Skills for Health

Rehearsing Uncertain Futures

Full Report

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The Institute for Employment Studies

The Institute for Employment Studies is an independent, apolitical, international centre of research and consultancy in public employment policy and organisational human resource issues. It works closely with employers in the manufacturing, service and public sectors, government departments, agencies, and professional and employee bodies. For over 40 years the Institute has been a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and human resource planning and development. IES is a not-for-profit organisation which has over 70 multidisciplinary staff and international associates. IES expertise is available to all organisations through research, consultancy, publications and the Internet.
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Executive Summary

Skills for Health, is the Sector Skills Council for the health sector across the UK. Its aim is to help employers in the sector improve the quality of health and healthcare through the development and utilisation of skills of all those who work within it.

One means of achieving this is to provide Skills and Labour Market Intelligence that helps employers make decisions and to inform the development of training and development activities.

To this aim Skills for Health conducts a wide range of skills research and labour market intelligence gathering exercises. Skills for Health draws on a range of robust national and regional industry-specific intelligence, and conducts research into specific skills related themes.

In many respects, such methods help employers understand what has happened, which may help indicate future trends. However, to assist employers to think in real depth about the future and to help them anticipate future developments Skills for Health has established an ongoing programme of scenario planning development, monitoring and application.

In 2009 Skills for Health commissioned the Institute for Employment Studies (IES) to develop a Scenario Planning exercise – Rehearsing Uncertain Futures. The aim of this was to help explore what the possible futures might look like, how the sector might respond to the challenges presented by these scenarios and, potentially, how the sector, and Skills for Health in particular, can influence the emerging future and plan effectively for future skills requirements.

A full description of the methodology is provided in the main report. A broad range of activities was undertaken to make the futures presented linked both with the past and with current trends in the sector. These included a series of interviews with sector experts; analysis of commentaries commissioned by Skills for Health; skills and labour market intelligence; three scenario-building
workshops attended by health sector representatives; development of three scenarios; and an application workshop with colleagues in Skills for Health.

The scenarios that were developed explore how the world might look taking into account the evolution of certain trends. They are alternative stories about the future, rather than forecasts, predictions or projections. The process that was undertaken resulted in three plausible, relevant and challenging versions of the future.

The three scenarios were: United we stand (based on the idea of the increasing influence of the European Union and reduced decision-making by the UK government); Business Class or Economy Class? (in which there is an increasing gap between what the state provides as a ‘safety net’ and what can be purchased by those with money and/or insurance); and It’s your choice, in which there is increasing diversity of provision and strong lobbying from special interest groups.

The scenarios that were developed were also tested in an application workshop, facilitated by IES and attended by Skills for Health Directors and Executive Directors. The Skills for Health participants explored the three alternative scenarios and considered the current evidence for their emergence.

The Skills for Health representatives also considered the likely skill implications of the various scenarios in relation to traditional occupational roles, and identified three new roles that might emerge in these environments. The delegates also considered the range of evidence that might indicate which scenario may become more prevalent as we move towards 2020.

These activities are part of Skills for Health’s suite of Skills and Labour Market Intelligence gathering activities. As this report is being published, two further application workshops are being conducted and sessions with employers to explore future signals are also being developed.

Skills for Health would be pleased to hear from you if you wish to get involved with any aspect of our work and attend any of our workshops. Please contact Debbie.Bibby@skillsforhealth.org.uk if you would like to be invited to any of our future workshops.
## Contents

1 Introduction 1
   1.1 What are scenarios? 3
   1.2 Approach to the work 4

2 The Interviews 7
   2.1 Outcomes from the interviews and the essay review 7

3 The Scenario-building Workshops 11
   3.1 Inviting participants 11
   3.2 The workshops 11

4 The Scenarios 21

5 The Application Workshop 25
   5.1 Discussion of the scenarios 25
   5.2 Response to the scenarios 26
   5.3 Emerging roles 26
   5.4 Impact on stakeholders 28
   5.5 Signposts 29
   5.6 Conclusions? 29
1 Introduction

Skills for Health, the sector skills council for the health sector across the UK, is charged with helping the sector develop a skilled, flexible and productive workforce to improve the quality of health and healthcare. Within the sector a wide range of social, technological, economic, political and environmental changes are currently taking place, and so it is likely that the workforce will change significantly over the next five to ten years, as the demands placed upon it.

Even for those changes that are very likely, the speed at which they will happen and the magnitude of their impact are both highly uncertain. It may also be the way in which different factors interact with each other that further drives changes to the future healthcare landscape. Indeed, there may be other changes not yet anticipated that traditional strategic planning has yet to consider.

To understand how these forces will influence the shape of skills and employment in the sector, Skills for Health conducts a range of skills research and labour market intelligence gathering exercises.

1.1 National and regional industry-specific intelligence

Skills for Health develops a range of regular assessments of the current and future skills needs of the health sector. These are developed using key national sources, including amongst others the Labour Force Survey, Annual Business Inquiry, National Employer Skills Survey, Higher Education Statistics Agency as well as a whole range of industry intelligence and bespoke surveys, consultation activities and industry sources. Skills for Health also have an online tool where many of these sources can be drawn upon on an ongoing basis.

1.2 Research themes

Skills for Skills for Health undertakes research into a range of themes which are designed to address gaps in our knowledge of the sector, encourage employers to
raise the level of skills in the sector and adopt new ways of delivering health care. Themes currently being addressed include:

- understanding ‘turnover and wastage’ in the health sector
- understanding productivity and performance
- third sector’ and the volunteer workforce.

1.3 Future-Oriented skills and Labour Market Intelligence

Alongside these more historical looking forms of skills and labour market intelligence Skills for Health seeks to develop insights that can help employer anticipate future skills and employment needs.

Alongside econometric modelling and input from specialist commentators Skills for Health has an ongoing programme strand of scenario planning, development and application. In 2009 Skills for Health commissioned the Institute for Employment Studies (IES) to develop a Scenario Planning exercise to help them to explore what the possible futures might look like, how the sector might respond to the challenges presented by these scenarios and, potentially, how the sector, and Skills for Health in particular, can influence the emerging future and plan effectively for future skills requirements. In the document Rehearsing Uncertain Futures Ian Wheeler, Divisional Manager Research and LMI at Skills for Health explains:

‘Rehearsing futures takes the imaginative approach of asking ‘what if’ questions but in a structured and collective way by members of a community. These rehearsals allow a number of different futures to be generated. These futures will be generated using a number of different factors. After a series of activities a panel can create a number of possible futures that may emerge for a sector. Each future is a detailed portrait of a possible reality for the health sector … ‘The community will help Skills for Health identify two things. Firstly, a set of indicators from which Skills for Health will be able to measure progress towards a different future. The community will also help identify a number of activities they would like to see pursued in order to work towards the most desirable future.

These indicators will help Skills for Health monitor and report on an ongoing basis the direction of travel of the sector. This will help skills for health report on the progress of the sector and on the progress of its initiatives.’


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1 Available as a pdf at: www.skillsforhealth.org.uk/workforce-design-development/workforce-strategy/skills-labour-market-intelligence.aspx
Between September 2009 and January 2010 IES undertook the programme of work that led to development of scenarios for Skills for Health and a final Application Workshop with members of Skills for Health. This report provides an account of the Scenario Planning process and outcomes.

1.4 What are scenarios?

Scenarios have long been a core element of different approaches to understanding and preparing for the future. Scenarios are stories that explore how the world might look taking into account the evolution of certain trends. They are:

- alternative stories about the future, not forecasts, predictions or projections
- two, three or more plausible, relevant and challenging versions of the future.

They provide a framework for thinking about the different ways in which the future might unfold from the present and how we might shape that future. Scenarios are stories that describe plausible alternative futures and how they come about. They are not predictions or forecasts but they do need to be credible, challenging and coherent, and can show good or bad potential futures.

There are several benefits of using a scenario approach to strategy. It helps avoid the trap of rigid strategy development which can carry an organisation too far down a given road which turns out to be a cul-de-sac. Secondly it helps to avoid reactive decision-making in which the current environment can dictate direction and foreclose options. Current preoccupations can distract people from thinking about the future and confine them to a limiting cycle of immediate concerns. Although it is essential not to view scenarios as forecasting, organisations that practise scenario building do get better at spotting the advent of surprising futures and can get a few steps ahead of those who don’t spot the signals on the horizon. Scenario planning methods can also help people and groups feel more comfortable with change.

Figure 1.1 shows the difference between forecasts and scenarios.
An analogy is a lens or prism through which different facets of life are seen. There are lots of different possible futures, as the way in which things will play out is an unknown, as are the possible impacts. Scenarios present possible futures which can then be used to develop an idea of what actions might be needed now in order to cope with the possible alternate futures. Scenarios are therefore not strategies – strategies map the potential actions that could be taken to cope with the various alternate futures.

1.5 Approach to the work

The project was conducted in five broad stages:

1. identification of the business and organisational features that provided the context to scenario planning
2. series of facilitated scenario building workshops with range of representatives from across the sector
3. scenario construction
4. scenario application workshop with Skills for Health delegates
5. reporting of the outcomes.

1.5.1 Stage 1: Context

Before facilitating scenario-building workshops it is necessary to develop a full understanding of the context within which the scenario planning will take place. Scenario planning is always a complex undertaking and it is probably at its most complex within a sector such as health.

Workforce skill requirements are typically affected by a range of issues and within the health sector these include:
Changes to the philosophy underlying health service provision.

The exponential increase in development of new technologies and diffusion of existing technologies.

Changes to boundaries between the professional groups and introduction of new roles.

Changing community demographics and health economies.

Government expectations of improved service delivery and service user expectations.

To clarify and confirm what were seen as the key drivers of change within the health sector, and provide the backdrop against which the scenario planning would take place, a series of interviews was conducted with sector experts to identify key issues for the sector. These interviews were used to inform the scenario-building workshops.

1.5.2 Stage 2: Scenario-building workshops

Three scenario-building workshops were conducted, attended by delegates who represented organisations and perspectives from across the sector and from the devolved administrations. Each of the scenario-building workshops followed the same structure (see Box 1):

**Box 1: Agenda for the scenario-building workshops**

An introduction to scenarios

An outline of the day’s activities

Overview of outcomes from the interviews and expert reviews followed by participant commentary/observations on the outcomes

Timeline exercise - what were the key developments that led to the situation today?

Looking Forward exercise: what will be the future drivers of changes within the strategic environment?

Uncertainty and Impact exercise: which of the identified drivers are the most uncertain but could have the highest impact?

Scenario Snippets creation exercise

Scenario Building exercise.

Explanation of next steps
A report of the proceedings was sent out to all participants following each workshop (all three reports are shown at Appendices 1, 2 and 3).

1.5.3 Scenario construction

The scenario snippets created during the workshops were then woven into three coherent scenarios by the research team. These constituted the briefing materials for the Application Workshop event with Skills for Health and this document is shown at Appendix 4.

1.5.4 Application workshop

The purpose of creating scenarios is to help determine the robustness of strategies in the face of possible future events, or alternatively, to help draft strategies. Indicators that can point to the increasing likelihood of one scenario unfolding rather than an alternative scenario, can also be identified by considering the way in which scenarios would play out over time and the factors that might trigger them. A workshop to use the scenarios to help Skills for Health refine their workforce strategies was held on 20 January.

1.5.5 Reporting

As indicated previously, all participants at each workshop received a copy of the report of that workshop. This report provides an overview of the process as a whole, including the application workshop.

