HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Adult social care, HC 1327

Tuesday 2 May 2023

Ordered by the House of Commons to be published on 2 May 2023.

Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris.

Questions 1 - 52

Witnesses

I: Helen Whately MP, Minister of State, Department of Health and Social Care; and Michelle Dyson, Director General for Adult Social Care, Department of Health and Social Care.

Examination of witnesses

Witnesses: Helen Whately and Michelle Dyson.

Q1 **Chair:** Good afternoon. This is the Health and Social Care Select Committee, live from the Palace of Westminster, where everyone is awash with excitement, having met the King and Queen this morning.

We have two distinguished guests before the Select Committee today. As people will know, Select Committees run lots of inquiries. We are doing a big one on prevention at the moment; we are also doing inquiries on cancer, community pharmacy, NHS dentistry and other subjects. But we intersperse those sessions with various topical sessions, and today we are going to be talking about social care.

I am delighted to say that, on that subject, we have Helen Whately MP, who is a Minister of State at the Department of Health and Social Care. We also have Michelle Dyson, who is the director general for adult social care at the Department. Thank you so much for joining us. We just wanted to catch up on some of these issues. Obviously, adult social care is one of the big issues that we see in our postbag as a Select Committee but also as constituency MPs.

Minister, if I may, I will start with you, on the subject of funding and funding reform. Obviously, over the last 13 years—and before that—there have been many promises made and proposals put forward. Back in July 2011, the Dilnot Commission—the Commission on Funding of Care and Support—published its proposals, setting a lifetime cap on personal care costs. There has been a long story since then, with many different Ministers holding your job.

Significantly, the health and social care levy was proposed by Boris Johnson's Government. It was announced in September 2022 under Prime Minister Truss—short-lived—that those charging reforms were no longer being pursued. Then, in the autumn statement of 2022, Chancellor Jeremy Hunt announced that the reforms would be delayed from October '23—this year—until October '25. They still include a cap on the amount that anyone in England would have to spend on personal care costs over their lifetime, but that doesn't include money spent on care before the reforms come into force.

I just wondered whether we could get from you at the top of the session a sense of where the ambition is. What is your ambition now, as Care Minister? What is the message that you want to go out to viewers of this Committee and to our constituents about the Government's intentions in respect of care costs?

Helen Whately: I am very happy to answer that. Thank you very much for inviting me to the Committee this afternoon.

You were asking about what I call charging reform—the reform of how care is paid for for people who are funding their own care. The

Government plans to bring in a cap on the amount that people put towards their own care, because we know that there is a proportion of people who end up hitting very high care costs. That is incredibly difficult for individuals and for their families and can use up their savings, for instance.

The Government is committed now, as we were before, in wanting to bring forward those reforms and to put in place a cap on the amount that people spend on their care. Clearly, as you mentioned in your opening question, the decision was taken back in the autumn that those reforms needed to be delayed for two years and to be implemented in October 2025 instead. The reason for that was the change in circumstances—the extra pressures on budgets for health and social care as we come through the pandemic, and, most conspicuously, the high level of inflation as a result of the war in Ukraine and all the pressures on budgets for local authorities.

The Government listened very much to the message that came through from local government, who need to implement these reforms and who were concerned about taking them forward against that context—particularly the funding pressures. Therefore, more time was asked for, hence the decision—the difficult decision, because of the importance of the reform—to postpone for two years, and for the funding against them to be retained in local authority budgets for the next couple of years to support the workforce in social care.

Q2 **Chair:** So Dilnot lives; Dilnot is alive and well. Which bits of Dilnot do the Government leave to one side, and which bits of Dilnot do the Government embrace wholeheartedly?

Helen Whately: In essence, as before, and even on the new timeframe, it is still a substantial reform, and there is a factor for local authorities about the amount of really difficult work that needs to be done to implement it—for instance, to be able to cope with the greater number of assessments that will be needed, with more people coming forward to get their financial position assessed for support, among other things.

A substantial amount needs to be done in order to implement it. The ability, therefore, in the timeframe, to make material changes to the reforms, as set out already, would be very limited. The decision we have taken is to delay the reforms as they were, rather than to make any changes, as you are alluding to.

Q3 **Chair:** Okay. The decision was taken, in terms of the structure of funding, to keep local authorities at the heart of that decision making and funding. Was there any discussion around changing that? There is no national funding stream for social care. It goes through our local authorities, which are already under intense pressure financially.

We all have constituencies. There is a boundary to our constituencies that will sometimes cross over county lines. We have constituents who move, which is their right. I have casework where people move from Hampshire to Southampton, and that is a completely different funding authority. Was the discussion had within Government, when you decided to keep

the reforms but delay them, about changing that fundamental vehicle of funding?

Helen Whately: Your question is whether a discussion was had at the point the decision was made. Given that I was not in post at the point that the decision was made, would you allow me to bring in Michelle to address that question?

Chair: Michelle, it is your moment.

Michelle Dyson: No, we do not envisage changing the funding structure of local government. The charging reforms build on the structure that is already there. Indeed, people already move from being self-funders into the publicly funded system. This is about moving more people who are currently self-funders into the publicly funded system, but the funding structure we envisage using is the one that is already there.

Q4 **Chair:** I know that was the decision taken, but I am asking whether there were active discussions about changing that? Were you lobbied to change that by Care England, for instance, by any other organisations or by the Local Government Association?

Michelle Dyson: No. It is fair to say that, during the pandemic, providers liked the fact that we funnelled money basically direct to providers, which we are no longer doing—we are funding local government, although we have taken powers, such that we can fund providers directly, if necessary. But, in the context of these reforms, no, I do not remember any lobbying of that kind.

Q5 **Chair:** Finally, to one or both of you—probably the Minister—in terms of October 2025, you could forgive the cynic for saying, "Before that time, there has to be a general election. There could be a continuation or a change of Government." Is there anything to say that October 2025 is now set in stone?

Helen Whately: In terms of delivering to the October 2025 timeframe, a lot of things will need to happen for local authorities to be ready to implement that. We had a timeline to deliver to October 2023. What we have done, in essence, is shifted that timeline—

Chair: By two years.

Helen Whately: That will include steps that will need to take place substantially during the course of next of year, for instance, for us to be ready to do that. We are working to that timeline now.

Q6 **Chair:** How much would an incoming Government, of either party, be bound by that date of October 2025?

