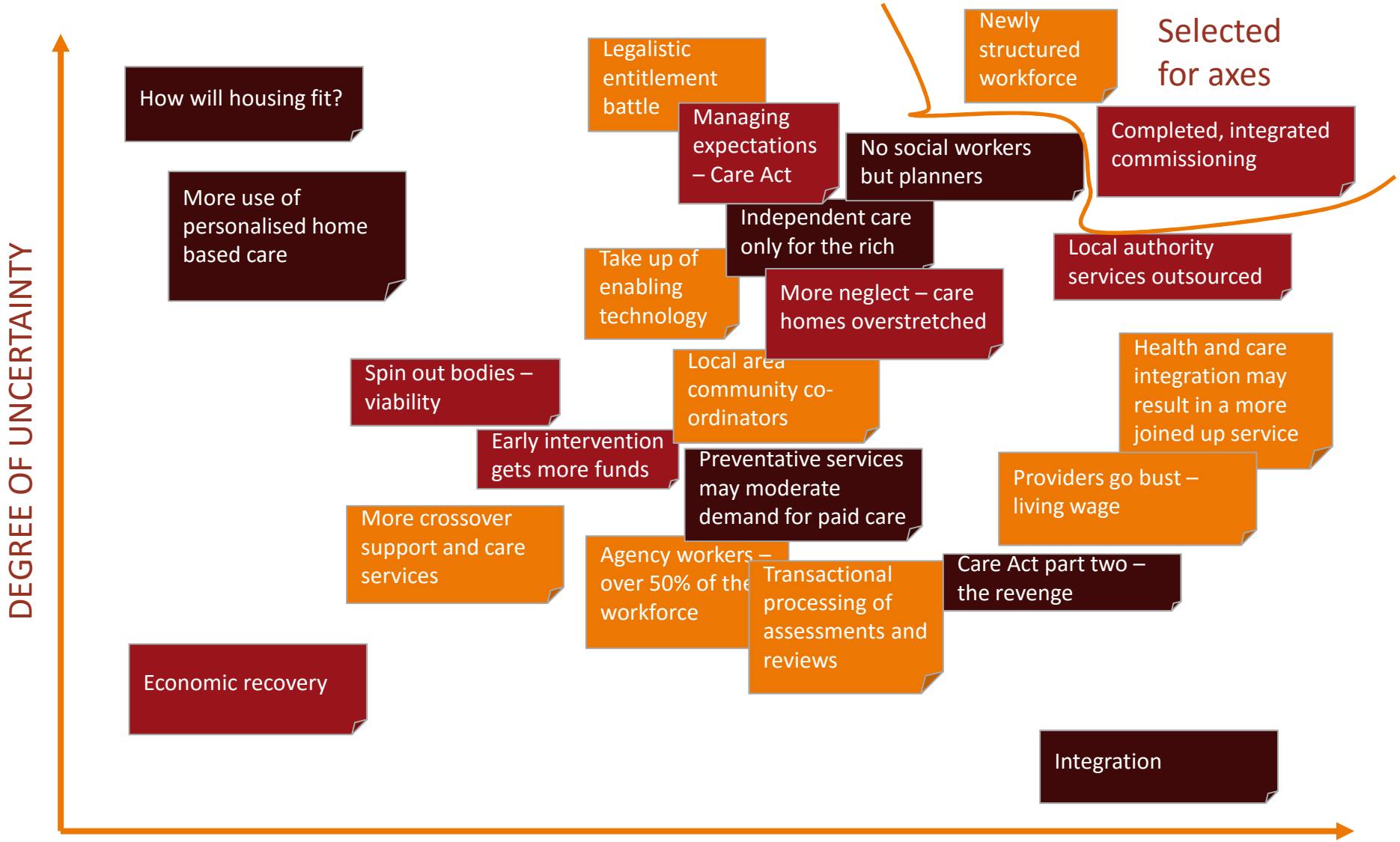
Scenario planning for the future of social care #socialcare2020 #NCASC15

