# Involving people in policymaking

## Reflections on The People's Panel

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# Contents

# 1. Introduction

# Introduction

1. This paper sets out some personal reflections on the challenges identified in the health and care system by Engage Britain's Citizens' Assembly (The People's Panel) and on what we learned from the process itself. The Panel consisted of around 100 participants broadly representative of the British public who met virtually over four weekends in Autumn 2021.

2. As a long-standing policy adviser and sometime agnostic about the value of deliberative events, this paper sets out a personal view on what I think we learned. After all, health policy already has an impressive research, analytical and policy development infrastructure both inside and outside of Government to draw on – and considerable experience of qualitative approaches. This is far less true of social care policy.

3. The People's Panel reaffirmed much we already knew but gave new insights into the underlying values which drive the public's views and what issues and language resonate with them. The public see the NHS as something precious, the "best gift the British people have ever given themselves". Its core value – care provided free at the point of use – still resonates strongly. But there is also anxiety over whether that care will be available in practice at the time of need. Whilst clinicians are trained to "do no harm", the public find that simply interacting with the health and care system can itself have a detrimental impact on their well-being.

4. The Panel concluded that health and care need extra capacity, primarily in terms of workforce, but also wanted to see major changes in how the system operates – and how it interacts and communicates with them. They wanted to be seen as people who are supported to live their best lives, receiving holistic care rather than a series of disjointed interactions focused on individual conditions. They care about relationships  (not just in individual clinical interactions or the treatment of individual conditions) but across the entirety of their interactions with the health and care system. They want the staff who provide that care to be valued and treated fairly.

5. The People's Panel prioritised seven issues – workforce, personal experience (four separate priorities which spanned how the system communicates with itself and its patients, difficulties navigating a complex and fragmented system and long waits for care), mental health and prevention.

6. The priority given to two of these at least – workforce and waits for treatment – were hardly a surprise. Regular survey evidence tells us this at far lower cost. 62% of respondents to the 2019 British Social Attitudes survey identified staff shortages and 57% identified "waiting times for GP and hospital appointments" as a cause of dis-satisfaction with the NHS. The value added of the Panel was perhaps more in understanding what people mean by these issues (which is largely as a set of relationships), drawing on their own experiences of what it feels like to interact with the system. This was reflected in the language which resonated with them, the values they brought to bear and how their initial views evolved after having a chance to debate and reflect.

7. Four of the Panel's seven priorities were around their personal experience of the system. But it was how the system communicates with itself and with users, rather than the length of waiting lists for individual treatments, which the Panel wanted us to work on first. There is always a risk of Group-think amongst the commentariat. And gaps in care can easily emerge in a service divided by institutional and professional rivalries. The Panel provides a useful reminder of not just what really matters to people but why it matters. The traditional focus of access (waits for treatment) is important to people – but so is how the system as a whole communicates with them and helps them navigate its complexities. That understanding is crucial to ensuring policies are framed and implemented the right way. So we put our energy into the practical changes that will make a real difference to people's everyday experience.

8. The rest of this paper gives some personal reflections on which health and care policy "dogs" barked loudly, which barked in more surprising ways as the Panel's deliberations evolved and which did not bark at all. I conclude with some observations on what this might mean for policy development and Engage Britain's own work.

**2. Dogs that barked**

# Workforce

1.  Only eighteen months after the public stood on their doorstops to show their appreciation of carers, it is perhaps unsurprising that the Panel identified *"the health and social care systems are failing to recruit, train and retain sufficient staff to meet current and future demands"* as the most important challenge.

2.  Panel members were generally highly supportive of health and care staff and appreciative of the many cases of excellent treatment and acts of kindness. These relationships matter. But there were also examples of quite shocking language and behaviour by staff. Some people felt that how they were spoken to, and even the quality of care they received, was influenced by staff making judgements about who they were – rather than what care they needed. Many told how their experience of care was adversely affected by a lack of staff and sometimes by whether those staff had the right expertise.

3.  The workforce crisis in the NHS has clearly penetrated the public consciousness. The UK has long had significantly lower numbers of doctors and nurses per capita than comparable systems (see Figure 2.1 for comparisons of doctor numbers). Some Panel members told how their own personal experiences of these systems compared with the NHS. Media coverage of a persistent failure to achieve targets to increase the number of GPs and vacancy rates for nurses may be cutting through. More recently, the impact of working conditions is showing an increasing impact on the ability of the NHS to retain staff. Around 50 in every 10,000 staff working in Hospital and Community Health services in June 2021 left the service within the next three months citing work-life balance as the reason. This was a new record (as shown in Figure 2.2).

**Figure 2.1:** Number of doctors per 1,000 inhabitants for the UK and comparator countries, 2020 or most recent data available
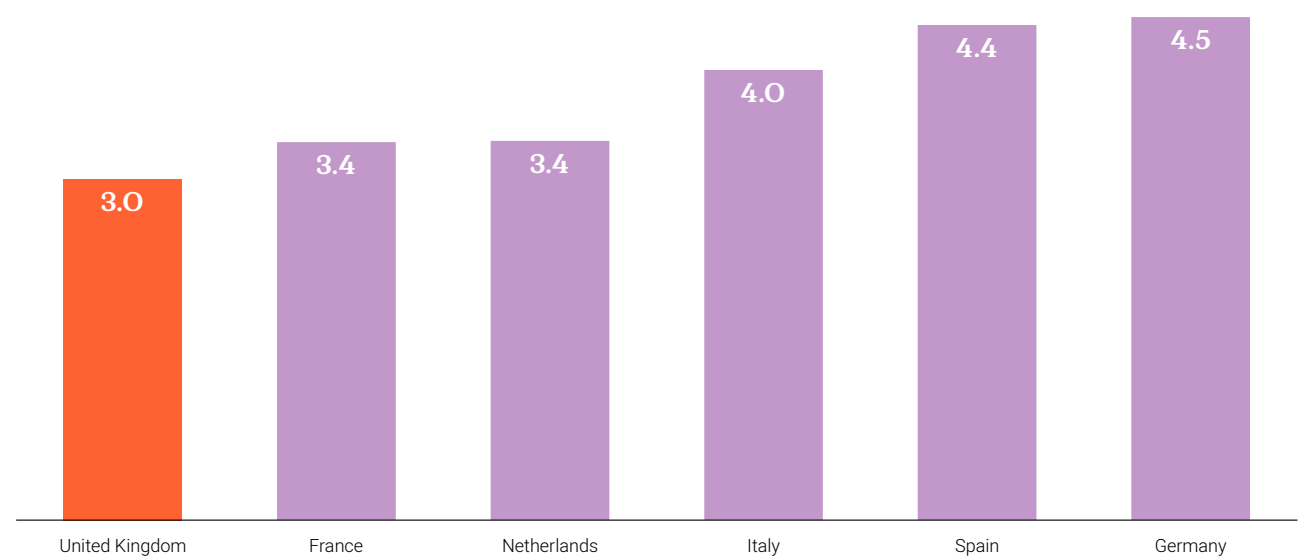


