The Strategy Unit.

Black Country & West Birmingham STP

Scenario Toolkit

Workshop participants should have received the horizon-scanning report "Exploring the Contextual Environment" for reading in advance of the workshop.

NHS
Midlands and Lancashire
Commissioning Support Unit

Introduction

This toolkit has been prepared as a ready-to-use workshop resource, enabling individual STP workstreams and member organisations to engage in futures thinking, as recommended by the Chief Medical Officer. No expert knowledge is required, and any staff or other stakeholders should be able to participate.

Scenarios are of proven value in helping organisations and systems to:

- Reframe their thinking about future priorities; and
- Increase their resilience and agility in a complex & changing environment.

The Strategy Unit is a local NHS organisation with unique NHS expertise and experience in futures thinking. It was commissioned by the Black Country's Local Workforce Action Board, in partnership with the STP Clinical Leadership Group, to support the development of robust and innovative strategic plans through the creation of a set of bespoke and plausible future scenarios.

The scenarios have been developed in partnership with local stakeholders, especially those with a knowledge of the factors affecting future clinical services and the associated workforce. They are already being used to inform the local response to the *NHS Long Term Plan*; the STP's next stage clinical strategy; and the strategic workforce agenda for the Black Country and West Birmingham.

Indicative Workshop Outline

1.	**Introduction to scenarios**	-	20 mins
2.	**Questions for 2030**	-	20 mins
3.	**Scenario groupwork**	-	65 mins
4.	**Scenario feedback and discussion**	-	40 mins
5.	**Next steps**	-	5 mins

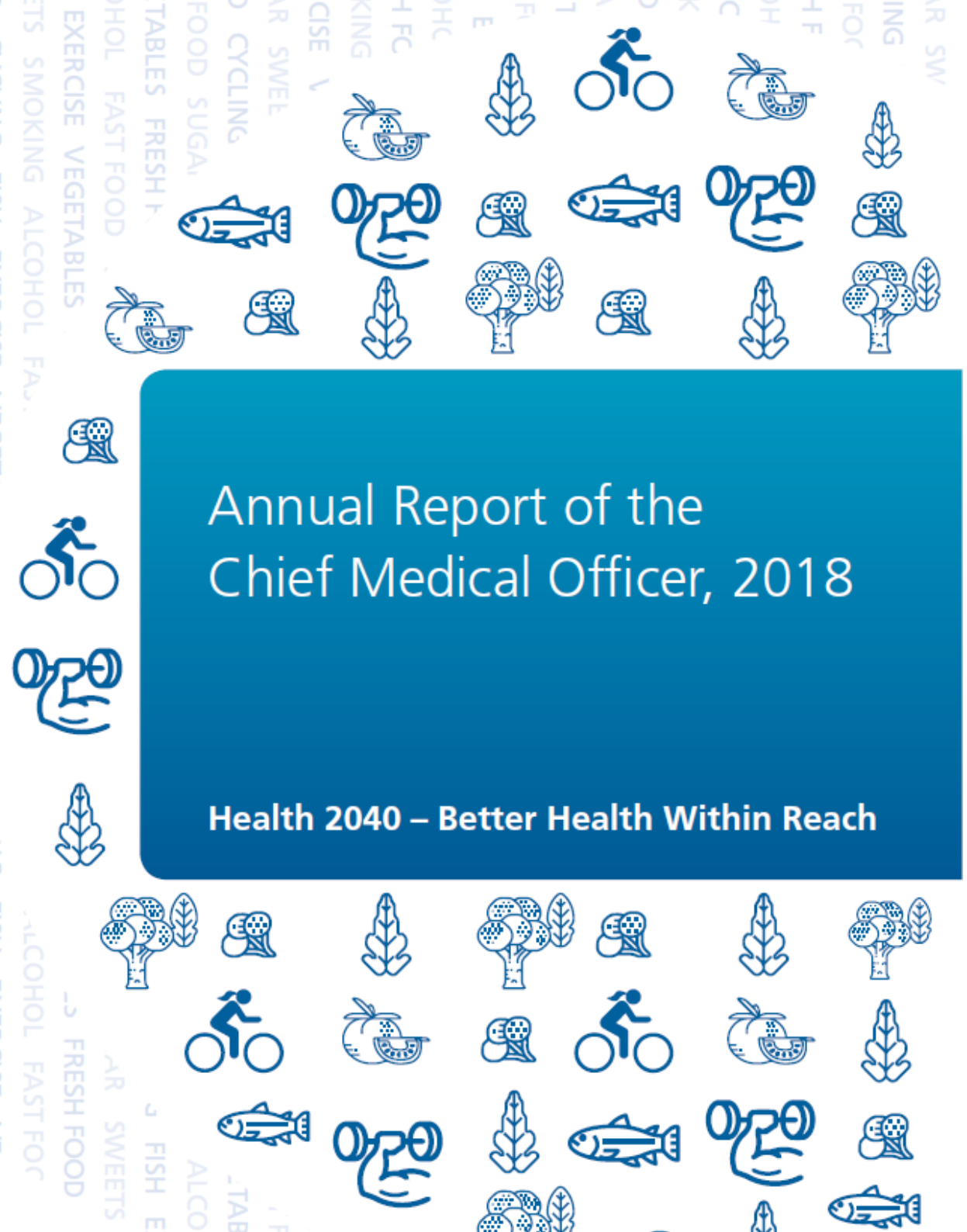
These are suggested timings that can be adjusted as appropriate for each event, although we recommend a minimum of an hour and a half (focusing on sections 3 & 4). The key consideration for workshop leaders is enabling colleagues to immerse themselves in a future scenario, to reflect on the potential consequences of that scenario and to think imaginatively about how to respond to it.

Introduction to scenario thinking

Why scenarios?

The future is uncertain; unless we consider the future and the uncertainties that could affect health, how can we plan effectively and know whether our current plans are 'future-proofed'?

'Futures thinking' is an important part of planning, helping us to imagine what different futures might bring.



https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2018-better-health-within-reach

Why scenarios?

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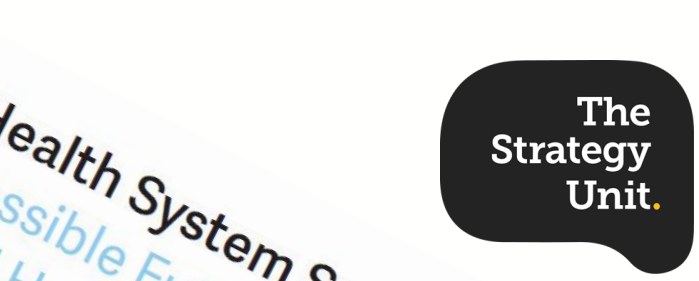
TURBULENCE **NOVELTY**

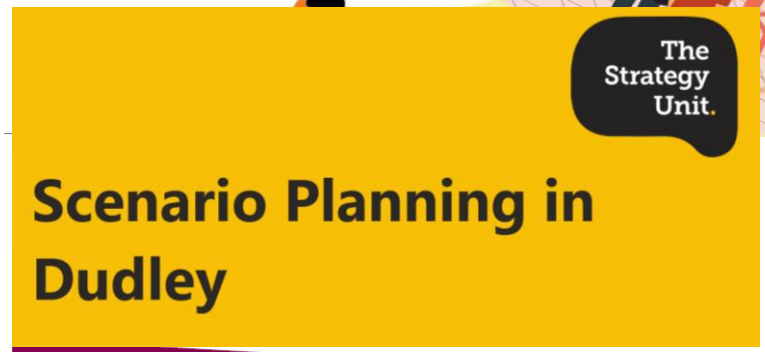
For public sector organisations in particular, an important aspect of today's significant challenges and contemporary worries lies in the mismatch of fast moving, connected events and issues….and the slow pace of institutional responses….. Given this mismatch between faster feedback loops and the slow pace of institutional innovation, the anticipation of increasing TUNA disruptions does not seem outrageous.

