



Adult Social Care Committee

Corrected oral evidence: Adult social care

Monday 14 March 2022

3.45 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 Jolly; Lord Laming; Baroness Shephard of Northwold; Baroness Warwick of Undercliffe.

Evidence Session No. 2

Virtual Proceeding

Questions 13 - 22

Witnesses

[I](#): Vicky Davis, Director, Local Government Value for Money, National Audit Office; Dr Anna Dixon MBE, Chair, Archbishops' Commission on Reimagining Social Care; Rt Hon Jeremy Hunt MP, Chair, Health and Social Care Committee; Vic Rayner, CEO, National Care Forum, representing the All-Party Parliamentary Group on Adult Social Care.

Examination of witnesses

Vicky Davis, Dr Anna Dixon, Jeremy Hunt and Vic Rayner.

Q13 The Chair: Good afternoon, everybody. This is the second public oral evidence session of the Adult Social Care Committee, and I am absolutely delighted that we have four extremely distinguished people to assist us this afternoon: Vicky Davis, the director of Local Government Value for Money at the National Audit Office; Anna Dixon, chair of the Archbishops' Commission on Reimagining Social Care; the Rt Hon Jeremy Hunt MP, chair of the Health and Social Care Committee; and Vic Rayner, chief executive of the National Care Forum, who is representing the All-Party Parliamentary Group on Adult Social Care today. Welcome to you all. I know that you are all very experienced at Select Committee inquiries, and you will know that the webcast is beamed live and that a transcript is being taken. I should declare my interest this afternoon as a governor of Sutton's Hospital, Charterhouse.

This is a very early stage of our inquiry, which is why we are so delighted to have you with us today. You will appreciate more than many people how congested and contentious is the field of adult social care. An immense range of activity is going into it, from policy-making to the politics of health and social care. The first task we have as a committee is to make sure that we ask the right exam question, that we find a topic that has not been so heavily trampled over that there is nothing new to say or that we get in the way of other inquiries that you are doing, for example. We want very much to make a contribution to the clarity of thought and the persuasiveness of the arguments for change. We have spent a fair bit of time so far listening to other people about what they are doing, taking advice and talking among ourselves—there is a fair amount of expertise around this table—about what we can do that will be meaningful in the short year that we have.

We have alighted on a topic that is in its early stages and has been refined but not overdeveloped. It is discrete, urgent and timely, as well as long overdue, and in the context of this question: why is adult social care invisible compared with, say, the health service? What is it about the situation of the unpaid community of carers that contributes to this invisibility, particularly that of the people they care for and the diversity of that community of people—young and old, disabled from birth with inherited disabilities and, right at the other end of the spectrum, the fragile elderly?

Our exam question is: what needs to change to fulfil some of those ambitions for independence, autonomy, greater quality of life and greater choice, whether you are a carer who wants to rejoin the workforce or whatever it is? We will be looking at all those questions and many more over the next few months.

One reason why we are so pleased to listen to you today is because you have all had such experience of this field and you know the very challenging and difficult questions, so you will appreciate why we have chosen this particular corner of the field to investigate.

I will start with a very basic question, but I can assure you that they will get harder after this. My question to each of you is: can you give us a short overview of where you are putting your effort at the moment and why, in the various situations that you are in?

Dr Anna Dixon: Thank you very much. As you said in your introduction, I am currently engaged as the chair of the Archbishops' Commission on Reimagining Care alongside my co-chair, the Lord Bishop of Carlisle, who is also a member of this committee, so I am sure that Bishop James may wish to contribute to what I have to say.

I am here, because I have been working in the field of health and social care for 25 years, and I first got involved in research and policy at the time of the royal commission. Having worked in policy, working for two different Governments at two different points of time as an adviser and director of strategy, I feel some degree of frustration that we have not made more progress with social care in this country. Most recently, I was an adviser to the independent review of adult social care in Scotland, which Derek Feeley chaired. I came back from that experience with a sense of urgency that we needed to do something but not just anything, and certainly not to see this as fixing a crisis.

In our remit in the Archbishops' Commission on Reimagining Care, we are trying to take a long-term view, to be radical, and to develop a vision for care and support. We are doing that, I guess unusually but as a church-sponsored commission, by drawing on Christian theology, principles and ethics. I suppose that is what makes the work we are doing different from some of the other reviews and inquiries that have gone before in that we are trying to get to the heart of care and caring: what are the principles that lie at the heart of reimagined care and support?

We are also, therefore, quite broad in our definition of care and support. We are not just focusing on what government does in the statutory system; we are focusing on the breadth of care, including informal care and support—what we do for one another, often out of love, as part of a community and indeed in families. We will do more than produce a long-term vision. We will set out recommendations for how to deliver that vision, and I am sure we can talk more about some of what is emerging from our work.

To conclude, to position our work, our focus is quite broad, but we are trying to look particularly at the role of communities and, in that, the role of faith communities.

The Chair: That is very good news. Thank you so much. There is a lot of overlap there, but in the best possible way, I think.

Jeremy Hunt: Thank you so much, Chair. I will be a bit more practical and brass tacks than Anna Dixon, who I was greatly privileged to work with at the Department of Health. We did a big report on adult social care in the House of Commons Health and Social Care Committee, so I am

focusing much more narrowly and trying to get those recommendations implemented.

The biggest gap at the moment is in local authority funding, and I am very worried that that is the bit that has been forgotten in all of this. There was a government manifesto commitment to deal with the catastrophic care costs for people who have dementia and other neurological conditions. There has been a debate about the level of the cap, but we will have a cap and I think that will be welcomed by a lot of people. I welcome it, as someone who did a lot of campaigning on dementia.

