



Select Committee on the Long-Term Sustainability of the NHS

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

Tuesday 8 November 2016

11.20 am

Watch the meeting

Members present: Lord Patel (The Chairman); Lord Bradley; Baroness Blackstone; Bishop of Carlisle; Lord Kakkar; Lord Lipsey; Lord Mawhinney; Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 16

Heard in Public

Questions 158 - 170

Witnesses

Christina McAnea, Head of Health, UNISON; Dr Stephen Watkins, MPU Section, Unite; and Dr Mark Porter, Chair, British Medical Association.

Examination of Witnesses

Christina McAnea, Dr Stephen Watkins and Dr Mark Porter.

Q158 The Chairman: Good morning. Thank you for coming to give evidence to this inquiry. Before we start it would be helpful if you would introduce yourselves—and if you represent an organisation, please say so. If you want to make an opening statement please feel free to do so; otherwise, we will go straight into questioning. We are broadcasting, so if you have any private conversations—this applies to Committee members, too—they might get picked up. But I doubt that you will have time to have a private conversation.

Christina McAnea: I am Christina McAnea. I am head of the Health Group at the trade union UNISON. We are the largest health and social care trade union in the country. We have about 450,000 members who work in the NHS or who are providing NHS services, either directly employed by the NHS or with the voluntary sector or private providers. They do everything. We have senior managers, nurses, midwives, occupational therapists, cleaners, caterers, porters. We have the full range. We do not recruit doctors or dentists. We also have around 300,000 members who work in the social care sector, mostly as social care workers but social workers as well. We have about 60,000 who work in the community and voluntary sector.

We have always supported the NHS. We think it is the most efficient way of providing healthcare, which is borne out by a lot of the evidence that is around. We are not a union that is averse to change and we have participated and worked with Government and employers in the past. Major changes have taken place within the health sector. Our main concern at the moment is around funding but the big issue for us as a trade union is the impact that the massive changes and the funding cuts in both social care and in the health sector have had on the workforce and, inevitably, what that impact has on patients and the care that they are able to provide. I am sure I can come to some of the detail on what our main concerns are in the questions.

Dr Watkins: I am Dr Stephen Watkins. I am a public health doctor and I am here today representing Unite which is the largest trade union in the country and the third-largest trade union in the NHS. I am here to present two pieces of evidence: Unite's main evidence and the evidence submitted by our medical section, the Medical Practitioners' Union.

We make a point in paragraph 19.9 of the MPU evidence that one of the distinctive features of the medical profession is its tendency to make decisions on when guidelines are applicable. It therefore will come as no surprise to you that Unite's main evidence is laid out as an answer to your question, whereas the medical evidence is laid out as a free-flowing, freestanding statement in answer to the fundamental problem. That reinforces the point we make in paragraph 19.9.

We would like to emphasise a few points today. Firstly, we would like to emphasise that the NHS needs more money. We have gone into some detail in both sets of evidence on why it needs more money. We have gone into some detail in both sets of evidence on why the best place to raise that money is through general taxation.

Secondly, we make the point that further spending on the NHS may well be self-financing because there are a lot of studies showing Keynesian multipliers for health spending of 3.6, of 4.0, or anywhere between 5.0 and 10. If the Keynesian multiplier is in excess of 2.5, the spending will lead to the raising of more taxation than is actually spent. Therefore, we believe that more funding of the NHS and of social care could be entirely self-financing.

Thirdly, we make the point that investment in prevention is necessary to contain spending on health and social care, that spending on social care is necessary to contain spending on healthcare and that spending on primary care is necessary to contain spending on hospitals. We refer to some of the cuts in those areas of spending as stripping the lead off the roof in order to make buckets to catch the rain.

The fourth major point we want to make is that markets are not a solution to the problems of the NHS. We go into some considerable depth, particularly in the MPU evidence, on why markets are not a solution to the problems of the NHS, and what the specific faults and flaws in markets are that make it inappropriate as a solution to the problems of the NHS. We say that the development of markets and procurement has gone too far.

I will make a very important point here. The MPU argued for commissioning long before it was fashionable. We first argued for it in 1988. We have some claim to have made a major contribution to shaping the form of clinical commissioning that was introduced in 1997. When we say that commissioning has gone too far and has become a procurement bureaucracy, this is not just some ideological antipathy to commissioning; it is actually a statement by an organisation that played a major part in bringing commissioning into being. Those are the main points we wish to make in our evidence today.

Dr Porter: Good morning. My name is Mark Porter. I am the BMA Council chair, which makes me the senior elected representative at the BMA. I am also a consultant anaesthetist working in the National Health Service.

You will be given, you are being given—I have looked at your website—and you have been given huge amounts of evidence, sometimes rather complex. But there are some central ideas which shine through that evidence and I would like to consider them for a few seconds now.

After years of cost restriction and growing demand, the NHS is more efficient today than it has ever been and yet its provider arm has slid into deep deficit and is expected to remain so. The Government's response has been to demand further efficiencies, which nobody believes will be

delivered, while allocating insufficient resources to fill the growing black hole. Instead, as detailed in the Department of Health's own evidence, it is pursuing a regime of financial control totals, special measures and intervention regimes that can only be designed to force money to the front of the minds of every board of directors in the National Health Service. I can understand that, but you will be aware where many fear that could lead. At the very least it absolutely impairs the ability of those boards to undertake and supervise the transformations that are necessary and have always been necessary for the continual improvement of patient care.

Instead, the BMA believes it is incumbent on Parliament to hold the Government accountable for their deliberate underfunding of the NHS, restating the principles that the NHS should be free at the point of use and be properly funded for the service it gives to the people of this country.

Q159 The Chairman: Thank you very much. Although today's session was mainly to try and get your views about the workforce issues that may in the long term affect the NHS and social care workforce, two of you particularly, but all of you, mentioned the pressures related to finance. It would be unfair not to allow you to comment briefly on this. I am going to change my question slightly towards funding issues, but we will keep it brief, I hope, so that we can get back to the main issues today.

We have had evidence, and you heard the statement from the Secretary of State last week, that, compared to the OECD, we have higher GDP spending on health and social care than some OECD countries, countering the argument that they do not have enough money; and, secondly, that any further funding should come, as you said, from general taxation. We are told that when the public is asked where the money should come from, they say taxation. But when they are asked to pay more taxes, they are not so keen. We are still looking for an ideal settlement for social care because we have been told in evidence that it is the social care pressures that are currently putting the pressures, as you mentioned, on healthcare and that therefore impinges on healthcare finances and maybe even the workforce. We are told that things such as co-funding are not a good idea. We are told that the possibility of a hypothecated tax is one way to look at it—but there are cons about that, too. So, briefly, from each of you, which funding model are you favouring and why?

