“Advancing the Outcomes Strategy”

Huon Gray
National Clinical Director for Cardiac Care, NHS England
Consultant Cardiologist, University Hospital of Southampton

Session: Cardiovascular Care Partnership
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Title: Advancing the Outcomes Strategy

Author: Huon Gray

Conflicts of Interest: None
Outline

• Why we needed a CVDOS
• Its political context & 10 Action Points
• Collaboration & Integration
• Future trends
• National Cardiovascular Intelligence Network
• Conclusions
CVD Mortality in England (all <75 yrs)
Causes of Death (England, <75 yrs)
(Source: ‘Living Well for Longer’ [ONS data], 2013)
### UK causes of Years of Life Lost (both sexes, all ages) 1990-2010


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<thead>
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Colors: **Communicable, maternal, neonatal, and nutritional disorders**  **Non-communicable diseases**  **Injuries**
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259 diseases and injuries & 67 risk factors

- Communicable, maternal, neonatal, and nutritional disorders
- Non-communicable diseases
- Injuries
Figure 7: Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years. The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.
CVD

- 200k deaths pa (1:3 of all)
- 4.9m adults have CVD (11.7% of population)
- 1.4m hospital admissions in 2010/11
  - 65% were patients under 75 yrs
  - >50% were emergencies
- Prevalence increases with deprivation - Inequalities
- CVD costs NHS & UK economy £30bn pa.

“Services for the prevention of CV Disease”
NICE Commissioning Guide 45. March 2012
UK health performance: findings of the Global Burden of Disease Study 2010


Interpretation The performance of the UK in terms of premature mortality is persistently and significantly below the mean of EU15+ and requires additional concerted action. Further progress in premature mortality from several major causes, such as cardiovascular diseases and cancers, will probably require improved public health, prevention, early intervention, and treatment activities. The growing burden of disability, particularly from mental disorders, substance use, musculoskeletal disorders, and falls deserves an integrated and strategic response.

www.thelancet.com  Published online March 5, 2013  http://dx.doi.org/10.1016/S0140-6736(13)60355-4
“The performance of the UK in terms of premature mortality….is below the mean of the EU15+…….further progress will require improved public health, prevention, early intervention and treatment activities……and deserves an integrated and strategic response”
Outline

• Why we needed a CVDOS
• Its political context & 10 Action Points
• Collaboration & Integration
• Future trends
• National Cardiovascular Intelligence Network
• Conclusions
National Service Framework for Coronary Heart Disease

“This Framework will transform the prevention, diagnosis and treatment of coronary heart disease. It will help professionals to give better, fairer and faster care everywhere, to everyone who needs it. We want a service that is amongst the best in the world. Our people deserve nothing less.”

Alan Milburn
Secretary of State for Health

March 2000
CVD Outcomes Strategy (2012-13)

Scope
“To improve outcomes for people with, or at risk of developing, CVD”

Context
- Increased Government focus on “the outcomes that matter most to people”
- Evidence based & cost neutral or saving
- Need to create a joined-up approach to CVD across the three outcomes frameworks (with shared implementation)
NHS Outcomes Framework

**Domain 1**
Preventing people from dying prematurely

**Domain 2**
Enhancing quality of life for people with long-term conditions

**Domain 3**
Helping people to recover from episodes of ill health or following injury

**Domain 4**
Ensuring people have a positive experience of care

**Domain 5**
Treating and caring for people in a safe environment and protecting them from avoidable harm
## NHS Outcome Indicators

### Overarching Indicators

1. Preventing people from dying prematurely
   - 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
   - 1b Life expectancy at 75

2. Enhancing quality of life for people with long-term conditions
   - 2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

3. Helping people to recover from episodes of ill health or following injury
   - 3a Emergency admissions for acute conditions that should not usually require hospital admission
   - 3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

4. Ensuring that people have a positive experience of care
   - 4a Patient experience of care for people at the end of their life

5. Treating and caring for people in a safe environment and protect them from avoidable harm
   - 5a Patient safety incidents reported

