

The background of the entire page is a dense field of fiber optic lights. Numerous thin, dark lines of fiber optic cables extend from the bottom towards the top, each ending in a small, bright, yellowish-gold light point. The overall effect is a shimmering, starry pattern against a dark background.

RSA

supported by

 accenture

**Reimagining the
future of health
and social care**

**How to learn the lessons
from the Covid-19 crisis
for a next generation
health and care system**

*by Hannah Webster
and Ruth Hannan*

July 2020

About the RSA

The RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) believes in a world where everyone is able to participate in creating a better future. Through our ideas, research and a 30,000 strong Fellowship we are a global community of proactive problem solvers, sharing powerful ideas, carrying out cutting edge research and building networks and opportunities for people to collaborate, influence and demonstrate practical solutions to realise change.

About Accenture

Accenture is a leading global professional services company, providing a broad range of services in strategy and consulting, interactive, technology and operations, with digital capabilities across all of these services. We combine unmatched experience and specialized capabilities across more than 40 industries — powered by the world’s largest network of Advanced Technology and Intelligent Operations centers. With 513,000 people serving clients in more than 120 countries, Accenture brings continuous innovation to help clients improve their performance and create lasting value across their enterprises. Visit us at www.accenture.com.

About Accenture Insight Driven Health

Insight Driven Health is the foundation of more effective, efficient and affordable health care. That’s why the world’s leading healthcare providers and health plans choose Accenture for a wide range of insight driven health services that help them use knowledge in new ways—from the back office to the doctor’s office. Our committed professionals combine real-world experience, business and clinical insights and innovative technologies to deliver the power of insight driven health. For more information, visit: www.accenture.com/gb-en/industries/health-index.

Acknowledgements

The RSA would like to extend thanks to our sponsors for this work, Accenture.

Our thanks are also extended to those who took time to engage with this work through interviews, workshops and feedback, with particular thanks to those involved in our advisory panel.

Thanks to colleagues across the RSA who contributed at various stages to this work; Charlotte Sumners, Ella Firebrace, Alex Lucas, James Morrison, Ian Burbidge, Sophie Freeman, Jake Jooshandeh, Amanda Ibbett, Ash Singleton, Will Grimond, Joseph Barnsley and Benny Souto. Thanks to Anthony Painter and Matthew Taylor for their contribution to drafting this report.

Author’s note

This report is supported by Accenture. The arguments and recommendations made in this report are the views of the RSA, not necessarily those of our supporting partners.

Contents

Executive summary	4
Chapter 1: The big challenges	8
Chapter 2: The required response	11
Chapter 3: Ten lessons from the Covid-19 crisis	18
Chapter 4: Scenarios for the future	22
Chapter 5: Achieving change at scale	26
Chapter 6: Conclusions and recommendations	28

Executive summary

Box 1: Overview

The past few months, amid pandemic, have in effect been a real-time experiment of the capacity of the health and care system to meet our needs over the coming years.

This short stimulus report outlines the fruits of work carried out in the lead up to the Covid-19 crisis alongside an 'in-the-moment' sense of what we have learned about the UK's health and social care system through the Covid-19 crisis, and how this might translate to profound change within the system. Based on consultations with those in the sector, we explore three feasible scenarios for change: system stasis, pandemic NHS, and care horizon. The purpose of these scenarios is to inform the possible direction and necessary pace of change for the health and social care system going forward.

We suggest how we can take the best elements from these very different scenarios to support ongoing thinking within government, the NHS (not least through the current NHS Long Term Plan), and beyond to move towards the health and social care system that we need: one that combines resilience, responsiveness, connected care and equity and which lays the foundations for innovation at scale.

We recommend both immediate actions to build on the successes in responding to the pandemic and a national process of deliberative engagement with embedded consent amongst professionals, people with lived experience and the public more widely as a foundation for a new health and care settlement for England.*

* This report primarily focuses on the health and social care system in England as powers within the system are devolved to Scotland, Northern Ireland and Wales. However, some of the research will be applicable across the whole of the UK.

The RSA, supported by Accenture, has over the previous months been working to review long-term trends impacting our health and care system as the Covid-19 crisis hit. Inevitably as the scale of the crisis became clear our focus shifted to the here and now experience of the pandemic.

Across the health and social care system, the case has long been made for significant reform to cope with a myriad of challenges. Whilst the Covid-19 crisis has strained the system to its very limits, it also presents a learning experience, a chance to do things differently as we emerge from crisis, enter a period of stabilisation and prepare the system for future shocks.

Throughout the pandemic, the NHS has received intense focus not least in the emblematic government slogan, 'Stay at home, protect the NHS, save lives'. One of the big lessons of the Covid-19 crisis has been that the 'system' is so much wider than the NHS alone, central though it self-evidently is to health and care. The system also includes the public health and the social care system, provided and delivered by local

authorities, the economic system that surrounds health and care such as providers of care homes of different types, and equipment such as PPE, and even includes the third sector, patients and the public themselves, as our choices from healthy living to volunteering to support those accessing care and support impacts the ability of the system to achieve its ends. Therefore, when we are considering ‘the system’ we are taking a wide perspective to include all the critical institutions and stakeholders who influence our health and wellbeing.

It is increasingly clear that this system exhibits the three conditions for change that the RSA has observed are necessary for latent possibilities to become manifest:

- Latent potential: an underlying desire and logic for things to be different that predates the pandemic.
- Precipitating factors: events that create momentum for change, not least the surge response we have seen with health, care and the community at large.
- The possibility of creating concrete ways of embedding change in social structures if we act collectively with purpose.¹

The crisis has brought the public closer to health and social care systems than they might ever have been before, not least through public health initiatives. A deliberative exercise would seize this opportunity to do things differently and inform how to embed change.

Long-term trends and challenges - such as the need to combine support for the individual’s health and support for their everyday needs, increasing demands and consequent cost, the impact of an ageing society with a range of long-term physical and mental health conditions - create a critical demand for change long acknowledged in every part of the health and social care system. The response to the Covid-19 crisis has accelerated the implementation of some of the workable mechanisms that may be adopted to overcome existing challenges – the rapid absorption of technology in new at-distance care and diagnosis being just one element.

Government, practitioners, wider stakeholders including innovators and providers of different types and, crucially, the public all have their role to play in seeing that a new system emerges during this window of opportunity. Covid-19 has highlighted an acute need for considered reform; we can convert need into action.

The critical questions are: what have we learned about our health and social care systems through the pandemic? On what principles could a health and social care system be ready to respond to the challenges of the next decade? Finally, how, harnessing the energy for change that was

1. Taylor, M. (2020) The conditions for change are ready, but are we?. The RSA [online] 25 March 2020. Available at: www.thersa.org/discover/publications-and-articles/matthew-taylor-blog/2020/03/change-opportunity-covid19 [Accessed on: 1 July 2020]

already present in the system pre-Covid-19 and accelerated change since it began, can we develop a system imbued with these principles?

Through conversations with key stakeholders, the RSA has identified key trends that present innovation opportunities to both enable and disable the system if deployed in different ways: changing ways of working, applying new technological innovation equitably and at scale, and reframing our relationships and responsibilities centred around support for communities and promotion of health, care and wellbeing have started to emerge.

