



Adult Social Care Committee

Corrected oral evidence: Adult social care

Monday 4 July 2022

3 pm

Watch the meeting

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

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Questions 149 - 164

Witnesses

[I](#): Gillian Keegan MP, Minister for Care and Mental Health, Department for Health and Social Care; Michelle Dyson, Director-General for Adult Social Care, Department for Health and Social Care.

Examination of witnesses

Gillian Keegan and Michelle Dyson.

Q149 **The Chair:** Good afternoon, everyone. It is a pleasure to see the Adult Social Care Committee in person this afternoon. Two members of our committee are virtual: Lady Shephard and Lady Fraser. We have apologies from Lady Campbell, who I am pleased to say is recovering well. Two Members will probably join us a little later.

I welcome Gillian Keegan, the Minister for Care and Mental Health. It is a great pleasure. I know what your diary must be like, so we are very appreciative of you and your diary secretary finding the time. We also have with us Michelle Dyson, director-general for adult social care in the Department of Health and Social Care. She has become an old friend; we have had the pleasure of hearing Michelle before. You are extremely welcome this afternoon, and so are your officials.

Let me give a very short background to where we are. Michelle, you were with us at the very beginning in an extremely important session, because you laid out the landscape for us. You were very frank and said that there were some things, such as co-production, where you were not entirely sure that you knew much of what was going on. Perhaps we can talk about that at some point in the afternoon.

Essentially, we wanted to explore some of the less-travelled pathways of adult social care. The one we focused on, of course, was unpaid carers and the people they care for and care about. Amidst all the work that is going on in this field in the all-party groups and your own work, the White Paper and last Session's Bill, there is a huge amount of activity. We were keen to find something where we could add value and that we could report on in a year, which is a very short time in the life of a Select Committee.

Unpaid care turned out to be an incredibly fertile and very powerful field of inquiry. It not only resonates across the whole field but is complex and very personal and fragmented, so it is quite elusive in some ways. Deliberately, by design, we decided that we would put a heavy emphasis on co-production, and that we would take as much evidence as possible on co-production from people with lived experience who could tell us what it was like on the ground trying to access appropriate care or trying to get a package that enabled them to live an ordinary life, rather than a life that was inevitably constrained by what they could get. Rather than default mode, we were looking for opportunities to see where local authorities had produced creative and generous ways of supporting the adult care population, maybe not generous financially but in spirit. All our evidence has been on those sorts of issues.

We are deeply conscious of the impact of money, and the lack of it. We are deeply conscious of the manpower and womanpower situation. Nothing escapes that. Looking through that lens, we see the way that it impacts on ordinary lives and limits them. Our questions this afternoon are as much about culture and language as they are about policy, frankly.

I know it is a very difficult challenge to make policy-derived culture. Culture eats policy for breakfast. We have in place the Care Act and the new ICSs, which carry expectations, yet unless we can crack some of the fundamental problems, they may not fulfil their promise. The Care Act is certainly a piece of legislation that has not done what it was hoped it would do.

A lot of those questions will surface in different ways today, but it is a conversation and not an interrogation. I hope that Michelle will feel free to chip in at any point. I will start with a fairly basic question. What has affected us is listening to carers, some caring for families and multiple generations. Some people are in fact highly gifted. They are trained social workers who are disabled and now dependent on families and on what they can do. Without exception, we have heard a tale—we have not led questions—of people who feel that they are invisible. That, of course, was the core of our inquiry.

What is this invisibility that we keep hearing about? They feel invisible. They feel that they are silent a lot of the time. They are often seen as a burden and a problem rather than as a contributor or part of a solution. Their work is valued externally, as it were, but they do not feel that it is valued, or that their contribution is seen for what it can provide, which is a very important part of the solution to the challenge of how to care best and how to create the best opportunities for better lives.

What do you think the Government can do, beyond the great policy statements and the White Papers, to change the perception of adult social care? We hear that the system itself is seen as the poor servant of the NHS. What can the Government do to address that big, big issue?

Gillian Keegan: Bearing in mind what you said, I will take it in two parts. There is the overall adult social care system and how that is seen in relation to the NHS, which is what it is always compared to. Then there are unpaid carers, who are of course a separate group of people, often family members caring for a loved one, often, but not always, in their own home.

First, there is no doubt, post the pandemic, that the profile of social care has massively changed. At the beginning we had a period when the most vulnerable people in our society were in care homes. We were looking at those situations and those figures every night, and care workers were pretty much their only lifeline. We saw cases in different parts of the world where that had not happened and the care workers had not stayed and looked after people, so we saw horrible situations. I think suddenly everybody realised and felt so vulnerable. Their loved one was in a care home, and effectively the only people keeping them alive when this very unknown pandemic—at that time it was very unknown—was going around were care workers. Care workers shot almost right to the top of public consciousness during the pandemic.

Of course, they were a lifeline to people all the way through, not only making sure that they were cared for; many care workers actually stayed in the care homes so that they could protect the people they were caring

for. Obviously, they had lots of equipment and stuff in there so they could try to facilitate visits as much as they could when they were allowed to. Their role and the fact that they were a lifeline became much more visible.

That is probably one of the positive things to come out of the pandemic. I have been in this role for the past eight months, and we have certainly celebrated care workers and carers several times with various events in Parliament and various weeks. We have had receptions in No. 10. In fact, there was a reception in No. 10 today to celebrate the NHS's 74th birthday, which included care workers and carers. I think a group went to Wimbledon yesterday. People now want to try to make sure that, when they offer these rewards, they offer them to care workers as well as the NHS. From that perspective, there has been a big change in their profile across the country. Ipsos MORI now puts it as one of the No. 1 most trusted professions in the country. As a politician, I am very envious of that. I think they became very visible because people could not see their own loved ones.

It is clear that adult social care reform is a top priority. Many people have talked for many years about how urgent it is. We know how difficult it is to raise sustainable funding to make sure that we can take on these big reforms. They have not been done before by successive Governments, but they are really important to do. On top of the pandemic, the reforms will make a massive difference to the visibility and the profile of the role. One of the things that we concern ourselves with is making sure that we can attract many people to want to work in social care. Most businesses are nothing without their people, but social care truly is nothing without its people. You definitely need to make sure that you attract people.

We know that we have a lot of work to do to build up and invest in the workforce, and to make sure that they can capture all their training and have career progression. That is a very normal expectation, but it does not work in this very fragmented workforce. Of course, the difference between that and the NHS is that the NHS is the NHS. It is public sector, whereas with care we are basically talking about close to 18,000 different employers in different forms and with very different business models across the country.

The reforms will focus very much on bringing the roles of social care workers to the fore. When you look at them, they are akin to many workers in the NHS. We need to make sure that we can facilitate career progression throughout those two professions. That is the first thing.

There are many differences in the numbers and the estimates of unpaid carers. I am sure you have seen that. Using the one that was last done in the census, which is invariably wrong because it is old information, there are about 5.4 million unpaid carers, but there are different estimates. Some are below that and some are above that. Many of them are caring for a relative at home, and many of them are caring for somebody in their own home.

One of my first concerns in this role, and one of the first things I looked at, because obviously we were mid-pandemic, was that a key part of supporting unpaid carers is making sure that they have the support they need in social care or in at-home nursing, if they need that, as well as respite and breaks. Anybody who has ever looked after a family member, or knows somebody who has, knows just how important it is to support the unpaid carer. During the pandemic, quite a lot of those services went, so we were keen to put enough focus on making sure that those respite services came back as soon as they could—obviously, based on when it was safe post the pandemic.

Part of the better care fund—if I remember rightly, it was £285 million—was specifically focused on making sure that we had respite services. I go round and talk to carers all the time. I chair my own advisory forum, but I have also been round to a number of carers' groups and have listened to them about what they get. I hear mostly that some people get very good support and some people think that they get virtually no support. It certainly is not uniform around the country.

I recognise, having had unpaid carers in my own family caring for people with dementia a number of times, that this is not a job that you signed up for. It is one that you did not think you were going to get, until the day before you got it, usually. It changes your life as much as life changes for the person you are caring for. The support that you need along the way is absolutely vital.

We recognise in the reforms that we definitely need to do more. We have up to £25 million to look at innovative models of how to support carers better. Anyone who divides that between each carer for however many pounds or pence it will be is missing the point. It is to look at what models will really work for local authorities to support unpaid carers, who are a vital part of our care system.

