HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Adult social care markets, HC 1293

Monday 19 April 2021

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Watch the meeting

Members present: Meg Hillier (Chair); Shaun Bailey; Olivia Blake; Sir Geoffrey Clifton-Brown; James Wild.

Vicky Davis, Director, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-102

Witnesses

I: Michelle Dyson, Director General, Adult Social Care, Department of Health and Social Care; Catherine Frances, Director General, Ministry of Housing, Communities and Local Government; Professor Deborah Sturdy, Chief Nurse for Adult Social Care, DHSC; Ian Trenholm, Chief Executive, Care Quality Commission; Sir Chris Wormald, Permanent Secretary, DHSC.

HOUSE OF COMMONS

Report from the Comptroller and Auditor General

The adult social care market in England (HC 1244)

Examination of witnesses

Witnesses: Michelle Dyson, Catherine Frances, Professor Sturdy, Ian Trenholm, and Sir Chris Wormald.

Q1 **Chair:** Welcome to the Public Accounts Committee on Monday 19 April 2021. We are here today to look at adult social care markets, an issue that has been of concern to the Committee and to the nation for some time, with numerous reports being written on the future of social care. Today, we are focusing our work on a recent National Audit Office Report that, among other things, has highlighted as challenges that the sector faces the perennial issues of staff turnover, vacancy levels and increasing demand. The Government is committed to delivering reform, but there is a long-term challenge regarding the financial health of the sector that remains concerning, and of course the impact of covid-19 on the sector has been immense, as this Committee has reported.

We have received a lot of very useful written evidence from across the sector, with one main theme running through it: that the time for talk is over and the time for action is now. We want to find out from our witnesses what Government is doing to help the sector out of covid, particularly for its long-term future.

We welcome our witnesses today: Sir Chris Wormald, permanent secretary at the Department of Health and Social Care; Professor Deborah Sturdy, who has recently joined the Department as chief nurse for adult social care; Michelle Dyson, interim director general for adult social care at the Department; Catherine Frances, director general for communities at the Ministry of Housing, Communities and Local Government, which is a key partner in the delivery of social care; and Ian Trenholm, chief executive of the Care Quality Commission, the regulator for the sector.

Before we go into our main session, I want to ask Sir Chris about things that are going on in our GP and primary care services. When a contractor is given the opportunity to run a GP practice as an APMS—alternative provider of medical services—that contract is awarded to a company. How is it that that company can then be bought up and passed on to someone else without oversight by your Department or the NHS?

Sir Chris Wormald: Where there are questions about the GP contract and exactly how it works, I will need to take them away, consult my colleagues at NHS England and then write to you on the specifics of the case. It is NHS England that would oversee that process, and I would rather not answer for it.

Q2 **Chair:** Okay, but is it right to say that once a contract is let, the contractor should be accountable to its local CCG and the local NHS, basically?

Sir Chris Wormald: The CCGs and NHS England, as you know, oversee the delivery of GP services. Anyone who is working under an NHS contract should be accountable in the way that the NHS is, both locally and nationally, for what they deliver in return for taxpayers' money. The principle is very clear and applies across the NHS, as you know. On the specifics of what you raise, I will consult my colleagues at NHS England and give you a full answer.

Q3 **Chair:** Is there any brake, from your Department's point of view, on allowing overseas companies to run local services, especially if they have just taken over a company? Is there any mechanism by which you would vet a takeover of one company by another, especially if that company is based overseas?

Sir Chris Wormald: Not by DHSC; as I say, I will come back to you with what the NHS's procedures are. I should also note, particularly as the CQC is here, that regardless of ownership, all NHS providers and GPs are inspected by the CQC on the same basis. That is the other leg of accountability: that there is a common inspection framework and a common intervention framework in the result of underperformance, regardless of ownership. That is correct, Ian, isn't it?

Ian Trenholm: Yes, Sir Chris, that is correct. We would look at an individual provider and assess issues around quality and safety issues. We would apply the "fit and proper person" test, if that was appropriate, and so on. We would look at whether a provider was fit to provide a service. The commissioning of that service is, as Sir Chris said, a matter for NHS England.

Q4 **Chair:** Can you tell me now how many times you have had to invoke the "fit and proper person" test—whether there have ever been any times when the CQC has raised that as a concern in primary care provision?

Ian Trenholm: Off the top of my head, I couldn't tell you the answer to that. We could certainly write to you separately on that.

Q5 **Chair:** Would it make a difference if the company was answerable to an organisation with headquarters overseas? Would that be something that you could still probe in terms of "fit and proper", or is "fit and proper" just down to the location?

Ian Trenholm: I think it would very much depend on the circumstances, so I will have to write to you separately on that.

Chair: Thank you; we can pick it up in correspondence. I now turn to James Wild MP for another question before we go on to the main subject.

Q6 **James Wild:** Thank you, Chair. This is another one for you, Sir Chris. The Queen Elizabeth Hospital in King's Lynn has 131 props holding up the roof in wards across the hospital; and last month, the critical care unit had to be closed for two weeks because of concerns about concrete planks in the roof. The hospital was built to last 30 years and is now 41 years old. Can you tell me when you expect to publish the process and criteria for the further eight new hospitals that the Government committed to in the

spending review, please?

Sir Chris Wormald: Again, I don't have the details of that with me, so I will write to you afterwards. We know the general position on the issue you raise, and it is a matter of concern, both to the Department and to the NHS. As you will know, actions are in hand, but I will write to you separately on the specifics of the hospital that you raise.

Q7 **James Wild:** Thank you. The hospital did receive £20 million recently for short-term funding, but that is literally just fixing the roof for the short term. We need a new hospital in King's Lynn.

Sir Chris Wormald: Yes, and I am sure you are aware of the Government's commitments in this space. The Committee has previously investigated the capital position of the NHS as a whole. I think we are all well aware of the investments going in, but also the challenges that individual hospitals can face.

Chair: We will continue, as a Committee, to investigate issues around capital funding, as well as revenue funding, in the NHS, but we will leave that there for now. That brings us into our main session, looking at social care, and I should stress that while we recognise covid has had a major impact on this sector, today's session is not specifically related to covid and social care, but is actually about the long-term, wider issues, so we are really pleased with the array of witnesses we have. To question them first, I am going to ask Mr James Wild MP to come in.

Q8 **James Wild:** Thank you, Chair. As you say, this is not a new topic for the Committee. Perhaps we can get each of your perspectives, but Sir Chris, could we start with you? What is the impact on care providers of not having had a longer-term funding settlement?

Sir Chris Wormald: We have a very clear picture of the care sector—both its successes and its challenges. Our primary source for our assessment of the actual state of care is that produced by Mr Trenholm at the CQC, which I am sure you have seen and which demonstrates that the actual care provided by care providers, in both the domiciliary and the residential space, has actually remained very solid over the last few years and, I think, Ian, has gone up slightly in the latest report, so we have a very clear picture of the quality of the care system.

The length of time you have a funding settlement for clearly impacts on your ability to plan. I think everyone would want there to be a longer-term funding settlement for social care—of the type that we have for the NHS, which the NHS has benefited from. That has not proved possible, for reasons the Committee, I think, understands, and that clearly limits—compared with the NHS—the ability to do longer-term planning. We shouldn't overstate this, however. The vast majority of the economy, in both the public and the private sector, does not have multi-year funding plans, yet it is able to make long-term decisions, so while it clearly limits the ability to plan long term—compared with those sectors that do have a long-term planning commitment—we shouldn't, as I say, overstate the case.

Q9 **James Wild:** The Nuffield Trust submitted evidence to the inquiry that referred to a broken provider market, and other bits of evidence that we received paint a similar picture. Do you think the levels of diversity and innovation in the sector are where they would be if there had been long-term funding?

Sir Chris Wormald: As I say, undoubtedly longer-term funding would help. I don't agree that it is broken, but I think we do agree that it needs to be improved. If you look at CQC reports on the quality of the care system, it is very comparable to what you find in the NHS, and is stable. However, the thrust of your question—do we want better long-term planning? Does there need to be more innovation in the sector? Do we want to see it develop, and do we wish to deal with the well-known challenges of the care system, none of which we deny? We would answer yes to all those questions.

Q10 **James Wild:** Mr Trenholm, paragraph 2.4 on page 32 of the Report states: "CQC has warned that the continuing lack of a long-term sustainable solution was having a damaging impact on the quality and quantity of available care." Would you elaborate on what you mean by that?

Ian Trenholm: In a number of ways, we see the reluctance of providers who rely extensively on publicly funded care to invest in long-term infrastructure and things like staff training. We also know that those geographical areas that performed best during the covid period were largely characterised by good joint working with the NHS, local authorities and the care home providers. Stable long-term funding positions enable people to invest in longer-term innovative care models around things like prevention. We would expect that new care models could be created if there was a long-term funding solution alongside the obvious business stability points that Sir Chris made.

As Sir Chris rightly said, quality at the moment is holding up and has improved gradually over the last few years. On average, using our normal measure, 85% of providers are either good or outstanding. That does to some extent hide some regional variation, but even in the poorer performing regions we still have 80% of providers that are good or outstanding.

Q11 **James Wild:** When you refer to long-term funding, what sort of period do you have in mind?

Ian Trenholm: I do not think we have a particular time period in mind. The concern that we hear from providers is that when they are entering into relationships with local authorities, they know that there are short-term injections of funding put in by Government, which means that providers are able to operate in the short term, but cannot make those multi-year investment decisions that ultimately will make the sector stable in the very long term. I think it depends on the circumstances. Staff training is one area of investment; investment in buildings and infrastructure is another. As you said right at the top of the meeting, there

are buildings that will have a 25-year or 30-year life, so I think it depends on the context.

Q12 **James Wild:** Sir Chris, when will we have a long-term funding settlement in place?

Sir Chris Wormald: That will be dependent on spending review decisions that are yet to be taken.

Q13 **James Wild:** What sort of period are you pitching for? How long a settlement would you seek?

Sir Chris Wormald: Clearly, that is for discussion; that will be common across Government, across the spending review period that the Treasury sets. From our point of view, most sectors do not work on long-term settlements. The particular challenge that we have arises when the NHS is able to plan long term, but its social care partners, with whom we work closely, plan a different timetable. From a purely technocratic point of view, we would want similar planning horizons across those two sectors to aid integration, but the decisions by the Chancellor and the Treasury on how much and what length of the taxpayer commitments the Government can take are based on much wider considerations than that.

Q14 **James Wild:** Local government would be keen to have a longer-term settlement as well. The Report refers to a 29% real-terms reduction in local government spending power since 2010. Are they being set up to fail in not being able to provide the services because they have not commissioned them, because they do not have the funding to do so adequately?

Sir Chris Wormald: I will ask Catherine from MHCLG to come in on this after I have spoken. No one denies that local government spending, and spending on adult social care, has been under pressure. We all know the story of early austerity policies that were necessary from 2010, and the effects that that has on budgets and services. The governing legislation—the Care Act 2014 —sets a standard for what we expect local authorities to be able to provide. At this time, we are not aware of any local authorities failing in their statutory duty under that Act, but we do not deny—I do not think that anyone does—that it has been a challenging period for local government, even before the pandemic. Is there anything you would like to add, Catherine?

