A Healthy Living: Four Stories From the Future of Care

By John Craig, Chief Executive, Care City

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About the Author

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John Craig has led Care City for four years, helping to grow its work, its team and its partnerships and supporting its transition to become an independent Community Interest Company.

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Preface

Care City is an innovation centre for healthy ageing and regeneration. Our mission is a happier, healthier older age for East Londoners. We pursue this mission by working as an innovation partner to East London's health and care system. We do research, innovation and development work of local benefit and national significance.

The notion of innovation partnership is important to us. Care City does not deliver health or care services – we work in partnership with patients and service users, providers and system leaders to make change happen. This document brings together some stories and themes from across many partnership projects, and it is important to acknowledge these partners.

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- Satalia
- UCL
- UCLPartners
- University of East London
- Many other care and healthcare providers in East London

It is an enormous privilege for Care City to work in partnership with these organisations, and with our many other partners. Nevertheless, any mistakes or errors are Care City's alone.

Kickstarting Care

> **“Even though recruitment in retail and hospitality has collapsed, care jobs are not full.**

Kickstarting Care

'That rules care jobs out then'. I am explaining to my chuckling colleague a government scheme, which we will use to pay some new recruits. The recruits need to be young, and the jobs need to be *new* – not existing vacancies. Across the country, right now there are 112,000 care vacancies, so that would be quite a stretch.

> **Our solution is to focus on something different, of interest to many young people – digital skills.**

Our solution is to focus on something different, of interest to many young people – digital skills. Care homes are rapidly entering the digital age and many young people – the argument goes – are already there. So, that's the plan – Kickstart Digital Champions. It will be like Jamie Oliver's Fifteen. Except that there will be twelve, and they will be spread out across East London's hard-pressed care homes. What could possibly go wrong!?

This is the kind of work we do at Care City. We are a community-interest company, created by the London Borough of Barking & Dagenham and North-East London Foundation Trust hospital. Our mission is a happier, healthier older age for East Londoners.

Making these jobs *digital* solves a second problem. Even though recruitment in retail and hospitality has collapsed, care jobs are not full. Young people – desperate for a job and a chance – often turn down the chance to work in a care home or homecare agency.

We know that some of these young people will catch the bug for care work. The relationships they will build, the fun and hilarity of the good days and the sheer importance of it all will change their lives. But in the information events and interviews, to those who are not sure that the care sector is for them, how sure can we be in second-guessing them. Would we want our own children to work in care? Should we want it for the young people of East London?

This document is about Care City's work, and what we are starting to learn about how to ensure the answer is an emphatic YES. It is about how we can change care to make it better for both care staff and those they care for. It is an argument for:

- Care that really helps people
- Care that is highly skilled
- Care that is a career not just a calling
- Care that is connected to healthcare

Care is More Than Caring About

> **“The feeling is that if care is work at all, it is work like no other, best understood as an extension of our loving relationships with our nearest and dearest.**

Care is More Than Caring About

At a school in East London, Peter, Grace and Violet are deep in discussion about life as a kid. Peter and Grace are talking about toys and gadgets. Violet's story is about freedom and roaming the neighbourhood. There is a roar of chatter in the classroom, but they are wrapt in each other. They all talk about reading and the joy of imagining strange worlds and adventures. Violet is seventy years older than Peter and Grace, but in talking about the differences in their childhoods they are amazed at how much they share.

> **"When Violet talks about her life as a carer, she is telling a love story. Similarly, when you talk to service users about paid care staff, they will time and again say that they are 'angels'.**

These are Violet's favourite moments of the intergenerational project she attends in East London, when the very idea of generations fades and human connection takes over. The project came at the right time for Violet. Violet has known her second husband, George, almost her whole life – they shared their childhood freedom on the streets of Romford.

Three years ago, George began to develop vascular dementia. He can no longer drive or cook and struggles to do many of the things that make life worth living. With Violet's help, he still grows fruit on his allotment and helps in the garden at a nearby Park.

Violet is an adventurous, sociable person. When she allows a thought for herself, she misses parties and the theatre terribly, and feels the isolation of being a carer. The chance to immerse herself in the lives of Peter and Grace for a morning is heaven. (We digress briefly to hear about a tricky love triangle with Matilda). It is immaterial to Violet that their teacher gets an hour for some admin – she gets as much from her morning as the children.

