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# Report of the Chief Officer of the Bradford City, Bradford Districts and Airedale, Wharfedale Craven Clinical Commissioning Groups to the meeting of the Bradford and Airedale Health and Wellbeing Board to be held on 28th March 2017.

**V**

**Subject: Cardiovascular Disease - Update**

## Summary statement:

This report will provide an overview of the challenges Bradford Districts Clinical Commissioning Group faced with regards cardiovascular disease (CVD), the actions it has taken and the outcomes seen to date.

It will also describe the lessons learned and next steps in the programme and seek support from the Bradford and Airedale Health and Wellbeing Board to deliver its longer term aims.

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**Portfolio:**

**Health and Wellbeing**

**Overview & Scrutiny Area:**

**Health and Social Care**

## 1. SUMMARY

### 1.1 Cardiovascular disease (CVD)

**Today…**

- 435 people will lose their lives to CVD
- …more than 110 people will be younger than 75
- 7 million people fight their daily battles with CVD
- 515 people will go to hospital due to a heart attack
- 190 people will die from a heart attack
- 12 babies will be diagnosed with a heart defect

There are around **7 million people** living with CVD in the UK: 3.5 million men and 3.5 million women.

An ageing and growing population and improved survival rates from CVD could see these numbers rise still further.

CHD kills more than twice as many women in the UK as breast cancer.
(British Heart Foundation – CVD Statistics)

Our triple aim is to improve health and wellbeing, care and quality and achieve financial balance and efficiencies in our services. To do this we have to make large scale change, engaging with our local population to sustain this change and challenge the current outcomes to achieve success.

This paper provides the Health and Wellbeing Board with the local picture of Bradford Districts CCG, the problems we were faced with regarding our poor outcomes, and the action we took.

It will also describe the outcomes we are now seeing across Bradford Districts CCG.

## 2. BACKGROUND

### 2.1 Bradford's population

The resident population of NHS Bradford Districts CCG is 336,000 and 48,100 of these people are aged 65 and over. In the CCG, 39.9% of people live in the most deprived fifth of areas in England.

In 2013/14 there were 11,471 people who had been diagnosed with CVD in NHS Bradford Districts CCG. Based upon Health Survey for England results applied to this CCG, the total number of expected CHD cases is likely to be around 17,000. For the whole of "Cardiovascular Disease", there are 28,000 patients diagnosed in the CCG.

Early mortality (under 75 years) rates from CVD are significantly higher than the national

rate at 28% of all deaths under 75, despite decreasing by 28% since 2004-06. This is the 7th worst CVD death rate in the whole country.

The health of people in Bradford is generally worse than the England average. Deprivation is higher than average and about 28% (41,000) of children live in poverty. Life expectancy for both men and women is lower than the England average.

- Over 28% of all deaths are under 75 years of age
- 14.3% of people have hypertension (high blood pressure)
- Over 2,000 people have cholesterol above 4mmol/l
- Each day there are 5 non-elective admissions for CVD events
- Spend in the last year was £4.5 million just for non-elective admissions for strokes and myocardial infarction (MI)

## 3. OTHER CONSIDERATIONS

### 3.1 Living longer

Life expectancy is 9.6 years lower for men and 8.0 years lower for women in the most deprived areas of Bradford than in the least deprived areas.

The population of Bradford is ethnically diverse. The largest proportion of the district's population (63.9%) identifies themselves as White British. The district has one of the largest proportions of people of Pakistani ethnic origin (20.3%) in England.

### 3.2 Adult health

In 2012, 26.7% of adults are classified as obese. The rate of alcohol related harm hospital stays was 787, worse that the average for England. This represents 3,700 stays per year. The local rate of smoking related deaths is worse than the average for England. This represents 825 deaths per year. Estimated levels of adult smoking are worse than the England average.

…CVD still remains one of the leading causes of death, and is one of the Health and Wellbeing priorities in the Bradford and Craven Sustainability and Transformation Plan.

