10 Year Health Plan working group: 'My care is centred around my needs, and I am listened to'

Co-chairs' report

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Introduction

‘My care is centred around my needs, and I am listened to’ is not a lot for our patients and service users to ask.

Given the daily sacrifice our citizens make to fund the National Health Service (NHS) and care system, it is not a lot to expect.

More than anything, driven by years of training and experience, it is what our staff wake up every morning wanting to be able to deliver.

Yet the complexity that exists today in how health and care is organised, governed, funded and delivered makes it so much harder than it should be to be able to realise.

We’ve reached a turning point in health and care in England and the 10 Year Health Plan provides the first real opportunity in a generation to face that head on: we are either brave, radical and uncompromising in reforming what it means to deliver and receive health and care in England, or we tinker round the margins of a system that Lord Darzi’s recent report acknowledges is currently designed to deliver the results we see today.

Since the publication of that report, we have brought together the collective voices of patients, carers, healthcare professionals and voluntary sector partners to compile this report. Informed by extensive engagement, visits within neighbourhoods and a rich evidence base, we have approached this report driven by 5 key principles:

- patients and their carers know who to call when they need help. Services and support need to be organised in a way that makes it simple to navigate and understand

- frontline health and care staff need to be in the driving seat to deliver care that is truly centred around patients and service users. The best examples of local transformation exist where staff are working - and often co-located - together and are empowered to design and deliver the kind of care they know their patients want to receive, irrespective of which organisation they work for

- creating the conditions for change needs to be given equal precedence to the change we want and need to see. The further away from direct frontline care and communities, the greater the reform that is needed. The centre needs to urgently prioritise only

those things that are going to enable the flexibility and freedom that frontline teams need to be able centre their care around people's needs

- change needs to be front-loaded in the next 3 years to stand any chance of realising our ambitions for 2035. Confidence in health and care amongst staff, patients and citizens hangs in the balance. With so much hope being invested in the government's new approach to health and care, anything other than rapid reform risks losing the faith so many staff and patients have put in the new reform agenda. The ambitions for tomorrow need to be built on change today

- reform is equally if not more important than additional funding. Even if public finances were better, additional funding alone would not be the answer. Fundamental structural reform - which sees a full speed shift to home, community, neighbourhood and place-based care - is required to meet that most simple of challenges that 'my care is centred around my needs, and I am listened to'

We will only succeed if we create the conditions through which local really can mean local, and our staff are enabled to reconnect with communities, reconnect colleagues and teams that are currently kept apart, and reconnect with the reason they became health and care professionals in the first place.

This report is a call to action for all of us - whether we are policymakers, practitioners, or communities - to unite around a shared purpose. With clarity of vision, determination and collaboration, we can turn this vision into reality and ensure that care is always centred around people's needs, and that everyone feels truly heard.

We would ask that each of the 7 enabler groups use these principles to drive the urgent changes needed to support our frontline staff to deliver the kind of care they know their patients want. With 7 million people waiting for health and care, the change we need has to be rapid and decisive.

'My care is centred around my needs, and I am listened to'. What might it feel like in 10 years' time if we really get this right?

We have developed 5 key descriptors that will determine whether we have been successful in ensuring that 'My care is centred around my needs, and I am listened to'. They are:

- people and their families and carers will have the tools, confidence, and support to manage their condition in the community if they are able

- people and their families will know who to call, if their health and care needs change or they need urgent support

- there will be no wrong door for healthcare and support. People will tell their story once, and receive holistic care from a range of public services

- staff from health, social care, local government and the voluntary, community, faith, and social enterprise (VCFSE) are working and valued as one team of teams, supporting the bio-psycho-social needs of residents in their neighbourhood and co-producing innovative ways of delivery care

- distinct disciplines will be valued and recognised, and staff will have the space, skills, and resource to deliver the healthcare people need

Our vision for how this translates into reality is set out below in what people can expect to be able to receive in their home, their local integrated neighbourhood team, their locality and their hospital in 10 years' time. Getting this right will mean much better outcomes in health and care. Not only will we see excellence in access to high quality care, but we will ensure people feel are cared for, supported and 'held' instead of feeling anxious and fearful about whether they can get the care they need when they need it.