A further report based on the proceedings of the application workshop will be provided to the Board of Skills for Health. This will be a document for internal use by Skills for Health to assist them in developing hypotheses regarding the staffing implications of the three scenarios created and identifying indicators to help with horizon scanning and future planning.
2 The Interviews

A total of 10 interviews were conducted during September 2009, transcribed and analysed. The interviews were conducted either face-to-face or by telephone. The discussion guide used to structure the interviews is shown at Appendix 5.

In order to facilitate open conversations the interviewees were given assurances of anonymity and so are not named here. They were representatives of a range of organisations including national skills bodies, regulatory and professional associations/bodies in the health sector, representatives of private sector providers and a legal professional who specialised in the health sector.

In parallel with this, Skills for Health provided the research team with a series of commissioned ‘thought pieces’, written by leading academics and clinicians and again focussing on the various challenges confronting the sector¹. Advance copies of the essays were provided to the research team so that the commentary in the essays could be incorporated with the information from the interviews to inform development of the briefing materials for the workshops.

2.1 Outcomes from the interviews and the essay review

The information that emerged from the ‘thought piece’ essays and from the interviews was synthesised and used to develop briefing materials that were provided to workshop participants ahead of each workshop. The briefing pack, showing the summary of the points that emerged from the interviews and review of the commissioned essays is shown at Appendix 6.

Broadly, the viewpoints emerging from the interviews and the essays pointed to the following issues as challenges for the health sector in the coming years:

¹ These can be downloaded free of charge as a pdf file from the Skills for Health website at: www.skillsforhealth.org.uk/workforce-design-development/workforce-strategy/~/media/Resource-Library/PDF/Skills-for-Health-Tomorrows-Workforce.ashx


2.1.1 The National Health Services

The NHS is a major presence in the United Kingdom’s health sector. How the service is organised, and the structures within it, are a major influencing factor.

Overall, this was the highest ranking influencing force emerging from the interviews and analysis. Other important elements integral to this challenge cluster are the workforce, and in particular the problems arising from an ageing health sector workforce, prediction of a continuing shortage of healthcare staff in many areas and a feeling that there has been a lack of any substantial progress on the deployment of staff to support strategic shifts in care delivery eg care in the community.

On the topic of training and development there was a view that training for medical staff needed to be broadened and that training policy must synchronise with operational staffing levels.

These issues were set against a backdrop of the funding crisis and a conclusion that the NHS fails to handle change well. It was also apparent that because of the complexity of the situation within the NHS it can be difficult to establish any clear relationship of cause and effect. Also, as it is a large organisation it can be slow to adapt to change and hence the overall tendency is for the status quo to be preserved.

The problems relating to effecting and managing change within the NHS can often be seen as intractable and indeed irresolvable. Governments of various hues have made plans for large scale change but these have only resulted in superficial changes. The situation has been made more difficult as senior managers often find themselves distrusted by both staff and politicians.

2.1.2 The economy

Healthcare funding and spending will be a major challenge for the NHS and the position had been further aggravated in the recent past by the recession and the fiscal meltdown. The recessionary pressures and slow economic recovery mean that the health sector would most likely have to create significant efficiency savings; funding is expected to become much tighter in future and it is likely that the NHS will be required to deliver significant annual improvements in productivity. This however is set against a world in which people are living longer and the balance between young and old is shifting in favour of the latter; this shift alone will bring a requirement for an increase in NHS spending of around 1% per annum in coming years.
2.1.3 The shape of health services

The main focus of this challenge centres on how the models of care need to change in order for the healthcare needs of the nation to be met over the next decade and beyond. While much of the work of the NHS in the 20th Century had focused on eliminating or controlling killer diseases the focus now needs to shift to accommodate the new demands such as people living for longer with chronic conditions, and community healthcare for the elderly. These issues have implications for the way in which the NHS is organised and resourced and for skill requirements of the workforce, including reconfiguring services to focus on prevention and looking at how technology is used to support models of care and medical research. Once again, these challenges will be set against a background of the need to drive up productivity and increase value for money.

2.1.4 Demography/ageing population

There is potentially a double impact on the health sector of an ageing population with the first being the impact of having to deal with meeting the complex health needs of a growing number of older people. The secondary impact arises from the effect on the health sector workforce of increasing numbers of health sector staff starting to reach retirement age. In addition, while climate change and other developments (such as enlargement of the EU) may serve to increase migration into the UK, the UK has increasingly become a source of nurses recruited by other countries, meaning that there are fewer trained staff to support an increasing, and increasingly elderly, population.

2.1.5 Political backdrop

At the time the work was conducted there was continuing uncertainty regarding the timing and likely outcomes of the impending election and what impact this would have in terms of, for example, future budgets and, perhaps more importantly, budget cuts for the NHS. Regional and national governance structures continue to have an influence on the development of health care strategies and policies as a consequence of the devolution of power from Westminster, and there was an acceptance that Government control and political interest in what the NHS is doing would continue to play a key part in directing policies that would affect day to day running.

2.1.6 Epidemiology and Public Health

There is a range of complex issues around public health that will have implications for the future health provision; for example increasing levels of migration, tourism, air travel etc. lead to a growing potential for the spread of an
Uncertain Futures Workshops

increasing array of communicable diseases and fears for increased risk of pandemics.

Such events will place increasing pressures on the NHS at a time when resources are shrinking. Other public health concerns centre on the impact a recession or unstable economic conditions might have on health inequalities. On the other hand there are increasing benefits arising from advances in medical science, which brings about a paradoxical situation in which on the one hand advances bring benefits on a macro scale to improve the nation’s health while on the other hand the additional care activities arising from the increasing longevity of the population will have cost implications at a time when budgets may need to be cut.

2.1.7 Social and lifestyle factors

Although the anti-smoking campaign has been successful in bringing down smoking rates, there has been little success in controlling the growing problems of obesity, binge drinking and sexual health. The consequences of rising rates of obesity and alcohol consumption are likely to be seen in the health of the population. A key challenge therefore will be the extent to which people can be encouraged to accept responsibility for their lifestyle choices and, consequently, their own health. These choices are likely to have implications for the demands they make of the services of the NHS. Unhealthy lifestyles are a growing threat to the nation’s health and a major reason why the NHS may struggle to meet its goals; the problem is further aggravated by the challenge of getting certain social groups to accept public health advice.

2.1.8 Environment

The commentators shared a level of unease about the ways in which climate change might constitute a challenge for the NHS. Immediate concern centres on how dramatic changes to weather patterns (in particular heat waves) might adversely affect the health of vulnerable groups such as the elderly. There was also a concern regarding the implications of major changes in the environment, eg the impact on public services in the UK should the effects of global warming trigger large scale population shifts, with people moving to the UK en masse.
3 The Scenario-building Workshops

3.1 Inviting participants

During September 2009 Skills for Health sent out an invitation to participate to members of their newsletter mailing list, followed up in October with a publicity item in a newsletter sent out primarily to HR and workforce planning personnel within the sector. Fifty-four individuals signed up for the three workshops; of these, 49 attended. The numbers were supplemented by Skills for Health staff who participated as full members of the workshops. Each workshop was attended by three researchers from IES who acted as note-takers for the sessions.

3.2 The workshops

The workshops took place on 20 October and 9/10 of December 2009, at Skills for Health’s London offices. The workshops were full day events lasting from 9.30am through until 4.30pm. A copy of the briefing (Appendix 6) was sent to participants in advance of each workshop.

The stages of the workshops are described below. More details can be found in the Appendices 1 to 3, which are the records of each workshop sent out to participants.

3.2.1 Interview headlines, challenges and uncertainties

Participants were invited to consider Figures 1, 2 and 3, which presented the challenges and key questions that had been identified in the expert papers commissioned by Skills for Health and in the interviews conducted with health sector representatives by the Rehearsing Uncertain Futures team. They were also asked to consider whether any issues were missing from the lists, if any issues identified had surprised them and if there was anything with which they particularly disagreed.
Future Challenges for Healthcare

The NHS Organisation
- What needs to change?
- How leaders can lead
- Defining and meeting training needs
- Tackling the retirement bulge

Economic
- A spending freeze
- Improving productivity
- Making technology deliver
- Meeting the needs of an ageing population

NHS Services
- Updating services to meet 21st century demands
- Shifting the focus from treatment to prevention
- Can we shift more responsibility for care to individuals and their families - and should we?
- Preventing private sector cherry-picking

Demography
- Keeping our trained staff
- The future of social services
- Paying for elderly care
- Geographical differences in provision
## Future Challenges for Healthcare

### Political
- How devolution will play out
- Imposed targets
- The future of trades unions

### Epidemiology
- Will continuing globalisation bring more pandemics?
- Will medical research bring real step changes?
- Equality of provision

### Social & Lifestyle
- Will unhealthy lifestyles lead to exclusion from healthcare?
- Developments in alternative medicine
- Managing public expectations

### Technology
- The spread of self-diagnosis
- Will technology support community care?
- Application of human genome mapping

### Environment
- Will climate change lead to population movements?
- Reducing healthcare’s carbon footprint
- New health challenges presented by climate change
Crystal Ball Questions – suggestions from interviewees

Will we have clean hospitals?

(What will be the) implications of scientific and technological discoveries?

Will alternative medicine become mainstream?

Will we have providers and commissioners?

What will society look like in 2020?

(What will be) the public sector financial position?

Will the government deal with the roots of social disorder?

Will there be continuity among the 4 countries of the UK?

Can the elderly expect a postcode lottery?

Will we have surplus midwives in Scotland and shortages in England - or similar?

How ‘hands-on’ will government be?

Where will healthcare workers work - hospitals or homes?

Can we get a sustained health promotion agenda going - like Scandinavia?

What will happen re recognition of non-EU qualifications?

Will we see more progression across professions - generic competences?
The participants discussed what surprised them, what they disagreed with, what issues they felt were understated or even absent from the analysis. No delegates disputed any of the issues identified; in the main it was felt that was that these were perhaps too conservative.

Participants also raised a number of issues that had been overlooked or needed greater emphasis. These included:

- a lack of strong leadership and management in the NHS
- the rise of self-diagnosis and the increasingly informed ‘consumer’
- fears of an increasing litigation culture restricting innovation and positive risk-taking
- increasing specialisation of health practitioners, and
- the need for ‘bolt-on’ training to extend – or remedy – earlier education and training.

In terms of the economic context, there was a widely-held belief amongst delegates that there would be budget cuts, rather than a budget freeze, within the sector. The role of the European Union was believed to be underplayed by the initial analysis, particularly regarding its role in helping to set future healthcare policies. The challenges around technology and IT were also believed to have received insufficient attention.

Participants also felt that the sheer pace of change was an additional challenge which was missing from the stimulus materials, along with the impact of constant change and the failure to consolidate developments.

The challenges of moving from an illness to a wellness agenda were believed to require greater emphasis and participants also questioned the current position regarding the provision of free care for those individuals who chose to pursue an unhealthy lifestyle. They felt that the potential for conflict between different public policy ‘agendas’ had been overlooked – such as the potential conflict between increasing individual choice and increasing individual responsibility for health.

There were questions about ‘personal budgets’ and the types of services which individuals might be expected to pay for (instead of being available through public funding) in future. Participants also believed there should have been some mention of alternative funding arrangements, issues around patient choice and demand management.

Regarding the ‘Crystal ball’ questions, the main comments were that these questions presume the continuation of England as the key entity in the UK (rather than increasingly regionalised healthcare) and also presume that the NHS might
16  Uncertain Futures Workshops

still exist largely unchanged in 2020 – participants queried whether healthcare could remain ‘free at the point of demand’. They also believed there was a need for questions relating to the role of (and indeed challenges for) for the private sector.

