A northern view to 2035: factors affecting the health, social care and public health workforces

Horizon scanning cluster workshop report

February 2014

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Acknowledgements

This horizon scanning workshop was held in partnership between the Centre for Workforce Intelligence, Health Education England, Health Education Yorkshire and Humber, Health Education North West and Health Education North East. Our thanks are due to colleagues who took part.
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1. Introduction

1.1 Background

The decisions we make today about skill mix, training places and operational models will all impact on whether the health, social care and public health workforces of the future are able to manage the key challenges of our changing society - particularly the rapidly ageing population coping with multiple long-term conditions. Strategic workforce planning is central to ensuring the system can meet these needs by reconfiguring the workforce to deliver better health and social care outcomes in the future.

As committees of Health Education England (HEE), the local education and training boards (LETBs) have a responsibility to support healthcare providers and clinicians in their regions to take greater responsibility for planning and commissioning education and training.

The CfWI supports long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis. Horizon scanning is the exploration of potential challenges, opportunities, and likely future developments. The CfWI’s horizon scanning vision is to generate high quality intelligence to inform long-range workforce planning that meets the needs of patients and people who use these services.

In order to support the ongoing development of their workforce strategies the three Northern LETBs – Health Education North West, Health Education North East and Health Education Yorkshire and the Humber - approached the CfWI to work in partnership with them to deliver a horizon scanning workshop. The workshop provided an opportunity to bring together selected stakeholders as a collective to explore the key factors affecting the health, social care and public health workforces over the next 20 years – and in particular, those most pertinent to the north of England. This report summarises the clustered factors identified at this workshop which will support the Northern LETBs in further developing their workforce strategies. It will also help to further inform the national work of the CfWI.

1.2 Overview of the day

The workshop took place on Wednesday 5 February 2014 at The Metropolitan Hotel, Leeds. It was attended by 27 delegates invited by the LETBs and drawn from a range of different backgrounds. This included members of the LETB Governing Boards, partnership councils and representatives from across the system including managing directors, directors of education and quality, workforce planning managers, deans, GPs, public health experts, technology leads and directors of nursing. A full list is in Appendix A.

Participants were asked to analyse the key factors that might impact the whole health, social care and public health workforce in the north of England to 2035. These factors were then clustered to show possible cause and effect before considering potential outcomes of the cluster and then ‘voting’ on the impact and uncertainty of these clusters.

Clustering workshops and the clusters that are generated are the first stage of working towards, and generating, scenarios.
1.3 The Northern England context

The LETB managing directors set the Northern England context of the day, drawing links to their key priorities for the next five years, and the future challenges and drivers for change they have identified. There were common themes across the North including:

- Delivering Health Education England’s mandate
- Primary care development
- Leadership and management to create the right culture and behaviours with specific work on dignity and respect in care
- Skills development – in both advanced practitioner roles for professional groups and assistant/associate practitioner roles for support staff – focused on the acquisition of basic skills for these staff
- Integrated service commissioning (all care sectors)
- Shifting models of care (in hospital / out of hospital)
- Emergency unscheduled care
- Shape of training review
- Ensuring security of supply of the workforce
- Improving quality of education and training
- Leading innovative and strategic approaches to funding
- Enabling an equal and diverse workforce.
2. The context of cluster workshops within the CfWI’s robust workforce planning (RWP) framework

2.1 The CfWI’s robust workforce planning (RWP) framework

The RWP is a structured approach to strategic workforce planning. The framework is composed of the following stages:

1. **Horizon scanning** explores the potential challenges, opportunities and likely future developments that could influence workforce planning. These include technological, economic, environmental, political, social and ethical influences on an unfolding future.

2. **Scenario generation** – where ideas from the horizon scanning stage are captured, synthesised and used to inform the creation of plausible future scenarios which are quantified and used to inform workforce planning.

3. **Workforce modelling** aims to project demand and supply for a range of plausible futures, as described by the scenarios. Further modelling is then conducted to determine the robustness of policy options for achieving a sustainable balance of demand and supply.

4. **Policy analysis** focuses on analysing workforce intelligence on future uncertainties. The impact of policy options is then scrutinised by considering multiple future scenarios, so that different options can be tested to see which one is the most robust. In some cases this will lead to favourable outcomes across all futures and in others the outcome is less clear, or less positive.
The RWP framework takes a multi stage approach to horizon scanning and clustering driving forces before moving onto scenario generation and the remainder of the framework. This is shown in Figure 2.

