# Central Bedfordshire
# Health and Wellbeing Board

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| **Contains Confidential or Exempt Information** | No. |
| **Title of Report** | **Enabling People to Stay Healthy for Longer** |
| **Meeting Date:** | 1 July 2015 |
| **Responsible Officer(s)** | Muriel Scott |
| **Presented by:** | Muriel Scott, Director of Public Health |

**Recommendations**

1. **That the Board agrees that delivering high quality Health checks remains a high priority and is committed to reducing variation by supporting and challenging those practices where performance needs to improve.**
2. **That the constituent organisations of the Board confirm their determination to reduce the harm caused by tobacco by signing the Local Government declaration on tobacco and the NHS statement of support for tobacco control.**
3. **That the Board notes the progress to date in supporting local residents to stay healthy for longer and endorses the next steps, including an update on progress in six months.**

| **Purpose of Report** | |
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| 1. | To receive an update on progress towards the Joint Health and Wellbeing Strategy priority of enabling people to stay healthy for longer.<br><br>To identify the areas where Health and Wellbeing Board action can have the greatest impact in improving outcomes. |

| **Background** | |
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| 2. | The re-freshed Joint Health and Wellbeing Strategy was agreed at the Board meeting in April. One of the priorities is to enable people to stay healthy, particularly to reduce premature deaths from Cardio Vascular Disease (CVD). |

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| | Unfortunately each year over 100 people in Central Bedfordshire die prematurely (defined as before the age of 75 years) from preventable Cardio Vascular Disease (CVD) and for women this is higher than other similar local authorities. We know that most premature deaths from CVD are preventable and relate to 9 modifiable risk factors: diabetes, high blood cholesterol, high blood pressure, psychological stress, overweight/ obesity, smoking and tobacco use, unhealthy diet, excess alcohol consumption and insufficient physical activity. There is also evidence to suggest that maternal nutrition and air pollution may also be linked.<br><br>The good news is that if people adopt healthy lifestyles, in most instances, CVD can be prevented or its onset delayed. If someone does develop CVD and it is identified early and managed well, then outcomes can be improved for both those affected and their families. |
| 3. | There are three main elements to support the delivery of this priority:<br><br>**Prevention:** To ensure that residents are supported to adopt as healthy a lifestyle as possible, focusing on the four modifiable lifestyle behaviours of physical activity, smoking, alcohol and excess weight/ healthy eating.<br>**Early identification:** To identify, as early as possible, those residents at high risk of / or with established CVD who are then offered support to reduce their risk.<br>**Effective management:** To ensure that good clinical outcomes for Long Term Conditions (LTCs) including CVD are achieved consistently by identifying General Practice level variation and then supporting colleagues in Bedfordshire Clinical Commissioning Group to reduce this. |
| 4. | There are a number of programmes are already in place to support this priority and these are outlined in paragraphs 5-7. The related outcomes, where available, are shown in Appendix 1 and reveal that, compared to the England average; the majority of outcomes are currently good, with the exception of the proportion of adults with excess weight. |
| 5. | ***Current Prevention Programmes:***<br><br>**Community Physical Activity Programmes** such as exercise referral, walk 4 health, No Limits, 50+, Explorer, and the wide range of activities available in open spaces, leisure centres and from libraries |