When George and Violet got together thirty years ago, it was a very tough time for Violet, and she called him her 'lifesaver'. Today, she is now more than reciprocating, but no one is counting. They are equally unable to imagine a different life. Whether Violet is talking about Peter and Grace, or about George, who is the carer and who is the cared for fades out of the story. What is left is love.

Many stories about care are like this and they are increasingly taken to be emblematic of care work. The feeling is that if care is work at all, it is work like no other, best understood as an extension of our loving relationships with our nearest and dearest. When Violet talks about her life as a carer, she is telling a love story. Similarly, when you talk to service users about paid care staff, they will time and again say that they are 'angels'. And this story is understandably embraced by the branding of care providers, always bedecked with images of hearts and cuddles.

However, these stories are only half the picture. It is the nature of life and of stories – even of war or pandemic – that people tell you not about the cold detail but about the human warmth. There is more to care work than this. When you dig further into stories like Violet and George's, hidden from view is the enormous hard work the carer is doing. The detail of this work and the help and support we provide for it is hugely important.

Love *does* matter, and it is *good* for your health. One way of understanding this is to look at data for people who are lonely. We do not have a list of lonely people but one approach – admittedly imperfect – is to look at people who live alone, which – it turns out – is strongly correlated with loneliness. In Barking and Dagenham, we can look at this thanks to research by Dr Jenny Shand, who has worked with a host of public servants to connect health, care and other data about people's lives, to understand them better.

"We are often reminded that if exercise was a pharmaceutical, it would be the wonder drug of our age. Love is the same. It feels good *and* it is good for you.

The data shows clearly that people in Barking and Dagenham who live alone – all else being equal – are sicker. They go to their doctor more often and they go to hospital more often. We are often reminded that if exercise was a pharmaceutical, it would be the wonder drug of our age. Love is the same. It feels good *and* it is good for you.

So, what about people who have a registered unpaid carer? What about people like George, who have the love and support of Violet? It feels like – all else being equal – they should go to their doctor less, right?

Wrong. It's not the case that carers reduce pressure on the NHS in quite this way. Again, Shand's research is instructive. Over time, loneliness undermines people's health. But at any given time, having a carer is critical to our getting help, healthcare included. In George's case, he would not get to the park without Violet's help. In the same way, it was Violet who first spotted the symptoms of George's dementia, made medical appointments, and pushed the doctors on the link to George's earlier heart problems. She continues to press the Memory Clinic for more help and support.

Unpaid care is enormously valuable, but we should be careful about this. According to Madeleine Bunting, 'in 2015 a team valued just the unpaid work of carers for the sick and elderly at £132 billion a year. Carers were saving the public purse £2.5 billion a week, or £362 million a day, or £15.1 million an hour'. Unpaid care is very valuable, but it is a mistake to see it as a straight-forward substitute for the NHS. It is our friends who cajole us to see the doctor, and often it is our friends who give us a lift to the appointment, and advocate on our behalf if we do not get the help we need. In Violet's case, sometimes she is a substitute for work the state would otherwise have to do and sometimes she is collaborating with health and care services, helping them to do more and to do better.

Across care – unpaid and badly paid – people do so much for so little, it is hard to make sense of it other than as an act of love, utterly unlike the work of other public servants. However, that is a reductive view of care work. Inside the black box of care, the details matter – what carers know, who they collaborate with and what tools they use makes a huge difference. It affects the health and well-being of those they care for and the sustainability of health and care services.

Our young Kickstarters care, but they want their working lives to be about more than *caring about* people. They want to become skilled, to build expertise and to progress. At the same time, the love-bomb branding of care can make them feel uncomfortable or unworthy. And as we shall see, the declining health of care recipients means that now more than ever, they need care that is more than caring about.

The argument that there is more to care than caring about is basic, but it matters because it contrasts with the dominant policy narrative about care. In Hilary Cottam's brilliant book, *Radical Help*, the starting point is that 'people who starve are almost always close to food'. The idea is that you cannot help people by doing things *for* them.

For troubled young people or those experiencing unemployment or homelessness, a supportive relationship can be transformative. Cottam writes, 'above all, relationships… we can remove a couple of life's building blocks and still stand tall, but if we withdraw the relationships that underpin us we topple over'. This is a great insight for most people most of the time.