### Improvement Areas

- Reducing premature mortality from the major causes of death
  - 1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
  - 1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7)
  - 1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
  - 1.4 Under 75 mortality rate from cancer* (PHOF 4.5)

- Reducing premature death in people with serious mental illness
  - 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

- Reducing deaths in babies and young children
  - 1.6 Infant mortality* (PHOF 4.1)

- Reducing premature death in people with a learning disability
  - 1.7 Excess under 60 mortality rate in adults with a learning disability

- Reducing premature death in people with serious mental illness
  - 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

- Reducing deaths in babies and young children
  - 1.6 Infant mortality* (PHOF 4.1)

- Reducing premature death in people with a learning disability
  - 1.7 Excess under 60 mortality rate in adults with a learning disability

### Alignment across the Health and Social Care System

- **Indicator shared with Public Health Outcomes Framework (PHOF)**
- **Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)**

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**NHS Outcomes Framework 2013/14 at a glance**

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**Overarching Indicators**

1a Patient experience of care for people at the end of their life
   - 1b Safety incidents involving severe harm or death
   - 1c Hospital deaths attributable to problems in care

**Improvement Areas**

- Reducing the incidence of avoidable harm
  - 5.1 Incidence of hospital-related venous thromboembolism (VTE)
  - 5.2 Incidence of healthcare associated infection (HCAI)
  - 5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
  - 5.4 Incidence of medication errors causing serious harm

- Improving the safety of maternity services
  - 5.5 Admission of full-term babies to neonatal care

- Delivering safe care to children in acute settings
  - 5.6 Incidence of harm to children due to ‘failure to monitor’
CVD-related indicators

NHS Outcomes Framework:
Domain 1 – **Potential years of life lost** from causes considered amenable to healthcare
  – Life expectancy at 75 (males/females)
  – Under 75 mortality rate from cardiovascular disease
Domain 3 – Indicator to be derived based on *proportion of stroke patients reporting improvement* in activity/lifestyle on the Modified Rankin Scale at 6 months

Public Health Outcomes Framework:
Domain 2 – recorded diabetes
  – take up of NHS health check
Domain 4 – mortality from all cardiovascular diseases (including heart disease & stroke)

Adult Social Care Outcomes Framework:
Domain 2 – **permanent admissions to residential & nursing homes**, per 1000 population
  – proportion of older **people (65 & over) still at home** 91 days after discharge from hospital into reablement/rehab services
  – **Delayed transfer of care from hospital**, and those which are attributable to adult social care
Cardiovascular Disease Outcomes Strategy

Improving outcomes for people with or at risk of cardiovascular disease

March 5\textsuperscript{th}, 2013

Living Well for Longer:
A call to action to reduce avoidable premature mortality

Jeremy Hunt
Secretary of State for Health

David Nicholson
Chief Executive
NHS Commissioning Board

Duncan Selbie
Chief Executive
Public Health England

Contents

Foreword 3

Executive summary: ambitions and actions 5

Chapter 1: Introduction 10

Chapter 2: Integrated care 20

Chapter 3: Prevention and risk management 25

Chapter 4: Management of acute cardiovascular conditions 31

Chapter 5: Living with cardiovascular disease and end of life care 47

Chapter 6: Making it happen 58

Annex A: Cardiovascular Outcomes Strategy: Summary of Potential Costs and Benefits 64

Annex B: Glossary 77
CVDOS Recommended Actions

• Seeing CVD as one condition (‘family of diseases’)

Vascular Disease – One Event Leads to Another

**Original Event = Stroke**
- MI Risk: 2-3 x greater risk\(^2\)^*
- Stroke Risk: 9 x greater risk\(^3\)

**Original Condition = PAD**
- MI Risk: 4 x greater risk\(^4\)**
- Stroke Risk: 2-3 x greater risk\(^3\)**

**Original Event = MI**
- MI Risk: 5-7 x greater risk\(^1\)^+
- Stroke Risk: 3-4 x greater risk\(^2\)**+

**CKD**
- MI Risk: 2 x greater risk
- Stroke Risk: Up 50%

**Diabetes** (type 2)
Because of the increased risk associated with diabetes, it should be considered a cardiovascular risk equivalent to a non-diabetic patient with previous MI

