The Strategy Unit.

Black Country Scenario Analysis

Part Two: Planning for Uncertain Futures

Four scenarios for 2030 and initial stakeholder reflections

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NHS
Midlands and Lancashire
Commissioning Support Unit

Contents

1. Executive Summary

This report summaries the second stage of the scenario analysis carried out to date with members of the STP and its clinical and managerial stakeholders. It is complemented by:

- The **Part One** report that surveys the emerging contextual environment for the STP's clinical services and associated workforce challenges; and
- A **Scenario Toolkit** that enables any STP workstream and/or member organisations to run further scenario events to inform the development of their own plans.

At a headline level, this report:

- Synthesises the discussions of STP members and stakeholders, based on evidence around broad trends and critical uncertainties, into a set of four divergent scenarios.
- Documents the process of what was, to many, a new experience.
- Records the new perspectives and reframed ways of seeing the priorities of the STP that the scenarios provoked in participants.

In an important sense, however, the reflections that the scenarios can generate and the actions that might be taken in response have only just begun to be harvested. The aim is for the scenarios to inform all relevant aspects of the STP's longer term planning, as it moves towards becoming a thriving Integrated Care System. In particular, it is intended to inform the development of:

- The STP's Long Term Plan;
- The next stage Clinical Strategy; and
- The strategic workforce development agenda.

The four scenarios developed (see Appendix 1 – Future Scenarios) describe a set of divergent, plausible futures, not as an attempt to predict a specific set of circumstances that are expected to come to pass but as an evidence-based way of increasing the agility, resilience and effectiveness of local plans.

Each scenario provoked reflections on the actions and mitigations that the STP might prioritise, and these reflections are reported in detail in the sections below.

In addition to the detailed reflections reported, it is also possible to identify a set of common themes from across the scenarios. These are described below and provide a potential agenda for action across the system:

System Dynamics

a) Relationships, trust and shared learning

There was consensus across all four scenarios that establishing stronger connections and relationships between individuals in different areas, organisations and sectors of the STP would allow the Black Country to function more effectively as a system. Trust would also be increased within the system, as a result, enabling individuals, teams or organisations to feel more comfortable to plan innovations and pilot projects together, and to share information on what they are doing and learning. This is supported by the evidence-base for integrated care that highlights the importance of time spent building and maintaining relationships.

b) Collective vision

Competition or conflict amongst individuals, organisations and sectors within the STP was felt to be detrimental to the success of the wider STP. The establishment of a genuinely shared collective vision towards which all parties direct their efforts should be established. This could include significant collaborative action to grasp opportunities around workforce development, digital technology, citizen engagement and action (with wider system partners) on the wider determinants of health and the area's economic prosperity. In many cases this need not involve the development on wholly new initiatives, but the identification, evaluation and rapid roll-out of learning from different parts of the system.

Workforce Transformation

a) Empowering front-line leadership

In order to be more responsive to changes that are occurring, our front-line staff need to be supported by mechanisms that enable them to experiment, to learn and to share their learnings (of 'failures' as well as of 'successes'). *Professor Al Mulley talks of "redesigning the front-end to be the learning front-end"*. Action in this area could be accelerated through the early development of the proposed ICS 'academy' function that would:

- Help to build a shared knowledge and understanding of the local population and of the solutions for achieving better outcomes;
- Provide and promote standardised approaches to evaluation, learning and system improvement, supporting a reduction in unwarranted variation and the locally appropriate spread of best practice; and
- Ensure that the ICS can coordinate improvement activities (including those promoted by national/regional bodies) and to make those activities sustainable.

b) *Flexible employment*

There appeared to be a recognition that continued attempts to fit people into predetermined roles and careers, rather than increasingly to shape roles and careers around people – their wider needs and interests, was unlikely to turn around the growing workforce crisis. How could both training and employment be more amenable to current and potential staff so that, as with patients, we view staff holistically not as narrow specialist inputs of a given type? There are already experiments in portfolio careers (e.g. through the GP Forward View) – how might these be further extended? What new roles might be created that meet patient needs and might also be more attractive to potential employees (e.g. people with the skills to be health coaches or to support digital applications)? It was felt that there could be much more energetic, boundary-pushing and joined-up activity in this area across the system.

c) *Generating the local workforce*

Previous economic analysis for the STP has shown the significant impact of NHS employment on the Black Country economy. As a consequence of generally higher professional training, the NHS workforce is generally better paid than the wider workforce. What potential is there to bridge the gap between the poorer employment (and subsequent outcomes) experienced by many Black Country people and the shortages in the NHS workforce? What new routes to clinical and technical roles might be designed? There are reportedly various projects across the STP that are exploring this potential, but the impact of a joined-up approach could be very significant – for the NHS, for the local economy and for wider local wellbeing. We discovered an ambition for the NHS to be much more active and engaged with local schools and colleges – whether through promotional events, training and development opportunities or even the sponsorship of a healthcare academy school. There was also a recognition of the opportunity to learn from other sectors (e.g. social care apprenticeships).

d) *One Black Country workforce*

The STP will not be able to deliver the desired transformation in healthcare outputs and outcomes without a workforce of the requisite scale and characteristics. Participants highlighted that the NHS and social care in the Black Country need to be seen as an employer of choice in order to improve recruitment and retention. Rather than multiple organisations competing for the same talent - with the associated and repeated transaction costs of staff moving between Black Country organisations – what is the potential for a collective approach to recruitment and employment across the Black Country? In addition to cost savings, working at STP scale may also support the provision of flexible working, shared experience from different settings and portfolio careers. There was also a recognition that recruitment to the Black Country can be affected by the relative attractiveness of living and working in the area. The STP could seek opportunities to collaborate with wider system partners and other anchor institutions in securing improvements in local infrastructure, transport connections, etc..