**Figure 2: CfWI horizon scanning, clustering and scenario generation method**

1. **Understand the system**
   - Making sense of the system including the past, present and possible futures.
   - Driving forces collection.
   - System mapping to better understand the interconnections.

2. **Cluster the driving forces**
   - Refine and simplify the driving forces and influences in the system.
   - Consolidate into clusters through cluster workshops.
2.2 Focal question

The role of the focal question is to capture the common focal issue that the process will address. In this case, the aim was to develop a 20-year view pertinent to the north of England encompassing the strategic environment and associated pressures on the health, public health and social care sectors. The focal question captured this in terms of the influences and challenges affecting the demand and supply of skills and competencies in these sectors.

**Focal question:**

‘Thinking up to the year 2035 for the north of England, what driving forces (both trends and uncertainties) may influence:

- Requirements of the future workforce for health, social care and public health?
- Workforce numbers, proportions, skills and competencies?’

2.3 Clusters

During a scenario generation process a set of clusters is created (see steps 1 and 2 of Figure 2). A cluster is a coherently defined set of factors and driving forces linked through cause-and-effect relationships that describe an aspect of the system under investigation. This encapsulates all the key factors and driving forces that will impact upon the key focal issue.
The coherence of a cluster can be tested by:

- ensuring each factor and driving force in the cluster is linked by causality and/or chronological dependence
- naming the cluster with a higher-level name that encapsulates the essence of the cluster.

A cluster should not include the direction of changes to the factors and driving forces.

Each cluster is evaluated for possible and plausible extreme outcomes that might arise from it over the scenario timescale. An assessment is then made of the impact and certainty of these resolutions.
3. Activities and outcomes

3.1 Activities completed during the workshop

Table 1 gives an overview of the activities completed during the workshop and describes the main outcome of each exercise:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Purpose</th>
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</thead>
<tbody>
<tr>
<td>1. Collecting the driving forces</td>
<td>To elicit the driving forces that impact the focal question</td>
</tr>
<tr>
<td>2. Clustering the driving forces</td>
<td>To group and simplify the driving forces into individual coherent clusters for building scenarios in the next stage of the RWP and scenario planning process</td>
</tr>
<tr>
<td>3. Determining the cluster outcomes</td>
<td>To produce two extreme/opposite outcomes for each cluster</td>
</tr>
<tr>
<td>4. Presenting the clusters</td>
<td>To present the clusters back to the participants</td>
</tr>
<tr>
<td>5. Ranking the clusters</td>
<td>To order the clusters by impact and uncertainty of outcome</td>
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</table>

3.2 Summary of what the clusters provide

The clusters generated at the workshop provide:

- Initial identification and clustering of the key factors and driving forces for the north of England across health, public health and social care to 2035. This could enable further engagement with LETB stakeholders as part of workforce strategy development.
- An indication of the possible outcomes for each cluster developed on the day by delegates.
- A ranking of impact and uncertainty of these clusters.
- The base material for further development into full scenarios as part of scenario generation, workforce modelling and policy analysis (as per the CfWI RWP framework) that would enable a fully developed view of the plausible futures that might unfold for the north of England.
4. Next steps and feedback from the LETBs

Feedback from the LETBs has shown that they found it useful to bring together some key thinkers from across the system to explore the drivers that will impact on the workforce both now and in the future. Following the event, the LETBs reported that they received very positive feedback from their delegates who found the day well-structured and liked the use of an evidence based methodology to funnel a range of drivers into certain and uncertain categories.

The LETBs have indicated that they intend to use this summary report to influence their future thinking and help with the development of their workforce strategies. It will help them to identify key challenges and opportunities to change the way in which they train and develop the workforce. They intend to undertake a second stage of the process in the North of England to take the clusters forward into scenarios.

Health Education North West (HENW) also plan to use the drivers at an event with their stakeholders to think through more local factors. They will then use this to underpin their strategic workforce transformation programme.

