

TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD**DATE: 21st March 2019****REPORT TITLE: Telford Healthy Hearts****REPORT OF: Tracey Jones Deputy Executive Quality and Engagement
Jacqui Seaton Deputy Executive Primary Care and
Medicines Management****1. RECOMMENDATIONS**

That the Board note the contents of the attached report which provides an overview of the programme of work “Telford Healthy Hearts” (THH) which the CCG is leading to improve cardiovascular health and improve outcomes for people in Telford and Wrekin.

Report of NHS Telford and Wrekin Clinical Commissioning Group To Telford and Wrekin Health and Wellbeing Board

1. Introduction

In line with the commitment within the joint Health and Wellbeing Strategy, NHS Telford and Wrekin Clinical Commissioning Group (CCG) has identified cardiovascular disease (CVD) as a priority for reducing preventable deaths and encouraging healthier lifestyles.

NHS RightCare is an NHSE approach to removing unwarranted variation to improve population healthcare. NHS RightCare produces data packs that allow local health systems to consider information from across patient pathways to identify the greatest potential improvements in spend and outcomes.

As most health conditions are linked to demographic factors such as deprivation and age, NHS RightCare compares systems to their closest demographically similar geographies. This is to provide realistic comparisons, taking into account the need for healthcare of different populations. Deprived populations will have much higher rates of admissions and worse health outcomes for conditions such as respiratory, CVD, cancer, diabetes etc. By comparing 10 demographically similar CCGs, ensures that comparisons are fair and meaningful.

Analysis of NHS Telford and Wrekin CCG's RightCare data pack concerning cardiovascular disease identified that there were opportunities for the CCG to improve both the clinical outcomes for patients and reduce associated costs, notably in non-elective admissions (Jan 2017).

The data identified quality opportunities relating to detection and improved management of CVD. These included:

- a) Improving the reported to estimated prevalence of hypertension to the average of the top 5 CCGs, which equates to an additional 1395 people
- b) Increasing the number of people with hypertension whose BP is <150/90 to the average of the top 5 CCG (additional 832 people).

Across the diabetes pathway RightCare have also identified that there are opportunities to improve hypertension management and cholesterol management.

2. Learning from success elsewhere

Following the RightCare approach, the CCG reviewed other CCGs who had successfully achieved an impact in this area.

In 2014 Bradford Districts Clinical Commissioning Group (CCG) had the seventh worst cardiovascular disease (CVD) mortality rates in under 75s England. However, local clinical and public health professionals saw a major opportunity to improve outcomes by transforming treatment of the high-risk conditions for CVD, for example, high blood pressure, high cholesterol and atrial fibrillation.

Although each of these conditions are a major risk factor for heart attack and stroke, and although preventive treatments are highly effective at preventing cardiovascular events, late diagnosis and under-treatment is commonplace.

The results of the Bradford's Healthy Hearts programme demonstrate how over a very short period of time, 21,000 people had their treatment optimised and over 200 fewer people suffered heart attacks or strokes. NHS RightCare is promoting the Bradford approach as a proven methodology to reduce variation in care and outcomes from CVD with associated reductions in costs.

The CCG's Head of Medicines Management arranged a protected learning time event for General Practitioners and Practice Nurses to hear directly from the staff who had implemented the programme in Bradford. This received exceedingly positive feedback from the attendees and a decision was taken to develop a similar programme of work within Telford and Wrekin.

3. Overview of Telford Healthy Hearts

Telford Healthy Hearts is a year-long programme that follows the principles and processes used in Bradford CCG with the aim of achieving a 10 % reduction in the

number of heart attacks and strokes as well as improvements in the detection and management of risk factors associated with these events. These measures are identified below:

Lipids

To increase the percentage of people with QRISK scores >10 who are on high intensity statins to 85 % (Baseline 54% (average)). Monitoring will be by individual practices with aim of all practices achieving 80%

Hypertension

To increase the % of patients, age 79 years and younger, with hypertension treated to target less than or equal to 140/90

To increase the % of patients, age 80 years and over, with hypertension treated to target less than or equal to 150/90

Atrial Fibrillation

To increase the % of patients diagnosed with atrial fibrillation who are on anticoagulants from 70 to 90%

In brief, General Practices will identify through their clinical systems patients who are at increased risk of heart attack and strokes and review their current medications to ensure that patients are being prescribed the most effective type and dosage .This process has been designed to enable the General Practitioner to screen out those patients for whom there is a clinical exceptionality to the prescribing changes.

