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Chapter Two: What will the future look like? A new relationship with patients and communities		
Getting serious about prevention		
We have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments. We need a range of new approaches to improving health and wellbeing.	*Incentivising and supporting healthier behaviour* For all major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.	Halton supports additional actions to incentivise and support healthier behaviour. There is strong collaboration across organisations and sectors within the borough on these issues. We also influence national and local policy by working with other local authority areas across Cheshire and Merseyside through CHAMPS. Our Director of Public Health also engages with counterparts across the North West England through the North West Directors of Public Health and their change manifesto. Halton also supports Food Active (formerly Heart of Mersey) in national actions on labelling and product formulation. We are working with Drinkwise on influencing local licensing policy, Minimum Unit Pricing and with the industry locally to improve standards. Halton has a number of co-ordinated

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		initiatives in place to make the night-time economy more vibrant, diverse and safer. These schemes include Purple Flag and Archangel. We work closely with Tobacco Free Futures to influence across the region and develop policy. Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce. As the lead agency, Halton Borough Council is co-ordinating and implementing local action and activity with take away outlets to increase awareness of healthier choices. We are developing targeted personal support around parenting programmes through our Children's Centres. We also have a number of initiatives that empower communities to act for themselves and for the population by influencing and improving health literacy.

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	Local democratic leadership on public health Local Health and Wellbeing Boards to drive health improvement. English mayors and local government need to be granted enhanced powers to allow local 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.	Halton has a strong and vibrant Health and Wellbeing Board. The Halton Health and Wellbeing Board has clear public health oriented priorities, that are shared across the participant organisations. The Halton Health and Wellbeing Board is already providing leadership, support and direction on alcohol, fast food, tobacco and other issues that affect physical and mental health. Local democratic leadership is also being provided though the Licensing Committee through encouraging the breathalysing of individuals entering licensed premises to assist licensees in refusing service and working on the late night levy. Supplementary planning guidance is also in place to allow the Planning Committee to limit take away outlets from opening near to schools and in clusters. Halton would welcome enhanced powers to allow local democratic decisions on public health policy to go further than prevailing national law, where appropriate.

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	Targeted prevention Proactive primary care needs to be central to delivery of evidence-based intervention strategies. Over the next five years England will become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.	NHS Halton CCG was pivotal in the introduction of the impaired glucose regulation (IGR) programme for diabetes in Merseyside. As part of the development of this work there was correspondence with NICE who were developing their recommendations at the time. The IGR pathway is linked with the Health Check and Healthy Weight programmes. It is being systematised across all practices in the borough. An evaluation of the IGR programme will enable improvement and learning and identify opportunities to address any unwarranted variation. We would expect there is considerable alignment between the programme we have in place at the moment and the national programme. We recognise that targeted prevention is essential. We have in place or are developing evidence-based action in regard to dementia, hypertension, cardiovascular disease (CVD), cancer and respiratory conditions. We have identified that around 40% of our population have poor health outcomes, experience significant inequalities and access support

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		late in the progression of their disease or condition. We believe that there is a significant opportunity to work differently to target prevention at this cohort of our population through working the voluntary sector and other organisations such as Cheshire Fire Service.
	NHS support to help people get and stay in employment There is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods – particularly in regard to mental health problems and musculoskeletal complaints. A new government-backed Fit for Work scheme starts in 2015. During the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.	We agree that the NHS has a greater role to play in supporting to help people get and stay in employment. We will investigate the implications of the Fit for Work scheme to see how we can maximise opportunities to help people get and stay in employment. We are already considering access to and maintenance of employment in a number of areas. For example, NHS Halton CCG is undertaking a redesign of MSK services, which will look to increase integration across the service and move from an activity based contract to outcomes based contract, these outcomes are expected to include a focus on maintaining and returning to work. Implementation of the Family Nurse Partnership will support young parents to

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		build confidence and return to training and/or employment. Finally, our Community Wellbeing Practices have been working on supporting people back into work alongside existing organisations in the borough.
	Workplace health There is merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.	As an employer, NHS Halton CCG provides incentives and practical support to enable staff to stay healthy and maintain their wellbeing. There are also opportunities for staff to act as "health ambassadors". OTHER NHS ORGANISATIONS? Halton Borough Council is recruiting a new Environmental Health post which will work with local employers to address workforce health. This role needs to be linked in with partners, including NHS partners, in the borough. We believe that there is more that we can do to help local employers improve the health and wellbeing of their workforce.
Empowering patients		
Personalised care will only happen when	*Improved information*	

