

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 11th April 2017 commencing at 1.00 pm

at Wolverhampton Science Park, Stephenson Room

A G E N D A

7	Black Country Sustainability Transformation Plan	Dr H Hibbs/Mr S Marshall	1 - 82
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WOLVERHAMPTON CCG

Public Governing Body
11th April 2017

Agenda item 7

TITLE OF REPORT:	Current update on the BC STP
AUTHOR(s) OF REPORT:	Steven Marshall
MANAGEMENT LEAD:	Helen Hibbs
PURPOSE OF REPORT:	To advise GM members of the current status of the BC STP
ACTION REQUIRED:	<input type="checkbox"/> Decision <input checked="" type="checkbox"/> Assurance
PUBLIC OR PRIVATE:	Public
KEY POINTS:	<ul style="list-style-type: none"> • The Trust has unilaterally set out an ACO proposal • This assumes all revenues flow to the Trust and unilaterally reconfigures the Health Economy and STP dynamics • The CCG need to consider the implications of this action
RECOMMENDATION:	For consideration and discussion
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	The STP has a key consideration in how services may be delivered in and underpin new models of care that support care closer to home and improve the management of Long Term Conditions
1. Improving the quality and safety of the services we commission	The intent is for the STP to improve the quality of the services delivered to patients
2. Reducing Health Inequalities in Wolverhampton	The intent is for the STP to reduce health inequalities both in Wolverhampton and across the Black Country
3. System effectiveness delivered within our financial envelope	The STP is designed to deliver collaborative systems working

1. BACKGROUND AND CURRENT SITUATION

- 1.1. The 5YFV (published October 14) laid out the challenge of how the health system might work in the future in order to address the quality and financial sustainability gap and proposed the creation of new delivery models of care – MCPs (Multi speciality Community Providers) and PACs (Primary and Acute Care system). The 5YFV operating plan, published in December of the same year, then laid out the creation of STPs which sought to consider place based commissioning at a more ‘strategic’ level i.e. a wider geographical footprint, in order to maximise economies of scope and scale and minimise clinical variation, for certain commissioned services.
- 1.2. On the 31st March the NHS issued “NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW” in which on the chapter regarding STPs (pp.31-34) it is stated “*all STPs need a basic governance and implementation ‘support chassis’*”
- 1.3. Under this specifically STPs will:
 - 1.3.1. Form an STP board drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate
 - 1.3.2. Establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations
 - 1.3.3. Where this has not already occurred, re/appoint an STP chair/leader
 - 1.3.4. Ensure the STP has the necessary programme management support by pooling expertise and people from across local trusts
 - 1.3.5. Be able to propose an adjustment to their geographical boundaries where that is thought appropriate by local bodies in agreement with NHS England
 - 1.3.6. The corollary to not being prescriptive about STP structures is that the way to judge the success of STPs - and their constituent organisations - is by the results they are able to achieve
 - 1.3.7. The full paper is attached as appendix 1

2. Current Status of BC STP and actions regarding these guidelines

- 2.1. The following actions have been undertaken at an STP level, following a joint leadership meeting on the 2nd March. This has been communicated to all members of staff
- 2.2. The formation of a Joint Committee
- 2.3. Establishment of Task and finish areas along with facilitators have been established as outlined below

Communications and engagement

- o AO sponsor: Helen Hibbs
- o Manager: Mike Hastings
- o Purpose: To establish both standard communications relating to this agenda and any shared requirements for public engagement and/or consultation

Governance

- o AO sponsor: Paul Maubach
- o Manager: Sara Saville
- o Purpose: To organise the governance of the joint committee, clinical board and the task and finish groups; and to evaluate the consequences of CCG statutory duties on any future arrangements

Finance

- o AO sponsor: Andy Williams
- o Manager: James Green
- o Purpose: To develop a shared approach to financial planning and identify key financial risks to the Black Country system and consequential actions / review

Infrastructure including IM&T

- o AO sponsor: Helen Hibbs
- o Manager: Claire Skidmore
- o Purpose: To determine the opportunities for joint working on the use of IM&T, estates and the Black County digital roadmap

Systems design and contractual frameworks

- o AO sponsor: Paul Maubach
- o Manager: Neill Bucktin
- o Purpose: To establish the scope of services between local place and system-wide services; and develop the methodology for enabling each CCG to implement their placed-based model(s) of care

CCG collaboration

- o AO sponsor: Andy Williams
- o Manager: Sharon Liggins
- o Purpose: To explore the opportunities for either the sharing of 'back office functions' and/or to collaborate of common systems and processes to improve the effectiveness of the four CCGs on current activities

- 2.4. The BC STP Sponsoring group also reiterated in principle the continuation of the major areas as identified within the original STP submission i.e. One 'Acute' system, One MH system, 4 local place based systems.
- 2.5. No formal appointment process or lead and/or programme support arrangements have been finalised as of yet

3. CLINICAL VIEW

- 3.1. N/A

4. PATIENT AND PUBLIC VIEW

- 4.1. Engagement and discussion will be necessary for the delivery of the STP

5. KEY RISKS AND MITIGATIONS

- 5.1. The paper is intended to prompt the discussion on risks

6. IMPACT ASSESSMENT

Financial and Resource Implications

- 6.1. There will be as yet not fully explored financial consequences of a change in the local system dynamics

Quality and Safety Implications

- 6.2. New Models of Care will need to fully consider the quality and safety implications

Equality Implications

6.3. Equality will need to be considered in light of any proposed changes

Legal and Policy Implications

6.4. Guidance is not proposing any change to current legislation

Name: Steven Marshall
Job Title: Director of Strategy and Transformation
Date: 31/03/17

ATTACHED:

Appendix 1



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NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW

March 2017

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EXECUTIVE SUMMARY

1. Next year the NHS turns 70. New treatments for a growing and aging population mean that pressures on the service are greater than they have ever been. But treatment outcomes are far better - and public satisfaction higher - than ten or twenty years ago.

2. With waiting times still low by historical standards but on the rise, and the budget growing - but slowly - it is the right time to take stock and confront some of the choices raised by this challenging context. This plan is not a comprehensive description of everything the NHS will be doing. Instead, it sets out the NHS' main national service improvement priorities over the next two years, within the constraints of what is necessary to achieve financial balance across the health service. (Chapter One)

3. Perhaps most importantly, we all want to know that the NHS will be there for us and our families when we need it the most - to provide **urgent and emergency care** 24 hours a day, 7 days a week. Staff are working with great skill and dedication to do so, and looking after more patients than ever. But some urgent care services are struggling to cope with rising demand. Up to 3 million A&E visits could have been better dealt with elsewhere. There are difficulties in admitting sicker patients into hospital beds and discharging them promptly back home.

4. That's why over the next two years the NHS will take practical action to take the strain off A&E. Working closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds. In addition, patients with less severe conditions will be offered more convenient alternatives, including a network of newly designated Urgent Treatment Centres, GP appointments, and more nurses, doctors and paramedics handling calls to NHS 111. (Chapter Two)

5. Most NHS care is provided by **general practice**. One of the public's top priorities is to know that they can get a convenient and timely appointment with a GP when they need one. That means having enough GPs, backed up by the resources, support and other professionals required to enable them to deliver the quality of care they want to provide.

6. We have begun to reverse the historic decline in funding for primary care, and over the next two years are on track to deliver 3,250 GP recruits, with an extra 1,300 clinical pharmacists and 1,500 more mental health therapists working alongside them. As well as improved access during the working week, bookable appointments at evenings and weekends will be available covering half the country by next March, and everywhere in two years' time. (Chapter Three)

7. **Cancer** remains one of the public's most feared illnesses, affecting more than one in three of us in our lifetimes, meaning most of us will face the

anxiety of ourselves or a loved one receiving this diagnosis at some point. Fortunately cancer survival rates are at record highs, and an estimated 7,000 more people are surviving cancer after NHS treatment than would have three years before. Identifying cancer earlier is critical to saving more lives. So we will speed up and improve diagnosis, increase current capacity and open new Rapid Diagnostic and Assessment Centres. Patients will have access to state of the art new and upgraded linear accelerators (LINACs) across the country. By taking these actions we expect at least an extra 5,000 people to survive their cancer over the next two years. (Chapter Four).

8. Increasingly, the public also understand that many of our lives will at some point be touched by **mental health** problems. Historically, treatment options for mental health compare unfavourably with those for physical conditions, particularly for children and young people. The public now rightly expect us to urgently address these service gaps.

9. Substantially increased investment will enable 60,000 more people to access psychological, or ‘talking’ therapies, for common mental health conditions over the coming year, rising to 200,000 more people in 2018/19—an increase of over 20%. We will also address physical health needs by providing an extra 280,000 health checks in 2018/19 for people with severe mental illness. New mothers will get better care. Four new Mother and Baby Units across the country, more specialist beds and 20 new specialist perinatal mental health teams will provide help to 9000 more women by 2018/19. An extra 49,000 more children and young people will be treated by community services. Both children and adults will benefit from reduced travel distances when they need inpatient care through an expansion and rebalancing of specialist beds around the country. 24-hour mental health liaison teams in A&Es, investing in crisis response and home treatment teams and placing 1,500 therapists in primary care will ensure more people get appropriate care when they need it. (Chapter Five)

10. As people live longer lives the NHS needs to adapt to their needs, **helping frail and older people stay healthy and independent**, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. Early results from parts of the country that have started doing this – our ‘vanguard’ areas – are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission. (Chapter Six)

11. We now want to accelerate this way of working to more of the country, through partnerships of care providers and commissioners in an area (Sustainability and Transformation Partnerships). Some areas are now ready to go further and more fully **integrate their services and funding**,

and we will back them in doing so (Accountable Care Systems). Working together with patients and the public, NHS commissioners and providers, as well as local authorities and other providers of health and care services, they will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover.

12. Mirroring this local action, we will also be taking further action nationally to ensure that the NHS can deliver more benefit for patients from every pound of its budget. While the NHS is already one of the leanest publicly-funded health services in the industrialised world, there are still opportunities to do better, as set out in the **NHS' 10 Point Efficiency Plan**. (Chapter Seven)

13. None of this is possible without the outstanding **staff** of the NHS. Although we have 3,000 more doctors and 5,000 more nurses than 3 years ago, and productivity continues to improve, frontline staff face great personal and organisational pressures from rising demand. As a crucial part of delivering the next steps of the Five Year Forward View, we therefore set out in this document how we will continue to support the NHS frontline over the next two years, with Health Education England expanding current routes to the frontline, and opening innovative new ones to attract the best people into the health service, whatever stage of their career they are at. (Chapter Eight)

14. In doing so, the NHS is on a journey to becoming one of the **safest** and most transparent health systems in the world. Chapter Nine describes next steps on this agenda. As well as harnessing people power, the NHS also needs to leverage the potential of **technology and innovation**, enabling patients to take a more active role in their own health and care while also enabling NHS staff and their care colleagues to do their jobs - whether that is giving them instant access to patient records from wherever they are, or to remote advice from specialists. (Chapter Ten)

15. There are considerable risks to delivery of this stretching but realistic agenda, but taken together the measures set out in this plan will deliver a better, more joined-up and more responsive NHS in England. One that is focussed on the issues which matter most to the public. That collaborates to ensure that services are designed around patients. And that is on a more sustainable footing, so that it can continue to deliver **health and high quality care - now and for future generations**. (Chapter Eleven)

CHAPTER ONE

THE NHS IN 2017

Next year marks the 70th anniversary of the National Health Service. Over that period medicine has been revolutionised and lives transformed. The Health Service's founding principles – of care for all, on the basis of need not ability to pay – have stood the test of time. During one of the most vigorous debates our country has seen – over Brexit – the NHS was centre stage.

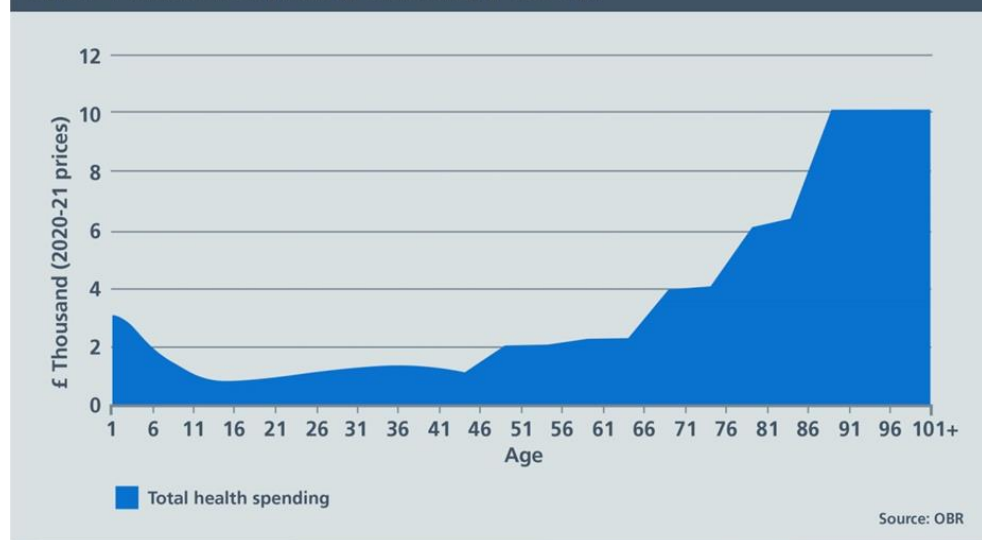
The case for the NHS is straightforward. It does a good job for individual patients, offering high quality care for an ever-expanding range of conditions. It reduces insecurity for families, especially at times of economic uncertainty and dislocation, because access to care is not tied to your job or your income. And as one of the world's most cost-effective health systems, it directly contributes to the success of the British economy.

That's because at a time when the UK is tooling-up for a new trading relationship with the rest of the world, a publicly-funded NHS means British businesses are not on the hook for an inflexible continental-style health 'tax on jobs'. In promoting the health of our children, vulnerable populations, working age adults and retirees, the NHS also helps reduce downstream sickness and unemployment benefits costs. And as the principal domestic customer of the nation's life sciences sector, the NHS helps fuel one of the industrial engines of our future economic growth.

But these are complex and challenging times for our country's most trusted and respected social institution. Pressures on the NHS are greater than they have ever been. The NHS in 2017 confronts five paradoxes:

- *We're getting healthier, but we're using the NHS more. **Life expectancy has been rising by five hours a day**, but the need for modern NHS care continues to grow.¹ Demand for health care is highly geared to our growing and aging population. It costs three times more to look after a seventy five year old and five times more to look after an eighty year old than a thirty year old.² Yet today, there are half a million more people aged over 75 than there were in 2010. And there will be 2 million more in ten years' time. Demand is also heavily impacted by rising public expectations for convenient and personal care, the effectiveness of prevention and public health, and availability of social care. Even more significant is the steady expansion of new treatments and cures, of which the public are often unaware.*

Figure 1: Health care spending rises sharply with age



- *The quality of NHS care is demonstrably improving, but we're becoming far more transparent about care gaps and mistakes.* Outcomes of care for most major conditions are dramatically better than three or five or ten years ago. Annual cancer survival rates are up.³ Heart attack and stroke deaths have tumbled.⁴ But greater transparency and rising expectations mean greater awareness of care gaps and variation. And although they are substantially lower than they were a decade ago, waiting times have been edging up.
- *Staff numbers are up, but staff are under greater pressure.* Over the two years from November 2014, there has been an increase of around 8000 more doctors and nurses working in the NHS⁵ but there are still gaps in some professions and specialties. Frontline NHS staff say their experience at work continues to improve, with this year's annual staff survey scores at a five year high.⁶ Yet only 52% of staff are satisfied with the opportunities for flexible working and 15% have experienced physical violence from patients, relatives or members of the public.
- *The public are highly satisfied with the NHS, but concerned for its future.* Perhaps surprisingly, newly published independent data spanning three decades shows that **public satisfaction with the NHS is higher than in all but three of the past 30 years.**⁷ And it reveals public satisfaction with hospital inpatients is at its highest for more than two decades. As a result The King's Fund says that "In 2016 the NHS remained popular with the public, far more so than it was 10 or 20 years ago".⁸ Looking internationally, 69% of the public in this country say they get good healthcare, compared with 57% in France and 59% in Germany, and only 47% in 22 other nations. But a higher proportion of our public are worried about the future of the NHS.⁹

- *There is now an underlying consensus about how care needs to change to 'future proof' the NHS, but the ability to do so risks being overtaken by what CQC has called today's 'burning platform'.¹⁰ That's why in Autumn 2014, in the wake of several years of contentious political and legislative debate, the NHS nationally came together - to chart for the first time its own direction for the years ahead.*

The NHS Five Year Forward View¹¹ crystallised a consensus about why and how the NHS should change. It described three improvement opportunities: a health gap, a quality gap, and a financial sustainability gap. It proposed a series of measures to bring about the 'triple integration' of primary and specialist hospital care, of physical and mental health services, and of health and social care. And it argued that while much of this lay within the power of the NHS itself to bring about, it was also dependent on well-functioning social care, extra capital investment, transformation funding to support double running costs, and activism on prevention and public health.

