I am UNISON's senior national officer for social care. UNISON is the UK's largest trade union and the largest trade union in the social care sector.

Sarah Pickup: Sarah Pickup, deputy chief executive of the Local Government Association, and among other things I lead on finance policy and also adult social care and health.

Q171 **Chair:** Thank you all for coming this afternoon. Just to begin, I suppose it is appropriate to go to Sarah Pickup first because the question is: how has funding provision changed since we as a Committee last looked at this issue in 2018? You were actually a witness to our inquiry then, so it is appropriate that we ask you first. What do you say different to us today than what you said four years ago?

Sarah Pickup: Thank you very much. In a way it is a shame, isn't it, to be back here talking about the same thing because I think the underlying issues perhaps haven't changed but some things have changed. I think there is a greater focus on adult social care than there was. It is much higher in the public perception and on the Government's agenda. There is a much greater ambition, but, although I don't think the fundamentals of financing have changed, whether that ambition is matched by the resources is a question.

In terms of how the funding has changed, there has been an increase in dedicated social care funding since 2017-18 of about £2.3 billion. That is against a backdrop where other general Government grant funding to social care authorities reduced by £0.7 billion, so there is an offsetting amount on the general council budgets.

One of the biggest changes over those four years is the increasing reliance on council tax and adult social care precept to fund adult social care, with an increasing proportion of the funding for adult social care funded in that way. There has also been an increase in ring-fenced funding; the precept funding is ring-fenced, but so are some of the grants

that are now forthcoming, so the pattern and the mix of funding has changed over those four years.

It has increased but we still believe that adult social care has had to deal with a funding gap of about £6 billion over the last decade; not over those last four years, but over the last decade. The councils have met that by making savings on adult social care itself, but also in making savings elsewhere in the council in order to protect adult social care because the amount of the council's budget that is spent on adult social care has increased in percentage terms.

Chair: Gavin Edwards, do you want to follow up anything there?

Gavin Edwards: Yes. From UNISON's point of view, there is a growing concern that problems around long-term funding for adult social care are becoming more acute. Research that UNISON has done, through freedom of information requests to councils, has shown that in 2022-23 there was a £2.4 billion shortfall for councils in London with regard to expected spending versus income. In 2023-24 that is another £2.3 billion and that is moving across different types of councils and councils of different political control.

There is definitely a deepening of those problems and, as Sarah has said, because adult social care is such a big part of the revenue spending of so many councils, there is only one effect that that is going to have, which is cuts in spending on adult social care but also trying to protect it. We have certainly seen at UNISON, notwithstanding the pandemic, increases in the numbers of inquiries that we get from our members around issues like staffing shortages, for example. That is certainly something that has become more acute in recent years, so the impact of the limits in funding that we are seeing is starting to have an impact on the ground. That is having a knock-on effect on the quality of care that people can receive as well.

Adrian Jenkins: The funding for social care has changed quite significantly. Casting our minds back to 2015-16, I think that was the point where, before that, both funding and spending had been falling in cash terms. Since then, funding has increased quite significantly in terms of specific social care grants and also in terms of very large increases in council tax, both for social care precept and council tax more generally. Certainly, in the middle of that period, from about 2016-17 onwards, we saw that even those big increases in resources were not enough to keep pace with the growth in spending.

Things seemed to change round a little bit in about 2019-20, where spending hasn't increased in social care quite as quickly as some of those social care resources. We have had some fairly consistently large increases in social care grants and big increases in precept as well, so I am not quite sure what has happened there.

Some of the increase in funding that we have had since 2015-16, a lot of that was about addressing that really severe crisis in funding that we had in the middle of the decade. Since then, as Sarah said, there is competition from other services within local authorities that probably had less funding over that period and have come back and started to compete for those resources.

Looking back over the last decade, it was a period where those early years were really severe and we saw overall local government reserves falling quite quickly. Since then, those reserves have started to move back upwards again. Therefore, I think funding has been better, particularly in the last two or three years, and certainly since 2016-17 onwards that funding has improved.

Q172 **Kate Hollern:** Thank you. If I can direct this question to Adrian, please. We spoke about public funding for adult social care from a mixture of the central and local government financing settlement, council tax and soon the health and social care levy. Is the balance right between these sources of funding?

Adrian Jenkins: I am not entirely sure that it is. I think it is right that social care is funded from a combination of grants from central government and from council tax as well, including the precept. Part of the problem is that the ability of different councils to generate income from council tax is very unbalanced. Some councils have been able to increase their income from council tax quite significantly, even with just the 2% or 3% increase in Band D every year.

To some degree I think that the way that the grants have been allocated—using the adult RNF and adjusting for council tax within that—have been quite successful in mitigating the disparities in different levels of tax base, but I think that more needs to be done probably just to make sure that all types of authority have the same access to funding, so I think it is right to balance those two things together.

Council tax has accounted for about 58% of the increase in those resources since the middle of the decade, so most of the heavy lifting has been done by council tax rather than government grants. I think that that is quite an important point. The issue with the health and social care levy is that most of that is going to be spent in local government on funding reforms—they will come with additional costs to local government as well, so I am not sure there will be all that much from that health and social care levy for local government itself to actually spend on existing services.

Q173 **Kate Hollern:** Thanks for that. You mentioned the council tax and how some authorities can raise significant amounts with, say, 1%, and others less so. Are you able to present data that can give us a sense of the disparities between the different regions of the country?

Adrian Jenkins: Yes, that is something we can do. We have been trying to work out—and we are not quite ready to share that yet—what it looks like in different parts of the country in terms of tax base, so the amount of council tax income that different authorities in different parts of the country can raise relative to the increase in grants. We would certainly see some county areas that have larger tax bases and more access to growing their council tax base. They have had larger increases in resources over the last five or six years than other parts of the country that have less access.

Where we do look at some of the more deprived parts of the country, some of the metropolitan districts, for instance, they have much smaller tax bases relative to needs, but I think they have had a reasonably good share of the social care grants because of the way the adult relative needs formula works.

Kate Hollern: We would certainly be interested in that detail.

Sarah Pickup: Could I assist? Without going into the precise details of the regions, on average, a 1% precept has added 1.45% to adult social care spending, but the range is from 0.68% to 2.2%, depending on your ability to raise council tax. Although the relative needs formula adjusts for council tax, it is very out of date and so the current increases in council tax are landing where they land.

The LGA's position has been that council tax is a poor way to fund social care in its totality, because it doesn't rise in line with the needs that you are trying to meet. We had argued in our Green Paper, back in 2018, that the Government should look at raising national taxation to fund social care, and indeed the Government did and put the levy in place but, as Adrian said, the majority of that levy in the first instance is going to the NHS and the bit that is coming to social care is being used to fund the charging reforms and some of the other White Paper reforms, but only to a relatively low level, so it doesn't address the issue we were suggesting needed to be addressed in 2018. It addresses a new issue.

Q174 **Florence Eshalomi:** Can I just come in on that point—just where you touched on the challenges of complex needs? I think it is a good thing that we are seeing advancement in medical improvement but that then has a knock-on effect on the additional care that people need in social care. Is there any work being done on looking at the range of the more complex element of people's needs?

Sarah Pickup: Yes. Obviously, that varies quite a lot between older people and people with complex disabilities, but there are some statistics about the kind of average size or cost of packages of care or direct payments budgets that are available to people. I do not have them in front of me, but there is data that shows that there is not only a rising volume of people needing support, but that the average complexity of need has increased.

That may be partly skewed because the people with less complex needs right at the bottom end tend to drop out of the system because of the eligibility squeeze and the shortfall of resources, so there is some unmet need at the lower end of need in the system.

Q175 **Florence Eshalomi:** From a staffing perspective, Gavin, how are staff within the care sector responding to the fact that, a few years ago, staff within a sector would have an understanding or a level of training to deal with that? Again, you are seeing more people coming forward with complex needs and how is that being managed with staff?

Gavin Edwards: Just coming back to Sarah's point about the need to match spending with the needs of local communities, I think that is the key point. The feedback we are getting from our members who work in social care is that the funding is not adequate for the needs of the modern population. We all know about unmet care needs, but I will receive reports on a daily basis from members saying that they are having to run between care recipients in a care home because there are simply not enough staff on shift.

We receive reports of people who are at end of life and should be receiving more intense end of life care, and people are simply not able to be with them when they should be. I think that the greater complexity of care that can be provided because of advances in medical science is an important point, but I think a lot of the basics are not being done and that continues to be a major problem.

