HOUSE OF COMMONS

Levelling Up, Housing and Communities Committee

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

Monday 13 December 2021

Ordered by the House of Commons to be published on 13 December 2021.

Watch the meeting

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

Questions 104-169

Witnesses

I: Sally Warren, Director of Policy, King's Fund; Natasha Curry, Deputy Director of Policy, Nuffield Trust; Charles Tallack, Assistant Director, The REAL Centre, The Health Foundation.

II: Chris Smith, Executive Director of Business Growth, Thirteen Group; Paul Teverson, Director of Communications, McCarthy Stone; Sue Ramsden, Policy Leader, National Housing Federation.

III: Professor Philip Booth, Senior Academic Fellow, Institute of Economic Affairs; Dr Eleanor Roy, Health and Social Care Policy Manager, CIPFA.

Examination of witnesses

Witnesses: Sally Warren, Natasha Curry and Charles Tallack.

Chair: Welcome, everyone, to this afternoon's session of the Levelling Up, Housing and Communities Select Committee. We have sessions with three panels this afternoon, looking at the long-term funding of adult social care, both the long-term issues and also the recent announcements by Government and what effect they have had on that long-term provision. As I say, we have three panels.

Before we come over to the first panel, we will put on record any particular interests that members of the Committee may have with regard to this inquiry. I am a vice-president of the Local Government Association.

Mohammad Yasin: I am a member of Bedford Town Deal Board.

Ian Byrne: I am a sitting councillor in Liverpool.

Rachel Hopkins: I am a vice-president of the LGA and I employ a councillor in my office.

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.

Brendan Clarke-Smith: I employ councillors in my office.

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

Q104 **Chair:** Thank you for that. Going over to our witnesses, all three are online this afternoon. There has been a slight change in our arrangements, so I will ask each of the witnesses in turn to say who they are and introduce themselves briefly.

Sally Warren: Good afternoon. I am Sally Warren, director of policy at the King's Fund, a think-tank that works to improve health and care in England.

Natasha Curry: Hi. I am Natasha Curry. I am the deputy director of policy at the Nuffield Trust, which is a think-tank aiming to improve health and social care. We do a lot of work looking at international models.

Charles Tallack: Hello. I am Charles Tallack. I am assistant director in the Health Foundation for our REAL Centre, which is a centre that is looking at providing evidence and analysis to support long-term decisions about the health and care system. The Health Foundation is also a charity, aimed at improving health and care for people in the UK.

Q105 **Chair:** Thank you all very much for coming and giving your time this afternoon. We will ask questions and, generally, we will probably want a response from each of you, although some may be specifically asked to one of you. If you agree with what somebody has already said, it is sufficient just to say, "I agree", because then we can get on and make sure we cover all the important subjects that we need to cover with you.

The last 12 months have seen a lot of announcements about social care or with various documents that include social care within them: the *Integration and Innovation* White Paper back in February, the Build Back Better health and social care plan in September and the *People at the Heart of Care* White Paper, which was just published in the last few days. There are a lot of documents, and the Prime Minister promised to "fix the crisis in social care once and for all". Do you think those various policy announcements will do that?

Sally Warren: My summary view would be unfortunately not, although there are some aspects of policy and some things that will help improve

the social care system in those documents. It is just not enough and not fast enough.

When I think about what you need to do to fix social care, I think of three things. One is that you need to adequately fund the existing social care system, so local authorities and providers can provide good quality care. For that, the spending review was absolutely critical, as I am sure we will come to talk about later. We do not believe the spending review has provided adequate funding for the cost pressures that will be facing the system over the next couple of years.

The second thing to do is system reform, so to change the system to improve the quality, the personalisation in the system. That was the *People at the Heart of Care* White Paper. There is a good long-term vision in that White Paper, but the pace and ambition over the next few years is, unfortunately, quite limited, with only £1.1 billion of investment over those three years.

The third part, for me, of what it would take to fix social care is changing the funding reform system, so changing what the charging system is, that balance between the individual and the state. In that, we had had a considerable step forward, in that we have a proposal to change that through the cap in the Build Back Better document and the source of funding and levy. That is progress, although the more recent changes to how the cap works mean that that is much less beneficial for people of moderate and low wealth in old age and for working-age adults than we had anticipated it would be.

Taking all three of those things together, I would say that we still do not have a plan that is going to fix social care.

Q106 **Chair:** We are going to come on to some of the details of that funding in the next question. You can certainly respond to the generality, Natasha.

Natasha Curry: I broadly agree with that assessment. The White Paper set out the broad general direction. We have had some initiatives in the innovation and integration Bill and some funding in Build Back Better. What we are missing still is a coherent plan and a clear logic model from where we are now and the problems that are in the system to how we then get to the vision that has been set out, and particularly within the budgetary envelope, which, as Sally said, to put it mildly, is quite modest.

What we have seen so far fundamentally fails to address the issue that not enough people are able to access enough good and affordable care at the moment. From what I have seen, I have not seen a plan that addresses that problem adequately.

Chair: Charles Tallack, thank you for joining us today at short notice.

Charles Tallack: Thank you for having me. I pretty much agree with everything that Sally and Natasha have said. I am not going to add a

huge amount. The way I have thought about this is that we need to look at the current plans against whether they address the challenges. I agree with Sally. There are lots of issues related to the funding of the current system. There are the issues around unmet needs, workforce, providing sustainability, quality of care, the things Sally talked about as well, such as personalisation. The other issue is about the way in which we organise and pay for care.

On the second of those, the policy announcement about a cap is very welcome. It does indeed address that issue of catastrophic cost for most people. However, on the first set of challenges, which relate to funding, I do not think they can be addressed. There are lots of warm words, the vision is fantastic, but I do not think it is properly funded. This is where we went wrong before, in the 2012 White Paper, which also set out a fantastic vision. It said it would be delivered within 10 years. It has not been delivered. That is just next year. When you look at why it has not, it has to be, fundamentally, the issue of funding and commitment.

Q107 **Bob Blackman:** I will start with you, Charles. Before September of this year, we have had all sorts of estimates around the amount of additional funding that the adult social care sector needed, but there has obviously been a number of announcements on policy and funding. Do you have an estimate for the gap in funding that there currently is in adult social care, taking into account all the recent announcements, such as charging reforms, the increase in NI contributions, the national living and minimum wage and moving towards a fair rate of care? Do you have a figure for what the gap is now?

Charles Tallack: We do have a figure.

Bob Blackman: Could you share it with us, then?

Charles Tallack: I certainly will. I am coming on to that. Can I say where we are starting from? Since 2010, the amount of funding for social care has increased by almost exactly 0% in real terms. That is despite demand pressures. There is an ageing population, a growing population. That means that per person, adjusting for age, funding is about 12% less than it would be had we met the demographic pressures.

Let us look forward. The first thing is meeting the demand pressures. The funding announced in the spending review for the demand pressures for social care amounts to about 2% per year, but the combination of the population ageing and growing and the price pressures mean that the overall costs rose by about 3.5%. It is not really enough to meet future demand.

However, the current system is also, as we have heard, underfunded, so if you want the gap based on addressing some of those issues, like around the unmet need demand, the figure is quite a lot larger. We estimate that if you met future demand, you increase the prices paid to providers so that they can raise quality and wages, and if you also made

some inroads into the unmet need by increasing the number of care packages by 10%, that would require an extra funding of £7.6 billion in 2022-23. That would rise to £9 billion.

Q108 **Bob Blackman:** That is a one-year cost of £7.6 billion.

Charles Tallack: Yes, which sounds a lot, but you need to look at that in the context of what has happened since 2010. For a sector like this, where ageing is incredibly important—it has large age pressures—we have not increased funding at all. Yes, it is £7.6 billion in 2022-23 and £9 billion in 2024-25. That is over and above that provided for in the spending review.

This is all for the current system. There is also, of course, funding for the cap, and separate provision was made in the spending review for that. We do not have detailed cost figures from the Department of Health and Social Care for that, but the provision there should cover the cost of the cap and increase the means test thresholds.

Q109 **Bob Blackman:** Can I be clear? You are not including the ageing population in your figure, so the increase of the number of people who are going to require care. You are just talking about the current level of people and funding required. Am I correct?

Charles Tallack: The £7.6 billion that I talked about covered the extra demand from a growing population, but also 10% extra care, if you like, a greater quantity, and paying what we think is a fairer price for care, which would create a sustainable provider sector.

Q110 **Bob Blackman:** The *People at the Heart of Care* White Paper says, "As we implement the cap on care costs and remove the unpredictable care costs people can face, the proportion of the levy that is required to support investment in adult social care in England will increase". Do you see that as a signal that, after three years, even if the proportion of the levy that is going to adult social care actually increases, which is a questionable point, given the health service position, the money will only go towards the charging reforms and not towards the wider system reform? Is that your view?

Charles Tallack: I don't know how much of it will go towards wider system reform. Certainly more of the levy needs to go towards the cap because, by 2024-25, people have not hit the cap. Most people will not have hit the cap of £86,000. The costs will not actually stabilise probably until around 2027-28. At that stage, more money will be needed from the levy to fund the cap. That will not take up anywhere near the amount of the levy so there is still room there to fund more, but we don't know what the Government's plans are, in terms of using more of that money, or whether they will be able to get it out of the NHS.

Q111 **Bob Blackman:** Last week, the "Panorama" programme drew attention to the lack of financial transparency and tax avoidance in some parts of the adult social care system. A report by the Centre for International

Corporate Tax and Accountability Research said, "Prior to any substantial increase in public funding, greater transparency and accountability across the sector are essential". Do you agree with that statement and how can we actually achieve it?

Charles Tallack: Sorry. This is about creating greater transparency and accountability within the sector for what?

Bob Blackman: The "Panorama" programme went into the lack of transparency and the various different schemes for tax avoidance in the sector. So there is a lack of transparency in the system. Its statement was, essentially, that there had to be greater transparency and accountability before you could actually get into more funding. Do you agree with that view—that there are things to fix in the system before you add extra money to it?

Charles Tallack: There almost certainly are things to fix, but this is a market in which there are many providers—17,000 different providers. It is not necessarily dominated by people who have complicated financial structures. My view on this is that we are trying to aim for a well-functioning, competitive market, and in those kinds of markets, additional funding does not just go through to profits, for example. It would go to improving quantity and quality. So we really need things that will improve the market. Part of that is about making sure that providers are funded properly. They have contracts with local authorities. Those contracts will specify quantity and quality of care, so there is quite a long way that you can go towards addressing this by proper funding of the private sector and having good contracts between local authorities and providers.

Natasha Curry: If I may come in on the markets point, we did a piece of work earlier this year looking at the deficiencies in the market. It is really important that this issue has been raised; it is one of the causes of instability in the market. But it is also very important, as Charles has alluded to, that most care is provided by small and medium-sized enterprises. About 70% of all care is provided by very small or medium-sized care homes, often single owners, family-owned, small agencies doing homecare. We are talking about a small, specific part of the market.