In our report, which came out a year ago last September, we recommended that local authority funding, just to keep up with demographic changes and without a big increase in the quality of care provided, goes up by £7 billion a year by the end of this Parliament. The Government have announced an increase of £2 billion a year. There is a very big gap between that and what I believe is needed. I am very concerned that the knock-on effect will not just be that we do not look after older people with the dignity and respect that they should be given and not look after disabled adults of working age whose needs and numbers are increasing, but that there will also be a knock-on effect on the NHS, which will not be able to discharge people from hospital when it needs to. That is the main focus of my attention.

The Chair: We are very keen not to produce 27 recommendations but to make five that can be implemented, so we will march along with you in that. We are not going to do the big questions that you address, but they will affect everything that we say, so we will have a constant dialogue with you as we go forward, and I am very happy about that. Vicky Davis, what about your current work?

Vicky Davis: A piece of work that we published last year on the adult social care market looked at the market as it was at that time and at the Department of Health and Social Care's role in overseeing, now and in the future, with the aim of making recommendations that would be useful as the reform proposals came forward. We have done work before on the care workforce, personalised commissioning, the interface between health and care, and, most recently in 2020, the response of the NHS and adult social care to Covid.

Our health team is leading a piece of work on integrated care systems, which speaks somewhat to Jeremy Hunt's point about the knock-on effects of the two systems on each other, taking an early look at the Integrated Care Systems (ICS) structures and whether the governance of them is being set up in a way that allows them to achieve their objectives. We are staying close to the adult social care reforms in following up on the implementation of the recommendations from our markets report last year, and those of the Public Accounts Committee, and thinking about the work that we will do in future.

With my other hat on, I am very interested in local government financial sustainability, so all those points about the local government funding landscape are very live for me as well.

The Chair: Thank you very much indeed. That is quite a menu.

Vic Rayner: I am speaking today from the perspective of one of the co-chairs of the working group of the APPG on adult social care. I share that co-chair responsibility with somebody with lived experience of care and support and somebody working as an unpaid carer. The APPG is trying to ensure that we look across the wider view of the system.

Over the last couple of years since the APPG was formed, we have focused a lot of work on the pandemic, working very closely with parliamentarians who are part of the APPG and providing very regular updates on how government policy is operationalising and the impact of that on the front line. I think it has been a helpful opportunity for parliamentarians across the House to hear from the APPG.

In the last year, we have been working very hard on a reform piece. We have produced a vision and values document, which I am happy to share with the committee if you do not already have a copy. We produced that prior to the Government's reform papers coming out, and it is quite clear that a lot of the language and approach in the vision element of that paper mirrors some of what is in the Government's reform paper. We share a vision of what social care should look like with groups such as Social Care Future and the commission that Anna Dixon is leading.

It was very clear that a lot of the work that we had done on value, which is about the contribution and the value of social care to the wider economy, is not included in the Government's understanding of what social care can contribute. A particularly strong focus in our work, which I know is mirrored by Jeremy Hunt's committee and others, is on the workforce and the absolute centrality of funding and rewarding the workforce in a way that means that people can have security in the care and support that they receive and that the workforce is properly recognised for the things that it does.

I welcome your committee's focus on the invisibility of care. It is absolutely true in relation to the unpaid care workforce and those receiving care and support. The paid workforce has also experienced a very high level of invisibility and a lack of parity between it and the NHS workforce. The APPG is very keen to get that contribution recognised.

Those are some of the areas that we are focusing on while we continue to look forward to some of the reform agendas of a fair price for care and the implementation of Section 18(3), all of which we think will present further challenges for commissioning and bringing finance and funding into the social care sector so that it has enough to deliver against the objectives that we need for communities.

The Chair: Thank you so much. That is good to know. We will certainly

be working more closely with you in future. There is a big overlap in our values and interests.

- Q14 **The Lord Bishop of Carlisle:** Thank you. I am grateful for all those summaries. I want to ask about the integration of health and social care, which is, of course, a major emphasis in the Health and Care Bill and has all sorts of implications, not least for the position, status, value, pay and so on of unpaid carers.

My question relates especially to the work that we are doing on the Archbishops' Commission. From the work that you have done and are currently doing, do you think that a satisfactory degree of integration can be achieved in the social care system as it currently exists through tinkering around and some improvements, or will this require a more radical level of action? Perhaps I could start with Anna Dixon, because this is something we have discussed a little.

Dr Anna Dixon: I was not pre-advised of the questions, so I did not know that one was coming, colleagues, but thank you very much, Bishop James.

Of course it is great to see the integration of health and social care progressing. It is something that we have worked on for a long time, from my days at the King's Fund, looking at international examples of how we can join up care for people. People are increasingly living with long-term conditions needing a range of care and support both within the NHS and across to social care. That is important.

However, from the work we did in Scotland, there was recognition, in trying to put these two very different systems together, that the entitlements and the meanness of the means test are just so different. Many people did not realise that they had to pay for care, and when they established that they did, it led to huge delays and a ballooning of things like NHS Continuing Healthcare, and a lot of unease for people who found themselves in the position of not really knowing whether they are entitled to have that care and support paid for under NHS Continuing Healthcare or have to pay for themselves. We see where these two very different systems butt up against each other. We see it in other ways in the workforce, and I am sure that colleagues will speak more about the lack of parity between NHS and care workers.

