

Health and Social Care Committee

Oral evidence: Adult Social Care Reform, HC 368

Wednesday 8 January 2025

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Deirdre Costigan; Jen Craft; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Joe Robertson; Gregory Stafford.

Questions 1-48

Witnesses

[I](#): Simon Bottery, Senior Fellow (Social Care), King's Fund, Sir Andrew Dilnot, Chair of Commission on Funding of Care and Support (also known as 'The Dilnot Commission') and Kathryn Smith, Chief Executive, Social Care Institute for Excellence.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]



Examination of witnesses

Witnesses: Simon Bottery, Sir Andrew Dilnot and Kathryn Smith.

Q1 **Chair:** Welcome to the first public evidence session of the Health and Social Care Select Committee's inquiry, "Adult Social Care Reform: The Cost of Inaction". It is a delight to have our witnesses in front of us today. We have Simon Bottery, Sir Andrew Dilnot and Kathryn Smith. Will you introduce yourselves and what you do?

Simon Bottery: I am Simon Bottery, senior fellow in social care at the King's Fund.

Sir Andrew Dilnot: I am Andrew Dilnot. I was the chair of the Commission on Funding of Care and Support in 2010-11.

Kathryn Smith: I am Kathryn Smith, chief executive at SCIE—the Social Care Institute for Excellence.

Q2 **Chair:** Thank you all. Andrew, let's start with you. You will have seen that Louise Casey has been appointed—the Government have commissioned another commission into social care. Could you reflect a little on your experience not just of chairing your commission but of trying to get its proposals implemented over the years? They have been enacted twice in legislation, and were then finally dropped by the Chancellor at the beginning of this Parliament. Might you give us some clues? What went wrong? More importantly, how do we get it right this time? I will start with Andrew and then ask Simon and Kathryn to comment.

Sir Andrew Dilnot: It is great to be here. I am delighted the Committee is covering this question. It is probably a record to have a set of proposals that received Royal Assent twice and still have not happened. That is not a record that anybody would like to have.

Being involved in the commission and in this work has been enormously enjoyable and interesting. This set of questions is incredibly important to how we run ourselves as a society. While it is easy to point the finger just at politicians, I think we all have to accept blame, and that includes me. I failed to articulate in a way that has achieved a strong enough consensus to get action. The population as a whole has not complained enough to their MPs. The media have not written about this enough, and politicians have not, in the end, had the courage to go forward and do something.

One thing that I reflect on is that this is exceptionally important and has extraordinarily significant impacts on the lives of people who need care, their families, the providers of care and our whole society. But, somehow, social care is still pretty invisible. One thing I was delighted about with respect to the new commission is that this is another chance to try to raise this set of issues up the agenda so that we all pay attention to it. That is one critical feature.



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The history of the last 15 years has been a history of ups and downs. There have been ups in the sense that we have repeatedly appeared to have consensus. Immediately after the commission of which I was a part reported, we appeared to have consensus across all three of the main English political parties that something like what we had recommended should be introduced.

Legislation was passed in 2014. It was to be implemented first in 2017, and then in 2016. Then, after the 2015 election, it was postponed. So we had a Conservative and Liberal Democrat coalition recommend its adoption, and then a Conservative Government pulled back from it. Then another Conservative Government recommended it and took it through Parliament—again, not in precisely the way I would have wanted, but they took it through. Then another Conservative Government pulled back from it.

Then, in the recent election campaign, the Labour party, before it was in power, formally, on the record, committed to going ahead with implementation in October 2025, but then abandoned it three or four weeks after the election. We have had every possible constellation of English political party say they are going to do it, and then say they are not going to do it.

Q3 **Chair:** Why?

Sir Andrew Dilnot: I think the reason why is partly to do with what I have already said: the invisibility. Somehow, for reasons I do not quite understand, not enough people make enough noise about it, so it feels like an easy thing to pull back from.

Secondly, there has been a fair degree of consensus about what should be done on the spending side—that we should properly fund the means-tested system. There has been consensus that the minimum requirement for a decent society is that you properly fund the care of those who cannot possibly afford to look after themselves, and that we should move to a social insurance-type system. However, there has not been consensus, or even much discussion, about where the money should come from.

The reason why the last attempt failed was that when it was legislated for, there was to be a health and social care levy, with a small part of the revenue paying for social care reforms. Once that levy was abolished by the Government headed by Liz Truss, that made it easier for the Treasury and Treasury Ministers to say that they do not have the money to do it.

One of the critical tasks facing Baroness Casey and her commission will be to try to get through that nexus. That is always tricky, because Treasury officials and Ministers are always very protective of their rights to talk about where money should come from. But if we are to get this through—whatever “this” is—being open about that will be critical.

Lastly, let me emphasise again that there are two separate but closely related issues here. The first is the funding of the existing means-tested system. We have to do that decently. The challenges facing families and



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local authorities at the moment are simply unacceptable in a society with the levels of income and wealth that we have today. We are just not doing that well. That is the clear, pressing, immediate, urgent task.

Related to that, we have to have a system that works for the population as a whole, and that means reform of funding. Funding is not the only thing that matters, by any means—there is a whole range of things that both Simon and Kathryn are probably much more expert on than I am—but if we do not get funding right, we are not going to get the other things right either.

There are two issues, and I think the short-term imperative of funding the means-tested system often gets in the way of producing a decent system that we can all be proud of.

Q4 Chair: We have not yet seen the terms of reference of the commission, so hopefully there will be an opportunity to feed in. Thank you. Simon and Kathryn, would you like to comment on advice for Louise Casey?

Simon Bottery: The first thing would be about the leadership of the commission itself. If you look back as far as 1999, the Sutherland commission essentially fell apart because even the members themselves could not agree on the basic principles. As Andrew said, the key issue was funding. Some members of that committee wanted to introduce free personal care, but other members felt that that was unaffordable. There was essentially a sort of guerrilla warfare campaign going on between the two sides.

You have to get the membership of the committee and clarity of thought right, but also, as Andrew said, you have to tackle the funding issue head-on. Otherwise, you end up with a perfectly formed system, which most people agree makes sense and would work, but there are simply not the funds in place to make it happen.

Kathryn Smith: For me, the best thing about the announcement about the commission is that it has got people talking about social care. That goes back to one of the points that Andrew made—that people do not talk loudly enough about social care. Throughout our lives, probably one in three people will be in contact with somebody who needs social care, but people do not know about it until they know about it. By the time they know about it, it tends to be too late, and it tends to be too late for people to start lobbying their MPs, because they are knee-deep in trying to care for people with really difficult needs or being cared for themselves.

Getting the conversation on the table is very good but, over the years, the King's Fund has produced analysis of the many Green Papers, White Papers, commissions and everything else we have had. I have worked in social care throughout all those Green Papers and White Papers, and every time one comes out, we think we are going to get somewhere, but to be honest, it is just groundhog day. What difference will this actually make? By the time the recommendations of this commission come out, it will be too late for too many people. While the commission needs to look deeply,



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working with people who draw upon social care, at what the future social care situation could look like and what the reforms could enable, we cannot wait for the end of that. There has to be action and funding now.

In terms of where it comes from, I do not have the answer to that, but I would suggest that when we think about putting extra money into health, we are not really thinking about the fact that we will not resolve the system in the health service if we do not resolve social care, and I am not convinced that health colleagues recognise that either. We should generate the evidence to show that if we could support people to live well in their communities, they would be less reliant on health services and hospitals. We have not got that right for a long time.

Chair: That is exactly, in a way, what we are trying to get to the nub of with this cost of inaction inquiry, because there could well be savings that could be made elsewhere. We are very interested in hearing about that.

Q5 Josh Fenton-Glynn: Thank you all for coming. It is quite a good week for you to be here, given all the other announcements. I re-read Sir Andrew's report earlier this week, and it struck me that, as you say, the thing missing from it is where the funding is coming from. I would be interested if you, Sir Andrew, with your hat on as a former chair of the Institute for Fiscal Studies, could speculate on where that could come from.

On Kathryn's point about people not being aware, one thing that I had forgotten was in the report was the stuff about how useful it would be to advertise throughout life and actually put funding into making people aware that they have social care. As a former social care leader on a council, I know that a lot of people are not aware that they have to pay for their care until they do. We have missed almost 10 years of public education on that. I wonder if you could speak to that and to what we can do to build awareness so that people plan a bit better for their future, rather than assuming that the tab will be picked up. First, Sir Andrew, could you speculate on where the money might come from?

Sir Andrew Dilnot: It is an important question. One thing is to think about the scale. I think the latest OBR public finance database had total Government spending this year at an estimated £1,279 billion. We spend a bit less than £30 billion on adult social care, of which about half goes on elderly social care—so about 1% of public spending goes on elderly social care. The reforms that were going to be implemented in October 2025 would have cost, in the long run, about £5 billion a year. These are tiny amounts of money compared to overall levels of public spending, and very small amounts of money compared to the amounts of money that have recently been added, with enormous support, to the health service budget. So the amounts of money involved are not the kind of amounts of money that, in general, would require an additional special stream of funding.

Q6 Josh Fenton-Glynn: I would gently suggest that, since the policing budget is £8 billion, £5 billion is not an insignificant amount of money.

Sir Andrew Dilnot: It is not insignificant, but it is very small relative to the health budget, and it is small relative to the amount that has just been



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added to the health budget without a special stream of funding. I think it would have been perfectly feasible at a number of occasions in the last 15 years to have gone ahead with this without a specific form of funding.

My view more generally is that the means-tested system should be funded through general taxation, just as we fund the means-tested system for anything else through general taxation. I think there is an argument that if the Government—if the country—agrees that it is going to add to people's entitlements, creating a new entitlement to social care support, then it is not unreasonable to expect people to pay for that. That is if the Government is doing it because the market fails and cannot do it; if the private sector were doing it, we would pay for it. That is not unreasonable.

