

# A strategic review of the future healthcare workforce

## Informing the nursing workforce



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*This paper was originally published in June 2013 and was republished in August 2013 to correct an editorial error relating to a statement made on page 21.*

# Executive summary

**This report considers the issues likely to shape the nursing workforce over the next 20 years in relation to the transfer of care into the community. It is part of the ongoing Centre for Workforce Intelligence (CfWI) horizon scanning work underpinning the nursing and midwifery (N&M) programme. The report is based on the views of a senior set of stakeholders with an interest in the nursing workforce. The CfWI will be engaging with employers and professionals to develop the themes in the report to inform supply and demand modelling in the medium and long term.**

In this report 103 'shapers'<sup>1</sup> likely to affect the nursing workforce in the future are identified from a literature review, stakeholder interviews and a workshop. Shapers are classified to one of six TEEPSE (technological, economic, environmental, political, social or ethical) categories. These shapers have been analysed to identify emerging themes. The findings and themes in this report are intended to stimulate debate and will inform supply and demand modelling for the nursing workforce in the medium and long term. The information contained in this report is based on expert interviews and has been complemented by secondary research where possible. Some of the information contained in the report is not based on evidence, but on the judgement and accumulated knowledge of our participants. The views in this report are not exhaustive.

The main nursing demand shaper up to 2030 is likely to be the increased numbers of older people with complex needs requiring community care. While this has often been described before, the sharp increase in the scale of demand and its changed nature is often underestimated, as is the major impact it will have on the nursing workforce. The relatively slowly and steadily increasing trend in the community care needs of older people seen so far in the 21<sup>st</sup> century will be replaced with a step change by 2030. The overall size of the population has been growing gradually and projections are that this will continue over the next 20 years.

Stakeholders interviewed identified that the major workforce supply risk is that the current approach to education and training is not fit for purpose in terms of large-scale transfer of care from acute hospitals to the community. A planned education and training response is required. The challenges include:

- planning the education and training system to train nurses to practise in a community setting
- attracting new recruits into the field of nursing when more care will be community and not hospital based

- training nurses to care for older people with complex needs
- managing the changing working patterns of potentially providing 24/7 care in the community
- managing the changing working environments for nurses providing more care in the community
- supporting programmes and continuing professional development (CPD) to increase the number of nurses moving from hospital to community settings.

There is a need to assess what workforce is needed to provide more care in the community, and what education and training is required. Even if this assessment happens immediately and translates into policy, supply from education/training will only keep pace with new community roles if steps are taken now.

The main nursing workforce challenge up to 2030 will be commissioning and making changes to the education and training system so that it can create the required high-level community nursing capacity in time to meet demand. The role of the registered nurse is increasingly becoming one of advanced practice, in terms of case management skills, specialist knowledge and multidisciplinary team working and leading. Nursing will thus become increasingly 'intelligently compassionate'.

There is an urgent need to start reshaping the education and training system now in order to achieve these changes in time. If not, a mismatched 2030 workforce could leave people in later life with complex needs unmet at home.

## Next steps

The horizon scanning project for nursing will consider 'leverage' – how to manage and influence the identified shapers. It could also consider widening the scope of the project beyond the transfer of care into the community, to include a better understanding of all current and likely future care pathways. This would assist comprehensive planning of the full nursing workforce required to 2030.

The next phase will also seek to link horizon scanning with workforce modelling. Horizon scanning can inform scenario generation, which in turn can inform workforce modelling. Together, all three processes can improve the quality of both workforce analysis and workforce planning.

<sup>1</sup> See definition of shapers on section 1.1.3

# 1. Introduction

## 1.1 Background

### 1.1.1 The Centre for Workforce Intelligence

The Centre for Workforce Intelligence (CfWI) is working to become the national authority on workforce planning and development, providing advice and information to the health and social care system. We produce quality intelligence to inform better workforce planning, in order to improve people's lives.

We support long-term and strategic scenario planning for the whole health and social care workforce, based on research, evidence and analysis, in order to build strong leadership and capability in workforce planning.

### 1.1.2 The nursing and midwifery programme

The CfWI nursing and midwifery programme aims to provide better-quality intelligence on the nursing and midwifery (N&M) workforce, enabling more effective and robust planning to improve people's lives. This horizon scanning piece of work is about considering the future and describing factors that could influence the future shape of the nursing and midwifery workforce.

The CfWI has undertaken a number of projects investigating the N&M workforce, including:

- workforce risks and opportunities – education commissioning risk summaries for health visitors, midwives, adult nurses, children's nurses, mental health nurses, learning disability nurses, practice nurses and public health nurses
- nursing and midwifery workforce information review and a review of practice nurse workforce information
- maternity planning tool review
- health visitor reports: current picture report; opportunities, challenges and good practice report; international briefing paper.

The 2012-13 CfWI nursing and midwifery programme consists of three linked project areas. We are:

- undertaking an in-depth review of the shift of care into the community and the implications this has on nursing workforce planning
- investigating the development of a maternity care pathway framework

- undertaking an analytical project that will deliver high-quality national supply-and-demand forecasts and will look at this from 1-to-5 and 5-to-20-year periods.

This document underpins our nursing programme and will inform scenario generation and further modelling. The horizon scanning reports focus on five to twenty years in the future and are about identifying probable futures and the potential implications for the future workforce.

### 1.1.3 About horizon scanning

**Horizon scanning** is defined as 'the systematic examination of potential threats, opportunities and likely developments including but not restricted to those at the margins of current thinking and planning' (Chief Scientific Advisers Committee, Office of Science and Technology, September 2004).

A '**shaper**' is an umbrella term that captures all the subjects of examination in horizon scanning, including issues, drivers, big picture challenges, trends, megatrends, wild cards and weak signals. In particular, the database described in this report contains 103 shapers likely to affect the nursing workforce in the future that fall into the three following groups:

- **Drivers** appear at a point in time (such as a key piece of legislation) and bring about changes to trends or patterns – about two-thirds of the database shapers are of this type.
- Trends are patterns of change over time (such as gradual changes in the age profile of the workforce) – about a quarter of database shapers.
- Megatrends are trends of such magnitude, scope and certainty that they have profound workforce implications (such as the gradual but inexorable increase in population size, increased age profile and incidence of disease) – about one in ten shapers.

## 1.2 Context

Stakeholder interviews were framed within the context of the shift of care from acute hospitals to the community. Many policy statements have been issued aiming to move more care out of hospitals and into the community, including the Health and Social Care Act (Department of Health 2011; HM Government 2012). The majority of contacts that people have with health services already take place in the community rather than in hospitals (Royal College of Nursing, 2010). Exact numbers are unclear, but approximately one third of nurses currently work in the community, including people's homes, nursing and care homes, health centres, GP surgeries and schools (NHS Workforce Review Team, 2008).

A number of those interviewed questioned whether the scope of the CfWI's nursing horizon scanning work should be widened. This became a theme discussed at the stakeholder workshop. The main views expressed were as follows.

- Further understanding of current and likely future care pathways is needed to plan services and the nursing workforce required. Care may shift more into the community but this is an assumption that should be subjected to analysis if planning mistakes are to be avoided.
- A better understanding of the amount of care currently provided in the different acute and community settings

