Department of Health & Social Care

Policy paper

Major conditions strategy: case for change and our strategic framework

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Applies to England

Contents

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Foreword

Good health should be fundamental to all our lives. But that is not the case for too many people living in England. In most instances, poor health arises from living with a least one of 6 major health conditions. That is why we have taken the decision to develop a major conditions strategy - a blueprint for improving outcomes over the next 5 years covering cancer, heart disease, musculoskeletal disorders, mental ill-health, dementia and respiratory diseases.

As Health and Social Care Secretary, I have been clear that my immediate focus is on ensuring that patients can get the care they need as we recover services from the shock of the COVID-19 pandemic. And we must acknowledge that the system remains under sustained pressure. But we also know that the needs of our population are changing rapidly and are fundamentally different from when the NHS was first created in 1948. Central to this is the rising incidence of multimorbidity. One in 4 of us are now living with at least 2 health conditions, and that proportion is expected to rise over time.

Only by adapting our model of care to tackle this multimorbidity challenge can we ensure the NHS is still there for us in 75 years. The ongoing development of integrated care systems means we have the right structures in place to join health and care up locally. Our approach at the centre must now evolve too. This means departing from the top-down approaches which have characterised the past and wholeheartedly embracing devolution, while recognising that the government will always play a central role in protecting and improving population health – whether through protecting our children from the harms of vaping or creating the right regulatory framework to accelerate the deployment of artificial intelligence (AI) technologies across the NHS.

Since announcing our intention to develop a major conditions strategy, the Department of Health and Social Care (DHSC) has met and worked with service users, unpaid carers, health and care staff and a wide range of charities, other bodies and the devolved governments to inform the direction set out in this document. An external advisory board, co-chaired by representatives from the NHS and government, has provided essential input and challenge.

This wide-ranging engagement has provided food for thought. We have heard how our citizens are not always empowered to live as healthily as they could, how people can find it difficult to navigate a fragmented system and that our present services are not always well placed to support people with more than one risk or condition. This means that support and care can be disjointed, waits are longer than they need to be, prescriptions interact unhelpfully and individuals living with long-term conditions can lack the ongoing help they need.

We have also heard many positive stories. About how advances in technology and research are now capable of unlocking new possibilities in secondary prevention, early diagnosis and treatment. About the potential for new workforce models in areas like rehabilitation, and the role of care navigation in delivering whole person care.

While this strategy is new, I believe there are lessons we can learn from the holistic approach taken by the Women's Health Strategy. One year on, over 300,000 more women have accessed cheaper hormone replacement therapy (HRT) and £25 million will be distributed across England for women's health hubs.

At this interim stage I am pleased to summarise what we have learned so far and share what we plan to do next. The document sets out our approach to making the choices over the next 5 years that will deliver the most value in facing the health challenges of today and of the decades ahead. It also makes the case for changing how we organise care, and in doing so breaking down the organisational and policy siloes between diseases.

Alongside our call for evidence and further work and engagement, the interim report will allow us to develop our final strategy over 2023 and into 2024.

The prospect of working differently to deliver real value for the people we serve is an exciting one. I look forward to working with patients and partners across the health and care system as we complete this important work.

The Rt Hon Steve Barclay MP

Secretary of State for Health and Social Care

Executive summary

The model of care which sustained us for the past 75 years must evolve considerably to meet the needs of the public in 75 years' time. We are living longer, but for too many people that life is experienced with many years in poor health.

This major conditions strategy begins with one question: how should our approach to health and care delivery evolve to improve outcomes and better meet the needs of our population, which is becoming older and living with multimorbidity?

We have chosen 6 groups of conditions to focus on: cancers, cardiovascular disease (CVD) (including stroke and diabetes),

musculoskeletal disorders (MSK), mental ill health, dementia, and chronic respiratory disease (CRD).

One in 4 adults has at least 2 health conditions (https://www.health.org.uk/publications/understanding-the-health-care-needs-of-people-with-multiple-health-conditions). The conditions we are focusing on together account for over 60% of ill health and early death in England. [footnote 1] Improving outcomes in each of these areas would transform the lives of millions of people and fulfil the UK government's aims to increase healthy life expectancy and reduce ill-health related labour market inactivity. That is the challenge we have set.

This strategic framework sets out our approach to addressing the challenge over the life course. It is not the full answer, but a framework for change. It begins by focusing on how we bear down on the principal lifestyle drivers of ill-health and disease, such as obesity and smoking. Almost everyone recognises that the hardest yards but biggest gains are found in primary prevention - and so we set out several things we want to do now, and several priority areas for ongoing development ahead of publishing the final strategy.

Another important element of the pathway is intervening early to reduce exacerbations and complications, which we term secondary prevention. This has risen to prominence following the COVID-19 pandemic, where it is likely that millions of people did not come forward as usual for check-ups, tests, scans and treatments (https://www.health.org.uk/publications/long-reads/elective-care-in-england-assessing-the-impact-of-covid-19-and-where-next). This strategic framework identifies and delivers several specific actions we will take now, recognising the very present and significant health risks that derive from low uptake of secondary prevention. But we want to be bolder still and see this as an area with significant potential in the final strategy.

We then come to early diagnosis, early intervention and quality treatment. If we can identify a major condition early, outcomes are far better and the impact on a person's life is much reduced. But historically the NHS has not performed well in ensuring a timely diagnosis - be that in dementia, stroke or MSK. There are signs of positivity with exciting new technologies and sources of data that enable staff to better see and treat disease at an earlier stage. We want to explore how to supercharge this agenda.

Our final step in the pathway is on supporting people as they manage living with major conditions. For many of us now and in the future, major conditions will be things we live with over many years, and while many long-term conditions cannot be cured, they can be managed well. [footnote 2] [footnote 3] It will not always be possible for them to be fully prevented or fully cured through treatment. In this context a different set of services - including in areas like care co-ordination, symptom management and support for family and unpaid carers becomes more important.

Underpinning all these areas are 3 cross-cutting enablers: digital technologies and innovation, research and leadership. If we can get these into the right place we can ‘make the boat go faster’. In some cases that involves getting government out of the way; in others it is about how we can better align regulators, funding and the system to create the conditions for innovation to flourish. Also underpinning these areas is a strong desire to tackle health disparities and promoting inclusion in health, as articulated through the NHS Core20PLUS5 framework.

This approach, which takes us away from single disease strategies, is significant but entirely consistent with our wider shift towards integrated care. We have grown accustomed to planning our health and care delivery around treating a person based on an individual health condition, often with a workforce model that favours specialism and an incentive structure which focuses on single episodes of activity. In some areas this has been beneficial: our world-leading institutions in cancer are obvious examples of where deep subject specialism unlocks innovation and redefines both outcomes and the subsequent standard of care. The challenge is to retain these strengths while pivoting to a model that is built around whole-person care. The creation of integrated care systems (ICSs) was an important first step, and this document will seek to continue that evolutionary journey.

A small number of countries sharing the same challenges, are leading the world in identifying solutions for their health and care needs. The Danish government recently produced a multimorbidity strategy (https://healthcaredenmark.dk/news-publications/publications/chronic-diseases-and-multimorbidity-in-denmark/), and elsewhere in Europe other countries, such as Finland, are looking to take a pan-disease approach where they are focusing on the integration of services (see the factsheet on Finland, under the heading ‘Country factsheets’ (http://www.icare4eu.org/projrep.php)). In developing this strategy, the UK is joining them in this approach.

This strategy has the potential to drive a transformation in parallel to our pandemic recovery. Our 3 recovery plans will help recover core access standards, but in parallel we need to help transform services for the future while maintaining their accessibility. Issues with inconsistent access to care are found right across the 6 condition areas - from mental health to cardiovascular disease. Any approach to redesigning services must address those immediate access challenges, too.

We need to be both stretching but realistic about how quickly we can turn things around. The 5-year timeframe set out creates a meaningful period to achieve results - as changes of this type don’t happen overnight - but avoids the pitfalls of longer-term strategies where too many deliverables are in years 9 or 10. The 5-year horizon aligns to the planning cycle for our new ICSs, which became statutory in July 2022 and have recently concluded their own 5-year planning cycle.

This strategic framework concludes by setting out how we intend to best concentrate efforts. This necessitates difficult choices. But learning from our conversations to date, we think we can make the most difference in the following 5 areas which will have the greatest collective impact across all the conditions:

- rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
- embedding early diagnosis and treatment delivery in the community
- managing multiple conditions effectively - including embedding generalist and specialist skills within teams, organisations and individual clinicians
- seeking much closer alignment and integration between physical and mental health services
- shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care

The health and care system is already making encouraging progress, including expanding our screening programmes in the community (such as the recently announced England-wide roll out of our targeted lung cancer screening programme), work on community diagnostic centres, and the commitment to develop practical information and evidence to support local investment decisions in prevention.

But that is only the start. The major conditions strategy will consider what more we can do - for example, using technology to identify opportunities for earlier testing of populations at risk, including opportunistic testing in non-healthcare settings, building on successful work on frailty to identify opportunities for anticipatory care, and exploring how approaches to care co-ordination that have worked well in one context could be adapted to another.

We will explore these themes and issues further as we develop the final strategy. However, strategies alone will not change outcomes. Delivery will require concerted effort from the UK government and the NHS working in tandem, alongside social care, patient representatives, industry and partners across the health and care system. It is a collective endeavour, but also a massive opportunity to preserve and protect good health for generations to come.

While the major conditions strategy's focus is on England, there is shared commitment to ensuring access to quality health and care services across the UK, as part of the UK government's commitment to level up the UK's health. In the Levelling Up white paper (https://www.gov.uk/government/publications/levelling-up-the-united-kingdom), the UK government committed to narrowing the gap in healthy life expectancy between local areas where it is highest and lowest by 2030, and to raising

healthy life expectancy by 5 years by 2035. The white paper recognises that, while health is largely a devolved matter, health outcomes are a shared interest for the whole of the UK and there is opportunity for all layers of government to work together with the purpose of levelling up health across the UK.

Our call for evidence closed on the 12 July 2023, and we will be analysing those responses to inform our thinking, as well as undertaking further substantial engagement to ensure that we hear from a wide range of voices.

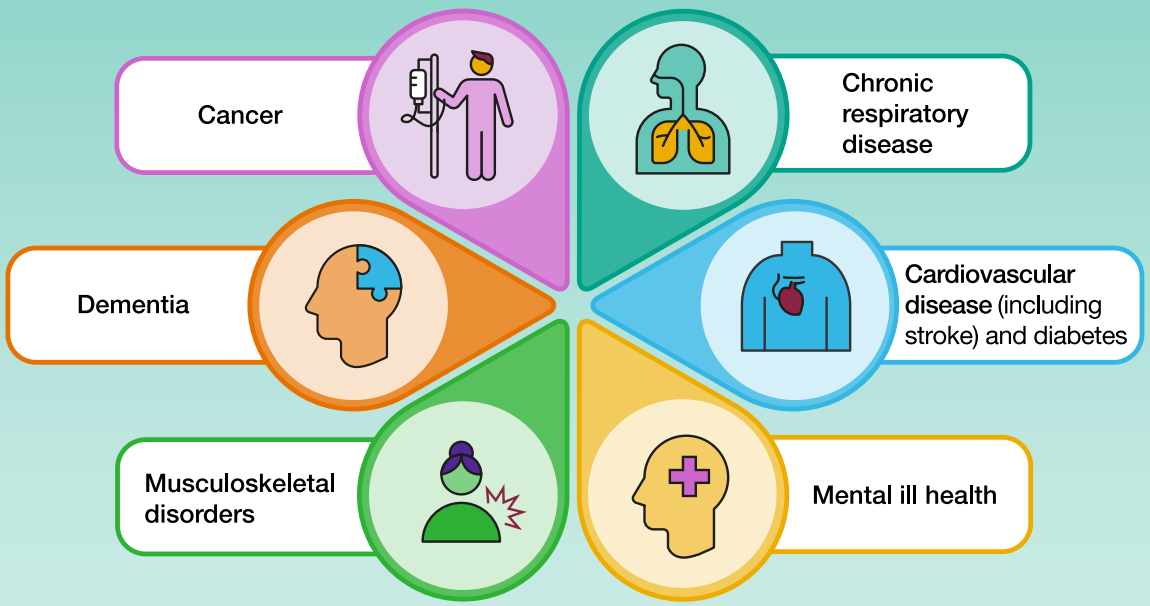
Delivering on the ambitions of this strategy is a collective endeavour, but also a massive opportunity to preserve and protect good health for generations to come.

Summary of strategic framework

Department of Health & Social Care

Major Conditions Strategy
Strategic framework

Together six groups of major health conditions drive over 60% of mortality and morbidity in England, and it is increasingly common for patients to experience two or more of these conditions at the same time.



Our strategic framework focuses on:

Primary prevention: acting across the population to reduce risk of disease

Secondary prevention: halting progression of conditions or risk factors for an individual

Early diagnosis: so we can identify health conditions early, to make treatment quicker and easier

Prompt and urgent care: treating conditions before they become crises

Long-term care and treatment: in both NHS and social care settings

To have the greatest impact, we will prioritise change in five areas:

1. Rebalancing the health and care system towards proactive prevention by **managing personalised risk factors**
2. Embedding early diagnosis and treatment **in the community**
3. Managing multiple conditions effectively – including through **aligning generalism and specialism**
4. Better connection and **integration between physical and mental health services**
5. Shaping services and support around people, giving them **more choice and control over their care**

Full description text is available (https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/summary-of-strategic-framework#description-of-image)

Chapter 1: our nation's health

There have been significant changes in society and in the health of people since the establishment of the NHS and social care system in 1948. The health and care system has been enormously successful in driving increases in life expectancy. Compared to 1948, 1979 or 2010, individuals are living longer (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2018to2020) and spending more years in good health (https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/). In its early years, the NHS significantly reduced the impact of infectious diseases (for example, through systematic and wide-ranging vaccine programmes) and then moved on to tackle early death from non-communicable diseases (https://www.england.nhs.uk/nhsbirthday/about-the-nhs-birthday/nhs-history/) (through innovations in treatment and reductions in behavioural risk factors such as smoking (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7042976/)). To continue to improve healthy life expectancy, we must now do more to promote good health and identify and treat non-communicable diseases as early and as effectively as possible.

This chapter sets out the 6 groups of major conditions that drive the majority of ill health and early death along with further detail on how health needs are changing and the value - and centrality - of health to our national life and wellbeing.

The 6 groups of major conditions

Six groups of conditions are collectively the greatest contributors to ill-health and early mortality.[footnote 1] These are:

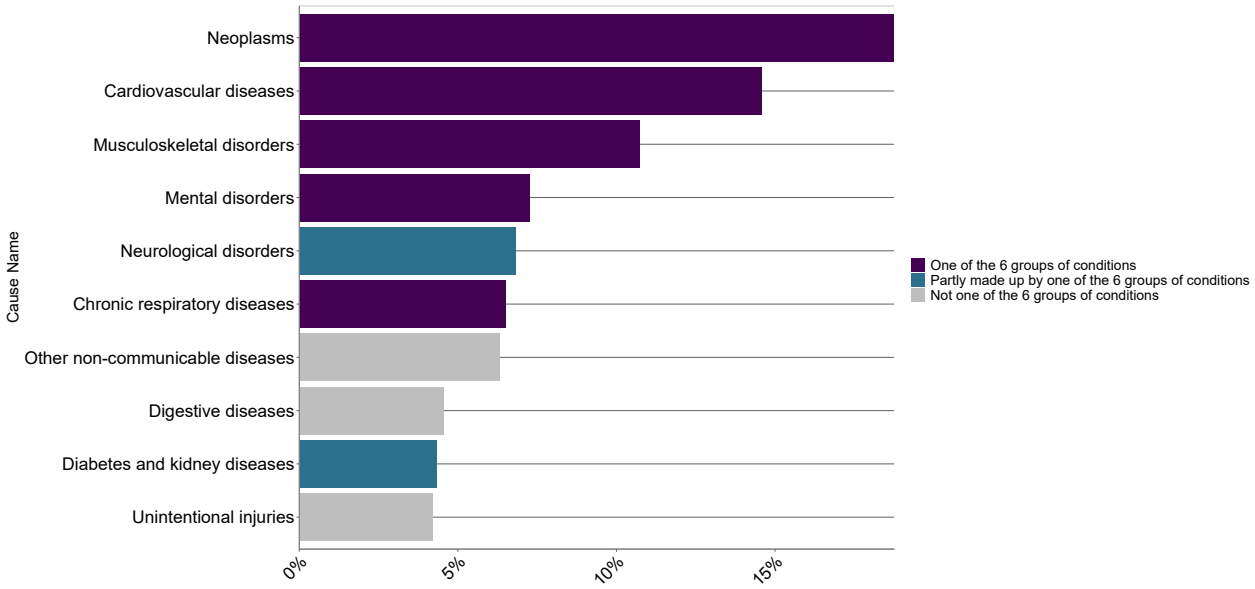
- cancers
- cardiovascular disease (CVD), including stroke and diabetes[footnote 4]
- musculoskeletal disorders (MSK)
- mental ill health
- dementia[footnote 5]

- chronic respiratory disease (CRD)

These conditions can affect people throughout their lives, including children, young people and working age adults as well as older people, and collectively they represent the cause of over 60% of the years lost to early death or lived in ill health.[footnote 1] In addition, cancer, circulatory diseases, respiratory diseases and mental ill health account for nearly 60% of the gap in life expectancy between the most and least deprived areas of England (2020 to 2021).[footnote 6]

Figure 1 shows that these 6 groups of conditions are leading contributors to the total disability-adjusted life year (DALY)[footnote 7] burden in England.