3.2.2 Looking back: The Timeline exercise

In order to understand the ways in which events will impact in future it is helpful to first look back at how events have played out in the past. For this reason in the next exercise participants were asked to discuss in small groups the significant events that had shaped the NHS as we know it today. They were asked to categorise the significant events that they identified as falling broadly into the spheres of politics, education, society, technology, legislation or environment (PESTLE). Each event was written on a post-it and these were then stuck on to a poster showing the timeline of developments (see Figure 3.1 below).

Figure 3.1: Timeline of developments

Across the three workshops legal and environmental developments appeared to have played a more limited role than events in the other categories. Early events identified as amongst the most significant included: the work of Florence Nightingale during the Crimean war; World War II and the development of
antiseptics and antibiotics and vaccinations; and public health developments during the 1850s, especially the impact of the introduction of the sewerage system. During the mid-twentieth century significant events included: changes to housing and nutrition, the introduction of contributions towards the cost of eyecare and dental care, and the introduction of ‘general management’ within the NHS.

In the later decades of the 20th Century the Thatcher Government, the rise of the internet, the introduction of the Community Care Act, the Bristol Enquiry and revelations about Harold Shipman were all believed to have been significant. Other events included the impact of population change, HIV and the Griffiths Report, the change to a Labour government in 1997, Agenda for Change in 2004, the introduction of GP contracts, NHS modernisation and widening of the EU.

Most recently the development of keyhole and subsequent day surgery, pay modernisation, the Maastricht Treaty and European Working Time Directive and the smoking ban were all viewed as significant events.

3.2.3 Drivers of change in strategic environment

In the next exercise participants were asked to identify a range of current and likely future drivers of change. They were then asked to classify drivers as either ‘contextual’ or ‘transactional’ factors.

Contextual factors are those factors in the external environment within which the health sector operates, for which it needs to act in response to – for example, the economy, an ageing population or global politics. In many respects these forces will shape the sector and those within the sector need to be aware of how these factors will affect it.

Transactional factors are those institutions, policies or groups with which the health sector will need to work or influence in order to achieve what it wants. These might include policy-makers, regulators, legal bodies, funding institutions, and professional or patient groups.

Participants were asked to place the factors they identified onto a ‘Strategic Environment’ map to provide an overview of the various factors impacting upon and within the health sector (see Figure 3.2).
The sets of factors identified by all of the groups of participants are shown in the individual workshop reports shown in Appendices 1 to 3.

In each of the three workshops the factors identified by participants were grouped into a smaller number of overarching factors. After participants had identified the factor groupings they were asked to classify each in terms of the extent of uncertainty as to the way in which these factors would play out and whether the factor was likely to have a high or low impact on the health sector. The factors were then located within the four quadrants of the ‘Uncertainty-Impact’ chart shown in Figure 3.3:
The outcome of this classification exercise was to give a distribution of factors for the factors identified by each workshop. Photographs of the actual factor distributions are shown in the workshop reports appended (Appendices 1 to 3).

The focus for the remainder of each workshop was on the factors identified as being of both **highly uncertain nature** (in terms of how it would play out over the coming years) and of **high impact**.

In the first workshop seven main factors emerged as being of high impact and high uncertainty and for which there was broad consensus across the two groups; workshop two generated eight and the third workshop generated ten factors.

The factors identified in each workshop are shown in Table 3.1 below. It is possible to see some commonality between all three workshop groups.

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<tr>
<th>Table 3.1: Workshop factors</th>
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<tr>
<td><strong>Workshop 1</strong></td>
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<td>The choice agenda</td>
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<td>Public/private provision</td>
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<tr>
<td>Education and training</td>
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<tr>
<td>Technology</td>
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<td>Socio-cultural-geographic groupings</td>
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<td>Finance</td>
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<td>The ageing population and dementia</td>
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*Source: IES Scenario Building workshops, October and December 2009*

### 3.2.4 Scenario building methods

There are two recognised methodologies for building scenarios – deductive and inductive. Essentially, the deductive approach involves first developing a framework and then creating stories that fit within that framework. This is often expressed in a quadrant where the two largest influencers shape the possible futures on an X and Y axis.

The inductive methodology reverses that approach by first creating stories and then crystallizing the framework that emerges from them. Both methodologies use drivers of change to populate the stories.
The Skills for Health workshops applied the inductive approach. The benefit of this approach is that it makes it possible to address a wider variety of drivers and their interactions in equal depth. The next stages of the workshops therefore were to build story ‘snippets.’ and then develop scenarios from a selection of those initial ‘snippets’.

3.2.5 Snippet and scenario descriptions

In each workshop sets of cards were produced for the working groups, in which each of the identified high uncertainty, high impact drivers was written on a separate card. Each group worked with one set of cards, drawing out three drivers at a time (eg technology, the choice agenda, and education and training) and exploring these successive combinations of drivers to create story snippets.

Participants were asked to think about the likely impact(s) of the combinations of drivers in 2020, but this required them also to consider the events that would need to happen along the way in order for these partial scenarios to arrive at the conclusion predicted.

The groups then picked a selection of their story snippets to develop into scenarios, with dates for the key events along the way. The storylines that were developed in each workshop are shown in detail in the individual workshop reports (appended).
4 The Scenarios

The scenarios and snippets produced by the participants across the three days of activities were then woven together with the other drivers to produce three coherent scenarios. These are shown in detail in Appendix 6, which is the briefing document that was sent to Skills for Health participants ahead of the application workshop (see Chapter 5 for details). The three scenarios developed from the workshops are briefly outlined below. The hexagon graphic is used to show the drivers that were used to generate the scenario.

**United we stand**

By 2020 the new international institutions needed to manage the stresses and strains of globalisation, are proving their worth. The European Union is much stronger, bolstered by additional members and a warm relationship with Russia. The European Parliament now outranks EU national governments and all regulations are harmonised across EC members. It is a more multi-cultural world, with the notion of social partnership being all-pervasive.

There is more of a sense of individual social responsibility. In health, not taking personal responsibility can lead to difficult questions: there are questions over whether people who are obese or who choose to smoke should be considered as eligible for treatment when the need for those treatments arose only because of personal irresponsibility. Funding is available but not at very high levels and disbursement or targeting of funds is informed by the notion that people have to
be seen to be making an attempt to look after themselves. Some things will have to be funded through insurance.

The increased concentration of resources coupled with some long-awaited technological innovations offers hope of mitigating the worst effects of an ageing population. However, this is a risk-averse world. The world certainly feels safer but progress comes at a price. Supermarket start to take the lead on alcohol advice and activities after years of complaints about the binge drinking culture. But there are mixed reactions to this: is it a responsible reaction to the social problems of overindulgence in alcohol or another example of the nanny state?

There is community action for, and largely run by, older people, mostly on a voluntary basis. It is possible that fears about the legal situation regarding health and safety, and safeguarding, would mitigate against this component of the scenario. But there are many people happy to volunteer (and many of them older people), and who better to advise people in the community than someone who has been through the experience themselves? The shape of households will have an impact on this, along with the cultural background of the family and the extent to which we are all multicultural.

However, this is a world in which Brussels sets the rules. Individual countries have very little say. Traditional UK institutions lose their role and are significantly reduced.

**Business Class or Economy Class?**

The emerging economies drive high global growth – but it is not shared by all. Despite increasingly elderly populations, most European nations have just enough tax revenues to maintain scaled-down versions of existing social welfare systems and service their debts. However the tight constraints on public spending translate into systems that are seen as increasingly inadequate by those forced by low incomes to rely on them, creating a polarised society of haves and have nots.
and infirm individuals to be maintained and supported in their own homes. ‘Robonurse’ will raise an alarm if help is needed. The Robonurse monitoring system could be anywhere in the world; it saves money and saves lives.

In this world body parts are available for sale via the web – if you have the money to buy them. Closer to home, healthcare products become increasingly available and it becomes possible to buy diagnostic tests and procedures through shopping malls and supermarkets.

**It’s your choice**

This is a fragmented world where there is no shared agenda for global progress and, apparently, little appetite to develop one. Catastrophic climate events have met with limited and patchy responses. There are frequent border clashes and ‘tribal’ wars and effective government action is absent. However, as devolution of powers is the response, this enables some to seize the opportunity to shape their own destiny for the better.

This scenario is perhaps most challenging for the healthcare model. There is no one single model. Institutions are ineffectual. People do not feel safe or secure and there are few funds for public services. Early on there is a ‘bonfire of the Quangos’ and this is very popular. Constraints in funding lead to tensions between young and old, and between different ethnic groups. It is a fragmented and self-centred world, with the emergence of special interest groups which are antagonistic to other groups and the rise of single issue political parties. By the middle of the decade there is a hung Parliament. As a consequence, while Central Government holds onto the powers to tax and raise revenues, budgets are decentralised. Local
people have the power to influence the distribution of local budgets through the vote, but the amounts of money available are not large. There is a need for prioritisation and there are arguments about the ways in which funds are allocated.

People then look to remove duplication in bureaucracies and there are increasing experiments with amalgamating hospital and local authority HR services. This leads to a multiplicity of local models, and no straightforward answer to the question of who ‘owns’ healthcare any longer. Technology allows individuals to undertake their own diagnoses and everybody owns their own data (diagnostic outcomes). The web facility ‘Medispace’ facilitates this. This is a fragmented model with no single predominant model and there is a multiplicity of different healthcare views.
5 The Application Workshop

In the final stage of the work the research team met with 12 Skills for Health directors to explore what implications the scenarios would have for the health workforce. The briefing document (Appendix 6) was sent out to all attendees ahead of the workshop.

An overview of the scenario methodology and the scenarios was given at the start of the day.

5.1 Discussion of the scenarios

Participants were invited to give their views on the credibility of the three scenarios and how they might emerge over the next 10 years. Could the Skills for Health representatives see the seeds of the future within these scenarios? What signs can be spotted today that indicate which direction society is travelling in?

The third scenario, ‘It’s your choice’ was thought in many ways to be starting to take shape already. Facebook and other social networking sites provide the means by which special interest groups can form, there have been citizens’ initiatives in the US that have tested out opportunities for proposing issues to put to the vote in local communities. Diagnosis sites exist already and organ sales over the internet (‘healthcare on E-bay’) would merely formalise what already occurs on an ad hoc (and, admittedly, illegal) basis. Regarding social inequalities, on the one hand there is a rise in ‘gated communities’ for the wealthy, while community groups serve to redress inequalities in local power and decision-making. One particular frustration to emerge from this model was that the available technologies are not being used effectively, such as to share patient records across hospitals. The view was the technology exists and improved IT systems would be ‘doable’; the problem lies with the NHS.

With the ‘United we stand’ scenario, while people did feel that increasingly there is an attitude of ‘you’ve brought it on yourself’ other aspects of this scenario did not
look very credible. Although there was likely to be more integration between the states of the EU the mechanics of operation were likely to remain as an add-on bureaucracy rather than replacing the authority of individual states. Participants felt it was likely that the UK would become more marginalised. The increasingly litigious culture in the UK was thought likely to militate against increasing reliance on volunteering as a way of improving support for people in the community.

Again for the ‘Business class or Economy Class’ scenario there were thought to already be some indicators in existence. It is effectively the split between those who can afford any procedure they wish, versus those dependent on the NHS and postcode lotteries, ‘writ large’. There have been NHS pilots of the use of monitoring technologies to maintain people in their own homes and so Robonurse is not far removed from this existing scenario. Diagnostics in the shopping mall is little more than an extension of the situation in which pharmacies have outlets in supermarkets and people can have tests undertaken in private surgeries in train stations.