Christina McAnea: We would definitely favour a direct taxation model. But the key point has to be that it is not just about funding the NHS, as you have already said, but about funding social care as well to a level that means that you can actually meet need. Over the past few years we have seen a 25% cut in the funding for social care, a 25% reduction in people receiving social care, and an even greater cut in the actual overall budget that is going to local authorities. That has had an immediate impact and an ongoing impact on NHS services. We have also had the lowest settlement for the NHS over the past five years—something coming out at 0.9% in real terms—which goes nowhere towards meeting the cost of both inflation within the NHS and rising demand. As you know,

traditionally the NHS has needed between 4% and 5% a year to keep pace with that. It has not been receiving that so that cumulative effect of the ongoing funding restrictions has meant that we are now facing an absolute crisis. The money that has been saved from the NHS has, by and large, come from squeezing the tariff but also from imposing pay restraint within the NHS, which is now beginning to bring its own problems in terms of impact on the workforce.

We would favour a taxation model and we would favour having a cross-party debate on how you deal with social care, particularly in England—there are differences across the UK, but certainly in England. There would have to be cross-party support for how you actually deal with the issue of funding for social care, social care services and where you raise the income. I have heard many suggestions, including taxing people when they die, so you tax the estates that are left. I think all of these would be controversial in their own right and in their own way, but if you could get proper cross-party consensus on how you would actually deal with the social care funding crisis, I think it is the only way to go forward.

Dr Watkins: First of all, if the Keynesian multiplier for health and social care spending is in excess of 2.5, then the problem goes away because the increased spending will raise the taxation that is needed to fund it. There are studies showing it to be 3.6, studies showing it to be 4.0, studies showing it to be well in excess of 5.0. Therefore, our first contention is that this is not really a problem.

We understand that perhaps not everybody will accept that proposition and so we address the question of taxation. It is true that people resent increasing taxation. They probably also resent increasing energy bills and increasing rail fares. In fact, people resent being asked to pay for anything. Nonetheless, I am not sure they resent that increase in taxation to the point of not actually wanting to see the services which it funds. There is a perception amongst the public that taxation has become less value for money for the individual and that is because it has, because of the fall in the levels of taxation paid by multinational corporations. Our first claim as to where taxation should come from is that multinational companies trading in this country should pay their fair share of tax.

There is no doubt that the introduction of free social care, which we strongly advocate, would necessitate increased taxation and it would necessitate increased taxation of individuals. But it must be noted that people deeply resent the risk to their savings involved in the current systems of social care charges. I think it ought to be possible to persuade people that they are getting good value for money out of the taxation that is necessary to pay for the introduction of free social care. That would be our response.

Dr Porter: The debate on how to pay for public services always, to my mind, focuses excessively on oversimplistic calculations as to cost. For example, income tax is less than one-third of general government receipts and yet it is general government receipts that fund that National Health Service. In other words, put up the public spending to support a

public service that people want. In the debate on this you, as parliamentarians, really have to get away from the idea that you can calculate an amount going in, how many pennies in the pound that converts to in income tax and that is what the country is being asked to vote for. I do not believe it is as simplistic as that. Aside from the fact that people have in the past responded to various political calls for various forms of hypothecated taxation, some of which were unwise, there is a general sympathy for the provision of public services that can and should transcend the debate we are having here.

There are other things that we can look at that can also help to constrain the cost of a public service that the people want. Probably at the top of a very long list I might include the very unwise decision to go into private finance initiatives over the last few years. I should declare the interest that I work in a hospital built by the private finance initiative. It is very good and so forth but, nevertheless, the inflexibility it brings to local healthcare economies up and down the country is one of the reasons for the major problems that occur in some of those healthcare economies when you look at how to fund the unitary payment. That is a dive into a very specific measure but it is also questioning that, despite what I said earlier about the NHS being very efficient, which I still stand by, there are still areas where we could make major savings by actually regarding the NHS as a public investment rather than as something that has to be paid for by some interaction with private industry.

Q160 The Chairman: To get back now to the workforce issues, again looking longer term, to 2025, 2030 and beyond, what do you think are the key pressures on the health and social care workforce?

Christina McAnea: You have your evidence and I hope this will come through. We have already talked about rising demand, pressure on both social care and healthcare, lack of funding and what has happened to the funding. One of the other key things is about staff shortages. We have some key staff shortages across different parts of the NHS, and geographically as well. We do an annual snapshot survey of our nursing and healthcare assistants. About 200,000 of our members fall into the nursing family. Some of the statistics that we get back from them, just this year, showed that nearly two-thirds felt there were not adequate staff to deliver safe and dignified care. That was up from 45% the previous year. Sixty percent were unable to take any or all of their breaks on any given day and 70% reported not having enough time to spend with the patients they look after. There is a whole load of other statistics which I will not go into but they are there. If you look at what happens with the Ambulance Service, we have a disconnect between demand—there is an almost constant 10% shortage of paramedics. It is higher in certain parts of the country; it tends to be higher in London. That puts additional pressure; if you do not have staff to deal with some of the crisis points, it puts pressure on the whole system.

There are specific issues in social care in terms of impact. One of the key things in social care which results directly from previous policies of cutting the funding that is going to local authorities, thereby cutting the

funding that goes to social care, is that they elect contracts usually driven by cost, which has an impact on the staff. We see a turnover of staff in social care of around 34.7%, which is not sustainable. That means that at any given time at least one in three of the staff who are out looking after the most vulnerable in our society have either just joined or are about to leave. There is this constant churn within the sector. We also have massive issues around pay in the social care sector. We have fewer than a quarter of councils who make it a condition of the contract that staff have to be paid for travel time. We have huge numbers of staff working in social care who are actually earning less than the national minimum wage. That is one of the reasons why you get this huge turnover. There is a crisis in social care which has to be dealt with which has a wider impact across the health service.

I have another two interlinked points about areas of major concern and key pressures. One is about pay restraint and the impact that has had on morale and people's ability and willingness to stay in the service. The other one is this huge change that is happening in the sector. It seems that we are in constant change. From 2012, when we had the massive reforms in England, up to now, when we have the proposals coming out from the STPs, this means we have vanguards, new models of care and all sorts of different initiatives taking place. Yet, because of the system we have had since 2012, we have much greater fragmentation. No one has taken responsibility. There is no single organisation that has responsibility for an effective workforce strategy. You might say that that is difficult to do in a fragmented system, but there should at least be some overarching workforce strategy and no one will take responsibility for that. That is a major issue.