Having said that, it is an important issue, and particularly the equity-backed large providers do create instability, because they are financially precarious. There is no transparency over ownership, and the impact is felt on those people living in care homes and their families, who suffer from the discontinuity of care.

There are several things that could be fixed to handle this better. At the moment, in the market, there are no rules to stop or discourage financially risky behaviour. Providers bear no responsibility for the continuity of care if they suddenly leave the market or change ownership. That falls on local authorities. There is something in the CQC market oversight regime, which was put in place to try and prevent financial

failure, but it is quite a reactive regime. The CQC does not have powers to step in proactively to prevent failure. It cannot require providers to stabilise or improve their financial position. Also, it only has capacity to look at a certain proportion of the market. There are inadequacies in the current frameworks.

The White Paper, and the Bill in particular, aim to strengthen that through the CQC assurance framework, which we welcome, as long as it is supportive to local authorities in strengthening commissioning and market-shaping. Our concern is that it focuses only on the commissioner side, with no onus on the provider and their behaviours, and no extra regulatory powers over provider behaviour. While we welcome that step forward and the recognition that it is a problem and that there is a need for transparency, it is not quite clear how we are going to achieve a solution to this issue.

To add to that, given the diversity of the market, we might need quite a nuanced approach to market management, given the breadth of type of organisation, ownership, size, etc. We do not want to discourage investment and innovation, but we want to prevent that instability and discontinuity of care.

Q112 **Bob Blackman:** Do you agree with Charles's estimate of this £7.6 billion gap in funding?

Natasha Curry: It is a reasonable estimate. We have not done our own, so I would trust the Health Foundation figures.

Sally Warren: Quickly reflecting on those three points, on Charles's £7 billion gap, we agree with that as a reasonable estimate for the gap. There is a practical point that if you suddenly have £7.6 billion, I do not think the sector could spend it and spend it well, because actually you have to think about, yes, you want to tackle unmet need, but until there is the capacity and therefore the workforce there, you cannot just magic up an extra 10%. It is the right sense of scale about how far away we are from an adequately funded system.

Secondly, on the levy, yes, absolutely, we would expect a higher proportion of the levy to go to social care as the cap costs begin to reach steady state. The important thing to say is we are talking about a future spending review that is working out how to share the proceeds of a levy. That levy is £12 billion or £13 billion out of what will be a total spend on health and care by that point of more like £170 billion to £180 billion, so it is really important that we look at the totality of spend on social care and not just the share of the levy, as the final point.

Very quickly on the point about transparency of the market, I would reiterate the point that colleagues have made about diversity of the market. Four Seasons and HC One, which were the two companies particularly addressed through the "Panorama" programme, have less than 8% of all care home beds in England, so the vast majority of

providers are not structured in this way. That does not mean that there is not an important point about transparency.

Some of that is about transparency of the financial position of providers and how they are engaging with commissioners and the regulator. There is also an important point about transparency to consumers. The Competition and Markets Authority has now, for several years, been recommending significant improvements by providers about the transparency they provide to consumers about price and what consumers are getting in return for price. There is a lot to do to try to improve transparency to mean that, when we are buying care, needing to access care, as a consumer, as a client, we have access to appropriate information that allows us to make good choices about the care we want and understand what that will cost us as well.

Chair: We move on now to look at the White Paper and the vision that it put forward.

Q113 **Mary Robinson:** The *People at the Heart of Care* White Paper aims to outline the Government's 10-year vision for adult social care. From the White Paper, do you get a clear understanding of the Government's vision and what the journey will be like over the next 10 years to achieve it?

Charles Tallack: The vision is great. What is lacking are the policies, the milestones and the funding to achieve it, which is really unclear. As I mentioned before, the 2012 White Paper also had a good vision that people would buy into. That just did not happen, because of the fact that the policies and the funding were not there really to back it up. The White Paper has set out a series of "I" statements: "We will know we have succeeded when people who are getting care can say x, y and z". Being able to assess the progress against those things would be really helpful, understanding where we are currently on those. How many people can say these things and where will we be in three, five or 10 years?

Q114 **Mary Robinson:** What do you think those milestones should be? What are the key indicators that we should be using to measure them?

Charles Tallack: I don't feel that I can actually set out what the milestones are. One of the big gaps in the White Paper is really, given the issues around workforce, a workforce strategy. It is really fundamental to the achievement of these. The people who provide care are the backbone of social care. I would hope for a workforce strategy. To me, that is quite a missing part of it.

Q115 **Mary Robinson:** Natasha, do you understand the vision over the next 10 years and the journey we are going to be heading towards to achieve it? What would you say are the milestones and indicators that we should be having included or watching for?

Natasha Curry: I would think similar to Charles: set out a vision, a direction of travel. It is not clear to me that we have a coherent plan and a route to get to that vision. It feels a bit piecemeal. As I said before, we

have a vision. We have a set of measures. We have some money. It is not clear to me how they all come together and what the logic is. It is not clear to me what the milestones are and I don't think we can set them, given the piecemeal nature of what we have seen so far. Like Charles said, the big missing piece is the workforce strategy.

Q116 **Mary Robinson:** If you were asked to give advice on this, how to put some flesh on to the vision, what would you be saying?

Natasha Curry: We would want a clearer description of what the system will look like. We have those "I" statements, so "I will be able to…" around choice, control and quality, which are laudable. As Charles was saying, how are we going to measure those? What are the key indicators that we want to see change? Where are we now? We don't have very good data around any of this, so we need better data now. Where do we want to get to in 10 years' time and how are we going to measure those?

I would want a really comprehensive description of a system that delivers quality, choice and control, and really focuses on the people who are drawing on social care, not losing sight of that, and then how the system supports them to draw on the care that gives them choice, control and independence in their own lives. There will be a suite of measures around workforce, the provider market, eligibility and funding—a whole range of things that need to come together to create a coherent plan. From what I have seen so far, we don't have that plan yet.

Q117 **Mary Robinson:** Sally, do you feel you are clear on the vision? What would you have to say about the milestones? What would you want to see and how could they be assessed?

Sally Warren: Much like Charles and Natasha, I think that the vision itself is absolutely fine. It is quite similar to previous visions. It talks about how I would imagine I would want my social care to be, should I need it. We always knew that we were never going to fix social care over a year or over three years. The fact that this is 10 years is also absolutely fine.

The key challenge for me, though, is the pace and ambition in those first few years and then the lack of any sense of progress after 2024. Given where we are, the first thing we need to do is stabilise the social care system. That is about stabilising providers, so we do not see exit and loss of capacity. It is about supporting our workforce to mean more people are entering the workforce and not leaving it. There is a period of stabilisation for me. From an indicator point of view, you can look at data like vacancy rates, turnover rates, the providers and what the number of beds entering and exiting the market every year is.

You then need to do some innovation and transformation once you have stabilised. At the moment, the White Paper is talking about a lot of small pots of money that are pilots or there is inevitably going to be bidding for. It feels quite small-scale in comparison to the scale of challenge.

When it gets to innovation, we need to be talking about different service models, what different housing can do, also what technology can do to support, prevention and early intervention, and, as my colleagues have said, a workforce strategy.

If you are thinking about indicators, I agree with what colleagues have said. We do not have great data at the moment. One really strong advantage of the capped costs model is that everybody needs to come and make themselves known to the local authority. That then means you can start to get much better data about everybody using social care, rather than only people who were funded through the state. That would be a really rich seam of data about what people's needs are when they first come and how they are being advised on other ways to meet their care and support needs. That might be in the community. That might be preventing greater onset of need.

Then you are starting to be able to understand their progress. Things like the adult social care user survey would be able to reflect everybody that is in the system. There is real potential, through opening up the social care system to everybody, through that charging reform, to then mean you can get much richer data about what people's needs are when they first turn up but also how well their needs are being met from their own perspective.

Q118 **Mohammad Yasin:** The White Paper says that it will support local authorities to strengthen their market-shaping and commissioning capabilities, including through £70 million of improvement funding over the next three years. How can the Government best support local authorities to shape their local care markets?

Sally Warren: There are two different ways to approach this question, or approach how local authorities need to be supported. The first is to say that, unless local government is adequately funded to be able to commission services that meet the needs of its local population, it is not really ever going to be able to shape its market. All it will ever be able to do is the bare minimum to get care packages out for those most in need in their system.

There needs to be adequate funding going to councils to mean that they are then paying a fair and decent amount for care, which would allow for innovation and investment by providers, be that in their own workforce, in technology or in capital. There also needs to be adequate funding to mean that they are able to meet the needs of their local population and have their own capability to understand the market. If you are not going to fund them adequately, we need to be realistic about how much they can actually shape their market.

Let us assume you are funding them adequately. There are then things you can do to help local authorities, because you do not want 152 local authorities all trying to work out what this means by themselves. There is the space that sector-led improvement can fill in here, so guidance about

what good market-shaping looks like, peer assessment to help people understand their current performance on market oversight and market-shaping and how you can share best practice between councils. Those are all things that local government, through the LGA and ADASS, have been pushing over the last few years, but the money in the White Paper, I hope, will mean that that can become a stronger, more consistent area of support and challenge for local authorities.

Q119 **Mohammad Yasin:** In the White Paper, the Government are saying that they will make sure that there is a guideline for local authorities, so they can pay providers fairly. What should this guidance include and how can Government ensure that providers are paid a fair rate?

Sally Warren: There are a couple of different aspects to a fair price for care. One is about trying to remove or reduce the cross-subsidy between those who pay for their own care and those who are funded by the state. The other bit is about generally increasing the unit cost that we are paying, generally as a country, for care.

Guidance would need to be really clear, particularly where it is about the cross-subsidy, about who and what services are eligible for that. Is it that everybody who is accessing care now can access the local authority rate, or is it going to be phased in in a transitional way? How does that work? Are there any exemptions? For example, if a provider is offering a different type of service, a different quality of service that they can demonstrably show is different to a local authority-funded service, can they legitimately charge a higher rate, or is that not possible?

Also, guidance would need to cover what the process for real-time evaluation of feedback is. To put it bluntly, if Government get the fair rate of care wrong or the process around that wrong, it will be hugely destabilising to the care sector. You could see providers having to exit the market very quickly if the price is wrong. A real sense of how a local authority locally is evaluating and understanding, but also how that is then being considered nationally is needed, so the Department of Health and Social Care and DLUHC can step in, if they need to, to better support the market.

Those would be some of the areas that I would talk about. There is obviously using things like the CQC assurance process. That is an important part of this. Providers can appeal local authority decisions as well, but that appeals process has tended to be quite slow. Something about speeding that up as well would really help that sense of this being a real-time interaction and market. A decision could have very quick impacts on providers.

Q120 **Mohammad Yasin:** Natasha, do you agree with Sally?

Natasha Curry: Yes. Her framing of the support to local authority commissioning is spot on. On the fair rates, I would emphasise how important it is that the two parts of this proposal come together. Allowing

access to council rates for self-funders could seriously destabilise the market if the local authority rates have not come up to a sustainable level.