### 3.3 Modifiable and non-modifiable risk factors

Modifiable risk factors include: smoking, high blood pressure, diabetes, physical inactivity, being overweight and high blood cholesterol.
Many risk factors can be changed (you cannot change the risk factor, only its effect). The effect of these modifiable risk factors can be reduced if you make lifestyle changes.

Non-modifiable risk factors are: age, ethnic background and a family history of heart disease.

Smoking, obesity, alcohol and low levels of physical inactivity all contribute to increases in cardiovascular risk. Linked with our higher rates of South Asian ethnicity (another CVD

risk factor) these factors will see an increase in people with hypertension (high blood pressure), diabetes (Type 2) and high cholesterol levels.

## 3.4 The Programme and action taken

On 14th February 2015 Bradford Districts CCG formally launched its local programme called "Bradford's Healthy Hearts" which was developed on the back of our poor outcomes.

Over 14% of people have high blood pressure (48,000 people) with an estimated 37,000 more having undiagnosed high blood pressure.; 21,000 people were known to have cholesterol levels above 4; and each day there are 5 emergency admissions for CVD with the annual cost of these at least £4.5 million (excluding planned elective care)

Our Clinical Board supported the establishment of the programme, and all our practices remain fully engaged and committed to the programme.

Bradford's Healthy Hearts set itself a challenging ambition to reduce cardiovascular events by 10% by 2020 – a reduction which will result in 150 fewer strokes and 340 fewer heart attacks. The CCG made the commitment that "We will no longer be the seventh worst CCG in the country"

A collaborative approach was taken across the whole of the healthcare pathway involving all stakeholders and patients to design a programme that would make a change to the way we care for people in the future.

This was to be the model of how we would start to make a change to the way we care for people in the future. This way of working is now being used across other programmes.

## 3.5 The programme targets:

- Cholesterol management – optimisation of treatment for those with existing CVD and those at risk of developing future CVD (those with a cardiovascular risk of >10% over 10 years)

- Blood pressure:

  - Increased identification of new diagnoses of high blood pressure (the BHH programme increased this by around 2,500 patients, which is about a 5% increase of previous figures.
  - Better treatment of those already treated for high blood pressure. This includes increasing the number of patients who self-monitor their own BP and who proactively seek help based on this monitoring. After less than one year of the blood pressure program, nearly 75% of people with high blood pressure are now better treated (4,400 more people).

- Improved management of atrial fibrillation (AF) (an irregular heart rhythm that vastly increases the risk of stroke) – through blood thinning/anticoagulation.

More than 13,000 more people in the Bradford area have had their statin medication improved, and more than 1,000 people are now on vital blood thinning and stroke preventive medicine which has reduced the risk of stroke by up to 75% in these patients. In addition to these major health benefits, the CCG estimates it has made net savings of £1.2m in the first fifteen months of the programme

In the first two years of operation, Bradford's Healthy Hearts campaign has significantly improved the health of its residents, by offering nearly 21,000 health interventions to patients in the Bradford area and since the start of the campaign; there have been 211 fewer heart attacks and strokes.

Residents of Bradford Districts CCG's area are now more aware of what is needed for a healthy heart.

Whilst Bradford Districts CCG established the Bradford's Healthy Hearts Programme, Bradford City CCG was expanding their programme, Bradford Beating Diabetes (BBD). Examples of good practice and challenges have been shared from each programme between the CCGs to enable both CCGs to support delivery of the vision "Better Health for people of Bradford" and "Reducing health inequalities". These examples of best practice are thus able to be tailored to the population need of the individual CCGs.

3.6 NHS Right Care approach

NHS Right Care is all about:

*Intelligence* – using data and evidence to shine a light on unwarranted variation to support an improvement in quality
*Innovation* – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy
*Implementation and improvement* – supporting local health economies to carry out sustainable change.

The aim is to provide local health economies with:

- a high-level overarching national case for change;
- a best practice pathway for individual conditions; and
- the best practice case studies for elements of the pathway demonstrating what to change, how to change and a scale of improvement.

