



Integrated primary and acute care systems (PACS) - Describing the care model and the business model

Our values:

clinical engagement, patient involvement,
local ownership, national support

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

| | |
|---|----|
| Contents | 3 |
| 1 Introduction and summary | 4 |
| 2 Illustrating the PACS care model: the core elements of a population-based accountable care model | 7 |
| 3 The PACS business model: options for commissioning and providing a PACS | 20 |
| 4 Appendix A: Summary of the core elements of the PACS care model | 29 |

1 Introduction and summary

Introduction and summary

- 1.1** Two population-based new care models are central to delivering the vision of the NHS Five Year Forward View: integrated primary and acute care systems (PACSS) and multispecialty community providers (MCPs).
- 1.2** The PACS and MCP vanguards now cover about eight per cent of England. But nearly all the sustainability and transformation plans (STPs) involve population-based accountable care models of this kind. So we want national coverage of these models to grow to 25 per cent next year and to 50 per cent by 2020. Linked to STPs, funding will be made available to support new sites from 2017/18 to achieve this growth, where they can clearly show they are planning to implement a PACS or an MCP model.
- 1.3** This framework document uses the learning from the nine PACS vanguards to support local health and care systems planning to implement a PACS model. It is best read alongside the recent MCP framework.¹
- 1.4** Like an MCP, a PACS is a population-based care model based on the GP registered list. A PACS aims to improve the physical, mental and social health and wellbeing of its local population and reduce inequalities. It can only succeed with general practice at its core.
- 1.5** A PACS brings together health and care providers with shared goals and incentives, so that they can focus on what is best for the local population. The current fragmented and complex contracting, funding and governance systems within the NHS, and between NHS and social care, frustrate a focus on population health. Joining up services in a PACS allows better decision-making and more sustainable use of resources, with a greater focus on prevention and integrated community-based care, and less reliance on hospital care.
- 1.6** PACSS and MCPs differ in scope and scale. Both include primary, community, mental health and social care, but a PACS also includes most hospital services. As a result, a PACS offers the potential to transform the entire hospital business model, across inpatient, outpatient, medical and surgical pathways. A PACS may also be larger than an MCP, serving the population of its local hospital as a minimum. In some smaller STPs, where there exists good geographical alignment between local health and care services, a PACS may cover the whole geography.
- 1.7** Wherever they emerge, PACSS will not exist in isolation but will need strong relationships with other providers and services. For example, the acute trust in a PACS may join a hospital group or other acute care collaboration (ACC) to support sustainability of acute services over a bigger geography. Some PACS vanguards, notably those in Salford Together and Northumberland Accountable Care Organisation, are establishing hospital groups in this way.
- 1.8** Each PACS will differ slightly, in how services are delivered, but there will be common elements. These elements are not novel in their own right - across the NHS there are examples of how these new services are being implemented. But the radical feature of the PACSS is their systematic implementation across a whole geography, supported by a new payment, contracting and organisational model.
- 1.9** The evidence from the PACS vanguards so far illustrate a care model operating at four levels of population need as described below. We will do further work with the vanguards and other new sites to refine and codify this model.

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf>

- 1.10** First, a PACS has a focus on prevention and population health management. This means recasting the relationship between local people and their health and care services. A PACS will connect people to community assets and resources to help keep them well, working with local government and voluntary sector, using social prescribing and other tools. A PACS will use person-level and population data to organise care around people's needs and preferences, not those of organisations.
- 1.11** Second, a PACS provides urgent care that is integrated with primary, community, mental health and social care, reducing the need for emergency or unplanned interventions. The hospital will deliver only the services it needs to deliver.
- 1.12** Third, a PACS ensures people with ongoing care needs receive more coordinated care, with more services in the home and community settings. It will deliver this through integrated, multi-disciplinary community teams, by linking hospital specialists to community-based care, and making greater use of technology to deliver care remotely.
- 1.13** Finally, a PACS will do all it can to manage people with the most complex health needs in the community. Through these measures, a PACS may reduce the number of hospital beds, with inpatient care only for those who need intensive or complex care.
- 1.14** A PACS will need a new business model to deliver the care model. PACSs will operate as accountable care models: providers will be commissioned, paid and held to account on the basis of shared goals for population health. This has significant implications for how commissioners and providers operate and are organised.
- 1.15** Commissioners will need to implement new contractual models for a PACS. Three PACS contracting models are emerging: the 'virtual' PACS, where providers are bound together by an alliance agreement; the 'partially integrated' PACS, where a contract is let for the vast majority of health and care services with a single budget; and the 'fully integrated' PACS, where there is a single contract for all local health and care services, operating under a whole-population budget.
- 1.16** Providers will need to consider the organisational or contractual form that best suits their local context. The PACS contract could be held by a new entity, formed for example through a joint venture between a group of GPs, an acute trust, and other local health and care providers, or held by an existing NHS provider.
- 1.17** The PACS model redefines the responsibilities between commissioner and provider. Commissioners will need a more strategic focus and to work in an integrated way across the NHS and with local government. Providers will need to develop new capabilities and skills, including population health management and the ability to manage multiple sub-contractors.
- 1.18** In summary, the evidence so far suggests five crucial elements for success of the PACS model:
- A real commitment to **partnership working** between local providers so that GPs in particular genuinely feel they are full partners in the model;
 - A **data-driven care model** that organises care around population segments;
 - Integrated **neighbourhood health and care teams**, working at a population size of 30,000 to 50,000;
 - Flexible use of **workforce and technology**, that can disrupt existing ways of working and span organisational boundaries;
 - A **contracting, funding and organisational model** that is designed to deliver the population-based care model.

2 Illustrating the PACS care model: the core elements of a population-based accountable care model

How can a PACS be developed?