The CfWI’s RWP framework takes a multi stage approach to horizon scanning, clustering driving forces before moving onto scenario generation and the remainder of the framework. Working with HEE and the three Northern LETBs, the CfWI will attend a meeting in early March to discuss and plan the next steps for all parties. The aim of this meeting will be to seek an understanding of the proposed next steps and approach to further develop the generated content that will support the LETB’s future thinking and development of workforce strategies.
5. Cluster summaries

5.1 Care closer to home

The ‘Care closer to home’ cluster was developed during the workshop by:

- Professor Oliver James - Chair, Health Education North East (HENE)
- Kelly Angus - Head of HR Services & Development, Northumbria Healthcare NHS Foundation Trust
- Dr Trish Livsey - Director of Academic Delivery, Liverpool John Moores University
- Dr Andy Maddox - GP, HENW Board
- Professor Vince Ramprogus – Pro Vice-Chancellor and Dean of the Faculty of Health, Psychology and Social Care, Manchester Metropolitan University
- David Regan - Director of Public Health, Manchester City Council
- Rebecca Malin  Deputy Director of Strategy and Business Development, Airedale NHS Foundation Trust

Table 2 shows which of the factor themes are covered by this cluster:

<table>
<thead>
<tr>
<th>Theme</th>
<th>Coverage</th>
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</thead>
<tbody>
<tr>
<td>Economy</td>
<td>✔️</td>
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<tr>
<td>Environment</td>
<td>✔️</td>
</tr>
<tr>
<td>Population</td>
<td>✔️</td>
</tr>
<tr>
<td>Society, culture and behaviour</td>
<td>✔️</td>
</tr>
<tr>
<td>Health &amp; wellbeing</td>
<td>✔️</td>
</tr>
<tr>
<td>Politics &amp; legislation</td>
<td>✔️</td>
</tr>
<tr>
<td>Research &amp; technology</td>
<td>✔️</td>
</tr>
<tr>
<td>Employment &amp; labour market</td>
<td>✔️</td>
</tr>
<tr>
<td>Services</td>
<td>✔️</td>
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<tr>
<td>Delivery model</td>
<td>✔️</td>
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<tr>
<td>Workforce</td>
<td>✔️</td>
</tr>
<tr>
<td>Workforce training &amp; education</td>
<td>✔️</td>
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<tr>
<td>Resources &amp; infrastructure</td>
<td>✔️</td>
</tr>
<tr>
<td>Service users</td>
<td>✔️</td>
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</tbody>
</table>

Figure 3 is a reproduction of the cluster produced by the participants during the workshop.
This cluster explores the key factors and how they interact to make it possible to deliver care closer to home for every person needing care in 2035. The cluster is based on the premise that the individual defines what they mean by ‘home’. It could be their own home, a traditional care setting or institution such as a prison but it is up to the individual to define.

The overarching theme of the cluster is integration. To an individual the most important factor is that they are able to orchestrate their own care. It doesn’t matter to them where the care comes from, or whether it is primary or secondary care, so long as they are in control. Joint commissioning will be a key factor to achieving this and blurred boundaries between care services will become the norm. Strong unified commissioning will be enabled by unified health and social care budgets. Personal budgets may look different by 2035 as more people pay for their own care, and with increasingly blurred boundaries between services there may be a need for ‘navigator’ roles to support an individual navigating the system in order to orchestrate their own care. There is likely to be a bigger role for the third sector and unpaid carers by 2035.

The digital revolution can also facilitate the delivery of care closer to home, with geographical barriers becoming less significant. For example, people living in the north of England could receive care from people in the south via new technology and vice versa - this is already happening to an extent with telehealth. Equally the location of family and carers becomes less significant if technology is available to support people at home, but there is a need to be mindful of the loneliness that could come with this type of care delivery. The group considered whether the digital revolution might change the workforce needed to deliver care in the future and
how it may impact on training – for example, would staff require a more generic skill set? Ways in which we will need to attract new workers, including terms and conditions, was identified also.

Specific to the north of England and how to fulfil care closer to home, is the large number of seaside towns and conurbations which can be quite isolated but where the population swells in the summer season. Typically it is difficult to recruit to these areas because they are so remote. When the population swells in the summer, A&E services in particular often face a pressure on their services with more people requiring care. The group questioned how care can be delivered closer to home with this transient population? Video-conferencing clinics to deliver high cost resources was one suggestion, again utilising technology and meaning that geography is less of a barrier.

It was also suggested that a factor and an issue for the future, with evidence of it beginning now, related to various local authorities in London seeking to move people out of the capital due to welfare and housing benefit reforms and cheaper accommodation in the north. Typically high-dependency individuals are starting to move to the north without any networks or sense of social cohesion in the local community, which puts an additional strain on care delivery and could see the health inequality gap widen.

