Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	17
Date of Meeting:	30 January 2019		

Title of Report:	NHS 10 Year Plan – Implications for the RUH
Status:	For approval
Board Sponsor:	Joss Foster, Commercial Director
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Appendices	Appendix 1: Further resources Appendix 2: Framework for assessing implications for the RUH

1.	Executive Summary of the Report
The NHS 10 Year Plan, published on 7 January 2019, sets the NHS's intentions for the period to 2028. This paper summarises the Plan, and headlines implications for the RUH alongside a framework for further detailed evaluation and monitoring.	

2.	Recommendations (Note, Approve, Discuss)
Board is asked to further discuss the implications of the Plan for the RUH, and approve the proposed approaches for: ▪ sharing the contents of the Plan across the Trust ▪ monitoring progress towards our delivery of the commitments set out within the Plan.	

3.	Legal / Regulatory Implications
The Plan sets out a series of commitments which will require action by the RUH; our progress towards delivering these commitments are likely to be monitored by the RUH's regulators, including the CQC, NHS Improvement and NHS England.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Appendix 2, currently under development, will highlight key areas of risk associated with the Plan as it relates to the RUH.	

5.	Resources Implications (Financial / staffing)
There are likely to be resource implications associated with a number of the commitments made in the Plan. Work is now underway to assess those implications.	

6.	Equality and Diversity
An Equality Impact Analysis will be completed prior to any significant service changes as a consequence of the Plan. The Plan itself outlines a range of measures designed to improve services for vulnerable groups, including people with learning disabilities, rough sleepers, people with mental health issues and those from BAME backgrounds, and reduce health inequalities (Chapters 2 – 3).	

7.	References to previous reports
N/A	

8.	Freedom of Information
Public	

NHS 10 Year Plan – Implications for the RUH

1. Introduction

The NHS 10 Year Plan, published on 7 January 2019, sets the NHS's intentions for the period to 2028. This paper summarises the Plan, and highlights key implications for the RUH.

The Plan, Executive Summary, accessible version and further resources can be found at https://www.longtermplan.nhs.uk/. Further links to useful information are provided throughout this paper, and a collated list of further resources is available in Appendix 1.

Section 4, Next Steps, proposes for Board's approval an approach to sharing the Plan across the Trust and monitoring progress towards our delivery of the commitments set out within the Plan.

2. Context

The Plan reflects:

- The funding settlement of an annual 3.4% annual funding increase over the next five years
- Outcome of consultation with staff, patients and professional bodies during 2018
- Developments from the NHS Five Year Forward View, in particular the experience of Vanguard sites

3. The Plan, and early implications assessment for the RUH

3.1 Chapter 1: A new service model for the 21st century

Sets out a new service model for the NHS, based on three principles:

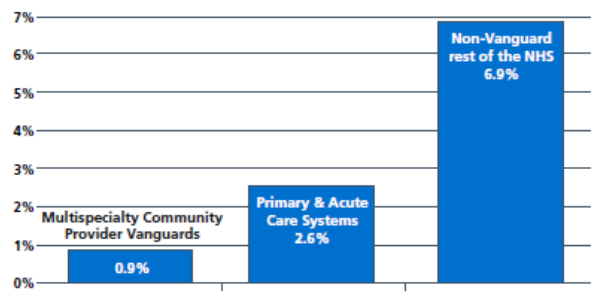
- More joined up and coordinated care, breaking down traditional barriers between teams, providers and funding
- More proactive services, using predictive prevention to avoid illness
- More differentiated support to individuals.

This will be achieved through five changes:

Out-of-hospital care

Reflecting the learning from the Five Year Forward View integrated care Vanguards (see right), the Plan commits to community service redesign, and an increased investment in primary and community health services as a share of the total NHS revenue – spending on these services will be at least £4.5bn higher in five years' time.

Figure 1: Growth in emergency admissions per capita 2014/15 to 2017/18: MCP and PACS Vanguards vs. the rest of the NHS.



Note: The MCP and PACS combined emergency growth rate is 1.6% which is statistically significantly lower than the rest of the NHS with 95% CI (the upper limit for a significant value is 3.1%).

Source: NHS England analysis of Secondary Uses Service (SUS) data.

The additional investment in community services is intended to deliver in five years:

- Community health crisis response services targeted to deliver within two hours of referral in line with NICE guidelines.
- Reablement care within two days of referral
- Additional community and intermediate health care packages, delivered by integrated teams working across primary care and local hospitals, freeing up one million hospital bed days
- Development of primary care networks, based on neighbouring GP Practices and covering 30,000 – 50,000 people. Individual Practices will enter into a network contract, with all funding

flowing through a single, pooled fund. Networks will be underpinned by a revised GP Quality and Outcomes Framework (QOF), and a new shared savings scheme, so Practices benefit from their contribution to reductions in avoidable ED attendance, admissions, delayed discharges and outpatient appointments as well as improved medication management.