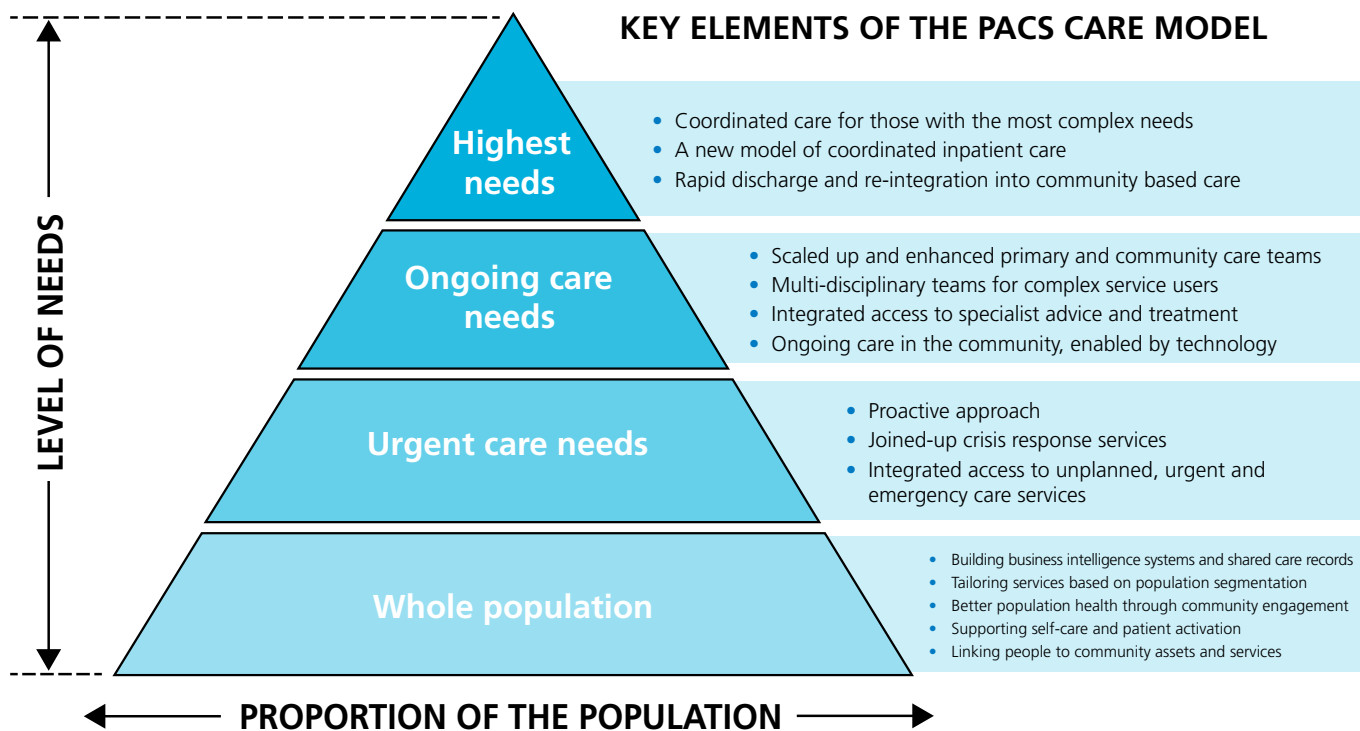
- 2.1 It may take several years for a PACS to reach full maturity and effectiveness. Based on the learning from the vanguards, five tasks are essential for success.
- 2.2 First, **build collaborative system leadership and relationships around a shared local vision for the local population**. This means engaging the community, commissioners and providers, including all local GPs, to agree on a different way of providing care. The PACS model offers the NHS and local government an opportunity to work more closely together to deliver social care as well as collaborate on a wide range of other services including housing, licensing, planning and public health.
- 2.3 Second, **develop a system-wide governance and programme structure to drive the change**. Partners should support the work with a programme 'engine room', staffed by their best people, clearly showing that this is not just a change programme, but is about developing a completely different way of working. It is also crucial to identify clinical leaders to drive the change - and give them capacity and resources to do so.
- 2.4 Third, a PACS must carry out detailed work to **design the care model, financial model and business model**, based on the needs of the local population. A 'logic model' should explain how the changes will lead to the outcomes that the PACS wants to achieve.² A PACS will adopt or adapt the NHS Rightcare method, which supports commissioners to understand and tackle unwarranted variation in the health outcomes and costs of their population (www.rightcare.nhs.uk). Aspirant PACSs will also need to establish the financial case, committing to a clear return on investment, so that there is a compelling and credible proposition for service change.
- 2.5 Fourth, a PACS must **develop and implement the care model in a way that allows it to adapt and scale**. Changes to services tend to be most effective when starting small. Most PACSs start testing the care model on a locality or neighbourhood basis. They will need a rapid-cycle approach to implementing and adapting the care model, with processes in place to both identify successes and rapidly address any failures.
- 2.6 Finally, a PACS will need to **develop and implement appropriate changes to contracting, payment and organisational form to support the delivery of the new care model**. (See Chapter 3.)

² Care models and logic models of the nine PACS vanguards are available on request from ENGLAND.pacsframework@nhs.net

The key features of the PACS care model

- 2.7** PACSs will increasingly form a common, identifiable model as they implement this framework in a systematic way, ensuring both the depth and the breadth of its components are implemented. None of the individual elements of the care model is in itself new; they are being applied across the NHS. The innovation is in applying them in a systematic way, across a whole geography, and supported by a new business model. To support vanguards and future sites, we are developing an 'implementation matrix' for each new care model. This will set out systematically the key elements required to implement each care model. For further information about this and other products and materials available from the new care models programme, as well as the vanguard examples detailed below, please contact england.pacsframework@nhs.net.
- 2.8** All PACSs build upon two key enablers - staff and technology. They empower a wide range of staff to work in different ways by creating new multi-disciplinary teams, redesigning more rewarding jobs that are sustainable and efficient, and implementing new professional roles. A PACS will also harness digital technology, not only to provide interoperable (shared) care records and real time data, but to redesign the process of care delivery.
- 2.9** As with the MCP, the PACS care model operates on four levels of population need. The PACS care model bears many similarities to the MCP model, but the wider scope of the PACS model has distinctive implications, in particular for hospital services. Figure 1 illustrates the care model and Appendix A summarises the key elements.

Figure 1 - The four levels of the PACS care model



A) Whole population - prevention and population health management

2.10 A PACS needs to practise population health management. This means two things. First, a PACS needs the data, systems and capabilities that give it deep understanding of its population - including skills and expertise that have traditionally been found in commissioning. This will enable a PACS to plan services and allocate resources by segmenting service users based on their demographics and needs. This should include planning services that are accessible for people with different protected characteristics and those who experience health inequalities. Second, a PACS needs to apply effective approaches to prevention, public health and self-care that unlock the power and potential of communities to reshape the relationship between service users and health and care services.

Building shared care records and business intelligence systems

2.11 A PACS will need connected, real-time data sets for all health and care services, accessible in all care settings and to patients and service users. These will be the foundation for the whole population health model. PACSs will ensure that they use and join up data safely, by conducting privacy impact assessments to ensure that they use data in line with the Data Protection Act 1998. They will also apply the tools developed with the integrated care pioneer programme by the Information Governance Alliance.³

2.12 At an individual level, consent-based shared care records help professionals deliver safe, personalised care. **Healthy Wirral** vanguard's shared care record brings together primary, hospital and community care records with mental health and social care information, so that service users no longer need to repeat the same information to different professionals. The **Salford Integrated Record (SIR)** was launched in 2009 and enables GPs and acute clinicians to access the combined data set from their respective patient administration systems. SIR2 is currently in development with an expected go live in late 2016. This new integrated record will combine richer data sets from GP, acute, mental health and social care. Users will be able to access the combined data seamlessly from their own systems in patient context. Many of the challenges of integration will be tackled with advanced tools that allow automatic demographic matching and mapping of clinical terms to common headings.

