Equality and Diversity Council, 9 October 2018
Template for Focus On Session

Template tips and suggestions

• Content provided in this template will be used to guide EDC discussions on the Long-Term Plan workstream.

• Feel free to amend the font size for your content, but remember to make sure that it is large enough to be read when printed. The minimum recommended font size is 18.

• You may wish to complete more than one template if the Long-Term Plan workstream covers a number of different elements (e.g. Cardiovascular Disease and Respiratory).

• Completed templates will be shared with EDC members, guests and the secretariat in confidence. As the content represents policy in development the information will not be published on the EDC webpages.

Prevention, Personal Responsibility and Health Inequalities

Where are we now?

Almost 40% of the disease burden in England is due to preventable risk factors, such as tobacco, alcohol, obesity and high blood pressure. Over 75% of deaths from Cardiovascular Disease (CVD) and almost 50% of deaths from Cancer, the two main causes of death, are linked to preventable risk factors.

England's disease burden does not compare well internationally:

- England has the 7th largest smoking-related disease burden when compared to 19 other high-income countries
- The UK is ranked amongst the worst in Europe for obesity rates for both children and adults
- The UK sits among the group of European countries where liver disease is on the increase while countries with historically high level of alcohol consumption, such as France and Italy, have steadily reduced liver disease

Comparisons between the regions of England demonstrate the potential for reducing the disease burden through prevention/tackling risk factors:

- The disease burden from smoking in the worst performing region is over twice that in the best performing region
- The burden for obesity is over 50% higher and the burden for alcohol 25% higher.

The radical upgrade in prevention envisaged in the FYFV has not yet materialised. The FYFV called for increased investment in primary and community care and yet since its publication the percentage of NHS resources spent in the acute sector has increased. The culture in the NHS is only beginning to embrace prevention and a pro-active focus on identifying and tackling health risks.

Where do we want to be?

To improve health life expectancy and reduce demand on the NHS it is not enough to offer excellent care when people approach the NHS with a problem, we need to be proactive in identifying people who are at risk of becoming ill and supporting them in reducing these risks.

On smoking, we want the NHS to make a significant contribution to delivery of a smoke free society (less than 5% prevalence) by 2030 by supporting over 1,000,000 people to stop smoking over the next 10 years. In 2017, 17% of men and 13% of women smoked (approximately 7.4 million adults in the UK).

On obesity, the NHS should support the national ambition to halve childhood obesity by 2030 and do more to reduce the health harm caused by obesity in the current population which is already putting significant pressure on NHS services.

On alcohol, the NHS should aim to significantly reduce alcohol-related harm and demand on the NHS, as measured by a reduction in alcohol-related admissions.

How will we get there?

Smoking:

- A national-wide rollout of the **CURE model** (developed in Greater Manchester): delivery of between 30-50% quit rates based on identification of current smokers, very brief advice, 1:1 specialist advice, prescribing nicotine replacement therapy and pharmacotherapy (where appropriate), support while in contact with NHS services and post-discharge follow-up to provide support prior to an appointment to verify the quit attempt.
- A national **BabyClear model**, building on work from the North East and Greater Manchester and follows the same underpinning principles of the CURE model, but delivered with a greater level of intensity to support the mother and unborn baby. It entails identifying and offering very brief advice to women who smoke at booking, specialist 1:1 advice and a weekly follow up routine to maintain momentum and support.

Obesity:

- A universal offer of brief advice and signposting to appropriate services
- A voucher scheme to ensure key targets such as postnatal women, low income and BME groups can access tier two services where these are currently not available or unaffordable for these groups;
- Ensuring Tier 3 services are available across all CCGs by 2024/25.

Alcohol:

- Alcohol intervention and brief advice (IBA) in primary care for people with conditions for which alcohol is a contributory risk factor.
- Routine BA in secondary care.
- Alcohol care teams (ACTs) in District General Hospitals

Prevention, Personal Responsibility and Health Inequalities

Where are we now?

1. Lack of clear system leadership leading to fragmented approach to delivering improvements, no clear system or programme aspirations or trajectory.

2. Inequalities in life expectancy and healthy life expectancy are nearly all worsening, with significant variation in trends across England.

- Healthy life expectancy at birth among the most deprived males in England was 51.9 years, compared with 70.4 years among the least deprived, almost two decades of life in "Good" health less. For females the figures are 51.8 years and 70.7 years respectively,

According to Global Burden of Disease

- CVD makes up 45% of the burden of disease in the most deprived areas and CVD, cancer, diabetes, respiratory disease and mental health make up a 90% of the total burden.

3. Not making best use of the NHS £ and NHS as anchor institutions
4. Contractual leavers and incentives not aligned to drive delivery

Where do we want to be?

As we improve outcomes for all, we improve them fastest for the poorest and most disadvantaged in society, helping to narrow the gap.

Reverse the negative trends and reduce the significant differences between the most and least deprived areas in life expectancy and healthy life expectancy and also in marginalised groups

Use NHS £ to best effect: through employment opportunities, volunteering, work experience and apprenticeships in disadvantaged communities where the NHS is a major economic force.

