NHS CONFEDERATION

The 2015 Challenge Declaration

ACADEMY OF MEDICAL ROYAL COLLEGES

Faculty of Medical Leadership and Management

Foundation Trust Network

Local Government Association

National Voices
People shaping health and social care

RCGP Royal College of General Practitioners

RCS ADVANCING SURGICAL STANDARDS

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Introduction: making the case for change

The NHS is there to improve our health and wellbeing, support us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It is just one part of a wider health, care and wellbeing system that depends on the NHS, local and national government, the third sector and business working together with, and in the interest of, individuals, families and communities.[1]*

Not only is the NHS crucial to this health and wellbeing system, and so to national productivity and prosperity, it is also a major source of national pride.[2†] This is matched – rightly – by high expectations on the part of the public. People who need care, support or advice want respect and acknowledgement; excellent access to modern, high-quality treatments when they are required; care that is compassionate and dignified and helps individuals (and their families and carers) take control; and services that work together to achieve the outcomes important to individuals regardless of who commissions or provides them. People who work in the NHS want to be supported to be compassionate, respectful and respected, as well as being highly trained, educated and skilled.

Much NHS care is rated very highly by patients and the public.[3,4††] However, while people's lives, needs and aspirations have changed radically since 1948, the NHS and its partners have not changed to anything like the same extent. The health service is largely structured to suit the treatment of episodic disease and injury rather than provide long-term, often complex, care in partnership with other agencies. We are not yet providing enough care outside hospitals, closer to home; care is too often not joined up,[5] personalised or planned in the context of people's lives and circumstances; we are not doing enough to ensure the NHS plays its role alongside its partners in prevention, health promotion and early intervention to achieve long-term improvements in community health and wellbeing. As highlighted by the Francis Report, we still need to do more to tackle pockets of poor practice and reform our culture to be one that consistently supports good quality, compassionate care.

These are not new challenges; they have confronted us for many years. But they are compounded by unprecedented financial pressure across the health and care system as the gap between demand and funding keeps growing. This financial pressure makes it both harder and more urgent to change. Together, this amounts to the most challenging set of circumstances faced since the NHS began.

As national organisations representing health and care charities, communities, staff and leaders across the health, care and wellbeing system, we, and many of our members and partners, have all been calling for this change in recent years.[6] We have now come together to amplify those calls, highlight the scale and nature of the challenge, make the case for change and lead a serious debate of the solutions with each other, with politicians and with the public.

This document is our coalition's analysis of the challenges that must be faced at the 2015 general election and beyond. It is a statement we hope the political parties will acknowledge and use as a framework against which they finalise manifesto and subsequent policy proposals. We intend to use it to hold all the parties to account as we approach the election, and the next Government as it implements future policy.

* As highlighted in the Local Government Association's work on rewiring public services.

† An Ipsos MORI poll this year showed that 75 per cent of the public believe the NHS is one of the best healthcare systems in the world.

†† An international study of 11 leading health services reported that 88 per cent of patients in the UK described the quality of care they had received in the last year as "excellent" or "very good", ranking the UK as the best performing country. A separate Ipsos MORI poll showed that 85 per cent of all recent inpatients are satisfied with their last visit to an NHS hospital, and 83 per cent were satisfied with their last GP visit.

The need challenge

Demand for our health, social care, and wider services that support people's wellbeing, is rising inexorably.

People are living for longer,[7]* partly because of the successes of the NHS and other public services. This is of course a good thing. The Office for National Statistics projects that the overall population will grow by about three million between 2012 and 2020, with the population aged 65 and over growing by 1.92 million.[8] The greatest growth is expected in the number of people aged 85 or older – the most intensive users of health and social care.[9]

As our population ages, a growing number of us will experience longer periods of ill health and have greater support needs.[10] The NHS's expenditure on older people as a group is significantly higher than that on younger people,[11,12]† and the Institute for Fiscal Studies recently calculated that even if NHS spending was 'protected' and frozen in real terms between 2010/11 and 2018/19, real age-adjusted per capita spending on the NHS would be 9.1 per cent lower in 2018/19 than in 2010/11.[13]