The Chair: Thank you very much indeed, Minister. Do you accept our general thesis that unless we find a way to raise the profile and the salience of the unpaid carer in society, we will go on asking huge amounts of them without giving them the opportunities for fulfilment and support that they need? How do we tackle the invisibility question?

Gillian Keegan: That has been quite a big focus in the White Paper, where we said that we absolutely need to support unpaid carers better. They are a vital part of the care system. First, we need to know who they are. During the pandemic, when we wanted to prioritise unpaid carers for vaccinations, we realised that we did not have the data on who all the unpaid carers were to make sure that we did that. I think you put a system in place where you sent letters out, Michelle.

Michelle Dyson: Yes, we used carer's allowance data. It was really complicated to get to it. It was a combination of carer's allowance data and local authority data. GPs also have a list of carers and their records. We were able to promote that, which was a force for good. If GPs know who among their local population has caring responsibilities, they can

give particular attention to those people. We really drove up the numbers of carers whose identity we were aware of throughout the system.

The Chair: Michelle, we hear a lot about the difficulties of language. Language is often a barrier. Often, people do not want to be known as "carers". They want to maintain a family relationship, which has dignity and continuity, without suddenly becoming an artificial aid to the person they love. How can we crack that? Have you thought about that in the department? Is there anything else that would work that would also allow them to be identified as carers?

Michelle Dyson: That is a really interesting point.

Gillian Keegan: We have not heard that.

Michelle Dyson: I had not heard that before.

The Chair: We have heard it a lot.

Michelle Dyson: Our focus has been more about how we make sure that all the systems at local level recognise the role of carers, however described. For example, we have put new duties at the integrated care system level for integrated care systems and NHS trusts. In the legislation we use the word "carer" because it has common currency. I have not heard the point that that creates a barrier.

The Chair: I am not going to labour the point, but it is quite important because it goes to the heart of a lot of things that go wrong. It goes to the heart of the fact that they see themselves as invisible. They become a carer and suddenly the relationship they have with the person they are caring for becomes slightly different. Without exception, we have heard it consistently: "We wish there was a way of maintaining our identity".

Gillian Keegan: That is important, and I have heard: "How do I continue with my work? How do I continue to go to my class? How can I still go on holiday with my friends or on a trip that I was planning?" Those practical elements of how you can keep your own life at the same time as having caring responsibilities are very much something that we heard.

In terms of identification, even with young carers the DfE is adding them to the census so that it can identify each of the young carers. The challenge we have is knowing who they are, or them being able to access us. That is part of what the up to £25 million is there for. It is to make sure that we can try to have some kind of carers' hub that will enable us to build networks and information. Information is key.

The Chair: Indeed. We will certainly be coming on to that. Thank you so much.

Q150 **Lord Laming:** Thank you, Minister, for coming along today and for your help. I suspect that you and unpaid carers have something in common about how to penetrate the social care field. Social care is provided through 150 local authorities and thousands of independent providers.

Therefore, trying to create a coherent picture is extremely difficult. We have every sympathy for you in doing that.

One of the things that comes through, as the Chair indicated, is that many carers find it extremely difficult to have a voice in the system. They have difficulty getting information about how their needs might best be met. They say how difficult it is to get any kind of recognition for what they are doing. We have been exercised by the failure in many places to implement the Act properly. We wondered whether you had a strategy to bring about some influence and co-ordination in this field.

Gillian Keegan: Yes, definitely. As you mentioned, the Care Act places a duty on local authorities to establish and maintain information and advice services related to care and support for all people in their area. We know that is easy to say, but the quality of what is done, how it is done and at what level by all the different local authorities is always the challenge. We are committed to making sure that people who draw on care get a good understanding of what might be available in their area, given their particular circumstances and what their loved one has been diagnosed with.

We have committed to providing dedicated funding of at least £5 million to pilot new approaches to providing personalised advice to those who draw on care and support and to get better evidence of what works. We have seen some brilliant examples. In Hertfordshire, for example, HertsHelp is a community and hospital navigation tool that helps people to identify and access community support. It seems to work really well and people engage with it very well. It helps them to maintain their independence, health and well-being.

In my own area, we have a dementia hub, which is fantastic. If your loved ones are diagnosed with dementia, you go there and there is training, power of attorney and all kinds of things at the hub, as well as getting a network, but it is a charity. It is an independent thing. If only everyone who has just had a diagnosis of dementia could have one of those hubs.

We know that ultimately we need to do better. I do not know whether you saw the programme that Ed Balls did. There was a chap whose wife had been diagnosed with dementia. He was spending his days building a website to help other people, so that they could avoid having to go through what he had been through, trying to figure out what you do when you get home with that diagnosis, thinking, "What next?"

We absolutely need to do more. We think we can play a role in gathering best practice and making sure that we help local authorities to do that. There are an awful lot of things in the reforms, in the capability building and in the digital aspects of digitising the sector, which will help enable the flow of data. Some of the basics that come from the reforms are probably also important for doing something that works well in a way that is sustainable. The key thing is making sure that you can update

information, and ultimately it needs to be done in a digital way. A lot of the reforms will help to turn those words into practice.

Michelle Dyson: I completely agree that the reforms have to be seen as a packet. One of the important reforms is that we have just taken new powers in what is now the Health and Care Act for the CQC to hold local government to account for the way in which it exercises its Care Act powers. The CQC and Ofsted already hold local government to account for how it exercises its children's social care functions, but it has never been held to account for how it exercises its adult social care functions.

From April next year, local government will be held to account. We will get transparency and we will be able to see who is doing which of their functions well. That will really help with the best practice that the Minister was talking about.

Q151 **Lord Laming:** That is very helpful. I have one more question. In the light of what you have said, do you think that we need a new vision about the way in which we view carers, particularly unpaid carers? At the present time, it feels, for many of them, as if it is professionals talking to professionals and that they have no part to play in what, after all, will be a major part of their life and will, as the Minister indicated, restrict their life very considerably. They are not consulted and they are not informed. In other words, the professionals feel that their commitment is to the patient, and they have no responsibility for the carer. Do we need to rethink the way in which we value carers, particularly unpaid carers?

Gillian Keegan: Yes, definitely, because they are part of the caring system. We saw some of that quite recently. The people you have been talking to may not have seen aspects of this, but when we made the changes to discharge and discharge to assess, a big part of that was making sure that the person who was caring at home, if that was the situation they were going into, was also part of the conversation and part of the discussion.

Some of the good practice in helping share the burden sometimes of carers has been trialled in Camden with something called family conferencing. It is not just one person; a group of family members have a conversation: "I can do this. I can do that. I can call every so often. I can take Grandpa out", or whatever it is. There is a bit more of a broader conversation. Quite often it is done very quickly, and sometimes people feel it is "done unto", which is obviously not right.

It is very important that unpaid carers' well-being is taken care of. Some of them are often quite elderly themselves, so it is very important that their well-being is taken care of. If they fall over, some very difficult decisions often have to be made. That is part of personalisation and bringing in the carer, or the partner, wife, husband or however they want to be called. I get the point that they have been the wife or husband for many years and they want to continue being referred to as that, with additional responsibilities. It is absolutely key. It is at the heart of making

sure that people feel valued and listened to and are part of the solution, but also that their needs are taken care of.

Q152 Baroness Warwick of Undercliffe: Thank you very much, Minister. In her introduction the Chair pointed out the amount of legislation, both recently and in the last few years, which theoretically should have done a great deal, but I think you recognised yourself that, even where something has been done, it is quite partial across the country so that nobody can rely on the consistency of the care they are likely to get, or be aware necessarily of what is available. This is all part of the huge wave of frustration that we found as a committee from unpaid carers. Basically, they told us, "We need hope that something will change".

You talked about the up to £25 million to identify and test a range of interventions to support unpaid carers. It would be an enormous help to us to have something a bit more specific. Could you tell us exactly what the interventions are? Who is expected to deliver them? What will their outcomes be, and why should that give the estimated 6.5 million carers in the UK some hope for change?

Gillian Keegan: The specific interventions that would give the most hope for change are, first, much better support, information and signposting to support when you are first in the situation that you have taken on a caring role. Usually, that is as a result of somebody being diagnosed with something, or having an accident or something. The first thing is to make sure that you feel better supported at the beginning of that journey.

