APPENDIX A

HEALTH AND WELLBEING PROGRAMME BOARD		AGENDA ITEM No.
		PUBLIC REPORT
Contact Officer(s):	Dr Henrietta Ewart, interim Director of Public Health	Tel. 01733 207175

UPDATE ON THE CARDIOVASCULAR DISEASE PRORITY WORK PROGRAMME

R E C O M M E N D A T I O N S	
FROM : Dr Henrietta Ewart, Interim Director of Public Health	**Deadline date : n/a**

The Health and Wellbeing Programme Board is invited to:

a) support the proposal that Public Health lead the establishment of a clinically focussed group to address the Healthcare and Rehabilitation/Reablement workstream;

b) are invited to consider and identify the lead officer for each of the other thematic workstreams;

c) to consider how the development of the Communications Strategy needs to respond to the emergent cardiovascular disease strategy and workstreams;

d) support testing The 'House of Care' model for its application to the CVD thematic workstreams;

d) comment on the proposed elements the CVD strategy identified in the mapping of the CHD and CVD programmes (venn diagram);

e) consider and comment on the proposal to use PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic workstreams.

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the following the decision taken by the Health and Wellbeing Programme Board (HWPB), at their May meeting, that cardiovascular disease (CVD) should be the top priority focus area. The HWPB tasked the Public Health Team with leading an exercise to scope CVD and propose a work plan with key performance indicators and outcomes to be considered and signed off by the HWPB/HWB.

An update was provided in July and this report provides a further progress report.

1.2 The development of a cardiovascular disease strategy links with the following priorities of the Health & Wellbeing Strategy 2012-15:

- Narrow the gap between those neighbourhoods and communities with the best and worst health outcomes.
- Enable older people to stay independent and safe and to enjoy the best possible quality of life.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide information on early thinking in mapping the relationship between the existing programme to reduce inequalities in coronary heart disease (CHD) and a wider strategy to reduce cardiovascular disease. It identifies synergies and opportunities for further development of a clinically focussed programme to address the Healthcare and Rehabilitation/Reablement workstream previously agreed by the Health and Wellbeing Programme Board.

It proposes scoping the establishment of a healthcare and rehabilitation workstream group with the membership of relevant stakeholders to achieve clinical engagement and ownership of this theme of the cardiovascular programme.

2.2 In relation to the other workstreams identified in the previous paper, (prevention and early intervention; continuing support) it invites the HWPB to identify the lead officer for each programme. A similar mapping exercise, taking into account existing programmes of work, could be undertaken to inform the development of the specific thematic action plans.

2.3 The HWPB is requested to consider the establishment of these CVD programme thematic workstream groups and in relation to the requirements of the Communications Strategy which is in development.

2.4 Appendix A provides maps selected indicators from national data sets to propose key metrics for each thematic group.

3. THE CHD AND CVD PROGRAMMES PURPOSE AND REASON FOR REPORT

3.1 The Peterborough, Borderline and Wisbech Local Commissioning Groups of the Cambridgeshire and Peterborough Clinic Commissioning Group have established a clinically led group to tackle reducing inequality in coronary heart disease outcomes (CHD), one of three strategic priorities identified by the CCG.

This programme has four workstreams:

1. **Health Check programme**
   Working in partnership with Local Authorities and primary care providers/public health to successfully implement the Health Check programme.

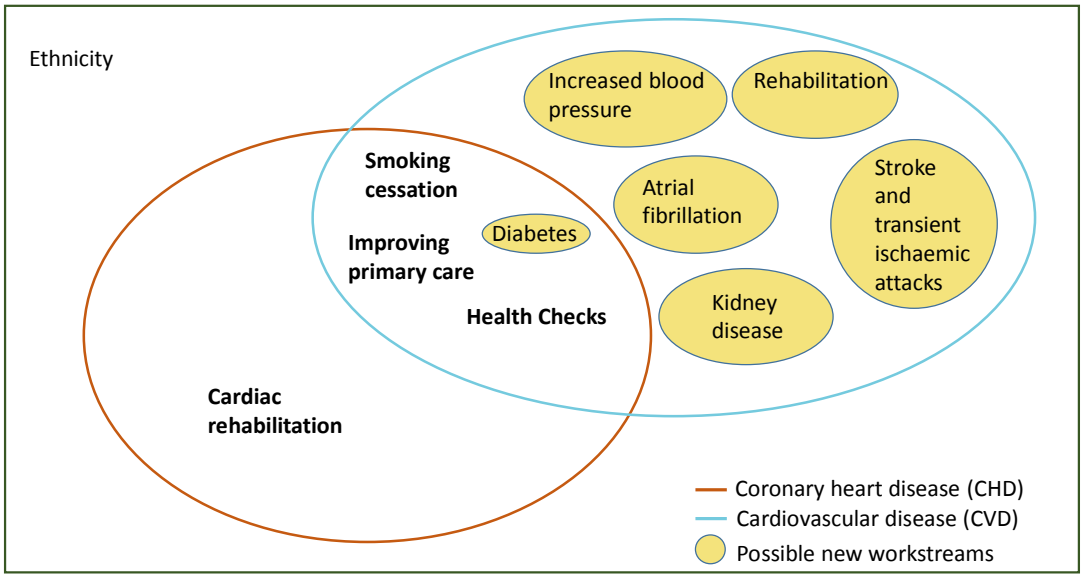
2. **Cardiac Rehabilitation**
   Effective use of current Cardiac Rehabilitation pathways and recommending to both commissioners and providers, areas for improvement based on local and national best practice

