15 February 2019	ITEM: 8
Health and Wellbeing Board	
NHS Long Term Plan: An Overview and Critique for Thurrock	
Wards and communities affected: All wards	
Accountable Director: Ian Wake, Director of Public Health Roger Harris, Corporate Director, Adults, Housing and Health	
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1. RECOMMENDATIONS

- **That the Health and Wellbeing Board consider and comment on the report and the themes that it addresses.**
- **That the Health and Wellbeing Board consider and comment on how the NHS Long Term Plan may be implemented in the context of the needs of the population of Thurrock and our existing system transformation agenda.**
- **That Health and Wellbeing Board members comment on the risks and opportunities associated with the wider proposed changes to the commissioning arrangements across Mid and South Essex STP.**
- **That the Health and Wellbeing Board members receive further information about how the new funding will be invested in Thurrock.**

2. Introduction and Background

2.1 Despite budgets increasing in real terms by circa 2% per annum over the past 8 years this is less than compared to an average of 3.7% per annum since the NHS was funded. During the same period, adult social care has seen a considerable increase in demand and public health budgets have reduced whilst demographic pressures have increased demand for health and care services.

2.2 In June 2018, the Prime Minister announced a new five-year funding settlement for the NHS; a 3.4% average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24, totalling a £20.5 billion increase over this period. To unlock this funding, the Department of Health and Social Care and NHS England were asked to develop a long-term plan. This document was published on 7 January 2019 and can be found here: www.longtermplan.nhs.uk

2.3 It is important to note that the funding settlement applies only to NHS England's budget. This means that some important areas of NHS spending including in the Department of Health and Social Care's budget; such as capital and education and training are not covered by it. Local authority public health spending and social care spending are also excluded. Consequently the plan is for the NHS only, and not the entire health and care system. It had been hoped that the Green Paper on long term funding options for Adult Social Care would also be published at the same time but that did not happen.

2.4 The NHS Long Term Plan is certainly long (comprising of over 120 pages!) and contains a plethora of eye catching commitments. These can be summarised around five key themes:

- Finance and Resources
- Prevention and Health Inequalities
- New models of integrated care
- Action to improve care quality and outcomes in different clinical specialities
- Workforce

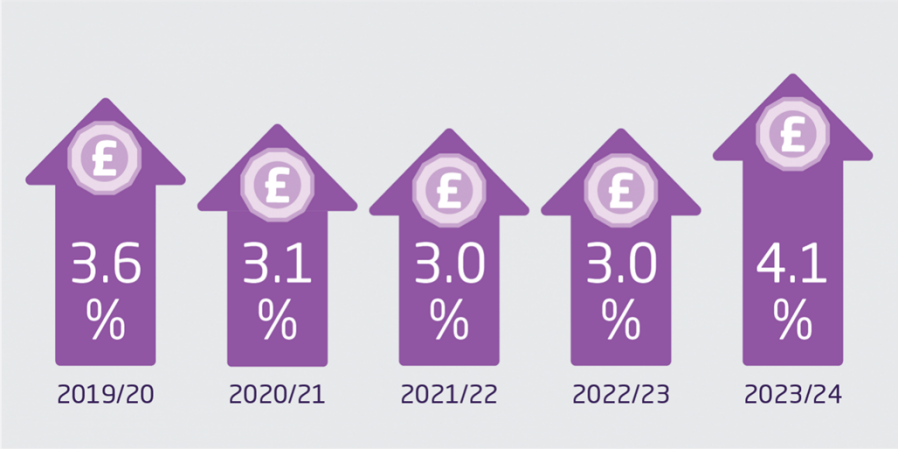
The digital agenda also features heavily throughout each of these themes.

2.5 There is much to welcome within the new NHS Long Term Plan, together with a few proposals that raise potential concerns. This paper discusses each of these five themes in turn and critiques what they may mean for Thurrock in the context of the needs of our population and our existing strategic transformation plans. A full summary of every commitment within the plan can be found in Appendix A

3 Finance and Resources

3.1 The plan sets out considerable real terms cash increases to NHS budgets in England of £20.5Bn over the next five years (figure 1). **This extra spending will need to deal with current pressures and unavoidable demographic change and other costs, as well as new priorities.**

Figure 1 Real Terms Growth in NHS England Funding 2019/20 to 2023/24

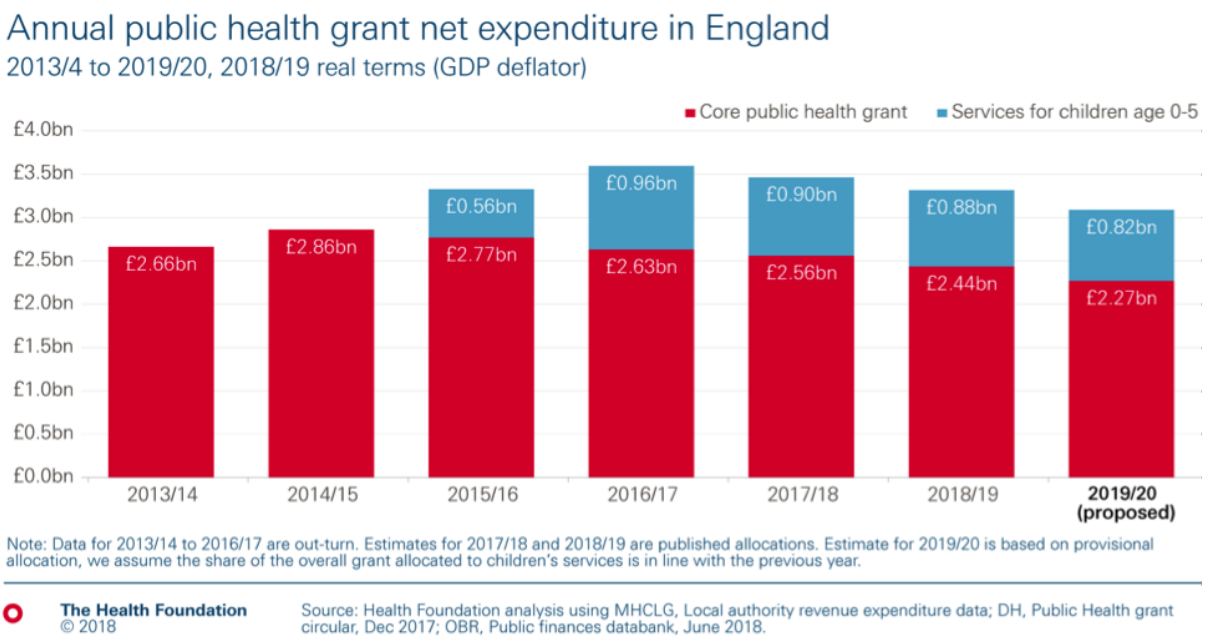


3.2 However future funding for Adult Social Care is not included within the plan and will be subject to a delayed Green Paper now due later in 2019 and possibly considered as part of the Government's Comprehensive Spending Review. Some commentators have labelled this decision a missed opportunity to tackle the issues faced by health and social care in a joined up way.