Taking into account pre-existing challenges, new opportunities to adapt to trends and the lessons to be learnt from the crisis, the RSA has developed three potential future scenarios: **pandemic NHS**, **system stasis** and **the care horizon** to explore potential futures where these trends and lessons are dialled up and dialled down in different ways. These are not designed to be exhaustive of all possible futures, instead they aim to articulate the breadth of possible ‘ideal type’ pathways to inform future thinking.

In this regard, the existing NHS Long Term Plan is an important step towards a more resilient, responsive and equitable health and social care system. However, to be fully connected and to learn lessons from this period of crisis, we recommend a People’s Health and Social Care Commission, which will seek to inform large scale systems change in this area led by citizen engagement and participation. Underpinning such a commission will be the values a new system must seek to embed: resilience, responsiveness, connectedness, care and equity. As a country, we came together to fight Covid-19 and this plan should engage widely so that we can collectively own the future of our health and care as we face long-term challenges over the next decade.

Box 2: Summary of recommendations

The Department of Health and Social Care should conduct a People's Health and Care Commission consisting of three core components:

- Public, stakeholder and expert reflection on what Covid-19 taught us about the health and social care system; how it operates and how its governed. This would be an attempt to understand the health and social care system as a whole, its strengths and its shortcomings. This phase would not impinge upon any public inquiry should that be established.
- A citizens' assembly, which should be convened on what is important to us, what we are prepared to contribute, what the values and principles of our health and social care should be and what the experience of interacting with this system should look and feel like.
- Expert led policy intervention and system redesign, with options for exploration by the citizens' assembly prior to the reforms being enacted in a new Health and Care Act.

Recommendations for applying new technological innovations equitably and at scale

- Central government should review digital service adoption during the Covid-19 crisis, with the aim to improve accessibility and a move towards increased digital take up.
- The NHS should invest in digital architecture such as cloud-based technology to support data sharing and communication capacity for itself and its partners. It should, in tandem, review its internal digital and data capabilities urgently.
- Enhanced connectivity between the NHS and care homes should be approached mutually to enable patients, families and care homes to be active partners in the discharge planning process and empowering them to make informed decisions to leave hospital in a timely manner.

Recommendations for reframing our relationships and responsibilities around support for, and promotion of, health, care and wellbeing

- Central government should provide increased funding for health and social care delivery, administered at the local level to meet context specific needs.
- Local authorities should consider supporting the following activities with additional funding (as recommended above), where possible in further partnership with central government and NHS England:
 - Investment in skills development for local health and social care workers to improve digital capacity.
 - Explore new ways of working and management such as self-managing teams.
- Local authorities and Clinical Commissioning Groups (CCGs) should consider the use of outcomes based or participatory budgeting approaches in distributing new funding, with the aim of improving citizen engagement and collaboration across the health and social care sector.
- An analysis of local systems and assets should be carried out in light of local responses to the Covid-19 crisis.

Recommendations for changing ways of working

- The Department of Health and Social Care should conduct a large-scale systems analysis to understand citizen touch points with the health and social care system. Informed by this analysis, shared system level objectives should be identified across health and social care delivery.
- Central government should review procurement rules and contracting requirements for health and social care to enable innovative practice to develop.
- Government should invest in a central capacity to allow individuals the right to ask health and social care organisations to share their records with relevant care providers, care workers and community service providers.
- The NHS and its partners should utilise predictive modelling where actions taken in one system has a direct knock-on effect on another, **potentially separately governed, system.**
- Local authorities should consider the creation of permissive legal spaces for experimentation and innovation as we emerge from the Covid-19 crisis to allow practitioners to explore new ways of working based on learnings from the pandemic.

The big challenges

The health and social care system in England has been working to meet the wellbeing needs of the nation for over 70 years. Yet its approach to change has been cumulative rather than radical. Adapting incrementally has enabled the system to ‘muddle through’ but, given long-term trends and challenges on the horizon, patching and muddling through may no longer be enough. Resources are just one dimension of the challenge, the system itself will need to significantly reform to effectively meet the needs of today and the future.

Figure 1: Healthcare system map



Even before the Covid-19 crisis there were elements of the system that needed radical change. It is important that as we look to the future of health and social care we do not lose sight of these aspects of the system. The RSA's framework for understanding crisis-response measures highlights how we might consider the long-term as well as crisis specific practice that may contribute to a new future.² Within this, a critical component is what we let go, old practices that are no longer fit for purpose.

Figure 2: Understanding crisis-response measures



To move towards a health and social care system of the future, ongoing challenges within the system will need to be directly addressed. A range of tensions arose in workshops conducted to inform this research. Stakeholders identified challenges preventing the delivery of their vision of health and social care. Leaders from across different roles, departments and organisations within the system described similar experiences, with challenges centred around:

The system

The lack of a cohesive system was something that stakeholders identified as a significant challenge; its outdated and hierarchical design, its complexity and fragmentation, a focus on time and task and its use of a market approach to commissioning that used performance indicators that were not always connected to wellbeing.

Public perceptions

Related to the disconnect between health and social care is the public perception of each part of the system. Many have limited comprehension of social care if they are not directly engaged with it. As highlighted in the RSA's report Radical Home Care there is deep societal misunderstanding of what adult social care is (and does); this lack of understanding can be influenced by the media's portrayal of social care and the wider framing of a system in crisis.³

2. Burbidge, I (2020) How to create real, lasting change after Covid-19. The RSA, [online] 29 April 2020. Available at: www.thersa.org/discover/publications-and-articles/rsa-blogs/2020/04/change-covid19-response [Accessed on: 1 July 2020]

3. Hannan, R (2019) Radical Home Care. [online] London: The RSA. Available at: www.thersa.org/globalassets/reports/2019/rsa-radical-home-care.pdf [Accessed on: 1 July 2020]

Population health

Population changes - including an aging population, more single person households, working age adults with disabilities and people without children – continually reframe priorities. These combine with the inequalities across the population's access to health and health outcomes. A decade ago, the Marmot Review reinforced the significant impact health inequalities have on not only our life expectancy but also on our wellbeing.⁴ At the very least, things have not improved. Indeed, the conclusion of a ten-year review of the report showed experience is unequal across different groups within society and has stopped improving.⁵ The social determinants of health had, it argued, worsened.

Commissioning processes

Specific attention was paid to commissioning and how this is often based on short-term incentives and outcomes that are not connected to the social value of a service and can often be designed for narrow short-term efficiency gains. There was a feeling that commissioning focuses too heavily on activity and not enough on relationships; whether this is between commissioners and providers or those who may be providing a service directly to the public. This is within a context of tight budgets and limited capacity.

Climate change

Despite the devastating impact of Covid-19, climate change remains the major threat to human health and wellbeing. Climate change in and of itself will have a devastating impact on people's health, for example through deaths associated with summer heat waves and the mental health impacts of economic displacement resulting from climate change.⁶ Addressing these challenges and how the UK's health and social care system can contribute to carbon neutrality must be taken into consideration. The NHS is the most significant public sector contributor to climate change, with 59 percent of emissions linked to procured goods.⁷ The issue of climate change and how health and social care addresses it was an ever-present issue with stakeholders.