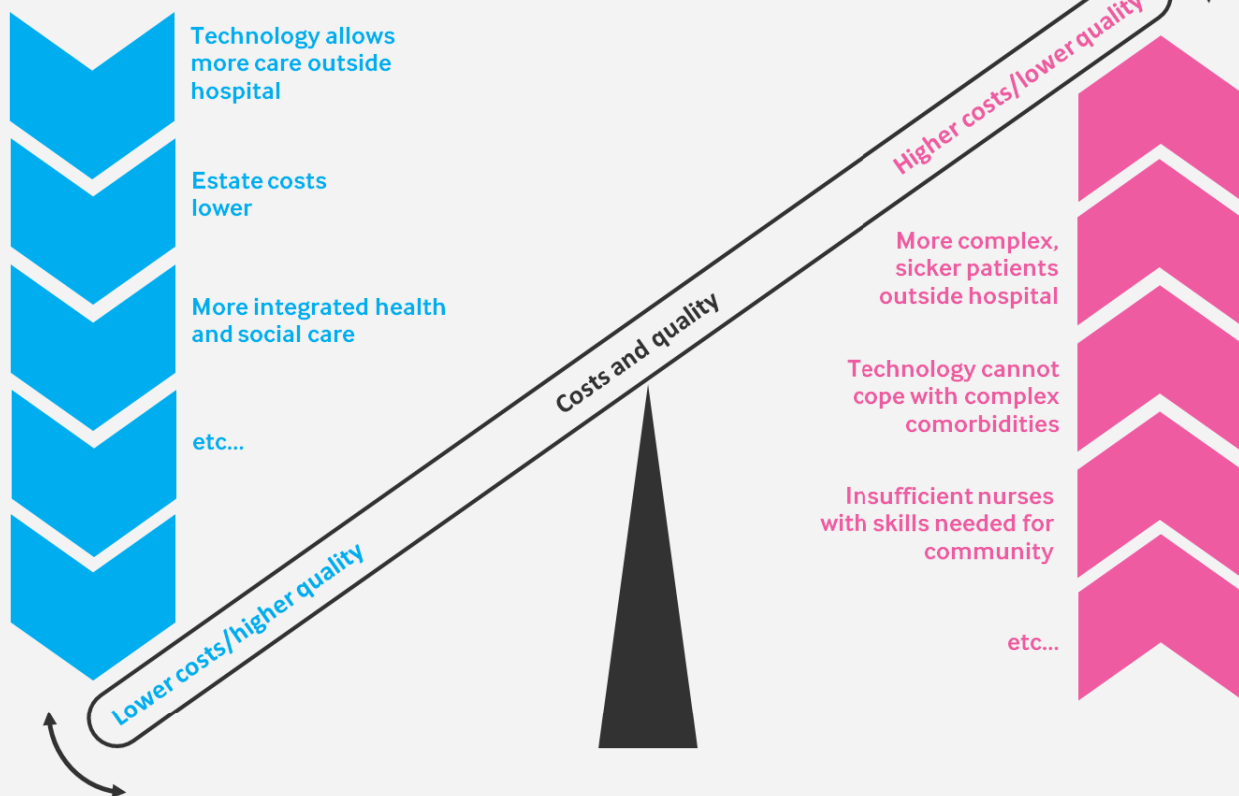
and the shape of the nursing workforce is required to form a baseline for workforce planning.

- The two main drivers behind much of policy, commissioning, and acute hospital provider behaviour are an assumption that care can be provided more efficiently outside of hospitals, and that quality of care will be improved. Whether this will hold true will be determined by a whole set of different shapers, the net effect of which is very uncertain over the next 20 years (Figure 1).

**Figure 1:** Many shapers will interact to determine community care costs and quality

What will be the net effect of the many different shapers that could affect the nursing cost and quality balance as more care moves into the community?

**Net effect:** Will community care be more efficient and better quality?



Source: CfWI

### 1.3 Purpose

This report considers the issues that might shape the nursing workforce<sup>2</sup> over the next 20 years in relation to the transfer of care into the community. It is part of an ongoing CfWI approach to horizon scanning with regard to nursing, to inform the future shape of the nursing workforce. The project's focus includes supply and demand factors, policy effects and the wider economic and social climate. The key questions considered are:

- What are the nursing workforce implications of the proposed shift of care into the community?
- How is this going to affect the role of the nurse, education and training, the shape of the nursing workforce, and workforce planning?

This horizon scanning document investigates the most frequently mentioned factors that will affect the nursing/maternity workforce over the next 20 years. It is intended to gather intelligence and provide an analysis on how each issue will have workforce implications. It is not intended to provide recommendations at this stage to address any future workforce issues. The next stage of the horizon scanning process is to develop this work further into scenario generation, where different scenarios for the future workforce will be investigated and quantified. This will then input into future workforce modelling, where recommendations can be made.

### 1.4 Methodology

The process that this project followed consisted of four stages:

- **Literature review:** While there is extensive literature on factors affecting nursing workforce demand, supply and deployment in relation to moving services into the community, there are far fewer papers taking a long-term view. A total of 248 papers were analysed in a literature review.
- **Interviews:** Telephone interviews were held with 20 stakeholders from a wide range of backgrounds, including service, commissioning and education nurse managers; working nurses; patients and carers; workforce planners; demand and supply experts. The purpose of the interviews was to identify any shapers that may impact the nursing workforce over the next 20 years in relation to the transfer of care into the community.
- **Workshop:** A stakeholder workshop involving 12 interviewees and 6 CfWI staff was held to identify further shapers and to begin to discuss and prioritise the shapers emerging from the interviews.
- **Shaper database:** Material from the above three sources has been incorporated into a database containing 103 shapers that may affect the nursing workforce over the next 20 years. Approximately 50 shapers were identified during the interviews. New shapers emerged during the workshop, and some others were subdivided. A smaller number (approximately 20) were identified via the literature review as additional to those discussed during interviews or at the workshop. The database is available to view on request, and has been incorporated into the CfWI horizon scanning system.

We have used the high-level categories: technological, economic, environmental, political, social and ethical (TEEPSE) to organise the shapers identified in the interviews and stakeholder workshop. Although many of the shapers fall into multiple categories, the category that the CfWI felt most relevant to the factor has been selected.

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<sup>2</sup> Parallel work has produced reports on the midwifery, medical and dental workforces.

**Table 1: Shaper summary headings**

Shaper name/title	Description and implications
<b>Summary:</b>	A short description of the shaper.
<b>Keywords:</b>	One to seven words that are relevant to the shaper.
<b>TEEPSE categorisation:</b>	Classification of the shaper as either a technological, economic, environmental, political, social or ethical driver.
<b>Main source:</b>	How the shaper was identified. In this report it was either identified through an interview, workshop or literature review (or any combination of all three methods).
<b>Main description:</b>	More detailed description of the shaper.
<b>Shaper type:</b>	Classifying shaper as a trend, driver or megatrend.
<b>Impact on nursing needs and/or services:</b>	High-level description of proposed workforce impact of the shaper.
<b>Source of impact:</b>	Reference of how the impact has been determined.
<b>Importance:</b>	Classifying importance as less important, fairly important, or very important.
<b>Uncertainty:</b>	Classifying uncertainty as very uncertain, not yet clear or as certain as can be.
<b>Sector impact:</b>	Gauge of the impact using a 1-3 scale (1 being low impact) on public health, health and social care.
<b>Timescales:</b>	Classification of when the shaper is likely to occur based on the scale of 1-5 years, 6-10 years, 10-20 years or 20+ years.
<b>Health outcome impact:</b>	Rating of how the shaper will impact on health outcomes ranging from very positive to very negative.
<b>Financial impact on the NHS:</b>	Rating of how the shaper will impact on costs in the NHS ranging from very positive to very negative.
<b>SWOT analysis:</b>	Rating of whether this shaper is classified as a strength, weakness, opportunity or threat.
<b>Who can influence/ manage shaper:</b>	Identification of which stakeholders should be made aware of this shaper.
<b>Further questions about this shaper:</b>	Any questions that have arisen as a result of the analysis of this shaper.
<b>Key references:</b>	Sources or links that contain more information about this shaper.

This work will feed into the wider CFWI framework to provide high-quality workforce analysis and intelligence. This will include the following high-level activities:

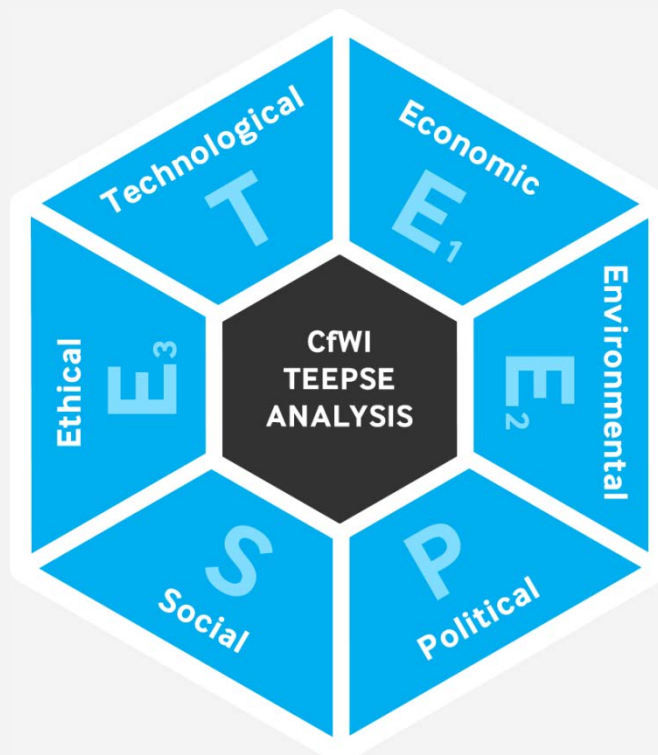
- grouping shapers and prioritising shapers in terms of impact/importance and level of uncertainty about the shaper occurring
- development of scenarios based on the prioritised shapers
- development of model
- analysis of model outcomes to provide information about the future nursing workforce based on the future scenarios developed.

