



Department
of Health

Living Well for Longer: One year on



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Description: Sets out progress over 2014/15 by Government, Public Health England (PHE) and NHS England to reduce premature avoidable mortality as set out in <i>Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality</i> . It also provides and outline of the next steps for partners in delivering ongoing improvements in premature mortality.
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Living Well for Longer: One year on

Prepared by

The Reducing Avoidable Premature Mortality Programme in The Department of Health



Foreword

Jane Ellison MP, Parliamentary Under Secretary for Public Health

In 2010, The Secretary of State for Health made clear his intention to focus on reducing premature mortality in England from the five big killers; cancer, heart disease, stroke, respiratory and liver disease.

His *Call to Action* challenged us to maximise the potential of the new system to work together towards England becoming amongst the best in Europe at reducing premature mortality by 2020. And last year in *Living Well for Longer: National support for local action*, we set out how the national collective efforts of Government, NHS England and Public Health England combine and align in support of local commissioners and providers as they lead improvements in health outcomes for our communities.

What has proved vital is our partnership with the wider community of activists in health and wellbeing. Our stakeholders and partners in the voluntary and community sector, nationally and locally, have helped drive the debate and have embedded the challenge to reduce premature mortality and health inequalities.

I am especially impressed by the relationships across the wider health and care system which have accelerated progress faster than we might have anticipated. The reforms have allowed us to do things differently and as a result the system is now in a much better place to deliver the ambitions we set out almost 2 years ago.

Across the spectrum of action for health, it is prevention where we will need to make the greatest strides in the years to come if we are to realise the Secretary of State's ambition, and if we are to make that a sustainable outcome. NHS England and Public Health England along with all the sectors arms-length bodies have placed prevention front and centre of their plans for the future.

We started out 2 years ago on this road to refocus the newly established health and care system on our core objective, to help everyone live well for longer. We said that "*this is an important time for us – to be bold and ambitious for health*". I believe we have been just that; not just at the national level, but importantly, at the local level and across the wider health and care system. It will be for all of us to now ensure we continue to challenge ourselves and each other to go further, faster towards our goal – to live well for longer.

A handwritten signature in black ink that reads "Jane", underlined with a single horizontal stroke.

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Executive Summary

Since 2010 this Government has made its commitment to reducing early deaths from the five big killers very clear. The Secretary of State's Call to Action in 2013 challenged the system to work together towards England becoming amongst the best in Europe at reducing premature mortality by 2020. It also started an open and honest debate across the newly established system on how best to reduce premature mortality.

In 2014, *Living Well for Longer: National support for local action* (LWfL) set out the detail of the national actions taken by the Department of Health, wider government, NHS England and Public Health England (PHE) in the prevention, early diagnosis and treatment of the five big killer diseases and to reduce health inequalities. It showed how the national organisations would support local leadership and interventions

A year later things have moved on further and faster than we might have anticipated; the reforms have allowed us to do things differently and as a result the system is in a much better place to deliver the ambitions of LWfL.

NHS England (in the *Five Year Forward View (5YFV)*) and PHE (in *From evidence into action*) have published long term plans which echo the need to prioritise and mainstream prevention as fundamental in improving outcomes for people and maintaining the sustainability of the health and care system. There is a similar emphasis in the voluntary sector.

Reducing premature mortality in the new health and care environment

Progress towards developing the systems and behaviour change required to deliver the ambition has been steady across the sector over the past year and, while the impact on outcomes will take a while to show, the plans are in place to demonstrate the system is prepared and on the right track.

This report addresses progress in three areas, identified by the Richmond Group in their report *What is preventing progress?* which provides the foundations for action. The first is shared system leadership. LWfL initiated the new system's drive towards improving outcomes for the people of England and demonstrated the Government's commitment to the joint system approach.

However the responsibility to drive and support those changes has transferred to local organisations supported by NHS England and PHE, working alongside their partners in local government. The *5YFV* sets out the plans both organisations have to work in partnership and establishes an overarching governance to ensure this collaboration becomes a reality.

The second theme is accountability and transparency which aligns with this Government's commitment to making sector wide information available in an easy to understand, regularly updated form that is useful to the public and professionals alike. MyNHS brings health and care data together in one place for the first time to allow comparison at a local level.

Finally, ensuring prevention is front and centre is a common refrain across the sector but for the first time, with the establishment of an NHS prevention programme there is a clear way forward. With an initial focus on diabetes the joint NHS Prevention Board will provide the structure through which NHS England supports PHE's strategies and priorities in public health, ensuring they are delivered.

Delivering *Living Well for Longer* and beyond

The deliverables are described under the familiar headings of prevention, early diagnosis and treatment. Some have been achieved early and others have flexed or been modified when an alternative action has emerged. These are listed below with detailed information provided in this report:

Prevention	Early Diagnosis	Treatment
<ul style="list-style-type: none"> • Reducing the burden of high blood pressure • Reducing obesity • Increasing levels of physical activity • Reducing smoking prevalence • Reducing harmful alcohol consumption • NHS Health Check 	<ul style="list-style-type: none"> • Symptom awareness campaigns • Cancer screening • Access to scientific and diagnostic commissioning information • Prime Minister's Challenge Fund Pilots 	<ul style="list-style-type: none"> • Stimulating a focus on premature mortality and incentives • Proton beam therapy • Service reconfiguration • Making every contact count • Reducing mortality for people with learning disabilities

Next steps

It is essential that NHS England, local NHS bodies, PHE and local authorities continue to build on progress, ensuring that the priorities of prevention, early diagnosis and effective, evidence based treatments are normalised in all future policy developments and account is taken of health inequalities.

Shared system leadership and recognising where there are common goals is fundamental to successful progress. NHS England and PHE have established clear structures and governance around common areas of interest with plans on how they will work together on cross-cutting themes.

Greater availability of accessible local information will stimulate self-improvement rather than relying on centrally driven performance targets. **Increasing accountability and transparency** will

mean localities have meaningful data and information to judge performance as well as hold organisations and professionals to account for the quality of their services and local outcomes.

That **prevention** is at the heart of a sustainable health and care system is now embedded in the plans and priorities of NHS England and PHE with a common understanding of priorities and a shared commitment to deliver. In addition, the health and care reforms have put the right organisations in the right places and the more devolved system is able to deliver responsive and tailored services to meet local needs, including on reducing early deaths and health inequalities.

There are also a number of more specific improvements underway to improve outcomes for patients, these include: **mental health, cancer, liver disease, acute kidney injury, sepsis, diabetes, self-care**, and on **new models of care**.

Looking to the future

One year after LWfL was published we find ourselves with an opportunity to make real change across the system. We have the right organisations in place, newly established mechanisms to support and collaborate with each other and clearly articulated commitments to delivering a paradigm shift in how health and care, in its broadest sense, is delivered.

There is consensus on the areas that we need to focus on to maximise the impact on the health and care system and on reducing premature mortality. We either know, or are building the evidence base of what works and are agreed about the benefits of working as a broad coalition to implement the processes, services and systems.

The document sets out the next steps under the previous headings of shared system leadership, accountability and transparency as well as putting prevention first.

It concludes that it is now time for the Department of Health to step back and let the system as a whole, as well as each component part, do its work; while Government continues to undertake the actions only it can carry out, including providing the framework within which the health and care system works which recognises the importance of reducing avoidable mortality.

For the future, the Department's role will be to hold partners to account to deliver all this, including how well the inequalities duties for the Secretary of State and NHS England have been fulfilled. We will remain an active partner in the coalition of effort across the system and will still play a key role in supporting the system at all levels to do what is necessary to reduce premature mortality and move us towards being amongst the best in Europe by 2020.

1. Introduction

- 1.1 When we published *Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality* (LWfL) the Department made a commitment to review and report on progress towards the delivery commitments in LWfL.
- 1.2 This document provides that update on LWfL at a national level and, as with the original, some case studies and information setting out how ideas and evidence are put into practice at a local level. It also includes information on programmes and projects which have been initiated since April 2014 that will be key to delivering the required reductions in premature mortality in the short and longer term. Finally it provides an outline on next steps for the national organisations.
- 1.3 It is important to note that, whilst we are confident the actions in LWfL will have an impact on reducing premature mortality, this will take time to become visible within the mortality statistics as will reductions in health inequalities. As a consequence this report focuses on the measures of activities undertaken and the changes in behaviours that will lead to the longer term reductions in mortality.
- 1.4 In addition, while the majority of deliverables in LWfL have continued to be seen as key to delivering the reduction in premature mortality, in some cases the evidence or priorities have changed so the discussion and outputs reflect these changes. For example NHS England's focus on prevention and management of acute kidney injury and sepsis and their work with Public Health England on diabetes prevention are priorities that have emerged since April 2014.

2. Setting the scene

- 2.1 This Government made clear its intention to focus on reducing premature mortality in England from the five big killers – cancer, heart disease, stroke, respiratory and liver disease - from the outset. The Secretary of State's *Call to Action*¹ recognised that, while great health improvements have taken place over previous decades, in comparative terms we perform poorly² and we continue to see deep-seated inequalities between different regions, smaller areas and groups in society. In light of this evidence the Secretary of State challenged the system to work together towards England becoming amongst the best in Europe at reducing premature mortality by 2020.
- 2.2 We recognised that achieving such a challenging ambition would require effective collaboration at national, regional and local level. The reforms to the health and care system required greater alignment of effort across the whole system to improve health outcomes and reduce health inequalities. The NHS and Public Health Outcomes Frameworks recognised this need to focus on premature mortality, with shared indicators included in both, requiring effort on all fronts, from prevention to earlier diagnosis to treatment.
- 2.3 *Living Well for Longer* (LWfL)³ set out the detail of this joint enterprise across the national players in the health and care system. Supported by the Reducing Avoidable Mortality Programme, it has provided the mechanism through which the Department of Health (DH), in partnership with system leaders, has led and facilitated this collective approach. LWfL brought together, in one place, the national actions taken by DH and wider Government, NHS England and Public Health England (PHE), in the prevention, early diagnosis and treatment of the five big killer diseases and shows how they will support local leadership and interventions.
- 2.4 Of course it is not all about government and national players. When the *Call to Action* was published in 2013 the Secretary of State was clear that he intended it to stimulate debate not just in the health and care sector, but in the wider community as well. What we have seen is a groundswell of interest and engagement with other stakeholders playing a key role in providing information, contacts and services which impact on the goal of reducing premature mortality.

