Bristol Clinical Commissioning Group

# Bristol Health & Wellbeing Board

| NHS 5 Year Forward View | |
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| Author, including organisation | Justine Rawlings<br>NHS Bristol Clinical Commissioning Group (CCG) |
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| Report for Information/Discussion | |

## 1. Purpose of this Paper

The purpose of this paper is to highlight the key points within the NHS Five Year Forward View, October 2014 which was written to 'set out a vision of a better NHS, the steps we should now take to get us there and the actions we need from others.'

## 2. Executive Summary

The report sets out the successes of and challenges facing the NHS and suggests that standing still is not an option because the following gaps would widen:

- The health and wellbeing gap including widening health inequalities
- The care and quality gap including variations in outcomes
- The funding and efficiency gap, suggesting the need for reasonable funding levels matched with system efficiencies.

The report reviews the actions required to meet these gaps in terms of:

- The action needed to tackle health and wellbeing
- The radical changes needed to tackle care and quality

And then sets out options for meeting the funding and efficiency challenge

## 3. Context

The Five Year Forward View is written to represent the shared view of the NHS' national leadership. The document says it 'reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders'.

## 4. Main body of the report

The full document and executive summary can be read at

http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

The Local Government Information Unit (LGiU) briefing is attached. (Appendix 1) which expresses a view of the report in relation to the interface between health and social care, the Better Care Fund and integrated commissioning.

Key bullet points from the report are:

### 1 Actions to be taken

#### 1 Radical upgrade in prevention and public health required

- Alcohol
- Obesity
- Smoking
- New workplace incentives and stronger localised public health powers for local government

#### 2 Patient control over own care

- Shared budgets combining health and social care
- Support for carers
- Better partner with voluntary sector and local communities

#### 3 Break-down barriers in how care is provided between family doctors and hospitals, physical and mental health, health and social care

- More care locally
- New support for those with multiple health conditions
- Localised models from a menu of options, including: multispecialty community provider, primary and acute systems etc
- Urgent and emergency care services redesigned to integrate A&E, GP OOH, UCC, NHS 111, ambulance services
- Smaller hospitals supported by bigger ones
- Midwife led services
- Support for frail older people in care homes

**2 Support to make the required changes**

- Backing for local leadership and limited number of joint commissioning models dependent on evaluation of Better Care Programme
- Support nationally for local flexibility in payment rules, regulatory requirements
- Backing for diversity, not top down restructuring
- Invest in workforce and technology, research and innovation

**4 Affordability**

- Drive efficiency and productive investment
    - Expectation that 2%-3% net efficiency/demand saving each year over the next decade possible across whole funding base if action on prevention, new models, sustainable social services and efficiency from wider service improvements
    - 3 options for closing £30bn gap by 2020/21: a combination of efficiency and funding which are considered viable

## 5. Key risks and Opportunities

These are outlined within the plan and need to be reviewed locally in conjunction with our existing plans.

## 6. Implications (Financial and Legal if appropriate)

None specific to this report.

## 7. Conclusions

The report concludes that continuing with a comprehensive, tax funded NHS is possible and that there are viable options for achieving this, involving the contribution of the NHS itself and of the government in support.

## 8. Recommendations

This is a summary for information and discussion. It is noted that local organisations will need to review this document in relation to their own existing plans.

## 9. Appendices

Appendix 1
Local Government Information Unit (LGiU) policy briefing
30 October 2014 ‘NHS Five year forward view’

LGiU POLICY BRIEFING

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# NHS Five year forward view

Christine Heron LGiU associate

30 October 2014

This briefing can also be viewed as a pdf

# Summary

This report by NHS England, with the other national NHS organisations, sets out a vision for the NHS. It indicates that there is a broad consensus about what the NHS should look like, and describes proposals for change over the next five years within the overarching headings of:

- a new relationship with patients and communities
- new models of care.

The direction of the report has been largely welcomed by health and care stakeholders, including politicians. There will be less agreement about how the vision can be achieved; for example, the extent of involvement of the private sector – the report is silent on the role of competition.

This report is different from previous visions in that, rather than looking inward to what the NHS will do itself, it presents the NHS as a proactive partner which needs to engage with other public and voluntary organisations and with communities – for example, working closely with local government and other partners on public health.

However, the report has much less to say about integration with adult social care.