- Enhanced Health in Care Homes vanguard model to be rolled out to all Care Homes by 2023/24.
- GPs to use Electronic Frailty Index to identify patients living with moderate frailty and target interventions for mental and physical health needs.
- Other measures including carer support, use of telemedicine, and focus on supporting patients with dementia through primary care networks.

Implications for the RUH:

- Opportunity to benefit operationally from improved community services, for example reduced reablement waits and the roll out of Enhanced Health in Care Homes programme.

- Implications of local Primary Care Networks are not yet fully understood. Some progress has been made within the RUH catchment area – for example the merger of Trowbridge and Frome Practices, but less advanced than some other parts of the country. Potential pressures could arise around the ability to recruit nurses, therapists and other AHPs including pharmacy as the multidisciplinary workforce in primary care hubs expand.

- Emphasis on developing services for patients with frailty is well aligned to RUH and BaNES Integrated Care Alliance plans.

Emergency hospital services

The Plan assumes that growth in demand for hospital services will continue in line with the last three years; any benefit from the investment in out of hospital care (see above) will be upside.

Key deliverables:

- Single, multidisciplinary Clinical Assessment Service (CAS) within integrated NHS111, ambulance dispatch, and GP OOH from 2019/20.
- Urgent Treatment Centres in place nationally by 2020, along with enhanced ambulance services to keep more people at home
- All acute hospitals:
    - To move to a comprehensive model of Same Day Emergency Care, achieving a third of acute admissions discharged on the day of attendance.
    - Provide same day emergency care SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20.
    - Provide an acute frailty service for at least 70 hours a week, delivering clinical frailty assessment within 30 minutes of arrival.
    - Emergency Care Data Set (ECDS) to be embedded within all UTCs by March 2020
    - New national pathways of care for stroke, heart attack, major trauma, severe asthma and sepsis to be developed, and a standard model of deliver in smaller acute hospitals serving rural populations; test and implement the new emergency and urgent care standards arising from the Clinical Standards Reviews by October 2019.
    - To support reduction in Delayed Transfers of Care (DTOCs) through therapy and social work at the beginning of the patient pathway, all patients to have an agreed clinical care plan within 14 hours of admission including Estimated Date of Discharge,

implementation of SAFER and multidisciplinary reviews on all hospital wards every morning.

Implications for the RUH:

- CAS already in place in BaNES and Wiltshire, although there are further opportunities for developing mental health access through the CAS (outlined in Chapter 6).
- Urgent Treatment Centre already in place in Bath. Work ongoing currently on implementation of ECDS throughout ED.
- Further opportunity for the RUH related to same day emergency care admissions – work in progress to assess the size of opportunity. Current services do not fully meet the 12 hours a day, 7/7 days a week requirement outlined in the Plan.
- Implication of new model of care for smaller hospitals unclear – may have potential impact on hospitals bordering the RUH catchment.
- Successful acute frailty service in place, although opportunity to extend to meet full specification detailed in the plan.
- Implications of new national pathways of care for stroke, heart attack, major trauma, severe asthma and sepsis and the new urgent care standards arising from the Clinical Standards Reviews as yet unclear.
- Implementation of SAFER bundle is ongoing.

Personalised care

- Patients waiting for six months for elective surgery to be specifically contacted and given the option of treatment at an alternative provider.
- NHS Personalised Care model to be rolled out nationally by 2023/24, including personal health budgets.
- Social prescribing to be rolled out nationally – over 1,000 trained social prescribing link workers by 2020/12
- End of life care - Personal health budgets to include specialist end of life care, additional training nationally to ensure all patients identified as being in their last year of life have a personalised care plan.

Implications for the RUH:

- Alternative providers are actively used within the local health system but are not currently routinely offered to patients specifically on waiting over six months, consideration will need to be given around whether alternatives exist within the local health system for all procedures.
- Personalised Care model not currently fully in place in local health system. Potential implication for discharge processes for patients accessing personal health budgets will need careful evaluation.

Digitally enabled primary and outpatient care

- Digital NHS 'front door' available through an NHS app providing health advice and connection with healthcare professionals
- Within five years, all patients to be able to choose to register with a digital GP Practice. GP payment formula to be adjusted to support growth in new digital models of primary care.
- Redesign of the traditional outpatient model – within five years, one third of face to face outpatient visits will be avoided

Implications for the RUH:

- Growth in patients choosing to register with a digital rather than physical GP Practice is likely to change the relationship between the RUH and primary care

- The RUH currently holds over 130,000 follow up outpatient appointments a year – achieving the Plan's ambitions would see over 40,000 appointments either avoided or realised in a different way – outpatient models are currently being reviewed at STP level.

