Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	**Enabling People to Stay Healthy for Longer – reducing premature mortality from cardiovascular disease**
Meeting Date:	20 January 2016
Responsible Officer(s)	Muriel Scott
Presented by:	Muriel Scott, Director of Public Health

Recommendation

1. **That the Board considers the roadmap to reducing premature mortality from Cardio Vascular Disease and identifies any further actions that either the Board or partners should be taking.**

Purpose of Report	
1.	To outline the roadmap to enable people to stay healthy for longer, specifically to reduce premature mortality from cardiovascular disease, one of the priorities within the Health and Wellbeing Strategy. To identify the areas where action is required of the Health and Wellbeing Board and others that will have the greatest impact in improving outcomes.

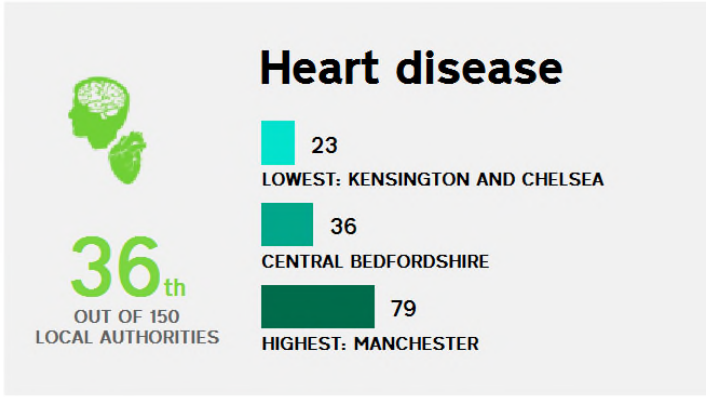
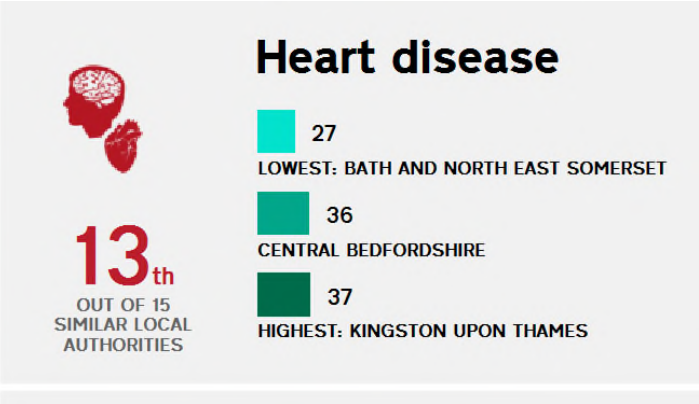
Background	
2.	Cardiovascular Disease (CVD) in practice represents a single family of diseases and conditions linked by common risk factors and the direct effect they have on CVD mortality and morbidity. These include coronary heart disease, stroke, hypertension, hypercholesterolemia, diabetes, chronic kidney disease, peripheral arterial disease and vascular dementia. Many people who have one CVD condition commonly suffer from another and yet opportunities to identify and manage these are often missed (Cardiovascular Disease Outcomes Strategy 2013) therefore it is critical that services are integrated around the person rather than one component of their medical condition. Unfortunately each year over 100 people in Central Bedfordshire die prematurely (defined as before the age of 75 years) from preventable CVD and for women this is higher than other similar local authorities. The infographics below show that although premature death rates in CBC compare well to the England average, when the same rates are compared to statistical neighbours there is significantly more that needs to be achieved. **Figure 1: Premature Mortality compared to the England average** 

Figure 2: Premature Mortality compared to Statistical Neighbours



Deaths from CVD are the biggest single contributor to the inequality gap in health within Central Bedfordshire.

As part of the review of Non Elective Admissions (NELs) in Central Bedfordshire, Heart Failure and Angina were identified as the 3rd and 4th highest causes of avoidable admissions in 2014-15. The commissioning for value packs published in 2015 (used to identify priority programmes to improve outcomes and value) also showed a higher spend on circulatory disease compared with similar CCGs. Therefore improving outcomes will also have a significant impact upon costs to the local public sector

