HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Management of the coronavirus outbreak, HC 206

Tuesday 9 June 2020

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Amy Callaghan; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Dean Russell; Laura Trott.

Questions 1 - 48

Witnesses

I: Daphne Havercroft, former carer for social care user; Professor Tine Rosgaard, Roskilde University, Denmark; and Paul Little, Director for Integrated Health and Care, Suffolk County Council and East Suffolk and North Essex Foundation Trust.

II: Anita Charlesworth, Director of Research and Economics, Health Foundation; Anna Severwright, social care user and Co-Chair, Coalition for Collaborative Care; and George Stoye, Associate Director, Institute for Fiscal Studies.

Examination of witnesses

Witnesses: Daphne Havercroft, Professor Rosgaard and Paul Little.

Chair: Welcome to the House of Commons Health and Social Care Committee. This morning we are focusing not on coronavirus but on one of the issues that coronavirus has brought to the fore, namely the social care system.

The Committee chose to do its first inquiry of the Parliament into social care, before the pandemic gripped us. Issues such as the way the social care system integrates with the NHS, the funding of the system and the support we give the social care workforce have become more important than ever. This morning, we are going to look at what happens in other countries and talk to some people who have used the social care system here, alongside some experts.

I give a very warm welcome to our witnesses this morning: Professor Tine Rosgaard from Denmark, Paul Little from Suffolk County Council, Anita Charlesworth from the Health Foundation, George Stoye from the Institute for Fiscal Studies, and Daphne Havercroft and Anna Severwright, who have both had recent experiences with our social care system.

We have two sessions this morning, two hours in total. We are going to look at some best practice from both around the world and here in the UK. We start by talking to Daphne Havercroft, who had a number of challenges accessing social care for her mother, Dorothy, who died last year aged 97. Barbara Keeley is going to talk to Daphne.

Q1 **Barbara Keeley:** Daphne, thank you for giving evidence to our inquiry about that experience. Can you start by describing your experience of trying to access care for your mother?

Daphne Havercroft: Thank you for giving me the opportunity to speak to the Committee about my family's experience. I will run through a summary of what happened to her and the key points that we found as a family.

She was living in her own home until October 2017, with support from her family, who lived nearby. She had two hospital admissions as an emergency at the end of October. She never returned home after the second one, although I think it would have been possible for her to have gone home safely if she and her family had been given the right support.

During the period from November 2017 to her discharge from hospital to a nursing home in December 2018, she spent a total of seven months in hospital and six months in a temporary placement in a residential care home. However, in December 2017 the hospital multidisciplinary team acknowledged that she wanted to go home, required palliative care and would need an extensive care package. That was never acted upon. My assumption is that neither the NHS nor the local authority were willing to fund the package. Therefore, despite her needing nursing care, she was sent to a temporary placement in a residential care home. I think that was because the authorities did not know what else to do with her.

The residential home placement was supposed to be for a maximum of six weeks for assessment, but she remained there for six months. That is an important point to note. The six-month stay was paid for from the better care fund. Her stay was only curtailed by a third admission to hospital as an emergency. She lived for less than five weeks after being discharged from her hospital admission to a nursing home. She died in January 2019.

The key points for us as a family were that we felt that her three emergency hospital admissions could have been avoided if her local authority and community health services had worked together to anticipate and deal with her symptoms of early vascular dementia, loss of independence and increased frailty and falls, which are very common in very elderly people. The acute care that she received in hospital was very good. We were very grateful for that, but the hospital discharge plan was not good.

We found that there was no integrated working between health and social care professionals to plan her hospital discharge. There seemed to be no continuity of care between health professionals and Dorothy's GP and other community health professionals. For example, her hospital consultant's recommendations in handover of care letters were not followed up correctly. My husband and I were Dorothy's attorneys and appointed by her to make decisions if she could not make them herself. Our experience of the social care system was that the Mental Health Act was routinely ignored, such that she was presumed to have the capacity to make important decisions when it was obvious to us that she could not make some decisions for herself without support. That caused her a lot of anxiety and distress, as it did us.

After she died, I discovered that in September 2018 she had told a social worker, "So far everyone who is meant to have helped has done harm." That prompted me to count up how many NHS and local authority professionals had been involved in her case from the months prior to her first hospital admission to her death. I counted 101 people, and that did not include hospital acute care staff or care home staff. I am sure that none of those 101 people intended any harm to Dorothy, but they did not take effective action to avert the crises that led to three hospital admissions. We did not see them working across organisation boundaries to plan and deliver an integrated health and social care package to enable Dorothy to go home safely and end her life there, which is what she wanted, as a lot of elderly people do.

My perception was that the priority of the hospital discharge teams and community health and social care teams was to spend as little money as possible to support an old lady to live at home safely and help her avoid repeat hospital admissions. I think their cost-saving attempts had the opposite effect. That is evident from her three emergency hospital admissions, the use of the better care fund to keep her in an appropriate residential care setting for six months and the cost of the involvement of 101 people in her case.

I will finish there. I hope that has been a good summary of what happened in our family.

Q2 **Barbara Keeley:** Thank you. What was your experience of the care planning process? It seems astonishing that there were 101 people involved with your mother Dorothy. You mentioned her dementia. Do you believe that her dementia deteriorated more rapidly than you might have expected due to all the challenges that were experienced during her care, in both hospital and the care home?

Daphne Havercroft: I will start with the care planning. The first point at which we asked for a care plan was when she was still living at home in 2017. We were asking for a care needs assessment under the Care Act. It did not happen. I think that was because the local authority had a big backlog of care assessment requirements, and they just did not get round to doing it. She had one in September 2017, a month before she went into hospital, but by then it was too late and the crisis had already occurred.

When she was in hospital and residential care, there were opportunities to do care needs assessments. They simply were not done. It was almost as if the question was about whether or not she had mental capacity to make specific decisions. We found ourselves in what was really a dispute with social services about whether she had capacity to make decisions or not. That dispute seemed to paralyse any action in doing a care needs assessment, so one was never done.

In October 2018, when the hospital discharge planning after her third hospital admission was taking place, I found myself having to write my own social care assessment and write my own healthcare assessment. Although there was a hospital discharge team and multidisciplinary planning for hospital discharge, it did not seem to extend to care planning. It was bizarre but I wrote the plans myself, which were accepted and acted upon.

Turning to the second question about the dementia, yes, it was definitely the case that the fact that she was in institutions for so long—hospital and residential care—caused her dementia to deteriorate. It was early vascular dementia. She wanted to go home. She was very clear that she felt she was being kept a prisoner. As a side issue, the deprivation of liberty safeguards were not followed at all during the time she was deprived of her liberty, so she became increasingly anxious and agitated. At the end of her life, she did not trust anybody, which I think is evident in what she said to her social worker. She felt that everyone, despite their best interests, had caused harm.

Q3 **Barbara Keeley:** What did you feel was needed to discharge your mother from hospital? It is astonishing that you had to develop your own care assessment and your own health assessment, and that those were acted on. What did you feel she needed at various points when she could have been discharged?

Daphne Havercroft: She needed to be listened to. She needed her family, who were also her attorneys for health and welfare and her power of attorney, to be involved, working with health and social care professionals, and with her, to plan the discharge. But it was almost like the health and social care professionals felt they knew better than her own family, and as her family we felt that we were sidelined throughout. Meetings took place with her without our knowledge and behind our backs. That is fine if she had agreed to it, but there seemed to be very little acting in her best interests. That is what it should have been all about—all of us working together, involving her in making her own decisions as far as possible, so that she could be discharged from hospital in a safe way and in her best interests.

Q4 **Barbara Keeley:** You must have felt so frustrated with the system. How do you feel our care system could be simplified to help people like you and your family navigate your mother's care?

