

Health and Social Care Committee

Oral evidence: The Casey Commission, HC 420

Wednesday 24 June 2026

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Watch the meeting

Members present: Layla Moran (Chair); Danny Beales; Ben Coleman; Dr Beccy Cooper; Josh Fenton-Glynn; Andrew George; Paulette Hamilton; Alex McIntyre; Joe Robertson.

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Witnesses

[I](#): Baroness Casey of Blackstock DBE CB, Chair, Independent Commission on Adult Social Care; and Sarah Coskeran, Deputy Director, Independent Commission on Adult Social Care.

[II](#): Stephen Kinnock MP, Minister of State for Care, Department of Health and Social Care; Ben Dyson, Director for Adult Social Care Strategy and Reform, Department of Health and Social Care; and Emily Roche, Director of Adult Social Care Workforce and Policy, Department of Health and Social Care.

Examination of witnesses

Witnesses: Baroness Casey of Blackstock and Sarah Coskeran.

Q1 **Chair:** Welcome to the Health and Social Care Committee and this one-off hearing on the Casey commission. We are going to get cracking. I will start by asking our first panel of witnesses to introduce who they are and what they do.

Baroness Casey: I am Louise Casey, and I chair the Independent Commission on Adult Social Care. Thank you for having us today.

Chair: Thank you for being with us.

Sarah Coskeran: I am Sarah Coskeran. I am deputy director at the Casey commission on social care.

Q2 **Chair:** Thank you both for coming. As a first question, Louise, have you spoken to Andy Burnham yet?

Baroness Casey: Yes, I have spoken to Andy Burnham before, during and where we are now. As you are probably aware, he is not the Prime Minister yet. He did an awful lot of work on social care in Manchester. We had already been up to Manchester and talked social care months ago. He was going to say something in the run-up to something or other—I think it was a *Guardian* article—and his team got in touch. We said, “Yes, you can say whatever you want to say. We are not influencing it. It is entirely a matter for you”.

Like everybody in the country right now, I will await the outcome of the next few weeks and see who the next leader of the Labour party is and therefore who the new Prime Minister is.

Q3 **Chair:** If he wanted to expedite the process, is that something you would be able to do?

Baroness Casey: Yes. The key thing here—we have discussed this before—is that when you are agreeing terms of reference the words are very important. It says “by 2028”. There is a person sat behind me who very carefully made sure it said “by 2028”, which gives us that ability. I have always said—Ministers have always been incredibly supportive of this—that, if we can bring the overall piece of work in earlier, we should.

The previous Health Secretary, the current Health Secretary and the Minister for Social Care have been really keen on this from the outset. What can we do as we go along the journey? What changes can be made now? What changes could we make ahead of any general election to set out the stall for what could happen potentially in the future? Could we use cross-party talks as a way of trying to manage those processes in parallel?

Q4 **Chair:** Very briefly—we are going to go into all of those different aspects with different questions over the next hour—where are we right now?



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How far along in this process have you got?

Baroness Casey: As I hope colleagues know, we have done a huge amount of work. I am going to have to take my jacket off.

Chair: By all means, please.

Baroness Casey: I put it on thinking it was the polite thing to do at a Select Committee. I do not think I have ever done a Select Committee without having some form of jacket on, but even I am struggling.

We have done a huge amount of consultation. We could probably go into the detail of that if people wanted to. We have had two cross-party talks. We have visited the constituencies and got alongside the Members, who represent social care and health in their constituencies, to try to understand that. We have done a lot of work. I made a speech in March—I am not going to make many speeches throughout this process—because we felt we were ready to essentially agree with the Department and with Ministers on three particular pieces of work, which I can go into if you want me to.

Chair: Not just yet, no. We will come back to that, if that is all right. Just a brief overview would be helpful.

Baroness Casey: As we head into the summer, we are at the stage where—again, I am sure it will come up—we have looked in detail at the last 22 reviews, White Papers, Green Papers, commissions since 1997 alone. That does not account for all the attempts before that. One thing that has been missing on quite a significant scale is a reset of the discussion with the public and to have a conversation with the public that is two-way on what their appetite is for a renegotiation of the social contract.

In order to do that—I am probably giving more away right now than I should—we hope that in July we will commence that process in quite a big and deliberative fashion, which will help us to guide the next phase of what the reform looks like. Stephen, the Minister of State for Social Care who is behind me, is very clear that, if we want to move more quickly on certain elements, we will do. We intend to publish a report this year outlining what changes we think could be made. Some of those are quite big and I can go into some of the thought processes behind them.

Chair: Absolutely, yes. We would be delighted to hear that.

Q5

Paulette Hamilton: Good morning, Baroness Casey. My questions are on the national care service. I want to read back to you some of the words that you used just before it all started. You said that the commission has been tasked with setting out a plan to implement a national care service in the first phase. That was a government manifesto commitment. Sorry, this is the wrong bit of it. Have I got my questions wrong? No, I have not.



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Simon Bottery, who is a senior fellow in social care at the King's Fund, suggested that the Government were yet to develop a definition of social care. For my first question to you, what is your understanding of a national care service?

Baroness Casey: First of all, the King's Fund is one of the many think-tanks and institutions that have done good work over the years looking at the issue of health primarily and the issue of social care. It would probably agree with us that the thing that is missing in all this is what the public thinks social care is. There is a real fault line between what the national health service does and thinks about social care, and then what the rest of us do and think about social care.

Most of the time, we think that that is local government. Actually, it is not just local government. It is individuals, families and carers. It is a massive amount of the private sector. The whole landscape of what people call social care is often provided by the lowest-paid and the most uncertain level of delivery that I have ever come across in my career in terms of delivering a public service in a rather complicated way.

What that means is that we are so far away from getting something that you might call a national care service. There are some things that we should be doing in the short term, but we should be thinking about what type of reform is needed in this country—the commission is just looking at England—that takes us not just to the first quarter of the 21st century but 2050 and onwards. What does that look like? Therefore, what has to be in scope is looking at where the NHS is in that.

If I can just jump straight into it, I was really pleased when I saw that this Select Committee had made absolutely clear that it did not agree with the removal of local government and other key partners, such as GPs, from the governance of integrated care boards. That is sending a really mixed message about trying to create something that is probably a national health and care service—

Paulette Hamilton: I just want to move you on because some of my colleagues—

Baroness Casey: I can talk for Britain. I apologise.

Paulette Hamilton: No, you are not talking for Britain.

Baroness Casey: I do. I blather on.

Paulette Hamilton: Other people will delve deeper into that.

Baroness Casey: Do stop me.

Q6 **Paulette Hamilton:** Given what you have just explained, do you feel that a national care service is possible? It seems quite fragmented. Could this actually be pulled together?



Baroness Casey: Yes. When people are in Government, they can pretty much do anything they want. The gift of Government is the ability to make change and get things done. It is not beyond the wit of anybody, including previous Governments, to set out what a national care service would look like. My view is that you cannot do that unless you work out what the national health service is providing and where care fits within that or alongside it.

Q7 **Paulette Hamilton:** Moving you on—this is the bit where I got mixed up; I have got it right now—in a speech last year, which was widely advertised, you argued that social care needs a “moment of reckoning” as the service does not have “national consensus” or a mandate and it needs its own “creation moment”, like the NHS. Keeping in mind this lack of clarity and the structural changes that are needed, what do we need, in addition to what you are doing, to implement a national care service?

Baroness Casey: The biggest thing that we need to do is engage directly with the public about what a national health and care service would look like and what their appetite is for their role in that. What do we expect from families? What do we expect of individuals? I do not just mean financially but generally. What is the deal? Particularly, when it comes to social care, what is the appetite of the public to pay differently and/or do differently?

We were in the Whittington in London not that long ago on what we would have called in the old days a geriatrics ward. It is probably called something much nicer than that now. I was really struck by this extraordinary consultant there, Clarissa Murdoch. We were standing in her ward and she said that the families who are supporting people on her ward are looking after people who have very severe dementia and other frailties for possibly a decade. That is very different from, say, 20 years ago, when those same human beings, frankly, may not have lived for that length of time.

That is what we are asking families and individuals to do. I say this as somebody who is quite frightened of this. The biggest thing that we are all frightened of is dementia. It is one of the things that people worry about significantly more than the discourse in policy circles realises.

Paulette Hamilton: Baroness Casey, I will just move you on slightly. Sorry, I only have a short space of time.

Baroness Casey: No, go for it.

Q8 **Paulette Hamilton:** You have made some really excellent points, but there is another point that I would like to bring to you. How far will your phase 1 recommendations go in defining a national health and care service and people’s entitlements?

Baroness Casey: That is a very good place to start. We will look at the issue of assessment and entitlements. At the moment, what is not laid out clearly—we will lay it out clearly—is what the public understand social



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care to be. There is not an easy website you can tap into that is run by the Government that says, "This is what is going to happen. This is what it is".

Some days I think to myself that we would be better off saying to the public, certainly in England, "You will not get any financial support until you are down to £23,500", at which point it will kick in. We do not even tell them that because we are a bit guilty about it. There is not a very clear way that we tell the public what it is, when it will happen and how it will happen.

The answer is, yes, we will do that this year.

Q9 Paulette Hamilton: That is brilliant. I have one last question. I was a nurse for over 25 years. I have just recently given up my registration. There is one thing that shocked me, between health and care. As a nurse, I had no idea what happened in care. It was only when I became the head of social care and I had a governance role in Birmingham city council that it became so obvious that a health and care service was so needed. Can you give me two things—I do like this as a last question—that you think need to happen to ensure that, in this first phase, people actually understand the differences?

Baroness Casey: It is not for the public to understand the differences. It is for the system to make those differences less divisive. A nurse who had been a nurse for a very long time said to me—she was very upset—that when people were admitted to her ward they were catheterised rather than taken to the toilet, if they were frail. Going to the toilet was not a medical issue, and therefore that seemed like a medically appropriate thing. There are people across all these professions crying out to see these changes. The idea that we divide more what is care and what is healthcare is a road that we have gone down too far already. We need to pull it back.

We need a greater recognition of how the public sees the difference between care and medical care. Let us take district nurses. We now have significantly fewer district nurses than we had a decade ago. We have more nurses in hospital, but we have fewer district nurses. That tells us something. I do not know the difference between one osteopath and another osteopath, one physio and another physio or one nurse who is called district and one care worker who is taking my blood pressure or possibly my bloods. We keep imposing on the public—we are still doing it now—a need to understand our system. We need to understand them and what is happening in their lives.

Paulette Hamilton: People will delve down a lot deeper into this, but I am going to hand back to the Chair. That is a good place to start.

Baroness Casey: I hope not. That was deep enough for me.

Q10 Josh Fenton-Glynn: Thank you, Baroness Casey. You talked quite a lot



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about the need for a national conversation. Can I go to a very specific conversation? How are the cross-party talks going?

