



# Developing the long term plan for the NHS

Specialty specific recommendations

October 2018

## STANDARDS

<p>Royal College of Ophthalmologists</p>	<ul style="list-style-type: none"> <li>- NHS England should mandate the national adoption of NICE guidance for all specialties.</li> </ul>
<p>Royal Colleges of Anaesthetists</p>	<ul style="list-style-type: none"> <li>- All surgical patients should be managed on a perioperative pathway of care, which incorporates appropriate interventions before surgery, the operation itself and recovery after a procedure</li> <li>- All patients undergoing elective surgery should undergo a preoperative assessment that is led or overseen by a consultant anaesthetist and that includes screening for alcohol intake, smoking, obesity and physical activity</li> <li>- Equitable access to high quality pain services must be available for all patients and include specialist pain management integrated with other key services, including psychological support.</li> </ul>
<p>Faculty of Sexual and Reproductive Health</p>	<ul style="list-style-type: none"> <li>- Digital access needs to be brought into the Standards framework, so that appropriate standards explicitly address aspects of the digital agenda</li> <li>- A minimum set of specific standards for training, service provision and patient access are required</li> <li>- Specialist SRH services should meet the requirements of the Service Standards for Sexual and Reproductive Healthcare, and equivalent standards should be developed for GUM services, drawing on sources such as the British Association for Sexual Health and HIV (BASHH) clinical guidelines</li> </ul>
<p>Faculty of Intensive Care Medicine</p>	<ul style="list-style-type: none"> <li>- Patient ratios should be as follows: the consultant: patient ratio (day time) should not normally exceed 1:8; the intensive care resident:patient ratio should not exceed 1:8; Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1; Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2</li> <li>- Admission to Intensive Care should occur within 4 hours of making the decision to admit and discharge from a unit must occur within 4 hours of the decision to discharge</li> <li>- There must be a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response. Hospitals should aim for equality of access post-</li> </ul>

	<p>critical care for all patients to ensure adequate follow up</p> <ul style="list-style-type: none"> <li>- Units should monitor and regularly review metrics of wellbeing as quality indicators, e.g. sickness rates</li> <li>- Bed occupancy should normally be around 85% to ensure safe patient flow. Consistent occupancy of 95% or above would indicate severe stress on the critical care service Involvement of intensive care teams with patients should not stop when a patient is discharged from ICU. Following the publication of the NICE quality standard in 2017 on Rehabilitation after Critical Illness, more Intensive Care Units are starting to develop services to ensure physical and psychological problems after intensive care are identified and managed appropriately.</li> </ul>
<p>Royal College of Radiologists</p>	<ul style="list-style-type: none"> <li>- NHS England's 2018 Annual Plan mentioned plans to re-structure cancer waiting times. We would assert that the blanket 62 day timeframe is sometimes not appropriate. Referral to diagnosis over referral to treatment is applicable for certain cancer types and should be standardised (and this should be determined through consultation with appropriate clinicians)</li> <li>- Rapid access to imaging tests with a clinical opinion (radiology reporting) and appropriate onward referral</li> <li>- Access to urgent IR services and all nonsurgical cancer therapies including radiotherapy; mechanical thrombectomy for stroke; providing radioisotope studies for early diagnosis of dementia/exclusion of Alzheimer's; whole body MR; and cardiac CT services</li> <li>- Imaging Services Accreditation Scheme (ISAS) could be used as a "from the box" quality management system for all imaging departments in England</li> <li>- The NHS Improvement National Imaging Optimization Delivery Board, with RCR input, is working on minimum reporting</li> <li>- Focus on stratified cancer screening programmes that are population based with equity of access across the country. The clinical areas and emerging techniques recommended for prioritisation are: demographic screening for lung cancer, breast screening using genomics to support stratification of high, moderate and population risk, screening, bowel cancer screening, rolling out mpMRI for prostate cancer screening with same day biopsy, discharge or follow up</li> <li>- Improved patient outcomes could be achieved with investment in models similar to 'Rapid Access Diagnosis Clinics' at Guy's and St Thomas' Hospital, particularly in areas of greatest unmet need</li> </ul>

