West Yorkshire and Harrogate
Health and Care Partnership

West Yorkshire & Harrogate
Joint Committee of Clinical Commissioning Groups

Summary report	
Date of meeting: 5 June 2018	Agenda item: 54/18
Report title:	Improving outcomes for people with CVD and Diabetes
Joint Committee sponsor:	Amanda Bloor (Chief Officer, Harrogate and Rural District CCG) and Steve Ollerton (Chair, Greater Huddersfield CCG)
Clinical Lead:	Youssef Beaini (Bradford Healthy Hearts Clinical Lead)
Author:	Sue Baughan (Independent Consultant funded by Academic Health Science Network (AHSN), Shane Hayward-Giles (RightCare Delivery Partner), Youssef Beaini (Clinical Lead), Tony Jamieson (AHSN project sponsor)
Presenter:	Youssef Beaini and Sue Baughan

Purpose of report: (why is this being brought to the Committee?)			
Decision	✓	Comment	
Assurance			

Executive summary

The purpose of this report is to recommend to the WY&H Joint Committee of CCGs that it supports the development of a common WY&H approach to deliver improved outcomes for people with CVD and Diabetes.

The WY&H Clinical Forum has identified the potential to make significant improvements in outcomes for people with CVD and Diabetes through joint working across WY&H. This supports the achievement of the WY&H target for improving CVD outcomes.

Proposed actions, estimated impact and resources required are included in this report.

Recommendations and next steps

The Joint Committee is invited to recommend that the WY&H CCGs:

a) adopt this WY&H wide improvement project.
b) identify a clinical and a project lead to work with the Clinical Lead and central project team to implement the actions identified in Phase 1, 2 and 3 of this project.
c) support the reporting and governance arrangements to enable the impact of this project to be measured and assured at CCG and WY&H level.

Delivering outcomes: describe how the report supports the delivery of STP outcomes (Health and wellbeing, care and quality, finance and efficiency)

Health and Wellbeing: Decrease in CVD mortality, decrease in adverse CVD events (stroke, MI etc)

Care and Quality: Increase in the number of people with or at risk of CVD and diabetes receiving beneficial interventions

Finance and Efficiency: Decrease in the amount of resources spent on care of those with CVD and diabetes

Impact assessment (please provide a brief description, or refer to the main body of the report)	
Clinical outcomes:	As Health and Wellbeing above
Public involvement:	Covered in section 6 of the main report.

Finance:	As Finance and Efficiency above
Risk:	Funding requirements and impact assessments are best estimates. Funding has not been obtained for 2019/20 onwards.
Conflicts of interest:	None

Improving outcomes for people with CVD and Diabetes

1. Purpose

1.1 The purpose of this report is to recommend to the Joint Committee that it supports the development of a common West Yorkshire and Harrogate (WY&H) Health and Care Partnership (HCP) project to deliver improved outcomes for people with CVD and Diabetes.

1.2 It is clear from both WY&H and locality plans that improving outcomes for people with CVD and diabetes is a priority. The opportunity for improvement across WY&H (as shown by the RightCare WY&H HCP Data pack and the PHE Size of the Prize[1]) could make a real difference to patient outcomes and financial sustainability.

a) Hypertension

Optimal anti-hypertensive treatment of all those with diagnosed hypertension across the WY&H HCP (69,700 people in 2015/16) would avert (within three Years) 420 heart attacks with a saving of up to £3.1 million and 620 strokes with a saving of up to £8.8 million (PHE Size of the Prize)

b) Lipid Management

The estimated adult population aged 30 – 85 years with a 10-year CVD risk of > 20% is 175,000 of which an estimated 51% won't be treated with statins (PHE Size of the Prize). Across the WY&H HCP there is the potential to treat a further 89,250 people. Statin therapy to reduce cholesterol by 1mmol/l in this group reduces the risk of CVD events by 20 – 24%

1.3 CCGs within WY&H are already developing improvement programmes in this clinical area. By adopting a common evidence-based approach, the HCP will benefit from economies of scale and shared learning which will lead to greater improvement for the population.