¹ *Living Well for Longer: A call to action to reduce avoidable premature mortality* (March 2013), Department of Health; <https://www.gov.uk/government/publications/living-well-for-longer-a-call-to-action-to-reduce-avoidable-premature-mortality>

² *UK health performance: findings of the Global Burden of Disease Study 2010*. Murray CJL, Richards, MA, Newton, JN, Fenton KA, Anderson HR, Atkinson C, Bennett D et al; *The Lancet* –381, 9871, pp 997-1020 (March 2013)

³ *Living Well for Longer: National Support for Local Action to Reduce Premature Avoidable Mortality* (April 2014), Department of Health; <https://www.gov.uk/government/publications/helping-people-live-well-for-longer>

- 2.5 A year later things have moved on further and faster than we might have anticipated; the reforms have allowed us to do things differently and as a consequence the system is now in a much better place to deliver the ambitions of LWfL. A recent report⁴ suggests that embedding public health within local authorities is expected to lead to better health outcomes and has ‘given cause for optimism’.
- 2.6 Overall, we continue to be relatively good at treatment⁵ and we are improving our capacity and capabilities in early diagnosis but the reality is that healthcare has only a limited impact on our health. Undoubtedly it is important that, once we are unwell, the care we receive is the best possible, and this has been demonstrated in improvements in stroke and heart attack care over the past decade or so.
- 2.7 However, to reduce the impact of long term conditions we need to re-focus attention on how people live their lives, the impact of social circumstances on health, our experiences and the opportunities we have to influence our own health. This is crucial not just because of the impact on individual lives but also if the system which we value and rely on is to be sustainable into the future. Now, through a coalition of effort, we are in a much better position to redouble efforts to address the prevention of disease and self-care across the system.
- 2.8 There is a new degree of consensus about direction of travel and emphasis on delivery of prevention services by the appropriate organisations at the right level. Both NHS England and PHE have recently published long term plans which echo each other in terms of the need to prioritise and mainstream prevention, be that primary prevention in public health or secondary and tertiary prevention in the NHS. Both documents acknowledge the need to ‘harness’ the potential of patients, employers, communities and all levels of government in addressing the issue of preventing the development of disease.
- 2.9 PHE’s new strategy⁶, *From evidence into action*, looks to stimulate a focus on creating and protecting health, not only treating ill-health; identifying the opportunities for tackling the major public health issues using evidence including behavioural sciences. These **evidence based priorities** include obesity, smoking and harmful drinking; the major lifestyle risks which contribute to our higher levels of premature mortality. There is also a significant focus on **new drivers and opportunities** to ensure a sustainable health and care sector, these include the chance to develop evidence-based prevention services, such as for diabetes, with the NHS and implement them at scale.

⁴ *In good health: Public health teams in local authorities Year 2*; (February 2015); Royal Society for Public Health; http://www.rsph.org.uk/filemanager/root/site_assets/our_work/reports_and_publications/publichealth_03.02.15.ind.2_.pdf

⁵ *Mirror, mirror on the wall: How the performance of the US health care system compares internationally* (June 2014); Davis K, Stremikis K, Squires D, Schoen C; The Commonwealth Fund <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>

⁶ *From evidence into action: opportunities to protect and improve the nation’s health* (October 2014); Public Health England; <https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health>

2.10 NHS England's *Five Year Forward View*⁷ (5YFV) is also explicit in its commitment to get '... serious about prevention'. This plan, though developed by NHS England, has signatories from the major health arm's length bodies; PHE, Health Education England (HEE), the Care Quality Commission, Monitor and the NHS Trust Development Authority (TDA).

2.11 It outlines the need to incentivise and support healthier behaviours through information, targeted personal support and wider changes. It also commits the NHS to work closely with local authorities, through health and wellbeing boards and directly, supporting them in their statutory responsibilities for improving the health of their populations. The intention is that the NHS will support the refocus on prevention through three main routes.

- The first, **empowering patients** by ensuring people have access to information and support to manage their health and where required with increased direct control over their care.
- The second is through **engaging communities**, involving them in decisions about the future of health and care; with better support for carers, working constructively with the voluntary sector and using the role of the NHS as an employer to achieve wider health goals.
- Finally, using the **NHS as a social movement**, accompanied by actions by the system itself.

2.12 There is a similar emphasis in the voluntary sector⁸, where there is a recognition that prevention should be at the heart of the health services and at centre of policy making. Enabling people to live longer, healthier lives at the same time as ensuring the health and care system is sustainable in the longer term.

⁷ *Five year forward view* (October 2014); NHS England; <http://www.england.nhs.uk/ourwork/futurenhs/>

⁸ *What is preventing progress? Time to move from talk to action on reducing preventable illness* (November 2014) <http://www.richmondgroupofcharities.org.uk/What-is-preventing-progress-2014.pdf>

3. Reducing premature mortality in the new health and care environment

- 3.1 Despite the significant changes the system has undergone over the past year a number of key developments have taken place which we believe have put us in a much stronger place in terms of action to reduce early deaths.
- 3.2 The Department of Health (DH) has grown into its system steward role. We have increasingly been able to step back from directly developing policy to leading and aligning policy and activity whilst holding others to account. NHS England and PHE have key roles in supporting local organisations to deliver services that are tailored to local need and to do so by developing and providing evidence to inform planning and implementation.
- 3.3 The Richmond Group of Charities identified three particular areas which they suggest should provide the foundations for action; to translate commitments and evidence into concrete actions and outcomes for the population. These are shared system leadership, accountability and transparency and the importance of prevention. We have used these as a helpful way to set out what has happened over the past year and plans for the future.

Shared system leadership

- 3.4 *Living Well for Longer* (LWfL) initiated the new systems drive towards improving outcomes for the people of England, setting out the scale of the challenge to reduce premature mortality and crystallising the themes of the greater emphasis on prevention. It also demonstrated the Government's commitment to the joint system approach.
- 3.5 However, it is no longer the Government's role in the new system to dictate to local services how they deliver the desired reductions in premature mortality. The responsibility to drive and support those changes has transferred to local organisations supported by NHS England and PHE, working alongside their partners in local government.
- 3.6 The 5YFV and *From evidence into action* both emphasise the need for all partners to work together and establishing the overarching governance to ensure this collaboration becomes a reality. This collaboration will focus on a number of cross-cutting common areas of interest, including prevention, new models of care, the NHS as a healthy employer and how to engage the public in taking more responsibility for their health. There is more about these, particularly on prevention, later in this document.

Accountability and transparency

- 3.7 The Government has been clear that the system should move away from a culture of targets to one of transparency; targets matter but they are not the best or only way to improve outcomes. It is about increasing the availability of accessible information to stimulate self-improvement rather than enforcing centrally driven performance targets; using natural professional competitiveness combined with the pressure of peer review.

- 3.8 On this, the system as a whole has much to learn from local government and public health where a wealth of information is already available on performance and outcomes, for example on local government's [LG Inform](#)⁹ and PHE's [longer lives](#)¹⁰. These sites provide meaningful data and information to enable intermediaries such as local healthwatch to hold organisations and professionals to account not just for the quality of their services and care but also for the outcomes.
- 3.9 Alignment and joint working has been integral to the design of the new whole system approach. At its heart are the outcomes frameworks which were co-produced by DH and system leaders. These provide a series of agreed global outcome measures which provide indicators, some shared, of how well organisations and localities are delivering the common goal of reducing premature mortality and there is an increasing focus on inequalities. The detail of how the outcomes are delivered is up to local areas, assisted by NHS England and PHE who are responsible for providing evidence and support for local commissioning and delivery.
- 3.10 To support this agenda more widely across the health and care sector the Secretary of State has commissioned system leaders to develop [MyNHS](#). This website provides easy to understand, regularly updated, information to the public and professionals alike. It brings health and care data together in one place for the first time, allowing comparison of the performance of local health and care services, GP practice, public health and health outcomes.

Ensuring prevention is front and centre

- 3.11 The importance of prevention has been acknowledged in many strategies and plans over the past decades. However, we have rarely had such a degree of consensus amongst all partners in the NHS and public health that this must be addressed now, if the system is to be sustained into the future.
- 3.12 The 5YFV makes it clear that NHS England is committed to supporting PHE's strategy and priorities on prevention and will work with them to ensure they are delivered. NHS England is also committing the NHS itself to becoming an agent for change through incentivising and supporting healthier behaviours; supporting local democratic autonomy to design place-based solutions; proactive primary care engaging in targeted secondary prevention, supporting people to stay in work and employers to support them to do so.
- 3.13 As part of the overarching governance to support delivery of the 5YFV, a joint NHS Prevention Board has been established across the partner organisations to ensure coordination of the programmes of work. There is more detail on the NHS Prevention Programme in 'Looking to the future'.

⁹ <http://lginform.local.gov.uk/>

¹⁰ <http://healthierlives.phe.org.uk/topic/mortality>

4. Sector Engagement

- 4.1 With his *Call to Action* in 2013, the Secretary of State for Health wanted to open an enduring and sustainable debate on reducing premature mortality. He felt it was too important an issue to discuss through short-term consultations; rather, he wanted there to be open and honest debate across the newly established system, and for that system to work hand in hand with experts in national charities, royal colleges and in academia.
- 4.2 Over the past 12 months, with the system being in transition, it has been essential to work with our partners across the wider health and care system at a local as well as a national level. We have engaged with many organisations and individuals whose activities directly contribute to reducing premature mortality and health inequalities, and some are working directly with us in DH, with NHS England and with PHE to help drive improvements in outcomes.
- 4.3 Some of this engagement has been through DH's formal channels such as the Health and Care Partnership, some has been through Twitter and the [Living Longer](#)¹¹ website which has hosted a range of blogs from a wide variety of contributors including Rethink, the Richmond Group, the Queen's Nursing Institute and the Royal Society for Public Health. We have engaged with the sector through other formal means such as the Public Health System Group convened by PHE, and the Public Health Cross-government Officials Group. Reducing premature mortality has also been a regular topic at Secretary of State's weekly meetings with stakeholders.
- 4.4 Much of our engagement with stakeholders has driven work forward on reducing premature mortality at the strategic level. For example in helping to shape and develop a whole system approach to prevention and better management of comorbidities¹². At the more specific level experts and system leaders have been working with us on focused priority areas such as:
- PHE have convened a Blood Pressure System Leadership Board which involves partners across national and local government, the health service, voluntary sector and academia. This cross-sector group ensures there is shared ownership of this issue and oversee a programme of work to improve the prevention, detection and management of high blood pressure. The first phase of their work culminated in publication of [Tackling high blood pressure: from evidence into action](#)¹³

¹¹ <http://livinglonger.dh.gov.uk/living-longer/>

¹² *Comorbidities: a framework of principles for system-wide action*; (May 2014) Department of Health; <https://www.gov.uk/government/publications/better-care-for-people-with-2-or-more-long-term-conditions>

¹³ *Tackling high blood pressure: from evidence into action*; (November 2014); Public Health England; <https://www.gov.uk/government/publications/high-blood-pressure-action-plan>

- NHS England have involved a broad range of partners in their specific work programmes on supporting improved follow up to health checks, and the implementation of NICE guidance on behaviour change in support of 'making every contact count'. Stakeholder events were held on both workstreams, and an Expert Reference Group has been established to support the behaviour change workstream.
- 4.5 PHE and the LGA working together with local councils are embedding a sector-led approach to performance improvement. The Health and Wellbeing System Improvement Programme in 2013-14, funded by DH, provided a range of products. These included peer challenges, an updated self-assessment tool and a wealth of shared knowledge and intelligence with a focus on reducing premature mortality and improving the quality of life for local communities.
- 4.6 What has been essential is the continued commitment to a common purpose by our partners and stakeholders beyond DH, PHE and NHS England. 'Living well for longer' has provided that focal point for debate across the health and care system, and with our partners in the wider system.