A conversation with the future

So far, with delegates, we have:

- Identified the certainties facing social care in the year 2020
- Identified the uncertainties – the things that could go either way in the year 2020
- Organised these according to their level of uncertainty and potential impact
- Mapped out the axes for four scenarios
- **Next step – develop the scenarios!**

Uncertainties for #socialcare2020 – prioritised



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Explaining the two axes

- X axis: level of success of integration
  - Still only symbolic / partial / specialist areas – lip-service to integration but in reality practising in silos
  - Completely integrated commissioning and shared budgets, including significant relevant elements of housing and support services
- Y axis: structure of social care workforce
  - Still as present – massive turnover and retention and recruitment problems, very high level of temporary and interim staff
  - Structured workforce including commissioned services at four levels:
    1. Core highly-paid and highly-trained retained staff (including across some key partners) for complex and strategic decisions: **permanent employment**
    2. Large pool of structurally managed **flexible workforce** (category managed including significant work with agencies)
    3. **Commissioned** services including a significant amount of transactional work, probably outsourced on partly by-results basis
    4. **Community provided** and managed services

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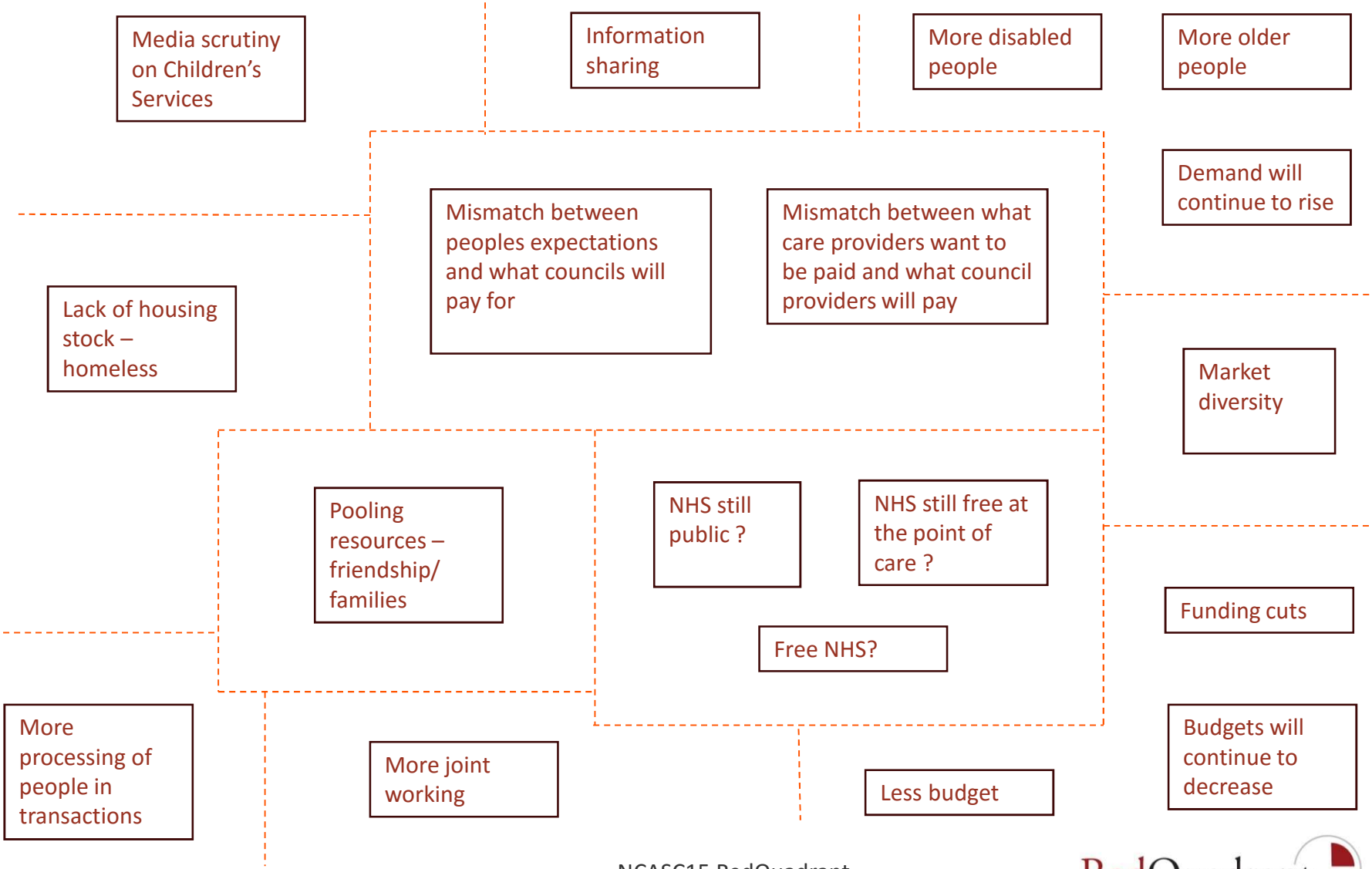
Both scenarios face all these **certainties**