## 2. Analysis

This section covers the analysis of the 103 shapers that were collected from the literature review, interviews and the workshop. Each of the six TEEPSE categories includes a table

summarising the ten highest-priority shapers. Shapers were classified to one of six **TEEPSE** categories, as in Figure 2.

Figure 2: CfWI horizon scanning TEEPSE categories



Source: CfWI

The majority of shapers fall within the **'political'** (29 per cent) or **'social'** (27 per cent) categories. The former are most frequently about aspects of national policy or the implementation of local plans. Shapers in the social category mainly cover population, health or staffing trends.

Most of the **technological** shapers (16 per cent) are either about new monitoring or treatment opportunities in people's homes or about technology that can support and assist nurses to work efficiently and effectively. **Economic** shapers (14 per cent) are dominated by financial constraint and the drive for efficiency; while **ethical** shapers (14 per cent) cover aspects of patient-centred care such as treating people with dignity and compassion or providing continuity of care. Only three shapers were identified that cover mainly nursing-focused **environmental** factors, and these all came from the literature

review. They were not discussed during interviews or at the workshop.

The highest priority shapers were identified via a combination of considerations. They are the nursing workforce shapers:

- described by the highest number of interviewed stakeholders and/or most discussed at the workshop
- described most frequently in the literature
- which combine the highest ratings for importance and the lowest level of uncertainty (this way of identifying priorities is therefore very similar to a traditional 'risk score' calculated as impact multiplied by likelihood).



## 2.1 Technological

Technology is already available to expand the scope of the treatment and care that can safely take place in people's homes. Examples include some types of chemotherapy, dialysis, echocardiogram (ECG) monitoring, respiratory support and intravenous therapy (IV) infusions. New developments, however, could introduce more fundamental change – telehealth monitoring equipment may allow nurses to assess, diagnose and even initiate treatments without themselves visiting the home on every occasion. Such technology can also

help patients further develop their own expertise in the self-management of their care (Table 2).

However, counterbalancing the expected increase in technology use, stakeholders noted that currently some community nurses lack access to the most basic types of computing facilities or smart communication devices. Playing catch-up may take several years and therefore slow down what can be achieved in practice over the next 20 years compared with what could be achieved.

**Table 2: The 10 highest priorities of 16 technological shapers**

**Importance** was estimated in terms of its impact on the nursing workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) Technology facilitating care management and provision in people's homes and other settings.</b> Importance: ●●● Certainty: ●●●</p>	<p>Currently the use of technology in people's homes is very limited. Future developments will allow a full range of comprehensive care and management to happen at home. Technology will allow staff to assess, diagnose, gain specialist advice, access multidisciplinary notes from all those involved, deliver drug treatments and monitor their effects, etc. to manage and deliver comprehensive home-based care safely and effectively. This may have implications on staff training.</p>
<p><b>2) Online diagnosis and prescription (or apps) may reduce demand for staff time.</b> Importance: ●●● Certainty: ●●●</p>	<p>Increasingly reliable and effective online interactive software (or apps) may increase the amount of self-diagnosis that happens. This could reduce the face-to-face time patients need from nurses or GPs if they work well and include, for example, prescriptions. It also allows a focus on critical interventions by staff. This could have an impact on the supply of the nursing workforce.</p>
<p><b>3) Integrated care staff need real-time access to specialist advice.</b> Importance: ●●○ Certainty: ●●●</p>	<p>Integrated care will need staff with generalist (or cross-profession) skills, both at case-manager and hands-on care-provision levels, because people at home will have a range of caring and health issues that will cross professional boundaries.</p> <p>Each of these issues deserves and requires specialist skills of many different kinds ranging across the health professions – nursing (general, mental health, stroke rehabilitation, cancer, etc.), medical, different types of therapist, pharmacist, etc. – and social care. This role could be made possible if the generalist had technology-assisted access to the patient's notes, real-time access to specialists for on-the-spot advice and confirmation, etc.</p>

Shaper name/title	Description and implications
<p><b>4) There is a challenge to get systems interconnected (e.g. 111, 999, GP accessing EOL-wishes register).</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Patients' expressed wishes about care may be recorded in their 'notes' (patient record). But when a crisis occurs, unless different systems intercommunicate well, then recorded wishes cannot be acted on by staff.</p> <p>The workforce needs communication support. For example, patients receiving end-of-life care may have expressed a strong wish to die at home (or their relatives may have done so). But when a crisis occurs a range of organisations may be contacted first – 999, 111, GP, community nurse, etc.</p> <p>If these have technology-based interconnecting communication systems then the expressed wish may be identified and acted on. If not, and the crisis is serious, then the default pathway is for a patient to be taken by ambulance to A&amp;E, admitted, and to die in hospital. The technological challenges involved in creating interconnecting communication systems are huge.</p>
<p><b>5) Epigenetics, personalised medicine becomes more widespread.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Epigenetics and personalised medicine is likely to become more widespread. The effects on the nursing workforce are uncertain.</p> <p>A Nursing and Midwifery Professional Advisory Board 'task and finish' group recently reported on the future of genetics/genomics in relation to nursing and midwifery, concluding that: 'Scientific advances in genomics are bringing unprecedented opportunities for a greater understanding of disease mechanisms across the spectrum of disease, from rare to common. They are also leading to more accurate diagnosis of disease, developments in diagnosis of genetic subtypes of common diseases and in developments of new therapies and more targeted therapies. The advances are rapid and have relevance across healthcare services, not just to specialist genetics services. Nurses and midwives represent the largest sector of the NHS professional workforce and are best placed to optimise the potential contributions of genomics for improving health. However, they face significant and complex challenges to integrating genomic healthcare into professional education and practice' (Task &amp; Finish Group, 2011).</p>
<p><b>6) Electronic communications technology is often lacking for community staff.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Currently, some community nurses lack ready access to basic computing and email facilities, let alone modern communications devices and other advanced technology that could enhance care and efficiency. This current gap will need to be closed before more advanced technology can become widespread.</p>
<p><b>7) Health visitor and community nursing can go online – 24 hr care.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>More health visiting and nursing care in the community could become available round the clock via increased use of online technology. This may require more nurses to work out of hours, but if enquiries come into a central point for triage this is not necessarily the case.</p>
<p><b>8) Electronic decision aids boost the 'no decision about me without me' principle.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Electronic decision aids can be used in discussion with a patient to help come to a shared decision between clinician and patient about treatment options. Based on clinical and other information about a patient, the tool will calculate risks associated with different treatment options, framing discussions.</p> <p>Examples of emerging use include breast cancer treatment decisions depending on type, stage of tumour, etc. and the uptake of prostate-specific antigen (PSA) testing in men for whom prostate disease is suspected. This may have implications on staff training and efficient/effective working.</p>
<p><b>9) Complexity of community care mounts insuperable barriers to technology adoption.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>The complexity of care may mean that technology advances cannot be adopted and their benefits not realised over the next 10 years at least. Comparable with current/recent national IT initiatives where complexity has presented some as-yet insuperable challenges.</p> <p>The full potential benefits for patients, staff and employers are not realised as adoption continues to be piecemeal. The implication is that the workforce could be less efficient and effective.</p>

Shaper name/title	Description and implications
<p>10) Online forums for advice/support allow anonymity.</p> <p>Importance: ●●○</p> <p>Certainty: ●●○</p>	<p>Online forums for advice and/or support can allow anonymity and are increasingly popular. This can widen consumer choice and the availability of information, but one drawback could be that some information is unreliable.</p> <p>This affects nurses – if their patients are seeking online advice anonymously, health professionals may not know whether their patients are acting on unreliable and potentially dangerous advice.</p>

Source: Most frequently cited shapers in the nursing shaper database 31/03/2012.