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statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.	Improve the information to which people have access—not only clinical advice, but also information about their condition and history. Within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.	NHS Halton CCG and Halton Borough Council, working with provider organisations, are developing a Health and Social Care Information Management and Technology (IM&T) Strategy that will enable citizens have access to their medical and care records.
	Support people to manage their own health Enable people to stay healthy, make informed choices of treatment, manage conditions and avoid complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.	In Halton we recognise that we need to create more opportunity to support people to manage their own health, as they are often 'experts by experience'. We are supporting the re-implementation of Expert Patient to support other initiatives. For example, NHS Halton CCG already commissions a comprehensive diabetes education programme. In conjunction with the Mersey Diabetes Network a further piece of work is being undertaken to further increase the number of people who access these programmes. We have also brought together our health and wellbeing services to ensure that they

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		promote self-care and health literacy. We are also developing social marketing approaches to self-care. Finally, NHS Halton CCG already commissions a Care at the Chemist scheme to support self-care. The conditions covered by this scheme will be expanded. NHS Halton CCG is also exploring the role of community pharmacy and how pharmacies/pharmacists can support people to manage their own health. We recognise that we need to do more to target support to the 40% of our population who have the worst health outcomes. The voluntary sector and local community networks are vital in this for it is they who can support broadening health literacy, enhancing community resilience and awareness, and moving to asset based approaches.
	Increase the direct control patients have over the care that is provided to them Patients should have choice over where and how they receive care. We will introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex	Progress has already been made in Halton in regard to personalised budgets and direct payments. We would be interested in exploring the implications of IPC further and would also welcome the exploration of 'year of care' approaches.

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	needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.	
Engaging communities		
We need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England.	*Better support for carers* We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – young carers and the carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.	
	Creating new options for health-related volunteering Volunteers are crucial in both health and social care. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10%	NEEDS MORE BUT: The Expert Patients programme will be an ideal opportunity to increase the number of volunteers providing peer support and

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	reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.	training to people with long term conditions. We also have a peer support programme for breastfeeding that provides a wide range of information, advice and support.
	Stronger partnerships with charitable and voluntary sector organisations The voluntary sector is often better able to	

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	reach underserved groups, and is a source of advice for commissioners on particular needs. We will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.	
	The NHS as a local employer The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by	

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	experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.	
The NHS as a social movement		
None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.	Rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are in fact precisely the sort of 'slow burn, high impact' actions that are now essential. They in turn need to be matched by equally radical action to transform the way NHS care is provided.	
Chapter Three: What will the future look like? New models of care		
Emerging models		
The traditional divide between primary care, community services, and hospitals is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three. Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the	• Increasingly we need to manage systems – networks of care – not just organisations. • Out-of-hospital care needs to become a much larger part of what the NHS does. 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	MSK? NHS Halton CCG has been developing a Strategy for General Practice Services as well as reviewing community nursing and out-of-hospital care.

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NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.	addressed at the same time. • We should learn much faster from the best examples, not just from within the UK but internationally. • And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money. We intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.	NHS Halton CCG has expressed an interest in participating in the HOPE exchange programme to increase the sharing of best practice internationally.

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A new deal for primary care		
General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals.	Over the next five years we will invest more in primary care. Steps we will take include: • Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas. • Give GP-led Clinical Commissioning Groups (CCGs) more influence over • the wider NHS budget, enabling a shift in investment from acute to primary and community services. • Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services. • Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off	Suspending the PMS review is clearly a key issue if this is to be made reality for Halton. Within the implementation of co-commissioning of primary care, NHS Halton CCG has the opportunity to support and help shape the new deal for primary care. With robust governance arrangements in place, member practices input into this will be essential and will help shape future local models. There are clearly risks over funding and having the management capacity to do this for Halton CCG.

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	potential returners. • Expand funding to upgrade primary care infrastructure and scope of services. • Work with CCGs and others to design new incentives to encourage new • GPs and practices to provide care in under-doctored areas to tackle health inequalities. • Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.	It does depend on more money being made available for primary care – as yet no formula developed to create fare share targets for pCrimary care allocations. Will Halton get any additional resources to make this a reality?
New care model – Multispecialty Community Providers		
Primary care is entering the next stage of its evolution. The traditional model has been evolving. Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer	To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients. • As larger group practices they could in future begin employing consultants or take them on as	NHS Halton CCG and partners are working on a strategy for general practice services and a new model for out of hospital care. There has been some initial thinking about models of care that wrap services around groups of practices. This could be the basis of a local MCP type model, although NHS Halton CCG is keen to focus on a model of Multispecialty Community Provision with existing partners as supposed to be focused on creating a Multispecialty Community Provider.

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some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.	partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff. • These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings. • They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy. • GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries. • They could in time take on delegated responsibility for managing the health service budget for their registered patients.	NHS Halton CCG has already indicated that the Urgent Care Centres could expand their offering to pick up more out-of-hospital care. There is a challenge as to whether this would increase service costs without rationalisation of acute hospital facilities. The implementation of the Strategy for General Practice Services in Halton will include exploring further partnerships with the voluntary and community sector and community pharmacy.

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	Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers. • These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours. We will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure.	
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. We will now permit a new variant of integrate 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	• In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to	It is difficult to see how, with two acute providers, a newly designated community FT and an established mental health FT this model would work in Halton. Implementation would be problematic and it is unclear what safeguards would be in place for out of hospital care, without significantly changing the current PbR contractual system.

