NHS
South East
Clinical Senate

South East Clinical Senate Response to 10 Year Plan

Q1. What does your organisation want to see included in the 10-Year Health Plan and why?

- A focus on the triple aim of improving quality of care (including patient safety), reducing health inequalities across communities, and delivering the best value care.[1] Across the health and care system – not just health, there is persistent lack of integration between health, wellbeing and social care services which potentiates fragmented patient journeys and siloed data. There needs to be a focus not only on data capture but also data analysis, ensuring we have accurate data which is sensitive to what we need to improve.
- Reducing health inequalities, which have widened over recent years.[2] The COVID-19 pandemic has shone a light on the extent of the issue. Additionally, the current cost of living crisis is worsening existing health inequalities.[3] The NHS can impact on health inequalities by both action on healthcare access, experience, and outcomes and through its ability to influence, support and take direct action on wider determinants of health. The NHS, as an anchor institution, working in partnership with communities, local authorities, educational organisations and Voluntary, Community and Social Enterprise (VCSE) organisations can maximise its social, economic, and environmental impacts to improve social determinants of health, health outcomes and ultimately reduce health inequalities in its local populations.[4]
- Equitable access to healthcare services for all by focusing on the healthcare access pathway[5]:
  1. Service approachability: How well is the service known to users and staff through outreach information?
  2. Service acceptability: How will cultural and social factors influence if a service is acceptable to users?
  3. Service availability: How does the service accommodate the needs of different social groups?

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[1] NHS England. (2023) 2023/24 priorities and operational planning guidance. Available online from NHS England » 2023/24 priorities and operational planning guidance

[2] Public Health England. (2020). Disparities in the risk and outcomes of COVID-19. Available online from COVID-19: review of disparities in risks and outcomes - GOV.UK

[3] NHS providers. Rising living costs: the impact on NHS, staff, and patients. Available online from Rising living costs: The impact on NHS, staff and patients

[4] South East Clinical Senate. (2023) Health inequalities within the southeast region through a service change lens. Available online from Health-Inequalities-within-the-southeast-through-a-service-change-lens-v.Final_.pdf

[5] Gainsbury S and Hutchings R; Nuffield Trust. (2021) Review of the Mayor of London's Health Inequalities Test. Available online from 1667818147_nuffield-trust-mayor-of-london-s-health-inequalities-test-web.pdf

4.Affordability: How does the service ensure it is 'affordable' to its users?
5. Quality and appropriate healthcare: How does the service ensure it delivers high quality care appropriate to users clinical needs?

- Focus on sustainable healthcare and working towards achieving NHS net zero targets. Tackling climate change has huge health, environmental, social, and financial benefits, and results in direct improvements for public health and health equity,[6] making it clear why achieving a net zero NHS needs to be a priority.
- Focus on population health and disease prevention, by making it easier for people to make healthier choices and supporting people to effectively implement behavioural and lifestyle changes required to reduce their risk of disease and improve their healthy life expectancy. It is estimated 40% of the NHS budget is spent on treating preventable diseases[7], providing clear evidence why we must shift healthcare towards prevention to save both lives and money.
- Where prevention is not possible, drive early diagnosis and treatment.
- Focus on the impacts of deprivation, poor oral health and clean air (or lack of).
- Mental health problems cost the UK economy at least £117.9 billion a year. Improving the mental health of the population will increase productivity and reap economic benefits as well as ease pressure on the NHS system.
- Shift towards more care closer to home (continue to localise where possible). This is considered the most inclusive, effective and efficient way to enhance people's physical and mental wellbeing.[8]
- Focus on personalised care and embed shared decision making into patient care. Enable and drive patient self-management where feasible and possible, promote and drive healthy lifestyle advice through social media, television, role modelling etc.
- Children, young people and child health services have distinct needs, they interact with the health system differently and often encounter a wider range of services than adults. There is a particular need to meet the physical and mental health needs of children and young people, recognising the impact on their healthy development and ability to participate in education.
- Co-production of services, emphasising that patient experience and insight as part of decision making should be paramount.

