Shaping the long term plan for the NHS

Building the future of care to 2028

For the attention of: Directors, policy and team leads, NHS England

From: The National Voices coalition of 140 health and care charities

National Voices

Summary of the key points

This briefing presents an account, in detail, of a coherent vision for improving health and wellbeing outcomes through interlinked actions across the priority workstreams of the long term plan. Here, we pick out single key points to help the teams involved.

Specific clinical priorities

- In addition to the clinical priorities identified (cancer, mental health and cardiovascular disease) the plan must also have something to say for people with other conditions, such as diabetes, musculoskeletal, neurological and rare conditions.
- On maternal and child health, recommit to existing ambitions to halve the numbers of stillbirths, neonatal and maternal deaths.
- On 'healthy childhood', commit to a goal for children and young people's health: halving health inequalities, reducing mortality rates and providing seamless services.
- Make end of life care a priority, and drive achievement of the national Ambitions.

Underpinning model: investment in a shift to holistic, personalised and coordinated care

- Across the clinical priorities *and* to tackle the challenge of multimorbidities and long term conditions, the biggest priority for investment should be joined up, strengthened primary and community level care, including from VCSE groups.
- All groups with single or multiple long term conditions can benefit from a shift to holistic, personalised and coordinated care.
- This shift means committing to the already developed personalisation plan, and putting its achievement into the goals of all workstreams for the long term plan.
- It means embedding the Comprehensive Model for personalised care in all local systems to benefit all patients (through shared decision making) and particularly those with long term conditions.
- The workstream on 'integrated and personalised care' should be reframed. This shift is not only about older people with complex needs. Multimorbidity occurs across the age range and is prevalent in young to middle age groups especially in deprived communities. What's more, parts of the Comprehensive Model are universal for all patients – such as participation in shared decision making.

Primary care networks

- Primary care networks (PCNs) should be developed at the speed with which local workforces are engaged, relationships established and trust secured.
- PCNs need to be further defined; coproduced with people and communities; and tasked to achieve the Comprehensive Model for personalisation.
- Population health management should be the context for these changes and needs prominence in the workstreams. NHSE/I should develop and promote a 'gold standard' approach to avoid the risk of this being a reductive, technical exercise; and ensure it is the driver of proactive strategies for better health and wellbeing.

Prevention – and secondary prevention

- Prevention needs new investment and strategies; but a further priority should be secondary prevention – saving very many quality years of life by preventing the exacerbation of existing conditions, and delaying or avoiding the onset of multimorbidities.
- Secondary prevention means much greater support for people's self-management.

Incorporating health inequalities in all key workstreams

- These new strategies and investments should all have health inequalities at the centre. Population health management, personalised care and strengthened, scaled up general practice should be targeted at those with most to gain: excluded groups and those with low health literacy and activation.
- The inclusion health agenda should be revived and inclusion health strategies should be part of all Sustainability and Transformation Partnerships (STPs)/Integrated care systems (ICSs) and primary care networks.
- Tackling inequalities should be a key goal for the three main clinical strategies –cancer, mental health, cardiovascular disease – and those for maternal and neonatal health, and for children and young people.

System architecture and enablers

- New NHS funding must go towards the transformation of primary/community care;

- Core NHS funding should also be rebalanced over the ten years, to strengthen care close to home;
- Primary care should be enabled to pull in resources from secondary care such as diagnostics and other clinical support, and to engage the expertise of staff currently based in hospitals, to support prevention, secondary prevention and holistic care closer to home;
- NHSE/I should explore the implications for acute care, from redesigning primary care, including where decommissioning is possible, and how to manage single disease pathways in future.
- Current approaches to outcomes and payment should be replaced, starting with the next round of NHS Shared Planning Guidance. A single, simple, cross-sector outcomes set should be adopted in partnership with other system leading bodies; and payment should reward the achievement of these outcomes.
- The NHS must up its game on identifying, supporting and training informal carers.
- Plans will be required to retrain current staff, and to educate future professionals, to gain the knowledge, skills and confidence to deliver personalised, holistic and coordinated care.

Partnership, including with the VCSE sector

- Overall, this agenda is developmental and relational, and can only be achieved through partnerships, especially with staff and professional organisations and networks, local government, and the VCSE sector, patients and communities.
- The VCSE sector needs to be recognised for its diversity of organisations and wide range of potential contributions – not just as alternative providers – and to receive a share of the new funding to maximise the value of these.
- NHS England should designate a single department or team to lead the development of enablers for the range of contributions that the VCSE can make.