Dr Watkins: I agree with much of what Christina has said. Indeed, there are similar findings in the Unite evidence from our own staff surveys: similar comments about social care. I would like particularly to echo her point about reorganisation of services. We have members in the Ambulance Service, many of whom are experiencing competitive tenders and privatisation. Almost all health-visiting services will be going out to tender or have gone out to tender as a result of the procurement regulations. To those who say that when we argue for the abolition of the current market structure that this will mean a major NHS reorganisation, I have to say that the market is itself the cause of constant reorganisation of the NHS—an unnecessary reorganisation and a reorganisation which does not further the improvement of services.

Staff morale is extremely low and we give some examples in our evidence. We describe the background to the low morale of junior doctors and the low morale of GPs. There is very low morale amongst health visitors who have seen their service built up over the last five years and now see those changes about to be reversed as a result of the Government's cuts in public health funding.

We see very low morale among staff, partly because they see the service as inadequate and inadequately funded and because they see themselves

as being blamed for that. They are not to blame but they see themselves as being blamed. I was present for part of the discussion before this and I heard discussions of the leaky bucket and the staff that we are losing. We really have to do something to make the NHS something that people want to stay in.

Dr Porter: I would like to raise one or two particular things in relation to medical staff. There is a background that many people here will be familiar with about the increase in medical specialisation recently, driven mostly by the need to serve patients better. I will not go in and question that and say it is going in the wrong direction. However, it does remind us that there are 15-year lead-in times between recruiting someone on a training programme and them actually working in a career grade post in some specialities, for example my own—shorter perhaps than one or two others but nevertheless with a long lead-in time. I think this interacts with some of the choices that we have made that make that challenge worse. One of them, for example, is investment in general practice and the way in which we support GPs working within the service, which at the moment is undergoing something of a crisis of confidence, leading to one of the highest vacancy rates ever recorded for general practice posts at 10%. The Government have promised 5,000 new GPs within five years and I am not aware of anybody who really believes that is actually going to happen. One can try for it but whether it will happen is something about which most people are sceptical.

We have a profound demoralisation amongst our junior doctor workforce. There are 55,000 across the UK and 45,000-odd in England. We are not just talking about the new contract for junior doctors for 2016 in England but about everyday occurrences such as the 90% of rotas that have gaps that the junior doctors deal with on a permanent basis. In other words, there are unfilled posts that the other people are simply expected to fill. It is an experience that happens at all times in all walks of life but it is so routine for junior doctors that I am really concerned that we are approaching a situation where we are completely alienating and demoralising the next generation of medical leadership within the National Health Service.

In line with that, I will finish on the specific problems by mentioning those of overseas staff. We are saying something quite new and quite profound to the members of NHS staff who came here from overseas. We are even tipping towards telling them that they are not welcome here at the moment. I believe that is completely wrong. The situation following the Brexit vote has unsettled quite a number of staff in the NHS. We are talking here about tens of thousands of doctors and many tens of thousands of people working in nursing and therapist posts and so forth. That was compounded by the recent Government announcement that we should aim for self-sufficiency in medicine—something which I think is both wrongly conceived given the international learning community that medicine is, but also something which speaks to those people who are here at the moment and says, “You are not valued and not wanted”. We are seeing that being reported back in what people tell us about their

experience in the service. People do not know what their future is, particularly because the Government is not revealing or talking about any of its negotiation objectives in relation to the retention of staff from overseas.

This goes beyond EU staff, to speak to those staff who came here from all over the world. There is a state of considerable disquiet at the moment that is unable to be resolved and, I think, is being exacerbated by some of the announcements being made at present. That is one of the reasons why the BMA has joined the Cavendish Coalition, a coalition of employers, providers, local authorities and so forth. We are very concerned about what we are saying to the members of staff who work in the NHS and social care and have come from overseas, wherever they have come from, and the real need to support them at the moment.

You ask about the long-term challenges. That is a very new one but I believe it is a challenge that will play out over the next 10 or 15 years to the detriment of health and social care.

Q161 Lord Warner: Can I bring you back to the longer term? In asking these questions we have a great deal of sympathy with the kinds of points you are making about the current situation, but our remit is sustainability in the long term—2030 and beyond. Admittedly there are implications for that in what is going on currently, but we have to focus on the longer term as well. I want to ask you some questions about the current pay system. I should say that I was a Health Minister for four years when the NHS budget was going up by 5%, 6%, 7% in real terms. I was also the workforce Minister. I did not see a lot of flexibility in the NHS workforce in that period of great growth when it came to addressing issues around new skill mixes as the services changed. Is there something inherent in a rather siloed national pay system which actually thwarts change? Putting it very brutally, has the national pay system outlived its usefulness at a time of great change in service development? Can you project forward and see whether there are issues in that kind of territory?

Dr Porter: My answer to your question is that I do not think so. Partly I will talk generally and partly I will specifically address doctors and my colleagues will address the other NHS staff. I think there are slightly different considerations and one of the things I must bear in mind is that the job and recruitment market for doctors is much more widespread than for non-medical jobs. It covers the UK and to a certain extent it covers internationally in a much more robust way than many of our local recruitment efforts for people at the junior end of, for example, nursing or therapy actually are. I think they have a much more mobile workforce and would want to keep it that way. That is one important point that needs making about national pay systems.

Another really important point is that the point of the pay systems is not so much to enable people to pay their mortgages as to support the existence of the health service that we want. The health service that we want is a comprehensive one with universal provision across the nation and such that we actually can have confidence that we are delivering a

health service to similar standards in one part of the country to another or, in those parts of the country that before the establishment of the NHS might have been very much more or very much less attractive. We have chipped away at a lot of those differences but if they still exist they will need to be moved on.

My real fear about moving to local pay is that we develop local markets that take us back to the days when people would choose which part of the country to work in based on the pay that was available rather than based on the opportunities for serving patients, which is what certainly most of my members would prefer to think about at the moment rather than competing one hospital against another or one practice against another in terms of pay. That is a really important thing to lay down.

On your point on flexibility, I will answer this purely by example. I mentioned that I am a consultant anaesthetist in the NHS. I work in a way which is utterly transformationally different to the way in which consultants worked when I was a junior doctor. There was nothing about a national pay system that stopped me doing that. The way in which I have changed my work and the way in which I have seen my colleagues change their work is based on the knowledge of what we can do to help patients and the best ways that we can do it. It is not about what the hourly pay at any one particular time is or about whether that pay is dictated from Whitehall or the DDRB or whether it is separate in Devon and Cornwall or anything like that. I would challenge the assumption that there are few changes and little flexibility. I would not necessarily peg it so closely to the period when you were a Minister and say that it all happened then—although I say to your colleague next to you, I was sitting in your office 23 years ago discussing the new deal and how to bring in flexibility for junior staff at the time.

