

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Wednesday 8 July 2020

3.55 pm

Watch the meeting

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. 12

Virtual Proceeding

Questions 75 - 83

Witnesses

[I](#): Caroline Abrahams, Charity Director, Age UK; Nigel Edwards, Chief Executive, Nuffield Trust; Neil Heslop, Chief Executive, Leonard Cheshire.

Examination of witnesses

Caroline Abrahams, Nigel Edwards and Neil Heslop.

The Chair: We now move to our second panel, on which we have three people. We have Caroline Abrahams from Age Concern. I first knew Caroline when she was working with what was then NCH—now Action for Children, so she has moved to the other end of the spectrum—as I have personally, as it were. We also have Nigel Edwards, who is from the Nuffield Trust, and Neil Heslop, who is from Leonard Cheshire. When we first introduce you, will you say who you are, and will those questioning also make sure that they say who they are, so that Neil Heslop in particular knows who is speaking? Our first question in this second session comes from Lord Hunt.

Q75 **Lord Hunt of Kings Heath:** We heard a lot of examples of innovation in the first session. We are looking at the health and care sector and people with long-term needs. Starting with Caroline, we would like to hear more about how you think the voluntary sector has contributed and what the lessons are for the long term.

The Chair: Did you get that?

Caroline Abrahams: Yes, I did. As Baroness Armstrong said, I am the charity director at Age UK.

In answer to your question about the role of the voluntary sector, certainly from an Age UK perspective our local Age UKs—we have about 130—turned themselves overnight into a sort of emergency service and spent a lot of their time delivering food. The problems that older people have had getting food are really quite considerable, and they are not over yet; they are still ongoing, I am afraid to say.

We are doing that and doing check-up calls on older people. For existing clients, a lot of their face-to-face services had to stop, but they use the telephone. We have done deals with companies and got iPads for older people who were not online. Almost anything that you can mention, really, they have done locally, and largely off their own bat.

Local co-ordination varies hugely from place to place. In some areas, the local authority and local resilience forums have taken the lead and have been very well resourced and efficient, whereas in other areas they have pretty much left it to the voluntary sector to do it. Some areas have well-developed primary care networks, as part of the NHS. They have proved to be quite successful and helpful new developments, but they are at very different stages of development across the country.

I think that the voluntary sector has been heroic; it has done a really good job, and it has not been stodgy. It has taken no time at all to change what it does to meet the needs of their beneficiaries. As we have said at Age UK, what are we for, if not for a situation such as this?

Neil Heslop: Thank you. I am chief executive of Leonard Cheshire, which is an international disability charity with 5,000 staff and 9,000 volunteers, supporting about 76,000 people with disability in 15 countries in Africa and Asia and, probably most relevantly for the Committee, through our network of 120 social care facilities, where we support about 3,000 individuals with complex needs, with a staff roster of about 4,500.

To answer your question, Lord Hunt, I think you have to have a reasonably good fix on where the voluntary sector was with respect to the whole social care landscape at the outset of the pandemic and then consider how it has responded.

I completely concur with Caroline's assessment of the response, but the reality is that the whole social care system is extraordinarily complex and fragile. That complexity and fragility has built up over many years; consistently, Governments have struggled to put in place an appropriate strategy for it, and that complexity and fragility has had a massive light shone on it.

The consequence of that is that there has been a massive strain on the resources of charity staff and charity finances to respond in the way Caroline described. Largely that has happened, but it has come at an extraordinary cost, and some of the outcomes could and should have

been substantially better, had there been far better planning in earlier times.

Q76 Lord Hunt of Kings Heath: Thank you very much. Nigel, may I turn to you? You have heard those two excellent contributions. Although reform of health and social care may be coming along, it is probably not coming any time soon. How can we learn some of these lessons in the architecture of health and care but also in the way statutory organisations can support the voluntary sector?

Nigel Edwards: I am chief executive of the Nuffield Trust. Our focus is largely on the formal health and social care sector, although I currently have teams evaluating volunteering in the NHS.

