

The Five Year Forward View: BMA summary

1. Context

On 23 October 2014 NHS England, together with its five partner organisations, published [the 'Five Year Forward View'](#), setting out a vision for the future of the NHS in England. The Forward View describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

It is important to acknowledge that the 'Five Year Forward View' is not a consultation and does not seek the views of other organisations and stakeholders. In addition, it is not yet certain that the vision set out will be adopted by the NHS, supported by the Department of Health. The Government could oppose the measures and make it difficult for NHS organisations to take them forward. It is also possible that the NHS organisations involved in designing the vision could lose some or all of the autonomy they have been granted from central control should there be a change of government in 2015, again making it difficult for the NHS to put the proposals into action. However, this paper has been written on the assumption that the plans set out in the document are taken forward.

2. Introduction

The 'Five Year Forward View' was published on 23 October 2014 and sets out a vision for the future of the NHS. It was developed by the partner organisations¹ that deliver and oversee health and care to create "a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services". It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

3. Why the NHS needs to change

There are some fundamental challenges facing all industrialised countries' health systems:

- Long-term health conditions now take 70 per cent of the health budget. At the same time many (but not all) people wish to be more informed and involved with their own care.
- Care needs to be organised so it is genuinely coordinated around what people need and want.
- It is unrealistic to think that NHS spending growth will return to the six or seven per cent increases seen in the 2000s any time soon.

3.1 Five year ambitions on quality

- To reduce variations in where patients receive care, partner organisations will measure and publish meaningful and comparable measurements for all major pathways of care for every provider by the end of the next Parliament.

¹ NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority

- To reduce variations in when patients receive care partner organisations will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities.
- The payment system will reward improvements in quality.
- The work of the NHS Leadership Academy and NHS Improving Quality will be reviewed and refocused.

4. What the future will look like

4.1 Prevention

Partner organisations will lead or advocate a range of new approaches to improving health and wellbeing.

- For major health risks – tobacco, alcohol, junk food, excess sugar – partner organisations will support hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing and product formulation.
- English mayors and local authorities should be given enhanced powers to allow local democratic decisions on public health policy.
- A national evidence-based diabetes prevention programme should be introduced, based on proven models and linked where appropriate to the new Health Check. A preventative services programme will expand evidence-based action to other conditions.

4.2 Empowering patients

- Partner organisations will invest in evidence-based approaches to support people to manage their own health e.g. group-based education and self-management educational courses.
- All patients will be offered a choice of hospitals and will be as involved as they want to be in their care and treatment.
- Integrated personal commissioning (IPC) will be introduced, blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy, IPC will provide an integrated ‘year of care’ budget that will be managed by patients or on their behalf by the local authority, the NHS or a voluntary organisation.

4.3 Engaging communities

- Partner organisations will find new ways to support carers. This will include work with voluntary organisations and GP practices to identify carers and provide better support. Flexible working arrangements for NHS staff with major unpaid caring responsibilities will be explored.
- A short national alternative to the standard NHS contract will be developed for charitable and voluntary organisations. Funders will be encouraged to commit to multiyear funding wherever possible.

5. Strengthening primary care

One of the key changes required to enable new models of care to develop will be to expand and strengthen primary and 'out of hospital' care. There are several immediate steps needed to stabilise general practice.

- Stabilise core funding nationally over the next two years while an independent review looks at how resources are fairly made available to primary care in different areas.
- Give CCGs more influence over the wider NHS budget.
- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build public understanding that pharmacies and online resources can help them deal with minor ailments and illnesses.

6. New models of care

Over the next five years and beyond the NHS will increasingly need to break down the traditional divides between primary care, community services and hospitals, and between health and social care, which act as a barrier to personalised and coordinated care. Progress has been made in some parts of the NHS but examples are too few and too isolated. England is too diverse for a single new model of care but that does not mean there are an infinite number of potential new care models. Partner organisations will identify the characteristics of similar health communities across England then jointly work with them to consider which of the new options constitute viable ways forward for their local services.

