



Select Committee on the Long-Term Sustainability of the NHS

Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 1 November 2016

11 am

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Members present: Lord Patel (Chairman); Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Baroness Redfern; Lord Turnberg; Lord Warner; and Lord Willis of Knaresborough.

Evidence Session No. 13

Heard in Public

Questions 135 – 142

Witnesses

Professor Paul Corrigan, Professor of Health Policy, Imperial College London; Shirley Cramer CBE, Chair, People in Public Health, Royal Society of Public Health; and Jo Moriarty, Senior Research Fellow and Deputy Director, Social Care Workforce Research Unit, King's College London.

USE OF THE TRANSCRIPT

1. This is an corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Professor Paul Corrigan, Shirley Cramer and Jo Moriarty.

Q135 **The Chairman:** Welcome and thank you for coming today to give us evidence, which will be very helpful to us. We are broadcasting this session and if the Committee members have any particular interests to declare they will do so, if they have not already done so. If you wish to make any opening statements, please do so, but otherwise will you please introduce yourselves from my left to right?

Professor Corrigan: I am Paul Corrigan. I am down here from Imperial College; I am actually an adjunct professor there and I am an independent management consultant. Would you like me to make an opening statement now?

The Chairman: If you have an opening statement, yes please.

Professor Corrigan: What is very difficult to appreciate in the middle of talking about the NHS is the depth of the change in the nature of the business. We can see it in almost every other industry, but the change in the nature of what sickness and disease are now has left us with a health service facing in the wrong direction. The fundamental change is that 70% of NHS funding is now being spent on long-term conditions. The nature of that experience is a different form of disease. Not just in this country but across the world there are attempts to completely reconstruct an industry to face this new form of disease. Diabetes has been around for a while but the extent of it, as a problem for the health service of these long-term conditions, needs a greater transformation than those of us in the middle of it appreciate.

Shirley Cramer: I am Shirley Cramer. I am the chief executive at the Royal Society for Public Health. I am also chairman of a UK-wide group called People in UK Public Health, which is looking at the future of the public health workforce. It incorporates Health Education England, Public Health England, the Department of Health and the Governments of Scotland, Wales and Northern Ireland.

Jo Moriarty: I am Jo Moriarty. I am senior research fellow in the Social Care Workforce Research Unit based at King's College, London. I am also somebody who has actually worked in the care sector; I originally started off as a nurse. So as I have grown older my connection with this subject has become more and more entwined.

The Chairman: Thank you very much. Do either of you have any opening statements you would like to make?

Shirley Cramer: Following up on many people you have heard from during your taking of evidence, we would like to see much more of a focus on prevention and improving and protecting the public's health so that we can reduce demand on the NHS. That involves creating a culture of health which we currently do not have where our citizens are able to maintain their own health and well-being and where services are focused

and geared towards prevention rather than focused and geared towards ill health.

Q136 The Chairman: Today we would like to explore with you some of the workforce issues relating to both the whole spectrum of healthcare and social care. In the current state, is the health and social care workforce equipped to deal with the Government's ambitious plans for the future, both in public health, healthcare and social care? What workforce issues do you think are the greatest threat to long-term sustainability?

Professor Corrigan: Given what I said just now, the answer has to be no. I do not think the current workforce is facing in the right direction with the right skills to deal with the vast majority of the healthcare problems that are coming across the door. Health Education England is spending most of its money on new entrants to the professions. Someone starting this year who will become a diabetologist in the year 2028 will be taught a series of specialisms and hyper-specialisms, when actually what people with diabetes need now is an understanding of a much broader nature of their health rather than their diabetes.

I only have the statistics for Scotland but there are some very interesting statistics. Of the people with diabetes in Scotland, only 16% only have diabetes. If we treat them as if they have only diabetes, we are wrong 84% of the time. Any other industry could not cope with that and yet we are training more and more of those specialists to be more and more interested in only diabetes. The nature of the training system, by the year 2028 when that person starts to practise, will be really out of date. That is my first point.