The sad truth, as you know, is that the social care sector has been somewhat neglected and is a highly fragmented and quite fragile bit of the system. One lesson from Covid, which bits of the NHS had certainly learned before, is about providing more direct input and help into social care, and in particular but not exclusively into care homes, to make sure that they have the right skills, equipment, training and access to expert opinion. Before this, there were some very good examples of that in Nottingham and Airedale as well as in Sutton, in south London, where the NHS was providing support.

It has been a bit unfortunate that we have tended to conceptualise social care as being something that helps the NHS, rather than being part of an integrated system. One lesson that we might take from this is that the NHS perhaps needs to take that more seriously elsewhere.

The second observation I would make in particular relation to the voluntary sector is that there is a bit of a theme that we see in other parts of the government response to the pandemic. There is a tendency to want to control elements of the response centrally, rather than relying on the initiative and ability of bits of local systems. Where that has been done, it has not always worked very well. We have seen it particularly, for example, in the centralising of testing and tracing, and not relying on the local intelligence you get from local authorities and the voluntary sector. This is an ongoing lesson for later about how we allow more of a decentralised response of the type that we have been hearing about from the other two witnesses.

Lord Hunt of Kings Heath: May I ask you about that last comment on the relationship between central and local? At heart, why do you think that central government has been so reluctant to put its trust in the local structures?

Nigel Edwards: I think that I agree with the premise of your question, which is that it appears to be a lack of trust. It may partly be because there is also a lack of understanding of the capability of the local structures, because so few people at the centre of the system have any direct experience of working in that setting. It seems to be a particular pathology, and a long-standing one that seems to have got worse.

It is exacerbated by the great anxiety that things will go wrong and people will be held accountable and, therefore, a desire to control. We have seen in other countries that, to be really effective, at some point the centre has to say, "These are the objectives, and now I am going to let go and ask you to deliver". It appears that we have a system of government and Civil Service that is nervous to do that, because they do not understand; and, of course, they may also appreciate that local government has been subject to probably the most swingeing part of public sector austerity over the last few years, so its capacity to respond has been somewhat attenuated.

Q77 **Baroness Pitkeathley:** This question is probably more for Neil and Caroline than for you, Nigel. I declare an interest as president of the NCVO.

Some of our witnesses have suggested that the greater flexibility that the voluntary sector has enjoyed during this pandemic has contributed to much more effective use of services. Do you think that means that we may or should move away from the contract culture and the rather tight restraints that have been placed on the voluntary sector in its relationship with local authorities recently?

Caroline Abrahams: I think the relationship, in my experience of the voluntary sector and councils, is made very problematic by the fact that in this space there is never enough money. The risk is that you end up with a race to the bottom, with penny pinching and people putting in bids that are not really very realistic in a desperate desire to win the business, as it were. As much as anything, the sheer lack of money in the system is part of what is at fault here. It is definitely true that, through the pandemic, some councils have been brilliant and have really been supportive to local Age UKs in letting them have the widest possible opportunities to use money in the best way they can for their local populations, whereas others have been more restrictive. My colleagues have enjoyed that extra space to be creative.

It gets you back to that old chestnut of outcomes-based commissioning. I have been around a long time, as Baroness Armstrong points out, and people have been talking about outcomes-based commissioning for as long as I can remember, but it never quite happens. I suppose that the truth is that I am a bit cynical about commissioning; it is always the answer, and it never quite works, really. We just need a rather different approach in this space, as you have suggested.

Baroness Pitkeathley: Neil, would you like to add something?

Neil Heslop: Yes. There are a number of different problems, from our point of view as a direct front-line supporter of individuals, trying to keep them safe and minimising death as a result of the virus.

I was incredibly heartened on 19 March when the Government settled £3.2 billion for local authorities, and leaders of councils essentially recommended that there be a temporary 10% increase in the first quarter of April through June to recognise the fact that the virus was

escalating our costs dramatically, the obvious things being staff absence and PPE. I was pretty encouraged at that point, but the reality is that, four months on, 70% of that cash has not got to us. Central government thinks it has done something good and stuff has been handed over, but it has got stuck in the system. It certainly has not made it through to us so that we can pay for PPE.

