



Department
of Health

Living Well for Longer

National Support for Local Action to Reduce Premature Avoidable Mortality



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Living Well for Longer

National Support for Local Action to Reduce Premature Avoidable Mortality

Prepared by

The Reducing Premature Mortality Programme in The Department of Health



Foreword

Jane Ellison MP, Parliamentary Under Secretary for Public Health

It's been a year since the Secretary of State for Health published "Living Well for Longer: a Call to Action to reduce premature avoidable mortality"¹ setting the challenge we face to be amongst the best in Europe in avoiding early deaths. He set out his Call to Action, to the new health & social care system, to galvanise action

to match the best countries in Europe and prevent early and avoidable deaths on an unprecedented scale – equivalent to **an additional 30,000 lives saved per year by the year 2020**. We know there is a huge amount more we can do to focus on those with the poorest health – people with mental illness or those who suffer the worst health inequalities in our society. We know that some minority ethnic communities have a high prevalence of certain diseases, which lead to premature deaths from some of the major killers.

The Secretary of State has made clear that it will take everyone to play their part to make the difference and not just until 2020, but beyond for future generations. I know the difference will be made at the community level by local authorities, empowered by their new public health responsibilities, and their health and voluntary sector partners.

However, I want local authorities, commissioners in councils and CCGs and providers to know what concerted effort and support they can expect from their national level partners as they consider their response to the Call to Action. Hence, this document is aimed at, and is a resource for, local health and wellbeing boards and the wider community sector. The document shows how the national collective efforts of Government, NHS England and Public Health England combine and align. We want to support local commissioners and providers as they lead improvements in health outcomes for our communities.

When the Call to Action was published it began an open debate about why so many people die prematurely in England. From raising issues about unacceptable variations in outcomes across our country; to the need for a greater focus on prevention and early diagnosis; and in raising our sights on what more we can achieve by going further and faster on treatment and care, a palpable energy has been created. This common purpose we now have must be nurtured and extended to involve everyone who can play their part.

This is an important time for us – to be bold and ambitious for health.

A handwritten signature in black ink that reads "Jane".

¹ [Living Well for Longer: a Call to Action to reduce premature avoidable mortality](#)

“Living Well for Longer shows how the national agencies are combining their efforts to reduce avoidable mortality. It showcases best practice, emphasising the importance of having both local and national strategies to tackle the five big killers and the need to reduce health inequalities amongst our most vulnerable groups.”

- **Celia Ingham Clark, Director for Reducing Premature Mortality, NHS England**

“We know that too many people are dying way too soon from diseases that are largely avoidable. It is critical that we all direct our effort and resource to prevention and early intervention and no one is better placed to do this than local authorities, working hand in glove with the local NHS, who are integrating their new responsibility for improving the public’s health with their wider remit of growing the local economy, providing decent housing, job opportunities, and reducing social isolation. For our part, Public Health England is determined to support them in every way possible, from sharing our knowledge and expertise and publishing progress to promoting examples of good practice. This document sets out the steps to be taken nationally to tackle avoidable mortality and enable people to live longer and to enjoy longer healthy lives

- **Duncan Selbie, Chief Executive, Public Health England**

“Living Well for Longer provides the system with a much needed overview of what’s going on at a national level to reduce premature mortality. It contains useful guidance and case studies to help hospitals focus on the prevention, early diagnosis and treatment of the five big killer diseases. It shows how hospitals can combine national and local priorities to treat their communities better.”

- **Sir Mike Richards, Chief Inspector of Hospitals**

“I really like this document – it brings together ideas and information on interventions across healthcare, focused on prevention, early diagnosis and treatment that will help GPs tackle the most important problems in their local area. It will help GPs play their part in reducing health inequalities, helping everyone to live longer and healthier lives.”

- **Professor Steve Field, Chief Inspector of General Practice**

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Executive Summary

Too many people die too early from diseases and illnesses that are largely avoidable. With the most common and biggest killer diseases being cancer, heart disease, stroke, respiratory and liver disease, we know that around 103,000 deaths of people under the age of 75 every year could have been avoided either through **prevention** of illness through public health interventions, **earlier diagnosis** of their conditions through greater symptom awareness amongst professionals and the public, and by having access to the highest quality **treatment and care**.

That is why in 2013, the Secretary of State for Health set out his Call to Action for the health and care system, in its widest sense, to join him to meet his ambition - ***to be amongst the best in Europe at reducing levels of premature mortality***. Efforts to deliver the ambition will require improvements in outcomes across the breadth of the new health and care system. It will not be possible to achieve this ambition by focusing our attention on treatment alone. We must also stem the flow of illness by helping people to live healthy lives, by taking timely precautions to protect health and by taking action earlier to detect disease and illness.

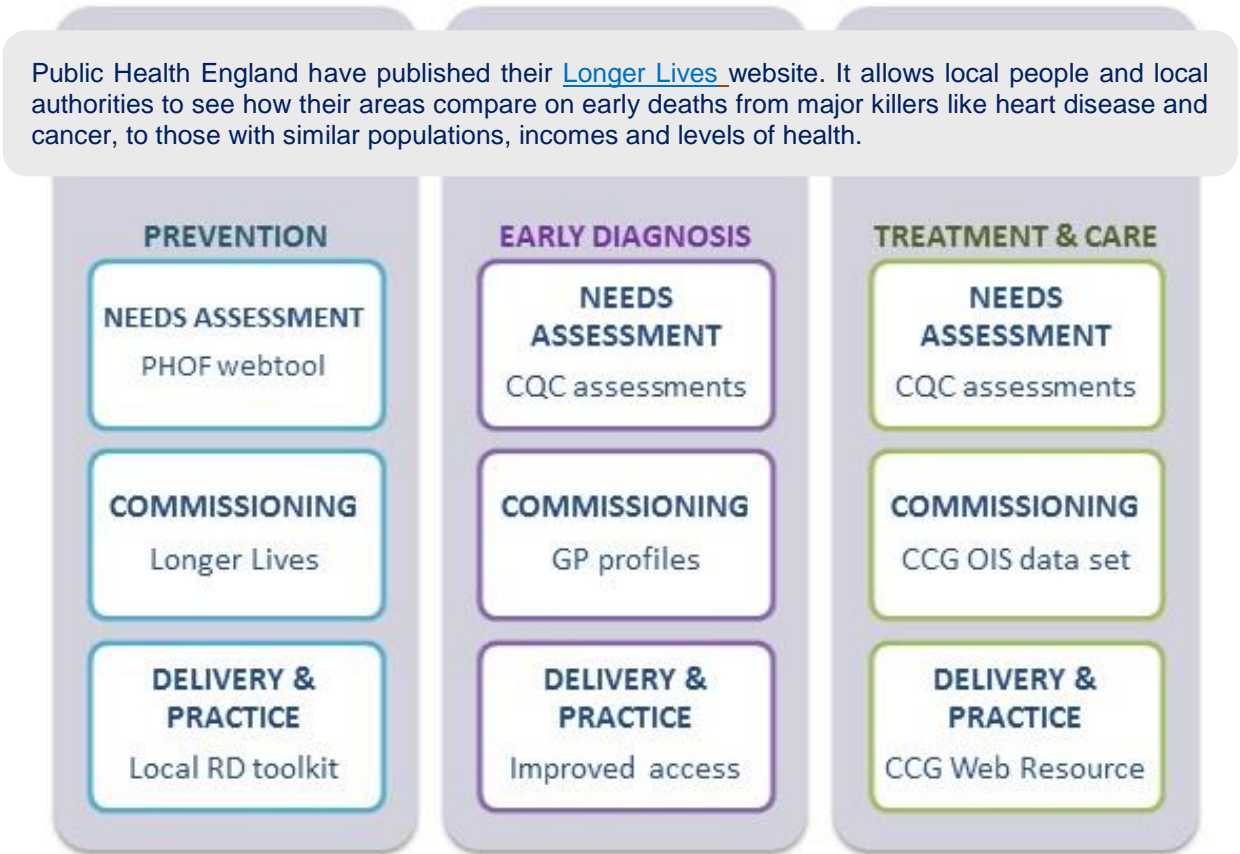
Living Well For Longer: National Support for Local Action to Reduce Premature Avoidable Mortality, sets out what that the national health & care system will do towards meeting the Secretary of State's ambition. We have set out in one place the actions being taken across the national health and wellbeing partnership of Government, Public Health England (PHE) and NHS England to reduce premature avoidable mortality. This will support the local actions and ambitions that each local authority and CCG will take across the country.

A locally led, clinically robust and outcome focused health and care system provides us with a great opportunity to set new and challenging sights for health improvement in England. The roles and responsibilities for all parts of the new health and care system are better defined than ever, with a greater sense of how each part of the system plays an essential part in improving outcomes for all, whether national or local, NHS or local government, statutory or voluntary sector. Focusing on the shared measures within the Public Health Outcomes Framework and the NHS Outcomes Framework, we have designed the new system to work in partnership through local health and wellbeing boards responding to their Joint Strategic Needs Assessments on improving the health of their populations and reducing premature mortality.

The document is not designed to be read from cover to cover – it is designed as a resource document. It is designed so that the reader can dip in and out of the document to get an idea of what national policy actions or support there is for delivering local priorities, as well as ideas of good practice and resources that might help local commissioning and service delivery. We expect users of this document to use it as a reference tool, to help them understand how the whole national system can support local action to help people live well for longer.

Living Well for Longer provides a national road map of the actions we will take across the health spectrum. It also provides complementary **ideas for local action** with case studies that demonstrate local innovation and good practice, encouraging local areas to learn from the best, and sharing the learning from their own successes. These ideas for local action are included to provide a sense of what is happening across the country to improve health outcomes – to provide a way of seeing how the national effort complements the collective efforts of every local health and wellbeing board and their partners.

Figure 1 Examples of the tools and resources available in Living Well for Longer



To do this, we have included web-links to the **tools and resources** published by PHE, NHS England, National Institute for Health and Clinical Excellence (NICE) and others including the Department of Health (DH) and other Government departments. These provide a road map for local areas to plan and deliver actions to reduce premature mortality, from prevention, to early diagnosis through to better treatment and care of the major killer diseases.

We have included a whole system delivery plan for 2014/15, collating the specific actions NHS England, PHE and DH will take to reduce premature mortality based on commitments in our business plans for the coming year. We will report on progress against these commitments in a year's time, when we will also look ahead to the future, looking to see where we can and should go further and faster to reduce premature mortality to be amongst the best in Europe.

1. Our Purpose

- 1.1 It has been a year since the Secretary of State for Health set out his ambition to be amongst the best in Europe by 2020 at reducing the rate of premature avoidable deaths in [Living Well for Longer: a Call to Action to Reduce Avoidable Premature Mortality](#). The challenge he made was that England would be amongst the best in Europe when it comes to tackling the leading causes of early death, starting with the five big killer diseases – cancer, heart, stroke, respiratory and liver disease. He gave this challenge to the entire health and care system and asked everyone to play their part in reducing the number of people who die too young, uniting the whole health and care system, nationally and locally, behind a common goal.
- 1.2 As he launched his Call to Action, the Secretary of State promised that the national level organisations: Government (spearheaded by the Department for Health (DH)); NHS England; and PHE would set out what their part would be in meeting this challenge. His purpose was to set out the range of actions to be taken by the national system to provide the direction of travel over the coming years.
- 1.3 This plan does this. It sets out, in one place, the breadth of actions taking place across DH, PHE and NHS England to reduce premature mortality; complementing, not duplicating, the local plans and the levels of ambition that health & wellbeing boards and CCGs will publish to improve health outcomes for their local communities.
- 1.4 This plan is also designed to show Parliament and our national level partners and stakeholders how we – DH, PHE and NHS England - are working together to achieve the ambition to be amongst the best in Europe at reducing premature mortality. This plan reflects the actions taken by other organisations also operating at a national level; for example, other Government departments, national health charities, professional bodies and our partners in retail and industry.
- 1.5 We provide not only an overview of the national actions aligned and focused on reducing premature mortality, but also provide access to helpful information on actions local agencies might wish to consider as they develop their own plans.

Local leadership supported by national action

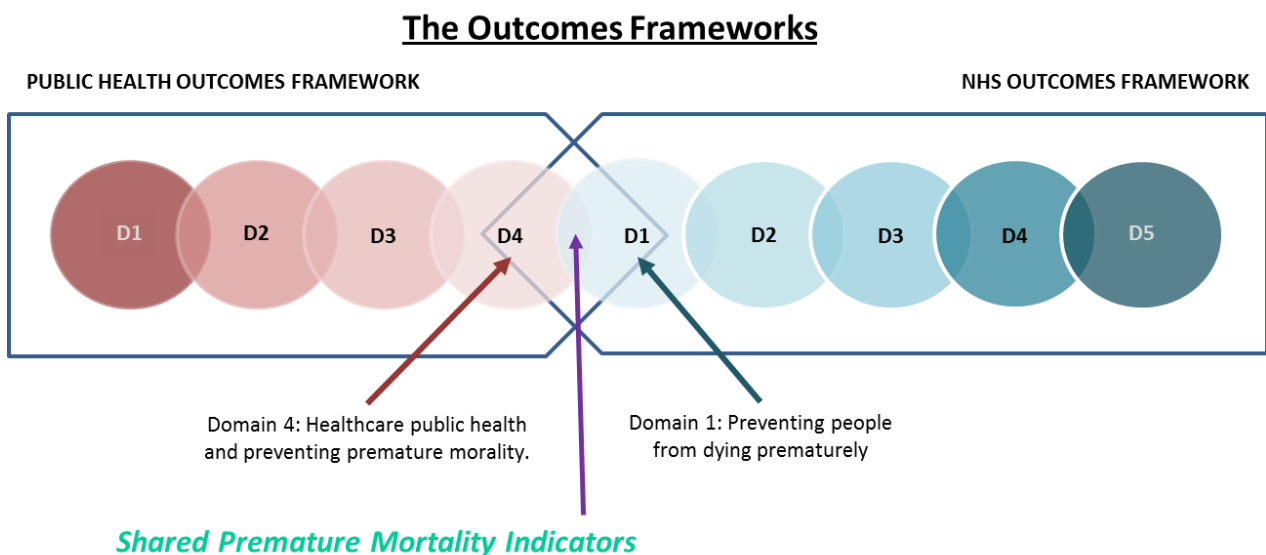
- 1.6 The government has given local authorities new statutory duties to improve health: local authorities (LAs) have protected resources through a ring-fenced budget, strong professional leadership through local Directors of Public Health and political leadership through council leaders, elected mayors and cabinet portfolio holders. CCGs listen, and respond, through the services they commission, to the health needs of local communities, and local healthwatch represent the public's voice in health and care decisions.
- 1.7 Local health and wellbeing boards bring these commissioning partners together assessing needs and agreeing priorities for local action through Joint Strategic Needs Assessments, and Joint Health & Wellbeing Strategies. NHS England have set out their expectations – in their planning guidance for CCG commissioners in England ([Everyone Counts: Planning For Patients 2014/15 To 2018/19](#)). CCGs are expected to publish a local level of ambition to reduce premature mortality as part of their wider strategic plans which will have been agreed with their health and wellbeing board, the wider local authority, providers and NHS England. Taken together these local responsibilities and duties provide the comprehensive and robust local infrastructure required to enable locally responsive actions designed to reduce premature mortality.
- 1.8 There is no similar formal infrastructure at the national level, and so a partnership programme has been established across DH, PHE and NHS England. As part of its role as system steward, DH brings this partnership together to provide the forum for maintaining strategic oversight at the national level based on existing assurance mechanisms for NHS England, Public Health England and the Department.

