HOUSE OF LORDS

Select Committee on Adult Social Care

Corrected oral evidence: Adult social care

Monday 23 May 2022

4.35 pm

Watch the meeting

Members present: Baroness Andrews (The Chair); Baroness Barker; Lord Bradley; The Lord Bishop of Carlisle; Baroness Eaton; Baroness Fraser of Craigmaddie; Baroness Goudie; Lord Laming; Baroness Shephard of Northwold; Baroness Warwick of Undercliffe.

Evidence Session No. 11 Virtual Proceeding Questions 85 - 89

Witnesses

I: Professor Donna Hall CBE, Chair, Bolton NHS Foundation Trust; Ian McCreath, Head of Think Local Act Personal (TLAP); Kate Sibthorp, Co-chair of the National Co-production Advisory Group, TLAP.

Examination of witnesses

Professor Donna Hall, Ian McCreath and Kate Sibthorp.

The Chair: We now move to the second part of our meeting. Before we do so, I have to correct myself. I did not mention that we are missing several members this afternoon. Sadly, Lord Polak, Baroness Jolly and Baroness Campbell cannot be with us. We look forward to seeing them the week after next.

We now move to a series of questions that pursue a slightly different narrative but also look at some of the extremely effective examples of change in place that we have seen. We have before us three wonderful witnesses to talk to us about these issues: Professor Donna Hall CBE, Ian McCreath and Kate Sibthorp. We will start with a question to Kate from the Lord Bishop of Carlisle.

Q85 **The Lord Bishop of Carlisle:** Kate, you have been here with us throughout, so you have heard what Luke and Fazilet have said to us. You have heard what they have been saying about negative stereotypes that still permeate society, especially when it comes to older adults and working-age adults with care needs and disabilities. It is quite clear that all of that has contributed in various ways to creating a fairly flawed definition and purpose for social care services.

As a committee, we are very keen, obviously, to establish a more positive narrative about adult social care both for older adults and adults with disabilities. As Luke put it earlier, we want to get the balance right between positivity on the one hand and realism on the other. I know that you have done a lot of thinking about this.

My question is whether you have any suggestions as to what this positive but realistic narrative might look like and how, in particular, equality might form part of it. How can we change attitudes as a starting point for designing a more effective system?

Kate Sibthorp: A huge amount of what Luke said about older people resonated with me as a mum to a young woman with learning disabilities and autism. To introduce myself, I am a mum to three children, all of whom are now grown up. My middle child, Maddie, has learning disabilities and is autistic. To give you some perspective, she needs support 24/7. She does not use speech to communicate, which means I am very much her voice in the relationship with our local adult social care service. The system sees me as an unpaid carer. We have support through direct payments. We get 43 hours' support per week, which means that Maddie's dad and I provide 75% of the care and support our daughter requires.

Maddie is a really beautiful person inside and out and is incredibly tolerant of us. She has taught us all a huge amount. I would describe my beautiful daughter as the beating heart of our family. I would say that we are all better people for having her in our lives. That is important because it is about valuing everybody; that is, people who are autistic and those

who have learning disabilities and how they make society a much better place by their presence within it.

I am co-chair of the National Co-production Advisory Group (NCAG). We work alongside Think Local Act Personal—TLAP—to help it co-produce the work it does.

For me, the current prevailing view of social care is one that has steadily been eroded. I go back to the 2000s when we had the *Valuing People* White Paper. For me, it has been two steps back and one forward, and then three steps back. We seem to have eroded the vision we had in the 2000s about people having rights and the value of independence, choice and inclusion. We seem to have moved more towards social care being seen as the bare minimum of keeping people fed and clean. That is not how I want it to be.

Social workers talk to people about the help they need with daily self-care tasks. They tend not to talk about what they want from life or what matters to them. I think we need to think about what gives people purpose in life; about how to grow friendships and relationships, and make people want to get out of bed in the morning. There are pockets of good practice, some of which I know Ian will talk about, but there is still a huge gap for me between what we aspire to in *Valuing People* and the Care Act, which we think is a great piece of legislation, and the reality check of the lives that people are actually living.