The journey that we have been on, which is mirrored among other staff, is one where we have adapted our way of working and I do challenge the thought that there is very little flexibility these days in the way that people develop their careers and jobs.

Lord Warner: I am thinking about nurse prescribing and the doctors' reaction to nurse prescribing and nurse practitioners in surgery.

Dr Porter: We wanted it done properly. There are many such people working in the place where I work.

Dr Watkins: I agree with most of what Mark has said. Many of the points he made are relevant to other groups of health workers, too. We say in Unite's evidence that we believe that the health service system of pay should be extended to cover social care as well, as we believe it could help solve many of the problems that Christina described. So I would agree generally with that.

On your point about flexibility, we do believe that flexibility is important. I do not think that the resistance to flexibility that you are describing is as strong as you say. There have been massive transformations in the way

people work and massive transformations in the skill mix. Perhaps they could have gone further, but I am not sure you can point to, as it were, national pay bargaining being in any way the obstacle to that. So I would support Mark's point.

I would also draw attention to the point that I drew to your attention jocularly at the beginning, but I will do so seriously now. The point we make in paragraph 19.9 of the MPU evidence is about the distinctive role of certain professional groups, including medicine, dentistry, non-medical public health specialists and senior scientists, in not simply following guidelines but in determining the scope and extent of their applicability. That is quite an important point that needs to be borne in mind when we develop the skill mix.

Christina McAnea: I am also chair of the NHS Staff Council, which brings together 15 trade unions. This is a debate we have quite frequently with the employers, with the pay review body and with the Government. A few years ago the Government asked the pay review body to look at regional pay. We all submitted evidence to it. It did visits, et cetera. The pay review body came back and said that it could not see any argument for having regional pay. I have to say that I dispute that the pay system itself invites inflexibility. It is a question I sometimes put back to employers by saying, "Name something you want to do in your workplace that Agenda for Change stops you doing but that does not involve cutting the pay and conditions of the workforce?" That is the thing that people say to me: "We want to do these things, but Agenda for Change stops us". No one as yet has been able to come back to me with an example of something they wanted to do in terms of service delivery or skill mix or doing something which is about deploying the workforce flexibly which has been stopped by having a national pay frame.

I would echo the points that Mark made that for many staff this is a national workforce. We have shortages of certain key skills, certain physiotherapies, various therapies, radiography et cetera. There is an element of it being a national workforce. It is also about maintaining standards. Stopping leapfrogging is the other one—we would get competition between trusts. We already see a little bit of that creeping into it at the moment in terms of nursing shortages where some will try and offer a particular package to recruit. I understand why they do it but I do not think it is good. If you are talking about long-term sustainability I think introducing a system which makes that easier will just make it worse in the long run in terms of being able to attract and retain good-quality staff.

On the issue of skill mix, we are totally up for skill mix discussions. I was not part of the group that went around doing health at the time when that was negotiated; I am assuming you may have been. When Agenda for Change was negotiated there was an expectation that there would be further gains to be made from a benefits realisation from further skill mix discussions. That has not taken place, but not because we have stopped it. We are constantly up for a discussion around this but there are no

resources. It is difficult to bring in massive change or even minimal change at time when you have such a restrictive pay policy.

Q162 Lord McColl of Dulwich: First of all I want to declare an interest. I am a trustee of the Wilson Foundation, professor of surgery at the University of London and author of the McColl report that transformed services for disabled people.

My questions are on poor morale which you have already dealt with quite a bit. How should poor morale be addressed? What are the risks to the long-term sustainability of the NHS of not addressing poor morale?

Dr Porter: I will dive in. Morale is not something that can be addressed by a single announcement or a single initiative, et cetera. It is to do with the long-term valuing of the workforce. In that I do not necessarily only mean valuing by government Ministers, for example. I mean it in the sense that many people who have worked in the NHS and in social care have a profound, lifelong feeling that the services they give are valued. They might be valued in different ways by different people. I think I give a very good service to my patients. I think they value the service I give and that gives me an enormous amount of job satisfaction. As it happens, I have also had opportunities to be involved in various aspects of planning care in my hospital which can be quite rewarding. Some people do not, and that might not be.

However, I think it also depends on how the service itself looks at and treats people. As you mentioned, I have alluded to the way in which junior doctors and GPs think at the moment, to the way in which they feel that the service treats them as a commodity rather than something to be valued as a long-term investment, something you can turn on or off when needed, put to one side, and change the conditions when they are a little bit inconvenient for the moment. The problem is that that sort of feeling compounds with the longer-term feelings of whether or not public sector workers are valued in general to give people at the moment a feeling that, "Well, do you know what? I am not sure there is a long-term career here. I am not sure there is a long-term something that is going to sustain me through decades of public service".

Certainly a lot of the younger people coming in to the NHS whom I talk to, having now sadly reached the age where people ask me to reflect on my career and so forth, talk about whether it will be the same for them. I do not detect the feeling that people believe that. They believe that the services are under threat long-term, that the promise that is made to the people is not something that is written in stone, if you will forgive me borrowing a metaphor there, and that the future is rather more uncertain than it has ever been in the past. All that contributes big-time to a feeling of a demoralisation that is palpably surrounding me as I talk to people not about what their work is like today but what it is like stretching into the future, and what it will feel like when they come to be at my point in life and look back on things.

I apologise for giving a very general answer but I genuinely think that it is something to do with how we value and motivate people for a long-term career in public service rather than necessarily what we do from minute to minute and the announcement that has been made that day or next week—albeit that those things contribute. I mentioned Brexit and the overseas doctors thing which I think will become a really important theme over the next few years.

The Chairman: Do you have some suggestions for what the solutions might be?

Dr Porter: It comes back to what we have all said in our different ways. At the moment the palpable feeling is that the NHS is dominated by cost control, by a feeling of crisis, by a feeling of demand that is out of control. A lot of that is contributed to by successive Governments that have given the impression that the NHS is a drain on the public purse and needs to be somehow constrained, forced to become more efficient, controlled and corralled for the future, rather than celebrated as something which is, forgive me, one of the reasons to be British.

Dr Watkins: I think Christina made some very important points at the beginning about pay and conditions. That is very central to morale and I agree with that. Mark made some very important points about the way people are valued. I agree with that—and, had he not already said that, I would have said that as my first point. Since both of those things have been said, I am going to add two further things to them.

