HOUSE OF COMMONS

Housing, Communities and Local Government Committee

Oral evidence: Long-term funding of adult social care, HC 35

Monday 25 October 2021

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Watch the meeting

Members present: Mr Clive Betts (Chair); Bob Blackman; Ian Byrne; Brendan Clarke-Smith; Florence Eshalomi; Ben Everitt; Rachel Hopkins; Ian Levy; Andrew Lewer; Mary Robinson; Matt Vickers

Questions 1 - 50

Witnesses

I: Stephen Chandler, President, Association of Directors of Adult Social Services; and Councillor Tim Oliver, Chair, County Councils Network.

II: Steven Scown, Group Chief Executive, Dimensions UK; Jane Ashcroft CBE, Chief Executive, Anchor; and Dr Jane Townson, Chief Executive, Homecare Association.

Examination of witnesses

Witnesses: Stephen Chandler and Councillor Tim Oliver.

Chair: Welcome, everyone, to this afternoon's session of the Housing, Communities and Local Government Select Committee. It is the first evidence session of an inquiry into long-term funding of adult social care. Welcome to those in the Committee today and those looking in.

The question has been asked, has the name of the Committee been changed to mirror the name of the Department? The answer is not yet; that is a decision for the future. We are still Housing, Communities and Local Government for this afternoon.

To begin, would Members of the Committee put on record any interests they have that may be directly relevant to this inquiry? I am the Vice-President of the Local Government Association. We will go around the table.

Ben Everitt: Thank you, Chair. I employ councillors in my office.

Andrew Lewer: In addition to my entry in the register of interests, I am a Vice-President of the LGA.

Matt Vickers: As noted in my entry in the register of interests, I have links to local councils.

Bob Blackman: I am a Vice-President of the LGA, I employ a councillor in my office and my sister works in the care sector.

Mary Robinson: I employ a councillor in my staff team.

Ian Byrne: I am a sitting councillor in Liverpool.

Rachel Hopkins: I am a Vice-President of the Local Government Association and I employ a councillor in my team.

Florence Eshalomi: I am also a Vice-President of the LGA.

Chair: Thank you very much. We have two witnesses to begin in our first panel this afternoon. The Local Government Association was sending a representative but unfortunately, for personal reasons, she cannot attend. We entirely understand that and will get some further written evidence from the association in due course. We have two expert witnesses this afternoon and we are pleased to welcome them. First of all, Stephen Chandler. Stephen, could you introduce yourself, please?

Stephen Chandler: Good afternoon, everyone. My name is Stephen Chandler. I am currently employed as the Director of Adult Services and Housing in Oxfordshire; that is my day job. I am here representing ADASS, the Association of the Directors of Adult Social Services.

Chair: Thank you. Councillor Tim Oliver.

Tim Oliver: Good afternoon. I am Tim Oliver. I am the Chairman of the County Councils Network, the Leader of Surrey County Council and also the Chair of Surrey Heartlands ICS.

Q1 **Chair:** You are both very welcome indeed. It seems as if we have been here before in the Committee, probably on several occasions, looking at funding for social care. 2018 was the last time we had a look at it, together with the Health Select Committee. Would you like to say how the pressures on the adult social care sector have changed in the last three years, if they have changed? In particular, of course, we have had the Covid pandemic and all the pressures and measures to respond to that. Could you tell us what has happened in the last three years to change the situation, with particular reference to Covid as well?

Tim Oliver: There has been an increase in demand for the services, both adult social care and children's services. That is partly related to Covid and partly just to the demographics.

Local councils have had to deal with the provision of PPE. There has been a reduction in income. There have been payments to sustain private and third sector providers that were not there before, increased unit prices to providers to cover extra costs and, indeed, additional staffing costs—enormous pressure on the whole service for workforce and the costs of delivering those services.

Stephen Chandler: Let me start by saying, "Good news". The good news is that more and more older people are living longer, and more and more young people with disabilities, lifelong conditions, those who have accidents are surviving and living lives. Great news: there are more people living longer with long-term conditions in this country.

However, as Councillor Oliver has said, that brings with it an increased demand for the support that they need to live ordinary lives, the things that you and I take for granted. There is a greater pressure on the budgets that local authorities have to meet their needs. As Councillor Oliver has also said, a lot of the support—and we have an increasing percentage of it—is short-term, so we are having to deal with money that comes through on a short-term basis, which makes it very difficult to make long-term planning assumptions.

Finally on this point, we have had a pandemic and that pandemic has changed the landscape in which councils have organised and delivered services. It has brought with it the increased costs associated with infection control, whether that is PPE, staffing or the physical space that people need to be safely supported within. Of course, we are also responding to support the pressure that the NHS has experienced. Every council across this country is dealing with an increased demand that is as a result of the increased activity within the NHS.

Q2 **Chair:** Increased demand, long-term pressures and short-term funding so far. Government have recently announced their plan for health and social care. We are going to come on to some of the specific funding elements of that in due course but, in general terms, does the plan address the pressures that you are under in providing the service and respond to them adequately?

Tim Oliver: I don't think you can address the pressures within the NHS without addressing the pressures within social care. The two are interlinked.

In particular, there needs to be focus on the point where the two systems come together, and that is the discharge to assess. There is a bottleneck for hospital beds, the shortage of hospital beds and then putting those patients ideally back into their homes and, if not, into some sort of social care package. What you need is some form of step-down facility or intermediate care, four or six weeks fully funded, to enable that transition. That is where there is an opportunity for the two systems to work closely together.

Q3 **Chair:** We will come on to look at the potential for more integration between the two systems in due course. Your views on the plan that was announced, Stephen Chandler? May I just ask you to speak up a bit?

Stephen Chandler: My apologies; I will try to be a bit louder. The plan does not address the here-and-now problems of increased demand, increased complexity of need as a result of the pandemic and the implications of the pandemic. It does not deal with the increased demand that councils are experiencing now and have been experiencing over the last few years. It provides a basis for the future in relation to care cap, and we will no doubt talk about that in subsequent questions but in relation to increased demand here and now, no, it does not.

Chair: We do not talk very much about social care before we get on to the issues of funding. Ian Byrne has some questions about that.

Q4 **Ian Byrne:** I will direct this first question to Councillor Oliver. Local government receives £5.4 billion of the proceeds of the new health and social care levy over the next three years. What will this money cover, and will it be enough to cover the reforms of social care that the Government announced?

Tim Oliver: Although we are waiting for some clarity on what that £5.4 billion is to be used for, my understanding is it will fund four elements. First, extended means-testing: part of the new system will involve local authorities having to assess the means of all potential users of the care system. It will fund the cap on care. Thirdly, it will fund workforce development and, lastly, a fair price for care. The fourth element, the fair price for care, will the biggest challenge in terms of delivery and funding.

None of that £5.4 billion will support the current pressures under the current system. It will provide some support for the transition into that new world but it will not deal with the current issues and certainly will not deal with the longer-term issues.

Q5 **Ian Byrne:** Can you put on a figure on it? What do believe should be the figure that we should be talking about to ensure that the issues that we have been discussing will be addressed?

Tim Oliver: The work that the County Councils Network has done shows that just to stand still in terms of delivering the current care between now and 2030 will be an extra £7 billion. You are looking at incredibly large numbers, but it is that sort of thing. Just to equalise care, to fund the fair price for care, that looks as if that itself will be about £750 million a year as well.

Stephen Chandler: I completely agree with Councillor Oliver's analysis and he is absolutely right to point out that the figures to sustain the service moving forward run into the large billions, which is why the £5.4 billion announcement seems very small given the commitments against it. As he said, we are yet to see the detail of how a number of those

elements will be applied. We know the total cost of care that each person will meet during their lifetime but we don't yet know how the fair cost of care will be applied to councils up and down the country.

Q6 **Ian Byrne:** I am going to come on to sustainability now. The plan says that the Government will ensure that local authorities have access to sustainable funding for core budgets at the spending review. What do you want to see in the spending review for adult social care?

Just to put it into context, in the recent report on local authority financial sustainability and the section 114 regime, this Committee concluded, "The failure to properly fund children's and adult social care, especially adult social care, is the single biggest threat facing local government financial resilience. Given that the cost of providing social care consumes between 60% and 70% of the budgets of top-tier councils, a solution to this funding crisis alone could largely restore local government finances." I think that is quite clear on the sustainability element. What are your thoughts on that?

Stephen Chandler: ADASS fully supports the Health Foundation's model and in that it said that we need a further £9 billion from 2024-25 onwards. We say that is needed because we need to have a fair employment deal for staff. Particularly we have said that care staff should be paid the equivalent of a band 3 NHS worker, which is £11.50 an hour. Let us be very clear: for most of us in this virtual and physical room, the thought of £11.50 an hour is not an unreasonable price to pay for staff, given that it is only through their intervention that older people are able to live safe and well lives, have their medication, get out of bed, have their food. It is through their invention that young people are able to leave home and enjoy the experiences that you and I took for granted when we left home. It is only through their invention that people who suffer life-changing accidents or illnesses are able to continue to enjoy family life.