People's care needs are also becoming more complex. 70 per cent of England's health and care spending is on the 30 per cent of people with long-term conditions. By 2025, 18 million people in England will have at least one long-term condition[14] and a growing proportion of the population have one or more long-term condition. Care for people with multiple long-term conditions is often very complex and, as their number grows, so does the impact on demand for services. It has been suggested that at least 30 per cent of all people with a long-term condition also have a mental health problem.[15] The Department of Health estimates that patients with a single long-term condition cost about £3,000 per year while those with three or more conditions cost nearly £8,000 per year; the number of people with three or more conditions is expected to rise from 1.9 million in 2008 to 2.9 million in 2018.[16]

We also have more adults living with disabilities. It is estimated that by 2030 the number of younger adults (aged 18–64) with learning disabilities will have risen by 32.2 per cent to around 290,000, and the number of younger adults with physical or sensory impairment by 7.5 per cent, from almost 2.9 million to 3.1 million.[17]

All of this means increasing amounts of ongoing NHS care, social care and other forms of support are needed by a growing number of people, who often have complex needs and multiple long-term conditions, a growing proportion of whom are very frail.

The ongoing failure to prevent or delay disease and ill health is exacerbating the rising demand for care. There has for a long time been insufficient action on prevention, health promotion, early intervention and tackling the wider determinants of poor health (such as education about healthy choices and poor housing).

There are still significant health inequalities, including by age, ethnicity and socio-economic group.[18] The Marmot Report[19] outlined that people living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas. The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods. Evidence shows that people living in deprived areas develop multiple conditions earlier than people in more affluent areas – and many people of working age have multiple conditions.[20]††

* An Office for National Statistics paper in 2011 stated that, between 1990 and 2010, life expectancy in England had increased by 4.2 years. A third of children born in 2013 are expected to live until they are 100 years old.

† Estimates from the Department of Health imply that in 2011 around seven times as much was spent on an average 80-year-old as on an average 30-year-old. Analysis by McKinsey and Co last year found that health and care expenditure on people over 75 was 13 times greater than on the rest of the adult population.

†† The Scottish School of Primary Care has shown that people living in more deprived areas develop multimorbidity 10–15 years earlier than those in more affluent areas. A recent analysis of nearly 200,000 patients registered with over 300 GP practices in Scotland has shown that multi-morbidity is the norm for people with chronic disease and, although its prevalence increases with age, more than half of all people with multi-morbidity are younger than 65 years.

One group particularly affected by health inequalities is people with a mental illness, who are almost twice as likely to die from coronary heart disease as the general population, four times more likely to die from respiratory disease, and are at a higher risk of being overweight or obese.[21] Many of these factors are interlinked, and a person's overall wellbeing will affect their ability to adopt healthy behaviours,[22] as well as their mental health.

Lifestyle choices also often contribute to the burden of disease:[23] smoking, excessive alcohol consumption and obesity are proven to increase the rates of preventable diseases. The cost to the NHS for treating these associated conditions is estimated at a cumulative £17.9 billion each year – almost a fifth of the annual NHS budget.[24] While we have made some progress with some public health issues, such as smoking, other trends, such as rates of obesity,[25]* are heading in the wrong direction.

Early intervention also needs greater emphasis. We have the highest birth rate for several decades, and poor child health outcomes are a particular concern.[26] England has the worst all-cause mortality rate in Europe for children under 14, and a high level of obesity among children, with 19 per cent of children aged ten to 11 years defined as obese.[27] There is also more to do in partnership with people with long-term conditions to keep them as healthy as possible for as long as possible. For example, the National Audit Office found that less than one in five people with diabetes are achieving recommended treatment standards that reduce their risk of developing diabetes-related complications.[28]

The response to growing demand will need to include recognition, mobilisation and utilisation of individual and community assets, with health at the heart of local integrated planning and services. As the Local Government Association emphasises, "to make a lasting and significant impact on health outcomes, health improvement must be the core business of local government and the responsibility for each citizen."[29]

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* If current trends continue, there will be 11 million more obese adults in the UK by 2030 (*The Lancet*, 2011). The health burden from obesity is largely driven by an increased risk of type 2 diabetes, cardiovascular diseases and several forms of cancer.