Since publication substantial progress has been made, although this year – 2016/17 – only represents Year One of the NHS' five year Spending Review (SR) funding settlement, and demands on the NHS are higher than envisaged when the FYFV was published. Now is therefore an appropriate moment to take stock of what has worked, and what hasn't. And then to make any necessary course corrections accordingly.

Progress since the Forward View – a balanced (but not comprehensive) assessment

Better health

- Action on prevention and public health, including plain packaging for cigarettes, first national diabetes prevention programme, sugar tax agreed to reduce childhood obesity, vaccinating over 1 million infants against meningitis and an additional 2 million children against flu, and public health campaigns including "Be Clear on Cancer" and "Act Fast"

Better care

- Agreed national blueprints for cancer, mental health, maternity, learning disabilities and GP services, backed by targeted initial investment.
- Better clinical outcomes – cancer survival at record high;¹² first ever waiting times targets for mental health treatments introduced and met. Dementia diagnosis rate up from half to more than two thirds.
- Improving experiences of care – overall adult inpatient experience at a record high.¹³
- First phase of fundamental care redesign under way through integrated 'vanguard' new care models.
- 20 hospitals moving out of CQC 'special measures', with 7 moving to a 'good' rating. This includes all 11 hospitals in the original 2013 cohort.
- Action to end inappropriate institutional learning disability services – 12% reduction in inpatients since March 2015.

- Patient safety continues to improve, with the proportion of patients experiencing four major causes of harm (urinary tract infections, falls, deep vein thrombosis and pressure sores) falling by around 8% over the last three years.
- But pressure on waiting times for A&E, routine operations, general practice and other services, with spill-over demand pressures including from preventative services and social care, which CQC warned were approaching a 'tipping point'.¹⁴¹⁵

Financial sustainability

- SR settlement provides real terms aggregate annual NHS England revenue funding growth, but with pressure on per-person funding levels and on areas such as capital investment.
- Improved financial grip – trust agency/locum staffing bills down by £700 million, and CCGs on track to contribute to an £800 million managed commissioner underspend this year, on top of £600 million last year. £1.8 billion a year from the Sustainability and Transformation Fund mainly deployed to support hospital pressures.
- Fairest ever needs-based NHS funding allocation to different parts of the country – reducing to zero the number of CCGs more than 5% under their target, while including primary and specialised services in a comprehensive inequalities-reducing allocation formula.
- Some areas have not been ambitious enough in their attempts to redesign services and need to raise their game on RightCare allocative efficiency improvement. Arguably too much fragmentation in the oversight and support provided by the various national bodies.

A fair conclusion from the NHS' recent history is therefore that we have a viable and agreed strategic direction, and progress has been made. But we have a Health Service under real pressure from rising demand within a tight funding envelope.^{16 17}

Given the importance of ending years of relative neglect of primary care and mental health, these pressures are confronting us with some difficult choices – about the relative priority of improving A&E services and cancer outcomes versus guaranteeing short waits for routine operations.

But the truth is that many of the wider changes to how NHS services are organised would be needed come what may, even if money were no object. The current pressures simply underline the need to get on with them.

Next steps – delivering for the next two years

The NHS Five Year Forward View set out why improvements were needed on our triple aim of better health, better care, and better value. This Plan concentrates on what will be achieved over the next two years, and how the Forward View's goals will be implemented.

Largely that will rely on effective local action by NHS bodies and their partners across the country. But the NHS' national leadership bodies will also have to step up and play their part, supporting local change with national action.

To that end, NHS Improvement has successfully brought coherence to the provider accountability structure that was previously split between Monitor for foundation trusts and the Trust Development Authority for NHS trusts.

Similarly, NHS England's work has evolved in three distinct phases since its creation. The first phase in the immediate aftermath of the passage of the Health and Social Care Act in 2013 and 2014 was successfully to de-risk the financial and operational transition to a new system, in which Parliament passed control of two-thirds of the NHS budget to over 200 new local groups.

The second phase, mostly in 2015 and 2016, was to use NHS England's independence and system leadership role to chart a consensus-based strategic direction for the NHS. Following the Five Year Forward View, specific national improvement blueprints were developed with key partners for urgent and emergency care, cancer, mental health, primary care, and maternity services. Real gains have since been made in each of them, as is set out in this Plan.

2017 marks the third phase of NHS England's life where the focus shifts decisively to supporting delivery and implementation of those key priorities, as detailed in this Plan. Together with associated documentation it also formally constitutes NHS England's 2017/18 Business Plan.¹⁸

But it also affirms the **shared vision of the Five Year Forward View and approach to implementing it of the national leadership bodies** of the NHS, including NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England, NHS Digital and NICE, working closely with a number of patient, professional and representative bodies.

Priorities and trade-offs

In setting national priorities and strategic direction, we draw on numerous sources, including but not limited to:

- The annual NHS Mandate¹⁹ framed by the Government. Issues are also identified by Parliamentary select committees.
- NHS England's direct work in multiple venues with the public, patients, staff and stakeholders.²⁰
- Healthwatch compiles an annual priorities list of the top five issues citizens want to see improved.²¹ For the second year running, mental health services topped the list. Convenient access to GPs, easier hospital discharge and better social care also feature prominently. These priorities are all addressed in this plan.

We also recognise there are benefits from constancy of purpose, not chopping and changing. The challenges we are tackling require sustained action over several years.

This Plan necessarily takes as its starting point the current legislative framework, and the funding the NHS has been allocated. Decisions on both are for government and parliament.

It is not, of course, a comprehensive description of all the good things the NHS will be doing – including on maternity and children’s services, diabetes, dementia care, care for people with learning disabilities, tackling inequalities, end of life care, and improving quality in challenged providers. Nor are these all the actions we will be taking to give effect to the Government’s 2017/18 Mandate to the NHS.

However within the constraints of the requirement to **deliver financial balance across the NHS**, the main **2017/18 national service improvement priorities** for the NHS are:

- **Improving A&E performance.** This also requires upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services. (We set out the plan for Urgent and Emergency Care in Chapter Two).
- **Strengthening access to high quality GP services** and primary care, which are far and away the largest point of interaction that patients have with the NHS each year. (See Chapter Three).
- **Improvements in cancer services (including performance against waiting times standards) and mental health** – common conditions which between them will affect most people over the course of their lives. (Chapters Four and Five).

Within a given funding envelope there are always limits to what can and cannot be done. While the NHS and the Government remain committed to short waits for routine operations, our new Mandate rightly recognises that there is likely to be continued pressure on waiting times for routine care and some providers’ waiting times will grow. Likewise, there is no reason in principle why extra spending on a drug treatment should automatically have a legal override so as to displace community nursing, mental health care or hip replacements – hence the new budget flexibility in the way NICE technology appraisals operate. And in times of modest funding growth, it’s right to challenge and tackle areas of waste or low value care, so as to free up investment head-room for the main priorities. (Chapter Seven sets out the details).

In order to deliver these and our wider goals, in 2017/18 we will work to **accelerate service redesign locally**. (Chapter Six sets out next steps on integrating care locally through Sustainability and Transformation Partnerships and Accountable Care Systems). We also intend to focus on the

enablers of the above, namely our **workforce, safer care, technology and innovation** (Chapters Eight, Nine and Ten refer).

These actions comprise the rest of this plan.

CHAPTER TWO

URGENT AND EMERGENCY CARE

Each year the NHS provides around 110 million urgent same-day patient contacts. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital.

Frontline staff have pulled out all the stops, but over this past winter there have been real difficulties. In providing nine out of ten patients with A&E care within four hours over the past year, the UK offers our patients the fastest national A&E treatment of any major industrialised country. However, in recent years the proportion of patients looked after within 4 hours has been falling – caused by rising demand in A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; the need to adopt good practice in hospitals consistently; and difficulties in discharging inpatients when they are ready to go home. So we need to take action to improve services for patients and reduce pressure on our staff.

What's been achieved in England over the past three years?

- Cared for 23 million A&E attendances in 2016/17, 1.2 million more than three years ago.
- Boosted the capacity and capability of NHS 111, which now takes 15 million calls each year, up from 7.5 million three years ago.
- Expanded “Hear and Treat” and “See and Treat” ambulance services so that they now cover 3.5 million people, with the provision of telephone advice and treatment of people in their homes saving needless trips to hospital.
- Developed an integrated urgent care model, offering a single point of entry for urgent care via NHS 111, and rolled it out to 20% of the population.
- Increased NHS staff uptake of winter flu vaccinations from 49% last year to 63% this year – the highest ever.

Key deliverables for 2017/18 and 2018/19

Trusts and CCGs will be required to meet the Government's 2017/18 mandate to the NHS that: 1) in or before September 2017 over 90% of emergency patients are treated, admitted or transferred within 4 hours – up

from 85% currently; 2) the majority of trusts meet the 95% standard in March 2018; and 3) the NHS overall returns to the 95% standard within the course of 2018. In order to do so:

- Every hospital must have comprehensive **front-door clinical streaming** by October 2017, so that A&E departments are free to care for the sickest patients, including older people.
- By October 2017 every hospital and its local health and social care partners must have adopted good practice to enable appropriate **patient flow**, including better and more timely hand-offs between their A&E clinicians and acute physicians, 'discharge to assess', 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities.
- Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care**. They need to:
 - ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care, thereby **helping to free up 2000-3000 acute hospital beds** – the equivalent of opening 5 new hospitals – and regularly publish the progress being made in this regard.²²
 - ensure that 85% of all assessments for continuing health care funding take place out of hospital in the community setting, by March 2018.
 - Implement the High Impact Change Model²³ for reducing DTOCs, developed by the Local Government Association, the Association of Directors of Adult Social Care Services, NHS Improvement and NHS England.
- Specialist **mental health care in A&Es**: 74 24-hour 'core 24' mental health teams, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and reach nearly half by March 2019, compared with under one-in-ten today.
- Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this. 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 this is 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.**
- Strengthen support to **care homes** to ensure they have direct access to clinical advice, including appropriate on-site assessment.
- Roll-out of standardised new '**Urgent Treatment Centres**' which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.
- Working closely with the Association of Ambulance Chief Executives and the College of Paramedics, implement the recommendations of the **Ambulance Response Programme** by October 2017, putting an end to long waits not covered by response targets. Actions taken will be subject to the results of evaluation and approval from Ministers.

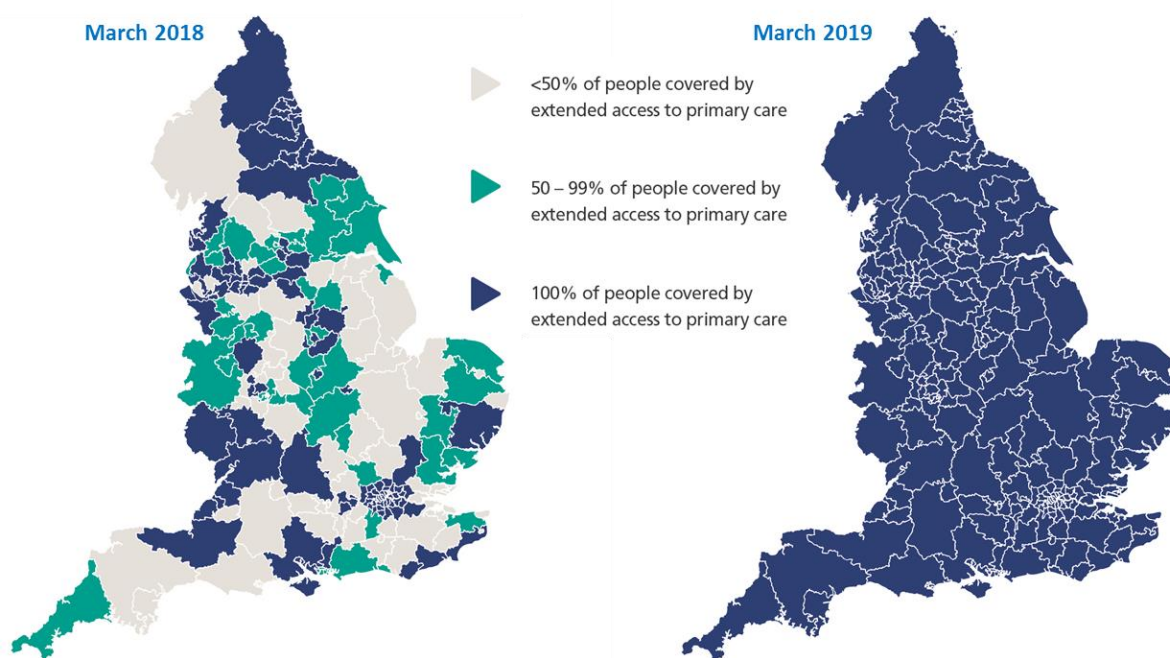
How changes will be implemented

- *£100 million in capital funding* will be provided to support modifications to A&Es to enable clinical streaming by October 2017.
- *Clearer local performance incentives.* Previous standard contract fines have been dropped. From April 2017 the rules governing the performance element of the £1.8 billion Sustainability and Transformation Fund (STF) for acute trusts that relates to A&E will be amended in agreement with Department of Health and HM Treasury.²⁴
- *Aligned national programme management.* To ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed a single national leader accountable to both NHS England and NHS Improvement. We will also bring together the work of NHS Improvement's and NHS England's national urgent and emergency care teams. From 1st April 2017 a single, named Regional Director drawn 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. Each RD will therefore act with the delegated authority of both NHS Improvement and NHS England in respect of urgent and emergency care.
- *Broader improvement support.* Building on the work of the Emergency Care Improvement Programme and the regional teams of NHS England and NHS Improvement, we will offer a broader range of improvement support to frontline staff to achieve the priorities set out above. This

will include extending to emergency care both the Getting it Right First Time Programme and the Model Hospital, together with joint work with the Royal College of Emergency Medicine and other professional bodies on workforce and a more standardised clinical operating model.

- Detail on the *technology* changes to support these approaches is included in Chapter Nine.

Figure 2: Roll out of extended access to primary care



CHAPTER THREE

PRIMARY CARE

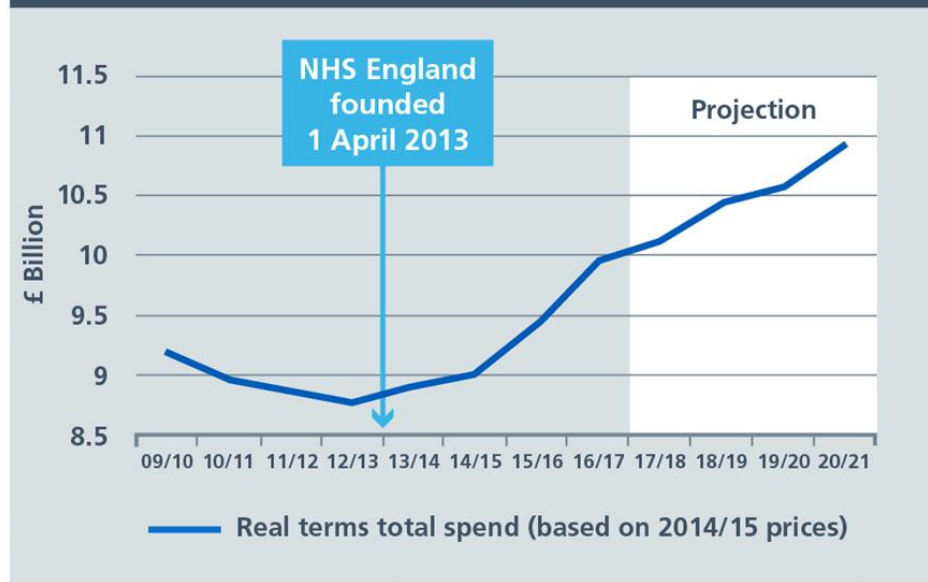
GPs have one of the highest public satisfaction ratings of any public service, at over 85%,²⁵ but we know improving access to primary care services is a top priority for patients.²⁶ General practice is undeniably the bedrock of NHS care and we have more GPs per head than Germany.²⁷ General practice provides over 300 million patient consultations each year, compared to 23 million A&E visits. So if general practice fails, the NHS fails. Yet a year's worth of GP care per patient costs less than two A&E visits, and we spend less on general practice than on hospital outpatients. For the past decade funding for hospitals has been growing around twice as fast as for family doctor services.