Figure 1: the proportional contribution of major health conditions to the total DALY burden in England (2019)



Source: Global Burden of Disease, 2019 (https://vizhub.healthdata.org/gbd-results/)

There are significant commonalities between these conditions. Many are most prevalent in older age groups, and there will be several million more over-65s in the country in coming years (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea14principalprojectionenglandsummary). They share similar causes: risk factors like smoking and obesity are linked to each of the 6 categories of conditions, as are living conditions like employment, housing, education and access to green space (see Wider Determinants of Health, Further Information (Fingertips) (https://fingertips.phe.org.uk/profile/wider-determinants/supporting-information/further-information), both directly and through making it easier or harder to make healthy choices[footnote 8]. Through these mechanisms, prevention activities can impact on multiple conditions at once, and more

prevention activity will be crucial to meeting the challenges of an ageing society.

We know that some risk factors have significant impacts across a range of conditions as illustrated in table 1.

Table 1: the proportion of the DALY burden of each of the 6 groups of conditions that is attributable to key risk factors from the Global Burden of Disease (https://vizhub.healthdata.org/gbd-results/) (GBD)[footnote 9]

Key risk factors	CVD	CRD	Neurological disorders	Cancers	Diabe
High fasting plasma glucose (blood sugar levels)	25%	Not applicable	5%	6%	100%
Tobacco	20%	45%	6%	28%	17%
High BMI	22%	6%	6%	7%	58%
Dietary risks	35%	Not applicable	Not applicable	6%	37%
High systolic blood pressure	45%	Not applicable	Not applicable	Not applicable	Not applic
High LDL cholesterol	26%	Not applicable	Not applicable	Not applicable	Not applic
Occupational risks	Not applicable	8%	Not applicable	9%	Not applic
Air pollution	5%	5%	Not applicable	1%	9%
Non-optimal temperature	6%	11%	Not applicable	Not applicable	2%
Low physical activity	4%	Not applicable	Not applicable	1%	11%
Kidney dysfunction	6%	Not applicable	Not applicable	Not applicable	Not applic

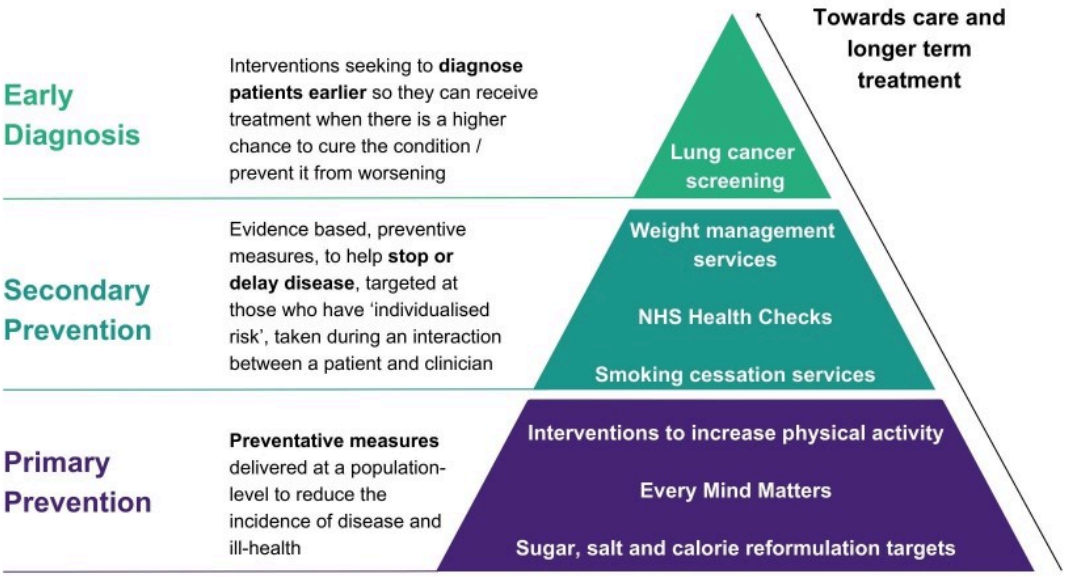
Key risk factors	CVD	CRD	Neurological disorders	Cancers	Diabe
Alcohol use	1%	Not applicable	2%	6%	-3% [footno

Note: The table above presents analysis from one source, GBD, and therefore is affected by limitations of GBD data. There is better availability of evidence for some conditions (such as CVD), and limited availability for others (such as mental health conditions). Therefore, we may expect the attributable burden to be higher than what is presented here.

Also, mental health conditions have not been included in the table above as no single risk factor was linked to a greater than 5% burden. This is partly because of the stringent acceptance of evidence for risk impacts that GBD accepts leaving only a few risk factors that have a partial impact on the condition (such as childhood sexual abuse and bullying, partner violence and environmental risks). Other wider risk factors which are known to affect mental health, such as working conditions, are not considered in GBD. Other evidence linking risk factors and mental health conditions, such as evidence linking smoking and depression risk is not included in GBD.

Figure 2 presents the definitions of preventative activities, from primary prevention, which is delivered at a population level, to secondary prevention which aims to help stop and delay disease for those at higher risk, and finally to diagnosing patients already with diseases earlier.

Figure 2: definitions and examples of different types of preventative healthcare interventions



These major conditions also share similar profiles: in many cases people are living longer with these conditions (https://ageing-better.org.uk/health-state-ageing-2022) and they are chronic and lifelong, requiring a different approach to treatment centred around helping people live well with their conditions. This means a greater focus on secondary prevention (such as managing hypertension to reduce the risk of further cardiovascular events) as well as a person-centred approach to care overall, that takes patient preferences into account and provides a holistic and long-term approach, from prevention activities right through to long-term treatment and end of life care.

This is particularly true for the many people who suffer from more than one of these conditions concurrently - for instance, we know that there can be significant mental health impacts from physical health conditions (https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/3-understanding-people). In addition, many of the actions to tackle these 6 groups of conditions will have real benefit for a wider range of other conditions too (such as renal disease and challenges associated with chronic pain).

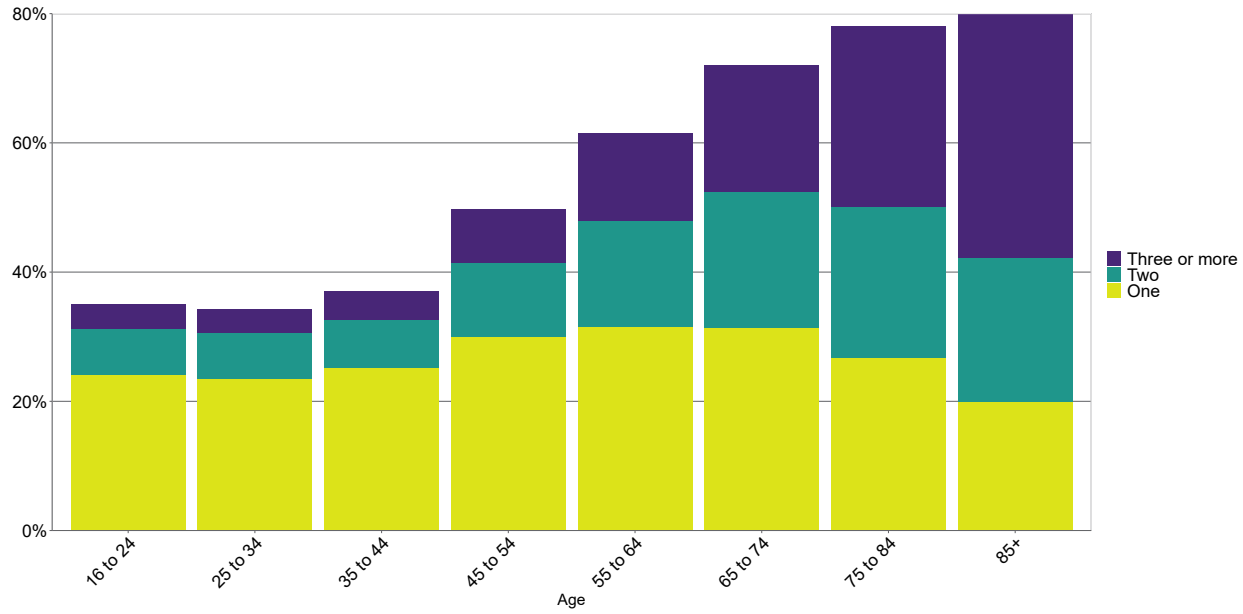
Finally, we know that behaviours at one stage of life can influence health later on (for example, regular physical activity habits throughout childhood and adulthood can help to reduce the risk of MSK and CVD in later years (https://www.cdc.gov/physicalactivity/basics/adults/health-benefits-of-physical-activity.html)) and that major conditions can affect people at any stage in their life. Children and young people, working age adults and older people all have specific needs and preferences to be considered in our models of prevention and treatment. That is why our strategy, and the rest of this document, will take a whole life course approach.

Our nation’s changing health needs

We have made huge progress since the NHS was founded in 1948. Healthy lifestyles, better availability of preventative interventions, and public health programmes, including immunisation and screening, have played an essential role in helping people to live longer, healthier lives over the last few decades. For example, the death rate from CVD has fallen by almost 80% since 1969 (https://www.bhf.org.uk/what-we-do/our-research/heart-and-circulatory-diseases-in-numbers/death-rates-over-time).

However, demographic change and the changing burden of disease are reshaping society and the health and care system. Figure 3 demonstrates that the likelihood of having a long-term condition rises significantly for older age groups: most people in the 55-64 age group and older have at least one long-term condition, including 80% of people over 85 (https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-urgent-and-emergency-care-services-january-2023/), and a rapidly increasing proportion of the population is over 65 (projected to be 3 million more people over the next decade and a half).[footnote 11]

Figure 3: proportion of age cohorts living with long-term conditions



Source: GP Patient Survey (https://gp-patient.co.uk/), 2022

As a result, we are spending a greater proportion of our lives with a limiting condition compared to a decade ago (https://ageing-better.org.uk/health-state-ageing-2022), while more and more people have multiple long-term conditions (MLTC); by 2035, two-thirds of adults aged over 65 will have 2 or more conditions and 17% will have 4 or more (https://academic.oup.com/ageing/article/47/3/374/4815738). Estimates from 2018 suggest one in 4 adults had 2 or more health conditions, with 92% of people with CVD and 70% of those with mental ill health having at least one other

condition (https://reader.health.org.uk/understanding-health-care-needs-people-multiple-health-conditions). For chronic obstructive pulmonary disease (COPD), almost 50% of patients have 3 or more comorbidities, with these often representing life-threatening conditions such as ischaemic heart disease.[footnote 12]

Living with long-term conditions and MLTC is not solely a problem in older age groups. Since 2011, over half of new cases of MLTC each year occurred in individuals younger than 50 years, and the median age of complex MLTC onset dropped below 60.[footnote 2] The problem also extends to children and young people: 16% of children up to 15 years old had one or more longstanding condition in 2017 to 2018, increasing to one in 4 for those aged 16 to 24.[footnote 13] In adults aged under 45, the most common type of long-term conditions were mental, behavioural and neurodevelopmental conditions, followed by MSK and respiratory conditions.[footnote 14]

This burden of disease has enormous implications for people's lives, their families, the economy and for the future of the health and care system. People with 2 or more conditions account for around 50% of hospital admissions, outpatient visits and primary care consultations, over half of NHS costs and around three-quarters of the costs of primary care prescriptions (https://www.health.org.uk/publications/understanding-the-health-care-needs-of-people-with-multiple-health-conditions).

In many instances those with a long-term condition report their experience of care (from GP practices, the main entry point for the health system) as good, or better, than those without a condition but those with mental health conditions report it being significantly worse (https://gp-patient.co.uk/). In addition, growing numbers of people living with multiple conditions have to contend with a health system that "tend[s] to be organised along single disease or single organ lines".[footnote 15] This can have a negative effect on their experience of care, as many report being frustrated with having to see multiple different healthcare professionals as a result of their multimorbidity and the potential for adverse drug effects grows as the number of drugs prescribed increases.[footnote 16]

There are significant disparities in how ill health affects our population (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2018to2020), which is part of the context for our mission to level up health across England and the UK. In general, people experiencing greater socio-economic deprivation die younger and spend a greater proportion of their lives in poor health than others. For instance, a woman in one of the most deprived areas of England[footnote 17], such as Blackpool, dies, on average, 8 years younger and spends 19 fewer years in good health than a woman living in one of the least deprived areas, such as Wokingham (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/datasets/healthstatelifeexpectanciesbynationaldeprivationdecilesengland

2018to2020). Different parts of the country face differing health challenges too: for example, older people are increasingly concentrated in rural areas (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongertrendsinsubnationalageingacrosstheuk/2020-07-20) which, due to their health needs, presents specific social and economic challenges locally and nationally.

There are multiple dimensions to disparities too, including factors such as gender and ethnicity as well as social exclusion experienced by people in inclusion health groups.[footnote 18] Women often face a one-size-fits-all health system (https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england) that does not consider their health needs by default. Men are less likely to access psychological therapies than women: only 36% of referrals to NHS talking therapies are for men (https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/men-and-mental-health), but around 3 out of 4 suicides are by men (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations).

Latest ONS data finds that from 2011 to 2014 overall life expectancy was higher among ethnic minority groups[footnote 19] than white and Mixed groups (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/ethnicdifferencesinlifeexpectancyandmortalityfromselectedcausesinenglandandwales/2011to2014), but there are significant other health differences between ethnic groups too. For instance, diabetes prevalence is 3 to 5 times higher in ethnic minority groups compared to the white British population.[footnote 20] People in inclusion health groups, such as people experiencing homelessness, face barriers in access to health and care, and have significantly worse health outcomes during their lifetime (https://bmjopen.bmj.com/content/9/4/e025192), which can be significantly shorter (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations)[footnote 21]. Additionally, it is estimated that people with serious mental illnesses have lower life expectancy by 10 to 20 years (https://onlinelibrary.wiley.com/doi/10.1002/wps.20128/abstract;jsessionid=B60892E7B3255CBFF2769094A7E3F60A.f04t04).

The development of the major conditions strategy will include consideration of disparities in health outcomes from multiple angles, including ethnicity, deprivation and inclusion health. This is an opportunity to make sure local services reflect the needs of local populations and that everyone in England has access to the care they need when they need it. The major conditions strategy will consider the differential impact on gender, in particular any women-specific or men-specific issues, and take a life course approach to health, considering wider determinants of health.