The second thing is that today there is some press around the nurse associates that the previous witnesses were talking about. One of the immediate things in the *Health Service Journal* is the problem that health associates may be giving out drugs. That is seen as a problem because of skill substitution. Actually, skill substitution is the only solution; it is not a problem. It is the skill substitution and the way in which we work down the trade into less and less professionalised jobs to deal with the degree of care that we are going to have to deliver. We still have a system which is spending most of the money on probably the wrong people.

Shirley Cramer: I could not agree more with that statement. One of the things that gives us some hope for a turnaround of the "Titanic", if you like, to prevention is looking at the role of people who might be helpful and supportive in improving the public's health and indeed public health. We have a 40,000 public health workforce in England, but we have done some work with the Department of Health and Public Health England and there are 15 million people in employment who have the ability or opportunity to improve and protect the public's health. These are people in a variety of professions. There are about 750,000 of them—we call them "early adopters" or perhaps "low-hanging fruit" who have the ability right now to make a difference in community support. I am talking here about the fire service, leisure services, housing, pharmacy and allied health professionals.

We have a lot of people who are currently in employment and who are keen to be seen as part of the prevention and health and social care workforce right now who are seeing people every day in their jobs. It is a contention of the work that we have been doing on the future of the public's health that we need to have this huge group of people, almost an army of people, who could be out there with prevention as part of their job and supporting people in communities. There is a huge amount of best practice being looked at. If you look at the West Midlands and Greater Manchester Fire Services, they are doing a huge amount of work, as are housing and Healthy Living Pharmacies. We can upscale and roll out so much more in this area which will really help to sustain and take demand away from the NHS.

Jo Moriarty: I would like to take up the point that Paul made when he spoke about the very small proportion of people who only have diabetes. Sube Banerjee, who was responsible for the first National Dementia Strategy, often quotes a figure that says that only 17% of people with dementia only have dementia and the remainder have another health problem. One of things that is a particular issue for the social care workforce is the fact that they are dealing with people with multimorbidity; they are dealing with people with very complex health conditions. In many ways the expectation, sometimes among people commissioning services and sometimes among the general public, is that anybody can do the job. People think it is about the old days of making somebody a cup of tea and making sure they are settled properly, whereas in fact they are doing very complex issues. Interestingly enough, many of the associate nurses have taken on extended roles in medicine management. We need a workforce that is dealing with people with these very complex conditions.

Lord Turnberg: Coming back to you on the need for diabetologists to deal with the workload that is likely to come at us, I think that misunderstands the nature of what a diabetologist might do. Most patients with diabetes and multiple illnesses have to be dealt with by their GPs and in the community. That is the vast majority. Diabetologists will only touch the tip of the apex of all that activity and are there to deal with extremely complex diabetic problems. This, of course, leaves aside the question of whether they will all be working on a cure for diabetes in 20 years' time and maybe it will have disappeared. We cannot predict too far on that.

The same is true of dementia. The majority of dementia patients are going to be dealt with in general practice and in the community. We need psychiatrists, of course, and we need experts, but the numbers are quite small. I think your ideas about diabetologists not being necessary is not quite right. Should we not be looking at a much wider spectrum of healthcare workers at a much more basic level to provide the support for the service that we need?

Professor Corrigan: Yes, we should. I would like them to work closely with diabetologists rather than be separated in buildings called hospitals

where the diabetologists are. At the moment psychiatrists are not centrally in buildings called psychiatry buildings; they are actually out in the community. The diabetologists could be out in the community.

Lord Turnberg: They are.

Professor Corrigan: Most of their training is spent in a hospital. If they are coming out, that is really good, but most of the training, if you look at the number of hours they spend, is spent inside hospitals. They are learning their trade in one building. That is not a good idea. I agree with you that the vast bulk of care needs to take place and already is taking place with a very different group of people. Most care is administered by patients and their carers: a vast proportion. Most of that is done with very little knowledge and training. Most care is self-care and, if we invested a bit more in that and improved the capacity of people to care for themselves, actually we would transform the outcomes.

Q137 **Lord Willis:** I am particularly interested in this division within the health service between specialisation and generic training. Everywhere we go we seem to see new silos being developed. As one of the architects of the nursing associates I am delighted that you have mentioned them. However, I cannot tell you the battle there is to try to get, for instance, a mental health nurse to treat somebody's physical needs. It is not at this very high level; it is really at quite a basic level. I would like your suggestions on how we move away from a system whereby we prize specialism but we do not prize genericism, to have high-quality, whole-person care at every level, not simply at specialist levels.

