

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Wednesday 10 June 2020

2.55 pm

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Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hogan-Howe; Lord Hunt of Kings Heath; Baroness Pinnock; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

Evidence Session No. 3

Virtual Proceeding

Questions 19 - 26

Witnesses

I: Sarah Pickup, Deputy Chief Executive, Local Government Association; Saffron Cordery, Deputy Chief Executive, NHS Providers; Kate Terroni, Chief Inspector of Adult Social Care, Care Quality Commission.

Examination of witnesses

Sarah Pickup, Saffron Cordery and Kate Terroni.

Q19 The Chair: Good afternoon, everyone. Welcome to our second public evidence session. There is a fascinating group of topics and witnesses today. I thank our witnesses for giving up their time to come and talk with us.

In the first session, which I estimate will last just under an hour, we want to look at where the public services are as regards collaboration among care, health and community services, what lessons for regulators and commissioners are coming out of this, and generally what our witnesses have learned about their own organisations, their collaboration, the challenges that has thrown up and what we are learning about how our public services have operated during this period.

As witnesses answer their first question, we should be grateful if they could introduce themselves and say where they are from. In our first grouping, we have three witnesses: Sarah Pickup, Saffron Cordery and Kate Terroni.

As ever, it comes to the Chair to ask the first question. What have been the main areas of public service success and failure during the outbreak? How do you think these lessons will shape, and could shape, our thinking for the future reform of the public sector?

Sarah Pickup: I am deputy chief executive at the Local Government Association. I have been there for about five years, and I worked in a council for about 27 years before that, 30 in total.

I will outline some successes first. Some of the successes, working between health and social care, were initially around the discharge to assess process—the arrangements to ensure that hospital beds were cleared to cope with Covid patients. Many barriers were removed. Relationships between health and care rapidly improved in areas where sometimes they had been difficult before. Local flexibilities meant that solutions could be found. In addition, 132 council-led hubs were set up very quickly to inform, advise and offer support to the public. Those things went well.

There has been significant redeployment, use of volunteers and links to voluntary organisations, particularly in relation to shielding and support. I want to highlight the local efforts to what we might call “right the ship” in relation to PPE, testing and food deliveries, where sometimes the initial national arrangements did not seem to be working. People pulled the stops out locally to work on that.

As to where there have been issues, I would highlight the lack of focus on social care in the first instance. The priority given to the NHS was completely understandable, but, in a sense, we needed equal priority for the care sector because we ended up with a crisis in one place, followed by a crisis in another setting. There are some lessons there.

The processes around some aspects have been a bit chaotic. The processes around the care home support plans and the £600 million infection control grant have been less than ideal, with things coming out in dribs and drabs and some quite rigorous conditions and limitations on what can be done. There are a few cross-government issues on data sharing and so on.

Finally, the crisis has laid bare the state of the social care sector and the challenges of delivering in a very diverse and dispersed model of mixed private and public sector delivery. In addition to the social care issues, what has come to the fore is health inequality and the need to focus on public health and prevention. We have found that areas and people who have been left behind and experience health inequalities have been more prone to the virus. We certainly need to think about that were there to be a second wave, and for the long term.

Reform of the funding of social care is an absolutely vital priority going into recovery.

Saffron Cordery: I am deputy chief executive at NHS Providers. I have been working in healthcare for around 10 years. Before that I was in local government at the Local Government Association.

At NHS Providers, we represent all 217 NHS trusts and foundation trusts across four sectors: acute, mental health, community and ambulance services. From our perspective, we would look at this in a couple of ways. The NHS has done a remarkable job in creating a huge level of capacity in the face of a pandemic. If we look at what the NHS has stood up in creating additional capacity, there are 30,000 new ICU beds to deal with the surge of patients. There are 30% more ambulance vehicles in the fleet; we have dealt with 105% more calls and incoming 111 services. We have created mental health A&E services, 24/7 mental health lines, et cetera, to take the burden off acute trusts.

An enormous amount was done to create additional capacity at the beginning of the pandemic, when it looked as though there was a risk that the NHS would be overwhelmed. That came in the wake of what we had seen in Italy. Alongside that, we have seen quite a lot of standing down, as well as standing up, such as the shifting of day-to-day routine appointments, stopping planned surgery and, as Sarah mentioned, discharging medically fit patients. Discharge to assess was implemented at astonishing pace and, overall, with astonishing success. The NHS and its partners have done a huge amount to create additional capacity and step up services.