> **A caring relationship is enormously important, and it is what they most want, but it is not enough**

However, ageing and disability do not work in quite this way. When recipients of care 'topple over' the cause can be very trivial – a lack of podiatry, a tiny trip hazard, the right pill taken at the wrong time of day – but it can trigger their move into residential care. For these people, a caring relationship is enormously important, and it is what they most want, but it is not enough. They need care backed by the right training, tools and support to retain their remaining health and independence.

Violet is unmoved by this analysis. Her retort is hard to answer; 'if carers are so good at accessing health and care support, why is there so little for George?'. Where we can agree is that there is more to being a carer than meets the eye, and that her love for George does not mean it is not hard work. The details of care matter – without her knowledge of dementia, of how George's medications interact and the tools and tricks Violet uses each day to get through, life for her and George would be even tougher. We need to understand both the ethic of care and the mechanics of care.

The Best Care is Highly Skilled

> **Care staff are skilled, but they could be massively more skilled, if only we gave them the chance. To make this happen, we need to rethink health innovation, and to put care staff at its heart.**

The Best Care is Highly Skilled

Tracy Sullivan likes to keep moving. She is a senior care worker in Havering, and works long shifts, five days a week. For many years she worked in a care home, but she is happier now in homecare, moving around, discovering new places.

Movement has always been part of Tracy's life, having grown up on a traveller site in Huntingdon. Single, and with her four children themselves grown up, Tracy is again more nomadic. She has moved house eight times in three years, and she knows that she won't stop still for long. For Tracy, the freedom to move is worth the associated moments of loneliness or invisibility.

Despite moving often, Tracy always finds work. She has the right skills and stories, and a folder of purring references. Where she is now, at a franchise of Kare Plus in Havering, Tracy is a key lieutenant. She is in charge of client assessments and reviews, she trains staff and she supports *her girls* to manage medications.

There is a nomadic invisibility to Tracy's professional life too, despite all her expertise. After twenty-five years working in care, Tracy has done a lot of training, but she has not a single care qualification. Tracy is well used to the lack of recognition care staff receive, but that does not stop it being a waste.

Brexit and our immigration rules have prompted a public debate about whether care staff are 'skilled'. The debate is polarised between those who say that care staff are unskilled and those who say they are highly skilled.

> **"There is a great deal of work to be done to systematically connect care staff to chances to learn – chances a nurse can take for granted.**

As we saw in the previous chapter, portraying care staff as angels obscures as much as it reveals. Equally, drawing an analogy between a care worker and a nurse, say, is an understandable way to defend their rights and their income, but it does not always help them. There is a great deal of work to be done to systematically connect care staff to chances to learn – chances a nurse can take for granted. Care staff are skilled, but they could be massively more skilled, if only we gave them the chance. To make this happen, we need to rethink health innovation, and to put care staff at its heart.

At Care City, we learnt this lesson by making a mistake. We wanted to put clever heart monitors in high street pharmacies, find people with a heart condition called atrial fibrillation and refer them directly to hospital. So, we trained the pharmacists. In fact, we were proud of the training we gave them. Then the pharmacists went back to their shops and gave the gadgets to their counter assistants to use. Counter assistants! We had not thought about counter assistants. The data we got was a mess and my colleague – thankfully a pharmacist – drove around Waltham Forest for days as a mystery shopper, finding these counter assistants and training them one-to-one.

Our pharmacist partners did nothing wrong – in fact, they were brilliant to work with and saved lives. The mistake was Care City's – and it is a common one. When we get new technology in the health and care system, we give it to amazing clinicians or middle class patients. However, a lot of new health tech is cheap, portable and smart – it is designed to be used by anyone. The people whose work is most enhanced by this technology are those who are not already very capable, independent professionals.

Having thought too little of these pharmacy counter assistants, their example now drives our work at Care City. These were generally young people who had gone out to find a job in a shop. They could have been in the newsagent next door. Now, thanks to an innovation, they were part of a team that could prevent a stroke and save a life.

Homecare staff can save lives too. Just like the heart monitor, the kit for taking vital signs is now portable and easy to use. Later, we worked with homecare staff and their managers to develop an enhanced service, about spotting ill-health early, and escalating only the right patients to the right clinician with the right data.

