CAPITA

Four futures for health and social care integration

2015

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Why this paper?

Over the next few years, the (potential) integration of health and social care for relevant groups such as the elderly and others with shared needs, is perhaps the greatest system leadership challenge we face in the UK.

The doyen of systems thinking, Peter Senge, coined the term 'wicked' to describe issues that have high technical complexity (he called it 'analytical complexity') ***and*** high human complexity. The integration of health and social care is a 'wicked' problem in that it has significant technical complexity as well as prodigious human complexity.

Complexities in the integration of health and social care

Technical complexity comes from the fact that there are many possible interventions – and the evidence base for which works best is still evolving – and, of course, for many individuals there will be a range of interventions, not just one. Moreover, there is the administrative-technical issue of who pays and who benefits from joined-up interventions.

Human complexity comes from the range of individuals involved: professionals who have both a justifiably proud loyalty to their particular profession and a particular ethos; carers who might be less informed, but are highly motivated; and, of course, there is the individual who has primacy of legitimacy, but whose very condition may undermine their ability to exercise it, which therefore brings in various formal legally-sanctioned participants.

To those areas of complexity envisaged by Senge we would add a third dimension, political complexity. The integration of health and social care also possesses high political complexity, which sets the context in which the human and technical issues play out. In the political complexity mix are the role of the state; the balance of local versus central control; the extent to which particular services should be free at the point of need and those that should be means tested; the changing role of the community and family; and, indeed, an economic aspect, with potentially productive people taking themselves out of the labour market to provide care.

How do we approach a problem that is more than 'wicked'?

So it seems we have an 'uber-wicked' problem. How do we begin to tackle this and develop a shared language with which to help us make sense of it, and chart a course? One technique frequently deployed to structure complexity in the private sector, but which is used less often in the public sector, is scenario analysis. A rigorous scenario analysis process is not an attempt to predict the future, or to describe what we would ***want*** to happen, rather it is a structured process for articulating uncertainty and for following the logic of potential futures to a remorseless conclusion.

In this paper, we're applying scenario analysis to the future of health and social care.

The particular technique of scenario analysis deployed here:

- considers two dimensions of uncertainty about what the future may bring over a long time frame – and definitely more than one parliament – say, ten years
- uses these as axes for a chart that maps a landscape for the future, as each area of uncertainty ranges from one end to the other
- describes the highly extreme worlds at each corner of the chart, and uses these as deliberate provocations to facilitate debate.

So how will scenario planning look for health and social care integration (HSCI)?

Two dimensions of uncertainty for HSCI

There are many dimensions of uncertainty, and some of them aren't considered in this exercise, other than incidentally. For example, the scope for disruptive technologies (powered exoskeletons? dementia vaccines?); or significant demographic change (major shifts in in/out-migration following EU withdrawal?); or major changes in societal norms (a 'blitz spirit' uniting the country against a compelling threat?). Moreover we don't consider the impact of a sudden reversal in financial fortunes for the sector – we assume that things stay pretty tight.

So what uncertainties *do* we in fact consider? We think there are two here:

1. Whether health and social care will be highly ***centrally*** directed or whether they will be directed ***locally***.2

2. Whether provision will occur along ***service or professional*** lines, or whether it will be ***user-centred***.

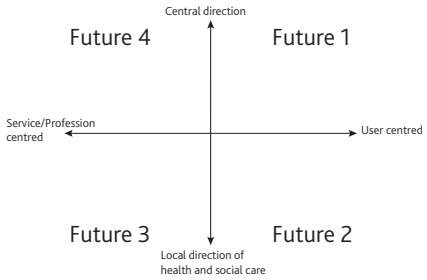
Central versus local direction

The prevailing sense currently is that the direction of travel is *away* from the centre, driven by an orthodoxy of devolution for local choices and a sense that some knotty problems are best dealt with at a more local level. However, it is unclear just *how* local it can or will go (combined authority, local authority, area, neighbourhood?) and, if we are taking a long-term perspective, then it is not inconceivable that pockets of crisis or a concern about postcode lotteries could lead to a centralising tendency when 'something must be done – and done now'.

