

HOW CAN THE NHS
BECOME A WELLNESS
SERVICE?

HOW CAN WE PREVENT
PREMATURE
MORTALITY?

HOW CAN WE PREVENT
CHRONIC DISABILITY OR
REDUCE ITS IMPACT?

WHAT PREVENTION
PROGRAMMES COULD IMPROVE
FINANCIAL SUSTAINABILITY?

The NHS
belongs to
the people

A CALL TO
ACTION

A CALL TO ACTION: COMMISSIONING FOR PREVENTION

NOVEMBER 2013

A call to action: commissioning for prevention



“MEDICAL PROFESSIONALS SHOULD TAKE MORE OF AN ONUS UPON THEMSELVES TO DO THE SOCIAL ASPECTS OF THINGS – THE SOCIAL WORK ALMOST...”

Click the image to view or visit:

<http://www.youtube.com/watch?v=WD-hQ-kciz4>

Executive Summary

Ten things for Clinical Commissioning Groups (CCGs) and their partners to think about:

- 1 NHS England exists to provide high-quality care for all, now and for future generations. Achieving this ambition will require a transformation in the health service. The health needs of the future - especially patients with long-term conditions - and the challenge of closing a funding gap that is estimated at **£30bn by 2020/21**¹ mean that we can't go on with business as usual.
- 2 Commissioning for prevention is one potentially transformative change that CCGs can make, together with Health and Wellbeing Boards and their other local partners. Implemented systematically, the evidence suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term.
- 3 Despite the fact that preventing premature deaths and chronic disability is better for patients and usually very cost-effective compared with waiting for people to become ill, in England it is estimated that we spend only about 4% of the NHS budget on prevention programmes.²
- 4 As part of the **strategic planning process recently outlined by the Chief Executive of NHS England**³, CCGs have been asked to submit five-year plans that will be signed off by June 2014. These five-year plans give CCGs the opportunity to reallocate resources away from acute services and invest in out-of-hospital services including prevention.
- 5 This document sets out a **five-step framework** intended to help CCGs think about how to commission for effective prevention. The first step is to identify and analyse the top health problems working together with local authority Directors of Public Health. **Across the UK, these are ischemic heart disease, lower back pain, stroke, lung cancer and COPD**⁴; in terms of Disability Adjusted Life Years (DALYs) lost; however, local trends and performance should also be analysed if they have not already.

Executive Summary

- 6 A set of common priorities and goals should be based on this analysis of epidemiology and current performance. These priorities should be few, highly targeted and shared with key partners such as Health and Wellbeing Boards, local government, providers and others. They should also be quantifiable so that progress can be regularly tracked.
- 7 Having set priorities, the next step is to identify evidence-based prevention programmes that can deliver them. These should encompass a mix of primary prevention, early detection and secondary prevention activities. Prevention of mental illness and hypertension screening, to take two examples, appear to be particular gaps in many parts of England given the burden of mental ill health, ischemic heart disease and stroke.
- 8 Resources need to be reallocated to fund priority prevention programmes. CCGs should consider the full range of resources available across their health economy, including local government, schools, providers, employers and others. The **Integration Transformation Fund**⁵ may also be deployed to fund joint prevention activities. Crucially, in order to be cash releasing for their area as a whole (rather than simply shifting costs) reallocated funds should be linked to reductions in acute activity and capacity over the medium term.
- 9 To ensure that prevention programmes are delivering results - including reduced acute activity - they need to be measured regularly with a mixture of process and outcomes measures. Innovative approaches should be implemented with an evaluation method in mind from the start. CCGs need the intelligence to assess whether prevention programmes are working and to act decisively if they are not.
- 10 Finally, we encourage CCGs to be bold. We cannot meet the health needs of the future and restore the NHS to an economic sustainability without making deep changes. Transforming the NHS from an illness service into a wellness services - and reallocating resources to do so - is one of the ways in which commissioners can really make a difference.

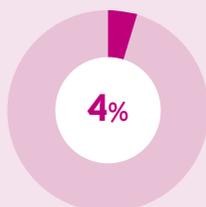
01. The UK performs poorly on several of the most important health problems compared to peers.⁶

Numbers in cells indicate the ranks by country for each cause, with 1 representing the best performing country. Countries have been sorted on the basis of age-standardised all-cause DALYs for that year. Only countries with populations of over 20m are shown here. Causes are ordered by the 20 leading causes of DALYs in the UK. Colours indicate whether the age standardised DALY rate for the country is significantly higher (red) or indistinguishable (blue) from the mean age-standardised DALY rate across the comparator countries, with 95% confidence. DALYs=disability-adjusted life-years. COPD=chronic obstructive pulmonary disease.

■ Indistinguishable from mean
 ■ Higher than mean

	Ischaemic Heart disease	Low back pain	COPD	Stroke	Lung cancer
Spain	3	2	4	9	8
Italy	5	4	3	11	6
Australia	6	3	12	1	4
Canada	11	5	9	3	15
Germany	15	18	8	5	10
France	1	13	2	2	13
Belgium	12	6	16	14	17
UK	13	15	17	13	12
USA	18	1	19	12	16

02. We spend a small amount of money on prevention.



About 4%⁷ of the total healthcare budget is spent on prevention.