The culture challenge

Culture change is required in response to both changes in people's needs and aspirations, and the high-profile scandals that have knocked public confidence in NHS leaders and staff.[30] Real progress has been made in many places, and we now need to build on this to achieve a fundamental shift by addressing culture at a whole-system level, with a common set of core values being shared across the system. The extent of new thinking and new behaviours required from the public, professionals and individuals using the health and care system is highlighted in the Berwick Report.[31]

Leaders' responses to Mid Staffs and other recent high-profile scandals, as well as other examples of poor care, must give people the necessary assurances that care will be accessible when it is needed and deliver good clinical outcomes and a positive experience. Standards are important to patients and the public, and play a crucial role in reducing variation across the system and improving outcomes for people. Equally, there is a danger that a 'compliance culture', where only targets matter, can lead to a concentration on defensively meeting assurance requirements to the detriment of the individual needs of patients and those of local populations.[32] Clearly, successful organisations are able to provide good outcomes and meet compliance needs. In looking beyond targets, concerns have been raised[33,34,35] that in parts of the NHS a culture emerged where meeting targets became more important than treating people properly. Measurement against national targets and regulation is important but will only show part of the picture, and often only pick up poor care after it's happened – local leaders must have ultimate responsibility for managing priorities, using data well to improve care[36] and preventing failures.[37]*

There is evidence from the NHS and other industries, including the oil industry, that top-down command and control cultures are the worst kind of culture for quality and safety.[38,39]† Models of clinical peer review, and sector-led improvement in other services – particularly local government, where peer-based challenge and support for councils' work with their health partners on health and wellbeing challenges has begun to support improved practice[40] – show what local leadership can deliver. The Berwick Report[41] argued the NHS should become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end. As the Francis Report highlighted, we need a more open and transparent NHS in which staff feel able to raise concerns and have honest conversations with patients. At an individual level, as highlighted by Professor Michael West[42] and others, there is evidence that staff engagement – enabling people to become more involved in decisions to help improve patient care – leads to better quality and outcomes in the NHS.[43,44,45,46]†† Creating an open, positive organisational culture can also foster innovation and help maintain morale,[47] while promoting professional autonomy and responsibility improves clinical quality.[48] We will need to continue to improve staff engagement,[49,50] involvement and support so that staff are able to consistently provide care that is of the high quality to which they aspire.[51] National bodies need to support and enable local leaders to continue to improve engagement in their own organisations.

There is also dissatisfaction that people do not have enough control and choice over the care they receive and are often not partners in decisions.[52] We need to move away from professional and technocratic definitions of quality, and ensure people have a say in defining the outcomes important to them and deciding how they will be achieved. The NHS Constitution sets out a right for people "to be

* These points are reflected across a range of professional bodies' responses to the Francis Report.

† A recent, large multi-method study of NHS culture showed that hospital standardised mortality ratios were inversely associated with positive and supportive organisational climates. The separate Berwick Report argued that fear is toxic to both safety and improvement, and that quantitative targets should be used with caution.

†† In a recent King's Fund commissioned review of leadership in the NHS, the authors state that engagement has many significant associations with patient satisfaction, patient mortality, infection rates, annual health check scores, as well as staff absenteeism and turnover.

involved in discussions and decisions about your health and care."[53] Yet people are often not well supported to make decisions about their care to reflect what matters to them.[54]* Evidence shows that individuals who are supported to engage make good decisions about care.[55,56] Families, friends, carers and advocates should be seen as partners in care, where this is what the patient wants,[57] while services and packages of support need to be designed and developed with individuals.[58]

Relational aspects of care, concerning relationships between a member of staff and a patient, including how nurses and doctors communicate with the patient and being treated with dignity and respect, are also a high priority for people.[59] Giving people and their families, carers and advocates a voice can range from personal conversations between a person and a member of staff to working with families and consulting representative bodies. Each of these points of contact helps to keep the care system focused on the needs of individuals, gives it the insights to drive improvement, and empowers service users to shape the care that is provided.[60]