In your home

Data and information available at the touch of a screen to every citizen provides tailored and personal information specific to each individual to enable them to make more informed - and improved - lifestyle choices, with a menu of interventions and advice to support them to do their best.

Booking appointments from the comfort of your own armchair will be much easier - with online consultations the norm not the exception, the ability to book care based on the next available slot irrespective of where (in or out of area) that care is being provided, and the ability to access data on the quality of that care to support people to make the best decisions.

Access to home-based technologies to support people with long-term and multiple conditions is now universal, with a range of episodes of care previously only delivered in acute settings now manageable within the home. Supported by community care, social work, voluntary sector providers and nursing teams, the number of 'virtual' wards is now higher than the number of 'actual' wards for the first time in NHS history.

'Anticipatory care' has been at the heart of the transformation of the NHS over the last decade, with integrated care boards (ICBs) having led the way on risk stratification across all secondary, community and primary care: all of which play an important role in the success of healthcare at home. The shift over the last decade to create more generalist

clinical roles has been an important factor in this, as has the upskilling of lower-banded clinical, support and social care roles.

The national campaign on health literacy - which is now embedded in the National Curriculum - has supported both staff and patients to make better use of technologies in the home.

There are integrated personal care packages for those who need it, with carer support being provided by skilled and trained professionals.

High intensity users of health and care have access to their own local integrated neighbourhood team, who ensure that navigation of health and care needs is as simple and as tailored to need as possible.

In your neighbourhood

Communities will know and be able to access their local integrated neighbourhood team. Operating on footprints of no more than 50,000 population, these small multi-disciplinary teams - consisting of primary, community, mental health, social care, local government and voluntary sector - work alongside general practitioner (GP) practices and larger locality teams to identify and support those people in the neighbourhood who need personalised packages of care, and additional support in navigating health and care support because of the complexity of their needs.

Working seamlessly with primary care providers, including community pharmacies, dentists, optometrists and audiologists alongside general practice, these teams focus on early intervention, prevention and continuity of care. The relationships they have developed - particularly with high intensity users, vulnerable patients and people with multiple chronic conditions and their families and carers - have helped restore trust in local health and care services and has created innovative new models of care by bringing disparate services together into one team.

At their heart, these teams support and empower people to stay healthy and well and maintain independence living in their own home for longer, by giving them the knowledge and confidence to manage their health and wellbeing, identifying and treating problems earlier, and connecting them to local support, for example social care and support on housing, financial and benefits advice and jobs and training. They also act as the first line support to unpaid carers and community and faith groups - supporting them to care for their people in the most effective way.

The space and capacity released within GP practices due to the onset of integrated neighbourhood teams has meant that primary care is now much more accessible and

there when patients need it, both in and out of hours. This has enabled GPs to use their additional capacity to give much greater focus to helping patients with long-term conditions and those who need complex care, and to return to being able to provide continuity of care for those patients who need and want it.

All of this has impacted significantly in shifting the dial on the amount of time being able to be spent on preventative care, immunisation programmes, improved screening and ultimately making real inroads into prevention and improving health inequalities.

These integrated neighbourhood teams link directly into locality and/or place hubs, where a range of different local services are organised and offered in a way that makes it simple for patients and service users to access.

In your locality and/or place

Locality hubs are now the backbone of the NHS and care system - based in the heart of communities and bringing together services under one roof for populations of around 250,000 people.

Based on a model of ‘Sure Start for Health and Care’ they are home to teams of district, community and mental health nurses - these locality hubs also bring together voluntary sector services, social care staff, employment support, local housing teams and even community police teams.

The onset of the national data sharing agreement transformed the ability of the teams in these hubs to provide multi-disciplinary support with much greater ease than had been previously possible. Risk stratifying patients in this way, alongside the rapid development of online consultations, has freed the way for a return to the continuity of care that some patients need and want.

The hubs also provide the base through which the local Integrated neighbourhood teams operate, with data interpreted by AI identifying which patients and service users require intervention and support.

Operating out of a mix of community buildings developed under the PFI programme as well as underutilised high street spaces, some of these hubs also include diagnostic facilities that are supported by secondary care teams working out of these community settings.

