

Commission on the
Future of **Health** and
Social Care in England

Summary of discussions at stakeholder engagement events

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Introduction

The commission held four stakeholder engagement events attended by a total of 55 people from a range of national and local organisations involved in the planning, delivery and regulation of services. They took place on:

- 29 October The King's Fund (London)
- 30 October The King's Fund (London)
- 4 November The King's Fund (London)
- 12 November Manchester

This paper summarises the discussions from those events.

Initially, these events were designed to gather additional evidence where it was felt there had been gaps in the call for evidence questionnaires (previously sent out to a range of stakeholders). However, after conversations with the project team and the commission representatives, it was decided that the focus of these events should be changed. Although there had been a high level of responses to the questionnaires, these responses had primarily focused on highlighting the problems that existed rather than generating solutions. Consequently, it was decided that these stakeholder events would focus specifically on exploring solutions.

Three broad themes were agreed for the discussions:

- funding
- entitlement
- organisation and delivery.

Using these themes, the following questions were constructed as initial discussion points:

- If the funding of social care were to be more generous, where would the additional finance come from and what changes would need to be made to the NHS to accommodate this?
- If all health and social care services were to be free at the point of need and based on entitlement, what criteria could be used for entitlement and what safety nets would need to be in place for those who did not meet eligibility?
- How could a more integrated approach to health and social care be delivered – eg, within existing structures, as a new national organisation, funded nationally but provided through local providers, etc? What would be the pros and cons of each approach?

Methodology

We used the following methods to gather evidence:

- round table discussion using a world café-style approach
- a facilitator to depict discussions graphically
- plenary discussion.

Questions were sent to participants in advance to allow them time to consider their responses.

Attendance

In addition to commissioners and staff from The King's Fund, the following participants attended each of the events.

Date	Name	Position	Organisation/Title
29 October	Caroline Abrahams	Director	Age UK
	Stephen Burke	Director	United for All Ages
	Martin Green	Chief Executive	ECCA
	Emer Harrington	Corporate Affairs Manager	Bupa
	Oliver Henman	Head of Partnerships	NCVO
	Heléna Herklots	Chief Executive	Carers UK
	Paul Jenkins	Chief Executive	Rethink
	Sally Light	Chief Executive	Motor Neurone Disease Association
	John Middleton	Vice President	Faculty of Public Health
	Sean O'Sullivan	Head of Policy	Royal College of Midwives
	David Pearson	Vice President	ADASS
	Richard Thompson	President	Royal College of Physicians
	Bella Travis	Policy Lead	Mencap
30 October	Ruth Abuzaid	Deputy Head of Care Services	Huntington's Disease Association
	Helena Brice	Policy Officer	Centre for Mental Health
	Helen Carter	Consultant in Public Health	Public Health England
	Jane Collins	Chief Executive	Marie Curie Cancer Care
	Gillian Connor	Acting Chief Executive	Hanover
	Andrew Cozens	Chair	Carers Trust
	Chris Drinkwater	President	NHS Alliance
	Geraldine Green	Senior Policy Officer (Interim)	Alzheimer's Society
	John Hughes	Medical Director	Sue Ryder
	Donal Hynes	Vice-chair	NHS Alliance
	Nick Kirwin	Director	ILC-UK Care Funding Advice Network
	Maria Lagos	Head of Sector Development and Innovation	Skills for Care
	James Lloyd	Director	Strategic Society Centre
	Ed Moses	Deputy Director, Strategic Partnerships	Public Health England
	Ellie Rose	Public Affairs Manager	Macmillan Cancer Support
	Merron Simpson	Special Adviser	NHS Alliance

Date	Name	Position	Organisation/Title
4 November	Joanne Bosanquet	Deputy Director of Nursing	Public Health England
	Simon Chapman	Director of Public & Parliamentary Engagement	The National Council for Palliative Care and Dying Matters
	Angela Coulter	Senior Research Scientist	University of Oxford
	Karl Demain	Deputy Director Strategy and Impact	Royal Voluntary Service
	Anita Donley	Clinical Vice President	Royal College of Physicians
	Stephen Goulder	Director of Corporate Services	SCIE
	Ellen Graham	Policy Manager	Public Health England
	Caroline Hawkings	Senior Public Policy Adviser	Scope
	Rea Mattocks	Lay Adviser	Royal College of Ophthalmologists
	Robert Melnitschuk	Policy and Advocacy Manager	Help the Hospices
	Rachel Noble	Policy Manager	British Dental Association
	Helga Pile	National Officer (social care)	UNISON
	Mark Platt	Policy Adviser	Royal College of Nursing
	Monika Preuss	Head of Strategy Unit	Public Health England
	Eve Richardson	Chief Executive	The National Council for Palliative Care and Dying Matters
	Alan Rosenbach	Special Policy Lead	CQC
Julia Scott	Chief Executive	College of Occupational Therapists	
Zoe Wyrko	Consultant Geriatrician	British Geriatrics Society	
12 November	Tracy Ellery	Deputy Chief Executive/ Director of Finance	Manchester Mental Health and Social Care Trust
	Kayleigh Hartigan	Senior Strategy Manager	NHS England
	Liam Hughes	Chair	Oldham Health and Wellbeing Board
	Mark Leaver	Strategic Lead – Business Change	Manchester City Council
	Michelle Lee	Associate Director	Tameside and Glossop Community Healthcare, Stockport NHS Foundation Trust
	Neil Matthewman	Chief Executive	Community Integrated Care
	Dave Nunns	Chief Executive	Healthwatch Wigan
	John Pantall	Executive Member, Health and Wellbeing	Stockport Borough Council