Again, we believe it needs to go into the workforce but also it needs to support our providers, who have done a fantastic job, not just during this pandemic, but pre-pandemic and certainly during the pandemic, but we know inflation is rising. It is not uncommon for me, in my day job, to receive letters from providers saying they are going to need a significant inflationary uplift next year to remain solvent.

It is for all of those reasons that we agree with the Health Foundation's analysis that £9 billion additional funding from 2024-25 onwards is needed to sustain the service.

Ian Byrne: Thank you; that is a good comprehensive answer. Councillor Oliver.

Tim Oliver: I agree with Stephen. Just to give you a couple of figures to put it into context, in Surrey we spend £1 million every day on adult

social care, £365 million a year out of a budget of £1 billion, and £0.5 million a day on children's social care. It is the council's largest single cost. Either we have to reduce the service that we are offering to residents or we have to find some additional source of money. That is as we speak today and that ignores the increasing demand, the increasing costs and the increase in the changing demographics, which will put further pressure on it. Long-term sustainable funding is absolutely key to the survival of all upper-tier authorities.

Q7 **Ian Byrne:** I will stay with you, Tim. You mentioned funding. Are local authorities planning to raise council tax in order to address funding pressures on adult social care? If so, by how much would they like any year-on-year council tax cap to rise?

Tim Oliver: I don't think any council would necessarily like to use council tax as a way of funding adult social care. There is the slight complication now in terms of persuading residents that that is the way forward, bearing in mind what the Government have said publicly around what the rise in national insurance contributions would be used for. The problem with using council tax is the differential amount that it raises across the country. Just as an example, I think 1% of the council tax in Stoke-on-Trent raises £700,000; 1% in Surrey raises £7.5 million. The money is possibly going to be raised in the wrong areas to support social care. I don't think any council will see that as the solution.

Ian Byrne: That is a good answer. Stephen, anything to add?

Stephen Chandler: Just to bring it alive with a practical example: a 1% council tax rise in Oxfordshire raises £1 million so it is an easy equation to follow. We know we have £9 million-worth of demographic pressures next year. If we were to take providers' average request for an inflation increase of 6%, that is another £6 million. Can anybody foresee an increase in council tax of 15%, 16%? I personally, as a resident, would baulk at receiving that through the post, especially when at the end of that month, in April, I will see the levy coming out of my salary.

We also know that just because that power exists does not mean that politicians in local areas are able to do that. We know that last year 67% of councils took up the full precept options. I am making no political statement there. Councillor Oliver has very eloquently explained the differential, which I think is probably the primary challenge to us in that, but there is also the political position on it.

Q8 **Ian Byrne:** Absolutely. It will lead to a two-tier system, different councils being able to afford different levels of care.

As well as through council tax and the social care precept, the Government's plan said that they expect existing pressures to be met through long-term efficiencies. That sounds like austerity to me but I am eager to know what you think. Where do you see the opportunity for such

long-term efficiencies, or would you call it further austerity measures, after 11 years?

Tim Oliver: There isn't any council, I don't think, at any tier in the country, that has not had to look for savings and efficiencies over the last 10 years or so, and many councils now have nowhere to go to find further savings without cutting frontline services.

Through Covid, in fairness to the Government, there has been good financial support for most councils. It is only upper-tier authorities during the last 18 months, but that money has been used specifically to support those that have needed it.

As we come out of this pandemic I look at my own council and many of my member councils and there is no obvious place for any of us to go. There are perhaps some savings that can be generated in shared back-office services, shared services, but in terms of frontline services there are just no savings that can be delivered safely.

Stephen Chandler: I agree again with Councillor Oliver in this respect. I have just two points to add. One of the biggest budgetary pressures that councils face is not from older people any more but rather working-age adults, the 18 to 65-year-olds. Councillor Oliver has said very clearly that councils have been working for at least the last 10 years on efficiencies and there is only so far you can go before the equation has less impact, and we are absolutely there.

From one of our ADASS budget surveys we know that 34% of directors reported that last year councils had to draw on reserves in order to address adult social care overspends. I would not want you to hear that efficiency is not possible—we are constantly looking for those opportunities to do things better, differently, new models of support—but in a sector that is seeing £8 billion-worth of savings needed over the last 10 years, there is only so much more that can be done. Given the scale of demand pressures and cost pressures, efficiency just will not be enough.

Q9 **Ian Byrne:** I want to stay on this because it is a hugely important point. Basically, the council tax idea has been dismissed as improbable. On the efficiency savings, which the Government have put within the plan, speaking to you both—and I know this certainly from my experience in Liverpool as well—there is nothing left to find efficiency-wise. Where does that leave the Government's plan?

Tim Oliver: With the need for more funding, I am afraid. The other biggest challenge that the upper-tier authorities now are facing is around the funding of special educational needs and disabilities. Many, many councils are having to subsidise or put reserves or further funding in over and above the high-needs grant. That is an area where, again, there is an exponential rise in demand, particularly now, certainly with a significant

increase in mental health issues for the younger people. If there were any savings to be delivered then SEND probably would be the first port of call for those. I don't think council tax would provide the solution because the way in which it is levied and collected is not even.

The most visible service that local authorities deliver is highways. I imagine most of you will get regular emails from residents about potholes and the need for improved roadworks. Again, I am afraid the majority of residents, unless they are accessing social care, don't see what we do. I don't think there is any other solution to this, apart from integrating better with the NHS. But purely looked at through a local authority lens, it just needs more money.

Q10 **Ian Byrne:** Lastly, after two years the Prime Minister has indicated that the proportion of the proceeds of the National Health and Social Care Levy going to adult social care will ramp up. What criteria should Government consider as they decide how to share the proceeds between social care and the NHS?

Stephen Chandler: I think it becomes really difficult when you are at risk of pitching one part of the care sector against the other, seeing which of us values the NHS more than social care. We know health and social care have to co-exist and that there is a symbiotic relationship between them. That is why we believe the Government need to look clearly and separately at adult social care funding support, alongside doing the same for the NHS but not to get to a point in three years' time where we are saying, "Which one of you deserves more of the £5.4 billion than the other?" I don't think that is fair on people working in the sector; I don't think it is fair on those of us that may be drawing upon those services.

Tim Oliver: I agree with Stephen on that. At the end of the day we need to have an absolute commitment from the Government in terms of how much of that levy will be coming into social care. It will not deal with the immediate issues and probably not for the next three years, but at the end of the day there is plenty of evidence of what the likely annual cost of delivering social care is going to be and that is what I would say the Government need to fund from the levy.

Chair: Thank you. We are moving on now to the impact on the social care market announcement.

Q11 **Rachel Hopkins:** I will go to Councillor Oliver first. As part of its new plan, the Government intend to bring legislation into force to ensure that people who fund their own care, self-funders, can ask their local authority to arrange their care for them so they can find better-value care. In response to that the County Councils Network's health and care spokesperson, Councillor Martin Tett, said the CCN wanted to "work with government" to ensure that this commitment "does not further destabilise local care markets." Could you elaborate on what he meant by that?

Tim Oliver: Just drawing on my own experience, I know at the moment the average price for a residential care bed that the council funds is about £750 a week and the average for a self-funder is £1,300. There are pretty similar numbers for nursing. You have some hundreds of pounds' difference between what the council is currently paying and what self-funders are paying. The residential care homes run on a mixed model. That works because in effect the self-funders are subsidising those that are supported by the local council. There seem to me to be only two ways that this can go. Either the cost of care is reduced and the care homes manage to deliver all of the care at the price the council is currently paying, or the councils will have to pay more and that will need to be funded. The point Martin Tett was making was that if you simply say all self-funders can access care at the same price as local councils, you will destabilise the market because that is simply not, I don't think, a deliverable solution.

Stephen Chandler: I am getting worried that Councillor Oliver knows so much about adult social care that he could do my job.

Q12 **Rachel Hopkins:** Another angle is that care providers as employers will have to pay the new additional national insurance employer contributions. How will that affect the adult social care market?

Stephen Chandler: You are absolutely right, and you will not be surprised when I tell you that providers are knocking on the doors of their local council saying, "As part of our fee settlement for next year, we will need to add this additional levy into the uplift we expect from you." So, unfortunately, there is a circuitous route on this.

The other issue that we have to be mindful of is that councils cannot be seen to treat residents unequally. A resident that asks a council for support in arranging their package, including the fees of it, cannot arrange that at a rate that will be different from either the council's rate or the self-funder rate because we would quite rightly be accused of operating an unequal situation. As Councillor Oliver has said, we find it very difficult to envisage a situation where the two options are either that fees are brought down to the rate that councils pay, and of course that will destabilise the market—in Oxfordshire, 55% of the care market is for self-funders—or we bring fee rates up from the current council level to something that is either close to or similar to self-funders'. Without the detail of how this will operate, it is impossible for us to know at this moment in time.

This was an announcement without a lot of detail around implementation.

Q13 **Rachel Hopkins:** Councillor Oliver, do you want to add any comment on the additional costs of the national insurance contributions from employers for care providers: is that just another pressure on budgets?

Tim Oliver: Yes.

Q14 **Rachel Hopkins:** Okay, thank you. What support, if any, might local government require to implement the new means test and cap on costs?