Citizen Engagement

There is a risk that strategic plans assume that citizens are biddable components of a model of care. The risk of plans failing are increased by the extent to which the real preferences, behaviours and constraints of local citizens are not continuously examined and understood. This goes some way beyond traditional communication and engagement activities to a much more lively and up-to-date understanding of the people we serve. Patient-centred intelligence is every bit as vital to population health management as is 'business intelligence' and formal population and performance data. Public support for the NHS remains strong but there is evidence that this is correlated with public perceptions of the accessibility and quality of care, and therefore that shortcomings in these areas can undermine that support.

How do we enable a step-change in patient- and community-centred care that reflects geographical, generational and individual needs and preferences? How can the provision of services at scale be combined with services that are personalised, accessible and responsive, in the way we have come to experience other sectors of the economy? How do we enable real conversations and mutual accountability between public services and the public they serve?

There is an opportunity to create new modes of active engagement and accountability between the health and care system and local citizens, through both digital and face-to-face mechanisms. There are benefits to be realised in terms of public understanding of the need for change, a greater willingness to engage in self-care (supported by shared decision-making), and support for community assets and initiatives.

Digital technology, innovation and research

The role of digital technology, both clinical and non-clinical research and associated innovations featured in all scenarios, but their benefits were not always equitably shared. Participants were in agreement that an effective, joined-up plan for digital technology and the prioritisation of research and innovation across the entire STP was needed to ensure that rollout and deployment of technological and clinical innovations are consistent and that there are no geographical, social or generational inequalities relating to access.

Participants also highlighted that training and education in the use of new technologies or innovations, both for the workforce and general public if necessary, should be prioritised to increase confidence and usage across different generations and conditions, so that their potential to improve health outcomes is maximised.

As with many of these emergent potential priorities, there will be examples of good practice scattered across the STP already. The greater opportunity may reside in harnessing that good

practice, assessing and evaluating its potential and, where appropriate, rapidly sharing it across the system.

Again, this is not simply a task that requires specialist technical and research expertise that can be determined remotely but one that needs to be explored and negotiated with local communities and with the STP workforce. There do appear to be real opportunities to improve and simplify healthcare through, for example, assistive technologies, artificial intelligence, interconnected devices and the like. None of these things will realise their potential, however, without adequate public and professional buy-in. There would also need to be a common approach to investing in priority technologies and innovations that are cost-effective and avoid the 'postcode lottery' effect.

Next steps

Participants highlighted the value of exploring these plausible alternative scenarios in a safe environment, away from day to day transactional considerations. They concluded that these scenarios and participants' responses to them should be socialised within wider STP forums, to allow others to add their reflections and to enrich and strengthen future decision-making.

Since the value of scenario work is so critically linked to engagement and participation – and because the research evidence indicates that standalone workshops are often of limited value when detached from ongoing processes – we recommend the following considerations for the STP:

a) Using the insights from this work to drive specific practical actions that could include:

    i. The re-prioritisation of a system focus on key areas of STP development to ensure its maximal effectiveness;

    ii. The development of targeted mitigation plans linked to potential future eventualities; and

    iii. The development of a means of identifying emerging changes in the STPs contextual environment so as to increase its agility and resilience throughout the following10 years and beyond.

b) Holding similar exercises within individual organisations within the STP and Black Country, using a common framework and agreeing to share the outputs of such exercises to increase collaborative system learning; and

c) Promoting the scenarios and the insights generated to other systems.

2. Introduction

This report covers the development of a bespoke set of local scenarios and the subsequent deployment of those scenarios in both a whole system workshop and a subsequent workshop with clinical leaders.

2.1 Scenario development

Following the analysis of the evolving contextual environment undertaken with stakeholders (see Part One report), a full day workshop was held with representation from the Local Workforce Action Board (LWAB), the Clinical Leadership Group (CLG) and other key system partners. This workshop was informed by the Part One report and included inputs from external advisers with expertise relating to the six themes that had been identified as key driving forces of the future contextual environment.