Key findings

These events stimulated a good level of debate and what appeared to be a genuine desire to explore ways forward. However, there seemed to be a reluctance to be radical in responding to the questions posed. At the initial events (29 and 30 October), participants seemed to be constrained by what they perceived to be politically acceptable solutions and were drawn in to discussing the question rather than giving new and innovative ideas. At the later events we specifically encouraged participants to consider and allow themselves more radical thoughts.

The views expressed during the events were wide and varied. Consequently, drawing common themes has been difficult. Below we summarise the high-level views that were reflected across all four events. In the next section we provide more detail about the responses to each of the three questions.

- There was a widely held view that the issue was broader than just health and social care. Housing was specifically mentioned as an example of where public services needed to be more widely joined up. Understanding the systemic nature of health and social care existing across a range of areas including public health, education, housing, etc, was seen to be crucial.

- Perceived political agendas often prevented participants from being creative with new ideas as it was felt they would not be politically palatable and consequently not worth discussing. A need to find a way of removing political point-scoring and finding political consensus appeared to be a strong driver to finding solutions and moving discussions forward.
- Giving individual patients/service users more power and autonomy to say where, what and how services should be provided was raised as a theme in a number of the events. These discussions also focused on giving individuals more financial responsibility and using this as a basis for building services around patients' needs and wishes.
- A need to engage the wider community at a local level was seen as a way to address local issues from a variety of perspectives (financial, workforce/capacity, empowerment). Giving more autonomy and power to currently established groups such as health and wellbeing boards was seen as one way of doing this.
- A number of conversations focused on commissioning. Considering how services should be commissioned and where commissioning should be located was seen as an area that needed further thought. Locating joint commissioning within a body such as the health and wellbeing boards appeared to be one way of bridging the health and social care divide.
- There was a view that change will not happen simply by attempting to change systems; there needs to be a cultural change.
- There was no appetite to undertake significant structural changes to the system. However, ideas were suggested for changing how money moves through the system:
 - joint commissioning through health and wellbeing boards
 - funding health and social care through a per capita system, which might negate the need for commissioning
 - personal budgets (already implemented in social care but not so common in the health economy), which would drive different priorities from an individual perspective.
- There was felt to be a need to have an outcomes framework that extended across health and social care and was driven nationally but delivered locally.

Summary of responses to questions

The following summary reflects the solutions to the questions posed, bringing together similar views from different groups and events.

Question 1: Funding

If the funding of social care were to be more generous where would the additional finance come from and what changes would need to be made to the NHS to accommodate this?

- Raise finances through taxation
- Better use of existing money
- Re-prioritisation of departmental allocation between health and social care or from other government budgets or top-slice all departments (1 per cent)
- Means test NHS care for long-term care

- Find money within the two systems, by integrating/aligning them better
 - at a local level through health and wellbeing boards
 - shared outcomes
- Charge living costs when in hospital (as have in social care)
- Charging for avoidable illness/injury, eg, smoking-related, sports
- Allow GPs to prescribe social care
- Encourage individuals to save for social care
 - co-payments and insurance as options
 - fully funded NHS with patient-commissioned care
 - auto-enrolment into insurance scheme
 - direct payments
- Tackle unmet need – those who can pay for social care but currently use unpaid carers
 - on basis that this will release money into the economy through more jobs
- Save money through improved housing strategy
 - older people have housing wealth
 - warm, affordable, appropriate housing would reduce health and social care costs
 - specialist housing geared to people with mental health needs
 - collaboration with construction industry and changes to rules around making housing more appropriate for disabled and older people
 - community-based housing prevents isolation and reduces care needs
- Social care needs to be redefined. How to make people independent
 - taking a whole services view, built around the individual
 - single point of contact
 - redefine/create a single ‘wellbeing service’
 - taking in and prioritising prevention
 - pool budgets and make it easier to do so
- Prevention is implicit if savings are to be realised
- Hospital hotels
- Using personalised budgets/direct payments or adaptation of these
 - could use Scottish model
- Re-prioritisation of departmental spending (eg, from defence, Trident) to enlarge the pot for health and social care
- Keep the pot the same but make the link between national insurance payments and spending more explicit to the public, to make future conversations about increasing/decreasing the pot easier
- Finding funds elsewhere
 - rebalancing financial priorities – ‘away from fighting wars’
 - chasing taxes from global corporations
- Charging
 - worried well pay for services that others can’t – enabling you to do more of the preventive work with those that wouldn’t otherwise have accessed it, eg, to prevent falls
 - where services are currently delivered alongside each other and makes no sense/ unclear to tell difference, eg, mental health, community nursing
 - outpatient visits or GP visits (if service and access improved)
 - in-hospital charging – hotel costs, meals, prescription charges