Source: OECD, Doctors (indicator) data, from 2020 or most recent available.

**Figure 2.2:** Proportion of English NHS HCHS Staff (excluding primary care) leaving their roles citing work life balance as the reason
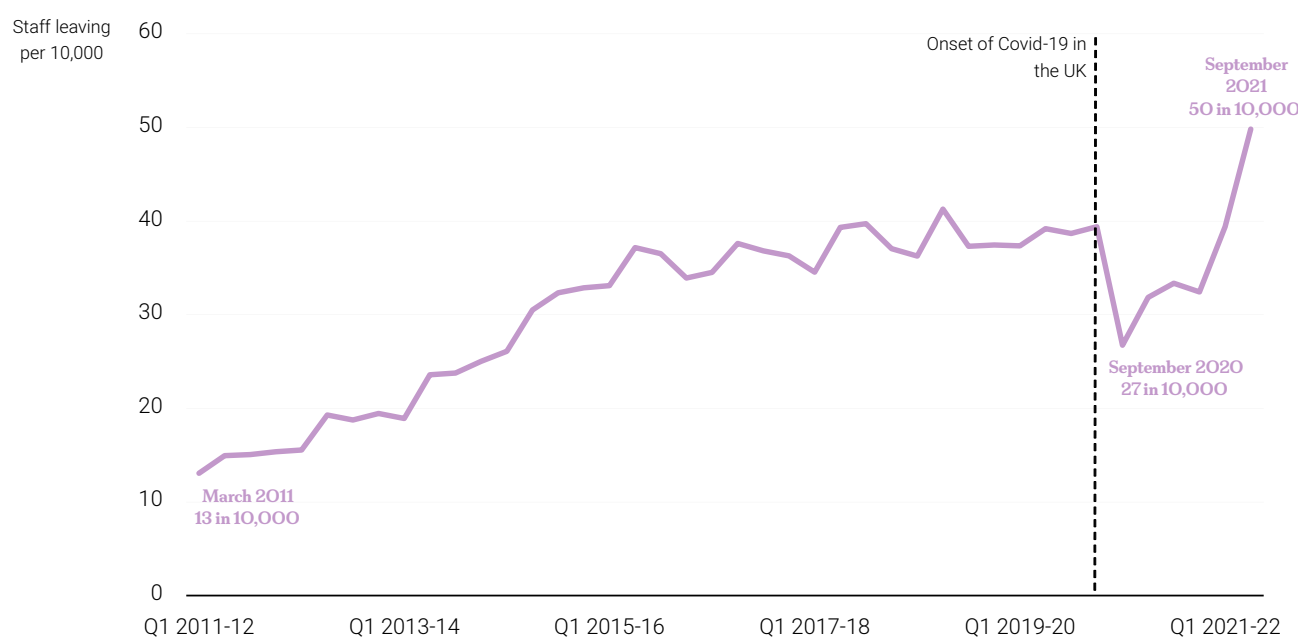


Source: NHS Digital, Workforce statistics, Hospital and Community Health Services reasons for leaving data, September 2021.

4. Social care has long been the policy "dog" which never barks. Public debate has been largely framed through the lens of people selling their house to pay for care. Or the impact on delayed discharges in the NHS, rather than on problems accessing care and the quality of that care. Occasional catastrophic failings in the quality of care, such as at Winterbourne View, provoke public outrage but the impact is often short-lived. The public's consciousness of the policy debate around social care has largely been limited to periodic explosions of public anger when opposition parties exploit public ignorance of how the existing system works to torpedo proposals for funding reform. Some commentators feared that reform was politically impossible whilst its salience was so low. And problems in the service were experienced as private misery in isolated homes, rather than publicly visible NHS crises such as ambulances queuing outside of A&E departments.

### What are Community Conversations?

Engage Britain held 101 Community conversations across England, Scotland, Wales between January and May 2021. These allowed small groups of users and practitioners of health and care to share their experiences of what is working well and what they wanted to change. Many reflected the experiences of people who are heavily reliant on health and care services for their day-to-day well-being and whose voices are often not heard in policy. These views were fed into the People's Panel to support their discussions.

5. But not this time. Social care featured very prominently throughout Panel discussions. As ever, after some initial discussions the Panel showed relatively little interest in the mechanics of the system. But real-life stories – both from Panel members' own experiences and those from over 100 Community Conversations (many amongst groups whose voices are rarely heard) – resonated widely.

6. The stress of the means-test (who pays for care) featured less prominently than that caused by the needs-test (whether people qualify for care). Some Community Conversation participants described having to fight to get support in the sort of language more commonly used to describe interactions with more coercive arms of the state (such as the criminal justice system) than on a social service aimed at people in need. People described their terror that annual reviews (seen as more about cost control than assessing their needs) would lead to services vital to their quality of life being withdrawn. Transformational stories about the impact great social care can have on people's lives can inspire ("the NHS saved my life but social care allows me to live my life").[1] Discussions amongst Panel members revealed a sense of injustice at the devastating impact of failures in care, which resonated far wider than those who had directly experienced them.

