Department of Health & Social Care

NHS England

Change NHS: staff engagement

Shifting from hospital to community

Stimulus slides used in staff engagement events Feb-Mar 2025

CHANGE NHS

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Why are we here today?

We know you are working harder than ever to get services back on track, to get waiting lists down and consistently deliver the best care.

Yet too often we are struggling to provide the right care, in the right place and at the right time. This is no good for patients and it is demoralising for you.

We know change is needed. But we also know that many of the solutions we need are already here, working somewhere in the NHS today.

Your views, experiences and ideas will shape immediate steps and long-term changes: a new 10 Year Health Plan.

What is the 10 Year Health Plan?

September 2024: Lord Darzi's independent investigation into the state of the NHS.

Now we know what the issues are, the Government wants to build a plan to tackle the challenges.

10 Year Health Plan will launch in spring 2025

The plan will set out the vision and roadmap to deliver the Government's aim of an NHS fit for the future, which delivers the three shifts:

Hospital to Community

"Too many people end up in hospital, because too little is spent in the community."

Analogue to Digital

"Parts of the NHS are yet to enter the digital era."

Sickness to Prevention

"Many of the social determinants of health … have moved in the wrong direction."

The plan will consider:

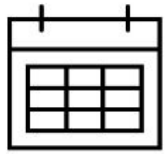
- what immediate actions are needed to get the NHS back on its feet and bring waiting lists down
- the long-term challenges to make the health service fit for the future.

This will be a team effort. We're going to listen to and co-design the plan with the public and staff. We want patients and staff to feel the difference in their daily lives.

Why now?

The NHS is in a critical condition, with public satisfaction with the health service at an all-time low. We need to do everything we can to get the NHS back on its feet.

Building an NHS fit for the future is one of this Government's five missions. By delivering a 10 Year Health Plan, the Government will best support the health service and get the nation's health thriving again.



The complexity of these issues, such as the rising number of people with multiple long-term conditions and the need for substantial reforms in the NHS, requires a long-term approach.

We want to make sure people using the system, staff, and health and care leaders are fully involved in this process and feel ownership of the plan.

The 10 Year Health Plan is…

Not the only part of Government's health mission

The wider determinants of health and some areas of health creation that need cross-government action (e.g. housing and education) will be outside the scope of the 10 Year Health Plan. This is part of the wider Health Mission.

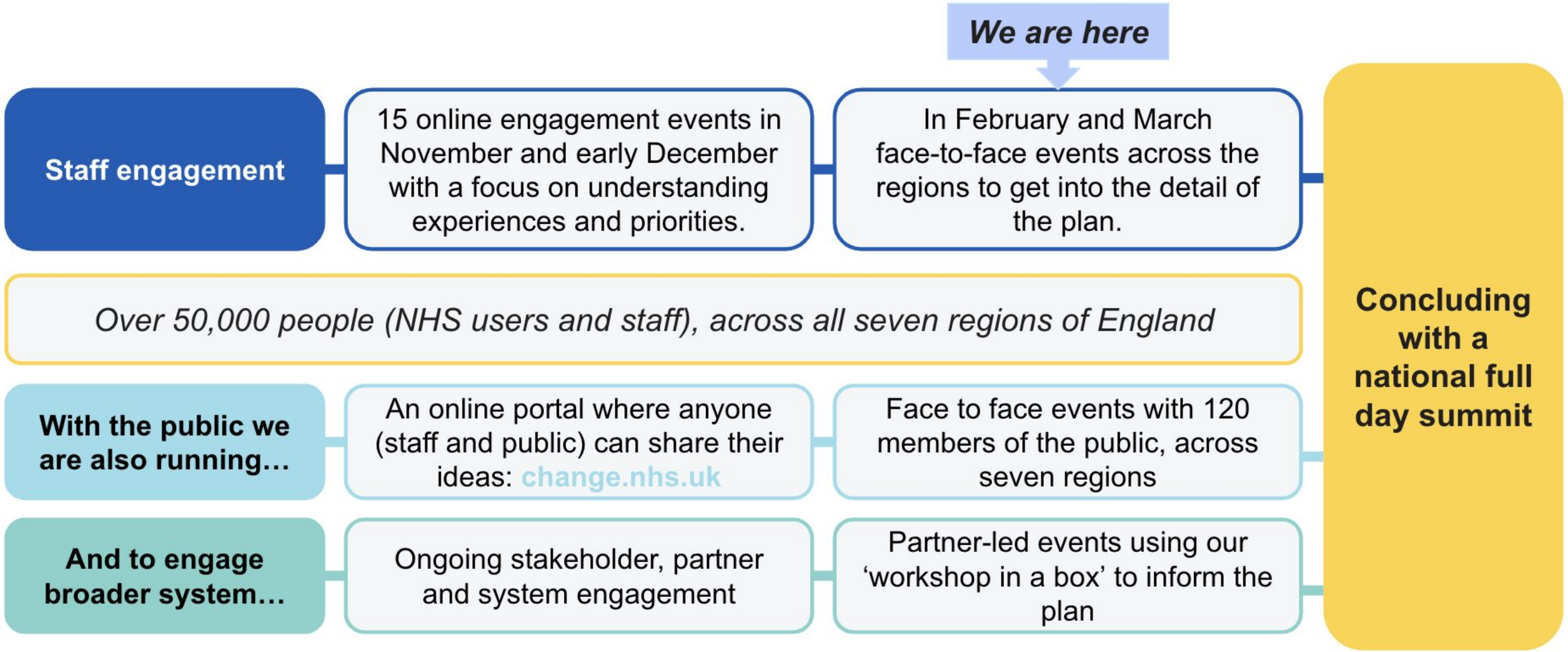
This plan will focus on secondary prevention - measures across the health and care system to help stop or delay the development or progression of disease in individuals and keep them in good health for longer.