5.1.1 Outcome 1 – every person needing care has it delivered in their community

When considering the plausible outcomes of this cluster the group decided that one outcome must inevitably be that every person needing care has it delivered in their community, which could be their home, by 2035. In order to achieve this, there is a requirement for the best workforce in the neediest places, in order to reverse the inverse care law. The duty on local authorities to reduce health inequalities will only then reduce the variations we currently see.

The group considered that the stepping stones to achieving this are already in place, albeit through a currently mixed local picture; nationally we have the infrastructure required in place. Ambitions to transform community services are underway; we have health and wellbeing boards and the Better Care Fund. However, there is the challenge of localism to consider whether reducing budgets for health and local government has seen a rise in costs for other government departments such as Work and Pensions. There will need to be more local control through community budget mechanisms which may require some double-running of costs or funding of services initially.

The fundamental difference this outcome will bring is stronger engagement and ownership by patients in their own care. Staff will need to tolerate uncertainty as a key factor, and recognise that there will be reorganisations initially as part of the changes required. Adapting to new technologies will be important and systems that are standardised and speak to each other will be crucial. A more structured and cohesive system will be vital in order to deliver care closer to home.

5.1.2 Outcome 2 – patient preference for hospital care remains as it is now

Whilst we assume that every person would prefer care closer to home, this may not be the case. The group considered another plausible outcome where patients, the public and politicians may prefer the unaffordable model we have currently. Health and education are two of the biggest political footballs and it is unlikely this will change over the next 20 years or so. This may in part be spurred on by the media, with most health based television documentaries and dramas being hospital focused. The ‘baby boom’ generation may feel more assured in hospital, resistant to change and prefer the traditional way of doing things including an attachment to the buildings associated with traditional care services.
This outcome would therefore see more of the same care delivered in an even more haphazard and fragmented model.

5.1.3 Impact / uncertainty voting
The results of the impact uncertainty voting were as follows:

- **Impact**: 27 / 106 (Ranked second)
- **Uncertainty**: 13 / 105 (Ranked fourth)

5.2 iCare
The ‘iCare’ cluster looked at technological impacts and was developed during the workshop by:

- Adam Wardle - Managing Director, Health Education Yorkshire and the Humber (HEYH)
- Jonathan Brown - Strategic Workforce Planning Manager, HEYH
- Jon Hossain - Deputy Post Grad Dean, HEYH
- Susan Michael - Education Commissioning Lead, HEYH
- Derek Marshall - Chief Workforce Strategist and Planner, HENE
- Mike Burgess - Associate Head of Workforce Planning, HENW

Table 3 shows which of the factor themes are covered by this cluster:

**Table 3: Cluster factor theme coverage**
CfWI assessment of the themes covered by this cluster

<table>
<thead>
<tr>
<th>Economy</th>
<th>Environment</th>
<th>Population</th>
<th>Society, cultural and behaviour</th>
<th>Health &amp; wellbeing</th>
<th>Politics &amp; legislation</th>
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<th>Workforce training &amp; education</th>
<th>Resources &amp; infrastructure</th>
<th>Service users</th>
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<tr>
<td>✓</td>
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Figure 4 is a reproduction of the cluster produced by the participants during the workshop.
This cluster explores the adoption of technological development and the impact it may have on demand for healthcare and supply of the workforce. The group considered three key themes within this cluster.

The first was new technologies and treatments and how they may have an impact on the way that health and care is delivered by 2035. For example, we already know of robotics, nanotechnology, genetics and artificial intelligence which could be specific enablers of change, but the ability to take advantage of these advances will depend on the ability of the health system to adopt new technologies. If the cost of implementing these technologies is prohibitive then their benefits will not be realised.

The second theme was based on the concept of technology-enabled prevention, and the possibility for patients to monitor their own health – for example via an app on their smartphone, or through auto-diagnosis. An app could provide tailored recommendations to improve people’s health and wellbeing with the aim of reducing the number of people using care in a primary setting. Telehealth may also be delivered directly to a patient’s home. However, the group decided that whilst these technological advances would provide a benefit they may also lead to patients feeling lonely and isolated if they are never able to visit a hospital and speak to someone in person. This could be particularly relevant for patients with multiple conditions who frequently also suffer with mental health issues.
After considering the improvements to care that technology could provide, the third theme was the impact on the workforce in relation to the skills and competencies that would be required in order to truly take advantage of the pace of technological change. It was noted that the surgeon of 2035 is likely to require a completely different skill set to the surgeon of today and training and education will have to change. Technological advances may also lead to changes in the way that education and training is delivered and could affect how, where and what our future workforce learns. There may be opportunities for students to learn at home from institutions based abroad for example. Technology may also widen the profile of the workforce by 2035 to include people with disabilities who will be able to perform tasks with physical aids that are not currently possible.