Secondly, and really important, are the respites. One of the things that is difficult about that decision when you become a carer is what happens to you and your life. If you work, what happens to your ability to work? If you do not work but have just started to enjoy your retirement and want to be able to continue, what do you do? I think respite is most important.

It is knowing that you have the social care system there along the journey. Quite often people's condition will progress. I have spoken to many unpaid carers who say, "I could cope until the point when my husband couldn't go all the way through the night, and then I had to get up every couple of hours to help with some specific care need that he had". She was doing that on her own, and it did not take long, waking up every two hours, for her suddenly to feel that she was doing it on her own. When she tried to get some night support she found it difficult to get.

Baroness Warwick of Undercliffe: Impossible.

Gillian Keegan: It was impossible to get it. The other thing about these key reforms is that we need to be able to have a much more sustainable social care system either at home, or in a home. It could be that it is respite in a home, where you go for a week or 10 days. Actually, many of the newer residential care homes are quite smart. They have guest facilities so that they can enable those kinds of things. The social care system and the reforms that we are doing need to be there to support unpaid carers as they go along this journey. Ultimately, most people want

to stay at home as long as they can, and that is better facilitated by better care at home. Sometimes technology can help as well. They do not have to become computer whizzes; the technology will do it for them. There is a lot of focus on what care technology can help with in the home and a lot of research on dementia, because, although not exclusively, many of the elderly people we are talking about could have dementia.

For working-age adults, it is much more about the ability to have control as well. It is making sure that direct payments work well. Many people want to have the control of being able to use direct payments but feel that they are taking on too much of a risk. If they have somebody and then that somebody is no longer there, what do they do? Are they stuck? Is anybody else going to help them? It is about providing back-up and making sure that they do not feel that by taking control they are taking full responsibility without any back-up.

The reform of the system is an underpinning foundation to make sure that there are better services and more supply of those services to enable a lot of those care models. We have an innovation and care fund, specifically to try to look to innovate and scale some of the brilliant practice that is there, but it is only in one or two areas. We need to be able to scale that and embed it, so that people everywhere get a much better service, which is much more supportive as their care journey changes or as the journey of the person they care for changes. Do you have anything to add, Michelle?

Michelle Dyson: Can I add how we envisage the up to £25 million working?

Baroness Warwick of Undercliffe: Yes.

Michelle Dyson: This is a pot of money that we will offer to local authorities for them to bid into. We envisage that going live in the autumn. We are trying to get ideas from the local level, which we will invest in and scale.

At national level we have commissioned research from the National Institute for Health and Care Research. That is coming to us, we hope, over the summer. We are approaching what best practice looks like from a research angle. Then we will go out to local authorities, ask them for ideas, choose the best ones, those we think we have most hope of scaling. We hope that will go live at the beginning of the next financial year and run for a couple of years. The plan would then be to evaluate it, take the best practice and roll it out across the country, using the new improvement funding that we have as part of our overall reform package.

Baroness Warwick of Undercliffe: Thank you very much. You said in response to the Chair that it was really important for people to know what was available in their area. It is part of the problem, is it not?

Gillian Keegan: Yes.

Baroness Warwick of Undercliffe: What we really need to focus on is

what people need, so the response has to be variable. One of the things that would make me quite anxious about this, although I think it is very encouraging and hopeful, is that if it is not focused on the actual needs of the person being cared for and the carer, we will fall into exactly the same trap as we have already. Different local authorities will be providing very different services and, again, nobody will know what to expect. Where is the hope in this? How will you ensure that there is a greater degree of reliability in the system?

Gillian Keegan: Everything we have talked about will improve the reliability. The fact that it has not been done before and that we are where we are does not surprise me. If you do not do these things, they will just evolve and develop individually.

Much of the support is done by the voluntary and third sectors. They are very good at community level at responding to need. The difficulty at the moment is capturing that need, knowing who the people are and where they are. Having a hub, a place where people can share information, make themselves known and join local networks will really help to make sure that their need is visible. A vast majority of people want to support and help their local community. A lot of the initiatives in the community since the pandemic have been brilliant and have continued since the pandemic.

I fear less when we have the ability to know where the unpaid carers are, understand more about them, understand what is on offer locally and look at the gaps. Obviously, the integrated care systems will also have that responsibility, where the NHS and the local authority will be looking at a group of people who are regular customers of both; often, they are people who are big users of the health and social care services. If there is a gap in need, hopefully through the ICSs or the voluntary partnerships working locally, people will look to fill that gap. People are very good at doing that.

The problem at the moment is that the need is quite fragmented. It is as you said at the beginning, Chair. I would not say that it is invisible, but it is a bit unseen at times, because we do not have full information. If any local authority tried to identify all their unpaid carers, they probably have a better chance now post the pandemic than they did before. Having that dynamic relationship is really important, particularly for those who do not yet rely on local authority services as well.

Baroness Warwick of Undercliffe: Thank you.

The Chair: Michelle, can I follow up on something you said to Lady Warwick? As I understand it, the up to £25 million will be solicited. You will go to specific local authorities that you think are doing exceptionally interesting interventions.

Michelle Dyson: No, we will open it to all.

The Chair: You will open it to all.

Michelle Dyson: We will see who comes forward. I should have said that one of the things we will ask and expect the local authority to come forward with in whatever plans they come up with and want us to fund is that those plans should have been co-produced with unpaid carers locally.

The Chair: That is very important. Are you asking that they test for scalability?

Michelle Dyson: We absolutely will. That is the core part of this.

The Chair: Absolutely.

Michelle Dyson: There is no point just funding something that is small but goes nowhere. It is where it goes afterwards that matters.

The Chair: Except that, as we heard from many pioneer projects we have learned about, local authorities do not necessarily want to adopt the Wigan deal in Bradford. Everybody has a slightly different demography, a slightly different take on things and way of doing things.

Lord Polak: In answer to Lord Laming, you talked about concentrating on the digital way of getting this out. Not everybody is able to access digital. I have had discussions with the Home Office on separate things on that issue. I understand that that is the future, but there are people who cannot access that way. Are you concerned for them too?

Gillian Keegan: During the pandemic, a lot of iPads were delivered. I cannot remember the exact number.

Michelle Dyson: Eleven million.

Gillian Keegan: I was going to say 11 million, but I did not trust that it was that many. Maybe it was 11,000.

Michelle Dyson: No, it cannot be 11 million, sorry. It was 11,000.

Gillian Keegan: That is more likely; 11,000 iPads were delivered to care homes. They have revolutionised aspects of visiting. You always ended up with the usual two or three people who were down the road, close by, or within a few miles going to visit. However, for the son in Australia or the daughter in the States it was once every blue moon—once a year or once every two years. Now, we find that being able to have those regular calls has revolutionised visiting. We all went through that learning experience trying to educate our parents on how to use an iPad. I still have a regular Sunday where I look at my parents' feet or nostrils, as they have not yet figured out how to hold it, but at least I know they are there. That is one aspect.

The sort of technology I was thinking about is the technology that will allow care at home to be much better. The Dementia Research Institute is looking at being able to monitor people in their homes, looking at their skeletons and when they may be moving differently, looking at various

patterns of things, and using the technology to try to predict, through simple at-home tests, things like urinary tract infections, which we know are a big reason why people go into hospital. It is that kind of care tech as well as monitors enabling you. It kind of does it for you; you do not have to be an expert. In fact, you do not really have to do anything apart from learn how to switch it off if it annoys you. It is that kind of possibility.

It is how technology will help in the future to keep people where they want to be, at home for longer, and keep them healthier at home. We are talking about elderly people, but lots of people go into hospital with quite common things—a fall or a urinary tract infection—and there are some things that you can look for. Working-age adults have quite a lot of technology that is accessible. It can be very enabling for people to be able to work, move around and get things the way they want in their house.

There are a lot of things coming down the track that will help people to live better in their home, whether they are elderly and do not need to know a lot about technology, or of working age and probably with a good understanding of technology. It is how it works to help them work and live better in their home and outside their home.

The Chair: Thank you very much indeed, and thank you for that useful supplementary, Lord Polak.