1.4 This paper recommends an approach to do this and calculates the potential effect on outcomes.

2. Background and Scope

2.1 The WY&H HCP plan includes an aspirational target for CVD: 'Reduce the number of people experiencing a CVD incident by 10% across the area by 2021.' In 2015/16 there were 3,520 non-elective admissions for stroke and 7,910 for MI. If this target were met there would be over 1,100 fewer CVD incidents across the WY&H HCP by 2021.

2.2 On 6 February 2018 the WY&H Clinical Forum identified the potential to make significant improvements in outcomes for people with CVD and Diabetes through joint working across WY&H. The Forum acknowledged the improvement programmes already in place within localities and the primacy of place-based working but recognised the benefits of sharing resources and spreading learning which would come from a common approach.

2.3 The WY&H Clinical Forum confirmed their support for a HCP wide improvement plan starting with actions outlined on hypertension as phase 1, with lipid management and glycaemic control as phases 2 and 3. The WY&H Clinical Forum asked that more information be submitted to the Joint Committee of CCGs to enable the Committee to take a view on whether to recommend to CCGs that they support the proposals.

2.4 The Joint Committee of CCGs discussed these initial proposals at a development session on 1 May 2018. The Committee supported phases 1, 2 and 3 in principle and recommended an approach which allowed for central co-ordination and shared resources, but not the establishment of a formal work programme. The Committee requested a report to the June 2018 Joint Committee meeting in public to enable formal recommendations to be made to the CCGs.

2.5 This paper takes into account the comments made at the Joint Committee development session.

2.6 The WY&H Clinical Forum stressed the importance of reducing inequalities in health outcomes as well as improving outcomes overall. In general, more deprived populations tend to have lower rates of disease detection. These proposals are expected to reduce inequalities in health outcomes, particularly by increasing the detection of hypertension and CVD.

3. Phase 1 (hypertension) June 2018 to March 2020

3.1 Increasing recorded prevalence of hypertension across WY&H HCP

Actions are listed in priority order based on estimated impact for resources invested.

1) Patients who are at risk of having hypertension but who are not yet diagnosed (4 or more readings of >140/90, where last reading still above 140/90)
2) Identify patients already on anti-hypertensive medication but not on relevant practice registers

Impact

Bradford increased prevalence of hypertension by 1% in 3 months through actions 1 and 2 above. Through actions 1 and 2 this improvement project aims to detect a further 18,250 people (2016/17) with currently undiagnosed hypertension. If we assume that 50% of these people go on to have their hypertension treated optimally there would be 54[1] fewer heart attacks and 80[1] fewer strokes across WY&H HCP in 3 years. The associated savings from this reduction in adverse events would be £400,000[1] from heart attacks and £1.1 million[1] for strokes.

3.2 Treatment optimisation

3) Identify and optimise treatment of patients diagnosed with hypertension, CHD, stroke or Diabetes whose BP is > 140/90
NICE recommendation is for tighter control limits than QOF, with 140/90 being the target for uncomplicated CVD.

Impact
For people with hypertension Bradford increased control to 140/90 from 63% to 76% in 16 months. If this effect was replicated across the HCP then a further 39,000 people (2016/17) with hypertension could be treated to 140/90. The predicted benefits of this are substantial as every 10mmHg reduction in systolic blood pressure reduces the risk of cardiovascular events by around 20%[2].

3.3 Prepare for Phase 2 (lipid management)

Work across the HCP to agree treatment and prescribing protocols for lipid management in preparation for phase 2 of the improvement programme. Development of standardised approach to interpretation of lipid tests and stratified risk management across the region.

3.4 Increasing recorded prevalence of hypertension across WY&H HCP

4) Identify people with undiagnosed hypertension

As part of the Healthy Hearts campaign Bradford ran a 'know your numbers campaign'. This cost £50,000 and although it had an effect it was not evaluated separately to the programme as a whole.

Leeds and Bradford have received funding (c£100,000 each for a 2 year programme) from the British Heart Foundation (BHF) Blood Pressure award programme, focussed on increasing detection of hypertension. Leeds programme focusses on checks with Leeds City Council employees (manual workers) and through community pharmacies in deprived areas. Bradford programme focusses on delivering checks at community venues and through group education sessions. The programmes will be evaluated. Both programmes started in winter 2017/18.