Daphne Havercroft: Certainly integrated health and social care. One thing I discovered quite late in the process is that GPs have a key role to play in co-ordination. I am not sure that the value they can contribute is being used. The contract that NHS England has with GPs is very much about them supporting people who are over 65 and identifying people with frailty. The way I read the contract is that it is to co-ordinate health and social care teams actively to plan and deliver care in the community to help the person live safely at home and reduce risk of emergency hospital admissions, and, when they come out of hospital, to make sure that they are in a safe environment and reduce the risk of them pinging in and out of hospital.

I am pretty good at finding out things and acting on them, but what we dealt with in trying to support my mother was the most difficult thing I have had to deal with in my life. If I found it difficult, how many other families are finding it even more difficult?

Q5 **Barbara Keeley:** She was in hospital for long stretches and not in any form of care. Did the medical staff seem to have any of the tools they might need to help with discharge and planning care assessment, or was there a yawning gap between medical staff and care staff and workers?

Daphne Havercroft: Yes, there is a big gap, certainly where I live, in health and social care. I felt that, understandably, hospitals want to get people out of their acute care beds. Everybody who has been through this will be familiar with the term, "Medically fit for discharge". That tends to assume that the person does not have any healthcare needs once they are discharged, but all it means is that they are medically fit for discharge from an acute bed. It does not mean that they are medically fit. Clearly, someone who has dementia, a progressive disease, and is at risk of falls is not medically fit.

How it seemed to work in Dorothy's case was that she had experience of three hospital discharges, and in all of them it was the NHS hospital wanting to free up a bed, so they pushed her over to the responsibility of social care, but without actually looking at what healthcare she needed when she got out of hospital and whether they had lined up everything with the GP and the community NHS services to make sure that that healthcare was delivered once she was out of hospital. Let social services organise it if she needs carers to come in and help with personal care, and so on, but make sure that the things that brought her into hospital are actually managed in the community. That just was not there. There are tools available to health professionals to do it, but my experience was that it does not get done unless you ask for it.

Q6 **Barbara Keeley:** It must have been such a battle for you and the family all the way through. You talked about GPs having a role. Did you get support as a carer? Was there a carer assessment? There wasn't an assessment for your mother, but did you ever get support as a carer and how did that happen?

Daphne Havercroft: No, we did not. We asked for a carer's assessment around the time we were pushing for a care needs assessment, but, no, we did not. We did not really pursue that because our priority was to try to get a care assessment for my mother.

Barbara Keeley: Thank you, Daphne.

Q7 **Dean Russell:** Daphne, I am sorry to hear about the experiences you have had. The question I have is related to the words you used about co-ordination. I was interested to understand how you felt the system was joined up, or in this instance was not joined up, and where you think things could have been improved across the different settings. You mentioned that three different hospitals were involved. How could that have been improved, in your view?

Daphne Havercroft: It was one hospital for the three admissions, to clarify, and they have a hospital discharge team—what they call an integrated hospital discharge team—made up of health and social care professionals. But there seemed to be no overall co-ordination to make sure that the health and social care elements of the discharge team actually provided an integrated assessment and package of care for hospital discharge. They seemed to work in silos.

My impression was that the social care professionals did not have the seniority or influence to get the input they needed from NHS staff, both in hospital and in the community, to make sure that the healthcare part was actually planned for and delivered. I think social care was left on its own to struggle with a very difficult situation; complex health needs needed to be dealt with, but they were just left to the side.

Q8 **Chair:** Thank you. We need to move on to listen to some other witnesses. Daphne, thank you for talking to us. I am sure that your mother, Dorothy, was a very special person. I was Health Secretary when she was admitted to hospital for the first time, and the least I can do is apologise to you for the fact that we did not manage to sort out the disjunction between the health and social care systems in time for Dorothy's care. I hope we can do something as a Select Committee to highlight both the problem and the solutions. Thank you for taking the trouble to talk to us in such detail about what you have been through.

I want to bring in another witness so that we can look at some parts of the world, and possibly even parts of the country, where those issues have been addressed. Professor Tine Rosgaard is social care professor at Roskilde University in Denmark. Thank you for joining us, Professor Rosgaard.

I will start with the care of older people. As we have just heard from Daphne, in the UK we have two systems—the health system and the social care system—and there are often arguments between the two systems as to who is responsible for someone's care. There are different care plans, and there is arguing over budgets. Sometimes the most important thing— the prevention measures that keep someone healthy at home—does not actually happen. Could you start by telling us how you address those issues in Denmark?

Professor Rosgaard: Certainly. Thank you for inviting me to be a witness. In Denmark, along with some of the other Nordic countries, we have more integrated health and social care systems, and they are managed at local level. We have had very decentralised systems. In recent years in Denmark, we have moved towards centralisation and we have reduced the number of local authorities from 271 to 98. It means that we have large— maybe not in British terms—local populations of at least 30,000 inhabitants or more. That has strengthened efficiency in the provision of social care in local authorities. Because of the tradition of integrating health and social care systems, we have established routines and systems that support communication between the two systems. The workforce receive a social and a healthcare education so that they can work in both the social care system and the healthcare system.

In recent years, we have worked to improve preventive efforts; for instance, we have preventive visits. Every inhabitant is offered a visit once a year by a social care assessor. It is for persons of 75 and over. They come into the home and talk to the older person about their needs, which could be anything ranging from financial issues or care issues, and health issues of course, to the housing situation.

We have established a new discharge practice. I was quite moved listening to you, Daphne, and your story about your mother. The discharge practice that we now have in place has improved the situation for many older patients who are to be discharged from hospital. We now have hospital-based multidisciplinary teams. They include primary and secondary healthcare professionals, and community-based care workers. They visit patients at the hospital before they are discharged and organise community-based care. They ensure that the different systems communicate and co-ordinate. That has improved the efficiency of discharge and increased patients' satisfaction with the services that they receive at home.

That is one initiative that I think can be said to have good effects. We have quite a number of evaluations in Denmark. We also have a national action plan for the older medical patient. That ensures that the regions, which are in charge of the hospitals, and the local authorities have to work together towards the same focus. It includes, for instance, more preventive initiatives, timely measures and better qualifications for staff in municipalities. Those are some examples of our recent initiatives.

Q9 **Chair:** Could I ask about care homes? As I understand it, you have had a policy of deinstitutionalisation, reducing the number of people in care homes, while increasing the number of people being looked after at home. How has that worked?

Professor Rosgaard: It has worked quite well. It is something we started in the late 1980s. We said that we did not want to build traditional nursing homes any longer, which were hospital-like, with many beds in one room and so on. Sometimes, people have the impression that we no longer have nursing homes in Denmark. We certainly do, but they are private abodes. It is like an apartment, with a kitchenette, a bedroom and a living room, with common facilities.

We have tried as best we can to provide care at home. There is no limit to the number of hours we provide at home, but sometimes the care needs might be so intensive that it is better for the older person to move into a nursing home. We try as much as we can to provide care at home. That is personal care—dressing, getting out of bed and so on—and cleaning services. It is free of charge. There is no stigma associated with it. People use the home care system across social class, and they do not have to pay for it.

There is a choice of providers. We have for-profit providers and some use a not-for-profit provider. Around 11% of people aged 65 and over use home care. That is relatively high in an international comparison. We also have around 45% of older people, 65-plus, who live in a nursing home.

Q10 **Chair:** We heard from Daphne that she thought that what happened with her mother, Dorothy, was that neither the health system nor the social care system wanted to take responsibility for Dorothy's care, presumably for budgetary reasons. How do you avoid those financial disincentives in Denmark so that people do not find they are being pushed from pillar to post between different parts of the system?

Professor Rosgaard: One of the reasons why we might be able to avoid it is that the local authority is in charge of community care. We also have a bed-blocking system to avoid delayed discharges.

Q11 **Chair:** Is the health budget and the social care budget one big budget that is all under the local authority?

Professor Rosgaard: No. The local authority has its own health budget, and the hospitals have their health budgets. The hospitals are under the regions. Therefore, there are some incentives for hospitals to avoid people staying in a hospital bed for too long. One of them, which has proved most efficient, is bed-blocking fines. They are used in different countries around the world, but it is basically saying that there is a financial disincentive. It is for the municipalities, if they are not able to organise community or home-based services, to deal with people who are discharged from hospital.