My first point is the sense that Christina did actually mention of the idea of whether there is a long-term effect of pay freezes and of the idea that you will squeeze pay. I have spoken to people who have retired because, had they continued to work, the addition to their pension from the extra years they had worked would have been less than the increase in their pension due to inflation had they retired. They were actually damaging their pension by continuing to work. That is a real indication of how pay and conditions have been squeezed.

I would also like to refer to a point which we make at some length in the MPU evidence in section 9 called “The History, Distortion and Future of the NHS”. We point out there that when the NHS was originally set up, it was set up as a partnership between the people, the professions and the people who work in the service. Over a period of time it has been progressively turned from that model first of all into a more Morrisonian model of nationalisation and then into a model of privatisation. One of the processes of that has been the breakdown of that relationship between the people and health workers upon which the success of the early NHS was so strongly predicated. We think that it is time that power moved back from bureaucrats, bean counters and business operatives to Parliament, the professions and the people. We make some concrete suggestions as to how that can be achieved in our written evidence.

Christina McAnea: As part of our submission to the pay review body we carry out a fairly extensive survey of our members. This year we

surveyed 21,000 members who work in the health service. We asked them a lot of questions about their pay, about morale et cetera. You have that in the pack but I will just pull out a couple of things. One of the things that surprised us was that something like 80% came back and said they had thought about leaving the NHS. We get people saying that but it does not actually mean they will do it. We dug a bit deeper and asked follow-on questions to try to get to the heart of whether they actually meant it. Almost half of them said they had seriously or very seriously considered leaving the service. We asked the reasons why and the top three things that came out were increased workload, stress at work and feeling undervalued. We have to accept that this feeling of being undervalued has a serious impact on how people feel about staying in their chosen career, profession and the organisation they work for. Those are the emotional reasons why it is important.

The reason why I mentioned pay restraint earlier on is that I think it feeds into this feeling of being undervalued. It also has a significant, emotional and real impact on people's lives. Some of the information we got back from that was the high percentage of staff who responded to our survey, who had had to do things like go to payday loan companies or pawn their belongings. About half had had to ask family and friends for financial support. About a third had had to either move home or re-mortgage their house. All of that will have an impact on how you are feeling about the organisation you work for.

I will give another example which may seem minimal. The Government have promised a 1% pay increase for the next few years in the public sector, to the end of this Parliament, but in the health service what they are saying is that the cost of the Government's new national minimum wage has to be funded from that 1%, which means that the majority of staff in the NHS will not even get 1%. Whilst that may only be a fraction of a percentage, that sends out a message that they are not even worth the 1% that is being given to the rest of the public sector. The cost of paying that would be roughly £280 million. That sounds a lot but it is just over £1 million per trust in England. When you think that trusts are spending £25 million to £30 million a year on agency costs, a tiny fraction of that would make a difference to people and to their morale.

Lord McColl of Dulwich: I speak a lot to general practitioners and I have worked for many years closely with them and in GP hospitals. One of the things that they say is that they are demoralised by the vast amount of paperwork they do. One, for instance, spends the whole of Sunday filling in forms. Then they have inspectors coming around who make the most inane remarks such as, "Ooh, yes, we've found an ampoule that is two weeks out of date". They say that that is what is what is really sapping morale. Do you have any feelings about that?

Dr Porter: You invite me to agree and I certainly would not not agree. There is a profound feeling amongst GPs, as you particularly mention, considering the way in which general practice is essentially run as a series of practices in local areas—as relatively small businesses. Whether

they are partners or salaried GPs within the practice is less relevant to that feeling that you are describing, which is that at the moment the inspection regime has become over-intrusive. There is an adage often bandied about that you cannot inspect quality—and people repeat that back, particularly after they have been subjected to the sort of visit you described. Not every visit is like that. Not every bit of content of every visit is completely non-directed towards quality of patient care. I would not say that. But too many of my colleagues say all the time that they really resent the time spent preparing for the continual inspections.

Lord McColl of Dulwich: They have to pay for it, too.

Dr Porter: We all have to pay for the regulation system in one way or another, even if it is only the GMC fees and so on. Each individual provider organisation also has to pay CQC fees, the CQC being the organisation you are talking about. At the moment, the CQC, like other parts of the regulation system, has been asked to become more self-funding. Becoming more self-funding means raising more funds from the people it inspects. The fees the GPs are paying to be inspected in this way are increasing. There is a consultation out at the moment about further increasing them over the next few years. That is one small part of the valuing and the demoralisation that we have been talking about.

Q163 **Lord Lipsey:** What long-term effect on morale do you think the sad saga of the junior doctors' dispute has had and what lessons should we learn from that for the future?

Dr Porter: I think it has had a profound effect. I mentioned earlier—and I will mention again—that we have taken the next generation of medical leaders and almost deliberately set out to upset them in a profound way, beyond anything that has been done before, in pursuit of an objective that I do not believe is worthwhile. When I say I do not believe it is worthwhile, what I mean by that is that the objective of providing proper treatment to patients as they need it around the week is one shared by the medical profession and by doctors. We have been at the forefront in actions over the last 25 years to put that in place. I do not believe, and no junior doctors believe, that this contract is actually directed at that because, if only for the most simple reason, if you walk into a hospital at weekends you will find junior doctors staffing it. The problems we have are related to other resource problems, not to junior doctors.

I do not want to say too much about the actual detail of that because at the moment we are trying to find our way, as you would expect in any form of dispute, towards a resolution that allows us to go forward and do what I believe is the shared objective of everybody in this, to care for patients. The diversion into thinking that the contract is a way of resolving the problems of caring for patients is something that will leave a lasting bad taste in the mouth, the minds and the memory, not just of junior doctors but of people who work with them, consultants and other doctors, but also the other members of staff who fear that the same approach will be coming for them next.

Dr Watkins: I will add two points. I would like to draw your attention to appendix 2 of the MPU evidence which addresses this issue of excess weekend death rates. The dispute has made junior doctors very angry and it has damaged their morale. It is very important that their anger is channelled appropriately. As an active trade unionist I am determined to do that. They were chanting, "Save our NHS". I hope they continue to chant that.

Q164 **Lord Warner:** I would like to ask a question about the issue of recruitment agencies. I have spoken to a number of staff in the NHS and in local government and what they say is that they have moved to a lifestyle of working through recruitment agencies rather than employers. This is not much to do with pay restraint per se. They get a bit more money but it is actually about control over their life. Are we living through a period where actually people want more control over their life than they can get through employment status? Is there something going on that we have not really mapped?