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[6] Economist Impact. (2022) Do no harm: healthcare professionals address sustainability and climate change. Available online from Do no harm: Healthcare professionals address sustainability and climate change I Economist Impact

[7] Wain R and Miller B. (2023). Public Services: Moving from cure to prevention could save the NHS billions: A plan to protect Britian. Available online from Moving From Cure to Prevention Could Save the NHS Billions: A Plan to Protect Britain

[8] The Kings Fund. (2024). Making care closer to home a reality. Refocusing the system to primary and community care. Available online from making_care_closer_home_reality_report_2024.pdf

- Understand and address the implications of anti-microbial resistance (AMR) (predicted to result in over 10 million excess deaths/year globally). The number of serious antibiotic resistant infections in England rose by 14.6% between 2022 and 2023. Patients in the most deprived communities are 43% more likely to acquire an antibiotic resistant infection than those in wealthy areas (38.1/100,000 versus 26.7/100,000).
- End of life care at home or hospice (fully funded), not in hospital.
- A focus on onboarding of patients and workforce in artificial intelligence (AI) and new health and digital technologies available, which is a common barrier seen operationally. It is important to recognise that 'one size doesn't fit all.' Different things need to be considered for different populations such as language and cultural barriers and presenting information in different ways to ensure we capture all parts of the population.
- Address the inadequacies of the NHS estate and ensure that form follows function in NHS buildings future proofed, fit for the future and with built in environmental sustainability.
- Address workforce establishments recognising that to meet current and future demand, a cost-effective skills and competencies approach to delivering healthcare needs is required. This will need appropriate regulation and the support of the Royal Colleges and Professional Societies/Organisations. A comprehensive plan needs to be in place for all roles, especially for those that are hard to recruit and retain, for example carer roles that social care particularly needs. There needs to be a focus on recruitment initiatives, for example, considering reintroduction of bursaries. Improvements in healthcare training need to be carefully considered, for example, embedding and empowering mandatory human factors training in the schools of Medicine, Surgery, Anaesthesia, Radiology, etc and funding simulation labs across the country to compensate for the reduced surgical caseloads per trainee in the last decades.
- Improving maternity services by focusing on safer, more personalised, and equitable care. There needs to be a focus on recruitment, retention, and specialist training for the maternity workforce to achieve these improvements.
- Ongoing advancements in specialist care, ensuring we are the world leader in healthcare.
- The NHS needs to continue to work towards being fully functioning 7 days of the week. This may include re-structing work patterns to include early operations and weekend work, to increase theatre and surgical flow capacity.
- Strengthened leadership and accountability to lead the key priorities, with good support in place for leaders. There needs to be an improvement in overall processes, which often links back to improving communication. Effective leadership is key to improve processes, communication, and ensure positive behaviour changes are implemented by the workforce, where necessary. Poor communication within the NHS is a common barrier to

providing high quality patient care. Commercial industries who have a customer focus e.g. pharmaceuticals and retail, may be able to support the NHS with enhancing communication skills. Additionally, effective leadership is needed to develop innovative ideas for improving the current state of the NHS such as funding regional and supra-regional clinical network jobs where professionals can swap and change between Trusts, to compensate for those local 'crises' that would otherwise block patient flow and job planning double consultant operating for complex procedures.

- Transformation on the scale that we need to see requires investment in change capabilities to enable adoption of new ways of working, such as the use of innovations like AI. We need to think beyond just funding the technology and fund the change as well.

In any major service change proposals, it is important to consider the impact of the proposed service change on all these important factors.

Overarching aims are not just to improve life expectancy but to reduce the gap between life expectancy and health life expectancy.

In answering the next questions, we would welcome references to specific examples or case studies. Please also indicate how you would prioritise these and at what level you would recommend addressing this at, i.e. a central approach or local approach.

Q2. What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Offering care and choice closer to home in local communities can improve service availability and access. It will mitigate for some of the common barriers to not accessing services, such as limited flexibility and practical barriers such as travel costs.

Generally, inpatient care is considered more carbon intensive than community care, due to factors including increased use of equipment, energy use, travel and the risk of hospital acquired complications.[9] Virtual wards support patients to manage their condition at home, when they would otherwise be in hospital. With virtual wards, there is a risk that digital technologies disproportionately exclude certain groups, including older populations and populations with higher levels of deprivation. It is important this is considered when planning the shift to community care, to prevent

[9] Tsagkaris, C et al. (2021) 'Using telemedicine for a lower carbon footprint in healthcare: A twofold tale of healing.' The Journal of Climate Change and Health. 1, 100006.

widening the health inequalities gap.[10] There are opportunities to use the voluntary sector to help those with less digital and health literacy.

