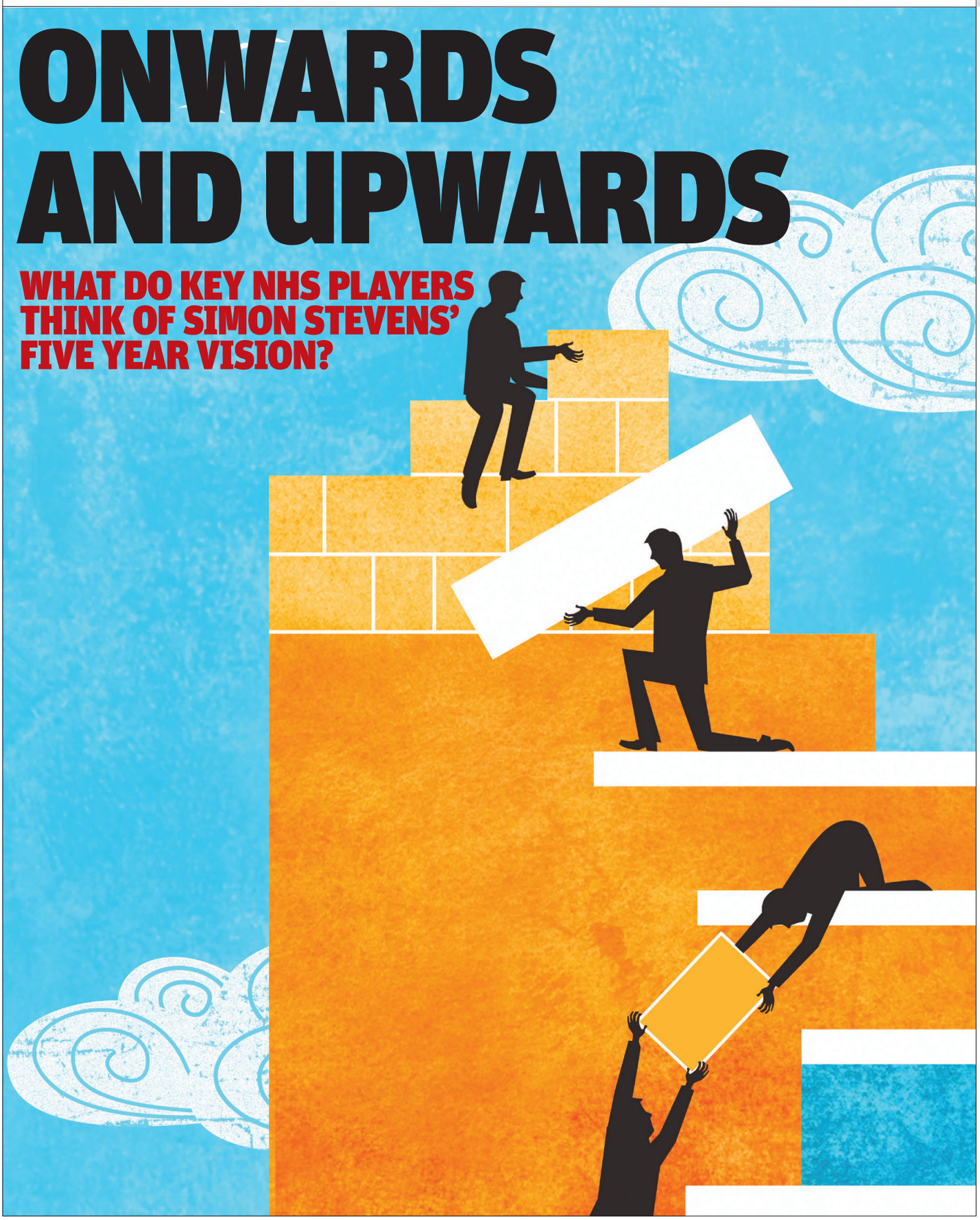
FORWARD VIEW

ONWARDS AND UPWARDS

WHAT DO KEY NHS PLAYERS THINK OF SIMON STEVENS' FIVE YEAR VISION?