Helen Whately: That is quite a hypothetical question, but I think that that work will be in progress at the point at which the next general election happens—whatever date that will be—to be ready for that October 2025 timeframe, and local authorities will be motoring towards that. In fact, we are currently doing things to support being ready for that. For

instance, as I mentioned a moment ago, something that needs to happen is that local authorities will need to do financial assessments for more people. That is an area where there is an opportunity for some process improvements, and we just released £27 million of funding for that work to happen across the country in the coming months. That is necessary for reform, but is also helpful, in any event, to make a process that has to happen more efficient.

Q7 **Chair:** You can see what I am driving at: yes, it is hypothetical, but, actually, for families doing some long-term planning—people who have mum or dad in a challenging situation now, which they can just about deal with through being unpaid carers, and so on, but who can see themselves ending up using the social care system within the next couple of years—it is not really theoretical. What I am trying to get at is, how much confidence can people watching this—our constituents—have that October 2025 is the horizon? Or is the horizon moveable again?

Helen Whately: I am trying to think what more I can say. October 2025 is the date that was announced, following the decision to delay. That is what we are working towards. There are steps that will need to be taken across local authorities to be ready for that.

I know that it is just as important now as it was when it was first announced as part of the reforms that some people find themselves incurring very high costs for social care. That understandably feels very unfair. You feel very unlucky. It is unlike health, for instance, where, if you are an unlucky person with very high costs of treatment, you get that through the NHS and it is supported. We want to have a fairer system in social care. Clearly, with the cap, there will still be costs to people, but they will know that there is a limit to the amount of money that they will need to spend on care.

Q8 **Chair:** There is a reason why I could join the cynics. It was controversial, right? It was controversial here to legislate for the health and care levy. We had to vote it through—the Government had to vote it through—and we got both flack and praise for that.

The praise side of that is that it was a dedicated funding stream to deal with covid catch-up and then, in its dedicated form, to move across for social care. The Truss Government, when asked the question, said that that was going to come from general taxation. It could concern us, as a Committee, if that comes from general taxation, because that means that it is up there to be bid for and eaten into along with everything else.

How confident are you that general taxation will meet these costs? They will be enormous, given the number of people you will bring in to the public consideration of care, as Michelle said, who are currently wholly outside of the public consideration and with the private sector.

Helen Whately: You are probably asking questions that would need a Treasury Minister in the room to go through expected revenue streams for the Government in the coming years, including beyond this spending review period. I do not think that there is a lot more that I can say.

At the time of the levy, there was some debate, and people challenged me, given that it, initially, the lion's share was for the NHS, shifting over time towards social care. People said, "Well, will that shift really take place?"

Chair: "Will it happen?"

Helen Whately: "Will it happen?" There were discussions even around that, and I was adamant at the time that we had a trajectory for social care. I just think that you are asking for a timeframe that is beyond what I can set out a substantial answer for, which probably is not helpful to the Committee.

Chair: You know how I worry Minister, and I do like to express my worries on this. Do you want to come in on this, James?

Q9 **James Morris:** On the point about the levy, you are saying that the amount that would have been raised by the levy is going to be protected out of general taxation, but is that happening? Can you point to where it is happening?

Helen Whately: We are talking beyond the current spending review period when we talk about reforms coming in in October 2025.

Q10 **Chair:** Well, we are, but of course a policy intention has been announced that points you in that direction. I know that Chancellors hate this—the guy who used to sit in this seat would not thank us for this conversation—but the truth is that a policy has been announced that writes part of the next spending review.

Helen Whately: I know there is a set of steps that we need to take during the course of next year to implement the reforms and make sure we are on track. Something that may be reassuring for the Committee—it is for me—is knowing the Chancellor's commitment in social care from his time sitting in that Chair and as Secretary of State for Health and Social Care. As Chancellor, he announced record funding for social care at the autumn statement—up to £7.5 billion. All those things are reasons to feel positive about this.

Chair: Okay. We are going to talk about workforce now. Obviously, the system doesn't work without money, and it doesn't work without people. We will start with Rachael Maskell, and then I will bring in Paul Blomfield.

Q11 **Rachael Maskell:** Good afternoon and thank you for coming along. Minister, can you explain why you have halved the workforce development budget from £500 million—the ambition set out in "People at the Heart of Care"—to £250 million?

Helen Whately: Thank you for the question. I am really pleased to be able to talk about the workforce in this session. To me, social care is its workforce, along with all the unpaid carers, including family and friends—it is important to recognise and show appreciation for them.

A lot of the challenge with meeting the need of people who draw on care and support is about ensuring there is a workforce. We all know about the vacancies and about care providers' challenges in recruiting and retaining staff, so it is all about the workforce.

The workforce was at the heart of the reforms that we set out in "Next steps to put People at the Heart of Care" a couple of weeks ago. Those reforms respond to what I have heard from many in the workforce, and from providers and others—I am sure you have heard this as well—about the need for more of a career structure for people working in social care, more opportunities for career progression, more recognition of the skills, capabilities and experience of people working in care, and more support for people to develop their skills and progress in social care so that they can, in turn, be rewarded for that.

That is why our workforce reforms, in essence, introduce a new care workforce pathway as a career path. We are setting out the roles and the way you can progress in social care. We are introducing new qualifications for new care workers, and we will fund hundreds of thousands of training places in those qualifications. The qualifications are for new care workers and for existing staff to develop their skills—for instance, skills that enable them to take on nursing tasks that are appropriate for care workers, and digital skills. I see those as really substantial, transformational workforce reforms. I have been told by the sector that they are exactly what is needed.

On your question about the funding for that, we have allocated £250 million, as set out in the recent "Next steps" document. In the run-up to setting that out, we looked at the overall pot of money allocated to reform and asked what the best possible use for it is in the light of the extra pressures on social care, the impact of inflation and the demand we are seeing. I take the view that we need to do reform hand in hand with making sure there is enough funding going into the frontline provision of care. We need to ensure there is enough funding going to local authorities, which, in turn, can be used to increase providers' fees, which are used to pay staff. For me, reform needs to go hand in hand with funding the frontline.

Q12 **Rachael Maskell:** But why halve the money set out in the ambition?

Helen Whately: In essence, when you have a limited pot of taxpayers' money, it is about looking at what the right amount is to spend on the things that I set out—on the career pathway, on a new qualification and on the training. That is set against the further funding that we think we need to give to frontline care, which would, for example, go into the rates that local authorities pay; that, in turn, can be paid to the workforce. I feel very strongly that reform—for instance, investment and training—needs to go hand in hand with ensuring that providers get the rates they need to pay the workforce. Both those things are really important.

