****

**NHSE policy documents – briefing for ARMA members**

Since the NHS Long Term Plan (LTP) was published on 7 January 2019, three further documents have been released which give further detail on how the LTP might play out. This document attempts to summarise key points from these which might interest ARMA members.

The documents are:

* NHS Operational Planning and Contracting Guidance 2019/20 – how the additional funding for the NHS should be used.
* Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan – includes the roll out of the Primary Care Networks model which will be important for the delivery of the ARMA “Core offer”.
* Universal Personalised Care: Implementing the Comprehensive Model – provides detail on the personalised care aspects of the LTP.

1. **NHS Operational Planning and Contracting Guidance 2019/20**

This document is focused on how the additional funding settlement for the NHS should be used. It is the start of the process of producing the local plans that will be the implementation of the NHS LTP. For 2019/20, every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long-Term Plan implementation plans, covering the period to 2023/24.

The document covers:

* System planning
* Financial settlement
* Operational plan
* Process and Timescale

**System planning**

Every STP/ICS must produce a system operating plan for 2019/20. This must include an overview of how the system will use its resources to meet population health need, including specialised commissioning and direct commissioning as well as CCG plans. It must also include a system aggregation showing how individual plans align to form a system plan.

All NHS providers and CCGs must be part of a plan. The focus should be on how to work together to provide efficiency savings, not cost shunting from one organisation to another.

**Financial settlement**

The focus of this section is on CCG funding settlements and tariff payments. It then addresses efficiency savings and steps that systems need to focus on to become more efficient. This includes working to make outpatients and community services more efficient through use of digital technology.

There is a list of ongoing opportunities which includes medicines value – e-prescribing; removal of low value prescribing; and greater use of biosimilars.

There is a list of specialist commissioning which includes reference to long term conditions, but specifically mentions hepatitis C and neurosciences. Also reference to rapid diagnosis of rare diseases, but in relation to genomics. Integrating specialist commissioning into locally commissioned services is also seen as an opportunity, including the move to a pathway approach to planning care for populations.

**Operational plan requirements**

This section lists the priorities seen as fundamental to transforming urgent and emergency and elective care. The nine deliverables are:

* Emergency care – reducing the time for which patients are hospitalised.
* Referral to treatment times – The expectation is that over 5 years the volume of elective care will go up, and waiting lists will come down, starting in 2019/20. However, waiting times commitments relate to 6 month and 52 week waits. The clinical standards review will look at waiting time standards (this is where we have a concern that the 18-week target may be changed/scrapped). There is also reference here to First Contact Practitioners for MSK patients.
* Cancer treatment
* Mental health – a series of deliverables for mental health includes a target that 50% of those on IAPT should recover. Depending how you define recover, this might be a barrier for MSK patients with long term conditions for whom managing their mental health is more realistic than recovery.
* Learning disability and autism
* Primary and community care – The focus of this is on primary care networks. STPs/ICSs must set out how they will achieve sustainability and transformation of primary care. Additional funding to primary care must deliver investment in transformation. A local workforce plan including multi-disciplinary teams and a primary care network development plan.
* Workforce
* Data and Technology
* Personal health budgets – by March 2021 50,000 – 100,000 people must have a personal health budget.

The longer-term deliverables are those in the LTP.

**Timeline**

Draft organisation/operational plans submitted by 19 Feb with 5-year plans by Autumn 2019.

For more detail see the [full document](https://www.england.nhs.uk/operational-planning-and-contracting/).

1. **Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan**

This covers the following areas:

* Addressing the workforce shortfall
* Solving Indemnity Costs
* Improving the Quality and Outcomes Framework (QOF)
* Introducing the Network Contract DES
* Going ‘digital-first’ and improving access
* Delivering new network services
* Guaranteeing investment
* Supporting research and testing future contract changes
* Schedule of future contract changes and development work

I have given a brief outline of the workforce, and network services areas as the most relevant to MSK.

