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PSNC Briefing 023/14: The NHS Five Year Forward View

NHS England and partner organisations published the NHS Five Year Forward View (5YFV) on 23rd October 2014. This document sets out the current and future financial context for the NHS, the vision of what the NHS needs to achieve over the next five years and new working models which may be implemented at a local level.

As such this document will provide the basis for future developments in primary care, which will impact on community pharmacy contractors. This PSNC Briefing summarises the key points in the document for community pharmacy teams and LPCs.

Introduction

The 5YFV has been published by NHS England, alongside the other national leadership organisations within the NHS: the Care Quality Commission; Health Education England, Monitor, Public Health England and the Trust Development Authority.

The document sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that the NHS can promote wellbeing and prevent ill-health. It represents the shared view of the NHS' national leadership and sets out a vision of a better NHS, the steps the NHS should now take to implement the vision and the actions that are needed from others.

Chapter 1 - Context

In Chapter 1 the current and future NHS context is explained, setting out how the organisation has improved its performance over the last fifteen years, but also the impact of financial restrictions as a result of the global recession. The document also describes the increasing pressures on the NHS which results from the aging population, increases in long term conditions (LTC) and demands from patients acting as consumers, and the trend towards less healthy lifestyles. These challenges are characterised by three gaps, which will over time widen, if change does not occur within the NHS and society:

1) The health and wellbeing gap;
2) The care and quality gap; and
3) The funding and efficiency gap.

Chapter 2 - What will the future look like?

Chapter 2 describes the changes that need to occur in the NHS.

Getting serious about prevention – the document says that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. It references the Wanless report on the future affordability of healthcare, published 12 years ago, which warned that the population had to be fully engaged in improving health and wellbeing if the NHS was to remain affordable; that warning has not been heeded - and the NHS is on the hook for the consequences.

The document references Public Health England's (PHE) new strategy, which sets out priorities for tackling obesity,

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smoking and harmful drinking, ensuring that children get the best start in life, and that the risk of dementia is reduced through tackling lifestyle risks.

It suggests that the NHS should work with PHE to deliver the above aims, but it should also become a more activist agent of health-related social change. This will involve leading or advocating a range of new approaches to improving health:

- **Incentivising and supporting healthier behaviour** – to tackle smoking, alcohol misuse and junk food and excess sugar, the NHS will actively support comprehensive, hard-hitting and broad-based national action, including clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. The NHS will also use its purchasing power to reinforce these measures;
- **Local democratic leadership on public health** – the NHS national bodies will advocate for English mayors and local authorities being granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health,
- **Targeted prevention** – the NHS has a distinct role in secondary prevention of disease linked to poor lifestyle and proactive primary care is central to this. The aim is that over the next five years England will become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the NHS Health Check. NHS England and PHE will establish a preventative services programme that will then expand evidence-based action to other conditions;
- **NHS support to help people get and stay in employment** - sickness absence related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. There is emerging evidence that well targeted health support can help keep people in work. The NHS will seek to test improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions; and
- **Workplace health** – the document suggests that there would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. There will be new incentives to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy and serve as "health ambassadors" in their local communities.

Empowering patients – the document highlights the importance of patients with LTCs being better empowered to manage their conditions effectively. The first step towards this ambition will be to improve the information to which people have access – within five years all people will be able to access their medical and care records and share them with carers and others if they wish.

The NHS will also invest more in evidence-based approaches to improve the knowledge of people with LTCs, such as group-based education for people with specific conditions and self-management educational courses. There will also be a greater focus on giving patients choice over where and how they receive care.

Integrated personal commissioning (IPC) will be introduced on a voluntary basis for people with complex needs. This will 'blend' health and social care funding for these individuals providing an integrated, 'year of care' budget that will be managed by the person themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities – the NHS will commit to four actions to build on the energy and compassion that exists in communities across England:

1) **Better support for carers** – better identification of carers and then provision of greater support;
2) **Creating new options for health-related volunteering**;
3) **Designing easier ways for voluntary organisations to work alongside the NHS** – using the skills of charities to provide services to groups of patients and advise on commissioning for people with specific needs; and
4) Using the role of the NHS as an employer to achieve wider health goals.

Chapter 3 – New models of care

The document says that the traditional divide between primary care, community services and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries if it is to effectively support people with complex LTCs. The direction the NHS will need to take will include:

- Increasingly needing to manage systems – networks of care – not just organisations;
- Out-of-hospital care needing to become a much larger part of what the NHS does;
- Services needing to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them;
- Much faster learning from the best examples from within the UK and internationally; and
- Better evaluation of new care models as they are introduced to establish which produce the best experience for patients and the best value for money.

Emerging models of care – the document describes a number of emerging models of care where GP practices are collaborating across an area working with other professionals and service providers. The NHS intends to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. The document states that England is too diverse to pretend that a single new model of care should apply everywhere, but that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. That's why the NHS approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled in the 5YFV constitute viable ways forward for the future.