2.13 Integrated data sets drawn from shared records need to be complemented by business intelligence systems that analyse health and care needs at the population level to inform the design and delivery of services. Health and care professionals should use these systems to provide simple risk stratification tools. For example, the **Healthy Wirral** vanguard is working with a private supplier to develop a care dashboard that will draw information from primary, acute and mental health services and enable GPs to identify patients at risk of deterioration. Through community-based IT tools, the **Tower Hamlets Together** MCP vanguard is helping GPs to reach and support people at risk of developing end stage kidney disease (ESKD).

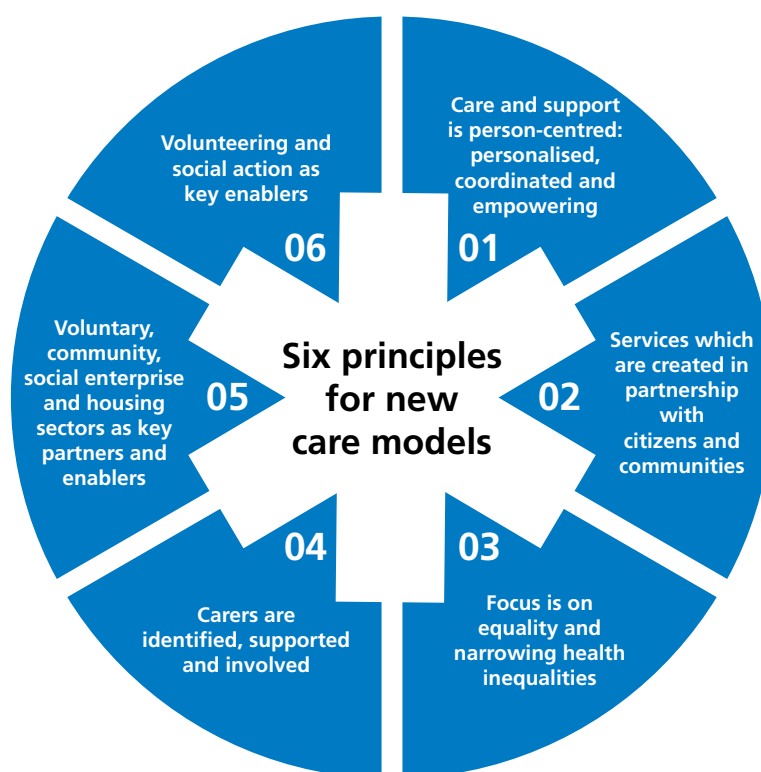
³ <http://systems.hscic.gov.uk/infogov/iga/resources>

Tailoring services based on population segmentation

- 2.14** These business intelligence systems support new service design through patient segmentation. For example, **South Somerset Symphony Programme** vanguard has used these techniques to identify the most complex four per cent of patients and provide them with intensive, personalised support through complex care hubs.
- 2.15** This segmentation approach can also help develop tailored preventative services. In **North East Hampshire and Farnham**, mental health crisis support was identified as a service gap that was driving A&E activity. The vanguard introduced The Safe Haven project, a crisis café which provides a safe, supportive, therapeutic environment which promotes independence, opportunity and recovery in the community. It is overseen by a steering group which transcends traditional agency and community boundaries. The model has now been expanded to cover six locations across North East Hampshire.

Better population health through community engagement

- 2.16** Both PACSs and MCPs will only be successful if they build new, stronger relationships with their local population, using the six principles for effective local engagement.



- 2.17** The Millom Alliance in **Better Care Together (Morecambe Bay Health Community)** is a good example of this kind of community engagement. The alliance is a partnership between GPs, the community trust, acute and ambulance trusts, social care and the community that has been in place since June 2014. As a result of a number of alliance initiatives, between 2014/15 and 2015/16 there was a 29 per cent reduction in the number of emergency occupied bed days in Millom and Duddon Valley.

Supporting self-care and patient activation

- 2.18** A PACS will improve patient activation through approaches such as health coaching, self-management and education that build knowledge and raise citizens' awareness, skills and confidence.
- 2.19 North East Hampshire and Farnham** recently launched a 'recovery college' offering courses in various psychological, mental and physical health conditions to help people improve their health and wellbeing. The first students reported an improvement in wellbeing between the first and final week of the course, plus a reduction in service usage.
- 2.20 South Somerset Symphony Programme** vanguard has implemented a health coaching model at scale. Health coaches ensure service users take responsibility for their own health by understanding what is important to them, and offering both empathy and challenge. Around 50 health coaches now work across the majority of the local GP practices.

Linking people to community assets and other public services

- 2.21** Clinical services alone have a limited impact on broader health and wellbeing. A range of other social and economic determinants, including good housing, financial stability and strong social networks, have much greater impact. PACS vanguards can help connect people to sources of community support and public services including schools, housing associations, job centres, and youth justice and probation services.
- 2.22** Social prescribing, care navigators and care coordinators can help link people to these resources. In **North East Hampshire and Farnham**, 'Making Connections' has been set up for the over 75s by Age UK and the CCG. GPs can refer people to the service and a care navigator will find local services that suit their needs. Modelled after a successful scheme in Western Australia, the **My Life a Full Life (Isle of Wight)** vanguard has recruited six local area coordinators who work with parish councils and the voluntary sector to connect people with community resources.
- 2.23** PACSs are also making links with wider local government services. In Garstang, part of the **Better Care Together (Morecambe Bay Health Community)** vanguard, the local team has partnered with the fire service over static caravan fire safety and with the police around dementia 'wanderers'. In Carnforth, local GPs have worked with schools to implement 'Let's Get Moving' - an initiative to get pupils exercising regularly, which involves pupils and teachers running a mile each day. **Salford Together** includes an initiative on health and housing that brings seven local housing providers together with social care and health teams who coordinate discharge and community services. This initiative is putting simple practical measures in place to reduce falls, decrease isolation and loneliness, and improve discharge support.

B) Urgent care needs - integrated access and crisis response teams

2.24 A PACS will focus on predicting and preventing the need for emergency or unplanned intervention. When crises do occur, community-based rapid response services will help avoid the situation getting worse. A single front door will make access to urgent care seamless. The traditional A&E department will be much more closely integrated with services in the wider system, with people only attending hospital when their needs cannot be met through a community response.

A proactive approach to urgent care

2.25 When a PACS is fully developed the need for emergency or unplanned responses should be much reduced. Stronger, more resilient communities, good care planning and expert multi-disciplinary case management should ensure that potential problems are identified and addressed well before the need for a 'blue light' response.

Joined-up crisis response services

2.26 When urgent care is needed, a PACS will provide community-based alternatives to avoid unnecessary attendances at the emergency department. The scale of a PACS offers the prospect of more sustainable primary care out-of-hours services. New workforce models may help sustain these services, for example by providing multi-disciplinary crisis response and 'hospital at home' services. For example, **Northumberland Accountable Care Organisation** vanguard is developing a same-day acute visiting service. Where needed, staff will admit directly to hospital wards, bypassing the emergency department.