Service/professional versus user-centred

The professions and their associated cultures are very powerful, they are funded differently, and they are held in different levels of esteem by the public. There are thus powerful forces which would tend to keep service provision in specialised 'siloes'. But, counter to this, there are: moves towards personalisation; a desire by many to take a more holistic approach to user/patient/client/resident care; the residual elements of the Care Act; an asset-based view which looks to individuals and their support networks as a resource for that individual; a growing focus on outcomes for the individual; and, not least, a societal shift to technology-mediated autonomy. By technology-mediated autonomy we mean, to use an analogy, that we're increasingly less likely to simply place ourselves in the hands of a travel agent for our holidays. Instead we research our options – eg, on Tripadvisor – manage our own choices and trade-offs (a nicer flight but cheaper hotel for example), and share our own user experiences for the guidance of others. The advent of 'digital,' offers us myriad new possibilities.

The landscape for our scenarios



The diagram to the left shows the landscape over which these scenarios will range, and the four extreme scenarios at each of the corners.

On the next pages we take each scenario and:

- tell a 'plausible story' about how we could (in principle) end up at that corner – there might be other ways of getting there, and you may think it is unlikely, but a story helps to make the scenario 'real'

- think about what it would mean.

Before we begin, a reminder about the ground rules here: these are *not* predictions about what we think *will* happen, nor necessarily what we *want* to happen. If we don't like an outcome then we can discuss how to avoid it coming about, or how we could manage it as well as possible, but these are simply 'stories to think with', no more than that.

Future 1 – Central direction and user-centred

Looking back from 2025, how did we end up here?

The ten years from 2015 saw a number of themes playing out. Scandals of a similar scale and gravity to the child social care scandals started to emerge in adult social care too. And, as some social services began to fail due to lack of funds, the postcode-lottery nature of care became a major political issue, especially when contrasted with the (relative) continuity of service provision from the NHS. As a result, social care services were increasingly moved into the NHS – the ageing population demanded it, and the febrile nature of a decade of complex political deals and marginal governments meant that powerful voting blocs got what they wanted.

This only increased the cultural challenges of what become an even more unwieldy and profession-driven structure and the management of complexity became a huge concern. What resolved this issue in the end was the success of the early trials in personal health budgets, started by the NHS England chief executive soon after he took over running the NHS in 2014. As with personal social care budgets earlier, personal health budgets were very effective. The vast majority of individuals were able to manage their total care needs or gain support from family or others, using a plethora of web portals and support mechanisms which arose to fill the gap. Additionally, the decline in resources meant that top-up payments and self-funding became more important and this nested well with personalisation and the direction of travel for universal credit and housing benefit.

Socially, individualism became more significant, with these personal budgets giving more power to people – for good or ill – in the same way as the option to cash

in pensions did, for example. A lack of local safety nets makes regulation of provision, and national minimum standards, very important. In 2025, individuals with health and care (and housing) needs are assessed against nationally-set standards, and allocated resources, often on a means-tested basis, which they then augment with their own money in order to access the health and social care that they choose.

For shorthand we will label this future ***'Regulated Consumerism'.***

What does this mean for various stakeholders?

In this world **users and carers** are the 'sense-makers' in the system and they have significant personal autonomy ('Tripadvisor rather than travel agent'). But it leaves a problem to be resolved for those who are unable to cope. **Communities** may be one source of help in some localities, as may the **third sector** or the **central or local state**.

For **professionals** and **providers** the challenge is one of responding as suppliers and participants in a retail market where they are funded as the result of individual choices and held accountable partly by market feedback. **Commissioners'** key role is as market shapers and makers, helping to address any market failure, and ensuring that there is some form of support for those who cannot help themselves.

Regulators are key in this future, enforcing and reporting on minimum standards to mitigate the risk of a lack of local safety nets and to provide professionally-assessed information to the market. But in the latter respect, regulators will be judged on the value that they add to the user-voice market feedback, and they will need to respond to that.

For **system leaders nationally** there will be the challenge of creating joined-up policy and interventions through quite broad tools of criteria for assessments, and regulation, which will then play out in quite a busy marketplace. For **system leaders locally,** the challenge will be in delivering a market of provision and/or providing services that are consumer-responsive in ways that may be culturally challenging.

Future 2 – Locally directed and user-centred

Looking back from 2025, how did we end up here?