The King's Fund's work on patient-centred leadership emphasises the importance of local leadership – rather than national diktat – in embedding these approaches.[61]† Local leadership has enabled real progress in many places to achieve change, for example, many trusts began a process of change when the failings at Mid Staffs came to light, well before the 2013 Francis Report.[62]†† So we must build on what is working as well as tackling the bad.[63] Given the size of the task, change needs to happen on a much larger scale at a much greater pace, with committed support from the national system.

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* The Health Foundation highlighted in recent evidence to the Health Select Committee's 2013 long-term conditions inquiry that "truly person centred care has not spread beyond core innovators", and set out the main barriers to person-centred care, along with solutions.

† A key finding from the King's Fund's recent work on patient-centred leadership is that national leaders need to create conditions in which local organisations have the freedom to deliver consistently high standards of care and where the needs of patients come first.

†† Most of the trusts responding to a national survey (70 per cent) considered that, by the time the 2013 Francis Report was published, they already had measures in place to improve and assure the quality of care that aligned with the Francis recommendations (Nuffield Trust, 2014). 67 per cent of trusts either agreed or strongly agreed with the statement "the trust took action after the publication of the 2010 Francis Report and is confident that these adequately reflect the recommendations of the 2013 report".

The design challenge

People's need for care, and their lives, has changed radically. But the health service largely operates as it did decades ago, when the predominant need/expectation was treating episodic disease and injury rather than providing long-term, often complex, care. The health and care system needs to redesign services so that care becomes more integrated, person-centred, coordinated, community-based and focused on supporting people's wellbeing and preventing crises.

Care is often still organised according to 'physical healthcare', 'mental healthcare' and 'social care', with each often delivered by separate organisations and groups of professionals.[64] People do not recognise these distinctions, frequently have need of all three forms of support, and often end up required to do all the work as their own 'service integrator'. As National Voices point out, "care is care is care" for the person who needs it.[65] The difficulties and distress caused to people through care being delivered by separate, poorly coordinated organisations is powerfully described by service users and carers.[66,67,68,69] There is growing evidence that outcomes and experience suffer because of the siloed nature of care provision.[70,71]* Conversely, service users, patients, carers and their organisations have described what it is that people would experience if this kind of care works well – in the narrative for person-centred, coordinated care.[72] Beyond social care, there is also often a lack of coordination and integration between the NHS and other local services such as education and voluntary and community organisations. Put simply, we are still a long way from all parts of the system working in an integrated way towards the same shared outcomes for health and wellbeing.[73]

The vast majority of contacts take place in community settings, and this care and wider support needs to be redesigned to support people's lives. This demands an imaginative approach, which involves collaborating more widely than just the NHS, thinking about non-health-based solutions, and using the assets and capabilities of people with long-term conditions and disabilities, and their families and communities. We need to do much more to support and enable people with long-term conditions to lead healthy lifestyles and take action to meet their social, emotional and psychological needs and to prevent further illness or accidents. The Local Government Association also highlights the importance of working with people as individuals in their family context, with assets and capabilities of their own, to determine what support they want – which leads to better health outcomes and less reliance on costly and high intensity health and social care.[74] Evidence of what support people want, and its value, continues to grow;[75] different models, involving different agencies, will be required to suit the particular needs of specific communities. Not only is supported self-care what many people want, it also supports good outcomes and is cost effective.[76]

Provision of health services in settings in the community, close to – and in – people's homes, is not currently adequate to meet demand – as shown by rising delays in people getting the support they need to leave hospital.[77,78]† The King's Fund has highlighted the need for system-wide changes if models of care that are more community based are to be implemented; their work also highlights the potential for such models to reduce emergency hospital admissions.[79] We also need to use specialist expertise more often in settings outside hospitals, as highlighted by

* Reviews of the research evidence argue that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly coordinated. A separate 2013 integrated care evidence review commissioned by the LGA said that "the review of available evidence shows that integrating care is yielding results such as reduction in waiting times and duplication of services. There is some evidence of reduction in elective admissions and outpatient attendances."