3. **Primary care Interventions**
   Improving management of prevention of coronary heart disease in primary care so that inequalities in CHD are decreased at both a GP practice level and across the LCG population

4. **Smoking Cessation**
   Working in partnership to increase the effectiveness of specific interventions, in response evidence based interventions.

3.2 There is significant overlap in the elements of the CHD programme and the proposed evidence –based healthcare and rehabilitation CVD workstream:

Building on established interventions to reduce inequalities in coronary heart disease to address cardiovascular disease.



3.3 Ethnicity is a key factor in cardiovascular and diabetes risk and should be considered in relation to all aspects of the programme - risk thresholds, interventions, communications and access/barriers to services - so that inequalities in outcome are addressed for the population of Peterborough.

3.4 The Public Health Intelligence Team have mapped selected indicators from the Public Health Outcomes Framework (PHOF), the NHS Outcomes Framework (NHSOF) and the Adult Social Care Outcomes Framework (ASCOF) against the three thematic workstreams in Appendix A for consideration by the HWPB.

3.5 There are 230 indicators available covering inputs, processes and outcomes so Appendix A provides a 'first cut' or 'straw man' for consideration by the thematic workstreams.

3.6 Inevitably, there is some overlap of indicators between workstreams and this may need to be worked through as the thematic action plans are developed by the theme groups to ensure appropriate accountability. This routinely collected data provides the means to ensure oversight of key outcomes of the CVD programme and track improvements over time although additional information may be required for operational management due to the timeliness of national reporting systems.

4. CONSULTATION

4.1 The half day stakeholder and workshop mapping in July focussed on the development of the British Heart Foundation 'House of Care' bid for a coordinated approach to the management and support of people with coronary heart disease. The bid was submitted on 11th August and the outcome will be known in November (shortlisted locations will have site visits in October/November).

4.2 In order to progress the Healthcare and Rehabilitation workstream, it is proposed that, following a stakeholder mapping, a second stakeholder workshop is convened with a focus on ensuring clinical engagement and that of relevant third sector and other groups e.g. the Stroke Association.

Consideration will need to be given to the potential overlap in membership between this and the Continuing Support workstream by the identified leads.

4.3 Appendix B sets out the discussion points at the original stakeholder workshop, many of which relate to social and environmental factors influencing cardio vascular disease risk. This will be of relevance to the Prevention and Early Intervention thematic workstream and relevant to the developing work on Healthy Schools and Healthy Places.

4.4 The CCG and Public Health England Centre have expressed interest in the development of the strategy and are keen to share promising practice.

5. RECOMMENDATIONS AND NEXT STEPS

5.1 In order to progress the development of the CVD strategy, the Health and Wellbeing Programme Board, as the steering group for the strategy, is requested to:

a) support the proposal that Public Health lead the establishment of a clinically focussed group to address the Healthcare and Rehabilitation/ Reablement workstream;

b) are invited to consider and identify the lead officer for each of the other thematic workstreams;

c) to consider how the development of the Communications Strategy needs to respond to the emergent cardiovascular disease strategy and workstreams;

d) support testing The 'House of Care' model for its application to the CVD thematic workstreams;

e) comment on the proposed elements the CVD strategy identified in the mapping of the CHD and CVD programmes (venn diagram);

f) consider and comment on the proposal to use PHOF, NHSOF and ASCOF indicators to monitor the outcomes of the three thematic workstreams.