7. Policy makers have often struggled to combine individual stories of injustice into a more universal narrative around social care which resonates with the public. Over the course of the Panel's deliberations, views began to coalesce around the social care workforce and resonated most strongly in the final voting. Indeed, there was even some debate about whether the challenges in the social care workforce were more of a priority than that in the NHS, something I had never heard in public deliberations before.

8. Why did this happen? The salience of social care has been rising slowly over time and the pandemic has shone a light on the sector. The public clearly recognises there is a workforce crisis, with large numbers of unfilled vacancies and almost one in three of the social care workforce leaving their jobs in 2020/21.[2] Average pay for those who work in social care is lower than almost any other sector (Figure 2.3), there are few opportunities to gain formal qualifications and there is little pay progression to reflect greater experience or responsibility. Skills for Care found that a Care worker with five years' experience would only earn around six pence per hour more than a new starter.[3]

9. Analysis by Skills for Care shows a clear relationship between the quality of care provided and staffing ratios, turnover rates and staff training.[4] Panel discussions focused on the need for sufficiently well trained, valued and

rewarded staff, to ensure safe high-quality care in a sector in which continuity of relationships is so important to quality of life. But over and above that, Panel members expressed very clearly that those who provide care, towards whom they often feel enormous gratitude and affection, should receive a fair deal. That jobs which do so much good should be good jobs.

**Figure 2.3:** Median salaries for care workers in England's independent adult social care sector compared to other low paying jobs



| Sales and retail assistants | Cleaners and domestics | Care workers | Launderers, dry cleaners and pressers | Kitchen and catering assistants |
| :---: | :---: | :---: | :---: | :---: |
| £9.22 | £9.07 | £9.01 | £8.72 | £8.72 |

Source: Skills for Care, The state of the adult social care sector and workforce in England 2021.

[2] Skills for Care, The state of the adult social care sector and workforce in England, October 2021, skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx. Further breakdown is provided in Appendix 2.
[3] Ibid.
[4] Quality of care measured by Care Quality Commission star ratings.

# Personal experience of the health and care system

10. Four of the Panel's seven priority areas for the health and care system were in overlapping areas of how they personally experience the system. These included how long they wait for treatment, accessing holistic care in a complex and fragmented system and how the system as a whole communicates with them.

11. Public concern about delays in getting treatment when they need it is hardly a surprise. It has featured heavily in public concern about the NHS for decades. The NHS' performance against waiting times targets for both routine and emergency care has deteriorated rapidly since 2015 (Figure 2.4) and been turbo-charged by the pandemic. The numbers waiting for routine treatment are already at a record high of six million. They are forecast to increase much further as those who did not seek (or were not able to obtain) treatment during the pandemic come forward for care. Waits for Ambulances and at A&E departments featured heavily in the news during the Panel's deliberations, with fears of a major winter crisis being imminent.

**Figure 2.4:** Percentage of people waiting for consultant-led elective care who have been on the waiting list for 18 weeks or longer
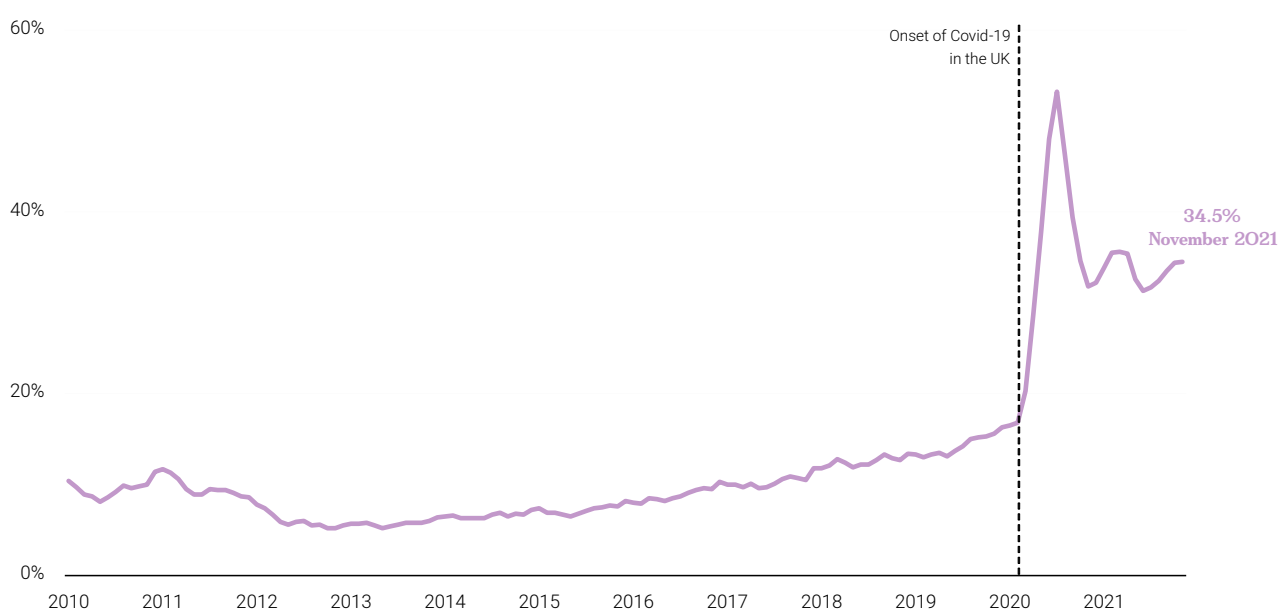


Source: NHS England, Consultant led referral to treatment waiting times data, November 2021.