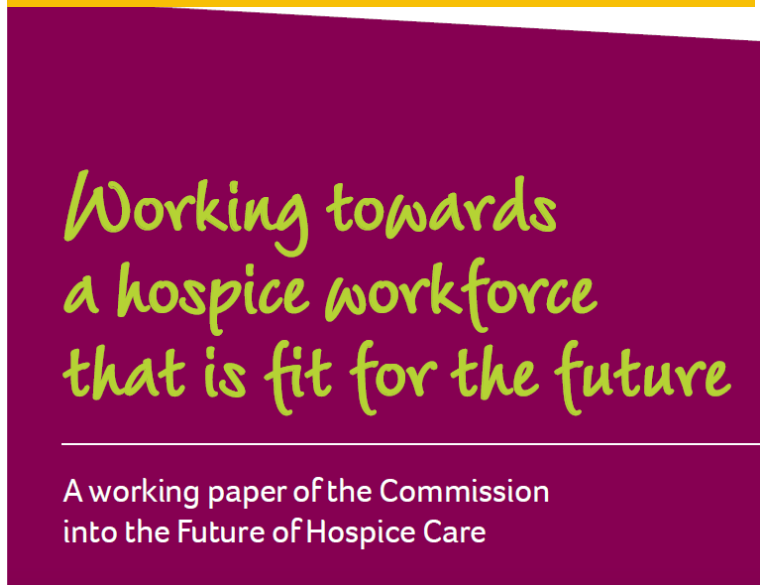
Ramirez & Wilkinson, *Strategic Reframing*

UNCERTAINTY **AMBIGUITY**

Examples of healthcare scenarios







Scenarios are……

…… a tool for learning at any stage of planning and monitoring processes and provide a valuable way of assessing risk

Neurosurgery, as traditionally practiced, is changing. Eric Hoffer observed,

"In times of change, learners inherit the earth; while the learned find themselves beautifully equipped to deal with a world that no longer exists."

Historically, learners have possessed certain attributes. They anticipate rather than react to change. They become essential facilitators within their altered environment.

Rich, J. (1997). In times of change learners inherit the earth. The 1997 presidential address. *Journal of Neurosurgery.*

Scenarios are……

The Strategy Unit.

- ☒ Forecasts or Predictions
- ☒ Preferences or Options
- ☒ Best or Worst Case

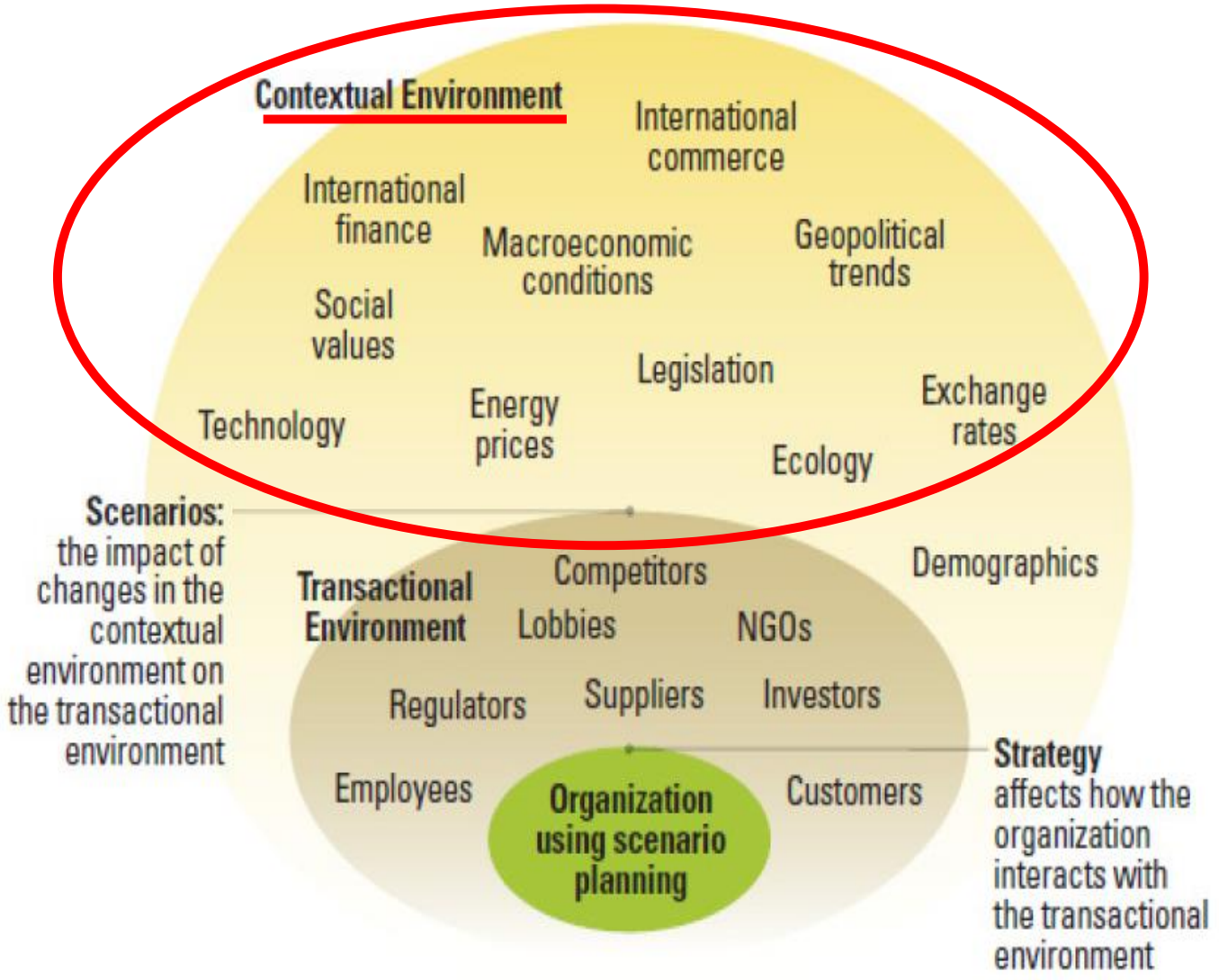
- ☑ Plausible
- ☑ Contrasting
- ☑ Internally Coherent
- ☑ Challenging

Scenarios are……

…… imaginative but realistic descriptions of potential futures and how they were shaped by their contextual environment.