For me, the narrative we are looking for needs to be the #socialcarefuture vision, which I am sure will not have escaped your notice. It is brilliantly succinct. It says that the purpose of social care is for us all to live in a place we call home, with people and things we love, in communities where we look out for one another, doing things that matter to us. It is so simple in many ways, is it not? Personal care tasks matter, but they matter because they enable people to live a good life; otherwise, what is the point? Why would anybody want to get up in the morning?

If you want some ideas about what the vision could look like in practice, you have the Think Local Act Personal framework and Making it Real, which can help with some of that and set out what good, person-centred care and support looks like.

One of the reasons why that vision and Making it Real are so good is that they have been co-produced. They have been co-produced with people who draw on health and social care services, but also people who work in organisations, both statutory and voluntary, and I think that is why they are so widely accepted and robust and why they are, essentially, common sense.

Thinking about the question of equality, we need to be much better at being inclusive and welcoming everyone into community life. My experience is that people who have learning disabilities are still very much shut away. Many are still in institutional settings where they are

out of sight and out of mind, whether that is a large care institution or a smaller supported-living setting.

What is key for me is the fact that you cannot be inclusive or welcoming if people are not there to be welcomed. How do we support people to be present in their communities? I do not mean just going for coffee with a support worker and not talking to anyone else in the local community while you are there; I am talking about people getting involved in local groups and activities and sharing space with others. That is largely about mindset and daring to go where everybody else is. It might sometimes be a bit daunting. It will not necessarily cost more money, but when you talk about inclusion and equality there is something about people just being present. If you are not present, you will not be seen. That is really important.

Linked to that, I was interested in what the previous witnesses said about housing and general housing design. Because general housing is not designed to be accessible, anybody who uses a wheelchair cannot get in and out of general housing. My house was built in the 1930s. I cannot invite someone who uses a wheelchair into my house for tea because they cannot get in without a lot of effort. The same thing applies to disabled people in supported living. They can never invite my daughter for tea. There are all these physical barriers in the built environment that stop relationships from happening. There is something really important about that.

The other side of it is the need for more services and more mainstream people—I do not know if you can class people as mainstream—or ordinary people to make the effort to connect with people who are marginalised. I do not think we should expect those people to keep coming into our world of meetings, committees, et cetera. We need to go where those people are and do some genuine co-production in the community, as well as the more traditional ways of working together, but we need some shared space. It should not be on our terms; it has to be on people's terms if you genuinely want to co-produce.

I believe that equality can be hampered by what I see as our natural instinct to seek out and be with people who we perceive to be like ourselves. While there is clearly a place for that—I want my daughter to mix with other people with learning disabilities, but not exclusively—I think life could be much richer if we could spend more time with people who we perceive as different. Social care can help with that. That is well within the spirit of the Care Act, particularly all the parts of the Act that talk about well-being and community. There are lots of places in the Care Act where it says "should" or "could" instead of "must". I think that a lot of what local authorities do is "must" and they do not have the time or investment to deal with the "could".

I am not sure how helpful it is to make a distinction between working-age adults and older adults. I was in a meeting last week where someone talked about young old people and old old people and the idea that we keep putting people in boxes and labelling them. I struggle with that. The

key thing is to see everyone as a unique individual with valuable skills and talents. They will have their own unique care and support needs. I think back to my mum. When she was in her 80s, we tried to get her on a bus to go to a local day centre for older people. She cried and did not want to go because it was full of old people. We need to see the human being and not the age.

If you are looking for comparisons around what a good life looks like when you need care and support, I am not sure it is helpful to look at other disabled people, whether they are older or younger. We need to look at what is a good ordinary life and try to enable people who are disabled, old or whatever just to live an ordinary good life. For my daughter, I need to think about what other 30 year-old people are doing and then whether those things make sense for her. Interestingly, a lot of her life would seem to be channelled by services into more of the things for older people that Luke was talking about.

There is also a point about carers. My experience is that there is a big gap in support for people like me who have adult family members with learning disabilities or autism. I find it very hard, almost impossible, to have any influence at local level, so they are missing out on co-producing with us, because if they talked to us we could help make services better.

The big issue for carers and equality for carers is that they need to know their rights and the rights of the person they are caring for, so we need to know what the law says. If you have that, you will create the demand for better. We are in a market economy. How do you create the demand and aspiration for better services so that we can drive and compel services to get better? You cannot do that if people do not know what their rights are and what they can aspire to. We do not tell people about that. The whole social care system seems to have stopped doing good, person-centred thinking and planning, which is all about aspirations and good lives, so we need more of that.