2.27 The **Mid Nottinghamshire Better Together** vanguard's 'call for care' service provides one single number for the local ambulance service, GPs and out-of-hours (OOH) health and social care professionals to access urgent health and care services. Following initial streaming the call is then transferred to a clinician (pathway coordinator) who will agree and coordinate the delivery of care. This reduces unnecessary GP, ambulance or A&E attendances and hospital admissions, and improves the experience for the service user.

2.28 Co-located hubs may also provide simplified access to integrated primary, community and social care urgent and emergency services. The **My Life a Full Life's (Isle of Wight)** integrated care hub houses 999 call operators, NHS 111 call handlers, paramedic clinical advisers, a crisis response team, GP out of hours services, district nurses, social workers, pharmacists, the private pendant alarm company Wightcare, occupational therapists and Age UK. The crisis response team co-ordinates the delivery of services, with instant access to each individual's records for all these organisations. Since April 2015, the crisis team estimates it has saved £725,000.

2.29 PACSs will all operate as part of a system where the following eight urgent care commissioning standards are met:

- Patients can make a single call to get an appointment out-of-hours (OOH);
- Data can be sent between providers;
- The capacity for NHS 111 and OOH appointments is jointly planned;
- The summary care record is available in the clinical hub and elsewhere;
- Care plans and patient notes are shared between providers;
- The system can make appointments to in-hours general practice;
- There is joint governance across local urgent and emergency care providers;
- There is a clinical hub containing (physically or virtually) GPs and other health care professionals.

Integrated access to unplanned, urgent and emergency care services

2.30 A PACS will simplify the route into unplanned or urgent and emergency care, providing people with the services that best fit their needs. **Northumberland Accountable Care Organisation's** specialist emergency care hospital (The Northumbria) is a single location where those who are the most seriously ill or injured receive specialist emergency care. Service users with less urgent health needs access care through local urgent care hubs which co-locate GPs, OOH providers, community teams and other urgent specialist advice. The Northumbria has recorded a 14 per cent reduction in emergency admissions since opening in June 2015 (7,496 people). This equates to a saving of over £6 million for 2015/16.

2.31 **Salford Together's** single integrated hub for the co-ordination of social care and community health service provision opened in 2014. It supports professionals in multi-disciplinary groups to prevent and manage crises in the community by providing a single point of access to district nursing, social care, community equipment and out of hours services. As the service develops it will help people to navigate wider wellbeing services and support mechanisms through a link to a public health database. It includes access to 24/7 telehealth/telecare monitoring.

C) Ongoing care needs - enhanced primary and community care

- 2.32** Ongoing care means different things for different segments of society. For the older population and those living with a number of long term conditions, services need to offer coordinated and tailored person-centred care alongside access to support and advice that allows people to maintain control of their day-to-day life. For a younger, more mobile population it may mean more flexible ways to access care.
- 2.33** A PACS will use its workforce and technology flexibly. Specialist care will be linked with generalists for the better management of chronic conditions. Mental health professionals will be embedded in physical health teams, and vice versa, to ensure that the wellbeing of people with long term conditions is addressed and that the inequalities in physical health outcomes for people with mental health conditions are reduced. Integrated social care services can reduce the impact and incidence of physical and mental ill-health by supporting people to live better, more fulfilled lives as well as providing essential services to those who need them.

Scaled up and enhanced primary and community care teams

- 2.34** Integrated primary and community-based care is core to the PACS model. It must always include a resilient model of general practice, with enhanced input from a range of other services. Teams will need greater input from pharmacists, social workers and mental health professionals, and hospital consultants among others, to better manage complex needs. As new teams move into community-based settings, teams will need to change and a systematic and standardised community services model will need to be developed, as Bromley Healthcare has done, supported by technology.
- 2.35** **Salford Together** vanguard is enhancing the range of services provided in primary care through extensive investment in practice-based pharmacy. Pharmacists in GP practices, in liaison with primary care teams, will be able to resolve medication needs for the frail and elderly and those with long-term conditions closer to home. **Northumberland Accountable Care Organisation** is also developing a GP pharmacy service to increase general practice capacity whilst improving care, quality and outcomes. The three-year programme will see recently qualified pharmacists integrated within general medical practices, rotating between the practice and the hospital.
- 2.36** PACSs will also be well placed to deliver improvements in access to general practice as described in the General Practice Forward View. National requirements around GP access will be included within the PACS contract, and applied as additional investment comes on stream, in line with the planning guidance annex on implementing the General Practice Forward View. A fully-fledged PACS should offer patients the choice of electronic appointments and prescriptions, and greater support for self-care, for example, through the use of health apps and telecare.

Multi-disciplinary teams for service users with complex needs

- 2.37** Integrated multi-disciplinary teams (MDTs), each serving neighbourhoods of around 30,000-50,000 people, are central to the PACS and MCP model. These MDTs will wrap around GPs as the holders of the registered population list. The teams will target those people who are at greatest risk of developing complex needs as well as those who already need high levels of support. Effective MDTs will include GPs, practice nurses, district nurses, social workers, acute consultants (such as geriatricians) and mental health and voluntary sector expertise. They will identify cases from the registered list and meet regularly to review them. Between these meetings there should be mechanisms for the teams to discuss cases in real time and to access advice and support from each other to avert crises. Each team member will thereby become more efficient, with less duplication of assessments and fewer contacts for patients. The scale of a PACS should allow for efficient procurement of mobile devices and technology to support this.
- 2.38** All PACS vanguards are implementing versions of these teams. The **Mid Nottinghamshire Better Together** vanguard has put in place PRISM (profiling risk, integrated care, self-management) teams across its 12 localities. People at high risk of future admission are identified and then given co-ordinated care by an MDT. Evidence suggests the teams have been particularly effective in reducing hospital length of stays, contributing to an overall reduction in bed day activity in 2015 compared with other areas.
- 2.39** In **Harrogate**, mental health advanced nurse practitioners and senior mental health practitioners work across all four integrated care teams to promote management of mental health problems to patients, offering assessment, advice, education and triage.
- 2.40** An important role for MDTs will be to offer patients personal health budgets. Giving people control to shape and manage their care and make meaningful choices is central to the NHS Five Year Forward View's vision. We will support all PACSs to adopt the integrated personalised commissioning (IPC) model fully, bringing greater precision to the commissioning and delivery of care, with personal health budgets available to a small but growing proportion of its population including those with complex long term conditions, wheelchair users, people with significant learning difficulties and mental health needs.

Integrated access to specialist advice and treatment

- 2.41** Advances in technology and clinical treatments, from minimally invasive surgery to secure teleconsultations, mean that fewer 'specialist' services now need to be delivered in a traditional hospital setting. A PACS will integrate specialist doctors and nurses into neighbourhood care teams to deliver a new way of accessing advice and treatment in the community. Clinicians and service users will be able to design pathways of care that are based around blending clinical skills, shared decision making and agreeing shared outcomes, minimising wasted time and resources.