Q13 **Rachael Maskell:** The challenge is that we have 165,000 vacancies. The average wage of somebody working in social care is 21p an hour less

than someone working in retail. In fact, Minister, your value is six and a half times that of a care worker. Can you understand why social care cannot be a choice—because of the low wage that people are on?

Helen Whately: I have two things to say on that. On why more people don't choose to go into, or stay in, social care, from all the conversations I've had and all the research I've seen, in part it is to do with there not being a clear career and not having opportunities to progress. It is to do with recognition and status, and care workers not feeling valued in that way. The other factor is pay. Both those things are important. That is why we are acting on both those things.

We are putting in place the structures to ensure that there is more of a career path, with opportunities to progress and care workforce pathway training; but we are not only doing that, because workforce reform was not ever funding for pay. Hand in hand with that, we need to ensure that we are putting enough money into frontline care, so that the providers can pay the workforce as needed in order to recruit and retain staff.

Q14 **Rachael Maskell:** But that is simply not happening. The average wage for our care staff is the minimum wage, at £10.42 an hour; if they had a job in the NHS evaluated as equivalent, they would be on £3,500 more. We have a good career, training, and educational opportunity structure in the NHS, called Agenda for Change. Is it not time that we employed social care staff from across the sector on Agenda for Change terms and conditions? Would that not bring parity of esteem, and assist not only with retention, which is the big issue, but integration?

Helen Whately: I do not believe that we would be in a position to do that. On the one hand, there is the funding—what that would cost and where that would come from. In any event, you need the structure that there is around Agenda for Change. The NHS has all its bandings and skills, and knows what people do at each level in way that social care does not. Social care does not have an agreed structure.

Q15 **Rachael Maskell:** It could do.

Helen Whately: Some other countries do, and we are looking at the structures and the career progression for social care in other countries. Healthcare is another example. We are looking for that potential for progression in social care. We need to do the work, which is why we are doing the care workforce pathway. We need to work with the sector on that. It would be no good for me to sit in my office and do it on a piece of paper. It will not be accepted or valued, and it will not work unless we do it hand in hand with providers and the wider sector, as we plan to. That is why we put out a call for evidence with the "Next steps" paper a couple of weeks ago. We will get input, so that we come up with a really good pathway that sets out what care workers do at different levels of experience and skill.

Q16 **Rachael Maskell:** That still doesn't explain why there is such a differential in the starting rate for the job. That really must be addressed, or else there will be a continual retention issue. On the issue of retention,

let me give an example: locally, it costs about £1,400 a week to keep somebody in acute care with delayed discharge, and £900 for a care package. That is a £500 differential. Locally, they found that people whose discharge was delayed deconditioned and required social care for the rest of their life in a residential setting, whereas the people who got the care package went home and became more independent and less dependent on care. When the Government say that they cannot afford this, I don't believe that can be the case. The money is going into the wrong part of the system. If social care staff were given an uplift—say, equivalent to Agenda for Change—you would not only see greater integration but move the resourcing into the right place, which could be a massive cost saving, so you would generate more resources to address the issue. Do you agree?

Helen Whately: What you are describing has clear parallels with what we are doing by putting extra funding into supporting discharge of people from hospital into social care, together with avoiding unnecessary admissions to hospital. As you said, and as I very well know, there is a problem with people deconditioning—particularly those who are frail, elderly and in hospital—and never being able to live as independently as they did before. The longer they stay in hospital, the more they will decondition and, for instance, lose their mobility. That is one reason why we put an extra £700 million into funding to support discharge last winter, and we are putting in £1.6 billion this financial year and next. Some £600 million of that has already been allocated; local areas know how much they are getting, so they can plan ahead. It is not just a winter fund; it is across the whole of this year, to make sure that there is a greater supply of social care—that is, to the extent that people are waiting for social care when they are waiting for discharge. It is not always the case, but where it is, we need to increase that supply.

Often there is a need for more domiciliary care, but we also know there is a need for more nursing care for people with dementia and complex dementia. We need to put in place all of that, which takes time and often involves the recruitment and training of staff. We need more funding for that because, financially, it is better than having people in hospital unnecessarily. Also, clearly it is better for individuals to be not in hospital when they are medically fit to be somewhere else. It is better to be at home or in an appropriate residential setting, if that is the right thing.

Q17 **Rachael Maskell:** With respect, the money is going into the wrong part of the system. I have a couple of quick questions to close. Some 54% of domiciliary care workers are on zero-hours contracts—24% across the board. Will the Government put an end to the use of zero-hours contracts: yes or no?

Helen Whately: Given that it was a Conservative Government, not a Labour Government, that took action on zero-hours contracts in the first place—

Q18 **Rachael Maskell:** Thirteen years on, can you see an end to them?

Helen Whately: What I want to see is more care workers having the sort of contract they want, with guaranteed hours, should they wish. Through the extra funding we are putting into social care this year, and through the extra funding for discharge, we are asking local systems—local authorities and integrated care systems—to identify in advance the social care that is needed, and to share with us their plans for meeting that demand. I have been signalling very clearly to local authorities, through these communications, that I think more care should be commissioned in advance. One of the problems, as I have heard many times from care providers, is spot purchasing of care, and not knowing in advance how much care you will be providing. There is difficulty employing staff on long-term contracts, because you might not know from one week to the next whether your care agency will be commissioned to provide that care. I want to see a shift towards more advanced commissioning, which gives more certainty to providers. That in turn enables providers to put staff on longer-term contracts.

Some staff genuinely have told me that they like having more flexibility, but many others do not, and we know that long-term contracts would be a better employment model for many people. It should help with recruitment and retention in the sector, so to me that is the direction of travel, supported by CQC assurance. As of this month, the CQC is embarking, for the first time, on assurance of local authorities implementing their duties under the Care Act. I have asked the CQC to look at the way local authorities commission care, because providing greater certainty and creating the conditions for a more stable and more robust care market is really important, for quality, for supply and for workforce terms and conditions.

Q19 **Rachael Maskell:** So the Government will not outlaw zero-hours contracts. Finally, when do we expect to see the workforce plan?

Helen Whately: On the NHS workforce plan, the work is ongoing. I am sure that it will be published soon.

Chair: Continuing on workforce, Paul Blomfield.

Q20 **Paul Blomfield:** Yes. I almost feel like apologising for pursuing the same issue, but it is an important one. I recognise what you are saying about the career pathway being important. I think we all agree with that, so can we park that for a minute? Those involved in delivering social care are probably doing a job for the most vulnerable in our society. Are you comfortable that they get the lowest pay in any sector or any job?