They provide worlds into which we can take our strategic issues and explore how they might evolve.

They allow us to shape plans that are more robust and more realistic.



Using Scenario Planning to Reshape Strategy, MIT Sloan Management Review, Summer 2017 (Ramirez et al, 2017). https://sloanreview.mit.edu/article/using-scenario-planning-to-reshape-strategy/

Scenarios mitigate our biases

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Anchoring bias.

People are **over-reliant** on the first piece of information they hear. In a salary negotiation, whoever makes the first offer establishes a range of reasonable possibilities in each person's mind.

Availability heuristic.

People **overestimate the importance** of information that is available to them. A person might argue that smoking is not unhealthy because they know someone who lived to 100 and smoked three packs a day.

Bandwagon effect.

The probability of one person adopting a belief increases based on the number of people who hold that belief. This is a powerful form of **groupthink** and is reason why meetings are often unproductive.

Blind-spot bias.

Failing to recognize your own cognitive biases is a bias in itself. People notice cognitive and motivational biases much more in others than in themselves.

Choice-supportive bias.

When you choose something, you tend to feel positive about it, even if that **choice has flaws**. Like how you think your dog is awesome — even if it bites people every once in a while.

Clustering illusion.

This is the tendency to **see patterns in random events**. It is key to various gambling fallacies, like the idea that red is more or less likely to turn up on a roulette table after a string of reds.

Confirmation bias.

We tend to listen only to information that confirms our **preconceptions** — one of the many reasons it's so hard to have an intelligent conversation about climate change.

Conservatism bias.

Where people favor prior evidence over new evidence or information that has emerged. People were **slow to accept** that the Earth was round because they maintained their earlier understanding that the planet was flat.

http://uk.businessinsider.com/cognitive-biases-that-affect-decisions-2015-8?r=US&IR=T

Scenarios reduce the likelihood of failure

Strategies fail

- 82% - Misleading prejudgements
- 64% - Misleading experiences
- 69% - Inappropriate self-interest
- 43% - Inappropriate attachment

Finkelstein, S. el al *Think Again: Why Good Leaders Make Bad Decisions and How to Keep it from Happening to You*, HBS Press 2013.

Vision is limited

- 80% senior execs felt their organisations lacked peripheral vision
- 67% corporate strategists admitted their organisations had been surprised by up to 3 high-impact events in the last 5 years
- 97% lacked an early warning system to prevent future surprises

Integrating organisational networks, weak signals, strategic radars and scenario planning. *Technological Forecasting & Social Change*, May 2013.

Scenarios help avoid blinkered thinking

1878 - The Americans have need of the telephone, but we do not. We have plenty of messenger boys. *Sir William Preece, Chief Engineer, British Post Office*

1878 - When the Paris Exhibition closes, electric light will close with it and no more will be heard of it. *Oxford University professor Erasmus Wilson*

1899 - Everything that can be invented has been invented. *Official at US patent office.*

1900 - X-rays are a hoax, *Lord Kelvin*

1932 - There is not the slightest indication that nuclear energy will ever be obtainable. That would mean that the atom would have to be shattered at will. *Albert Einstein*

1954 - If excessive smoking actually plays a role in the production of lung cancer, it seems to be a minor one. *W.C. Heuper, National Cancer Institute*

1977 - There is no reason for any individual to have a computer in his home. *Ken Olson, Digital Equipment Corporation*

Scenarios help to develop dynamic capabilities

“the firm’s ability to integrate, build, and reconfigure internal and external competences to address rapidly changing environments”

In order to meet new challenges, organizations and their employees need the capability to:

- Sense and shape opportunities and threats
- Seize opportunities
- Maintain effectiveness through enhancing, combining, protecting, and, when necessary, reconfiguring the enterprise’s assets.

https://www.davidjteece.com/dynamic-capabilities/

Harvard Business Review

Scanning the Periphery

by George Day and Paul J. H. Schoemaker

Between 2001 and 2004, Mattel lost 20% of its share of the worldwide fashion-doll segment to smaller rivals such as MGA Entertainment, creator of a hip new line of dolls called Bratz.

Harvard Business Review

Scanning the Periphery

by George Day and Paul J. H. Schoemaker

MGA recognized what Mattel had failed to—that preteen girls were becoming more sophisticated and maturing more quickly. At younger ages, they were outgrowing Barbie and increasingly preferring dolls that looked like their teenage siblings and the pop stars they idolized.

As the target market for Barbie narrowed from girls ages 3-11 to girls about 3-5, the Bratz line cut rapidly into the seemingly unassailable Mattel franchise.

Mattel finally moved to rescue Barbie's declining fortunes, launching a brand extension called My Scene that targeted older girls, and a line of hip dolls called Flavas to compete head-on with Bratz.

But the damage was done. Barbie, queen of dolls for over 40 years, lost a fifth of her realm almost overnight—and Mattel didn't see it coming.

https://hbr.org/2005/11/scanning-the-periphery

Harvard Business Review

Scanning the Periphery

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KEY QUESTIONS TO ASK

- What have been our past blind spots? What is happening in these areas now?
- Is there an instructive analogy from another industry?
- Who in your industry is skilled at picking up weak signals and acting on them ahead of everyone else?
- What important signals are you rationalizing away?
- What are your mavericks and outliers trying to tell you?
- What future surprises could really hurt (or help) us?
- What emerging technologies could change the game?
- Is there an unthinkable scenario?

https://hbr.org/2005/11/scanning-the-periphery

Questions for 2030

EXERCISE

Imagine you are suddenly transported from now to 2030.

What's the question you'd most want to ask about health and care in the UK and/or the things that have shaped it?

- Reflect individually for 2 minutes
- Share in groups for 8 minutes
- Plenary feedback for 10 minutes