One of the ways in which Scotland sought to do this was by establishing a National Care Service. It has started to put care on a level with the National Health Service in having a voice and a profile nationally, by starting to look at reducing some of the charging in the care system and, indeed, very much looking to have pay parity between health and social care. I feel that is one of the fundamental divides.

As you know, Bishop James, in thinking radically about the long-term future, we are saying, "Are we at a Beveridge moment where we need to do something more radical?". Thinking about the fact that care happens to all of us - at some point in our lives, we will be a caregiver or in receipt of care - and in recognising the universality that this affects us all, we

need to consider what that looks like in a more universal response. We cannot get there overnight, but we believe that we may need to look at that and start to bridge it in a more fundamental way, rather than just looking at structures and people's entitlements and making what people can expect in care and support simpler and clearer for them.

Those are some of the emerging ideas that we are starting to discuss as part of the Archbishops' Commission.

The Lord Bishop of Carlisle: Thank you very much indeed, Anna. Talking of a Beveridge moment, perhaps we could launch from that to Jeremy Hunt for any views on this business of integration, not least now that we have a health and social care department.

Jeremy Hunt: It is a very important question. There is a fundamental tension between Governments who tend to want to do things in a top-down way and impose integration from the top, and the reality that these things always work much better when they are driven by the enthusiasm and the relationships between people on the ground.

As someone who tried, with Oliver Letwin, to impose integration on the health and social care systems with as much of an iron rod as we could from 2014 to 2016, I can definitely say that it does not work because people have too much else on their plates. We tried to use the better care fund as a kind of bribe: "If you want to access the better care fund, you have to do all these integration things". What happens is that people find ways to tick the boxes to access the cash, but then do not go along with the spirit of what you want, because their purpose is to get the cash; it is not to properly integrate health and social care.

You want to encourage that to happen locally, but there are two things that government has the responsibility to get right. First, if the adult social care sector continues to be underfunded—I do not want to sound like a cracked record on this—the NHS will be very reluctant to form big, deep relationships with the adult social care sector, because it will be worried about taking on its financial liabilities and you will get more reluctance on the NHS side.

More importantly, however, some very basic bits of plumbing are required from the centre. One of them is to have fully transferable electronic health and care records that can be accessed by any local authority and NHS organisation across the health and care system in a local area. It seems to me that a national initiative to make that happen would be extremely valuable. It will happen. It is starting to happen in some cases anyway, particularly across the NHS side of the system, but it needs to be turbocharged. I would like to see a lot of heft on that.

The Lord Bishop of Carlisle: That is tremendously helpful. Thank you.

Vic Rayner: The APPG has been looking at this area quite a bit, and the Care Minister, Gillian Keegan, recently came to meet with us to discuss some of our perspectives on integration, particularly in the White Paper.

We were able to give a valuable case study about an organisation called Look Ahead, which works across London in mental health services and to talk about what a fully integrated service looks like in practice.

Part of the challenge is that the Government are looking at this through a kind of structural lens, and properly integrated services are much broader than just those that are commissioned. There are lots of things about how integrated services fit in with the broader community and a multidisciplinary approach. Although it must be about people, we feel that in the current structure that is being put forward there are gaps in how people's voices are represented. There are concerns about the absence of the voices of people who use care and support at some of the decision-making tables, the voices of people who are unpaid carers and the voices of the people who are providing care and support services. All the ambitions for integration, many of which we support, including things like having integrated workforce plans, fall down without those elements being properly represented.

You cannot workforce plan by having only the people who commission or fund services there. You have to have the people who employ the workforce and can deliver them and support their training and development. You cannot have a proper digital integrated strategy if you are not talking to the people who receive care and support and not asking them who they want to have access to their data, who they want to be able to share their electronic records with, which is data about them. Fundamentally, you need them at the table to say, "This is who I think it is important sees my information, because that will enable better integrated care for me".

It feels very much like we are talking about a lot of structural processes without the voices of the most important people and those whose lives are supposed to be most transformed by integration at the right table.

The Lord Bishop of Carlisle: That is a helpful perspective. Thank you.

Vicky Davis: Following on from what Vic Rayner said, it will be no surprise to hear that, with our remit, the NAO has looked more at the structural challenges and barriers. Work that we have done and reported on about the interface and integration has looked across four areas—financial, cultural, strategic and structural—a lot of things that are pulling in different directions in health and care. A lot is said about financial pressures in local government. There are also, of course, financial pressures on the NHS that have an impact at the interface. Short-term funding, which I am sure we will come to later, has had a big impact on social care. There are fundamental differences in the national influence and status of the two sides, and a fair bit has been written and said about how that presented itself in the Covid response.

Lastly, difficulties with data sharing can prevent care being co-ordinated smoothly. That has already been touched on, but a question remains about where the health and social care workforces sit here and whether either of them has a workforce strategy, let alone an integrated one.

The Lord Bishop of Carlisle: That is very helpful. Thank you.

The Chair: Thank you so much. What a good question in the context of us looking at the most unstructured part of the whole care force.

Q15 **Lord Bradley:** I must briefly declare interests as trustee of the Centre for Mental Health and the Prison Reform Trust, chair of council at the University of Salford, and an honorary fellow of the Royal College of Speech and Language Therapists.

I want to delve a little more deeply into some of the excellent responses all four of you have made. As you know, and I will repeat, the committee has decided to concentrate its work on the invisibility of adult social care and assumptions underlying the current social care system. We are looking for practical solutions that can improve the experience of those who rely on care and those providing unpaid care.