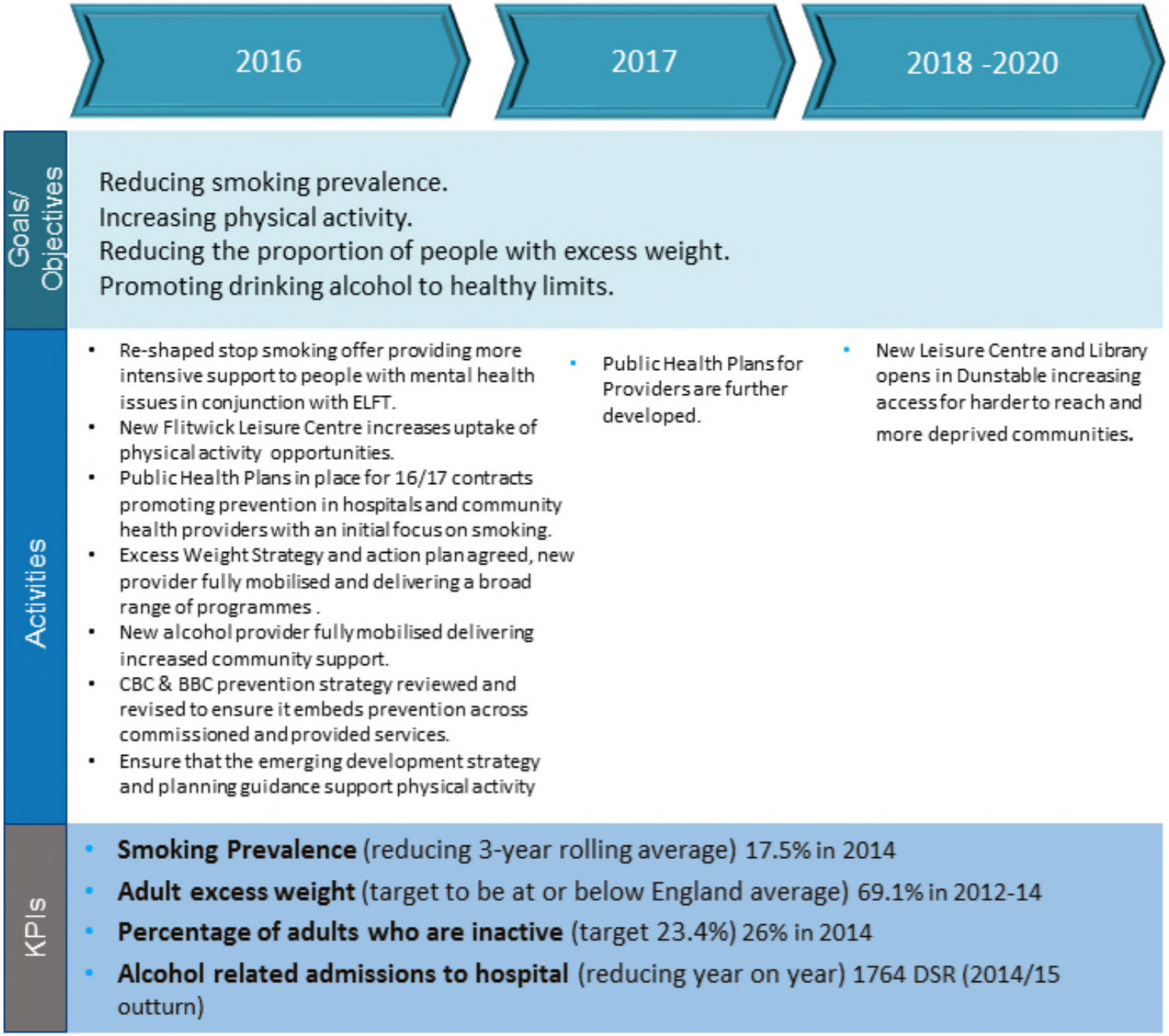
We know that most premature deaths from CVD are preventable and relate to 9 modifiable risk factors: diabetes, high blood cholesterol, high blood pressure, psychological stress, overweight/ obesity, smoking and tobacco use, unhealthy diet, excess alcohol consumption and insufficient physical activity. There is also evidence to suggest that maternal nutrition and air pollution may also be linked (Longer Lives 2014).

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.

What do we need to do to reduce early deaths from CVD?	
3.	We need to take action on the modifiable risk factors outlined above and prioritise the following: **Preventing people from developing CVD by:** • Reducing smoking prevalence. • Increasing physical activity. • Reducing the proportion of people with excess weight. • Encouraging people to stick to safe drinking limits. **Identify people at high risk of developing CVD by:** • Increasing the uptake of Healthchecks in the areas of higher deprivation and to the most vulnerable groups. **Reducing the variation in the** e**ffective management of CVD by:** • Ensuring that good clinical outcomes for CVD are achieved consistently across General Practices, particularly for hypertension and diabetes. A summary of a number of actions to date is outlined in Appendix 2.