That's why the General Practice Forward View set out a detailed, costed package of investment and reform for primary care now through to 2020. It will mean more convenient access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and better integrated with community and preventive services, hospital specialists and mental health care. In doing so we are working with the Royal College of GPs, the General Practitioners Committee, the National Association of Primary Care, and others. See the [General Practice Forward View](#).²⁸

What's been achieved in England over the past three years?

- More convenient access to primary care services, with 17 million people now able to access GP appointments at evenings and weekends.
- First steps to expand the primary care workforce, including an additional 300 GP trainees, and 491 clinical pharmacists. New national mental health service for GPs launched.
- 560 new schemes completed and over 200 in progress to modernise GP surgery buildings, IT and equipment.
- New 'vanguard' models of scaled primary care across 23 areas, covering nearly 10% of the population, which have seen lower growth in emergency hospital admissions than the rest of England.
- In the years prior to the creation of NHS England, investment in general practice was falling in real terms. Each year since the establishment of NHS England we have made sure it has gone up, with real terms funding increasing by 8% over the past 3 years.

Figure 3: Real terms General Practice funding has increased over the past 3 years



Key improvements for 2017/18 and 2018/19

- *More convenient patient access to GP services.* As additional GPs, therapists, pharmacists and nurses come on stream we want to improve access to convenient and needed practice appointments. During daytime surgery hours, practices are increasingly ‘streaming’ patients so as to offer convenient same day urgent appointments, while preserving continuity of care for patients with more complex long term conditions. 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 who shut for half days each week will not be eligible for a share of the £88 million extended access scheme.
- For many people with jobs, particularly self-employed and hourly paid workers, tackling inequalities in access will mean making available bookable evening and weekend appointments. **By March 2018, the Mandate requires that 40% of the country will benefit from extended access to GP appointments at evenings and weekends, but we are aiming for 50%. By March 2019 this will extend to 100% of the country.** This does not require every practice itself to be open each evenings or weekend, but it does mean that patients anywhere will be able to book appointments when they need them. To provide these additional services, general practices will increasingly cooperate with other practices in formal or informal networks.
- *Boost GP numbers.* The Government has set an objective of an extra 5000 doctors working in general practice by 2020. Numbers entering GP training are up by 10% since 2015 and HEE will fill a further 230

places in 2017/18 to ensure they reach 3250 trainees per year. Initial applications for GP training in 2017 are up by 5% on the same time last year. Practical action to boost GP retention, as set out in the GP Forward View, will include:

- The GP Career Plus scheme in 10 sites across the country, supporting retention of experienced doctors by allowing them to continue working without the responsibilities of a partnership.
 - The Time to Care programme, investing £30 million to help practices reduce their workload and free up GP time.
 - The new NHS GP Health Service, to support doctors suffering from mental ill-health and addiction.
- *Expand multidisciplinary primary care.* We will:
- increase the number of **clinical pharmacists** working in GP surgeries from the 491 we are co-funding today to over 900 by March 2018 and over 1300 by March 2019. Not only will patients benefit from pharmacy services, but the introduction of clinical pharmacists will also help free up GP time to focus on those patients who need it most, for example, by supporting patients to manage high risk conditions such as high blood pressure earlier and more effectively, preventing cardiovascular disease. Clinical pharmacists and will also help to ensure efficient use of medicines.
 - **800 mental health therapists** will be placed in primary care by March 2018 rising to over 1500 by March 2019. These therapists will lead the way in how we integrate physical and mental healthcare outside of hospital.
 - HEE is supporting universities to train **3000 physician associates** by 2020. HEE will work with NHS England to incentivise up to 1000 of these staff to work in General Practice.
 - HEE has also published findings on how to improve the future of **general practice nursing**. NHS England and HEE will work with partners on this, backed by £15m as promised in the GP Forward View.
- *Modernise primary care premises.* We have been investing steadily in upgrading primary care facilities, benefiting both patients and staff. Over **800 further infrastructure projects** are identified for investment by 2019.

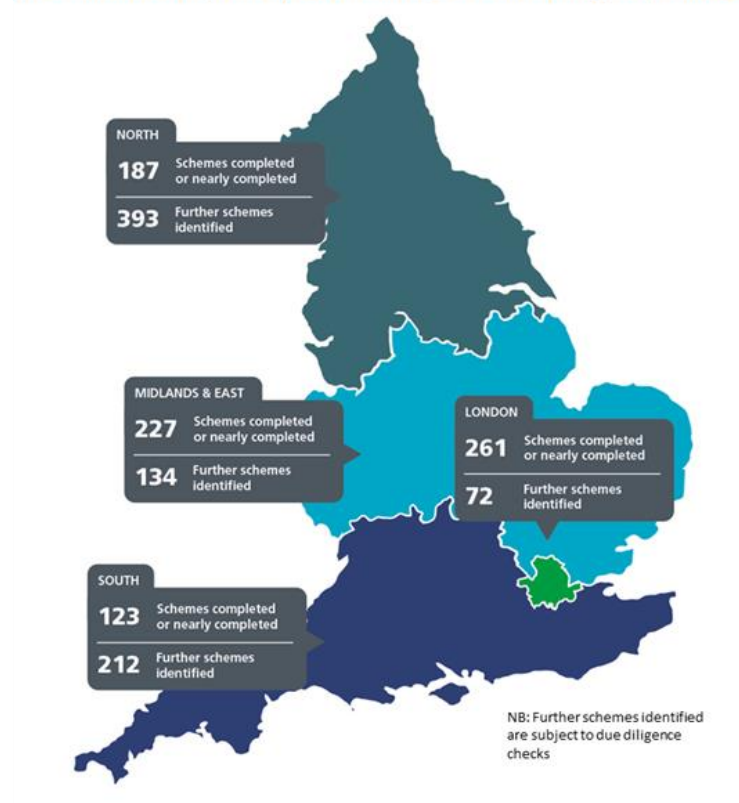
How changes will be implemented

- *Continue to increase investment* in GP services, so that by 2020/21, funding will rise by £2.4 billion, a 14% real terms increase. Targeted national investment in a growing number of clinical pharmacists and mental health therapists embedded in primary care.
- *Encourage practices to work together in 'hubs' or networks.* Most GP surgeries will increasingly work together in primary care networks or hubs. This is because a combined patient population of at least 30,000-

50,000 allows practices to share community nursing, mental health, and clinical pharmacy teams, expand diagnostic facilities, and pool responsibility for urgent care and extended access. They also involve working more closely with community pharmacists, to make fuller use of the contribution they make. This can be as relevant for practices in rural areas as in towns or cities, since the model does not require practice mergers or closures and does not necessarily depend on physical co-location of services. There are various routes to achieving this that are now in hand covering a majority of practices across England, including federations, ‘super-surgeries’, primary care homes, and ‘multispecialty community providers’. Most local Sustainability and Transformation Plans are intending to accelerate this move, so as to enable more proactive or ‘extensivist’ primary care. Nationally we will also use funding incentives - including for extra staff and premises investments - to support this process.

- *Contract reform.* The 2004 GP contract linked a proportion of practice income to performance against detailed indicators – the Quality and Outcomes Framework (QOF). There is now wide agreement that this particular approach has run its course, and is now partly a tick-box exercise.²⁹ We will seek to develop and agree with relevant stakeholders a successor to QOF, which would allow the reinvestment of £700 million a year into improved patient access, professionally-led quality improvement, greater population health management, and patients’ supported self-management, to reduce avoidable demand in secondary care.

Figure 4: Roll out of primary care Building and Technology improvements



CHAPTER FOUR

CANCER

The NHS Five Year Forward View identified cancer as one of our top priorities because more than one in three of us will get cancer in our lifetimes. Better prevention, earlier diagnosis and innovative new treatments mean we have a realistic opportunity to make major improvements in survival.

But large increases in the number of people being referred for cancer check-ups is placing strain on services, with one of the eight cancer waiting times standards not having been met for several years.

What's been achieved in England over the past three years?

- Highest cancer survival rates ever – latest survival figures show an estimated 7000+ more people surviving cancer after successful NHS cancer treatment compared to three years prior.
- Big expansion in cancer check-ups – over 1.7 million people urgently referred by their GP this year, up by 500,000 people compared to three years ago. 450,000 more people are being seen in under 14 days.
- New fast track funding for the most promising new cancer drugs approved by NICE, matched by rigorous NHS England assessment and price negotiation, has helped eliminate a £125 million overspend in the Cancer Drugs Fund budget. Six new molecular diagnostic tests funded by the NHS this year.
- 300,000 fewer smokers – lowest smoking rate since records began. Plain packaging introduced.
- NHS England's cancer taskforce has agreed a detailed improvement blueprint to 2020, in partnership with patient groups, medical experts and research organisations. See [Cancer taskforce report](#)³⁰ and '[one year on](#)' document.³¹

Key improvements for 2017/18 and 2018/19

- *Better cancer survival.* Within two years, **more than 5000 extra people a year will survive cancer** as compared to now.
- *Expanded screening to improve prevention and early detection of cancer.* Introduction of a **new bowel cancer screening test** for over 4 million people from April 2018. Compared to the old bowel screening test, almost a third of a million more people are expected to complete screening from 2018/19 and a fifth more cancers will be caught earlier. The introduction of **primary HPV testing for cervical screening** from April 2019 will benefit over 3 million women per year and could prevent around 600 cancers a year.

- *Faster tests, results and treatment for people with worrying symptoms.* Expand diagnostic capacity so that England is meeting all 8 of the cancer waiting standards, compared to seven out of eight today. We will focus specifically on the **cancer 62-day from referral to treatment standard** ahead of the introduction of the **new standard to give patients a definitive diagnosis within 28 days** by 2020. Performance incentives for achievement of the cancer 62-day waiting standard will be applied to extra funding available to our cancer alliances. By March 2018, introduce 10 new multi-disciplinary Rapid Diagnostic and Assessment Centres across England, and by March 2019, rollout Centres in each of the 16 cancer alliances. Expand access to the latest molecular diagnostics capability across England, with hi-tech test volumes set to grow from around 55,000 to around 70,000 a year.
- *Access to the most modern cancer treatment in all parts of the country.* Implement the **largest radiotherapy upgrade programme in 15 years** by October 2018, patients will have access to sustainable high-quality, modern radiotherapy treatments wherever they live. The first 23 hospitals have received new or upgraded equipment in early 2017, and over 50 new radiotherapy machines in at least 34 hospitals will be rolled out over the next 18 months, subject to the customary HM Treasury approval of the capital business case (see map). In addition, further modern cancer drugs available thanks to our reshaped cancer drugs fund and the new Accelerated Access approvals process with NICE. Roll out personalised follow up after cancer treatment, starting with half the country's cancer alliances in 2017.

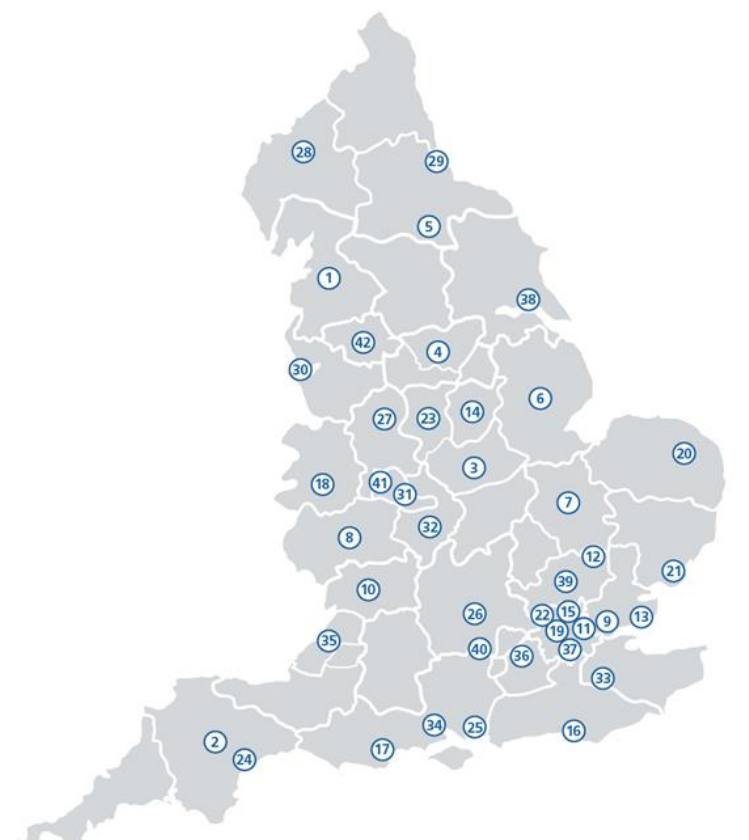
How changes will be implemented

- *Targeted national investment,* including £130 million for a national radiotherapy modernisation fund. £36 million has been spent so far, with a further £94 million planned to be spent over the next 18 months. In addition a National Cancer Diagnostics Capacity Fund is supporting earlier diagnosis and living with and beyond cancer.
- *Expand the cancer workforce:* HEE to have trained 160 non-medical endoscopists by 2018, alongside 35 more places for ST1 clinical radiology training.
- *Clear accountability and delivery chain.* Performance goals for CCGs and cancer providers, matched by unprecedented transparency using the new [cancer dashboard](#).³² CCG ratings published in July. Aligned local delivery infrastructure through 16 cancer alliances coterminous with their constituent STPs. Three cancer vanguards creating population cancer budgets so as to integrate commissioning of cancer surgery, radiotherapy and cancer drugs for 9.6 million people. Single national programme management team led by a single national cancer director and national clinical director, aligning the work of NHS England, NHS Improvement, Health Education England, Public Health England, and

other Arm's Length Bodies, and working closely with Cancer Research UK and Macmillan.

- See our full Cancer [implementation plan](#).³³

Figure 5: Roll out of cancer care Radiotherapy upgrade programme



NHS hospitals that have already received funding for new or upgraded equipment in early 2017

1. Lancashire Teaching Hospitals NHS Foundation Trust
2. Torbay and South Devon NHS Foundation Trust
3. University Hospitals of Leicester NHS Trust
4. Sheffield Teaching Hospitals NHS Foundation Trust
5. South Tees Hospitals NHS Foundation Trust
6. United Lincolnshire Hospitals NHS Trust
7. Peterborough and Stamford Hospitals NHS Foundation Trust
8. Worcestershire Acute Hospitals NHS Trust

NHS hospitals that will receive funding for new radiotherapy machines in the next 18 months

9. Barking, Havering and Redbridge University Hospitals NHS Trust
10. Gloucestershire Hospitals NHS Foundation Trust
11. Imperial College Healthcare NHS Trust
12. Cambridge University Hospitals NHS Foundation Trust
13. Southend University Hospital NHS Foundation Trust
14. Nottingham University Hospitals NHS Trust
15. North Middlesex University Hospital NHS Trust
16. Brighton And Sussex University Hospitals NHS Trust
17. Poole Hospital NHS Foundation Trust
18. Shrewsbury and Telford Hospital NHS Trust
19. The Royal Marsden NHS Foundation Trust
20. Norfolk and Norwich University Hospitals NHS Foundation Trust
21. Ipswich Hospital NHS Trust

22. Royal Free London NHS Foundation Trust
23. Derby Teaching Hospitals NHS Foundation Trust
24. Royal Devon and Exeter NHS Foundation Trust
25. Portsmouth Hospitals NHS Trust
26. Oxford University Hospitals NHS Foundation Trust
27. University Hospitals of North Midlands NHS Trust

NHS hospitals that have already received funding for new or upgraded equipment and will receive funding for new radiotherapy machines in the next 18 months

28. North Cumbria University Hospitals NHS Trust
29. The Newcastle upon Tyne Hospitals NHS Foundation Trust
30. The Clatterbridge Cancer Centre NHS Foundation Trust
31. University Hospitals Birmingham NHS Foundation Trust
32. University Hospitals Coventry and Warwickshire NHS Trust
33. Maidstone and Tunbridge Wells NHS Trust
34. University Hospital Southampton NHS Foundation Trust
35. University Hospitals Bristol NHS Foundation Trust
36. Royal Surrey County Hospital NHS Foundation Trust
37. University College London Hospitals NHS Foundation Trust
38. Hull and East Yorkshire Hospitals NHS Trust
39. East and North Hertfordshire NHS Trust
40. Royal Berkshire NHS Foundation Trust
41. Royal Wolverhampton NHS Trust
42. The Christie NHS Foundation Trust

CHAPTER FIVE

MENTAL HEALTH

The NHS Five Year Forward View pointed out that one in four of us will experience mental health problems, and mental illness is the single largest cause of disability. Yet mental health services have for several decades been the ‘poor relation’ compared to acute hospital services for physical conditions. Fortunately there is now good evidence that tackling some major mental health problems early reduces subsequent problems, improves people’s life chances, and also saves money for the wider economy.