Not a plan for social care

The Government is developing a new national care service through a separate programme of work, which will complement the 10 Year Health Plan.

The 10 Year Health Plan will set the vision for what good joined-up care looks like for people with complex health and care needs and how we can support health and social care services to work together better to provide that care.

What is the overall programme of engagement?



Why have these shifts been so difficult to achieve to date? So far, staff have said:

Underinvestment has created infrastructure and capacity challenges	Medical model and public expectations reinforce hospital-centric care	Disconnected services that struggle to work together	Outdated technology and systems create barriers to modern healthcare
Underinvestment in community and prevention Workforce shortages and insufficient training infrastructure Facility and capacity gaps limiting service delivery	Healthcare system built around hospitals rather than communities, due to public and professional preference for hospital-based treatment Embedded resistance to prevention-focused approaches	Services developed in silos with poor integration Disconnect between health and social care Complex, bureaucratic organisational boundaries	Aging IT infrastructure not designed for integration Systems unable to support modern healthcare needs Outdated IT infrastructure limits digital transformation
“Overwhelming workload combined with staff shortages leading to burnout and compromised care standards”	"Deeply ingrained medical model of fixing problems rather than preventing them"	"Staff working in silos, acute and community seen as separate entities not a team approach"	"Systems are outdated and we lack the basic infrastructure to support new technology"

What are the current barriers to change?
So far, staff have said:

Insufficient resources prevent sustainable transformation	Staff shortages and disengagement hinder change delivery	Fragmented systems hinder effective coordination	Digital transformation risks leaving people behind
Insufficient protected time and resources Immediate care demands overshadow transformation Short-term funding cycles prevent long-term strategic investment	Recruitment and retention challenges across services Disconnect between leadership and frontline Limited capacity for staff development and engagement during change	Coordination needed across multiple stakeholders Poor integration between health and social care sectors Difficult to measure system-wide impact	Varying digital literacy creating barriers to adoption Risk of widening health inequalities through digital solutions Implementation challenges around access and security
"Implementing change without proper resources is setting up for failure"	"Poor engagement between senior leadership and those delivering/receiving care"	"Breaking down silos between primary, secondary and community care"	"Digital divide worsening health inequalities for those who lack access to the internet"

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Shifting from hospital to community

Building understanding of the shift

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Shifting hospital to community: summary

Why do we need to provide more care in communities and reduce reliance on hospitals?

- People are living longer but with more complex health conditions.
- They are not always getting the right care in the right place.
- This is leading to increased pressure on hospital services.

See more on slide 13

We have an emerging vision for how we can achieve this shift…

- A comprehensive neighbourhood health offer in every community
- Greater control over how people access services, centred around their needs
- Delivery of more services in communities or at home, including access to home tech
- Professionals working together in partnership with patients to coordinate care

See more on slides 14 and 15

What could be the impact of shifting more care into communities?

- Improved patient outcomes and lower mortality rates
- Improved patient quality of life and higher levels of satisfaction with their care
- Reduced hospital admissions and A&E attendances - freeing up capacity for those that need acute care

See more on slide 16

Shifting hospital to community: summary

We are not starting from scratch…

… there are some great examples out there:

- Integrated Neighbourhood Teams
- Community Diagnostic Centres
- Community Appointment Days

See more on slide 17

From a staff perspective - why has this shift been so difficult to deliver in the past and what are the current barriers?

- Lack of funding and resources to support the transition
- Cultural and organisational resistance
- Workforce challenges
- Need for investment in infrastructure and staff development

See more on slide 18

From a public perspective - what are the key concerns about this shift?

- Concerns about staff expertise
- Ability to access hospital services when needed
- Fragmentation of services and care coordination
- Need for clear standards of care

See more on slide 18

Why do we need to provide more care in communities and reduce the reliance on hospitals?

People are living longer but with more complex health conditions

- There are lots of people who require ongoing care. In the Census, **almost half of the population have a long-standing health problem**.
- While life expectancy is increasing, **people are expected to live longer with major illness.**

People are not always getting the right care in the right place

- **Hospitals are not the best place to receive care if it is not clinically necessary.** For 80 year olds, 10 days of bed rest in hospital ages the muscles by 10 years.
- In June 2024, there was an average of **12,000 patients a day who were ready to leave hospital but couldn't** (increase of 43% compared to June 2021).
- In 2023, **12% of people who couldn't get a GP appointment went to A&E**. This was 696,000 people.

This is leading to increased pressure on hospital services

- The **number of people waiting for treatment is at a record high**, in particular for those waiting for long periods of time for treatment.
- **Care in hospitals is also the most intensive part of the NHS to run** - the majority (approx. 60%) of NHS capital spend is on acute care.

Our emerging vision to support everyone to stay healthy for longer - by 2035…..

A comprehensive neighbourhood health offer in every community

Much of the care currently delivered in hospitals will be provided in or closer to home.

As a result, hospitals will be freed up to focus on delivering high-quality care to those who need it.

People will have far greater control over how, where and when they access services

The NHS app will be the digital front door for the NHS, complementing face-to-face options.

Those who want to use it will be able to book appointments and access a range of local services.

Most initial assessments and diagnostic services will be delivered in the community or at home

We will have:

- scaled **effective community-based alternatives** to hospital care
- increased **community diagnostic capacity**
- harnessed the potential of **virtual care**.

Our emerging vision to support everyone to stay healthy for longer - by 2035…..