	<ul style="list-style-type: none"> <li>- To support and streamline diagnostic pathways, we recommend roll out of i-refer</li> <li>- Ready access to image-guided interventions could have a major impact on clinical outcomes. Interventional radiology (IR) uses imaging to guide the clinician in specific surgical procedures safely</li> <li>- RCR's radiotherapy guidelines should be implemented.</li> </ul>
<p>Royal College of Surgeons of Edinburgh</p>	<ul style="list-style-type: none"> <li>- The definition of care standards should be derived through transparent consensus methods by sub-specialty associations with input from the subspecialty groups within each college e.g the SSB within the RCSEd</li> <li>- Increased understanding of the effects of targets and performance indicators in healthcare provision settings is necessary</li> <li>- It should be made easier to share good ideas. Processes to identify excellent processes or practices that facilitate effective and efficient healthcare should be developed.</li> </ul>
<p>Royal College of Emergency Medicine</p>	<ul style="list-style-type: none"> <li>- It would be perverse to abandon the Four-Hour Standard precisely at the point that the funds become available to restore system performance. The available evidence suggests that with right level of investment these targets remain valid practical objectives that improve patient care.</li> </ul>
<p>Royal College of Psychiatrists</p>	<ul style="list-style-type: none"> <li>- Mental health services urgently require expansion. The strategy should commit to the biggest expansion in access to mental health services across Europe, empowering the disempowered with a much-needed focus on tackling inequalities, fit for a modern NHS. Invest an additional £6.198bn (£5.677bn revenue and £521m capital) in mental health services between 2019/20 – 2023/24 and a further £7.456bn (£6.520bn revenue and £936m capital) between 2024/25 – 2028/29. This will take spending by CCGs and NHSE on mental health from 10.8% in 2017/18 to around 13.1% in 2028/29 of the total estimated NHS England budget. This would mean that the funding uplifts required for delivery would be in the range of 5.5% to 6.8% above inflation for the period up to and including 2023/24. Spending growth could then slow slightly to between 4.3% and 4.6% above inflation for the remainder of the period to 2028/29, with the majority of workforce commitments by then in place.</li> </ul>

## WORKFORCE

### Royal College of Ophthalmologists

- Investment in Ophthalmologists specialty training places to ensure there are enough doctors qualified in Ophthalmologists to meet the predicted 30-40% increase in demand over the next 20 years
- National workforce planning expertise and resource to work with clinical specialty experts and Colleges to produce clear picture of ideal workforce for medical, non-medical clinical and community staff provision for predicted demand
- HEE funded support to provide national training programme for all non-medical professionals to deliver care safely in regional community and secondary care networks with ophthalmologists
- Recognition by NHS England, Commissioners and Trusts on the negative impact on training and professional standards by taking routine cases out of the Hospital Eye Service and ensure training must be protected in service transformation or changes in provider
- National and regional long-term workforce planning with appropriate training provision to meet local population demands and reduce dependency on ISTCs and AQPs.

### Royal Colleges of Anaesthetists

- A single, coordinated plan to recruit, train and retain an adequate workforce in anaesthesia, critical care and pain medicine should be published
- Medical Associate Professions (MAPs) should be regulated in statute and government should bring forward legislation without further delay
- All employers should support a cultural shift towards a 'no-blame' learning environment that prioritises the safety of patients
- The Department of Health and Social Care, in coordination with the relevant devolved organisation and arm's-length bodies, should support the development of a national morale and welfare strategy for all NHS staff
- Dedicated capital funding should be available for the provision of adequate facilities that enable NHS staff to work in a comfortable working environment.

<p>Faculty of Sexual and Reproductive Health</p>	<ul style="list-style-type: none"> <li>- The Ten-Year Plan must speak to HEE's Workforce Plan to ensure investment in clinical training</li> <li>- Training for local GPs, medical students and nurses must be a mandatory part of specialist sexual and reproductive health services' contracts</li> <li>- Existing training of the workforce in contraception and sexual and reproductive health relies on the voluntary input of doctors and nurses through their involvement in the FSRH and other medical Colleges. This is vulnerable as demands on HCPs increase. We would like to see the AoMRC work with its members and NHS England to review the sustainability of this model and how it can be better supported in the long-term plans for the NHS.</li> </ul>
<p>Faculty of Intensive Care Medicine</p>	<ul style="list-style-type: none"> <li>- The ACCP role is a key solution to middle grade cover in critical care units, providing a stable and sustainable workforce that is able to provide continuity of care on medical rotas. The FICM has developed a national curriculum, a national register and appraisals pathways for ACCPs and is working with HEE on the essential issue of regulating this new workforce.</li> </ul>
<p>Royal College of Radiologists</p>	<ul style="list-style-type: none"> <li>- Before any other strategic commitment, NHS England must collaborate with Health Education England, NHS Employers and the Department of Health to address workforce issues across the NHS, giving support for additional funded training numbers and the retention of staff the appropriate credence. Everything else is academic.</li> </ul>
<p>Faculty of Pharmaceutical Medicine on behalf of Clinical Pharmacology Skills Alliance</p>	<ul style="list-style-type: none"> <li>- Given the importance of medicines to the NHS, the long-term plan must focus on the development of cross-cutting skills in medicines use and clinical research across the whole workforce</li> <li>- The long-term plan recognises the current and future challenges relating to the use of medicines [e.g. caring for an ageing population, pharmacogenomics] but it should also ensure the NHS workforce is equipped to respond to them. It is vital that healthcare professionals are appropriately trained to manage the complex problems that emerge in clinical practice. It is also critical that the UK is able to employ the staff it needs to deliver against these and other pressing needs. The UK must be accessible when it comes to recruiting people from overseas.</li> </ul>
<p>Royal College of Psychiatrists</p>	<ul style="list-style-type: none"> <li>- Build a strong and resilient mental health workforce with 70,348 more staff on the ground by 2028/29 (excluding Mental Health Support Teams), of which 4,018 will be psychiatrists.</li> </ul>

## DATA

<p>Royal College of Ophthalmologists</p>	<ul style="list-style-type: none"> <li>- Auditing of national clinical data is proven to raise clinical safety standards and enhance learnings and training to improve patient outcomes. National ophthalmic funding for three years for each of the sub-speciality areas (Cataract, ARMD and Glaucoma) would cost a total of £0.9m over a three-year period</li> <li>- Providers can use NOD data to plan for the predicted demand</li> <li>- Other branches of medicine can adopt principles as data is uniquely collected via Electronic Medical Record (EMR) systems.</li> </ul>
<p>Faculty of Sexual and Reproductive Health</p>	<ul style="list-style-type: none"> <li>- Hold accurate and high-quality data. A digital agenda is only as good as the quality of data which it holds. Building on the need for effective data capture across the NHS, the digital agenda should extend beyond immediate issues of patient care.</li> </ul>
<p>Royal College of Radiologists</p>	<ul style="list-style-type: none"> <li>- In partnership with NHS Digital and Public Health England, NHS England should focus on methods for obtaining the crucial data, circumventing obstacles to patient consent and GDPR issues.</li> </ul>
<p>Royal College of Surgeons of Edinburgh</p>	<ul style="list-style-type: none"> <li>- Research capacity, the use of data and how it is harnessed also need to be included within the plan. The NHS has a rich resource in its data and this needs to be utilised to ultimately improve patient care.</li> </ul>

## DIGITAL/IT

### Royal College of Ophthalmologists

- A joined-up network between hospital clinical and administrative IT systems and optometric systems is required much like the GP-Pharmacy join up
- National support for Ophthalmologists-suitable electronic patient records (EPR) solutions which fulfil College standards in all providers
- Recognition that where aspects of AI will greatly enhance efficiency and diagnostic accuracy it may also lead to an increase in case identification and service demand.

### Faculty of Sexual and Reproductive Health

- To ensure inequalities are not widened through digital services and technology, the Ten-Year Plan should address issues of equal access
- Data must also be available to measure patient access. Key measures could focus on patient capability, usage and awareness
- Support integrated forms of working within SRH. The FSRH has long argued for a model in which nurses and GPs are linked to consultant leads for support and advice. Digitally based communication would be invaluable in sustaining this model.

### Royal College of Radiologists

- Underpinning all integration needs to be full IT connectivity across primary, community and secondary care
- Investment in IT infrastructure to support development of regional radiology networks, provision of radiotherapy, multidisciplinary team meetings (MDTMs) and joined up working
- Urgent investment in PACS terminals.

<p>Royal College of Surgeons of Edinburgh</p>	<ul style="list-style-type: none"> <li>- A national review of IT systems and their fitness for purpose would be vital if we do not repeat the fiascos of the past (most trusts having different systems, many do not talk to each other, outdated software –Window XP or windows 7, virus attacks closing down vital IT clinical systems</li> <li>- Modern efficient IT/data systems, the use of 'Big' data, development of artificial intelligence are likely to revolutionise healthcare</li> <li>- The development of virtual fracture clinics have improved efficiency and reduced outpatient clinics in T &amp; O and could be a model for other specialities.</li> </ul>
<p>Royal Colleges of Anaesthetists</p>	<ul style="list-style-type: none"> <li>- Payment systems should incentivise integrated care pathways, not isolated interventions, in order to deliver the best outcome for patients</li> <li>- Tariffs must be structured to ensure that providers will not be financially worse-off for providing consultation and pre-admission that results in a shared-decision to not pursue a surgical treatment option</li> <li>- No reconfiguration of services which result in reduced capacity of hospitals to diagnose, treat or provide postoperative management of patients should be approved without a fully-costed and clinically-supported plan for the provision of community-based care</li> <li>- The NHS Outcomes Framework, NHS Adult Social Care Framework and Public Health Outcomes Framework should be replaced with a single framework that captures integrated care outcomes.</li> </ul>
<p>Royal College of Ophthalmologists</p>	<ul style="list-style-type: none"> <li>- Appropriate national consistent arrangements for funding of safe networks of care including in the community.</li> </ul>
<p>Faculty of Intensive Care Medicine</p>	<ul style="list-style-type: none"> <li>- Where services are planned for reconfiguration (i.e. through the local Sustainability and Transformation Partnership), the regional Critical Care Operational Delivery Network should be engaged as soon as possible in the discussion for advice and specialty input.</li> </ul>
<p>Royal College of Radiologists</p>	<ul style="list-style-type: none"> <li>- For cancer services, we recommend fully-funded and networked Cancer Alliances, which are fully integrated with all other health care providers. The current situation where STPs, Cancer Alliances and Vanguard are not coterminous in terms of population or commissioning encourages a</li> </ul>

	<p>piecemeal approach to complex services covering many financial boundaries.</p> <ul style="list-style-type: none"> <li>- The radiotherapy network structure as envisioned in the NHS England service reorganisation could support integration of service delivery, reducing waste and releasing efficiencies, if the IT infrastructure were fully in place</li> <li>- Closer integration of palliative anticancer therapies and community palliative care will improve patient experience, facilitate more patients dying in their preferred place of care and, possibly, reduce demand for poorly performing end stage active anticancer interventions</li> <li>- A review of the tariff system will also encourage integration among departments as competition for funding will be removed. As a broad way forward, we would encourage a capitated, whole population budget, with an improvement payment scheme that includes a gain/loss share arrangement.</li> </ul>
Royal College of Surgeons of Edinburgh	<ul style="list-style-type: none"> <li>- Social care is not included in NHE's remit for the 10 year plan but it is difficult to conceive a plan which does not take social care provision into account. There is currently a focus on an integrated agenda and social care, particularly it's integrated with the health sector needs to be considered.</li> </ul>
Faculty of Sexual and Reproductive Health	<ul style="list-style-type: none"> <li>- System fracture between NHS and local authorities needs to be addressed.</li> </ul>
Royal College of Psychiatrists	<ul style="list-style-type: none"> <li>- Empower mental health leaders to develop the healthcare services of the future through Integrated Care Systems and Partnerships.</li> </ul>

## PUBLIC HEALTH

### Faculty of Sexual and Reproductive Health

- It is vital that the NHS achieves value for money in its investment over the next decade – this will require a focus on prevention as well as reviewing the tariff and payment systems that currently ‘reward’ hospital-based care
- For the investment in the NHS to work for women, health and social care must be considered alongside prevention and health promotion. This will require joined up thinking and working between national agencies, including HEE, PHE and NHS England as well as Local Authorities.

### Faculty of Pharmaceutical Medicine on behalf of Clinical Pharmacology Skills Alliance

- We support a focus on investments and public health initiatives that aim to protect people from harm and reduce demand on the NHS. We recommend investing in partnerships between clinical pharmacology and pharmacy at the primary-secondary care interface to support complex polypharmacy.

### Royal College of Surgeons of Edinburgh

- Public health is not included in the scope of NHS England’s 10 year plan. Cuts to public health with have a hugely detrimental impact on the health of the population and will ensure additional pressure is added to the health system over time Whilst this is devolved to Local Authorities, this must be considered within the plan. The true effects of current public health cuts will be increasingly felt over the 10 years.

### Royal College of Anaesthetists

- The Department of Health and Social Care should commission an independent review of the provision and effectiveness of public health services, with a mandate to consider the option for returning responsibility for public health to the auspices of the NHS
- We support the recommendation of the Royal College of Paediatrics and Child Health for the introduction of statutory and comprehensive personal, social and health education programmes and sex and relationship education across all primary and secondary schools
- The Department of Health and Social Care should produce a long-term marketing strategy, supplementary to the long-term plan for the NHS in England, with the aim of enabling better self-management of personal health and decisions about an individual’s own health and care.

## INAPPROPRIATE CARE AND UNWARRANTED VARIATION

### Royal College of Radiologists

- *iRefer* and Clinical Decision Support System from RCR should be funded for every hospital and GP practice to enable appropriate referral and thereby foster efficiency and reduce waste in imaging services
- The *Getting It Right First Time* programme, delivered in partnership with NHS Improvement, is dedicated to identifying, and striving to eradicate, unwarranted variation in care
- A review of the payment by results system is also urgently needed to allow for the most appropriate treatment to be given to a patient determined solely on medical circumstance, and not by which treatment attracts a higher tariff for the trust
- Day surgery should be considered the default for planned [elective] surgical procedures where clinical evidence of outcomes supports this. Unwarranted variation in day surgery rates needs to be corrected.

### Faculty of Pharmaceutical Medicine on behalf of Clinical Pharmacology Skills Alliance

- Targets on minimum standards to reduce medicines wastage in the NHS should be implemented.

### Royal College of Anaesthetists

- Clinically appropriate alternatives to surgical treatment, including the option of 'no surgery' should be explicitly discussed with all patients before referral onto a surgical pathway.