I believe we need a lot more investment in learning programmes for families and people who access services. I did a partners in policymaking course, which some of you may have heard of, delivered through the people who now run In Control. It was absolutely life-changing for my family and I know it has been life-changing for hundreds and thousands of others, yet the system invests minimally in our learning and development, even though we are the ones who are around for the long haul and are delivering a huge percentage of the care and support in our society.

The Chair: I am awfully sorry to stop you. This is absolutely riveting—

The Lord Bishop of Carlisle: It is.

The Chair: —but I know that Baroness Barker has to leave in about eight minutes. Could I ask you to pause for a moment? I hope we can come back to you. I also apologise to the Lord Bishop.

The Lord Bishop of Carlisle: It was wonderful. I was going to say much the same. Thank you so much, not least for answering most of the supplementaries that I wanted to ask you as well, particularly about community.

The Chair: Lady Barker, I will go straight to you because I know you have to leave at five. We have already had the reference to Making it Real, so I think that makes perfect sense.

Q86 **Baroness Barker:** My question is to Ian. The Making it Real guidance has, by all accounts, resulted in material, tangible changes with local authorities. What do you think are the lessons that could be learned and scaled up from the Making it Real experience you have had so far?

Ian McCreath: Making it Real itself is a framework for how to do personalised care and support, so it is for people working in health, adult social care and housing and for those who access services as well. The idea of the Making it Real framework is to take the principles, values, policy and the law—the Care Act—and turn them into something real and tangible in everyday language that gives people confidence that they can understand what their next step is, or what their actions or priorities might need to be. The idea of Making it Real itself is not something that can bring about transformational change; it is only people themselves who can do that. What Making it Real does is give people a clear road map and framework and a way to begin to understand in a tangible sense what needs to change.

The real power of it—Kate has alluded to it as well—is that the Making it Real principles themselves were co-produced. Therefore, we are able to talk about "I" and "we" statements. The "I" statements are constructed and developed with people who draw on care and support in what they expect to experience, how they expect care and support to be organised and arranged, how they are supposed to be treated, and their role and place within the care and support environment. The "we" statements are about how organisations and providers can adapt and put those things in place and make real changes towards personalised care and support.

The Making it Real framework is a way of framing the conversation. It enables people to get together in a local area to begin to look at where the priorities are for change. If you have a vision, purpose and focus, that is a lens through which you can explore all kinds of different things. That is what makes the Making it Real framework so powerful.

The framework itself is organised into different sections, so it is able to look at different parts of the system and experience of using care and support. It looks at well-being and independence. We have heard about the importance of meaningful lives and the importance of choice, control and independence, and how often that is talked about in policy but is severely lacking in people's experience of care and support. It talks about information and advice. Kate was talking about the importance of individuals having that equal status and place in developing what is required in a neighbourhood or community, but also in their own lives

and care and support as well. It looks at active and supportive communities; it looks at flexible integrated care and support. Staying in control runs very much through Making it Real, recognising that people's lives change in a very personal way but also through services. So we need to make sure that that experience enables people to retain that sense of control; and it also looks at the workforce and how that itself needs to adapt and change.

The framework itself is what enables the discussion, conversations, relationship building and some of the building blocks that underpin personalised care and support to take hold and to take root. It can be used in any number of ways by any number of organisations. We work with local authorities that can sign up to Making it Real. It has worked most successfully where it has been supported by real strides towards co-production and a commitment to working with local people. Members of NCAG and TLAP with expertise and experience of Making it Real will work with members of the local authority and council and connect with local people as well. There are examples in Leicester, Doncaster and elsewhere.

When you begin to have those workshops and co-production conversations, you begin to understand what you want. That is the vision, and the "I" and "we" statements in Making it Real. You also understand the experience on the ground, where we are starting from. Then we can begin to see what is important, what needs to change and where we need to focus our energies and creativity. Where can we draw in examples from elsewhere that give us some confidence that the way we are going and the next steps are ones that will lead to positive changes?