Focusing on Outcomes

- 1.9 Alignment and joint working is an integral part of the design of the new system. It is clear that reducing avoidable premature mortality will take a whole system approach; treating illness alone will not give us the shift in outcomes we need to see. To reach our goal we need to drive further and faster in prevention and early diagnosis too.
- 1.10 To ensure this, in the Call to Action the Secretary of State set out his expectation that our joined-up approach should stem from the alignment of the [Public Health Outcomes Framework](#) (PHOF) and the [NHS Outcomes Framework](#) (NHSOF). Shared indicators across both frameworks were deliberately designed to reflect the common goal of reducing premature avoidable mortality.

1.11 That is why Domain 4 of the PHOF and Domain 1 of the NHSOF contain shared indicators on premature mortality (see figure 2). These shared indicators will drive action at the local level to prevent those deaths that could be avoided through public health interventions such as getting people to take more exercise or stop smoking, or in tackling the wider social determinants of health - what is termed **preventable mortality**; or through health care interventions such as early diagnosis of diseases or conditions and through effective treatment – which is termed **amenable mortality**.

Figure 2



- Under 75 mortality from all cardiovascular diseases
- Under 75 mortality from cancer
- Under 75 mortality from liver disease
- Under 75 mortality from respiratory diseases
- Excess under 75 mortality in adults with serious mental illness
- Infant mortality

1.12 The NHSOF also includes an important indicator on the premature mortality of people with learning disabilities, namely; 'Excess under 60 mortality in adults with learning difficulties'. Whilst a similar measure is not included within the PHOF, public health and preventative actions will be essential for improvements in outcomes for this group.

1.13 There is also alignment with the Adult Social Care Outcomes Framework (ASCOF). There are two shared indicators between the three Outcomes Frameworks:

- Employment of people with mental illness/those in contact with secondary mental health services
- Employment of people with a learning disability

1.14 Whilst these do not directly measure premature mortality, progress on these measures will give us confidence that in the long-term lives will be longer and more fulfilled.

1.15 We will co-ordinate and publish an annual update on progress towards the Secretary of State's ambition, and set out the actions that will be taken in future years across DH and wider Government, PHE and NHS England to reduce premature mortality.

Meeting our Ambition

1.16 The Call to Action set out clearly the scale of what we have to achieve if England is to be one of the best in Europe in supporting our citizens to have long and fulfilling lives. We would save 30,000 lives a year across the big killers if we achieved the best outcomes for everyone – through better performance in prevention, early diagnosis and treatment, and through reducing avoidable health inequalities.

1.17 This is not a target though - it is an achievable ambition to which we must all aspire if we are to be amongst the best in Europe. We are not trying to count lives saved in a crude manner, by 'banking' lives saved. We know it doesn't work that way. Reducing premature mortality is a simple ambition, but complex to achieve.

1.18 To ensure we are working together to meet the ambition set by the Secretary of State for Health this document provides a high level overview of the nationally led programmes that will be undertaken over the next year to deliver this vision. It demonstrates what the collective effort of the national system will be, and what local partners on health and wellbeing boards, and health and care services can expect from the national agencies.

1.19 This document aims to inject impetus into the prevention of avoidable deaths over and above current trends. In the short-term, actions will focus on those we can have an impact on now. This means helping people modify entrenched habits, identifying the consequences of their lifestyle as soon as possible and treating diseases with the most effective therapies currently known. This will put us in a very different place in five years' time.

1.20 These impacts must be felt across all age groups and not just by people under 75 years of age or those middle aged adults where the 'quick wins' in the next 5 years could be made. That would not be sustainable, or right. Action must be taken to reduce death in people as early as possible in life, from birth, through infancy and childhood, to grow healthy adults who can enjoy a healthy older age. This will also help us not only to live longer, but more importantly, to *live well* for longer.

- 1.21 Although the measures for our ambition focus on under 75 mortality, our intention is to improve outcomes for people at all ages – right across the lifecourse. In a society where we can expect to live longer lives, we need to make sure we are doing all we can to ensure we live those extra years of life in good health.
- 1.22 We also need to put in place actions that enable a sustained reduction in premature mortality beyond the first five years. This will mean significantly shifting our emphasis to ‘upstream’ actions including higher rates of physical activity, balanced diets and a major reduction in smoking as we move towards 2020.
- 1.23 These actions will be targeted to include children and young adults and people who have a first episode of mental illness (often at a young age) where the life expectancy and quality of life gains in maintaining or modifying health behaviours are greatest. See [Improving Children and Young People’s Health Outcomes: a system wide response](#) and [Better Health Outcomes for Children and Young People](#) (February 2013).

2. The Size of the Challenge

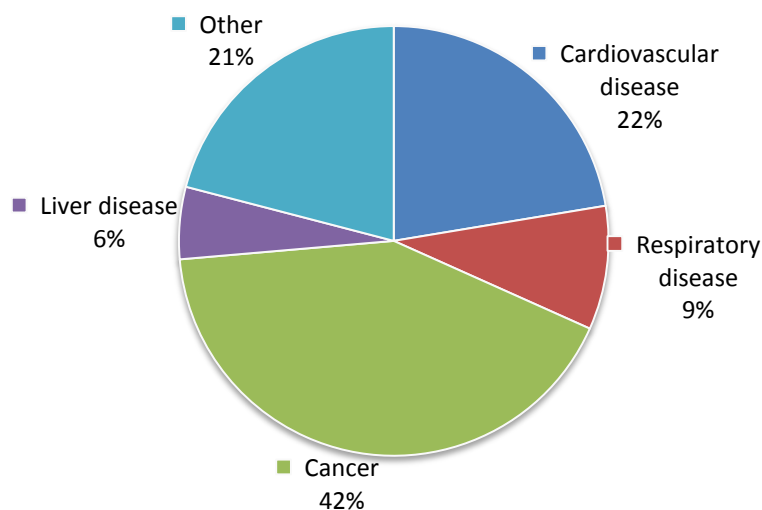
2.1 A child born in England today should expect to live a longer, healthier life than ever before. Yet, in 2012, one in three deaths in England was before the age of 75² and over three quarters of those deaths³ were a result of the five big killers. In 2012:

- 62,000 people died of cancer
- 33,000 died of cardiovascular diseases
- 14,000 died of respiratory diseases and
- 8,000 died of liver conditions under the age of 75 (see figure 2).

2.2 For the average local authority with a population of around 350,000 this means that each year around 450 people die prematurely of cancer, 250 people from heart disease and stroke, 100 people from respiratory disease and 50 people from liver disease.

Figure 3 Percentage of all deaths for people aged under 75 years

% of all deaths for people aged under 75 years

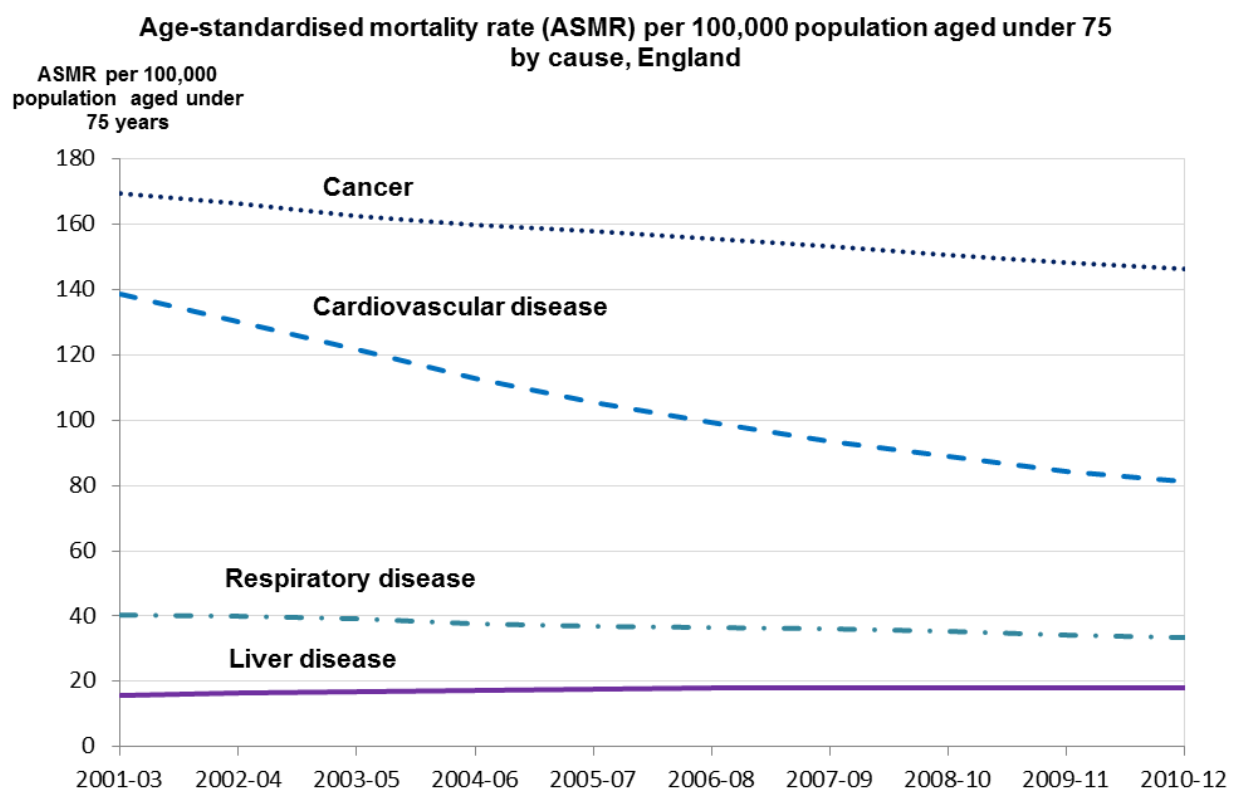


² PHE Longer Lives Website

³ Preventable mortality is by definition capped at age 75. Deaths under 75 are chosen largely because of the difficulty of ascribing cause of death in 75+ age groups where there are often multiple morbidities.

- 2.3 Last year's Call to Action coincided with the publication of the Institute for Health Metrics and Evaluation's seminal work on the Global Burden of Disease (GBD) in 2012, which focused specifically on the UK⁴. The findings of the GBD showed that whilst our mortality rates had decreased substantially over the last 20 years they continued to be consistently and significantly poorer than in comparable countries,⁵ with the UK coming 14th out of 19 in 2010.
- 2.4 However for liver disease our mortality rates are rising contrary to most other causes of premature death, and compared to most other European countries, where rates are falling or have levelled off. Between 2001 and 2011, the number of people who died from liver disease in England rose from 10,584 to 12,985, which is a 23% increase in liver deaths.⁶ We know that the main contributory factors to liver disease are excessive alcohol consumption, obesity and viral hepatitis (Hep C).

Figure 4 Age-standardised mortality rate (ASMR) per 100,000 population aged under 75, per cause, England



⁴ Murray et al, *United Kingdom Performance on Health: Implications from the Global Burden of Disease Study 2010*, The Lancet & Institute of Health Metrics and Evaluation, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)60188-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60188-9/abstract)

⁵ Includes comparable EU countries, USA, Canada and Australia

⁶ (ONS, 2011: Mortality Statistics: Deaths Registered in 2011 (Series DR) Tables 1–4 and Tables 6–14 (Excel sheet 1118Kb))

2.5 However, it is clear that in order to be amongst the best in Europe, we will need to go further and faster in reducing rates of premature mortality. Figure 5⁷ is taken from the GBD and shows that the greatest risks factors contributing to deaths from the major killers are largely preventable. Tobacco smoking is still by far the biggest risk to our health, causing almost 80,000⁸ avoidable deaths every year. High blood pressure and body mass index (BMI) are the second and third most important factors so we must push harder than ever to improve the health behaviours and the circumstances for all people so that they can live healthier lives. The GBD study is currently being updated and the next iteration will include regional breakdowns of disease burden.

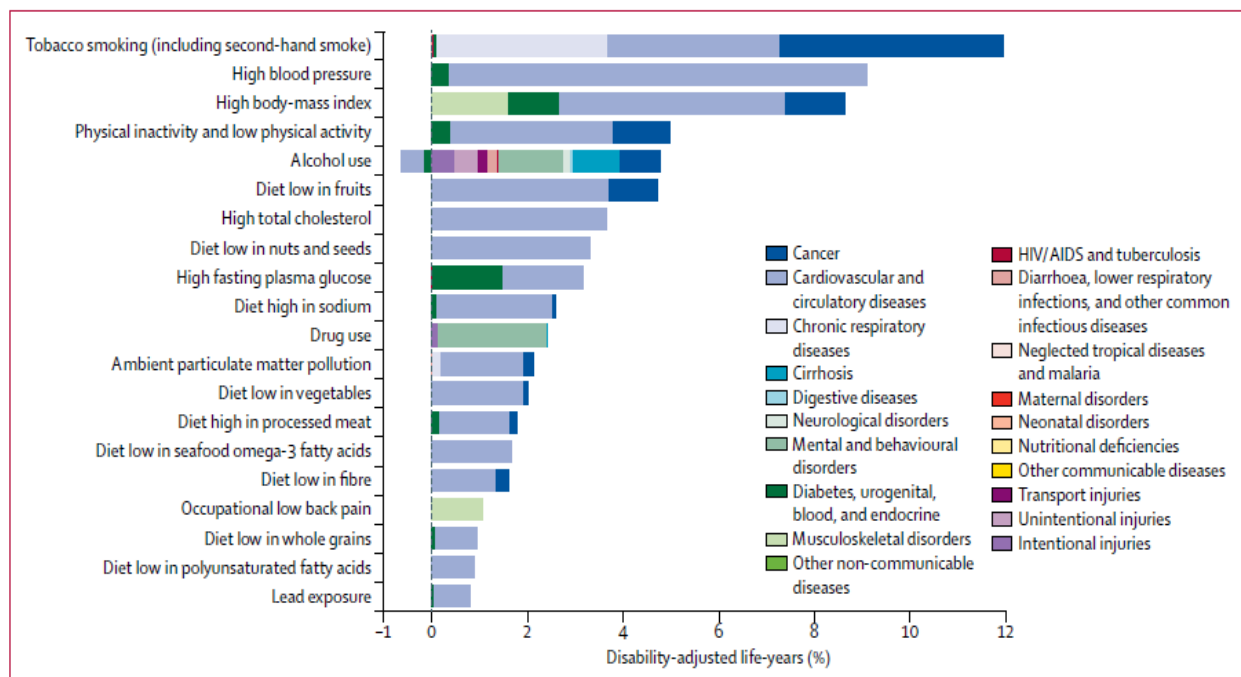


Figure 5 Burden of Disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability adjusted life years

2.6 As we focus the efforts of the health and care system towards prevention, earlier diagnosis and effective treatment of the five big killers, there will be numerous benefits to the wider population, not just those immediately at risk of premature mortality. Addressing the illnesses that individuals face will also improve their quality of life. As the title of our document suggests, this is about enabling the population to live *well*, not just longer. The GBD showed that whilst we strive to live longer, the greatest burdens on how well we live are musculoskeletal disorders and mental and behavioural disorders.

⁷ Reproduced from the Lancet article, 2012, "UK health performance: findings of the Global Burden of Disease Study 2010"

⁸ HSCIC Statistics on Smoking, England - 2013

- 2.7 In the future, as the population ages, it will become more usual to live with more than one health issue at the same time (co-morbidity). We estimate⁹ that the number of people living with more than one long-term condition will increase from 1.9 to 2.9 million in the next decade, which will challenge the traditional way of delivering services and managing disease. People will face complex physical, social and emotional problems, as there is a strong relationship between the prevalence of long-term conditions, the quality of health outcomes and relative deprivation. Depression, for example, is one of the most common co-morbidities with other long-term conditions.
- 2.8 However, co-morbidity is not simply a problem of ageing. It is an important issue for young people with complex needs as they move to adulthood and are no longer under the care of a single clinician, or for people with mental illness for whom we know more needs to be done to address their physical as well as mental health needs.

