Cardiovascular Disease

Where are we now?

In England, cardiovascular disease (CVD) is the second highest cause of premature death. It affects 7 million people, causes 1 in 4 premature deaths and 1.6 million disability-adjusted life years. CVD is also a key driver of health inequalities, accounting for 27% for men and 24% for women of the life expectancy gap between rich and poor with premature death rates being three times higher in the most deprived populations.

People in lower socio-demographic groups are more at risk of multiple behavioural risk factors. As much as 85% of CVD is preventable by modifying risk factors.

There is considerable international variation in performance on diagnosis and treatment rates, and in the management of risk factors through primary prevention. NHS performance on diagnosis and treatment falls considerably short of comparative countries like Canada and the United States.

Whilst significant gains were made in CVD mortality between 1990 and 2010, this improvement has slowed recently, and the CVD burden curve has flattened, presenting a significant opportunity to improve this through improving prevention, diagnosis and treatment.

Where do we want to be?

If the NHS aspires to become the best health system in the world over 10 years, it must transform its outcomes on CVD.

The 2017 Commonwealth Fund rankings on health care outcomes place the UK 10th out of 11. This is predominantly due to low 30 day survival scores for heart attack, stroke, and mortality amenable to health care.

Modelling the impact on mortality from heart disease and mortality from stroke in relation to the proposed key interventions and triangulating these with trends in other countries shows that an 18% reduction in heart disease deaths and a 25% reduction in stroke deaths should be possible.

How will we get there?

International evidence points towards three major areas to reducing risk factors to keep people healthy and to optimise care through improved identification and treatment. A three-part strategy is proposed:

1. Optimising care by maximising diagnosis and treatment
2. Minimising individual risk factors through targeted NHS interventions
3. Minimising population risk through regulatory interventions

The interventions proposed to deliver these goals are:

- At scale interventions in primary care networks to optimise treatment in people with already diagnosed atrial fibrillation, high blood pressure and high cholesterol
- At scale interventions to mobilise communities and increase detection of undiagnosed atrial fibrillation, high blood pressure and high cholesterol
- These interventions focused on the high risk conditions will be enhanced with support for multiple lifestyle risk factor behaviour change.

Questions / discussion points for the NQB

- Are the interventions proposed for the long-term plans the correct ones to be developed?
- Are the interventions likely to be achievable?
- Is there a workforce available/potentially available to deliver the interventions?
- Have we missed anything from the proposed plan?
- Is there anything that should be taken out of the proposed plan?

Prevention, Personal Responsibility & 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 (Identification and Brief Advice) in primary care for people with conditions for which alcohol is a contributory risk factor.
- Routine brief advice in secondary care.
- Alcohol Care Teams (ACTs) in District General Hospitals

Prevention, Personal Responsibility & 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 life expectancy, compounded with high levels of mistrust of mainstream health professionals.

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, accessing in an instant, information which was previously only available via an appointment with a 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. We propose to 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. This will enable these communities to have choice and capacity to share responsibility for managing their health and wellbeing and avoid inappropriate and unplanned service use. (PHE, Institute of Health Equity, Sir Michael Marmot, evidence study, 2015).

Prevention, Personal Responsibility & Health Inequalities

Where are we now?

1. Lack of clear system leadership leading to a 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 levers 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 the 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.

- Holders of public office act in accordance with the 7 principles of public life.

How will we get there?

- Clear system leadership with a national ambition and 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:
  - agreeing data sets and measures, and effective use of collective analytical resources;
  - allocating resources and developing appropriate incentives; and
  - adding value through programmes to share notable practice, increase knowledge and capability.

- Help 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 groups.

- Fund a support programme and pilot new and innovative interventions for groups such as homeless, gypsy, Roma and traveller groups.

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

Questions / discussion points for the NQB

1. Does the Board agree the priorities for prevention, health inequalities and personal responsibility workstream?

2. How can NQB 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 Board facilitate cross-system alignment on the implementation of our proposals?

6. Does the Board 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?

Respiratory Disease

Where are we now?

Respiratory disease affects 1 in 5 people and is the third biggest cause of death in England. The recorded prevalence for both COPD and asthma have been growing slowly, and mortality rates for respiratory disease have been progressively increasing from 63,000 deaths in 2011 to 69,000 deaths in 2015.

Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally.

Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes.

International evidence shows that the UK scores poorly on outcomes related to respiratory disease; in 2010 the UK was ranked worst out of 27 member countries of the Organisation for Economic Co-operation and Development (OECD).

Where do we want to be?

The long-term vision for respiratory disease is for the NHS in England to have the best outcomes for respiratory disease that is equal to or better than international counterparts.