It wasn't easy. When we offered homecare staff the chance of a more complicated work day, some chuckled and shook their heads. Their care jobs were just one of the many things they were juggling in their lives. Some GPs were sceptical too. And when we talked about care staff escalating patients to GPs, one chuckled and said, 'ah, great, a different number to phone and not be listened to!'

However, other homecare staff leapt at the chance. Among them were immigrants who had been nurses in other countries, desperate for a chance to translate their expertise into a career in London. Among them also was Tracy Sullivan. Daunted at first, after ninety-minutes of training, she started to believe that she could do it. And with Tracy's experience, she knew the difference it might make to her service users. Tracy is now a confident Expert Carer, and during COVID-19 – with her clients struggling to access healthcare – was able to spot a client with dangerously high blood pressure, preventing them becoming seriously unwell by alerting their GP.

> **"For the first time, she has had conversations with colleagues like district nurses that felt like 'two professionals discussing a client'.**

While that experience particularly will stay with Tracy, the biggest difference it has made for her is relational. For the first time, she has had conversations with colleagues like district nurses that felt like 'two professionals discussing a client'. That's after twenty-five years of experience, and just ninety-minutes training.

The project proved hugely popular with staff and service users generally. And the data showed that recipients of homecare are little more healthy than those in care homes. The gap between the ill-health homecare staff deal with everyday and what they are trained and supported to do is large and growing. It is causing rising stress and declining productivity and staff retention.

We knew what we were doing was important, but homecare is not a sexy topic for funders and policy-makers. Perhaps the project would be just another pilot, with a great write up, some talks at conferences, but no real impact.

What came next was the COVID-19 pandemic and lockdown. For general practitioners, being unable to see their patients face-to-face has been hugely stressful. They have been in survival mode, doing anything they can to help their patients. In that context, homecare staff have been vitally important partners. The idea that they might be the ones to advise doctors about who needs an appointment has moved from the margins to the mainstream.

For many patients over the last year, care staff are the ones who have literally made medical appointments happen. They have advised GPs about who they need to see, taken observations, and held smartphones up for patients. They held the speaker to their ear to help them hear and – carefully, with dignity and permission – faced the camera to wounds and injuries, helping doctors to see.

In Barking and Dagenham, Havering and Redbridge, that is why the Clinical Commissioning Group – encouraged by Care City – is for the first time investing health money into the homecare system, to expand this work. Homecare staff can be partners to primary care, and everyone can benefit.

However, the enhancement of homecare does not end with spotting ill-health, diagnostics and supporting consultations. Homecare staff can also support recovery from illness. We are also now prototyping Enablement Champions within care, an enhanced role for senior care staff, supporting people to adhere to healthcare plans, enabling them to retain more independence for longer, and again easing pressure on the health system.

> **“To achieve change in health and care, you have to keep pushing day after day.**

At Care City, the word we come back to again and again – think collective eye-roll in the team meeting – is ‘relentlessness’. To achieve change in health and care, you have to keep pushing day after day. The odd thing about this work is that – while technically it has been difficult – it has felt like pushing at an open door. We have been running to keep up with these innovations as much as pushing them.

To understand this, let’s look a bit closer at our mistake with the pharmacists and counter-assistants. The dominant idea about technology is that it is for automating stuff – for making people redundant. One example that has captured the public imagination is the self-driving car. Experts are sceptical that the self-driving car is anywhere close. However, technology journalists have learnt that we cannot get enough of stories about Uber and Tesla that suggest the self-driving car is already with us. Stories about robots taking the jobs of taxi drivers – rather than enhancing everyone’s driving – fit the templates in our heads about the role of technology.

Our assumptions about technology shape the direction of innovation, and this happens in health and care too. Ask people about health innovation and they will tell you about care robots and AI radiography. Soon, on this view – and this should raise some questions about the logic behind it – we will have too many health and care staff not too few.

However, as the work of Nobel economist Joseph Stiglitz has shown, there is a different perspective on technology and innovation, which focuses not on *replacing* people’s work but *enhancing* it. This is what our work in care is about, and this is why it has been able to gather momentum – because it is not just about enhancing services, it is about enhancing the work of the people involved.

Our values shape how we innovate. If we believe in the potential of care staff, and the potential of new technology and workforce innovation to enhance their work, we could make truly life-saving, life-enhancing care the norm. By focusing on how technology can enhance care work and make care staff more valuable – rather than how care robots can replace them – we can transform prospects for care staff and those they care for.