That process is different in different areas. The framework itself is consistent. We can apply it in lots of different ways, but it is the conversations that root it in place. The reality of what people are doing and what is important is where the real power lies and where change comes from Making it Real. For example, local authorities might use it to look at how they do their direct payments process. What does that experience need to be like? How do we make sure that an individual retains maximum choice and control, whether it is a direct payment, an Individual Service Fund (ISF) or a managed budget? What is the information we give? What kind of support is it? How do we do the assessment? How do we link people into their local communities? Making it Real is a framework to open up the reality of what current practice is and how that can be changed or amended to improve processes, reports, expectations and relationships at local level to result in tangible change as well.

In addition to local authorities, equally it can be used by providers in terms of what their experience is like and how personalised their offer to people is in reality. How can their practice evolve and change? What is the experience of the people who use their services, again rooted in that co-production, conversation and equal relationship between people who

are accessing and drawing on care and support and people providing or commissioning it?

Equally, the Care Quality Commission (CQC) is adopting Making it Real as part of its new assurance framework from 2023. There is an opportunity to make sure that those same principles run through the assurance of local authorities' regulated care and support providers, integrated care systems, dentists and primary care general practice. It is that flexibility that roots it in a very tangible way back to the vision and principles that are already there in policy. It is in the Care Act and the White Paper, but often it is that link to make those changes and expectations tangible and real that is lacking. Making it Real opens up the conversations. It gives people the opportunity to say what they do not know and confidence that they can do something this complex and multi-layered only by working together in co-production.

Baroness Barker: Are there any data about this that we could look at?

Ian McCreath: What we can do is send you over examples—it is probably easier to write them down—of how it has been used, by whom and to what effect.

Baroness Barker: Thank you very much. It would be helpful to get a sense of the scale, because part of my question is about scaling up. There are more than 10 million older people, for example. I am not questioning the validity of the approach, but we have to see it in context. Stuff that would help us do that would be very helpful.

Ian McCreath: Absolutely. If you look at the website of Making it Real and the directory of organisations and local authorities that have signed up to it, you can see the scale of it and how the framework has been applied and used so far.

As to where we need to go next with it, it is already underpinned by and relates back to the Care Act. It already connects to the White Paper. The real scale and opportunities of it will arise particularly with the assurance framework as well as in defining what good looks like across whole swathes of the care and support system.

The framework itself can be picked up and used by anybody. It can also be accessed to support offers around the framework itself, but the work of TLAP and others around Making it Real is to try to articulate and understand the building blocks and tangible changes and differences that will result in realising the Making it Real vision. All the work across TLAP and the partnership and a range of other organisations and movements, such as #socialcarefuture, New Local and others, is pushing for the same ambition around personalised care and support.

For example, recently we have done a lot of work on understanding the issues with and barriers to direct payments, connecting people to real choice and control. Too often, the practice of a local authority around direct payments means that the principle of giving people choice and

control is lost and there is still too much direction and oversight and not enough trust. That is at the heart of the Making it Real framework, but it is also the basis of a series of reports, workshops, materials and resources available to all local authorities on how to reflect on their current practice and put forward practical changes and steps that can improve the experience of direct payments, which will then result in greater choice and control and give people more personalised care and support.

There is a limit to the amount of engagement and support TLAP itself can give to people to put that into practice, but what we are looking at, at the start of 2022 and 10 years of reform, is making sure that that is the lens through which policy development is understood and that some of the tangible and practical building blocks of good, personalised care and support are understood, as well as the CQC assurance framework underpinning it.

Baroness Barker: If somebody could point us to any research about what effect this approach has had on providers and provision, that would be enormously helpful. Apologies that I have to go.

The Chair: That is a very important exchange. I will pick up from where Baroness Barker left off. One question that occurs to me—I will not ask the question I intended to ask because I think it is now redundant—is: where are the limits? Where does that leave your organisation? Is it a universalizable model? How do you control quality? It is very interesting to us to hear you say that it is a way of making it possible to implement the Care Act—which, sadly, has not been implemented—by giving people a set of tools, clear pathways and decision-making structures, as I understand it. There is then the CQC assessment process. In a way, you have the design and the delivery there, which is important. What would stop it being the thing that everybody reaches for?