The devolutionary drive that began during the first coalition government of the 21st century continued through the 'age of the smaller state'. Local government's success in making cuts, and the importance of the local political mandate in making difficult decisions, meant that it was easy for the Treasury to justify further devolution of services, especially after the clear successes in Greater Manchester and Scotland in the late 2010s. Local government had developed a new set of tools that it had found enabled it to make acceptable cost savings – through evidence-based, user-centred service change, and a focus on helping expensive cohorts to reduce system costs as a whole. It deployed those tools to health as well, and the local system is now very effective at addressing people's individual needs – no less and certainly no more.

Convergence of professional training and gradually-earned professional respect and demystification meant that we saw more practices with GPs and spun-out social work practices co-located – and eventually merged. We saw an enlightened attitude to whole, person-centred approaches, including engagement with housing providers. This more integrated approach led to more preventative interventions.

But there had to be a trade off as people realised they couldn't have everything and tough choices had to be made. As public health become ever more embedded in local government it became more politicised too – local choices for health priorities became more and more relevant, which actually helped to re-energise local democratic engagement. Some hospital wards – and even whole hospitals – were closed (local authorities had got quite good at 'de-commissioning'). In 2025 this does mean that there are some parts of the country where it is better to have certain illnesses than others but, by and large, people have come to accept this in the way that, back in 2015, people didn't really challenge other local public service inequalities. Key to this is the fact that they are – and feel that they are – driving what happens. The 'lottery' part of 'postcode lottery' makes it seem random, but in this scenario people don't feel that it is random, they feel in control.

For short we will label this future ***'Me in My Place'.***

What does this mean for various stakeholders?

In this world the 'sense-maker' is the **local authority**, working with local partners as **commissioners**. It is perhaps a simpler world for **users and carers** than our Future 1 because the support is integrated and joined up, based on local circumstances, for the individuals. In some places that may include an element of choice but in others it may not – this will be a local design choice, not a national one.

Communities have a key role as being the place where democratic discussions about relative priorities play out, and some of the **regulator** function will be in the form of local 'scrutiny' type arrangements. There may also be some national thematic regulation but the existence of legitimised different standards in different localities will make national regulation quite nuanced. There will be opportunities for communities to put forward their own solutions in areas where local politicians and professionals take an asset-based view of working with citizens.

Providers need to be able to adapt on a localised basis in response to the different needs articulated by the commissioners, and will also face the challenge of integrating across services siloes themselves.

There are huge challenges for **professionals,** and their professional bodies, in bringing this world about, with significant changes to practice, training, multi-skilling, cross-accreditation and more – in fact, this is *the* major **national system leader** challenge. The **local system leader challenge** is all about operational integration to a clear and relevant local narrative, and developing information and policy frameworks capable of handling the decisions required.

Future 3 – Locally directed and service/profession centred

Looking back from 2025, how did we end up here?

"But I'm only the Leader of the Council, it's not as if I'm the Chair of the Health and Wellbeing Board…" – that quote to the public accounts committee was probably the moment that, for many, represented just how far we had come. The trend – through the Better Care Fund and other integrative initiatives administered locally by the HWBs and gradually controlling, actively , more and more of the local public service economy – continued, and more and more funding streams got drawn in to the purview of the Health and Wellbeing Board.

However, no one ever really got to trust local politicians with direct control of health money. The professionals learned how to work together with grudging respect, but there was no real integration, in much the same way that planners, social workers and teachers had 'kind of got along' when they all worked for a council, but never really united around outcomes. Fears of litigation abounded, and limited, the amount of multi-skilling that took place. Various workarounds were put in place around information-sharing – and while nobody thought the solutions were particularly elegant, they did, actually, work well enough. The occasional examples of closer integration either died when key people moved on, or proved not to be transferrable to other places. Moreover, experiments with giving people control over combined budgets led to many instances where poor outcomes were achieved – the causality and timescales required were too complex for relatively uninformed individual choice.

By and large, here in 2025, most people are able to find their way around the professional siloes of health, social care and housing. The rhetoric and reality of the smaller state has detuned people's expectations and they've decided that they don't actually want to pay for anything better. Pragmatically, the HWB provides signposting and support help to those cohorts of people with multiple complex needs where there's a business case to do so.

The politicisation of local health spending decisions has led to an increasing need for local control, with all levels of provision – apart from the very highly specialist – gradually moving to a local council level through the local commissioning board, the HWB. This has been helped by the inevitable mergers between authorities, which have created units of local accountability that better fit with health service economies of scale anyway.