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\(^*\)Includes angina and sudden death. Sudden death defined as death documented within 1 hour and attributed to coronary heart disease (CHD)

\(^1\)Includes death

\(^2\)**Includes only fatal heart attack and other CHD death; does not include non-fatal heart attack,

\(^3\)**Includes TIA


CVDOS Recommended Actions

- Seeing CVD as one condition (‘family of diseases’)
- Integration of services
- Risk factors
CVDOS Recommended Actions

• Seeing CVD as one condition (‘family of diseases’)
• Integration of services
• Risk factors, NHS Health Check

NHS Health Check is a national risk assessment and management programme for those aged 40 to 74 living in England, who do not have an existing vascular disease, and who are not currently being treated for certain risk factors. It is aimed at preventing heart disease, stroke, diabetes and kidney disease and raising awareness of dementia for those aged 65-74 and includes an alcohol risk assessment. An NHS Health Check should be offered every five years.

The programme systematically targets the top seven causes of premature mortality. It incorporates current NICE recommended public health guidance, ensuring it has a robust evidence base. Economic modelling suggests the programme is clinically and cost effective. 

Top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Each year NHS Health Check can on average:

- prevent 1,600 heart attacks and save 650 lives
- prevent 4,000 people from developing diabetes
- detect at least 20,000 cases of diabetes or kidney disease earlier

*The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

 Courtesy: Susan Ismaeel (PHE)
CVDOS Recommended Actions

- Seeing CVD as one condition (‘family of diseases’)
- Integration of services
- Risk factors, NHS Health Check
- Case finding in $1^0$ care
- Better management in, and support for, $1^0$ Care
- Inherited cardiac conditions (incl. FH)
- Improve survival from OHCA (CPR, AEDs, First Responders, Education, Registry)
- Raising awareness
- 24 x 7 CV Services
- Care planning (phys & psych support, self care, EOL care)
- Information (CVIN, Benchmarking – those at risk, quality of care)
- Research

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Andrew Lansley, SoS for Health
UK Stroke Forum Glasgow, 1 Dec 2011

• “In the New Year, work will begin on an **Outcomes Strategy** for cardiovascular disease. This will create a **joined-up approach across the NHS, public health and social care**, to secure the improved care set out in the Outcomes Frameworks.”

• “**Widespread engagement** will be central to this work.”
Top ten priorities from patients and carers

1. Communication
   – between all health sectors & including social care
   – between professionals, patients and carers
   – treat me as a person / respect and dignity

2. ‘Joined up services’ – coordination of care at all levels, particularly for people with comorbidities

3. Continuity – seeing the same doctor / health professional and not different people each time

4. Support for patients and carers – psychological, emotional – starting with those at risk e.g. obese

5. Prevention - to include starting early – education in schools
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6. **Discharge planning** & follow up when home, including appropriate rehabilitation

7. Access to financial and **practical support** – e.g. rails fitted

8. **Long term care**, planned management and support for rest of life as required

9. **Access to services** particularly transport, convenient times for appointments

10. **Education** of staff (especially primary / community) in specialist aspects of care
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<td><strong>Early detection</strong>, diagnosis, risk management</td>
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<td><strong>Patient engagement</strong> / awareness empowerment</td>
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Tackling Cardiovascular Diseases: Priorities for the Outcomes Strategy

Prevention is better than cure

Support to live with cardiovascular diseases

Person-centred treatment

July 2012
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### CVD Risk: Ageing Population

#### England – Population Projections (Principal) –
% Growth to 2012, 2017 & 2022

**Projected % Increase in Population**

- **0-19** to grow by 1% 2010-2012, 1% 2010-2017, 1% 2010-2022
- **20-44** to grow by 7% 2010-2012, 6% 2010-2017, 5% 2010-2022
- **45-64** to grow by 5% 2010-2012, 4% 2010-2017, 3% 2010-2022
- **65-74** to grow by 20% 2010-2017, 21% 2010-2022
- **75-84** to grow by 10% 2010-2017, 11% 2010-2022
- **85 plus** to grow by 44% 2010-2022