Care Should be a Calling *and* a Career

> **Care's status as a calling is wholly compatible with it being a career through which people learn and progress.**

Care Should Be a Calling *and* a Career

As a boy in India, Ajeesh Thomas wanted to be a teacher. In 2005, he was 23, a qualified accountant, with a lucrative career ahead of him. However, that year he felt deeply that something was missing. He came to London in search of a new life and answered a profound sense of vocation to work in care.

Ajeesh found a job at Ebury Court care home in Rush Green in Havering, where he has worked ever since, committing himself to improving the well-being of its residents. As he has worked with his colleagues to improve the care home, so he has thrown himself into self-improvement. He has earned a Level 3 diploma in palliative care, one at Level 4 in health and social care and a Level 5 Diploma in leadership and management.

Today, Ajeesh has a huge range of responsibilities in the care home, and he has become the teacher that he wanted to be as a boy. He trains, coaches and supports staff across the home. Like all the best teachers, he remains an avid learner, liaising closely with District Nurses, GPs and listening acutely to what they say. He loves to learn about the health of his residents, but over time, that learning has brought frustration. Ajeesh could see how the excellent care they received could be even better.

As for so many care staff, 2020 was a gruelling year for Ajeesh. He lived apart from his own family – even as they coped with sickness – thinking constantly of both of them and of his residents. If his mind was not made up already, COVID-19 made him certain – Ajeesh wanted to be a clinician. However, he is hugely committed to Ebury Court, where he has worked and flourished for so many years. This was the dilemma facing him – choose between your residents and colleagues in the care home and an apprenticeship at the local hospital.

> **“Becoming an Apprentice Nursing Associate – and then a Nursing Associate – is an increasingly important route into nursing.**

Thanks to the work of Care City (and partners including Skills for Care, the local CEPN, UEL, NELFT and NEL HCP), Ajeesh has been able to do both – to become an Apprentice Nursing Associate without leaving Ebury Court. The Nursing Associate role bridges the gap between support workers and Registered Nurses. Like nursing, it is a role regulated by the Nursing and Midwifery Council. Nursing Associates work at the direction of a registered nurse or another registered professional but may not require direct supervision – direction can be via detailed care planning and regular communication. Becoming an Apprentice Nursing Associate – and then a Nursing Associate – is an increasingly important route into nursing. Opening this route up to the hundreds of thousands working in care homes could be incredibly powerful.

Fifty years ago, the main requirements of ambulance staff were first aid skills and a heavy right foot. Ambulance *drivers* are now paramedics and their admittedly vital driving skills now seem incidental to their extraordinary clinical skills. Paramedics are the only clinicians trained to deal with any presenting health problem, and in recent years they have hugely influenced the way medicine is practiced.

Perhaps one day, people will look back at the language of care staff, and see it as equally quaint as 'ambulance driver'. Paramedics drive and care staff care, but it is their health and care skills we really need. Similarly, perhaps we will be able to look back and understand that care's status as a calling is wholly compatible with it being a career, through which people learn and progress.

However, constructing a career ladder for care is not simple, and Ajeesh's Apprentice Nursing Associate role is a helpful microcosm of these challenges.

Reasonably enough, ANAs are apprenticed to a nurse. Residential homes and homecare agencies, therefore, are caught in a Catch-22. They would hugely benefit from a Nursing Associate – as many will tell you – because they do not have a nurse. But they cannot have an Apprentice Nursing Associate *because they do not have a nurse*.

For a social enterprise, these kinds of Catch-22 problems are exciting, because of the value of unlocking them. Our approach is about providing remote supervision from a hospital-based nurse to a cohort of apprentices. Like most complex problems, the solution looks simple in the end:

- The nurse is not the only supervisor. They help the Apprentice build supervisory relationships with other clinicians – the GPs and District Nurses who are also supporting their clients.
- The Apprentice quickly learns to focus on those relationships, so that they do not miss opportunities to observe practice and learn. This in turn takes some of the workload from the manager of their care setting, liaising with health colleagues.
- These health colleagues in turn see the benefit of this continuity and growing expertise, both in their workload and in the outcomes for care recipients, sustaining and growing the model.

"We want to create another ladder for care staff and to bring more health and rehabilitation skills into care homes.