The wording used in the documentation is "fair rate". I am not sure whether that is the same as "sustainable". Who defines "fair"? The guidance will need to be really clear about what "fair" means. Does it include overheads? What is a reasonable return on investment? Who decides what is fair and what happens if there is a dispute? What happens in the event that a provider is providing to multiple people who come from different local authorities who might have agreed a different rate? Are we going to see cross-subsidisation creeping in again, but geographically?

There is a really important point here about what data will be used. There is a real asymmetry of information, as we already discussed about lack of transparency, so we need really good data about costs in order to do these negotiations fairly.

There are a couple of other things that guidance will have to cover. Over what time period will the fair rate be set? Are we going to project into the future and take account of future cost pressures? How are we going to do that? Again, what data will be used? What role will the NHS play in here, because we know that the NHS commissions some care and it tends to pay a higher rate. Will it be party to these discussions? How will that work?

There is quite a lot of learning that we can take from other countries. Scotland tried to introduce a national care homes contract. It has really struggled, because it has failed to agree what a fair rate is. That is something we can learn there. Japan and Germany, two other systems we have looked at, have opted for a national fee framework, which is then adapted at a local level. It gives clarity and quite a lot of structure around the local negotiations that take place. There are things we can do to make this process smoother. It is really important that we get it right, so as not to destabilise the market.

Q121 **Mohammad Yasin:** The White Paper also says that it will not introduce a system to allow the public to appeal certain social care decisions made by local authorities. Do you agree with that decision, Natasha?

Natasha Curry: My understanding is that that will be kept under review, but it is not an issue that I am close to. There are other organisations that would be better placed to address that.

Q122 **Mohammad Yasin:** Charles, do you have any views?

Charles Tallack: Not particularly. I must admit that I don't understand the logic of that. There is a reason why it was put into the Care Act, and I don't really understand why that has been decided and what the impacts are. I am not an expert but, at first glance, I question the wisdom of it.

Sally Warren: I agree with Charles and Natasha. It was introduced as part of the original Care Act, as a way to give people confidence that the decisions would be fair and reasonable, and that there would be a way to seek an appeal if they did not feel that it was fair and reasonable. I can understand that you might not want to overwhelm local authorities with an appeal process, but if you are not going to introduce that, you need to be clear with the public about how they can be confident that the decisions are fair and reasonable and what action they can take if they feel that they are not. If not the exact appeals process from the Care Act 2014, we need to understand what the alternative is; otherwise, people may not have confidence in the decisions being taken locally.

Q123 **Chair:** Coming back to Sally, presumably individuals still have a right to the ombudsman, though, if they feel that they have been improperly treated in the system.

Sally Warren: Yes, but I guess the issue might be how long that takes. In particular, this was going to be an appeal process about the decisions about your cap and how your care costs are metering towards the cap. It could be that you have progressed quite far along the cap before the ombudsman process has concluded. It might also be that the ombudsman does not have the capacity to deal with those kinds of issues. I guess it is a capacity and timeliness issue.

If Government can set out what they think the alternative is and why they think the alternative is appropriate and robust, that would be absolutely great. At the moment, we haven't seen that. We have just been told, "We are not going to be introducing that at the moment but are keeping it under review."

Q124 **Rachel Hopkins:** The White Paper provides more detail on measures to support the social care workforce. Do you expect these measures to resolve issues around vacancy rates, retention, progression and morale?

Sally Warren: The short answer is no, but I can give you a longer answer as well. The White Paper sets out a number of quite welcome measures around the skills levels in the workforce and some wellbeing initiatives, so pilots around occupational health, a new digital hub and some good initiatives to help people have their skills and qualifications be more portable across the sector. That is all really welcome.

When you then stand that up against some of the stark realities at the moment about the vacancy rate in the sector, which has been going up every month since the spring, when you look at the turnover, when you are hearing stories from providers where they are unable to deliver care at the weekend because they have staff who either have left or are isolating, I feel that the set of proposals fails to fundamentally tackle the big issue. There is nothing on pay, for example; it is all about skills and qualifications.

I will give you a bit of a comparison. In the last six weeks, the Government have made two announcements about investing in social care for this winter, the last one being on Friday evening. In total, they have found £465 million to invest in the social care workforce up until March 2022. That is £465 million over four months. For the White Paper, it is £500 million in total across three years. It gives you a sense that the scale of investment is not up to the challenge ahead, but also the opportunity ahead.

Social care is a huge opportunity as an employer. It is a great place to work. The work you do can be completely transformative for the people you are supporting. 1.5 million people work in the sector right across the country, so there is a huge economic potential here if we really embrace and support the workforce. My fear is that the White Paper is doing some nice, important things but failing to tackle the really big issues.

Rachel Hopkins: Natasha, you were nodding there.

Natasha Curry: Yes, I completely agree. The lack of a coherent workforce plan is the biggest gap in the White Paper. We know that there is a workforce crisis now. We have been looking at the experimental data that the Department has published recently. We think that at least 40,000 people left the sector in the six months to the end of October. That could be as high as 70,000, taking into account the messiness of the data. That represents a shrinkage of the workforce of between 3% and 4%. That is a huge shrinkage, given what we know about demand and need rising as well, and we are not even properly into winter.

We are already seeing the impact of that, with people not being able to be discharged from hospital. We hear that people cannot access care in their own homes. This is a crisis that is happening now. The White Paper, as Sally said, says some nice things, with really welcome support for the workforce training, etc, but it does not coherently address the current crisis and set out a strategy for the long term.

We are facing a combination of issues now, which are some longstanding issues around low pay, poor conditions and perception of low value, but also, at the moment, the consequences of Brexit, with people being pulled into other industries where there are shortages of staff, such as hospitality and retail. The care sector cannot compete with the wages that they can offer. There are changes to immigration rules that mean that there is no easy route to recruit internationally. Now there is the vaccine mandate, which is causing some people to leave the sector as well, so we are facing a really serious issue now. There is nothing in the White Paper that addresses that. As Sally said, two pots of money have been released recently to try to address issues in the immediate term. We need a well thought-through plan now and into the long term to address this issue.

Q125 **Rachel Hopkins:** Charles, do you agree? Do you have anything further to add?

Charles Tallack: I agree with all that. Reading the White Paper again, it was quite good on vision, but it was lacking in addressing the fundamental challenges, so looking at what the underlying challenges are. Clearly, the money that was put into the workforce, the £500 million, is welcome. Is it adequate and is it aligned to the challenges? It really, really isn't.

I have my own comparison. Sally gave us a helpful comparison. If you think about that £500 million for the workforce, that basically amounts to the equivalent of 6p per hour per worker. Obviously it is not going to go into the wages, but that shows the small amount, because that provides a bit of a benchmark against which to judge it. There are massive problems with workforce issues, which Natasha has really well described. This does not really begin to tackle what the fundamental challenges are.

Q126 **Rachel Hopkins:** The White Paper announces £25 million of funding to test new initiatives to support unpaid carers, as well as an entitlement of five days' unpaid leave. What is your assessment of the White Paper's provisions for unpaid carers?

Sally Warren: I have a couple of different reflections on this. The £25 million is welcome. It is good to test and try out new interventions. That is positive. A number of the other commitments in the White Paper around, for example, technology or housing can also support people who are carers.

That is positive, but again, we need to come back to the absolute fundamental: if the social care system is not adequately funded, so there are high levels of unmet need and there are high levels of discontinuity of care because of the amount of providers in real difficulty and the amount of paid carers leaving the sector, that fundamentally means that the burden and pressure that is put on unpaid carers is overwhelming and too much for many.

What do unpaid carers need? They need a social care system that they can rely on to provide support to the person drawing on care and support, so they are confident that it is there when it is needed, so that the unpaid carer can balance their own responsibilities, be that employment or other connections in the economy and society, with their role as an informal carer. At the moment, the lack of that strong, fundamental part of the social care system means that the pressure on carers is too much. As we have discussed in the last 45 minutes, the White Paper and the set of reforms do not do enough to tackle those fundamental weaknesses in the social care system.

Natasha Curry: I would agree with all that. £25 million is very welcome, but it does not go far enough when you think of how many millions of unpaid carers there are that we know about. Our analysis shows that there are 13,000 fewer carers getting direct support now than there were six years ago. That is despite what we know is happening to service provision. There are a lot of people struggling with no support.

There is a lot of talk in the White Paper about giving carers advice and guidance, but we really need to provide direct support and respite care when they need it. There is a long way to go to make sure that carers are adequately supported. The five days' unpaid leave is also welcome. That would be helpful in an emergency, but it really does not go anywhere near what carers need to balance maybe their own employment or other responsibilities or activities in their lives.

Q127 **Rachel Hopkins:** Charles, do you have anything to add?

Charles Tallack: I have nothing to add at all. Natasha and Sally have both described it really well. It is pretty much exactly what I think. I was going to quote the same thing as Natasha: the reduction that has taken place over the last while. This is small compared to that. This ticks the box for carers, but it does not actually really address the fundamental issues.

Chair: Thank you very much indeed to our witnesses for your evidence this afternoon. That has been really helpful for the Committee, understanding the facts and the challenges that are facing social care. If we have any points to pick up on, particularly with Charles and the calculation of those figures you gave us, we might well come back to you, just to set out for us clearly, so we can relate to that in our report, when we produce it. Thank you all very much indeed.

Examination of witnesses:

Witnesses: Chris Smith, Paul Teverson and Sue Ramsden.

Chair: Good afternoon. We have two witnesses with us in person this afternoon and then we have a third witness online. I am going to ask you all to introduce yourselves to begin with, at the start of this session.

Chris Smith: Good afternoon, everyone. My name is Chris Smith from Thirteen Group. We are a housing association based in Teesside, but we work across the north-east, North Yorkshire, West Yorkshire and the Humber. We provide affordable accommodation for rent and sale and have just under 35,000 properties. About 10% of that could be classed as specialist and/or supported. We are not a care provider as such, but we work with care providers in some of the settings that we deliver. We are also a deliverer of a number of commissioned services, such as for homelessness, people fleeing domestic abuse, prison leavers and move-on accommodation. We are a housing developer and a Homes England strategic partner.

Paul Teverson: Good afternoon. I am Paul Teverson, director of communications for McCarthy Stone. We are a UK developer and operator of retirement communities. We operate 475 retirement communities around the country. That includes 104 extra care communities, including in many of the constituencies of the Members around the table. We also have a CQC-registered domiciliary care team as part of our business.

Sue Ramsden: Good afternoon, everybody. I am Sue Ramsden from the National Housing Federation. The federation represents housing associations in England. Housing associations provide about 75% of the country's rented, supported and sheltered housing and are also quite significant providers of registered care, with about 15,000 care home places. It is not-for-profit providers of both care and supported housing.

Chair: Thank you. You are all very welcome this afternoon. Brendan Clarke-Smith is going to explore the issue of the different kinds of accommodation that are available.