What further work, if any, have you undertaken on these topics? How do you think our proposals can complement the ongoing work on adult social care that you have exemplified? I will start with Vic Rayner.

Vic Rayner: A big part of our work has been about trying to make some of that invisibility visible through our report on vision and values. There is a coalition on the vision in a sense, but very little understanding of the contribution of adult social care or about the workforce, unpaid carers and the people who receive care and support. The Care Act is very strong on assets and the contribution of people. In the White Paper and the reform agenda, we seem to have lost some of that recognition, very much looking at social care as something that does not provide a net contribution to communities.

There are some very worrying trends emerging, particularly the ones that we are hearing in the APPG about some of the pressures on funding and the commissioning of services that are limiting people's access to ongoing care and support. We found that was happening over the winter when there was pressure on the workforce. Your committee could be very clear about the unacceptability of services being curtailed in a way that curtails people's independence. We saw a lot of that during the pandemic in people's ability to be out and about in communities. We are left with a long legacy, particularly for working-age adults who will have had limits on supported employment opportunities, educational and training opportunities, and opportunities to go out and visit and be independent by utilising transport systems. We will have to rebuild a lot of those structures.

The worry is that the approach to the funding of adult social care going forward will not maximise the opportunities for people to be independent. There are strong concerns, as Jeremy Hunt outlined, that we will not have enough money in the system and that the people who will suffer the most are those who are not only unable to have the level of independence they currently have but who will not be able to maximise their independence in the way the vision describes they should. There is a

mismatch coming down the line between the vision of what people should be able to do and the funding that sits alongside it.

Lord Bradley: That is extremely helpful. Thank you.

Vicky Davis: A lot of our work has drawn attention to the data gap in these areas—unpaid care and unmet need—and the understanding of the outcomes delivered. Our emphasis has been on recommending how the department could first assess where those gaps in understanding are and then look to plug them. We remain very interested in seeing where progress on that has gone. It would be interesting to ask how the data gaps feed into the reform plans and whether the reform plans are flexible as that data comes to light. I think the committee's focus on invisibility is essential to making sure that aspects are not overlooked.

Reforms are being constructed and implemented in a rather poor data environment. The gaps are recognised by all concerned, but it would be good to ask, in that spirit, what care looks like in the future, what assumptions have been baked in on levels of unpaid care, unmet need and even self-funder subsidy, what the outcomes will look like and what measurement and oversight of all that will add up to and look like in a performance framework, but also thinking through how that experience differs in the types of care provided, where it is provided, and the geographical and regional differences in the outcomes.

One criticism of the social care outcomes framework as was was that it did not cover the entirety of what was being delivered under social care and it did not get into well-being and user perspectives significantly enough. That is an area that this committee could add to, looking ahead to the type of care that people may want in the future.

Lastly, I hear some concerns from the sector about the backlog of assessments and some concerns that the level of unmet need and potentially of unpaid care will rise in the short term.

Lord Bradley: I think that is right: data gaps and data sharing are important.

Dr Anna Dixon: In our work to date, we have been very focused on a listening and engagement exercise. We have been particularly keen to hear from people who draw on support and their carers. It is not surprising that we have heard that the current system simply does not work for them, does not recognise their individual need or the idea of personalisation, and that there is a lot of bureaucracy if people wish to take control and use direct payments. People find trying to access help and support in the current system bewildering, and that is particularly true of unpaid carers, who are unsure what help and support is available, if indeed they identify themselves as carers.

We have heard that people who draw on care and support feel that they do not matter, which is even worse than invisibility. During Covid, we have seen almost a reinforcement of ageism in terms of vulnerability and

people's rights if they live in a residential setting—visiting rights and the right to leave their homes being denied.

It is critical for the committee to do more, as we are all trying to do, to make the importance of care and support visible to those who need it but also to the wider society and economy, and to make visible some of the human suffering where people are being denied care. Although we are trying to lift our gaze to the long term, there is no way we can ever reach that long-term vision unless over the next few years some radical and urgent steps are taken like the one Jeremy Hunt mentioned: funding the current means-tested system so that some of that unmet need is met again.

I also urge the committee to look at the gap between implementation of the Care Act and reality, the sense in which people already have rights and entitlements that they are not getting and how that implementation gap can be closed. It is more than just highlighting good practice, although that is part of it. There is a need to put greater pressure on the Government not only to start the work towards a future vision with the White Paper and the innovation fund but to do more to ensure that people who draw on care and support today, and their unpaid carers, are getting the right care and support to which they are currently entitled. It is about addressing the impact of the significant unmet need on individuals which is limiting their life and life opportunities and has a cost, both economic and social, for everyone.

Lord Bradley: Thank you so much. That was a very interesting answer.

Jeremy Hunt: The problem of invisibility is deeply entrenched, and it is very important for us as parliamentarians to keep talking about it and keep reminding the Government about it so that it does not go away. I was part of that problem as a new Cabinet Minister in 2010 when I signed up to the austerity package, which I believed then was the right thing for the country in the aftermath of the financial crisis. I still believe that. I am not trying to be politically controversial. I was Culture Secretary at the time. I did not understand what the impact of local authority cuts would be when we implemented those changes—they are silent cuts, really. You take away pressure from local authorities and there is no immediate impact, because no one's care packages is immediately reduced. It becomes much harder for new people to access packages, so it is a kind silent, invisible cut. It took several years for it to work through the system.

