Department of Health

Living Well for Longer:

A call to action to reduce avoidable premature mortality

DH Information Reader BOX

Policy HR/Workforce Management Planning/Performance	Clinical Commissioner Development Provider Development Improvement and Efficiency	Estates IM & T Finance Social Care/Partnership Working
Document purpose	Consultation/Discussion	
Gateway reference	**18716**	
Title	Living Well for Longer: a call to action to reduce aviodable premature mortality	
Author	Public Health Policy & Strategy Unit/NHS Commissioning Unit	
Publication date	**05 March 2013**	
Target audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Voluntary & community sector, commissioners and providers of other public services, Government departments	
Circulation list	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Local Authority CEs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, GPs, Voluntary Organisations/NDPBs, other Government Departments, Clinical Commissioning Groups	
Description	LIVING WELL FOR LONGER is about challenging and inspiring the health and care system, in its widest sense, to take action to reduce the numbers of people dying prematurely. By establishing a common vision that we know our stakeholders support, this 'call to action' aims to open a debate about the challenges we face.	
Cross reference	Cardiovascular Disease Outcomes Framework	
Superseded documents	N/A	
Action required	N/A	
Timing	N/A	
Contact details	Dr Felicity Harvey Department of Health Richmond House SW1A 2NS 020 7210 4850 www.dh.gov.uk/health/2013/03/mortality	
For recipient use		

Living Well for Longer:

A call to action to reduce avoidable premature mortality

First published March 2013
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

Contents

Foreword 3

Chapter 1 Measuring up to the best – the challenge we face 5

Chapter 2 Working across the health and care system 12

Chapter 3 Taking action 14

- Building a new health and care system 14
- The role of government 15

Chapter 4 Action to improve transparency and accountability 20

- Measuring success 21
- Improving our position 22
- Reporting on progress 22
- Next Steps 23

Chapter 5 A Call to Action 24

References 25

Foreword by Jeremy Hunt, Secretary of State for Health

We have made great strides in improving the health of the nation in recent decades. However when I became Secretary of State for Health, I was shocked to discover that, despite these improvements, too many people in this country are dying too young from diseases that are largely avoidable.

I want us to be up there with the best in Europe when it comes to tackling the leading causes of early death, starting with the five big killer diseases – cancer, heart, stroke, respiratory and liver disease. But the striking picture of our health outcomes across these major causes of early death published in the Lancet recently*, shows that we have a long way to go before we are confident that we can achieve this aspiration.

My intention in launching this call to action is to focus attention on premature mortality and challenge the health and care system to do more about it. Being amongst the best in Europe requires us to make a step change in improving the health of the nation. The scale of the challenge is significant, but I am confident that this ambition will resonate with you all. Government will play its part, but government cannot do this alone.

This call to action is directed at the health and care system locally and nationally, across the breadth of public services that affect the health and wellbeing of people living in England today. Locally this will take strong partnerships across local councils, Clinical Commissioning Groups and health and care providers and their partners with leadership from health and wellbeing boards.

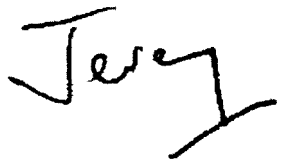
Nationally, wider government as well as the Department of Health, the NHS Commissioning Board and Public Health England, will need to co-ordinate their efforts and work together in doing what should, and can only be done nationally. We also need to see action on the wider social determinants of health that drive the health inequalities that still persist. All of us need now to determine what we will do to avoid premature mortality, guided by the outcomes frameworks for public health and the NHS where shared measures for premature mortality are designed to lead to greater alignment of actions.

I want to open an enduring and sustainable debate on reducing premature mortality – it is too important an issue to discuss through short-term consultation efforts. This call to action is designed to generate open and honest debate, leading to action, over future months and

* The Lancet has published a UK digest of the ground breaking research by the Institute for Health Metrics and Evaluation based at the University of Washington, on the global burden of disease

years, to see what more all of us can do, and do better, to reduce premature mortality. To begin this, I have posed some challenging questions throughout this document.

Today, I call on all those involved across the health and care system and beyond to come together to determine what they should be doing to support their local communities to live longer, healthier lives. We will not be the best in Europe immediately. But we need to start making changes now. It is time to be bold and ambitious for health.



JEREMY HUNT
Secretary of State for Health

Chapter 1 – Measuring up to the best – the challenge we face

1.1 Great strides have been made in improving our health in recent years. As a nation, we are living longer than ever before.[1] However, in spite of this progress, we are not yet at the level of the best – too many people are still dying at too young an age. We want people right across society to live longer and to spend more of their lives in good health. So, our aspiration should be ambitious and challenging – for England to have the lowest rates of premature mortality[2] amongst our European peers.

Fig 1: Under-75 all cause mortality rate for European countries (2010 or nearest)[3]

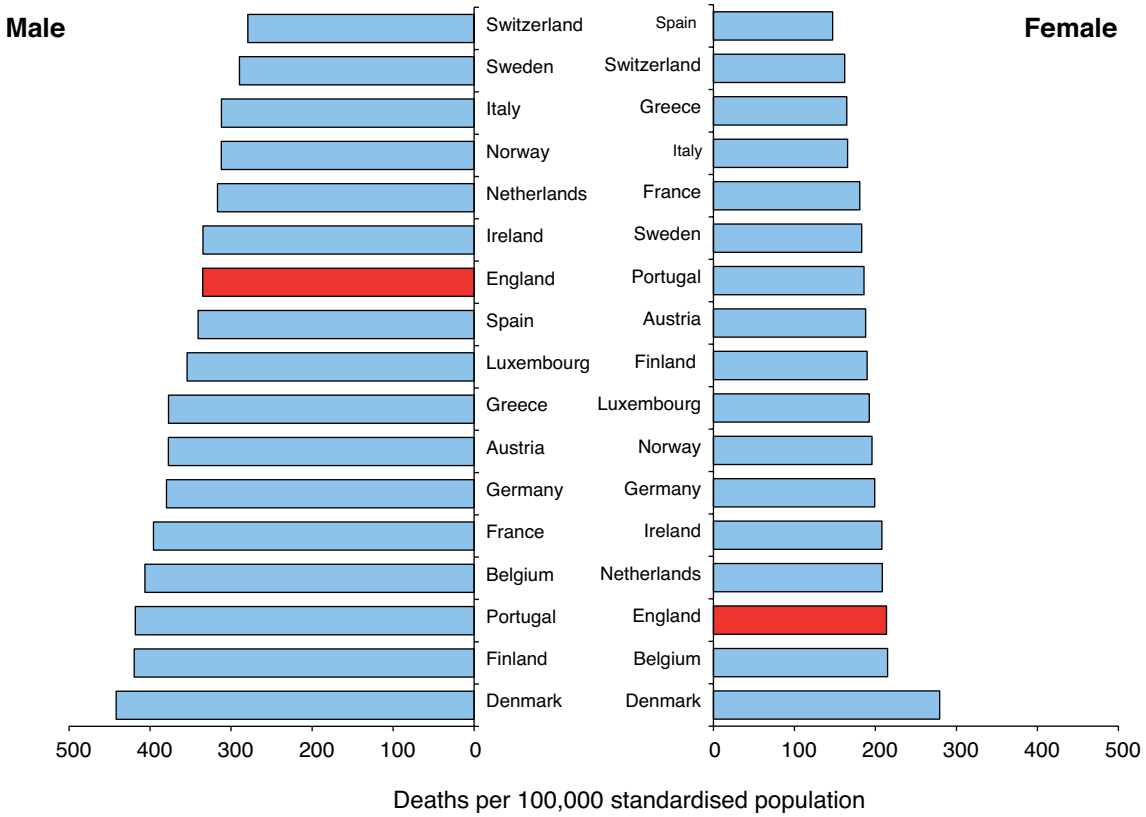


Fig 2: Under-75 circulatory disease mortality rate (2010 or nearest)[4]