ALAMY

JENNIFER DIXON

THE POWER OF SMALL CHANGES

There is broad agreement on where the NHS needs to go – we now need to spell out how precisely we are going to get there, starting with a revolution in how we support improvement

The *NHS Five Year Forward View* is a pithy, intelligent summary of where the NHS needs to go and an estimation of the money needed to do it. Mission well accomplished; there has been strong political consensus on its message after publication. But now the difficult bit – achieving the productivity assumptions set out while improving quality of care. As a report, it's long on the "what", but short on the "how".

Changing the policy and regulatory "system" cocktail can help nudge progress. A first step would be to develop a coherent approach between at least NHS England, Monitor, the NHS Trust Development Authority and the Care Quality Commission on improving care beyond dealing with failure. Questions include: what are these bodies doing to improve quality; what are the assumptions underpinning their work; and where are the gaps? Once designed, constant calibration with consistency of purpose over time will help.

But getting the national extrinsic milieu right for commissioners and providers clearly isn't enough. The action needed is at regional and local level – in particular, leading strategic change across groups of providers in an area, and widespread front line change. Nudge must be complemented by support to help staff translate their intrinsic motivation into more widespread action. What kind of support? I would suggest there are three major types required.

Learning from success

First, we need to support major transformational change (aimed at manager and clinician leaders) across areas to accelerate new models of care. We should look hard at practical examples of where in the NHS there has been successful change at scale and examine carefully what it actually took to achieve. The consolidation of stroke and cardiac services in London is an obvious example. Sure strategic leadership will be needed, as will basic management skills and in particular, practical operational excellence.

Second, we need specific collaboratives to boost pace in some key areas including: developing primary care federations; accelerating integrated care on the back of Pioneers and better care fund plans; forward view models of care; and integrated personalised commissioning. These may not be nationally driven collaboratives, but voluntary regional, area or provider based approaches.

'Basic practical skills in quality improvement are present in pockets of the NHS but non-existent elsewhere'

Third, and most needed, is therapeutic dosage across the NHS of formal quality improvement skills in frontline staff (managers and clinical staff, particularly physicians). This is very much a Berwickian agenda. Currently, basic practical skills in quality improvement are present in pockets of the NHS but non-existent elsewhere. Scotland has made a head start, focusing initially on skilling up staff to improve safety. This should be a priority in England, alongside other improvements including flow in emergency care and early and safe discharge of the frail elderly.

The Health Foundation's funded projects over the last decade show some impressive changes in the use of basic quality improvement techniques in efficiency as well as safety. Changes are empowering the front line to make and measure the myriad of small changes that add up to something big. A few vanguard centres across the UK have built up capability and now have a sustainable quality improvement infrastructure – fledgling versions of what is seen in centres of excellence in the US we have all heard about.

In the first half of 2015 the Health Foundation will publish a series of UK case studies to encourage good practice. In our experience, younger physicians in particular need little encouragement – they are hungry for the opportunity. Investing in the above depends on the current "survival of the fittest" approach to improvement (aka do what you can), or on developing a more systematic support. The former results in progress that is not fast enough.

Support at all levels

Finally, where should this type of support come from? It could be provided at different levels, whether nationally or regionally, through commissioners and providers. Academic health science networks, the Advancing Quality Alliance in the North West and local examples at Salford Royal and Sheffield demonstrate how varying forms of support exist across the health service. But rocket boosters are now needed.

Now is the time to get this right in the NHS more than any other time in the last 20 years. The challenge is also to design an intelligent improvement infrastructure that is stable for the medium term and self-sustaining in the future. ●

Jennifer Dixon is chief executive of the Health Foundation.

MARK BRITNELL

THE NEW STEVENS DEAL

Sir David Nicholson famously challenged the NHS to find billions in efficiency savings – but his successor is also demanding that the politicians who set the budget make their contribution

The *NHS Five Year Forward View* published by NHS England neatly demonstrates both the vital role and the strict limits of politics as a force for good in health and care.

First, the inescapable truth: politics determines resources.

No society on earth believes that health and care services should be provided exclusively on a self-pay basis. In every country questions of funding, and therefore access, are overtly political: it has been the dominant political issue in the United States at least since Barack Obama first proposed healthcare reform in the 2008 presidential election; it played an important part in the manifesto of the Bharatiya Janata Party in this year's Indian general election; and funding for NHS and social care services will be an important issue in the British general election in 2015.

