

# Next steps for the NHS five year forward view

BMA summary and analysis, April 2017

This paper highlights key areas of interest for doctors and the BMA contained in 'Next steps for the five year forward view' (the Plan). It's not intended to be a comprehensive summary of the document, which can be read in full on the [NHS England website](#).

## Background

The NHS FYFV (five year forward view) was published in October 2014. It set out a vision for the future of the NHS and explained why improvements were needed to achieve the triple aim of better health, better care, and better value. It described various models of care that could be provided in the future, defining the actions required at local and national level to support delivery.

This new Plan concentrates on what will be achieved over the next two years, and how the FYFV goals will be implemented. However, our view is that there is little in the paper that is new – much of what is described is already in progress or being planned for. The notable exception is the chapter on integrating care locally. This provides more clarity about NHS England's view of STPs and ACSs (Accountable Care Systems) and how these might develop.

## Contents

- [Urgent and emergency care](#)
- [Primary care](#)
- [Cancer](#)
- [Mental health](#)
- [Integrating care locally](#)
- [Funding and efficiency](#)
- [Strengthening our workforce](#)
- [Patient safety](#)
- [Harnessing technology and innovation](#)



## Urgent and emergency care

The Plan does not contain any new announcements in this area. Instead, it reiterates previously announced funding and the targets recently stated in a [joint letter](#) from Simon Stevens and Jim Mackey to all trusts.

The key deliverables for 2017-19 include:

- revised performance standards for A&E as per the NHS mandate:
  - by September 2017, over 90% of emergency patients meet the four-hour target
  - in March 2018, in the majority of trusts, 95% of patients meet the four-hour target
  - during 2018 all trusts return to the 95% standard
- by October 2017, every hospital must have comprehensive front-door clinical streaming and adopt good practice to enable patient flow, including discharge and handover processes
- ensure that the extra £1bn for social care is used in part to reduce delayed transfers of care, thereby **helping to free up 2,000-3,000 acute hospital beds**
- specialist mental health care in A&Es: 74 24-hour 'core 24' mental health teams, available in more than 25% of acute hospitals by March 2018 to reach nearly 50% by March 2019
- increase the proportion of **NHS 111** calls receiving clinical assessment from 22% to 30%+ by March 2018. **GP out of hours and 111 services will increasingly be combined.** By 2019, NHS 111 will be able to book people into urgent face-to-face appointments where needed
- NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management
- roll-out **evening and weekend GP appointments to 50% of the public by March 2018 and 100% by March 2019**
- roll-out of '**Urgent Treatment Centres**', open 12 hours a day, seven days a week, integrated with local urgent care services, appointments bookable through NHS 111 and GP referral.

### Implementation

- Previously announced £100m capital funding provided to enable clinical streaming
- Access to STF (Sustainability and Transformation Fund) as per revised A&E targets
- Single, named Regional Director – from either NHS Improvement or NHS England – will hold to account both CCGs and trusts in each STP area for the delivery of the local urgent care plan

## Primary care

The Plan clearly recognises that 'if general practice fails, the NHS fails' and that general practice has been historically underfunded. However, it mainly repeats announcements made in the GPFV (General Practice Forward View). It reiterates the desire for practices to work at scale, explicitly stating that there are multiple routes to achieve this (ie not just via an MCP, but through federations or super-practices) but does not restate the 50% population coverage target for MCPs/PACS. There will be funding incentives to support this process, but no detail is provided in the Plan.