† The inability of community health services to meet demand is very likely to be the reason why delayed transfers of care for reasons attributable to the NHS have risen from around 60 per cent in 2010/11 to 70 per cent in 2013/14 (the overall number of delayed transfers having remained stable) – figures from King's Fund Quarterly Monitoring Report (January 2014). Monitor's *Closing the gap* report suggested "delivering right care in the right setting" could free up £2.4–£4 billion: integrated care to prevent hospitalisation (£1.2–£2 billion), direct shift of acute care to more cost-effective setting (£1–£1.6 billion) and self-management (£0.2–£0.4 billion).

the Future Hospital Commission which suggested specialist medical teams work in partnership with primary, community and social care.[80]

Where care in communities – including support for self-care – is not meeting people's needs, this generates huge pressure on hospitals.[81]* We need to provide more community-based care to support hospital care itself to remain sustainable.[82] While some people will experience better outcomes in hospital,[83,84] a large proportion of the patients cared for in hospital could have better outcomes and experience of care if they were treated outside hospital.[85,86,87] The hospital sector accounts for the largest proportion of all NHS spending[88] and a very significant part of the NHS's assets, both in terms of estate and staff,[89,90] remain invested in a heavily hospital or institutionally-based model. Hospital beds and the duration of patients' hospital stays have both fallen to some extent, in line with international trends,[91] as the hospital sector manages rising demand through efficiency. The acute sector will need radical solutions to address the pressure from the increasing number and complexity of patients,[92] as well as to manage the short-term risks of shifting resources away from hospitals, particularly maintaining quality and ensuring alternative services manage demand so that people have less need for hospital treatment.

At the same time, there is growing concern that the lack of continuity of care outside normal working hours, across hospital, community and primary care settings, negatively affects patient outcomes and experience. One example of this would be the evidence of increased mortality rates for people who are admitted to hospital at the weekend.[93] This represents a clear case for moving towards a seven-day health and care system. In developing seven-day services, solutions to financial, service design and workforce challenges will need to be found.

Despite the limitations of the way care is organised in many places, it can be very challenging to secure support for changes from patients, the public and staff. Change cannot be credible without close alignment of patients, local communities, managers and staff around the vision for change. This requires early, genuine and constructive engagement; this is not easy and requires time and money.[94] Change should be based on what local communities need and evidence of what works, and should enable and facilitate the health and care system to be more effective.

While current structures, nationally and locally, should not be set in stone, the temptation of major, top-down restructuring must be avoided. Major structural reorganisations are costly and it can take years for new organisations to become fully competent after they are created. They also distract attention from improving models of care and hinder the ability of local leaders to work together and build the strong relationships that are crucial for large-scale service change.[95]

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* The Nuffield Trust has suggested that poor access to preventive services (from primary, community and social care services) is likely to be an important factor in the 26 per cent rise in the overall rate of emergency admissions for conditions that are potentially avoidable – such as asthma and pneumonia – between 2001 and 2013.

The finance challenge

The gap between funding for the health system and the rise in demand is making it increasingly hard to see how the current model can be sustained without more radical change. Projections from NHS England suggest that, assuming the health budget remains protected in real terms and we continue with the current model of care, the gap between funding and demand will grow to £30 billion a year by 2021.[96] Cost pressures on the NHS are projected to grow at around 4 per cent a year up to 2021/22,[97] and health providers are required to make efficiencies of 4 per cent each year.[98] There is scant evidence, even internationally, that this has been achieved over a significant period across a health system.