We will label this future ***'Local Drift'.***

What does this mean for various stakeholders?

The key 'sense-maker' of the system in this world is the **Health and Wellbeing Board as it has evolved by 2025.** While it is driven by the council, which provides that element of democratic input, there are also other professional voices influencing the local commissioning. There is scope for involvement by local **communities,** but only if the HWB/ commissioners let them in.

For **users and carers** there is the challenge of working across a disparate system, though this may be mitigated a little for those with the most complex needs, due to local commissioners having an incentive to save money through interventions joining things up for those individuals – eg, an intermediary or adviser to work the system on their behalf.

Providers are likely to remain organised around service lines, but will need to adapt to local circumstances. Providers who can offer joined-up solutions will be welcomed if they can devise procurement ways of accessing the multiple funding streams.

For **regulators**, while they can benefit from the relative simplicity of being able to regulate individual services/professions, they will need to adapt to regulating in a context of no national standards, 'though there may still be nationally-imposed *minimum* standards. Regulators *could* play a value-adding role in this world by offering nationally benchmarked assessment to aid local commissioners.

The **system leadership** challenge here is very local, and is about governance and commissioning across a number of independent strands, ensuring appropriate information and *relationships* exist to facilitate this.

Future 4 – Centrally directed and service/profession-centred

Looking back from 2025, how did we end up here?

All the signs were there back in 2015 – and earlier. The resources available for social care – especially adult social care – simply reduced and reduced. Councils got better and better at ensuring that their service

users were accessing every possible national source of support, helping them to apply for benefits to which they were entitled, and so nationally-sourced benefits became an ever-more important part of the mix.

For central government, rather than addressing issues through more council funding, it became easier (and felt more targeted) for successive administrations to keep the hard cases out of the headlines through the benefits system, offering top-up payments to those in need through tax credits, means-tested benefits or nationally assessed schemes. Moreover, by having control over all of the purse strings it was easier for central government to move money around based on policy priority changes. The newly created Department for Work, Pensions and Social Care is a large government department with a very different ethos to that of the Department for Health. In some cases, having a qualifying claim for support means receiving some form of financial benefit to access services from a market, in other cases it means receiving a nationally commissioned service, locally delivered.

The difference between the 'benefits' mentality and the 'universal service' provision of health exacerbated the difficulties of bringing the professions more closely together, and the user experience of these services is quite different in 2025. Self-funding for social care has become significantly more important and we are at last seeing signs of people making provision for future care needs as a result. Social care now is a little like housing was back in 2015 – relatively limited state-provided (social housing), and means-tested benefits helping people access private provision (private rental). In this analogy the role of the housing association is taken up by social care spin-out organisations that have managed to achieve independent viability as alternatives to the private market and which are no longer state controlled. Such organisations do exist in 2025 but they are operating in a much less certain world (and without the asset base and revenue certainty enjoyed by housing associations).

Public spending savings have largely come from reducing social care funding, rather than from preventative investment and the joining up of services.

It suits many of the national lobbying groups and charities to be able to campaign for changes at a national level, and they can be very successful in drawing attention to specialist needs which may not have a voice in a more localised situation.

For short we will label this future ***'Care as a Benefit'.***

What does this mean for various stakeholders?

The 'sense-maker' in this world – by default – is the **individual and their carer/family** and is quite polarised between self-funders on one hand and 'claimants' on the other. Despite the central control, the experience on the ground may be quite different depending on the level of provision in different areas and the range of provider options. Some **communities** will be willing and able to support people in navigating the system, and some may be able to offer top-up care, but this will vary widely.

Providers may find more scope for nationally-let contracts, and national frameworks, and **regulators** will be able to work to national arrangements too.

Health commissioners proceed as now, influencing whatever joining up they can, but **social care commissioning** becomes more akin to determining benefits policy and operationalising assessment and means testing. The **social care profession** on the assessment side becomes more akin to benefits assessment than 'care package provision' and this would be a significant cultural change.

System leadership is very difficult in this world – it becomes a very deep policy question nationally, and individual local 'civic entrepreneurs' may occasionally be able to achieve system results.