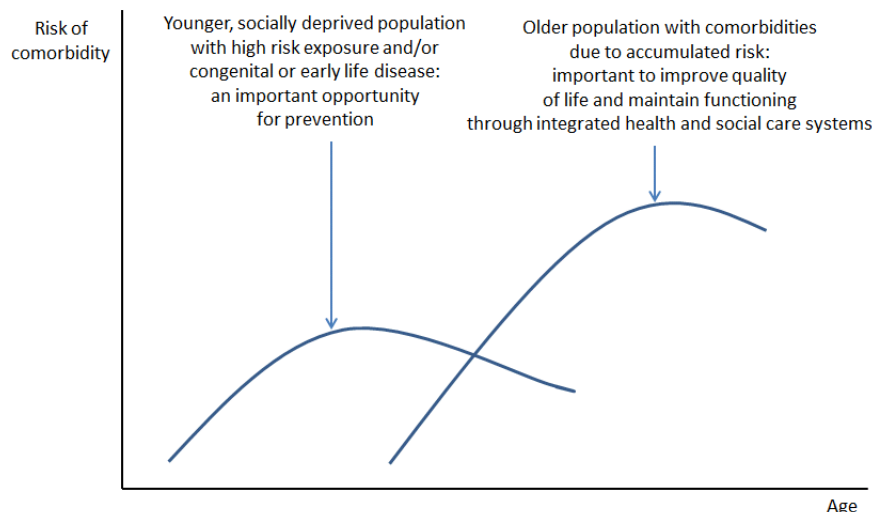


Figure 6 Illustration modelling two populations with co-morbidities who require different types of intervention

- 2.9 We are looking to the long-term. In accepting the challenge to meet and sustain the ambition to reduce premature mortality, it is vital that we put in place actions that aim to improve outcomes beyond 2020. So it is important that we drive improvements in outcomes for our children and young people so that they have a good start in life resulting in greater chances of good health throughout a long and healthy life.

⁹ Long Term Conditions Compendium of Information: Third Edition, Department of Health, 2012

Making sure *everyone* is living well for longer

- 2.10 It is paramount that these improvements happen for all in our society. There are stark variations in outcomes for people from different socioeconomic backgrounds, the socially excluded, people who suffer mental illness, and those communities who suffer discrimination, such as people from some minority ethnic communities, those who are physically, sensory or learning disabled, homeless etc. A targeted approach is needed to ensure we improve the health of all.
- 2.11 The Marmot Review ([Fair Society, Healthy Lives](#)) highlighted the impact of the social gradient in health. This means the lower a person's social position, generally the worse his or her health and wellbeing. Health inequality must be at the forefront of our minds in trying to tackle the causes of ill-health and disease. For example, more than twice as many people from the poorest backgrounds die of circulatory disease than those from the most affluent backgrounds.
- 2.12 These variations are reflected in the differences in premature mortality rates that we see between local authorities (LAs). That said, they do not explain all variations; some of the most deprived areas have lower premature mortality rates from, for example, cancer and cardiovascular disease than some of the least deprived areas. Further information on these sorts of comparisons, alongside advice on how mortality rates can be reduced is available on the PHE [Longer Lives](#) website.

Figure 7: Local Authority mortality comparisons based on social deprivation

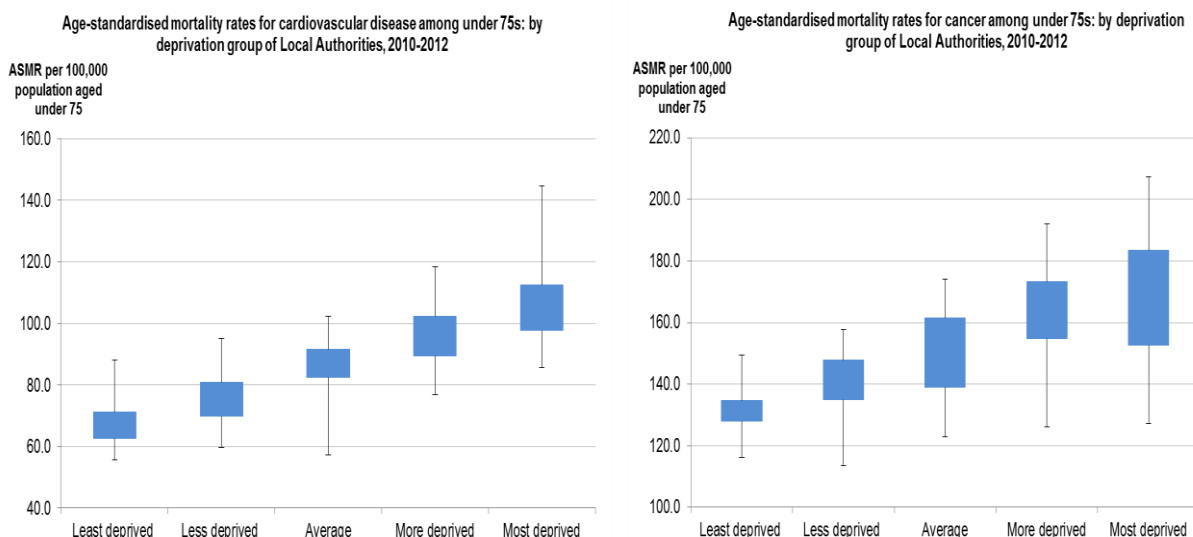
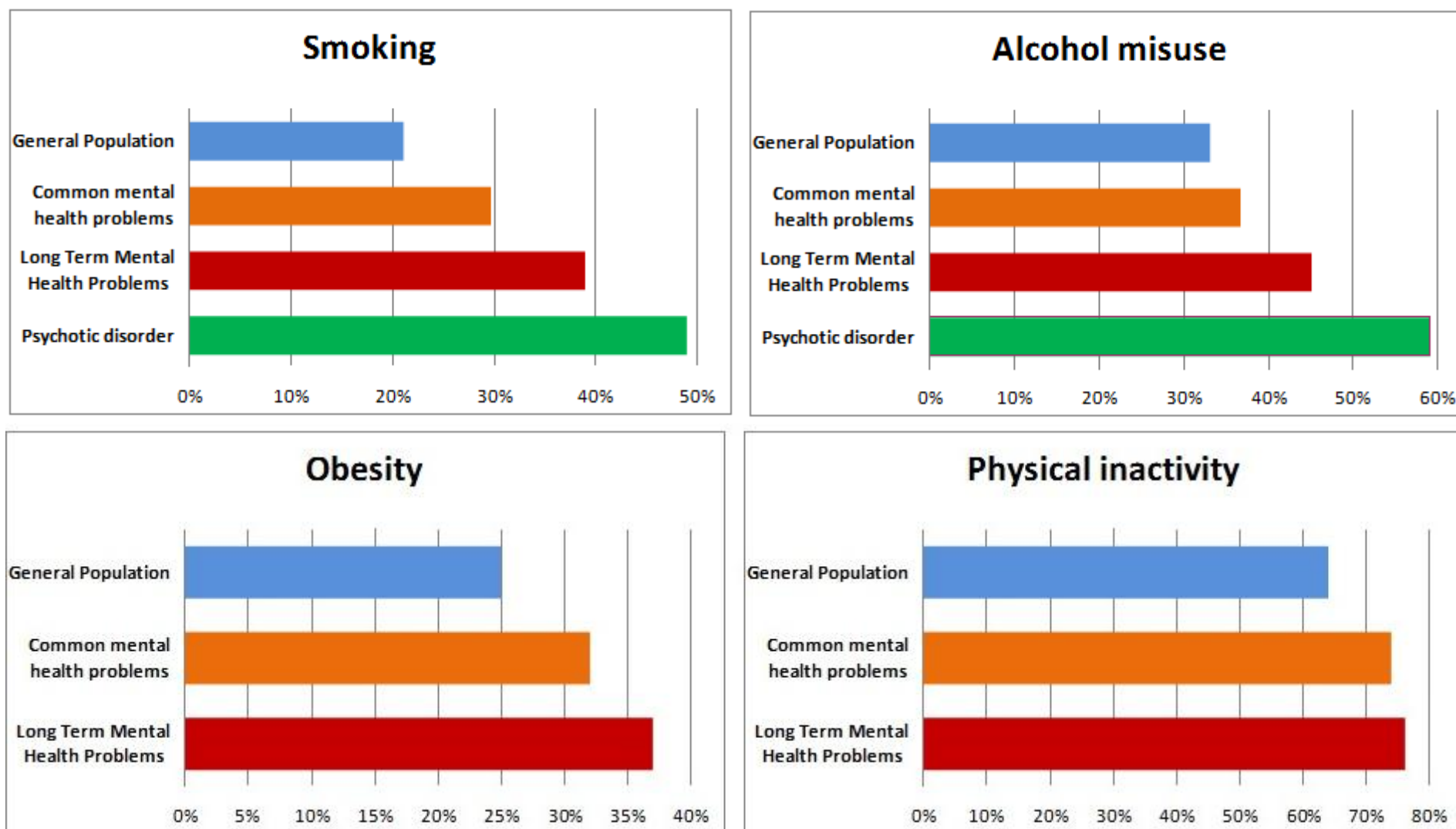


Figure 8: The prevalence of modifiable risk factors is much higher for people with mental health problems and increases with severity.



1. Source: Health Survey for England (2010). Those with common mental health problems are identified by the GHQ12 questionnaire. ; 2. Source: Adult Psychiatric Morbidity Survey (2007). Note that those with psychotic disorders are also likely to be included among those with Long term mental health problems. 3. Answers positively to the question: "Do you smoke cigarettes nowadays?".; 4. Weekly alcohol consumption >21 units (men), >14 units (women).; 5. Body Mass Index >30.; 6. Weekly physical exercise does not exceed 30 minutes on five days.

- 2.13 The clustering of risk factors in individuals and communities have profound health and social impacts. For example, children with mental disorders are 17 times more likely to be excluded from school, 6 times more likely to smoke regularly, 4 times more likely to regularly drink alcohol, 5 times more likely to self-harm or commit suicide. If the mental disorder continues in adulthood, they will have higher levels of mental illness, substance dependence, financial problems, work problems, drug related and violent crime, including violence against women and children.
- 2.14 There is compelling evidence on the health disadvantage faced by many people from black and minority ethnic (BME) groups, those with disability, and those facing discrimination due to their sexual orientation. Some risks are similar across groups: Indian, Pakistani and Bangladeshi men and women and Black Caribbean women have 2-5 times the diabetes risk of the general population. Pakistani and Bangladeshi groups appear to be at particular risk of poor health compared with the general population.
- 2.15 People with learning disabilities in England die on average 16 years sooner than the general population, with over 1,200 premature deaths in people with learning disabilities each year. 22% of those deaths are in people under the age of 50. The 2013 confidential inquiry into premature deaths of people with learning disabilities, found that the central issue leading to premature mortality was delays in investigations, diagnosis and treatment.
- 2.16 There is also good evidence that people with mental health difficulties experience up to three times more physical health problems than the general population and have a significant life expectancy gap compared to the general population. People living with mental health problems have greater exposure to the risks which lead to physical illness including smoking, poor diet and lack of exercise and weight gain associated with medication as illustrated in Figure 8. These problems are further compounded by stigma, discrimination and disadvantage, such as a lack of employment and educational opportunities.
- 2.17 The health and social care system is committed to finding ways to improve access to preventative healthcare for those in disadvantaged areas or groups, so as to help tackle health inequalities. Specific legal duties on health inequalities have been introduced and the Secretary of State, NHS England, PHE, other arm's length bodies and CCGs are required to have regard to reducing health inequalities. Health inequalities will be measured and monitored through the Public Health and NHS Outcomes Frameworks. NHS England, CCGs and Monitor also have duties to integrate services in a way that could reduce health inequalities

Case Study: TB - The System Working Together on the Frontline

Preventing the spread of TB, and treating those with the disease, requires a multi-agency approach between local government, the NHS, housing, police and civil society organisations. The Redbridge TB Partnership is a great example of the new health and social care system can work. By increasing awareness among patients and healthcare professionals about TB - in an area with many at-risk groups - it supports TB prevention, early diagnosis and treatment through partnerships and delivers and supports local Health Buddies, awareness sessions, and TB-specific training. More information can be found **here**: [Redbridge TB Partnership](#)

3. The System Working Together

How we work together

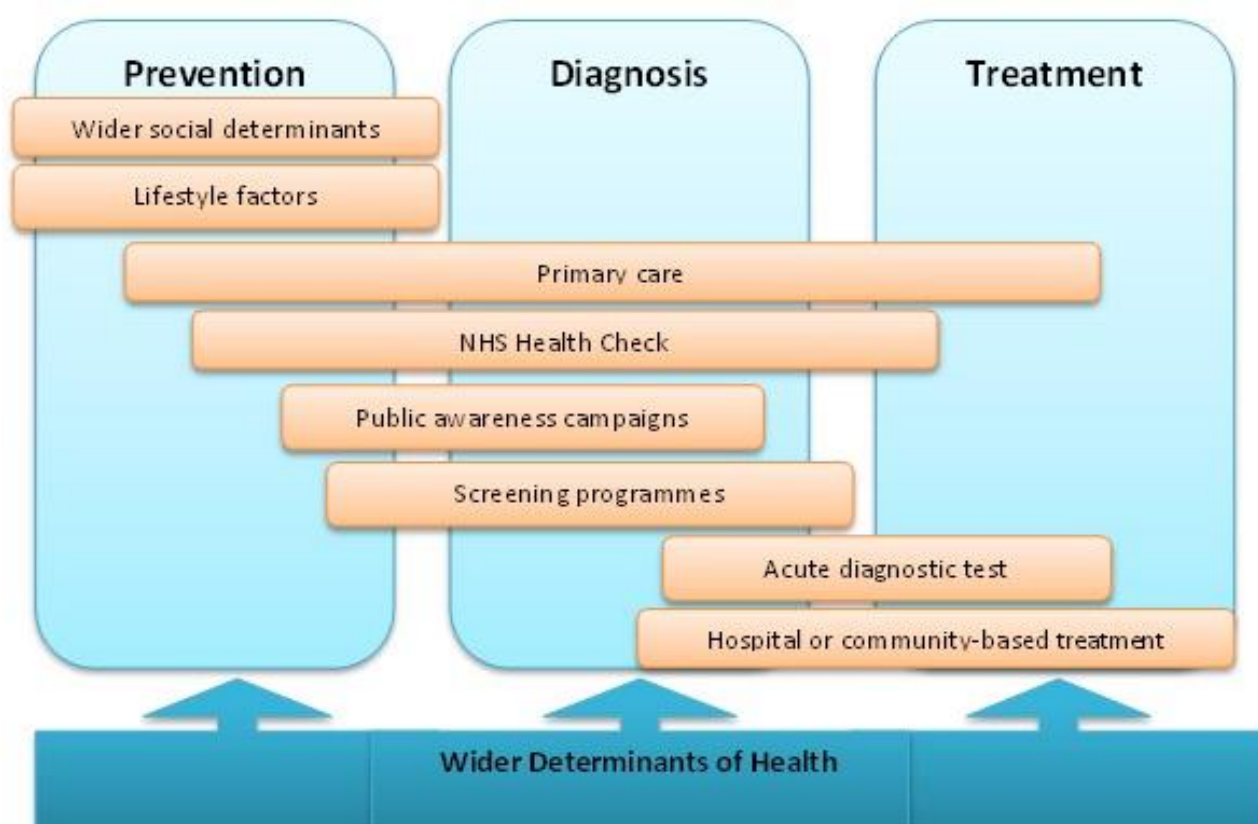
- 3.1 The new public health, health and social care system came into being in April 2013 with the intention of focusing on improving outcomes, rather than on outputs and processes. The national collective commitment to reducing avoidable mortality is clear and set out in agreed priorities, summarised below:
- In the [Department of Health Business plan for 2013/14](#) Secretary of State stated that one of his overarching priorities for the department was: *“to prevent people from dying prematurely by improving mortality rates for the big killer diseases, to be amongst the best in Europe, through improving prevention, diagnosis and treatment.”*
 - In the [NHS Mandate for 2014/15](#) DH set an objective for: *“NHS England, working with CCGs, is to develop their contribution to the new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020.”* This is also underpinned by the principles and values set out in the [NHS Constitution](#).
 - In the [Health Education England Mandate Refresh for 2014/15](#) HEE have a objective to: *“Play a leadership role in bringing an integrated system wide focus to the workforce to prevent people from dying prematurely.”*
 - In April 2013 [Public Health England](#) published their [Priorities for 2013/14](#) which included: *“Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol.”*
 - The high level purpose of the [Section 7A agreement](#) is to improve population health thus reducing both illness and premature death. The agreement for 2013/14 states: *“The NHS has a critical part to play in securing good population health. This agreement between the Secretary of State for Health and National Health Service England (“NHS England”) enables the NHS CB to commission certain public health services as part of the system design to drive improvements in population health.”*¹⁰
- 3.2 We know that the real difference will be made at the community level by local authorities empowered by their new public health responsibilities co-producing local activities with their health and voluntary sector partners. But it is important to be clear what can be done once, nationally, on behalf of, and in support of all, and recognise what needs to be adapted and refined locally for the most impact.