Baroness Casey: I knew you would ask me about cross-party talks. Cross-party talks are going to be difficult. They are going well at the moment. Everybody agrees on the diagnosis of the problem. The trick is going to be shifting from that to agreeing on what the solution is. That is partly our job, not only to lay bare what the evidence is but to find solutions that can gain cross-party consensus. That is where the dialogue with the public is going to be so important and powerful because we can reflect that back to colleagues in the cross-party talks.

To be fair—I must be absolutely clear—we have had really good discussions. They are not short discussions. We had really good discussions at both of them. We had really strong attendance, and I am confident—

Q11 **Josh Fenton-Glynn:** You said “both of them”. Does that mean there have been only two sets of cross-party talks?

Baroness Casey: There have been two sets of formal cross-party sit-downs, and there have been a lot of bilateral conversations that I and my team have done directly.

Q12 **Josh Fenton-Glynn:** Those are bilateral between you and the parties, not between two parties.

Baroness Casey: Correct, yes.

Q13 **Josh Fenton-Glynn:** Is it enough to have two sets of cross-party talks? Is it enough to have two meetings?

Baroness Casey: Yes, or else I would have had more. What you do behind the scenes is often as important as what you do in front. A lot of the conversations behind the scenes are as important as when we all sit down together. We will be having another one early autumn, probably around September time, when we are getting stuck into the big conversation. That will be the right time. Then it depends on what happens in the future. As someone who has worked in, around and for politics for a long time, you will understand that we just need to weather what happens in the next few months as well.

Q14 **Josh Fenton-Glynn:** Talking about the national conversation, you have talked about how many organisations are involved. There are 6,200 GP practices, 700 hospitals, 200 NHS trusts, 42 integrated care boards, 317 councils, 153 unitary authorities, 164 district councils, 18,000 providers and the CQC. Are all the different bits of the system talking to each other? I suspect I know the answer to this.

Baroness Casey: God, no. Do you think they are talking to each other? When they come before you, do you get a sense that they are all talking to each other?



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Josh Fenton-Glynn: Of course not, no.

Baroness Casey: The answer to that is definitely no. That is partly why I said right at the beginning what I think about almost the symbolic, let alone real, changes to the structure of the governance of integrated care boards.

We are saying that we should be thinking about neighbourhood health and a left shift. Neighbourhood health is called “place” nowadays. Everybody has to call something “place”. It is an area. It is Northallerton or Islington. They are actual places with names, and places with names are run by local authorities.

Being a public servant, I am on record over the years as saying that coterminosity of geographical locations would make life a lot easier for those of us running public services, and it would make collaboration easier.

Q15 **Josh Fenton-Glynn:** As a former cabinet member for social care, I know very well that integration between health and care. One of the constraints that you are operating under is that phase 1 must sit within existing spending plans. How transformative can they be within existing spending plans?

Baroness Casey: I do not see it as a constraint. There is something incredibly important about it. Taxpayers are already paying quite a lot of money. Certainly, most people pay taxes all their lives. They are paying an average of 41% council tax toward adult social care. When they hit the point that they are older or need help, we generally make them pay towards their own care.

You could get every stakeholder to agree that there is a need for more money. It is that classic thing. If I was looking at homelessness or lots of other things, I could probably get people to agree on one thing, which is that more money is needed.

We ought to be—and I am—looking at what could be done within existing resources. My frustrations are probably already apparent to you, but they are where we can do better within the existing resources. I think there are things that can be done within the existing resources.

Q16 **Josh Fenton-Glynn:** Okay, so what?

Baroness Casey: That will be the subject of the report later this year. To give you the direction of travel, we have multiple assessments over multiple periods of time, to the degree that people now say, “I need a navigator to work this out”. People are literally applying for funding to employ navigators. When in God’s name did we think that it was okay that we made our public services, primarily funded by the taxpayer, so blinking complicated that charities are going out and raising money for navigators?



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It is incumbent on the people running those services to think about how you do that more straightforwardly. You have a lot of assessors doing assessing from different places. Let us move into it. I am slightly obsessed partly because I am getting old. I hit 60 last year. I know—it is a shock, isn't it? It is a lot of money spent on hair. Domestically, I have social care situations to worry about.

What is really interesting is that we have to work out how we do a better job for people, at least so that they know what is going to happen. We met a man in the carers centre in Newcastle who was given two leaflets when his wife was diagnosed with dementia. One was for personal independence payments, which he did not need and would never have qualified for. The second was for how to pay less council tax, which he did not need and did not want.

We could not tell him, simply and straightforwardly, what the diagnosis meant, whether there was any treatment—remember, they are in a hospital environment thinking, "Somebody is going to treat me for something", but they did not—and what was going to happen next. We can solve that.

Q17 Josh Fenton-Glynn: Just to pull you off the tangent, talking about how we can deliver things within the same umbrella, there is one thing that feels quite obvious to me. I look at my local hospital and about 20% of the beds taken up there are taken up by people who should be in care settings. Does there need to be more of a free flow of resource between social care and the NHS?

Baroness Casey: You are on the money there, both figuratively and in terms of other ways. We have seen examples where there is one employer for something such as reablement. Essentially, the local authority puts its reablement people in lock, stock and barrel with the NHS bit in one health trust. Reablement is about stepping people out of hospital into somewhere else. There are not many examples of that, but we have seen some.

That immediately gets rid of this divide. It means that you are doing one assessment and you are doing one deal with the public. At face value, it looks like it is cheaper—it certainly spends less money—but it is also better for the public, which is the thing I am rather obsessed with.

Josh Fenton-Glynn: Good social care is the shift to prevention that we keep hearing about. With that I will hand back to the Chair.

Q18 Ben Coleman: Very quickly, about the conversations you have had, I just wonder whether you have spoken to Hammersmith and Fulham council, which is the only place in England that is providing home care for free. It tells me that, as a result, it has seen a reduction in entries to care homes, which of course are different things. They are the only people who have been doing it for free for several years, since 2015. Have you talked to them or do you intend to?



Baroness Casey: We have talked to them.

Sarah Coskeran: There is absolutely a lot that we can learn. As with Hammersmith and Fulham, there are places across the country—we know it is not all in crisis—where there are good efforts, initiatives and steps that are being taken to make care more accessible for people.

We have found, though, that too often that feels like it is despite the system and led by particular individuals. In the case of Hammersmith and Fulham, it was the local population campaigning for change. We want to look at what you need across the whole system and what you need nationally to improve—

Q19 **Ben Coleman:** I meant that simply in terms of the financing of it. Does making it free work because you save money elsewhere?

Baroness Casey: Both in Hammersmith and Fulham and in Scotland, it is not evidenced that it necessarily means that less money is spent on social care. It may stop people going into care homes, but is that a good thing or a bad thing? Are people withdrawing? We think it is more complicated. It is one of the things that we are looking at.

Q20 **Ben Coleman:** You are looking at that?

Sarah Coskeran: Yes.

Baroness Casey: Definitely, yes. Let me just say it out loud. When people say things like, "Let's have a national care service", are they saying that we are suddenly going to find the money from everybody in some way, shape or form so that a totally free care service will be available for people? When you look at the places that say they are doing that, it is not all free.

Q21 **Ben Coleman:** It is all free in Hammersmith and Fulham.

Baroness Casey: Some of it is free in Hammersmith and Fulham.

Q22 **Ben Coleman:** Home care is free.

Baroness Casey: Home care is free, but not when you need other care, such as going into a care home.

Q23 **Ben Coleman:** That is a different thing.

Baroness Casey: It is a different thing. It might help to look at one aspect of it. That is all I am saying. I am conscious of where you represent, and good for you. We are not saying that this is not something that we are looking at. This is what I said at the very beginning and what I think Sarah is attempting to say. We want to look at everything and see how everything pieces together and what differences the new aspects would make.

My worry is that we ought to keep looking at what the public will see as social care if they look at it in 2050, not just what will make it easier



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now. We have to do both. We have to get on with some stuff now and we have to do quite a significant reform of what health and social care looks like.

Chair: We will come back to that.

Q24 **Joe Robertson:** I would like to take you to a conversation about dementia, if I may, and particularly the modern service framework that is in development. I share the concerns of some of the leading charities that the ambition and the bold transformative change that we need may not be realised in the MSF. Can I ask you to comment on that generally and, more specifically, should there be an ambition to reduce deaths from dementia? With cancer, heart disease and others, it is one of the biggest killers in this country.

Baroness Casey: I cannot convey to you how strongly this policy area needs to be looked at, driven and pushed. It is an elephant in the room. It is the biggest killer. It is the thing that the public worries about the most. It is a very underdeveloped area of policy within the Department of Health and more generally.

We did a big push on this in the Nuffield speech in March. At that point I said that we needed to up the action on the trials around dementia, the scientific approach, and consider it alongside what we are trying to do on other diseases and conditions. David Cameron had a push on dementia, but it has gone quite quiet ever since. That is not just now. It has gone quite quiet in policy terms ever since.

I have asked for and it has been agreed that we will have a dementia tsar. I know that is old school; forgive me. I have been a tsar in my time. Sometimes what you need is somebody who is utterly dedicated and has the credibility to work across the system and be heard. It is somebody who would come before this Select Committee and account for the work. It is somebody who will be accountable to Ministers and who has to drive the whole dementia work forward. I am pushing very hard for that, and it has been agreed by Ministers that it will happen.

Q25 **Joe Robertson:** Having won the argument on the dementia tsar, how quickly would you like to see that role appointed?

Baroness Casey: I do not think the Chair will mind my saying this, but, in the scheme of Government moving in recent times, to have asked for it in March and for it to have been agreed and under way by now is quite quick. I take that and think, "Thank you". They will recruit, and they have told us that it will happen very soon. Of course, I will be watching and helping to make sure that it lands in the right place.

Q26 **Joe Robertson:** Can I just ask you something on the diagnosis targets for dementia? I was critical that it came out of the NHS planning guidance, but I will put that to one side. I take the Government's wider point that driving things with endless targets does not necessarily lead to better outcomes. However, accurate diagnosis of dementia is clearly



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going to be key, particularly down the track as we get the potential for treatments. Can you say anything about embedding targets for accurate diagnosis within dementia, whether that be in the modern service framework, the NHS planning guidance or elsewhere? Can you explain, as you see it, the role for that and how important it is?

Baroness Casey: At this stage, I would not feel sufficiently qualified to take a view on what targets should be put in what places. Maybe that is a failing on my part, but I cannot sit before you now and say, "That target should be here and that target should not" in part because there are often unintended consequences of targets and they need to be thought about quite carefully.

In the area that we are talking about and in social care more generally, there appear to be no targets for assessment times. Let us take motor neurone disease, which is another bugbear of mine. It seems to me that we have targets in some area of business in the NHS but no targets elsewhere. I think that is because this area of the elderly and dementia is unloved and does not have the same status as other areas both in medicine and more generally.

The power of the voice of the elderly is often overstated. People think they are incredibly powerful. Where I am looking, they are unheard and unseen. Living in the weather that we are in right now, there are people who are even less seen. I just cannot bear how we seem to have neglected the area of the elderly, how we treat them in society and how we look after them.