However, there have been some huge challenges, some of them completely unforeseen. Among the challenges has been the lack of a successful testing regime so far. We could have done a whole lot better, which would have made it easier for the NHS front line—and all the public sector, frankly—as well as local communities and the public. We came to it way too late and we did not have a comprehensive plan.

Personal protective equipment has been a big challenge. It has put us in a place where we have had to deal with some very difficult situations. There have been issues around distribution and changing advice. There have been issues around how we manage the levels of risk that we face across all our services.

The final challenge—I concur with Sarah—is around care homes and what has happened in care homes. Come any public inquiry, we need to look at what happened there.

One lesson that we have definitely learned is that we need both better strategy and better planning on some elements. Testing is a case in point. Recent experience from the provider sector is that we need better consultation and engagement with those who actually roll out the plans on the ground. Last Friday, things were announced about changes in visiting times and changes on the wearing of masks for all NHS staff in hospitals. That came in without any prior consultation with those implementing it. That is not acceptable; we need to work with every part of the system that is implementing the plans. Every part of the system is

involved, and every part of the system wants to do their best, but right now, without consultation and engagement, that is very challenging.

Kate Terroni: I am chief inspector of adult social care at the Care Quality Commission. I have been in the job for about a year. Prior to that, I was director of social services for a large county council.

During Covid we have seen some excellent examples of innovation. We have seen joint working and providers coming together to respond to the changing circumstances in an exceptional way. I absolutely recognise the efforts of the health and social care workforce in getting to this stage.

Going into Covid there were significant issues, particularly in social care, that have made it even more remarkable for us to be at the point we are now. Last autumn, in the Care Quality Commission *State of Care* report, we flagged the urgent need for long-term funding resolution for social care. We also talked about the challenge for our workforce, particularly in social care.

Skills for Care tells us that, before Covid, there were 122,000 vacancies in the social care workforce and turnover rates running up to 37%, depending on the role. That was pre-Covid. Our *State of Care* report found very variable integration around the country. From work we did a couple of years ago, when we looked at systems, we know the conditions for good joined-up working and, therefore, good outcomes for individuals. They are things such as strong local leadership, a clear vision, good understanding of the local population and how to prioritise resources accordingly.

As we have gone back over the last week to talk to local system leaders—directors of social services and chief executives of health trusts—the same components have been there. The parts of the country where there is strong understanding of a local population's need and the ability to move resources around to respond to a crisis, as well as good involvement of the people who use services and their families and the voluntary sector, have been the places that have been able to rise to the challenge, in comparison with others where those conditions have not been in place. Going forward, I am keen that we continue to see that integration, and we need to accelerate it across the country. As I say, there have been some fantastic examples. It is important that we do not stop focusing and that we find a resolution for long-term, sustainable funding for social care.

What has been great about the last 12 weeks is the rising profile of social care and the social care workforce. We are finally starting to hear about social care workers. They are talked about with the same sort of parity of esteem as our NHS workers, who are also fabulous. How do we ensure that that carries on, and how does it translate to improved career structures, terms and conditions, et cetera? There is a real opportunity for us to take some of the positives of the crisis and ensure that that becomes our long-term way of working across health and social care.

The Chair: Thank you all. One of the big issues is how regulators and, indeed, those who are thinking about different ways of doing things actually make sure that integration works in the right way in each different place. There is a huge issue around commissioning and integration. We have not sorted the legislation out, but it has been an issue on the ground. Maybe we can come back to that.

Lord Filkin: This is a question for Sarah. Saffron was very clear that, apart from the many good things that were done, one of the things that was not good enough was the way central government consulted and involved other crucial parts of the response to the crisis. She instanced that from the perspective of the NHS. Sarah, you did not mention anything about how central government worked with local government. Did that imply that it was all fine?

Sarah Pickup: No, I am afraid it did not. We have been talking to central government departments all along, but particularly where there have been areas of work that cross government department responsibilities, such as shielding, we had some difficulty. We were getting different announcements and different lists and requirements from different parts of government, and they all had to be sorted out at local level.

In particular, I highlight the recent discussions about the infection control grant and the care home plans. Guidance came out in dribs and drabs. One of my colleagues said it was like trying to construct a piece of Ikea furniture with a piece missing and the instructions being posted daily in bits and pieces. It was really difficult.