Professor Corrigan: I would start by saying that division of labour is a good thing. It works well in every industry and there is no reason why it should not work in health. The difference about the division of labour in most other industries is that it is organised, rather than being organised by people in individual bits. My analogy is always the Shard. About 20,000 firms built the Shard and they were specialists; they were specialists in particular things. Plumbers were good at doing plumbing; they were not generalists. However, somebody organised them rather than actually allowed them to organise themselves. In the health service we do not have the equivalent of a tough supply-chain organiser that would organise for me, as a patient, the various specialisms and would say to the diabetologist, "Paul Corrigan is not your patient. Do not think you can see him on a Tuesday because someone else has to see him on a Wednesday." It is the organisation of that that we do not have because we have not put anybody above these very, very high-status specialists.

The Chairman: The old hands round the table might say that that used to be the case but no longer is.

Lord Mawhinney: You are encouraging us—at least I took it as an encouragement—to direct more resources towards helping people to improve their own care. The word you used was, if we did that, the scene would be—your word—"transformed". What does "transformed" mean?

Professor Corrigan: Transformed would mean that a health service would understand that, for people with long-term conditions, the vast majority of the time they are being cared for they are caring for themselves. At the moment the health service primarily sees that the care for people with long-term conditions only takes place when you come up against somebody who works for the National Health Service. We do not invest in the 5,800 waking hours that someone with diabetes looks after themselves. What I mean by transformation is that if we increased the productivity of those 5,800 hours by 5%, we would transform the health service. If people were better at looking after themselves because we invested in it, the capacity for them to self-manage would mean many fewer emergency admissions—and that is the problem for long-term conditions.

Lord Lipsey: I am agreeing with everything you say instinctively, but I am struck by what happened in our first session today, which was also about workforce planning, where the witnesses were also sympathetic to what you are saying—except that they only talked about increasing the number of nurses by 25,000 and the number of doctors. They did not mention changing any other people's possibilities. Could you talk about what practical things are necessary? To take a possible example, should we be increasing the pay of those providing social care quite considerably and, if necessary, diminishing the pay of consultant physicians, the number of whom has soared in recent years for reasons that are not apparent to me?

Jo Moriarty: That would be a very controversial action which I am sure would get a lot of support from the millions of people who work in the social care sector. You are right that the Low Pay Commission is very firm that the national minimum wage and now the introduction of the national living wage has been a transformative element in social care for people who were underpaid beforehand. The one difficulty that employers are faced with is that it has led to a very flat pay structure so that, with a few very poor examples of organisations that underpay people by not giving them travel time and so on, you tend to find that most workers earn the national living wage, but there are very few opportunities to acquire increments or to be promoted. Sometimes that acts a disincentive to undertake further training and often it leads to people who have received training trying to move from social care into the NHS. Obviously it has been an incredibly important positive step, but there are difficulties in the actual overall pay structure.

Baroness Blackstone: How do we make self-care happen? What are the practical steps that have to be taken to make this a reality?

Professor Corrigan: As somebody said in the previous session, I think that practical steps are being taken in an increasing part of the country on this. GPs are now experiencing being overwhelmed in a way with which they cannot cope. So they are looking to change the boundaries of the work they do and trying to get assistance from different sorts of organisations. One of the ways that is probably growing fastest is

something called social prescribing, which is simply a GP prescribing that you need some activity. GPs have been telling their patients—this happened to me two weeks ago—they have to go out and do more for some time—but they are only just beginning to realise that people do not. If you prescribe to a health trainer and the health trainer then puts you into a series of contacts either for exercise or group activity, then you are beginning to take some of the pressure off the GP and spreading the load to a whole range of voluntary sector organisations that are already there but need some money to make this happen. This is not a free good.

Baroness Redfern: Picking up on Jo's mention of pay structure and career progression, do you not think that good managers should be looking specifically at that to enhance those people who want to progress even more?