DRIVING FORCES MATRIX

Driving Force	Metric	Range of Black Country Outcomes
Population Health	Average life expectancy	*75 – 76 – 77 – 78 – 79 – 80 – 81 – 82 – 83 – 84 – 85*
	Nature of disease burden	*Very similar - Fairly similar – Moderately Different – Very different*
Citizen Expectations	Scope of services free at point of need	*Significantly reduced – Reduced – No change – Increased – Significantly increased*
	Role of citizen in health and care	*Citizen-driven – Driven-citizens*
Clinical Advancements	Frontline impact of advancements	*Marginal – Moderate – Significant – Very Significant – Radical*
Digital Technology	Degree of automation in care	*Very low – Low – Moderate – High – Very high*
	Main control of data	*Individual – Commercial – State*
Level of Funding	Health spending as % GDP	*2% -3% - 4% - 5% - 6% - 7% - 8% - 9% - 10%*
	Social Care spending as % GDP	*0.4% – 0.6% - 0.8% - 1.0% - 1.2% - 1.4% - 1.6% - 1.8%*
Workforce Availability	Vacancy rates	*5% - 6% - 7% - 8% - 9% - 10% - 11% - 12% - 13% - 14% - 15%*
	Degree of novelty/ integration in roles	*Very low – Low – Moderate – High - Very high*

Table 1 - Driving Force Matrix

Participants were invited, first, to describe a wide range of potential futures in terms of these six driving forces; and, secondly, to refine those initial scenarios into a contrasting, challenging, coherent and plausible set of 4 scenarios.

Following the initial construction of the scenarios in the workshop, more detailed narratives were subsequently developed. The scenario method provides an open framework for ongoing collaborative learning, so these scenarios can continue to be revised and refreshed, as required, informed by these and/or other factors.

Full narratives for the scenarios can be found in Appendix 1 – Future Scenarios. They are summarised below.

In the **Digital Village** 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 address inequalities in access, experience and outcomes.

In the **Generational Ghetto** scenario, 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.

In the **Municipal Fortress** 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.

In the **Ghost Town** 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.

2.2 Initial Scenario Deployment

A subsequent half-day workshop was held for a broader group of LWAB and CLG members plus other STP leaders and a second evening workshop was held with clinical representatives from across the STP. Both events enabled participants to become immersed in one of the four scenarios that had been developed. The focus of the workshops was on beginning to identify the potential impact of the scenarios on the STP's clinical services and workforce, and to consider how that impact might be maximised or mitigated (as appropriate).

After an introduction to the nature of the scenarios and how they should be used, participants at both workshops divided into four groups to separately consider each scenario. It is important to note that the value of the scenarios lies as much in how they can help participants to reframe current perspectives and priorities, regardless of how the future actually evolves, as in how they might respond to a particular scenario should it materialise. In their respective groups, participants were asked to consider and discuss a set of structured questions, and to prepare a presentation for the subsequent plenary session on the nature of their scenario and their initial reflections on it. The key questions considered were:

- *What is 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.*
- T*hinking now of current and emerging STP plans and assumptions, list the main challenges/ opportunities created by this scenario.*
- *What does the scenario make you think the STP and its stakeholders should do more of, do less of or do differently*?

In the plenary session, participants questioned each other about what they had each reported, and began to identify common themes.

In the following sections, we summarise initial stakeholder reflections and discussion from both workshops, including the responses made by each participant to the questions above.

3. Ghost Town Scenario

Group Summary

There was consensus in both workshops about the plausibility of this scenario. They reported that it seemed worryingly likely but expected that, should this scenario begin to be realised, there would not be such a lack of energy, motivation and action to change the negative outcomes portrayed. One participant gave an example of a relative who chooses to pay privately for care due to long waiting times and what the relative perceives to be an unsatisfactory customer experience offered by the NHS. Others pondered the attractions that such a scenario might hold for some politicians or private healthcare companies.

Participants also wondered about the following questions from the perspective of 2030.

- Had there been any opposition to this scenario? What had central government, staff, trade unions and the public done to resist its evolution?
- How had demography changed - were people continuing to live longer?
- Had patterns of staff training changed? Were healthcare professionals being trained within the private sector rather than transferring from the public sector?
- How was the mismatch playing out between patient expectations and what can feasibly be delivered? Did increased silo working make it more difficult to access particular services, and how equitable was that access across the Black Country?
- To what extent were community initiatives and social capital playing a role in mitigating the workforce crisis and negative patient outcomes?
- What was the impact of Brexit - e.g. on workforce numbers from the EU?
- Had digital and technological advancements impacted the workforce significantly? Had they, for example, facilitated flexible working to alleviate staffing problems? And was there a digital plan to support these enhancements – e.g. staff education, information governance and data sharing?
- How had investment levels in the NHS changed over this period and where was it allocated?
- How has social care been impacted in this scenario?
- Have the population quietly accepted this trajectory, and has this varied between the generations?

When participants turned to considering the challenges and opportunities that current and emerging STP plans might encounter under this scenario, some participants highlighted the challenge of avoiding the complete collapse of the system if recruitment and retention into general practice is not improved. Others highlighted that engagement with the workforce and making the

NHS and social care an employer of choice would be a vital challenge in order to improve the retention of experienced staff and their willingness to be trained for the future. Some highlighted the challenge of too much pressure being placed on clinicians regarding unmanageable workloads and they questioned how workforce numbers could be increased if training spaces cannot be filled. They also highlighted challenges regarding the fulfilment of political commitments to alleviate workforce problems and funding challenges at a local level, particularly in light of the increasing desires for more flexible and agile working patterns and lighter workloads.