Q153 The Lord Bishop of Carlisle: Minister, you spoke earlier about some of the practical difficulties for unpaid carers of retaining their own life and identity while they are caring. Of course, there is also a financial dimension. A number of the unpaid carers with whom we have been in touch told us they were living in something closely akin to poverty. Thanks to the White Paper, we know that carer's allowance increased last April by £2.10 to £69.70 a week. What other plans do the Government have to support unpaid carers financially?

Gillian Keegan: Most of the support for unpaid carers is in benefits, and the DWP is responsible for benefits and assessment. In addition to carer's allowance, unpaid carers who are caring for someone over 35 hours a week and are on low incomes can claim income-related benefits such as universal credit and pension credit. I do not pretend to understand the benefit system in any great detail; it is quite specific. Those benefits can be paid to carers at a higher rate than those without care and responsibilities, through the carer element. There is a carer element of universal credit, which I believe is about £168 per calendar month. The additional amount for carers in pension credit is £38.85 per week. In February 2022, my understanding is that carer households in receipt of universal credit were receiving an additional £2,000 a year, more or less, through the carer element. The support system, in terms of benefits, recognises additional support through the carer element.

Then we have the bigger issues that everybody is talking about—the cost of living. We have a number of schemes that have been announced, and I

am sure more to come, that look at energy, and other bills that have skyrocketed. We have all seen our bills go up two to three times over the last year or so. A number of those schemes are aimed towards those on lower incomes, so I would expect carers to be at the front of the queue. For anybody who is really struggling right now—I have this locally as a constituency MP and we get people coming into the CAB or into my office—the household support fund that the local authorities have, which was increased by half a billion pounds to £1 billion, is there to be spent on exactly those cases. The local authorities are there with this pot of money. I know they have not spent it all; it is there to help people specifically in those circumstances.

As always with many government schemes, people are never really aware of what they are entitled to, and that is another challenge. In this case, I say to people, “Just go to the council and they will tell you all the different schemes”, because some of them have only just been announced and some of them are this pot of money, which is up to their discretion.

The Lord Bishop of Carlisle: That is very helpful, thank you. Do the local authorities draw on that central money themselves or is it already distributed to them so that they can distribute it themselves?

Gillian Keegan: It is done via DLUHC. My understanding is that it is distributed to them so that they can distribute it themselves; there are not lots of rules around it. It is there to provide flexibility. It is similar to what we did at the beginning of the pandemic when it had the flexibility to deal with what was missing, where the gaps were and where the need was locally. We can write to the committee, because it is DLUHC, unless you know how they do it, Michelle?

Michelle Dyson: No, I do not.

The Lord Bishop of Carlisle: Thank you very much.

Q154 **Baroness Fraser of Craigmaddie:** I have a supplementary following on from the discussion about financial support for carers. We would like to know what has happened to the plan for paid carer’s leave.

Gillian Keegan: Yes, that was something from BEIS, which is the department looking at that. I know it still intends to see what it can do to make sure that it can facilitate that. The disappointment was that there was nothing in the Queen’s Speech for legislation.

My understanding from BEIS is that it is still looking at how it can facilitate that. It consulted on it and it is still looking at ways it can facilitate it, as and when it can bring something forward. It is still live, but because it did not come forward in the Queen’s Speech I understand that it was disappointing for some, because they wanted to understand when they were going to get it. Most people still think it is a good idea; I guess that is what I am saying.

Q155 **Baroness Fraser of Craigmaddie:** We have had a number of

discussions around the committee room about co-production, listening not only to what people think is a good idea but to what people need. I would put paid carers' leave in the "what people need" category.

When Michelle came to speak to us at the beginning of our inquiry, we had quite a frank discussion about the challenges of embedding co-production and making it a driving force for the Government to help local areas to innovate. I understand that the Government have put forward a £30 million investment in the White Paper to help local areas to innovate in the support and care they provide. What are the expected outcomes for this investment and where will co-production play a part?

Gillian Keegan: First, co-production will be at the heart of this. What is co-production? I spent 30 years in business, and co-production is working with your customers to design something that meets their need. That is effectively what it is. That is the way you do everything when anyone is trying to address a need; you do it in co-production with your customers. It is a very important part of making sure you get the right solutions. There are pockets of that and some of the social care sector is very good at innovating. You see some really good examples. Of course as a Minister, and many of you will recognise this, you always get to see the very best things, so you see the very best practice where they are good at innovating.

However, it is similar to probably a more systemic issue that we have in the country, if I am honest. The challenge that we are trying to address, full stop, is to go from innovating to embedding and scaling innovation. Generally, the OECD has various figures on where we are good as a country at innovating, but we fall back when it comes to scaling. It is probably a similar challenge in this sector.

Our new innovation and scaling investment is aimed exactly at that challenge: to make sure that we provide local areas with some pockets of funding, that they will match fund and then commission and scale up the models that we know work. We will also fund expert support for people who have been there, done that, so that they help local areas to tackle the practical problems that are part of any change process.

The outcomes of the investment will be that, because we are the Government and we need a much stronger evidence base for specific models, as Michelle alluded to, we will have evidence on how local areas can successfully embed change. Most significantly, we will have delivered new services in real time to local people. We will set up those services to sustain, once the support from the fund comes to an end, and the evaluations are there to enable us to do that.

I am a very practical person, so we have these conversations all the time when I am trying to work out how we turn the words into something my aunt, who is caring for my uncle with frontal lobe dementia, will see. How will that work? How will they see it? How will they know that all this love and care and money is being bestowed on them? It is very important. That is the challenge when you are doing things at a national

scale through 152 local authorities, 18,000 private providers and a whole host of voluntary sector and community groups that are also providing a lot of the service.

There are quite a lot of models where we can innovate further. I get quite excited thinking about what more for direct payments, what more for personal budgets, what more for shared lives and some of those models. How much further do they have to go? What could they be really useful for? What more can we do to make sure that the respites are value-adding for everybody, not just a convenient place to go for a couple of hours? There are a lot of things we can do. A lot of people are very hungry to make this change. The co-production side means that that hunger is always there.

Michelle Dyson: Can I comment?

The Chair: Please do, Michelle. Tell us what has been happening since we saw you last.

Michelle Dyson: Yes. To be clear on what I was saying last time, we are pretty proud of how we did our White Paper. We strongly feel that it was co-produced; we worked with more than 200 organisations and individuals. There is lots we do on co-productions. The Minister has a regular forum for those with lived experience. We give a grant to Think Local Act Personal, which brings the voice of people with lived experience into the department for us.

The challenge I took away last time was that we had put out a White Paper, but it had all those lists of commitments. The challenge I took away was how, in taking forward the lists of commitments, we would make sure that co-production, including with people with lived experience, was embedded at every level.

We are trying to do that in an intelligent way, so it is not just that every meeting we have must have X, Y and Z people at it. We are thinking about where it makes most sense to embed co-production and with whom. For example, with the unpaid carers' pot of money, which I mentioned earlier, we think it makes most sense to say to local authorities, "You can only have this money if you show us that your plans have been developed in co-production". We will do the same with the £300 million of housing money that we may come on to talk about. We will say to local authorities, "We have a pot of money to hand out, but we want to see that the things you want to spend that money on have been co-produced". It is the same with the £30 million innovation fund that the Minister spoke about.

The digital and technology work we are doing is the most advanced of all the different commitments that we made. We get fantastic feedback about the co-production we are doing there. In fact, we have taken it as a model for what we need to do in all the other parts of the work we are doing.

To give an example that may not be so directly relevant to this committee's work but shows how we are taking an intelligent approach, in the work we are doing on workforce, the co-production challenge we have set ourselves is how we can make sure that we are getting to the very front-line care workers themselves. It is easy to get to their employers and it is easy to get to those who represent their employers, but how can we get to the real people we are actually talking about?

We have taken your challenge on board; it was a great challenge. I hope you think we have made some good progress.

The Chair: We would be delighted to think we had some influence, because that runs through everything we will be saying. It is very good, and thank you for sharing that with us. Thank you, Lady Fraser, for your questions.

Q156 **Lord Bradley:** Good afternoon. You have answered fairly comprehensively on innovation, Minister. Can I press you a little further on the issue of scaling up? All of us, in different ways, have been involved in national programmes where we go around the country, see good practice and see innovation, but we are really frustrated that it is not rolled out nationally and not scaled up sufficiently to make the impact across the country, accepting local variation, that we hoped it would.