4. Institute of Health Equity (2010) Fair Society, Healthy Lives: The Marmot Review. [online] London: Institute for Health Equity. Available at: www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf [Accessed on: 1 July 2020]

5. Institute of Health Equity (2020) The Marmot Review: 10 years on. [online] London: Institute for Health Equity. Available at: www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf [Accessed on: 1 July 2020]

6. World Health Organisation (2003) Climate Change and Human Health - Risks and Responses. [online] Geneva: World Health Organisation. Available at: www.who.int/globalchange/environment/en/ccSCREEN.pdf?ua=1 [Accessed on: 1 July 2020]

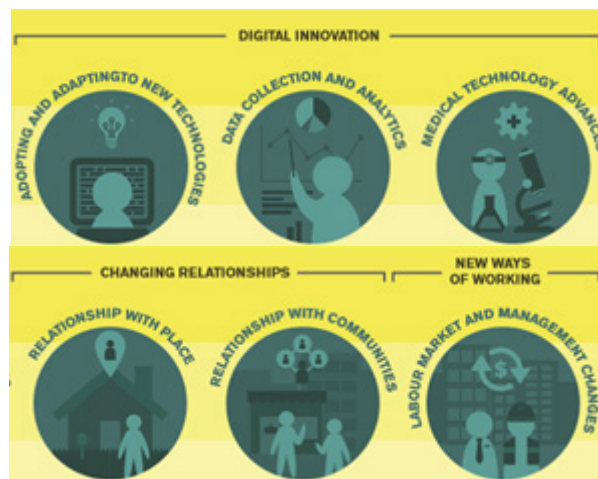
7. The King's Fund (2013) Time to Think Differently. [online] London: The King's Fund. Available at: www.kingsfund.org.uk/blog/2012/11/it%E2%80%99s-time-think-differently [Accessed on: 1 July 2020]

The required response

From workshops with health and social care leaders, practitioners and researchers, three core opportunity areas on the horizon for the system emerged:

- Applying new technological innovations equitably and at scale.
- Reframing our relationships and responsibilities centred around support for and promotion of health, care and wellbeing.
- Changing ways of working.

Figure 3: Opportunity areas for health and social care



The challenges identified in our conversations with stakeholders prior to the crisis are still valid now; if anything, they have been accelerated and amplified during the crisis. In combination with new levels of funding, these three areas of opportunity could reform the whole life cycle of service provision. We explore further below.

Applying new technological innovations equitably and at scale

Practitioners and stakeholders across our workshops identified three aspects of technology posing long-term opportunities for the health and social care setting; firstly the repurposing of existing technology (often to improve communications), secondly technology designed specifically for the health and social care setting (including medical advances) and, thirdly, data collection and analytics to predict individual health problems but also population health and care needs.

These technologies and data innovations offer a new way of imagining the future of our health and social care system; one where delivery of services happens on virtual as well as place-based lines, where the workforce are enabled to work more efficiently and where health and social care is increasingly personalised. Across each of these areas, innovations are beginning to emerge in the health and social care context. This rapid scaling of innovation needs to be tested and learning taken on board to see how these can be taken forward.

Repurposing of existing technologies

Using technologies that are routinely available to the public can transform access to health and social care services, move the NHS from a sickness service and social care that responds to crisis, to one that proactively supports the management of good health, and enable flexible and efficient working for professionals who are excluded by traditional working patterns.

- Digitisation has enabled patients to be seen remotely or in the locations that is convenient to them.
- Smart technology (phones to homes) for personal management of care could offer an entirely new way of managing early intervention for health and social care provision.⁸ This set up could support those accessing care to live independently by providing automated cues or escalation to contact a key professional (like their GP or care worker) or the emergency services.
- Existing communication apps, such as WhatsApp and Teams (which was recently rolled out across the NHS) in a health and social care context allow citizens to communicate with service providers in a way that they are used to and that is immediate. They allow staff across health and social care to work more flexibly and efficiently.⁹
- Use of platform models of social care provision with a cloud-based personal records are being used successfully by innovative social care providers like North West Care Cooperative and Wellbeing Teams (see case study in *New Ways of Working*)^{10, 11}
- The expansion of the Operational Pressures Escalation Levels (OPEL) framework (a system more popularly used in hospitals), provides daily reporting on PPE levels, staffing, infection rates and outbreaks to care homes, and GP practices in Greater Manchester which allows early warning of system instability and swift action to be taken.¹²

8. For example PatientMPower developed a smart watch enabled app to monitor oxygen saturation and provide early warning of possible Covid-19 cases. More information at info.patientmpower.com/covid-remote-monitoring

9. NHS Digital (2020) Almost half a million MS Teams messages a day sent in the NHS during COVID-19 lockdown. [online]. Available at: digital.nhs.uk/news-and-events/news/almost-half-a-million-ms-teams-messages-a-day-sent-in-the-nhs-during-lockdown. [Accessed on: 1 July 2020]

10. More information can be found at: nwcarecoop.co.uk/

11. More information can be found at: wellbeingteams.org/

12. Greater Manchester Combined Authority (2020) New tech platform supporting Greater Manchester response to COVID-19. [online]. Available at: www.greatermanchester-ca.gov.uk/news/new-tech-platform-supporting-greater-manchester-response-to-covid-19/. [Accessed on: 1 July 2020]

Technology designed for the health and social care sector

A rapid advance of digital technologies within health and social care is transforming what is possible. To have a world class health and social care system that is affordable, our services should embrace these technologies and incorporate them into a new way of working, ensuring equitable access.

- Genome sequencing offers a huge potential for personalised and preventative care. An early and scientific understanding of risk – alongside external factors – could allow for the creation of risk registers and personalised information and care.
- 3D printing could see the mass production of human tissue and organs according to population needs and the removal of a reliance on donation.¹³
- E-prescribing has the potential to reduce the time taken to access prescriptions, both for those administering prescriptions and those receiving them. By removing the need for face-to-face contact – when feasible – a much more efficient process can be achieved.

Data collection and analytics

The management and development of health and social care systems are still held back by poor access to data, whether you are a manager, a clinician or a researcher. What has become even more evident during Covid-19 is that lives can be saved when information flows freely.

- Clinical data gathered at the point of care is a critical component in tackling disease – such as Covid-19 – and developing treatment and vaccines. Many tools exist to enable this now, such as GISAID and Nextstrain which combine to gather and analyse data.¹⁴
- Genomic data offers the potential to be brought more closely together with routine health care data and to enable targeted treatments and sophisticated research. Successes such as the tracking of Salmonella outbreaks by Public Health England (PHE) could, if scaled to other needs, help to promote preventative intervention in crises.

Box 3: Healios case study

Healios: provider of secondary mental health support through an online platform,* working in a place-based way through implementation manager to create a bridge between local NHS service and Healios. They have created efficient data-sharing agreements with the NHS to enable smooth and efficient service delivery to patients.