Just as the Nursing Associate role has opened-up opportunities in hospitals for people to progress out of low pay, we hope we can do the same for staff in care homes and homecare agencies. Is that a pipe dream? Some would say it is, but they would have said the same of the ambulance drivers.

To be fair, this is still a work in progress. We are confident about the collaborative arrangements for *apprenticeships* like Ajeesh's. Next we need to show that we can get the funding and supervision right for when he qualifies. We need to make system support for registered Nursing Associates in care homes part of business as usual. When we do, we believe it will save time, money and lives, but until then it is just one more ask of hard-pressed partners, clinicians and system leaders, and we are grateful for the chance to work with them.

We certainly think there is huge potential for these apprenticeships, and we are already prototyping a new one. Just as there should be a pathway from care work to nursing – without having to leave the sector – so there should be to physiotherapy. We are in the early stages of working with care staff, physiotherapists and occupational therapists to build a similar collaboration. We want to create another ladder for care staff and to bring more health and rehabilitation skills into care homes. This is critical for residents being discharged from hospital, including for those hospitalised with COVID or with Long COVID.

If we cannot simply enable these career ladders because people like Ajeesh are inspiring, let's do it because the current system is broken. Demographics and austerity mean that recipients of publicly funded care are older and sicker than ever, demanding greater knowledge and skill. However, because care – the career, service and business model – has not been able to respond, there is a

growing gap between what care staff are trained and supported to do, and what they have to deal with in practice. Dealing with medications, exacerbations of health conditions and profound dementia are now the norm for care staff. This means that care work is not just minimum wage, it is high stress, and this combination drives care workers from their jobs, with an annual staff turnover rate of 31%.

The health system is struggling to recover after its COVID heroics and for people with long term conditions it is estimated to take up around £7 in every £10 of total health and social care expenditure. Health needs partners who can help people to get out of GP practices and hospitals and stay out of them for longer, but care has not been helped to respond.

The final perversity of this system is that not only are care staff not prepared for the levels of ill-health they will encounter, neither can they learn on the job. The driving force for pay rises in care is now the minimum wage, but governments are better at raising the legal minimum than funding care providers to pay it. As a result, pay differentials in care are squeezed ever harder. After a decade of experience, senior care workers can expect an increment of perhaps thirty pence an hour.

As we pitch our Kickstart Digital Champions opportunity to young people across Barking and Dagenham, Havering and Redbridge, the real question we should ask ourselves is, are we doing the right thing? Would we encourage our own son or daughter or friend to work in care? We think we are doing the right thing, because we can tell them – honestly – that care is starting to change.

> **“The idea that care staff might reinvent healthcare might seem crazy too. It might also be something to keep an eye on.**

Perhaps, surprisingly, one of the things that will help young recruits to care to succeed in these ways is that few believe they will. That is not just about the power of proving people wrong, it is about how innovation works.

The best GPs now employ paramedics to perform their home visits, because they are better at it than GPs. Had that been on the cards when the paramedic profession started to strengthen, the medical establishment might have halted its progress. However, ambulance drivers were so far from medical practice, that will hardly have felt credible.

Clayton Christensen called this ‘disruptive innovation’, a term that has received a great deal of criticism recently. But Christensen was not interested in messing things up in quite the way this sounds. He was interested in innovations that disrupt normal market dynamics – innovations to which competitors simply do not respond as economics teaches us they should. When personal computers began as cheap, simple children’s toys, the makers of computers that filled whole rooms were hardly worried. When eBay began, it was an idea so ludicrous, they were all but guaranteed to have no competitors.

The idea that care staff might reinvent healthcare might seem crazy too. It might also be something to keep an eye on.

The Health of the People is the Highest Law

> **“Whatever happens to the funding of care, care itself – the service, the workforce, the infrastructure – needs radical attention. Rather than hoping politicians fix care, local leaders can forge their own paths to change care for the better.**

The Health of the People is the Highest Law

South London's Walworth Road, which runs from Camberwell to Elephant & Castle, is an odd place to look for inspiration about the future of care. But when you are stuck on the 176 – as I was daily for a long time – the Walworth Road is what you look at. Towards Elephant stands Herbert Morrison House, where Herbert himself wrote the 1945 Labour manifesto, shaping public services for generations.

