NHS England Board meeting

Paper Title: NHS Prevention

Agenda item: 7 (Public session)

Report by: Professor Sir Stephen Powis, National Medical Director

Paper type: For approval

Organisation Objective:

NHS Mandate from Government	☐	Statutory item	☐
NHS Long Term Plan	☒	Governance	☐
NHS People Plan	☐		

Executive summary:

Covid-19 has resulted in significant additional demand and excess mortality, including non-Covid excess mortality.

In an effort to address and reduce this trend, NHS England undertook a rapid review, with the Chief Medical Officer for England, of programmes and initiatives across NHS England that broadly contribute to secondary prevention.

The review found:

(i) There is a strong evidence base behind the interventions NHS England already delivers as part of its LTP programmes;
(ii) While central commissioning of certain preventative interventions provides value for money, engagement of communities has to be led locally;
(iii) There is a need for a greater focus on identifying and supporting people who are not currently engaging with services until they are in poor health.

This paper sets out proposed recommendations to start to embed a coherent and evidence-based approach to prevention across local partnerships, with the NHS playing a much stronger role in this agenda than it has done historically.

Action required:

The Board is asked to approve our recommendations that:

(i) NHS England should extensively engage ICSs to work out how best to prioritise secondary prevention, and the best ways of achieving improvements in health locally
(ii) ICSs should be supported to prioritise secondary prevention as part of their strategic plans, and;
(iii) To support local planning NHS England should publish a tool summarising the highest impact interventions and supportive resources relating to the prevention and management of respiratory disease, CVD and diabetes.

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Background

1. During the last century life expectancy at birth increased steadily and, as the prevention and management of infectious diseases improved, the causes of poor health changed. Non-communicable diseases, such as cancer, cardiovascular (CVD) and respiratory disease are now the leading cause of death in adults[1].

2. In recent years these improvements in life expectancy have stalled[2]. This trend started prior to the Covid-19 pandemic and single year life expectancy estimates indicate life expectancy *decreased* in 2020[3]. Similarly, healthy life expectancy (the average years of life lived in good health) is no longer improving[4] and there are particularly stark disparities in the number of years people can expect to live in good health between different areas of the country[5].

3. Analysis suggests that 42% of the burden of poor health and early death in England in 2019 could be attributed to known modifiable risk factors[6]. Tobacco, diet and alcohol make up the majority of preventable risks contributing to the burden on non-communicable disease. The prevalence of modifiable risk factors tends to be clustered in particular segments of the population, which in turn drives disparities in outcomes.

4. These clinical conditions remain largely preventable by reducing modifiable risk factors (obesity, alcohol and tobacco consumption), much of which – at population level - is the subject of local and national public health campaigns, regulation/legislation and wider public policy. However, effective management of long-term conditions and intervention at various stages in life when people come into contact with health services (secondary prevention) – including identifying and providing optimal treatment for hypertension, high cholesterol and atrial fibrillation, effective long-term management of diabetes and cancer screening - can also make a significant contribution to reducing morbidity and mortality.

5. The NHS Long Term Plan, published in 2019, set out a number of NHS England-led initiatives which would be launched to contribute to the secondary prevention and management of the conditions which cause the greatest burden of premature death and disability.

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[1] ONS, 2017. Causes of death over 100 years. Causes of death over 100 years - Office for National Statistics (ons.gov.uk)
[2] ONS 2021. National life tables – life expectancy in the UK: 2018 to 2020. National life tables – life expectancy in the UK - Office for National Statistics (ons.gov.uk)
[3] OHID 2022. COVID-19 Health Inequalities Monitoring for England (CHIME) Tool CHIME - COVID-19 Health Inequalities (phe.gov.uk)
[4] ONS, 2022. Health State Life Expectancies Health state life expectancy, all ages, UK - Office for National Statistics (ons.gov.uk)
[5] ONS 2022. Health state life expectancies by national deprivation deciles. Health state life expectancies by national deprivation deciles, England - Office for National Statistics (ons.gov.uk)
[6] Office for Health Improvement and Disparities analysis. 2022. Based on Global Burden of Disease. 2019. https://www.healthdata.org/data-visualization/gbd-results

6. Since 2019, the Covid-19 pandemic has resulted in significant additional demand and mortality, including non-Covid mortality, due to a combination of lifestyle factors, delayed presentation, and inevitable disruption to routine and emergency care. For example, non-Covid related excess mortality over the past year was primarily driven by cardiovascular disease (CVD), liver disease and diabetes, and the sustained period of high urgent and emergency care (UEC) demand is understood to be driven primarily by respiratory disease and CVD (of which diabetes is a major risk factor).