There was concern about how to increase recruitment by changing people's mindsets to want a career in the NHS and social care and how to educate individuals about potential career options in these sectors. Ensuring the full roll out, acceptance by staff and usage of technologies to alleviate workforce pressures in this scenario was also seen to be difficult and some were concerned about regaining the public's confidence and trust in health and social care. Others expressed concern that not everyone would be able to afford private healthcare if the NHS deteriorates, creating an equity gap. Individuals also highlighted the negative impacts associated with a high prevalence of silo working - increased competition between geographies and organisations; pockets of expertise; inhibition of service integration; staff sharing and collaborative working; and difficulties managing people who use multiple services.

In terms of opportunities, participants felt that this scenario created a sense of urgency and a call to action to prevent its realisation – for example, to alleviate workforce challenges by championing integration (using social capital, community and local authority support), embracing innovation to find new ways of working in clinical practice, using those in other roles such as physicians' assistants to alleviate pressures on clinicians and embracing digital solutions to improve work/life balance. Conversely, it was also recognised that, if this scenario emerged, there would be a need to embrace the privatisation of some services, building relationships and increasing collaboration, resource, workload and skills sharing between the public and private sector.

Some suggested that the private sector concept of performance related pay could be embraced by the NHS, whilst others felt that better collaboration could have financial benefits for the private sector through the successful winning of large financial contracts, but also financial benefits to the NHS through not having to provide expensive services that the private sector might own. Such agreements could have quality benefits for patients and work-life balance benefits for the NHS and social care workforce as the NHS would be less stretched.

In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

The STP and its stakeholders should consider:
More
• Encourage joint working, collaboration and role sharing; • Encourage patients to take responsibility for their own health; • Roll out of digital technologies amongst the workforce and patients, supported by appropriate education; • Increase flexible and agile working opportunities for those who want them (e.g. 1 day a week for special interest) facilitated by an optimistic aim of over-recruitment; • Increase openness and create a culture of honesty within the STP, to improve trust and subsequently staff retention and recruitment; • Leadership at the front line to drive change in recruitment and retention initiatives; • Reduce the costs of training professional staff to the NHS and social care; • Improve training and development processes for existing staff to allow the fast-track development of those who want to progress**;** • Budget for innovation to improve retention and recruitment; • Bravery of leaders to drive change; • Innovative and collaborative approaches to improving recruitment and retention.
Less
• Planning for the short term - we need to think ahead; • Time spent talking and planning - we need to invest more time in making change; • Bureaucracy and protectionism; • Competition between services and silo working; • Rigidity of working practices and hours (e.g. 12-hour shifts.
Differently
• Plan for multiple different scenarios and contexts going forward; • Explore what both patients and staff want at multiple levels within the STP; • Improve the awareness of health and social care careers amongst both young people and older career changers - run an education campaign, offer careers counselling through schools and job centres, target those selecting T-levels, offer work experience placements, create an apprenticeships hub; • Offer alternative training options for health and social care careers, create new apprenticeship programmes, offer rotational placements across health, social care and local authorities; • Make team-level negotiation about flexible working and shift cover a routine part of service planning;

- Increase the attractiveness of health and social care in the Black Country as a brand, reduce competition within the Black Country for talent, standardise career development opportunities and digital and clinical advancement roll out;
- Provide a nurse bank to give staff the flexibility to choose shifts and earn extra money;
- Allow data sharing between the public and private sector;
- Ensure expectation management takes place so the general public do not have too high expectations of their healthcare (e.g. clinicians telling patients that they cannot see a GP the same day);
- Do all that they can to champion removing the pension cap to improve retention and recruitment;
- Learn from the success of other sectors (e.g. social care apprenticeship schemes that target both career changers and young individuals; performance related pay schemes in the private sector to improve retention and recruitment).

Plenary

Participants found this scenario to be worryingly plausible. Some highlighted the existence now of geographical and organisational barriers; lack of consistency in service delivery and funding across the STP; long shift work and inflexible working; tensions between organisations; and members of the general public choosing the private sector for more rapid, high-quality treatment. Meanwhile others noted high levels of pressure currently on clinicians, a high expectation from patients to receive care as and when they want and a lack of funding available to find new innovative solutions to solve the recruitment and retention crisis.

In order to change this trajectory, participants identified the following priorities:

- To empower citizens and staff to voice more clearly and powerfully what they want from the health and social care of the future;
- To increase the ease of working in the NHS and social care by improving system thinking and system-wide integration across the STP. The Black Country was described as a loyal area that has a high motivation for integration and cross-area working amongst the front-line workforce;
- To increase education and awareness campaigns, as well as work experience placements, to increase interest in a range of health and care careers, both for first-time workers and for career changers. There was some scepticism about "branding" the Black Country as a single employer, as each local community may have slightly different needs and workforce requirements;

- To focus on funding, to allow more innovative ways of GP working to be developed. Without viable funding, we can only tweak around the edges and not make any substantial changes to improve workforce retention and recruitment;
- To improve retention in a context where staff are commonly approached by private providers offering benefits that the NHS and social care cannot. There was a strong consensus that making the NHS and social care good places to work by allowing individuals to realise their career aspirations and by offering incentives such as flexible working, career support, development and pay incentives could improve this.