The key improvements for 2017-19 include:

### Access

- During 2017/18 **practice profiles will be published** including patient survey results and ease of making an appointment
- From October 2017 the new agreed GP contract means that practices that shut for half-days each week will not be eligible for a share of the £88m extended access scheme
- By March 2018, the NHS mandate requires 40% of the country to be able to access **evening and weekend GP appointments**, but the target is 50%. By March 2019 this will be 100%

### GP numbers

- Target of extra 5,000 doctors working in general practice by 2020
- Practical action to boost retention, as per the GPFV (including GP Career Plus scheme and NHS GP Health Service)

## Expand multidisciplinary primary care

- Increase the number of clinical pharmacists working in practices to 1,300 by March 2019
- 800 mental health therapists in primary care by March 2018 and over 1,500 by March 2019
- Incentivise 1,000 of the 3,000 newly trained physician associates to work in general practice
- Improve general practice nursing backed by £15m as promised in the GPFV

## Premises

- Over 800 further infrastructure projects are identified for investment by 2019

## Implementation

- Funding will rise by £2.4bn by 2020/21
- Develop a successor to QOF
- Encourage practices to work together at scale:
  - aim is for most practices to work together – combined population of at least 30,000-50,000 providing the scale to offer multidisciplinary care
  - does not require mergers or closures, does not necessarily depend on physical co-location
  - describes it in terms of networks of hubs, but acknowledges there are multiple routes, including federations, super-practices, primary care homes and MCPs

## Cancer

The Plan talks about having a realistic opportunity to make major improvements in survival.

Key improvements for 2017/18 and 2018/19 include:

- within two years more than 5,000 extra people a year will survive cancer as compared to now
- a new bowel cancer screening test for over 4m people from April 2018 and primary HPV testing for cervical screening from April 2019
- expansion of diagnostic capacity so England is meeting all eight of the cancer waiting standards. Focus will be on the 62-day referral to treatment standard ahead of the introduction of the new standard to give patients a definitive diagnosis within 28 days by 2020. By March 2018, 10 new multidisciplinary Rapid Diagnostic and Assessment Centres will be introduced, with roll-out Centres in each of the 16 cancer alliances by March 2019
- the largest radiotherapy upgrade programme in 15 years by October 2018

## Implementation

- Targeted national investment, including £130m for a national radiotherapy modernisation fund
- Expansion of the cancer workforce
- Clear accountability and delivery chain – performance goals for CCGs and cancer providers, matched by unprecedented transparency using the new cancer dashboard

## Mental health

The Plan generally reiterates the outcomes and actions of the FYFV for Mental Health Implementation Plan, although does include some new detail. For example, the Plan identifies that there will be four new mental health units for mothers and babies, which is a welcome development in these locations.

Key improvements for 2017-19 include:

- an increase in psychological ('talking') therapies – 60,000 more people will get treatments for common mental health conditions by the end of 2017/18, rising to 200,000 more people getting care by 2018/19
- four new mental health mother and baby units (East Anglia, North West, South West, South East) and 20 new or expanded specialist perinatal mental health teams
- 150-180 new specialist inpatient beds for children and young people in underserved areas of the country and investment in crisis resolution and home treatment teams for adults to reduce the need to send people out of area for non-specialist inpatient care
- an extra 140,000 physical health checks for people with severe mental illness in 2017/18, rising to 280,000 in 2018/19

## Implementation

- Targeted earmarked national investment for expanded services, alongside an overarching CCG ‘investment standard’ directing growth in mental health funding – this raises **concerns that funding is ‘earmarked’ rather than ring-fenced** and so may not reach frontline services due to the wider funding problems and deficits across the NHS
- Reform of mental health commissioning so that local mental health providers control specialist referrals and redirect around £350 million of funding
- Mental health providers to work with their local councils in same way as acute hospitals to reduce delayed discharges for people stuck in psychiatric inpatient units
- A Children and Young People’s Green Paper due for publication in autumn 2017
- A single national programme management team led by a national mental health director and national clinical director

## Integrating care locally

The chapter on STPs and ACSs provides more clarity on NHS England’s thinking and their direction of travel. The section on increased community participation and engagement is encouraging, but there is no specific focus on either clinical, or workforce, engagement. There are no announcements of any additional funding for the changes being made, and no detail about how the £325m of capital funding announced in the Budget will be allocated. Overall, our fundamental concerns about the sheer scale of cuts to be made, the lack of transformation funding and the lack of accountability remain. Without the appropriate funding upfront, there is a risk that even more money and time will be spent setting up these structures with no corresponding improvement in results.