3.3 Despite being strong on prevention (see section 4), the plan also does not address Public Health Grant funding to local authorities, and the Government confirmed further reductions to the Public Health Grant in

2019/20 at the very end of 2018 (Figure 2), again drawing criticism from some for not thinking 'in a joined up way'.

Figure 2



3.4 When the Prime Minister announced the new funding settlement, she was clear that all NHS organisations must get back into financial balance by 2023/24. The plan gives further commitment to return the provider sector within the NHS to financial balance by 2020/21. To achieve this, NHS Improvement will deploy an accelerated turnaround process in the 30 worst financially performing trusts and a new financial recover fund of £1.05 billion will be created for trusts in deficit who sign up to their control totals

3.5 Part of the financial issues faced by NHS Providers centre around the flawed way in which the NHS financial regime operates. By rewarding activity in secondary care on a cost per case basis, whilst commissioning community providers on block contract the system both financially dis-incentivises community prevention activity that keeps patients out of hospital, and makes it difficult of secondary care providers to control costs when faced with difficult to predict and costly levels of unplanned activity. The measures in the plan seek to address this through changing the payment system from activity based payments to population based payments. There is also a further move away from individual to system control targets centred on new Integrated Care Systems (ICSs) that will operate at STP level – in our case this is Mid and South Essex.

3.6 ICSs will become the level of the system where commissioners and providers (for both the NHS and local authorities) make shared decisions

about financial planning, and prioritisation. The plan states that beyond 2019/20 Government will introduce further financial reforms that will support ICSs to deliver integrated care. Through a process of earned financial autonomy NHS England will give local health systems greater control over resources on the basis of a track record of strong financial and performance delivery, assessed in part through the new ICS accountability and performance framework.

3.7 The plan requires the NHS to deliver savings from administrative costs of more than £700 million, with £290 million to be delivered from savings in commissioning – CCG's have been told that they need to reduce their running costs by 20% by 1st April 2020. There is also focus on improved productivity through 10 priority areas which largely expand on existing schemes such as centralised procurement, e-rostering, e-prescribing, stopping procedures of limited clinical value and improving access to information.

What this means for Thurrock

3.8 Historically, the south and mid Essex health economy has been one of the most financially challenged in England, and so new resources are always welcome. It is however possible that Trusts within our own STP may be subject to further centralised 'Turn Around' processes referenced within the plan. The projected deficits for BTUH, Mid Essex Hospital Trust and Southend Hospital University Hospital Trust for 2018/19 are £27M, £60.7M and £10.9M respectively. Without system reform, there is a danger that 'more of the same' will result in growth monies being used to plug secondary care deficits.

3.9 The financial reforms in terms of a move away from activity based reward and towards population health outcomes are a welcome reform that seeks to address flaws in the current system that result in Trusts acting only in their own financial interest without regard to system wide impact. It also signals a move away from transactional commissioning towards population health that closely mirrors our own ambitions for a Thurrock Integrated Alliance Contract with system wide targets and financial risk and reward mechanisms. However, there is a clear direction of travel to set system level targets at STP and not CCG level which adds a potential level of complexity into local plans and moves system wide commissioning away from other Thurrock local authority level place based initiatives. Setting population and system outcomes at STP rather than borough level also risks making them less meaningful and relevant to the needs of the Thurrock population.

3.10 Government announcement of further reductions in the Public Health Grant (PHG) for 2019/20 only days before the publication of an NHS Long Term Plan that places increasing prevention and addressing health inequalities at its heart, drew much criticism from sections of the public health profession on social media. Whilst public health should be seen as far more than commissioning of programmes from the PHG, obvious conclusions about a lack of joined up Government strategic thinking could be drawn. A combination of successful re-procurement of contracts funded from the PHG in Thurrock and three year financial planning by the DPH has mitigated the risk of substantial PHG decommissioning in 2019-20. However, it is clear that additional prevention ambitions set out in the Long Term NHS Plan will need to be funded through accessing a part of the additional £20.5Bn NHS growth monies rather than by relying on existing PHG resources. The commissioning mechanisms by which this is done, and how these new prevention services interface within those commissioned and delivered by Thurrock Council remains unclear in the plan and will perhaps need to be determined at a local level.

4 Prevention and Health Inequalities

4.1 The plan commits to a ‘more concerted and systematic approach to reducing health inequalities’, with a promise that action on inequalities will be central to everything that the NHS does. To support this ambition and to ensure that local plans are focused on reducing inequalities, specific, measurable goals will be set. Local areas will need to set out how they will achieve this in 2019, drawing on a menu of evidence based interventions developed by Public Health England. Changes to commissioning allocations for CCGs will ensure that a higher share of funding is targeted at areas with high inequalities and a review of inequalities adjustment to funding formulae will be undertaken.

4.2 The Plan specifically recognises that there are two major sets of work which need to progress in parallel:

- Population Health Management approaches – which requires action by everyone, including the NHS
- Place Based Approaches – including action on wider determinants such as planning, housing, education and employment outcomes and many other aspects the NHS is not set up to deliver on

4.3 We will not see improvements in health of the population without both. The NHS Plan itself explicitly acknowledges this where is says:

Action by the NHS is a complement to, but cannot be a substitute for, the important role for local government. In addition to its wider responsibilities for planning, education, housing, social care and economic development, in recent years it has also become responsible for funding and commissioning preventive health services, including smoking cessation, drug and alcohol services, sexual health, and early years support for children such as school nursing and health visitors. These services are funded by central government from the public health grant, and funding and availability of these services over the next five years which will be decided in the next Spending Review directly affects demand for NHS services.

4.1 The plan goes on to state that:

As many of these services are closely linked to NHS care, and in many case provided by NHS trusts, the Government and the NHS will consider whether there is a stronger role for the NHS in commissioning sexual health services, health visitors, and school nurses, and what best future commissioning arrangements might therefore be.

4.2 The plan sets out a series of health improvement initiatives aimed at embedding prevention firmly within the 'day job' of NHS providers as opposed to being something commissioned from afar by local government. Trusts will gain increased responsibility for smoking cessation including implementation of 'The Ottawa model' which prescribes that all patients should have smoking status recorded and smokers offered specialist support to quit including Nicotine Replacement Therapy of other pharmacological interventions. The model will include a new smoke-free pathway for maternity services including focussed sessions and smoking cessation treatment for pregnant women who smoke. A new universal smoking cessation offer is also to be included as part of all specialist mental health services, including the option for patients admitted to in-patient mental health facilities to use e-cigarettes.

4.3 New weight management services are to become part of Primary Care for people with hypertension, a BMI of 30+ or type II diabetes.

4.4 The plan also talks about increased provision of Hospital Alcohol Care Teams to reduce significantly the number of A&E attendances, hospital bed-days and ambulance call outs that are alcohol related.