7. With ICSs and the Health and Care Act 2022 seeing the development of a new health commissioning landscape and partnership working locally, and significant learning available from the response to Covid-19 and vaccination programme, a significant opportunity now exists to build consensus and action on those measures which will save and improve lives and reduce future growth in demand for NHS and other services.

Reviewing the opportunity in the new health landscape

8. The NHS remains uniquely placed to be able to support secondary prevention in people with healthcare needs, and to be a key partner in wider prevention initiatives. For the purpose of this paper, secondary prevention refers broadly to the NHS contribution to improving healthy life expectancy and improving population health in England – particularly the early diagnosis of disease or identification of clinical risk, and early intervention designed to prevent or slow disease progression

9. Integrated Care Boards have a duty under Section 14Z34 of the Health and Care Act 2022 as to improvement in quality of services. The Act provides that: *"(1) Each integrated care board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness."*

10. In particular, as NHS staff deliver well over 1.5 million patient contacts every day, and are highly trusted by members of the public, the NHS has a significant opportunity to 'make every contact count' by ensuring staff are aware of when and how to provide advice and/or refer relevant patients to secondary prevention programmes.

11. In October 2022 the National Audit Office published its report 'Introducing Integrated Care Systems (ICSs): joining up local services to improve health outcomes'[7]. It recommended that NHS England should clarify what a realistic set of medium-term objectives looks like for ICBs, building on the work done on core NHS objectives to ensure ICSs can make progress on prevention and local priorities.

12. The recent King's Fund's report into CVD[8] identified that whilst stakeholders

[7] https://www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/
[8] 'Cardiovascular disease in England: Supporting leaders to take actions', King's Fund, October 2022

were largely positive about the national landscape, there was a view that it was 'fragmented', 'siloed' and lacking an overall structure, with insufficient alignment between the multiple initiatives and links with related conditions (e.g. diabetes). This finding echoes our own conversations with systems on prevention.

13. In response to the pandemic trends in excess mortality and the new health landscape post Health and Care Act, during the summer the NHS CEO commissioned the NHS National Medical Director to work with the Chief Medical Officer to undertake a rapid review of a number of programmes and initiatives across NHS England which broadly contribute to secondary prevention. The review found:
    (i) There is a strong evidence base behind the interventions we are already delivering as part of our clinical programmes;
    (ii) Central commissioning of certain preventative interventions provides value for money, but engaging communities is a key driver of participation and (in line with the learnings from the Covid-19 vaccine programme) is best led locally;
    (iii) There is a need for a greater focus on identifying and supporting people who are not currently engaging with NHS services until they are in poor health.

14. Following the review this paper sets out proposed recommendations to start to embed a coherent and evidence-based approach to prevention across the NHS – reducing health inequalities and saving lives.

Recommendation 1: NHS England should extensively engage ICSs to work out how best to prioritise secondary prevention, and the best ways of achieving improvements in health locally

15. To embed a strong focus on prevention and effective long-term conditions management within local partnerships we recommend implementing a two-phase engagement approach with ICSs, focused on both the short-term imperative for action now and longer-term sustained focus on prevention by the NHS and its partners.

16. As a first phase of work, over the coming weeks, we will:
    (i) Provide advice to ICBs on the highest impact interventions within the direct scope of NHS provision to reduce preventable admissions and to reduce excess mortality in the short-term, while also improving health inequalities over the longer-term;
    (ii) Hold a senior-level round table with a number of key ICS leaders and other partners to gather initial views, including on innovative approaches such as the use of technology and the NHS App, and;
    (iii) Seek evidence from local systems of best practice in the delivery or organisation of preventative services which has been successful in improving outcomes and/or engaging larger numbers of people from high-risk groups.