The financial challenge varies between local health economies,[99] with an increasing number of NHS providers in deficit at the end of 2013/14[100] and evidence of a deteriorating position across all providers.[101] Most trust finance directors (around two-thirds) are very or fairly concerned about balancing the books by the end of 2015/16.[102]* Some providers also face a very significant burden of PFI debt repayment.[103]

There is a clear need to shift resources into community settings, which will require a managed transition. This will need to include investing in change,[104] and addressing the short-term risks of shifting resources out of hospitals – particularly maintaining quality and ensuring alternative services manage demand so that people have less need for hospital treatment. And if an area's Better Care Fund plans do not succeed in reducing demand on hospitals, the effect locally will be to increase the efficiency savings required of hospitals to up to 8 per cent during 2015/16.[105,106]†

The public is well aware of the financial pressures on the NHS, with 88 per cent believing the NHS will face a severe funding problem in the future.[107] NHS leaders are also deeply concerned about the scale of the financial challenge. A recent NHS Confederation survey found that, assuming the NHS's budget remains flat in real terms, 51 per cent of NHS leaders feel that large-scale changes are needed in order to maintain current levels of care; while 45 per cent believe that, even if the NHS makes large-scale changes, this alone will not ensure it can maintain current levels of care.[108]

Financial pressure on the NHS is exacerbated by financial pressure in social care. When people's needs are not met by social care, they turn to the NHS, which experiences the impact in the form of increased demand.[109]†† The latest annual survey of social care budgets carried out by the Association of Directors of Adult Social Services found mounting pressures, with 13 per cent of savings during 2013/14 alone from service reductions, despite large efficiency savings.[110] The Local Government Association has pointed out that "continuing to make this level of savings is simply not possible without severe consequences for the people in need of services."[111]

Health economists have shown that redesigning services to be fundamentally more productive could fill a large proportion of the NHS funding gap;[112]††† as such, this is essential. However, service change alone will not fill all of what is a huge funding gap,[113] and releasing savings will not always be straightforward.

* Monitor's latest quarterly review found that under-delivery of the cost improvement plans on which trusts' financial positions rely was 'unlikely' to be recovered by year end 2013/14.

† Leading health and care organisations highlighted the issues that needed to be addressed for local areas to achieve sustainable change through the Better Care Fund process in a joint statement published in March this year.

†† A 2012 NHS Confederation survey of NHS chief executives and chairs found that 66 per cent said shortfalls in local authority spending had impacted on their services over the previous year.

††† The potential savings from changes to services, including improving productivity within existing services, delivering the right care in the right settings, and developing new ways of delivering care, add up to £10.6 – 18 billion in Monitor's analysis. This would be by far the largest contribution to filling the funding gap identified in their report *Closing the funding gap*.

Further options for responding to the funding gap are limited and involve tough choices.[114] NHS savings so far have relied heavily on cutting the prices paid to providers, reductions in administrative staffing (despite already very low administrative and management spend in the NHS[115]), and wage restraint – rather than redesigning services to be fundamentally more efficient.[116] Analysis by Monitor shows there is also some limited scope to make further efficiency savings through better procurement, though this could only fill a relatively small proportion of the overall funding gap.[117] This analysis also suggests non-recurrent savings could be available through wage restraint and selling under-utilised land and buildings, but argues indefinite wage restraint is not sustainable and highlights practical difficulties in realising the full potential value from selling estates.[118]

Ongoing wage restraint since 2010/11 is predicted to save a cumulative, vital £5 billion by 2015, but we cannot rely on this indefinitely. The time has come for an open and honest debate on reform of the NHS pay and conditions framework. This would need to consider the role of Government, employers and other bodies in setting conditions, and the cost and value of the NHS "pay and reward package". This debate needs to develop a consensus on the way forward in the context of continuing constraint on public finances and also taking into account the development of staff roles, cross-boundary working and changing skill mixes, as well as the potential risks of pay limits in the absence of reform of the structures.

As a number of experts have highlighted, the tough choices required in order to bridge the increasing gap between flat funding and rising demand mean we need an open and honest debate about the future levels, and sources, of funding for health and social care.[119]

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The leadership challenge

High-quality leadership is crucial at times of challenge and when transformational change management is required. This is true of the NHS at both a national and local level.