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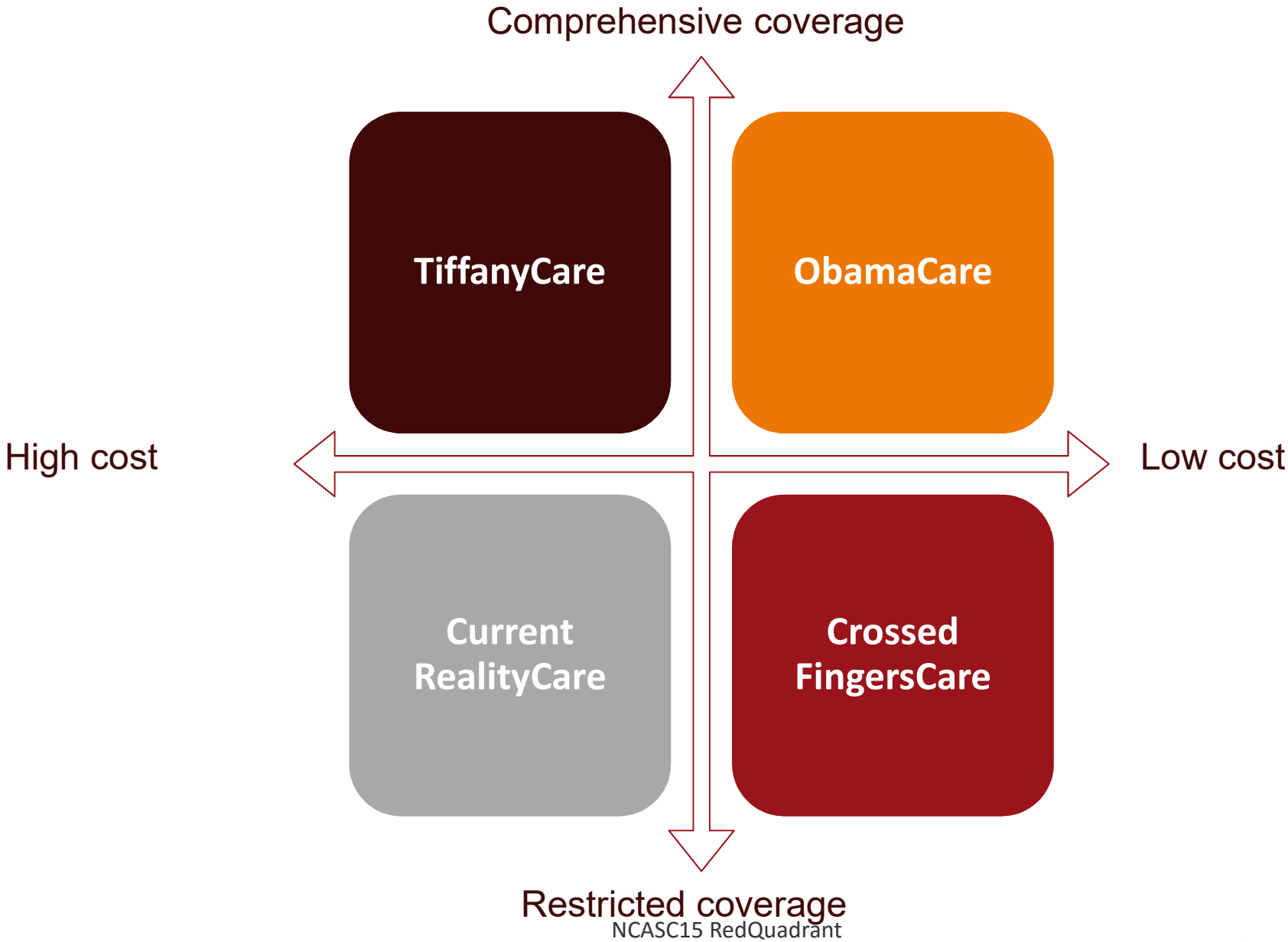
Example scenario axes – United States health care



