



Select Committee on Economic Affairs

Uncorrected oral evidence: Social care funding in England

Tuesday 29 January 2019

3.35 pm

Watch the meeting

Members present: Lord Forsyth of Drumlean (The Chairman); Lord Burns; Baroness Harding of Winscombe; Lord Kerr of Kinlochard; Lord Lamont of Lerwick; Lord Layard; Lord Tugendhat; Lord Turnbull.

Evidence Session No. 9

Heard in Public

Questions 81 - 90

Witnesses

I: Colin Angel, Policy and Campaigns Director, United Kingdom Homecare Association; Douglas Cooper, Project Director, Competition and Markets Authority; Professor Martin Green OBE, Chief Executive, Care England.

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Examination of witnesses

Colin Angel, Douglas Cooper and Professor Martin Green.

Q81 The Chairman: Welcome to the Economic Affairs Committee. You have probably been following our inquiry. We are most grateful to you for coming today.

The first question is about money. We have had pretty much general agreement from our witnesses that more funding is needed. Could you succinctly indicate what you think will happen if nothing is done? The system has proved amazingly resilient, despite repeated warnings. How long do you think short-term funding solutions can continue?

Professor Martin Green: The situation is getting critical. You are right to say that the system was very resilient over past years, but you will have seen from the *State of Care* report by the Care Quality Commission that things are now at a tipping point. I think we will see a postcode lottery, so services in some areas that are predominantly publicly funded will start to close, or there will be no development or investment in the fabric of buildings, staff training, et cetera. We will see fragility in the market and certainly closures, but we will also see interesting differentials between the quality of services in some areas that are driven by self-funders, as opposed to areas driven by publicly funded placements.

Douglas Cooper: In the Competition and Markets Authority study of care homes, a question we looked at closely was to assess the claims that funding levels for care homes from local authorities were unsustainable. We undertook a major study, drawing on evidence that we used our powers to collect from care homes, giving us an insight that was not previously available. We found persuasive evidence that, although homes reliant primarily on local authority funding were generally able to cover their operating costs, there was no return on capital and no incentive for them to invest or modernise. We are concerned that the consequence will be a decline in the quality and availability of care homes catering for local authorities over time, against a period of increasing need.

Colin Angel: I share Martin's view that there are two markets in the home care sector: a state-funded market and a private pay market. Privately purchased home care, unlike residential care, is a relatively small proportion, at about 30%. In the state-funded sector, I think we will see a continued negative impact on pay rates, with care workers not being well paid for the work they do, which will manifest in hourly rates and in care workers not getting their travel costs reimbursed, as well as in damage to training budgets. All those things add up to a high workforce turnover.

We are already seeing a polarisation of care providers who concentrate solely on privately purchased care, and a few others who are exiting the market. There have been large-scale financial failures of large organisations; we had a very near miss in the home care sector before Christmas. The overall impact on the human side is an unstable market

where, if a provider changes or fails, people do not necessarily receive the same care workers, with whom they have built a relationship. That in itself has an impact on what it is like to be a care worker, with the experience of building relationships with service users that are broken as the market becomes fragile and providers fail.

The Chairman: We have had some depressing evidence on the latter point.

Q82 **Lord Turnbull:** I may need to declare an interest of some sort, in that my mother-in-law spent about two years in a home. I could call it a hybrid home; in other words, she was sitting in her room, next door to people funded by the borough, but she was a self-funder.

Reading the report from the CMA, I was shocked to learn of the disparity between what self-funders are charged and what is paid by the local authority. There is a 30% or 40% difference, which leads me to think that the self-funders have a raw deal and are effectively cross-subsidising the declining input from the state sector. I do not know whether that means that hybrid homes that take people from both sources cannot exist because of the disparity in how they are funded.

What do you think about the situation of the self-funder probably paying more than the actual cost, and the local authority paying less?

Douglas Cooper: That is certainly right, in that we found large disparities for large care home groups that could be at around 40%, or a bit smaller for smaller care home groups. We worry that that will lead to the market segmenting into two distinct groups.

At the moment, the joint occupancy model for care homes is very common; many draw a mixture of self-funded and local authority-funded residents. There are strong incentives for homes in a local market where they can rely solely on self-funders. Without the cross-subsidy element, they can offer better deals, better value and better quality for the self-funded residents. The consequence will be that local authority-funded residents will be pushed out and the quality of care, if any care is provided to them, is likely to diminish over time.

Professor Martin Green: We should not see it as a cross-subsidy; we should see it as one lot of people probably paying the real costs of care, and local authorities not doing so. I do not think that people realise how low those figures are. In Windsor and Maidenhead, for example, they pay £2.48 an hour to deliver care to people who have several health problems, many of whom are living with dementia. Those figures are totally unsustainable. It is made up of the weekly rate; if you divide it by seven days and then by 24 hours, you are looking at ridiculously low figures. How is anybody supposed to deliver a quality service on that level of funding? It is not possible.