We are all born. Once we are born, we are all going to die. As the sun comes up and goes down, that is going to happen. Why we cannot think about that in terms of how we organise ourselves and public policy I do not know.

The most amazing thing has happened, which is that life expectancy has doubled in a century, but we have stuck our heads in the sand about what that means. We cannot continue to stick our heads in the sand about it. There will be people on wards right now who are so hot and so dehydrated. Will anybody be taking them water to make sure they stay alive today? That is how bad it is. That is how unloved this particular area of policy is.

Q27 **Joe Robertson:** On the matter of targets, the waiting times for a dementia diagnosis and then from diagnosis to referral are far too long. All the other big killers—of course, dementia is the biggest—have far better waiting times, although they are not as short as they perhaps should be. Unless there is a target or some very specific ambition, I worry that it will continue to be the unloved issue that it should not be.

Baroness Casey: Yes, that is fair. The modern service framework has to be a lot more than using words such as "pathway". I dread the word "pathway" partly because I do not want to look down what that pathway



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is going to be. It is like when somebody says to me, "There is a social care front door". I say, "I hope it is a front door we never have to go through".

We have to be much clearer about those sorts of issues. If the modern service framework stands up to scrutiny and does the sorts of things you have just talked about, people who have been diagnosed—think about the man in Newcastle—will know where they stand.

I would like there to be a time when there are treatment options, in the same way that we drive treatment options for other major diseases. I would like us to think about how we do that as well. I am really pleased that, after my ask for that in March, I have been reassured by Ministers that they are with us in terms of trying to up the level of trials and motor that much more.

Q28 Joe Robertson: I will finish by going back to an earlier exchange that you had with my colleague around removing local authority representation from integrated care boards. That seems to me the very opposite of integration at a time when we need more. Can you say a little bit more about that? Do you disagree that it should happen at all or, if you see it as inevitable, how can we get around the issue of less joined-up working when we need more of it, particularly for social care?

Baroness Casey: I used to have a boss, Sheila McKechnie, who used to say, "It is left hand, right hand". For years I had no idea what she meant, and now I know what she means. Essentially, the left hand is doing one thing and the right hand is doing another thing, but it is the same body doing it.

From the rough sleepers onwards, which was 1998-99, I have been around a long time. The system does not always knowingly know what it is doing. I am hoping this fits into it not knowingly knowing what it is doing. As they are restructuring integrated care boards into much bigger things because they need to and want to, what happens at the same time is that something else drops off that is actually quite significant.

If you had had me here before those changes were proposed, I would have argued that local authorities were already the minnow in the sea, quite often of sharks, in this scenario. They have no equal voice. If you think of where people live and what people think, they often think their local council is theirs, if you see what I mean.

If this was the Home Affairs Committee, you would have had me saying, for years, that coterminosity between public services would mean something to the public and it would make running those public services more straightforward. It would be the same in crime as it would be in health.

You have the police service potentially restructuring. I know this is not mission critical, but you have these two big giants. You have health,



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which is a giant, and then you have something like the cops, who are also giants. They are politically sensitive and they have a higher profile than what you can do around local government.

My worry, the continuation of my worry, is that local government is not just a key partner for which you can decide whether it is going to be one of 15 on your board in the world of health. This is what my colleague over there was talking about. There are 20 people on a ward who cannot be discharged. Whose problem is that? That is now seen as the local authority's failure, rather than our failure to brigade ourselves, organise ourselves and sort ourselves out so that it is all of our problem.

The acute trusts run the show, and local authorities are bit parts that get the crumbs that fall from the table. Until that psychologically changes and they are seen as equal partners, I cannot see how you reform all of this, including social care.

Chair: I will disagree with you and say that that is mission critical. Thank you very much for saying that.

Q29 Dr Cooper: You have answered my question, really. I will just see whether we can dig a bit deeper. What are the main reasons for the relationship between the healthcare service and social care? Give me one or two. You have given me the power disparity. Why do health and social care not work better together? It is clearly a no-brainer. In your vast experience, why do they not work better together?

Baroness Casey: You cannot do a left shift unless you have met your elective waiting time targets. I completely understand that. I understand why, if you are in central government and you are trying to get waiting lists down, you do not let anybody do anything other than waiting lists. To quote a colleague, people are being waterboarded in the back of some room to meet the waiting list targets, while I am saying, "What are you doing about the left shift into neighbourhoods?" That is the reality of politics. It is the reality of Government. It is the reality of local government. It is the reality of life.

Occasionally, you ask somebody like me and others to say, "How do you find a way through it?" These people are not bad people. The people trying to get waiting lists down are good people trying to do the right thing because there are loads of people who want waiting lists to go down. The people trying to do the left shift are also good people, but over time you want to be able to do both.

I am not sure that people set out not to get it right. We have seen enormous numbers of places where good practice gets you closer, but quite often that good practice gets you to the co-location of teams in the same portacabin, which is slightly different from those three teams doing one thing together. It is one bit of the hospital doing one set of assessments for step-down or discharge, another bit of the system chasing people out of the hospital as quickly as possible—God love them,



what a job—in order to let people come through, and a third bit of the system being the local authority's social care, which has its own rules, its own datasets and its own way of doing assessments.

The good practice there is that they are all in the same place and are able to talk about the same patients and members of the public in the same way.

Q30 Dr Cooper: I hear you. Reflecting on what you said, the deep and fundamental divide is around central Government direction on where you put your money, emphasis and resources. At the moment, it is on getting waiting lists down. It is very difficult to look at other things in the system while that is the emphasis. Is that a fair reflection?

Baroness Casey: I would point to the domination of the acute trusts and what they are trying to deal with. Remember, I do not want them not to exist.

Dr Cooper: We all need them when we get sick, yes.

Baroness Casey: I am a member of the public, and therefore I am very clear about the NHS. I am very clear on how beloved it is, how needed it is and how it has stood the test of time. It is something that we think will always be there. I do not want to be overly negative about it.

Q31 Dr Cooper: No, I understand. We will all need an acute trust if we are sick. We do not want a public health doctor if we are having a heart attack. In order to get to where we want to go, which is the NHS and social care working together as we need them to work together, how do we fix the fundamental problem that you have identified? Is it funding flows?

Baroness Casey: It will be a mixture of things. This is one of the big questions that we are responsible for answering. I am probably not completely ready to give you the answer to that now, but the direction of travel for me definitely takes us down the route of making it simpler for the public, thinking about multiple assessments, and making it clearer to the public what is going on in their lives and what the differences are. I am pushing very hard—colleagues in the Department of Health know this—on neighbourhood health. I am using the language of the NHS 10-year plan. I am very keen that we look at a left shift and how social care is integrated into that in a different way.

The other thing that I just want to say in answer to your first question is that, when NHS colleagues talk about integration, they are largely talking about integrating themselves. They are not integrating with local authorities. It is really interesting. You go along and get the presentation, and it is just very interesting. They use the word “care”. A lot of healthcare uses the word “care”, but that is not the care that allows me to get help to be fed so that I do not choke or to be showered or taken to the loo.



That is partly why we need to reset the conversation with the public about what care and health is. Paulette—I hope you do not mind my using your first name—I think back to what you said about your 25 years as a nurse and the way you described it. A lot of people in the professions and a lot of the public do not see the differences between these things and just want somebody to help them.

- Q32 **Dr Cooper:** That is a really good point. Healthcare stands on its own as a system—it is beloved, as you say—and social care does not. Social care is integrated into arguably a very strange world, which does not really look like a social care world. The local authority world looks like emptying bins and sorting out all sorts of problems. Social care is a very distinct problem from the vast majority of other local authority issues. Is it therefore reasonable to say that social care—and there were reasons why social care was put into local authorities—sitting with local authorities is part of the problem because social care is a different beast from local authorities?

Baroness Casey: That is so interesting. Maybe I am just too old. I remember when local government took over social services; I know the history of it and when it switched. Basically, local authorities are the public. They are closer to the public than any other institution. Councillors are the public represented. They stand in a very different role. It has become much harder for colleagues in local government. I am one of their worst critics and biggest allies—do not get me wrong—but we ought to be a little careful, first, in saying that health would do it any better. We know full well that it would not.

- Q33 **Dr Cooper:** I am not saying that it would do it any better, Baroness Casey. All I am saying is that the NHS has autonomy. You were talking about parity of esteem between health and social care. We all know that local authorities, unfortunately, get kicked whenever anything goes wrong. Social care is incredibly important. It needs to have good close relationships with health. Is that feasible and realistic if social care remains in the local authority setting?

Baroness Casey: Yes, it is. It definitely is. One ought to look at the voice of primary care as part of that. If you look at what is happening around GPs, neighbourhoods and community health, if you were to ask them, they might also make the argument that they do not have parity with acute trusts. The closer you get to the public, the further you get from big buildings.

I totally understand what local authorities then have to deal with, particularly when it comes to adult social care. Remember, children's social care is fully funded and fully organised. In the world of adult social care, there is a huge financial assessment. The idea of assessment is twofold for local authorities. First, they have to look at how much money we have, what our banks are doing and verify it. It is a huge process. I am not saying it is wrong. I am just saying that we forget to talk about that bit. Secondly, they have to do these assessments.



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Parity is often about culture and respect. A nudge in that direction is what I am trying to do. Colleagues in the NHS probably think it is a shove, but I am attempting a nudge.

Dr Cooper: That is interesting.

Q34 **Andrew George:** There does not appear to be any ambiguity or ambivalence in your answers so far. Why can you not produce a report now?

Baroness Casey: There are two reasons. The first reason is that I feel a lot of people have done reports more quickly and failed. We ought to be able to brigade the evidence and the solutions in a really substantive and proper way.

Q35 **Andrew George:** But 2028?

Baroness Casey: It is by 2028. Somebody sat behind me very carefully put the word "by" in.

Q36 **Andrew George:** That is helpful. You are anticipating it coming sooner.

Baroness Casey: Joking aside, we need some time, in particular, to do a really deep dive and conversation with the British public. If you look at the 21 reviews since 1997 and their predecessors, that is something that was missing. It is about what you think social care is, what you think you should be doing and what that looks like. It is not just money. It is also what we expect a citizen or a member of the public to be doing.

I did not have to look after my own parents for a protracted period of time, but I have almost family where we are looking after those parents for a very protracted period of time. The world has changed, and we need to have that dialogue with the public. I intend to do that really thoroughly and well.

The other thing is that, as you have probably gathered, some of the questions we are grappling with are big. I am worried about going too soon. Let us face it: everybody always likes a bit of restructure. Ministers and Prime Ministers arrive, and often the first thing they do is machinery of government changes. I would caution against restructuring for the sake of restructuring. I do not want to get it wrong, and it is incumbent on us to get it as right as we possibly can.

Q37 **Andrew George:** One area that you acknowledge is wrong is the workforce in terms of pay and conditions, and—my colleague Danny Beales will come in and ask about visas in a moment—the balance between home-produced care workers and recruitment overseas. What are the main fault lines there, if we are to have a workforce that is capable, competent and secure enough to be able to provide for the future, particularly if you are looking decades ahead to ensure that we have a resilient service?