12. But the strength of feeling amongst Panel members, sharing the impact of a fragmented system on people's mental well-being (over and above the delay in getting treatment itself) felt new. The Panel's highest priority for work on solutions was *"Poor communication between different services, departments and patients leads to delays and gaps in receiving important care, which causes confusion, distress and disappointment for patients, especially for those with complex conditions and care needs"*.

13. Maybe the importance to the public of how the system as a whole communicates should have been less of a surprise than it was. Gomez-Cano et al found that the biggest predictor of patient satisfaction for cancer patients was how their care had been co-ordinated and administered.[5] Work by The Kings Fund with National Voices and Health Watch England found that patient experience with NHS admin processes places a heavy practical burden on patients and carers, restricts their access to care, negatively affects their wellbeing, and has knock-on consequences for staff[6]. Research by the National Institute of Health Research (2017) identified the biggest category of concern (21.7%) was communication either from staff to patient, staff to staff, or patient to staff.[7] Examples included confusion about when patients were due for surgery, with resulting uncertainty about when they could eat and unnecessary missed meals.

14. In recent years, there has been an increased focus on how individual clinicians communicate with patients and communicate between themselves (such as the CQC's 2017 report on GP practices) but far less on how the system as a whole communicates with patients.[8]

15. We already know that waiting times are going to be a major challenge for the NHS for many years to come. How the NHS communicates with patients, to support them during those waits to access care, will be even more critical. But this poses three particular challenges for our health and care system.

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[5] Mayam Gomez-Cano, Georgios Lyratzopoulos and Gary A Abel, 'Patient experience drivers of overall satisfaction with cancer patients: evidence from responders to the English cancer Patient Experience Survey, Journal of Patient Experience, 7:5, October 2020, journals.sagepub.com/doi/full/10.1177/2374373519889435, pp.758-65.

[6] Leo Ewbank, Laura Lamming, Julia Cream and Lillie Wenzel, Admin matters: the impact of NHS administration on patient care, The King's Fund, June 2021,

[7] Jane K O'Hara, Caroline Reynolds and Sally Moore et al, 'What can patients tell us about the quality and safety of hospital care? Findings from a UK multicentre survey study', BMJ Quality & Safety, 27:9, March 2018, pp.673-82.

[8] Care Quality Commission, The state of care in general practice 2014 to 2017, April 2018, cqc.org.uk/publications/major-report/state-care-general-practice-2014-2017.

16. First, there is little comprehensive data on how big a problem this is. The NHS primarily uses data for performance management and comparing institutions. So there is a risk that if it is not counted, it does not count. Existing data on individual "patient episodes" tells us little about the overall experiences of people with repeated interactions and multiple chronic conditions. Panel members spoke of their exhaustion at having to co-ordinate their own care, especially at times when they felt particularly unwell. Yet almost all of the large data-sets collected by the NHS focus on interactions with individual organisations. With rare exceptions, such as the Cancer Patient survey, there is remarkably little data available across patient pathways or whether people are falling through gaps (lost records, referrals etc).

17. Second, organisational structures and clinical specialisms can create mindsets which focus on key aspects of a patient's care but struggle to see the whole person. A system designed around individual patient episodes is less suited to a world of increasing incidences of multiple chronic conditions and sub-specialisms amongst clinicians. Panel members found it all difficult to navigate. The new Integrated Care Systems face a mammoth task integrating the health and care system at the only level which really matters – the patient.

18. Third, how the system works may be far clearer to the people working in it (although there is evidence to cast doubt on this) than to their patients. The Design Centre's work with NHS Trusts in Southampton, Chesterfield and London found many A&E patients did not understand how triage worked and what stage of the process they were in. Better communication played a vital role in reducing patient frustration and was even linked to a reduction in incidents of violence in the A&E department. Some hospitals do not offer hospital appointments until close to the surgery date as a perfectly understandable way of minimising wasteful "no shows". But unless somebody has told the patient that this is how the system works, they can endure months of anxiety not knowing whether they have got lost in the system or how long they are likely to have to wait.

# Mental health

19. Whilst Panel members discussed and had personal experiences of many clinical conditions, the only one they prioritised above the rest was mental health. It is an area which has often struggled to get "equal billing" to physical conditions in either policy debates or funding. This was manifest in two ways. First, as one of the seven priorities voted on by the Panel. The focus of these discussions was very much on how the health and care systems could support well-being, rather than simply on clinical treatment. But secondly, mental health was seen as an important element of almost all the other priorities. Panel members were mindful of both the additional challenges faced by those with mental health issues in getting the health and care support they need. And the adverse impact that interacting with the system can have on those who work in it or who rely on it.

20. This increased salience of mental health issues may partly reflect the impact of the pandemic on mental well-being and the need for support. There is certainly greater awareness of long waiting times and unmet need. But this may simply be turbo-charging the impact of evolving societal changes. There's now greater awareness and falling stigma attached to talking about mental ill health. People (particularly younger generations) have access to the language (and confidence to talk about things) which were previously "not spoken about".

# Prevention

21. The dynamics of the Panel's discussions around prevention followed roughly the same trajectory as is common in many deliberative exercises. The initial focus of discussions was around people needing to do more to improve their own health, with occasionally quite censorious comments about the burden created for the NHS by those who do not (especially with respect to alcohol and drug misuse). Those discussions, typically, stop short of denial of treatment as opposed to other groups being given greater priority.

22. Two distinct themes emerged as the discussions evolved: Did people have access to the information they needed to make healthy choices? And did the health and care system take a sufficiently holistic, long-term view to allow people to access timely care, before their condition deteriorated? By the end of the Panel, the focus had shifted to how people can get the support they need to make the right choice, although there were dissenting voices. Panel members stressed the importance of schools to a healthy start to life and establishing good habits in the young. They also worried that vulnerable members of society had fewer opportunities to act on the information they had to make healthy life choices.