4.5 The NHS Diabetes Prevention Programme that seeks to identify those most at risk of developing diabetes and intervene with lifestyle modification programmes is set to receive double its current funding. The plan also sets out ambition to address inequality in access to foot care teams for patients with diabetes, and trial a programme of diabetes referral through the prescription of very low calorie diets to those who are newly diagnosed.

4.6 Immunisation and screening programmes are given prominence in the plan with a new responsibility for CCGs to ensure that they are reducing health inequalities. At present responsibility for commissioning and monitoring immunisation and screening rests with NHS/Public Health England specialist teams.

4.7 By 2023/24 the plan sets out an ambition to increase the number of patients with serious mental ill-health receiving a health check by 110,000 a year to 390,000 a year.

What this means for Thurrock

4.1 The shift in focus for the NHS from an illness treatment service to (at least in part) one that focuses on preventing disease is hugely welcome. Every day in the NHS in England there are circa 1M contacts between patients and clinicians, and these present a tremendous opportunity for the health service to engage the population in a conversation about improving their health and wellbeing. Perhaps for too long, many clinicians have seen health improvement as someone else's responsibility and any move to change this is positive.

4.2 The plan sets out clear action on health inequality with a higher share of growth monies being targeted towards geographies with high levels of health inequity. What is less clear moving forward, is the geographical foot print on which this funding i.e. CCG vs STP will be rewarded or whether health inequality will be calculated as differences in health outcome *between* or *within* the geographical area. A funding formula based on the levels of health inequality within Thurrock is likely to be more generous than a funding formula

that compared the level of health inequality within Mid and South Essex to England.

4.3 Smoking cessation services are currently commissioned and directly provided by the Thurrock Public Health Service. The focus this year has been on targeted support to smokers with other long term health conditions as the APHR 2016 identified that reducing smoking prevalence in this cohort will have the biggest impact on secondary care demand in the shortest possible time (however a universal offer is also available to any smoker who requests it). Performance against target has been significantly below the planned trajectory and the stop smoking core team have struggled to engage Primary and Secondary Care clinicians in activity to funnel smokers into cessation services. Embedding and integrating stop smoking support within existing long term condition pathways in both primary, secondary and mental health trusts is highly desirable if as a system, we are going to act in a coordinate way to reduce smoking prevalence through cessation activity, and the strategic direction in the long term plan supports this approach. A paper with specific proposals as to the best mechanism to achieve this will be brought back to the Thurrock Integrated Care Alliance.

4.4 Public Health also already commission Alcohol Liaison Teams in hospital settings jointly with Essex and Southend Councils. Identifying and treating patients with underlying alcohol addiction is highly cost effective and returns system savings within year. Similarly weight management programmes including Sliming World, Weight Watchers and community weight management including exercise on referral are commissioned from the Thurrock PHG. The NHS Plan provides further scope and potential resources to expand these services.

4.5 Thurrock was one of the first wave adopters of the NHS Diabetes Prevention Programme. Additional resources through the NHS Long Term Plan to expand this programme are welcome.

4.6 National evidence suggests that people with serious mental ill-health experience some of the worst health inequalities of any group in England dying on average 15-20 years earlier than the general population. Action to address this has been set out in the recent papers to Health and Wellbeing Board and HOSC as part of a wider approach to transforming mental health services. A new Public Mental Health working group will bring forward new models of care over the next 12 months and expansion of new local approaches to embed cardio-vascular health checks in EPUT care pathways is welcome. However, although the NHS Plan has ambitions to increase the number of checks, population health gain will be limited unless this is

undertaken in conjunction with lifestyle modification (and where appropriate) pharmacological interventions to reduce risk in those highlighted through this programme.

4.7 Focus on improving the coverage of immunisation and screening programmes set out in the plan is also welcome. These are currently the responsibility of the teams of dedicated Public Health England staff based in NHS England regional offices. They have generally felt remote and disconnected from both the wider Public Health Local Authority based system and CCG Primary Care transformation, despite GP practices being responsible for many of the programmes. Moving forward, if CCG's are given specific responsibilities for improving coverage rates there is an opportunity to integrate with our local Primary Care development work and team.

4.8 The proposals in the plan for the Government and NHS to consider a greater role in commissioning of Public Health services including sexual health, health visiting and school nursing came somewhat 'left-field' and has not to date been discussed with the public health professional body through usual channels such as the Association of Directors of Public Health or Faculty of Public Health. It is worth noting that currently the single public health commissioning function retained by the NHS – immunisation and screening programmes is the worst performing of all commissioned functions. Whilst there is perhaps some merit for re-integrating sexual health services into NHS commissioning functions (commissioning responsibilities are currently split with local authorities commissioning contraception and GU medicine services and the NHS commissioning HIV treatment), the case for the NHS commissioning school nursing and health visiting is less clear. These are clear public health functions that in Thurrock have been successfully integrated into our Brighter Futures Programme and align well with other local authority functions within children's services. A move to the NHS potentially adds an additional level of complexity and moves public health functions away from the Director of Public Health and specialist public health staff, for little obvious gain.

4.9 In conclusion, there is much to like within the NHS Long Term Plan in terms of a move to embed prevention within the work of the NHS and strengthen responsibilities of CCGs in reducing health inequalities. The Thurrock Public Health Team will need to work with senior officers in the CCG and NHS providers through the Thurrock Integrated Care Alliance to develop and agree plans to implement the proposals on prevention set out in plan locally.

5. New Models of Integrated Care

5.1 The plan confirms the shift towards integrated care and place-based systems which has been a defining feature of recent NHS policy. Integrated Care Systems (ICSs) will be the main mechanism for achieving this – the plan says that ICSs will cover all areas of England by April 2021 – and will increasingly focus on population health.

5.2 The plan outlines several core requirements for ICSs (such as the establishment of a partnership board comprising representatives from across the system) but stops short of setting out a detailed blueprint for their size or structure. Systems will be required to 'streamline' commissioning arrangements, which will 'typically involve' a single CCG across each ICS. It also recognises that NHS organisations will need to work in partnership with local authorities, the voluntary sector and other local partners to improve population health. A new NHS Integrated Provider Contract, Alliance Agreement will be available in 2019 which will allow the contractual integration of Primary and Community Care, and support funding flows and collaboration between providers across the health and care system.

5.3 From 2019, population health management tools will be rolled out, enabling ICSs to identify groups at risk of adverse health outcomes and inequalities and to plan services accordingly. Existing approaches to bringing together health and social care budgets are also encouraged, with an expectation that the social care Green Paper will set out further proposals. Recent funding through the BCF and IBCF has been very important and extremely welcome – however these are only short term and what is required is a long term, publically acceptable way of funding the growing demand for Adult Social Care. There will also be a review of the Better Care Fund. It is dis-appointing that the LTP does not recognize the important role that the BCF has played in both drawing extra resources into the health and care system but also how it has facilitated better joint working – especially in Thurrock.