Ian McCreath: With the Care Act and the White Paper, what you have is policy and law rooted in a lot of the right stuff. It is rooted in well-being, community, choice and control; it puts people in control and at the heart of their care and support. What is lacking is knowledge of how to put that into practice, and part of what is lacking is the commitment to fund and invest in those elements that will make it easier to put those things into practice. We have heard various examples today, one of which was referred to by Kate. She talked about co-production and putting people in control. People themselves are not given the investment and support to have the confidence, the learning and the opportunity to make those changes happen.

Having the policy and the law is not enough. What the framework does is give you a lens through which to begin to drill down and understand how to interpret the policy and law in various different facets and aspects of care and support. TLAP itself cannot effect that kind of change, but the framework can be applied to make sure there is that consistency of approach from a whole range of different perspectives and parts of the system. For example, TLAP is connecting people with lived experience to

policy leads in the Department of Health and Social Care to understand how to implement the White Paper, where the priorities should go and how we will design the next steps of reform. It is the Making it Real principles that shape and guide those decisions and discussions.

The CQC, in its assurance framework, wants to make sure that personalised care and support, choice, control, independence, the Care Act and White Paper are at the heart of the new assurance framework. It was the Making it Real "I" and "we" statements that unlocked how to do that for the CQC. The "I" statements were taken as a whole. The "we" statements were then co-designed and co-produced with members of NCAG and those with lived experience to make sure they met the requirements of the framework, but it makes sense of what their task is if they are going to try to implement the Care Act.

Equally, we need to look at the conditions in which this stuff will be possible on the ground. What kinds of leadership approaches, mindsets and paradigms do people need to understand their own role and contribution? With something as complex and diverse as not just social care but health and social care, communities, businesses and individual citizens, you need something that binds it together. You need that vision. Policy is not enough. You need something practical. You need a road map, so you have the vision of #socialcarefuture and the Making it Real framework that lays out the questions that need to be understood and responded to and how you organise your next steps.

It is about equity and access; it is about meaningful lives and well-being, which is universal. It allows you to ask questions about what those things mean and what is getting in the way with different groups, different ages and different protected characteristics, but fundamentally it all links back to something that is universal. Again, you can use the framework to understand health disparities and inequalities as well.

Fundamentally, it is self-directed support in how to get direct payments working better and individual service funds so that people have control over the budget and can make decisions about their own care and support and support planning. But that is not enough in itself. You need to make sure that there is innovation and there are opportunities and diversity in the marketplace as well. The only way you can do that effectively is by co-production. Again, the Making it Real framework gives you some of the tools and ways in to have those conversations. It is not the only one that can shape and look at innovation and market development, but there is a thread that goes through what needs to happen with commissioning and how commissioners need to work better and more closely with people who draw on care and support themselves.

The Chair: We might come back to you and ask for some other examples. I would like to see a way of getting a lot of people in a room with you and get them to take us through what they would have to do in order for us to see that approach working. We need to think about that.

We are now going to move on to another brilliant example: Wigan.

Professor Donna Hall, thank you so much for your patience. We are very grateful to you for being with us the whole time. I hand over now to Lord Laming for a couple of questions.

Q87 **Lord Laming:** Donna, thank you very much for helping us. We are really keen to learn from good practical examples of change and would love to hear from you how the Wigan Deal on adult social care came into being. Whose vision was it, and how was that vision translated into day-to-day practice? Fire away.

Professor Donna Hall: Thank you, Lord Laming, and for the invitation today. It is great to be here. I have enjoyed listening to all the witnesses so far.

The Wigan Deal was not any one person's idea. Very often, people come in in a heroic leadership way, whether as a political leader or executive leader. They set out a vision; that person leaves and then there is a new version when a new person starts.

I left Wigan three years ago. The beauty of the Deal is that it is about a place and it is designed by the people with the people. It is a fantastic example of co-production. A couple of witnesses have mentioned the importance of services that are co-designed by people with lived experience. If you were a business, why would you design services without thinking about the needs of customers and service users?

It started back in 2010. A member of the House of Lords, Peter Smith, Lord Smith of Leigh, who has passed away, sadly, was leader of Wigan Council for many years. I think that at a House of Lords event he met a woman called Hilary Cottam. I do not know whether you have read her book *Radical Help*. She wrote it about five or six years ago. It is all about redesigning the welfare state, including adult social care, children's social care and everything, in a different and more relational way.