Ironically, we were expecting to get about £3 million for that quarter to meet those emergency costs, and we have had less than a third of that. Therefore, we have had to raise charitable money to pay for the difference, to pay for PPE and for staff, and that cannot be right. Central government thinks it is doing its bit. As Caroline said, some local authorities have been fabulous and fantastic partners in a crisis, while others have totally gone missing.

The Chair: I am sure we will come back to that issue. I think that some local authorities have said that they were forbidden from giving it directly for PPE, which seemed a bit weird—but we will investigate that.

Q78 Lord Davies of Gower: Good afternoon, panel. Over the past few weeks, we have heard described a lack of integration between health and social care. What effect do you think this lack of integration has on the ability of services to care for people with complex needs during the pandemic? It would be very interesting to know how you think these shortcomings could be rectified, if you agree with the premise. I might direct this to Neil, to start with.

Neil Heslop: There was an earlier observation, I think from Nigel, about people in central government not necessarily having experience of what was happening on the ground. If one thinks of social care writ large as the poor relation of the health service—and I think most people would accept that as a core thesis—within that, the practical implication for working-age adults with disability is one step further removed in understanding.

How that manifests itself is that, when testing finally started to open up and the DHSC opened up that testing for members of staff who were symptomatic, they did so for care homes, for the over-65s. All our staff were excluded from that. A few weeks went by and we managed to get a Back-Bencher to put a question to the Secretary of State in the House, and the policy got changed. But the very fact that anyone thought that was a smart way in which to develop policy and roll it out is illustrative of the lack of understanding of the social care sector, full stop, and within that the nuances and differences between working-age adults with disabilities and the larger numeric number of those over 65.

The Chair: Nigel, this is very much your territory.

Nigel Edwards: Yes. We are somewhat hampered by a lack of good data, and I think it is something that we will want to study in the next few months.

As is always the case when we talk about the NHS, the experience is patchy. In some places, health and social care appear to work together very effectively, and in others it has been more difficult. The rapid clearing of beds at the beginning of the crisis was facilitated very often with very positive help by health and social care, and facilitated, it has to be said, by a removal of some of the funding and choice rules that sometimes got in the way and caused disputes between different agencies.

It is probably fair to say that too much focus has been on the care home sector, which is really important and has had a particular problem, but the domiciliary market is equally fragmented and even more difficult to engage. It has certainly had a great deal of difficulty in getting access to PPE and support from the NHS for training in the use of PPE. Indeed, it did not get access to testing; there was self-referred testing some weeks after that was made available to NHS staff.

We are slightly in the territory that we were talking about with Lord Hunt, which is that there is a real need to reset how this relationship works. More fundamentally, as we start to talk about reforming the social care funding system, the important lesson that we need to take is that, if you do not fix the provider side of your system, just fixing the funding side will not help you. So the second lesson is probably to have better and more formal mechanisms for people across the system and to have a handle on all the different types of social care.

It is worth pointing out that quite a lot of people self-pay for social care. We tend to focus entirely on the local government elements of social care, but quite a lot is provided outside that. Finding some way in which to knit it all together so that people across a local area are sighted on who is vulnerable, who is receiving these services and whether the providers have the support that they need to do it properly has been lacking.

There have been some unfortunate cases where health and social care have not got on quite so well. This is probably not a systems issue but more a local management and leadership issue, so there is not an obvious policy intervention there. In many cases, the working together has been fairly effective.

We can look to Scotland and some of the things that it has done about explicitly recognising the role of social care and creating more shared leadership, perhaps helped by its integrated systems. Northern Ireland has exploited that as well, by being able to redeploy staff into social care. That offers us some clue to what needs to happen in the English system.

The Chair: Caroline, do you want to add anything here?

Caroline Abrahams: Yes, definitely. The issue that you raise here, Lord Davies, is absolutely fundamental. A lot of what has gone wrong with care homes in particular—and I am going to talk particularly about care homes, because they have been such a feature of the pandemic—is

largely due to this issue. It is the problematic interface between health and care.