17. During Q4 2022/23 we intend to launch a broader programme of engagement.

This would align closely with the implementation of the Fuller Stocktake with a focus on identifying and testing ICS-led solutions to embedding prevention, including:

(i) Highlighting further examples of innovation and excellence in delivery from ICSs which could be adapted and adopted elsewhere – both those led by ICBs as commissioners of NHS services, and those led by Integrated Care Partnership (ICP) participants, including local authorities and the voluntary sector;

(ii) Seeking views on how we can use and align all of our collective levers across systems to ensure that prevention is fully embedded in local practice, and where we can innovate and build on the learning from the Covid-19 vaccine programme;

(iii) Engaging ICPs and their constituent organisations on how data can be securely and effectively shared and analysed to improve the planning and targeting of services and reduce unwarranted variation, and;

(iv) Co-creating a sustainable and effective model of prevention, which seeks to achieve better engagement from higher risk population groups, delivers new mechanisms to access these communities alongside general practice and wider primary and community care teams, and considers options to be more ambitious on structures to support delivery.

Recommendation 2: ICSs should be supported to prioritise secondary prevention as part of their strategic plans

18. ICSs bring together a number of organisations, including the NHS, many of which have either statutory duties relevant to promoting better health and outcomes for their populations, or related charitable purposes. As such, they provide a unique platform on which these organisations can agree and work together on these common goals.

19. In addition to the need to improve health life expectancy, there are two key short-term imperatives for a strong focus on secondary prevention:

(i) Between 1 July 21 and 1 July 22 the ratio of expected to reported deaths in England was 1.1 or above for CVD (heart failure and ischaemic heart diseases), diabetes and liver cirrhosis/disease, and;

(ii) The NHS is experiencing a sustained period of high demand for urgent and emergency care, and analysis undertaken in the Midlands region suggests that leading drivers of this demand (volumes of A&E admissions) are respiratory disease and CVD (for which diabetes is a major risk factor). We are seeking to replicate this analysis at a national level and it appears to be supported by existing national data, including statistics published by NHS Digital[9].

20. By pursuing the approach set out in paragraphs 16 and 17, and particularly providing clear advice on the highest impact interventions which can be – and are already being – implemented by the NHS, our aim is to inform the further development of strategic planning by ICSs, ICBs and ICPs to address these

[9] Source: NHS Digital, NHS Outcomes Framework, Unplanned admissions for chronic ambulatory care sensitive conditions in England 2020/21

issues.

Recommendation 3: To support local planning NHS England should publish a tool summarising the highest impact interventions and supportive resources relating to the prevention and management of respiratory disease, CVD and diabetes

21. One of the issues for ICSs is that prevention is a broad term, with differing views about where the priorities lie. To support planning and delivery by member organisations of ICSs we have therefore developed a web-based resource summarising the most impactful interventions relating to the prevention and management of CVD, diabetes and respiratory disease, all of which offer the potential to deliver benefits at an individual patient level within 36 months. We have worked with the Office for Health Improvement and Disparities (OHID) and NICE in its development.

22. A high-level summary of the high impact interventions advice is included as an annex to this paper. Full details of each programme is being published on the NHS England Prevention Programme web pages. The tool will be iterated over time to ensure it offers a 'live' menu of resources NHS England can offer or signpost to further evidence and resources to assist implementation.

Strategy and financial implications

23. The promotion of key interventions in relation to CVD, diabetes and respiratory disease is consistent with the existing ask of ICBs in relation to the LTP and the ways of working set out in the NHS Operating Framework.

24. There is currently significant investment across our existing LTP programmes to support these objectives. The Health Inequalities adjustment in ICBs' baseline also provides an opportunity for a focused investment on the secondary prevention asks within the Core20PLUS5 approach. Health inequalities funding mobilised from partners, including the Institute of Health Improvement and The Health Foundation, will further enhance ICBs' resource capacity to capitalise on the secondary prevention opportunities for the Core20PLUS population cohort.

25. Over the medium-term this work needs to align closely with implementation of the Fuller Stocktake, the development of a new vaccine and immunisation strategy and continued recovery and transformation of screening programmes, our existing work on reducing health inequalities and Population Health Management, and the negotiation of the 2024/25 GP contract.