How will we know when we're successful?	
4.	The actions, milestones and KPIs are all set out for each element of the programme in the following pages. The overarching indictors are: • **Premature Deaths from CVD per 100,000 population** (target to be ranked as better than average compared to statistical Neighbours. The current CBC rate (2012-14) is 59.7 and is ranked as similar compared to statistical neighbours where the average rate is 61.9. • **Reduced Non Elective Admissions from heart failure and angina** - the baseline (2014-15) is 378 admissions for heart failure and 239 admissions for angina.

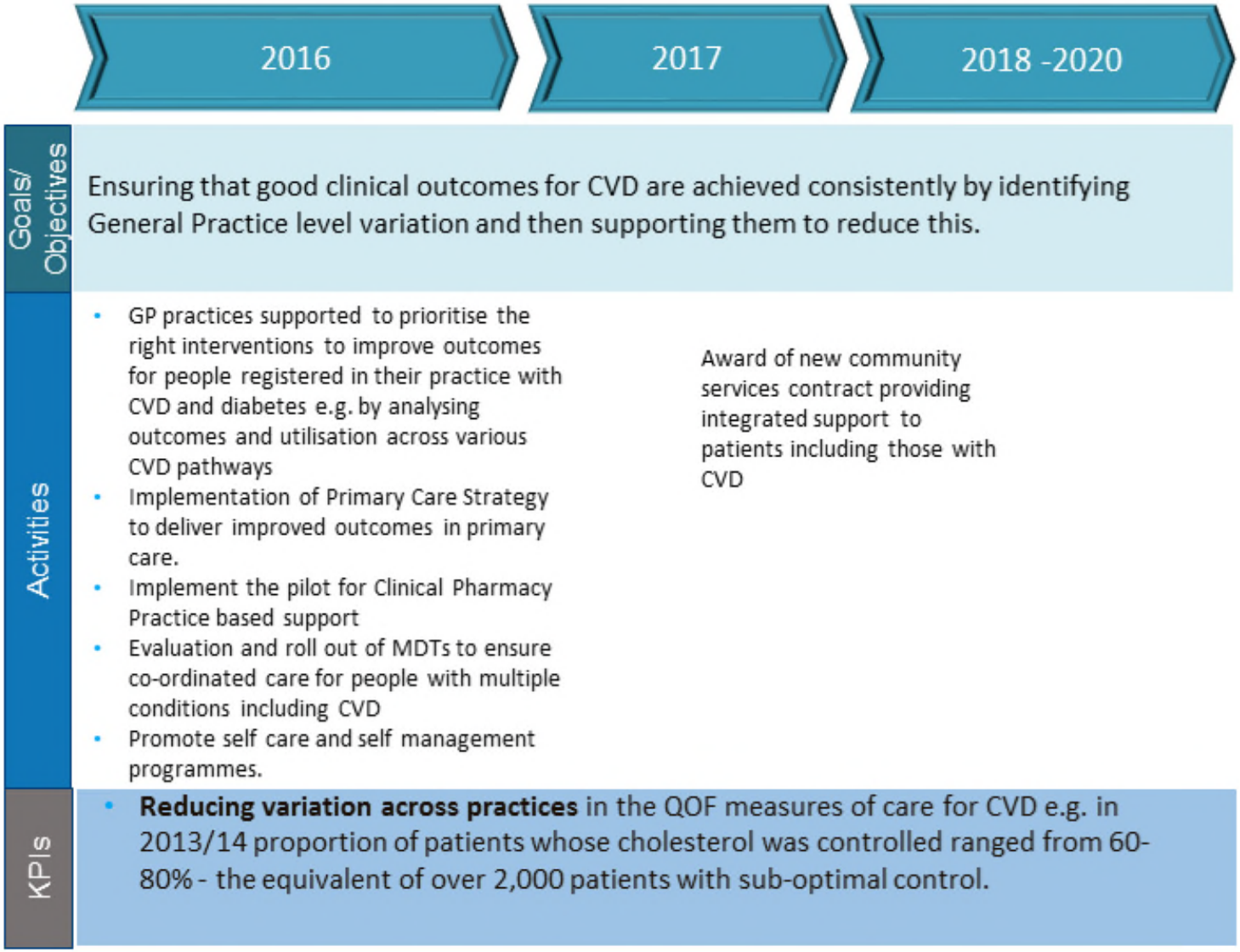
Preventing people from developing CVD



Identify people at high risk of developing CVD

	2016	2017	2018 -2020
Goals/ Objectives	Increasing the uptake of Healthchecks in the areas of higher deprivation and to the most vulnerable groups		
Activities	• Review the quality, outcomes and cost effectiveness of the Healthchecks programme. • Explore alternative models of delivery to reduce variation and increase uptake of offer. • Assess the impact that Healthchecks have had on referrals to services where reduce cardiovascular risk. Work with practices whose referral rates are low to undertsand why and how pathways could be more effective.	• Consideration of alternative programmes e.g. the national blood pressure programme • Further targeting of the Healthchecks programme to the most vulnerable groups	• Implementation of a new model to identify people at high risk of CVD reflecting need and available resource.
KPIs	• Proportion of **Healthchecks delivered** (target 100%) 2014/15 outturn 77% • Proportion of people **newly diagnosed as being at high risk of CVD** (no national target) April – September 2015 = 217 people • Proportion of people **referred to services** to reduce their risk (increasing year on year) April – September 2015 no referred = 27		

Reducing the variation in the effective management of CVD



What do we need organisations and individuals to do to deliver these outcomes?	
	Health and Wellbeing Board
5.	• Lead the integration of services with a focus on prevention, as well as delivering care to those who are at highest need of acute care and complex care packages. • Hold constituent members of the Board to account for delivery of the actions outlined in paragraphs 6-9.
	Central Bedfordshire Council
6.	• Ensure that the Making Every Contact Counts preventative approach is embedded within relevant provided and commissioned services e.g. care providers encourage and signpost clients to stop smoking services. • Use planning and development powers to deliver environments which encourage residents to be physically active. • Encourage front line staff to complete the on-line level 1 stop smoking advisor training e.g. housing support staff. • Deliver effective services to help residents modify their lifestyle. • Consider developing a greater understanding of how residents can be better supported to take action to change their lifestyle. • Review and revise the prevention strategy 'Never too early, Never too late'.