Colin Angel: The home care sector is slightly different. As I said earlier, we have a much smaller private purchase market. People buy different services in home care; we do not have one person sitting in a room next

to somebody who is paying a different rate. People purchasing their own care are generally purchasing longer visits, better continuity of care worker, and a wider range of activities. They are probably looking for more communication with families and more regular assessment and care planning. The provider will have the additional transaction costs of dealing with a large number of customers, rather than one large local authority. There is a high risk of people not paying their bills at the end of the day, which has an additional cost in credit.

The cross-subsidy in home care would be harder to demonstrate, because you would have to charge high prices to a relatively small cohort of self-funders to subsidise local authorities. In the home care sector, state-funded providers are just trying to get to the end of the year on the money they currently have.

The Chairman: I do not understand that argument. Do you agree with it, Mr Cooper? I thought that you were very clear about the point being raised.

Lord Turnbull: I think he was talking about people receiving care in their own homes; it is the difference between at home and in a home.

The Chairman: And your figure of £2.48 was based on an annual cost of what?

Professor Martin Green: It was based on about £430 a week, which is what the local authority is paying, but, of course, the provider has to provide a 24-hour service, seven days a week, so it works out at that very small hourly rate.

The Chairman: That is a bit of a politician's trick.

Professor Martin Green: I do not think it is a politician's trick. The bottom line is that, if you look at those figures and at the level of dependency of the people being looked after, even on a politician's trick it is a stark and very low figure.

The Chairman: Yes, but the issue Lord Turnbull was raising was that people who are paying for themselves pay 40% more, which is money they have to find, and therefore they are subsidising the others. That was the issue.

Professor Martin Green: It was the issue, but—

The Chairman: Telling me that it is only £2.40 an hour is not going to help.

Professor Martin Green: But some of that will be about the sustainability of the business and the lack of being able to invest. Even if people are paying the true costs of care, and, as Lord Turnbull said, they pay significantly more when they are self-funders, that might translate to being about a cross-subsidy, but it might also be about the fact that you

do not have money in the business to invest in infrastructure, staff training, et cetera.

The Chairman: But Mr Cooper's point was that the danger then is that you just have the people who are paying the 40% extra and you do not provide places. Do you accept that?

Professor Martin Green: I think that is right, and that is going to happen more and more. We will not have publicly funded places, because people will start exiting that market.

Q83 **Lord Kerr of Kinlochard:** On exactly that point, we were told by Policy Exchange that care providers were beginning to withdraw from areas where there was an insufficient number of self-funders. Can you stand that up? Is it provably happening?

Professor Martin Green: Yes, it is. If you look at the *State of Social Care* report, which the Care Quality Commission delivers to Parliament, you will see that there is a reduction in the overall number of beds. Underlying that, there is also the issue that the new beds are all in particular areas. There is attrition in areas that are predominantly publicly funded and new services are being developed in areas where there is more affluence and private funding.

It is not only about the figures; it is about how the distribution of the figures impacts on the potential to have both choice and quality in some areas of the country. It underlines the fact that we are walking towards a postcode lottery, which is being developed by the fact that there is no clear policy on the true costs of care. It is not being delivered as a national strategy.

Lord Kerr of Kinlochard: It is not a true lottery, because there must be a pretty close correlation geographically with relatively wealthy areas.

Professor Martin Green: There is that correlation, but all the new services are being developed in wealthy areas and all the attrition of services is happening in poorer areas. If somebody relies on publicly funded provision, that means that neither choice nor quality will be available to them, because lots of services will not be sustainable and will close.

Lord Layard: If the number of people in care homes is falling, where are those people going? What is happening? If homes are closing, is somebody taking them over? For example, is a local authority taking them over, or another provider?

Professor Martin Green: Some of them are actually closing, but some of them are being transferred to other providers. I accept that. We could look at the demographics and at work such as that of Professor Carol Jagger in Newcastle. She has identified that in the next 10 to 12 years about another 400,000-plus people will need 24-hour care.

One challenge, which Colin will be able to talk about more knowledgeably than me, is that often people are given low-level community packages by their local authority that keep them just on the cusp of being able to manage in their own home, but they are not given residential care because of the cost issues. Lots of issues underline this, but we have to remind ourselves that not only are we walking into a problem now but, looking at the demographics, unless we get some clear and strategic planning, there will be large areas of the country where there will be no provision for people who need it.

Q84 Lord Layard: The CMA has suggested that there should be an independent body responsible for overseeing local authorities' delivery of social care. What could that achieve that cannot be achieved by more money? To say that people are falling short because they do not have the money to avoid the situation does not help much. What is the argument for that independent body?

Douglas Cooper: In our recommendations, along with the one on the oversight body, we included one that there should be feedback advice to central government about the requirements of funding, with the obvious implication that the funding must be adequate to meet the level of need.

