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

Summary of responses
to the call for evidence

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In June 2013 the commission issued a Call for Evidence, which sought the views of interested organisations and individuals on how health and social care in England is organised and funded and whether the systems could better aligned to meet the needs of patients and service users.

The commission received 67 responses from a wide range of stakeholders. The commission read and analysed every response received and is very grateful to all who took the time to contribute their thoughts and expertise. This document is a summary of those responses.

The Call for Evidence set out three broad questions:

1. What are the most significant problems that the current arrangements cause? Does the boundary between health and social care need to be redrawn? If so, where and how? What other ways of defining health and social care needs could be more relevant/useful?

2. Should the entitlements and criteria used to decide who can access health and care be aligned? If so, who should be entitled to what and on what grounds?

3. Should health and social care funding be brought together? If so, at what level (ie, local or national) and in what ways? What is the balance between the individual and the state in funding services?

Overall there was broad agreement with the case put forward in the Call for Evidence that the way in which health and social care is currently funded and organised merits revisiting. Some questions asked in the Call for Evidence were very well covered, others elicited fewer responses.

Some key issues highlighted in the responses:

- the divide in the funding of health and social care is particularly detrimental in end-of-life care

- the impact of the wider environment on health and social care should be considered, for example, the positive role that housing can play in enabling individuals to live healthy and fulfilling lives

- there is an argument that structures already exist to facilitate integration at a local level, specifically through health and wellbeing boards

- there is scope for health and social care services to work together without extensive reorganisation of the system architecture, for example, respondents cited shared information and IT systems that are better integrated and leadership that encourages trust and collaboration across organisations

Question 1

Does the boundary between health and social care need to be redrawn? If so, where and how? What other ways of defining health and social care needs could be more relevant/useful?

Many responses highlighted the difficulties that people have in accessing NHS continuing care, citing a lack of information and inadequate rights of redress. Some argued that the NHS concentrates on acute and primary care and leaves people with complex health needs to bear the financial consequences of a means-tested social care system. Organisations representing carers highlighted the strain that this puts on families and argued that the value of care provided by informal carers is not sufficiently recognised.

Groups representing people with particular needs highlighted issues that affected them, for example people with Down's syndrome living longer and likely to develop dementia in their 50s, or people with a diagnosis of motor neurone disease, who are likely to require social care but for whom such care is always provided in crisis and not anticipatory.

Many argued that health and social care needs should be defined in a way that allows boundaries to be realigned around the individual. There was resistance to any extensive reorganisation of the health and social care system.

What in your experience are the most significant problems that the current arrangements cause?

Responses cited a lack of joined-up working between services, resulting in confusion for patients and for their carers. Some said that money would be better spent on preventive measures rather than on acute and episodic care. Many gave examples of the problems under the current arrangements.

- Care workers in one scheme took a meal up to the flat of a resident who was too ill to come down to the restaurant but refused to take her husband's meal on the same tray (Joseph Rowntree Trust).

- John lives in a group home with three younger men; when he reached 65 he was retired from the day centre (presumably because he transferred from learning disability to older persons' team); the minibus collects the other men in the morning to take them to the centre and support workers say 'he gets very angry and upset and we don't know how to explain it to him in a way that will make sense' (Joseph Rowntree Trust).

- Huntingdon's is neuropsychiatric, but the vast majority of services don't recognise it as psychiatric so patients and their families are 'in chaos with a huge gap in treatment and support' (Huntingdon Disease Association).

- 'The most common consequence of a lack of integration we see is people who are terminally ill receiving an inappropriate admission to hospital, finding themselves trapped there without any route back in to care in the community, and usually dying there, often with no clinical need to be in hospital' (Marie Curie).

We have outlined some of the issues we think there are. Do you think there are any further issues or problems with the current arrangements that we should give more, or less, attention to in our work?

Some respondents made the point that the system of Payment by Results for hospital care is a barrier to integration of services, rewarding acute providers for episodic care and not incentivising care provided by different organisations across the NHS and social care outside hospitals.

One respondent pointed out that some interfaces are a litmus test for effective integrated care, including parental mental health and child welfare, dementia, dying at home and transitions for young people with mental health problems. These are where we might find best practice.

How far do you think the need for fundamental change is recognised by: professions and organisations within the NHS and care system; people who use health and care services, including carers; the wider general public?

Many argued that professionals in frontline services may understand the concept of integration and be in favour of it, but the public lacks an understanding of how the system works.