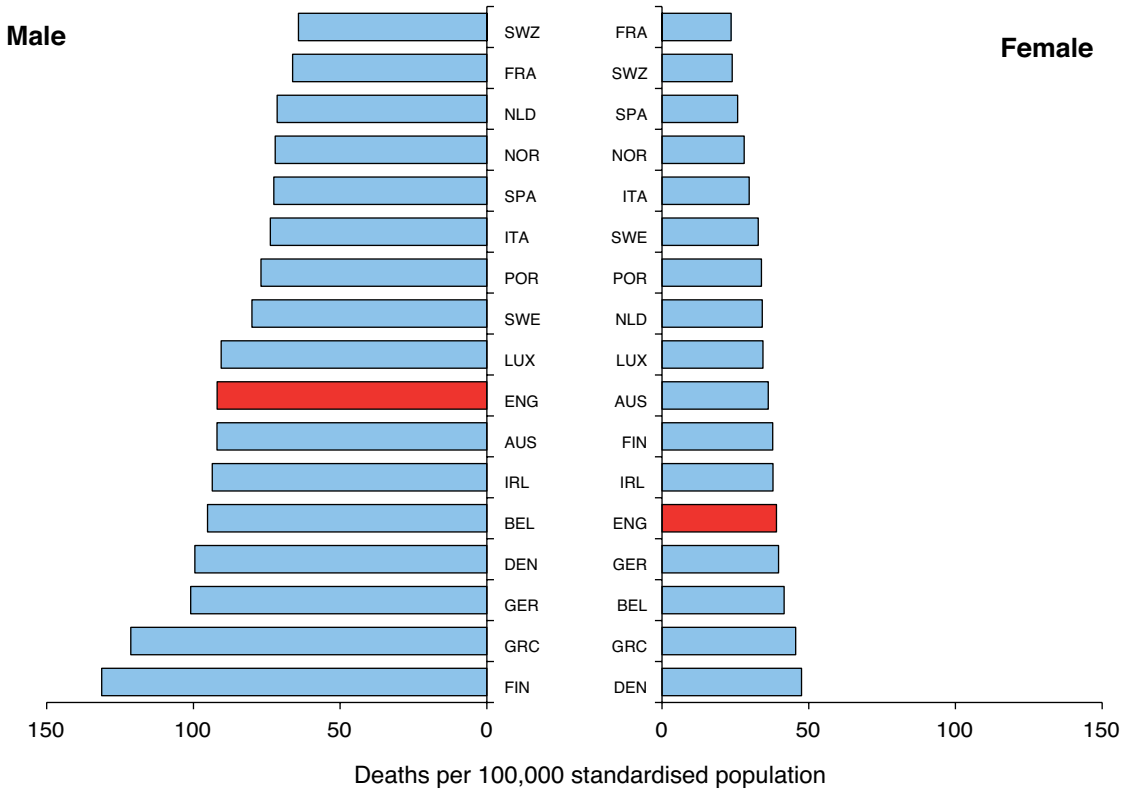


Fig 3: Under-75 cancer mortality rate (2010 or nearest)[5]

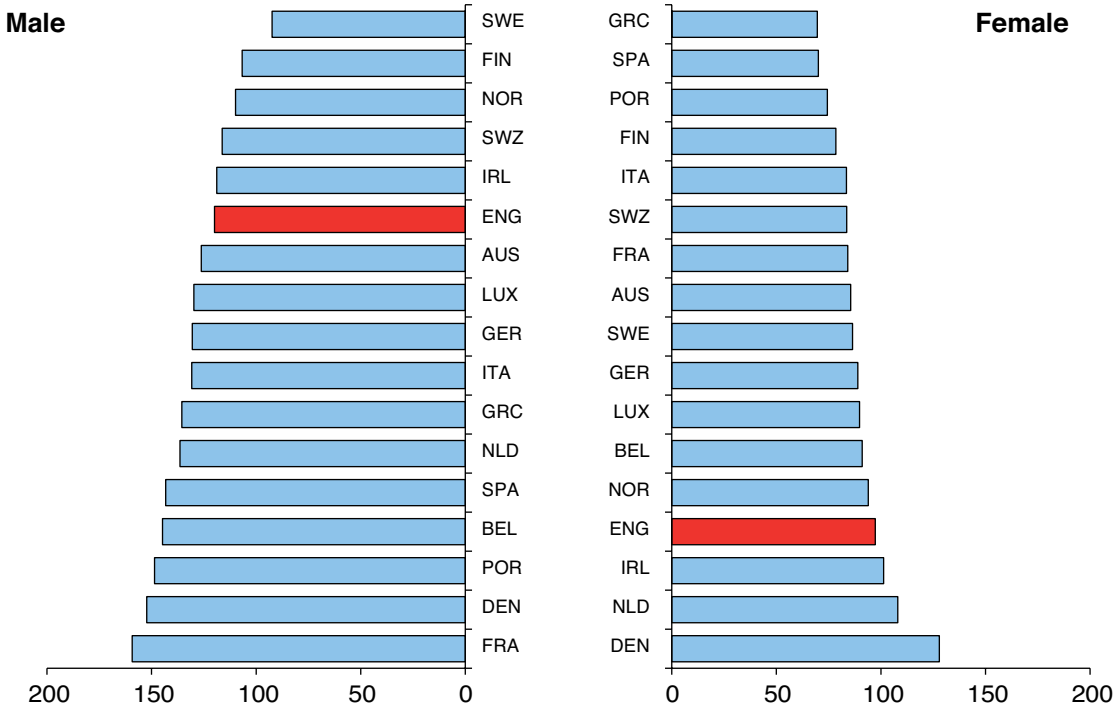


Fig 4: Under-75 respiratory disease mortality rate (2010 or nearest)[6]