* More information can be found at: www.healios.org.uk

13. Lee, A., Hudson, A., Shiwardski, D., Tashman, J., Hinton, T., Yerneni, S., Bliley, J., Campbell, P. and Feinberg, A. (2019) 3D bioprinting of collagen to rebuild components of the human heart. [online] Pittsburg: Science Magazine. Available at: [science.sciencemag.org/content/365/6452/482.abstract](https://www.sciencemag.org/content/365/6452/482.abstract) [Accessed on: 1 July 2020]

14. More information can be found at: www.gisaid.org and nextstrain.org.
Reimagining the future of health and social care

- Integrated care records available to all parts of the health and social care system which are currently rare and present significant challenges to citizens navigating the system and practitioners; Greater Manchester has developed the GM Care Record.¹⁵

The rapid deployment of technology during the Covid-19 crisis, that previously had been deferred, has been significant. An obvious example is the move to video or phone consultations, which stakeholders stated had freed up time to engage in preventative work with patients with long-term conditions. Prior to the pandemic there were 1.2 million face-to-face consultations every day in primary care alone.¹⁶

However, without necessary digital infrastructure across health, care and partners it will not be possible to embed new innovation in an equitable and universal way.

Box 4: Policy consideration: technology for all

Access for citizens is essential to ensuring that geographical inequalities or access based on literacy, accessibility or connectivity are not exacerbated. Without addressing current – and potential developing – inequalities, new technologies pose new risks. For example, remote technologies adopted during the Covid-19 crisis to allow patients to safely access consultations, will not have been accessible for all equally. Those who are not able to access technology or are not literate in navigating digital services risk being excluded from this new approach. This might happen across geographical, income, literacy or other lines.

Alongside any IT strategy within health and social care, we need a digital access strategy that puts technology in easily accessible places - libraries, opticians and pharmacies - and supports citizens with the skills they need to participate in digital health and social care.

Reframing our relationships and responsibilities centred around support for and promotion of health, care and wellbeing

Place based health and social care can connect up existing local infrastructure to find greater connections in support of citizens and public health. Successful models build on the strengths of a community and its residents, working with stakeholders from various sectors to enable all residents to thrive.

This would include more collaboration – private/public/voluntary, health/social care, etc. High street pharmacies and retailers have increasingly pulled together with the NHS and social care to provide easy access to services in the crisis and provide support to the most vulnerable.¹⁷

15. More information can be found at: healthinnovationmanchester.com/TheGMCareRecord/

16. Heitmuller, A (2020) The Future NHS is Out There. [online] London: The RSA. Available at: medium.com/bridges-to-the-future/the-future-nhs-is-out-there-ab89f91ffdf [Accessed on: 1 July 2020]

17. NHS (2020) NHS high street check-ups top 300,000. [online]. Available at: www.england.nhs.uk/2020/06/nhs-high-street-check-ups-top-300000/. [Accessed on: 1 July 2020]

Some examples include:

- A move to outcomes-based commissioning with services embedded in the community, connected to local organisations. The approach moves away from a model of commissioning of outputs (sometimes called ‘time and task’), for example number of visits or meals being prepared for home care, to one of outcomes; what does the client hope to achieve and what needs to happen to achieve this, although there are challenges with this model – who defines the outcomes and how success is measured. Monmouthshire’s model of social care provision is a strong example of this.¹⁸
- Ottawa’s 15-minute neighbourhood model,¹⁹ which was gaining traction prior to the pandemic, centres services within a perimeter that can be walked within the titular 15 minutes. People, place and health are seen as core components of leading a good life in this model.
- Personal budgets, including personal health budgets, were cited as examples that can contribute to the inclusive growth of local communities and a stronger way health and social care can be embedded to local infrastructure. Individuals are given a fixed amount to spend on their wider wellbeing and preventative health care. Individuals are afforded more autonomy about how and what they spend the budgets on, it focuses on wider wellbeing as opposed to basic activity such as dressing and washing.
- Healthcare Improvement Scotland are hosting citizen juries to explore how the public are able to have more oversight and inform their health care systems.²⁰
- Several models of community-based care are being developed to enable empowerment and greater control of health and care by those accessing support. Examples include a number of platform-based care cooperatives and micro-providers.
- Asset-based health and care looks to start from a position of strength within local communities – what individuals and communities can do. Thurrock is an area that is moving to a whole system approach.²¹

18. More information can be found at: www.monmouthshire.gov.uk/social-care/

19. “A 15-minute neighborhood is a neighborhood in which you can access all of your most basic, day-to-day needs within a 15-minute walk of your home. It is also sometimes called a complete neighborhood.” Daniel Herriges (2019) 7 Rules for Creating “15 minute neighbourhoods”. [online]. Available at: www.strongtowns.org/journal/2019/9/6/7-rules-for-creating-15-minute-neighborhoods. [Accessed on: 1 July 2020]

20. Healthcare Improvement Scotland (2020) Our Voice Citizens’ Jury. [online]. Available at: www.hisengage.scot/informing-policy/citizens-jury/. [Accessed on: 1 July 2020]

21. Billingham, L. (2017) Teach a man to fish...Sustainable whole system transformation in Thurrock. Social Care Institute for Excellence, [online] Available at: www.scie.org.uk/news/opinions/transformation-in-thurrock. [Accessed on: 1 July 2020]

Box 5: Greater Manchester community hub case study

Greater Manchester has created community hubs across the 10 boroughs of Greater Manchester to help respond to the Covid-19 crisis.*¹ The hubs enable close working between local authorities, community organisations and volunteers to enable residents to access help and support through the crisis. The hubs have enabled a different way of working and responding to community needs that some of the 10 boroughs are now looking to continue post-lockdown.

* More information can be found at: www.greatermanchester-ca.gov.uk/coronavirus/support-for-residents-and-vulnerable-people/

Stakeholders felt that the need to develop place-based support and better community involvement and ownership was critical to the future of health and social care. The Covid-19 crisis accelerated this need in an entirely new context. The crisis response saw citizens, volunteers, charities and service providers come together to find new ways of supporting local needs in a socially distant environment.

It could be argued that part of the challenge in utilising the NHS volunteer army was the centralised model of recruitment and deployment. By contrast, locally embedded activities, such as those led by Mutual Aid groups, were more quickly able to get off the ground. These often actively involved coordination of local responses, including between community organisations and local authorities.

Changing ways of working

New ways of working and organising staff emerged as a strong mechanism for reform in our conversations with stakeholders. This ranged from the development of self-managing teams in social care, to health professionals being given more autonomy of practice with a reduction in bureaucracy.

Discussion on the need for a new model of health and (in particular) social care is not new, but the vast majority of existing provision is yet to embed new and innovative ways of working. Investment in supporting existing staff is essential in creating change that lasts and will be a critical component of embedding any new practice.

Some of these emerging new ways of working include:

- Self-managing teams: operating on the fringes of social care but offering a more autonomous way of working. By allowing groups of care workers to self-organise, greater efficiencies can be found – which are often place specific - leaving more time spent for care provision.
- Care Cooperatives: owned by those providing the care, meaning that their wellbeing and ability to deliver care is at the heart of how the cooperative is organised and managed.
- The Cares Family: aiming to tackle social isolation through a model of connecting older and younger neighbours, the model

- of mutual benefit shifts the model of social care to one of parity.
- Here: a health practice in Brighton that feels strongly about being able to bring ‘wholeness’ at work, they work in a ‘mindful’ way and support staff to give and receive feedback and have difficult conversations.²² Here have a specific ‘Enabling Team’ to create the right conditions for their service provision.

Box 6: Wellbeing Teams case study

An organisation built on principles of self-management working in home care sector.* During the pandemic staff were rapidly able to adapt if staff or clients became ill, and used a range of technology to stay connected with one another and families - this included the use of Slack software to manage key information provision to staff as guidance changed on a regular basis. Wellbeing Teams worked with Community Circles to provide tablets to clients to enable them to remain connected with family over Skype.† Due to the autonomous nature of the team they were able to adapt support provision when regular service options were closed due to lockdown.