Q12 **Chair:** A number of members of the Committee want to ask you questions, Tine, but first I want to bring in Paul Little, who is the director of integrated health and care for Suffolk County Council and East Suffolk and North Essex Foundation Trust, one of the areas of the UK that has tried to be a trailblazer in the integration of health and social care. Thank you very much for joining us, Paul Little. Are you doing the kinds of things that Tine was just talking about in Denmark? Does your approach solve the kind of problems that we were hearing about from Daphne and her mother Dorothy's care?

Paul Little: Can I start by acknowledging the poor experience Daphne had? It is incumbent on professionals like me to do everything possible to ensure that it is not repeated and does not happen again.

In answer to your question, yes, we are trying to increasingly look to ways in which we can organise the delivery of services to people as a system rather than as a set of separate organisations. In Suffolk, about five or six years ago, we started to move from a conversation about integration to a situation where what we would do would be to—*[Inaudible]*. That included the integration of community services working with primary care, and in particular a focus on prevention and working to deliver services in people's communities that avoided the need for people to be admitted to hospital.

Of course, some people need acute care, but there is a lot one can do with an integrated approach between health and social care, particularly if crises arise for somebody; it might be a chronic condition or some aspect to do with their personal care. If you can organise integrated support for people in their own home, or indeed in a care home if that is their normal place of residence, and tackle the crisis in the person's home and avoid taking them into hospital, not only does that avoid the admission but it is a much better experience for the patient or person needing that support.

We have come a long way in the last five years, and we are making increasing efforts for the experience of being discharged from hospital to be a much more integrated experience. In particular, when the discharge route is planned, the focus is a combined approach between health and social care for the support people need. In other words, it is a rehabilitation focus that really looks at how one can ensure that a person's ability to be as independent as possible is fully maximised.

Q13 **Chair:** Can I ask you very directly, are you reasonably confident in Suffolk that the kind of experience that Daphne had with Dorothy would not now happen?

Paul Little: I could not of course guarantee that—

Q14 **Chair:** I understand you cannot guarantee it, but are you reasonably confident?

Paul Little: I have certainly never heard from any of the services that I am responsible for, or from people we are supporting, about experiences that are as extreme and as difficult as that. I would be loth to say it was impossible; it might be happening.

We know, because we monitor it, how effective we are in terms of being able to deliver things. We know, particularly when looking at the length of stay of older people in hospital, that there is not only an issue of managing demand on the whole system but that the experience of older people of unnecessarily extended stays in hospital has a detrimental effect on their long-term health and wellbeing.

It is not just an issue about bed numbers; it is a germane issue about the experience of long-term better outcomes. The way we are trying to move forward as a system in Suffolk is to focus on that patient experience and that—*[Inaudible.]*

Q15 **Chair:** Paul, I am afraid it is not a terribly good line. Do you have any metrics or numbers that demonstrate, since you introduced the new approach, that it has been working?

Paul Little: Yes, I have. Hopefully, you can hear how effective we have been. An early comparison we did—this was the subject of a case study you referred to previously—was in February 2017, when we started with that discharge process. We were looking at delay numbers that were peaking at around 49 per day.

Q16 **Chair:** Forty-nine a day?

Paul Little: That was a peak; it was not always like that.

A year later we looked at the numbers, and they were approaching 10, so we had made good and significant progress over the year. To give you a broader overall idea of—*[Inaudible]*—we moved from an average—*[Inaudible]*—per 100,000 population that year, in 2017-18. For the last complete year, 2019-20, we moved that down to 3.9. We are ambitious to get it to zero, but that shows significant progress and that is against a regional average of—*[Inaudible]*—and a half.

Chair: Thank you. Those are very interesting examples of what has been happening, both in the UK and in Denmark.

Q17 **Dr Evans:** Tine, I am interested, as a GP myself, in the Danish and the Nordic approach with regard to the culture around care. Often in my experience, having spent 17 years training and working around Birmingham, the Indian subcontinent is very good at looking after older people and wanting to keep families at home. My brother's fiancée is Danish and talks about the care in the approach they take as a society to their older people. Is there something that impacts on the way in which Denmark is able to put its care packages in place from the approach it has and the culture in terms of the Nordic approach. Do you have any comments around that?

Professor Rosgaard: The sound was not good. Sorry.

Q18 **Chair:** It was a question about whether there is something about Nordic culture that has influenced your approach to the care of older people.

Professor Rosgaard: Most of all, it is in terms of the formalisation of social care. We have quite a different culture. We regard the responsibility for providing personal care, in particular, to be a public responsibility. That is not to say that informal carers are not involved in the provision of care at home—they are to a high degree—but more often it is spouses. Adult children, for instance, are less likely to be involved with providing bathing, getting dressed and so on.

There is a social contract in Denmark. If you are of working age and you participate actively in the labour market, in particular women—we have a high degree of women who work—we have the social contract that care for frail older people is the responsibility of the local authority.

Q19 **Amy Callaghan:** Tine, I am particularly interested in the multidisciplinary team that you have for assessing patients in order to allow them to leave hospital. Would you class the MDT as an essential aspect of ensuring that both health care and social care work collaboratively together for the benefit of the patient?

Professor Rosgaard: Were you specifically talking about the discharge system?

Q20 **Amy Callaghan:** Yes, the discharge multidisciplinary team.

Professor Rosgaard: I am not sure it is the multidisciplinary aspect of it that makes it work. I think it is the presence at hospitals of somebody who knows about the community care system and is then able to be the broker between the two systems. It is often one person who visits the patient, but of course they are communicating and co-ordinating with other people in the system, and being the broker for a person who is of course in a limited position to exercise their powers and so on because they are a patient.

It is also very helpful for family members. They know, on the other side, that when the person is discharged there is somebody who will help them. It is basically that you do not have to wait until you come home and then somebody visits you. Everything is organised beforehand.

Q21 **Laura Trott:** I want to ask both Tine and Paul about workforce issues—*[Inaudible]*, Tine, to give you a bit of background on our workforce, about a third—*[Inaudible.]*

Chair: Laura, we are having a problem hearing you.

Laura Trott: In our workforce over here, we have a vacancy rate of around 120,000. A third of our workforce leaves every year. Is there anything we can learn from Denmark, Tine, about how you organise your workforce?

Paul, how have you coped and is there anything you have done locally with your workforce that has helped you achieve some of the great stats that you outlined?

Professor Rosgaard: It is difficult to give you a recipe, but because we have a highly professionalised workforce, there is a certain pride in the job. I am not saying that it has tremendously high status, but it is seen as a career. You need an education and over the years it has become more medicalised. We have two different degrees: social and healthcare helpers; and social and healthcare assistants. In particular, the assistants have been promoted as mini-nurses, although that is not a nice way to say it, so they have taken over some of the tasks nurses were in charge of, and that has helped to create a sense of pride in the profession.

They are increasingly used instead of nurses. They take upon themselves quite complicated tasks. In general, because of their education, they are considered a profession. Therefore, it has become more difficult to recruit staff over the years and we are aware of working condition issues. We have tried to increase wages. They are still lower than if you are a nurse or a teacher, but the wages have increased over the years.

One thing that is interesting for me is that we have introduced reablement as a national policy in Denmark. We are the only country in the world to have done that. Every time a person applies for home care, they are assessed for reablement. Staff members who work in reablement have a much higher tendency to say that they find their work meaningful. That is because working to develop people's independence and skills is very rewarding.

Q22 **Chair:** Paul, could you respond to Laura's question?

Paul Little: Certainly, workforce is a challenge. The consistency of delivery is so highly dependent on a well-motivated workforce that any fluctuations and difficulties with that will inevitably have an impact on the quality of care. From a social care perspective, we try to make sure that we engage directly with our market providers and do everything we can to ensure that there is a reasonable financial settlement—*[Inaudible]*. We cannot guarantee, though, how that is passed down to market providers.