The value of health

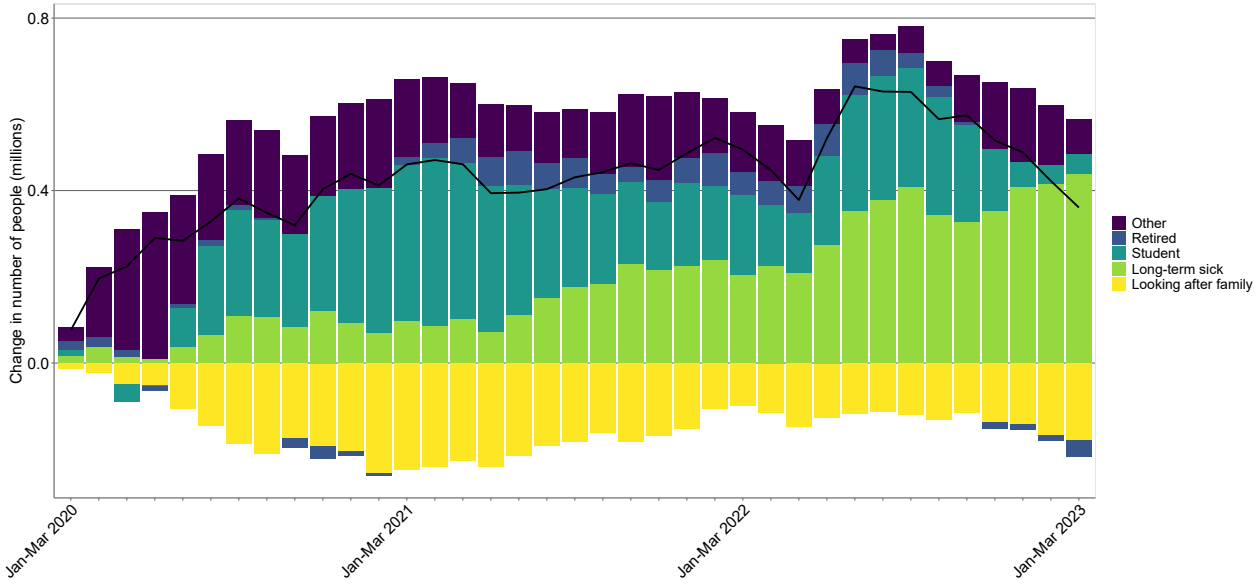
The health of the nation is critical for the health of our economy, our public services and, above all, the wellbeing and life chances of all our citizens.

There are now 8.65 million economically inactive people in the UK (https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa) (people who are neither working nor available for work), a rise of 281,000 since early 2020, with 50- to 64-year-olds and people with work-limiting health problems largely driving the increase (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentunemploymentandeconomicinactivitybyagegroupseasonallyadjusteda05sa). Long-term sickness is now the most common reason for being economically inactive, with 2.52 million people of working age reporting this as the main reason in March to May 2023.[footnote 22]

Much of the recent increase in long-term sickness has been driven by people with a mental health condition, MSK or CVD, and around a third of those long-term sick report 5 or more health conditions.[footnote 23] Figure 4 shows the change in the number of people who are economically inactive by reason from early 2020 through to early 2023, which includes significant growth in those inactive due to long-term sickness over that period. Tackling economic inactivity due to long-term sickness is a top priority for the government. The chancellor announced £2 billion at the Spring Budget 2023 to support disabled people and people with health conditions to work.

Alongside the impact on individuals, the economic cost of ill health is substantial. Economic costs of lost output due to illness (https://www.oxera.com/insights/reports/the-economic-cost-of-ill-health-among-the-working-age-population/) among working age people were estimated earlier this year to be around £150 billion per year, or 7% of gross domestic product (GDP), and have grown substantially since 2016. Furthermore, the impact does not fall equally, with higher economic inactivity due to poor health in some regions (https://www.ippr.org/research/publications/getting-better-health-and-labour-market) (rates in the North East are 5.7% versus 3.1% in the South East).[footnote 24] More generally, if health in all local authorities attained the level of the 10% of local authorities with the best health outcomes, labour productivity would rise by at least 1.5% per hour worked (by comparison labour productivity has risen by 0.7% on average each year since 2010 (https://www.ippr.org/research/publications/health-and-prosperity)).

Figure 4: change in the number of people who are economically inactive by main reason, ages 16 to 64 (UK), January to March 2020 to January to March 2023



Source: ONS, 2023 (https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa/current)

Together, these conditions represent over 60% of all ill health and early death [footnote 1], and in the UK in 2019 about 10% of GDP was spent on health (https://pubmed.ncbi.nlm.nih.gov/31901175/) (rising to 12% since the pandemic). The major conditions individually incur significant health costs. Diabetes, for instance, is an expensive condition to manage and treat - particularly so when it comes to its complications. In 2019, the NHS spent at least £10 billion a year on diabetes across the UK, equivalent to 10% of its budget.[footnote 25] Action to tackle the prevalence of major conditions has the potential to offset some of the cost pressures on the NHS and social care services, with more effective prevention releasing significant sums for other NHS services.

Most importantly, we can also see the impact of ill health on individuals. Developing one or more of the major conditions naturally has significant effects on an individual's life, as well as that of family and friends. Almost half of adults with one or more longstanding conditions described their general health as fair, bad or very bad (47%) compared with 8% of those without a longstanding condition.[footnote 15]

Chapter 2: keeping people healthy through primary and secondary prevention

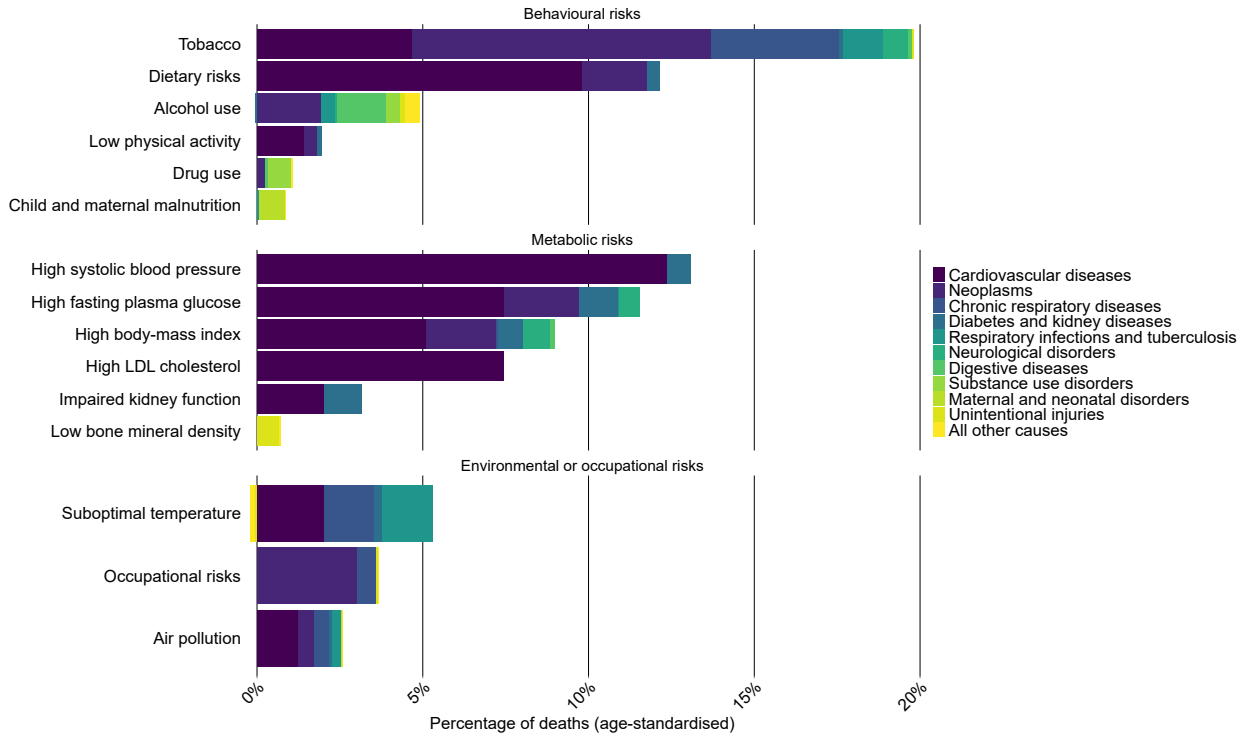
Empowering people to create healthy lives

Creating healthy lives is not just a matter for government. It also means empowering and enabling people to manage their own health and engage in healthy behaviours across their lives. Action starting from childhood and through adulthood can help individuals across the population to live healthy, active lives, well into old age (https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review).

Many behavioural risk factors are formed early in people's lives. For example, the majority of smokers start smoking before turning 18 (https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england), and people who start smoking at a young age lose on average 10 years of life expectancy (https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs). Smoking remains the biggest single cause of preventable illness and death (https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html), driving health disparities and directly contributing to developing all major groups of conditions - for instance, smokers are 25 times more likely to get lung cancer than non-smokers (https://www.cdc.gov/tobacco/sgr/50th-anniversary/index.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Ftobacco%2Fdata_statistics%2Fsgr%2F50th-anniversary%2Findex.htm). Equally, poor diet and physical inactivity, which contribute to overweight and obesity, drive health disparities and a range of major groups of conditions (https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives). For instance, a woman living with obesity is more than 3 times more likely to have a heart attack than a woman of healthy weight (https://www.bhf.org.uk/what-we-do/our-research/heart-statistics).

We also know that tackling these risks can impact on a wide range of conditions. Forty per cent of dementia cases are potentially preventable or delayable if action is taken against 12 known risk factors across the life course.[footnote 26] Approximately 42% of ill health and early death (measured in DALYs) in England is attributable to identified risk factors, many of which are preventable (https://www.healthdata.org/research-analysis/gbd), including 9 out of 10 strokes.[footnote 27] These can be physiological factors such as high blood pressure, or behavioural factors such as smoking tobacco. As shown in figure 5, tobacco, obesity and diet-related factors, low physical activity and alcohol and drug use account for most of the burden of ill health and early death that has been attributed to known modifiable risk factors.

Figure 5: age standardised mortality attributed to risk factors, broken down by cause of mortality, England (2019)



Source: Public Health England (https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html), 2021

To tackle this, the UK government is taking an extensive range of actions against behavioural and other risk factors driving ill health. We are a global leader on tobacco control and we now have the lowest smoking rate on record - 13% in England (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/smokingprevalenceintheukandtheimpactofdatacollectionchanges/2020). This is down from around 20% in 2010 and 45% in 1974 (https://ash.org.uk/resources/view/smoking-statistics). To realise our goal to be smokefree by 2030, we are committed to helping more people across the UK quit smoking. Our strong regulation, world-leading anti-smoking marketing campaigns, funding for highly effective local stop smoking services and robust enforcement against illicit tobacco sales have put us on the right track. We are now taking forward innovative proposals to help smokers quit, including funding a new national ‘swap to stop’ scheme - the first of its kind in the world - to offer a million smokers across England a free vaping starter kit (https://www.gov.uk/government/news/smokers-urged-to-swap-cigarettes-for-vapes-in-world-first-scheme). We are also launching a UK-wide consultation about mandating quit-themed information messages and advice (also called ‘pack inserts’) inside tobacco packets to help more smokers quit.

We are investing an additional £780 million to produce a world-class treatment and recovery system to reduce drug and alcohol-related harms (https://www.gov.uk/government/news/largest-ever-increase-in-funding-for-drug-treatment). Working with the Department for Education, we have also invested around £300 million in Family Hubs and Start for Life programmes

(https://www.gov.uk/government/news/thousands-of-families-to-benefit-from-local-support-in-rollout-of-family-hubs) in 75 local authorities with high levels of deprivation to support parents and carers to nurture their babies and children.

We are also working to support people already living with obesity to achieve and maintain a healthier weight. NHS England (NHSE) is expanding new specialist clinics for children living with severe obesity (https://www.england.nhs.uk/2023/06/nhs-to-open-new-specialist-clinics-for-obese-children-and-young-people/), and on 7 June 2023, we announced a 2-year pilot backed by up to £40 million to explore ways to make the newest and most effective weight loss drugs accessible to more eligible patients living with obesity outside of hospital settings (https://www.gov.uk/government/news/new-drugs-pilot-to-tackle-obesity-and-cut-nhs-waiting-lists)

We are also designing and testing innovative ways of using technology to bring services to people and empower them to make healthier choices. In partnership with the City of Wolverhampton Council, we are piloting the free digital Better Health: Rewards app (https://www.gov.uk/government/news/government-backs-new-scheme-to-improve-peoples-health-in-wolverhampton), which launched in February 2023. Over 28,000 residents have registered on the app, equivalent to over one in 8 adults in Wolverhampton. Learning from similar successful initiatives in other countries, the app offers financial incentives for completing personalised weekly physical activity and diet challenges to support behaviour change. We have developed new partnerships with national and local businesses, including major supermarkets, gyms and the local football club to ensure the financial rewards are attractive to Wolverhampton residents and incentivise participants to make healthier choices. The pilot is expected to finish in October 2023, and we will evaluate its impact to inform our future approach towards tech-driven health behaviour change.

Creating healthy lives means encouraging healthy behaviours for both physical and mental health. We know that the majority of mental health problems are established early on in life (https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health/wellbeing-in-mental-health-applying-all-our-health), and so we are extending coverage of mental health support teams in schools and colleges (https://www.england.nhs.uk/mental-health/cyp/trailblazers/) to at least 50% of pupils in England by the end of the 2024 to 2025 financial year. We also know that suicide rates are particularly high among men, who make up around three-quarters of all suicides (https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/men-and-mental-health). We have committed to publish a new national suicide prevention strategy this year, which will reflect new evidence and national priorities for preventing suicides across England, including action to tackle risk factors that particularly affect men.

We will continue to combine supporting and empowering individuals to engage in health-promoting behaviours for their own health and that of their families with government action to positively shape the environment and the options for people. Both will be needed, and both are possible.

Primary prevention: tackling the wider determinants of health

We recognise that our physical, social and economic environment has a significant influence on our health (https://www.gov.uk/government/publications/health-profile-for-england-2018/chapter-6-wider-determinants-of-health). The wider determinants of health such as income, education, work, housing, relationships, families, access to nature and our physical environments can have enormous impacts on our health and our behaviours, and impact people throughout their lives and across generations (https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review). Research suggests these wider determinants are more important than healthcare in determining health outcomes (https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health).

The establishment of ICSs in 2022 means that local authorities, the NHS and the voluntary and community sector can come together to improve the lives of people in their area. We are building on this further: in responding to the Hewitt Review, the government reiterated its support for systems, and the unique opportunity they present to make meaningful long-term improvements to populations' health and wellbeing. The NHS therefore has an important part to play in addressing these wider determinants and delivering on population health outcomes.

Tackling these wider determinants is key to progress towards our UK-wide healthy life expectancy targets, as set out in the Levelling Up white paper (https://www.gov.uk/government/publications/levelling-up-the-united-kingdom) published last year. We know that they affect health directly, and that they drive MLTC. For example, poor air quality both contributes to causing and exacerbates respiratory and cardiovascular conditions, lung cancer and dementia (https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2022-air-pollution).

The circumstances we live in also affect health indirectly by influencing our behaviours and choices, which in turn impact health outcomes. Access to affordable, healthy food and safe, unpolluted open spaces, for instance, are vital for people to be able to make positive dietary choices and increase their physical activity levels, which in turn impact on obesity levels and other conditions (https://www.gov.uk/government/publications/health-matters-obesity-

and-the-food-environment/health-matters-obesity-and-the-food-environment--2). The prevalence of obesity in year 6 children is twice as high in the most deprived areas compared to the least deprived (https://commonslibrary.parliament.uk/research-briefings/sn03336/).