Action and Impact
Consider adoption and spread of the Bradford and Leeds BHF funded programmes once impact of the programmes is known. There is an interim evaluation in winter 2018/19.

4. Phase 2 (lipid management) September 2019 to March 2021

1) Optimise statin treatment for those with diagnosed CHD and/or diabetes and less than optimal management of cholesterol

2) Identify those at very high risk of developing CVD and optimise treatment.

3) Identify those at high risk of developing CVD and optimise treatment.

Potential impact
The estimated adult population with a 10-year CVD risk > 20% is 175,000[1] across WY&H and of those 89,250[1] aren't treated with a statin. If this joint project identified and treated 10% 8,925 people would receive treatment and an estimated 223 to 406 CVD events would be prevented over 5 years[3].

5. Phase 3 (Reducing the risk of CVD in people with diabetes focussing on glycaemic control) March 2020 to March 2021

5.1 People with diabetes have a 5 – 8 times increased risk of CVD. Optimising control of hypertension, cholesterol and Hba1c significantly reduces that risk.

5.2 If all CCGs in the STP optimised the control of Hba1c in those with diabetes to the average of the best 5 in their group of similar 10, the RightCare data indicates that more than 4,200 people would benefit.

6. Patient and public involvement

6.1 Involving patients and the public in the development and delivery of this project is essential. The project will seek to understand and build on work already carried out in place and existing place-based mechanisms will be used to deliver any additional activity needed.

7. Resources required

7.1 The total resources required for Phase 1 actions 1,2 and 3 and for the infrastructure for phases 2 and 3 is set out below;

2018/19	£75,650
2019/20	£122,300
2020/21	£60,650
Total	£258,600

7.2 Resources have been secured from sources external to the HCP to cover the funding required for 2018/19. Public Health England has supported the development of this programme and will continue to provide support through its CVD prevention programme. Part of this support will include a programme manager for approximately 1 day per week until 31st March 2019. The British Heart Foundation has also been supportive of this approach and has confirmed in principle a range of support including education sessions and evaluation. A number of potential sources of funding have been identified for the shortfall for years 2019/20 and 20/21 including AHSN membership funding, BHF, NHS RightCare, NHSE North and the National Diabetes Prevention Programme.

8. Governance

Day to day operation

8.1 Led by Youssef Beaini (clinical lead), a small central team including a project manager (to be appointed) will work with clinical and project leads from localities to develop the treatment protocols, clinical searches, education programme and other resources needed to support CCGs and practices to take the actions outlined in this paper. Locality leads will be responsible for implementing improvements at local level using existing mechanisms to provide support and governance.

Oversight and reporting

8.2 The Joint Committee has identified Amanda Bloor and Steve Ollerton as sponsors for this project. They will provide strategic advice and support. This project will report to the Joint Committee quarterly (every 6 months to the

public session). Reporting will be aligned with Atrial Fibrillation programme update as both contribute significantly to the HCP's CVD aspirational target (2.1).

9. Recommendations

9.1 The Joint Committee is invited to recommend the West Yorkshire and Harrogate CCGs to:

a) Adopt this WY&H wide improvement project.
b) Identify a clinical and a project lead to work with the Clinical Lead and central project team to implement the actions identified in Phase 1, 2 and 3 of this project.
c) Support the reporting and governance arrangements to enable the impact of this project to be measured and assured at CCG and WY&H level.

[1] This calculation uses the same benefit (NNT) and savings estimation as PHE Size of the Prize https://www.healthcheck.nhs.uk/commissioners_and_providers/data/size_of_the_prize_and_nhs_health_check_factsheet/

[2] Ettehad, D. et al. 2016. Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis. *The Lancet*. 387 (10022), pp.957 – 967. The article can be found on The Lancet website, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01225-8/abstract

[3] (NNT 22 – 40 Cochrane Review 2013, Cholesterol treatment trialists review Lancet 2012)