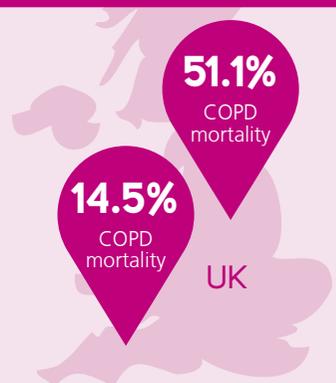


Estimated amount invested on interventions early in life.⁸

03. We could prevent many deaths.

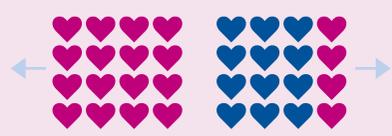
For PCTs in England, the rate of COPD mortality ranged from 14.5 to 51.1 per 100,000 population.

7,800 deaths from COPD could be prevented in England each year if, after adjusting for deprivation, all commissioners reached the top quartile.⁹

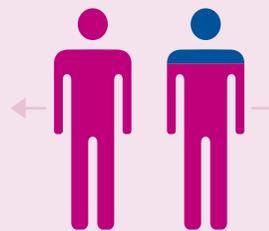
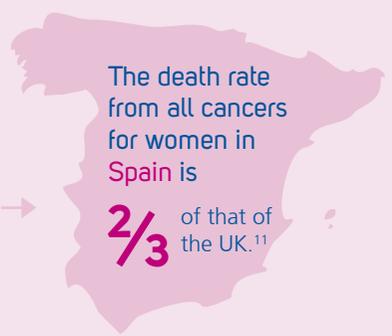


3,700 Is approximately how many deaths from breast and bowel cancer that could be prevented a year if cancer survival in England matched the best in Europe.¹³

Ischaemic heart disease

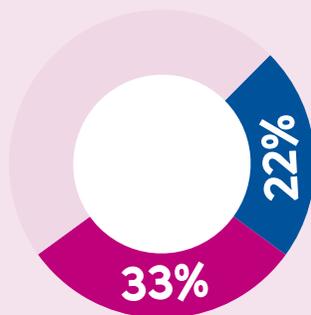


Cancer



04.

We could also prevent chronic disability or reduce its impact on people's wellbeing.



Mental and behavioural disorders (22%) and MSK disorders (31%) account for over half of all years lived with disability in the UK.¹⁴

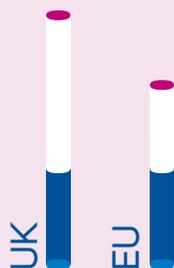
05.

We don't do enough to tackle the underlying risk factors that are associated with premature death and chronic disability.

Cigarettes



UK women, on average, smoke 3% more than the EU average.¹⁵



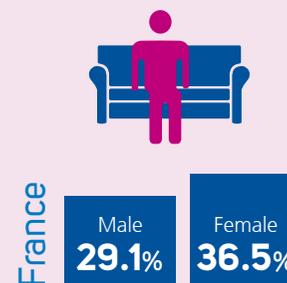
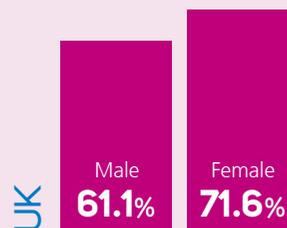
Alcohol

The average consumption of alcohol by adults in the UK is 10% higher than the EU average.¹⁶



Physical Activity

In the UK in 2008, 61.1% of males were estimated to be physically inactive and 71.6% of females.¹⁷



06.

Given the opportunity to improve, CCGs should be thinking about how to reallocate resources to prevention.

It is estimated that if the public were fully involved in managing their health and engaged in prevention activities

£30,000,000,000 could be **SAVED**.¹⁸



6-10%

the annual expected rate of return on investment to be achieved by investing in interventions early in life.¹⁹