We have been able to influence through discussion some of the policies that went out, but on the infection control grant we know that the biggest cost for the care providers is personal protective equipment, yet providers are not allowed to spend the grant on that. They have to spend it on staffing. There are very rigorous requirements about the information councils must collect in order to give any of the second tranche of grant at all. We do not think that is right, and we have not been able to get our message across on that.

In places, it has been good, and we have had some influence. We have also had experience, although not so much in the health and social care sector, where announcements have been made that, "People must go back to work on Monday", or "Schools will happen then", without thinking of all the preparation it takes to put those things in place. That is very similar to the things that Saffron said, but with differences in different areas.

Lord Filkin: Did you have any clear structural involvement in policy and implementation planning, or was it episode by episode?

Sarah Pickup: There is some structured involvement with different departments. There are some political structures in place with MHCLG, and some officer engagement on the financial arrangements. With DHSC, we have regular meetings with both Ministers and officials. There is a

twice-weekly meeting between the LGA and social care providers and the departments. There are some structures in place, but it does not mean that we are not sometimes taken by surprise.

- Q20 **Lord Young of Cookham:** I want to ask about the integration of health and social care. I was interested to read paragraph 30 of the evidence we had from NHS Providers: "Covid-19 has accelerated innovation and collaboration across the healthcare system". It went on to give as one of the reasons reduced governance requirements. Could we dig a little deeper? Exactly how has the crisis encouraged greater collaboration, and what are the implications for governance and accountability?

Saffron Cordery: As our evidence says, we have seen a speeding up of integration, collaboration and innovation. One of the best examples is probably discharge to assess, which we have seen working incredibly well. It is speedy discharge of patients who are medically fit from hospitals to a care setting or with a care package. That has worked incredibly well.

It happened so speedily because a number of the elements that slowed it down, such as continuing healthcare payments, were completely suspended. Where there were plates grinding between the different bits of the public sector—between health and local government in this circumstance—they were completely removed, and we have been able to get on with things.

One of the elements that comes into play is the fact that we are reflecting on the coronavirus pandemic. We are in no way through it yet, so let us remember that; if you talk to my members, we are still in the middle of it. The coronavirus pandemic has made us focus on making things happen quickly, and not having financial considerations, for example, as the first thing we must think about alongside other elements. That is not to say that people are not being careful. They are, of course, being careful, but they are thinking, first, about what they absolutely have to do to put in place the capacity to make public services work as effectively and efficiently as possible to move people to the places they need to be, to manage the surge in coronavirus patients.

I do not want this to sound as though people have just been throwing caution to the wind, because they have not, but they have definitely focused on doing what they need to do within their professional competence in order to make things happen. It is about not seeking permission but asking forgiveness. That is one of the critical changes we have seen. It has had to happen. There have been no choices around that.

Your point about governance and accountability is well made. We are operating in a crisis at the moment. There are appropriate checks in place. It is not that everything is happening without trust boards, for example, being aware of or assessing the risk. There has been a greater degree of autonomy and flexibility afforded to individual organisations

and individual teams and departments in those organisations on a “needs must” basis.

I cannot stress enough that there has been a huge amount of co-operation in the way trusts, in particular, have been operating, and other local partners, too. The mutual aid between local organisations is absolutely astonishing. A lot of it is because factors that usually come into play, such as financial settlements and who is the leader or the primary actor in a particular patch, have gone, and we are focusing on getting the job done.

I am going to put in a “however”, though. Some changes that have been made, probably very fast, might not be undone, and they could probably have benefited from local consultation and engagement. We have seen some changes across London in reconfiguring services and putting specialised services in one place, for example. That is probably a major change, and it could have an impact on longer-term service delivery that may benefit from public engagement. It has been done on the basis that we need it for now but let us make sure we go back and review some of those decisions.

The Chair: Thank you, Saffron. Does anybody want to add anything?

Kate Terroni: We published a report a week ago about 300 examples of innovation around the country. One of them is a hospice in Essex, which expanded its reach during Covid, and worked with GPs, community teams and care homes to provide an enhanced offer around bereavement support, advanced care planning, et cetera.

Innovation is happening. It is about how we capture and keep the stuff that has worked well, and how we learn from other things that have happened quickly. I echo what was said about the efforts that enabled the discharge to assess model to achieve what it achieved. We still do not fully know the implications as regards the long-term impact on care homes. It is critical that we keep evaluating decisions and activities that happen at pace so that we fully understand what they mean for people who receive services.