Integrated Care Systems

Integrated Care Systems – comprising primary and acute care, physical and mental health, health and social care – rolled out to all parts of the country by April 2021. Every ICS will have:

- A partnership board, drawn from commissioners, trusts, primary care networks, local authorities, voluntary and community sector and other partners.
- A non-executive Chair, sufficient clinical and managerial capacity drawn from constituent organisations to enable implementation of system-wide changes and a named accountable Clinical Director of each primacy care network
- Greater emphasis from the CQC on partnership working and system-wide quality
- New license conditions planned to support NHS providers to take responsibility for wider objectives in relation to use of NHS resources and population health; longer-term NHS contracts that include clear requirements to collaborate in support of system objectives
- Clinical leadership aligned arounds ICSs – Cancer Alliances, Clinical Senates and their clinical advisory boards will be made coterminous with one or more ICS

New fast-track process to assess proposed mergers of NHS providers, led by NHSI.

Changes to funding flows and contracting arrangements will underpin the move to ICS, including a new Integrated Care Provider contract available for use from 2019, allowing contractual integration of primary medical services with other services.

Performance management of ICSs through:

- New ICS accountability and performance framework, including an 'integration index' to measure public perception of joined up, personalised and anticipatory care
- System-wide objectives agreed with the relevant NHSI/E Regional Director

Local approaches to blending health and social care budgets will be supported, using one of four optional models:

- Voluntary budget pooling between a council and CCG for some or all of their responsibilities
- Individual service user budget through personal health and care budgets
- NHS to oversee a pooled budget for health and social care (the Salford model)
- CCG and local authority ask NHSE to designate the council chief executive or director of adult social care as the CCG accountable officer.

The Better Care Fund will be reviewed in 2019.

Implications for the RUH:

- An Integrated Care System is in development across BSW with appointment of single CCG accountable officer and operational planning for 2019/20 will be integrated. Integrated Care Alliances within both BaNES and Wiltshire are also moving forward.

- Building effective links in to the developing Somerset ICS is underway to ensure the interests of the RUH-facing Mendip population continue to be represented.

3.2 Chapter 2: More NHS action on prevention and health inequalities

Sets out new commitments by the NHS to improving prevention, focussed on the growing and ageing population, unmet health need, expanding frontiers of medical science and innovation, and the opportunity to improve health by directing people to the optimal care setting and prevention of avoidable illness.

The Plan sets out a series of commitments to address the top risks factors for premature deaths in England, as identified in the Global Burden of Disease survey:

Risk factor	Long Term Plan commitments
Smoking	▪ By 2023.24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services ▪ Smoke free pregnancy pathway for expectant mothers and their partners ▪ Universal smoking cessation offer as part of specialist mental health services
Obesity	▪ Access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension and an BMI of 30+ ▪ Funding of the NHS Diabetes Prevention Programme to double of over the next 5 years, and a new digital service to be developed ▪ New hospital food standards to be published in 2019 ▪ Expansion of nutrition training in medical schools
Alcohol	▪ Hospitals with the highest rate of alcohol-dependence admissions to develop Alcohol Care Teams in the next five years
Air pollution	▪ NHS to cut business mileage and fleet air pollution emissions by 20% by 2023/24 ▪ 90% of NHS fleet to use low-emission engines by 2028 ▪ Primary heating from coal and oil fuel in the NHS to be fully phased out
Antimicrobial resistance	▪ Continue implementation of five year action plan on Antimicrobial Resistance

Implications for the RUH:

- The Plan's commitments has implications for elements of RUH service delivery, for example the requirements to offer smoking cessation services to all patients who smoke by 2023/24, delivery of the new hospital food standards, 90% of NHS fleet to use low-emission engines by 2028 and implementation of five year action plan on Antimicrobial Resistance. Work to understand the detailed implications is underway (see Appendix 2)

Health inequalities
The Plan sets out further measures to address health inequalities, including:

- Continued higher funding allocation to geographies with high health inequalities, underpinned by a more accurate assessment of need for community health and mental health services, from 2019. All local health systems to set out during 2019 how they will reduce health inequalities by 2023/24 and 2028/29.
- Enhanced and targeted continuity of carer model for the most vulnerable mothers and babies
- All women who smoke to be offered specialist smoking cessation support
- Increased physical health checks for people living with severe mental health problems
- Focus on improving health and care for patients with learning disabilities, and for people who are homeless.
- Greater support and coordination of services to support carers
- ICSs to support the development of local charities, social enterprises and community interest companies to provide services and support to vulnerable groups.