5. Delivering *Living Well for Longer* and beyond

- 5.1 Progress towards developing the required systems and behaviour change to deliver the ambition has been steady across the sector and, while the impact on outcomes will take a while to show, the plans that are in place demonstrate the system is prepared and on the right track.
- 5.2 This section sets out the detail of what has been achieved in the last year at national level in terms of the specific deliverables set out in LWfL. Some have been achieved early and others have flexed or been modified when an alternative action has emerged or priorities have changed.
- 5.3 We have considered the deliverables under the familiar headings of prevention, early diagnosis and treatment to ensure consistency with the original document.

Prevention

Reducing the burden of high blood pressure

- 5.4 Raised blood pressure is the second biggest risk factor for disability and premature mortality. We have seen improvements in prevention, detection and management in the last decade which have prevented or postponed many deaths. However, in comparison to international leaders we have significant scope for improvement. Evidence suggests only four in 10 adults with high blood pressure in England are diagnosed and managed effectively, in part because people are often unaware they have the condition or of the risks to their health of uncontrolled high blood pressure.
- 5.5 High sodium intake is a major contributing factor to high blood pressure, and reductions of 15% in salt intake have been achieved since 2001 by Government working with industry. This equates to over 5,000 premature deaths saved each year.
- 5.6 Despite the significance of the condition, there had not been a government programme on the topic in recent years. PHE have now brought together insight and expertise from a wide range of partner organisations in establishing the Blood Pressure System Leadership Board, with representation from national and local government, the health system, voluntary sector and academia.
- 5.7 The Board's first joint product, [*Tackling high blood pressure: From evidence into action*](#)¹⁴, proposes areas of focus for the prevention, detection and management of high blood pressure. It sets out how organisations at all levels can tackle these issues, and sets out commitments amongst Board members to contribute towards this.

¹⁴ Tackling high blood pressure: from evidence into action; (2014); Public Health England; <https://www.gov.uk/government/publications/high-blood-pressure-action-plan>

- 5.8 This is supported by a [resource hub for local leadership](#)¹⁵, [public-facing quiz](#)¹⁶, [economic review of interventions' cost-effectiveness](#)¹⁷ and [data on local performance variation](#)¹⁸ which is intended to be used alongside the plan. These materials have had over 20,000 visits since they were launched in November. Important work continues on implementation and to communicate key insights from the programme to activate and support local professional leadership. Partners are also working to inform and engage the public on this issue.
- 5.9 In LWfL, and as part of the wider programme on blood pressure, PHE undertook a marketing pilot in partnership with local colleagues in Wakefield. More than 3,500 individuals were tested and received lifestyle advice across community, pharmacy and workplace settings. Following evaluation PHE are developing a toolkit for local use and adaptation by areas interested in developing their own testing initiatives (including medical protocols, marketing materials and learning points).
- 5.10 More broadly PHE is embarking upon a new lifestyle-focused marketing programme for mid-life adults, which will address the risk factors for high blood pressure.

Stockport CCG is working to raise awareness of the importance of knowing your blood pressure. They estimate one in four adults in Stockport has high blood pressure and the hypertension programme '[Know your numbers](#)' aims to ensure more people know if they need to take action.

As part of the programme, health kiosks were set up for six months (April to October 2014) at sites across Stockport to allow individuals to measure their blood pressure, weight, body mass index (BMI), body fat content and heart rate. The technology proved popular, people were attracted to health kiosks as a method of receiving health information.

For more information go to <http://stockportccg.org/blood-pressure-2/>

Reducing obesity

- 5.11 The prevalence of obesity has levelled off in recent years, but remains too high. Sixty two percent of adults and 29.5% of children aged 2-15 are either overweight or obese¹⁹. Obesity presents a significant public health challenge; it is the leading cause of type 2 diabetes, heart disease and cancer and health inequalities are manifest. Tackling obesity remains a priority for the Government and as a consequence PHE and DH have continued to focus considerable attention on obesity policy.
- 5.12 The Government has made significant progress in school food. The [School Food Plan](#)²⁰, was published by the Department for Education in 2013, and is designed to increase the

¹⁵ <https://www.gov.uk/high-blood-pressure-plan-and-deliver-effective-services-and-treatment>

¹⁶ <http://www.nhs.uk/Tools/Pages/bloodpressurequiz.aspx>

¹⁷ <http://www.optimitymatrix.com/events/optimity-matrix-report-cost-effectiveness-review-of-blood-pressure-interventions-is-published>

¹⁸ <http://healthierlives.phe.org.uk/topic/hypertension>

¹⁹ Health Survey for England - 2013, Trend tables (Dec 2014): www.hscic.gov.uk/catalogue/PUB16077

²⁰ <http://www.schoolfoodplan.com/>

quality and take up of school meals, and inspire a love of good food in children to help boost academic performance and allow them to lead healthy lives.

- 5.13 The Plan outlines actions to improve food and food awareness in schools. These include revising the existing school food standards, setting up breakfast clubs in schools with a high proportion of pupils entitled to free school meals, and including a separate strand for cookery in the new Design and Technology curriculum. Alongside this, every pupil in reception, year 1 and year 2 attending a state-funded school is now entitled to a nutritious, healthy free school lunch.

Local produce & healthy eating at an inner city school

At Charlton Manor Primary School in South East London a corner of the school grounds has been turned into a secret garden for learning, contemplation, food production and as a wildlife haven. Pupils are responsible for keeping livestock, including chickens and bees, and the resulting produce is either used in the school kitchen or sold by the children. The programme promotes links overseas and helps the children see how they can learn from or inspire other countries to use their land to produce local and sustainable food. They are now taking on more land to create even more locally grown produce, and expanding to involve a network of local schools.

Recognising the importance of healthy eating and eating together, the headmaster has invested in a state-of-the-art teaching kitchen and employs teaching chefs to give the children the best possible learning experience. The children are involved in planning menus and serving lunch and it is no surprise that the school has achieved the Gold Award for Healthy Schools London.

- 5.14 There has also been considerable attention paid to obesity by the research community, the McKinsey Global Institute published a report in November into reducing obesity with a focus on costs and impact²¹ and the Scientific Advisory Committee on Nutrition (SACN) produced a draft report²² on carbohydrates (not obesity specifically) which was out for consultation until September. SACN's final report on carbohydrates is due later in 2015, along with PHE's review of the evidence on reducing sugar.
- 5.15 Forty two businesses have committed to reduce calories, including sugar, through the Public Health Responsibility Deal's calorie reduction pledge. Some impressive reductions have been made in major brands by reformulation and developing smaller portion size packs. Seventy per cent of the high street takeaways and fast food restaurants also have calories clearly labelled.
- 5.16 The [Change4Life](http://www.nhs.uk/change4life/)²³ social marketing programme continues to work to ensure fewer children become overweight through inspiring families to eat well and move more. The programme has high levels of engagement with local authorities and schools and more than 70,000 local supporters. *Change4Life* is on target to reach 500,000 sign-ups by end of financial year 2014/15. There were more than 292,000 registrations to the summer

²¹ *Overcoming obesity: An initial economic analysis*; (November 2015); McKinsey Global Institute; http://www.mckinsey.com/insights/economic_studies/how_the_world_could_better_fight_obesity

²² <https://www.gov.uk/government/consultations/consultation-on-draft-sacn-carbohydrates-and-health-report>

²³ <http://www.nhs.uk/change4life/Pages/change-for-life.aspx>

2014, 10 Minute Shake-up campaign and the 2015 [Sugar Swaps campaign](#)²⁴ which started in January, is supporting families to cut back on sugar in their everyday food and drink.

Increasing levels of physical activity

5.17 Physical inactivity directly contributes to one in six deaths in the UK²⁵ and the link between physical activity, ill-health and obesity is well established; with recent evidence²⁶ suggesting that exercise is more important than obesity in promoting longevity.

5.18 The Government remains committed to promoting and increasing the levels of physical activity and has a national ambition, reflected in the Public Health Outcomes Framework, for a year on year increase in the proportion of adults doing 150 minutes of physical activity per week and a similar reduction in those who are 'inactive' (less than 30 minutes a week).

5.19 We have a well-developed and wide-ranging programme of actions to achieve this. This includes:

- Investing almost £222m in programmes such as the PE and Sport Premium for Primary Schools, School Games, and Change4Life Sports Clubs.
- Investment of £1.2m in five English cities to deliver a range of interventions to support residents to build walking into their day-to-day lives.

5.20 In February 2014, the Government published [Moving More, Living More](#)²⁷ (MMLM), a cross-Government campaign to deliver a physical activity legacy from the 2012 Olympic and Paralympic Games. The Minister for Public Health chairs a sub-group of the Cabinet Committee for Olympic and Paralympic Legacy which has achieved significant progress in the last year in taking forward the commitments in MMLM.