¹⁰ Please note the NHS Commissioning board is now known as NHS England.

How we are supporting local delivery

- 3.3 Actions to save lives and improve their quality and to reduce health inequalities are delivered through the co-production of local solutions by local government, local NHS organisations and the voluntary and community sector. The organisations with national responsibilities have a supporting and enabling role to play which maximises the impact of local actions. For example providing national support and guidance, evidence, toolkits and data and information for comparison purposes.
- 3.4 In addition, we are working directly with our own partners to increase our reach to local delivery. For example, PHE is working closely with the Local Government Association, who have published a web-resource for Local Authorities that highlights good practice and evidence based interventions. Find out more at: <http://www.local.gov.uk/public-health>.
- 3.5 Figure 9 illustrates that whilst some actions have an impact across the health spectrum (eg primary care services) some will have a concentrated effect on certain parts of the spectrum (eg ensuring access to high quality treatment). Placing power in the hands of local partners will ensure that universal programmes like screening are accessible to local communities and take into account local age, social and ethnic composition, and provide a particular emphasis on reducing inequalities in uptake.

Figure 9 National Actions across the health spectrum



- 3.6 The next part of this plan sets out the actions that can and will be taken at the national level on prevention, early diagnosis and treatment.

4. Prevention

- 4.1 Preventing illness and keeping people healthy is fundamental to this Government's long-term aims for society and the economy. We want healthy and engaged children who can excel at school, supported by healthy parents. We want those children to become productive adults in a society where everyone can look forward to a healthy and fulfilling older age. Living well for longer brings together the aims of improving quality of life and reducing burdens on society and increasing economic activity.
- 4.2 Supporting people to reduce a whole range of health harming behaviours is effective at any age and is where we can make the most gains in the short term whilst building for the future. In the Call to Action, the Government made it clear that the greatest gains for reducing premature mortality would be made in the medium and long term through efforts to prevent illness and disease. In 2010, of all premature deaths well over half could have been avoided through public health interventions. However, we know that for some, action to prevent the diseases they died from would have needed to take place years, or maybe even decades ago. We can and will act now. Working on 'upstream' factors – such as giving every child the best start in life and reinforcing positive behaviours throughout life will enable people to enjoy their lives and reduce the risk of an early onset of cancer, heart disease or other killer diseases.
- 4.3 The Global Burden of Disease 2012 report (see Chapter 2) identifies the main risk factors contributing to early death and reduced quality of life in the UK. The top five comprise:
- Smoking tobacco
 - Having high blood pressure
 - Being overweight or obese
 - Lack of physical activity
 - Excessive alcohol consumption
- 4.4 These risk factors have consistently been the main challenges for the public's health, and drive priorities for national action on prevention. There are many ways to maximise the impact needed across these priorities and it is important that all methods and means are used simultaneously.

Population-wide Interventions

4.5 It is important to influence behaviour on a societal scale so that we can support everyone to take responsibility for their own and their families' health. Whilst it is for individuals to decide what to eat, whether to go for a run, or whether or not to have that next cigarette, we know that their health behaviour can be positively influenced by high quality social marketing programmes. This is why the government has successfully run a range of population level initiatives aimed at helping individuals lead healthier lives.

Influencing the Public's Behaviour

4.6 PHE have published their Marketing Plan for 2014-17. This describes the role for national marketing programmes, the support offered to local government and an expanded focus on premature mortality. This includes:

- A broader focus on early diagnosis, building on the success of the 'Be Clear on Cancer' model
- New prevention initiatives in mental health, alcohol and adult nutrition, including an expanded role for digital support products
- New support for the NHS Health Check programme and encouraging 'checking' more broadly

4.7 The latest evidence from the behavioural sciences is enhancing our efforts to keep people healthy. We now have a greater understanding of people's in-built responses to the world and how these affect behaviour. We are using these insights to design programmes and interventions that have a more powerful impact, as they go with the grain of how people actually think and behave.

4.8 A research team in the Department of Health (DH) and Public Health England (PHE) is applying these behavioural insights to a range of health and care challenges. One example is the NHS Health Check programme. The team is working with local authorities across England to test a range of deceptively small changes that may make a big impact, both to increase attendance at the NHS Health Check and promote positive behaviour change after the Check. Early research is showing positive results, and all at low or zero additional cost. Research results will be published over the coming months.

People and places

- 4.9 The key opportunity arising out of the public health reforms has been the ability to focus truly on population level actions. Local authorities (LAs) are focused on meeting the needs of local people in the places they live. Since April 2013, LAs have a statutory duty for health improvement, underpinned by the resources and expertise through the allocated ring-fenced public health budgets and leadership of the directors of public health. Combining this political and professional leadership, LAs can respond to the health and wellbeing needs of local communities and citizens, with the local flexibility to integrate these responsibilities with their existing ones for education, transport, housing and more.

Ideas for Local Action:

To find out more about asset based community development take a look at what the LGA says about this approach:

http://www.local.gov.uk/c/document_library/get_file?uuid=bf034d2e-7d61-4fac-b37e-f39dc3e2f1f2&groupId=10180

You can see what inspired this approach in England - the Asset Based Community Development Institute, Northwestern University, Chicago (www.abcdinstitute.org/)

- 4.10 An important shift in how local areas are approaching improving health outcomes for their communities is taking place. Asset Based Community Development (ABCD) is based on understanding the strengths and capabilities of individuals and communities in a local area. Community assets encompass the resilience of people (individual level), social networks and community cohesion (community level) and green space or volunteering opportunities (institutional level). Significantly, the ABCD approach opens up the potential to shift from the focus being on the problems we face, to maximising the opportunities for improvement – and is more likely to offer scope for innovation and co-production. In some areas in the country, this approach is already delivering results.

Case Study: Fruitables – Harrow

An innovative and exciting new initiative has been established in Harrow named 'Fruitables' where parents are supported to run fresh fruit and vegetable stalls in primary schools playgrounds. Parents and children can now buy affordable fresh produce in a convenient way. The aim is simple, to reduce excess weight and get more people eating healthy foods. Alongside the stalls there are also short classes on how to cook healthy meals. Parents who run stalls gain useful skills in managing stalls, customer services and food hygiene. The stalls have been a hit with schools who have used the project as a platform to focus on healthy eating and with parents and children who regularly buy all the stock available at the stalls.

Protecting the Public's Health

- 4.11 The UK's childhood immunisation programme has resulted in the incidence of childhood infectious diseases being at very low levels. Diphtheria, polio and neonatal tetanus no longer occur in UK children. As a direct result of these programmes, there has been a reduction in associated illness, mortality and burden on the NHS.
- 4.12 It is important to maintain existing immunisation programmes and extend their population coverage, as well as introducing new programmes. The fall in Measles, Mumps and Rubella (MMR) coverage since the early 2000s has led to several very serious outbreaks of measles across the UK causing illness and a risk of mortality. The MMR catch-up campaign committed to ensure that 95% of all 10-16 year olds had received at least one dose of MMR vaccine by the end of September 2013. The programme was delivered mainly through primary care. An evaluation of the campaign at the mid-point (approximately 20 August) found that the campaign had achieved its objective.
- 4.13 A recently published study undertaken by Public Health England has provided new evidence that the Human papilloma virus (HPV) vaccination programme is successfully preventing HPV infections – a major cause of cervical cancer - in young women in England. Vaccination coverage for HPV in 2012/13 was 86.08%.
- 4.14 The extension of the flu vaccination programme during 2013/14 to all children under 17 years of age is expected to lower the public health impact of flu appreciably, both by directly averting a large number of cases of disease in children, and, by lowering flu transmission in the community, indirectly preventing flu in unvaccinated younger children, people in clinical risk groups and older adults. The expert advisory body on immunisation, the Joint Committee on Vaccination and Immunisation (JCVI) has recently estimated that each year, on average, approximately 2,700 people may die in England because of influenza. When fully implemented, it will prevent around 1,800 deaths - the vast majority of which would be in those aged over 65 - 12,000 hospitalisations and 400,000 GP appointments.
- 4.15 In autumn 2013, immunisation was offered to two and three year-old children, with seven geographical pilots for four to eleven year olds (up to and including pupils in school year 6). In autumn 2014, immunisation will be offered to all two to four year olds, with pilot work for older children extending into secondary schools.

Influencing the conditions for health – The Responsibility Deal

- 4.16 The Department of Health has a role to play as a convenor of interests on a national scale and has the ability to bring together industry and non-government bodies with an interest in improving health and reducing health inequalities.
- 4.17 By working closely with industry there is the potential to harness the power of businesses and organisations to play their part in shaping an environment which supports people to make healthier choices and contributes to overall efforts to improve the public's health. Partnerships have been established and are driving actions such as the [Alcohol Network](#), the [Food Network](#), the [Health at Work Network](#), and the [Physical Activity Network](#).
- 4.18 Organisations signing up to the Responsibility Deal commit to taking action voluntarily to improve public health through their commercial actions, and their community activities as well as through their responsibilities as employers. This voluntary action is expressed as a series of pledges covering alcohol, food, health at work and physical activity that organisations sign up to as either national or local partners.
- 4.19 The DH will continue to broaden and deepen participation in the Responsibility Deal encouraging organisations to sign up to be either national or local partners. Working with the Local Government Association, PHE and a range of stakeholders, the DH has developed a [toolkit](#) which sets out menus of simple and effective actions which different types of local businesses can take to support their customers and employees to make healthier choices. Local authorities can use this toolkit to update and broaden existing local schemes or to develop new schemes; they can also bring these ideas together with existing programmes and use existing local branding if they wish.
- 4.20 PHE will support engagement and partnership opportunities that local authorities take to work with businesses that improve outcomes for their communities. For example many local authority areas have Community Alcohol Partnerships involving health agencies, education partners, local community police teams and communities with local retailers to address issues such as under-age sales and alcohol related crime.

Ideas for local action:

To find out more about the pledges under the Responsibility Deal, go to;
<https://responsibilitydeal.dh.gov.uk/pledges/>

Case Study: Business for health in Wigan

More than 60 Wigan businesses including Heinz, Wigan & Leigh College, Lowri Beck and Ash Hire Ltd are excelling at improving staff wellbeing.

The businesses have all gone through the Good Health; Good Work Charter, a nationally recognised accreditation by Public Health England that recognises employers who demonstrate a commitment to improving the health and wellbeing of their employees. The charter gives businesses the opportunity to gain official recognition for their dedication to the wellbeing of their staff. More information on the service can be found [here](#) [Get Active Wigan and Leigh](#).

Behaviour Change Opportunities

4.21 Over the last three years Government has set out commitments and ambitions relating to the most prevalent risk factors, and PHE has established its programmes of work to support actions nationally and locally in these areas.

Smoking

Deliverable	Impact	Timing
Running Smokefree marketing campaigns that deliver 750,000 quit attempts in 2014/15.	Contribute to the downward trend in smoking prevalence towards 18.5%	<ul style="list-style-type: none"> April 2015

4.22 Smoking is the biggest preventable cause of death in England, resulting in nearly 80,000 premature deaths each year, and is a direct cause of several diseases often co-existing together – co-morbidities. For the first time, less than 20% of adults in England smoke. Nevertheless this is still too high, and we know that rates are much higher in certain areas and among particular groups of people, eg 42% of all tobacco smoked in the country is by people with a mental illness.

4.23 There is also a strong relationship between smoking and occupation, with smoking rates much higher among people in routine and manual occupations compared to those in managerial and professional occupations.

4.24 That is why Government set out [Healthy Lives, Healthy People: a Tobacco Control Plan for England](#) (March 2011), which includes our ambitions on reducing smoking prevalence:

- To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015
- To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015
- To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

4.25 The plan also sets out evidence based action across the following six areas:

- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to second-hand smoke
- effective communication for tobacco control

4.26 The Government has used the Children and Families Act 2014 to introduce measures that will protect children and young people from the harms associated with tobacco. These measures include creating offences or taking powers to prevent:

- the proxy purchasing of tobacco on behalf of children under the age of 18
- regulation-making powers to control the sale of e-cigarettes to people under the age of 18
- regulation-making powers on smoking in vehicles with children present
- regulation-making powers to introduce standardised packaging of tobacco products

4.27 The European Commission's decision to revise the Tobacco Products Directive is a major step forward and will come into effect in the UK in 2016. The Directive will, for example:

- regulate tobacco products in relation to some elements of their packaging and stronger labelling requirements, including bigger combined picture and text warnings on both sides of cigarette packs
- prohibit flavourings, such as menthol, in cigarettes and roll-your-own tobacco
- introduce new measures with regard to tracking, tracing and cross-border distance (internet) sales of tobacco products
- introduce new regulatory requirements for herbal products for smoking and some electronic cigarettes.

4.28 However the UK Government is considering further action. On 3 April 2014, Sir Cyril Chantler published his independent review of the public health evidence on [Standardised Packaging of Tobacco](#). In response to the Chantler Review, Jane Ellison MP, the Minister for Public Health, made the following statement in the House of Commons:

In light of this report and the responses to the previous consultation in 2012 I am therefore currently minded to proceed with introducing regulations to provide for standardised packaging. However, before reaching a final decision and in order to ensure that that decision is properly and fully informed, I intend to publish the draft regulations, so that it is crystal clear what is intended, alongside a final, short consultation, in which I will ask, in particular, for views on anything new since the last full public consultation that is relevant to a final decision on this policy.

4.29 PHE has commissioned work from the National Centre for Smoking Cessation and Tobacco Control (NCSCT) to support smoking cessation practitioners by:

- delivering a national programme of accredited training and support
- helping link people, including those suffering long-term conditions, to other supportive services.

4.30 The Pregnancy Challenge Group's report, [Smoking cessation in pregnancy: a call to action](#), provides a welcome focus and PHE have committed to developing important relationships with key partners required to initiate and support a rapid and sustained downward trend in smoking during pregnancy.

4.31 To target smoking cessation services at individuals with common or serious mental health problems DH and PHE are planning several interventions in 2014/15, such as:

- Making Every Contact Count (see paragraph 7.10 for more detail) for people with serious mental illnesses (SMIs) to give up smoking
- Publishing evidence based guidance for commissioners of smoking cessation services in Local Authorities
- Publishing best practice guidance on implementing smoke free mental health units
- Supporting the move to identify best practice in the use of mental health medication during periods of smoking cessation
- Taking forward a smoking cessation campaign targeted for mental health patients

Ideas for local action:

- Do you know what your provider options are for smoking cessation services?
- Do you know what the smoking prevalence rates are in your different communities?
- How accessible are your smoking cessation services to people with mental health problems?
- NICE tools give advice on return on investment for tobacco control measures, take a look [here](#).

