⚙ WIRRAL

Health and Wellbeing Board

Date:	Wednesday, 12 November 2014
Time:	4.00 pm
Venue:	Committee Room 1 - Wallasey Town Hall

Contact Officer:	Pat Phillips
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AGENDA

1. **DECLARATIONS OF INTEREST**

    Members of the Board are asked whether they have any personal or prejudicial interests in connection with any application on the agenda and, if so, to declare them and state the nature of the interest.

2. **APOLOGIES FOR ABSENCE**

3. **MINUTES (Pages 1 - 2)**

    To approve the accuracy of the Minutes of the meeting of the Health and Wellbeing Formal Board on 17 September, 2014.

4. **UPDATE ON RESPONSE TO BETTER CARE FUND SUBMISSION**

    Verbal report – Graham Hodkinson.

5. **NHS ENGLAND UPDATE ON WINTER PLANNING AND FLU PLAN.**

    Verbal report – Andrew Crawshaw.

6. **UPDATE ON CHILD SEX EXPLOITATION IN WIRRAL (Pages 3 - 16)**

7. **WIRRAL'S PHARMACEUTICAL NEEDS ASSESSMENT (PNA): UPDATE ON PROGRESS AND TIMESCALES. (Pages 17 - 18)**

8. UPDATE ON CHILDREN & FAMILIES ACT

To be circulated at the meeting – Julia Hassall.

9. CARE ACT IMPLICATIONS - UPDATE ON PROGRESS AND EMERGING PLANS (Pages 19 - 28)

Written report and presentation – Graham Hodkinson.

10. QUARTERLY SUMMARY OF HEALTH WATCH

Verbal report – Phil Davies, Chair, Healthwatch Board.

11. FOR INFORMATION (Pages 29 - 98)

- NHS Five Year View

- From evidence into action: opportunities to protect and improve the nation's health.

12. DATE OF NEXT FORMAL BOARD MEETING

The date of the next formal Board meeting is Wednesday 11 March, 2015 at 4:00pm, Committee Room 1, Wallasey Town Hall.

HEALTH AND WELLBEING BOARD

Wednesday, 17 September 2014

<u>Present:</u>

Cllr C Jones	Portfolio Holder for Adult Social Care (in the Chair)
Cllr P Gilchrist	Leader of the Liberal Democrat Group
Ms F Johnstone	Director of Public Health
Cllr T Smith	Portfolio Holder for Children's Services
Mr G Hodkinson	Director of Adult Social Services
Mr A Cannell	Chief Executive, Clatterbridge Cancer Centre
Mr A Hassall	Director of Strategy & Partnerships, Wirral University Teaching Hospital
Mr K Carbery	Business Manager, Public Health, Wirral Council
Mr J Lancaster	Director of Operations, Wirral Community NHS Trust.
Ms V McGee	Cheshire and Wirral Partnership NHS Trust
Ms S Cumiskey	Cheshire and Wirral Partnership NHS Trust
Dr P Naylor	Wirral Health Commissioning Consortium
Mr R Freeman	NHS England
Chief Superintendent John Martin	Merseyside Police
Paul Murphy	Merseyside Fire and Rescue

58 APOLOGIES FOR ABSENCE

Apologies were received from Councillor P Davies, Councillor J Green, Ms J Hassall, Director of Children's Services, Mrs A Roberts, Voluntary and Community Action Wirral, Mr P Davies, Healthwatch, Wirral, Mrs J Webster, Head of Public Health, Mr S Gilby, Wirral NHS Community Trust, Mr D Allison, Wirral University Hospital Trust and Mr A Crawshaw, NHS England.

59 DECLARATIONS OF INTEREST

Councillors C Jones and P Gilchrist declared a personal interest in all agenda Items by virtue of them both being appointed Governors of Cheshire and Wirral Partnership Trust.

60 MINUTES

That subject to the addition of Mr A Hassall to the apologies for absence and the addition of Chief Superintendent John Martin to the attendance list, the accuracy of the Minutes of the Health and Wellbeing Formal Board held on 9 July, 2014 be approved as a correct record.

61 RE- SUBMISSION OF THE BETTER CARE FUND SUBMISSION

Ms Jacqui Evans, Department of Adult Social Services and Ms Sarah Quinn, Wirral CCG attended the meeting and provided members with an update on the Better Care

Fund's re Submission. Jacqui Evans acknowledged the support of colleagues and outlined the key areas – the National Context, Re-Submission requirements, Key areas for discussion and Timelines and next steps.

Members commented on the report and Jacqui Evans and Sarah Quinn responded to members questions.

Mr G Hodkinson commented that the challenge was huge at a time when the demand for growth was huge however Wirral was in a good a position as any Health economy and everyone was very committed to working together. Dr Peter Naylor endorsed these comments and took the opportunity to thank Jacqui Evans and Sarah Quinn for all their hard work and this was echoed by the Chair of the Health and Wellbeing Board.

Resolved – That the re submission of the Better Care Fund Submission be agreed.

WIRRAL HEALTH & WELLBEING BOARD

Meeting Date	12 November 2014	Agenda Item	

Report Title	Update on Child Sex Exploitation on Wirral
Responsible Board Member	Clare Fish

Link To HWB Function	Board development	
	JSNA/JHWS	X
	Health and social care integrated commissioning or provision	X

Equality Impact Assessment Required & Attached	Yes		No		N/A	x
Purpose	For approval		To note	X	To assure	

Summary of Paper	This report is written following the enquiry into Rotherham Metropolitan Borough Council by Professor Alexis Jay, published in August 2014. It is an outline of the issues arising from the Rotherham Enquiry. It provides details of work that is already taking place to address Child Sexual Exploitation (CSE) in Wirral, and future work is planned. It includes a proposal with regard to how the Local Safeguarding Boards and the Health and Wellbeing Board work together.

Financial Implications	Total financial implication	New investment required	Source of investment (e.g. name of budget)
	£ 8000 There will be costs to funding some of the promotional work that is part of the Wirral Safeguarding Children's Board's Action Plan.	£	Local Safeguarding Children's Board

Risks and Preventive Measures	Without a coordinated multi agency strategy, children may not be appropriately safeguarded from CSE. Preventive measures will be outlined in this report.
Details of Any Public/Patient/ Service User Engagement	• A meeting of leaders of young people's involvement and participation services has been arranged to put in place a set of focus groups with young people to better understand their needs and what works to protect and safeguard them, particularly where

	there may be resource issues.
	• Improved engagement of minority ethnic communities through community leaders and the minority ethnic achievement service will be developed, and included more specifically in the action plan.
	• Arrangements for providing support to all victims will be reviewed and developed as required, and this will be particularly informed by focused work with young people.
Recommendations/ Next Steps	The Board is asked to consider the report and to note the progress to date. The Board is asked to consider the proposed protocol that concerns how the Local Safeguarding Boards and the Health and Wellbeing Board work together in relation to safeguarding issues, such as CSE.

Report History		
Submitted to:	Date:	Summary of outcome:
n/a		

Publish On Website	Yes	X	Private Business	Yes	
	No			No	x

Report Author: Simon Garner
Contact details: simongarner@wirral.gov.uk

Update on Child Sex Exploitation on Wirral

Introduction

Child sexual exploitation is tackled effectively when there is clear and committed leadership and where safeguarding professionals cooperate together. In Wirral direction is provided through the Local Safeguarding Children Board and a regional approach to strategic partnership working. This report sets out a plan of action, delivered with key partner agencies, to identify and support young people at risk of CSE. It explains the range of responses and services that are provided and how greater engagement of the community will support early identification of the risks.

Background

The report by Professor Alexis Jay estimates that 1,400 children were sexually exploited in Rotherham between 1997 and 2013. Professor Jay's report describes the level of abuse as 'appalling' and says it included the rape of girls as young as 11 by large numbers of male perpetrators.

In response to the report Alan Wood, the president of the Association of Director's of Children's Services, has stated that:

"The publication of the Independent Inquiry into Child Sexual Exploitation in Rotherham this week must serve as a call to action for all safeguarding partners to ensure that that the voices of children, young people and their families raising similar concerns in the future are both heard, believed and acted upon and that the necessary help and support is provided when they need it most".

Professor Jay's report made 15 recommendations which included:

- Undertaking and reviewing risk assessments on vulnerable children.
- Protecting children who are looked after, particularly those placed out of borough and those likely to be exposed to CSE.
- Local Authorities to ensure outreach work is available to young people who might not access services.
- Ensuring responses to CSE are properly resourced and communicated.
- Agencies working together to respond to CSE including ensuring long term and therapeutic support is available to victims.
- Engagement between authorities and minority ethnic communities.

The full recommendations can be found in Professor Jay's report and all of which have been considered in developing an action plan for Wirral.

Within Professor Jay's Report, reference is made to the former Director of Public Prosecutions, Keir Starmer, who revised the Crown Prosecution Services guidance on child sexual exploitation in October 2013. The guidance was revised to include a list of stereotypical assumptions previously thought to undermine the credibility of young victims. These included:

- "The victim invited sex by the way they dressed or acted."
- "The victim used alcohol or drugs and was therefore sexually available."
- "The victim didn't scream, fight or protest so they must have been consenting."
- "The victim didn't complain immediately, so it cant have been a sexual assault."
- "The victim is in a relationship with the alleged offender and is therefore also a willing partner."
- "A victim should remember events consistently."
- "Children can consent to their own sexual exploitation."
- "CSE is only a problem in certain ethnic /cultural communities."
- "Only girls and young women are victims of child sexual abuse."
- "Children from BME backgrounds are not abused."
- "There will be physical evidence of abuse."

All of these assumptions have been referred to at some point in historic files read by the authors of the Rotherham report, and usually cited as reasons given by the Police or Crown Prosecution Service for not pursuing suspected perpetrators. This list of stereotypes will be used as a reference point to challenge perceptions of CSE, and responses and behaviours across the Council, partnerships and in the community. This will be done by using this checklist to underpin and inform training, supervision of professionals and case file auditing, to ensure cultural issues are addressed.

The Association of Independent LSCB Chairs have also issued a response to the Rotherham CSE report based on work undertaken by LSCB's across the country to respond to CSE. Their research points to a number of essential factors to enable an effective response to CSE. These include:

- Organisations being alert to the reality of the sexual exploitation of young people.
- Police and children's services having active strategies to disrupt criminal networks.
- Organisations being aware that challenging behaviour by young people shouldn't be discounted as bad behaviour, and may be a cry for help.
- Local leaders being aware and ready to hear the reality of life for vulnerable young people and to ensure professionals are free to voice their concerns – which will be heard and respected.
- Acknowledging that combating CSE requires the active involvement of the whole community and service agencies.
- All child safeguarding education and training should contain a comprehensive section on sexual exploitation, recognising that it has profound health consequences, so that health professionals are supported to respond appropriately to victims.

Key Strategic Partnerships

Health and Wellbeing Boards (HWBs) are responsible for linking the NHS, public health and social care with a wide range of partners. HWBs provide the platform for ensuring commissioned services meet the needs of their local populations. The HWB's decision on whether to prioritise child sexual exploitation should be an informed one, based on a local understanding of the issue. The Local Safeguarding Children's Board, Safeguarding Adults Protection Board and the Health and Wellbeing Board (HWBB) have a draft protocol in place to describe how they work strategically together to address safeguarding priorities in the area. This protocol will be considered at the next meeting of the HWB

Local Safeguarding Children Boards (LSCBs) play a key part in promoting a good response to child sexual exploitation through their co-ordination and monitoring of single and multi-agency safeguarding activity, convening a sub group as appropriate and having a child sexual exploitation strategy, which also links to safeguarding of children missing from care or home and trafficked children. This approach is adopted in Wirral.

Services are needed that provide a range of interventions to young people who have experienced child sexual exploitation, or to adults who later disclose their childhood experiences. These interventions should range from signposting for support, to long term therapeutic interventions. Current service provision will be reviewed in consultation with young people.

A good response to child sexual exploitation requires a multi-agency approach because each agency has specific responsibilities and expertise to offer. The Child Sexual Exploitation sub group of the LSCB provides leadership of this multi-agency approach and leads on the delivery of the CSE action plan.

The Current Position in Wirral Council

In Wirral the prevention of Child Sexual Exploitation is a priority action area for the WSCB, all activity is currently being reviewed in the light of the Jay Report and it's recommendations. This is enabling all partners to test their own responses to vulnerable children, young people and their families, and the effectiveness of our multi agency systems to detect and respond quickly to each and every instance of child sexual exploitation.

In 2012 the Board established a multi-agency strategic CSE sub group including partners from social care, the local authority, police, health agencies, education, public health and the Response service. The sub group works to an action plan linked to an agreed Merseyside protocol for responding to CSE. An important part of the work undertaken is to raise awareness of the risks of CSE.

Prior to this sub group there was a partnership group, reporting to the Area Child Protection Committee and then the LSCB that met to respond to a local report written in 2004 in relation to young runaways and children at risk of sexual exploitation. There was an action plan from the report that the group was responsible for implementing.

In Wirral, there are at any one time between 15 and 30 children who are being considered as at risk of CSE. This does not mean they all require a social work assessment , but it does mean that there needs to be a Multi Agency Child Sexual Exploitation (MACSE) meeting to share relevant intelligence and information to determine how to respond to each child's circumstances. This approach is part of an agreed protocol between Liverpool, St. Helens, Sefton, Wirral and Knowsley and Merseyside Police. The protocol, launched in May 2014 supports the work to identify and provide an assured response to children at risk of CSE. There is a further action going forward to ensure the protocol is embedded fully in practice.

When children are identified as at risk of CSE, they are referred to the MACSE meeting. These meetings have representation from Children's Services, the Police, Health and Catch 22. Catch 22 provide 1:1 support and direct work with children referred. The meeting enables intelligence to be gathered about where there is a risk of CSE , who may be at risk and who they may be at risk from. The information helps inform the Police regarding action against potential or actual offenders as well as addressing local areas or groups who require a more coordinated strategy to reduce risks.

Children may be referred for preventive services and support or a social work assessment. Children would then be subject to a plan to address the presenting safeguarding concerns.

There is an action plan which sets out a range of interventions at a strategic multi agency level, a number of which have already been completed. The CSE sub group has reviewed this action plan and continues to work on evidencing the impact of each of the actions taken. It has also reviewed the referral pathway to ensure that it is clear to professionals how they refer children who they are concerned may be at risk of CSE.

There is a regional group for CSE led by an Independent Chair of a Local Safeguarding Children's Board. The group has met recently for the first time to agree terms of reference and begin a self assessment of readiness to deal with issues of CSE across the region, in the light of the Rotherham enquiry. It takes account of previous reports and research, and tools provided by the National Working Group who advise Government on the issue of CSE.