The health and social care levy, while not perfect in every way, was quite an interesting idea. One of the things that Baroness Casey will undoubtedly want to look at and think about is whether there is an argument for something like that. It is important to remember that most of the money from the health and social care levy was not to go to social care; it was to go to health. I do think there is an interesting set of arguments about whether, if as a nation we decided to extend entitlements to social care to move to something like social insurance for social care, there should be a revenue line with social care's name in it.

Chair: A hypothecated tax.

Sir Andrew Dilnot: Or something a bit like a hypothecated tax. As Josh says, I was for many years at the IFS, and hypothecation makes tax economists feel a bit twitchy, but there is something about having the name of a function on a revenue stream that protects it and makes it easier to introduce. We need to look at that set of arguments in both a principled and a pragmatic way.

The point I am making, though, if we go to Mr Fenton-Glynn's point about police, is that these amounts of money are not large relative to the overall Government Budget, so it should be feasible, if we can get enough political consensus, to get something done without causing a large perturbation to the overall public finances.

Q7 **Chair:** Simon, has the King's Fund done any work on where this money might come from?

Simon Bottery: Yes. We have also spoken to the public and looked at what the research evidence tells us about public opinion. When you look at the evidence, there is a remarkable consistency in what the public expects. The public expects that there should be a partnership between the individual and the state, with the individual, where they are able to, taking some responsibility for their costs, particularly in old age. It is a different situation entirely for working-age adults, but people accept that, for old age, where people have the capacity to, they should be responsible for thinking about some of the costs—but they think that the majority of the costs should be pooled and should be borne by the state. That comes across really consistently in all the evidence I have ever seen. I have



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spent days sitting with members of the public in deliberative events talking about this, and it comes across very clearly.

In terms of where the money should come from, look at the successful systems around the world. There are really only two models that people use: in Scandinavian countries, they typically use a general taxation model; and in other parts of western Europe and other parts of the world, they use a formal social insurance model, where a chunk of money comes out of people's salary every month and goes into a pot to contribute towards the social care needs of people at that time.

The one area that we found extremely contentious when we talked about it in funding terms was people's houses. When you talk about that, there is a very strong sense that houses should not be touched. What I think the commission could and should look at is whether it is simply about saying that housing wealth cannot be touched under any circumstances or whether people would consider some percentage of housing wealth being touched. I think that would be a valid area for it to look at, but it is a deeply controversial issue.

Chair: That is very helpful, thank you. I have a few quickfire questions from the Committee. I will get round as many as possible in the next 10 minutes.

Q8 **Andrew George:** I just want to work out, Andrew, whether you feel optimistic for Baroness Casey. From what you are saying, in the last decade or so, things have kind of muddled along. I am trying to interpret your language and your body language with regard to how confident you feel. Do you think it would take the media to slavishly regurgitate the ill-informed words of an American billionaire to get the debate moving? What is needed in order to give you confidence? I do not think you are confident, and you do not exude confidence in Baroness Casey.

Sir Andrew Dilnot: I am never confident in the short term, but I am terribly confident in the medium and long term. I think it is so blindingly, bleeding obvious—excuse my language—that something should be done here that, in the end, in an intelligent and affluent civilised society, we will get this done.

To be absolutely blunt, I think the critical thing here will be the Prime Minister. One of the things that makes me feel most optimistic is that my understanding—although, as the Chair says, we only have the terms of reference—is that Baroness Casey has said that she needs to report directly to the Prime Minister and that will be what goes on. My experience and my hypothesis is that, to get something like this done, a Prime Minister has to be committed to it. On the two occasions when we have had legislation in the last 15 years, that is where we got to. Lord Cameron became committed to this, and that is how we got the legislation in 2014. Boris Johnson is criticised for many things but in this area he really did care about doing something about social care and because of that, in the teeth of considerable opposition within his own party, something



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happened. I think Sir Keir's views will be critical in this. If the Prime Minister gets behind this, I think something will happen.

I am optimistic. I am always vague about timescales, but we will get this done and we must, because how can we look ourselves in the mirror and not deal with this? I was struck by something that the current Secretary of State said in the House a couple of days ago. Talking about the NHS and stories we see about social care, he said, "Those stories belong in pre-war Britain," and carried on, "They should shame the Conservative party." I think they should shame all of us. He then said, "I am determined to end two-tier healthcare in this country, so that whether you are the richest or poorest person in Britain, you get timely, quality treatment, free at the point of use." I cannot think of any reason why that statement should apply to somebody who has pancreatic cancer but not somebody who has dementia or severe arthritis. I think we will get this done because it is so obvious that we should, but on the precise timing, who knows?

Q9 Gregory Stafford: I want to quickly ask about the timings. You talked about an urgent need in the short term and, Kathryn, you said that this commission will be too late for too many people. What is your feeling on the timescales? What is actually going to happen over the next three years that will be different from what you did and will make the difference? Would you have liked to see this commission report earlier?

Sir Andrew Dilnot: I would certainly like to see it report earlier and I very much hope that it will. I do not get the impression that Louise Casey is somebody who likes to hang about. I cannot think of any reason why it should take three years—I simply cannot. The commission that I was part of took a year from being commissioned to final reporting. It is vital to try to bring people along—it will be very important for Louise Casey to be able to talk to people as she is going along, and it will be very important for her to take evidence from as wide a group of people as possible—but three years seems to me an inappropriate length of time. In particular, it gets us too close to the next election.

Something else that I have definitely learned is that, to make a decision on this, that decision is ideally made in the first half of a Parliament, otherwise events get in the way. One of the things I really hope is that, once Louise Casey starts on this, she will think, "Okay, let's get going." Producing a report potentially a year or six months before the next election just does not seem like the right timing.

Q10 Ben Coleman: Kathryn, you suggested that you have some concerns about how well the NHS gets it, and that it needs to sort out social care in order to achieve its own ambitions. As a former cabinet member for adult social care and health, I share those concerns. Would you like to say a bit more about that?

Kathryn Smith: Anecdotally, I have felt it over a long period of time with lots of different issues. For example, trying to get joint health and social care records and trying to get the health service on board with that is not easy, especially with GPs. Recently, I sat on a roundtable that was



predominantly health consultants and others; it was just me and one other social care person. They were genuinely fascinated, because they were hearing things that they did not know. Why would an orthopaedic consultant know about how social care could make a difference, and could help to prevent falls, help somebody to eat well and be cared for well, and help to manage people's continence needs, so that they are not running to the toilet and falling over? How would they know that?

One of the questions asked previously—I think it might have been Josh—was about how we get this out there. The biggest problem here is that people do not understand what social care can do. It is not about care homes, and it is not just about older people. It is about all working-age adults, as well as older people. It is about supporting people to live well in the community and manage their conditions well. I was going to make that same point: why on earth does somebody with pancreatic cancer have everything paid for by the NHS, free at the point of delivery, but somebody with dementia, which is also a terminal medical condition, does not? Why would the public know that? It does not make sense.

- Q11 Jen Craft:** I want to quickly touch on the issue of funding. Simon, you mentioned that you have done work with the public to test where they think the money to pay for this should come from, and that the individual should pay some costs but the state should bear the majority. Do you have a feeling for the general appetite, whether in the media, among the public or more widely, for a levy, an increase in tax or an increase in a particular type of national insurance? Would people be willing to do that, or is that the huge sticking point in selling this—that it will essentially have to be paid for by individuals at some point?

Simon Bottery: When you look at the evidence, the levy that Boris Johnson was due to bring in was a popular policy when it was announced. It had quite wide public support. When you ask people, they say, "Yes, we are willing to pay in order to see a better social care system." They get it. When you specifically ask people about where social care is in their list of priorities for things that they want sorted, they will put it quite high. They will say, "Yes, it is high up our agenda."

However, when you ask people, unprompted, about what things they most want sorted out, social care typically does not come anywhere. They will talk about immigration, police and the economy, but social care will come in quite low down. So there is a bit of work, to put it mildly, that needs to be done to go from social care being a thing that matters to you when you are thinking about it, when you have an urgent need for it, or when your mum, dad or sister has an urgent need for it, to its being a thing that you recognise is a fundamental part of the country's health and care landscape.

- Q12 Dr Cooper:** Sir Andrew, if you, and not Baroness Casey, had been asked to do the review, do you anticipate that you would find anything that you did not find previously, or do you think the landscape is largely unchanged?



Sir Andrew Dilnot: At a structural level, it is largely unchanged, but it is worse. Over the last 15 years, the number of people in the age group of which I am now nearly a part has increased much more rapidly than the funding, so we have seen a reduction in the number of people who are receiving state-funded support and care, despite the fact that the number needing it has grown. So the urgency has increased. I am sure that we will come on to all the problems that we see: staff under unbelievable pressure, inadequate numbers of staff, decisions that none of us would like to make being asked of local authority employees, care not being provided to people who need it, and an NHS with many more people in hospitals than should be there. It has become more urgent.

In our review, we essentially said two things. The first was that you have to fund the means-tested system properly. I think that that is even more urgent now than it was then, and the gap between what is being provided and what is needed is bigger. The second was that—going back to Simon’s point—we have to find a way of pooling risk for the population as a whole, so that people are actually able to plan. That is fundamentally there.

The issue that we were explicitly not asked to look at—where the money should come from—is essential. Although we do not yet have the terms of reference, I think that is something that Baroness Casey’s review will have in scope. That really requires some work. I think the fundamental position is structurally the same, but actually worse than it was then.

Q13 Deirdre Costigan: Thank you for coming to speak to us today. Sir Andrew, we have been talking about the Casey commission, but of course the Government have already set out some steps to transform adult social care. One in particular is bringing in a national agreement around fair and consistent pay for social care workers throughout the country, along with a career progression system, that will hopefully make those workers feel valued and lead to better quality social care. Do you think that is a good first step by the Government and the Department, and does it give you reasons to feel positive about the Department’s commitment to taking the next steps that will be required to fully transform social care?