5.2 Response to the scenarios

The Skills for Health members discussed each of the scenarios. To some extent elements of all scenarios were thought to be in existence already. Some elements provoked much debate: on the one hand, the idea of almost total devolution of legislative responsibility to Brussels was seen as unlikely, but it was acknowledged that in some respects, it would take very little additional legislation to build upon (for example) the provisions of the E111 card. Recent case law was seen as starting to push developments towards a European entitlement. The development of local community groups was seen as supporting the notion of increasingly localised provision, often delivered primarily on a voluntary basis, but contrasted with this was the belief that an increasingly litigious culture would serve to militate against this.

5.3 Emerging roles

The Skills for Health delegates were asked to consider some of the types of roles that might emerge from these scenarios (Table 5.1). Three new possible roles were envisaged as emerging: a level 4 Generic Community Worker; a Personal Health Navigator and a Remote Diagnostic Technician.
5.3.1 Generic community worker, level 4

This role would work with people with long-terms conditions and the role would be part health, part social care and part education. There would be considerable variety in the range of employers and practice. There would be little consistency in central provision. Within the Business or Economy Class scenario participants saw this being a state or centrally funded role that would largely be focussed on providing support for disadvantaged families, although there was scope for this role to exist in the private sector too. However, the state-funded role may diminish if it becomes unaffordable.

5.3.2 Personal health navigator

This is someone who is an ‘amalgam’ of advocate, information organiser, broker. It is a care co-ordinator role, with the three different components being differentially emphasised in different situations.

There is one key question relating to this role. Is the navigator’s prime client the funding body or the individual? In many ways there is a similar question relating to the role of the social worker now.

They would see the market place maintaining the quality of the role, rather than a regulator. Who they work for would set the level at which they are paid. There would be a common role but different manifestations of it in the different settings. Under the United We Stand scenario the group felt that there was a good possibility that the role would fit within the voluntary sector.

5.3.3 Remote diagnostic technician

This role would involve monitoring banks of telemetry. The role might also involve undertaking trend analysis and systems diagnostics. Because the role is based in a control room, there could be tiers of technology rather than people, with just occasional monitoring by a person. It could be based anywhere in the world. This role could also be responsible for allocating visits by District Nurses on the basis of the outputs of the monitoring – if a person is okay, it may be deemed unnecessary to visit them that day.
The main responsibilities of these emerging roles are summarised in Table 5.1.

### Table 5.1 Emerging roles

<table>
<thead>
<tr>
<th>Role</th>
<th>Level 4 Generic Community Worker</th>
<th>Personal Health Navigator</th>
<th>‘Remote’ diagnostic technician</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsibilities/ background</strong></td>
<td>For children with long term conditions</td>
<td>Advocate, information interpreter guider, assistant to manage the system, co-ordinator</td>
<td>Monitoring telemetry</td>
</tr>
<tr>
<td>Part health</td>
<td></td>
<td>Enabler of high quality decision making</td>
<td>Directing ‘incidents’</td>
</tr>
<tr>
<td>Part social care</td>
<td></td>
<td>GP Role out of the medical framework</td>
<td>Trend analysis</td>
</tr>
<tr>
<td>Part education</td>
<td></td>
<td>Shift in power from GP to patient</td>
<td>(Planned maintenance schedule) System diagnostics Not (necessarily) a person (much of this could be done by technology) Employed anywhere in the world</td>
</tr>
</tbody>
</table>

*Source: IES application workshop for Skills for Health, 2010*

### 5.4 Impact on stakeholders

In the next session the Skills for Health delegates considered the impact of the three scenarios on a selection of stakeholders. An example stakeholder group is shown for each scenario in Table 5.2 below:

### Table 5.2: Impact on stakeholders

<table>
<thead>
<tr>
<th>Scenario</th>
<th>It’s Your Choice</th>
<th>United We Stand</th>
<th>Business or Economy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholder group</strong></td>
<td>Patient</td>
<td>Health Care Assistants</td>
<td>Nurses</td>
</tr>
<tr>
<td>Impact</td>
<td>Overall less feeling of security</td>
<td>Slight raising of skills and shift in skills set</td>
<td>NHS:</td>
</tr>
<tr>
<td></td>
<td>More greater numbers of people, however they will be more highly skilled</td>
<td></td>
<td>• increased difficulty in recruiting • increased immigrant nursing</td>
</tr>
<tr>
<td></td>
<td>Confusion - it’s all different</td>
<td></td>
<td>Increasing dependency on vocational/voluntary/social consciences participation in caring for poorer communities</td>
</tr>
</tbody>
</table>
Institute for Employment Studies

29

Scenario It’s Your Choice United We Stand Business or Economy

Very individualistic, ‘Why aren’t I getting that?’ Instruction of people to use technology Nurses as managers of virtual teams from technicians, social care etc

Lots of choice and control if I have ability to manage this:

• polarisation between those who can manage and those who can’t

Enabling people to make some decision

Worried if I’m making the right choice - too much choice

Helping understand

Need more education

Undertake some roles currently restricted by professional roles

How will I pay for extras?

Will I need to move to get services I need?

Source: IES application workshop for Skills for Health 2010

5.5 Signposts

The final part of the work was to consider the issues that would signify that the environment was moving in the direction of one or other of these scenarios. Some initial suggestions are shown in Table 5.3 and these will be developed in greater detail later this year (late 2010) to assist Skills for Health in their future monitoring activities.

Table 5.3: Examples of signposts to the three scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Within the health sector</th>
<th>Nationally</th>
<th>Internationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business or Economy</td>
<td>There is already effectively a split between those who can afford any procedure they wish through private provision and insurance, and those who are dependent on the NHS. Pilots have been run testing the use of monitoring technologies to maintain people in their own homes, ‘tele-care’ is an often-used</td>
<td>Some areas are better served than others (geographical disparities). Further recognition/acceptance of disparities in service would indicate two-tier service becoming more accepted as way forward. National debate on what services should continue to be provided by NHS (eg suggestions that podiatry be removed). If debate culminates in agreement that</td>
<td>Wealthy people already go overseas for procedures not available in UK (eg selecting gender of baby). A further signal would be if companies in other countries started actively advertising services to UK residents.</td>
</tr>
</tbody>
</table>
### Signal location

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Within the health sector phrase; ‘Robonurse’ not far removed from this existing situation. ‘Diagnostics in the shopping mall’ is little more than extension of current situation in which pharmacies have outlets in supermarkets and people can have tests undertaken in private surgeries located in railway stations.</th>
<th>Nationally some services should not be provided by NHS this would signal increased likelihood of this scenario.</th>
<th>Internationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>United We Stand</td>
<td>Increasingly an attitude of ‘You’ve brought it on yourself’, intolerance of free health provision for socially induced ill health (eg liver transplants for alcoholics). (Signal against) Increasingly litigious culture in the UK likely to militate against any increase in reliance on volunteering as a way of improving support for people in the community.</td>
<td>(Signal against) Although more integration between EU states is likely, the mechanics of operation are likely to remain as an add-on bureaucracy rather than replacing the authority of individual states.</td>
<td></td>
</tr>
<tr>
<td>It’s Your Choice</td>
<td>Available technologies are not being used effectively, such as sharing patient records across hospitals. The technology exists and improved IT systems would be ‘doable’; the problem lies with the NHS. More attention on reforming NHS collaboration using technologies would make this scenario more likely.</td>
<td>Facebook and other social networking sites provide the means by which special interest groups can form. Rise in ‘gated communities’ for the wealthy, while community groups serve to redress inequalities in local power and decision-making.</td>
<td>There have been citizens’ initiatives in the US testing out opportunities to propose issues to ‘put to the vote’ in local communities. Diagnosis sites exist already and organ sales over the internet would merely formalise what already occurs on an ad hoc (and, currently, illegal) basis already. Change in legislation relating to sale of organs would signal increasing likelihood of this scenario.</td>
</tr>
</tbody>
</table>

*Source: IES application workshop for Skills for Health 2010*
6 Conclusions

Scenarios are living documents which should be embedded in future strategy processes.

They can be used to develop, test and validate strategies against potentially different futures, to identify what strategies apply in all scenarios or where contingency plans might be needed. They can be used to consider how the future might be influenced so that more preferred scenarios emerge.

The work has culminated in identification of some signposts for Skills for Health to monitor in the coming years. It is clear that there are already signs that indicate that some elements of each scenario may be emerging, some more strongly than others. Exemplar signals have been identified and reports in the press and other media are being currently being collated for later examination as evidence for any of the three scenarios emerging as more likely than the others. Continuing monitoring of signals will be an important component of Skills for Health’s future activities to ensure that they stay ahead of the emerging workplace context.

A start has been made on identifying the staffing and development implications of the alternate scenarios to inform Skills for Health’s future skills strategies. However, use of the scenarios need not be restricted to this: all organisations in the health sector potentially can use the scenarios as a basis for considering their medium and long term workforce strategy.

Further work is now underway to explore the additional implications for the private and charitable/voluntary sectors.

The next stages for Skills for Health will be to integrate the findings from these sectors with those reported here; develop a robust monitoring, horizon scanning and reporting process; and refine their strategies to make them sufficiently robust to deal with these possible alternate future worlds.
Appendix 1: Summary of expert papers and interviews in preparation for scenario building workshop

Introduction:
This report details the views expressed in specially commissioned expert papers and confidential interviews from a sample of healthcare stakeholders.

The overall aim is:
1. To condense extensive and varied raw text data
   • into key categories between challenges, drivers and plausible outcomes
   • to highlight connections and interconnections.
2. To provide a useful starting point for the group to take the next step in scenario building, out of which strategic models and frameworks for possible alternative futures will emerge to inform future workforce strategies.

Inductive Research searches for patterns, concepts and/or hypotheses through the reading and coding of transcripts. It aims to identify (mutually) shaping and interactive influences, in this case, to create focused generalisations and emergent themes (challenges, drivers and plausible outcomes).

The approach taken is to identify and rank the key challenges to the future healthcare environment which contributors identified, to pull out the main drivers which will impact how those challenges may play out, highlighting areas of agreement and disagreement and to float some plausible, potential outcomes for each challenge.