This briefing will be of interest to councillors and officers in councils with social care and public health responsibilities, and also to all councillors with an interest in the future of the NHS.

# Briefing in full

## Background

The report is jointly presented by the 'combined national leadership' of the NHS: NHS England, the CQC, Monitor, Health Education England, the Trust Development Authority and Public Health England. It also indicates that it represents a 'broad consensus' of patient groups, clinicians, local commissioners and

frontline NHS leaders.

It describes how the NHS has survived, and even made improvements, during a sustained period of financial constraint. For example, it has recently been judged the highest performing health system of 11 industrialised countries by the Commonwealth Fund.

However, the NHS is facing a range of huge challenges, some of which are common to all health systems, and some specific to England. Challenges include continued lack of funding growth, new treatments and technologies, changing patient health needs and preferences, variations in care, the need for faster diagnosis and uniform treatments for cancer, developing prevention, developing primary care, integrated health and social care, and improving mental health and learning disabilities.

The NHS must change to meet these challenges, and change must involve long-term strategic planning, not short-term expediency. ‘Muddling through’ would inevitably widen the gap in health and wellbeing, variations in quality of care, and problems with funding and efficiency.

## What the future will look like – a new relationship with patients and communities

The report indicates that the NHS has often provided a ‘factory model of care and repair’ with limited engagement with communities and partnerships. As such it has failed to ‘fully harness’ the energy of patients, communities, employers and national and local government. This section describes how the role of the NHS in relation to the wider health, care and wellbeing sectors should change.

### Getting serious about prevention

The NHS supports Public Health England priorities and will work to deliver them through incentivising and supporting healthier behaviours, supporting national action such as changes to labelling and marketing, and using the ‘substantial combined purchasing power of the NHS’ to reinforce this.

The NHS will work with councils in their public health role and agrees with the LGA that councils should have enhanced powers to go further than national laws to promote good health, such as restricting fast food outlets in certain locations. While councils provide broad-based public health programmes, the NHS has a distinct role in targeted prevention, with primary care as central to this, through measures such as NHS Healthcheck. Evidence-based prevention programmes will be pursued – it makes no sense to spend ever more on bariatric surgery rather than proven lifestyle intervention programmes. The English NHS will be the first country to implement a national evidence-based diabetes prevention model, and will then apply this to other conditions.

The NHS will help people to get and stay in employment through well targeted support. It will examine how it can work more closely with the Department for Work and Pensions to see whether money can be invested across programmes to make downstream savings to DWP. It supports measures such as providing financial incentives for employers who provide NICE recommended workplace health programmes. It will become a national exemplar in the support it offers its staff, and will encourage them to become ‘health ambassadors’ in their local communities.

### Empowering patients

A range of measures are proposed so patients have more control over their services and their health:

- Better information and clinical advice, greater use of technology, investment in evidence-based approaches such as group based education and peer support.
- Making good on long-standing promises to increase choice in where and how people receive care.
- Integrated personal commissioning (IPC) a new voluntary approach to 'blending' health and social care funding for people with health and social care needs – will include care plans, voluntary sector advocacy and 'year of care' individual funding managed by the individual or on their behalf.

### Engaging communities

Proposals for building on the 'energy' and 'compassion' of communities include:

- Better support for carers, especially the most vulnerable – young carers and those over 85.
- Increasing health related volunteering and helping volunteers to become 'part of the extended NHS family'. For example, developing accrediting community responders in rural areas. NHS England also supports LGA proposals for volunteers to receive a ten per cent reduction in their council tax.
- Stronger partnerships with the voluntary sector, including streamlining contracting, and a commitment to multi-year funding.
- Making greater progress in being a 'progressive employer' e.g. challenging mental health stigma.

The report also describes a role for the NHS as a 'social movement'. It indicates that none of the initiatives identified are *individually* crucial to the success of the NHS, but *together* they will build up an approach to engagement and empowerment that will help moderate rising demand. They should not be seen as 'discretionary extras' but as essential 'slow burn, high impact actions'.

## What will the future look like? New models of care

The report indicates that the NHS is still widely based on the 1948 model which established a series of divides: between family doctor and hospital, physical and mental health, health and social care, prevention and treatment, and empowerment and control. However, patients need services that are integrated round their needs rather than split by organisational boundaries, and people with long term conditions need ongoing support rather an episodic response. A range of new models will be needed to deliver necessary change.