Scenario groupwork

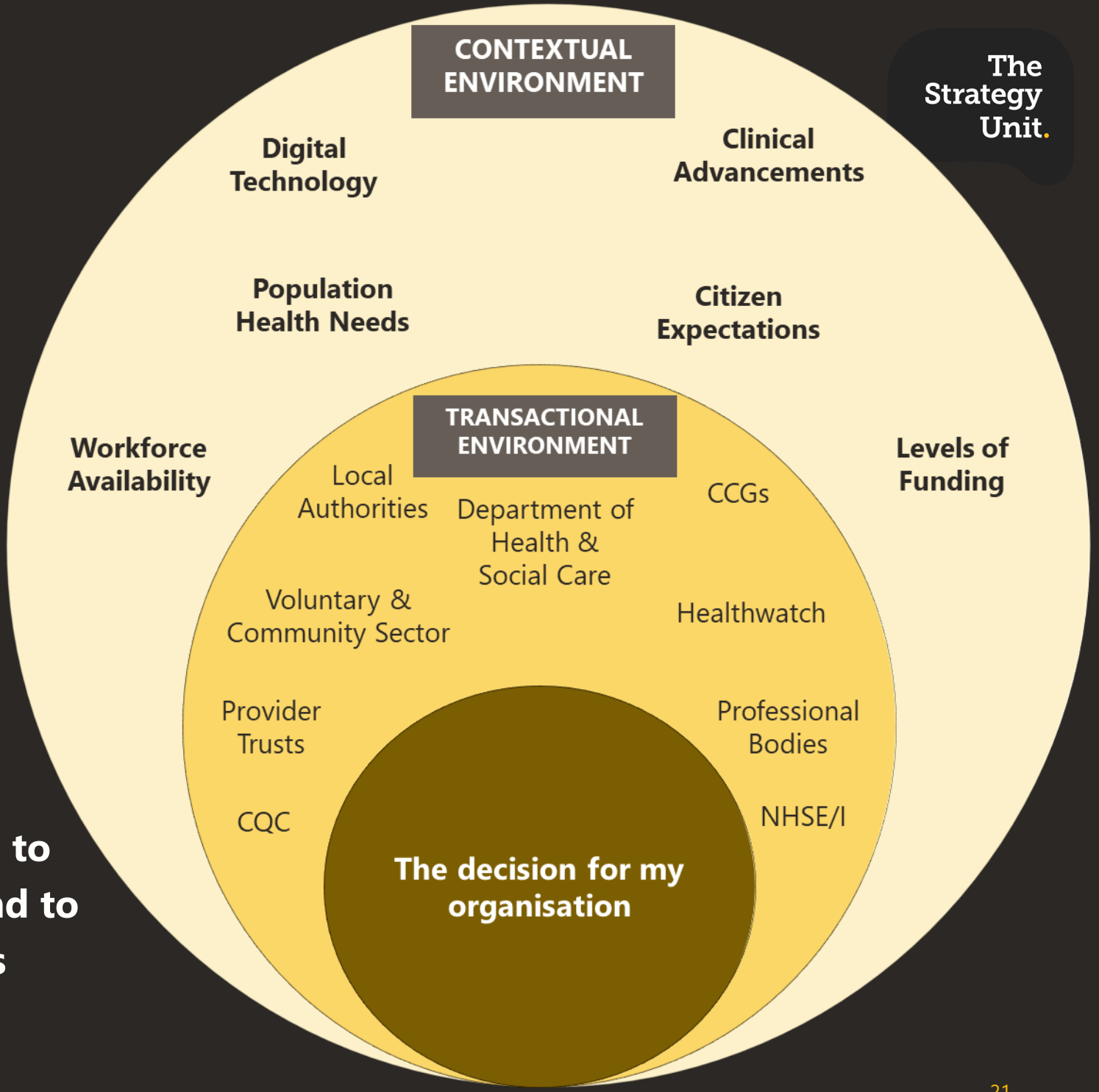
Work so far

1. Delphi exercise conducted with local stakeholders

- 53 contextual factors
- Rated by impact & uncertainty
- 6 driving forces

2. Desktop research undertaken by the Strategy Unit

3. STP workshops held to develop 4 scenarios and to share initial reflections



Digital Village

Generational Ghetto

Municipal Fortress

Ghost Town

Group Work

- Arrange yourselves into 4 groups – one for each scenario – try to make it a mixed group across specialties/disciplines/sectors/organisation
- Identify a facilitator/note-taker
- Distribute scenario narratives and associated response forms
- Group members introduce themselves

TASK 1

- **Individually**, read the full narrative for your scenario, and make notes in response to the first two items on the scenario response form (10 mins)
- In **groups**, share your reflections on those two items (15 mins)

TASK 2

- **Individually**, list the main challenges/ opportunities created by this scenario and what you think the STP should do in response (10 mins)
- Discuss in **groups** (30 mins)

Scenario Response Form Example

What's your gut reaction to this scenario in one brief phrase?	Plausible and an ideal view of health systems in the future.		
Thinking of the scenario narrative itself (not its impact on the STP), identify two questions that are unanswered.	1. How had an ageing population influenced workforce recruitment, retention, skills, and the willingness to embrace technology? 2. What impact had socio-economic status, deprivation and social class had on health outcomes in this scenario?		
Thinking now of current and emerging STP plans and assumptions, list the main challenges/ opportunities created by this scenario.	1. Black Country people prefer to live and work in their local areas. The workforce could be grown by making the NHS more attractive to locals, e.g. through appropriate training posts. 3. This supports the digital prevention agenda, self-care and more personalised healthcare. 4. The "stranglehold" of increased regulation can disempower workforce and increase the recruitment and retention challenge, especially amongst the younger workforce.		
What does the scenario make you think the STP and its stakeholders should do – • **more of?** • **less of?** • **differently?**	**More** • Encourage joint working, collaboration and role sharing; • Planning of funding generation and allocation to ensure the roll out of these technologies is achieved; • Educating the public and individuals in the health service regarding disease profiling and demand and supply.	**Less** • Rigidity of working practices and hours (e.g. 12-hour shifts); • Lack of consideration for those without access to digital resources; • Focus on our individual organisations and reinforcing competing priorities.	**Differently** • Improve the awareness of health and social care careers (e.g. run an education campaign, offer careers counselling in schools/job centres/agencies); • Focus on a population health management style approach, including the digital intelligence and infrastructure to support it; • Increase our ability to collaborate with the private sector.

Sharing scenario insights

In turn, each group briefly summarises its scenario and shares its key reflections (40 minutes).

Ghost Town

In this scenario, increasing service pressures and a lack of flexibility and work-life balance in public sector roles has driven workforce challenges from bad to worse. It is now not uncommon to see reports of 20% vacancy rates in some areas. The impact of these challenges on the accessibility and quality of services has led to increasing use of private sector services by those who can afford them (and by companies that see the self-interest in maintaining staff mental and physical wellbeing). Satisfaction with, and support for, the NHS is beginning to slide.

Digital Village

A growing sense of mutual responsibility for social, economic and environmental outcomes, combined with an increasingly digital-literate population and 'on-demand' culture, has led to a degree of renewal in public and voluntary sector services, if not yet any radical improvement in population health and wellbeing. There is, however, a strong, popular determination to address inequalities in access, experience and outcomes.

Generational Ghetto

Generational differences have created stark variations in care needs and in attitudes towards taking responsibility for individual health and wellbeing. The influence of younger generations on political debate has shaped a future of health and care tailored towards the priorities and capabilities of the young. Older generations have struggled to adjust.

Municipal Fortress

In this scenario, two dynamics collide: ongoing funding restrictions and demand pressures make providers more inward-looking whilst frustration with Westminster politics and deteriorating public services creates a reinvigorated but politicised localism. In the latter part of this period, Local Authorities have been seeking to drive change in all aspects of local life, focused on geographies to which people feel a natural affiliation. The dynamics of this collision are not yet resolved.

Next steps

Next Steps

- Share conclusions and agree actions
- Use for ongoing development
- Feed back your reflections to the STP

Workshop resources

N.B. These scenarios form a set designed to support the development of robust strategic plans in the Black Country STP. The alternative plausible futures that are described are not intended as recommended or preferred scenarios, neither do they represent the policy of the NHS, the STP or the Strategy Unit.

Digital Village Scenario

Summary

In this scenario, a growing sense of mutual responsibility for social, economic and environmental outcomes, combined with an increasingly digital-literate population and 'on-demand' culture, has led to a degree of renewal in public and voluntary sector services, if not yet any radical improvement in population health and wellbeing. There is, however, a strong, popular determination to addressing inequalities in access, experience and outcomes.