Local leaders have a crucial role to play in addressing all of the challenges set out in this report. Despite the many changes already underway or planned for in local areas, the NHS Confederation's survey found a lack of confidence among NHS leaders in their local health economy's ability to achieve the large-scale service changes that will be required; seven out of ten are not confident in achieving these changes.[120]

In order to redesign services, commissioners and providers across health, care and other preventative and public health services will need to forge strong, equal partnerships with each other. Health and wellbeing boards have an important role to play in the shared leadership that is needed. Local leaders will also need to fully engage people who use their services, local communities and staff, so that plans for change reflect their needs, values and wishes.

We have also made clear in this report the importance of local leadership in embedding the cultural change required for the NHS to involve patients and citizens as leaders, enable patients to have more control and be partners in decisions, and engage staff in continually improving care.

Evidence shows that consistent leadership gives confidence to staff, stakeholders and regulators and is important in embedding change.[121] Yet many NHS chief executives are only in post for a relatively short period – averaging around two years among acute trusts.[122] The pressures facing chief executives contribute to the NHS's difficulty in recruiting and retaining them.[123] The NHS has also struggled to meet the challenge of diversifiying its leadership. BME leaders have been declining as a proportion of the senior leadership of the NHS.[124] Women are also still in the minority in NHS leadership roles, despite recent progress.[125] Continuing to increase the engagement of clinicians in leadership will also be crucial.[126] Addressing these issues will need to be part of ongoing efforts to strengthen NHS leadership.

Many examples already exist of the types of leadership approach that will be needed.[127] National government, and national bodies, must allow local leaders the space to continue to develop these approaches, which would be stifled by top-down, performance-management approaches.

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The workforce challenge

Planning, training and support for our staff have not changed as fast as people's needs. A recent King's Fund paper highlights that "workforce redesign is needed not only because of a potentially dwindling workforce, but also because the nature of healthcare work is changing and the skills of the current workforce are not well matched to future needs";[128] the authors conclude the scale of the challenge is "immense".

NHS workforce planning has traditionally gone through cycles of 'boom and bust'. Analysis suggests[129] that there will be considerable challenges after 2015; the NHS already has staff shortages in some local areas and for some types of care.[130] The possible imposition of staffing ratios or longer-term impact of pay restraint making the NHS less attractive could increase these challenges. Workforce planning also needs to align with decisions about service change – for example, to deliver the national consensus that more care should be provided in community settings, the community workforce needs to expand and work differently in line with this demand. Currently, figures from the Royal College of Nursing show a recent reduction in community nurses,[131] the Centre for Workforce Intelligence (CfWI) has highlighted the existing GP workforce in England has insufficient capacity to meet current and expected patient needs,[132] and the Royal College of GPs argue there has been decreasing investment in general practice – "the part of the system that is best placed to lead the change patients need".[133] The CfWI has also highlighted more multidisciplinary and flexible working will be required for more community-based care.[134]* A move towards seven-day care will also have an impact, with demand for staff groups already in short supply – such as radiologists and urologists – likely to increase.[135] This needs to be planned for.[136]

Job roles for clinicians in the NHS are based on the historical occupations of nursing, medicine, science and allied health professionals and their related support roles. There has also been a strong trend toward specialisation in medicine and nursing over the past decade, and specialist roles add value.[137] Now, as healthcare needs are increasingly more complex and multidimensional – and often combined with a need for social care – roles will also need to evolve to provide more 'holistic' care; there needs to be a shift toward building generalist skills with 'expert generalists' needed as part of the mix. Alongside this there may also need to be development of 'extensivists'[138] to deal with high acuity patients and a range of roles that help patients and service users 'navigate' the healthcare system. Healthcare technology and biogenetics will dramatically alter the skills needed for doctors in ways that can barely be predicted and our training and workforce deployment systems will need to be more flexible to respond to these changes. Greater interdisciplinary working and changing roles will be required to support integrated care. Support roles will also need to develop so that compassionate care can be provided across the boundary of health and social care.

