HOUSE OF LORDS

Adult Social Care Committee

Corrected oral evidence: Adult social care

Monday 7 March 2022

4.45 pm

Watch the meeting

Members present: Baroness Andrews (The Chair); Baroness Barker; Lord Bradley; Baroness Campbell of Surbiton; The Lord Bishop of Carlisle; Baroness Eaton; Baroness Fraser of Craigmaddie; Baroness Goudie; Baroness Jolly; Lord Laming; Lord Polak; Baroness Shephard of Northwold.

Evidence Session No. 1 Virtual Proceeding Questions 1 - 12

Witnesses

I: Michelle Dyson, Director-General of Adult Social Care, Department of Health and Social Care; Tom Surrey, Director of Adult Social Care Policy, Department of Health and Social Care; Jason Yiannikkou, Director of Integration and Legislation, Department of Health and Social Care.

Examination of Witnesses

Michelle Dyson, Tom Surrey and Jason Yiannikkou.

Q1 **The Chair:** Good afternoon, everyone. It is a huge pleasure to be able to introduce our first public session of the Adult Social Care Committee. We are broadcasting, so I will want my colleagues to declare interests the first time they speak. You will all know that this is being webcast live and we will take a transcript.

I am very pleased to be able to welcome our first three witnesses this afternoon: Michelle Dyson, who is the director-general of adult social care at the Department of Health and Social Care; Tom Surrey, who is the director of adult social care policy at the same department; and Jason Yiannikkou, who is the director of integration and legislation in the same department. It is marvellous to have you with us at such a busy time for you, and we very much appreciate it.

You will be aware that this is the first session of this committee. We spent some time looking at this very active field of adult social care and trying to decide where, as a committee with a short shelf life, we can make the greatest impact on an area that has been relatively neglected.

After taking a lot of advice and sharing our own expertise as a committee, we have decided on one of the areas that are most invisible in what we have concluded is an invisible area of policy. The whole of adult social care is relatively invisible compared with health. We have decided to look at the situation of the unpaid carer community—those who offer unpaid care and those who are cared for—and to ask what the future looks like if nothing changes, but also to look at the limitations of the unpaid carers community in terms of those who would choose other forms of care, such as the young working disabled. Where are the limitations on adult social care? That is the basic exam question that we have set ourselves and it has many ramifications.

We have been consistently told that one of the fundamental challenges facing adult social care is that it is invisible. Would you agree with that? Could you tell us what the Government have done in their own work to try to understand the reason for that and to challenge it? How are they going to attack it in the reforms that are presently in train?

I have a sub-question that came out of a conversation we just had as a committee. As a group of officials, where do you go to find out about unpaid, informal care and the situation that this enormous group of 13 million people are in? Who do you see as their advocates? Where do you see the sources of knowledge, expertise and information that you can draw on?

Michelle Dyson: Let me start with your overarching question on the invisibility of adult social care. I do not quite see it like that, and I think that things have really changed over the past three years. In fact, I was at an all-day conference last week with Kent council on reimagining care. The leader of the council opened by saying exactly that—that the profile of adult social care has really changed over the past three years. Some of

that is not for a good reason, but because social care was very much in the headlights during the pandemic, particularly during the first and second waves.

There are some things that are good about that. For example, the Ipsos MORI trust index lists the most trusted professions. For the first time, carers appeared in that list. I have not checked that far back, but one of my stakeholders told me this. They were certainly not there in 2019. In 2020 and 2021, they were there, which is indicative of how society at large is seeing care workers as a really trusted profession—higher, I should say, than civil servants. When he was first appointed, the Prime Minister said on the steps of Downing Street that he was going to fix social care, so I do not think it is right to say that social care has been invisible over the past few years.

With our new reforms, I think and I hope that social care will gain more and more prominence. As I am sure you know, we are putting an extra £5.4 billion into social care over the course of this spending review. We have set a really ambitious agenda over the next 10 years: a vision that we co-developed with a lot of stakeholders and those with lived experience. The Government have taken on the question of catastrophic costs that have dogged the country for 20 years or so, and have ringfenced a levy to pay for it. It does not feel to me that social care is invisible, although, when you are in competition with health, it is always difficult.