Stephen Chandler: We know that with the care cap will come what is called the care account. Each of us will need to have a care account to monitor the expenditure we make. At the very least that will need either a change to local government's information systems or new systems. It certainly will require additional assessors to carry out the financial assessment and the care assessment. It will require councils to be able to routinely monitor that person's care costs against their care account. So quite a bit of people infrastructure and system infrastructure will be needed, never mind the work ensuring that people understand what the care account means for them as well as operating it.

Rachel Hopkins: Again, that is additional pressure on the budget.

Tim Oliver: Yes, absolutely. To give you some Surrey figures, 81% of those accessing care in Surrey are self-funders, so of 12,000 beds only 19% are funded by the council. That is 80% more people that we would have to administer and the costs of that inevitably would be significant, even if we can build the resource quickly enough to do that.

Stephen Chandler: It is just a matter of circumstances but you happen to have two people, in Councillor Oliver and me, talking from two shire counties where there are significant self-funder populations. It is important that the Committee also understands the level of impact in inner cities as well as, without being geographicalist, northern counties. It is also important to recognise that this was part of the Care Act that we did not get to implement back in 2016. While I am really concerned about ensuring that there are sufficient resources to implement it, this is a part of the Care Act that we in the sector felt was unfinished business, for want of a better term. So we need to be careful that we don't, because of our concerns about the funding of it, overlook that this was an important requirement of the Care Act that many, many people up and down this country were really pleased to see implemented and really frustrated when it did not get implemented back in 2016.

Chair: Moving on, the Government have made some announcements and they have also announced that there will be more to come in a White Paper.

Q15 **Ben Everitt:** We have the White Paper coming and the Government have suggested it will include issues around choice, quality and accessibility of social care and the social care workforce. It is the "what else do you want" type of question: what else do you think should be in there?

Tim Oliver: As always, the devil is in the detail. Those are all sensible areas to be covered, but at the end of the day, what does that mean in practice? I think we are all pretty clear on what we need to do, and to that extent hopefully the White Paper will bring some sort of flexibilities and freedoms, but it is not just about funding; it is about improving the

standard of care that is delivered, and about transitioning into better ways of doing things. It sounds as if the White Paper will be sensible—we shall see.

Q16 **Ben Everitt:** A diplomatic term. Stephen, do you have anything to add on that?

Stephen Chandler: First, let's reflect that the pandemic brought a significant focus on care homes, understandably, but also it is important to recognise that the majority of people receiving support from local authorities are not getting that through a care home. They are getting it in their own homes or in some other form of housing-related support. We believe the White Paper needs to ensure that there is a broader understanding and focus on non-residential and nursing-type models of support, whether that is extra care housing, housing with support, live-in carers, as well as maximising the role that technology plays in helping people make good decisions about their care and support and helping people live better lives through nudge theory and so on.

We know that the pandemic shone a light positively on the role that the voluntary sector plays in providing support to individuals and we think the voluntary sector is a very valuable resource in helping people maintain their levels of independence, but that needs to form part of a coherent, funded plan. Penultimately, we know that unpaid carers equally played a fantastic role in supporting people and we need to ensure that there are robust support mechanisms in place to help people continue to carry out that caring responsibility that means they give very person-centred support but also are able to do so reducing the demand on councils.

Finally, there need to be new models of support beyond what we know today. Why would social care be any different to any other aspect of life where as we look forward we think about developments, modernisation, transformation, whether it is a technological transformation or the way that people organise and have control over their own lives and their own support arrangements? Rather than rely on people like Councillor Oliver and myself to play such a role in their lives when they need support, they are able to have much more choice and control over the way that that is done. That will require people like me to commission care and support differently and will require us as councils to support people in taking that control differently, but it is a real opportunity for us to create a 21st-century social care support arrangement.

Q17 **Ben Everitt:** We will come on to explore different models of care in the future in the latter part of this session. I am struck by something that Tim said—that it is not just about funding. When we go back to that, both of you gave incredibly comprehensive answers to the questions from my hon. Friends from Liverpool and Luton and it was all about funding. The challenge here may be not thinking about funding in terms of revenue

and cash and more about the balance of economics. Is it economically viable to be a provider in the market in certain areas at the moment? Is this something that could be covered by the White Paper?

Tim Oliver: Is it economically viable to be a provider? I think that is something that you need to ask the providers. During the pandemic we have been able, through government funding in part, to give them greater support and I am sure there is a number of providers that would not have survived had it not been for that. At the moment the model seems to work but there are these pressures that we have talked about, going forward.

The other things that perhaps we need to focus on are, first and foremost, we need to put the individual at the centre of their own support. They need to have a level of control over that. We need to promote independence, as Stephen has talked about, extra care facilities. The longer we can keep people living independently the less they are dependent upon social care and the outcomes are that much better. I think everybody now understands that a real focus on prevention and earlier intervention is absolutely the way to go. Particularly where you are looking at mental health issues, having mental health advisers in schools and so on will be beneficial.

I think also it is about leadership and Stephen has touched on this a bit. We in local government have the responsibility for delivering and co-ordinating social care but there needs to be coherent and cohesive leadership and in particular in collaboration with the NHS. To that extent, I think the systems need to be seen as equals. We have heard significant sums of money being announced for the NHS, which is great, but we have not heard the same announcements for social care and in my view the two go hand-in-hand.

Lastly, there needs to be a performance framework that can ensure that there is a consistency of quality improvement and so on. It is not just about money. There are absolutely other things that can be done and need to be done.

Q18 **Ben Everitt:** Stephen, do you have anything to add?

Stephen Chandler: Yes. I think the pandemic has provided, to a degree, a period of stability for providers because some of the pressures that existed in the service pre-pandemic were funded through that route through infection control grants, hospital discharging funding and workforce grants. We know that at the end of this financial year those support arrangements—free PPE, infection control grants, workforce grants, hospital discharge funds—all end and there is no view that they will continue. I think that when you talk to some of our colleagues who are providers later on this afternoon you will hear a very clear message from them that they are right on the edge of sustainability. I hear it when providers talk to me each and every day, citing the increased costs.

One of the things we have not talked about as yet is the role that the workforce plays in this. Workforce is such a critical resource for the changes we need moving forward, but also in delivering a sustainable situation today. We know that there are significant increasing vacancies in the adult social care sector at the moment. I am doing my utmost to try to retain staff, never mind even getting to a point where I can talk about increasing the staff in the sector. We need to talk about workforce much more positively and much more long-term than we have been doing so far.

Q19 **Ben Everitt:** A final question from me, predominantly for Tim. The Government say that they will work with local government to develop the White Paper. How is that going?

Tim Oliver: I think there have been some initial conversations but we are keen to have a much greater involvement as the White Paper starts to be formulated. We absolutely encourage the Department to make contact. We have some ideas and suggestions and we would definitely like to share them.

Stephen Chandler: From an ADASS point of view, we have had a number of conversations with Government about the White Paper, but we have talked up until now about a White Paper. It is important to recognise that there are two White Papers in the Government's reform announcement, an integration White Paper and an adult social care White Paper. We have to make sure that we do not overlook an opportunity that both those White Papers offer us.

Chair: That leads us very nicely to the issue of integration of health and social care.

Q20 **Matt Vickers:** Some evidence suggests that the stabilisation of the adult social care market is dependent on the successful integration of health and social care. Do you agree and, in your assessment, what progress is being made on the integration of the two?

Stephen Chandler: I don't agree, and let me explain what I mean. Integration is not a new concept. In fact, integration in various guises has been operating across the country for decades. Mental health has been the forerunner of integrated arrangements for decades now and there is a wide variety of integration arrangements across the country. In Oxfordshire we have an integrated mental health service and an integrated discharge service. I don't think it is the solution on its own. I believe, however, that integration offers us some significant opportunities moving forward. I am sure Councillor Oliver will want to talk about the role that ICSs play in progressing that. Intermediate care is another practical example.

Tim Oliver: I take a slightly more positive view than Stephen about the benefits of integrating health and social care. 33% of those receiving

adult social care are working-age adults, so these are not just elderly people in care homes. They are working-age adults. If you look at the wider determinants of health, which I think is a useful lens to look through at these things, 20% of the things that will make a difference to your life expectancy and your general health are direct health interventions—those are the things that I am imagining in the new ICS structure that the integrated care board will own and deliver—30% are our own behaviours, what we eat, whether we exercise and so on, and you have public health interventions that can help support that, and the other 50% are the things that local government and its partners can deliver. It is the quality of housing, access to green space, socioeconomic factors and so on. I think when we talk about health and the health and well-being of individuals we need to look across the whole piece. It is not just about pure health interventions.

Assuming that the new ICS structure comes into effect from April 2022, it creates 42 independent care systems across the country and there seems to be sufficient flexibility within those to deliver care in the way that is appropriate locally. Then you have the integrated care partnership, which I think will be led by local government in many areas as the way in which you can pick up the other 70% or 80% of the wider determinants. That is all about having a shared ambition, a common goal, working to the same metrics, and that needs a good integrated approach between the health system and local government and its partners.