Catherine Frances: All I would add is that we get the same feedback, of course, from local government colleagues that it would be easier for them to plan on a long-term basis with long-term certainty. As outlined by Chris, the Government have taken these decisions to prioritise shorter-term spending in local government, as in much of public spending, over the last few years, for understandable reasons in the covid context.

Looking forward for local government, the statistics in the Report are quite interesting. As Chris says, it is important that local councils take decisions about how they prioritise their spend on social care versus their other areas of prioritised spending. They have been gently increasing the spend

on social care since 2015-16, and the most recent settlement—the 2021 settlement—I am sure you know was a 4.5% real-growth settlement, ahead of covid hitting and the support and challenges that that has brought. Looking into 2021-22, there is a cash-terms increase in the settlement of over 4%, although I am sure that the Committee will remind me that some of that is from council tax. Local councils will have to find their way through this. We think that they are adequately funded, but they will need to make their own decisions, as Chris says, to make sure that they are meeting their commitments under the Care Act. It is their statutory responsibility to do that.

Q15 **James Wild:** Just looking at the sustainability of the model, the Report refers to the majority of local authorities paying "below the sustainable rate per week for care home placements". How can you incentivise them to pay market rates when they do not have the funding to do so?

Catherine Frances: I will come in there, and I may then wish to hand over to Michelle Dyson from DHSC. We do not dictate from central Government what is a fair rate of care payment in each local area. Each local council will face a different sort of marketplace, a different combination of its own provision and outsourced provision, and a different combination of self-funded individuals and state-funded individuals. The Care Act sets out the requirement that they should pay the fair rate, and DHSC takes steps to publish the rates being used by local authorities.

The key aspect is that it is at local authority accountability level that those councils need to be held to account on whether they are delivering at the right level, and we would expect their local reporting procedures to kick in. The other point to make is that DHSC is currently developing proposals, as you will have seen in the White Paper, for new assurance mechanisms which will enable them, through CQC, to have a greater oversight of what is going on in the sector. I will hand over to Michelle to follow up.

Michelle Dyson: Thank you, Catherine. You have covered all the points that I would cover. The only thing I would add is that when we publish the average fee rates paid by local authorities and we publish the percentage uplift, we do that in year in order to enable people to use that transparency, comparing and contrasting statistical neighbours—that methodology—to challenge local authorities to the extent they think those rates are too low.

Q16 **James Wild:** So you have been challenging local authorities for paying too low a rate.

Michelle Dyson: No, sorry, I did not mean that we were challenging them. We enable providers and their representatives, who see what we publish. They can use that information to make those challenges.

Q17 **James Wild:** How concerned are you that local authorities' spending power has reduced to such a degree that there is this huge differential—I would call it a premium—for self-funders, who have to pay 41% more than local authorities do for the same service. How concerned are you about that position?

Michelle Dyson: You would always expect individuals to have to pay more than a local authority, with its purchasing power. As we have been saying, after the squeeze, more money has been going into local authorities over the past few years, and we have seen them spending more on adult social care. This is ultimately a matter of local accountability under the Care Act 2014, albeit under the new powers we are proposing to take that we announced in the health and care White Paper, we will in future have more assurance over what goes on at local level. At the moment, however, this is a matter of local accountability.

Q18 **James Wild:** I understand the local accountability point, but I think that if my county council was sitting here, it would point to that 29% real-terms cut as making their local accountability slightly more challenging.

Sir Chris Wormald: Can I make a comment before we go on? The last point that Ms Dyson made is extremely important. Our governing legislation at the moment, as the Committee is aware, is heavily predicated on local authorities' direct responsibilities for care in their area. This Committee and others have previously argued that while local accountability should be maintained, there ought to be greater powers of central oversight, and our proposals in the White Paper that Ms Dyson mentioned respond to that. We are not diminishing local accountability for services and statutory duties of local authorities, but we are seeking to put in more assurance mechanisms to allow us and our colleagues at CQC to assess what is going on in the system at a national level. That is not the same as nationalising it—it will still be mainly a local authority-run and accountable system—but there will be more powers of national inspection and national assurance and data. All of those things are directly responding to things that this Committee has previously raised and other issues raised by the Committee. For an awful lot of what we have been debating here, we see those proposals as being part of the answer.

Q19 **Sir Geoffrey Clifton-Brown:** Good afternoon, Sir Chris. I do not mind whether you or Ms Dyson answers this question. Some people have estimated that the cost increases for care homes this last year alone have been in the order of 10%, with considerable increased costs due to covid—PPE, cleaning up and so on—and considerable increased costs in minimum wage, and yet some of them have lost substantial numbers due to covid. Where is the sustainability not just for some individual care homes but for the sector as a whole?

Sir Chris Wormald: I will ask Ms Dyson to comment and then Mr Trenholm. You are correct that, of course, there have been a lot of additional costs associated with covid faced by the care sector. I am sure all of us will want to put on record our thanks and gratitude for the way in which the sector has responded to the crisis, and particularly the work that our frontline colleagues have done in very difficult circumstances. I am sure everyone will agree with that. We have put in both at local authority and individual care provider level significant additional resources, and I will ask Mr Trenholm to comment on that. Actually the market in social care over the last year has been considerably more stable than it has been in previous years, for a variety of reasons, but I will ask Ms Dyson to talk

about the funding and Mr Trenholm to talk about what he has seen in terms of market stability.

Michelle Dyson: We have put in a lot of support for care homes during covid. Specifically on the PPE question we have been providing them with free PPE and we have now announced that is going to go on until March 2022. More generally last year, in 2021, we put in about £1.1 billion of ring-fenced funding for things like paying wages for staff who were having to isolate because of covid. We put in around £150 million of extra funding to support testing and we put in £120 million of funding to support the workforce in the early part of this year when the workforce was under very, very intense pressure, and we are continuing some of that funding into this year.

Separate from that there has been un-ring-fenced funding put into local authorities for support with covid—around £4.5 billion in 2020-21 and then into this year another £1.5 billion—so a lot of extra funding to care homes and the rest of the sector to cope with the incredible pressures that they have been under; and what we have seen—and I am going to hand over to Mr Trenholm at this point—is fewer care homes coming out, or fewer exits. This is after all a private sector market. We have seen fewer exits than we would expect in a normal year, and we would surmise that that is to do with the extra support that we put in. Over to you, Mr Trenholm.

Q20 **Sir Geoffrey Clifton-Brown:** Just before we leave you, Ms Dyson, have you done any work as to how many care homes you expect to cease trading in this coming financial year?

Michelle Dyson: We know how many will normally leave the market—and that is what Mr Trenholm is about to come on to. We monitor very closely—the CQC monitors the big providers, but we do some monitoring as well, on a monthly basis, to see what we can see going on. We also did a review in the autumn of every local authority, to get a handle on what they perceive to be the risks locally in terms of their markets. So yes, we are monitoring this, and clearly it is for the local authority to deal with the risks at local level, to manage its market; but we are not seeing anything that makes us worried at this point in time, and we are continuing to put money into the system, as I have said. Can I hand over now?

Chair: Certainly. Mr Trenholm.

Ian Trenholm: Sir Geoffrey, if I could just deal with your last question first, and then I will come on to your broader question secondly. In terms of care home closures, for the last couple of years, we take enforcement action which results in closure on about 60 care homes a year—so in 2019 we closed 63 care homes. In the same time period, 482 care homes voluntarily closed; so it is a factor of around nine times more that close in a given period than we close through enforcement action. In 2020, those figures were that 65 closed through enforcement action and only 361 voluntarily closed.

That was slightly counterintuitive because fewer care homes closed voluntarily than in 2019, which was a pretty typical year. During the first quarter of this calendar year, the slowing continued—in other words, there was more capacity in the market than one would expect. All that translates into probably 1,000 or so more beds that remain in the market than one would normally have expected. It is too early to form raw assumptions about why that might be. The point Ms Dyson made about additional Government support has definitely interrupted that normal pattern of closures and has kept some locations open.

To move on to your broader question, I would recognise probably three sectors in adult social care that have behaved quite differently during the covid period. Non-specialist care—the conventional care home or nursing home—has very much borne the brunt of the covid period. They have seen a lot of margin erosion, for a lot of the reasons you described, and additional cost in terms of PPE and so forth. Some of that has been mitigated by Government support, but not all of it.

We estimate that, on average, there has been a 10% reduction in occupancy levels. We would typically calculate that, to make a modest margin, a care home would be looking at a 90% occupancy rate. What we saw last year was an 80% average occupancy rate—that is about the level where most care homes would break even. Some care homes are operating below a break-even point, and are being kept alive by that support.

It is very important to recognise the mix between publicly funded care and privately funded care. We have seen a big reduction in the number of private funders, which means that care homes are taking on more publicly funded care proportionally, and that is having an impact on margins. The reason for that is simply that if people are at home and cannot get into care homes, they will not pay to put their loved one into a care home. People may keep their loved one with them in their own home for longer. It follows that when society starts to open up and covid starts to go away, people will start placing their relatives into care homes. When we talk to care home providers in this sector, they talk about a two-year road to recovery to get back to more reasonable utilisation rates.

In terms of specialist care, for people with learning disabilities and supported-living type environments, we are seeing a pretty resilient sector. The level of intensity and specialism of care has meant that the sector has stayed pretty resilient and at the moment is looking okay. The third group of providers, which is domiciliary care—caring in people's homes—has had a fair amount of local authority support. We have had some positive stories about the way that individual councils have continued to pay and have ensured that the payment of invoices is done quickly. Domiciliary care has a very flexible cost base, so if the number of hours of care reduce, they have been able to furlough people and take advantage of other Government support. Domiciliary care is managing to maintain margins and collect business in a way that those businesses that operate in the non-specialist care home business, who have fixed costs,

are not able to do. Also, domiciliary care is less exposed to the public/private pay market that we see in non-specialist care. I hope that gives you a sense of some of the moving parts in this sector.

Chair: Thank you Mr Trenholm. That is a useful backdrop to some of the challenges that we will probe further. Let's go back to James Wild.

Q21 **James Wild:** Thank you, Chair. On the monitoring point, Mr Trenholm, can you confirm that the CQC monitors the 65 large providers that account for about 30% of the beds? What happens to the other two thirds of the market? Who is monitoring that for its resilience?

Ian Trenholm: The short answer is the local authorities. The way that the market is set up is effectively a triumvirate between the Department looking after policy, our looking at the whole market for quality and safety and our supporting local authorities to be the financial regulator and market maker for the whole social care market in their area, which includes both public pay and private pay.

Q22 **James Wild:** Ms Frances, how well prepared do you think local authorities are for potential provider failures in those areas? The CQC is looking at the bigger players, but smaller, regionally significant providers could still go under. How much testing have you done of their contingency plans, for example?