'In 2009 David Nicholson could see no prospect of additional resources. Simon Stevens seeks a different political deal'

Simon Stevens played his cards skilfully on this highly political issue, building on ground that was prepared by his predecessor. The "Nicholson challenge" famously required the NHS (and, by implication, social care) to show how they were going to continue to meet growing demand without any increase in real resources.

Sir David Nicholson estimated that his challenge would require around £15bn of efficiency savings over the lifetime of this parliament. Mr Stevens has projected the same analysis over the lifetime of the next Parliament and, unsurprisingly, concluded that the cost of meeting rising demand through an unreformed system would rise to £30bn over 10 years.

There is, however, an important difference between the Nicholson approach and the Stevens approach. Writing in 2009, Sir David could see no prospect of additional resources, and challenged providers to meet rising demand exclusively by improving efficiency.

Mr Stevens seeks a different political deal. He argues that an improving economy can afford to make a contribution that meets around half the cost of rising demand; in return he offers a commitment by health and care providers to meet the remaining half through improved efficiency.

Seen in the longer view, the Stevens deal is that over the 10 years (2010-2020) roughly a quarter (£8bn) of the cost of growing demand for services should be met by the taxpayer, with three-quarters accounted for by sustainable efficiency gains delivered by service providers.

Decisions about the resource implications of the Stevens deal are exclusively political. They require elected officials to make choices between tax and spending priorities and commit the required level of resources to health and care services. No one should blur that message. It is overtly political and it is for the political system to give an answer.

The clear implication of the forward view is, however, that – having accepted responsibility for the unavoidably political question – the political system should challenge health and care providers to deliver their side of the deal. If the resources are available, it is for those providers to deliver the efficiency gains required to ensure they meet demand, and to do so while also delivering a quality of service that matches reasonable expectations.

It is the link between the requirement to deliver ambitious objectives for efficiency gain, and the requirement to improve quality levels in some services, that leads to the specific proposals in the forward view. It is simply not possible to deliver either the required levels of efficiency gain, or the required levels of quality improvement, by administrative tinkering.

Rhetoric about the need for more emphasis on community services, more collaborative management, and a higher priority for preventative activity is not new. Historians of the NHS can find references in the speeches of Aneurin Bevan himself; what is new is that delivery of these objectives has now become an existential challenge.

The forward view offers a menu of options; it recognises that different solutions will fit different circumstances and that it is outcomes that matter, not structures. It offers hope that there is a growing understanding that "no change is not an option", and that form should follow function – not the other way round.

But it is called a forward view and that it is all it is; it is not a plan. It leaves the challenge firmly in the hands of service providers to deliver efficiency gains on a scale that is without precedent in any major healthcare system on the planet. That is the sense in which it demonstrates the limits of politics; if the resources are provided, Mr Stevens says, it is for service providers to deliver. That is the "Stevens deal". ●

Mark Britnell is chair and partner of Global Health Practice at KPMG.

ANDREW HINE

APPLY PROVEN CHANGE NOW

The forward view presents an NHS with the pace and power of a sprinter, the stamina of the marathon runner, and the flexibility of a gymnast – but the health service will fail if it doesn't act now

The *NHS Five Year Forward View* published by Simon Stevens and NHS England is bold. It is radical, insightful, essential and welcomed. It is also risky.

The forward view sets out a vision of a new NHS that our country must create, which is more proactive, responsive, personal, productive and viable. Because, simply, our current NHS has served us outstandingly through generations but cannot, unreformed, meet our future needs. Mr Stevens has set the NHS on a journey, where politicians invest and the NHS simultaneously transforms itself, which is a wish that citizens must hope comes true.

The report describes an NHS that is true to the values of our country, but builds on the best innovation and experience in healthcare internationally. The best health organisations and systems across the world have achieved some of what the forward view envisages. Few, if any, have done it all. In this way, it is bold, radical and insightful. The NHS has an almost unique opportunity now to consistently transform healthcare, which will make it a world class leader. It is essential that this opportunity is seized.