The group decided that the pace of technological change is inevitable. A key driver of the potential impact technology may have on how health and care is delivered is closely linked to the health systems’ ability to adopt new technologies successfully.

5.2.1 Outcome 1 – North adopts new technologies fully
In the first outcome technology has been fully adopted by the north of England as a result of patients demanding change to the existing health and care system, and the political will supports these changes. Significant investment has been made in improving technical infrastructure, including the roll out of high-speed broadband across the north of England, reducing the risk of widening health and access inequalities. There has been evidence of better patient outcomes from early adopters and subsequently there has been a change in working practices to support the adoption of new technology. Innovation is encouraged and learning shared, new partnerships are forming and areas of the country are offering niche services as innovation develops. The health and care system has been able to recruit the right people with the right skills and has been able to develop and train them to make the best use of technological advances. There has been a shift in focus from healthcare intervention to prevention and the systems are in place to support information security, sharing and accessibility.

5.2.2 Outcome 2 – North adopts new technologies partially
Another plausible outcome could be that the north of England only partially adopts new technologies whilst the south of England fully adopts them. This has been caused by a lack of political will to change and an uneven balance of spending geographically. This in turn leads to a widening of health inequalities between the north and south and an inability to attract the right people to work in the north. Money is being spent on ‘fire fighting’ instead of innovating. New recruits are not able to use the skills learnt in training when moving into the ‘traditional’ workplace where time is not available to harness innovation. There has been a failure to plan and invest in new technological advances and systems are not in place to support information governance and accessibility. Any innovative thinking has been met with tough media reactions. There is a possibility under this outcome that another country captures the market, with service users travelling overseas for their healthcare.

5.2.3 Impact / uncertainty voting
The results of the impact uncertainty voting were as follows:

- **Impact**: 36 / 106 (Ranked first)
- **Uncertainty**: 30 / 105 (Ranked second)
5.3 **Constant cultural / societal evolution**

The ‘Constant cultural /societal evolution’ cluster looked at changes in culture and expectations, and was developed during the workshop by:

- Elaine Readhead - Managing Director, HENE
- Kirstie Baxter - Head of Transformation, HENW
- Juliette Greenwood - Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust
- Cath Siddle - Director of Nursing, Patient Safety and Quality, North Tees & Hartlepool NHS Foundation Trust
- Mike Wright - Executive Director of Nursing, County Durham and Darlington NHS Foundation Trust
- Dr Nick Land - Medical Director, Tees, Esk and Wear Valleys NHS Foundation Trust
- Kate Ardern - Director of Public Health, Wigan Council

Table 4 shows which of the factor themes are covered by this cluster:

*Table 4: Cluster factor theme coverage*

<table>
<thead>
<tr>
<th>Economy</th>
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<th>Population</th>
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<th>Workforce training &amp; education</th>
<th>Resources &amp; Infrastructure</th>
<th>Service users</th>
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</table>

Figure 5 is a reproduction of the cluster produced by the participants during the workshop.
This cluster explores the cultural and societal impacts on delivering healthcare, whilst recognising that there is constant evolution and therefore in 10 years things may look very different.

The group explored several themes and drivers, beginning with the changing nature of community and questioning the impact of virtual community and technology. It was suggested that with technological advances society has become used to having knowledge at its fingertips and has therefore come to expect instant access to everything without having to wait. This short termism is in turn reflected in government policy where long-term horizon scanning is not prevalent, rather the focus is on short-term fixes. With five more elections before 2035 there is potential for five or more reorganisations of the health system, that is if the NHS still exists in 2035.

The group also noted how the virtual network created by technology has shrunk geography. Often people’s closest friends no longer live next door or around the corner but hundreds of miles away, spread around the country or all over the world. This could pose a problem should a crisis emerge as there can be a lack of physical contacts.

The positive aspects of technological advances and virtual communities were also considered in the availability of immediate access to knowledge and the inherent ability to self-treat.
Other changes in society could include a ‘post-modernist fear of the metanarrative’ where people have lost confidence and have a fundamental distrust of organisations, authority and professionals. Society has moved away from big ideas and there is a lack of faith in politics and the mainstream. Society today expects perfection from its services whilst at the same time distrusting them. This has led to discrepancies in expectations, in particular around quality and what is regarded as ‘good’.