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these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.	kickstart the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways. • In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital. • At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries. PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small	It is unlikely that the developing MCP model in Halton would be in a position to take over a DGH or indeed aspires to do so. The most radical model would need to legislation - if all GPs were part of this it could be indistinguishable from the CCG and conflicts of interest may arise. Halton's local environment does not lend itself to a PACS model.

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	number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.	
New care model – urgent and emergency care networks		
Over the next five years, the NHS will do far better at organising and simplifying the system.	This will mean: • Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists. • Developing networks of linked hospitals that ensure patients with the most serious needs get to	NHS Halton CCG is leading a Mid-Mersey group examining the options for stroke services, including the location of hyper-

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	specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured. • Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes. • Proper funding and integration of mental health crisis services, including liaison psychiatry. • A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully. • New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.	acute services at a single hospital site. How will this be funded given very low levels of NHS growth funding?
New care model – viable smaller hospitals		
England already has one of the more centralised hospital models amongst advanced health systems. It is right that these (smaller district general) hospitals should not be providing complex acute services where there is evidence that high	We will now take three sets of actions. First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of	Both our acute providers are considered to have hospitals that are “small”. Changes to the system could pose a financial risk to NHS Halton CCG.

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volumes are associated with high quality. Some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country. In some case there may be a need to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities.	delivering safe and efficient services for smaller providers relative to larger ones. Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures. Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the forthcoming Dalton Review, we intend to promote at least three new models: • In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. • In another new model, a smaller local hospital might have some of its services on a site provided by	

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	another specialised provider. • And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.	
New care model - specialised care		
In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur.	In services where the relationship between quality and patient volumes is strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets.	
New care model – modern maternity services		
Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years. Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with	To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will: • Commission a review of future models for maternity units, to report	

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fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.	by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS. • Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them. • As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.	
New care model – enhanced health in care homes		
One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.	In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.	
How will we support the co-design and implementation of these new care models?		

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Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above. However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding. In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel. In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so. It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies	We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop: • Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs. • A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be. • National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several hundred million pounds on bodies that directly or indirectly could	

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jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.	support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore 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. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to	

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	use accrued savings on their balance sheets to help local service transformation.	
Chapter Four: How will we get there?		
We will back diverse solutions and local leadership		
Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. There is no appetite for a wholesale structural reorganisation.	NHS England intends progressively to offer CCGs more influence over the total NHS budget for their local populations, ranging from primary to specialised care. Joint commissioning models will include Integrated Personal Commissioning as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. Changes in local organisational configurations should arise only from local work to develop new care models or in response to clear local failure and the resulting implementation of special measures.	
We will provide aligned national NHS leadership		
NHS England, Monitor, the NHS Trust Development Authority, the Care	We intend to develop our shared work:	

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Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services.	• Through a combined work programme to *support the development of new local care models.* • Monitor, TDA and NHS England will work together to create 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. • NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling. • Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients. • The key NHS oversight organisations will come together regionally and nationally to *share intelligence, agree action and*	

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	monitor overall assurance on quality. The National Quality Board provides such a forum, and we intend to reenergise it.	
We will support a modern workforce		
We need a workforce with the right numbers, skills, values and behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important. Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. These increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. We have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.	By supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them. Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models	

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	of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care. HEE will work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come. More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage recruitment and retention in parts of the country and in	
Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce.		

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	occupations where vacancies are high.	
We will exploit the information revolution		
Progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. The NHS is not yet exploiting its comparative advantage as a population-focused national service. The NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense - at times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.	In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards. A National Information Board has been Established. The NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include: • Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care. • An expanding set of NHS	NHS Halton CCG and Halton Borough Council are currently developing a joint health and social care strategy which will cover all the points listed in this section.

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	accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion. • Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care. • Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere. • Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.	

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	• Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.	
We will accelerate useful health innovation		
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 we 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	

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	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, we 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	

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	doing so can be supported by those manufacturers who would like their products evaluated in this way. • A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them. • The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE. • The average time it takes to translate a discovery into clinical practice is however often too slow.	

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	So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.	
Accelerating innovation in new ways of delivering care		
We have an unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'. The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system,	Over the next five years we intend to: • Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites. • Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of	

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with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.	answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care. • We 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.	
We will drive efficiency and productive investment		

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It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.	*Demand* On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years. *Efficiency* Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this. A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some	

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	others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff. Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting,	

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	from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years. *Funding* NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. • In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity	A key question for Halton is how the allocation formula may impact on future funding growth. Halton is likely to get a bottom range of uplift for CCGs, although the inclusion of primary care (formula still be developed) and some specialised services in CCG commissioning responsibilities may help reduce over target for Halton.

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	gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion. • In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion. • In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21. Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-	

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	funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.	