26. Further, in the context of the New NHS England programme, we will explore scope for closer alignment of our LTP clinical programmes on secondary prevention and management of long-term conditions, with a view to providing greater efficiency and coherence in our support offer to ICSs.

Next steps

27. Subject to the approval of the Board, we will:
    (i) Further refine our engagement plans and supporting products;
    (ii) Launch planned engagement work over the coming weeks, with a view to scaling up engagement in the New Year.

28. A steering group chaired by the NHS CEO will be established to support corporate prioritisation and alignment of our approach to prevention with this work.

Annex – Secondary Prevention High Impact Interventions Summary

Full details and evidence base for these interventions can be found on the NHS England website Prevention Programme pages.

Cardiovascular disease

Community Pharmacy Hypertension Case Finding – supports the detection and subsequent treatment of hypertension and CVD, improving outcomes, reducing the burden on GP practices (where most case finding takes place) and reaching people who may not attend general practice.

Cholesterol search and risk stratification – involves case finding and treatment of hypercholesterolaemia in people with high CVD-risk conditions, post-acute CVD event and in those with familial hypercholesterolaemia.

NHS Health Check – local authority-commissioned service for 40-74-year-olds, delivered in most cases by GPs. 1 in 4 NHSHC attendees are identified as at risk of CVD and would benefit from lifestyle changes and where that is unsuccessful, blood pressure or lipid lowering therapy.

Case finding and direct-acting oral anticoagulation (DOACs) to prevent atrial fibrillation (AF) related strokes - NHSE has put in place a programme, including procurement agreements, to expand DOAC access in line with increased case finding.

Cardiac rehabilitation for patients post ACS and diagnosis of heart failure – supporting patients with chronic or post-acute cardiovascular disease to lead an active life and reduce their risk of further acute illness.

Optimising management post ACS, including lipid management - regular monitoring within primary care for patients who have had a high-risk cardiovascular event to ensure they are on the right medication to reduce their risk of further acute illness.

Optimisation of hypertension treatment – in addition to improved diagnosis, ensuring those with an existing diagnosis are receiving and adhering to the right medication to control their hypertension.

Optimisation of Heart Failure treatment through annual reviews - managing blood pressure, atrial fibrillation, cholesterol and anticoagulant use to identify and address deterioration early.

Diabetes

NHS Diabetes Prevention Programme – identifying people at risk of developing Type 2 diabetes and referring them onto a nine-month, evidence-based lifestyle and behavioural change programme.

Structured Education – supporting individuals diagnosed with Type 1 or Type 2 diabetes, and their family members and carers, in developing their knowledge and skills to self-manage diabetes and reduce their chances of deterioration or exacerbation.

Delivery of 9 Diabetes care processes / achievement of treatment targets – annual review and monitoring of key lifestyle and physiological measurements, with appropriate interventions where needed, to reduce the risk of complications associated with diabetes.

Modifiable risk factors

Tobacco dependence identification and treatment in secondary care – identification of smokers in inpatient hospital settings and maternity services, providing advice and treatment (behavioural and/or pharmacological).

Weight Management services for people with diabetes and/or hypertension e.g. the NHS Digital Weight Management Programme – identification by GP practices and community pharmacists and referral to structured service to support people to lose weight and reduce their associated clinical risk.

Alcohol Care Teams – identification of people with alcohol dependency in acute hospitals, and provision of specialist interventions and referral into community services for ongoing support and treatment.

Respiratory conditions

Spirometry in diagnosis of asthma & COPD – targeted testing in primary care settings to identify and further explore reduced lung function, providing the opportunity for preventative action (eg referral to Stop Smoking Services) and/or treatment and support to manage a condition.

Inhaler and medicines optimisation – action to ensure appropriate medicines use, particularly inhalers, to reduce exacerbations and mortality.

Pulmonary Rehabilitation (PR) for COPD – support and exercises to improve lung function following exacerbations of COPD, to prevent further deterioration and exacerbations.

Personalised Asthma Action Plan (PAAP) for all Children and Young People (CYP) with asthma – ensuring CYP and their families have support and education to manage their conditions, particularly reviewing inhaler techniques, to reduce exacerbations and prevent deaths.