Sir Andrew Dilnot: I think it is a good step rather than a bad step, but I think it is inadequate in scale and vision. We have to recognise that at the moment, social care is a private market. It is delivered by the private sector. There are 1.5 million people—wonderful people, almost without exception—working, providing care in exceptionally difficult circumstances, under enormous strain, but doing it in ways that preserve the dignity of those that they are looking after, but they are not paid enough. And because there are 1.5 million of them, to have them paid appropriately costs a very large amount of money—the amounts of money that have been indicated are simply nothing like what could make a big enough difference there. So I think it is good in the sense that it demonstrates that there is an awareness that this is a challenge, but it is nothing like equal to the scale of the challenge.

There are two big options here. We could nationalise the whole thing: we could move it to something like the NHS. I do not think that is politically



on the cards. If we do not nationalise it, then we have to make the market that is there work, and we have not done anything yet that will really make that work. These are good steps and they indicate a desire to do something that will make a difference, and they will make a difference, but they will not make anything like enough difference to give those wonderful people working in this sector a proper career structure, the hope of decent career progression or the hope of adequate pay. We have to do something much more for them, and on a much greater scale than what has been done so far.

- Q14 **Joe Robertson:** Coming back to the idea that perhaps the public do not rank social care as being as important as other issues, might the problem be that they do not necessarily characterise their concerns as relating to social care? It is a label problem. They are worried about whether they will be able to pass on money to their children or keep their house, or long-term frailty in older age, or indeed concern for their own parent, but they will not respond that that is a social care problem, and we accidentally put it into another category like health or taxation, when actually a concern for the social care issues is actually much higher in people's priorities; it is just that we mislabel it or we think that people understand social care in the same way as decision makers do.

Simon Bottery: I think that is very fair. If you characterise it as "care of the elderly", for example, those issues will be relatively high up. There is a question about the specific language. When the work was being done about implementing Andrew's reforms, the DHSC looked at using the term "care and support". They found that the public understood that, and they understood that there was a grade—that care was more intense than support—so they started to use the term "care and support". Having said that, and having spent the last 10 years trying to get attention to social care and feeling that we have probably had some success in that, I am not sure that we should be looking at another term. The basic principle of "Let's turn this into an issue which is about care of your brother and sister with a disability or your elderly parent"—I think that is a more effective way of communicating these issues, certainly.

- Q15 **Paulette Hamilton:** I have a really quick question about Baroness Casey and the review. You have made some really powerful points, but the point I want to make is this. All right, the review will take three years maximum. All right, Baroness Casey I think will speed that along a lot more quickly. I also think it is really good that Sir Keir is there and she is going to feed back to him quite quickly. The three parties are involved and the review is going ahead. If it identifies two or three glaringly obvious points on which we need change now, will we be waiting for the three years, or will people like the King's Fund, yourselves or SCIE be lobbying Government to implement that change earlier, even though the review is still going on?

Sir Andrew Dilnot: That goes straight to it. I think that Louise Casey will work out very quickly what needs to be done, and she should say what needs to be done quickly. I think she will find that the whole sector and



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everyone who is interested will be vigorously supportive of getting something done. In the end, it will turn on the Prime Minister.

Q16 Paulette Hamilton: So you do think it can be done a lot quicker, with that pressure.

Sir Andrew Dilnot: It would be perfectly feasible to expect the Government by the end of this calendar year—by the end of 2025—to say, “We know what needs to be done. This is what we are going to do.” That is perfectly feasible. We understand the challenges and the options; it is really a matter of political courage and decision making. We all know that things can be done very quickly. Once a Government or a House of Commons decides it wants to get something done, it is possible to get something done very rapidly. One of the many lessons we learned during covid was that, actually, we can respond very quickly. This is a chronic rather than an acute problem, but it can be addressed very fast.

Paulette Hamilton: Unfortunately the last Government did not do that. They were very supportive, yes, but it did not get done. That is the slight difference we have now, with the review that is coming, if the sector absolutely gets behind Baroness Casey and says, “We need to see immediate action”—in my humble opinion.

Q17 Danny Beales: I have one follow-up question about what has been discussed so far, and then I will get to my substantive question. It seems from our discussion today that, after 25 years of discussion about reform—you talked about the Sutherland review of 1999—there still is not consensus on the core question of how to fund the changes we need. As you say, we all have a sense of broadly where we should get to, but after 25 years of commissions, investigations and inquiries, and really good work, including by yourself, I have not heard a consensus on a funding model from all three of you. At this point, if we went around this table, I am sure there would not be consensus, within or across the political divides. Is three years an unreasonable timescale to try to reach that consensus, bearing in mind that it has not been reached in 25 years of reforms and investigations?

Sir Andrew Dilnot: I am not sure that it has not been reached. It has been reached, actually. It has been passed through Parliament, twice. In the run-up to this election, the party that is now in government, and the person who is now Secretary of State for Health and Social Care, said that they were going to do it. There has been repeated consensus and repeated promises to deliver, but just not actual delivery.

My own view is that this is now a matter of political courage and decision making. I do not think we need a very long time to work it out; we just need someone to decide what they are going to do. My own view is that three years is a completely unnecessary period. If we could simply focus on this, we could get it decided very quickly. I am sure Louise Casey needs some months, not least to talk to people, but after a few months Louise Casey sitting down with Keir Starmer should be enough, instead of waiting three years and getting the Prime Minister to concentrate on it



three years from now. I do not think we need to wait three years. I think a period during which Louise Casey is able to acquaint herself with what is going on—

- Q18 **Danny Beales:** May I challenge that? In what I have heard from all three of you so far, I have not heard a consensus on how a national care service should be funded. I have heard a number of options. You have presented challenges in terms of media and public opinion, as well as the political division that has arisen, so there does not seem to have been sustained consensus, based on the changing political decision-making landscape. I might be wrong, but from what Simon has said, there seem to be quite deep conflicts in public understanding about intergenerational fairness and fairness in the use of assets, which directly conflict with the principles of means-testing. Do you feel there is a consensus, publicly and politically, that is easily come to—I am keen to be challenged if this is the case—about how we should fund a significant investment in social care?

Sir Andrew Dilnot: I will turn to Simon, but my view is that this is a case where we need some political leadership. It comes down to that and not hiding behind waiting until everybody has agreed. In the end, getting political agreement as to where the money comes from may turn out to be very tricky. It is very hard to see what the upside is for an opposition party to say yes. I think it is a question of political leadership. I am an economist, not a political scientist, but at the moment we have a Government with a very large majority, and if they have the courage to say they should do something and it is a sensible thing to do, I think they should get on with it.

- Q19 **Danny Beales:** I hear that as there not being a consensus, but you are looking for decision making. I respect that. My reading of the situation is that there has been a request for Louise Casey to come up with the groundwork to take those decisions. One of the things that struck me early in your presentation was that you talked about significant costs in the system, and how they are fundamentally invisible. I think that comes to the core of what the inquiry is looking at: the cost of inaction—the invisible costs that are in the system of having not acted for 25-plus years. I would welcome the thoughts of all three of you on what you feel the costs are of inaction on social care, be that individually, for society, for the economy or for the NHS.

Sir Andrew Dilnot: On the train on the way in, I wrote a list. One of the important things to realise is that there are costs that accrue to a wide range of different people. There are costs that accrue to individuals, families, the health service, providers, staff and local authorities. We can run through them very quickly. To individuals the cost of inaction starts with the actual financial costs that people face, which can be large and unknowable. I have often likened needing social care to being in a shop with no prices. You know how much it will cost each week or month for your partner, mum or grandma to be looked after, but you have no idea how many weeks or months it will go on for, so you do not know what the cost will be. There is a direct financial cost.



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There are cross-subsidies; people who are paying it themselves are actually cross-subsidising local authorities because they are paying a higher rate, in particular for residential care, than local authorities. There are the savings that people build up, particularly those who are not especially wealthy, just in case they need a large amount of social care. Now, 80% of 65-year-olds will need social care before they die, but the amount that each of them will need is unknowable. Most of them will not actually need very much, but a small number will need an awful lot. In the current system, all of them are faced by needing to set aside enough money just in case they are one of the unlucky ones. A significant cost of inaction is that many people, not with especially large amounts of income and wealth, are setting aside money that they will not actually need because there is no pooling of the risk.

Then there is the enormous fear, anxiety and distress caused by the current system, which is a huge cost to individuals, as is the lack of care—care that should be delivered but cannot be because we are not funding the system properly. Because of that we are getting premature loss of function and of life. Individuals are losing the ability to achieve activities of daily living, and losing their lives prematurely, because of care that is not there that should be, and we have people wishing that they were not there because they feel they are a burden. Added to that, we have the misery of people who do not need to be in hospital but are. Those are the costs to individuals.

The costs to families and friends are all of the above, and being faced by horrible decisions about whether now is the time to spend money putting in a stairlift or a downstairs loo, or whether they should keep that money in case grandma needs more care later on. There is an impact of informal care on people's ability to work and function.

On the health service—and I suspect this will be high up your list—there are the direct effects of ill health and harm caused by poor care. I am very keen for us to talk about incontinence. We are rather British, so we tend not to talk about incontinence. Kathryn, to her great credit, talked about incontinence, and I talk about incontinence a lot. If you are an elderly person with significant social care needs, you are very likely to have some continence challenges. That is quite likely to lead, if you have not got a downstairs loo and you have to get upstairs to get to the bathroom, to your falling down the stairs and ending up in hospital with a broken hip or a broken leg, unnecessarily, and the direct burden of that on the NHS.

Then, of course, there is the indirect effect on the NHS, because there is not good social care that we can get people into when they need to leave the NHS. We have NHS hospitals with many people in them who should not be there, who do not need to be there. It is more expensive for them to be there and it is much less good for them. The frustration that causes to clinicians is extraordinary.

Then we need to think about providers. The lack of a functioning market means that there are very low returns to innovation and investment, so there is not much innovation and investment going on. They are squeezed.