What’s been achieved in England over the past three years?

- Decisive investment upturn, with overall mental health funding up £1.4 billion in real terms compared to 3 years ago.
- 120,000 more people getting specialist mental health treatment this year than 3 years ago, including over 20,000 more children and young people.
- The dementia diagnosis rate increased from half of people to more than two thirds, enabling earlier care and support.
- Over two thirds of the country now covered by criminal justice liaison and diversion services, up from under a quarter 3 years ago. Use of police cells as a place of safety for people with mental health problems has seen more than a 3-fold decrease over past 3 years.
- This year the NHS has introduced, and met, the first ever national waiting times standards for mental health services, 25 years after targets were set for surgical operations.
- NHS England’s mental health taskforce has agreed a detailed improvement blueprint to 2020, in partnership with patient groups, clinicians and NHS organisations. See [Mental Health Taskforce Report](#),³⁴ [Implementation Plan](#)³⁵ and [One Year On Report](#).³⁶

Key improvements for 2017/18 and 2018/19

With carefully targeted and affordable national funding, supplemented by investment from local CCGs, we are now delivering one of the biggest expansions in access to mental health services currently happening in Europe.

- *Big 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 the end of 2018/19 – an increase of over 20%. Alongside this, we are working with NICE to help facilitate faster access to new digital therapies.
- *Better mental health care for new and expectant mothers:* **4 new mental health Mother and Baby Units**. In East Anglia, the North West, and

South West and South East. Boost bed numbers in the current 15 units so that overall capacity is up by 49% by 2018/19. And **20 new or expanded specialist perinatal mental health teams**. This will mean being able to provide care and treatment to at least 2000 more women with severe mental health problems in 2017/18 and 9000 more women by 2018/19.

- *Improved care for children and young people.* An extra 35,000 children and young people being treated through NHS-commissioned community services next year compared to 2014/15, growing to an **extra 49,000 children and young people getting the care they need** in two years' time.
- *Care closer to home.* For children and young people, NHS England will fund 150-180 new CAMHS Tier 4 specialist inpatient beds in underserved parts of the country to **reduce travel distances** for treatment, rebalancing beds from parts of the country where more local CAMHS services can reduce inpatient use. For adults, investment in crisis resolution and home treatment teams will reduce the need to inappropriately send people out of area for non-specialist inpatient care - from 2018, it should mean a one third reduction in adults sent out-of-area for inpatient psychiatric treatment.
- *Specialist mental health care in A&Es:* 74 24-hour **mental health teams** at the Core 24 standard, covering five times more A&Es by March 2019, than now. The service will be available in more than a quarter of acute hospitals by March 2018 and nearly half by March 2019, compared to under 10% today.
- *Better physical health for people with mental illness.* An extra 140,000 **physical health checks** for people with severe mental illness in 2017/18, rising to 280,000 health checks in 2018/19.
- New specialist Transition, Intervention and Liaison (TIL) mental health services for **veterans**, accessed through four areas across England from April 2017
- New specifications for mental health provision for people in secure and detained settings to be in place during 2017
- Investment in mental health provider **technology** through Mental Health Global Digital Exemplars (see Chapter Ten)

How changes will be implemented

- Targeted earmarked national investment for expanded services, alongside an overarching CCG 'investment standard' directing growth in mental health funding.

- Expand the mental health workforce – 800 mental health therapists embedded in primary care by March 2018, rising to over 1500 by March 2019.
- Reform of mental health commissioning so that local mental health providers control specialist referrals and redirect around £350 million of funding. Enables expansion of local services and reduction of inappropriate out-of-area placements.
- 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.
- Clear performance goals for CCGs and mental health providers, matched by unprecedented transparency using the [new mental health dashboard](#).³⁷ CCG ratings published in July 2016.
- Support the development of the Children and Young People’s Green Paper due for publication in autumn 2017.
- Single national programme management team led by a national mental health director and national clinical director, aligning the work of NHS England, NHS Improvement, Health Education England, Public Health England, and the other Arm’s Length Bodies. We will also continue to work closely with our key partners, including Mind, Young Minds, the Mental Health Foundation and the Royal College of Psychiatrists.
- See our full [mental health implementation plan](#).³⁸

CHAPTER SIX

INTEGRATING CARE LOCALLY

Next steps for STPs and Accountable Care Systems

The NHS Five Year Forward View said: *“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. 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. 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. And services need to be integrated around the patient.”*

To give life to this vision the FYFV argued for a new approach using five rules of thumb:

- Focus on keeping people healthier for longer through *service improvements and outcomes* not just administrative reorganisation per se. Distinguish means from ends, so that systems flex in pragmatic ways to support the work that now needs doing. (Hence taking a permissive approach to parts of the country that wanted to move away from tariff payments, and to those areas that wanted cross-organisational system ‘control totals’.)
- *Co-produce major national improvement strategies* with patients’ and voluntary groups, staff and other key stakeholders (as for example with the mental health, maternity and learning disabilities taskforces).
- *‘Horses for courses’* not ‘one size fits all’. Recognise that England is diverse both in its population and care delivery so support and test plural models in different parts of the country. (Hence local STPs to debate and develop locally-grounded proposals and plans.)
- *Evolution not Big Bang* – inevitable if the focus is on continuous improvement, adaptive change and learning by doing (hence the vanguards).
- *Back energy and leadership where we find it* – if in one area that comes from local government or the third sector partnering with the NHS they may take on a wider strategic leadership role for the health and care system, as in Greater Manchester. In other places that leadership role has fallen to CCGs and emerging GP groups, and in yet others it is an NHS trust that has the capability and authority

to take on the convening role for change. The point is to focus on the assets available to catalyse change in given communities.

Across England, commissioners and providers across the NHS and local government need to work closely together – to improve the health and wellbeing of their local population and make best use of available funding. Services that are planned and provided by local government, including housing, leisure and transport as well as public health and social care, impact on the health and wellbeing of local people. Addressing the wider determinants of health affects demand for primary and acute services. Equally, the demand for social care is affected by the availability and effectiveness of NHS services such as stroke rehabilitation and other primary and community services provided to people in their own homes and care homes. Local health and care systems only work smoothly and effectively to provide effective services and minimise delays when there are good relationships and clear joint plans in place locally.

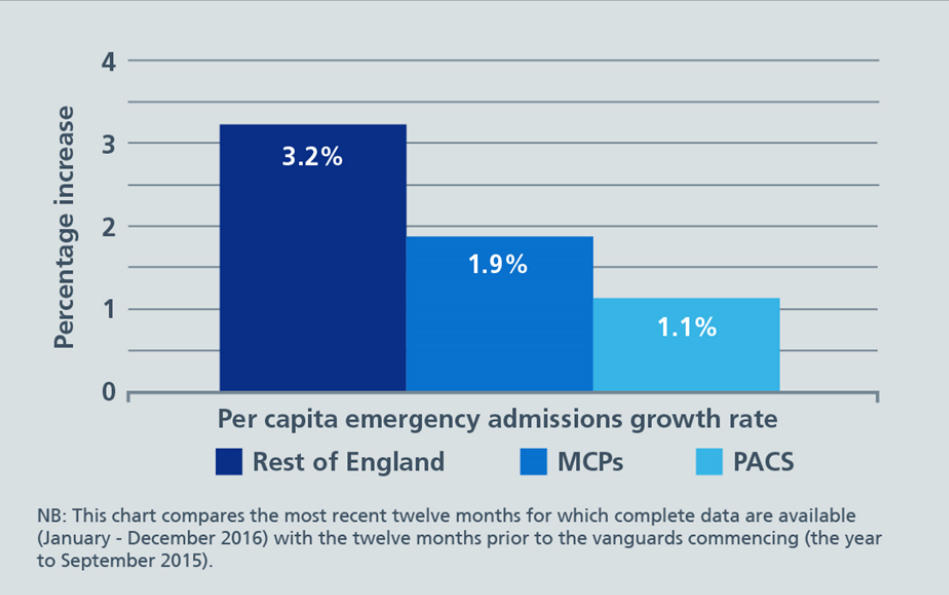
New care models

One way in which this approach has been given expression is through the vanguard programme. Over the past 18-24 months fifty areas around England covering more than five million people have been working to redesign care. They have focused on:

- better integrating the various strands of community services such as GPs, community nursing, mental health and social care, moving specialist care out of hospitals into the community ('Multispecialty Community Providers' or 'MCPs');
- joining up GP, hospital, community and mental health services ('Primary and Acute Care Systems' or 'PACS');
- linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency ('Acute Care Collaborations' or 'ACCs'); and
- offering older people better, joined up health, care and rehabilitation services ('Enhanced Health in Care Homes').

Compared to their 2014/15 baseline **both PACS and MCP vanguards have seen lower growth in emergency hospital admissions and emergency inpatient bed days than the rest of England.** Given sample sizes and duration it is important not to over-interpret the data currently available. However, comparing the most recent twelve months for which complete data are available (January-December 2016) with the twelve months prior to the vanguard funding commencing (the year to September 2015), **per capita emergency admissions growth rates were: PACS vanguards 1.1%, MCP vanguards 1.9%, versus the non-vanguard rest of England which was 3.2%.**

Figure 6: MCP and PACS vanguards have seen lower growth in per capita emergency hospital admissions than the rest of England



Alternatively taking the full financial year April 2014-March 2015 before the vanguards were selected as the baseline period, per capita emergency admissions growth rates were: PACS 1.7%, MCPs 2.7% and rest of England 3.3%. Vanguards such as Morecambe Bay, Northumberland and Rushcliffe are reporting absolute reductions in emergency admissions per capita. As intended, the benefit has been greatest for older people. The Care Homes vanguards are also reporting lower growth in emergency admissions than the rest of England, and meaningful savings from reducing unnecessary prescribing costs.

Sustainability and Transformation Partnerships

Our aim is to use the next several years to make the biggest national move to integrated care of any major western country. Why? As the CQC puts it:

“The NHS stands on a burning platform - the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today’s population needs... transformational change is possible, even in the most challenging of circumstances - we have witnessed it, and seen the evidence that it delivers improved care. As the boundaries between organisations and sectors become increasingly porous, peer review and transparency will become ever more important.” Prof Sir Mike Richards ³⁹

This will take the form of Sustainability and Transformation Partnerships covering every area of England, and for some geographies the creation of integrated (or ‘accountable’) health systems.

STPs began life as pragmatic vehicles for enabling health and care organisations within an area to chart their own way to keeping people healthier for longer, improving care, reducing health inequalities and managing their money, working jointly on behalf of the people they serve. They are a means to an end, a mechanism for delivering the Forward View and the key national priorities in this Plan.

These partnerships are more than just the ‘wiring’ behind the scenes. They are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most. They are a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them. At their best, they engage front-line clinicians in all settings to drive the real changes to the way care is delivered that they can see are needed and beneficial. And they are vehicles for making the most of each pound of public spending; for example, by sharing buildings or back office functions.⁴⁰

More fundamentally they require engaging with communities and patients in new ways. In order to mobilise collective action on “health creation” and service redesign, we need to recognise that, as the Five Year Forward View argued:

“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 underdeveloped 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.”

In making this transition to population-based integrated health systems, the NHS will be guided by several principles building on those identified above:

- **STPs are not new statutory bodies. They supplement rather than replace the accountabilities of individual organisations.** It’s a case of ‘both the organisation and our partners’, as against ‘either/or’.
- **The way STPs work will vary according to the needs of different parts of the country.** Place-based health and care systems should be defined and assessed primarily by how they practically tackle their shared local health, quality and efficiency challenges. We do not want to be overly prescriptive about organisational form. This

approach to health and social care integration, building on the Better Care Fund, is also supported by government who have said:

“The government will not impose how the NHS and local government deliver this. The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports, including: Accountable Care Organisations such as the one being formed in Northumberland, to create a single partnership responsible for meeting all health and social care needs; devolution deals with places such as Greater Manchester which is joining up health and social care across a large urban area; and Lead Commissioners such as the NHS in North East Lincolnshire which is spending all health and social care funding under a single local plan.”⁴¹

- However to succeed, all STPs need a **basic governance and implementation ‘support chassis’** to enable this type of effective working. All NHS organisations will therefore from April form part of a Sustainability and Transformation Partnership, which will:
 - Form an *STP board* drawn from constituent organisations and including appropriate non-executive participation, partners from general practice, and in local government wherever appropriate. Establish formal CCG Committees in Common or other appropriate decision making mechanisms where needed for strategic decisions between NHS organisations. (The governance arrangements now in place across Greater Manchester provide one example of how this can be done within the current statutory framework.) In the unlikely event that it is apparent to NHS England and NHS Improvement that an individual organisation is standing in the way of needed local change and failing to meet their duties of collaboration we will – on the recommendation of the STP as appropriate – take action to unblock progress, using the full range of interventions at our disposal.
 - Where this has not already occurred, re/appoint an *STP chair/leader* using a fair process, and subject to ratification by NHS England and NHS Improvement, in line with the national role specification. NHS England will provide funding to cover the costs of the STP leader covering at least two days a week pro rata.
 - Ensure the STP has the necessary *programme management support* by pooling expertise and people from across local trusts, CCGs, CSUs and other partners. Where CCGs wish to

align their management teams or even governing bodies more closely with those of the STP geography, NHS England will generally now support that. NHS England will also deploy its own local staff under the direction of STPs where appropriate.

- Be able to propose an adjustment to their *geographical boundaries* where that is thought appropriate by local bodies in agreement with NHS England. Over time we expect these may flex pragmatically depending on local circumstances. In any event, patient flows, for example for specialised services, may mean planning across several STP areas.
- We will work with STP leads, NHS Clinical Commissioners, NHS Providers, the NHS Confederation, the Local Government Association and other appropriate bodies in the development of STPs and the policy framework they will operate in
- The corollary to not being prescriptive about STP structures is that **the way to judge the success of STPs - and their constituent organisations - is by the results they are able to achieve**. We will publish metrics at STP level that will align with NHS Improvement's Single Oversight Framework for NHS provider trusts and NHS England's annual CCG Improvement and Assessment Framework, which will be published in July.

Community participation and involvement

Making progress on our priorities and addressing the challenges the NHS faces over the next two years cannot be done without genuine involvement of patients and communities. Nationally, we will continue to work with our partners, including patient groups and the voluntary sector, to make further progress on our key priorities.

Locally, we will work with patients and the public to identify innovative, effective and efficient ways of designing, delivering and joining up services. And by prioritising the needs of those who experience the poorest health outcomes, we will be better able to improve access to services, reduce health inequalities in our communities and make better use of resources.

Last year STPs produced and published initial 'Mark 1' proposals covering the next five years. Some of these contained suggestions for major changes in local services that require formal public consultation. All of them require local engagement with patients, communities and staff.

Healthwatch has set out five steps to ensure local people have their say:

1. Set out the case for change so people understand the current situation and why things may need to be done differently.
2. Involve people from the start in coming up with potential solutions.
3. Understand who in your community will be affected by your proposals and find out what they think.
4. Give people enough time to consider your plans and provide feedback.
5. Explain how you used people's feedback, the difference it made to the plans and how the impact of the changes will be monitored.⁴²

As STPs move from proposals to more concrete plans, we expect them to involve local people in what these plans are and how they will be implemented.

In addition, where significant hospital bed closures will result from proposed service reconfigurations, NHS England will in future require STPs to meet a 'fifth' new test in addition to the four existing ones put in place in 2010. Under those current rules, planned closures can only go ahead with support from GP commissioners, strengthened public and patient engagement, clear clinical evidence and assurances that they are consistent with patient choice.

From 1 April 2017, NHS organisations will also have to show that proposals for significant hospital bed closures, requiring formal public consultation, can meet one of three common sense conditions:

- That sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
- That specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or
- Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

Hospitals will still have the freedom to flex their number of beds throughout the year to manage their budgets, and the responsibility to determine how many beds they can safely staff.