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| | **Stop Smoking Services** which support people to stop smoking with a focus on more vulnerable groups and those smoking in pregnancy. This also includes a school based prevention programme and the promotion of smoke free homes and cars which will be further enhanced by new legislation to protect children from second-hand smoke. In addition the quality schedules for acute trusts for 2015/16 includes the agreement that all patients with Chronic Obstructive Pulmonary Disease (COPD) who smoke will be referred to the stop smoking service.<br><br>**Weight Management** the newly commissioned weight management service for adults and children will have a strengthened focus on prevention and early intervention services. They will also work with Health Visitors and Schools Nurses to ensure a consistent approach to supporting healthy weight, nutrition and increased physical activity for children and families.<br><br>**Workplace health and wellbeing programme** to support local employers (including CBC) promote a healthy workplace and consequently increase productivity. The 2015 CBC workplace programme is a programme of events and will be used to identify what works and what staff want, ultimately feeding into the wellbeing strategy in 2016. A similar approach is being used with local employers and has the potential to improve workplace health for a significant number of residents. |
| 6. | ***Current early identification programmes***<br><br>**Health check programme** is a 5-year screening programme for eligible people aged between 40-74 years. The positive outcomes for the programme in 2014-15 are shown in Appendix 2 however performance against target by practice shows significant variation (Appendix 3) with one practice delivering only 18.5% of their health checks target and another 168%. This has significant implications, with the patients in some practices getting far greater opportunities to have their risk if CVD identified and managed early.<br><br>A **Lifestyle Hub** is currently being piloted in the Chiltern Vale locality to support individuals to modify their lifestyle; the majority of people have been identified through the health check programme.<br><br>**National Screening Programmes** are well established for the early identification of cancer cervical, bowel and breast screening. Rates of screening are significantly higher in Central Bedfordshire than the England average. |

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| 7. | ***Effective Management***<br><br>**The Excellence in Long Term Conditions Programme** is led by the BCCG and includes work with localities to address variation in care, training for clinicians, increased emphasis on self-care and the development of evidence based templates to improve consistency of care.<br><br>The outline of the programme is shown in Appendix 4. |

| **Reason(s) for the Action Proposed** | |
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| 8. | Whilst the programmes identified above will continue to be delivered, evaluated and reviewed, alone they are unlikely not deliver the outcomes at the scale or pace required. The NHS Forward View is clear that the future health of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.<br><br>In line with this and the emerging CBC 5-year plan the additional programmes are proposed. |
| 9. | **Multi-agency excess weight strategy and delivery** – a programme to ensure that we are working effectively across partners to prevent and reduce the proportion of people with excess weight. This will build on the existing offer from public health, leisure services, planning, natural environment and partners e.g. Sport England and the University of Bedfordshire to ensure opportunities are maximised and outcomes are improved.<br><br>Providing prevention and weight management programmes are necessary but not sufficient, people need to engage with and complete the programmes. Having crucial conversations with those affected by excess weight is not easy but health professionals must encourage and support people to regain a healthy weight. This is not a value judgement on the choices individual's make but an important intervention to help people live healthy longer lives. Obesity is described as the next epidemic and failure to address this will also lead to long term consequences for health and care services. |
| 10. | **Mobilisation of the new contract for alcohol treatment and prevention** which will improve outcomes through early intervention, community based delivery, sustained recovery and place a greater emphasis on prevention. The new 5-year contract starts in September 2015 and has a performance related element. |
| 11. | **Re-shaped stop smoking offer** providing more intensive support for more vulnerable groups including routine and manual workers, those with mental health issues and mothers smoking during pregnancy. |

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| 12 | **Tobacco Control**<br>Local Government and NHS Organisations both have a critical role in reducing the harm caused by tobacco and ensuring that supporting people to stop smoking is a key priority for all partners. The declaration for Local Government and the NHS statement of support both outline the commitment and actions required to tackle tobacco related harm. Whilst we can be confident that the actions within the pledges are being promoted already within the Council and BCCG, signing them would provide public recognition of this commitment. |
| 13. | **Review Health checks Programme** using the data from the new data management system, which supports the delivery and analysis of health checks performance and outcomes. An options appraisal of future options for delivery of health checks will commence in October 2015 using 2 quarters of validated data and the increasing body of evidence regarding the effectiveness of the checks. |
| 14. | **Community Physical Activity programme**<br>The inactivity rate in Central Bedfordshire is 28% i.e. 1 in 4 adults are failing to do enough physical activity to benefit their heath (that's equivalent to 50,000 adults doing less than 30 minutes in a 7 day period). To bring physical activity into the everyday lives, in addition to the broad programme of community based physical activity, we will be;<br>• Ensuring physical activity pathways are available to patients accessing other public health prevention programmes such as weight management and alcohol treatment.<br>• implementing a new targeted free activity programme using Our Parks, a community physical activity programme running in 5 parks in the 20% most disadvantages areas<br>• introducing a new assessment tool to measure health improvement of people accessing community activities. |
| 15. | **Improving Wellbeing Programme** – a three-year programme to help people maintain and develop good mental wellbeing which is being launched on 30 June focusing initially on 5-ways to wellbeing (Connect, Be Active, Take notice, Keep learning, Give) The second event later in 2015 will focus on wellbeing for Children and Young People and will be developed in conjunction with the Youth Parliament. |

| **Issues** | |
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| Governance & Delivery | |
| 16. | There are existing systems in place to assure the delivery of the programmes required to enable people to live healthily for longer. Progress will be reported to the Health and Wellbeing Board on a six-monthly basis but these are 'slow-burn, high impact' actions so short term changes may be difficult to see at a population outcome level. |

| Financial | |
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| 17. | These programmes will need to be delivered within the available resources and opportunities to improve outcomes and deliver efficiencies will be pursued. Elements of the programme are also part of the Better Care Plan for Central Bedfordshire. |
| Public Sector Equality Duty (PSED) | |
| 18. | 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 |
| | If yes – outline the risks and how these would be mitigated |

| **Source Documents** | **Location (including url where possible)** |
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| Joint Health and Wellbeing Strategy | |

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Presented by Muriel Scott

Appendix 1: Outcomes and Indicators 2009-2015
Appendix 2: Outcomes from the delivery of Health checks in 2014-15 in Central Bedfordshire
Appendix 3: Practice level variation in the delivery of Health checks 2014/15
Appendix 4: Excellence in LTC Programme Outline

# Appendix 1: Outcomes for Staying Healthy for Longer indicators in Central Bedfordshire 2009 – 2015

Central Bedfordshire Council
Health Profiles
Produced by Public Health England
http://www.apho.org.uk/resource/view.aspx?RID=50215

Coloured indicator shows compaison with England for each year
Significantly better than England average
Not significantly different from the England average
Significantly worse than England average#

| Indicator (Number from Health Profile) | | Type | Time Period | 2015 | | | | | Trend 2009-2015 | Trend line data (as per Health Profile) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | CB Number | CB Value | England Average | England Worst | England Best | | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
| Children and young people's health | 7 Smoking status at time of delivery | % | 2013/14 | 369 | 12.6 | 12 | 27.5 | 1.9 | | 19.6 | 17.4 | 15.4 | 12.6 | 14.1 | 13 | 12.6 |
| | 9 Obese children (Year 6) | % | 2013/14 | 437 | 15.9 | 19.1 | 27.1 | 9.4 | | 8.1 | 7.3 | 14.3 | 16.2 | 15.5 | 14.7 | 15.9 |
| Adult's health and lifestyle | 12 Smoking prevalence | % | 2013 | n/a | 15 | 18.4 | 30 | 9 | | 18.3 | 19.8 | 21.2 | 17.5 | 16.1 | 18.3 | 15 |
| | 13 Percentage of physically active adults | % | 2013 | 264 | 53.8 | 56 | 43.5 | 66.7 | | 14.3 | 12.1 | 11.3 | 10.9 | 55.8 | 55.8 | 53.8 |
| | 14 Obese adults | % | 2012 | n/a | 23.7 | 23 | 35.2 | 11.2 | | 20.9 | 24.8 | 24.2 | 24.2 | 24.2 | 23.7 | 23.7 |
| | 15 Excess weight in adults | % | 2012 | 448 | 69.1 | 63.8 | 75.9 | 45.9 | | | | | | | 69.1 | 69.1 |
| Disease and poor health | 18 Hospital stays for alcohol-related harm | DASR per 100,000 | 2013/14 | 1320 | 518 | 645 | 1231 | 366 | | 1221 | 1220 | 1374 | 1521 | 1521 | 518 | 518 |
| | 20 Recorded diabetes | % | 2013/14 | 12062 | 5.9 | 6.2 | 9 | 3.4 | | 3.4 | 3.63 | 5.08 | 5.3 | 5.5 | 5.7 | 5.9 |
| Life expectancy and causes of death | 25 Life expectancy - male | Years | 2011-2013 | n/a | 81 | 79.4 | 74.3 | 83 | | 78.4 | 79.1 | 79.2 | 79.5 | 80.1 | 80.5 | 81 |
| | 26 Life expectancy - female | Years | 2011-2013 | n/a | 83.9 | 83.1 | 80 | 86.4 | | 82.1 | 82.4 | 82.5 | 83 | 83.6 | 84 | 83.9 |
| | 28 Smoking related deaths | DASR per 100,000 | 2011-2013 | 333 | 255.6 | 289 | 472 | 167 | | 196 | 183.6 | 202 | 192 | 182 | 261 | 255.6 |
| | 30 Under 75 mortality rate: cardiovascular | DASR per 100,000 | 2011-2013 | 133 | 62.6 | 78.2 | 137 | 37.1 | | 70.1 | 63.5 | 59 | 56.6 | 51.9 | 64.8 | 62.6 |
| | 31 Under 75 mortality rate: cancer | DASR per 100,000 | 2011-2013 | 295 | 135 | 144 | 203 | 104 | | 109.6 | 106.4 | 110.2 | 104 | 102.9 | 135 | 135 |

n/a in CB number = actual number not available

Blue text shows a change in definition
Coloured indicator shows comparison with England in each year
NB definitions of some indicatiors has changed over time

## Appendix 2: Outcomes from the delivery of Health checks in 2014-15 in Central Bedfordshire

| | Central Bedfordshire | |
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| | **Referrals** | **% of Invited** |
| Health Checks offered | 13,910 | 49.2% |
| Health Check delivered | 6,838 | |

| | **Referrals** | **% of Delivered** |
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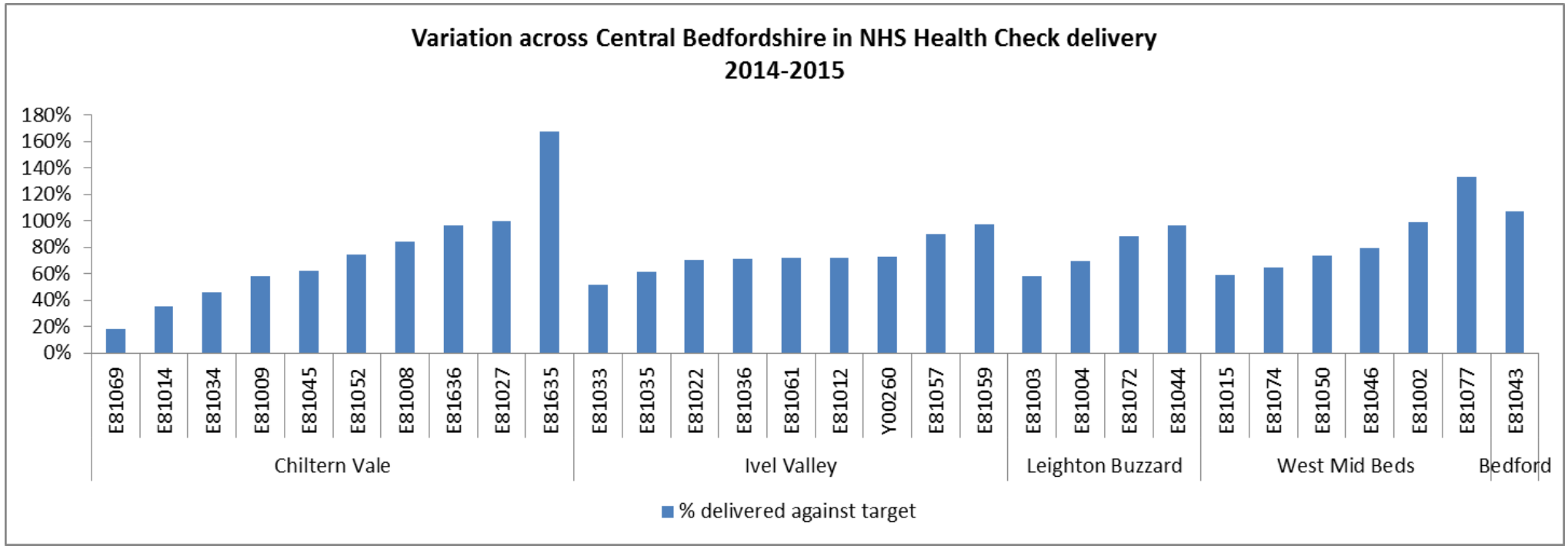
| High Risk Register (CV risk >20%) | 269 | 3.9% |
| BMI≥30* | 1,648 | 24.1% |
| BMI≥40 | 147 | 2.1% |
| GPPAQ inactive | 2,682 | 39.2% |
| GPPAQ active | 3,231 | 47.3% |
| Newly diagnosed hypertension | 82 | 1.2% |
| Newly diagnosed Type 2 diabetes | 41 | 0.6% |
| Referred to Stop Smoking Service | 100 | 1.5% |
| Referred to a weight management programme | 76 | 1.1% |
| Newly prescribed statins | 255 | 3.7% |
| Awareness of dementia discussed (65-74 years only) | 353 | 5.2% |
| AUDIT-C (alcohol) screen completed | 4,655 | 68.1% |