Confidentiality:
The information provided to participants is given on the basis of full confidentiality. No information contained in the report analysis, expert papers and interview notes will be disclosed to anyone outside this exercise. The information will be used uniquely for the purpose for which it was intended and all materials provided were anonymised for the analysis. Interviewees have not been identified because they were guaranteed full anonymity. Authors of expert papers are acknowledged as the final versions of their papers will be available from the Skills for Health website.
Contributors

Expert papers were commissioned by Skills for Health from:
Bryan Stoten, Chair of NHS Warwickshire
Graeme Martin, University of Glasgow
Jim Buchan, Queen Margaret University College Edinburgh
Candace Imison, Kings Fund
Nick Bosanquet, Imperial College, London
Chris Ham, University of Birmingham

Interviews were undertaken with ten individuals within the health, legal and learning and skills sectors who were given assurances of anonymity and so cannot be named.
## Contents

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Drivers &amp; Plausible Outcomes</th>
<th>Page Number</th>
</tr>
</thead>
</table>
| 1. The NHS Organisation    | NHS Workforce Training  
|                            | Organisation  
|                            | Leadership  
|                            | Handling Change                                  | Page 5 - 12 |
| 2. Economic                | Healthcare Funding  
|                            | Healthcare Spending  
|                            | The Recession                                    | Page 12-15 |
| 3. NHS Services            | Models of Care  
|                            | NHS Core Principles                              | Page 15 - 17 |
| 5. Political               | Government  
|                            | Trade Unions                                     | Page 18-20 |
| 6. Epidemiology            | Public Health                                     | Page 20-21 |
| 7. Social & Lifestyle      | Health Risks  
<p>|                            | Public Expectation                                | Page 21-23 |
| 8. Technology              | Use and Transfer of Data                          | Page 23-24 |
| 9. Environment             | Global Warming                                    | Page 24     |</p>
<table>
<thead>
<tr>
<th>Challenge/Theme</th>
<th>Frequency – Comments</th>
<th>Overview of Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenge Ranking 1st</td>
<td>120</td>
<td>The highest ranking challenge that has emerged from the analysis of the expert papers and interviews is the NHS itself. One of the important elements integral to this challenge cluster is the workforce, and as a driver it attracted most comments. Other important elements giving shape to the size and complexity of this challenge cluster include:</td>
</tr>
<tr>
<td>THE NHS ORGANISATION</td>
<td></td>
<td>1. Organisation: what is it that needs to change – are the structures in place fit for purpose?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Leadership: an insight into what has to change if leaders are to deal with the new agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Training: ensuring training needs are met</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Handling Change: the unique features of handling change in the NHS</td>
</tr>
<tr>
<td>Areas of Agreement</td>
<td></td>
<td>The topics that attracted a measure of agreement included the problem of the ageing workforce, the prediction of a continuing shortage of healthcare staff, the funding crisis, the lack of progress on the deployment of staff to support strategic shifts in care delivery eg care in the community, the recognition that training for medical staff needs to be broadened, that training policy must synchronise with operational staffing levels and the conclusion that the NHS fails to handle change.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ‘McKinsey Management Consultancy recommends to the Secretary of State for Health that the NHS should slash its workforce by around 10% or 137,000 staff’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Driver</th>
<th>Frequency – Comments</th>
<th>Comments &amp; Illustrative Quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS WORKFORCE</td>
<td>46</td>
<td><strong>Supply Issues</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ‘Diminishing Workforce: in past 5 years specific medical professions have had staff shortages. In next 10 - 20 years, unless there is an influx of skills into the UK, this will be a major issue. Private sector (not just health sector) is able to offer support staff higher pay’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ‘…health ministers (of whatever party) will argue for both pay restraint and a return on investment that has been made.’</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Workforce Planning</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ‘Traditional reliance on junior doctors as a mainstay of service provision is under threat as a consequence of their reduced working hours....’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o ‘Global recession .... funding for the NHS and social care will become much tighter after the current spending review in 2011....With around 70 per cent of NHS Budget being spent on pay it is inevitable that the use of the workforce will come under increasing scrutiny’</td>
</tr>
</tbody>
</table>
### Areas of agreement

The NHS will have increasing numbers of staff retire over the next 5 years.

- The healthcare workforce is ageing alongside the wider population. If the workforce is fit and retires later this will not be a problem, but if not we could see significant gaps in the workforce. Some are already predicted in the community nursing workforce.

As staffing costs are such a large proportion of the NHS budget they must be a target for cuts and the resulting headcount reductions will make managing the service very difficult and carry considerable risk.

- the fiscal challenge (is) the ‘greatest ever leadership challenge for the NHS… with little or no cash increase from 2011/12 the NHS will need to plan for real term funding to fall by 2.5 - 3% per annum…it is unavoidable that this will also translate into fewer staff. …foundation trusts plans could lead to the cut of 16,500 nursing jobs - a cut of one in ten jobs in the NHS’

### Areas of disagreement

‘I would call for calm about predictions …it is the case we have 250,000 qualified nurses and 100,000 in the community but not practising their skills in the NHS. ’

<table>
<thead>
<tr>
<th>Driver</th>
<th>Frequency – Comments</th>
<th>Comments &amp; Illustrative Quotations</th>
</tr>
</thead>
</table>
| NHS WORKFORCE | **Plausible Outcomes** | 1. Government/DOH set up a fast-track system to develop and introduce new roles in response to gaps in the existing workforce skill mix – the gaps need to be bridged if emerging demands on the service are to be met or the introduction of major change programmes are to progress.  
2. Transfer to jobs where new services are being introduced or areas of skills shortages; training programmes to support  
3. Trade Unions and professional bodies go head-to-head with the Government and employers over measures to accelerate changes to the workforce  
4. Staff turnover and absenteeism rates climb and put services in certain places at risk |
<table>
<thead>
<tr>
<th>Driver</th>
<th>Frequency</th>
<th>Comments &amp; Illustrative Quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRAINING</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td><strong>Training Priorities</strong></td>
<td></td>
<td>‘Current training programmes, particularly for doctors, focus on the biomedical model. Little is taught about the way healthcare is delivered and the way in which technical innovation might support different ways of practice. We need healthcare professionals to be innovators in process redesign as well as clinical innovators. Managers are too removed from clinical practice to effectively drive this innovation’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘The NHS training priorities are not to increase the number of people in the entry level jobs - it is to develop the capability of the team already there to deliver better services’</td>
</tr>
<tr>
<td><strong>Synchronising Training to Workforce Places</strong></td>
<td></td>
<td>‘What will happen to staff completing their training and entering the NHS at a time when fewer posts will be available?’</td>
</tr>
<tr>
<td><strong>Supporting organisational change</strong></td>
<td></td>
<td>‘…. more investment in specialist bridging training for hospital-based and other acute-sector nurses who are interested in working in the community sector and … efforts to establish community orientated pre- and post-registration education courses to increase the supply pipeline’</td>
</tr>
<tr>
<td><strong>Policy Changes</strong></td>
<td></td>
<td>‘The move to all graduate entry for nursing was based on education led arguments that nursing must become a graduate profession to meet the needs of complex care delivery …’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Regulation of health professionals e.g. by 2011 doctors will need to demonstrate to GMC every 5 years that they are fit to practice. Re-validation will also be applied to nursing and other medical professions in due course’</td>
</tr>
<tr>
<td><strong>Areas of agreement</strong></td>
<td></td>
<td>Need to synchronise training programmes with operation and workforce planning; also that clinical training has to be much broader.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Implicit in current training programmes is the assumption that the professional is the authority and source of medical knowledge. Professionals need to be taught how to engage patients as ‘co-producers’ of their health and care.’</td>
</tr>
<tr>
<td>Plausible Outcomes</td>
<td>Plausible Outcomes by Driver</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>1. An exhaustive and far-reaching review is carried out to determine what training is needed to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. support organisational change arising from initiatives e.g. ‘Shift the Balance of Care’</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. meet emerging healthcare agenda</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. deliver austerity measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. support impending policy changes</td>
<td></td>
</tr>
<tr>
<td>2. Training has to be done at lower cost to accommodate the drive to cut costs – hence more coaching, a shift to online training and on-job training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Effort is made to synchronise training with workforce requirements as a cost saving measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Specifically training to help the health professional adapt to the impending change could be as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Delivering and demonstrating value:</strong> Professionals will need to demonstrate value in the care they deliver. There will be growing pressure for them to take on leadership roles and be accountable for spending. This will not only require leadership and managerial skills but the skills to innovate and improve the process of care. Team working will become the norm. The greater focus on team working means that as well as needing <strong>team-working skills</strong>, professionals will need to define their unique contribution to the team. The pressure upon doctors’ time and the importance of rapid accurate diagnosis for efficient use of resources means that doctors are likely to focus on their role as diagnostician and care planner rather than as an administrator of treatment.</td>
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<td><strong>Coping with the exponential rise in information and knowledge:</strong> Professionals will need to make much greater use of information technology to support clinical decision making, and be expert knowledge managers as well as <strong>navigators</strong>. The increasing engagement of patients in their own care may mean that professionals also support patients to navigate clinical information more effectively.</td>
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<td><strong>Supporting self-care - enabling patients to be co-producers of care:</strong> Professionals will need to have the skills to <strong>help engage patients in their own care</strong>. Different patients will have different capabilities and so professionals will need to be able to adjust flexibly to this. Clinical teams will need to help patients navigate their way through a complex care system and support them in their transition between one provider and another. There is likely to be an increasing need for clinical teams to be expert at <strong>navigation and support across clinical pathways</strong>.</td>
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<td><strong>Promoting improvements in public health:</strong> There is a demand for professionals to promote health as well as treating illness. This will increasingly include genetic counselling as they speak to patients about the relative risk of disease created by an individual’s genetic make-up.</td>
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<td><strong>Managing the rising burden of chronic disease:</strong> Patients are living with disease, and as they get older, people will often have more than one disease, frequently a combination of social, physical and mental health problems. There will be an increasing need for generalists.</td>
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</table>
Adapting to technological change: Technological change is likely to drive changes in demarcation between primary, secondary and tertiary care. The pressure to deliver specialist care in the community may drive a separation between ‘hospitalists’ (physicians, experts in managing patients in a hospital setting) and new office-based specialists who would work alongside practitioners in the community. Clinical roles will need to be flexible and able to adapt to changing technologies. Continuing professional education and development will be of increasing importance.

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<tr>
<th>Driver</th>
<th>Frequency – Comments</th>
<th>Comments &amp; Illustrative Quotations</th>
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<tbody>
<tr>
<td>ORGANISATION</td>
<td>19</td>
<td><strong>Performance &amp; Productivity</strong></td>
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<tr>
<td></td>
<td></td>
<td>o ‘Primary care, practice based commissioning provides an opportunity for groups of practices to work together to improve efficiency’</td>
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<td>o ‘A feature of service line reporting and practice based commissioning is the involvement of clinicians leading the search for improvements in performance’. The most important opportunities for productivity improvement may relate to variations in clinical practice rather than management costs and back office functions</td>
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<td><strong>Managing Change</strong></td>
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<td>o ‘A solution to inefficiencies could include more flexible working patterns and creating jobs that fill the gaps in service eg emergency care practitioners in the ambulance service’</td>
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<td>o ‘We are getting better at working across health and social care’ - we need to accelerate this’</td>
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<td>o ‘We need to get smarter at our horizon scanning and really understand from the academic world what some of the changes might bring’</td>
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<td><strong>Power &amp; Influence</strong></td>
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<td>o ‘The public, politicians and healthcare professionals will continue to influence health sector but professionals’ influence is declining ‘I think it's increasingly the public, I think the role of professionals has diminished. …I think inevitability it's shaped by politics …The balance has changed and I think it has to be seen much more as a partnership into the future’</td>
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<td><strong>Structures</strong></td>
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<td>o ‘Foundation Trusts have not yet played a very distinctive role in developing staff and more and more decision making seems to be passing to the SHAs. Foundation Trusts will soon be the main employers: on manpower there are few signs of what they regard as vital for the business...’</td>
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</table>
### Areas of agreement

Programmes of change such as Service Line Reporting help to build organisational capacity.

### Plausible Outcomes by Driver

**ORGANISATION**

1. The funding crisis engenders a greater spirit of cooperation and commitment to engage with cross-cutting projects and programmes that are aimed at improving performance, delivering productivity, eliminating waste and streamlining processes and improving service delivery.
2. Task groups are introduced in PCT and Trusts etc as a means of raising morale; the aim is to tackle the problems of change and shifting services. Membership of these groups is in addition to the day job.
3. New structures are designed to accommodate new staffing complements (in the event of job losses) or to drive forward new working practices configured in such a way to deliver cost savings/productivity.
4. Best practice is shared around the NHS and the devolved administrations (Scotland, Wales and Northern Ireland) in terms of reviewing new ideas of how best to organise for both change, functional delivery and productivity.