Accountable Care Systems

ACs will be an 'evolved' version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In

return they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital. Specifically, ACSs are STPs - or groups of organisations within an STP sub-area - that can:

- Agree an *accountable performance contract* with NHS England and NHS Improvement that can credibly commit to make *faster improvements* in the key deliverables set out in this Plan for 2017/18 and 2018/19.
- Together manage *funding for their defined population*, committing to shared performance goals and a financial system 'control total' across CCGs and providers. Thereby moving beyond 'click of the turnstile' tariff payments where appropriate, more assertively moderating demand growth, deploying their shared workforce and facilities, and effectively abolishing the annual transactional contractual purchaser/provider negotiations within their area.
- Create an effective *collective decision making and governance structure*, aligning the ongoing and continuing individual statutory accountabilities of their constituent bodies.
- Demonstrate how their provider organisations will operate on a *horizontally integrated* basis, whether virtually or through actual mergers, for example, having 'one hospital on several sites' through clinically networked service delivery.
- Demonstrate how they will simultaneously also operate as a *vertically integrated* care system, partnering with local GP practices formed into clinical hubs serving 30,000-50,000 populations. In every case this will also mean a new relationship with local community and mental health providers as well as health and mental health providers and social services.
- Deploy (or partner with third party experts to access) rigorous and validated *population health management capabilities* that improve prevention, enhance patient activation and supported self- management for long term conditions, manage avoidable demand, and reduce unwarranted variation in line with the RightCare programme.
- Establish clear mechanisms by which residents within the ACS' defined local population will still be able to exercise *patient choice* over where they are treated for elective care, and increasingly using their personal health budgets where these are coming into operation. To support patient choice, payment is made to the third-party provider from the ACS' budget.

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

- The ability for the local commissioners in the ACS to have delegated decision rights in respect of commissioning of primary care and specialised services.
- A devolved transformation funding package from 2018, potentially bundling together national funding for GPFV, mental health and cancer.
- A single 'one stop shop' regulatory relationship with NHS England and NHS Improvement in the form of streamlined oversight arrangements. An integrated CCG IAF and trust single oversight framework.
- The ability to redeploy attributable staff and related funding from NHS England and NHS Improvement to support the work of the ACS, as well as to free up local administrative cost from the contracting mechanism, and its reinvestment in ACS priorities.

This is a complex transition which requires careful management, including of the financial framework so as to create opportunity while also reducing instability and managing risk. That's why ACSs require a staged implementation. This also provides the opportunity to prove their ability to manage demand in ways that other areas can subsequently adopt. We expect that candidates for ACS status to include successful vanguards, 'devolution' areas, and STPs that have been working towards the ACS goal. In Q1 2017/18, NHS England and NHS Improvement will jointly run a light-touch process to encourage other STPs (or coherent parts of STPs) to come forward as potential ACSs and to confirm this list. Likely candidates include:

- Frimley Health
- Greater Manchester
- South Yorkshire & Bassetlaw
- Northumberland
- Nottinghamshire, with an early focus on Greater Nottingham and the southern part of the STP
- Blackpool & Fylde Coast, with the potential to spread to other parts of the Lancashire and South Cumbria STP at a later stage.
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- West Berkshire

In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area. A few areas (particularly some of the MCP and PACS vanguards) in England are on the road to establishing an ACO, but this takes several years. The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.

CHAPTER SEVEN

FUNDING AND EFFICIENCY

By definition a tax-funded NHS depends on a well-performing UK economy. Over the last seven decades of the NHS' life, growth in NHS funding has closely followed the ups and downs of wider economic cycles. Since the recession of 2008 the economic picture has again become more challenging. Despite real terms protection, NHS funding growth is much slower than the historic long term trend.⁴³ The NHS Five Year Forward View set out three alternative scenarios for minimum funding levels in the year 2020, but did not specify minimum funding or efficiency requirements for each year in the run up to 2020. NHS funding has fared better than other public services, and the Spending Review provides real terms growth in NHS England revenue funding, although age-weighted real terms funding per person will go down in 2018/19 and 2019/20, and capital investment has been limited in recent years.⁴⁴

At the end of 2016, thanks to the dedicated work of local NHS commissioners and providers the NHS and its partners produced initial STP proposals, followed by operational plans and contracts for 2017/18-2018/19. These initial STP proposals are now being updated in the light of these operational plans. These will set out clear accountabilities for delivering local goals and key national milestones - including better A&E performance, improvements in cancer, mental health and primary care services, and financial balance within agreed local control totals supported by decisive action on major efficiency programmes. Substantial progress has been made but this work is not yet complete so significant risks to delivery remain such as the bed occupancy reductions required, workforce supply, capital requirements and residual financial gaps. NHS England and NHS Improvement will work with local health partners to address these and will then publish a national operational update during the first quarter of 2017/18, setting out final agreed control totals and plans for the year. Under all circumstances the NHS will benefit from creating the maximum 'headroom' from available efficiencies, and this is the approach we will be taking:

The NHS' 10 Point Efficiency Plan

The evidence from multiple sources suggests three truths:

- Overall, the NHS is one of the industrialised world's most efficient health care systems, and substantially lower cost than other advanced European countries such as France, Germany, Sweden or Switzerland. The Germans spend 30 percent more per person on health care than we do.⁴⁵ And since 2010 the NHS has been increasing its productivity faster than the rest of the UK economy.⁴⁶

- As the Office for Budgetary Responsibility has projected in their latest Fiscal Sustainability Report, notwithstanding any action to address future cost pressures, health spending is likely to rise significantly as a proportion of GDP over the coming decades, as a result of demographic pressures but also growing technology costs and rising demand.^{47 48}
- BUT despite those two truths, it is also the case that there are still substantial opportunities to cut waste and increase efficiency in the NHS, just as there are in every other country's health care system.⁴⁹ In a tax-funded health service, every pound of waste saved is a pound that can be reinvested in new treatments and better care for the people of England. With 2017/18 funding fixed, substantial efficiencies are needed to create funding headroom over and above that.

Most annual efficiency gains will continue to be delivered locally taking account of the specific opportunities in different areas and organisations, for example improving staff retention, reducing sickness absence and ensuring proper staff rostering.

In addition there are some particularly **large efficiency opportunities that now require concerted action right across the NHS**, with national implementation support. These are part – but not the whole – of the efficiencies the NHS will be delivering in 2017/18, alongside local programmes. But they are a critical part of the NHS' ability to 'square the circle' in balancing its budget. Effective delivery against these programmes is therefore no longer optional for each NHS organisation. Instead they are now mandatory requirements for every trust and CCG in 2017/18, and NHS Improvement and NHS England will oversee their delivery.

1. Free up 2000 to 3000 hospital beds (NHS Improvement/NHS England/with local authorities)

At present around 2500 hospital beds are occupied by patients who are fit to leave hospital but are awaiting social care, and an equivalent number are occupied due to delays in community health services. This means we are not providing the most appropriate care for these individuals, who are often frail, older people; we are causing delays for other patients in A&E departments who are waiting to be admitted to a hospital bed; and we are sometimes having to delay routine operations for other patients. That is one reason why the NHS itself supported the call for well-targeted extra social care funding.

The Chancellor used his March Budget to make available an additional £1 billion for local authority-funded adult social care in 2017/18 and a further £1 billion over the following two years. In doing so he made clear that it should in part be used by councils to ensure extra home care and care home places to free up more hospital beds:

“£1 billion of this will be provided in 2017/18, ensuring councils can take immediate action to fund care packages for more people, support

social care providers, and relieve pressure on the NHS locally. Building on the approach to the Better Care Fund, councils will need to work with their NHS colleagues to consider how the funding can be best spent, and to ensure that best practice is implemented more consistently across the country. This funding will be supplemented with targeted measures to help ensure that those areas facing the greatest challenges make rapid improvement, particularly in reducing delayed transfers of care between NHS and social care services.” HM Treasury, March 2017⁵⁰

It is therefore essential that **hospital trusts now work with their local authorities, primary and community services to reduce delayed transfers of care and contribute to freeing up 2000-3000 beds. We have mapped the beds blocked by delayed transfers related to social care to each hospital and responsible local authority. We are now developing improvement trajectories for hospitals to deliver in part by working with their local authorities**, and we will regularly publish the progress being made against these objectives. In addition, hospitals, community services and CCGs are required now to adopt good practice to ensure appropriate patient flow, as set out in the Urgent and Emergency Care section of this Plan.

2. Further clamp down on temporary staffing costs and improve productivity (NHS Improvement lead)

Great progress has been made over the past year in cutting around £700 million from trusts’ bills for agency staff, from £3.7 billion in 2015/16 to around £3 billion in 2016/17. Applying caps on hourly rates and use of mandatory pricing frameworks, the effect has been greatest in agency nursing. But around £1 billion is still being spent on agency and locum doctors. Last year five such medical locums billed the NHS more than £2 million between them. To try and pin this on ‘shortages’ misses the obvious point that these are individuals who are actually available to work and are doing so – but in a way that is unfair to their permanent colleagues and is placing an unacceptable burden on the rest of the NHS.

Trusts are now being set the target of making a **further cut in agency and temporary staffing costs in 2017/18**, of which around £150 million should come from reduction in medical locum expenditure. NHS Improvement now requires public reporting of any individual locum costing the equivalent of over £150,000 a year, and trust chief executives are required to sign off personally on any agency shift costing more than a nationally specified amount per hour. NHS Improvement will be working specifically with the Royal College of Emergency Medicine on ways to convert A&E locums into substantive posts. Similar controls are now in place to cut the use of expensive interim executives – in both providers and commissioners.

3. Use the NHS' procurement clout (NHS Improvement lead)

As part of the 'Carter' programme, NHS Improvement will standardise and improve trust procurement to release £350 million of savings in 2017/18 on a baseline of over £8 billion of annual expenditure on supplies and devices. Smarter and collaborative procurement will mean purchasing certain categories of product on behalf of the whole NHS. **All trusts will be required to participate in the Nationally Contracted Products programme**, by submitting and sticking to their required volumes and using the procurement price comparison tool to switch to better value products.

4. Get best value out of medicines and pharmacy (NHS England lead)

The NHS spends around £16 billion a year on drugs, of which about £9 billion arises from GP prescribing and £7 billion from hospital treatment (of which about half is directly reimbursed by NHS England's specialised services budget). The NHS drugs bill grew by over 7% last year, with particular growth in hospital-driven prescribing. This was considerably faster than growth in the overall NHS budget. In some cases newer medicines displace other hospital costs or older categories of treatment. However within this fast growing pharmaceutical expenditure there are also opportunities for efficiency:

- NHS England is co-funding clinical pharmacists embedded in general practice to support GP prescribing and optimise medicines usage. Formulary decisions will now typically be made regionally rather than by each CCG, as recommended by the Accelerated Access Review.
- NHS RightCare will be used to drive improved uptake of NICE-recommended medicines that also generate downstream savings - for example anticoagulation to reduce strokes.
- Four regional Medicines Optimisation Committees will coordinate the pursuit of medicines optimisation opportunities, including in care homes, multiple prescribing, use of generics and biosimilars, and reducing medicines wastage.
- NHS Clinical Commissioners and CCGs are reviewing the appropriateness of their expenditures on medicines, identifying areas of prescribing that are of low clinical value or are available over-the-counter often at a lower price - such as for minor conditions such as indigestion, travel sickness, cough remedies and upset stomachs. Following consultation, NHS England will support them in taking action on their top medicines of low clinical value that should not normally be prescribed (which cost £128 million a year) by developing national guidance with CCGs. We will also work with CCGs, providers, patients and manufacturers to consider other medicines and products of low clinical value, to ensure that NHS funding is used on those things that have the most impact on outcomes for patients.
- NHS England's new commercial medicines team will directly negotiate with pharma companies, in conjunction with NICE where appropriate,

- on new win/win fast track reimbursement arrangements for selected drugs, as recommended by the Accelerated Access Review.
- NHS Improvement will be supporting hospitals to save £250 million from medicines spend in 2017/18 by publishing and tracking the uptake of a list of the top ten medicines savings opportunities. As savings are realised the top ten will be refreshed with further products or switches that deliver best value.
 - NHS Improvement is working with hospitals to consolidate pharmacy infrastructure such as medicines stores across wider geographies to deliver further efficiencies and free up pharmacists' time for clinical work.
 - Following public consultation, NICE and NHS England have established a £20 million budget impact threshold for further discussion on phasing and affordability of new spending, effective April 2017.
 - The Department of Health is continuing to drive important savings in the supply chain for dispensing medicines.

5. Reduce avoidable demand and meet demand more appropriately (PHE and NHS England lead with local authorities)

One of the greatest opportunities for increasing efficiencies in the NHS is the reduction of unwarranted variation in care. Across the NHS there are very large variations in the number of people seeing a GP, being referred to hospital and receiving operations that are not explained by clinical need. In a financially constrained system, unnecessary care given to one patient results in needed care being denied to another. The NHS will, therefore, be increasing its work to reduce this variation and ensure that care is delivered to those most in need and those most able to benefit from it.

Real world examples of the sort of progress that is possible have recently been shown through the RightCare programme. Locally reported results include:

- Bradford CCG – 210 fewer deaths from stroke, 38,000 new people self-caring to manage blood pressure and avoid demand for services. £1.6 million saved.
- Ashford CCG – 30% reduction in acute MSK demand and a 7% reduction in MSK spend through introduction of a triage service.
- North Kirklees CCG – introduced new material for hospital and practice use explaining the cost of over-the-counter prescriptions, leading to £100k annual saving.
- Slough CCG – new complex care case management service reducing targeted demand on A&E by 24% and non-elective admissions by 17%.
- Blackpool CCG – reduced demand from frequent callers by 89% (999 calls), 93% (A&E attends), 82% (admissions). Saved £2 million.

In 2017/18 we will build on these examples, and focus work to scale up demand moderation relating to prevention, emergency care and elective services, as follows:

Prevention

Multiple programmes to prevent illness and support health have been kicked off following the NHS Five Year Forward View. These are diverse and include, for example: falls prevention undertaken by fire services during home visits to older residents; the world's largest evidence-based diabetes prevention programme now covering half of the country; and 150 dementia-friendly communities covering 18 million. We will now take action, including:

- Expand the Diabetes Prevention Programme, a partnership between NHS England, Public Health England, and Diabetes UK, which provides tailored, personalised help to reduce **risk of Type 2 diabetes**, including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes. In 2017/18 this means an estimated 130,000 referrals and around 50,000 people on programmes. In 2018/19 these figures could rise to as many as 200,000 referrals and more than 80,000 people on programmes.
- Tackle **obesity** in particular in children through tougher action on sugar and junk food. Following our public consultation, NHS England will set out action shortly on ensuring NHS premises offer appropriate food and drink options for staff, visitors and patients. In 2017/18, PHE will publish specific targets to reduce the sugar contents of nine food categories. In addition, from 1 April 2018, the Government will introduce a nationwide levy on sugary soft drinks, which is expected to raise £385m in the first year with the proceeds to be invested in encouraging sports and exercise in schools.
- NHS provider trusts will have to screen, deliver brief advice and refer **patients who smoke and/or have high alcohol consumption** in order to qualify for applicable CQUIN payments in 2017/18 and 2018/19. In 2017/18, all mental health trusts will become smoke-free, expanding to all acute trusts in 2018/19, leading to all NHS estates becoming smoke-free by 2019/20.
- By 2018/19, Public Health England will lead work with Local Authorities to reach over 2.8 million more people with an **NHS Health Check**. This will identify around 280,000 people at high risk of cardiovascular disease and facilitate follow up, preventative care; 70,000 patients with high blood pressure, 14,000 patients with type 2 diabetes and over 4,600 patients with chronic kidney disease who will be diagnosed earlier and treated by the NHS.

- In 2017/18, PHE will expand the **childhood flu vaccination** to include children in school year 4, to reduce incidence of disease. This will be delivered as part of the phased roll-out of the children's programme.
- The NHS will **work with employers** to help people with a health condition to stay in work. About half of people with a health condition who fall out of work do so because of mental illness. Working with the West Midlands Combined Authority, we will support the trialling of a "wellbeing premium" that will encourage employers, through a fiscal incentive, to look after their employees' health and wellbeing, and to support those at risk of falling out of work. In addition to this, we are working in partnership with the Work and Health Joint Unit (a partnership between DWP and DH) to test new ways to improve the integration of and access to health and employment support to help people get and stay in work. As part of this we are supporting three trials involving around 12,000 people in Islington, the West Midlands and Sheffield City Region. These trials apply well-evidenced approaches derived from Individual Placement and Support – a model that helps people with severe mental illness return to work – to help people with more common physical and mental health conditions get and stay in work. These randomised control trials will report interim findings in 2018 and final results in 2020, providing a strong evidence base on which to consider wider roll-out.
- Prevention of **cardiovascular disease**. Cardiovascular disease (CVD) mortality has fallen dramatically over the last 30 years, but it remains the second highest cause of premature death, as well as being a major contributor to health inequalities. CVD is highly preventable through proven treatments for high risk conditions, recommended in NICE guidance. For example, anticoagulation for patients with atrial fibrillation (AF) reduces stroke risk by two thirds. Yet half of the people with known AF who suffer a stroke have not received anticoagulants. If everyone diagnosed with AF who could benefit from anticoagulants received them, then 5,000 strokes could be prevented each year.⁵¹ In 2017/18, NHS RightCare will work with CCGs covering an additional 13 million people to identify and implement optimal value CVD interventions, deploying electronic audit tools such as GRASP-AF and new models of care to improve detection and treatment of people with high risk conditions. Public Health England will work with STPs and NHS England, including the RightCare programme, to support the implementation of identified preventative interventions at scale. Effective progress on this will also reduce the risk factors associated with dementia.
- A programme to **promote healthy communities** and support disabled people and those with long-term conditions to manage

their own health, care and wellbeing. Through an extension of the Integrated Personal Commissioning model, we will reach over 300,000 people by the end of 2018/19, including in the best ACS and STP geographies, and then if successful scale it substantially thereafter. We will work collaboratively with the voluntary sector and primary care to design a common approach to **self-care and social prescribing**, including how to make it systematic and equitable.