Jo Moriarty: Yes, absolutely. One of the positive aspects of social care is that it is one of the few industries in which people without qualifications can go in and make a career for themselves. It does happen but you often find that it is down to an individual. Somebody will tell you that they had a manager who had faith in them or they worked for an organisation that invested a lot in training.

Baroness Redfern: So you think more needs to be done with good managers really focusing on that.

Jo Moriarty: Yes, absolutely. I would add a small point to the point about self-care. Obviously, self-care is important but, looking at the age structure of the population, one of the things that has really happened in this blurring of the health and social care divide is end-of-life care. It is important to remember that with people's aspirations, sometimes it is not about self-care, it is actually about enabling people to make a good death. One of the mistakes that has been made in the past has been to assume that everybody has the capacity to improve, but many long-term conditions are terminal.

Q138 **Baroness Redfern:** I would like to put a question to Shirley following her very eloquent introduction. Looking at the public health workforce in 15 to 20 years, we know that public health comes into local authorities and there has been some really good work done there. How do you see the public health workforce in 20 years, particularly on prevention as well? I know it is difficult to measure prevention but, if we could tackle prevention, we could not only save some money but improve people's lives as well.

Shirley Cramer: There has been some work done on this. A new plan has been devised called Fit for the Future which was led by Public Health England but actually many stakeholders were involved: Health Education England, the Department of Health and other UK devolved Governments. It is very important that we have flexibility and mobility within our workforce so that they can move between different countries. In this plan we were trying to have a multifaceted look at who should be doing what, where and when and how to bolster the capacity and capability for

prevention. A number of things come. One is what I first mentioned, which is about a social movement for health. I do not think we should underestimate this, because some local authorities are doing excellent work in prevention and they have managed to mainstream it in all their activities with the voluntary sector, social enterprise, community interest companies, the private sector and their own staff. That is one thing we really need to work hard on.

Another is creating an attractive career. One of the things we have not done enough of is to have clear developmental career pathways for the public's health. That involves looking at experience people have had, looking at qualifications and looking at how that is standardised across the UK. We need clarification on entry. We need good apprenticeships in this area because we need a much more diverse workforce as well. We need portfolio careers: people who can work in different settings and have expertise in different settings where we recognise that their experience before counts towards the next stage of their development. That has been helped by the Public Health Skills and Knowledge Framework that has just been renewed. We can map to that and it is going to be extraordinarily helpful.

We need to inform children, and teenagers in particular, about the opportunities for existing health and care roles—and new ones, because we believe that new ones will be developed. Link workers and co-ordinating workers are some of the issues that have been mentioned. The issue about systems leadership is huge in this area, because in the future people are really going to have to manage work and lead across different systems. That has a different skill set and competency set. We need to get some of this work rolling; it is about joining up things.

Staff mobility has been an issue across the entirety of health and care, and that is around mobility between the NHS and local authorities. That has a lot to do with terms and conditions and things that somebody could go away and sort out that would make life a lot easier for recruiting this particular population to health roles. Regarding CPD for staff, cutbacks always happen first with training, but that be the last thing we cut, in our view on the committee. We need to equip all parts of the workforce with the skills they need to succeed, and that is about working across the new holistic system. The MECC approach—making every contact count—is now being rolled out in various places across the NHS. This is really good news because this is trying to embed prevention across a workforce that has been very siloed. We need to embed prevention in all undergraduate curricula. That feels like common sense.

However, none of this happening fast enough or urgently enough in our view—because these are things that need to be happening now. We have the STPs, the vanguards, the new models of care. These are underpinning issues and the wider workforce—the piece I mentioned at the beginning—is the piece that can help make the transformation that Professor Corrigan mentioned, because you then have a much larger capability. We are not suggesting that this group of people does not have

any training. In fact, the committee has worked out that there is a level of training that the wider workforce would need to build confidence in dealing with a whole host of different issues, but it needs to be the right training for the right people. It is about acknowledging that their work has a role in the public's health. It is about acknowledging the work they do and possibly having it in their job descriptions and then evaluating the work they can do on a place-based, geographic location which will lead and support the transformation.

Baroness Redfern: Do you think that, in enhancing that, we would be better working in clusters for career progression as well as clusters for acute sectors? It would give flavour, enhancement and more choice for people in their careers.