Sarah Pickup: The discharge to assess model is a good example of what has happened; the necessary powers and funding were put in place to enable local areas to get on and do what they have actually aspired to do all along. Discharge to assess was something we were aspiring to do regardless of the crisis, and it has taken away the barriers that stopped us doing it. That is important. Sometimes people are on a treadmill of monitoring and reporting upwards. Freeing local areas to make things work together has helped them to move on in leaps and bounds. There have been changes in both health and care.

My note of caution would be, inevitably, about the focus on personalisation when you are working with speed, and about safeguarding. We need to look at that very hard. We want to keep what is good, but we may need to put a few of the particularly person-centred

checks and balances back in place. I am less keen on putting back the checks and balances about reporting upwards than the things about individuals.

- Q21 **Baroness Wyld:** Can we examine more closely the experience of the end- user in all of this—the person receiving the services? What can we learn for good or for ill about the ability of public services to collaborate in order to deliver the person-centric approach that Sarah began to talk about?

Kate Terroni: Sarah made the valid point that, where things are happening at speed, the absolute focus on individual choice and control has possibly become secondary, and it is critical that we get it back. It is an evaluation piece; it is understanding, as we catch a little breath at this point in the pandemic, what the experience has been like for people who receive care.

When we regulate the quality of care, our focus is absolutely on people getting person-centred care in a way that is delivered to meet their needs. It is essential that we keep that focus on the ability of services to provide joined-up care to support the individual.

Sarah Pickup: What the crisis has shown is that, when empowered to do so, local areas can collaborate to deliver change quickly and efficiently. However, we need to channel that differently going into a non-crisis situation, to collaborate to deliver personalised care. It is directing what we now know we are able to do quickly and well to deliver something slightly different.

Even through the crisis, the aspiration of discharge to assess that 95% of people over 65 are discharged to their own home is a good first step in making sure that that care is personalised. If you go to your own home and are assessed there, you have a much better chance of being able to stay there and have a personalised solution put in place. I am quite sure that we do not have that exactly right. I am quite sure that there have been instances when people may not have ended up in their first-choice location because we were working quickly and at pace. We are demonstrating the ability to work together to deliver, and we need to refocus that on the individual.

Saffron Cordery: What we also need to look at in personalised care has been our ability during the crisis to continue with a number of important services—for example, what is provided by mental health trusts and others in maintaining as far as possible the appointments and consultations that are absolutely critical for the people using those services. There has been innovation in switching quickly to digital consultation and digital therapy, and the 24/7 crisis lines that have been put in place for mental health. They were a long-term aspiration, so that is really helpful.

We need to think about mental health accident and emergency, which is also important. I think someone mentioned this element earlier and it is

an important focus. We talk about personalised care, but certain groups may have been overlooked in the pandemic, and, from my perspective, children and young people sit there. There is a whole host of life chance issues such as education. More broadly, safeguarding for children and young people is a particular concern. The number of young people accessing mental health services, for example, has dropped dramatically. We need to think about what that means for them and their future.

Q22 Baroness Tyler of Enfield: Looking ahead, but making sure that we learn the lessons from the pandemic so far, do you think what has happened calls for new ways of working between health and social care? I am particularly interested in whether you think shared targets from the Government and different accountability arrangements, such as pooling of budgets, would facilitate a new way of working together.

Sarah Pickup: First of all, I should declare that in local government we are not particularly in favour of top-down local targets, whether shared or not. Top-down targets can have perverse implications, like the delayed discharge target that has been around for ever. We have dealt with it through discharge to assess now, and it is no longer a problem, but of course there are lots of people not going into hospital so it could recur. Nevertheless, it diverted resources away from keeping people out of hospital and supporting people in the community. It was not necessarily putting the resource where it could have maximum impact.

The key is that local leaders should have the space, powers and funding to develop local services. In our discussions with ICS and STP chairs, they say that the work the NHS had started on system by default, which is that we need to work at a lower level than the national level, was something they are keen to continue. I do not know if you have come across that. Many of them were already there and had seen the value of engaging properly and equally with local government in local systems. Some of it is about building on what was already there in some places.

Pooled budgets have been around for a long time. We probably need more of them, or at least aligned budgets, and we certainly need joint decision-making and joint commissioning for community services. In every place, we need primary community and social care infrastructure to prevent the escalation of needs, for both health and social care.