Although there may be isolated improvements in service delivery and patient outcomes in this scenario, there was consensus that what was described as the 'defeatist and passive approach' taken to the growing workforce problems should be rejected. This scenario should be a call to action for the STP to co-produce a future with the workforce and general public that values staff, improves patient outcomes and, ultimately, is something for the Black Country to be proud of.

4. Digital Village Scenario

Group Summary

Participants recognised the plausibility of the scenario and, for some, this "citizen-led healthcare" scenario reflected an ideal view of health systems in the future. "Why shouldn't we check on Mum's blood pressure on my phone when I've finished ordering my shopping?". However, some individuals questioned whether current health and care system plans and implementations would support the emergence of such a future.

In considering the scenario itself, participants commonly found themselves wondering about the following issues from a 2030 perspective:

- What was the incentive to work in health and social care? How had an ageing population influenced workforce recruitment, retention, skills, and the willingness to embrace technology?
- How are the increased funding levels being financed? What were the taxation levels in this scenario?
- How were secondary care, social care and mental health care impacted in this scenario, particularly regarding the high level of digital relative to face-to-face interactions? How were patient outcomes affected?
- Has this digitally driven society created an equity gap (for example by age, literacy, deprivation)? Has this impacted patient outcomes?
- How will personalised care pathways which are digitally driven and well-coordinated be implemented, and by whom?
- What information governance structure is in place? Who owns the data and how much control do people have over accessing it? Has there been time to implement these digital advancements uniformly across the Black Country; have other external technological factors influenced this scenario's development (e.g. connectivity, advancements in research/ other sectors)?

In considering the challenges and opportunities created by this scenario, several participants felt that health was only one issue that would be impacted by the digital revolution envisaged. That revolution would likely shape other aspects of life over the coming 10 years that could have a feedback effect on health (e.g. fitness levels, food consumption). Some thought that the investment data and security infrastructure required to support this digitally-driven system could be challenging to obtain. Most participants were also concerned about the culture of patients and staff and the engagement required to support this scenario - for example, how the current workforce would adjust to such a digitally-driven health and care system and what shape and size of the workforce would be needed to make a success of a such a digital model.

Some felt that the workforce transformation which would need to be enabled would be hard to achieve against a background of staff instability, increased flexible working and early retirement of experienced senior staff. The capacity required to keep pace with digital change in the workplace could add to the pressures already felt by staff. Moreover, participants also wanted to understand how public perceptions about the nature and status of health and care professions could be addressed to increase recruitment and retention.

Participants also wondered:

- How increasing patient expectations could continue to be met; and
- How inequalities of access would be identified and addressed and how certain groups could be engaged to get the most benefit out of digital advancements.

Overall, it was recognised that significant efforts would need to be harnessed to realise such a digitally-driven model of health and care.

It was also felt, however, that this scenario presented several opportunities - for example, the enablement of cross-sectoral care records and information sharing; real time data generation; a more standardised approach to health activity across the digital landscape, and; the rapid adoption and roll-out of new digital advancements. Some participants highlighted that this scenario would provide support for the digital prevention agenda, self-care and more personalised healthcare. They also thought that increased usage of AI and digital could offer cost-saving opportunities. Moreover, they suggested that real digital progress within health and care could help to attract a more diverse talent pool, with strong technical skills, into the NHS.

In response to being asked how current and emerging plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

The STP and its stakeholders should consider:
More
• Talking to each other about how common issues are addressed; • 'Selling' the potential of digital tools; • Sending of consistent messages to all parties; • Help guiding the public's expectations to a more realistic viewpoint; • Encouragement of the use of apps by medics to aid their day-to-day work; • Promotion of self-care interventions for the general public; • Evaluation of the digital space to assess what is available; • Planning of funding generation and allocation to ensure the roll out of these technologies is achieved; • Generation of strategies and plans to increase engagement of patients and clinicians on digital technology.

Less
• Failure to consider those without access to digital resources; • Lip service to the STP and its mission; • Silo working in the sector and across the public sector.
Differently
• Be open to changing the mechanisms of delivery of care over time to meet the changing needs of the public; • Create a shared digital model to standardise roll out across the region; • Focus on a population health management style approach, including the digital intelligence and infrastructure needed to support it; • Pilot more projects; • Share existing pilots across the STP footprint; • Ensure training of older staff takes place, to increase engagement regardless of age profile; • Run campaigns to increase digital engagement of staff and patients; • Solve data sharing issues so that live systems can be accessed by multiple individuals across the system, and so that patients can better access their own information.

Plenary

Participants thought that this scenario was plausible and that it shed light on several key opportunities to improve patient care and experience and workforce recruitment and retention. They also felt that it would present several challenges - for example, patient expectations, inequalities (e.g. age, wealth, learning difficulties, geography), digital infrastructure and investment and workforce acceptance. The road ahead looks uncertain. Workforce transformation and the induction of the population into being more proactive managers of their own health and using digital technology to assist them in this endeavour were recognised as critical to making a success of such a future model of care. In order to tackle these challenges and embrace digitalisation of health and social care, participants identified the following priorities:

- To be open and willing to change the mechanisms of delivery of care over time to meet the needs of the public, as their expectations and needs evolve.
- To ensure that future funding is allocated equitably to ensure the consistent roll out of digital technologies across diverse geographies.
- To manage two levels of technical change - a specialised approach to Population Health Management with the under-pinning infrastructure and intelligence plus carefully-crafted front line solutions that are easy to use, societally acceptable, save money and can transform the way that health and social care are currently delivered.