Implications for the RUH:

- The Plan's commitments has implications for elements of RUH service delivery, for example the requirements to offer 75% of women from BAME and the most deprived groups continuity of care from their midwife throughout pregnancy, labour and the postnatal period by 2024, and improved access and support for patients with learning disabilities accessing NHS services. More detailed work to understand the full implications is underway (see Appendix 2)

3.3 Chapter 3: further progress on care quality and outcomes

The Plan sets out a range of measures to improve quality and outcomes for children and young people and major health conditions.

A strong start in life for children and young people

Area of focus	Commitments
Maternity and neonatal services	Accelerate actions to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025, through: ▪ Saving Babies Lives Care bundle to be rolled out across every maternity unit in 2019. An expansion to the SBLCB will be published in 2019, focussed on preventing pre-term birth, for implementation by 2020. ▪ Maternal Medicine Networks to be developed to improve access to specialist care and advice ▪ Maternity Incentive Scheme to continue ▪ By spring 2019, all maternity services to be part of the National maternal and Neonatal Health Safety Collaborative ▪ By March 2021, most women will receive continuity of care through pregnancy, birth and postnatally ▪ Roll out of maternity digital care records; all women will be able to access their maternity notes and information through their smart phones by 2023/24 ▪ Improved access to perinatal mental health care, including care for partners, and developing maternity outreach clinics which bring together physical and psychological health services. ▪ National roll out of multidisciplinary pelvic health clinics and pathways

	▪ All maternity services to offer an accredited, evidence-based infant feeding programme by 2019/20 ▪ Neonatal critical care services to be expanded and redesigned, following the Neonatal Critical Care Review, including care coordinator in place across clinical neonatal networks from 2021/22 and an expansion in the neonatal nursing workforce.
Children and young people's mental health services	New commitment that funding for children and young people's mental health services will grow faster than overall NHS funding, to deliver: ▪ Expansion of services to ensure that 100% of children needing speculate care can access it by the end of the 10 year period, underpinned by a new four week waiting time access standard for specialist mental health care. ▪ Continued delivery of access standards for eating disorder services ▪ Mental health support embedded in schools and colleges ▪ Development of transitional mental health services for young people aged 18 – 25.
Learning disability and autism	▪ Increased uptake of annual health checks to improve preventative care for young people with learning disabilities. ▪ Over the next five years, national learning disability improvement standards will be implemented, applicable to all NHS organisations. This will include a 'digital flag' identifying a learning disability or autism by 2023.24. ▪ Reduced waiting times for specialist assessment, and, by 2023/24, all children and young people with a learning disability or autism will have a designated keyworker. ▪ Reduction in people with a learning disability receiving long term inpatient care by 2023/24, and increased investment in intensive, crisis and forensic community support. ▪ By 2023/24, all care commissioned by the NHS will need to meet the Learning Disability Improvement Standards, and assessed as such by the CQC
Children and young people with cancer	▪ Development and implementation networked care to improve outcomes for children and young people with cancer ▪ Cancer genome sequencing for all children with cancer by 2019 ▪ Access to CAR-T cancer therapies ▪ Increase in children and young people taking part in clinical trials to 50% by 2025 ▪ From September 2019, all boys aged 12 and 13 to be offered vaccination against HPV ▪ Children's hospice grant to double from £11m to £25m by 2023/24
Other health services	Children and Young People's Transformation Programme to oversee delivery of children and young people's commitments in the Plan ▪ Focus on improving the childhood vaccination programme ▪ Roll out of Clinical Networks for children with long-term conditions such as asthma, epilepsy and diabetes from 2019/20 ▪ Paediatric critical care and surgical service networks to be developed ▪ By 2028, move towards 0-25 years services to improve transition to adult services.

Implications for the RUH:

- Many of these commitments reflect activity which the RUH is already progressing. Further detailed work to understand the full implications is underway (see Appendix 2).

Better care for major health conditions:
The Global Burden of Disease study shows five top causes of early death in England: heart disease and stroke, cancer, respiratory conditions, dementias and self-harm; these inform the priorities in the Plan.