## 2.2 Economic

The economic shapers (Table 3) fall mainly into these groupings:

- current and future funding constraints leading to a drive for efficiency and a cap on meeting demand
- patient-held budgets, consumer demand and providers' response to these factors.

The next few years will be a period of relative economic constraint for healthcare when compared with the past decade of growth. The 'Nicholson challenge' is to save £20 billion by 2015 by becoming 4 per cent more productive each year (Nicholson, 2010). This makes the general economic driver a

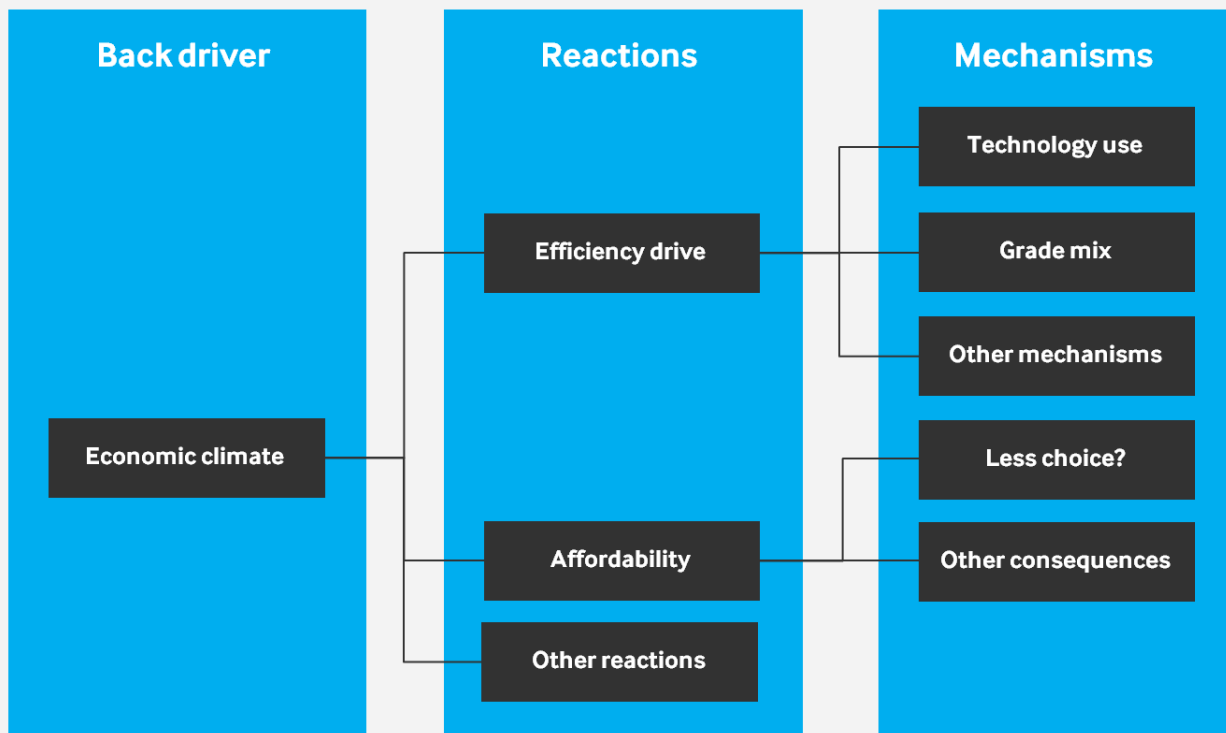
fundamentally important shaper of the nursing workforce – one of a few shapers that could be termed **back drivers** because they influence a large number of other shapers (Figure 3).

The expected expansion of patient-held budgets could become a very important economic shaper over the next 20 years. Some stakeholders felt that people might choose to buy less expensive care from unregistered staff. However, it could also be that patients and carers with complex needs increasingly turn to trusted sources of expertise and compassion – the skills typified by experienced community and outreach clinical nurse specialists.

The general economic driver will be of fundamental importance as a back driver that influences a large number of other shapers.

Figure 3: General economic constraint will drive many other workforce shapers

## Back driver: Economic climate



Source: CfWI

**Table 3: The 10 highest priorities of 14 economic shapers**

**Importance** was estimated in terms of its impact on the maternity workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) The economic climate increases the drive for a more efficient workforce.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The NHS is currently working with the Nicholson Challenge to save £20 billion by 2015 (i.e. to be about 4 per cent more productive per year) through 'doing more with less'. This is managed mainly via the Quality, Innovation, Productivity and Prevention (QIPP) agenda.</p> <p>Given that expenditure on nursing is the biggest single NHS cost, this may lead to further pressures to find more efficient ways of working. These could include further work on efficient rostering, pressures to dilute skill mix, scheduling visits, etc.</p>
<p><b>2) Economic pressures: affordability vs choice and community care development.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Continuing economic constraint and pressures could lead to a mismatch between the drive for increased patient choice and what <i>could</i> be provided in people's homes and community clinics, compared with what is affordable in terms of the number and types of treatments commissioned and the numbers and skills levels of staff employed to manage and deliver care.</p>
<p><b>3) Community care policy lacks implementation clarity (funding, training).</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>There are many policy statements about moving more care to the community but these need clarity in terms of implementation. What funding is required and how will it be provided? What staff training is needed and how does the current system need redesigning? How will the required changes be achieved?</p>
<p><b>4) Nurse numbers may fall as 20 years of constraint replace decades of growth.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>For decades, NHS real growth expenditure has been on average 4 per cent p.a. Current planned expenditure to 2015 is set at 0.1 per cent real growth p.a. There could be budgetary constraint even after 2015. This could lead to a slowdown or reversal of past trends for annual increases in numbers of nurses employed.</p>
<p><b>5) More care delivered in the community may reduce overall health costs.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>'Community nursing interventions, when well planned and coordinated, reduce unnecessary hospital admissions, shorten length of inpatient stay, promote self-care and resilience in our communities, and prevent ill health occurring in the first place' (Royal College of Nursing, 2010). If these premises hold true, then the cost per patient of healthcare could reduce as more care shifts into the community. However, this depends on the extent of current unmet need: more staff contacts with patients in their homes could lead to a greater volume of care provided at the same or greater overall cost.</p>
<p><b>6) More efficient deployment reduces workforce costs per patient.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Employers will seek greater efficiencies via flexible rostering, skill mix changes and sickness absence control. However, there has been managerial focus on such methods for years, so it is unclear how much more can be achieved.</p>

Shaper name/title	Description and implications
<p><b>7) Patient-held budgets, allowing people to choose and pay providers, become more widespread.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Personalised health budgets are part of Government policy. The current reality is patchy. As the case manager role develops, experienced nurses will be well placed to work with patients to make this more widespread. The patient-choice agenda will lead to increased numbers of people holding a budget with which to choose and buy the types of care they want. This could have a wide range of effects, most of which are uncertain.</p> <p>For example, will it lead to care deficits due to unrecognised needs that then need to be met via emergency intervention (therefore increasing overall nursing demand)? Or, alternatively, it could better match actual need and thus reduce overall nursing demand. People could choose to buy more social care than nursing, or care from cheaper suppliers (e.g. more HCA care). The experience of holding a budget could see people becoming better informed and confident about managing their own care, which might reduce nursing needs.</p>
<p><b>8) Marketing by providers will increase.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Potential and current providers will market their services increasingly. Patients will increasingly be directly influential in choosing and paying providers.</p> <p>This may impact on nursing in a number of ways – it could lead to a diversification of employers with differing terms and conditions, role requirements and career pathways. It could be that more people buy social care or cheaper healthcare, rather than pay for highly qualified nurses with specialised knowledge and experience. The outcomes in terms of patients' health are uncertain and high risk.</p>
<p><b>9) Health increasingly becomes a commodity, e.g. laser eye surgery.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>People will probably buy more healthcare as specific individual packages. Laser eye surgery is a current example. There could be many more over the next 20 years. This has wide-ranging potential effects on the nursing workforce, many of which are uncertain or unknown.</p>
<p><b>10) Richer skill mix could improve outcomes and reduce overall costs.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Some contend that a workforce with more degree-level entrants and richer skill mix in service settings increases the quality of care, improves outcomes and thus could reduce overall healthcare costs in the long run.</p> <p>There is some research evidence to support this, but also a lot of null evidence and a general lack of research. Unless the case is proven that a more expensive skill mix reduces overall healthcare system costs, the competing cost pressures on employers may make richer mixes and more staff per patient unlikely to occur in the next 10 years at least.</p>

**Source:** Most frequently cited shapers in the nursing shaper database 31/03/2012.

## 2.3 Environmental

The three shapers described in Table 4 were derived from the literature review. Environmental shapers were not discussed

by interviewees or at the workshop as they were not seen as the most influential with regard to nursing.