Actions developed in response to the Recommendations from the Rotherham Enquiry

An assessment of Wirral's partnership actions to date has been undertaken against the content and recommendations of the Jay Report. The actions detailed below have been or are being implemented to strengthen our strategies and approaches to further ensure our ability and capacity too respond to each and every instance of Child Sexual Exploitation.

- Practice guidance has been written to support the Regional CSE Protocol. Briefings will be given during November on how CSE is recognised and responded to across agencies and professionals.

- "Chelsea's Choice", is a theatrical production which provides excellent awareness for, parents, professionals and young people on the issue of CSE. This will be presented at venues around Wirral everyday for a week during February 2014. Dates are being set and schools being approached to stage the play and a workshop, which will follow.

- Meetings will take place this autumn with Head teachers of Primary and Secondary schools where they will be provided with the materials they need to raise awareness in their schools with staff and pupils.

- A group of key professionals will meet in November to look at what services we have and what we can do together to better identify and respond to these young people. The meetings will involve the Director and Strategic Director.

- A meeting of leaders of young people's involvement and participation services has been arranged to put in place a set of focus groups with young people to better understand their needs and what works to protect and safeguard them, particularly where there may be resource issues.

- A "problem profile" on CSE will be written, based on all the known intelligence/relevant data held across different agencies to inform strategic decision making and local practice development. It requires collective ownership across all partners to support its development and a committed/effective analyst to review and identify key findings and intelligence gaps. A meeting is in place to progress completing this work by the end of October this year.

- Thematic multi agency audits of cases will be undertaken in the coming weeks, where children have been harmed or at have been at risk of harm from CSE. Children's voices will be central to the audit and risk assessments will be reviewed on vulnerable children. The audits will include current cases and cases where there have previously been concerns in relation to CSE. There will also be a focus on children looked after who are placed out of borough.

- A meeting of the three party leaders is scheduled to take place at the end of October 2014 to discuss the findings of the Jay report and the response in Wirral. Following this, regular meetings of the Safeguarding Reference Group will be scheduled to ensure clear political oversight.

- Training for members on CSE is being delivered in November 2014.

- Wirral's Multi Agency Safeguarding Hub (MASH) is now operational. The development of a MASH facilitates early information sharing; healthcare professionals are often in possession of key information, along with the Police and Social Care. It is vital that all representatives are involved to develop the most effective response.

- The promotion of services available to young people is being strengthened following focused work that is planned with young people.

- Partner agencies are undertaking an audit of the 'readiness' of their organisation to respond to CSE; this will be monitored through the CSE sub group and additional actions will be incorporated in the current plan.

- Engaging community groups such as taxi drivers and 'night time' economy workers to identify and offer support to vulnerable young people is already taking place, with further work scheduled.

- Improved engagement of minority ethnic communities through community leaders and the minority ethnic achievement service will be developed, and included more specifically in the action plan.

Recommendations

The Board is asked to consider the report and to note the progress to date. The Board is asked to consider the proposed protocol that concerns how the Local Safeguarding Boards and the Health and Wellbeing Board work together in relation to safeguarding issues, such as CSE

Background papers/reference material

1. The Rotherham Enquiry. Professor Alexis Jay : August 2014
2. "If only someone had listened": Office of the Children's Commissioners enquiry into child sexual exploitation; November 2013
3. Health Working Group Report on Child Sexual Exploitation: An independent group chaired by the Department of Health focusing on: Improving the outcomes for children by promoting effective engagement of health services and staff ; January 2014.

Report Author: Simon Garner
Job title: Corporate Safeguarding Manager
Date: 29th October 2014

Appendix 1: Protocol for the relationship between the Wirral Health and Wellbeing Board, the Wirral Safeguarding Children's Board and the Wirral Safeguarding Adults Partnership Board.

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Protocol for the relationship between the Wirral Health and Wellbeing Board (HWB), the Wirral Safeguarding Children Board (WSCB) and the Wirral Safeguarding Adults Partnership Board (SAPB)

1.0   Aim

1.1   *Safeguarding is everyone's business*. As such, all key strategic plans for individual agencies, partnership forums and board's should include safeguarding and the promotion of individual's welfare as a cross cutting theme to support the effective and appropriate delivery of services to Wirral residents.

1.2   The main aim of this protocol is to reinforce this message through the development of a strong relationship between the Wirral Health and Wellbeing Board (HWB) and the Children's (WSCB) and Adults (SAPB) Safeguarding Boards.

1.3   The protocol sets out a framework designed to secure effective joint working between the three Boards to ensure children, young people and adults in Wirral are safeguarded and have their welfare actively promoted.

2.0   Purpose of the Wirral Health and Wellbeing Board (HWB)

2.1   Health and Wellbeing Boards were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

2.2   In April 2013 the Wirral Health and Wellbeing Board (HWB) became a statutory committee of Wirral Council. The Board provides the opportunity for elected members, the NHS, Local Authority officers, and voluntary and community representatives to agree how to work together to achieve better health and wellbeing to all Wirral residents.

2.3   It is the duty of the HWB to tackle health inequalities and to make sure that local people are given every opportunity to live healthy lives. Health inequalities are not inevitable or immutable and reducing health inequalities is a matter of fairness and social justice.

2.4   The vision of the Wirral Health Wellbeing Board is to enable local people to live healthy lives, tackle health inequalities and increase wellbeing in the communities and people of Wirral

2.5   The mission of the Wirral Health and Wellbeing Board is to work across professional and agency boundaries to drive innovation to make a difference to the health and wellbeing of local people by:

   • agreeing priorities and actions to reduce health inequalities and promote health

Draft HWB, WSCB, SAPB Protocol April 2014

and wellbeing
- developing a Health and Wellbeing Strategy
- developing a framework for the effective performance monitoring of the Health and Wellbeing Strategy
- discussing and evaluating joint performance

3.0 Purpose of the Wirral Safeguarding Children Board (WSCB)

3.1 All local authority areas were required to establish a Local Safeguarding Children Board (LSCB) under Section 13 of the Children Act 2004. The Wirral Safeguarding Children Board (WSCB) was established in 2006.

3.2 Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

3.3 The role of the WSCB is to scrutinise and challenge the work of agencies both individually and collectively for the purposes of ensuring agencies adequately safeguard and promote the welfare of children and young people.

4.0 Purpose of the Wirral Safeguarding Adults Partnership Board (SAPB)

4.1 The SAPB is the lead organisation for ensuring all adults in Wirral are able to lead safe, fulfilling lives and are not subject to abuse, neglect, harm and exploitation by others.

4.2 The key objectives of the SAPB, as set out in the Care Act 2014 are:

- to help and protect adults in its area who have need for care and support, are experiencing, or who may be at risk of abuse or neglect, and as result of those needs are unable to protect themselves against the abuse or neglect or risk of it
- to co-ordinate and ensure the effectiveness of what each of its members does.

4.3 The role of the SAPB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to vulnerable adults by individual agencies and to ensure inter agency working in this respect is effective.

Draft HWB, WSCB, SAPB Protocol April 2014

5.0   The Need for Co-ordination of Effective Communication and Engagement between the Boards

5.1   All key strategic plans for the HWB and other influential Boards should include safeguarding and the promotion of individual's welfare as a cross cutting theme to support the effective and appropriate delivery of services to Wirral residents.

5.2   It is the responsibility of the WSCB and the SAPB to scrutinise and challenge these arrangements to ensure adequate safeguarding arrangements exist; it is particularly important that this scrutiny and challenge exists for influential commissioning bodies such as the HWB.

5.3   The Wirral Health and Wellbeing Strategy will become a key commissioning strategy for the delivery of services to children, young people and adults in Wirral and so it is critical that in drawing up, delivering and evaluating the strategy there is effective interchange between the HWB and the Safeguarding Boards.

5.4   To ensure this relationship functions there needs to be formal interfaces between the HWB and the two Safeguarding Boards including:

- The needs analyses that drive the formulation of the annual Health and Wellbeing Strategy and the Safeguarding Boards' Business Plans. This needs to be reciprocal in nature ensuring both that safeguarding boards' needs analyses are fed into the Joint Strategic Needs Assessment (JSNA) and that the outcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of the Health and Wellbeing Strategy and the individual Board Business Plans in a context of mutual scrutiny and challenge;
- Annually reporting evaluations of performance on Plans again to provide the opportunity for reciprocal scrutiny and challenge and to enable Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

5.5   This is reinforced in *Working Together 2013* which states that LSCB's should work with the Health and Wellbeing Board, informing and drawing on the Joint Strategic Needs Assessment.

5.6   The opportunities presented by a formal working relationship between the HWB, the WSCB and the SAPB can be summarised as follows:

- Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA, in line with the draft Working Together guidance
- Aligning the work of the WSCB and SAPB business plans with the HWB Strategy and related priority setting.

Draft HWB, WSCB, SAPB Protocol April 2014

- Ensuring safeguarding is ''everyone's business'', reflected in the public health agenda and related determinant of health PDGs and strategies.
- Evaluating the impact of the HWB Strategy on safeguarding outcomes, and of safeguarding on wider determinants of health outcomes
- Identifying coordinated approach to performance management, transformational change and commissioning
- Cross Board scrutiny and challenge and ''holding to account'': the Health and Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance and contribution to the HWB Strategy.

6.0 Arrangements to Secure Co-ordination between the Boards

6.1 In order to secure co-ordination between the HWB and the Safeguarding Boards it is proposed that the three Boards will work together by:

- The HWB consulting and engaging with the WSCB and SAPB on the review of the Joint Health and Wellbeing Strategy.
- Formally sharing annual plans during the formulation stages to enable co-ordination and coherence where there are business overlaps.
- The WSCB and SAPB providing assurance to the HWB that satisfactory arrangements are in place for Safeguarding adults at risk and children and young people and highlighting concerns where they do not believe that this is the case.
- The WSCB and SAPB scrutinising and challenging the integrated commissioning and quality assurance arrangements across health and social care to ensure that they adequately take account of safeguarding issues.
- The HWB providing information in respect of health and well-being to the WSCB and SAPB annually, to which they will provide a formal response.
- The WSCB and SAPB Independent Chair formally presenting the annual reports to the HWB and the HWB providing a formal response.
- HWB through the Director of Public Health presenting their annual report to WSCB and SAPB
- Identifying a named individual/post to act as a contact point to ensure co-ordination of relevant activities.
- Ensuring that messages and information about keeping children and adults safe are disseminated within partner organisations, including collaborating on stakeholder events
- Ensuring action taken by one body does not duplicate that taken by another
- Where appropriate ensuring that there is cross-Board representation to facilitate coordination and prevent duplication of activity

7.0 Relationship between the WSCB, the HWBB and the Children's Trust Board

7.1 A separate protocol exists which establishes and defines the relationship between the WSCB and the Wirral Children's Trust Board (WCT). The protocol reinforces the message that safeguarding is everyone's responsibility.

7.2 The protocol establishes that the WCT is accountable for overseeing the delivery of the Children and Young People's Plan (CYPP) and for ensuring services deliver improved outcomes for children and young people. The WSCB is responsible for challenging each relevant partner of WCT, through the WCT Board, on their success in ensuring that children and young people are kept safe in the Borough.

7.3 The WSCB and the WCT have established a mutual reporting and challenge regime which compliments the relationship both Boards have with the Health and Wellbeing Board.

8.0 Accountability

8.1 Neither the WSCB nor the SAPB are directly accountable to the HWB so their role in relation to it would be one of equal partners underpinned by this protocol. This would facilitate both Safeguarding Boards' responsibility to scrutinise and highlight any safeguarding concerns they may have relating to the work of the HWB, the WCT or its member organisations.

8.2 This Protocol will be reviewed a year after its agreement and bi-annually thereafter or when national guidance affecting one of the Boards is revised or introduced.

9.0 Resolution Process

9.1 Where there is concern that this protocol is not succeeding in ensuring strong partnership working to keep children and adults safe and healthy, resolution should be sought through communication between the Chair of the HWB, the Independent Chair of the WSCB/SAPB, the Lead Members and the Directors of Children's Services and Adult Services and Public Health.

10.0 Signatures

……………………………………………………… Date…………………………..

Chair, Wirral Health and Wellbeing Board

……………………………………………………… Date…………………………..

Chair, Wirral Children and Adults Safeguarding Boards

Draft HWB, WSCB, SAPB Protocol April 2014

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WIRRAL HEALTH & WELLBEING BOARD

Meeting Date	12 November 2014	Agenda Item	

Report Title	Wirral's Pharmaceutical Needs Assessment (PNA): Update on progress and timescales
Responsible Board Member	Fiona Johnstone

Link To HWB Function	Board development	
	JSNA/JHWS	X
	Health and social care integrated commissioning or provision	X

Equality Impact Assessment Required & Attached	Yes		No		N/A	x
Purpose	For approval		To note	X	To assure	

Summary of Paper	This paper summarises the progress to date towards the publication of Wirral's Pharmaceutical Needs Assessment (PNA) and proposes a timescale for the statutory consultation period.		
Financial Implications	Total financial implication	New investment required	Source of investment (e.g. name of budget)
	£ None	£	£
Risks and Preventive Measures	n/a		
Details of Any Public/Patient/ Service User Engagement	An electronic survey was sent out to the Wirral Borough Council email database of approximately 50,000 residents. Survey details were also published in the Wirral Globe as part of a press release and on the council website. A total of 1,192 responses were received.		
Recommendations/ Next Steps	The Board is asked to note the progress to date and approve the proposed timescales.		

Report History		
Submitted to:	Date:	Summary of outcome:

Publish On Website	Yes	X	Private Business	Yes	
	No			No	x

Report Author: Jane Harvey
Contact details: janeharvey2@wirral.gov.uk

Wirral's Pharmaceutical Needs Assessment: Update on progress and timescales

Background
- Pharmaceutical Needs Assessments (PNAs) are carried out to assess the pharmacy needs of the local population. The PNA presents an overview of local pharmaceutical service provision; reviewing access, range and adequacy of service provision and choice of provider to build on the sectors capacity and capability to help address health inequalities and support self-care in areas of greatest need.

- NHS England will rely on the PNA when making decisions on applications to open new pharmacies. Each Health and Wellbeing Board must publish its first pharmaceutical needs assessment by 1st April 2015. Wirral's current PNA can be accessed at www.info.wirral.nhs.uk/pna

Progress update
- A draft PNA has been developed under the direction of Wirral's PNA Development Group (including members from Public Health, Local Pharmaceutical Committee and NHS England). This group has reported directly to Wirral's JSNA Executive Group.