Baroness Casey: The Minister responsible for that area of work is the next person giving evidence. He has made huge strides in it. It is for Minister Kinnock to answer that rather than me. I did feel some relief to know that there is a fair pay agreement. There is £500 million allocated to it. Change will come during the time that we are doing this review. That feels like one of the things that need to be got on with, and the Government are getting on with it. That is good. I have boxed that off as something—

Q38 **Andrew George:** Let me just interrupt. Half a billion will deliver a 20p an hour pay rise?

Baroness Casey: What the social care commission is trying to do is to look at what the overall system, if there is going to be one system, looks like. Within that, what would my starting point be? It is a bit like when we did the troubled families programme and before that the family intervention programme. We did that under the Conservatives and a version of it under Labour. The starting point—I regret not doing it now—was that we had people called family intervention workers who were not quite social workers, but they had no professional qualification. There was no register of them; there was no training of them.

One of the first starting points that you could do would be to try to carve out an actual profession. We could use some of that money to put them on the path of status and moving in the right direction. There are things that could be done that do not have to wait for big changes.

Q39 **Andrew George:** It is not just pay, of course. A lot of domiciliary services require paid travel time; they have to make sure the care is provided in sufficient quantity and they are not rushed through that; they have to be able to park somewhere nearby to take equipment. Presumably, you are going to be looking at all of that and making recommendations in terms of both the pay and the conditions in which they are operating.

Baroness Casey: The Government are already looking at that area of work and are already making changes.

Andrew George: You are satisfied.

Baroness Casey: We will double-check along the way, but so far, to be fair to them, they are the first Administration in a long time to try to look at those sorts of issues and to do something about it. The fact that zero-hours contracts will go out the window for care workers is a first, and I am very grateful for that on behalf of anybody who has had to have care workers come into their home.

I am not trying to avoid your question. I am just trying to say that the Government have a work programme. They need to get on with that work programme. We are running in parallel, trying to figure out what reform should look like. We agreed with the previous Secretary of State, the Minister of State and the new Secretary of State that they carry on



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with their work according to the manifesto and all the commitments that they have laid out; we run in parallel trying to figure out some of the difficult questions; and we collaborate.

Q40 Andrew George: Moving on to unpaid carers, you have highlighted that the burden is growing largely, you are suggesting, because social care just is not able to perform. What is your latest assessment in terms of what is required in order to provide family and other carers sufficient backing so that part of the social care economy does not simply fall over?

Baroness Casey: I am really conscious of time. What is very interesting about the history of what we call social care is that we—all of us collectively and previous Governments—have had a go at doing certain things to alleviate specific problems along the way. Addressing unpaid carers is a good thing to do. There are other areas that we have talked about today that I would put in that same category.

It is not like everything is terrible and nothing is working. There are some things that are okay and some things that are working. They may not just be good enough. I must make sure I say that. There are countless colleagues and volunteers all around the country doing unbelievable work every single day, who must be thinking, "What on earth is Louise on about? Calm it, Casey". I just want to be clear about that.

On unpaid carers, it is really interesting that it goes into the stocktake. On the whole, none of us wants to be a burden and we want to look after people. We want to look after our family, our friends and, some of us, strangers. That is humanity.

Over a period of time, a whole thing has happened. People have lived for longer, which means it is trickier to provide that level of care. We have seen a withdrawal of what we would have thought of as care services from families and communities. We have done some propping up with good things such as carer's allowance. I have to say that an almost godson of mine works in a CAB as a leading adviser. He says, of all the people who walk through the door, when somebody says, "I need help with carer's allowance", that is the one where they all back off and think—he is called little John; he is huge; he is about six foot tall—"We must get John to do it because he is the only one who can do it". These are good things, but we could make them easier.

My cry, really, on behalf of carers is that they need things such as definite respite. There are some practical things that seem impossible, and we could be better at that within the existing resources.

Q41 Danny Beales: Good morning, Baroness Casey. I have had the pleasure of visiting a number of care providers in my constituency in recent months. I must say that visa changes are the issue that they bring up first and foremost with me. You have held a lot of conversations and engagement. What feedback or concerns have you heard about changing migration rules and the impact on the quality of care and staffing? In



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particular, what has been raised with me is that staff come over on visas; they are trained up after a number of years and they become expert; they are not able to be kept beyond a handful of years; and they leave service. It feels like a brain drain away from social care. What have you heard? What views do you have about the visa system? Would you support a visa for the whole social care system rather than one linked to employers, which can also be open to abuse?

Baroness Casey: First of all, it is a problem that is inherited as a busted system or no system of social care. It is a specific symptom of something much bigger, which your colleague asked about earlier. What is our approach to care workers? How should they be paid? Are they on zero-hours contracts? Are they paid to move between places? It is part of a much wider issue of care workers.

We have picked up in some areas that people are concerned about visa changes. I am sorry to be utterly blunt, but I have also picked up that the people who are unhappy with those visa changes will say that there is a problem with those visa changes. I just have to be really open about this. The people who do not like the visa changes will say, "This is an issue". There are other genuine areas where visa changes may make it really difficult for care homes or domiciliary care providers.

My job in the middle of this is to be pragmatic and sensible about the way forward, but sometimes politics gets in the way.

Q42 Danny Beales: Do you have any emerging views in your initial report about this area? Should they align with health visas and the approach in healthcare?

Baroness Casey: No. I have other views about what we should do in terms of visas, but that is my personal opinion. What I have to do in this job is manage what is ahead of us and try to make the best sense of it.

Should we have people who want to be care workers who are 16, 17 and 18? If someone is a care worker at 17, she should be able to be—it is always a she; why is it not a he? I will come back to that another day—to be the chief nurse of the local hospital. We are so far away from that being a reality. I would rather we started there.

How would you create a sense that this is a really decent job for people to do? They gain skills; they have qualifications; they are registered; they are DBS checked. It is an honour to look after somebody who is either disabled or frail. It is an honour. I worked directly with people when I was homeless—

Q43 Danny Beales: The honour that those people have who are caring is not able to be continued. They are not able to continue to care because of the structure of the visa system. They want to. They are expert after three, four or five years, but they are not able to stay in the care system, and they leave. Is that not a problem?



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Baroness Casey: As you know, that is right now a question that is above my pay grade and I do not intend to get into it.

Q44 **Danny Beales:** Will your initial report say anything about the changes that are happening and the impacts on the service now?

Baroness Casey: We will assess, as we move into our autumn and winter report, whether there are legs in that or not.

Q45 **Chair:** Can I come back to a couple of things that you have discussed, particularly around local authorities? As you know, unitarisation is going on; strategic authorities are being pulled together. There is a lot going on in the local authority space at the same time as a reorganisation in the NHS. Meanwhile, this commission is doing its work, but at the moment you are the submarine. At some point you will fully emerge, and we are excited for it. As you know, this Committee has been pushing on this from day one. I share your concern about left hand, right hand, but in fact there are three hands: you are the third.

Can you comment on the ability of the Government to understand how this needs to join up and what effect the changes in the local government Bill that is being put forward might have on this? What are the risks and the opportunities that you see?

Baroness Casey: As I said earlier, I am a great believer in named places. I am not somebody who likes the word “place” very much, but I like to know who I pay my council tax to and I can associate myself with that. If you asked the public that, they would probably say the same thing.

If you look at social care, an individual or family has to deal with the district council when it comes to housing, with the county council when it comes to social care, and then health is somewhere else. That is quite complicated, and I would really have liked—I still would like to see this at some point, when the reckoning happens—us to have been much better at coterminosity.

Q46 **Chair:** That is not happening, is it? In my own area, the health board is not going to be coterminous with any of the larger authorities.

Baroness Casey: Some of the local government reorganisation will be better for social care. Bringing housing into social care or social care into housing can only be a good thing. I cannot see that that is a bad thing. Changes such as those in local government reorganisation will be really powerful and good.

I was up in North Yorkshire. We were there. They went early with the unitary. They have got it right, or believe they have, and nothing that I could see made me disagree with that. I was very struck by how they have reorganised adult social care across North Yorkshire with all the districts integrated. I know it is still early days—they are only a couple of



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years into it—but it gives me hope that that could be a really good way of playing to the best of local government reorganisation.

Q47 **Chair:** What I am trying to get to is that there is a lot of uncertainty in the NHS and in local authorities. Are you seeing any of that play out in social care, as you go around the country?

Baroness Casey: We are used to uncertainty. The NHS is one of the most restructured entities, but it carries on. It pretty much carries on in the way that it has always carried on. At the end of the day, local authorities are elected by the people who elect them, and they will carry on. That connection with the public, particularly for colleagues in local government, will remain incredibly powerful.

Q48 **Chair:** As you know, the vision for how this is going to work from Government is that health and wellbeing boards are going to suddenly have this power to bring everyone together. Do you have faith that that will work?

Baroness Casey: That is one of the things we are going to look at carefully. I do not really want to make restructuring recommendations, if I am honest.

Q49 **Chair:** That is the plan. That is in the Bill.

Baroness Casey: It is in the Bill. I do not particularly want to come across that in a year's time and say, "Well, that is all wrong". Do you know what I mean? That would just be false.

Q50 **Chair:** That is sort of my point. We have a chance to warn them that this is not the right path to go down. For example, we have an amendment down to the Bill saying, "Do not remove local authorities from ICBs because we think that is a strategic mistake, knowing where you are headed". It is very helpful that you have clarified where you are headed. Are there other things in the Bill that we should be pushing on to clear the path so that, when you report, this is not an inadvertent thing we have made more difficult?

Baroness Casey: I could probably go away, if that is okay, double-check my homework and come back to you if I think there is something else that would be helpful. I will also do that directly with colleagues in the Department of Health.

My thing about the local government one, on the ICBs, is that it is as cultural and symbolic as it is real because you can make health and wellbeing boards work. You can get collaboration between colleagues in local government and colleagues in the Department of Health, but it takes a mind shift.

I will leave you with this thought. The world of social prescribing has become a thing, and everybody really likes it. I am sure I would like it too, particularly if I was on the receiving end of it. There is a part of me that looks at that and thinks, "Is that social care?" There I am, sat next



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to two volunteers in Shrewsbury who are running a loneliness project. Their main referrals now are from social prescribing. They are people who are lonely, who have mental health problems and who need things to do in the community. That is where they are getting their referrals from—no money, but referrals. People can make that kind of cultural shift.

Maybe I am getting old, but we sometimes go down the path of, “I thought about it and it is new, and therefore it will work”. We ought to check what is happening in the room next door, whether somebody has done it already and whether there is a better way that they do it differently. That is all I would say.

Q51 Chair: Linked to that is the funding. Again, local authorities are very strapped for cash. They used to commission many of these services. They now cannot. GPs are seeing the fallout. They are trying to socially prescribe things. We are in a vicious cycle.

