NHS England

QUALITY AND CLINICAL RISK COMMITTEE PAPER - NHS ENGLAND

Title: Progress in Reducing Premature Mortality

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Purpose of paper:

- The Committee has indicated that it wishes to consider progress against each domain of the NHS Outcomes Framework.
- This paper sets out a summary of:
  - Trends in relation to indicators in Domain 1 of the NHS Outcomes Framework; and
  - International comparisons between England and other parts of Europe; and
  - The work in hand across NHS England in relation to each of the indicators in Domain 1 and the objectives set for Domain 1 in the Mandate.

Key issues and recommendations:

- That the Committee notes progress made in reducing premature mortality;
- That the Committee notes the programme of work underway to improve performance in this area; and
- That the Committee notes the key risks and how these are being mitigated.

Actions required by Committee Members:

- To advise on any actions that should be taken to further mitigate the risks described and improve the likelihood of successful implementation of the programmes of work to reduce premature mortality.

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The Mandate from the Government to NHS England

1. The NHS Mandate is the mechanism for the Government to set NHS England's objectives. One of the key objectives for NHS England is to demonstrate progress against the five parts and all of the outcome indicators in the framework – including, where possible, by comparing our services and outcomes with the best in the world. There are additionally specific objectives for Domain 1 in the Mandate, which are:
    - Working with CCGs to develop our contribution to the new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020
    - To make significant progress in supporting earlier diagnosis of illness, particularly through appropriate use of primary care, and tackling risk factors such as high blood pressure and cholesterol. This includes working with Public Health England to support local government in the roll out of NHS Health Checks
    - To make significant progress in ensuring people have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence (taking account of the Pharmaceutical Price Regulation Scheme agreement), and services for children and adults with mental health problems
    - To make significant progress in reducing unjustified variation between hospitals in avoidable deaths, so that standards in all hospitals are closer to those of the best. The NHS should measure and publish outcome data for all major services by 2015, broken down by local clinical commissioning groups (CCGs) where patient numbers are adequate, as well as by those teams and organisations providing care. To support this, the Government will strengthen quality accounts, which all providers are legally required to publish to account for the quality of their services;
    - To make significant progress in focusing the NHS on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more. As the country's largest employer, the NHS should also make an important contribution by promoting the mental and physical health and wellbeing of its own workforce.

Status of NHS Outcomes Framework Domain 1 indicators

2. Domain 1 of the NHS Outcomes Framework focuses on reducing premature mortality. Premature mortality comprises two overlapping areas: preventable mortality, which is primarily associated with public health issues, and amenable mortality, which describes mortality that might not occur if better health care is

delivered. NHS England's role is principally in driving improved outcomes to reduce amenable mortality through the healthcare commissioning system, but we also work in close liaison with Public Health England regarding their work on preventable deaths[1].

3. The indicators in the NHS Outcomes Framework that describe premature mortality include some which focus on the general population and some relating to specific groups of diseases. The indicators address all age groups (see Annex A which lists all the NHS Outcomes Framework Domain 1 indicators and their definitions). Performance against the NHS Outcomes Framework is reported regularly to NHS England's Board (see Annex B for the latest report).

4. The purpose of this paper is to provide more detailed information to the Quality and Clinical Risk Committee regarding our progress in reducing premature mortality.

5. It is worth noting from the outset that a significant issue in relation to assessments of performance in reducing premature mortality is the tendency of politicians and political and economic commentators to draw comparisons between the relative performance of England (or the UK more generally) and other countries, rather than making year on year comparisons with the historic domestic position. Our assessment of the desired trajectory of improvement is therefore drawn both in relation to past domestic trends and international comparisons.

6. In the latest report to the Board, nine out of the 13 rated indicators in Domain 1 of the NHS Outcomes Framework were on or better than trajectory. These include: the number of potential years of life lost (PYLL) for adults and children, the under 75 mortality rates from cardiovascular disease, liver disease, and cancer, and rates of infant mortality, neonatal deaths, stillbirths and five year survival for children's cancers. The indicators where performance is worse than trajectory include: life expectancy at 75 for men and women, under 75 mortality rate from respiratory disease (where our position relative to other European states continues to decline), and excess under 75 mortality rate in adults with serious mental illness.

7. Much of the data available relates to 2012, before NHS England, Public Health England (PHE) and CCGs took on their commissioning responsibilities. However, the most recent ONS provisional monthly data (Annex C) shows some plateauing of the reduction in PYLL that appears to relate particularly to

[1] We recognise the limitations on the definition of "amenable mortality". ONS are due to revisit this definition this year. However, we have taken a more pragmatic approach of considering NHS interventions that reduce premature mortality however it is defined.

cardiovascular disease. There does not appear to be a similar plateau in PYLL for cancer.

8. The UK Government is a signatory to the World Health Assembly's 2012 framework commitment to reduce premature mortality from non-communicable diseases by 25% globally by 2025. In England and Wales, deaths considered preventable have fallen from 109,753 in 2003 to 93,602 in 2012 (a decrease of 15%), and those considered amenable to medical intervention have fallen from 74,398 to 53,165 over the same time period (a decrease of 29%).[2] Where international comparisons were possible in the latest report for the Board on the NHS Outcomes Framework Domain 1 indicators, England was better than the international trajectory on life expectancy for men at 75, however was worse on mortality rates in under 75s in both respiratory and liver disease (although these comparisons could only be made up until 2010).

9. Analysis of UK health performance in the Global Burden of Disease Study 2010 also showed that the performance of the UK in terms of premature mortality was persistently and significantly below the mean of EU15+.[3] Total health spending accounted for 9.3% of GDP in the United Kingdom in 2012, which is equal to the OECD average.[4] This year the European Observatory on Health Systems and Policies has also been working on a report on reducing avoidable mortality in England, which looks at how we can close the gap with European countries and identifies scope for action. The report is still being finalised but highlights areas which would gain from a particular focus: mortality in childhood, mortality among older women, COPD and chronic liver disease.[5]

10. Rates of premature mortality are strongly influenced by a wide range of socioeconomic factors. The Longer Lives webpages on the Public Health England website show very clearly the correlation between socioeconomic deprivation and overall rates of premature death, although not all variation is explained in this way, for example some of the most deprived areas have lower premature mortality rates from cancer and cardiovascular disease than some of the least deprived areas.[6]

11. We also know that people with serious mental illness currently have an overall mortality rate three times higher than the general population, which can largely be attributed to higher rates of smoking amongst people with a serious mental

[2] Office for National Statistics (2014). Avoidable Mortality in England and Wales, 2012
[3] The Lancet, Volume 381, Issue 9871, Pages 997 - 1020, 23 March 2013
[4] OECD Health Statistics 2014
[5] European Observatory on Health Systems and Policy 2014 (not yet published). *Policy dialogue report*
Reducing Avoidable Mortality in England: Closing the gap with European countries and identifying scope for action
[6] http://longerlives.phe.org.uk

illness. We also know that people with learning disabilities in England die on average 16 years sooner than the general population, and that England has higher child death rates than the average in Western Europe (including, as part of the UK, ranking 31 out of 33 of high income countries on stillbirth rates).