The success of locality hubs in keeping people healthy for longer, ensuring wherever possible they can be cared for at home when they are sick, was in part driven by the new community standards on effective discharge and hospital admission introduced at the

beginning of the 10 Year Health Plan supported by the shift in funding from acute to community set out in the first 3 year spending review (SR) back in 2025.

Commissioned by ICBs and governed at place, joint commissioning of services between health and social care is now the norm not the exception. Joint commissioning has ensured alignment of service delivery between health and social care, which, alongside the co-location of teams has helped to develop an innovation culture amongst local professionals now working together to provide the best deal for their communities.

The combination of local integrated neighbourhood teams, health and care services operating out of locality hubs and joint commissioning of health and care (including the commissioning of the private sector) has helped ensure pathways of care are simplified, risks better aligned and funding is used in a much more productive way. End of life care is a great example of a pathway that has been transformed because of this approach - people are now supported in the home in a co-ordinated way, acute care is delivered in an organised way that makes sense to the patient, and hospice care is commissioned and delivered as part of a single, joined-up pathway. This progress is underpinned by ensuring everyone is offered the opportunity to develop an advance care plan before they reach crisis point, with the outcomes measured in terms of adherence to their plan.

Staff surveys have consistently improved over the last 10 years as staff are empowered to provide care that is centred around the needs of their patients, service users and community. Patient surveys show confidence in local NHS services is at its highest since records began.

Secondary care staff now also work into and alongside locality and neighbourhood teams and are central to the improvement management of people with long term conditions and multi morbidity. This not only ensures the individual gets a better, more tailored and co-ordinated service, but it helps ensure they get a better quality of life, can continue working and contributing to society - all securing improved economic growth.

More broadly, this approach to joined up working has embedded a life course approach to health and care delivery, where children, young people in transition, working age people and older people all benefit from a core health and care offer delivered in or as close to home as possible.

Of course, even where those services are delivered outside of hospital, hospital staff - clinicians and support staff - play a crucial role not just in working in tandem with their locality or place hub, but also by delivering previously acute services through the hubs themselves. This joined up approach has, over time, eliminated some of the previous barriers to discharge and has created an aligned local approach to who needs admitting to hospital in the first place.

In your hospital

The early progress made by integrated neighbourhood teams and locality hubs and the subsequent improvement in urgent care delivery, meant that acute providers were able to shift their focus onto normalising elective waiting times - which at the time had the biggest single impact on improving health outcomes and reducing health inequalities.

Hospitals now compete for patients based on waiting times as well as local accessibility with the next generation NHS App allowing patients to shop around for the fastest access to elective care at the touch of a screen.

Emergency departments (EDs) have become significantly de-risked. They work alongside community hubs in a ‘health village’ approach, with patients able to access same day urgent care closer to home at one of their local hubs. Demand for ED services has reduced significantly. Many of the staff who traditionally worked in acute settings are now bringing their experience into the community setting - with healthcare jobs made more attractive by the shift of services into localities.

One of the biggest impacts for hospitals has been creating the headroom and capacity to refocus on quality of care as well as innovation, research and life sciences. Clear structures in hospitals mean acute-based consultants are aligned geographically with neighbourhood and place, and the growth in the number of generalists means more clinicians now work across neighbourhood, locality and hospital irrespective of which trust they work for.

Implications for enablers

Our vision for creating a system where ‘my care is centred around my needs, and I am listened to’ is clear. The challenge is how we enable that change. Tinkering around the edges of existing ways of working is not going to deliver the radical difference our staff and patients want and deserve to see.

Fundamentally, this is going to require a completely reimagined planning process, mindset, and very different conversations between all parts of the system.

For example, we do not necessarily need massively more staff. We need to change the way they learn and work and create the conditions in which they can come together to do what patients need. So, in the short term, we need to encourage employers to free up their

staff to work together in the above models. In the longer term we need to look at changes to the employment model.

In the short term, staff should develop more skills in multidisciplinary teams (MDTs) from peer-to-peer support. However, in the medium to longer term, we need to change the way they learn, so that different disciplines train and learn together, with a greater emphasis on generalist skills; so that they are able to adapt and learn throughout their careers.

Below, we set out a series of questions and challenges for each of the 7 enabler groups whose responsibility it is to create the conditions though which this re-imagining can happen at pace.