**LEADERSHIP**

17

**Historic perspective**

- Perspectives of Senior Leadership: Blackler interviewed 25 reputedly successful NHS CEs ... his findings documented the pressures...'rather than being given scope to help lead the reforms of the NHS, chief executives were treated as little more than conduits for the policies of the centre.'

**The Leadership Challenge**

- Perspectives of Senior Leadership: Blackler study concluded that it was questionable whether CEs were leaders in the sense of having any discretion, given the strength of the politicians' level of mistrust of senior leadership teams in healthcare... most likely feed through negatively to the frontline as service characterised by change for change sake and conflict rather than delegation of power and authority, partnership working and a consistent message about what was required.
- ‘Leadership: poor perception that staff have of senior leadership teams with respect to key issues such as delivering patient care, communications, and managing change effectively. Leaders are taking steps to address these problems but there is still strong evidence of a lack of ‘honest’, novel, credible, authentic and sustainable signals being
### Leadership 2.0

‘Leadership: leading a health service organisation is really about facing up to a set of wicked problems but we associate leaders with precisely the opposite - the ability to solve problems, act decisively and know what to do... we have become conditioned to the idea of heroic and charismatic leaders and transformational leadership’

### LEADERSHIP

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<tr>
<th>Plausible Outcomes by Driver</th>
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<tbody>
<tr>
<td><strong>1.</strong> Appointing Chief Executives: candidates undergo rigorous assessments to seek evidence of experience and competencies to deal with ‘wicked problems’ and the unique challenge of managing/leading an organisation handling increasing levels of uncertainty and complexity</td>
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<tr>
<td><strong>2.</strong> DOH organises Master Classes, training events and initiates the setting up of ‘Action Learning’ sets to help existing CEs develop an understanding of, and the skills and coping strategies to deal with, the dilemma of the ‘wicked problem’ as a fundamental tenet to running an Acute Trust or a Primary Care Trust</td>
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<tr>
<td><strong>3.</strong> Leadership development programmes put a high priority on helping senior staff and key decision makers to understand the dynamics of how to deal with the ‘wicked problem’ in an organisation such as the NHS and establish also the importance of raising levels of employee engagement with suggestions of how this can be achieved</td>
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### Problems of handling Change in the NHS

- ‘The problems that leaders face...can’t solve ‘wicked problems’ through proven management processes’ there are 2 types of problems ‘tame problems’ and ‘wicked problems’. ..., Wicked problems are more complicated than tame problems; ..., they have a consequence on the system as a whole. No clear relationship of cause and effect...such problems are often intractable and indeed irresolvable.’
- ‘Handling Change: ‘the health service is fantastically resistant to change....government after government has had big plans’. - these only resulted in superficial changes. ‘The health service is like one of those sort of enormous cushions ...when
### Uncertain Futures Workshops

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<th>Driver</th>
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<th>Comments &amp; Illustrative Quotations</th>
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<tr>
<td></td>
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<td>you punch it and it goes oh God here we go again and it sort of swells up back to where it was before’</td>
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**Leading on Change**

- ‘We cannot solve ‘wicked problems’; we can only learn to live with them and learn to ask the right questions by engaging a wider community and transferring authority to the collective to help resolve them. … the pressure to act decisively often leads to trying to solve the problem as a tame one”

**Areas of agreement**

An almost universal acceptance that the NHS has a problem in handling change.

- ‘the health service, because it is a large organisation, tends to preserve the status quo and changes very slowly. It works in the interest of the people who work there rather than the public it serves’
- ‘Managers at this level face the full weight of system inertia and do not have the revitalising effect of day to day contact with patients. Also have to contend with powerful culture of blame’

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<tr>
<th>Plausible Outcomes</th>
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<tr>
<td><strong>HANDLING CHANGE</strong></td>
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<tr>
<td>1. A detailed study is conducted to determine what are the unique features of handling change in an organisation like the NHS including for example ideas of how to remove ‘the blame culture’</td>
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<td>2. A programme is launched to raise awareness of the implications of working with ‘wicked problems’ via staff training courses and team briefing in order to help develop the quality of followership support and staff engagement throughout the NHS</td>
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<td>3. Older staff who are resistant to change are targeted for support and challenge under the performance management and appraisal process</td>
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<td>4. Employee communications is given high priority – weekly ‘Town Hall meetings’ are held throughout to pull Chief Executives, Directors and staff together to discuss in open dialogue the day-to-day and strategic issues</td>
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<td>5. A user-friendly online employee attitude surveying programme is made available to measure staff sentiments and responses to events, actions of key decision makers and leaders – this service offers a continuous input of data via links to the employee’s work-station or designated input facilities and offers real-time analysis and feedback to Management Boards and Line Managers</td>
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<td>Challenge/Theme</td>
<td>Frequency – Comments</td>
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<tr>
<td>Challenge Ranking</td>
<td>42</td>
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| 2nd | ECONOMIC | o ‘..people are living longer and the balance between young and old is shifting in favour of the latter…. this will require increased NHS spending of around 1% per annum in coming years’
 o ‘NHS spending has increased rapidly in the last decade and is now over £100 billion. Funding is expected to become much tighter in future and will require the NHS to deliver much greater annual improvement in productivity’
 o ‘A collapse in the private residential and nursing home markets could place further pressure on hospitals and community care’

Areas of agreement
Healthcare funding and spending will be a major challenge for the NHS and the position has been further aggravated by the recession and the fiscal meltdown

‘…no funding uplift from now on: if there is no economic recovery, health sector could have to create significant efficiencies and the nation would have to prioritise what they require from the NHS’

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<th>Driver</th>
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| HEALTHCARE FUNDING | 21                   | o ‘NHS spending has increased rapidly in the last decade and is now over £100 billion. Funding is expected to become much tighter in future and will require the NHS to deliver much greater annual improvement in productivity’
 o ‘The factor likely to drive greatest disruption to current healthcare delivery is the prospective squeeze on healthcare funding in the UK’

Areas of agreement
The pattern of funding enjoyed by the NHS over recent years will no longer be possible.

 o ‘In contrast to the past decade, during which healthcare funding enjoyed continuous expansion, with annual rates of growth around 5%, the prospects now are... lower growth if not reduction in health spend’
 o ‘Over past decades, there have been periods of greater/less NHS funding. In the past 5 years it has had more generous funding. From 2011/12 public sector funding is likely to be cut’
## Plausible Outcomes

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<tr>
<th>Driver</th>
<th>Frequency</th>
<th>Comments &amp; Illustrative Quotations</th>
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| HEALTHCARE SPENDING | 12        | - “As a result of an ageing workforce/the pension scheme - there will be an incentive to stay on ...pay will become more age related”  
- “Funding for the NHS and social care will become much tighter after the current spending review in 2011....With around 70 per cent of NHS Budget being spent on pay, it is inevitable that the use of the workforce will come under increasing scrutiny”  
- “Contracting UK and global economies will force down healthcare spending .....I am actually quite in favour of bearing down on cost. I think there is an awful lot of waste in the health system”  

Areas of agreement  
Historically spending patterns were on an upward trajectory as a result of having to provide more services and adopt new techniques, treatments etc. coming out of medical research, but it is now recognised that ‘the show is over’ and spending has to be cut back because of economic difficulties. |
THE RECESSION

The recession will have an impact on demand for services with rising unemployment likely to result in increased levels of physical and mental ill-health.

Future tax increases to help finance the public debt taken on to deal with the recession may result in a reduced number of high earners willing to fund a universal and comprehensive health service that they perceive as being used disproportionately by people on low income.

Key points of agreement

The recession is affecting the NHS in multidimensional ways – it is driving up demand for services, it is going to affect allocation of Government funds and will drive other care providers out of business who at present are taking pressure off the NHS.

The collapse in the private residential and nursing home markets – e.g. highly leveraged companies unable to renegotiate debt burden could place further pressure on hospitals and community care.

Plausible Outcomes

1. The UK economy officially moves out of recession but because of the fiscal problems and national debt, funding levels for the NHS remain depressed and run well below what is required for the next 5-10 years.
2. Investment in capital programmes, and non-core activities is held in abeyance.
3. The workforce becomes demoralised, staff turnover rates continue to rise and we see the departure of our most talented clinicians and other key staff to take up more lucrative overseas appointments.

NHS SERVICES

The main focus of this challenge centres on how the models of care need to change in response to a complex set of factors that collectively need to be factored in so that the NHS is organised, resourced and has a workforce with the right skills in the right place to meet the healthcare needs of the nation over the next decade and beyond.

Key elements to the challenge dynamic include:

1. current services that evolved to deal with the killer diseases of the 20th Century need to shift to accommodate the new threats and demands such as chronic diseases and community healthcare for the elderly.
2. reconfiguring services to focus on prevention.
3. how technology is used to support models of care and medical research.
### Overview of Challenge

4. the impending challenge of driving up productivity and value for money
5. the impact on healthcare policy change arising from devolving power from Westminster to Scotland, Wales and Northern Ireland

Reviewing and reshaping models of care to fit with the demands of a changing healthcare landscape will be required.

- ‘If the NHS in England continues along its current trajectory there will be an increasing disconnect between needs of the population and services provided...the NHS will be addressing the main problems of the last century rather than new problems of the current century’
- ‘Changes to care: ...the service will move towards the logic of Derek Wanless' fully engaged scenario and the current commitment expressed by the Secretary of State that prevention strategies must be moved to the heart of any national health strategy’

**Areas of agreement include:**

The need to reassess the models of care, enhance primary care and shift the focus to prevention.

- ‘The reforms being pursued in Northern Ireland, Scotland and Wales appear to bring about the shifts needed to move to the new model of care ....the emphasis of these reforms is to emphasise the importance of prevention’

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### MODELS OF CARE

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<th>Frequency – Comments</th>
<th>Comments &amp; Illustrative Quotations</th>
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| MODELS OF CARE | 32 | o ‘The ageing population has developed in the past 20 years and will continue for the next 30 years. Implications for how to manage chronic and complex diseases; need to sustain people at home/in community; more emphasis on primary and community care instead of acute care. How to ensure rapid access to healthcare and diagnosis, and rehabilitation to enable return to home/community. How to integrate health and social care better’
| | | o ‘Technologies such as automated analysis - medical devices that can self monitor and call upon expert /professional help automatically allow clinicians to manage people better at home, avoiding costly hospital admissions’ |

**Areas of agreement**

How care models need to change; that primary care needs to be enhanced and the focus must move more towards prevention.
```
Areas of disagreement

A disagreement raised by one contributor is that the current reforms will work against the prevailing agenda that is beginning to take shape. He suggests that the effects of this anomaly will be unhelpful in directing resources to the wrong place. Another contributor feels progress is stalled as far as primary care is concerned.

- ‘Care will need to be offered closer to home... current health reforms in England were designed primarily to improve patient access to hospital services, these reforms will continue to suck more resources into hospitals unless there is a change of direction’
- Primary Care – no one is going to make a decision until the new Government comes in – ‘Richard Branson got out of primary care because there is no clear direction regarding where it is going’
```

