Draft Peterborough Cardiovascular Disease Strategy 2016 - 2021

1. INTRODUCTION

This strategy has been developed to improve cardiovascular health for people living in Peterborough. It is concerned with preventing cardiovascular disease (CVD), improving the outcomes of people with CVD and reducing inequalities in outcomes across Peterborough.

Cardiovascular disease is an overarching term that describes a family of diseases sharing a common set of risk factors. The underlying cause is the build-up of fatty deposits lining the arteries (atheroma), which contribute to conditions such as heart disease (including heart attack, angina and heart failure), cerebrovascular disease (stroke and transient ischemic attack (TIA)) and peripheral arterial disease.

Circulatory diseases such as heart disease and stroke were the second broad cause of death (behind cancer) in 2014, accounting for just over a quarter (27%) of all deaths. Although mortality from CVD has fallen over time, there is considerable variation in CVD mortality according to geography, ethnicity and social position. Cardiovascular diseases, such as stroke, also have a serious impact on quality of life and can cause considerable disability.

Peterborough is significantly worse than the national average for premature deaths from CVD and CVD considered preventable and is ranked 122nd out of 150 local authorities for premature deaths from heart disease.

In more than 90% of cases the risk of first heart attack is related to nine modifiable risk factors; high blood cholesterol, smoking and tobacco use, overweight and obesity, high blood pressure, poor diet, insufficient physical activity, psychosocial stress, diabetes and excess alcohol consumption.[1] Evidence shows that these risk factors are often clustered in more disadvantaged population groups[2] and individuals will often have a number of these risk factors and may also have more than one clinical manifestation of CVD. However, patients often receive care from multiple different teams in different settings. There is a need for a more co-ordinated and integrated approach to care to improve outcomes.

It should also be noted that services for the prevention of CVD also contribute to the prevention of other non-communicable disease, including type II diabetes, chronic kidney disease, chronic obstructive pulmonary disease and some cancers.

Achieving improvements in CVD outcomes requires a joint approach across Local Authority and NHS services and this strategy has been developed in partnership between Peterborough City Council and Greater Peterborough Local Commissioning Group (LCG).

2. BACKGROUND

Cardiovascular Disease has been identified by Peterborough Health and Wellbeing Board as the top priority focus. Feedback from stakeholder events was that a population-based approach to prevention should be adopted which should be linked to existing strategies for targeting people at high risk of CVD, such as NHS Health Checks. A need to improve treatment pathways and outcomes for people with CVD was also identified, including acute interventions and reablement, for example in stroke. Three thematic workstreams were identified for the CVD programme in Peterborough;

- **Prevention and early intervention** – reducing risk factors for CVD through lifestyle modification, behaviour change and changes to the environment.
- **Healthcare and rehabilitation/reablement –** including treatment and support for people with CVD to prevent or slow deterioration of their condition and enable recovery from episodes of poor health as far as possible.
- **Continuing support –** including health and social care for people with chronic and long term impacts of CVD, providing effective treatment and promoting independence as far as possible.

The Peterborough Health and Wellbeing Board Strategy for 2016-2019 highlights that the following need to be addressed:

- Premature deaths (age under 75) from CVD are higher than average
- Preventable deaths from CVD are higher than average
- Emergency hospital admissions and premature deaths from heart disease are higher in deprived areas
- Diabetes and coronary heart disease are more common in South Asian communities

A number of programmes of work have been established to improve CVD outcomes across Cambridgeshire and Peterborough and it is important that this strategy complements and does not duplicate this work. Cambridgeshire and Peterborough CCG identified 'Tackling Health Inequalities in CHD' as a priority with a focus on NHS Health Checks, cardiac rehabilitation, primary care interventions and decreasing smoking prevalence. The programme was expanded for 2015-2017 to include CVD and incorporate Atrial Fibrillation and Stroke.

Cardiovascular disease is a working group of the Proactive Care and Prevention workstream of the Sustainability and Transformation Programme for Cambridgeshire and Peterborough and there is also an Elective (non-emergency) Cardiology workstream.

The Health System Prevention Strategy for Cambridgeshire and Peterborough[3] chapter on cardiovascular disease suggests that the strategic focus for short to medium term savings for the NHS should be on cardiac rehabilitation, and atrial fibrillation and hypertension diagnosis, management and prevention.