6.1 Multispecialty Community Providers

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, other practices may want to evolve to offer a wider scope of services and deliver care in different ways. To enable this, it will be possible for extended group practices to form, either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care.

- They could employ consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers and others.
- They would shift outpatient consultations and ambulatory care out of hospital settings.
- They could take over the running of local community hospitals which could expand diagnostics and other services such as dialysis and chemotherapy.
- GPs and specialists could be credentialed to admit some patients directly to acute hospitals with out-of-hours inpatient care supervised by resident 'hospitalists'.
- They could take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with the local authority, a combined health and social care budget could be delegated to the MCP.

6.2 Primary and Acute Care Systems

A new variant of integrated care will be permitted, allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services. The leadership to bring about these Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances, e.g. deprived urban communities where general practice is under strain, hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of FTs to kick-start the expansion of new style primary care. Safeguards will be needed to ensure this happens in ways that reinforce out-of-hospital care rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
- In other circumstances, a mature Multispecialty Community Provider could take over the running of its main district general hospital, creating a blend of the two models.
- At their most radical, PACS would be accountable for the whole health needs of a registered list of patients under a delegated capitated budget.
- This model is complex and, as such, will be tested in a small number of areas in order to develop prototypes that work, before they are promoted to the wider NHS.

6.3 Urgent and emergency care networks

Over the next five years the NHS will improve the organisation of urgent and emergency care and make it easier for patients to navigate the system.

- More appropriate use will be made of primary care, community mental health teams, ambulance services and community pharmacists as well as urgent care centres. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a greater range of tests and treatments.
- Networks of linked hospitals will ensure that patients with the most serious needs get to specialist emergency centres.
- Hospital patients will have access to seven day services where this makes a clinical difference to outcomes.
- There will be proper funding and integration of mental health crisis services.
- A strengthened clinical triage and advice service will link the system together and help patients navigate it successfully.
- New responses will be developed to the workforce requirements that will make new networks possible.

6.4 Viable smaller hospitals and specialised care

Local hospital services should be sustained where it is affordable and has the support of local commissioners and communities. NHS England and Monitor will consider whether adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. Partner organisations will also work with smaller hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

At least three new organisational models for smaller acute hospitals will be developed, to help them gain the benefits of scale without necessarily having to centralise services.

- A local acute hospital might share back office or whole institution management with similar hospitals, not necessarily located in their immediate vicinity.
- A smaller local hospital might have some of its services provided by another specialised provider.
- A local acute hospital could form an integrated provider with primary and community services (PACS model).

In services where the relationship between quality and patient volume is strong, NHS England will work with local partners to drive consolidation through a programme of three-year rolling reviews. Providers will be asked to develop networks of services over a geographical area, integrating different organisations and services around patients using methods such as prime contracting and/or capitated budgets.

6.5 Other new care models

- Modern maternity services – there will be a review of future models for maternity units which will make recommendations on how best to sustain and develop maternity units; tariff-based NHS funding will support the choices women make; it will be easier for groups of midwives to set up their own NHS-funded midwifery services.
- Enhanced health in care homes - partner organisations will work with 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 rehabilitation services.

6.6 Design and implementation of new care models

Some parts of the country will be able to continue commissioning and providing high quality services using their current care models. Other places will need to consider new options. In some areas, it is likely that several of these alternative models will evolve in parallel. There will need to be a new type of partnership between national bodies and local leaders to ensure success. Partner organisations will work with local communities and leaders to jointly develop:

- Detailed prototyping of the new care models, identifying current exemplars, potential benefits and risks, and transition costs.
- A shared method of assessing the characteristics of each health economy to help inform local choice of preferred model and allow joint intervention in health economies that are furthest from where they need to be.
- Greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.
- National flexibilities in the current regulatory, pricing and funding regimes.
- A model to help pump-prime and fast-track a cross section of the new care models.