- Shifting money out of acute care to social care, community and preventive
- Could increase national insurance and take it back to what it was originally intended to be (ie, if you put in, you get out), but with the choice to opt out
- Mandatory private insurance scheme
- Reducing waste in current health and social care system to release more money for social care and preventive
 - the tariff (Payment by Results) is seen as a problem
- Encourage greater personal responsibility/manage expectations about what is available
 - encourage planning/saving
 - equity release... but will this work in 30/40 years when current cohort without housing assets get older?
- Truly joined-up funding of health and social care
- Need a long-term trajectory for the Better Care Fund
- Consider the wider determinants of health and social care needs in the round
- A focus on public health, prevention and *healthy* life expectancy

Question 2: Entitlement

If all health and social care services were to be free at the point of need and based on entitlement, what criteria could be used for entitlement and what safety nets would need to be in place for those who did not meet eligibility?

- Ideas around different criteria included:
 - charges for situations when people had some individual responsibility, eg, smoking, drinking, dangerous sports, obesity
 - urgency of need
 - co-payments and introducing payments for some things (meals when in hospital was the most frequently suggested)
 - scoring points or accumulating some spending power through being a ‘good citizen’ that could be later cashed in for health and social care
 - make lower end services free and higher end services paid for
- Increase community cohesion
 - make use of the assets that existed within individuals or the community
 - make much more use of voluntary organisations as brokers between people and services
- The system should support, incentivise and enable people to stay well
- Keeping whatever eligibility criteria was decided low to catch people before their needs became acute
- Widening GP prescribing (or others’ prescribing) to include things like exercise classes, library membership, etc
- Ideas about using other facilities, eg, hotels are often cheaper than hospitals and provide a more customer-focused service
- Tax rebates on leisure club membership

- Wetherspoons and Sainsbury's cafés provide good cheap food as well as somewhere social and warm to sit and be
- There were some redistribution ideas – why don't people in prisons have to sell their homes or make a financial contribution to their keep like others do in order to pay for social care
- There was considerable support for it all coming from the existing national budget
- There was some thinking that the current original principles were OK but that their application and interpretations had changed over the years and perhaps were no longer helpful
- Work being done around dementia-friendly communities was cited as having some potential mileage for other areas
- Contributory principle was discussed which could be in cash or kind
 - insurance-based system but using a time bank type idea
- All those over 85 or under 18 have free services
- All those over 85 forfeit their right to anything other than palliative care
- Call for increased role of voluntary sector, especially as brokers
- A need for a single gateway into all services
- Need a single outcome framework for health and social care
- Need a National Institute for Health and Care Excellence (NICE) equivalent for social care
- A time-share scheme, looking after others' relatives in different parts of the country
- GP practice with a link-worker focused on older people
- Health and wellbeing boards are a possible way forward bringing together professionals from different backgrounds
- A primary care model is good, as it involves no structural change
- A key-worker system (Scotland)
- Use of community navigators
- Care organised around the needs of the person based on their NI contributions
- Everyone has a personal budget of, eg, £500,000
- Social care insurance
- Micro commissioning where groups of people with the same condition are supported to commission care appropriate for their needs
- More needs to be done on upstream prevention
- Integration needs to be wider than just health and social care and needs to include other agencies such as housing

Question 3: Organisation and delivery

How could a more integrated approach to health and social care be delivered – eg, within existing structures, as a new national organisation, funded nationally but provided through local providers, etc? What would be the pros and cons of each approach?

- There was generally a sense that there was lack of clarity about what people are entitled to.
- There needs to be more clarity regarding what people were entitled to from the current systems and who delivers what
- There needs to be a nationally agreed but locally delivered set of entitlements and criteria
- Need to look at how we meet people's needs more holistically across health and social care
- Have a key worker who works across health and social care
- Need to make sure that the right services are in place
- Need to think about integrating commissioning (100 per cent), at a local level. Health and wellbeing boards could be a place for this to start
- Integrate health and social care within the health system overseen by local boards (could be health and wellbeing boards but not based in the local authorities)
- Funding across the system could be calculated on a per capita basis
- Be prescriptive about the outcome but not the means
- Sharing of information
- Do we need to assess people around wellbeing and what part does housing play in this?
- Accommodation costs could be charged for people in long-term care within the NHS (nursing homes)
- Cultural change needs to happen before thinking about structural change. The NHS needs to change. There needs to be a culture where people and organisations are able to make tough decisions
- The NHS needs to recognise that social care is becoming more prominent in the 21st century
- Need to move away from social care being about services and more about how people live their lives
- There needs to be a national outcomes framework with local responses to how this is delivered
- Need to find ways of funding social care in a way that saves money from health