NHS Blueprint
EoE Conference

https://www.england.nhs.uk/long-term-plan/
https://www.england.nhs.uk/long-read/strategic-commissioning-framework/

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A cultural change

- NHS England is an “Arms Length Body” and is **indirectly** under the control of the Secretary of State
  - Department of Health agrees a mandate with NHS England each year setting out what they are to achieve and then NHS England are free to work out how best to deliver this.

- Department of Health and Social Care is **directly** under the control of the Secretary of State
  - Brings the setting of national policy and its implementation under one organisation
  - Brings Health and Social Care back together (as much as they can be)
  - Staff become Civil Servants rather than the broader term of Public Servants (and relationships are a bit different, now with “the government” rather than with “the NHS”)

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The politics and the Politics

- The politics (with a little p) will continue as they always have.

- Policy will be shaped centrally (with differing levels of external involvement and transparency) as it always has been.

- However, when Politics (with a capital P) comes into play, instead of saying what NHS England has to achieve and leave them to ensure it is delivered, the government now directly has to ensure it is delivered.

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More levels?

• DHSC	57,000,000	(i.e. 1 of them)
• Regions	8,100,000	(i.e. 7 of them)
• ICB	1,500,000	(i.e. 36 of them)
• Place	350,000	(i.e. 160 of them)
• Neighbourhood	40,000	(i.e. 1400 of them)
• GP	9,000	(i.e. 6000 of them)

- Approx 1 acute mental health, 2 community and 3.5 acute physical health NHS providers per ICB

- Or 0.3 acute mental health, 0.5 community 0.8 acute physical health NHS providers per Place

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CSUs started at 25 and reduced over time

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Commissioning Support Unit functions

- Develop a solution once, use it multiple times
- Learn from one part, share with all the other parts
- Build expertise in one place and all benefit from it.
- “Approx 1 acute mental health, 2 community and 3.5 acute physical health NHS providers per ICB” so can see how this works for acute physical…
- But… for delegated specialised services, patient choice accreditation/validation/performance management, acute mental health, community, probably need a pan ICB approach in some ways…

“Data” function (understanding the context)

- Population Health Management
- Loads of words around this but that is what we are talking about – link as much as possible together (at a patient level, as up to date as possible incl non health factors too)
- Use it to:
  - find unmet need,
  - inequalities of access,
  - identify full cost of entire patient journey,
  - try predicting the future demands on the NHS
- https://future.nhs.uk/populationhealth/groupHome

“Data” function (understanding the context)

- So over here they have, for a particular condition, a greater reliance on acute whilst over they have a greater reliance on primary and community care.

- Which approach gives the best balance of
  - value for money (which could include increased benefits costs, if any, until patient is discharged),
  - accessibility,
  - quality/outcomes

- Based on level of pollution, greenspace, age etc. we would expect Y respiratory disorder patients and have a statistically significant level of Z… why?

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“Data” function (understanding the context)

- Needs to support:
  - Region (do it once, adapt it many times)
  - ICB
  - Place
  - Neighbourhood (is data size enough to use to predict things)

- User front end / engagement is crucial to this

“Data” function (quality of care)

- Staff/patient feedback/complaints/safety incidents
- Outcomes (how define this – discharged within X attendances, no readmission within Y days…)
- Where change has not been delivered as expected (referral rates not reduced, lengths of stay not reduced etc.)
- Again – makes sense to solve the problem once on a regional basis…

Long terms approach

- What direction of travel will deliver the most (affordable) benefits to our population over the next 5 years
  - Fed by population health management
  - Plus how do we start to deliver this in the short term

- Cannot escape national “must do’s”
  - **Hospital to community** (more convenient for patient and quite often cheaper too)
  - **Analogue to digital** (the benefits are there but pain to be felt first)
  - **Treatment to prevention** (takes a lot of, not sure of right word(s), confidence/clairvoyance/sagacity to invest for the future rather than now especially when so many pressures now)

Providers

- Medium Term Planning: “responsible for collaboration, productivity and quality”
- An eye to the future is Advanced Foundation Trusts who can then hold Integrated Health Organisation contracts.
- So lots of focus on their own efficiency and own services but also with an eye to what is happening across organisations and thinking about what is best for the system rather than for themselves (i.e. prevention and left shift)

And then, possibly to undermine it all

- A lot of talk about allocating resources to deliver outcomes, a focus on longer term allocations, marketing shaping etc.

- Whilst the payment guidance focusses on activity x price for acute physical health services
  and
  ICBs do not have surplus or ring fenced funds
  then
  ICBs are going to struggle to take this longer term view.

- Instead there will continue to be the focus on validating to avoid paying (well maybe not that extreme a point)

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I mentioned regions a lot

- ICBs will work regionally on some things
- However NHSE/DHSC will have regions that hold ICBs and Providers to account and help them improve
- Those NHSE/DHSC regions will no longer be commissioners (so more is coming to ICBs to do but next year)
- Strategic Leadership, Performance Oversight and Improvement/Intervention [feels very much like Strategic Health Authorities if you remember back to when there were 10 of them around 2006 to 2013]

To summarise

- A lot of similarity to now but with more focus on standardised processes rather than individual approaches
- An increased focus on information so it can serve all levels (neighbourhoods through to regions)
- A slow move to ICBs saying what is needed and Providers collaboratively saying how it is delivered

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Over to you

- Final Q&A
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