I shall just say a little bit about that. Of the people living in care homes, 80%-plus have dementia, but they also have complex comorbidities. They very often have cancer or diabetes, or whatever it might be. These are sick people. It has been well known for many years that people in care homes very often have problems in accessing good NHS treatment. Actually, it is much easier to access NHS treatment if you are living in your own home than if you are in a care home. The NHS has acknowledged this by setting up a scheme called enhanced health in care homes, which was part of the long-term plan that it is in the process of rolling out. Frankly, that is an acknowledgement that it often does not work very well in care homes. So there is a long-standing problem here.

Secondly, when you look at who actually works in care homes to care for these people, you can see that they are all care staff. Generally speaking, in a care home there is nobody who is clinically qualified or skilled, which is bonkers. We have just written something, which I am very happy to send to the Committee after this hearing, basically saying that we should look at what other countries are doing, which is that they have clinically qualified staff in care homes, working alongside care staff. In other words, expecting care staff to do a good enough job for people such as this is going to be problematic. It means that they are hugely reliant on community and GP services coming in to help. What happened during the pandemic was that in some areas it continued to work reasonably well but in some areas it did not work at all. Services withdrew and unqualified care staff were left pretty much alone. There were problems getting drugs as well—there were all kinds of issues.

In some other countries, such as Denmark, they have fused the professions and created a new form of professional who actually does some low-level healthcare alongside what we would call social care. Given the client group that we are talking about here in care homes, which is also true of many people receiving home care, as Nigel has said, we are way behind the times. We should be thinking much more creatively about integrating skills in professionals.

The other issue is that there is no doubt that, for the NHS, to a degree social care is “other”. I have huge time and respect for the NHS, but it is very complicated and very big. If you are working in it, it is hard enough navigating that, let alone creating the interfaces with all these other services.

There are developments around the integrated care systems locally, which may have some of the answers to all this, but we really need to join up at every level. I am afraid that the pandemic has found out the fault lines between these services, which has undoubtedly led to more people losing their lives than would otherwise have been the case. It is not anybody’s fault—I am not casting blame—but it is a systemic issue that we absolutely now have to solve.

Lord Davies of Gower: That was a really interesting response; thank you, Caroline. I wanted to clarify what qualifications people need. Are you saying that they do not need any qualifications to be involved with a care home?

Caroline Abrahams: They are very paltry. There are also 110,000 vacancies in social care all the time, so, basically, they are prepared to have anyone who is willing to work in social care. It is very much viewed in jobcentres as the bottom of the pile for work. If you cannot do anything else, sometimes you are pushed in the direction of social care, which is mad. Again, we just have to professionalise this.

The other problem here is that, if you work in care as a care worker, you get considerably less money and worse terms and conditions than if you do the identical job, which is called a healthcare assistant, in the NHS. If you were going to start somewhere, a good place to start is to set an ambition, even if you cannot do it absolutely straightaway, of equalising the terms and conditions for people doing the same job in both systems.

Q79 **Baroness Tyler of Enfield:** I want to pursue the point that Caroline was making. I am interested in your view about whether—and, if so, why—unmet care needs that were already there have risen during the pandemic. I am particularly thinking of the overlooked areas to which I think both Nigel and Neil referred, such as domiciliary care and care for people with learning disabilities.

Caroline Abrahams: We know that some of what has happened during the pandemic is that, in some cases, older people and their families have decided that it was too risky to have people coming into the home, which was a perfectly logical decision, given what we knew about the virus, and so have refused services.

The concern is that, now that they want them back, will they get them back? I have heard a little bit of evidence from the learning disability field about people wanting their services back and being told that, if they have not needed them for a bit, they would have to be reassessed. That is one issue to watch.

The other problem has been less severe than we feared at one point. In some cases, councils or providers have said that, because a lot of people were off sick, people have to have reductions in their packages. That is outside the formal easement system set up by the Act, which allowed local authorities to be able to pause some of their legal duties for a period. Those have all now just stopped. As of yesterday, the last council that was using it has stopped using it. However, I am afraid that we have also heard that it is at least as true for disabled adults as for older people, as I hear in my role as co-chair of the Care & Support Alliance. There have been examples of councils almost pretending that they have triggered the law without actually triggering the law and weaselling out of some of their responsibilities.