I have tried to follow all the initiatives you have expressed this afternoon, which are obviously welcome. There are two specific points. How will the levers in the new improvement fund lead to scaling up, rather than the frustration of going around and seeing lots of pilots that are either in progress or have been in progress but have not been rolled out for lack of resources or other reasons, such as change of leadership or personnel at local level? You mentioned the role of the CQC coming in. It is a regulator and it gathers information, but is it a real driver of operational change at local level? Could you tell us a bit more about how, this time, scaling up will be a success?

Gillian Keegan: It is absolutely the right question. One of the things we hear often, and I am sure this is your experience, is that if only everything around the country was as good as the best public service, we would be sitting here with much easier roles to play. That is the continual challenge. The first thing we will make sure we embed is a strong monitoring and evaluation theme in the fund. Developing the evidence base and spreading learning is one of the core objectives.

Maybe this is my naivety, because it is the first big reform I have done, but it seems critical to me, having done lots of transformation in the business world, that one of the most important things is that we are helping the sector to improve delivery, with over £70 million in improving and supporting it and helping it to develop its capabilities. I was just on a call looking at aspects of market sustainability and how they are understood.

The real question you always ask is, "How are we going to make sure they have the capabilities to do this?" Some of it is new stuff. Some of it

is quite technical and detailed. It is having investment in improvement and support specifically to make sure that we are there with local authorities, helping them along the journey and helping to grow with them. That parallel support offer will also offer further opportunities for local authorities to come together and learn from each other.

Hopefully, from what I have seen, one of the potential positives of this reform nearly getting there and then not a number of times is that there is a great deal of built-up demand in local authorities to be able to do this a lot better. We will be working with the local authorities, with providers. We have care and health improvement funding, which is the £70 million where we are working with them to design how we will do that. We all understand that you have to make sure that when you look at this five years on in the rear-view mirror, you do not have a whole load of brilliant initiatives that did not really go anywhere.

Having not long been involved in the world of politics—I have only been a Minister for a couple of years—I often read autobiographies or biographies of people who have done it before. When I was in the Department for Education, I read about Ken Clarke in 1992, and it was almost the same speech that I was going to give that day. The “what you need to do” and writing down what needs to happen is not the difficult bit. Delivering it, scaling it, and doing the hard work to continuously improve it in such a way that people embrace change, as opposed to being fearful of it, is critical. That is the way we are approaching it.

From my perspective, in the department they are very collaborative in the way they work with local authorities, particularly with the DASSs, and with groups such as Think Local Act Personal that help us to make sure that we and they can co-produce. It is one thing saying the word “co-produce”; how are they going to find the people with lived experience locally who want to get involved in the process? That is why we invested in TLAP to help them to fund somebody who will help local authorities do that.

It is a very collaborative process and even with assessment, which of course is the ultimate thing that will drive these areas—what we monitor and assess—we are approaching it collaboratively. There are some difficult things in introducing a new assurance framework, but we are doing it in a collaborative way. I am sure lots of people have given the same answer. I hope that this time we can really give it. It is a 10-year programme and hopefully we can keep focused on it over 10 years. I think the ICS is happening at the same time. That is another fundamental foundation pillar, a much-needed game-changer. If we can get those two 10-year programmes working well, we have a very good chance of finally cracking this big nut, as I know a lot of people have been very concerned to do for a long time.

The Chair: Thank you very much.

Q157 **Baroness Shephard of Northwold:** We have been talking a lot to you, Minister, about how you make happen at local level policies that have

come from the centre when you are not in charge of those who deliver the policies. In many of the great departments of state, of course, this is one of the conundrums. I was so interested to hear that you were going to make the same speech as Ken Clarke did years ago, and I absolutely believe you. You have some levers, obviously, and some of the levers are described in the White Paper.

In the White Paper, co-production is strongly recommended in the partnership approach to market-shaping and commissioning for local authorities to take account of. That is one strong lever that you will be able to apply, because they will not have anything to commission with unless, obviously, they at least observe what is required in the use of the funds they are given. How would that co-production, partnership approach, or whatever you call it, apply to market-shaping and the commissioning of digital approaches, to take an example? Is that impossible to answer? It may be, but I hope not.

Gillian Keegan: First, on the other aspects, it is very important that we get market-shaping, commissioning and the fair cost of care right. Those happening at the same time will be key because we have seen poor commissioning leading to poor outcomes, and we have seen a big problem, particularly in residential care, in the difference between local authority rates and self-funding rates, which differ again. From that perspective, we know we need to change that, and that will be measuring those things.

On digital technologies, the first thing on digital is that we need to digitise the sector. A lot of it is still done on paper. When it came to trying to understand what was happening during the pandemic, the department had to work to put in a completely new tool that had not existed before called capacity tracker to pick up data on what was going on in illnesses, absence of staff, vaccine rates and so on—all the things that you needed to be aware of, particularly in the early stages of the pandemic.

One of the discoveries was that a lot of social care providers did not have broadband, did not have computers in some cases, and did not have digital records. There is a lot that we have to do to digitise the sector. When you think of where we are going, trying to better integrate with local authorities and local health providers as well as the NHS, if you do not have a way of digitally sharing those records, it will be extremely difficult. We have set ourselves a target for digital social care records applying to those registered with the Care Quality Commission. I think it is to go from 45% to 80% by 2030.

Michelle Dyson: By 2024.

Gillian Keegan: By 2024. Gosh. What are we doing by 2030 then? A hundred per cent, I guess.

One of the things that we will be trying to do is to make sure that we enable that, because it will be very difficult for local authorities to manage the very fragmented 18,000 different employers if we do not have digital capability.

Baroness Shephard of Northwold: It is hugely encouraging that you already know the scale of the problem. At the start of the pandemic, the DfE had no idea how many computers there were in schools, for example, because it is not centrally required. You are already aware of the scale of that problem, so that is good. Clearly, it is one of the levers you could use. I hope you agree.

Gillian Keegan: In terms of getting data?

Baroness Shephard of Northwold: Yes.

Gillian Keegan: Yes, 100%. We have much better data than we had. We were probably in a similar position to the DfE at the beginning of the pandemic. I think that is probably fair.

Michelle Dyson: We had only CQC data. We had virtually nothing. As the Minister said, we had to build a system from scratch. We have now taken powers in the Health and Care Act to require providers to give us data, so we will be on a much better footing going forward.

Baroness Shephard of Northwold: Thank you so much. That is positive.

Baroness Barker: It is not uncommon for a carer to have difficulty just following a relative around different departments in a hospital.

Gillian Keegan: Yes.

Baroness Barker: What are the odds of us getting really good data between health and social care if even the NHS cannot do it properly?

Gillian Keegan: It is something that we are continually trying to improve. A new data strategy was published on 13 June to make sure that we can share health and care records and that the NHS can better share records. We know that that is a key part of the reforms that the Secretary of State has talked about several times, although he was probably not the first Secretary of State to have tried to do that, because we know some of the difficulties that there have been along the way.

Digital technology now is much simpler to do than it probably was with some of the systems that were tried in the past. I am not saying it is simple, but with all the legacy systems there are probably less disruptive ways in which it can be done now. It is very much a goal of the Secretary of State, and the technology should enable it. We have the NHS Transformation Directorate in NHS England helping us as well. Right now, Google can tell that all of us are in here, and with three little words can tell everybody else which particular metre square we are in. Digital has amazing capabilities that we need to—

Baroness Barker: Why, during the pandemic, could the NHS not tell local authorities who was in hospital with Covid? I am really concerned that there is a narrative building up about local authorities not being competent and all we have to do is saddle them with more legal

responsibilities, when, in fact, I think that is a very misleading portrait, particularly of what local authorities did throughout the pandemic.

Gillian Keegan: That was not a narrative that either of us has used, so I do not know where you heard it—not from me. There is a difference between saying how brilliantly local authorities handled the pandemic and how much work we need to do to go on a 10-year reform journey. Of course, if we did not need to do anything, a 10-year reform journey would not be in front of us. There is a 10-year reform journey in front of us with lots of things that we need to do.