Our concern about the oversight body was that local authorities vary a lot in their ability to deliver meaningful plans for the future provision of care. Although a few were able to produce quantified forward estimates of the demand for services in their areas, most did not do so, which creates an environment in which the care sector cannot have confidence about where it should invest. Behind that, obviously, without some degree of stability and foreseeability about funding levels, local authorities are not in a position to make commitments, and the sector is forced to rely increasingly on the self-funders.

Lord Layard: Is it a proposal that the sector supports?

Colin Angel: In the home care sector, we absolutely support an oversight body. Logically, it would be the Care Quality Commission, because it has data about the experience of people using services, which can then be mapped on to the way local authorities commission care.

I absolutely agree that, if there was enough money in the system, we probably would not have this problem to start with. However, councils were given market-shaping responsibilities in the Care Act 2014, and there is no policing of whether those responsibilities are undertaken adequately. I have asked repeatedly for DHSC and the Local Government Association to confirm whether they do any monitoring, and the answer is that they do not police the Act; they rely on people bringing cases in the courts.

The ability of some local authorities to understand and accept prices that reflect the true costs of care would be improved by an oversight body that could report on that. In the last financial year, I FOI-ed every council in the country and asked them to show me how they had calculated what

an hour of care should cost, and only one in seven councils could show me something that looked vaguely like a price calculation. The rest could not even show me how they worked out what they should pay for care.

Professor Martin Green: I absolutely agree with Colin; we need oversight, which would properly be done by the Care Quality Commission. The proof that it is needed is the variability in both commissioning and how people use resources effectively. Some councils use them much more effectively than others, so there is a need for somebody to sit in loco parentis over the system and say that there are ways to get better outcomes for the money. We need to challenge authorities that are not commissioning in the most effective way.

The Chairman: Would you like to name some names?

Professor Martin Green: My list would be very long.

The Chairman: I was thinking of ones that are doing well.

Professor Martin Green: My list would be very short.

The Chairman: What would be on it? You might want to write to us.

Professor Martin Green: Some councils do better than others. Some councils engage better with the sector. For example, some of the things that are happening in Manchester are quite interesting, because of a new and more joined-up approach to care services. I can honestly say that I do not think anywhere is an exemplar of good practice. Partly, that is because we have a system that is not enabled to have oversight.

Q85 **Lord Kerr of Kinlochard:** I was wondering where the money should come from. The Nuffield Trust told us to look abroad at examples of countries where social care is administered at local level but within a national framework for eligibility and national funding. I see the argument, because, as the Local Government Association told us, "the pattern of growth in need does not reflect the pattern of growth in business rates, even in aggregate nationally". What would be the arguments against having either totally national funding or national funding to equalise regional differences resulting from disparities in locally raised revenue?

Professor Martin Green: First, before we decide where the money is going, we should apportion the money on the basis of what we need. We talk endlessly about integration, yet we have a system where there is significantly more money in the NHS than there is in social care. I would be in favour of trying to devolve the money to be much more about the individual having control, rather than the bureaucracy, because that could lead to more flexibility in how the money is spent, for the benefit of maintaining people as independently as possible.

There is a challenge in the difficulties of matching the level of funding in social care with the level of funding in the NHS, for example. If we are to

have a discussion about how the money is delivered, let us first have a discussion about how much money we actually need in the system.

Lord Kerr of Kinlochard: Yes. You could start at either end of the problem. The present funding system does not look logical, and it looks as if it may become more illogical over time. There is no reason why we should not think about a more logical system. This Committee is unlikely to conclude that the social care sector should be amalgamated with the National Health Service; that does not look right. It seems to me that the local administration of social care is right. If any of you dissent from that, could you speak now?

Colin Angel: I am not sure that I necessarily dissent from that, but I am not sure that local authorities always make particularly good decisions in how they manage markets or fail to manage markets. The oversight function would become an even more compelling response if you were looking at keeping stuff at local level, making sure that authorities do the things that are required of them and making sure that the funding is ring-fenced, so that it has to be used on delivering services for the local population.

Lord Kerr of Kinlochard: Where is the money coming from?

Colin Angel: It comes from central government, with a small proportion from local taxation.

Lord Kerr of Kinlochard: Does all of it come from there, or does it come partly locally, with a redistribution and equalisation element?

Colin Angel: Yes, it is predominantly central government funding, with some local government taxes, et cetera, but the majority of it is from central government taxation.

The Chairman: Professor Green, when you talk about giving people a package, would that be a sort of social care voucher scheme? I know that you have done a fantastic amount of work on dementia, and so on. I am not quite sure how that would work with people who are very frail.

Professor Martin Green: It is interesting that it is always older people who are said not to be able to manage their own budgets. Lots of younger people with learning disabilities similarly cannot manage their own budgets but are helped to do so by advocates. We should find a system, just as we do for people with learning disabilities, to enable them to manage their own budgets.

I am interested in how we get some innovation. I would love to see whether amalgamation of direct payments with a personal health budget, for example, could bring a much more integrated approach to delivering care for a person that would keep them functioning at the highest possible level.