Over the last 50 years or so there has been a rise in the number of women in the workplace, along with an increase in the retirement age. Together this has seen a change in the profile of the volunteers holding society together and delivering very important services and unpaid care. The group considered how this has changed from predominantly unpaid females to people who have retired at 60 and have extra time on their hands. Who will do it in 2035 when the retirement age has increased further and people are working longer hours? Also, whilst people are living longer we are noticing a rise in long-term conditions and people are not enjoying healthy lives as they live longer. Who will fund the additional care requirements?

The group considered whether the lack of trust we are seeing in society is leading to an increase in regulation which in turn reduces quality. They felt that clinicians spend more and more time on paperwork and less time with patients, which makes it increasingly difficult to recruit. Many people are dissatisfied with their roles and are impatient with the ever increasing levels of regulation. This in turn reduces the quality of care that is provided since we cannot be efficient or deliver the compassion that we would like.

5.3.1 Outcome 1 – Society fully engaged with health and wellbeing

When considering the plausible outcomes of this cluster, the group decided the first outcome is a society fully engaged with health and wellbeing. Citizens take ownership of their own health, which is supported through early education in schools. The media are positive and constructive in their portrayal of healthcare and healthcare systems. There is a culture of wellbeing, a consciousness of health issues and a shared understanding of quality. Social media and technology perform an ever increasing role in delivering this, promoting wellbeing and providing both information and a means to self-care. Healthcare professionals are able to support the public to take ownership of their own health through everyday contacts as they have received training to support this.

5.3.2 Outcome 2 – Fragmentation and individualism leading to inequality and ill-being

The second plausible outcome is a fragmented society with an individualistic attitude. This leads to a rise in health inequalities. Society fails to challenge the societal cognitive distortion and paradox – it believes in things which are not compatible. For example, it wants perfection from the system yet is unwilling to put any time or effort into it.

The rise of technology leads to increasing levels of isolation and the potential for cyber bullying. Whilst many may expand their friendship groups, the lack of personal contact close to home could have a detrimental effect, particularly on the elderly who once relied on neighbours checking in on them.

Increasing levels of regulation drive out any compassion in the system, meaning societal causes of disease continue to go unchecked or challenged. A lack of compassion and willingness to contribute to society means that those who have been marginalised become even more so, with no one helping them become healthy productive members of society. This fragmented society with increased regulation and decreased compassion leads to a failure to educate a flexible workforce that is able and willing to redesign roles as needed.
5.3.3 Additional discussion points

The group also shared several other issues they had discussed whilst developing the cluster but that were not directly related to it.

It was recognised that there is a need for reorganisation and development within the current workforce, in particular the non-clinical Band 1-4 staff. The group suggested that Band 7 leaders in nursing are currently spending more time on administration than on clinical leadership around modelling high quality care and compassion – effectively managing rather than leading. If they could use the Band 1-4 administration workforce differently, educating some Band 4’s to take on some of this work and allowing progression to Band 5 or 6 for example, then the Band 7 nurses would have more time on the wards to engage with patients and lead their teams.

However, it was noted that there is a lack of ‘room in the system’ to do this and in some cases resistance to the approach since training is not in place to develop the Band 4 administrators, and the change would need to be well-managed to ensure the support and acceptance of staff to the changes.

Another point related to the junior doctor workforce, and the difficulty we face retaining them in the North. A ‘golden handcuff’ was suggested as a way of retaining them, where if they remained in the region to work for five years then they would have their student loans written off. Increased recruitment of local students was also discussed, with the need to potentially invest more in these students rather than simply accepting high calibre students from other areas who would leave upon completion of their training.

5.3.4 Impact / uncertainty voting

The results of the impact uncertainty voting were as follows:

- **Impact**: 21 / 106 ( Ranked fourth)
- **Uncertainty**: 44 / 105 ( Ranked first)

5.4 Turning it upside down, inside out

The ‘Turning it upside down, inside out’ cluster looked at a different vision of care and was developed during the workshop by:

- Mark Purvis – Director of Postgraduate GP Education, HEYH
- Professor Maggie Pearson – Pro Vice-Chancellor and Dean for Health & Social Care, University of Salford
- Jenny Cavalot – Interim Head of Education Commissioning and Workforce Strategy, HENW
- Dr Andrew Brittlebank – Deputy Medical Director (Medical Performance), Northumberland, Tyne and Wear NHS Foundation Trust