Q128 **Brendan Clarke-Smith:** Good afternoon, everybody. This inquiry has heard quite a lot of contributions about care homes, and that they are not the only way of addressing people's care needs. We have heard lots about the different types of accommodations and so on. Would you please be able to summarise for us the types that are actually available for people at the moment, both for older people and for working-age adults? Paul, I visited one of your things in my own constituency. Perhaps you can tell us a little more about what McCarthy Stone do.

Paul Teverson: I would be delighted to. We refer to our developments as retirement communities and we think that they are a third way to live in later life when you need that bit more support and companionship, and potentially care. One of the other two options is in a care home, in a room that you do not own, that you rent. You have that lack of independence and the care is provided to you. Or you can soldier on in your own home, where you have a carer who comes in—perhaps it is a different carer every day—but you essentially remain quite isolated and potentially quite lonely.

We like to think of what we do as the third way to live in later life, when you need that bit more support, and we have two core products that we classify under the retirement community banner. One of those is a housing with support type development, which I think you visited last year. That is where you have a house manager, a shared lounge and other shared services, and essentially all the property maintenance is taken care of for you, as well as your own private apartment or bungalow, as well as gardens and other facilities and a 24-hour call line if you need out-of-hours support.

Then we have our retirement communities with care, which is a more integrated form of retirement community, where we have a CQC care-registered team based on site. There are 16 or 17 people there, providing 24-hour care and support. There is a full-service restaurant there, a lot more facilities, in terms of hairdressers, salons and potentially gyms. It is a much more integrated form of housing.

We think that there are benefits in both types of housing, moving forward, because it provides choice for the older consumer. One of the other key aspects of retirement communities is the age restrictions. It is 60 and above in our retirement community with-support schemes and 70

and above in our with-care schemes. The average age of our customers is actually much older. It is 79 in our with-support schemes and 83 in our with-care schemes. That is at the point of entry, so they then age moving on from that.

We think that it is a fantastic concept. It is a third way to live. I know it is something the Committee has supported before. We would support a broader national strategy, and potentially even a taskforce, to try to unleash the potential of the sector.

Q129 **Brendan Clarke-Smith:** Sue, how does this affect your organisation particularly?

Sue Ramsden: In terms of the range of different types of housing that housing associations provide, we have examples of extra care, that model where the care team are on site. It is very much integrated with the housing provision but people have their own flats and their independence, with some communal areas. Those could be properties available at affordable rents, shared ownership or for sale from housing associations.

We are going to go on to look at housing choice, so recognising the range of different options that are out there. There are also designated properties, so communities open to older people. We call it retirement living or sheltered housing, where, again, you have your own flat, so the key thing of having your own front door, but some communal space, and options around additional facilities or support, telecare services to help people live and continue to live independently well into deep old age.

For younger people, again, there is a range of options. There is shared living or independent flats with staff available, either visiting staff or staff available on-site. If you look at the range of different care and support needs across the community, there are housing options out there that are bespoken and there to cater for those needs. Sometimes those can be quite profound needs, so, for example, people with quite severe autism, who may need one or two members of staff on-site to enable them to live independently.

The key defining feature around supported, sheltered retirement housing is that it is somebody's own property. It is their own front door. They have a tenancy. They have security of tenure. They have control over their own environment and the purpose is there to promote independent living.

Chris Smith: The important point is that the vast majority of people who require care and support live in their own homes. That can be a general needs property. It could be a bungalow or a flat. If they have that low-level support or some adaptations and alterations to enable them to stay there independently, that is an important part of the overall mix, without it being specialist.

Sue mentioned sheltered and extra care, where those vital facilities are on-site, where people have their own properties but can access the services if they need them. That is an important part of the overall diversity of range, of mix that we have. To reiterate, in terms of adult social care, services around mental health, people with autism, learning disabilities, etc, there are the shared schemes that Sue mentioned, whereby there might be, typically, people living in one accommodation. They have their own room, etc, but they will share common facilities. There is the core-cluster type of scheme, where people have their own property but there is a core scheme that delivers the services for a number of people. They can be a really good way of getting some key services to a lot more people within that setting.

Q130 **Brendan Clarke-Smith:** We speak a lot about choices. You have detailed some of the options that are available to people so far. Do we feel that people currently have sufficient choice? For our inquiry, the Government published a 10-year vision in terms of adult social care. Do we think that, in 10 years' time, people with care needs are also going to have that sufficient choice? Is that going to be expanded? Is it likely to have more problems?

Paul Teverson: In terms of choice, the simple answer is no, essentially. In terms of choice, I will answer the question in two ways. There is a lack of choice in terms of the supply and provision of housing options in later life. There is also a lack of choice in the provision of affordable options in later life. I will expand on both of those.

As a sector, the retirement community sector delivers about 7,500 units or new properties of retirement development a year. We think that demand is actually closer to 30,000 new properties a year, so there is a massive disconnect there. As a country, we only have about 700,000-odd units of retirement accommodation, and there are 12 million or 13 million older people, so there is a big gap there. In terms of the retirement communities with care, the integrated retirement communities, supply is only about 70,000 there, so it is really lacking compared to other countries, such as Australia and New Zealand, on a pro rata basis on the size of the population. 7,000 units is obviously in the context of around 240,000 new units that we deliver as a country, so there is a potential there to expand delivery.

In terms of affordability, the retirement community sector has historically failed to deliver where the real need is. We have let our average sale price drift up over £300,000. The sector has historically been either in the social rented sector or perhaps in the luxury end, where it is £750,000 plus in the high-end luxury retirement villages. We think that there is a real need in that mass middle market. By that, we are talking about people with housing equity in the £150,000 to £200,000 bracket, particularly in the north, the midlands and the levelling-up areas of the country. Our research shows that there are about 2 million people in that bracket who our sector simply is not providing for.

As part of our new strategy, which we have not done before, we are looking to address that in three ways. Our shared ownership business has just been set up. It has become a registered provider. We have just become a strategic partner with Homes England. We will be delivering 1,500 affordable shared ownership units over the next five years. We have just partnered with Anchor Hanover, which is the leading organisation in the social rented sector for older people, to deliver five affordable-for-all retirement villages. Every tenure will be on those retirement villages, from social rented through to outright purchase.

In all of our history, we have only really provided a for-sale option. In the last two or three years, we have launched a private rental option, alongside a private shared ownership option. We are looking, maybe perversely in the housebuilding sector, to bring our prices down, because we think that there is a mass market opportunity that we and the sector have missed.

Sue Ramsden: I would support that, in terms of what is happening in terms of different parts of the market. The Housing Association role is largely to provide affordable housing. Alongside the severe shortage in the country of social rented properties, there is a severe shortage of specialist social rented properties.

I would take the question back to, "A choice of what?" Is it a choice of accommodation, a choice of care provider, a choice of location or issues around price? It would be useful to reflect on the fact that we do not really have a system that is founded on choice at the moment. It is quite a long distance to travel to get to such a system, and there are key issues around supply that will frustrate that choice, alongside things like advice and information for people, in terms of understanding the range of options that are out there. We need to start with addressing the issue of the strategic overview of need when we are looking at what we need to build in the future, as well as issues of choice.

Chris Smith: I would agree with a lot of that. If people choose to stay put because they want to live in their own home, it will depend on their local authority, their assessment process and whether the people qualify for support, because the bar for that has got higher over the years as more people have demanded those services. Equally, if they need an adaptation to stay in their own home, that is means-tested and it depends on what local authority budgets are. It is great to see more money being allocated within the White Paper for disabled facilities grants. That would be really helpful.

The models we have for extra care, etc, could be more flexible. Currently, if you want to go into extra care, it is a great model. You have your own independence but you have the surety that there is care on-site and all the social aspects of that scheme as well. That helps things like isolation and wellbeing as well.

Some of the models can be a bit inflexible. If, for example, somebody gets a dementia diagnosis, they may not be able to stay in that scheme because the care will not provide for that. There is a lot we can do to provide more choice in the schemes we have and make them more flexible.

Paul mentioned shared ownership. As I mentioned earlier, we are a Homes England strategic partner, like Paul's organisation. We are going to deliver an extra 4,000 units over the next five or six years, and nearly 50% of that will be shared ownership. It is a great model for older people, especially to help them to downsize into more appropriate accommodation, so we will be looking to do more of those kinds of offers for people. Again, with the new model, it will be easier for people to access that, and it could be even more flexible and allow more people to buy less and keep more of that capital to use in other ways as well.

There is not enough choice, currently. There is a lot more to do to understand what those needs are across the piece. We are touching a lot on older people. Sue mentioned the other categories of working-age adults. There is certainly not enough accommodation for those niche groups who are underprovided for currently.

Q131 **Chair:** I am conscious of time, so we need you to think about answers, and if you agree with something that someone has already said, just say that to us. That is helpful. Moving on to the *People at the Heart of Care* White Paper, there was a statement in there about making every decision about care a decision about housing. That seems a pretty good ambition. Do you think, generally, the whole issue of housing is properly addressed in the Government's plans?

Sue Ramsden: It is really important to have that vision. That statement is a really powerful statement. If we don't have a vision, we have no hope of putting in place plans around adequate housing choice.

Q132 **Chair:** It is often forgotten, is it not? People often talk about care as though it is just people in care homes, and actually most people are in their own homes.

Sue Ramsden: Exactly, so the importance of that vision to the housing sector is particularly strong. Quite widespread support was expressed at the publication of the White Paper, so the recognition of the importance of housing in terms of broad health outcomes as well as specialist and supported housing and also the recognition to support alternatives to care and the funding that is available within the White Paper were all extremely welcome. In terms of the gap with the vision, there are very immediate pressures that the White Paper does not alleviate, particularly around workforce issues, and there is an awful lot of work to do around how we get to that vision.

Chris Smith: I agree with what Sue said. There needs to be an awareness-raising piece between health and adult social care around

what housing can bring, the importance of that and how we can help as part of the solution.

Q133 **Chair:** Moving on to Paul, you have mentioned a specific objective you think Homes England ought to have whereby at least 10% of the new housing that it is supporting should be specially designed for older people. How did you get to 10%? Also, as something to add into it, in the past, we have also had discussions at previous hearings and Select Committees on previous inquiries about local plans being required to allocate a certain percentage of land for housing for older people. Would those two things work hand-in-hand?

Paul Teverson: Yes, absolutely. Going back to the other question, we are very supportive of the vision, but perhaps it is a bit light on the detail. In terms of the two pieces of detail, we think there is a really ambitious role for Homes England to play and we think that a really ambitious reform of the planning system is needed.

In terms of Homes England, overall, we think there is the need to get from the roughly 7,000 properties we are delivering now to 30,000. That is based on a lot of industry research. Organisations such as Savills and Knight Frank and others in the sector have looked at the demand. If you think that the over-85s are doubling in the next 20 years and there will be 5 million more older people generally over 65 in the next 20 years, we are going to need to double that supply just to maintain the current level of provision. If we want to do better than we are doing now, we need to do more than doubling it. That is how we have arrived at the 10% of the overall housing supply, which is 30,000.