Programme of work to improve performance in Domain 1: Reducing Premature Mortality

12. In Everyone Counts 2014/15 (the planning guidance), CCGs were asked to set levels of ambition against seven indicators spanning the five domains of the NHS Outcomes Framework. This is the first time the NHS will be able to articulate outcomes objectives so that it is clear for the population what the NHS as a whole is working towards. Individual CCG plans are being brought together to tell a national story on the ambitions of the NHS in terms of clinical effectiveness, patient experience and patient safety outcomes.

13. 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) and on average, the CCGs with the worst baselines are being the most ambitious i.e. a narrowing of proportional variation. Nationally the aggregate ambition is approximately 1-2% less than the estimate analysts had modelled for overall expected reductions in PYLL. Our baseline projection, based on mortality data up to the end of 2012 suggested that the baseline level of reduction in potential years of life lost would be around 14% by 2020.

14. There are a number of reasons related to the methodology of the national estimate trajectory and the local levels of ambition which may explain why the national aggregate appears to be less than the estimate. Provisional PYLL data to April 2013 obtained from ONS suggests this may have over-estimated the projected reduction. The slight softening of the reduction in PYLL rate in the provisional PYLL data may reflect the recent economic challenges facing the NHS and a period of sustained flat real investment in the NHS. The levels of ambition on PYLL also exclude the contribution of services commissioned through NHS England's specialised commissioning functions, therefore the actual planned rate of reduction in PYLL may be higher than 12%. The national aggregate ambitions will be presented to EGM in the next couple of months. In the meantime Area Teams are working with the CCGs in their areas to assure their progress against their PYLL ambitions.

15. 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 100,00)	PYLL (per 100,00) <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 update 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

16. We have also sought to increase the focus on addressing local health inequalities. Alongside the requirement to set levels of ambition in Everyone Counts we asked CCGs to set out in their strategic plans how they intend to address health inequalities. During the course of 2013/14 we considered how we could strengthen the existing Quality Premium on reducing PYLL lost through causes considered amenable to healthcare and in 2014/15 have consequently included a new element within the Quality Premium which is focused on social deprivation, which is a major predictor of inequalities in health outcomes[7].

17. Work to ensure improvements against the indicators in Domain 1 of the NHS Outcomes Framework and against the objectives set in Domain 1 of the NHS Mandate falls across several different programmes being taken forward by NHS England. This is set out in Annex D. The Director and Deputy Director for Reducing Premature Mortality have a coordinating and influencing role in relation to all the programmes and projects that are working to deliver improvements in Domain 1.

[7] http://www.england.nhs.uk/wp-content/uploads/2014/03/qual-prem-guid-1415-rev.pdf

18. As shown in Annex D, a significant proportion of Domain 1 work falls under the Prevention and Early Diagnosis programme, which was established as one of the organisation's 31 priorities in this year's Business Plan. We have established a Programme Board for that programme which the Director for Reducing Premature Mortality chairs. The Terms of Reference for the Programme Board are in Annex E.

Risks to delivery and mitigation

i. *Organisational focus on generic rather than disease-specific issues*
NHS England has been established as an outcomes-focussed organisation and has taken the decision not to structure itself around disease-specific programmes of work. This presents opportunities for realising the benefits of a generic approach (e.g. to long-term condition management), however there are risks in Domain 1, for example, where conditions are explicitly differentiated in indicators and require a specific and specialist focus. We are mitigating against this risk by having good oversight of the breadth of work going on to improve outcomes for patients with specific conditions, as set out in Annex C and in publications such as 'Action for Diabetes' and the refreshed cancer strategy which is currently in development.

ii. *The internal working arrangements of NHS England may not facilitate transmission of policy on reducing premature mortality into actions for implementation in other parts of the organisation*
There is a risk that the accountability for improvements in Domain 1 and the clinical leadership and input on making those improvements may not have a clear route through to the objectives and activities of other directorates. This is mitigated by active engagement in the current organisational alignment work, and through direct engagement with colleagues in regional and area teams and with the Strategic Clinical Networks.

iii. *The independence and autonomy of individual CCGs that is integral to the structure of the NHS following enactment of the Health and Social Care Act in 2013 may hinder the take-up of local commissioning actions that can reduce premature mortality*
The autonomy of CCGs and their independence from NHS England is an important constituent of the current NHS structure and is designed to facilitate a focus on local priorities. Therefore the route of influence to reduce premature mortality is indirect. CCGs take account of the advice of local Health and Wellbeing Boards that in turn are informed by local Joint Strategic Needs Assessments to influence priorities for health improvement. We work with colleagues in PHE to ensure that information distributed to local public health staff is congruent with our strategy. We are also working with colleagues in the

Commissioning Strategy Directorate to provide information and support to CCGs and to gain their insight and input to our policy development. This is through links to the Commissioning Assembly and via support tools such as our web-based resource on reducing premature mortality.

iv. *Low priority may be given by front-line staff and local healthcare commissioners to the prevention of ill health rather than its treatment*
There is a risk that GPs and NHS commissioners more widely do not see the prevention and early diagnosis agenda as part of their core activities. As the NHS has to accommodate further funding pressures, there is a risk that commissioners (NHS England included) will focus on traditional clinical approaches to disease management rather than prevention. If the NHS is to be sustainable into the future, it must play its part in preventing ill-health (or further ill-health). We are mitigating this risk by establishing a communications and engagement strategy for NHS commissioners (including GPs) with robust evidence on the case for investment in prevention.

v. *Any reduction in premature mortality is more dependent on public health and societal change than on amenable mortality*
Many of the indicators on premature mortality in the NHS Outcomes Framework are subject to the influence of both public health and healthcare. Our close working relationship with colleagues in PHE and in the Department of Health is important so we can support their work in reducing preventable deaths, for example by measures that reduce smoking and excess alcohol use. Where we can align our work with these colleagues, for example in encouraging behaviour change in healthcare staff, it should be possible to influence both preventable and amenable deaths.

vi. *The effect of many of our current strategies to reduce premature mortality will only be realised in the longer term*
Workstreams on behaviour change and on follow through from NHS Health Checks are focussed on health improvement and disease prevention, e.g. reduction in obesity may reduce the risk of developing diabetes. By their nature, the impact of such interventions on mortality is likely to be realised only after several years. We are aiming to have a suite of work programmes that are likely to be effective over different timeframes. For example, work to improve early diagnosis of lung cancer is already identifying more people with early disease and this has translated into a higher proportion of people having curative surgery.

vii. *The delay in data publication means we only have historic data to assess performance, and it is therefore difficult to assess the impact of our work contemporarily*

The most recent publicly available data for most of the Domain 1 indicators report figures from 2012, before NHS England, PHE or CCGs had taken on their commissioning responsibilities. NHS England has therefore obtained provisional data for the domain 1 indicators for which this is feasible (PYLL for adults and children and under 75 mortality from major causes of death). This gives monthly mortality data with a lag of two months. Funding issues will need to be addressed to continue to obtain this data in 2015-16.

