BMA

The NHS long-term plan: What does it mean for BMA members?

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British Medical Association
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Overview

On the 7th January NHS England published their much anticipated long-term plan for the NHS. This briefing for members provides a summary of the key announcements, and what they may mean for doctors.

The plan sets the strategic direction for the NHS in England over the next 10-years, and will be followed by local areas developing their own plans to deliver the ambitions within it. The BMA will continue to engage locally and nationally to ensure that, now the long-term plan has been published, we help ensure it delivers a health service that doctors want to work in, and that provides high-quality care for patients. We have been clear that while it sets out welcome ambitions, these will be difficult to deliver in the face of inadequate funding, staffing gaps, pressures on social care, and the risks that Brexit poses to the NHS.

The BMA's media response to the long-term plan is available here. You can read the BMA's response to NHS England's consultation on the long-term plan here.

> "If we are to truly transform the care we give to patients, and create a sustainable, world-class health service, this long-term plan must deliver beyond grand ambition and address the realities faced by doctors, NHS staff and patients today."
>
> **Chaand Nagpaul, BMA council chair**

Workforce

- A workforce implementation plan will be published later in 2019, once the amount of funding for training, education and CPD (continuing professional development) has been set by government, which will include:
  - new national arrangements to support NHS organisations in overseas recruitment
  - a focus on reducing geographical and specialty imbalances
  - a shift from a dominance of highly specialised roles to more generalist ones
  - a 'new deal' on tackling bullying and harassment of frontline staff
  - education and training changes which may be needed to maximise the opportunities of technology, artificial intelligence and genomics in the NHS
  - plans to recruit an additional 1,500 new clinical and diagnostic staff for cancer, across seven priority specialisms between 2018 and 2021
  - plans to meet the commitment of an additional 5,000 GPs – a commitment from the General Practice Forward View (2016)
  - consideration of the potential benefits and operation of a professional registration scheme for senior NHS leaders, similar to those used in other sectors of the economy and amongst other NHS professionals.

- A national workforce group will be established to implement the plan, led by NHS Improvement, along with Health Education England and NHS England.

- Funding for expanded community multidisciplinary teams will be provided through new Primary Care Networks (primary care networks – groups of GP practices covering populations of between 30,000 to 50,000). These will provide GP practices with access to clinical pharmacists, link workers, first contact physiotherapists and physician associates, with additional groups such as community paramedics to be added in future. Details are being discussed as part of the ongoing national GP contract negotiations and will be announced in due course.

- The plan includes a range of new nursing initiatives, including a 25% increase in nurse undergraduate places from 2019/20, more funding for clinical placements, five-year job guarantees for graduates and a new online nursing degree.

- The long-term plan highlights vacancies as a major strain on the workforce and states that the current number is unsustainable.

- There will be a review of NHS workforce data collections and sources.

- An extra £1 million a year to extend the work of the Workforce Race Equality Standard (WRES) into 2025. In addition, each NHS organisation will set its own target for Black, Asian and Minority Ethnic representation across its leadership team and broader workforce by 2021/22.

- The plan mentions support for flexible working and using technology to enable staff to indicate shift preferences further in advance but does not provide detail.

- Incentives will be developed to ensure that the specialty choices of trainees meet the needs of patients by matching specialty and geographical needs, especially in primary care, community care and mental health services.

- The plan commits to working with the BMA to look at ways to allow trainees to switch specialties without re-starting training; accelerate development of credentialing; and how to reform and re-open the Associate Specialist grade.

BMA analysis

- The long-term Plan is relatively light on new information when it comes to workforce, with much of the detail postponed until the publication of the workforce implementation plan later in 2019. The BMA welcomes the creation of a national workforce group which will oversee the implementation of the plan and we will be writing to NHS Improvement to ensure that we are represented on this group.

- We welcome the commitment to 'a new deal' on bullying and harassment and look forward to more detail on this. It is essential that more comprehensive and widespread efforts are made to address bullying and harassment, as discussed the in the BMA's 2018 report.

- The GPFV (General Practice Forward View, 2016) commitment of increasing GP numbers by 5,000 has been reinforced, but they are now needed 'as soon as possible', with no mention of the original target date of 2021. Achieving this increase, even without a target date, will be a major task given that GP numbers have decreased since the GPFV was published.

- It is encouraging that vacancies have been acknowledged as a problem, however, data quality in this area needs to improve. Currently job adverts are used as an inadequate proxy for vacancies, and medical vacancies are not broken down by grade. For effective workforce planning to take place, the definition for what constitutes a vacancy should not be locally determined by individual employers. The BMA therefore welcomes the decision to carry out a review NHS workforce data collections and sources.