- Information sources for the PNA have included Wirral's JSNA, NHS England, Census data, Health & Social Care Information Centre (HSCIC), service user and community pharmacy questionnaires.

- A total of 1,192 responses have been received from the public survey. From Wirral's 94 community pharmacies, 89 have responded to the pharmacy survey.

Next steps & timescales
- The Board is obliged to ensure a minimum 60 day pre-publication consultation period. Groups to be consulted will include community and hospital providers, local pharmacies, Clinical Commissioning Group, Local Medical Committee, Local Pharmaceutical Committee, local Healthwatch, NHS Trusts and Foundation Trusts, other professional bodies, voluntary and community groups, patients and the public.

- It is proposed that the consultation for Wirral's PNA commences on the 3rd November 2014 through to 12th January 2015. Following this period, the revised PNA will be brought back to the Health and Wellbeing Board in March 2015 for final sign off prior to publication by 1st April 2015.

Recommendations
- The Board is asked to note the progress to date and to approve the proposed timescales for consultation.

Report Author: Jane Harvey
Job title: Consultant in Public Health, Wirral Council
Date: 23 November 2014

WIRRAL HEALTH & WELLBEING BOARD

Meeting Date	12 November 2014	Agenda Item	

Report Title	Care Act Implications - Update on Progress and Emerging Plans
Responsible Board Member	Graham Hodkinson

Link To HWB Function	Board development	
	JSNA/JHWS	
	Health and social care integrated commissioning or provision	✓

Equality Impact Assessment Required & Attached	Yes		No		N/A	✓
Purpose	For approval		To note	✓	To assure	

Summary of Paper	This paper highlights key changes that will have a significant impact on Wirral Council from April 2015. It builds upon the earlier Cabinet report and previous papers to CESG, setting out the key legislative changes that the Act brings, by setting out emerging plans based on capacity requirements to meet the increased demand anticipated as a result of these changes.

Financial Implications	Total financial implication	New investment required	Source of investment (e.g. name of budget)
	£	£	£

Risks and Preventive Measures	
Details of Any Public/Patient/ Service User Engagement	
Recommendations/ Next Steps	

Report History			
Submitted to:		Date:	Summary of outcome:
List of Appendices	1. Wirral Council Funding Allocations for the Care Act 2. Proposed Care Act Programme Governance		

Publish On Website	Yes		Private Business	Yes	
	No			No	

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WIRRAL

DASS Report to Health and Wellbeing Board

12 November 2014

Care Act Implications - Update on Progress and Emerging Plans

<u>**Executive Summary**</u>

This paper highlights key changes that will have a significant impact on Wirral Council from April 2015. It builds upon the earlier Cabinet report and previous papers to CESG, setting out the key legislative changes that the Act brings, by setting out emerging plans based on capacity requirements to meet the increased demand anticipated as a result of these changes.

1   <u>Background Information Brief Summary of the Key Changes</u>

1.1   On 14 May 2014, the Care Bill received Royal Assent and became the Care Act 2014 (hereafter "Care Act"). It comes into effect on 1 April 2015 apart from the funding reform elements, which are scheduled to come into effect on 1 April 2016. Implementation depends heavily upon regulations and guidance for detail. The 2015 regulations and guidance have now been published along with cost estimates fro the new burdens associated with the Care Act. These need to be understood and provision needs to be put in place to meet the new demands. Consultation on the 2016 regulations and guidance scheduled to take place at a later stage.

1.2   The Care Act legislates to provide social care protection and support to the people who need it most, and to take forward elements of the government's initial response to the Francis Inquiry, to give people peace of mind that they will be treated with compassion when in hospital, care homes or their own home. The Care Act brings together existing care and support legislation into a new, modern set of laws which builds the system around people's outcomes and wellbeing.

1.3   The Care Act aims to reform the care and support system into one that:

·   Focuses on people's wellbeing and support to help them remain independent for as long as possible.
·   Introduces greater national consistency in access to care and support.
·   Provides better information to help people make choices about their care.
·   Gives people more control over their care.
·   Improves support for carers.
·   Improves the quality of care and support.
·   Improves the integration of different services.

1.4 The Care Act aims to establish a new legal framework for Adult Social Care, putting the wellbeing of individuals at the heart of care and support service. The Government believes that the Care Act marks the biggest transformation to care and support law in over 60 years. It is intended to replace over a dozen separate pieces of legislation relating to Adult Social Care with a single modern law. It aims to put people more in control of their own lives and to reform the funding of care and support to ensure that:

- Everyone receives the care they need and that more support goes to those in the greatest need.
- The unfairness and fear caused by unlimited care costs is ended.
- People are protected from having to sell their home in 'their lifetime' to pay for care.

1.5 Given these changes, the Care Act outlines the most significant change in Adult Social Care in decades with changes to underpinning legislation, eligibility criteria, funding, changes to the status of Adult Safeguarding and a host of other associated areas.

2 Implications for Wirral Regarding Capacity

2.1 The Council will need to consider the implications of the changes arising from the new legislation. Some of the key issues that the Council will need to address are:

- Understanding the implications for the Council of a national eligibility framework.
- The implications for assessment and care management staff with a move to proportionate assessments with an 'asset based' approach i.e. enabling people to determine the best way in which their needs can be met utilising their own resources, with any additional support being provided via the Local Authority.
- The need for clear information about self-funders; not just in care homes but also those with eligible needs who are purchasing community based support services, who will be entitled to an assessment of need, support plan and annual review.
- Increased demand for assessment relating to full fee payers could lead to some delays in placement depending upon frequency of that demand.
- Gaining an understanding of the new processes that will need to be put in place for the provision of 'care accounts' including:
  - Financial assessments of self-funders
  - The monitoring of self-funders' eligible care costs, based on what the Local Authority would pay for the care i.e. 'reasonable cost', not on the amount the self-funder is paying
  - Production and provision of 'care account' statements for self-funders

- Assessing the financial implications of the cap on care costs and of an increase in the upper threshold for financial support from the Local Authority.
- Awareness of those people, including carers, who have unmet needs who would be eligible for social care services.
- An understanding of the numbers of carers who will be entitled to an assessment, to support planning where relevant.
- The financial implications of extended carers' support services – which will be non-chargeable.
- The implications arising from the responsibility of ensuring there are sufficient preventative services which delay people's need for long term care and support.
- The development of processes to recover costs for meeting a person's eligible needs where funding responsibility lies with another Local Authority.
- The resource implications of extended responsibilities in relation to transitions from children to adult services.
- The implication of extended responsibilities to provide written information and advice to people with non-eligible needs on what can be done to prevent or delay the need for care and support.

2.2   There is also an expectation set out in the Care Act that adult social care will increasingly integrate services with local health partners. This has been considered alongside the Better Care Fund (BCF). There is a requirement for this to be fully reflected in the Section 75 Pooled Budget with the Clinical Commissioning Group (CCG) for 2015/16.

3   Resource Implications

3.1   Financial

Ensuring that the reforms are adequately funded presents the Council and consequently its partners with a significant risk. The Government has stated that it is committed to funding the reforms and has allocated £470 million nationally. The Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) believe that that the reforms will cost significantly more than the original estimates. They are in direct dialogue with the Department of Health revisiting the original financial impact assessment of the new responsibilities.

The Government has identified a national allocation of £470m to fund the Care Act reforms. This amount has come from existing local Government and CCG spending allocations including elements associated with the Better Care Fund. In addition, the Government announced an allocation of £19m nationally (£125k for Wirral) for 2014/15 for implementation costs.

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A breakdown of the national resources as set out earlier in the year with the expected allocation for Wirral is set out below:

Funding Stream	National	Wirral	Comment
2014/15			
Implementation Grant	£19m	£0.125m	One Year Grant
2015/16			
New Burdens Funding	£335m	£2.498m	Provisional Revenue Settlement 2015/16
Care Bill Implementation	£135m	£0.976m	Better Care Fund from Wirral CCG

The most recent guidance on implementation released 24 October 2014 considered the above envelope and some changes to the funding framework based on Local Authority risk emanating from the new demands.

The analysis demonstrated that Government considers that there is sufficient flexibility within the overall £470m budget to meet the additional costs of carers' rights and law reform. However, since all the relevant budgets are demand-led, there remains a risk of higher costs.

It is suggested that these risks could be further mitigated by:
- Local flexibility within the revenue grants to reduce activity or manage demand, subject to decisions on local prioritisation. None of the grants will be subject to ring-fencing.
- Developing proposals for in-year monitoring of key activity related to areas of highest risk (e.g. carers assessments, DPAs
- The ongoing development of the approach to sector-led improvement, which will support authorities in identifying and responding to risk.
- Development of additional guidance and tools for Local Authorities to respond to areas of risk, e.g. model approaches to self-funder assessments, building on feedback from local government from, for example, the national stocktake surveys for the Act.

3.2   Next steps in relation to the financial envelope

The financial envelope remains largely unchanged. The final impact assessment, revised, will be published alongside the regulations and guidance for 2015/16.

A second consultation-stage impact assessment relating to the 2016/17 reforms will be published with the draft regulations and guidance for the second phase of the reforms in December.

The outcome of the consultation on funding formulae, including final detail of 2015/16 allocations and the distribution of the new Carers Grant, will be published in December.

3.2   Workforce

Initial workforce implications have been assessed based on the implications of implementing the reforms. Staff within adult social care services will need to be provided with training and advice once the required changes in working practices are more clearly understood. The reforms will require staff to adopt new models of care delivery to help manage the demand of increased activity levels but also deliver preventative and personalised approaches to care arrangements. As a result, the workforce planning and in particular, the wider development of a joint workforce such as integrated health and social care teams, will need to be adapted to ensure partners are cognisant and compliant with requirements of the Care Act. This will require Human Resources support in relation to Terms and Conditions, retraining (culture and capability) and restructuring.

A further table setting out where it is expected that the funding will be initially required is set out at Appendix 1. This includes just over £1M for assessment and review capacity.

A proposal set against Future Council re-modelling has been put together that shows of the detail of additional posts needed in Adults to deliver against the Care Act. This has been set against the new burdens funding. 30 additional posts (outside of the BCF allocation) are required at a cost against the new burdens funding of £977,300.

3.3   Implementation Planning

Whilst the reforms set out in the Care Act are welcomed, the new responsibilities present significant challenges and risks as well as opportunities for the Council. They consist of financial risks, the scale and pace of the implementation and additional demand through new carers and assessment responsibilities.

This means that that the implementation will be highly sensitive and dynamic. In order for the Council to successfully implement these reforms to the timescale set by the Government, health and social care partners will need to be closely involved in planning and delivery of the new statutory duties.

There is a national programme in place, co-led between the DCLG and the LGA with ADASS involvement. There is also a regional programme, led by ADASS North West Branch, with a lead officer and sub groups. The Council is working with and contributing to these work groups.

In order to gain a detailed understanding of the changes and the implications for the Council, a programme of work will need to be implemented by the Council led through adult social care to consider in detail the implications of the Act and to scope and plan the implementation of the required changes.

It is recommended that a programme manager is appointed by the Director of Adult Social Services to lead the work through 'Care Act Programme Board' is established with work streams identified against key areas of work. This work will also enable the Council to identify future resource requirements arising from implementation of the new responsibilities.

An initial board profile has been attached at Appendix 2.

4   Recommendations

1.   To support the appointment of a programme lead using the implementation grant.
2.   To note and support the principle of using new responsibilities funding in the manner outlined.
3.   To note the level off risk to the Council and support the programme governance framework as suggested.

Author's Name:	Graham Hodkinson
Author's Title:	Director Adult Social Services
Author's Contact Number:	0151 666 3651
Date Report Written:	24 October 2014

Wirral Council Funding Allocations for the Care Act

Wirral		
Adult social care new burdens funding (£335m nationally)		**Your allocation, £000s**
Assessment & eligibility	*Funding for early assessments and reviews*	*1,088*
IT	*Capital investment funding including IT systems*	*360*
Capacity	*Funding for capacity building, including recruitment and training of staff*	*150*
Deferred payments	*Year 1 funding for the implementation of the universal deferred payment scheme*	*825*
Information	*Funding for a national information campaign*	*75*
Total		*2,498*
Care Bill implementation funding in the Better Care Fund (£135m nationally)		**Your allocation, £000s**
Personalisation	*Create greater incentives for employment for disabled adults in residential care*	*22*
Carers	*Put carers on a par with users for assessment.*	*120*
	Introduce a new duty to provide support for carers	*239*
Information advice and support	*Link LA information portals to national portal*	*0*
	Advice and support to access and plan care, including rights to advocacy	*179*
Quality	*Provider quality profiles*	*36*
Safeguarding	*Implement statutory Safeguarding Adults Boards*	*58*
Assessment &Eeligibility	*Set a national minimum eligibility threshold at substantial*	*290*
	Ensure councils provide continuity of care for people moving into their areas until reassessment	*32*
	Clarify responsibility for assessment and provision of social care in prisons	*48*
Veterans	*Disregard of armed forces GIPs from financial assessment*	*18*
Law reform	*Training social care staff in the new legal framework*	*33*
	Savings from staff time and reduced complaints and litigation	*-98*
Total		*976*
Grand Total		*3,474*

Proposed Care Act Programme Governance

WBC Cabinet / Scrutiny Committees	Care Act Programme Board — Chair: Graham Hodkinson	Health and Wellbeing Board

Executive Members (Sponsor Group)

WORKSTREAMS

Information and Guidance Lead Officer: Kevin MacCallum	Finance, Deferred Payments and Charging Lead Officer: Sandra Thomas / Lucy Jones	Assessment, Eligibility and Transitions Lead Officer: Chris Beyga / Phil Wall	Commissioning Lead Officer: Jacqui Evans	Safeguarding Lead Officer: Simon Garner

ENABLING SUB-GROUPS

Communication and Customer Engagement Lead Officer: Boo Stone / Julie Walker	Policy Group Lead Officer: Sandra Thomas	Carers Lead Officer: Carol Jones	Workforce Development Lead Officer: Jo Williams	ICT Change Lead Officer: Sandra Thomas	Legal Perspective Lead Officer: Vicki Shaw

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NHS

FIVE YEAR FORWARD VIEW

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

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

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

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

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

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improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On 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 as a share of national income.

16. 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. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. 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, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

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- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

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having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result 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.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these 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.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also 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.

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Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we 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 support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, 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.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be 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.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when 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'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and 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.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding 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.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

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promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex 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

More broadly, 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. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. 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 – the approximately 225,000 young carers and the 110,000 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.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% 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.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, 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 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.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

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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. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - 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 NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care.   As a result there is now quite wide consensus on the direction we will be taking.