If I may, Chair, just give you one quote on staffing shortages direct from a care worker. This is what one person said to us at the end of 2021, "People aren't getting regular baths or showers, just a wash. There is no time to do the job properly. Some are not getting dressed until 2.00 pm and assisted feeding is rushed. Staff are exhausted, angry and upset because they know they just don't have the time to do everything that they should". I think, yes, of course we need to look at new needs but the basics are quite often getting missed.

Q176 **Kate Hollern:** Can I just ask finally: we know it is very difficult for local councils to forecast the growing needs and the desperation in some areas. Is there anything that either of you would like to see the Government do to help that situation?

Adrian Jenkins: From my point of view, the one thing that would be really helpful would be greater forewarning about what resources are available, what grant increases we can expect, what the rules will be, what the maximum increase in precept is, for instance. Even at this point, we don't know if there will be any further increase in grant in 2023-24 or 2024-25. All the resources from the Spending Review have already been allocated in the current financial year. There is no further growth allocated for future years.

I cannot quite believe that that will be all local government will have and that there won't be any further increases in grant, so knowing more about it earlier I think would help an awful lot. Clearly, the quantum of funding that we have had, including council tax, has, I think, been enough to fund the increase in spending that we have had. However, that is probably only keeping steady state with where we have been, addressing some of the immediate concerns that there have been—the immediate pressures that there have been on the service.

Therefore, if we are going to have an increase in what local government does there will need to be quite a big increase in the amount of funding that is available to us. Typically, we have seen about £900 million-worth of additional funding every year from council tax and from grants. That is about a 5.5% increase in cash terms per year. To get more out of the service, I think there will need to be more money going into it.

Sarah Pickup: Certainly, at a national level, we use PSSRU figures to project forward demand. We use OBR figures to project forward inflation. I think you have some questions later about how inflation has changed, but some of the greatest uncertainties at the moment affecting our ability to project forward are the changes to the National Living Wage where however hard councils are trying to plan to meet the kind of next uplift it changes and it is not firmed up, because it is a percentage of median pay. It is very difficult to plan to accommodate it either in councils' own pay scales or in commissioning of services.

Then, of course, there is the cost of the charging reforms because it is so uncertain. Estimates and assumptions have been made in impact assessments and in councils' own work, but it is very difficult to be certain about the impact of those charging reforms and, in particular, the impact of section 18(3), which is where self-funders will be able to ask councils to commission care at the rates that they currently pay. That could cause a big cost pressure on councils, but it is quite hard to project.

Kate Hollern: Do you have anything to add, Gavin?

Gavin Edwards: Yes. Just on the point about the short-term nature of a lot of the funding that is coming in. I think that that is a really crucial point. We may come on and talk about the infection control fund and the recruitment and retention fund a little bit later. These are significant pots of money that are coming in on a short-term basis, but I don't think that allows councils to plan ahead.

This is a vital public service that we are talking about and, in fact, at a regional level we should be able to plan ahead in terms of what the offer is going to be on social care. I think the short-term nature of those pots of money means that that is simply just not possible.

Kate Hollern: Very difficult to plan on a short-term basis.

Chair: Moving on to short-term issues, Bob Blackman.

Q177 **Bob Blackman:** Thank you. Leading on to my question, as you have already mentioned, looking at the immediate future, we have the National Insurance employer contributions rising. We have inflation rising, which obviously has an impact on staffing levels and—I am sure, Gavin, you will tell us—the demands for extra pay, quite reasonably. What is the position in terms of the funding pressures at the moment and do we have an estimate of how much immediate short-term funding needs to be provided? I will start with Sarah first.

Sarah Pickup: Thank you. When I talk about immediate pressures here I am looking forward and setting aside the fact that there isn't enough funding to do everything that needs to be done now, so I am looking at inflationary and other pressures.

When the Spending Review and the settlement were put in place, the LGA's view was that settlement for 2022-23 was sufficient to meet the forward pressures in that year, but that there was a £1 billion gap opening up by 2024-25. Of course, we have been recasting our figures because of the change in OBR estimates and the change in the National Living Wage projections, and we are still in the process of finalising those calculations. They are not signed and sealed yet.

Just to give you an idea, we think that a gap has now opened up in 2022-23, just on that kind of inflation and wage pressure of about £400 million. Then we think that there is a further £800 million in 2023-24. That is partly because the National Living Wage uplifts for the following year have to be prepared for in the year before because when you hit 1 April you have to pay that new higher rate. Then there will be a further shortfall—around £500 million—in addition to what we had previously said in 2024-25.

There is an immediate impact. If you see that alongside the requirements on councils to implement the fair cost of care—and the requirement that a proportion of that funding has to be spent on uplifts to fees, and you think how much uplift there is going to have to be before you have any impact at all on a fair cost of care because the cost base is going up—there is quite a tangle of policies there that are going to impact on both councils and on providers.

Q178 **Bob Blackman:** There are obviously the short-term funds that came under Covid—as I think has been mentioned already—which ended in March. Have you also factored in the impact of those short-term funds ending in the current financial year?

Sarah Pickup: We haven't factored them in. There is a gap. Inevitably there will be a challenge as providers have to manage without the funding that they had used to help support their businesses generally—the infection control funds and others.

The other bit of funding that we are concerned about that has just finished is the discharge to assess funding. It wasn't the infection control

and the money that goes to providers, but the funding that enabled councils and the NHS to work together to discharge people from hospital into care settings with additional funding to do it. That has now ended. It has only just ended so we wait to see whether there is a consequent problem.

Gavin Edwards: On the removal of the infection control fund, there is the human impact. It is easy to talk about this—about high level figures. There is the human impact, which is that care workers are one of the very few groups in society who, according to government guidance, are being told to self-isolate and stay away from work if they test positive for Covid; quite rightly so. Yet the funding to pay their sick pay during those periods has been removed.

As a result, in the week that that funding was removed, we were flooded with inquiries from members working in social care saying, "I am going to lose hundreds of pounds a week. I don't know how I am going to put food on the table", and also, quite dangerously, people saying, "I can't afford to lose that money and I am going to go into work". Of course, we would advise against that; of course, we would.

However, the infection control fund—the clue's in the name—was helping to control infections in care homes, and we all know the devastating impact that that had at the height of the pandemic. The danger is that the removal of that fund and the seeming inability of most social care providers to pay proper, normal sick pay, in particular during periods of self-isolation as a result of Coronavirus, could lead to more outbreaks in care homes and most certainly will lead, completely unfairly, and through no fault of their own, to care workers losing significant amounts of money simply because they have contracted Covid-19.

Q179 **Bob Blackman:** Given that employers have to pay employers' National Insurance increases and have to face other pressures, are you seeing employers reducing staffing or lowering quality? Are you seeing those pressures?

Gavin Edwards: The reason it is difficult to see those pressures is because those pressures are so acute anyway, for a range of other reasons. It does seem to me that, in terms of staffing levels, staffing pay and often the exploitation of the workforce through things like failure to pay for travel time and extremely short care visits in domiciliary care, for example, those have been very long-term issues.

Are they getting more acute? We certainly continue to receive very large numbers of inquiries around those issues as well, so all the evidence suggests to me, from the workforce, that these long-term problems are not getting any better. That is probably the best I can say.

Adrian Jenkins: I think that, in the short term, in terms of overall funding, there is that issue around not knowing the funding that will come through in 2023-24.

Bob Blackman: I am looking at the immediate current position, this financial year if you like.

Adrian Jenkins: I don't know much about the spending side. I think the issue is that there is no more funding coming through now for 2022-23. In that sense, the authorities know what is available and they know there is nothing else coming through as far as we are aware.

Bob Blackman: I think it would be very helpful, Sarah, if you could give us your detailed calculations when they are prepared. Thank you.

Q180 **Chair:** To follow up on one of the issues mentioned there about the temporary funding during Covid, one of the challenges, as I understood it, certainly from my own council in Sheffield, was a real concern for many people about discharging them into care homes from hospital and, therefore, a tendency where possible to put people into care packages in their own homes, which are often a lot more expensive.

Certainly, social care budgets were probably overspent because of that—because of the extra help did not compensate. Now the extra help has gone, some of those people are still at home with a care package and it is very difficult then to undo that and put them back into the care home they might have been normally discharged to in the first place. Is that a wider problem, or is it specific to certain authorities?