Helen Whately: To start from the top, I set out really clearly my ambition for the care workforce to be recognised and valued for the work that they do.

Q21 **Paul Blomfield:** Can I press you on that? Value relates to career opportunities, training, and support—that is, their management—but fundamentally, value is also about pay. They are the lowest-paid workers in this country. Are you happy with that?

Helen Whately: To that, I would say two things. I can talk about the national living wage going up. We all know about that. It went up by almost 10% earlier this month to £10.42 an hour, a pay rise of £1,600 per annum before tax for somebody working full time. That said, I do not want people to think of social care as being a national living wage job. I think that people should be rewarded for what they do, and I want there to be an opportunity for career progression in social care. When people gain more skills, that should be recognised.

Fundamentally, beyond the level set by the national minimum wage, what people are paid in social care is determined by their employers, and what their employers pay is a function of the combination of what self-funders pay for their care, the funding through local authorities, and the fee rates that they set. One thing that is clearly a factor in the fee rates that local authorities set is the support from central Government for the cost of social care. That is why the up to £7.5 billion announced in the autumn statement is really important—because it is an above-inflation increase in funding for social care. That is intended to enable local authorities to make material investments in social care. They have discretion as to how they do that.

However, one of the criteria of what we call the MSIF—the market sustainability and improvement fund—which is part of the grant funding coming from the Government, is to enable them to increase fee rates to providers, which in turn enables providers to reward their workforce. That, to me, is what we can do in central Government to support the pay of the workforce.

Q22 **Paul Blomfield:** Thank you for that. I note two of the points you made, which are that you want to see the workforce better paid, and you do not want social care to be seen as a national living wage-paid job. That is good to know. There are those who would contest whether the money that the Government are putting in is sufficient to improve the pay of the workforce—but let us not have that argument. Given your ambition for the workforce, which you have just described to me, will you be disappointed if we do not see a significant increase in pay for those working in social care?

Helen Whately: I think I have been clear in my communications to local authorities that I want to see significant improvement and an increase in the supply of social care. We want the funding that is going into local authorities—the grants and extra support for discharge, for instance—to allow there to be an increase in the provision of social care over and above the baseline. For instance, I want us to be in a much better position over the coming months, particularly as we go into winter, to make sure there is social care for people who need to be discharged from hospital. That is dependent on the workforce being there to provide that social care, which has a relationship with pay.

However, I am thoughtful about the Government's place in this. The role of the Government is in supporting the sector. Local authorities play a very important part. They know their local care market and employment

market; they know better than I do what is needed in a particular geography. Though I can give a strong steer about my expectations for supply, I would not pretend that I have all the answers, sitting here in Westminster.

Q23 **Paul Blomfield:** To go back to the Chair's opening question about what your ambition is, the pay of the workforce is a critical issue. As you described it to me a moment ago, your ambition was that you wanted to see the workforce better rewarded; you did not want this to be seen as a national living wage job. You have not quite answered my question, which was: would you be disappointed if there is not, as a result of the Government's injection of funding, a significant increase—

Helen Whately: I just don't want to be drawn—

Paul Blomfield: Recognising the Chair's opening comments that you were putting a lot of responsibility on to local authorities, local authorities have had more than half their funding cut. The additional injection does not go a long way towards giving them the agency to transform the situation on their own. What is your ambition for care workers' wages?

Helen Whately: The local government settlement is in real terms increased this year. Particularly given our focus on social care, we want that to be able to increase supply, and meet the growing need for social care. I just don't want to be drawn into saying something that is a very simple, black and white thing, which is not the way I think. I want to see people rewarded in social care. Something I feel very strongly about, which has come through to me in many conversations with care workers over the years, is the importance of the progression point and people being able to be recognised for their experience and skills. That not being recognised is sometimes articulated as a frustration.

We also need to make sure we address the other thing that I am sure you will have had plenty of emails and conversations about: the questions about whether care workers, particularly domiciliary care workers, are really paid for their travel time or for having to wait for appointments. There are some problems with the model to which they are paid. It is quite complicated and sometimes it is done based on hours of actual care, rather than paying for the duration of a shift, for instance, which leads to some of these problems as to whether travel time is or is not being funded. I want to make sure we are confident that domiciliary care workers are being properly paid for the hours of work that they are doing, but there is a complexity in it.

Some important things we are doing are, on the one hand, funding into the sector and, on the other hand, the CQC assurance of local authorities, including how they commission care, because how they commission care is so important in how then providers deliver it and the relationships that providers then have with their staff.

Q24 **Paul Blomfield:** You have anticipated my next question, which is about domiciliary care workers' travel time. We know that despite intentions to

the contrary, there are domiciliary care workers who are still not paid for travel time and, as a consequence, their overall pay from the start of the working day to the end of their working day is de facto less than the minimum wage. What are you going to do about it?

Helen Whately: Clearly, no provider should be paying somebody less than the national living wage—

Paul Blomfield: They shouldn't, but what can you do to ensure that that doesn't happen?

Helen Whately: On the one hand, there are routes for workers who believe they are being paid less than the national living wage to try to get that addressed. On the other hand—I have been looking into it and I have spoken to some providers about what is going on with this model—in part this is because of people being paid for the exact period of care that they provide and sometimes being paid a rate for that which is intended to cover the travel time and waiting time but then actually the travel time turned out to be longer or the wait was longer. Did it really cover that?

I think there is a problem with the way that employment works. I do not have an answer here and now for how you fix that, because that is at the moment in the relationship between provider and employee. What I think I have been doing is, first, sending a very clear message that clearly everyone should be paid at least the national living wage—that is only legal—and secondly, making sure that the quantum of funding is going in there, so that the rate should indeed cover the cost of care, including, crucially, the cost of paying the workforce properly.

Q25 **Paul Blomfield:** Couldn't you just require employers to pay people for travel time?

Helen Whately: I don't think it is as simple as that.

Paul Blomfield: There is probably a bigger discussion to have there.

Helen Whately: There is a complicated model. I want to be clear: people should, of course, be paid for all hours that they are working. There is no question about that. And people should always be paid over the national living wage. There is absolutely no question about that.

Q26 **Paul Blomfield:** I guess it would seem to most people quite simple that you start a day at, let's say, 8 o'clock in the morning and you finish it at 6 o'clock in the evening, and you have chunks of time that you work. You spend a significant amount of time, if you are a domiciliary care worker with 15-minute visits, travelling between those visits. I think everybody would accept that that is effectively part of your working day. Why can't people just be required to be paid for it? Why is it complicated?