One challenge with moving more care from hospitals to communities is that currently the financial and workforce growth has not been aligned to a vision of care focused on communities. There has been a considerably larger financial and workforce growth in the acute hospital sector compared to the primary and community sector. To ensure the shift towards more community care is a successful one, the financial flow of investment needs to be reprioritised, with communities receiving proportionately more than acute hospitals. Additionally, there needs to be more incentives for the workforce to progress their careers in the community. A responsibility lies with professional bodies and regulators to ensure the workforce have the necessary skills and experience of community work from the outset of their training.[8] A significant growth in financial and workforce investment is needed in the community to address the increasing patient demand for care in the community and the increasing complexity of conditions which patients are presenting with. The need for workforce expansion also needs to be recognised, because it is more cost effective to support large centres than small.

If clinical models for moving more care from hospitals to communities are well designed and robust, they can result in positive clinical outcomes, which are equal if not better than hospital care.[11]

It is clear, to successfully deliver more care in the community, there needs to be an initial large investment in time and funding, but this will reap the benefits further down the line, as well-designed schemes may deliver care at a lower cost in the long term.[11]

There needs to be a focus on capturing high quality, sensitive, accurate data within the community setting to demonstrate the range of services which are delivered and to effectively measure productivity and quality improvement.[8] Innovative and appropriate use of wearable technology, for example use of movement sensors for detection of lack of movement (for recurrent falls), can improve efficiency and quality of care within the community.

The following factors should be considered for equitable access, when moving more care into the community e.g. to local health centres:

[10] South East Clinical Senate. (2023). Embedding Healthcare Sustainability in major service change. Available online from Embedding-sustainability-in-service-change-final-report.pdf
[11] Monitor (2015). Moving healthcare closer to home: Summary. Available online from moving_healthcare_closer_to_home_summary.pdf

- Ensuring that the complete patient journey, into and between services is fully understood including each point at which vulnerable groups experience barriers in accessing the service (including the inclusion health populations).
- Ensuring access to timely diagnostics and results.
- Ensuring physical access for elderly / disabled users has been considered.
- Ensuring appropriate travel options have been considered.

There is a large range in admission rates for the elderly and frail that reflects:

- How proactive care is in the home and in residential care homes.
- Hospital at home and urgent community response.
- Early frailty assessment and action where required with good community links.
- Advance care planning and good end of life care[12].

In the South East between March to August 2024 it is estimated that c.1240 admissions/week of those aged over 80 could have been avoided equating to 567,522 bed days over a 12 month period.

Major themes for emergency department attendances are infections (respiratory, urinary, skin); falls-related; urethral catheter related, frailty and poor end of life care. Rapid response teams can play a vital role in helping to reduce these admissions.

There needs to be a focus on improving frailty care moving forward, which will ultimately help to reduce admission rates and shift more care from hospitals to the community.

In the South East, there are a significant number of patients in hospital across the region who no longer require hospital care. Patients who have been inpatients for more than 14 days and do not meet the criteria to reside occupy 12% (just over 1500 beds) of the region's total bed base. This is significantly higher than other regions whose figures range from 6.5% to 10.1%.

Getting these patients home safely in a timely manner needs to be a key priority and requires effective collaborative working with local authorities and voluntary sector partners, who support discharge processes.

Seamless 2-way communication, between patients and care teams is a vital aspect in ensuring a successful shift in care from hospitals to communities, which will not come without its challenges.

[12] NICE. (2015). Older people with social care needs and multiple long-term conditions. Available online from Older people with social care needs and multiple long-term conditions

Q3. What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

Poor integration with existing IT systems and Electronic Health Record (EHRs) represents a key barrier, as does lack of standardised data sharing agreements across healthcare organisations. Paternalistic attitudes and behaviours in allowing patient access is another. There are several platforms currently facilitating patient access to healthcare records, but the information should be interoperable to present a 'single source of truth' to patients. There should be a safe and seamless 2-way sharing and flow of information pertinent to patient care between patients and healthcare providers and between different health and social care providers.

The implementation of patient access to EHRs has the potential to:

- Increase health inequities, related to factors such as digital and health literacy, internet access, language and cultural barriers. Policy needs to mitigate this through changes to help the vulnerable groups.

- Increase patient harm and possible safeguarding risks through anxiety engendered by what patients see on EHR and possibly misinterpret. To mitigate issues of patient anxiety, patients need to be aware of the purpose of the tests, the timing of result release, likely findings, and next steps in the event of abnormal results. Timely and adequate communication between healthcare professionals and patients is the key to the successful implementation of a direct result release via portals.

- Increase workload both through reviewing and explaining viewable medical information in lay terms and reduce efficiency. These very real issues of healthcare providers key concerns, along with fears over increased burnout and legal concerns need to be addressed and mitigated when making better use of technology in healthcare.