Table 5 shows which of the factor themes are covered by this cluster:
Table 5: Cluster factor theme coverage
CfWI assessment of the themes covered by this cluster

<table>
<thead>
<tr>
<th>Economy</th>
<th>Environment</th>
<th>Population</th>
<th>Society, culture and behaviour</th>
<th>Health &amp; wellbeing</th>
<th>Politics &amp; legislation</th>
<th>Research &amp; technology</th>
<th>Employment &amp; labour market</th>
<th>Services</th>
<th>Delivery model</th>
<th>Workforce</th>
<th>Workforce training &amp; education</th>
<th>Resources &amp; infrastructure</th>
<th>Service users</th>
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Figure 6 is a reproduction of the cluster produced by the participants during the workshop.

*Figure 6: Turning it upside down, inside out*

This cluster is based on a model of ‘Iris’, a fully representative participant of the health and care system. The group explored a range of factors which would combine to provide Iris with the best possible care in 2035.

Iris is an elderly individual who suffers from a range of health conditions; she is partially sighted, has limited mobility and dementia. In the context of an ideal health and care system, however, whilst Iris has these health needs, they are mitigated as far as possible thereby allowing her to lead an active and independent life, engaging fully and contributing to the community. Any specialist care required by Iris is provided swiftly and at the point of need to an extremely high quality. Importantly, younger generations don’t perceive Iris as a burden, but rather a valuable asset and member of society.
In achieving this vision of care, the group discussed technological advances, with a view on how they can be fully utilised to enhance the quality of life and help individuals maintain full independence. They suggested that technology will play a large role in breaking down barriers, helping people to obtain information from a range of sources and sharing knowledge with other patients and service users. This allows individuals to explore the services available to them and make informed choices about their care options much more easily.

In terms of workforce requirements, aligning skills appropriately to future need and reconsidering how specific skill-sets are delivered in the future will be increasingly important. A vital consideration will be the definition and commissioning of solutions in the delivery of health and care services – who will do this in the future and what training will they need?

The group also considered whether the current welfare state will continue until 2035; who will pay for services and will services be provided only by private businesses?

The group finally reflected upon the significance of unlocking community capacity and being positive about people’s assets rather than focusing solely on their deficits. Some groups in the North, particularly those who suffer some of the greatest inequalities, can become disempowered and disengaged from society. With a trend of northern communities being ‘written off’, there may be a need to be more positive about people’s ability to act as they see fit, rather than how health, social care and public health leaders prescribe.

5.4.1 Outcome 1 – Interdependent, resilient, inspirational solution

The group considered two plausible outcomes. The first relies heavily upon a radical change in current thinking of patients, service users and people across the health, care and public health system and how they interact. To enable transformation to an independent and resilient model of care the group identified significant changes to service definitions and mode of delivery for the future. Here, the group described Iris as an independent user of care, but also interdependent, whereby a community network is able to help and support each other and enable a community model of care in the future. Iris exercises effective utilisation of and is enabled by crowd-sourcing, technology and social media platforms to drive improvements in and access different co-produced services in the future. A key factor is also the design and ability to reshape the physical environment in which she lives to suit her care requirements.

To achieve this outcome it was identified that immediate and sustained commitment to new models of care would be required by health and social care leaders working together. A distributed leadership model was highlighted as a key factor. In the future the power of people being able to shape and design their care was identified as a central element. Barriers of a bureaucracy-centred society were described as significant risks. Over time the experience and learning from the use of new models will help improve and shape her own and other people’s care. Enabled by the increased experience and knowledge she becomes an expert in her own requirements and can contribute to identifying and meeting other people’s needs as well.

5.4.2 Outcome 2 – Iatrogenic, isolated, resource-intensive, inert, insolvent

The second plausible outcome sees ‘more of the same’ current practice, with some sporadic evolutionary tweaks to models of care. This instance is described profoundly as iatrogenic\(^1\), with the system creating as many, if not more, problems than it solves out to 2035. The sector continues to operate in a paternalistic manner, with Iris seen purely as a service user and a drain on limited resources. The state sets out what the

\(^1\) Defined as preventable harm resulting from medical treatment or advice to patients.
right outcomes for people are and Iris has to abide by that, rather than decide for herself how to achieve the best level of care.