5.21 Examples include ongoing work to translate the Chief Medical Officer's guidelines into easily communicable messages for health professionals and the public; measures to increase the amount of walking and cycling. To this end, the recent Government amendment to the Infrastructure Bill is another clear indication of Government's commitment to find the resources needed to support cycling and walking infrastructure in

²⁴ <https://sugarswaps.change4life.co.uk/>

²⁵ *Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy*; (July 2012); Lee I-M, et al; The Lancet 380:219-29
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61031-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61031-9/fulltext)

²⁶ *Physical activity and all-cause mortality across levels of overall and abdominal adiposity in European men and women: the European Prospective Investigation into Cancer and Nutrition Study (EPIC)*; (Jan 2015); Ekelund U, et al; Am J Clin Nutr, 10.3945/ajcn.114.100065
<http://ajcn.nutrition.org/content/early/2015/01/14/ajcn.114.100065.full.pdf+html>

²⁷ *Moving More, Living More: The Physical Activity Olympic and Paralympic Legacy for the Nation*; (Feb 2014); HM Government; https://www.gov.uk/...data/.../moving_living_more_inspired_2012.pdf

this country and raising public awareness with campaigns such as Sport England's recent [This Girl Can](#)²⁸ campaign.

5.22 In October 2014, Public Health England published, *Everybody active, Every day* (EAED). Building on MMLM, this framework aims to increase the levels of physical activity in local communities by identifying key areas where more action is needed. Public Health England have been organising a number of workshops across England to stimulate discussion about ways to take forward the recommendations in EAED.

Getting fit and having fun

Fit Reds is a local community health outreach programme in Barnsley offering men age 35+ the chance to take part in an 8 week football fitness course. Participants are also offered access to an indoor gym as well as diet and nutrition sessions to help reduce the high levels of cardiovascular disease in Barnsley. It's been so successful they plan to offer courses to women this year. <http://barnsleyfcommunity.co.uk/health/join-the-fit-reds-programme>

5.23 Finally, as part of the Responsibility Deal, the department has been working successfully with a range of organisations to promote physical activity. Organisations have been reaching out in a variety of ways, such as subsidised gym membership, walking groups, programmes for minority groups to promote the value of being active.

5.24 The Department of Health will continue work across Government and with other partners to increase opportunities for people to be active and achieve its national ambition for a more active nation.

Responsibility Deal – Active Travel Pledge

Heathrow is investing in cycling and in 2012 opened the *Heathrow Cycle Hub*, the only airport with its own bike shop. The facility provides staff with discounted cycles, equipment and clothing, servicing where the labour is free and runs both maintenance and rider training. Heathrow is also an affiliated racing club with British Cycling. As well as the cycle hub, Heathrow has over 500 cycle parking spaces around the campus that are both covered and secure and there are additional locker and showering facilities available to staff.

Reducing smoking prevalence

5.25 Tobacco use remains a major public health challenge; smoking is harmful not only to smokers but also to people around them. There has, however, continued to be good progress over the past year on delivering the national ambitions to reduce smoking rates in England by the end of 2015, set out in the [Tobacco Control Plan for England](#)²⁹. These were to reduce rates from:

- 21.2% to 18.5% or less among adults, with the current figure at 18.4%,
- 15% to 12% or less among 15 year olds, with the current figure at 8%, and

²⁸ <https://www.sportengland.org/our-work/equality-diversity/women/this-girl-can/>

²⁹ *Healthy Lives, Healthy People: a Tobacco control Plan for England*; (March 2011); Department of Health; <https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england>

- 14% to 11% or less among pregnant mothers (measured at the time they give birth), with the current figure at 11.4%³⁰.

5.26 Adult smoking prevalence in England fell to 18.4% in 2013 which is the lowest figure since records began and down from 19.5% in 2012. However, within this there are significant inequalities. Smoking is higher among people in routine and manual jobs, and there is a direct correlation between smoking and income – those who earn the least smoke the most. For example, smoking prevalence is 11% for those on higher incomes, but 23% for those on lower incomes. Similarly, smoking prevalence among more highly educated groups is 10% but rises to 34% among those with lower qualifications.

5.27 As it committed to do in LWfL, PHE is running an annual Smokefree marketing programme with the aim of triggering 750,000 quit attempts. This activity is currently still live but we are on track to meet our challenging target.

5.28 Significant progress has been made under the Government's comprehensive Tobacco Control Plan for England which was published in March 2011. A focus has been on protecting children from tobacco and nicotine. In 2011, the sale of tobacco from vending machines was stopped and by April 2015, the open display of tobacco at retail points of sale will no longer be permitted. New laws have been made to stop smoking in vehicles carrying children from October 2015 and to stop adults buying tobacco on behalf of children. Regulations to introduce standardised packaging for cigarettes and an age of sale of 18 for e-cigarettes will be considered by Parliament before the end of March 2015.

5.29 The UK actively supported the negotiations for a new European Union-wide Tobacco Products Directive, which was agreed in 2014. This Directive will bring the sale of flavoured tobacco (including menthol) to an end and will end the sale of small packs of cigarettes which can be more popular with children. Larger pictorial health warnings will be required and new rules relating the sale of e-cigarettes will also come into place. New arrangements, including unique security features, will also come into place across the European Union to contribute to efforts to control illicit tobacco.

5.30 To promote health and wellbeing, DH has worked to encourage communities across England to reshape social norms, so that tobacco becomes less desirable, less acceptable and less accessible. The Government wants all communities to see a tobacco-free world as the norm and aims to stop the perpetuation of smoking from one generation to the next. Health Ministers have spoken in Parliament about their aspirations for a tobacco free generation. In recognition of this work in 2015, DH has been awarded the prestigious American Cancer Society's Luther L Terry Award for exemplary global leadership in tobacco control.

³⁰ *Statistics on Women's Smoking Status at Time of Delivery, England - Quarter 3, 2014-15*; (March 2015); <http://www.hscic.gov.uk/catalogue/PUB16957>

Reducing harmful alcohol consumption

- 5.31 Alcohol is amongst the four biggest behavioural risk factors for illness and death and continues to be an area of concern for the health and care sector, with greater harm among more disadvantaged groups.
- 5.32 Through the Responsibility Deal, companies committed to voluntarily remove one billion units of alcohol from the market (around 2%) by the end of 2015. This was achieved two years early and is already 0.3bn over target. Reducing the strength of alcohol in people's drinks is expected to contribute, at no cost to the public purse, to a significant decrease in health harm. Even small reductions by many companies affecting a wide customer base are expected to help reduce health harm³¹. Six new pledges were agreed in 2014, including a pledge to sell no further single-serve cans with more than 4 units of alcohol, and are expected to help improve these results.
- 5.33 Commitments to provide consumer information are also valuable. For example, supporting alcohol misuse identification and brief advice programmes, such as the NHS Health Check, delivered by health professionals, which have strong evidence of changing behaviour.
- 5.34 Companies committed to having 80% of bottles and cans displaying unit content, the Chief Medical Officer's lower-risk guidelines and a warning about drinking when pregnant by the end of 2013. An independent report in November 2014 found that 79.3% of labels provided all three elements correctly (meeting the commitment); 92.8% provided correct pregnancy information; 87% provided correct unit content; and 82.8% provided correct lower-risk drinking guidelines³².
- 5.35 Pubs and shops committed to a voluntary display of unit and health information. Ipsos Mori carried out an independent survey this year, of whether the public saw such information. Their report found that over a quarter of respondents reported seeing a British Beer and Pub Association (BBPA) information image; over two in five 18-24 year-olds reported seeing at least one BBPA image; over a quarter of respondents have seen something similar, but different, to BBPA materials; more than half those seeing different materials also reported seeing BBPA materials.
- 5.36 The remit letter³³ has asked PHE to review the evidence and provide advice on the public health impacts of alcohol and evidence-based solutions. PHE have brought together an expert advisory group including key academics to identify the latest data on harm from

³¹ *Second interim monitoring report: 2013 data: Monitoring the Public Health Responsibility Deal Alcohol Network pledge to reduce 1 billion units of alcohol sold by the end of 2015*; (December 2014); ONS; <https://www.gov.uk/government/statistics/units-of-alcohol-sold>

³² *Audit of compliance of alcoholic beverage labels available from the off-trade with the Public Health Responsibility Deal Labelling Pledge*; (November 2014); Campden BRI; <https://responsibilitydeal.dh.gov.uk/campden-bri-report-on-responsibility-deal-alcohol-labelling-pledge/>

³³ PHE Remit letter: 2014-2015; (June 2014); Department of Health; <https://www.gov.uk/government/publications/phe-remit-letter-2014-to-2015>

alcohol and evidence on the impact of various policy approaches. PHE are currently undertaking an evidence review and the report to Government will be submitted in the spring.

NHS Health Check

- 5.37 NHS Health Check is an ongoing national programme to assess, increase awareness and manage risks for people aged 40-74 who have not been diagnosed with an existing vascular disease. Modelling shows that through systematically addressing the top seven causes of preventable mortality the programme has the potential to detect and help people manage and prevent development of disease or death.
- 5.38 Over the past 12 months PHE has been supporting local authorities through a range of mechanisms to increase the number of health checks offered and received by people aged 40-74 across the country, as part of the NHS Health Check Programme.
- 5.39 Specifically PHE has developed and launched new branded resources to enable local authorities to promote health checks locally and content for the NHS Health Check pages on the NHS Choices website including a service directory and case stories. This has been well received; within the first few weeks over 100,000 people had viewed the site. Publication of PHE's competency framework and workbooks; piloting of an improvement offer; the publication of NHS Health Check data on the *Longer Lives* atlas; delivering a programme of webinars and the inclusion of prompts in the CQC inspection content are a few of the key actions that have served to strengthen delivery quality and reach.
- 5.40 In 2014/15 PHE set out a shared commitment to offer the NHS Health Check to 20% of the eligible population and to increase uptake towards 66%. Local authorities have made excellent progress and are on track to offer the NHS Health Check to more than 3 million people, nearly 250,000 more than in 2013/14. While efforts have also been focussed on increasing uptake we know that effecting behaviour change is complex. PHE will continue to develop, support and disseminate the findings of projects that evaluate the impact of projects that apply behavioural insights to increase uptake.
- 5.41 For the programme to maximise its prevention potential it is also essential that people taking up an NHS Health Check receive the correct clinical and behavioural support that they need to reduce the risk of preventable diseases. PHE, NHS England and DH will continue to work together to encourage and enable NHS Health Check commissioners and providers to deliver this critical element of the programme. This is illustrated by the recent commitment by NHS England and PHE to introduce at scale national evidence-based diabetes prevention programme for those people found to be at risk of diabetes following the NHS Health Check.

Ensuring Cornish fishermen get their NHS Health Check

Commercial fishermen in England are at particularly high risk of poor health outcomes. Cornwall Council set out to address this issue through the NHS Health Check programme, offering health checks for fishermen, on the quayside, by a dedicated outreach service and support for lifestyle changes, including cooking sessions to encourage healthy eating whilst at sea.

A similar approach has been developed for local farmers; taking health checks to where farmers meet.