On your specific question about how we learn about unpaid care, the place we tend to go to is Carers UK, which is a really impressive organisation that represents unpaid carers. When I was fairly new in my post, one of the most moving things I did was to meet with a series of unpaid carers, which Carers UK organised. They were talking about their experiences during the pandemic. I do not know if we have time, but Tom Surrey might want to add a bit more detail about our sources of intelligence on unpaid care.

Tom Surrey: Michelle has already mentioned the great work of Carers UK, but there are other representative organisations that we work with. Particularly where there is an interaction with young carers, we work closely with Barnardo's and with the Carers Trust. As Michelle said, a number of our stakeholder forum groups have direct representation of individuals with caring responsibilities, be they for their own family members or others who they have cared for in the past. I am thinking in particular of the membership of our dementia programme board, which includes those living with dementia and those caring for people with dementia, for example.

That personalised voice and hearing it first-hand has been critical to the design of our reform work across the board more generally, including the White Paper that we published back in December, where we spoke to and worked with over 200 organisations and individuals in the preparation of that. We have a broad route to hearing directly from carers and their representatives.

The Chair: In the White Paper, we could see that you had engaged very warmly with those groups. I shall deny myself the privilege of a supplementary and move straight on to Lord Bradley, if he wants to follow up.

Q2 **Lord Bradley:** I declare my health interests in the register, particularly as a trustee of the Centre for Mental Health, as an honorary fellow of the Royal College of Speech and Language Therapists, and as chair of council at Salford University, among others.

Can I just pursue the question of engagement with unpaid carers? You are dealing with central policy. How do you envisage that engagement being effectively undertaken with the new Integrated Care Systems (ICSs) across the country to ensure that their voice is heard?

Tom Surrey: As the ICSs are building up, there are a number of pieces of work, and I may ask Jason to supplement this as our lead on the integration White Paper, which is at the core of this. In those proposals, we will be looking to the Care Quality Commission to develop an assurance programme on integrated care systems, and I am sure that one of the things that it will look at is the breadth of engagement that is happening locally. A key part of that is about the National Health Service and local authorities engaging positively in a local place, but also that wider engagement with service providers and community representative groups.

It is important to recognise that underpinning this are the duties that the Care Act places on local authorities to consider carers when they are designing and commissioning their services. In fact, in many of their actions on social care, they have a duty to take into account the views of carers and to consult with them. That would be the basic underpinning. I do not know whether Jason wants to add more on the ICSs.

Jason Yiannikkou: Tom covered quite a lot of it. I would add that the ICS includes something called the Integrated Care Partnership—the ICP—which is designed to bring together health and local government, as well as a wide range of other partners from within the system. That has the potential to be a really helpful and lively space with a job to do to plan long term for that system. It has quite an important responsibility as well as a convening power.

There is an increasing recognition that there is a profound interdependency between the different services and sectors that the ICS covers, and the importance of drawing in voices from users and carers as part of the development of services has been strongly felt in health as well as in care. In some ways, care has slightly led the way, but health is increasingly conscious of the importance of this, so this is a moment that I hope we can seize upon.

The Chair: Thank you so much, all three of you, for your extremely useful and interesting answers.

Q3 **Baroness Barker:** We are not short on papers or policy, are we? We

have had an absolute flurry of them. Part of the job of our committee is to try to draw some sense of coherence out of those. One of the things that we have recognised and which is an important point to put to you is that we have a health—I emphasise health—and care system that is, in fact and in practice, predicated on the assumption that people will have close family who will look after them and be responsible either for navigating or for delivering their care.

The point we want to make to you is that an increasing number of people do not. We want to ask you about the extent to which that has been acknowledged and plays a part in the planning and thinking that has underpinned some of the policies and documents that we have seen.

Michelle Dyson: To what extent have we factored in the reliance on family carers? We manage social care through some very sophisticated models that predict the level of demand. We have an organisation called the Care Policy and Evaluation Centre, which sits as part of the London School of Economics. It has a sophisticated model that projects demand way into the future, and it is that demand model that feeds into the amount of money that local government gets for social care. We do not assume that families will pick up the slack. We model on the basis of what we think the needs are.

I completely take your point. I know that local authorities think a lot about how you can leverage in the community as part of social care. A few months ago, for example, I visited Camden Council in London, which was thinking quite deeply about this. It had a really great example of somebody who had no family. She was deteriorating and they said that in normal circumstances they would have just put a package together to make sure that she would take her medicine. She had been the caretaker of the building in which she lived, and everyone in the building knew her and had good relationships with her.