I became Health Secretary, and by about 2014-15 we were starting to get regular winter crises. I did all the short-term things that I could do in the NHS to fix them, but I concluded in the end that the long-term pressure that was creating these winter crises was the pressure from the social care system—there were other factors, but it was one of the principal causes—which was making it so much harder to discharge people from hospitals.

There is invisibility inside government and inside the NHS. At the start of Covid, there was a sudden decision to empty hospitals in the face of a pandemic, and infection prevention and control in care homes was thought to be a problem for the social care sector to sort out, not a responsibility of the NHS. However, the impact on struggling care homes of requiring hospitals to get rid of huge numbers of people very quickly was enormous. They had their arms twisted left, right and centre to take people, which was undoubtedly very damaging and lives were lost.

Invisibility exists, but I have to say that things are a lot better than they were 10 years ago. There is some understanding. I think Theresa May did an excellent job when she formally changed the name of the Department of Health to the Department of Health and Social Care. All Health Secretaries now have to pay lip service to social care in a way that they did not before. That is not enough, but it is a step forward from where we were, so I think we are heading in the right direction. I do not want to be totally negative about this. However, I do think that, to cut a long story short, there is still a very long way to go.

Lord Bradley: Thank you very much.

The Chair: Thank you very much. We have wonderful witnesses.

Q16 **Baroness Warwick of Undercliffe:** Thank you to all our panellists. It has been illuminating so far and enormously helpful.

Jeremy, your committee has done a lot of inquiries in this area, although I think you have tended to focus largely, at least recently, on workforce and funding issues. We as a committee are not going to deal with those big issues, but, as the Chair said right at the beginning, they are bound to have an impact on whatever we recommend; they will certainly underpin the way we approach our issues. It would be useful for us to know about what you have already focused on—local authority funding—as the key issue that you would prioritise. You have also said that you would like to see fully transferable health records specifically.

Could you say something about the reforms that you propose are aligned with the Government's proposed reforms? That might help us to understand whether there are gaps that we might look at. Secondly, focusing right down on to the issues that we are dealing with, how would you help us to focus on the key issues where we might make a difference, given your anxieties about the way in which the Government have responded to recommendations so far and some of the criticisms already made by other witnesses? How, with your vast experience in this area, will you help us to focus on these issues or pinpoint the ones that we ought to deal with?

Jeremy Hunt: Thank you for asking such a thoughtful question. We all have to deal with the realpolitik of the situation, which is that the spending review has been set and is not likely to change. Indeed, the financial pressures have just increased dramatically because of what has happened in Ukraine.

It is not all bad news. When the cap starts to bite, and the Government have announced when that will happen, more than £2 billion a year will go into the social care sector. That will happen in the next three years, and I think for the healthcare levy they will find additional money from the NHS in future spending reviews, so more money will go progressively into the care sector. It will be through the cap mechanism, which does not address local authority requirements.

The most valuable thing is to think about what can be done that does not necessarily require huge amounts of extra cash, because that is where we are for the rest of this Parliament. We should flag the financial problems of local authorities, because there is always a chance, as Anna Dixon will remember well, of getting top-ups in budgets, which is not to be neglected.

Vicky has talked about workforce pressures. Back in 2018, I pushed hard for Theresa May and Philip Hammond to give the NHS a 10-year plan and a five-year funding settlement because of the seven years that it takes to train a doctor. I said, "How can you possibly know how many doctors to train if we don't have at least a 10-year plan as to where we want the NHS to be?" That was my main motive for doing it. Simon Stevens and I—Simon Stevens was my partner in crime in this—discovered that it was enormously beneficial to the NHS to have a long-term, 10-year, plan in place. Off the back of that agreement to have a 10-year plan we put in place a long-term plan for cancer, a long-term plan for mental health and a long-term plan for general practice. None of these plans were perfect, but they were very important for all those sectors.

The biggest trick we are missing in social care at the moment is not having a proper 10-year plan. The Prime Minister said to me at a Liaison Committee meeting that he would give the social care sector a 10-year plan. You can find words where the Government have claimed they have a 10-year plan for social care. However, I do not really see one. I see plans for the short and medium term, not a really big vision answering questions such as whether we want to keep building more care homes. In Denmark, they have decided that they do not want more care homes; they want everybody to be looked after at home. I leave that as an open question, but it is an important question to answer. I think the social care sector wants to know the answer to that question too, because it depends on a lot of private sector investment and it wants to know what it should be investing in.

Where do we want the NHS to get to in integration in two years, five years or 10 years? What sort of IT systems will be used? What will we do with direct payments, personal budgets and those kinds of areas? The Government have said lots of quite encouraging things, but it has not been pulled together in a long-term plan that the sector can unite behind in the same way that Simon Stevens did very successfully for the NHS. It is not necessarily free, but it is not very expensive either, and I think it would be enormously helpful.

Baroness Warwick of Undercliffe: Thank you very much. You

mentioned that at least Secretaries of State now pay lip service to integration and the importance of social care. We had, funnily enough, similar evidence from civil servants that there is at least now positive awareness of the issues. However, I know that people around the table have all had to fight to try to get acknowledgement, even in the White Paper, of the role of unpaid carers in particular and of the people they care for. That awareness is there, but it has not been translated into action. Do you have any practical suggestions, bearing in mind the invisibility issue, about how we might say something specific about that?

Jeremy Hunt: The great advantage of Select Committees is that Governments like to say yes if they can, so it is good to try to find some recommendations that the civil servants in the Department of Health and Social Care can try to say yes to. However, in truth, we have to beat the drum. This is not just a practical issue and it is not just a financial issue; it is also a moral issue. We must not forget that moral context.