Introduction

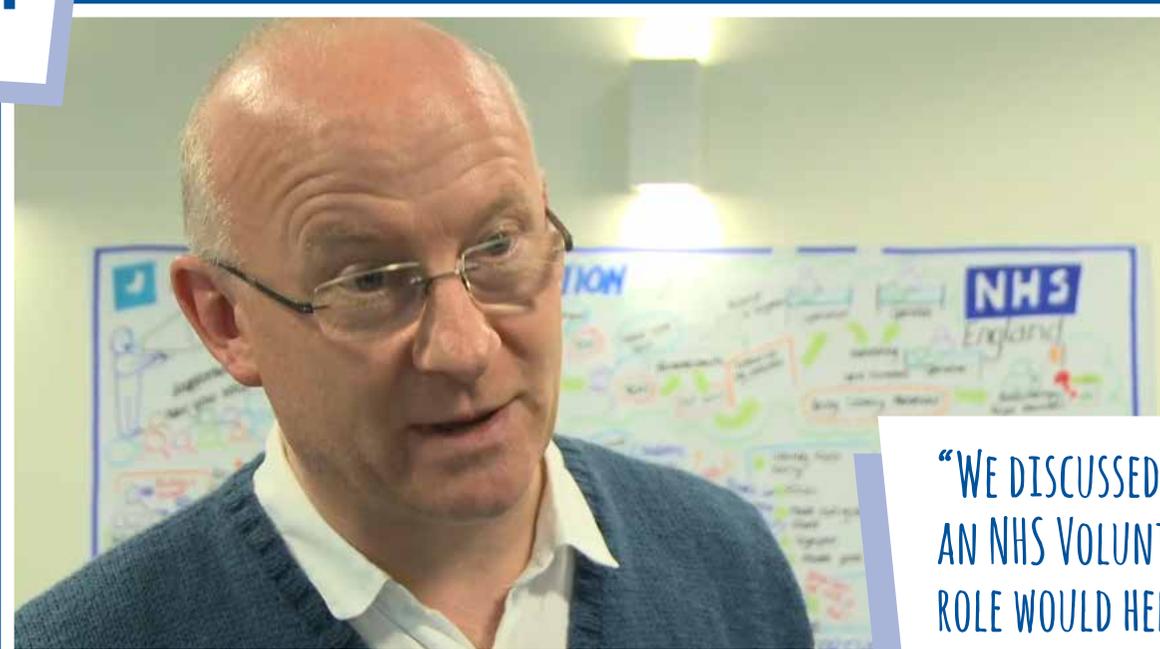
In July **'The NHS Belongs to the People: a Call to Action'** was published to mark the 65th anniversary of the NHS.

It makes the case that the NHS must change to survive, both because people's health needs are changing and because a large and unsustainable gap-projected to be about £30bn by 2020 / 21 - is opening up between the funding the health service can expect to receive and demand for services. The Call to Action is a period of extended debate with patients, the public and the service about how the NHS needs to change to meet these challenges.

As part of the Call to Action, NHS England will be publishing a series of thought pieces aimed at stimulating debate with Clinical Commissioning Groups (CCGs) and their local partners, and to help them think about changes that could be made to significantly improve the value of healthcare provision in England - that is, to improve outcomes at the same or lower net expenditure. This is the first in that series. It is on the subject of how commissioners can allocate greater focus and resources on services that help people to live healthier lives, prevent illness or, when it does occur, diagnose illness early and prevent it from getting worse.

We recognise that different CCGs will be starting from different points, and that the ideas in this document will not be applicable everywhere. This document is not intended to be a complete account of all that can and should be done to prevent illness and premature mortality. Instead, the objective is to stimulate ideas, discussion and debate as CCGs consider what to commission over the next five years. As commissioners, we should be thinking beyond specific interventions alone and identifying the attributes or building blocks that should be in place in a health system that takes prevention seriously.

The case for prevention



Click the image to view or visit:

<http://www.youtube.com/watch?v=EYALIQQuxVw>

“WE DISCUSSED A NEW ROLE IN THE NHS, AN NHS VOLUNTEER COORDINATOR. THIS ROLE WOULD HELP THE NHS INTERACT WITH VOLUNTARY GROUPS AND ENCOURAGE JOINT-WORKING BETWEEN THE NHS AND CHARITIES”

The case for prevention

For years, pundits and practitioners alike have argued that prevention is better than cure. Clearly patients would prefer to avoid getting ill in the first place (primary prevention) or, if they do get ill, ensure that it is diagnosed at an early stage and that arrangements to manage the condition effectively are put in place as soon as possible to allow them to continue living autonomous and active lives (secondary prevention).

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies²⁰ on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence (NICE). And although some interventions take many years to pay-off, others do not - for example, suicide prevention has an immediate impact and effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission. The impact of suicide prevention is immediate.

IN ENGLAND AND WALES, APPROXIMATELY 42% OF THE MORTALITY DECREASE FROM CORONARY HEART DISEASE BETWEEN 1981 AND 2000 WAS ATTRIBUTABLE TO MEDICAL AND SURGICAL TREATMENTS, WHILST ABOUT 58% WAS ATTRIBUTABLE TO THE CHANGE IN RISK FACTORS—SHOWING THAT PREVENTATIVE INTERVENTIONS CAN HAVE A SIGNIFICANT IMPACT OVER THE MEDIUM TERM.²¹

Prevention is also an important way of tackling the persistent inequalities in life expectancy and healthy life expectancy across England. For example, premature mortality rates are two-and-a-half times greater in the areas with the highest rates compared to the areas with the lowest. Not only is reducing this unwarranted variation the right thing to do, CCGs also have legal duties to address inequalities in both access to services and in health outcomes.

Yet nationally, expenditure on prevention is low. Analysis of PCT budgets in 2011/12 suggested that about 3% of expenditure in England is on prevention (about £38 per head), although earlier analysis suggests this may be slightly higher estimated at about 4%²²-when secondary prevention activities are included.