Shirley Cramer: That would really be helpful. We are seeing more and more of that in really good practice in various places where groups of people are working together, coming up with joint solutions, collaborations and decisions that are really helping people on the ground. Sharing data is very important, as are integrated budgets, as you probably know.

Lord Warner: This all sounds jolly good, but where is the driver? Who is in charge of this programme? We are already going through a row at the moment about whether public health money has been stolen to support the Government's claims on funding for the NHS. Who can actually drive this agenda? It is all very well having local pilots and developments, but where is the drive from the centre to come that will not be politically interfered with?

Shirley Cramer: I think that is a really good question because one of the issues that everybody has to deal with is joining things together. In my view, Public Health England is in the best position to do that at the moment because they are the ones with the plan and they are the ones with the energy around this issue. But it is working with Health Education England, and in fact they have been working well together, certainly around some public health issues, with the Department of Health. It would be easier if it did reside in one place rather than being stretched across various systems. Local authorities have taken a big leadership role in many of these areas and we have seen that across place-based initiatives. The system is quite complicated and therefore you need to have all parties at the table to make many decisions—and there does need to be a driver to put it all through.

Lord Turnberg: Thinking about a prevention strategy for 20 years' time, how much thinking is being done now about efforts to predict susceptibility? It depends so much on modern science and genomics, and on the ability to screen people, predict their susceptibility and do something to prevent them developing a disease. That is a whole new area which we have not covered.

Shirley Cramer: I know that Public Health England is doing a lot in this area and working across the piece with the Department of Health. It is a

priority area and one of the things we have been told is that the UK wishes to remain in a leadership role in these areas and to be leading the charge on them. Although I am talking about place-based prevention, it is very clear that for the particular skills moving 20, 30 or 40 years ahead, our system should be geared towards these areas where we would be able to have good screening programmes.

Lord Turnberg: Is there an educational programme amongst public health professionals on what the genomic agenda is?

Shirley Cramer: I understand that this will be in the curriculums for people who are training to be public health specialists: that would be the 40,000 public health workforce. Many in the top echelons of that workforce are the technicians and people who have all the particular public population health skills that will be needed.

Q139 **Lord Warner:** Moving back to the social care workforce, we learned at the end of the last session that there was no one in charge of this at national level. What are the key challenges for this workforce over the next 10 to 15 years? Do we need to produce more oomph in that national drive? What are the challenges that are going to be presented to the health service if we do not actually improve the effectiveness of that workforce?

Jo Moriarty: That is a really important point. The VODG, an umbrella group of voluntary organisations and providers, has estimated that by 2035 we will need another 400,000 care workers. That is on top of the most recent estimate from Skills for Care that there are 1.43 million people working in social care. Obviously there is huge increase in demand—but, as the Committee has already heard, there are reasons why it is not always seen as a profession of choice. It is often seen as being of low status. It has mixed problems with retention. People talk about problems with retention in social care as if they were everywhere, but that is not true. We have been very fortunate to have been funded by the Department of Health to do a longitudinal study of the social care workforce in four different parts of England. What is astonishing in the six years in which we have been doing the work and the three times we have been contacting people in the sample is how many of them are still either in the same workplace or still in the same profession. It is more variable than that and I think it is also about making the work more enjoyable—things such as giving people autonomy.

One of the difficulties about the way that social care is prescribed is that it is so task focused. The reason why that happened was that often families were finding that the worker was meant to assist the person to get up in the morning and then they would arrive late in the afternoon and find the person still in their pyjamas. So it gives more accountability for families but it means that workers themselves cannot act in an autonomous way. We had a really good example from somebody who took part in our research who was talking about how she went to see somebody who had been recently discharged from hospital. She had been home for two days. On the third day she was trying to encourage her to

get up, have a bath and make her breakfast, which was obviously important in terms of her health outcomes. She had only been given half an hour to do this; she needed 45 minutes. When she phoned up the agency, they said that they did not have anybody else who could help. She ended up staying with the woman and working unpaid time. That is a cogent example of where difficulties in the way that social care is provided have implications for the health service.

Lord Warner: Is that not a funding issue? Basically, you are saying that the funding does not enable them to do the job.