It is recognised that increased usage of EHRs by patients able to access and use patient portals could redirect non-digital healthcare resources to those patients not able to access and use patient portals. Additionally, increased EHR usage can improve the usefulness of information exchange on EHR platforms and justify delivery of patient portals. Being creative in developing innovative and useful features of these systems, in particular 2-way flows of information and data, is imperative. An in-depth knowledge and understanding of the levers for increasing patient access to healthcare records is required to develop mediated health

communication targeted at raising the awareness of access to EHR and bringing patients further along the entire usage process.[13]

Healthcare professionals can help engage patients in their care and promote patient autonomy and informed decision-making through better understanding of what functionality patients require via patient portals and through guidance on how to access and use portals. Healthcare professionals also need support through ensuring that they have the time to teach patients and to adapt their record keeping to transparent and immediate access. Clearly encouraging patient portal use has the additional benefits of enabling all stakeholders to share information and prevent duplication of effort. Healthcare leaders and researchers should develop, evaluate, and disseminate the results of innovative portal efforts to equitably engage patients and healthcare professionals. They should also engage diverse patients in the design and testing of portals and features. Teams from technology departments could be dedicated to facilitating the introduction of new technology.

Limited health and digital literacy are common and impact on confidence and satisfaction with telemedicine, therefore clinical services need to take account of people unable to access services digitally. Engaging with service users to co-design services will assist to mitigate adoption and uptake risks. The NHS must continue to invest in the infrastructure necessary to deliver virtual services, including offering flexible, multimodal options that can meet the preferences and needs of diverse patient populations. It is important to ensure alternative options, for example face to face appointments, are offered to vulnerable groups who may not be able to attend virtual appointments. More complete data collection to identify who is accessing face to face or virtual appointments, according to relevant protected characteristics and health inclusion groups is recommended.

When healthcare organisations implement health IT programs to be used by any patient (young, old, computer savvy or computer novice), step-by-step training programs must be developed for older adults and/or technology naive patients. Training sessions could be divided into those for digital naive generations, and those for late adopters of technology. Simple instructional culturally appropriate videos (e.g., animations) would be another way of augmenting training. Unsurprisingly clinician encouragement of patient EHR use is strongly associated with patients accessing EHR. However, research shows that there are also disparities in who receives clinician encouragement related to education, income, sex, and ethnicity[14].

[13] South East Clinical Senate. (2024). Patient access to healthcare records. Available online from South-East-Clinical-Senate-Patient-Access-to-Healthcare-Records-Report.pdf

[14] Sisk BA, Lin S, Balls-Berry JJE, Servin AE, Mack JW. (2023) 'Identifying contributors to disparities in patient access of online medical records: examining the role of clinician encouragement'. JAMIA Open. 6(3).

Well-designed EHR have the potential to improve communication, increase patient empowerment, self-management and patient satisfaction. For example, people with kidney disease in the UK were afforded a 2-way communication with their healthcare professionals, viewing their results and letters and being provided with a platform for the recording of patient-entered data such as home blood pressure readings (Renal Patient View)[15]. Such systems are designed to encourage patient participation in the management of their condition, and ultimately to increase patient empowerment and self-management, which are associated with improved clinical outcomes. To move care from hospital to patients' communities or homes, there is a need for a universal care record that can be accessed freely by GPs, hospitals and clinics. Apart from the current IT barriers to this, with different organisations using different systems, a barrier that could be readily removed would be the implementation of a Government-backed national NHS information governance agreement, compulsory for all delivering patient care. Breaking down digital barriers between NHS providers is critical to enable the building of the universal care record, providing a dataset that spans primary, secondary and community care. This would be used by AI and big data analysis systems of the future for the purposes of:

- Provision of training datasets for automated systems
- Support for automation of diagnostic processes
- Automated triage of patients
- Targeted health interventions
- Population Health analysis and its role in preventative medicine.

AI has an increasing role in healthcare. There is evidence that the pros of use of AI interventions outweigh the cons[13].

AI has the potential to reduce primary care workload and administrative burden through its use in:

- **Inbox management** - e.g. prioritising patient messages, generating draft responses and editing physician messages to optimise communication.
- **Clinician documentation** – e.g. draft progress notes in real time during visits, draft prior authorisation, disability, and durable medical equipment requests.
- **Between visit management** – e.g. identify patients in need of disease screening/monitoring using unstructured and structured EHR data to determine exclusions, identify patients with incomplete screening/monitoring (e.g. missed appointments), automate communication with patients, provide scheduling and/or staff notification and generate tailored messages to patients related to the between-visit care needs.