I believe we have a problem in public services at the moment. Very often they are designed to keep people out, particularly in social care. We heard this morning the announcement about the children's review and the incredible profits being made by private sector providers of children's services at a time when services are so stripped and children are struggling. In a way, we have introduced a market paradigm into care and it is not working. I think we have tried to keep people out through eligibility criteria. I know that in the past the committee has heard from fantastic people such as Clenton Farquharson from TLAP on how eligibility criteria say to people, "You're not bad enough yet. Go away, get worse and come back when you are in a worse position, and then we might be able to help you".

In Wigan, the whole Deal started in adult social care. We started to try to think about how to prevent people falling into social isolation, loneliness and mental health issues. How do we try to identify people who need our support, whether it is people of working age, older people or children who draw on adult social care? Let us try to think of a different way of working

with them. Let us try to invest in the social infrastructure and community infrastructure around them so that there is something beneficial and helpful for them to do, based on what they like doing rather than what we think they like doing.

We were very expensive as a social care provider but we did not have very good outcomes. I remember that in the first year of being chief executive in Wigan back in 2011 I said, "Could we try to make some savings?", because it was the first year of the funding cuts. I was told that, if we tried to save £500,000, people would die and we could not make any savings. We realised we were spending money on lots of things that were not very good and people did not actually enjoy them, but we thought they were the right thing for people because we had not listened; we had not asked people, "What do you enjoy doing on a day-to day-basis?" We were putting people into day centres and shipping them around on a council minibus. They were doing activities in the day centre, but we did not really base what we did on what people wanted. It was pre Making it Real, but it was very much along those lines.

We used an anthropologist to help retrain all our adult social care workers to listen deeply rather than just assume we knew what was best for people and tick a box. We were not asking the person about themselves and seeing everyone as a unique individual. We were giving them what we thought was the best package of care because it was the most expensive, but it was not what they needed and wanted.

We designed something called the Different Conversation Toolkit, which was very similar to Making it Real. I wish we had had Making it Real at the time because it is fantastic, it really is. I completely agree with what Kate said earlier about the #socialcarefuture vision. That is the best I have seen. As a committee, I would use that, if you have not already.

We decided to invest in prevention. We did things that were quite unusual. We tripled the size of our reablement team. I am not sure whether you have come across reablement, but it is a service local authorities run to try to support people when they have had a spell in hospital to get them back on their feet. We saw people in Greater Manchester, our neighbours, cutting their reablement service, but we thought we had to work with NHS colleagues and primary care colleagues and invest in keeping people out of hospital. It is not the best place for people. Keep people fit and well and safe at home.

We also developed a deal for adult social care where basically you are treated like an adult and are given choice and control over the services you receive. People working in multidisciplinary front-line teams, including social workers, social carers, support people and voluntary sector people, will all work together as a team around you.

I know from my own personal experience—you will too—just how difficult it is to navigate the complexity of social care. I remember that when my mum came out of the hospital I now chair in Bolton to die at home she had 22 different bits of health and social care coming up her drive on one

day. It was like a major project management exercise. Luckily, she had family to support her. For people who do not have family it is really difficult.

We gave absolute permission to innovate to integrated place-based front-line teams. We managed to save £160 million by working in this different way with communities. We put £13 million into the community and voluntary sector to support people to do fantastic things, whether it was to do with mental health, dementia support, supporting people around rugby memories—people with or without dementia could get involved in that—or men's walking football. In the end, we managed to add an additional seven years of healthy life expectancy in the most deprived neighbourhoods in Wigan by relentlessly putting money into prevention and valuing and trusting staff. People mention trust being really important. I think that some people who work in social care are scared to do the wrong thing, because there is a very tick-box culture in many parts of it.

I chair a charity for people with learning disabilities, called Possibilities. It is very asset-based co-production. We work across the north-west of England. We find it is very different in each of the local authorities we work with. Some places such as Wigan are amazing. They do some brave and courageous things. We have built housing for people with severe autism; it is co-designed with them. The spaces are designed for them and with them. We have brilliant examples of people who have gained independence, have got jobs and have gained friendship groups.

As I think Kate said earlier, if the housing is not there, people have to live at home or in an institution. It was great, and it is still going on. The Deal was not about me or Lord Smith; it was very much about the place. If you are interested in finding out more, the King's Fund has looked at it and written a good evaluation of how it works, what makes it work and its success.