I wanted to drill down on the constraints because the constraint that you have is to stay within the existing spending plans from Government. Meanwhile, as you yourself have pointed out, there are people who are spending tens and sometimes hundreds of thousands of pounds on their care. The overall quantum that is being spent on social care by the public goes far beyond what Government are spending on social care because of how much the private sector, as you have said, is involved.

When you are looking at the settlement that you are moving towards, are you just focused on what Government are spending or are you looking overall at how much the individuals of our country are spending on this? Are you going to be coming up with a funding settlement that takes all of that into account?

Baroness Casey: I will be careful about using the expression “coming up with a funding settlement” because we need to have the big conversation with the public about appetites across the board. It is an independent commission, but it has to work within the current fiscal rules and guidelines. We need to be careful about over-raising expectations. It has to be very managed.

When we looked at what evidence and information is there, the bit that I found quite interesting is that there is not a lot of information historically that has been gathered about precisely what you have just talked about. We are dependent—by “we” I mean the Department of Health as much as the commission—on a private organisation called LaingBuisson. I can only remember it because it has such a nice name. Essentially, they are the people who can tell you what is happening in private care homes, not anybody else.

When you start a review like this and you know lots of other good people have looked at it before, you go looking through all of the cupboards to try to work out what they know and how they know it.

Q52 Chair: What we know from our “Cost of Inaction” report is that there is



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very little out there in terms of actual evidence.

Baroness Casey: There is very little out there.

Q53 **Chair:** In fact, one of our recommendations for you guys was, "Can you go get it?" It sounds like you are trying your best.

Baroness Casey: We are. I thought there would be greater financial modelling about what the population might require and need as time went on. We know that we have people in hospital who we should be discharging and what not discharging them costs us. I am making it sound slightly more extreme than it is, but it did not feel like there was a lot more, which is another reason why we have had to commission and take bits of work.

Q54 **Chair:** Specifically, I just want to understand, for my own expectation management, what is in scope and what is not. For example, we are looking at personal accounts that people could build up over time to pay for their social care or an insurance model.

Baroness Casey: Everything is in scope.

Q55 **Chair:** Is everything in scope? It is possible that you will look at all these as solutions.

Baroness Casey: Everything is in scope, yes. Partly, that is why the next job is to do this big conversation with the public. Also in scope is finding out what their appetite is for helping themselves.

Q56 **Chair:** Understood. You are having the conversation with the public; you have had the cross-party talks. You are very good at answering direct questions, and so I am going to ask you one. Do you feel there is genuine political will, not just right now or as a sticking plaster, in the medium and long term to solve this problem?

Baroness Casey: Well, the history shows that, when it gets close, the answer to that question is no, from death taxes to dementia taxes. It is largely around the money. There does appear to be this sense that sometimes what you do is to state the bleeding obvious.

We have two big things happening. First, we have the reckoning around the population. People now know that they are looking after or being looked after as they get older, and it does not feel good enough. The number of people now who have dementia, the number of people over the age of 65, the length of time that people are still with us after 85—they are the fastest growing group—and the types of comorbidities and illnesses that they have have become in much sharper focus, which is very helpful politically.

The other one that is really interesting and challenging is what is happening with working-age disabled, to use the shorthand. You can see just this exponential growth of people who self-define in that way: 16.8



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million of us would now say that we have either a long-term condition or a disability. That is between a quarter and a third of the population.

When you are dealing with those long-term but seismic changes, that is like a mirror. Holding it up and providing, God willing, some solutions to it might make this easier. It has to be a no-fail operation. That will be hard to do, but everybody wants to do it, Chair.

People can see that this is going to happen. There are too many people who are too worried about either working-age adults who should be working or, as they get older, people who today are on one of those wards that I can think about, which we were in only a couple of weeks ago, having a terrible time. It is time that we did something about it.

Chair: We will end it there because we need to talk to the Minister. Thank you so much, Baroness Casey. Thank you, Sarah, for coming as well.

Examination of witnesses

Witnesses: Stephen Kinnock, Ben Dyson and Emily Roche.

Q57 **Chair:** We have the Minister responsible, Stephen Kinnock. Would you mind starting by introducing yourselves and what you do?

Stephen Kinnock: Hello, I am Stephen Kinnock. I am the Minister of State for Care.

Emily Roche: I am Emily Roche. I am the director for adult social care workforce and policy at the Department of Health and Social Care.

Ben Dyson: I am Ben Dyson. I am the director leading on adult social care strategy, funding and integrated care.

Q58 **Dr Cooper:** Good morning, everybody. I want to ask about the national care service. We heard from Baroness Casey this morning around her commission and how that is progressing. Minister, could you give us an update from your perspective around your vision for this service and any further detail that you can provide at this time?

Stephen Kinnock: Yes, thank you very much for the opportunity to speak with you today. We are absolutely committed to creating a national care service. Of course, it needs to be fleshed out and further defined.

As things stand, I see it as having three main planks. One is around the quality of care; one is around choice and control, so the person who is the recipient of care has that sense of choice and control; and the other is about better and joined-up services, particularly around integration. You could summarise it as quality, control and integration. If we can get to a national care service that is based on those three driving principles, we will be in a much better place.



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The Government have not been sitting on their hands and waiting for Baroness Casey to flesh out those three core principles. We have been working very hard by delivering £4.6 billion of additional funding for local authority social care: £1.6 billion this year, rising to £4.6 billion by 2028-29. We are delivering the fair pay agreement. We have given unpaid carers the biggest increase in carers allowance since the system was created in the 1970s. We are working at pace on the digital social care record. We have a neighbourhood health strategy, which is primarily about preventing avoidable admissions and getting services far more joined up at a local level, upstream. There is a range of work that is ongoing while Baroness Casey is developing that fundamental strategic rethink.

Q59 Dr Cooper: Thank you, Minister. That is a good, succinct summary to start with. My colleagues will come in on various parts of that. My question is around integration. When Baroness Casey was here, we were discussing the issues that we all are aware of around the health service and social care working together effectively. Could you discuss what the Government are doing at the moment, notwithstanding the Casey review, to address those issues and structural divides and how we are moving forward, particularly in light of, perhaps, the NHS Bill, ICB restructuring, local authority devolution and reorganisation? Perhaps you could talk about the steps that are being made at the moment.

Stephen Kinnock: I listened with interest to the discussions about ICBs and the role of local authorities. The guiding principle for everything we do is integration. It is almost as if you could talk about a fourth shift. In the 10-year plan, we talked about hospital to community, sickness to prevention, and analogue to digital. There is a fourth shift, which is from fragmentation to integration.

Q60 Dr Cooper: That is arguably quite difficult, Minister.

Stephen Kinnock: It is difficult to do. The old saying is "culture eats structure for breakfast". You can do as much restructuring as you like, but, fundamentally, we have to change the culture. The culture is that there is too much dominance by acute trusts. We have to do the left shift. That means giving local authorities a really strong voice on adult social care. It means giving GPs a strong voice on primary care. Community health providers have to be at the table. That is why we have our neighbourhood health strategy, and that is going to be driven by the health and wellbeing boards.

Q61 Dr Cooper: Just coming to that point—my colleague raised this earlier—sometimes the devil is in the detail. One of the issues that Baroness Casey did raise is that within the NHS Bill our local authority colleagues are no longer statutory appointees on integrated care boards. Given what you have said about the fourth shift being integration, is that something that should be reconsidered?



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Stephen Kinnock: The NHS Bill creates much stronger integration between ICBs and strategic local authorities. There is going to be a very strong role for local authorities, articulated through strategic local authorities and the mayoralities in particular. That is about scale. It is about them enabling a much larger population oversight through this integration. That will be a good thing in terms of providing better strategic commissioning and more joined-up services.

At a more operational level, at the coalface, the health and wellbeing boards are responsible for bringing together all the key players. Local authorities are absolutely central to the health and wellbeing boards. They will be driving forward the integrated neighbourhood teams so that we have those joined-up integrated services at neighbourhood level.

Q62 **Dr Cooper:** The health and wellbeing boards have been pretty patchy to date in terms of how effective they have been and how much power they have had. Arguably, the structure that you are describing is, in effect, social care sitting in the unitary authorities and reporting into health and wellbeing boards, and then health and wellbeing boards having some sort of reporting—TBD—into integrated care boards.

That feels like we are removing that direct strategic input from the social services themselves. I absolutely appreciate the point about strategic authorities—that is very welcome—but social services, as I understand it, unless you want to tell me differently, will sit at a unitary authority level.

Stephen Kinnock: The local authority voice in terms of the strategic planning, as articulated through the NHS Bill, will be at strategic local authority level—unitary authorities, as you describe them.

The key point is how you get the best possible connection between strategy and delivery. Our view is that you do that with a strategic overview of a population size of up to 1.5 million, which is what we are going to do by giving that voice to strategic local authorities.

Q63 **Dr Cooper:** Just to be clear for the people listening because it can get a bit confusing, what we are talking about are unitary authorities, but strategic authorities are with a region. For example, in my area we are going to have Sussex strategic authority and four or five unitary authorities. They are different. A strategic authority is not the same as a unitary authority, which is the unit of delivery where the social care services will sit.

Stephen Kinnock: Yes, that is right. We are saying that the strategic authority level is where local government will have its voice in terms of the overall planning and strategic development.

Q64 **Dr Cooper:** Forgive me, Minister, but how will that work for social care? The directors of social care will sit in the unitary authority. The health and wellbeing boards will sit in the unitary authority. At strategic authority level, where is the social care voice?



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Stephen Kinnock: That will be through the mayoralty, which will have the overall strategic role of bringing together all the unitary authorities. I do not think that we are prescriptive about who the mayor should appoint to that planning and strategy process. That is going to be up to her or him.

Q65 **Dr Cooper:** It feels like there might be some technicalities, which I appreciate, but, to be very clear again, the strategic authority will have a mayor—for the most part, granted, not in all places at the moment. Then there will be a board, which essentially will be the unitary authority leaders and deputy leaders. They will hold the mayoralty to account. That is political leadership—great—but there is a strategic piece here, where the directors of social care will sit in the unitary authorities. Are you suggesting that there will be a social care director in the strategic authority?

Stephen Kinnock: Yes.

Dr Cooper: Thank you for clarifying that. I have no further questions.

Q66 **Joe Robertson:** Forgive me, Minister, but it seems like your plans are going to make the situation more complicated. You say that integration is crucial to delivering better social care, and I agree with you, yet you are removing local authorities from integrated care boards. For my area, the Isle of Wight council will lose its position on the integrated care board, but retain all of the responsibilities it currently has. How can that possibly lead to improvements? In my view, it could end up taking us backwards.

Stephen Kinnock: We will have a clear connection between strategy and delivery. If we get the overall strategic work right through the strategic local authorities, and the very clear guidance that we have given on neighbourhood health that the health and wellbeing boards have to have that key role—they have to have the relevant local authority social care leadership involved in those, with a strong voice—alongside the other key players in terms of neighbourhood health, you will have that pivotal link between the strategy at the broader population level and how that filters down through the system.