In developing this strategy relevant national documents and evidence based guidance has been used such as the Department of Health Cardiovascular Disease Outcome Strategy and NICE commissioning and public health guidance for CVD prevention.

3. KEY FINDINGS FROM THE PETERBOROUGH CVD JOINT STRATEGIC NEEDS ASSESSMENT

A **Cardiovascular Disease Joint Strategic Needs Assessment** (JSNA) was requested by the Health and Wellbeing Board to inform the development of the CVD workplan. The key findings from the JSNA[4] include:

- Peterborough has a relatively young and growing population with a relatively high proportion of black and minority ethnic (BME) residents compared to nationally.
- The prevalence of CVD rises with age and is also higher in more deprived populations. South Asian populations in the UK are known to have higher rates of premature coronary heart disease (CHD).
- Borderline & Peterborough practices comprise the majority (17/22, 77.3%) of practices in the most deprived quintile within the CCG. Within this quintile, prevalence is significantly higher than the CCG for CVD, CHD and diabetes despite a lower proportion of population being aged 65 or older.
- Although premature mortality rates from CVD have fallen substantially in recent years, Peterborough has significantly high mortality rates for CVD under the age of 75. There also appears to be a widening gap in premature CVD mortality for females in Peterborough.
- Circulatory diseases (including coronary heart disease and stroke) contribute a third of the gap in life expectancy between Peterborough and the national average for men, and half for women.
- In Peterborough, smoking prevalence was 34.7 % in people in routine and manual occupations, the highest in the East of England in 2013.
- Estimates based on the 2012 Active People Survey suggest the percentage of adults classified as obese in Peterborough is 24.1%, which is 2.5% higher than the estimate for Cambridgeshire (21.6%). The estimated percentage of adults classified as either overweight or obese in Peterborough is 65.5% whereas in Cambridgeshire it is 65.0%.
- CVD risk factors are relatively high in the relatively younger and more deprived population in Borderline and Peterborough LCGs, who may not be diagnosed with CVD yet, but are at high risk of developing disease and requiring services as they age.
- Hospital admissions and deaths data for circulatory diseases in Peterborough show a correlation with wards with a high proportion of BME groups. These wards are also the most deprived. Central, Park, Ravensthorpe, West, East, North and Dogsthorpe wards have higher % BME, % living in income deprived households, standardised mortality ratios for deaths from circulatory diseases and coronary heart disease (all ages) and higher standardised emergency admission ratios for coronary heart disease.

4. STRATEGY VISION AND OBJECTIVES

The vision is to improve the cardiovascular disease health of people living in Peterborough. This will be achieved by developing programmes and supporting individuals and communities to address those risk factors which influence CVD. This includes ensuring that there is equal access to CVD services and those individuals with CVD receive optimum care and are able to manage their condition. The three thematic workstreams form the strategy framework (prevention and early intervention, healthcare and rehabilitation, continuing support).

The objectives of the strategy are:

- To reduce premature mortality from cardiovascular disease
- To reduce inequalities in CVD outcomes between the most deprived and least deprived areas of Peterborough
- To improve access to prevention and optimised management of CVD

Improvements in CVD outcomes will be measured by the following overarching indicators. Additional indicators will be developed under the 3 thematic workstreams.

Under 75 mortality rate from cardiovascular disease, directly standardised rate per 100,000 (PHOF indicator)

Under 75 mortality rate from cardiovascular disease considered preventable, directly standardised rate per 100,000 (PHOF indicator)

Difference between the 20% most deprived wards in Peterborough and the remaining wards in under 75 mortality rate from cardiovascular disease (? Health and Wellbeing Strategy indicator)

