Middlesbrough: Overview & Scrutiny Committee

Life Expectancy in Middlesbrough: Cardiovascular Disease [CVD]

1 Overview

- More older people living longer with long term conditions (effects of demographic changes and better health care that prevents mortality but not morbidity)

- More (relatively) younger people who are poorer living with a long term condition (effects of entrenched inequalities)

Both of these will put immense pressures on the health care system over the coming years. Some primary prevention activities are hugely cost effective and can actually impact life expectancy targets (and inequalities) in the relatively short term. Smoking should still remain the priority for the foreseeable future and despite the recent legislation, there is still a lot to do

2 What are the current challenges the NHS faces in Commissioning for CVD?

- We need to do 'everything'
    - Need to balance investment in primary/ secondary/ tertiary
    - How to get investment in primary prevention while still treating legacy of ill health
    - Need to meet waiting time guarantees which are top of government agenda
    - Technological developments driving high cost end
    - Whilst ageing population and lifestyle changes are fuelling demand
    - Investing in public health areas when there are financial pressures

- Commissioning to tackle the lifestyle risk factors:
    - Preventable, but hard to change behaviours
    - High rates of Smoking
    - Lack of physical activity (a sedentary lifestyle)
    - Rising levels of Obesity
    - An unhealthy diet
    - Excess alcohol
    - Real evidence needed and shared about 'what works' on changing behaviour

- Commissioning for the treatable/ partly treatable risk factors:
    - Requires increased resources in staff time, drug costs, etc
    - Hypertension (high blood pressure)
    - High cholesterol blood level
    - Rising numbers with diabetes linked to obesity

- Tackling inequity across the population
    - NSF and NICE useful in setting national standards for service provision
    - But: inequity in take up of services by population groups
    - Inequity in health due to deprivation and lifestyle
    - Inequity can widen as wealthier take up health promotion messages quicker than the poor

3 Tackling the legacy

- Systematic, industrial scale primary prevention screening programmes across South Tees using a mixed model approach (community & workplace) identify people at risk of
    - Cardio-vascular disease (and then ensure appropriate services, treatment interventions are in place and adequately funded) e.g. we will need to significantly increase our statin prescribing
    - Hypertension (approximately 30,000 adults in South Tees with *undiagnosed* hypertension).
    - Diabetes (approximately 3000 adults with *undiagnosed* diabetes

- Screening programmes to identify people at risk of diabetes (possible in the region of >10,000 adults here). These individuals can be offered evidence based interventions to prevent or delay the onset of diabetes. All the micro-vascular changes begin at least 10 years before a person is diagnosed with diabetes. These 'pre-diabetic' individuals are at high risk of CVD and can be prevented through targeted screening and intervention. Again, a systematic programme needs to be commissioned and delivered.

- Smoking is a highly addictive substance. Expand stop smoking substantially to provide more specialist advisors in pregnancy and as a core service, help support all the commissioned stop smoking services that form part of the delivery (e.g. through pharmacies, GPs, other providers). This is possibly one of the most cost effective and evidence based interventions that can be offered and will have an early impact on some of key targets such as life expectancy and CVD.

4 Where should Commissioning for CVD be in 3 years?

- Accessible Services
    - Shift of services to community where appropriate
    - No barrier to take up of services for patients

- Increased Capacity
    - New models may be needed: eg diabetes care, to meet the rising prevalence and demand

- More emphasis on preventative services
    - Look at screening services: eg over 40's at risk
    - Ability to identify, engage and treat at risk groups such as ethnic minorities

    - Starting young: target groups to give best possible start in life and reduce risks later on/ life changing moments
    - Promoting breast feeding and smoking cessation in pregnancy
    - Targeted to improve equity and increase take up by deprived groups

- Engagement of Primary Care through PBC as well as QOF
    - Aim to achieve excellence in levels of QOF and prescribing
    - Reduce variability between practices

- Choice of service delivery: patient centred (eg cardiac rehab)

- Delivering national standards for treatment
    - 18 week waits (pressures on arrhythmia/ EP)
    - NSF and NICE guidance
    - HCC: Heart Failure review (community clinics)
    - New Stroke guidance due shortly

- Commissioning based on outcomes, not just activity through PbR

5 Aside from Commissioning, what can the town and the range of partners within it, do to tackle CVD?

- Addressing lifestyle risk factors
- Affecting the prevailing culture in the town
- Smoking cessation: single most effective thing that can be done to reduce the risk
- More opportunities for exercise
- Environment that promotes exercise as part of daily life
- More healthy food options available
- Tackling alcohol consumption
- Targeted services at deprived wards – access to population and premises
- Opportunities for blood pressure checks with 'low uptake' population groups
- Setting a positive example as organisations
- Healthy Lifestyles, Healthly Culture, Consistent Messages

Abbreviations:
NSF = National Service Framework
NICE = National Institute for Health & Clinical Excellence
CHD = Coronary Heart Disease
CVD = Cardiovascular Disease
HCC= Health Care Commission
EP= Electrophysiology
PBC = Practice Based Commissioning
PBR= Payment by Results
QOF= Quality Outcomes Framework