I think the question you are really getting at, which is a very good question, is how we get the health and social care systems, the local authorities, the NHS and the local health providers to work better together, and there was some progress on that. Sharing data and making sure that they work more collaboratively has been something that we have been trying to ensure for a long time. There was a lot of good practice through the pandemic with the work on discharge, the better care fund and the work that they did together, but the foundation of the integrated care system is where we really start to bring it together, and that is another 10-year journey. You are right that there is still not enough sharing of critical data to make sure that the system works well on the ground for people between the NHS and social care.

Michelle Dyson: We talked about the Care Quality Commission digital care records that we are building right now and the desire to go from 45% to 80% of providers having digital care records by 2024. Those digital care records are being developed in such a way that standards are set to ensure that they are interoperable with the care records that the NHS uses. It is all being built to ensure integration. It is not a quick fix, but we will get there.

Q158 **Baroness Eaton:** Minister, earlier you mentioned that a lot is being done in the voluntary sector and in community groups, so my questions are about capacity building. What is in the White Paper that will enable greater capacity building in individuals, unpaid carers and local communities? To what extent are user-led organisations considered part of that capacity building?

Gillian Keegan: They are absolutely essential. We have been working very closely with care users. As Michelle mentioned earlier, I have established my own expert advisory group of care users to hear directly from those drawing on care and support, which is important, because that is when you really know whether you are making a difference, and I can use those insights to make sure that I am in a position to ask the right questions. The team has spoken to hundreds of care users to shape the reform programme and our work on dementia. Michelle mentioned 200 organisations, and on dementia it was 254 organisations, so there are many. I do not know what it was like before, but it seems that this is a bit of a step change in how things are done. Of course, local authorities are best placed to understand their populations, and they understand

them very well, so that they can plan their support needs. Working better with the NHS, they will be in an even better position.

Our adult social care White Paper sets out more collaboration and more integration to try to make sure that we understand what people with lived experience need and how to build on the community assets that are there and look for the unmet need. Where is the unmet need? It gets back to the same pot of money, which is the capability funding, the £70 million to strengthen the local authority market-shaping, commissioning and contract management capability, and the power of the Think Local Act Personal group, which will really capture the views of care users. Hopefully, it will make a big difference.

There have been some good initiatives where they have looked at different models as a result. There was one in the south-west where local authorities commissioned members of the community to provide the care, to have community groups, building from the people in the pandemic who went round with the food parcels and helped people who needed help with their shopping—to have those micro-providers. There is a lot more that we can do to innovate in how we get people to help, who are very happy to do so. Right now, one of the problems with signing up to help is that you think you may never be able to get rid of the obligation, and you are in there for ever. It is being able to share that and do it on a basis that works for people. There is a lot of innovation in those models as well.

One of the things we are all very keen on is how to build from what we learned through the pandemic, which is the power of local communities that did everything to help their neighbours, whether it was in a couple of streets or in a village, and how we can build on that and commission aspects of it to provide local care support to enable people to live more independently at home. That is one of the innovations that we have seen. When we evaluate that, it could turn out to be a very good model that works really well in villages or in certain places or certain types of place.

The Chair: Something occurred to me while you were saying that, Minister. Is that the sort of innovation that, if drawn to your attention, you would be really interested in? We took evidence from that group, and it was impressive. The question that you put is the question we asked ourselves: “Why can’t everybody do this?” What is the role of the Government in ensuring that, if they want to and they want to tailor it to their own situation, they can do it because there is a bit of extra validity, credibility and even perhaps some incentive money?

Gillian Keegan: Yes, we will be looking at all of the above. When we mention innovation, normally people think of technology, but it can be processes, a different way of doing things with different groups, innovation in models of care, and innovation in technology. There are many different types of innovation, and we are interested in all types. This is the power of having the users’ experience. Many users would love that model.

The Chair: Absolutely. They are clearly responding very positively, so it is encouraging to hear you say that.

Q159 **Baroness Barker:** I will preface my remark with the observation that, currently, an estimated 1 million people aged over 60 are ageing without children, and by 2030 there are likely to be 2 million. It is a group that is ignored. I do not think I have ever seen them reflected in policy at all, yet we have a health and social care system that is implicitly—in the case of our current Health Minister, explicitly—built on the assumption that your family will look after you and will sort things out for you. In most cases, particularly in times of transition such as hospital discharge, if you do not have a family, you are really stuck.

On that basis, we have been talking to people, and we found that those who either do not have or do not wish to have unpaid carers have particular trouble in accessing systems. To what extent will policy start to reflect the needs of that group of people?

Gillian Keegan: It is a very important group. It is not just people who do not have children. Sometimes people have children who live many miles away. My parents have three children, but nobody lives within 250 miles of them.

Baroness Barker: That is why I used the particular phrase “ageing without children”. It has been specifically crafted to cover that.

Gillian Keegan: To include people who did not have children or people whose children are not local. It is about needing flexibility for people who do not have anybody nearby who can help and do not want to rely on unpaid carers, and what care and support is available for them. Some of the models we have been talking about and some of the innovation will work equally for people. Often, people are on their own and quite lonely even if they have family members. I remember my nan saying that she had her two daughters less than two miles away, but, “There are still 23 hours in the day when I’m lonely”, because she had been with my grandad for 60-odd years and was not used to being on her own.

There is a mixture of models and circumstances. Getting the budgets working, the independent payments, is a point of control that, if I think about what would give more control if you were in that situation, we need to develop further. Independent budgets mean that you are in control of who you bring into care and so on. That can be very flexible, but the problem with independent budgets is that people fear the risk of supply and not having people who are there. There are a number of innovations that we could do in that world to try to develop security in those models.

Michelle Dyson: To build on that, there are some local authorities doing really interesting things about harnessing the power of the community. As the Minister said, we saw evidence of that during Covid, and it is how you build on that.

I visited one local authority where they were talking about a lady who was living all on her own, and all her family were abroad. She had been

the caretaker in the building where she lived. The local authority got all the people in that building together to see what they could individually offer her, and the local authority played the role of holding the ring and supporting all the members of the community in that building. It was a very heart-warming story. Their point to me was, "We really want to build on this".

It would have been easy for them to say, "This is a lady who needs a package of care. We'll send someone in for half an hour a day to make sure she takes her medicine". Actually, that was not what she needed; she needed people to alleviate her loneliness. People came in and they helped her get all her photos together and retell her life. They said she got a new lease of life from that. Their point was that what we need to be doing going forward is to harness that community spirit, which is there, but people in the community do not quite know how to bring to bear all their good will to help those who need their help.

Baroness Barker: Loneliness is a distinct problem for people ageing without children. Ageing without children is something different. What good is an independent payment if you are a person on your own who has dementia? I would be interested to know whether you know of a local authority that even knows how many people are ageing without children in their area, because I have yet to come across one. This is a completely different issue.

Michelle Dyson: The example I just gave was someone ageing without children. That is why I gave you that example. I cannot tell you whether local authorities know how many people are in that situation, but she was in exactly that situation.

Baroness Barker: Yes, and there are 1 million people who have nobody when they come out of hospital, for example. It is a really big issue.

Michelle Dyson: That local authority was saying, "We want to find more innovative ways of helping exactly these sorts of people". There is the old-fashioned way of doing it, which is just to say, "They need someone to make sure that they get out of bed and are fed", and then there is the more innovative way of harnessing the community and getting the local authority to support the community to support others.

Baroness Barker: There is also the issue of enabling individuals to plan for their own care, which a lot of them want to do, because they know that they are ageing without children, but they are not currently enabled to do that.

Gillian Keegan: An important part that we have not spoken about is the innovation in housing that we need to happen over the forthcoming period, and having the right support for people who are ageing without children or ageing with someone they are caring for who has dementia, and they have their own care needs as well, or many other circumstances. There is a £300 million fund to unlock some of the models that work very well. The ones I have seen that work fantastically are

where you have your own proper apartment with a bit of outdoor living space and a lot of fantastic facilities that everybody in the community can use as well. Those are the types of models when you think about planning for care.

A number of people I spoke to who were living in that situation said, "I'm on my own. I've got a brother who lives in New Zealand, but he's not much use to me. Here, I can be with the community. I can meet lots of people, not just people who are elderly but lots of different people". A lot of different support was there if you needed it, but you also knew that you went about independently until you needed a bit of extra support, so it was a very flexible model. That will also be a part of the offer, which may or may not suit people. There is definitely more we have to do in making sure that we have housing that will support people.

