



Adult Social Care Committee

Corrected oral evidence: Adult social care

Monday 18 July 2022

3.40 pm

Watch the meeting

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

Evidence Session No. 21

Heard in Public

Questions 165 - 177

Witnesses

[I](#): Councillor David Fothergill, Chairman of the LGA's Community Wellbeing Board; Martin Samuels, Strategic Director for Social Care and Education at Leicester City Council; Tandra Forster, Executive Director for Adults and Communities at Southend-on-Sea Borough Council; Laura Gaudion, Interim Director of Adult Social Care and Housing Needs, Isle of Wight Council.

Examination of witnesses

Councillor David Fothergill, Martin Samuels, Tandra Forster and Laura Gaudion.

Q165 **The Chair:** Good afternoon, everybody. Welcome again to the Select Committee on Adult Social Care. We have only one absence this afternoon: the Lord Bishop of Carlisle.

We have four extremely important and interesting witnesses, all drawn from local government. We are delighted to see Councillor David Fothergill, Martin Samuels, Tandra Forster and Laura Gaudion—four people with unique experience in their areas as well as collective experience because they all know what local government is facing at the moment in relation to adult social care, with an overview from Mr Fothergill. We are absolutely delighted to have you with us and very conscious that on a very hot afternoon it is quite something for you to make this time to be with us. We really appreciate it because it is a very important session for us.

In the course of this inquiry, we have been looking at the situation of unpaid carers, disabled people and older people together, and how unpaid carers are faring in a situation and at a time when resources are extremely short and when there have been many missed opportunities, to be frank, and some disappointments. We have been asking why adult social care is invisible. I will ask you whether you agree with that. There are views from, for example, the Government that adult social care is more visible than it ever has been, but the unpaid carer—and the disabled person, the young disabled person, the old person—in the system still do not feel visible or that they have a voice. That is much of the evidence that we have heard over the past few weeks.

We have been asking why this is the case and how this impacts on their lives. What could be changed and what could be changed without—well, not without resource, obviously, but without it failing at the first hurdle because it does not solve the problem of insufficient money and insufficient people? Workforce issues and funding issues are so fundamental, yet what we are trying to do, without being naive, is to find the evidence that suggests that across the country in local government solutions are being found to some of the basic questions and issues around relationships or navigation systems and support for unpaid carers, innovative ways of thinking and doing things. That is what we would like to do in the analysis in this report: to bring some of the practical changes forward and to make them more obvious and maybe able to be taken up by other local authorities. You are in the centre of all this. You have to make these very difficult decisions at a very difficult time and we fully appreciate that. That is where we are coming from. We are very aware that there is a huge amount of kindness and resourcefulness in the people in the adult social care system. Obviously, we would like to hear about the culture as well as the practical policies as they impact on people. That is a bit of background.

I will put two questions to you all, and I will start with David. Do you think that we are correct in our analysis of what we have heard, that

adult social care and particularly unpaid carers and the disabled people and elderly people who they are caring for are still relatively invisible in terms of the contribution they make and the needs and desires they have to live what they have told us over and over again is an ordinary life? What steps can you see that could be taken to raise that visibility so that we have a higher platform for them? Is there any scope for development and improvement that would not take significant resources? That leads to the larger questions. Can you tell us a bit about how you see the current challenges? Are the failures that we have heard about regarding service delivery and the relationship between local authorities and the people who they are responsible for all related to financial challenges? They are two questions but they are related. I am sorry, they are rather challenging, David, as well.

Councillor David Fothergill: Thank you very much for the opportunity to speak to you. First of all, I congratulate you and your committee on what I think is some really important work. I know that you are taking a different approach to this and we welcome that. I am absolutely delighted to be here and thank you for the invitation.

In terms of visibility, it does feel that it is an invisible service. This is at the national level as well as at the local level. There is no way, for instance, that adult social care has the same profile as, say, the NHS. There may be several reasons for this. People do not understand it, people do not believe they will ever need it, and people probably think of it negatively, given that if it ever does get a media profile, it is often framed as a service that is broken, in crisis or is a problem to be fixed.

More literally, social care can be invisible, given that it often takes place behind people's front doors, unlike, say, at a GP surgery or a hospital, which is very tangible. We therefore need a major push from all of us—national and local government, the media, the NHS, the voluntary and community sector and our partners—to reframe social work positively so that it is no longer the invisible service. At the LGA this is what we did in our own green paper on the future of adult social care and well-being in 2018 and subsequent publications that we have done. We have talked about people living the lives they want to lead and an equal life as part of making social care about all of us, not just some of us. In this way, we spoke of shared values such as caring about each other and looking after the most vulnerable, and the desire for meaningful relationships and to make an active contribution to our communities.

More broadly, we sought to demonstrate the importance of social care to our local, regional and national economies, as well as its role as a major employer. You are right that it is seen as the invisible service. I will give you an example. Many of you will know that as a councillor you go to lots of parish councils. I have probably been to 2,000 parish councils in my life and at every one of those parish councils, I am asked about potholes in the roads and pavements. I can count on one hand the number of times that people have spoken to me about adult social care at those parish council meetings. It is not at the front of people's minds unless

they have a relative who depends on it. We need to overcome that lack of awareness.

If I can turn to your second question, which is the current challenges and the finance, we have to be absolutely brutally honest here. It is clear that we can trace the origins of current challenges over the last decade to the increase in costs of £8.5 billion while total funding has only increased by £2.4 billion. That includes the Better Care Fund. The resulting funding gap of £6.1 billion is being managed in two ways. We have either saved to the service—we have made £4.1 billion in savings from social care—or we have made £2 billion in further savings from other council services by cutting them faster than they would otherwise have been cut. For the latter, you can say these are important services to people's well-being, such as parks and leisure and transport. These are the things that the public often talk to us about. We are being judged on things that we have to cut to be able to fund social care because it has been underfunded centrally to such an extent.

This is the context of the current funding challenge, the consequences of which continue to play out. For instance, the latest evidence from ADASS shows that just over half a million people are awaiting a care needs assessment, a care package, a direct payment or a review of an existing care plan. That is up from 400,000 people in November, so within just a few months we have seen a 25% increase. The funding challenge also has obvious consequences for the care workforce. The sector faced a turnover rate of 28.5% across 2021, equivalent to approximately 410,000 leavers over the year—410,000 people leaving social care. Every day there is an average of 105,000 vacancies. These recruitment and retention challenges are driven particularly by the issue of care worker pay, with capacity shortfalls especially prominent in domiciliary care.

There is, therefore, no getting away from the fact that funding is a huge part of the problem, which is why we continue to call for a greater share of the health and social care levy to come back to adult social care immediately. The issue of funding has other consequences. In a series of round tables we held on the future of social care last year with people who use social care providers, councils and other sector experts, the issue of trust came up quite frequently. Several participants noted that severe funding pressures have led to the commodification of care and given rise to a system that follows the public pound and has an onus on compliance. Such a system does not create the right environment and the right conditions for trust and innovation. There are some issues and some challenges that will be with us, we believe, for many years.

The Chair: That is very helpful. What you have just said, the language you used about commodification and compliance, is exactly what we have heard. People are respectful of the challenges faced by social workers and the challenge to trusted relationships. There is no getting away from it. They feel that they are part of a process that involves a lot of boxes being ticked. Do you think that it is unrealistic of us in this atmosphere to call for a change in attitude, culture, expectations and values around

adult social care?

Councillor David Fothergill: I think it is the right thing to do to call for all those changes, and that the four of us on this panel would agree with and fully support those changes. We constantly butt up against that old challenge, though, which is funding. If one of the problems is the high level of turnover of our social care staff, part of that problem is the amount that we can pay and how they are rewarded and that will always come back to funding. There has been great disappointment that of the social care levy that has been raised, such a small amount is aimed at the social care sector, because we thought that that was the opportunity to fix social care. Unfortunately, that has not been the case.

The Chair: We will try hard to be realistic while at the same time being challenging with things. Putting a higher value on the professionals and the unpaid carers for their contribution, we feel, helps to change the dialogue and the dynamic as well, we hope. Can I put those same questions to Tandra, then Laura and then Martin? Tandra, what do you think?