- We welcome the commitment to work with the BMA in developing incentives to deal with geographical and specialty trainee shortages, which must focus on providing high-quality training placements across geographical areas. We maintain that flexible pay premia of the kind used in the junior doctor contract should not be developed further. Well-resourced terms and conditions that are developed in partnership with doctors, and which recognise and value those working the most onerous shift patterns, are the best way to tackle workforce shortages over the long-term.

NHS funding

The plan has confirmed the new funding settlement announced by the Prime Minister in June 2018 promising NHS England's revenue funding would grow by an average of 3.4% in real terms a year over the next five years, delivering a real-terms increase of £20.5 billion by 2023/24. It sets out five 'tests' to put the NHS back onto a sustainable financial path:

1. **The NHS (including providers) will return to financial balance**
   - The NHS will use the funding settlement to balance the NHS books nationally and reduce the provider deficit.
   - Overall reforms to the payment system will move funding away from activity-based payments and ensure a majority of funding is population-based.
   - Urgent and emergency care will move to a blended payment model, of activity-based and block payments
   - 2019/20 will be a transitional year, with new one-year control totals.
   - NHS Improvement will deploy an accelerated turnaround process in the 30 worst financially performing trusts.
   - Beyond 2019/20 further financial reforms will be introduced that will support ICSs (Integrated Care Systems) to deliver integrated care.

2. **The NHS will achieve cash-releasing productivity growth of at least 1.1% per year**
   Efficiency and productivity gains of at least 1.1% a year will be made over the next five years, focussing on:
   - improving the availability and deployment of the clinical workforce, further reducing bank and agency costs
   - procurement and administrative savings
   - delivering pathology and imaging networks to improve the accuracy and turnaround times on tests and scans
   - improving efficiency in community health services, mental health and primary care.
   - delivering value from the £16 billion spent on medicines
   - reducing inappropriate interventions that are not clinically effective
   - improving patient safety will reduce patient harm and the substantial costs associated with it through a new ten-year national strategy, to be published in 2019
   - the NHS Counter Fraud Authority will continue to tackle patient, contractor, payroll, or procurement fraud.

3. **The NHS will reduce the growth in demand for care through better integration and prevention**
   See sections on 'Service reform' and 'Prevention and health inequalities'.

4. **The NHS will reduce unjustified variation in performance**
   Individual programmes have been designed to narrow variation in health outcomes and reduce inequalities.

5. **The NHS will make better use of capital investment and its existing assets to drive transformation**
   In addition to the £3.9 billion capital investment announced at the Spring and Autumn budgets 2017, NHS long-term capital investment will be considered in the 2019 Spending Review. Reforms to the capital funding regime will be set out in detail alongside this.

BMA analysis

Additional funding

– Although extra funding for the NHS is welcome, this additional funding will only be applied to NHS England's budget rather than the overall health budget (Department of Health and Social Care expenditure). This means it excludes vital areas such as education and training, capital investment and also public health. It is crucial that there is also growth in these areas as they have a huge impact on patient care.

– It is also widely agreed that this extra funding does not go far enough to cope with rising patient need. As the BMA has highlighted, improving the quality and range of care provided would require an increase in spending at a faster rate – growing by 4.1% annually over the next 15 years. A significant proportion of the additional funding announced will also go towards filling large provider deficits, reducing the funding available for service improvement and transformation.

Payment system reform

– We welcome the proposal to move away from activity-based payment systems due to our concerns with the current national tariff as the main way for paying acute providers in England. The national tariff enables many different providers to treat patients for different conditions or procedures, including from the independent sector, which can lead to fragmented services and care.

– The BMA would prefer to see a payment model that facilitates and encourages closer working between different parts of the health service, around the needs of patients. Population based systems, such as capitation, may be able to achieve this as they allow funding to follow the patient and cover the care pathway. However, these systems must reflect local population need and take a range of issues into consideration, such as differences in rural and urban populations and services.

Efficiency savings

– Efficiency factors have been judged as the biggest challenge to achieving financial balance by NHS providers. Although the 1.1% per year savings set out by the plan are lower than the efficiency factor set in previous years for providers, achieving these savings may be unrealistic given the local deficits that exist.

– 44% of trusts overspent their budgets in 2017/18, with the NHS provider sector as a whole ending 2017/18 with a deficit of £960 million. These deficits have nearly halved but are still significant, with NHS trusts are forecasting to end 2018/19 £558 million in deficit.[1] Therefore, plans to achieve the 1.1% productivity growth must not require providers to make additional savings that they cannot afford which could impact clinical quality and put patients at risk.