### Expanding and strengthening primary care and out of hospital care

This is one of the most important changes, due to the pressures facing these elements in the health system. NHS England will be taking immediate steps to establish a 'new deal for primary care', including stabilising core funding, giving CCGs more influence over the NHS budget, using a challenge fund to provide more funding, increasing the numbers of GPs trained, and incentives to encourage doctors and new practices in under provided areas.

### Multispeciality community providers (MCPs)

MCPs involve extended groups of primary care practices which could be federations, networks or single organisations. They provide a much greater range of services for their registered patients. For example, they may employ consultants (such as geriatricians) or take them on as partners, and employ therapists, pharmacists, nurses and social workers. MCPs would shift the majority of outpatient consultations from

hospitals. As MCPs develop, some GPs could be allowed to directly admit patients to hospital, and they could take on delegated responsibility for managing NHS budgets or pooled budgets. (As well as MCPs, the report indicates there will still be a place for smaller GP practices.)

### Primary and Acute Care Systems (PACS)

In this model, single organisations could provide primary care and hospital services plus mental health and community care services. There would be different arrangements dependent on local situations. For example, in deprived areas which struggle to provide sufficient primary care, hospitals would be allowed to open GP surgeries with registered lists. This would allow the investment power of foundation trusts to expand primary care; safeguards would be needed to ensure the primary care element was not used to drive patients into traditional services provided by the hospital. Alternatively, a mature MCP could take over running a district general hospital with an expanded range of treatments and diagnostics. A developed PACS could become accountable for the whole health needs of a registered list of patients under a delegated capitated budget; this would be similar to Accountable Care Organisations developing in America and elsewhere.

### Urgent and emergency care networks

The NHS will improve and simplify the urgent and emergency care system. Ways of doing this will include greater evening and weekend access to GPs, nurses in community bases able to offer a much greater range of tests and treatments, ambulance services empowered to make more decisions, and greater use of pharmacies.

There will also be networks of hospitals linked to speciality emergency centres, building on the success of trauma centres in reducing mortality for people who have had strokes and heart attacks. Hospital patients will have access to seven-day services where this improves outcomes, and there will be integrated mental health crisis services. Patients will be helped to navigate the system more easily.

### Viable smaller hospitals

The report indicates that local hospitals should not provide complex, high volume acute services, so some services will need to be shifted to other locations. However, local hospitals providing clinically effective services and supported by commissioners and communities have a role in the new NHS landscape. NHS England and Monitor will consider whether the NHS payment regime needs to be amended to allow small units to remain viable. New models will include:

- a local acute hospital may share management of the whole organisation or the back office functions of a similar hospital not in its immediate vicinity – a hospital chain
- a smaller local hospital may have some of its services on a site provided by another specialised provider – satellite sites
- a PACS model integrated provider.

### Specialised care

NHS England will work with local partners to develop services where there is a strong relationship between number of patients treated and health outcomes, pursuing the model of specialised stroke units into some cancer and other services such as orthopaedics.

### Modern maternity services

NHS England will commission a review of future models of maternity units to report by summer 2015. The

review will investigate how tariff-based funding can support women's choices rather than constraining them, and how groups of midwives can be facilitated to set up their own NHS-funded midwifery services.

### Enhanced health in care homes

In partnership with councils and the care home sector and 'using the opportunities created by the Better Care Fund' (BCF), NHS England will develop new models to enhance the health input into care homes, such as medication reviews and in-house rehabilitation services. Such approaches have been found to improve quality of life and reduce hospital use by a third with significant cost savings.

### Developing the models

The report indicates that England is too diverse for one imposed model of care, but at the same time there are similarities between areas which mean that they are likely to benefit from similar approaches. For example, the outer rings of Manchester and London are likely to have much in common, but little in common with Devon. Cumbria, Devon and Northumberland, however, are similar health economies.

NHS England will support local areas to co-design and implement models that work for them; it will be careful to ensure that new methods are tested out, piloted and fast-tracked. Pump-priming could involve unlocking NHS property assets and accrued savings in foundation trusts 'to help local service transformation'. Some areas, where improvements have been made and services are already working effectively, are likely to continue with the commissioning and delivery approaches already underway. However, many areas will be expected to develop several new models. In some areas 'it may make sense for local communities to discuss convergence of care models for the future', but with 'a new perspective which looks beyond their individual organisations' interests towards the future development of whole healthcare economies – and are rewarded for doing so.'