Sarah Pickup: I suppose it depends on whether you see it as a problem, because the policy we have is home first. That when you come out of hospital the first place that we should try to get you to is your own home, and it should not be a cost issue whether you can go there or not. It should be whether you can be supported at home. In fact, we often have the opposite problem, which is people are put into care homes because it is easier and actually they did not need to be there and they end up staying there and the cost falls on the council. Depending on where you are and what the services are, this problem can fall in a number of ways.

We operate very closely with the NHS on a 'home first' principle and also discharge to assess, so out of hospital and home. Of course, we ought to be putting in enablement, reablement, rehabilitative services so that people can regain some of their former ability, because a lot of people are not at their best when they are discharged from hospital and, quite often, if they receive the right sort of therapeutic input, their need for support reduces as time goes on.

I would say that it is very variable and it will depend on what local policies have seen but, on the whole, you would not want to move people from home who can be supported at home back into care homes.

Chair: Moving on to look at the charging reforms that have come in, Mohammad Yasin.

Q181 **Mohammad Yasin:** The new charging reforms, including the £86,000 cap, will launch in October 2023. The Government have published

guidelines for local authorities to prepare. In your view, Sarah, how is this preparation progressing?

Sarah Pickup: The Government have published consultation on the guidelines for the charging reforms and they have published the guidance for the fair cost of care, but I think you are referring more to the cap and the taper. The final guidance is yet to be published. I think we are expecting it in May, and there is quite a tight timeline to get to that October 2023 deadline.

To be fair, the Department is working very closely with the sector on preparations for this. There has been a lot of work on the workforce that is going to be needed to do the additional assessments, on the technology changes that are going to be needed to meter towards the cap. Of course, it is all still to be done and there is a real worry that there will not be sufficient workforce available to do the necessary assessments in the time available.

We will look at mitigations, such as self-assessment or light-touch assessment, where people are already in a care setting and what you are doing is assessing their need in order to meter towards a cap. Perhaps they don't need such a comprehensive care assessment as someone whose needs you are seeing for the first time.

There is a lot of work under way, but until the final guidance is published, although councils will be getting going on this they obviously cannot be doing their recruitment yet. The trail blazers will start on that sooner but what people are doing now is their calculations about the impact. The calculations of the impact at the front of people's minds is the impact of section 18(3) and the fair cost of care because, of course, the impact of the cap comes much later in the next Spending Review period.

Q182 **Mohammad Yasin:** Thanks for that. LGA has some serious concerns about the £3.6 billion funding and is saying that it is not going to be enough. In your view, this funding allocated to local authorities to implement the reforms, is it sufficient?

Sarah Pickup: No, we don't think it is. That in particular relates to the early funding of the fair cost of care, aligned with section 18(3). The reason is that if self-funders are able to access care at the councils' rates, if all self-funders did that, the care providers' income would go down by the difference between the self-funder rate and the council rate. That would be quite a substantial sum.

Either the council has to pay more on average for each of the places it buys, or providers have to accept less income. That might work out in some places—the combination of the two—but we think the £600 million per year in a full year is insufficient to deal with that. That is just to deal with that reduction of cross-subsidy and, of course, a fair cost of care is ultimately aimed at improving services, improving pay and improving quality.

We think that trying to do those two things together means that a lot of the funding will be needed just to stand still. If you see that alongside the previous issue about inflation and just how much pay and prices are going to increase just to stand still, it is going to be a challenge.

Q183 **Mohammad Yasin:** The LGA also said that some councils will face a huge battle to balance their budgets. Existing pressure on them will get worse and there is also a serious risk of impact on the ability to deliver quality care. Do you agree on how big the risk is?

Sarah Pickup: Yes, it is particularly large in areas with lots of self-funders. I am talking here about this particular aspect because it is at the forefront of the minds of finance directors, never mind directors of adult social services. I know some finance directors have said to me that they see this as the biggest financial risk on their budget.

We have been doing some work on one area that has a very high level of self-funders and digging down into the market. We do not have the results of that yet, but I think it reinforces the difficulty of self-funders being able to request that placement. Of course, we don't know how many will, but if you have a care home that is 50:50 or 60:40 and you were a self-funder, why wouldn't you ask the council to commission your care at the rate the council pays? If you do, there is a problem.

The other thing is that, if you calculate a fair cost of care using a model—we can do that, it is not rocket science, is it, to say what the component parts are of delivering a package of care—it does not take into account some of the context, which is that some of the care providers have significant debt and some of them have private equity funding behind them. The actual cost to them of delivering the care may exceed what is deemed to be a fair cost of care and, therefore, even in an area where the council is paying a pretty high fee level, they may still be charging self-funders quite a lot more. That is not reflected in any of our costings, even those that we have done at the LGA.

Mohammad Yasin: Gavin, would you like to come in?

Gavin Edwards: Yes, on precisely that point. I think that is really key. We talk about the fair cost of care but it must be allied with reform of the sector. There are serious fundamental issues in the care sector that cannot only be reduced to the amount of money that local authorities are getting, or the amount of money that local authorities commission care.

I would refer the Committee to a report that came out in 2019 from the Centre for Health and the Public Interest. That looked at the finances of particularly private equity organisations that are involved in private care. It said that, for the five largest providers backed by private equity, it pays £102 per bed per week in interest costs. That is, 16% of the weekly fees that councils are paying is just going towards paying off their debt. Now, that is a broken model. Unless we reform out that kind of practice in the social care sector, we are literally going to be wasting money.

Of course, there is a whole range of other sharp financial practices and tax avoidance schemes and rental arrangements within very complex corporate structures that go with these organisations. They particularly dominate the care home sector. They dominate. This is not a small problem. It is a really big problem. Therefore, yes, we should talk about additional money for the sector, of course, as I already have. It is really important, but we must also talk about reform of this kind of thing as well.

Adrian Jenkins: I think it is a huge risk for authorities, especially around the fair cost of care, as Sarah said. When speaking to councils we advise that that is one of the biggest risks that they are talking about as well. Just looking at some of the work that, say, the County Councils Network has done with LaingBuisson on some of these costs. Their estimates for the new fair cost of care are from about £900 million to about £1.6 billion and that is way in excess of the amount of funding that is going to be available. I take two things from that. One is that the cost is almost certainly going to be a lot higher than the funding that is available, and the second thing is just the huge range of those forecasts, which suggests that forecasting it is really difficult and that people don't know what the costs are going to be.

One thing for me would be that the Government are mindful of that. The £600 million may be just a first estimate of it, but they do need to be open to providing more funding if that is available—once the real costs do emerge. Without that funding being put in place, the cost will be way too high for local authorities to bear.

Q184 **Chair:** Sarah Pickup, you mentioned about doing a particular in-depth look at one authority. Do you know when that work will be available?

Sarah Pickup: It should be available fairly soon. We are actually doing two authorities—one with a lot of self-funders and a different one. Once it is available and that authority is happy, I am happy to provide it for the Committee.

Chair: That would be very helpful. Thank you very much. Moving on to the issue of the fair cost of care, Florence Eshalomi.

Q185 **Florence Eshalomi:** You have all touched on it briefly and we can see that the current model is unsustainable where, in essence, local authorities are paying below market rate. If you are self-funded you get that premium.

Sarah, the Government have obviously launched this new sustainability and fair cost of care funding to look at the guidance and producing confident guidance. Are you confident that the fair cost of care will be achieved and, if not, why?

Sarah Pickup: We probably have touched on this, but I think if you read the guidance it very carefully talks about moving towards a fair cost of care, accepting that any sum of money may not be the right sum. The

problem with that is of course moving towards a fair cost of care is in line with the section 18(3) policy, which allows self-funders to buy. Moving towards it might mean that there is a gap between the loss of income from self-funders and the fair cost that councils might pay.

Our own assessment over a number of years and supported by the Institute for Fiscal Studies is that there is about a £1.5 billion cost per annum to the sustainability of the market. By that we mean that if councils paid the cost of care for both care homes and home care in the market, we reckon that that is about £1.5 billion per year. The full year allocation of funding for this is £600 million per year. I think that the recent County Councils Network estimated that there was an underfunding of this policy by £850 million a year, which if you add £600 million to £850 million you get close to the figure that we were talking about. Therefore, I think there is a serious risk of underfunding.

If you were given a sum of funding to move towards the fair cost of care, without the other policy, you would do your best, wouldn't you? You would up your fees to the extent that was possible with the funding available and people would be slightly better off, although there would probably still be some cross-subsidy. But because the two policies are coming in together, it poses a much bigger challenge for councils and providers.