Christina McAnea: Yes. When we have asked our members that, the two things that come back around why they go to agencies are flexibility and lack of flexibility in the standard NHS contract. That is the biggest reason and the other one is always pay. They do get more money for it but the key one is flexibility. There are a number of trusts which have actually tried to address that by introducing more flexible working for their staff. We have had trusts where a nurse has come back from maternity leave and asked if they can do a four-day week and particular shifts and they have been told they cannot. They then go to an agency and they are given precisely that shift because that is what they want.

Some trusts are trying to address that by having a package but obviously they have to ensure that they have good cover. We are happy to work with them on that. We have given a commitment to NHS employers on behalf of all of the trade unions that we want to work with them to try to reduce the agency staff bill by trying to come up with incentives or more inventive, imaginative ways to look at rostering, to look at the kinds of contracts that staff have and to agree better flexible working packages. You are absolutely right; that is what has happened.

Lord Warner: There is an issue there.

Christina McAnea: There is a massive issue there.

Dr Watkins: You linked that to employment. It is absolutely possible for a competent employer and a competent manager to arrange flexibility for their staff if they choose to do so—and they are going to have to do so if they want to address this problem.

Q165 **Lord Willis of Knaresborough:** I would like to pick up from Lord Warner's comments but concentrate on the workplace itself. What has rather depressed me about your answers this morning is not that you have concentrated on pay—I fully expected you to do that and it clearly is a really big issue—but that you have not actually balanced that with

saying that there is a lack of ownership of decision-making, there is a lack of trust, there is a risk-intensiveness within the professional people. I have not met a professional yet who does not want to have ownership of what they do, to be trusted in what they do. I wonder if you could comment about what we could propose in our report which would bring the professional back into the professionalism of the job.

Christina McAnea: This is about everyone. Not just staff who would be seen as professionally qualified but everyone who works in the NHS would probably share the sentiment that they want to be involved in the decisions and they feel that the job they do impacts on patient outcomes and patient care. One of the things we are asking for, particularly at this time when we have STPs and, as I said earlier about models of care and all the rest of it, is that there is a disconnect. People are beginning to feel that all these things are happening up here and at some point I am going to be told what I am going to be expected to do and I may have to change my working practices, change my workplace, change the patient group that I look after, et cetera. If it is discussed with them in the sense that it is good for patients, then most would be happy to go along with that. They want to feel that they are co-producers of the change, that it is not just something that is happening to them.

One of the problems is that the system that we have now means that that is very difficult to achieve. We have registered strategic health authorities. Simon Stevens is trying to introduce 44 STPs to bring a bit of order back into the system—I hope. People are still nervous that those will be seen as vehicles to make the savings that they have been told to make and therefore that they will result in massive cuts. What we are saying is that now is the time to have a new discussion with staff in the workforce—either a new compact or a new workforce agreement. I do not mean going back to the old Agenda for Change or indeed the doctors' contract. I do not mean one that necessarily will encompass all terms and conditions, but one that give them some certainty that engaging in the discussions around the necessary change to improve the care that is delivered to patients, to meet the integration agenda and all the rest of it—that they are not then putting at risk their own employment contract. We should give that kind of certainty to staff: that actually you can take part in these discussions, you can engage in change, you can look at what is best for patients and change your professional working practices, but at the same time that will not result in completely undermining your terms and conditions. Quite frankly, they look across to social care and they think, "I don't want that to happen to me. If that means I have to retreat into the acute sector, that might be what I will do".

Lord Willis of Knaresborough: When I go into a Magnet hospital in the States, I see exactly that with the nursing workforce. They do feel empowered; they do feel in charge. It does not seem to be a quantum leap from where we are to get that into our system. That in itself encourages people to stay, it cuts down budget and it gives employers the opportunity to pay more.

Christina McAnea: Sorry, which hospital did you say?

Lord Willis of Knaresborough: Magnet hospitals in the States, where that model is operating. It creates a budget through the health economy to actually give better terms and conditions because people are not spending out fortunes on agency staff.

Dr Watkins: Unite's evidence has not concentrated on pay and conditions. It has obviously mentioned it but it has not concentrated on it. It has concentrated very much on this issue that you describe of how we re-establish partnership between the professions and the people. Within the MPU part of the evidence it contains some very concrete proposals on how we can do that.

Dr Porter: There is one counterexample that the Committee will find relevant, specifically about general practice, which is that we are approaching almost half of people who work as GPs who are not contracted principal partner GPs but work as locums, sessional, salaried. When you ask people who move into that mode of delivering general practice, not the universal but a very important reason given by many people is that they can no longer cope with the completely open-ended and unlimited commitment that the NHS currently places upon partners in general practice and thereby they regain control over their lives by deliberately choosing to go salaried or sessional or work as locums.

I know people who have worked for decades as partners who have taken the deliberate decision to move into this work now in order to bring themselves a control over their life that they feel has been completely lost by the demands being placed on them by the NHS at the moment through the contractor route. This is not an argument for doing that. Many people would rather that the NHS was able to offer GPs better employment or better circumstances than it does at present and they would rather go back to work as partners, being able to have a control over the professional end of their lives as well but can no longer cope with the workload and business aspects that are driving them out. That is something that should be of great concern to us all.

Q166 **Lord Scriven:** We started to get onto what I want to talk about, which is new models of care. This morning you have already mentioned it. Clearly, as demographics change, as technology changes, new models of care are going to have to come around. I have two questions. First of all, looking at the long term, what do you think your role as professional bodies and trade unions can be in helping bring that about? Secondly, what will the NHS have to do? You have mentioned money, pay and conditions and I do not want to talk about those. What else will the NHS have to do to help the workforce in terms of that change and in terms of a new model of care? What is the role that you can play as professional bodies and trade unions in helping bring that about? What are the key issues that you need to address or will bring to the table? What will the NHS have to do, other than money, funding and pay and conditions which we have already heard about in your evidence?

Dr Watkins: Certainly Unite would be very keen to encourage our members to participate in discussions with the local community about the

nature and the model of healthcare that is required in their local area. We place a great emphasis in our evidence on this idea of local partnerships between the people and the professions in devising the most appropriate way to develop models of care that suit the needs of that locality. It is also important that there is continuing emphasis upon an evidence base. It is one of the things that most angers me about some of the initiatives that have come forward recently: they have not been evidence based. There needs to be that genuine belief that we can make the service better and we can work together to do that. This is not something that should go on in some closed committee room and then we come out with some edict that everybody has to follow. It has to be something that we are all committed to and we all work to achieve.

