FIVE YEAR FORWARD VIEW

October 2014

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FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is 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**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. 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. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we 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. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

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. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, 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. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be 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. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we 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 new Health Check. NHS England and Public Health England 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. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

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'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our 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 by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise 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.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *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. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work 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.*
- *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.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it 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 needed by their registered patients.

- As larger group practices they could in future begin employing 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 other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- 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 Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by 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 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this 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, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would 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, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any 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. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some 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 costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – 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. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

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, previous versions of local 'five year plans' by provider trusts and CCGs suggest that 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, we 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. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create 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, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

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 (described in chapter two) 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.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, 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 in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus 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.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year 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 performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View 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. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, 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. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. 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 of the sort laid out in chapters three and four 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 (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* 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.

- 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 this Forward View, 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.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.