**Source:** ONS Population Projections. 2010-Based
Identifying & Managing CVD & Risk in the Community: CHD Prevalence

England – CHD Prevalence

Source: Health Survey for England – Adult Trend Tables 2006
Long Term Conditions: Heart Failure Prevalence

England – Heart Failure – Prevalence (%) by Age & Sex - 2009
General Practice Research Database 2010

Source: General Practice Research Database 2010, reported in British Heart Foundation
Coronary Heart Disease Statistics . 2010 Edition

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men 0-44</th>
<th>Women 0-44</th>
<th>Men 45-54</th>
<th>Women 45-54</th>
<th>Men 55-64</th>
<th>Women 55-64</th>
<th>Men 65-74</th>
<th>Women 65-74</th>
<th>Men 75 plus</th>
<th>Women 75 plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>0.9%</td>
<td>0.4%</td>
<td>3.1%</td>
<td>1.6%</td>
<td>13.7%</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Prevalence of Heart Failure (%)

0-44 45-54 55-64 65-74 75 plus
England 0.0% 0.0% 0.2% 0.1% 0.9% 0.4% 3.1% 1.6% 13.7% 12.5%
Long Term Conditions: Heart Failure - Future Prevalence

England – Heart Failure – Prevalence Cases – Projected Numbers to 2022 – Based on General Practice Research Database 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Women</th>
<th>Men</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>371,156</td>
<td>344,728</td>
<td>715,884</td>
</tr>
<tr>
<td>2017</td>
<td>398,461</td>
<td>387,815</td>
<td>786,276</td>
</tr>
<tr>
<td>2022</td>
<td>453,129</td>
<td>450,342</td>
<td>903,470</td>
</tr>
</tbody>
</table>

Source: General Practice Research Database 2010, reported in British Heart Foundation Coronary Heart Disease Statistics . 2010 Edition Heart Failure rates by Age/Sex applied to ONS Population Projections.
England – Impact of Rising Trend in Obesity - Predicted Increase in Cardiovascular Disease Prevalence over & above Impact of Ageing

Source: National Heart Forum. A Prediction of Obesity Trends for Adults & their Associated Diseases (NHF. February 2010)
CVD Risk: NICE Prevention Guidance


Potential Future impact in reducing nos. of deaths

Baseline

Number of Deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>CVD Deaths</th>
<th>CHD Deaths</th>
<th>CVD Mortality reduced - more active travel - Low est</th>
<th>CHD Mortality reduced - more active travel - High est</th>
<th>CVD Deaths reduced - Salt down 3g pd to 6g pd - Low est</th>
<th>CVD Deaths reduced - Salt down 3g pd to 6g pd - High est</th>
<th>CVD deaths reduced by 1% food energy from IPTFAs - Low est</th>
<th>CVD deaths reduced by 1% food energy from IPTFAs - High est</th>
<th>CVD deaths reduced by reducing sat fat from 14% to 7% of energy intake</th>
<th>CVD deaths reduced by reducing Cigs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>190,857</td>
<td>88,236</td>
<td>9,146</td>
<td>2,924</td>
<td>14,000</td>
<td>20,000</td>
<td>4,500</td>
<td>7,000</td>
<td>30,000</td>
<td>13,000</td>
</tr>
<tr>
<td>2010</td>
<td>178,705</td>
<td>80,338</td>
<td>18,292</td>
<td>2,924</td>
<td>14,000</td>
<td>20,000</td>
<td>4,500</td>
<td>7,000</td>
<td>30,000</td>
<td>13,000</td>
</tr>
</tbody>
</table>