Dr Porter: One key thing to say is that new models of care are not necessarily something that only arise when there is a specific national initiative so to do. I can think of any one of a number of things that have happened in my own professional field over the last 25 years which have come from entirely within the profession. They have been promulgated almost without anybody in the NHS management knowing about it and suddenly care is transformed because we have some new ability to help patients, a new clinical standard or some new way of organising ourselves, directed towards patients. There is a continual ferment of change in the NHS. Sometimes it falls behind a little and needs pushing along in a co-ordinated way; sometimes it needs active support.

The role of any professional body—and we do this, we have a session in a couple of weeks' time doing what I am about to describe—is to get together a number of our members to look at and discuss the new things that are happening at the moment in how the NHS is organised and how doctors can take the best advantage of that for themselves and their patients. We then write this up as a narrative, circulate it and talk about it with our members. We take part in the learning community that is allowing people to develop as they move through and as the services move on. I think that is the role of any professional body such as the BMA, such as the trade unions, the royal colleges, professional associations, et cetera. It is something that is part of our core role: to help our members so that they can help patients.

That is something that we have to hold on to, rather than sometimes, which can be a temptation, to resist anything that is new simply because it is seen as or badged as something being done to save money. I know you said not to talk about money and I am not going to. But I will say that at the moment one of the big problems that anything called new models of care or anything like that suffers under is that it is seen as part of the Government's approach to drive efficiencies through the health service rather than being seen as something which is there to improve patient care.

Lord Scriven: How would you change that? The issue for this Committee is to make recommendations about how to cut through that. If you feel that frustration, what is it from your perspective that would need to

change to make the new models of care be seen as more about patient care rather than cost?

Dr Porter: Do not have them driven in national initiatives that are directed towards efficiencies. We are not here to talk in detail about sustainability and transformation plans, but nevertheless they are there. About nine of the 44 have been published; more will be published as we go through. They will inevitably be seen, because of the debate that is happening at the moment over public investment in the NHS, as a way of making efficiencies and driving towards that 5% per annum efficiency target that the NHS has been inappropriately tasked with finding. We should be driving that and celebrating it as a way of improving service for patients rather than having it pegged to next year's financial targets.

Christina McAnea: I agree with what my colleagues have said about what our role is. We are primarily a trade union but, having said that, we have various professional groups; we have an ambulance sector, a nursing sector, an occupational therapy group, et cetera. We work very closely with them in producing good practice and guidance. One of the key roles for us is to be there to reassure our members and give them the confidence to participate in discussions at local level on these kinds of changes and not necessarily be seen as obstructionist. This goes back to what I was saying. I think it has to be done in a managed way. To be able to give our members that confidence to participate and take part and see things in the best interests of patients rather than think about what will the impact be on them, we have to remove the fear that people have that changes are being introduced to drive down costs and will therefore inevitably have a detrimental impact on them.

One of the key things the NHS has to do is to improve communications and get back to having a system where staff engagement means genuine staff engagement. One of the big problems we have with the STPs, and there are probably good reasons why this happened, is that it feels like it is being done in secret. It feels like something that happened behind closed doors and now they are saying that they need to engage the staff and the workforce in this. That should have been at the heart of it at the beginning; they should have been open and out and discussed it with staff. That just has not happened.

Dr Watkins: Could I add one further point? The STPs should not just address the question of what the health service can do to solve its own problems; they should also address the question of what the broader society can do to address the problems of the health service. Healthcare demand and social care demand are capable of being altered by areas of public policy. We give examples in our evidence of the commercial determinants of health, of the role of welfare policy, of the significance of healthy ageing. We give evidence of how you can help slow down the creation of dependency. Those things ought to be a centrepiece, certainly for a committee which is looking at long-term sustainability, of the question of how public policy is driving the growth of a dependent elderly population with obesity and diabetes; it has to be central to sustainability

and transformation programmes. The professional associations and the trade unions cannot be accused of not raising those kinds of issues, but when we raise those kinds of issues we are patted on the head and told, "Go away; can we just settle down to this real, immediate problem of balancing this year's budget?"

- Q167 **Lord Bradley:** For this session I should declare that I am a retired member of Unite—very retired. Looking at new models of care and the integration agenda, Steve, particularly as a public health director in Stockport, which is part of the Greater Manchester devolution deal, do you see the new models of care and that integration agenda not only between health and social care but between physical and mental health as something that you, in workforce terms, are involved in, and that you can influence the direction of travel within those changes? Do you see them as exemplars of what can be done nationally and then in the long term for addressing many of the issues you have raised this morning?

Dr Watkins: As a director of public health I can be involved in that. Whether I could be if I were at a more junior level in the system, I do not know. I doubt if I could. I do not see a great amount of staff involvement. I see a great deal of staff suspicion of what we are doing in the Greater Manchester process because they do not know enough about it. You can ask me if that is not my fault as much anybody else's. I am not here as a director of public health today—but, yes, I am sure I could have done more. The Greater Manchester process is driven by a concept of public sector reform which is based on developing resilient communities. It is based on the optimisation of the use of all public resources and it is based on a very close collaboration with industry around the development of the economy, around a welfare to work programme which is not punitive but is around supporting and helping people into work. I am actually quite proud of what we are going to do in Greater Manchester.

I do not necessarily think that Unite would be as confident of my saying that as I am. There is still some suspicion around that process. But, speaking personally, I am very proud of what we are trying to do in Greater Manchester. Whether it will succeed, I do not know. I sometimes think government does not want it to succeed and would rather blame us for the collapse in the system than see us succeed in making it work. We will see.

- Q168 **Lord Willis of Knaresborough:** For someone so young, you are so cynical. We received evidence earlier this morning from the Centre for Workforce Intelligence which basically said there that another 1.432 million professional healthcare workers will be required for 2035 and another 1.329 care staff at that level. Given the fact of current vacancies, given the fact that we have never, ever been able to accurately predict workforce needs, what suggestions can you give the Committee as to how, by, say 2030, we can have a sustainable workforce, properly planned and executed? Just give me three ideas, each of you, which we can recommend to the Government: "If you do this, we will have an appropriate workforce in 2030/2035". It is a simple question.

Dr Porter: It is a simple question that demands, and indeed has, a simple answer. I am afraid it comes down to funding levels now and projected into the future. I would propose that if we can restore proper public funding of health and social care it would be better directed at the crisis in general practice, at the hospital deficits, at reversing the cuts in public health and propping up the terrible, inadequate funding in social care. But, at the end of the day, nothing is more important than recognising that we underfund these areas rather than trying to find a non-funding solution.