There could be an interesting use of the tax system. For example, we could have tax disregards on inheritance tax for the money that you

spend on your long-term care or, indeed, if you top up care, you could have that as a disregard for your tax. There is a combination of measures that could maximise the amounts of money in the system and put the citizen much more in control, and, if they were unable to be in control, their advocate or power of attorney would be in the driving seat.

The Chairman: Perhaps I am being thick, but how could you have a disregard for inheritance tax purposes? Surely, if you had spent the money, there would be no inheritance tax.

Professor Martin Green: If you were spending the money in your care package, it might be through the process of spending it at a particular time, while you were still being taxed on your income over and above that. It would incentivise people to spend more on their care, if they knew that they were going to get a tax incentive.

The Chairman: Tax incentive on what?

Professor Martin Green: On money they have spent on their care. I appreciate what you are saying; in effect, they have spent it so it is not taxable. But if you said, for example, "I'm going to spend a significant amount of money on my care, I'm going to put that money in myself, and later on, when I die, my next of kin will see a tax advantage on my estate", that would be an incentive.

The Chairman: I see. If you set it aside as a fund, you would be exempt for tax purposes. Have you written anything about that?

Professor Martin Green: Not very thoroughly, no. I have thrown some ideas out into the ether, but it is in no way worked up.

The Chairman: People might be interested to hear about it.

Professor Martin Green: There are better brains than mine that could do that.

Q86 **Lord Tugendhat:** How successful do you think attempts have been to create a market in social care provision, and how suitable is the sector for marketisation?

Colin Angel: From the home care sector point of view, the private pay market, although significantly smaller, has functioned well for decades. It functions like a proper market: people make decisions about whether they wish to purchase and what they are prepared to pay.

Local government has proved that it can outsource most of its provision, but councils still act as a near monopsony purchaser in many local areas, particularly the further north you go in the country. In the state-funded market, our view is that councils know, and are often willing to exploit, their dominant purchasing power. Over the last year or two, more providers have withdrawn from commercially non-viable packages of care or are no longer willing to tender for local authority services in some areas.

Professor Martin Green: Creating that market is similar, although probably easier, in residential care than it is in domiciliary care, because the levels of publicly funded provision in domiciliary care are much higher. The market works in a situation where people make choices about the services they will use and have the resources to make those choices. It is difficult in areas where people do not have high levels of equity in their property, for example, so they do not have the capacity to buy in services at the true cost.

Douglas Cooper: In our study, we looked at whether the market was working well for consumers. We found no reason to believe that there were problems from the fact that it was largely private sector provision. Indeed, there was good evidence that private sector providers were generally considerably more efficient than local authorities, where they were still providing care. Obviously, there were some problems in markets for self-funders; it is very confusing and challenging to make effective choices. On the state-funded side, we have already talked about the problems of the levels of funding.

On commissioning behaviour, quite a lot of concern was voiced about some of the approaches used by local authorities, such as dynamic purchasing systems. Our view was that the problems identified were largely a reflection of the pressures on local authorities and the funding challenges they faced, which were driving down prices and forcing local authorities to make prioritisations of price over quality, but we felt that was not primarily a result of the commissioning approaches adopted.

Lord Tugendhat: As I understand it, for-profit care home providers account for 83% of care home beds. Has that proportion changed very much in recent years? When the phrase “for profit” is used, to what extent are the Mom and Pop providers involved in the business—people who have one or maybe two care homes—and to what extent are chains involved? In nursery schools, a significant proportion of the market is accounted for by quite large companies. How does that compare?

Douglas Cooper: The great majority of care homes tend to be small, single operations; around two-thirds of care homes are single-home operations. The large chains account for around one-third of care homes and maybe 40% of capacity. I do not have figures on how the for-profit sector has changed over time.

Professor Martin Green: It is increasing, but only gradually. A lot of that is about new developments. Some of the older, smaller provision is exiting the market because there is no way to pad the funding difficulties. A chain of 350 care homes can make some economies of scale, whereas a private provider with one care home finds it difficult to make ends meet, particularly with the levels of public funding.

Lord Tugendhat: In those circumstances, to what extent is there price competition? To what extent does a chain compete locally with a smaller operation to create a situation in which it can acquire that operation at a lower price?

Professor Martin Green: I do not think they do that. Often chains have a desire to build new facilities, for example. A challenge in our system is that about 40% of the provision is coming to the end of its life, so more and more buildings are coming to the end of their lives. We need not only to replace those but to deal with the increased capacity that we will need because of demographic change. In a way, they are fairly distinct markets.

Lord Tugendhat: Are the chains British-owned, or are some of them foreign-owned?

Professor Martin Green: It is a mixture. Some are financed by international capital and some are owned by people from the UK.

Colin Angel: The home care sector, where we have no bricks and mortar provision, or very little, is even more characterised by small and medium enterprises than the residential sector. We have some corporate providers, but none of them has anywhere near dominant provision even in local areas.