The forward view is risky. Asking politicians for £8bn in a time of austerity felt very bold, and offering to find the other £22bn required if politicians provide the £8bn may prove overly generous, if the chancellor or his successors continue as he has started with his autumn statement commitment. However, having found £2bn, it may prove politically much easier, and frankly attractive, to any future chancellor to find the other £6bn if doing so commits the NHS to the excruciating challenge of finding £22bn to make good on their own deal.

Five years of unprecedented "Nicholson challenge" cost constraint will be followed by five years of unprecedented savings funded transformation under the forward view. The NHS should now be prepared for its bluff to be called. And that's not a lot of notice; even Joseph (he of technicolour coat fame) had seven bumper years to prepare for seven years of famine.

So, like the patients and communities it serves, the NHS faces not just a short term diet programme – this is a question of a permanent lifestyle change. The forward view is of an NHS with greater pace, greater power, greater stamina and greater flexibility – the pace and power of a sprinter, stamina of the marathon runner and flexibility of a gymnast. Combining all these skills simultaneously is rare – even Daley Thompson (for those of a certain age) didn't possess all those qualities.

So is this possible? In short, the answer is yes. But only if the NHS focuses on

'The best systems internationally provide care at home, not just close to home, and above all, know patients are key players in the solution'

rigorously implementing proven change now, rather than losing time seeking a new silver bullet solution.

The future NHS faces unprecedented challenge. But so do almost all other health systems. The challenge of responding to this is well understood, but in most systems leaders are not confident to change. They often delay acting even when the need to change is known. During 2014 KPMG surveyed over 500 healthcare leaders in 50 countries. Seventy-three per cent said their systems need to change fundamentally, but only 35 per cent said their organisations need to change, and only 19 per cent said they were definitely ready to change.

We also brought together in London 65 healthcare leaders from 30 countries across six continents and asked them to sum up the keys to healthcare transformation – what to do and how to do it. We then compiled the findings into a report, to set out what works, and how this can be achieved by the NHS leaders.

Long term thinking

How the best systems have transformed themselves is clear: they have applied long term thinking to fix short term problems; they are continually self-questioning in search of greater improvement; they never deviated; and they started immediately. There are also similarities in the way they implement the best systems: they provide care at home, not just close to home; they use information excellently and engage their people consistently; and they change care across systems, not just within organisations. Above all they know that patients are their purpose and key players in the solution, not the problem.

The forward view embraces this and other learning. The future it describes is essential for the NHS to succeed. It is something that we as citizens must wish for. Getting there will require a huge effort by the NHS. It appears that the politicians are lining up to play their part.

The NHS can lead the healthcare world if it achieves the transformation of care the forward view envisages. ●

Andrew Hine is UK head of public sector and healthcare for KPMG.

SIR SAM EVERINGTON

STOP 'CHICKEN SHOP MILE'

We need to make sure we tackle all the social determinants of health, including obesity promoting fast food – and GPs must get the time and resources to play their part in such holistic care

Over recent years we have gradually witnessed the closure of churches, pubs and other constants in our communities. For many people the GP is one of the few people left providing continuing support in our lives, alongside our families.

Primary care, with all its variability, is also one of the most cost effective health systems in the world. So, while in need of modernisation to meet modern challenges, it is worth preserving.

This has been recognised in the *NHS Five Year Forward View,* which steps outside tradition to focus on preventative medicine and care in the community. It also acknowledges that more of the same – hospital and specialist care – is not going to solve worsening healthcare among many.

Where I practise in Tower Hamlets, the difference in life expectancy between rich and poor is 11 years. You'll reach old age 20 years earlier so a 50-year-old will have the same number of consultations in primary care as a 70-year-old living in a wealthy area.

At the start of life, at five-years-old, half have severe tooth decay and vitamin D deficiency, cognitive development is 10 per cent below the national average and 11 per cent are obese. By the age of 11, obesity rates have doubled and, in reality, the problem has become just part of a spectrum of malnutrition among the majority of children. This, of course, is not helped by the 42 chicken shops per secondary school – Mile End Road running through the heart of Tower Hamlets is known as "chicken shop mile".

General practice, therefore, has three tasks. To be the vanguard and leaders of preventative healthcare; to move substantial amounts of care into the community; and be a key part of commissioning holistic health services. The government and NHS England have set a clear goal of bringing primary, secondary and tertiary commissioning back together.

