HEALTH AND WELLBEING BOARD				
Report Title	Reducing Cardiovascular Disease in Lewisham			
Contributors	Jane Miller, Deputy Director of Public Health		Item No.	6B
Class	Part 1	Date:	20 January 2015	
Strategic Context	The Cardiovascular Disease Outcomes Strategy looks at those aspects of CVD where there is most opportunity to improve outcomes Whilst Cardiovascular Disease has not been identified as a specific priority outcome within the Lewisham Health and Well Being Strategy, it is addressed by several of the priority outcomes. The NHS Health Check Programme is a mandatory commissioning responsibility of the local authority.			
Pathway				

1. Purpose

1.1 To update members on progress in reducing cardiovascular disease and to highlight areas for increased focus such as improving prevention and risk management and improving and enhancing case finding in primary care.

2. Recommendation/s

2.1 Members of the Health and Wellbeing Board are recommended to:

- Note and discuss the report
- Agree to prioritise brief interventions on alcohol, smoking, promoting healthy weight and physical activity
- Promote the health check programme
- Improve the diagnosis and management of hypertension

3. Policy Context

3.1 The Cardiovascular Disease (CVD) Outcomes Strategy[1] identified for commissioners and providers of health and care services the ten key actions that will make a difference in improving outcomes for CVD patients, in line with the NHS, Public Health and Adult Social Care Outcomes Frameworks. These were as follows: Manage CVD as a single family of diseases; Improve prevention and risk management; Improving and enhancing case finding in primary care; Better identification of very high risk families/individuals; Better early management and secondary prevention in the community; Improve acute care; Improve care for patients living with CVD; Improve end of life care for patients with CVD; Improve intelligence, monitoring and research and support commissioning.

[1] DH March 2013, Cardiovascular Disease Outcomes Strategy: Improving outcomes for people with or at risk of cardiovascular disease

3.2 The NHS Health Check programme is a mandatory public health service for the local authority. The health check is a systematic vascular risk assessment and management programme to help prevent various cardiovascular diseases including heart disease, stroke, diabetes and dementia and kidney disease. It targets the top 7 causes of preventable mortality: high BP, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

3.3 The eligible cohort includes people between 40 to 74 years of age who do not have any diagnosed CVD at the time of the check. The check is offered once every five years. The Department of Health expects 20% of the eligible population to be invited each year over the 5 year rolling programme with an uptake of between 50 and 75%.

3.4 There are many indicators in the Public Health Outcomes Framework relating to CVD. They are related to mortality, the health check programme and health improvement (smoking, alcohol, physical activity and excess weight). These are listed in Appendix 1, attached to this report.

3.5 The key indicators considered in this report are : a) Under 75 mortality rate from all cardiovascular diseases (Persons), b) Cumulative % of the eligible population aged 40-74 offered an NHS Health Check c) Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check, d) Cumulative % of the eligible population aged 40-74 who received an NHS Health check.

3.6 Cardiovascular disease (CVD) is addressed by several of the priority outcomes of the Lewisham Health and Well Being Strategy. One of the key aspirations of the priority outcome 'Reducing the number of emergency admissions for people with long term conditions' is the systematic identification, diagnosis and risk profiling of cardiovascular disease to be implemented across all GP practices. The priority outcomes: Achieving a Healthy Weight; Reducing Alcohol Harm; and Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking all contribute to the prevention of CVD.

3.7 Reducing Inequality is one of the two principles informing Lewisham's Sustainable Community Strategy and reducing cardiovascular disease supports its priority of healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and well-being.

3.8 The JSNA www.lewishamjsna.org.uk, has highlighted the high rate of premature deaths from cardiovascular disease in Lewisham and the lower than expected number of people diagnosed with CVD.

3.9 As a family of long term conditions, improving CVD outcomes is integral to the Clinical Commissioning Strategy and the Adult Integration Programme.