**Table 4: The 3 environmental shapers identified**

**Importance** was estimated in terms of its impact on the nursing workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) Pressures on food supplies result in price rises and poorer diets.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>'Feeding nine billion people in 2050 with an environment that cannot sustain six billion today is a challenge of great proportions.' (The Economist, 2011).</p> <p>This will be felt first and hardest in the less developed world, but the UK may not be immune. The health effects would increase demand for nursing.</p>
<p><b>2) Epidemic of new forms of healthcare-associated infections.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>At their peak, hospital-acquired infections cost the NHS an estimated £1 billion per year. The rate of policy-targeted infections (e.g. for <i>Clostridium difficile</i>) has been reduced, but as cost constraints increase, they could reappear and new forms of problem could appear over the long term, increasing demand for nursing if numbers of cases rise. Education/training in how to improve infection control is, however, now well established, and could be adapted to new situations.</p>
<p><b>3) Major epidemic or national disaster – lack of response plans.</b>  <b>Importance:</b> ●○○  <b>Certainty:</b> ●○○</p>	<p>There may be local response plans in place for incidents such as motorway crashes, but planning to meet the effects of a major epidemic or other national-scale disaster on the nursing workforce is more difficult to achieve, and local plans are not currently coordinated at a national level.</p>

**Source:** Most frequently cited shapers in the nursing shaper database 31/03/2012.

## 2.4 Political

The 29 political shapers mainly fall into three categories (Table 5):

- Policy and planning in relation to the shift to community care and the provision of more integrated care across health and social care boundaries, to realise the large-scale savings and big improvements in quality of life for people in the community, aspired to by current policy. Interviewed stakeholders (and the earlier literature review) suggest that a step change is needed.

To date, national policy has been reflected only in local, rather patchy implementation of change. If the future remains one of local response to policy, it is unlikely that policy aims will be fully achieved within 20 years.

- The development and expansion of roles related to the management and provision of complex care in community and integrated settings. These are wide-ranging and include case managers integrating care; advanced and specialist practitioners; care navigators; nurses taking on management, diagnosis, prescription and treatment work previously done by doctors; and much more advanced and extensive multidisciplinary team working.
- The third category is education and training in relation to the move towards more community and integrated care.

A major concern expressed by stakeholders in relation to the last of these categories is that the current nursing education system is not yet configured to meet the supply requirement created by a large-scale shift to community care:

- The majority of pre-registration nursing students undertake courses with a strong emphasis on acute

hospital settings, and their placements are usually there. Most work in hospitals for a number of years before considering a community post (during which time some may take specialist training).

- The number of district nurse courses has declined, as did – until the recent focused provision of new places – those for health visiting. For the most part, nurses who move into general practice settings do so without specific training in practice nursing, gaining experience and specific training once in place.
- Clinical nurse specialists often gain their advanced skills and experience by identifying a need among their patients. Usually via their own initiative, they develop a portfolio of CPD, learning (and sometimes masters-level specialist training) to create their particular skill sets that then prepare them to work in hybrid hospital-community outreach roles.

Apart from the specific current health visiting initiative, there is no national target or aim in terms of the number and type of nurses needed to work in expanding community settings (for example, how many appropriately trained cancer or heart failure specialist nurses are required based on an analysis of the numbers needed to meet need).

In some cases there is a regional plan, probably most often seen emerging from long-established cancer networks. There is also no specific specialism in the care of older people recognised in the nursing education system, even though the numbers of those patients are set to become one of the most urgent demands over the next 20 years (see section 2.5).



**Table 5: The 10 highest priorities of 29 political shapers**

**Importance** was estimated in terms of its impact on the nursing workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) The current approach to education and training is not fit for purpose in terms of transfer from acute to community.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>There is a need to assess what workforce is needed to provide more care in the community, and what education and training the workforce needs. Even if this assessment happens now and translates into policy, supply from education/training may not keep pace with new community roles.</p> <p>Nurses typically undertake pre-registration education for three years with mostly hospital placements, and then work in hospital for some time (and/or undertake specialist training) before considering a post in the community. Thus there is a time lag of at least five years and usually longer between providing new pre-registration places to working in the community. A related issue is the lack of specific curricula for the care of older people.</p>
<p><b>2) The lack of specific training in care of older people creates a skills gap.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>There is currently no specific nursing registration in care of older people. Coverage varies between providers in terms of both pre-registration education and CPD. This is the case in both hospital and community care of older people which, while sharing many common elements, also requires some differences in skills sets. Given time lags, the effects of this will continue to be felt for at least ten years, even if policymakers decide now to change this.</p>
<p><b>3) A step change may be needed to the rate of shift to community care.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>Policy has been aiming to move more care from acute to community settings for at least the last 20 years. While change has happened (e.g. shorter lengths of hospital stay, development of some outreach services) this has been mostly manifested as local initiatives rather than fully planned national implementation.</p> <p>Growth in community-located nurses over the past 20 years has been about the same as the acute hospital growth rate. A big change in patterns is required in order to transfer services, let alone meet the policy objective to 'transform'. Will the next 20 years see the same rate of change or a big step change?</p>
<p><b>4) Community care moves may continue to be sporadic, piecemeal, local developments.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>Community care moves (including integrated care) tend to be locally developed, from the bottom up. This makes them well adapted to local circumstances, but patchy and not available everywhere. This depresses overall demand for community nursing. The future may therefore see increased demand.</p>
<p><b>5) The care practitioner role appears, working across traditional professional boundaries.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Highly skilled specialist generic workers, or care practitioners, emerge. This is not the apparent contradiction in terms that it at first appears.</p> <p>As more complex treatments and care are given in the community, there is a need for specialist knowledge: heart disease, stroke, cancer, asthma, diabetes, neurological, etc. But these specialists need to be generic as they will work across the traditional professional boundaries (nurse, doctor, therapist, social worker).</p> <p>This could happen at both registered and assistant practitioner levels. Pathway redesign work often prompts this as a potential solution. This could include rapid response, early intervention, and rehabilitation.</p>

Shaper name/title	Description and implications
<p><b>6) Proactive case management needs rapid development to progress integrated care.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Case management involves case finding, assessment, care planning, and care coordination for a patient across professional and organisational boundaries.</p> <p>Experienced, skilled community nurses or specialist outreach nurses should be naturally suited to excel in this role. Are there enough of such nurses in the supply pool?</p>
<p><b>7) More understanding of care pathways to plan services and workforce.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>A better understanding of care pathways and how these might change is needed in order to plan service provision – and the workforce to deliver it.</p> <p>For example, often the assumption is that nursing in the community will cost less. However, there are many factors that affect what work is needed, how long it will take for each patient, and the skills level needed to provide care (for example, travel time, shift patterns, availability of back-up and advice, re-engaging with the patient as the nurse enters the home each time). More information is needed about these factors to estimate the workforce required and therefore costs.</p>
<p><b>8) 'Any qualified provider' makes education and workforce planning more difficult.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The 'any qualified provider' aspect of the new legislation could lead to a more diverse range of providers, including from the private sector. This could make it harder to get information and make decisions about education numbers and placements, and result in many aspects of workforce planning becoming harder to coordinate and undertake effectively.</p>
<p><b>9) The failure to meet rising demand has unknown consequences.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>If the NHS is unable to meet rising demands, there could be a wide range of uncertain and unknowable consequences for the way care is funded and, in turn, provided, with uncertain impacts on the nursing workforce.</p>
<p><b>10) There is a 'protecting our professions' response.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Staff may respond to developing drivers by a protectionist response. This may have pros and cons: some expressions of this could be negative and reactionary, slowing down beneficial change; other aspects could protect patients and the public by retaining safe and effective proven ways of working.</p> <p>Some of the demands to which 'protecting our profession' becomes a response could come from patients and the public (e.g. for more information, more contact time, different types of care). Others could come from the Government or employers (e.g. skill mix changes, role expansions, working terms and conditions).</p>

Source: Most frequently cited shapers in the nursing shaper database 31/03/2012.