Q186 **Florence Eshalomi:** Gavin, the National Audit Office report in March 2021 stated that "local authorities paid below the sustainable rate per week for care home placements for adults". The Department does not challenge those local authorities who pay low rates. Do you think that we are going to reach this fair cost of care?

Gavin Edwards: In all honesty, no. I have no confidence that that will happen. To me the fair cost of care includes care workers being paid sick pay. It includes them being paid at least the real Living Wage, everybody being paid for travel time between care visits and sleeping shifts being paid at least National Minimum Wage rates, so people are not receiving £30 payments for a 10-hour overnight shift.

For me, those things should be non-negotiable in the fair cost of care because what is happening at the moment is that care workers are being caught in this commissioning process between a sector, which is largely private sector and profit making, and commissioners who—as we have already heard so far in this session—are starved of funding and acutely underfunded.

The main cost to the providers is their workforce and these issues that I have just listed are what is being squeezed. It causes misery for people who are doing nothing but working extremely hard to provide high quality care for people. They are being exploited on a daily basis and that cannot be allowed to continue. Does the process that is set out, the kind of numbers game that we are talking about—of course numbers are very important, I am not downgrading that—going to take account of those

kinds of issues so that we have that step change in the way that care workers are treated? No, I don't think that that will happen on what is set out at the moment.

Q187 **Florence Eshalomi:** Just on the numbers, Adrian, £1.4 billion has been allocated over three years to progress towards a fair cost of care. Do you think it is enough?

Adrian Jenkins: All the evidence that we have suggests that it isn't enough. The report that the County Councils Network did with LaingBuisson gave a large range. I think, as Sarah has mentioned already, the shortfall is about £850 million per year. That is quite significant.

The other thing that we don't know yet is how that funding will be allocated. We know what the quantum is but we only have that first tranche in the current year of £162 million. That has been allocated based on the old relative needs formula, but the £600 million—the two tranches next year and the year after—we do not know how they will be allocated yet.

The old formula is very old. It does not necessarily reflect the cost of providing that care or the new cost associated with the fair cost of care, so I think we would be looking for the Department to step forward and say what the new formula would look like, so that authorities know what they are going to get. It is a question, I suppose, of the overall amount of funding that is available relative to the cost, but how that is allocated between authorities and what those costs will be. Some authorities have lots of self-funders but expect their costs to be a lot higher.

Q188 **Florence Eshalomi:** One of the challenges is obviously different local authorities then responding to their local needs, working with their different providers and working with staff and unions. There is a timeframe of local authorities being asked to report back on their submit cost of care exercise, market sustainability plan and spend report by 14 October 2022. Do you think that any local authorities are on track to meet this, bearing in mind all the issues that we have already highlighted just now?

Adrian Jenkins: I suspect most local authorities will be under a huge amount of pressure to get anywhere near that. They are really complicated areas to deal with, especially areas that have a lot of self-funders. There is a huge amount of work to get through to understand what is going on. I am sure authorities will do their best and will submit something, but I would imagine there is an awful lot more work to do beyond that.

Q189 **Florence Eshalomi:** Sarah, are you working with local authorities?

Sarah Pickup: Yes. We are saying that the timescale is extremely tight, particularly to produce the strategy. People have to do the fair cost of

care exercise and if you are going to do that properly you need to engage with your providers, you need to consult.

We understand why that is needed in a timely way because, if you can influence the distribution of the £600 million for the following year, you have to have some data to do it with. However, we think that it is very difficult for councils to even do a draft strategy until they know how much funding they will have. If the cost of care exercise was done in that timeframe, but the strategy came after the funding allocation, that would make more sense.

Florence Eshalomi: To receive the funding councils have to submit that by 14 October.

Sarah Pickup: Yes, it is a bit catch-22, isn't it?

Q190 **Florence Eshalomi:** Yes. The other element is that the scope of the funding and the exercise is limited to 65+ care homes and 18+ domiciliary care. Do you feel that this is the right approach?

Sarah Pickup: I think it is the right approach given the policy that is being implemented, given the adult social care charging reforms, because it is the 65+ care home sector where the cost cap kicks in to the greatest extent. It is not irrelevant in working age adults but there are way fewer people who are likely to hit the cost cap.

The other thing is that if you are doing a fair cost of care exercise, for domiciliary care and different categories of care homes, there are sufficient numbers of placements where you can do an average cost of care for a person with dementia in a nursing setting or a person with physical support needs. If you think about people with learning disabilities, mental health challenges, physical disabilities, you almost need a fair cost of care exercise per person. It has to be much more personalised, but I do still think it is relevant to look at what a fair price for care is. I think it could work two ways in the working age adult market. You need to make sure that providers are paid enough, but you also need to make sure that councils are not paying too much. Reference across to the children as well there.

Q191 **Florence Eshalomi:** Lastly on that, we have all touched on the fact that, on the fair cost of care, we should be looking at services paying quality. Essentially this guidance will be asking local authorities to spend at least three quarters of this funding on increasing their fees to providers and up to a quarter on implementation activities. Again, do you feel that this is practical and the right approach?

Gavin Edwards: My view on this is that we have to make sure that the money reaches the frontline. That is absolutely key.

I will come back to the point that I made earlier about reform. The experience with additional money going into the sector—for example,

with the infection control fund—is that there is very little accountability or monitoring or transparency about where that money goes.

To give you a comparison with the infection control fund, which was supposed to ensure that care workers were paid full normal wages for periods of self-isolation, at least half of care workers did not have that experience when they needed to self-isolate during the pandemic. Of course there are some employers in the care sector who do the right thing and look after their staff as best as they possibly can, but a lot of employers in the care sector will not do that.

If through this process we are going to see increases in money going into the care sector under a fair cost of care, then we have to make sure that the money reaches the frontline and is spent on the right things because some of that money through the £1.75 billion that was spent on the infection control fund was not spent on making sure that care workers received full normal wages for self-isolation. There is probably a case to be made for greater investigation into where some of that money ended up.

Sarah Pickup: Yes, I think it is just the first year where 25% is to be spent on implementation costs—25% of £160 million exactly—to allow councils to do those fair cost of care exercises and produce their plans and so on and thereafter there isn't that same split. I think it is reasonable to accept that there is a cost to doing that.

In terms of monitoring, I have to say it doesn't feel light touch to local authorities who are filling in all sorts of returns on where the money has gone and what they have done with it. The infection control fund was for a multiple range of purposes, but I fully accept your point.

Gavin Edwards: Yes, to clarify, it is not that it was light touch—I don't think that that was a phrase that I used—it is that there are very few guarantees in the system. There is very little that local authorities can do to ensure; they contract out the service for a period of time and the money is often passported along. They can check in, they can ask, but there is very little transparency with these companies rather than with the local authorities.

Florence Eshalomi: Adrian, anything to add?

Adrian Jenkins: I found that the amount of money that was allocated in the first year, the current year, of £160 million wasn't particularly large, and then to split it up in what seemed like a fairly arbitrary way, 25/75, just did not seem to make sense. Councils are under a lot of pressure to get things done this year and I would have thought giving them a little bit more flexibility would have been a better way to handle it.

Florence Eshalomi: Hopefully it will only be for that first year, as they have outlined.

Q192 **Darren Henry:** We mentioned that £1.4 billion is being allocated towards the fair cost of care over three years. Adrian, you mentioned that, in your view, it would be £850 million short and that you have evidence for that. Could you just expand on what evidence you have for that?

Adrian Jenkins: The evidence I have seen is from the work that the County Councils Network commissioned from LaingBuisson, the work using cost of care models to work out what the cost would be. Clearly, they are working on lots of assumptions and working nationwide. They have done work with groups of councils as well about what they think the costs are, but in the published report—I think it was only in March this year—one of the things that is striking is just the range of different outcomes in the modelling, which is very dependent on lots of different variables that we don't know about yet and assumptions about what those costs will be. I think there have also been estimates from other bodies that have come up with similar sorts of figures, at least around the £900 million to £1 billion region. A number of different sources are suggesting that that is probably the right kind of cost, but there is lots of uncertainty.

Chair: Moving on to the White Paper that came out in December, Andrew Lewer.

Q193 **Andrew Lewer:** The Government published their 10-year vision for social care, "People at the Heart of Care", in December. To begin with, I am interested in your overall responses to that White Paper and your view as to whether it will help local authorities or not. I will perhaps start with Adrian Jenkins.

