

Medical Directorate Senior Management Team Meeting

2 October 2014

4d Deterioration in Rate of PYLL Improvement

Purpose of Paper

Decision Required (e.g. approval of policy)	Debate / Co-production (e.g. Strategy document)	Assurance (e.g. Budget Report)
		X

Action(s) requested:

- SMT is asked to note the attached analysis of provisional ONS mortality data from mid-2011 to 2014 which indicates that there is likely to be a discernable decrease in the rate of improvement of PYLL in 2013 and to approve submission of this paper to the Chief Executive/EGM.

Sponsoring Director: Celia Ingham Clark

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Programme:

N/A

Discussion (please indicate with an “X” below)

Essential	Desirable	Unnecessary
	X	

Involvement Thus Far (please indicate with an “X” below)

Operations	Finance	Patients and Information	Transformation	Medical	Nursing	HR	Policy	Commissioning Development
				X				

Tracking and Approval Process

Paper to be Submitted to ETM?	Possible ETM Date	SMT Comments

Executive Summary

- SMT is asked to note the attached analysis of provisional ONS mortality data from mid-2011 to 2014 (which is expected to be published in November 2014) which indicates that there is a discernable decrease in the rate of improvement of PYLL in 2013. It is too early to say yet, but this may coincide with the beginning of a long-term change in the rate of improvement from PYLL.
- Given the timing of the change in PYLL improvement, which dates from around the time of the health reforms, and coincides with 'Living Well for Longer' (SofS's call for action to reduce premature mortality in March 2013), this has the potential to generate significant comment and speculation about the cause of the decline in the rate of improvement.
- Due to the time-lag between undertaking many clinical interventions and their impact on mortality, any sustained change in the trend of PYLL may relate to events during the preceding years, which pre-date the establishment of NHS England (or the 2012 health reforms more generally).
- Analysis undertaken by NHS England suggests that there are a range of opportunities at hand which could enable us to accelerate the rate of improvement in PYLL if we could deliver a sustained focus on key priorities across the NHS over the next 5 years.

Action the Senior Management Team is being asked to take

- SMT is asked to note the attached analysis of provisional ONS mortality data from mid-2011 to 2014 which indicates that there is likely to be a discernable decrease in the rate of improvement of PYLL in 2013 and to approve submission of this paper to the Chief Executive.

Recommendation(s)

- To note this paper and the attached analysis and approve its submission to the Chief Executive/EGM.

Deterioration in the Rate of PYLL Improvement

Purpose

1. This paper provides a covering note and high level policy analysis (see Appendix 1) to accompany the attached paper summarising the analysis undertaken by the Outcomes Analysis Team into trends in the rate of Potential Years of Life Lost (PYLL).
2. The intention is for this paper and attachments to be submitted formally to NHS England's Executive Team and to the Department of Health as part of our formal accountability arrangements. SMT is therefore being asked to note the attached analysis and to approve submission to EGM/the Chief Executive.

Issue

3. One of the overarching indicators in Domain 1 of the NHS Outcomes Framework is potential years of life lost from causes considered amenable to healthcare in (i) adults and (ii) children and young people.
4. The attached analysis, which is based on new provisional mortality data that we have obtained from ONS shows that PYLL in men has been improving steadily until 2010, but in 2012, 2013 and 2014 the improvement has been much more gradual. Further, male PYLL is likely to have deteriorated for the first time in 2013 and this deterioration is partly linked to a particular peak in male PYLL in April 2013, which is as yet uninvestigated.
5. Data to end July 2014, shows some improvement from the 2013 position. It appears though that the improvement is less than the previous trend (NB this hasn't been tested significantly at this stage though). It therefore remains possible that we could be about to see a general change in the trajectory of improvement that we have seen in the recent past.
6. The provisional data has not been published to date, but we expect it to be published in November, in the interests of transparency of data.

Analysis

7. The overall trend in PYLL reduction historically has been driven by the rate of PYLL reduction in CVD, and in particular from heart disease. Much of the past improvement in mortality for CVD was driven through significant improvements in treatment such as statins, aspirin, anti-coagulation, anti-hypertensives and revascularisation, as well as through public health improvements such as the banning of smoking in public places.