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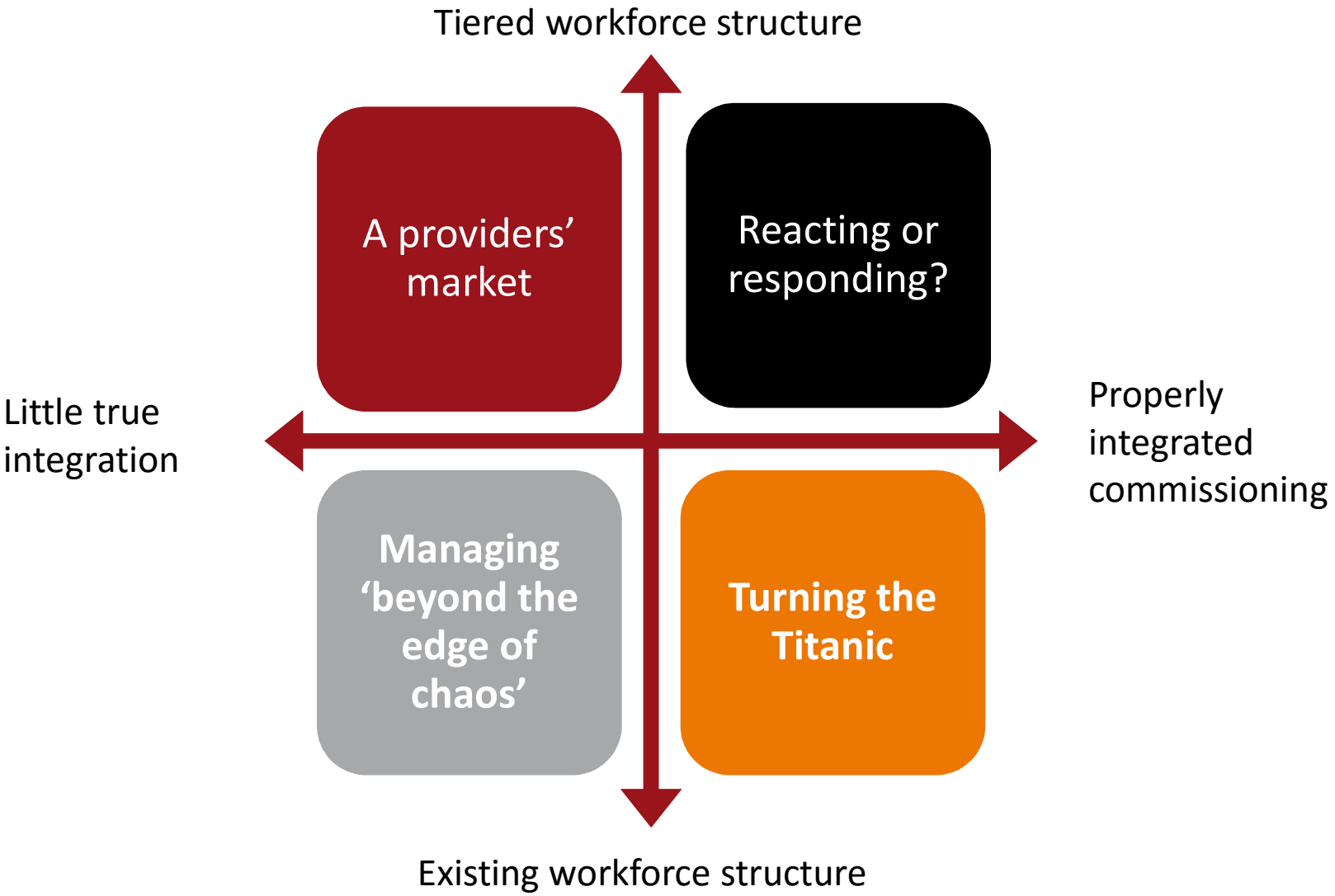
Scenario plot based on axes