The case for prevention

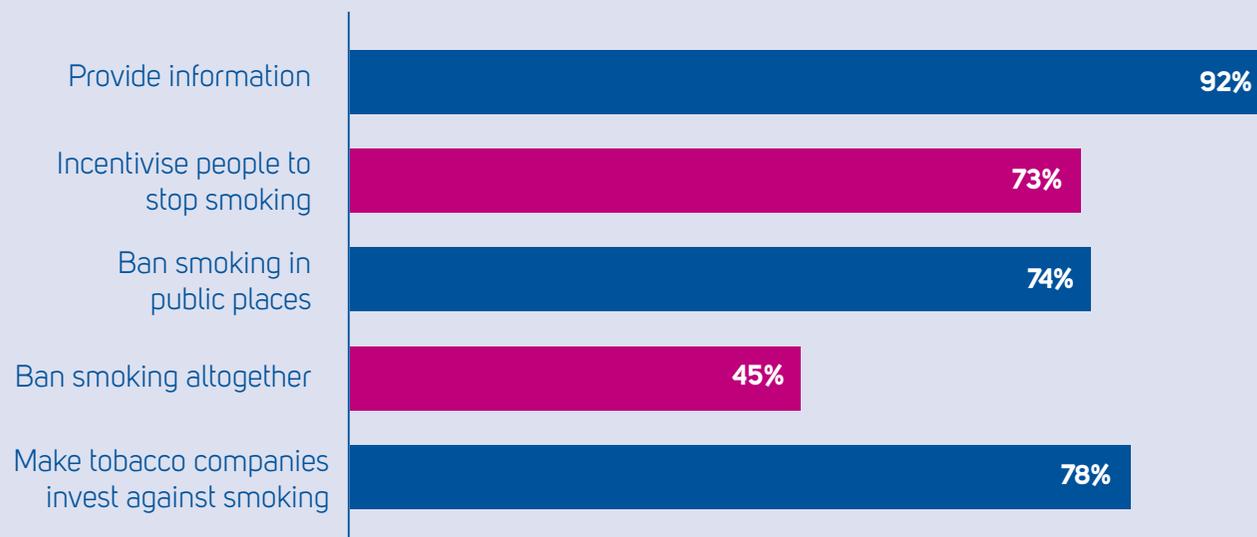
The public understand that prevention needs to become core business for the future NHS. Not only do they think that individuals have a responsibility to look after their own health²³ - about two-thirds of people agree with this - they also strongly support action to enable this; for example, discouraging smoking or unhealthy eating (**See Figure 01**).

So whether on grounds of health need, cost or public expectations the case for developing a wellness rather than solely an illness service is compelling.

The question is how to do it.

Figure 01 - Public support for anti-smoking measures²⁴

What, if anything, do you think the government should do about smoking?



Source = Ipsos Global Advisor

Commissioning for prevention



“WE SHOULD LINK SCREENING AND
PROBLEM IDENTIFICATION SEAMLESSLY
INTO WHAT PEOPLE DO DAY-TO-DAY
AND WHERE THEY ALREADY GO.”

Click the image to view or visit:

[http://www.youtube.com/watch?v=vuqVdF2k050 &t=0m46s](http://www.youtube.com/watch?v=vuqVdF2k050&t=0m46s)

Commissioning for prevention

To respond to the health and economic challenges described in the Call to Action, commissioners, together with Health and Wellbeing Boards, local government, providers and other partners, will be developing plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans.

The Chief Executive of NHS England, Sir David Nicholson, has recently issued a **letter to commissioners**²⁵ describing this process. Commissioners are asked to submit a first draft of their plans in February 2014, with a final draft submitted for sign-off in June 2014. The substantial demand and financial pressures faced over this five year period mean that local plans must include transformative reforms that significantly improve the value of health and care provision as well as more incremental improvements.

In addition, the health services financial settlement for 15/16 includes the creation of an **Integration Transformation Fund (ITF)**. This will see the establishment of a pooled budget of £3.8bn, which will be committed at local level with the agreement of Health and Wellbeing Boards. The ITF creates further incentives and resources to invest in prevention - particularly out-of-hospital services - and early detection. However, it will also require the NHS to make savings of over £2bn in existing spending on acute care.

COMMISSIONING A HEALTH SERVICE THAT PREVENTS ILLNESS IS ONE OF THE TYPES OF TRANSFORMATIVE CHANGES THAT IS NEEDED TO MEET THE CHALLENGES OF THE NEXT FIVE YEARS.

We propose the following framework for moving towards a truly preventative health system.