- 2.42** In practice, this will mean that diagnostic tests will be carried out in the community where feasible. Decisions about treatment options will involve the user and their carer/family when appropriate. Elective surgery will increasingly take place as a community-based or outpatient procedure. Pre-operative discussions for hospital procedures needn't be in the hospital; admission can be on the day of the procedure. Rapid discharge will be combined with community-based therapy, with rehabilitation and social care teams supporting recovery.
- 2.43** Integrating specialists into neighbourhood-based teams will also allow PACSs to take a radically new approach to proactive care in long-term conditions. Clinical consultants and specialist nurses will work with GPs and other community-based staff to optimise management of diseases across the whole pathway. For example, **South Somerset Symphony Programme** is implementing community-based virtual clinics for patients with Type 1 diabetes.
- 2.44** Alternatives to outpatient appointments will be scaled up, with fewer follow-up appointments. 'One stop' models will mean service users don't need to attend multiple locations at different times for the same condition. For example, the cardiology and respiratory teams in **Stockport** have set up a one-stop diagnostic clinic for patients with breathlessness to accelerate testing and diagnosis across these two specialties.
- 2.45** Traditional referral pathways will change. PACSs will use e-referral systems as part of the national programme to make all referrals digitally by 2018. And instead of being sent from a primary care doctor to a hospital, people will be able to access advice and guidance from specialists in the community. The **Better Care Together (Morecambe Bay Health Community)** advice and guidance scheme uses technology to provide advice from hospital specialists to GPs electronically, and is operating across 16 specialties and 43 GP practices.

Ongoing care in the community, enabled by technology

- 2.46** Technology is redefining the way that traditional outpatient care is delivered. Using learning from systems where physicians now handle patients via telehealth and in person, PACSs will explore how these new processes can be implemented at scale. PACSs are already testing how a variety of telehealth solutions can enable GPs and users to seek advice from specialists whilst in a GP practice consulting room.
- 2.47** For example, virtual hospital consultations for residents in the Millom community of **Morecambe Bay** have helped reduce unplanned hospital admissions by 23 per cent. The osteoarthritis team in **Harrogate** is offering telephone clinics to confirm the results of MRI tests, reducing the number of people seen face-to-face.

D) Highest care needs - coordinated community-based and inpatient care

2.48 In a PACS, incentives will be aligned towards prevention. People with the most complex needs, and their carers, need expert advice on treatment options, ongoing support to manage their wellbeing, and practical help to enable them to remain independent. Social care integration is crucial in providing expert assessment and access to equipment alongside clinical care. PACSs will work to minimise admissions to hospital and care homes. Where hospital admission is necessary, PACSs will provide high-quality inpatient services, with care coordinated with the wider system, to return people to good health. In many cases PACSs may identify people with high care needs but low clinical complexity, and provide care and support services in the community to help them live as independently as possible.

Better care for patients with complex needs and high costs

2.49 For high cost patients with multiple long term conditions, and complex needs, the unique link between primary, community, social and hospital care within a PACS gives the opportunity to develop an approach that blends the generalist and specialist skills around the needs of the patient. For example, a PACS will develop clinical roles which specialise in complexity and follow the patient between hospital and community settings - the 'extensivist' model.

2.50 **South Somerset Symphony Programme** vanguard has set up complex care hubs to improve support, prevent avoidable hospital attendances and admissions, facilitate early discharge, and avoid further deterioration for people with multiple long-term conditions. A unified approach and single care plan is accessible to both primary and secondary care and other partners in a timely way. As well as improving outcomes for patients, this new way of working has helped the local system recruit new doctors where it was previously struggling. Early results indicate a 30 per cent fall in emergency admissions and reduced length of stay when patients are admitted.

A new model of coordinated inpatient care

2.51 Within a PACS, hospital inpatient care will be for those with the most serious care needs; all other care will be in the community. For services such as end of life or maternity care, where the place is critical to a good experience, high quality inpatient services will be part of a wider community- and home-based offer.

2.52 During a hospital stay, a PACS will attend to the patient's full needs whether they are physical, mental or social. Continuity of care will be paramount, with high quality care provided 24/7. Patients should not move onto a ward after surgery unless this transfer is absolutely necessary for their clinical care.

- 2.53** Inpatient care will be co-ordinated and connected with GPs, social care, community services, carers and families, with easy in-reach for community support. This will improve care co-ordination, reduce the risk from multiple hand-offs, and ensure smooth admission and discharge. Practically, this could mean joint ward rounds between the enhanced primary care team (GPs, nurses, social workers and therapists) and hospital clinical staff, to review patients on their case load when they have been admitted. Frimley Park hospital, part of the **North East Hampshire and Farnham** vanguard, has employed a GP to work alongside the hospital respiratory team, spending one day a week with the complex discharge team to identify people who could be discharged and provided with a care package in the community.
- 2.54** Regular review will ensure that even when acutely ill, patients receive care and support from teams who know them and their condition well. This will enable early supported discharge back into the integrated community multidisciplinary team when appropriate. GPs will be able to discharge patients or 'step down' services when appropriate. Further rehabilitation and recovery will be provided in the community.
- 2.55** More radically, a PACS could think about managing some wards across the acute and community divide - imagine a single clinical team with half their patients in acute beds and the other half in 'virtual beds' at home.
- 2.56** An international example involved a provider that completely redesigned their system of inpatient care to improve quality and reduce costs. A physician, nurse, and pharmacist visit each new patient within 90 minutes of admission to review their case and devise a single care plan with the patient's input. Lean methodology was used to redesign and reconfigure clinicians' roles, all acute care processes, and even the physical setting to make them more efficient, effective, and patient-friendly.

Rapid discharge and re-integration into community based care

- 2.57** Patients will be fully involved in their discharge planning even before admission. Arrangements needed for further care will be clear and responsibility will be clearly allocated when patients move from one care setting to another. Services will be designed to facilitate reintegration into less acute settings. A PACS will enable local services to work together to deliver a smooth transition between inpatient and community settings, implementing the best practice already set out in NICE guidance.⁴
- 2.58** **Mid Nottinghamshire Better Together** vanguard has already established a multi-disciplinary intensive home support service (IHSS) to reduce hospital admissions and facilitate discharge. They are exploring recruiting advanced nurse practitioners (ANPs) to make this service nurse-led. These ANPs will follow people from primary care, through intermediate care and into the hospital, and they will do the same for discharge, ensuring a seamless transition between care settings.