**3. Dogs that barked in interesting ways**

# Funding

1.  During the Panel's first weekend, the need for increased funding featured heavily, creating some personal fears it might crowd out discussion of everything else. This did not seem particularly surprising. The NHS has emerged from the least generous decade for funding increases in its history (Figure 3.1) and support for greater funding continues to score highly in the British Social Attitudes survey and elsewhere. I would simply not have predicted that increased funding for health and care would not be prioritised (or even long-listed) by the Panel on the final weekend. Is this evidence that public support for greater funding for health and care is more superficial than commonly assumed?

**Figure 3.1:** Average year-on-year increase in UK government spending on health in real terms (2019-20 prices) by government
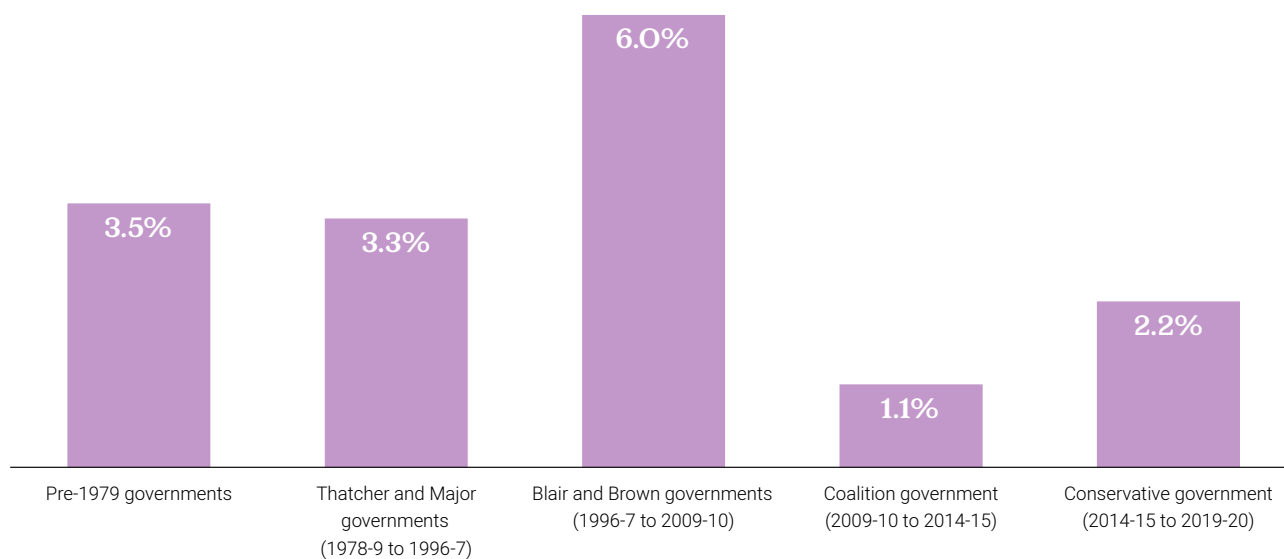


Source: Institute for Fiscal Studies, IFS Green Budget Chapter 6: Pressures on the NHS, 2021.

2. I don't think so. Shortage of funding underpinned much of the discussion in all the Panel sessions. The Government announced a new Health and Care levy on 7 September 2021, a few days before the Panel's first meeting, when the discussion of under-funding featured most heavily. Although there was far from universal awareness of the Government's announcement at the start of the deliberations, we certainly heard no significant dissent at the Government's proposal to increase taxes to finance improved health and care services (although there was certainly some discussion about which taxes should be raised – and on whom).

3. It is possible that Panel members may subsequently have inferred that underfunding had now been addressed and that they should turn their attention to what it should be spent on. My personal view is that it seems more likely that once Panel members had the opportunity to debate and reflect on what they had heard, they developed clearer ideas on how they wanted that extra money spent (predominantly to recruit, develop and retain staff) which moved them beyond the funding itself.

## Waste and inefficiency

4. Panel members also evolved how they thought about waste and efficiency across their meetings. Around one quarter of the Panel picked the "ineffective and inefficient use of resources" as a top challenge in the first weekend. Initially, some of the discussion focused on very visible examples of waste (multiple ordering of blood tests) and mis-use of the system (such as people going to A&E for relatively minor symptoms). Yet waste was not prioritised explicitly in the final session.

5. It is possible that the Panel decided that the NHS's efficiency compared favourably to other health systems in light of what they heard from experts, and that waste was not an issue. While there is certainly considerable evidence that the NHS is a relatively efficient health system, this seems unlikely.

6.  More plausible from the way that discussions evolved was that, as they reflected on what they were hearing, the Panel's focus shifted from individual (and often highly visible examples of waste) to how a fragmented system which treats patients as collections of body parts is itself very wasteful. Fragmentation within the system wastes resources because the bits of the system do not talk to each other and patients fall through the cracks. Dealing with individual conditions wastes resources because these conditions interact (such as the Panel member whose chronic condition worsened because, in the absence of a hip operation, he could not exercise).

7.  The framing of attitudes towards fragmentation and poor communication seemed to be that they were not just bad for patients but symptoms of a system which wasted resources. This may suggest the public is more open to being convinced of the case for the redesign of clinical services on efficiency grounds than is often assumed. But it may also give pause for thought to politicians that the fabled "front line", to which they like to channel resources, should be seen as the experience that people have when accessing the system, not just the clinicians they meet. Interactions with receptionists, whether clinicians have the right information to provide timely care and whether people have to repeatedly retell their stories to fight for the care and support they need, is very much part of people's front-line experience.



**Poor communication:** People repeatedly retell their stories to fight for the care and support they need

# Health inequalities

8. As with many deliberative events, evidence on health inequalities did not resonate particularly strongly with Panel members in the terms that health experts mostly look at them – inequalities of health outcomes between different groups. There is some evidence that Panel members viewed those disparities as resulting at least in part from people's life choices as opposed to structural determinants.