I would say there certainly is concern and an issue around the relative status of care workers to health workers, which can mean that it is a less attractive profession. The availability and stability of staff is problematic as a result. We know that there are seasonal variations when people have more options—*[Inaudible]*—for example—*[Inaudible]*—towards the end of summer and over Christmas, there is a great—*[Inaudible]*—for the retail sector—*[Inaudible]*—in the short term.

It was interesting to hear what the professor from Denmark was saying about reablement. We have a similar focus in Suffolk as a first support—*[Inaudible]*. Our experience is that people involved in that work, particularly—*[Inaudible]*—their functioning, their level of independence and their mental wellbeing can be a really motivating part of the experience—*[Inaudible]*—really ensuring that—*[Inaudible.]*

Chair: Thank you.

Q23 **Barbara Keeley:** Could we clarify the picture around the situation in Denmark? Tine, you mentioned for-profit providers and not-for-profit providers. What is the balance between them? I think you mentioned that people have a choice between them. How does that work?

The second point is that we have mainly been talking about care for older people. You have exclusively talked about that, Tine, in terms of Denmark. What about care for working-age people with disabilities and learning disabilities? Is that structured in the same way? In this country, 50% of the spending of local authorities is on social care for that group of people. How is that structured in Denmark?

Professor Rosgaard: It is structured quite differently. Home care is regardless of age, but the majority of services go to older people. Services for people with disabilities are organised differently, and it is not my area of expertise so I should not comment on that.

To turn to your second question, in 2003 we introduced free choice in provider of home care. That means that every municipality or local authority should try to ensure that an alternative provider to the local authority is providing services. That is achieved in nearly all of the 98 municipalities or local authorities. A third of users are using a for-profit provider. It is still financed by the local authority. The user is assessed in a similar way, or an identical way, and there is no charge, but they can purchase supplementary services, which they have to pay for from their own purse.

Q24 **Barbara Keeley:** It is still a local authority provision, and a third is for-profit providers?

Professor Rosgaard: Yes. Provision is split between for-profit providers and municipality/local authority, but a third of people use a for-profit provider. It is mainly those who need cleaning services. Those who are frailer and need personal care tend to trust the public provider more; also, we have had some unfortunate bankruptcies in recent years.

Q25 **Paul Bristow:** I have a couple of questions. The first is to Tine. I was interested to read, and to hear a few moments ago, about the integrated training programme for social care staff that covers both social care and healthcare settings. Are you finding shortages in either setting? Because you are training individuals in both disciplines, do you find that people move into one over the other, or are people willing to go between both settings?

Paul, I am interested to know if you feel the market operates effectively for providers of home care. Do you believe you are paying enough, for example, per hour? Is that attracting enough providers into the market? I sometimes feel that we do not focus on home care enough.

Professor Rosgaard: I will say something about the flexibility of the workforce. Both social healthcare helpers and assistants work in hospitals, in residential care homes and in home care. They work across the two sectors. When they start their education, it is not that they decide which sector to work in. It is quite flexible for them to move around.

When I do interviews with the workforce, they often talk about the education as a stepping-stone. They start out as helpers, and then they become assistants. Quite often, their ambition is to become a nurse at the end. They see it as a progressive movement.

Paul Little: For home care providers, certainly in our local experience, the market can be very unstable. That is partly about the financial viability of those providers. Aside from the important issue of how much a care worker gets paid and how that is a motivation in terms of the workforce, as we were previously saying, there is the sustainability of some businesses. Most of our home care providers are for-profit businesses and can be really affected by the level of funding in the system.

As a local authority, or with my local authority hat on—I am also employed by the health trust, as the Chair indicated earlier—we spend a lot of time with our commissioning team, our contract management team, engaging with providers on a regular basis. We work with them in every way we possibly can to ensure that there is stability. Unfortunately, it is very common for us to have to cope with provider failure, which is most often about the financial viability of the business.

We are fortunate in the way we have commissioned home care in Suffolk in that we have quite a range of providers. When those wobbles or issues with individual providers have happened, we have become quite skilled at managing the market in a way that is not to the detriment of the care of the individuals we are serving. Our business continuity planning is a really important part and it takes a lot of energy from the local authority just to manage the stability of the market. It is definitely an issue that we need to manage.

Chair: Thank you very much indeed. A very big thank you to Paul Little from Suffolk County Council for joining us, and Professor Rosgaard from Denmark, and for giving us your very informative answers. I think Daphne might stay with us for the next session. You are most welcome to do so. There may be some further opportunities to bring you in as we talk about the next focus, which is funding issues.

Examination of witnesses

Witnesses: Anita Charlesworth, Anna Severwright and George Stoye.

Chair: We now move to our second session of this morning. We have some expert witnesses, George Stoye from the Institute for Fiscal Studies, and Anita Charlesworth from the Health Foundation, but before we hear from them, we are going to talk to someone else who has used the social care system in England. Anna Severwright is co-chair of the Coalition for Collaborative Care and has a genetic condition that causes her chronic, severe pain. James Davies is going to talk to her about her experience of the system.

Q26 **Dr Davies:** Good morning, Anna, and thank you for joining us today. I know you initially trained as a doctor and, sadly, are unable to practise as a doctor. I am sure that gives you an insight into the situation you have faced as your condition has developed. First of all, as a working-age person, how do you feel the social care system has treated you so far?

Anna Severwright: Good morning, and thank you for inviting me to speak to you today. Before I talk about the social care system from a funding perspective, I want to comment on the integration that we have just heard about between health and social care.

As someone who uses quite a lot of health and social care in my life, what I need is for them to be working together towards one common goal, and that that goal is set by me, so that I can get on as best as possible with my life. To be honest, the structure and the system they do that in does not really matter to me. What matters is the outcome and people’s lives.

Big is not necessarily always better. People talk about bringing social care into the NHS or joining them. Health is big at the moment. At one point, I had seven consultants, a GP, a physio and wheelchair services. They are not talking to each other, so I do not necessarily think that we need one big structure, but all those people need to be working around the person towards that common goal. That is just my thought on integration as someone who uses a lot of health and social care.

As a 34-year-old who has found myself needing social care for about the last eight years, I am really grateful for the care I receive. It keeps me fed, clean and watered, but I feel that I am not able to live a normal life. I do not have enough hours to be able to go out at the weekends and in the evenings, and do a lot of the normal things that make life worth living for us.

My life got split up into chunks. How long will it take me to have a shower? How long do I need to get dressed? How long for food preparation? That is not what I want my life to be about. I find myself in the position quite regularly where I have to think, "Well, I only have two hours left this week, so do I want to do food shopping, have another shower or go and meet up with a friend?" It is quite a hard place to have to live your life when you have to quantify the things you want to do into a small number of hours a week.

Another aspect around the funding of social care is that a lot of us who use social care fear cuts; we fear our hours being cut. When I got a letter last year about my review being due, I tweeted about that sense of fear. It makes me feel sick to think that my review is coming up because it is so out of my control, and those hours could be cut. Many people got in touch and said that they felt the same. It is such a scary time for us when we are under review. I know many people who have had their hours cut, often by up to a third, just like that. That is a third less life that that person can effectively be getting on with and living.

I use direct payments. I receive a direct payment from the local authority, and I employ my own PAs. That is great because it means I get choice over who comes in and out of my house, and who I employ. The amount of money we get is quite low. It remains a low-wage job, which makes the recruitment and retention of PAs quite difficult. I know that is a problem across the whole system.

Direct payments are a fantastic thing. They were brought in to give people like me, and people of any age, choice and control over their care. As money has got tighter in the system, the system and the local authorities have tried to claw back a bit of control, so direct payments have lost some of the sense of flexibility. There is an awful lot of scrutiny now over how we use our money. There are a lot of rules and things that we cannot spend money on. It certainly does not feel like direct payments are giving us the choice and control they were designed to give.