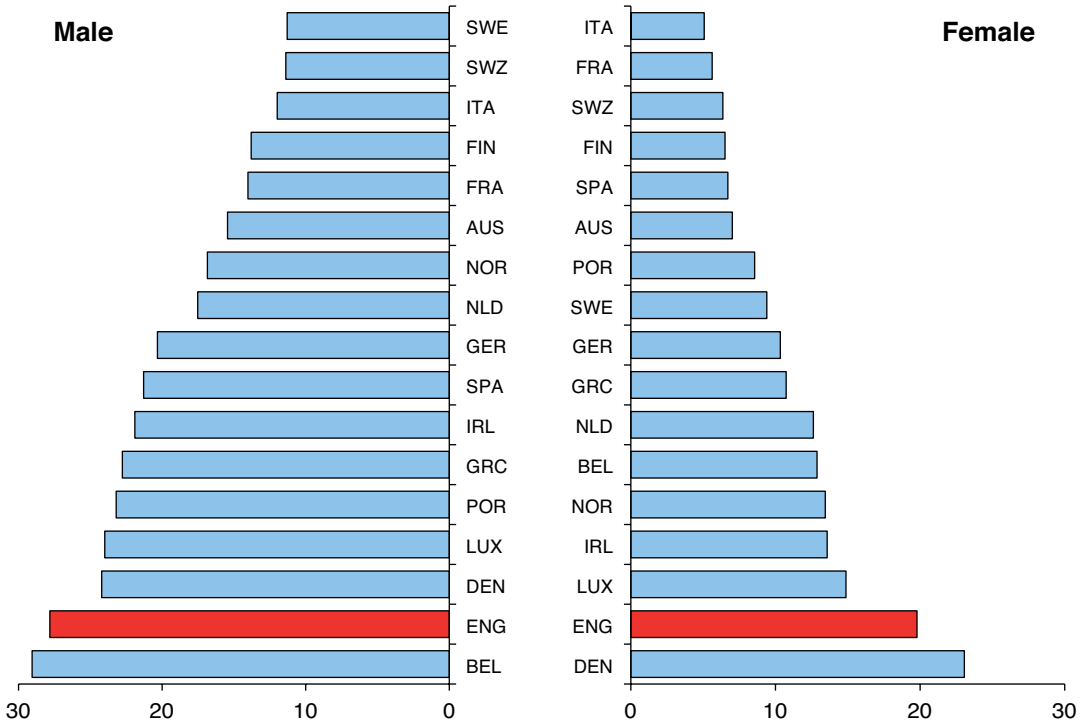
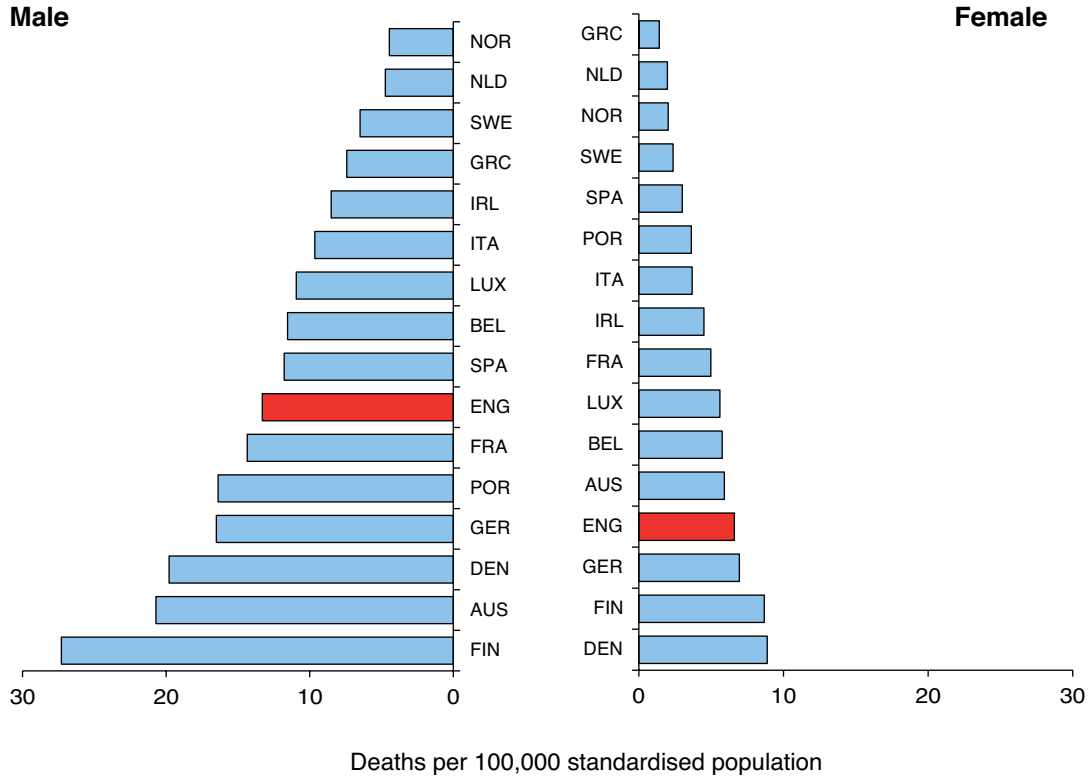
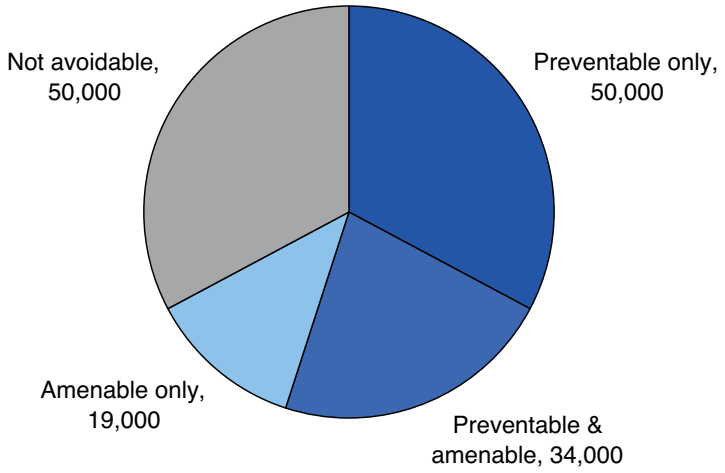


Fig 5: Under-75 liver disease mortality rate (2010 or nearest)[7]



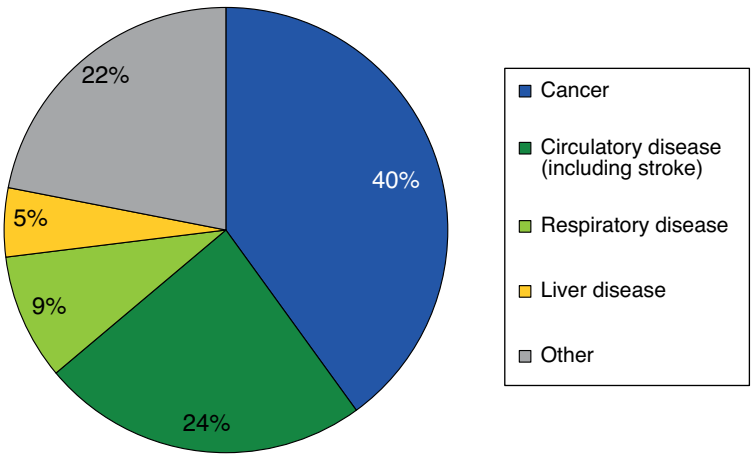
1.2 Many of these deaths are avoidable. Around two thirds of deaths among the under 75s are avoidable – that is around 103,000 deaths. These deaths could be avoided through public health interventions such as getting people to take more exercise or stop smoking, or in tackling the wider social determinants of health – what is termed preventable mortality, or through health care interventions such as early diagnosis of diseases or conditions and through effective treatment – amenable mortality.

Fig 6. Number of avoidable deaths among under-75s in England (2010)[8]



1.3 Last year in England, over three quarters of all deaths in people under 75 years were as a result of the five big killers. 60,000 people died of cancer (excluding liver cancer), 37,000 died of circulatory diseases, including stroke, 14,000 died of respiratory diseases and 8,000 died of liver conditions (including liver cancer) under the age of 75.[9]

Fig 7: Causes of death for people aged under 75 in England[10]



1.4 For the average local authority with a population of around 350,000 this means that each year around 400 people die prematurely of cancer, 250 people from heart disease and stroke, 100 people from respiratory disease and 50 people from liver disease (although there are large variations across local authorities).

1.5 The Institute for Health Metrics and Evaluation have extended their seminal work on the Global Burden of Disease 2012 to focus specifically on the UK.[11] The findings of this timely study show that whilst our mortality rates and years of life lost have decreased substantially in the UK over the last 20 years, our increased years of life are more likely to be spent in poor health.