Neil Heslop: To come back on that, and to build on what Caroline said, it is important to have a bit of a context about the 10-year run-up to the beginning of the pandemic. Over that period, as funding has been taken out—some £7.7 billion—and as costs have gone up by somewhere between £1 billion or £2 billion across the whole marketplace, at a time where demand has been increasing, the actual year-over-year number of working-age adults receiving publicly funded social care has actually been in decline, down by up to 600,000 people.

That is a long-term trend. As Caroline has said, that trend has accelerated. Certainly, we have done a number of surveys between April and June, where we have been talking to 1,200 working-age adults about their experience, and 55% are telling us that they are having reduced support.

What has been the long-term trend has got worse during the pandemic, but the nature of how it has got worse really just points to the fact that we have to be so much more sophisticated about how we think about the entirety of the system. The point that Nigel made about domiciliary care is absolutely right on. Caroline has just spoken very powerfully about the situation in care homes for the over-65s. It is a completely different situation from that for working-age adults with disability, our cohort of 18 to 64 year-olds, with our mix of support. I have 500 nurses who together provide support with some clinically trained support workers. It is a very complex system, and it always amazes me that, at the centre of government, the understanding that, while large numbers of people failing to get good-quality social care are the over-65s, it is actually the smaller numerical cohorts of 18 to 64 year-olds who represent pretty much 50% of the cost. Thinking about those cohorts' requirements in a clear-eyed way to understand the difference in the needs and the difference that those needs imply for system reform is very important.

The Chair: We really could go on, on this, but I am going to move on now, otherwise we will not get our last two questions in.

Q80 Lord Filkin: Welcome to the panel, and thank you very much for your time. I am going to ask in a minute about primary prevention, and whether we have learned something from the crisis about the need to give it greater priority.

However, we have spoken quite a bit about new ways of working. Are there any further reflections that you would like to add about what new ways of working, by the voluntary or statutory sector or both together, should be adopted as good practice more generally?

Nigel Edwards: The most obvious one is the shift away from face to face to digital and web, which is more convenient for many patients. However, there is a cohort of people who find that technology challenging and difficult, and that will need some thought.

The other innovation is, because we are trying to minimise contact with people, starting to think about whether particularly vulnerable people and people being shielded at home can have more of their services provided

to them at home and done by a single worker rather than a succession of different people coming to visit them.

That would require some rethinking of the training that people are given in the longer term. Experience in the Netherlands suggests that those jobs are also likely to be more rewarding and easier to recruit and retain people into. There are quite a few examples where it has been discovered that quite a lot of the occasions when we have asked people to come in and be seen turn out not to be achievable over the telephone, never mind by video or via the internet.

Lord Filkin: Thank you very much, Nigel. Neil, may I have some quick, general and high-level points?

Neil Heslop: On the speedy response at its best, some authorities resolve matters literally within an hour and a half, whereas others have yet to respond four months later. That is fundamentally about management; it has nothing to do with funding—it is just management. On speed of action, the worst could learn from the best, enormously.

On technology, in how we delivered services and how that has enabled us to support people in a creative way, we have had to do things in a different way. The consequence is that we have amazed ourselves and others, and some of our partners, with the art of the possible. We have to hang on to that for dear life.

Lord Filkin: Caroline, do you have any quick comments, before we turn to prevention?

Caroline Abrahams: As Nigel mentioned, but it is worth reinforcing, the speed of being able to get people out of hospital by getting rid of some of the bureaucracy and fighting around who pays has definitely helped. There is an ambition to try to keep that going, which I personally think is the right thing to do.

Digital has, of course, worked really well for some people, but for older people who are not online the difference between their quality of life, if they have been online or not, through the pandemic, has been enormous, because they have just been so cut off. This is very much a topic of the day and tomorrow, on the media: the notion that we could move, particularly with GPs, to the first contact always being digital or a triage system of some kind, rather than face to face, is not necessarily going to work very well for older people, particularly if they have a hearing impairment, for example.

Q81 **Lord Filkin:** Thank you very much. It is noticeable, and the early data show it, that people who are obese, have diabetes or serious coronary health diseases have died disproportionately. What does that say about our attitude to primary prevention and what we should do for the future?