At the moment, there is quite a big power imbalance and a lot of fear. For example, I get letters quite regularly that say in bold: "If you do not return this form in 14 days, your direct payment may be stopped." It is that kind of relationship with the local authority, rather than one of trust and working together to enable people to get on with their lives.

Financial contribution is a big thing for me. If I received continuing healthcare or a personal health budget via NHS funding, I would not have to pay contributions. But I receive that payment, so I am assessed through a very complicated system that I do not understand—a means assessment—for my contribution. There is currently no lifetime cap.

I started needing care in my 20s. I may need it until my 60s or my 80s. Who knows? Compared with peers of my age who do not need care, through no fault of my own, because I need social care, I will have spent quite a lot of money on social care, so I am at a financial disadvantage. There is a disincentive for me to save because, if I ever reach £14,000 of savings, they would start to be taken towards my care, and at £23,000 I would be a self-funder. For working-age adults, that is quite an issue.

The final point I want to talk about is, what are we funding for? If we are trying to increase funding for more of the same, we will be failing social care. I have never met anybody in their 50s, 60s, or 70s who says to me, "I hope when I get a bit older and frailer that my family put me in a care home." I meet people all the time who say, "Don't let them send me to a home." We should not have a system that people fear having to need in their older age. People my age talk about it being a fight; fighting the system. There is a constant sense that we are having to fight for our rights and fight to have a life.

If we believe, which I hope we do, that disabled people, older people and people with learning disabilities deserve an ordinary and a good life, like everybody else, and to be part of the community, to live in our own home and be able to contribute to society, because we have a lot to offer, we need to fund a system that truly allows that, not just more of the same. Thank you.

Q27 **Dr Davies:** That is really helpful; thank you. You have covered so many areas. What strikes me is that you feel that the independent person you want to be is limited to some extent. You presumably feel that with more support you could be doing more with life. What kind of proportion of life do you feel you live to the full? What gap is there in the provision you receive?

Anna Severwright: It is quite large. I get 31 hours a week of social care, of which 20 are for things like personal care and food preparation. They are the things that are keeping me fed, clean and watered. There are just under 12 hours of social inclusion, which, effectively, is the bit for me to be able to go out. I live by myself, so I need support to get about. As someone in my 30s, that is not a lot of time. If, in the evening, I think. "Oh, I'd like to go and meet up with so-and-so," that spontaneity is completely not there. I have to plan well ahead, even down to what time I go food shopping. I need to know that I have a PA who can come with me. It has a big impact on my sense of self. I spend an awful lot of time at home by myself, quite lonely and quite fed up.

Q28 **Dr Davies:** If you were to change things, am I right in thinking that fundamentally you would introduce more trust in the system for those receiving the care and in modelling the support they receive?

Anna Severwright: I would like the conversation to start from a different place. When people are assessed or reviewed or whatever, it should be about what matters to you in your life and what you want your life to look like and then how social care can enable that, rather than starting with breaking me down into lots of little tasks.

Trust is important. I would like to feel that I work with social care as equal partners, that we have an open conversation and that they trust me to use the money in the way that is best going to meet my needs, rather than it feeling like I am constantly having to justify and battle just to get the basics that I am getting now.

Dr Davies: That is really helpful. Thank you very much.

Q29 **Chair:** Thank you; very thoughtful questions. Thank you very much for joining us, Anna. I am sure we will bring you in a bit more as we move to talk about funding in much more detail.

I welcome two very knowledgeable experts: George Stoye of the Institute for Fiscal Studies and Anita Charlesworth from the Health Foundation. Thank you both very much for joining us.

Anita, I want to talk to you about some of the modelling that you have done at the Health Foundation. We have a spending review that the Government have said they intend to deliver by the end of this year. Obviously, things are in the air a bit with coronavirus, but we have to assume that that is still going to happen.

These things can change, but it is likely to be a three-year funding review, of which the final year would be the financial year 2023-24. As I understand it, you have done some modelling that looks at the impact of the two big things we have to think about, which are the demographic changes—the growing numbers of people who are going to need social care between now and then—and the workforce pressures. Could you talk us through your analysis of what the annual social care budget would need to increase to by the end of that three-year period, if we are to deal with those demographic and workforce pressures?

Anita Charlesworth: Yes, of course. Thank you very much for inviting me.

The position on the demographics is that regardless of whether or not you think current social care delivers appropriate access or quality, and we have heard today in the two experiences of users that there are real and serious doubts about that, we have a growing ageing population and we have more younger adults of working age living with long-term health conditions that require support. Over the period to 2023-24, if we were to deliver the current quality of care and access to care to the growing number of people who need it, we would need to find another £2 billion on top of the estimates from the Office for Budget Responsibility of the spending power of local authorities going forward, without any more funding announcements.

There is a second big pressure, alongside demographics, from the workforce, and coronavirus has brought that into sharp relief. In particular, there is the situation around the pay of the workforce. Social care work at the moment is highly skilled work, but it is not recognised in pay on average. The Government have set an ambition to increase the national living wage in England up to, if economic conditions allow, two thirds of median earnings. The average wage at the moment for social care is very close to the national living wage; it is 2% above.

What we looked at is increasing the average wage in social care in line with the figures for the national living wage that the Government have set overall, and then a little bit more, recognising the fact that we have significant vacancies; we are very reliant on overseas workers. About 17% of the workforce comes from overseas, and the new migration policy will make that a challenge. Our numbers are not a very big increase. If social care wages, on average, were 5% above the national minimum wage, adding that to the demographic pressures gives you a funding gap of £3.9 billion at the end of the spending review period.

Q30 **Chair:** Does that £3.9 billion increase bring us up to the two-thirds level that the Government have said they are committed to?

Anita Charlesworth: To make it tangible, the OBR says that in 2023-24, assuming that the Government and the Low Pay Commission agree that the time is right for the minimum wage changes to occur, the national living wage would be £10.30. What we model is a median hourly wage in social care of £10.80—50p an hour more on average.

Some people would be at the minimum living wage, but more experienced people would obviously be above that. That is the average and that is what we model. Five per cent. above the national living wage is not some pay bonanza; it is a pretty modest pay situation, especially when you think about the labour market context and the shortages in international recruitment.

Q31 **Chair:** Carry on. You were talking about if we were going to increase the provision of care.

Anita Charlesworth: The £3.9 billion allows us to have a system where access does not get worse. It allows us, essentially, to keep up with very basic pay pressures. As we have heard, there is a very great deal of concern both about access to care and the amount of care that individuals receive, as well as the squeezing of care packages and the sustainability of the market.

To give you a bit of context for that, it is fairly difficult to look over long time periods at what has happened to people's access to care because there were big revisions to the way we count the number of users of care in 2014-15. Since 2015, the number of older people who need help with the activities of daily living—things like washing, dressing and eating—has increased by about 60,000, but the number of people who are getting help through the adult social care system has fallen by 40,000. There is clear evidence that over recent years, as funding has been highly constrained, people who would previously have had care are no longer getting care.

It is fairly difficult to go back long term on the numbers, but we know that 2010-11 was the peak in spending in social care in real terms, when we allow for inflation. If we had kept that level of access, quality of care and funding for providers, and kept pace with the growing number in the population and the cost pressures in the system, we would be spending about £10 billion more in 2023-24 and not the £3.9 billion I talked about. If we wanted to make sure that we were paying the living wage, it would be about £12 billion.

In one sense, £12 billion is a huge amount of money, but we heard earlier about Denmark. In internationally comparable definitions of spending on social care, we spend just under 1.5% of GDP on social care. Denmark spends 2.5% of its GDP on social care. If we spent the full £12 billion in 2023-24, we would go from spending just under 1.5% of GDP to 1.7% of GDP.

Twelve billion pounds is a lot, but it is 0.2% of GDP in one of the richest countries in the world for a service that is a fundamental pillar of our welfare state, and which is letting down so many people now. It was the ambition of the 2014 Care Act to put people at the centre of their care and allow them to make a contribution to society and live meaningful lives. I do not think that 0.2% of GDP is very much when you look at it that way, and it would still be way less than Denmark spends.