Accountability and Oversight - simpler, tighter and joint in neighbourhoods and at place:

- develop and introduce a new suite of community and primary care standards to drive a new focus on community activity to support the implementation of the new model of care

- ensure there is a standard core national offer that people can expect within neighbourhoods that includes general practice, pharmacy, optometry, dentistry and audiology. This would not only be beneficial in helping patients better understand what they can expect as minimum standards, but would also create a nationalised approach to delivering these core services that would be welcomed by staff and professionals

- undertake a rapid overhaul of existing targets and expectations to significantly reduce the overall number of ‘asks’ on health and care providers to provide the headroom and focus on delivering the new community standards at pace

- utilise the 3-year SR to develop a 3-year planning process that allows systems to develop a bridge between where we are now and where we are trying to get to, with equal focus on reform and transformation as well as delivery. This requires a completely reimagined planning process, mindset and very different conversations between all parts of the system

- set out how the commissioning support infrastructure could enable ICBs to better exercise their commissioning powers to enable the creation of a neighbourhood health service

- set out how we overhaul and modernise the primary care contracting architecture to ensure that the new contracting arrangements incentivise activity that will deliver the new community and primary care standards

- create the conditions to support the short-term sustainability of the VCFSE sector by mandating service contracting on a minimum 5-year basis

- develop a shared national outcomes framework - tight or loose, allowing local flex but tight accountability for achieving a relatively small number of shared outcomes

- ensure the regulatory approach or framework and operating model are geared to support integration - for example, to incentivise more hospital-based outpatient work into communities, building on success of virtual wards and so on

- develop a long-term initiative on improving health literacy from childhood through youth, adulthood and later life

- ensure the 10 Year Health Plan is accompanied by a capacity plan to deliver it - including workforce, IT and capital. We need all 3 and ideally, we would have one plan instead of the NHS Long Term Workforce Plan (2024) as well as a digital plan and an estates plan

Money and contracting - joint, inclusive, shift to community:

- reform and support improved commissioning. ICBs need to demonstrate a route map to making joint commissioning between local authorities and NHS the norm not the exception. How will the centre focus improvement resources on supporting ICBs and local authorities to move to an overtly integrated approach

- reform and support improved primary care contracting - provider reform in the non-hospital space

- systems need to be able to demonstrate a percentage shift in funding from acute to community over the course of the 3-year SR. We will only shift the balance towards neighbourhood and community development if backed by a clear financial strategy

- set out how we will provide VCFSE with longer term funding - 5-year funding envelopes enable more sustainable service development and delivery by the VCFSE

- urgently review and reform the Better Care Fund to return it to its original purpose of driving health and social care integration, with core health and social care funding being met separately. This should include a dedicated funding stream for VCFSE and responsibilities on ICBs and local authorities to stimulate the VCFSE market

- review of palliative and end of life care to move towards sufficiency as well as quality

People - investing in generalism at the heart of an integrated, customer-focused approach with staff enabled and supported to innovate at the frontline:

- investment shifts to community and primary care (see above) need to go hand-in-hand with workforce modelling to retain and expand community health professionals, GPs and primary care staff, enabling a parallel reduction in acute staffing over time

- develop a 10-year plan for the social care workforce to run alongside a revised 10-year plan for the NHS workforce

- review training to move to default position of all training being joint at a local level, except where it makes sense to be more specialist, and opening up local training to VCFSE where appropriate

- explore scope for new roles or align roles to multi-morbid and ageing population

- shift the emphasis in clinical training from specialist to generalist and within practice, emphasise team approaches to ensure better continuity of care, including between hospitals and primary care

- urgently review how regulators can ensure curricula are fit for purpose

- fundamental change in approach to unpaid carers, that treats them as part of the team and provides more training and support. This should also address how we provide digital education and training tools for patients and carers

- make care co-ordinators and navigators a mainstream part of every local system - to support people with multiple long term conditions to manage their care; and professionals to navigate the system more effectively (but recognising that ultimately, we should not need care co-ordinators when our system is no longer fragmented)

- improve training in customer-facing communications and handling skills among all public facing staff

Data - more comprehensive and fully inclusive at local level, easier to share:

- undertake an urgent, fast-paced national review to ensure the right data sharing protocols are in place to cover all local partners to ensure interoperability: this is central to driving joint working across different teams

- improve collection of data in community services, social care, extend to VCFSE where appropriate

- ensure procurement rules are in place to make interoperability of data systems a pre-curser to any future tendering processes

- prioritise work to ensure we can better track people's journeys through health and care - for example, including in and out of hospital

- NHS number as the common identifier in all services

Physical infrastructure - more emphasis on making primary and community health settings fit for purpose, with good digital and comms infrastructure, co-location and local the default:

- ensure systems undertake a rapid audit of all primary and community estate - to be followed by a utilisation plan to support the development of locality hubs

- prioritise future capital spend in primary and community care settings - all ICBs should be required to develop an infrastructure plan that evidences this to drive greater development of community estates (this should also be aligned with local authority community infrastructure investment plans through joint commissioning arrangements)

- voluntary and community sector estate should be enabled to house some community and primary care services which would improve accessibility including for excluded groups

- where parts of hospital estates become available, priority should be given to transferring use to primary and community care

- create a single spine for communications and IT in primary care settings. This will have a significant impact on realising productivity gains

- co-location should become the norm. While this alone will not drive integration it will accelerate and support it

- review of phone and online systems including 999 and 111 to make it clearer for the public who to call in different situations; overriding aim of ensuring people with chronic conditions and/or end of life and their carers know they can get support on phone or online 24 hours a day, 7 days a week

Research and/or life science innovation - more applied research that is applicable to making the best of all our resources locally as per the hospital to home shift:

- shift the research emphasis towards patient experience, including basics like what works in supporting people to adhere to their prescribed medication regimes; and what works best in terms of integrated approaches, including social care

- align the work of NHS Impact, local Health Innovation Networks, and Applied Research Networks to prioritise supporting systems to develop neighbourhood health services for example on how to support people to take more responsibility for their health

- develop a national education programme to support people to maximise the use of digital tech, including for those who are not digitally included; (for example, using local hubs as places where those offline can still access online consultations and so on)

- ensure the NHS is a learning organisation with research at its heart, so is therefore constantly changing and/or innovating to support the delivery of this model

Mobilising change - provide the headroom to drive transformation by being clear on limited national priorities and aligning policy and resources to give local teams the support they need to drive change:

- create a fundamentally different service offer, changing not just the model of care but the relationship between patients and clinicians and the citizen and the NHS

- the centre should review its role and resource in terms of what needs to be deployed at all levels - what do the 3 shifts mean to them and how can we create additional improvement and support resource from existing national teams that can easily be drawn down by local systems and teams to provide additional local capacity to drive change

- create the headroom to enable change - the centre needs to work to reduce ‘the overall ask’, be really clear on its (limited) priorities and be disciplined in not creating additional in-year demands on the service unless absolutely necessary (significantly strengthen the national Department of Health and Social Care and NHS England gateway process and move to a one in, one out model)

- ensure policy is aligned to support innovation - for example, capital investment, accountability, regulation and payment mechanisms all need to be developed in the

round to ensure that everything nationally is geared to creating the conditions to support and accelerate change

- create the conditions to rebuild trust and strengthen joint working across the army of health and care communications professionals to support and drive change locally to create new optimism amongst staff, patients and communities - significantly shift the current national communications focus from national politics and media to driving and celebrating local change

- invert the lens on what success looks like - need to start telling the story as much through patient stories, service improvement and local change as we do through national targets

Conclusion

Everyone involved in delivering health and care is watching, waiting and most of all hoping that this 10 Year Health Plan will create the conditions for the change they desperately want to deliver. The appetite for fixing our health and care system has never been greater.

This group has undertaken their task with an energy driven by hope, but with a focus and determination driven by the urgency of the task ahead. We are grateful to them all for the dedication in the past weeks.

That same sense of urgency and hope needs to now sit at the heart of each of the 7 conversations about how we make this vision a reality: tinkering round the edges will not get us where we need to be - this moment requires radical thinking and a fundamental paradigm shift in what it means to plan, finance, organise and deliver health and care going forward.

Ensuring 'my care is centred around my needs, and I am listened to' should never be too much to ask.

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