⁴ Transition between inpatient hospital settings and community or care home settings for adults with social care needs www.nice.org.uk/guidance/ng27

3 The PACS business model: options for commissioning and providing a PACS

The PACS business model: options for commissioning and providing a PACS

- 3.1** Changing the care model is the most critical task for developing a PACS. Achieving this change requires effective system leadership and strong relationships and trust between the various partners. It needs an agreed vision and a shared understanding of the new care model and each partner's role in it as well as a strong financial case backed by evaluation and learning mechanisms.
- 3.2** A PACS may take a transitional approach in its development, but sooner or later it will need a new business model to sustain it for the long term. This new business model will redefine the roles of and relationship between providers and commissioners.
- 3.3** A PACS will need to be formally commissioned so that money flows and contracts support the goals of the care model. Providers will also need to consider new organisational structures to support their staff to achieve the goals of a PACS.
- 3.4** A common theme from all of the vanguards is that they wanted national help in working out the best approach. This chapter should be read in conjunction with the MCP framework. Many of these challenges will be similar to those facing MCPs but the scale and scope of PACSs mean that there will also be distinct challenges.
- 3.5** In a number of geographies, including those with PACS and MCP vanguards, commissioners will be changing how they contract with providers during 2017/18 or 2018/19, rather than rolling forward existing contracts for two years.

Who commissions a PACS and what is their role?

- 3.6** A PACS is a whole population health and care system. At its most developed it will include primary, community, mental health, social care and most acute services for the population it serves. In terms of acute services, a PACS will include all secondary care and some tertiary care services. Some specialised services commissioned by NHS England could be in scope for a PACS. These services could be commissioned collaboratively with the local commissioner(s), which could involve including some services in the PACS contract itself. Depending on circumstance, it may also include other local authority services like public health.
- 3.7** Commissioning a PACS will require NHS and local authority commissioners to work closely together and agree robust and sustainable collaborative commissioning arrangements. We expect PACSs to explore expanded collaborative commissioning models that bring together funding for NHS and social care services that have historically been funded separately. This will include agreements to pool budgets and develop shared decision making processes.
- 3.8** Accountable care models like MCPs and PACSs redefine the roles of commissioner and provider. NHS England is working with a number of vanguards to establish which activities must always remain with the CCG (or other commissioners), and which activities an MCP or PACS would perform under contract.

- 3.9** Commissioners will retain a strategic role, which would likely include setting contract outcomes, managing the procurement process, overseeing the PACS delivery against the contract, and ensuring service user voice and choice are maintained. The PACS provider, meanwhile, would have the freedom to define the detailed service model, determining how providers (including sub-contractors) would work together to deliver this and defining the operating and governance model across the PACS.
- 3.10** As PACS models emerge, CCGs and other commissioners may need to address potential conflicts of interest. Some of the people driving the development of a PACS may currently work in CCGs but in future may wish to take up a role in the new PACS provider organisation. That is entirely understandable and legitimate. In some places it may not be possible for a CCG to commission the PACS without experiencing significant conflicts of interest. NHS England would expect CCGs to take appropriate steps to address this situation, for example by working with NHS England, and with neighbouring CCGs and local authorities, to ensure that a fair and transparent commissioning process is undertaken. What is appropriate will depend on the specific circumstances but as a principle, we would expect existing CCG staff who expect to migrate to a prospective PACS to divest themselves of any involvement in CCG business related to the procurement. NHS England is working with vanguards and with legal advisors to establish protocols for managing conflicts of interest in commissioning new care models, and will publish additional guidance later this year.
- 3.11** In all cases in planning and delivering services local consideration of equality and health equalities is required, and local commissioners and providers must be able to evidence how they have done this.

What are the contractual models for a PACS?

- 3.12** As for MCPs, there are three broad versions of contracting for a PACS emerging: a virtual PACS, a partially integrated PACS and a fully integrated PACS. All three are voluntary options and local areas will need to make the choice that best meets their needs. Although these are not sequential models, it may be that local systems work through these options in stages, as a way of enabling relationships to develop and as a means of managing risk.
- 3.13** In a **'virtual PACS'**, providers of services within the scope of the PACS care model and (if required) their commissioners would enter into 'alliance arrangements'. Strictly speaking this is not a new contractual model, as it overlays rather than replaces traditional commissioning contracts. An alliance agreement could establish a shared vision, ways of working and the role of each provider in the PACS. Some local systems are describing this kind of arrangement as an 'accountable care system'. As with MCPs, the virtual PACS model is easier if GPs have already come together to operate at scale. This type of arrangement is a pragmatic step forward and is the least disruptive. It adds an extra layer to an already complicated set of contractual arrangements, rather than simplifying these. It is the weakest form of a PACS in terms of its rights to create and manage integrated provision, and its ability to deploy resources flexibly.

- 3.14** Some virtual PACSs are already emerging among the vanguards. The **Mid Nottinghamshire Better Together** alliance identified that current contracts and incentives for providers do not encourage organisations to work together, so they are developing a new way of contracting and paying for services that is based more on outcomes than activity. To help address this they developed an alliance contract between all the local providers and the two CCGs, which went live in April.
- 3.15** The second model is the **partially-integrated PACS**. This is a step beyond an alliance approach in which commissioners re-procure, under a single contract, all services that would be in the scope of a fully-fledged PACS except for core primary medical services. The resulting contract could include some aspects of local enhanced primary care services. By agreement, it could also add QOF and directed enhanced services. The contract holder would be required to integrate directly with primary medical services delivered under general medical services, personal medical services and alternative provider medical services.
- 3.16** Commissioners in a number of the vanguards, including **South Somerset Symphony Programme** and **Northumberland Accountable Care Organisation**, are exploring the potential for letting contracts to partially integrated PACS providers in 2017/18.
- 3.17** The third model is the **fully integrated PACS**. Here the PACS holds a single whole-population budget for the full range of services in scope including primary medical services. It best reflects the logic of the new care model with the greatest freedom to redesign care and workforce roles. It can more easily redefine the line between what the CCG does and what the PACS does. Getting there is complicated, more radical and furthest away from the status quo.
- 3.18** These three versions serve to illustrate a spectrum of what is possible. All three are voluntary options. Developing a new care model is an organic process, and a single national contracting solution will not work everywhere. Local areas will need to work through the trade-offs between: (i) the degree of formal integration they want to achieve; (ii) their appetite for change; and (iii) the pace at which they wish and are able to proceed. Some areas may choose to stick with an alliance or the partially integrated model. Others may find this doesn't enable them to secure enough of the benefits of the fully integrated PACS. It is too early to say; the different models have not yet been fully developed or implemented. Some PACSs may develop from a relationship that develops between an MCP and a local acute provider, but an MCP arrangement is not a necessary precursor.

What organisational form might a PACS provider take?

- 3.19** One of the key objectives for the PACS model is to encourage more co-ordinated care between health and care providers. A PACS will need to bring together a range of services that currently sit across a number of different providers. Therefore, in developing plans to deliver a PACS, prospective providers will need to agree an organisational form and decide how it will relate to GP practices and other staff groups.