## 2.5 Social

The majority of the 27 social shapers fall into either demand or supply categories (Table 6):

- population growth boosting demand, along with changing disease profiles
- supply trends including likely numbers of newly qualified nurses, the effect of factors such as hours of work and working alone rather than in busy ward teams on community nursing recruitment and retention, and the age structure of the workforce and retirement patterns.

The different demand shapers provide an example of what might be termed a multiplier effect (Figure 4). The overall size of the population has been growing steadily and projections are that this will continue over the next 20 years (ONS, 2011). Thus, even with no other shapers in place, the demand for nursing will grow.

However, this demand is multiplied by a series of other population demographic shapers. There will be a higher

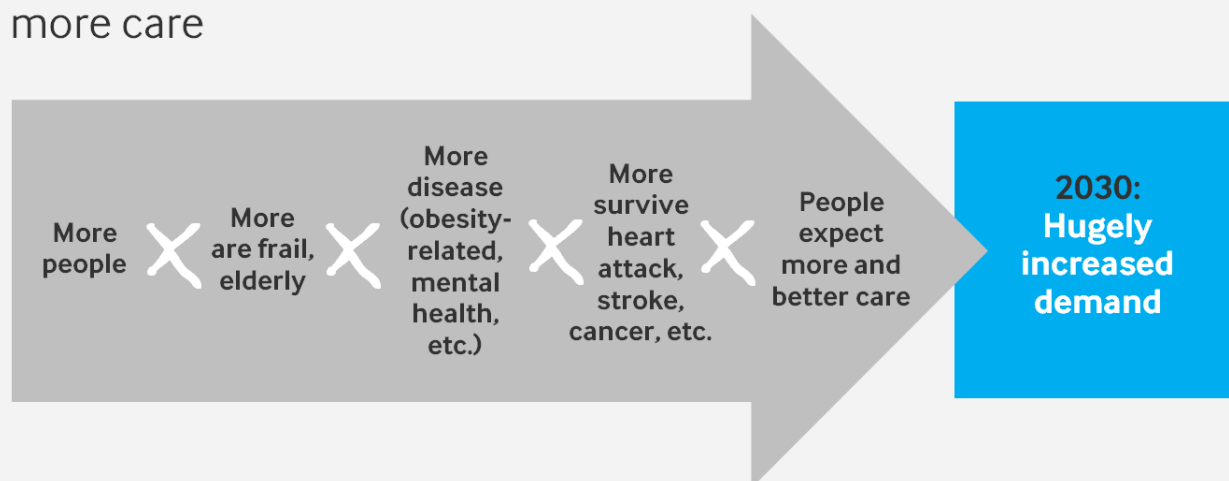
proportion of ageing people with complex nursing and other health and social care needs. There will also be a higher proportion of the population living with the effects of cardiovascular disease and diabetes, as the consequences of today's higher obesity levels emerge over the coming 20 years.

Currently 25 per cent of UK adults are overweight and 10 per cent of children below the age of 11 are obese (NHS Choices, 2012). These levels are much higher than 20 years ago and the numbers are increasing. Obesity causes damage to the cardiovascular system that remains hidden for most people until they reach middle and older age. This increase in numbers needing nursing care will be further multiplied because survival rates for such diseases as heart attack and stroke will continue the improving trends seen over the last 20 years. Even if no new treatments emerge, the spread in availability of the best current treatments such as primary angioplasty will continue. Most survivors require continual treatment (e.g. with drugs or via an implanted device) or periodic interventions, and need active heart failure and rehabilitation nursing services.

**Figure 4:** The multiplier effects of population growth and disease profile shapers

The overall size of the population is projected to grow and thus the demand for nursing will grow. This demand is multiplied by a growing percentage of the population with increased disease burden and higher expectations.

### Multipliers: More people, sicker, surviving longer and expecting more care



Source: CfWI

**Table 6:** The 10 highest priorities of 27 social shapers

**Importance** was estimated in terms of its impact on the maternity workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) There are more ageing people with a complex mix of physical and mental healthcare and social care needs.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Currently about half of patients admitted to hospital are over 65, and about 10 per cent are over 80; longer lengths of stay for older people also mean that nurses provide care on a daily basis for a higher percentage still of older patients. (NHS Information Centre, 2011).</p> <p>About 30 per cent have mental health issues (e.g. dementia, depression), and many have a number of disabling chronic conditions. There will be increased numbers of very old, frail people with complex health and social care needs in the community, often with no family or other support network, and who may not speak English as their first language. This has been termed 'silver tsunami' (Jeste, 2011) and 'carequake' (Department of Health, 2010), with a potentially big demand to increase the nursing workforce.</p>
<p><b>2) Capacity is needed to create confidence to practise independently.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>To work in community settings without immediate backup requires confidence. To take on widened roles across professional and sector boundaries increases this need.</p> <p>More complex or dangerous treatments delivered at home (e.g. drug infusions) also require confident practitioners. In addition to training and experience, electronic communications (decision aids, video conference, etc.) could help offer immediate support and thus also be important in giving confidence.</p>
<p><b>3) Lengths of stay continue to reduce in acute sector.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>In the search to reduce their costs, acute hospitals are likely to want to continue reducing lengths of stay. This will push ever more acute need/demand into community settings and increase the intensity of work for staff.</p>
<p><b>4) Better outcomes increase survival and thus increase the demand for nursing.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>People who survive emergency events such as heart attacks and strokes need nursing care for the immediate recovery phase in hospital, and then services such as rehabilitation and support to live with stroke disability or heart failure, often for many years.</p> <p>Over the last 20 years the percentage surviving has more than doubled, creating a need for nursing care that would not exist had they died. Increased use of e.g. primary angioplasty in specialist centres will improve survival rates further. Coupled with a likely increased number of heart attacks as the incidence of obesity-related disease grows, the need for more nursing shoots up. (MINAP 2011)</p>
<p><b>5) Increasing population (all ages) increases demand for nursing workforce.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The UK population grew at an average of 0.6 per cent each year during the first decade of this century, compared with 0.3 per cent p.a. in the 1990s and 0.2 per cent p.a. in the 1980s. Given the causes (people living longer, birth rate, net migration) it is likely to continue to grow over the next 20 years. (Nursing and Midwifery Council, 2010b)</p> <p>Thus even if the need for 'nursing-per-person' stays the same, there will be an increased demand for nursing. Coupled with changing age structure and better survival rates for many conditions (see other drivers for details), the likely growth rate in NHS activity is expected to continue to outstrip population growth, adding further to the overall demand for nursing care.</p>

Shaper name/title	Description and implications
<p><b>6) The disease burden latent in the current obese population emerges.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Obesity causes damage to the cardiovascular system that remains hidden for most people until they reach older age. Estimates suggest a three quarters increase over the next two decades in the population that could be suffering from the effects of heart disease, diabetes and related illnesses as a result of rising obesity. (NHS Choices 2012) (Wang, McPherson, Marsh, Gortmaker, Brown 2011)</p> <p>There is a high degree of certainty here, because the unseen damage caused by current obesity to arteries and organs has already happened, and will inevitably emerge as a need for treatment over the coming 20 years and beyond.</p> <p>This increased need for nursing care is compounded because, as treatments improve, more people survive the acute attacks associated with these diseases (such as heart attack or stroke). The combination of increased disease rates and better survival will greatly increase the demand for nursing.</p>
<p><b>7) Consumers expect and demand more.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Demand for nursing could increase because the public expects and is willing to pay for ever more care (whether costs are met via taxation, efficiencies, private payment or insurance).</p>
<p><b>8) There could be changing disease profiles.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>The disease profile may change, which in turn will affect the type of nursing skills needed. Breakout of new diseases could drive new systems/standards of nursing and change the way care is thought about and delivered. For example, the emergence of HIV radically changed nursing in a number of ways. It of course affected infection control and workforce protection procedures, and knowledge about how to monitor and manage a patient with HIV over very long time periods. But the reaction of patients to such procedures also led nurses to consider how patients see them and how nurses could think and act in ways that preserved the sense of trust from patients and addressed issues such as stigma. Could new diseases emerge that have similarly radical but different effects on nursing as a profession?</p>
<p><b>9) There are fewer newly qualified nurses due to education intake reductions.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>The number of places in pre-registration education has declined in recent years. This appears to be the result of reduced numbers of places rather than applications, which remain buoyant (Buchan &amp; Seccombe, 2011). Will this continue into the future?</p>
<p><b>10) 24/7 community care becomes the norm and changes the current role of nursing.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●●</p>	<p>Currently, many nurses work in the community because the work is often 9-5, Monday-Friday, rather than the shift work patterns associated with hospital work.</p> <p>More care in the community will require 24/7, 'virtual ward' developments. This will affect the supply of nurses who wish to work in the community, requiring community providers to utilise the kinds of recruitment, retention and deployment approaches already used by hospitals.</p> <p>Nurses will also need to be prepared to work in relatively isolated roles compared with those on a busy hospital ward – a different form of team-working environment.</p>

Source: Most frequently cited shapers in the nursing shaper database 31/03/2012.