People will feel that care is centred around their needs, preferences and choices

Continuity of care will be prioritised, and patients and their carers will not feel like they have to repeat their medical history, even when seeing different clinicians.

Professionals across acute, community and social care working in teams to coordinate care…

…**working in partnership with patients and carers – to support people to stay well in the community** and maintain their independence, but know who to contact if their health and care needs change or they need urgent support.

Access to home-based technologies to support people with LTCs will be universal…

… with a **range of episodes of care previously only delivered in acute settings now manageable within the home.**

In-person services will continue to be available for those who will benefit from them and/or who choose them.

What could be the impact of shifting more care into communities?

Moving care from hospitals and towards greater use of primary and community care can…

…improve patient outcomes and experience of care

- The King's Fund reported in 2022 that patients generally have a **higher satisfaction with community-based care compared to hospital care**, particularly in terms of accessibility and personalised attention.
- NICE recommends community-based interventions for managing long-term conditions like diabetes and hypertension, **citing evidence of improved health outcomes and reduced complications**.
- A 2023 study showed that patients who received care from a consistent team of healthcare professionals in a community setting had **better outcomes for chronic conditions and lower mortality rates.**

… reduce pressure on hospitals and support system savings

- NHS England's Enhanced Health in Care Homes programme reported a **23% reduction in emergency admissions and a 29% decrease in A&E attendances for care home residents** who received enhanced community-based care**.**
- A 2024 report by the NHS Confederation found that areas with higher investment in community care had 1**5% lower non-elective admission rates and 10% lower ambulance conveyance rates**, leading to significant cost savings.

We recognise we are not starting from scratch - there are already some great examples out there…

Integrated Neighbourhood Teams

- Embracing **multidisciplinary models of care** that bring together primary, community and mental health services.
- **Team Up Derbyshire**, part of Derby and Derbyshire ICS, works across health and social care to see people in a neighbourhood unable to leave home without support.
- This has created a **reduction in ambulance call outs** and **reduced hospital stays.**

Community Diagnostic Centres

- CDCs provide patients with **diagnostics in the community**, like MRI scans, ultrasounds, and blood tests
- **Finchley Memorial Hospital CDC** in north London, performs over 50,000 diagnostic tests annually.
- Patients can access **tests within minutes of their homes**. Early data shows reduced waiting times and improved patient satisfaction.

Community Appointment Days

- Aim to deliver easy access to **personalised care for patients with MSK conditions**.
- Developed by a collaboration between a **social enterprise, Here, and Sussex Community NHS FT.**
- A range of staff in a **non-health setting have conversations**, focusing on what matters to someone, and working alongside them to make that happen.

What are the key concerns from staff and the public around shifting from hospital to community?

What we've heard from staff so far

- **Lack of funding and resources** to support the transition from hospital to community care
- **Cultural and organisational resistance**, particularly hospital-centric mindsets
- **Workforce challenges** including recruitment and retention issues
- Need for **significant investment in community** infrastructure and staff development

"Rerouting finances into primary and community is the only way to achieve substantial, sustainable transformation"

What we've heard from the public so far

- **Questions about the expertise** and qualifications of community professionals
- **Concerns about maintaining appropriate access to hospital services** when needed
- **Worries about fragmentation of services** and care coordination
- **Need for clear standards of care** across all settings

"If you bring it to the community instead of hospital there's not the same level of care. They may not know much about what to do."

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Shifting from hospital to community

Discussion 1: Shifting to a model with a greater emphasis on generalist skills

What do we mean by the move from specialist to a workforce with more generalist skills?

The move from a specialist to a more generalist workforce means moving away from a model where healthcare professionals are highly specialised in one particular area, towards a model where they have a broader range of skills and knowledge that allows them to work across different areas of healthcare.

This doesn't necessarily mean fewer specialists, but those specialists having a broader suite of generalist skills and working in different teams and environments to now.

Deep expertise in one specific area such as cardiology or pediatrics.	→	**Professionals have a wider range of skills and knowledge,** allowing them to assess and manage a variety of health conditions.
Focused roles often confined to area of specialisation, with limited involvement in other areas of healthcare.	→	**Adaptable roles** that can work across different settings and specialties, providing more holistic and integrated care.
Referral-based system. Patients are often referred from one specialist to another for different aspects of their care.	→	Reduced referrals with specialists with more generalist skills being part of an integrated team coordinating care and managing the range of patients' healthcare needs.

Examples of where this is already happening

NHS England Enhance programme

The Enhancing Generalist Skills programme is a professional development initiative aimed at equipping all healthcare professionals with the generalist skills needed to deliver person-centered care in a complex and evolving healthcare system.

Since spring 2022, seven regional trailblazers have been piloting Enhance across England, supporting over 400 engaged and enthusiastic multi-professional learners to date. The programme is showing promising early results in terms of improving collaboration, communication and patient care.

The Whittington Integrated Community Respiratory (CORE) Team

The CORE team operates across Haringey and Islington, London, with three locality-based teams supporting patients with COPD and breathlessness conditions. Care spans multiple settings: patients' homes, GP practices, specialist clinics, rehabilitation venues and hospital wards.

The integrated team combines respiratory consultants, specialist nurses, physiotherapists, psychologists, pharmacists, dieticians and smoking cessation specialists. Regular consultant-led MDT meetings optimise patient care across all settings, with GPs incentivised to identify cases and provide evidence-based care.