In the House of Lords, you have a lot of people who understand that the reforms everyone wants for the NHS will fall over unless we address the issues in social care. Therefore, we need to win the argument, which I do not think we have yet. There is no point in having a big Covid backlog plan if you cannot get beds for people who need operations because they cannot be discharged into the social care sector. There is a moral impetus for NHS patients, as well as for vulnerable older people. Sometimes you can make those points very powerfully in your Lordships' House, so that is what I encourage you to do.

Baroness Warwick of Undercliffe: Thanks very much. Chair, I do apologise; I should have declared my interest as chair of the National Housing Federation. Housing associations build three-quarters of all supported housing, and that is one of my interests in this area.

The Chair: It is never too late to declare your interests. Thank you.

Baroness Warwick of Undercliffe: Thank you very much indeed, Jeremy.

The Chair: Thank you so much.

Q17 **Baroness Barker:** In your introduction, you said you had a broad vision for social care. Dr Dixon, rooting hers as she did in the church, has set out what might in some ways be a different and perhaps exclusive vision. How would your vision manifest itself in practical terms, in practical initiatives?

The Chair: Is this a question to Jeremy Hunt, Baroness Barker?

Baroness Barker: Yes.

The Chair: Jeremy, are you still with us? We may have lost Jeremy.

Baroness Barker: In which case, can one of the other speakers pick it up?

Dr Anna Dixon: Thank you very much, Baroness Barker. Clearly there is an emerging consensus about the vision of what we want for ourselves if we need care and support. I would like to acknowledge Anna Severwright and the work of Social Care Future. Anna is also a member of our Archbishops' Commission, and I know that she will now advise the committee—that is fantastic—about living a good life, in effect. That is fundamentally what we all want. Care and support are about enabling people to live, work and play and, if they have faith, to participate in worship in their faith community. In that sense, we have a vision.

I agree with Jeremy Hunt that what is missing is a plan. I hope that is where the Archbishops' Commission will come in and that it will fill the gap between the vision and the Government's White Paper—we have feedback on this—where there is a sense that there is no plan, no north star, and no real clarity about where we want to get to in 10 years and what steps we need to take to get there.

Maybe the Government cannot clearly commit beyond three years in funding and so on, but we hope that in setting out the road map, the steps that will need to be taken, whether by the current Government or into the next Parliament, those steps will take us towards that destination. The issue is: what is that destination, can we describe it, and can we describe how we get there? Realistically, if we are to be radical and aspirational about where we want to get to—I think we all recognise that it is a very different system of care and support than the one we have today, which, as we keep saying, is failing people—it will take 10 years to implement. We have to be realistic about the time it will take to get there.

We certainly want to play our part in setting out very clearly who needs to do what, and we will be making recommendations back to the church and, much more broadly, to wider society and government. We hope that as we do this work—again, this is very much part of work with others—we are building public as well as political support. That is where your committee can, as Jeremy said, do a lot to build the political will, the cross-party support, for the actions that will be needed for the destination we all want to get to.

The Chair: Thank you so much, Anna.

- Q18 **Baroness Shephard of Northwold:** I want to do two things before I put my question to Vicky Davis. One is to declare my interest in that my husband is in a care home and is self-funding. The other is to comment briefly on the points made by Jeremy Hunt, not least on the question of local government normally being pretty invisible to national government. That was certainly my experience, which is even longer than Jeremy Hunt's. It was one reason why I wanted to be a MP: just to find out if it was the case, and it is the case. I agree that a lot of the work that he has done, and other people have done who are equally enthusiastic, in forcing Governments to see the service as a whole from the point of view of the consumer service has started to break down the invisibility of local government to national government, but there is still a long way to go.

I want to put this question to Vicky Davis. A lot of the answers already given by Jeremy Hunt, and indeed by others, have focused on the issue behind this question. Your report on the adult social care market in England suggests that the lack of long-term vision for care and short-term funding has hampered local authorities' ability to innovate and plan for the long term. I think we are all convinced of that; we were to start with, but we are even more so after this afternoon. If at all, do you think the Government's proposed reforms tackle your concerns and, if so, what are the limitations in the proposed reforms in tackling this particular problem? We have talked about it all, but perhaps, from your particular viewpoint, you could be really specific.

Vicky Davis: Thank you, Baroness Shephard. It is certainly true that our report said that and we recognise that, having waited quite a long time for the White Paper, it sets out a long-term vision. It is a 10-year vision, notwithstanding the points Jeremy and others have made about that. It is certainly a vision that sets out a more person-centred preventive model of care, which I think few would argue with. I recognise the points others have made about how far that goes. My understanding of some of the sector response from our engagement with stakeholders is that although it is seen as a step in the right direction, it is seen as a starting point with very much more detail needed to try to operationalise that vision. That is where we get into whether it is a vision or whether it is a plan. It is probably more a vision, with more detail needed to turn that into a plan.

The question for the sector is: is it a funded plan? Again, the overwhelming response we have had when we have talked to people out in the sector is that there is a real concern that it does not fund social care or what will be needed going forward in terms of demand and implementing the reforms. From a National Audit Office point of view, how much funding is put into the system is very much a policy decision. However, we recognise that the funding now covers more than one year. There was a return to the days of a one-year funding cycle for a number of years, and then there was progress, and it is now three-year funding, as we know. However, that transition phase as reforms are implemented will be considerable. There will be a lot of work to come in increasing capacity as well for operationalising this, not least at local government level. Even the detail of how that extra funding will be distributed is yet to come.