- To change the culture of staff and patients to embrace digital technology, potentially through training and campaigns.
- To invest time and resource into tackling the current data protection, sharing and security challenges, so that strides can be made in areas such as real time data sharing and predictive modelling across the system.
- To seek a national digital model. The group reflected that some digital changes will occur naturally and will help to improve health outcomes for the majority. Without a national model, however, there is a distinct risk that each 'digital village' could become an island, and that inequality gaps could widen.

Although participants felt that achieving this scenario was a big ask within ten years, putting plans in place now and engaging with the workforce and general public to embrace such a digital model could increase the likelihood of it becoming a reality.

5. Generational Ghetto Scenario

Group Summary

Several participants across both workshops found this scenario plausible, not least because they recognised generational tensions within today's society (e.g. differing degrees of reliance on the state, variance in health seeking behaviours, attitudes to technology and new treatments) and could imagine these tensions increasing over ten years. However, even though it was recognised that generational tensions will always be unavoidable, some individuals questioned the likelihood that this scenario would evolve, as for example friends, family and neighbours could influence each other to reduce the stark divides between generations. Participants were struck by the impact that the described generational tensions had on current notions of community and integration.

From the perspective of 2030, participants wondered:

- Why there was little mention about the 40-60 age group – were they more like their younger or older generational counterparts?
- What, if any, attempts had been made to bridge the generational gap divide?
- What impact had generation differences had on the wider health and social care economy?
- What impact has this scenario had on social care? Are individuals aged 65+ who are living longer with a lower quality of life continuing to increase demand on services over the 10-year period? How have their social care needs been addressed? Has any support been given to families of the ageing population to care for them?
- What impact has digital technology had on health and care in this scenario?
- What impact had socio-economic status, deprivation and social class had on lifestyle choices and health outcomes in this scenario?

When considering the challenges and opportunities that current STP plans might encounter under this scenario, some participants felt that a key challenge lay in the extent to which either the over 60s or the under 40s age groups would influence future service configuration, as well as how the needs and expectations of both could simultaneously be met. Meanwhile, others felt that wider determinants of health, including education, employment and housing, could also challenge and exacerbate health and care related generational differences. They also felt that meeting the care needs of older individuals could present difficulties, as plans may need to be put in place to support care home expansion and the provision of care at home for more individuals. Some also expressed concern about the future levels of taxation and funding for health and social care services that would be required to meet the needs of all generations.

Several participants questioned the attractiveness of traditional health and care roles to the younger generation, especially if the sector fails to embrace digital technology or manage to the desire for portfolio careers. Establishing the culture required to embrace new technological

developments – in the workforce, the population and the administrative infrastructure – was also seen as a key challenge. Investment would be required in training to support individuals across generations to utilise new technologies. Communicating innovations and sharing information and learning between individuals and organisations - reducing duplication of projects, research and development or roles - would continue to pose a great challenge.

Regarding opportunities, some highlighted that breaking down barriers and silos within health and social care, and linking more effectively with the voluntary, community, education and private sectors could be beneficial. For example, engagement of the voluntary and community sector to increase health-related support to Black Country citizens, particularly those of the older generation, could help to bridge the generational divides and build community resilience. Other participants felt that digital technology presents opportunities to improve health and care across generations. It was noted that the preferences and needs of younger and older citizens could be met by varying the model of care offered to different generations, with a personalised care approach at the generational level (e.g. a prevention, convenience-based approach for the younger; a person-centred approach favouring quality of relationships, social prescribing and continuity of care for the older).

In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

The STP and its stakeholders should consider:
More
• Acting on opportunities to increase the spread of innovation through collaboration; • Creating the mechanisms and mindset for enabling the spread and adoption of digital opportunities (e.g. pilot projects); • Adopt more of a focus on the social, behavioural and cultural factors, including mechanisms and mindsets, involved in the spread and adoption of technology; • Building strong and well engaged communities regarding looking after their own health; • Supporting a holistic approach to manage an ageing population; • Work with local authorities to improve wider social determinants of health; • Invest in enhanced cancer diagnosis' as rates will likely continue to rise; • Focus on growing and developing younger leaders who will drive positive change in health and care; • Supporting intergenerational projects to improve health across the system; • Digital planning, modelling, implementation of technology at pace and socialisation of plans with all Black Country stakeholders across system.
Less
• Focus on our individual organisations and reinforcing competing priorities - we should be viewing our efforts in the context of the overall NHS workforce, 'our Black Country', and improving things for our area;

• Reactive care - we need more considered decision making; • Complex decision-making processes which make it harder to bring change; • Thinking of populations split by ages – wider social determinants and deprivation may be more important distinctions to make; • Focus on organisational change that distracts from planning and implementing for the future; • Focus on individuals' medical needs and more focus on their social needs.
Differently
• Make use of highly sophisticated technology, including AI and real time data, to improve learning and efficiency for clinicians when doing their job; • Focus on economic growth, education of all ages on healthy living, supporting children's services and building family networks so that knowledge and outcomes can be improved to bridge the generation gap. • STP should engage with young and older individuals equally to plan to equitable distribution of resources between them; • Share and implement good practice around digital opportunities and wider initiatives - taking on a responsibility and culture as an organisation to ensure that good clinical and digital research are put into practice and don't just gather dust • Increase our ability to collaborate with and benefit from working with other sectors, including social care, the third sector and the private sector.