Instead, the council co-ordinated all those people in the building to support her, not just in taking her medicine but in making sure that she was less lonely. They went through her memories and sorted out her photographs with her, which they said really contributed to her well-being. I know that lots of councils are thinking about how you can leverage in the community in that way, not least building off what we have seen during the pandemic.

I would mention a couple of other things in this context. There is an interesting commission on reimagining care which the Archbishop of Canterbury and the Archbishop of York have launched. It is early days, but that looks at the role of community, as I understand it, in supporting people. The point that I am trying to get at is that it is not necessarily a dichotomy between the state and the family. The role of community is really important.

Finally, we announced in our White Paper a pot of money worth up to £30 million for innovative care models. That sort of innovation is what we are looking for. An example of an innovative model is the shared lives model.

I met people who are participating in it and have been very inspired by what they do. You have people in the community who contract with the council to support someone with learning disabilities, who comes and lives in their house in what some people might call an adult fostering type of model. There are all sorts of models of that kind, which councils are experimenting with, and we want to use that £30 million pot to galvanise more of that.

Q4 **Baroness Campbell of Surbiton:** So far, the committee has heard that many of the failures to provide a clear response to people and their families' diverse needs are tied up with the lack of co-production in the delivery of care. As you will all know, co-production is very different from consultation, listening or involvement, because it includes policymakers, politicians and others tasked with social care provision working together when designing care policy or delivery. What role, if any, did co-production play in developing the Government's adult social care White Paper?

So far, it does not reflect that this has been adequately grasped. I would like to know your understanding of co-production and how much it has been used in developing the White Paper specifically. What role will co-production play in influencing the Government's reforms to ensure choice, control and independence for those receiving care and unpaid carers? Tell me how you would define co-production, and how it is being used and will be used in the future?

Michelle Dyson: I do not know whether my definition of co-production comes up to the high standards that you set. We are really happy to learn and to do it better in the future, and your challenge is a great one.

In terms of what we did on the White Paper, we had over 200 individuals and organisations involved in that process. Some were organisations that represent those who use care and support, and some were people who use care and support themselves. We put at the heart of our White Paper the "I" statements that have been developed by Think Local Act Personal. It is all based on what people want for their care and support needs.

We tried really hard to do it right. The White Paper is only a staging post in our reforms, because in every bit of the White Paper we made commitments where there is further detail to be worked out, whether it is what we have promised on unpaid carers, the innovative care models that I just talked about, or our workforce or housing proposals. All of them have been described at a pretty high level in the White Paper, so the next level of working out how we implement and deliver these things is massively important, and I am really keen that we do that in as much of a co-production approach as possible. If we have not done it as well as we should have done, we would really like to know that and to learn how to do it better.

Baroness Campbell of Surbiton: Do you have any co-production strategy in the department that sets out how it is done, whom to involve and the way to involve?

Michelle Dyson: I am not aware of anything called a co-production strategy. There may be such a thing, but I have not been here for that long. I look to Jason and Tom, if they know of any such thing. In principle, a strategy is a strategy. The real question is whether we do it well enough and, at a practical level, whether what we are doing is good enough. That is the thing that I would be interested in learning about.

Baroness Campbell of Surbiton: It could be a lot better. It was recently done extremely badly in the disability strategy. As you will know, it was taken to court on those grounds. There is a co-production methodology and paper somewhere in the bowels of the Department of Health and Social Care. I know, because I wrote it over 10 years ago. You might want to dust it off, because co-production is an entirely different methodology to the one that you are using at the moment.

The Chair: Thank you, Jane. The officials have quite a lot to learn, but it is very gracious of them to say that they are very keen to learn as well.

Baroness Campbell of Surbiton: Yes, absolutely.

Q5 **Baroness Fraser of Craigmaddie:** I need to declare my interests, as it is the first time I have spoken. I am chief executive of Cerebral Palsy Scotland, trustee of the Neurological Alliance of Scotland, and chair of the Scottish Government's National Advisory Committee for Neurological Conditions.