[15] Hazara AM, Durrans K, Bhandari S. (2019) 'The role of patient portals in enhancing self-care in patients with renal conditions'. Clin Kidney J. 13(1):1-7.

- **Individualised decision support** – e.g. identify relevant information in structured and unstructured EHR data to prioritise differential diagnoses for new symptoms, recommend medication options for chronic conditions, considering prior medication prescriptions, allergies, adverse effects noted and potential drug interactions in structured and unstructured EHR data. There is significant potential to use of AI systems to support better diagnosis and increases in productivity in image-based specialisms such as Clinical Radiology and Histopathology. AI systems in Clinical Radiology form more than 75% of available AI products in medicine by discipline[16]

Although AI has many potential advantages for its use in EHR, this also comes with some potential risks including:

- **Inbox management** – risk of dehumanising the clinician-patient relationship and sidelining clinicians from important conversations that would benefit from human interaction.
- **Clinician documentation** – risk that the volume of documentation produced may exacerbate burnout, it requires monitoring for safety and usefulness.
- **Between visit management** –the accuracy of AI output is dependent on accuracy of training input. AI has the potential to fabricate or confabulate information impacting patient safety.
- **Individualised decision support** – Some suggestions may be wrong, and safety and usefulness of AI suggestions requires checking. Moving towards a foreseeable future where diagnosis is carried out autonomously by AI systems, risks of equity in AI training datasets and diagnostic drift will need to be mitigated. This brings requirements for new education and training of the workforce, as they shift from 'doing' to 'monitoring and assuring' diagnosis.

New technologies come with inherent risk. The Government should support the NHS to manage and, indeed, cover this risk. Similar assurances of Government backing would reassure industry in developing new technologies. Equally, the NHS would benefit from Government support for clinical trials, without which new technologies cannot be safely implemented.

Models of care which focus on digitally enabled care help towards meeting the NHS commitments to sustainable healthcare and achieving the NHS net zero targets.[10]

[16] https://radiology.healthairegister.com

Q4. What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Spotting illnesses earlier (early diagnosis)[17]

- Tests need to be accurate, minimally invasive and cost effective.
- Innovative and new technologies will have increasing use e.g. AI, digital interventions such as remote monitoring.
- Early diagnosis needs to be useful to patients e.g. improve quality or life or mortality.
- Risk that screening / early diagnosis programmes result in overdiagnosis / false positives and negatives.
- False positive screening tests will increase the burden on the NHS and increase waiting lists further e.g. for further imaging / endoscopy services.

Tackling the causes of ill health (prevention)

Shifting to models of care which focus on evidence based-population health management, including disease prevention is essential to increase life expectancy and reduce morbidity and mortality from diseases in the long term.

Reducing the need for healthcare in the first instance by focusing on preventive medicine and reducing health inequalities, is considered an important principle of sustainable healthcare. Preventative programmes which proactively engage those at greater risk of poor health outcomes can help to reduce health inequalities.

Key areas of preventable illness in childhood include respiratory illness and obesity. 1 in 11 children have asthma and allergy is increasingly prevalent. 80% of obese young people remain obese as adults and report being stigmatised due to their weight, the impacts of which include bullying and poorer educational outcomes, increased risk of depression, anxiety and social isolation.

Several challenges have been identified to pushing the agenda for prevention including[18]:

- Lack of clarity over the meaning of prevention. There is currently no clear prevention framework which can be used to guide systems to set targets on prevention, benchmark spending or monitor progress in prevention.

[17] McCartney M, Macdonald H. (2024) 'Early diagnosis is not always an unmitigated good, we need to make it useful for patients and clinicians. 385:q973

[18] NHS Confederation. (2024). Unlocking prevention in integrated care systems. Available online from Unlocking prevention in integrated care systems | NHS Confederation

- It can be difficult to demonstrate the impact of prevention. Particularly in the short term, the benefits of prevention work can be hard to evidence, which can make maintaining focus challenging.
- Limited capacity and funding to shift resource use into the field of prevention.
- The ongoing focus on the immediate short term operational and financial pressures, rather than investing in the long term.
- Lack of joined up care across the community and not utilising the full potential of all system partners e.g. VCSE organisations.
- Childhood vaccination uptakes are decreasing, presenting a further challenge in the area of disease prevention.[19]

To prioritise disease prevention in the future, there needs to be a focus on the work around the national framework for measuring prevention spending, including an agreed definition and metric for preventative services. It is essential to capture sensitive data to be able to effectively evaluate preventative programmes. There needs to be more incentives to focus on preventive healthcare with increased funding into this area to protect the health of our future generations.