Commissioning for prevention

Figure 02 - A framework for commissioning prevention

	1 Analyse key health problems	2 Prioritise & set common goals	3 Identify high-impact programmes	4 Plan resources	5 Measure & experiment
Mature	<ul style="list-style-type: none"> Local of analysis of deaths, chronic disability & risk factors in place, with understanding of sub-populations & potential future trends Performance bench-marked nationally 	<ul style="list-style-type: none"> Small set of priorities focused on top health problems Priorities supported by all major players local health economy Priorities are quantified, including early detection 	<ul style="list-style-type: none"> Jointly commissioned primary & secondary initiatives highly focused on risk factors & key causes of morbidity and mortality Early detection initiatives identified 	<ul style="list-style-type: none"> Reallocation is meaningful & phased realistically Innovative use of health economy-wide funding including ITF Investment linked to reduction in acute capacity over time 	<ul style="list-style-type: none"> Outcome & process metrics in place to measure progress on each prevention priority & programme Experimental approaches where evidence base is poor that can be evaluated
Emerging	<ul style="list-style-type: none"> Local analysis of causes of premature deaths, chronic disability & risk factors is in place Collaboration with peers in the area/region to understand relative performance 	<ul style="list-style-type: none"> Priorities are focused on the big problems but set organisation- by-organisation Some key players are not engaged in prevention goals Quantified targets are not yet shared 	<ul style="list-style-type: none"> Isolated primary & secondary programmes driven by different organisations No early detection activities outside nationally mandated programmes (e.g. screening) 	<ul style="list-style-type: none"> Targets for reallocating resources over time established Funding for priorities provided organisaiton- by-organisation; little joint commissioning Plans in place to deploy ITF 	<ul style="list-style-type: none"> Outcome & process metrics in place to measure progress on each prevention priority but tend to be long-term Innovations are difficult to evaluate
At the start	<ul style="list-style-type: none"> Data on premature deaths, chronic disability & risk factors are national only Understanding of performance v peers is anecdotal 	<ul style="list-style-type: none"> Priorities attempt to embrace too much Priorities are driven by legacy activities rather than epidemiology Priorities are not translated into targets 	<ul style="list-style-type: none"> Prevention initiatives are limited to national screening, QOF-driven activities & other centrally driven initiatives 	<ul style="list-style-type: none"> Priorities not backed up by reallocation in resources Funding driven by what's been done in the past rather than future needs 	<ul style="list-style-type: none"> Difficult to measure progress against preventative priorities Measures are very long-term (e.g survival rate) and reactive (e.g. prevalence)

Commissioning for prevention

1 Analyse the most important health problems at population level.

A first step is to understand the major causes of premature mortality and disability locally (where this has not already been done as part of a **Joint Strategic Needs Assessment** or a similar process) now and in the future. This should be done in concert with local government Directors of Public Health, from which CCGs have a duty to seek public health advice.

We have a good understanding of the causes²⁶ of premature mortality and disability, as well as underlying risk factors, across the UK.

Although life expectancy and overall health continues to improve in absolute terms, these data show that the UK (and England) underperforms compared with our peers both in terms of age-standardised premature mortality rates and in terms of years lived with disability. Compared with 19 other countries, the UK has significantly greater rates of years of life lost due to premature mortality for ischaemic heart disease, chronic obstructive pulmonary disease (COPD), lower respiratory infections and breast cancer amongst several other conditions. (The UK does perform better than its peers for patients with other diseases, such as diabetes and chronic kidney disease). There are also significant inequalities within England (see **Figure 03**).

The main causes of chronic disability are different from the causes of premature mortality. They include lower back pain, falls, neck pain, musculoskeletal and mental disorders. By combining premature mortality and years lived with disability into a measure known as Disability Adjusted Life Years (DALYs), we can develop a picture of the most important health problems in the UK. The top five (for all ages) are ischemic heart disease, lower back pain, stroke, lung cancer and COPD (see **Figure 04**).

Commissioning for prevention

Figure 03 - Age-standardised YLLs relative to comparator countries and ranking by cause in 2010 ²⁷

	Ischaemic Heart disease	Lung cancer	Stroke	COPD	Lower respiratory infections	Colorectal cancer	Breast cancer	Alzheimer's disease	Cirrhosis	Self-harm	Other cardiovascular & circulatory	Road injury	Pancreatic cancer	Prostate cancer	Oesophageal cancer	Preterm birth complications	Congenital anomalies	Aortic aneurysm	Non-Hodgkin lymphoma	Brain cancer
Italy	5	6	12	3	1	8	12	5	8	2	2	15	8	1	2	14	11	7	11	7
Spain	3	8	11	7	6	11	3	14	10	3	10	9	1	3	8	7	10	2	5	10
Australia	6	3	2	9	3	14	6	9	3	9	1	14	2	16	9	11	9	10	18	3
Germany	15	10	6	10	9	10	11	3	16	8	16	5	15	7	12	13	6	4	3	4
Canada	12	15	1	11	10	6	10	17	6	14	3	12	6	6	7	16	17	8	19	5
France	1	13	3	1	7	7	14	7	14	17	17	13	7	9	18	6	2	5	8	15
UK	14	12	13	17	18	9	18	11	11	4	14	4	4	11	19	18	16	18	17	6
USA	18	16	5	19	15	3	8	18	15	12	12	18	14	5	10	19	18	11	16	1

- Higher than mean
- Indistinguishable from mean
- Lower than mean

Numbers in cells indicate the ranks of each country for each cause, with 1 representing the best performing country. Countries have been sorted on the basis of age-standardised all-cause YLLs for that year. Only countries with populations of over 20million are shown here. Causes are ordered by the 20 leading causes of YLLs in the UK. Colours indicate whether the age-standardised YLL rate for the country is significantly lower (dark blue), higher (red), or indistinguishable (light blue) from the mean age-standardised YLL rate across comparator countries, with 95% confidence. YLLs=years of life lost. COPD=chronic obstructive pulmonary disease.