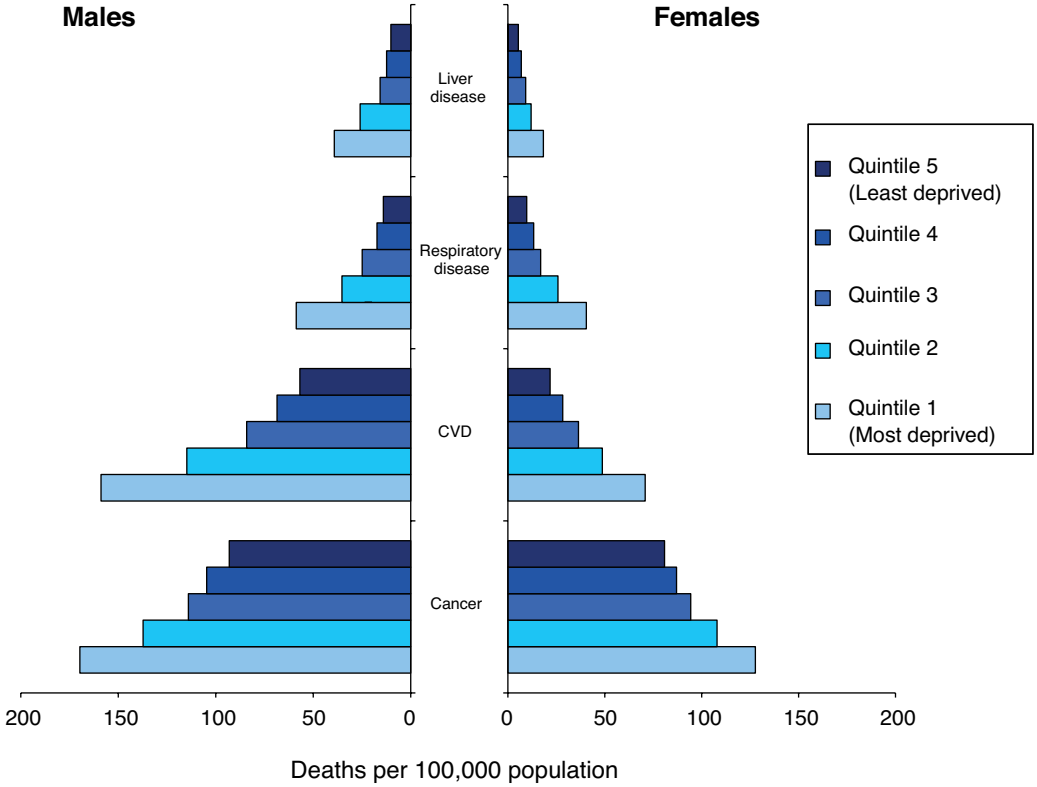
1.6 For simplicity's sake, we are choosing just one of the indicators highlighted by the study – under 75 mortality; and we are focusing on England. While the absolute numbers differ, the trend we need to combat does not. Scotland, Wales and Northern Ireland will address these issues in their own health and care systems.

1.7 Improvements in the UK – and England – have been patchy in comparison with those in other developed countries. For example, whilst we have made substantial progress in health outcomes over the last 20 years, rates of premature mortality have not improved at as quickly as other European countries, worsening our relative position by 2010. This relative decline is strongest for men and women aged 20-54.

1.8 By focusing on early death, and on these five killers in particular, we are not ignoring the fact that people also die from other causes, or struggle with other long term conditions, such as raised blood pressure or Type 2 diabetes. Indeed, we know that taking action to address the big killers will bring benefits across the spectrum of ill health. We also know that many people will be living with more than one of these long-term conditions at the same time – and in fact, people in our more deprived communities are more likely to live with multiple morbidities. And whilst we focus on premature mortality – deaths under the age of 75, we still need to maintain our efforts in preventing avoidable deaths in older age – for example in improving cancer mortality rates amongst older people, where we compare badly to other countries. The actions we need to take in preventing premature mortality are the same actions that we should take in increasing healthy life expectancy at all ages.

1.9 Sir Michael Marmot's review of health inequalities in England[12] has demonstrated a social gradient in health: the more socially deprived people are, the higher the chance of avoidable premature mortality. This is strikingly apparent across the five big killer diseases. Figure 8 shows that for both men and women, it is more likely that those most deprived have higher rates of premature mortality from the major killer diseases.

Figure 8 – Mortality rate from the big killers across deprivation quintile[13]



1.10 This stark picture of health inequality must be at the forefront of our minds in trying to tackle the causes of ill-health and disease. For example, more than twice as many people from the poorest backgrounds die of circulatory disease than those from the most affluent backgrounds. It will be essential that in working towards our ambition, we are taking deliberate action to tackle the underlying social determinants of health that drive these unacceptable health inequalities.

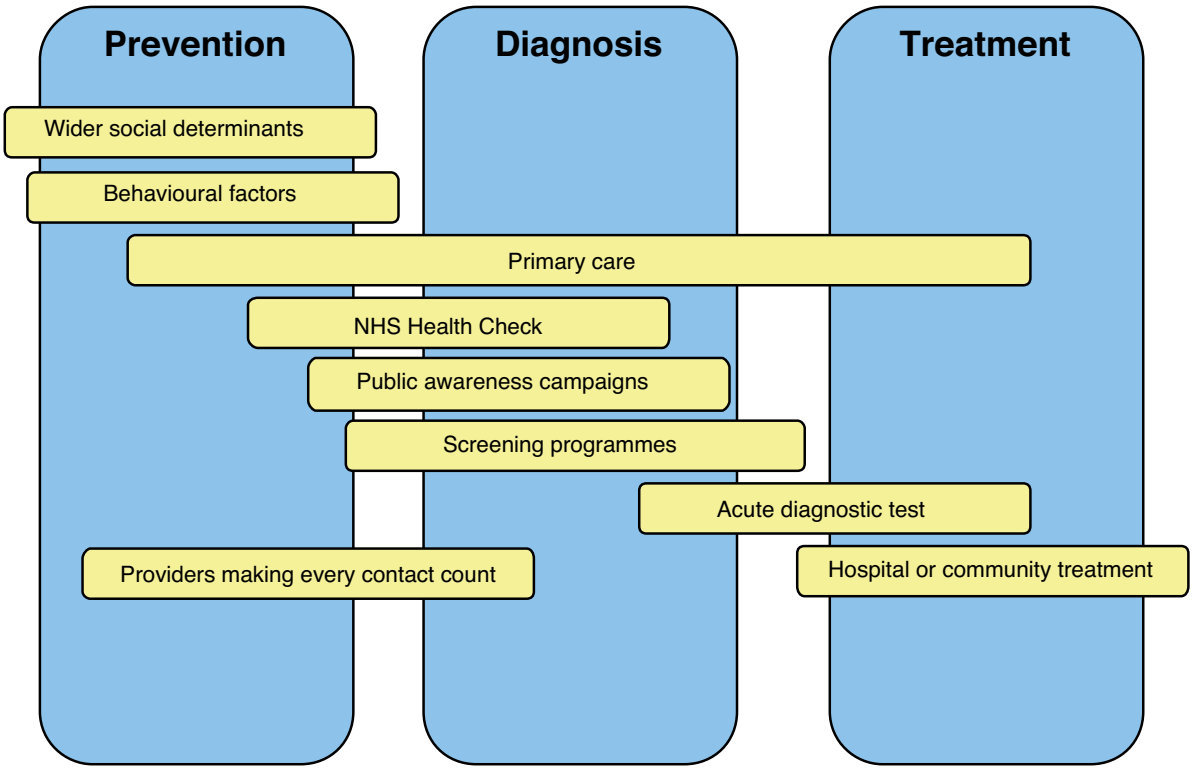
1.11 We also know that whilst the number of people overall who engage in multiple risky health behaviours, such as excessive drinking, or smoking, or having a poor diet, has reduced, people from poorer backgrounds, and the most vulnerable are still more likely to undertake three or more of these behaviours.[14] We know this is likely to lead to a much earlier onset of some of the major causes of early death such as cancer or CVD.