Tandra Forster: I would absolutely agree with the points made by Councillor Fothergill about the status of social care. I agree that these are essential tasks that help us live our everyday lives, but it is not until you need them that you become curious about what they are. The visibility is the challenge. People are interested if it is them or a loved one who needs care and support, but otherwise it does not have the focus that NHS clinical actions do—if we think about the focus on A&E and life and death situations. Clearly, social care is a very broad support that can be offered. It is about living your life as independently as possible, so it can be anything from personal care tasks to getting into employment, volunteering, and being part of the community. That, therefore, is part of the solution.

The more that we can help people live independently in the community the more visible they become and the more visible social care will become—not just that in itself but the very work that you are doing as part of this committee, the work that the LGA is doing, and the work that ADASS is doing. Indeed, I hear more and more in the press about NHS colleagues raising the profile of social care generally and then the critical importance of unpaid carers. I think that will help them become more visible.

The Chair: Thank you so much, Tandra. That is a generous interpretation, too, from our point of view. Laura, what do you think?

Laura Gaudion: It will come as no surprise that I agree with my two colleagues who have spoken before me. I have nothing significant to add to the picture that they have outlined. Instead, if you will forgive me, I will focus on the latter part of your question, which was around the scope for development and improvement that does not take significant resource.

The Chair: Please, that would be great.

Laura Gaudion: It is my observation in that space that adult social care remains hidden largely due to a lack of understanding from people in our communities. We have not been very good historically in our transparency and promoting the good that our services do for local people. When I first came into post I made a point of meeting many residents across the island, those in their own homes and those who were living in care homes. Without exception, people wanted to remain in the place that they called their own home, with the people who they loved, with the people who they chose to be with. We need to refocus adult social care in that space, making it clear to local residents that this is an opportunity and not a burden.

There is a stigma attached to adult social care and there has been for many years. From my personal experience, I was fortunate enough to know all my grandparents, each of whom at one stage or another needed help. Accessing that help was incredibly challenging. There was a perception that the local authority would simply run off with the money that they had worked hard for and preserved as an inheritance for their children and that in asking for help they were admitting they could not cope.

For our informal carers, the picture tends to be quite complex. Many of the people I speak to regularly do not see themselves as carers and do not want to be seen as carers. They are stepping into a space where their loved one, their family member, needs them to be. They remain a husband, a wife, a daughter, a niece, and that is their primary role. If we can improve transparency for adult social care, become more visible in our local communities and help people to understand that this is not about reducing their worth as that other role but supporting them with the challenging situation they find themselves in, it will enable us to start to develop and improve how we work with local communities.

In a slightly shorter answer to your question, the use of local accounts in that space for adult social care is something that we do not maximise. By engaging with our communities about our achievements and the positive stories and by hearing from people who have been supported by adult social care and hearing their stories it will go a long way towards supporting that profile. For me, that comes at relatively little or no cost and that is something we can act on now while we work our way through the challenges we know are ever so prevalent in terms of workforce and funding for adult social care.

The Chair: Terrific. That is so good. We have struggled with language and, as you say, a lot of people do not want to be known as carers because it diminishes their relationship. We have not been able to find alternative language other than to refer to them as the family carer or whatever. If you can help us with some creative thinking around that, that would be great. Everything you say is music to our ears because it is about how you raise the profile without incurring massive costs and diverting funds away from other things. Thank you so much, Laura.

Finally—not least but finally—Martin.

Martin Samuels: Yes, it is always an interesting challenge coming last in a group of such experts, so I will perhaps focus on one point. Very often, people come into the social care system as a 'distressed purchaser'. Something happens, there is some kind of crisis in their life, which leaves them in a position where they need to make changes in their life, often quite fundamental changes, in a very short amount of time. On occasion, people can find that they have to move from their own home into a care home with two or three days' notice, so it is quite upending. It means that people's relationship with the social care system is often quite a difficult one, because we only enter their lives at that time of crisis. They almost feel pushed into making decisions—life-determining decisions—very quickly and often on very little information.

The consequence of that focus on the acute end of social care—and obviously much of the discourse about social care tends to focus on hospital discharge, which is very much the acute side of things—is that two things happen. One is that that leads us to be very focused on us as providing a service, as opposed to the individual who will be living the rest of their life. If you focus on providing a service as opposed to the life that someone leads, that can very rapidly push you down a particular route. It also leads us to even further overlook the people who are in the community, living their lives, perhaps just needing to draw on a bit more support from day to day.

We did some analysis recently within my own authority in Leicester. We found that fewer than 20% of the people who entered the adult social care system entered it through hospital. More than four out of five are in the community, but because all the focus is on hospital discharge there is very little attention given to the broader system. If we receive support or national focus, or focus from our colleagues in the NHS, it is always on that end, of hospital discharge. That does lead to the system having less visibility of people who are trying to live the life they choose to live in the place that they feel is home. It also draws in the resources that are available, so that the resources are very much pushed into getting people out of hospital rather than enabling people to have a good life.

Again, I am experiencing that in my own authority. I have a growing waiting list—and Councillor Fothergill mentioned this from the ADASS survey—of people who need fairly minor house adaptations or assessments to enable them to live better in their own home. I do not have the staffing capacity to get to them because the staff that I have are very much focused on getting people out of hospital. It just is a further way that our focus on us as a service means that the majority of people who draw on the services, who draw on care, become that much more invisible.

Q166 The Chair: Thank you, Martin, that was terrific, especially about the distortion in the system. We will come on to talk about housing, but what you say about adaptations is important.

Can I ask you a slightly larger question? As you described it, putting the emphasis on the producer, as it were, is it possible to introduce or reintroduce the notion that what matters is the relationship between the social care worker and the person? Have we gone so far or is the system so obstructed that we cannot realistically advocate that because people will say that it is not possible any more?

Martin Samuels: My response would be: not only is it possible but it is necessary. In many areas, that is what we are trying to do. For example, in Leicester we have become very aware that the processes we had were not really engaging with people. It was strongly brought home to me the way that we were perhaps losing sight of the individual. People who draw on services were saying that when that envelope arrives through the letterbox, which is the paperwork for the annual review, which is meant to be engaging with someone to work out what is important to them and how we can best enable them to achieve that, they had a sense of dread and a real concern that the system was going to do something to them.

At the very start of my career I worked in jobcentres and benefits offices and it was very striking, the different cultures that we had in parts of the organisation. I think that this is relevant to where we are in social care now. When I worked on the benefits side of the organisation, there was a set of rules to be followed and processes to be adopted, and so long as you went through the process in the right way the answer that emerged was the right answer, regardless of whether it suited the individual at the end of it. You had followed the process; that was the answer.

I think that it has too often become all too easy for adult social care staff to feel constrained by the process and to feel that so long as we follow the process we have done the right thing. What we are trying to do is to get to the culture that I experienced when I worked on the job-broking side of jobcentres, where the whole focus was on how we can secure a good outcome for this individual. Yes, there are rules, and yes, there are processes, but essentially those are a means to have a person-centred conversation.

Indeed, one of our complaints is that we can feel ourselves too bound up by the processes and by the legislation. Yes, without question, there are serious challenges in the funding that is available and the workforce that is available, but we do actually have significant agency. How social care is undertaken within our authorities is hugely determined by the culture of the workforce, the culture of how we engage with people. If you have a person-centred, strengths-based approach, you can transform the experience of people. That is one of the things we have been trying to do in Leicester.

The Chair: Martin, that is marvellous. What you say about people feeling dread when they get their assessment, we have heard that, absolutely, in those words, by a disabled witness we had, tremendously competent but who felt that he really did not want to engage with the social work system because he was afraid. Thank you for your positive encouragement on that. I will now stop asking questions and hand over

to Lord Laming.

Q167 Lord Laming: This is a carry-on question to Martin. He will not be surprised to hear that we have had a lot of evidence that seems to link very clearly with his experience in benefits, which is that people who suddenly find themselves needing social care have hopes and aspirations about how this will enable them to continue to live their lives in the way they wish, but what they are met with is a formulaic tick-box response, which means that at the end, instead of feeling helped, welcomed and supported, they feel alienated and upset. Could you develop further your thoughts on how social care can be changed so that it does not follow your experience in the benefits office, which I am afraid at the present time is the picture that has come across to us so frequently?