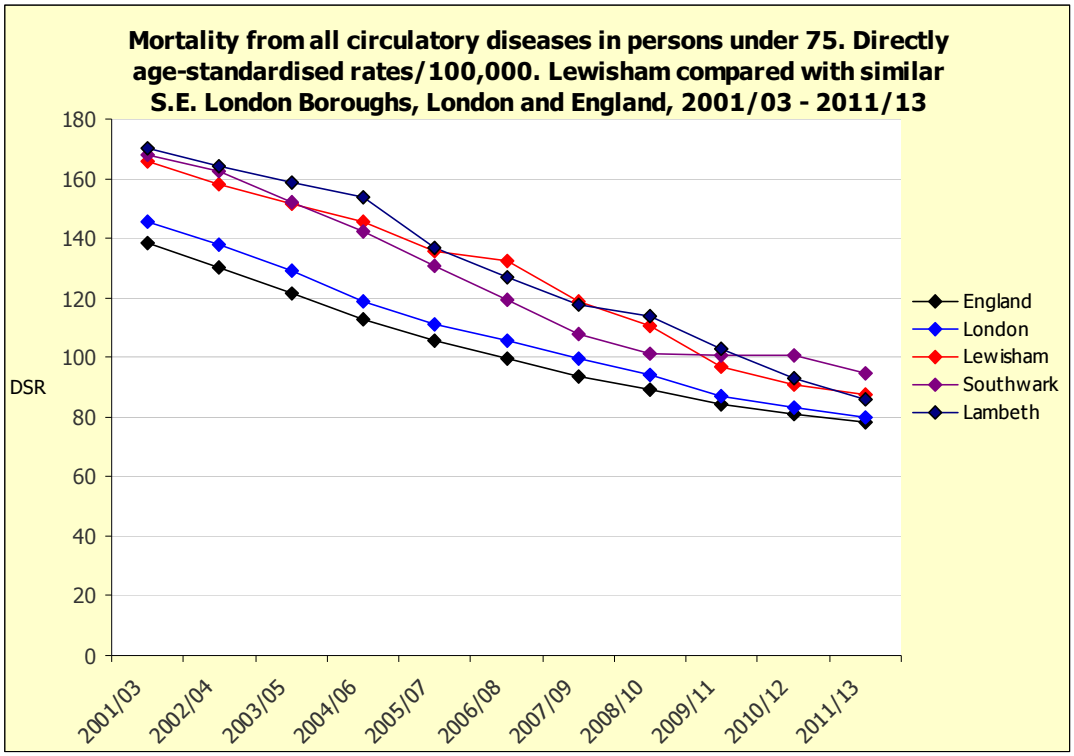
4. Background

4.1 CVD is an overarching term that describes a family of diseases (including stroke, heart attack and peripheral vascular disease) sharing a common set of risk factors. Chronic kidney disease and diabetes are also included in the CVD family of diseases as they have similar risk factors and are associated with a greater risk of CVD.

4.2 CVD affects the lives of millions of people and is one of the largest causes of death and disability in this country. Huge improvements have been made in the prevention and treatment of CVD over the last decade, with a 40% reduction in under 75 mortality rates between 2001 and 2010. Over the same period, the difference in under 75 mortality rates between the most and least deprived areas in England has narrowed.

4.3 Despite these improvements, comparisons with other countries show that England could still do better in improving CVD mortality rates. With an ageing population and the current levels of obesity and diabetes, unless there are improvements in prevention, past gains will not be sustained. England could also do better in terms of other outcomes, particularly the quality of life for patients living with CVD.

4.4 Lewisham has high premature mortality rates from circulatory disease compared with London and England and CVD is a major contributor to the life expectancy gap between Lewisham and England.



4.5 However, Lewisham has lower levels of detected disease. In 2013 there were 32,709 people diagnosed with hypertension in Lewisham. This was lower than expected and 10.3% of adults (an estimated 20,000) could have hypertension who have not been diagnosed.

5. NHS Health Check programme

5.1 The health check programme is now well established in Lewisham and provided by general practice, pharmacies and the Community Health Improvement Service, Lewisham and Greenwich Healthcare Trust.

5.2 The 30 minute risk assessment involves a series of simple questions about lifestyle (smoking, alcohol, diet and physical activity) and family history, measuring blood pressure and cholesterol and recording weight, height and waist measurements in order to assess someone's risk of developing cardiovascular disease.

5.3 A new Lifestyle Referral Hub service has been launched offering a "one-stop shop" for people who have received a NHS Health Check and are referred to local lifestyle services.

5.4 The Lewisham NHS Health Check programme has won 'Team of the Year' at the first ever national Heart UK awards for its work in carrying out NHS Health Checks in pharmacies in Lewisham.

5.5 The Lewisham community pharmacy service is one of the most successful elements of the Lewisham NHS Health Check programme, with approximately 25 per cent of health checks being undertaken by pharmacies.

	2013/14	**Apr-Sep 2014/15**
Number of health checks offered	18,543 people	9,271 people
% eligible population	27%	N/A
Number of health checks received	7,075	3,128
% uptake	38%	N/A
% identified with high or very high risk	8%	7%

5.6 The health check programme has been successful at identifying people with CVD risk. In 2013/14, 1,620 people were identified with moderate CVD risk, 540 people with high CVD risk and 156 people with very high CVD risk.

5.7 The table below shows that referrals to lifestyle services have steadily increased as a result of the establishment of the Lifestyle Hub, apart from smokers to the Stop Smoking Service.