Jo Moriarty: It is partly a funding issue but it is partly about the way that those funds can be spent. It is about not giving organisations the autonomy to say, "Today you will have an hour-long visit; tomorrow you might be able to manage with a shorter one". Funding is a huge issue but it is not entirely funding based.

Q140 **Bishop of Carlisle:** You mentioned earlier that social care is something that you can enter without too many qualifications. That is one of the great advantages of it. However, as health and social care are integrated more and more, as we hope they may be, is that going to present a difficulty—and, with the recruitment of another 40,000 social care workers, what is going to be the problem there?

Jo Moriarty: There are certain statutory minimum things in terms of health and safety that people have to do once they enter. Obviously, successive Governments have put quite a lot of investment in training. A lot of the money provided for Skills for Care is allocated to developing training programmes for employers. It is more about making the training more relevant to the things that people are doing. Rather than it being the minimum, it is more about understanding issues such as the overlap in the example that Lord Willis gave of a mental health nurse not wanting to treat somebody for a physical condition. It is about people recognising the complexities of somebody's own health problem: recognising depression among residents of care homes rather than just assuming that they do not want to do something.

Professor Corrigan: The integration of a very heavily professionalised organisation called the NHS and an undertrained organisation such as social care means that the integration could be like this rather than like that. The respect that people have within the National Health Service, probably quite rightly, is around the range of qualifications, and therefore growing that respect for people in social care is crucial if the integration is going to be real.

Q141 **Lord Willis:** I think that point is very important. When you look at the Cavendish report, for instance, and my own work since then, the whole issue about trying to give care workers some form of qualification which is transferrable and transposable is absolutely essential. I recommended something similar to an e-passport: being able to accredit skills with an appropriate professional worker. However, the care sector was not remotely interested. What do we do to get the care sector, whatever that

means, to engage with the issue of appropriate training, certification and passportability? Without that, we will not have the sorts of things we are talking about and it will just continue as it is at the moment.

Jo Moriarty: Within the care sector there is often a historical concern about red tape and people feeling that there is a lot of control over what they do. But things such as the Care Certificate are a really positive example of people trying to create a workforce that is capable of working within the health sector and within the social care sector. The difficulty is that care workers are not regulated and therefore there is no impetus for them to keep their own records of CPD that they have done: that is also an issue.

The Chairman: We talked earlier about pay being one of the issues, particularly in certain areas such as London. If you were addressing the issues about pay, do you think the current model is sustainable fiscally?

Professor Corrigan: Given the degree of demands that we know will be there and given your emphasis on sustainability, if we roll forward the present structure of the health service to meet that additional demand with the same professionalisation, I do not think it is sustainable. The challenge has to be not just around pay but around how we spread the load of that amount of care with a range of different people who are not paid as much at the top level. I think all three of us have been saying that.

Another point about pay is that there is an enormous hierarchy from the best paid to a social care worker, but there are other incentives apart from pay. If you were to look at merit awards in the National Health Service, you would find that they nearly all go to consultants. That means that other people do not have any merit. That is not true, but that is where merit awards go. It does have money linked to it, but if we were to change the nature of merit awards into a more horizontal way, then it is an incentive. Why does a social care worker not get a merit award? They have a lot of merit. This is not just pay; it is a different form of incentive.

The Chairman: Merit awards no longer exist in the part of the country where I live, but I gather that in other areas they still do.

Jo Moriarty: I think funding is a huge issue. Last week the United Kingdom Homecare Association issued a report that claimed that only 20% of councils paid what they considered to be an appropriate rate for home care. The gaps are getting bigger between what the sector is saying is the cost of providing care and what local authorities are able or willing to actually fund. In the past, 20 years ago, we were more optimistic about the proportion of people who would fund their own care in their old age—but, with what has happened in terms of employment, the impact upon pensions, issues about home ownership, that will not be the case. A huge pressure, particularly for politicians, is on trying to help the public improve their understanding of what help they are likely to get if they need social care and support and what they think they are going to get.

The Chairman: We heard in previous evidence that as far as social care is concerned, we may require a workforce of as many as 1.3 million in the social care area. Are there people who would be willing to go into that and what will make them go into that?