Area of focus	Commitments
Cancer	▪ By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three quarters of cancer patients, through increased awareness, lower referral thresholds, faster access to diagnosis and treatment and improved screening. ▪ Bowel Cancer Screening Programme to include Faecal Immunochemical Testing, and the age for screening to start to move to 50 from 60. ▪ HPV primary screening for cervical cancer by 2020 ▪ Review of current cancer screening programmes and diagnostic capacity, led by Sir Mike Richards, to be finalised by summer 2019. ▪ Development of lung health checks by 2022, including mobile CT scanning ▪ Primary Care Networks to focus on improved early diagnosis and referral of patients in their areas by 2023/24. Faster Diagnosis Standard in place from 2020. ▪ Roll out of Rapid Diagnostic Centres (RDCs) from 2019; investment across the NHS in additional CT and MTI capacity ▪ Proton Beam facilities in London and Manchester ▪ Improved support for radiotherapy services, including revised specialist commissioning payments for radiotherapy hypofractination. ▪ Genomic testing available for all newly diagnosed patients from 2020/21 ▪ Personalised care planning, including needs assessment care planning and health and wellbeing information and support available for all patients by 2021. ▪ Stratified follow up pathway in place for breast cancer by 2019, prostate and colorectal in 2020 and other cancers by 2023.
CVD	▪ Improve effectiveness of the NHS Health Check, and extend testing for Familial Hypercholesterolaemia ▪ Enhanced focus on early treatment in primary care through primary care networks, underpinned by the creation of a national CVD prevention audit for primary care. ▪ National network of community first responders and defibrillators to improve immediate resuscitation ▪ By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.
Stroke	▪ By 2023/24, Integrated Stroke Delivery Networks will ensure that all stroke units meet the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke, including access to mechanical thrombectomy and enhanced access to CT perfusion scanning, MRI scanning and use of artificial intelligence to enhance interpretation of diagnostic results. ▪ New credentialing programme for thrombectomy ▪ Roll out of new post-hospital stroke rehabilitation models to commence in 2020 - SSNAP to be updated to include rehabilitation and ongoing care post-hospital episode
Diabetes	▪ Extend provision of structured education and digital self-management support trials, including flash glucose monitors for all type 1 patients by April

	2019, and, by 2020/21, all pregnant women with type 1 diabetes to be offered continuous glucose monitoring. ▪ Primary care networks to focus on improved care for patients with diabetes, and achievement of diabetes treatment targets.
Respiratory disease	▪ From 2019, RightCare to include focus on reducing variation in the quality of spirometry testing. ▪ Population health management approaches to be used to identify previously unrecognised patients who would benefit from pulmonary rehabilitation; generic cardiac and pulmonary rehabilitation programmes to be developed and rolled out across the NHS to increase capacity for rehabilitation. ▪ Pharmacists within primary care networks to support improved medication management for asthma patients
Adult mental health	Many of the commitments for adult mental health reiterate those made in the Five Year Forward View for Mental Health ▪ Continued expansion of Improving Access to Psychological Therapies services for adult with common mental health problems; new access standards to be developed and tested. ▪ New models of care to be developed by 2023/24 for adults with severe mental illness. ▪ 24/7 community-based mental health crisis response services to be available in all areas by 2020/21 ▪ Mental Health liaison services in Emergency Departments to be at 'Core 24' standards from 2023/24 ▪ By 2023/24 NHS 111 will be the single, universal point of access for people experiencing a mental health crisis; alternatives forms of service for those in crisis to be expanded. Specific waiting times for emergency mental health services will be in place by 2020. ▪ Reduction in acute out of area inpatient placements by 2021. ▪ Reducing suicide to remain a priority.
Short waits for planned care	▪ Expansion of back and neck pain community services through primary care networks, including direct access MSK First Contact Practitioner services. ▪ Sufficient funds allocated to grow the amount of planned surgery year-on-year for the next five years to cut long waits and reduce the waiting list. ▪ Use of independent sector capacity to continue, and Capacity Alerts to be introduces to support GP/patient decision making about choice of provider ▪ Reintroduction of 52 week wait fines ▪ Review of waiting time standards as part of the Clinical Standards Review ▪ Patients waiting 6 months for elective surgery to be offered an alternative provider ▪ Split of hot and cold sites encouraged where possible
Research and innovation	▪ Commitment to continued expansion of research and innovation, in support of the Life Sciences sector deal, and with a view to increasing the number of people registered to participate in health research to one million by 2023/24. People will be able to participate and register via the NHS App by 2020. ▪ Targeted investment in areas of transformative innovation, including the development of the new NHS Genomic Medicine Service. ▪ Simplified pipeline for developing innovations, linked to AHSNs and through the expansion of the NHS Test Beds programme. ▪ New MedTech funding mandate for health technology and pharmaceuticals which have been assessed as cost saving by NICE. ▪ AHSNs to have greater involvement in spreading innovations, including RightCare, GIRFT and NHS Innovation Acceleration programmes.

	▪ NHS Export Collaborative to be developed with Healthcare UK by 2021.