Picking up on Saffron's last comments, we must not lose some of the benefits we have through digital consultations and things that can free up primary care time to help support people in communities and prevent hospital admissions.

Kate Terroni: Local system leaders being held to account locally is a very powerful way of getting change. When CQC did system reviews back in 2017, we went into places where there had been historical pooled budgets and joint commissioning arrangements. We still found that people's experience of health and social care was fragmented, disjointed and often confusing.

I was on the receiving end of a system review while I was a director of social services back then. There was something about our local health and well-being board holding me as director of social services and my health chief execs to account in CQC's findings about how we worked together, to ensure that people had a seamless experience of how health and care is delivered.

There needs to be adequate funding, but we have a lot of things already in place. We need to continue to see how system leaders come together with a focus on their local population and local accountability to ensure that they are responding to the needs.

Saffron Cordery: I would differentiate targets, regulation and accountability. Targets so far have been top-down. We are not talking about locally drawn targets that a local system agrees it is going to achieve. At the moment, we are talking about national level performance targets, not even outcomes. That is probably where we need to go.

Casting my mind back 15 or 20 years, we used to have the notion of the loose-tight approach in how we organised public services to achieve the outcomes we wanted. Perhaps there is something to learn from that in this crisis. We have been able to speed along some different ways of working, which have been freed of the shackles of targets for a little while. There is something interesting in that.

Targets certainly skew behaviours. I am not totally against targets; they can be a very helpful measure, and what is measured matters. At the same time, they skew behaviours and priorities on many occasions. We need to think very carefully about how we are measuring, and whether we are looking at targets or outcomes. Our current testing process is a good example of looking at a target—100,000 tests a day—without having any intention behind it as to the value of those tests and how they facilitate what they need to facilitate.

Lord Hunt of Kings Heath: I get the fact that our witnesses do not like targets very much. I understand that. I used to be Minister of targets for the Department of Health once upon a time, and I still feel that they have some value.

If not locally, is there benefit in central government going back to what we had, which was targets that joined different departments together? It was an attempt to get more cohesion at central government level so that it avoided conflicting targets, funding systems, et cetera, when they came down locally. Do our witnesses have any views about how central government could help them collaborate in the future?

Sarah Pickup: A lot of focus is put on local systems working together. As I indicated at the beginning around the different messages coming from different central government departments on things such as shielding, it would be good to have the example set at central level.

I would never say, "Don't have any targets", but we should think very carefully about what they are. Do not have one thing that contradicts a target somewhere else. Do not have a DWP target that conflicts with something that the DHSC set. Use them very carefully and with caution. It is far better to have local targets that are closer to local delivery and save national targets for things that need national targets, not for services for individuals at local level.

Saffron Cordery: We definitely need the alignment that Sarah talked about. It is also about making sure that when one bit of policy is being developed—such as system working, which is incredibly important—we bring our other agencies and regulatory bodies along more quickly. It is not the fault of those bodies; it is the legislation that controls them. If system working is coming to the fore, we need system-wide regulation potentially to support it, if that is the way we are going. If we are still focused on an institutional model, institutional regulation works, but regulating apples by using pears does not work very well. It is very tricky for the individual organisations that are trying to work within multiple regulatory frameworks.

The health service is used to working in an incredibly complex and highly regulated environment, but overlaying it with different types of regulatory framework and different policies that move in different directions is not helpful. With a whole set of national targets on top of that, it is incredibly difficult, as you know, having chaired a trust.

Kate Terroni: Our previous system reviews found very few incentives for system working in the way that CQC currently regulates health and care providers. Currently, we hold a GP accountable for the safe delivery of the policy of care in their practice, an acute trust for theirs and a home care agency for theirs. Thinking about how we might want to regulate differently going forward and take the learning from this situation, we are interested in placing increasing emphasis on how, as well as running your bit of the system well and delivering high-quality care, you work within your system with other providers to ensure that people get joined-up care. That is something we are keen to move forward on.

Q23 **Baroness Pitkeathley:** Thank you for anticipating my question, which is about system-wide regulation. Saffron has already given her opinion about that. A couple of you indicated that people have been more willing to take risks, with less emphasis on reporting. Would a system-wide regulatory intervention enable us to continue with safeguarding while making it more efficient? If not, do you have any other approaches to suggest?