Jo Moriarty: It is about making the job more attractive. It is also about apprenticeships and enabling people to see it as an interesting and attractive career path. Many of the people who go in have very high levels of job satisfaction. The work is varied and interesting and employers have tried to attract people on that level—trying to present it not so much as a well-paid job, because it is not, but as a job in which there are opportunities to make a difference to people's lives.

Lord Warner: If the Government woke up one morning and gave the publically funded adult social care sector £3 billion extra phased in, would that sector sort out all these problems itself or does there need to be some central driver to go with that money to produce the workforce you need with the skills they need for 2030?

Jo Moriarty: No. You need a central driver. One of the things that recent events have shown quite clearly is that the social care market does not operate as a true market. Many of the problems that happen within social care are because the market is not operating properly. There was a very interesting report from the Manchester Business School earlier this year which talked about the way that some companies that provide care homes actually have shell companies; there is a lot of offshore investment. The report argued that there was potential to use that money in a better way.

Skills for Care has worked very hard. It was a very positive development to set it up and it has worked hard on trying to get a coherent voice across the sector. The sector itself is quite diverse and if it was given £3 billion tomorrow, I think it would need some sort of central way. We know that often people replicate old-fashioned ideas, so if we look at the investment in people support, we know that care homes and nursing homes are still being built. It has been quite difficult to implement assistive technology in people's own homes, and all the work that has been done on assistive technology suggests that it is done better in countries which have perhaps a slightly more statist view of how support for people should be provided. In Scandinavia there is better infrastructure for assistive technology than in the United States.

Lord Willis: If we are aiming for an integrated health and social care system, why on earth would we have a separate organisation perpetuated for social care?

Jo Moriarty: One of the things that is quite astonishing is that you could get documents from the 1970s talking about joint integration plans and you could give them a new cover and a new logo, and nobody would know the difference; they would say that they had been published last week.

Lord Willis: It has to happen before my old age.

The Chairman: That is not far away.

Q142 **Baroness Blackstone:** What is the key single suggestion for change that this Committee ought to recommend to make the NHS more sustainable?

Professor Corrigan: There is a line of interventions, from pure prevention through to demand management, which is absolutely essential for sustainability. The NHS, as against local government, finds the notion of demand management a little bit immoral because its job is to meet demand. That is actually not its job; its job is to negotiate with that demand. But in the work that is done in health and well-being boards between local authorities—which have been very good for the demand management of social care—and the NHS, which has been very bad at it, the key is how we manage that demand with the consumers in such a way as to reduce the pressure on the system. Without that, all the other things we are doing mean that the system is overwhelmed.

Shirley Cramer: We have a very complex system and a lot of unintended consequences in the system. A much more joined-up system with integrated budgets and integrated data would help to loosen up all the things that need to happen to make the prevention agenda one that is at the top rather than the bottom. We need to prioritise, as I said earlier, people in social care, health champions, health trainers and people in the community who can help to prevent people going to their GPs or being in hospital. I have been at hundreds of meetings where people have said this is important. I have yet to see many people come up with solutions. We need to be a bit braver in the way we do it. How about training the wider workforce? It will not cost much: they are all in jobs already; they are all keen to do this work. Why would we not spend a little bit of money getting them geared up and seeing what difference that can make? We need to do a lot more implementation rather than just analysing the problem. That is my view at the moment.

Jo Moriarty: Not being an expert in the NHS, I feel quite reluctant to say this, but I would say that there is too much emphasis on recruiting people at an early age and not enough attention paid to those who leave, who have already been trained. We did some work looking at the costs of qualifying a social worker and one of the things we found was that it actually cost about as much to train a social worker as a physiotherapist or a nurse on a year by year basis. The problem is, because there is so much exit from the profession, you are constantly needing to retrain more and more people to make up for those who have left. Some of the practices in the NHS, such as 12-hour shifts, do not fit in with what we are being told from other parts of government about the need to have a more portfolio career, about a need to have a step-down retirement and things like that. The assumption is that they will recruit people at the age of 18 and will keep on recruiting them, rather than thinking that we actually need to train people for their lifetimes.

The Chairman: Thank you very much for coming today. It has been

most helpful. If you have other material that you would like us to have, please send it to us. Something may occur to you during a conversation and we would welcome that.