Staff perspectives on moving towards generalist skills

Training and support to build confident, multi-skilled teams	Culture that values specialists and generalists	Workforce structures for integrated care	Maintaining excellence through clear support
Training and development, including cross-speciality, with protected time Mentoring between specialists and generalists Support teams through identity transition	Competency frameworks for generalist roles Generalist career progression pathways Recognition frameworks for generalist skills Maintain specialist skills	Robust information sharing systems Integrated team structures and clear role definitions Standardised assessment, specialist referral and escalation protocols	Strong clinical governance frameworks Continuous access to specialist advice Regular quality evaluation Supervision structure and peer support networks
"Need for extensive training and support to develop generalist skills while maintaining specialist expertise"	"Need to make generalist roles as attractive and valued as specialist positions"	"Clear protocols for when to involve specialists while maintaining holistic care"	"Access to specialist advice and guidance when working in generalist roles"

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Shifting from hospital to community

Exercise 1: In your experience what do generalist skill sets look like and what currently stops certain roles from developing them?

Obstacles to change - what could stop certain roles from developing more generalist skills?

Cultural/Professional Identity Barriers

- Years of professional identity built around specialist expertise
- Career progression traditionally linked to increasing specialisation
- Professional status and recognition tied to specialist knowledge

Safety and Quality Concerns

- Regulation organised by profession
- Worry about missing important specialist details and making mistakes outside expertise area
- Uncertainty about clinical responsibility and risk management in broader practice

Practical/Skills Barriers

- Need for extensive retraining to broaden clinical knowledge
- Keeping up to date across multiple areas simultaneously
- Maintaining competency in both specialist and general skills
- Time pressure limiting ability to learn new areas

Structural/System Barriers

- Training pathways designed for specialisation
- Professional bodies and standards organised by specialty
- Clinical guidelines often specialty-specific

Career Impact Worries

- Unclear career progression and professional development in generalist roles
- Potential impact on pay and conditions
- Future job market uncertainties

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Shifting from hospital to community

Exercise 2a) Encouraging clinical staff to build generalist skills

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Exercise 2b) How can non-clinical staff play a greater role in i) The coordination of care? ii) the delivery of care?

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Two examples of how others are using non-clinical roles to support this shift

Health coaches: Yeovil NHS Trust

Yeovil NHS Trust and local GPs introduced health coaches to improve outcomes for patients with long-term conditions while managing service demand.

These coaches take a holistic approach, using personalised coaching to build patient motivation and support achievement of self-identified goals.

Evaluation demonstrated improvements in diabetes management, weight loss, mood and social connection. GP appointments for these patients decreased from 70% to 50%, showing reduced service demand.

Care navigators: Waltham Forest & East London

Health and social care navigators in Waltham Forest and East London provide coordinated care for high-risk patients, including those with long-term conditions and older adults.

Operating within integrated teams of GPs, lead nurses, social workers, and geriatricians, navigators help build and implement personalised care plans.

They serve as a central point of contact, coordinating care across primary, secondary, and community services while ensuring adherence to care plans through regular provider and patient engagement.

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Shifting from hospital to community

Discussion 2: The impact of shifting to work more in communities

The impact of shifting to work more in communities on staff

Delivering more care closer to home will also mean a significant change for NHS staff. Care will be provided wherever people go – in homes, online, in schools, at work and in other non-healthcare settings.

More care outside of hospitals means that more staff will be training in the community and working in neighbourhood teams, joining up with other local services and organisations working toward shared outcomes for shared populations.

From the majority of **NHS staff currently working in hospital settings.**	→	**To staff finding themselves working in a variety of community settings and in patients' homes.** The NHS Long Term Workforce Plan projects that the community health workforce needs to grow by 3.9% annually over the next 10 years to meet the increasing demand for community-based care.
From a large percentage of **NHS staff working within organisational boundaries**	→	To staff increasingly working in **collaboration with other health and care professionals and community organisations across organisational boundaries.**
Staff working within **clear lines of authority and decision making** within a hospital environment	→	With potentially greater autonomy and responsibility for decision-making as a result of working independently in community settings.

Staff perspectives on the impact of this shift on day-to-day working life

Adapting to mobile working life	Independent decision making	Managing unpredictable workdays	Maintaining professional identity and connections	Delivering care in community settings
Reliable mobile equipment and tech Scheduling to account for travel time Access to suitable clinic spaces between visits	Remote access to clinical support and peer consultation Clear decision-making frameworks Robust emergency escalation protocols	Flexible scheduling Realistic workload allocation Clear boundaries for working hours On-call and handover systems	Regular team learning and development time Opportunities for informal skill sharing Mentoring relationships	Safe care protocols for different settings Systems for managing treatments Guidance for adapting clinical procedures
"No proper base for staff to work from between visits"	"Lack of immediate access to senior clinical support"	"Impact on work-life balance due to extended working hours and travel"	"Risk of professional isolation needs addressing through team structures"	"Need to adapt to different facilities and equipment availability"

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Shifting from hospital to community

Exercise 1: Benefits and risks

What are the potential benefits and downsides of staff shifting to work in the community

Potential benefits for staff shifting to work more in communities…

- **Increased autonomy in decision-making**, enabling staff to develop broader clinical judgment.
- **Better work-life balance** through predictable hours and flexible scheduling.
- **Deeper patient relationships** through home-based care, enhancing professional satisfaction.
- **Career development opportunities** through exposure to diverse conditions and settings.
- **Supportive environment** fostering interdisciplinary teamwork.

Potential downsides for staff shifting to work more in communities…

- **Professional isolation** when moving from hospital teams to independent community work.
- **Managing complex patients with less support** and limited access to diagnostic tools.
- **Need to develop skills** in handling uncertainty and preventive care approaches.
- **Travel time** reducing clinical hours, particularly in rural settings.
- **Safety concerns** when working in patients' homes.