Adrian Jenkins: Our view was coming at it from the funding point of view. We had had that information from the spending review about the sorts of funding that would be available and were looking specifically at what had happened to all that funding. We had £5.4 billion over three years that had come from the spending review to fund the various reforms, £3.6 billion of which had been allocated for the specific reforms, the cap changes and means-test changes and the fair cost of care. We were looking at the amounts that were available—the £1.7 billion that had not been allocated at that point.

Our view was that it was quite disappointing to see what was in there. There are obviously things that are worth doing, but it seems as if the amounts were fairly arbitrary and they did not seem very specific. I didn't think the amounts even added up to the £1.7 billion, so it seemed as if it was still at an early stage of what was going to happen.

Specifically again for local authorities, the issue there was the smallest packages of funding. We don't know how they are going to be used or how they are going to be allocated. Again, the way that that funding is made available is very short-termist and that just makes it very difficult for local authorities to plan how much of that funding is going to be allocated on what particular basis and using what formulas, whether

competition-driven or based on pilots. It is difficult to know. In some ways it felt, from a financial point of view and from a funding point of view, a little bit underwhelming. We were expecting a little bit more from it.

Gavin Edwards: Yes, I would agree with that last point about a lack of ambition. There are elements in the workforce elements of the White Paper that are welcome. We have a new focus on career progression, tentative moves towards registration for care workers and changes to the care certificate. They are welcome elements, no doubt about it, but the White Paper does not address the huge fundamental problems facing the care sector. Because of the language used around fixing social care by the Government, people's ambitions were lifted to that, but there is nothing in the White Paper about pay and conditions for care workers. Search as you may, it is not in the White Paper.

There is nothing about a long-term plan for the care workforce, nothing about national structures or partnership working with trade unions, there is nothing about private equity—issues we touched on earlier. Perhaps most importantly of all, there is nothing that addresses the structures in the social care system that currently seem to encourage a complete lack of accountability and buck-passing. At the moment, when something goes wrong the care providers can always blame the local authority for not giving them enough money and the local authorities can always blame the Government for not giving them enough money, and the Government—as they have done—can always point the finger at everybody else and say, "It is your fault. You should have done these things".

Nobody would tolerate these things in the NHS, nobody would tolerate this lack of accountability for improving services, yet with the Department of Health and Social Care and with the Ministers in the Department of Health and Social Care, there seems to be this constant tendency to keep things at arm's length and not get involved in the sector. I think that is fundamentally one of the things that needs to change

Sarah Pickup: We support the positive framing of social care in the White Paper. The ambition is a good one and reflects quite a lot of what we would say we want for the social care sector. Some of the focus on prevention, unpaid carers, housing, new models of care—not just about funding the same thing but funding different things—is all good. We also recognise that there is an increased focus on improvement support and funding for training, career structures and wellbeing of the workforce.

However—and there has to be a "however", doesn't there—the funding that is allocated for each of these tranches is kind of change funding. It is, "Here is some funding to see if you can think of ways to get more extra care housing in place; here is some funding to train the workforce better". There is no core funding to buy the services that you then

design. The problem we have at the moment is unmet need and under-met need and a lack of investment in prevention.

The aspirations of what we need to have are there—some funding to help develop some of it and a recognition of existing good practice and a desire to draw on it and to fund improvement—but what isn't there are the pounds to buy the package of care for Mrs Jones in the extra care housing or to fund the prevention package for that community in whichever town or community it is. That is the challenge. The challenge is not the ambition; it is how we are going to deliver that ambition. It is like the Care Act. The Care Act is a good piece of legislation and we support it, but we don't think it was properly funded for delivery. In particular, there was a duty of prevention that was not even costed in the impact assessment of the Care Act back at the time. We are in danger of having similar problems here.

Q194 **Andrew Lewer:** You have touched on this a little bit already, Sarah, but just to broaden it out a little bit, the White Paper has these plans in it to assist local authorities with market-shaping—sort of some of the things you were touching upon a little bit in terms of the packages. What is your impression of that section of it?

Sarah Pickup: Local authorities already have a duty of market-shaping under the Care Act. Sometimes they struggle to do it. It depends on the capacity and also it is quite hard to work to shape a market when you are barely struggling to procure what you need to deliver care day to day. Nevertheless, there are some good models of care out there. I know our chairman is taking the Minister to visit some extra care housing facilities in his area this very week, so there are good things to see.

Of course, it is welcome that there is some funding to look at innovative models of care and to build on and draw on and see how we can use what is already there and to look at good models, so we do welcome it, but the question is, so then what. How are we going to shift from where we are to where we need to be? We need to work with providers to change the shape of care, and we need new sorts of providers as well. Particularly with working-age adults, we need much more personalised and smaller packages around the individual.

The key thing is that you have to then pay for it. We can invent these models of care, but we need to then shift—the cake is only as big as the cake is, and I think therein lies the problem.

Andrew Lewer: Gavin, market-shaping and the plans within the White Paper for that.

Gavin Edwards: What I would add, without wanting to go too far beyond the remit of the Committee, is that we have to ask the question whether or not a market-based model is the right one for a crucial public service. I think that that is an obvious question—the elephant in the room that needs to be addressed. Vital public services require long-term

planning, they require national standards on what people can receive from care, and national standards on how care workers, for example, should be treated. Instead, because we have this market-based model and because it is acutely underfunded, the sector lurches from crisis to crisis. That is essentially a choice that successive Governments have made—it has happened over a long period—yet, as a country, I would say that perhaps we should be demanding a different model for social care from the Governments that we elect, one that puts in place the kind of long-term planning and long-term investment that other public services in this country benefit from.

Q195 **Andrew Lewer:** You identified primarily the funding issues, which we are always talking about, and rightly. Are you looking for a more centralised prescription from Government to local government over this to achieve that aim?

Gavin Edwards: I think that that goes to the heart of the matter. I would say it is important that we have locally delivered services. It is very important that local authorities are best-placed to understand the needs of their local population. You can't have a social care system that is delivered from Westminster. I don't think anybody is realistically suggesting that, but what you do need is a system that can respond to need and that has national structures. At the moment you are getting constant undercutting because of the market, and because local authorities don't have the funding that they need they are commissioning on price, so it is often the cheapest rather than the best quality of care. We need to move to a situation where we are designing services based on quality of care so that we have a world-class service. That is not possible with the system that we have at the moment because of the lack of accountability and because of the crises that keep happening. We need to move to a different model of social care. I would question whether or not having it dominated by profit-making providers is the right way of doing that.

Andrew Lewer: Adrian, your views on market-shaping and the White Paper's guidance within it.

Adrian Jenkins: Unfortunately, that is not my kind of area. I don't have much to add on that, I am afraid.

Q196 **Andrew Lewer:** All right. Let me move on to ask about the concerns that both the LGA and UNISON had in the evidence that you have given us about assurance within adult social care. Did the White Paper address any of those concerns, Gavin?

Gavin Edwards: Which particular elements of assurance are you asking about? Is it in terms of the assurance that when money is invested in the system that we are getting the kind of outcomes that were originally intended? Yes, and I would loop back to some of the things that I have said already about the infection control fund and recruitment and retention fund, when these short-term pots of money are put into the

sector. UNISON has written to the Chair of the Public Accounts Committee to ask for an investigation into how that £1.75 billion has been spent on the infection control fund because it isn't as transparent as it should be. I think there is a serious question mark on where some of that money ended up.

Ultimately we need to have a system whereby we do have that kind of confidence. Whether or not that means under the current model, if we are assuming that that is going to continue under the current commissioning model, local authorities need additional funding in order to expand the amount of monitoring that they can do. Because of the pressures that are on local authorities, we know that it is extremely difficult for them to do that.

In the case of the infection control fund, they were having to monitor spending with organisations that they didn't even have contractual relationships with, they just happened to be care homes that were in the geographical area. There is more the Government can do even if they are not going to make any particular radical changes to the model on transparency. I would suggest that, ultimately, we do need to move to a different model if we are going to get a bit more bang for our buck, and taxpayers are asking, "Is my money really reaching the frontline and being spent on social care?"