Catherine Frances: I will refer to Michelle in one moment, if I may, on the testing of plans and on working with the sector. The short answer to that is that the DHSC has worked with colleagues in ADASS and the LGA to support local authorities in developing good market strategies and sector-based solutions, helping those who need the most help and looking at common themes on whatever has come through.

Regarding central Government, it is important that the Committee understands a few things. First, we have put the big covid funding into the market over the last year and into the future. We know from MHCLG that about 45% of the covid spend by local government is on adult social care. We have throughout 2021 been in touch with local government to ask them to use some of that funding to keep cash support going into their local providers, to keep in touch with providers—even those they do not normally have a contractual relationship with—and to operate on an open-book basis with those providers. In fact, we asked them to do that as far back as last April.

Looking forward into the next year, Michelle Dyson alluded to the fact we have put £1.5 billion of un-ringfenced support into councils, in addition to the stand-alone social care funding. DHSC colleagues have written to councils, with MHCLG support as well, to ask them to use some of that funding to support their local market, to make sure they understand where the risks are and to either put in cash support or to look at fees or anything else that may be helpful to support them. If you are okay with it, I will hand over to Michelle Dyson to talk about the sector-based improvement work that DHSC has supported.

Michelle Dyson: We carried out in the autumn the service continuity in care market review, jointly with ADASS and the LGA. We went to every local authority and asked them what was going on and what risks they were worried about. Every single one of them responded, and on the back of that we have an ongoing programme that provides support to local authorities for all their Care Act duties. We run that programme through ADASS and the LGA. We have used that programme to support the local authorities who, on the back of the review, told us that they wanted more support with their providers and their market.

Q23 **James Wild:** But have you done any table-top exercises or similar to test some of these contingency plans?

Michelle Dyson: I couldn't tell you whether we have actually looked at the plans. I know that we got responses back from every local authority. To the extent that that is a contingency plan, we have those. I cannot tell you whether we have actually looked at the thing called a contingency plan. Maybe we should come back to you on that, if that is okay?

Q24 **James Wild:** That would be helpful. The Report says that the survey you just referred to found that "43% of local authorities said they were at, or expect to reach, a critical point in their ability to ensure continuity of care provision across at least one service". That reads as quite an alarming sentence in the Report. How have you responded to that particular concern?

Michelle Dyson: Many of the issues that came back at the time when we did the review, in the autumn, related to workforce, so we stepped in with that £120 million in January. Others were concerned about covid-related issues, which again we feel we have addressed. There are a handful of local authorities that we felt needed more intensive support, and that is where we have deployed our programme of funding that I referred to, which we run through ADASS and the LGA.

Q25 **James Wild:** Thank you. Going back to Mr Trenholm on sustainability of providers, the Report highlights that 39% of large for-profit care home providers and 34% of for-profit care-at-home providers have liabilities that exceed their assets. How worried are you about that?

Ian Trenholm: We are worried in the sense that we work very closely with those providers. I think the danger of trying look at headline statistics is that it moves away from the fact each of those 65 providers will have very different financing structures and very different details behind some of those numbers. What we do behind the scenes—this is really the purpose of the market oversight function—is work very closely with those providers, and have regular conversations with them around their particular business, so we are in a position to make a decision to talk to local authorities if we think a big provider is going to fail and there is likely to be service cessation. Talking about the headline numbers is perhaps not the best way of viewing this; I think we have to look at each of those providers as individual businesses.

Q26 **James Wild:** Do you have the powers that you need? A number of the

pieces of evidence that the Committee has received refer to the difficulties of discerning ownership of some of the businesses, with opaque structures and limited transparency in accounts. How big a problem is that?

Ian Trenholm: Again, I think it depends on the individual entity. We have had challenges with some individual entities, while others work with us very clearly and openly. I think that all of the organisations in the 65 largest providers recognise that we, as the regulator that registers them, are fundamentally in a position to challenge their registration and to make a judgment that they are not able to continue if they are not prepared to put sufficient information on the table for us. On a number of occasions, we have had to be fairly robust in some of our conversation. We have been able to do that.

Q27 **James Wild:** Are you comfortable that you have the powers you need to intervene in the market, with providers, to ensure that the patient care being provided is adequate? We have a health Bill coming forward; are you pitching to get any further powers in that Bill, for example?

Ian Trenholm: Not in terms of intervening from a financial point of view, no. That has never been our role. Our role is to work with the largest providers, to report on those providers, and to give an early warning to local authorities, for them to discharge their local responsibilities, as Ms Dyson spoke about earlier. It is not our job to be a financial regulator in any form. In that sense, we are not pitching for additional powers. There are of course going to be specific—largely administrative—details that we would like to tweak, based on experience of operating the scheme for the last six years, but we are not pitching to be the financial regulator for any part of the social care market at the moment.

Sir Chris Wormald: There is one very important proposal in the White Paper, which is to give the CQC a role in looking at local authority commissioning, as well as looking at the supplier side of the market. That is a significant new power for the CQC, to get an overview of how the whole market works, both for our local authorities doing their commissioning, which of course includes their market-making role, as well as looking at supplier viability.

I also want to emphasise the point that Ian made: our job is to ensure there is a good market; it is not to regulate or manage individual suppliers, or to cause them to survive when they would not have otherwise. The purpose of all this activity is to ensure that there is a good market so that people get a good service and their care is not disrupted. It is not about financially managing the private sector players who are involved.

Q28 **James Wild:** Thank you. Sir Chris, have you done any work to identify how much additional budget the CQC will require to take on what I imagine will be quite a considerable workload, judging from what is in my mailbox about commissioning decisions by the CCG in my area?

Sir Chris Wormald: I will ask Michelle and Ian to comment.

Michelle Dyson: We are at the beginning of drawing up those proposals. They need legislation, so they are going to come before Parliament, and then they will need secondary legislation and so on. We are starting down the road of doing informal consultation, so we are not yet in the place of putting price tags on the proposals.

James Wild: Okay. I am sure Mr Trenholm will be speaking to you about that.

Q29 **Chair:** Mr Trenholm, have you done any modelling? You probably see this coming down the line. What do you think you would need to do it?

Ian Trenholm: As Ms Dyson said, I think that really this is a question of scale and scope. So, at this stage, we are at White Paper stage. Once the legislation goes through, we can form a view as to how much this will cost and how it will be paid for. At this stage, we are having constructive conversations with the Department, but I don't think we are in a position to put a price tag on anything yet.

Q30 **Chair:** You have a different statutory footing. I have raised the example of Ofsted, which has had to take on more but with less money, and some schools have not been inspected for 11 years. I am not suggesting that you would have an 11-year gap between inspections of care homes, but do you think that you will be able to be robust enough to put the case publicly for what you really need?

Ian Trenholm: Yes, I think we will, but I think we have a different funding model from Ofsted. We levy fees, with a fee for registration. So, if you look at my £228 million turnover budget, £200 million comes from provider fees. That takes care of the majority of things. We then do a series of roles—operational roles—

Q31 **Chair:** Which is the pertinent point, because if you are doing it from fees, does it mean that fees will increase for you to do this extra work that is being outlined as a possibility in the White Paper?

Ian Trenholm: That is a matter for legislation. At the moment, it is a question of whether it is fee-funded or funded by a grant-in-aid from the Department, and none of those decisions have been made yet.

Chair: That is just worth flagging, I think. Back to you, Mr Wild.

Q32 **James Wild:** Thank you. Ms Frances, you referred to the additional funding that has been provided, including the un-ringfenced funding that has gone to local authorities. How confident are you that the additional funding—the covid funding—is getting to where it is most needed and how closely have you looked at that?

Catherine Frances: We have covered in quite a lot of previous hearings how we are looking at the covid funding going through local government. We have basically instituted a monthly monitoring process with councils, which we did relatively early on in 2021, and we are seeing from them their patterns of expenditure. It is not audited expenditure details as it comes through on a monthly basis; it is just the finance director saying,

"This is where I think I am". On that basis, we publish it on a monthly basis.

The last round of that data to be published was our 10th round, which was published just before the pre-election period started for local government. What you can see in there is for the 2021 expenditure. With apologies for repeating things we have said in previous hearings, you can see that their levels of expenditure are really significant. Social care is the biggest single area of spend, but you can also see that Government grant funding that has gone in is in excess of what local government thinks it is spending. Actually, the figures have moved slightly more, as it were, in their favour since the last hearing we had on this issue. We have asked them what proportion of their spending is not only going on social care, to which the answer is about 45%, but also what proportion of their social care expenditure they think is going to providers in that covid bucket. I think you can see in the Report there is a figure of 87%; some of the returns from the sector ever so slightly modify that, but that is the ballpark that we are in. So, we can see that level of funding and resourcing coming through. What we do not know yet, and I am afraid we will not know until late in June, is how local government has budgeted for social care versus other services for the coming financial year, because we get that sector data in at that point.

Q33 **James Wild:** Thank you, that is helpful. I will just turn, in the final bit of my questioning of this section, to the role of unpaid carers. The Report highlights the crucial role that 7.3 million carers play, particularly as there is also a huge number of young carers. Local authorities have duties under the Act to look after carers on a similar basis to the people who are being cared for. To what extent do you think they are discharging that duty and sufficiently supporting carers? Perhaps I can start with you, Ms Frances.

Catherine Frances: I think that the best people to ask about this actually are DHSC. We fund the local government sector on the basis of all the forecasts that come from DHSC, which include both demographic forecasts for social care and all the associated estimates that come from there. However, in terms of the accountability for setting the policies in relation to social care, it is DHSC, and then the local accountability for delivery. Do you mind if I hand over?

James Wild: Professor Sturdy, do you want to come in on this question?

Professor Sturdy: I think I will hand it over to Michelle.

Michelle Dyson: I think the answer to this is the same as the one we have been discussing before, in the sense that as you rightly say, the Act sets out a lot of duties for local authorities in relation to unpaid carers. It is for local authorities to perform those duties; we support them with guidance and with a programme of best practice. In the future, when we have our new assurance model and the CQC looking at what is going on, that will be one of the things that I would expect us to look at, because that new assurance model will be looking at how local authorities are

performing their Care Act duties. I would just add that we have done quite a bit for unpaid carers during the course of the pandemic, including making sure that they been prioritised for vaccination.

Q34 **James Wild:** Okay, so at the moment, you do not really have a view, because it is their statutory duty. They discharge it, whether they do it well or not, but then you are putting in place this new assurance model, presumably because you are concerned that some of them are perhaps not doing it. Is that fair to say?

Michelle Dyson: Sir Chris, I don't know if you want to come in on this. The new assurance model is very much complementary to the local accountability, but it will give us a national picture of what is going on, in a way that we do not have at the moment. It will give us national data, and we will have CQC views on what is going on and, in extremis, the ability to intervene, although we would expect that to be very rare.