* More information can be found at: wellbeingteams.org/

† More information can be found at: www.community-circles.co.uk

The challenges identified with traditional ways of working (which many feel have developed through the use of new public management) are the hierarchical structure, with a focus on targets and reporting, which can be seen to have contributed to the reduction in staff autonomy and the challenge of providing relational-based care. The challenges of this model were laid bare by the crisis.

Interestingly, the NHS demonstrated incredible agility with staff rapidly being redeployed (dental nurses supporting intensive care teams for example) and decision-making being entrusted to staff so the capacity to change is there even if not universally evident in non-emergency times.

In social care, organisations who were already demonstrating innovative ways of working have adapted to the crisis rapidly, including managing PPE supplies.

However, concerns of social care moving in the wrong direction were flagged across our conversations with stakeholders, with some noting a pattern of increasingly flexible work and low pay (especially in social care). With a renewed focus on key workers, these barriers to ‘good work’ in the social care sector in particular could finally face intense public and policy-maker focus.

22. More information can be found at: hereweare.org.uk/about-us/our-story/


Ten lessons from the Covid-19 crisis

Whilst many of the precise changes in policy and practice emerging from the Covid-19 response may no longer be relevant when the crisis subsides, there are lessons to be learnt from how the health and social care system was able to respond. In some ways, the system has shown how adaptive it can be to change, but questions on how sustainable these changes are and how they become embedded for the long-term remain.

We spoke to health and social care professionals and stakeholders two months into the pandemic to understand what lessons emerged from the crisis. Reflecting on these lessons will allow our health and social care system to move towards a more resilient, responsive, connected care and equity model.

In building on the short-term innovations in response to the Covid-19 crisis – where our systems innovated at pace and scale, services moved online and communities rallied to support vulnerable and isolated citizens - critical lessons must be learnt about how the system efficiently and effectively operates.

Figure 4: Ten lessons from the Covid-19 crisis

	Lessons for the future of health and social care	Where we have seen this during the Covid-19 crisis
	<p>1. Health and social care systems need to be more connected.</p> <p>Rather than run on their own track, health and social care systems need to be viewed as intrinsically connected elements of the same system.</p>	<p>The quick response to free up hospital beds moved vulnerable patients from hospitals to care homes. According to a survey by ADASS (the Association of Directors of Adult Social Services), a quarter of directors of adult social care thought that the majority of care home Covid-19 infections were attributable to this rapid hospital discharge.²³ A review by the National Audit Office has revealed that it is not possible to know how many of those discharged were tested for Covid-19.²⁴</p>

23. Home Care Insight (2020) Rapid discharge to care homes during COVID-19 crisis had tragic consequences, says ADASS. [online]. Available at: www.homecareinsight.co.uk/rapid-discharge-to-care-homes-during-covid-19-crisis-had-tragic-consequences-says-adass/. [Accessed on: 15 June 2020]

24. National Audit Office (2020) Readying the NHS and adult social care in England for COVID-19. [online]. Available at: www.nao.org.uk/press-release/readying-the-nhs-and-adult-social-care-in-england-for-covid-19/. [Accessed on: 12 June 2020]

Lessons for the future of health and social care

Where we have seen this during the Covid-19 crisis



2. We need to put social care on an equal footing with health care.

Improving connectedness within the system will only be successful if both halves are considered equal in policy making, and in public opinion.

By the beginning of June 2020, almost one third of Covid-19 deaths had occurred in care homes.²⁵ This figure is the result of an institutional imbalance between care provision and the NHS and a number of compounding factors; the care sector struggled to access – and afford – essential PPE, was given far less central support and attention than its healthcare counterpart and qualified for extensive testing far later.²⁶



3. Central leadership and governance needs to be agile and adaptive.

Responding with agility and pace is essential in such a fast-moving environment. Being prepared with solutions can support a government to do this, allowing them to scale existing preparations rather than create them anew.

The health and care supply chain was inadequately stocked, and reliant on over-stretched global networks to rapidly adapt to the increased demand on PPE.



4. Clear messaging helps public health.

The public responded at scale to the beginning of the lockdown, and largely understood their responsibilities during the early stages of the pandemic. But, as **messaging altered** and instead the public were required to 'stay alert', the public mood began to shift against the lockdown measures. This exemplifies the importance of clear, specific and timely communication on public health points.

The contradictory messages on when people were able to break lockdown contributed to confusion in the public.



5. Professionals can work more efficiently when given greater autonomy.

Across the health and social care sector, bureaucratic barriers to efficient working have been lifted as organisations and departments prioritise how their time is spent. Stakeholders we spoke to felt that when trusted to do so, professionals had worked effectively and were able to dedicate more time to service delivery.²⁷

We have seen an enormous response from the scientific community, able to operate flexibly and adaptively from rapid research into the virus itself, vaccines and treatments, epidemiological models, testing, whole systems mapping of distribution of medical technologies.

25. Booth, R. and Duncan, P. (2020) More than 16,000 people in UK care homes have died from coronavirus. The Guardian, [online] 16 June 2020 Available at: www.theguardian.com/world/2020/jun/16/more-than-16000-people-in-uk-care-homes-have-died-from-coronavirus

26. National Care Forum (2020) COVID-19 testing chaos set to continue for social care. [online]. Available at: www.nationalcareforum.org.uk/ncf-press-releases/covid-testing-chaos-set-to-continue-for-social-care/. [Accessed on: 1 July 2020]

27. Department for Health and Social Care (2020) Guidance: Care Act easements: guidance for local authorities. [online]. Available at: www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities. [Accessed on: 1 July 2020]

Lessons for the future of health and social care

Where we have seen this during the Covid-19 crisis



6. Health inequalities will widen if not actively addressed.

Societal inequalities across income, race, gender and housing have played out in the risk of infection and risk of fatalities at the hands of Covid-19. As we emerge from the current crisis it is essential that overcoming these inequalities is a central aspect of the recovery.

Public Health England's report into the impact of Covid-19 on BAME groups states that 'emerging evidence suggests that excess mortality due to Covid-19 is higher in BAME populations' and that this 'can be exacerbated by the housing challenges faced by some members of BAME groups', as well as the increased likelihood of working 'in occupations with a higher Covid-19 exposure' and of 'using public transportation to travel to their essential work'.²⁸



7. Digital access and literacy is a public health issue.

The need for rapid adoption of new technologies as lockdown began encouraged health and social care providers to find new ways of communicating within their organisation, with partners, and with service users. But the rapid adoption meant that there are still unanswered questions around how to ensure everyone is able to access services equally.

The potentially exclusionary need for smartphone technology to access any contact tracing or symptom reporting app.²⁹



8. The system needs additional resource to be flexible.

The NHS has been able to manage the number of Covid-19 cases in hospitals and the response of professionals has been extraordinary, but this has been at the expense of a large proportion of other activities. Creating a system with room for increasing capacity in times of crisis will be essential in ensuring that the system prevents a backlog of appointments of those with conditions outside the main targeted response. This will require protocol for how to collaborate with external partners (charities, community organisations, the public) as well as internal.