Innovative and new technologies, such as AI, remote monitoring and point of care testing (POCT) which is quality assured, are seen as enablers to tackling the causes of ill health and improving disease prevention.

The South East Clinical Senate have identified several recommendations to tackle cardiovascular disease (CVD)[20]. These specific recommendations can be generalised to help tackle several preventable diseases and causes of ill health:

1. **Establish multi-organisational leadership** – Improving CVD prevention requires robust leadership and management support at all levels. For example, it is important to have CVD prevention leads and champions throughout the entire system and at all levels, advocating for the entire CVD pathway, including primary prevention.
2. **Support patient education and promotion of self-management** – Tailored person-centred patient education and promotion of self-management have shown to be effective, leading not only to better hypertension and cholesterol control but also improved lifestyle change (e.g. diet and physical activity) and patient engagement. The use of new technologies, such as AI-driven personalised education tools, integrated into national digital health platforms e.g. NHS app, to provide tailored education and support for patients should be explored at a national level. Data analytics should be used at regional and

[19] NHS England. Childhood Vaccination Coverage Statistics, England, 2023-24. Available online from Childhood Vaccination Coverage Statistics, England, 2023-24 - NHS England Digital
[20] South East Clinical Senate. (2024). Enabling improvement and reducing inequalities in Hypertension and Cholesterol Detection and Management in South East England. Available online from South East Advice & Recommendations | South East Clinical Senate

system levels to target CVD prevention to communities which need it most, with the aim to reduce health inequalities. At a practice level, consistent advice and support should be offered to patients to achieve a healthy lifestyle, periodically assessing diet and exercise, providing tailored guidance and resources, supporting smoking cessation and informing patients about local health initiatives to promote sustained lifestyle changes. The person-centred approach to care should be adhered to, including considering people's needs and preferences.

3. **Support organisational change, focusing on team changes** - creating multi-disciplinary teams, strengthening community-based interventions, or assigning responsibilities in the CVD prevention pathways to health professionals other than the patient's physician, have shown to be effective and to reduce barriers. There are clear benefits of integrated care as many people with CVD have multiple and sometimes complex comorbidities, requiring integrated continuity of care across multiple providers and services. At a national level, this may involve supporting the expansion of nonphysician healthcare practitioner-led (e.g. nurse- or pharmacy-led) interventions by expanding the scope of practice for allied health professionals.
4. **Facilitate provider training and implement provider reminder and clinical decision support systems** - Provider education is an important and effective element in quality improvement strategies and may focus on training in guidelines, accurate measurements, data entry, communication, motivational interviewing, and provision of advice on behavioural change. Provider education initiatives are effective at practice as well as at system-level, leading to rapid and sustained improvements in hypertension control, for example.
5. **Establish robust audit and feedback mechanisms** - Audit, feedback, and benchmarking are continuous improvement initiatives that can be used to evaluate performance and present data reflecting the status of guideline use and provider adherence to national standards. Audit and feedback mechanisms have been shown to improve quality of care for CVD.

Q5. Please share specific policy ideas for change. Include how you would prioritise these and what timeframe you would expect to see this delivered in, for example:

• Quick to do, that is in the next year or so

- AI governance.
- Workforce regulation for new roles.
- Improve financial flows and incentives to facilitate an increase in community-based care and focus on preventative care.

• In the middle, that is in the next 2 to 5 years

- Increase workforce in primary and community health services.
- Transitioning to community care.
- Ensure NHS net zero plan is embedded in everything we do e.g. including a test for service change.
- Improved integration with health, wellbeing and social care.
- Focus on reducing duplication of work e.g. streamlining reporting accountability at national / regional levels.
- Infection prevention and control (AMR).
- Accelerate preventative programmes, especially with a focus on those vulnerable groups. Adopting inclusion health framework by organisation.

- Implementation of a universal NHS information governance agreement – across the whole UK. This would enable greater collaboration between services and provide the critical population health datasets needed to safely and equitably implement new AI and big-data driven technologies.

• Long term change, that will take more than 5 years

- Full health, wellbeing and social care integration.
- Seamless coordination and communication between patient/carer, health and social care and other public services.