Sir Chris Wormald: I think there are three drivers to the proposals we set out in the White Paper; obviously, it will be up to Parliament whether they are implemented. The first is the concerns that a lot of people will have had that the Care Act 2014 does not give the levels of national assurance that people would want, as I have said before and as this Committee has raised before.

The second is covid. As I think I have said to this Committee before—I have certainly said it to a Committee, and I think it was this Committee—we have been far more interventionist in the social care market during covid than we have ever been before. We have done a lot around data, and we have pushed our legal powers to the absolute limit to do it. I do not think anyone envisages that after covid we would return to the status quo, so we are putting in a number of measures to allow us to do the things we have been doing over the past year, but on a much clearer legal basis, rather than the mixture of legal powers, voluntarism and persuasion that we have been using over the past year.

Thirdly and very importantly, the White Paper is, of course, about how we integrate well between health and social care, and in particular how we try to move the system towards focusing on population health much more, as opposed to separate, siloed services. That requires us to have some—I emphasise "some"—of the same arrangements for social care that we have for the NHS, particularly around data and assurance, but as I say, while retaining systems that are basically local government-run and accountable. So there are three sets of drivers, one of which is the one that you raised.

Q35 **James Wild:** Thank you. Probably the final one from me on this part: over 1 million people are entitled to carer's allowance, but 320,000 people do not claim it. What analysis has the Department done to understand that, and how to encourage a much higher take-up, Sir Chris?

Sir Chris Wormald: I think I will leave that to Michelle.

Michelle Dyson: Carer's allowance is run by the Department for Work and Pensions, so I would need to get their views on that. I am afraid I cannot answer that straight off.

Q36 **James Wild:** Okay. Obviously, 320,000 people is a lot of people who are not getting support that they are entitled to, so I am a little bit surprised that the Department of Health does not have a view on that, given that you are the policy owner for this area. If you could come back to the Committee with what the Department for Work and Pensions is doing to encourage people to take up funding that they are entitled to, that would be very helpful.

Michelle Dyson: We will. Thank you.

Q37 **Chair:** I, too, am surprised at that lack of curiosity, or maybe we are misinterpreting that. Are you aware of this figure? Do you keep an eye on it? Do you talk actively to DWP about how to improve the take-up of carer's allowance, which is a vital lifeline for a lot of people?

Michelle Dyson: I personally have not had the conversations, but I am sure my colleagues do.

Q38 **Chair:** Could you write to us with the details? We are slightly surprised here in the room.

Can I come on to some of the issues? It is a bit like groundhog day, Sir Chris. This Committee has been here a number of times, talking about why the care system is not working and about the oversight of your Department. It has social care stuck in the title but, so often, it seems that its oversight has not been as effective as it could be. How are you going to work with MHCLG to improve the oversight of commissioning? We can talk about the White Paper endlessly and about what has gone wrong in the past, but what are you doing right now to make sure that commissioning improves, because the White Paper won't lead to changes for some time yet?

Sir Chris Wormald: I will say several things and I will also ask Ms Dyson to comment, as she leads this stream of work. I don't think it is groundhog day, to be honest. The issues we address in the White Paper, as I have said, are a number of the issues that the Committee and others have raised.

Q39 **Chair:** Sir Chris, we are going to come on to the White Paper. The White Paper is just a White Paper at the moment. The change that has been apparent in the last year is because of covid, but the underlying problems are still the same. We have had years and years of discussion about investment in social care and about better quality assurance, and yet today we have heard many of the same old problems.

Sir Chris Wormald: I don't think you can say the White Paper is just a White Paper. It challenges the way the Government brings forward proposals—

Chair: We are going to get on to the White Paper a little later, so I will

shelve that for now.

Sir Chris Wormald: But those are the things we are doing to improve the system. As I have said, during the period of covid, we have been doing a lot of the things without powers that we are proposing under the White Paper. We have been working directly with care homes, we have been funding care homes directly for the first time, we have been collecting considerably more data and we have been working very closely with local government, in the way that Michelle has described. People in the NHS and in the care sector have been saying that joint working between care and the NHS is better than it has ever been before during covid, and I might bring in Professor Sturdy to comment on some of these issues in a moment.

So a whole range of the things that we want to see have been happening over the last year. The point is that those things have been happening by a mixture of direct money, stretching powers and voluntarism. But that is what we have been doing over the last year. We are now formalising those things into a set of proposals to put them on a firm basis going forward.

Q40 **Chair:** In short, you are saying that covid has been a catalyst for doing things that should have been done before.

Sir Chris Wormald: Yes, again I think I have said before that—

Chair: If you have said it before, you don't need to say it again, Sir Chris. We can move on.

Sir Chris Wormald: Covid shines a light upon what is strong and what is weak in the system. We have all seen that, and that it what it has done.

Q41 **Chair:** My point at the beginning is that it shone a light on something that this Committee was certainly well aware of and that we have discussed with you before. I would like to go to Ms Dyson or Professor Sturdy. We have some specific questions for Professor Sturdy, so did you want to bring Ms Dyson in here?

Michelle Dyson: Shall I come in on your question on what we are doing to increase commissioning? One, more funding is going in. Two, as Sir Chris has said, during covid we have got much better data, and we want to build on that, so we are going to take powers in the Bill to get data, but there is lots we can do on data before that.

Three, we are doing something that doesn't feature very extensively in the NAO Report, which is the very large amount of research we are doing through the Care Policy and Evaluation Centre at LSE, including on the very important question of those with moderate needs. That will tell us the value for money of how different local authorities invest in supporting those of moderate needs and what the outcomes are.

Another important issue that is worth bringing to the Committee's attention is that there is a new work centre that is being set up, led by the University of Birmingham, with the intention of getting the research out

there into the system to support commissioning, among other things. I think there is quite a lot that is new that is going on.

Q42 **Chair:** When you talk about the funding increase, are you talking about the increase in council tax that councils have been allowed to raise to fund social care, or do you mean the covid funding?

Michelle Dyson: No, I didn't mean the covid funding. There is the covid funding, but I meant the real increases that Catherine Frances talked about earlier.

Q43 **Chair:** We keep hearing it. I know it's a line to say that you are giving more money to local government than before, but there have been 10 years of austerity cuts, with many councils having 40% to 50% reductions to their budget. I was a chair of social services in the past, and I know the battles to fight for this un-ringfenced budget. It is social services that always takes the hit, so let's just be clear that more funding does not mean enough funding, unless you are suggesting it is enough.

Michelle Dyson: No, I was making the point that there is more funding than there was a few years ago.

Q44 **Chair:** There is more funding than there was the previous year, and obviously there is the covid money. I want to touch on the covid funding, if I may, probably with Ms Frances. We have some very good evidence, which I would commend to anyone watching this, and certainly to our witnesses. On the £3.2 billion given directly in March and April last year to local authorities to respond to covid-19, MHA, which is a charity provider of residential care across the UK, highlights that, "Little of this funding made it through to an uplift in funding to care homes which was originally expected from Government rhetoric." Of the 188 local authorities that they work with, only 5% gave a 10% increase, and they had a response and a smaller uplift from 35%. But the rest—that's more than 60% of the local authorities they work with—gave no uplift and, therefore, no additional funding from that pot. Obviously, those councils were giving to their local homes, so they were not looking at the overall picture of that one provider, which operates nationally. Are you confident, Ms Frances, that the money that was provided by Government went to the right places, and what monitoring have you done of that?

Catherine Frances: I have not seen all that evidence, but there was a period of time in 2020 when there was a very active debate going on about how much of the covid funding going through was actually getting directly to care homes. You will remember that that was the point when Ministers wrote to local authorities, asking them to operate on an "open book" basis and to make sure that they were passing on sufficient funding. What we have found is that it is a bit of a mixed economy here. Some of DHSC's funding—for example, the infection control fund, which is directed very much at safety—has particular requirements. It is different in different tranches, but for one tranche, 80% has to go to providers. It has been different at different levels, but it is specified that you have to hand that money over.

More widely, on un-ringfenced funding, local government has more choice about what it does, but we have monitored what they have done. There are two key statistics that I can give you. First, of their covid expenditure, 45% is on adult social care. Secondly, as is set out in the Report, of the money that has gone on social care, 87% seems to have gone to providers. We have talked extensively to councils, just as DHSC has, and we have found that they have also supported providers in lots of other ways. Sometimes it has been with PPE; sometimes it has been with advice and all the other things. But the balance that is struck between central Government saying, "Sometimes we are saying you must hand over this amount to your provider"—

Q45 **Chair:** We are aware that some of it was ring-fenced and some not, but the challenge is that you have some local councils doing their own local assessments. Some will be providing money to national providers, and others to ones that are very specific and local. I want to know what visibility the Department has about what is going on. Maybe Ms Dyson will want to come in on whether some care homes and chains of care homes or charities are struggling more than others because they just happen to have had less from their combined local authorities than others. It seems to me that there is not really a clear pattern. The global figure is in the Report, but have you done any analysis of the impact on individual providers, given that a number—although fewer— are going, as we heard earlier from the CQC? We saw 361 voluntarily close in the last year.

Catherine Frances: MHCLG has not done anything across the sector. I will bring DHSC in, but the comments of CQC earlier about the underlying stability of the market at the moment are notable. We think that each individual council will have a different perspective on the balance of providers that it has in its local area. Whether it is dependent on a large number of very small providers or a fewer big providers will vary area to area, so we have asked, council by council, what people are doing, and we have full visibility of that in terms of their response, but we do not have visibility down provider lines.

Q46 **Chair:** Ms Dyson, do you?

Michelle Dyson: No. We have visibility of our ring-fenced funds. We know council by council what they were spent on. They were ring-fenced, but—

Q47 **Chair:** Do you have any oversight of the provider market and who might have done well or badly out of this?

Michelle Dyson: Not by individual providers.

Catherine Frances: But I think CQC—

Q48 **Chair:** You are going to the third in my list. Mr Trenholm.

Ian Trenholm: At an individual provider level we will look at the 65 we talked about earlier on. We have ongoing conversations with the other providers, but it is not our role to be the reporter for the whole market, if that is the question.

Q49 **Chair:** No, and clearly you are not the financial regulator, so there will be gaps there. At the moment it seems that no one has really got an overview of that, from what you have all said to me.

Ian Trenholm: Certainly from a CQC point of view, our core role is to register and regulate individual providers, and we have a specific role around the 65, but we have no other role in terms of how—

Q50 **Chair:** Absolutely. I am just suggesting that maybe there is a gap there.

Can I come on to the enhanced assurance work that you have been doing? It has taken a long time, Sir Chris, to get to the point of providing better guidance on that. If you couple that with the funding pressures over time, there are concerns. Why has it taken so long to get that enhanced assurance work completed, or begun?

Sir Chris Wormald: Michelle, do you want to pick that up?

Michelle Dyson: Sorry, by enhanced assurance, do you mean the proposals that are in the White Paper?

Chair: Yes.

Michelle Dyson: The White Paper came out, amazingly, when we were still in the middle of the second wave of the pandemic, so the pandemic has no doubt put back our thinking. It has been very intense in the Department and in the sector more generally.