The cancellation or postponement of appointments and procedures deemed to not be a priority. The NHS Confederation estimate that hospital waiting lists could be as high as 10 million by the end of 2020.³⁰ This poses a huge risk that people do not get the care that they need. A similar challenge is emerging in social care where the Coronavirus Act 2020 saw a temporary roll back in the Care Act 2014. Eight councils have used this easement meaning some are no longer receiving care they are usually entitled to.³¹

28. Public Health England (2020) Beyond the data: Understanding the impact of COVID-19 on BAME groups. [online] London: Public Health England. Available at: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID-stakeholder_engagement_synthesis_beyond_the_data.pdf [Accessed on: 1 July 2020]

29. House of Commons (2020) Oral evidence: The impact of Covid-19 on DCMS sectors: Digital inclusion, HC 291. [online]. Available at: committees.parliament.uk/oralevidence/387/html/#Panel1. [Accessed on: 1 July 2020]

30. Sky News (2020) Coronavirus: 'Most realistic' scenario says 10m will be on NHS waiting list by Christmas. Sky News, [online] 16 June 2020 Available at: news.sky.com/story/coronavirus-nhs-waiting-list-could-more-than-double-to-10-million-by-christmas-warn-health-chiefs-12003860

31. Samuel, M. (2020) Eight councils have triggered Care Act duty moratorium in month since emergency law came into force. Community Care, [online] 16 June 2020 Available at: www.communitycare.co.uk/2020/04/30/eight-councils-triggered-care-act-duty-moratorium-month-since-emergency-law-came-force/

Lessons for the future of health and social care

Where we have seen this during the Covid-19 crisis



9. Local and community assets should be explicitly part of the system.

The global nature of the Covid-19 crisis exposed the risks to a system reliant on pressurised supply chains. Instead, local production and manufacturing capacity provides a more agile supply chain.

Communities overcoming supply chain challenges with local provision of PPE. In Greater Manchester, central procurement was devised to ensure that PPE could quickly reach social care providers that need it.³²



10. Effectively deploying new technology and data insights supports efficient responses.

The NHS sits on a wealth of data but as Axel Heitmüller writes for the RSA, it is information poor.³³ Data is often designed for reporting metrics, and it rarely can be shared between departments or organisations due to infrastructure limitations. But to effectively manage an overhaul of health and social care, as we have seen in the pandemic, data utilisation and sharing is key.

Some of the most effective responses to the Covid-19 crisis have come from countries able to effectively utilise a range of sources of citizen data to identify and mitigate risk. In Taiwan, where there have been less than 500 cases and less than 10 Covid-19 fatalities (as of June 2020), datasets from their National Health Insurance Administration, National Immigration Agency and Customs Administration were collated.³⁴ Artificial Intelligence was run on this data to identify those at risk due to medical or travel history.

32. Financial Times (2020) Covid-19 has revolutionised the NHS. Financial Times, [online] 16 June 2020 Available at: www.ft.com/content/59f2aff6-857d-11ea-b6e9-a94cfd1d9bf


33. Heitmüller, A (2020) The Future NHS is Out There. [online] London: The RSA. Available at: medium.com/bridges-to-the-future/the-future-nhs-is-out-there-ab89f91ffdff [Accessed on: 1 July 2020]

34. Shapiro, D. (2020) Taiwan shows its mettle in coronavirus crisis, while the WHO is MIA. Brookings Institute, [online] 19 March 2020 Available at: www.brookings.edu/blog/order-from-chaos/2020/03/19/taiwan-shows-its-mettle-in-coronavirus-crisis-while-the-who-is-mia/

Scenarios for the future

How well health and social care systems are able to become resilient, responsive, connected and equitable will be the outcome of a number of as yet unknown decisions and actions from players at a national, local and individual organisational level. On this journey there is a large degree of uncertainty, and there is no single path of virtue.

Scenario mapping offers an exploration into what a future might look like as a series of ‘ideal types’ or ‘imaginaries’ and avoids the pitfalls of making a singular prediction. Instead, the breadth of possible outcomes – good or bad – can be brought to life. In this section we unpack hypothetical narratives for how we might emerge from the Covid-19 crisis into a ‘new normal’, imagining a new world for health and social care, and playing out how individual experiences might change.



Pandemic NHS

After its initial debate in September 2020, parliament agrees to extend the emergency Coronavirus Act 2020 to 2025 without need for debate again until 2022. Renamed the Pandemic Prevention Act, the Act extends powers to prioritise the NHS response to pandemics, which sees implicit limits to other treatments and services.

The Act is supported by significant investment in acute hospitals, with specially designed ‘fever hospitals’, based on the original Nightingale hospitals. These are mostly dormant but provide latent capacity to support rapid response to potential future crises – including, but not limited to, pandemics. Much of the distanced healthcare provision developed in response to the Covid-19 crisis of 2020 is maintained and built upon; GPs prescribe health apps and smart watches to enable patients to better manage their own health better, and primary care to manage patients remotely.

Social care is redesigned to support transitions from hospital and those who have high acute needs; with Care Act easement now widely used across local authorities. Care workers see their roles shift in purpose, with a roll out of crisis training informing the new normal within their roles. All services previously commissioned by local authorities are now the sole responsibility of Clinical Commissioning Groups with need and design directly controlled by NHS England. Services that directly prevent or reduce the impact of the pandemic are prioritised.

A need to build infrastructure that can rapidly deploy equipment, PPE and medicines to any part of the country as needed is recognised. This extends to digital infrastructure. An innovative AI model based on Amazon’s stock and supply system is developed, with a significant workforce of former retail staff overseeing the system as self-managing teams in key hubs across the country. These new ways of working are facilitated by investment in online collaboration and communication tools to support remote and distanced working within and between agencies.

NHS England develops a rapid response service that can be deployed to parts of the country deemed infection hot spots; the service has extensive powers to take over existing public health, local authority and NHS infrastructure with powers to alter service design and quarantine houses, streets and even cities to prevent the wider NHS system and economy being decimated as a result of the pandemic.

To underpin the new service all citizens are required to use a track and trace app, without its use the NHS is unable to anticipate recurrences of Covid-19 and an array of other targeted health conditions and infections as decided by the Secretary of State for Health; this along with new smart technology enable the system to predict population health needs more accurately.

Opportunities

- By prioritising responsiveness, the system would be more ready for any future crises and may be able to adapt to needs other than pandemics (such as population change, public health needs, environmental changes).
- Building latent capacity into the system would ensure that needs are met in crises.
- Improved system and health tracking could offer routes to preventative and early intervention healthcare by creating mechanisms to alert health and care professionals about a range of events.
- Creating a culture of preparedness could also mean improving communication points and efficiencies between different areas of the system.

Risks

- Health inequalities would be set to widen if the provision of health and social care is stripped back; those who can access private health care have a greater likelihood of treatment for deprioritised needs and conditions.
- Digital first approaches to pandemic prevention could exacerbate digital inequalities.
- Reduced capacity to deal with general health and social care need would impact the ability of citizens to lead healthy lives.
- Those with existing long-term conditions could become increasingly disconnected from their communities with those with dementia being particularly affected, if ongoing direct, personal needs are not also prioritised.