The proposal aims to achieve the following:

- Every person with respiratory disease to receive an accurate diagnosis supported by a spirometry reading
- Every person participating in an NHS Health Check will be assessed for lung health
- Cancer Lung Health Check pilot sites to incorporate respiratory diagnostics
- Expansion of pulmonary rehabilitation services
- Education programmes for patients diagnosed with respiratory disease
- Medicine optimisation (including correct medicines for respiratory conditions and every person prescribed an inhaler to be shown correct technique)
- Reduction in community acquired pneumonia and associated hospital admissions
- A focus on winter pressures and improvement management of respiratory patients in acute settings

How will we get there?

Three thematic areas have been identified to improve outcomes over the next 10 years in respiratory disease care. These areas are:

1. Early detection and accurate diagnosis
2. Optimal treatment, including empowering patients to self-manage
3. Improved management of respiratory patients in acute settings, particularly during winter

The proposal relies on a population management approach to case-finding, diagnostic hubs within primary care networks, clinical pharmacists in general practice, digital options to supplement pulmonary rehabilitation, and supported self-management.

It also recognises that some of the biggest gains to health outcomes can be found in smoking cessation, which is being taken forward by the Prevention workstream.

Questions / discussion points for the NQB

- Are the interventions proposed for the long term plan the correct ones to be developed?
- Are the interventions likely to be achievable?
- Is there a workforce available/potentially available to deliver the interventions?
- Have we missed anything from the proposed plan?
- Is there anything that should be taken out of the proposed plan

Clincial Review of Standards

Where are we now?

- Standards have delivered change across the system.
- Standards have been a hurdle when implementing change (suspension of sanctions).
- Previous reviews on a case-by-case basis.
- Take the opportunity for a systematic review and ensure standards remain:-
    - Clinically relevant; and
    - Work for patients.

Review to look at:

Cancer Standards:
- A new faster diagnosis standard of 28 days being monitored from 2020.
- Performance is mixed across the current standards.

Mental Health Standards:
Standards currently focus on:
- Early Intervention in Psychosis.
- IAPT Access thresholds.
- Accessibility of eating disorder services.

RTT Standards:
- RTT list size is at 2007 levels.
- 52 wk waits increasing.
- 18 wk RTT performance slipping.

Urgent & Emergency Care Standards:
- 4hr standard seen to be A&E and not the responsibility of the wider UEC system.
- Overall performance is falling against the 4hr target.
- 94% of patients with minor conditions spend less than 4 hours in A&E.
- 23% of zero length of stay patients wait 4 hours before they are admitted.

Where do we want to be?

Ambition is to have a suite of standards that are:
- Focused on safety and outcomes.
- Prioritising those most in need.
- Support the changing landscape.
- Clinically relevant.
- Meaningful and work for patients.

Developing thinking around the extent to which standards should be:

- What is their intended use (performance / patient information / clinical reference / contractual)?

- Level of stretch – should they be minimum acceptable levels, set the ambition, be a mixture?

- Breadth of measures – should there be a single / couple of high level standards or a range of measures?

How will we get there?

Options are being developed for consideration within each of the four domains.

Proposals include:

- Minimum standards.

- Trajectories setting levels of ambition.

- Composite assessment across a suite of measures.

- Increasing breadth of standards to a wider range of issues.

Views are being sought from wide range of stakeholders. Timescales for next steps will be determined once proposals have been narrowed down.

Costing and modelling of impact of any changes across the system will be critical.

Questions / discussion points for the NQB

1. How meaningful are current standards to patients and the public?

2. What purpose should standards meet? Are they aspirational, a driver for change, minimum acceptable levels?

3. Urgent & Emergency Care – transition from a single headline figure to a suite of standards across a pathway.

4. RTT – increase clinical responsiveness and align more closely to a patient's experience of the pathway.

Healthy Childhood & Maternal Health

Where are we now?

Children and young people (CYP) aged 0 to 24 years make up **30%** of the population of England. Infant mortality rates, are amongst the highest in Europe at **30% higher than median EU15+**, and have plateaued at 3.9 deaths per 1,000 live births year (2,651 deaths in 2016) for the third consecutive year. Without action, UK infant mortality rates could be 140% higher than other comparable countries by 2030.

We know that 60% of child deaths occur during the first year of life, and **70% of those are in the neonatal period.** Conditions consequent on preterm birth are the most common cause of death in infancy, such as perinatal conditions and congenital abnormalities, with poverty and disadvantage a major contributory cause of preterm birth and low-birthweight.