I think a lot of people will be ageing without children, or certainly without children who are very close to them to be able to do the daily stuff. An annual visit, or even a monthly visit, does not change the challenge of your day-to-day needs or knowing that you can plan for your needs if they get worse. Everyone's needs will get worse to some degree. That is part of the ageing process. Knowing that you have a flexible support service is an important part of it. I do not know what will happen with the housing innovation because there are a lot of people who are interested in that market, but we need to innovate in that as well.

The Chair: I will stop you at that point, Lady Barker, because the next question, from Lady Goudie, is precisely on that.

Q160 Baroness Goudie: Good afternoon, Minister. It is nice to see you again. Thank you. Following Baroness Barker, an issue that the committee and I are very involved with is how lack of reasonable access to housing is a major obstacle to independent living. We know that most people would prefer to live independently on their own with some support from the community, friends and others. How will the Government's commitment to supported housing remedy the current crisis in the supply of accessible housing? Do those commitments match the scale of the crisis?

We know that some families would be very happy to move around the corner if their house could be fixed in the way it needs to be done and have all the developments inside. That takes a long time to get local authorities to do. It varies from local authority to local authority, but it can still take up to nine months or a year to get the agreement to do some of the planning and then to get the work implemented.

In some cases, the person, or the family or the couple, needs a grant. If it happened much quicker, it would save the Government and local authorities a huge amount of money if more people could stay in their home. More people would be able to come home from hospital, and the people in hospital would not try to make a decision—this is not being nasty—about a person's home without seeing it and knowing how the person has lived there for a long time. Being able to stay in your own home is absolutely vital and vital for society as a whole.

Gillian Keegan: I completely agree. DLUHC has announced that an older person's housing task force has been set up, which I will be a member of, chaired by the Housing Minister, to look at aspects of this. We have not had the first meeting yet. There are several things: the planning aspects, not only how you facilitate changes within someone's home; and the grant aspect. We have the disabled facilities grant, which is £573 million and helps about 50,000 people a year. It is about how we make sure that that is—

Baroness Goudie: It takes a long time.

Gillian Keegan: —getting to the right people quickly enough. Then you have what I was talking about earlier, which is that it may not be possible, or even desirable, for everybody to stay in the family home. Since I have had this job, I look at mine and how many steps up and steps down there are to get to various layers, and that is just on one floor. I keep trying to break it to my husband that he will not be able to stay there in his old age, but he is still convinced that he will. There are practicalities in some of the older houses that are difficult to get around. That gets us to what you would choose to do.

The one thing we all know when we go round a care home to visit our relatives is that none of us wants to be saying, "I want that chair right there so that I've got the best view of 'Murder, She Wrote'". None of us wants to be in that situation. None of us wants to go into a care home. All of us want to stay in our own home, preferably, or in a home that is less burdensome than our own home but is set up to enable us to live at home longer, independently and with a lot of fun and activities put on.

There is a lot of innovation that we can do in this space. Obviously, we are trying to address a range of different needs. For working-age adults, we need to make sure that we have the right housing and facilities to enable people to have completely full lives. For those with learning disabilities, we need supported living models that enable people to live in the community. There are a number of different housing needs.

There is a lot of focus on this in the Department for Health and Social Care and DLUHC. As people move out of homes because they find something that is better for them at that stage in life, it frees family homes for people who are looking for family homes, so there is some sense in that as well.

Baroness Goudie: In Portugal and Spain, they have been using robots, other forms of technology and other ways of keeping in touch with people in their homes, and that has worked very successfully. I have seen that through Covid. I did not know it was going to come up in this committee; I went to see it because a scientist friend of mine was involved in the development. We should be looking at that as well. Most people can manage some form of technical support, with support from others; they can do texting and all the other things, and are capable of managing it themselves if there is somebody at the other end.

Gillian Keegan: Voice control is obviously a big breakthrough technology that works now for most people. I agree. There is a lot of scope, and that will be part of looking at innovation in the tech sector as well. I was sold on the robotic Hoover, so bring on the robots as far as I am concerned.

Q161 **Baroness Warwick of Undercliffe:** Can I follow up on the whole question of supported housing and focus on accessibility? It is not a requirement for developers to ensure that in any new accommodation accessibility is taken into account. In other words, because we are building for the next 30, 40 or 50 years, we are building inaccessibility into our planning system. Is there any way in which your department, or you as Minister, could seek to influence that? It seems to me that it is one of those areas that is very practical, very obvious and very lacking.

Gillian Keegan: Yes. There are some steps that DLUHC is taking. It did something recently done in Part M, I think.

Michelle Dyson: We are not experts on this, but BEIS has consulted on it.

Baroness Warwick of Undercliffe: It is not requiring it, is the answer.

Gillian Keegan: Normally, when somebody starts to consult on something, it is because they are aware that it could be something that we need to do. I guess that will be a conversation that I will continue with the Housing Minister, whom I will see a fair bit of as part of the older people's housing task force. It is important and it is common sense that we consider aspects of new housing and what can be done. That is probably why they have started down this road.

Baroness Warwick of Undercliffe: There are also financial consequences in giving people independence. It keeps them out of the state care system and therefore saves everybody a lot of money.

Gillian Keegan: It is the same with everything we talk about. If only you did the upfront stuff, it would prevent a lot of stuff later. It is also a continual challenge to enable that. It is having the focus on the reform of social care and the financing of it, having the focus on the integration of health and social care, and having the focus on housing and how we get the right housing—because we are lacking in housing—all at the same time. Hopefully, we can make sure that we put those things together, which is why it is very good that they mentioned in the White Paper the older people's housing task force knowing that it was something that we needed to work through. Allied to that is making sure that there is accessibility for working-age people.

The Chair: We were very pleased to see the heavy emphasis on housing in the White Paper, because we have been waiting for that, and making the case for it, frankly, for decades. Making standards of accessibility mandatory is the only way you will change the market for housing and specialised housing. There is a huge market in the older generation for houses that are adaptable. Developers know that and are sympathetic to it, but they need to be told that they have to do it. We look to you in that

task force to drive that, because there is a unique opportunity now and it is very timely. Sorry, that is a small sermon from the Chair. It is unnecessary, I am sure.

Gillian Keegan: No, I agree.

Q162 **Lord Bradley:** Picking up your point about the integration of health and social care, particularly the integrated care systems under the Health and Care Act, our witnesses have expressed some doubt about how parity will be achieved between social care and the National Health Service in the new bodies. They particularly question the current dominance of the NHS within the system; how there would be a degree of levelling up between the two elements of the system, and how the voice of social care providers, unpaid carers and individuals with health needs will be represented and accounted for in an integrated care system. What proposals do you think you might make to ensure that voice is properly heard?

Gillian Keegan: I heard that as we were going through the Health and Care Bill. I would say it is more than just the two; it is also mental health, because that is another area. Let us be honest, the NHS was established in 1948 as a national system, but the same decision was not made then about social care, so the NHS has grown up in one way and social care has grown up in another way. It is absolutely clear that if you put the system around the people, which is what we are trying to do more and more, and is the whole point of user experience co-production, and the same person is using all those services at different points, normally quite closely together, those processes are really key.

It is the same with mental health. There is a big overlap between mental health and physical health. That is why the integrated care systems are an absolutely key part of recognising the shift in our understanding of the role mental health plays in our overall well-being, of the role social care plays in helping us to stay at home longer, and in helping us to rehabilitate after we have been in hospital, or prevent us going into hospital. It is clear to me that, because they all act around us and we are one person, these things need to work very well.

First, we have the integrated care system, comprised of the integrated care board, which is the NHS commissioning body, and the integrated care partnership, which is a joint committee of the ICB and the upper-tier local authorities and others. They will have some local voices as well. There are a number of different leads for people with learning disabilities and other areas that are often not considered, such as palliative care and those kinds of things to make sure that those voices are heard. The new legislation will increase the integration between health and social care.

The pandemic and the better care fund gave us some early signs of success. Obviously, there was seed funding, but there was additional money volunteered from local authorities and largely from NHS systems as they realised that if they put their budgets together they could make much better decisions as a joint group. It should remove barriers to data

sharing, which has been a problem. It should enable joint decision-making where there have been two separate duties with different responsibilities. It should increase workforce-level integration as well, so people work much more effectively. It puts more power and autonomy in the local systems.

As it is written, it is very good. It will require culture change and a change in relationships. The NHS, local authorities, social care providers and other parts of the health system will need to be part of realising those ambitions. Ultimately, it will depend on leadership at the ICS level, which has been a big focus. It is a big focus of the Secretary of State, not only in getting Sir Gordon Messenger to come in and review leadership at this point. It is ultimately about leadership and not allowing behaviours that will not enable integration in the right way—people who do not want to share information or whatever.

It requires the integrated care boards to be set up. They came into being as of last Friday. I had my first meeting with the chairs of a group of them. They have a body. I will certainly meet them regularly to make sure that we understand what the barriers are and what needs to happen to build on this. It is very new. I have a lot of hope.

What was different in 1948 when they made the decision about the NHS versus social care was that people did not live as long, and people did not live as long with as many conditions because of medical science. People largely lived in their communities local to their families. People were looked after pretty much all the time in my family history by their families. The world has completely changed since then. Thankfully, we have a large, elderly demographic who are a big part of our society and are still contributing a lot to our society, and all of us will be a part of it, so we all have a vested interest.

The demographics are not just changing in this country; they are changing in many countries, and it is a challenge. It is not an option not to improve aspects and not to take forward these reforms in social care and in integrating the health service and social care. They are not optional; they are required.

Lord Bradley: Do you think that when you meet the 42 chairs in the very near future it would be helpful to advise them that, when they are establishing their local place-based advisory committees for the commissioning of services, they ensure that the voices of unpaid carers and social providers are at the table so that there is consistency across the 42 areas and that their voices are heard from the start of the new organisation?

Michelle Dyson: We at the department are putting out guidance to say exactly that. The integrated care partnership, as the Minister said, has the local authority on it, but you cannot sensibly have a body that has everyone who represents all the many players in social care on that body. What we can say, and are saying, to every integrated care system is, "You must draw up your strategy in consultation with all those different

groups". We are designing that guidance in a co-production way to make sure that we give them exactly the right steer, so I am confident.

Lord Bradley: To push it right down to local level—the voice and the place—not just at strategic level within ICBs is really important.

Gillian Keegan: Very much so. As a constituency MP, I meet my local ICS lead at least once a month, which is his worst nightmare because I am now the Minister responsible for it. He gets my questions all the time. It is an important part of making this work better locally. Somebody mentioned that even within the NHS you need to go from place to place and see a number of people to get a diagnosis of something and how can we better improve that. We all know that we can better improve that, and that is part of the reforms that the Secretary of State has been speaking about recently.

Lord Bradley: Thank you.

Q163 **Lord Laming:** Minister, in one of your earlier comments, you referred to an objective being the integration of health and social care, but in a point you made a bit later on you indicated that you know it is impossible to integrate two entirely different systems that have entirely different histories. Like you, we attach a lot of importance to the integrated care systems, but they do not necessarily have coterminous boundaries. What machinery will you have at hand to make sure that these integrated care systems actually deliver services for the kinds of people we have been talking about, rather than being, to put it brutally honestly, talking shops and producing lots of ambitious statements?

We get an awful lot of statements in the field of health and social care—a huge number—but we are interested in delivery on the ground, as Lord Bradley has just asked about. What machinery do you have to hand to make sure that these integrated care systems deliver something so that unpaid carers notice a difference?

Gillian Keegan: First, there are many people relying on the integrated care systems working better and making better decisions at a local place level, with the pooling of budgets and being able to take a common view of a common problem. How we measure the shared outcomes is what you are looking at. There will be a new shared outcomes framework that will support local organisations to work together more closely and jointly prioritise the things that matter for most people locally. So there will be a framework to help them take that high-level intention, work through the details and make sure that organisations can better collaborate towards a shared purpose, which involves a person-centred approach. That is part of it.

The new shared outcomes will also be underpinned by metrics. We mentioned before that what you measure is what you get. We will be working on setting and delivering what the outcomes will be, and they will have a regulatory or oversight role. If you read the White Paper, there is a lot of signalling of what will come. We will be working to make sure we put those things in place. Of course, we need to measure what

has changed as a result of this structure being put in place. If nothing has changed, it is just another three-letter acronym, and we have tried all of those before. Something has to change.

You can think of some ways you would measure aspects of how people get access to the services and how the budget is moving around. The teams will be working on a number of things. There will be a framework and some metrics, but it is too early to define what they are.

Michelle Dyson: There will also be CQC regulation of the ICS itself. We have already talked about CQC regulation of local authorities, but this would be separate CQC regulation of the ICS and whether it is meeting its objectives.

Lord Laming: Thank you.

Q164 **Lord Polak:** Lord Laming just asked what machinery you have in hand. If I may say so, it is quite refreshing that we have someone who is practical and has run a business in the position you are in, and I hope that that will translate into real action. What sort of mechanisms will be put in place to ensure that local authorities are carrying out their duties under the Care Act 2014 in respect of unpaid carers and individuals who feel that they are being denied their legal rights to care and support?

Gillian Keegan: This is an important question, because post pandemic some people feel that they have not had access to support or have been waiting too long to be assessed for support, or that support has reduced instead of what they feel they need. From April 2023, as Michelle outlined, the CQC will assess the performance of local authorities' delivery of their duties against the Care Act 2014. That is quite a big deal, and they think it is a big deal. We recognise that we are not going to leave them alone in that process. We will be on the journey with them and investing in making sure that the capacity, the capability and the investments are in the right place, and we will be developing that over time.

Lord Polak: What will happen if they do not succeed?

Gillian Keegan: The results will be published. We have not yet worked out exactly when. We will give them some time for what comes in when. We are still ironing out some of the finer details.

Michelle Dyson: There is ultimately a power of intervention by the Secretary of State.

Gillian Keegan: It is very visible. It is the first time it has been done. We need to make sure that we get it right. That is why a lot of effort and money is going into making sure that we build up the capability and fund some of the systemic market problems such as the fair cost of care, and that we do not have cross-subsidisation, which creates its own instability. As with all these things, the devil will be in the detail.

I regularly meet the CQC, and I am sure Michelle does too. It is a very open relationship. We can learn aspects of what we would do differently and where we think we need to learn. You get a lot from the CQC in understanding and information. We are collaborative.

Ultimately, we are looking to make sure that every local authority in every area and every person in that area—unpaid carer, somebody who has paid care or somebody who is working in the sector—feels that the system has improved for each and every one of them over the journey. It is quite a bold ambition. I think it is a very ambitious programme, but it is very important for all the reasons we have talked about. Every one of us looks at our old age and thinks, “What’s that going to look like? How do I make sure it looks better?” That is pretty much all over the country.

We want to make sure that we have really reformed the system so that it meets all our desires, and gives us personalised, independent choice and control over ourselves and over our ageing with dignity as we age in life. Maybe it could have come sooner, but we are grateful that it is coming now, and I think the sector is approaching it like that.

The Chair: Thank you very much, Minister. Thank you, Lord Polak. It is a good note on which to end, not least because we will have a vote in the next two or three minutes.

I thank you on behalf of us all. You have spent some considerable time with us and you have been very frank and open. You will see from the questions that we have asked how concerned we are about the people who were most impacted by the pandemic and who lost most, in fact. It is not a comparison with the people who lost so much in the care home sector, but these are the people we knew less about. We have learned a great deal about their poverty, their frustration, and, to be honest, their anger in many cases at the fact that they have to, as they call it, fight the system.

We would very much like to write a report that gives hope and realism that the things you are putting in place will really make a difference to them. They are equally realistic; these people ask for very little, in fact. That is what is so humbling about listening to them. They are very modest in their demands. They do not want a huge amount. They are not asking to be top of the heap. They are asking to be treated with dignity and fairness, and to have their contribution realised and what they do not just for the people they care for but for the whole community. That is what we want to see.

Michelle, it is great to know that you are now involved so intimately with the real issues and realities of co-production. It is a serious and difficult business listening to people, and acting on what they say will make the difference because these people really know. We are very grateful to you and your colleagues, and we look forward to no doubt continuing the dialogue after our report is finished. Thank you very much indeed.