In conclusion (for now)

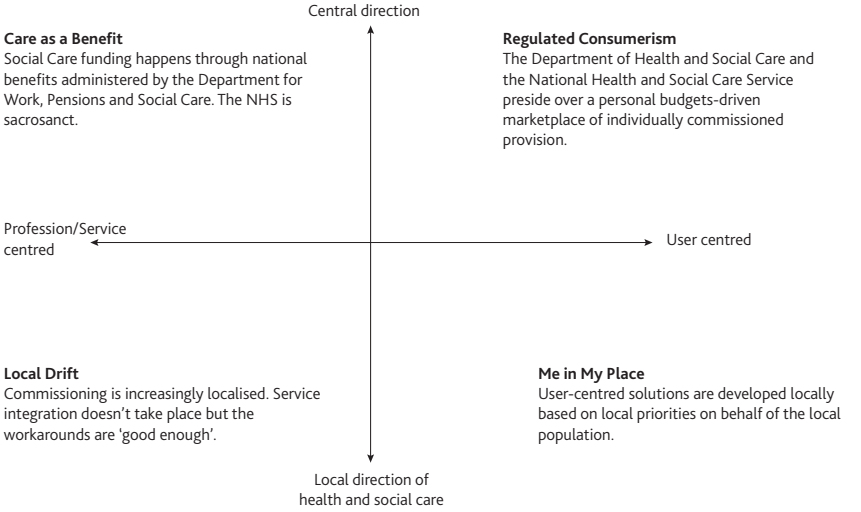
We remind you that the ground rules of this exercise are that we are not predicting the future – these futures (summarised in the diagram below) are not necessarily what we think will certainly happen, nor do we necessarily find them desirable.

None of these futures is likely to play out to the deliberately extreme extent to which they are described. However, unless we remain exactly where we are now we will tend towards some of these futures more than others, and this thinking helps us to get ready. We may find a blend of these futures emerging – within the UK we may find different models in the different nations – and we may find that there is a default national picture that strong local areas are able to become exempt from, to do their own thing.

However, the nature of scenario analysis is not to make firm conclusions – that defeats the point. The purpose of this paper is to provide a framework for discussion, and for relevant leaders – whether they be commissioners, providers, regulators, local or national politicians – to consider how the world in which they must lead may change over the next ten years.

Many leaders will simply have to react to how the complex political, economic, social and technological forces play out, and these scenarios will help them to understand the range of possibilities that they may need to deal with.

Other leaders will be in a position to influence the outcomes – will they agree about which of these outcomes is most preferable? Will they agree about means to achieve desirable outcomes? What will happen if they don't? This note aims to provoke that discussion.



Implications summary

Scenario/Stakeholder	Regulated Consumerism	Me in My Place	Local Drift	Care as a Benefit
Users/carers	Sense makers with huge personal autonomy	Recipients of locally determined service	Will have to work across a disparate system	Work across disparate system with a 'claimant' approach for social care
Communities	May assist those who find choice difficult	Engage in local democratic discussions about priorities	Will have a role if allowed in	May be able to help – if geared up to do so
Local authority		Sense-maker for the locality	Key support to HWB's policy and performance tracking	Marginalised role, sweeping up if possible; may be a provider
Health professionals	Challenge of responding as suppliers/participants in a competitive retail market	Changes to practice, training, multi-skilling, culture change …	Adapt to local direction of HWB but no staff integration challenge	Relatively little change
Care professionals				Profound change to ethos – either a supplier or a 'benefits assessor'
Commissioners	Market shaping	Work with LA	Proceed in siloes	Health largely unchanged; for social care is now about benefits policy
Providers	Retail providers to individuals	Different arrangements in different places – but need to join up to offer packages	Different arrangements in different places	May be scope for national or large scale regional contracts for care or assessment
Regulators	Providing information to individuals and enforcing minimum standards	Will be predominantly local 'scrutiny'	Can regulate siloes though must adapt to different local circumstances	Can work to national arrangements
National system leaders	Challenge to create join-up through individual choices and market mechanism	Will be driving cultural and practice change	Small role	Plays out in policy debates
Local system leaders	Have to make the market work locally	Will create a local, democratically-mandated narrative and drive implementation	Have to make governance and commissioning work across the siloes – relationships will be very important	Very hard to create system leadership locally – some may succeed

Jonathan Flowers, Local Government Market Director, Capita

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