Patients who could benefit from changes will be contacted by letter to inform them of the changes that have been made to their next prescription and given an option to opt out by returning a slip to their practice. As part of the letter which will detail why they have been identified, information about where to find help to make changes will be shared. This includes the Telford Healthy Hearts webpage

<https://www.telfordccg.nhs.uk/your-health/telford-healthy-hearts> as well as Telford Healthy Lifestyle services

http://www.telford.gov.uk/info/20087/healthy_telford/687/healthy_lifestyle_hub

Telephone: 01952 382582

The clinical components are supported through a communication and engagement approach that aims to provide/ signpost people with high risk factors to reliable information sources and available resources in the community to achieve behavioural changes. This stream of work is part of our joint asset based approach that has been developed through our CCG and Local Council neighbourhood programme.

The information below provides a greater level of detail of the areas of clinical intervention and the accompanying communication and engagement work that will underpin the project.

4. Clinical Workstream

A clinical lead has been identified in every Telford and Wrekin practice and monthly face to face meetings are being held with the clinical leads to ensure engagement and progress (these meetings commenced in Dec 2018).

To assist practice staff in enabling people to make changes to their lifestyle factors when people attend their GP for routine appointments the CCG has commissioned Motivational Interviewing training. This is being provided to all Telford and Wrekin practices as part of the THH work. The offer has also been extended to Healthy Lifestyle Advisers and community pharmacists. This training will take place in March and May 2019.

Clinically there will be four workstreams – each lasting 3 months and running in sequence:

Statin dose optimisation

- This is the first workstream and will run until May/June 2019
- This involves identifying people with cardiovascular risks (i.e. > 10% risk over the next 10 years) and those with existing cardiovascular disease and ensuring that they are offered statin treatment as appropriate.
- It also involves identifying people with cardiovascular risks and those with cardiovascular disease who are prescribed a statin that is not a high intensity

statin. These patients will be offered and encouraged to accept dose optimisation where appropriate.

- Centralised EMIS searches have been performed to support this work. Template letters have been drafted and approved and clinical management guidelines are in place.
- The letters used to inform patients of the changes have been used successfully in Bradford.

Hypertension

- This involves identifying patients who haven't yet been diagnosed with hypertension and ensuring that they are offered appropriate treatment.
- It also involves ensuring that people are treated to target and receiving optimal treatment.
- Patients will be encouraged to get more involved in the management of their hypertension by increasing population understanding of blood pressure readings, understanding targets and understanding the risks associated with hypertension.
- As part of this workstream we will be designing an optimal Hypertension Management Pathway that works for patients and an overstretched Primary Care system – we will be looking at the monitoring requirements associated with the drugs and ensure that the monitoring burden is limited to encourage improved management and better attainment of the NICE treatment targets (where appropriate).
- The CCG will be working closely with Telford & Wrekin Council's Public Health Team following their successful bid to the British Heart Foundation to pilot a community blood pressure monitoring service. Further information about this project is provided in Appendix Two.

Atrial Fibrillation

- This workstream will focus on identifying people with atrial fibrillation and ensuring that they are receiving appropriate treatment (particularly anticoagulant treatment)
- There will be a focus on patient education to ensure that there is a population understanding of atrial fibrillation and the risks associated with the condition. The education will also focus on the benefits of anticoagulant treatment.

Heart Failure

- This workstream will focus on ensuring that patients diagnosed with heart failure are receiving optimal treatment.