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Shifting from hospital to community

Exercise 2: Recruiting staff to work in community settings

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Shifting from hospital to community

Discussion 3: Building trust and shared risk management between hospital and community services

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Staff perspectives on building trust and shared risk management

Breaking down information barriers	Building one team across care settings	Creating shared responsibility for risk	Integrated processes and service delivery	Fostering a unified care culture
Clear communication protocols Shared records and real-time information sharing Standardised documentation	Regular joint team / MDT meetings and case conferences Cross-setting rotation and shadowing Shared learning and development	Shared risk assessment, escalation and incident review Shared decision-making and governance frameworks	Standardised operational procedures and quality standards e.g. service interfaces and patient transfer Joint resource management	Collaborative leadership models Shared goals and values Innovation and joint problem-solving Transparency
"Lack of automated processes and shared systems means there is lack of visibility of the full picture"	"Create opportunities for staff to work across both settings - to understand each other's roles and constraints"	"Clear clinical governance arrangements for integrated working"	"Joint protocols and pathways needed for consistent approach"	"Break down the 'us and them' culture between hospital and community"

Examples of how others are seeking to build trust and share accountability between hospital and community services

Leeds integrated discharge teams

Leeds Teaching Hospitals NHS Trust has an integrated discharge team that includes staff from both hospital and community settings. These teams work together to assess patients' needs, develop discharge plans and ensure a smooth transition to community-based care.

The team includes nurses, social workers, therapists, and representatives from community healthcare providers. This team meets regularly to discuss complex cases, share information and make joint decisions about discharge plans, leading to reduced delays and improved patient outcomes.

Early Supported Discharge (ESD) Schemes

In stroke care, some hospitals have ESD teams that provide intensive rehabilitation and support to patients in their homes. This requires close collaboration between hospital and community therapists, nurses and other healthcare professionals, with clear accountability arrangements to ensure continuity of care.

These schemes rely on strong trust and communication between hospital and community teams. Hospital staff need to trust that community teams have the skills and capacity to provide appropriate care and support to patients discharged early.

Bradford REACT Service

The Marie Curie REACT virtual ward enables end-of-life patients to receive care at home rather than in hospital.

Palliative care consultants identify suitable A&E patients who, with consent, receive 72-hour REACT team care before transitioning to mainstream services. Results show reduced hospital stays from 38 to 17 days.

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Cross cutting group 1: What does the NHS need to do differently as an employer, to be a great place to work?

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Staff perspectives so far on what the NHS needs to do differently as an employer, to be a great place to work

Building careers and nurturing talent	Supporting people to thrive at work	Providing tools for excellence	Fostering trust and innovation
Clear progression pathways and protected training time Mentoring and development Meaningful recognition and fair rewards	Proactive wellbeing and mental health support Sustainable staffing levels and workload Flexible working and adequate rest facilities	Modern facilities and IT systems Reliable tech with comprehensive support Workspaces that enable effective working	Transparent and compassionate leadership Meaningful staff input into changes Innovation and cross-team collaboration
"Support staff to develop new skills and take on new challenges"	"Look after staff wellbeing - happy staff provide better care"	"Poor IT infrastructure making simple tasks time-consuming." "Mobile devices for community staff transformed how we work"	"Less top-down management, more engagement with frontline staff"

How can the NHS offer more flexible working, while also providing a 24/7 and fully responsive service

Some parts of the NHS already offer more flexible working options while maintaining a 24/7 service. For example:

- **Implementing shift patterns with flexible working options.** Many community nursing teams offer options like compressed hours, part-time work and job sharing to accommodate staff needs.
- **Utilising technology to enable remote working.** NHS 111 relies heavily on a virtual workforce of call handlers, nurses and doctors who work remotely. This allows for 24/7 coverage with staff working flexible hours from various locations.
- **Self rostering.** The Royal Free London NHS Foundation Trust has implemented electronic self-rostering for many staff groups, allowing them to choose their shifts and working patterns, leading to improved staff satisfaction and retention.

According to the latest NHS Staff survey results…

There are improvements across all areas measuring 'work-life balance' since 2021:

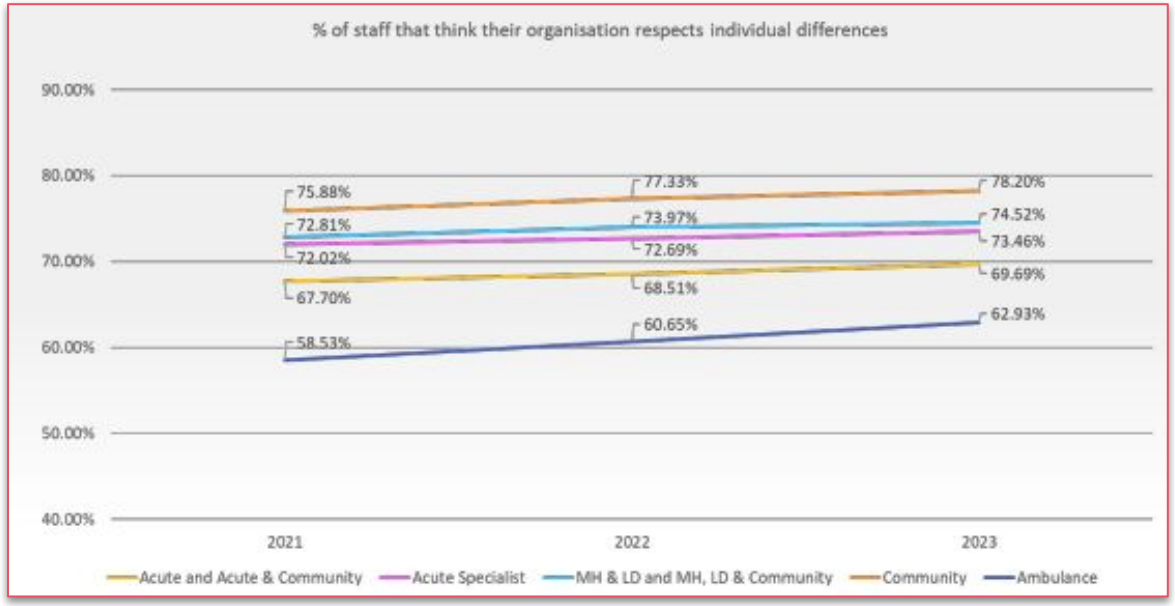
- Almost **50%** of staff said their **organisation is committed** to helping them **balance their work and home life.**
- **56%** of staff said they **achieve a good balance** between their work life and their home life.
- **71%** said they can approach their immediate **manager** to talk openly about flexible working.
- Overall, **staff satisfaction with the opportunities for flexible working patterns has improved** following a decline between 2020 and 2021 and is now at a five-year high.