Helen Whately: It is. Would you like me to write to you on that? As I say, I started exploring this recently and it did turn out to be more complicated. I started out coming at it exactly the way you said it and saying, "Isn't it as simple as that? Don't you just pay something for the shift?" That is not always the model that is in place, so it is more

complicated. I am very happy, separately, to follow up with you with more about how it works.

Q27 **Paul Blomfield:** I would love to press you further on that. I am conscious of the time, so it would be helpful if you do write to us. I have a final question that shifts us on to a different part of the workforce, which is the unpaid workforce—the estimated 4.7 million carers in this country who care for their family members. To return to the Chair's opening question about your ambition for social care, this sector of people feel they do not get enough financial support or opportunity for respite, and they are not supported as much as they might be through the benefits system. What is your ambition to support their contribution?

Helen Whately: You will have noticed that when I answered the first question I talked about unpaid carers—some people call them family carers, but it is not always family, with people looking after a friend or a neighbour—and the importance of their getting support and recognition. Being a carer can be really demanding and really hard. Of course, it can be something that people do out of love for the person they care for, and some say they would not want anyone else to do what they do, but that does not stop it being really hard or those people needing support.

The first thing that we have already been doing is trying to improve our ability to identify and know who those people are who are doing a lot of caring. That can now be done by GPs, for instance, and can go on people's records, and schools also now identify young carers. To identify people who are carers might seem like a small step, but it is an important one and the first step towards recognising and supporting people.

There is then the need to make sure that the funding is there for support for people who are unpaid carers. Last year, just a little under £300 million was spent from the better care fund on respite and support for unpaid carers; this year, a little over £300 million is earmarked from the better care fund to support people. We have allocated £25 million in our reform budget for work on reform in our support for unpaid carers.

The third area of work is to do with making sure that carers do actually get the support they are entitled to. The Care Act 2014 sets out what local authorities should do to support unpaid carers, both in assessing their support needs and then making sure that that is put into practice. At the moment there is no oversight—no way of anyone knowing the extent to which that actually happens or not. The CQC assurance process that we are implementing—the CQC has started on it—will be the first time that there is actually some oversight of that and some way of knowing the extent to which that is or is not happening. One of the things that the CQC will look at is whether unpaid carers are getting the assessments that they should be getting. Is the support being put in place as it should be under the Care Act? To me that is quite a substantial step forward in trying to make sure that unpaid carers get the support that they need.

Paul Blomfield: Thanks very much indeed. I would like to pursue that further, but I think we are running out of time.

Q28 **Chair:** Yes, you read the room well.

I have a final question on the workforce that is perhaps one for you, Michelle. In the Government response to our workforce report, which was published a couple of weeks ago, the Government stated that they would set out some detailed plans for a portable care certificate, which was something that we recommended and you accepted. Could you give us any more detail on the preparations in that respect? I know that it is of interest to the sector.

Michelle Dyson: That is part of the reforms that the Minister was describing. It is really important, because at the moment you have the slightly mad situation in which someone gets a care certificate with one employer, and when they move to the next employer, the second employer does not recognise the care certificate with the first employer. A really important part of our reforms, then, is to have a regulated care certificate, such that it is recognised wherever you go. We are on course to deliver that and then to fund the training that sits underneath it.

Q29 **Chair:** The "People at the Heart of Care" paper will have included that—

Michelle Dyson: Yes.

Chair: But what does "on course to deliver that" mean in terms of the timeframe?

Michelle Dyson: Our workforce reforms have a very complex series of deliverables. I would have to write to you about exactly what is going to happen when, but it will certainly be within the next year or 18 months. I cannot remember the exact timings on that particular element.

Q30 **Chair:** Okay. It would be good if you could do that.

Michelle Dyson: Yes, sure.

Chair: You have already responded to accept the need for it in our workforce report. We are always looking for updates.

Michelle Dyson: We absolutely accept the need for it.

Q31 **James Morris:** There was an intention, and I think most people would agree that it was a good idea, to reform the DoLS system; why have the Government abandoned that?

Helen Whately: You are absolutely right about the intention to reform DoLS and move to the liberty protection safeguards, or LPS. Lots of work has been done on that. That was one of the difficult decisions in looking at priorities in the light of inflation and pressures on resources.

Q32 **James Morris:** So it was too costly to implement?

Helen Whately: There were significant resource demands. There is a lot of work to do to make the shift from DoLS to LPS, so those resource pressures are the reason behind delaying it. It continues to be an important thing to do, and I should emphasise that the decision was not taken lightly at all.

Q33 **James Morris:** I am just trying to understand. I think there was a common view on the current system of DoLS. First of all, there is a very big backlog, which means that we have people in institutional settings who have not got the kind of assurance and protections around the deprivation of their liberty. The new system was designed to upgrade that and modernise it. I think the Bill to contain the legislation was passed, from memory, four or five years ago. This is a very important area to ensure that some of our most vulnerable people have the necessary protection. I am just trying to shine a light on why this has been put back on the basis of it being "too costly", given that the current system looks as though it is broken, and it was broken five years ago.

Helen Whately: I am looking over to see whether Michelle can add anything, beyond the resource challenge.

Michelle Dyson: There absolutely is a resource challenge. One thing I would say is that there are some local authorities that have reduced their waiting list, so it is not an impossible task under the current system. We need to support local authorities to do that.

In terms of why we have delayed it, as the Minister says, it is a resource constraint. This is a really, really complex reform. Our consultation paper on it ran to hundreds of pages. We have had 750 responses. It is really complex both for us to implement and for local authorities to implement, so it is simply a prioritisation issue. We will publish a summary of the responses we have had back, and when we do have the capacity to pick this up again we are in a very good place to do it, having done this very complex consultation.

Q34 **James Morris:** What I am trying to get to is whether there is an agreement that the current DoLS system is inadequate. The Government may be delaying it, but is the Government still accepting the need for change?

Helen Whately: We still accept the need for change. We completely accept the need to move to the liberty protection safeguards. A lot of work has been done on that. We have done the consultation, and we intend to publish a summary of the responses on that. It is just that it is going to take longer; we will have to delay it because of the constraints on resources.

Mrs Hamilton: Good afternoon.

Chair: Be afraid. *[Laughter.]*

Q35 **Mrs Hamilton:** No—I am the best. This afternoon I will be asking you about different aspects related to prevention. As you both know, at the moment, because of the workforce issues that have been talked about and some of the stuff relating to finance, within local councils and ICBs they have really looked at how they can develop prevention, to the extent that they have talked about neighbourhood networks, primary care networks—anything to try to prevent people from going into hospital. My question is around the trips and falls issue, and the waiting times. Some

years ago, although I can't remember when, the Government did say they were going to put a four-year limit—was it four years?