Scenario Narrative

Throughout the 2010s, and following the 2008 financial crash, it had been deemed economically necessary to cover UK public services in a cloud of austerity. Services struggled to keep up with growing demand; financial pressures on one service appeared to increase demand pressures on other services; working in the public sector became less attractive; and political difficulties in agreeing the UK's relationship with the EU appeared to distract government and parliament from other initiatives. As the UK ticked over into the 2020s, the cloud of austerity began to thin. There had been early signs that the public mood was shifting: the public reaction to several crises indicated a growing impatience where issues were felt to be inadequately addressed, and there were heightened expectations about what government and business should do in response. Key moments in this transition included:

- Popular anger at what was felt to be the inadequate and heartless reaction of public and private sector bodies to the Grenfell fire tragedy;
- The renewed ascendance of concern about environmental degradation, exemplified by the impact of the 'Blue Planet' TV series in finally shifting the approach to single-use plastics, public sympathy for 'Extinction Rebellion' protests, and the welcoming of Greta Thunberg's 'school strike' movement that prompted Parliamentary recognition of a climate crisis.

There was an evident shift in broader societal attitudes. Things that had been tolerated by earlier generations (or, at least, insufficiently addressed) became a focus of popular concern: for example, the 'Me Too' movement challenging sexual harassment and abuse; and the 'No Room for Racism' campaign in football. These attitudes also began to impact public services. A survey in 2017 found that 93% of people felt that the NHS then had a funding problem, and a third of them thought that problem was severe.; 66% were personally willing to pay higher taxes to maintain services.

Digital Village Scenario

A key element in changing attitudes was played by the rapidly expanding internet companies, the 'FANGs' [Facebook, Amazon, Netflix and Google], that were ubiquitous and potent (for good and ill) during those years. By contrast with what had gone before, the FANGs provided, and further encouraged, immediacy of (virtual) contact, accessibility of information (though with anxieties about whether that information was 'fake'), personalisation of products and services, and expectations of 'always-on' provision. Experiences that people increasingly had of these digital services began to spill over into their expectations of public services. Why should accessing domiciliary care or medical appointments be so different to summoning an Uber; or accessing personal health care information to online banking? Yet, access to services remained dependent on a single, struggling professional group.

What began to emerge through the course of the 2020s was a national mood that embraced digital advances (with spin-off economic and social benefits for the regions where digital industries were able to flourish) but resisted the potential atomisation of the digital realm. The 'rampant individualism' of the late 20th and early 21st Century subsided, and a new sense of mutual social responsibility arose that included a concern for the equitable treatment of diverse social groups. There was an unsurprising rise in social capital and in the contribution of the voluntary and community sector to health and care needs, too, as people combined global digital engagement with local community action.

This mood enabled a restoration of health funding increases to their historic average of approximately 4% a year above inflation, if not to the 7-11% levels seen around the turn of the Millennium. It also supported an ongoing shift of spending towards mental health, community and social care services. The differential treatment of cancer and dementia patients was felt to be an injustice that had to be remedied. Questions began to be raised about whether it was justifiable to invest in novel treatments for a minority when much larger cohorts remained disadvantaged.

These funding shifts supported the consolidation of new models of care and, most noticeably from 2023, began to turn the tide on workforce shortages. Health and care careers started to carry a higher social esteem, especially amongst younger, socially motivated generations and the move to a more benevolent funding regime for training courses. Indigenous recruitment began to improve; and staffing and funding increases combined to reduce work pressures and sickness and vacancy rates – the latter falling by 2029 to an unprecedented average of just 5%. The impact on social care roles was smaller, so, from around 2025, we started to see the automation of some functions through integrated digital monitoring mechanisms plus robotic solutions to reduce isolation, provide direct virtual access to staff and improve mobility. Other dynamics influencing recruitment and retention patterns over the last 10 years include:

Digital Village Scenario

- The new immigration policies introduced in 2022 following the UK's delayed exit from the EU could have created serious additional challenges for public services (as had the uncertainty of the preceding 6 years). In reality, the 'Global Skills' programme delivered a balanced approach – easy access to work visas for EU and non-EU staff but on limited-term contracts for a maximum of 5 years. Though this added to workforce turbulence, the net effect was positive, and it found popular support because it met the needs of UK public services, avoided permanently depriving other nations of their own workforce, and provided a mechanism for skills and knowledge transfer to less developed countries;
- Pensions policies had become a negative factor as higher-paid staff, especially, were faced with the conflicting pressures of later pension ages and pension savings limits. In the end, political judgement leaned in favour of easing savings limits for some rather than maintaining a lower pension age for all. If you are under 50 now, you will be working till at least 70 (albeit on reduced hours), and for those aged 30 and under it could be 75;
- At same time, domestic expectations for flexible working, portfolio careers, and better work-life balance continued to increase. Headcount increased considerably more than FTE, and the workforce challenge shifted from the relative simplicity of recruitment and retention to the complexity of coordinating an ever-more dynamic workforce operating in a broadening range of roles. These challenges had to be dealt with at scale, not by individual organisations in competition with each other. We started to see the development of single employment vehicles across health and care systems, and further mergers between provider organisations (within and between systems). Last year saw the closure of the last standalone General Practice in the Black Country, so now all GPs are employed either by Primary Care Networks or by larger NHS organisations. Younger medical trainees avoided the partnership model with its responsibilities and inflexibility, and there was also a natural logic that flowed from 10 years of working in an increasingly integrated manner.

Without these improvements in funding and the net workforce position, the public desire to uphold the scope of services free at the point of need may not have been sustainable. Of course, those funding increases had, in part, been made possible by means-testing pensioner benefits. There have been real improvements in responding to lower-level mental health needs, through both human and automated means, and some significant investment has also been required to support ongoing digital developments. This latter has included enabling the interoperability of personal digital devices with NHS digital records accessible equally by patients, clinicians and population health managers. People have demanded, however, strict controls around the management of their data to mitigate concerns both about companies profiting from their data and about criminal groups or governments accessing and interfering with digital data. This is what led to the 2024 increase in maximum GDPR fines from 4% to 7% of total annual worldwide turnover, and to economic and political sanctions on two foreign governments.

Digital Village Scenario

There had been early recognition in the late 2010s that the potential benefits of digitally-supported services might increase the inequality of access and outcomes. For a period, this is exactly what occurred until there was clear popular and political will, offended by patent injustices, to tackle inequalities like never before. Models of care developed that were more tailored to the needs and circumstances of defined cohorts, supported by increasingly actionable health intelligence that, along with the associated economies of scale, drove integration in both of digital infrastructure and service provision. By 2027, initial healthcare interactions for the bulk of the population shifted to online, AI-managed triage that is citizen-driven and immediately accessible (including a virtual A&E function): direct referrals were generated as required to the full range of professions/MDTs. For minority cohorts such as those living with long term conditions or expectant parents, more proactive models led by a named clinical adviser, began to emerge. To address the digital divide that had been widening, we saw the policy shift permitting technology seen as an essential component of a care plan (e.g. tele-monitoring, limited 5G data access) to be provided on prescription. None of us would claim that inequalities have yet been abolished – there are particular concerns now around rural deprivation – but it is certainly possible to sense a strong public determination to reach that goal through the 2030s.