Nigel Edwards: One of the potential reasons our case fatality rate is high compared with that of many other similar countries is that we seem to have a higher rate of coronary disease and, indeed, obesity.

It is already part of the NHS's long-term plan to address that. The interesting question is whether, given all the other challenges that the NHS is going to face—in particular, the productivity challenge created by the need to have much greater enhanced infection prevention and control, in primary as well as secondary care—that is going to diminish the overall productivity of the system and maybe divert attention away from it. It will be very important that, in the mandate set by the Department of Health and Social Care for NHS England, and how NHS England takes forward its prevention programme, it is given more salience than it has been in the past. Chapter 2 of the previous *Five Year Forward View* that the NHS came up with was about prevention, but it has not been clear that that has been given the weight that improving cancer outcomes or waiting times for surgery has been given. There is probably more work to do there.

Of course, it is not just the NHS's job, it should be said; the evidence that the NHS can make a huge impact on primary prevention is somewhat limited. The role of wider society, and our policy on food, regulation of fast-food outlets and, in particular on income inequalities, probably all have more impact than anything that the NHS is able to do.

Lord Filkin: Neil, do you have any comments on primary prevention, perhaps commenting on the Government's ambition to improve healthy life expectancy by five years?

Neil Heslop: Looking backwards before looking forwards, the ONS stats show that two-thirds of the people who have died have had a disability, which has been a very sobering reality. That really points to the criticality of what you are describing. Where we have seen the best outcomes is where the quality of some of the support around direct care has been the greatest in exercise, nutrition and so forth. That has to be the wake-up call for all of us, right across society. That is stuff we all know—we all know about obesity and healthy eating—but, societally, we do not have the trends going in the right direction, and we fundamentally have to.

Caroline Abrahams: I guess I want to say that it is definitely never too early, but it is definitely not too late either. One thing that we have been involved in through the Richmond Group is a programme with Sport England called "We Are Undefeatable". You may have seen it on TV. It basically encourages people with comorbidities to stay active, whether they are young people with cancer or severe asthma or older people with Alzheimer's disease. It is never too late, and however little you do makes a difference. It has been great to see Sport England reaching out to charities and wanting to work together on that. There is a lot more that we could do, but, on the bigger picture, as my colleagues have said, historically it never gets its place in the sun. One fears that, with so much else to do, it will not this time either.

Lord Filkin: I hope you are wrong, but let me pass back to the Chair.

The Chair: I move on to Lord Bourne, who is going to ask our last questions.

Q82 Lord Bourne of Aberystwyth: I am very interested in this prevention strategy. I would like to ask a focused question on reducing loneliness and to what extent we should seek to introduce this as part of a public health strategy on how we reduce loneliness. If you think that is a good idea, how do we do it? Perhaps Caroline could go first.

Caroline Abrahams: Clearly, we have found out lots more about loneliness over the last few years. It definitely has an adverse health impact. You have probably heard the stats: chronic loneliness is equivalent to smoking 15 cigarettes a day, apparently—all of that. There is quite good and growing evidence about the adverse impacts on people's physical as well as their mental health from loneliness.

The stats about the pandemic are quite interesting. At first glance, they appear to show older people's loneliness as static or even plateauing and younger people's loneliness going up.

We have discussed what that actually means at Age UK, and we think that young people's lives have been completely disrupted by the lockdown and their inability to socialise in their usual way, even though they are usually very adept at using new technology. With older people, we are picking up less actual what we might call pure loneliness and more issues around anxiety, depression, mental health difficulties and loss of well-being. So there is a subtler range of issues, which include isolation and being alone, but that is just one of a cluster of issues.

That just goes to show that loneliness certainly deserves its place in the mix, but it is not just about that—it needs to be about the general approach to well-being. Everyone says, and I think they are right, that we are going to see a huge demand for support for people of all ages coming out of the pandemic.

Neil Heslop: Loneliness is one of those dimensions for people with disabilities that we have to work on, across the banner of complete social inclusion. It has particular characteristics and requires particular interventions, such as those Caroline talked about with Sport England, and all those programmes for all people to become active together, along with improved digital access.