## How will we get there?

The report sets out a range of ways in which the five-year vision will be achieved.

### Aligned national NHS leadership

The major national organisations will work together on issues such as performance, technology, workforce and training, and innovation in diagnostics, technology and care. The report gives the example of 'health and care new towns' and new urban areas in which health and care can be designed from scratch alongside other public services such as education and affordable housing.

### Efficiency and productive investment

NHS organisations and independent analysts indicate there will be a gap between resources and patient needs of nearly £30 billion a year by 2020/21 without continued efficiencies and with continued flat funding. Action will be needed to reduce demand, to continue to make efficiencies, and to provide 'staged funding increases as the economy allows'. All three elements need to be in place to address the funding gap, and the report explores various options. It indicates that 'nothing in the analysis suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable', but the NHS and central government both need to do their part.

### Backing diverse solutions and local leadership

The report discusses working with local authority adult social care, and this section is quoted in full below to give a clear sense of direction.

'We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.' (p.28)

The report goes on to state 'across the NHS we detect no appetite for a wholesale structural reorganisation'. It strongly advises against the tendency of successive governments to 'repeatedly tinker with' the health authority/PCT/CCG tier of the NHS. It states there is no right answer to how these functions are arranged, but 'there is a wrong answer, and that is to keep changing your mind.' The 'default assumption' is that local organisational configurations should arise from local work on new care models, or to address clear local failure.

# Comment

While some elements of the forward view are inevitably familiar (better use of technology, improved training, more innovation, for example) there is a definite shift in emphasis. When, for example, has a major NHS report had a prominent section on the NHS as a social movement? Similarly in its example of dementia, the report says that the NHS will support initiatives such as dementia friendly communities as well as early diagnosis and treatment. An outward looking, partnership based NHS will clearly be a highly welcome development.

Commentators have been positive about the direction of the forward view, and about the approach of NHS England Chief Executive, Simon Stevens. (Stevens was health advisor in the previous Labour government before moving to UnitedHealth, an American private health firm.)

Kings Fund Chief Executive, Chris Ham points to a 'clear vision and compelling case for change' in the document, with the launch led by Stevens with 'passion and confidence'. He goes on to comment in his blog, 'The appointment of a leader who knows the NHS from the inside and who is rapidly gaining the confidence of those providing care creates a once in a lifetime opportunity to change fundamentally how the NHS is run.'

Given the high profile of the interface between health and social care, a lack of detail on this issues has been interpreted by some commentators as a lack of enthusiasm from the national NHS leaders. Three factors are probably in play:

- The NHS is extremely concerned about the impact of the Better Care Fund, and whether it is able to deliver reductions in demand to compensate for the transfer of funding – local plans so far suggest that local NHS organisations are sceptical.
- This is a national political issue, with Labour and the Liberal Democrats, to varying degrees, proposing measures such as pooled budgets and an increased role for health and wellbeing boards in commissioning integrated services.
- The report could not be clearer that top down, compulsory restructuring would be a Very Bad Thing!

> This is clearly laying down a marker for any politicians getting too enthusiastic about reform in the run up to the election.

As yet the BCF has not proved its worth, and health and wellbeing boards are still at an early stage. It is likely that, at present, some boards will indeed be insufficiently prepared or ambitious to take on a leadership role over health. As such, the caution in the document is probably quite sensible. Having said this the document does feel somewhat lukewarm on the topic of integration, so this is an area to watch in future.

A more welcome element is the focus on NHS organisations going beyond seeking individual success to considering and supporting the health economy as a whole – the idea about foundation trusts using surpluses for the benefit of the local system, for example. The message is that foundation trusts can have an enhanced role, such as providing primary care, but only if they change from being fiefdoms sucking in resources. This is in line with the lack of emphasis in the report on competition and the private sector. In subsequent interviews, such as with the Guardian, Stevens has clarified that there is a role for NHS funded private healthcare, but so patients can get treatments such as hip operations – the bulk of health services would continue to be delivered by the NHS. It seems that to Stevens at least, privatisation is now in the box marked 'patient choice'.

**For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk**