Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	Yes/no.
Title of Report	Longer Lives
Meeting Date:	7 November 2013
Responsible Officer(s)	Sanhita Chakrabarti and Celia Shohet Assistant Directors, Public Health
Presented by:	Sanhita Chakrabarti

Action Required:

1. Receive the plan to deliver better outcomes for people identified with long term conditions in Central Bedfordshire

Executive Summary	
1.	In July 2013, The Health and Wellbeing board received a paper on Longer Lives which is a new website showing significant variation in early death rates in Cancer, Lung disease, Heart disease, Diabetes and Liver Disease. The board requested that a delivery plan to tackle premature mortality in Central Bedfordshire was developed. Evidence suggests that if we are to tackle the challenge we face, we need to make improvements across the three domains of prevention, early diagnosis and treatment. Two thirds of deaths under 75 are avoidable, largely through improved public health. (Ref Call to Action on Premature Mortality DH).
Background	
2.	Public Health England, on the 11 June 2013, published a set of data to highlight the numbers of people in England dying prematurely (defined as before the age of 75). The data is for the period 2009- 2011. The data show that people in Central Bedfordshire have a lower premature mortality rate compared to most other parts of the country. The rate of premature mortality has fallen year-on- year. In the period 2005-07, 274 people in every 100,000 of the population were dying prematurely, this dropped to 237 people in the period 2009-11.

	However, when compared with the new grouping of local authorities, Central Bedfordshire has a higher overall rate than all but one local authority within the same group. Within the new grouping Central Bedfordshire also has higher rates of premature mortality from cancer, heart disease and stroke, and lung disease. Only liver disease shows Central Bedfordshire has a lower rate of premature mortality than all but one area in its comparator group. The Health and Wellbeing board considered a paper on the 18th July 2013.
3.	**<u>Action since July 2013</u>** a) Locality Profiles have been finalised for the four of the BCCG localities in Central Bedfordshire - Ivel Valley, Chiltern Vale, West Mid-Beds and Leighton Buzzard. These out-lined specific population level variations in outcomes and have been discussed with the locality boards as well as BCCG Executive. Actions have been identified to address variation in care and improve outcomes in primary care, they have also informed the BCCG Commissioning intentions and locality service delivery plans. b) The small area analysis for locality profiles has revealed quite stark health inequalities within Central Bedfordshire. The outcomes for people with long term conditions living within the more deprived areas, including the Chiltern Vale and Leighton Buzzard locality areas is suboptimal compared to other parts of Central Bedfordshire as well as National averages. c) Comparison of indicators across health and wider determinants suggest that when compared with statistical neighbours identified within Longer Lives, Central Bedfordshire has worse outcomes for Child Poverty, GCSE attainment, Long term unemployment, smoking in pregnancy, physically active, obese adults, and hospital stays for alcohol, diabetes and smoking related deaths. All the indicators mentioned have positive association with premature mortality for Heart Disease and Stroke, Cancer, Lung Disease and Liver disease. (appendix 1) d) All JSNA chapters on conditions that lead to premature mortality have been refreshed to provide a strategic overview the evidence base and recommendations to improve outcomes for people identified with long term conditions. e) Meetings have taken place with officers responsible for Housing, Environment, Travel, Early years, Child Poverty and Employment in the young.

	f) Central Bedfordshire figures around deaths due to lung disease and cancer were relatively poor compared to the similar local authorities in the 'Longer Lives; comparator groups. Tackling smoking is a key intervention in tackling deaths due to lung conditions. BCCG respiratory implementation group has been informed about evidence based interventions in tackling smoking in people already diagnosed with respiratory disease. Public Health will work closely with clinicians within hospitals and primary care to raise the profile of effective counselling and pharmacotherapy to tackle smoking in people diagnosed with respiratory conditions.
Detailed Recommendation	
4.	**What we are going to do stop people from developing 'Long Term Conditions?** Smoking, poor diet, obesity and lack of physical activity contribute to the development of all the diseases that result in premature mortality. Reducing Childhood Obesity (Priority 3), Helping people make healthy lifestyle choices (Priority 7) are existing priorities within the Central Bedfordshire Health and Well-being strategy 2012-2017. There are existing monitoring mechanisms about plans to tackle unhealthy lifestyles in the people in Central Bedfordshire. The Health and Wellbeing Board recently considered a paper on this on the 13th May 2013.
5.	**<u>Liver disease</u>** Central Bedfordshire was considered **2nd out of 14 similar local authorities**. Alcohol, Obesity and Hepatitis contribute to development of liver disease. Although , the figures around mortality for Liver disease for Central Bedfordshire is favourable compared to similar local authorities, it is important to keep the focus on reducing harmful drinking and vaccinating for hepatitis in people who are at high risk. Community based service provision to help people tackle harmful drinking, was increased in September 2013. NHS Healthchecks now include questions regarding alcohol intake to support the early identification and prevention of problem drinking.

6.	**<u>Cancer</u>** **Central Bedfordshire was considered 14th out of 15 similar local authorities**
	JSNA 2012/13 has identified: • Premature mortality (below the age of 75 years) from cancer in England, ONS Cluster and Central Bedfordshire fell between 1993 and 2010. However, cancer still causes the most premature deaths in Central Bedfordshire (41.5%) followed by circulatory diseases (24.2%). • The most common cancers resulting in death in those aged 75 years or under are lung, colorectal, oesophageal and prostate cancers for males and breast, lung and colorectal cancers for females. • Lung cancer has the greatest impact on mortality rates in the most deprived areas of Bedfordshire • Breast Cancer Screening Coverage for 2012 in Central Bedfordshire (74.5%) for 2012 was lower than that recorded for England (77%) • Cervical Cancer Screening uptake and Bowel cancer Screening uptake are above those recorded for East of England and England for 2011/12 • Locality profiles for the five BCCG localities showed significant variation in primary care in screening coverage at GP practice level, Variation was also noted in two week referral rates, two week referral rates converted into cancers and cancers presenting at emergency units. **What we can do to diagnose Cancer Early?** • Increased bowel, breast and Cervical cancer screening coverage starting with the GP practices where there is low uptake of the programmes • Local awareness And Early Diagnosis Initiative (LAEDI) includes reviewing the GP Practice Profiles , use of the primary care audit , implementation of the Willie Hamilton risk Assessment Tool and support for education and training of the GPs **How will we improve the care of people diagnosed with Cancer?** • Reduce variation in referrals for two week pathways and encourage early referral and diagnosis.

7.	**Lung disease** **Central Bedfordshire was considered 14th out of 14 similar local authorities** **JSNA 2012/13 has identified:** • COPD and Pneumonias contribute to majority of deaths due to lung disease • The prevalence of COPD in Central Bedfordshire is 4,230 (1.52%) in 2013[i], which is increasing over time . This is mainly due to the population ageing as COPD is strongly associated with age. Smoking contributes to COPD getting worse. The prevalence of COPD over the next 3-5 years in Central Bedfordshire and nationally are forecast to show a slow increase of about 0.05% per year. • Chiltern Vale has the highest prevalence of COPD. The higher prevalence for COPD at Chiltern Vale could be due to pollution, partly from the A5 and the M1 becoming trapped in the valley where Dunstable is situated. In addition, there is evidence that Chiltern Vale has a high prevalence for smoking compared within Bedfordshire. **What can be done for people to prevent people develop COPD?** • Minimising the risk of contracting COPD either by not starting, or stopping smoking, avoiding and controlling risks in the environment and workplace will decrease the cost of healthcare • Improving opportunistic testing in primary care. Late diagnosis has a substantial impact on symptom control, quality of life, clinical outcome and cost because undiagnosed people receive inappropriate or inadequate treatment. **What can we do to optimise the condition for people who develop COPD?** • Evidence based interventions such as Flu vaccination for COPD patients and smoking cessation therapy with combination of pharmacotherapy and counselling have been identified to be the interventions that are the most cost-effective and clinically effective. • Long-Acting Muscarinic Antagonists (LAMA) or Long-Acting β-Agonists together with Inhaled Corticosteroids (LABA+ICS), Assessment for Oxygen therapy and adequate pulmonary rehabilitation are important clinically effective and cost-effective interventions that optimise clinical condition in COPD patients.

8.	**<u>Heart Disease and Stroke</u>** **Central Bedfordshire was considered 12th out of 15 similar localities.** We will need to have a focussed approach on Cardiovascular Disease (CVD). CVD is a common condition caused by atherosclerosis (furring or stiffening of the walls of arteries). Although CVD may manifest itself differently in individual patients, CVD in practice represents a single family of diseases and conditions linked by common risk factors and the direct effect they have on CVD mortality and morbidity. These include coronary heart disease, stroke, hypertension, hypercholesterolemia, diabetes, chronic kidney disease, peripheral arterial disease and vascular dementia. **Early identification of people with high risk of Cardiovascular group of diseases** **NHS Health Checks program** is a national program for people between the ages on 40-74 and identify people with high risk of cardiovascular disease. When people are diagnosed with high risk of cardiovascular disease, effective interventions such as blood pressure medication and enrolment into smoking cessation and obesity management programs is prescribed. In 2012/13, 10,487 people took up NHS Health Checks of whom 491 people were identified with high risk of cardiovascular disease and 207 people were diagnosed with high blood pressure. **Stroke :** • In 2013, the observed people diagnosed with of stroke is 4,081 (1.47%) in Central Bedfordshire; West-mid Beds and Chiltern Vale localities have higher observed prevalence of stroke than NHS Bedfordshire. • In 2012, the observed prevalence for CHD in Central Bedfordshire is about 65% of the estimated prevalence and indicates that around one third of the cases are still unidentified. • The rate of emergency readmissions for stroke within 30 days for Central Bedfordshire is 3.1%; this is higher than England and East of England (2.9% and 2.1% respectively). **Preventing stroke:** **Atrial Fibrillation** is a common cause of stroke that is caused by blood clots (embolic stroke). Detection and treatment of AF, a form of irregular heartbeat, is an effective strategy for the reduction of stroke among those with this condition. However, because it is uncommon (compared to high blood pressure), the overall effect is limited (NSF-standard five). In 2013, the prevalence of AF recorded in Central Bedfordshire is 4,153 (1.5%); Chiltern Vale (1.6%) and West Mid Beds (1.6%) localities have a slightly higher percentage of AF diagnosed than Central Bedfordshire (Figure 8).

The observed prevalence of **hypertension (high blood pressure)** in Central Bedfordshire in 2013 is 38,306 (14.0%), which is slightly higher than NHS Bedfordshire prevalence of 13.8%. Chiltern Vale and West Mid Beds localities have the highest prevalence of hypertension.

Coronary Heart Disease

In 2013, 8,464 (3.1%) of persons residing in Central Bedfordshire were diagnosed to have CHD and are on the disease register, which is slightly higher than the prevalence for Bedfordshire.

The observed prevalence for CHD in Central Bedfordshire is 62.6% of the estimated prevalence indicating about a third of the population with CHD have unrecognised or undiagnosed disease. This compares to 58.2% for England and 59.1% for East of England.

CHD monitored through recommended care management indicators in primary care, and the state of their health. There is not a sizeable gap in the results between the localities in Central Bedfordshire except. Leighton Buzzard tends to have results below the other localities in Central Bedfordshire.**What are the unmet needs/ service gaps?**

Gaps in Stroke/Transient Ischaemic Attack

- **Gaps in estimated and observed prevalence:** There is a gap in estimated and observed prevalence of stroke. There is also a need for identifying undiagnosed atrial fibrillation and hypertension to prevent future risk of stroke and TIA attacks.

- **Gaps in access and equality:** The rate of emergency readmissions for stroke within 30 days for Central Bedfordshire is 3.1%; this is higher than England and East of England (2.9% and 2.1% respectively)

- **Gaps in multiagency support:** The proportion of patients under the age of 75 discharged to home or usual place of residence in Central Bedfordshire is 62.1%, which is significantly lower than East of England (75.4%) and England (77.9%)

Gaps in cardiac diseases

- **Gaps in Early detection:** There are gaps in estimated and actual prevalence of heart failure which is predicted to increase by 20%-30% over the next 8 years. There is a gap in acceptance of NHS Health check offered and delivered. Around 50% of the population do not accept the invitation. The number of diagnosed hypertensive and AF are lower and needs improvement.

- **Gaps in service structure and provision:** Heart failure services need to do more in reducing the prevalence of the disease amongst patients 45 years and above. Evidence from assessing the capacity of Community Heart Failure nursing service shows that there is a scope to improve the current workload and partnership work with hospital based cardiology services. There are gaps in implementation of cardiac rehabilitation services. However, the cardiology service for Bedfordshire has been redesigned, procured and awaiting implementation in 2013. This will address the gap

- **Gaps in multi-agency support:** There are also gaps in multi-disciplinary supporting end-stage disease to aid better symptom management, and enabling patients to die a dignified death in their preferred place of care. This will be addressed by the redesign of the cardiology service

Recommendations for consideration:

- **Improve early detection:** Detection and treatment of high blood pressure and detection and treatment of Atrial fibrillation to reduce stroke (NSF standard five)

- **Improve Heart Failure (HF) care** in the community that will reduce the number of unplanned admissions and complications of heart failure. This will be addressed by the redesign of the cardiology service

- **Reduce admissions/re-admissions**: Active case management of heart failure within community should be considered to reduce the rate of acute re-admission and complications. The cardiology redesign has taken consideration of this and implementation may result in lower admission rates

- **Improve Access**: Patients from most deprived areas and those who infrequently access health care services should be supported with the involvement of multidisciplinary professionals closer to home.

- **Improve Secondary prevention**: Commissioning cardiac rehabilitation, particularly the extension of hospital phase II rehab into phase III will improve the quality of care received by patients who may not want to go back to hospital for cardiac rehab. Phase 3 cardiac rehab has been planned and is part of the current redesign work

	• **Improve Primary Prevention**: The majority of patients who are offered NHS Health Checks can be supported with lifestyle interventions with improved access to physical exercise, smoking cessation and sport activities over and above the current provision particularly for the most vulnerable and disadvantaged. Improve uptake of NHS Health Checks through raising awareness to the population and empowering them to make right decision of accepting the invitation of health checks. • **Improve Quality indicators achievement for patients** on CVD registers for blood pressure and indicators for stroke suggesting room for improvement for these indicators. • **Service review of current Cardiac care pathway and a systematic review** of practice under performing on key indicators will facilitate improvement and ensure patients receive the optimum quality care. In 2013, Public Health produced profiles for each of the localities, part of which contained analysis of CVD and primary care indicators • **Improve service model:** Bring services closer to home and provide services in integration with primary care, secondary care, social services and other participating agencies, that will provide more choices of location (community or acute) for various interventions with probable increased uptake in services to meet the needs of more patients. This will be addressed by the redesign of the cardiology service • **Health promotion and community action:** Greater public and professional awareness of the problems of cardiovascular disease is needed, including the links between lifestyle factors such as diet and exercise, and the links with disease and disability. In particular, people need to be made more aware of the health benefits of physical activity, eating at least five portions of fruit and vegetables each day, reducing the amount of sodium/salt and reducing saturated fat in the diet. The population should be empowered to identify signs and symptoms of stroke and TIA to seek timely help.
9.	**How will improving the wider determinants of health contribute to the wellbeing of people of long term conditions?** There is good evidence to indicate that improving outcomes which relate to the wider determinants of health will contribute to the wellbeing of people with long term conditions and therefore reduce premature mortality.