On price competition, there is very little bidding down. In the state-funded sector, providers are all struggling to deliver services on what local authorities are willing to pay.

Lord Tugendhat: Is it possible to make any kind of generalisation about differences in cost or quality of care between homes run by chains and those run by small businesses, or facilities being more comfortable and up to date? Are there any generalisations that you would volunteer?

Colin Angel: I cannot speak for residential care. In home care, people are generally buying a service that is more flexible and responsive to their needs and preferences, rather than buying one commissioned by a local authority whereby a social worker has decided a plan of care that must be adhered to rigidly, whether somebody's care needs change or not.

Professor Martin Green: There are some differences. A lot of it relies on the amount of potential to invest in the buildings. We need to be clear that if we are to have choice and if we are to respond to individual needs, we need a diverse market with different types of services, so that people can make choices about what they want. We have to recognise that we need both in our market.

Q87 **Lord Burns:** We have heard quite a lot about the case for greater integration between the NHS and social care. Can I explore how far it might be possible to take that? Is it an operational type of question about people being able to work together in a fashion, or can it be taken as a question about the organisations that have the overall responsibility? Are there any halfway houses? The phrase is greatly used, but I hear rather less about what specifically it would involve.

Professor Martin Green: Yes, we have to reclaim the term integration. Too much of the discussion about integration is about organisations,

when actually integration is defined by the experience of the person who uses the service. I always use the airline analogy. If I sit on an aeroplane and go out of Austrian airspace and into German airspace, a massive administrative process goes on in the background, but I am not aware of it at all; I just know that I have a flight from A to B.

One challenge is to talk about integration in terms of the outcome. We need to recognise that we can have different organisations that will work together to deliver an integrated outcome, so we should not be too hung up on whether we have one organisation or funding stream. What we need is one clear outcome. I work on three distinct high-level measures. One is the personal experience—how the person experiences care; the second is the outcomes that are delivered; and the third is the effective use of resources. If we had a template that measured success against those broad headings, we would see how we could use what we have in the system to deliver some of that.

Lord Burns: What organisational integration is needed to achieve it?

Professor Martin Green: Some organisational integration may be needed, but it is not a prerequisite for an integrated service. To go back to the airline analogy, those are very different organisations, but I have an integrated service.

One thing that is very irritating is the constant talk from people such as the Department of Health about integration, and then they develop an NHS recruitment campaign, and we have Health Education England and Skills for Care, with vastly different levels of resource. In an integrated system, you would use all your resources to train and support people to deliver an integrated outcome. We hear a lot of talk about integration, but we do not see much evidence of it being delivered. We have recruitment campaigns coming up, and one is about nurses in the NHS and the other is about nurses everywhere else. Nurses are nurses. If you need a nurse, you are not that bothered whether they come from the NHS or a social care provider; you just need a nurse.

Colin Angel: In the home care sector, we hear a lot about integration, and it equates to things such as pooled budgets and shared office space, so it is about organisation and finance. I would much rather see things that concentrated on improving people's experience. Martin's example of an integrated service that you do not even know is happening would be a good definition. Rather than necessarily pooling budgets, we could look at people's experience.

In the provider sector, there is a fear that the power balance between health and social care potentially leads to two risks. One is that care becomes very medicalised, with people always thinking about health conditions rather than social care needs. Secondly, there is a race to the bottom, whereby budgets are pooled and organisations get together, and it is not long before one of them says, "We can buy care cheaper, so why don't we buy all the care at the lower rate?" Then we get into some odd

market behaviours and more dominant purchasing power. That is a risk of integration based purely on things such as pooled budgets.

Lord Burns: Do you think that if we had improvements in integration it would lead to more people remaining in their own homes for longer? That is often mentioned in the context of people spending time in hospital beds when they could be at home.

Colin Angel: It certainly could, but at the moment, particularly with health, what do we purchase? It is a “keep people just about on the tracks” type of service, rather than being more about integration and prevention. Home care services can be the eyes and ears in somebody’s home, alerting GPs to deterioration in condition, supporting people and keeping them out of hospital.

Lord Burns: Mr Cooper, do you have anything to add?

Douglas Cooper: This was not an area that we examined, so I defer to my colleagues.

Lord Burns: Professor Green, you mentioned briefly the case of Manchester, where they are taking some steps. Could you tell us more about their experience?

Professor Martin Green: They are trying to get a more integrated service across the whole of the city. They are reaching some challenges, often about the cultures in organisations rather than the structures. Moving everything into one big structure might not be the answer; it might be about doing some work on culture change and outcome measures, and aligning some of the outcome measures across the system. It is noticeable that the system works on different measures of success. If you do not align the outcome measures, you will not have a system that is truly integrated.

Lord Burns: Can you give us a feel about what that would involve?

Professor Martin Green: If I am an adult services director, for example, and I develop a wonderful community service that keeps people out of hospital, and savings accrue to the hospital, they do not necessarily flow down into the service that I have delivered in the locality. Some of that stuff needs to be addressed.