8. Given the timing of the change in PYLL improvement, which dates from around the time of the health reforms, and coincides with “Living Well for Longer” (SofS’s call for action to reduce premature mortality in March 2013), this has the potential to generate significant comment and speculation about the cause of the decline in the rate of improvement. However, due to the time-lag between undertaking many clinical interventions and their impact on mortality, any sustained change in the trend of PYLL may relate to events during the preceding years and which pre-date the establishment of NHS England (or the 2012 health reforms more generally). In particular it may be that we are now at a point where we will not see sustained improvements going forward from the clinical and public health interventions referred to at paragraph 6 above.
9. In 2014/15, for the first time, we asked CCGs to set a specific and quantifiable level of ambition in relation to premature mortality. Our baseline assumption was that under a do-nothing scenario we would have expected an improvement trajectory of around -14% PYLL rate by 2020. However, CCGs have now submitted their ambitions to the national support centre. In terms of reducing premature mortality, the provisional national aggregate ambition is to decrease PYLL by approx. 12% by 2018-19 (from a 2012 baseline), which is approximately 1-2% less than the estimate analysts had modelled for overall expected reductions in PYLL. This reinforces the view that we may be about to see a sustained softening of the past rate of improvement over the next 5 years (and possibly beyond).
10. The particular peak in deaths in April 2013 requires further analysis to understand its causes. We note though that there was an article published in May 2013 in the British Journal of Healthcare Management which examined the causes of an unexplained increase in deaths during late 2012. This article (which needs to be treated with a degree of caution) referred to a surge in mortality starting in late 2012, into Spring 2013 and speculated that this may be due to the cold weather at the time and some sort of respiratory virus. We note that April 2013 was particularly cold and there was a period of several weeks when much of England was frozen. This is certainly one of the factors we would need to give further consideration to in any analysis.

Can we reverse this trend?

Delivering national priorities for reducing premature mortality

11. It is clear from work undertaken in relation to Domain 1, that there are a range of well-established and clinically proven interventions which could, if we were able to ensure a sustained focus on delivering them across the NHS, potentially serve to accelerate the rate of reduction in PYLL over the next 5 years and beyond.

12. In 2013, to support CCGs in setting a level of ambition on reducing potential years of life lost we published a resource at the same time as Everyone Counts which sets out the evidence base for reducing premature mortality through a range of clinical interventions. This resource was developed in partnership with PHE and has also helped us to identify priorities for future work nationally to reduce premature mortality. The resource (available at <http://www.england.nhs.uk/ourwork/sop/red-prem-mort/>) identified a number of key priorities for reducing amenable mortality as set out below:

	Intervention	Potential Benefit - Lives saved (per-100,000)	PYLL (per-100,000) <75
1	Implementation of NICE guideline on Acute Kidney Injury	19	(PYLL reduction all ages estimated at 161)
2	Implementation of the Sepsis Six Care Bundle	18	-
3	Implementation of British Thoracic Society Care Bundle for community acquired pneumonia	6	83
4	Increased prescription of anti-thrombotics (warfarin) for patients with atrial fibrillation	4	28
5	Earlier stage of diagnosis of cancer	3	29
6	Intermittent Pneumatic Compression to prevent post stroke Deep Vein Thrombosis	2	14
7	Prevention of Venous Thromboembolism	2	-
8	Increased uptake of cardiac rehabilitation	1	10

Reconfiguration of hyper acute stroke services along the lines of the London stroke services reconfiguration was also identified as a priority, although assessments of the relative benefits of national roll-out are complex due to questions about replicability across different geographical areas.

13. Appendix 2 sets out a paper that was recently approved by Medical Directorate SMT about the strategic priorities for Domain 1 to inform the Five Year Forward View. In particular, we have identified sepsis and atrial fibrillation as areas where there are evidence based clinical interventions which are broadly cost neutral, or cost saving and which could, if implemented consistently across the NHS have a significant impact on reducing premature mortality.
14. Further, we are working up plans in relation to improving stage of diagnosis of cancer and supporting the implementation of the NICE guidelines on behavioural change which have the potential to further impact on the overall rate of PYLL by reducing the incidence of CVD and improving survival rates from cancer.

Driving Local Improvements

15. Although the levels of ambition set by CCGs on PYLL were disappointing, in that they failed to meet (let alone exceed), our expected rate of improvement, they do set a quantifiable basis on which CCGs can monitor their progress in reducing PYLL going forward.

16. There is an existing Quality Premium on reducing PYLL lost through causes considered amenable to healthcare. This provides a financial incentive for CCGs to set themselves stretch targets on PYLL and there is currently broad scope for CCGs to determine the focus of the target set under the Quality Premium.
17. We could explore the possibility for future years of restricting the nature of the Quality Premium to a “pick list” of high impact clinical interventions to drive to ensure a local focus on delivering improvements in the areas that are likely to be the most impactful. This would still provide some scope for clinical priorities to be determined locally and there could be a provision enabling Area Teams to agree to set a Quality Premium in other areas by exception, where there is a sound local imperative for doing so.

Conclusion

18. Provisional ONS data shows a slowing in the rate of improvement on PYLL reduction from 2012 onwards which could generate significant interest. As the data reflects historic trends there is nothing that we can do to prevent the slowing in the rate of improvement, which in any case will to a large extent have been affected by events that occurred before the establishment of NHS (apart from the specific peak in April 2013)
19. We do however, have opportunities to take action which should accelerate the rate of improvement in PYLL reduction if we could deliver a sustained focus on key priorities across the NHS over the next 5 years.

Action

20. SMT is asked to note the attached analysis of provisional ONS mortality data from mid-2011 to 2014 which indicates that there is likely to be a discernable decrease in the rate of improvement of PYLL in 2013 and to approve submission of this paper to the Chief Executive.