6. BACKGROUND DOCUMENTS

1. Living well for longer-a call to reduce avoidable premature mortality; Department of Health March 2013
2. Commissioning for value focus pack NHS Cambridgeshire and Peterborough CCG-focus area cardiovascular disease (CVD) pathway, Public Health England, June 2014
3. Ryan's reference to data sets ?

(*Appendix A to HWPB report*)
PHOF = Public Health Outcomes Framework
NHSOF = National Health Service Outcomes Framework
ASCOF = Adult Social Care Outcomes Framework
Other = Healthcare related metrics sourced from the Health & Social Care Information Centre
Table 1: Prevention & Early Intervention Work Stream Metrics

#	Framework	Indicator
1	PHOF	1.16- Utilisation of outdoor space for exercise/health reasons
2	PHOF	2.12 - Excess weight in adults
3	PHOF	2.13i - Percentage of physically active and inactive adults - active adults
4	PHOF	2.13ii - Percentage of active and inactive adults - inactive adults
5	PHOF	2.14 - Smoking prevalence
6	PHOF	2.14 - Smoking prevalence - routine and manual
7	PHOF	2.17 - Recorded diabetes
8	PHOF	2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check
9	PHOF	2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS health check who received an NHS health check
10	PHOF	2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS health check
11	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Persons)
12	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Male)
13	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Female)
14	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)
15	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Male)
16	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Female)
17	NHSOF	1.1 Under 75 mortality rate from cardiovascular disease
18	NHSOF	2.4 Enhancing quality of life for carers
19	Other	Directly age-standardised rate per 100,000 population of deaths attributable to smoking for all persons aged 35+ in the years 2003-05, 2004-06 and 2005-07
20	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.

Table 2: Healthcare, Rehabilitation and Reablement Work Stream Metrics

#	Framework	Indicator
1	PHOF	2.17 - Recorded diabetes
2	PHOF	2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check
3	PHOF	2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS health check who received an NHS health check
4	PHOF	2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS health check
5	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Persons)
6	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Male)
7	PHOF	4.04i-Under 75 mortality rate from all cardiovascular diseases (Female)
8	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)
9	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Male)
10	PHOF	4.04ii-Under 75 mortality rate from cardiovascular diseases considered preventable (Female)
11	ASCOF	2B(1)- Older people at home 91 days after leaving hospital into reablement
12	NHSOF	1.1 Under 75 mortality rate from cardiovascular disease
13	NHSOF	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the modified Rankin scale at 6 months
14	Other	Emergency hospital admissions for stroke
15	Other	Emergency hospital admissions for diabetes
16	Other	Proportion of patients of all ages discharged back to usual place of residence within 56 days of emergency admission to hospital with a stroke.
17	Other	Deaths within 30 days of a hospital procedure: stroke: indirectly standardised rate, all ages, 3 year average trend
18	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.
19	Other	Emergency hospital admissions for stroke
20	Other	Emergency hospital admission for diabetes
21	Other	Deaths within 30 days of a hospital procedure: stroke: indirectly standardised rate, all ages, 3 year average trend
22	Other	Mortality from all circulatory diseases, directly age-standardised rate, persons, under 75 years, 2004-08 (pooled) per 100,000 European Standard population by local authority by local deprivation quintile.

Table 3: Continuing Support Work Stream Metrics

#	Framework	Indicator
1	ASCOF	1.a -Social care related quality of life
2	ASCOF	1.b - Service users with control over their daily life
3	ASCOF	1.c(1)- People receiving self-directed support
4	ASCOF	1.c(2) - People receiving direct payments
5	ASCOF	2A(1)- Permanent admissions to care homes: people aged 18 to 64
6	ASCOF	2A(2)- Permanent admissions to care homes: people aged 65 and over
7	ASCOF	2B(1)- Older people at home 91 days after leaving hospital into reablement
8	ASCOF	2B(2)- Older people receiving reablement services after leaving hospital
9	ASCOF	3D(1)- Service users who find it easy to get information
10	ASCOF	3D(2)-Carers who find it easy to get information
11	ASCOF	4A- People who use services and feel safe
12	ASCOF	4B- People who say the services the use make them feel safe and secure
13	NHSOF	2.0 Health related quality of life for people with long term conditions
14	NHSOF	2.1 Ensuring people feel supported to manage their condition (proportion of people feeling supported to manage their condition)
15	NHSOF	3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the modified Rankin scale at 6 months
16	NHSOF	3.6 Helping older people to recover their independence after illness or injury (i. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service, ii. Proportion offered rehabilitation following discharge from acute or community hospital)
17	Other	Proportion of patients of all ages discharged back to usual place of residence within 56 days of emergency admission to hospital with a stroke.