Dr Watkins: There is also something about consistency of policy. In my evidence I mentioned that we spent the last five years building up the health visiting workforce and the school nursing workforce because they were perceived as being a very important preventive service. We are going to spend the next five years running them down again because that is what the public spending result of last year was in terms of the public health grant. That is a nonsense. It is an absolute nonsense that we cannot adhere to a long-term strategy. We need to be prepared once again to have a properly planned health service with properly planned manpower needs. We need to stick to those and not depart from them to meet short-term problems.

Lord Willis of Knaresborough: Who should do that?

Dr Watkins: First and foremost the Government have to set that in place in terms of the funding arrangements and in terms of the willingness to commit to a long-term strategy.

Lord Willis of Knaresborough: Unless the Government know the workforce they will need to provide, they cannot do the former.

Dr Watkins: The Government cannot predict perfectly. There will be some factors which they cannot predict but there will be other factors which they can predict. They should certainly make the best predictions that they can and stick to them, and they should offer people long-term, secure career prospects based on standing by the predictions they have made.

Christina McAnea: I would say a serious commitment to reforming the social care workforce and investing in the social care workforce. One of the things which is in our evidence is that we would ask for a commitment to the Ethical Care Charter that sets out the blueprint for how you deal with this. Evidence is now coming out from councils that have adopted the Ethical Care Charter that they have seen improvements in the care and outcomes for people who are using the services, and also recruitment and retention of staff. For us, that has to be one of the key ones.

I would also say having a fair reward package: not just net pay but having something which lets staff know that they are actually valued for the job they do—so having a long-term commitment to having a fair reward package and not one that is constantly being chipped away at. We

were in the process of trying to negotiate new redundancy terms within the NHS when the Government brought in their new proposals a year or so ago. That kicked all of that out and made people feel a bit uncertain and we saw a bit of a rush of people trying to leave. Things like that do not help in terms of long-term sustainability.

Training is central to this as well—and having training which allows for a much better skill mix. There are some interesting developments taking place just now around apprenticeships and nurse associates, et cetera. Investing in staff who are capable of doing much more could make the NHS much more efficient. You would have a wider pool of people to attract and a wider pool of people to take them from.

Q169 Lord Warner: This question is really directed more towards Christina and Steve. What are your two unions doing on the whole issue of portability of qualifications, particularly on reskilling and retraining? What initiatives have you taken?

Christina McAnea: I sit on the Skills Academy for Health and we are working very closely with the academy, particularly around training on the bands 1 to 4 and trying to develop training packages that go across a wider range of people and trying to ensure that we get much better investment in those staff because we think it will actually improve things for the bands 5 and upwards—the professionally registered staff, as it were. I am not quite sure what you mean by portability.

Lord Warner: An in-service training course in Manchester that would carry commitment in Cornwall.

Christina McAnea: We are trying to push very hard to say that with the developments in apprenticeships, particularly the higher-level apprenticeships, there should be a national standard for them. The problem at the moment in the way apprenticeships can develop is that practically any employer can come forward and any provider and say, “I want to run an apprenticeship” and, provided it meets fairly broad criteria, they will get the go-ahead to do that. Some of our concerns are that the quality will be hugely variable. Some standards have been set so people can provide the training in some of the NHS apprenticeships, but they have been set as something like “adequate”. That is the only standard they have to meet and we would argue that it should certainly be higher than that. So we are doing a lot with the organisations. We work quite closely with Health Education England and the Skills Academy for Health to try and make sure we get consistent standards for those staff across the board.

Dr Watkins: This question raises the very important issue of why we need to maintain some kind of national planning and national pay system. We have a problem in public health at the moment that the National Health Service, Public Health England and about half of local authorities operate one kind of approach to the grading of public health specialists and the other half of local authorities have a different view. That seriously affects the capacity of public health specialists to move

between those two different markets. It also means that those authorities which have chosen to not recognise the professionalism of public health specialists are not getting the best public health specialists, and they may well be the local authorities which need the best public health specialists. I do not want to see that problem duplicated across a whole range of professional groups, as might happen if we had more local pay systems.

It is important that education is properly planned so that the validity of the certificates issued by one employer can be recognised by another employer. Portability is predominantly a question of having effective quality control. I do not mean silly inspection systems, I mean proper quality control of the nature of the education that is offered and then of a willingness by employers to recognise that. Certainly we would support that.

Q170 The Chairman: I have a feeling I know the answer you will give to my last question—but let me try. On the basis that this inquiry is about the long-term sustainability of the NHS, what one suggestion might each of you have that we might adopt as a recommendation that will deliver long-term sustainability of the NHS?

Dr Porter: You are quite right that we have all emphasised again and again the importance of the commitment to proper funding. There are a whole variety of ways of funding health services across the world and many of them work very well. I would not, for example, say that the health service in Germany is not a very good one, and yet it is funded in a completely different way to the one here—and there are other examples everywhere else.

Along with a commitment to proper funding we need a restatement of what the health service offers to the people of this country and what it is for. For me the most important part of that is the comprehensiveness of what it offers, the universality of the offer and the way in which the entire country sees it as something that is offered to people at the time of their greatest need. To me the single thing that this Committee could do to support the long-term sustainability of the NHS is to re-emphasise that its founding principles must not change: that a temporary, I hope, problem with funding of public services does not translate into retrenching away from an idea that was a good one when the NHS was introduced, has remained a good one throughout and will sustain us through into the 21st century. In other words, a service that is free at the point of need, for the people who need it, when they need it.

Dr Watkins: We have gone a long way from it, so we must return to the original concept of the National Health Service as a socially provided mechanism by which the people pursue their health as a social goal supported by their professional advisers. That involves addressing the determinants of health and it involves providing healthcare and social care planned to meet need.

Christina McAnea: Everybody has talked about funding so I am not going to mention it. I think there needs to be a clear recommendation of

the recognition of the link between social care and health and that you cannot have one without the other. Running down social care has a direct impact on the long-term sustainability of the NHS. I would make two points on that. One is that we need, as I mentioned earlier, something like an ethical care charter to ensure that you have a long-term sustainable workforce within the social care sector. For the NHS, given the size of the challenge, the change that is coming and being planned about integration, et cetera, then again we need something like a new charter for staff to give them a feeling that they are in it for the long haul and that they can engage in change without putting at risk their own employment status.

The Chairman: Thank you very much. Thank you for coming today to help us with this evidence. If, following the conversation we have had, you feel there is some other material that would be helpful, please feel free to send it to us. We will get a transcript in due course of today's session. Please correct any mistakes relating to accuracy, but you cannot change the content. Thank you for coming today; we appreciate it.