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Managing ‘beyond the edge of chaos’

- It’s 2020, and we’ve just launched our twelfth initiative to reduce agency spend. It feels now that the agency people we push out will be leaving the workforce and not necessarily coming back. Agencies, meanwhile, are significant players wielding real power in the market. 2020 is the first year where the headline and drinks sponsor of the NCASC conference are both agencies.
- Meanwhile, we can’t handle the demand. We still value the power of early intervention and prevention – but it’s lip service really – people are trying to do prevention, but ultimately it’s about shunting people or bad, barrier-raising ‘demand management’. A huge amount of bureaucratic energy is going into fighting to keep people on the other side of the line – proving their need falls to other organisations. As a result, we’re incredibly reactive and can’t plan budget as a number of intra-care court cases could see massive costs swing either way. There’s still no really good evidence base on prevention.
- An increasing number of entities are unable to meet their statutory duties, particularly on the social care side. We’re seeing an increasing amount of emergency provision around really serious needs and continually going cap in hand to seek money for ‘in year pressures’. Often, we get nothing – so it’s back to crisis management for another year.
- The reserves are empty and we are righting for a limited number of people willing to be permanent employees. Richer authorities have a better chance of survival but especially in non-metropolitan areas and for counties, the pressures seem unmanageable.
- Perhaps even worse, our continued fights to introduce integration and systems leadership are beginning to tarnish those ‘brands’ and there’s an increasing vocal ‘stick to your silos’ movement both outside and within care. Care co-ordination is a relatively well resourced part of the system but consistently failing to deliver.
- A number of care/health partnerships were set up in the hope of being financially ‘rescued’, only to find the partner was also in financial difficulty.
- Domiciliary care is at a bare minimum and really insufficient, and residential care is being shut down as quickly as we can do it.
- We do as little analysis of outcomes as possible – it’s too depressing and we can’t change anything anyway.