The NHS delivers a maximum of 15 per cent of healthcare so if you want to improve people's health, you need to tackle all the social determinants of health including employment, education, the environment and our creativity. Put simply, if you educate and employ, you improve health. So why not have the housing association worker at the same reception desk as the GPs?

At the Bromley by Bow Centre in Tower Hamlets we offer 100 different projects under one roof, from cooking and gardening groups to tackle social isolation to adult learning programmes (literacy, numeracy and IT). We also offer advice on social welfare, legal issues and money management. All the neighbouring practices now connect patients via social prescribing to nearly a thousand different voluntary sector projects in the area.

'At five-years-old, half of Tower Hamlets children have severe tooth decay and vitamin D deficiency, and 11 per cent are obese'

This April, Tower Hamlets Clinical Commissioning Group is likely to take on full primary care commissioning and, in the not too distant future, we will get back most specialist commissioning. We have a fantastic team of managers and clinicians commissioning holistic healthcare with many early successes, recognised by *HSJ* as CCG of the year award 2014. The sadness is that all of this could have been achieved without the chaos of the Health and Social Care Act. The good news is that the focus has shifted towards care pathways, designed for a population and fundamentally changing the role of the hospital. The vast majority of diabetic care has shifted into the community with the amazing support of a diabetologist who gives advice to GPs via mobile phone, visits practices for teaching sessions, and now sees only complex cases in the hospital. A fantastic success for patients.

Yet we cannot state strongly enough how the spiralling workload combined with the reductions in resourcing for primary care in the last seven years (with the addition of minimum practice income guarantee, alternative provider medical services, and personal medical services reviews) are having an enormously destabilising effect on primary care in areas like ours.

GPs are now completely focused on keeping their practices afloat, coping with the ever rising level of demand, and therefore struggling to take on all these new tasks. On top of concerns over resources is the burgeoning cost of regulation. One chief executive of a hospital estimated that he faced 80 different inspection regimes a year. I see my local hospital managers overwhelmed with managing inspection teams and taken away from the crucial day job of improving patient care.

The path set out by the five year plan gives a clear direction for prevention and primary care. A tough rationalisation of regulation with a shift of focus to development rather than judgement must be added to this. ●

Sir Sam Everington is a GP at Bromley by Bow Centre in east London.

JEREMY TAYLOR

A FLAG TO RALLY ROUND

It may not be perfect but we can all get behind the NHS Five Year Forward View – not least its call to engage patients, carers, volunteers and the voluntary sector

The *NHS Five Year Forward View* is a smart document: visionary, engaging, commendably short. It elegantly captures much of the current consensus on priorities for health reform. It symbolises this consensus by presenting itself as the joint work of six national system leading bodies. It launches a cleverly pitched bid for resources that, judging by the recent autumn statement, has already had some effect.

'The forward view doesn't overcome the NHS/public health/social care divides. It doesn't integrate the implications of the Care Act or Barker commission'

The forward view speaks compellingly about the engagement of patients, carers, volunteers and the voluntary sector. It powerfully makes the case that such approaches are not "nice to haves" but integral parts of the health and care endeavour.

We in the voluntary sector are used to airy generalities about "putting patients first". But the forward view contains specific commitments that, if implemented, will make a difference.

It signals an intent to invest in evidence based approaches for people with long term conditions, to identify and support hidden carers, to bolster volunteering and to simplify the contractual minefield for voluntary sector organisations, especially those too small to compete for tenders.

I declare an interest since National Voices and a number of other national voluntary organisations have had the opportunity to shape some of this content. The soaring phraseology about "the NHS as a social movement" and about harnessing "the renewable energy represented by patients and communities" is, however, Simon Stevens' own.

What are the prospects for harnessing this "renewable energy"? At National Voices we are optimistic, but wary.

The scale of change implied by the forward view is considerable. It requires political backing, money, time, headspace and change management expertise. It demands a willingness to engage, share, collaborate and let go. These are tender plants, scarce at the best of times. And the current state of the NHS – a frantic effort to keep the existing show on the road – does not provide fertile soil for them to grow.