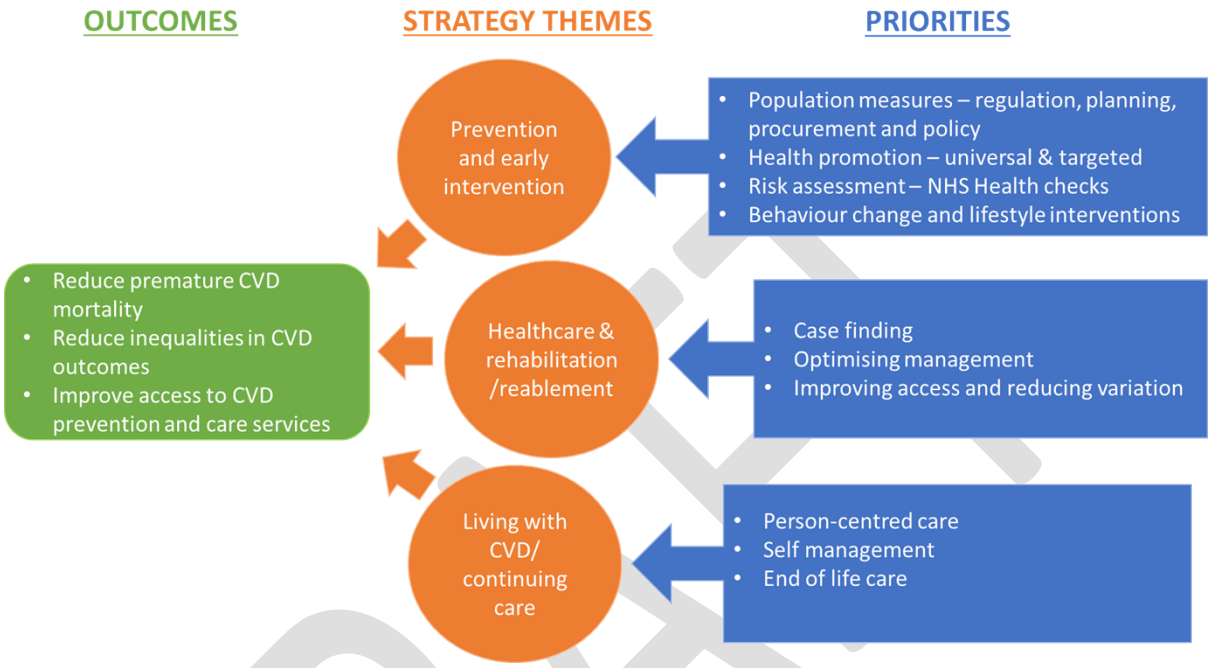
NICE public health guidance on CVD prevention[5] makes recommendations for developing a comprehensive regional and local CVD prevention programme which includes the following good practice principles:

- Ensure a CVD prevention programme comprises intense, multi-component interventions.
- Ensure it includes initiatives aimed at the whole population (such as local policy and regulatory initiatives) which complement existing programmes aimed at individuals at high risk of CVD.
- Ensure it is sustainable for a minimum of 5 years.
- Ensure appropriate time and resources are allocated for all stages, including planning and evaluation.

It is also important that a collaborative approach is taken with strong leadership for CVD prevention. Cardiovascular disease has been made a priority by the Peterborough Health and Wellbeing Board and the JSNA has provided an understanding of the prevalence of CVD and its risk factors in the community.

5. PRIORITIES FOR ACTION

A 'Peterborough CVD Programme Steering Group' of key stakeholders has been established to develop the strategy. The priorities for action have been considered for each of the workstreams and are detailed in this section and summarised in the figure below.



Workstream 1: Prevention and early intervention
Lead organisation: Peterborough City Council
Population measures: reducing population exposure to cardiovascular risk factors to create a healthy Peterborough environment and encouraging residents to make healthy life choices. This will involve regulatory services, planning and public procurement and policy. For example, encouraging healthy diet choices in public buildings by reducing the availability of foods that are high in fat, salt and sugar; regulating access to items that increase CVD risk such as tobacco and developing an environment that promotes physical activity. **Health promotion:** provision of information to inform and educate the public on cardiovascular disease and its risk factors. Health promotion activities should be at a universal level aimed at the whole population and also targeted at specific communities/groups with increased cardiovascular disease risk. The monthly 'Healthy Peterborough' campaign launched in 2016 has included heart disease and stroke as well as risk factors such as physical activity and smoking. Continuation of this campaign will help embed these messages. The South Asian population are at increased risk of cardiovascular disease and it will be important to work with community leaders to develop campaigns targeted at this community. Other areas that can be targeted are workplaces, particularly with routine and manual workers and schools.

Risk assessment: NHS Health Checks are a systematic programme for those aged 40 to 74 to assess a person's risk of heart disease, stroke, diabetes and kidney disease. In Peterborough NHS Health Checks are provided by GPs and work has been focused on improving the quality of health checks and supporting practices to invite those most at risk. In order to improve access to health checks, the procurement of Point of Care testing equipment is being considered to enable health checks to take place in community settings as well as in GP practices. This will enable key results to be communicated to patients immediately. Other groups at increased risk of CVD who are not eligible for a NHS Health Check should also be considered, such as the South Asian population aged 30 to 40, people with suspected familial hypercholesteraemia and people with severe mental illness, including schizophrenia and bipolar disorder.