Implications for the RUH:

- Move to earlier diagnosis for major health conditions may change the profile of patients referred to the Trust, with a potential for increased numbers of patients with lower initial complexity.
- The Plan contains no specific reference to centralising Primary PCI services, although centralisation of Hyper Acute Stroke Services remains a priority for service development
- Potential benefits to the RUH from increased mental health support, particularly in front door areas and inpatients with mental as well as physical health needs.
- Changes to access standards expected from the Clinical Standards Review in October 2019 may have significant implications for service delivery.
- Routine offer of an alternative provider after 6 months on the elective waiting list has not been required to date, and will need support from CCGs to introduce, particularly for specialist work where there is no other local provider.
- Opportunities for the RUH to exploit our strengths in innovation and areas of specialised services

3.4 Chapter 4: NHS staff will get the backing they need

The NHS will need more staff, working in rewarding jobs and a more supportive culture. The Plan states a focus on development of primary care and generalist skills to balance the development of more specialist hospital based care in recent decades.

Health Education England (HEE) alignment with NHSI to improve workforce planning nationally.

Area of focus	Commitments
Workforce implementation plan	▪ Workforce Implementation Plan to be published in 2019; NHSI, HEE and NHE to establish a national workforce group to oversee implementation. ▪ Chief Midwifery Officer role to be created
Expanding nurses, midwives, AHPs and other staff	▪ Aim to improve nursing vacancy rate to 5% by 2028. ▪ 50% increase in clinical placements to be funded from 2020/21 ▪ Every graduation nurse and midwife to be offered a five-year NHS job guarantee within the region where they qualify. ▪ New online nursing degree to widen participation from 2020, offered at less than the current cost of degree courses ▪ Growth in apprenticeships - 7,500 new nursing associates to start in 2019, an expectation that all entry-level jobs will be offered as apprenticeships before considering other recruitment options and the opportunity for providers to take on a lead employer model. ▪ Annual national recruitment campaigns to be developed with the Royal Colleges and trade unions for priority roles ▪ Chief Allied Health Professionals Officer to further develop the national AHP strategy ▪ Expansion of numbers and role of community pharmacists through primary care networks.

Medical workforce	▪ Growth of medical school places from 6,000 to 7,500 per year ▪ Focus on growth of generalist training and roles to support patients with increasing co-morbidities, along with growth in GPs to support primary care networks. ▪ Two-year fellowships to be offered to GP trainees. ▪ Work with Royal Colleges, BMA and the GMC to increase opportunities and support to switch specialities, develop incentives to match speciality/geographical needs, enhance generalist skills and accelerate the development of credentialing.
International recruitment	▪ Expectation that international recruitment will continue to meet the gap between current workforce pressures and increased numbers in training over the next five years. ▪ New national arrangements to be developed to support NHS organisations in recruiting overseas, including working with professional regulatory bodies to ensure regulatory processes are effective. ▪ Continued work with the government on the post-Brexit migration system.
Supporting current staff	A new NHS Chief People Officer will take responsibility for: ▪ Improved health and wellbeing ▪ Flexible working ▪ Clarifying expectation on induction and mandatory training ▪ Enable staff to move more easily between NHS organisations ▪ Set expectations for support for staff raising concerns Other measures include: ▪ NHSI Retention Collaboration to improve staff retention by at least 2% by 2025 ▪ HEE to increase proportion of total budget spend on workforce developing in the short-term, with a focus on primary care and community settings. ▪ Accelerated development of multi-professional credentials, for example the Advanced Level Nurse Practitioner scheme. ▪ Development of a model employment culture across the NHS – reduce bullying and harassment, flexibility, wellbeing and career development. ▪ Each NHS organisation to set its own target for BAME representation across its leadership team and broader workforce by 2021/22. Workforce Disability Equality Standard to be developed.
Productive working	Ensuring staff are making the most of their skills and expertise will be a key focus for the NHS workforce implementation plan. ▪ HEE Workforce STAR tool to be deployed to support the work. ▪ E-rostering to be in place by 2021 ▪ Review of workforce data will be undertaking as part of the workforce implementation plan.
Leadership and talent management	▪ New NHS Leadership Code to set out the cultural values and leadership behaviours ▪ National workforce group to look at options to improve the NHS leadership pipeline, building on the Kerr and Kark reviews
Volunteers	▪ Enhanced volunteering opportunities, in particular for young people from deprived areas and for those with learning disabilities and mental health issues, with a national ambition to improve staff to volunteer ratio to be in line with top performance Trusts (2:1).

Implications for the RUH:

- This area of the plan is of critical importance to successful delivery. Work to understand this and any risks in more detail will follow publication of the Workforce Implementation Plan (to be published later in 2019).
- The intention to enhance generalist training presents opportunities for generalist services at the RUH, though there could also be potential longer term risks for specialist areas particularly where there are existing workforce pressures.
- Opportunity to build further on our existing expertise with apprenticeships.
- Opportunity to review and benchmark our approach to volunteer recruitment and utilisation.

3.5 Chapter 5: Digitally enabled care will go mainstream across the NHS
Expectation that the model of care will look markedly different in ten years' time, with a 'digital first' option for most services, digital tools supporting care, monitoring, self-care and clinical decision making, and enhanced data sharing between organisations.