**Appendix 3: Practice level variation in the delivery of Health checks 2014/15**



**Appendix 4: Excellence in Long Term Conditions Programme Outline**

**Aims:**

• To increase prevention and early identification of those at risk of developing a Long Term Condition (LTC)
• To standardise high quality care, reduce variation and ensure consistency across LTC management in all practices
• To develop and implement SystmOne templates to support practices to manage patients with Long Term Conditions and improve quality and consistency of care.

**Objectives:**
• To develop templates that are evidenced based and deliver best practice.
• To support all practices across the CCG to use the best practice templates.
• To benchmark practices and provide assurance of the use of the templates and improved quality of LTC care across the CCG.
• To identify and promote self management programmes.
• To up skill the GP workforce in LTC management

**Strategic Fit**

It supports the case for change for General Practice as outlined in the document 'Improving General Practice - A Call To Action' (NHSE 2014). General Practice has a key role in the care of patients diagnosed with a long term condition, especially frail older people who have co-morbidities and complex needs. Within the development of primary care across Bedfordshire and the emerging GP Federations there are opportunities to change the way care is delivered across primary and secondary care through vertical integration. The 'Bedfordshire Plan for Patients 2014 -2016' sets out Bedfordshire Clinical Commissioning Group's aim to help more patients to remain at home as stable as possible and independent, to enjoy a quality of life free from frequent crises and avoidable hospital visits.

**Scope**

1. **Improving the primary care offer for patients in terms of access and quality of care (variation and LTC management)**
In conjunction with the GP Variation project, we will pull together a CCG-wide programme, standardising performance and quality management of GP practices, drawing together existing sources of information and triangulating those sources in a more meaningful way for clinicians to understand and respond to. An individualised practice approach will be taken to this in order to achieve significant improvement in quality metrics including Quality and Outcomes Framework. This links with co-commissioning.

**2. Better support for complex and frail, elderly patients**
The development of care planning, case management and locality level MDT working to prevent avoidable emergency admissions during 2015/16. We intend to develop more streamlined working between primary and secondary care, community nursing, social care, geriatrician, mental health and Continuing Health Care through vertical integration.

**3. Prevention and early identification of those at risk** - Currently 100% of GP practices have identified 2% of their practice's population identified as being at risk of hospital admission. These patients now have a personalised care plan (PCP) and if required, a care coordinator.

**4. Standardised high quality care, consistent across all practices**- Ensuring all practices across the CCG are all using the best practice templates.

**5. Self-management**- Building upon work commenced in 14/15 patient information days/conferences for disease specific or co-morbidities (Diabetes up 21/5/15). Roll out of the Lifestyle Hubs in Central Bedfordshire as a means of promoting self-management.

**6. Workforce developmen**t - Evaluation of the Practice Nurse (PN) development programme (April-Jun 15) to ascertain needs for 15/16. Procurement of new courses as identified by 14/15 PN Training Needs Assessment and implementation of course by end 15/16. The continuation of the GP symposia to focus on complex diabetes and renal care. Training programme to be considered for new template production (Atrial Fibrillation, Hypertension, childhood asthma & stroke)