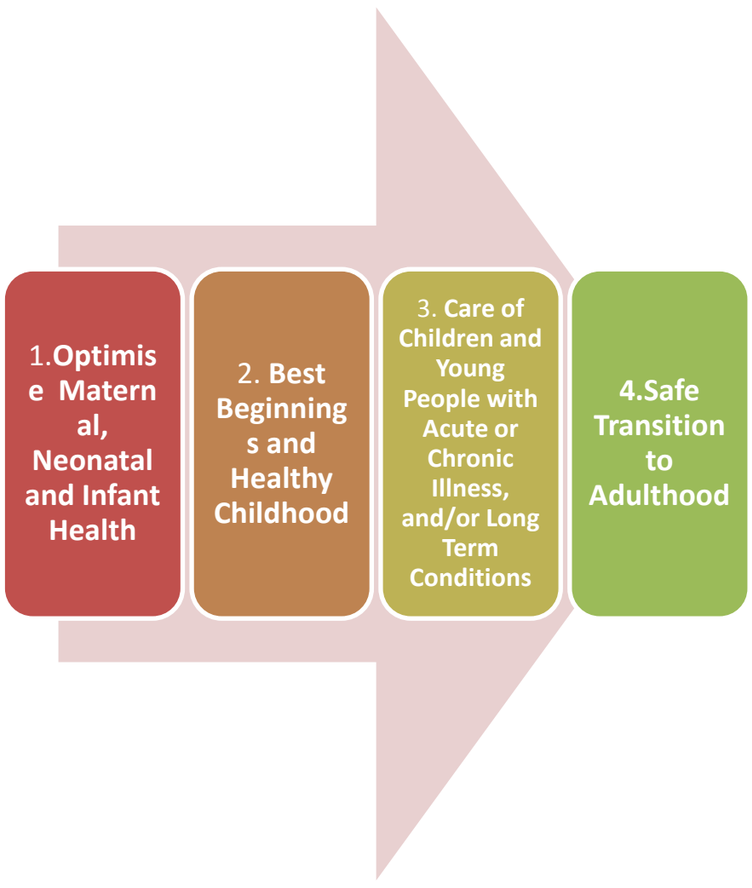
There are a number of maternal health related issues to address, such as smoking and obesity in pregnancy, resulting in a higher risk of poor birth outcomes. Furthermore, we know at least 20% of women experience a **mental health problem** during pregnancy or within the first year after having a baby.

For older CYP, the UK has higher 'medical' i.e. non-communicable disease and communicable disease mortality than the EU15+ average, and higher mortality than comparable Western countries in common infections (e.g. sepsis, meningitis) chronic respiratory conditions such as **asthma and in epilepsy.**

The outcomes for children and young people living with **long-term conditions** in England are mediocre or poor by comparison with other wealthy countries . **Cancer** remains the most common cause of death for children aged 1 to 15 years, accounting for 20.6% of deaths in 2016.

Where do we want to be?

We propose to unite the Maternal, Neonatal, Infant, Children and Young People's Physical and Mental Health and Well-being Agenda's under a whole Life Course approach.



Retaining the triple aim to **reduce maternal and neonatal mortality and stillbirths**, we are suggesting a **National Transformation Programme** which extends the successful Maternity Transformation programme to incorporate Children and Young People.

The approach needs to be a **digitally enabled life course approach** enabling us to influence health behaviours, to implement better prevention and early intervention which will improve **physical and mental health.**

How will we get there?

We have identified the following key issues in each life course phase:

- Optimise Maternal, Neonatal and Infant Health: Starting at the beginning with Better Births for every woman by improving maternity services England , better neonatal care to ensure the right birth happens in the right place with the right level of healthcare support and services.

- Best Beginnings and Healthy Childhood: To give children the best start in life by ensuring their emotional, physical and developmental need are met, and those who have language deficits are supported to close this gap and be school ready. This can in some part be addressed by working with cross-system partners to acknowledge the effect of the social determinants of health - poverty, inequality and social disadvantage

- Care of children and young people with acute or chronic illness and for long-term conditions: Ensuring that NHS care for children and young people is safe, effective and efficient and that meets their needs.

- Safe transition to adulthood: This involves robust Transition from child-centred to adult-delivered services, with the young person at the centre of the process, taking ownership of their condition, leads to a safe Transition and makes health economic sense.

Much of this will involve **change to system architecture** and the developments of new and **innovative care models**. These are integrated vertically, horizontally, with services outside of the NHS, and which are networked to achieve maximum benefit. This needs to be delivered by a **workforce** with dedicated paediatric skills and knowledge driven and led by a national transformation programme.

Questions / discussion points for the NQB

We want to build on the success of the 'NHS Five Year Forward View' and programmes such as the Maternity Transformation Programme Board to propose a life course approach that involves fundamental system architecture change and new integrated approaches to caring for Children and Young People.

- What do the group think are the key mechanisms/platforms for enabling the improvement and integration of clinical care pathways for Maternity and CYP? i.e how can STP's ICS's, PCNs and regulators shape and embed new models of care?
- What does the system require in terms of leadership to improve clinical quality outcomes for Maternity and CYP?
- What levers can be used to drive quality improvement through a life course approach, across the health care, social care and public health systems
- What are the potential obstacles that could stop the long term plan from improving the care the NHS from a systems and quality perspective?
- How do we tackle workforce shortages and encourage paediatric training/upskilling? eg. neonatal nurse and health visitor shortfalls, providing GP's, pharmacists etc with additional Paediatric skills.