- 3.20** In all cases, a PACS will need to be a formal legal entity, or group of entities acting together, that is capable of bearing the financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance. The robustness of this organisational form will be assessed as part of the new 'joint assurance' process being developed by NHS England and NHS Improvement. It is quite likely that many existing organisations that deliver parts of the proposed PACS model will be unable in isolation to be credible holders of a fully integrated PACS contract, and they will need instead to forge a new entity.
- 3.21** The precise form of legal entity of a PACS will be for local determination. This could either be a contractual structure (such as a contractual joint venture) or a single organisation. This entity may, of course, sub-contract elements of the services to existing or new providers. If it is a single organisation it is equally conceivable it could be a new entity as it could be an existing NHS entity. Options include:
- an **existing NHS trust or foundation trust taking a lead role** across the system.
 - a **limited company or limited liability partnership (LLP)**. This could be newly formed as a corporate joint venture vehicle for the purposes of delivering the PACS contract. It would need to meet all the safeguards and assurance tests that will be applied by NHS England and NHS Improvement in the light of issues that have arisen in some previous cases where this has been tried by trusts. Parties to a joint venture may be shareholders or members and would need clear decision-making rights over the running of the PACS and its budgets. A joint venture company would need to be sufficiently robust to hold a contract as a single legal entity with the commissioner.
 - a **community interest company (CIC)** - a company, bringing parties together with community interest values and using its assets and profits to improve the care of the population.
- 3.22** Vanguard are already exploring different organisational forms which could have the potential to be commissioned as a PACS. In South Somerset providers are considering creating a new entity, Symphony IACO (Integrated Accountable Care Organisation) Joint Venture, as a partnership between Yeovil District Hospital FT and local GPs. Salford Together has established a new integrated care organisation (ICO). The ICO brings together 2,000 members of staff from across the city's health and social care system into a single organisation. The ICO has a combined budget of £213 million and is responsible for providing district hospital services, community health services and social care, as well as securing Salford's mental health services, home visits and care homes. In Northumberland, Northumbria Healthcare NHS Foundation Trust is developing an accountable care organisation which has the potential to be commissioned as a PACS.

3.23 With the vanguards, the national bodies will develop examples of organisational forms in local systems, to avoid other local systems needing to initiate duplicative work. The work with the vanguards and experience from the GP access fund have already highlighted a number of issues related to organisational form:

- **Pensions.** Where the PACS is a lead provider, engaging GPs and others under sub-contracting arrangements, there was a concern that income derived under those arrangements would not be pensionable for the purposes of the NHS pension scheme. We have agreed with the Department of Health to amend regulations to allow GMS/ PMS contractors to pension subcontracted income subject to certain conditions, and are working with them to review the need for further changes;
- **Clinical negligence.** The Department of Health and NHS England are working with the NHS Litigation Authority to provide information to potential PACS providers on their options for securing cover. We will work with the medical defence organisations and the commercial insurance industry where required to ensure clarity around the PACS model of care;
- **Parent guarantees.** NHS England and NHS Improvement are working with vanguards to understand how parent guarantees could operate for independent PACSs;
- **VAT.** NHS England and the Department of Health are in discussion with Her Majesty's Revenue and Customs (HMRC) about the VAT rules that will apply to PACS arrangements, with a shared desire to maintain NHS providers' existing ability to reclaim VAT on contracted out services;
- **Regulation.** The CQC is committed to supporting the new care models, and will explore the right approach to registration in each case. Depending on the organisational form and accountability arrangements, this could include a single CQC registration for a PACS. Prospective PACSs will be subject to the fundamental, legal principles governing CQC registration, as are all health and adult social care services. Prospective PACSs are encouraged to make early contact with the CQC about issues concerning organisational forms and registration and to get in touch with a locally-based CQC contact to explore their specific needs.⁵ This will also allow the CQC to learn and adapt its approach.

How can GPs relate to a PACS?

3.24 General practice must be at the heart of the PACS model, as with the MCP model. The PACS model opens up the prospect of a wider set of options for how GPs and other clinicians could relate to the NHS. Depending on the organisational form, these professionals could include any one or more of: (i) partners or stakeholders in a CIC or other limited company; (ii) subcontractors or independent contractors operating under a clinical chambers model, where the PACS manages the service infrastructure; (iii) employees of a main PACS contract holder; or (iv) employed within a staff mutual organisation. This provides the opportunities for GPs and others to relate to a PACS in a way that works for them.

⁵ Questions can be directed to: enquiries-newmodelsofcare@cqc.org.uk

- 3.25** There would be local flexibility for the organisation holding a PACS contract to agree remuneration and new ways of working to support the integration of services. GP participation in a PACS arrangement also has implications for their current contractual arrangements. One option is that GPs participating in a PACS leave their current contractual arrangements permanently.
- 3.26** Discussions with the vanguards have shown that, for now, many GP partnerships wish to retain the option of returning to their GMS or PMS arrangements in future, not least because of the perpetuity of these contracts. We are discussing with the Department of Health an amendment to the relevant primary care legislation to create such an option. This amendment could provide a mechanism for GPs who are enthusiastic about the model to move with greater confidence to a new PACS. An amendment to regulations would create a formal provision by which commissioners could agree with GPs/practices to 'suspend' a GMS or PMS contract for a defined period of time that aligns to the PACS contract term and which allows for a return to a GMS or PMS contract at a defined future point. In the interim, the suspension would allow the PACS contract to provide for the provision of primary medical services to the relevant patient list, and GPs could take a full part in the PACS arrangement in all of the ways described above. The terms on which GPs did so would be a matter for local discussion in line with the new care model.
- 3.27** One option to consider in the partially integrated PACS model is to manage primary medical care contracts differently at a local level, helping to implement the care model but without all aspects of primary care services being provided for in any new contract. Possibilities include additional integration agreements overlaying GMS/PMS or sub-contracting arrangements, which could break down boundaries and commit GPs to new ways of working (e.g. by working at scale, redesigning the workforce, and developing operational protocols). By agreement, these arrangements could also add QOF and DESs. In all of these arrangements, the governance and accountabilities must be sufficiently strong to deliver the care model effectively.

What will a PACS contract comprise?

- 3.28** Like an MCP but with a wider scope, a PACS will deliver services that are currently commissioned through both primary medical services contracts (whether GMS, PMS or APMS) and NHS standard contracts, as well as any local authority services that are determined to be in scope. The contract which underpins a partially or fully-integrated PACS needs to be a hybrid of these as the MCP contract will be. It will need to set the terms upon which the PACS will be paid and how it will be held to account by its commissioner(s) to achieve specified outcomes and standards across the defined range of services, including what happens when things go wrong or when there is a breach of the contract's terms. NHS England is currently developing a national MCP contract. A PACS contract, to be developed by summer 2017, will be substantially similar to the MCP contract and learning from the MCP contract will be applied to the development of the PACS contract.