Continue to build on good evidence base of what works

All local areas and programmes to have evidence of the progress they have made in narrowing the gaps they faced in 2018.

More systematic approaches to prevention and case finding

Clinical programmes with clearly articulated ambitions in relation to health inequalities

Funding allocated representative of need

7 Principles of public life

How will we get there?

Clear system leadership with a national ambition, the development of national /programme specific metrics to support a mix of local services to meet a diversity of local need.

Secure strategic alignment between different components of the Long Term Plan to address health inequalities including clinical programmes, primary care and other key programmes

Support localities integrated systems by:

i. agreeing data sets and measures, and effective use of collective analytical resources .
ii. allocating resources, an developing appropriate incentives
iii. adding value through programmes to share notable practice, increase knowledge and capability

Helping general and dental practice and staff in other clinical areas become more inclusive for patients who face the biggest barriers to access, such as homeless, Gypsy, Roma and Traveller and other groups.

Funding a support programmes and piloting new and innovative interventions for groups like homeless, gypsy and Roma travellers and other groups

Work with anchor institutions testing and extending knowledge on NHS as anchor institutions in their diverse communities and spreading the learning across the system.

Prevention, Personal Responsibility and Health Inequalities

Where are we now?

We are living for longer with more complex health and care needs. People with one or more long-term condition now make up 30% of the population and account for at least 70% of NHS spend.
Similarly, they utilise 50% of all GP appointments, 64% of all outpatient appointments, and occupy 70% of hospital beds.
By 2035 two-thirds of adults are expected to be living with multiple health conditions with 17% expected to have four or more conditions.
we need to move swiftly toward "fully engaged scenario", and place a strong and clearer focus upon what people can do for themselves.
Progress in empowering people to take control of their own health is evident and a quarter of patients – 14.6 million – in England are now registered to securely book hospital and primary care appointments, order repeat prescriptions, view their patient records and see their test results without having to phone or visit their clinician or GP surgery, creating efficiencies, easing pressure on clinicians and freeing up contact time for those who really need face to face support.

The majority of those who are not 'activated are ready, with just a little support from existing digital initiatives, to manage their own health , access online services and even harness readily available technology to measure and monitor their blood pressure and other 'vital signs', giving them access in an instant to health information that was previously only available via an appointment with a clinician.

A relatively small number people, clustered, on the whole, in less than half a dozen marginalised groups or communities * consider themselves to be not well served by the NHS. These groups face significant barriers to GP registration, are living with poor health and consequent lower than average live expectancy, compounded with high levels of mistrust of mainstream health professionals alienation.

Where do we want to be?

We want a future where everyone will be enabled to be "fully engaged" in taking responsibility to maintain and improve their health, accessing and using services appropriately and taking control of aspects of their healthcare management, with a clearer focus upon what they can do for themselves, as well as what the NHS can help them with, in order to realise the benefits that this will bring for patients, the public and the NHS.

We want to scale up the effort of existing digital programmes to empower and support people with complex health needs to take more control of their health and wellbeing. Still less than 50 % of adults living with long term conditions feel they have the knowledge , skills and confidence to manage their health and wellbeing on a daily basis.

Evidence shows that people who have the highest knowledge, skills and confidence have 19% fewer GP appointments and 38% fewer A&E attendances than those with the lowest levels of 'activation'. We need to have identified those who are ready, with just a little support, to manage their own health, in particular, through promoting online services and harnessing digital and readily-available technology to measure and monitor 'vital signs' such as blood pressure and BMI, this accessing, in an instant, information which was previously only available via an appointment with the GP or consultant.

Disadvantaged communities for example 'health champions in disadvantaged communities, such as Irish Travellers, are helping to spread health promotion messages in appropriate ways, seeing uptake of vaccinations and health checks and adaptation of behaviour in areas like breast feeding.

How will we get there?

We need to focus efforts on our cluster of identified groups and communities who face stark inequalities in access to , outcomes from and experience of health care and implement a community health champion programme which has proven efficacy in providing bespoke and intensive support which improves confidence and health literacy within marginalised communities which in turn enables them to have choice and capacity to share responsibility for managing their health and wellbeing and avoiding inappropriate and unplanned service use. (PHE, Institute of Health Equity / Sir Michael Marmot , evidence study , 2015)

Questions/Issues for the EDC

1. Does the EDC agree the priorities for the health inequalities workstream?
2. How can EDC member organisations support delivery of the plans?
3. How can we help support the system to deliver on the recommendations?
4. Are there any lessons learned from the development of the ‘NHS Five Year Forward View’ that we should take into account?
5. How can the EDC member organisations facilitate cross-system alignment on the implementation of our proposals?
6. Does the EDC agree that this scheme has the capacity to radically tackle health inequalities and low levels of confidence and health literacy/ knowledge of the NHS in marginalised communities, in accordance with the Marmot evidence base?