Sarah Pickup: Local government, with the exception of some services, has not been heavily regulated by a regulator in recent years. We have been operating a sector-led improvement approach. The LGA operates with councils to run peer reviews. We do improvement work with councils. More recently, in the last year or so, we have been working with NHS Confederation, NHS Providers and others to put in place peer

reviews across health and care systems, and to take a cross-sector approach looking at outcomes and what we need to do together.

We would start from the place that advice from your peers and other places that have achieved learning from good practice is what will help to deliver an integrated approach. I endorse what Kate said about the system reviews, which I think were useful, partly because they were not inspections. People did not have to put on their best coat and parade in front of the inspectors. They could say, "Gosh, they are here to help, and we can find out where we need to go to improve. Which bits of our system are rubbing up against each other and what do we need to change?"

There is a need for a system-wide approach. I would stop short of saying that it should be through formal inspection across the board. A bit like targets, that can have perverse incentives. Improvement support is really important. I would not say that we do not need regulation of care provision; it is important where we are charged with the safeguarding and care of individuals in hospitals and care settings. Those settings are regulated and that is different from working a system for outcomes. We should not think about the two as the same thing.

Kate Terroni: We will always need to hold providers to account for their individual delivery. We know that what matters to people with complex needs is how well their care is co-ordinated around them. Can you be an outstanding provider if all the other providers around you are falling apart and delivering poor quality care? Should there be increasing emphasis, if you are an outstanding provider, at looking outside your place and saying, "How am I working with the local community health trust or the local care home to ensure that they are also providing good joined-up care?"

I do not think it is about targets or inspection. In our unique role of having an overview of health and care across England, we can hold a mirror to local places and say, "This is what the data tells us. Show us how you are working with your local population to understand their needs and design services and deliver them in a co-ordinated way." We can give them that reflection so that they can discuss it publicly within their place to say, "This is what we thought we were doing well. This is what CQC says we could do better. This is where the ingredients of best practice are around the country. How might we learn from that and adapt the way we are working accordingly?"

Saffron Cordery: I agree with elements of what Sarah and Kate said. A lot of very good providers are working with all the institutions across their patch to float everyone, so that everyone is at the right level.

One of the elements that we do not talk about, but which we need to remember, is that commissioning plays a critical role. When we are talking about regulation, we need to remember that sometimes organisations and providers are dealing with the implications of commissioning decisions. That has to be brought to bear. We need to be

clear about when we are regulating individual institutions and when we are regulating systems and what the role of commissioning is in that. If a service is not effectively commissioned, it could be partly the fault of the provider, but it is also almost solely the fault of a commissioner. There is a bit of it that we are not talking about.

Q24 Baroness Pinnock: I am a serving councillor on Kirklees Council in West Yorkshire, so I have a direct interest to declare.

Could you think about the time before the crisis began and the resource pressures that were obvious then? Together with the workforce pressures and capacity issues, have any of those problems limited the ability of providers to respond effectively to the pandemic?

Sarah Pickup: In this context, do you mean social care providers in the social care market?

Baroness Pinnock: Yes.

Sarah Pickup: I thought you might.

Baroness Pinnock: In this context, yes, okay.

Sarah Pickup: My short answer is yes; definitely, there was an impact. We have just had a look at the responses on the care home support plans. A lot of providers were on the edge before the crisis. We know that the cost of dealing with the crisis is huge. We know that the cost of PPE alone is enormous. Councils are providing financial support to providers, but it is about making sure you have the right workforce, training and support from the health service.

The care home plans show that people are now coalescing around the homes and supporting them together, but I am not sure that initially there was that focus. I think community and primary care support was directed to the acute trusts to help them with the crisis they were facing, and in the short term many care homes lost some of the support they had. It is probably back in play now, but that has shone a light on the valuable role that very low-paid care workers have and the vital contribution they make to society.

We need to make sure that we do not forget that moving forward, and think about what we can do to value, and demonstrate that we value, that workforce, other than just clapping and saying thank you. We need to think about what we can do to provide a sustainable workforce, and to reward them appropriately going forward.

Baroness Pinnock: Can I expand the question to include domiciliary care? A lot of our attention has been given to care homes.

Sarah Pickup: I include domiciliary care in my comments. The challenges of delivering domiciliary care are huge when you think about going into people's own homes, which could be set up in any way. In a care home, you can set things up. You have other challenges in a care home because there are a lot of older people together, but care workers

going into people's own homes inevitably face different situations and scenarios in many cases. They have a very challenging job because they work alone. They do not have a colleague to call on to support them.