Q51 **Chair:** The White Paper now seems to be the solution to everything, but some of these things could have been done without a White Paper. Enhanced assurance did not require a White Paper, did it?

Michelle Dyson: During covid we have been doing an awful lot in terms of getting data from the sector. We have amazing data at the moment. Some of it is on covid-related issues such as testing and so on, but some of it is on more long-term issues, so we have data now on occupancy, staff vacancies and that sort of thing.

Q52 **Chair:** Do you think you have data gaps still to be plugged? This is something that we and the NAO have raised a number of times, and the Report goes into it. Gaps in data are a big issue for us. What gaps still remain that you would like to see filled?

Michelle Dyson: I think there are two different issues here. We are getting great data at the moment, but that relates to putting money into the system for covid and saying, "Please can you fill in our capacity tracker?" as a quid pro quo. So there is a question of how we get that data, and indeed with what frequency. What we are asking for at the moment is probably not reasonable in a non-covid environment, so we need to consult on all of that.

There is the data that we currently have that we will want to have for the future. How is it reasonable for us to get that in the future? Then there is the data that we do not currently have, and the Report flags up some of that on self-funders and unpaid carers. Again, we have some plans there.

We are planning to publish a data strategy by the end of this year, which will look at what data we need and what is a reasonable way of getting it that does not impose too many burdens.

Q53 **Chair:** The burdens issue is a concern that has come up a bit in the evidence as well. Can you walk us through a practical example of data that you are currently collecting that is burdensome and what options you might have for making that manageable for the provider but useful to you?

Michelle Dyson: This gets to the question of whether there are technology solutions to make this easier. That is what we are going to want to look at, but we will want to do this in a collaborative way, because we are very much aware of those issues.

Q54 **Chair:** Well, technology solutions are all very well. I wouldn't say it's easy in the NHS, because we have a back catalogue about failures in NHS IT, but if you have lots of independent care home providers, some of which are very small, and you talk about technological solutions, are you talking about entering the data on an app that they can simply download, or about investment in software and so on, which is an extra cost and potentially a burden to those small providers?

Michelle Dyson: We have already been supporting providers with technology during the pandemic. We have provided 11,000 iPads, for example; there's one in most care homes. We have got them good deals on broadband. And NHSX is looking at further work of that kind.

Chair: Thank you. I now go to Sir Geoffrey Clifton-Brown.

Q55 **Sir Geoffrey Clifton-Brown:** May I come to you again, Ms Dyson, to back up, or try to clarify the answer to, the Chair's question on how much money actually went from local authorities to support the social care sector, and take you to paragraph 2.26 on page 40 of the Report? You asked local authorities to publish support to providers, and all local authorities published some information, but less than half of local authorities completed the optional template and, in aggregate, only £300 million out of the £3.1 billion could be identified from these returns. So I wonder how much work you have done to see whether, in this crisis, local authorities were supporting the social care sector directly or were just using this money in aggregate to help them with covid costs in general. If you divide the £3.1 billion identified in that paragraph by the 25,000 homes, that is only £120,000 per home; and if the figure is only £300 million, it's only £12,000 per home. So it looks as though quite a lot of this money was going in to support the local authority sector, but not actually going into the social care sector to help it with its extra costs. Am I right or not?

Catherine Frances: Chair, would you mind if I took this question?

Chair: No, Ms Frances.

Catherine Frances: I think the story over the last year or so is of two different types of data collection systems coming up to full strength. The

easier data collection system to fix was that which MHCLG started to run and which we have talked about previously—the monthly collection. There, we can give you some assurance, in so far as local authority officers, when filling in their returns, are telling the truth; we believe that they are. Our data suggests that 88% of the funding that has gone on social care through local authorities has gone to providers. The figure in the Report, in paragraph 2.26, is 87%; that is in the same ballpark, and it is probably subject to change just by which particular data point you are looking at.

What DHSC found earlier in the pandemic was that there was just such a large number of providers and settings that, as Michelle has said, had no previous relationship of sending through really routine data and high-quality data that sometimes that data was much more patchy. But I will bring Michelle in here, because I think what has been notable in the course of the last year is that, as DHSC have exercised some leverage through the grant funding going in, we have seen the rates of return from the provider side suddenly start to come up and to mirror the response rate—it's not quite as high, but almost as high—that we get from local authorities. Michelle, maybe I can bring you in here.

Michelle Dyson: The challenge is, are we confident about how the money that we put in has been spent? As we have talked about, there are two different types of money going in to help social care. There is the un-ringfenced money, which Catherine has just spoken about, and our ring-fenced grants. On our ring-fenced grants—this is principally the infection control fund, which is over £1 billion of funding—I think we are confident it has gone to providers, because we have returns on what it is being spent on. A big chunk of it has been spent on paying sick pay for staff who are having to self-isolate because of covid; that is pay that is being handed out by providers. Another chunk of it has gone on preventing staff who would normally move between settings, working in two different providers, from moving—stopping that happening, to prevent the spread of covid. Another part of it was spent on, for example, putting in place—buying—pods, or whatever they were, to support outdoor visiting.

Q56 **Sir Geoffrey Clifton-Brown:** May I stop you there? From memory, the infection control fund, which was the only ring-fenced fund, was £600 million out of the £3.1 billion. You say that of course you know the ring-fenced money, because it would have been illegal not to apply that money, but by far the greater proportion of the money was not ring-fenced. That is my point: how do you know that that un-ringfenced money found its way to helping specific social care locations?

Michelle Dyson: I will bring Catherine back in, because that was where the un-ringfenced money came from, but let me just be clear on the DHSC ring-fenced money. Originally, the infection control fund was £600 million. Then we added an extra £546 million—again, the infection control fund. Then we added £149 million to support testing, and then we added £120 million to support the workforce. All that was in '20-'21. For this year, we have done a further £341 million tranche of the infection control fund. All that is ring-fenced. It is the MHCLG money that is un-ringfenced.

Chair: Ms Frances, can you be brief, please?

Catherine Frances: Yes, of course. Forty-five per cent. of overall social care spending by local authorities has gone to adult social care. Our estimate is that about 35% of the un-ringfenced funding has ended up on adult social care. The ring fences have done their job elsewhere. As Michelle has said, ICF and all the other funds have done their jobs.

Q57 **Chair:** So about a third—35%—of the un-ringfenced funding.

Catherine Frances: Of the un-ringfenced funding, exactly, and 45% of the overall spend of local authorities has gone to adult social care services.

Q58 **Chair:** I have a last couple of quick questions about the adult social care outcomes framework, which we moved off. Professor Sturdy, as the professional in that area in the Department, and being fairly new to post, what do you want to see in that and what step change do you think needs to be made?

Professor Sturdy: I think it is about the personalisation agenda, ensuring that we have really strong input from people at the frontline of services, and their families where appropriate—that whole person-centred framework, focusing absolutely on that individual. The challenges for that are around the professional agenda—people are shifting their thinking. There is some work that we need to do with professionals to help them put that person at the centre, and to do that in partnership with carers.

Q59 **Chair:** That is interesting, and it brings me to Ian Trenholm. We talked earlier about what you would need in terms of resources to deal with any of the new powers in the health and care Bill. What expertise do you need, bearing in mind what Professor Sturdy has just said?

Ian Trenholm: In terms of what is in the health Bill, as I said earlier on, we need to look at scope and scale, and at the skillsets that we need there. On the things that Professor Sturdy mentioned, we look at some of those at an individual provider level anyway, as part of our core methodology, so our inspectors are looking at those sorts of issues. We are looking to develop our methodology over the coming year, to pick up these sorts of things—

Q60 **Chair:** And how do you weight that? I should have checked this beforehand, but in your inspections, how do you weight personalised care actually being delivered, and what is your assessment of what is happening out there in that arena?

Ian Trenholm: First, it is a significant weight. I cannot put a number on it—we use five key questions, of which care is one. Certainly, in adult social care, we look at that person-centred component, which runs all the way through a number of other areas. In terms of what is happening out there, a lot of care providers—the vast majority—have done a fantastic job over the last year. They have still managed, despite all the real challenges around covid—masks, PPE and the things that are almost anti-personal—to deliver a good experience for the people they are looking after. That has been a huge challenge for them.

Q61 **Chair:** We could have a whole session just on personalisation of care, so unfortunately we will have to leave that there.

Sir Chris, a lot of money has gone into the sector all of a sudden because of covid. Is money going in next year to continue to support homes that are under occupancy and all the rest of it? Also, there is the White Paper, with potential that some of that could continue. With all that public investment, do you think there is a case to make for greater transparency about what providers do—that it comes with that very important string attached? Are there any plans to deliver on that?

Sir Chris Wormald: Transparency is always important. We have heard quite a lot in this hearing about the various types of transparency that we have. Open inspection is probably the single most important one, but the data changes that Michelle described are also extremely important. I agree with the basic principle that you set out: we are going to invest more in the sector. With that goes a need for greater transparency. In particular, as we hopefully move towards the vision that the White Paper sets out of a much more integrated system between health and care—

Q62 **Chair:** That's great, but if you are an individual resident or relative and you want to know what is happening and where your money is going, in terms of your support or your relative's support, do you have any intention to take a greater approach to transparency? Given that a lot of those are private businesses, is there any tension there, and what discussions are you having with the sector?

Sir Chris Wormald: Obviously, the most important thing is that people who have friends or relatives in care homes will want to read the inspection report to know the quality of care being delivered in that institution.

Chair: That's the quality; I'm asking about the money.

Sir Chris Wormald: Obviously, these are private businesses, which will have financial publication requirements—

Q63 **Chair:** Sorry, we can talk around this subject, but I am saying that they are receiving taxpayers' money to deliver something. You agreed that there is a general principle that they should be more transparent, but how far are you prepared to go, what discussions are you having with the sector, and what push back are you getting?

Sir Chris Wormald: I'll bring in Michelle, but we should be transparent about the investment made on the public sector side. Obviously, as I say, there are data requirements that go with this business. There are particular requirements in terms of inspection and regulation that go with regulated businesses, so there is a transparency requirement, but I don't think we are increasing that.

Michelle Dyson: There is nothing more to add to what I said: we are going to be working on a data strategy during the course of this year, looking at what data we need in future, and we are taking powers in the

Bill for that purpose, but nothing that specifically goes to your question, Chair.

Chair: Mr Trenholm, do you have something to say on that?

Ian Trenholm: I was going to make the point that we have a "Give feedback on care" service, whereby people who have any issue about the quality of care can contact us. We then mediate between that individual and the service. If it is an issue about funding, people will sometimes complain about billing and other funding matters. But on your broader value-for-money question, which I think is what you were driving at, we do not have the power to enforce that. We encourage providers to talk openly with the people they provide services to, regardless of how the bills are paid, and whether it is publicly or privately funded.