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We have endless stories of providers handing their contracts back to the local authorities because they simply cannot make things work.

This large sector could be a source of growth. The Government is committed to growth. This could be an area where we would see economic growth if we had a sensible model. We don't and so we can't.

Staff are under really intense pressure, are not paid enough and have very few opportunities for career progression. All of that is a function of the structure that we have.

Local authorities are the final group I want to talk about. The inadequate funding of social care means that all other services that local authorities provide are being squeezed and the decisions that local authority staff are asked to make would try the wisdom of Solomon. If any of you want to experience a really stressful period, go and sit alongside somebody who is making decisions in a local authority about how to allocate the inadequate resources to people who desperately need care.

All the things in that long litany—I am sure there are many others that Simon and Kathryn could add—are either direct or indirect costs of inaction. While fundamentally I believe that we should act in this space because it is wrong not to, it is now the case even more than it was 15 years ago that not doing so is placing massive instrumental costs on both individuals and the NHS. That is another really powerful set of arguments for action. Sorry to go on at such length.

Danny Beales: I do not know whether Simon or Kathryn would like to add anything.

Kathryn Smith: Andrew has covered a lot of the points that I was going to make, but I would just like to embellish some of them a little bit and also talk about some of the different options that I have seen. I want to go back to the impact on the NHS and I will pick on incontinence; as we do not talk about it enough, I will talk about it some more. I want to talk about the risk from somebody needing more support. For example, you have somebody who is incontinent and at the moment social care is not supporting them properly. Quite often, she—I am going to say "she"—might be forced to stay in bed with incontinence pads that might get changed four times a day, if she is one of the really lucky ones who get home care four times a day, and she will be left to sleep in her own pee or whatever else overnight. That leaves that person, first, at risk of pressure sores and other things, which can be really serious and lead to them going into hospital. It also risks their mental health and wellbeing, depression—that can cause other issues. We have already talked about the risk of them trying to manage themselves, getting out of bed, falling over or whatever and trying to get to the hospital. There are so many other issues that we could give examples of where the impact is to the health service.

I am going to give you what is a real-life example, but this real-life example could be multiplied a million times. It involves somebody I have worked with recently, whose mother has quite advanced dementia. Son is



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disabled and not able to get care and support. I think they have probably been waiting for an assessment for more than a year now. The person has had to give up work to look after both of them. She is now looking at what benefits she might be able to claim. She is extremely lonely and fed-up. She is dealing with quite a difficult life, and that is making her more and more susceptible to depression and to other things that will impact on her own health, which means she will draw on the care service. In the meantime, her disabled son has not been able to get to work because of other parts of the system not working together.

I am bringing this example in to try to highlight that, while reforming social care and reforming social care well might not be explicitly one of the Government's missions at the moment, it would support some of the other missions, like the economy, the workforce, getting people into housing and so on. This young man cannot get to work because the other parts of the system are not working well to support him, so he is having to work from home. He is getting isolated and lonely and is likely to end up with mental health issues and other social care issues. In the meantime, mum is falling, and daughter is struggling to look after her. Mum fell just two nights ago, cracked her head and ended up in hospital. Nobody is sleeping. This situation is happening a million times over across the country. It is a really, really difficult situation.

Over the last year or so at SCIE, we have been focusing on innovation and good-quality care. That really needs to be considered, and you can see the difference it can make to people's lives, but unfortunately, it is not paid for. Even when people do find some money to pay for innovation, they cannot keep it up.

Q20 Deirdre Costigan: To follow on from that point, over the last 20 years we have had the Treasury come back on every iteration of your report, Sir Andrew, and other options put forward with the answer that it costs too much. Do you think the Treasury fully understands the overall cost of not taking action, in terms of the issues that Kathryn has outlined? For example, people are sat in expensive hospital beds because there is not a social care system that will allow them to go home and live independently; people are getting sicker at home as they wait to get into those beds, or they are falling down the stairs, as you said, Sir Andrew, because they have no downstairs bathroom; people are having to give up jobs to look after elderly parents, or they are becoming mentally ill because of the pressures of doing that, as you have outlined, Kathryn. From the discussions you have had with Government and with Treasury in particular, do you have any reflections on how well or not the overall cost of doing nothing is assessed by Treasury?

Sir Andrew Dilnot: I do not wish to appear to be unduly critical. The people working in the Treasury are doing a very difficult job, and they are people of extremely high ability and commitment to public service. I do think there can be a tendency to think about things in a rather static way, looking at the costs of reform and of funding the means-tested system properly without thinking about the benefits that flow to individuals' wellbeing and possibly also the wider economy and the cost of things like



the NHS. There can be a tendency to have too static a view and too accounting a view of it, simply working out what the costs of action will be and not thinking about attempting an assessment of the benefits of that action.

On the whole, I think that we should be doing this because of the benefits in terms of human flourishing—that is really why we should do it; that is why we founded the welfare state after the Beveridge review in the 1940s. That is really why Government should act. None the less, I think it is now the case that the instrumental costs of inaction have reached a point where they quite possibly dwarf the costs of doing it properly.

Q21 **Chair:** Do you think the money could be recouped?

Sir Andrew Dilnot: My instinct is that in the short run, there can be significant benefits, in particular to the NHS. I do not think that means NHS spending would fall, because I think it would mean that, rather than the NHS spending money, for example, on having people in hospital beds who should not be there, it would spend the money on having people in hospital beds who need elective care. I also think honestly that in the long run, it is likely that if we did social care better, the costs of social care and of the NHS would rise. That is because if we did social care better, people would live longer. The sense is that the longer people live, the more likely it is that they will have a period of high dependency at the very end of their lives.

In the end, we have to face up to the fact that the reason we should do social care well is the same reason we should do the NHS well. We do not have an NHS to make the economy run well; we have an NHS so that people can lead flourishing lives. That is why we should do social care well. However, the lack of doing social care well in the last 15 years means that we are creating enormous pressures on the NHS, and I think that in the short to medium run, if we did social care better, we would release funds within the NHS to do what we want the NHS to do much more effectively. I do not think that we will reduce costs, certainly in the long run, by doing social care well, but that is not really why we should do social care. I do think that, in the short-to-medium term, we are doing it so badly that it is causing massive knock-on costs to the NHS, and to the wider economy.

I think that the thing to think most optimistically about, regarding the possible recouping, is that, actually, if we did social care well—the example that Kathryn has just given is an example of this—more people could work and the supply of labour could be a bit higher. If we did social care better, and had a proper market, then we would see much more innovation and investment in the sector itself. We could create a dynamic sector. We could become world leaders in social care.

Therefore, I think there are potential benefits, and any benefit here will look pretty large relative to the costs of reform. The national economy will be between £2.5 trillion and £3 trillion soon, and making social care—which involves a very large number of people—work better could be a dynamic feature in the economy.



Q22 Deirdre Costigan: How do you think we can make that argument with the Treasury? How do we bring the Treasury to a position where they understand that—that the wider cost of doing nothing includes, for example, the amount of money that we pay out in welfare benefits?

Sir Andrew Dilnot: I think that the King's Fund, for example, may be planning to do some work on this, and I know that the Health Foundation is also thinking of doing so. I think that looking at what the costs are that are now being imposed on the NHS is a really interesting thing to do. As I say, I do not think that, if we reduced those costs, we would reduce NHS spending, but we would increase NHS output significantly, so I think that that would be a powerful thing.

Something that has not been much done with the Treasury is talking much more about the impact of the failure of the market, as it stands, on the economy as a whole. That is a discussion that I have begun to have with the Treasury. I think that talking about that some more is really valuable.

To go back to the point I made earlier, this state of the world, where needing social care is like being in a shop with no prices, means that, unless you are unbelievably wealthy, you are going to be very unwilling to spend money that you do not need to spend immediately, because you are so worried about what the long run could be. If we want to have risk pooling, then we have a chance of releasing the expenditure of a much larger group of the population in social care, and that has a chance of creating a labour market where people can be better paid and where there is a market for innovation and investment, and of turning the social care sector into an engine of growth.

We already see, for a small number of really very affluent people, some quite exciting innovations in social care, such as in the Richard Osman novels, which many of you will have come across. So, if you are wealthy enough, you are able to take those opportunities, but that is a tiny proportion of society. If we can create a system in which a much larger group in society can take control of their own care and take their own decisions, then we have a chance of creating something dynamic and exciting.

Q23 Deirdre Costigan: Okay, although I think that a disproportionate number of murders happen at the home in the Richard Osman novels!

Just to continue in that vein—it would be useful to hear from Kathryn, who kind of opened the discussion on this, but this also may be a question for Simon as well—the Treasury currently uses the Green Book approach for assessing change and new policies, and I think it is quite focused on the immediate costs and the immediate benefits of changes. How can we actually change the Treasury's approach to that, so that it accounts better for long-term impacts? There may be ways to monetise that; how can we put a figure—put a number—on it? Is there a way that we can push the dial with the Treasury on that?

Simon Bottery: I think there is an opportunity emerging from the development of what is called client-level data. That is about being able to



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track individuals through the social care system and then into the healthcare system. Once that is fully up and running, it provides the opportunity to see what actually happens to people who are receiving care services—what use do they make of their GP services, or their A&E services? You can then start to see, potentially, how social care impacts the NHS, and you can potentially monetise that if you choose to.

At the moment, there is limited data on it. There is some data that shows that where you cut spending on social care, there is an increase in A&E usage. There is evidence that can show a direct correlation between a reduction in social care and extra use of the NHS, but it is limited.

I have to say that, like Andrew, my suspicion is that there is not a single smoking gun—a piece of evidence or research that enables us to say, “Aha! This shows that by spending £1 on social care, you are saving £2 or £3 in the NHS.” My suspicion is that you are not going to see that. What you are going to see is the accumulation of lots of effects across lots of other public services. That will be in the NHS, but it will also be in housing, the police service and the benefits system. There are a wide range of benefits from social care spending, but there will not be one single bit of evidence that proves value.