- 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 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.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

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and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, 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. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

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'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why 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.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: 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. So 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 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.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, 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 some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

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 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. 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.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

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 integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

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

- 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 kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

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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 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

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

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 the 379 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 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.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And 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.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, 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 delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

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

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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. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- 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. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this 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 a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

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the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

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 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.

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 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

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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?

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 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.

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 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 use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

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

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

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. 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. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

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. These will include Integrated Personal Commissioning (described in chapter two) 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. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, 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 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. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, 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. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. 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.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have 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: 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.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, 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. And 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.

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 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.

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. HEE will therefore 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 occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that 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 of 'letting a thousand flowers bloom'. 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.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year 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 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.

- 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

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

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.

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We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

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 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 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. 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

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partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger 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, 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.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- 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 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

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 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, 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 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-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.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

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ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation

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Public Health England

Protecting and improving the nation's health

From evidence into action: opportunities to protect and improve the nation's health

October 2014

From evidence into action: opportunities to protect and improve the nation's health

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services.

October 2014

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Foreword

We have an ambition: for people of this country to live as well as possible, for as long as possible. But on current trends, we are going to fall short because we face an epidemic of largely preventable long-term diseases. We may be living longer, but we – and future generations – risk spending many of these extra years in poor health unless we do a better job of tackling major risks such as obesity, poor diet, physical inactivity, smoking, and excessive alcohol consumption. If we fail, it will be the most vulnerable and the most deprived communities who will bear the heaviest burden.

It will be neither effective nor feasible to attempt to solve these problems by ramping up our spending on hospitals, clinicians and services. Resources are scarce and all sectors, from the NHS to local authorities, are under huge pressure from constrained budgets and rising demand.

What we need is a fundamentally new approach to creating and sustaining health, mental and physical, at every stage of life and across all our communities.

It is an approach that acknowledges that our health is shaped by where and how we live: by our jobs, families, homes; but that also

recognises the power of individuals to change their lifestyles, especially if they get the right support at the right time.

We have an opportunity, with the creation of Public Health England, the NHS Five Year Forward View and the momentous return of public health to local authorities, to put this approach into practice.

We have looked to the evidence to identify where we should focus our efforts. This report sets out seven key priorities where, through working closely with our partners in local and national government, with the NHS, the voluntary and community sector, and with industry and academia, we can make a significant difference over the coming five to ten years. In real time, these will not be quick wins, but in public health time, which is measured in decades, they could be.

None of this is easy, but we will demonstrate that it is achievable. First, because we know what success looks like – take, for instance, the interventions that have led to dramatic falls in death rates from heart disease over the past decade[1] as proof of what is possible.

Second, because we have opportunities to do things differently. These we must seize because they have the potential to magnify the impact of what we do in public health. In other areas of our life think of the power and reach of digital technology. Now combine that with new insights from the behavioural sciences, and it is clear we are on the cusp of a revolution in how we promote healthy lifestyles. Likewise, new evidence and new knowledge – about the importance of the early years, for example, or the links between mental and physical health – could transform the scope of public health.

So this provides the opportunity for public health to think big. We won't be alone because there is an unprecedented consensus that prevention and early intervention belongs at the heart of this country's health agenda. That is why, at Public Health England, we are working hand in hand with local government to promote the uptake of all those effective interventions to prevent disease and improve population health. That is why we will help to deliver the NHS Five Year Forward View. And that is why we seek to enlist the power of employers to promote the health and productivity of their workforce.

To improve the population's wellbeing we need these ideas to take root locally, in people's neighbourhoods and communities. So it is vital that, as they respond to local needs and priorities, we support local authorities – drawing on the expertise of the Local Government Association and SOLACE – to tap into the power of 'place-based approaches' and community development, harnessing the collective assets and resources available locally to address local needs.

This document sets out our commitment to support our partners with a programme of work that:

- ensures credible, evidence-based advice is available on the key issues relating to the public's health

- develops our ability to engage and support the public in making healthier choices

- mobilises support for broader action on improving the public's health

What we are looking to stimulate is a new movement that focuses on creating and protecting health, not only treating ill-health. This document is an invitation to our colleagues across the health professions, local and national government, the voluntary and community sector and the public, to join us in applying the evidence of what we know works to achieve the step-change in the nation's health that we all seek.

David Heymann
PHE board chair

Duncan Selbie
PHE chief executive

Our health today

In recent years, we have seen significant increases in access to and the quality of healthcare, backed by significant growth in resources. Life expectancy continues to rise as premature mortality for eight out of ten of the commonest causes of death falls.[2]
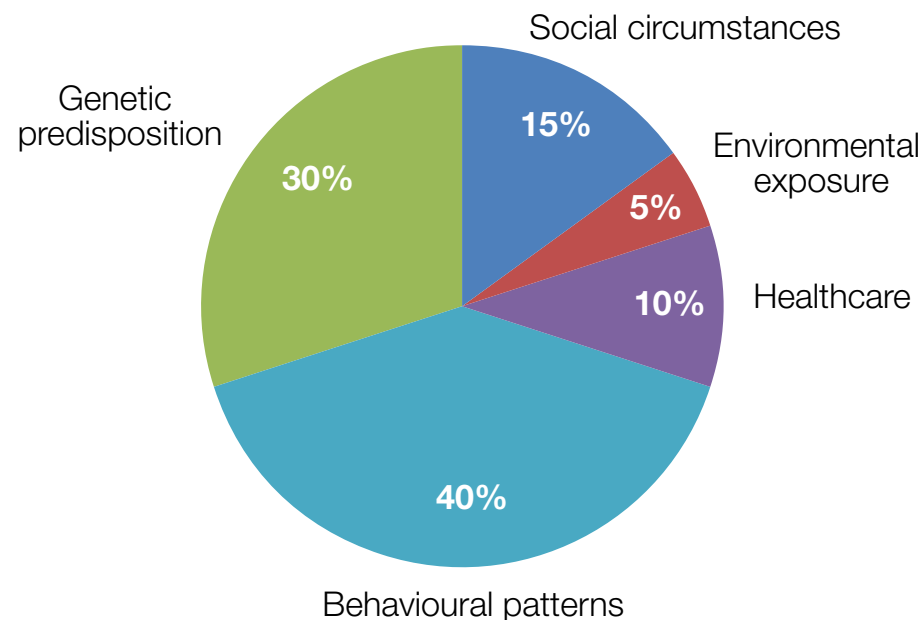
Yet, as the Department of Health set out in *Living Well for Longer*, we are falling further behind other comparable countries in relative terms; we are living longer but with many of our later years troubled by ill health. As a nation we still continue to see deep-seated inequalities between those with the most and those with the least in our society, and across different regions of our country. In addition, the cost of ill health is increasing – treating type II diabetes costs the NHS £8.8 billion a year[3] – and our increasingly sedentary lifestyles – we are 20% less active than we were in 1961[4] – mean we need to take action now.

We see these trends despite universal access to the NHS and despite the significant increases in resources allocated to the NHS in recent years.[5] The truth is that healthcare has a relatively limited impact on our health. The environment around us, our genetic inheritance, how we live our lives and the opportunities we have together largely determine our health.[6] International studies suggest healthcare contributes only about 10% to preventing premature death[7] (Figure 1), although this varies in different settings.

As our joint work with the Royal Society for the Prevention of Accidents, *Delivering accident prevention at a local level in the new public health system*, showed, injuries continue to be a significant cause of disability and early deaths, particularly for the young and old. We also know there are considerable inequalities in the burden of unintentional injuries across the country.

Proportional contribution to premature death[8]

Social circumstances 15%
Environmental exposure 5%
Healthcare 10%
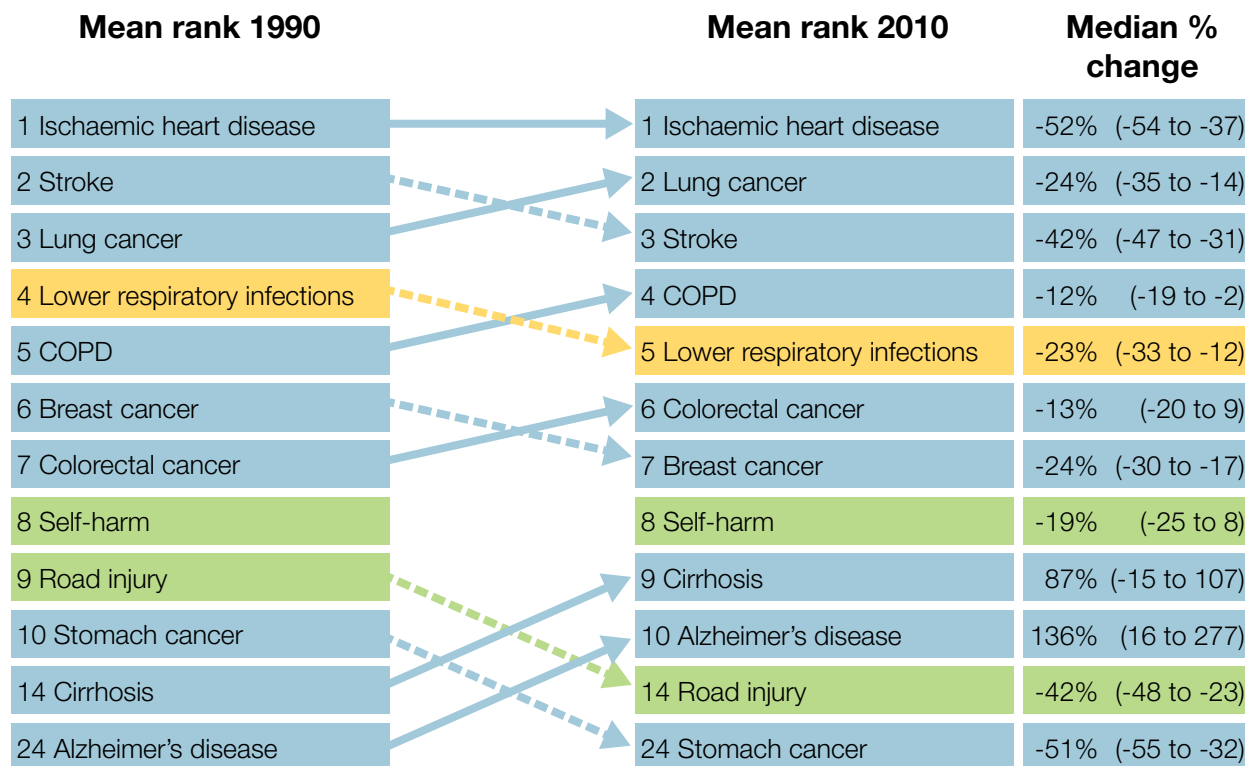Behavioural patterns 40%
Genetic predisposition 30%

Figure 1 In the US, McGinnis et al show how healthcare plays an important though proportionately small role in preventing early deaths. Similar studies have supported these findings in the UK. Improving how we live our lives offers far greater opportunity for improving health.

In order to improve the surveillance data for injuries, we will step up our work with emergency medicine colleagues to develop potentially powerful new data feeds from A&E.

We need a new approach: where we encourage everyone to gain more control of their health; where prevention and early intervention are the norm, recognising that action on health inequalities requires action across all the wider determinants of health; and where the assets of individuals, families and communities are built upon to support improved health.

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Mean rank 1990	Mean rank 2010	Median % change
1 Ischaemic heart disease	1 Ischaemic heart disease	-52% (-54 to -37)
2 Stroke	2 Lung cancer	-24% (-35 to -14)
3 Lung cancer	3 Stroke	-42% (-47 to -31)
4 Lower respiratory infections	4 COPD	-12% (-19 to -2)
5 COPD	5 Lower respiratory infections	-23% (-33 to -12)
6 Breast cancer	6 Colorectal cancer	-13% (-20 to 9)
7 Colorectal cancer	7 Breast cancer	-24% (-30 to -17)
8 Self-harm	8 Self-harm	-19% (-25 to 8)
9 Road injury	9 Cirrhosis	87% (-15 to 107)
10 Stomach cancer	10 Alzheimer's disease	136% (16 to 277)
14 Cirrhosis	14 Road injury	-42% (-48 to -23)
24 Alzheimer's disease	24 Stomach cancer	-51% (-55 to -32)

Legend Communicable Non-communicable Injury

Figure 2 From 1990 to 2010, the years of life lost to ischaemic heart disease, stroke and lung cancer[9] reduced by 52%, 42% and 24% respectively, but these remain the top three causes of premature mortality in the UK.

Health drivers: how we live and the circumstances of our lives

The way we live our lives has a major impact on our health. The *Global Burden of Disease* study demonstrates the impact on our health of poor diet, obesity, lack of exercise, smoking, high blood pressure and too much alcohol. The study also demonstrates that mental illness is the largest single cause of disability and represents 23% of the national disease burden in the UK.[10]

The circumstances in which we find ourselves also have an impact on our health – they impact on the opportunities we have to make healthy choices.

While individuals' behaviours do matter (for example, studies show around half of the health inequalities between rich and poor are the result of smoking[11]), the reality is that our health is impacted by a range of wider determinants including:

- good employment
- higher educational attainment
- safe, supported, connected communities
- poor housing and homelessness
- living on a low income
- social isolation, exclusion and loneliness
- stigma and discrimination

Improving health and closing the gap between those with the most and those with the least requires action across all of these.