Another thing to remember is that the crisis has brought social care to the fore, mainly focused on care homes. Care homes are not the place where most people receive their support. Two-thirds of people, if not more, receive their care at home. The focus has been on older people, but over half the social care budget is spent on working-age adults. They have been affected by the crisis too, but they mainly live in supported living and in their own homes, so they are affected differently.

We are focused on care homes. Domiciliary care and supported living are there, but there are all sorts of other ways in which we should be personalising, and do personalise, services for people. We must not go out of this crisis thinking that we have to commission care homes and domiciliary care better. We must of course make sure that those services are properly supported, but we must also look to redesign services around the needs of individuals and what they want, and help them to live a good life.

Kate Terroni: I echo a lot of Sarah's comments. Earlier in the session I talked about the Skills for Care data showing that there was a gap of 122,000 carers and a turnover of 37%. At the peak of the pandemic, our domiciliary care and social care providers were telling us that their sickness rates were up to about 25%. They are now back down to 9%. The massive challenges at the start were exacerbated. Providers were having to backfill staff who were off sick, ensure that they were trained and that they understood how to meet the unique needs of the individuals they support. All of that has added to the challenge. It is remarkable that the sector has risen to it.

Q25 Lord Hunt of Kings Heath: Can we turn to the voluntary sector for a moment? Could you reflect on how well statutory agencies locally worked with the voluntary sector? Looking to the future, particularly for commissioners, do you foresee a new role in relation to the statutory sector and the voluntary sector? Given the financial challenges that many voluntary organisations have faced and are facing, which have proven very difficult, do you foresee being able to give more support, certainly in the short to medium term, for voluntary organisations?

Sarah Pickup: The voluntary and community response to the crisis has been amazing. Many people have come forward through the national call for volunteers, and locally. There were some challenges with needing volunteers locally, them being available on the national app, and never the twain shall meet. I think some meeting has been arranged, and it has improved somewhat. Nevertheless, the reality of volunteering is that it is a local activity; you do it in your local community. We have some great examples of councils working with the voluntary sector and other agencies, across the board, to put in place action to support shielded individuals, people who are vulnerable and staying at home and people who cannot afford things because they are out of work.

We do not want to lose any of that. It has always been our position that fundamental to the delivery of the NHS long-term plan, and certainly the kind of social care support we would like, is an appropriate primary social and community infrastructure. The need for community capacity building was something we were highlighting before the crisis. We know that to help people live a good life, we do not want them to have to depend on statutory services. When there is good community support, you reduce the need for that. You reduce loneliness. With some of the people who are now delivering shopping to people, maybe some of those things will continue. It would be great not to lose them.

We must not lose the focus on building community infrastructure. It is not something you can just leave on its own. Commissioning for me is as much about enabling, supporting and sustaining things as it is about contracting for things and buying them. It is making sure that you identify the need and the fact that there are things to make it happen. You do not have to do it all, but sometimes you need to enable, support and sustain. If a lead person in a voluntary agency moves on, that support can fade away. How do you regenerate, move on and find the next way to support? It is about sustaining community capacity building and support going forward.

Saffron Cordery: I would look at it from the perspective that coronavirus has shed light on some of the challenges that the voluntary sector faces. We are in the middle of a crisis and a pandemic, and we have seen giving to the charitable and voluntary sector reduce and fall through the floor. That is incredibly worrying.

Local services—whether local government services, NHS services or education services—are under huge levels of pressure. Over the decades, there has been increasing reliance on the voluntary sector to deliver statutory services. We are in a situation where some of the big blue-chip voluntary sector organisations are suffering substantial losses in their income, which is putting them at risk as organisations, but we rely on them locally to work with us, local government and other bits of the public sector. That demonstrates that we need to shore up our public services more effectively and, in particular, local government funding, because it plays the facilitative, enabling, community leadership role that is absolutely critical in the engagement of the voluntary sector working locally.

A whole bag of issues has been thrown up by coronavirus through voluntary giving shifting massively from condition-specific charities to healthcare charities. Although there has been an astonishing show of support and solidarity for healthcare, it does not sustain the NHS because healthcare charities are supportive of NHS services. They cannot pay for NHS services. It is a knotty issue.