To go back to the point that Andrew and Kathryn made, although we need to understand what the impact is and what the value of social care is in a monetary sense, ultimately it is a moral question. The most vulnerable people—I know people don’t like the term “vulnerable”, but I will use it here—and those who need the most support should be entitled to a decent level of support that allows them to live their lives in the way they choose, with a degree of dignity. I would not want us to get away from that moral dimension, because if you look purely for the economic cost, you are always going to struggle.

Chair: I am going to move on to Greg Stafford, and then there are important questions for Kathryn that I want to get to.

Q24 **Gregory Stafford:** I am going to carry on from that discussion. I accept that there is no single piece of evidence that is going to change the way the Treasury or anyone else sees this, but obviously we do need that evidence base and that data. How robust is the data that is out there? Where are the significant gaps that could be investigated, either by the Casey commission or independent groups like you, to start to plug those gaps and move the argument forward, if not to change minds in a wholesale way?

Simon Bottery: You almost need to start from the second part of that question, which is, “Where are the gaps?” rather than, “Where is the evidence?” At a very simple level, we have very little evidence about the outcomes of adult social care and the impact it has on individuals in a usable way. We have a lot of anecdotal evidence. We can come up with lots of stories and anecdotes about the huge difference that a particular bit of social care or support will make to someone’s life, but when you look at

the outcome, in terms of the effect on their employment and their health, we really lack that basic data.

Local authorities at one time tried to move towards what is called outcomes-based commissioning: the idea that you commission your service on the basis of what it achieves for an individual, rather than a chunk of service, like an amount of time spent. Largely, they failed to do that, because they found it extremely difficult to measure those outcomes. At a really basic level, you need to start there, in terms of building up that evidence base about what difference that social care makes to that individual's life across a whole range of areas.

Then there are very large swathes of social care about which we have very little evidence. I have given a couple of examples of where there is evidence of an impact on the NHS, but it is reasonable to ask questions where people aren't getting it. When you think about it, if someone is not getting the support they need, and is not entitled to it from the state, there are really only three things that they can do. They can either pay for it themselves, and then you can see the sorts of things that people end up spending money on. In some cases, they spend hundreds of thousands of pounds on their care. They can rely on their family and friends. Some of the most humbling stories I hear are from people who provide huge amounts of care, often to their life partner.

If you speak to someone who is looking after their wife who has dementia and is providing 60, 70, 80 hours of care a week, they will be looking after them during the day but also quite often during the night. That has a massive impact on that person's life. If they are not getting the support they need, that is exactly what they are doing. There is good evidence about the impact of large amounts of caring on people's mental and physical health, but again, that could be better.

If they are not paying for themselves or relying on their family and friends, they are going without. Then what happens? There is a huge impact on their individual wellbeing, but there is also a knock-on effect across the rest of the system with the use they make of the NHS and the benefits system. Really, you need to start by asking what we need to know and fill in the gaps. There are an awful lot of gaps to be filled in, realistically.

Q25 Gregory Stafford: I accept what you are saying; it is interesting to hear. I will come to Sir Andrew and Kathryn to add to that point. How robust is some of the data that we are already measuring—things like waiting times or demand for services—either through the NHS or through social care?

Sir Andrew Dilnot: I agree with Simon. The data in social care is weak. It is striking how weak it is compared with the NHS, but that is for a structural reason: most social care is provided by one of tens of thousands of private sector providers, so we just do not have a nationalised, centralised way of collecting the data.



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In this space, there is some data that we can probably rely on most strongly. For example, we don't call them delayed transfers of care any more, but the NHS has reasonable records of the number of people who are in hospital beds who ideally would not be. In terms of a hierarchy of the kind of data that the Committee could put together and use in discussions with Government, that is relatively easy to get hold of and relatively robust, and there is now a large amount.

What is harder to get to, but also important, is how many people are coming into the NHS to be cared for because they have had inadequate social care— how many of the hip fractures or pelvis fractures, often among elderly women, are simply unnecessary? Looking at the aggregate data and making some rules of thumb could help us.

It is very hard to get hold of data about who is not getting care who should be; they are not even getting into the system because the waits for assessments are so long. But by looking at the average waits for assessment and the stock of people waiting for assessments, which will be an underestimate of the number who really are waiting because many are discouraged from even getting into the system, there is a hierarchy of data that we could build up.

It is not as good as it should be. Particularly, we do not have the best data among users of social care, and we really don't have good data for people who are not using social care because it is not accessible to them, and that is probably the most important bit. There are ways of getting estimates—the King's Fund, the Health Foundation, SCIE. They will be estimates with uncertainty, but they will give us some sense of the scale.

Q26 Ben Coleman: I want to throw something in. We are talking a lot about evidence and the cost of care. Andrew, your report talks about the problems of having different funding streams for health, which is free, and social care, which is not. Simon, you have said that there isn't the money to make it free, and Kathryn, you have said that we need to look at the savings to the NHS, among other things. I am paraphrasing all that.

I thought it would be worth getting your views on one thing. In my constituency of Chelsea and Fulham, Hammersmith and Fulham council, of which I was the deputy leader until the election, offers care at home for free. It is for everyone, irrespective of their income or assets, just as healthcare is free for everybody. It does that because it thinks that charging for care is a tax on disability as much as on old age.

There is not a means test or restrictive eligibility criteria assessment. The residents there get the care that they need—you talked about people not getting care and having falls and so on—not just what they can afford. The council's experience is that that keeps people living independently at home for longer. As a result, I am told, the number of people entering local care homes has fallen significantly. The council also believes that it saves the NHS money in admissions and readmissions, but we would need academic work done on that.

To come to the issue of evidence, we have this one example. It is the only



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place in England where care is free to everybody at home. Are you aware of any evidence that reducing care costs to individuals reduces demand and costs elsewhere in the system?

Kathryn Smith: I do not know if I am aware of statistically significant evidence, but anecdotally I think that is absolutely right from the things we have seen. By the time people have to pay for their own care, they are not rich. You do not need to have much in savings to have to pay for your own care. People are frightened of doing that because they do not know how long they are going to be paying and where it is going to go.

I have seen examples where people have not sought the care they needed for their mother because they would have to pay for it and could not afford it, so they managed without. The mother then ends up worse in hospital, and so on. I think I have spoken to you about that example before; I would love to go out and see her. That is a really good example of a preventative measure to keep people living better at home for longer.

Having worked in a local authority in a previous life, looking at the means tests, I can say that when we have an appeal and a room full of probably eight senior council workers considering whether somebody is spending too much on doughnuts or cigarettes to be allowed to have that for free—I am telling you that that costs more than just giving that person the extra bit of money in the first place. There is evidence that if we funded the preventative measures better, we would reduce the impact on the more expensive things.

Going back to Greg's question about the evidence, if I was going to fund a commission, this is what I would be funding. We need to find this evidence. I have seen it. The problem is that I have seen this evidence from providers that have done their own research into how their innovative services save money. But it is the providers' own evidence. People will say, "That's biased." Some independent evidence needs to be developed.

The evidence we have from social care is things such as the Association of Directors of Adult Social Services survey, which told us that, as of March, there were over 418,000 people waiting for an assessment of care or for the direct payments to start. We have evidence from organisations such as Skills for Care that tell us that the vacancy rates are 8.3% higher than in the general economy because of the funding, and so on. But we do not have an overall independent evidence set that shows us the true cost of inaction on social care and the potential savings if we manage that differently.

I agree with what both Simon and Andrew have said. We are here to make people's lives better. The NHS does not exist to save money; the police do not exist to save money. They exist to make people's lives better, as does teaching and every other public service. Why don't we think like that for social care?



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Simon Bottery: On Ben's point, Hammersmith and Fulham is an interesting example. It would be useful to look at the experience there, not least because what Hammersmith and Fulham is doing is what Scotland did, in essence.

There was a natural experiment, in a way, in 2000 or so when Scotland introduced free personal care. It is a very popular policy in Scotland. They introduced it because they thought that using free personal care would encourage people to stay at home longer, which is what people want—to be independent at home as long as possible—and to reduce the use of residential care. What they have never done is explore to what extent that actually happened. When you ask them why not, they say, "We like our policy. Why should we do this work for the benefit of England?"

Looking at what has happened in Hammersmith and Fulham, my understanding is that one of the effects is that people receiving care are receiving more hours of care than they had previously. It would be valuable to look at what impact it has on take-up—how many more people are receiving care because there is no means test—and try to explore the impact on those individuals.

Q27 **Ben Coleman:** I would like to have Andrew's view as well, but I have to say that you are making an extremely strong point. I think the council does not have the resources to undertake the depth of academic study—rigorous study—that would be needed to identify the answers to the questions you have raised.

It would be helpful if that sort of resource was made available, because it is doing a unique experiment and I think that it started for the same reason in Scotland—because it was the right thing to do. Looking back, it probably would have made sense for some sort of measurement to be built in back in 2015, when it began. But we are where we are. Andrew, do you want to comment on anything you have heard there?

Sir Andrew Dilnot: No, I haven't looked at what has happened in Hammersmith and Fulham. I have looked a bit at what has happened in Scotland and, as Simon said, it is popular, but it has left the acute problem of people with very high needs exactly where it was. So we still have a situation in Scotland where the social care system there is facing enormous pressure and people with very high needs find themselves on their own.

I think that, as others have said, it would be really interesting to have a study of both Scotland and Hammersmith and Fulham, to see what the effects are. But I think it is very striking that where we make social care more accessible, we make people's lives better. Again, that is pretty blindingly obvious, but it is an important thing to follow up on.

Q28 **Joe Robertson:** I was going to ask a question about how we evidence that spending money on social care leads to at least some savings in the NHS. But Sir Andrew, you made a comment earlier that perhaps runs against what I thought was a settled consensus here, so I might invite you to clarify this idea that more investment in social care will ultimately lead



to more spending being needed in the NHS, because people will live longer.