Digital Village Scenario - Response Form

What's your gut reaction to this scenario in one brief phrase?			
Thinking of the scenario narrative itself (not its impact on the STP), identify two questions that are unanswered.	**1.** **2.**		
Thinking now of current and emerging STP plans and assumptions, list the main challenges/ opportunities created by this scenario.	**1.** **2.** **3.** **4.** **5.**		
What does the scenario make you think the STP and its stakeholders should do – • **more of?** • **less of?** • **differently?**	**More**	**Less**	**Differently**

Generational Ghetto Scenario

Summary

In this scenario, generational differences have created stark variations in care needs and attitudes towards taking responsibility for individual health and wellbeing. The influence of younger generations on political debate has shaped a future of health and care tailored towards the priorities and capabilities of the young. Older generations have struggled to adjust.

Scenario Narrative

The results of the 2016 referendum highlighted a stark contrast in generational attitudes towards leaving the European Union, with polls on a selection of voters suggesting 27% of 18-24 year olds relative to 60% of 65+ year olds voted to leave. As time elapsed, differences in priorities and power between the generations became increasingly apparent, not least with regards to health and care. By 2023, life expectancy and health needs differed markedly across generations:

- Those aged 65+ were living longer but had a lower quality of life. Their burden of disease, particularly regarding specific chronic and cognitive health conditions (dementia, arthritis and osteoporosis), had increased, as had the complexity of their care needs, placing ever greater demand and cost on public services;
- Hopes that the next generation would turn things around were dashed as it became clear that changing behaviours relating to smoking, drinking and diet in Black Country 40-60 year olds would not meet planned trajectories. A sense that public services should meet individual needs and not restrict individual choices had contributed to this. Demand and cost both seemed set to follow historic upward trajectories;
- By contrast, younger generations had become more aware of their mental and physical health and how to maintain and enhance it. This began to generate a reduction in preventable conditions such as type 2 diabetes and stroke. The growing use of digital technologies, including the collection of big data and the use of artificial intelligence to store and process it, also contributed to the analysis, prediction and diagnosis of diseases. For this cohort, average healthy life expectancy began to increase.

The on-demand availability of digital health and wellbeing led to younger age-groups being better informed about managing both their physical and mental health. Exposure to mindfulness and broader learning about health and wellbeing in schools (woven into all subjects, not just as a standalone topic) underpinned this shift in awareness and action. There were some instances of misleading information and guidance being propagated:

Generational Ghetto Scenario

- One strand of 'fake news' encouraged readers to take cannabis oil to prevent cancer. For a (thankfully short) period we saw an uptake in pressure on clinicians to prescribe medicinal cannabis, as well as a significant increase in illicit online purchasing. It was reported that a handful of suicides may have been partially attributable to this trend, and there was some evidence of an increase in A&E attendances relating to depression and psychosis;
- A plethora of health-related apps offered ways to monitor and improve mental and physical wellbeing. Some were genuine, evidence-based tools; others appeared to be little more than attempts to play on the concerns of the sick or 'worried well' and to generate income from apps and related products. Early work linked to an 'NHS apps library' provided some indication of product value but, in due course, it became necessary to develop an additional strand of NICE appraisal. AI-supported monitoring of online content also enabled an NHS logo to appear next to search results for products and therapies that had a sufficient evidence-base.

Despite these issues, there was a net benefit from digital tools as well as from the social connectedness that people found online which helped them to cope better with the stresses of everyday life. The development of an AI-policing of digital content also stemmed the tide of behaviours that had been causing significant issues, not least on mental health. When it came to accessing health and care services, young people were developing higher expectations of what they should receive and how they should receive it. Those brought up expecting a GP or others to manage their care needs and access to services became at increased risk of disadvantage, as the culture of services shifted towards being citizen-driven.

The overall increase in disease burden and subsequent demand on health and care services (e.g. bowel cancer prevalence in under 50s) prompted the system in 2025 to integrate its health and social care budgets, with the lead role being played by health and reflecting the integrated view of the Department of Health and Social Care. Whilst post-Brexit economic challenges constrained government spending power, there was no major financial crisis. As a result, overall funding levels for health and care changed little as a proportion of GDP over the 2020s. Integration in service delivery provided some efficiencies to mitigate the rising complexity of different generations' health and care needs. It also eased the rollout of certain digital technologies such as AI diagnostics for diabetic retinopathy and melanoma, and AI-driven logistics, stock-supply and bed-management tools. Several significant clinical advancements were made, including the completion of sequencing of half a million genomes by the Genomic Medicine Service aiding the diagnosis and treatment of rare diseases.

Generational Ghetto Scenario

By 2028, the exposure to health and wellbeing information and advice that the younger generation had had from an early age through the internet, apps and social media was significantly influencing both how they approached their careers and their how they influenced political debate. Local and national politics, once largely shaped by the over 50s, became subject to real pressure from the under 40s. Many lobbied central government to charge people for treatment made necessary by their own lifestyle choices; others began to question whether local government had any role at all (lots of contracting was being consolidated at regional or national level, many services were now entirely digital, and municipal debates appeared very tired and ineffectual). Youthful political pressure resulted in:

- Greater investment in preventative and enabling services (including clinical advancements for early diagnosis and treatment of life threatening conditions, and whole-population genomic sequencing), and reduced investment in reactive provision and services that were regarded as outdated or inefficient;
- Action by government and business on supporting healthier lifestyles – for example, tackling childhood obesity by restricting the calorific content of snacks and meals aimed at children, introducing a minimum price for alcohol in England, restricting the frequency of junk food adverts and the geographical density of fast-food outlets; and
- Increased support for digital technologies that enhance self-care; widespread use of artificial intelligence and AI-powered health checks and triage assistance via smartphone apps; telemedicine and remote consultations, spurred on by the rollout of 5G networks across the black country; patient-driven healthcare such as NHS-endorsed fitness trackers for self-monitoring of biometric data; sophisticated monitoring systems for those with chronic conditions such as high blood pressure and type 2 diabetes.

There was a frustration amongst the young about the lack of willingness in their elders to adequately embrace preventative models of care based on self-management. They felt they were having to pay for their elders' choices, whilst their own choices had become restricted: it was they who had to bear the costs of university education that had been free to previous generations and to pay the taxes that sustained the pension mountain, at the same time as they struggled to get onto the housing ladder from which others had profited in earlier decades. Now, in 2030, we face inter-generational tensions that are very real and, sometimes, quite unpleasant. The growing development and implementation of key clinical advancements and digital technologies has created a model of care tailored towards the technologically savvy, creating access issues for other cohorts.

Generational Ghetto Scenario

Careers in health and care that involved data, technology and leading-edge prevention and treatment became very attractive, partly because of the transferability of skills to and from other sectors; careers involving tending to those who had not cared well for themselves were much less so. Average vacancy rates remained around 10% but the picture was very different depending on the nature of the role.