Plausible Outcomes

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MODELS OF CARE
1. Progress on shifting the way care is delivered is painfully slow due, in part, to lack of funding, resistance amongst professional groups and the trade unions in response to the new Government’s declared position on future funding for the NHS
2. Acceptance of self-care is patchy; in some areas it is readily taken up but in other localities it attracts criticism as a result of poor outcomes
3. Lack of funds restricts the opportunities to push forward innovation especially ideas involving technology
4. Nursing staff are reluctant to move across to drive forward the Community Care programme – the resulting tension in the workplace lowers morale and leads to more staff exiting the service
5. The demand for care continues to rise as predicted
6. A Tory Government encourages more private sector providers to enter the healthcare market – they ‘cherry- pick’ the services to provide, leaving the NHS to cope with the ‘difficult and expensive ones’
7. Scotland, Wales and Northern Ireland are able to pilot some innovative approaches; working on a smaller scale these achieve the necessary transformation of services to match demand, helped in part by the effects of having in place a strong national identity and drive for self-determination
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### NHS CORE PRINCIPLES

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|        | 7                    | o ‘Government commitment to nationally-funded, free at point of delivery NHS; - this principal has shaped the health sector. There is now divergence between devolved administrations: e.g. in Scotland there is strong commitment to nationally funded, NHS delivered health sector, while in England there is focus on patient choice and plurality of provision.  
  o Scotland’s ‘Better Health, Better Care’ policy has focus on NHS - patient mutuality and person-centric care. England with its purchaser - provider division between commissioning bodies (SHAs) and delivery bodies (Trusts) does not have this approach (Scotland has integrated health trusts)  
  o ‘User charges: increasing existing charges for prescriptions and extending charges to other areas eg visit to the GP or hospital specialist. Top up payments for experimental drugs, introduced following the Richard’s Review’  
  o ‘NHS coverage limiting the scope of NHS benefits package by defining a set of core services ... individual to pay directly for services outside the scope of the package’  
  o ‘Private funding: incentivising the middle and high income earners to take out private medical insurance’ |

### Challenge Ranking

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<tr>
<th>Challenge/Theme</th>
<th>Frequency – Comments</th>
<th>Overview of Challenge</th>
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</table>
| DEMOGRAPHY/AGEING POPULATION | 25 | Demography is a challenge to the NHS in three areas. First, there is the double impact on the NHS of an ageing population; the primary impact on the NHS of having to deal with this problem comes from having to meet the complex health needs of a growing number of older people; to a lesser degree, the secondary impact arises from the effect on the health sector workforce of an increasing number of NHS staff starting to reach retirement age. The second element of the demographic challenge is the potential threat of population migration because of climate change so perhaps the migration of healthcare staff in and out of the UK. The third element of the challenge cluster concerns the ‘economically active’ population.  
  o ‘A high priority will be to meet the needs of an increasing number of older people in the population... will require support from both the NHS and Social Services. ...includes services for older people with dementia and other chronic conditions to enable them to live independently in the community for as long as possible’  
  o ‘The UK is moving from being an active recruiter of nurses to a passive ‘source’ of nurses to other countries. In 2007/08 there were more than 11,000 verification requests from UK registered nurses as part of the process of applying for a job in another country. This was at its highest level in the last 20 years and continues a recent upward trend’ |
### Challenge/Theme

#### Areas of agreement

The scale and gravity of the challenges that the ageing population will present to the NHS over the next 5 years

‘As the baby boomers age there will be particular demands on services for the elderly, not only as a result of their particularly unhealthy lifestyles and greater numbers but also because this generation of older people have higher expectations than previous ones’

### Plausible Outcomes

#### AGEING POPULATION

1. The provision and resourcing of care in the community falls progressively more and more to state funding
2. Factors aggravating the situation are:
   a. failure of the family unit to provide funding and direct care for an elderly relative
   b. the impact of the collapsed property market and slow recovery mean personal wealth is used up more rapidly to meet costs of care
   c. the recession drives many private care homes out of business
3. Government encourage more voluntary sector and charitable organisations to enter the market
4. More and more elderly folk fall back on the NHS as lack of care leads to a life threatening event – flooding of A&E units
5. Increasing incidence of cases of neglect and fatalities are reported that illustrate the early signs of an approaching crisis
6. Lack of resources and staff to provide care for the elderly leads to a crisis of national proportions
7. Loss of confidence in the Government of the day; triggers a snap election and creates ongoing political turmoil
### Areas of agreement

An acceptance that Government control and political interest in what the NHS is doing would continue to play a key part in directing policies that would affect day to day running.

- ‘...the service will move towards the logic of Derek Wanless’ ‘fully engaged scenario’… and commitment by the Secretary of State that prevention strategies must be moved to the heart of any national health strategy…’
- ‘None of the changes to the health sector can occur without state organisation….the role of public sector as planner, organiser and facilitator cannot be ignored although the necessity of the state taking on the role of provider may well diminish…’

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<tbody>
<tr>
<td>GOVERNMENT</td>
<td>12</td>
<td>‘The creation of the Scottish Parliament is one event that has shaped the health sector….’</td>
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<tr>
<th>Plausible Outcomes</th>
<th>Plausible Outcomes by Driver</th>
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</table>
| GOVERNMENT         | 1. Both political parties will argue strongly for pay restraint and return on investment already made in the service  
2. Political pressure will be on the NHS to demonstrate value for money; historically track record of this has not been too impressive (evidence is that promised benefits arising from new contracts and the outcomes of Agenda for Change have not materialised)  
3. A number of strategies will be considered and/or introduced by Government to drive forward productivity and reduce spending; these could include:  
a. pay: either freeze pay or negotiate pay reductions, perhaps in return for agreements with trade unions to avoid compulsory redundancies  
b. pensions: renegotiate the NHS final salary pension scheme eg to close the scheme to new entrants and/or to move to pensions being based on average earnings  
c. staff numbers: reduce the number of staff employed through vacancy freezes, voluntary redundancies, and reduced use of agency/locum staff, as well as negotiation on working hours  
d. sabbaticals/career breaks: negotiate opportunities for staff to take career breaks and sabbaticals on reduced pay  
e. productivity: tackle variations in productivity between key groups of staff such as doctors and nurses eg through improved job planning, appraisal and clinical excellence awards |
### Plausible Outcomes

**Plausible Outcomes by Driver**

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<th>Driver</th>
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<tr>
<td>TRADE UNIONS</td>
<td>2</td>
<td>o ‘Public sector trade unions are less inclined to sacrifice pay for job protection; they are more concerned to protect pay, especially for staff on low wages. The willingness of unions and employers to negotiate on issues such as productivity will be tested to the limits and may result in conflict of a kind not seen in recent history of the NHS’</td>
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<td>‘What will happen to staff completing their training and entering the NHS at a time when fewer posts will be available.... the prospect of surpluses and possible redundancies among clinical and non-clinical staff will strengthen the hand of government and employers negotiating on the productivity agenda’</td>
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### Plausible Outcomes

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<tr>
<td><strong>TRADE UNIONS</strong></td>
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<tr>
<td>Plausible Outcome 1</td>
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<tr>
<td>1. An escalating level of industrial relations unrest in response to the drive for productivity, given the focus is on staff pay and conditions</td>
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<td>2. Strong political lobbying and support coming from opposition parties as a challenge to Government policy</td>
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<td>3. Final stages of industrial unrest will see different strategies being adopted by the various professional groups and non medical staff to challenge Government and DOH plans (demonstrations, all types of brinkmanship including strike action to bring about a return to the status quo)</td>
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<tr>
<td>4. Government will move to apply industrial relations legislation to curb excesses of staff and trade union activity judged to be putting key health services and patients’ lives at risk</td>
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<tr>
<td>Challenge/Theme</td>
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| Challenge Ranking 6th | 13                   | The complexity of this challenge cluster includes a whole range of issues around public health; for example the worrying trend of pandemics and the pressure that such events put on the NHS at a time when resources are shrinking. With increasing levels of migration, tourism, air travel etc. there is a growing risk of spreading a whole array of communicable diseases. Other more localised public health concerns centre on the impact a recession or unstable economic conditions will have on health inequalities as a result of stress and dramatic changes to lifestyle for the unemployed. And then there are the consequences on the nation’s health and the NHS of a shifting disease burden that exponentially will drive up demand of services and put pressure on resources. There are the implications and benefits arising from advances in medical science. The paradox is clear; on the one hand we have advances that bring benefit on a macro scale to improve the nation’s health but on the other hand we will have to wrestle with the ethical issues that such advances bring and the fact that additional care activities arising from the research will have a cost implication at a time when budgets are going to be cut.  
  - ‘The shifting disease burden: premature death rates for cardiovascular diseases and cancer have declined but chronic conditions such as diabetes, asthma, COPD, heart failure, arthritis and mental illness have become more significant’  
  Areas of agreement:  
  - ‘There is an acceptance that we face a growing threat to public health from communicable diseases and the pandemic’  
  - ‘There will be a continuing threat to public health from communicable disease such as pandemic flu, and diseases such as SARS, West Nile Fever and Ebola virus, as well as the likely emergence of new diseases’  
  Areas of disagreement  
  One commentator expressed a view that medical research would yield only incremental gains for the development of new medicines rather than step change; whereas other comments suggested that outcomes would continue to be more far reaching.  
  - ‘Over the next ten years the future developments of new medicines are likely to result in incremental rather than step change’.
### Plausible Outcomes

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<tr>
<td><strong>PUBLIC HEALTH</strong></td>
<td>1. Risk of pandemic creates impetus for more cross-border collaboration in terms of early warning systems; increasing levels of co-ordination via the World Health Organisation</td>
</tr>
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<td></td>
<td>2. Governments see this is as the new frontline to bring about influence and change in countries rather than the ‘shock and awe of regime change’ as seen during the Bush-Blair years</td>
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<td>3. Greater emphasis placed on use of screening techniques by countries for specific diseases as a response to threat from migration of people and air travel</td>
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<td>4. Global warming increasingly changes the boundaries of endemic diseases as the environmental factors shift as a result of changing weather patterns and the migration of vectors</td>
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<td>5. A major pandemic hits with disastrous consequences on the NHS</td>
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<td>The shifting disease burden is further complicated by the onset of health complications arising in the population from obesity and misuse of alcohol/drugs</td>
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### Challenge/Theme

<table>
<thead>
<tr>
<th>Challenge/Theme</th>
<th>Frequency – Comments</th>
<th>Overview of Challenge</th>
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</thead>
<tbody>
<tr>
<td><strong>SOCIAL &amp; LIFESTYLE</strong></td>
<td><strong>12</strong></td>
<td>The dynamics of this challenge centre on the extent to which people in society can be encouraged to adopt an appropriate mindset towards managing their own health and how they use the services of the NHS. Currently there is a paradox: on the one hand there is the success of the anti-smoking campaign which has to be contrasted with the lack of success on the growing problems of obesity, binge drinking and a continuing upward trend of sexual health problems. Contributors also raised the issue of the exponential impact on healthcare as the baby boomer generation with its unhealthy lifestyle moves into old age.</td>
</tr>
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</table>
### Overview of Challenge

- **Areas of agreement**

  Unhealthy lifestyles are an ever present and growing threat to the nation’s health and a major reason why the NHS will struggle to meet its goals; the problem is further aggravated by the challenge of getting certain social groups to accept public health advice.

  - ‘NHS solidarity may be further undermined by continuing and perhaps increasing differences between socio-economic groups in their willingness to change their behaviours and lifestyles in line with public health advice’

  - ‘We are likely to see consequences of rising rates of obesity and alcohol consumption in the health of the population’

### Areas of agreement

- Increased levels of per capita income and educational attainment have contributed to rising public expectations of the NHS both among the young and people in middle age and those approaching retirement.
  - ‘Many medicines only offer ‘marginal improvements’ on alternatives but combined with public's higher expectations creates ‘strong demands’ on health system’

### Comments & Illustrative Quotations

#### HEALTH RISKS

- **Frequency - comments:** 7

  - ‘Lifestyle is a key driver on health issues and the current areas of concern include obesity, alcohol misuse and health issues associated with sexual behaviour’

  - As the baby boomers age there will be particular demands on services for the elderly not only as a result of their comparatively unhealthy lifestyles...’