	Evidence shows that poor quality housing e.g. with damp and mould, leads to later respiratory problems. Air particulate matter also has an adverse effect on respiratory health and cardiovascular health. Long term unemployment and child poverty are often associated with unhealthy lifestyle choices, poor mental wellbeing and housing conditions, all of which can contribute to long term conditions and premature mortality. A workshop was held in August to capture the current activities, strategies, gaps and future opportunities to improve progress across the Council to meet the Public Health outcomes framework. This workshop included outcomes relating to a number of the wider determinants of health. It was clear that there is a significant amount of work already underway to address the wider determinants of health, for example, implementation of the all-age skills strategy will better match training to jobs to people as well as dealing with the whole skills system in terms of employability and the availability of good local information, advice and guidance for all ages. In addition a recent report on barriers to employment and inequalities was recently commissioned and has identified a number of areas for action. Following the workshop and review of the evidence base regarding the wider determinants and premature mortality, it is has been recommended that a deeper dive or progress reviews are undertaken. This is to assure the Board that all possible action is being taken to improve outcomes and make best use of the resources already available across the local system. There are already governance arrangements who oversee progress against the wider determinants of health e.g. the Acting Early Group is responsible for ensuring progress in addressing Child poverty. These groups should undertake the deep dives and report their findings to the JSCG. The deep dives could include **Housing and homelessness** Potential areas for consideration: • Provision of affordable housing • Improving standards in the private housing sector • Provision for vulnerable groups e.g. people recovering from drug and alcohol misuse and/or mental health issues, offenders • Reducing 'cold' housing and fuel poverty: improving economic standing and energy efficiency of dwellings **Environment and air quality** Potential areas for consideration: • Addressing development projects to ensure air quality standards are maintained. • Increasing sustainable and active travel e.g. Dunstable Travel Hub

	Early years/child poverty Potential areas for consideration: • Identifying the impact of welfare reform • Co-ordination and targeting of services to key areas and groups • Identification of children eligible for Free School Meals **Employment particularly, young people and vulnerable groups** Potential areas for consideration: • Youth unemployment and those with long term health conditions • Economic participation in terms of young women
10.	**Reporting on progress**
	• Prevention and improvement of lifestyle will be monitored through Priority 3 and Priority 7 of the health and wellbeing strategy • Variation in primary care will be reviewed through the annual refreshing of the Joint strategic Needs Assessment and locality profiles. • Annual reporting of mortality, gap in life expectancy, disability free life years and other indicators that are monitored via Public Health Outcomes Framework, NHS Outcomes Framework and CCG indicator set. There is a annual reporting schedule via Director of Public Health Annual Report and Joint Strategic Needs Assessment Refresh. • The NHS Outcome Framework 2013/14 and Public Health Outcomes Framework 2013-16 have a series of indicators relating to premature mortality. These are monitored regularly: **<u>NHS Outcome Framework 2013/14 indicator set relevant to conditions leading to premature mortality</u>** . • Potential years of life lost from causes considered amenable to healthcare: adults [over 20 yrs] • Potential years of life lost from causes considered amenable to healthcare: children & young people [under 20 yrs] • Life expectancy at 75 (males)/(females) • Under 75 mortality rate from cardiovascular disease • Under 75 mortality rate from respiratory disease • Under 75 mortality rate from liver disease

	• Under 75 mortality rate from cancer • Under 75 mortality rate from • 1 and 5-year survival from all cancers and breast, lung and colorectal cancers; • Excess under 75 mortality rate in adults with serious mental illness 1.5 • Infant mortality 1.6.i • Neonatal mortality and still-birth • 5 year survival from all cancers in children (under 15s) • Reducing premature death in people with learning disabilities **<u>Public Health Framework 2013-16</u>** • Smoking prevalence, • Cancer diagnosed at stage 1 and 2, • Cancer screening coverage, • Access to non-cancer screening programmes, • Take up of the NHS Health Check programme, • Mortality rate from causes considered preventable, under 75 years mortality rates,

Issues	
Strategy Implications	
11.	Action to reduce premature mortality will impact on all there of the cross-cutting priorities within the Health and Wellbeing Strategy and will require the effective delivery of the priority to help people make healthy lifestyle choices.
Governance & Delivery	
12.	It is proposed that monitoring and progress and performance be delegated to subgroups supporting the Health and Wellbeing board within existing structures
Management Responsibility	
13.	The Director of Public Health is accountable for delivery and the Assistant Director of Public Health is responsible for day to day delivery
Public Sector Equality Duty (PSED)	
14.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

	Are there any risks issues relating Public Sector Equality Duty	No
	No	Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**

Presented by Sanhita Chakrabarti