- Further action to **identify and support carers**. We will develop quality markers for Carer Friendly GP practices that promote carer identification, health checks, flu jabs and referral/signposting to advice and support, in order to reduce carer breakdown and improve carer health-related quality of life. We will also help health and social care organisations to support carers, including young carers, to avoid reaching breaking point, so that they, and the cared-for person, will be less likely to end up in hospital. This is being done in partnership with Greater Manchester Health and Social Care Partnership, West Yorkshire, Surrey Heartlands and others, and with a cohort of 15 new care model vanguards.
- Support **disabled people and people with complex health needs** to benefit from a personal health budget, with expansion to over 20,000 people in 2017/18 and 40,000+ in 2018/19. We will provide 10,000 Personal Maternity Care Budgets to new mothers by end of 2017/18 through the seven Maternity Pioneer areas.
- We will also continue to maintain focus on **diagnosis and post-diagnostic support for people with dementia and their carers**. These are key drivers to keeping in their own homes, preventing crises and avoiding unnecessary admission to hospital.
- We will support eight STP areas to take part in our new one year **Building Health Partnerships programme** to facilitate strong engagement with the voluntary sector and local communities on actions that improve wellbeing and self care.

Reduce avoidable demand for emergency care and meet demand more appropriately

In both 2015/16 and 2016/17, cost-weighted acute activity commissioned by CCGs has grown, at around 2.5% a year. Within that total, emergency admissions and delayed discharges have crowded out inpatient elective activity. While acute hospital bed days are up by about 1% over the latest twelve month period, within that total, non-elective bed days are up by double that at around 2%.

Although these emergency growth rates are in line with the medium term trend, cost growth has exceeded income growth. Additional funding has been provided in the form of £1.8 billion from the STF. Taken together with the £800 million of system reserve which commissioners were required to set aside to cover risks in the provider sector, the NHS has, therefore, been locked into a cycle where the extra funding needed to pay for hospital services could not be used to invest in extra services that could moderate growth in this demand. The NHS is starting to break out of this cycle, both by increasing hospital productivity and – as the new care models are starting to demonstrate – using existing resources more effectively to reduce rates of emergency admissions and lengths of stay.

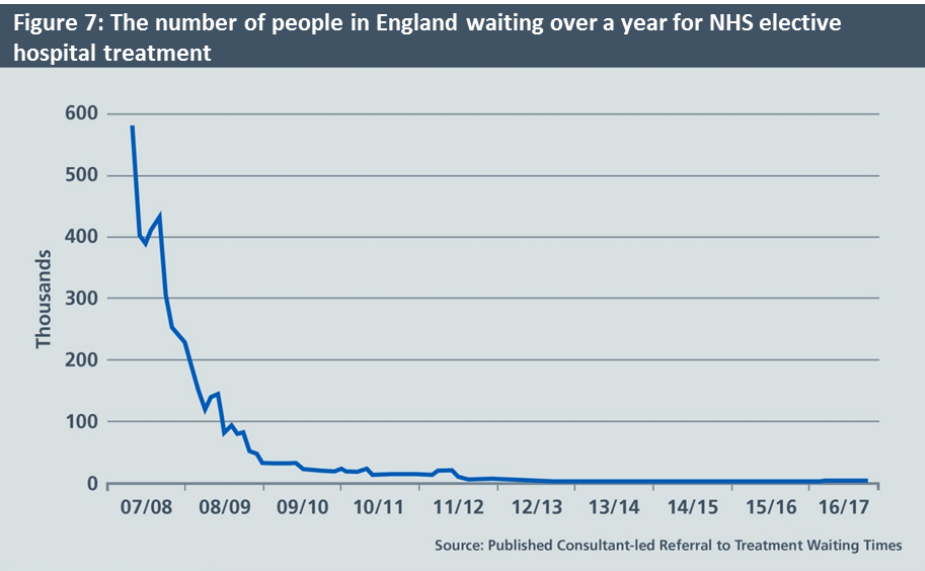
Looking to 2017/18, it is vital that we accelerate progress in both these areas.

- Chapter Two sets out our **comprehensive plan to reduce the growth in ‘minor’ cases that present in A&E departments**. This includes: better access to GP care; a more standardised ‘urgent treatment centre’ offer to the public; a higher proportion of 111 calls handled by a clinician; more flexibility for ambulance services to decide how patients need looking after, including on site by paramedics without the need for conveyance to hospital; better support for frail older people in care homes; GP streaming alongside A&E departments; and beefed up mental health services in A&Es.
- Every part of the country – be it an STP or ACS (see Chapter Six) – will from April be **measuring and managing emergency hospitalisation rates**. There is a meaningful opportunity for improvement. By comparison with other countries, our figures show that “While admission rates for congestive heart failure are around a third of the EU average and point to effective treatment at the primary care level, the same is not the case for asthma and chronic obstructive pulmonary disease, where hospital admissions were well above the average.”⁵² In July 2017, NHS England will publish metrics for each STP benchmarking their emergency admission rates and bed days. CCGs will be held to account for improvement.
- Vanguard are entering their third year and now need to take clearer financial accountability for reducing emergency hospitalisation growth in their area. To that end, **2017/18 national funding for each PACS, MCP or UEC vanguard will be available to STPs as a funding source to pay for excess emergency admissions growth in their area**. The STP in which they operate will be able to use the vanguard funding provided by NHS England to pay for the lower of a) emergency admissions growth above the vanguard’s agreed local emergency 2017/18 contract volumes *or* b) any emergency admissions growth for the vanguard’s patients above the 2017/18 national emergency admissions growth rate in 2017/18. That way we can be sure that vanguards are explicitly

focused on demand management and delivering better performance than the rest of the country. They now need to fulfil their early promise and demonstrate how they ‘earn their passage’.

Reduce avoidable demand for elective care

30 years ago over 200,000 people were waiting over a year for an operation; today it is well under 2,000. Compared to 15 years ago, the NHS has doubled the number of hip replacements and nearly tripled the availability of knee replacements.⁵³ And over the past fifteen years the maximum waiting time standard has fallen from 18 months to 18 weeks. Where ten years ago just under half of patients waited more than 18 weeks for treatment, now only around one in ten patients do.



Looking out over the next two years we expect to continue to *increase* the number of NHS-funded elective operations. However given multiple calls on the constrained NHS funding growth over the next couple of years, elective volumes are likely to expand at a slower rate than implied by a 92% RTT incomplete pathway target. While the median wait for routine care may move marginally, this still represents strong performance compared both to the NHS’ history and comparable other countries.

During 2017/18 CCGs and trusts will also step up their work to get more value out of the NHS’ growing, multi-billion pound investment in elective care. For GPs and CCGs this will mean tackling clinical practice variation in referrals. For trusts this will mean tackling variation in clinical quality and productivity revealed by the Getting it Right First Time (GIRFT) programme. And for CCGs and trusts jointly it will mean redesigning care pathways to promote optimal patient care in line with RightCare. Specifically:

- Building on recent progress which has seen GP referral growth slow to a modest 1.6% year-to-date, NHS England will work with upper quartile higher referring GP practices and CCGs to **benchmark clinical appropriateness of hospital referrals** using CCG dashboards and a new tool from NHS Digital, and then deploy clinical peer review. In doing so we will look to increase the impact of the Academy of Medical Royal Colleges' 'Choosing Wisely' initiative.⁵⁴
- CCGs will review their **referral management** processes and guidance, where appropriate redesigning patient pathways for example to allow speedier access to physiotherapy for musculoskeletal patients with back pain.
- GPs practices and hospitals are moving to universal use of **e-referrals** by October 2018. This offers a new specialist '**advice and guidance**' option avoiding the need to default to an outpatient referral. It also embeds decision prompts on local providers with the shortest waiting times, to help with **demand/capacity 'smoothing'**.
- GIRFT will work direct with consultants on the appropriateness of certain procedures of **questionable clinical value** such as some spinal surgery procedures.
- Detail on the IT changes to support these approaches is included in Chapter Nine.

6. Reduce unwarranted variation in clinical quality and efficiency (NHS Improvement lead)

The **Getting it Right First Time** (GIRFT) methodology drives quality and productivity improvement in over 30 clinical specialties that cost trusts over £45 billion a year. The primary objective of GIRFT is to improve quality of care and outcomes for patients. By doing this, it will also deliver savings by reducing complications and litigation and improving outcomes, to the value of £400 million in 2017/18.

Since most elective hospital admissions are daycases and so not dependent on beds, hospitals will work to improve **theatre productivity** in line with GIRFT benchmarks. They also need to free up 2000-3000 inpatient beds with local councils which can then partly be used for additional funded elective inpatient admissions.

Subject to appropriate local public consultation, we will in principle support well-designed and affordable STP proposals that seek to **split 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities** so as to allow efficient use of beds for planned surgery, avoiding the risk of cancelled operations from emergency admissions. STP schemes that are proposing this include the South East London elective orthopaedics

centre, the 'restack' of services between Bournemouth and Poole hospitals, and a number of other proposals to redesign services across neighbouring district general hospitals across the country.

Differential availability of services and functions in hospitals and community settings across the week leads to variation in care for acutely unwell patients, and delays in progressing treatment. The Academy of Medical Royal Colleges has endorsed four **priority clinical standards**. The aim is that the proportion of the population for whom they are available seven days a week should reach 50% by April 2018. By November 2017 the whole population should be covered by five specialist services – emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care – meet the standards seven days a week.

Action will continue to be taken to reduce the inappropriate hospitalisation of **people with learning disabilities**. Hospitals are not homes, and the aim is to improve the quality of people's lives, their ability to control the services they are offered, and tackle premature mortality. Since the 'Transforming Care' programme began implementation in Spring 2015 the number of people in inpatient units has fallen by 11%. Over the next two years it will fall at least a further 25% points, as better community alternatives are provided across England.

CCGs commission NHS **Continuing Health Care** for over 150,000 people with long term care needs each year. Together with the Department of Health in 2017/18, we will be consulting on the National Framework, ensuring that assessments and decisions around care packages are taken with patients and their carers within no longer than 28 days.

7. Estates, infrastructure, capital, and clinical support services (NHS Improvement lead and DH lead)

Clinical support services such as **diagnostics laboratories and imaging services** are vital in supporting patient care. The NHS spends over £2.5 billion a year on these services. We need to ensure pathology services across England deliver the fastest and highest quality possible support to trusts. By improving the deployment of pathologists and imaging services, the NHS can both improve services and save up to £130 million annually.

The NHS also needs to protect and improve its **estates and facilities**. Facilities management has a direct bearing on patient experience, for instance by ensuring that premises are safe, warm and clean environments for staff and patients and by preparing high quality and nutritious hospital food. The NHS spends over £6.5 billion maintaining and running its estate and facilities. Here too there are opportunities to achieve efficiency savings, for example through reducing unwarranted variation in energy costs. NHS Improvement will support hospitals to achieve over £100 million in savings in 2017/18.

The NHS and Department of Health are aiming to dispose of **£2bn of surplus assets** over the Spending Review period, so as to create headroom for investment and to free land sufficient for 26,000 homes. The forthcoming **Naylor review will set out the action plan** for doing so. This principally relates to land and assets held by provider trusts and NHS Property Services and Community Health Partnerships, since the majority of premises used by GPs, other family health services, and third party providers are not owned by the NHS. The Naylor review also recommends a new NHS property organisation, a key function of which will be to provide a single, strengthened source of strategic estates planning expertise for the NHS.

In the March 2017 Budget the Chancellor said “At Autumn Budget I will announce a **multi-year capital programme** to support implementation of approved high quality STPs.” And “In the Autumn a further round of local [STP] proposals will be considered, subject to the same rigorous value for money tests. Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land to reinvest in the health service.” An initial down-payment of £325 million divided evenly over the next three years has been announced for well-developed STPs “where there is the strongest case to deliver real improvements for patients”.

8. Cut the costs of corporate services and administration (NHS England and NHS Improvement)

NHS administrative costs are already far lower than other comparable major countries. Latest OECD data show that on a like for like basis we spend only 2p in the pound on administration, compared to 5p in Germany and 6p in France.⁵⁵

Like the rest of the public sector, the health service needs to concentrate its resources on front line service delivery as much as possible. At the same time, administration and back office functions play a vital role in keeping the NHS going, from payroll and HR facilities through to sourcing medical supplies and keeping GP practices and hospitals well stocked.

NHS administration therefore has an important role to play, but its costs need to be managed carefully. The scale of the NHS makes it possible to achieve substantial efficiencies. In 2017/18, we will take action on the following areas:

- NHS provider trusts are spending over £3.2 billion a year on back office administration for finance, payroll and similar services. If all trusts reduced their costs to the current average they could save £400 million a year. NHS Improvement is targeting **savings of over £100 million in 2017/18**, as trusts move to consolidate these services, where appropriate across STP areas. NHS Improvement is

establishing a set of national benchmarks across the key corporate services functions to enable individual trusts to compare their performance and identify where improvements can be made.

- The NHS Litigation Authority, now known as **NHS Resolution**, is also contributing to cost reduction. As part of a new five-year strategy, NHS Resolution will provide support closer to the time of incidents, and facilitate local resolution and learning. For example, NHS Resolution will use an early notification model for cases of severe brain injury at birth from April 2017. NHS Resolution will aim to reduce costs by identifying and investigating these incidents earlier, providing the opportunity to resolve disputes in a less adversarial way, possibly through deploying alternative models for dispute resolution. The approach will also support learning with the aim of reducing the actual incidence of harm and its associated costs to the system. NHS Resolution will also continue to save money for patient care from claims when no compensation is due, and by challenging over-charging, fraudulent and excessive claims. From 2017/18 the NHS Standard Contract is being amended to prevent law firms from operating from or touting for business in NHS premises.

- **NHS England and CCGs have cut more than £250 million in real terms from running costs over the past three years. We will now cut another £150 million** in real terms by the end of 2019/20, in addition to savings made by other ALBs. As STPs and ACSs ramp up we will work with them to make further efficiencies by combining management support across providers, CCGs and CSUs.

- NHS England and NHS Improvement have distinct and enduring statutory responsibilities under current law. In addition to our shared local work with local CCGs and trusts, NHS England's statutory duties include independently allocating £110 billion of NHS resources to different parts of the country and across programmes of care, directly managing £16 billion of national specialised services including pharmaceuticals, and overseeing over 30,000 contracts with GP practices, pharmacists, dentists and opticians. However our ways of working and cultures need to evolve and change. There are opportunities to **streamline aspects of our joint work** in 2017/18:
 - Each Regional Director and their team will act on behalf of both organisations in overseeing implementation of the Urgent and Emergency Care plan in a certain number of STPs.
 - The two organisations will create unified programme management groups to deliver key clinical priorities in this Plan. These will have a single jointly appointed leader, including for urgent and emergency care, mental health,

cancer, maternity, and technology implementation. We also intend to promote closer collaboration between RightCare and the broader Operational Productivity programme, of which GIRFT is a major clinical component. This will better support the shared aim of reducing unwarranted and costly clinical variation across primary and secondary care and strengthen the clinically-led approach that is vital to its success. We will also look to share certain functional resources.

- As STPs become designated Accountable Care Systems, they will - within the scope of current law - have a single 'one stop shop' relationship with NHS England and NHS Improvement.

9. Collect income the NHS is owed (NHS Improvement lead)

In respect of cost recovery from non-UK residents, the National Audit Office says that “the best available estimates suggest that the NHS is recovering significantly less than it could”.⁵⁶ The Government has set the NHS the target of recovering **up to £500 million a year**, up from £97 million three years ago. Twenty trusts will now pilot new processes to improve the identification of chargeable patients. As agreed with GP representatives, by Autumn 2017 the Department of Health will amend the General Medical Service regulations to require GP practices to ask all new patients whether they hold a non-UK issued EHIC card, and then pass this information to NHS Digital so that these patients can more easily be identified in secondary care and appropriate recharging to other EEA countries can automatically occur.