**Workforce**

Workforce is identified as the priority for primary care. Various steps are set out to enable recruitment of an additional 5,000 doctors and 1,000 nurses.

There is a reimbursement scheme for additional roles to enable increased multi disciplinary teams. Five roles are listed as being eligible for reimbursement:

* clinical pharmacists,
* social prescribing link workers,
* physician associates,
* first contact physiotherapists
* first contact community paramedic.

ARMA has raised with NHSE the fact that the role is First Contact Practitioner, not physiotherapist. If reimbursement is only available for physiotherapists in the role, we are concerned this will mean other professional training does not see FCP as something worth investing in, so reducing a potential source of suitable FCPs. This would be counterproductive in the context of a measure designed to address a workforce shortfall.

**Primary Care Networks**

Primary Care Networks (PCNs) are intended to bridge the divide between primary and community services. They focus on provision of services, not on commissioning. They will become the foundation of integration to deliver to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.

They are about primary care practices contracting to work together. A PCN should cover a population of around 50,000 patients (minimum 30,000) so that it is large enough to support a multidisciplinary team.

Networks will have a network agreement. Delivery will require collaborative working by members. Members of a network will be GP practices plus specialist, physical and mental health services and secondary care in the area.

Each PCN must have a clinical director and one lead practice which receives the funding for the network. NHS England will provide a range of support to PCNs.

**Delivering new network services**

There will be seven service specifications to be delivered in 2019/20:

(i) Structured Medications Review and Optimisation;

(ii) Enhanced Health in Care Homes, to implement the vanguard model;

(iii) Anticipatory Care requirements for high need patients typically experiencing several long term conditions, joint with community services;

(iv) Personalised Care, to implement the NHS Comprehensive Model;

(v) Supporting Early Cancer Diagnosis;

(vi) CVD Prevention and Diagnosis; and

(vii) Tackling Neighbourhood Inequalities.

Anticipatory care - Based on individual needs and choices, under the Anticipatory Care Service, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which include musculoskeletal conditions, cardiovascular disease, dementia and frailty. Typically, this involves a structured programme of proactive care and support in which patients with multi-morbidities will have greater support– including longer GP consultations where appropriate - from the wider multidisciplinary team.

For more detail see the [full document](https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf).

1. **Universal Personalised Care: Implementing the Comprehensive Model**

The document defines personalised care: people have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual strengths, needs and preferences.

There are six components to the model:

1. Shared decision making

2. Personalised care and support planning

3. Enabling choice, including legal rights to choice

4. Social prescribing and community-based support

5. Supported self-management

6. Personal health budgets and integrated personal budgets.

The document sets out the key principles of each component and what evidence would show that it is implemented.

Social prescribing – includes a reference to the need for this to be appropriately funded. There should be a one stop shop connector service with link workers (up to 5 per Primary Care Network) about to connect people to community groups and voluntary organisations that are supported to receive referrals. There should be community based approaches to providing peer support. ARMA would argue that there is a role for patient groups in providing this peer support.

Supported self-management – This can include:

* Health coaching or structured group coaching course
* Self-management education approaches (face-to-face and virtual), which include disease-specific, generic and online self-management courses
* Peer support through a link worker

Personal health budgets – People will have an indication of how much money they have available for healthcare and support, enough to meet the health and wellbeing needs and outcomes agreed in the personalised care and support plan. They will be able to use the money to meet their outcomes in ways and at times that make sense to them, as agreed in their personalised care and support plan.

**Implementation**

The document lists 21 actions needed to deliver personalised care at scale. These include:

* Workforce training, including to all GPs.
* An intensive face to face training programme for 75,000 health care professionals by 2023/4
* Recruit and train over 1,000 social prescribing link workers by 2020/21
* Work with partners in the voluntary and community sector, and others, to explore the best models for commissioning the local voluntary and community sector to support innovative provision.
* Support for programmes to enable self-management
* Train up to 500 people with lived experience to become system leaders by 2023/24.

For more details see the [full document](https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf).

Sue Brown 12/2/19