7. How to get there

Diverse solutions and local leadership

- CCGs will progressively be offered more influence over the total NHS budget for their local populations, ranging from primary to specialised care.
- A limited number of models of joint commissioning between the NHS and local government will be defined and championed. These will include IPC, Better Care Fund-style pooling and

possible full joint management of social and health care commissioning, perhaps under the leadership of the Health and Wellbeing Board (HWB). A full evaluation of the 2015/16 Better Care Fund is needed before any national decision is made to expand it further.

- Changes in local organisational configurations should arise only from local work to develop the new care models or in response to clear local failure.

Aligned national leadership

- Partner organisations will create a combined work programme to support the development of new local care models.
- Monitor, TDA and NHS England will work together to create greater alignment between their respective local assessment, reporting and intervention regimes for FTs, NHS trusts and CCGs.
- The National Quality Board will be re-energised under the leadership of the senior clinicians of each national NHS leadership body alongside CCG leaders, providers, regulators and patient representatives.

Modern workforce

- New measures will be put in place to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. HEE will work with employers, staff and commissioners to identify the education and training needs of the current workforce so they can deliver new models of care. This will require greater investment in training and the active engagement of clinicians and managers.
- HEE will work with its statutory partners to commission and expand new health and care roles through implementation of the Shape of Training review and the State of Care review (nursing).
- NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign and encourage recruitment and retention.

Information revolution

- To lead a sector-wide approach to information and technology, the National Information Board (NIB) has been established, bringing together the NHS, public health, clinical science, social care, local government and public representatives. The NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:
 - Comprehensive transparency of data
 - Fully interoperable electronic health records
 - Family doctor appointments and electronic and repeat prescribing available routinely online everywhere.
 - Bringing together hospital, GP, administrative and audit data to support quality improvement, research and the identification of patients with support needs.
 - Patient opt outs will be retained.

Accelerate health innovation

- Partner organisations will support the roll out of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker, lower cost Randomised Control Trials embedded within routine general practice and clinical care.
- NHS England will explore how to expand the 'commissioning through evaluation' programme and the Early Access to Medicines programme. This will be easier if costs are borne by manufacturers who want their products evaluated in this way.

- NICE will examine how to expand work on devices and equipment and how to support the best approach to rolling out high value innovations while decommissioning outmoded technologies and treatments to help cover costs.
- A small number of 'test bed' sites will be developed to serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes.

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 produce a mismatch between resources and patient needs of nearly £30 billion per year, by 2020/21.
- To sustain a high-quality comprehensive NHS, action will be required on three fronts:
 - Demand – the NHS needs a more activist prevention and public health agenda and new models of care, as set out previously. Over the medium term, results of these initiatives could be significant.
 - Efficiency – NHS efficiency gains have been estimated at around 0.8 per cent net annually. This will not be adequate and the NHS needs to accelerate some of its current efficiency programmes, recognising that some are not indefinitely repeatable, e.g. pay restraint. Partner organisations would like the NHS to achieve 2 per cent net efficiency gains each year to 2020, possibly increasing to 3 per cent over time. This would require investment in new care models and would be achieved by a combination of 'catch up' (all providers match the performance of the best), 'frontier shift' (better ways of working are achieved) and moderating demand increases.
 - Funding – With real terms flat funding and productivity gains of 0.8 per cent per year, the £30 billion gap would be cut to £21 billion by 2020/21. If efficiencies of 1.5 per cent per year were delivered the gap would be halved to £16 billion. Staged funding increases close to 'flat real per person', i.e. taking account of population growth, combined with investment to facilitate the move to new care models and ways of working, and demand and efficiency gains worth 2-3 per cent net each year, would close the gap by 2020/21.
- Decisions on these options will need to be taken in the context of how the UK economy overall is performing. However, there is nothing to suggest that continuing with a comprehensive tax-funded NHS is intrinsically undoable.