5.4 The move towards a more interconnected NHS will be supported by a 'duty to collaborate' on providers and commissioners, while NHS England and NHS Improvement will continue efforts to streamline their functions. The plan suggests that progress can continue to be made within the current legislative framework but also puts forward a list of potential legislative changes that would accelerate progress, in response to requests from the Health and Social Care Select Committee and the government. The proposed changes include allowing joint decision-making between providers and commissioners and reducing the role of competition in the NHS.

5.5 In line with the Forward View and the *General practice forward view*, improving care outside hospitals is one of the headline commitments in the

plan. Encouragingly, the plan backs this goal with money: by 2023/24, funding for primary and community care will be at least £4.5 billion higher than in 2019/20 – ensuring that their share of NHS spending increases over the period.

5.6 The plan confirms that general practices will join together to form primary care networks – groups of neighbouring practices typically covering 30–50,000 people. Practices will enter network contracts, alongside their existing contracts, which will include a single fund through which network resources will flow. Primary care networks will be expected to take a proactive approach to managing population health and from 2020/21, will assess the needs of their local population to identify people who would benefit from targeted, proactive support. To incentivise this, a 'shared savings' scheme is proposed, under which networks will benefit financially from reductions in accident and emergency (A&E) attendances and hospital admissions. The existing incentive scheme for GPs – the Quality and Outcomes Framework (QOF) – will also see 'significant changes' to encourage more personalised care.

5.7 Alongside primary care networks, the plan commits to developing 'fully integrated community-based health care', ending the current fragmentation of primary and community health care. This will involve developing multidisciplinary teams, including GPs, pharmacists, district nurses, community psychiatric nurses, reablement teams, community geriatricians, adult social care staff, allied health professionals and staff from the third sector working across primary care and hospital sites. Over the next five years, all parts of the country will be required to increase capacity in these teams so that crisis response services can meet response times set out in guidelines by the National Institute for Health and Care Excellence (NICE). Access to social prescribing will be extended, with more than 1,000 trained link workers in place by the end of 2020/21.

5.8 There is also a strong emphasis on developing digital services so that within five years, all patients will have the right to access GP consultations via telephone or online. Primary care networks will also roll out the successful approach pioneered by the enhanced health in care homes vanguards so that by 2023/24, all care homes are supported by teams of health care professionals (including named GPs) to provide care to residents and advice to staff.

What this means for Thurrock

5.9 The move to integrate primary and community health care around mixed skill workforce teams serving populations of 40-50K is welcome and replicates the

model set out in the Tilbury and Chadwell Case for Change document already being rolled out locally including our mixed skill Primary Care workforce and Community Led Solutions teams, whilst building on it to encompass some new posts including Community Geriatricians. The LT Plan references the role of promoting self-care of these new teams and this is perhaps an area which is underdeveloped in Thurrock and which we need to focus on in 2019/20. The Public Health Team will bring forward proposals for self-care in our 2019/20 Service Plan.

5.10 The commitment to expand social prescribing with 1000 new social prescribers nationally by 2021 is also welcome and dove tails into the need to increase capacity locally. Perhaps one criticism that could be made is that 1000 new social prescribers nationally is under-ambitious given the scale of demand on Primary Care.

5.11 The focus on in-reach services to care homes also mirrors best practice already happening in part of Thurrock, where paramedics, GPs and pharmacists undertake weekly proactive review of residents and provides additional resources to ensure this occurs borough wide.

5.12 The move the population based health again links well with existing work locally, where Thurrock has plans that are significantly more developed than other localities in our STP area. The Better Care Together Thurrock programme forms the strong basis of a Population Health Management Programme, and the new Mede-analytics data lake will provide functionality to develop the risk stratification tools referenced in the plan, together with opportunities for identification and early proactive management of cohorts of patients at risk of serious adverse health events in 2019/20.

5.13 The proposals on Integrated Care Systems leave further questions, largely around geographical footprint. Better Care Together Thurrock forms the basis of a local ICS, triangulating population with place, community and integrated data, and delivering new models of integrated care. Although the plan stops short of specifying new geographical footprints for ICSs, it does talk about a single CCG for each ICS. There is a strong likelihood that locally, this will be at STP footprint. This geography makes little sense to Thurrock in terms of place base initiatives and builds an additional level of complexity in terms of boundaries crossing multiple local authorities. It presents a danger in terms of slowing down local transformation work if Thurrock is forced to operate in a wider system with other localities that have less developed integrated plans.

5.14 The LT Plan references new Alliance agreements and integrated provider contracts which may allow us to short cut proposals to develop something

similar through the Thurrock Integrated Care Alliance. However, the LT Plan also raises questions relating to top down control from NHS England. It states that each ICS will need to agree system wide objectives with their relevant NHSE Locality Director and these will be a mixture of national and local priorities. More ominously it talks about ICSs needing to "earn" greater authority from NHSE to develop local initiatives, raising the Spector of centralised top down command and control. It is unclear how this will work in practice.

5.15 Finally, as referenced in section 3 there is little detail on Adult Social Care or integrated funding over and above some negative commentary on the Better Care Fund and talk that NHS funding being used to 'prop up' councils. If the plan is serious about integration of health and care, this separation of funding streams seems counter-intuitive.

6. Action to improve care quality and outcomes in different clinical specialities

6.1 Perhaps the most striking part of the plan is the sheer number of commitments relating to a group of clinical specialities where outcomes in the UK have sometimes lagged behind other similar western health systems. Priorities include cardio-vascular disease, cancer, mental health, maternity and neonatal health, diabetes and respiratory care.

6.2 **Cardio-vascular health.** The plan references an ambition to prevent up to 150,000 heart attacks, strokes and vascular dementia cases by 2029. Initiatives to achieve this will include improving the effectiveness of the NHS Health Check programme, hypertension case finding, expanding testing for Familial Hypercholesterolaemia, a national primary care audit on CVD prevention, rapid access to Heart Failure Nurses in hospital, improved access to echocardiography in Primary Care and scaled up cardio rehabilitation.

6.3 Specific ambitions for stroke care include implementation of more HASU units, implementation of high intensity stroke rehabilitation lasting six months or more, and a ten-fold increase in the proportion of patients who receive thrombectomy after stroke leading to 1600 more people being independent after their stroke by 2022.

What this means for Thurrock

6.4 Thurrock already has robust plans for Cardio-vascular disease prevention though the Long Term Conditions Working Group that match many of the ambitions set out above including hypertension case finding, improving the

management of cardio-vascular disease in Primary Care through stretched QOF, improving the effectiveness of NHS Health Checks and upskilling of the Primary Care workforce in CVD management. The move to Integrated Medical Centres provides opportunities for increasing access to ECGs in Primary and Community Care, and the MSB hospital reconfiguration provides for creating a new HASU. There are however opportunities to use LT Plan investment to expand cardiac rehabilitation programmes for patients with Heart Failure.