Commissioning for prevention

Figure 04 - Age-standardised DALYs relative to comparator countries and ranking by cause in 2010 ²⁸

	Ischaemic Heart disease	Low back pain	COPD	Stroke	Lung cancer	Falls	Major depressive disorder	Other musculoskeletal disorders	Neck pain	Alzheimer's disease	Drug use disorders	Lower respiratory infections	Anxiety disorders	Colorectal cancer	Road injury	Asthma	Breast cancer	Migraine	Alcohol use disorders	Other cardiovascular & circulatory
Spain	3	2	4	9	8	4	7	16	8	15	12	5	1	11	10	2	3	17	3	11
Italy	5	4	3	11	6	7	11	2	15	5	10	1	5	8	15	7	12	18	1	10
Australia	6	3	12	1	4	3	1	17	3	10	17	3	14	14	13	19	6	19	4	2
Canada	11	5	9	3	15	1	6	18	12	17	15	9	3	6	5	15	11	6	7	1
Germany	15	18	8	5	10	9	12	8	7	3	6	10	11	9	6	8	10	4	12	17
France	1	13	2	2	13	15	10	13	5	9	3	8	18	7	14	14	14	3	16	16
UK	13	15	17	13	12	8	2	14	4	7	18	18	15	10	4	18	18	16	10	9
USA	18	1	19	12	16	2	8	19	18	18	19	15	17	3	17	12	9	1	11	13

- Higher than mean
- Indistinguishable from mean

Numbers in cells indicate the ranks by country for each cause, with 1 representing the best performing country. Countries have been sorted on the basis of age-standardised all-cause DALYs for that year. Only countries with populations of over 20million are shown here. Causes are ordered by the 20 leading causes of DALYs in the UK. Colours indicate whether the age standardised DALY rate for the country is significantly higher (red) or indistinguishable (blue) from the mean age-standardised DALY rate across the comparator countries, with 95% confidence. DALYs=disability-adjusted life-years. COPD=chronic obstructive pulmonary disease.

Commissioning for prevention

Finally, local areas should understand the risk factors that underlie many of these health problems. UK-wide the top five are tobacco use, hypertension, high body mass index, low levels of physical activity and alcohol consumption.

CCGs should work with local government Directors of Public Health and Commissioning Support Units to develop a localised picture of these key epidemiological trends.

Public Health England's **Longer Lives**²⁹ website includes local data on major causes of death, the risk factors that lead to these and evidence of effective interventions. It will also be important to understand where CCGs are currently performing better or worse than their peers using tools such as the **Commissioning for Value**³⁰ packs that have recently been prepared and sent to all CCGs.

Figure 06 - Underlying risk factor of physical inactivity associated with premature death and chronic disability



The **CCG Outcomes Tools**³¹ produced by NHS England can also help CCGs understand their relative performance on the indicators that underpin the NHS, Public Health and Adult Social Care Outcomes Frameworks. An analysis of both epidemiological trends and current performance (where comparable outcome data exist) provides a solid basis for prioritising prevention programmes and investment.

Commissioning for prevention

2 Working together with partners and the community, set common goals or priorities.

As obvious as it sounds, we recommend that CCGs think carefully about priorities. Good strategies make choices: they should not attempt to focus on everything at once even if some 'business as usual' activities must nevertheless go on.

Priorities should also be quantifiable. Prevention goals may be expressed in a number of ways: for example, as reductions in the number of years of life lost from treatable conditions or a reduction in preventable acute episodes. CCGs will also

want to consider how to quantify early detection; for example, by modelling expected versus actual prevalence and incidence to identify areas or GP practices that may benefit most from early detection initiatives.³² Tools such as the STAR,³³ developed by the London School of Economics and the Health Foundation, can help CCGs and their partners compare the relative value of health interventions and assist with priority setting.

CCG leaders will also need to invest considerable time ensuring that these priorities are shared.

This is especially the case for preventative activities. For example, working through Health and Wellbeing Boards and with local authorities, schools, housing associations, third sector partners, patient groups and local employers may be critical to effective primary prevention and early detection programmes. Similarly, local health and social care providers will need to be engaged when considering how to commission better secondary prevention. The most effective prevention programmes enjoy a high level of shared ownership.

Commissioning for prevention

3 Identify high-impact prevention programmes focused on the top causes of premature mortality and chronic disability.

Having analysed the main causes of mortality and disability, the next step is to work together with colleagues from across the system - including Directors of Public Health and local government - to understand the range of evidence-based programmes that could address the most important health problems locally.

CCGs should consider commissioning well-evidenced **primary prevention** programmes focused on the key risk factors (see **Figure 07**) where they are not already in place. The cost-effectiveness of smoking cessation initiatives³⁴ is well documented. But prevention programmes in other areas³⁵ are much less common. For instance, despite the fact that 50% of lifetime mental illness (excluding dementia) arises by age 14³⁶ prevention programmes are comparatively rare. And there's also a lot we can do to prevent or intervene early including prevention and early diagnosis of mental

illness, systematic community interventions in schools to reduce childhood obesity, controlling the density of alcohol outlets and working with specialist providers that help people lose weight. More generally, the NHS could support many more people to make healthy lifestyle choices by making every contact with the health service count using brief interventions and other behaviour change approaches.