Due North,[12] the report of the inquiry on health equity for the North, sets out fresh insights and thinking on how we might do this. And we must recognise the link between mental illness and physical health. Essentially, those with mental illness die on average 15-20 years earlier than those without. The life expectancy of people with serious mental illness in 2011 was comparable to that of the general population in the 1950s.[13]
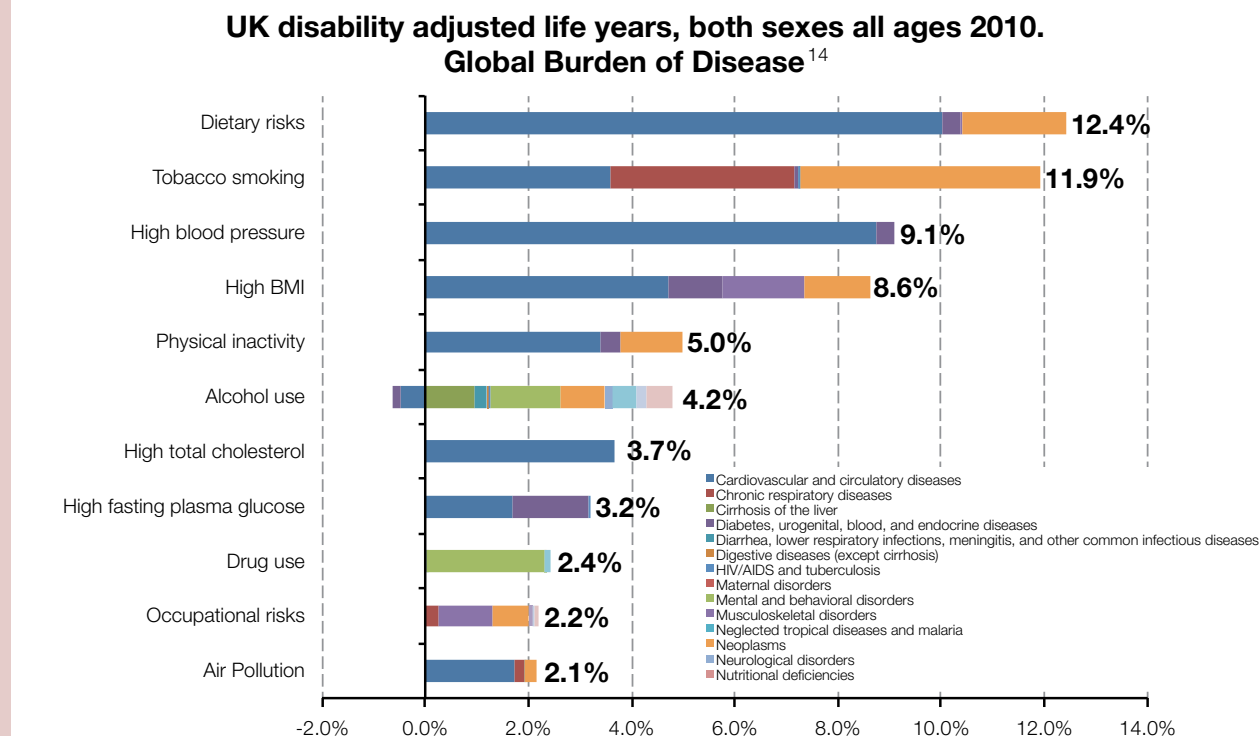
Figure 3 The way we live has a significant impact on our health. Good diet and more exercise would help us live healthier lives.

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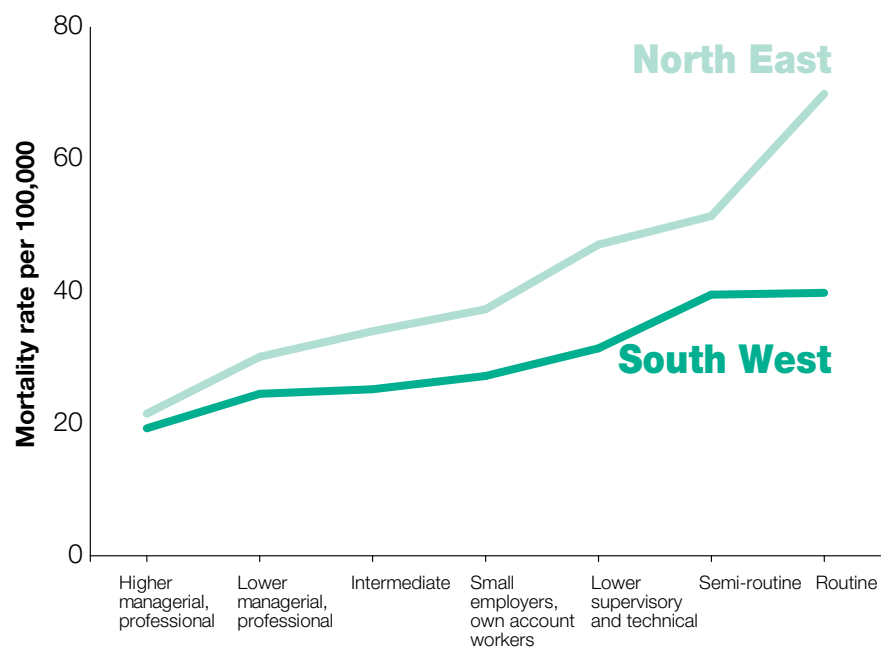
Figure 4 There are stark health inequalities[15] stemming from unemployment and socioeconomic status, as well as geography across the country.
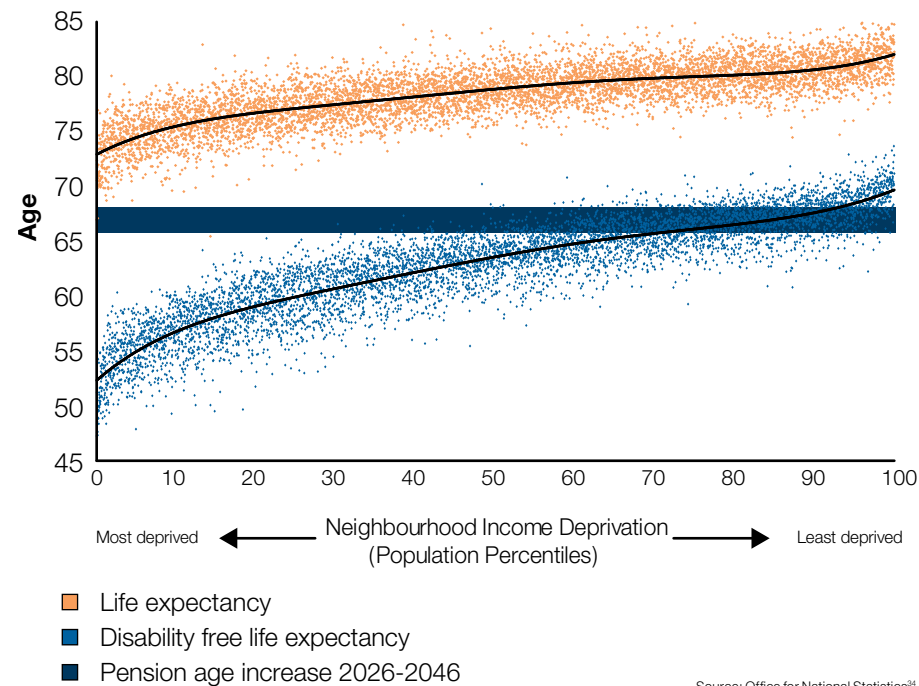
Figure 5 Although life expectancy[16] continues to increase, we are living longer with disease as more and more of us live with long-term conditions.

Continuing to protect the public from threats to their health

Although we have seen very significant reductions in the burden of infectious disease and the impact of some environmental hazards, these remain a very significant risk to the public's health.[17]

The potential threats from infectious disease are diverse and challenging. TB, HIV and hepatitis C all continue to pose serious public health challenges within our population. We must also be alert to, and able to respond to emerging infections such as the newly identified Middle East respiratory syndrome coronavirus (MERS-CoV). In doing this, we must retain a global outlook, recognising that in our increasingly connected world infectious disease could easily be carried from country to country. The Ebola outbreak in West Africa reminds us of the global impact of infectious disease and the need to maintain effective measures to identify and respond to outbreaks, both at home and abroad.

We will remain vigilant in preparing and planning for major outbreaks, ensuring we are able to respond early and effectively to new and emerging threats to our health. We are introducing new whole genome sequencing capabilities, which are allowing us to adopt new approaches to identifying outbreaks, understanding the transmission of infectious disease and to the management and prevention of outbreaks.

Public Health England

Protecting and improving the nation's health

Returning from West Africa?
Information about Ebola

There is a large Ebola outbreak going on at present in West Africa

- the risk of Ebola is low for most travellers
- however, malaria is a much more common infection in West Africa and can have similar early symptoms. It is treatable if diagnosed quickly, so contact NHS 111 for advice if you feel unwell
- if you are staying in the UK and develop symptoms such as:
  - fever (more than 38°C)
  - headache
  - body aches
  - diarrhoea
  - vomiting

within 21 days of returning from Sierra Leone, Guinea or Liberia, you should contact NHS 111 and tell them where you have travelled.

If you are in transit to Scotland, Wales or Northern Ireland, and develop these symptoms after arrival, you should contact the relevant number and tell them where you have travelled:
 - Scotland: NHS 24 (dial: 111)
  - Wales: NHS Direct Wales (dial: 0845 46 47)
  - Northern Ireland: contact your GP or local Emergency Department

If you are in transit to another country and develop these symptoms after you have left the UK, you should seek immediate medical attention there.

For more information visit: **www.gov.uk/phe** or **www.nhs.uk/conditions/ebola-virus/pages/ebola-virus.aspx**
For health advice, call **NHS 111**

Figure 6 Ebola information poster published by Public Health England in response to the Ebola outbreak 2014, and displayed at major airports.[18]

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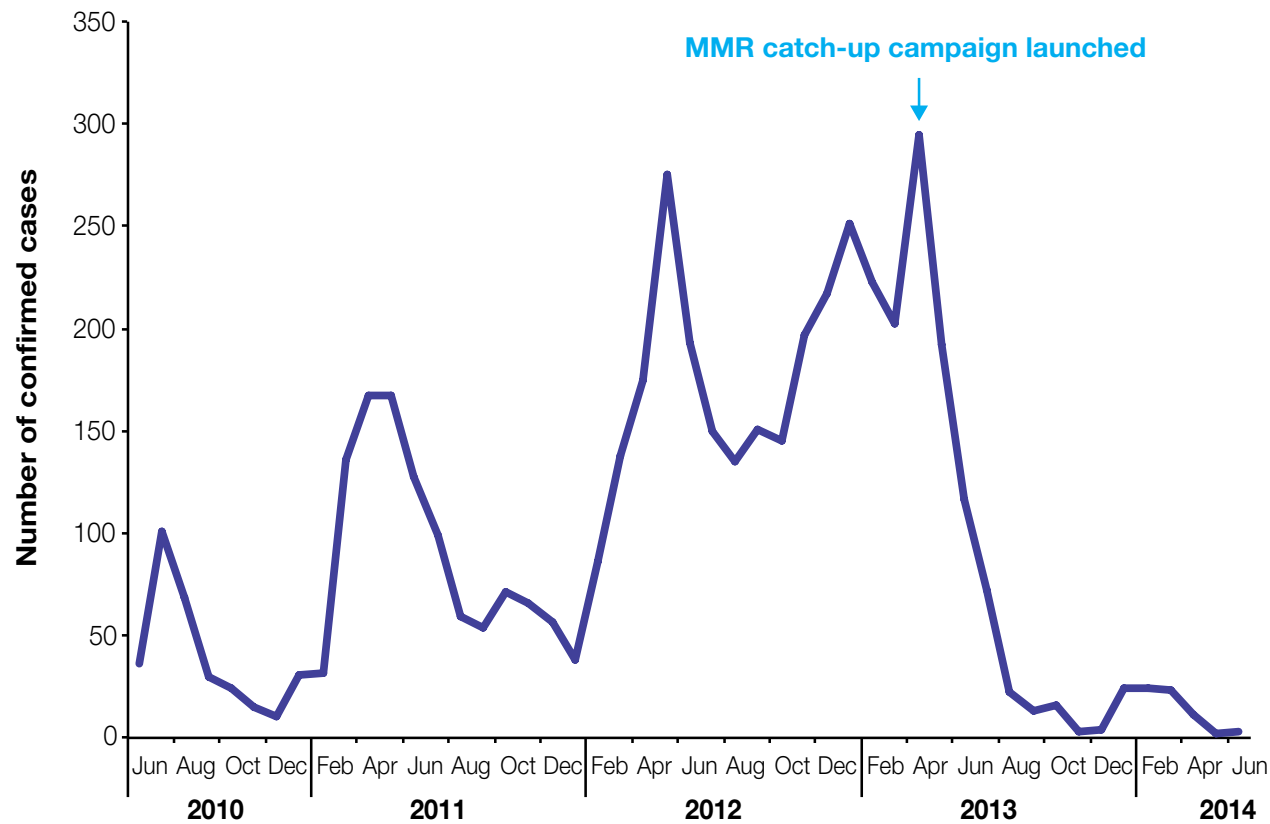
Figure 7 The successful introduction of a measles, mumps & rubella catch-up campaign to vaccinate unprotected children had an immediate impact on the numbers of cases of measles.[19]

Looking to the future

We have seen real successes in recent years, from reducing premature deaths from heart disease to reducing teenage pregnancies. But some of the key trends continue to go the wrong way. Across our population, obesity continues to rise and 62% of adults are now overweight or obese.[20] We are projected to be 35% less active in 2030 than we were in 1961,[21] and alcohol-related deaths have doubled over the last 20 years.[22] Alcohol and obesity are the leading causes of liver disease, the only major disease in the UK for which mortality is still increasing.[23]

We need to understand better what contributes to these trends which, in turn, will shape the health of our population. PHE will develop the capability to forecast the likely future direction of health trends – we aim to be the health equivalent of the Office of Budget Responsibility, with an authoritative analysis of the public's health in the long term. Initial modelling with the UK Health Forum considers the impact of obesity and smoking over the next 20 years.

