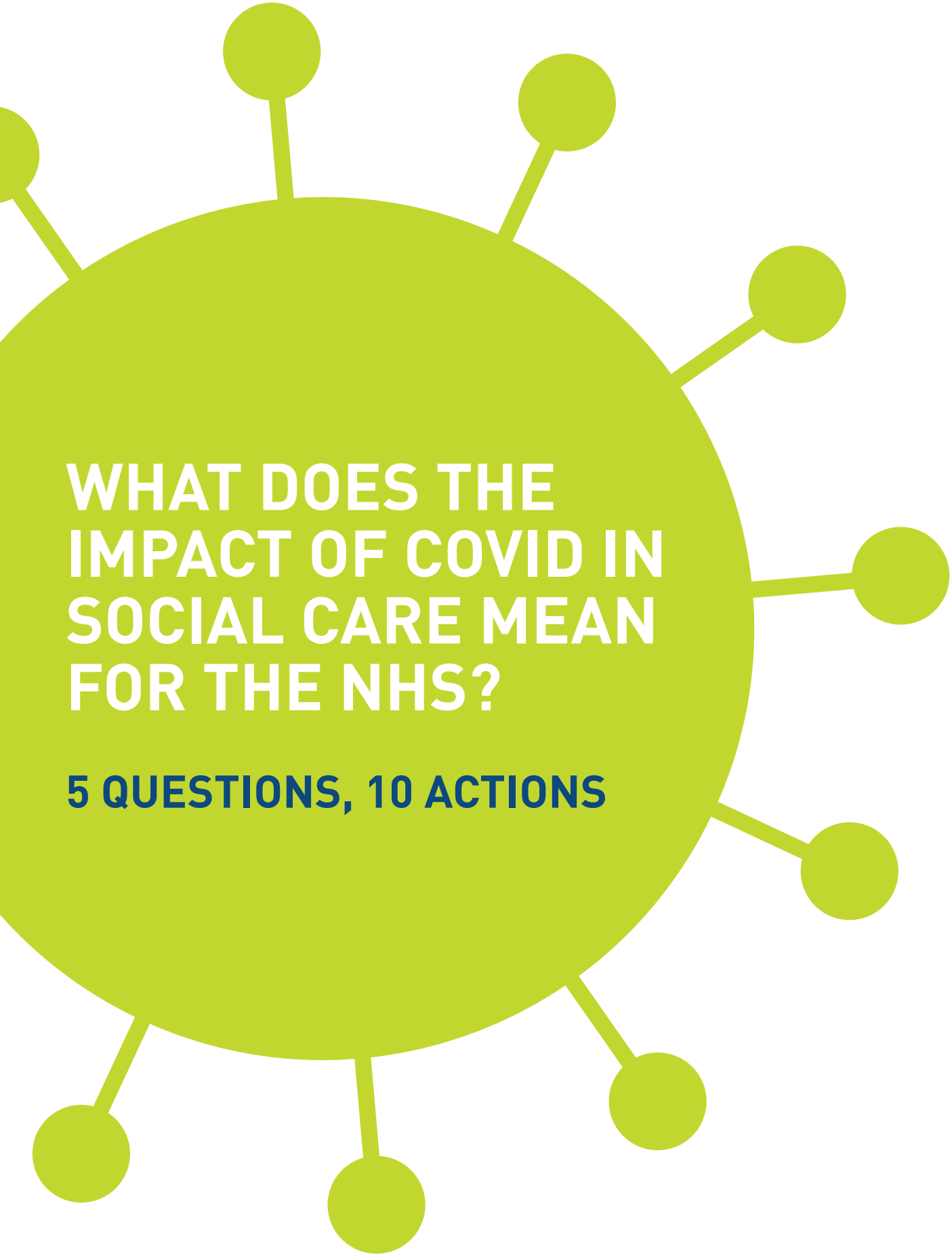

WHAT DOES THE IMPACT OF COVID IN SOCIAL CARE MEAN FOR THE NHS?

5 QUESTIONS, 10 ACTIONS

IMPOWER

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The national and local response to Covid across health and social care has been significant and will be felt for some time. The pandemic forced England's health and care systems to deliver change at a pace not experienced before and in a more localised way. Having navigated through the immediate crisis response, there is a real opportunity for leaders to build a new and better system through the next phase of recovery and future reform.

At IMPOWER, we have invested significant energy in thinking about the impact of Covid on the care sector. Through interviews with Directors of Adult Social Services we shaped five questions that, when answered, will set the direction for social care to bounce forward from the crisis.

For colleagues in the NHS and the health sector more generally, the future shape and funding of social care is part and parcel of how integrated care systems will work, how to lock in benefits, how flow across pathways will be supported, and how trusted relationships can be maintained and developed further.

We are still in a period of significant uncertainty, and leaders need to maintain a system operating model that manages change in demand while providing sufficient contingency to respond to spikes in Covid as well as the normal winter pressures.

This paper sets out what we think this will all mean for local health and care systems this winter and over the coming years.