Figure 07 - Primary prevention programme

For every £1 spent on preventative action



Case study: Weight management in Norfolk

NHS Norwich CCG and Public Health NHS Norfolk and Waveney jointly commissioned a pilot programme with Slimming World as part of the CCG's tier 2 weight management services. Evaluated by the University of East Anglia, at the end of the first 12 weeks the mean weight loss was 5.5kg, with 47.4% of participants achieving 5% weight loss and 9.4% achieving 10% weight loss. Health related quality of life scores had also increased across all dimensions.

Due to the success of the pilot, an interim service has been commissioned whilst a county-wide procurement for tier 2 services is completed. The CCG is also working with Slimming World groups to accredit 60 volunteer community champions and provide easy access to community physical activity programmes.

Source: NHS England

Commissioning for prevention

Case study: Atrial Fibrillation (AF) Detection Programme in NHS Erewash CCG

NHS Erewash CCG has identified the reduction of health inequalities with a specific focus on cardiovascular prevention as one of its key strategic priorities. Clinical leads have introduced an Atrial Fibrillation (AF) detection programme in place of the existing pulse palpation method, using flu clinics and opportunistic screening during routine consultations to test patients aged 65 and over.

Between June 2012 and January 2013, 6,556 people (37% of the relevant population) aged 65 and over were screened for AF, and the percentage of patients diagnosed with AF by GP practices in the area has increased by an average of 7.7%. Analysis suggests that early detection and subsequent treatment with warfarin will have prevented about eight strokes, of which two or three would have been fatal, already saving some £144,000 in acute costs, not to mention both the short and long-term rehabilitation and social care costs.

Source: NHS England

CCGs should also consider what steps they can take to improve **early detection** of health problems. For example, we know that despite having higher rates of hypertension than many other countries, we do less than our peers to control high blood pressure even though it is a key driver of premature deaths from ischemic heart disease and stroke, amongst other diseases.⁴⁰

This is despite a good understanding of how to diagnose and treat most cases of hypertension in a cost-effective manner, before it becomes a source of emergency or acute demand.⁴¹

Similarly, much of England's lower cancer survival rates can be attributed to diagnosing patients at later stages than our peers.

THERE IS SUBSTANTIAL UNWARRANTED VARIATION ACROSS ENGLAND IN WELL-EVIDENCED EARLY DETECTION ACTIVITIES SUCH AS BLOOD PRESSURE CONTROL AND BLOOD GLUCOSE MONITORING. THIS VARIATION TENDS TO REINFORCE EXISTING HEALTH INEQUALITIES.

Source: Public Health England

Commissioning for prevention

Finally, CCGs should consider commissioning **secondary prevention** programmes aimed at preventing the top causes of premature mortality and chronic disability. It is unclear whether systematic programmes are in place across the country to prevent the deterioration of conditions such as musculoskeletal disorders, mental illness, substance use, vision and hearing loss despite evidence that they consume a large proportion of (acute) expenditure.⁴² Several studies have indicated that only a minority of patients benefit from the full suite of interventions recommended by NICE for these and other conditions.⁴³

For example, despite having one of the highest asthma prevalence rates in the world (particularly for children) - and estimates that three-quarters of asthma admissions and 90% of deaths are preventable - NICE's quality standards have not been fully implemented everywhere. NICE calculates that implementation of secondary prevention interventions could save 2-2.5% of what is spent on asthma by the NHS each year (approximately £1bn⁴⁴).

ONLY A QUARTER OF ADULTS WITH
ASTHMA HAVE A SELF-MANAGEMENT
PLAN EVEN THOUGH PATIENTS WITHOUT
A PLAN ARE FOUR TIMES MORE LIKELY TO
HAVE AN ASTHMA ATTACK REQUIRING
EMERGENCY CARE.

Source: NICE

Commissioning for prevention

4 Plan the resource profile needed to deliver prevention goals.

A meaningful strategy entails choices about how resources will be committed in the future to deliver on priorities or goals. As the **Call to Action** makes clear, the NHS should not expect more than a flat real-terms funding settlement (i.e. no increase above inflation) over the period of the next Parliament at least. Instead, CCGs will need to consider allocating their resources differently - investing more in prevention by shifting some resources away from acute provision.

We know there is wide variation in what different areas expend on the same 'programme budget' or health problem, even after the data are standardised for age, sex, deprivation and so

on. For instance, in the financial year 2008/09 - 2009/10 the amount spent by different Primary Care Trusts on cancer inpatients varied nearly 2.5 times (weighted for age, sex and need) across England.⁴⁵ This suggests there is considerable scope for reallocating resources without reducing quality or outcomes. The recently produced **Commissioning for Value** packs will assist CCGs to identify in which programme budget areas they are outliers compared to CCGs with similar populations and deprivation.