Source: NICE. Prevention of Cardiovascular Disease at Population Level (PH25) (NICE. June 2010)
• Manage CVD as a single family of diseases
• Improve prevention and risk management
• Improving and enhancing case finding in primary care
• Better identification of very high risk families/individuals
• Better early management and secondary prevention in the community
• Improve acute care
• Improve care for patients living with CVD
• Improve intelligence, monitoring and research and support commissioning

“the NHS CB and PHE will look to establish a cardiovascular intelligence network (CVIN) bringing together epidemiologists, analysts, clinicians and patient representatives. The CVIN, working with the HSCIC, will bring together existing CVD data and identify how to use it best;
Cardiovascular Health Intelligence Network - Our Delivery Approach

**INTELLIGENCE INTO PRACTICE**
To embed information/intelligence into local service improvement

**TOOLS AND RESOURCES**
To continue to develop relevant and timely tools/resources through a single portal

**RESEARCH AND DEVELOPMENT**
To take a strategic lead on the creative/innovative development of information
Early deliverables relevant to SCNs

- **Data and Tools Workstream:**
  - Cardiovascular Key Facts: epidemiology (Dec 2013)
  - CVD, Renal and Diabetes SCN Profiles & summary key messages: (Dec 2013)
  - Diabetes Footcare Activity Profiles (February 2014)
  - NHSE Commissioning for Value CCG CVD Focus Packs (23rd May 2014)
  - Integrated cardiovascular profiles 2013 (2nd July 2014)
  - Diabetes and Obesity key facts (July 2014)
  - Atlas of Variation in Healthcare for Cardiovascular Disease?
  - Updated prevalence modelling?
Early deliverables relevant to SCNs

NCVIN into Practice workstream:

- Series of Cardiovascular master classes in each of the SCNs commencing September 2014

NCVIN Research and Development workstream:

- Facilitating access for SCNs to MINAP data through discussion with NICOR
The National cardiovascular intelligence network (NCVIN) analyses information and data and turns it into meaningful timely health intelligence for commissioners, policy makers, clinicians and health professionals to improve services and outcomes.

Cardiovascular disease (CVD)

The work of NCVIN includes coronary heart disease, stroke, hypertension (high blood pressure), hypercholesterolemia (excess cholesterol), diabetes, kidney disease, peripheral arterial disease (affecting blood vessels) and vascular dementia (caused by reduced blood flow to the brain).

Our services

CVD statistical and epidemiological analysis and interpretation

We analyse health data from surveys, audits and statistics displaying the results in easy to understand maps, charts and interactive profiles to allow comparisons to be made between places and organisations. Our expertise includes prevalence modelling, patient experience data, social marketing, health economics and summarising evidence of what works. Find out more

Translation of CVD health data and information into practice

Through training, advice, workshops and clinical champions we help local health professionals to understand and use CVD data and information to improve services.

Working together across the health and care sector

We work with the Health and Social Care Information Centre (HSCIC), NHS England, professional bodies, National Institute for Health and Care Excellence (NICE) and academic institutions to find new ways to get the most meaning from data through collaboration, research and data linkage Find out more
Conclusions

• CVDOS stresses an integrated approach to prevention & care

• Challenges to better ‘integration’:
  – System change across existing boundaries & defining scope
  – Recent major organisational change & financial constraints
  – Activating levers for change (commissioning, benchmarking, QOF, CCG OIS, Tariff, NHSIQ, NICE, Networks etc.) & policy
PUTTING PATIENTS FIRST

Business plan 2014-15 to 2016-17
Figure 1 – Our Delivery Model

- Research & evidence
- Communicating intent
- Clinical leadership
- Identifying & championing innovation
- Patient & public participation
- Identifying interdependencies
- Alignment with partners
- Leadership for change
- Spread of innovation
- Commissioning support & development
- Issuing guidance
- Setting standards
- Incentives (including finance, competition)
- Engagement to mobilise
- System drivers
- Transparent measurement
- Improvement methodology
- Rigorous delivery
- Funding & resourcing
- Commissioning assurance & system oversight

