

Board of Directors (in Public)

Item 3.1

Subject: Next Steps on the NHS Five Year Forward View
Date of Meeting: 25th April 2017
Prepared by: Tony Wilding, Director of Strategic Partnerships & COO
Presented by: Tony Wilding, Director of Strategic Partnerships & COO

| BAF Ref | Impact on BAF |
|----------------|---------------|
| 1, 2, 3, 4 & 5 | None |

Background

At the end of March 2017 NHS England published 'Next Steps on the NHS Five Year Forward View' which sets out the NHS's main service improvement priorities for the next two years within the context of the financial challenges faced by the NHS today. There are nine areas of focus within the document which are summarised below to provide a synopsis of the plan for the Board of Directors.

1. Urgent and Emergency Care

The main areas of focus for the coming two years will be:

- Front door clinical streaming in A&E's using GP's by October 2017.
- Improving patient flow by adopting good practice on timely hand-offs of patients, discharge to assess, trusted assessor and seven day discharge capabilities.
- Improving delays for social care using the £1b provided by the government in the spring budget.
- Specialist mental health care in A&E's.
- Enhancing the use of 111.
- Evening and weekend GP appointments to 50% of the public by March 2018 and 100% by March 2019.
- Strengthen support to care homes.
- Standardise urgent treatment centres to be open 12-hours a day seven days a week.
- Implement the ambulance response programme by October 2017.

2. Primary Care

Key improvements for the coming two years are:

- More convenient patient access to GP services as additional GP's, therapists, pharmacists and nurses come on stream by streaming patients into same day urgent appointments while preserving continuity of care for patients with long term conditions.
- An additional 5,000 doctors in general practice by 2020.
- Expand multidisciplinary primary care with increased numbers of clinical pharmacists and mental health therapists, train 3,000 physician associates and improving general practice nursing.
- Engage practices to work together in 'hubs' or networks.

3. Cancer

Cancer remains one of the NHS's top priorities, as one in three people will get cancer in their lifetime. The main focus for the coming years will be:

- Faster tests, results and treatment for people with worrying symptoms. The key to this will be to expand diagnostic capacity, which will need to be a key focus for the Trust to ensure we have sufficient capacity available to deliver the additional demand this will place on our services. The main focus will be on the 62-day referral to treatment target (this is already in place) ahead of the introduction of a new 28-day standard to give patients a definitive diagnosis by 2020.
- Access to the most modern cancer treatments in all parts of the country by implementing the largest radiotherapy upgrade in 15 years using a £130m fund.
- To support the delivery of this programme there will be a clear accountability and delivery chain with performance goals for CCG's and cancer providers matched by unprecedented transparency using the new cancer dashboard CCG ratings published in July. There will be aligned local delivery infrastructure through 16 cancer alliances coterminous with their constituent STP's.

4. Mental Health

The key improvements outlined in the document cover the following areas:

- A big increase in psychological (talking) therapies with 60,000 more treatments in the coming year increasing to 200,000 by the end of 2018/19. The Trust has put in a partnership bid with Mersey Care for funding to deliver an Increasing Access to Psychological Therapies (IAPT) for patients with CVD and we are awaiting news as to whether our bid has been successful.
- Increasing support for new and expectant mothers with 4 new mental health mother and baby units, including one in the North West.
- The other improvements include perinatal support, improved care for children and young people, care closer to home, specialist care in A&E's and improved care for veterans.

Through the work of the CVD programme board we are engaging more with colleagues from mental health services to bring physical and mental health services closer together and as a Trust, moving forward we are also looking to develop further partnership opportunities with Mersey Care.

5. Integrating Care Locally - Next Steps for STP's and Accountable Care Systems.

There are 8 pages of the new document dedicated to the next steps for STP's, which reflect the FYFV vision using five 'rules of thumb', these are:

- Focus on keeping people healthier for longer through service improvements and outcomes not just administrative reorganisation per se.

- Co-produce major national improvement strategies with patients and voluntary groups, staff and stakeholders.
- 'Horses for courses' not 'one size fits all' solutions that reflect our diverse population (hence local STP's to debate and develop locally grounded proposals and plans).
- Evolution not big bang.
- Back energy and leadership where we find it.

There is emerging evidence that the new models of care programme vanguards are starting to see improved performance against the national performance in areas such as reducing A&E attendances and emergency admissions.

In relation to STP's the aim is to use the next several years to make the biggest national move to integrated care of any major western country as the acute model of care can no longer deliver the care that today's population needs. To move this forward the expectation is that this will take the form of Sustainability and Transformation Partnerships and for some geographies the creation of integrated or accountable health systems.