On the specific reforms, the cost of charging reform and moving to a fair rate for care is based on assumptions that, by their nature, will be highly sensitive and uncertain. That is being played out in an environment where we know there have been data gaps historically. Knowing whether the totality of funding will be enough is another concern, which I think the department recognises.

The question, therefore, is whether the funding will reflect the scale of that challenge. A lot of people in the sector are talking about considerable funding gaps, which is their concern. However, we cannot ignore the wider funding landscape for local government. Spend on adult social care makes up a large and increasing proportion of spending for local

authorities with social care responsibilities and, at the same time, there is an increasing reliance on a precept for permanent funding for adult social care, which needs to be taken into account. All that was before the inflationary pressures that we are now seeing. There is certainly a step in the right direction, but the funding question remains.

Baroness Shephard of Northwold: That is terrifically helpful to us, and you have given some good pointers for the committee, so thank you very much indeed.

Q19 **Baroness Eaton:** Before I wade into this question, I have to say that I fully agree with Lady Shephard's comments. My background is in local government. The relationship between national government and local government was often a big issue. In many areas, not just in social care, a lot of work needs to be done to the benefit of the public in general to get that relationship better; certainly in the social care field it would.

We have mentioned a lot that practical suggestions are very important in the agenda we are looking at. What is the relationship between the broad vision and identifying practical recommendations? How would you prioritise those recommendations?

Vic Rayner: Thank you for that question. It is great to have an opportunity to focus on some of the practical. As I said at the beginning, we feel that the vision and values document produced by the APPG has a lot of synergy with the vision of the reform paper, but the value element seems to me to be completely missing.

A point to emphasise for your Select Committee is one from the APPG about the workforce. Jeremy talked about having a 10-year plan for the NHS and how important that was. What he failed to mention was that, prior to that 10-year reform and plan being agreed, the NHS had gone through *Agenda for Change*, which had brought into real terms the pay levels for staff across the whole of the health sector. When he started to talk about a 10-year plan for the NHS, it was absolutely with the recognition that the workforce issue—not the shortages necessarily, but pay, terms and conditions—have been looked at and addressed. Therefore, when you talked about having 6,000 more doctors or 50,000 more nurses, you knew what the costs were for that.

The challenge for social care is that we have a very large workforce, as I am sure the committee is aware, of 1.6 million roles in adult social care. We have a turnover level of nearly 30% on average, and that varies significantly in different parts of the country and in different sectors in social care. Twenty-seven per cent of the workforce is 55 years or over, so nearly a quarter of the workforce will be thinking about retirement in the next 10 years, if not before, and 82% of it is female. The average age of workers is 44 years. If you look at the projections on workforce, Skills for Care, which is the sector skills body, talks about needing an additional 490,000 people working in the sector by 2035. A combination of the Health Foundation, the Nuffield Trust and the King's Fund have together predicted that 627,000 more workers will be required by 2030 if we want

social care to improve in line with the vision. Therefore, we have a massive problem.

I am afraid I disagree with Jeremy that we can say that the spending review is where it is, and we do not have more money to bring in because we need to address workforce shortages now, which is fundamentally about pay, terms and conditions. The APPG has looked at that from lots of different angles. It is one of the biggest challenges, and unfortunately the White Paper does not even address it.

Going back to your question about invisibility of local government, of course if local government does not get more funding to support social care it cannot transfer that through contractual prices to providers that then cannot raise the pay level of staff. Therefore, we end up in this endless cycle, which does not serve the workforce at all well but fundamentally underserves people who receive care and support and, of course, unpaid carers who then cannot rely on a workforce that is constantly changing with turnover levels because of insecurity through pay, terms and conditions.

If there is something very practical that the committee could make recommendations about, it is that workforce agenda.

Baroness Eaton: Thank you.

Q20 **Baroness Jolly:** The committee is keen to explore the relationship between those receiving care and those providing unpaid care. Anna, how, if at all, does your work explore the often complex relationships between unpaid carers and those for whom they care?

Dr Anna Dixon: Thank you. This is fundamental to our work. We have put forward a series of principles and values, and one of those is on mutuality. There is a lot of talk of independence, which is obviously very important for people who draw on care. However, we also want to recognise that care is about relationships, not only between those who draw on care, their family and unpaid carers, but with others in the community and the importance of a sense of being able to contribute and to give and receive.

We are hearing a lot about that. We held a joint round table engagement event with Carers UK where we invited unpaid carers to share their experiences and to talk about the role of their faith and faith communities in supporting them as unpaid carers in the community. What comes through loud and clear is that the primary concern for unpaid carers is that the person they care for gets the care and support they need, because if they do not get it then they often bear the consequences. Those consequences can include leaving work, so there are significant consequences financially for the individual who is caring, which certainly can involve becoming quite isolated, and they can impact that person's own mental health and well-being.

They also see, positively, when the person they care for gets the care and support they need and the difference it makes to their quality of life,

enabling them to do the things they enjoy and restoring a relationship of love that is not one of duty and necessarily feeling they have to provide that care. That is what needs to come back into this. Unfortunately, with the cutbacks in funded care and support, many people, particularly if they have a low-paid job, have very little choice about whether to provide unpaid care for their loved ones, because there is nothing else. That is why we need a properly funded care and support system. It is fundamental.

Obviously it is also important for those who choose to provide quite a significant proportion of care and support for their loved ones that they are properly supported in doing so—and that they do not have to make personal sacrifices, financially or in their own health and well-being—by getting breaks as they need them and the right information and support and sometimes training to do their caring role.