- 3.29** The PACS contract will be of longer duration than those that are typically offered to NHS providers at present but with an initial early break-point (e.g. after the first two or three years of the contract term). This is to provide stability and support ongoing investment in care redesign. In the period before the breakpoint, there would be scope to learn and adjust through an agreed mechanism. At the time of the break-point, if the break 'right' is not exercised, then there may be the ability to vary the contract, e.g. to add a wider range of services. The contract will also allow for some ongoing adaptation, e.g. additional GP practices joining. The development of the PACS would be set out in the procurement.
- 3.30** An important role for commissioners will be to describe the full scope of services to be delivered by the PACS, and develop a service specification. The specification will consist of mandated national requirements, core elements of the PACS care model, and local service requirements and standards. The mandatory requirements will include relevant legislation, NHS Constitution commitments and objectives set in the Government's Mandate to NHS England. As a probable single provider, it will be particularly important for a PACS to support and safeguard the patient choice agenda.
- 3.31** The intention is that a fully-integrated PACS will receive a single budget - the 'contract sum'. The sum will cover the whole population budget, a portion of which becomes the PACS performance payment. In an MCP a risk/gain share mechanism across different organisations is designed to align incentives across the whole system, but the wider scope of a PACS means this is either unnecessary or will be much less significant in scope.
- 3.32** Merging separate existing funding streams into a single payment made to the PACS should allow for more flexible allocation of resource, directed towards the areas in which the funds will have the greatest impact on population health. The whole-population budget will cover the full scope of services to be provided to its population. The population of a PACS is defined as the patients registered with participating GPs, plus an estimate for its share of people living in the PACS locality who are not registered with a GP.
- 3.33** The initial value of this whole-population budget will be calculated on the basis of the current commissioner spend across services in scope. For services where commissioner spend is uncertain, an approximation will be made of the share of the contract value associated with the PACS population. The intention is for whole-population budgets to be multi-year, adjusted broadly in line with changes in CCG allocations, and to achieve reasonable improvements in provider efficiency.
- 3.34** A performance payment component of the total PACS contract value reflects the aim of the PACS in improving population health, quality, and outcomes, enabling a focus on specific quality improvements. International capitation systems generally include quality incentives, as does general practice in England. The PACS performance payment will effectively supersede the existing commissioning for quality and innovation (CQUIN) and quality and outcomes framework (QOF) schemes for providers that become part of the PACS. Given that CQUIN is a smaller proportion of provider income than QOF, we expect the scale of the PACS performance payment to reflect this. It would be easier to bring about this change under the fully integrated PACS model. The intention is for the performance payment to be stretching but achievable - to get the right balance between supporting improvement and a high level of earn-ability. We know that current performance payments form part of the core cost base of the provider; they are certainly not just marginal.

How could a PACS be procured?

- 3.35** The commissioning bodies that could be party to a PACS contract are one or more of: a CCG (or multiple CCGs), NHS England (in respect of those services that it directly commissions), and the local authority (if social care or public health, including health visiting services, is provided by the PACS). As with the award of any other NHS commissioning contract, commissioners must comply with procurement regulations - both the NHS Procurement, Patient Choice and Competition Regulations 2013 and the Public Contract Regulations 2015.
- 3.36** However, commissioners have the flexibility to design their procurement process and selection criteria for contracting healthcare services to suit local circumstances, as long as the process is consistent with the principles of transparency and equal treatment. Commissioners will need to complete a number of steps to ensure that they conduct a process that complies with procurement law and with other legal obligations. The new care models team can advise on this.

4 Appendix A: Summary of the core elements of the PACS care model

Appendix A: Summary of the core elements of the PACS care model

| Care model element | Sub-element |
|---|---|
| 1. Whole population - prevention and population health management | <p>Building shared care records and business intelligence systems</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Connected, interoperable data sets that can be accessed across all care settings • Business intelligence systems in place that analyse health and care needs at the wider population level |
| | <p>Tailoring services based on population segmentation</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Services that are designed based on patient segmentation approach • A specific focus on preventative services that are tailored to the needs of different communities |
| | <p>Better population health through community engagement</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • The six principles for effective local engagement approach are implemented |
| | <p>Supporting self-care and patient activation</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Improving patient activation through evidence-based approaches such as health coaching, self-management, and education programmes. For example - implementing the Patient Activation Measure tool (www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/) |
| | <p>Linking people to community assets and other public services</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Implementing a recognised social prescribing model • Partnership with local government, community groups, voluntary sector, and other organisations that represent people who use services |
| 2. Urgent care needs - integrated access and crisis response teams | <p>A proactive approach to urgent care</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Early signs of problems are identified and addressed well in advance of the need for a 'blue light' response • Proactive and responsive community services are put in place that can prevent potential acute illness and quickly address unpredictable but low level need |
| | <p>Joined-up crisis response services</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Community-based alternatives, that do not require potential service users and their carers to travel, are put in place to avoid unnecessary attendances at the emergency department • PACSs will implement the eight commissioning standards for urgent care and enhanced access in primary care |
| | <p>Integrated access to unplanned, urgent and emergency care services</p> <p><i>This means:</i></p> <ul style="list-style-type: none"> • Simplified routes into unplanned or urgent and emergency care, providing people with the services that best fit their needs |

| Care model element | Sub-element |
|---|---|
| 3. Ongoing care needs - enhanced primary and community care | Scaled up and enhanced primary and community care teams <i>This means:</i> <ul style="list-style-type: none"> • A systematic and standardised primary and community services model, with a balance of generalist and enhanced roles |
| | Multi-disciplinary teams for service users with complex needs <i>This means:</i> <ul style="list-style-type: none"> • Multi-disciplinary teams in place working together to plan and coordinate a proactive care model • Offer personal health budgets to patients who want them |
| | Integrated access to specialist advice and treatment <i>This means:</i> <ul style="list-style-type: none"> • Specialists integrated into neighbourhood care teams within the community • Offering patients choice • Elective surgery and diagnostics increasingly in community settings • Hospital discharge should be combined with community based therapy |
| | Ongoing care in the community, enabled by technology <i>This means:</i> <ul style="list-style-type: none"> • Telehealth solutions implemented • Electronically facilitated access to specialist advice and guidance in place |
| 4. Highest care needs - coordinated community-based and inpatient care | Coordinated care for those with the most complex needs <i>This means:</i> <ul style="list-style-type: none"> • Implement an extensivist model for high cost patients with the most complex needs |
| | A new model of coordinated inpatient care <i>This means:</i> <ul style="list-style-type: none"> • During a hospital stay, a PACS system must attend to the patient's full needs whether they are physical, mental or social • Inpatient care will be co-ordinated and connected with GPs, social care, community services, carers and families, with easy in-reach into the hospital for a patient who is admitted • Coordinated discharge planning |

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

Our values: clinical engagement, patient involvement, local ownership, national support

www.england.nhs.uk/vanguards