6.5 **Cancer.** The LT Plan has a bold ambition to increase the proportion of cancers diagnosed at stage 1 and 2 from the current 50% to 75% by 2028. It aims to achieve this by increasing knowledge of GPs to recognise the early stages of cancer, accelerate diagnosis and treatment and maximising early diagnosis by identifying more cancers through screening.

6.6 A new Faecal Immunochemical screening test will be rolled out as part of the Bowel Cancer screening programme that has shown to increase uptake by 7% and the age at which screening starts will be lowered from 60 to 50. Similarly a new HPV Primary Screening test for cervical cancer will be implemented across England by 2020. Lung health checks to identify lung cancer earlier implemented together with mobile lung CT scanners in supermarket car parks.

6.7 A new 28 day maximum cancer definitive diagnosis standard will be implemented from 2020 together with a radical overhaul of the way diagnostic services are delivered for patients with suspected cancer including a roll out of Rapid Diagnostic Centres across the country equipped with the latest kit and expertise. There will be new capital investment in MRIs and CT scanners to address the fact that the NHS has the third lowest number of scanners per head of population in the OECD34 group of countries. Finally there will be investment in advanced radio-therapy and immunotherapy techniques including proton beam therapy and a routine offer of genomic testing to everyone with cancer who would benefit clinically, from 2023

What this means for Thurrock

6.8 Cancer is the single biggest cause of death in Thurrock and historically our outcomes have been poorer than England's both in terms of cancer waiting time standards, fragmented diagnostic pathways, screening programme up take and early diagnosis. As such, the new investment set out in the plan is welcome. Perhaps the challenge will be implementation on the ground; we do not have a good track record on meeting existing cancer wait standards and have populations within the borough who have often not taken up the offer of

cancer screening programmes. As a local health and care system we will need to bring forward plans to address these challenges.

6.9 **Mental Health.** The Plan references a huge range of ambitions to improve the treatment (and to some extent the prevention) of mental ill-health in both adults and children and young people. The Long Term Plan makes a renewed commitment to grow investment in mental health services faster than the NHS budget overall for each of the next five years. NHS England's renewed pledge means mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24. Children and Young People's Mental Health service funding will grown faster than over-all mental health funding with 70,000 more children and young people being able to access mental ill-health treatment services by 2020/21.

6.10 There will be new waiting time standards for children's eating disorder and crisis services. Plans already set out in an earlier government response paper to a consultation on children's mental health are repeated including expanded CAMHS services and new Schools Based Mental Health Support Teams. There will also be a new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood based around the 'iThrive' model.

6.11 A new approach to young adult mental health services for people aged 18-25 will support the transition to adulthood will extend current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults. The new model will deliver an integrated approach across health, social care, education and the voluntary sector, such as the evidenced-based 'iThrive' operating model which currently covers around 47% of the 0-18 population and can be expanded to 25 year olds.

6.12 For adults, the plan talks about an expansion of IAPT services for treatment of Common Mental Health Disorders with 380,000 additional adults being treated by 2023/24, together with an integration of provision with other physical long term condition treatment programmes. For those with Serious Mental Ill-Health, the plan references "New and Integrated models of Primary and Community Mental Health Care" with "access to psychological therapies, improved physical health care, employment support, personalised ad trauma-informed care, medicines management and support for self-harm and co-exiting substance misuse"

6.13 Expanding crisis care features strongly in the LT Plan including a commitment to 24/7 community based crisis care by 2020/21 including home treatment,

integration with NHS 111, RAID services in A&E and alternative provision for those in crisis including Sanctuaries, Save Havens and Crisis Cafes.

What this means for Thurrock

6.14 New investment in mental health services should be broadly welcomed. The 2018 Children's and Adults Mental Health JSNAs together with LGA Peer Review and Thurrock Healthwatch research identified structural problems with children and adults local mental health systems. The proposals within the NHS LT plan fit well with transformation work already underway in Thurrock. There is a potential opportunity to main stream the three-year funding for our Schools Based Mental Health Wellbeing Service, and for the development of new models of care for Common Mental Health Disorders and SMI set out in the January 2019 HOSC Paper on Mental Health Transformation. A new 24-7 Crisis Care pathway has already been developed with plans for roll out in 2019/20 which will meet the commitments set out in NHS LT Plan ahead of schedule. However perhaps one criticism of the NHS LT Plan commitments is that they remain largely clinical and perhaps do not match local ambitions to create a more holistic offer better integrated with community and place based initiatives.

6.15 **Neo-natal, maternity and child health.** The plan sets out a wide range of initiatives to improve clinical outcomes in this area, together with an ambition to reduce still birth, maternity mortality, neonatal mortality and serious brain injury by 50% by 2025.

6.16 There are commitments to implement the *Saving Babies Lives Care Bundle* by 2020 which has shown a 20% reduction in still births at maternity units where it has been piloted. Continuity of care for pregnant women and new mothers will also be improved with an ambition that 20% of all pregnant women will have the opportunity to have the same midwife caring for them throughout their pregnancy, birth and post-natally by March 2021. There will be increased access to evidence based care for women with post-natal depression and Personality Disorder diagnosis with an extension of help from 12 to 24 months after giving birth. This will include an expansion of access to psychological therapies with specialist perinatal mental health input and will include parent-infant, couple, co-parenting and family interventions including support for fathers.

6.17 A physio-therapy offer for women in the post-natal period who suffer faecal incontinence and pelvic organ prolapse will be expanded. There is a commitment to deliver an accredited infant feeding programme like the UNICEF Baby Friendly initiative in all maternity services. More broadly, there

is a commitment to expansion of the neonatal workforce including allied health professionals supporting neonatal nurses.

6.18 The plan prioritises improvements in childhood immunisation coverage to the base level standards in the NHS PH function agreement. It also recognises that children and young people are most likely to attend A&E inappropriately and recommends developing new models of urgent care as part of a Community Multi-speciality Provider approach. Perhaps most significantly it recommends creation of a new 0 to 25 year old service model for young people that offers person-centred age appropriate care for children and young people and integrates physical and mental health.

What this means for Thurrock.

6.19 Again there is much to be welcomed in the plan although Maternity Service Planning in south Essex is notoriously complex, not least because of significant migration of expectant mothers from areas outside Essex into local units. As such, planning for delivery on the ground is likely to be challenging. Strategic Partnership arrangements for children and young people in Thurrock need to be strengthened and new delivery plans will need to be developed as part of this process. It is unclear whether proposals to address inappropriate A&E attendances by children by creating new community provision will be successful. Evidence on creation of Minor Injuries Clinics in the community suggests that they had little to no impact on A&E use, and simply created additional supply-side demand.

6.20 **Acute and emergency Care.** The plan includes a significant package of measures aimed at reducing pressures on A&E departments. Many of the measures build on previous initiatives, including the introduction of clinical streaming at the front door to A&E and the roll-out of NHS 111 services across the country.