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ANNEX C

ONS monthly provisional mortality data – January 2001 to May 2014

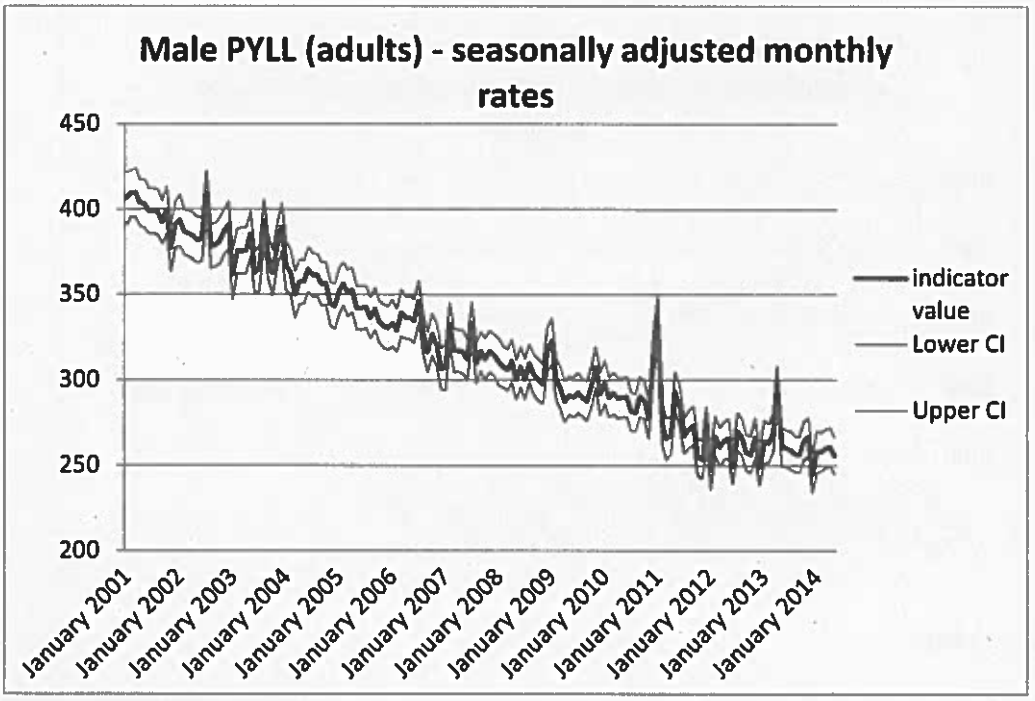
We have now received the first ONS provisional **monthly** data from January 2001 to May 2014 for the Domain 1 indicators listed below. Please note that this data is **provisional** (ie has not been subject to the full quality assurance process). It has not been published by ONS in this form but there is no restriction on our publication or use of the data provided it is always **clearly marked as provisional** until it is updated following the release of the final annual dataset, in the autumn following the end of the relevant calendar year.

1. We have obtained seasonally-adjusted standardised rates for:
    a. Indicator 1a.i – PYLL from causes considered amenable to health care – adults, including breakdown by condition
    b. Indicator 1a.ii – PYLL from causes considered amenable to health care – children and young people
    c. Indicator 1.1 – Under 75 mortality from cardiovascular disease
    d. Indicator 1.2 – Under 75 mortality from respiratory disease
    e. Indicator 1.3 – Under 75 mortality from liver disease
    f. Indicator 1.4 – Under 75 mortality from cancer
2. We also have raw data for the above indicators by age band and condition.

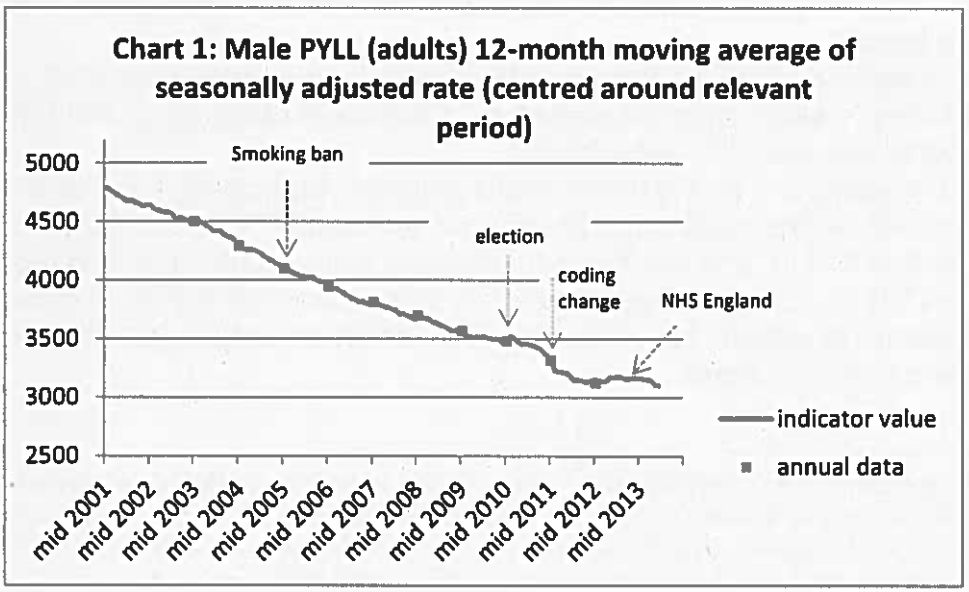
Previously we had annual data up to 2012 (this data is also included in the graphs on page 2). Initial investigation has shown that:

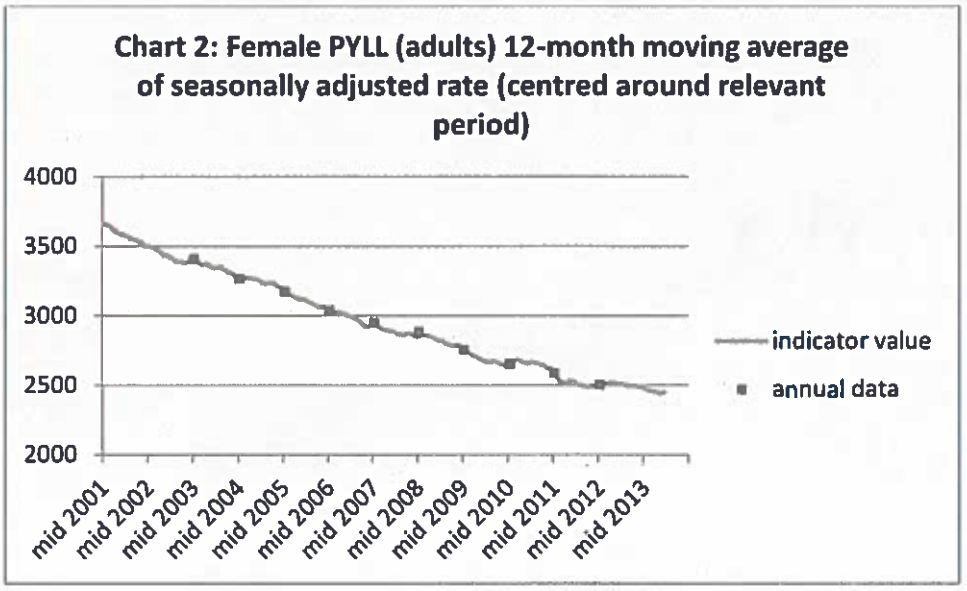
For Indicator 1a.i – PYLL from causes considered amenable to health care – adults, male and female:

> Even though the series have been seasonally adjusted (removing regular seasonal effects and calendar effects) there is a lot of irregular fluctuation from one month to the next (see example below), which could be due to a variety of causes such as extreme temperatures:



ONS will send the data showing the trend cycle data in the next few days so that we can see the underlying trend (with irregular component removed). In the meantime I have produced a smoothed chart of the same data (averaging the rates for 12 months and centring around the relevant mid-year point) which gives a better indication of the underlying trend, for males and females:





Key points:

1. Our new monthly data shows a continuation from mid- to end-2011 of the plateau in PYLL improvement which appeared to begin for males between 2009 and 2010 (see table)
2. A change in ICD10 coding rules in January 2018 makes 2010/11 difficult to interpret. [1] For the purposes of quick analysis we are treating the period 2001 to 2010 separately from 2011 to 2013.
3. For women there is a slowing in PYLL improvement but not as sharp as for men. This may have started in the second half of 2011 (see Chart 2 and table below)
4. Is this bad news? This flattening off had been anticipated in our APC modelling[9] - which shows a projected 2.5% annual reduction in PYLL (for all persons) between 2011 and 2013.
5. CVD mortality is a strong driver of this indicator, particularly for men (PYLL from CVD deaths makes up 59% of male amenable PYLL and 32% of female amenable PYLL), and the new data shows a similar flattening off in mortality from CVD in the last few years. We will look further into the trend in the other amenable conditions, but initial indication is that amenable **cancer** does not show a flattening trend.

[8] The Office for National Statistics (ONS) introduced a new version of the 10th revision of the International Classification of Diseases (ICD–10) used to code cause of death. An ONS bridge coding study showed that overall this had a small impact on coding of cause of death (95% of deaths remained in the same ICD10 chapter), but there was a disproportionate effect on coding of deaths from CVD, which showed a 5% decrease. Much of this is due to recoding of vascular dementia which was assigned the underlying cause cerebrovascular disease (I67.9) in ICD–10 v2001.2, but is corrected to vascular dementia (F01) in ICD–10 v2010. F01 is not considered amenable while I67.9 is, so these deaths no longer appear in the amenable PYLL figures from 2011 onwards.
http://www.ons.gov.uk/ons/rel/subnational-health3/results-of-the-icd-10-v2010-bridge-coding-study--england-and-wales--2009/2009/index.html

[9] Age-period-cohort modelling. This projection method is currently under review in OAT. It holds period effects constant into the future (an attempt to simulate maintaining quality of NHS care) and projects cohort effects based on historical patterns.

Average reduction in PYLL per year		
	Males	Females
2001 to 2009	-3.6%	-3.5%
2001 to 2010	-3.5%	-3.5%
2009 to 2010	-2.4%	-3.7%
mid 2011 to Nov 2013[10]	-2.7%	-2.2%

6. We are awaiting:
    - Confidence intervals, which would help us assess whether some of the patterns we are seeing in the unsmoothed data could be explained by random movement
    - ONS output showing the underlying trend
7. We don't yet have, but are expecting next month, data to enable us to look at deprivation and possibly regional breakdowns.
8. We will do a similar analysis for indicators 1a.ii (childrens PYLL) and 1.1 – 1.4 (under 75 mortality indicators) over the next couple of weeks.

[10] Provisional data

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ANNEX D

NHS England work to reduce premature mortality (Domain 1)

NHS Mandate objectives

NHS Mandate objective	Activity	Programme / Governance	Partners, key stakeholders
Working with CCGs to develop our contribution to the new system-wide ambition of avoiding an additional 30,000 premature deaths per year by 2020	• This is an overarching objective, and all work listed below contributes to this. • Member of Commissioning Assembly Quality Working Group	Oversight by Director for Reducing Premature Mortality	DH, PHE
	• As an overarching piece of work, we published a resource for CCGs setting out high-level interventions for reducing premature mortality	Prevention and Early Diagnosis Programme	PHE
To make significant progress in supporting earlier diagnosis of illness, particularly through appropriate use of primary care, and tackling risk factors such as high blood pressure and cholesterol. This includes working with Public Health England to support local government in the roll out of NHS Health Checks	• Supporting PHE with awareness campaigns such as Be Clear on Cancer, and with screening programmes such as bowel scope screening	Prevention and Early Diagnosis Programme	PHE
	• Member of Public Health England programme board for their hypertension programme	Prevention and Early Diagnosis Programme	PHE
	• Delivering an action plan to improve the clinical follow up to NHS Health Checks by March 2015, including: o Communications and engagement strategy o Influencing and improving primary care (and joint) commissioning of clinical follow up to NHS Health Check	Prevention and Early Diagnosis Programme	PHE, Commissioning Strategy (primary care commissioning)
	• Compiling evidence of good practice innovations and economic modelling of impact of delivering earlier diagnosis of illness in a number of areas including cancer, cardiovascular, respiratory and liver diseases, and diabetes, and feeding learning into commissioning processes	Prevention and Early Diagnosis Programme	

To make significant progress in ensuring people have access to the right treatment when they need it, including drugs and treatments recommended by the National Institute for Health and Care Excellence (taking account of the Pharmaceutical Price Regulation Scheme agreement), and services for children and adults with mental health problems	• Based on existing/successful acute stroke service reconfiguration examples (London, East of England), NHS England is producing a resource kit to offer to CCGs and SCNs to use to assess the case for change locally and to provide them with templates to use during any reconfiguration processes. o Includes frameworks and process maps, and service use models based on distance and sites number. o This will be ready in October 2014, and we are currently considering the best way to make this available to those CCGs/SCNs who wish to take forward based on local need.	Highest Quality Urgent and Emergency Care programme	
	• Improving Access to Psychological Therapies (IAPT) programme: is now at 15% access to those that need it, programme is working on increasing access	Parity of Esteem programme	
	• Cancer Waiting Times Taskforce and action plan to redress breaches in operational standard on 62 day cancer waiting times	Commissioning Operations Directorate	Medical Directorate
	• Work to redress breaches in operational standard on diagnostic waiting times	Commissioning Operations Directorate	Medical Directorate
To make significant progress in reducing unjustified variation between hospitals in avoidable deaths, so that standards in all hospitals are closer to those of the best.	• Clinical audits and consultant outcomes publication	Medical Directorate	
	• Publication of specialised commissioning outcomes indicators	Specialised Commissioning	
	• Publication of GP practice data	Patients and Information Directorate	

The NHS should measure and publish outcome data for all major services by 2015, broken down by local clinical commissioning groups (CCGs) where patient numbers are adequate, as well as by those teams and organisations providing care. To support this, the Government will strengthen quality accounts, which all providers are legally required to publish to account for the quality of their services	• Publishing hospital service-level (team) markers in ten clinical areas	Patients and Information Directorate and Medical Directorate	HQIP HSCIC PHE (Intelligence networks)
	• PHE's Living Longer Lives website – showing comparative mortality rates across the country	PHE	NHS England
To make significant progress in focusing the NHS on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more. As the country's largest employer, the NHS should also make an important contribution by promoting the mental and physical health and wellbeing of its own workforce.	• Delivering an action plan on making every contact count by March 2015, including: o Communications and engagement strategy o Influencing and improving primary care commissioning of behaviour change interventions o Influencing and improving secondary and community care commissioning of behaviour change, particularly focussing on maternity services, community nurse services, and services which support their own staff to make healthy living behaviour changes o Influencing and improving food sold and served to the general public in hospitals o Influencing and improving NHS England's health and wellbeing strategy for its own staff	Prevention and Early Diagnosis programme	DH, PHE, HEE

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	• Compiling evidence of good practice innovations and economic modelling of impact of NHS contributions to preventing illness, and feeding learning into commissioning processes	Prevention and Early Diagnosis Programme	PHE

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NHS Outcomes Framework indicators

NHS Outcomes Framework indicator	Activity	Programme / Governance	Partners, key stakeholders
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care - (i) adults	• This is an overarching objective, and all work listed below contributes to this. • As an overarching piece of work, we published a resource for CCGs setting out high-level interventions for reducing premature mortality • The programmes on acute kidney injury (AKI), sepsis and VTE within Domain 5 will also all impact	Prevention and Early Diagnosis programme Domain 5	
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care - (ii) children	• HQIP have tendered for an 18month development pilot to create a National Child Death Overview Panel Database, to facilitate sharing of outcomes and trends	Medical Directorate	HQIP, DH, PHE
	• Focus on improving care of children with asthma, including development of standardised paediatric asthma management plans, assessment tools and referral and transition pathways, and national data and audit.	Children and Young People Programme	Child and Maternal Health Intelligence Network (ChiMat)- PHE Maternity and children's SCNs
	• Parenting programme to reduce the onset of mental ill health & children and young people's access to psychological therapy (IAPT for children and young people)	Children and Young People Programme	
1b Life expectancy at 75 – (i) males	• This is an overarching objective, and all work listed below contributes to this.		
1b Life expectancy at 75 – (ii) females	• This is an overarching objective, and all work listed below contributes to this.		

1.1 Under 75 mortality rate from cardiovascular disease	• The deliverables on NHS Health Check follow up and making every contact count outlined in the table above will contribute • Providing secretariat to joint group of NHS England, PHE, NHS IQ and charities for co-ordinated action on delivering the CVD Outcomes Strategy • Supporting NHS IQ to roll out of GRASP-AF and other case-finding tools for CVD • Supporting DH breathlessness awareness campaign pilot • Working with the Chief Coroner to help identify more families with Familial Hypercholesterolaemia (FH) and other families at risk, and exploring scope for a national database of FH cases • Working with stakeholders on promotion and site mapping of automatic external defibrillators (AEDs) – bid produced jointly with BHF and Yorkshire AHSN as part of the regional innovation fund. • Delivering an action plan to improve the clinical follow up to NHS Health Checks by March 2015 • Supporting NHS IQ to implement the 'Lester-plus' tool for assessing CVD risk assessment and management in mental health settings • Work to improve early supported discharge from stroke	Prevention and Early Diagnosis Programme	
1.2 Under 75 mortality rate from respiratory disease	• The deliverable on making every contact count outlined in the table above will contribute • Supporting NHS IQ to consider the case for roll out of GRASP-COPD • Supporting DH breathlessness awareness campaign pilot • Delivering an action plan to improve the clinical follow up to NHS Health Checks by March 2015	Prevention and Early Diagnosis Programme	

	• Focus on improving care of children with asthma, including development of standardised paediatric asthma management plans, assessment tools and referral pathways.	Children and Young People Programme	
	• Funding national audit of COPD.	Medical Directorate	
	• Supporting PHE to develop a TB strategy	Prevention and Early Diagnosis Programme	
1.3 Under 75 mortality rate from liver disease	• The deliverables on NHS Health Check follow up and making every contact count outlined in the table above will contribute (specifically need to follow through from Health Checks on obesity management to reduce liver disease associated with obesity) • Working with PHE on a framework for reducing alcohol misuse	Prevention and Early Diagnosis Programme	
	• Liver CRG is working on an approach to improve the management of Hepatitis C taking into account new treatments that are available	Specialised Commissioning	
1.4 Under 75 mortality from cancer – (i) one-year survival from all cancers 1.4 Under 75 mortality from cancer – (i) five-year survival from all cancers 1.4 Under 75 mortality from cancer – (i) one-year survival from breast, lung and colorectal cancer 1.4 Under 75 mortality from cancer – (i) five-year survival from breast, lung and colorectal cancer	• The deliverable on making every contact count outlined in the table above will contribute • Working towards a refreshed national strategy for cancer • Working with PHE and DH to support their Be Clear on Cancer campaigns • Establishing a programme of work to assess impact of innovative routes to earlier diagnosis, and feeding learning into commissioning processes • Maintaining delivery of Cancer Drugs Fund • Exploring potential gains from genomics innovation • Contributing to Cancer Waiting Times Taskforce	Prevention and Early Diagnosis Programme	

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1.5 Excess under 75 mortality rate in adults with serious mental illness	• We established a national CQUIN this year which encourages physical health risk assessments and treatments in people with serious mental illness in mental health units covering 25,000 patients • Supporting NHS IQ to implement the 'Lester-plus' tool for CVD risk assessment and management in mental health settings	Parity of Esteem programme	
	• Suicide prevention programme	Patient safety programme	
	• Establishment of the Crisis Concordat programme aiming to transform access to crisis care and cease the use of police cells as a place of assessment	Department of Health	
1.6.i Infant mortality	• HQIP have tendered for an 18month development pilot to create a National Child Death Overview Panel Database, to facilitate sharing of outcomes and trends	Medical Directorate	

1.6.ii Neonatal mortality and stillbirths	• Developing a care bundle to reduce stillbirth and early neonatal deaths
	  o Expert input from the wider system (colleges, academics, providers, ALBs)
	  o Focus of care bundle interventions on following areas: fetal growth restriction, fetal movement, cardiotocography interpretation, and smoking during pregnancy.
	  o Early implementing in North Region SCNs from November 2014.
	  o Also developing implementation plan for use of tools and levers inc payment system, for 16-17 onwards.
	• Neonatal CRG looking to deliver all extreme premature and low birth weight babies in major tertiary neonatal intensive care
	• Congenital Cardiac CRG looking at pathfinder to increase detection of Congenital heart Disease at 20 week anomaly scan
		Maternity Services programme	

	• Delivering an action plan on making every contact count by March 2015, including influencing and improving secondary and community care commissioning of behaviour change, with one of the particular points of focus on maternity services		
1.6.iii Five-year survival from all cancers in children	• Increasing clinical trial recruitment from 60%-80% within 5 years	CRG on children's cancer	
1.7 Excess under 60 mortality in adults with learning disabilities	• Establishing a learning disabilities mortality review function. o Our intention has always been for the procurement to be completed by end March 2015 which is the business plan commitment. However, following recent discussions with HQIP, the March 2015 timescale is simply unachievable. We now expect to have a preferred provider in place for a review function by end of Summer 2015. o from the Nursing Directorate (Jane Cummins) to sign off the revised timeline before making this public knowledge.	Learning Disabilities programme	Medical Directorate

Prevention and Early Diagnosis Programme Board

Terms of Reference
Draft for Discussion v0.7.1

Contents

Background

Currently, England's rates of premature mortality are worse than those in many comparable European countries for conditions such as cancer, heart, respiratory and liver disease. It is widely accepted that much of the difference in outcomes is attributable to stage of diagnosis in cancer (suggesting late presentation in the UK compared with other countries) and to modifiable risk factors such as smoking, obesity and alcohol consumption for all the major disease groups. There are also significant inequalities between different communities and groups within England for overall life expectancy, quality of health and the care people can expect to receive towards the end of their lives.

The NHS, NHS Improving Quality and Public Health England should be seeking to tackle inequalities in premature mortality from causes amenable to health care by promoting awareness of good health and wellbeing and raising awareness of decisions and behaviors that put people's health at risk. Where people do develop symptoms, we should seek to promote earlier diagnosis, at the same time recognising that adequate access to effective services in the community and risk management of comorbidities are essential to prevent further deterioration in health and wellbeing.

Successfully reducing premature mortality through prevention and early diagnosis will be dependent on aligning work across primary care, community and mental health services, diagnostics and acute services, as well as ensuring that financial incentives drive appropriate behaviors within the system. This will require effective collaboration between different parts of NHS England.

A long-term strategy for reducing premature mortality will depend on integrated planning between public health and the NHS at a local level and through CCGs and their Health and Wellbeing Boards. At a national level, the NHS Outcomes Framework and the Public Health Outcomes Framework have shared indicators around reducing premature mortality. In working towards continuously improving quality standards and health and social care outcomes nationally, the role of the Care Quality Commission (CQC) will be critical as it develops new quality rating systems for hospitals and for general practice.

Purpose

The Prevention and Early Diagnosis Programme Board will have executive responsibility for the Prevention and Early Diagnosis Programme, including:

1. Authorisation of projects;
2. Ensuring that costs and benefits are fully assessed;
3. Ensuring alignment with the wider work of NHS England, the Department of Health , Public Health England (PHE) and Health Education England (HEE);
4. Signing off of implementation plans;
5. Change control;
6. Monitoring of risks and issues and making decisions about the need for escalation of risks and issues;
7. Project closure.

Interfaces

The Board will be responsible for making links with and assuring alignment between a range programmes and initiatives that will support prevention and early diagnosis. These are listed below:

1. NHS England's Mental Health Programme, which includes work on a new CQUIN (from 1 April 2014) to promote screening for physical illness in people with psychosis.
2. NHS England's Learning Disability Programme, which includes work to deliver a learning disability mortality review body by March 2015.
3. NHS England's Patient Safety Programme which includes:
    i. work to develop NHS Outcomes Framework indicator 5C through a systematic case note review of hospital deaths;
    ii. a sepsis programme;
    iii. an acute kidney injury programme;
    iv. a VTE screening programme; and
    v. a suicide prevention workstream.
4. NHS England's Maternity, Children and Young People's Programme which includes:
    i. Development and delivery of a pathway for women with postnatal mental health problems;
    ii. A model for integrated care from pregnancy through to the transition into adult healthcare;
    iii. Development of a Maternity and Perinatal National Clinical Audit
    iv. Review and collate evidence for best practice models for preventing still births.
5. Work within NHS England's Patients and Information Directorate to deliver transparency about outcomes through publication of outcomes data.
6. NHS England's Nursing Directorate programme on the health and wellbeing of 0-5 year olds.
7. NHS England's programme on Long-Term Conditions, Older People and End of Life care.
8. NHS England's work to improve cancer outcomes, which includes work to deliver:
    i. Early diagnosis of cancer
    ii. Improving survivorship with integration of health and social care
    iii. Improving access to treatments for older patients
9. NHS England's long-term strategy work on the six characteristics of a successful health economy: citizen participation and empowerment; wider primary care provided at scale; a modern model of integrated care; highest quality urgent and emergency care; productivity of elective care; specialised services concentrated in Centres of Excellence.
10. The work of the Strategic Clinical Networks and Academic Health Science Networks in support of prevention and early diagnosis.
11. NHS Improving Quality's 'Living Longer Lives' programme.