Behaviour change and lifestyle interventions: There are a number of initiatives already in place in Peterborough, such as smoking cessation clinics, Let's Get Moving, Fit For Live and Morelife Family Clubs, Operation Smokestorm, Healthy Eating and Cooking Sessions as well as events and campaigns. The Public Health Team provide an Integrated Lifestyle service which includes six qualified Health Trainers whose clinics are being embedded within key locations including GP Practices and community settings. Procurement is underway for a new Integrated Lifestyle service, with a new provider starting delivery in April 2017. This will include extended smoking cessation activity as part of a wider Tobacco Control initiative, the Health Trainer programme, physical activity programmes for children, families and adults, outreach Health Checks and weight management interventions across Tier 1,2 and 3. There is a need to ensure that any behaviour change and lifestyle services are effectively coordinated and targeted and provided in culturally appropriate settings. Consideration should also be given to training appropriate Peterborough City Council staff on motivational interviewing so that they can use these skills with people at increased risk of CVD, for example using the Making Every Contact Count approach.

Key partners:

- Peterborough GPs and Practice Staff
- Greater Peterborough Executive Board
- Community Leaders
- Local businesses
- Schools

Workstream 2: Healthcare and Rehabilitation/Reablement
Lead organisation: Greater Peterborough Executive Board
Case finding: There is considerable variation between GP practices in the prevalence of conditions which contribute to cardiovascular disease, such as atrial fibrillation (AF) and hypertension. It is estimated that there are approximately 2,300 patients in Peterborough with AF who are undiagnosed. People with untreated AF have a 5 times higher risk of stroke and strokes caused by AF are often more severe. The Cambridgeshire and Peterborough Health System Prevention Strategy recommends that work on improving the diagnosis of AF and hypertension should initially focus on Peterborough. Case finding tools are available to identify those at high risk of CVD conditions. In addition, including pulse checks in blood pressure checks and as part of flu clinics may help identify new cases of AF. The NHS Health Check also offers an opportunity to diagnose and treat hypertension, including through lifestyle interventions. **Optimising management:** There is again variation in terms of the management of CVD conditions across Peterborough. Less than half of people with known AF admitted to hospital with stroke are on anticoagulant treatment at the time of their stroke.[6] There are opportunities for improving the management of AF, hypertension, heart failure and coronary heart disease which should be maximised. Tools are available to be run on GP practice systems to help identify those patients who do not appear to be managed appropriately. **Improving access and reducing variation:** Cardiac rehabilitation is a structured set of services that enables people with coronary heart disease (CHD) to have the best possible help (physical, psychological and social) to preserve or resume their optimal functioning in society.[7] Research suggests that achieving 65% uptake of cardiac rehabilitation would result in a 30% reduction in unplanned cardiac readmissions. Improvements should be made along the pathway to improve the numbers of people being referred for cardiac rehabilitation and uptake and completion rates. Through the Cardiology workstream of the Sustainability and Transformation Plan, work has started to review and standardise cardiology pathways across Cambridgeshire and Peterborough. There are currently variations in access to Specialist Heart Failure and AF Nurses across Peterborough.
Key partners: • Peterborough GPs and Practice staff • Peterborough and Stamford NHS Hospital Trust • Peterborough City Council • Cambridgeshire and Peterborough NHS Foundation Trust

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Workstream 3: Living with Cardiovascular Disease/Continuing Care
Lead organisation: Peterborough City Council/Greater Peterborough Executive Board
Person-centred care: People with CVD as with other long term conditions, should have a holistic assessment of their needs for rehabilitation and long-term support which should consider their physical, psychological and social care needs. A written care plan should be produced in partnership with the patient to meet the needs identified, involving carers and families where appropriate. For people living with long term conditions, care should be planned around the individual and their needs rather than separate conditions or where treatment is provided. This will allow for a more co-ordinated, integrated, personalised and person-centred approach which has been shown to improve experience of care. **Self-management:** Engaged, informed individuals and carers is one pillar of the House of Care[8] model to achieve person-centred care. Patients should know how to access the services they need when and where they need them. Electronic systems and tele-medicine solutions make it possible for patients to enter and view test results online and share them with professionals and carers and enable greater communication between patients and health professionals. These systems should be considered to promote independence and encourage self-management. **End of life care:** Many CVD patients receive suboptimal care at the end of life and are not dying in their place of choice.[2] There is a need for timely identification of people who are likely to be in their last year of life and planning their care with them. These care needs should be documented and coordination should take place across primary and secondary care to enable this.
Key partners: • All health and care professionals, patients and carers • Voluntary organisations