The aim in making this transition to population-based integrated health systems is that the NHS will be guided by several principles, these include:

- STP's are not new statutory bodies; they supplement rather than replace the accountabilities of individual organisations. Importantly it is a case of 'both the organisation and our partners' as against either/or.
- The way STP's work will vary according to the needs of different parts of the country.
- The government will not impose how the NHS and local government deliver the changes required.
- To succeed all STP's need a basic governance and implementation 'support chassis' to enable effective working. From April all NHS organisations will form part of a Sustainability and Transformation Partnership which will:
 - Form an STP board drawn from constituent organisations including non-executive participation, partners from general practice and local government.
 - Establish formal CCG committees in common or other appropriate decision making mechanisms.
 - Where this is not already occurred re/appoint an STP chair using a fair process and subject to ratification by NHSE and NSHI. NHSE will provide funding for 2 days per week pro rata.
 - Ensure the STP has the necessary PMO support by pooling expertise from trust's, CCG's, CSU and other partners.
 - Be able to propose adjustment to their geographical boundaries in agreement with NHSE, overtime 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.
 - The judge of success of STP's will be based on their results. NHSE will publish metrics at STP level that will align with NHS Improvements Single Oversight Framework for NHS provider trusts and NHS England's annual CCG Improvement and Assessment Framework, which will be published in July.

There is guidance on how STP's need to ensure community participation and involvement and also a new 'fifth' test that must be passed where significant bed closures are proposed.

The final part of this section of the document is given over to discuss to Accountable Care Systems (ACS's). ACS's will be an 'evolved' version of the STP that is working as a locally

integrated health system. These are systems where NHS organisations, both commissioners and providers, often in partnership with local authorities choose to take on a clear collective responsibility for resources and population health. They provide joined up better coordinated care. Moving forward it is envisaged that ACS's can:

- Agree an accountable performance contract with NHSE and NHSI than can credibly commit to make faster improvements in the key deliverables in the 'next steps' plan.
- Together manage funding for a defined population.
- Create an effective collective decision making and governance structure, aligning the on-going 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 provide vertically integrated care system with GP's and mental health providers.
- Deploy rigorous and validated population health management capabilities.
- Establish clear mechanisms by which residents within the ACS's defined local population will still be able to exercise patient choice.

The final paragraph of this section says that over time ACS's may lead to the establishment of Accountable Care Organisations (ACO's) 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 in England are on the road to establishing an ACO but this will take 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.

6. Funding and Efficiency

This section of the document focuses on the NHS's 10-point efficiency plan against the backdrop of the three truths, which are:

- The NHS is one of the industrialised world's most efficient health care systems.
- Health spending is likely to rise significantly as part of GDP over the coming decades as a result of demographic changes, growing technology costs and rising demand.
- But despite these two truths there are still substantial opportunities to cut waste and improve efficiency.

The 10-point efficiency plan covers the following areas:

- 1) Free up 2,000-3,000 hospital beds.
At present around 2,500 hospital beds are occupied by beds for patients who are fit to leave hospital but are awaiting social care.
- 2) Further clamp down on temporary staffing costs and improve productivity.
This includes plans to further reduce agency and temporary staffing costs by £150m in 2017/18 and a focus on reducing medical locum costs.
- 3) Use the NHS procurement clout.
As part of this programme all trusts will be required to participate in the Nationally Contracted Products programme. This could have a significant impact on the Trust, as a high volume, high complexity centre and this will need to be effectively managed moving forward.
- 4) Get best value out of medicines and pharmacy.

The NHS spends £16b annually on medicines split between £9b in primary care and £7b from hospital treatment. The NHS drug bill increased by 7% last year with a particular growth in hospital driven prescribing. There are a number of initiatives within the document as to how best value can be derived including NHS improvement 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.

5) Reduce avoidable demand and meet demand more appropriately.

This work stream focuses on tackling unwarranted variation in care, including referral thresholds, improving prevention (with a focus on CVD), healthier workforce and working closely to identify and support carers. There is also a focus on reducing avoidable demand for emergency care and how demand could be met more appropriately. There is also a focus on avoidable demand for elective care, which includes the 'Get it right first time' programme, benchmarking the clinical appropriateness of hospital referrals and extending the use of the advice and guidance option in the e-referral system.

6) Reduce unwarranted variation in clinical quality and efficiency.

The main areas covered within this priority are 'Getting it right first time', theatre productivity, looking at options to split 'hot' and 'cold' planned surgery clinical facilities. There is also a need to meet the '7-day services' standards for heart attacks by November 2017.

7) Estates, infrastructure, capital and clinical support services

This work relates to the current work streams we are engaged in covering the estates and clinical support services functions and where there are opportunities to release savings. There is also a focus on the sale of surplus assets and a multi year capital budget to be announced in the autumn to support the implementation of approved high quality STP's.