I have the advantage, perhaps, of looking within both the health system and local government and I see those opportunities that are not necessarily being delivered. That is not through anybody's fault. Different systems are in different stages of development, but I think that devolution of responsibilities and accountabilities to the health system and to local government would be a very good starting point. At the moment you have the situation where local government can at times be competing with the NHS about bed space and bed price. You are in a competitive system, even though you are both public authorities. There needs to be a multidisciplinary approach. The more the two systems can come together and have those conversations, the better the delivered outcomes will be and the more cost-effective they will be.

Q21 **Matt Vickers:** What levers and drivers do you think need to be put in place to support closer integration, nationally and locally?

Stephen Chandler: I will try to recover some of my negativity from the last answer. As somebody who spent the first half of his career in the NHS and the second half in local government, I am a practical example of integration.

We think a number of things are critical to success. The first is empowerment of health and well-being boards. They need to play a really strong role at place level where, as Councillor Oliver said, local

government will have a much stronger role to play. We think that the type of leadership that seeks to bind those opportunities and benefits that Councillor Oliver described will be critical and that is leadership across the sector, not just in local government but within the NHS. It is about ensuring that integration delivers on the commitments in the NHS long-term plan and also the commitments that will come out of the social care and integration White Paper.

A number of things are critical. The long-term plan talks about community services, social prescribing, personal budgets—concepts and options that are much more familiar in local government that if we deliver at a system level across health and social care will deliver even greater benefits than we have been able to realise to date. It is strong leadership, creative use of the resources at a system and at a place level, and robust governance with the health and well-being board at a place level, in conjunction with overview and scrutiny committees, delivering that oversight.

Q22 **Matt Vickers:** Do you have anything to add, Councillor Oliver?

Tim Oliver: I completely agree with that. I think the governance is important, and a duty to co-operate. There has to be some requirement that all authorities come together. The local government and the health system should both own, and often do own, the health and well-being strategy. That is the overarching vision that each area will have for its residents and it is just a question of making sure that the right organisation is visibly delivering that and accountable after doing so.

Q23 **Matt Vickers:** What do you make of recent media reports that the Government are considering introducing a national care service?

Tim Oliver: I will go first on that one. I personally cannot see that that will assist. Not all of social care is about medical issues or medical interventions. I cannot see at the moment that that will add any significant value. The NHS has as priorities its four-hour waits and its elective backlog to deal with and I am sure that is what it would like to focus on. Delivery of social care needs good local community knowledge. It is not something that you can control or direct centrally. It needs to be done at the ground level, so personally I would leave the current structure as it is.

Stephen Chandler: I will build on that a little bit by saying local government helps people coming out of the criminal justice system to get their lives back on track, it helps people who are homeless find accommodation and it helps young people. That is what local government is really good at. I am not convinced that a national care system would be able to replicate that. We know our communities at a local level and we work with them. I think we should address some of the shortfalls in the current system but nationalising it or creating a national care system is not the way forward.

Chair: I will move on now to models of care for the future.

Q24 **Mary Robinson:** I seek your views on some of the evidence that we have received that suggests that the adult social care market needs to shift to different types of provision, such as away from care homes and towards domiciliary care and community-based models. Do you agree, and how can the Government support and encourage the transition to these different models of care?

Stephen Chandler: I absolutely agree that we should be moving away from the current model of care. I don't know about you but as I look forward to older life I want to continue to remain as independent as possible, living in my own home in my own community, but I am resigned to the fact that I am likely to need some form of support as I get older. I want that support to still be controlled as much as possible from me in my own home. For me, the new models of care have to enhance what is currently available to help people remain independent in their own homes. You mentioned home care. I would also introduce technology as a way of helping me make good choices, prompting me to exercise and be mobile. I would want to build up on the experience of the pandemic around communities, so connecting me with my community much better so that I avoid becoming isolated, lonely, depressed—all of those things. I think it is out of hospital, out of care home, out of formal care, remaining in my own home for as long as possible.

However, recognising that, there are large numbers of us who will need some form of support that is not possible in our own homes. That is why models of care such as care at home, carers coming in and residing in my home if that is possible, as well as the extra care housing model that can be and should be used much more than it is currently and to support people with many more conditions than is possible currently. We have been doing some work in Oxfordshire recently, supporting people with learning disabilities to use extra care facilities. We have also been developing extra care for people with dementia. Again, it is using some of those models for conditions that previously would not have been thought possible.

There remains a role for residential and certainly for nursing care, but it is much more specialist than is needed currently and in my view will be less so in the future.

Q25 **Mary Robinson:** Thank you. I will follow up on that. We have talked about the impact of the pandemic and some quite natural progressions in transition, but if this is going to be the way forward how can the Government support and encourage the transition to the different models? What is the role of the Government in this?

Stephen Chandler: I think the Government need to start talking much more about models of support that are not care home related. Government often talk about social care through the lens of care homes,

and I can understand that to a degree, but as we move forward we have to move the conversation forward. We then have to support, through transitionary support, care home providers that might be able to use their assets differently to develop extra care as an option or different models. Also there needs to be support for home care organisations to develop a much more resilient and larger workforce to support these new models. Government need to start talking clearly about models that are not care home oriented and then transitionary support for existing care homes to move to them and new models to evolve.

Q26 **Mary Robinson:** Tim Oliver, do you have anything to add to that?

Tim Oliver: I agree with what Stephen said. I think it is analogous to possibly what needs to be done in the NHS, which is to shift the focus from the acute system into community settings and down into primary care. All of these are on a spectrum. There will be a role inevitably for residential and nursing care, but that should be more the last resort rather than the first resort. It is building on the preventative activities that need dual funding. We need to put money into the system at the front end to stop people deteriorating and needing residential care. As Stephen said, investing in extra care facilities or independent living, investing in intermediate care so that there is a stepdown facility where people can be rehabilitated and so on. It will take time but I think the system will start to shift.

Q27 **Mary Robinson:** I will stay with you, Tim Oliver. Several submissions have supported the commissioning of care services based on outcomes. Do you agree with that approach? What could the Government do to support greater use of outcomes-based commissioning?

Tim Oliver: Stephen will probably have a more detailed response to that. I think that it is right in principle. In life now we are all—and I think quite rightly so—focused on outcomes. Just doing something does not mean that you are doing it the right way and it will have the right outcome. We have seen a live example of that in people working from home. Many people said that that was not possible and presenteeism was important because, "If I can't see you are working, I can't see what you are doing." It is moving to a position where you can measure, and the measurement is as important. We need to justify what is happening and demonstrate that there are those improvements. Getting to an outcomes-based commissioning process—it possibly exists in some areas, but it is challenging, in the early days at least, to transition to that sort of approach; but I definitely support it.

Q28 **Mary Robinson:** Stephen Chandler, right in principle, but what can we do to make it happen?

Stephen Chandler: You don't have to look very far to see some very practical examples. At a strategic level ADASS published nine statements to help support reform, which had outcomes-based commissioning as

well. The LGA's seven principles equally do that. Social Care Future, which is a group of organisations supporting people who received services, equally came up with good life principles. You don't need to look very far.

The Government have mentioned co-production in the context of White Papers. I would say co-production in relation to moving from the here and now, where I commission 25,000 hours of homecare, to a position where I am commissioning who knows how many outcomes for the people of Oxfordshire has to be the way. We have to stop measuring things as though they were widgets and start measuring the impact that services and support have on people's lives. I think we will be surprised at what people tell us matters to them. It may not be what you and I might have thought as professionals, which is why co-production has to be so important as we move this agenda forward.

There are lots of examples across the country where outcomes-based commissioning is in place. We have just recently changed our reablement and our homecare contracting in Oxfordshire to an outcomes-focused arrangement. Historically you can look at Wiltshire and there are other examples across the country where it has already been in place that we can learn from.

Q29 **Mary Robinson:** This is quite a wide question. What is your assessment of the state of regulatory oversight on the adult social care sector?

Stephen Chandler: ADASS has been working with DHSC and CQC in developing the framework for future regulatory oversight of the sector, so in relation to how the future measures might look we are confident that they will be asking the right question. However, I am very, very concerned on behalf of directors and local government up and down the country that regulatory oversight will be introduced before any of the reforms and any of the additional investment will have reached systems. We will be using a modern measuring lens to look at councils that have been struggling for decades.

A salutary reflection, if I may: when we asked directors of adult services in the last survey how confident they were that they would be able to meet their legal responsibilities under the Care Act, 72% said they would not. You could translate that into 72% of directors believe that they will not be able to meet the regulatory framework moving forward, which is why it is so important that we stabilise financially local government and adult social care services within that, and that we provide a very clear long-term plan for the development of services. Otherwise, we will end up measuring councils with a modern lens on an old-style delivery, and let's not be surprised if we find lots of councils fail to meet the bar.

Mary Robinson: Tim, would that be your assessment?

Tim Oliver: Yes, what Stephen is saying is that there is a need to reform the regulatory oversight and I would agree with that. There is an inconsistency in terms of how it is applied and I am sure that it is, I am guessing, about asking the right questions to get the right answers, so reform of that is necessary.

Chair: Ian Byrne has a short supplementary question.

Q30 **Ian Byrne:** It will be short, Chair, yes, or I will get shouted at. A really, really quick one about commissioning.

From my perspective I firmly believe that in-house provision is far better than outsourcing to private companies; they are for-profit. What would your seek be in a perfect world with regards to bringing resources back in-house into council ownership?