Q32 **Chair:** How do we compare internationally if we look at all the OECD countries, the G7 or the EU? Denmark is one country, and the Nordic countries are very well known for their welfare states. How do we compare more broadly?

Anita Charlesworth: The picture is that taking the OECD as a whole, the average is 1.7% of GDP. There is a big contrast between northern Europe and southern Europe, and I feel that we have some choices to make here.

Southern Europe has a long tradition culturally of family-based support and has comparatively low levels of female participation in the labour market. The northern European countries have a higher share of GDP. Denmark is not the highest; Norway, the Netherlands and Sweden are all above 3% of GDP. Northern Europe has much more emphasis on formal care and higher levels of female labour market participation.

We are wanting to spend more like a southern European nation but we have labour market structures that are more northern European. In the end, you cannot have your cake and eat it. We have to choose as a society. If we are choosing as individual care users to have a more formalised system, and our economic and social structure wants that, it has consequences. The social care issues are not a problem; they are the consequences of success. They are the consequences of rising life expectancy and profound changes in society's attitudes to disability, and the transformation of our family structure, our economy and the lives of women in particular and their ability to work. There are consequences, and we need to resource those consequences and not see that as a problem.

Q33 **Chair:** The Institute for Fiscal Studies is always telling us that we have to face up to the consequences of the choices we make as Governments and societies. George Stoye, what would you add to the analysis that we have just had from Anita? Do you agree with it?

George Stoye: Thank you, and I thank Anita too. I largely agree with what Anita says. It is very important to note that how much we need for social care is driven by the system we want and what we want to provide with that funding. If we want to provide better-quality funding, we need to think about how we find the funding for that.

On top of that, there is the question of how we get the money also. Most social care is funded on a local authority basis, which is quite different from healthcare, which is central Government spending. We are talking about the gaps in social care, but there is a question as to whether that is money expected to be raised by local government or ring-fenced and brought from central Government. What we have seen over the last few years is an increasing expectation that there should be equalisation in the quality of social care and access to it across different areas, but at the same time we have seen local government expected to raise more of the revenues itself.

We have a tension there. If we want to improve standards of care and spend more on social care, we also have to think about who is paying for that in terms of the local authority.

Q34 **Chair:** I want to ask you both specifically about the evidence that we heard from Anna. We have had quite a lot of discussion about demographic changes and the ageing population, but younger people with disabilities who need care are an increasingly important part of what the social care system is there to do. Anita, what are your reflections on the evidence that we heard from Anna?

Anita Charlesworth: Anna's evidence was really important. Before I come to the financial bit of it, it was important because we are seeing a gap at the moment between the vision that was set out in the Care Act 2014 that was focused on putting people at the heart of decisions about their care and not focusing just on a very reductionist model that treats people as a series of baths to be had, meals to be provided and times to get up and get dressed. It starts with the question of how the system can support people to live the life that they want to live. That is the overwhelming duty of social care. We need extra funding to make that a reality; that is absolutely clear. We need extra funding per person to make that a reality. All the modelling is that, over the next few years, we will have an increase in the number of people who need that support.

The other thing is that we need reform as well as funding. Because of the pressure to cut costs, we have commodified social care and turned it into targets that are contracted for, where the contracting is overwhelmingly a race to the bottom on price. The system does not contract. The financial flows do not operate around what the individual wants and needs, how we measure the outcomes of that and how we align the funding to that.

We are, hopefully, at a paradigm shift moment with social care. What we need to do in all of the work in the spending review and elsewhere is to put the Care Act at the heart of it and make the money work, both in terms of its amount and in the way we design contracting models and funding flows around the vision that so many people supported.

Q35 **Chair:** George, do you have anything to add?

George Stoye: I agree with everything that has come before. One thing related to that is that within social care we have very little information on a consistent basis, particularly across the country, on who is receiving care, what type of care they are receiving or the outcomes those people are getting. If we really want to improve care and change the system, we need to start collecting that data so that we can understand what is going on.

Q36 **Chair:** Anna, do you have any additional comments on the basis of what Anita and George said?

Anna Severwright: I think they have made some great points. Looking internationally, we can see what the other countries are doing and say, "That sounds wonderful," but obviously we need to look at how we fund that and prioritise it in the funding.

I agree with George that we need better data, but it is about what data we collect. A lot of data is collected; councils can tell you how many people are on direct payments, but they cannot tell you the quality of those direct payments because they do not ask people like me, family carers and other people in the system what our experience is of using a direct payment. They just count numbers of things. We need to look at what data we collect and ask people like me, Daphne and others for our experiences.

Q37 **Barbara Keeley:** The broader question I want to ask is over and above the funding to meet the demographic challenges and pay issues that you have just run through very helpfully, Anita. There are different options that exist to address the broader problems in our current system, which, as we have heard, leave people with a gap in the care they need, but also with catastrophic costs. From what Anna was saying, she is going to spend a very large amount of money on care across her life.

We heard earlier that Denmark has free personal care and a highly professionalised workforce. Which options would you go for, over and above the current gaps?

Anita Charlesworth: It is welcome that you raise that, because we clearly have three issues that we need to address with funding. One is access. The second is quality of care and the resilience of the sector. The third is remuneration for the workforce, which relates to the second. All those things at the moment would be necessary but not sufficient to have a social care system fit for the 21st century. The balance of responsibility at the moment between the individual and the state is manifestly unfair, and individuals are left with catastrophic care costs.

Sir Andrew Dilnot reviewed the options in 2011 and recommended a cap on care costs. In the 2014 Care Act, that was enacted, and it is the law of the land that care costs should be capped but we have never implemented that. Given the scale of the challenges in the system, there is a very strong argument for moving quickly to implement the cap on care costs. That cap, if it is about £46,000, would add over £3 billion to the cost.

The alternative would be to go for free personal care, which is the model in Scotland. Free personal care would be slightly more expensive, depending on how you designed it. The key differences between the cap on care costs and free personal care are that neither pay for the full cost of care; both require individuals to contribute. Free personal care in Scotland is a payment of £180 a week towards the cost of residential care, with an extra £80 a week if you need nursing care. Obviously, a week in a care home is much more than £180, so on average that meets about 25% of care costs. That helps individuals from the beginning when they move into a care home, but if individuals need to stay there for a long time or they have very high needs, they are not protected against very high costs.

A cap on care costs means that individuals contribute at the beginning, but they are protected from very high costs. That shifts the balance of state spending to those in greatest need. In the end, it is a judgment call between those two things as to which unfairness you think is greater. As Sir Andrew Dilnot said, this is an uninsurable risk in the private market and there is an absolutely clear role for the state to protect those in greatest need. A cap on care costs seems to be an appropriate place to start. It does not rule out some elements of free personal care going forward, if you want to do that, but it would correct a major fault line in our system. We could do it quite quickly because it is already the legislation of this country.

Q38 **Barbara Keeley:** You talked about a very important thing as being the workforce and paying the living wage, and I agree with you that 5% above the national living wage does not really give us career progression; and people who work in care deserve that. We heard in terms of Denmark how important the training was. It was more of a health-based training.

Skills for Care has a pretty derisory budget in this country. It is £28 million. Health Education England has a £4.9 billion budget. Shouldn't we be including a line in all our modelling that gets us away from that absolutely derisory position for training and career development? Shouldn't we be looking at spending billions on our 1.5 million care staff?

Anita Charlesworth: The workforce issues are absolutely critical and almost more important than some of the funding issues. The funding issues create a window for the workforce issues to be addressed, so they are connected.

There are a couple of things to say about that. Only half of the social care workforce have a relevant qualification, and that is hugely linked to the very high turnover. We need to make sure that we have the budget, as you say. Also, we need to stabilise the workforce. The progression point is also very important, because if there isn't a career in social care that people can see, they won't train.