Q26 **Lord Hogan-Howe:** There are two parts to my question. What does Covid-19 mean for, first, the agenda to regionalise the NHS and, secondly, a prevention strategy for health?

Saffron Cordery: What the coronavirus crisis has taught us about regionalising the NHS is that there are times when a regional structure is important. When you need a big emergency planning response and oversight, the regional structure is incredibly important. It has the ability to look over a large area and corral the troops, as it were, to make sure that a geographic patch is adequately supported, safeguarded and looked after and can provide the emergency services that are needed. It provides a good command and control framework.

It tells me that the lesson is about looking at what powers are appropriate for each level. Is it appropriate to have those kinds of command and control powers at regional level to look over a patch? They might not be so appropriate on an individual institutional basis, for example. That element of regionalisation is interesting.

From an NHS perspective, each of the regional directors has provided an important point of contact in the crisis, not always acting as the intermediary between the local and the centre but providing additionality, something that helps to make sure there is a coherent response. That is where I see a regional agenda playing out in the crisis. There are many other regional functions—bringing systems together, for example—but in a crisis context it is about what works best at what level.

The Chair: And prevention?

Saffron Cordery: That is an interesting one. My personal view on prevention is that there is a really important local system role. Prevention sits very well in a local community or local government patch focus. Population health can be looked at through what happens in communities and probably across local government boundaries. That is where we will see population health planning working best.

There are important prevention elements when we are talking about public protection, but for healthcare prevention and looking at health inequalities, I would see it across a local patch rather than a regional patch, although some functions will be there.

Kate Terroni: We are turning our attention to the issue around unmet need. As coronavirus has continued, people are delaying getting access to the care and support that they require when they require it. They are delaying going to their GP, looking at a nursing home placement or accessing home care. On prevention, I am concerned that, when people endeavour to get access to health and care, it will be much more likely to be at a crisis point, rather than in a slightly more planned approach.

The issue was there before coronavirus. Back in the autumn, Age UK said that 1.5 million people were not having their full care and support needs met. This week is Carers' Week; about one in six adults cares for a relative. What impact has coronavirus had on the reliance on carers' informal care to support people, and how sustainable is that? There is something for me about unmet need and the focus on the increasing role

that I suspect carers have been playing during this time, when they were providing huge support before coronavirus.

Sarah Pickup: Prevention inevitably has to be local. The way social care has been structured in the past, with the focus on an eligibility-driven system, has driven funding away from prevention, and that is where we need to invest. We need to do it with our health colleagues. Working with GP surgeries and primary care partnerships, we can identify people who are at risk of long-term conditions and so on before they get further down the road to need more support. That will be vital.

That links to my thoughts about the ICSs. If we are going to have ICSs as a way of structuring the health service, they need to be empowered, and not always overruled by the national system. They must be joined. If you call it an integrated care system, and it is not integrated with local government and social care and is not properly on the basis of an equal partnership, it is not an integrated care system; it is a layer of the NHS. It depends what you want. If you want integrated care systems, they have to be equal. Good integrated care systems are doing what they need to do at that level, but they recognise that most of the activity and the delivery is at place level, at health and well-being board level, with local councils working with local GPs and local health partners, community services and acute trusts.

Baroness Pitkeathley: Picking up on what Kate said about it being Carers' Week, the survey that came out for Carers' Week showed that an extra 4.5 million people had taken on informal caring roles during this time. That is a lot of unmet need.

Lord Hogan-Howe: On prevention, the contributors emphasised the local, which I can see, but, particularly in this crisis, with immunisation, healthcare generally, water quality and border control, there is surely an element of the national. We need consistency to prevent cross-border contamination.

Sarah Pickup: There is a public health component to the crisis. Public health is a mixed responsibility between Public Health England and local delivery through local public health teams. Yes, often with very big strategic things such as immunisation or water quality you need a national framework, but particularly with immunisation, for example, the delivery is local. You have to find ways to make sure that you can do it effectively. It is like testing and tracing; you make it happen at local level. Local directors of public health and their teams have great experience that they can bring to bear to make these things work.

The Chair: I now have to curtail the session. Thank you. As witnesses, you have given us lots of things to think about. You will have appreciated that the Committee members have lots of ideas about this sort of thing. We will continue our deliberations and our thoughts.

When you leave, if there is anything you think we should have asked you about, or you have not said but think you should have, or would have

liked to say, please contact us and let us have more information. Thank you enormously for giving up your time today, because I know you are all very busy.