WHAT WE HEARD FROM DIRECTORS OF ADULT SOCIAL SERVICES

Pressing Questions	Summary of responses
1 **Is structural integration more or less important than a national funding solution?**	Integration for integration's sake is not the answer. But it does offer solutions if done right ahead of a national funding solution. The unique power of adult social care is in its local understanding, innovation and community partnering. The top down 'command & control' culture of the NHS will likely continue to stifle local innovation and undermine connectivity with local communities. Many would argue that the sector risks losing this at its peril.
2 **What is the right balance between acute hospitals and local communities?**	There should be a focus on a new community health and care offer as a foundation for renewal. The future national strategy must not focus solely on the acute settings, but place greater emphasis on local social care and community organisations to lead any crisis response. Investing in these services now to create greater local resilience will be critical.
3 **Where is the radical ambition to re-shape the provider market?**	Social care will reshape its provider market. We need to know how this ties into a more vertically integrated health provider landscape. Although in the short term the sector needs to maintain market provision of care homes, there has never been a greater opportunity to fundamentally change the out-of-hospital model and shake up the provider market.
4 **How does this create a step change in the ways frontline staff work?**	By developing enabled, embedded, multidisciplinary work across pathways. Frontline professionals see the value of these new ways of working, both for the people they support and their personal work-life balance. We need to support this through digital tech and collegiate ways of working.
5 **Does this mark a paradigm shift in the value and importance of social care?**	It could but it will be highly localised. The brand of adult social care has changed for the better. The sector must be braver at holding the mirror up on performance. It must measure and evidence the value it provides. Measuring outcome productivity (outcomes achieved for money invested) is a good way to do this and will support the case for a funding settlement.

THE 10 ACTIONS THAT LEADERS IN THE NHS SHOULD CONSIDER IN LIGHT OF WHAT WE ARE HEARING

Q1 Is structural integration more or less important than a national funding solution?

Integration for integration's sake is not the answer. But it does offer solutions if done right, ahead of a national funding solution

Agreeing reallocated budgets within system financial envelopes is already a huge issue. Further integration will only exacerbate this. Legally, Directors of Adult Social Services cannot sign off a budget that ends in deficit, and the budget challenges are huge - for example, a £106m deficit[1] is forecast across the South West. This means that unless new arrangements can be agreed, there will be a system issue with quality provision, with outcomes or with funding. It will certainly be an ask for doing even more with even less.

ACTION 1: Assure the adult social care financial position is accurate in system models before the end of summer and reviewed through autumn.

System level envelopes need to understand the financial pressures on adult social care within local government. Leaders need to look at where money is flowing under block arrangements. Starting conversations around the real cost of service provision now and avoidable demand across health and care is crucial – cost shunting between any commissioners and providers is not part of the future. Further, experience from Covid suggests that community health and care services continue to be the poorer cousin to acute trusts. If there is to be a renewal of approach that focuses on independence, keeping people out of hospital and supporting them to live well in their communities, then we need a whole system view on whether we are willing to invest in this as a genuine alternative to hospital and how do we do this at scale. Not only does this require money – but a long-term commitment to support the infrastructure to deliver it.

ACTION 2: Ensure there is dedicated agenda time on key pressures for local government.

Listening to adult social care voices at ICS and shadow ICS boards will be key to driving collaboration and beneficial integration from the bottom up. Complexity means that achieving good outcomes will require thinking about how best to listen to local government in the coming period.

ACTION 3: Identify named neighbourhood change leads; encourage them to collate and share barriers to delivery.

Better place-based collaboration must be built into system operating plans. Structural integration alone will not drive better outcomes. From our experience, the real returns from integration come when culture is integrated and the monies support patient need. This is built from neighbourhood and place upwards and - done right - will represent good integration and be a sign of a maturing ICS. Agree neighbourhood plans and aggregate to an ICS level to hold onto truly local health and care needs.

Q2 What is the right balance between acute hospitals and local communities?

Supporting a shift to a new community health and care offer should be the foundation for system renewal

Provider collaborations have been strengthened through Covid. New community models of care have emerged in many places through effective trialling in the face of a crisis. Collating the benefits, evidence and evaluating these models of care offers an ability to build back better. But this does need to consider how social care works with different providers, including primary care and the private market, and needs to listen actively to local government's view of what community services could be. Staffing has also become a significant barrier to delivering change.

1 https://www.hsj.co.uk/finance-and-efficiency/100m-deficit-real-danger-to-stps-covid-recovery/7028002.article

ACTION 4: **Invest time in understanding the true baseline for local people plans.**

Many of the new models of community step-up and step-down care have been put in place at speed. Leaders rapidly need to understand where the system workforce is now operating, how they have been working, and what impact this is having on spend when compared to budget. In addition, leaders need to seek evidence of impact (length of stay, patient outcomes, etc) so the true returns of these models can be assessed and fed into planning.

ACTION 5: **Support health and care colleagues to undertake case reviews so that the Covid-related change to demand is evidenced.**

To build a new model of community-based out of hospital care, leaders also need to look at the new type of demands (co-morbidities, new mental health complications, etc) and ensure that they have a patient and customer voice forum to test all proposals.

Q3 Where is the radical ambition to re-shape the provider market?