1.12 There is a strong association between smoking and mental health disorders. Overall smoking prevalence among psychiatric patients is two to three times higher than among the general population, ranging from 40-50% among people with depressive and anxiety disorders to 70% or higher among patients with schizophrenia. This contributes to a shameful inequality in outcomes for people with serious mental illness who have a 20-year shorter life expectancy than the general population.[15]

1.13 The wider determinants of health also have a greater impact on people from poorer backgrounds. For example, research has shown that violence, as well as being a major cause of poor health and wellbeing, costing the NHS £2.9bn a year, has a disproportionately high impact on people from areas of high deprivation.[16]

How can we make greatest impact where we need to – in reducing health inequalities?

Chapter 2 – Working across the health and care system



2.1 If we are to tackle the challenge we face, we need to make improvements across the three domains of prevention, early diagnosis and treatment. Two thirds of deaths under 75 are avoidable, and around 80% of those are preventable,[17] largely through improved public health. As the diagram above demonstrates, many interventions span one or more of these domains.

2.2 From April, local government will be the major force for improvements in public health as it takes on responsibility for health improvement. This complements its local responsibilities for tackling the wider determinants of health, such as air quality,[18] road deaths, transport, noise, violence, housing, fuel poverty, and use of outdoor space. Bringing together lead responsibility for preventative action across this wide spectrum will lead to a unified approach to tackling the causes of ill health. The Public Health Outcomes Framework includes a range of indicators that focus on these issues, representing the preventative actions that can be taken on the social determinants of health.

2.3 Maximising opportunities across primary care will be essential to reducing premature mortality, as their role spans prevention, early diagnosis and treatment. We need especially to do much more to improve our rates of early diagnosis. Action in primary care will make sure we are not only identifying the key risk factors, diagnosing illness and long-term conditions as early as possible, but ensuring proper case management of people's conditions and risks with appropriate and timely referral to secondary care for further treatment.

2.4 GPs and community pharmacy are ideally placed to deliver preventative programmes such as NHS Health Checks, brief interventions and making the most of the fact that we know that people generally respond well to professional health advice. They are essential in identifying risk factors and early diagnosis of illnesses, so that effective treatment and care can have the greatest benefit possible.

2.5 The local healthcare system led by Clinical Commissioning Groups (CCGs) will be empowered to respond to the needs of their patients taking steps to commission the right services. Therefore the relationship between CCGs, primary and secondary care is critical to the impact we need to make to increasing rates of early diagnosis and providing secondary care.

What more can be done across primary care, especially general practice, to get up to the level of the best, particularly in early diagnosis?

2.6 We know that we would avoid around 10,000 deaths per year if cancer survival matched the best in Europe, and many of these avoidable deaths are in people under 75 years.[19] This will require a combination of earlier diagnosis and better treatment. We also know that clinical outcomes vary across specialities and across trusts.

Why is variation in clinical outcomes of acute treatment so big, both within and across trusts?

What can be done to reduce these variations?

2.7 By taking effective action across the spectrum of prevention, diagnosis and treatment we will drive down the numbers of people dying prematurely, and reduce the burden of illness as a whole. In so doing our focus will not simply be about helping people to live longer; it will be about supporting them to improve their quality of life – particularly if they are living with long-term conditions. But, we will only achieve this ambition through harnessing the leadership and expert capacity across the system nationally and locally.

Chapter 3 – Taking Action

Building a new health and care system

3.1 As a result of the reforms to the health and system, from April 2013, the health system will be better placed to bring about change. But reducing premature mortality will still be a major challenge – this is reflected as a priority for the new system in the outcomes frameworks for public health and the NHS, in the Government's mandate to the NHS Commissioning Board and as a guiding principle for the work of Public Health England.[20]

3.2 Local authorities, supported by Public Health England, and the National Institute for Health and Clinical Excellence evidence,[21] will lead the charge to reduce preventable early death, through their new health improvement responsibilities. For the first time, local authorities will receive a ring-fenced budget (£5.45bn over the next two years) to focus on improving public health.

3.3 The NHS will lead on reducing premature mortality that is amenable to health care interventions. In the new system, local clinicians will have the freedom to design the services that meet the needs of their populations. An independent NHS Commissioning Board will oversee continuous improvements in quality of treatment and care. The mandate to the NHS Commissioning Board set out our ambition for England to become one of the most successful countries in Europe at preventing premature deaths, and set an objective to make measurable progress towards this by 2016. Domain 1 of the NHS Outcomes Framework focuses on preventing people from dying prematurely and acts as a catalyst for driving improvements.

3.4 Local health and wellbeing boards, involving local authorities, clinical commissioning groups and Healthwatch will look strategically at the current and future health and social care needs of their local populations, and agree local priorities for action. This will underpin local planning enabling the right services and other activities to be planned for their area across the spectrum of prevention, early diagnosis and treatment. This call to action aims to encourage and inspire health and wellbeing boards as the system leaders to develop their own local challenge – or call to action, driving local change for local people, responding to the issues their communities face.

3.5 The voluntary and community sector, professional bodies and academic experts will have a major role to play in helping to drive innovation and making sure the public and patient voice is heard. Their direct relationship with the public, patients and professionals will provide an invaluable network both to draw best practice from, and to promote the purpose of this call to action.

3.6 However, doing more of the same won't get us as far as we want to go. Public Health England will have a major role in working with local government, the NHS and other partners to push the boundaries of innovation – looking for the next big thing – or the very many small things we can do to be healthier and live longer.

3.7 We will also need to work harder across the system to take account of the fact that many people suffer from a number of conditions simultaneously. The increasing prevalence of multiple morbidity is an important factor in tackling preventable mortality. Evidence from the OECD[22] shows that the most vulnerable and deprived in our communities are more likely to suffer from multiple morbidities; for example people with mental health problems are the most likely to suffer from at least two or even three major conditions.

What will your organisation do over the months and years ahead to help the people that you support to live longer, healthier lives?

The role of government

3.8 Alongside the wider health and care system, government has a key role to play in creating the right environment for promoting good health, and driving innovation in the system so that we can all do more. The Public Health White Paper, *Healthy Lives, Healthy People,* in 2010 introduced a new vision for improving public health, based on an understanding of the wider determinants of health, a broader-based response engaging a wider range of interactions with behavioural impacts. This has led to the identification of the priorities for action on prevention in a newly reformed public health system, based on strong evidence and focused on the key risk factors that cause premature death. So we know that taking action on the major risk factors – smoking, excessive alcohol consumption, poor diet and lack of physical activity – and tackling the wider social determinants of ill health will make a significant difference to our rates of premature mortality.

3.9 This requires action from right across government – not just from the Department of Health – on issues such as tobacco, alcohol, physical activity, local environmental quality including noise and air quality, housing (including fuel poverty), employment, violence and re-offending, access to green spaces, active travel, food and diet.

What more can be done by local organisations and/or national bodies working in partnership to bring about a step change in the health of the nation?

What are the barriers and incentives to delivering what we have already signed up to?