The latest NHS Staff Survey results

Staff survey and workforce data demonstrates we have more to do before we can say inclusive workplace environments are the norm…

- **Women make up 77% of the NHS workforce** but are under-represented at senior level.
- Just over **24% of the workforce are from black and minority ethnic backgrounds** but face discrimination across many aspects of their working lives, including **27.6% experiencing bullying, harassment or abuse.**
- **25% of disabled staff** have experienced **bullying from their colleagues**.
- **23.5% of our LGBT+ colleagues** face **bullying and harassment** at work compared with 17.9% of heterosexual staff.

However, staff are increasingly likely to feel their organisation respects individual differences such as cultures, working styles, backgrounds and ideas.

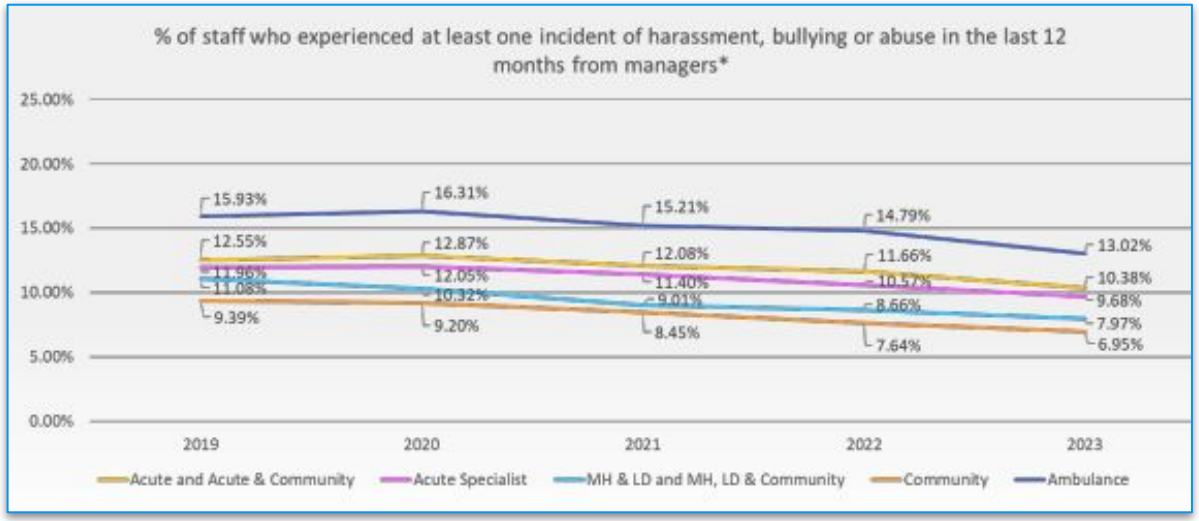


The latest NHS Staff Survey results

The proportions of staff saying they experienced harassment, bullying and abuse from patients, managers or other colleagues are all at a five-year low

Although at **25.15% of staff saying they experienced harassment, bullying and abuse from patients/service users, relatives or the public** is still high.

The level of harassment, bullying and abuse from managers experienced within the last 12 months has **continued to decrease**, showing consistent declines between 2020 and 2023 in all trust types.



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Cross cutting group 2: Should areas in the country that struggle to recruit get additional funding to offer higher salaries?

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The NHS faces a significant challenge in recruiting and retaining staff across the UK, but some areas struggle more than others.