6.21 The plan commits to rolling out urgent treatment centres (UTCs) across the country by 2020 so that urgent care outside hospitals becomes more consistent for patients. UTCs will be GP-led facilities and will include access to some simple diagnostics and offer appointments bookable via NHS 111 for patients who do not need the expertise available at A&E departments. Alongside this, the plan aims to improve the advice available to patients over the phone and extend support for staff in the community by introducing a multidisciplinary clinical assessment service (CAS) as part of the NHS 111 service in 2019/20.

6.22 Over the same timeframe, all major A&E departments will introduce same day emergency care (also known as ambulatory emergency care). This will see some patients admitted from A&E undergo diagnosis and treatment in quick succession so that they can be discharged on the same day, rather than staying in hospital overnight. The plan estimates that up to one-third of all people admitted to hospital in an emergency could be discharged on the same day by rolling out this model. Despite ongoing concerns about operational performance in emergency care, the plan does not make any commitment on the four-hour A&E target, postponing any decision to restore performance standards until the Clinical Review of Standards reports in the spring.

6.23 Unlike some previous NHS strategies, the long-term plan does not assume that moves to strengthen primary and community care will reduce demand for inpatient hospital care. Instead, its plans for hospital bed numbers and staffing assume that acute care will grow broadly in line with the past three years (although the plan does not specify what figure it is using for this).

6.24 The plan includes an ambitious pledge to use technology to fundamentally redesign outpatient services over five years. The aim is to avert up to a third of face-to-face consultations in order to provide a more convenient service for patients, free up staff time and save £1.1 billion a year if appointments were to continue growing at the current rate. It is not yet clear what this redesign will involve.

6.25 Although the plan notes that these changes will have implications for how waiting-times performance is calculated, there is no commitment to meet the 92 per cent target for 18-week waits. Instead, over five years, the volume of planned activity will increase year-on-year to reduce long waits and cut the number of people on the waiting list (currently more than 4 million). The commitment to reduce long waits is given teeth by the reintroduction of fines for providers and commissioners where patients wait 12 months or more.

What this means for Thurrock

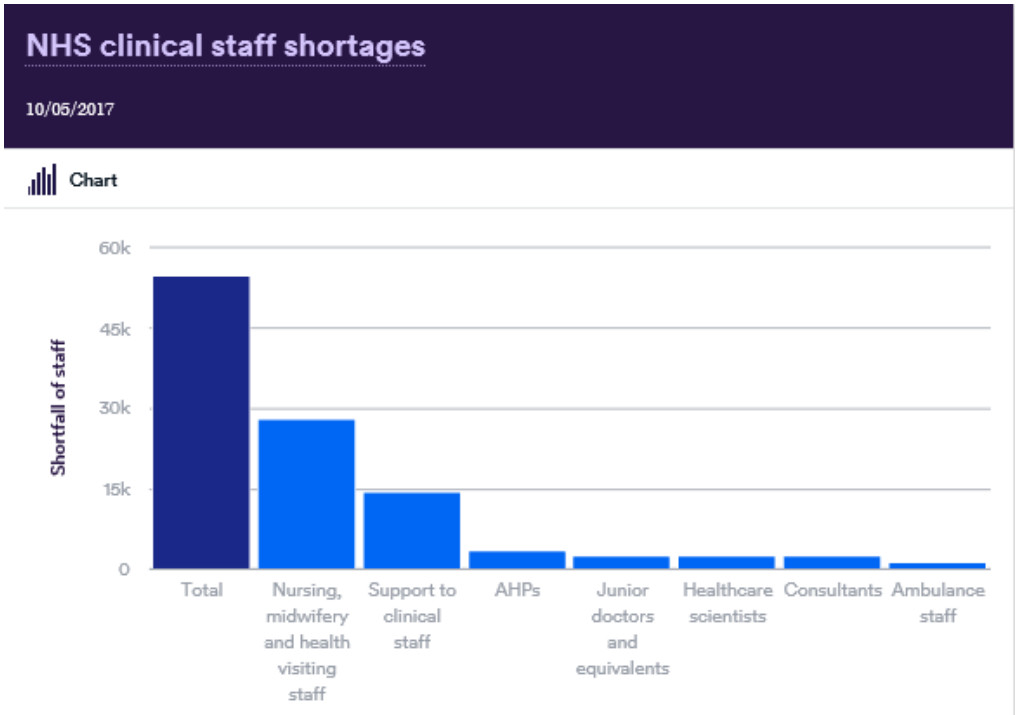
6.26 Some measures set out in the plan are already in place at Basildon Hospital including new approaches to ambulatory care and ‘same day’ wards. A lack of reform of the four-hour A&E waiting target is perhaps disappointing as it could be argued that treating patients who attend A&E with non-urgent or emergency conditions creates perverse clinical priorities and encourages misuse of the system. However, this was perhaps filed in the ‘politically too difficult’ box when the plan was developed.

6.27 Referencing DTOCs without considering Adult Social Care funding or transformation within the plan is perhaps short-sighted, although it is worth remembering that Thurrock benchmarks extremely well against CIPFA comparators on DTOC suggesting existing arrangements are largely effective. It remains to be seen whether the proposals that rely on deploying new technology can be delivered or whether or whether or not they will be effective in enabling providers to improve performance. We will need to wait for the publication of the clinical review of standards to better understand government expectations.

7. Workforce

7.1 Workforce shortages are currently one of the biggest challenges facing the health service. There were approximately 50,000 vacancies across all types of clinical staff in 2017 according to the National Audit Office. (Figure 3)

Figure 3



7.2 The plan recognises the scale of the challenge and sets out a range of specific measures to address it, although many will not be finalised until after the 2019 Spending Review which sets the budget for training, education and professional development. NHS Improvement, Health Education England and

NHS England are tasked within the plan to form a cross sector National Workforce Group and publish a workforce implementation plan later in 2019.

7.3 The plan does set ambitions to reduce the nursing vacancy rate from 11.6% to 5% by 2028 by increasing the number of undergraduate nursing placements by 25% by 19/20 and offering new routes to nursing qualification including a new online nursing degrees and expansion of the nursing apprenticeship programme. It also reiterates the DH commitment to increase medical school places by 1,500 per year and suggests that this figure could increase further subject to the Spending Review. There is also ambition to increase numbers of paramedics and physio-therapists, podiatrists, speech and language therapists and radiographers working in Primary and Community Care, although again the plan is light on detail, stating that the Chief Allied Health Professions Officer will bring forward further proposals as part of a new national strategy on AHPs.

What this means for Thurrock

7.4 Workforce remains a major challenge in Thurrock. We are the second most under-GP'd area in England and have significant shortages of all clinical staff. Our proximity to both London and more affluent areas of Essex make attracting and retaining staff to the borough challenging. Our local transformation programmes including Integrated Medical Centres and New Models of Care aim to address this by making Thurrock an attractive place to operate as a clinician and our links to both the new Anglia Ruskin University Medical School and proposals for a new London Southbank School of Health and Social Care campus at Purfleet may also assist in the medium term.

7.5 The NHS LT Plan makes multiple commitments throughout that are dependent on successful increases in the clinical workforce, yet firm proposals to address the current shortfall are limited. Until these are brought forward following the forthcoming government spending review, this remains a major risk for us.

8. Final reflections and conclusions

8.1 There is much to feel optimistic about within the NHS Long Term Plan, and many proposals that mirror local transformation work already underway in Thurrock. New models of care for a mixed skill integrated community and primary care workforce match our own ambitions for Better Care Together Thurrock, and similarly new integrated alliance contracts, collaboration between NHS providers and commissioners and population health management approaches fit will with the local direction of travel set by the

Thurrock Integrated Care Alliance. Similarly ambitions on mental health transformation, cardio-vascular disease management, diabetes, and integrated data.

8.2 What is less clear is the impact of organisational reform set out in plan. Whilst the plan stops short of specifying that the new ICSs will operate at STP level, this remains a strong possibility locally. Slimmed down CCGs (likely also to operate locally to operate at our STP level) risk slowing down transformation plans in Thurrock on Population Health and integrated care that are more advanced than some of our neighbours, and also risk moving focus away from Thurrock as a place, and resources away from local Primary Care transformation which has been so successful. There is an urgent need to agree with STP colleagues the different logical footprints for various aspects of NHS commissioning and transformation to take place over. We have benefited from being co-terminous with our local CCG and we don't want to lose that essential ingredient to good, close, local working.

8.3 The focus on shifting the NHS from a treatment to (at least in part) preventative service is hugely welcome, particularly at a time of reducing funding to other preventative services in the local health and care system, perhaps most obviously the Public Health Grant. Delivering this will however require significant organisational development activity if we are going to shift the attitudes of many in an NHS workforce that have historically not seen prevention as part of their job. It will also require leadership at a local level to move funding in CCG baselines from treatment to prevention initiatives if the ambitions in the NHS plan are to be realised. The NHS does not have a great history on funding prevention and public health budgets were often the first to be plundered in PCT days when acute services overspent.

8.4 Moves to consider a greater role for the NHS in commissioning of sexual health, health visiting and school nursing services came somewhat 'left field', with little further explanation. It is worth noting that the poorest performing Public Health services since the 2012 reforms have been those immunisation and screening services commissioned from the NHS. Further fragmentation in commissioning of particularly school nursing and health visiting locally risks adding additional complexity to our local Brighter Futures model.

8.5 Perhaps one of the greatest criticisms of the NHS LT Plan is that it is largely inward looking. The new funding will remain more or less entirely within the NHS itself and proposals for the long term funding of adult social care or wider prevention remain subject to future government strategy. Prevention is almost entirely focused on individuals without setting this in the context of wider determinants of health or community; settings that evidence suggests have

much greater impact on over-all health outcome than individual care management or lifestyle modification approaches.

8.6 Finally, much of the plan is dependent on successful expansion of the NHS workforce. Again the strategic ambition is positive but the plan is light on detail and this is perhaps the biggest risk to successful implementation locally.

9 Implications

9.1 Financial

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

The NHS Plan sets out a considerable new investment into the NHS locally with year on year increases in CCG baseline budgets totally £20.5Bn nationally. Funding will come down into CCG baselines and local plans will need to be developed to meet the ambitions set out in the plan including a new significant role in prevention that will not be able to be funded from the Public Health Grant.

9.2 Legal

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

This paper is a summary of the NHS Long Term Plan. There are therefore no legal implications for this report.

9.3 Diversity and Equality

Implications verified by: Roger Harris, Corporate Director, Adults Housing and Health

The initiatives outlined in this report will assist in future strategic planning to address health inequalities, placing a requirement on the local NHS to bring forward detailed plans to address variation in health outcome between different populations and linking future funding partly on success in reducing health inequalities. It is not clear at this stage between which geographical footprints reduction in health inequalities will be assessed.

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Appendix 1: The NHS Long Term Plan: Commitments

This document itemises the commitments in the plan.

Chapter 1: A new service model for the 21st Century

Section	Commitment
1.8	Within 5 years expected to improve the responsiveness of community health crisis response services within two hours of the referral in line with National Institute for Health and Care excellence (NICE) guidelines where clinically judged appropriate
1.8	All parts of the country should be delivering reablement care within two days of referral
1.9	Practices enter into network contract
1.10	From 2019 NHS111 will start direct booking into GP practices across the country, as well as referring onto community pharmacists. Clinical Commissioning Groups (CCG) develop pharmacy connection schemes for patients who don't need primary medical services
1.15	We will upgrade NHS support to all care home residents who would benefit by 2023/24, with an Enhanced Health Care (EHCH) model rolled out across the whole country
1.17	From 2020/21 Primary Care Networks will assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed.
1.25	From 2019/20 embed single multi-disciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP Out of Hours services
1.26	By Autumn 2020 fully implement Urgent Treatment Centre model
1.30	Every acute trust with a "Type 1 Accident and Emergency" department (ie fully staffed with Consultant Physicians) will: • move to a comprehensive model of Same Day Emergency Care (SDEC). The SDEC model should be embedded in every hospital, medical and surgical specialities during 2019/20 • provide an acute frailty service for a least 70 hours a week. Work towards clinical frailty assessment within 30 mins of arrival • test and begin implementing new emergency and urgent care standards
1.33	From 2020, embed Emergency Care Depts into UTCs and SDEC services.
1.34	By 2023 Clinical Assessment Service will typically act as single point of access for patients
1.39	Rolle out NHS personalised Care Model reaching 2.5m people by 2023/2024 and aiming to double that within the decade.
1.40	Over 1,000 trained social prescribing link workers will be in place by end of 2020/21 rising further by 2023/24 (no mention of how the actual interventions will be funded in plan, a major concern for local authorities and voluntary sector.)
1.41	Accelerate roll out of Personal Health Budgets (PHB). By 2023/24 up to 200,000 people will benefit form PHB
1.44	Over next five years every patient in England will have the right to choose telephone or online consultations from their GP
1.47	Re-designing out patient services over the next five ears
1.51	By April 2021 Integrated Care Systems (ICS) will cover the whole country

Chapter 2: More NHS action on prevention and health inequalities

Section	Commitment
2.9	By 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
2.10	Adapted model available for expectant mothers and their partners
2.11	New universal smoking cessation offer be available as part of the specialist mental health services for long-term users of specialist mental health, and learning disability services
2.14	Target support offer and access to weight management series in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
2.20	Over next five years, hospital with highest rate of alcohol dependence-related admissions will be supported to fully establish specialist Alcohol Care Teams
2.21	By 2023/24 NHs will cut business mileage and fleet air pollution emissions by 20%.
2.26	During 2019 all local systems expected to set out how they will specifically reduce health inequalities by 2020/24 and 2028/29
2.26	Expect all CCGs to ensure that all screening and vaccination programmes are designed to support a narrowing of health inequalities
2.28	By 2024 75% women from Black and Minority Ethnic communities and similar percentage of women from the most deprive groups will receive continuity of care from their midwife, throughout out their pregnancy, labour and post natal period.
2.30	By 2020/21 will ensure that at least 280,000 people living with Severe Mental Illness (SMI) have their physical health need met.
2.30	By 2023/24 increase the number of people with SMI problems receiving physical health checks to an additional 110,000 people per year
2.31	Over five years we will invest to ensure that children with Learning Disabilities have their needs met by eyesight, hearing and dental services.