9. While the Panel appeared relatively sanguine around inequalities of outcome, they expressed a visceral dislike of inequalities in access to services, particularly amongst groups seen as vulnerable. This provoked a sense of injustice which resonated strongly, especially in response to tangible examples of people who suffered disproportionately from things that everybody found hard. Navigating the system was widely viewed as a source of stress and anxiety in its own right. So the additional difficulties faced by those suffering from mental ill-health or by vulnerable individuals without somebody to advocate for them was strongly felt. But despite outrage at personal stories of people being treated differently because of who they were, perspectives that the NHS structurally discriminated against particular groups hardly resonated at all.

10. Tackling health inequalities in the traditional sense of health outcomes was not prioritised as a separate issue by the Panel. By contrast, ensuring access at the point of need for vulnerable groups permeated virtually every discussion Panel members had in firming up their priorities. Interestingly, this extended to almost every criteria where statisticians find significant inequalities in health outcomes.

↑ Entrance

↑ Parking P

→ Medical S

No Smoking

**4. The dog that refused to bark**

# System reform

1. By far the widest gap between the issues debated and prioritised by the Panel, and those debated in the Westminster village, is the degree of interest in reforming systems, structures and incentives (the so called "wiring diagram"). Panel members certainly had a thirst for understanding whether other health systems (there is very little comparative evidence on social care) did things better and what England, Scotland and Wales could learn from each other. But their focus was on the practical evidence, with barely a word on the sort of abstract system reforms beloved by politicians.

2. It seems natural that the public care about the quality of care they receive without caring very much about the intricacies of how it is organised. Passengers care about their trains running on time without needing to know who designed the signalling system. It seems equally natural that managers take an active interest in the "wiring diagram" of how services are organised in order to deliver high quality and safe patient care.

3. What is more surprising is the energy politicians expend on introducing abstract reforms which have little meaning to the public, users or even many who work in the service. The current Health and Care bill represents yet another attempt to "rewire the system". Unlike the previous Lansley reforms, this one has considerable support within the NHS and is largely focused on giving statutory underpinning to changes which are happening already. But whatever the merits of particular system reforms, perhaps a take-away from the Panel would be that politicians need to do a much better job at communicating how those reforms will deliver practical improvements to patient care.

**5. What did we really learn?**

# What did we really learn?

1. Engage Britain is experimenting with a different way of doing policy – putting people at the heart of finding ways forward. It means the case for change is inevitably rooted in people's values – that's where the public starts. But it is not where people finish – they are interested in seeing actual improvements and, as the Panel has shown, focus in on practical things that they want to see changed. The Panel members brought their own experiences and could tap into the insights from over 100 Community Conversations – small groups of people discussing what matters to them – including many voices not traditionally heard in policy debates. After their initial deliberations, the Panel themselves decided what they wanted to know more about, developed their ideas of the key challenges facing health and care in their own language and then voted on those priorities. They remained focused on the challenges they wanted to prioritise, free from pressure to come up with solutions. At all stages, it was up to Panel members to decide what resonated and what they wanted to take forwards.

2. The Panel members themselves valued being involved in the process but they were only one hundred people in a (virtual) room. So in my concluding remarks, I ask whether they have come up with anything new or interesting for policy-makers. And do their views resonate more widely than amongst themselves?

3. In one sense, the four headline priorities (workforce, personal experience of the system, mental health and prevention) were not particularly surprising. The public clapped for carers because they value them, are grateful for the care they receive and want them to be valued and well treated. The values of the system – especially free at the point of use – continues to resonate strongly. But there is anxiety about whether care will be there when they need it. Too many of their interactions with that system cause genuine distress. So while the public are very open to paying higher taxes to fund health and care, they want to pay for a better system not just a bigger one. And one which supports them as a person.

4.  But we knew this already, so what is the value of the process for policy makers? I think it is three-fold:

**Why things matter is just as important as what matters if we are going to develop the right policy solutions.** Waiting times for treatment are hugely important – but they are only the most visible aspect of the challenges people face in navigating the system, of understanding what is happening and in getting the care they need (which will make a difference to their life, not just their condition). So reducing waiting times, whilst hugely important, is not enough. Similarly, the public is concerned not just about the numbers of staff – but also that they are well-trained, well-valued and have the space and time to do their jobs. Because they see health and care as being about relationships – and often the continuity of a relationship with a person they trust.

**The language and framing of policy discussion has a big impact on whether it resonates.** The Panel's initial interest in the "wiring diagrams" of how health and care is organised or the social care means-test rapidly waned – whereas the impact of personal stories continued to resonate – especially when they could be framed into universal concerns. I think there are important lessons here about how we talk about social care. It is too often introduced through the lens of "why it is different from the NHS". What it does is described in accessible language (domiciliary care) or through the complexity of the funding arrangements. In a similar vein, discussions of inequalities in health outcomes (at least a part of which the public attributes to personal choices) does not cut through to anywhere near the same extent as inequalities in accessing services at the point of need – which is seen as a gross injustice.

**Giving people the chance to reflect and debate matters.** The topics prioritised in the final session were all present from the first deliberations. But there was considerable evidence that they "shape shifted" in terms of framing and language. This was true of debates on resourcing, access and waste. The Panel began with views rooted in their own experiences. New material and perspectives either resonated (in which case it either reinforced those initial views or led to some reframing) or they did not resonate, rapidly being dropped from the discussions. This suggests that one-off events and polling will pick up "short hand" for the public's concerns, but can mislead on what they really care about – and what messaging will ultimately resonate with them.

5.  It is not enough to let the public in to just one bit of the policy process. The People's Panel brought together a representative group to identify the key challenges with the health and care system that the public could get behind. We have validated this through polling to ensure the views of the hundred people on the Panel do resonate with the public at large and have not been contaminated by particularly powerful stories, charismatic experts or killer facts.