Action on tobacco

On smoking – in England the rate of smoking prevalence is just below 20%; in Luxembourg it is 17%.[23]

3.10 Tobacco use is the single biggest behavioural risk factor for premature death.[24] The latest figures show that 79,100 or 18% of deaths in adults aged 35 and over in England can be attributed to smoking.[25] Concerted action has led to smoking prevalence among adults falling below 20% for the first time since statistics have been collected.[26]

3.11 However, we know that still more action is needed to reduce levels of smoking further faster, if we are to have the lowest levels of premature mortality in Europe. If the prevalence rate could be reduced by one half of a percentage point per year for the next three years (to 18.5%), approximately 6,700 cumulative premature deaths could be avoided by 2015. Therefore, the Government will continue to implement the Tobacco Control Plan[27] including through:

- Ending displays of tobacco products in small shops in April 2015.
- Deciding whether to introduce standardised packaging for tobacco products following the recent consultation. This consultation sought the views of interested people and organisations on whether this measure would bring any additional public health benefits.
- Continuing to run high profile marketing campaigns, such as Stoptober, targeting smokers most at risk of dying prematurely from a smoking related illness, such as those with a mental illness or long-term condition.
- Through Public Health England, supporting local authorities to pursue evidence based tobacco control policies, with cessation efforts targeted at those for whom giving up offers the greatest advantage such as people with mental illness and pregnant women.

What new actions (aside from standardising packaging, as this has already been consulted on) do you think government and local authorities could take to have the greatest impact on helping children resist the temptation to start smoking and to help those who smoke to stop?

Are there innovative ways to help smokers who are the focus of numerous campaigns to change their behaviours across multiple risks such as smoking, drinking, physical activity and diet? Or to help those who are tackling other challenges arising from deprivation as well as trying to stop smoking?

Action on diet and physical activity

On physical activity – in the UK 63% of the population does less than 30 minutes of physical activity five times a week, compared to 16% in Greece.[28]

On diet – in the UK, we eat on average fewer than three portions of fruit and vegetables a day, compared to over five a day in Italy.[29]

3.12 It has been estimated that poor diet is a factor in perhaps 70,000 preventable premature deaths each year.[30] The Government is taking action through the Responsibility Deal, working with the food industry to reduce trans-fats, sugar and salt in our diet. We continue to work on a new salt reduction strategy to help reach our target of no more than 6g per day per person – directly seeking to reduce rates of raised blood pressure, the leading risk factor for cardiovascular disease. New initiatives will start shortly to reduce saturated fat consumption and we want to shift the balance of promotional activity towards healthier foods. The new 'Be Food Smart' campaign is already promoting the Change4Life message through TV, radio and online advertising.

3.13 We estimate that around 48,000 deaths per year in England are attributable to being overweight or obese.[31] Action to improve diet is critical to tackling obesity, a major cause of heart and liver disease, stroke, type 2 diabetes and some cancers. The Call to Action on Obesity in England[32] sets out a comprehensive approach and set of actions to tackle obesity at local and national level, for children and for adults.

3.14 Through the Responsibility Deal, our major food retailers and manufacturers are for the first time taking co-ordinated action to help people eat fewer calories through measures such as reformulating to reduce calories in familiar dishes, reducing portion sizes and promoting lower calorie options. Change4Life is reinforcing the message with the new 'Be Food Smart' campaign. The 'Be Food Smart' meal mixer app has been a great success. It has been downloaded more than 200,000 times, making it No.1 in the iTunes Food and Drink charts since its launch.

3.15 As well as all this, the Department of Health's Change4Life campaign is spreading the message of the positive benefits of physical activity on health. The £36m investment in the School Games and Change4Life School Sport clubs is paying dividends in helping to ensure a physical activity habit for life especially for the least active.[33] The School Games has over 11,000 schools signed up providing sporting opportunities for millions of children and young people. Additionally, the Responsibility Deal Physical Activity Network has already engaged more than 260 private and voluntary sector partners through a series of pledges to drive up physical activity levels.

3.16 Action to drive up levels of physical activity is taking place across government. The Department for Transport is promoting active travel (walking and cycling for travel purposes) which is accessible and can be easily incorporated into everyday life. For example across a town of 150,000 people, if everyone walked an extra 10 minutes a day, 31 lives could be saved.[34]

3.17 The Department for Culture, Media and Sport are working to secure an Olympic legacy is increasing sports participation across the population. In addition, access to pleasant local environments, such as outdoor and green spaces, helps to encourage physical activity. An example of this is securing the future of the Walking for Health initiative, now led by Macmillan Cancer Support and The Ramblers.

What more can be done to incentivise the purchase and consumption of a healthier diet, and to support an increase in physical activity levels, to help reduce the risk of conditions like diabetes or cardiovascular disease?

What are the innovative and value for money approaches we should look to roll out at local level, making the most of the advantages and opportunities of the newly reformed health and care system?

Action on alcohol

On alcohol – in the UK we consume 10.2 pure alcohol litres per capita, compared to 6.9 litres in Italy.[35]

3.18 Alcohol is the third biggest behavioural risk factor for disease and death in the UK after smoking and poor diet.[36] In 2011, there were nearly 6,800 deaths directly related to alcohol, and an estimated 15,000 in total attributable to alcohol in England.[37] Rates of alcohol consumption have risen over the past 50 years, and in contrast to other EU countries, incidence of deaths due to liver disease is increasing.

3.19 The Home Office consultation on several proposals from the Government's Alcohol Strategy ran from 29 November 2012 to 6 February 2013. This included consulting on a minimum unit price for alcohol of 45p.[38] This intervention has the potential for a major impact on a range of alcohol related harms, including on health, where it is estimated to save 700 lives per year after ten years.

3.20 Through the Responsibility Deal, we will look to remove a billion units of alcohol sold annually, by December 2015. We will be working with our trade partners as well as with local authorities and Public Health England to deliver this challenging ambition.

How can local areas best work with all local and national partners to prevent and address the harms to people's health that can arise from alcohol?

Chapter 4 – Action to improve transparency and accountability

4.1 Knowing how well we are doing is what drives us to improve. And we know that there is unacceptable variation in the quality of services across the country. Evidence suggests transparency has a positive effect in improving our care services and our health outcomes. An example of this is the publication of Tobacco Control Profiles by the London Health Observatory on smoking rates nationally and at local authority level in England since 2009. This has helped drive local and national action on tobacco control and smoking cessation, helping to contribute to lowest national level of smoking prevalence we have ever seen. Another example is variations in heart surgery, where surgeons have voluntarily published outcome data since 2005. By 2010, risk adjusted mortality rates for cardiac surgery had significantly dropped, with England and Wales performing 25% better than the European average.[39]

4.2 The Government's information strategy for health and care in England[40] sets out how transparency and more open data can drive improved performance, accountability, treatment compliance, better experiences of care and better outcomes.

4.3 We want every locality in the new system to understand how it compares with similar areas in England and how England compares across Europe. And we want to support members of the public and interested groups to challenge their local health and wellbeing boards and local commissioners where they could be doing more to achieve better outcomes. Local government has a strong track-record in driving improvement as a result of greater transparency and accountability.

4.4 In April, we will launch a new website that makes available simple, comparable information about mortality rates, general information about risk factors and other key outcomes related to the big killers for each local authority area in England. Developing this website is a key priority for the new public health agency, Public Health England.

4.5 These data will be presented with links to published documents such as local Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), as well as other material to allow people to assess for themselves how well their local health and care system is responding to the challenge of premature mortality in their area. Over the next two years, we will continue to improve the website, with easier access to more and better data.

What more could be done to bring every area up to the level of the best?

Measuring success

4.6 The ambition to be amongst the best in Europe is a long-term goal. We know that there are milestones along the way that will show us that we are making progress.