Plenary

Participants found this scenario plausible, although they believed the divide may also extend to wider socio-economic determinants of health. They were concerned that divides across the population could have such a large impact on patient and workforce expectations, health needs and the ability to engage with the current model of care. In order to tackle these challenges, the following priorities were identified:

- Collaboration and the sharing of learning across the STP, its organisation and sectors, is important. There is a need to create a collaborative culture of 'one Black Country', to avoid being dismissive of others' work and to want to share our successes and innovations with each other.

- Ensuring digital education and training is offered going forward, to train a workforce that can take best advantage of digital opportunities (in terms of general digital literacy and more specialised knowledge pertaining to clinical advancements) and to enable patients to utilise technology to improve their own health.

- Improving relationships between the STP and its stakeholders and the private sector. Understanding the optimum balance between what the private and public sector are responsible for in health and social care to meet range of plausible future challenges and demands, as well as gauging public acceptance and attitudes towards this are vital.

- Investing in clinical and digital research should be a priority for the STP, in order to maximize the potential benefits for both staff in order to increase the ease of their day job, as well as for patients to improve the quality and timeliness of their care.
- Focus on equipping the younger generation with the knowledge and willingness to improve health and care outcomes for future generations, through education, training and development, to ensure that they are digitally enabled, prioritise self-care and will be strong leaders of health and care in future.
- Support the older generation through plans such as care home expansion, care at home initiatives, efforts to build family network and digital training.
- The need for more effective, joined up and well-socialised plans of action across the STP its stakeholders and various sectors (for example on digital and prevention), to ensure that everyone is aware of aims going forward.

Overall, participants from both workshops felt that this scenario was something that should not be allowed to materialise. It should prompt the STP to respond and to take steps that build a better future where generational differences are not a burden but are embraced and used to shape the health and social care that each individual requires.

6. Municipal Fortress Scenario

Group Summary

The immediate reaction of participants to this scenario was of "doom and gloom" regarding the financial situation, relationships and the prospect of having a politicised divide between central and local government. Some participants stated that it would precipitate local protectionism, encouraging pockets of excellence whilst generating a 'postcode lottery' system. Although they could see the potential for avoiding the emergence of this scenario, there was not great optimism about the potential for engaging with local government.

In considering the scenario from the perspective of 2030, participants found themselves asking:

- What does a workforce strategy look like in a context of increasing localism? Has the political turmoil put people off working in health and care?
- What health outcomes have been prioritised, and how and where were they delivered? Have patients remained at the heart of healthcare delivery? How has the quality of patient care been impacted?
- What was the NHS and social care's place in the global community, and what was the impacts of these external influences?
- Has the private sector influenced future funding streams?
- What have been the governance arrangements and the level of autonomy to make decisions at a local versus a national level, and has this changed over time? What role have statutory regulation of standards played? How have the regulators responded in this scenario?
- What was the level of competition and who were the key decision makers?
- Has local political influence dominated PCNs, and what was the impact of the Combined Authority?
- Why has the locus of power moved to local government rather than to social movements or social media?
- Where did the people come from to be active in local politics? Did this create division locally?

Overall, participants highlighted several challenges arising from this scenario, stressing that there may be a diversion from the primary purpose of health and social care delivery to work for the best outcomes for local people. They were quick to point out, however, that each challenge contains an opportunity. It was noted that there needs to be recognition that forms of leverage for change may shift in future. There were also concerns that the people who proved themselves to be most

effective electorally might not necessarily be the most effective stewards of local services within a system context. As a result of the diversity of interests, and the associated vigorous promotion of multiple (potentially conflicting) causes under this scenario, there were concerns that this could lead to a lack of robust governance, strategic direction, decision-making, alignment with national priorities and, ultimately, the trumping of evidence-based clinical decisions by popular preference. It was felt that having several local entities may result in a lack of collaborative strategic leadership over the system, and that this could generate two contrasting challenges: on the one hand, individuals may accept the decisions that are made on a local level and then work collaboratively in response, or they may work to resist or oppose the decisions on a local level. Participants were also concerned about how public perceptions of the objective truth, opinion and prejudice would change, for example perceptions of vaccination programmes, and the scale at which this could influence others in this locally driven model.