10. Financial accountability and discipline for all trusts and CCGs (NHS Improvement and NHS England)

The Government’s Mandate to the NHS for 2017/18 requires it to “ensure overall financial balance in the NHS” with “all parts of the system – commissioners and providers – meeting their control totals”.⁵⁷ This is going to require tough decisions and decisive action.

Financial performance has improved across the NHS over the past year. Commissioners have generated an £800 million managed underspend, and most trusts are on track to meet their control totals. But as the NHS goes in to the next two years of intensified financial challenge, financial success will require managing a number of important risks and dependencies, including reducing both NHS-related and social care-related blocked acute beds as set out in the chapter two; the level of emergency admissions growth; effective deployment of available capital to unleash trust efficiencies; and workforce availability in key staff groups. In 2017/18, funding has been allocated up-front to frontline services so there is no substantial national 'bail out' fund that can cover off poor financial control by individual trust boards or CCG governing bodies. The importance of

individual trusts and CCGs meeting their financial control totals and sticking to their budgets is critical. So in 2017/18:

- Each provider trust and CCG will again be set a financial control total (which may by prior agreement be flexed between organisations within an STP or ACS system control total) and which they must meet.
- 70% of the national Sustainability and Transformation Fund will again be tied to delivery against trust-specific financial control totals.
- Provider trusts not agreeing control totals will lose their exemption from the default fining regime in the NHS standard contract, and CCGs missing their financial goals will lose access to the CCG Quality Premium. From August 2017 CQC will begin incorporating trust efficiency in their inspection regime based on a Use of Resources rating.
- Trusts and CCGs missing their individual (or, where applicable, system) control totals may be placed in the Special Measures regime. CCGs in that status will be subject to legal directions and possible dissolution.
- Some organisations and geographies have historically been substantially overspending their fair shares of NHS funding and their control totals, even taking account of access to the STF. In effect they have been living off bail-outs arbitrarily taken from other parts of the country or from services such as mental health. This is no longer affordable or desirable. So going into 2017/18 it is critical that those geographies that are significantly out of balance now confront the difficult choices they have to take. Where necessary this may mean explicitly scaling back spending on locally unaffordable services, so that they go in to the next two years with a viable and balanced income and expenditure plan, delivering locally the Government's Mandate requirement for the NHS to balance its books.

CHAPTER EIGHT

STRENGTHENING OUR WORKFORCE

Despite a growing workforce, NHS staff are under real pressure. The number and complexity of the patients they care for continues to increase. Some geographies and types of job are hard to recruit to. Further challenge arises from ongoing pay restraint and uncertainty for our international staff.

Perhaps surprisingly, given these well understood pressures, frontline NHS staff say their experience at work continues to improve, with overall employee engagement scores now at a five-year high.⁵⁸ But there's still much to be done to ensure all staff – including nurses, therapists, doctors in training, support staff, midwives, health visitors and scientists - are properly supported. This chapter of the Plan summarises some of the key actions we will be taking.

What's been achieved in England over the past three years?

- More staff, including 8000 more doctors and nurses and the highest number of GPs in training ever.⁵⁹
 - New roles, including 2000 Nursing Associates in training to create both a new role and a career ladder from healthcare assistant to registered nurse, 650 new physician associates in training, and 500 new clinical pharmacists working alongside GPs.
 - New routes into the NHS, including new on-the-job apprenticeship route to becoming a registered graduate nurse and over 2000 nurses completing HEE's return to practice programme.
 - Frontline staff report improved working conditions. The annual NHS staff survey⁶⁰ published in March 2017 shows another year of improvements, with NHS staff engagement scores at their highest level in five years. And across 32 key measures, over 80% were more positive than last year.
 - Action taken on workplace culture and employee support. The percentage of staff witnessing potentially harmful incidents is at its lowest in five years, at the same time as the percentage of staff able to report those concerns is at its highest in five years.⁶¹ The new NHS Workforce Race Equality Standard is holding a mirror up to individual employers' practices in supporting Black and Minority Ethnic nurses and other staff.
 - The Care Certificate, introduced in 2015 for new healthcare assistants and social care support workers, sets out 15 standards that describe the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care.
- 90% of NHS staff report their organisation takes positive action on staff health and well-being. Feeling unwell as a result of work-related stress is at its lowest reported level in five years, but still stands at 37%. So a new

national 'CQUIN' incentive scheme is promoting workplace health, including musculoskeletal, mental wellbeing, and weight management. 130,000 more NHS staff got flu jabs this winter compared to last, a record high.

Key improvements for 2017/18 and 2018/19

The NHS in 2020 is going to be looking after more patients, better funded and larger than the NHS of today. We are therefore going to need to continue to improve productivity and grow our frontline workforce, especially in priority areas such as nursing, mental health, urgent and primary care. Achieving this will require more training, more recruitment, better retention and greater return to practice after time out of the workforce. It will also require flexibility as roles and places of work evolve in line with changes to the practice of medicine and the shape of health care.

More people are training to join the NHS every year than are leaving it. Health Education England forecasts at least 25,000 to 50,000 net additional clinical staff could be available for NHS employment by 2020, partly depending on the NHS holding onto the staff it already has. This will enable the NHS to reduce its dependence on agency and locum staff.

The NHS will need more registered nurses in 2020 than today, as will the social care system. HEE forecasts growth of at least 6,000 extra nurses but this could be considerably higher if the NHS successfully focuses on:

- *Education and training.* The number of newly qualified nurses available to be employed will increase by up to 2,200 more per year in 2019, as a result of expansion in nurse training places commissioned by HEE between 2013 and 2016.
- *Retention.* Improving retention to the level of two years ago would mean around 4000 more whole time equivalent nurses per year. A new nurse retention collaborative run by NHS Improvement and NHS Employers will support 30 trusts with the highest turnover.
- *Return to practice.* There are over 50,000 registered nurses in England not currently working for the NHS. It takes three years and £50-70,000 to train a nurse, but only £2000 and three to twelve months to retrain a returning nurse. We will target a further 1500-2000 nurses to be supported to return to work over the next two years.
- *New fast track 'Nurse First' programme.* We will consult on creating a Nurse First route to nursing, similar to the Teach First programme. It will provide financial support for graduates from other related disciplines to undertake a fast track 'top up' programme to become a graduate registered nurse - in the first instance targeting mental health and learning disability nursing.

- *Support new Advanced Clinical Practice (ACP) nurse roles.* These senior nurse roles are valuable in their own right, and also have been shown sometimes to offer a better alternative to medical locums and unstable Tier 1 hospital rotas. Training is typically service-based alongside an accredited university programme. HEE and NHS Improvement will publish a new national ACP framework, and deploy ACPs in trusts in the first instance where they can make a demonstrable impact in high priority areas such as A&E, cancer care, elective services or reducing locum costs by converting medical posts.
- *Use e-rostering and effective job planning* to ensure right staffing at the right time. Building on successful pilot projects for nurses and healthcare support workers in 2016/17, NHS Improvement will publish guidance on electronic rostering to ensure high quality effective care at the bedside (measured by number of care hours delivered per patient according to their clinical needs). This will help further reduce agency spend through more effective deployment of substantive staff, and will make rostering more staff-friendly through use of technology. The benefits of e-rostering and job planning will be promoted for all other staff groups, particularly allied health professionals and pharmacists, to deliver similar benefits for hospitals and their staff. NHS Improvement will focus during 2017/18 on supporting trusts in getting best value from electronic tools to support better job planning for hospital doctors, and implementing newly-issued job planning guidance. The focus will be on maximising direct clinical care time, eliminating unwarranted variation in the number of patients treated per clinic and per theatre list, and reducing extra-duty payments.

In terms of the **medical workforce**, while we still have fewer practicing doctors than the European average (as we also do for nurses), we have seen a 50% increase since 2000⁶², and the number of consultants and GPs available to work in the NHS by 2020 is forecast to rise further.

- *Undergraduate medical school places will grow by 25%* adding an extra 1500 places, starting with 500 extra places in 2018 and a further 1000 from 2019. These will be mainly geared to producing more of the doctors the NHS needs such as GPs and psychiatrists. This expansion is currently being consulted upon.
- *Expand GPs numbers.* HEE will train over 15,000 GPs between 2015 and 2020, GP trainee numbers have gone up 10% year on year since 2015, and HEE will target a further 231 places in 2017/18 to ensure the target is met of 3,250 GP trainees per year. The initial round of applications for 2017/18 is 5% up on the equivalent stage last year. (See Chapter Three for more detail on primary care workforce expansion.)

- *Tackle pressures on doctors in training.* **Junior doctors** are a crucial part of the NHS workforce, and the NHS needs to do a better job of engaging with the senior doctors of the future. HEE, NHS Improvement, NHS Employers and their partners are committing to tackle head on non-contractual pressures confronting junior doctors. Following consultation with junior doctors over recent months, action to improve working conditions will include these first steps:
 - Ensure doctors receive their proposed rota a minimum of eight weeks and final rota by six weeks before they start new rotations, as specified in the code of practice agreed by HEE, NHS Employers and the BMA. From October 2017, NHS Improvement will monitor trusts' adherence to the six week standard monthly, with a review after six months. HEE will ensure trusts have trainee details 12 weeks before rotations begin.
 - From this year, provide Specialty Training applicants with an online 'Swap Shop' allowing applicants to swap with others in their cohort or into vacant places, alongside an improved process for trainees wanting to move regions. Also a guaranteed training location for doctors who need to be in a particular region because of ill health or disability, or because they care for someone who is unwell or disabled.
 - From April 2017, streamline the process for doctors moving between trusts to reduce the duplication of pre-employment checks, mandatory and induction training, starting at a regional level.
 - Introduce, in 2017/18, a new programme making £10 million available for HEE to implement new plans with the Colleges to improve support for doctors returning to training after maternity leave and other approved time out.
 - Improve engagement with senior clinicians. Guardians of safe working hours and directors of medical education will set up a junior doctors' forum in each trust. From June 2017, NHS Improvement will make new information resources available to facilitate engagement, and work with HEE and the GMC to ensure adequate engagement is taking place.
 - We commit to continuing to engage with junior doctors locally and nationally, and to taking forward proposals outlined in HEE's recent progress report.

Action will be taken to address **specific staff shortages**, including:

- *Emergency Medicine:* HEE is running an expanded intake of the run-through ACCSEM course, and will add an extra year of 75 additional training posts.

- *Endoscopists:* HEE will operate an accelerated programme to train non-medical endoscopists, with the first 40 staff completing their training in 2016 and another 160 by the end of 2018.
- *Ultrasonography:* We will train 200 healthcare professionals in sonography by 2019/20 to support maternity services.
- *Radiology:* expanded training to build imaging capacity, growing the number of new CCT holders from the current average annual output of approximately 170 to 230 by 2021/22.

The NHS will continue to develop **new professional roles**, including doubling the number of Nursing Associates to 2000 this year, continuing to grow the Physician Associate workforce, and expanding clinical pharmacists and mental health therapists embedded in primary care as set out in Chapter Three.

Action on **NHS staff health and wellbeing** will be extended.⁶³ In 2017/18 all trusts will have a plan in place to improve the health and wellbeing of their workforce. By 2018/19, the CQUIN incentive payment will be paid to NHS providers that improve the health and wellbeing of their staff by 5% (on a 2015/16 baseline), as measured by the staff survey. We are introducing the new NHS GP Health Service, to support doctors suffering from mental ill-health and addiction.

The NHS will become a better and **more inclusive employer** by making full use of the talents of its diverse staff and the communities it serves. On workforce race equality, over the next two years trusts are expected to show year-on-year improvements in closing the gap between white and BME staff being appointed from shortlisting, and reduce the level of BME staff being bullied by colleagues. The programme to improve the employment opportunities for people with learning disabilities will be expanded. And in 2018/19 over four-fifths of trusts, CCGs and national NHS leadership bodies will have set their baseline measurement for the new Workforce Disability Equality Standard and set out their first year action plan. The NHS will work actively with Government to safeguard and secure the contribution made by international nurses, doctors and other staff as the Brexit negotiations proceed.

Leading STPs and ACSs (see Chapter Six) will work with their staff and trade unions on ways of **encouraging flexible working and 'de-risking' service change** from the point of view of individual staff. This could take the form of an NHS staff 'passport' to enable, for example, nurses to work in both primary care and in hospital, helping support team-based working. Since only 52% of staff are currently satisfied with the current opportunities for flexible working, it might also mean discussing with staff side representatives and unions new options to encourage individuals who are currently choosing agency or locum work back in to substantive NHS

employment. The practicability of term time contracts, seasonal hours, and annualised hours contracting will also be tested.

The national leadership bodies will take action to implement the next steps of the 'Developing People, Improving Care' framework for improving **leadership and improvement capabilities** across the health and care system, with a particular focus on systems working, building improvement skills for staff at all levels, and compassionate inclusive leadership. The framework set out a number of immediate actions in 2017/18, including making available support for systems leadership development to each STP footprint, developing the role of local leadership academies, launching a system-wide programme to address discrimination against staff with protected characteristics, supporting organisations to improve talent management, and establishing a national support function for senior leaders. We are also developing specific improvement capability programmes for boards and executive teams and for primary care practitioners, and CQC and NHS Improvement are jointly creating a single 'Well-Led' Framework.

Refreshed workforce planning will now confirm these estimates and requirements. **HEE will publish its annual Workforce Plan in April.** Local Workforce Action Boards will support their STPs in revising, updating and delivering their workforce plans.

CHAPTER NINE

PATIENT SAFETY

Like healthcare systems all over the world there are times when things go tragically wrong. We all understand that healthcare is a people business, and that with the very best intentions people will make mistakes. Improving safety is about reducing risk and minimising mistakes. The NHS has embarked on a journey to become one of the safest healthcare systems in the world.

What's been achieved in England in the last three years?

- A complete overhaul of CQC standards, and comprehensive ratings inspections of all trusts, as well as primary care providers. The CQC has completed its first round of acute hospital inspections which has seen 31 hospitals go into 'special measures' turnaround and 20 come out – including 7 moving to a 'good' rating.
- The introduction of the duty of candour and new protections for those who raise concern and blow the whistle mean that the NHS is now more transparent:
 - Introduction of an Independent National Officer (INO) for whistleblowing based in the Care Quality Commission (CQC) to lead and support a network of individuals within NHS trusts appointed as 'local freedom to speak up guardians'.
 - Consultation on new legislation to prohibit discrimination against applicants believed by the prospective employer to have been whistleblowers, published in March 2017.
 - Whistleblowing statutory framework extended to include student nurses and student midwives, meaning those people are now afforded protection under the Public Interest Disclosure Act; our intention is to extend the definition further to include other healthcare students in 2018.
 - NHS Prescribed Persons for the NHS extended to include NHS Protect, Public Health England, Healthwatch England and Health Education England and Local Education and Training Boards.
- Patient Safety Collaboratives, each established and led locally by an Academic Health Science Network, are now delivering a locally-owned improvement programme in order to create safer systems of care, to learn from errors (including medication errors) and reduce avoidable harm. Sign Up To Safety is a 3 year, voluntary national campaign launched in June 2014 as part of a set of initiatives to reduce avoidable harm, save lives and improve patient safety across the NHS in England.
- NHS Litigation Authority - from April 1st 'NHS Resolution' – has introduced a national Safety and Learning Service to work with NHS organisations, with the use of Scorecards, to help them understand

their claims data to better assess where local interventions would have the greatest impact in reducing high volume or high cost claims. NHS Resolution has also supported the national campaign and in 2015/16 provided over £18m of Sign Up To Safety incentive payments to support local safety improvement plans across the country.

- Rigorous inspection, with CQC's completion in January 2017 of comprehensive ratings of all trusts, primary care and adult social care providers, providing a baseline assessment of the quality and safety of these services. These comprehensive inspections have helped trusts to understand the specific areas where improvements are needed and to take targeted action, and have provided increased transparency on performance for people who use services.