Stephen Chandler: I do not believe there is a single model that in itself assures success. You have to look at it on an individual-by-individual basis. You have to look at the ability of the sector to deliver against its outcomes; you have to look at the investment. I have worked predominantly in systems where services have been outsourced and I have seen some fantastic services come from that. I have equally had some experiences of some in-house provision. I do not think just saying, in the same way as I said earlier around integration, that an integrated model assures itself of success. It is a tool. Whether in-house or out-of-house, it is just another tool.

Q31 **Ian Byrne:** What I have witnessed with the services that have gone out into the private sector, there has been a real fall in quality of service. That is my experience in Liverpool. I am not expecting you to answer that. For me it is a fundamental issue about how we drive up better terms and conditions for staff. How are we going to square the circle if we carry on outsourcing services and it is based for profit over healthcare?

Stephen Chandler: Your point about investing and paying a decent rate for care is important, but in Oxfordshire all of our services are outsourced and we have one of the best regulatory outcomes for people through CQC ratings. Again, it is too simplistic to say in-house equals good, outsourcing equals bad, in the same way as it would be equally unfair to say outsourcing equals good and insourcing equals bad.

Chair: We will move on. Thank you both very much indeed for coming this afternoon and answering all our questions so fully and comprehensively. That has been appreciated.

Examination of Witnesses

Witnesses: Steven Scown, Jane Ashcroft and Dr Jane Townson.

Chair: We have two witnesses here in the room with us for our second session. They will introduce themselves shortly. We have Jane Ashcroft who is joining us online. Jane, over to you first. Could you introduce yourself and say who you are, please? That will be helpful to start our proceedings.

Jane Ashcroft: Thank you, Chair. Good afternoon, everybody. I am Jane Ashcroft. I am chief executive of Anchor. We are a not-for-profit provider of housing and care for older people. We provide a range of retirement housing, extra-care and residential care services to about 60,000 older people, working in 85% of local authorities across England.

Chair: Thank you. In the room with us, Steve Scown.

Steve Scown: Good afternoon, I am Steve Scown, chief executive of Dimensions, the largest not-for-profit providers of services for people with learning disabilities and autism. We employ 7,000 colleagues and support 3,000 people in 90 local authorities, providing residential care and supported living.

Chair: Welcome as well. Dr Jane Townson.

Dr Townson: Thank you. I am Jane Townson, chief executive of the Homecare Association. We represent and support 2,350 providers across the country, ranging from very small to very large, from predominantly state-funded to predominantly private pay funded generalists and specialists.

Chair: Thank you all for coming to be with us this afternoon. Members of the Committee will ask questions. They will put them to one of you, or to one of you and then the next one, or they will ask an open question and any of you can come in who wants to answer it. Andrew Lewer will start off on the funding pressures.

Q32 **Andrew Lewer:** This Committee last explored the issue of long-term funding of social care in 2018, along with the Health and Social Care Select Committee. Can you explain how pressures on the adult social care system have changed since then in the last two or three years and how Covid in particular has affected the situation? I will ask Jane at Anchor first.

Jane Ashcroft: Over the last three years a number of factors have impacted, from our perspective, on the adult social care sector. We see a significant increase in demand both for our retirement housing and extra-care services, where we have a significant waiting list, and also in our residential care homes, with more people needing our services and seeking to move in and use our services. We have seen a reduction in the percentage of people using our care services who are funded by the public purse and an increase in the private payer percentage, a slight move. We were previously just over 50% local authority funded and that has moved down to just below 50%.

Probably the most significant change I would note over the last three years has been the pressure on the workforce. We have seen a significant increase in turnover in some groups of our workforce and an increased difficulty in recruiting. We have sought to invest heavily in our workforce over the last three years. We have a range of activities to recruit and attract people and to retain experienced colleagues. We have a very strong commitment to training and development and we continue to do that to seek to be ahead of the living wage so that we are rewarding a very important and professional workforce.

During the period of pandemic, despite the fact that in our care homes we have seen a reduction in our occupancy, we have not seen any reduction in the need for workforce. The additional requirements of the pandemic: obviously supporting our residents has been our major focus but there have also been additional requirements and extra workload around the management of the testing system and the management of the visiting so that relatives can visit their loved ones in care homes, which has been incredibly important, and a range of issues around infection control, which have also been critical.

We have also seen cost pressures, in addition to the cost pressures around workforce, in relation to some of our other key areas of expenditure—utilities, food prices and of course the need to provide more equipment for people to maintain high standards of infection control. I am happy to talk about any of those in more detail, but those would be my summary comments.

Andrew Lewer: Thanks very much. Staying with the Jane theme, over to you.

Dr Townson: In addition to the things that Jane Ashcroft has said, I would like to highlight the increased complexity of need. As numbers of older and disabled people needing support have increased and funding has been squeezed, care has been rationed. So, in homecare in order to receive state funding you effectively have to have fairly advanced healthcare needs as well. The typical time that a person is in a homecare service in the state-funded part of the market is between about one year and one and a half years, so we are only seeing people quite close to the end of life. That is a big challenge when we start talking about prevention because you need to start investing much earlier than we currently are.

Steve Scown: We probably have a slightly different pattern or see things differently in the sense that we support working-age adults with learning disabilities and autism, so we have not seen the significant increase in demand that the two Janes have referred to; we have seen a continuing trajectory of increasing demand at the same pace as before. We have noticed that people who we support who are not supported 24/7—that is, they have their own home and live on their own with a small package of hours—are much more likely to have their hours reduced. We have seen

a number of examples where that has placed them at risk of certain issues. For example, three years ago we would not have been talking about cuckooing; now we are supporting people who are vulnerable to that sort of behaviour.

On workforce, we had quite a good pandemic in terms of recruitment and our staff vacancies reduced through the pandemic. I think people saw social care as a good thing to do—secure employment, valuable, rewarding. Six months ago there was a tipping point where there has been a material change in that, and our turnover numbers have gone in totally the wrong direction since April.

In terms of pay, we have struggled to stay above the National Living Wage. This year we do not have anybody on the National Living Wage but we are barely above it. That has become an increasing challenge each year because our contract prices are not increasing at the same rate as our costs.

Q33 **Andrew Lewer:** In order to take on all of that, last month the Government published their plan for health and social care. How far do you think the plan addresses the pressures that you have just described? I will stay with you, Steve, because the pressures that you have described are slightly different ones.

Steve Scown: They don't, frankly. You heard from the previous witnesses how that money is going to be spent. I don't think the services that we are providing are going to see any benefit from that whatsoever, certainly in terms of our staff costs. Pay rates are going up and today's announcement has added to that challenge. So a blunt answer is that it is not going to help us very much at all, I don't think.

Dr Townson: I agree. For a start, the reforms don't come into effect until 2023, so we have to get to then without any additional money that we know of at the moment. There were strong hints, as was discussed in the previous session, that councils have to find that extra money through raising council tax or generating efficiencies.

As Jane said, the workforce is our biggest challenge. In Homecare we have just published data showing that the volume of hours purchased in the United Kingdom has increased by 11% just in one year. As demand is increasing, supply is going in the reverse direction. Providers are reporting a 75% reduction in applications for jobs. Care workers are leaving faster than they have ever known. This is not helped by some of the government policies as well, with regard to, for example, vaccination as a condition of employment. We are really struggling in Homecare because out of all of the services, probably the one that is squeezed by commissioners is homecare often purchased by the minute at fee rates well below cost, so it has become almost impossible to pay staff what they deserve and to pay them fairly.

I mentioned earlier the complexity of need, the kind of training that they have to have now. During the pandemic that intensified. Care providers were asked to do wound care and administer insulin and verify death, and all manner of things that they did not have to do before.

Jane Ashcroft: My concern is that the supply of social care will be even further squeezed before the changes that have been announced are implemented. As colleagues have said, the short-term pressures are profound. In Anchor our national insurance bill will go up by £2.5 million on 1 April. We anticipate that the fee increases that local authorities may be able to discuss with us will be in the region of perhaps 2%.

We are concerned about supply across a range of services. In our case we have a small number of care homes at the moment where we are not able to accept any further residents into the homes because we are not able to attract any further staff. We have strong demand from potential residents and their families and we are very keen to work with local authorities and with the NHS on discharge, but the staffing issue is so significant. So the changes, as Steve and Jane have both said, are into the medium term. While an impetus for change is something that we have been calling for and we are pleased that there is a direction of travel, in order to get to the medium term I am very concerned about how we meet the short-term challenges.

Andrew Lewer: Thank you very much. There are quite a few things that would come in in the course of the meeting, so I will hand back to you, Chair.

Q34 **Chair:** One of the Government's proposals in the plan they announced was that self-funders can go to their local authority and ask their local authority to arrange their care for them at the price that the local authority would normally pay for the care for people it funds. What will be the impact of that particular change? There is supposed to have been money provided from the levy to cover that cost. Is it your feeling that that will happen? Do you have any idea what the impact of that will be?