The Prime Minister recently mentioned that one of the things the Government are interested in is guaranteeing apprenticeships as we come out of Covid-19, with the worry about the increase in unemployment. The number of apprentice starts in social care actually fell by 50% in the last year, so we need to look properly at making it a career. That is about training and budgets for training. It is also about staffing structure.

We need to think about whether all of that is enough or whether it might be time for us to have a proper look at considering making it a registered profession. A lot of the options are quite difficult in a fragmented system without any register. There are issues associated with a register.

The Government have committed to an NHS workforce strategy, but not a health and care workforce strategy. There is no care workforce strategy. The Department of Health and Social Care at the moment, as I understand it, has no plans for a social care workforce strategy, but we desperately need one that looks at all the issues really well and aligns training, budget, the pay situation and career pathways.

Q39 **Dr Evans:** I have a question for Anita, and then George. Governments of all colours and all persuasions over the last 20 years have struggled with the concept of dealing with social care. Matt Hancock sent a letter to all MPs just after Christmas asking for ideas. I want to throw it open to you guys.

If you were to design a system straight off the bat from tomorrow, given everything we have heard, what would you design to fund it, and how? I am looking for some ideas and concepts. I appreciate that you have talked about the position in the Care Act, but how do we fund this? What would you say off the bat, from your experience, is the best model?

Chair: Before you come in on that, the House of Lords and the House of Commons decided to have one-minute's silence in memory of George

Floyd at 11 o’clock. To make it easier, I am going to suspend the session now. We will start again, with both Anita and George having the chance to answer Luke’s question when the suspension has finished.

A one-minute silence was observed

Chair: Luke, would you re-ask your question for Anita and George, so that we can all remind ourselves of the line of inquiry you were following?

Q40 **Dr Evans:** You have had a couple of minutes to think about it, Anita and George, and no doubt will solve the problem for us. My question was, if you were to redesign the system from a financial background starting straight off the bat, what would you choose and why?

Anita Charlesworth: I want to argue that we should focus on four different areas: funding, regulation, commissioning approach and workforce. We need to look at all four as an integrated programme.

The funding side, as I identified, is the role of the state. Fundamentally, the balance between the individual and the state is tilted too much to the individual, so it is unavoidable that there needs to be more public funding of the core system, as well as a Dilnot cap. In terms of how you raise that, there are some real choices about the extent to which you fund it purely from general taxation or whether, in the model of some other countries—Germany and Japan spring to mind—you have something more ring-fenced in national insurance or whatever. There is a very legitimate and important debate to be had.

On the commissioning front, as I said, there is a real need to align the way we commission social care with the vision set out in the 2014 Care Act. At the moment, because we just treat it essentially almost like widgets and numbers of parts, and so on, we design out innovation in the system. Cost-cutting is the enemy of efficiency and innovation in the long run. We need a long, hard look at that as well.

There are real questions about whether it is an under-regulated sector. We ought to look at the regulatory framework. On the workforce, we would model to professionalise the workforce to recognise, develop and accredit the skills of those in the system, and reward them.

On integration with healthcare, all the evidence shows that budgetary integration is not the way to deliver real service. It is integration wrapped around the individual. Things like integrated training are probably much more important than integrated budgets. In the workforce, I would think a lot about how you create common skillsets and common cultures—the issues that ultimately deliver what feels like integration to the individual. Integrating the budgets of a local authority and a health body very rarely leads directly to individuals feeling that it is a joined-up system.

George Stoye: I want to touch on Anita’s first point, which was about funding. I would argue very strongly that it should principally come from broad-based taxes. There is discussion about hypothecating tax—having a ring-fenced social care tax. I guess we do not really do that for most other parts of Government spending. There are some downsides.

You can have two types of hypothecation. First, you could have a pure hypothecated tax where you raise a set amount of money and say that whatever you raise will go towards funding a particular service. For example, if you raise £20 million through the tax, that is what you have to spend. That has limitations in the sense that you are tied to what you can spend based on what you raise. For a long time, people spoke about hypothecating national insurance contributions to make that pay for the NHS. In 2008, the revenue and the spending were basically equal, but shortly after that revenues collapsed, as part of the crisis, while spending kept going up for the NHS. You would not have that flexibility if you had a purely hypothecated tax.

You could, instead, have a partially hypothecated tax, where you tell people that at least some of the money is going towards that. The problem is that you cannot really tell how much is spent on something from a partially hypothecated system. We saw that in the early 2000s. Gordon Brown announced increases in national insurance to fund the NHS, but of course we had much bigger increases pretty much across the board, so it was not purely funded by the national insurance rises.

Instead, what we think might be a bit more sensible is to use broad-based taxes, thinking specifically about VAT, national insurance or income tax, which is where we raise about two thirds of our revenue. Again, there are pros and cons of raising money from those different taxes, but it would allow you to trade off those things and to raise money in a way that is sustainable and affects lots of different people.

Q41 **Dr Evans:** One of the big successes, you could argue, was auto-enrolment with regard to pensions. We just heard Anita mention the Japanese model and the German model, and there is potentially a debate and an appetite around exploring that. Do you guys at the IFS have a view as to whether a sensible solution is grading it through auto-enrolment for social care? Do you have any thoughts as to how that would work, both the pros and cons?

George Stoye: I have to admit that I have not thought about it exactly. You are talking about an auto-enrolment system for an insurance fund for social care.

Q42 **Dr Evans:** Yes, or feeding in. Anita, do you want to come in on that? As a general concept, is it a possible halfway solution that could bring everyone together? It has been mentioned a few times, and I certainly get asked in my GP role, “Why don’t we do this?” Patients ask me and it seems a solution.

Anita Charlesworth: The German system is now both employees and employer. I think they pay 2.25% of wages into an insurance fund for what we would call social care. They started that in 1995. It started at about half that rate and it has evolved. It also builds off all the infrastructure of social insurance that they have in Germany, because that is how they organise their healthcare system.

You can look at Germany and say there is an awful lot to be said for that system. People are very clear about the principle, and what they are paying and what they get in return. They like that, and as care needs increase, they raise the premium. People understand why it is being raised and what is involved. All the social partners contribute.

We do not have that tradition, so we would have to create the infrastructure a bit more, unless we tried to adapt the national insurance system to it. The other thing is that it would fall quite heavily in our system of national insurance on those of working age, who already have a lot of burdens, particularly after the 2008 recession. If we are about to come out of Covid with an economic shock, would we want the current generation of older people to contribute as well? It is not very easy to do a lift and drop from that system.

I understand that the economists' arguments against hypothecation are well made and important. At the same time, one of the potential barriers to reforming social care and getting people to agree to spend more is lack of trust and confidence that money will flow to those important priorities, such as trying to create a system that is adaptive. It is not that we just have a problem with social care, we solve it and it goes away. Our needs for social care will constantly change. We need a more adaptive system so that we do not have a kind of reform in one period, take our eye off it for 10 or 20 years until it reaches absolute crisis point and then have an emergency response again.

Anna Severwright: I would like to comment on a couple of things. People my age do not really value social care, understand it or think they will need it. Asking them to pay into an insurance scheme would be quite challenging, and a lot of people would not want to do that. Then there are children with disabilities who are perhaps never going to be able to pay into a scheme. One concern for me would be that you end up with a two-tier system, where people who have paid in more get a better service than the people who have perhaps not been able to pay in.

A final thing is that I think a wider tax is better than a separate tax. In recent years when our council tax letters come through, they say that council tax has been put up because of social care; all these people are costing us all this money for social care. It almost puts the blame on to people like me or older people, who need care through no fault of our own. If it comes out of general taxation, there is less stigma attached to needing social care.

Q43 **Dr Evans:** Anita, could you give me a one-word answer to this question? Out of all the countries, from all your information, if you had to go into care, which country would it be?

Anita Charlesworth: Probably a Nordic.

Dr Evans: Thank you.

Chair: Dean has to go to the Chamber, so he will ask his question now.

Q44 **Dean Russell:** My question builds on the previous one. One of the things I am very conscious of is that in the commercial world a lot of effort is put into the concept of the single customer view, following the pathway right the way through for the customer. The data, the care, the support and, in that instance, the sales follow the customer all the way through.