Prevention

4.7 On the major risk factors we need to be making demonstrable reductions in prevalence levels. As the figures below show, our rates of smoking and alcohol consumption and our levels of obesity are currently significantly higher than the best in Europe. We must narrow the gap if we are to rival the best:

- On smoking – in England the rate of smoking prevalence is just below 20%; in Luxembourg it is 17%.[41]
- On alcohol – in the UK we consume 10.2 pure alcohol litres per capita, compared to 6.9 litres in Italy.[42]
- On obesity – in England 25% of the population is obese, compared to 10.3% in Italy.[43]
- On physical activity – in the UK 63% of the population does less than 30 minutes of physical activity five times a week, compared to 16% in Greece.[44]
- On diet – in the UK, we eat on average less than three portions of fruit and vegetables a day, compared to over five a day in Italy.[45]
- On cholesterol – in the UK 65% or the population have high cholesterol, compared to 48% in Greece.[46]
- On raised blood pressure – in the UK 28% of the population have raised blood pressure, compared to 25% in Switzerland.[47]

Early diagnosis and treatment

4.8 The NHS Commissioning Board has been set an objective in the mandate to deliver measurable progress towards reducing the level of premature mortality by 2016. In meeting its objective, the Board could make significant progress in:

a. Making every contact count so that clinicians are supporting patients to lead healthier lives.

b. Supporting early diagnosis, particularly in primary care.

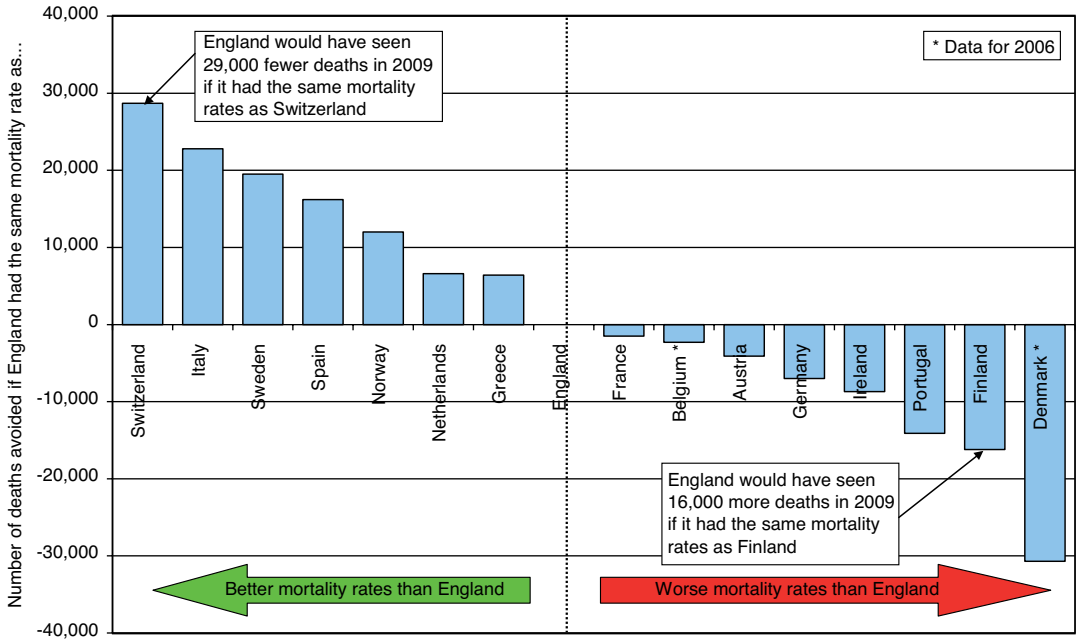
c. Promoting access to the right treatment.

d. Reducing variations in avoidable deaths between hospitals.

Improving our position

4.9 Our long-term ambition is to be amongst the best in Europe. This call to action sets out the challenge for the whole system. If everyone had access to the best treatment that is already available, we could avoid an extra 30,000 deaths per year by 2020.[48] That's nearly a third of all deaths that we currently measure as avoidable.

Figure 9. Number of deaths England would have avoided if it had the same under 75 mortality rates as other European countries (2009)



4.10 We are currently eighth in Europe for under 75 mortality[49] and these 30,000 extra deaths avoided would put us on a par with where the top European country – Switzerland – is now. But these other countries are improving all the time. While it is difficult to know where they will be by 2020, we could and should do better and should be aiming to be in among the five countries with the lowest rates of premature mortality by 2020.

Reporting on progress

4.11 We have worked closely with our partners across the health and care system in developing this call to action. It is built on valuable and open dialogue with our partners and stakeholders across the whole system.

4.12 Over time, we need to build on our existing commitments such as our ambition to save an additional 5,000 lives per year from cancer.[50]

4.13 We in government will hold ourselves accountable for progress through Secretary of State's Annual Report on the performance of the Health Service. Public Health England will also report annually on progress. The NHS Commissioning Board will report annually on how it is delivering on its objective through the Mandate to reduce premature mortality. Through strengthened relationships we will continue to work with our colleagues across government to do more to tackle the wider social determinants of health.

4.14 Complementing national action we look to health and wellbeing boards and their local partners to be setting themselves ambitions and reporting on progress.

Next Steps

4.15 We want to build a movement that takes the call to action to inspire and combine ideas and action from individuals and organisations across the health and care system – in its widest sense. To support this, we will bring together partners and stakeholders over the coming months and years to see how well we are doing in reducing avoidable premature mortality, and to see what more we can do together.

Chapter 5 – A Call to Action

5.1 Our ambition is for England to have the lowest rates of premature mortality amongst our European peers. If everyone had access to the best treatment that is already available, then following existing trends we could avoid an extra 30,000 deaths per year by 2020.[51] As the new heath system is established, we have a once in a generation opportunity to make a step change and meet the challenge.

5.2 This will only happen if all parts of the wider health and care system play their part and work together. Health and wellbeing boards will provide the system leadership and play their role in ensuring that the local system is working well for their population. They are ideally placed to set their own ambitions and challenges that drive down their rates of premature mortality, responding to the needs of their citizens. Local authority health scrutiny functions will play an important role in reviewing and examining the planning, provision and operation of the health service in local areas.

5.3 At a national level, the NHS Commissioning Board, Public Health England and the Local Government Association need to provide support to local commissioners to develop the best possible services for their local population. Our partners in professional bodies and the voluntary sector will need to come forward with their expertise and insight to support action and help to drive innovation. And in government, the Department of Health needs to lead and coordinate cross-government action to support healthy lifestyles, provide the challenge as system steward and address the wider determinants of health.

5.4 This call to action therefore goes out to all and asks everyone to play their part in demanding the very best of our health service for each and every one of us. Reducing the number of people who die too young and striving to be amongst the best in Europe for low rates of premature mortality are ambitions that can unite us all behind a common goal. We must all act now to help people live healthier and longer lives.

References

1 Office for National Statistics (2011) *Interim Life Tables, 2008-2010* http://www.ons.gov.uk/ons/rel/lifetables/interim-life-tables/2008-2010/sum-ilt-2008-10.html

2 Premature mortality is taken to be all deaths among those under the age of 75. However, not all of these deaths are deemed 'avoidable' through better prevention or improvements in the health system. While reducing avoidable mortality is the ultimate aim, it is difficult to compare between countries. Therefore, international comparisons focus on premature (under-75) mortality, a large portion of which is deemed avoidable in England.

3 England under-75 mortality rates for 2010 from Office of National Statistics (www.statistics.gov.uk/statbase/Product.asp?vlnk=6725). Comparisons with the EU-15 countries, as well as Norway and Switzerland, are generally for 2010 and from the WHO Health For All database (www.euro.who.int/hfadb) and Detailed Mortality Database (data.euro.who.int/dmdb/). Data is from 2009 for France, Greece, Italy and Luxembourg, and from 2006 for Belgium and Denmark.