Is it not the case that, provided people live longer and healthier lives, you should be able to deliver ultimately savings, or at least per capita savings, in the NHS? I think that was the view of the chief medical officer in his annual report two years ago. It is about living longer and, when life comes to an end, dying quicker and not being left, you know, using services unnecessarily. May I just invite a clarification of that, or a view on it?

Sir Andrew Dilnot: We don't know the answer to this, but what we do know is that the older people are when they die, the more likely it is that they will have a period of significant dependency towards the end of it. That may be dealt with in the NHS, or it may be dealt with by social care.

Specifically in terms of social care, I think that if we do social care better, people will live longer, better and more flourishing lives. That is why we want to do it. The probability is that we will end up with higher social care costs towards the end of people's lives.

Social care costs vary with the degree of dependency and increase with increasing dependency, so I would not want to make a long-run argument that doing social care better will mean that in the long run we will spend less. We will spend less earlier in people's lives and we will give people better and more flourishing lives, but I think it is quite conceivable that we will end up, with the economy as a whole, spending more on social care, because if we have the wholly desirable outcome of people living longer, then we are likely to have a bit more dependency.

It is also worth saying this. I do not want this in any way to sound like a counsel of despair, but we will also go on paying people's pensions for longer, which is wholly desirable. One of the great triumphs of the last 150 years across the world is that we live longer. And to hear people talking about the burden of ageing makes me fume with anger. It is not a burden; it is fantastic. It is wonderful. The alternative is being dead, so it is great that we live longer.

Living longer means that we go on consuming for longer. Some of that money will come from us directly; some of it will come from the state. That is to be welcomed. I would not want to make an argument that by doing social care better, we will save money in the long run.

But in the short to medium run we definitely will, because we are doing social care so badly that we are jamming up the NHS in a wholly unhelpful way.

- Q29 **Joe Robertson:** Isn't the point that the maximum human life has not increased? People have always been able to live to 90 or 100; it is just that a few hundred years ago so few people did. Provided we can get people there healthy, or healthier, they tend to die quicker, which is obviously better than taking a long time to die when your time comes. That was the point. I accept that there are some unknowables in that, but I did want to slightly challenge this notion that by spending more on social



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care you inevitably somehow spend more—

Sir Andrew Dilnot: I don't think it is inevitable, but I think it is likely, and it is not just social care and NHS spending; it is also pensions spending.

Q30 **Joe Robertson:** Now looking beyond the funding issue, have you, Kathryn, or anyone else seen innovations in social care across the country that, if the funding was in place, would scale and roll out very well to a more systemwide approach across the whole of the country?

Kathryn Smith: Yes. I have been looking at innovations quite a lot over the last couple of years. Specifically, at the moment SCIE is supporting the Government's accelerating reform fund, which is supporting local areas to innovate in their areas. It is fairly early on, but we are seeing lots of innovations in things like shared lives schemes, digital technology and things like that. Let me give a few examples.

A couple of the ones that I have specifically been out to see are based on digital. One is using a digital app called PainChek, which uses artificial intelligence to scan a person's face. It is specifically for people that have a cognitive impairment and cannot communicate how they are feeling—for example, if they are in pain. This will tell the carer if the person is in pain. It will give them the right set of questions to ask to find out what kind of pain and what support they need.

This app is not being used on its own; it has been combined with a different care model that has a higher level of training, the staff are paid more, and there are higher numbers of staff. In the instance that I went out to see, this is specifically targeted at people with dementia. What they have found is that these people are no longer on neuroleptic drugs, not on drugs that are managing their challenging behaviour, because they do not have challenging behaviour any more; their pain and their behavioural symptoms are being managed well, and they are being well cared for. They have also found a reduction in costs relating to medication and to coming in and out of hospital, because these people are no longer going in and out of hospital.

Ultimately and most important, people have a better quality of life. You can see this vividly when you look at the service. To go back to one of the things that Simon said earlier, it is not quantitative. You cannot do a statistical study on people's quality of life. I was working in local authorities when we were trying to do outcome-based commissioning, and my local authority had to stop it because we could not quantify it. How do you quantify that somebody has a better life? You can see it, but I could not prove it to our council. That is really quite difficult. This is one service that has done its own research to demonstrate this, and they have councils funding it, amazingly. There is one sticking point: they have councils funding it because councils are responsible for social care, but the savings are to the NHS. That that is one of the sticking points in trying to roll that out.



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Another example is one I went to see in Oxfordshire not so long ago. It was a care home—the best standard care home I have ever seen, and I have seen a lot of care homes. The people who live there pay an absolute minimum of £2,500 pounds a week, which sounds like a lot of money, but it is not as much as being in hospital. The majority of people in that care home are people who have gone there because nobody else can care for them; otherwise, they would be in hospital. It is fantastic.

I walked around this care home and saw the activities they were doing. You do not see any people wandering about. You do not see anybody sat watching “Bob the Builder” in the lounge because there are not enough care staff to turn the TV over. You do not see people sat doing children’s jigsaws. Everybody is meaningfully occupied and happy, and they have statistics to show that these people have not been into hospital, as they would have done before.

Q31 **Chair:** What is the name of this care home?

Kathryn Smith: Nightingale. Some of the people who live there are costing £7,500 a week. When I have repeated this example to civil servants recently, I have been met with quite a lot of shock—“How can they pay that?” I checked, and 75% of the people living in this care home are council-funded. The council is paying that because it cannot get care for these people anywhere else, and having them there has stabilised them and given them a good quality of life. There are other examples of that around the country. I am not suggesting giving every care home £7,500 a week, because that is not going to turn the culture of care around, but it is about the models of care that are employed in these places, the training and the number of staff they have—the staff-to-resident ratio is much higher, so that people can be managed well, have their needs met well and be supported to live independently.

These are just care home examples. I have also seen examples out in the community. I will give you another digital example. I cannot remember what it is called, but this is a medication that, again, has artificial intelligence—technology—built in. Quite often, people who are supported to live in the community—and they do not necessarily have a cognitive impairment—forget to take their medication, which means they are not keeping on top of their condition, and they get worse and other things happen. This technology is quite simple. The tray that people have for their medication has technology built in so that if the medication is not taken at the right time, the person who is supposed to be taking it is given an alert. If it is still not taken, a carer is given an alert to contact them.

What they have found—again, they are doing their own research on this—is that this kind of technology has supported people to make sure they take their medication at the right time. They then do not need that medication any more, because they have got on top of the symptoms. They are able to live better. They might need different medication, but ultimately it has really helped them. Again, local authorities are paying for that, but the medication is an NHS issue.



Q32 **Josh Fenton-Glynn:** To what extent do you think the failure to reform is driving inequalities in both access to and quality of social care? Do you think there are ideas for reform that could address that?

Kathryn Smith: There is a huge impact on the inequalities in access to care, and that is worsening. Marginalised groups and people in deprived areas are disproportionately affected, and people are being left without the right support and care they need. Andrew spoke previously about how the hugely wealthy can pay for whatever care they like; if it is available, they can do that and can get some great models of care. People who have absolutely no money and no means to access anything can get the means-tested support and care, but that level is really low, and that has changed hugely. When I started out in social care, we supported people more than we do now. Some things have moved on positively, like personalisation, but we support fewer people proportionally than we used to in that sense.

Then there are people who quite simply either cannot afford to get the right care or do not know how to even find out what the right care would be. We have stories of people whose situation has worsened, and they have ended up stuck in the house, in a really difficult position. People have died from not getting the right support and care they need. People have ended up in hospital. Predominantly, the people who have been hit the hardest are those from marginalised groups and poorer people.

Q33 **Josh Fenton-Glynn:** I think that is probably true. There was a National Audit Office report in 2023—I am trying really hard not to say “last year”—which outlined the social care issues. One of the things it mentioned was significant authority to authority differences, which will be partly driven by the finances of those authorities. Without wishing to diminish Hammersmith and Fulham, I suspect that its council tax base is somewhat greater than that of some other authorities. When we are looking at a national care service, is there an inequality issue because of how local authorities are funded?

Kathryn Smith: That is huge. SCIE runs sessions with local authority social services directors quite regularly to hear about what their issues are. One of those directors is currently the director in Bradford and was previously the director in Hertfordshire, and he tells us that the issues people commented on in Hertfordshire were things like transport not turning up on time. People in Bradford are just lucky to even get a service. I am not going to put words into his mouth, but there is a disparity in what is available. My experience in local authorities has all been in northern local authorities, and there is definitely a north-south divide. What the local authority can afford to pay for gives a different level of quality in care, even for means-tested people, than what there might be somewhere else. The service I went to see in Oxford would not exist in Bradford.

Q34 **Josh Fenton-Glynn:** I know West Yorkshire care quite well, because I used to sit on the West Yorkshire ICB. We have a regional disparity and also a disparity with some marginalised groups. There is also the ability to advocate for oneself, and whether someone has family to advocate for



them. I have recently had involvement with the care system; I used to run a care service and I still find it difficult. Do you recognise that this is something that is a problem, in terms of the broader inequalities in care?

Kathryn Smith: Definitely, and being able to advocate for yourself, or having somebody to advocate for you, is a huge issue. If you look at the costs of social care across the ages—this is my own personal soapbox—and the package of care for a child, compared to an adult with learning disabilities, compared to an older person, they could all have the same presenting need but the availability of care is smaller the older they get. Now, don't get me wrong, it is not good enough for working age adults either, but it is even worse for older people. I think that is a lot to do with parent power and advocacy, who is shouting the loudest, and those people who have not got somebody to advocate for them. If you are in need of care yourself, you are not in a great position to advocate. To use Simon's word from earlier, you are already feeling quite vulnerable and quite difficult. You do not know what is out there, and you are just trying to make each day go. If the person who is caring for you is also struggling with that, then they are going to struggle to advocate. If you do not have any family carers in the first place, the chances are you could be sat in your flat in squalor for a long time before anybody notices that there is a problem.