Practical priorities' for NHS digital transformation:

- Create straightforward digital access to NHS services, and help patients and their carers manage their health.
- Ensure that clinicians can access and interact with patient records and care plans wherever they are.
- Use decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition.
- Use predictive techniques to support local health systems to plan care for populations.
- Use intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administrative burden.
- Protect patients' privacy and give them control over their medical record.
- Link clinical, genomic and other data to support the development of new treatments to improve the NHS, making data captured for care available for clinical research, and publish, as open data, aggregate metrics about NHS performance and services.
- Ensure NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.
- Mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.
- Encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.

Area of focus	Commitments
Empowering people	▪ Continued development of the NHS App (along with the NHS Apps Library and NHS login), as a standard online way for people to access the NHS. ▪ By 2020, every patient with a long-term condition will have access to their health record through the Summary Care Record, accessed via the App. By 2023/24, all pregnant women to be able to access their maternity record via the App. ▪ Development of a range of apps to support particular conditions – for example diabetes.

Supporting health and care professionals	▪ All community based staff to have access to mobile digital services, including the patients care record within 3 years. ▪ Expansion of digital leadership through the NHS Digital Academy programme.
Supporting clinical care	▪ New wave of Global Digital Exemplars ▪ By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and LHCRs will cover the whole country. ▪ Technology to support redesign clinical pathways, for example, for outpatient follow-ups. ▪ By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices.
Improving population health	▪ By 2021/22, systems that support population health management in every Integrated Care System across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.
Clinical efficiency and safety	▪ Enhanced infrastructure to support digital developments - by 2021, 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.

Implications for the RUH:

The RUH has a developed a strong foundation upon which to build towards these commitments given the significant digital investment already made, for example investments in Millennium platform, e-prescribing, cyber security, and most recently patient flow. The Plan's commitments are however broad and will require more detailed evaluation of impact through the approach identified at appendix 2.

3.6 Chapter 6: Taxpayers investment will be used to maximum effect

The new funding settlement announced in June 2018 delivers a real terms increase in NHS funding of £20.5bn by 2023/34; a 3.4% increase year on year.

The NHS is expected to meet five 'tests':

Test 1: The NHS (including providers) will return to financial balance

Three key objectives:

- Continue to balance the NHS's books nationally
- Reducing the aggregate provide deficit each year, and returning to balance by 2020/21
- Reducing year-on-year the number of trusts and CCGs individually in deficit, so that all NHS organisations are in balance by 2023/24.

Measures to support these objectives include:

- Changes to payment arrangements and allocations to take better account of the costs of delivering efficient services locally, achieved by phasing in an updated Market Forces Factor over the next five years.
- Reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population-based.
- Move to a blended payment model, beginning with urgent and emergency care.

- ICSs to become the level of the system where commissioners and providers make shared decisions about financial planning, and prioritisation.
- New Financial Recovery Fund to support the return to financial balance in the provider sector.

Test 2: The NHS will achieve cash releasing productivity growth of at least 1.1% a year
Ten priority areas over the next two years:

- Reduction in bank and agency costs though eRostering by 2021 and the use of evidence-based approached to determining staffing numbers by 2023.
- Procurement savings by aggregation of volumes and standardising specifications, supported by the new NHS procurement organisation Supply Chain Coordination Limited
- Delivering pathology and imaging networks to improve the accuracy and turnaround times on tests and scans, and reduce unit costs
- Improved efficiency in community health services, mental health and primary care.
- Medicines management, including the new statutory and voluntary pricing and access schemes for medications
- Further efficiencies in administrative costs from providers and commissioners
- Improved space utilisation, delivering a 5% reduction in non-clinical space, and a reduction by a third from 2007 levels in the NHS's carbon footprint
- Reduction in ineffective interventions
- Improved patient safety through a new ten-year national strategy, to be published in 2019.
- NHS Counter Fraud Authority to continue to tackle patient, contractor, payroll, or procurement fraud.

Test 3: The NHS will reduce the growth in demand for care through better integration and prevention
See Chapters one, two and three of the Plan (pages 2–9 of this paper).

Test 4: The NHS will reduce unjustified variation in performance
See Chapters two, three and six of the Plan (pages 6-15 of this paper).

Test 5: The NHS will make better use of Capital investment and its existing assists to drive transformation
Maximise the productivity benefits we generate from our estate, through improving utilisation of clinical space, ensure build and maintenance is done sustainably, improve energy efficiency and release properties not needed to support the government's target of building new houses.

Reforms of the NHS capital regime to be considered.

Implications for the RUH

- The RUH has already some experience with blended payments, however wider mandated changes to payment mechanisms outlined in test 1 will inevitably mean significant changes to the financial framework within which we operate; 2019/20 is a transitional year, with the full impact expected by the end of the first five years of the Plan.