The building that inspired me is a few doors down. Walworth Clinic was built in 1937 by the council as an early integrated health and care centre. The building included a GP, maternity and dentistry services, together with spaces for learning and contemplation and even a solarium. Inscribed above the door are the words 'the health of the people is the highest law'. At least, 'health' is the translation they chose – other translations say welfare or good or salvation. These distinctions mattered less in Cicero's time, just as they mattered little to these 1930s reformers. Their notion of health was inclusive, and everyone had something to contribute.

The relative public largesse of 1937 was rapidly overtaken by the War, and afterwards the creation of the NHS institutionalised a narrower view of health, as distinct from care. This narrower view was not novel, but after the war it became dominant. This narrow view of care can be traced back to the Poor Law a hundred and fifty years earlier. Then, 'care' was a bed and a roof for the poor, while doctors dispensed medicine for communicable disease. However, without the Second World War – or if arguments between politicians and doctors had been resolved differently – health and care in the UK might not now be so easy to distinguish.

> **"The evolution of health and care has seen winners and losers, and care staff have generally lost out.**

Today the distinction between heath and care makes less sense than ever. More and more, doctors grapple with the complexities of people's lives, while care staff care for older, sicker people, with little choice but to engage with their healthcare. What began as two distinct activities are now just two tribes.

These two tribes have not evolved at random. Care staff have been systematically cut off from higher levels of knowledge, power and earnings. The evolution of health and care has seen winners and losers, and care staff have generally lost out.

This document is an argument for a particular view of care:

- Care that really helps people
- Care that is highly skilled
- Care that is a career not just a calling
- Care that is connected to healthcare

That fourth principle can be a lightning rod for anxiety and irritation. Bringing together two tribes by now so different and unequal could easily exacerbate inequality. There are two risks, that health *does to* care and that it *takes from* care. The risk of *does to* is about the medicalisation of care, both who is in charge and how it works. This is important, but doctors do share concerns about medicalisation, and fields like geriatric medicine have worked for decades to rebuild medicine around the needs of frail people.

At the same time, doctors are everyday confronted with the consequences of social failure, and doctors recognise the personal nature of our goals and preferences. Doctors also profoundly want the loss and trauma of COVID-19 to be made to mean something positive and to build new partnerships.

The *takes from risk* is about a brain drain of the best staff into health. However, this already happens. As we saw, without the chance to become a Nursing Associate, Ajeesh might have had to leave Ebury Court to progress. Care City's project is about helping staff to develop health skills *within care*. But even this is a slightly tribal response – if the worst-case scenario is that no sooner do you give a young jobseeker a care job in Barking than they take a plum clinical role in Great Ormond Street, it is hard not to be excited.

> **"At a system level, health has what care needs and care has what health needs.**

In other words, both these worries about the future of care are just too pessimistic. We should not fear medicine based on a stereotype, nor should we fear the consequences of raising the skills and aspirations of care staff. And the more health and care become equal partners, the smaller these risks become.

At a system level, health has what care needs and care has what health needs. Health has money and a great deal of complex work to do, but it cannot quickly get the doctors and nurses it needs. Their staff are overworked, to the point that they cannot retain them. Care is de-skilled and under-funded – it desperately needs better work and better pay and progression. Apart, neither model is sustainable – together they both can be.

In 1998, 35% of public service spending went on the NHS, but by 2018, it was 47%. The 2021 Budget, in which health was 'protected' but care cut further threatens to take this figure past 50%. Right or wrong, this is the reality health and care leaders face. For both, progress relies on them working together to resolve this contradiction. The need for a funding solution for care – now a regular political headline – is real. The need for a workforce strategy – also long-promised – is equally real, and we need it to be radical.

While the money is moving in opposite directions, the groups of people health and care staff look after are gradually converging. The proportion of care users whose needs are complex and expensive is growing, and these people also receive very significant healthcare. The needs of staff *and* service users should drive a rethink of what care staff do and of how health and care staff collaborate.

But how can we do that? In this document, we have described scalable training, tools, services and workforce models that can be part of the answer. However, it is not enough for an innovation to be scalable – the question is, *how* will it be scaled and by whom? Our current work suggests some possibilities:

Platforms

Care work is rapidly moving to digital, smartphone-first platforms, which support everything from billing to care planning. For example, one such platform – Birdie – is now facilitating the spread of our enhanced model of domiciliary care to parts of Nottingham, supporting it through their app. It is enabling new collaborative working between care workers and GPs that benefits care recipients and better connects professionals.