Blood Pressure

Deliverable	Impact	Timing
Pilot, evaluate and consider scaling of a health marketing campaign aimed to engage communities and support early diagnosis of high blood pressure .	Increased early diagnosis of high blood pressure; promotion of adult wellbeing and checks	<ul style="list-style-type: none"> • Pilot: March 2014, • Impact headlines: April 2014 • Evaluation: Summer 2014

4.32 Almost 30% of adults in England¹¹ have high blood pressure, of which over 5 million are undiagnosed.¹² As the second biggest risk factor associated with premature mortality it is vital we take a strong approach to tackling high blood pressure.

4.33 That is why PHE have made stimulating and supporting activity across the system to improve our performance in relation to high blood pressure one of their major programmes of work for 2014/15. They will work with partners nationally and locally to develop a shared plan to:

- tackle risk factors, to support prevention of high blood pressure
- increase early detection of high blood pressure
- achieve better clinical and community systems for management of high blood pressure
- improve public awareness and understanding of high blood pressure
- reduce inequalities in relation to hypertension outcomes

4.34 As part of this work, PHE piloted a health marketing approach in Wakefield in March 2014 to engage communities on blood pressure and to support early diagnosis. This will be evaluated in the summer of 2014 and PHE will consider scaling-up the programme later in 2014. PHE will also develop resource packs to support local leadership on high blood pressure.

4.35 A focus on this issue could have a particularly significant impact on groups with a higher prevalence of high blood pressure such as more deprived groups or the Black African and Black Caribbean communities.

¹¹ Health Survey for England 2012 published Dec 2013, http://data.gov.uk/dataset/health_survey_for_england

¹² CVD intelligence network key facts briefing <http://www.yhpho.org.uk/resource/view.aspx?RID=188005>

Obesity

Deliverable	Impact	Timing
'Healthy Lives, Healthy People: A call to action on obesity in England' sets out the national ambition for fewer adults and children with excess weight by 2020	Fewer adults and children with excess weight	<ul style="list-style-type: none"> Update: December 2014 On-going

- 4.36 Obesity is a major public health challenge and a priority for this Government (see the Obesity Call to Action below). Sixty two percent of adults and 28% of children aged 2-15 are either overweight or obese ([Health Survey for England, 2012](#)). Being overweight or obese means people are at a higher risk of type 2 diabetes, heart disease, stroke, liver disease and some cancers. In terms of public health action, alongside issues such as deprivation, it is particularly important to bear in mind the higher prevalence of obesity in certain ethnic minority groups such as Africans and South Asians. Obesity in pregnancy can result in negative long term health effects for the child and future adult - eg the five-fold increase in cardiovascular disease risk if the mother has a BMI of 40 compared to a BMI of 25.
- 4.37 There are now almost 2.5 million people with Type 2 diabetes in England, and the prevalence continues to rise year on year, driven by the obesity epidemic, at a rate that outstrips that of all other long term conditions, often requiring significant and life-long limiting medical management. Someone who is diagnosed with Type 2 diabetes will die approximately 6 years earlier than those without diabetes.
- 4.38 The Government's '[Healthy Lives, Healthy People: A call to action on obesity in England](#)' sets out national ambitions for a downward trend in overweight and obese children and adults by 2020. DH is helping people to cut their calorie consumption by working nationally with the food industry (through the Public Health Responsibility Deal), to make sure people have the right information about what they and their families eat. We are working with our partners to enable the spread of good practice of local initiatives tackling obesity and reducing health inequalities.
- 4.39 Prevention of obesity is important, as is early identification and interventions to prevent the development of co-morbidities. PHE is responsible for supporting local authorities in their delivery of the National Child Measurement Programme (NCMP) and manages the national collation and analysis of vital data and intelligence, which informs local action on tackling child obesity. The programme is a key asset for bringing together the range of local partners with a role in healthy weight priorities, including schools, professionals and through sharing of results parents and carers, to achieve healthier lifestyles.

4.40 Currently DH and PHE are focusing on the following:

- a) Working with business - the Public Health Responsibility Deal (see paras 4.16 - 4.20).
- b) Change4Life and the Public Health Responsibility Deal (RD) are helping people improve a number of aspects of their diet. Last year saw the launch of a new voluntary and consistent front of pack nutrition label to help people make better informed and healthier choices. Companies representing over 60% of food sold in our supermarkets have committed themselves to adopting the new label. Businesses are also taking action on saturated fat and salt content of food. Two new RD pledges have recently been launched to ensure further progress on reducing salt levels in a wide range of foods consumed both in and out of the home, to help maintain the momentum towards the 6g average population intake goal.
- c) Supporting behaviour change - the Change4Life programme continues to help people change their behaviour, improve their diet and increase physical activity levels.
- d) Ensuring schools and other government departments play their part – we are working with the Department for Education on implementing the School Food Plan and investing in school sport to boost activity levels.
- e) Supporting local authorities and other local partners by helping to spread good practice, supporting commissioning of effective and high quality weight management services, and developing and providing data and evidence to support action.
- f) Supporting LAs through the development of a peer challenge on child obesity programme with the Local Government Association (LGA). PHE supports a 'place based' approach for health improvement encouraging improvements in the physical and social environments to promote healthier lifestyles.
- g) Providing the evidence and supporting local practice – PHE, working with stakeholders, promotes the evidence for effective interventions (such as the current review of the obesity care pathway) and supports local practice by sharing learning and expertise.
- h) Working with other government departments and the wider private and public business sector to utilise the Government Buying Standards for Food and Catering Services.

4.41 The Department for Communities and Local Government has included a specific section for health and wellbeing in its national planning guidance. The Planning Practice Guidance supports the national planning policy in the National Planning Policy Framework (March 2012). The new health and wellbeing section should be a significant help for local planning authorities, NHS commissioners and service providers as well as Health and Wellbeing Boards. It covers issues such as public health e.g. supporting opportunities for behaviour change and the reduction of health inequalities; health infrastructure and mitigating health impacts of new developments.

Ideas for Local Action:

- Does your planning department take into consideration how the design of the local area can help to keep people active?
- Active travel is another great way of increasing physical activity and reducing air pollution- take a look at some great school-based case studies from [Sustrans](#).
- To find out more about the changes to local authority planning guidance have a look at:
<http://planningguidance.planningportal.gov.uk/blog/guidance/health-and-wellbeing/what-is-the-role-of-health-and-wellbeing-in-planning/>

Physical Activity

Deliverable	Impact	Timing
A year-on-year increase in the proportion of adults who meet the UK Chief Medical Officers' physical activity guidelines; and decrease the proportion of adults who are inactive (do less than 30 minutes of physical activity a week).	Greater number of physically active adults	<ul style="list-style-type: none"> • December 2014 • On-going
500,000 more families signed up to Change4Life through the <i>10 magic moves</i> and healthy eating <i>smart swaps</i> campaigns.	Fewer children and adults with excess weight and a greater number of physically active adults	<ul style="list-style-type: none"> • <i>10 magic moves</i> - August 2015 • <i>Smart swaps</i> - January 2015

4.42 Physical inactivity in the UK is a contributor to around 17% of premature deaths. The decline in regular physical activity in the last 50 years is well documented, although it is only in the last 5-10 years that we have had adequate data to describe the problem. This decline appears to be evident in most, if not all, areas of people's lives. The importance of physical activity in preventing more than 20 chronic conditions is highlighted by WHO guidance¹³.

4.43 Physical activity has positive impacts throughout an individual's life. It takes many forms, from childhood play and school sport, through everyday walking and cycling, to exercise, dance, sport and fitness activities for fun as well as through structured health interventions.

¹³ World Health Organization (2010) *Global Recommendations on Physical Activity for Health*.

- 4.44 The government has launched '[Moving More, Living More](#)' to encourage greater cross-sectoral and cross-departmental action, including organisations and people across the country to commit to the changes that will deliver a more active nation as part of the legacy of the London 2012 Olympic Games.
- 4.45 In partnership with local government and key national strategic partners such as Sport England, UKActive, Sustrans, Walking for Health and the National Centre for Sports and Exercise Medicine, PHE will:
- Launch a national physical activity framework to support implementation of evidence based interventions to promote physical activity at a local level
 - Work with key stakeholders to promote structured physical activity interventions with measurable outputs for health and social care, including people with mental health problems
 - Work to understand better the barriers to physical activity for specific groups within the population, to help us to reduce inequalities in physical activity across England.

Ideas for Local Action:

Do you know how physically active your citizens are? Do you know where to find information on physical activity? Take a look at [Moving More, Living More](#) for innovative ideas about physical activity commitments individuals and organisations can make.

Alcohol

Deliverable	Impact	Timing
Remove one billion units of alcohol from the market by the end of 2015.	Reduce the strength of alcohol in people's drinks	<ul style="list-style-type: none"> Update: April 2014 December 2015
PHE will produce a report for government on the public health impacts of alcohol and on possible evidence-based solutions by the end of March 2015.	Contribute to a reduction in alcohol harm.	<ul style="list-style-type: none"> March 2015

4.46 Alcohol is among the four¹⁴ biggest behavioural risk factors for illness and death with over 60 diseases or conditions that can be caused by drinking alcohol. Harmful drinking causes cardiovascular disease and increases the risk of various cancers and being a major cause of cirrhosis of the liver. It has been estimated that in 2010 alcohol accounted for over:

- 4,000 deaths from liver disease
- 7,000 deaths from cancer including 1,200 from breast cancer alone, and
- 300 deaths from cardiac arrhythmias¹⁵.

4.47 The Government is taking national action to prevent the worst examples of promoting cheap, discounted alcohol and introduced a ban on selling alcohol below the price of duty and VAT in Spring 2014, and strengthening the ban on irresponsible promotions in pubs and clubs.

4.48 The Department is also challenging industry to increase its efforts, building on what has already been achieved through the Public Health Responsibility Deal. The past thirty years have seen a steady increase in the strength of beers and wines and we need to reverse this trend. Particularly relevant to this is that over 30 alcohol retailers and producers have pledged to remove one billion units of alcohol from the market (around 2%) by the end of 2015, principally through improving consumer choice of lower alcohol products.

4.49 The billion unit reduction pledge is subject to independent monitoring and the first interim report shows that in the first year the number of units in the market was reduced by 253 million units. This represents a quarter of the billion unit reduction that the industry has committed to achieving over the four years to the end of 2015.

¹⁴ Global Burden of Disease 2010, The Lancet, March 2013

¹⁵ Updating England-specific Alcohol Attributable Fractions, Centre for Public Health, Liverpool John Moores University, 2014.

4.50 Because much alcohol attributable harm occurs in middle or older age groups as a result of years of drinking above the lower-risk guidelines, even a relatively small reduction of around 2% in the total annual consumption is likely to have a significant impact upon long-term and chronic illnesses.

4.51 PHE and NHS England are also supporting local authorities and CCGs in tackling the harmful effects of alcohol, through targeted local action:

- a) From the 1st April 2013, we began implementation of an alcohol risk assessment within the NHS Health Check available to all adults between 40 and 74;
- b) Continue funding a Directed Enhanced Service for GPs to assess and, where appropriate, deliver alcohol brief advice to newly registered patients;
- c) Expansion of Identification and Brief Advice in a range of settings is underway, particularly in primary care settings, including community pharmacy;
- d) Offering advice and support to selected areas with significant levels of alcohol-related harm through a network of Local Alcohol Action Areas.

4.52 In addition, PHE is supporting local implementation of:

- Alcohol Care Teams in hospital settings coordinating care and services in the community.
- Alcohol service(s) for frequent alcohol related attenders at hospitals.
- Specialist Alcohol Treatment to deliver both health and psychological care to encourage recovery.

Drugs

4.53 Though drugs are not one of the biggest behavioural risk factors across all age groups they are a significant and growing contributing factor to the UK's premature mortality rate and disease burden. Among the 20–54 age group, drug use disorders are the sixth leading cause of years of life lost. For all age groups, the contributions of drug use disorders to premature mortality in the UK rose by 577% from 1990 to 2010.

Ideas for Local Action:

If your local area is struggling with high levels of drug abuse find out what central Government is doing to support local action in the [National Drug Strategy](#).

To provide direct support and accurate information on drugs see what the [‘talk to frank’](#) service has to offer.

Working with Individuals

NHS Health Check

Deliverable	Impact	Timing
Support local authorities to increase the number of NHS Health Checks offered to 20% each year and increase uptake towards 66%.	Increased number of eligible people receiving an NHS Health Check.	<ul style="list-style-type: none"> • 20% offered each year: March 2015 • Towards 66% uptake by March 2015

4.54 The NHS Health Check is a national risk assessment, risk awareness and risk management programme targeted at men and women aged 40-74 who have not been diagnosed with an existing vascular disease or being treated for certain risk factors. The programme systematically addresses the top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption. This programme has the potential to detect at least 20,000 cases, per year, of diabetes or kidney disease earlier, helping people to manage these conditions better and improve their quality of life, and to prevent:

- 650 premature deaths
- over 4,000 people a year from developing diabetes
- 1,600 heart attacks and strokes

4.55 Local Authorities are required to offer an NHS Health Check risk assessment to their entire eligible population every five years and to seek to improve the percentage of people taking up their offer of a risk assessment each year. The risk reduction actions following on from an NHS Health Check are the shared responsibility of local councils (behaviour change interventions) and the NHS.

Case Study: For some inspiring stories about how **Health Trainers** can improve health behaviours, symptom awareness and encouraging interaction with the health and care system go to <http://www.healthtrainersengland.com/case-studies>

4.56 PHE will support local authorities and the NHS to:

- a) Achieve coverage of 15m 40-74 years olds offered an NHS Health Check every 5 years, which amounts to an increase from 16.5% of the relevant population offered an NHS Health Check in 2012-13 to 20% pa thereby ensuring total coverage over a five year period
- b) Support local authorities to increase uptake with a national ambition to increase uptake towards 66% by March 2015 (currently 48%).
- c) Support local implementation through the delivery of PHE's 10 point action plan, including the introduction of a National Framework for Quality Improvement, Branding and Marketing Toolkit and testing of behavioural insights on improving uptake.
- d) Advance the use of the digital media through the introduction of new interactive website information and tools for the programme, including access to a national service directory.
- e) Develop an improvement offer which spans both local government and the NHS to drive improvements in uptake and outcomes.
- f) Develop a web-based interactive map used to display current and cumulative data on offers and uptake of NHS Health Check at local authority level as part of the Longer Lives resources.

Ideas for Local Action:

- Do you want to know about innovative NHS Health Check Programmes? Take a look here: www.healthcheck.nhs.uk
- Are all your councillors and district/town and parish councillors in two tier areas aware of the scheme and encouraging residents to attend their NHS Health Check?
- Are your residents getting advice from their GP on how to live a healthy life?
- Do you monitor the uptake of NHS Health Check along the social gradient in your area?
- Have you considered access to NHS Health Check for people with common mental health problems

5. Early Diagnosis

- 5.1 Even with our best efforts at preventing disease, some illness will always occur. However, there is much we can do to stop illness leading to early death, if we can act as soon as the warning signs appear. Diagnosing conditions early is an essential part of *Living Well for Longer* and encompasses increasing symptom awareness in patients, improving primary care's ability to identify diseases and national population screening programmes. It is often those people who are most at risk who are slowest to come forward. These people are also likely to be relatively disadvantaged, so we need to target interventions at them if health inequalities are to be reduced.
- 5.2 Below is a list of key early diagnosis deliverables.