In addition, the extra powers that NHS England is granting to ACSs should be available as an option for all areas, and seem inconsistent with NHS England’s claim that it is taking a permissive approach to organisational form.

## New care models

- Both **PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days** than the rest of England
- The benefit has been greatest for older people
- The Care Homes vanguards are reporting lower growth in emergency admissions than the rest of England, and ‘meaningful savings from reducing unnecessary prescribing costs’

## STPs (sustainability and transformation partnerships)

STPs are now referred to as sustainability and transformation partnerships. The plans published at the end of 2016 are referred to as ‘Mark 1’ proposals that still require local engagement with patients, communities and staff, with some suggestions requiring formal public consultation.

Key principles:

- **STPs are not new statutory bodies.** They supplement rather than replace the accountabilities of individual organisations
- NHS England **does not want to be overly prescriptive about organisational form**
- All STPs need a basic **governance and implementation support framework:**
  - STP board from constituent organisations, including partners from general practice and local government
  - **re/appoint a STP chair/leader** using a fair process
  - ensure STPs have the necessary programme management support by pooling expertise. NHS England will **support CCGs who want to align management teams or governing bodies**
  - STPs can propose **adjustments to their geographical boundaries**
- STPs – and their constituent organisations – will be **judged on their results.** Metrics will be published at STP level to align with NHS Improvement’s Single Oversight Framework and NHS England’s CCG Improvement and Assessment Framework

## Community participation and engagement

- **Progress cannot be made without genuine involvement of patients and communities.**
- Where **significant hospital bed closures are proposed, NHS England will require STPs to meet the new 'fifth' test** in addition to the four existing ones.<sup>1</sup> (This is not new but it is helpful to link the test to the STPs.)

## ACs (Accountable Care Systems)

ACs will be an 'evolved' version of an STP that is working as a **locally integrated health system**, with clear collective responsibility for resources and population health. In return they get **far more control and freedom over the total operations of the health system** in their area.

Specifically, they can:

- agree an accountable performance contract with NHS England and NHS Improvement that commits to faster improvement on the key deliverables set out in this Plan over the next two years
- manage funding for their defined population, with shared performance goals and a financial system 'control total'
- create an effective collective decision making and governance structure
- demonstrate how provider organisations will operate on a horizontally integrated basis, whether virtually or through actual mergers
- demonstrate how they will simultaneously operate as a vertically integrated care system, partnering with local GP practices formed into clinical hubs serving 30,000 – 50,000 populations
- deploy population health management capabilities to improve prevention and support self-management of long term conditions, manage avoidable demand and reduce unwarranted variation in line with the RightCare programme
- establish clear mechanisms so that the population will still be able to exercise patient choice, increasingly using personal health budgets

In return, the NHS national leadership bodies will offer ACs:

- **delegated decision rights in respect of commissioning primary care and specialised services for local commissioners**
- **devolved transformation funding package from 2018**, potentially including national funding for GPFV, mental health and cancer
- single **'one stop shop' regulatory** relationship with NHS England and NHS Improvement
- ability to **redeploy attributable staff and related funding** from NHS England and NHS Improvement to support the work of the ACs

Successful vanguards, 'devolution' areas and STPs working towards the ACS goal are likely to be candidates for ACS status, including Greater Manchester, Northumberland, Dorset and West Berkshire. Some ACs may establish an **accountable care organisation**, where commissioners in the area have a contract with a single organisation for the majority of health and care services and for population health in the area.