Better outcomes for all
Figure 2 – Our business areas

**High quality care for all, now**
- Prevention & Early Diagnosis
- Parity of Esteem
- Access to Urgent & Emergency Care
- Patient Experience
- Patient Safety
- Medical Revalidation
- Compassion in Practice
- Equality and Health Inequalities
- Maternity, Children and Young People
- Long Term Conditions, Older People & End of Life Care
- People with Learning Disabilities
- Primary Care Commissioning
- Public Health, Health & Justice and Armed Forces
- Specialised Services Commissioning
- Challenged Geographies
- Access to Elective Care
- Data, Digital Services & Customer Service
- Planning, Resources and Incentives

**High quality care for all, for the future**
- 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
- Seven Day Services
- Economic Contribution of the NHS

**Developing our organisation**
- Excellent Organisation Programme
- Customer Contact & Complaints
- Primary Care Support Services
- Corporate Services
- Commissioning Support

(N=31)
1. Prevention and early diagnosis

<table>
<thead>
<tr>
<th>Responsible National Director</th>
<th>Bruce Keogh</th>
</tr>
</thead>
</table>

**Scope of the business area**

The purpose of this business area is to prevent people from dying prematurely and to improve outcomes for patients as set out in domain one of the Outcomes Framework. Our aspiration is for England to become one of the most successful countries in Europe at preventing premature deaths, and the objective set out in our Mandate is to lead the system to avoid an additional 30,000 premature deaths per year by 2020.

<table>
<thead>
<tr>
<th>Objectives of the business area</th>
</tr>
</thead>
</table>

We will do this by:

- **supporting CCGs and Strategic Clinical Networks to identify their own clinical priorities** to address unwarranted geographical variations in premature mortality and to set and deliver on levels of ambition on reducing premature mortality

- **focusing attention on high-risk groups**, such as those with serious mental illness and learning disabilities for whom life expectancy is currently significantly lower than the general population. Developing commissioning guidance, tools and levers to drive change. This includes establishing a learning disability premature mortality review function

- **driving the provision of high quality, innovative patient-centred scientific services** to support accurate and timely diagnosis which is integrated across all delivery sectors with influential scientific leaders, aspirational providers and informed commissioners

- **developing a more holistic and unified approach to preventing ill-health across public health and healthcare**, working jointly with Public Health England (PHE), to address risk factors leading to preventable disease (e.g., tobacco, alcohol, poor diet) and supporting healthcare professionals to maximise their contribution to the prevention agenda by making every contact count. We will particularly focus on addressing the significant rise in alcohol misuse, which is contributing to increasing mortality from liver disease – the only big killer for which mortality outcomes are not improving.
<table>
<thead>
<tr>
<th><strong>Key deliverables</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Provide support to PHE on four cancer and two other symptom awareness campaigns by March 2015.</td>
</tr>
<tr>
<td>Produce an action plan to improve patient management following an NHS Health Check by March 2015.</td>
</tr>
<tr>
<td>Produce an action plan to improve the NHS contribution to prevention through ‘making every contact count’ by March 2015.</td>
</tr>
<tr>
<td>Publish comparative composite quality marker scores on ten clinical services by March 2015.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Increase the percentage of CCGs with confirmed access to scientific and diagnostic commissioning information to 75% by March 2015.</td>
</tr>
<tr>
<td>Scope a programme of work, in conjunction with PHE, to address alcohol misuse by June 2014.</td>
</tr>
</tbody>
</table>
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  — Recent major organisational change & financial constraints
  — Activating levers for change (commissioning, benchmarking, QOF, CCG OIS, Tariff, NHSIQ, NICE, Networks etc.) & policy

• Successful implementation will require collaboration
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- Government
- NHS England
- Public Health England
- Health Education England
- Local Authorities
- NICE
- NHS Improving Quality
- Strategic Clinical Networks
- Commissioners
- Primary Care
- Academic Health Science Networks
- Patients & Carers
- Charities
- Specialist Societies
- Royal Colleges
- NHS Trust Development Agency
- Monitor
- Care Quality Commission etc.
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