	Bedfordshire Clinical Commissioning Group
7.	• Ensure that prevention is mainstreamed into clinical pathways and services. • Ensure that the Primary Care Strategy and Co-commissioning arrangements mainstream healthy lifestyle, early identification and reduction in variation of care for patients known to have high blood pressure, diabetes and Stroke. • Promote self-care and self-management programs for all patients with CVD and Diabetes. • Include Public Health Plans into the quality schedules with providers, including the Luton & Dunstable Hospital.

	Primary Care (GPs and Community Pharmacists)
8.	• Deliver brief interventions and signpost for further support when patients would benefit from lifestyle modification. • Achieve the targets for the delivery of Healthchecks. • Refer patients in need of support to relevant services. • Review variation in outcomes and care for patients with CVD, specifically hypertension, cholesterol and other outcomes for diabetes.
	Provider Trusts
9.	• Implement the public health plans. • Take every opportunity to take preventative action e.g. when patients with a condition that would benefit from lifestyle modification, such as being more active or weight loss, that this is discussed as a core component of their care. • Encourage staff to complete the on-line level 1 stop smoking advisor training. • Promote self-care and self-management programs for all patients with CVD and Diabetes.
	Patients and Residents
10.	• Attend the Healthchecks appointment when invited. • Take medications as prescribed and attend any medical reviews. • Reduce and maintain alcohol intake to healthy limits. • Achieve and maintain a healthy weight. • Keep physically active. • Don’t smoke.

Issues	
Governance & Delivery	
11.	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	
12.	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 part of the Better Care Plan for Central Bedfordshire.
Public Sector Equality Duty (PSED)	
13.	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

Source Documents	**Location (including url where possible)**
Joint Health and Wellbeing Strategy	http://www.centralbedfordshire.gov.uk/health-and-social-care/health/Health-and-Wellbeing-Board.aspx

Appendix 1: Outcomes for Staying Healthy for Longer indicators in Central Bedfordshire 2009 – 2015
Appendix 2: Update on new programmes which commenced in 2015
Presented by Muriel Scott