Additionally, risk factors (behavioural and otherwise) often cluster, further driving the increase in experience of multiple conditions and health disparities.[footnote 16] For example, those living in deprived areas or circumstances who drink alcohol at increasing or higher risk levels are also more likely to smoke, have a poor diet and low exercise levels, and experience poor mental health, including severe mental illness.[footnote 28]

Both national and local government action can be vital in shaping the environment in which people make choices, and government can make changes to help people live more healthily. For example, we are:

- working with stakeholders and industry to reduce sugar, salt and calories in food (https://www.gov.uk/government/collections/sugar-reduction), including for baby food and drink
- working through the Food Data Transparency Partnership (https://questions-statements.parliament.uk/written-questions/detail/2023-07-17/194380) to enable and encourage food companies to demonstrate progress on the healthiness of their sales
- working with the Department for Culture, Media and Sport on the new sport strategy to unite government and the sport sector in increasing opportunities to get active
- helping children be more active in schools through the school sport and activity plan (https://www.gov.uk/government/publications/school-sport-and-activity-action-plan) jointly with the Department for Education and the Department for Culture, Media and Sport

In addition to working with local government, we will continue to collaborate with other departments. We have also:

- set legally binding targets to reduce exposure to the most harmful air pollutants (https://www.gov.uk/government/news/new-legally-binding-environment-targets-set-out)
- ensured safer, more stable and better-quality homes through the Renters (Reform) Bill (https://bills.parliament.uk/bills/3462)
- introduced a new cross-governmental commitment to ensure everyone is within 15 minutes of a green or blue space (https://www.gov.uk/government/news/natural-england-unveils-new-green-infrastructure-framework)
- established Active Travel England to help deliver over £3 billion of investment through the second cycling and walking investment strategy (https://www.gov.uk/government/publications/the-second-cycling-and-walking-investment-strategy) to increase cycling and walking

We are also working with the Department for Levelling Up, Housing and Communities to ensure that the Levelling Up Partnerships (LUPs) programme (https://www.gov.uk/government/news/levelling-up-at-heart-of-budget), which received £400 million of capital funding in the spring budget, improves the health outcomes of the selected areas which face the greatest health disparities. English devolution and LUPs provide important opportunities for us to work together at different levels of place to pilot opportunities that further empower local authorities and combined authorities to act on policies that deliver good health outcomes which are the right local solutions for their populations. Different issues can require work on different geographical footprints, but ICSs provide an important structure for collaboration and joint planning on health between the NHS, local authorities and other partners to deliver better health for local people.

Secondary prevention: stopping or delaying the progress of conditions

Improvements in secondary prevention - evidence based, preventative measures to help stop or delay disease - have driven significant advances in healthy life expectancy over the last century (https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/). Through ICSs and integrated care boards (ICBs), the NHS has a greater role in identifying and offering targeted interventions to people at risk of developing more serious illness. There is a robust evidence base for secondary prevention interventions and this approach has a proven track record of reducing risk in individuals and populations (https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/).

We want to bring services into the community and make it easier for people to access diagnosis and treatment. That is why we are investing £645 million over 2 years so the NHS can expand services offered by community pharmacy (https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/), including expanding the provision of blood pressure services this year to increase the number of people diagnosed with hypertension. This could save up to 10 million appointments a year, equivalent to around 3% of all appointments, and give the public more choice in where and how they access care (https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/).

To further bring services to people, we are:

- evaluating self-sample cervical screening tests for women who have not attended previous screening appointments
- increasing the number of people who self-monitor at home, including their blood pressure, and making this as convenient as possible for them and

their general practice

We are also exploring other ways to make secondary prevention services smarter, which means delivering more personalised services. The NHS Health Check (https://www.nhs.uk/conditions/nhs-health-check/what-is-an-nhs-health-check/) programme addresses 7 of the top risk factors for CVD, diabetes, kidney disease and some types of dementia. The check helps people to understand their individual risk and supports them to take action and access treatment. At current rates, estimates show that the NHS Health Check programme could prevent 2,500 heart attacks and strokes every year (https://www.nhs.uk/conditions/nhs-health-check/what-is-an-nhs-health-check/#:~:text=In%20its%20first%205%20years,diagnosed%20with%20high%20blood%20pressure). We are modernising the programme through a new digital NHS Health Check (https://www.gov.uk/government/news/new-digital-health-check-to-tackle-deadly-cardiovascular-disease) which will run alongside and bolster existing in-person checks. This is a new, innovative platform that will give users more choice about where and when to have a check and empower people to take action to improve their health independently.

To further help people take control of their health, Professor John Deanfield, the first UK government Champion for Personalised Prevention, is leading a taskforce of experts and leaders (https://www.gov.uk/government/news/government-to-consider-radical-new-approach-to-prevent-life-threatening-cardiovascular-disease) from health, technology, behavioural science, big data and health economics to develop an ambitious and innovative vision for a modern, personalised prevention service. We will say more on this in the major conditions strategy.

By driving secondary prevention at a local level, services can be shaped to meet the needs of different communities and to address disparities. The NHS Core20PLUS5 approach (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) sets a national ambition for tackling disparities, while recognising that ICSs are best placed to identify the needs of their populations, and of groups that experience unwarranted variation in access, experience and outcomes. The approach promotes close integrated working with community-based partners and the communities themselves. Diversifying the way in which health services are delivered means that more people can be reached.

For example, hypertension (high blood pressure) is the leading known modifiable risk factor for CVD in England (https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-high-blood-pressure). It affects around 12.5 million people, of which an estimated 4.2 million are undiagnosed (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/articles/riskfactorsforundiagnosedhighbloodpressureinengland/2015to2019). For those who are diagnosed with hypertension, only 5.4 million (62.7%) are optimally managed.[footnote 29] If we improved the number of

people diagnosed with hypertension by 10%, and those managed optimally by 10%, in one year we would prevent around 7,400 CVD events.[footnote 30]

While we have made good progress in driving secondary prevention, there remains more to do, not least as part of the NHS Core20PLUS5 approach. The major conditions strategy will explore how we can boost these services to above pre-pandemic levels and extend them to the most vulnerable groups and places with the highest need, where the greatest impact can be made. We will also explore how systems are embedding prevention into ICS and ICB plans, and making them central to integrated neighbourhood teams as recommended by the Fuller Stocktake (https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/).

Chapter 3: early diagnosis, early intervention and quality treatment

Identifying issues early

We know that if we are able to identify major conditions early, the outcomes for treatment are far better and the negative impact on people's lives is much reduced. Identifying issues early can have enormous impacts on people's wellbeing - for example, by reducing the impact of a major condition, enabling people with MSK to remain in work (with all the associated mental and physical health benefits of employment), supporting someone through their first incidence of mental ill health or by increasing survival significantly for people with cancer. Early diagnosis is good for the NHS, good for communities and, above all, good for patients.

We will therefore use the major conditions strategy to identify opportunities for earlier diagnosis and lessons that can be shared between conditions and between ICSs. We will also seek to identify opportunities to secure more equitable access to diagnosis.

We have much to build on. The NHS screening programmes are an efficient and proven method for early diagnosis of some cancers and bring real benefits, with cancers detected via screening more likely to be diagnosed at an early stage when outcomes can be more favourable, with more treatment options available (https://www.longtermplan.nhs.uk/areas-of-work/cancer/). Supported by a recommendation from the UK National Screening Committee, we recently announced that we are rolling out a national targeted lung cancer screening programme

(https://www.gov.uk/government/news/new-lung-cancer-screening-roll-out-to-detect-cancer-sooner). This is expected to reach 100% of the eligible population by 2030.

Similarly, Early Intervention in Psychosis (EIP) services are world-leading in providing holistic care to people experiencing a first episode of mental ill health, which can drastically improve health outcomes and prevent lifelong ill health.

Increasingly, too, we are able to target individuals based on their personal risk factors - for example, the UK National Screening Committee is considering how the NHS can undertake more targeted and personalised screening, based on predictive analysis of individual risk factors.

Technology is playing an important role here too. In the future, screening could involve new digital technologies including AI to streamline programmes so that they are more efficient. To support this work, the department and NHSE are working with AI developers to ensure they are able to access the necessary high-quality, diverse and representative screening imaging data needed to develop and test AI products. In addition, the 'Genome UK: 2022 to 2025 implementation plan for England' announced a £26 million innovative cancer programme led by Genomics England in partnership with the NHS to evaluate cutting-edge genomic sequencing technology, to improve the accuracy and speed of diagnosis for cancer patients and use AI to analyse a person's DNA, alongside other information such as routine scans.

Improvement in early diagnosis will come through new, individualised and targeted diagnosis, but it will also come through reducing the variation in uptake of existing screening programmes and diagnosis. Evidence suggests that for cancer, people living in more deprived areas are more likely to be diagnosed at a later stage compared to people from less deprived areas (https://www.cancerdata.nhs.uk/stage_at_diagnosis), which is in part a reason for lower survival rates. The NHS Long Term Plan (https://www.longtermplan.nhs.uk/) (LTP) set an ambition to diagnose 75% of stageable cancers at stage 1 or 2 by 2028.

Likewise, not enough people have access to an accurate and timely dementia diagnosis - with significant variation across the country. A formal diagnosis unlocks access to care and support for the person with dementia, as well as their families and unpaid carers and empowers people to manage their condition and plan for the future. The national ambition is for at least two-thirds of people with dementia to have a formal diagnosis, but the pandemic has delayed progress. In March 2020, the dementia diagnosis rate (https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data/may-2023) dropped below the national ambition for the first time in almost 4 years, with current rates around 63%. This is why the NHS has committed to recover dementia diagnosis rates in the priorities and operational planning guidance for 2023 to 2024.

Taking a whole-person approach

The quality and effectiveness of healthcare will increasingly rely on taking a whole-person approach. This means doing more to integrate the care and treatment provided to a person within the life they lead and want to lead. This is because the shift to the prevention and management of conditions over a lifetime requires a stronger partnership between the person being supported, their family and unpaid carers in some circumstances, and the people and organisations that are helping them.

Other conditions can significantly impact the experience of having a major condition. For example, we know that systems do not always make the reasonable adjustments needed to support people with a learning disability and autistic people to access care. People with Down's syndrome are at significantly higher risk of experiencing other conditions, and people with a learning disability have a 49% rate of avoidable death, compared to 22% in the general population (https://www.kcl.ac.uk/research/leder). Throughout this work, we need to look at people as individuals with needs that do not fit neatly into condition specific pathways.

In many ways, this is most noticeable in our approach to bringing together treatment for both physical and mental ill health, not least because we know that a major physical condition can be a significant driver of mental ill health, and because people with severe mental illness are statistically more likely to also have a physical health condition (https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing), have more risk factors for poor physical health and often develop multimorbidity at a younger age.

We are already making some progress in this approach. In the NHS LTP, we committed to providing 390,000 people with a severe mental illness with a full annual physical health check in 2023 to 2024. In 2018, NHSE published guidance on talking therapies for people with long-term physical health conditions to ensure that psychological services are tailored for people with physical health conditions too. Further, we have announced this year that the government will modernise and digitise mental health services in England, providing wellness and clinical grade apps free at the point of use, pilot cutting-edge digital therapies and digitise the NHS Talking Therapies programme.

Our NHS Long Term Workforce Plan sets out an ambition to grow the mental health workforce by 73% by 2036 to 2037. In the major conditions strategy, we will outline how we will go further to implement more physical health support across mental health pathways, and more mental health support across physical health pathways, supporting patients with their wellbeing to prevent the deterioration of mental health and the need for clinical treatment. People with mental health needs require holistic support,

including social care and physical health care. In the NHS LTP, almost £1 billion is being invested in community mental health transformation, to integrate services and provide care closer to home for people with mental ill health.

A high proportion of people who are using or misusing drugs or alcohol also have a mental health condition. In 2021 to 2022, 70% of people starting drug and alcohol treatment had a mental health treatment need, but a fifth of those were not receiving mental health treatment (https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022). That is why we are developing a Joint Action Plan with NHSE to identify ways of improving mental health treatment for people with drug and alcohol misuse conditions, including improving access to existing mental health services and establishing better links with substance misuse services.

We also look to build on existing work to move towards achieving parity between physical and mental health. We have made some progress in improving support for people's mental health and wellbeing and tackling and reducing stigma. However, investment in treatment and support for mental ill health has historically trailed behind physical health, and while investment in recent years has increased (https://www.england.nhs.uk/mental-health/taskforce/imp/), services remain under pressure to close the treatment gap after the pandemic.[footnote 31] While introducing access and waiting time standards is an important step towards parity, these currently cover only 3 service areas (NHS Talking Therapies, children and young people's eating disorders, and early intervention in psychosis).

In addition, although the NHS mental health workforce has increased, staff shortages remain the major constraint to improving and expanding services, and we will aim to tackle these shortages through the Long Term Workforce Plan. As a first step we will define what parity of esteem, or valuing mental health equally with physical health, means for healthcare so that we can understand how future strategies, actions and progress help us work towards achieving it. We are also introducing patient-reported outcomes measures in mental health services that can enable focus on personalised, high-quality care.

We recognise that there is more to do in ensuring we consider the whole life course, and tailor services accordingly. For example, we know that half of all mental health problems have been established by the age of 14, rising to 75% by age 24.[footnote 32] As a result, there is real opportunity to focus on perinatal and infant mental health, and early intervention for young people. We are already taking forward some of this work through our Family Hubs and Start for Life Programme, which includes £100 million to enable 75 local authorities to establish and improve perinatal mental health and parent-infant relationship support.

We will also consider how we can ensure that we have systems in place to identify and treat conditions which are rare in each age group. For example, cancer is rare during childhood, adolescence and young adulthood (https://ukhsa.blog.gov.uk/2021/03/15/cancer-in-children-and-young-people-what-do-the-statistics-tell-us/), which creates challenges starting with diagnosis. Cancer is often one of the last things a GP would expect to see in a young person, particularly as it is something they will likely encounter only a few times in their whole career. We will explore how we can best support services and people experiencing rare forms of cancer, including learning from international examples such as Australia's Zero Childhood Cancer program.

NHSE is also committed to providing every cancer patient access to the right expertise and support, including a clinical nurse specialist or other support worker. The NHS LTP committed to provide people with cancer access to holistic assessments of their needs and appropriate planning of care and support. This includes people at all stages of their journey, including those receiving palliative and end of life care, to ensure appropriate plans are put in place to deliver the wraparound support required. We will explore whether this approach is also appropriate for other groups of conditions.

Chapter 4: living with major conditions

Many of us now and in the future will live with major conditions over many years. It will not always be possible to fully prevent or fully cure such conditions through treatment. For those patients with several conditions and their carers, care co-ordination that takes account of all their needs is particularly important. Further detail on the areas of treatment across the 6 condition groups that we think offer strong potential for impactful change are set out in annex B.

Alongside these distinct opportunities within conditions, we will also explore interventions that can address more than one condition, such as:

- pain management
- medicines management (including polypharmacy)
- end of life care
- the mental health of people with physical conditions
- the physical health of people with mental health conditions

Supporting person-centred care: complexity, diversity and variation

The effective support and management of major conditions will increasingly require the management of complexity, and moving away from a single condition approach. For example, systems will need to adapt to manage the complexity of multiple conditions with the consequent need to co-ordinate clinical support across primary, community and secondary care - ensuring, for example, different medicines are used in ways that do not lead to adverse outcomes.

Secondly, systems will have to grapple with the complexity of integrating treatment, care and support into people's lives over the long term, with the likelihood of different periods of intensive support or treatment followed by periods where less support is needed, as well as moving between health and social care services.

We will also need to ensure the health and care system is able to take a holistic approach to mental and physical health, supporting people to live well, maximising opportunities for recovery and rehabilitation where possible, and supporting people to manage their own health both through prevention and ongoing management. As part of this, we see significant possibilities in developing our approach to social prescribing, and will be exploring this further as part of the development of the major conditions strategy.

Where recovery is not possible - for example, for people living with dementia - the health and care system should still focus on high-quality, integrated and personalised care, including social care. The whole really will need to be greater than the sum of the parts, and the people with lived experience of major conditions we have worked with have often told us that the individual services they have received have been very good but the alignment and co-ordination between them have not been good enough.

Empowering people

Empowering patients and service users takes many forms, and there are excellent examples we can draw upon from good practice in recent years. [footnote 33] Patients regularly report that they want to be more involved in their care, and where patients are empowered they are able to discuss the benefits and risks of treatment options and consider how these align with their personal goals, before reaching a shared decision about their treatment and future care, whether curative or palliative (https://www.nuffieldtrust.org.uk/resource/do-patients-feel-involved-in-decisions-about-their-care). In many cases, people themselves are best placed to

manage their conditions and can also lead their own recovery and rehabilitation with support. We have seen many examples of this being done successfully across a wide range of conditions, including those such as dementia where patients may previously have been less involved in shared decision-making. Empowering patients to make decisions about their care can also have wider benefits to them, their families, unpaid carers and communities.