The past 10 years have shown that a "one size fits all" health and care model is unsustainable. The differing generational expectations are resulting in stark differences in levels of demand placed on health and care services and the workforce. There is as yet no indication that the generational divides will be bridged. In time, we look set for a healthier population and the ability to redistribute health and care funding into other critical areas such as education and the environment. Until then - maybe another 10 years hence – significant challenges will remain in coping with the choices of older generations.

Generational Ghetto Scenario - Response Form

What's your gut reaction to this scenario in one brief phrase?			
Thinking of the scenario narrative itself (not its impact on the STP), identify two questions that are unanswered.	**1.** **2.**		
Thinking now of current and emerging STP plans and assumptions, list the main challenges/ opportunities created by this scenario.	**1.** **2.** **3.** **4.** **5.**		
What does the scenario make you think the STP and its stakeholders should do – • **more of?** • **less of?** • **differently?**	**More**	**Less**	**Differently**

Municipal Fortress Scenario

Summary

In this scenario, two dynamics collide: ongoing funding restrictions and demand pressures make providers more inward-looking whilst frustration with Westminster politics and deteriorating public services creates a reinvigorated but politicised localism. In the latter part of this period, Local Authorities, with increased representation of smaller parties and independents, have been seeking to drive change in all aspects of local life. The prime level of social and political interaction are geographies to which people feel a natural affiliation, and these geographies tend to see themselves in competition with each other. The dynamics of this collision are not yet resolved.

Scenario Narrative

Moving into the 2020s, NHS organisations finally felt some relief from the tight funding restrictions of the previous decade. Initially, at least, there was widespread public support for increasing investment to improve quality and access, and there was also an economic climate benign enough to permit this (albeit economic growth remained below the long-term trend). Those increases avoided a major financial crisis. At the same time, they were insufficient to fully meet increasing demand and they failed to provide the financial and operational headroom for delivering material transformations in models of care. The same was true of the capital investment needed to transform the physical estate and digital infrastructure (although commercial companies continued to advance the digital solutions available to those who could afford them). There was no incentive or capacity for local NHS organisations to look beyond the day-to-day operation of the services for which they were accountable. Despite national policy, though in line with established statute, competition continued to trump collaboration. It was a kind of survival mode. Despite the repeated assertion of common themes in the 2014 *Five Year Forward View*, the 2018 *Long Term Plan* and the 2024 *System Transformation Plan*, there was no wholesale transformation in health and wellbeing, although there were plenty of examples of real improvements in specific service areas, often the fruit of the vision and commitment of individual clinical leaders.

These ongoing challenges in health care were compounded by the failure to deliver a long-term solution for social care. Central Government had taken over 3 years to develop what was expected to be a transformational approach to social care: the white paper that finally emerged in 2020 proposed little more than tinkering at the margins.

Municipal Fortress Scenario

The main consequence of this played out in the lives of those with little voice and who were often disengaged from political processes. Issues did flare up publicly, however, when other 'always-on, easy-access' services such as emergency services and food banks felt the knock-on effects of constraints in other services. It began to feel like political parties in Westminster simply didn't have a proper grip on the local, on-

the-ground impact of their (lack of) action. Issues with healthcare services – challenges with access, extended waiting times, increases in reports of poor quality care – continued to attract greater public attention. Local populations continued to feel a real sense of ownership of their local hospital and other services, but they were also feeling increasingly dissatisfied with them.

Through the latter 20th century and the first two decades of the new millennium, advances in digital technology created the potential for unprecedented levels of personal access, connectivity and exposure to information and advice. Most of these advances were led by the private sector, however, so that the dawn of the digital age in health was clouded by reports of 'digital inequality' where the benefits of these advances accrued especially to the young, the more affluent and/or the more educated members of society. This digital revolution necessarily began to influence the expectations that these sections of society had of public service provision, too, and it informed attitudes that came to expect responsive, streamlined and integrated solutions of the kind they experienced in other aspects of life.

That growing popular frustration with 'Westminster' politics, regardless of the party in power, was turbo-charged by the Brexit fiasco, although it was by no means the only driver:

- The roll-out of infrastructure and apps to support digitally-enabled services experienced delays and cost-overruns typical of national programmes and caused significant challenges for services that had been told to implement new models of care that depended on digital;
- Issues of school performance and management appeared, perplexingly to many, to have passed beyond local influence following the 'academisation' of the entire primary and secondary education sectors, despite there being several good examples; and
- The lack of effective, at-scale action on prevention and the wider determinants of health and wellbeing created significant frustration amongst stakeholders in local economies.

Municipal Fortress Scenario

In areas like the Black Country, that had never quite recovered from de-industrialisation, globalisation and the financial crash, Westminster began to seem as far away as Brussels. It didn't seem to care about the inequality, disadvantage and deep frustration experienced by Black Country people. Confidence in, and engagement with, national politics plummeted.

As much as Local Authorities had diminished in scale in the preceding decades, and remained dependent for so much on central Government, local politics entered into a much more vigorous phase during the 2020s. Elements of this were adversarial and, at times, unpleasant as extremes of right and left began to attract greater support. The 2022 local elections saw a shift towards smaller parties and independent councillors; and local issues started to take on much greater significance. Local jobs, schools, transport, environmental conditions and public services were prominent amongst those issues, and there was a greater awareness of the co-dependencies between diverse aspects of local life and their impact on health and wellbeing. At the same time, growing citizen concerns with diverse aspects of local life also led to a resurgence in community action – some of this injecting new life into existing voluntary and community sector organisations (like the Scouts) but plenty else took place informally through relatively ad-hoc groups linking via social media. Attendance at council meetings (both real and virtual) increased enormously, and the real-time debate around them (not least on social media) transformed the impact of what was discussed and decided. Expectations of speedy and effective action on local issues were firmly placed at the feet of Local Authorities, and the new breed of local councillors was highly motivated to oblige – they were impatient, partisan activists by nature, riding a surging wave of local democracy. They wanted to assert local political control over planning and delivering all local public services, and in influencing private sector decisions, too. There were also signs that this drive for increased integration and collaboration within a defined geography (often but not always coterminous with municipal boundaries) was in some cases creating a competitive dynamic between local areas, leading to a greater resistance to collaborations beyond the controllable local level.

With no change in statutory duties or funding, councils in the latter 2020s nevertheless sought a range of levers they could use to exercise pressure on other bodies, within the full scope of their powers. But how could they make a real difference to local services, economies and environments with the depleted tools and capacities of 21st Century local government, and with no sign of Westminster wishing to cede any of the power (or resource) it had accumulated? There have been three types of lever commonly employed:

Municipal Fortress Scenario

- Hard legal power. Where defined duties and powers exist, members have directed officers to execute those powers more aggressively, mindful of wider local priorities and objectives, and have sometimes appeared to stretch the bounds of established powers (some cases before the courts may encourage or restrain this trend). Leaders of local statutory and voluntary organisations, and business leaders too, are commonly summoned before council committees and put under significant pressure when it is felt they are not 'playing ball' (increased by the online streaming of sessions).
- Formal influence. Where authorities have a role within the governance of autonomous local bodies, there has been an increased assertiveness by council representatives, in some cases effectively assuming control of those bodies (whether single organisations or collaborative partnerships). A larger portion of this representation is now undertaken directly by members rather than officers and this has led, amongst other things, to a US-like politicisation of many local debates and decisions.
- Informal pressure. Social media and similar mechanisms are being used as digital channels for carrot and stick approaches - 'encourage and reward' or 'name and shame'.