Q64 **Chair:** Any well-run organisation would want to ensure that it spends as much money on possible on residents, but we have seen scandals in this sector where bad actors have prioritised profit over care. It may be a rare thing, but it does happen. Sir Chris, are there any plans to have some better financial oversight where people are making unfair profits out of the people they are caring for? The profits are part of the mix in the private sector, clearly.

Sir Chris Wormald: We do not look at profit per se. We look at the quality of care. The scandals where people have not provided the quality of care that they should are picked up by the CQC inspection and the enforcement regime that Ian described. I do not think we would take a view on profit or not; we care about whether the service provided meets the standards, regardless of how much money the institution is paid. That might be a cause, but the symptom that we deal with is the quality of care, and that is the regulation system.

Chair: And that is the forced closures that Mr Trenholm oversees. Okay, we will leave it there for now. I will now throw to Olivia Blake MP. Over to you, Ms Blake.

Q65 **Olivia Blake:** Thank you, Chair, and apologies if my internet isn't very good today. Sir Chris Wormald, how effective do you think local authorities are at managing and influencing local care markets?

Sir Chris Wormald: Again, I will bring in Michelle on this. Overall, I think that local authorities have done a tremendous job, particularly during the pandemic, not just on social care but across the piece. As we have said before and as this Committee has observed before, there are variability questions between local authorities, which we have discussed before. We want a clearer national picture of what those variations are, which is why we want an enhanced CQC role in assurance and the various data requirements that Michelle was describing.

Obviously, the overall outcome is the quality of the care, which, as we have said, has held up very well, as evidenced by the CQC inspections. Of course, the result of all this activity is, "Is the actual care good?" It can be better, but, as we have said, the evidence of inspection is actually quite

positive on care. Michelle, do you want to add anything on the variability questions?

Michelle Dyson: I think we have seen some really interesting things going on, in terms of local authorities getting together at regional level to get data on their care markets and thereby manage them. For example, in London they created a tool to gather all that data. They have also commissioned the academics that we work with at the London School of Economics to help them with that. I know that other local authorities have used the programme that we fund, in terms of spreading good practice; they have been looking at innovation in terms of models of care. There are some really interesting things that local authorities are doing collectively to manage their markets.

The other thing I would say is that to some degree this does go down to individual local authorities being very good at managing things through their personal relationships. They know their providers, they can see what is going on, and they know when they are in trouble or not.

Q66 **Olivia Blake:** You have spoken about regionality and I am really pleased that you did, because I wonder if there is a bit of a conflict between the private system, having open books, knowing what your neighbours are paying, and whether that approach could be overridden by closer working across localities. We see that in the NHS. Is that something that you would like to see mirrored in local authorities?

Michelle Dyson: It is never going to be like the NHS, because it is a mixed market and it is owned locally by local authorities, which have the duties. I am really encouraged by what we see going on, with different things going on in different regions, responding to the fact that the markets in different places are different.

Q67 **Olivia Blake:** How concerned are you about the exit strategy for the covid funding that has been put in place? I assume that the argument will be made by providers that they need that funding to continue, and I am sure that local authorities will make the same argument as well. How confident are you that there is an exit strategy, or do you think that it will just become part of the baseline funding that is going into the sector?

Michelle Dyson: The extra money that we are putting in is for a specific purpose: it is to pay for sick pay, because we know that there are still outbreaks of covid in care homes, or to pay for people travelling to go and get their vaccine. It is for specific covid purposes. Hopefully there will come a time when we no longer need that, but I don't see that happening quite yet, hence why, for example, we have said that free PPE is going to continue until next March.

Olivia Blake: Does anyone else want to come in on that?

Sir Chris Wormald: If I could just pick up, I think that the issue you raise is exceptionally important. Mr Trenholm commented right at the beginning of this hearing about the dual effect of the extra money that has gone in, which has clearly not only assisted people with covid but stabilised the

system; the effect on the market of covid itself; and what we can expect to happen as hopefully we come out of the covid period. The thing I would observe is that there are a lot of moving parts in that and we will clearly have to work very closely with our local government partners and the sector itself on how those various parts are moving, so that we allow, as it were, for a smooth transition. We can't take those decisions now, for reasons that you all understand—not least that covid is not beaten yet—but I think you put your finger on exactly the right set of issues that we will need to be addressing carefully with our partners as we go forward.

Q68 **Olivia Blake:** Going back to the longer-term view—this is to Catherine Frances—do you think that authorities have enough funds to meet their statutory duties to a good and sufficient level and standard?

Catherine Frances: Yes. I can only speak about the period where we have actually given them a funding allocation—so, for this next year. Maybe the Committee would find it helpful if I just explain how we do a spending round. In relation to adult social care, we take from DHSC some rather good modelling, which is peer reviewed, about the underlying demographics and what that does to the likely number of people who need support under the Care Act—exactly as you say: to meet the basic Care Act requirements. That is what we model into the spending round, which then of course gets a set of ministerial decisions taken on it and is combined with other areas, but we have funded that in the spending review.

Sitting on top of that this year is exactly the funding that you are rightly talking about—the covid funding of £1.5 billion and then other grants going in for public health measures and social care measures. There we need to take stock of how it pans out over the course of the year. In another hearing we have talked about how we will keep our monitoring switched on for some time with local government, as we see what happens to their expenditure, to give us some assurance that we really understand what is happening in the sector. Stepping off this particular escalator is going to take a little bit of care, and we are going to have to do it carefully with our colleagues both in DHSC and locally, to make sure that we get that right.

Q69 **Olivia Blake:** Can I move on to workforce and ask, quite simply, where the long-promised workforce strategy promised is?

Sir Chris Wormald: To state the obvious, this has been delayed. I don't think it is a secret that the last couple of years have not played out exactly as the Government had planned. The issue of workforce is clearly both vital and linked with long-term reform and long-term funding. Just like in the NHS, it is very difficult to answer those questions separately from each other, so we would expect to be bringing forward workforce proposals at the same time as we bring forward spending proposals—which is not saying we are not doing a lot of things around workforce already. We might bring in Professor Sturdy in particular, whose role, as the Chair has said, is new and is absolutely key to all this.

Q70 **Olivia Blake:** We have clearly had the NHS people plan, which we have discussed here before. How do you feel the plan, when it arrives, will fit with that plan, especially when it comes to nursing as a skill and profession? Perhaps Professor Sturdy would like to come in on that.

Professor Sturdy: Yes, I am very happy to answer that. I think it is important that we look at the whole of the nursing profession in the round, not just in the silos of the NHS and social care, because obviously the supply chain in terms of undergraduate nurses comes from no one single place. We also have to talk about careers in social care, rather than jobs, so I think there is a real opportunity to set this out from novice to expert and actually work with the sector to think of new roles within it, such as advanced nurse practitioner roles. I know that North Tyneside CCG—I was talking to them a matter of weeks ago—are looking at developing some of those posts in partnership with some of their local providers, and an appropriate evaluation of that, so I think we have a real opportunity.

The other thing that is critical, which the role of the chief nurse brings, is to start changing the narrative: instead of saying, "We work in a care home," we should actually start talking about these as nurse-led services. When you think of them in a different context, we are talking about the autonomy, complexity and leadership that is needed in that sector, so we need to start thinking and talking about this in a different way. Having been in post a matter of months, I have already commissioned a scoping piece of research to look at the role of the registered nurse in care homes, because we do not have that evidence base. There is quite a lot that we need to do in terms of creating that evidence, learning from it and starting to develop that, to give the sector itself some confidence that this is a really positive choice for some nurses.

Q71 **Olivia Blake:** On that, Sir Chris and Michelle Dyson, where will the money come from for this workforce development and when can we expect it? That sounds fantastic, but how are we going to deliver it?

Sir Chris Wormald: As I have said before, these are spending review questions, and of course for a sector such as this, it is the key spending review question. Even more so than the NHS, this is a people business, and the vast majority of expenditure goes on workforce, one way or another, so it is completely central to the spending review going forward.

I would say—this very clearly goes with what Professor Sturdy has just said—that money is of course part of the question, but there are lots of other questions that are not money dependent: questions around career structures, around the narrative and around the kind of professionalism that Professor Sturdy was describing. The money is important, but it is not all of it, and we do need the sort of professional leadership that Professor Sturdy has just described and that she will, of course, be bringing.

Q72 **Olivia Blake:** Can I ask about parity of terms and conditions, and also pay, within the two sectors of the NHS and care—which I hate separating—and how you will work to alleviate that issue, so that we do not leave staff who skill up into the NHS or vice versa, for example in

learning disabilities?

Sir Chris Wormald: I will ask Professor Sturdy to comment as well. As we all know, there are issues, but they are quite nuanced, and this goes with what Professor Sturdy was saying about having to look at the nursing market as a whole. The vacancy rates for nurses across the two sectors tend to be quite comparable, despite very different terms and conditions and, in some cases, pay. That suggests—as I say, I will ask Professor Sturdy to comment—that there are obvious attractions to working in the NHS and there are attractions to working in care, and we need to be clear about there being great careers in both. As I say, vacancy rates do not appear to be that dependent on classic pay issues, because we are talking about sectors that have different appeals. Professor Sturdy, this has been your life's work, so I will leave you to comment.

Professor Sturdy: Thank you. I think Sir Chris is right: people want to take different roles in nursing for different reasons. The attraction of working in social care is that longer relationship that you have with somebody, those person-centred relationships that you have, and sometimes working in smaller teams. It is horses for courses: people choose different career paths for different reasons, and again, the terms and conditions are different.

Social care is a predominantly private market with different employers, which is very different from a national service, so we do not have that kind of parity in terms of pay and conditions. In my experience, some providers are paying comparable rates to the NHS, because they have to because of market forces. Certainly, that has been my recent experience when I was a director of a service.

Q73 **Olivia Blake:** Finally for Professor Sturdy, I have a question on about wellbeing. Clearly, this year will impact significantly on wellbeing for many reasons. How much focus do you think you will need to put into that going forward?

Professor Sturdy: I think a lot has been done to date around supporting staff, but there is more to do. It is not just about the immediacy of the aftermath of the impact of covid on people who have gone above and beyond in a way that none of us could have expected—great thanks to everybody for all they have done. We also have to think of the potential for post-traumatic stress later down the line. That is something about which I, in this role, and employers more generally have to be conscious.

The work that has been done nationally by the hospice movement, Samaritans, Mind and others to provide ongoing support for people has been really good, but employers themselves have addressed a lot of these issues, particularly the bigger providers, in terms of supporting and making sure that their staff remain buoyant in what has been an exceptionally challenging period of time for people.

Chair: Thank you. Mr Trenholm, very briefly please, and then I will go to Mr Bailey.

Ian Trenholm: Just to add to that, it is worth noting that both in health and care, we see how well employees are treated as an issue of leadership. That is something that we routinely look at.

Chair: That is a relief, because it is not something that can be a flash in the pan as a result of covid. It is going to be a long haul for a lot of people. I am glad that is recognised. Over to Shaun Bailey MP.