## Funding and efficiency

The Plan recognises the financial strain that the NHS is under and sets out plans to work more efficiently. These plans are essentially a further roll-out of recommendations from Lord Carter's review of efficiency in hospitals. Every trust and CCG is required to implement efficiency opportunities in 2017/18, with NHS Improvement and NHS England overseeing the delivery. These include:

- freeing up hospital beds by reducing delays in transfer of care
- reducing temporary staffing costs
- improving procurement – trusts to take part in the Nationally Contracted Products programme
- getting value out of medicine and pharmacy – including greater use of clinical pharmacists in general practice
- reducing avoidable demand
- reducing unwarranted variation in clinical quality and efficiency
- collecting income that the NHS is owed
- ensuring financial accountability and discipline for all trusts and CCGs – implementing processes to achieve financial balance

### Efficiencies

The Plan focuses on making efficiencies but it is clear that **unrealistic efficiency factors are the biggest challenge to achieving financial balance by NHS providers**. Although the 2% efficiency factor for 2016/17 set for the provider sector is lower than previous years, it is still an unrealistic achievement for providers given the local deficits that exist.

### Deficit position

The document references improving financial grip and CCGs being on track to contribute to an £800m managed commissioner underspend this year. However, recent NHS England board papers<sup>2</sup> have shown that clinical commissioning groups' forecast deficit for this year now stands at £550m, worsening by nearly 50% in two months.<sup>3</sup> In addition, it is worth reviewing performance in the last financial year. In last July's financial 'reset', the combined financial plans for NHS trusts set a planned deficit of £580m for 2016-17, after accounting for the £1.8bn STF. As it turned out, the provider sector reported a year-to-date deficit of £886m at Q3 2016/17.<sup>4</sup> So, although deficits are looking to be better than last year, **it seems unlikely that CCGs and providers will meet this year's targets**.

### Quality services

NHS England has stated that those trusts overspending will have to significantly scale back and possibly cut 'locally unaffordable' services. However, there is no guidance or detail on what these services should be. Vital services must be protected and trusts must be able to maintain and improve the quality of care provided for patients.

### Social care

The Plan includes a welcome reference to the current financial crisis in social care and how an underfunded and inadequately resourced social care system impacts on the beds available in the NHS. However, the £1bn announced in the spring budget for social care in 2017/18 (and a further £1bn over the following two years) is not an adequate solution as it **does not go far enough to plug the social care funding gap**, which is predicted to be £2bn in 2017/18, and £4bn by 2020/21.<sup>5</sup>

## Strengthening our workforce

The Plan acknowledges the fact that NHS staff are under real pressure and that some geographies and types of job are hard to recruit to. There is a need to continue to grow the frontline workforce especially in priority areas such as nursing, mental health, urgent and primary care.

To grow the medical workforce, the Plan talks about increasing undergraduate medical school places; expanding GP numbers by training 3,250 GPs per year; developing new professional roles such as physician associates; working with the RCEM to address shortages in emergency medicine. These are all things that have been announced previously and the Plan does not offer any new solutions. However, it does confirm that **HEE will publish its annual Workforce Plan in April 2017**, which may contain more detail on how some of these initiatives might develop over the coming years.

The Plan contains some helpful actions to **improve working conditions for junior doctors**. We were asked to input into this section, so many of the points reflect our position and are welcomed. First steps will include:

- doctors to receive their proposed rota at least eight weeks, and final rota by six weeks, before they start new rotations, as specified in the code of practice. From 2017, monthly monitoring of trusts' adherence to the six-week standard with a review after six months. HEE will ensure that trusts have trainee details 12 weeks before rotations begin
- an online 'swap shop' for specialty training applicants so they can swap with others or take vacant places, and an improved process for trainees who want to move regions
- a guaranteed training location for doctors who need to be in a particular region because of ill health or disability or because of caring responsibilities for someone who is ill or disabled
- a streamlined process to reduce the duplication of pre-employment checks, mandatory and induction training, starting at a regional level
- in 2017/18, £10 million for HEE to work with colleges to improve support for doctors returning to training after maternity leave and other approved time out
- a junior doctors' forum in each trust, set up by guardians of safe working and directors of medical education

We will work with NHS England, HEE and other partners to make sure these measures are implemented properly and deliver real improvements to the working lives of junior doctors.