The document says that in all cases one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. It describes a **new deal for primary care**:

Over the next five years the NHS will invest more in primary care. Steps it will take include:

- Stabilising core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas;
- Giving Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services;
- Providing new funding through schemes such as the Prime Minister's Challenge Fund to support new ways of working and improved access to services;
- Expanding as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increasing investment in new roles, and in returner and retention schemes and ensuring that current rules are not inflexibly putting off potential returners;
- Expanding funding to upgrade primary care infrastructure and scope of services;
- Working with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities; and
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

The document describes seven new care models that may be suitable for use in England:

Multispecialty Community Providers (MCPs)	This model will involve the formation of extended groups of GP practices either as federations, networks or single organisations. They would become the focal point for a far wider range of care needed by

	their registered patients, for example employing consultants and nurses previously based in hospitals to work alongside community nurses, therapists, pharmacists, psychologists, social workers and other staff. They would shift the majority of outpatient consultations and ambulatory care out of hospital settings, potentially also taking over the running of local community hospitals, providing better access to a wider range of diagnostic services. They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to MCPs.
Primary and Acute Care Systems (PACS)	In this model a single organisation will provide NHS list-based GP and hospital services, together with mental health and community care services. The leadership to bring about these 'vertically' integrated PACS may be generated from different places in different local health economies. In some places it could be driven by the local hospital trust, but it may also be the next development for an MCP which takes over the running of its main district general hospital. At their most radical, PACS could take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States and Singapore.
Urgent and emergency care networks	The document describes the need for the NHS to be much better at organising and simplifying the emergency care system. This will mean helping patients get the right care, at the right time, in the right place; this it says will include 'far greater use of pharmacists'. Urgent and emergency care networks will ensure more appropriate use is made of primary care, mental health teams, ambulance services and community pharmacies. Networks of linked hospitals will be developed to ensure that patients with the most serious needs get to a specialist emergency centre.
Viable smaller hospitals	Some commentators have argued that smaller district general hospitals should be merged and/or closed, but England already has one of the more centralised hospital models amongst advanced health systems. Action will be taken to help sustain local hospital services where the best clinical solution is affordable and it has the support of local commissioners and communities. This will include a review of the payment system for hospitals, examination of new models of medical staffing for smaller hospitals and the creation of new organisational models for smaller acute hospitals, e.g. sharing back office management functions with other hospitals and acting as a site for provision of specialised services by another hospital.
Specialised care	In some hospital services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to specialised facilities and equipment, and the greater standardisation of care that tends to occur. This approach

	may be best applied to the most specialised surgery and the treatment of some cancers. NHS England will work with providers to drive consolidation of services which will include the development of networks of specialised services.
Modern maternity services	NHS England will commission a review of future models for maternity units which will make recommendations on how best to sustain and develop maternity units across the NHS, giving women greater choice in the location of where they give birth.
Enhanced health in care homes	One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. NHS England will work in partnership with local authority social services departments, the local NHS and the care home sector to develop new shared models of 'in-reach' support, including medical reviews, medication reviews and rehab services.

The document suggests that some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above. However many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes and live within the expected local funding.

In some places, including major conurbations, NHS England therefore expect several of these alternative models to evolve in parallel. In other geographies it may make sense for local communities to discuss convergence of care models for the future.

NHS England will work with local communities and leaders to identify what changes are needed in how national and local organisations best work together in order to support the development of new models of care. This will include detailed prototyping of each of the new care models described above and the development of national flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models. They will also design a model to help pump-prime and 'fast track' a cross-section of the new care models.

Chapter 4 – How will we get there?

This chapter describes a range of complementary approaches that will be needed to achieve the vision. These include the national NHS leadership bodies:

- **Backing diverse solutions and local leadership** – this will include support for local development of the models described above, but also avoidance of further structural reorganisation of the NHS;
- **Providing aligned national leadership** – including working together to support the development of new local care models;
- **Supporting a modern workforce**;
- **Exploiting the information revolution** - nationally the focus will be on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards;
- **Accelerating useful health innovation**;
- **Accelerating innovation in new ways of delivering care** – this will involve combining different technologies and changed ways of working in order to transform care delivery – so called 'combinatorial innovation'. A small number of 'test bed' sites alongside Academic Health Science Networks and Centres will be

developed to support this approach to innovation. The NHS will also explore the development of health and care 'new towns', where new town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints; and

- **Driving efficiency and productive investment** - it has previously been calculated that a combination of growing demand, no further annual efficiencies and flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year. To sustain a comprehensive NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

On demand the document makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of hospital care.

On **efficiency** the document suggests that the NHS should be able to achieve a 1.5% net efficiency increase each year over the next Parliament if the NHS is able to accelerate some of its current efficiency programmes. The document recognises that some efficiency programmes that have contributed over the past five years will not be indefinitely repeatable.

The document says the ambition would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. It would require investment in new care models and would be achieved by a combination of 'catch up' (as less efficient providers matched the performance of the best), 'frontier shift' (as new and better ways of working are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period.

On funding the document notes that NHS spending has been protected over the past five years. Three future funding scenarios are described:

1) Flat real terms NHS spending overall – this would represent a continuation of the current budget protection;
2) Flat real terms NHS spending *per person* – this would take account of population growth; and
3) Flat NHS spending *as a share of GDP* – this would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way:

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion;
- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion; and
- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in the 5YFV, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

The document says decisions on these options will need to be taken in the context of how the UK economy overall is performing, during the next Parliament.

To read the full 5YFV document, visit the NHS England website.

If you have queries on this PSNC Briefing or you require more information please contact Alastair Buxton, Head of NHS Services.