Martin Samuels: Yes, indeed. On the point about benefits, as you were asking the question I was reflecting that, of course, pretty much everyone who draws upon adult social care will also be drawing on the benefits system. In the same way that a great many people find it quite difficult to differentiate the adult social care system from the NHS, a lot of people's experience is that the distinction between the social security system and the adult social care system is not very clear. People are in a very confusing situation where the social security system, the NHS and adult social care are all engaging with them, but with very different cultures and very different approaches. That can be deeply bewildering to people who are just trying to get on with living their own lives. I have heard it said by a number of people that, in fact, simply working your way through the system is almost a full-time job and, for me, that is a terrible comment about the system that we have developed. Of course, this is a system that has been developed by people and, therefore, we could change it.

To respond to your question, in Leicester we are very clear that people want tailored support and that they are not always experiencing this. One sign, perhaps, of some of the progress we have made is that people are telling us that—or perhaps, more realistically, we are now hearing them when they say that. We do also receive many compliments in the system, so I would not want you to have the impression that we have a hugely dissatisfied cohort of people in the city. Nonetheless, it is very clear that we are not meeting the needs and expectations of people.

What we have been looking to do is to work very closely with people in the city. We have brought in TLAP (Think Local Act Personal) and we have been doing work with Social Care Future. That user-led voice has been absolutely central to the work that we have been doing to try to understand the issues that block our ability to engage with people and to ensure that we are focusing on their experience and their outcomes, rather than looking inwardly at our own process.

We have been revising our guidance and our policy to make processes and approaches more person-centred, more human-centred. We have taken a whole look at our assessment and review process, and all my staff have been through training programmes to help them move away

from that culture of, "Here is the process and we need to follow it absolutely" to instead focus on the individual. Interestingly, some of the staff have found that challenging. They have found it culturally a real threat to their position in the system and their way of thinking. Sometimes, if you have followed a process directly and in detail, you cannot be criticised for the outcome, and one of the things that I am having to develop in my staff is that willingness to take accountability and responsibility for the outcome that is experienced by the individual, rather than simply saying, "I followed the process and what happens is not my responsibility".

We have been trying to be explicit in asking people what matters to them, so that we can then design our services and the approach with them. We have been building up a group of people with lived experience so that we can develop our approaches in concert with them, rather than officers in effect going into a darkened room, thinking deep thoughts and then coming out and saying, "This is the answer".

We have a long way to go, but it is very evident that we are starting to engage with people in a different way, having listened to them. One of the perhaps surprising consequences of that is that, in fact, we are seeing that the rate at which demand for care is growing has been slowed down a little bit by that. One of the comments made earlier was that people just want to live their own life in their own community. No one grows up saying, "I really want to be a recipient of adult social care. I really want to live in a residential care home". Having these more person-centred conversations with people is enabling people to stay in their own home for longer. It means they have a better quality of life and that often requires a smaller amount of formal social care than perhaps if we had simply followed a process and taken over their life. I am very much in the position where I say to my staff, "If we do the right thing, in the right way, at the right time, with the right person, that is the cheapest way of doing it".

Lord Laming: That is most encouraging. If there is anything that you can send us on that, that would be extremely helpful. From your wider national perspective, do you feel that it is an uphill struggle? It sometimes seems as though local government has lost interest in adult social care, it has outsourced as much as it possibly can and, frankly, it has put up the defences. Is that your impression or is that wholly wrong?

Martin Samuels: I think that local authorities are very interested in adult social care, but possibly more because of the financial side of things rather than the impact on communities. I am very conscious that it is in no small part the growth in demand for adult social care—and, therefore, the growth in my adult social care budget—that is putting strain on the rest of the council's budget. As Councillor Fothergill was saying, it is very rare for members of the public to ask questions about social care, compared with highways and parks and the like. There is a significant interest by local authorities in social care, but without that understanding of that community element. In many respects, because we have been so

reduced over the last decade, all too often we are focusing on the limited services that we provide, as opposed to the outcomes that we enable our local residents to achieve.

Lord Laming: Thank you so much. That is most helpful.

Q168 **Baroness Fraser of Craigmaddie:** My question is to Tandra. We have heard from David Fothergill and others about the invisibility of adult social care and we have been discussing what matters to the person receiving care. I want to change the focus to unpaid or family carers, whatever term we can find to describe them. We have heard so much from family carers and unpaid carers about how they feel forgotten and unsupported. They definitely feel invisible. The data we have had confirms that direct support for carers has dropped since 2015. We would be keen to hear from your perspective in Southend-on-Sea what challenges you see and what would enable you to see a tangible change for this group of unpaid carers. Do you have examples of what is happening in Southend-on-Sea as to how you are promoting the well-being of unpaid carers? Most importantly, we want to know where the role of unpaid carers sits in your whole area of strategic planning for adult social care.

Tandra Forster: I want to start with the importance of carers, in particular family carers and unpaid carers. They struggle with the terminology because nobody wants to be defined as just a carer. They are somebody's husband, wife, daughter, friend. That is probably the reason for the challenge. You cannot underestimate the importance of unpaid carers, and never more so since the pandemic, because we really could not have got through the pandemic without families pulling together and supporting their loved ones. Added to that, in the current workforce crisis and the challenge we have in the formal care workforce we are relying ever more on families supporting their loved ones.

I do not think you will be surprised by any of the challenges that I will suggest. I do not think that they are unique to Southend. Generally, we have a finite amount of resource available to assist carers, so what we have to do all the time is work with a range of people and try to help as many people as possible, but with that pressure of trying to make our limited resources go as far as they possibly can.

More recently, the cost of living circumstances are also having a significant impact. I know that there is an awful lot in the press around benefits for carers, but that will have a significant impact. Finances were already challenged and they will be challenged further. Because of the financial challenge, there may be a perception that support has dropped. We certainly had to make changes during the pandemic, but I think our offer is diversified. It is maybe not always as straightforward to see what the support is that goes to carers. There was a reference to direct payments and, of course, the Care Act gave us a great deal of flexibility in how we work with people and how in particular it recognises the role of the carer and how we may be able to support them to support their loved one.

There is a greater diversity of what people might receive individually because of their circumstances and what will help them to continue to care for their loved one, which might be beyond day services or respite care, which are still there and are still working but it might be a more individual, personalised care plan for the carer, if you like, to help to keep them supported.

In Southend, we do have a carer support contract, which is associated with a grant for meeting carers' needs. We have also developed a dynamic hospital discharge advice guide for those whose cared-for are coming out of hospital. We rely on various community groups as well to work directly in specialisms. We have a dementia community support team. That will connect individuals and the people who care for them into groups to help them with social isolation as well as practical advice, information and guidance. We also have links to mental health providers, such as Trust Links, which is specific to Southend, as well as Mind, Choice and Mencap for people with learning disabilities.

We are working towards a better mechanism for carer-specific information. We know that we are not very good at it. There was a reference earlier to how we can help people more. We are committed to strengths-based working, as Martin has outlined. We are working with Partners4Change in Southend, where we have developed some innovation sites to help shift those conversations and place people at the centre. If you change the way you ask the questions and the way that you relate to people, you will get a better outcome. There are many different ways of accessing information, thinking about the internet and how people might come through the web and get advice. The other thing that we are doing is looking at our universal offer. What is the support out there that anybody could tap into without having to talk to anybody in particular? It is frontloading that information and we are in the process of developing that.

In terms of listening to individuals, we are thinking an awful lot about coproduction at the moment. We have a set of strategies where we did a huge amount of coproduction. There is a specific one for carers, and we talked to people with lived experience, but we are trying to look at what we do to encourage and promote ongoing involvement so that it is not just a one-off. Something that we have done for quite a long time is when you are retendering for a service you would have a group of stakeholders, which would include people with lived experience, and they could input: "What does that specification look like? What do we think of those service offers?" Those tend to be one-off and what we are trying to look at is what we can do ongoing to get the carers engaged.

The point about the relationships is key in this. The relationship we develop with carers and their loved ones and how our social workers engage is so critical. In that strengths-based working, building up that relationship is key. That will help unlock what Martin described, listening to what people have to say and treating them as experts in their own life. Very often, you can have a much more shared discussion. The bottom

line is that finances are a challenge and I do not see that in the short term being resolved, even with the changes that might come through the NI increase. It has to be a respectful partnership, one in which we are listening to people.

Carers are central to our strategic thinking and we have an all-age strategy. We must not forget that carers can start from a very young age and we need a consistent approach that reaches out to all ages; then developing information, advice and guidance, looking at digital, looking at technology, looking at how we work with people so that we can be flexible in how they come up with their own solutions for what might make a difference to them, and being prepared for changes, encouraging integration and partnership to meet people's needs.

Martin outlined the many different conversations that an individual would have, and we need to think about how we can work better with other parts of government or other local services to improve the experience of individuals and reduce that stress that they will be going through. As we have said, most times people will come to this because there has been a dramatic change in their life, a stroke or whatever it may be, so what is it that we can do? As well as our carer strategy, we have an ageing well and a living well strategy. We are trying to be as connected as possible with partners and with people with lived experience to try to improve the experience for individuals and address that balance in terms of the relationship with them.

Baroness Fraser of Craigmaddie: You have a specific carer strategy that is for all ages?

Tandra Forster: Yes.

Baroness Fraser of Craigmaddie: Is that specific to unpaid carers or is that a general carer strategy?

Tandra Forster: It is unpaid carers but we do have a workforce strategy. A huge amount is going on at the moment, as you can imagine, in social care. We need to address the workforce challenge that we have. We have increased the amount of money we pay to external providers. Obviously, the cost of living crisis is somewhat dampening any impact, but it is more than that. It is raising the profile of social care, talking about visibility, and people seeing coming into care as a real profession, and doing something joined up. I should say that the carer strategy is joint with our health partners as well. It is all ages, children and adults, and it is joint with our health partners and working with the community and voluntary sector.

Baroness Fraser of Craigmaddie: Thank you very much.

The Chair: That is impressive, Tandra. Could we have a copy of your carer strategy, please? We would very much like to see that.

Tandra Forster: Yes, absolutely.

Q169 **Baroness Barker:** I am interested in all of that. Can I ask one question before I go on to the questions that you might have been alerted to? How many people in your area are ageing without children?

Tandra Forster: I do not have that number but I can get that. Are you thinking about the number of childless couples who are living alone?

Baroness Barker: I am thinking of people who are ageing without children, and the reason for asking it is because they are a group who do not appear in any policy documents and in very few assessments, yet they are one of the largest growing groups of older people, we think, certainly among women. We do not even know how many men there are because we do not register that, but it is immense. Given that we have a health and social care system that is, in practice—and sometimes explicitly in the mouths of Ministers—predicated on people having close relatives, and that means children, who will advocate for them at key points, yet there are millions of people who do not. That is the issue that I am trying to dig at.

My question to you is this. We have an increasing number of people who either do not have family carers or do not wish to have family carers, yet we have a system that relies on them being there because the system would fall over if they were not. What are you doing to deal with that and to change how you work in the future?

Tandra Forster: I completely agree and we will have that data on individuals who are either childless or who have survived their family if they have had children. I will make sure that is provided.

You are absolutely right, not everybody who approaches the council will have family members or friends or connections who can help them. Our commitment is to support people to live as independently as possible and to stay in the community. That is why we are doing an awful lot of work on workforce, looking at how we can promote greater take-up in employment, looking at how we can work with NHS partners to create career pathways, and looking at international recruitment. There is no doubt that we rely on the unpaid workforce, but we recognise that we will continue to need the formal paid workforce as well, particularly for people, as you say, who have no one else.

In terms of advocacy, there are advocacy groups that we can recommend who will work on behalf of the individual. If somebody comes to us who does not have a family member who can help and guide them through the process, we invest in advocacy support for them. There is mental capacity advocacy as well, where people have dementia; obviously, people's circumstances are different. Our strategies that I have already referenced are based around helping people remain as independent as possible and creating a range of opportunities and options for them to do that; in particular, extra care housing, different housing opportunities, looking at the disabled facilities grant and how we might use that, and looking at different forms of home care and support in the community to help them to stay at home.

I am aware that Martin has his hand up so I do not know whether he wants to come in on that question as well.

Q170 **Baroness Barker:** I wonder whether I could address a question to both of you. Do you agree that our system is now somewhat outdated because it is built on the assumption that there will be a lot of direct or indirect provision of services by local authorities when, in fact, there will not? What is most important to most people is the process of assessment and understanding what their needs are specifically and the services that are around that can be arranged, more likely, increasingly in future, not provided by you, but you are the one group of people who have the social care assessment experience that other people do not.

Martin Samuels: If I can come in on that, that precisely fits the reason I raised my hand. I want to give a practical example that I think fits this quite well.

At a previous authority I worked in, our meals on wheels provider gave notice on the contract we had with it. It said that it was not able to make this service work. Our initial reaction was that we would run a procurement tender and find a partner that would deliver a meals on wheels service. I said to the team, "Can we first of all engage with the people who are receiving this service to understand what their needs are?" We were able to engage with everyone individually to understand their circumstances and their context. In fact, for every single one of them, we were able to identify a means by which they could engage with their local community, so that they were able to address that need and ensure that they received meals. Sometimes there was a lunch club they could go to, or it was as simple as a local pub running a group, or a local café walking the meal around to them, or whatever. There were almost as many different solutions as there were individuals.

The key thing was that none of this was a formal service. None of it was formal care. What it did require was that members of my team had the time to sit and engage with individuals to understand their context and their needs and then to understand the local community and to be able to make those connections. In some areas, that role could be known as a community catalyst or a local area co-ordinator. There are many different models, but it does rely on there being people who understand the local system and the local context and can make those connections.

One thing that has been very noticeable over the last 10 years or so is how many local authorities, if they had such services, have then closed them down, because they are not formal provision of care and therefore not at the top of the list of, "You have to do this". I would argue that not only does it have a huge impact on quality of life for the individual concerned—we are talking about being centred on the quality of life, the ability of someone to live the life they choose in the home that they choose to live in—but it is a significant means of saving money and making resources go further. By enabling people to live the life they choose without calling on services, clearly if you are not providing services there is no cost associated with that. Not only do people have a

better outcome, but it is cheaper for the local authority. It is quite challenging sometimes to justify why we should be supporting those services. Many authorities do not have them. I certainly do not have as much of that service as I would wish to in Leicester.

- Q171 **Baroness Eaton:** My question is to Laura. As a committee, we are aware that the Care Act 2014 contains the principles that would make all the difference if they were implemented. We have been looking at how and why the law might be strengthened. To what extent is the failure to implement the Care Act 2014 a failure of funding? Is there something about the culture that it is necessary to change? Are there cultural issues that prevent the Act being fully implemented? How reflective is this of the Isle of Wight Council's ability to implement the Care Act? What would be needed to enable the council to implement the Act fully? That is quite a tall order of questions, I think.

Laura Gaudion: I will start at the beginning and please pull me back if I go off on a tangent.

The lawyer in me, which was where I started my career, feels very passionately about legislation and about it being supported by guidance that is not only deep and well considered but accessible and relevant. For me, that is part of the challenge in terms of the Care Act. The Care Act in itself is a fantastic piece of law. It brings about significant changes that give a person choice and control and the ability to be the conductor of their own orchestra when they are looking at their care needs.

What is not aligned with that is the basic steps that help us to empower that person in the way that the legislation intends. Yes, that is linked to funding. Yes, that is linked to the workforce and the resource of a skilled workforce to be able to support people to take control in the way that the Act envisages, but it is about more than that. It is about taking a step back and considering the culture itself, as you have said.

We always find that in times of increased stress, workloads or crisis, people react in a very similar way. They do whatever is easiest rather than what is right. A shift from a time and task-based care offer, where you can provide a person with a dollop of care in the morning, at lunchtime and in the evening to ensure they are okay, to working out with that person and their family, their loved ones and the people who are invested in that person's life the outcomes they want to achieve takes time.

Those outcomes are incredibly important. Conveying what those outcomes are to the person who will deliver that, either formally or informally, becomes then equally challenging. How do you price a contract for an outcome to help somebody regain their independence? How many hours does that take? How much time? How many care workers? How much skilled professional input is necessary? Each person is so different and that difference is what makes them unique.

For us as a local authority on the Isle of Wight, there is no one-size-fits-all solution. While the Care Act provides us with an overarching vision that is only to be commended in terms of what it delivers for local people, it stops short of providing the support that local authorities needed to change that culture, to shift how things were done. I have had many conversations with local care providers over many years now around that shift from time and task to supporting people to achieve the outcomes that they have identified through their assessment, through their discussions with our advocacy services and the support of their families. It always comes back to the same questions. How many hours will that take? What is the hourly rate? Because we get sucked into that cycle, we get ourselves to a place where we lose sight of what is really important: the individual's total well-being, empowering the person to live the life that they choose in the place that they choose to live that life. It is not an easy fix.

What we have done here on the island is seek to shift that culture, to help people understand that an outcome is what we want, not time and task. We let our home care contracts back in October 2020. They came into effect in February 2021, working with three key providers, to deliver outcomes for people in their own homes. We are in the early stages of that process. It is a 10-year contract and we are just at the end of that first year but working really hard with our partners who are delivering care and support to bring about that shift for people. The largest challenge in bringing about that shift has been people and their families themselves. We say, "These are the outcomes". "Yes, but I would like somebody to come at eight o'clock in the morning. I need somebody for an hour on Thursday evening". Helping to change that mindset is quite difficult. It comes down to the relationship and it comes down to trust.

If I may just piggyback on the last question on how we can start to see things shift and whether the local authority is the right body to be buying all these services and dishing them out, I remain of the view that a commissioning role is almost obsolete in today's society. People need to have control of their own destiny. We need to support them through direct payments, through personal budgets, through the use of personal assistants and recognising what families are actually contributing in this space as well so that people really do have the choice and control that the Care Act intended for them to have.

My team are fierce advocates of each and every person they support and I have lost count of the number of conversations I have had with social workers who will quite happily go toe to toe with me as their director to point out that, no, this is the outcome that this lady is entitled to. We must not lose sight of the ability to support people in our communities. Yes, cost will always be a pressure; yes, funding will always be an issue; but, for me, workforce trumps all that. If we have the right workforce, if we have the time for that workforce to be effective, and if we have a workforce that is skilled in understanding not only their Care Act obligations but how best to communicate with people and to understand

what they want in their life and the outcomes they desire, we will do much better by the people we serve in our local communities.

Baroness Eaton: Thank you. That was very heartening. It was good to hear something so positive while also recognising the resource issue. I have one quick point. You mentioned the lack of guidance on the back of the Act. Could you clarify a little bit what difference that makes? I tend to think, maybe wrongly, that guidance can often be ignored and it is often an excuse for not doing it.

Laura Gaudion: I think you are absolutely right and it can be, but I do think that it brings about a consistency that we tend not to see nationally. I genuinely believe that one size does not fit all when it comes to social care. We try to wedge people into a hole at our own peril because choice and control are so fundamental. Guidance would help local authorities align their offer more strategically and provide a greater consistency rather than a postcode lottery, while ensuring that the intent of the Act shines through in the decisions we make and the way we implement changes locally.

Each local authority is a political beast of its own being. We are controlled by our democratic leaders, who have their own priorities and their own directions of travel for what they wish to deliver for their electorate. The guidance in that space provides statutory officers such as me with an extra tool to be able to emphasise some of these key and important points that may—and I am not for one moment suggesting on the Isle of Wight that is the case—or could be seen as a luxury when we are looking at the financial constraints we currently have.

Baroness Eaton: Thank you. That was really helpful.

The Chair: We may have a Division shortly. Can I just ask my colleagues who exactly is in the House, apart from Lady Warwick? Is it just you, Lady Warwick?

Baroness Fraser of Craigmaddie: No, I am in the House, Lady Andrews, as well. I think that Lord Polak is also in the House.

The Chair: I think that he will have left already, sadly. I suggest we take Lady Warwick's question next so that if she has to vote we can continue. I am sorry to jump around on that, Lady Shephard, but could you hold off until we hear from Lady Warwick? Are you happy with that, Diana?

Q172 **Baroness Warwick of Undercliffe:** Yes, I am happy to do that. Several of you have mentioned the assessment system and the problems associated with the assessment system. We have certainly had a lot of evidence on what, in effect, is its failure, with a very large number of people who are not assessed or with assessments that are so perfunctory that they do not believe that they will deliver their needs. It is clearly a very widespread problem. We have seen that, of course, in the challenges of hospital discharge.

This is really a question for David Fothergill. I would like you to say

something about the way that the LGA has approached this because it is clearly such a major issue right across local authorities. Could you also look at the recent Health and Care Bill and the proposals for future reform in the *People at the Heart of Care* White Paper, which include much greater scrutiny of local authorities by the CQC? We were interested in this. We have talked about local authorities taking into account the views of carers or those being cared for, but how closely were local authorities themselves involved in informing and shaping the changes that will result in the CQC intervention? Given what we have heard about the limitations, how do you think that local authorities might respond to closer scrutiny by the CQC?

Councillor David Fothergill: Thank you very much, Lady Warwick, for that question. First of all, let me say that the LGA welcomes greater scrutiny in this area. It is only by having greater scrutiny that we will have improvement, so we do welcome this.

When assurance was first proposed, we acknowledged the Government's desire for greater transparency in that area. We said from the outset that we favour the approach based on that shared agreement of what good looks like, particularly the importance of person-centred and locally flexible care and support, which Martin and others have just been talking about.

We were very clear at the outset with the Government that we do not support the introduction of regulation over local government until a sustainable funding settlement has been achieved. There is a great danger here that we begin to assess all local authorities and find that every one becomes "inadequate", and I am not sure where that gets us. We do need a system that is being fixed before we begin to measure it. There is a great danger in labelling all our services with a "failure" tag, which will make the situation worse. We have great concerns about that, particularly if there is a single-word rating, as there is with Ofsted, of course.

We have highlighted the risks of several aspects of reform, particularly over assurance, charging, fair cost of care and so on, all converging at the same time on councils. There is this layer, in effect, upon local authorities and social care departments where there is a whole range of things coming in at once and it is becoming a perfect storm of how we cope with all these changes at a time when we are still very engaged in the recovery from the pandemic pressures. The LGA has a lot of concerns. We welcome that greater scrutiny, but we think that things need to be put right first and that we would then be able to have a much clearer picture.

Having said all that, we have worked very collaboratively with the Department of Health and Social Care and the CQC to shape proposals. Throughout our work to date with them, we have promoted a number of principles that we think should underpin future work on and the final design of that social care assurance framework. First of all, we think that there is an absolutely vital role for the voice of lived experience. We must

talk to people who are users of the service. It is a central development of assurance and is genuinely coproduced. We think that it has to build on existing foundations. There are already assurance frameworks that we can work with to develop.

There has to be transparency and democratic accountability. Local authorities are democratic bodies. We live and die every four years by the democratic process, and we believe that those services and the way that there are comparisons need to be within that democratic accountability framework, particularly through our own scrutiny panels. We have promoted consistency and flexibility for assurance to work optimally. There has to be an approach that recognises the local nature of social care, and that flexibility is so important, we believe, to the current system. That is difficult to legislate for in terms of assurance.

Most importantly, there is a real need for the assurance model to be developed as a national partnership, reflecting partnerships that already exist within local systems of support, improving people's health and well-being. We seek to work alongside our partners in that mutual responsibility for developing the services, particularly within the NHS and with our other colleagues in the voluntary sector. Leading from assurance, it is important, we believe, that it is not just councils, it is also local partners that are part of that assessment framework.

Linked to all that there has to be, we believe, the assurance that to be able to get the maximum benefit from it all information should be shared. There is a need for all partners to work together here. Still, too often, we hear about the NHS and social care not being able to share information and data. We also recognise that any new burdens that come as a result of the assurance framework would add further cost pressures on to local government.

We recognise the additional commitment to social care funding over the next three years but we believe that the move towards all these other changes and the move to assurance will make this difficult, and our great concern is that there is so much layering of change that in fact all services will be perceived in completely the wrong way. That will then have a detrimental effect on staff, who may decide that that is no longer the career they want to be in. There are some dangers here that we can create.

In considering the offer, the department must work closely with local government. We believe that there have to be sector-led improvements. We are very keen that the LGA helps and works alongside the CQC to ensure that that is the case. We welcome the Government's expectation that statutory intervention will be exceptional and a last resort, but careful thought needs to be given to the unintended consequences of those ratings. I come back to that if we just tag social service areas as "inadequate" or "requires improvement", as with Ofsted, we will see similar issues beginning to emerge. It is much more important that we get longer descriptions of what the issues are, what the challenges are and what the opportunities are.

We have some real concerns, but equally we are engaging very closely with the CQC and government to try to allay some of those concerns.

Baroness Warwick of Undercliffe: Thank you very much. How far has the Care Act 2014 informed those considerations? Everybody believes that that has been a great framework within which to operate, but I was very struck by Laura's assessment that it did not provide the guidance that might ensure that there was greater if not uniformity, at least consistency within local authorities. Could you say something about that?

The Chair: Thank you. If you need to go, we will carry on because we are slightly short of time. David, could you give a fairly brief answer to that?

Councillor David Fothergill: I can, indeed. I think that the intentions are there and I think that the intentions of the 2014 Act are good, but there is still a long way to go on it. It has informed, clearly, the CQC work and the thoughts on assurance, but there is a lot of work still to be done.

Q173 **Baroness Shephard of Northwold:** My question is also to David Fothergill. One of the questions we have been trying to get answers to throughout our whole look at this area is what difficulties local authorities have in providing services in very rural areas. You are very well placed, Mr Fothergill, because you have a national role but, of course, your local and elected role is in a very rural county. We understand the problems, obviously, but some areas have been held up to us as providing an outstanding service, even with the difficulties of communication and access that rural areas have. What would you like to tell us and what more do you think might be done to support some areas to achieve the success of others?

Councillor David Fothergill: Thank you very much, Lady Shephard. It is opportune. I did some work this morning. Somerset is a great place to live. It is a lovely place to live and lots of people want to live there, particularly in the later stages of their lives.

It is interesting to compare the 2011 census figures with the 2021 census figures that have been released. Whereas our under-19 population has declined and our 20-to-24s have been relatively stable, we have 25% more over-65s than we had 10 years ago. That is 30,000 people who are now living in Somerset and who are calling on services. It is great that we are a rural county but it does show that people want to come here, particularly in their later stages of life. That causes real tension in areas such as this. Larger geographies can mean increased travel time and increased cost, particularly in domiciliary care.

Again, if I take a Somerset example, one area where I think we have been really successful is on Exmoor, where we have developed 200-plus businesses as micro-providers, helping people to set themselves up as micro-providers to provide that domiciliary care. That challenge has meant that we have had to take a very different stance on that, which I am not sure you would need to take in an urban or suburban area.

However, certainly on Exmoor it is about getting people to set themselves up in small businesses to be able to provide that very localised care.

There is another aspect of this, which is the Government's charging reforms that will come in. Section 18(3) of the Care Act will make medium-term spending forecasting much harder for us, particularly as in rural areas we have more self-funders so that will have quite an impact on the rural areas. I think the Government can help us there as we estimate the cost of reform, to make sure it is kept under review and to make sure that any additional burden that is brought in as a result of that, particularly on those rural areas, is accounted for.

We, as the Local Government Association, do not argue for funding distribution because we represent all members so that becomes difficult. The formulas the Government are using were designed over 15 years ago and it is over nine years since they refreshed the data. When you look at what has happened in nine years and that extra 25% coming into Somerset aged over 65, I think there is a real need to look at that data and those formulas of how funding is allocated.

Baroness Shephard of Northwold: Thank you very much. We have had a similar increase in the area where I live, Norfolk. The result is obvious with, of course, increased pressure on the NHS so it does need to be taken care of. Thank you very much. Thanks, that is all I have to ask. It is an excellent answer, thank you.

Q174 **Lord Bradley:** This question was from Lord Polak to Tandra. Tandra mentioned the advocacy arrangements, to an extent, in Southend so I will be interested to hear from another local authority, particularly Leicester, so if I may, I will address this question to Martin instead.

Martin, unpaid carers and individuals with care needs often feel powerless as a result of not being able to challenge a decision taken by a local authority. Some have put forward the possibility of an independent organisation that could act as a critical friend to the local authority and embed more opportunities to challenge the system. Would you support such a proposal? How would your local authority best support it? How do you think it could be organised within a city like Leicester?

Martin Samuels: Thank you. Picking up on the comment Tandra made, most local authorities—Leicester is the same as Southend—have a carer support contract in place with a third-party organisation. In Leicester, it happens to be Age UK. In that sense, it is an independent organisation that can speak on behalf of carers and can act on their behalf, as well as being contracted by us to provide services and support to carers.

However, there is more to it than that. As you were asking the question, I found myself thinking of Healthwatch, which exists as an organisation that is intended to represent the views and perspectives of patients. The fact it is called Healthwatch, I think, often leads people to assume that it is purely an NHS-focused organisation. But the contracts for Healthwatch are held by local authorities and it is local authorities that receive the funding for that. Healthwatch is intended to be a watchdog for not only

the NHS but also adult social care. Certainly, in Leicester, I have regular meetings with the lead individuals from our local Healthwatch organisation. Part of my role is to both understand the work it is doing with social care and to make sure that is being used to guide and influence the work that we do, but also to encourage Healthwatch to indeed see itself as being just as interested in adult social care as they might be in the NHS. Therefore, to an extent the system already has organisations that can act as advocates. The question is whether they are acting as advocates for unpaid carers in particular.

The challenges will be that, to be honest, Healthwatch organisations are pretty small and pretty thinly resourced, so their ability to do very much is limited. The Healthwatch organisation in Leicester is no more than a handful of people. They are very committed and do what they can, but it is not exactly a well-resourced organisation. Unfortunately, as a local authority, because what was originally a specific grant that we received for Healthwatch has long ago been subsumed into the general funding we receive and then that general funding has been significantly reduced, the funding that is available is quite limited. There is a range of things that potentially are available, but they are not really of significant scope.

The other point that comes to mind is that, of course, for an awful lot of unpaid carers, the person they are caring for is often, by definition of the fact that they are being supported by an unpaid carer, not within the care system, so we are very often in a position where we may not know who these unpaid carers are. That also links with the question that has been raised about people not wanting to identify as such.

One of the things we found is that the process of people coming into the assessment system is sometimes a bit unclear and not particularly streamlined. Therefore, you can have a situation where people perhaps do not know when they should be seeking an assessment, or perhaps are less aware of where they ought to go for support. There is a number of challenges in terms of where we can go. But there are bodies in place that could undertake that function.

Lord Bradley: Am I right in thinking that Healthwatch, as you have identified, flows through to the integrated care board as the representative of those outside the statutory sector and it should be reinforced that it is health and social care it is dealing with in that role on the ICB?

Martin Samuels: You are absolutely right. By statute, Healthwatch is both a member of the integrated care board and also for some years has been a member of the health and well-being boards, so it has that key role. It is certainly true that Healthwatch does tend to be seen as an NHS-facing organisation as opposed to a health and social care organisation.

Lord Bradley: Following on from community health councils.

Martin Samuels: Yes.

Lord Bradley: That is very helpful. Thank you, Martin. I have a second question for David, if I may, regarding the new Health and Care Act. As you know, David, as well as I do, integrated care systems are now being established across the country following the provisions of the Health and Care Act. What new opportunities suggested by the Local Government Association's written evidence to us do you think the new provisions of integration offer for adult social care, particularly in respect of its integration with the NHS and the third sector? Crucially, how do you think carers and unpaid carers can be really heard in these new structures as they develop, and how can their voice be taken into account as services are developed on the integrated model and commissioned in local communities?

Councillor David Fothergill: Thank you very much indeed, Lord Bradley. I think as everybody knows, integrated care systems, or certainly ICBs, came in on 1 July, so it is very early days at the moment and probably just a bit too early to judge. We have seen a mixed picture across the 42 ICSs. We think it will mark a step change in how the NHS approaches population health. A fact I frequently quote is that 80% of people's health is determined by factors outside of the NHS and those 80% factors are really sitting with local authorities in terms of housing and other support. It is important that we begin to focus the NHS approach into population health and I think the ICS development gives us that opportunity.