8) Cut the costs of corporate services and administration

NHS administrative costs are already far lower than other comparable countries, we spend only 2p in the pound compared to 5p in Germany and 6p in France. There are however still opportunities to reduce costs and NHSI is targeting £100m in 2017/18 in reduced administration costs. There are also plans to further reduce NHSE and CCG running costs by £150m by 2019/20.

9) Collect income that NHS is owed

In respect of cost recovery from non-UK residents the government has set a target of recovering £500m per annum. Twenty trusts will now pilot new processes to improve identification of chargeable patients, which can then be rolled out to all trusts.

10) Financial accountability and discipline for all trusts and CCG's

This priority outlines the Government's mandate for 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. This is going to require tough decisions and decisive action.

Delivery of financial control totals is critical so in 2017/18:

- Each provider Trust and CCG will be set a control total.
- 70% of STF will be tied to delivery of trust specific control totals.
- Trusts not agreeing a control total will lose the exemption from the default fining regime.
- Trusts missing their control total may be placed in special measures.
- Some organisations or geographies have historically been substantially overspending their fair share of NHS funding and they must tackle this and deliver the mandate for the NHS to balance its books.

7. Strengthening our Workforce

The introduction to this section acknowledges the pressure NHS staff are under despite a growing workforce. This is driven by the complexity of patients we are treating, recruitment issues, pay restraint and uncertainty for international staff.

Key areas for improvement for 2017/2018 and 2018/19 are to improve education and training and increase the number of nurses in training. To improve retention, which if we achieved the levels of two years ago would mean we would have around 4000 more WTE nurses per year. As part of the return to practice initiative there are currently 50,000 registered nurses not working in the NHS. The aim is to target 1500-2000 nurses to return over the next two years. There is also a focus supporting new advanced clinical practice (ACP) nurse roles. HEE and NHSI will be publishing a new national ACP framework, and deploy ACP's in trusts where they can make a difference in high priority areas such as A&E, cancer care, elective services or reducing locum costs by converting medical posts. The use of e-rostering and effective job planning will be further developed with NHSI focusing during 2017/18 on supporting trusts to get best value from these electronic tools to support job planning and implementing newly issued job planning guidance. The focus will be on maximising direct clinical care time, eliminating unwarranted variation and reducing extra duty payments.

There will be additional undergraduate medical school places; however these are mainly geared to GP's and psychiatrists. There are a number of initiatives to tackle pressures on junior doctors and plans to improve communication with senior medical staff.

Other initiatives proposed include developing new professional roles, more action on NHS staff health and well-being, making the NHS a more inclusive employer and how STP's and ACS's will work with staff and trade unions on ways to encourage flexible working and "de-risking" service change. The final proposals focus on improving leadership and capabilities across the health and care system and HEE will publish its annual workforce report in April.

8. Patient Safety

The section on patient safety is relatively short with only three pages highlighting the plans for the coming two years. The main points are:

- As part of the drive to prevent healthcare acquired infections there will be a focus on E. coli infections giving them the same level of attention as MRSA and Clostridium difficile, for example, displaying numbers of infections on ward information boards.
- Learning from deaths and making the NHS the world's largest learning organisation. This includes improved support and communication with bereaved families and carers; improving the standards and understanding of data on harm and mortality and ensure that services for people with learning disabilities and mental health problems are part of the core learning.
- The CQC aim to improve inspections and the new healthcare safety investigation branch will be operational, undertaking up to 30 investigations where the learning from patient safety can be maximised.
- Reducing medication errors.
- NHSI will develop and deliver a new patient safety incident management system (PSIMS). 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.

9. Harnessing Technology and Innovation

The final priority area cover the IM&T agenda and the work programmes in this plan are underpinned by an agreed, costed and phased NHS technology plan, building on the recommendations of the Wachter review. The main focus is on helping people in managing their own care.

There will be a key focus on digitising hospitals and how the Global Digital Exemplars (GDE's), which includes Alder Hey and the Royal Liverpool and Broadgreen University NHS Trust, to develop blueprints and spread the learning and how they can work with "fast follower" sites to do this.

There will be a new NHS digital academy to train the next generation of Chief Information Officers by increasing the skills to align information technology with business and clinical needs.

By December 2017, every A&E, Urgent Treatment Centre and e-Prescribing pharmacy will have access to extended patient data either through summary care record or local care record sharing services.

The use of NHS e-referral will be mandatory for all GP referrals by October 2018 and there will be an increased use of the "advice and guidance" function of this software package.

The last part of this section talks about innovation for future care improvement; this includes the roll out of mechanical thrombectomy treatment for stroke, which has been highlighted as a potential service development for the trust.

Conclusion

The Next Steps on the NHS Five Year Forward View has mapped out the next steps for NHS organisations for the next few years. The Executive Team are already working on a number of initiatives that form part of this plan so we are well placed to deliver key elements of the plan.

Recommendation

That the Board of Directors note the content of this paper that will help to inform the Trust strategy and operational plans moving forward.