RCPsych Summary/Briefing

NHS England Five Year Forward View

Note: the following is not exhaustive, and reading relevant sections of the Forward View in detail is recommended. The Executive Summary is on pages 3-5 of the document.

Simon Stevens was quoted in the HSJ (23.10.14) as saying that for the ‘first time ever the NHS itself has set out a clear sense of direction for how services need to evolve.’ He has appealed to all the political parties to support the plan and the direction the NHS should take.

Andy Burnham was also quoted in the HSJ on 23rd October 2014: He argued that the forward view would not bring about reforms as quickly or as extensively as he would like, but welcomed it overall as a “big endorsement of our vision”, which “provides the basis for a new consensus on the NHS”. He also noted the “significant” absence of any mention of competition. “The onus is now on the government to say how much of this do they endorse,” he said.

Opportunities for RCPsych

Mental health and learning disabilities are highlighted as areas requiring more improvement over the next five years, along with faster diagnosis and more uniform treatment for cancer, readily accessible GP services, prevention and integrated health and social care. (p.7).

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

BOX 3.2 (p26): FIVE YEAR AMBITIONS FOR MENTAL HEALTH

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

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

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children’s services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

There is a clear ask here for further funding from government for mental health, and no case made for a rebalancing of funding from physical to mental health.

Summary of specific initiatives for/linked with mental health:

- Commitment to publish ‘meaningful and comparable measurements for all major pathways of care for every provider by the end of the next Parliament’ to help narrow gaps in quality of care (‘Five-Year Ambitions on Quality’, p.8)
- Workplace mental health initiatives including incentives for employers to provide effective NICE recommended workplace health programmes and commitment to NHS as employer to do this, and to offer support to its 1.3m employees to stay healthy, and serve as ‘health ambassadors’ in their local community. [Might Royal Colleges also wish to model this?]
- Time to Change - indicating that the NHS as a local employer should be signing up, and encouraging the NHS to offer more supported job opportunities to experts by experience, such as people with learning difficulties, who can help to drive changes in culture and services. (p.14)
- Commitment to empowering patients - enable access to records, managing own health, informed choices and peer support communities, with a nod to the role of the voluntary sector (p.12) [How might this work for especially vulnerable patients?]
- Greater integration, year of care payments and range of models for how services might move towards better integration without top-down dictats; particular models are proposed for adoption in different areas, but it will not be about ‘1000 flowers bloom[ing]’.
- General promotion of prevention and early intervention and leaning toward primary and community care
- Mention of the Crisis Care Concordat: ‘proper funding and integration of mental health crisis services, including liaison psychiatry’ (p.22)
- Various proposals to support carers
• Fairly ambitious plans for working through/developing and evaluating the various suggested models of more integrated care all of which will need a mental health element
• They will commission a review of future models for maternity units to report next summer which provides an opportunity for Perinatal.

Public Health

'Getting serious about prevention' - much emphasis is given to the need for a 'radical upgrade in prevention and public health'. Although this is not explicitly discussed in relation to mental health, with the exception of dementia, there are arguments to be made for mental health in this area (e.g. evidence-based parenting programmes (surely part of ensuring 'children get the best start in life' and minimum unit pricing - it does mention that 'a third of people drink too much alcohol')). (pp 9-10).

It is argued that the NHS 'can and should now become a more activist agent of health-related social change' through leading or advocating for 'a range of new approaches to improving health and well-being'.

Note: It states that 'Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government'. (Exec Summary, para 2).

Through the College's Public Mental Health Network, the Mental Health Champions and the College Divisions we could seek involvement with the various local/regional initiatives that are peppered throughout the document providing examples of innovative approaches to care, e.g. 'The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents' - are we involved in both these Commissions?

There is agreement with the Local Government Association (LGA) that local authorities should have enhanced powers to allow democratic decisions on public health policy 'that go further and faster than prevailing national law - on alcohol, fast food, tobacco and other issues that affect physical and mental health' [my emphasis - it is new to include mental health in these contexts]. (p10).

Targeted prevention - mentions proactive primary care being central to the NHS's role in secondary prevention.

Ambition: to become the first country to implement at scale a national evidence-based diabetes prevention programme. This will be modelled on proven UK and international models. NHSE and PHE will establish a preventive services programme to expand evidence-based action to other conditions.

This presents opportunities for us to help ensure the mental health elements of such conditions are fully considered.

Cancer prevention: smoking
They will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase
[their] focus on pregnant women and those with mental health conditions. (p37).

**New models of care**

England described as too diverse for a 'one size fits all' approach. A number of new models of care will be available for areas to adopt. These will focus on breaking down the historical divide between primary care, community services, and hospitals, recognising that patients increasingly need services based in all three.

'Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time'. (p.16).

**New care model – Multispeciality Community Providers (MCPs)**

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

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

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. [They] will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

**New care model - urgent and emergency care networks**

This includes proper funding and integration of mental health crisis services, including liaison psychiatry.

**New care model – viable smaller hospitals (pp 22-23).**

Three models are envisaged, to build on the forthcoming recommendations of the Dalton Review, focusing on e.g. sharing back-office functions, integrating local acute services with primary and community services, and smaller hospitals having some services provided onsite by a specialist provider.

**New care model – specialised care (pp 23-24).**

This focuses on consolidating specialist care into fewer centres, e.g. for stroke and cancer patients and specialised surgery.
New care model – enhanced health in care homes
This focuses on providing more active health and rehabilitation support in the community to delay admission to avoid or delay permanent admission to a care home, and ensuring that people with dementia living in care homes have their health needs regularly assessed and met to help avoid admission to hospital.

Local partnerships with Social Services Departments and the opportunities presented by the Better Care Fund will be used to develop in-reach support including medication reviewed, medical reviews and rehab services. This work will build on models that have been shown to improve quality of life, reduce hospital bed use by a third, and save more than they cost.

New care model – modern maternity services
This states that research shows that for low-risk pregnancies babies born in midwife-led units or at home do as well as babies born in obstetric units, and have fewer interventions. NHSE will commission a review of future models of maternity units to report by next summer (2015). This will focus on developing maternity services in safe, effective and efficient manner, and will be carried out alongside other initiatives, such as increasing midwife numbers.

[This review presents an opportunity for the Perinatal Faculty to help influence improved mental health provision in the perinatal period].

Other mechanisms:

- They will 'create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and ‘fast track’ a cross-section of the new care models.

Alignment of NHS leadership
NHS England, Monitor, the NHS Trust development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England are being asked to work more in concert to 'improve the[ir] impact and reduce the burden on frontline services', specifically through:

- supporting the development of new local care models
- greater alignment between their respective local assessment, reporting and intervention regimes for Foundation Trusts, NHS Trusts and CCGs, 'complementing the work of CQC and HEE'. This will include 'more joint working at regional and local level, to develop a whole-system, geographically-based intervention regime where appropriate'.

NHSE will also develop a 'new risk-based CCG assurance regime. This will lighten the quarterly assurance reporting burden from those that are high-performing, and set out a new 'special measures support regime' for those that are struggling'.
[DN: how will under-performance be assessed? To what extent might this include a failure to commission appropriate and sufficient mental health services?]

- existing flexibilities and discretion will be use to deploy national regulatory, pricing and funding regimes to support change in specific local areas when it is in the best interests of patients.

**Research**

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

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

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

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

**Innovation**

They will explore the development of health and care ‘new towns’. England’s population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this. (p35)

*Mental health should be fully considered in such developments.*