12. PHE's programmes of work on health and wellbeing including:
    i. The 'Be Clear on Cancer' campaigns and new awareness and symptom awareness pilots on breathlessness and blood-pressure;
    ii. Roll-out of the NHS Health Check;
    iii. Development of the 'Living Well for Longer' website, including the proposal to develop practice level ratings for diabetes.

13. HEE work programmes on workforce training and development needed to support prevention and early diagnosis.

14. The DH's programme of work on Making Every Contact Count.

Key Functions

The Prevention and Early Diagnosis Board will:

1. Oversee delivery of the deliverables set out under the Prevention and Early Diagnosis section in NHS England's Business Plan 2014/15 in the timescales specified;
2. Work with DH, PHE and HEE to ensure development of a coherent system-wide strategy for prevention and early diagnosis;
3. Ensure there is a clear programme of work to support a reduction in mortality from cancer, CVD, respiratory disease and liver disease;
4. Provide a coherent approach to programme leadership;
5. Act as the formal approvals board for initiation of projects, programmes and workstreams aimed at prevention and diagnosis;
6. Ensure there is a clear benefits strategy and delivery plan for the programmes and projects it governs;
7. Identify strategic and directional risks and issues for the programme;
8. Provide assurance to the National Medical Director by monitoring progress across the programme and determining when risks and issues should be referred to the cross-cutting Domain Programme Board, or escalated directly to Medical Directorate SMT where a risk is imminent;
9. Ensure that stakeholders are engaged appropriately across the programme and that there is a coherent approach to communications;
10. Provide a forum for collective consideration of business cases for recommendation to the cross-cutting Domain Programme Board, and then the Clinical Directorate's Senior Management Team;
11. Work to ensure there are strategic links with other key programmes across the organisation and the wider system;
12. Ensure the involvement and buy in of key internal delivery partners within the work programme, as required;
13. Ensure that adequate mechanisms are in place for monitoring progress in delivery of aligned work programmes by external systems partners;
14. Work to resolve risks and issues that have been escalated to it by programme teams.

15. Agree that all Board papers may be shared internally unless explicitly stated otherwise.

Scope

The scope of the programme is limited to the agreed programmes of work set out from page 9, or as decided following agreement of the Board to a change of scope request.

Roles and responsibilities

1. The **Prevention and Early Diagnosis Programme Board** has responsibility for ensuring that the benefits required from agreed programmes are realised.

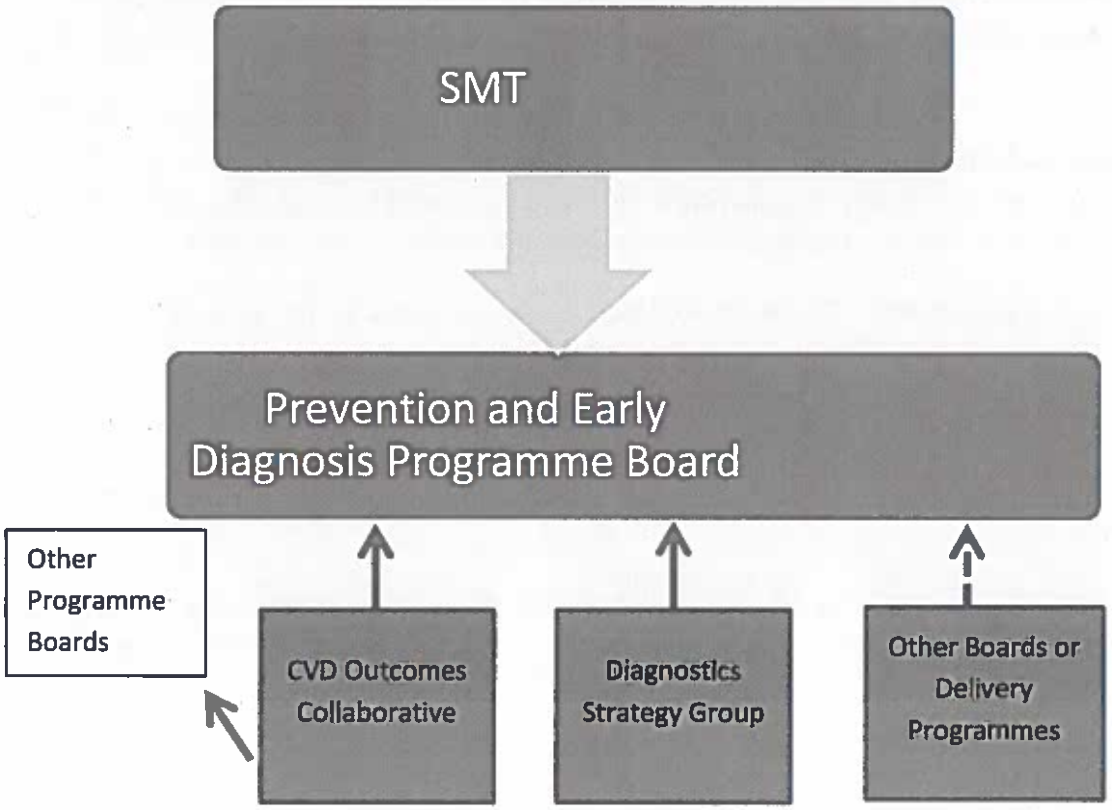
2. The **Senior Responsible Owner (SRO)** is the programme's owner and champion and is responsible for delivery of the programme.

3. **Senior representatives** from other work programmes may be invited to the Prevention and Early Diagnosis Programme Board to advise the group, participate in decision making or contribute resources where there is a common purpose or objective.

4. The **Domain Team Lead for the Prevention and Early Diagnosis Programme** will be responsible for day to day execution of the programme plan and for dealing with issues that might affect achievement of the programme plan.

Governance

Clear accountability, responsibility and forums to allow good communication will be critical in achieving success therefore the following governance structure, which shows lines of accountability, has been agreed.