Capital investment

– It is crucial that government provides sufficient long-term capital investment to the NHS, including for the transformation of NHS estates. The £3.9 billion already committed to estates is far from what is needed. Therefore, the announcements in the Spending Review 2019 will be crucial.

– The 2018 budget confirmed that the use of PFI for new projects will be terminated, however, existing PFI contracts will continue. The long-term plan makes no reference to PFI and the long-term strategy for PFI hospitals.

1 The Kings Fund (2018) Trusts in deficit.

Service reform

- The plan sets out five key areas for reform of the NHS service model; **primary and community care**; **emergency and urgent services**; **personalised care**; **digitalisation; and local integration.**

- £4.5 billion has been allocated to primary and community care services, funding the rollout of PCNs. Funding for primary and community care will increase at a faster rate than overall NHS funding. Practices will be mandated to join PCNs, but without giving up their GMS contract. Multidisciplinary teams (GPs, pharmacists, district nurses, social care staff and others) will provide enhanced services within the networks, and in primary and community care hubs (which offer access to a range of primary, community, preventative, and non-urgent secondary (outpatient) services at a single site).

- With the aim of reducing pressure on hospitals, more care is expected to be provided at UTCs (Urgent Treatment Centres) and the UTC model will be implemented nationwide by autumn 2020. A single Clinical Assessment Service (across NHS111, ambulance dispatchers, and GP out-of-hours providers) is also expected to be in place in 2019/20. All major A&E departments will also adopt a Same Day Emergency Care model (with patients admitted, treated and discharged the same day when appropriate) during 2019/20.

- NHSE intend to roll out the NHS Personalised Care model (which focuses on supporting patients to manage their own conditions and to make shared decisions with clinicians regarding their care) nationally, reaching 2.5 million people by 2023/24, with an aim for 200,000 people to have a PHB (personal health budget) by 2023/4 and to have trained 1,000 social prescribing link workers by the end of 2020/21.

- Over the next five years, every patient will have a right to access telephone or online consultations. The plan also aims for digitalisation and virtual appointments to remove the need for up to 30 million outpatient visits a year.

- ICSs– which bring together different parts of a local health system to jointly plan care for patients in their area – are now expected to cover the whole country by April 2021. The plan establishes a blueprint for the development of every ICS – including a requirement to engage directly with GP leaders via PCNs, and that each ICS will need to agree system-wide plans with NHS England and NHS Improvement. Less advanced systems will receive intensive support from regulators to progress towards ICS status, and the number of CCGs will also be reduced, with an aim of a single CCG per ICS footprint.

- The Integrated Care Provider (ICP) contract will also be available in 2019, as an alternative to the ICS model and with an expectation that they would be held by public and statutory bodies – NHS England has also set out its hopes for legislation that would support this and potentially limit competition and privatisation within the NHS (see 'proposed legislative change' below).

BMA analysis

- BMA members have identified that organisational barriers are a hindrance to quality patient care and professional relationships, with 92% of doctors saying that they were unhappy with current arrangements between primary and secondary care in a 2018 survey of all BMA members. Therefore, the ambitions set out in the plan to reduce those barriers is welcome. Achieving this will be challenging given the pressure the entire health system is under – in the past funding set aside for transforming services has had to be diverted to deal with day-to-day pressures.

- Increasing capacity in primary and community care has the potential to benefit the whole NHS if implemented effectively. The BMA has long argued for greater investment in general practice (most recently in GPC's *Saving general practice* paper), which in recent years had received a shrinking proportion of the NHS budget. We will look closely at the detail of the £4.5bn funding settlement when this is made available.

- The plans set out for PCNs clearly have implications for general practice and are part of ongoing negotiations between GPC and NHS England. Many practices have already been working as part of networks on their own initiative – though the contractual changes outlined in the plan will certainly facilitate and support that trend. We are working to ensure the changes are beneficial for GP practices allowing them to work across the community and welcome that no practice would need to give up their GMS contract as a result of the establishment of PCNs.

- It is vital that in pursuing its ambitions for an expanded primary and community care model, the NHS continues to support secondary care and other parts of the health service which are also under pressure. The plan makes a welcome commitment not to reduce bed numbers in secondary care, but as the BMA has highlighted there is a need for an increase in bed capacity. The plan also does not make any commitments to return the NHS to regularly meeting key waiting time targets such as the four-hour A&E wait and the 85% bed occupancy target. This is worrying, and reflects the fact that the extra funding made available by the government is still not enough to deliver the level of service doctors want to provide to their patients, and that patients should reasonably expect.