Social care will reshape its provider market. We need to know how this ties into a more vertically integrated health provider landscape

Public and private providers have adapted quickly through Covid and national guidance. Working alongside our clients, IMPOWER has seen 20-30% increases in discharge to assess since March. The trend for vertical integration across health systems – with primary care, community care and mental health – we foresee continuing at pace, with block payments supporting this move in the short term. This will inevitably have a significant impact on social care provision – usually smaller, more spread out, and with a large degree of involvement from voluntary and community sector organisations. There is also the issue of growing instability in the care home market given the activity and financial pressures felt during Covid.

ACTION 6: **Ensure VCS representatives are present at discussions on the design of new models of care.**

While there is a need to bolster health services, building and empowering neighbourhoods and places to support the needs of the local population by providing infrastructure (resources, funding, support) and empowering them to shape their own provision will improve outcomes and reduce costs. The role of the voluntary sector in this will be crucial. Developing the relationships between health, care and places will be vital if people are to have trust and confidence in those services as alternatives to acute hospitals.

ACTION 7: **Work with public health colleagues to ensure delivery is based on behavioural science.**

Social care has focused on a home first model of supporting independence for a long time now. How patients, especially those with multiple long-term conditions, can be better supported to stay at home and self-manage is a key change. This will have a digital component, but we need to look at extending more behavioural change models to support self-management and risk reduction. This would follow the successes of approaches such as the National Diabetes Prevention Programme.

Q4 How does this create a step change in the ways frontline staff work?

By developing enabled, embedded, multidisciplinary work across pathways

The challenge is substantial. One of the real breakthroughs will be aligning local labour markets across health and care with system needs.

NHS leaders can learn a lot from the social care response to this – more teams in rapid assessment and discharge, for example. But to embed the returns from greater multidisciplinary working we believe there is a need to consider the following actions:

ACTION 8: **Set clear joint expectations of how colleagues will work and make decisions at an ICS level.**

This means a common understanding of roles, a common language that is neither 'health' nor 'social care', undertaking joint workforce planning for this winter and beyond, and building the management information and dashboards that will support seven day working patterns.

ACTION 9: **Understand what is working, and what could work even better by having a named evidence lead.**

From our work, we know that 45-55% of frontline workers reported that they could have done their job better if they had the right technology. Ask, test and iterate to build back better for the patient. The step change in how GPs, outpatient appointments and multi-disciplinary team sessions have moved digitally has been covered extensively. Holding onto this benefit in future system operating models is critical.

Q5 Does this mark a paradigm shift in the value and importance of social care?

It could work but it will be highly localised

There will be a health and social care dividend after Covid. It is likely that this will be both financial and social. The social contract – the debt and value we place on the NHS and social care – will be higher than ever. To get the most impact from this, and crucially set population behavioural assumptions, we need to:

ACTION 10: **Build a bottom-up change plan, not a top-down one.**

Focus on neighbourhoods and places. While this was a global pandemic, it is felt acutely community by community. A high functioning and effective system in the future will be made of many close-knit but purposefully different health and care neighbourhoods and then places. Getting this right is more art than science – it needs to be built on common foundations and evidenced best practice, but over that the deep understanding of people's needs must be addressed. From a system point of view, this feels like a leap of faith – top-down is easier to control and manage – but a view that enables bottom-up growth is the future.

CHECKLIST

Understanding what keeps Directors of Adult Social Services up at night and how systems can support their concerns is critical to success through this winter and into the future ways of making integrated care systems work for their populations.

Use this quick checklist to assess your readiness around an inclusive agenda:

Action setting	Yes	No
Is there a clear plan for how the issues facing social care will be managed in your ICS / shadow ICS, and joined up with pressures and changes in the NHS?		
Have the lessons and evidence of impact for what has worked well, and what would have been 'even better if' been captured and shared?		
Has a future inclusive ambition been set and does this drive the new system operating model?		
Have financial settlements and whole system operating models been set-up for future success?		
Are the enablers and tools to support performance and commissioning (such as whole system flow models, joint workforce plans and aligned local digital roadmaps) in place?		
Do you feel close enough to the vision for social care, their challenges and how it works now?		

If you've answered 'no' to any of these questions, contact us to find out how we could help.

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ABOUT IMPOWER

IMPOWER is an award-winning independent consultancy focussed exclusively on improving public services. Since 2000, we have developed innovative solutions with our clients in local government and health, helping them to deliver better public services that are more effective, more affordable and sustainable.

Working in partnership with teams in the NHS and across local government, we have defined, identified and delivered better outcomes for neighbourhoods, places and systems. IMPOWER's unique EDGEWORK® approach enables our partners to understand and navigate complex systems.

What we do

We work in partnership with an inclusive ambition across health and care at many different levels:

- **Intermediate care services which respond to individual needs, prevent hospital admission and support discharge**
- **Managing avoidable demand and designing new models of care**
- **Neighbourhood, place, and system models which proactively support people to live independently in their own homes**

We are a recognised supplier to the Crown Commercial Service (CCS) on the Health Systems Support Framework (HSSF) and the Management Consultancy Framework for Health and Community.

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