Deliverable	Impact	Timing
Complete the second wave roll out of bowel scope screening (with at least 60% of centres to have started by March 2015).	Greater coverage of Bowel scope screening. Expected increase in early diagnosis for bowel cancer	• 60% : March 2015
Run a pilot of Faecal Immunochemical Test (FIT) for bowel cancer screening and evaluate (acceptance rates, sensitivity and costs) during summer 2014.	40,000 kits to be sent out; inform possible roll out	• Results: Spring 2015
Report on the first year of the pilots of Human Papillomavirus (HPV) primary screening (6 sites operating HPV screening in place of cytology).	6 sites offering HPV screening in place of cytology	• Initial results: spring 2015
NHS England Area Teams to work with PHE and Local Authority Public Health colleagues to address variation in screening coverage.	Create performance 'floors' and take action when these are not met	• Ongoing
Review results from breathlessness pilot campaign and if successful consider regional campaign	Early diagnosis of range of diseases associated with breathlessness	• Campaign results: Autumn 2014
Increase the percentage of CCGs with confirmed access to scientific and diagnostic commissioning information to 75%.	Enable effective monitoring of rates of early diagnosis in a wider range of CCGs	• March 2015
Evaluation of Prime Minister Challenge Fund pilots that provide evidence on how to improve access to general practice services and develop more innovative and sustainable models of primary care.	Develop a set of common evidence-based principles for improving access to primary care	• March 2015

Symptom Awareness and Campaigns

- 5.3 An excellent example of symptom awareness is the *Be Clear on Cancer* (BCOC) campaigns which highlight the symptoms of a range of cancers and encourage people with the relevant symptoms to visit their GP. A process of testing locally and regionally is conducted to ensure that campaign messages are balanced and do not cause anxiety, and to assess the impact on NHS services. If appropriate, campaigns are then run nationally across England. The campaigns are evaluated and decisions on which to run next are based on the analysis of the evaluations.
- 5.4 The national lung cancer campaign which ran from May-June 2012 led to an estimated 700 additional cancers being diagnosed when compared to the same period in the previous year. Approximately 400 more people had their cancers diagnosed at an early stage and around 300 additional patients had surgery as a first treatment of diagnosed lung cancer.
- 5.5 A series of other campaigns are under way or in planning to improve symptom awareness and early diagnosis in the population:
- **Breathlessness** – local pilot stage: The pilot aimed to raise awareness of breathlessness as a symptom of conditions such as chronic obstructive pulmonary disease (COPD), lung cancer and heart failure – and to encourage people who get out of breath during everyday activities to go to their GP. It is thought there are over 3 million people living with COPD in the UK, of which only about 900,000 have been diagnosed¹⁶. The pilot campaign ran for 4 weeks, in Oldham and Rochdale (within the Greater Manchester and Lancashire Strategic Clinical Network). The campaign (led by PHE in partnership with DH and NHS England) will measure the effectiveness of this campaign to discover what does and does not work.
 - **Hypertension** – pilot stage: High blood pressure is the second biggest risk factor of disease leading to premature mortality in the UK, and is a major risk factor for stroke, heart attack, heart failure, chronic kidney disease and cognitive decline. Almost 30% of adults in England¹⁷ have high blood pressure, of which over 5 million are undiagnosed.¹⁸ High blood pressure is usually symptomless, so cannot be identified without testing. In March 2014 PHE and local partners piloted a health marketing approach in Wakefield. It aimed to engage communities to increase early diagnosis of high blood pressure and promote lifestyle improvement. The pilot targeted people in lower socio-economic groups, those disengaged from primary care services and those with risk factors for hypertension. The pilot will be evaluated in the summer of 2014.

¹⁶ NHS Choices. Chronic obstructive pulmonary disease. Access via: <http://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease/Pages/Introduction.aspx>

¹⁷ Health Survey for England 2012 published Dec 2013, http://data.gov.uk/dataset/health_survey_for_england

¹⁸ CVD intelligence network key facts briefing <http://www.yhpho.org.uk/resource/view.aspx?RID=188005>

- 5.6 Improving symptom awareness is the responsibility of all parts of the primary care community. Pharmacies have been recognised as having a key role in the *Be Clear on Cancer Campaign* programme. [Pharmacy Fact Sheets](#) have been developed in conjunction with Cancer Research UK to raise awareness with pharmacy teams of the common symptoms for the cancers that are being targeted with a view to pharmacy teams encouraging people to visit their GP early, if they think the person coming to the pharmacy has relevant symptoms and has had them for long enough.

Primary Care's Role in Early Diagnosis

- 5.7 Work with primary care to support GPs and other primary care professionals in improving their ability to diagnose earlier needs to happen alongside public campaigns. Whilst recognising that GP practices see small numbers of cancers each year, we can improve symptom recognition and clinical judgement amongst professionals. Improving early diagnosis in primary care has four strands of work as set out below:

WHAT	HOW
Risk awareness and symptom recognition: Increase symptom awareness for the public and professionals, and provide support to GPs in early diagnosis	<ul style="list-style-type: none"> • Significant event audits to help GPs see where diagnosis could have been improved • Training for GPs to better recognise early symptoms • IT systems to produce 'pop ups' when combinations of symptoms are recorded.
Data: Make data and information more available and transparent	<ul style="list-style-type: none"> • By driving professional pride to make improvements in clinical practice • So that members of the public are aware of the quality, care and accessibility of GP practices in their area • By using GP registers as a source of epidemiological data to support needs assessment and service planning
Inspection: Inspection of general practice will provide the means by which the public can have confidence in the quality of service they can expect to receive at their GP surgery	<ul style="list-style-type: none"> • By defining what good care looks like • By supporting improvement and, where needed, taking enforcement action • By conducting thematic reviews of particular conditions
Access: New models of primary care commissioning improving access	<ul style="list-style-type: none"> • By extending access to improve convenience and continuity of care including extending access times, and greater use of telephone, email and video consultations

Broadening Access to Primary Care

- 5.8 Poorer health outcomes tend to be associated with areas where there are lower numbers of GPs (per weighted head of population), possibly a symptom of the same underlying cause, deprivation. NHS England is considering how best to improve services in deprived areas. Work is also underway to identify how to recruit and retain GPs and practice staff in deprived areas, including better arrangements for return to practice.
- 5.9 Changing how services are commissioned and provided can broaden access. Making it easier for patients to see their primary care team should help improve early diagnosis rates, particularly in areas with stark health inequalities and/or insufficient numbers of GPs. There are already several examples of GP practices federating to provide a wider range of services, but also widening access to primary care professionals.
- 5.10 The access pilots under the Prime Minister's £50m Challenge Fund offer the opportunity to test innovative forms of access. These pilots will consider all forms of access to improve convenience and continuity of care including:
- a) Extended access at evenings and weekends
 - b) Greater use of telephone, email and video consultations
 - c) Providing access across a number of different sites
 - d) Joining up of urgent care and out-of-hours care
 - e) Better use of telecare, including healthy living apps
- 5.11 NHS England's emerging strategic framework for commissioning primary care services will set out further action to improve access. NHS England are exploring with CCGs ways in which primary care and community health services can be commissioned on a joint or collaborative basis.
- 5.12 Another way of broadening access to primary care is to look beyond general practice. Ninety nine percent of the population, even those living in the most deprived areas can get to a pharmacy within 20 minutes by car and 96% by walking or public transport. The position has improved substantially for those living in the 10% most deprived areas, suggesting there is good access to community pharmacies in deprived areas.

Ideas for local action:

Do you know where your area ranks in terms of general practitioners per head of population? Try looking at the [National General Practice Profiles](#).

5.13 NHS Improving Quality (NHS IQ) has also developed the 'GRASP Suite' of primary care audit tools to help GPs improve the detection and management of two cardiovascular conditions, atrial fibrillation (AF) and heart failure (HF). Each of these toolkits contains a case finder, which helps GPs identify patients presenting with symptoms which may indicate the presence of undiagnosed AF or HF, and a management audit tool comparing current management with NICE Guidelines. The case finding and toolkits elements of GRASP-AF and HF will have an impact on the recorded prevalence of these conditions and will allow us to monitor the increase in recorded prevalence of each of these conditions over time.

Screening Programmes

5.14 The NHS provides screening programmes that aim to prevent or provide early diagnosis for groups of people across the life course. PHE sets standards for these programmes, assesses the evidence of their effectiveness and assures the public of their safety. Screening saves lives and not just from cancer:

- a) Each year PHE and the NHS find, and treat, life threatening or life shortening diseases in around 1,000 new-born babies
- b) Each year around 1,000 at risk babies are born without HIV as result of the screening programme in pregnancy
- c) Over 1,000 babies can also avoid being infected with Hepatitis B.
- d) It is estimated that the NHS Abdominal Aortic Aneurysm Screening Programme will save approximately 700 lives within the first 10 years of screening, eventually rising to up to 2,000 per year.

Ideas for Local Action:

- Do you know your uptakes rates for different groups of your population for the screening programmes?
- Do you want to get some ideas on how you can increase your uptake rates amongst your hard to reach groups?
- Take a look at what they did for the early detection of cancer through community engagement in [Grimsby](#).

5.15 **NHS cancer screening programmes** aim to prevent or diagnose early a number of cancers where there is a sound evidence base of clinical and cost-effectiveness, with the overall aim of contributing to the reduction in mortality from all cancers. PHE and NHSE work closely on the commissioning of screening services and the proposed outcomes are:

- **Breast cancer** - Experts estimate breast screening in the UK saves 1,300 lives a year in women aged 50 to 70. A major trial is underway to assess the effectiveness of screening women aged 47 to 73.

- **Bowel cancer** – the original home testing kit programme (faecal occult blood testing) is estimated to reduce mortality from bowel cancer by 16%. The age range has recently been extended for men and women up to age 74 (previously 60-69). We are looking at ways of increasing coverage by piloting improvements to the screening methodology (including the use of faecal immunological testing from April 2014) and working to break down barriers to screening, especially amongst more disadvantaged communities. The roll out of bowel scope screening to men and women aged 55 is estimated will save up to 3,000 lives per year when fully implemented after 2016.
- **Cervical cancer** – reduce incidence of and mortality from cervical cancer through diagnosing and treating abnormalities of the cervix before they become cancerous. It is estimated this will save around 4,500 lives a year in England. To make the service more personalised for women, we have recently introduced HPV testing for women with low grade abnormalities and women who have previously been treated by the programme. We are also piloting primary HPV testing, which has been estimated to prevent a further 600 cancers a year.

5.16 PHE will therefore:

- a) Deliver Wave 2 of the Bowel Scope Screening programme, so that at least 60% of local screening centres are live by March 2015
- b) Work with the NHS to ensure full roll-out of the Bowel Scope Screening programme by December 2016
- c) Assess the evidence of screening for lung and ovarian cancer when major trials report in 2015

5.17 It is known that prevalence of risk factors for cancer is much higher amongst those with a common or serious mental illness so it is important that cancer screening programmes reach this segment of the population. PHE will undertake a special inquiry to understand uptake of breast, bowel and colon cancer screening amongst people with mental health problems to address how uptake and follow up compares to the general population. It will also identify effective interventions in increasing uptake of cancer screening in people with mental health problems. It is estimated that increasing accessibility and uptake of cancer screening among those with either serious mental illnesses or common mental health disorders (CMHDs) to the levels of the general population could save 218 lives¹⁹ per year.

¹⁹ **Sources:** Hippisley-Cox, J. and Pringle, M., 2005. Health inequalities experienced by people with schizophrenia and manic depression: analysis of general practice data in England and Wales: first report to the Disability Rights Commission April 2005; Peto, J, Gilham, C, Fletcher, O, Matthews, F. E. (2004) The cervical cancer epidemic that screening has prevented in the UK *The Lancet* - 17 July 2004 (Vol. 364, Issue 9430, Pages 249-256); Tran E, Rouillon F, Loze JY, et al. (2009) Cancer mortality in patients with schizophrenia: an 11-year prospective cohort study. *Cancer* 115: 3555–3562.; Werneke, U, Horn, O, Maryon-Davis, A, Wessely, S, Donnan, S & McPherson, K 2006, 'Uptake of screening for breast cancer in patients with mental health problems' *Journal of Epidemiology and Community Health*, vol 60, no. 7, pp. 600 - 605.; Cochrane Database of Systematic Reviews, 2006 "Screening for colorectal cancer using the faecal occult blood test: an update";

Targeting Resources for vulnerable populations

People with mental illness

- 5.18 As noted above, people living with mental health problems have greater exposure to the risks which lead to physical illness including smoking, poor diet and lack of exercise and weight gain associated with medication, as well as wider social factors such as low income. There is good evidence to show that there are much higher death rates from the five big killers among people with mental health difficulties. They experience up to three times more physical health problems than the general population and can die up to 20 years earlier.
- 5.19 This is why we are encouraging primary care to improve early diagnosis and earlier interventions with people with mental health problems (often in collaboration with their mental health provider).
- 5.20 There are a number of clinical tools available to support improvements in services for this group, for example the [Rethink Integrated Physical Health Care Pathway](#) and [The Lester resource](#). The latter is a clinical tool used to support improvement in the management of physical illness in people with mental illness based on NICE evidence, and developed jointly between several royal colleges (Royal Colleges of Psychology, General Practice and Nurses) and third sector partners. The tool aims to improve methodical screening and to ensure both physical and mental health conditions are jointly addressed.

People with learning disabilities

- 5.21 In March 2013 the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) reported that 48.5% of deaths of people with learning disabilities are avoidable. Because of their intellectual disability they need a targeted approach.
- 5.22 The NHS England Mandate set an expectation that year on year progress will be made against Domain 1 of the NHS Outcomes Framework which includes an indicator on reducing premature death in people with a learning disability (Excess under 60 mortality rate in adults with Learning Disabilities). The Mandate also gives NHS England an objective to support children or young people with special educational needs to access the services identified in their agreed care plan and to ensure that the parents of children who could benefit have the option of a personal budget based on a single assessment across health, social care and education.
- 5.23 NHS England has included in its planning guidance ([Everyone Counts](#)) an expectation that CCG plans will clearly set out action to make rapid progress in reducing health inequalities, promoting health and delivering parity of esteem for people with learning disabilities.
- 5.24 NHS England is also carrying out an evidence review of interventions to reduce premature mortality in people with learning disabilities, which will be completed this spring. This will inform work over the next couple of years to improve outcomes for people with learning disabilities.

6. Treatment

- 6.1 Even when diseases have established themselves, there is still a lot we can do to improve quality of life and extend lives through effective treatments. However, treatment standards show unacceptable levels of variation across the country. It is our intention to narrow these variations and reduce health inequalities, ensuring that anyone who does get ill has a high quality service and experiences the best outcomes possible.
- 6.2 The findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, made clear that the tragic events at Mid Staffs were not only a failure of the Trust Board but a wider system failure. The Government published the initial response in *Patients First and Foremost* (March 2013) and a more detailed response in [*Hard Truths: The Journey to Putting Patients First*](#) (November 2013).
- 6.3 These responses set out priorities and actions to achieve reliably safe, compassionate and high quality care, with stronger accountability. This includes:
- The introduction of fundamental standards below which care should never fall
 - The appointment of Chief Inspectors for hospitals, adult social care and primary care
 - Greater transparency and a new duty of candour
 - A programme of action on leadership; and
 - A new failure regime to ensure fast and effective action where the safety of patients may be at risk.
- 6.4 The response also commits to:
- continual improvement in safety including ensuring safe staffing levels
 - the creation of a national programme for safety improvement, and
 - new dedicated hospital safety website.
- 6.5 A new care certificate will ensure that healthcare assistants and social care support workers have the right fundamental training and skills and a pilot is underway through which aspiring student nurses gain up to a year of pre-degree care experience.

Clinical Leadership

- 6.6 Clinical leadership is at the heart of the reformed NHS. From the National Medical Director and Chief Nursing Officer to the local governing bodies of CCGs, clinical expertise is represented at every level. Every CCG appoints a clinical leader who represents the clinical voice of its members and represents that CCG at the NHS Commissioning Assembly.