## 2.6 Ethical

The identified ethical shapers are mainly either about the requirement for care providers to adopt a patient-centred approach or about trends for patients and carers to take on increased self-management of care. Shapers described in the

latter category describe positive effects of this trend but also point to risks if inappropriate levels of self-care and responsibility are passed from nurses to patients and carers (Table 6).

**Table 1: The 10 highest priorities of 14 ethical shapers**

**Importance** was estimated in terms of its impact on the maternity workforce and classified as 'very important' (●●●), 'fairly important' (●●○), 'less important' (●○○) or 'unknown' (○○○).

**Certainty** was classified as 'highly likely' (●●●), 'unclear' (●●○), 'very uncertain' (●○○) or 'unknown' (○○○).

Shaper name/title	Description and implications
<p><b>1) People with complex, chronic needs, and their relatives, demand integrated care.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The DH, patients' organisations and professional bodies have all issued statements that people living in the community with complex long-term health and social care needs should receive integrated care. They all agree that this often – indeed usually – does not happen now. The demand for improvements in the coordination of care will become louder and more urgent over the next 20 years. This may affect nursing numbers, skill mix, approach, and locations.</p>
<p><b>2) Safety net needed for people unable to self-manage or make choices.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The patient choice agenda is likely to become more of a reality, with some people becoming expert in self-managing their care and deciding when to bring in different types of staff support. But there needs to be a safety net system for people unable or unwilling to manage such matters.</p> <p>Staff – presumably the GP or case manager, when there is no family or carer available – will have to take decisions on their behalf. The number of patients in this category will increase as, for example, dementia numbers increase.</p>
<p><b>3) 'No decision about me without me' becomes more a reality.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>The principle of 'no decision about me without me' is the Government's policy. Current reality is patchy, although some areas of nursing (such as cancer care) have a good track record of having specialist nurses discussing and agreeing patterns of care with individual patients. The demand for this right to be a reality will become ever stronger as cultural attitudes continue to shift in this direction.</p>
<p><b>4) The shift to community could mean more lonely vulnerable people with unmet needs.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>Most people want to leave hospital and return home as soon as they are able. However, moving more acute care into the community is not without risk. Without family or wider community support, some people may feel more lonely, vulnerable and have unmet immediate care needs when in their homes rather than in hospital. Appropriate staffing levels, good prioritisation/scheduling of visits, telehealth and e-monitoring will all need to be well utilised to reduce this risk.</p>
<p><b>5) There is a transfer of risk to patients and families.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Aspects such as personal budgets and 'big society' may mean that risks currently taken largely by the NHS shift onto patients, carers and the wider community. The impacts of this on the nursing workforce are uncertain. For example, it may increase nurses' role as trusted advisors.</p>
<p><b>6) There is an increase in self-managed care and lay carer involvement.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>The impact of trends towards more carer and patient management of care on nursing could be wide ranging and uncertain.</p>

Shaper name/title	Description and implications
<p><b>7) The majority of patients are keen to reduce time spent in hospital.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●●</p>	<p>Most people want to leave hospital and return home as soon as they are able. They do not want to go into hospital if care can be managed and provided at home. This is a fundamental demand driver that interacts with population demographics. It changes the levels and type of demand in the different care settings.</p>
<p><b>8) Person-centred care could become even more of a priority.</b>  <b>Importance:</b> ●●●  <b>Certainty:</b> ●●○</p>	<p>Patients, many nurses, and policy statements have for the past decade (at least) sought more patient-centred care. Care should be personalised, treating people with dignity and compassion, taking account of their wishes. Yet reports continue to emerge about extensive shortcomings in current services, including failures to meet nutritional needs and respect dignity (Care Quality Commission 2011, Commission on Dignity in Care for Older People 2012). The demand for more patient-centred care will almost certainly continue and probably be expressed more strongly. 'Intelligently compassionate nursing' – easy to agree, hard to ensure?</p>
<p><b>9) There is an internet information overload – so trust and reliance on nurses increases.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>Some predict that information availability will make people more able and likely to make their own choices about care. However, information may become so widespread, uncontrolled, unreliable, inaccurate and confusing that instead people may turn to trusted sources like nurses and ask them to assist and advise when making choices.</p>
<p><b>10) No one receives the healthcare that could fully benefit them.</b>  <b>Importance:</b> ●●○  <b>Certainty:</b> ●●○</p>	<p>No one receives all of the health care, in its widest sense, that could benefit them now – and there seems little reason to expect this not to be true in 20 years' time.</p> <p>In terms of preventive care, assessment and monitoring, advice, psychosocial care, integration of care, patient-centred, evidence-based care, etc. there is always going to be something missing. And if not missing, then over-prescribed, under-prescribed or inappropriately used. There will never be enough nurses available or employed to provide all the possible care to everyone with any kind of need; and those who are employed will never have enough time or treatment funding to deliver all they could for every one of their patients. Nurses can never do everything possible.</p>

Source: Most frequently cited shapers in the nursing shaper database 31/03/2012.