Jane Ashcroft: We are concerned about the impact of that change without sufficient funding to bridge the gap. In the previous session the witnesses identified the range of fees in care homes in different parts of the country. If we look at the data from recent reports—there are a number of reports available—the range of care home fees, if I focus on care homes, is very significant in different parts of the country, with no direct link to the affordability or the cost of delivering care in those particular areas. The introduction of a fair price for care mechanism and something that very clearly identifies the true costs of care delivery are going to be critical if a levelling up or levelling down is not to have a dramatic impact on the sector. Again my concern is about the amount of supply that may fall away from the sector if providers are not able to maintain a sustainable service.

Q35 **Chair:** Jane Townson, looking across the board at various of your members, how are they responding to this?

Dr Townson: Section 18(3) of the Care Act 2014 has already been brought into effect in home care. Some providers have experience already of councils putting requests for care for self-funders on their procurement portals at their rates. In our studies of fee rates for homecare, it is the areas of greatest deprivation that have the lowest fee rates for homecare. Providers cannot make it work economically on those fee rates because we have to be compliant with national minimum wage legislation, we have to be compliant with care regulations, and they do not vary depending on where you are in the country.

The real concern is that we are already in some places on the brink of sustainability anyway. There are a lot of small and medium enterprises in our sector. Over 85% have fewer than 50 employees and many rely on a mix of state-funded and private pay funded work to keep the whole thing going. If that gets taken away we will see many more providers having to hand back work, cease trading, sell their businesses, as we are already seeing, but maybe in a more accelerated fashion.

Q36 **Chair:** I will just pick up one point there before I come on to Steve Scown. You mentioned the national minimum wage. The Government have announced a 6.6% increase. Will that have a significant effect on your members, the care providers?

Dr Townson: Absolutely, because in the care sector, general staff costs are a very high percentage of the total. In homecare it is about 70% of total costs; in care homes it is probably nearer to 60%. Unless that increase is funded, which in previous years has not always been the case, providers will struggle to cover those costs. It is not just the headline rate; you also have the impact of the on costs—pension, national insurance, holiday pay, sick pay and in the case of homecare, travel and mileage. We are likely to be quite badly hit by increases in fuel prices. There are probably over 5 billion miles driven every year in homecare.

Steve Scown: On the national living wage I spoke to my finance director this afternoon before coming in here. With the new national living wage rate, I need a 4% uplift next year just to stand still. My average increase in contracts price for the last three years has been 2%, so you can immediately see there is a real issue emerging there.

The other point you raised about self-funders does not apply to us but one observation I would make is that often the Government do not take into account the quantum of work to implement new ways of working. We are working with local authorities that have a 50% vacancy rate on social workers. That sort of issue is often under-evaluated by the Government, I would say.

Q37 **Chair:** We talked about the challenge of increased costs and the fact that

the levy is not going to deliver here and now to meet those costs. Looking at the spending review in two days' time, very briefly—I do not want you to write the Chancellor's speech for him completely—what would you want to see out of there that would make an immediate difference?

Steve Scown: If you are asking for a figure, I would not offer a different figure to the one from the previous session identified from the Health Foundation of £14 billion. That is roughly the number by 2030.

Dr Townson: It is important that we see social care as a means of investing rather than just as a cost. Skills for Care recently published data indicating that the value of social care to the economy is about £50 billion. International evidence shows that having a strong foundational economy—health and social care and education are part of that—is essential for the tradeable economy to function. We are a major employer; we employ more people than the NHS. If those people are earning money, they will be spending that in their local economies. So we would see it as a call for investment to help the economy. Without health we cannot generate wealth.

Jane Ashcroft: I would agree with Steve's point that the Health Foundation number would be a very good number to see in the budget. I would build on Jane Townson's point that the consequence of undersupply in social care on the economy is dramatic. We know there are 10 million unpaid carers, people stepping out of the workforce in order to provide care because they are not able to access it through any other route. That undoubtedly has an impact on many people's quality of life but it also has an impact on the economy. We do need to see investment in social care as an infrastructure investment, an opportunity to create jobs. Hopefully we might come on to talk about how housing-based options can help with the social care conundrum and there are opportunities for investment there. So there are potential economic upsides that need to be considered, while also recognising that there is a need for some immediate investment. That Health Foundation number is probably as a good a place—if I had an ask, that would be it.

Q38 **Chair:** If you want to refer to the housing issue, now—it is something that is obviously clearly important to your organisation—I am happy to take your comments on that.

Jane Ashcroft: Thank you; that is great. Our organisation, because we provide a range of services for older people, sees the benefit of specialist housing for older people as a means of preventing people needing more intensive social care services. Across Anchor, of our 60,000 residents, 6,000 of those people live in our residential care services, which are focused predominantly on dementia care, but the majority of our residents live in purpose-built retirement housing, most of them with no care provided because they are able to maintain a degree of

independence. We do think that—very relevant for the remit of this Committee—further investment and further opportunity for the development of age-specific housing for older people, built in a way that fits into local communities, is connected to other generations—I know sometimes people raise concerns about building age-specific housing that is not part of the community.

We saw during the pandemic the huge benefit of retirement living services where people were able to have support and were able to maintain a sense of community. We saw lower levels of loneliness and isolation in retirement housing services than for some older people who were shielding in their own community and were not able to contact others.

As an organisation, Anchor, along with other housing providers, has been keen to encourage the Government when thinking about planning requirements, when thinking about future areas for investment, to consider the development of older people's housing, not just in its own right but as part of support for the social care agenda, to make sure there is a range of choices for all of us in later life, which can reduce the spend from the public purse.

One brief example, if I may: we did some work on the value of extra-care housing and found that the public purse saved £6,700 for every extra-care resident using the extra-care service compared to somebody living in the community or needing to move into a specialist residential care home. We submitted information about that to the inquiry through our written evidence.

Q39 **Chair:** Thank you very much indeed for those important points. The Committee has looked at some of those issues and has supported that approach in the past.

In terms of the slightly longer term, the Government have promised a White Paper to look at issues to do with choice, quality, workforce and accessibility of care. First of all, Jane Townson, is that something on your agenda, looking at those issues, and have the Government now been in touch with you to get your input into the development of that White Paper?

Dr Townson: We certainly had a rush of invitations to meetings to discuss different elements of this. What I feel is still missing is an overarching strategy for our country. When my great-grandma was born in 1879 there were only 60,000 people over 85. We now have 1.6 million or so over 85. By the time I get there, there will be 3.5 million or more. We cannot cope now, so what are we going to do to shift the needle? Other countries, such as Sweden, invest heavily, as was discussed earlier, in community and home-based support. They have 33% or more of their people over 80 supported in their own homes. Here it is probably nearer to 10% or 15%.

The entire conversation is often just about care homes. That is what you hear from politicians, that is what you often hear from officials. We spent the entire pandemic turning up to every meeting saying, "Hello: homecare exists". Altogether, if you add in the people supported at home by informal carers, the people with unmet need, which Age UK estimates at 1.5 million, and the people receiving paid-for homecare, that is about 15 million people compared with only half a million in the combination of care homes and hospitals at any one time. We need to focus on them, because if we keep them well there is then less pressure on the more expensive settings.

Chair: Steve Scown, have the Government been in touch with you for your input into the White Paper?

Steve Scown: No. Rarely would that be the case. The other thing I would make an observation about is that it is the usual suspects who are asked. Organisations representing service users are rarely asked on those sorts of things. That is something that the Government should do more of.

On the White Paper, I would like to think that we could move away from seeing social care as one big single homogeneous lump. There are very different parts to it. Services for older people are much closer to, and there is much closer interdependence with, the NHS. That is very different from the sorts of services that I provide for working-age adults who want a job, who want a relationship, who want independence, who want to live on their own.

We do look at social care through a lens of, usually, large residential care homes for older people because that is the funding lens that is looked at. I hope the White Paper has some courage behind it so that we see social care as not being that lump. We saw that in the pandemic with the guidance that the Government were issuing. It was invariably aimed at residential care and supported living was an afterthought two weeks later.

My final point is workforce. I am fed up with waiting for a government workforce strategy for our sector. Select Committees call for it; CQC has just called for it yet again.

Chair: We are going to move on to one or two questions on that in a second. Jane Ashcroft, any comments there about the White Paper?

Jane Ashcroft: I would agree with Steve's comments about the diversity of the social care sector and the need for that to be fully recognised in the White Paper and not seen through any one particular lens. I would also emphasise the need for the voice of providers and service users. It is notable that while local authorities have an important role to play, there is still an assumption often that if local authorities are involved in the debate that means that the providers of care are involved. That simply is

not the case. The vast majority of services in social care are provided by the independent sector and it is quite rare for the voice of providers to be involved in the debate, so I would very much call for the White Paper to ensure that provider voice as well as, very importantly, that the voice of people who use services is reflected. Certainly the need for a workforce strategy for the social care sector—I do not think there is anybody that is not calling for that, so we can only hope that one of those will be forthcoming very soon.

Chair: We move on to the workforce issues.

Q40 **Florence Eshalomi:** You have all touched on the workforce in one way or the other throughout the course of this afternoon. Jane Ashcroft, you mentioned 10 million unpaid carers. Carers UK estimates that is 13.5 million. As the eldest of three girls growing up, I was an unpaid carer for my late mum, who suffered from a disease called sickle cell anaemia. Throughout this lockdown Carers UK estimates that an additional 4.5 million people were now caring for someone. Those are big issues across the workforce.