If current trends persist, one in three people will be obese by 2034 (Figure 8) and one in ten will develop type II diabetes (Figure 9). Yet, if we could reduce obesity back to 1993 levels, five million cases of disease could be avoided (Figure 10).[24]

BMI projections for all adults 18+ 'steady progress' scenario
Source: UK Health Forum
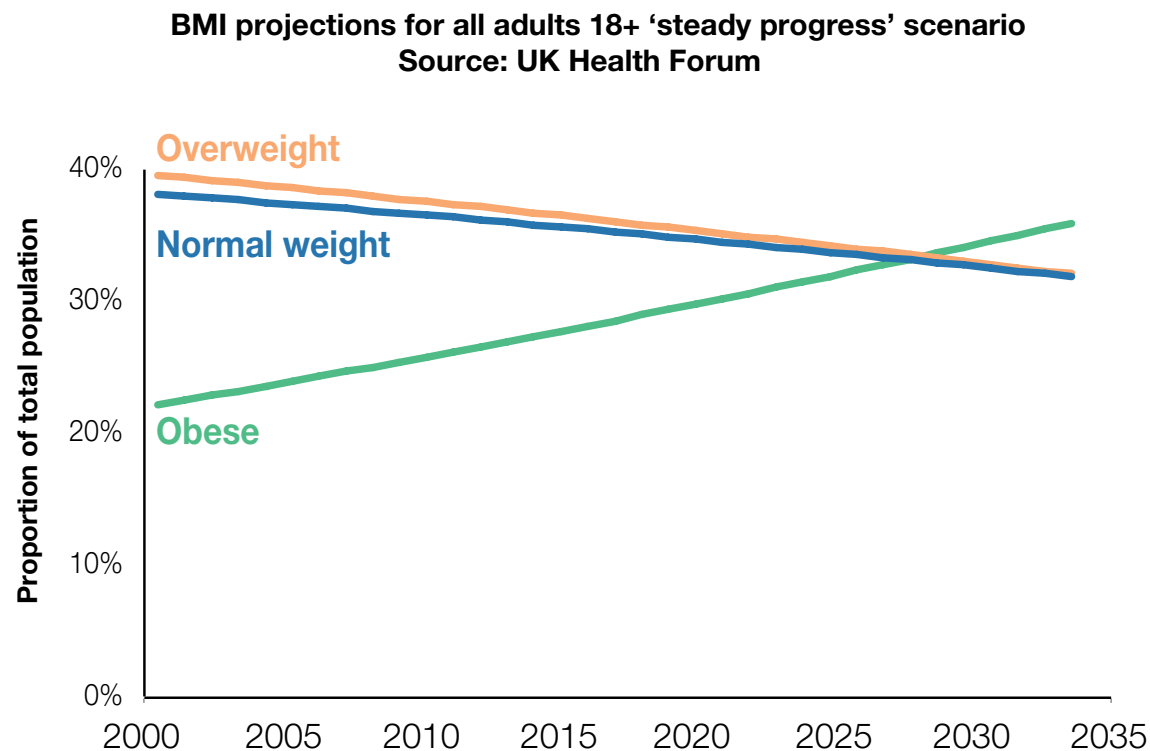
BMI was categorised according to WHO BMI cut-offs for normal weight (<25 kg/m²), overweight (25-29.9 kg/m²), and obesity (≥30 kg/m²).

Figure 8 Body mass index projections for adults where current trends continue (based on Health Survey for England data 2000-2011).[25]

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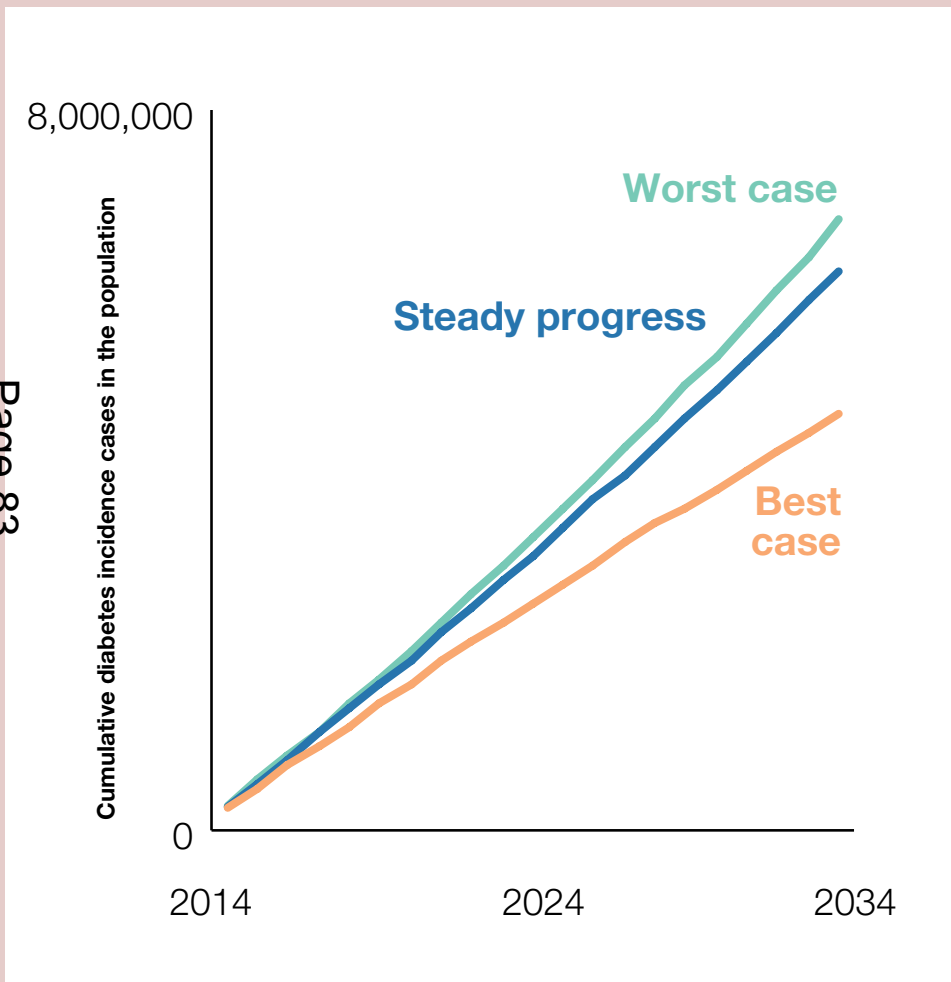
Figure 9 Projected type II diabetes incidence with different levels of intervention.[26]

MI = myocardial infarction
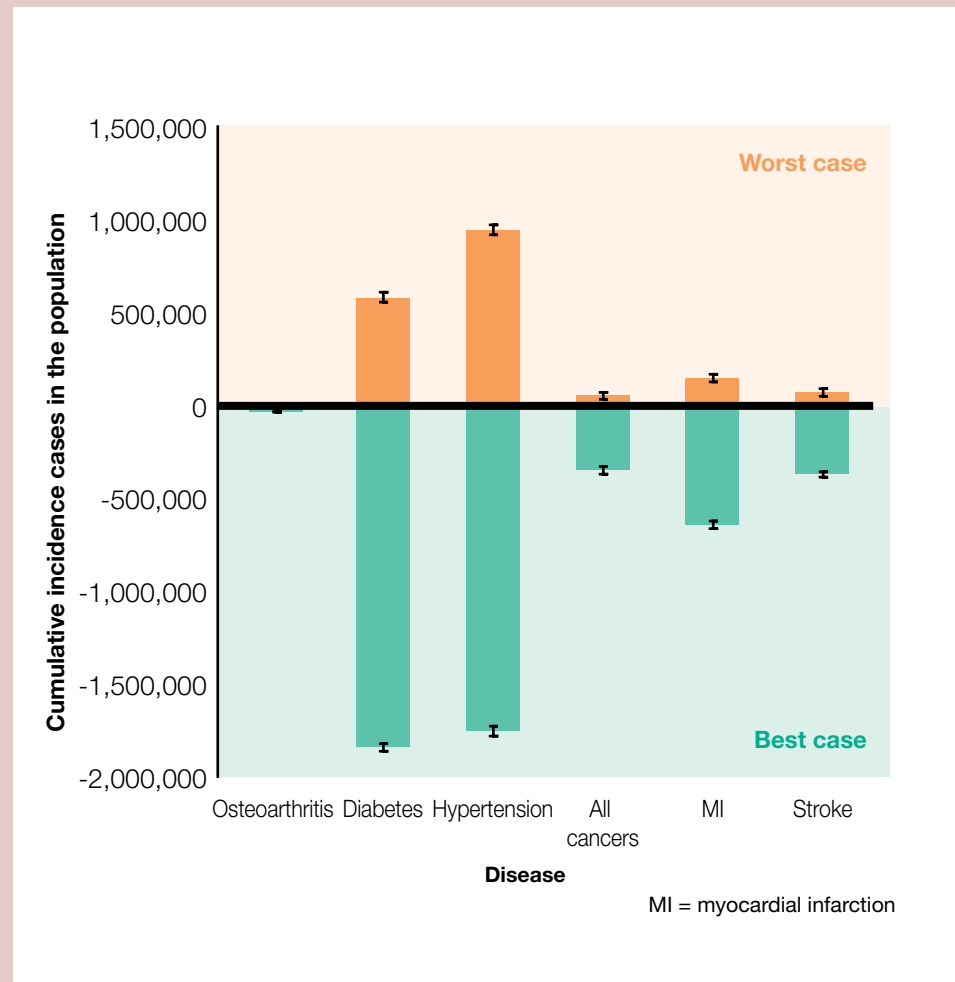
Figure 10 Initial modelling suggests that over five million incidences of disease could be avoided if we could get back to what we weighed in 1993 by 2034 rather than maintaining current trends.[27]

| Contents | Foreword | Our health today | Health drivers | Protecting health | Looking to the future | Our seven priorities | New drivers and opportunities | References |

Click here for priorities

Our seven priorities

We have identified seven priorities where we will focus our efforts. These are supported by the evidence in the *Global Burden of Disease* study[28] that emphasises just how important these factors are from an epidemiological perspective in determining our health, and also how the same risks contribute to so many of the conditions and diseases that cause ill health and premature death. And we know these require action on contributory factors, such as physical activity. In addition, as the work of Professor Sir Michael Marmot and others have established,[29] the evidence shows that a good start to life is the key to lifelong health and wellbeing.

We will also focus on dementia as a leading public concern, recognising that a focus on these same risk factors will help reduce people's risk of dementia and delay its onset.

We will continue to prioritise protecting the public from infectious disease, maintaining our capacity and capability to prevent and control outbreaks effectively. In particular, we want to see progress in tackling tuberculosis and reducing the threat from antimicrobial resistance.

We will pursue each of these, recognising three underpinning themes:

- that we are concerned with population health and also with the impact on individuals, and that mental and physical health are equally important to our wellbeing

- that we must act in a way that reduces health inequality and ensures everyone is able to benefit

- that we recognise the importance of place and the strength of building on all of a community's assets

The seven priorities are not our only areas of interest, nor do they represent the full range of contributions that we make to protecting and improving the public's health. They are, however, the areas we identify as most in need of improvement in the next 5 years and where we will relentlessly focus our efforts.

PHE will focus on securing improvements against seven priorities:

- **tackling obesity** particularly among children

- **reducing smoking** and stopping children starting

- reducing **harmful drinking** and alcohol-related hospital admissions

- ensuring **every child** has the **best start** in life

- **reducing the risk of dementia**, its incidence and prevalence in 65-75 year olds

- tackling the growth in **antimicrobial resistance**

- achieving a year-on-year decline in **tuberculosis** incidence

We cannot do this alone. PHE will work with local and central government, clinical commissioning groups and the wider NHS, universities, industry, employers, and the voluntary and community sector to build support and commitment for improving health, making evidence and knowledge on 'what works' available to all in a form they can use and spreading best practice. Above all, we need an active partnership with people so they take greater charge of improving their own health.

1 Tackling obesity

Outcome:

An increase in the proportion of children leaving primary school with a healthy weight, accompanied by a reduction in levels of excess weight in adults.

Why focus on obesity?

Being overweight is associated with increases in the risk of cardiovascular disease, diabetes and some cancers.[31] It is also associated with poor mental health in adults, and stigma and bullying in childhood.[32]

We know that poor diet has a direct impact on health: an estimated 70,000 premature deaths in the UK could be avoided each year if UK diets matched nutritional guidelines.[33] We also know that one in two women and one in three men are insufficiently active for good health.[34]

There are stark inequalities in levels of child obesity, with prevalence among children in the most deprived areas being double that of those children in the least deprived areas.[35] If an individual is poor, he or she is more likely to be affected by obesity and its health and wellbeing consequences.

Where are we now?

Being obese or overweight is becoming the social norm: the number of children who are obese doubles from reception to year six,[36] while among adults 67% of men and 57% of women are obese or overweight.[37]

National Child Measurement Programme 2012/13[38]

Around **one in ten** children in reception is obese (boys 9.7%, girls 8.8%)

Around **one in five** children in year 6 is obese (boys 20.4%, girls 17.4%)

Child obesity: BMI≥95th centile of the UK90 growth reference

Figure 11 Prevalence of excess weight among children.

Over the next 18 months, PHE will:

- work with NHS England to implement the commitments to tackling obesity set out in the NHS Five Year Forward View

- produce an independent report for government on sugar and diet, including evidence reviews on fiscal measures and promotions and advice from the Scientific Advisory Committee on Nutrition

- publish the evidence-based Everybody Active, Every Day framework[30] and refresh the eatwell plate and 5 a day approaches

- run the New Year healthy eating campaign and summer physical activity campaign, and increase the number of families signed up to Change4Life by 500,000

- support local authorities to deliver whole system approaches to tackle obesity, including through supporting healthier and more sustainable food procurement

2 Reducing smoking

Outcome:

A reduction in the proportion of 15-year-olds who smoke.

Why focus on smoking?

Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness.[39] Nearly eight million people still smoke,[40] with most having started in childhood.[41] There are stark inequalities – people in routine and manual jobs are more than twice as likely to smoke as those in managerial and professional roles;[42] teenagers are almost six times as likely to smoke throughout pregnancy as women who are over 35;[43] people living in Kingston upon Hull are almost twice as likely to die from smoking as those living in Kingston upon Thames;[44] and 33% of tobacco is consumed by people with mental health problems.[45] The best way to stop children smoking is to reduce smoking in the world around them, helping adults to quit so that smoking is no longer the norm. We want to secure a tobacco-free generation; our most disadvantaged communities have the most to gain from this.

Where are we now?