- 6.7 NHS England employs 25 National Clinical Directors (NCDs) to provide expert advice and clinical leadership to NHS England on conditions and services ranging from obesity and diabetes to emergency preparedness and critical care. The NCDs ensure that credible clinical advice is at the heart of NHS England's work and help the NHS make its decisions based on the very best possible clinical evidence.
- 6.8 The National Clinical Directors are helping to support work across the system to reduce premature mortality by providing expert advice and clinical leadership, by championing key interventions and by mobilising and coordinating action through local and national networks.

Ideas for Local Action:

- **Celia Ingham-Clark**, National Director for avoidable mortality, is championing improving the nutritional quality of hospital food.
- Does your local hospital trust provide effective food and nutrition labelling for staff, patients and visitors?

Working with Health Commissioners: NHS England's support for CCGs

Deliverable	Impact	Timing
Provide clinical advice and support for CCGs in setting and delivering their levels of ambition for reducing premature mortality throughout the year to March 2015.	Clear articulation of overall contribution of the commissioning system to reducing premature mortality, with a view to ensuring a clear focus on improving outcomes in commissioning plans	<ul style="list-style-type: none"> • Ambitions published: September 2014

- 6.9 NHS England is committed to delivering year on year improvements in outcomes. [‘Everyone Counts’: Planning for Patients’ 2014/15-2018/19](#), sets out NHS England's planning guidance for local health commissioners. Its focus on outcomes needs to be translated into specific measurable ambitions which can be used to track progress. Working with clinicians, staff, CCGs and key stakeholders NHS England has set out the seven specific ambitions which CCGs and their partners will be asked to commit to. This includes setting a quantifiable level of ambition in relation to ‘securing additional years of life for the people of England with treatable mental and physical health conditions’. The whole planning process is being improved for 2014/19 (see Figure 106) to ensure greater integration of services, stability and support.

6.10 Additionally, *Everyone Counts* makes it clear that there are three further vital measures where NHS England would expect to see local service delivery plans proposing rapid improvements set out in. These are:

- improving health, which must have just as much focus as treating illness;
- placing special emphasis on reducing health inequalities; and
- moving towards parity of esteem, to make sure that we are just as focused on improving mental as physical health.

6.11 It will be for local commissioners to decide how to construct local levels of ambition on securing additional years of life. Two year operational plans and five year strategic plans are expected to be published by April and June 2014 by CCGs.

6.12 In order to support CCGs in delivering this ambition NHS England has produced a web resource which is intended to provide a starting point to assist commissioners with the planning process and to provide advice on the comparative benefits (and costs where known) of implementing a range of clinical interventions.

Ideas for Local Action:

NHS England's premature mortality web resource can be found [here](#) along with the [CCG outcomes tool](#).

6.13 This resource should be used in conjunction with others that have been developed to support the planning process, such as the CCG Outcomes Tool, which enables CCG outcomes to be compared against a range of indicators. NHS England will continue to develop this resource including the high impact interventions which have been identified to date:

- Implementation of NICE guideline on acute kidney Injury
- Implementation of the Sepsis Six Care Bundle
- Implementation of British Thoracic Society Care Bundle for community acquired pneumonia
- Increased prescription of anti-thrombotics (warfarin) for patients with atrial fibrillation
- Establishment of hyper-acute stroke services
- Earlier stage of diagnosis of cancer
- Intermittent pneumatic compression to prevent post stroke deep vein thrombosis
- Prevention of venous thromboembolism
- Increased uptake of cardiac rehabilitation

- 6.14 *Everyone Counts* sets out the measures for the Quality Premium for 2014/15. The 'quality premium' is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.
- 6.15 The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. This includes a measure on reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality. The guidance on the measure suggests that CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.
- 6.16 NHS England will provide support to CCGs in delivering these outcomes. For more detail on NHS England's deliverables for 2014/15 see the delivery plan at the end of the Document.
- 6.17 The universal offer that applies to all CCGs includes:
- **Practical support on participation** – The interactive web based *Transforming Participation in Health and Care* tool already provides advice, good practice, evidence and case studies on approaches to good public participation. This will be supplemented by resources that will be made available through commissioning support units (CSUs) aimed at engaging local communities in developing and commissioning services that meet their needs, and using insight and market research techniques to understand those needs better.
 - **Any town health system and Better Care Fund models** – To support CCGs in preparing plans, the [Any town](#) health system model was published in January. The Better Care Fund modelling tool enables health and wellbeing boards to predict costs and outcomes of particular integration interventions between health and social care. The Better Care Fund will provide £3.8bn from April 2015 to support this integration.
 - **Data packages** – data and analysis packs showing the local opportunities for improvement and setting out relative performance e.g. [Commissioning for Value](#) packs released in October.
 - **Strategic planning workshops** – Local workshops designed to kick-start the planning process and build local relationships to create a joint vision and prepare for planning submissions. They will provide practical and technical advice about translating a strategy into a financial and operating plan and will support joint ways of working through advice on creating local governance arrangements aimed at galvanising action and initiating stakeholder discussions.

- **Learning events** – This will support the spread and adoption of learning, best practice and technical expertise. NHS England is planning to create a programme of webinars and learning events on key topics across three broad areas; best practice sharing; thought leadership; and support for the technical aspects of planning and delivery.

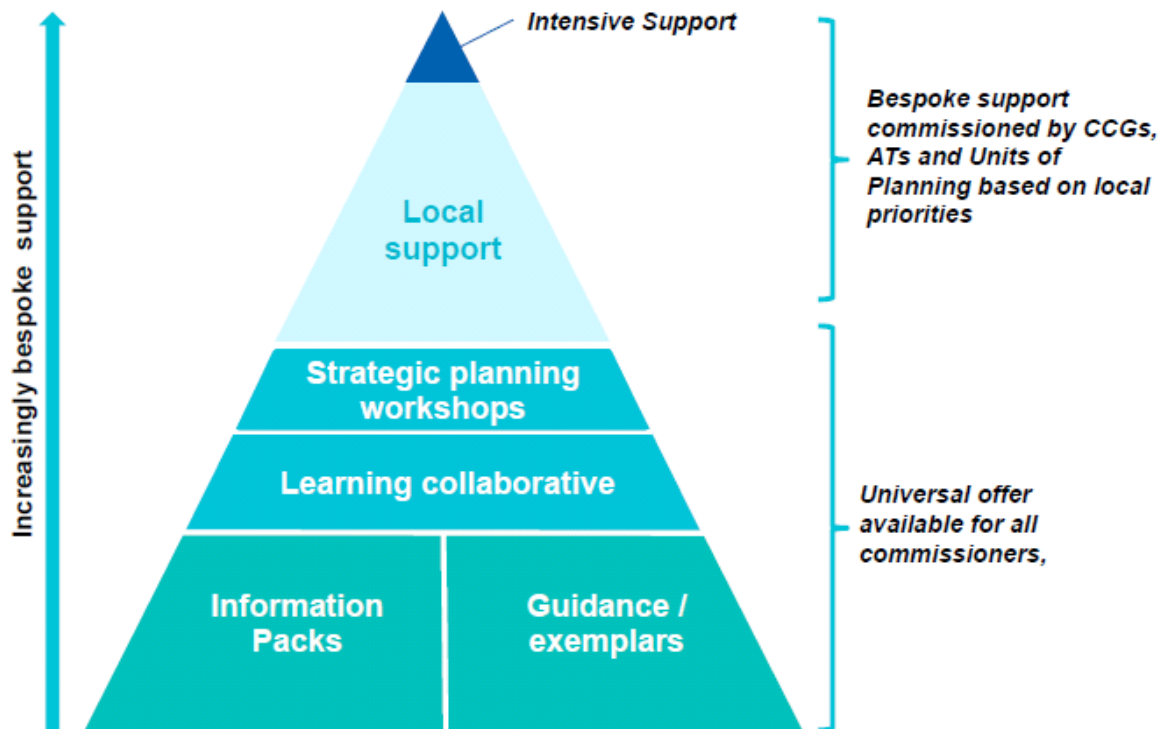


Figure 10: Support to CCGs from NHS England

Promoting better management of co-morbidities & ‘Parity of Esteem’

- 6.18 Action to improve the management of co-morbidities is already underway across the system. NHS England are developing a ‘house of care model’ in which personalisation is key and supports a patient’s ability to self-manage. NICE is developing guidelines on behavioural approaches; the Royal Colleges are working together on joint guidelines for care of those with multiple conditions; general practices are using data to identify groups of patients who have multiple conditions in order to offer them joined-up care that avoids multiple consultations.
- 6.19 NHS England and DH have recently published [‘Transforming Primary Care’](#). This focusses on people with the most complex needs and will promote the delivery of more personalised, proactive care. A key commitment is that by the end of June 2014 all people aged 75 and over will have a named GP to oversee their care.
- 6.20 By bringing partners together to begin tackling co-morbidities jointly across the system. The partners have co-produced a set of guiding principles for the prevention and management of co-morbidities that would support commissioning across the health and care system to improve health outcomes and reduce health inequalities by taking account of the wider causes of ill health and narrowing the social gradient. You can find the guiding principles here: [Co-Morbidities Framework](#)
- 6.21 This co-morbidity work applies equally to people with mental illness and it is why the government has pledged, “no health without mental health” and released [‘Closing the Gap: Priorities for essential change in mental health’](#). This includes the implementation of the NHS England’s ‘Parity of Esteem’ programme – which, by giving equal consideration to both mental and physical health, aims to redress the disadvantages experienced by people with mental health difficulties. To support the integration of physical & mental health care with social care, the government is planning the pooling of at least £3.8 billion (with an expectation of the final figure being considerably more) to help every health and wellbeing board in the country to develop its own plan for joined up health and care locally. This is also supported by PHE’s forthcoming publication, ‘Wellbeing and Mental Health: Public Leadership and Workforce Development’.
- 6.22 Delivering improved outcomes for people living with mental health problems will require increased access to smoking cessation services, more mental health residential units becoming smoke-free environments and increased access to physical health screening and treatment for people living with mental health problems.
- 6.23 NHS England is working with partner organisations including PHE and NHS Improving Quality (IQ) to develop a ‘Lester Plus’ tool which will help Mental Health providers carry out physical health screening and appropriate interventions. This tool is based on the current Lester tool but includes additional important physical health measures. Other best practice examples such as the Rethink Physical Health Pathway are included in NHS England’s web resource to support CCGs in reducing premature mortality.

- 6.24 NHS England is introducing a new Commissioning for Quality and Innovation (CQUIN) payment for mental health. One of the four National CQUINs in 2014/15, it will incentivise healthcare providers in mental health settings to carry out physical health assessments and interventions of all patients with serious mental illness, and in collaboration with the patient's GP ensure onward referral to specialist services as required. All mental health inpatients and those cared for by intensive community teams e.g. assertive outreach teams and early intervention teams, will be the primary focus of the CQUIN in the first year.
- 6.25 NHS England are asking healthcare providers to assess multiple aspects of physical health and the CQUIN's first indicator focuses on recording key cardiovascular risk factors and any interventions instigated to address these physical health risk factors. This CQUIN brings together the important relationship between physical and mental health and promotes a holistic approach to the patient.
- 6.26 The CQUIN's second indicator aims to improve communication with the patient's GP focusing on the correct coding of mental health diagnoses as well as physical health conditions and any on-going monitoring or treatment requirements.

Ideas for Local Action:

- Do you want to know more about the Lester tool and other resources? Take a look here at the [National Audit of Schizophrenia](#) website.
- Do you know what the plans are in your area for implementing the CQUIN on Mental Health?
- For a summary of the issues and around the physical health of those with mental illness read Rethink's latest report: [Lethal Discrimination](#).

7. Making it happen

- 7.1 Reducing premature mortality requires the aligned effort of the entire health and care system. A number of cross-cutting actions are needed to ensure the programmes of work described above happen in concert.

Increasing Transparency and Accountability

- 7.2 Transparency and open data is a Government priority which supports: accountability of services; informed patient choice; more effective and efficient care; and effective commissioning.
- 7.3 NHS England and PHE publish information at the local level on key measures that describe rates of premature mortality, such as disease prevalence rates (estimated vs. reported). Publishing the discrepancy between the known number of diabetics (2.50m) and how many there are estimated to be (3.35m), for example, should create demand for greater levels of case detection by primary care and improved treatment and better outcomes through CCG commissioning.
- 7.4 In June 2013, PHE launched their [Longer Lives](#) website which allows local people and local authorities to see how their areas compare on early deaths from major killers like heart disease and cancer, to those with similar populations, incomes and levels of health. The data is regularly updated (February 2014 was the last update) and in response to feedback, more information is being added such as showing trends over time, breakdown of the causes of death which contribute to major killers, data for smaller areas, and further comparators. During 2014/15 PHE will enhance links with the LGA, NHS England and NICE websites and data.
- 7.5 The *care.data* programme will offer the ability to produce information that can save lives, quickly find new treatments and cures, and support research by linking existing data securely and safely across healthcare settings and providers. In order to realise its potential, though, patients, service users and clinicians must have absolute trust in the way their data will be protected and used.
- 7.6 The national intelligence networks which sit within PHE will also provide intelligence to local authorities and the NHS to aid service improvements and improved outcomes. There are intelligence networks for cancer, cardiovascular disease, mental health, and maternity and children.

Workforce

- 7.7 The health and care workforce are the hands and feet which will deliver the care, advice, encouragement and treatment needed to tackle the five big killers. Health Education England (HEE) is working to ensure that the best training is in place. We need a workforce that is prepared to meet the challenges of the future, namely an ageing population and individuals with increasingly complex needs. For this reason the Department of Health has been working with HEE to ensure the workforce has the skills to deliver the change in direction we're hoping to see towards better integration between providers, more community based services and a stronger focus on prevention.
- 7.8 In the [refreshed mandate](#) from the Government to HEE for 2014/15, key commitments have been made to equip professionals with the skills needed to reduce premature mortality. HEE has an objective to: ***'Play a leadership role in bringing an integrated system wide focus to the workforce to prevent people from dying prematurely'***.
- 7.9 The HEE Mandate also carries commitments to develop the skills of the workforce on integrated care, co-morbidities and reducing health inequalities. There is also a recognition that mental health is a matter for all health professionals and training at all levels should reflect this. HEE will:
- Work with the Royal Colleges and educational institutions to commission education and training that takes account of reducing premature mortality
 - Work with the regulators to consider the need to reduce premature mortality when approving curricula
 - Design training for mental health and physical health professionals to ensure they are aware of the links between an physical and mental health
 - Embed physical activity within undergraduate curricula for health professionals

Making Every Contact Count (MECC)

- 7.10 Through the NHS Mandate DH has challenged NHS England to ensure that the NHS focuses on preventing illness, with staff using every contact they have as an opportunity to help people stay in good health. NICE have published an update to their [behavioural change guidance](#) which sets out practical interventions to 'make every contact count' and NHS England is planning to support implementation the guidelines.
- 7.11 Healthy Living Pharmacies (HLPs) are excellent examples of *making every contact count*. One of the distinctive features of a HLP is a trained Health Champion who engages proactively with the community they serve, using every interaction as an opportunity for a health-promoting intervention, *making every contact count* to improve people's health, reduce mortality and help to reduce health inequalities.

7.12 But the MECC approach is not only about the NHS. It is about using training and support to ensure all staff delivering services directly to the public, take the opportunity to talk to those they come into contact with, to encourage them to make positive changes in their lives. It could be by signposting them to quit smoking services, advice to improve their diet or reduce social isolation. It is already being delivered at a local level in non-health and care settings. For instance, in Salford, MECC is being delivered by a wide range of frontline public sector and third sector workers. This includes porters in hospital, call centre staff in the local authority and reception staff in local social enterprises.