There are a lot of practical things that can be done to ensure that relationship is one where people can give out of love and perhaps not out of necessity.

Baroness Jolly: Thank you. Vicky Davis, does the National Audit Office have a view?

Vicky Davis: It is not something we have traditionally looked at. We have tended to look more at the structures and what the Department of Health and Social Care and the policymakers themselves understand from data on that relationship. We have tended to seek the views of people receiving or giving care largely through representative organisations, including Vic's organisation. We tend to talk to representative groups to find out more about the experience on the ground.

The Chair: Thank you. Vic Rayner, could you write to us about your own experience on this since we are rather short of time? Thank you so much. That will be really important.

Q21 **Baroness Fraser of Craigmaddie:** Dr Dixon, I note that you were involved in the Feeley report. I am currently speaking to you from Glasgow. I kept a very close eye on the development of the Feeley recommendations, and one thing that came out was the point that has been coming from a few of you that social care should be an investment, not a burden, and wanting to empower people who access social care. What worries me, as Vic Rayner said, is that the Feeley report—as it has been picked up and potentially implemented over the next 10 years with a 10-year plan by Scottish Government—might end up in that nasty arena of lots of structural processes being put in place to establish a national care service but the voices of the most important people then left out.

My question to you, Anna, and to Vic if we have time, is that we are keen to ensure in this committee that the voices of the people who receive the care and those who provide it—I want you to focus on unpaid care, Vic, because you have spoken about *Agenda for Change* and how we need to look at the workforce—are heard directly in our inquiry. How have you, in

your work, ensured that people with lived experience are playing a role and feeding into the work? If we have time—I am pushing it I know, but it is very important to many of us here—what role, if any, co-production has played in what you have observed. Can you give examples from your work on your inquiries?

The Chair: We only have time to hear Vic Rayner on that.

Vic Rayner: In that context, the APPG has worked on the basis that the co-chairs of the working group include people with lived experience, people who are receiving and delivering unpaid care. In that sense, there has been a constant steer on that.

We, along with everybody else working in the care sector, are learning how to do effective co-production. We are far from doing it; the power very clearly often sits with people commissioning or delivering services, and there is a huge amount of work to do on that.

Outside of work in the APPG but brought into it, we have worked particularly over the last two years on issues of visiting where those receiving care and support and the relatives have been absolutely high on the agenda, and we have done lots of work to try to co-produce support for those in care homes to enable visiting. It is very clear that the voices are often so far away from power that it is very possible for them to be ignored or to become single voices that are then intended to represent the perspectives of 8 million or more unpaid carers, for example, or 4 million to 5 million people who are receiving care and support.

If you are thinking about recommendations for the committee, we need people to invest in meaningful co-production and have measures that test the outcome of reforms or policies on those who receive care and support. It is hard enough getting practical implementation of policy that care providers can operationalise, never mind getting close enough to people who receive care and support and unpaid carers because we have not invested properly in the infrastructure to allow those voices to be heard. I talked in particular about the ICSs. We have a new opportunity in England for integrated care systems to have those voices meaningfully represented. If you can add your voice to supporting that, it will be very helpful.

Q22 Baroness Campbell of Surbiton: I have a very tiny question. You will know, Vic, that there is a huge difference between co-production and involving the voice of users. I am particularly keen to have our committee understand that difference so that our report reflects the importance of co-production. It has been one of the 20 years of objectives that direct users are involved throughout the development, planning and rollout stages. Can you give us any tips on what you typically understand co-production to mean and how you have been implementing this in your all-party group?

Vic Rayner: Thank you very much for that question. We have lots to learn. We have tried to listen hard and draw on the experience of groups led by people who are using care and support services. It is no surprise in

a way that the vision of the APPG is in line with the vision created by Social Care Future, which is an organisation led by those who are using care and support services. It is about trying to ensure that we learn from and use an expert set of voices that have come together and been enabled.

As I understand it, we are unique in the context of APPGs in having a co-chairing arrangement. We are trying hard to make that meaningful, so that that in itself does not become lip service to co-production. For us at the APPG, it is about embedding how we ensure all those voices are represented right at the start. We have been developing the reports, for example, to make it very clear that all the working groups need to have people who are using care and support services represented in them and for those voices to be heard. However, there is a huge amount to learn. Even though social care has a person-centred focus, you will know more than me how far away from enabling people to control their own lives it really is. We are, therefore, working against some of that tide.

Baroness Campbell of Surbiton: Can you all remember the work of rights to control and how difficult that was?

Vic Rayner: Of course we do, yes.

Baroness Campbell of Surbiton: Thank you very much.

The Chair: Thank you, Vic, for that last and very helpful answer. Indeed, you have been wonderful witnesses. You have helped us to clarify many of the questions we have in our minds. It has been genuinely illuminating, very frank and very useful indeed. This is not the last conversation we will have with you. We will check with you as we go along, because it is extremely important that we optimise our knowledge and your experience as we go through this process. Thank you so much for being so supportive of what we are trying to do as well. It means a lot to us to have your support.

Dr Anna Dixon: I was going to offer a written note to follow up on Baroness Fraser's question that I was unable to answer.

The Chair: Thank you. If anyone feels like doing homework on things they have not been able to say, please do. That will help us no end. Thank you so much, we really welcome that.

Dr Anna Dixon: Great. Thank you very much. We wish you all the best with your work as a committee.

The Chair: Thank you very much indeed.

Dr Anna Dixon: We will keep in touch as our work develops. Thank you.