We have done a number of things supported by the National Lottery Community Fund, which put loneliness out there as a key funding challenge. We have sought to build on some of the digital innovations that we have to provide connections between individuals and groups of different ages. That is an obvious thing, but we were not doing it before. Clearly, you have to overcome the tech barrier to enable some of those things, but I absolutely think that loneliness has a really important place in our overarching approach to how we overcome some of the fundamental inequities.

Lord Bourne of Aberystwyth: Nigel, do you have anything to add?

Nigel Edwards: Those are both excellent answers. I agree with both of them, and I do not have much to add.

The Chair: Do I have any wind-up questions from anyone?

Q83 **Lord Hunt of Kings Heath:** I was very interested by the loneliness question. Thousands of people volunteered to help the NHS through the pandemic, and many of them have not been used. I wondered whether there was a facility to try to encourage those volunteers and agencies to think about a volunteer force for the future, in the face of loneliness.

The Chair: I am afraid that colleagues still had difficulty in hearing that. Lord Hunt is saying that a lot of people have volunteered for the NHS over the recent past and the NHS has not had the capacity to use them. In future, should we not think about how to encourage people who want to volunteer and contribute to help to tackle loneliness? This is for you, Nigel.

Nigel Edwards: We go back to a theme that I mentioned at the outset, which is the challenge between running things centrally and locally. I am not sure that this is a job for the NHS on its own. My local authority, for example, seems very good at mobilising and working with the voluntary sector to help with befriending. This is a real opportunity, given that we got lots of people to volunteer, and we ought to make sure that we do not lose some of that enthusiasm. I do not particularly have faith in a national machine to be able to do that. Along with many of the other lessons that we have learned from the pandemic, it is about the importance of enabling some of the local organisations to do that, and perhaps to give them assistance. Helping them to use the GoodSAM app that has been made available would be a better avenue. We could certainly help with that with some national messaging on the importance of continuing to help and volunteer.

The Chair: Do Neil or Caroline want to come in on this?

Caroline Abrahams: Yes, please. One thing that we have discovered about the NHS responder scheme is that it is rather transactional in its design. Loneliness is about relationships. It might be great to have somebody to come along and collect your prescription for you—that might be priceless at the moment—but, if you want to get to know somebody and have a friend, for most if not absolutely everybody it is more about building a longer-term relationship.

We have found that some NHS responders have left that scheme and come to join as volunteers for local organisations, exactly as Nigel said, because that is where it is at, really. For older people, obviously, both Age UK and the Silver Line, which is part of us now, have large volunteering and befriending schemes, which have been fantastically useful. There is a huge demand for those services for old people during the pandemic, because people want to have new friends that they can get to know. The responder scheme was an interesting idea, but, in the end, it is probably better to do it locally, and there is a lot of infrastructure there to support it.

Neil Heslop: That is broadly right. One thing that we are recognising is that the sentiment to volunteer is fundamentally about individuals being able to give their time or talent. The challenge for organisations is to create a flexible way in which to match those things to the need. For some people, that face-to-face relationship, built up over many months with individuals, is hugely important. For the younger generation, it is more about wanting to give four or five hours on Thursday night and wanting to know what they can do that is useful.

As a charity, you want to tap into both those sentiments, but the logistical challenge—and I think this is where the NHS has sometimes struggled with what Caroline has described as the transactional—is the matching in real time between the sentiment to do something and what was actually needed to be done. It is very difficult, but, going forward, we cannot have a volunteer force that is exclusive of different lifestyles and ages, because we want to create avenues for that sentiment to be given expression. For organisations such as ours, that presents all sorts of challenges, but ones that we have to step up to.

The Chair: Thank you. Does any other Member have a question that they would like to put to the panel?

It has been a fascinating session, and there are lots of things that I am sure we will be pursuing as we go on. To all the contributors, I say that we really appreciate your time and effort on this. If, on reflection, you think of anything that you perhaps should have said or wanted to say but did not get the chance to say, or if you want to send us any other written evidence following on from what you have said, we really would appreciate that. I thank all three of you very much indeed. It has been a fascinating session.