Ensuring Quality – from sector led improvement to regulation

Local Government

7.13 Local authorities have a tried and tested approach to continuous improvement and have developed this in relation to driving improvements in public health outcomes by adapting the sector-led improvement model. This rests on the principle that each local authority is responsible for its own performance and improvement, but they can work together and support each other as peers. The sector-led improvement programme provides LAs with support to enhance performance, including comparative performance data, evidence-based guidance on best practice, peer challenges from experts and bespoke training. The Department, PHE and the Association of Directors of Public Health are working with the LGA on further refining the sector's offer for 2014-15.

Primary Care

7.14 There is now a Chief Inspector for General Practice who will provide vital information to patients, practices and to commissioners on the quality of services delivered. Inspection will increase transparency in outcomes, but also ensure quality standards are being met by being responsive to significant changes in data. Inspection will focus on an assessment of services provided for vulnerable older people, people with long-term conditions, mothers, children and young people, working age people, the most vulnerable and those with mental illness

7.15 For the working age population inspection will include looking at:

- How well and conveniently the appointments system works
- How easy is it for patients to get simple diagnostic procedures such as blood tests on site if appropriate

7.16 For mothers, children and young people inspection will look at:

- Co-ordination of care with maternity services, health visiting and school nursing
- How well practice staff are able to identify children who are very unwell and in need of urgent care or treatment

- 7.17 Inspection will help improve early diagnosis rates by assessing critical significant events such as the review of all patients diagnosed with cancer late or emergency admission by practice. Thematic reviews will take a closer look at the diagnosis and management of major diseases. Follow-up activities will help practices identify areas where they need to make improvements and consider how they might make those improvements.

Ideas for Local Action:

Take a look at “[A fresh start for the regulation and inspection of GP practices and GP out-of-hours services](#)” setting out how CQC will inspect GP services?

Hospital Services

- 7.18 In 2013 the Care Quality Commission (CQC) appointed a Chief Inspector of Hospitals to ensure that the principles of patient safety and quality treatment are upheld in hospitals across the country. The CQC has also appointed a deputy chief inspector for mental health championing the interests of patients and ensuring that health services are safe, effective, caring, well-led and responsive to people’s needs.
- 7.19 CQC will carry out a mixture of announced and unannounced inspections. The new inspections will get to the heart of patients’ experiences as CQC are committed to look at the quality and safety of the care provided, based on the things that matter to people. Through this approach, CQC will have a richer and broader understanding of the quality provided. To find out more about the methodology of the inspections and what they’re looking for visit CQC’s [website](#).

Involving the wider system

Working across Government

- 7.20 The Government has a programme that supports reducing premature avoidable mortality spanning several departments of state and has a role to play as a convenor of interests on a national scale. The Department of Health is the ‘steward’ of the health & social care system and has the responsibility to promote and lead action to improve health outcomes across Government. Legislation and national campaigns on obesity, alcohol and cancer screening will continue to form part of the government’s work, supporting the work of other key partners in the health and care system – NHS England and PHE. The role of the Responsibility Deals in this has already been described at paragraphs 4.16 onwards.
- 7.21 The government is committed to supporting families and providing the best start in life for children. Policy areas include the [troubled family initiative](#) (Department for Communities and Local Government (DCLG)), the [pupil premium](#) (Department for Education (DfE)) and the provision of [free school meals](#) (DfE).

- 7.22 The DCLG's lead initiative to drive down the number of fatalities from fires in the home is the [Fire Kills](#) campaign. The national campaign promotes fire safety messages and encourages fire safer behaviour through media advertising (press, radio and online), creating news stories for promotion both locally and nationally, and through working with partners in the commercial and voluntary sectors.
- 7.23 All government departments are paying increasing attention to their impact on health and inequalities given the priority assigned to reduce health inequalities across government. Areas of action include fuel poverty ([Fuel Poverty: Framework for future action](#), Department of Energy and Climate Change (DECC)), air pollution (Department for Environment and Rural Affairs (DEFRA), [Preventing Air Pollution](#)), gang violence, inclusion health, homelessness and healthy workplaces. Modelling shows that a significant number of deaths from respiratory disease can be attributed to air pollution, while fuel poverty accounts for many winter deaths, including an increase in the number of cardiac events during this period.
- 7.24 The Government is committed to a number of initiatives which will help reduce air pollution from transport. These include:
- a £600m Local Sustainable Transport Fund for local authorities which is supporting the delivery of 96 sustainable transport projects (a further £78.5m was announced in late 2013 by the Department for Transport to support more revenue sustainable transport schemes),
 - supporting Bikeability cycle training
 - an additional £107m to further support cycling; and
 - £57m paid out through the Green Bus Fund supporting the purchase of more than 850 new low carbon buses.

8. Next Steps

Delivery

- 8.1 A considerable amount of work is already underway which is making great progress towards reducing premature mortality. Where the Government is implementing new programmes these are set out in our one year delivery plan in the next chapter. This is the first step to realising our five year vision and provides a structure for us to track the progress we are making throughout the year.
- 8.2 In April 2015, at the end of the first year, DH will publish an annual outcomes report that will be fed by data from the PHOF and the NHSOF. This report will also announce our year two delivery plan, which will depend on current trends and the latest evidence of effective interventions.

How we will track progress

- 8.3 It is important that the programmes of work described in this document are underpinned by a robust, fair and transparent assessment of progress.
- 8.4 The outcome frameworks discussed in Chapter 1 provide the measures by which the system is able to understand what progress is being made in improving the health of the nation. Data from these frameworks will help to track how well progress is being made (including reducing health inequalities) through increased data transparency. The outcomes frameworks provide a focus for activity by service providers on the five biggest causes of avoidable mortality: cancer, heart disease, stroke, respiratory disease and liver disease. These look across prevention, early diagnosis and treatment and provide an important disease focus on what needs to be done to reduce premature mortality across the system.
- 8.5 Whilst the shared indicators across Domain 4 of the PHOF and Domain 1 of the NHSOF provide the focal point for the efforts of the Public Health and NHS systems respectively, it is vital that the full picture provided by our rich data and intelligence streams is acted upon. Outcomes data from the frameworks is published publicly and will be used to inform the annual progress report on Reducing Premature Mortality.

Future planning

- 8.6 DH, NHS England and PHE will be looking ahead to the future just as local agencies will. Through strategic planning the direction of travel and future priorities will be set out and reducing premature mortality will continue to provide a significant focus of this work.
- 8.7 PHE is producing a Health and Wellbeing Framework in 2014, which will set out the state of the nation's health and wellbeing. It will also project future health needs and detail a range of evidence-based interventions which different parts of the health system can take to improve population health and wellbeing and reduce health inequalities.
- 8.8 NHS England is currently developing a strategic framework for commissioning primary care (general practice, community pharmacy, primary care dental services and optometry). The strategic framework for commissioning primary care will:
 - a) describe the national direction of travel for primary care, based on a vision for the future of primary care and its contribution to the overarching strategy for health and care in England;
 - b) describe the characteristics of high quality primary care and how this can contribute to the five domains of the NHS Outcomes Framework;
 - c) set out how NHS England, as commissioner of primary care services, will promote, enable and assure local action to improve the quality of primary care and work with CCGs, local professional networks (LPNs) and other community partners to develop local strategies for primary care and more integrated out-of-hospital services
- 8.9 As part of this work, Improving General Practice – A Call to Action was launched in August 2013. This identifies variations in services delivered as a challenge to be addressed by general practice, including ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances. The emerging findings can be found in the Phase 1 report.
- 8.10 A similar exercise focussing on community pharmacy was published late in 2013 and further information about the strategic framework will be published in 2014.

Maintaining Momentum- Developing a Community for Action

- 8.11 The Community for Action (CfA) was established at the same time as the Call to Action and aims to promote action across the country to reduce avoidable mortality. It is a network of local and national organisations, the community and voluntary sector, local government, CCGs and health and wellbeing boards to engage with stakeholders across a wider level. The Community for Action is a platform for stakeholders to showcase their work and for conversations to take place on the breadth of activity taking place.
- 8.12 The Community for Action offers members the opportunity to share information and experience on activity which contributes to reducing avoidable mortality locally and nationally. The CfA uses existing communication channels - face to face, online platforms and fora, conferences - to recognise local work, as illustrated in the diagram below.
- 8.13 To join the Community for Action please visit <http://livinglonger.dh.gov.uk/>, look for the discussion on twitter via the hashtag #LWFL or email us at rpmp@dh.gsi.gov.uk.

Figure 11: How the Community for Action will Work



9. Delivery Plan 2014/15

- 9.1 This delivery plan sets out the actions that will be taken over 2014/15 by the national partners for health and wellbeing - the Department of Health, Public Health England and NHS England as the national level contribution towards the Secretary of State's ambition, for England to have amongst the lowest rates of premature mortality in Europe. It will be reviewed and refreshed annually, taking into account new evidence and potential actions.
- 9.2 The deliverables set out below will provide the basis for an assessment of progress which will be published annually.

AMBITION		For England to have the lowest rates of premature mortality amongst our European peers.		
OBJECTIVES		Establish a common purpose across the new health and care system in its broadest sense to reduce avoidable premature mortality		
		Promote a greater emphasis on prevention and early diagnosis of the biggest causes of premature death		
		Increase transparency and accountability of outcomes across the health and care system of actions to prevent, increase early diagnosis and better treatment of the risks and diseases that cause premature death		
	Owner	Deliverable	Impact	Timing
1	Department of Health	With our stakeholders, NHS England and Public Health England we will use the framework of 'Living Well for Longer: National support for local action to reduce premature mortality' to put a system-wide focus on prevention, early diagnosis and treatment of the 5 biggest causes of avoidable and premature death.	Key partners and stakeholders feel supported to deliver system-wide, joined up programmes to support achievement of the SofS's ambition.	<ul style="list-style-type: none"> • Ongoing • Annual Report: April 2015
1a	Department of Health	Conduct an annual refresh of the delivery commitments included within 'Living Well for Longer; National support for local action to reduce premature mortality.'	National actions continue to be aligned towards reducing premature mortality	<ul style="list-style-type: none"> • April 2015
1b	Department of Health	Publish an annual national report on progress towards the Secretary of State's ambition	Transparency and accountability of national collective actions	<ul style="list-style-type: none"> • April 2015

PREVENTION

	Owner	Deliverable	Impact	Timing
2	PHE	Pilot, evaluate and consider scaling of a health marketing campaign aimed to engage communities and support early diagnosis of high blood pressure .	Increased early diagnosis of high blood pressure; promotion of adult wellbeing and checks	<ul style="list-style-type: none"> • Pilot: March 2014, • Impact headlines: April 2014 • Evaluation: Summer 2014
3	DH	Remove one billion units of alcohol from the market by the end of 2015.	Reduce the strength of alcohol in people's drinks	<ul style="list-style-type: none"> • Update: April 2014 • December 2015
4	PHE	Produce a report for government on the public health impacts of alcohol and on possible evidence-based solutions by end of March 2015.	Contribute to a reduction in alcohol harm.	<ul style="list-style-type: none"> • March 2015
5	DH	'Healthy Lives, Healthy People: A call to action on obesity in England' sets out the national ambition for fewer adults and children with excess weight by 2020	Fewer adults and children with excess weight	<ul style="list-style-type: none"> • Update: December 2014 • On-going
6	PHE	500,000 more families signed up to Change4Life through the <i>10 magic moves</i> and healthy eating <i>smart swaps</i> campaigns.	Fewer children and adults with excess weight and a greater number of physically active adults	<ul style="list-style-type: none"> • <i>10 magic moves</i> - August 2015 • <i>Smart swaps</i> - January 2015

PREVENTION

	Owner	Deliverable	Impact	Timing
7	DH	A year-on-year increase in the proportion of adults who meet the Chief Medical Officers' physical activity guidelines; and decrease the proportion of adults who are inactive (do less than 30 minutes of physical activity a week).	Greater number of physically active adults	<ul style="list-style-type: none"> • December 2014 • On-going
8	PHE	Running Smokefree marketing campaigns that deliver 750,000 quit attempts in 2014/15.	Contribute to the downward trend in smoking prevalence towards 18.5%	<ul style="list-style-type: none"> • April 2015
9	PHE	Support local authorities to increase the number of NHS Health Checks offered to 20% each year and increase uptake towards 66%.	Increased number of eligible people receiving an NHS Health Check.	20% offered each year: March 2015 <ul style="list-style-type: none"> • Towards 66% uptake by March 2015

EARLY DIAGNOSIS

	Owner	Deliverable	Impact	Timing
10	PHE	Complete the second wave roll out of bowel scope screening (with at least 60% of centres to have started by March 2015).	Greater coverage of Bowel scope screening. Expected increase in early diagnosis for bowel cancer	• 60% : March 2015
11	PHE	Run a pilot of Faecal Immunochemical Test (FIT) for bowel cancer screening and evaluate (acceptance rates, sensitivity and costs) during summer 2014.	40,000 kits to be sent out; inform possible roll out	• Results: Spring 2015
12	PHE	Report on the first year of the pilots of Human Papillomavirus (HPV) primary screening (6 sites operating HPV screening in place of cytology).	6 sites offering HPV screening in place of cytology	• Initial results: spring 2015
13	NHS England	NHS England Area Teams to work with PHE and Local Authority Public Health colleagues to address variation in screening coverage.	Create performance 'floors' and take action when these are not met	• Ongoing
14	PHE	Review results from breathlessness pilot campaign and if successful consider regional campaign	Early diagnosis of range of diseases associated with breathlessness	• Campaign results: Autumn 2014
15	NHS England	Increase the percentage of CCGs with confirmed access to scientific and diagnostic commissioning information to 75%.	Enable effective monitoring of rates of early diagnosis in a wider range of CCGs	• March 2015
16	NHS England	Evaluation of Prime Minister Challenge Fund pilots that provide evidence on how to improve access to general practice services and develop more innovative and sustainable models of primary care.	Develop a set of common evidence-based principles for improving access to primary care	• March 2015

TREATMENT				
	Owner	Deliverable	Impact	Timing
17	NHS England	Provide clinical advice and support for CCGs in setting and delivering their levels of ambition for reducing premature mortality throughout the year to March 2015.	Clear articulation of overall contribution of the commissioning system to reducing premature mortality, with a view to ensuring a clear focus on improving outcomes in commissioning plans	• Ambitions published: September 2014
18	NHS England	New CQUIN to encourage screening for co-morbidities in SMI comes on-stream.	Providers financially incentivised to identify and manage co-morbidities in people with psychosis and schizophrenia	• April 2014
19	NHS England	New Quality Premium on PYLL and social deprivation comes on-stream.	CCGs incentivised to reducing inequalities in premature mortality outcomes	• April 2014
20	NHS England	Publication of Proton Beam Therapy (PBT) clinical access policies for routine commissioning.	Define the national mandatory access for extension of the PBT overseas programme and in advance of commissioning the NHS England service in 2018.	• December 2014
21	NHS England	Develop a specific case for acute stroke service reconfigurations in two geographical Locations.	Increase stroke survival rates	• April 2015
22	NHS England	New congenital heart disease review – launch consultation on the new standards and specifications which will inform future commissioning	Improve outcomes for children and adults with congenital heart disease	• Consultation launched: by September 2014 • Commissioning : 2015/16
23	NHS England	Produce an action plan to improve the NHS contribution to prevention through ' making every contact count '.	NHS staff better equipped to provide appropriate behaviour change advice during contact with patients	• March 2015

EARLY DIAGNOSIS/TREATMENT FOR VULNERABLE POPULATIONS

	Owner	Deliverable	Impact	Timing
24	NHS England	Evidence review of interventions to reduce mortality for people with a Learning Disability (LD) completed.	Evidence base assessed for reducing premature mortality in people with a learning disability	• April 2014