Chapter 3: Further progress on care quality and outcomes

Section	Commitment
3.9	NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury.
3.10	In 2019 aim to roll out the care bundle across every maternity unit in England.
3.12	Spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative.
3.13	By 2021 most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.
3.15	Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by the end of 2019/20.
3.15	By 2023/24, all women will be able to access their maternity notes and information through their smart phones or other devices.
3.39	We will actively support children and young people to take part in clinical trials, so that participation among children remains high, and among teenagers and young adults rises to 50% by 2025.
3.40	From September 2019, all boys aged 12 and 13 will be offered vaccination against Human Papilloma Virus-related diseases, such as oral, throat and anal cancer.

3.45	From 2019/20 clinical networks will be rolled out to ensure we improve the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. (How these will differ from the Networks which the NHS rolled out between 2005 – 2010 remains to be seen)
Milestones for Cancer	• From 2019 NHS will start to roll out new Rapid Diagnostic Centres across the country. • In 2020 a new faster diagnosis standard for cancer will begin to be introduced so that patients receive a definitive diagnosis or ruling out of cancer within 28 days. • By 2020 HPV primary screening for cervical cancer will be in place across England. • By 2021, where appropriate every person diagnosed with cancer will have access to personalised care, including needs assessment, a care plan and health and wellbeing information and support. • By 2022 the lung health check model will be extended. • By 2023, stratified, follow-up pathways for people who are worried their cancer may have recurred. These will be in place for all clinically appropriate cancers. • By 2028, the NHS will diagnose 75% of cancers at stage 1 or 2.
Milestones for cardiovascular disease	• The NHS will help prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years. • We will work with our partners to improve community first response and build defibrillator networks to improve survival from out of hospital cardiac arrest. • 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.
Milestones for stroke care	• In 2019 we will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy. • By 2020 we will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long-Term Plan. • By 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke so that each year 1,600 more people will be independent after their stroke. • By 2025 we will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.
3.80	From April 2019 will ensure that, in line with clinical guidelines, patients with type 1 diabetes benefit from life changing flash glucose monitors.
3.80	By 2020/21, all pregnant women with type 1 diabetes will be offered continuous glucose monitoring, helping to improve neonatal outcomes.
3.89	Mental health will receive a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24.
3.91	The Five Year Forward View for Mental Health set out plans for expanding IAPT services so at least 1.5 million people can access care each year by 2020/21. We will continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long-term conditions. By 2023/24, an additional 380,000 adults and older adults will be able to access NICE-approved IAPT services.

Milestones for mental health services for adults	• New and integrated models of primary and community mental health care will give 370,000 adults and older adults with severe mental illnesses greater choice and control over their care and support them to live well in their communities by 2023/24. • By 2023/24, NHS 111 will be the single, universal point of access for people experiencing mental health crisis. We will also increase alternative forms of provision for those in crisis, including non-medical alternatives to A&E and alternatives to inpatient admission in acute mental health pathways. Families and staff who are bereaved by suicide will also have access to post-crisis support. • By 2023/24, we will introduce mental health transport vehicles, introduce mental health nurses in ambulance control rooms and build mental health competency of ambulance staff to ensure that ambulance staff are trained and equipped to respond effectively to people experiencing a mental health crisis. • Mental health liaison services will be available in all acute hospital A&E departments and 70% will be at 'core 24' standards in 2023/24, expanding to 100% thereafter.
3.108	The local NHS is being allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list.
3.114	We will work to increase the number of people registering to participate in health research to one million by 2023/24.
3.115	By 2023/24 the new NHS Genomic Medicine Service will sequence 500,000 whole genomes.
3.117	From 2020/21 we will expand the current NHS England 'Test Beds' through regional Test Bed Clusters.
3.119	**We will invest in spreading innovation between organisations. Funding for AHSNs, subject to their success in being able to spread proven innovations across England, will be guaranteed until April 2023**

Chapter 4: NHS staff will get the backing they need

Section	Commitment
4.12	Improve nursing vacancy rate to 5% by 2028
4.15	Extra 5,000 nursing undergraduate places funded from 2019/20
4.18	Continue investment in growth of nursing apprenticeships with 7,500 new nursing associates starting in 2019
4.19	Grow wider apprenticeships in clinical and non-clinical jobs in the NHS with the expectation that employers will offer all entry-level jobs as apprenticeships before considering other recruitment options.
4.36	Improve staff retention by at least "% by 2025
4.42	Each NHS organisation will set is own target for BAME representation across its leadership team and broader workforce by 2021/22.
4.48	By 2021 NHSI will support NHS trust and FTs to deploy electronic rosters or e-job plans
4.54	Double the number of NHS volunteers over the next three years.

Chapter 5: Digitally-enabled care will go mainstream across the NHS

Section	Commitment
5.12	In 2019/20, 100,000 women will be able to access their maternity record digitally with coverage extended to the whole country by 2023/24.
5.13	We will work with the wider NHS, the voluntary sector, developers, and individuals in creating a range of apps to support particular conditions
5.13	By 2020, we aim to endorse a number of technologies that deliver digitally-enabled models of therapy for depression and anxiety disorders for use in IAPT services across the NHS.
5.14	Support for people with long-term conditions will be improved by interoperability of data, mobile monitoring devices and the use of connected home technologies over the next few years
5.14	By 2023, the Summary Care Record functionality will be moved to the PHR held within the LHCR systems, which will be able to send reminders and alerts directly to the patient.
5.17	Supporting moves towards prevention and support, we will go faster for community-based staff.
5.21	Over the next five years, every patient will be able to access a GP digitally, and where appropriate, opt for a 'virtual' outpatient appointment.
5.22	By 2024 all providers, across acute, community and mental health settings, will be expected to advance to a core level of digitisation.
5.25	By 2022, technology will better support clinicians to improve the safety of and reduce the health risks faced by children and adults.
5.26	During 2019, we will deploy population health management solutions to support ICSs to understand the areas of greatest health need and match NHS services to meet them.
5.28	By 2021, pathology networks will mean quicker test turnaround times, improved access to more complex tests and better career opportunities for healthcare scientists at less overall cost.
5.28	By 2023, diagnostic imaging networks will enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret
Milestones for digital technology	• During 2019 we will introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in *The Future of Healthcare*. • By 2020, five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations, three additional areas will follow in 2021. • In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's LHCR across the country over the next five years. • 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 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. • By 2022/23, the Child Protection Information system will be extended to cover all health care settings, including general practices. • By 2023/24 every patient in England will be able to access a digital first

	primary care offer (see 1.44). • 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