The NHS also faces the challenge that the majority of staff are trained to work in, and are then employed in, hospital settings when it increasingly needs to provide care in community settings, often in multidisciplinary teams. The Independent Commission on Whole Person Care highlighted the scale of the cultural challenge to the multidisciplinary working essential to achieving coordinated care. Various evaluations of integrated care pilots found that, in getting staff from different professions and different organisations to work better together, it is difficult and time consuming to break down cultural barriers and agree shared goals in a coordinated manner.[139] Some proposals have already been made to address the need for training in community settings for doctors, and nurse training also needs to be reformed.[140] A major effort is needed to develop the staff we already have to work within emerging new models of care. This is because most of the professionals who will be working in the NHS in ten years' time are working in the NHS today.

* A 2013 Centre for Workforce Intelligence paper outlined ways in which the multidisciplinary community workforce could work differently to alleviate some of the pressure on GPs and improve joint working across primary and community care.

The technology challenge

Technological developments – especially changes to information and communications technologies – have contributed to us living our lives very differently from a few decades ago. The NHS has begun to respond to this,[141] and needs to be supported to fully realise the potential for technologies to help transform care and improve efficiency.[142]

Systems must be designed to meet the needs of patients and those who care for them. Many people are already undertaking some health transactions online, such as ordering repeat prescriptions, checking hospital reviews or booking hospital and GP appointments. For a lot of people, their appetite to use digital technologies as part of their care goes further beyond this in ways often not yet reflected in service delivery. For example, while 32 per cent of people say they would be likely to consult GPs by email if they could, just 1 per cent have actually done so.[143] Equally, as more people use wristwatches, GPS devices and apps to track steps, heart rate, calories burned, mood and other personal statistics, there is potential for far greater use of telehealth to support self-care. Growing the use of digital technologies can also help empower people to exercise greater control and choice in their own care through ready access to information.

Health literacy is closely linked to outcomes for patients;[144] and with increasing amounts of health information being presented online, the NHS needs to ensure that groups with lower levels of internet use, such as older people and more deprived groups,[145]* do not miss out. Digital exclusion will need to be addressed, including by catering differently for those who are accessing no, or limited amounts of, information and support online.[146]

There are already a number of programmes where collecting data and comparing performance enables trusts to improve clinical performance.[147] Information technology can also play an important role in improving patient safety. For example, moving from paper-based to electronic patient records would allow important information to be shared more quickly and reduce the risk of records being lost or misplaced.[148] However, organisations are often hampered by limited support in the system to build their capability and skills to make best use of digital technology in these ways.[149]

NHS organisations must also be better supported to harness technological innovation in order to reduce costs while improving people's outcomes. *Innovation, Health and Wealth*[150] highlighted that longstanding and well-known barriers to the adoption of innovation must be overcome so that 'game-changing' innovations can spread as part of the NHS's response to the financial challenges it faces.

> "Organisations are often hampered by limited support in the system to build their capability and skills to make best use of digital technology"

As leading health and care organisations, we call on the decision-makers to explicitly recognise these seven challenges.

We propose these challenges be accepted as the burning issues facing the health and care system, and call for an open and honest conversation with the public about the choices and consequences involved in meeting the 2015 Challenge.

To join the conversation, email **2015Challenge@nhsconfed.org**, or on Twitter use #2015Challenge

* It was reported that in 2011 only 41 per cent of people aged over 65 years – and 60 per cent of socio-economic class DE households – accessed the internet at home.

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    - £48.321 billion to secondary care (54.2 per cent) including general and acute, maternity and A&E
    - £21.637 billion to primary care (24.3 per cent)
    - £9.119 billion to community services (10.2 per cent)
    - £8.608 billion to mental health (9.7 per cent)
    - £1.416 billion to learning difficulties (1.6 per cent).

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129. Centre for Workforce Intelligence (2013), *Future nursing workforce projections. Starting the discussion.*

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149. NHS Confederation (2013), *Challenging bureaucracy.*

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We are now calling for a positive, shared vision for the future. This vision must encapsulate the needs, assets and wishes of the people using the health and care system, and the values of the people working in it.

Change must be both local and national. Public and staff concerns about change must be addressed by building confidence in the future, rooted in clear accountability and responsibility.

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