Q35 Josh Fenton-Glynn: Do you think moving more universally to rolling out a strengths and assets-based care system would lead to better outcomes with healthcare and people being able to live healthier for longer?

Kathryn Smith: Yes, if it was funded properly—absolutely. Going back to your earlier question about innovation—this is quite sad—I have been out to see a service where they were trialling a new innovation and had had some successes. The day I went to visit it, it was closed down because they did not have enough funding to do it. One of the issues with the funding system in social care—where it is crisis, followed by cash injection, then back to crisis—is that it does not give anybody the opportunity to do proper long-term planning. That means that things like truly looking at strength-based approaches and personalised approaches end up sitting around on the periphery. The sector does not have the time or space to make it the main thing because it is too busy dealing with the crisis.

It goes back to a point that was made earlier by Gregory, I think, on the short-termism of what we are looking at. I think that is a challenge of how our Governments are structured: most Governments are thinking about the short term and the quick and easy wins. Actually, it is going to take strong and positive leadership to make an impact on social care.

Q36 Chair: What kind of time period are you looking at? The Government would say that they are bringing back multi-year settlements for local authorities, when before it was yearly. They would say that they are giving a bit more certainty, but that is for three years. What kind of horizon are you looking at?

Kathryn Smith: I will be happier when they have, rather than when they have just said that they will.



Chair: Fair enough.

Kathryn Smith: A three-year settlement would be a good start. We are not there yet, but it would be a good start. It is really hard, even for organisations such as ourselves, which are supporting the system, to manage a budget when we literally do not know what we have got in April. Local authorities are often in the same situation, so how do you make a long-term plan? If we were to reform social care now, we would see some immediate differences—of course we would—but some of the benefits that Andrew was talking about we would not see for 10 years. It needs a strong, determined Government to put in place funding and reform for a system that is for the longer-term benefit. As has been mentioned, there is a good majority there, so there is not a reason why it should not be done now. We need to grasp the nettle and make it happen.

Q37 **Paulette Hamilton:** I am going to give you a bit of a rest, Andrew. My question is directed predominantly to Simon and Kathryn and is about the care market. The preface to it is that I was a nurse for many years and had no idea about social care. I went into local politics and became the cabinet member for adult health and social care in Birmingham. That is a massive system, and the problem in that system with regard to the care market that really drove me mad was this. We would give out packages of care. I was someone who really believed in direct payments—empowering people to get their own services. But when they had large packages of care, the problem we had was that private organisations would, at the drop of a hat, hand the whole lot back to us and we then had to pay double to get that care delivered by other partners, because they saw the susceptibility in the market and they would take advantage of it.

What could the future look like for the market if reforms are not forthcoming, given some of the wicked issues that we see going on at the moment? That is only getting worse, because of what you talked about earlier—the current inaction and things being pushed down the road.

Simon Bottery: It is a very topical question. If you asked providers that question, they would say that there is a really serious risk of more of them going out of business or handing back contracts, because of the extra cost burdens that have been imposed on them in the last six months or so, since the Budget. That is a really valid concern.

If you look at the last 10 years, what you see is that the costs to providers have increased year on year, because of the introduction of the minimum wage. Social care tends to pay staff at or around the minimum wage. The minimum wage has been increasing by more than inflation, and those costs have been passed on to providers. For some, that has been extremely difficult to deal with, but what has happened generally is that providers have been able to pass on those costs to local authorities, and local authorities have felt that they have to pay increased rates year on year in order to be able to ensure that they have a market that can provide services. But what local authorities are doing in turn, because they have a limited budget, is reducing the number of people they provide care to, so they ration care.



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You have this really unfortunate vicious circle whereby increasing costs are met ultimately by local authorities as much as possible, but that results in fewer people receiving services; and if we stack more costs on to providers without making sure that local authorities are funded sufficiently well to be able to pay them, there is a really serious problem that we are facing.

I think that is the most immediate issue, but you also see issues in that providers are able to command greater fees from self-funders than from local authorities. There is a real injustice about that. If you are paying for your fees yourself and you are paying 40% more than the local authority is paying, there is a real injustice. But it also creates an unfortunate market dynamic, which is that if I am building a care home, I am going to build a care home in an area that has a large number of self-funders, because I can recoup fees more effectively there than in an area where there are very few self-funders. You will see that the majority of the care homes that have been built in the last five to 10 years tend to have been built in areas with large numbers of self-funders. It creates these imbalances in the market, which ultimately mean that a local authority in a more deprived area may struggle to attract companies to build care homes.

There is a range of issues, and they go back to the point that if we are not able to pay a fair rate for the care that is provided, we will see the impact in local authorities having to pay enough but reducing the number of people they support. We will also see imbalances in the market in terms of where services exist.

Kathryn Smith: Twenty years ago, I was an inspector at a predecessor to the CQC. We used to get people coming to us that had bought a big building and wanted to set up a care home, because there was profit in it. It doesn't happen any more—people don't do that now. I am not saying nobody makes a profit in care; of course they do, and some keep doing it. But the people that make the profit generally tend to be the ones that are supporting self-funders.

Over the last 20 years we have seen contracts handed back and the market retracting. One of the issues with this is that it is reducing people's choice and control. If we look at home care—not just care homes—I cannot remember where I saw this statistic, but there has been some work to show that to be able to provide good quality home care, providers need to be charging £30 an hour.

A lot of local authorities are refusing to pay more than the minimum wage. When people have got personal care and direct budgets, they cannot afford to pay the hourly rate. The number of people that are available to provide home care, or care homes, to those who are not self-funders is becoming less and there is less choice out there for people.

I've worked in social care since I was 13. I have been an inspector, a care assistant, a senior leader, a commissioner, and I have been in the charity sector. What I thought was good quality care as a professional was turned



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on its head when I was looking for care for my granddad. I took my auntie around the care homes that I had been an inspector at—"It wasn't good enough, I wouldn't put him there". It completely changed my mind.

We need to define what good quality care is first—what do we think is an acceptable standard of care for everybody? Going back to if we were to provide the right level of support and care for everybody—regardless of their location and means—what is the basic level of care that we are looking for? I don't think we have a universal view. I know what my view on it is now, but I think it is something that would need considering.

Are we funding the market enough to provide that level of care? As has already been said, most of the care market is private. They might love the job, but they aren't in it for love. They're in it to make money. If they cannot make any money—or if it is costing them—they will either give the responsibility back, or look at ways to save money, which might not be in the best interests of the person that they are providing for.

Q38 Paulette Hamilton: The challenge is, should it remain in the private sector?

Kathryn Smith: All of those innovations I've talked about were in the private sector. I think the private sector can innovate—it absolutely has got the ability to innovate, but that is not universal. If we are going to talk about a national care service going forward—and what I mean by national care service is what I've heard talked about in terms of a national set of standards, guidance, pay and so on—we need to be very clear on the minimum level of care. And when I say minimum, for some people it is probably the maximum that we are looking for. The private sector needs to be incentivised to provide that. If we look at any other market or anything else that is delivered by the private sector, we don't expect them to do it and not make a living out of it. We need to make sure that we are clear on what is to be provided and how it will be paid for.

Paulette Hamilton: That is a good place to stop.

Q39 Andrew George: I think you can answer the question I've been allocated relatively quickly. Therefore, I would like to ask a supplementary question on the back of what Joe was asking Andrew earlier.

I think you have twice said that if we improve health and social care and people live longer, it will result in a larger social care bill because people will need more care towards the end of their life if they are living into their 90s, rather than popping off in their 70s. What evidence base do you have for that, or is it based on a reasonable assumption?

Sir Andrew Dilnot: The evidence base is not fantastic, because data in social care, particularly life cycle data, is not good. There was some evidence that we looked at 15 years ago when we did our work, and some evidence that I have seen since then, which suggests that is the case. Let me be clear that I am not talking just about social care costs: critically, I am talking about pension costs as well. I am talking about the overall public finance cost. If we do social care better, people live—



Q40 **Andrew George:** That is a different matter, isn't it?

Sir Andrew Dilnot: It is a different matter, but as far as Government are concerned with the public finance costs, it is actually extremely germane and terribly important. I don't think that I would start with trying to say the best argument for doing social care better is that we will save money; I am not sure that we will. The best argument for doing it better is that we are not doing well at the moment and we can give people more flourishing lives if we do; but in the short run, if we do social care better, we will free up very significant NHS resources. At the moment, we are putting an enormous and unnecessary strain on the NHS.

Q41 **Andrew George:** So in the cold hearts of the Treasury, they will look at the pension budget and this and perhaps make rather cold-hearted calculations on the back of that. I am sorry to be vague, but I was not sure whether it was Professor Darzi or someone else who indicated that if you improve people's health and wellbeing into their 90s, the social care and health care budget is less than if they fall ill in their 70s. I would like to see—

Chair: It was the chief medical officer who made that point.

Andrew George: Thank you very much. That would be useful for us, because this is very central to the question we are asking. I think there is a fairly obvious answer to this question, so I will give you a minute to answer it. The Government have their three shifts—all of which I am sure are very agreeable to everybody—one of which is the shift from hospital to community. To what extent will the failure to address the issues in adult social care impinge on the ability of the Government to deliver that particular shift? I think the answer is obvious, but I thought that I would ask you anyway.

Sir Andrew Dilnot: I think it is fairly obvious, but the answer is massively. We have a massive number of people in hospital right now who don't need to be there, and there are two categories in that group. There are those who are in hospital for non-social care—not because of a social care failing, but because of something else—but they cannot get out, because social care is not available. There is then a group, which is probably smaller, who are in hospital because of failings of social care and now still cannot get out. It is a huge problem and a huge challenge for the Government.