There will also be a focus on **NHS staff health and wellbeing** – in 2017/18 all trusts will have a plan in place to improve the health and wellbeing of their workforce. By 2018/19 a CQUIN payment will be made to providers that improve health and wellbeing by 5%, as measured by the staff survey.

Leading STPs and ACSs will work with staff and unions on encouraging flexible working, eg an NHS staff passport so nurses can work in both primary and secondary care.

## Patient safety

Key patient safety improvements identified for 2017-19 include:

- preventing healthcare acquired infections
- improving maternity safety – 44 local maternity systems will be in place from April 2017 to lead and deliver transformation of services
- learning from deaths – trusts will be asked to publish data on deaths judged as likely to have been caused by problems in care, along with actions taken to learn and prevent such deaths in the future
- improving inspections and investigations and a new patient safety incident management system

## Harnessing technology and innovation

The programmes in the Plan are to be underpinned by an agreed, costed and phased NHS technology plan, building on the recommendations of the [Wachter review](#). **Sufficient funding must be directed to the right places if technology improvements are to be realised.** There is real risk that funding will be diverted to other areas due to the wider funding problems and deficits across the NHS, which will jeopardise success in improving technology for patients and the NHS.

Key areas of focus include:

### NHS apps

- The NHS Digital Apps Library will be launched in spring 2017 offering at least 20 apps
- NHS Choices will become NHS UK by September 2017 – patients will be able to book appointments and access their health record through NHS UK
- Roll-out of free wi-fi to all GP surgeries, subject to HM Treasury approval

### Digitising hospitals

- In the future, hospitals will choose a hospital they want to partner with and implement the same IT system, keeping IT 80% the same making only the 20% of changes that are absolutely necessary to meet local needs
- A new digital academy will be launched by September 2017 to train a new generation of Chief Information Officers and Chief Clinical Information Officers

### Technology to support NHS priorities

- Online triage services for NHS 111. By December 2017 all areas will have an available NHS 111 online digital service to connect patients to Integrated Urgent Care.
- Developing and testing new NHS 111 specialist modules of clinical triage for paediatrics, mental health and frailty
- Access to extended patient data for every A&E, UTC and ePrescribing pharmacy by December 2017. Access to primary care records, mental health crisis and end of life plan information in 40% of UTCs and A&Es
- A system in place across all STPs for booking appointments at particular GP practices and accessing records from urgent care providers by December 2018

### Elective access and unwarranted variation

- By summer of 2017 GPs will be able electronically to seek advice and guidance from a hospital specialist without the patient needing an outpatient appointment.
- An updated online patient appointment system will be launched in summer 2017, allowing patients to book their first outpatient appointment with access to waiting time information on a smartphone, tablet or computer.
- By October 2018 all referrals into consultant-led first outpatient appointments will be made via the NHS e-Referral Service.

### Innovation for future care improvement

- Begin the roll-out of new treatments funded by NHS England's specialised commissioning, including mechanical thrombectomy treatment for stroke
- Expand the NHS's genomics capability, collecting 50,000 samples in 2017/18 rising to 90,000 in 2018/19
- Create a more fertile environment for clinical trials by enhancing the Health Research Authority, harmonising approval and recruitment processes, and streamlining bureaucracy, including through the use of digital tools

1 <https://www.england.nhs.uk/2017/03/new-patient-care-test/>

2 <https://www.england.nhs.uk/wp-content/uploads/2017/03/board-paper-300317-item-9.pdf>

3 HSJ – CCG deficit forecast sinks by £180m in two months. Accessed 30 March 2017.

4 NHS Improvement (2017) Quarterly Performance of the Provider Sector as at 31 December 2016

5 The Health Foundation (2017) Briefing: The social care funding gap: implications for local health care reform. March 2017.

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