8% of 15-year-olds in England are regular smokers and a further 10% are occasional smokers.[46]
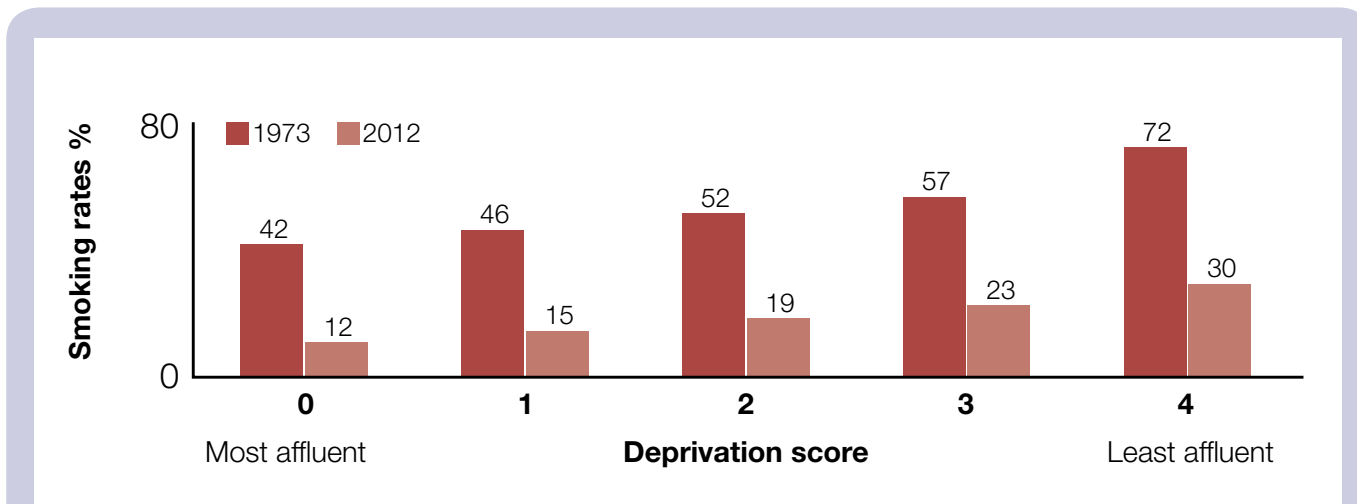
Figure 12 Smoking rates have declined much less rapidly among lower socioeconomic groups[47]

Over the next 18 months, PHE will:

- stimulate 500,000 quit attempts through smokefree campaigns, including Stoptober, a New Year health harms campaign, and combating smoking in cars
- produce an independent report for government on e-cigarettes
- continue to advise government on the evidence for the introduction of standardised packaging of tobacco products
- work with government, local authorities, the NHS, and the voluntary and community sector to develop tools to support effective commissioning
- provide seminars across England to support local partners in addressing smoking and mental health, smoking in pregnancy and making the case for comprehensive local tobacco control
- work with the National Offender Management Service, NHS England and mental health charities to reduce the prevalence of smoking within the prison population; and support NHS mental health services to become smoke-free

3 Reducing harmful drinking

Outcome:

A reduction in the number of hospital admissions due to alcohol.

Why focus on drinking?

Alcohol is the leading risk factor for preventable death in 15-49 year olds.[48] Nine million adults now drink at levels that increase the risk of harm,[49] of whom 1.6 million show signs of alcohol dependence.[50] From 2001-2012, the number of people who died due to liver disease in England rose from 7,841 to 10,948 – a 40% increase and in contrast to other major causes of disease that have been declining.[51]

The harm of alcohol falls not just on individuals but on society as a whole. Overall, alcohol harm costs society £21 billion a year, with the costs to the NHS at £3.5 billion.[52]

We see massive inequalities in where its impact is felt. People with mental illness are more likely to misuse alcohol;[53] and the most deprived fifth of the population of the country suffers two to three times greater loss of life attributable to alcohol.[54]

Where are we now?

In 2012/13, there were 326,000 hospital admissions where alcohol was the main reason for admission.[55]

Figure 13 Infographic depicting alcohol misuse damages to health[56]
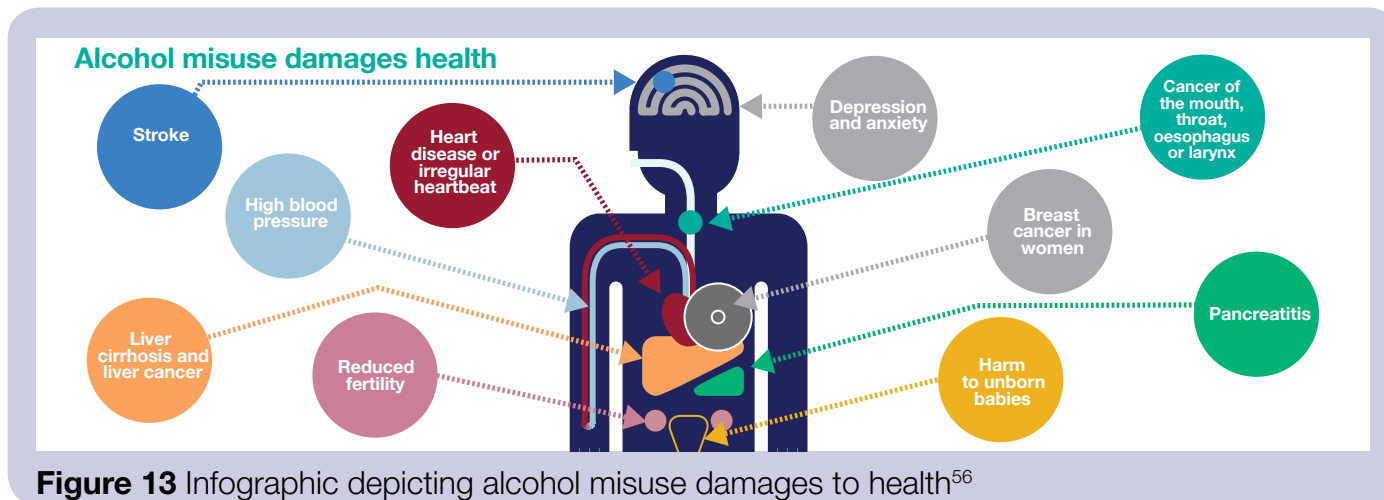
Over the next 18 months, PHE will:

- use alcohol as the trailblazer for a new whole system approach that establishes what works and is clear on the return on investment, enabling government, local authorities and the NHS to invest with confidence in evidence based policies, prevention and treatment interventions
- produce an independent report for government on the public health impacts of alcohol and on evidence-based solutions
- produce a framework on liver disease outlining public health actions to tackle liver disease, including alcohol
- expand the Longer Lives web tool to include indicators on alcohol treatment and recovery, and to identify variations in performance
- launch Liver Disease Profiles to support local authority health and wellbeing boards to understand liver disease and its risk factors in their area and, in turn, design effective local population level interventions
- continue to set out the evidence base for the introduction of a minimum unit price for alcohol
- consider the evidence for the inclusion of health as a licensing objective

4 Ensuring every child has the best start in life

Outcome:

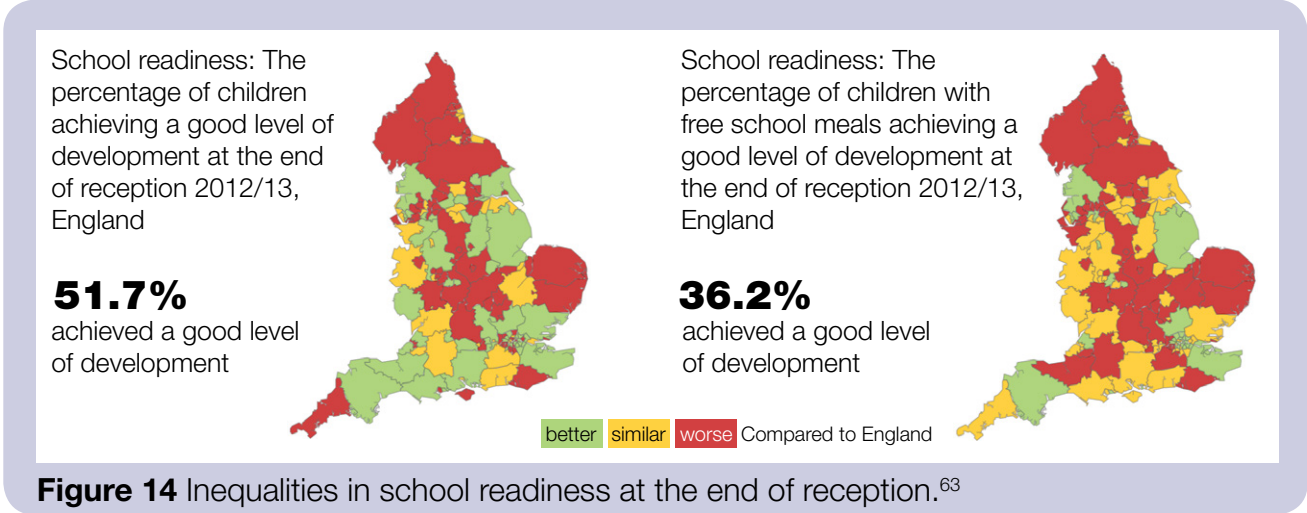An increase in the proportion of children 'ready to learn at two and ready for school at five'

Why focus on the best start in life?

Getting a good start in life, building emotional resilience and getting maximum benefit from education are the most important markers for good health and wellbeing throughout life.[57] We know that 80% of brain cell development takes place by age three[58] and how we care for infants shapes their lives. Early attachment and good maternal mental health shapes a child's later emotional, behavioural and intellectual development.[59] Enabling children to achieve their full potential and be physically and emotionally healthy provides the cornerstone for a healthy, productive adulthood.

Socially disadvantaged children are more likely to have speech, language and communication difficulties than their peers, which has implications for their educational attainment and future life chances.[60] There is also evidence of difficulties with peer relationships, emotional problems and impaired social behaviour. For example, 60% of young offenders are found to have speech, language and communication needs.[61]

Where are we now?

In 2012/13, 52% of children reached a good level of development at the end of their reception year, with 36% of children eligible for free school meals reaching this level.[62]

School readiness: The percentage of children achieving a good level of development at the end of reception 2012/13, England

51.7% achieved a good level of development

School readiness: The percentage of children with free school meals achieving a good level of development at the end of reception 2012/13, England

36.2% achieved a good level of development

better similar worse Compared to England

Figure 14 Inequalities in school readiness at the end of reception.[63]

Over the next 18 months, PHE will:

- support local authorities in developing integrated children and young people's services as they take on commissioning responsibilities for the Healthy Child Programme for 0-5s
- promote the importance of high-quality universal services as a foundation for good health for all our children and as a platform for early intervention and targeted support
- develop and strengthen the evidence, including working with the Early Intervention Foundation as a 'What Works Centre for Early Intervention'
- expand the Start4Life Information Service for Parents from 0-2 years to 0-5 years and sign up over 200,000 more parents
- expand newborn bloodspot screening to include four new inherited metabolic disorders
- work with NICE on the implementation of the quality standards and pathways for emotional and social wellbeing in early years
- lead and co-ordinate the Childhood Flu Programme, working with NHS England
- increase coverage of measles, mumps and rubella immunisations for all children at five years

5 Dementia risk reduction

Outcome:

Reduced prevalence and incidence of dementia among 65 to 74-year-olds.

Why focus on dementia?

It is estimated that more than 800,000 people in the UK have dementia, and this is projected to increase to over 1 million by 2021 and over 2 million by 2051.[64] Four-fifths of people over 50 fear that they will develop dementia.[65] As well as the huge personal cost, the overall economic impact of dementia in the UK is estimated to be £26 billion per year.[66]

In the absence of a treatment or cure, it is important that we take action to reduce the numbers of people getting dementia, postpone the onset of dementia and/ or mitigate its impact. The ground-breaking Blackfriars Consensus,[67] published earlier this year, makes the case for concerted action to reduce people's risk of dementia by supporting them to live healthier lives and manage pre-existing conditions that increase their risk of dementia, such as depression or diabetes. Focusing particularly on avoiding or delaying the onset of dementia for people within ten years of retirement age will mean more people can enjoy a healthy and independent life for longer. Alongside a focus on dementia risk reduction, we also want to support people with dementia to live well to reduce its impact on individuals, their families and carers.

Where are we now?

There are currently estimated to be over 135,000 people aged 65 to 74 living with dementia in England.[68]
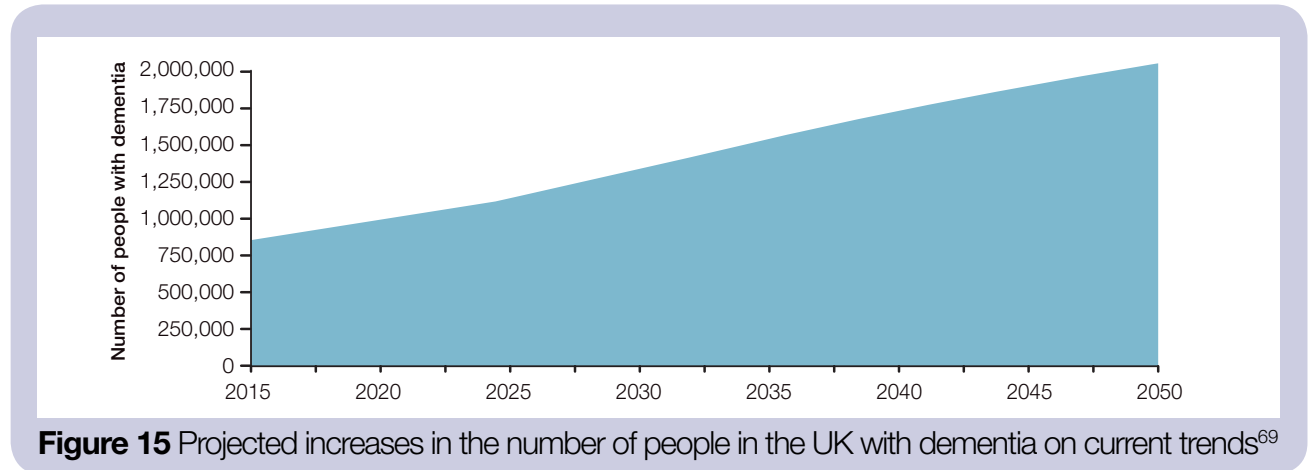
Figure 15 Projected increases in the number of people in the UK with dementia on current trends[69]

Over the next 18 months, PHE will:

- raise people's awareness and understanding and support them to take actions to reduce their risk of dementia by running a major new healthy living marketing campaign aimed at 40 to 60-year-olds, and by working with University College London Partners to develop a new personalised risk assessment calculator for incorporation into the NHS Health Check

- work with NHS England and other partners to build dementia risk reduction into care and support for predisposing conditions and raise awareness of inequalities in dementia, supporting people to receive a timely diagnosis and the care and support they need. This includes work with the Alzheimer's Society and the Depression Alliance on actions to prevent depression and incorporating dementia risk reduction as a key outcome in health improvement programmes, such as the NHS Health Check

- work with Health Education England, the royal colleges and others to increase professionals' understanding of dementia risk reduction

- work with academics and other partners to develop measures for modelling of dementia incidence and prevalence, while continuing to build the evidence base for dementia risk reduction