Chair: Four hours.

Mrs Hamilton: A four-hour limit, where if people had issues, if they had tripped and fallen—

Chair: This was in the Long Term Plan.

Q36 **Mrs Hamilton:** In the Long Term Plan—thank you—it said that those people would be seen. My issue is that I have not heard a great deal about that since. So my first question, to Helen, is: where are the Government on this policy at this moment in time? My question to Michelle—I will do two in one for speed—is: if you're expecting local authorities to really deliver on the prevention agenda on the ground, trips and falls are some of the main reasons why some of our elderly and disabled people are going back into the acute system, so should we not be looking at managing this better? What are you saying we need to do better on the management side to help with this?

Helen Whately: I am trying to flip my head into my urgent and emergency care recovery plan work, because under that plan we are investing in and improving community response services and fall response services.

Chair: You're right: it was recommitted to in that.

Helen Whately: Yes. We are rolling out the seven days a week, 8 am to 8 pm—I can't remember whether it is called the community response service or falls response service—across the whole country. That is because we know that if somebody has a fall but they can be cared for and looked after at home, rather than by admitting them to hospital, that can be much better for outcomes. There is good evidence on that where those services exist, so part of the UEC recovery plan has a flow of work on making sure those services are available across the country. I don't have in my head where we are on the four-hour response, and I would have to get back to you separately on that because it is more under the auspices of the UEC activity.

On trips and falls, before you turn to Michelle but at the risk of stealing what she was going to say, I want to mention making sure that there is appropriate housing for people with care needs. That is an important part of what we do in social care. On the one hand, we have over £500 million allocated this financial year for the disabled facilities grant for home adaptations. For instance, this is to help people with their mobility problems, or to put in wet rooms or things like that so that they can continue living at home but can also make the home safer.

As part of our reform funding, we are putting £102 million into additional support for home adaptations. These are things that could be smaller and done more quickly—for instance, addressing a step, a trip hazard or something like that—to enable somebody to continue living at home and

safely at home. Those adaptations that are reducing the risk in a home are a really important part of reducing the risk of people having falls.

Q37 **Mrs Hamilton:** May I come back to you on that? In many local authorities—I am sure other MPs will say the same—some of the issues we get in our mailbag are about the fact that we don't get the adaptations in quickly enough, so although the funding may be there, the local authorities' ability to do it at pace is still lagging behind. What work is being done to ensure that you are not just announcing these policy areas to say, "We have put this money in," but you are ensuring that it is done? I am not going to lie to you, Minister: at the moment there is a gap between the funding going in there and the work being done in an appropriate time. Some people are waiting two or three years to get these adaptations sorted out.

Helen Whately: Yes, it is something we see. The average amount funded through the disabled facilities grant at the moment is an adaptation costing about £10,000. Something of that kind of cost may involve a relatively long timeframe. The new thing we have announced—£102 million for home improvement services—is exactly to address the problem that I think you are flagging up: things that could and should be done more quickly may cost materially less but we need to try to speed them up. If somebody is in hospital waiting to be discharged but a relatively minor adaptation needs to be done, this is about getting that done quickly to help them to be discharged and not spend a long time in hospital. Michelle may be able to add more to what I have just said.

Michelle Dyson: I can't add anything more on the important point that you raised. To go back to your broader question, I have seen some really great examples of that community response. I went to Greenwich and saw the hub with the GP, the social worker and the physios all there ready to jump in when the call came in. There is a great opportunity for us, having set up integrated care systems. After all, the community response thing is all about the join-up between health and social care. You need both services to be at the ready, and there is a great opportunity with integrated care systems to get that moving.

One of our reforms that we don't talk about a huge amount is on data. Social care is notoriously lacking in data. As of April, we are now for the first time collecting data on every person in the local authority-funded social care system. It is obviously pseudonymised. In due course, we will be able to join that up through their NHS record and see individuals moving through the system. We will be able to see exactly the things that you were talking about on that prevention agenda. We will be able to see what interventions are put in place and whether they work, or whether people are just cycling through the system. I suggest that once we have that data, which will be available not just to central Government but locally to local authorities and hopefully providers, it will help to inform our work and our future interventions in this space.

Q38 **Mrs Hamilton:** In my final question, if we have time, I am going to concentrate on prevention, because that is my area today. I have a

wonderful centre in my area that deals with sight loss. It does an awful lot of intensive work with people with disabilities, but particularly with sight loss, to ensure they become and remain independent. Now, I am going to connect that to the workforce. All this work is being done—you have talked about all the money that is going into the sector and about great pockets of work being done—but the problem is that many of these organisations get to the stage of needing staff to continue their wonderful work of preventing people from going further into the system and having problems, but they cannot employ them. It goes back to the fact that if you want to prevent people from going into the system, you have to pay staff the right level of money, whether they are in social care or domiciliary care, so that they will be interested in carrying on working in that sector. Helen, what is the Government doing to ensure we are not just attracting good people into the sector to help us with this preventive agenda, but retaining them? Without good people supporting the people in my area with sight and hearing loss, they are going to deteriorate, end up in the care sector fully and be in trouble.

Helen Whately: Let me draw out one of the things you just said there. You talked about the importance of retention, as well as recruitment. Retention is really important because staff gain skills in any job, particularly if they are supported by training. They also get to know the people they look after—those relationships are valuable—and other people in the system. For instance, they get to know GPs and the hospital. All those things can make the system work better, and people get better care.

I had a conversation recently during a hospital visit when I was looking at what is going on with discharge. I spoke to the team of clinicians who were involved in discharge and looking after some of the frail and elderly patients in the hospital. They said that, during the pandemic, they went out to one of the care homes, spoke to the staff there and helped to train them up on some of the things they should do to avoid admissions when it would be better for the person to be looked after in the care home and not be admitted. They then said, though, that over the year or so since they had been out to visit that care home there had been a lot of staff turnover. So they were then getting people admitted and because the staff had changed, only the previous staff that were trained up would have known how to look after those people still in the care home. To me, that was an example of where the turnover of staff can be such a bad thing for the individuals they are looking after and for the system as a whole. That is why retention is so important. How do we improve retention? By having a better career path for people working in social care, by investing in training to support people to gain their skills and by making sure that there is recognition as part of that and funding to go into social care so that, as you gain more skills, your pay reflects that. All of those things need to go hand in hand to achieve what we are looking for.