One of the things that seems to have come out today is the fact that things are so disjointed, and there are so many silos within and between the health and the social care space. I am interested to know whether any studies have been done around the savings that would be made by putting a more technical data-driven solution in place around producing a single customer view. Do you have any thoughts around improving care in that way?

Anita Charlesworth: George can say quite a bit about the potential for savings as we better integrate and align health and social care. I will leave that to him.

I am not aware of any studies in that regard, but one of the things that is clearly coming from the Covid-19 experience of social care is that there is a very important role to be played by technology, and harnessing the potential of technology and data analytics. The data is weak, so we do not understand or know properly where our sources of inefficiency are or where there is potential to significantly increase value. Going back to an earlier question, I was absolutely remiss to overlook technology and data in the reform agenda. It needs to be there as well.

Q45 **Paul Bristow:** I have two questions: one for Anna and one for Anita. Anna, I thought you were an excellent witness. You have given us a real insight into what it is like for working-age adults in the social care system.

There are two things. I was really interested to hear what you said about incentives for saving and that you have no incentives for saving. Presumably, lots of people would have the same ambitions as anybody else about wanting to own their own home and to provide for any future family, and so on. I want to understand what you feel might be done about that, rather than simply just paying for it all through general taxation. Do you feel there is any sort of system that could be put in place to try to incentivise savings among working-age people with disabilities?

Secondly, you told us about the personal independence payments and that you feel that, as funding has been tightened, local authorities are now trying to control what you are able to spend personal budgets on. Why do you feel they are doing that? What is their incentive to do that?

Finally, after Anna has spoken, I am interested in the commissioning side of home care and your thoughts on that, Anita. What attachment are commissioners or local authorities putting on value over price, in your experience?

Anna Severwright: With regard to savings, I am not sure I can solve that for you. I have had genuine conversations with my family that at some point I will probably inherit half a house. That money will go completely. I would become completely a self-funder, and that money will be spent on social care.

Some people might think that is right and some people might think it is wrong; I don't know. If I was not having social care and I inherited half a house, I could think about investing that money and doing all sorts with it. Obviously, if I spend it very quickly—I don't know on what—it would not go on social care. For me, there is some sense of inequity. Perhaps the only thing that could come in, if we are still going to contribute to care, is some sort of cap, so that once I have spent £40,000 in my lifetime on care, any money I then save, inherit or earn would be mine and would not be touched for social care. Perhaps that would be fairer. I do not have a great answer, I am afraid.

On direct payments and the sense of control that the local authority seems to want to put on them, I hear the term a lot, "It's Government money." It is the mistaken idea that because it comes via the state they are responsible for it, and they do not trust me as an adult to be able to make decisions and say, "Okay, this is my life. I am employing PAs. I want to do this, this and this, and this is the best way for me to meet my care needs." It is treating us a bit like a child and saying, "We need to see everything you use it on."

I think they are also trying to make sure that they can claw back any that you do not use, which is fair enough. For example, I am not allowed to use PA hours or social care money on collecting prescriptions, going to the GP or going to hospital appointments because that is a health need. Of course I do—I hope they are not watching this—because in reality how else am I going to get to the hospital appointments that keep me well and reduce my need for future social care to increase? That is the kind of example of the silly rules that a local authority has put on how you use your social care.

It does not make any sense, because if I stop going to GP appointments and stop going to my hospital appointments, my health will get worse and my care needs will increase, and then I will cost the system more money. I feel it is just a sense of control for them. It is a sense of fear of what we will go off and do—that we will start spending it all on massive TVs or something. I really do not think we would. It costs them a lot of money to do all of that monitoring. They would be better off saving that money and trusting us a bit more to get on with our lives.

Paul Bristow: Thank you, Anna. That is very persuasive.

Anita Charlesworth: At the moment, there is relatively little innovative contracting going on. Most of the contracting for home care is very much aligned with the fact that the care planning approach, as Anna described earlier, identifies a series of tasks that the system deems are eligible. Then it works out the minutes for the duration of those tasks and contracts for that number of tasks of that duration. That is the primary model of contracting for home care. That is then passed through to the workforce, who also get an employment structure and system around that, which is about them performing a certain number of tasks. Then there are all the disputes about travel between, and all those issues.

There are some international examples of people trying to do much more innovative things. There is an example in the Netherlands, which the King's Fund did a very good case study on, of an integrated social care and nursing model in the community. That has a budget for a staffing allocation, and then they determine what individuals need. The workforce deliver that without all the—*[Inaudible]*—"I'm a nurse, so I can't help with your meal," or, "I'm a social care nurse and so I can't do this."

There are some international examples. There are a couple of parts of the UK that have been piloting some of those models, and I think the King's Fund has been working to evaluate some of them. They are worth a look.

Q46 **Paul Bristow:** Anita, do you feel it is possible to develop a system where you can commission for outcomes rather than for activity, which is what you are describing?

Anita Charlesworth: That should be the ambition. One of the things that the Government should set themselves as a task is to answer the question of how we would do that. How would we get as close as we possibly could to that? What they need to do is to start with the principles in the 2014 Care Act and the outcomes and approach that that sets out, and then say, "What is the commissioning model that is most likely to help us get to that?" rather than running things in parallel. We have the ambitions of the Care Act and then we have a commissioning model, and it does not feel like the two can come together and meet.

Q47 **Rosie Cooper:** Anita, I have always believed that we can find solutions to social care issues. The big question we find difficult so far, if not absolutely impossible, is who pays. That results in a very poorly resourced sector. In your evidence, you described the current underpayment of care providers. What impact does that underpayment have on care providers and on social care users, and how much would it cost to put right?

Anita Charlesworth: The evidence that we have is from the Competition and Markets Authority in relation to care homes. They estimate it at about £1 billion. We also have some data from the Homecare Association. Its estimate is that, pre Covid-19, on average local authorities were paying about £17 an hour for home care, and the cost was closer to £21 an hour. I think they estimate that it would be about £1.5 billion to close that gap.

Covid-19 will have added to people's costs. One of the questions around that is whether it is a short-term or long-term addition. Will social care staff need to wear PPE in a different way in the long term, in which case their costs would rise? The other thing we do not know about residential care is whether bed occupancy rates will recover, or will we have a sector with lower occupancy because of infection control and because of some people's concerns around social care? That will add to costs if we want to keep the sector in a similar configuration to today.

Q48 **Rosie Cooper:** Over and above the funding needed to fix the current problems that you have just described, Anita, we know there are lots of different options that will address the broader problem, especially the means-tested system, which leaves catastrophic care costs. I know that because my father was receiving care for about three years. Of the models where you know the costs, which would you favour?

Anita Charlesworth: The Dilnot cap. The Dilnot cap does not require us to throw out our current system, which has huge consequences in deliverability and transaction costs. It allows us to address one of the most egregious issues in our system, which is that individuals in the greatest need bear that catastrophic cost.

It is a building block. I think of social care, to some extent, as a form of Lego. You put it in, but it does not preclude you from doing other things if you want to. If you want to make more personal care free at a later stage, when as a society you feel that you have some money you would like to devote to that, you can do it. It is a first step, but it is not an alternative to some of the other options. It facilitates those as well.

Chair: Thank you very much indeed. Social care is a huge issue, but we have made a very good start in this morning's session. We are going to have Sir Andrew Dilnot and, indeed, Skills for Care coming in and talking at subsequent sessions.

That brings to a conclusion this morning's session. A very big thank you to our witnesses. In this section, we heard from Anita Charlesworth and George Stoye, who have given us their expert evidence, and we are very grateful for that. Most of all, I thank Anna Severwright for her very powerful testimony, and before that Daphne Havercroft, who also gave extremely powerful testimony about the issues she had accessing social care for her mother, Dorothy.

Thank you all very much for joining us. Thank you to my colleagues on the Committee and the technical team in the House of Commons. That concludes this session.