You can argue that there should be a middle piece, which is the ICB and the local authority being on the ICB. I would say that it is probably best to have fewer layers rather than more layers. What we are doing here is having that key strategic development role and then the direct connection through to the health and wellbeing boards through the local authority role on the health and wellbeing boards.

Chair: I feel like an organogram would be useful at this stage.

Q67 **Ben Coleman:** Thank you, Minister and your colleagues, for coming today. I have to say that this little bit is desperate. There is absolutely nothing from the Department that suggests that it really understands how local authorities work. My own experience of having sat on an integrated care board for three years is that the NHS is not interested in



how local authorities work. It makes these large statements—"We are going to get strategic authorities to do all this"—when you do not have the strategic authorities, or, in London, you have a strategic authority that has no responsibility or budget for social care at all. It all sits with the local authorities in London.

There is no adequate response that we have received as a Committee to the questions we have asked again and again about how you are actually going to do this. We are still waiting for a response from Penny Dash, having raised this at our last Committee meeting. If you look at consistent meetings that we have had where we have raised this, we are not getting any comfort from the Department of Health and Social Care that you understand local authorities and that this is any more than a paper exercise that will fail.

I will come to London specifically, because I am the Member of Parliament for a London constituency. Remember that London is 16% of the population of England. You have a mayor, as I say, who has no powers in the area of social care. There is no structure between the local authorities in London and the mayor to enable him to exert the authority that you are planning, and yet you have come up with this idea. We have no details of how it is going to work.

Equally, you have a local government reorganisation that is taking place, where strategic authorities are due to come into being, but that is going to take years and the Bill comes in much more quickly. What is going to happen in the interim?

We have a system that works. I notice that neither of your colleagues here today—Ms Roche and Mr Dyson, you can come back at me—has a local authority background. I do not know how many people in the NHS have it. My contention is that the NHS does not get local authorities. It constantly seeks to dictate to them and this is the latest example of that. Unless we get this right, as Louise Casey was saying, we will not succeed, not just in making social care better, but in a whole range of other areas. Are we going to get real, concrete detail of how you plan for this to work, including in London, where there is no structure in place that is suitable for this?

Stephen Kinnock: I will bring Ben and Emily in now. The one thing I would add is that it is really important to underline the importance of what we are doing on neighbourhood health. That is about bottom-up organic change. That is about changing the culture. There could not have been stronger and clearer guidance, in my view, from the Department on how we are going to design, develop and deliver neighbourhood health. I co-chair the neighbourhood health oversight board with Dr Penny Dash, and I am like a broken record on that board. We must ensure that local authorities are front and centre of the way that we do neighbourhood health.

Q68 **Ben Coleman:** But they are not.



Stephen Kinnock: I have been on visits. I went to the Washwood centre in Birmingham.

Ben Coleman: That is brilliant. That is terrific.

Stephen Kinnock: It was excellent because the local authority played a crucial role in the design and development of adult social care services.

Q69 **Ben Coleman:** We are absolutely as one on that and I really respect the work you are doing there. It is tremendous, but in London the plan that the Government have come up with does not work. I have been talking about this for two years now, since one of your colleagues was in front of us. In London, you need to change fundamentally the relationship between the mayor and the local authorities. If you are going to do it in social care, you are going to want to do it in lots of other areas, and I am not aware that this has been discussed with London leaders; I do not know whether it has even been discussed with the mayor. We have no detail of what is going to happen on something that affects 16% of the population at least. There are other parts of the country that will have similar concerns. Mr Dyson, I see you are nodding here.

Ben Dyson: On the question of social care leadership in the Department, Emily and I are members of a team that also includes Sarah McClinton, the chief social worker, with extensive experience in local government, and Iain MacBeath, who has direct experience of running social services in a local area. Although I do not have personal experience of running social care services, I work very closely with colleagues who do. We have a very close relationship with directors of adult social services up and down the country. I will not get into the territory of the debate about who should be represented on ICBs.

Q70 **Ben Coleman:** Why will you not get into that? Is that not the fundamental point here?

Ben Dyson: I do not want to prejudice the parliamentary debate that will take place on that.

Q71 **Ben Coleman:** You will not be prejudicing parliamentary debate. You need to spell out what you mean, surely.

Ben Dyson: The 10-year health plan is predicated in part on the principle that real change happens largely at a place level, as Baroness Casey described earlier. The place level is essentially the area represented by the unitary authority and the health and wellbeing board. ICBs and strategic commissioners have an important role, but much of the detailed service design and decisions about how you use resources differently, how you partner differently with the social care sector and how you involve unpaid carers and so forth happens at a much more local level.

Q72 **Ben Coleman:** Forgive me for interrupting you. That is not how it works, in my experience. ICBs are going to commission services that local authorities are going to have to provide. I would have thought that local



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authorities need much more representation, not a reduced representation, on integrated care boards to have some sort of parity.

Ben Dyson: Local authorities are largely responsible for commissioning social care services, with the exception of continuing healthcare.

- Q73 **Ben Coleman:** A lot of the funding comes through the better care fund and the budgets do not match. The timings of the budgets do not match for that. For example, local authority budgets work to one timetable. The better care fund of the NHS works to another. I am talking from direct experience here. Are you looking at changing that?

Ben Dyson: Yes.

- Q74 **Ben Coleman:** You are, so the timing of the budgets would coincide.

Ben Dyson: I completely agree that we need to align planning timetables and planning systems. The Better Care fund is an excellent example of that. I completely agree.

I would stress, though, that the majority of social care funding comes through local authorities. ICBs are largely responsible for commissioning healthcare services. The health and wellbeing board is the place where ICBs, local authorities and indeed social care providers and voluntary partners come together to agree, "What is the way in which we are going to design and deliver better services for people with frailty or people at end of life?"

- Q75 **Ben Coleman:** So it does not matter whether you have a strategic authority on the integrated care board or not. That is irrelevant, because it is all going to be health and wellbeing boards that decide.

Ben Dyson: I do not think that that is quite what I am saying. I am saying that both are important.

- Q76 **Ben Coleman:** Why is it important to have the strategic authority on an integrated care board if it is all going to happen through health and wellbeing boards?

Ben Dyson: I am suggesting that the 10-year health plan is predicated on the principle that much of the detailed service design happens at that place level.

- Q77 **Ben Coleman:** Does the health and wellbeing board make a proposal to the ICB and it takes the decision?

Ben Dyson: The ICBs are responsible for saying what those local providers should be responsible for, so what the population health outcomes are that a group of neighbourhood health providers is responsible for.

- Q78 **Ben Coleman:** Who is responsible for budgets? Is it the health and wellbeing board or the ICB?

Ben Dyson: The ICB allocates the budget.



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Q79 **Ben Coleman:** In London you will have the Mayor of London allocating the budget for 41 local authorities. Is that right?

Ben Dyson: Local authorities are responsible for how they use the budgets that are allocated to them.

Q80 **Ben Coleman:** Let me ask you a different question. Have you looked specifically at London and the way it is structured at the moment? Have you looked at it? If you have, have you thought about how to address the challenge? Have you looked at it—yes or no? It is only a yes or no question.

Ben Dyson: Yes.

Q81 **Ben Coleman:** What problems have you identified as a result of looking at London particularly, with the relationship between the mayor, who has no health responsibilities except a little bit for public health, and the local authorities, which have total social care responsibility?

Ben Dyson: The challenges we are describing exist both in London and in other areas.

Q82 **Ben Coleman:** What have you looked at for London, though? What are you looking at where strategic authorities, which do not have any responsibility for health, are going to be agreeing the budgets for local authorities, which are going to be removed from integrated care boards? Have you recognised that problem and how are you planning to address it? Are you planning to create structural changes in the relationships?

Ben Dyson: I am going to have to come back to a policy set out in the 10-year health plan, which the Minister has described, that is predicated on ICBs giving resources to local healthcare providers, Government giving resources to local authorities and using the health and wellbeing board to bring those people together.

Q83 **Ben Coleman:** We have all read that. I was not asking that question. I very much appreciate that you are striving to answer the question as best you can, and thank you for that. The question is that there is a particular challenge that does not seem to be explicitly addressed, which is the fact that either you do not have strategic authorities in place or you have them in place but they have no health powers. That is going to very much change the balance with the local authorities, which are not aware that they are going to, in effect, have someone else sitting on the board, taking decisions for them, who does not have formal authority in this area. Have you recognised that and are you doing anything to address that?

Ben Dyson: I believe that the Government and the Department are addressing that.

Ben Coleman: Can you write to us about how you are specifically addressing that? I most appreciate that.



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Q84 Chair: I am so sorry, but we really need to move on. Can I just endorse that line of questioning? Minister, come on. I mean, come on. What was your response to that exchange? My colleague is absolutely correct. We are a broken record on this issue over and over again. All we want are some quite basic answers. This should not be rocket science, yet we do not get basic answers, whether it is on the Floor of the House or here.

Would you undertake to write to us this week? This should have been already thought through. This is not new stuff, I hope. We need to understand so that our colleagues on the Bill Committee can relay to the Bill Committee whether it should back our amendment that we have put down that you should not be removing local authorities from boards. From where I am sitting right now, we have yet to hear a cogent argument for why this should happen.

Stephen Kinnock: Yes, absolutely. I will do that, Chair.

Chair: I am assuming yes.

Stephen Kinnock: That is all very clearly noted.

Q85 Alex McIntyre: Thank you for your answers so far, Minister. The commission has been told to operate within existing financial and fiscal constraints. That is not realistic, is it?

Stephen Kinnock: There are two points there. One is the phase 1 and what we can do before an overall rewiring of the way in which adult social care is funded has been agreed. Those phase 1 recommendations and changes need to take place within the existing fiscal envelope. That may well involve some reprioritising of resources though, as Baroness Casey was saying.

The fiscal envelope for adult social care is going to be the No. 1 challenge that needs to be addressed in phase 2. That is of course where we are seeking to build a national consensus and cross-party consensus, so that this issue of how to fund adult social care does not become a political football and get weaponised. Our party is just as guilty of doing that as others. We have to ensure that that does not happen. To clarify, when we talk about the fiscal envelope, phase 1 is current and phase 2 is about changing the fiscal envelope, potentially completely.

Q86 Alex McIntyre: Are all options on the table for that phase 2 report?

Stephen Kinnock: Yes, absolutely. There are many ways of skinning that particular cat.

Q87 Alex McIntyre: Given the emergency that we are currently facing in the social care sector, do you think that the timescales involved with dealing with that funding are the right timescales, or should we be accelerating that?

Stephen Kinnock: As Baroness Casey made clear, it is by 2028; 2028 is a deadline, not a target. I am absolutely clear that it needs to be quicker. I will tell you quite clearly that I did not agree with the position that the



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Chancellor and the Prime Minister took in terms of the timeframe that was given to Louise Casey. It needs to be brought forward. I hope that we can work at pace, as and when we have a new Prime Minister, to ensure that we have the Treasury, No. 10 and the Department of Health and Social Care working in lockstep and recognising the urgency of the issue.