#### PUBLIC EXPECTATION

- **Frequency - comments:** 5

  - ‘Increased levels of per capita income and educational attainment have contributed to rising public expectations of the NHS both among the young and people in middle age and those approaching retirement’

  - ‘Many medicines only offer ‘marginal improvements’ on alternatives but combined with public's higher expectations creates ‘strong demands’ on health system’

  - The NHS is there to meet our health needs as a matter of right and that situation will remain unchanged. One commentator expressed a view that people are willing to compromise on certain areas of service to protect the idea of a universal service whereas others
Institute for Employment Studies

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<th>Driver</th>
<th>Frequency - comments</th>
<th>Comments &amp; Illustrative Quotations</th>
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<tr>
<td></td>
<td></td>
<td>took the view that expectations on the NHS would continue to be high.</td>
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<tr>
<td></td>
<td></td>
<td>o ‘There 'remained loyalty and commitment' to the idea of a universal health service and the public were prepared to compromise on quality to retain the universal service.’</td>
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<table>
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<tr>
<th>Challenge/Theme</th>
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<th>Overview of Challenge</th>
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</thead>
<tbody>
<tr>
<td>Challenge Ranking 8th TECHNOLOGY</td>
<td>11</td>
<td>There are three areas where Technology is making its mark in healthcare. First we see how technology and its application is influencing people in society as the patient or potential patient. The very act of accessing, via technology, information about health issues is shifting patient expectations, including attitudes towards the hallowed patient-doctor relationship. More directly assistive technologies offer support for the patient, his or her carer and family to access information, knowledge etc. as a means of administering self-care in the home. The second area of focus is where technology is being used as a major tool in several mission critical areas such as speeding up and assisting with the transfer of data between professionals. The third area is the use of technology over the last 30-40 years to advance medical research.</td>
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<td>o ‘The increasing access to healthcare information as a result of the population being more technologically sophisticated is changing the nature of the doctor-patient relationship</td>
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<td>o ‘Assistive technologies will play a part in helping individuals look after themselves in the home.’</td>
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<td>o ‘Since the 60s and 70s the use of computers has led to rapid developments in medical research’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Supported care: … action to enable individuals, carers and families to play a part in looking after themselves will include using assistive technologies in the home…’</td>
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</tbody>
</table>

Areas of agreement

Technology will have an impact on the patient-doctor relationship

‘The vision laid out in 1997 by Jennings et al is still to be fully realised, but describes well the potential for change in the balance of power and control between professional and patient’
### USE AND TRANSFER OF DATA

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<tr>
<th>Driver</th>
<th>Frequency - comments</th>
<th>Comments &amp; Illustrative Quotations</th>
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</table>
|        | 7                    | ‘If clinical information is shared digitally between professionals duplication of clinical effort can be avoided’  
|        |                      | ‘NHS organisations are strengthening information systems to develop patient-level costing to better understand opportunities for improvement’  
|        |                      | ‘Technology: since the 60s and 70s use of the computer has led to rapid development in medical research; e.g. the human genome mapping, resulting in medical interventions that could not have been predicted’ |

### ENVIRONMENT

<table>
<thead>
<tr>
<th>Challenge/Theme</th>
<th>Frequency – Comments</th>
<th>Overview of Challenge</th>
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<tbody>
<tr>
<td>Challenge Ranking 9th</td>
<td>5</td>
<td>Under the heading of Environment the commentators share a level of unease about the impact of climate change as a challenge for the NHS. Immediate concern centres on how dramatic changes to weather patterns might adversely affect the health of vulnerable groups such as the elderly. On a broader front there is a view that whilst the NHS should now start planning for climate change i.e. ensuring the service is carbon neutral, little will be done within the time horizon under consideration. And lastly there is a concern regarding the implications of major changes in the environment - e.g. the impact on public services in the UK should the effects of global warming trigger population shift, with people moving to the UK en masse.</td>
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<tr>
<td></td>
<td></td>
<td>‘Global warming causing population shifts – impacting on public services in UK’</td>
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<tr>
<td></td>
<td></td>
<td>‘Global warming: the health sector will need to start thinking about global warming in the next 10 years e.g. creating a carbon neutral health service – but is unlikely to institute changes because of global warming in this period’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The effects of global warming are likely to precipitate more frequent heat waves in the UK – with a health impact on vulnerable old people’</td>
</tr>
<tr>
<td>Areas of agreement</td>
<td></td>
<td>Not much is known or likely to be done in the near future to help to scope the problem of climatic change and the impact it will have on the health sector.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Environmental changes: The greatest unknown. There is little evidence of reduction in CO₂ emissions’</td>
</tr>
</tbody>
</table>
Appendix 2: Interview structure

Structure and focus of the interviews

Each interview followed the same structure and addressed the issues outlined below:

1. Key challenges:
   ■ What are the (up to three) key challenges facing the health sector today?
   ■ What has really changed in the last 20 years?
   ■ What changes might we see in the next 10 years?

2. Looking back:
   ■ What are the (up to three) pivotal events in the past that have created the health sector as we know it today?

3. Looking forward – factors:
   ■ What factors will most shape and influence the health sector in the next 10 years? (*Prompts: e.g. demographics, technologies, the economy*)
   ■ Which three are most important and why?
   ■ What three surprises could disrupt the anticipated evolution of the health sector?

6. Looking forward – actors:
   ■ Who is setting the ‘rules of the game’ today for the health sector? (*Prompts: e.g. politicians, professionals, Joe Public*)
Appendix 3: Workshop reports example from 21st October 2009

What are scenarios?

Scenarios have long been a core element of different approaches to understanding and preparing for the future. Scenarios are stories that explore how the world might look, taking into account the evolution of certain trends. They are:

- alternative stories about the future - not forecasts, predictions or projections
- two, three or more plausible, relevant and challenging versions of the future.

They provide a framework for thinking about the different ways in which the future might unfold from the present and how we might shape that future.

There are several benefits of using a scenario approach to strategy. It helps us to avoid the trap of rigid strategy which can carry an organisation too far down a given road which turns out to be a cul-de-sac. Secondly it helps us to avoid reactive decision making in which the environment can dictate direction and foreclose options. Current preoccupations can distract us from thinking about the future and confine us to a limiting cycle of immediate concerns. Although it is essential not to view scenarios as forecasting, organisations that practise scenario building do get better at spotting the advent of surprising futures and can get a few steps ahead of those who don’t spot the signals on the horizon.

Objectives/purpose of specific intervention

The purpose of the work is to assist Skills for Health to explore what the possible futures might look like, how the sector might respond to these and potentially how the sector, and Skills for Health in particular, can influence the emerging future. The work will identify:
a set of indicators so that changes in the skills and employment needs of the sector can be monitored

■ activities that should be promoted into the sector

■ intelligence and insights to inform the strategic plan.

What is the process of building scenarios?

The process of developing scenarios requires consideration of a range of possible futures which prepares those involved to look beyond their normal frames of vision. Scenarios encourage exploration of what might happen. They are constructed to explore What if? rather than Whether.

Scenario building consists of three stages – orientation and information gathering, followed by the scenario-building workshop and then deepening and fleshing out the sketch scenarios. It is necessary at the outset to develop an understanding of the context within which the scenario planning will take place and what the drivers of change are likely to be – in this case, within the health sector. This provides the backdrop against which the scenario planning will take place. To provide this background information interviews are conducted with a range of key informants prior to the building workshops. In this intervention Skills for Health also provided early drafts of papers they had commissioned as part of the work.

Interview headlines

From the interviews and the commissioned papers a range of challenges and questions about the future were identified and formed the starting point for the day’s discussions. The challenges identified were:

■ the NHS organisation  ■ technology
■ demography  ■ NHS services
■ social and lifestyle issues  ■ epidemiology
■ economic issues  ■ environment
■ politics

(more details are given in Appendix 1)

The challenges and questions were displayed and participants discussed what surprised them, what they disagreed with and what they felt had been missed out. Nobody disputed any of the issues identified and people agreed that the issues identified would be important in dictating how health sector developments pan out in the UK. One thing that participants felt had perhaps been overlooked was the potential for conflict between different public policy ‘agendas’ – such as the
potential conflict between increasing individual choice and increasing individual responsibility for health.

**Timeline**

In the first exercise participants broke into two smaller groups and discussed the significant events that had shaped the NHS as we know it today. Both groups were asked to categorise significant events as falling broadly into the spheres of politics, education, society, technology, legislation or environment and then placed post-its with their identified events on to a poster showing the timeline of developments. This is shown in Figure 1, below. It was noted that legal and environmental developments seemed to have played a limited role.

**Figure 1:**

![Timeline of developments](image)

**Drivers of change in strategic environment**

Participants were then asked to identify the likely drivers of future change.

Each group produced a list of drivers that were classified as ‘contextual’ – factors in the external environment within which the health sector operates – or ‘transactional’ – factors closer to the health sector itself. The two sets of factors identified by the participants are shown below.
Figure 2:

Figure 3:
After the groups had finished discussing the factors they were asked to classify the factors in terms of uncertainty as to the nature of their impact, and whether they would be likely to have high or low impact on the health sector.

The outcomes of this classification exercise for the two groups are shown in the two pictures below. Seven main factors emerged as being of high impact and high uncertainty and for which there was broad consensus across the two groups.

- The choice agenda
- Public/private provision
- Education and training
- Technology
- Socio-cultural-geographic groupings
- Finance
- The ageing population and dementia

**Figure 4:**

![Uncertainty and Impact Diagram](image-url)
Scenario-building methods

There are two recognised methodologies for building scenarios – deductive and inductive. Essentially, the deductive approach involves first developing a framework and secondly creating stories that fit within that framework. The inductive methodology reverses that approach by first creating stories and secondly crystallizing the framework that emerges from them. Both methodologies use drivers of change to populate the stories. In these workshops we are using the inductive approach, as this makes it possible to address a wider variety of drivers and their interactions in equal depth.

Each of the seven drivers was written onto a card and each group worked with a set of cards, drawing three drivers at a time and exploring these successive combinations of drivers to create story snippets.

Scenario descriptions

The groups picked a selection of the story snippets to develop scenarios. The three storylines that were developed were:

- ‘Local is beautiful’ – how local volunteer groups may grow up around GP practices, supplementing local provision, with training for volunteers being provided online.
‘Healthcare on e-bay’ – how technology may facilitate access to second opinions and an increasing market in professional consultations.

‘The Dementia Divide’ – technological developments in treatment are successful but expensive; NICE declines to fund, leading to expanding gap in ability of more and less wealthy communities to cope with the impact of dementia.

Next steps

You are welcome to comment on, or add to, these workshop notes.

Two further scenario building workshops will be held in December. The stories from all three workshops will then be woven together to create two or more fully fledged scenarios which are plausible, relevant and challenging for healthcare 2020. These will then be shared in an application workshop with Skills for Health in which IES will help SfH explore the issues emerging for workforce planning to 2020 and beyond.

We very much appreciate your assistance with this work so far. If you have any queries please do not hesitate to contact either:

Linda Miller: linda.miller@employment-studies.co.uk

or

Paul Fairhurst: paul.fairhurst@employment-studies.co.uk

Thank you