People living with MLTC often take many different medications (https://www.gov.uk/government/publications/national-overprescribing-review-report). While many of these medicines will be vital to help people live well for longer or to control symptoms, medicines can have harmful side effects and complicated regimens can make them difficult to take. Up to 10% of all hospital admissions in older people are medicines-related.[footnote 34] Shared decision-making with patients, considering alternatives to medicines where appropriate and offering structured medication reviews for those with long-term conditions can all help reduce overprescribing.

We have already made a good deal of progress in empowering patients, with programmes to expand choice (https://www.england.nhs.uk/personalisedcare/choice/), advance care planning (https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/) conversations, personal health budgets (https://www.england.nhs.uk/personalisedcare/personal-health-budgets/) and providing more information to patients (https://www.england.nhs.uk/personalisedcare/shared-decision-making/).

NHSE has developed a comprehensive model of personalised care (https://www.england.nhs.uk/personalisedcare/comprehensive-model-of-personalised-care/), and has exceeded its LTP target of 2.5 million people benefiting from personalised care (https://www.longtermplan.nhs.uk/areas-of-work/personalised-care/) 2 years early. Overall, over 7.1 million individuals have now benefitted from a personalised care intervention (https://www.england.nhs.uk/long-read/annex-operational-performance-update/). Currently more than 175,000 people hold a personal health budget (https://digital.nhs.uk/data-and-information/publications/statistical/personal-health-budgets/2022-23-q4/personal-health-budgets-q4-2022-23). We are also moving forward with our vision for personalised adult social care reform, set out in the recently published Next steps to put People at the Heart of Care (https://www.gov.uk/government/publications/adult-social-care-system-reform-next-steps-to-put-people-at-the-heart-of-care/next-steps-to-put-people-at-the-heart-of-care). This includes key developments such as introducing person-level data collection to provide deeper insights into care journeys and outcomes, allowing us to better optimise interventions and improve people's experience of the pathway through the health and care system.

Going forward, the NHS is committed to expanding personalised care. This means providing safe and convenient care at home, including care homes, using technology to enhance the role of patients and service users in

decision-making and initiatives including integrated neighbourhood teams and virtual wards. It also means working with systems and patients to understand how to increase uptake of supported self-management, which continues to be one of the most cost-effective interventions available.

We are also undertaking work to give patients the information they need to make decisions about their own care. We have made great strides in ensuring that patients can access their own data, as well as building on the NHS App as a vehicle for providing access to relevant information. Work on summary care records (SCRs) and digital social care records (DSCRs) has also made it easier for patients and services to share information across different services, including between health and social care settings, improving the integration for those whose care spans health and social care, including many people with dementia.

In line with the NHS Constitution, patients have a right to choose where some of their care is provided. In May 2023, we set out how we will make it easier for patients to exercise their choice of provider in elective care.

At the point of referral (for example, at a GP appointment), patients will now be actively offered a list of providers which are clinically appropriate for their condition. This will be a minimum of 5 providers, where possible. Patients will also be informed of their right to choose and encouraged to raise this at the time of the referral.

Those already on waiting lists will also benefit from improved choice. From October 2023, all patients waiting over 40 weeks who have not had a first outpatient appointment booked or where a decision to treat has been made but the patient does not have a date for their treatment, will be able to initiate a request to transfer to another provider and receive treatment more quickly via the Patient Initiated Digital Mutual Aid System (PIDMAS). We have set an ambition to expand this solution to further long wait cohorts in future depending on the level of uptake and impact on clinical capacity.

We will also increase public awareness of patients' right to choose (https://www.gov.uk/government/news/more-choice-to-help-cut-hospital-waiting-times) through a national campaign.

While we are making good progress on this work, we also want to make sure people living with health conditions are able to make informed choices about their care and manage their condition well. As part of our final strategy, we will look at ways to enhance this, including exploring the role personalised care planning and personal health budgets can play in this work.

Alongside this, we recognise that those who provide care and support to people with major conditions go beyond the health and care system workforce, to people's families and friends. Unpaid carers, including young carers, provide invaluable practical, emotional and physical support to help

people achieve their activities of daily living. Caring can be rewarding, but it can also have negative impacts on the carer. This strategy recognises the important contribution unpaid carers make to the lives of those living with major conditions as well as the need for unpaid carers to be identified, recognised and supported. The strategy will continue to seek their views and input.

‘Pre-habilitation’, rehabilitation and recovery

As part of building services to support the lives people want to live, we want to pursue the full potential of pre-habilitation and rehabilitation .

‘Pre-habilitation’ involves supporting people to prepare for treatment for a major condition. Targeted lifestyle changes while waiting for surgery for an MSK condition or in advance of cancer treatment can greatly improve patient outcomes while also helping people feel more in control of their recovery. This approach involves our health service truly working in partnership with patients and those supporting them.

We also know the importance of systematic support for rehabilitation, to enable people to recover from, and live better with, a major condition. This in turn helps people maintain independence, decreases the risk of other diseases and reduces the burden of long-term conditions.

We know that this can have huge impacts. Targeted cognitive rehabilitation for people with dementia can reduce the functional impact of the disease on their daily lives (https://www.nice.org.uk/guidance/ng97/chapter/recommendations). NICE recommends pulmonary rehabilitation for many patients with COPD (https://www.nice.org.uk/guidance/qs10/chapter/Quality-statement-4-Pulmonary-rehabilitation-for-stable-COPD-and-exercise-limitation), as the evidence suggests that this can improve quality of life, reduce anxiety and depression, reduce symptoms and mean patients spend less time in hospital (https://www.nice.org.uk/guidance/qs10/chapter/quality-statement-5-pulmonary-rehabilitation-after-an-acute-exacerbation). However, more needs to be done here, as only 36.9% of eligible patients were offered a referral to a pulmonary rehabilitation service in 2021 to 2022 (https://www.asthmaandlung.org.uk/conditions/copd-chronic-obstructive-pulmonary-disease/world-copd-day/delayed-diagnosis-unequal-care).

Such gaps between need and access also exist for other conditions. We will explore both how different condition-specific rehabilitation services can learn from one another and the potential for greater use of community-based rehabilitation services that cover a range of conditions.

One of the most exciting and impactful developments in rehabilitation in recent years is ‘social prescribing’.[footnote 35] Through social prescribing initiatives, people can be referred to peer support which provides opportunities to talk, share experiences and learn from people with similar experiences.

Rehabilitation and community support is also a form of prevention. When people get to the point where hospital admission is a risk, it is important to have strategies in place to support people in the community. Equally when patients are ‘stepping down’ from hospital care there are significant benefits to having a range of community rehabilitation services to maximise recovery and support self-management and to relieve pressure on the acute part of the system.

End of life care

Personalised care and empowering patients and service users is particularly important as people near the end of their lives. Patients and families benefit where palliative and end of life care is considered from diagnosis onwards and integrated into care for people with any condition that means they may die in the foreseeable future.[footnote 36] Palliative and end of life care involves psychological, social and spiritual support for the patient and their family and/or carers as well as pain and symptom management. People may receive palliative care earlier in their illness, while still receiving other therapies to treat their condition.

According to recent data, slightly less than 50% of all people dying in England receive palliative care and support (around 240,000 in 2018 to 2019). Existing estimates suggest that many more individuals could benefit from receiving palliative care - up to around 215,000 additional people (455,000 in total), based on 2018 to 2019 mortality figures and estimates that up to 90% of all people dying in England may have palliative care needs.

We recognise that high-quality palliative and end of life care ought to include the opportunity for individuals to discuss their wishes and preferences so that these can be taken fully into account in the provision of their future care, also known as advance care planning (ACP).[footnote 37] When ACP is done well, people feel they have had the opportunity to plan for their future care. As part of this strategy, one area which we are keen to explore further is how best we can use ACP for those with a major condition or, indeed, multiple conditions.

We are also aware that there is evidence that highlights inequalities in access to palliative and end of life care. To address this, NHSE has commissioned and managed projects actively seeking to address the needs

of under-served populations, including people experiencing homelessness and ethnic minority groups who are not proficient in English. Moreover, NHSE has funded palliative and end of life care strategic clinical networks to enhance improvements within local populations, including a specific focus on health inequalities. NHSE will continue to work towards improving access, early engagement with services and reducing health inequalities through a number of national workstreams for palliative and end of life care that will consider an all-age approach and work with people of lived experience.

Person-centred care and empowering patients, their carers and service users will be central to achieving effective outcomes for those of us - more with each passing year - who are living with major conditions over the long term. To ensure this happens and to deliver improvements across the strategic framework described in this and earlier chapters, we will need to put in place or reinforce several key enablers, which are the subject of the next chapter.

Chapter 5: enabling systems

Digital technologies and innovation

Data and digital technology represent an enormous opportunity to drive improvement across the health and care system. Placing accessible, secure digital tools in the hands of people and staff will:

- improve how care is delivered
- empower individuals to better self-care and self-manage
- enable data to flow safely between clinicians and care settings
- deliver new clinical models of care.

Improved collection and utilisation of data will also help us to:

- better understand people and what works best for them
- intervene earlier to prevent ill health
- have a greater understanding of where health inequalities are arising and how best to tackle them
- better plan services and allocate resources

We have published key strategies that set out our vision for technology in health and social care as we continue to ‘Digitise, Connect and Transform’.

[footnote 38] We are working to digitise information across the health and care system, ensuring core infrastructure is in place so that information can be recorded and flow across care settings. Electronic patient records and social care records are the cornerstones of this. These will give caregivers and people better access to critical, real-time information when needed, enabling the delivery of better, safer care.

We are connecting information and services together to give people across the health and care system better information with which to plan and make decisions. We are working to connect patient information from different care settings through a life-long shared care record at ICS level, as well as ensuring data for research and development and population health planning purposes is made available safely and securely. The contract for the NHS Federated Data Platform will be awarded in autumn 2023 and will provide ICSs the capability to link data together to gather insights on current and future needs for their populations.

We are transforming the experience of health and care for people and staff. For staff this will mean better decision-making support to ensure people have the best care possible. This will include optimising the use of data and AI to improve the ways in which conditions are screened, diagnosed, treated and managed, thereby supporting clinicians to make the best use of their expertise, save time and improve outcomes for patients.

This is why we have announced a new £21 million ring-fenced AI diagnostic fund to accelerate the rollout of diagnostic AI technologies in the NHS. For people, this will mean better and easier access to health information and the ability to self-serve. Following publication of the medical technology strategy in February this year, we are also developing an end-to-end innovation pipeline to ensure novel and high impact products that address national priorities are adopted at speed and scale to benefit patients and the health system.

On 26 May we announced plans to launch an Innovative Devices Access Pathway (IDAP) later this year. The pathway will facilitate access to innovative technologies by providing innovators and manufacturers with a multi-partner support service, including targeted scientific advice that brings new products to patients sooner. This will align with work on the early value assessment (https://www.nice.org.uk/about/what-we-do/eva-for-medtech), which will improve the process for well-evidenced digital health technologies to be adopted in the NHS. We are also working to expand the NHS App, giving people better access to digital therapeutics, their personal health data and primary and secondary care services.

Across all of this, we recognise the need to design and deploy digital approaches inclusively, given over 10 million adults are estimated to lack foundation-level digital skills (https://www.lloydsbank.com/banking-with-us/whats-happening/consumer-digital-index.html). We will need to continue to ensure that digital offers complement other channels or modes or support so that no

one is disadvantaged in access to, experience of and outcomes from healthcare.

We are also constantly working to identify innovations in health technology and therapeutics, supporting their implementation and building evidence bases that demonstrate their value at scale in the real-world. The Academic Health Science Networks (AHSNs) recently published real-world evaluation to facilitate adoption at scale (https://www.ahsnnetwork.com/blogs/what-is-the-value-of-real-world-evaluation/), a practical guide for innovators working with the AHSN network. This seeks to address a fundamental challenge, the ability for the health and social care system to adopt well-evidenced transformational health-tech innovations at sufficient pace and scale.

Research

More widely, we also recognise that to tackle major conditions effectively we need to translate research into the prevention, identification and treatment of groups of conditions into population and patient benefits across the UK. The National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI) have invested heavily in major conditions research for many years, driving many of the advances in prevention and treatment which will be help us to meet the challenges and seize the opportunities identified in preceding chapters. For example, NIHR research demonstrated that a high-sensitivity troponin blood test can identify heart attacks quickly and accurately (https://www.nihr.ac.uk/news/nihr-launches-shape-the-future-campaign-calling-on-people-to-be-part-of-research/33239). The test is now used in most NHS trusts, preventing avoidable admissions and saving the NHS more than £100 million every year.

We will undertake further work as we develop the major conditions strategy to ensure effective alignment with the research agenda. DHSC is investing £100 million in a set of NIHR policy research units, including for cancer, dementia and neurodegeneration and mental health, and the Office for Life Sciences is investing over £200 million to deliver 5 of its key, UK-wide healthcare missions (https://www.gov.uk/government/news/government-to-use-vaccine-taskforce-model-to-tackle-health-challenges), 3 of which are major conditions (cancer, dementia and mental health) and 2 of which focus on key risk factors of major conditions (obesity and addiction). This will support our strategy by focusing research on preventing, diagnosing, monitoring and treating conditions early and developing innovative treatments.

We are also investing in research on preventing the drivers of groups of conditions, including obesity, smoking, alcohol use and inequality. For example, we have announced a second round of funding for health determinants research collaborations (https://www.nihr.ac.uk/documents/specification-document-call-for-proposals-nihr-

health-determinants-research-collaborations-hdrc/32383) which enable local authorities to conduct high-quality research to tackle health disparities. We plan to expand the successful public health intervention studies teams (https://phirst.nihr.ac.uk/) from 6 to 10 teams, and have invited a new collaboration between the NIHR schools for public health, social care and primary care to work together on research which will identify how we can act early to prevent poor health outcomes.

Following the Lord O'Shaughnessy review (https://www.gov.uk/government/publications/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review/commercial-clinical-trials-in-the-uk-the-lord-oshaughnessy-review-final-report), we are establishing 2 to 3 clinical trial acceleration networks (https://healthmedia.blog.gov.uk/2023/05/25/what-were-doing-to-speed-up-clinical-trials-in-the-uk/), which will support a joined-up approach to clinical trials and are expected to include a focus on the major conditions. COVID-19 highlighted that those communities worst hit by the pandemic were also less likely to be engaging with research, which impacts the ability of research to tackle health inequalities and meet the needs of the whole population (https://www.nihr.ac.uk/blog/why-reaching-out-to-communities-is-key-to-putting-people-first-in-research/32559). Key to the success of the major conditions strategy will be improving partnerships with people and communities in health and care research.

Leadership

Finally, none of this is deliverable without effective and supportive leadership.

We recognise that the UK government has an important role to play, including by reducing the number of central targets on systems. In the next phase of the major conditions strategy we will focus on understanding how central government, working in partnership with NHSE, can better enable systems to improve the health of local populations and support the delivery of local approaches and innovation. Our shared outcomes toolkit will support this local approach by supporting local areas to develop their own robust shared outcomes. Cross-border workforce movement and co-operation across the UK are ingrained in the NHS. Therefore, we are also committed to engaging with the health services in the devolved governments to ensure the strategy accounts for the cross-border elements of our health and care services and works efficiently for the whole of the UK.

We are also looking to ICSs to develop, drive and deliver care that supports the objectives and ambitions of the major conditions strategy, including by incorporating the aims of the strategy into future joint forward plans set out by ICBs, and future integrated care strategies developed by ICPs. We will be building on the principle set out in the Hewitt Review

(https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems) that we should look to move beyond a model that relies on central strategy setting and local implementation, to an approach that seeks to address local needs through experimentation and improvement. ICSs will be supported to develop, adopt and adapt approaches that best meet the needs of their populations.

Chapter 6: next steps to the major conditions strategy

We recognise that difficult choices will have to be made about where we prioritise our efforts. We want to build on our engagement, the call for evidence and all the comments we have heard in the development of this document to ensure that the major conditions strategy will have real impact in changing how the health and care system operates over the next 5 years.

With that in mind, we intend to focus our efforts on exploring how we can make real change in 5 key areas, which we think will have the greatest impact across all the groups of conditions. These are:

- rebalancing the health and care system, over time, towards a personalised approach to prevention through the management of risk factors
- embedding early diagnosis and treatment delivery in the community
- managing multiple conditions effectively - including embedding generalist and specialist skills within teams, organisations and individual clinicians
- seeking much closer alignment and integration between physical and mental health services
- shaping services and support around the lives of people, giving them greater choice and control where they need and want it and real clarity about their choices and next steps in their care

Across all 5 of these priority areas, we will work to reduce inequalities in health outcomes, so the community you live in does not make it more likely you will experience ill health.