Lord Laming: We would like that very much indeed. That is terrific. On what you described as the most expensive model used by social workers and others, that would apply equally to your neighbouring local authorities. What was the difference in Wigan? Why are your neighbouring local authorities, even if it is just for budget bottom line, not doing something similar? What can we say that would encourage people to think in what you call the Wigan way?

Professor Donna Hall: You could tell them to read the King's Fund evaluation. The biggest risk we face in social care is not to change the way we do things, because the whole service will fall. Things will collapse. I chair a foundation trust in Bolton where we have, on average, four wards full of people with nowhere to go because their social care has been stripped back. We do not pay people enough. We have to start to see care as a valued profession.

Looking back at the Beveridge report, care was forgotten about at the time, was it not? He realised that he had forgotten about it, but by then it

was a bit too late. We had set up the NHS, but it was done like that largely because women did care for free. You could argue that for lots of people it has not really changed. As a society, we need to shift towards valuing care. People who work in social care are the most patient, amazing and wonderful people, and we need to value them and treat them like that. People do not do it because it is hard to subvert the existing system, the tick-box culture and the very risk-averse commissioning culture. We need some courageous leaders, including politicians, at social care level.

Lord Laming: We are interested in teamwork across organisational boundaries in health, particularly social care and the like. Has the Wigan model improved relationships across organisational boundaries?

Professor Donna Hall: Yes, it is absolutely essential. A huge amount of this was co-designed with the NHS, primary care networks and the police. We worked intensively to risk-stratify the population and find out who needed help before they ended up in accident and emergency threatening to take their own lives, or having tried to do so. Risk stratification is something that clinical commissioning groups tend to do, but very often people do not act on it. For us, it was about focusing on prevention and multiagency working.

We worked out that we were spending, on average, £250,000 per year per family on families we were just passing around the system without building a relationship with them and helping them. At the end of the year, with a £250,000 spent, they were in a worse position or the same position as they were at the beginning of the year. We have to think differently about how we use the resources we have in public services, and how public servants work together in a place around a person and a family to provide the support they need by listening to them, and then coming up with an answer that does not have to fit eligibility criteria but is much more personalised. I hope that is okay.

Lord Laming: That is terrific and inspiring; thank you very much indeed.

Q88 **Baroness Goudie:** Professor Hall, I heard what you said about the number of people who turned up unexpectedly. I am helping somebody at the moment. One day we had 18 people turn up, with the appointments not necessarily being known about.

To what extent did the commissioning process change to enable the Wigan Deal on adult social care, and how, and who did you have to convince to make this change?

Professor Donna Hall: Being really honest, this was a bit of a struggle—

Baroness Goudie: I am sure.

Professor Donna Hall: —because there was a bit of a risk-averse mindset in the clinical commissioning group at the time. There was a change of leadership. It is amazing what a change of leadership can do in shifting a whole organisation's mindset and culture.

Eventually, we worked together to co-commission on a primary care network basis. We would get GPs working together in a local neighbourhood with consultants at the local hospital, the community and voluntary sector, and the council and social care, to come up with a plan for individuals rather than having very strict silo commissioning services. The Clinical Commissioning Group (CCG) commissions over 500 different services, but they are not wrapped around a person. They are all separate and really expensive, and they do not have co-production at the heart of it. We managed to shift that, but it was really hard. I carry the battle scars to this day. I am hopeful, with the new integrated care systems where local authorities have to work with the NHS in the 42 statutory areas, that there will be a better, much more person-centred approach to commissioning in the future.

The Chair: Thank you very much. Our final but by no means least important question is from Baroness Shephard.

Q89 **Baroness Shephard of Northwold:** Chair, Professor Hall has answered a lot of the points in the question. I want to ask, I hope, some relevant things, briefly. You have said that it has worked in Wigan because you have a sense of identity and a sense of place. Can you tell me the size of the population you are dealing with?

Professor Donna Hall: Altogether we have 323,000 people living in Wigan borough.

Baroness Shephard of Northwold: That is the total size of the area.

Professor Donna Hall: Wigan is the ninth-largest metropolitan borough in the UK.