Some emphasised that they felt that organisations and individuals are already trying to work together on the ground. The Department of Health has already created an aligned Joint Outcomes Framework spanning adult social care, NHS and public health, and local areas are trying to tackle obstacles created by the fragmentation between different organisations by the development of single organisations (eg, primary care, social care, children's services, community health services and acute services). In other areas, organisations are improving joint decision-making across health and social care, by, for example, setting up one commissioning team with a unitary board. One respondent cited the higher than expected number of bids to become health and social care integration pioneers as evidence that organisations recognise the need for integration.

Question 2

Should the entitlements and criteria used to decide who can access health and care be aligned? If so, who should be entitled to what and on what grounds? Is it possible to balance national consistency with different local needs?

Does the boundary between health and social care need to be redrawn to ensure that people can receive good-quality well-co-ordinated treatment, care and support that meets their needs in a timely, safe and dignified way?

There was a strong emphasis on end-of-life care in the responses to this question. Some argued that the split between the funding of health and social care at the end of life should be removed and cited the Care and Support White Paper (2012), which said 'we think there is much merit in providing free health and social care in a fully integrated service at the end of life' and end-of-life services were suggested as the best place to look for examples of integration.

More broadly, many responses identified aligning entitlements to health and social care as a particularly difficult issue, with concerns that alignment could entail an erosion of free NHS care. One said that the costs of moving to social care being provided free as well as NHS services would be way beyond the current public purse while a move to means-tested social care and NHS services would not have political or public backing feeling. Another argued that the introduction of a common statutory framework governing access to NHS and social care could result in an overall erosion of the rights of people who need care and support.

A minority argued that it would be both more efficient and more equitable for both health and social care to be free at the point of use.

One response suggested that the core entitlement for most aspects of current NHS provision should remain universally accessible, free at the point of delivery and based solely on need and that those same principles should be applied to those elements of social care that have been identified as having an evidence-based effect on health. There would need to be a sliding scale of contribution, based on the individual's resources and their level of need. Another idea was joint assessment to determine access to health and social care, but success here would depend on the calibre of assessments and willingness by commissioners to fund necessary requirements.

There were worries about unintended consequences if entitlement to care was determined locally, in particular that it could result in internal migrations of sub-sections of the population from one area to another.

What are the barriers to achieving better co-ordinated and integrated care? Why have they not been overcome in the past? What would be needed to surmount them?

Responses to this question focused on two areas: IT solutions that would allow different organisations to share information, and communication and trust between professionals working in different areas.

Some felt that social care providers have not been part of the drive towards adoption of electronic care and data exchange and that there could be incentives for local authority-funded providers to invest in electronic care documentation. Public demand may currently be stifled by an underdeveloped market and low awareness of health and social care technologies that can assist people's daily living.

Many responses cited the importance of effective cross-boundary working by professionals. Key factors cited were: agreed objectives, clear roles and responsibilities, good communication, a culture of trust and respect and supportive leadership.

Is there a better way of defining health and care needs? Could this be done without changing current funding arrangements? If not, what kind of changes would be needed?

One suggestion was to focus on meeting 'care' needs rather than 'health care' or 'social care' needs, to improve integration and lead to a more holistic approach for those people with the most complex and enduring care needs. This could potentially remove the stigma associated with receiving 'help from social services'.

Some responses mentioned community assets as an underdeveloped resource that could be developed to build communities' own solutions to their health and care needs, and could potentially be routed to support others.

Question 3

Should health and social care funding be brought together? If so, at what level (ie, local or national) and in what ways? What is the balance between the individual and the state in funding services?

If so, how could this be done and should it be at local or national level, or a mixture of both?

Some respondents felt that separate funding streams create misaligned incentives within the system, for example, in delayed transfer of care where the current tariff system does not incentivise care outside of hospital. NHS and social care funding should therefore be fully integrated with the criteria for state funding of different conditions decided at a national level. Funding would then filter down to a local level for distribution.

Others argued that it is important to consider how best to meet the range of health and care needs of a local population. This means enabling local autonomy over how health and social care funding is aligned and brought together to meet care needs of the whole person.

One response suggested that one-off interventions (such as elective surgery) should be funded by the NHS, but ongoing care jointly funded, which would make pooled budgets workable at a local level, where the population is 300,000–500,000.

However, integration of health and social care funding may not in itself make a profound difference – with respondents pointing to Northern Ireland, where barriers to integrated care are still in place despite integrated budgets. One respondent argued that redrawing the boundaries of health and social care would not necessarily deliver well-co-ordinated treatment and that standards such as meeting the needs of patients in a 'timely, safe and dignified way' should apply regardless of structural or administrative factors.