The potential "stranglehold" of increased regulation was described as a challenge by participants who saw it as generating a disempowered workforce and as increasing the recruitment and retention challenge, especially amongst the younger workforce. With the lack of economies of scale, money will be spread too thinly, leading to decreased funding and major cuts in services. This could lead to an NHS postcode lottery. The resultant variation in healthcare provision could widen gaps in outcomes, leading to increased health inequalities. There were concerns that there may also be generational and socio-economic inequalities regarding accessing and responding to healthcare services that are increasingly digitised, especially if (as was thought likely) those technologies are predominantly generated in the private sector.

The challenge of heightened competition was a common theme amongst participants who envisaged a reduced sharing of ideas due to differences in ethos and limited resources. The NHS and social care could therefore suffer cuts and closures, meanwhile public expectations of the NHS and social care continue to rise. Ultimately, a proliferation of the privatisation of several healthcare services may result. In general, participants wondered how the wellbeing of the general public would be affected as a result of these changes, as well as their sense of purpose and hope. To align expectations about service provision, participants stressed the need for open, realistic dialogues with the population on shifts in policy and funding, and their effect on the demand and supply of healthcare.

Participants believed there was scope for transforming these challenges into opportunities, providing leaders took a whole-system perspective beyond just health and social care, that there was greater collaboration and engagement, and if local stakeholders consider opportunities for investment in education and in the workforce. It was felt, for example, that Black Country people prefer to live and work in their local areas, creating an opportunity to grow its own workforce through making the NHS more attractive to local people, perhaps through appropriate training posts. Moreover, participants stated that harnessing community action in a constructive manner,

including selecting the influencers with strong local connections, and harnessing public support, for example for Primary Care Networks (PCNs) and community assets, could help to improve the trajectory for health and social care. Participants also noted the opportunity to instil in individuals a stronger desire to take more responsibility for their own health. The use of social media was mentioned as a useful resource to generate a movement of change and to educate the population and healthcare professionals alike.

In response to being asked how current plans should be enhanced as a result of considering this scenario, participants recorded the following suggestions:

The STP and its stakeholders should consider:

More

- Relationship management between local partner organisations – it is time-consuming but crucial;
- Whole system thinking, having a strategy in place in all areas of the Black Country and communicating that across and within organisations, collaborative working across primary and secondary care;
- General public engagement, co-design and shared decision making on future STP plans;
- An STP 'flying squad' that could be parachuted into areas of concern;
- Using social media to communicate with the public and healthcare professionals;
- Educating the public and individuals about health and care services data that is collected (e.g. for disease profiling/ demand and supply);
- Target schools and colleges to build civic pride and future workforce capacity, develop parenting skills;
- Have a balanced approach between strategic and local working;
- Targeting the most vulnerable for support;
- Making data on social attitudes and preferences part of PHM.

Less

- Protectionism over localities rather than viewing the larger picture;
- Competition and fighting over power;
- Spending on consultancy;
- Time spent on meetings;
- Governance that generates work for lawyers;
- Having stakeholder events less often but ensuring that the meetings that do take place are with the right people;
- Reliance on central government solutions;
- Planning without the population's views.

Differently
• Engage with populations and the workforce in all areas; • Generate more realistic expectations of services; • Work for the best patient outcomes; • Cast the net wider for engagement events by having people in the room from other sectors; • Decide the areas that the STP requires help with and their priorities; • Focus on how to build resilience in the population to identify and support the most vulnerable in society; • Focus on innovation and it's spread (depth and breadth); • Reassess regulation and its purpose; • The NHS should run a school academy chain.

Plenary

Overall, it was felt that this scenario painted a picture of a worryingly controlling local system. For example, there is ambiguity around the future government landscape and a strong likelihood that the scenario would result in a postcode lottery system favouring areas of those with higher socio-economic status. It was felt that this scenario was not too far distant from the position currently emerging. In order to change this trajectory, the workshop identified the following priorities:

- To increase collaboration across all parts of the system, including community-based initiatives, and with the general public to collectively focus on improving health and social care services in the Black Country.
- To prioritise the most vulnerable in society to reduce inequalities regarding digital and physical healthcare provision. For example, increase planned care for the elderly and people with long term conditions. Although this is a challenging, slow and ongoing process, initiating this now could drastically improve outcomes for this demographic of people.
- To educate the system and its population, starting from school-age individuals, clarifying what the health system is there to provide/not provide, and encouraging the population to take greater responsibility for their own health.
- To focus on the workforce - for example, by making the NHS a more attractive place to work, offering interesting training posts, especially for the younger workforce, investing in the Black Country as a place to improve workforce recruitment and retention (e.g. its infrastructure and transport system).

Participant's saw several disadvantages to an increased localism and concluded that there is now a pressing need for urgent action to ensure that health and social care services do not come to reflect such "doom and gloom".

Appendix 1 – Future Scenarios

SCENARIO	SUMMARY
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, 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.
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.

1. Digital Village

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 address 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.

A key element in changing attitudes was played by the rapidly expanding internet companies, the 'FANGs'[1], 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 seemed to remain 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:

[1] Facebook, Amazon, Netflix and Google.

- 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.

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.

2. Generational Ghetto

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:

- 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.

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.

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.

3. Municipal Fortress

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 had 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. 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.

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:

- 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?

4. Ghost Town

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. 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. 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 state-led provision of the full range of services, free at the point of need?

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