Baroness Shephard of Northwold: That is excellent, because it gives me an idea of how you can have a total local authority area with a sense of identity. However, do you think that such an approach could be made to work in a large, far-flung rural area, such as a county that might have eight separate district councils and a very much greater number of institutions? If so, how do you think that may work?

Before this work was started, there must already have been—is this the case?—a lot of good will and a sense that it could be done for Wigan. It is very different if you say, "Can we do it for North Yorkshire or Norfolk?" People think it is not different, but it is because of scale, separation and the existence of many different communities in large rural counties, which, after all, are your administrative management tool. It is hard to instil a notion of one identity, whereas in Wigan, with that size of population, you could and you have. That is not to detract from the fantastic story you have told us this afternoon. It has been an inspiration, but these are sticky questions. I am just intrigued to know how we might be able to suggest that such a pattern could work elsewhere.

Professor Donna Hall: That is an interesting question and it was one that the King's Fund asked us many times when it came to spend almost a year living with us to see how it worked, speaking to staff and

residents. It wanted to look at the replicability of it in other places. Interestingly, it said that what made it different was clarity and constancy of purpose, which could happen at county council level—what we were there to do as public servants—sticking with that clear, reformist mindset, reforming public services and having that clear narrative, very similar to the Making it Real narrative. It is very simple and clear and guides all conversations, but within that you have individual towns and villages in that broader context that need a different emphasis and focus. I think that is where the integrated neighbourhood teams come in. In Wigan, with a population of 323,000, we have seven.

All the international evidence shows that populations of between 30,000 to 50,000 are the best footprint to do integrated neighbourhood services. A bigger county council, as long as it has the right mindset and framework of how it is going to work with citizens, can do quite a lot of devolved working with those neighbourhoods—villages, towns and shires, if you like—to make them bespoke and bright for those local citizens. Lots of London boroughs—I have been to speak to Islington—want to do the deal. Manchester City Council did it and called it Our Manchester, but obviously it is a big city and so a very different demographic from Wigan.

Baroness Shephard of Northwold: It is a different mindset and different sense of identity.

Professor Donna Hall: Completely.

Baroness Shephard of Northwold: From what you are saying, it is the sense of identity of Wigan as a whole. I hate to say this, but it is like a football team, or whatever it might be. I am not pouring cold water on it. I think it is fantastic. I am trying to see how it could be made to work with some ease in different kinds of communities. That is all I am after.

Professor Donna Hall: I absolutely understand.

Baroness Shephard of Northwold: I think it needs several clones of yourself. That would be helpful.

Professor Donna Hall: I am not sure that is a good idea, but thank you.

Baroness Shephard of Northwold: You have answered it, fine. What you have said is so inspiring. Thank you so much. There is such a lot of food for thought.

The Chair: It is quite a challenge. I am not going to attempt to sum up. I have just a couple of questions to Donna at the end of that. Clearly, some of the model has been adopted by others. You mentioned Manchester and Islington. Do you think you could do a bit of extra homework for us and try to identify the places that have been moved enough to try to replicate it? Quite clearly, you have absolutely cracked something that is really fundamental.

Among the many striking things you have said, the thing that I take away is that the greatest risk is not to change adult social care and not to

innovate. We have heard a tremendous amount about innovation this afternoon and about barriers to scalability, but also the many mind-shackled barriers to this. It is about evidence, confidence in the system and people's ability and willingness to change.

We have been talking about what it takes to change at every stage this afternoon, starting with Luke. There was some wonderful personal testimony by Kate about the value of bringing up a severely disabled child, not just to the family but the whole community.

We have gone from the global, as it were, to the very specific, the personal and the family. It has been an extraordinary session. I thank all of you, not just for talking to us but for doing what you are doing and enabling us to see that there are things that can happen. If we as a committee can identify, articulate and maybe amplify some of what you are doing because it works, we will be doing something, I hope, to enable you to do more and for the system to embrace change.

I think I share your optimism about the integrated committees, Donna. We are certainly in a better place than we were last year. Let us all work to make sure it happens.

Sorry, I did not mean to make a speech. Thank you so much on behalf of the committee. We would be very pleased if you would stay alongside us in the rest of our work and make sure that what we say at the end are things that you think are worth saying. Thank you very much indeed. This session is now formally closed.