As chapter 2 sets out, we will focus on how we bear down on the principal lifestyle drivers of ill health and disease, such as obesity and smoking, as well intervening early to reduce exacerbations and complications. We will consider how we can rebalance the health and care system, over time, towards a personalised approach to prevention. We know this can have real benefits in stopping or delaying the progress of conditions - for example, by more effectively identifying and managing conditions such as hypertension, as well as risk factors such as obesity and smoking.

As part of this, we will explore how we can empower people to make healthier choices - giving them the information they need and the freedom to decide what is best for them. Furthermore, for the reasons we set out in chapter 4, we are also keen to evaluate how we can proactively identify and support people at risk, including actively identifying frailer people and supporting them before they experience a crisis. As part of this, we will also continue to assess how we can best support people to lead the lives they want to live, including supporting people to stay in, or return to, work.

We will consider how we can better embed early diagnosis and treatment delivery in the community. As chapter 3 sets out, if we are able to identify major conditions early, the outcomes for treatment are far better and the negative impact on people's lives is much reduced. We will explore the potential here for using new technology such as AI, developing new patient pathways of care to enable earlier diagnosis and the opportunities for earlier diagnoses created by screening programmes.

We will also explore how we can support people to manage multiple conditions most effectively, as we explored in chapter 4. For example, we will consider how we can embed both generalist and specialist skills within teams, organisations and individual clinicians, as well as considering how we could explore patient pathways (or portions of those pathways) that better reflect the needs and symptoms of patients in the round, rather than being tied to - or having to move between - siloes defined by specialisms.

We will investigate how we can drive stronger alignment and integration between physical and mental health services. This will include exploring how we can better support people with serious mental health conditions to manage their physical health, as well as better supporting the mental health of people suffering from a physical condition.

Finally, we will consider how we can best shape services and support around the lives of people, giving them - and their carers - greater control where they need and want it and real clarity about their choices and next steps in their care. As part of this, we will consider how we can develop more robust models of person-centred care, as well as how we can use technology to make the experience of interacting with the NHS more seamless. We also see great potential in further work on developing effective models of rehabilitation and pre-habilitation, as well working to develop more holistic approaches to pain and distress management, and palliative and end of life care.

As we develop the final strategy, we will also want to consider how we can drive improvement across individual groups of conditions, where these require specific interventions. We will also ensure that all of the further work over the coming months responds to the importance of tackling health disparities and promoting inclusion in health, as articulated through the UK-wide levelling up mission on healthy life expectancy and the NHS

Core20PLUS5 framework, NHSE will be developing a handbook to support Core20PLUS5 implementation.

We recognise that this has to be a collective endeavour, with contributions from citizens, the health and social care sector, the wider public sector (including national and local government and devolved governments), industry and all with an interest. We recognise that in many areas there is excellent work happening already, and we want to draw on that knowledge and experience, as well as identify examples of existing best practice we can spread and share across the health and care system.

In the next phase we will continue to engage closely with people with lived experience, academic and other experts and representative organisations. We will work within the framework set out in this document and further develop the themes and issues we have identified. We will also draw on the recently closed call for evidence and potentially add further themes and issues suggested by that process within the overall framework.

Furthermore, while this report is focused on England, and we recognise that health is a devolved matter, we are keen to engage across the UK on health inequalities, take joined-up action wherever possible and share knowledge on what works.

We are keen to continue our engagement with clinicians, stakeholders, charities, carers and people with lived experience. If you want to be involved, you can contact us at majorconditionsstrategy@dhsc.gov.uk.

Annex A: our existing commitments

The major conditions strategy will build on the commitments we have made thus far - and we will work with existing programmes of work across the department, NHSE and across government.

To tackle the drivers of ill health, we are:

- working with the Department for Levelling Up, Housing and Communities to ensure that the LUPs programme, which received £400m of capital funding in the spring budget, improves the health outcomes of the selected areas which face the greatest health disparities
- working with stakeholders and industry to reduce sugar, salt and calories in food, including for baby food and drink
- working through the Food Data Transparency Partnership to enable and encourage food companies to demonstrate progress on the healthiness of their sales

- refreshing the Public Health Outcomes Framework to ensure we have the right metrics to measure and drive progress on the factors which shape our health
- working with the Department for Culture, Media and Sport on the new sport strategy to unite government and the wider sport sector in increasing opportunities to get active
- helping children be more active in schools through the School Sport and Activity Plan jointly with the Department for Education and the Department for Culture, Media and Sport
- launching a UK-wide public consultation on introducing mandatory cigarette pack inserts with positive messages and information to help people to quit, including asking for additional evidence and experience internationally on the use of inserts around ‘switch to vaping’ or nicotine replacement therapy (NRT) or cessation support
- funding a new national ‘swap to stop’ scheme - the first of its kind in the world - to offer a million smokers across England a free vaping starter kit

To support prevention, earlier intervention and diagnosis, we are:

- committed to recover the dementia diagnosis rate to the national ambition of 66.7% of people with dementia having a formal diagnosis
- investing £645 million over 2 years so the NHS can expand services offered by community pharmacy, including expanding the blood pressure (BP) services this year to increase the number of people diagnosed with hypertension
- increasing the number of people who self-monitor at home, including their blood pressure, and making this as convenient as possible for them and their general practice
- piloting the expansion of the Digital Weight Management Programme through the NHS, to people living with overweight or obesity who also have an MSK condition
- expanding access to intensive support for children living with severe obesity through 30 specialist clinics, doubling the ambitions set out in the NHS LTP for 15 clinics
- rolling out a 2-year pilot backed by up to £40 million to explore ways to make the newest and most effective weight loss drugs accessible to more eligible patients living with obesity outside of hospital settings
- introducing a national targeted lung cancer screening programme for people aged 55 to 74 who are at high risk of lung cancer, identifying up to 9,000 cancers at an earlier stage each year
- investing £50 million in digital health technologies for self-management, including prevention, of MSK conditions
- investing an additional £780 million to produce a world-class treatment and recovery system to reduce drug and alcohol-related harms

- increasing coverage of mental health support teams in schools and colleges to at least 50% of pupils in England by 2025
- supporting local areas to deliver and increase NHS Health Check participation
- making a digital NHS Health Check for CVD available by spring 2024
- finalising the newly developed adult breathlessness pathway (pre-diagnosis): diagnostic pathway support tool (https://www.england.nhs.uk/long-read/adult-breathlessness-pathway-pre-diagnosis-diagnostic-pathway-support-tool/) and encouraging its widespread use
- developing an ambitious vision for a personalised CVD prevention service in England through the taskforce led by Professor Deanfield
- evaluating self-sample cervical screening tests for women who have not attended previous screening appointments
- expanding the NHS Diabetes Prevention programme
- investing around £300 million in Family Hubs and Start for Life programmes in 75 local authorities with high levels of deprivation to support parents and carers to nurture their babies and children

To improve treatment and longer term care, we are:

- continuing to develop the Lung Health @home programme to increase access to supported self-management for those with CRD
- making the NHS Type 2 Diabetes Path to Remission Programme available across England
- introducing the WorkWell Partnerships Programme
- undertaking two consultations, the first, Occupational Health: Working Better (https://www.gov.uk/government/consultations/occupational-health-working-better) is seeking views on proposals aimed at increasing employer use of occupational health services. While the other, Tax incentives for occupational health (https://www.gov.uk/government/consultations/joint-hmt-hmrc-consultation-on-tax-incentives-for-occupational-health), is aimed at employers and exploring the role of tax incentives in boosting occupational health provision by employers. Together these consultations will inform the government's approach to supporting occupational health provision, and so both of these consultations should be read together
- defining and scaling MSK community hubs to increase access to an integrated support offer for people with MSK conditions
- integrating employment advisors into MSK pathways to help individuals with MSK conditions to remain in or return to work
- exploring ways to best understand people's lived experiences of dementia
- developing a joint action plan with NHSE to improve mental health treatment for people with drug and alcohol misuse conditions, including

improving access to mental health services and better links with substance misuse services to deliver joined up care
- bringing forward a ‘mental health and wellbeing impact assessment tool’, to support policymakers to consider the mental health and wellbeing impacts of all policies
- exploring the possibility of expanding social prescribing into other parts of the health and care system, with our national partners
- exploring how we can improve care for MLTC
- investing £100 million of new funding for a set of NIHR policy research units
- simplifying cancer service standards, focusing on outcomes rather than processes to ensure we always incentivise the best decisions for patients, and to deliver improvements to diagnosis of cancer to give patients greater certainty, sooner
- introducing AI decision support tools into acutely admitting stroke units to interpret scans in order to help guide treatment and transfer decisions for stroke patients, allowing more patients to get the right treatment, in the right place, at the right time
- providing an extra £406 million over the next 5 years through the spring budget to tackle the leading health-related causes of people not being able to work, targeted at services for mental health, MSK and CVD

Annex B: what the major conditions strategy will mean for each condition

Cancer

What the data tells us and our existing commitments

One in 2 people in England will be told they have cancer (https://www.longtermplan.nhs.uk/areas-of-work/cancer/) at some point in their lives. There are around 3,800 children and young people up to the age of 24 (https://ukhsa.blog.gov.uk/2021/03/15/cancer-in-children-and-young-people-what-do-the-statistics-tell-us/) and around 390,000 adults diagnosed with cancer each year (https://www.macmillan.org.uk/dfsmedia/1a6f23537f7f4519bb0cf14c45b2a629/9468-10061/2022-cancer-statistics-factsheet) in the UK. Cancer survival is the highest it’s ever been - this is in part due to prioritising early diagnosis and improvements in treatment.

There were nearly 2.9 million urgent suspected cancer referrals seen in the past year (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/), more than double the number a decade earlier. Our efforts to encourage people to come forward - including the NHS 'Help Us Help You' campaigns - are working.[footnote 39]

Despite the significant increase in demand, for those who have been diagnosed and need treatment, 91.3% of cancer patients received treatment within 31 days against a target of 96% in May 2023 (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/). The NHS Long-Term Plan set an ambition for 75% of stageable cancers to be diagnosed at stage 1 or 2 by 2028. In doing so we aim to support an additional 55,000 people to survive their cancer for at least 5 years after diagnosis.

To meet this ambition, NHSE is implementing a comprehensive early diagnosis strategy by:

- lowering the age for bowel screening and extending lung health checks
- giving primary care teams direct access to certain diagnostic tests and clinical decision support tools to help identify cancers earlier, and trialling a new route of referral from community pharmacies
- using genomic testing to identify people with Lynch syndrome or the BRCA mutation who are at greater risk of developing cancer, so that we can check them regularly

Reducing the risks

Across different types of cancer there are common risk factors: smoking, alcohol consumption, low levels of physical activity, poor diet and overweight or obesity.[footnote 40] Stopping smoking, reducing alcohol consumption, engaging in physical activity, improving diet and reducing excess weight can all reduce the risk of cancer. The incidence of cancer is also associated with deprivation, with greater prevalence in more deprived areas (https://www.medicinesresources.nhs.uk/cancer-in-the-uk-2020-socio-economic-deprivation.html).

In the wider environment, sun exposure can increase a person's risk of developing skin cancer (https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/sun-uv-and-cancer/how-does-the-sun-and-uv-cause-cancer) and exposure to air pollution is associated with lung cancer (https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/air-pollution-radon-gas-and-cancer/how-can-air-pollution-cause-cancer), along with other chronic respiratory diseases. Reducing sun exposure and air pollution can reduce the risk of cancer.

Most cancers are linked to ageing and lifestyle factors, but some are linked to a genetic risk factor. For instance, mutations in the BRCA gene are

associated with an increased risk of breast and other cancers. NHSE is piloting testing for the BRCA mutation in the Jewish population (https://nhsjewishbrcaprogramme.org.uk/). NHSE is also testing all endometrial and colorectal tumours to diagnose people with Lynch syndrome (https://www.england.nhs.uk/2023/04/life-saving-nhs-test-helping-to-diagnose-thousands-with-cancer-causing-syndrome/), which carries a genetic predisposition to certain types of cancer.

Identifying, intervening and delivering quality care

Early diagnosis is crucial to improving cancer survival. NHSE's comprehensive early diagnosis strategy (https://www.england.nhs.uk/cancer/early-diagnosis/) is based on 6 core strands of activity, from raising awareness of cancer symptoms and encouraging people to come forward, to identifying and testing more risk stratified approaches to find cancers in people at higher risk and supporting timely and effective referrals from primary care.

Diagnostic checks are a key part of many elective care pathways, including cancer. In 2021 the UK government awarded £2.3 billion to transform diagnostic services over 3 years. There are 114 community diagnostic centres (CDCs) currently operational, delivering over 4 million tests, checks and scans since July 2021, including vital cancer checks and scans (https://www.gov.uk/government/news/4-million-checks-tests-and-scans-carried-out-by-cdcs).

From a very early stage, some cancer tumours can emit circulating tumour-derived components into bodily fluids like blood plasma. Circulating tumour DNA (ctDNA) is a marker of particular interest for improving earlier diagnosis, as it might be possible to use this to identify cancers at an earlier stage, often before they manifest themselves symptomatically.

The NHS Genomics Unit is funding a national transformation project, to provide evidence on ctDNA testing in the NHS to support diagnosis of cancer for patients who currently cannot have a tumour biopsy or do not yet have a confirmed diagnosis. This is being delivered through a pilot of patients with suspected non-small cell lung cancer (NSCLC) who do not have a confirmed diagnosis from across the NHS Genomic Medicine Service. The pilot aims to test at least 700 patients across all 7 NHS Genomic Medicine Service geographies.

The NHS is streamlining cancer pathways to support diagnosis within 28 days - for example, through the implementation of non-specific symptom pathways and best practice timed pathways. By June 2023, 108 non-specific symptom pathways were already live.

Living well with and beyond cancer

Having access to good long-term care is essential to improve quality of life both for people living with the consequences of cancer treatment and for people living with cancer. NHSE is committed to providing every cancer patient access to a clinical nurse specialist or other support worker, and access to personalised care, including a needs assessment, a care plan and health and wellbeing information and support.

More people than ever before are surviving cancer: the number of people living with and beyond cancer in the UK is predicted to grow (https://www.macmillan.org.uk/about-us/what-we-do/research/cancer-statistics-fact-sheet) from 3 million in 2020 to 5 million in 2040. As such, more people are living with the consequences of cancer treatment or are managing the continuing symptoms. Understanding how to improve the quality of life for this growing population is therefore an increasingly important part of cancer service delivery.

For children with cancer, we expect support to be tailored to their specific needs. NHSE has introduced the under-16 Cancer Patient Experience Survey for patients and their parents or carers so that we can learn from their experience. There is a clear opportunity to deliver improvements to support people while children are in hospital, and NHSE is working with DHSC on initiatives to ensure that carers are fed, and children can access play facilities and therapy.

Key enablers for delivering change

Continuing to make progress on our ambition for cancer is ultimately dependent on sustained investment in the cancer workforce, and diagnostic and treatment capacity.

Research is vital for developing technologies to enable earlier diagnosis, finding new treatments and medicines and identifying new vaccines. There has been good progress here, including the work that the NHS Cancer Programme is leading to accelerate the take up of innovation across cancer pathways, investment in the Office for Life Sciences' UK-wide Cancer Mission and the UK government's Cancer Drugs Fund.

Data sharing is also important to support treatment. Cancer treatment often involves primary and community care services, so integrating data across services could improve transparency for the patient and the healthcare workforce.

Next steps

To target screening to underserved groups, we are evaluating self-sample cervical screening tests for women who have not attended previous appointments.

We recently announced that we are rolling out a national targeted lung cancer screening programme (https://www.gov.uk/government/news/new-lung-cancer-screening-roll-out-to-detect-cancer-sooner). This is expected to reach 100% of the eligible population by 2030.

To improve the patient experience by more clearly focusing on outcomes and to give clinicians greater flexibility to introduce new technologies and working practices, NHSE will implement the recommendations of the clinically led review of cancer service standards.