5.4.3 Impact / uncertainty voting
The results of the impact uncertainty voting were as follows:

- **Impact**: 22 / 106 (Ranked third)
- **Uncertainty**: 18 / 105 (Ranked third)

5.5 Impact vs uncertainty
As part of the final stages of cluster development, delegates ordered the four clusters by impact and uncertainty of outcome using voting. Figure 7 shows the position of each cluster. The top right quadrant shows the highest uncertainty and highest impact and is therefore coloured red. The bottom left quadrant is coloured green to show the least impact and uncertainty, and the other two quadrants are yellow to show medium levels of uncertainty and impact.

![Figure 7: Impact vs uncertainty](image-url)
6. Appendix A

6.1 List of delegates

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation / LETB represented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derek Marshall</td>
<td>Chief Workforce Strategist and Planner, HENE</td>
</tr>
<tr>
<td>Elaine Readhead</td>
<td>Managing Director, HENE</td>
</tr>
<tr>
<td>Professor Oliver James</td>
<td>Chair, HENE</td>
</tr>
<tr>
<td>Kelly Angus</td>
<td>Head of HR Services &amp; Development, Northumbria Healthcare NHS Foundation Trust</td>
</tr>
<tr>
<td>Cath Siddle</td>
<td>Director of Nursing, Patient Safety and Quality, North Tees &amp; Hartlepool NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Nick Land</td>
<td>Medical Director, Tees, Esk and Wear Valleys NHS Foundation Trust</td>
</tr>
<tr>
<td>Mike Wright</td>
<td>Executive Director of Nursing, County Durham and Darlington NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Andrew Brittlebank</td>
<td>Deputy Medical Director (Medical Performance), Northumberland, Tyne and Wear NHS Foundation Trust</td>
</tr>
<tr>
<td>Mike Burgess</td>
<td>Associate Head of Workforce Planning, HENW</td>
</tr>
<tr>
<td>Jenny Cavalot</td>
<td>Interim Head of Education Commissioning and Workforce Strategy, HENW</td>
</tr>
<tr>
<td>Dr Trish Livsey</td>
<td>Director of Academic Delivery, Liverpool John Moores University</td>
</tr>
<tr>
<td>Professor Kate Ardern</td>
<td>Director of Public Health, Wigan Council</td>
</tr>
<tr>
<td>Dr Andy Maddox</td>
<td>GP, HENW Board</td>
</tr>
<tr>
<td>Professor Vince Ramprogus</td>
<td>PVC and Dean of the Faculty of Health, Psychology and Social Care, Manchester Metropolitan University</td>
</tr>
<tr>
<td>Professor Maggie Pearson</td>
<td>PVC and Dean for Health &amp; Social Care, University of Salford</td>
</tr>
<tr>
<td>David Regan</td>
<td>Director of Public Health, Manchester City Council</td>
</tr>
<tr>
<td>Kirstie Baxter</td>
<td>Head of Transformation, HENW</td>
</tr>
<tr>
<td>Name</td>
<td>Organisation / LETB represented</td>
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<tr>
<td>Adam Wardle</td>
<td>Managing Director, HEYH</td>
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<tr>
<td>Jonathan Brown</td>
<td>Associate Director of Strategic Workforce Planning, HEYH</td>
</tr>
<tr>
<td>Jon Hossain</td>
<td>Deputy Post Grad Dean, HEYH</td>
</tr>
<tr>
<td>Mark Purvis</td>
<td>Director of Postgraduate GP Education, HEYH</td>
</tr>
<tr>
<td>Rebecca Malin</td>
<td>Deputy Director of Strategy and Business Development, Airedale NHS Foundation Trust</td>
</tr>
<tr>
<td>Juliette Greenwood</td>
<td>Chief Nurse, Bradford Teaching Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Susan Michael</td>
<td>Education Commissioning Lead, HEYH</td>
</tr>
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**CfWI Facilitators:**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Matt Edwards</td>
<td>CfWI</td>
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<tr>
<td>Zoë Dodd</td>
<td>CfWI</td>
</tr>
<tr>
<td>James Trendell</td>
<td>CfWI</td>
</tr>
<tr>
<td>Charlotte Burge</td>
<td>CfWI</td>
</tr>
<tr>
<td>Gemma Harrison</td>
<td>CfWI</td>
</tr>
<tr>
<td>Peter Wood</td>
<td>CfWI</td>
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Centre for Workforce Intelligence
209-215 Blackfriars Road
London SE1 8NL United Kingdom

T +44 (0)20 7803 2707
E enquiries@cfwi.org.uk

www.cfwi.org.uk