Now that I have got that over and done with, thank you very much, Michelle, for speaking about co-production—or not, as Lady Campbell may have challenged—in the development of policy. I am quite interested in my supplementary question to ask you whether you have examples of where co-production has improved the delivery of care and where you are looking to develop policy. You mentioned Camden, and we have had papers about the Royal Borough of Hammersmith and Fulham, for example. How does the policy identify areas of good practice that can then be supported to scale up?

Michelle Dyson: I think what you are asking is how we spread best practice in delivery. Is that right?

Baroness Fraser of Craigmaddie: Best practice for this whole area is huge. I am thinking about whether you have examples of where co-production has led to improvements in practice and how you support that to scale up.

Michelle Dyson: I see what you mean. I do not think I have any to hand. I go on visits an awful lot and I hear about great things going on in all sorts of different places, but on the way in which we spread best practice, if I can call it that, we have a fund called the care and health improvement programme—we always call it CHIP (Care and Health Improvement Programme). We give that money to the Local Government Association and the Association of Directors of Adult Social Services. We ask them to support local government with that money to do things better and to work, through co-production, with their providers and

communities on prevention, for example. That is the mechanism whereby I would expect, in a systematic way, people to spot really good examples and spread them elsewhere, rather than through us in the department.

Q6 **Baroness Shephard of Northwold:** My question is for Michelle, who has already mentioned the extra £5.4 billion that will be spent on adult social care reform. I do not think she said this, but £3.6 billion will, of course, be spent on the cap and the extension to the means test. I wonder whether you can explain, in your planning, how the extra £1.7 billion will be spent. One is always travelling hopefully, but could you explain whether there has been an assessment of how much difference that £1.7 billion might make in improving adult social care immediately and in the long term, given that the demands will increase?

Michelle Dyson: On your question about how the £1.7 billion will be spent, we have said that at least £500 million will be spent on the workforce, at least £300 million on housing, at least £150 million on technology, up to £25 million on piloting changes in services for unpaid carers, and at least £70 million on improvement, which is what I was just talking about—the programme for how you spread best practice—along with various other bits and pieces.

If you add all that up, you will notice that it does not come to £1.7 billion, and the reason for that is that this is money over the next three years. It is sensible budgeting not to tie everything down. A lot of this is subject to procurement processes, so we do not know how exactly it will pan out, so we have not allocated every last million, but it is fully our intention to spend £5.4 billion overall, of which, as you say, £3.6 billion has been allocated for the changes to how you pay for care.

Do we think it will work? The main point to make is that our White Paper, which is supported by the £1.7 billion, is a 10-year vision. The money that we have is only for the next three years, because of the way the spending review cycles work, so we would not claim that that £1.7 billion is going to transform adult social care and tick off every bit of the vision as set out in the White Paper, because that is a 10-year vision, albeit that £1.7 billion is a very serious amount of money to support reform.

The other important point to make is that that money is not about funding the baseline pressures. The baseline pressures, such as demographic pressures or the increase in the minimum wage, that has been funded through the Local Government Finance Settlement, completely separately from this money. This money is purely about reform.

Will it do everything that we want it to do in the three years? It is really hard to say. On the workforce side, for example, we know that training improves retention rates, and the £500 million on the workforce will enable five times more investment in national, state-funded training than has ever been paid for before for care workers and registered managers. With luck, although it does not work like this and things are never as exact as that, we should see an improvement in retention rates. Each bit

of our funding pot will have a business case alongside it, eventually, which will say what we are hoping to achieve, but that is a work in progress at the moment.

Q7 **The Lord Bishop of Carlisle:** I should declare my interest as the lead bishop in the Church of England for health and social care, but also as the co-chair of the archbishop's commission for reimagining social care, which, Michelle, you mentioned. You suggested that you would like Tom to answer this question, which is about the White Paper on adult social care and how it relates in particular to unpaid carers, which is one of the main focuses of our investigation. The White Paper contains a pledge of up to £25 million towards a range of interventions that will support these unpaid carers.

I have four questions, if I may, about that pledge. How was that figure determined? How did you come to £25 million? What sort of difference is it going to make? What is the potential impact of that £25 million when it is spent?

Tom Surrey: As Michelle just set out, there is a full process under way to put the meat on the bones of the White Paper and to really work with our partners and with local government to shape the best way to spend that money to most effect, so I do not want to be too definitive at this point, because I think it is actually really important that we work with providers, with carers and with local government.