Lord Turnbull: Is it fair to say that there is a massive game of Old Maid going on? Different organisations have budgets and, if you set up a care package with the characteristics of A, and a different care package, organisations will say, “If we choose that one, more of it will be on the health budget, and, if we choose this one, more of it will be on the social services budget”. A lot of time is wasted with each trying to minimise the input they have to make.

Professor Martin Green: Yes. I remember 30 years ago the debate over whether it was a social care bath or a health bath, when actually it is just somebody who needs bathing in order to remain human. We find

ourselves in positions where we keep getting into a debate about who pays rather than what is needed.

Lord Turnbull: Early on, we received a number of representations from people who said that we should just treat the care system like the health system and integrate them. A characteristic of our health system is that we have designed it on a very expensive basis for the taxpayer; the personal contributions are almost in single figures as a per cent, and are very small. The taxpayer pays the rest, and there is no means test. Care is extensively means-tested.

Am I right in thinking that nobody would think it realistic to try to realign care on the basis on which we currently run the health service? First, it would be too expensive, and, secondly, if a lot of the care was provided by the state, the huge contribution from families and their own resources, from neighbours, et cetera, would tend to get backed out. There is a behavioural response. You might think that something was only going to cost you X, but if you did it it would actually cost you a great deal more than X.

Professor Martin Green: That goes to the heart of whether you have a full conversation about the whole health and care service and how you deliver an outcome across that system. If you did that, it would be very difficult, because you would have to have tough conversations about what was classed as free at the point of need in both health and social care. I do not see much political, or indeed citizen, will to have that conversation. In a way, we start from a false premise by talking about one bit of the system rather than the whole system and what it costs.

Colin Angel: At the moment, we have not even seen the Green Paper on the funding of adult social care on its own. I realise that there have been a few other things going on, such as exit from the European Union, but we are still waiting for the Green Paper to have the conversation about the balance of responsibility between the individual and the state for social care.

The Chairman: We try to avoid the B word.

Lord Turnbull: There has been talk about more money from the state, which could be via local authorities, central government or even via the welfare budget, from the attendance allowance. Do we not have to face the fact that, ultimately, people—the users and their families—have to make a larger contribution? Getting that accepted and not getting it called a death tax is proving extremely difficult, but at some point the personal contribution has to be more logical, and in aggregate it has to be larger.

Professor Martin Green: Yes, probably, but you have to start the conversation, and the moment anybody mentions starting the conversation, politicians back away rather than standing forward. It requires a degree of political leadership to say that we are going to have that conversation. We could use the platform of the Green Paper,

although, of course, the question I want to ask is whether there is any plan for a White Paper. If there is not, are we just going to have the current system tweaked, when we need radical reform?

Lord Burns: It depends on the response to the Green Paper.

Professor Martin Green: Exactly. The challenge is that we have to have those conversations, but they will not happen on their own; somebody has to lead them from somewhere, and it has to be politics, I am afraid.

Q88 **Baroness Harding of Winscombe:** I declare my interest as chair of NHS Improvement.

I would like to talk about staff working in social care. We have heard about the high vacancy and turnover rates in social care, and I would be interested in your views on what needs to be done to reduce them. Is it simply a question of money? What else needs to change in the way people are recruited, retained and developed in social care?

Colin Angel: It is largely but not exclusively money. Yesterday, I looked at data about the home care workforce. In England, the independent sector staff turnover is 41.7%, while it is 12.5% for front-line care workers in the same roles in local government employment. They are doing the same job but with a different turnover rate, which I think is about terms and conditions of employment.

Baroness Harding of Winscombe: Can you be more specific?

Colin Angel: It is about pay levels and things such as the length of home care visit that a care worker will do. There are better pensions in local government.

We need to improve the public perception of social care as a career, and it needs better pay. The national living wage should not be the aspiration for the social care workforce; we need rates that look equivalent to the same jobs in the NHS. We need to think about workers' experience—for example, how long they can spend with people and whether they can see the same people and develop relationships over time, as well as reducing the amount of time they spend travelling and making sure that there is good professional development.

Although the B word has been banned from this conversation, competition between employers after the UK's exit from the European Union is likely to get higher in social care. We should think about those turnover rates now and what it is going to be like if the labour market changes significantly.

Professor Martin Green: I agree with all those things. I, too, think that we need to craft a narrative about the benefits of working in social care and some of the things that are good about it, such as the flexibility and autonomy and the difference carers can make to people's lives. We need a training regime and a career pathway that goes right across health and social care, so I question why the Government will put £100,000 a

minute into training staff in only the NHS and then sit back and tell us that it is all an integrated system. Increasingly, we will need staff who move seamlessly between systems, just as service users do. We will have to work smarter, not harder, because the fact of the matter is that the demographics are heading only one way.