For more information see: <http://www.healthcheck.nhs.uk/document.php?o=788>

System wide prevention activity

5.42 With prevention being identified as key in delivering a sustainable health and care system PHE and NHS England have come together with experts to develop a new NHS Prevention Service. Senior leadership and governance for this is being provided through the newly established NHS Prevention Programme Board which includes Diabetes UK. The initial focus will be on developing the diabetes prevention programme but will also include work on implementation of other specific commitments from the 5YFV.

5.43 Immediate tasks are to commission a review of the national and international evidence of diabetes prevention programmes, seek expressions of interest from local health economies to be involved in development of the programme and establish the baseline for current service provision of weight management services.

Early diagnosis

5.44 Despite improvements in prevention, some disease will always occur and acting promptly when warning signs appear is essential in preventing premature death. Increasing symptom awareness amongst the public, improving identification of disease in primary care and effective screening are all means by which we can improve early diagnosis and hence access to the right treatment, with a particular need to focus on disadvantaged groups where late presentation is a particular concern.

Symptom awareness campaigns

5.45 The Department of Health has, since 2010/11, funded a programme of symptom awareness raising campaigns under the brand *Be Clear on Cancer* (BCOC). These have been designed to tackle late presentation of patients with possible cancer symptoms and thereby promote earlier diagnosis of cancer, when the cancer is more treatable. Since April 2013 PHE has led on the campaigns, in partnership with DH and NHS England continuing to encourage people to seek early advice if they experience symptoms.

5.46 During 2014/15 the campaigns have focused on:

- A national campaign on breast cancer in women over 70 (from February to March 2014) following the success of the regional pilot in early 2013;
- regional campaigns on oesophago-gastric (North East and Border TV regions) and ovarian (North West TV region) cancers (from February to March 2014);
- a repeat of the national lung cancer campaign (March to end of April 2014);

- a local skin cancer pilot in the South West (June to July 2014);
- a repeat of the national ‘blood in pee’ (bladder and kidney cancers) campaign (October to November 2014);
- a local pilot on prostate cancer in black men, in six London boroughs (October to November 2014); and
- a national oesophago-gastric cancer campaign (end of January to end of February 2015).

5.47 PHE have also made available campaign specific briefing sheets for trusts, GPs and community pharmacies to support the cancer campaigns.

5.48 The BCOC campaigns are supported by a significant body of evidence that indicate the impact of the activity. For example, in the months surrounding the 2012 national lung cancer campaign there were 700 more people diagnosed with lung cancer than the same period the previous year. Also approximately 400 more had their cancers diagnosed at an early stage and around 300 additional patients had surgery as a first treatment of diagnosed lung cancer³⁴.

5.49 When looking at the 2013 BCOC national bladder and kidney cancer campaign, in England there was a 26% increase in the number of urgent GP referrals for suspected urological cancers (including suspected bladder and kidney cancers) from October to December 2012 to October to December 2013. For the same time period, in England, the number of bladder, kidney and all urological cancer diagnoses resulting from an urgent GP referral for suspected urological cancers increased by 8.2%, 22% and 14% respectively, with larger increases for males than females³⁵.

5.50 In addition to the campaigns on cancer, PHE have undertaken two other campaigns. The first, a pilot aiming to raise awareness of breathlessness and aid early diagnosis of a range of diseases such as chronic obstructive pulmonary disease, heart disease and lung cancer was run in Oldham and Rochdale in early 2014. Encouraging results (77% said that the advertising would make them more likely to go to the doctor and 16% said that they had already taken action as a result of seeing the advertising) from the local activity resulted in the scaling up of this pilot to the regional level in the East of England in February 2015.

5.51 The second was a local rheumatoid arthritis pilot in Nottingham City and Hardwick CCGs in February 2015. The pilot focused on recognising and acting on the signs of rheumatoid arthritis, a disease that can cause serious disability if left untreated. Work is underway to

³⁴ An evaluation of the impact of large-scale interventions to raise public awareness of a lung cancer symptom; (January 2015) Ironmonger L, Ohuma E, Ormiston-Smith N, Gildea C, Thomson CS, Peake MD. *British Journal of Cancer* 112, 207–216. doi:10.1038/bjc.2014.596 <http://www.nature.com/bjc/journal/v112/n1/abs/bjc2014596a.html>

³⁵ *Improving Outcomes: A Strategy for Cancer – Fourth annual report* (December 2014); Department of Health; www.gov.uk/government/publications/the-national-cancer-strategy-4th-annual-report

ensure rigorous evaluation which will include pre and post campaign evaluation and a range of activity metrics.

Cancer screening

Improving Coverage

- 5.52 There has been a national and international long term trend showing a gradual fall in cancer screening coverage over the last ten years, but there are options for reversing this trend where appropriate, particularly in disadvantaged groups. PHE is working with NHS England via the Public Health Section 7A agreement to develop a system of performance improvement through the use of performance floors, and strengthened governance for screening.
- 5.53 NHS England is working closely with Cancer Research UK to take forward the ACE programme (Accelerate Coordinate and Evaluate) which is looking at options for improving early diagnosis of cancer. The programme, which will be subject to a full evaluation, includes a workstream on screening uptake for vulnerable groups – seven projects are looking at effective ways to remove barriers to screening for a range of vulnerable groups including those with sensory impairment, learning difficulties or minority ethnic groups.
- 5.54 DH Behavioural Insight team is developing a project on improving coverage in cervical screening. In addition, a major research study on increasing uptake of cervical screening in young women and bowel screening in disadvantaged groups are due to report in 2015/16.

LWfL commitments on cancer screening

- 5.55 There are three specific cancer screening commitments from PHE in LWfL. The first was to complete the second wave roll out of bowel scope screening with at least 60% of local screening operational by 31st March 2015, with 100% operational by the end of December 2016. At publication, this commitment has been exceeded, with 39 centres (63%) live by mid-March.
- 5.56 The second commitment was to run a pilot of faecal immunochemical testing (FIT) for bowel cancer screening, a more accurate and simpler to use home testing kit than the current Faecal Occult Blood (FOB) testing kit, with the intention of evaluating acceptability to the public along with clinical and cost-effectiveness. As FIT is easier to use, it is anticipated to increase the uptake of bowel screening.
- 5.57 NHS cancer screening programmes began piloting FIT in spring 2014, and this pilot completed in October 2014. The pilot involved 40,000 men and women over six months from many screening centres in the South of England, North West and West Midlands. The formal clinical and cost-effectiveness evaluation report is expected at the end of March 2015. Expected outcomes are a higher participation rate across all groups in society and higher detection rate of cancers and advanced adenomas.

- 5.58 Finally, there was a commitment to report on the first year of the six pilot sites of human papillomavirus (HPV) testing as primary cervical screening. From May 2013 sites in Liverpool, Manchester, Northwick Park (Harrow), Bristol, Sheffield and Norwich have been using HPV testing as primary screening (HPV TaPS) for cervical disease, rather than the currently used cytology test. Only HPV samples that are positive will undergo cytology, whilst those women who are HPV negative can return to routine screening.
- 5.59 A formal evaluation of the pilot is taking place, and an interim report is due to go to the UK NSC in March 2015. Cancer Research UK has estimated that, when fully implemented, HPV primary screening could prevent an additional 600 cases of cervical cancer a year.

Access to scientific and diagnostic commissioning information

- 5.60 NHS England is working to ensure that scientific and diagnostic services are available to support both prevention and early diagnosis across the life course and ongoing monitoring of disease status by improving the scientific and diagnostic commissioning information available to commissioners.
- 5.61 NHS England is leading a range of activities relating to the future commissioning of diagnostics within both specialised and CCG commissioning, which over time will begin to inform new approaches to the prediction and prevention of disease as well as the application of new targeted therapies, in support of delivering the ambitions set out in the 5YFV.

Prime Minister Challenge Fund Pilots

- 5.62 NHS England committed in LWfL to evaluate the Prime Minister Challenge Fund pilots to provide evidence on how to improve access to general practice services and develop more innovative and sustainable models of primary care and improve patient experience.
- 5.63 They have 20 pilots in wave one involving over 1100 practices and covering over 7m population and these will continue through to September 2015. The intention of the evaluation is to develop a common set of evidence-based principles that can be used by others in developing their approaches to improving access to services. A further £100m has been announced for a second wave of pilots to run during 2015/2016. NHS England is currently working on the wave two selection and wave two pilots to be announced later in March.

The **Extended Primary Integrated Care (EPIC) project** has extended access to primary care services in parts of Brighton and Hove by thinking about how General Practice delivers its functions.

To help people who need health guidance rather than medical care some GP practices have introduced care navigators. These specially trained staff work with voluntary care organisations Age UK and Neighbourhood Care to provide proactive advocacy and support to the community, particularly for those who are living on their own or with complex needs.

They have also increased access and reconnected GPs to local community assets by working with local pharmacists to set up 'primary care' centres to give patients a more responsive and flexible service, providing same-day appointments, from 8am to 8pm on weekdays. On weekends patients have access to two sites which are open from 8am to 5pm and a further two sites, open from 9am to 5pm.

Treatment

5.64 There is a lot we can do to extend and improve the quality of lives through effective treatment and LWfL identified the need to ensure that the quality of treatment is more consistent across the country. LWfL set out a number of areas where NHS England have been working to ensure people receive high quality care and experience the best outcomes possible.

Stimulating a focus on reducing premature mortality across the NHS

5.65 Given the priority reducing early deaths has across the system it was important to establish a way to articulate the contribution the commissioning system makes to reducing premature mortality, ensuring commissioning plans focused on improving outcomes not just outputs. The measure of this ambition is in potential years of life lost (PYLL).

5.66 NHS England committed to providing clinical advice and support for CCGs in setting and delivering their levels of ambition throughout the year with the aim of all CCGs having agreed levels of ambition to reduce premature mortality. This was achieved in September and cumulatively CCGs have set a level of ambition of 12% reduction in PYLL to 2018/19.

Incentives

5.67 In April 2014 NHS England strengthened the existing quality premium on PYLL to ensure a clear focus on delivering greater improvement in areas of high social deprivation.

5.68 In addition, to support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with severe mental illness, a new CQUIN was introduced in April 2014. The CQUIN incentivises providers of mental health services to ensure that service users have recorded comprehensive physical and mental health diagnoses and that this is shared with the service users GP. There are now 75 organisations providing relevant mental health services which are signed up to the CQUIN. The CQUIN is expected to continue in 2015/16 to progress improvements for patients with severe mental health illness.