The key thing to recognise about the £25 million, going back to a point I made earlier, is that the Care Act places a duty on local authorities to provide support and advice for carers. That should be funded through the wider settlement that local government receives each year, and Michelle described the needs assessment and demographic analysis that underpins that wider settlement, so this is additional money.

One of the things that we heard loud and clear from the carer organisations and others over the production of the White Paper was that there are some fantastic services available for unpaid carers, be they information, advice, respite care, or day care services and access to those, but that is not universally the case and it is not universally as innovative or engaging as it can be.

So, this money is very much intended to seed fund some of those proposals, to gather the best practice and to allow that to disseminate more widely through our improvement programme, rather than to directly fund those services, although that would be an option that we would consider, if there were good cases coming towards us for that.

As the Chair mentioned, with the volume of unpaid care in the system, and indeed with the amount of people who take on caring roles and give the support to them, I do not think we have said, "This is the right amount of money to provide everything that we want". We have identified an amount of money that we think we can credibly spend over a three-year period to really generate that innovation and best practice,

and to capture that and share it more widely, so that we improve the consistency of services.

In that second point, I have tried to answer your second question, which was about the impact we have. We would like to see a greater consistency of support for carers across the country, with more innovation and more really impactful models being delivered by local authorities in their support for individuals.

The Lord Bishop of Carlisle: Thank you very much indeed. You have certainly answered my third question, which was about how you are going to allocate the funding. You said that you do not want to be too specific at the moment, which I entirely understand. Can you give us any idea of what will be prioritised? From what you have said so far, I take it that sorting out what constitutes best practice and how that can be built on might be your answer, but would that be correct?

Tom Surrey: That is certainly part of it. We said throughout the White Paper that there are three key priorities for unpaid carers, and we have talked about that best practice and innovation space.

We are also very interested in how carers are identifying. The Chair mentioned in her introduction a number of around 13 million, which I think is an estimate from Carers UK. We keenly await the data from last year's census, which will give us the first robust indication of the number of unpaid carers in the country. We are also looking at how unpaid carers self-identify and identify through their GP records, and whether we can encourage that use.

The third point is about encouraging some of the wider best practice that we see, in particular in social and economic engagement for carers, looking at the use of social prescribing by our NHS colleagues and seeing whether there are opportunities to make more of that and to ensure that our carers, in carrying out the amazing work that many of them choose to do, and in looking after family members through love, duty and compassion, are not having to compromise their own social and economic engagement in carrying out that role.

The Chair: Thank you very much, Tom. That response has struck many a chord with us.

Q8 **Lord Polak:** My question is on the responses that you just gave there, Tom. There are a couple of things that I was not sure about, which you have now made clear. When you talked about the £25 million, you threw in that it is over three years, so it may not go quite as far as one would have hoped. I would like you to clarify that.

At the beginning, you talked about a full process to shape what you are going through. I am pressing a little what the bishop asked. How do you decide how much money you want to spend before you have done the full process? Is this not the wrong way round, given that you may find that you would like to spend much more in this area? You could do the process first and then decide from that how to spend the money.

Tom Surrey: On the point about absolute clarity, the £25 million is over a three-year period. The important point there is that the White Paper sets a 10-year vision. We are tied to a three-year funding cycle. A key element of spending this money will be to evaluate that best practice and that impact, and to build the case for more investment if it is concluded that it is needed, through the next spending review and spending reviews beyond that, to make sure that that 10-year vision for unpaid carers captured in the White Paper is delivered.

Lord Polak: We really need to go to the Treasury, then, do we not?

Q9 **Baroness Goudie:** My question is to you, Tom, but to anyone else who might want to come in. It is great to meet all three of you today. The Government's White Paper on adult social care emphasised the importance of keeping people independent in their own homes for as long as possible, which is one of my pet things on this issue. Can you explain how the £300 million, which was promised to integrate housing into local healthcare and care strategies, particularly supported housing, and the £70 million per year investment in the care and support specialist housing cash fund, will make this a reality?

How will it be allocated? Perhaps you might be able to give me some timelines over the next 10 years. If you cannot, maybe you could write to the committee at some point. What will be the balance of funding between support for people in their own homes and new builds with care? Will the new builds be new builds with housing associations or new builds for people to purchase?