In our position statement Person Centred Care 2020, National Voices calls on political and health leaders to "make people the priority, not the system". Despite the patient friendly language, time and again we see professional, financial and organisational priorities trumping the priorities of patients and their families. To reverse this imbalance is the biggest challenge for reform, but key to making the forward view real.

We see the imbalance in action when access to services is rationed; when people are "blamed" for turning up at accident and emergency; when they experience the over-medicalised death they didn't want; when they find themselves endlessly "passed from pillar to post".

We see it in positive developments too, so that, for example, the purpose of integrated care initiatives becomes framed as reducing cost and hospital admissions, rather than improving health and quality of life.

We see it in NHS England right now, as it presides over yet another reorganisation of specialised commissioning in the face of considerable concern from patient organisations and leaders.

Even the forward view itself is not immune from this "system" thinking. While the whole of chapter two is devoted to "a new relationship with patients and communities", chapter three on "new models of care" barely refers to this, and nor does chapter four on implementation.

Mr Stevens exhorts the NHS to "think like a patient, act like a taxpayer" but the forward view unconsciously betrays an older NHS mindset: "think occasionally about patients, act like a technocrat".

And of course there are other problems with the forward view. As an NHS document it doesn't overcome the NHS/public health/social care divides. It doesn't integrate the implications of the Care Act or the Barker commission. It is the imperfect child of an imperfect system.

For all that, the forward view feels like the only game in town right now – a flag that everyone can rally round. We are keen to play our part.

Let's start by breathing human life into the new care models. They should be vehicles for "mainstreaming" person centred coordinated care. They must herald a new deal for people with long term conditions realised through care and support planning. They must integrate the rich contributions of the voluntary and community sector to health, holistic care, independence and wellbeing. We need less "system", more "people". ●

Jeremy Taylor is chief executive of National Voices.

DAME JULIE MOORE

DON'T RELY ON THE BANKS

Skimping on training more healthcare staff is a false economy – the NHS needs to invest right now so it can wean itself off its dependency on expensive agency staff

It is well reported that in the developed world we are facing significant demographic challenges – more people living to extreme old age, often with several chronic diseases. This is creating a challenge for both health and social care.

We must remember that this is in fact a success story and is testament to the advances in society, public health and medicine in recent decades.

We recently had an incident in the trust where a junior doctor did not recognise a heart attack. It turns out that this particular doctor had never seen a patient who had had a heart attack.

Thirty years ago when I was a junior nurse, it seemed almost every other patient came in with a heart attack and almost everybody in the ward could recognise changes on the electrocardiogram.

Impact of new treatments

Due to the introduction of legislation such as the ban on smoking, the impact of new procedures such as angiography and the use of new drugs such as statins, no longer do we have large numbers of people dying suddenly in their 40s and 50s from a heart attack.

This is good news both for the individuals and for society as these people can now continue to work and contribute to society for another couple of decades. However, they will now live to be older, perhaps developing a chronic disease later on in life.

These changes have taken decades to emerge and make an impact and it is right that we plan our health and social care system accordingly, for the long term. These problems cannot be addressed by single issue, short term fixes.

Successful strategies to cope with these demographic developments will take years to implement and we need a political accord for a long term plan to deliver the healthcare we know we will require to sustain us through the next decade and beyond.

The model of healthcare needed at the inception of the NHS has served us well but it does need redesign for the 21st century.

Because the problems in healthcare are complex and numerous, we need a variety of solutions if we are to continue to provide the excellent services the NHS currently delivers.

The *NHS Five Year Forward View* recognises the need for a long term plan, underpinned by a sustained period of stability with reasonable assurance over finances.

It further recognises that a variety of solutions and models are going to be needed to reflect local needs and local situations.

The issue I think we still need to address is staffing.

The necessity of the right numbers of staff with the right qualifications and training for the delivery of high quality care is well recognised.

This is evidenced by the increased numbers of staff of all grades now employed in the NHS in response to the increased focus on quality of care. However, this has led to a problem in itself in that in order to meet the need for more staff, more and more organisations are relying on bank and agency to fill gaps. This is not a clinically or cost effective solution.

We need to train more staff, including doctors, if we are to continue to deliver high quality care in a variety of settings in the future.

Saving money by not training more healthcare staff is a false economy in terms of both quality of care and finances. The savings in not training a doctor are more than lost in the cost of locum provision being incurred across the NHS.