The intentions underlying the Health and Care Act and the integration White Paper give us real reasons for optimism, with the focus on improving population health outcomes, addressing health inequalities, as well as the renewed focus on personalisation requiring greater collaboration; we talked about that earlier. On the relationship between the NHS and its partners in local government, the community and the voluntary sector, we all need to work together much more closely within these ICSs to be able to plan and deliver those services. Of course, that includes proper engagement with people who access social care. There is a real need at the moment for the ICSs not to become too big and too self-occupied. They need to reach out, they need to be talking to service users and the population generally to find out what needs to be tackled.

Many of the ICS leaders have spoken of the need to change approach from a system that treats illness to one that promotes health, which is in the title: the National Health Service. We have to promote health and that is key for us going forward.

One of the great things about the whole system of ICSs is that they are very flexible; ambiguity is built into them and local factors can be played out. Our great concern for ICSs is that there is a risk that there is an imposition of national targets by government, particularly as they focus on acute hospitals, for example, and focusing on hospital-based targets, we believe, would miss the point of population health.

Although we have a separate assurance scheme, which I talked about earlier, for both adult social care and the ICSs, there is a need to put

those together to make sure they complement one another. There is a real danger here that we develop different assurance systems that allow things to either fall through the cracks or begin to skew the relationship between local authorities and the NHS. Unfortunately, at the moment we do not seem to be seeing very much joining-up at all in those two areas of assurance and that is a concern for us.

However, you are absolutely right, in these big 42 systems we need to make sure people are put at the centre of them and we continue to focus on what is really important for them.

Lord Bradley: That is helpful. I agree, obviously, it is only from 1 July but they have been planned for some time. Would you agree with me that there is always a concern that unless the voice of carers, however described, is in the room from the start then they quickly fall off the edge of consideration as services develop?

Councillor David Fothergill: I agree with that completely, there is that need. I will raise one other issue. Most of the integrated care systems are beginning to develop very well and I think there is some good feedback coming out. There are some areas of the country where the footprint does not match local authority boundaries and crosses lots of local authorities. In Somerset, we are a single footprint with the NHS. It works very well and therefore we can focus on those important issues about engaging with people. In other areas, where they cross two or three counties—in certain areas they cross over 14 different authorities—there are concerns that too much time is spent negotiating the system as opposed to talking to people who receive care through it.

Lord Bradley: Thank you, David. That is most helpful.

Q175 **Baroness Jolly:** To what extent is it possible for you, as a local authority, to step in when the central government fails; for example, to increase carer's allowance or respite care? Do you have any scope or resources that can fill these gaps? Are there any friendly local charities? Can you draw on other local agencies and sectors in partnership with you to provide additional support and, if so, how do unpaid carers find out about it?

The Chair: Is that to Laura? Laura, we cannot hear you. In that case, I will put the question to Tandra and then we will come back to Laura if she is there. Tandra?

Tandra Forster: I took there to be two parts to that question. One was general, about the funding that is available and what we can do if the Government are not able to fund, and the second one was about how people find out about the support that is available. I will take the second one first.

We have a statutory responsibility around information, advice and guidance. As a local authority, we have a responsibility to put in place arrangements to ensure people have access to information, advice and guidance. We can do this in many ways, through our social workers, our

social care workers, and also the community and voluntary sector out there who we work with to make sure that we get information out there. Obviously, we use our websites as well. We spend a lot of time trying to connect people to our assets in the community so that they can get the support they need, whether that is from formal agencies or from the community and voluntary sector or microenterprises.

The first question is more of a challenge. Local authority funding is obviously dependent on its council tax base, the grants it gets from government and the Better Care Fund. The degree of flexibility will depend largely on the ability of that individual local authority to raise additional funds. Somewhere like Southend is probably going to find it more difficult than—I will not name an alternative local authority—other local authorities that have a stronger council tax base and can perhaps increase the amount of funding. But it would be very difficult for a small unitary authority to step in and bridge that gap, not least because one of the ways we would do that would be to increase council tax and clearly there are parameters around the levels to which we are able to increase it. If you think about the cost of living crisis at the moment and what we are trying to do to work with people, increasing council taxes is going to have a direct impact on everybody, including unpaid carers. I will stop there. I think Councillor Fothergill has his hand up as well.

Councillor David Fothergill: I want to support very strongly the point that local authorities exist to look after their local people. That is what we do and we know our place in terms of our locality very well. There is no way that any local authority would not rise to the challenge, and I think we have demonstrated that many, many times over recent years, particularly around Covid. So I think local authorities will but some local authorities will find it even more challenging because of that low council tax base.

I will also make the point that some of us have already started to move on this. We have already started to find savings in our area. We have put in and moved to the national minimum wage for our carers. A lot of work has already begun but local authorities know that they exist to look after local people.

The Chair: Lady Jolly, do you have a second question?

Baroness Jolly: Yes. I live in Cornwall. Local volunteers raise an enormous amount of money for local hospitals. We have a lot of small community hospitals peppered around Cornwall. I wondered whether local charities elsewhere ever added to the funds held by a local authority for these sorts of things.

Tandra Forster: Do you want me to come back in on that?

Baroness Jolly: Yes, either you or David.

Tandra Forster: Not directly to local authority funds but certainly local groups will raise funds for groups that provide support. It is not funding

directly for the local authority in the way you described but, yes, we benefit. One of the things we have done in Southend is to set up a community investment board, where we put some money out to the local community. We have an advisory board made up of people with lived experience to work collaboratively with the community and voluntary sector, and that will result in partnership funding. While it is not coming into local authority budgets, the local authority is investing money and other people are match-funding for particular services.

Laura Gaudion: I hope you can hear me now. I am sorry about the technology glitch this end. From a local authority point of view here on the island, we have protected the funding we have available to support carers. We commission our carer support from an independent charity on the Isle of Wight, which undertakes all our carers' assessments and provides full carer support. That was part of the work we did following the consultation with our local community around our last carer strategy.

We are in the process of refreshing our carer strategy, again engaging very heavily with our local community and with local people to make sure that how we deliver services is what they want.

For me, one of the most startling pieces of information I came across when I first came into this role is the fact that carer's allowance is £67.25 a week. To be eligible you have to be delivering 35 hours of care and support to the person you are caring for. That makes the hourly rate we pay our informal carers, our family carers, £1.92. If we expect carers to be able to maximise their income, they have the opportunity to access three further benefits: housing benefit, council tax benefit and council tax relief. There are four separate applications to be able to access benefits to support them to care for the person at home. That person is incredibly busy, they are undertaking an awful lot of support for their loved one or their family member. To expect them to do that is a significant additional burden.

That is where we have stepped in to help. While we cannot increase the amount of carer's allowance they receive or make additional funding available to them, as part of the role my finance and charging team undertake when they are looking to assess people for their own contributions to care and support, we also look at how we can maximise income through benefits for the family and support the family with the applications they need to make to be able to access that full range of benefits that is available to them. That piece of work is done by our carer support service, the independent charity that we commission, which also utilises its own charitable funds to provide additional support and volunteers to keep carers on the island, as well as their loved ones and family members, safe.

Therefore, my answer to your question is that we do the very best we can with the resources we have available. There are things we cannot subsidise. There are challenges we cannot resolve. However, we certainly look to maximise the offer we have for local people when it comes to their caring support roles. That is through respite, through additional

support and through as much advice, information and guidance as we can make available to them across all aspects of their home life and looking after the person who they choose to look after.

Baroness Jolly: That is really helpful. Thank you very much.

- Q176 **The Chair:** There is a second question, which I will quickly put to Martin Samuels. Martin, we have an issue on this committee in that we have been told time and again that one of the big challenges is for carers, the disabled and elderly people to navigate the system, the lack of intervention and support so they feel they are on their own. What can a local authority do to change this, to create some clearer and more authoritative pathways? What are the gaps that have to be plugged? Who is doing well and where can we learn from?

Martin Samuels: To an extent, both Laura and Tandra have answered elements of this. It is certainly clear that the system people need to navigate is bewilderingly complex. Laura clearly brought out the number of social security benefits people potentially could apply for. We have already brought out the complexity of dealing with the NHS, social care and social security. Therefore, that is clearly one of the important tasks for someone to do and the local authority is probably the most logical and most obvious place.