6.  But one Panel does not allow trade-offs to be made, ideas to be iterated or solutions tested against the challenges they were meant to address. To support people across the country to come together and develop solutions to the nation's greatest challenges, Engage Britain is trying to combine familiar concepts – like polling, Citizen's assemblies, co-design and message testing – into a holistic process. One where the public calls the shots at every stage. The next stage involves people co-designing solutions to the challenges the Panel prioritised. It will draw on all relevant expertise to develop solutions that will make a difference in practice. This will then be reported back to a reconstituted Panel, to allow them to manage the trade-offs and iterate their ideas in light of the evidence.

7.  Personally, I feel humbled by how seriously the members of The People's Panel took their role. Their bravery in sharing their own stories. Their willingness to debate and to listen to others. Their appetite for finding out more and making things better. And perhaps most of all, their very British sense of what is fair and what is unjust. The members of the Panel represent a massive antidote to stories of a polarised society of warring tribes, culture wars and Twitter storms. It was an honour to get to know them.

# 6. Appendices

# Appendix 1: Areas prioritised by The People's Panel

1. **Workforce** – The health and social care systems are failing to recruit, train and retain sufficient staff to meet current and future demands.

2. **Fragmented system** – Poor communication between different services, departments and patients leads to delays and gaps in receiving important care, which causes confusion, distress and disappointment for patients, especially for those with complex conditions and care needs.

3. **Lengthy process and waiting times** – The referral process is disconnected and inefficient because it is outdated and has not evolved with the needs of people and advances in technology. There is poor information flow between primary, and specialist care, and poor communication between health and care services and people using them.

4. **Integrated health and social care** – Service users are not always signposted in a timely manner to the appropriate health and social care services that best meet their needs. Delays in intervention can adversely impact patient outcomes.

5. **Mental health services** – Experience suggests there is a lack of understanding, awareness, and education about mental health. This results in societal stigma and a lack of willingness and/or ability of people of all ages to understand what they are feeling, to talk about it, and to come forward to access early support.

6. **Holistic health and care** – The system doesn't require professionals to look at the bigger picture, which results in treating individual conditions and not the whole person.

7. **Prevention and early intervention** – People can find it challenging to make an informed choice which leads to lifestyle issues creating pressures on the NHS. This is due to a lack of education in schools, the scope and consistency of the information provided through life (including about mental health) and a lack of knowledge and support for what is needed to act on the information.

# Appendix 2: Supporting graphs

**Figure 6.1**: Percentage of People's Panel members who voted for each issue as being among their top seven on the penultimate weekend
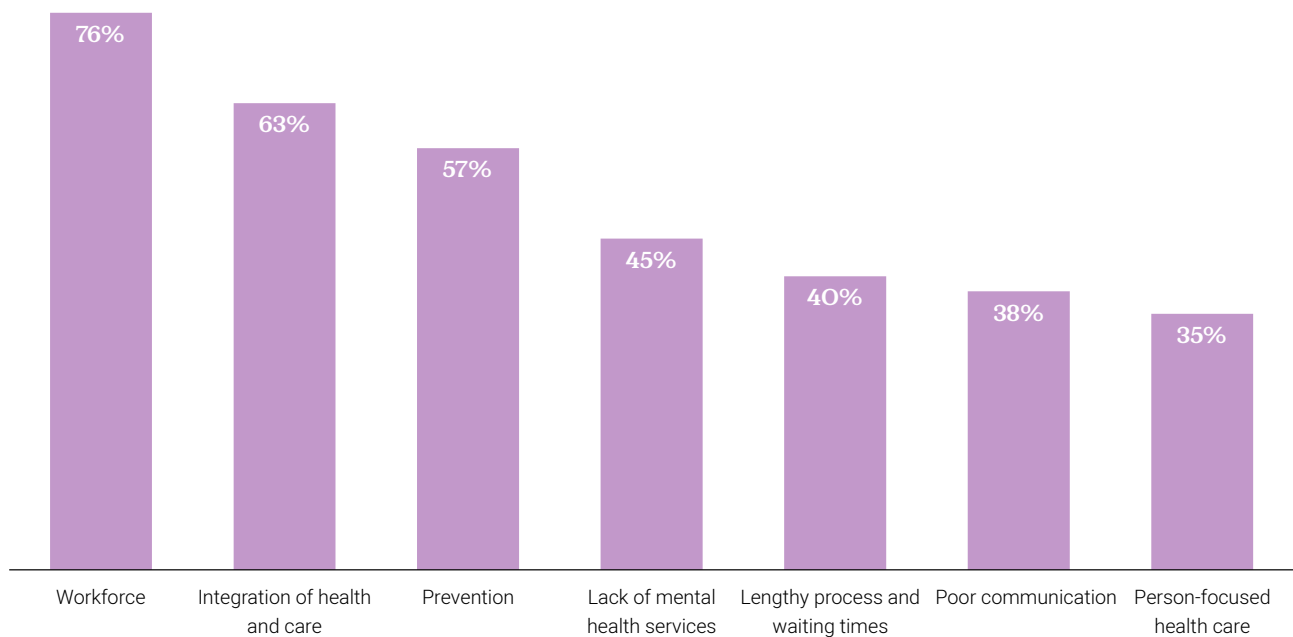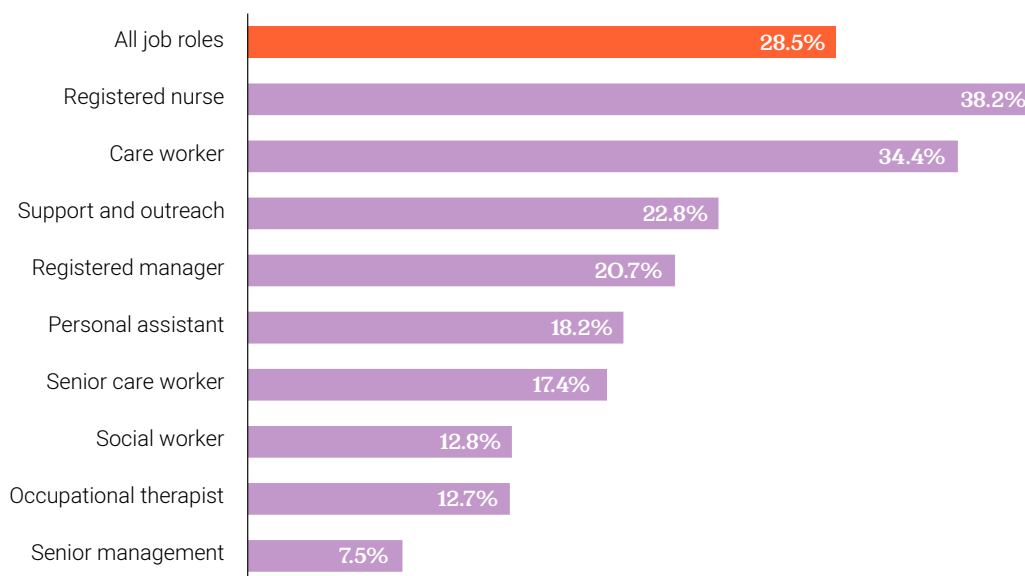