- The plan clearly emphasises ICSs as NHS England's preferred model of integration, with ICPs (which the BMA has expressed significant concerns about) only briefly mentioned. The timeline and blueprint for ICSs also provides important clarity regarding when and how they will come into force and the clear expectation on ICSs regarding clinical engagement, with recognition of the need to engage GPs, is welcome but ICSs must properly engage with frontline clinicians across all branches of practice. It is essential that NHS England must be clear about the funding each ICS will receive and what capital investment they will have to pursue any plans they produce.

Prevention and health inequalities

- The plan focusses on the top five leading lifestyle factors leading to premature death in England: smoking, poor diet, high blood pressure, obesity and alcohol and drug use. It also includes air pollution and lack of exercise.
- In each of the areas it covers specific actions such as offering NHS-funded tobacco treatment services to all people admitted to hospital who smoke; funding a doubling of the NHS diabetes prevention programme; and establishing alcohol care teams in those hospitals with the highest rate of admissions related to alcohol dependence.
- In order to help tackle health inequalities, the plan commits NHS England to continue targeting a higher share of funding towards geographies with high health inequalities.
- The Government and the NHS will consider whether there is a stronger role for the NHS in commissioning certain public health services (sexual health services, health visitors, and school nurses).

BMA analysis

- The role of the NHS in delivering specific measures (such as expanded alcohol care teams) is welcome and important, but the effectiveness of NHS-led measures will be limited without commitments to effective population-wide measures, such as a minimum unit price for alcohol; reducing sugar levels in food; and greater restrictions on junk food marketing.
- The ambitions set out in the plan are being severely undermined by repeated cuts to funding for local government to provide public health services, as the BMA has previously highlighted. Only by adequately funding public health, both through the NHS and by reversing cuts to local authorities and services that tackle smoking, alcohol consumption, physical inactivity and diet, will the government meet their ambition to really prioritise prevention.
- The plan rightly states that action by the NHS should be a complement to, rather than a substitute for, the important role of local government. There is a recognition that the NHS has a role in funding and commissioning preventative health services, which is welcome if this leads to an injection of much needed resources into local public health services. However, any new funding for NHS services will need to start by supporting existing services rather than demanding further work from an already over-stretched public health staff.
- The NHS commissioning services will also not solve the problem of the attack on the pay and conditions of public health staff in local authorities and the consequent loss of staff to the service. Nor will it help reinforce the autonomy of public health professionals within local authorities and their vital right to speak out on behalf of the local populations.
- As the plan recognises, inequalities are associated with significant financial and health costs. While there is a welcome focus on the measures the NHS will take, such as targeted funding, the factors that influence inequalities are much wider than the health system, and the government as a whole should be adopting a health in all policies approach to prioritise prevention.

Care quality and outcomes

The plan highlights a range of priorities for improving care quality and outcomes:

A strong start in life for children and young people

- It sets out work programmes to improve care quality and outcomes for children and young people in several areas including maternity and neonatal services, mental health services, learning disability and autism support, cancer and redesigning other health services.
- Key targets include accelerating action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025; introducing maternity digital care records; and improving postnatal physiotherapy.

Better care for major health conditions

- The plan focuses on the top five causes of early death in England: heart disease and stroke, cancer, respiratory conditions, dementia and self-harm. For each it sets out action and ambitions such as improving early cancer diagnosis for three-quarters of all patients by 2028 and preventing up to 150,000 heart attacks, strokes and dementia cases.
- It renews the commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years, including expanding access to IAPT (Improving Access to Psychological Therapies) services and expanding emergency mental health support.

The plan also includes commitments to supporting research and innovation as a means of improving outcomes.

BMA analysis

A strong start in life for children and young people

- The focus on child health is important and something the BMA has consistently called for. While there is a welcome emphasis on perinatal mental health, BMA members have expressed concern that there remains some way to go to ensure specialist perinatal mental health services are available to all mothers that need them.
- The commitment to funding for children and young people's mental health services to grow faster than both overall NHS funding and total mental health spending is positive and in line with calls from the BMA. However we have also previously highlighted concerns that promised funding is not reaching frontline services. The plan is also unclear on the specifics of how the additional funding will expand community-based mental health services. The positive impact of the new funding will depend on these issues being addressed.
- Our members have also highlighted concerns about the transition for individuals from child to adult mental health services, we therefore welcome the recognition that a new approach is required to support those aged 18-25.
- While there is some discussion of the role of the NHS in supporting those with a learning disability or autism, and a recognition that waiting times are too high, there is no specific target and few specific measures or funding to reduce the time children and young people are waiting.