Q74 **Shaun Bailey:** Thank you, Chair. Sir Chris, does the Department think that the best place for a person is not necessarily in hospital?

Sir Chris Wormald: I will give you the answer that my clinical friends give me, who are much more knowledgeable than I am. It is very person specific. There are people who very much need to be in hospital and are receiving vital treatment. There are also downsides to being in hospital, particularly for older people for whom staying in hospital too long can be physically bad for them. That is well identified. For those people, timely discharge is absolutely vital. I don't think there is a single answer to your question, but the default should certainly not be that people are in hospital.

Chair: That was a long answer to a short question. Can we keep the answers a bit shorter?

Q75 **Shaun Bailey:** Sir Chris, thinking about long-term planning, if we put the £3.1 billion that has been committed to the hospital building programme into adult social care, how long could adult social care providers plan for with a £3.1 billion injection? We have had these year-on-year plans, so what would that do?

Sir Chris Wormald: Our total spending on adult social care, as set out in the NAO Report, is approximately £20 billion. You can do the math yourself on what would happen if you moved funds around. However, that is not our approach. What we want to see—this is locked into the White Paper on integrated care—is services that work much more closely together, which are both keeping people out of hospital in the first place through preventative health measures and ensuring that if people need to be in hospital, they are there for the right length of time. Those integration questions are absolutely central to this.

Q76 **Shaun Bailey:** Sir Chris, when it comes to your Department more broadly, in terms of how you plan operationally, how long are your plans? In terms of the internal running of the Department, procurement and things like that, do you plan on a year-by-year basis, a three-yearly basis or a five-yearly basis? How does that work?

Sir Chris Wormald: It is entirely dependent on how long our money is in particular areas. On the NHS side, where we have a long-term plan, the Department's plans would match that. On capital, we have long-term commitments and we plan on that basis. Obviously, if we have short-term money, our ability to do that is more limited. We would plan in detail for the period that we have money and then it would be more scenario-based after that, so there isn't a single—

Q77 **Shaun Bailey:** Sir Chris, on that basis, would you say that it is a fair assessment from both my local authority and a local not-for-profit provider, Sandwell Crossroads, that the adult social care sector is seen as the poorer cousin to the NHS?

Sir Chris Wormald: Clearly the NHS has a particular place in the national consciousness and a particular place—

Shaun Bailey: Sir Chris, I think there is probably a briefer answer that we can give on this one. Do you agree with the assessment of my adult social care providers that adult social care is seen as the poorer cousin to the NHS?

Sir Chris Wormald: That is not terminology I would use, no.

Q78 **Shaun Bailey:** Okay. On planning, which we have talked about today, I have had quite an in-depth conversation with some of my care providers on the staffing point. What impact assessment have you done on HCAs and other professionals leaving the sector as a result of precarious employment because of the fact that, as I say, we are operating on what is effectively, according to my care providers, a year-on-year funding basis?

Sir Chris Wormald: I will ask Michelle to give you the numbers. What we see in the sector—I think this is set out in the NAO's Report—is that turnover is too high. That is undoubtedly the case. A considerable amount of that turnover, however, is within the sector, rather than to the outside. Michelle, do you want to pick that up?

Michelle Dyson: I will give the figures. As Sir Chris has said, turnover is too high. It is about 30% and has been for some time. Around two thirds of that is people moving to other care providers, so they are staying within the adult social care sector but are moving between providers.

Q79 **Shaun Bailey:** That is helpful, but the point I was trying to make was about the broader impact on the sector. You said that it involves people moving around, but I would not say that it is always a straight switch, if that makes sense. What assessment have you done of the impact of people leaving the sector? As you said, turnover is too high. What impact will that have on the delivery of the service to the most vulnerable?

Michelle Dyson: We have not done any direct impact assessment on that point. However, as we said earlier, the quality of care, as judged by the CQC, remains high, with 84% good or outstanding, as of April 2021 despite the high turnover rates.

Q80 **Shaun Bailey:** Okay, but given the pressures that staff in the sector are under, which we have talked about, and the data issue that we have discussed, do you know what is going on on the ground? Are you confident that you actually know the experience of, say, an HCA, in terms of their feeling towards their role in the profession at the moment?

Michelle Dyson: We know that the workforce is under huge pressure. We hear that all the time. As we said, that is why we know that we need to

bring forward a workforce strategy. We know that part of our reform needs to be investment in the workforce.

Q81 **Shaun Bailey:** Thank you. I am conscious of the need to keep this as tight as possible. More broadly, the approach that the better care fund takes is more collaborative. However, earlier in the session, the focus was on ensuring that individual local authorities still provide funding. What is the Department's approach here? Is the Department trying to push for a more integrated, collegiate approach in terms of how things operate on the ground, or do you still want that individual accountability for individual local authorities?

Sir Chris Wormald: As ever, it is a very important question that you ask, and as ever we want both. Clearly, in line with the principles of managing public money both locally and nationally, what we want is people who are clearly accountable for the budgets they hold, who know what they want to achieve with them and who can be held to account. I am sure that is what you would expect. In local areas, however, we want care providers, the NHS, the voluntary sector and a wider community to do the kind of personalisation described by Professor Sturdy. Clearly, that involves multi-agency working and people working together. That is at the heart of the ICS proposals in the White Paper.

The balance we are trying to hit is to allow that kind of local collaboration—to not have bureaucratic barriers to it around funding and all those sorts of things—while maintaining clear lines of accountability for taxpayers' money. That is difficult, and I do not need to tell the Committee about that. Both those things are wanted, and we want to be working towards them. When we have looked around the world at the examples of this working, the absolute key to it is having great data locally. The key to whether we can make it work is whether there is really good population health data locally that allows people to coalesce locally around the right issues in a timely enough manner. They are challenging reforms, but the challenge is to allow that kind of approach to the public service that starts with the individual, while retaining proper lines of accountability for individual pieces of cash that allow taxpayers to know what happens with their money.

Q82 **Shaun Bailey:** But surely, Sir Chris, it will have to go one way or the other. The approach to accountability will either have to be regionalised, or a much more individualised approach will have to be taken. From looking at the BCF structure and the feedback, it has to be one or the other. We cannot have our cake and eat it.

Sir Chris Wormald: Yes, and our proposals put the ICS model at the heart of the system, where people are coming together locally, looking at the local needs and then contributing to meeting those local needs, but from budgets that they hold. I do not think that anybody is proposing a sort of division between the national NHS spending and local authorities' responsibility towards social care. That basic accountability for public money—one local and one national—remains, but we want people to be

able to spend it in a joined-up way locally. That is what the ICS proposals are all about.

Q83 **Shaun Bailey:** That is really useful, Sir Chris. More broadly, in terms of the Department's understanding of what adult social care is, the feedback I have had is that it seems, from a lot of the policy pronouncements, that it is care homes. We know that is not the case. It is dementia care; it is a broad range of things. For example, I am in my late 20s, but I could require adult social care services. How are you ensuring, as a Department, that what is maybe being perceived as pigeon-holing is broken down, particularly when it comes to funding decisions and policy development? From my conversations with the sector, there is a concern that the Department is still pigeon-holing adult social care into care homes, effectively.

Sir Chris Wormald: I would point you back to the description given by Mr Trenholm earlier on to do with the three things we are dealing with. We are very aware that we are dealing with all three, and that they are different, though related. Your question comes down to those things. One is the expertise available within the Department, where we need civil servants and people who come from the sector, such as Professor Sturdy. We have various other advisers who come from the sector or who have spent their lives doing this. The second part comes from inspection. Evidence is brought to us independently by Mr Trenholm that covers all three sectors of the market. The third is, of course, how we liaise with our partners, particularly local government and ADASS, which Ms Dyson mentioned earlier, as well as sector representatives and others.

Those are the basic ways that we keep ourselves informed and in touch with the sector. I go back to what I said about professional leadership in this area—

Q84 **Shaun Bailey:** Thank you, Sir Chris. I think that the point I really want to make. I don't know whether it has already been made today—if it has, perhaps I can reiterate it. And this is not from me, but from my care providers. As you try to reform the sector, can you please make the statement today that you will ensure those reforms are not just packaged, as you say and as I have just said, around that care home offering, but in fact understand that the sector is broader?

Also, I might as well say this while we are at it: can we try to ensure that this perceived narrative of perhaps being the poorer cousin of the NHS is broken down, because there is a lot of anger among my providers at the moment that—quite frankly—they are not really valued for what they do? And they are very concerned over where these reforms are going and over the narrative that is forming the basis for them.

Sir Chris Wormald: Yes, and of course we appreciate those comments; I completely agree with what you have said. And as I say, if you look at our White Paper, you will see that it is considering how we reform NHS care and wider care together, so that you get the kind of personalised approaches that Professor Sturdy pointed to. Easy to say—very difficult to do, for the reasons I was describing earlier, namely that we also want very

clear understanding of who is responsible for which money and why they are spending it. That is our challenge.

As I say, it is an easy thing to say—I think your constituents are exactly right—but administratively it is very difficult. And we have to trust local people to do it. I am sure that the Committee has seen this too, but whenever I have seen this work, it is because we have enabled local professionals to get together and have a sensible conversation about what to do, as opposed to there being national guidelines, etc. I am sure that everyone has seen that in their own constituencies.

Q85 **Chair:** Okay—a thousand flowers will bloom under Sir Chris Wormald's stewardship. Perhaps that is not quite what you said, Sir Chris.

Sir Chris Wormald: That is not quite what I said, but I'll take it.

Chair: That is about the best you get as a compliment, I think. Anyway, over to James Wild MP.

Q86 **James Wild:** I just want to turn a bit more to the reform. Obviously, this has been much promised by Governments of all colours and persuasions over the last 20 years or so; I have not totted up all the White Papers and Green Papers, but I think there are quite a few. Sir Chris, when can we expect precisely to see this plan?

Sir Chris Wormald: The Prime Minister set out the position on the plan at the Liaison Committee a few weeks ago, and I don't have anything to add to what he said.

Q87 **James Wild:** Okay. In terms of expectation management—because, as this hearing and previous reports have shown, there is a lot in this sector that that people think needs to change—how ambitious is the vision going to be within the plan?

Sir Chris Wormald: Obviously, I can't comment on future policy before it is announced in the usual way. However, the way that we are approaching this, and this has come out during this hearing, is that there are three phases of things. There are things we are doing right now, which Michelle and others were describing earlier, around covid, some of which we will want to keep; there are the reforms that we set out in the White Paper, which are largely about making the current system work better; and then there are the manifesto commitments of the governing party, which, as I say, will come forward in the usual way.

Q88 **James Wild:** In developing the proposals—at the start of the hearing, you were talking about the market and the impact of long-term assessments, and pointing to the CQC report showing that the market is working broadly okay—will you use this process as an opportunity to drive more innovation and more diversity in providers? The approach that the councils have had to take is largely to use larger providers in order to drive down the costs, which doesn't necessarily deliver the best care for people.