5.69 NHS England is expected to introduce new CQUINs with a view to improving the detection and management of acute kidney injury (AKI) and sepsis in 2015/16. Both AKI and sepsis are identified as short to medium-term priorities for reducing premature mortality by NHS England. Consideration is also being given to the extension of the Quality Premium PYLL measure and the CQUIN mental health measure.

5.70 Decisions by NHS England on the 2015/16 Quality Premium and CQUIN schemes are expected later in the spring. Over the coming year NHS England will also be reviewing the design of incentives in the light of the 5YFV.

Proton Beam Therapy

- 5.71 Proton Beam Therapy (PBT) is a very precise form of radiotherapy which uses charged particles (protons) rather than conventional X-rays. It can be effective in treating a number of complex cancers and avoiding damage to critical tissues near the tumour.
- 5.72 It is particularly effective in improving the outcomes from the treatment of cancer in children and young people as it decreases the long term side effects and risk of late second malignancy and consequently increases patient lifetime benefits.
- 5.73 In April 2008, the first patients were sent abroad for PBT treatment on the Proton Overseas Programme. The National PBT Service Development Programme was formally established in 2012 where the government announced £250m of public capital funding to develop the new PBT centres. There is a Prime Ministerial commitment to open two new centres (the first by 2018) while continuing to fund all clinically appropriate patients for overseas PBT treatment.
- 5.74 NHS England is committed to publishing PBT clinical access policies for routine commissioning. This contributes to delivering the ambitions on premature mortality by defining the national mandatory access to the PBT overseas programme before the NHS starts to provide a UK service in 2018.

Stroke services

- 5.75 NHS England set out clearly in the 5YFV the benefits, in terms of outcomes for patients, of configuring some services to centralise specialist provision. LWfL included a commitment on reconfiguring stroke services where NHS England has been working with networks to understand the appetite and barriers in different localities and CCGs for service reconfiguration. In line with the commitment in LWfL to build on the London experience, Manchester's new stroke service is expected to go live at the end of March. Birmingham has already undergone some change with the next steps of reconfiguration currently in development.
- 5.76 NHS England is supporting local communities to develop the case for reconfiguration of local stroke services. A reconfiguration resource kit for CCGs based on existing and successful acute stroke service reconfiguration examples has been produced by NHS England to facilitate this.

Congenital heart disease review

- 5.77 In LWfL NHS England committed to, and is currently undertaking, a review of services for children and adults with congenital heart disease. The aims of the review are to get the best outcomes for patients; to tackle variation so that services across the country consistently meet demanding performance standards and are able to offer resilient 24/7 care; and to improve patient experience.

5.78 The consultation on draft standards and service specifications closed in December, with around 450 responses and an independent report on the responses was published in early March. The board of NHS England is expected to make its decisions on the review's recommendations in summer 2015, with the expectation that services will be commissioned against the new specifications and standards in 2016. Work is underway with national and local commissioners, providers and patient groups to establish timely and appropriate commissioning processes as well as improvements in the available information about the performance of congenital heart services.

Making every contact count

5.79 Improving health outcomes needs action at individual, community and national levels; 'making every contact count' (MECC) focuses on individuals and groups improving health and wellbeing and contributing to overall improvement.

5.80 DH has been working to support a system wide approach to implementation and key organisations including NHS England, PHE and HEE are undertaking work to support the delivery of MECC across health and social care. MECC is also a core component of the *Framework for Personalised Care and Public Health*³⁶, and is directly linked to 23 of the indicators in the Public Health Outcomes Framework. There is recognition of the importance of staff having the right skills to deliver these interventions and work is ongoing to ensure it is built into the Public Health Workforce Strategy.

5.81 The [Mandate](#)³⁷ sets out an objective for NHS England to make significant progress 'in focusing the NHS on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health' and to 'make an important contribution by promoting the mental and physical health and wellbeing of its own workforce'.

5.82 NHS England will produce an action plan by the end of March to improve the NHS contribution to prevention through the implementation of NICE guidance on behaviour change relating to obesity, physical activity, alcohol and tobacco in support of MECC and to reduce health inequalities. The action plan will focus on clinical leadership and engagement through effective communications and partnership working; the development of commissioning resources, tools and levers and supporting system leaders, HEE and PHE, on defining the requirements for workforce training and education.

5.83 NHS England will also strive to be an exemplar in the development of its own strategy on workforce health and wellbeing, and support NHS Employers in respect of the wider NHS workforce.

³⁶ *Framework for Personalised Care and Public Health for Nurses, Midwives, Health Visitors and Allied Health Professionals*; (Nov 2014); Public Health England & Department of Health; <https://www.gov.uk/government/publications/framework-for-personalised-care-and-population-health>

³⁷ <https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>

Making every contact count is a way of working that can make a real difference to people's lives. The focus might be on individuals losing weight, quitting smoking, reducing alcohol intake, or helping to reduce social isolation – it's about living well for longer. For those at the [West Midlands Fire Service](#), it can mean:

- getting an elderly woman's carpet replaced because there's a real risk of her tripping;
- looking out for new squats on the way to and from work to have conversations with the homeless about fire safety, and giving information on local services;
- climbing through someone's window to have a chat about alcohol harm reduction because that was the only way they would let you in; and
- working with a 15 year old with 30 or so arrests with the outcome that they stay in education, are now living independently and don't do the sorts of things anymore that got them arrested in the first place.

Learning disabilities

- 5.84 *Living Well for Longer* recognised that it is often people who are most at risk of poor health outcomes who are slowest to come forward and that they are also likely to be relatively disadvantaged. To address this we need to understand how best to target interventions and contribute to reducing health inequalities.
- 5.85 As part of this NHS England commissioned an evidence review of interventions to reduce mortality for people with a learning disability; the main conclusion of which was that there is a lack of clear evidence of what works. As an interim solution NHS England published a document that set out, amongst other things, ways for the system to make reasonable adjustments to ensure equity of access to services. NHS England made £1.5 million available in 2014/15 to support the work required to establish a national learning disability mortality review which will begin collecting data about the causes of premature mortality in people with a learning disability with a view to identifying learning about ways of improving outcomes for them in 2015/16.
- 5.86 NHS England has asked the Healthcare Quality Improvement Partnership (HQIP) to commission the review as a National Clinical Audit Confidential Enquiry under the National Clinical Audit and Patient Outcomes Programme. HQIP is in the process of tendering for a preferred provider and we expect a national mortality review to be established during 2015/16. NHS England is undertaking preliminary work to scope options for improving uptake of GP health checks for people with learning disabilities.

6. Next steps

- 6.1 One year after LWfL was published we find ourselves at a pivotal point of opportunity to make real change across the system. We have the right organisations in place, newly established mechanisms to support and collaborate with each other and clearly articulated commitments to delivering a paradigm shift in how health care in its broadest sense is delivered.
- 6.2 We are confident that the evidence based actions set out in this report will have had a positive impact on reducing premature mortality. This is corroborated by the extensive information included in this report setting out additional activity across the system. It is not yet possible to identify the impact of these activities on overall mortality rates or inequalities for a number of reasons.
- 6.3 Mortality statistics are volatile and notoriously difficult to interpret, not least because they reflect a vast array of different factors that will come into play over the whole life course of any individual. We will, however, continue to monitor mortality rates and health inequalities over the longer term to help identify changes in future trends and take action accordingly.
- 6.4 There is a consensus on the areas we need to focus on to maximise the impact on the health and care system and importantly, from this document's perspective, on reducing premature mortality and health inequalities. For example the work commissioned by NHS England and DH from the European Health Observatory³⁸. We either know, or are building the evidence base, on what works and are agreed about the benefits of working as a broad coalition to implement the processes, services and systems.
- 6.5 With all aspects of this work, account needs to be taken of the different needs of different communities and groups to ensure health inequalities are reduced, especially those associated with premature mortality. Research³⁹ tells us that while the proportion of the population that engages in unhealthy behaviours has declined significantly in the past few years these reductions have not been spread evenly across the population.
- 6.6 To improve the overall health of England and reduce the pressure on the NHS we need to ensure that the actions we take particularly enable those at higher risk of unhealthy behaviours, for example those in lower socio-economic groups, to live longer healthier lives.

³⁸ Reducing avoidable mortality in England: What can be done? Karanikolos M, Nolte E, Varsamis D, Ingham Clark C, Bhogal J, and McKee M; Eurohealth, 20, 4, pp39-42 (December 2014)

http://www.euro.who.int/_data/assets/pdf_file/0011/266186/EuroHealth_v20n4.pdf?ua=1

³⁹ *Clustering of unhealthy behaviours over time: implications for policy and practice*; (Aug 2012); Buck D and Frosini F; The King's Fund; http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/clustering-of-unhealthy-behaviours-over-time-aug-2012.pdf

Shared system leadership

- 6.7 The 5YFV and *From evidence into practice* both highlight the need for the NHS and public health to empower people to manage their own health more effectively in a range of ways which dovetail and complement each other.
- 6.8 This will range from helping the public to engage with information about making healthy choices through digital and mobile technology as well as continuing with the tried and tested routes such as marketing campaigns. It includes improving the information that people can readily access about diseases and interventions, linking into the existing work on digital information. It also involves increasing the direct choice and control patients have over their care in terms of what treatment they have and where, and the new integrated personal commissioning to manage a 'year of care' budget for themselves.
- 6.9 Without a shared vision and collaborative working between the NHS and local authorities, championing the individuals' role in determining their health and wellbeing, this will not become a reality.
- 6.10 The second area where shared leadership will be key is in the rise of place-based approaches where local authorities lead their partners in health, public health and elsewhere to develop local solutions that integrate services and ensure sustainability and resilience. PHE are committed to develop an evidence base on community development interventions.
- 6.11 NHS England has also identified the need to engage with communities and the public at a more fundamental level, outside the routine provision of healthcare. The NHS has a unique position of trust within communities and will be looking to extend its influence in supporting carers, creating new options for health-related volunteering as well as making it easier for voluntary sector organisations to work with the NHS. The NHS will also be seeking to use its role as a major employer to lead the way in improving the health of its population for example through its management of employees with mental health conditions.

Accountability and transparency

- 6.12 The work on transparency will continue across the national organisations. There is a shared willingness to make data and information on quality and performance available in clear and meaningful ways that can be tailored to a variety of audiences.
- 6.13 DH is undertaking a programme of work to consider the future direction of the outcomes frameworks (public health, NHS and adult social care), and how they can promote greater alignment. This work aims to support commissioners, patients and the public, not only to have access to this information on outcomes but to use and interpret it, so that they are fully informed about the quality of care available to them.