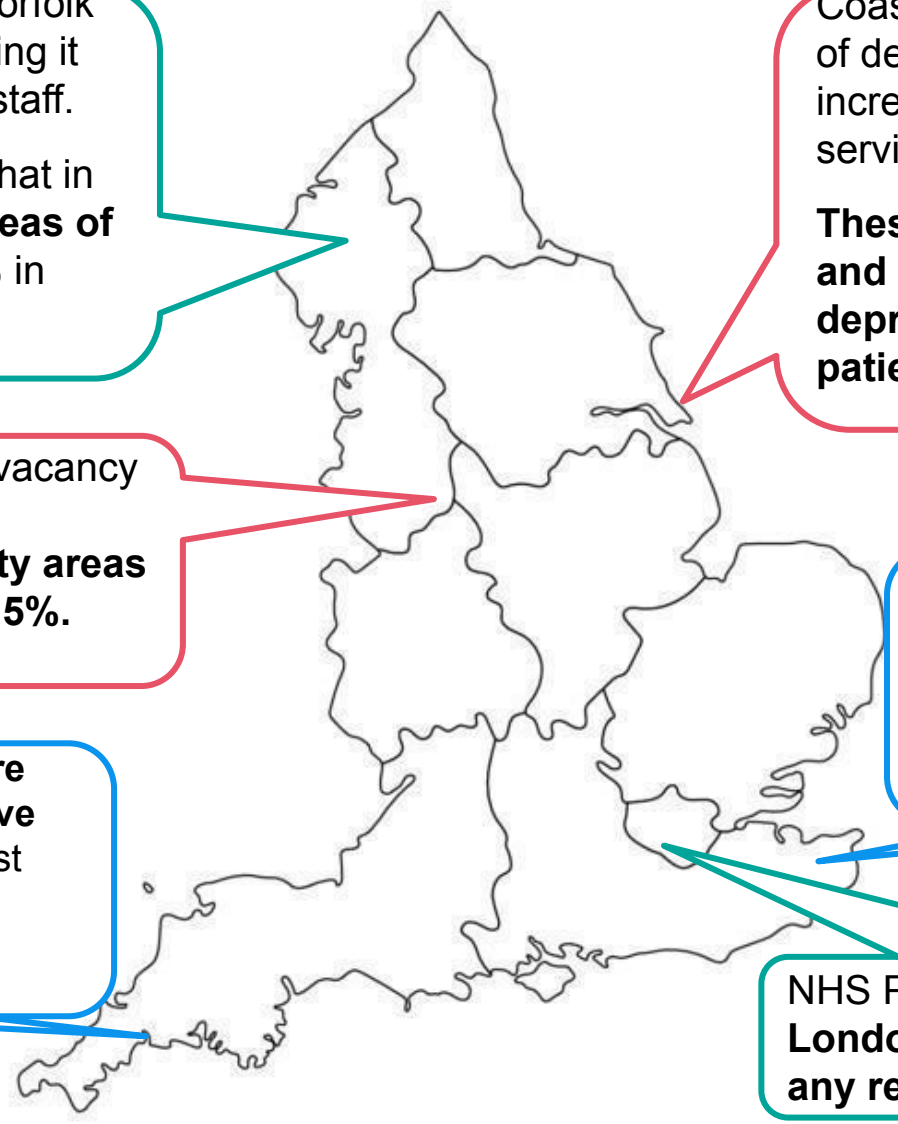
Counties like Cumbria, Cornwall and Norfolk often have dispersed populations, making it difficult to provide services and attract staff.

The British Medical Association found that in **2023, the GP vacancy rate in rural areas of England was 7.7%**, compared to 5.4% in urban areas.

Coastal communities often have higher rates of deprivation and health inequalities, increasing the demand for healthcare services but making it harder to recruit staff.

These areas have 15% fewer consultants and 7% fewer nurses per patient, while deprived areas have fewer GPs per patient.

2023 NHS Digital data showed that vacancy rates for nurses were higher in more deprived areas, **with some inner-city areas having vacancy rates exceeding 15%.**



Kent and Medway Integrated Care Board have offered relocating GPs £15,000 to join local practices, including the coastal areas of Thanet, where health inequalities are greater.

NHS Cornwall and the Isles of Scilly are offering a 'golden hello' bonus incentive payment of £20,000 for every new dentist who accepts a post within an NHS dental practice that has been approved for the scheme.

NHS Providers reported in 2022 that **London has the highest vacancy rate of any region in England, at 11.5%.**

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Cross cutting group 3: What cultural change is needed to deliver change across the shifts?

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Key themes of staff perspectives so far on what cultural changes are required to deliver the three shifts?

Collaborative culture across departments and organisations	Environment that encourages innovation and learning	Ensure patient needs and outcomes drive all transformation efforts	Collaborative leadership approaches that enable transformation
Cross-departmental teams and projects Shared objectives across services Collaborative decision-making processes Knowledge sharing	Safe spaces for testing new approaches and controlled risk-taking Systematic learning capture and sharing Recognise and celebrate innovation attempts	Embed patient voice in decision-making and measure what matters Design services around patient journeys Build community partnerships	Collaborative leadership Local decision-making Visible support for change Clear accountability frameworks
"Working across organisational boundaries needs to become normal"	"Build culture where learning from mistakes is valued"	"Real co-production with communities, not just consultation"	"Leaders need to walk the talk and demonstrate new behaviours"

Of the key themes identified, there was some nuance between different staff groups and which sector they worked within on what cultural changes are required to deliver the three shifts…

Collaborative culture across departments and organisations

Different staff groups highlighted differing professional integration challenges:

- Doctors focusing on bridging the primary / secondary care divide.
- Nurses highlighted hierarchical barriers between professions.
- Other clinical staff emphasised cross-disciplinary learning needs.
- Administrators and managers concentrated on removing organisational barriers
- Social care workers pointed to poor health/social care interface.

"Get rid of primary/secondary care divide (and change mindset that the 'other' is the problem)" (Doctor)

"More collaboration meetings between community and hospital teams" (Nurse)

"Breaking down barriers between teams and organisations" (Manager)

Staff working in different sectors described differing organisational integration challenges:

- Primary care and community services striving to maintain local identity while integrating with broader systems.
- Mental health services particularly struggled with bridging the mental/physical health divide.
- ICS/ICB staff grappled with complex governance issues.
- Local authorities and public health highlighted service gaps.