Q88 Alex McIntyre: ThinkLabour, I think, has published something today, and the Social Market Foundation published something earlier this year, saying quite clearly that the burden on local authorities to fund large chunks of social care is not sustainable going forward. It currently accounts for 25% of council tax revenues. Is taking that out of local authorities and funding this at a national level something that you think we should be looking at long term?

Stephen Kinnock: Local authorities were hollowed out by 14 years of austerity. The way in which this issue has been constantly kicked down the road is not acceptable. All options should be on the table in terms of how we fund it. We of course have to recognise that the public finances are in a very parlous state. We are currently paying £100 billion a year just to service the interest on our debt.

We have to recognise that the financial position has to be one that is properly costed and funded, and that we are not at all writing a blank cheque here. I hope that we can bring recommendations forward on how to fund this and build that cross-party consensus, so that, ideally within this Parliament, we have a fully funded and costed model that we can move forward on together, in a sustainable way, that will transcend the vagaries of the parliamentary cycle.

Q89 Alex McIntyre: Moving on to workforce, the fair pay agreement is not expected until 2028. We have massive shortages in the meantime. How is the Department going to deal with that?

Stephen Kinnock: The £500 million for the fair pay agreement is very much a down payment. That is for one year. It is very important that, as we move into a new and reformed way of funding adult social care, or at least into the new spending review process, we continue to deliver that pay rise for care workers.

We currently have 1.6 million care workers in our country. I want to pay tribute to the amazing work that they do. It is quite encouraging to see that the number of vacancies is going down and the number of hires is going up. That is not going as fast as we would like to see, but there are some encouraging signs that we are turning it into a more attractive profession.

Q90 Alex McIntyre: To put that into context, Minister, 335,000 people left a role in the sector last year, many of whom cited pay and conditions as the main reason for doing so. Despite the 1.6 million who are doing a very good job, we have a shortage. We have a lack of people and places.



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What can we do now to deliver that in advance of further changes down the line? I appreciate that the cavalry is coming, but what is the Department doing today to make sure we can fill some of those vacancies more quickly, not least given the comments earlier made about changes to the immigration rules? A lot of care providers in my constituency are concerned that that will mean that there will be a lot of staff leaving the sector without the replacements there ready to be hired.

Stephen Kinnock: Given the fiscal constraints that we just discussed, there is something about making the profession more attractive, valuing it and giving it the esteem that it really deserves. I believe that it should have parity of esteem with the health workforce. We are working on the care workforce pathway, which is building a career pathway for progression.

Q91 **Alex McIntyre:** When can we expect to see that?

Stephen Kinnock: I will hand over to Emily, who is our in-house expert on workforce issues. That is up and running. It is backed by £10 million in the 2026-27 financial year. We also have the assessed and supported year in employment. We have the adult social care learning and development support scheme. We are doing that pathway work.

Q92 **Alex McIntyre:** In terms of that pathway, in practical terms, for a simple MP such as me, what does that mean this year in my constituency, for people working in the care sector in Gloucester?

Emily Roche: The care workforce pathway is already out there. It is being delivered by our delivery partner, Skills for Care. For the first time ever, it sets out the set of roles that you can expect to go through in a career in care, from being brand new to care, to being a care worker, to an enhanced care worker, who might do more delegated activities, through to a manager, etc. It sets out the kind of development and training that providers should make sure that people have at those levels.

As the Minister said, alongside that, the Department provides £10 million of funding for training qualifications that providers can be reimbursed for, including the level 2 care certificate. It is a first step towards what Baroness Casey was saying about having a clear pathway, paired with the FPA. We would want to build on that and keep expanding it. In fact, it was expanded to a few extra roles earlier this year.

Q93 **Alex McIntyre:** We have had the report from someone the Department knows well, Alan Milburn, reporting back to the Secretary of State and Department for Work and Pensions on the number of people not in employment, education or training. What discussions is the Department having to join those work streams together? It seems that there is a real opportunity here if we have a sector with lots of vacancies and a lot of young people who are not in employment. If we are making the sector more attractive, how do we tackle that group particularly?



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Emily Roche: We are in discussion with DWP and the review team about that group. I cannot share any more at the moment about where we are getting to, but I could come back to you with further details on that in due course.

Q94 **Alex McIntyre:** Do you know when we might have more details on that? Are you able to share that?

Emily Roche: I do not have a date right now, but the discussions are very live at the moment.

Q95 **Alex McIntyre:** Fine, thank you. In terms of the broader workforce plan across health and care, how important do you think the future of the care workforce is going to be, not least given we are still waiting for the long-term workforce plan that has been pushed back several times now?

Stephen Kinnock: It is absolutely vital. I am very pleased that adult social care workers are within the scope of the 10-year workforce plan.

Q96 **Alex McIntyre:** Do you know when that is coming?

Stephen Kinnock: This summer.

Q97 **Alex McIntyre:** Summer 2026?

Stephen Kinnock: It is the civil service summer. It is a particular meteorological year.

Q98 **Alex McIntyre:** I will come back to summer definitions in a moment. I have quite a lot of questions to get through and not very much time because I am covering for a colleague. If we move on to carer's assessments, 73% of carers have not received a carer's assessment. Why do you think they are not receiving those assessments and what action is being taken to improve the uptake?

Stephen Kinnock: This speaks to the fragmentation challenge that we were talking about earlier. The system is too fragmented. I am pleased that local authorities are committed to modernising the so-called front door, so that first point of contact. We have launched a discovery and testing programme to look at how best Government can support people in navigating the system. We are testing prototypes, in terms of web content, now with people with lived experience. We will be coming forward later this year with a proposal to create a much clearer, more accessible and user-friendly front door to the system, where you are not being sent from pillar to post on assessments; you are getting it done in one single point of contact.

Q99 **Alex McIntyre:** There has been an important Supreme Court judgment recently about protecting vulnerable people at risk of abuse. It has overturned key elements of the deprivation of liberty safeguards framework. How are the Government making sure that people who lack capacity continue to have their rights and protections upheld? Importantly, previously the Department said that we were to get a



consultation on the liberty protection safeguards in the first half of 2026. Given we have, by my reckoning, six days left of the first half of 2026, are we still expecting that in the next week and, if not, when?

Stephen Kinnock: You will be aware of the Cheshire West ruling, which created a radically different approach to this issue. That got challenged. The Supreme Court has, in essence, overturned Cheshire West. One reason that we have not done the deprivation of liberty work that you just mentioned is that, once that challenge came in on Cheshire West, it did not make sense to launch anything until we had clarity on that piece. We now have that clarity.

We of course respect the Supreme Court's judgment. Our job now is to put that into practice. We issued public guidance on 15 June, but there is no reason at all why people in the relevant authorities cannot start immediately to adapt their systems to the new Supreme Court ruling. I know that it is a controversial issue and there are strongly held feelings on all sides.

The point I would make is that the impact of the Cheshire West ruling was to very significantly increase the backlog of cases, because it so lowered the bar in terms of the assessments that needed to be made. It led to a lot of very intrusive assessments on people who would not necessarily need that. I am optimistic that, thanks to the Supreme Court ruling, we are going to have a more effective and humane system, and get through this backlog, which is a big problem.

Q100 **Alex McIntyre:** You have just spoken about the backlog and the impact that that is having on extremely vulnerable people. Earlier this year we had absolutely horrendous news from St Andrew's Healthcare in Northampton about the alleged treatment—there is an ongoing case there so we have to be a bit careful—of vulnerable people in its care. Do you think that the Department has got a grip of some of the challenges that are facing vulnerable people in our health and care system?

Stephen Kinnock: One area of Baroness Casey's speech in the Nuffield Trust think-tank was on safeguarding. I was really pleased to see that and I am really pleased that we have acted swiftly. We have now created a National Adult Safeguarding Board, chaired by Sarah McClinton, reporting direct to me. Its first job is going to be to do a review of all the statutory guidance on safeguarding, because there clearly is room for improvement. The answer to your question is that we need, from the centre, to get much more of a grip on this. This safeguarding board is going to play a key role in that, but we also need to drive that culture change through the whole system.

Q101 **Danny Beales:** Thank you very much, Minister. To quickly follow up on your point about parity of esteem between the social care and health workforce, would that extend to parity of approach around immigration and visa rules? In the present proposals health workers have one set of proposals about indefinite leave to remain and visas, while the social care



workforce is on a completely different proposed pathway. Is that parity of esteem?

Stephen Kinnock: We hugely value the role that care workers from overseas come to play, providing such care and compassion. It is hugely appreciated and valued. It is the Government's policy to reduce our overreliance on overseas labour. We want to have a system that is really attractive to our homegrown talent and to ensure that we have adult social care being something that people who are resident in this country really want to do.

We have until 2028 to do a lot of the redeployment of people who have been displaced, because there are lots of abusive, unscrupulous employers out there. We have had 1,550 licence revocations, 35,000 displaced workers and 60,000 affected overall. Our top priority is those people who have been so badly treated by unscrupulous employers that have had their licences revoked, and who are now displaced. We have until 2028 to redeploy those people in the adult social care sector. That is low-hanging fruit that we should take advantage of.

Q102 **Danny Beales:** I agree with you on that point, Minister. Would a single national care visa help tackle exploitation, rather than people's employment and presence in the UK being tied to those unscrupulous employers?

Stephen Kinnock: I am really interested in that proposal. I know that it is something that Unison is very keen on. It has done some really interesting work on this and I absolutely think that it is something we should explore. Obviously that needs to be done in lockstep with our colleagues in the Home Office.

Q103 **Danny Beales:** Turning to making some of these changes happen, you have talked before at this Committee about the role and importance of modern service frameworks for dementia and frailty. There is one for palliative care, which you have talked to us about before. They seem to be doing quite a lot of heavy lifting in terms of delivering the improvements that we are hoping for and that Baroness Casey may be envisaging. We understand that their development is under way. How are they being aligned with Baroness Casey's review and initial findings, and what teeth will they have?

Stephen Kinnock: On dementia specifically, we are very keen to move as quickly as possible on Baroness Casey's recommendations on dementia. We want to get up from the 300-odd people doing these trials to 2,000. We are waiting for NICE to come back. I think on 9 July NICE is going to be giving its view on the donanemab and lecanemab. That is something that we want to move forward with as quickly as possible.

In terms of the modern service framework, we have done a lot of stakeholder engagement. We had a webinar with 200 key players on that just recently. We have to bring forward a very clear definition of what the outcome needs to be in terms of both the clinical treatment for dementia



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and the wraparound care that is required. That is going to be the basis for the modern service framework. We have agreed fully with Baroness Casey's recommendation that that modern service framework needs to be published by the end of this calendar year.

Emily Roche: On the modern service frameworks, as well as setting out the "what" of the outcome and the pillars of how to get there, they will also set out which parts of the system are responsible for each part of delivery and the strategy to support delivery and oversee uptake of those standards as well. They will go further than that.

Q104 **Danny Beales:** Do they speak to local authorities as well as the NHS?