Q134 **Chair:** Can you share with us some of those calculations? You do not have to do that here, but if you would write to us, that would be helpful.

Paul Teverson: Yes, absolutely. Yes, we will write to you with those details and the original research. In terms of Homes England, we think that 10% national target, so 10% of the Government's 300,000-unit target, so delivering 30,000, should be added to Homes England's target as well. To their credit, they currently have a 10% target for specialist and supported housing, so it is not a massive jump to say 10% just for specialist, older-persons housing, so retirement communities.

Potentially, they could even go further. They deliver about 35,000 new homes and support another 170,000, so if they were to aim for that 10%, you instantly revolutionise the market out there. As I mentioned, our shared ownership business is now an affordable housing provider and will deliver 1,500 units. To its credit, Homes England is investing in this area, but we think they can massively increase their Older Persons Shared Ownership—OPSO—scheme. In the last couple of years, they have delivered 200 or 300 units a year for affordable shared ownership for older people. There is masses of potential there, and Homes England are really aware of that and the need to reform OPSO so that it really works

for private sector companies and other people, because it is a missed opportunity at the moment.

In terms of planning, the *Housing for Older People* report that your Committee wrote a couple of years ago was fantastic. It called for a much better local plan landscape, more housing needs assessments, more sites identified and potentially a new use class for retirement communities. Today, we look at local plans and the same research by Knight Frank says that 50% of local authorities don't have a plan for older people's housing, so there is a massive gap there.

Q135 **Chair:** That is helpful, and we will follow up that point. Chris, we talk a lot about housing for older people, but working-age adults are also in a position where they need particular forms of housing very often. Should there be targets for that as well?

Chris Smith: Paul referred to it. We need to have robust housing needs assessment, whether that is older people, people with autism or whatever, across the piece. Currently, that just is not available. It is not well planned. People know more about older people because they can get that from the demographics, but when you are talking about long-term health conditions, often we do not know what the true need is out there, it is not really diagnosed, people do not really understand how to get that information and it is certainly not shared between different parts of the sectors. Health might have one view. Social care might have another view. We certainly do not have robust figures, so the first thing is to have those proper housing needs assessments including all those partners, so we have transparency of what we mean by that.

It would be a good thing to set targets. As part of our Homes England strategic partnership, 10% of our programme has to be to deliver supported housing, which is great. As Paul mentioned, Homes England has a really strong role to play here in working with housing associations to deliver more. In order to do that, we need to understand what the long-term plan is and how that is going to be delivered.

Critically, in all of this, it cannot only be about capital. It has to be about revenue funding that will support those services once those schemes have been built, because that is a critical barrier now to a lot more people getting involved and delivering these schemes. People want to do more, but navigating that system around who pays for what, who is going to commission it and how long for is a nightmare. Until that is sorted out and that vision is aligned as well, we will not get that delivery at that scale.

Sue Ramsden: On the particular issue of section 106, planning and the recognition that section 106 delivers quite significant amounts of affordable housing at the moment, we need to retain that supply and reasonably secure routes around more affordable housing. It is about the overall place of planning and the importance of those strategic local plans to assess need.

We have an awful lot of data in this country around the need of the population and protections around numbers. We know children coming up through the system who are in need of care and support who will become adults. We know these figures and can project into the future in terms of housing need and the need for services to support those people, but we need that strategic-level thinking at a local level in order to, alongside targets, put everything else in place. Targets are important. They focus people's minds and help break down some of the barriers to delivery, but we also need the strategic planning in place.

Q136 **Ian Byrne:** This first question is for Sue. Thirteen Group wrote in evidence that, in the north-east, a typical extra-care property costs between £160 and £200 per week, while a hospital stay costs £2,000 to £4,000 over the same period. The White Paper announced £300 million to shape the specialist housing market and £210 million for the care and support specialised housing fund over the next three years. Is this enough? If not, what should it be?

Sue Ramsden: Is it enough? No. Is it a starting point? Yes, and it is really important that, within the funding, the Government have recognised the importance of revenue funding. That money is not just capital funding. As Chris has mentioned, the lack of revenue funding is a real barrier to new development and meeting the housing, care and support needs of the population out there.

Regarding your question about what is needed, the ambition of Government is to start a 10-year journey, so coming back to the point about vision, the importance of that and recognising that you need to give providers confidence with long-term plans in order to inject, for example, the private money that comes into this alongside the public investment; that is the housing association model. You need to give people long-term assurances and keep stressing that this is a priority for Government. The £300 million is a starting point.

Ian Byrne: That is a politician's answer, Sue.

Sue Ramsden: The sector is very conscious of the cuts that we have seen in revenue funding over the last 10 years, since the ringfence was taken off the Supporting People budget, which was there to fund housing-related support, and also the very significant pressures on local authorities in terms of funding for care and support services.

Chris Smith: There are some positives around it. It is not enough, but we need to do those assessments and make sure that we have that longer-term plan. Some of the positives about the funding are that it is ring-fenced, there is a suggestion of revenue in there—we need a bit more detail around that—and it can be used for new-build and refurbishing and repurposing. That is really important because there will be a lot of buildings out there that can be repurposed. If you think about how town centres are developing, there could be some opportunities for regeneration and place-making there, so that is really good.

Challenges are that the timescales are really tight in terms of the funding available and how long it takes to get a scheme up and running from scratch. It can take two years with a fair wind, so that is a challenge. At the moment, build cost inflation is having a massive impact, so things are just costing more. That could be a blip or it could be part of the future, so, whatever that funding is, we are going to get less for that funding as it currently stands. It is a great start, and I am heartened by the words in the strategy that say "at least", so I am hanging on to that and assuming more will come.

Paul Teverson: I have three quick points. You are absolutely right to highlight the health savings from retirement communities in our housing with support schemes. It is about £2,500 a year that we save the NHS and social care. In our housing with care schemes we save the NHS and social care up to £7,000 a year, so there is masses of potential there to save the system lots of money.

The announcements in the White Paper, as others have said, are really good. It is just a start. It is going to deliver a handful of units, a few thousand, but it is better than nothing. The real potential here is what Homes England can do and planning reform to unleash the billions of pounds of investment waiting on the sidelines in the private retirement sector, waiting to come in, but it needs the right framework to be able to come in in the way it has done in other countries. The White Paper was very light on Homes England and planning. We would have liked to see a lot more detail around those two points.

Q137 **Ian Byrne:** What should the money be used for? How should it be allocated?

Paul Teverson: In terms of the money they have already identified, they are probably identifying it in the right way, given the limited amount they have, so the £300 million for housing strategies and supported housing and £200 million for the care and support specialised housing fund, which is grant-funding whole schemes of extra care communities, which is good. That is particularly in the social rented centre, but it does not really do much for the private sector, and it is just not enough even for the social rented sector.

There is potentially a much more ambitious funding role from central Government and Homes England and then unleashing the private sector billions of pounds. It comes from unlocking people's housing equity, essentially. That is what will fund the new schemes, but investors will not invest in that sector unless they have assurance around planning consents, timelines and funding regimes, which there just is not at the moment. There is a bit of investment coming in and the sector is trying to grow. We are going to need something like a code for the sector, a retirement village Act for the sector or even a taskforce, which the Minister has recently referred to, to really provide the assurance that people can invest in this country in retirement communities. At the moment, that is lacking.

Q138 **Ian Byrne:** In written evidence, the National Housing Federation called for three core areas of funding, which were capital funding, funding for housing-related costs and funding for support costs. First, could you describe the difference between these funding areas? Secondly, does the White Paper deliver sufficient support for each of these three areas?

Sue Ramsden: In terms of the way that housing associations work, capital funding is needed for new-build or refurbishment, because you are providing an affordable product, the rent is below the market level, you are constrained by the amount of rent that you can charge and you want to provide something that is affordable to the people that you seek to meet the housing needs of. The capital funding is there to fund the costs of the building.

The revenue funding for support is there to provide support to the residents that live there around independent living skills, helping people to manage their property and their own quality of life. There is a blur between care and support, and one of the positive things about the White Paper is that it consistently refers to care and support. Care can be very narrowly defined as a personal-care-related task, so the support and community that helps people with care and support needs to live within that housing.

There is then the rent that the person living there will pay that covers the ongoing maintenance and building costs within that scheme. Those are the three components that need to be there, which may be commissioned separately, but you need that solid foundation in order to have financial stability for any scheme.

Ian Byrne: That is a good answer. Paul, would you like to add anything to that?

Paul Teverson: No, others are more qualified on that point.

Ian Byrne: Chris, would you like to add anything?

Chris Smith: No. Sue has explained it brilliantly, but it is that support that is really important, because small interventions can stop people needing to access higher care costs or prevent it for longer.

Q139 **Ian Byrne:** To finish, for the basis of the report, when we talk about this being a first step and having a 10-year vision that is getting outlined for the first three years, what would you want capacity-wise at the end of the 10 years? When you are talking about a couple of thousand, what do we actually need?

Sue Ramsden: I want to go back to the point that we are looking at cost savings here in some examples. There is a need to stress the value-for-money point around housing-based models for care, where you are looking at alternatives where very institutional forms of care or the value of giving people more independence and control of their environment

can, in many instances, reduce their need for care. I don't want that point to be lost.

Where do we need to get to? That has to come back down to the analysis of housing need within a local area and population projections around communities in need and some sense of quality in what we aspire, as a society, to be able to provide people who have care and support needs.

Paul Teverson: At the risk of repeating some earlier points, we need a really clear framework for what this sector is about, a really clear understanding of what a retirement community is and really clear definitions around terminology so we can all sit around this table in two or three years' time at least and know exactly what we are talking about. Hopefully, by 10 years, we will have a really clear framework for delivering that and will be meeting that 30,000 units a year to keep pace with what we think demand will be.

Chris Smith: In terms of that capacity, we need that shared vision across all the different sectors that will be delivering this and an understanding of what can be done, how all those funding streams align to the better impact and that emphasis on personal outcomes, so that person-centred approach, rather than funding streams, schemes, settings, etc. It is about the person and their individual choice at the time.

Q140 **Bob Blackman:** How well does our planning system cope in terms of decisions about care being decisions about housing?

Paul Teverson: I have covered that in the round. It was great to see in the White Paper that every care decision is a decision about housing, but it also has to be a decision about planning. It is those three groups coming together, and they need to be integrated. In a unitary authority, that is potentially slightly easier. In split districts and counties it is a lot more complicated. It is almost a marriage of convenience, and planners are not necessarily the most communicative people, potentially. They do a wonderful job but are massively under-resourced and can go hiding when things get—

Bob Blackman: You know that as an applicant for planning permission.

Paul Teverson: I am slightly biased on that point, but in our experience, and particularly during Covid, things have got considerably worse in planning. We had one scheme in Romsey that took 650 days to get planning consent, and it was really difficult to contact the case officer, who was working one day a week. The councils are under-resourced and it is not the planners' fault; it is just very difficult, and councils have a statutory duty to decide an application in 13 weeks. The average we are seeing is 46 weeks at the moment.