What is the right balance between the individual and the state in paying for services? Could this be made more consistent between the NHS and social care?

A body representing insurers recommended that the government should review the case for creating an easy-to-understand interaction between state welfare and private insurance, and some respondents proposed incentives to help people prepare for the costs of care in later life, such as tax-free savings explicitly earmarked for that purpose.

What values and principles do you think should be used to guide our thinking about how health and care should be funded?

Some respondents argued that the values that support pooling financial risk in health should also be applied to social care. Another respondent said that the dichotomy between the state and individual is a false one when it comes to funding services as all services will be paid for by individuals or through taxation – the key issue is to define the level at which risk should be pooled.

Many emphasised that funding should be adequate to ensure that everyone is able to live with dignity and that no one should be denied care on the basis of their financial means. Several respondents argued that care should centre on the individual and not departmental dividing lines and that therefore funding should follow the individual.

Key principles cited were that investment should be made upstream as prevention and early intervention were crucial in maintaining the health of a population. Integration should inform all future policy and guidance, and high standards should be set for quality and innovation.

Would a more integrated approach to health and social care funding require a completely different system? To what extent could improvements be made through adjustments to the current arrangements?

Many respondents argued that adequate change could be made through the current system. There were worries that a new system may just create different boundaries and would cause different difficulties. There was some optimism that health and wellbeing boards will be able to fulfil the role of overall planning of care in local areas and that they could potentially be further developed to cover all health and care services including acute services.

The implications of full integration of health and social care for the workforce would be profound; funding for education and training of the health and social care workforces are currently deeply asymmetrical. Pay for the social care workforce would need to be raised; some roles would be duplicated and would disappear.

Question 4
Are there other views or evidence that you think we should consider?

Many respondents, not only those with a direct interest in housing, argued that housing should be considered as part of the health and social care landscape. Integration should go beyond health and social care, and that an individual's wellbeing is just as dependent on having access to adequate housing or a benefit payment as it is on access to health and social care services. At the end of life, housing that is inaccessible or unsuitable, or a lack of financial support can force a person in to hospital.

Some made the point that early intervention and prevention extends beyond housing and into welfare advice, economic development, public health, cultural services, social care, all of which can prevent or delay more expensive responses delivered through a means-tested social care system or from the NHS. These areas provide scope for local authorities to contribute to the health of their populations.

Some respondents emphasised the importance of considering the needs of working-age disabled people and those with long-term health conditions, inclusion of which would complement the issues of an ageing population with its associated health needs.

Finally, others emphasised that there is a crisis in social care funding that will not be resolved through integration alone; money committed from the NHS since the comprehensive spending review in 2010 has not necessarily achieved greater working.

List of respondents

Age UK

Allied Health Professionals Association

Alzheimer's Society

Anne Cooper

Association of British Insurers

Aston Research Centre for Health Ageing

British and Irish Orthoptic Society

British Dental Association

BUPA UK

Care and Repair, England

Care Quality Commission

Carers Trust

Carers UK

Chartered Institute of Housing

Chartered Society of Physiotherapy

Chief Nursing Officer BME advisory group

College of Occupational Therapy

Di Galpin

East Sussex County Council

Gateshead Council

Healthcare Financial Management Association

Healthwatch Wandsworth

Help the Hospices

Herts Valley CCG

Housing Learning and Improvement Network

Huntingdon's Disease Association

John Lish

Professor Jon Glasby, University of Birmingham

Joseph Rowntree Foundation

Marie Curie Cancer Care

Mary Smith

MIND

Motor Neurone Disease Association

NHS Alliance

Office for Public Management

Outlook Care

Parkinson's UK

Partnership Assurance Group

Public Health England

Ray Williams

Recruitment and Employment Confederation

Dr Ros Altmann

Routine Health Outcomes Ltd

Royal College of Anaesthetists

Royal College of Midwives

Royal College of Nursing

Royal College of Opthamologists Lay Advisory Group

Royal College of Paediatrics and Children's Health

Royal College of Physicians

Royal Voluntary Service

Scope

Sheffield City Council and NHS Sheffield CCG

Skills for Care

Social Care Institute for Excellence

Society of Local Authority Chief Executives and Senior Managers (SOLACE)

Staffordshire County Council

Sue Ryder

The Association of Directors of Adult Social Services in conjunction with the Local Government Association

The College of Social Work

The Debenham Project

The National Council for Palliative Care

The Relatives and Residents Association

The Voluntary Organisations Disability Group

Turning Point

Unite the Union

United for all Ages

Wandsworth Healthwatch