Jane Townson, you mentioned a 75% reduction in job vacancies and adverts. In all your views, what is your experience of attracting and retaining staff over the course of the pandemic and what do you think the outlook is for attracting and retaining staff beyond this pandemic?

Steve Scown: Our experience during the pandemic was quite good in the first year of it. Our recruitment rates went up. People saw it as secure work—I am not being funny. It was better than furlough or the dole. We have seen that reverse since April. Since April we have lost 7.2% of our workforce. They are going for better-paid jobs so we are finding ourselves, in an employment sense, competing against the likes of supermarkets, coffee shops, hospitality and so on. So I am quite pessimistic at the moment. Frankly, until we pay social care staff what they are worth—that should be at parity with NHS colleagues, which is a £7,000 uplift per person—social care will not be seen as the attractive career that I think it should be. I have worked in it for 14 years and I love it; it is the best job I have ever had, but at the moment it is not an attractive proposition for young people.

The Government's decision to spend £500 million on the workforce is a great move, absolutely great, and we do need to professionalise the workforce, we do need a far better career structure. I started as a student nurse and I am chief executive and all the rest of it, so I have got a great career, but at the moment it is not attractive. Diplomas do not pay your rent and do not stop you going to a foodbank. We just need to pay our colleagues what they are worth.

Q41 **Florence Eshalomi:** Do you think it is not just pay but equally the low status of the workforce in terms of the fact that again you have all outlined the demanding role and the fact that you are seeing carers

having to take on more responsibilities, including unpaid carers? Do you think that is an issue?

Steve Scown: Yes, I do. Status is absolutely an issue. It was seen during the pandemic to be a valuable role, a contribution—we stood and clapped for our NHS colleagues and our social care colleagues—but ultimately status requires pay.

Dr Townson: We are in a similar position to the position that nursing was in 100 years ago when people were clamouring for professionalising it. We need the same. The £500 million is obviously a positive step but that only works out at about £111 per person per year. I cannot think of many people who could do many qualifications with that. Is it really enough to professionalise an entire workforce? That would be my question.

Earlier I mentioned the complexity of needs. Thirty years ago residents used to drive up to care homes in their cars and go off and play bingo and that kind of thing. Now there are very much higher levels of frailty, dementia and so on. Many people are at home with those conditions as well. It is not just about healthcare skill; it is about softer skills, negotiating, dealing with conflict, dealing with family members who are very stressed. If you are a registered manager, you may have to go and find clients. The roles are incredibly challenging. In other walks of life nobody would dream of running a £3 million or £4 million business for £40,000.

Jane Ashcroft: You commented on the updated number of informal carers. Thank you for that revised number. Many of the great people in my organisation have been informal carers and that is what has brought them into care. Jane and Steve have perfectly described the complexity of the work that we ask people to do. We ask people to do work that is emotionally demanding, physically demanding, intellectually demanding and we have to reward that and we have to absolutely recognise the professionalism.

It also means that I only want people who are talented and compassionate working in my organisation. It is not just a numbers game and there is a real danger at the moment that because we are very focused on the number of vacancies and the real concerns about numbers we have to be very careful that we understand that not just anybody can be a carer. Special people are needed and have to be properly supported.

I am concerned about burnout. Steve described how we recruited well in the pandemic and then things became more difficult at the beginning of this year because the market opened up for people and other options were available. Certainly I am seeing people now who are incredibly tired and we are losing people in management positions and all the way through the delivery chain.

The other issue about status is very important. The clap for carers was absolutely critical and was much valued but it was not going to put the dinner on anybody's table. One of the areas where I would expect to see equivalence of status is around the vaccination issue, where I do think some of the care workforce in care homes feel that there is an inequity. There should be parity across all health and care services.

Dr Townson: We have not mentioned migration either, which is having both a direct and an indirect effect. For example, hotels have normally relied on workers from other countries. That has obviously dried up and they are now targeting our sector. Certain parts of the care sector—London, the south-east—have higher levels of people from other countries working there, but also areas like live-in care. Some forms of homecare have care workers living 24/7 in somebody's home; that traditionally has a lot of recruitment from countries like Poland and that has become very difficult. We have a general workforce supply problem and that is not confined to our sector. Some of our members are offering £12.50, £1,000 starting fees and all of that but they are still not managing to fill vacancies.

Q42 **Florence Eshalomi:** On the vacancies, the Skills for Care annual report stated that 105,000 staff vacancies were being advertised on an average day in 2020-21. What levers do you think need to be in place to address that, not just high vacancy but, as you have touched on, the high rate of turnover. Something you have all mentioned in terms of the care workforce strategy: what do you think needs to be in and what more can we do to push the Government to start that?

Steve Scown: I would not add much more to what I have said previously. You have to pay people enough. I absolutely agree with Jane. We need great colleagues to work with because it is an incredibly demanding job, but we have to pay enough. I will keep going back to it; that is first and foremost. Once you pay people enough you can offer the career structure, you can then offer the training, you can then become what we try to be at Dimensions. We try to be a sticky organisation. We try to encourage people that once they have joined us they stick with us. Why? Because we offer a career structure, we offer great career development. But at the end of the day you have to want to walk through the door to do the job.

Dr Townson: I agree with that, and many people come into care because they want to make a difference. In my previous role when I was a provider CEO we did have staff leaving to go to retail but they came back because they did not get that emotional reward from the work.

In homecare, yes, the pay rate is key, but how the care is commissioned and purchased also has a big impact on care workers. If you are electronically tagging a care worker, paying them by the minute at very low rates and in certain parts of the United Kingdom, in some areas, the

number of 15-minute visits, short visits, makes it really stressful because they feel that they cannot meet the needs of the people who they are supporting, then they go around in this permanent sense of guilt and worry. So it is not just the money; it is how that money is used.

Q43 **Florence Eshalomi:** On that point, if you think about carers and staff in London, but then in rural areas how long it takes you to get from A to B. Throw in the traffic in London and it will take you quite a while to get from A to B anyway.

Jane Ashcroft: Yes, that is a good point—the ability for people to get to work. Clearly in the domiciliary care setting travel is an issue, but in many residential care settings or extra-care schemes, if we are not close to a bus route, if it is difficult to get somewhere, that whole issue about how much we pay, the ease of getting to work, being a flexible employer is very, very important.

Also I noticed in the Skills for Care report that was produced recently, it noted that turnover rates were lower in establishments with higher CQC scores. That is an interesting dynamic. Better care is provided by a stable workforce because it is all about relationships. Colleagues get to know residents and those relationships blossom and the quality of care is great. Also, people in care want to work somewhere that they are proud of. They want to be involved in high-quality care. Those two factors are completely mutually beneficial and those have to relate to the funding of services and the way that services are provided.

Dr Townson: Can I just follow that? The Office for National Statistics recently produced a report showing that care quality ratings in care homes were higher in areas of lower deprivation. The areas of high deprivation have the worst quality ratings. The quality is related to income and how much you have to invest in training and pay and support and supervision. What you want is to create a virtuous circle.

Florence Eshalomi: Not to disclose anything, but I have been alerted of some very serious incidents in my constituency as well, representing a south London, inner-London constituency with high levels of deprivation. There are some issues in some of those care homes. I will leave it there, Chair.

Chair: We move on to an issue that has been raised before but which we need to explore further with you—integration of health and social care.

Q44 **Brendan Clarke-Smith:** In some of the evidence so far there is a suggestion that the stabilisation of the adult social care market will depend on successfully integrating health and social care. What is your assessment of the progress of that? How do you feel that has gone so far and have there been any regional differences? What is the experience of it at the moment?

Dr Townson: The word "integration" means different things to different people. My concern about it is that people go straight to an organisational structural solution or thinking. I prefer the word "collaboration" because on the ground that is what needs to happen. Even within the NHS people talk about the NHS as if it were some single entity. It really is not. You have all these different trusts, you have GPs working as independent businesses, you have community pharmacists. What unites everybody is the person who is receiving care. It is joining things up for them so that you do not have to tell your story to 25 different people. There are some areas of the country that are doing a better job of that but right now, for us as social care providers, it is really hard to engage in the conversations about integrated care systems and everything. All the time that the budgets are in silos we are going to struggle to make a difference.

Q45 **Brendan Clarke-Smith:** As for what needs to be in place, you would say the budget is the starting point for that?

Dr Townson: Even in Northern Ireland, which has been held up as having the joint health and social care trust there, the money is still in separate streams. Homecare has the poorest fee rates of the entire United Kingdom in Northern Ireland even though it is supposedly commissioned by heath. For me that does not bode very well. We have to understand the differences that Stephen and Tim raised earlier. It is those social determinants of help that are so key to all of us, not just healthcare itself. I do not know how optimistic I feel. We have been discussing integration for donkey's years and we do not seem to be any further forward.

Q46 **Brendan Clarke-Smith:** Finally on that point, if you do not mind me asking, there have been some recent reports about how the Government may be introducing a national care service. What would your take on that be?

Dr Townson: I do not think it is going to happen in 10 months of Sundays because it will cost too much. There was a question earlier about in-house provision, but on average that costs twice as much as outsourcing. If we cannot even afford to pay for the outsourcing properly, what chance is there of having it done in-house? The reason it was outsourced in the first place was because councils could not make it work in terms of investment and all kinds of things. I think it is quite problematic.