Q141 **Bob Blackman:** What else has to be done? You say that it is not doing it at the moment. What would you ideally like to see over the next five to

10 years, where we actually get to a position of parity?

Paul Teverson: Chris Pincher, the Housing Minister, has alluded to all of the solutions, so more investment in town planning is essential. We would like to see the taskforce that the Minister has referred to come together. The planning journey starts with really strong national planning guidance, which is reflected in local plans, in housing needs assessments, in site identification and in affordable housing and CIL policies. We are not against paying those, but we are against paying them where they are not considered against our type of accommodation because we have so many extra costs. We want a fair assessment.

Schemes can pause because of that issue because a lot of the time, planners are not expecting an application for retirement housing; they are expecting applications for homes for younger people or affordable housing. Our sites are windfall sites because there is no planning policy there for us to hang our hat on, so it is a bit of a shock.

Sometimes, particularly people in the social care department, ironically, can oppose some of our schemes because they think we are dragging in older people who will then fall on their system to need funding. The reality is they have older people in their district or authority already. Our residents move three or four miles. If you are 83, you are not moving very far. Because they have not done the housing needs assessments, they are not expecting this and there is no plan policy, so there is a real education role there that is needed, but it starts with national planning policy first.

Q142 **Bob Blackman:** Do you think the Planning Bill will be the answer?

Paul Teverson: They are not looking at that at the moment. We would love it to be and it has the potential to be. The housing White Paper, *Fixing our Broken Housing Market*, said all these things and that it would look at it. It was a good document. It was half a page on these things, but nothing has been done since then, and the situation has just got worse. These are warm words, but we need delivery.

Q143 **Bob Blackman:** Sue, what do you think needs to be done?

Sue Ramsden: Anything that encourages local planning authorities to look at housing need for these groups is absolutely vital. I am not sure what the best mechanism to achieve that is.

Q144 **Bob Blackman:** What do you identify as being the problem areas at the moment?

Sue Ramsden: The problem is the absence of that and the lack of that strategic assessment at a local level.

Q145 **Bob Blackman:** Is that an assessment of need? Is it an assessment locally? What is missing?

Sue Ramsden: It is that sense of what the need of the local population is around the groups of people who could benefit from specialist housing. As I mentioned earlier, the data is there if people chose to look for it.

Chris Smith: I agree with what has been said. There is a real disconnect in local authorities with the people who write the housing strategies. They should be considering what the housing needs of all groups are. The specialist stuff is very underplayed. The information is not there, so the translation of that into planning policy just does not come through. You will rarely see a planning application with specialist accommodation in. You see more with older persons accommodation because that is easier.

With specialist accommodation, you rarely see that. Section 106s tend to just concentrate on affordable housing and general needs stuff, so, as mentioned earlier, it has to be that assessment of what is clearly required in that locality, and then that will follow through in terms of planning policies and delivery.

Q146 **Florence Eshalomi:** I apologise for my lateness. It seems like I have missed a really insightful debate on these really key and important issues.

I represent Vauxhall, just across the river, and as with some of the stuff that you mentioned, Paul, in terms of the type of housing, we have many large-scale high-rise developments and an equally high elderly population. First, to you, Chris, in the written evidence, Thirteen Group highlighted and welcomed the recognition of housing providers in February's *Integration and Innovation* White Paper. However, you also said that this needed to go further, and that the housing sector should be one of the main delivery mechanisms for health and social care. In your view, what would you want to see in the upcoming White Paper on integration?

Chris Smith: It is a thing that has come through, but we need to have one comprehensive way of really identifying and assessing specialist and supported housing requirements and services that are needed in that locality. I am not quite sure yet what the sizes of these localities are, but there needs to be one agreed assessment criterion that is really common, so that people understand that.

They need to set out a long-term vision of what needs to be delivered, by whom and when. Funding pots need to be aligned. They are all over the place. Nobody has a full picture of what is available out there to really deliver on this strategy. That is funding for capital and revenue, because they do need to come together. All of those need to be aligned and pointing in the same direction.

Commissioning, as it stands, in terms of the services, needs to be completely overhauled. Paul mentioned the difficulties with commissioners and what they might see as people coming from outside their borough into their borough, and them having to pick up the burden of that cost, in their view. It needs to be far more pan-local-authority,

across a wider service area, because some of these services are not just in one locality. There could be people drawn from all sorts of places who need that accommodation. Commissioning needs to be overhauled. It comes from too many different places. People have different drivers and want different outcomes.

Critically, to get there, we all need to be able to speak the same language. We all speak differently. We all have different views. We all have different methodologies in terms of what success looks like. We need that aligned vision where people really get behind it, understand what funding is there, set out that long-term plan and have some delivery mechanisms with targets, if required, so that we know that we are making progress.

Q147 **Florence Eshalomi:** That is really helpful. Paul, you mentioned earlier that 50% of local authorities have no plan for older people's housing. Should there be any responsibilities for housing in terms of integrated care partnerships?

Paul Teverson: We would like to see housing, health and planning united on those integrated care partnerships. I mentioned earlier that care starts with housing, but it starts with planning, so there is that journey there. I am not sure if there is a role for the private sector and the public sector providers of specialist housing, but we would be very happy to be around that table.

London is quite a good example. We have essentially stopped developing in London because it is really difficult, because the GLA's policies are quite tough even though it recognises that the fastest-growing demographic in London is older people, which you would not naturally think. That then makes it hard and quite costly for us to bring schemes forward, so we have left one of the largest parts of the country, which is unfortunate because there is a real need there. The care partnerships have a big opportunity to bring everybody together around the table and solve that.

Sue Ramsden: I want to mention the broader role of housing and social housing providers. One of the key roles of ICPs is around addressing health inequalities and that strategic role that the ICP plays around co-ordinating local resources and looking at overall improved health outcomes, and the importance of housing as a determinant of those outcomes. This is something that we have also recognised much more across the pandemic. This is not just about specialist housing. It is not just about housing for people with care and support needs. It is about housing broadly as a determinant of health, and it is about social housing providers and the potential of what else they can bring to those local partnerships.

It is not widely known what social landlords do beyond their landlord role, so their roles in health and wellbeing, employment and skills support for tenants, that ongoing work with communities and as key anchors within

those local communities. These are all important things that can contribute to that ICP and we need to have those housing providers around that table.

Chair: Thank you to all three of our witnesses for giving some really insightful and detailed responses to a range of issues. It shows the important role that housing has to play in delivering care and also taking pressure off the NHS as well. Thank you all very much indeed.

Examination of witnesses

Witnesses: Professor Philip Booth and Dr Eleanor Roy.

Chair: Thank you both very much for joining us today. Would our two witnesses introduce themselves?

Dr Roy: Good evening. My name is Eleanor Roy. I am health and social care policy manager for the Chartered Institute of Public Finance and Accountancy.

Professor Booth: I am Philip Booth. I am a professor of finance, public policy and ethics at St Mary's University, Twickenham, and director of the Vinson Centre at the University of Buckingham. I am also a senior academic fellow at the Institute of Economic Affairs.

Q148 **Chair:** Dr Roy, CIPFA produced a figure that said that if there was no change to the means and needs test eligibility system, demand for publicly funded adult social care would increase by 11% by 2023-24, and the Government would be required to spend an extra £20 billion to provide the same level and quality of care. There have now been changes to the means tests and the cap on costs. Do you have a revised figure to replace the £20 billion that you produced before? How much do you think that figure of the requirement for extra funding that is needed is now?

Dr Roy: I am going to have to disappoint the Committee there, in line with quite a few witnesses before me, and say that we don't have a revised figure. The reason that we don't have a revised figure for that is because of the limitations on some of the data that is available, given the proposals that are on the table. In particular, the proposed funding reforms to introduce a cap on care would mean that, as you know, a lot of self-funders would come into having their care funded from the public purse, but the self-funder population and the care that they receive is not particularly well understood at the moment, as has been pointed out by earlier witnesses. The data that is available is largely based on surveys, so the picture that it paints is only partial, so it is very difficult to determine the extent of the impact on the public purse as a result of that proposed reform.

I would like to point out that the Government estimate that the proportion of older adults in receipt of public support would increase from a half to two-thirds, but that does not provide any further details of the

associated cost and does not take into account any figures for working-age adults.

We would also like to see further detail on the fair price of care policy ahead of any revision. That is referred to in both the White Paper and the September policy paper. That would also impact on the speed at which people would get to the cap. As that seeks to narrow the differential paid, it would impact on those figures, but as yet we have seen no detail as to how that is intended to operate in practice. We do not feel it is appropriate or possible to present an accurate representation at this point in time.

Q149 **Chair:** Would it be possible to set out for us in a note after this hearing how you got to the £20 billion figure and the issues in terms of the Government's announcements that could affect that figure, the clarity of which you are still uncertain of? Maybe you could even provide any upper and lower limits that might move us forward to in terms of those particular changes and the extra money that may be needed. Could you set something out for us?

Dr Roy: We certainly can, yes.

Q150 **Chair:** The extra data you would need is the other issue. In the *People at the Heart of Care* White Paper, there was a reference to the need for accurate estimates of future demand and additional funding required. I presume you agree with that, but it is the fact that that is not there now that enables you not to be able to do the calculations precisely.

Dr Roy: Yes, we would be happy to provide that information.

Q151 **Chair:** Professor Booth, do you have any comments on that?

Professor Booth: I agree with Eleanor. There could well be a whole load of second-round effects that could almost dwarf the estimates of the increase in costs arising directly from the cap. The Government have suggested something like £5 billion in steady state, but that is really before the process of ageing kicks in. They use the date there of 2027.

Things like allowing people to access care homes at the same cost as local-authority-funded residents, as a result of local authorities using what Government describe as their buying power, would be regarded by some as, rather than buying power, the monopsony power of being a single buyer. If they use that power to a greater degree, including in relation to the cost of self-funded residents, it could disturb the financing model of the whole care home sector. That could have quite significant and unpredictable impacts on the cost of care for both self-funded and local-authority-funded individuals.

Q152 **Chair:** We had evidence before from other witnesses that nobody is quite sure what the eventual bills or sums will be that are involved in that particular change. It is a bit of a shot in the dark, to some extent.

Professor Booth: Yes.

Q153 **Ian Byrne:** According to the Government's care and support statutory guidance, last updated in August 2021, local authorities have the discretion to set a higher upper capital limit for people receiving care outside the care home. How has this worked in practice, and do we know what the cost has been to local authorities?

Professor Booth: Eleanor will correct me if I am wrong, but my understanding is that it is not used very much in practice by local authorities. Very few of them raise the capital limit. My view is that they should have the freedom to do that. I am a great believer in local authority autonomy as long as they finance that themselves through locally raised taxes. My understanding is that there is not a great deal of national variation, but Eleanor will be better than me in terms of the detail of the figures.

