Title: Workforce Intelligence and the future care requirements of an ageing population.

Interview with Professor Alison Leary and Sally Hardy (April 7th 2025).

Background: Understanding Future Workforce Needs

Professor Alison Leary MBE, working as a NICHE collaborating partner, leads our Workforce Intelligence Network (WIN) workstream. As Professor of Healthcare and Workforce Modelling at London South Bank University Alison has led multiple workforce-related projects both in the UK and internationally, including work with the World Health Organization.

Working with Alison and her team brings a level of expertise to better understanding how data can be used to address population health and care needs in Norfolk and Waveney area, particularly taking into consideration requirements of coastal and rural communities. Alison's work with NICHE is helping forecast future care demands, especially considering the area's rapidly ageing population.

Norfolk is projected to have one of the oldest population profiles in England. Over the next decade, it's expected to see an increase of 50,700 people aged over 65. By 2041, the number of people aged 85+ is expected to double (Norfolk Insight, 2025). The British Geriatrics Society highlights that one in five people in England will soon be over 65, with men expected to live to 88 and women to 91 on average (Oliver, 2014). This demographic shift brings significant challenges, particularly in addressing complex chronic health conditions, social isolation, and increased demand for dementia, palliative, and community-based care. These demands place considerable pressure on primary care services to provide continuity for patients aged 75 and older.

SH: What's the purpose of WIN, and what insight has the data revealed so far?

AL: *WIN aims to apply workforce intelligence methods, commonly used in other industries, to healthcare. The intention was to use routinely collected data to support informed decision-making in Norfolk and Waveney. However, that's proven difficult, partly because this approach is still seen as unconventional in healthcare. Lots of people in healthcare collect the data, but not all use data.*

In contrast to industries like aviation, nuclear energy, or retail—where business intelligence is central—healthcare tends to focus on retrospective data and doesn't always use it effectively. Many healthcare professionals collect data, but few apply it meaningfully. Our work uses data to explore equity issues (e.g. workforce race and disability profiles) and patient safety, such as linking workforce changes to hospital mortality rates (Pereira et al., 2025).

SH: Your workforce equity report highlighted unique patterns in Norfolk—what did you find?

AL: *Norfolk's workforce doesn't reflect the national profile, especially in terms of ethnic diversity, even in Norwich. Ethnic minority representation is mostly among newly qualified staff, which raises retention concerns. There's a "boomerang" pattern: new staff stay a couple of years, leave, and often return later in their careers. This results in a dip in mid-career professionals, identified as the most proficient group in turn affecting continuity and quality of care. We're also doing predictive modelling to understand future service needs in North Norfolk, which is ageing rapidly. This includes analysis of local authority and Office of National Statistics (ONS) data, as well as systems thinking work with a General Practice (GP) in Great Yarmouth. Often, healthcare only examines parts of a service, but we're looking at the whole system to support long-term planning.*

SH: There are many global reports that highlight workforce shortages. What are your views on workforce planning in healthcare?

AL: *The workforce is ageing while demand is rising. The traditional NHS approach uses "activity" as a proxy for workload, which doesn't reflect complexity of the work taking place. This often leads to cost-based decisions, such as diluting skill mix, such as hiring more staff at lower grades, which can negatively impact outcomes. Our upcoming WIN paper shows how these decisions are linked to higher mortality.*

Healthcare productivity should consider effectiveness and outcomes, not just activity. In industries like aviation, they evaluate risk and safety comprehensively. In contrast, healthcare often overlooks the value of experienced staff and the critical coordination roles; like nurses acting as care organisers or "project managers" of people's complex care needs.

SH: What about Allied Health Professions (AHPs)? Is there sufficient data on their contributions?

AL: *Unfortunately, no. While AHP data collection has begun, it's insufficient for detailed analysis. Unlike nursing, which is broadly split into registered and support roles, AHPs include 42 different professions. There isn't yet the granularity in the data to track their specific interventions or impact. With THEO, (NICHE Workstream 2) we'll gather some signals from AHPs, but not enough for rigorous analysis. So this is one of the things we are really looking at with THEO project, to see whether there is a model of nursing, whether primary nursing (Manthey, 1980) or another model, that will hopefully help reduce length of stay, and we are hoping to look at that evidence with THEO.*

SH: Who should be hearing about these insights? How do we influence change?

AL: *We must share our findings through publications, but getting them in front of the right decision-makers is challenging. Change is unlikely without local interest and political will. That's why our work with Norfolk coastal communities is so important.*

Despite low social care vacancy rates, demand is high. District nursing and rehabilitation services are crucial for keeping people out of hospital, and we need to invest in an agile, community-based workforce. If I could invest in one area, it would be social care.

I often compare this to flying: you wouldn't board a plane if the pilot only had minimal training and relied heavily on autopilot. Similarly, healthcare needs experienced professionals who can make nuanced decisions under pressure. Delegating to less qualified staff adds a supervisory burden, causing stress and anxiety for registered professionals. We've published research showing how this impacts their wellbeing (Leary et al., 2024).

SH: I read a study recently on Lebanese nurses experiencing high anxiety and physical strain due to poor working conditions (Elbejjani et al., 2020), so that echoes global workforce concerns.

AL: *Absolutely. I regularly hear from distressed professionals. Basic working conditions, such as not being able to take breaks, no where to take them except in their cars for example, these stories are unacceptable. Leaders often dismiss these as minor issues, but they significantly impact performance, intention to stay and wellbeing.*

SH: So how do we move forward with our WIN evidence-based recommendations?

AL: *We continue to produce strong evidence and engage those in positions of power, the decision makers and commissioners. Globally, there's a shortage of healthcare workers, and the usual response is to cut corners on safety. But we must draw a line.*

The most effective care models invest in district nursing and general practice. Workforce decisions need to be based on actual demand, not just short-term financial constraints. Unlike other industries that consider risk and consequences, healthcare is still overly driven by annual budgets.

That said, I'm optimistic about our work in Great Yarmouth. Their openness to systems thinking and demand-led planning is refreshing. There's genuine appetite for change there—and they've read the research!

SH: Thank you, Alison.

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