Emily Roche: Certainly the dementia and frailty one, which I am closest to, is going across social care and health, and looking at all the partners involved in delivery as part of that.

Q105 **Danny Beales:** Will there be specific requirements and recommendations for action from local authorities?

Emily Roche: I cannot go as far as to say that we are going to have a definite list of actions for local authorities, but we are looking at the full set of partners involved in delivering social care.

Q106 **Danny Beales:** They are responsible for social care.

Emily Roche: Yes, so I would expect that they probably will be. I just cannot tell you right now, 100%, "Yes, I have a list" yet.

Q107 **Danny Beales:** Are local authorities engaged in the development? Is the LGA, for instance, engaged in the development of them?

Emily Roche: Yes. We have a really wide set of stakeholders. To what Baroness Casey was saying earlier about the medical model and social model, this is one of the places, in the dementia and frailty MSF, where those two are really coming together. We are debating how the two come together best for people who have these conditions.

Q108 **Danny Beales:** In terms of their development—Baroness Casey touched upon this earlier around some of the specifics—we have had concerns raised from Alzheimer's Society, Alzheimer's Research UK and Dementia UK about what the content of the modern service frameworks may be. Could you, yes or no, confirm that three key areas are going to be covered in the MSF? One is around times to diagnosis and clear standards and targets. Will that be included in the MSF?

Emily Roche: First, I will say that Alzheimer's Society and the other charities are part of our task and finish group on the MSF.

Q109 **Danny Beales:** They are very concerned and they have written publicly.

Emily Roche: I am aware of that.

Q110 **Danny Beales:** They are involved, but not necessarily happy with the



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involvement, it would seem.

Emily Roche: I am pleased to say that each of the areas that they have written to you on, which I think are around earlier diagnosis, the pathway and the push on research, are all being covered by the MSF. I am not going to commit to you today that we are going to go for an 18-week target. Going back to what Baroness Casey said, we are looking at a range of outcomes and metrics as part of that.

Q111 **Danny Beales:** My question was whether there will be specific targets around times for diagnosis, not 18 weeks per se. Will there be metrics and clear standards or targets around the time of diagnosis?

Emily Roche: We are considering them at the moment, yes.

Q112 **Danny Beales:** You are considering it, okay. On the point about pathways, Baroness Casey touched upon how she was uncomfortable about the word "pathway". Will there be specifics about what the follow-up support and the journey will be rather than generic terms such as "pathways"?

Emily Roche: Yes. The MSF is looking at, post-diagnosis, how we can have a common set of expectations as to what service users can expect in terms of ongoing treatment as well as the social support in the settings that they live in. We are looking at that fully as part of the MSF.

Q113 **Danny Beales:** Will there be specifics about what the pathway will be rather than just recommending one?

Emily Roche: I expect so, yes.

Q114 **Danny Beales:** You have mentioned access to research and new emerging treatments. Will there be clear measures to provide access to those to patients?

Emily Roche: Yes. Do you want to come in on this?

Stephen Kinnock: The MSF is a work in progress, as you will have picked up from Emily's comments, but we are absolutely committed. We have a task and finish group that is bringing together key partners from across health, adult social care, the voluntary sector, and people with lived experience. It is absolutely clear that the issues that you raise, Mr Beales, are front and centre of how we are going to get a modern service framework for dementia and frailty.

Q115 **Danny Beales:** If those are in there, if people are happy, and if this is the major step forward that we hope it is and that it has been suggested to us that it will be, there will be the importance of implementation in the system. How will the MSF have teeth in terms of its adoption? How will the dementia tsar that has been talked about and adopted have teeth? What powers will they have in ensuring that the MSF is adopted?

Stephen Kinnock: My experience of being a Minister over the last two years is that you absolutely have to have targets and metrics, and a



mechanism in place to monitor and ensure that those targets and metrics are being delivered. That is what I do across my portfolio. I have a monthly meeting with every one of the senior teams, from GPs to pharmacy, adult social care and dentistry.

The job of a Minister is to ensure that, when the system has agreed that this is the way we are going, that is the way that we have to go, and it is our job to hold the system's feet to the fire and make sure that happens. Part of this is about leadership and about culture. Defining the targets, of course, is not the be-all and end-all. You do also have to ensure that those targets do not become perverse incentives.

Q116 Danny Beales: So there will be clear targets and leadership. Will there be any reporting on the MSF that is required from delivery partners to the centre? Will there be a reporting mechanism such as an annual publication of that data? Will the tsar have any powers? Those may be mechanisms, but I would be interested in what they will or will not be.

Stephen Kinnock: I will hand over to Emily on that, but the broad point I would make is that, where parts of the system are failing, you need to intervene and provide support to make them work more effectively. I do not think it is about going around with a big stick and clobbering people on the head. It is about identifying where support may be needed where some parts of the system are doing much better than others, so that we eliminate all of that unwarranted variation.

Any MSF worth the paper it is written on has to have those mechanisms in place. You have to have a delivery plan. You have to have a monitoring and evaluation plan. You have to have a reporting back plan. I fully welcome the idea of having the dementia tsar, because that will give a bit of extra day-to-day force to the Minister's ability to ensure that there is accountability in the system, but Emily may wish to add to that.

Emily Roche: All I would add is that, at the stage of development that we are at with the MSF at the moment, having gone through the evidence base for the different interventions across diagnosis, treatment and support, those questions about how we report on metrics and the role description of the tsar are very live things that we are working on at the moment. It might be wise for us to write back to you when those things are a little clearer.

Q117 Chair: That is very helpful. Minister, can I start the last set of questions by asking you to flesh out a little the comments that you made about your disappointment that the Chancellor and the Prime Minister had pushed the date? We share that disappointment, and the urgency could not be more real. Given that the restraint in the Casey commission is that it cannot recommend things that are outside of current spending plans, what does the Treasury have to do with this anyway?

Stephen Kinnock: The Treasury had a particularly hands-on role in terms of phase 2 of Baroness Casey's work. That is fundamentally about



how you rewire the funding of adult social care, and that is where the Treasury was very keen to put in a timeframe that would, effectively, have meant that you are going into the 2029 general election with a manifesto pledge rather than having agreement much earlier in this Parliament.

The reason why I just did not agree with the Treasury's position on this is that, the closer you get to the 2029 general election, the more politically fraught and acute the debate becomes and the less likely it is that you are going to get that consensus. It was simply self-defeating, so we really need to look at that. I was very pleased to hear Baroness Casey's views today that she is ready to move in a more accelerated fashion, and I would fully support that.

Q118 Chair: To that end, do you believe that there is the political will to deliver the changes needed as quickly as possible?

Stephen Kinnock: I am 100% convinced that there is.

Q119 Chair: I believe you do, but that is not really my question, and I think you know that too.

Stephen Kinnock: Yes. I think there is very clear public support for change. It is a deeply difficult and fraught situation for families who may have a relative or loved one who gets Alzheimer's relatively early in their lives, and who start looking at how on earth they are going to be paying for care for what could be 15, 20 or 25 years. There are others who are much more fortunate and not in that position, and everybody can see the unfairness of that.

We all, I hope, agree that every political party in this place, and every person who cares about their family and their community out there, understands that you have to pool risks in life. You have to find a way of having fairness and social justice at the heart of how we pool risks to fund the public services that we need. We can all start from that principle.

Where the rubber will hit the road is, when Baroness Casey comes forward with a proposal on the funding model, how we socialise that with the other political parties. As she said, a lot of important work will go on behind the scenes. We cannot have all of those discussions out in the public. It has to be a discussion between political parties in a very grown-up way about settling on a way forward and developing that consensus.

Then I hope that there would still be time within this Parliament to develop and communicate that consensus, and engage with the public and all of the key players—local authorities, the voluntary sector, and community health providers—on how we tie it up with our neighbourhood health strategy. There are some really exciting opportunities to change the game here, and I would just urge every political party in this place to see the opportunity and not to weaponise this.



HOUSE OF COMMONS

Q120 **Chair:** As you know, this is a cross-party Committee, and we do see it and are impatient for it. Just so that I can really nail this down, the way the terms of reference are written is to say "by 2028". There is the national conversation that may or may not be launched in July and over the summer. If it comes back and she gets conclusions by the end of 2026, let us say, if she wanted to publish them, could she?

Stephen Kinnock: Yes.

Q121 **Chair:** Regardless of what the Treasury and the PM—as then was, although it looks like there might be a change; who knows?—want, she could and will publish, and she has your blessing to do that. Is that where we are?

Stephen Kinnock: Yes. That is why the inclusion of the word "by" around the dates was very important. You know Baroness Casey. She is not backward in coming forward. This is an independent commission. It is really important to stress that there is a strong firewall between the commission, the DHSC and me. I have been involved in the cross-party talks, but I have had no involvement in terms of the timeframe and the timeline. There is no point in setting up an independent commission and then not enabling it to be independent. That is why it is so good that we have Baroness Casey as such an independent and strong voice. She will bring forward recommendations as and when she sees fit, but, of course, she does have to ensure that her recommendations are landed with the Treasury and with No. 10.

Q122 **Chair:** So they could still delay if they wanted to. There is still a mechanism by which they could delay this.

Stephen Kinnock: They could. Of course, Baroness Casey's work is independent, but I think she would agree that there is not a huge amount of point in bringing something forward that the entire machinery of government then does not agree with, so there is going to be a navigation process through all of this.

Q123 **Chair:** This comes back to my point about political will, but we will see what happens at the top of Government. Who knows? There might be a change of heart.

As my very final question, there are ordinary people out there who are currently perhaps looking for assessments, or are worried that mum and dad are getting to that stage. What will they see that is tangibly different by the end of this Parliament? If we are on our current trajectory, what is going to be different, not planned to be different, by the end of this Parliament?

Stephen Kinnock: I started off by talking about quality, control and joined-upness. On quality, it is about care workers who are motivated, properly remunerated and respected. The fair pay agreement is very important for that.



On choice and control, there are 4.7 million unpaid carers. What an incredible job they do in our society. We have given them the uplift, but we have also launched the review on paid leave for unpaid carers. That is an example of increasing choice and quality.

On integration, we have work to do on the front door and the digital offer to people so that they are not being sent from pillar to post, and on neighbourhood health. We need that really strong role for local authorities in the health and wellbeing boards, defining what an integrated neighbourhood team is, and working with local authorities and care providers to ensure that people are not going into hospital when they do not need to be there. The best way to deal with the downstream problem that we have of delayed discharge—

Chair: It is social care, absolutely.

Stephen Kinnock: —is to solve the upstream problem, and that is through the neighbourhood health service.

Q124 **Chair:** Do you genuinely think that all of that is going to be changed for everyone in this country by the end of this Parliament?

Stephen Kinnock: It is our responsibility to make that happen. In order to make it happen, we need everybody to roll up their sleeves and strain every sinew to deliver it. I think that the will is there. The ambition is there. The desire to achieve those quality of life-changing improvements for people is there. Of course, we now need to make sure that we pull the levers and make it happen.

Chair: Thank you very much. Thank you for your time this morning.