Source: Engage Britain; Vote occurred after the penultimate weekend to decide which seven issues (of 35) The People's Panel would discuss and prioritise on the final weekend. Ultimately health and care workforce and poor communication were prioritised to take forwards into co-design.

**Figure 6.2:** Turnover among English NHS HCHS Staff groups, September 2020 - September 2021

| Staff group | Turnover |
|---|---|
| All staff groups | 10.54% |
| HCHS Doctors | 14.3% |
| Midwives | 11.7% |
| Support to ST&T staff | 11.0% |
| Support to doctors, nurses & midwives | 10.6% |
| Scientific, therapeutic & technical staff | 10.5% |
| Nurses & health visitors | 10.0% |
| Central functions | 9.5% |
| Support to ambulance staff | 9.4% |
| Senior managers | 8.9% |
| Hotel, property & estates | 8.8% |
| Managers | 8.4% |
| Ambulance staff | 8.1% |
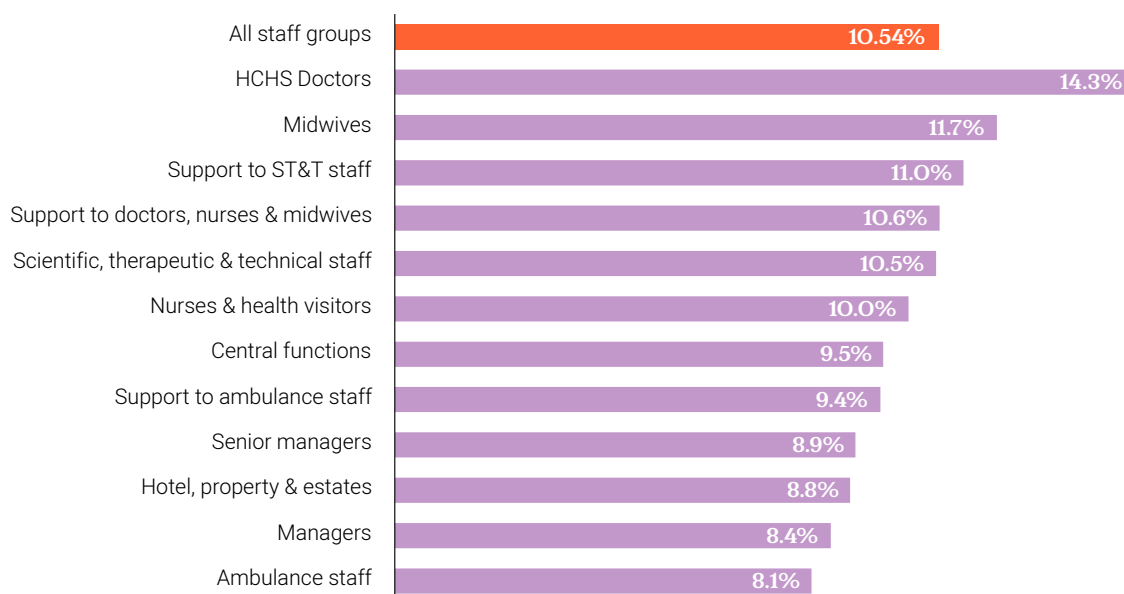
Source: NHS Digital, Workforce statistics, HCHS staff in NHS trusts and CCGs turnover tables, September 2021.

**Figure 6.3:** Estimated turnover among English adult social care staff groups, 2020-21

| Job role | Turnover |
|---|---|
| All job roles | 28.5% |
| Registered nurse | 38.2% |
| Care worker | 34.4% |
| Support and outreach | 22.8% |
| Registered manager | 20.7% |
| Personal assistant | 18.2% |
| Senior care worker | 17.4% |
| Social worker | 12.8% |
| Occupational therapist | 12.7% |
| Senior management | 7.5% |

Source: Skills for Care, The state of the adult social care sector and workforce in England 2021.

# About John Hall

John Hall is Director of Annapurna Strategy and a consultant for Engage Britain. His previous roles include Director of Strategy at the Department of Health, Director of Economics at the NHS Regulator (Monitor) and Deputy Director for Health and Care Spending in HM Treasury.

# About Engage Britain

Engage Britain is an independent charity, giving people a say on what matters most to them. We want to make our country stronger by taking on its problems together. Everyone should be a part of the country's big decisions. And we're finding answers to Britain's biggest problems by grounding them in what people live through every day.

We're bringing together people with different views, knowledge, and experiences from across our country. And helping them not just to debate but create the plans for change they want to see. Then we're working with them to make those changes happen. We're pulling people and those in power closer. And proving the public's practical, realistic solutions can benefit Britain.

That's how we make our country work for us all.

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