Better care for major health conditions

- There are a number of specific commitments and ambitions to tackle major causes of death, such as cancer, cardiovascular disease and stroke. However, there is limited recognition of multimorbidity or the long-term management of chronic conditions and the effect this can have on care and services. This misses a key opportunity to reconsider how we think about and treat major health conditions.
- The increased share of the NHS budget for mental health services is again welcome but needs to reach frontline services.
- The plan commits to expansion of IAPT services. It is important that this is not at the expense of psychological therapies in secondary care, which data recently published by the BMA has highlighted are being deprioritised.

Research and innovation

- While there is some recognition of the role research and innovation has to play in the NHS, and specific measures such as increasing the number of people registered to participate in research – in line with calls from the BMA – the plan fails to recognise that everything the NHS does is built upon research. Specific innovations such as genomics have an important role to play, but should not be prioritised at the expense of giving NHS staff the time and training to participate in research more generally.

- The plan does not recognise the impact of the UK leaving the EU, which for research will be significant. For example, support for research into rare conditions is particularly dependent on a continued relationship with partners in the rest of the EU. The approval of new medicines, devices and technologies may also be delayed as a consequence of our exit from the European Medicines Agency. It is vital that research is a key priority of our future relationship with the EU.

Digital and technology

- 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 Local Health Care Records will cover the whole country.
- By 2021, NHS Improvement will support NHS trusts and foundation trusts to deploy electronic rosters or e-job plans.
- During 2019 controls will be introduced to ensure new systems purchased by the NHS comply with agreed standards.
- By 2020 every patient with a long-term condition will have access to their Summary Care Record via the NHS App.
- Digital-first primary care will become a new option for every patient. Over the next five years every patient in England will have a new right to choose this option – usually from their own practice or, if they prefer, from one of the new digital GP providers.
- By 2020, five geographies will deliver a longitudinal health and care record platform, to facilitate care planning between NHS and local authority organisations, three additional areas will follow in 2021.
- By summer 2021, we will have 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.
- In 2021/22, we will have systems that support population health management in every ICS across England, with a Chief Clinical Information Officer (CCIO) or Chief Information Officer (CIO) on the board of every local NHS organisation.
- By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices.

BMA analysis

- The plan provides some additional details and timescales for policies previously outlined in the DHSC's document, '*The future of healthcare: our vision for digital, data and technology in health and care*' (October 2018). We will soon be publishing a more in-depth analysis of the vision, taking into consideration the additional information provided in the plan.
- The Secretary of State promised in his September 2018 letter to BMA Chair, Chaand Nagpaul, that he would be pushing every NHS Trust towards implementation of e-rostering, so the BMA welcomes the presence in the long-term plan of a deadline for completion.
- With such a wide range of promised technological innovations, a significant financial outlay will be required. The plan does not provide any detail on additional funding allocations for digital development, so it remains to be seen how each part of this ambitious programme will be resourced.

Next steps and proposed legislative change

NHS England have set out the next steps for the delivery of the long-term plan. This includes the development of local delivery plans as well as a list of potential legislative changes for Parliament's consideration.

Local delivery plans

Local health systems will receive five-year indicative financial allocations for 2019/20 sto 2023/24 and be asked to produce local plans for implementing the long-term plan. This will include:

- by April 2019 to have developed one-year plans for 2019/20
- by Autumn 2019 to have published local five-year plans.

Proposed legislation

- Within the 'Next Steps' section of the long-term plan, possible legislative changes are included which would enable 'more rapid progress' towards the aims of the plan. The document stipulates that generally the aims of the plan can be achieved without legislative change but would be expedited by changes to the law.
- NHS England have developed a provisional list of potential legislative changes for Parliament's consideration. It is proposed that new legislation would:
  - Give CCGs and NHS providers shared new statutory 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 to 'place-based' NHS commissioning.
  - Support the more effective running of ICSs by letting trusts and CCGs to exercise their functions through joint committees.
  - Support the creation of NHS integrated care trusts.
  - Remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care.
  - Cut delays and costs of the NHS automatically having to go through procurement processes.
  - Increase flexibility in the NHS pricing regime.
  - Make it easier for NHS England and NHS Improvement to work more closely together.

BMA analysis

- Much of the proposed legislative changes are to facilitate the introduction of 'place based' commissioning, namely integrated care systems (ICS) and integrated care providers (ICP). This includes specific recommendation to remove the 2012 Health and Social Care Act competition and procurement regulations, a long-standing priority of the BMA.

- Any legislative changes would be subject to the appropriate parliament processes and scrutiny including pre-legislative scrutiny. The BMA will proactively engage on all relevant areas of legislative change with a view to influence the shape of the future legislation.

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