6 Tackling antimicrobial resistance

Outcome:
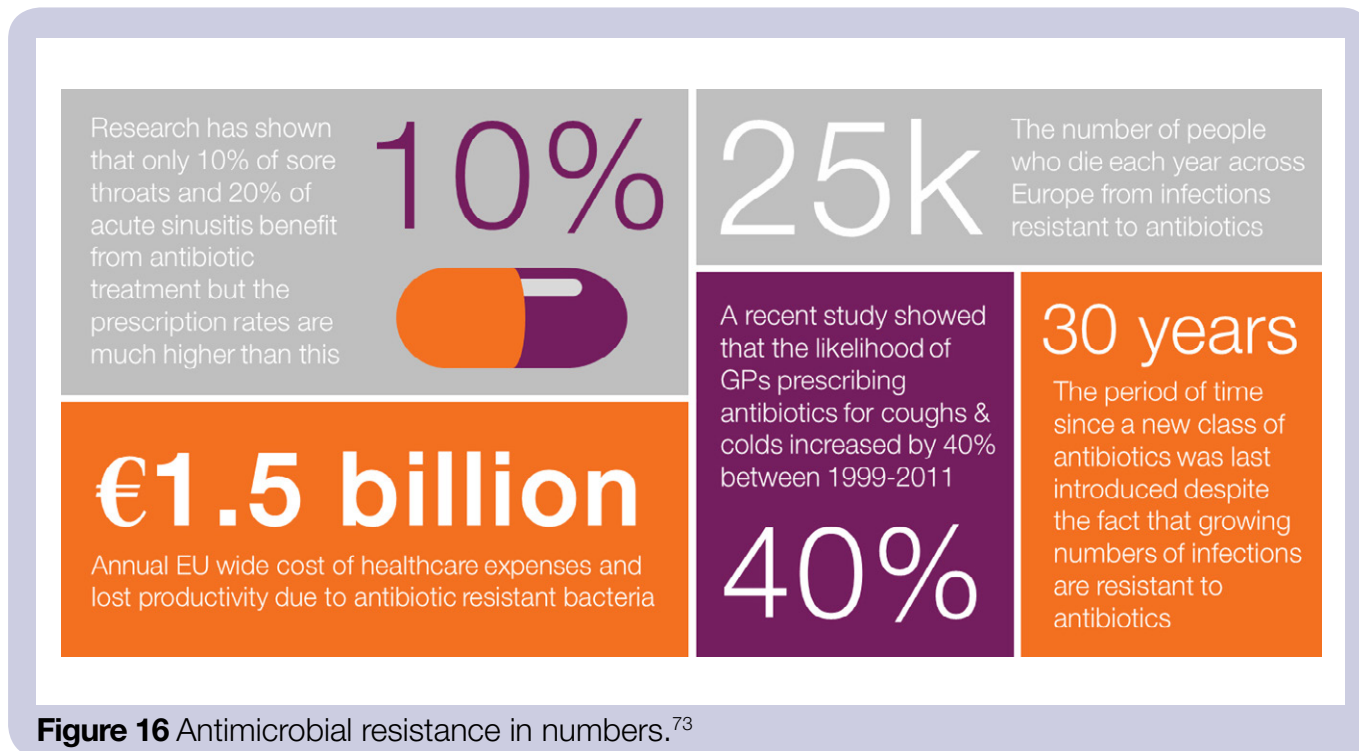
Reductions in the number of serious infections that are resistant to treatment.

Why focus on antimicrobial resistance?

Infections caused by resistant organisms are more difficult and more expensive to treat and often fail to respond to standard treatment, resulting in prolonged illness and greater risk of death. Across Europe, the European Centre for Disease Prevention and Control estimates that 25,000 people die each year as a result of hospital infections caused by five key resistant bacteria, adding – on a conservative estimate – €1.5 billion to hospital treatment and societal costs.[70] Many of the medical advances in recent years, such as organ transplantation and cancer chemotherapy, are dependent on the availability of antibiotics to prevent and treat associated bacterial infections. Inappropriate use and overuse of antimicrobials such as antibiotics is a major driver of antimicrobial resistance.[71]

Where are we now?

The number of antibiotics prescribed in England increased by 6% between 2010 to 2013. The number of bloodstream infections caused by resistant organisms has also increased over this period. For example, one in five bloodstream infections with *Escherichia coli* are now resistant to at least one key drug.[72]

Research has shown that only 10% of sore throats and 20% of acute sinusitis benefit from antibiotic treatment but the prescription rates are much higher than this

10%

€1.5 billion
Annual EU wide cost of healthcare expenses and lost productivity due to antibiotic resistant bacteria

25k
The number of people who die each year across Europe from infections resistant to antibiotics

A recent study showed that the likelihood of GPs prescribing antibiotics for coughs & colds increased by 40% between 1999-2011

40%

30 years
The period of time since a new class of antibiotics was last introduced despite the fact that growing numbers of infections are resistant to antibiotics

Figure 16 Antimicrobial resistance in numbers.[73]

Over the next 18 months, PHE will:

- develop a new national strategy for infection prevention and control across the health and care system

- implement improved surveillance and feedback systems for antibiotic prescribing and resistance to drive down inappropriate prescribing in primary and secondary care

- develop a 'One Health' report encompassing antibiotic resistance and consumption data across the human and animal sectors

- deliver a new data capture system for reporting of healthcare-associated infection

Seven priorities	1 Tackling obesity	2 Reducing smoking	3 Reducing harmful drinking	4 Best start in life	5 Reducing dementia risk	6 Antimicrobial resistance	7 Reducing tuberculosis

Click for next section

7 Reducing tuberculosis

Outcome:

A year-on-year decline in tuberculosis incidence.

Why focus on tuberculosis?

UK incidence is four times higher than in the US.[74] Tuberculosis also continues to disproportionately affect the most deprived communities, with 70% of all cases coming from the 40% most deprived communities.[75]

If current trends continue, England will have more tuberculosis cases than the whole of the US within two years.[76] London is widely cited as being the tuberculosis capital of Western Europe, with examples of outbreaks in other countries originating in the UK.[77] Other comparable countries have seen sustained declines in rates over the past decades, mainly due to improved control.[78] Failure to prevent, diagnose and adequately treat tuberculosis cases in the UK is also leading to the development of drug resistance, onward transmission and outbreaks, including outbreaks of multidrug resistant tuberculosis.[79]

Where are we now?

In 2013 there were 7,290 cases of tuberculosis reported in England, which is a rate of 13.5 cases per 100,000 population.[80] A total of 2,985 cases occurred in London alone, a rate of 35.5 cases per 100,000 population, nearly three times higher than the national average.[81] This is mirrored by rates in Leicester (53.1), Birmingham (38.0), Luton (41.3), Manchester (37.0) and Coventry (36.2), demonstrating that tuberculosis is predominantly concentrated in large urban areas (2011-2013 average rate).[82]
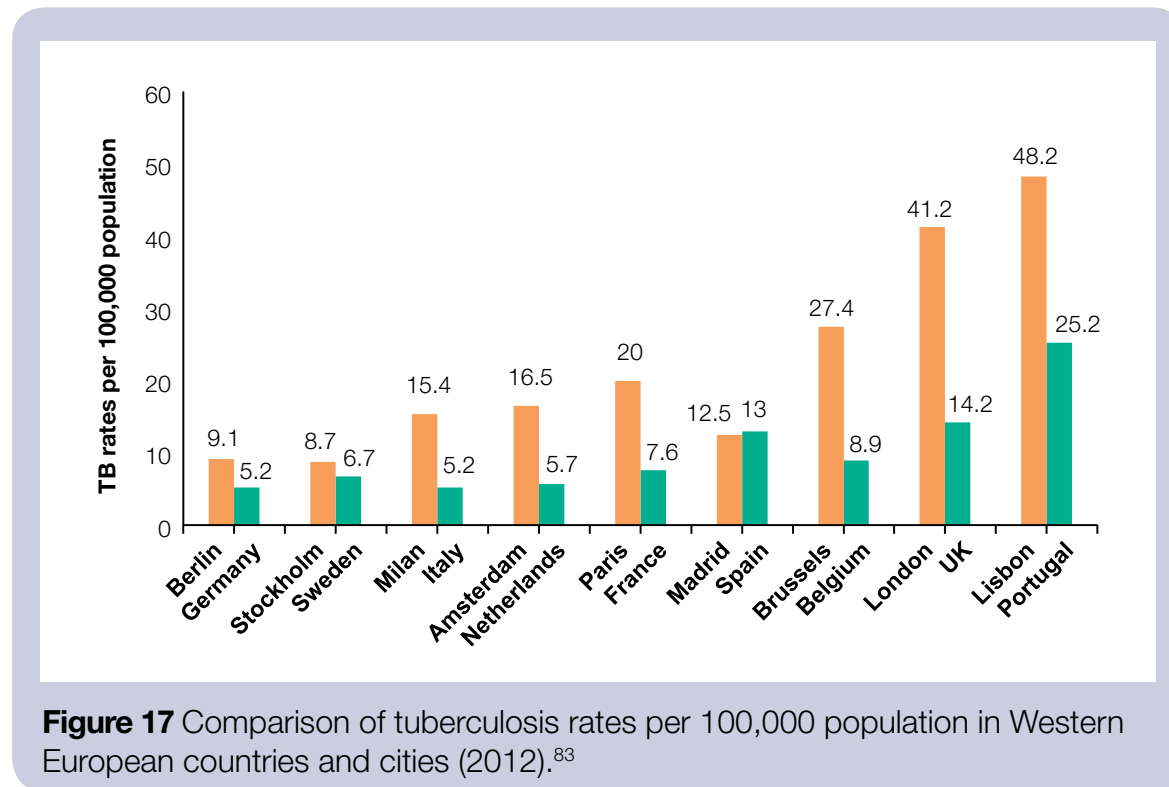
Figure 17 Comparison of tuberculosis rates per 100,000 population in Western European countries and cities (2012).[83]

Over the next 18 months, PHE will:

- publish a collaborative tuberculosis strategy, in partnership with NHS England
- work with local partners, including local authorities and NHS, to set up local TB control boards, focusing on areas of high incidence
- support NHS England to introduce active case finding in underserved populations and the systematic implementation of new entrant latent tuberculosis testing and treatment
- run a pilot programme of whole genome sequencing for TB

New drivers and opportunities

Our starting point for the priorities in this document is that we cannot maintain the status quo. A sustainable health and care service will be one that helps people to stay healthy, and not one that only treats illness.

In driving this agenda forward, the new public health system can take advantage of six 'game-changers' which, combined, offer a unique opportunity for positive change and much faster progress.

The first of these is the application of **behavioural science in the digital age**, which offers the opportunity to reach people we have not been able to reach before. Using digital and mobile technology, and the insights of behavioural science, we can provide personalised support on a mass scale.

Not only is 82% of the population online,[84] but today's smartphones and wearable technology, for example, are allowing us to measure our own heart rates or count how many steps we take every day.

PHE will develop new approaches to motivate and support people to make healthy changes in a way that resonates with them. We will partner with one or more universities to bring to bear in depth the insights of social and behavioural science in tackling our seven priorities. We will make greater use of competitions and other innovative approaches to encourage the best ideas in applying digital technology to promote behaviour change and improve health.

We will continue to support local authorities and the NHS in adopting digital tools, building on the Change4Life and Stoptober campaigns, which already engage hundreds of thousands of people each year and on innovation programmes such as our Health X competition for new health-related apps.

The second game-changer is the importance of **place-based approaches** under the leadership of local authorities, working with clinical commissioning groups and professional bodies including the Chartered Institute of Environmental Health, Faculty of Public Health and Royal Society for Public Health. At its heart, this means developing local solutions that draw on all the assets and resources of an area, integrating public services and also building resilience in communities so that they take control and rely less on external support.

PHE will support the work of local authorities on integrating health care and other local services and will work with national partners such as Citizens UK to build powerful national and local networks. We will also develop the evidence base on community development interventions.

The third game-changer is the opportunity to develop evidence-based **NHS preventative services** and implement them at scale. As the NHS Five Year Forward View sets out, a greater investment in prevention, integration and supporting health is necessary to sustain the NHS we all want to see, within the resources that are likely to be available.

PHE will develop a new preventative services programme with NHS England, which will assess the evidence, design the interventions and support the implementation of proven approaches to prevent disease. We will start with diabetes, where our ambition over the next five years is to be the first country to implement at scale a national evidence-based diabetes prevention programme.

The fourth game-changer is **transparency**, so that everyone can access information on performance or need, and the evidence on 'what works'. Meaningful data and information will allow communities and decision-makers to make better decisions about how to improve health, and will increase accountability.

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PHE will publish the evidence and intelligence we hold in an engaging and relevant way, and ensure that our information products are easily accessible and useful. We will develop a much clearer focus on the economic case for prevention, being clear on the return on investment in the public's health, including the practicalities of how to implement and how to ensure the expected returns are realised and savings cashed. We will build on our initial products in this area, for example the local authority Spend and Outcome Tool (SPOT) and the return on investment tools developed by NICE.[85]

We will establish a partnership with the Chartered Institute of Public Finance and Accountancy and local authorities to focus on the cost effectiveness of, and return on investment from, public health interventions. Our joint work will provide reliable data on patterns and trends in spend by public bodies on services and infrastructure that are relevant to the determinants of health. We will then relate these patterns of spend to (a) patterns of health need and outcome locally and (b) the existing evidence base on cost-effectiveness in order to help local authorities and clinical commissioning groups make decisions on future spending priorities. We will also expand our work on the atlases of variation to establish a new

National Variation and Value Service providing the definitive analysis of population level variations in the supply of care.

In all of this, we will develop robust, practical and relevant approaches that we know local authorities and the NHS are looking for. For example, the Well North programme[86] we are developing with Manchester University and local authority and academic partners across the North will build on hotspot analysis to identify communities that use lots of hospital services and propose targeted preventative interventions to both improve health and reduce the reliance on hospital-based services.

The fifth game-changer is the powerful contribution of **employers** to improving people's mental and physical health. The link between health and work is increasingly well understood: good quality work promotes better health, and a healthier workforce is a more productive one. As the Chief Medical Officer's annual report for 2013 sets out, successful strategies have been developed for helping people with mental health conditions return to work.

This year, we have launched a national set of standards on workplace health – the Workplace Wellbeing Charter – which provides

a 'roadmap' for businesses wanting to improve the health and wellbeing of their staff.

The sixth game-changer is to redefine our approach to improving health through the application of the concept of **wellness**. Historically, we have only measured illness and healthcare activity. Neither adequately captures our experience of health. We are keen to see wider measures of wellness adopted to give a much broader, person-centred view of health and the application of this concept systematically across the health and care system.

We need to establish clearer terminology, develop reliable measures and be able to more effectively develop, collect, share and use the evidence of what works to improve wellness and wellbeing. We are helping to establish a world first – a 'What Works Centre for Wellbeing' – to do just that.

Taken together, we believe these game-changers present a real opportunity to improve the public's health and deliver on the priorities we have chosen. We will align our resources behind these, working across the whole public health system: local and central government, the NHS and clinical commissioning groups,

universities, professional bodies, industry, employers, the voluntary and community sector and the public themselves to deliver tangible improvements. Our focus will be on what works and turning evidence into action.

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