Referrals	**2013/14**	**Apr-Sep 2014/15**
Stop Smoking Service	302	109
Weight Management	539	347
Alcohol Services	27	23
Physical Activity	678	449

6. Improving primary care

6.1 Improving and enhancing case finding in primary care is vital if there are going to be improved CVD outcomes. Lewisham identifies less people than expected on all GP cardiovascular disease registers, and performs below the England average in identifying and managing cardiovascular disease (coronary heart disease, stroke and transient ischaemic attack, hypertension, heart failure and atrial fibrillation) in primary care. There is much variation between practices within Lewisham.

6.2 The health check programme has identified 1,405 people with high blood pressure (twenty percent of all the people who received a health checks in 2013/14. In

addition, it is important that General Practice has a systematic approach to identify patients with hypertension who are not eligible for the Health check programme.

6.3 Better early management and secondary prevention in the community is also required for improved outcomes. There needs to be a robust system in place to clinically manage those patients with a high CVD risk once they are identified, including those with hypertension.

7. Financial Implications

7.1 There are no specific financial implications in this report, however, it will be important for the board to be aware of the possible impact of any savings made in the future on the programmes associated with improved CVD outcomes.

8. Legal Implications

8.1 Members of the Board are reminded that under Section 195 Health and Social Care Act 2012, health and wellbeing boards are under a duty to encourage integrated working between the persons who arrange for health and social care services in the area.

9. Crime and Disorder Implications

9.1 There are no crime and disorder implications from this report.

10. Environmental Implications

10.1 There are no environmental implications from this report.

11. Equalities Implications

11.1 There is variation in outcomes between primary care. A health equity audit was recently undertaken of the health check programme. The health checks programme.

11.2 The programme is successful at reaching both men and women (51% women, 49% men).

11.3 The health check programme is successful at reaching the black and minority population. Black African, Black other, Chinese and other ethnic groups all used the service more than would be expected looking at the demographic make-up of Lewisham, however the Indian population was under represented.

11.4 The programme reaching a broad range of ages between 40-74. As the programme has become more established the age profile of those having health checks has become younger.

11.5 There is no information about groups of people from the other protected characteristics (Equality Act 2012) accessing the programme.

12. Conclusion

12.1 Plans to commission services, including primary care, health checks and lifestyle services aligned to the neighbourhood model, as part of the Adult Integration Strategy, are likely to improve the prevention, early diagnosis and risk management of cardiovascular disease, as long as there is a continued focus on brief interventions, increased uptake of health checks and decreased variation in primary care.

Background Documents

Paragraph 4.5 Source: CVD Profile 2014, Public Health England
www.lewishamjsna.org.uk/reports

Paragraph 5.5. Source: CVD Profile 2014, Public Health England
www.lewishamjsna.org.uk/reports

Paragraphs 11.-1 to 11.4. Source: Health Equity Audit – Lewisham NHS Health Check Programme, Lewisham Public Health Department, Dr Farzana Qadri, Lewisham GP ST2, 2013 www.lewishamjsna.org.uk/reports

If there are any queries on this report please contact **Danny Ruta, Director of Public Health**, **London Borough of Lewisham**, on **020 8314 8637,** or by email at: **danny.ruta@lewisham.gov.uk.**

Appendix 1

PUBLIC HEALTH OUTCOMES FRAMEWORK

2.03 - Smoking status at time of delivery %	2013/14	Female	5.9%
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	Persons	25%
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	Persons	38%
2.12 - Excess Weight in Adults	2012	Persons	61%
2.13i - Percentage of physically active and inactive adults - active adults	2013	Persons	57.8%
2.13ii - Percentage of active and inactive adults - inactive adults	2013	Persons	25%
2.14 - Smoking Prevalence	2013	Persons	20.6%
2.14 - Smoking prevalence - routine & manual	2013	Persons	30.7%
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14	Persons	28%
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	2013/14	Persons	38%
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health check	2013/14	Persons	10.7%
2.18 - Alcohol related admissions to hospital per 100,000	2012/13	Female	370.7
2.18 - Alcohol related admissions to hospital per 100,000	2012/13	Male	895
2.18 - Alcohol related admissions to hospital per 100,000	2012/13	Persons	614
4.04i - Under 75 mortality rate from all cardiovascular diseases per 100,000	2011 - 13	Female	58.5
4.04i - Under 75 mortality rate from all cardiovascular diseases per 100,000	2011 - 13	Male	119
4.04i - Under 75 mortality rate from all cardiovascular diseases per 100,000	2011 - 13	Persons	87
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable per 100,000	2011 - 13	Female	35
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable per 100,000	2011 - 13	Male	76.8
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable per 100,000	2011 - 13	Persons	54.9