One of the first things is the question of identification. We have already mentioned that one of the real challenges is that many carers do not identify as being a carer. We found that sometimes quite an issue. We have gone out and advertised services, support and advocacy for carers and people do not respond because they do not think of themselves as a carer, so it is important for us to think about the language we address. Therefore, in Leicester rather than talking about "carers" we ask, "Are you caring for someone?" That may sound like a slightly semantic difference, but that change in language can make a big difference.

Connections with other services such as the NHS, and particularly GPs, can be important. Of course, everyone has a GP. GPs very often will have that kind of information about whether someone is providing care for someone or, alternatively, they may know someone is providing care to their patient, so they can be helpful in helping us to identify people. Earlier I spoke a bit about the local area co-ordinators. Again, those roles, whatever we call them—care navigators or social prescribers; many roles exist in different ways—can be an important way to understand who is there and needing to draw on support, and also what support is there.

One thing we need to think about is how people connect with those services. Our default very often now is to go to the digital offer. In Leicester, we have a website called MyChoice, which is designed to give information about a very wide range of services and support that are available in the community that people can call upon and, in a sense, they can design around their own particular needs. We recognise, of course, that not everyone has access to the internet, or even if they have access potentially may not know how to use it. Therefore, we need to

ensure that we are consistent, we are engaging with people and there are clear routes for people to access; phone lines and the like are still important.

We recognise that there are gaps in this. We know, for example, if people ring our single contact line for the city council, they can often be on the phone waiting while it rings for five, 10 or 15 minutes, which can be difficult for people to wait for. Then making sure that the person who answers the phone has that good knowledge can be tricky as well.

We are always trying to make sure that the information is available to people in a way that they can access simply and quickly. Part of the challenge we have is that, because these are largely community activities and community services, not only is there a bewilderingly wide range of them—as there should be, because they are at community level and communities are different—but they tend to change quite regularly. That is one thing that we in the public service can find difficult. We can be focused on, “Here is a service. We have a three-, four- or five-year contract for it and it should be pretty stable throughout that period”. With a lot of community capacity, because it is developed by people who are passionate, keen and enthusiastic, but perhaps are giving of their own time, it can change on a regular basis by the natural process of things. Therefore, the effort involved in keeping a map of what is there is really quite significant. That principle of having people who are connected with their communities constantly collecting that information so that we can present it in a clear way is important. We cannot do it once and then expect it to stay in date for more than a very short amount of time. I am not sure whether I am starting to wander off the topic of your question, so I will stop at that point.

The Chair: No, but I will stop you because we are short of time. The question is whether there ever could be a universal system or whether these are local choices and so on. I would like to ask Laura, Tandra and David to reflect on this question in particular, because it is so important. Maybe between us all, we can come up with something reflecting good practice that is also extremely transferrable, shall we say? Thank you very much.

Q177 Baroness Goudie: Good afternoon. My question is to you, Martin, but at the same time perhaps others could consider this and if they have a view they might like to send it in, in writing, with other evidence they are going to be sending to us.

Martin, while access to supported housing is key to enabling independent living, as we have discussed earlier—and I feel very strongly that people should be able to live in their own home—our committee has heard that there is a lack of a strategic approach to accessible and supported housing in local authorities. To what extent is supported housing part of Leicester City Council’s strategy in planning for adult social care? What proportion of housing is accessible and adaptable at short notice? What strategies are you adopting to increase supply? What are the obstacles to an integrated approach to housing and social care and how can they be

overcome? Perhaps you can also quickly answer how you can adapt somebody's home without having to get planning permission and so on. I know that there is a lot in the question.

Martin Samuels: There is a lot in that. I suspect it would not be too difficult to spend an entire two-hour session on that, and the topic would merit it.

Baroness Goudie: Absolutely you could, yes.

Martin Samuels: One thing that has been said, which I think is very true, is that every care decision is a housing decision. It is one of those points where the connection between adult social care and housing is fundamental. Sometimes when we focus on the integration between adult social care and the NHS, while recognising the importance of that, it can be easy to overlook the—I would argue equal—importance of adult social care being integrated with housing.

I note that in fact all four witnesses today come from unitary authorities and therefore authorities that have responsibility both for adult social care and for housing. I have to say that that offers a very significant benefit. I have worked in a two-tier system. I worked in a county council that had responsibility for adult social care and we had a number of districts that had responsibility for housing, which led to a significant increase in the complexity of the system. Working in a unitary system, where I have a housing director whose desk is just across from mine, when we are in the office, gives a very significant benefit.

I could describe the process we are going through in Leicester to develop a strategy, but I am aware there is only limited time. I will say that I suspect what we are doing in Leicester is not particularly different from what other authorities are doing elsewhere in the country. We have a 10-year strategy for supported living and extra care. It is based on the belief that good housing and support are fundamental to the ability of someone to maintain a good level of health and well-being, contribute to their community life, and participate in education and employment; in other words, for people to live the life they choose to live in the place they call home, they need to have a place they can call home. That is fundamental.

We have done a significant amount of demand forecast analysis, understanding the demographics of our local population and looking at the flow of people of different ages into the need for different types of housing. We renew that forecast every couple of years. We have identified that we think we need 551 additional units over the next 10 years. My sense over the last year or so has been that that is probably an underestimate; this will be properties specifically for people who required supported living or extra-care housing. I sense that we are probably underestimating that number and, of course, many people need a bit of help but do not need to be in supported living as such. Housing centres where there is a warden or someone like that could make an enormous

difference in people's lives, but those sorts of services are often the casualties of the savings we have had to make.

We have found significant challenges in taking this forward in a very urban area such as Leicester. The census says we are now the third most densely populated area of the country outside London. Finding sites to build this sort of housing is extraordinarily difficult.

Issues about funding uncertainty have also been a major factor. The committee may well be aware that there was a consultation by the Government in 2017 to change the rules on housing benefit. That had the effect of stopping dead virtually every single supported-living scheme that was being developed in the whole country, because there were additional costs and charges involved and they all depended on people having access to additional housing benefit. Very often in the conversations I have had with potential providers and potential developers—as they are building a scheme that will be there for 20 or 30 years at a minimum—some kind of certainty about what income they might be able to have from that, to be sure that it is cost effective, is fundamental.

Finally, there is a real issue with changing the culture. We often find that it is hard for people to make that decision, to say, "Actually, I do need a bit of help. Perhaps I need to be living somewhere where someone is available to support me". That is psychologically a difficult step for many people to take. There is often a real concern about becoming institutionalised or going into some kind of home, and clearly if these are working effectively they should not be "homes" in the sense of an institution.

There can also be a culture change required among our own staff. It is very easy for social care staff to default to the simplistic options of residential care, home care or day opportunities, and not think about some of these wider opportunities.

Then there are issues in terms of culture change for policymakers. Although it is very encouraging that the Department of Health and Social Care is talking about supported housing much more than it used to, it is noticeable that most of the engagement we have with civil servants, and indeed with Ministers, is very much focused on traditional models of care, on the assumption that people are in much more dependent situations, and not thinking about the many, many thousands of people who have growing needs but which could potentially be met through a bit of support that did not get into eligible social care.

Baroness Goudie: Thank you very much. That was very helpful and still leaves a lot of questions to be answered. I also take the point about how it is always that they could go into residential when it would be much better to stay at home. My aim is that everybody should be able to stay—my colleagues know this—in their home. I feel it leads to a better life. Thank you again and thank you everybody else who has answered our questions.

The Chair: I will suggest, Laura, if you do not mind, that you put your responses in writing and, indeed, everyone else—David and Tandra as well—because it is ridiculous to have the housing question right at the very end when we are short of time. It is horrendously important and complicated. I like what David said about every care decision being a housing decision; of course it is. We have been incredibly lax in ensuring that housing is integrated into policy-making. The social care White Paper does it for the first time and even that, I think, lacks a bit of conviction.

I will wrap up what has been a fantastic session, a really, really excellent session. You have answered our questions with frankness, conviction, thoughtfulness and detail. It was exactly what we wanted and exactly what we hoped for. You reinforced some of the things we have identified ourselves and also challenged us in ways and gave us language and perspective we would not have had otherwise. I am extremely grateful to you and every member of the committee will want to echo that as well. Thank you so much. If there are things you want to say in more detail, please feel free to drop us an email, which will be great. In the meantime, I now officially declare this session closed and thank my colleagues for their time and their hard work as well. Thank you so much.