'We need to train more staff if we are to continue to deliver high quality care in a variety of settings in the future'

'Short term savings today are going to lead to greater problems in the next 3-5 years and beyond. To combat this must invest far more in training and education'

Need for investment

Short term savings today are going to lead to greater problems in the next 3-5 years and beyond.

To combat these potential issues before they arise, I think we need to invest far more in the training and education of our next generation of healthcare professionals. ●

Dame Julie Moore is chief executive of University Hospitals Birmingham Foundation Trust.

ZARA HYDE PETERS

TACKLING THE 'HOW'

The forward view offers support to make real progress in the NHS. Partnerships, when sustainable and genuine, are the only way to deliver long term solutions.

After a number of years spent in developing, reviewing and implementing strategic plans in both the private and public sector, I read the *NHS Five Year Forward View* with real interest and curiosity. I considered the implications as a relatively new NHS employee, but also as a taxpayer and current and future consumer of the services. In public services, those employed to deliver wear many hats relative to their organisation. There are three areas I found interesting and relevant to my experiences.

The first is the challenge of prevention, with an explicit admission that this huge influence of future healthcare demand is not within the remit of the NHS to manage or control. In fact, even influencing the agenda is highly dependent on the willingness of other public sector agencies. Reversing the current trend requires behaviour change on a grand scale against the background of a world that has changed quickly and irreversibly. In the field of physical activity alone, urban development, accessible open spaces, school environments and the pace of working lives underpinned by technology development flies in the face of a small number of pioneering healthcare professionals promoting physical activity for health.

In the city I work, where social and health inequalities are significant, joint working is more than "nice to have" – it's necessary. National recognition of the shared ownership of this challenge across government departments would be most welcome in response to the importance placed on this aspect of health. In advocating prevention as a health imperative, the forward view appeals to everyone who believes in individual responsibility and accountability, empowering people to look after themselves.

'There's a lot of good practice to draw support from this rational view of what we need to do'

Having firsthand experience of developing a model of integrated health and wellbeing, the second area of interest in the forward view is the discussion of new models of care in our communities. I welcome the view that there needs to be a variety of approaches based on local need and providers. When I first joined the NHS I was quite transfixed by the commissioning complexity and the fragmentation of local provider networks that means that two similar areas (demographically, economically or geographically) could have completely different provider structures.

The forward view talks about partnerships and herein lies the real common ground across all localities. If radical change is to be achieved without massive provider restructuring, partnerships are the solution. My own experience of partnership working is that when there is a single, absolutely agreed imperative – for example, staging the London Olympic Games in 2012 – many organisations find ways to flex and work together that they had never dreamt of. However, these are partnerships of convenience and as soon as the imperative recedes, normal operation resumes. Genuine, sustainable partnerships based on mutually recognised interdependency and trust is the only way to deliver long term improved health outcomes. Facilitating the development of these partnerships, and recognising and celebrating them, is an important priority for all those working in this space. I have been fortunate enough in my time with NHS Leadership Academy to review healthcare systems and public governance generally with thought leaders from the Harvard Kennedy School. One of the lenses through which we view systems is the authorising environment. This describes the (sometimes unwritten) boundaries, both formal and informal, that influence behaviours in an organisation or service. My own experience of the most highly regulated agencies is that a strong adherence to perceived authorising environments significantly affects behaviours across the system, creating some barriers and also occasionally some quite dysfunctional operation. Breaking down these barriers whilst adhering to safety and quality is another significant obstacle for new models of care, including navigating of the minefield of data protection and management in multiprovider partnerships.

Perhaps the most interesting area is the aspiration to have an integrated approach to mental and physical health. Coming from an environment where care of mind and body for better performance are inextricably linked, it feels intuitively right to want to achieve this objective. This links back to partnership working in the first instance, as it's not an easy journey to embark on from the current service delivery in many areas.

The forward view offers support for real progress and there is a lot of good practice which can draw support from this rational view of why and what we need to do. The real challenge for all of us is the how. ●

Zara Hyde Peters OBE is part of the NHS Leadership Academy Executive Fast-Track programme and programme director of health and wellbeing at Birmingham Community Healthcare Trust.