How these local dynamics will play out it is impossible to know, including whether decisions affecting local health, wealth and wellbeing become conflictual. In the Black Country, economic and social outcomes remain somewhat becalmed. Is this a creative tension that will drive change, or a destructive conflict that will undermine what has already been hard won?

Municipal Fortress Scenario - Response Form

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What does the scenario make you think the STP and its stakeholders should do – • **more of?** • **less of?** • **differently?**	**More**	**Less**	**Differently**

Ghost Town Scenario - Response Form

Summary

In this scenario, increasing service pressures and a lack of flexibility and work-life balance in public sector roles has driven workforce challenges from bad to worse. It is now not uncommon to see reports of 20% vacancy rates in some areas. The impact of these challenges on the accessibility and quality of services has led to increasing use of private sector services by those who can afford them (and by companies that see the self-interest in maintaining staff mental and physical wellbeing). Satisfaction with, and support for, the NHS is beginning to slide.

Scenario Narrative

The poignant headline 'Nurse quits NHS to stack shelves in Lidl for better pay and less stress' spread across newsfeeds in 2018. This was reflective of the wider climate of pressure taking its toll on health and social care professionals, and it provided an opportunity for fundamental questions to be raised regarding the long-standing battles that staff were facing: from pay restraints and stressful working conditions to the wider lack of adequate work-life balance within strained public services. The percentage of nurses leaving the NHS for reasons other than retirement drastically increased in 2018 and continued to surge. The resulting recruitment shortages following the Brexit agreement and the government axing nurse education funding, pushed recruitment into further decline.

As this situation played out into the 2020s, difficulty in retaining a work-life balance along with the lack of flexibility in roles continued to make caring professions unattractive: retention issues deteriorated, and training places went unfilled. Some relief accrued from planned increases in the state pension age, resulting in a higher proportion of people over 65 in the workforce. This had its benefits, mobilising the knowledge and experience of these individuals, but the lack of flexibility in working arrangements precipitated increased rates of sickness and absence. The increased desire for flexibility and early retirement resulted in the older workforce being pushed out: losing staff to other occupations and exerting significant pressure on current staff and the younger workforce.

Outside of the EU, the UK was able to derogate from the working-time directive, and this paved the way for a variety of experiments by organisations in order to cope with demand. Some simply increased their demands on staff time, whilst others introduced twelve-hour shifts, 5-days a week. This resulted in substantial productivity gains for employers and some financial benefit for employees.

Ghost Town Scenario - Response Form

These developments were at odds with the expectations of increasing proportions of the working-age population: younger generations especially wanted non-linear careers and saw flexible working as paramount to their lives. There was an overall scaling of technology to assist the expansion of life-changing diagnosis and treatment (e.g. the 100,000 Genomics project), however, the loss of staff to other professions (and to the private sector) hampered this, slowing the pace of adoption of clinical advancements and digital technology to well below the pace required to meet growing service demands. For example, owing to the ongoing shortage of radiologists within the NHS, many people experienced delayed scan results, diagnosis and treatment. Advancements in clinical imaging and radiology across the 2020s meant that scans became more complex than ever and required more time and expertise to accurately interpret. Here, critics of central government were swift to point out policy failings: claiming that the state was 'too late' in committing a plan and funds towards training an adequate number and calibre of radiologists to keep abreast of complexity and demand. Perversely, increasing the pension age drove many to consider retiring earlier (or at least to reducing their hours), and this was compounded by punitive tax changes impacting higher-earning clinicians in primary and secondary care. This led to the further privatisation and outsourcing of services, precipitating the biggest shift in the economic landscape and availability of health and social care funding since the inception of the NHS itself.

Despite the healthcare system working towards greater integration, the scarcity of funding in this period generated greater resource competition between organisations, compounding the phenomenon of silo-working. The final Brexit settlement, the level of economic activity and the pay differentials heightened the competition between the private and public sector and the overall service delivery. This led to the leakage of the workforce moving to the private sector and resulted in the *de facto* privatisation of several healthcare services. Despite citizen expectation around the range and quality of services being 'free at the point of delivery', it should not have come as a surprise that those with adequate financial means were seeking to pay for private care rather than relying on the NHS. In 2021, we saw the effects of the ongoing crisis in public healthcare combined with economic recovery that triggered the first rise of private healthcare insurance. The citizens who had the means of paying for private healthcare were symbolic of the rising expectation and demand of healthcare. Conversely, those facing deprivation and undergoing financial hardship generally had a lower expectation of the scope of healthcare, but were more reliant on healthcare professionals, which further widened the health inequality gap.

The increased uptake in private healthcare services, the post-Brexit trading arrangements and the uncertainty around access to clinical advancements significantly influenced the economic landscape and the availability of health and social care funding and wider resources.

Ghost Town Scenario - Response Form

The marginal decrease in healthcare funding meant a slight increase in social care funding but necessitated trade-offs in the funding of services. The centrepiece for the 2018 NHS Long Term Plan was a commitment to bring about measurable improvement in population health and reduce health inequalities. Nevertheless, this was hinged on actions across government as well as in the NHS to make progress on integrating health and social care and building on the development of new care models and STPs. Instead, scarcity of health and social care funding created greater competition for resources and encouraged greater silo-working instead. The slow take-up of innovative technologies and the modest frontline impact of advancements delayed the inception of integrated model of care and had a knock-on effect on access to care and improvement in prevention and self-care. It also created inequalities in access to healthcare. The middle-classes took a balanced approach to managing their own health, engaged in healthier behaviours and were the greatest users of the available digital resources (the uptake of video consultation with a GP was most popular with this cohort). On the other hand, those in deprived areas were least willing and able to use digital technology due to financial constraints and their expectations of public healthcare. This raised fundamental questions regarding equity of provision for the whole population.

As we enter the 2030s, high vacancy rates and low staffing levels in the NHS paint a worrying picture on political, social and economic levels. It is difficult to envisage how the system will find a sustainable equilibrium between public and private services and, at the same time, further extend integrated care models. Increasing funding is one thing; increasing the attractiveness and sustainability of being a public sector employee these days is quite another. As it stands, we face previously unheard of vacancy rates; workforce demand outweighs supply, compounded by greater levels of privatisation; and many services are in survival mode, struggling to maintain, let alone improve, quality and outcomes. The resultant variation in expectations and levels of access to public services across society has increased outcomes differentials, generated diverse responses to the challenges of prevention and self-care between those in highest and lowest income quintiles, and led to increased health inequalities.

Research in previous decades demonstrated that popular support for the NHS (and, presumably, for the increases to its funding that consistently outstrip other public services) is intrinsically linked to:

- Perceptions of the quality and range of services that are free at the point of need; and
- The attitudes and behaviour of the workforce.

Given the current state of service delivery, the proportion of the public who are funding aspects of their own care, and the stress under which the employees that remain must work, how close might we be to a point of no return as regards popular support for the

Ghost Town Scenario - Response Form

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