6.14 There is also an ongoing process to review and develop the [MyNHS](#) site with users, professionals and organisations. Secretary of State sees this as a key mechanism to embed the culture of transparency throughout the system. Future updates include a commitment to provide information at a local authority level on the health and wellbeing of their population which will provide context for the other health and care economy information on the site.

Ensuring prevention is front and centre

6.15 Over the next 5 years, first and foremost there must be a focus on prevention. This is clearly articulated by both NHS England and PHE in their forward plans but for the first time the governance and mechanisms are being put in place to deliver collaboratively. The NHS Prevention Programme Board will provide shared senior leadership and governance and ensure these programmes of work are developed collaboratively. Reducing health inequalities will be a particular focus.

6.16 The initial area of work for the programme is implementation of a national diabetes prevention programme. PHE is working in partnership with NHS England and Diabetes UK to implement the programme, as outlined in *Evidence to Action* and [The Forward View into Action](#)⁴⁰. This work will involve assessing the evidence of what works, co-designing the interventions and supporting the implementation of proven approaches to prevent diabetes.

6.17 These interventions will be implemented in a small number of demonstrator sites in 2015/16 and evaluated before a planned national roll out in 2016/17. This will allow us to achieve our aim ‘to be the first country to implement at scale a national evidence-based diabetes prevention programme’⁴¹.

6.18 In addition, DH is looking to incentivise local authorities to make tangible progress against key public health outcome indicators through the Health Premium Incentive scheme. A pilot scheme in 2015/16 will share £5 million among those authorities that achieve real improvement in drug misuse service outcomes and another indicator that they can choose themselves to reflect their own local priorities. There will be a default indicator on the NHS Health Check for those that don’t actively make a choice.

6.19 Perhaps most importantly is the recognition that the NHS itself needs to become a greater agent for change in health-related social behaviours through:

- **Incentivising and supporting healthier behaviours** on things like drinking, smoking and diet, using the purchasing power of the NHS to reinforce these measures. This will be supported and underpinned by PHE’s use of behavioural science and digital and

⁴⁰ *The Forward View into Action: Planning for 2015/16*; (Dec 2014); NHS England; <http://www.england.nhs.uk/ourwork/forward-view/>

⁴¹ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf

mobile technology; enabling the system to personalise support at scale through new approaches to motivate and support people to make healthy choices.

- **Supporting local democratic leadership** on public health through health and wellbeing boards and supporting greater powers for local authorities in public health policy. This will complement local authority led place-based approaches to develop local solutions and resilient communities.
- **Targeting secondary prevention**, particularly through proactive, evidence based primary care interventions which provide considerable scope to rapidly reduce health inequalities⁴². PHE will be developing a new preventative services programme with NHS England. This will start with diabetes, assessing the evidence; designing interventions that are proven will prevent disease and support implementation. This work which is being taken forward in partnership with Diabetes UK will be a key programme to deliver reductions both in premature mortality and disability and also to demonstrate effective collaboration.
- **Supporting people to get jobs and stay in employment**, in particular looking at how access to NHS services for those at risk of leaving work due to ill-health.
- **Supporting employers** to provide effective workplace health programmes for their staff, starting with NHS Employers, encouraging NHS staff to act as health ambassadors in their local communities.

6.20 There is an expectation that PHE will continue its work in widening the reach of the Workplace Wellbeing Charter, an award scheme to promote workplace health, while ensuring this is aligned with the Public Health Responsibility Deal Health at Work Network pledges. PHE will also continue to build the evidence base and support DH in developing policy in this area.

6.21 DH will continue to work to support efforts to reduce participation in risky behaviours, taking account of their social distribution. In particular we will need to continue to work with industry to improve public health. They have a significant role to play given their role as employers, but also as producers and retailers of food and alcohol.

6.22 DH will also be working on the European Tobacco Products Directive, which must be transposed in UK law by May 2016, will introduce a range of new tobacco control measures, including a ban on flavourings such as menthol, larger health warnings, bring an end to small packs of cigarettes and tobacco and introduce measures to counter illicit trade in tobacco. The Directive will also introduce regulatory controls on electronic cigarettes.

⁴² *Tackling inequalities in life expectancy in areas with the worst health and deprivation*; House of Commons Committee of Public Accounts: Third Report of Session 2010–11; <http://www.publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/470/470.pdf>

Treatment: improving outcomes for patients

Mental health

6.23 Mental health was identified in LWfL as an area where health outcomes from the major killer diseases are particularly poor. To help address this the recently published *Mental Health Act 1983; Code of Practice*⁴³ includes advice service providers can follow to better look after the physical health of people suffering mental ill health. This recognises the huge disparity in premature mortality rates for people suffering mental illness.

Cancer

6.24 International comparisons demonstrate that although incidence of cancer in the UK is below the European average, there is a historically poor survival gap between the UK and other parts of Europe. Most of this data is from patients diagnosed in 2007 or earlier and we have made progress in England in improving outcomes since 2007.

6.25 A comparison of all-stage survival in 2012 with a baseline of 2004/07 shows increasing survival across all cancer types⁴⁴ and in the 2014 *Fourth Annual Report on the Cancer Outcomes Strategy*⁴⁵ we projected that, based on our current rate of improvement in survival, 12,000 additional people diagnosed from 2011-2015 will survive their cancer for five years compared to those diagnosed from 2006-2010. We would not claim that all the improvement is down to actions set out in the strategy, but we do believe that these actions have had a significant impact on cancer survival in this country and will continue to do so.

6.26 Although this is good news, we know there is still more to do. There are still deep inequalities and wide variation in outcomes from cancer across England, which demonstrates that there is significant scope for improvement. This is why in January 2015 NHS England announced a new independent Cancer Taskforce to develop a new cancer strategy which will focus on better prevention, quicker diagnosis, and better treatment, care and aftercare for all those diagnosed with cancer.

6.27 The strategy will be published by the summer. If we are able to deliver the vision set out in the 5YFV at sufficient pace and scale, NHS England believe that, over the next five years, the NHS can deliver a 10% increase in those patients diagnosed at stage 1 and stage 2. This is equivalent to about 8,000 more patients living longer than five years after diagnosis.

⁴³ Mental Health Act 1983: Code of Practice; (January 2015); Department of Health; <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

⁴⁴ 1-year cancer survival increased from 59.7% for adults diagnosed in 1997 to 69.3% in 2012 and 5-year survival increased from 41.9% for adults diagnosed in 1997 to 49.0% in 2008.

⁴⁵ *Improving Outcomes: A Strategy for Cancer – Fourth annual report* (December 2014); www.gov.uk/government/publications/the-national-cancer-strategy-4th-annual-report

- 6.28 NHS England also launched a major early-diagnosis programme, working jointly with Cancer Research UK and Macmillan Cancer Support to test new approaches to identifying cancer more quickly. Examples include self-referral for diagnostic tests, lowering the threshold for GP referrals, and setting up multi-disciplinary diagnostic centres so patients can have several tests done at the same place on the same day.
- 6.29 In addition, NHS England committed a further £15 million over three years to evaluate and treat patients with a modern, more precise type of radiotherapy, stereotactic ablative radiotherapy (SABR). This evaluation programme will mean a significant increase in the number of cancer patients eligible to access SABR treatment by around 750 a year. The programme will widen the number of cancers being treated by SABR, including cancer that has spread to another part of the body. This new investment is in addition to NHS England's pledge to fund up to £6 million over the next five years to cover the NHS treatment costs of SABR clinical trials, most of which are being led by Cancer Research UK.

Liver disease

- 6.30 Liver disease is one area where we have not seen the improvements in mortality rates that have been evident in the other major diseases. While the rates have broadly levelled off in recent years liver disease is the third commonest cause of premature death in people of working age, and continues to make a major contribution to premature mortality and health inequalities. Mortality rates from liver disease are substantially higher in the UK than other countries in Western Europe.
- 6.31 Alcohol, obesity and viral hepatitis are the main contributors to liver disease and, are largely preventable risk factors. Work is underway to prevent liver disease through tackling alcohol consumption and obesity which have been discussed earlier in this document. Viral hepatitis, in particular hepatitis C, contributes to morbidity and premature mortality from liver disease and liver cancer. On World Hepatitis Day (28 July 2014), PHE published its annual report *Hepatitis C in the UK*⁴⁶ summarising progress since the 2004 hepatitis C action plan for England, but showing the continuing rise in serious liver disease due to chronic hepatitis C infection.
- 6.32 PHE has also been working with NHS England and the voluntary sector to develop a *Hepatitis C Improvement Framework* which aims to improve case-finding, prevention, diagnosis and treatment programmes, especially for high-risk populations such as people who inject drugs. The long term goal is reducing the burden of disease from end-stage liver disease and liver cancer. This framework is due to be published in the spring. To support commissioning of hepatitis C services, PHE also publishes a hepatitis C commissioning template which helps commissioners estimate the local prevalence of

⁴⁶ <https://www.gov.uk/government/publications/hepatitis-c-in-the-uk>

hepatitis C and the costs of treatment. [Mathematical modelling](#)⁴⁷ suggests that access to the new, more effective treatments for chronic infection have real potential to stem this rise.

- 6.33 Hepatitis B infection, the other viral cause of chronic liver disease, can be effectively prevented by vaccination. In October, the [Joint Committee on Vaccination and Immunisation](#)⁴⁸ recommended that a combination vaccination including hepatitis B should be used in infants, provided that it could be procured at a cost effective price.
- 6.34 PHE is taking a number of additional actions to help tackle the condition. These include developing a liver disease framework and publishing a report on children and young person's liver disease in addition to an updated report from the National End of Life Care Intelligence Network on end of life care for people dying with liver disease, both of which are expected later this spring. PHE has a strategic partnership working with the Lancet Commission⁴⁹ on liver disease on taking forward its recommendations.
- 6.35 PHE has also developed the information available to support commissioning decisions, with publication of local authority liver disease profiles in November 2014. These were designed for use by local authority Health and Wellbeing Boards and the evidence is that they are being used widely. PHE will work with Institute for Health Metrics and Evaluation to publish a report of the Global Burden of Disease 2013 model (for liver disease) with an update for England compared with other countries, which will include analysis by English region and by deprivation. During 2015/16, PHE will also produce an analysis of the independent role of obesity in liver disease compared with alcohol and infections.