Q39 **Mrs Hamilton:** Minister, you have said this a number of times to a number of us, but the question I am asking you is: when? You know what the answers are. We are sitting here and we know what the answers are.

When are we going to start to see some of those improvements so we can not only employ good staff, but retain good staff? We must keep good people out of the care system, because ultimately, they move into the health system, which is buckling at the moment.

Helen Whately: I would like everything to happen now— tomorrow, if not today. I am always hugely impatient. Michelle would attest that when I see the timelines for the reforms, I am always saying: "Does that have to take three months? Does that have to take six months? Do we have to take six weeks on that consultation?" I always want to do things quicker, but I recognise that if you do not give enough time for things, you do not give people the opportunity to contribute and you do not take the sector with you, they will not be happy with where you get to. So, for instance, on this career pathway for the care workforce, we put out the call for evidence. That needs to be open for a number of weeks to give organisations time to reflect on it, think what they want and then feed back in. Then we need to go through those responses in order to set out what we think that progression and that pathway should be like. There will have to be some iterations for us to get to a good answer. Much as I would like to do it just like that, we all know that we have to go through a process like that for it to be good enough to do the job that we want it to do.

Q40 **Mrs Hamilton:** So would you say it will take a couple of years?

Helen Whately: I am trying to think—again, you asked a moment ago—what the whole timeline is until we actually have the career pathway agreed and published and I think we are looking at next year, but I would have to—sorry, Michelle.

Michelle Dyson: I do not want to commit because I think I might get it wrong, so we should write to you on that.

Helen Whately: I think we have done, to some extent, a timeline in the "Next steps to put People at the Heart of Care" document we published, which shows some of the timelines of all the different workforce reforms.

Mrs Hamilton: I feel I have taken enough time so I will hand back to the Chair. Thank you.

Chair: We will finish in about 10 minutes or so.

Q41 **Dr Johnson:** It is important when people get care or their relatives are in a care home that they know that the care will be of a high quality. We have had some news reports suggesting that that is not always the case. It is heartbreaking when you entrust someone so vulnerable into something that does not work.

Apparently, there are 23,793 care homes and of those, over the last year, 3,654 required improvement and 309 were inadequate. That is essentially one in six not coming up to scratch. What are you doing about that?

Helen Whately: You make a really important point—I am looking at the figures in front of me—about the quality of care. All of us want for our constituents as we do for members of our family who receive care, whether in residential care or care in the home, for it to be good quality care, safe and, in fact, going beyond safe to help people live their lives as fully as possible and improve people's quality of life. As of the beginning of this month, 83% of all social care settings regulated by the CQC were rated good or outstanding. The remainder were not good or outstanding; there was therefore a reason to be concerned and to want to see those settings improve.

In response to your question of what we are doing about it: the CQC clearly plays an important role in this, ensuring that it inspects and identifies where there are problems, and that care providers are supported to do better.

As I said earlier, I think the CQC assurance of local authorities is a really important part of this, because of the local authority oversight of social care in their area, and local authorities' ability and responsibility to shape the markets, and to ensure that care providers, for instance, have the funding they need and the certainty to be able to invest in the quality of care and the workforce, and to recruit, train and retain staff.

To me, quality goes hand in hand with workforce. Having a well-trained workforce that is retained within social care, rather than the level of turnover we have at the moment, is a really important part of quality. At the moment, around half of people working in social care do not have a formal care qualification. I am sure many of those people will be providing very good care, but we know that overall it is a good thing to be trained in the skills needed to provide care.

We know that people benefit from training in the skills to look after people with dementia and complex dementia. We have a growing number of older people with complex dementia and the care needs to do with that. The training for the workforce that I have been talking about is crucial, as well as the important role of CQC and CQC oversight for quality.

Q42 **Dr Johnson:** One in six places are failing on assessment, roughly speaking. Why are they failing? What are the most common reasons for them failing a CQC inspection?

Helen Whately: I don't have the specific answer to that question. I do not know whether Michelle does, or whether we need to write to you on that.

Q43 **Dr Johnson:** It is quite difficult to solve a problem if you do not know what the problem is.

Helen Whately: Yes, but CQC will be quite specific, and will do detailed reports on the reasons why it has expressed concerns about care.

Q44 **Dr Johnson:** For each individual home, yes, I understand that. But if one in six care homes, housing roughly one in six people receiving care, are

not good enough—either requiring improvement or not adequate—it would be helpful, would it not, to understand why those homes are usually failing, so that one could put in steps to address them?

Helen Whately: There will be a range of reasons. For so much of quality of care, the workforce is very important. I think it is important to recognise and appreciate workforce skills, but I want us to have a more qualified, more highly trained workforce. That is why part of our reforms is to support the workforce with training. The skills of the registered manager are very important. That is an area where there are vacancies and turnover. As part of our workforce investment, we are putting in place more training and support for registered managers, who provide such important leadership to the whole staff in a care setting.

Social care nursing is a part of nursing that is sometimes overlooked. In the pandemic, I wanted the social care workforce and nurses in social care to have a stronger voice in the system. That is why we created and appointed a chief nurse for adult social care, who has been leading work on supporting the social care nursing workforce and skills in that part of the social care sector.

We also have a chief social worker, and I am working with her on what we can do to boost the social work workforce, which is an important part of our social care system, as well. All those areas of work are ongoing.

Q45 **Dr Johnson:** You hope that will reduce the number of care homes that are not adequate?

Michelle Dyson: May I just add that the role of local authorities here is really important? I have spoken to directors of adult social services. They are really conscious of which of their care homes are in which category. In some cases, they see it as their role to manage out certain care homes. So, that is what they are doing, in a safe way. But we should not forget their role in the hierarchy.

Q46 **Dr Johnson:** What do you mean by "manage out"? We know that for elderly people who are in care, moving institution—moving home—can be quite harmful to their health, particularly for those with dementia and similar conditions. Is it not better to implement changes to improve a home rather than manage it out, particularly if that means that people receive inadequate care for longer—it is always longer than desirable—when it is possible to fix it quicker?

Michelle Dyson: I would defer to the judgment of the director of adult social services in any particular local authority on that. You are right that there is clearly a really difficult balance to be struck, but they make those judgments regularly.