Tom Surrey: I will immediately take the option to write to you over the coming months as we develop the detail of exactly how the money will break down, but perhaps I can give you a feel for where we see the difference. The Chair will remember from her time in government, when I had the great pleasure to work for her on exactly these issues, how difficult a nut it is to crack to really drive up the supply of specialist and supported housing in local areas.

It is important to note that probably the best estimates that I have seen of future demand for specialist and supported housing are around 125,000 units by 2030. To be completely clear about it, that would cost many billions to provide. Therefore, the £300 million is not an investment primarily designed to put capital money into the system. What it is designed to do is engender a much wider market response to this demand, and that will form the three key factors.

There is definitely something about the word "integration" there. As I am sure you will know, delivering housing supply of any type, but especially specialist housing supply, needs all elements of local government—both upper and lower-tier authorities—as well as the planning system, the health system, the social care system, and the housing associations and private developers, to coalesce around a single vision. An important part of this will be designing those plans and making sure that every upper or lower-tier local authority area or ICS region has a clear plan in place that

identifies the need in its area and the trajectory for delivering that. This will not, as we say, be an immediate, short-term fix.

The CASSH programme (Care and Support Specialist Housing fund) that you mentioned is a really important part of this and is providing capital and grant subsidy for housing developers and housing associations in particular, but it is fair to say that over the last couple of years, and indeed from its introduction, the spending profile on that has not always materialised. We know that in the last year that has been particularly challenging due to the pandemic.

Capital subsidy will continue through the CASSH programme and through the wider affordable housing programme; the £300 million will enable places, and indeed the private and housing association sector, to coalesce around a vision of what they want to deliver in that place. That is very much about proof of concept. In some local places and local authorities, we are seeing a significant amount of specialist and supportive housing delivered, but that, again, is not universally the case yet.

We also see a role for the £300 million as providing funding for some of the services for residents who live in the specialist and supported housing sector. We have heard many times from developers and housing associations in particular that their confidence in the market has been shaken because of the pressures on revenue funding. If we can address that in the margins, that would be a great achievement as well.

Q10 **Baroness Jolly:** Thank you all very much for making the time. I welcome all these moves to help me remain independent whenever the time comes. Who should be involved in the decision-making process? Clearly I should, along with local authorities, a care worker, friends and family, but what is the role of social workers in making these decisions? Who else might be involved? Who makes the final decision on this matter?

The Chair: Tom, that is probably one for you, although it is a very hard question, is it not?

Tom Surrey: I am afraid it is a very hard question. I am not aware of who the final arbiter would be in any decision in that space. You have captured the vision that we would hope for in the White Paper, which is that you are absolutely integral in that decision-making process. If that requires support from carers or social workers to enable you to clearly express your choice and independence, that should be facilitated.

Baroness Jolly: I hope that everybody in all possible local authorities where I might end up would be receptive to those views. Thank you very much.

The Chair: Thank you, Tom. You did really well on that.

Q11 **Lord Laming:** Thank you very much indeed. It is great to have the three of you with us at the beginning of our process. I should declare that I have no relevant interests to declare for this matter. At the beginning of

our time together, Michelle did not agree that social care can be described as being invisible, but maybe we could all agree that social care is very much the junior partner in the department, in the NHS and in the media.

We are very interested in the integrated reforms in the White Paper, and it would be very helpful if you could share with us how social care will be engaged in the integration of services. Could you place a particular emphasis on whether users and carers will play a part and whether they will notice any difference?

Jason Yiannikkou: It is a really good question, because it brings some of these themes together. In some ways, I would push back a little on the junior partner point. You are making a point that is historically accurate in some ways, but the way I would put it, and what came out as we developed the Integration White Paper, is that the question that social care will ask of someone—which, to strip it down, is a question about how you want to live your life—is increasingly the question that healthcare needs to ask.

As we developed the paper, we saw the increasing importance of the management of complexity as an aspect of healthcare as well as of social care. There is a convergence between the two that is becoming stronger by the day and by the decade. That is what we are seeking to respond to. In some ways, there is a lot that health can learn from social care. We are trying, through the integration process, to bring them together, not just because they need to join up around someone's life and experience and the people who are caring for them, although those are really important, but so they can learn from each other. The learning is absolutely not all one way.