Currently we have a challenge with the workforce, so we have to get the workforce working smarter, not harder. We have to embrace technology. The technology that is embraced in the care sector, and to some extent in health, needs to be not only about the back-office functions but about the experience of the service user, using technology to give them greater independence, in particular to be able to self-manage long-term conditions, rather than always thinking that there has to be a response from the NHS or, indeed, from social care.

It will require a complete change in the way we perceive social care careers, establish social care career pathways and integrate them within the NHS, and use the resources available in the NHS and other places more effectively. Along with the stuff that you are doing at NHSI, Lady Harding, we should recognise that we need to put resources behind the development of social care services and start to think about creative approaches to social care, just as we think about how we improve healthcare. The conversation needs to be cross-sectoral, rather than just in silos.

Baroness Harding of Winscombe: In the health service, there is a lot of evidence that improving retention is actually about being a better employer rather than paying more.

Professor Martin Green: Absolutely.

Baroness Harding of Winscombe: I am interested in how much you think that is true in social care as well.

Professor Martin Green: It is true in social care, although there are issues about the base you start from. If in the NHS people are saying, "I'm being a better employer, but I've taken as a given the index-linked pension, the £100,000 a minute on training and the amount of support I have for mentorship—oh, and my employer is being more flexible", that is a better offer than, "We need to be more flexible in social care".

Baroness Harding of Winscombe: The feedback is more basic. People say, "I need a locker to lock away my purse. I'd like hot food if I am working through the night, and don't charge me to park in the car park". How much of that do we need to drive into social care?

Professor Martin Green: A lot. There are the practical things, such as the car parking stuff. Colin's members have to travel a lot in their job, and car parking is a challenge for them. Why do we not give them permits to be able to park, because they are delivering a social service? It is some of that stuff.

There are creative things. I recently discussed with insurers whether they would develop a good motor insurance policy for younger people in the care sector. Younger people in the care sector find car insurance prohibitive. Often, particularly in rural areas, the only way to get to their job is by having a car. There are a range of things that we need to think about to make an attractive package for people to become care workers. To go back to the point I made earlier, we must have a proper career pathway.

Baroness Harding of Winscombe: Do you think we should be looking at social care as an accredited and regulated profession?

Professor Martin Green: Definitely. I would like a clear approach to accreditation and a meaningful qualifications framework. I would like to look at pre-practice qualification, even if it was just basic induction, standardised across the system. There are things we could do, but some of them need to be integrated into what is currently provided as an offering by the NHS so that we use our resources much more effectively to get an outcome that is a worker who is trained and competent to move across systems, just as citizens move across systems.

Baroness Harding of Winscombe: I have one final question, and I am heading towards the Brexit word, I am afraid. Do you agree with the recent report from the Migration Advisory Committee that an easier route for migrants into social care would not assist recruitment problems? Do you think that is the case across the whole country?

Colin Angel: I can see the logic in that, particularly with the turnover figures that I referred to earlier. Improving terms and conditions would certainly help; I do not just mean pay, but the experience of being a care worker and public perception.

However, we will be plugging a leaky bucket whatever we do, under the current system. Reducing the numbers of workers from outside the European Union will put additional strain on the care sector in the next couple of years. Social care workers will not meet the qualifications for salary levels in our future migration system, and we need a measure for the social value of work, not just qualifications and wages.

The Chairman: We heard some horrendous evidence from care workers. We were told of one case where a care worker got up at 4.30 in the morning to start a shift at 7.30 and got home at 11.30, because she could not afford a car, which was your point, and had to rely on public transport. That may be an outlier case, but we had evidence from care workers that they are not regarded in a professional way by others in the health service.

Yet from my own anecdotal knowledge these are amazingly dedicated people, who are paid the absolute minimum and expected to turn things around in a very short period of time. I understand the point about resources, but if the argument is just about other supplies of cheap labour and not actually about improving quality, we are not going to

achieve much, are we?

Colin Angel: I spend much of my time looking at Freedom of Information Act inquiries to expose what authorities are paying for care compared with the minimum price for home care that we publish and revise at least once a year. When I did that a couple of weeks ago, the shortfall between what authorities were paying at the start of April last year and our minimum price was £1.82 per hour of care. Some authorities are squeezing things so much that more financial resource is part of the solution.

The Chairman: Would you be prepared to share that information with the Committee?

Colin Angel: I have already shared it with the clerk, but, yes, I can share it again.

The Chairman: I am talking about the data on specific authorities.

Colin Angel: Yes.

The Chairman: Thank you.

Professor Martin Green: We need a long-term solution, so we need a long-term plan, and it has to be about integrating the workforce across the system and giving them parity of status. Your points were well made: these are people who are incredibly dedicated and are transforming lives, yet they get none of the recognition, resources or training that is commensurate with that level of support. We have to see that as our long-term objective, and in the short term we might have to have a conversation with the Migration Advisory Committee about how we plug a short-term gap towards a long-term strategy.

The Chairman: We are not going there.