5. Communication and Engagement

The aim of the communication and engagement elements is twofold:

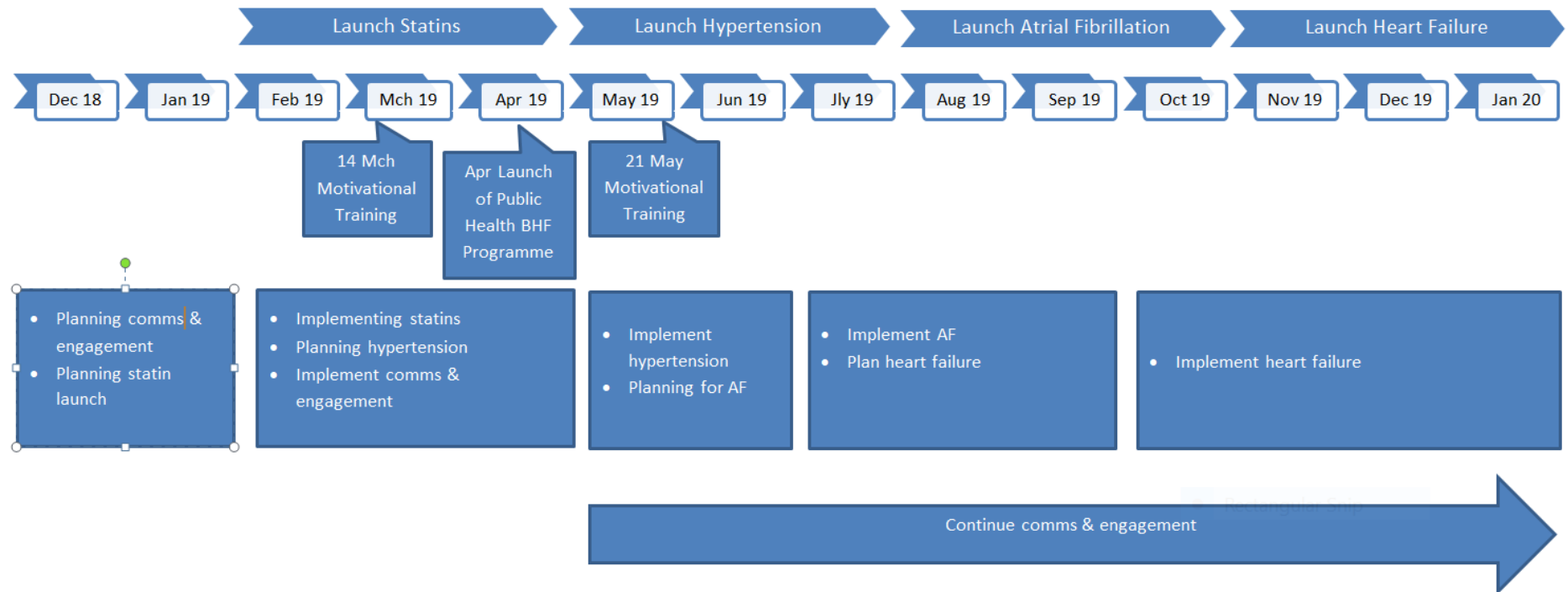
- a) To assist people in being aware of the THH programme.
- b) To provide information as to why this approach is being adopted and where they can source assistance to make lifestyle changes.

To promote awareness of the campaign, a combination of methods will be utilised:

- Collaborative working with community sector partners including Patient Participation Groups, Telford and Wrekin Healthwatch, Community Health Champions, Age UK.
- Commissioning of paid for media.
- Use of social media channels.
- Attendance at community group events across the duration of the programme including targeted attendance for groups at higher risk.
- Resources available to support the second aim include pull up banners, posters, information leaflets and web based resources.

Appendix One

Telford Healthy Hearts Timeline



Appendix Two Public Health / British Heart Foundation Hypertension Detection Project



BHF Project
Appendix Two.docx