Disconnected IT systems preventing efficient working with lack of joined-up working with community services" (Primary Care)

"Poor integration with physical health services creating fragmented care pathways" (Mental Health)

"Complex governance arrangements and organisational boundaries limiting integration" (ICS/ICB)

Of the key themes identified, there was some nuance between different staff groups and which sector they worked within on what cultural changes are required to deliver the three shifts…

Environment that encourages innovation and learning

- Doctors emphasised reducing risk aversion, while nurses focused on learning from incidents.
- Other clinical staff prioritised service innovation opportunities
- Administrators emphasised developing a process improvement culture
- Social care workers highlighted inadequate support for innovative approaches.

"Limited support for innovation initiatives" (Doctor)

"No time for improvement projects" (Nurse)

"Lack of improvement culture" (Manager)

- Acute services focused on overcoming risk-averse culture.
- Community and primary care highlighted workload as a barrier to innovation.
- Public health emphasised the need for evidence-based approaches.
- Local authorities stressed resource limitations as a key constraint.

"Risk-averse culture affecting development with resistance to change" (Acute)

"Poor support for innovation in community settings limiting service development" (Community)

"System-wide prevention strategy required but challenging to implement" (Public Health)

Of the key themes identified, there was some nuance between different staff groups and which sector they worked within on what cultural changes are required to deliver the three shifts…

Ensure patient needs and outcomes drive all transformation efforts

- Doctors worried about targets overshadowing patient experience, while nurses struggled with documentation burden limiting patient interaction time.
- Clinical staff emphasised service flexibility, while administrators focused on developing meaningful metrics
- Social care workers advocated for truly person-centred care over process adherence.

Different sectors approached patient-centred care differently:

- Primary care and community services emphasised population health management.
- Mental health focused on holistic care approaches.
- Public health stressed addressing health inequalities.
- Local authorities emphasised prevention and wellbeing initiatives.

"Targets prioritised over patient experience" (Doctor)

"Documentation preventing patient interaction" (Nurse)

"Making targets meaningful to staff and patients" (Manager)

"Step away from the sickness model towards prevention and wellbeing" (ICS/ICB)

"See patients are people who are all just trying to get by, not just conditions" (Mental Health)

"Focus on prevention and wellbeing in communities rather than just services" (Local Authority)

Of the key themes identified there was some nuance between different staff groups and which sector they worked within on what cultural changes are required to deliver the three shifts…

Collaborative leadership approaches that enable transformation

Role-based views showed different leadership needs:

- Doctors emphasised clinical leadership in change processes.
- Nurses called for more compassionate leadership, and other clinical staff stressed the importance of innovation support.
- Administrators emphasised the value of system-wide experience.
- Social care workers sought stronger senior leadership support.

Perspectives on leadership revealed varying priorities in different sectors:

- ICS/ICB emphasised system-wide governance.
- Primary care and community services advocated for local autonomy.
- Mental health stressed accountability.
- Public health highlighted the need for consistent leadership support.

"Clinical leadership needs to be at the forefront of change" (Doctor)

"More compassion from senior managers" (Nurse)

"Managers to have experience across the system" (Manager)

"Develop collaborative leadership models across the whole system" (ICS/ICB)

"Top-down impositions limiting local solutions and innovation" (Primary Care)

"System-wide prevention strategy needs consistent leadership support" (Public Health)

Department of Health & Social Care

NHS England

Change NHS: staff engagement

Cross cutting group 4: What would need to be true to enable you to innovate or change things in your role?

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Staff perspectives so far on what would need to be true to enable them to innovate or change things in their role

Protected space for innovation	Building a safe-to-try culture	Enabling local decision making	Developing innovation capabilities
Innovation time in job plans and schedules Adequate staffing levels with ring-fenced improvement resources Reduce administrative burden to create capacity for innovation work	Visible leadership support with innovation strategy Safe spaces for experimentation and "smart failure" Recognition to celebrate improvement efforts	Delegate decision-making authority to local teams with clear risk frameworks Streamline approval processes to enable rapid testing of ideas Pathways for scaling successful innovations	Training in improvement methodologies Networks for sharing learning and expertise Mentoring programmes and accessible expert support
"Innovation needs time - can't do it in margins of the day job"	"Culture where it's safe to try things and learn from mistakes"	"Autonomy to implement changes in our area"	"Learning from others who have innovated successfully"

Staff perspectives so far on what inefficiencies they see in their day-to-day lives that should be tackled

Unifying fragmented digital systems	Reducing administrative burden	Efficient allocation of available resources	Enhancing service integration
Implement single sign-on across all systems Automate routine data sharing between platforms Modernise core technology infrastructure	Streamline approval processes and documentation requirements Automate routine administrative tasks Standardise core operational procedures	Implement real-time equipment and space tracking Develop efficient staff scheduling systems Create streamlined inventory management processes	Establish standardised communication protocols Create unified care pathways across services Implement structured handover processes
"Multiple systems that don't talk to each other creating double work"	"Multiple levels of approval for simple decisions"	"Wasteful use of supplies due to poor stock management"	"Information not being passed between teams effectively"

Staff perspectives so far on what innovations should be led nationally and what should be done locally

Consistent national infrastructure while enabling local flexibility	Enable delivery of locally focused care	Central coordination with local autonomy in resource management	A connected national system that spreads innovation effectively
Unified technical infrastructure and data standards Flexible frameworks that support local adaptation Clear governance structures for system-wide coordination	Local service design and implementation authority Rapid, community-specific innovation cycles Flexible operational workflows based on local needs	Clear national resource frameworks with local decision rights Shared resource pools with flexible access Integrated workforce planning and development systems	Knowledge-sharing platforms and networks Clear pathways for scaling successful innovations Active learning communities across organisations
"Core infrastructure should be nationally led to avoid fragmentation"	"Local freedom to design services that meet community needs"	"Local decision-making on resource use"	"Learning networks across all areas"