CVD, including stroke, and diabetes

What the data tells us and our existing commitments

CVD, including stroke, is the second biggest killer in England. In 2021, 125,445 people died from CVD (https://fingertips.phe.org.uk/profile/mortality-profile/data#page/1/gid/1938133413/pat/159/par/K02000001/ati/15/are/E92000001/yrr/1/cid/4/tbm/1) and 30% of these people died prematurely (https://fingertips.phe.org.uk/profile/mortality-profile/data#page/4/gid/1938133009/pat/159/par/K02000001/ati/15/are/E92000001/iid/40401/age/163/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1). There are an estimated 6.4 million people with CVD conditions (see 'BHF Statistics Factsheet, England' at Heart Statistics, BHF (https://www.bhf.org.uk/what-we-do/our-research/heart-statistics)) and an additional 3.6 million people with a diabetes diagnosis (https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/quality-outcomes-framework-qof). Diabetes overlaps with both CVD specifically and multimorbidity generally: a person with diabetes is twice as likely to have heart disease or a stroke than someone who does not, and at a younger age (https://www.cdc.gov/diabetes/library/features/diabetes-and-heart.html). We also know that:

- CVD is a major driver of health inequalities. People living in England's most deprived areas are 4 times more likely to die prematurely than someone in the least deprived (https://www.gov.uk/government/publications/nhs-health-check-programme-review/annex-c-data-on-the-distribution-determinants-and-burden-of-non-communicable-diseases-in-england)
- addressing health inequalities is key: 24% of people diagnosed with type 2 diabetes live in the most deprived areas, compared to 15% in the least deprived[footnote 41]
- CVD and diabetes have big impacts on the economy and labour markets. In England, the cost to society for CVD was approximately £15.8 billion in 2015, and to healthcare services £7.4 billion in 2017(see 'BHF Statistics Factsheet, England' at Heart Statistics, BHF (https://www.bhf.org.uk/what-

we-do/our-research/heart-statistics). Around one in 4 strokes occur in working age people (https://www.stroke.org.uk/what-is-stroke/are-you-at-risk-of-stroke)

- for diabetes, the total indirect costs to society are estimated at £13.9 billion with the total cost of direct patient care for diabetes estimated at an additional £9.8 billion[footnote 42]

This shows there is potential to make significant gains against our commitments on increasing healthy life expectancy, closing the gap between richest and poorest, and addressing economic inactivity, by delivering on the targets set out in the NHS LTP to prevent 150,000 strokes, heart attacks and cases of dementia by 2029.

The NHS LTP also sets out how the NHS will improve quality of treatment and outcomes for people living with type 1 or type 2 diabetes.

Reducing the risks

Up to 80% of premature CVD deaths are preventable (https://www.kingsfund.org.uk/publications/cardiovascular-disease-england). Despite this, while CVD death rates have been declining in recent decades, this decline has slowed and is beginning to level off.[footnote 43] Also, modifiable risk factors - notably high blood pressure, high cholesterol, diet, obesity, physical inactivity, smoking and air pollution - explain the vast majority of CVD, and in some cases exposure to these risk factors is increasing.[footnote 44] There is an opportunity to prevent CVD through action on these risk factors which also drive many other conditions.[footnote 45]

Action on the wider socio-economic determinants of health also plays a role in reducing CVD and type 2 diabetes. In some cases there is a direct link to CVD - for example, living in cold homes, as a result of low income, debt or poor quality housing, increases the risk of heart attack or stroke.[footnote 46] We will continue to make the case for CVD as part of cross-government interventions.

Identifying, intervening and delivering quality care

This framework sets out some of our key CVD activities, but we are doing much more to identify people at risk, intervene at an early stage and deliver quality care for CVD.

NHS operational planning guidance sets objectives for improving detection and management of people with hypertension and high cholesterol, to drive delivery of NHS LTP commitments. In addition, the guidance sets ambition for ICBs to consider how they can best implement new technologies, including home testing. To help deliver these targets, NHSE has also published high impact interventions for CVD which are already being implemented by the NHS. This includes interventions for detection and

management of cholesterol in people at risk of CVD, and case finding and treatment of people with atrial fibrillation.

The BP @home programme, launched during the pandemic, is a prime example of using technology and home testing to improve management of hypertension. It allows people to monitor their own blood pressure and submit readings to their GP, by telephone, email or via digital platforms. All ICBs have now implemented BP @home, and over 220,000 blood pressure monitors have been distributed around England since October 2020.[footnote 47]

The NHS Diabetes Prevention Programme (DPP) also supports people at risk of developing type 2 diabetes to make lifestyle changes as either a face-to-face group programme or digital service.

If people do experience a CVD event, urgent and emergency care (UEC) is vital. The time to emergency treatment can make a significant difference to outcomes. For stroke, NHSE has committed to a 10-fold increase in thrombectomy, but thrombectomy is only effective if provided within a specific time window. Therefore, in December 2022, we announced investment in cutting edge AI to diagnose and determine the best treatment for patients who suffer a stroke. In addition, the UEC recovery plan commits to improving A&E waiting times and ambulance response times.

Living well with CVD and diabetes

Longer-term management of CVD is also important. The NHS has funded Rehabilitation Enablement in Chronic Heart Failure (REACH-HF) - a self-help manual for people with heart failure and caregivers to manage their condition. In financial year 2021 to 2022, NHSE provided funding to train 60 facilitators supporting over 1,800 heart failure patients with home-based cardiac rehabilitation.

NHSE has also published the national integrated community stroke service (ICSS) model document, which provides guidance on delivery of responsive and needs-based community rehabilitation for stroke survivors. The ICSS is an integrated, 7-day per week service, providing early supported discharge, high-intensive and needs-based community stroke rehabilitation and disability management.

We are also making the NHS Type 2 Diabetes Path to Remission Programme (https://www.england.nhs.uk/diabetes/treatment-care/diabetes-remission/) available across England. This supports people who are living with overweight or obesity and type 2 diabetes with a low calorie, total diet replacement treatment, improving diabetes control and reducing the need for medication. In nearly half of people this can put type 2 diabetes into remission.

For end of life care, the NHSE update of the heart failure palliative end of life care guidance will be published imminently.

Key enablers for delivering change

In addition to the enablers on leadership and ICSs set out in the report, we are using data to enable leaders to implement new approaches and technologies, and transform CVD prevention services. CVDPREVENT, a national primary care audit, now offers near real-time data on hypertension and cholesterol as well as 4 other conditions that contribute to stroke, heart attack and dementia.

Next steps

To go further we are:

- developing an ambitious vision for a world-leading personalised CVD prevention service in England, through the Professor Deanfield Taskforce
- expanding the NHS Diabetes Prevention Programme (DPP)
- exploring options for tackling early diagnosis of CVD

Musculoskeletal health

What the data tells us and our existing commitments

Poor MSK health is the leading contributor to the global burden of disease, with 20 million people in the UK living with an MSK condition (see the State of musculoskeletal health (https://www.versusarthritis.org/about-arthritis/data-and-statistics/the-state-of-musculoskeletal-health/)). In addition, one in 8 report living with at least 2 long-term conditions (https://fingertips.phe.org.uk/profile/msk/data#page/4/gid/1938133186/pat/159/par/K02000001/ati/15/are/E92000001/iid/93453/age/164/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0), one of which is MSK related. MSK conditions are one of the leading causes of years lived with disability in the UK today, accounting for 21% of YLDs, with low back pain the top cause (see the State of musculoskeletal health (https://www.versusarthritis.org/about-arthritis/data-and-statistics/the-state-of-musculoskeletal-health/)). They are also one of the main reasons given for ill health inactivity, with 21% of those economically inactive reporting MSK conditions (https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2022/employment-of-disabled-people-2022).

MSK conditions affect people across the life course and cover a range of conditions, including conditions of MSK pain such as osteoarthritis, back

pain and fibromyalgia, osteoporosis and inflammatory conditions such as rheumatoid arthritis and spondyloarthritis.[footnote 48]

Prevention, early detection and treatment can enable people to live in good health, remain independent and connected to the community, reduce the pressure on health and social care services and support people with MSK conditions to thrive in work.

Reducing the risks

There are multiple risk factors that can heighten people's susceptibility to MSK conditions. These include living in an area of high deprivation, older age, being a woman, having a mental health condition, and genetic predisposition.[footnote 49]

There are also many modifiable risk factors that include physical inactivity, living with overweight or obesity, diets deficient in vitamin D or calcium, and smoking.[footnote 48] For a high number of MSK conditions, secondary prevention will also be effective.

Identifying, intervening and delivering quality care

There is opportunity for significant improvement in both the prevention of MSK conditions and outcomes for people living with an MSK condition. We can promote better MSK health through physical activity, encouraging maintaining a healthy weight and balanced diet, education on MSK health and conditions, improved mental health, smoking cessation and alcohol moderation.

Importantly, many conditions of MSK pain have gradual onset and progression, meaning there is good opportunity for early identification and secondary prevention. Evidence shows that early identification, interventions in secondary prevention, long-term care and self-management, alongside timely referrals where necessary and utilising shared decision-making improve patient outcomes and can show positive return on investment (https://www.gov.uk/government/publications/musculoskeletal-conditions-return-on-investment-tool).[footnote 50] For people living with lower back pain, osteoarthritis and fibromyalgia there are significant opportunities to improve care, particularly access to personalised supported self-management in the community.

Identifying osteoporosis within our population and intervening after a person experiences their first fracture could help us to greatly reduce the risk of further fracture. Existing secondary fracture prevention initiatives, namely fracture liaison services, could present a viable and effective route to improving health outcomes and reducing years lost to disability for those at risk of osteoporotic fracture.

Accurate recognition and urgent referral for those with signs and symptoms indicative of inflammatory disease to ensure they receive the right treatment will also lead to better outcomes, supporting people to sustain quality of life and ability to work.

Living well with MSK conditions

Support for many MSK conditions is often over medicalised and the best approach involves accounting for the biological, psychological and social drivers, both unique to the individual and shared across populations.[footnote 48] This requires a personalised approach to care that includes non-pharmaceutical interventions and supported self-management, particularly for conditions of MSK pain.

Key enablers for delivering change

The spring budget announced a package of measures to support individuals at risk or experiencing MSK conditions to live and work well, including:

- integrating employment advisors into MSK pathways to help individuals with conditions return to or remain in work. This builds on the success of the employment advisors in the NHS Talking Therapies programme which is currently being rolled out in England
- making best use of digital health technologies to support people with MSK conditions to better manage symptoms and remain in the workforce. This includes providing free access to digital therapeutics for MSK problems via the NHS App and other national digital channels. These services will not require a GP for referral so that they are readily available 24 hours a day, 7 days a week, to accommodate demand
- designing and scaling up of MSK community hubs aligned with integrated neighbourhood teams to expand access to community based physical activity interventions, including access to vocational support, helping people with MSK conditions remain in or return to work
- exploring how best to support MSK primary and community service improvement and leadership, including improving collection of data, helping to give MSK greater parity with other conditions

Next steps

We will look to:

- improve secondary prevention and the use of non-pharmaceutical interventions, embedding a biopsychosocial and personalised approach and building upon the progress made through the NHS LTP, such as the integration of first contact practitioners, health coaches and social prescribers in primary care and the resources developed through the Best MSK Health Pathway Improvement Programme

- advocate the use of population health management methodologies to target the right kind of support based on individual circumstances and need to those who need it most, enabled by increased integration of care pathways and collaborative working across local health care services as well as social services and voluntary, community and social enterprises
- aim to improve services where medical treatment is necessary. Together with NHSE we will explore supporting the provision of fracture liaison services. This could include identifying people at risk of further osteoporotic fragility fracture and implementing strategies to reduce risk of future fracture (including falls) and mortality

Dementia

What the data tells us and our existing commitments

As the leading cause of death in England (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathregistrationsummarystatisticsenglandandwales/2022), dementia presents a huge and growing challenge for health and social care. The number of people living with dementia in England is set to rise to 900,000 by 2025 and to over 1.3 million by 2040.[footnote 51] An estimated 70% of older people living in care homes may have dementia or severe memory problems (https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=It%20is%20estimated%20that%2070,dementia%20or%20severe%20memory%20problems). Seventy-seven per cent of people with dementia also have at least one other specific health condition (see Dementia comorbidities in patients (https://www.gov.uk/government/publications/dementia-comorbidities-in-patients/dementia-comorbidities-in-patients-data-briefing)).

We know that there are disparities in dementia. Some groups are more at risk of potentially preventable dementia than others (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0275309) and there are disparities in dementia diagnostic rates across the country (https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data/may-2023). More research is needed into dementia risk factors, including disparities such as those that exist between different ethnic groups, by gender and by deprivation.

The national ambition is for two-thirds of people with dementia to have a formal diagnosis. In March 2020, the dementia diagnosis rate dropped below the national ambition for the first time in almost 4 years, reflecting the impact that the pandemic has had on memory assessment services and GP referrals into those services. We have committed to recover diagnosis rates to the national ambition of two-thirds.

We have committed to double funding to dementia research to £160 million a year by financial year 2024 to 2025. We are making progress towards this, including through the £95 million Dame Barbara Windsor Dementia Mission, which focuses on accelerating the development of new treatments and boosting the number and speed of clinical trials.

Reducing the risks

Twelve risk factors account for approximately 40% of dementias globally, meaning that 40% of cases could potentially be prevented if action is taken on these risk factors across the life course.[footnote 52] However, only 33% of people are aware it is possible to reduce their risk of dementia - far fewer than those aware they can reduce their risk of CVD (75%) (see Public attitudes to dementia (https://www.dementiastatistics.org/attitudes/)). Risk factors include wider determinants of health, such as poor air quality, which can contribute to a decline in mental ability and possibly dementia in older people. Social isolation, hearing loss, smoking and a sedentary lifestyle are also risk factors.[footnote 53] Other conditions, such as obesity, hypertension, diabetes and depression also put people at higher risk of dementia.

Identifying, intervening and delivering quality care

Our vision is to improve the lives of people living with dementia and their carers now, as well as the lives of those who may be affected in the future. We must create a society where every person with dementia, their families and carers, receive high-quality, compassionate care, from diagnosis through to end of life.

Access to an accurate and timely dementia diagnosis opens the door to care and support, empowering people to play an active role in managing their condition and enabling them and their families to plan for the future. We have taken several actions to improve dementia diagnosis rates, including:

- providing £17 million of government funding to address dementia waiting lists and increase the number of diagnoses
- piloting the Diagnosing Advanced Dementia Mandate tool to improve diagnosis in care homes
- working with GP IT system providers to improve identification of people who may have dementia.

There is currently no cure or approved disease-modifying treatment for any type of dementia. There are drugs that provide symptom relief, but these do not treat or prevent the progression of the illness. However, with continued scientific progress and more disease modifying treatments in development, it is important to ensure the NHS is prepared for new treatments so that people with dementia can access clinically proven and cost-effective treatments when they become available.

Living well with dementia

Providing high-quality integrated and personalised support following a dementia diagnosis is crucial. This includes social care reforms, support for unpaid carers, and equipping the workforce to provide high-quality dementia care. Earlier this year we published our Next steps to put People at the Heart of Care (https://www.gov.uk/government/publications/adult-social-care-system-reform-next-steps-to-put-people-at-the-heart-of-care/next-steps-to-put-people-at-the-heart-of-care) report, which sets out our plans for adult social care, including ensuring that people can access quality and tailored care.

Compassionate, personalised treatment, care and support throughout the progression of dementia is essential. This includes timely and appropriate ACP so that people living with dementia and their unpaid carers have the opportunity to discuss their wishes, needs and preferences for their future care, to enable people with dementia to 'live well', and one day, 'die well'. Part of enabling people with dementia at the end of life to 'die well' is the provision of high-quality, personalised, palliative and end of life care.

Key enablers for delivering change

Timely data, research and technology have a key role to play, as improved collection and utilisation of data can help us better understand the impact of health disparities and measure variations in the provision and effectiveness of post-diagnostic support. Better harnessing the role of technology can support people with dementia to live independently in their own home and help them receive high-quality, integrated and personalised care, as well as providing support to unpaid carers.