The NHS Right Care programme has developed a case study around our programme which can be shared and replicated across England.

NHS Scotland is piloting the BHH programme, and around 14 CCGs in England have contacted us so far to explore implementing the BHH programme. Public Health England have invited us to showcase the BHH programme at several of their CVD masterclass events nationally and are keen to continue this. We have been invited and are collaborating with the British Heart Foundation and Public Health England to develop a national cholesterol management tool which incorporates the BHH lipid work.

Our programme has received national recognition with four national awards (one of them the prestigious British Medical Journal award 2016).

We have invested in education both in our clinical teams across the CCG and also in our patients. Our GPs and practice nurses have had regular update and best practice training sessions.

Our monthly patient education sessions evaluate very positively each time. These are run on a variety of CVD related topics and provide advice and information on a range of areas from: how to reduce CVD risk, to how blood pressure medication works and how patients can take more charge of their own health.

For newly diagnosed patients with high blood pressure, a 12 month contract was successfully awarded to an external health provider, to deliver education to patients over 4 sessions aiming to improve knowledge of: the disease; how to reduce high blood pressure; how to measure and monitor their own blood pressure (patients are given their own accredited BP machine) and importantly what, if any action to take on reviewing their results.

Our Bradford's Healthy Hearts Website/page has been a huge success with a true stakeholder approach to its development. Local campaigns have brought the programme into media and helped raise awareness.

We have put a great deal of emphasis on how patients can look after their own health, and have tailored our approach by hearing from our patients on what they need in terms of advice, help and support.

3.7 Lessons Learnt

1. **Process** – provide support to practices, develop clinical searches, resources and ensure messages are evidence based. Engage stakeholders and patients from the very beginning. Incentives are not always financial, improvements and healthy competition between practices has been a driver in success. Monthly practice level reports were developed to show improvements (CCG and Practice level)

2. **Pathways** – population focus – think big. Ensure patient choice is evident throughout each step in the pathway. Think "outside the box"

Next steps

We have recently submitted a bid to the British Heart Foundation for funding to support the "Detection and Management" of individuals previously undiagnosed with hypertension. Should we be successful with this, our aim is to work collaboratively with our local stakeholders in the community.

## 4. FINANCIAL & RESOURCE APPRAISAL

The annual cost of emergency admissions for Cardiovascular disease in the Bradford Districts CCG area is at least £4.5 million (excluding planned elective care). The CCG estimates it has made net savings of £1.2m in the first fifteen months of the programme.

See also next steps above.

## 5. RISK MANAGEMENT AND GOVERNANCE ISSUES

There are regular meetings of the BHH programme board, made up of the Cardiovascular lead, Senior Responsible Officer, representative from the communications team, secondary care cardiology lead, pharmacy lead, and CCG Head of Service Improvement. This board reports to the Bradford Districts CCG clinical board.

## 6. LEGAL APPRAISAL

Not applicable

## 7. OTHER IMPLICATIONS

Not applicable

### 7.1 EQUALITY & DIVERSITY

Not applicable

### 7.2 SUSTAINABILITY IMPLICATIONS

Not applicable

#### 7.3.1 GREENHOUSE GAS EMISSIONS IMPACTS

Not applicable

### 7.4 COMMUNITY SAFETY IMPLICATIONS

Not applicable

### 7.5 HUMAN RIGHTS ACT

Not applicable

### 7.6 TRADE UNION

Not applicable

## 7.7 WARD IMPLICATIONS

Not applicable

## 8. NOT FOR PUBLICATION DOCUMENTS

None submitted

## 9. OPTIONS

Not applicable

## 10. RECOMMENDATIONS

The Health and Wellbeing Board are asked to:

- Consider how the lessons learnt from the Bradford Healthy Hearts programme could be applied to the priorities of the revised Health and Wellbeing Strategy 2017-2022 (in development).

## 11. APPENDICES

None

## 12. BACKGROUND DOCUMENTS

None