Key improvements for 2017/18 and 2018/19

- *Preventing healthcare acquired infections.* The NHS, led by NHS Improvement, will build on its success in reducing the incidence of MRSA bloodstream infections and C. difficile infections to make the same progress on Gram-negative infections such as E. coli, Klebsiella and Pseudomonas bloodstream infections. By 2020/21 the level of such healthcare associated infections will fall by 50%. This will be achieved with a system-wide approach by relevant providers and commissioners:
 - Extending mandatory data collections to more cases and publishing and learning from locally comparable data on key infections published by Public Health England.
 - Following guidance and tools developed by NHS Improvement to support local teams to prevent Gram-negative bloodstream infections.
 - Giving E. coli infections the same level of priority as MRSA and Clostridium difficile through, for example, displaying numbers of infections on ward information boards.
- *Maternity safety.* 44 Local Maternity Systems will be in place from April 2017, leading and delivering transformation of maternity services by implementing *Better Births* for their STP, including:
 - Providing more personalised, safer maternity services with women having access to unbiased evidence-based information. Women will be better able to make choices about their care and have more continuity of care during the ante natal, birth and postnatal periods. Seven 'early adopter' areas delivering new models of maternity care for 125,000 births a year and over 15% of the population by the end of 2018, including offering improved continuity of care to over 20,000 women.
 - Working to achieve the national maternity ambition to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon

after birth by 20 per cent by 2020, demonstrating progress towards the national ambition to reduce rates by 50 per cent by 2030.

- *Learning from deaths.* We want the NHS to become the world's largest learning organisation, with a culture that uses all sources of insight, including from complaints⁶⁴, to improve services and quality of care, particularly for the most vulnerable. As part of the implementation of the CQC report Learning, Candour and Accountability, trusts will be expected to have proper arrangements for learning from deaths of patients in their care. From April 2017 trusts will be asked to publish data on all deaths judged as likely to have been caused by problems in care – along with actions taken to learn and prevent such deaths in future. This information will be provided quarterly and summarised in each organisation's annual Quality Accounts. Alongside such learning, the NHS will also:
 - Improve support to and communication with bereaved families and carers.
 - Improve the standards and understanding of data on harm and mortality.
 - Ensure that services for people with learning disabilities and mental health problems are a core part of this learning.
- *Improving inspections.* The CQC will develop a more targeted, responsive and collaborative approach to regulation, including specifically considering how to regulate new care models and complex providers. CQC will work with NHS Improvement to deliver the Use of Resources rating of NHS acute trusts.
- *Improving investigations.* From April 2017 the new Healthcare Safety Investigation Branch will be operational, undertaking up to 30 investigations where learning from patient safety can be maximised, and advising the NHS on how to improve its own investigations. Revised guidance on investigating serious incidents will also be published by NHS Improvement. Together these changes should ensure safety incidents are investigated appropriately, to ensure patient concerns are allayed and learning is spread quickly across the NHS.
- *Reducing medication error.* We will also develop plans to reduce the level of medication error across the NHS, ensuring that patients can always be confident that the medicine they are prescribed is the right one for them.
- *Patient Safety Incident Management system (PSIMS).* NHS Improvement will develop and deliver a new Patient Safety Incident Management System. This will be designed for all healthcare settings and will make it easy and rewarding to record patient safety

incidents, provide feedback, and enhance learning from what has gone wrong.

- *Global leadership for patient safety.* The NHS approach to patient safety is widely recognised as world-leading. We continue to work with national and international partners to ensure we can best benefit the safety of patients in England, for example through contributing to and leading WHO patient safety initiatives and the pan-European Patient Safety Expert Group.

CHAPTER TEN

HARNESSING TECHNOLOGY AND INNOVATION

The major work programmes mapped out in this Plan are underpinned by an agreed, costed and phased NHS technology plan, building on the recommendations of the Wachter review. It will simplify patient access to care, in the most appropriate location, while supporting people in managing their own health. Specifically, during the coming two years we will implement solutions that:

- Make it easier for patients to access urgent care on line.
- Enable 111 to resolve more problems for patients without telling them to go to A&E or their GP.
- Simplify and improve the online appointment booking process for hospitals.
- Make patients' medical information available to the right clinicians wherever they are.
- Increase the use of apps to help people manage their own health.

Helping people manage their own health

The way that people use services has changed over the past ten years, often expecting to have the option of accessing services online or by telephone. Over the next two years the NHS will make very significant steps towards increasing how its services can be accessed online, whilst remembering that healthcare is about people and that many patients want and need the reassurance of a real person to talk to face to face.

The NHS has led the world for ten years with its health and care website "NHS Choices" www.nhs.uk which provides comprehensive and trusted advice on conditions and services. In 2016 there were more than 1.5 million visits per day of NHS Choices; over 550 million through the year. Progress has also been made in enabling patients to access their GP record online: 95% of GPs offer online appointment booking, repeat prescriptions and access to their summary care record. 10.4 million people are now registered for online services with 1.9 million repeat prescriptions ordered online in February 2017, 1.1 million appointments managed online and 1 million views of patient records in the same period.

- *NHS apps.* In Spring 2017 we will launch the NHS Digital Apps Library with the initial offer including at least 20 apps with categories for Mental Health and Diabetes. This will comprise three tiers of application – 'NHS approved' apps which have a published evidence base, assessed by a process developed with NICE, demonstrating that

they can help a person manage and improve their health; 'NHS connected' apps which means that they have been tested and approved for connection to NHS systems, allowing you to download information from NHS systems into the app; and 'Health apps' which will be directory of other health applications which you may choose to use. From April 2017, developers will have the ability to self-assess themselves against NHS criteria, such as where they store your data and whether they sell or use your data for other purposes. The 'NHS connected' category will become vibrant during 2017 and 2018 as we make it easier for app developers to connect to NHS data sources.

- *Support for children's health.* From April 2017 parents in London will have access to their children's health record through the online "red book".
- *Personal online access.* By September 2017 we will have upgraded NHS Choices to become NHS.UK, which will offer a more personalised and tailored experience. It will then be possible for patients to book appointments and access their personal health record through NHS.UK.
- *Free wifi in GP surgeries.* Building on the success of the NHS wifi early adopter stage, which commenced in January 2017 and saw us roll out free wifi for patients and professionals across approximately 1,000 surgeries, the wider rollout to the remainder of GP surgeries over the next year, subject to HM Treasury approval, will help encourage the uptake of online health services.

Digitising hospitals

While the NHS leads the world in the use of IT in primary care, the adoption of information technology in the acute, community and mental health sectors lags behind. In 2015, NHS England conducted a survey of information technology adoption, known as the Digital Maturity Assessment. From this we are able to see the best, the worst and the large number in the middle. In September 2016 we announced the first 12 Global Digital Exemplar acute trusts and since then we have announced four more.

Global Digital Exemplars. These organisations are the most advanced IT hospitals in the NHS and have committed to work to become world class exemplars for the rest of the NHS to learn from. Their task is not only to become great, but to work with other acute trusts to develop a blueprint that can be deployed to other hospitals, reducing the time and cost for further adoption. Our intention is that, in the future, hospitals won't merely choose an IT vendor, they will choose a hospital that they want to partner with and implement the same system, keeping the IT 80% the same and making only the 20% of changes that are absolutely necessary to meet local needs. Subject to HM Treasury capital approvals, the first **Acute GDEs** are:

- Alder Hey Children's NHS Foundation Trust

- Cambridge University Hospitals NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- Imperial College Healthcare NHS Trust with Chelsea and Westminster NHS Foundation Trust
- Luton and Dunstable University Hospital NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Royal Free London NHS Foundation Trust
- Royal Liverpool and Broadgreen University Hospitals NHS Trust
- Salford Royal NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust
- West Suffolk Hospitals NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

In order to spread the learning and ensure that the blueprints really are suitable for other hospitals, the GDEs will be partnered with “fast followers” who will work with the GDEs during their implementation and begin deploying the blueprints elsewhere in parallel. The GDEs are currently identifying their “fast follower” sites, and these will be confirmed over the coming quarter.

Over the past few months we have also conducted a search for **Mental Health digital exemplars**. Subject to HM Treasury capital approvals, successful organisations will be:

- Berkshire Healthcare NHS Foundation Trust
 - Birmingham and Solihull Mental Health NHS Foundation Trust
 - Mersey Care NHS Foundation Trust
 - Northumberland, Tyne and Wear NHS Foundation Trust
 - Oxford Health NHS Foundation Trust
 - South London and Maudsley NHS Foundation Trust
 - Worcestershire Health and Care NHS Trust
- *NHS Digital Academy*. By September 2017 we will launch a new academy to train a new generation of Chief Information Officers and Chief Clinical Information Officers. By increasing the skills to align information technology with business and clinical needs we will increase the chances of successful adoption of new information technology and its use to drive quality and efficiency.

Technology to support the NHS priorities

Urgent and Emergency Care

- NHS 111 Online. Throughout 2017 we will be working to design online triage services that enable patients to enter their symptoms and receive tailored advice or a call back from a healthcare professional, according

to their needs. We will be testing apps, web tools and interactive avatars in local areas and using detailed evaluation to define the best approach. By December 2017 all areas will have an NHS 111 online digital service available that will connect patients to their Integrated Urgent Care via NHS 111.

- NHS 111 Telephone: Clinical decision support systems are well used throughout the health system. They have supported our ambulance services and urgent care services for many decades. The developments in technology mean these systems are improving exponentially - becoming more personalised and intelligent and able to process more data in real time. From summer 2017 we will be developing and testing new specialist modules of clinical triage for Paediatrics, Mental Health and Frailty and demonstrating the impact of risk stratification. By March 2019 an enhanced triage will be available across integrated Urgent Care, with the potential to also support Urgent Treatment Centres, Care homes and Ambulance services.
- To ensure that patients get the right care in the most appropriate location, it is also important that clinicians can access a patient's clinical record. By December 2017 every A&E, Urgent Treatment Centre and ePrescribing pharmacy will have access to extended patient data either through the Summary Care record or local care record sharing services. We will also have access to primary care records, mental health crisis and end of life plan information available in 40% of A&Es and UTCs.
- By December 2018 there will be a clear system in place across all STPs for booking appointments at particular GP practices and accessing records from NHS 111, A&Es and UTCs supported by improved technology APIs and clear standards.
- During 2017 we will begin the work with vendors to seamlessly route electronic prescriptions from NHS 111 and GP Out of Hours to pharmacies via the Electronic Prescription Service (EPS). This will speed up the supply of medicines, and significantly reduce the time and cost involved.

Elective access and unwarranted variation

Analysis of activity across the NHS shows very large variations in the number of patients being referred to hospital outpatients, being followed up repeatedly in outpatients and receiving elective operations. These variations cannot be explained by differences in health need and are often present between different GPs in the same area and different doctors in the same hospital. Patient and clinician time is wasted on repeating tasks because the information collected by another clinician is not available, and straightforward tasks that could be undertaken by many patients online are still done by clinical staff.

- 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.
- In the summer 2017 an updated online patient appointment system will be launched, providing patients with the ability to book their first outpatient appointment with access to waiting time information on a smartphone, tablet or computer. Alerts will advise patients which hospitals have longer waits so that that they can avoid these hospitals if they wish.
- The NHS e-Referral Service is currently used by patients to arrange just over half of all referrals into consultant-led first outpatient appointments. By October 2018 all referrals will be made via this route, improving patients' experience and offering real financial and efficiency benefits.

Digital contribution to research

The ability to collect, aggregate and analyse the data generated by the NHS is not only critical to delivering the triple aims of healthcare, but also underpins the NHS and wider life sciences research strategies. Interoperability will be key to successfully making use of NHS data to support the life sciences research strategy.

Innovation for future care improvement

The UK has a world-leading life sciences industry which is both a magnet for investment and an engine for economic growth - enhancing productivity, driving healthcare innovation and employing over 220,000 people across the regions of the UK. Many important healthcare technologies - from vaccines to MRI scanners - have been nurtured by our strong science base and universities, innovative culture and leading healthcare system.

Over the past year alone:

- NHS England agreed to commission nationally 33 ground-breaking new treatments, including auditory brainstem implants for people with profound hearing loss; microprocessor controlled prosthetic knees for people with lower limb loss; and Ivacaftor for young children with cystic fibrosis.
- A new Innovation and Technology Tariff (ITT) aims from April 2017 to expedite uptake and spread of innovation across the NHS. The first six innovations will mean 160,000 patients eligible to benefit. These products include those that reduce obstetric anal sphincter injuries as a result of episiotomies; reduce incidence of ventilated associated pneumonia which causes between 3,000 and 6,000 deaths every year; and provide effective treatment for clostridium difficile without the use of antibiotics.

- We have also established a national Clinical Entrepreneurs Programme, and the NHS Innovation Accelerator which has supported adoption of innovations that at least 390 organisations are now using.
- 13 new NHS Genomic Medicine Centres have been established across the country to collect samples, engage patients and family members in the programme to establish the infrastructure needed to make genomic medicine a routine part of NHS care. These centres have collected over 25,000 cancer and rare disease samples. Over 20,000 whole human genomes have been sequenced. By sequencing the genomes in these samples not only can we better understand these diseases, we can also target specific treatments on the patients who will benefit most from them.
- PHE has supported ground-breaking research which has led to a new technique for sequencing the genome of the bacteria that causes tuberculosis. This technique will enable faster and more targeted treatment of people with TB. Speedy diagnosis will also help scientists detect and respond to potential outbreaks as they happen. This matters since the UK still has one of the highest rates of infection in Europe.
- The NHS has invested in the Small Business Research Initiative Programme to support 80 small and medium enterprises.

For 2017/18 and 2018/19 the NHS will take further steps to enhance our global position:

- Begin the roll out of new treatments funded by NHS England's specialised commissioning, including mechanical thrombectomy treatment for stroke.
- NHS England will publish an Implementation Plan setting out its delivery contribution to the UK Strategy for Rare Diseases in 2017/18
- Expand the NHS's genomics capability, collecting 50,000 samples in 2017/18 rising to 90,000 in 2018/19. By the end of the 2018 calendar year, 100,000 whole human genomes will have been sequenced. By the end of 2018/19, we will also have developed a genomic medicine service for England, underpinned by a new consolidated genomic laboratory infrastructure and facilitated by informatics, data and analytical platforms to enable the sequencing data we generate to improve clinical practice.
- 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.
- One of the unique features of the NHS is the central role of general practice and this creates valuable opportunities to study 'longitudinal' data. NHS England and MHRA increased the number of GP practices registered on the Clinical Research Practice Data Link system (CPRD) by 25% in 2016/17 and in 2017/18 we will recruit an additional 1800-2000 practices to CPRD.
- In 2017/18, the NHS Innovation Accelerator will select another round of innovations that address the population challenges prioritised by STPs.

- Academic Health Science Networks and ‘test beds’ will take collective responsibility for driving national adoption of proven innovations, in line with the Accelerated Access Review.
- The NHS's international reputation has already led to major agreements with China, the Middle East and Latin America over the last few years, helping put money back into the NHS and UK economy and strengthening our investment in R&D. Healthcare UK (the export organisation for the UK's health and care sector) has helped health sector organisations win over £5 billion worth of contracts over the last three years. Healthcare UK aim to grow our exports by around 15% per annum to 2020.

More generally, under the banner of the government's Industrial Strategy, the life sciences sector deal will bring government and the NHS together with industry and charities to create new jobs and economic growth across the UK as well as aiming to improve care for NHS patients. The NHS is a key contributor and a committed partner to providing an environment where technologies can be developed and tested, and used to transform services to improve outcomes and reduce cost. This opportunity sits alongside further strengthening of the science base and clinical trials capability and the creation of an environment which enables small biotech and medtech companies to thrive and grow, and enhancement of our medicines manufacturing capabilities.

As medicine transforms over the next 20 years, the cutting-edge technology in our Universities combined with the NHS presents unique conditions to create new industries, companies and jobs based in the UK and transform the way innovation is delivered to patients, offering an attractive place to research and test new treatments in partnership with innovators. Potential areas include artificial intelligence, the application of genomics to medicine, the development of a range of new diagnostic tools, and therapies for conditions that will enable more healthy aging.

CHAPTER ELEVEN

CONCLUSION

The NHS Five Year Forward View reminded us that the Health Service was born at a time of national austerity and international strife:

“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.

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 our analysis 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.”

That remains our considered view.

So while this Plan doesn't seek to be the final word on the future of the NHS, it does chart practical and realistic next steps for the next few years.

Get these right, and patients, staff and the taxpaying public will all notice the difference.

And the NHS will earn the right to make its case for their continuing support, now and for future generations.

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²⁴ The 2017/18 non-appealable rules are expected to be:

- Q1 performance payment will be made if on the A&E 4 hour target a trust achieves the higher of either 90% or an improvement on its own January-March 2017 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off by the relevant Regional Director and the National UEC Director.
- Q2 performance payment will only be made if a trust meets the higher of either 90% or an improvement on its own Q2 2016/17 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off from the relevant Regional Director and the National UEC Director.
- Q3 performance payment will only be made if a trust achieves the higher of either 90% or an improvement on its own Q3 2016/17 performance, and is implementing specified improvement measures such as A&E front door streaming and trusted assessor, with sign-off from the relevant Regional Director and the National UEC Director.
- Q4 performance payment will only be made if a trust meets 95% in March 2018.

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