Dr Roy: I cannot speak with any particular level of detail. To my knowledge, there is no data collected on how the discretion is applied, so we cannot provide an overall picture of how it is used, although clearly it would have to be set out in each council's individual charging policies. With the data that I hear about or the cases that I hear about, I would agree with Philip in that I would say it is not widely used. Given that the discretion was maintained under the Care Act, which also contained a proposal for the cap, off the top of my head I can think of no reason why it should not remain. Again, there are many issues that need to be clarified, but I would agree that if there is nothing to point to an obvious reason for it to be removed, that discretion should remain with local government.

Q154 **Mary Robinson:** Professor Booth, in 2019 you published a paper called *Integrating Health and Social Care: State or Market*? Since then, the Government have published a White Paper on integration in February 2021, which is now a Bill before Parliament. The Government are bringing forward another White Paper on integration. In your view, are the Government going about integration in the right way?

Professor Booth: No, they are not, but I don't think there would be anybody on the Committee who would agree with the approach I would take. We have in the UK, more or less, the only healthcare system in the world that is both funded and almost entirely—about 93%—provided by central Government. Canada has a similar system, but there is rather more localised, local government provision. That really means that, when you look at the health and social care sector, it is like two tectonic plates that can never properly integrate and merge; they just rub against each other. You have a healthcare system, on the one hand, that is Government-funded and Government-provided, and you have a long-term care system, on the other hand, where, by and large, where you get government involvement, it is local government involvement, and then there is pluralism both in finance and provision.

Most countries in Europe have a more pluralistic health system too. Germany is quite a good example. In Germany, you move quite

seamlessly through health and long-term care with a mixture of funding from your own resources and funding and provision from your social insurer, so the whole question of integration is much easier. We have this artificial divide.

It made sense to Beveridge, obviously, when he developed the idea of a national health service, although he did not necessarily suggest an entirely centrally planned model, but in those days, by and large, long-term care took place in the home and a hospital was a place you went to be cured of an illness. Life is now much more complicated and the need for integration is that much greater, and our systems cannot provide it.

Q155 **Mary Robinson:** Could a system that moves more towards a pooled operation of an integrated service be part of the answer?

Professor Booth: Really, the answer has to be a movement towards a social insurance system for healthcare provision that can be naturally integrated with long-term care, where taxpayers and social insurance premium payers can choose their health insurance provider and there is a plurality of both providers and finance in healthcare. Something like they have in Holland, Germany or Switzerland is what I would suggest, and then integration will happen naturally.

Q156 **Mary Robinson:** Do you see any prospect of this being brought forward or placed into the system in any way?

Professor Booth: No, not really. The biggest healthcare reforms actually happened under the Blair Labour Government. By and large, the history of Conservative Governments is that they tend to be even more supportive of the NHS in order to demonstrate their credentials in that way. When you get reform happening, it has tended to be under Labour Governments. You could have had such reform under the Blair Labour Government when Alan Milburn was Health Secretary, but I don't think it is going to happen now.

Dr Roy: Philip is right. I cannot necessarily agree with the thrust of his proposals entirely. However, I would agree that, perhaps, the route to integration has been somewhat bumpy. It is not impossible, despite the different systems at play. We have already seen that, where you can improve the understanding across the organisational boundaries, you can get a step closer to integrating and, in particular, improve the understanding of the financial landscape at play across health and local government.

Some of the issues that we have seen with integration to date stem from the question about what integration actually means. To many people it means a structural reform, so are we trying to achieve better integration within the NHS itself and between commissioners and providers in our community? A lot of the time, that is what it feels like. Are we trying to more closely align health and social care services as a system of personal care? Are we trying to more broadly align all the services that impact on

wider determinants of health and wellbeing by bringing in health and social care but also public health and housing, etc? If we could fundamentally answer that question, the path might be a little less bumpy.

With the integration White Paper last year and the Health and Care Bill, we certainly raised concerns that they seemed to be quite NHS-centric, with the building of systems involving NHS partners. Given that it was primarily driven by NHS England, that is perhaps unsurprising. What we are seeing now, since the publication of the Bill, is a wealth of guidance coming out, which indicates that there is a better understanding and an evolution going on. I am hopeful that the next White Paper that we see might start to clarify some of the thinking and provisions around how the organisations come together in these partnerships and work better at place-based level.

Q157 **Mary Robinson:** Staying with you, Dr Roy, part of the challenge is that there are two very different systems, run in different ways and funded differently. In its written evidence, CIPFA said, "The sharpness of the differential between social care as a largely paid-for service and health as an essentially free-at-the-point-of-use service should be reduced". What could be done to achieve that?

Dr Roy: As you will note from our evidence, we are quite clear that we consider the levels of spending and how it is split between the state and the individual to be political decisions. That includes elements of charging for the NHS if that was something that was on the table, so we make no recommendations in that regard. However, to our way of thinking, reform should be three things. It should be strategically informed, financially sustainable and equitable. The steepness of the differential between charging for health and care, for us, is a matter of equity.

Currently, the decision on long-term care needs being classed as health or social care is largely dependent on chance in terms of what condition has developed. It is a well-exercised argument that I probably do not need to exercise. If you have a cancer diagnosis then your care is funded by continuing healthcare, but if you develop dementia then you are subject to a means test. That, fundamentally, to us, is a tick against the equity box that has to be addressed. Regarding how that is done, as I say, we don't make any judgment on levels of spend or how it is funded, but we do stand beside others in saying that social care could be more appropriately addressed by involving an element of risk-pooling.

In terms of how to free up some financial space for that, we very firmly hold the view that taking a long-term perspective would enable more sustainable planning, so linking financial planning to demographic pressures. Taking a zero-based perspective across all Government spending with a view to rebalancing some resource would also be helpful. For example, if you look at those of retirement age, the largest areas of public spending are in pensions, acute care and benefits, which may not

contribute to long-term demand for services and reducing that demand in a way that other spending might.

We also believe strongly that the mindset around investment in prevention needs to be changed and that needs to be front and centre. Local government holds a lot of the levers that impact on wider health and wellbeing, including social care and public health but also the wider services such as housing and neighbourhood services. Preventative investment in these areas could significantly reduce demand for services in the future. We welcome the fact that the recent White Paper has prevention as a core part of the vision, but we were disappointed that there was not a greater ambition or focus in terms of the policy, and that it was not backed by a particularly high level of investment.

It is also important to mention public awareness in this regard because, in our experience, many of those who have not had direct experience of the social care system are not always aware of the differential between free at point of use for the NHS and charging for social care. Again, we welcome the intention of the White Paper to raise and improve the information and awareness of the social care system and how it operates.

Q158 **Mary Robinson:** Professor Booth, do you have anything to add?

Professor Booth: The only thing I would add is that if you look at the last Office for Budget Responsibility long-term fiscal projections, which were in July 2020—I don't think it did them in July 2021—it suggests that, in order to stabilise the national debt at 75% of GDP, you would need, over five decades, to increase taxes by about 15% of national income. Quite a lot of that was because of the spending promises that were made between 2018 and 2020 by the May and then Johnson Governments. Now we have had some more spending promises as well that are additional items of spending separate from the increases in spending that will arise as a result of demographic pressures.

This is a very significant concern of mine. Rather than looking forward at that really serious challenge, which I don't think any politicians have begun to address—indeed, you could argue that it is too late to address it—we are just increasing spending piecemeal on new items of spending in the long-term care and social care area in order to try to pay off particular interest in it. As far as the Conservatives are concerned, this is people who, by and large, own their own homes and would like their house values protecting.

If there is to be more spending in certain areas, I would agree with Eleanor that you need to start with a zero-based spending review, so that you also take a hard look at items where you might need to reduce spending in order to increase spending in other areas, especially given how much local authority spending on those parts of the care system for which local authorities are responsible has been squeezed in the last 10 years. That would be my priority, rather than protecting the assets of well-off people.

Q159 **Mary Robinson:** Just staying with you, there are lots of White Papers. We have the Health and Care Bill currently making its way through Parliament. Do we need another integration White Paper?

Professor Booth: I have been writing about this issue since 1995. That is 26 years. I remember talking to Stephen Dorrell not long after I wrote that pamphlet, and he said he decided not to introduce the then Conservative Government's proposals for so-called partnership schemes because he thought it would just make things worse. Now, of course, every Government have looked at it since and decided that reforms would actually not improve the current system. Nothing really has moved forward very much in 25 years. I don't really think things will improve given our existing structures for the delivery of healthcare.

Dr Roy: At this point, we have come so far down the road, even since 2016 with the advent of SDPs. In some areas, they are much further down the integration road than in others, and I would hate to see that stopped or wasted. There are lessons that can be learned, and I know that some of the guidance that is coming out and the work that is going on in the Department is looking at areas where things are working well and looking to share best practice better and learn from peer assessment, etc.

Given what we have on the table then, yes, it would be beneficial to have another White Paper because, even since the Bill has been published, there has been this evolution and starting to understand the complexities involved at the centre. Also, a lot of other events have happened since the Bill was published, such as the White Paper proposals to reform social care. We have also had changes to public health at the national level, and the increased focus on health inequalities that have been highlighted by the pandemic. This presents an opportunity to pool these areas together a bit more into the vision for integration, which sometimes feels a little like piecing together a jigsaw.

The Bill, as it is presented, intends to maintain flexibility and subsidiarity for local areas, which CIPFA 100% stands behind. Local need must drive the path, and local areas know their need better than anybody else. However, in terms of the overall outcomes and the arrangements for finance, it could be made easier for budgets to be shared and pooled. In particular, around the governance arrangements, we need better clarity on where exactly the lines of the playing field are, because our concern relates to looking at performance and evaluation and how you are able to see any progress or determine success if the systems are too diverse and too different in how they approach things and are structured. There is an opportunity to bring a lot of that together in a further White Paper.

Q160 **Mary Robinson:** Can I very briefly follow up on that? Clearly, for local authorities, auditors would be there and they would be going through the audit process and making recommendations and so on. Very often, at local authority level, there is an impression that they do not feel that they can change an awful lot. Is it your contention that, from CIPFA's point of

view, audit itself could be difficult in an integrated system?

Dr Roy: I have to start by saying audit is not my strong point. As I understand it, local government finances would remain separate, so, when I say I think there is more opportunity for pooling budgets, I am not necessarily talking about different arrangements to what is already there. Lots of places use section 75 arrangements and use them well. What I hear back is that they are not always clear on the purposes for which they can be used, so they find it quite restrictive and they would quite like to have that freed up.

At the moment, it is used in relation to social care, and perhaps there is a feeling that it could be used more widely to better influence those wider determinants of health and wellbeing. We are not suggesting anything that would materially impact on audit procedures.

Q161 **Chair:** Very briefly, to Dr Roy, in terms of the public who are the recipients of care, or not the recipients in some cases, we are talking here today about complicated issues of budget compatibility and integration, which often people assume means amalgamation of organisations. Should we not be talking about how we can better co-ordinate and get co-operation of service delivery to the people who actually need the care?