Next steps

NHSE has commissioned the Office for Health Improvement and Disparities (OHID) to develop a resource to support investigation of the underlying variation in dementia diagnosis rates. This includes the assessment of underlying population characteristics such as rurality, ethnicity and age to help us better understand variation and enable targeted investigation and provision of support at a local level to enhance diagnosis rates. NHSE will continue mapping Alzheimer's disease medicines and explore establishing a steering group to ensure the system is ready to deploy any new treatments. Most importantly, we want our plans to be grounded in the experiences of people living with dementia and their unpaid carers. We will explore ways to best understand people's lived experiences of dementia.

CRD

What the data tells us and our existing commitments

Respiratory disease[footnote 54] is the third biggest killer in the UK. It affects one in 5 people, from children to older people, and places demands on primary, secondary, community and specialised care, particularly during winter (see Respiratory disease, NHS (https://www.england.nhs.uk/ourwork/clinical-policy/respiratory-disease/#:~:text=Respiratory%20disease%20affects%20one%20in,the%20biggest%20causes%20of%20death)). Respiratory disease also creates most disruption to the lives and wellbeing of people in the most deprived areas, with the avoidable mortality rate for respiratory disease being 6.5 times higher for men and 8.4 times higher for women in the most deprived parts of the country compared with the least deprived (see the 2nd Atlas of Variation (https://fingertips.phe.org.uk/profile/atlas-of-variation)).

Reducing the risks

The data tells us that a focus on prevention can help to improve outcomes for people with CRD. In particular, we know that smoking makes breathing more difficult. The harmful chemicals in smoke can damage the lining of the lungs and airways (see What are the risks of smoking? (https://www.nhs.uk/common-health-questions/lifestyle/what-are-the-health-risks-of-smoking/)). Stopping smoking can help prevent COPD from getting worse (see Causes of COPD (https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/causes/)). We also know that obesity is a major risk factor for some respiratory diseases, being attributable to almost 30% of asthma in the UK.

We also know that we can reduce the risk from flu, pneumonia and COVID-19 with winter vaccination campaigns run annually. As part of the NHS Core20PLUS5 programme (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/), work is being done within NHSE to improve vaccination uptake among people with COPD in the 20% most deprived communities and in those groups experiencing poorer than average health access, experience and outcomes.

We are also undertaking work to ensure good long-term condition management in primary care, as we understand this can reduce the risk and severity of CRD. This includes incentivising primary care, through the GP contract, to monitor and provide support for those with COPD and asthma, including through annual reviews, a personalised action plan, appropriate inhaler optimisation and advice on smoking cessation (see Quality and outcomes framework guidance (https://www.england.nhs.uk/publication/quality-and-outcomes-framework-guidance-for-2023-24/)).

Identifying, intervening and delivering quality care

We are working to ensure early and accurate diagnosis in the community via high-quality objective testing - quality assured spirometry and fractional exhaled nitric oxide (FeNO). This can be performed in both primary care, community settings and in secondary care.

Integrated respiratory care pathways can maximise time people spend well at home and ensure best use of UEC (see GIRFT Respiratory National Report (https://gettingitrightfirsttime.co.uk/medical_specialties/respiratory/)). Palliative and end of life care and ACP are key to supporting people to live well with advanced disease (see Universal principles for advance care planning (https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/)).

A care bundle for community acquired pneumonia (CAP) has been incentivised via the Commissioning for Quality and Innovation (CQUIN) scheme in financial year 2022 to 2023 - we are awaiting data on take-up of the incentive but early indications are that there is a mixed picture in terms of degree of implementation. The care bundle is designed to support the interventions with the strongest evidence of improving outcomes for people attending hospital with CAP (see Community acquired pneumonia (https://www.respiratoryfutures.org.uk/features/cquin-for-community-acquired-pneumonia-returns-for-202223/#:~:text=Community%20acquired%20pneumonia%20is%20included,to%20improve%20care%20for%20patients)).

We are also looking to expand pulmonary rehabilitation - a highly evidenced and high value programme of exercise and education that transforms the lives of those with chronic lung disease. The benefits include increased ability to be active and exercise, improved wellbeing and reduced breathlessness as well as having health utilisation impacts including reduction of hospitalisation bed days (see Pulmonary rehabilitation (https://www.england.nhs.uk/ourwork/clinical-policy/respiratory-disease/pulmonary-rehabilitation/)).

Living well with CRD

We are looking at ways to support self-management for people with respiratory disease and chronic long-term conditions. This might form a combination of information and education along with support to encourage behaviour change.

An NHS LTP ambition is also to increase access to supported self-management. A piece of work is underway with the NHS @home team with a specific objective to increase access to education, exercise and activity through personalised approaches so more people are empowered to play a more active role in managing their condition.

Lung Health @home has developed a suggested approach that systems can take to achieve these objectives, with supporting tools and resources. The next steps are for this approach to be tested with small number of demonstrator sites with testing in further sites to follow.

Key enablers for delivering change

Integrated respiratory care pathways can be a key enabler in ensuring equitable access to the interventions that help people deal effectively with acute episodes of illness or exacerbations along with those best evidenced approaches to keep people stable and living well. An integrated care pathway for CRD is in development as part of national NHSE work on outpatient transformation. There are examples of these pathways being developed and implemented in different parts of the country and there will be services that offer parts, but not all, of an integrated pathway. Sharing of best practice will be important in implementing these pathways more widely.

There is an NHS LTP workstream underway to improve quality and timeliness of diagnosis, particularly by increasing the number of people trained to perform and interpret quality-assured spirometry. Funding has been provided specifically to increase the number of people trained.

CDCs are being established to deliver additional, digitally connected, diagnostic capacity in England, providing patients with a co-ordinated set of diagnostic tests in the community, in as few visits as possible, enabling an accurate and fast diagnosis on a range of clinical pathways including pulmonary fibrosis.

As part of this, a pathway for the diagnosis of undifferentiated breathlessness is being piloted in a small number of CDCs with a view to wider rollout.

Next steps

To tackle the drivers of ill health, we are:

- launching a public consultation on introducing mandatory cigarette pack inserts with positive messages and information to help people to quit
- rolling out targeted lung health checks for people aged 55 and 74 who have ever smoked
- providing further resources and tools as part of commissioning recommendations for systems to support an increase in access and completion of pulmonary rehabilitation, particularly among groups less likely to take up the offer

Mental ill health

What the data tells us and our existing commitments

For common mental health conditions and severe mental illness (SMI), prevention, early diagnosis, better care and long-term management can avoid conditions worsening and enable patients to maintain their mental

wellbeing (see Mental health and wellbeing plan: discussion paper (https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper)).

Reducing the risks

Mental health problems often start early in life. Half of all mental health problems have been established by the age of 14, rising to 75% by age 24. [footnote 48] This is why intervening as early as possible is essential. As an example, through the Start for Life Programme we are funding support for parent-infant relationships to help prevent adverse physical and mental health outcomes as children grow. We are also extending coverage of mental health support teams in schools and colleges to at least 50% of pupils in England by the end of 2024 to 2025.

To support cross-government working, DHSC will also implement a 'mental health and wellbeing impact assessment tool'. This will support policymakers across government to consider the mental health and wellbeing impacts of all policies without undue burden. Initially this will be used to develop cross-government policies for the major conditions strategy, before further policy roll-out.

Identifying, intervening and delivering quality care

In recent years, much progress has been made to better support people's mental health and wellbeing and to tackle and reduce stigma, but there is still some way to go to in achieving parity of esteem between physical and mental health (see Mental health and wellbeing plan: discussion paper (https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper)). Later this year we will define what parity of esteem means for healthcare so that we can understand how future strategies and actions help us work towards achieving it.

Ensuring timely treatment is one of the core pillars towards achieving parity. While introducing access and waiting time standards is an important step towards parity, these currently cover only 3 service areas. DHSC and NHSE will work together to look at how best to implement the mental health waiting times standards set out in the Clinical Review of Standards (CRS). As a first step, NHSE have communicated their intention to publish waiting time metrics in line with the CRS for mental health UEC by the end of September 2023, and for the community waiting times by the end of March 2024. Continuing work to drive up the use of patient reported outcome measures (PROMs) will also support the delivery of high-quality, patient-centred care.

Employers have an important role to play in supporting employee's mental health and wellbeing. We will also explore government's role in supporting employers to improve the support they provide for the mental and physical

health of themselves and their employees, (as data shows that mental ill health cost businesses £53 to £56 billion in 2020 to 2021 yet return on investment for employers is £5.30 for every £1 invested (https://www2.deloitte.com/uk/en/pages/consulting/articles/mental-health-and-employers-the-case-for-investment.html)).

Living well with mental ill health

People with SMI report a lack of holistic, person-centred care, that adequately considers their mental and physical health needs and wider support needs such as housing and employment (see Mental health and wellbeing plan: discussion paper (https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper)). This has detrimental impacts on the individual's physical health. Data shows that people living with SMI statistically have a higher prevalence of physical health conditions, often develop multimorbidity at a younger age and die on average 15 to 20 years earlier than the general population, with two-thirds of those deaths from preventable physical illnesses (see Severe mental illness (SMI) and physical health inequalities: briefing (https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing)).

This means access to physical healthcare is particularly important for people with SMI. The NHS LTP sets out a transformation programme to develop integrated models of care and holistic support closer to home. The major conditions strategy will outline how to do more to implement physical health support across mental health pathways.

Additionally, a high proportion of people who are using or misusing drugs or alcohol also have a mental health condition (https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2021-to-2022/adult-substance-misuse-treatment-statistics-2021-to-2022-report#mental-health). In 2021 to 2022, 70% of people starting drug and alcohol treatment had a mental health treatment need, but a fifth of those were not receiving treatment. That is why we are developing a joint action plan with NHSE to improve mental health treatment for people with drug and alcohol misuse conditions.

Further, a high proportion of people who smoke also have a mental health condition. People with long-term mental health conditions are much more likely to smoke (at 25.2% 2021 to 2022) compared to the prevalence of smoking within the general population (13.8%, 2022). Smoking is a key contributing factor to the reduction in life expectancy experienced by people with SMI (see Public health data (https://fingertips.phe.org.uk/search/smoking)).

We also recognise that living with physical health conditions can impact an individual's mental health and wellbeing. Over the long-term, poor wellbeing

can have detrimental effects on our life satisfaction and productivity at school and work, and can further impact our physical health (see Mental health and wellbeing plan: discussion paper (https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper)).

Key enablers for delivering change

To drive change we will:

- accelerate research with a £42.7 million investment in the Mental Health Mission, to understand how mental, physical and social conditions interlink, and support research and novel treatments. The NIHR's £30 million Mental Health Research Initiative has funded more than 100 new mental health projects in areas of unmet need since June 2021 (https://www.gov.uk/government/news/chancellor-reveals-life-sciences-growth-package-to-fire-up-economy)
- fund the modernisation and digitalisation of mental health services in England, as announced in the 2023 Spring Budget, including improved access to wellness and clinical grade apps via the NHS App and other national digital channels
- pilot cutting-edge digital therapeutics that have the potential to transform service delivery, and undertake further digitisation of the NHS Talking Therapies service

Next steps

We will:

- continue to work across government, with NHSE and our delivery partners to develop a plan for delivering the commitments outlined here
- continue to consider the submissions to last year's Mental health and wellbeing call for evidence to identify further options to support the objectives of the major conditions strategy and priority areas for mental health support and services

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1. OHID internal analysis of GBD 2019 data (https://vizhub.healthdata.org/gbd-results/?params=gbd-api-2019-permalink/8defdd4e02ae2a492849e6bb566fba8e).
2. Head A and others. Inequalities in incident and prevalent multimorbidity in England, 2004-19: a population-based, descriptive study (https://doi.org/10.1016/S2666-7568(21)00146-X). The Lancet 2021: volume 2, issue 8, pages 489-497 (viewed on July 2023)

3. Throughout this paper ‘major conditions’ is used to refer to only the 6 groups of conditions this strategy will focus on, while long-term conditions will be used when the literature’s focus is wider than just the 6 groups of conditions.
4. Included due to the overlap between diabetes and both CVD specifically and multimorbidity generally: a person with diabetes is twice as likely to have heart disease or a stroke than someone who does not, and at a younger age.
5. Dementia is part of a group of conditions called neurological disorders. These are any disorders that affect the nervous system, and cover an array of conditions including headache disorders, Alzheimer’s disease and other dementias, Parkinson’s, idiopathic epilepsy, multiple sclerosis, motor neurone disease and other neurological disorders.
6. See the Fingertips Segment tool (https://fingertips.phe.org.uk/profile/inequality-tools) (based on quintiles of deprivation).
7. DALYS are a time-based measure that combines years of life lost due to premature mortality (YLLs) and years lived with disability, a metric for time spent in less than ideal health, weighted by severity (YLDs). They therefore target mortality and morbidity.
8. Mental health: environmental factors (https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/2-understanding-place)
9. Some totals per condition will sum to more than 100% as the impact of each risk factor on a condition is considered completely independently of other risk factor impacts. Dementia falls within neurological disorders, and this will also include other conditions.
10. GBD analysis (https://www.healthdata.org/news-events/newsroom/news-releases/lancet-alcohol-consumption-carries-significant-health-risks-and) suggests that ‘for young adults ages 15 to 39, there are no health benefits to drinking alcohol, only health risks, with 59.1% of people who consumed unsafe amounts of alcohol in 2020 between ages 15 and 39 years and 76.7% male. For people over age 40, health risks from alcohol consumption vary by age and region. Consuming a small amount of alcohol (for example, drinking between one and 2 3.4-ounce (approximately 100 millilitres) glasses of red wine) for people in this age group can provide some health benefits, such as reducing the risk of cardiovascular disease, stroke and diabetes.’
11. Between 2020 and 2035, ONS projections estimate that the population will grow by 2.6 million, made up of 3.2 million more people aged over 65 (and 500,000 fewer people under 65) (https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea14principalprojectionenglandsummary).

12. Morrison D and others. Managing multimorbidity in primary care in patients with chronic respiratory conditions (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5024357/), NPJ Primary Care Respiratory Medicine 2016: volume 26, page 16043 (viewed on 10 July 2023)
13. Health Survey for England 2018 Longstanding Conditions report (https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018)
14. Health Survey for England 2018 Longstanding Conditions report (https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018)
15. Whitty C and others. Rising to the challenge of multimorbidity (https://www.bmj.com/content/368/bmj.l6964). British Medical Journal 2020: issue 368, l6964 (viewed on July 2023)
16. The Academy of Medical Sciences 2018. 'Multimorbidity: a priority for global health research' (https://acmedsci.ac.uk/policy/policy-projects/multimorbidity), page 62 (viewed on July 2023)]
17. Deprivation is defined using the English indices of deprivation 2019 (https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019). Blackpool falls in the most deprived 10% of local authorities nationally, and Wokingham falls in the least deprived 10% of local authorities nationally.
18. From NHS England - Inclusion health groups (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/): 'Inclusion health (https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health) is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.'
19. Although there was a temporary disproportionate increase in mortality rates among ethnic minority groups during the pandemic, these rates have since returned to pre-pandemic levels (https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england).
20. L M Goff. Ethnicity and Type 2 diabetes in the UK (https://onlinelibrary.wiley.com/doi/10.1111/dme.13895)(viewed on July 2023)
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(https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31869-X/fulltext)(viewed on July 2023)

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32. Five Year Forward View for Mental Health - one year on report (https://www.england.nhs.uk/mental-health/taskforce/), page 5.

33. For example, the work of Think Local, Act Personal - TLAP 'I' statements from Making It Real 2018 (https://www.local.gov.uk/our-support/partners-care-and-health/autistic-people-and-people-learning-disability/support-people)
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35. Social prescribing (https://www.england.nhs.uk/personalisedcare/social-prescribing/) is a key component of universal personalised care. It is an approach that connects people to activities, groups and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.
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37. NHSE published Universal Principles for ACP (https://www.england.nhs.uk/publication/universal-principles-for-advance-care-planning/) in March 2022 to provide a consistent national approach to ACP.
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48. Musculoskeletal health: Applying All Our Health (https://www.gov.uk/government/publications/musculoskeletal-health-applying-all-our-health))
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54. For these figures, respiratory disease is defined by the Health Resource Group Respiratory System codes ICD 10 S00-T88. Note that this differs from the definition of CRD in this report, with the main difference being lung cancer is included in this broader definition of respiratory disease, and it is not in our definition of CRD (but instead sits in cancer).