Brendan Clarke-Smith: Thank you. Steve, what is your take on this?

Steve Scown: Two points. On integration, I don't understand it; I don't understand what it means. Your point that it means different things to different people is very valid. I think it is being seen through the lens of older people's services and the impact on the NHS. I think services for

working-age adults, people with learning disabilities, are not on that integrational agenda at all, from what I can see.

In terms of the national care service, I don't know what that means. If it means the medicalisation of social care and the NHS being in charge of services for people with learning disabilities, it would be the biggest retrograde step this country could ever make. I have spent 40 years trying to enable people with learning disabilities to have choice and control and get them out of institutions. NHS runs institutions. No thank you.

Brendan Clarke-Smith: Thank you; that is useful to hear.

Jane Ashcroft: I have very little more to add. At a local level we have some good relationships where we deliver quite integrated services. As Jane said, there can be a partnership model that works. It is too early for me to understand what the ICSs are about. My concern is that the cost of process and people will be more money that goes out of delivery and into managing a complex system. One of the concerns is there is a lot of complexity. Every time we change the system we seem to add resource and cost to the means of processing, rather than putting the resource and the focus on the delivery of services to people who use services.

Chair: Finally, we move on to models of care.

Q47 **Bob Blackman:** Some of the evidence that we have received talks about changing the model of how care is provided away from care homes and towards more domiciliary care and other community-based organisations. Do you agree with that process? If so, how can the Government encourage that development to take place? I will start with Jane first and then go around.

Dr Townson: Definitely we need to invest in home-based and community services. We are always going to need care homes and we are always going to need hospitals, but to deal with the demographics, the aim, as I said earlier, should be to support people to live well at home. That will mean as well not just rationing it. What happens at the moment is that we neglect people until a crisis is reached and they end up in an acute hospital and maybe get discharged to a care home. If we can put in that money at the front end—what we want the Government to do is to invest.

People talked about lots of billions earlier but we must be getting close to £160 billion that the Government are pouring into the NHS right now. Councils only have a total of about £22 billion for all of the social care, even though it is many more people. Even if we doubled that, that would not be outrageous compared with NHS spending. I do not know why we are all so lily-livered about asking for a decent amount of money so that we can look after more people in their own homes.

Bob Blackman: I suspect that the Government would come back and

say, "Yes, but where is it coming from? The taxpayer." Jane, can I ask you the same question?

Jane Ashcroft: Yes, I certainly think that moving the model— Care homes are specialist care, often for people living with dementia and/or at the end of their life. There is definitely a role for care homes, I say, as a care home provider, but people are wanting later-life choices. There are a wide range of options that can improve prevention, can improve wellbeing. It would be most helpful if we could have support for the development across a range of tenures of retirement living options, multigenerational options. The number of older people in this country is growing so the range of options that people need is growing.

We know that in this country about 0.5% of the over-65 population live in some kind of retirement village, retirement housing environment. We are an international outlier. If we moved to 5%, just 5% of people over 65, we would need hundreds of thousands more units of retirement housing.

One of the things that we have to overcome is that we talk about people wanting to age in their own home and the image of the own home is this place that people have lived in since they were in their early 20s. That is no longer real. People move around in different life stages and have different needs. I can live in my own home and it can be a specific retirement village, it can be something that is purpose-built for later life, it is something that I can buy or rent in my early 60s and somewhere where I can age well, be less likely to fall, less likely to be lonely and isolated, less likely to need health and social care services. We have to reframe the way we think about ageing and living longer and have some kind of a proactive approach to ageing, which could include investing in a variety of choices for people in later life. That would have a big benefit for the social care system but would also have a big benefit for all of us for the quality of life that we can look forward to in the future.

Steve Scown: If we are looking at it from a working-age perspective, people with learning disabilities and autism, I think the right models are there. Rarely are they funded properly. The best models I have seen are when people have choice and control and have some independence and they are in control of the service they are receiving. If we can do that properly I do not think we need new models. The models we are doing need to be done properly and funded properly. That is where the best outcomes are. In terms of outcomes, I know that the previous session touched on outcomes. I do not know whether we are going to get a chance.

Bob Blackman: Funnily enough, that is my next question. You have anticipated it.

Steve Scown: I will try to answer that one, then. We should move to towards outcomes-based commissioning, but can we please have outcomes determined by the person?

Q48 **Bob Blackman:** You are all professionals in this field. What do we mean by outcomes commissioning in this sense? That would be helpful to understand.

Steve Scown: It is giving people the life that they want rather than what some procurement officer thinks that they should have. If you want to sum it up in an elevator pitch, ask people what life they want and if you give it to them and they are happy and they are in control of who supports them and they are making those choices, that is a starter for 10 on what outcomes are about.

Q49 **Bob Blackman:** But there is a constraint on resources. Do resources then constrain what you can do in terms of outcomes commissioning?

Steve Scown: There is very good evidence that where people understand what is available they can make the best choice of how to use those resources to the best ends. There is no evidence that people with a personal budget want a bottomless pit. There is absolutely an acceptance that resources are constrained and there is a limit, but if you are going to spend £10,000 trying to give me a life, let me choose how that £10,000 is spent, not some procurement officer in a local authority office.

Dr Townson: On the subject of money and investment, though, it is all being poured in the NHS, supposedly to help their elective recovery, but a lot of the reason that they are stuck is because they cannot discharge people back to the community. What we are trying to say is, can we use the money that we do have more intelligently?

With outcomes, at the moment if you take homecare, it is purchased by the minute. All that is measured is how many minutes a care worker spends with that person. Does that person—

Bob Blackman: Not the quality of what they do for them.

Dr Townson: No. At a big ICS level we should be looking at things like healthy life expectancy and then how does that translate. Sometimes just the simplest intervention—Jane mentioned it—about making sure someone is not lonely and is connected to their community. That keeps their confidence, they are less likely to fall, less likely to need healthcare. There is evidence for that already. It does not necessarily cost a lot; we just need to think differently about it.

One of our challenges is the mechanisms for doing the commissioning. Other countries have started to think a little bit more carefully about this. We are going to need a radical reform of our approach to commissioning. I always find it interesting to think about self-funders in this regard because they are their own commissioners. Why can state-funded people not have the same degree of control as somebody who is paying for their own care?

Jane Ashcroft: Yes, that is a point I want to emphasise as well. In the care home sector, because there are a lot of people paying for their own care, when you talk to somebody about what they want, in effect they are talking about outcomes, how they want to live their life. People spending their own money make choices about how to spend that money. That principle needs to be built into how we commission for outcomes. This is not a procurement process; it is not like buying a product and looking for the best value-for-money pencils or food or utilities. It has to be about services and I do not think that commissioning for outcomes would cost more money.

Steve Scown: All I would say is that if we do that we need to have a regulatory framework.

Q50 **Bob Blackman:** I was going to come on to exactly that point. My goodness me! You anticipate the questions very well. What is your personal assessment of the regulatory framework that we currently have and what needs to change, if anything? I will start with Steve, as you posed the question.

Steve Scown: On the outcomes basis I think we need to have a regulatory framework that is prepared to measure and judge people on the outcomes and providers—on the outcomes people have achieved, rather than the processes and the outputs as it is at the moment. I think the CQC's strategy is okay. I am waiting for it to deliver it, because what we experience on the ground is not in line with its strategy.

Dr Townson: I think the intent of the CQC system is positive. It is hard to get an "outstanding" rating and you do have to demonstrate improved outcomes, so a lot of the mechanisms are there but, as Steve said, not always implemented in the most consistent manner. That has got worse during the pandemic. There is a lot of focus on process and it feels like trying to catch people out.

Then there is the regulation—or the oversight, shall we say—at a system level. The point we have made many times is that the quality of care is directly linked to how it is commissioned. If you are purchasing care at £12.68 an hour by the minute, how can you possibly expect a provider to do a good job when you cannot even pay your staff properly or meet your regulatory obligations?

There ought to be some rules. Councils need to have enough money but it should be unlawful to commission at fee rates below what is possible to be compliant with regulations.

Jane Ashcroft: An intelligence-based approach to regulation and a proportionate approach is very important. That is the direction that the CQC is travelling in. That intelligence-based approach needs to draw on the experiences of people using services and people working in services. We are clear that we are in partnership with the regulator because we all

want to deliver the best quality care. The people who are best placed to tell us about the quality of what we do are the people using those services, and their families. We have to constantly work on that partnership.

In the earlier session you talked about the regulatory framework and how that will apply to the commissioning environment. It is going to be very important that that lands well because that could be a very positive step forward if it lands in the right way and is appropriately focused.

Chair: Thank you to our three witnesses. This has been really helpful to the Committee. We have learnt a lot about the challenges and the problems facing care providers at present in the whole range of different ways that you provide care. That is the important thing. There is not just one model of everyone in a residential home. It is very different and it is making sure we understand those different aspects and the variety of the ways that care is provided that is important when we come to look at solutions, going forward.

Thank you very much indeed for helping the Committee with that understanding. That brings us to the end of our evidence session for today.