4 Sources as above, based on ICD10 codes I00-I99

5 Sources as above, based on ICD10 codes C00-C97

6 Sources as above, based on ICD10 codes J00-J98

7 Sources as above, based on ICD10 codes K70, K73, K74. Switzerland excluded due to coding differences.

8 Office of National Statistics

9 Office of National Statistics. ONS methodology defines all deaths among those aged 75 and over as not avoidable. Therefore, avoidable, amenable and preventable mortality shown in relation to all deaths among those aged under 75.

10 Office of National Statistics, based on the ICD10 codes described above for international comparisons.

11 Murray et al, *United Kingdom Performance on Health: Implications from the Global Burden of Disease Study 2010*, The Lancet & Institute of Health Metrics and Evaluation, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60188-9/abstract

12 UCL Institute of Health Equity 2010, Professor Sir Michael Marmot *Fair Society Healthy Lives,* http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report

13 Office of National Statistics, Under-75 DSRs per 100,000 population

14 The King's Fund, 2012, Buck & Fonseci *Clustering of Unhealthy Behaviours Over Time*, http://www.kingsfund.org.uk/publications/clustering-unhealthy-behaviours-over-time

15 Brown S, Kim M, Mitchell C and Inskip H (2010), *Twenty-five year mortality of a community cohort with schizophrenia, British Journal of Psychiatry* 196: 116–121; Parks J, Svendsen D, Singer P et al. (2006) *Morbidity and Mortality in People with Serious Mental Illness*, 13th technical report. Alexandria, Virginia: National Association of State Mental Health Program Directors.

16 Bellis et al, *Protecting People, Promoting Health* North West Public Health Observatory, October 2012, http://www.nwph.net/nwpho/Publications/Protecting%20People%20Promoting%20Health%20Web.pdf

17 See paragraph 2 and figure 6 for detail

18 It is known that long-term exposure to particulate matter increases death rates from heart disease. This may either be because particles play a part in causing heart disease or it may be because particles make heart disease worse. The Committee for the Medical Effects of Air Pollution or COMEAP published a report in December 2010 which estimated that 2008 levels of air pollution had an effect on mortality equivalent to 29,000 deaths in that year (2008) at typical ages

19 Department of Health, January 2011, *Improving Outcomes: A Strategy for Cancer* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

20 Department of Health, November 2012, *Transparency & Accountability: The Public Health Outcomes Framework for England, 2013-15* http://www.dh.gov.uk/health/2012/11/phof-technical-refresh/

21 NICE have published a Local Government Public Health Briefing on cost effective evidence based public health actions which local authorities may implement in order to reduce premature mortality from cancer, heart disease, stroke and respiratory and liver disease. Full access to NICE's public health briefings for local government can be found at www.nice.org.uk/localgovernment/PublicHealthBriefingsForLocalGovernment.jsp and a full list of NICE public health recommendations can be found at www.nice.org.uk/prematuremortality

22 OECD, 2011, *Health Reform: Meeting the challenge of ageing and multiple morbidities* http://www.oecd.org/els/healthpoliciesanddata/49151107.pdf p178

23 Percentage of population who are daily smoking among those ages 15 or over, from OECD (http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LVNG), England data from analysis of General Lifestyle Survey for England (amongst those aged 16 and over).

24 Department of Health, November 2012 *Chief Medical Officer's Report 2011* Volume 1, chapter 3 page 194 http://www.dh.gov.uk/health/2012/11/cmo/

25 The Health and Social Care Information Centre, *Statistics on Smoking – England 2012* http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-smoking--england-2012

26 Office for National Statistics, September 2012, *Integrated Household Survey April 2011 – March 2012* http://www.ons.gov.uk/ons/rel/integrated-household-survey/integrated-household-survey/april-2011-to-march-2012/stb-integrated-household-survey-april-2011-to-march-2012.html#tab-Perceived-general-health-and-smoking-prevalence

27 Department of Health, March 2011, *Healthy lives, healthy people: a tobacco control plan for England* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf

28 World Health Observatory for Europe http://gamapserver.who.int/gho/interactive_charts/ncd/risk_factors/physical_inactivity/atlas.html

29 European Food Safety Authority, grams of fruit and vegetables per day (one portion = 80g), excluding fruit juice, http://www.efsa.europa.eu/en/datexfoodcdb/datexfooddb.htm

30 O'Flaherty et al*, Potential cardiovascular mortality reductions with stricter food policies in the UK*, Bulletin of the WHO, July 2012 http://www.who.int/bulletin/volumes/90/7/11-092643.pdf

31 NHS Atlas of Risk, http://www.nhs.uk/Tools/Pages/NHSAtlasofrisk.aspx

32 Department of Health, October 2011, *Healthy People, Healthy Lives: A Call to Action on Obesity* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130487.pdf

33 Sport, Physical Education and Activity Research (2012) *Evaluation of the Change4Life Sports Clubs Programme 2010/11*. http://www.nhs.uk/Change4Life/supporter-resources/downloads/SPEAR_Change4Life_Sports_Clubs_Headline_Findings.pdf

34 Derived from World Health Organisation, Regional Office for Europe (2011) *Health Economic Assessment Tool for Walking*

35 Organisation of Economic Cooperation and Development (2009 for Italy, 2010 for UK)

36 Department of Health, November 2012 *Chief Medical Officer's Report 2011* Volume 1, chapter 3 page 194 http://www.dh.gov.uk/health/2012/11/cmo/

37 Office for National Statistics (2013), *Alcohol-related deaths in the United Kingdom*, http://www.ons.gov.uk/ons/dcp171778_296289.pdf

38 Home Office, November 2012 *A consultation on delivering the Government's policies to cut alcohol fuelled crime and anti-social behaviour*, http://www.homeoffice.gov.uk/publications/about-us/consultations/alcohol-consultation/alcohol-consultation-document?view=Binary

39 http://www.rcseng.ac.uk/media/medianews/death-rates-for-nhs-cardiac-surgery-25-better-than-european-average-says-first-international-audit

40 Department of Health, May 2012, *The Power of Information*, http://informationstrategy.dh.gov.uk/

41 Percentage of population who are daily smoking among those ages 15 or over, from OECD (http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_LVNG), England data from analysis of General Lifestyle Survey for England (amongst those aged 16 and over).

42 Organisation of Economic Cooperation and Development, http://www.oecd.org/els/healthpoliciesanddata/HealthAtAGlanceEurope2012.pdf

43 Percentage of population who are obese, from OECD (http://www.oecd.org/els/health-systems/HealthAtAGlanceEurope2012.pdf), England data from analysis of Health Survey for England)

44 World Health Observatory, http://gamapserver.who.int/gho/interactive_charts/ncd/risk_factors/physical_inactivity/atlas.html

45 European Food Safety Authority, grams of fruit and vegetables per day (one portion = 80g), excluding fruit juice, http://www.efsa.europa.eu/en/datexfoodcdb/datexfooddb.htm

46 Prevalence of high cholesterol levels (≥ 5.0 mmol/L), from WHO, standardised for age (http://apps.who.int/gho/data/#)

47 Prevalence of raised blood pressure (SBP ≥ 140 or DBP ≥ 90) from WHO, standardised for age (http://apps.who.int/gho/data/#)

48 Based on projections of existing trends in the population and the effects of existing policies in both the NHS and public health on under-75 mortality rates. Projections also include the impact of every person having access to some of the best diagnosis and treatment already available on the NHS across a range of disease groups. For disease groups where this information is not available, comparisons are based on bridging the gap between England and the best performers in Europe. The comparison is with the current mortality rate in England.

49 Based on the comparison described in note 48 above.

50 Department of Health, January 2011, *Improving Outcomes: A Strategy for Cancer* http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123394.pdf

51 See note 48

2900722 Mar 2013
Produced by Williams Lea for the Department of Health