Sarah Pickup: When assurance was first proposed in the White Paper and now the Bill, we acknowledged the desire for greater transparency around adult social care and we said from the outset that we favour an approach that is about a shared agreement, about what good looks like. We have in fact been working with DHSC and CQC on moving towards what a model could look like. However, we were clear also from the outset that we did not support the introduction of regulation over local authorities and still there was a sustainable funding settlement because you are setting councils up to fail.

Councils will tell you that they struggle to deliver against Care Act responsibilities and they regularly survey directors who say just that. Putting in assurance arrangements midway through the implementation of reforms and alongside a lot of other changes as well around integrated care systems and partnerships and so on poses a very big risk about whether the majority of councils have any chance of being seen as doing a good job in relation to their Care Act responsibilities.

We are hopeful that this will be a kind of assurance focused on improvement and helping councils to improve. There is a risk that it drifts towards an inspection-style approach and that any simplification of the complexities of what councils are delivering in relation to adult social care into something that tries to give a headline or whatever poses a huge risk in terms of how well money is spend. The context is everything with this assurance, isn't it? The context has to be the funding; the context is how well the NHS is performing in your area, how good is your partnership. If

those things aren't taken into account, there is a real risk it is seen as punitive rather than supportive, transparent and open.

Andrew Lewer: Anything on that, Adrian?

Adrian Jenkins: Nothing else to add, no.

Q197 **Andrew Lewer:** Just briefly then, Sarah, further to the question to Gavin about prescription from the centre versus flexibilities in terms of market-shaping and in terms of the system, does the LGA seek further centralised guidance on this ,or is it predominantly a funding issue in terms of providing the services?

Sarah Pickup: I don't think we seek further centralised guidance because the Care Act sets out a pretty good framework. Of course, there is some updating in the White Paper that is helpful and we can always learn. We shouldn't sit in the past, but we know a lot about what good care looks like. It is not only about funding, but of course you cannot get away from the fact that we were sat here four years ago—perhaps people were sat here four years before that—talking about the core funding for adult social care. It is not just about it supporting the NHS, it is about helping people live their lives and it is increasingly transparent.

I think in a sense that Covid brought out the extent to which some people depend on social care, both carers and people who need that support. I do not think central prescription is the answer. I think it is sharing of ideas. The LGA runs a national sector-led improvement programme for social care and the idea is to share best practice and to offer peer reviews. We think peer reviews, peer challenge and peer support are all very important parts of how councils can improve their care provision, but they do need to be resourced to do so.

Q198 **Andrew Lewer:** Yes. I always found peer review useful, except that everybody said everything they did was really brilliant and it was quite hard to decide which was which.

Was there anything in "People at the Heart of Care" that wasn't there that any of you would have liked to have seen? Adrian, anything missing from there that you wanted to see?

Adrian Jenkins: Not necessarily, but one point I think is very important is that a lot of the headlines have been about the additional funding that came through for social care—the £5.4 billion, the amount that was funded as part of the Health and Social Care Levy. A very important point for me is that all of that is for new things. It is either for additional new costs that will fall on local government from the reforms, the cap and the fair cost of care, and then the remaining £1.7 billion, which I think—as Sarah said—is for looking at how you might improve rather than for buying the things that local government needs to do its day-to-day job. For me, I think a lot of that funding, in many ways, would be better off used just to support what local government is trying to do every day, rather than just about changing what it is doing.

Andrew Lewer: Gavin, omissions or further thoughts?

Gavin Edwards: Obviously I have talked about some of the more fundamental issues, but one easy win that I was disappointed was not included in the White Paper is not something that would cost a huge amount of money, which is national partnership working in social care. You will know, I am sure, that the Social Partnership Forum in the NHS brings together employers, trade unions and the Government, which is chaired by a care Minister, and allows them to talk about important policy areas in the NHS at a very early stage as a sounding board and discussion. That was a huge benefit to the NHS during the outbreak of coronavirus. They were able to talk through some of the practical issues at a very early stage and then roll out solutions.

We should be doing the same thing in social care. There should be a place where the LGA councils, as commissioners, the providers of social care and the social care trade unions should, on a formal basis, I believe sponsored by Government, be able to come together and do precisely what is done in the NHS and talk through some of those issues. Obviously, not everybody is going to agree, but I think there is a lot of overlap in the interests of people who would be able to talk about very important issues.

A recent example would be mandatory vaccination. If only the Government had brought that policy to a similar body as the one I have just set out and gone through those issues at an early stage, perhaps a lot of time, money and effort on a policy that ultimately failed would have been avoided. I think something that could have been in the White Paper that would not cost a huge amount of money, but could make a significant amount of difference, would be national partnership working.

Andrew Lewer: Yes. You were not the only person to express reservations about that one. Sarah, final thoughts?

Sarah Pickup: To be fair to DHSC, there was some national partnership working on that very issue. Clearly the unions weren't involved, but I have to say that the generality of advice was not followed through. On the White Paper, I think the Government are yet to put in place their formal governance arrangements for delivery, and such an oversight body would be useful.

The thing that I think was missing was the need for a workforce strategy. The White Paper talks about the £500 million and the things that will be done with it, which was re-announced on the day the levy came into being, but there isn't set out a proposal to do a workforce strategy for social care or to bring it alongside the proposals for the NHS workforce strategy. Given that that workforce is at the heart of delivery and that we have a very big capacity problem at the moment in the sector, I think it is something that would have been welcome.

Andrew Lewer: Funny you should say that. Chairman.

Chair: Absolutely, yes. Moving on to the workforce and, indeed, to unpaid carers as well, Ian Byrne.

Q199 **Ian Byrne:** Before I get into that, I have a quick question, just for the record. I will direct this to all today: is the current vastly privatised market-based adult care model that we are talking about broken? Adrian.

Adrian Jenkins: That is not something that I particularly look at, so the question is probably better answered by Gavin and Sarah.

Gavin Edwards: You might be able to predict what my answer is going to be, which is absolutely, yes. Let's take what happened during the pandemic with care workers being asked to work without proper PPE, being left without sick pay when they had coronavirus, which we know contributed to outbreaks of coronavirus in care homes, which killed large numbers of people. If that is not a broken system, I don't know what is.

Sarah Pickup: I would say that it is broken to the extent that it doesn't work as we would want it to work. It is not that there aren't good components within it. I think there are different ways you can properly deliver care. There is some good provision out there, but I think it is the way in which it is set up. As demonstrated by some of the proposals that have come forward from Government, it illustrates that it is definitely not a perfect market, is it? Just to use market forces to deal with social care has not worked. It does require intervention as well.

Q200 **Ian Byrne:** I will direct this one to Gavin first. I just want to touch on the ADASS report, which came out in November 2021, which said: "Red lights are flashing right across our dashboard. Despite magnificent efforts by the committed, courageous and compassionate people working in social care who are delivering extraordinary amounts of care and support, services are failing to meet everyone's needs and older and disabled people are suffering. The survey findings come ahead of the expected publication of the Government's white paper… ADASS is calling as a priority for action to raise the pay and status of care work and put it on a professional footing in the long term".

The Government have allocated £500 million over three years of policy reforms aimed at the social care workforce. Care staff have also been added to the shortage occupation list. To what extent will these reforms do what ADASS has asked for? Gavin.

Gavin Edwards: I don't believe they will address the fundamental problems because the fundamental problem with the care workforce is that people who were doing an incredibly difficult job, which requires huge amounts of hard work and commitment, are not paid enough for doing that job. That is the direct result of government policy. Until that government policy changes and more money is put into the system so that people can be paid what they deserve to be paid, then these problems will continue.

The ADASS report that you refer to came at a very similar time to the UNISON survey on staffing shortages on a very similar issue. We were told by our members that 67% of them were actively looking to leave the sector. You cannot run a public service on that basis when you have two-thirds of people trying to get out. There was *The Times* story over the weekend, where we had four in 10 care homes refusing to take people, so then it is having a knock-on effect on the NHS as well. Social care is important in its own right, but it also having a devastating effect on the NHS. Look, there needs to be a step change in the ambition of Government. Whatever the political stripe of that Government, there needs to be much more ambition because the Prime Minister did stand on the steps of Downing Street and say he would fix social care. This White Paper will not fix social care. We need more ambition.

Sarah Pickup: The £500 million investment is welcome and we do need to invest in the training and development. We need proper career structures and staff do need support. We probably need to take it a step further. That is the beginning of a sort of structure to careers in the social care sector and it needs to be seen alongside the NHS, not because people should aspire to move from social care into the NHS, but because people might move backwards and forwards in the future.