- Our Better Value, Better Care (QIPP Delivery) Group is currently actively reviewing the ten opportunities outlined in test 2 – initial findings indicate reasonable progress already in hand across the majority of areas.

3.7 Chapter 7: Next steps

National implementation framework to be published in Spring 2019. Local health systems to receive five-year indicative financial allocations for 2019/20 to 2023/24 and be asked to produce local plans for implementing the commitments set out in the Long Term Plan in 2019.

ICSs are critical to implementation of the Plan, and will be in place nationally by April 2021.The Health Foundation will support QI capacity and capability in ICSs to support implementation of the plan.

The Plan identifies three areas of development to underpin the Plan:

A new way of working

- NHS England and NHS Improvement will implement a new shared operating model designed to support delivery of the Long Term Plan, focussed on supporting service improvement transformation across systems, strong governance and accountability mechanisms across the NHS and improved use and quality of data for decision making.
- As ICSs take hold, organisations will take on greater collaborative responsibility, with 'Mutual Aid' an integral feature of system working.

Possible legislative change

Provisional list of potential legislative changes developed for Parliament's consideration, to:

- Give CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability, both for their local NHS system and for the wider NHS
- Remove specific impediments in the 2012 Health and Social Care Act to 'place-based' NHS commissioning, for example lifting restrictions on how CCGs can collaborate with NHSE.
- Support the running of ICSs by letting trusts and CCGs exercise functions and take decisions jointly.
- Support the creation of NHS Integrated Care Trusts
- Remove the Competition and Markets Authority's power to intervene in NHS provider discussions, and its powers in relation to NHS pricing and NHS provider licence conditions.
- Repeal the specific procurement requirements in the Health and Social Care 2012 Act
- Increase flexibility in the NHS pricing regime
- Allow NHSE and NHSI, at a minimum, to establish a joint committee and subcommittees to exercise their functions.

Engaging people

NHS Assembly to be established in 2019, to being together a range of organisations and individuals to advice the board of NHSE and NHSI on implementation of the plan.

4. Next steps

The following steps are proposed to **share the content** of the Plan within the Trust:

- Presentation to senior managers at What's Going On briefing, 25 January.
- Development of a web page, signposting staff to further resources (see Appendix 1)

The following steps are proposed to **monitor progress towards delivery of the Plan:**

- Updates following key publications related to the Plan (see below):

Spring 2019	National NHS 10 Year Plan implementation framework published
Summer 2019	Richards review of current cancer screening programmes and diagnostic capacity published
October 2019	Publication of Clinical Standards Reviews
2019	New Ten Year National Patient Safety Strategy Workforce and Capital plans published .

- Assessment of current RUH performance against the commitments outlined in the plan (appendix 2) updated and monitored through Strategic Assurance Committee from March 2019.

- Relevant teams to conduct more detailed review the implications of the plan – this has commenced in HR and Finance.

Appendix 1: Further resources

The 10 Year Plan	NHS 10 Year Plan NHS 10 Year Plan Executive Summary Long Term Plan website NHS Providers briefing on the 10YP
Previous Strategy Documents	NHS Five Year Forward View Five Year Forward View for Mental Health
New models of care	Summary of the Vanguard sites Information on primary care networks Enhanced Health in Care Homes vanguard model NHS Personalised Care model Digital GP services - Babylon
Integrated Care	Integrated Care Systems home page Kings Fund review of the Salford model
Improving health care	NHS Diabetes Prevention Programme NHS five year action plan on Antimicrobial Resistance maternity digital care records Learning Disability Improvement Standards Rapid Diagnostic Centres 'Core 24' mental health liaison service standards Global Digital Exemplars
Workforce	HEE Workforce STAR tool NHS AHP strategy Kerr Review - empowering NHS leaders to lead Kark review - Fit and Proper Persons Requirement

Appendix 2: Implications for the RUH

Chapter	Ref	Commitment	RUH baseline	Risk assessment	Next review date	Lead	Further information
Chapter 1: A new service model for the 21st century	1.8	Reablement care within two days of referral	tbc	tbc	Annual	System	n/a
	1.28 - 1.30	One third of acute admissions discharged on the day of attendance	tbc	tbc	In year	Medicine, Surgery, Women and Childrens	https://www.acutemedicine.org.uk/guidelines-and-reports/samba18-interim-report/
Chapter 3: further progress on care quality and outcomes	3.36	By 2023.24, all NHS care will need to meet the Learning Disability Improvement Standards	tbc	tbc	Annual	Trust-wide	https://improvement.nhs.uk/documents/2926/v1.17_Improvement_Standards_added_note.pdf