Sir Chris Wormald: Mr Trenholm might want to comment, but it is actually a very mixed market. As I say, 65 providers cover 30% of the market. There are then some mid-range providers and a large number of small providers operating in individual places.

Although I obviously cannot comment on future policy, I think the points you make about innovation and driving innovation in the sector are absolutely crucial. Unlike in many areas of human activity, the technology around this market has not changed very much. We have seen some individual pieces of very exciting development and different thinking, but it certainly has not had the kind of technological innovation that some areas of the economy have had or that the NHS and health have had. We will certainly want to be encouraging, as you say, a diversity of types of provision, and, in particular, on the division whereby you either get domiciliary care or are in a care home—those are obviously questions that we will want to address and, as you say, innovation should come in.

It would be interesting to ask Professor Sturdy which areas she would most like to see innovation take place in.

Professor Sturdy: I think there is some real opportunity around domiciliary care. One of the things we have seen during the pandemic is that workforce stepping up and taking on roles at times when district nurses have not been able to support them, or because of the restrictions around covid, so I think there is a real opportunity for the domiciliary care workforce to develop. As long as we have proper assurance frameworks, accountability frameworks, training and skills development and oversight, I think there is some real opportunity. And as people make different choices from care homes, in terms of how they want their care provided in the future, I think there is real opportunity particularly in that sector.

Q89 **James Wild:** Great; thank you very much.

Ms Dyson, how many people do you have in your team who are actually developing these proposals? I note from figure 16 in the Report that there is a—well, I'm not sure what the adjective is, but there is a plethora of meetings going on here. In your team, have you got the resource to make sure you meet the deadline to produce the proposals?

Michelle Dyson: Yes, I think I have. Clearly, we are having to manage covid at the same time, but I have now got a large team and we do have enough people to work on reform. It's clearly not just us. It is really important that we work together with the many, many experts in the sector—in fact, we had a whole load of meetings just before we went into the period of sensitivity for the local government elections; I think we saw about 70 different organisations, as part of that—as we start to work up our thinking.

Q90 **James Wild:** That's helpful. Is that the local government organisations, or organisations in this space in total, whether that's providers, charities or—

Michelle Dyson: It was all different types of providers, organisations representing people with lived experience, organisations representing providers, and local government. And we had a series of five or six different meetings with different groups.

Q91 **James Wild:** You have just highlighted that it's not just you; it's not just the Department of Health—and we obviously have an MHCLG witness here today. It's about getting that wider buy-in. Again—to pick up on the earlier point about carer's allowance and DWP—there are lots of Departments playing here. Are you playing nicely? Has everyone got the same objective here?

Michelle Dyson: You're quite right: we have a very close relationship with MHCLG, but I am also in touch with my counterparts in DWP, DFE and others. It is really important that we approach this jointly.

Q92 **James Wild:** Can I ask about the modelling in the Report? It forecasts, effectively, a doubling of costs over the period to 2038, with significant drivers coming from, in particular, learning disability support. How much confidence do you have in that modelling? Is it going to be the basis of the proposals? Are there weaknesses in the modelling that mean you discount some of what is a huge growth in cost?

Michelle Dyson: The model is owned and run for us by the Care Policy and Evaluation Centre at LSE, which I have mentioned before, and we have a lot of confidence in it. It is a very widely respected model; clearly, no model can ever be perfect, especially when it is looking so far into the future, but we have a lot of confidence in it. However, the model is looking at demographic pressures, and clearly when we are looking at reform, we are looking more broadly than just demographic pressures.

Sir Chris Wormald: Can I just add something on the pressures? Although it creates a huge problem for me and Catherine and our Treasury friends, the cost driver here is a huge societal success in terms of people living considerably longer, particularly people with learning difficulties now living much longer into adulthood than previously. That is a big part of the cost driver, so although it is a big problem in financial terms, it is actually a credit to the NHS, local government and others that many people are having much longer lives than they did previously.

Q93 **James Wild:** One area—paragraph 3.11 on page 52—talks about where there are some gaps in what the modelling looks at, and one of those is the changing mix of care and where there is greater use of care at home, which I think a lot of us would agree is probably the best place to start with care. If that is not properly captured in the model, how are you looking at that and assessing it in developing your proposals?

Michelle Dyson: The answer is that we are doing research—again, through LSE—on that issue, among others. Some issues are captured by the model, but other issues are better captured through research, rather than through pure modelling.

Q94 **James Wild:** And are you confident you will have that in good time? I

mean, we are a good chunk of the way through the year now, and summer comes, and suddenly that December deadline—which I presume is when this paper will appear—is upon us. When are you getting that modelling? Is this an ongoing, iterative process, or do you have some already?

Michelle Dyson: Inevitably, all of this is ongoing and iterative, but I am confident that we will have what we need for our reform proposals.

Q95 **James Wild:** Okay. One of the areas that the NAO talks about as particularly pressing for the reforms is providing future accommodation. When will there be a clear cross-Government strategy? You have DWP paying out significant amounts of welfare payments to people who are living in supported accommodation, and MHCLG providing some limited increase in the level of supported accommodation. Where is the plan that pulls all that together? Is that going to be part of this long-term reform?

Catherine Frances: Perhaps it is helpful for me to come in there. On the issue of housing and accommodation, there are, as you say, quite a set of Departments that are interested and have direct levers. Also, as we are talking about a complex social care market, we are talking about quite a complex housing market as well, so we have to interact in that way. At the moment, we do not set out a national sense of, "This is the combination of accommodation and, say, people support that you need in order to deliver social care." We do not do that nationally, because we think that that mix will vary place by place, for all the reasons we have talked about previously.

What we do do nationally is a few big pieces. First, both DHSC and us in MHCLG essentially put capital support into the system. In MHCLG, with the affordable housing programme—which is £11.5 billion, so really quite a large programme—10% of that is targeted for supported housing. In addition to that, DHSC have by comparison a relatively small grant, but a significant one: the care and support specialised housing fund, worth about £70 million, which is to support the development of specific housing development for people who have ongoing resource needs, and particularly need their own front door, communal spaces and that sort of thing.

Then, in MHCLG, we also use our levers over the planning system. As the Report rightly notes, we do not specify from the centre, "This is the number of housing units you should create for supported housing", but we do require local government to go through that process and think about their mix locally. We have issued guidance in 2019 to help local authorities deliver on their expectations there, and you may know that we recently also consulted on options to raise the accessibility of new homes.

It is quite a mixed economy that goes into the housing market, but then it always is. Our fundamental approach is to put these levers in but let the balance be struck locally. I can't really comment at this point—with apologies—on where we go in future, for future reform, but I hope that

gives you some assurance that we are all joined up in Government: both us in DH, and also DWP colleagues too.

Michelle Dyson: Can I just mention a couple of further points to that? We, in DHSC, put nearly £600 million into the disability facilities grant, which is another important grant: that is about making changes to people's homes to enable them to stay in their homes for longer. The only other point I would make is that there is quite an important commission being led by the Social Care Institute for Excellence. The commission is on the role of housing in the future of care and support. It is going to report—I forget whether it is interim or final—this summer, so we will be watching that with interest.

Q96 **Chair:** Thank you to our witnesses. I just want to go back to Sir Chris Wormald on a couple of points that are topical and not related directly to this issue. You have been asked by the Cabinet Secretary, Sir Chris, to provide details of any of your senior officials that have had either links with Greensill or indeed have second paid employment. Can you give us any update on whether any of your officials are caught up in this?

Sir Chris Wormald: I have not seen anything that worries me. There are, of course, a lot of people within DHSC who have second roles. We have people who have academic posts. We have people who also work as clinicians in the NHS. As you know, a lot of civil servants are trustees of charities or special constables or military reservists, etc. So we have a lot of people who have outside interests; but when we checked, so far I have seen nothing that concerns me.

Q97 **Chair:** And can you confirm whether any of your officials have had meetings with Greensill, because we know that NHS England has. Today, Lord Prior, as the chair of NHS England, is named in newspaper reports. I can't comment on the ins and outs of that, and am not doing so, but do you know if you have had any meetings with Greensill, given that Greensill has got contracts with certain NHS trusts?

Sir Chris Wormald: Yes, there have been discussions between Mr Greensill and his representatives and the Department about the two schemes that have been in the press. I believe the National Audit Office is going to look into all this for you, so there will clearly be a full assessment, but in my look at the decision making around those schemes, again, within DHSE, I haven't seen anything to concern me.

Q98 **Chair:** Okay. Particularly the pharmacy scheme—how much was the Department involved in that?

Sir Chris Wormald: The history of the pharmacy scheme—obviously this has quite a long history. It was 2013 when this was originally introduced. At that point it was run by the Government Banking Service in association with Citibank. It was retendered in, I believe, 2018 by the Cabinet Office, and it was at that point that Taulia, with Greensill as a subcontractor, took over the scheme. DHSC would have been involved—indeed was involved—in discussions about both; but we were not the contracting party. The scheme itself, in the second period from 2018, was administered on behalf

of Government by the BSA, so we would have been, via one of our NDPBs, involved in that.

Q99 **Chair:** Okay. We are going to be looking at supply chain financing in a lot more detail. We have obviously looked at it a bit before, and we will be picking that particular point up, but thank you for that clarification, and we look forward to seeing the full published information, which no doubt will come from all Departments in due course.

A final question from me. I do not normally raise constituency issues but this is a wider issue for the NHS: I was talking to a constituent recently about a Spanish nurse who is not able to come and work in the NHS because of the way the system works now that we are not in the EU, and because the experience transfer does not count in the Spanish system. That brought me to think about the wider issue of the number of NHS staff who come from other countries outside Europe, some of which will be on the red list, so they will not be able to come to this country because of covid. Is anyone doing any work on that? What do you think are the risks to our NHS as a result of Brexit and covid?

Sir Chris Wormald: We look at that all the time, so we do work on it. I did not check the numbers this time, I am sorry. Last time I looked, the number of EU nationals working in our NHS remained higher than it had been on referendum day.

Q100 **Chair:** It's not so much the total number but the flow. My concern is about the flow. Are we cutting off certain groups that were useful to our national health service who are no longer incentivised to come and work from the EU? And are there others who may be cut out because of covid?

Sir Chris Wormald: When I previously looked at the numbers—as I say, I have not checked—

Q101 **Chair:** Could you write to us with that information? And perhaps you could pick up on the issue of Spanish nurses in particular. It may be interesting to know whether that applies to other European countries, too.

Sir Chris Wormald: The NHS does look at that but so does the Department, because we look at the impact on the social care workforce of all the various changes, so there is a departmental involvement. Our colleagues at HEE have a number of international programmes.

Q102 **Chair:** When Brexit was happening, was it feeding into the discussions that some of those professional roles would be challenged?

Sir Chris Wormald: It has been widely discussed, including in public.

Chair: Perhaps you could write to us with more detail rather than going into the detail at this point in the session.

I thank our witnesses. Our uncorrected transcript will be up on the website in the next couple of days, and our Report will be out at some point in May, depending on various Prorogations and recesses of Parliament.