System stasis

In a bid to process the backlog of deprioritised appointments as quickly as possible, the NHS bounces back into old processes that are familiar and have the necessary protocol set up. There is a fear that if too much were to change, further delays will be made to cancelled cancer treatments, mental health provision and other appointments that have been put on hold over the crisis.

Aware that things can not continue exactly as they were, a new NHS Crisis Recovery Fund is established to support CCGs and Hospital Trusts to build up their capacity to return to fuller provision. Many chose to establish funds for crisis preparations and innovative preventative approaches. But without national consistency and coordination, many learn the hard way about technologies that fail to live up to expectations.

In doing so, a moment for systemic change is missed, but public opinion still lands favourably on the financial settlement. Budget put aside for increasing the pay for those working within the NHS is a critical factor in maintaining public support.

Other public services fare less well. Austerity becomes the default position for a government navigating their second recession in as many decades. Community and local services feel the brunt. Social care providers in particular receive a poor settlement in comparison to their health care counterparts and aside from a one-off payment of thanks, social care workers fail to see much increased value in their work – financial or otherwise.


For those accessing healthcare, their experience may have only incrementally changed. Online consultations are more frequent after the crisis, at least for those comfortable with the digital experience, often resulting in exclusion of those citizens already experiencing health inequalities.

Opportunities

- An essential injection of additional funding to a system which is – particularly after the current crisis – in need would ensure that everyone who needs care could receive it.
- Increased budgets could be an opportunity to increase the pay for health and social care workers, meeting demands that the public may make on the value of this work.
- A less disruptive approach may be preferred by the public after a number of months, or more, of disruption.

Risks

- A superficial financial response to the crisis risks perpetuating the myriad of existing problems within the system. The system could remain unprepared for crisis.
- Public perceptions of the provision of health and social care – and the policymakers behind it – may not withstand another decade of austerity in other public services.
- Without structural mechanisms for sharing evaluations, learnings and co-commissioning new practice – including how funding is distributed locally – could remain at the fringes.



A care horizon

The Covid-19 crisis sparks a national debate on the importance of social care, how it should be funded, its purpose and how it should operate. The government commits to supporting health and social care services as equals in the coming years in its New Health and Care Deal launched a year after the effective end of the first lockdown, 4 July 2021.

The new approach places significant emphasis on population health, with health and social care working in tandem, wellbeing underpinning all service design. Health and care professionals, as well as other specialised support (pharmacies, private wellbeing services etc) now work together in community hubs, staff work closely with the community to develop an understanding of their population as well as utilising the extensive health data available through all citizens' use of track and trace technology, smart watches and health apps.

The system from the perspective of the citizen works through a series of well-designed synchronous local partnerships with the NHS and the more community-focused social care and public health system still retaining their identity. Citizens are given greater voice in the care they receive overall with renewed energy and support given to quality services offered to those holding personal budgets.

Professionals work closely with those who may be living with a disability, old age-related condition or health condition and their families to develop a plan with goals that are always based on them living their best life. Social care staff – now called Wellbeing Workers – are recognised as key professionals and paid accordingly. They work closely with the same clients to build a strong relationship and no longer provide basic tasks. Data sharing between health and social care is facilitated by joint agreements, to ensure in particular that vulnerable citizens receive necessary care.

Public health teams work closely with colleagues in the NHS to provide additional support to vulnerable communities, post-pandemic, to help them recover. Though acute hospitals have shrunk significantly with areas and equipment mothballed, they are maintained only in readiness for virus outbreaks. This is not without local political controversy.

Additionally, online support has supplemented in-person services, enabling some freeing up for those with the most acute need or who those are unable to use online services. Professionals have more time to offer targeted services to specific communities working closely with population health colleagues to enable a wellbeing prevention model of care.

Opportunities

- New models of professional development could emerge at the intersection of health and social care, as well as opportunities for shared learning and development.
- Improved experience of care and support across the system as health and care professionals would have greater freedom to support whole person wellbeing.
- Community mobilisation and deployment would provide opportunities for care within a familiar and supportive context.

Risks

- This would rely heavily on professionals being able to move from a hierarchical, bureaucratic, task focused model.
- This would require significant upfront funding to enable the system to adjust to the new model and to address population health needs.
- Significant adjustment to the current training given to many health and care professionals would be essential.
- There would be a potential risk of size of workforce required to meet population need initially.

Achieving change at scale

In moving to a period of stabilisation, taking on board lessons from the Covid-19 crisis will be essential in creating a health and social care system fit for the future. Four core principles for a future system emerge from the opportunities for change explored throughout this report:

- **Resilience:** having the right capacity in the right place to respond to volatile demands and needs across the system.
- **Responsiveness:** where the system is sufficiently flexible and agile to respond to individual needs for health and social care services and support.
- **Connected care:** where all providers and stakeholders are able to coordinate to ensure the best outcomes at individual and community levels.
- **Equity:** where unequal health and care outcomes between different socio-economic, demographic, and health condition groups are eliminated over time.

To achieve this, agility, flexibility and adaptability will be key success factors. In particular, trends which were already on the horizon for health and social care provide new opportunities to move towards such a system and to improve the provision of care. As the scenarios articulate, dialling up and down engagement with these can lead to substantially different outcomes for the future. This might include:

- Investing in long-term adoption of new technologies – accessible by all – to improve efficiency and citizen experience.
- Matching the needs and assets such as community groups, health and social care providers and public health of local communities for whole place wellbeing as has been adopted by the Guy's and Thomas' Charity's urban health programme.³⁵
- Greater autonomy for health and social care staff, with more time for service delivery and greater value for social care workers in particular.

Critical to the ability to have impactful change within the health and social care system is the ability for new practices and ways of working to scale alongside new technologies and connected methods of delivery.

³⁵. Guy's and St Thomas' Charity (2020) Urban Health. [online]. Available at: [gsttcharity.org.uk/content/urban-health](https://www.gsttcharity.org.uk/content/urban-health). [Accessed on: 1 July 2020]

Seeking change by only invoking the big levers of institutions – policy, economic, legal, and so forth – will only get us so far, crucial those these will be. Trust needs to be built through an understanding of who is best placed to work with opportunities posed by these trends and to mitigate their risks.

The system has shown extraordinary capacity to adapt throughout the Covid-19 crisis. But there have been deficiencies in capacity, resilience, coordination, and there has to be concern over the sustainability of intensive levels of activity. This is particularly true given the knock-on impact the crisis response has had on other serious health conditions, compounded by the individual and organisational toll of working to such levels of intensity.

We need to establish a process of identifying innovations, harnessing opportunities and aligning actions for change across the domains of the individual, the community and our institutions. This could include:

- Identifying early successes in innovation through a renewed commitment to monitoring and evaluation.
- Naming critical and context specific factors in such successes and their ability to scale.
- Convening partners from across geographical locations and communities of practice to share learnings on these success factors.
- Building space in commissioning processes for iterative development of innovations to ensure outcomes continue to meet changing population needs.

Conclusion and recommendations

We have argued throughout this report, that the conditions needed for large scale, radical change are present in our health and social care system. A combination of long entrenched challenges - from funding and commissioning to population needs that develop faster than the system can respond - have been exacerbated by the current Covid-19 crisis.

Looking ahead to longer term change, we find ourselves at a unique juncture: where the conditions for change appear to be present and where all have been asked to cooperate and sacrifice in order to protect the health needs of everyone, most particularly those who have had to be shielded and others who are at risk.