That £500 million is just the start. It has to be only a down-payment and it doesn't tackle a lot of the other issues. It does not tackle the perception of care workers, whether they are valued by society and by Government. We have fairly recently published a position statement where LGA, ADASS, CSA, Skills for Care, SCIE and TLAP came together to call on the Government to deliver a long-term care workforce strategy. I am sure we can send you the position statement if you do not have access to it, but it highlights tackling the issue of care worker pay as well as the investment in their careers.

There is a need to think about things like regulation as well. We do not have a firm line on regulation, but we do need to think about how you are going to recruit, retain and reward the workforce that we need for social care, which will of course help people live better lives and improve quality, but it will also be of benefit to the NHS. The NHS itself will say that the NHS cannot succeed without a working social care system.

Q201 **Ian Byrne:** I agree with everything that you have just said, but can that be achieved in the current system and model that we are talking about? You are talking about higher rates of pay, you are talking about retention of staff, but you are fighting against a model that you have just said is broken.

Sarah Pickup: I think it is not impossible to achieve it, but of course you have to fund it and you have to create the mechanisms to do it. The Government are at liberty to make laws and regulations that require people to do things. They are at liberty to set a national living wage and when the national living wage goes up it is good news for a care worker, but it is not good news for the competition between the care sector, the

supermarket and the hospitality industry. I do not think it is impossible, in fact it may be more feasible than completely throwing the current system out of the way and trying to start again, which would be very challenging.

Gavin Edwards: I agree that trying to rip up a system and start again contains its own dangers and there would need to be steps along the road for any proposals for reform. The point is that those proposals for reform have to have ambition and they have to be looking to create a world class social care system in this country and we cannot do that on the basis of bargain-basement commissioning, trying to constantly push down care workers terms and conditions. All of the incentives in the current system are to do that from a local authority perspective, and from a provider perspective.

We are seeing the fruits of that in the system we have and that is why we have so much unmet care need and why hospitals cannot discharge people into care homes. It is totally dysfunctional and should be addressed as a matter of urgency. We can start along the road of doing those things now but there is nothing in the White Paper that will allow us to do that.

Q202 **Ian Byrne:** Does the White Paper grasp the significance of how highly skilled and important these jobs are? We need a cultural change in how this sector is addressed because it is, as we have seen during Covid, now one of the most important facets of our society.

Gavin Edwards: I totally agree. If we had some form of national partnership working, you could go through a job evaluation process and you could evaluate precisely the skills that people need to work as a care worker, the amount of hard work they have to go through, the emotional intelligence required to be a really good care worker, and the level of commitment. You could put that into a process. In the same way we are coming up with a theoretical fair cost of care, we could come up with a national standard for the treatment of care workers. There is nothing stopping the current Government from doing that now. Initially, it could be done on a voluntary basis. Local authorities could ask people to opt in to a kind of gold standard for the treatment of care workers and over time we could move to a situation where Government encouraged and pushed providers to opt in to that kind of thing. These are all options on the table. Again, none of them are contained in the White Paper.

Ian Byrne: Is there anything there, Adrian?

Adrian Jenkins: Part of the problem is that we do not really see any proper attempt to work out what the cost is of what the Government want social care to do nor any attempt to work out what the workforce needs in terms of funding even just to stand still. It tends to be that this is the amount of money that ends up being available for the sector, some from adult social care precepts, some from grants. There is no understanding of what is that sufficient to do, what is it intended to do. It

is about taking a step back and looking at what the sector needs in respect of workforce reform and what that costs, or just the cost of managing the current workforce. It does not seem very scientific to say that there is an amount of money made available and the local authority has to decide what to do with it. I would like to see something that takes it back to first principles.

Q203 **Ian Byrne:** Thanks for that. Sarah, we heard from the Alzheimer's Society and Carers UK that many carers are not having carers assessments or have not even heard of them. How can local authorities ensure that everyone who is eligible for a carers assessment obtains one?

Sarah Pickup: In local authorities, at the moment, there are waiting lists for carers assessments; there are waiting lists for all sorts of assessments because there are insufficient staff. It is one of the impacts of there being insufficient funds to fully implement the provisions of the Care Act.

I also have to say that it is not always easy to get information to people who do not have it. I was a director of adult social services and we worked very hard with our local carers' organisation, but we still had people who said, "Well I didn't know", and we tried everything—we tried leaflets in GPs surgeries, a website and libraries. However hard you try there is still a gap but that does not mean that you should not try harder.

The information and advice component of the White Paper is important if it is directed properly. People still do not always recognise that they are a carer. GPs have a responsibility to identify carers and to notify them. There is a whole series of things that can go wrong: people not knowing that they are a carer and that they might be entitled to something; people worrying about accessing it; and then councils having the resources to do the assessment, and once they have done the assessment to offer something by way of support.

It is really important to support carers and we no doubt should devote more resources to it, but when faced with the presenting need of someone who needs services themselves and the carer that is offering support, inevitably some prioritisation sometimes happens.

Q204 **Ian Byrne:** This is my last question on carer support. The Joseph Rowntree Foundation in its 2021 Poverty Report estimated in the UK more than 250,000 carers were living in relative poverty—that is before the cost of living crisis. The carers survey in 2019 as well found that carers who do more than 50 hours a week reported poorer health, with 25% reporting bad or very bad physical health and 29% reporting bad or very bad mental health. These are staggering statistics and the work that they do is important

I will go to you first, Gavin. What is your response to measures to support carers within the People at the Heart of Care White Paper?

Gavin Edwards: I may defer to the other witnesses. Obviously, UNISON would want to see carers treated fairly. It should be clear that I am here today to represent the paid care workforce. A lot of our members may incidentally be unpaid carers as well.

Ian Byrne: Absolutely.

Gavin Edwards: Obviously we want people to be treated fairly and equitably, but perhaps Sarah or Adrian may be better placed to answer that question.

Sarah Pickup: There are a lot of good models for supporting care out there, such as direct payments for carers and different forms of respite, which is what the White Paper talks about, but it is the ability to offer and deliver them. We welcome money to pilot new approaches, but, in a sense, we probably already know some approaches but we do need to be able to resource them. I am reluctant to come back to resourcing all the time, although the Committee's task is to look at the funding of adult social care, so I suppose it is fair enough.

Ian Byrne: Fair enough, yes.

Sarah Pickup: We do need to look after carers. We need to help them stay in the workforce, so people need to be enabled to stay at work—not feel pressured to give up work—and to get the support that enables them to do that. Usually, people care because they want to, and they are willing to go above and beyond and do amazing things, and sometimes a very little bit of support can help.

Q205 **Ian Byrne:** Is there enough of that within the White Paper?

Sarah Pickup: The White Paper says there is £25 million to identify and test a range of new interventions. The £25 million will allow that to happen but I am not sure it is going to go very far in providing those interventions to the carers who need them.

Ian Byrne: When you are talking about the number of carers we have?

Sarah Pickup: Yes, and the value of the support that they offer in the economy

Ian Byrne: And what they bring—the money that is saved for the economy and the NHS. Would you like to touch on that question, Adrian?

Adrian Jenkins: No, that's all right.

Q206 **Florence Eshalomi:** I know we are talking about adult social care and looking at that element. The carers allowance starts from 16 and over. One of the things I have done was being a carer for my late mum who suffered from sickle cell anaemia. During the pandemic, we saw so many more younger people taking on carer responsibilities. Do you feel there is an oversight in recognising the value and work of young, unpaid carers?

Sarah Pickup: I think it is a recognised challenge in children's services and in adult care when you know there is a child responsible for care. There are ways of supporting young carers. They should not be having to do that. A parent should not be dependent on a child for their care. They will want to do certain things and there are good models of support, but whether they are available to all the young carers and whether all the young carers are identified I am not in a position to say.

Q207 **Chair:** Some information we had at the last inquiry was that of paid care staff, 50% were on zero-hour contracts and 50% left within a year. Is that still the sort of figure around?

Gavin Edwards: The latest figures from Skills for Care, which, to be fair, probably does the most comprehensive overview of the care workforce, show that 25% of the overall care workforce are on zero-hours contracts, but that goes up to about 42% when you are talking about domiciliary care. So, zero-hours contracts are more prevalent in domiciliary care than in the rest of the care workforce, although it is a feature across the whole of the workforce.

Q208 **Chair:** Do any of you know how many local authorities insist that when they contract with care providers those care providers pay the real living wage?