Acute kidney injury

- 6.36 Acute kidney injury (AKI) is seen in 13–18% of all people admitted to hospital, costing the NHS between £434m and £620m per year and resulting in substantial numbers of preventable deaths. To address this, NICE guidance⁵⁰ was published in 2013 to foster improvements in early intervention and highlight the importance of risk assessment and prevention, early recognition and treatment in a variety of settings.
- 6.37 In 2015, 'Think Kidneys', the NHS programme for AKI, will commence measurement and reporting across all providers and support improvement across England by providing expertise to the Safety Collaborative and other initiatives to reduce harm associated with AKI.

⁴⁷ <https://www.gov.uk/government/publications/hepatitis-c-in-the-uk>

⁴⁸ <https://www.gov.uk/government/groups/joint-committee-on-vaccination-and-immunisation#minutes>

⁴⁹ *Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis*; Williams et al; (November 2014); <http://www.britishlivertrust.org.uk/lancet-leading-experts-call-end-uk-postcode-lottery-liver-disease-treatment-detection/>

⁵⁰ *Acute kidney injury: Prevention, detection and management of acute kidney injury up to the point of renal replacement therapy*; (August 2013); NICE; <https://www.nice.org.uk/guidance/cg169>

Sepsis

- 6.38 Sepsis claims over 37,000 lives every year in the UK which is more than lung cancer and breast cancer combined⁵¹. It also costs the NHS around £20,000 for each hospital admission⁵².
- 6.39 Research shows that early recognition and intervention saves lives, estimates suggest as many as 15,000 per year in the UK, reduces the time patients spend in hospital and is cost effective. The Secretary of State's recent focus and the publication of information on patient safety⁵³ is an important step in challenging the system to do more on sepsis and other risks to good treatment and care.
- 6.40 NHS England has set up a cross-system Sepsis Programme Board to bring together work being undertaken by various bodies on early recognition and treatment of sepsis. Among other things HEE is developing educational materials, NHS England has developed a CQUIN to reward rapid recognition and treatment of severe sepsis in patients admitted to hospital as emergencies, and work is going on in liaison with the Academy of Medical Royal Colleges to enable audit and improvement in sepsis management in primary and secondary care.

Diabetes

- 6.41 Diabetes is a major risk factor for premature mortality, contributing to over 22,000 additional deaths each year as well as health inequalities. Having diabetes doubles the risk of cardiovascular disease (heart attacks, heart failure, angina and strokes) and it is often accompanied by other long-term conditions.
- 6.42 Estimates suggest that diabetes costs approximately 10% of the total expenditure on health with approximately 80% of those costs incurred in treating potentially avoidable complications. There have been improvements in the quality of NHS care for people with or at risk of diabetes which has led to improvements in health and care outcomes as well as mortality among people with diabetes⁵⁴.
- 6.43 However, there is more to be done to improve outcomes and patient experience and in 2014 NHS England published their *Action for Diabetes*⁵⁵. This set out the actions they are taking over the next few years to improve outcomes for adults with and at risk of diabetes.

⁵¹ UK Sepsis Trust, accessed 12 February 2015, https://www.facebook.com/TheUkSepsisTrust/info?ref=page_internal

⁵² *Time to act - Severe sepsis: rapid diagnosis and treatment saves lives; Appendix 2: invited evidence from the UK Sepsis Trust*, (September 2013); Parliamentary and Health Service Ombudsman; <http://www.ombudsman.org.uk/time-to-act/glossary-and-appendices/appendix-2-invited-evidence-from-the-uk-sepsis-trust>

⁵³ <http://www.nhs.uk/NHSEngland/thenhs/patient-safety/Pages/patient-safety-indicators.aspx>

⁵⁴ *Action for Diabetes*; NHS England; (January 2014); <http://www.england.nhs.uk/ourwork/qual-clin-lead/action-for-diabetes/>

⁵⁵ *ibid*

These include the development of a sample service specification for services to support CCGs to put in place appropriate services for their populations; this is now available on the [NHS Commissioning Assembly website](#)⁵⁶.

6.44 In addition, NHS England is working with Diabetes UK and the Association of British Clinical Diabetologists on a national root cause analysis project. Acute trusts have volunteered to participate in the project which is currently collecting data on adverse inpatient events in those with diabetes, including mortality. The results will help inform future inpatient care and will be presented at the Diabetes UK Annual Professional Conference in March 2015.

Self care

6.45 The 5YFV highlights the fact that over a quarter of the population in England have at least one long term condition and increasing numbers having multiple conditions. It estimates that approximately 70% of health and social care spending is targeted towards those 15 million people. As a consequence, managing those needs in an effective, joined up manner is now central to the role of the NHS.

6.46 The 5YFV recognises that even patients with long term conditions probably spend less than one percent of their time in contact with health professionals. The rest of the time they manage on their own. There is good evidence that patients who receive services that are tailored to their needs and circumstances, and who have the skills and support needed to manage their own care, experience health, better outcomes and fewer costly episodes of unplanned care. The 5YFV therefore makes a key commitment to do more to support people with long term conditions to manage their own health and care.

6.47 NHS England has recently launched the *Realising the Value Programme* which will identify key evidence based approaches to care which empowers patients and engages communities (such as self-management and peer support) and develop tools to support their implementation across the NHS and local communities. This work will include testing with local communities, and will give consideration to culture and systems barriers, to enable greater implementation of self-management and person centred care in addition to developing a methodology for assessing the costs and benefits.

6.48 Other areas of activity to promote self-care include the Patient Activation Measure (PAM) learning set. As part of this, five CCGs and the UK Renal Registry are currently testing the use of the PAM, to help assess an of individual's motivation, alongside their skills, knowledge and confidence to manage and make decisions about their own health and care. This work will be evaluated and will offer learning on how the PAM can support a personalised approach to care and self-management.

⁵⁶<http://www.commissioningassembly.nhs.uk/pg/dashboard>

- 6.49 In addition to this, NHS England is conducting a survey to test clinician support (CS) for patient activation. The CS PAM questionnaire has been supported by a number of Royal Colleges, and over 1800 clinicians have responded. Analysis of the data is currently ongoing. The results will help to understand how clinicians perceive their role in supporting patient self-management, the issues and barriers they face, and any additional support they may need.
- 6.50 Finally, the Coalition for Collaborative Care was established in 2014 and brings together an alliance of people and organisations committed to achieving person-centred, collaborative care. NHS England and the Coalition recently published the *Personalised Care and Support Planning Handbook*⁵⁷ on care and support planning for people with long term conditions. The Handbook is designed to help commissioners and practitioners turn the aspiration of improved personalised care and support for people with long term conditions into a reality; moving from providing single, unconnected episodes of care to working in partnership with patients over the long term.

Enabling people with a long term condition to manage their own health on a day to day basis improves the experience of care as well as improving outcomes. There is a wide range of tools to aid **self care**, including:

- Diabetes UK's '**Living with Diabetes**' days (http://www.diabetes.org.uk/How_we_help/Living-with-Diabetes-Days/). These are run across the country and provide advice on maintaining a healthy diet and becoming more confident in managing their diabetes day to day. For more one to one support there is peer support which puts people in touch with someone who knows first-hand what it's like to live with diabetes (http://www.diabetes.org.uk/How_we_help/Peer-Support/).
- **My Stroke Guide** (<http://mystrokeguide.com/>) is a self-management tool to support people who have been affected by stroke. It was designed by The Stroke Association with stroke survivors and carers, and provides practical tools to help them understand stroke and deal with its effects alongside peer support to combat feelings of isolation.
- The British Lung Foundation's **COPD Patient Passport** (<http://passport.blf.org.uk/>) uses a step by step approach to help patients discuss, understand and manage their condition better.

New models of care

- 6.51 The 5YFV acknowledges that future developments will not be about disease or group specific services but about different models and networks of care. The way services are provided in primary care, community services and hospitals is often an important factor in delivering coordinated and person centred care.
- 6.52 Over the next few years, as set out in the *Forward View into Action*⁵⁸, NHS England will be working with innovative providers and commissioners to support development, evaluation and ensure the new care models provide the best experience for patients and value for money. To do this, twenty nine 'vanguard' sites were selected on 10 March to take the lead on the development of new care models. The aim is to transform how care is

⁵⁷ Personalised Care and Support Planning Handbook; NHS England; <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

⁵⁸ *The Forward View into Action: Planning for 2015/16*; (Dec 2014); NHS England; <http://www.england.nhs.uk/ourwork/forward-view/>

delivered locally and act as the blue prints for the NHS moving forward. NHS England will work with local vanguard sites to develop dedicated support packages, and help in overcoming barriers and building capability to enable and accelerate change in ways that can be replicated elsewhere. The programme will be backed by a £200 million Transformation Fund.

6.53 The three areas for redesign include:

- Integrated Primary and Acute Care Systems – joining up GP, hospital, community and mental health services;
- Multispecialty Community Providers – moving specialist care out of hospitals into the community;
- Enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.

Looking to the future

6.54 The vision started and articulated by the Secretary of State in 2013 is now embedded in the plans and priorities of NHS England and PHE. There is a common understanding of the direction of travel, and a shared commitment to deliver.

6.55 The health and care reforms have put the right organisations in the right places. As envisaged, they have provided a more devolved system that is able, supported by NHS England and PHE, to deliver responsive and tailored services to meet local needs, including on reducing early deaths.

6.56 LWfL played an important role in initiating the new system's drive towards improving outcomes for the people of England. It set out for all the scale of the challenge and highlighted the themes of early diagnosis, treatment, and shone the spotlight on prevention. It is now time to step back and let the system as a whole, as well as each component part, do its work; while Government continues to undertake the actions only it can carry out, including providing the framework within which the health and care system works which recognises the importance of reducing premature mortality.

6.57 It is also essential that NHS England, local NHS bodies, PHE and local authorities continue to build on progress, ensuring that the priorities of prevention, early diagnosis and effective, evidence based treatments are normalised in all future policy developments.

3.14 Shared leadership and recognising where there are common system goals is fundamental to successful progress. NHS England and PHE have established clear structures and governance around common areas of interest with plans on how they will work together on cross-cutting themes.

3.15 Greater availability of accessible local information will stimulate self-improvement rather than relying on common centrally driven performance targets. Increasing transparency will mean localities have meaningful data and information to judge performance as well as

hold organisations and professionals to account for the quality of their services and local outcomes.

6.58 For the future, DH will continue to consider the evidence on delivering high quality, cost effective health and care. We will work with our partners to evaluate what actions are required by the system to generate those improvements and hold partners to account to deliver those changes. We will remain an active partner in the coalition of effort across the system and will still play a key role in supporting the system at all levels to do what is necessary to reduce premature mortality and move us towards being amongst the best in Europe by 2020.