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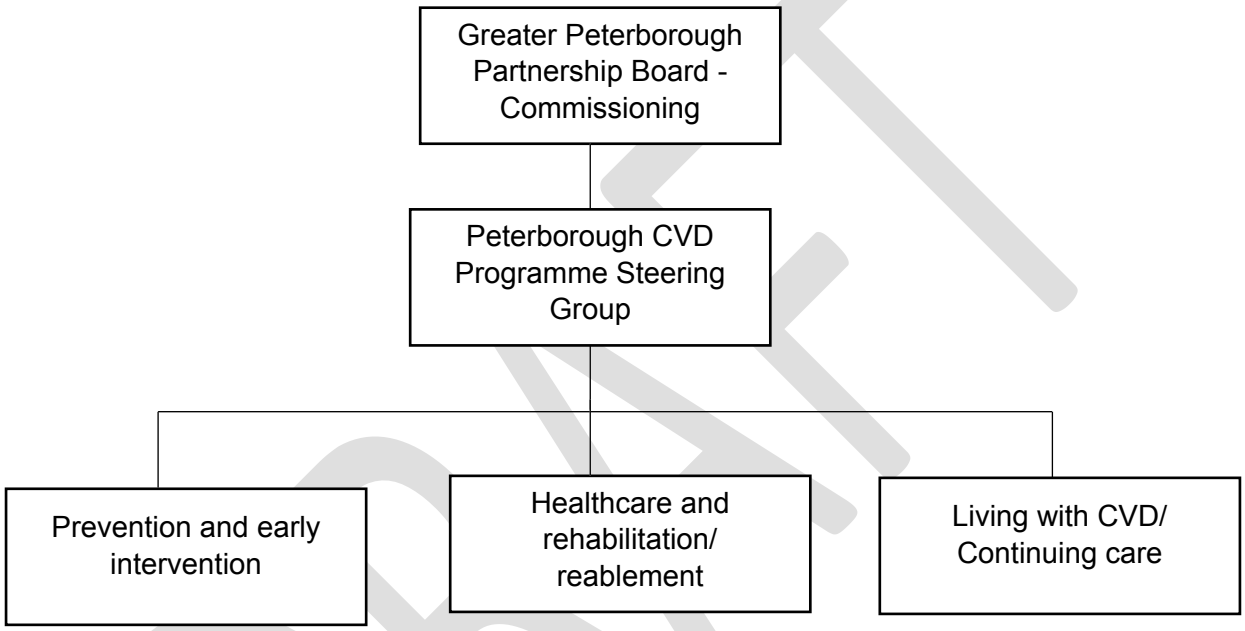
6. STRATEGY DELIVERY

In order to deliver the strategy and improve cardiovascular health in Peterborough, working groups have been developed around each strategy workstream. These working groups will develop implementation plans that will be monitored by the Peterborough CVD Programme Steering Group.

The Steering Group will report to the Greater Peterborough Executive Partnership Board – Commissioning and will also produce reports for the Peterborough Health and Wellbeing Board. The reporting arrangements are shown in the figure below.



7. REFERENCES

[1] Services for the prevention of cardiovascular disease: commissioning guide. June 2012. NICE.
[2] Cardiovascular Disease Outcomes Strategy. Department of Health.
[3] Health System Prevention Strategy for Cambridgeshire and Peterborough. December 2015.
[4] Cardiovascular Disease Joint Strategic Needs Assessment. Peterborough City Council.
[5] Cardiovascular Disease Prevention. Public Health Guidance. June 2010. NICE.
[6] CVD Primary Care Intelligence Packs: Stroke
[7] Cardiac rehabilitation services: commissioning guide. November 2013.
[8] The King's Fund (2013). Delivering better services for people with long-term conditions: Building the house of care. London: The King's Fund.

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