I would not want to overclaim what a single White Paper can do to make some of this happen when you are asking me about practical differences, but there are some things in the paper that we would point to, which I hope are helpful. We talk about joint working between health and social care, and getting a single team around someone as much as possible to help with their different needs in a single effort, rather than having them and the people supporting them move between different services. It is a person-centred approach.

Linked to that, a shared care record would mean that we are not asking people and those caring for them to join the dots and tell the same story over and over again, but allowing the information and the way it flows to do that job for them to some extent.

Finally, this is less immediately patient-centred, but some of what we say about decision-making in planning and governance is quite important. One of the concepts that we have talked a lot about, as has Professor Sir Chris Ham, is mutual accountability. That is about the people who are making strategic decisions in local authorities and the NHS, at both system and place level, looking each other in the eye and thinking about how they are going to work together to help the client groups and the

local populations they both serve in their different ways, moving away from a sectoral approach to a much more joined-up one.

If these things together can be given a chance to bed in, we will see some practical impacts over time, but they will vary from person to person and from geography to geography. I am quietly optimistic that if we can get all the elements pointing in the right direction, we will be able to make a significant difference.

Lord Laming: That is enormously helpful. Thank you very much indeed. You will understand then that, for the user of services and their carers, it often feels as if health and social care go down two separate lines. They feel that they are totally different organisations. I am not clear, and I wondered if you could help us on this, how that can be broken down, so that integrated care becomes a reality rather than just a vague concept.

Michelle Dyson: I want to come in briefly on something that is so important. It is a really practical example that Jason mentioned, but I just wanted to highlight it—the digital social care records. We have said that we will get 80% of social care to have digital records. I have been in care homes where they are still writing physically. We have evidence that shows that if you get a digital record it will save 20 minutes for every care worker for every shift, so that will yield time for care workers to spend with people, as well as enable the sharing of information, so that you genuinely feel that there is one system. That is a small but really practical example of how we are moving this agenda forward.

Q12 **Lord Laming:** Given the different funding mechanisms between health and social care, what are your hopes about more integrated working, despite the fact that they are fundamentally different in the way they are financed and organised?

Jason Yiannikkou: The phrase we used quite deliberately in the Integration White Paper was "pooling and aligning". We wanted to keep it fairly broad in the way we described it. There are formal mechanisms for pooling money, and they work well in some situations, but what we also see working well in a number of different systems and places, which comes back to the mutual accountability point, is people sitting down and saying, "Here are our shared problems. Here are the issues that are really affecting the people in our geography. Here are our total resources for dealing with that. They may not be all that we want, but they are significant. What can we do collectively to make the most difference?"

Once you start from that frame of reference, rather than perhaps thinking about "my budget" and "your budget", you start to make some progress. If you start to think about a population as a population with a set of interconnected and interdependent needs, you again start to make progress. Some of this is about how you almost reframe the problem and articulate goals and outcomes in a way that is not sectoral or siloed.

Lord Laming: That is enormously helpful. I have one quick question, if I may. As we go forward in all this, how will the department know whether

any of this is working or whether we are talking to ourselves?

Jason Yiannikkou: That is a fantastic question to end on. There is no single metric that will tell us. We have a number of established measures of health and well-being that we need to pay attention to. This is a long game. The CQC is doing some really interesting work—the Bill asked it do this—to look at systems, and within systems it will also look at places, and to think about how well that joined-up aspect is working.

The other thing that will help us to understand this is getting into patient experience, user experience and carer experience. I would really want to privilege the role of experience and the measurement of that as part of this, because the measurement of how joined-up something is cannot be an abstract thing. It has to be how it feels for the person at the centre of care. Ultimately, we have to come back to that.

Lord Laming: Well done. I wish you great success.

The Chair: Thank you so much, Lord Laming. Those were terrific questions and answers. I am afraid I do not have time to call a supplementary, so my apologies to Lord Bradley.

Can I thank you on behalf of the committee? You have shown today not just what we would expect from every public servant, which is for you to be on top of your brief, but a tremendous conviction that what you are doing has to work and to make a difference for people whom you so obviously care about and want to involve in your own work.

This is the first of the conversations. We may well have another one with you, and we may well come back to you with additional questions. It has been a pleasure and we have learned a lot. I am sure that we will be joint companions on the road for reform over the next year or so, so I hope you can help answer and accelerate the questions and answers that you are looking for as well. With that, thank you again on behalf of the entire committee.