Helen Whately: On the quality side, one thing that has multiple values is that we are moving to digital care records—I have spoken to home care providers and seen this on visits I have done—and one of the values of having a digital care record is that it is a tool. When a care worker visits somebody in the home, they have in front of them a smartphone, tablet or

something like that, with a set of all the things that they need to do and that they record as they do them—for instance, the medications that they make sure somebody takes, and recording how well or happy the individual they are seeing is. That information is then available to, for instance, the team manager and selected family members, with permission, and perhaps handed on to the next care worker who visits that individual. Some of that can also help to improve the quality. Care providers are looking at this data, using AI, to identify when there are certain signs that might mean that somebody's condition is deteriorating and they might need some medical help earlier than they would otherwise get it. It can also reduce some of the mistakes that you will know can happen with medication. That is another thing that is taking place to improve quality.

Q47 **Dr Johnson:** Thank you; that is very helpful. I do not know the answer to this question, but are there any awards for particularly great social care or for innovations in social care? As the Minister responsible, do you deliver any of those?

Helen Whately: Yes, there are awards. Our chief nurse for social care has instigated several awards.

Dr Johnson: Are they quite new?

Helen Whately: Yes. She was appointed during the pandemic, so it is relatively new. I believe very strongly in recognising achievement in social care, not only for individuals but to support innovation. One of the things in our social care reforms is a new innovation and improvement unit within the Department to support the identification of successful innovations in social care and the scaling up of innovation.

Q48 **Dr Johnson:** Thank you. The other question I want to ask is based on what Paulette said about housing, when you talked about trips and falls and suchlike. What work do you do on housing with the local planning authorities or Mr Gove, the Secretary of State? It seems to me that we are increasingly building higher-rise homes—two and three-storey houses—that are more compact in size and footprint. One thing that has been raised with me is that the population as a whole is getting older, and the number of people who may require domiciliary care is rising, and if we are building three-storey houses with upstairs bedrooms and nowhere to sleep downstairs, we are building ourselves into a difficulty. What work are you doing to try to help to ensure that we get the housing stock that we need for our ageing and potentially care-needing population?

Helen Whately: We recognise that growing need given an older population, and what sort of housing stock we will need so that people can live independently for longer—most people want to continue to live in their own home—so we have launched an older people's housing taskforce, jointly with DLUHC, to look into what we need to do to make sure that there will be the supply of the sort of housing that is needed for our future population. It is not an easy thing or a question of the Government

building a lot of new property, or even of local government doing that; for the most part, we need the market to deliver, but there is to some extent a market failure, and I am concerned that the market is not delivering enough of that sort of housing. Our older people's housing taskforce will therefore look at what we need to do, whether it is with planning, with regulation or to enable private investment into the future housing stock that we need for our future population as it ages.

Q49 **Dr Johnson:** Thank you very much—that was a good answer.

My other question is a more general one. Care home costs are very expensive. I know we are going to put a cap on the care cost, but if you are in a care home there is still an accommodation cost, which means it can still be very expensive. Many people save, anticipating that this cost may come upon them in later life. My grandfather used to say to me, "Caroline, there is no point in saving, darling. There is no point in us saving a penny for our care homes, because if we do, we will be paying to sit in the chairs in our care home next to the chap who didn't save, who the Government are paying for." Will my grandad still be right?

Helen Whately: It is about how we fund social care. We talked at the beginning about the charging reforms and, as I see it, the importance of them for addressing the unfairness whereby if you are an unlucky person who needs a lot of care, or a member of your family needs a lot of care, it can end up being a big bill if you are somebody who has assets or savings and are therefore funding your own care.

On your point about the person in the next chair, I think we all agree that we should be funding care for people who cannot afford it—there is no question about that. I want us to introduce the cap that was delayed until October 2025, so that there is a limit on the amount that people pay for their care costs. Yes, you are right to say that there may be an element of what are sometimes described as hotel costs as well, but we want to move to a model that is better and fairer than the one we have, while being as fiscally responsible as we need to be as a Government.

Dr Johnson: Thank you.

Q50 **Chair:** Finally, from Grandad Johnson to a quick-fire question on domiciliary care workers, which we talked about quite a lot with Paul Blomfield. It was said to me the other day that a number of domiciliary care workers are ready to work and able to be employed, except that they cannot pass a driving test because they cannot get one. In Bradford, you currently have a 23-week wait for a driving test. Obviously, being mobile, as Paul was discussing earlier, is a key part of being a domiciliary care worker. Is this an issue that has come across your desk? If not, is it an issue that you would be willing to talk, cross-Government, to your colleagues about?

Helen Whately: I don't think a single person or provider has said to me that difficulty getting people through driving tests is the barrier to employing domiciliary care workers, but I would be very happy to look into

it. If it is causing a material problem, it is something that I would like to look into.

Q51 **Chair:** We all know, as constituency MPs, the casework around people who cannot get driving tests. The prospect and probability that some of them may be domiciliary care workers has to be worth looking at.

Going back to the UEC, we often talk about the tens of thousands of people who are in the acute sector who do not need to be. Getting that patient flow right is key to helping the acute sector. Obviously a proportion of them would go home, you would hope, with the right domiciliary care package, but some of them would not; they would go into the residential care sector. If the hospitals got on top of that issue, and cleared the decks of those who are bed blocking—to use the colloquial expression—could the care system cope?

Helen Whately: Unpicking that, of the between 12,000 and 13,000 people who are medically fit to be discharged but are currently in hospital beds, a proportion are people who are waiting to be discharged home who will not require any social care at all. The wait is to do with tests needing to be done and with getting results, pharmacies and transport—things that are in the domain of hospital processes. There is a proportion of people who are waiting to go home but need domiciliary care, a proportion of people who are waiting to go into some form of residential care, and a proportion of people who are waiting to go into a community healthcare setting. There is that mix.

In most places, out of the people who are waiting for some kind of care, it is either domiciliary care or more complex residential care for people with dementia that I particularly hear about, but sometimes on the community side it is reablement. It is a mixed picture.

We have asked local systems and authorities to forecast the capacity of the social care they need to meet the demand for the coming months and particularly for the winter, and then give us a picture of what they are planning to commission so that we can see if we have enough social care to look after all those people. To me, an ideal to get to is not having someone waiting in a hospital bed for a domiciliary care package to be arranged. Domiciliary care ought to be the bit of the system that you have a strong supply of, because the pressure on limited hospital beds means that they need to be there for people who need to be in hospital. There is a journey to go to get there.

Q52 **Chair:** You have asked that question, which is good to hear, because otherwise Minister Quince's success becomes Minister Whately's problem. It sounds like you are working together.

Helen Whately: We sit next to each other in the Department.

Chair: Is that at the DHSC hot desks, which I hear are very popular over there? Excellent—I will let you get back to your work. Thank you very much, Minister Helen Whately and Michelle Dyson from the Department of Health and Social Care, for this topical session on care.