Dr Roy: Absolutely, and that has to be the driver and overarching aim. Person-centred care where you go through the system and only have to tell your story once should absolutely be the driver. Unfortunately, the mechanics behind the scenes still have to operate together, so while it is not particularly interesting, perhaps, to the public and they do not have a particular interest in it, it is important to get the behind-the-scenes bits working properly in order that we can then move towards the type of transformation that enables that patient journey to be more seamless.

Chair: Let us move on to something that might help: technology.

Q162 **Ben Everitt:** Professor Philip, I will start with you. Hello. It is nice to see you again. In your answers to Mary's questions, you were talking about your paper, in which you note that, because health and care were set up differently many years ago, they have co-existed separately and become more distant. "Tectonic plates" was the phrase you used. In the same paper, you talk about the fact that the way we assess medical need has also not kept pace with modern life. The phrase you used is that it is as if email, apps, home monitoring and so on have not even been invented.

One of the many White Papers we have had at the moment was the *People at the Heart of Care* White Paper, which does put some initiatives in to promote greater use of technology and digitisation within the social care sector. Do you think these go far enough, and what part can that play in driving that integration that, admittedly, I do not think you were too confident we can achieve?

Professor Booth: Again, the problem with the White Paper is this central planning approach, which you would expect me to be sceptical of because innovation in this field tends to happen from the bottom up. You need experimentation. Things sometimes need to go wrong and then good ideas need to be copied rapidly. A large state-run organisation employing 1.6 million people is not necessarily the best way to achieve that, so there is lots of discussion in the literature about developments in technology.

For example, older people tend to find it quite difficult to use smartphones, tablets, etc. Some use them incredibly proficiently—more proficiently than I would—but some really do struggle with them. There are devices that are more similar to the types of things you might see in a museum with quizzes on and so on that can be developed for older people who can put them on top of the television, which they can use very effectively. In order to get the rapid experimentation and adoption of these types of technologies, it is difficult to see it happening in what I am going to describe as a nationalised system unless you risk making mistakes on a mass scale because you do not get that small-scale experimentation that you get when you have more pluralistic systems.

When I say "pluralistic systems", people might be thinking I am referring to markets, which to some extent I am, but you can have pluralistic systems that have more decentralised authority, with decision-making at local government level or other forms of Government-funded bodies that are not necessarily private-sector companies as well. It is this top-down central planning approach that makes it quite difficult to see the rapid development of new technologies.

Hospital in the Home is something I mentioned in that paper, which has been adopted in Australia. NICE has done an international survey of Hospital in the Home. It seems to be successful wherever it has been adopted. There have been little experiments in the UK, but again, it is very difficult to see these things being adopted and to see this radical change in a top-down, centrally planned system.

Q163 **Ben Everitt:** It is really interesting to hear you reference the Australia example there. Are there any other models that we could look at around the world where they are doing something well that we could copy?

Professor Booth: There are things happening in many places in the world. I have mentioned Germany and Holland before, where you get a really different pattern of delivery and a really different experience in terms of the integration between long-term care and healthcare.

On technology you have caught me on the hop slightly. I could not answer that directly, but I will say this needs to be demand-led and patient-led. Since I wrote that paper we have seen a big movement, for obvious reasons, towards video consultations for general practitioners. Some people really hate that, but for other people who perhaps would not have gone to a doctor unless they could have done it over video, it is

a real godsend, so it needs to be patient-led rather than top-down-driven. The patient should be in charge here.

Q164 **Andrew Lewer:** There are different types of insurance models for adult social care, including private insurance, social insurance, mandatory insurance and voluntary models. Philip, initially, could you describe some of the leading models, the most interesting models, and how they work?

Professor Booth: When it comes to long-term care, you have social insurance models such as those in Germany, where you have, effectively, a compulsory social insurance premium that you have to pay, you choose your social insurer and then the social insurer provides a package of health and long-term care benefits. That package of health and long-term care benefits can come from a really quite diverse range of providers. In Germany, as well as having compulsory social insurance, people above a certain income can choose to opt out of that system and make their own provision, either paying as they need services or paying separately, effectively, for private insurance.

Within that system, long-term care is pretty well integrated into healthcare, although technically there is a separate levy for long-term care. People also insure separately for benefits that will not be covered by the statutory system. In that respect, you might expect it to be rather similar to the UK, but in the UK there is almost no use of private long-term care insurance at all. The market essentially dried up in 2010. If you are looking for successful insurance markets, I would do the classification slightly differently.

The more successful insurance markets seem to be ones that provide cash benefits rather than benefits in kind. The risk of benefits in kind is that technology makes the cost of providing the benefits more expensive so it provides a big risk to the insurers, so they provide a cash benefit, which also provides the maximum amount of freedom for the individual to purchase whatever forms of service they wish, including perhaps making payments to relatives for providing informal care.

Also, the more successful types of insurance are often tied to other forms of insurance, such as in the United States, where you often find that more successful forms of insurance are tied to life insurance products or permanent health insurance products as well. But the idea of an independent long-term care insurance market in which people pay a premium in order to receive a guarantee of a provision of long-term care, either in their own home or in a care home, hasn't really taken off anywhere that I can think of.

What I quite like, and is the only intervention I would make in terms of changing long-term care funding, is Peter Lilley's proposal for what would, at least initially, be a state-backed long-term care insurer, where those people who were worried about losing all their assets could insure against the loss of their assets up front around the time of state pension age. You could do that and then not have a care cap and all the

complications that come with that, and then people who chose not to avail themselves of that but still lost their assets because they needed care really could not complain about it. Although there are certain problems with that, they are not nearly as great as the problems that go along with the solutions that the Government have chosen.

Q165 **Andrew Lewer:** You have identified one possible element of insurance to be developed within the current setup in England. Either within the current setup in England or in a developed or revised system, do you think there are other spaces for insurance models?

Professor Booth: Yes, there are, and there are no real restrictions on them developing, so why we insure less than people in the US, Germany and Israel, which are, I think, the three major markets relative to national income, might be regarded as a bit of mystery; but it might also just be because, culturally, we are not used to insuring for health-based insurance risks. It might also be because it is quite rational not to insure. We insure against our house burning down because that would be a catastrophic risk for us and we would potentially lose all our assets. What you insure against when you insure for long-term care is not being able to pass quite so much in terms of assets on to the next generation who might themselves be, by that time, relatively well off and in their 50s and 60s and so on, and may not need the inheritance to that great a degree.

It may simply be that people rationally choose not to insure because they don't see the risk as sufficiently large. Of course, they don't like losing their home if they have to go into a care home and self-fund, but, in advance, people seem not to choose to insure themselves against that risk. I would adopt the Lilley scheme, personally. It is low-risk to the Treasury and it would provide the option there for anybody who wanted to insure themselves against a catastrophic loss of their assets.

Q166 **Andrew Lewer:** Of course, the insurance principle was the foundation of the welfare state under Lloyd George and then added to with Attlee. That is the traditional, conventional social care that people tend to think of, which is people above retirement age. The other element of social care, often overlooked, is the working-age people with disabilities. Is there any scope for insurance solutions within that, or do you think it is more restricted to people at or over retirement age?

Professor Booth: That is much more difficult, and it depends on the nature and the reason for disability. If it is apparent from a very early age, perhaps even before somebody enters the workforce, that is not really an insurable risk. If it is genetically related, that would also be very difficult to insure. But if it is disability that arises from an accident, whether it be a work-related accident or otherwise, that is an insurable risk. There is scope for insurance there without doubt, and many people have that form of insurance.

Q167 **Andrew Lewer:** Finally, Eleanor, do you or CIPFA have any views on this subject matter?

Dr Roy: Clearly, CIPFA's interest is in the public finances, so, framed in that context, we provided in our written evidence a snapshot of some of the different proposals that have already been put forward, including mandatory insurance and a couple of voluntary schemes, and highlighted the risks and benefits to each. I will not reiterate that. The concern we have is that the cost curve for social care stretches decades into the future and is dependent on shifts in public policy, so we struggle to see how private markets could find that attractive or deal with shocks in that event. The state can shift levels of funding in response to shocks in a way that the private sector cannot.

It is also worth pointing out that, in some of those countries that are operating mandatory insurance models, such as Germany, as Philip mentioned, and Japan, there is also quite a large injection of funding from general taxation, because there are safety nets that would need to be included within those systems. For example, even in a mandatory system, the level to which the revenue is raised would depend on the level of the contribution and the extent of the requirement to do so. That could be impacted on by wider shocks, such as a period of high unemployment or a period of slow and sustained growth in wages, both of which would impact on the level of funding available.

You do see there is a need for funding through general taxation as well to address these issues around resilience, so a combination of models is probably what would be required.

Andrew Lewer: Yes, it would be some sort of hybrid. Those are very interesting comments.

Q168 **Ian Byrne:** I have a quick question for Philip. Building on what Eleanor said there, it has been a fascinating evidence session, but, Philip, what would be your thoughts on a progressive income tax system, with a higher rate of income tax for those that can afford it most to deliver a health and care system free at the point of delivery for everybody in this country? Surely that is what we should be looking at.

Professor Booth: We already have a very strange progressive income tax system, with rates that go from 20% to 40% to 60% back to 40% and then up to 45%. The question is whether or not, over the coming decades, the taxable capacity of the economy, putting aside questions of whether we would like the tax burden to be much lower, as I would, will be able to support the public services that we provide now. If you look at the OBR forecasts, it does not look that great.

Some people might point to Denmark and Sweden and countries like that, although their tax burdens are not that much higher than the OBR's suggestion that taxes might have to rise by 15 percentage points of national income over 50 years. That is bigger than the gap between our tax burden and the Swedish tax burden. The interesting thing about countries like Sweden and Denmark is that their tax systems are not much more redistributive than our tax system because you get very

heavy levels of taxes on the less well-off as well. You start paying income tax in Denmark when you are earning about £4,500 a year, for example.

There is no straightforward solution to this that comes simply from increasing taxes, given the demographic pressures that there are over the next 50 years, which are really pretty serious.

Q169 **Chair:** When we looked at this issue before as a Committee, we suggested taking a percentage of everyone's estate to help fund social care, so that you do not have to look at an insurance scheme to insure yourself against losing a large chunk of your home, because everyone would provide a small percentage of it. Would that not be another way around?

Professor Booth: The Peter Lilley scheme deals with that quite well in that you could insure yourself against needing a large sum of money for long-term care. He suggests that the money is taken from your estate or at least when your house is ultimately sold, so you could choose to participate in that or not participate in it, depending on whether or not you wanted to take the insurance risk. There is no need to make such a scheme, in effect, compulsory.

Chair: Thank you both very much indeed. This has been a very interesting session. It is occasionally good to have a session where all the witnesses do not agree with each other, or necessarily with members of the Committee. It is certainly challenging and interesting for the Committee to hear that evidence today. Thank you both very much indeed.