CCGs will also want to consider how they can leverage the full range of resources to fund prevention priorities. The **Integration**

Transformation Fund creates a pooled budget that can be deployed with the agreement of Health and Wellbeing Boards to invest in prevention - particularly out-of-hospital services - and early detection. However, it is also likely that existing budgets controlled by other local partners could be deployed more effectively - be they schools, local government, local business or health and care providers. To facilitate this collaboration, CCGs may wish to consider contracting approaches that enable risk and resource sharing.

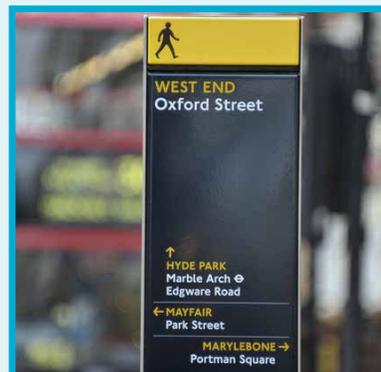
Commissioning for prevention

Case study: Legible London ⁴⁶

Many people are put off walking around cities and towns because they do not know the way, signage is inconsistent and distances aren't easily identifiable. Based on extensive research, Legible London helps Londoners choose walking over public or private transport by presenting 'wayfinding' information in a range of media, including on maps and signs. The initiative aims to improve population health by supporting residents to choose walking over public or private transport, but also to reduce vehicular congestion and air pollution. Used in other cities around the world, 62% of interviewees stated that the new system would encourage them to walk more and 91% of interviewees stated that the system should be rolled out across the capital.

Although its health outcomes have not yet been established, we do know that even relatively small increases in physical activity can have a significant health impact. This is also an example of the type of initiative that can only be implemented with close collaboration between different public services.

Source: <http://www.tfl.gov.uk/microsites/legible-london/>



Finally, it is crucial that reallocation of expenditure to fund prevention programmes is linked with a reduction in acute activity and capacity in the medium-term. Prevention programmes may reduce demand for expensive acute services, but in order to be cash releasing for the health economy as a whole (rather than simply shifting cost from commissioner to provider) they should also be linked to planned reductions in acute capacity. This, of course, is difficult to achieve. But given the scale of the challenge ahead it is critical that CCGs five-year plans contain steps for reducing acute capacity expenditure.

Commissioning for prevention

5 Measure impact and experiment rapidly.

CCGs WILL NEED TO EXPERIMENT RAPIDLY. THIS MEANS ENSURING THAT SUCCESS CAN BE EVALUATED QUICKLY ENOUGH TO ADAPT PROGRAMMES WHERE THEY ARE NOT WORKING – OR SCRAP THEM IN FAVOUR OF MORE EFFECTIVE ALTERNATIVES.

To ensure prevention programmes are working - not least to reduce acute expenditure - they should be measured using a mix of process, outcome and cost-effectiveness metrics. Where the evidence or impact of programmes is uncertain, CCGs and their partners should consider implementing them with a research or evaluation design in mind from the beginning. For example, a number of prevention initiatives have been implemented in such a way as to enable randomised control trials (RCTs) to be done.

Although regarded as the gold standard, RCTs are not the only robust way to evaluate interventions:

they may be impractical, too expensive or too long-term - in which case there are a number of alternative approaches.⁴⁷

CCGs will need to experiment rapidly. This means ensuring that success can be evaluated quickly enough to adapt programmes where they are not working - or scrap them in favour of more effective alternatives. One reason we have not historically been good at prevention is that our knowledge is patchy and incomplete, so it is essential that CCGs have the room to innovate whilst at the same time being ruthless about measuring results.

Questions for CCGs and their partners



Click the image to view or visit:

<http://www.youtube.com/watch?v=vuqVdF2k050&t=2m8s>

“WE NEED TO EMPOWER COMMUNITY GROUPS TO TRANSFORM SERVICES. LONG-TERM CONDITION GROUPS, SUCH AS DIABETES, CAN DELIVER MORE RELEVANT CARE FOR PATIENTS WITH A LONG-TERM CONDITION.”

Questions for CCGs and their partners

The NHS needs to transform to survive. Health needs arising from long-term conditions are threatening to overwhelm the NHS. At the same time, public resources are likely to be highly constrained for many years to come leading to a £30bn funding gap by 2020/21. If we are to tackle the trends that drive this dire economic forecast, the NHS must get much better at preventing premature mortality and chronic disability.

This thought-piece has outlined an approach CCGs could take to commissioning for better prevention. It is intended to help CCGs as they develop their own five-year strategies, in line with NHS England's strategic planning process. As CCG leaders develop their plans, we encourage them to ask three key questions:

1

Have you analysed the key causes of premature death and chronic disability locally and set commissioning priorities that address them?

2

Are your priorities genuinely common - are they shared with other local players such as Health and Wellbeing Boards, local government, providers, patients and the public?

3

Have you planned a future resource profile that enables you to reallocate funding to high-impact prevention programmes and, as a consequence, to reduce acute capacity over the medium term? Are you leveraging the full range of resources from across the health economy?

For more information, or to discuss these ideas with the Strategy Unit at NHS England, please contact england.calltoaction@nhs.net.

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