ANNEX E
RESTRICTED: MANAGEMENT
Prevention & Early Diagnosis Terms of Reference - Final
Membership

Celia Ingham Clark	Domain 1 Director (SRO)
[redacted]	Domain Team Lead, Acute
Emma Doyle	Head of Open Data and Transparency, Patients & Information Directorate
Hilary Walker	Head of Programmes for Domain 1 'Living Longer Lives', NHS Improving Quality
Jane Landon	Deputy CEO, UK Health Forum
[redacted]	Domain Team Lead, Prevention and Early Diagnosis Programme
Karen Turner	Head of Delivery, Parity of Esteem Programme. NHS England
Kate Davies (or nominee)	Head of Public Health, Armed Forces and their Families and Health & Justice Commissioning
[redacted]	Senior Strategic Planning Manager, Partnerships Team
[redacted]	Analyst Team
Matt Kearney	GP and primary care advisor, Public Health England
Matthew Fagg	Domain 1 Deputy Director
Mike Durkin (or nominee)	Director of Patient Safety
Nigel Acheson	Regional Medical Director, (South)
Peter Elton	Clinical Director, Greater Manchester, Lancashire, South Cumbria Strategic Clinical Network
Raymond Jankowski	Head of Healthcare, Public Health England
Sabrina Susan Fuller	Head of Health Improvement, Nursing Directorate
[redacted]	Senior Programme Lead, Primary Care Strategies
Sue Hill	Chief Scientific Officer

Meetings

Prevention and Early Diagnosis Programme Board meetings will begin from April 2014 and, thereafter will meet every eight weeks. The agenda and papers for discussion will be coordinated and collected by the Domain Team Lead for the Prevention and Early Diagnosis Programme and sent to members at least three working days prior to meetings. The following standing papers should be submitted to the meeting for regular review and discussion. The list is not exhaustive and may be varied in terms of composition or frequency at the discretion of the Programme Board:

1. Business cases for approval
2. Programme Highlight Reports
3. Minutes
4. Action log
5. Risk and issue log.

Secretariat

The secretariat will be provided by the Prevention and Early Diagnosis Programme Support Team. It will:

1. Co-ordinate Programme Board meetings.

2. Provide administrative support – capturing and sharing minutes and action notes from meetings.

3. Provide reports - work with delivery partners to provide management information on the portfolio of services/act as a central point of information for members, attendees and other stakeholders.

4. Facilitate the management of action plans – manage action logs including logging, monitoring and follow up of actions with action owners to help achieve resolution.

5. Manage associated documentation in a systematic way.

6. Issue documents to members and attendees so that they receive them in a timely and consistent way in advance of, and following meetings.

7. Facilitate risk and issue management – manage the risk and issue log.

Deliverables for 2014/15 from the NHS England Business Plan

Deliverable from the Business Plan	Description of projects (*still to be signed off by Programme Board)	Project Manager	Start date	End date	NCD input
Provide clinical advice and support for CCGs in setting and delivering their levels of ambition for reducing premature mortality throughout the year to March 2015.	Maintain resource for CCGs setting out high-level interventions for reducing premature mortality	[redacted]	Ongoing	March 2015	All
	*Co-ordinate learning from innovative approaches to early diagnosis in cancer across the country, leading to new commissioning advice/changed levers	[redacted]	April 2014	March 2015	Sean Duffy Erika Denton
	*Work with SCNs and other partners to pilot new pathways to early diagnosis for other conditions (e.g. COPD, AF, diabetes), build learning into commissioning guidance	[redacted]	June 2014	March 2015	Huon Gray Tony Rudd Jonathan Valabhji Mike Morgan Erika Denton
	*Commission economic analysis of benefits of prevention and early diagnosis	Matt Fagg	June 2014	March 2015	All
Provide support to PHE on four cancer and two other symptom awareness campaigns by March 2015.	Attendance at DH/PHE meetings providing NHS England input; linking with NHS England colleagues in regions and area teams	Matt Fagg / [redacted]	Ongoing	Ongoing	Sean Duffy Erika Denton Huon Gray Mike Morgan Tony Rudd
Produce an action plan to improve patient management following an NHS Health Check by March 2015.	*Communications strategy to engage clinical leaders (national and across the country) to promote prevention and early diagnosis (and particularly to promote NHS engagement in the Health Check programme)	[redacted]	April 2014	March 2015	Huon Gray Tony Rudd Jonathan Valabhji Michael Glynn Richard Fluck
	*Commissioning tool to support CCG commissioners to capacity plan for and signpost to post-Health Check follow up and support				

Produce an action plan to improve the NHS contribution to prevention through 'making every contact count' by March 2015.	*Communications strategy to engage clinical leaders (national and across the country) to promote prevention and early diagnosis (and particularly to promote the NICE behaviour change guidance) *Commissioning tools/resources to support CCG commissioners to implement the NICE behaviour change guidance	[redacted] (until September 2014)	April 2014	March 2015	Huon Gray Tony Rudd Jonathan Valabhji Michael Glynn Richard Fluck Geraldine Strathdee Sean Duffy
Publish comparative composite quality marker scores on ten clinical services by March 2015.	Joint project with Patients & Information Directorate to publish composite quality marker scores on hospital teams.	Project Manager being recruited	June 2014	March 2016	All
Ensure more than 70% of all scientific and diagnostic services are part of accreditation programmes and demonstrate robust quality assurance measures by end of March 2015.	Development of Physics and Engineering Service Accreditation	[redacted]	Ongoing	March 2015	Erika Denton Jo Martin Michael Glynn and others
	Increase participation in accreditation across scientific services, and in conjunction with others for diagnostics		Ongoing	March 2015	
	Embedding accreditation as a quality measure in commissioning specifications and other levers		Ongoing	March 2015	
	Implementation of the Pathology Quality Assurance Review (including development of assurance dashboard)	[redacted]	April 2014	March 2015	
Increase the percentage of CCGs with confirmed access to scientific and diagnostic commissioning information to 75% by March 2015.	Communications, engagement and providing clinical advice	[redacted]	April 2014	March 2015	

Continued/… Increase the percentage of CCGs with confirmed access to scientific and diagnostic commissioning information to 75% by March 2015.	Scoping to identify baseline position, confirmation of levels of access and information available, and developing simple dashboard measure for compliance with the metric	CSO team	April 2014	March 2015	
	Working with Area Team and CCGs in Birmingham, Black Country and Solihull Area Team on advice, toolkits, resources for diagnostic commissioning and a plan for roll out across England.	CSO team	April 2014	March 2015	
	Develop web based resource and evidence based information for CCGs and specialised commissioners	CSO team	April 2014	March 2015	
Scope a programme of work, in conjunction with PHE, to address alcohol misuse by June 2014.	Produce joint statement of action against alcohol misuse between PHE and NHS England, and scope need for commissioning tools	Amanda Fadero, Area Team Director, Surrey and Sussex	April 2014	April 2015	Michael Glynn