Lord Layard: I have one more question on the EEA workforce. It is only 6% but if there is high turnover it will wither very quickly if we do not let people come in to replace them. Is there a higher turnover rate for EEA workers than for domestic workers?

Colin Angel: I do not think there are any data that would answer that question. I do not know whether Richard has come across anything.

The Chairman: It is a very good question.

Colin Angel: It is a fantastic question; I just do not have data that would answer it.

The Chairman: If later you have the answer, you might write to the Committee.

Q89 **Lord Lamont of Lerwick:** I apologise for being late and therefore missing a very large part of your evidence.

My question is very simple. It is about the complexity of the system and the ability of ordinary people to navigate it. A lot of people do not understand that the NHS is free at the point of consumption and the contrast with care; they do not understand that different local authorities have different levels of service and charges. What can be done to make it more accessible and comprehensible for the patient?

Professor Martin Green: First of all, it needs to be simplified and people need to be much clearer about the offering in social care. For example, people think that they know what the offering in health is; it is debatable as to whether or not they do, but they think they know what the offering is. The complexity of social care is, first of all, that it is a very complex system and, secondly, that it is very different in particular areas.

A good example was the Care Act, which is partially suspended. It talked about portability and people being able to take their care from one area to another. What people did not understand was that that would not be possible if they were going from an area that had one set of services to another area that did not. The assessment might be portable, but the service delivery offering might be totally different. That is a real challenge.

The nature of social care is that it is very much a distress purchase, so we will have to try to find a way to get people to understand that they might have to make provision, and that they should be thinking about that before it becomes a crisis. Getting people to think about difficult things is very difficult.

Q90 **The Chairman:** We know about that.

You touched briefly on the last question, Professor Green. In what ways could we make greater use of technology to assist care workers, as well as the people they are looking after, and to help people to remain in their homes for longer, or is that just a kind of fashionable view? Are the practicalities of doing it more difficult than would appear?

Professor Martin Green: I do not think it is more difficult than it would appear. We have lots of opportunities to use low-level technology to transform people's lives. I recently saw a good example in a care home. They had a very easy system. There was a pressure pad in the bed; when the person got out of bed in the middle of the night to go to the bathroom, a small tunnel of blue light took them to the bathroom; if they had not returned to their bed in 10 or 12 minutes, somebody was alerted. The person who was alerted could speak to them and ask, "Are you all right, John?", and John would say, "Yes, just leave me alone", or, "No, I need some help".

That was really useful, because it meant that the member of staff did not have to wander around endlessly at night to see if everybody was all right. It enhanced the dignity of the person, who was able to have much more independence but was supported and safe. It was quite cheap to retrofit the piece of equipment. It saved staff time, enhanced user

experience and made more efficient use of staff resource. Those sorts of things can be really helpful as direct services to people.

We need to look at some of the back-office functions. I was in a care home recently talking to a lady. She and I had a cup of tea, and the care worker could slip into an iPhone that the person had had so many millilitres of liquid, push a button, and it went into the care plan. There was a clear audit trail that that person had had their liquids. That, of course, stopped the care worker having to rush to the office to write it all down. It was a more failsafe system and enabled the care worker to have more time to talk to residents.

There are some simple ways to use technology that help to deliver a better experience for the service user and more efficiency in the system. We have to start thinking strategically about making a greater noise when we see good technology. I suppose I should criticise myself, as I have been quite bad at that, and I will get better in future.

Douglas Cooper: I agree with Professor Green's point. Anecdotally, the take-up of information technology in the sector purely for administrative tasks could be greatly extended to improve the efficiency of back-office functions.

Colin Angel: In home care, technology is being used to improve productivity, with better rostering of care workers, and making sure, through route planning, that travel distance and time is limited. We are seeing the development of systems that can detect a care worker not turning up or being late, and notifying families when that happens, as well as being concerned about whether something has happened to the worker.

Online records, including medication records, with real-time information, can, with the service user's permission, be shared with family members, giving them greater confidence that care is being delivered. There are things that assist people with independence and remaining at home, such as being able to order their medicines, booking appointments and—something I am particularly keen on—online grocery shopping, which is delivered to their front door and they get the products they want roughly at the time they specify.

The Chairman: On the point about looking after the care workers, monitoring when they arrive and so on, it sounds to me as if it could be used to prevent them doing what they often do, which is to spend an extra five minutes having a cup of tea. It is rather a threatening thing, is it not? It sounds a bit big brotherish.

Colin Angel: When those systems are introduced, there are some anxieties among the workers that they are being monitored—

The Chairman: Which they are.

Colin Angel: —and that it is for keeping tabs on them, rather than saying that it is something that will look at their safety. There is a

company that develops badges and mobile phone apps with accelerometers, so that if you take a fall while you are working, the badge or mobile phone will alert your employer that you may have had an accident. The message that there is technology that looks after lone workers can be communicated better than it currently is.

The Chairman: No doubt they have sent a sales representative to Norfolk. Thank you very much indeed. It has been a very helpful session, and we are grateful to you.