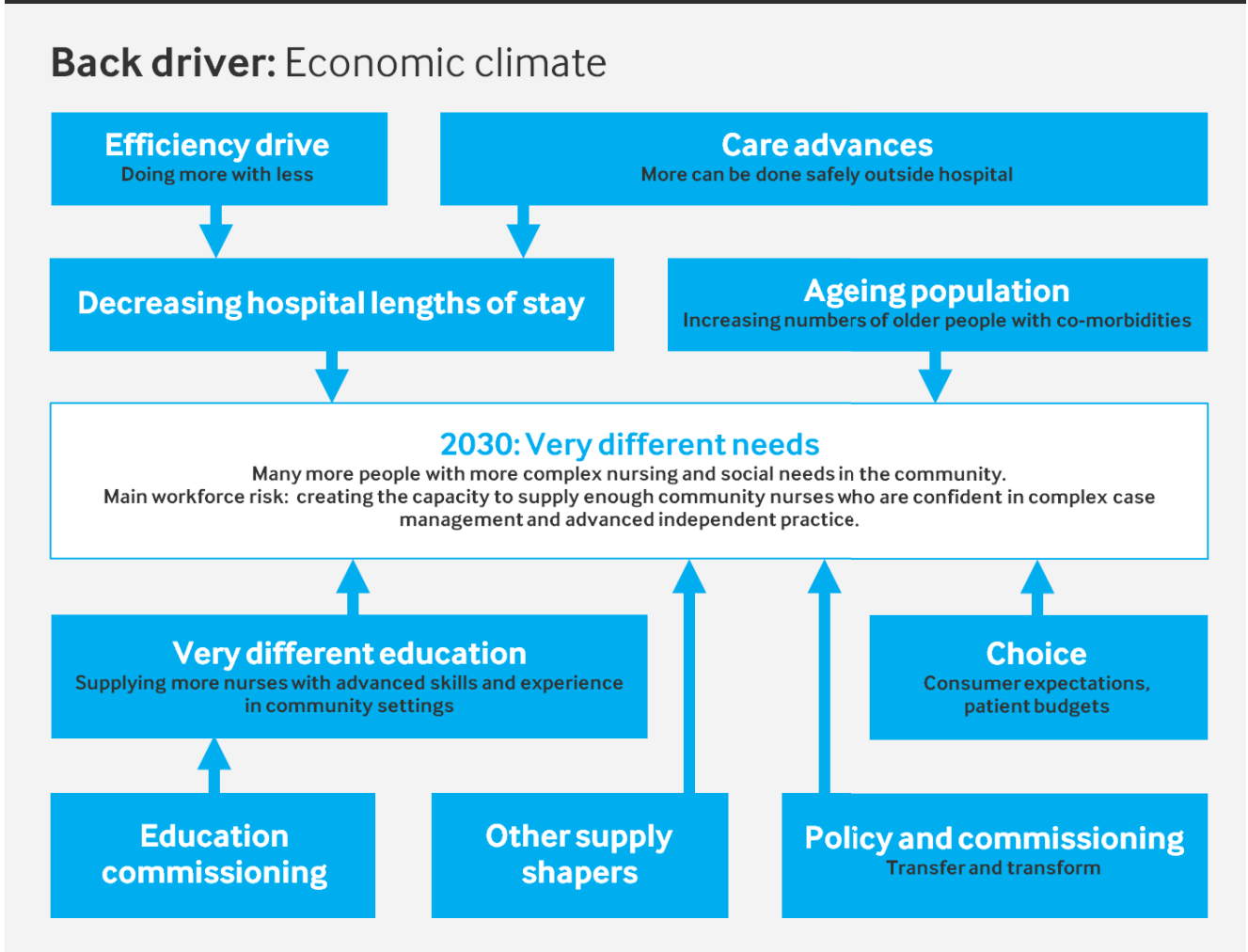
# 3. Conclusion

## 3.1 Priority shapers and how they interact

Workshop participants identified that, in relation to the transfer of care into the community, the main nursing demand shaper to 2030 is likely to be the increased numbers of older people with complex co-morbidities requiring community care (Figure 5). This increased demand will occur mainly because of:

- population growth and continuing improvements in outcomes (survival rates)
- economic pressures and technology advances driving further decreases in acute hospital length of stay
- policy and choice drivers pushing in the same direction – towards more and more care being delivered in people’s homes rather than in acute hospital settings.

**Figure 5: Priority shapers of the nursing workforce to 2030**  
The priority workforce challenge will be how to ensure that enough nurses with the necessary skills and experience can be supplied to meet greatly increased numbers of people with complex care needs in the community.



Source: CfWI



Figure 5 illustrates what the workshop identified as the priority nursing workforce challenge: how to ensure that enough nurses with the necessary skills, knowledge and experience can be supplied to meet this need.

Far more nurses will be needed with skills and knowledge in complex case management (assessment and diagnosis, coordination across professional boundaries, and prescription skills) and advanced specialist practice knowledge in care delivery (for people living with co-morbidities such as heart failure, stroke, diabetes, cancer, respiratory disease, etc.).

They will need to have acquired such skills, knowledge and experience, along with the confidence to practise independently in community settings rather than acute hospitals, as is mostly the case now. Currently, there is no readily available supply pool large enough to meet this need.

While the new NMC standards (Nursing & Midwifery Council, 2010a) can facilitate a broader, community-related education in future, there could be a time lag of ten years or more during which educational changes must be debated, courses commissioned and designed and placements arranged, and nurses must move through undergraduate courses to

registration and then gain experience. The Nursing and Midwifery Professional Advisory Board (PAB) – a board of clinical professionals who provide expert advice on nursing and midwifery workforce planning to the Department of Health – is assessing the post-registration career framework as a priority, and could thus advise on the necessary CPD changes.

The main nursing workforce challenge to 2030 will be commissioning and making changes to the education and training system so that it can create the required high-level community nursing capacity in time to meet demand.

The role of the registered nurse will increasingly become one of advanced practice, in terms of case management skills, specialist knowledge and multidisciplinary team working and leading, and nursing will become increasingly 'intelligently compassionate'.

There is also a feedback loop that could have important effects: as the nursing workforce with the necessary skills expands, those supplying the care will become part of the demand driver as they recognise and develop what they can safely and effectively deliver in community settings.

## 4. Next steps

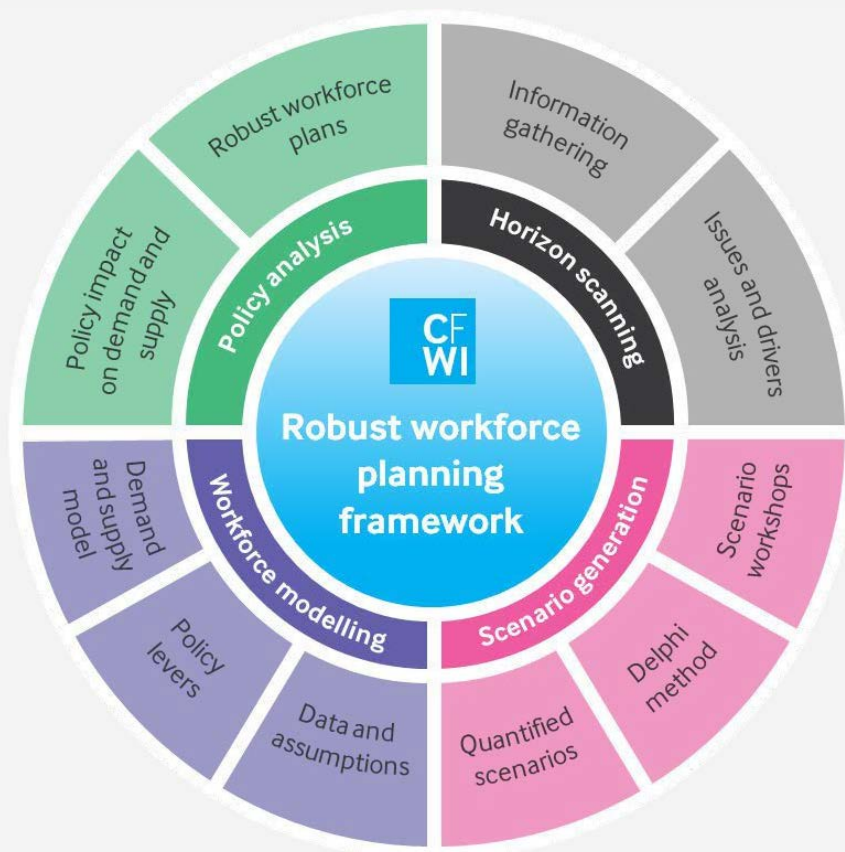
### 4.1 Purpose

The main purpose of this phase of the project has been to generate a database of nursing workforce shapers, and begin

to categorise and prioritise them (i.e. the activities listed in the top left hand box of Figure 6).

**Figure 6** Linking horizon scanning with workforce modelling

Horizon scanning can inform scenario generation, which in turn can inform workforce modelling. Together, all three processes improve the quality of workforce intelligence and planning.



Source: CfWI

Although the identification of priorities was begun at the workshop, most of the detailed classification contained in the database as it stands now was carried out by the author of this report. The project will need to move forward by involving stakeholders in a wider verification of the classifications and ratings in the database, aiming to gain a reasonable level of consensus about which are the highest priorities.

For example, the database includes a field suggesting whether each shaper is manageable by policymakers, commissioners, employers or working nurses. More work is required on who can do what to manage shapers or, where they are unmanageable (e.g. megatrends like increasing population), how their effects may be mitigated. The work will move on from the identification of the most important shapers to consider leverage – how to manage and influence them. The

CfWI could also consider which shapers it can itself most influence. As discussed in an earlier section, the CfWI could also consider widening the scope of the nursing horizon scanning project beyond the transfer of care into the community, to include a better understanding of all current and likely future care pathways. This would assist comprehensive planning of the full nursing workforce required to 2030.

This report can be taken by itself and considered independently of the wider programme by anyone with a general interest in possible future developments affecting the nursing workforce. It will also be used to inform a series of scenario generation workshops held by the CfWI to engage with stakeholders to describe a range of plausible ways the future might unfold (as opposed to trying to 'predict' the future). Scenarios are based around clusters of interrelated

shapers, which come together to form a coherent description of a plausible future. The scenarios can then inform modelling of the nursing workforce and strategic decision making, by testing the impact of decisions across a range of plausible futures. This will enable better informed and more robust long-term planning.

The next phase will seek to link horizon scanning with workforce modelling. Horizon scanning can inform scenario generation, which can in turn inform workforce modelling. Together, all three processes improve the quality of both workforce analysis and workforce planning.

If you would like find out more about the next stages of this project, or would like to get involved, please contact the nursing and midwifery team: [nursing@cfwi.org.uk](mailto:nursing@cfwi.org.uk).

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