At the same time, the functionality of these platforms is growing quickly. Care City is working with Satalia – a leader in the kind of AI that allocates delivery slots for online supermarkets – to look at the scheduling of care and healthcare at home. Right now, scheduling district nursing or homecare just within one team is literally a full-time job. What if great technology could help these people to collaborate across teams – gave them the logistical support they needed to delegate the right task to the right homecarer with the right skills?

In care today, we take poor systems and logistical support for granted. Our imagination for what care can do is limited by capabilities that other sectors left behind long ago. What if we could take excellent logistics for granted – how might we imagine care then?

> **“What if they saw care as a platform for preventative health? What new pathways might we design to the benefit of the health system, care staff and service users?**

Pathways

As clinicians – pushed by their experiences of COVID-19 – explore the potential of digital technology, they are increasingly redesigning care pathways to make them more accessible outside of clinical settings. As pathways open up, new opportunities are created for care staff to contribute.

One example is provided by a company called Healthy.io, with whom Care City have collaborated. Healthy.io has a solution called Minuteful for Wound, which uses smartphone cameras to help highly-skilled Tissue Viability Nurses to track the characteristics of wounds – size, colour and shape. If that sounds marginal, note that wound care costs the NHS £8.3bn a year, and is vital to the health and independence of many older people. These TVNs are not being deskilled – the app gives them the time to do their job properly, and to make eye-contact with patients rather than pages of notes. If we can use this app in hospital, why not extend it to care staff, so that they can help nurses to monitor wound healing and spot potential issues.

Pathway by pathway, clinical leaders are reimagining pathways in silos. Often, their imagination is limited by a lack of boots on the ground. They would love to be able to reach people in their own homes and communities, but they do not have the resources. What if they saw care as a platform for preventative health? What new pathways might we design to the benefit of the health system, care staff and service users?

Providers

The care market is made up of a large number of small providers but also a smaller number of large providers. Some of these large providers are beginning to engage with work like Care City’s, and to see the potential at scale of enhanced health in care. The ability of these large organisations to draw together the technological and workforce changes required may give them an edge as momentum behind these changes grows. We expect some leading care providers to start to integrate these innovations at speed in the coming years, bringing them to the wider attention of the health and care system and the public.

If this is a process that is to work to everyone's benefit, it is a conversation that will need to be actively managed by politicians and system leaders. While care is largely delivered outside of the public sector, the continuity in what care does, mean this is largely accepted. As relationships between health and care start to change, will this interface be portrayed as a new front of privatisation, making creativity and innovation more difficult? To get ahead of this debate, we may need to create some rules of engagement, to focus innovation on securing and enhancing the public interest.

> **Care City wants to keep helping to drive this change – building prototypes of the future, training staff and helping systems to change.**

These *three Ps* – platforms, pathways and providers – will be vitally important to transform care for the better. Whatever happens to the funding of care, care itself – the service, the workforce, the infrastructure – needs radical attention. Rather than hoping politicians fix care, local leaders can forge their own paths to change care for the better. Care City wants to keep helping to drive this change – building prototypes of the future, training staff and helping systems to change.

If they do, the prize is enormous:

- Care as a platform for preventive health – supporting service users to retain their health, well-being and independence
- Care as a by-word for opportunity – offering entry-level jobs that give staff meaningful paths into nursing, physiotherapy or social work (without the need to leave the sector)

If we take this prize, care can help to remake places for the better. When construction booms, we think only of the benefits. Construction work – largely done by men – is *wealth-creating*. When care booms, we think only of the costs. Care work – largely done by women – is *deficit-creating*. That just is not true, and this hypocrisy has lasted too long. However, when we let care become and remain a low-pay, low-productivity sector, we conspire with this hypocrisy. We need care work and a care economy for healthier lives – for staff and service users alike – and for healthier places.

To do this, we need first to see care work as work. Care as an act of love makes a great metaphor for things writers want to write about – gender economics, bureaucracy and culture. We need a new story about care that works for care staff and those they care for. They need care work that is helpful and skilled, that offers prospects and progression and pay, and works in equal partnership with other public servants to make a difference to people's lives. Let's build it.

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