Q42 **Andrew George:** I have a supplementary question on that. The figures that I picked up in Cornwall alone indicate that of the delayed discharges in the acute sector over the last year, only 25% can be attributed primarily to a lack of social care packages. Others are actually a combination of a lack of primary—

Sir Andrew Dilnot: That figure sounds right. I saw some figures in the last couple of days about Liverpool, where it looks like it is about a third, but we also need to distinguish between stocks and flows. Delayed discharges for social care are often lengthy. If you have one elderly gentleman or lady in hospital for 20 days because there isn't any social



care, that is probably at least 10 elective activities that are not possible. A figure like 25% or 33% may be roughly right, but that is still a large and not necessary figure.

- Q43 Jen Craft:** Following on from the hospital delayed discharge issue, one of the questions that came up, which follows the discussions that we had about how this is paid for and who pays, is that where the savings are realised, it is often not in the Department that has to pay the upfront costs. Do you have any thoughts on models that can prevent readmission to hospital or delayed discharge—for example, virtual frailty wards—and whether that is necessarily a staff training issue in the social care sector? If so, should that potentially be a cost borne by local ICBs or the health service, or is it more about collaboration?

Sir Andrew Dilnot: I won't claim to be an expert on those particular questions, but they point to an absolutely central question, which both Kathryn and Simon have raised, about the interaction between local authority budgets and NHS budgets. I think one of the questions that it would be helpful for this Committee to think about some more, and essential for Baroness Casey to address, will be that of where budgetary responsibility lies. Social care is a local authority financial responsibility, and that is a hangover from the fact that in 1948 it was the one bit of the welfare state that was not centralised. It got left with local authorities. At that time, it was not a very large activity; it has grown massively.

There are strong arguments for local variability in provision, because the way in which it makes sense to provide social care in the highlands will be very different from the way in which it might make sense to provide it in the centre of a large metropolitan area. But if we were starting from a clean sheet of paper, I cannot think that we would finance it locally. That leads to precisely the kinds of regional inequalities that Josh pointed to and Kathryn talked about.

It also leads to a kind of peculiar dance each year, when the Treasury will often say, "We're proposing that the amount of funding available for social care will increase by x ," but the amount of funding that it is delivering for social care increases by x minus some significant amount, and the gap is to be met by changes in council tax. If we were starting from scratch, it is not at all clear that we would think that council tax was a sensible way of raising funding for social care, and of course we need huge equalisation. The distinction between the budgets of those who are financing and the budgets of those who are actually having to pay is critical, and is a huge obstacle to doing these things well.

Simon Bottery: I cannot speak to virtual wards, but in terms of preventing readmission, reablement and intermediate care services are incredibly important. We talked about evidence earlier. There is pretty good evidence for reablement as an approach in terms of essentially getting people back on their feet—often quite literally. It allows them to regain their independence and therefore has a massive effect on their lives, but it also prevents additional costs to the health service.



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The last numbers I looked at, in the national audit of intermediate care a few years ago, suggested that we could do two or three times as much reablement and intermediate care as we currently do—there was that level of demand for it. So when we are talking about innovation and where we should be innovating, for example, I think there is also a case for looking at stuff that is actually working and spreading it more widely across the system, as well as looking for the pockets of new things that are coming up.

Kathryn Smith: That was exactly my point.

Q44 **Jen Craft:** To go a little wider, and focusing on collaboration and who pays, Sir Andrew, you touched on how paying for adult social care through the same mechanism by which people pay for their bin collection—local council tax—is perhaps not necessarily how people would opt to do it. This is perhaps a wider question, but do you think that, in the failure to grasp this—whether that is the Government or the general public—there is something around general societal attitudes towards disability as a whole? Perhaps people do not want to, or cannot, imagine themselves becoming disabled, whereas everyone can imagine themselves needing to use the NHS at some point during their life. People do not want to imagine disability entering their lives, and perhaps there is a reluctance to address this issue head-on because it is not seen as universal.

Sir Andrew Dilnot: I think that is right. It is part of the invisibility. Of course, that's nuts: 80% per cent of us are going to need social care, and need it enough that we will pass the now extraordinarily tight local authority assessment test, so this is coming at almost all of us. A very small proportion of us will be walking up a hill at the age of 93 in full health and will have a heart attack and die, but 80% of us are going to pass the local authority test. We don't like looking at it. I think it is part of a wider set of issues about the invisibility of older people in general.

Ben Coleman: And the disabled.

Sir Andrew Dilnot: And also disability. It is also critical to remember that half of what Government spend in the UK is spent not on elderly care but on working-age adult social care, and that is a group of the population that is very marginalised and not talked about. Facing up to these things is critical, but part of the reason that we don't face up to it is—to go back to the question of public education, which I think Danny raised—that we have a system we are embarrassed by. The reason that politicians, on the whole, don't talk about social care is because we don't have a system we can be proud of. If we had a system with a founding myth that we could be proud of, then we would talk about it.

One of the critical reasons for reform is to create a structure that people are willing to talk about, because it is a structure that gives people some agency and ability to control their own lives. Until we do that, I don't think we will find politicians and the media talking about it. Politicians will not want to talk about it because it is not something to be proud of, and the media will not want to talk about it because it is slightly terrifying. At the



moment, social care is terrifying: it is like standing in the middle of the road with a lorry driving towards you, and the best you can hope for is to die before the lorry hits you. You are not going to want to focus on that, so if we can move to a structure where people have some agency, then maybe we will get some more talking about it. We are not good at talking about it.

Q45 **Jen Craft:** Is a shift needed in attitudes towards disability? I think about some of the framing around entitlement and scrounger narratives that we see in some of the nastier parts of discussion on this issue. If some people receive care that they need to go about their lives, this is not receiving something above and beyond what most people can expect.

Sir Andrew Dilnot: I am sure that is right. We need a shift in attitudes to those who need it, and also recognition that self-reported life satisfaction among people receiving care is strikingly high—often higher than it is for the population as a whole. It is not about being in some ghastly waiting room for the end. This is about people leading good, fruitful, flourishing lives, and we can help us all do that by facing up to it.

Simon Bottery: The House of Lords Committee used a very useful phrase, which was evident to the Committee. It was someone with a disability saying they wanted a “gloriously ordinary” life. They simply wanted to be able to do the stuff that everybody else can do, when they wanted and needed to do it. That is what we would all want if we had a disability or if we relied on social care: we would like to have that gloriously ordinary life.

Q46 **Dr Cooper:** I am going to end at the beginning, if you like. I am a public health consultant, so I hear a lot of what you are saying about being a Cinderella service, being invisible, not getting the funding that you need, and needing to invest now for generational change in 10 years. If I think about social care and prevention together, I think there is a great opportunity that we keep missing. My specific question to you is, do you think social care reform could include a significant focus on a public health, or social care or national care budget—whatever the relevant wording is—that budget for ageing well, which builds capacity in older people and the care system aligned? Do you think that is something we should push for?

Sir Andrew Dilnot: Yes.

Q47 **Dr Cooper:** Great. Feel free to expand.

Kathryn Smith: We can expand to also include younger and disabled adults. I will give you another example. I compete at horse carriage driving, and a young lady competes with me and she is tetraplegic. She is better than me as well, which is really annoying. She had a car accident when she was 15, and she is now tetraplegic. She has a personal budget and a very forward-thinking social worker who helps her to manage her personal budget in a way that suits her. She has managed to teach herself to do some of the most intimate care procedures with one hand, which I have to say I am slightly worried about—she should have more care than she has got, but I am sticking to the positives for this purpose. She uses



her personal budget to pay for her carers to help her to compete in the horse carriage driving. That is her passion. That was her passion before she had an accident, and she has kept that up. Apart from two examples I am going to give you, I have not known her in hospital a single time since I have known her. I have not known her to have social services out. I have not known anything apart from two examples. One of those examples is that her adapted car broke at the same time as the lift in her accommodation broke. She could not leave her bedroom for six weeks. Within that six weeks she got pressure sores and she got depressed. She ended up having additional support workers out to her, and she ended up really down. She was on a really bad trajectory until these things were fixed and people managed to bring her out again. Just now, she is snowed in. She cannot get out of the house because of the snow. She is isolated. She is lonely. It is still early days—it has only been a couple of days—but I can see the same trajectory.

The reason I am giving you this story is, when we get social care right, when we get intervention right and we support people to live their gloriously ordinary lives, the fact that they are happier means that they are less susceptible to other things. Living well makes a huge difference to your ability to manage other things. I am aware that we are about to run out of time and I wanted to pick up on something that was said earlier about the chief medical officer's comment about getting ill at 70 or 90. I think the reason for the additional cost is because, if you develop long-term care needs at 70, you don't necessarily die at 70; you have got long term care needs for 20 years, whereas if you live well to 90, you might not have those care needs until you are 90.

Andrew George: Exactly. That is what he was implying.

Q48 **Dr Cooper:** I am sorry; I know we are going to run out of time, but I am interested in what Simon said—perhaps Andrew and Kathryn have said this as well—about the fact that social care does not set the world on fire. You have done a lot of work, and social care is now being discussed more in this Committee, in the media and so on, but is there a case to be made for a national care service that encompasses preventative care? From myself, healthcare and social care is a better way of looking at what we are trying to do and what Kathryn is talking about, which is that culture of care—the culture of change that allows the UK population to be proud of something. Is that something that the King's Fund has considered—looking at a catch-all that says, "We are about caring, regardless of where you are in the health system"?

Simon Bottery: Yes, and it is not just the King's Fund; looking at health and social care as two sides of the same basic coin is quite a widely adopted approach, but the money, respect and attention don't follow in the same way. That will be a chance. One of the potentials for this commission, or any other commission, is that it has the opportunity to bring some public attention and talk about health and social care in that context.

Chair: The bell suggests that we have reached the end of our session. I



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simply end by saying a massive thank you to all three of the witnesses for appearing today. It was incredibly rich and useful to us, and it has set us on a very good path for the rest of our inquiry.