Therefore, we suggest that the future of the health and social care system should be determined collectively. As has been evident in recent months we are all part of the story and any approach to change should reflect this. Expertise will be needed to help guide us through, but the major task of reform should be participatory; not left to them or, indeed, policymakers alone.

The public also understand a need for change. Our survey revealed that a quarter (25 percent) of the population felt the health and social care system to be mostly or entirely unfit for purpose. Further, a quarter (24 per cent) thought that after the Covid-19 crisis, people should be given more say over their health and social care provision.

With this in mind, our core recommendation is the establishment of a **People's Health and Care Commission**. This should be built in addition to much of the work of the NHS Long Term Plan, developing actionable recommendations to support a move to a more resilient, responsive and equitable, connected health and social care system.

Box 7: A People's Health and Care Commission

A People's Health and Care Commission would offer a new kind of policy development, building actionable change from people's lived experience of the health and social care system. Understanding the Covid-19 crisis response will be essential in moving forward. However, such a commission needs to be much more than a review of what went well and what went wrong, necessary though that undoubtedly will be; instead it should seek to address too the history of our health and social care systems and what can be achieved in periods of stability as well as periods of crisis.

A People's Health and Care Commission should consist of three core components:

1. Public, stakeholder and expert reflection on what Covid-19 taught us about the health and social care system; how it operates and how its governed. This would be an attempt to understand the health and social care system as a whole, its strengths and its shortcomings. This phase would not impinge upon any public inquiry should that be established.
2. A citizens' assembly, which should be convened on what is important to us, what we are prepared to contribute, what the values and principles of our health and social care should be and what the experience of interacting with this system should look and feel like.
3. Expert led policy intervention and system redesign, with options for exploration by the citizens' assembly prior to the reforms being enacted in a new Health and Care Act.

Together, this work should lay the foundation for the next generation of health and social care, in all its dimensions. Its approach would move away from traditional policy and practice making, and instead formalise the new role the public have established during a period of crisis. To do this effectively and equitably, the process should be underpinned by the following principles:

- The whole system should be under consideration, through the lens of how it is experienced by citizens, and not the policy silos that currently exist.
- The process should be owned by the people, and engagement led.
- All levels of the system should be included; national, local and individual.
- Diverse voices must be included in the conversation, particularly BAME citizens and those with lived experience of long-term conditions or disabilities.
- Digital elements should be used, underpinned by a requirement for assisted equity of access and digital literacy.

Whilst the scope of such a People's Health and Care Commission should be wide-ranging by definition, and adaptive to learnings about people's priorities, there are some aspects of the system that our research to date suggests are critical components to reform:

- Scaling technological health and social care innovation.
- Crisis preparedness.
- The experience of health and social care.
- The value of health and social care work.
- Preparedness for population change, aging population, responsiveness to needs.
- Governance and oversight mechanisms.
- Funding models, particularly to support social care as part of a wider system.

The public are now part of the health and social care system in a way that we have never been before. There is a justification for public involvement, and as such response and recovery needs to step out of the normal political process. This in itself, would be an act of leadership and one that could command public support and legitimacy for the whole system and the changes it will need to make in the decade ahead.

There are also a number of critical actions that can be taken in the short-term. We have posed a range of opportunity areas that can support national and local policymakers and practitioners to emerge from the crisis into a better future for health and social care. If and how these areas are utilised will set the direction for change, the course of which our scenarios offer some narratives for.

Ultimately, different elements of each of the scenarios are attractive in terms of the core principles we have presented. Pandemic NHS is based around the application of digital technology, agile organisational principles, and science in order to best respond to health need resiliently and at scale. System stasis will be necessary to maintain some form of ‘business as usual’ as future possibilities are explored enabling continued responsiveness, albeit with questions of the sustainability of that scenario. And A care horizon sees a more connected system at the local level, focusing our minds on the people – those needing support, their families, and professionals for whose needs we have to meet equitably.

In the short term, a number of changes can be made across opportunity areas to reach the best balance of these scenarios, with change happening across national and local policymakers and stakeholders.

Box 8: Recommendations

Recommendations for applying new technological innovations equitably and at scale

- Central government should review digital service adoption during the Covid-19 crisis, with the aim to improve accessibility and a move towards increased digital take up. Specifically – though not exclusively – age, economic status, geographical location, language and clinical conditions should be considered. This review should culminate in a digital access strategy.
- The NHS should invest in digital architecture such as cloud-based technology to support data sharing and communication capacity for itself and its partners. It should, in tandem, review its internal digital and data capabilities urgently. This should be informed by the identifiable needs during a period of crisis, such as the Covid-19 crisis, as well as during usual practice.
- Enhanced connectivity between the NHS and care homes should be approached mutually to enable patients, families and care homes to be active partners in the discharge planning process and empowering them to make informed decisions to leave hospital in a timely manner. This should avoid a return to delayed discharges and in doing so prepare for the next pandemic infection

Recommendations for reframing our relationships and responsibilities around support for and promotion of health, care and wellbeing

- Central government should provide increased funding for health and social care delivery, administered at the local level to meet context specific needs.
- Local authorities should consider supporting the following activities with additional funding (as recommended above), where possible in further partnership with central government and NHS England:
 - Investment in skills development for local health and social care workers to improve digital capacity.
 - Explore new ways of working and management such as self-managing teams.
- Local authorities and Clinical Commissioning Groups should consider the use of outcomes based or participatory budgeting approaches in distributing new funding, with the aim of improving citizen engagement and collaboration across the health and social care sector. This should contribute to greater flexibility in commissioning local services.
- An analysis of local systems and assets should be carried out in light of local responses to the Covid-19 crisis. A key objective of this should be to identify opportunities for sustainable supply chains within local ecosystems and to facilitate a green recovery.

Recommendations for changing ways of working

- The Department of Health and Social Care should conduct a large-scale systems analysis to understand citizen touch points with the health and social care system. Informed by this analysis, shared system level objectives should be identified across health and social care delivery.
- Central government should review procurement rules and contracting requirements for health and social care to enable innovative practice to develop. This could include using a sandbox model to test new systems that will enable scale and spread.
- Government should invest in a central capacity to allow individuals the right to ask health and social care organisations to share their records with relevant care providers, care workers and community service providers.
- The NHS and its partners should utilise predictive modelling where actions taken in one system has a direct knock-on effect on another, potentially separately governed, system. Such predictive insights have been clearly lacking in the UK response to the current pandemic.
- Local authorities should consider the creation of permissive legal spaces for experimentation and innovation as we emerge from the Covid-19 crisis to allow practitioners to explore new ways of working based on learnings from the pandemic. Such spaces will help in the long-term to create a more adaptive health and social care system.

The RSA (Royal Society for the encouragement of Arts, Manufactures and Commerce) believes in a world where everyone is able to participate in creating a better future. Through our ideas, research and a 30,000 strong Fellowship we are a global community of proactive problem solvers. Uniting people and ideas to resolve the challenges of our time.



8 John Adam Street
London WC2N 6EZ
+44 (0)20 7930 5115

Registered as a charity
in England and Wales
no. 212424

Copyright © RSA 2020

www.thersa.org

ISBN 978-1-911532-78-1