Sarah Pickup: I do not have that data. People can be on tricky ground when they put requirements in contracts, but I do know that some councils have tried very hard to go beyond that and to say, "We will pay you this uplift provided it flows through to the care workers". There are some councils really trying to do the right thing.

Q209 **Chair:** Why can't councils put that in contracts?

Gavin Edwards: There is the UNISON ethical care charter, which we have asked councils to sign up to, and 46 councils have signed up to that charter covering domiciliary care. That charter that is being signed up to includes things like making sure that people are paid for travel time, that they do not have 15-minute care visits, and that people are paid at least the real living wage and of course the London living wage in London. At least 46 councils have taken that step. Of course, that comes with a cost and with difficulties, but we think that it has made quite a big difference in those 46 councils. However, that does not equate to a nationwide strategy that a Government could put in place for paying people a real living wage.

Q210 **Chair:** Why do councils have problems putting things like that in contracts?

Gavin Edwards: One of the things you hear from council procurement officers, which I think is what Sarah was referring to, is that there are legal impediments to doing that via the procurement process. The truth of that is probably a matter that is open to legal and other debate, but there are councils that, as a matter of fact, commission on the basis that

all the care workers providing services in a particular area of their council will get paid the real living wage. The fact that that happens is significant.

Q211 **Chair:** One final point. Last time we looked at social care provision, we had a Committee visit and looked at the situation in Germany. The German model allows for family members to be paid to deliver care at a slightly lower rate than would be paid through a formal procurement system, but it partly gets round this unpaid carer problem in a different way. That may be cheaper for councils; it may cut across the idea of a paid workforce. Where do we all stand on that?

Sarah Pickup: I think in exceptional circumstances some people are enabled to use direct payments to pay a relative, but, from a government perspective, if you pay a relative to care, where is the line between what you pay for and what is informal care because you are the partner, son, daughter of someone. I suppose it goes to whether unpaid care should become paid care. It is a very tricky situation. There is a possibility of doing it through direct payments in certain circumstances where the alternative is that you would have a paid carer. There are different ways of doing it, such as my daughter will do the care if I can use my direct payment to pay the cleaner. There are different combinations of things you can do.

I am not an expert on the German model, but it is not very generous in the money it offers by way of direct payments to people to support their care needs.

Gavin Edwards: Our preference would be that you have a system whereby you get high quality care provided by a paid workforce, but obviously there are gaps in the system that at the moment are filled in by unpaid carers. I agree with Sarah that the issue of definition would be a tricky one to introduce. Given that we have a huge 1.6 million care workforce in this country being poorly treated that should be the focus and we should deal with those issues. There may be other more innovative approaches that could be used, but we have such massive problems with the existing workforce and perhaps we should focus on addressing those first.

Chair: The issue of Health and Care integration has been one that is regularly talked about and discussed. Darren Henry, over to you.

Q212 **Darren Henry:** I will ask this question of all of the witnesses, starting with Sarah.

The Government issued their Health and Social Care White Paper on integration in February. What is your assessment of it? In particular, can you mention anything that you think might be missing?

Sarah Pickup: We see the integration White Paper as a follow-up to the current Health and Care Bill going through Parliament, which sets up integrated care systems and talks about integrated care partnerships at system level jointly set up by councils and integrated care boards—the

NHS in the system—to more effectively integrate care at a system level. There is a presumption of subsidiarity in those arrangements; there is a primacy of place. That was in the White Paper. It is in the guidance, but it is not in the Bill, because the Bill is aimed at setting up the systems and all the formal legislative things you need to do it.

The LGA has worked closely with the NHS and DHSC on these proposals and our worry always was about follow-through of the place-based approach—the fact that most of the commissioning and delivery of care and health services that need to be integrated should be done at local authority level where health and wellbeing boards already pool budgets and so on.

At its best, because it is still a White Paper, the way it follows through, it should support the intentions that the Bill has to have a primacy of place, to integrate at place level and to make sure that integrated care boards in the NHS do push their budgets down to place level and work in partnership with councils to deliver integrated care for people.

We also welcome the resetting out of the focus on prevention and on population health. It is a follow-through from the Bill and, if it is seen through in the right way, perhaps it can ensure that the intentions are delivered.

There are of course risks with it. The proposal for a single accountable person at place level could be contentious. Personally, I think that, done in the right way, it can be compatible with both the accountabilities of an integrated care board in the NHS and with councils' own responsibilities. It will all be in the delivery. We should be encouraging the pooling of budgets particularly around reablement, intermediate care, prevention and the things that prevent people needing health and social care services in the future. We need joint activities from councils and health services to do that.

I think the jury is out. One final thing to say, and it references health and wellbeing boards, is that place-based arrangements build on what is there. Perhaps there are some other arrangements in large areas where you have something below the health and wellbeing boards, but you do not set up parallel structures to the things that are already there; you adapt them and change them if they are not quite right. I hope that helps.

Gavin Edwards: I will try to avoid repeating things that I have said already. My reflection on integration is that there will be a limited amount of success that will come from this in any integration when one half of the partnership, for example social care, continues to operate in crisis mode. There will be limits on the benefits that come from integration, which is something that UNISON in principle is in favour of.

From the point of view of the workforce, if it is easier for staff to move between social care and the NHS, that would be a good thing. It would be

something that our members would welcome. But the fact of the matter is people are not going to move from the NHS into social care when pay in the social care is so much lower than in the NHS. There needs to be some sort of equity.

Sarah has quite rightly mentioned a couple of times the lack of a people plan for social care. We have an unfunded people-plan in the NHS. If we are really talking about integration, would it not be sensible to have an integrated people plan for both health and social care that works for both sectors and is properly funded? For me that would be a really committed successful approach to integration rather than some of the reforms on the table at the moment, some of which are welcome, but, at the end of the day, are more around tinkering rather than producing the fundamental integration I have just referred to.

Darren Henry: Adrian, do you have anything to add?

Adrian Jenkins: Nothing to add.

Q213 **Darren Henry:** No? Nothing missing?

Adrian Jenkins: Not from me.

Florence Eshalomi: We are sleeping, aren't we?

Q214 **Chair:** We have covered quite a wide range of issues, quite rightly too. A lot of complex issues and changes are proposed and there are big concerns over funding. Is there anything else we ought to be giving some attention to or thinking about that you want to share with the Committee before we conclude today and move on to further consideration in due course?

Sarah Pickup: It is for the Committee to note the series of things that are being required of councils in the adult social care space all at the same time. We are coming out of Covid and there is a set of things to deal with there: a backlog of assessments and a shortfall of capacity in the care sector. We have the charging reforms that, as we have heard, are going to place quite a lot of pressure on councils to deliver. The date for implementation of liberty protection safeguards is yet to be finalised and that is going to be placed on councils as well. There is also all the work around the integration—integrated care partnerships, place-based working—which requires council input and requires activity to do the pooling of the budgets, to liaise with new partners in the systems. All of these things are coming at councils at once. Let me not forget the adult social care assurance that councils are going to have to prepare for and interact with in terms of more data collection. The coincidence of these things places a pressure on councils. That is just for noting; that is all. Thank you.

Chair: I do not think we can forget that; it has been made really clear during the course of our deliberations today. Anything else?

Gavin Edwards: Just one very quick one from me. We have referred to the lack of a people plan for social care several times in this session. UNISON is one of the co-chairs of the future social care coalition, which is a very broad-based organisation that includes employers, providers, politicians of all political parties, including four former health Ministers, and that organisation has produced a framework for the people plan. I can send that to the Committee Clerk if that would be helpful and you may want to include it in your deliberations.

Chair: That would be helpful, thank you.

Adrian Jenkins: We are just placing all the social care funding in the context of wider local government funding. We have been waiting for a fair funding review and other reforms of local government funding for three, four, five years now and, in some cases, that will fundamentally change the amount of funding that authorities have. Some are significantly underfunded, others will see reductions. It is important to realise that a lot of this funding is out of date now and does need to be updated. Council tax equalisation in particular is going to be a huge issue as part of that.

Chair: I remember that when we had evidence from the political representative of the LGA from both parties earlier there was a very clear message that you cannot sort out local government finance unless you sort out social care funding and I think that there is a lot of truth in that.

Thank you all very much indeed for coming and giving us a lot of detailed information today. It is really appreciated, and you have promised to come back with more information when you have it, or to pass it on now in its current form.

Thank you all very much indeed. That brings us to the end of our public proceedings for today.