Scenario 1: little true integration and traditional workforce(s)

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A providers' market

- We still have problems with disintegrated system but it's two sets of chaos. It's silo'd; we live in a world in 2020 where nobody really has the economies of scale to manage the four tiers of the workforce successfully. But also there is no, or limited, prevention or intervention, there is more demand coming in that the council can't handle, and we are looking at more outsourcing of the transactional element of the work.
- Commissioning and contract management are really complex. The advantages are that we don't spend a lot of time handling quality and delivery issues unless things go wrong. The agencies are relatively effective and are providing staff development we can only envy – or jump across and get for ourselves. They know it, too, and continue to charge a premium price, particularly for 'payment by rewards' review and assessment. They have sophisticated machine-learning supported systems that they want to sell us – but we can't afford.
- Given the reductions in budgets, we are looking more and more to cut back only to statutory duties. Demand is increasing in both the health and care elements. Residential, support, and domiciliary care are all at bare minimums.
- The NHS has achieved a relatively fully integrated workforce by retaining and even increasing a lot of central planning and direction, which means that more people get shunted out of healthcare and into social care, and though the NHS is also partly crippled by the cost of agency staff, the model works well for them.
- Large providers are frustrated because they think they can offer better joined up solutions, but they can never make headway against multiple teams of commissioners and care co-ordinators most careful not to take on any additional responsibilities and costs to their part of the system.
- It feels like our system is functioning – barely – but everything is a stopgap.

Scenario 2: little true integration, tiered workforce structure

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Turning the Titanic

- Money, money, money. We finally got our budgets and commissioning together, just at the moment when it was no longer enough.
- There's no flex in the system to do the prevention we know we really need, so we have integration without prevention – we're seamlessly doing the wrong thing. A few pathfinder areas have carried out pilots and got some *really* good evidence on early intervention, so we all have an idea of what we *should* be doing – we just never quite seem able to get there!
- We are putting all our money into integration but don't have the staff to deal with current demand, so most of our effort goes into firefighting.
- And on a bigger scale, we're closing residential care and reducing universal services and we know that we aren't really able to put the replacement services properly into place. We are avoiding the biggest mistakes which would lead to escalation of need… but not all of them!
- That firefighting, fortunately, no longer includes arguing over the cost of care, which helps, but the cultures and approaches of individual units haven't really changed as much as we would have liked.
- There's a huge boom in systems leadership training and work as people try to deal with complexity, and commissioning has become one of the most respected and well paid roles because we can see the systems aspirations rely on them.
- So the question is, now our powerful and well-trained commissioners have got their arms around the whole system, are their brains big enough to find a way to change the course of the Titanic, **after** we've been holed by the iceberg?

Scenario three: properly integrated commissioning, traditional workforce

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Reacting or responding?

- It feels like, for the first time, we're close to a fully integrated system. Not all the models are fully working but we know where we are going – and we have leaders and partners that are close to full agreement on how to run as a whole systems.
- We are facing real challenges making the changes this requires – and, of course, introducing proven prevention at the same time as dealing with existing demand often feels impossible. There are challenges with staff shortages and areas where integration is planned but still on the to-do list.
- But it does feel that we're able to more or less deal with the peaks and troughs of demand coming in, in a system with a genuine intent to focus on moderating that demand – making sure the demand coming in is reduced or predictable.
- From the point of view of the citizen, the experience is really getting joined up. We're just the local public sector and people know where to go and what they'll get. We have definitely banked the savings from not having people go from pillar to post in the system and the big impact there was reducing the number of different assessments.
- Resources are allocated to where the need is most without the silo thinking and without too much grinding of gears. We are really working on maximising the amount of appropriate informal care provided. We are providing less care needed in general but it is proving far more effective.
- We have a fully integrated workforce – NHS from mental to community health to even acute working in an integrated and commissioned manner with local authorities in a seamless manner where patients do not know the differences.
- Sometimes it feels like we're still just reacting to legislation and demographic pressures, but *sometimes* it feels like we're managing a deliberate, planned response.

Scenario for: integrated commissioning, tiered workforce

Do you like the names for our scenarios?

Do they ring true?

Come to stand BL24 (upstairs in the speakers' corner area) to vote on:

- The most likely scenario
- The worst scenario
- The best scenario
- The three things we can do to avoid the worst
- One thing we can do to encourage the best!

WHAT NEXT?

We believe in conversations

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