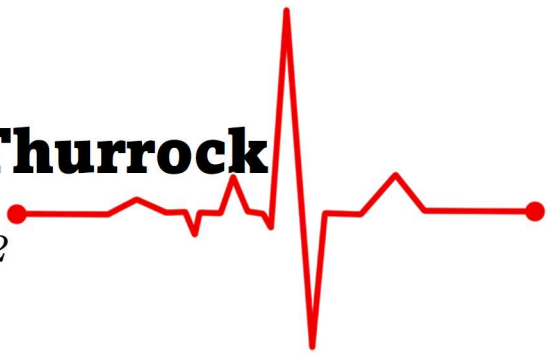
Reducing the Impact of Cardiovascular Disease in Thurrock



Annual Report of the Director of Public Health, 2022

Thurrock Public Health

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Foreword

In my first Annual Public Health Report for Thurrock, I have chosen to look back at the impact of the report from 2016, with a view to identifying further improvements in care for long term health conditions, looking through the lens of improving outcomes for cardiovascular disease (CVD).

The COVID-19 pandemic has highlighted the impact of profound and enduring inequalities in health across the country and CVD remains the clinical condition that contributes most to inequalities in premature mortality across the community. A relentless focus on improving quality of care for and reducing inequalities in CVD should not just improve CVD outcomes but also identify broader improvements in health and care services.

Much CVD care happens in General Practice, and many recommendations from 2016 were directed at this element of care. Despite the disruptive impact of the COVID-19 pandemic on General Practice, measurable improvements in quality of care for CVD since 2016 can be identified in Thurrock. However, we have also identified inequalities in CVD outcomes that can and must be addressed, including for people from a minority ethnic background, people living with serious mental illness and people with learning disability.

Thurrock Public Health Team will continue its close partnership working with local GPs to build on the gains made since 2016 and close the inequality gaps we have identified.

Dr Jo Broadbent

Director of Public Health

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Executive Summary

The 2016 Annual Public Health Report for Thurrock[1] explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. A number of issues were highlighted, including variable access to primary care, differences in the quality of care between practices, and associated impacts on patients and consequent hospital admissions. The report made a series of recommendations to increase the effectiveness and cost-effectiveness of care in Thurrock across a range of health conditions. Much has changed since 2016, both proactively in terms of national health policy and local health systems, and reactively as a consequence of the Covid-19 pandemic. This report reviews progress since then for one of the LTC clusters outlined in the 2016 report: Cardiovascular Disease (CVD).

Why focus on Cardiovascular Disease?

Of all the disease groups, CVD causes the highest levels of premature mortality: 1 in 4 premature deaths (before age 75) in the UK are due to CVD and it is the leading contributor to health inequalities[2]. Analysis of local data shows that for mortality attributable to socio-economic inequality, CVD is also the greatest contributor in Thurrock, accounting for 35% of excess deaths[3]. Yet if risks are detected and managed in line with NICE guidance, focusing on CVD provides the greatest potential to reduce health inequalities and reduce premature mortality. As outlined by the World Health Organisation (WHO), the key behavioural risk factors for CVD are smoking, unhealthy diet/obesity, lack of physical activity, and harmful use of alcohol[4], all risks which can be ameliorated with support and appropriate policies.

What has changed since 2016?

Both national and local drivers of CVD care have developed since 2016. The NHS Long Term Plan, published in 2019, set out a range of goals for reducing the number of strokes and heart attacks and reducing the inequalities associated with CVD by 2029, with a particular focus on high blood pressure (hypertension).

Improvements in clinical pathways for CVD in Thurrock have been seen since 2016[2]. However, part-suspension of QOF during the pandemic has made it difficult to make direct comparisons with the findings of the 2016 report. (Moreover, exact comparison with the 2016 report is not appropriate due to nationally driven organisational change in primary care with the establishment of Primary Care Networks). Measurable quality improvements do include:

- Whilst it is not possible to attribute success to individual initiatives, overall analysis does show that numbers of diagnoses for hypertension across Thurrock have increased from 1,321 in 2016/17 to 2,567 in 2021/22. There is still a gap between current register numbers for cases of hypertension and the national target that 80% of expected cases be detected by 2029, but the gap is smaller in Thurrock than in other areas of MSE. When it comes to treatment of patients on the hypertension register, all four Thurrock PCNs are working beyond the national target for those aged over 80, and close to target for those below 80, and again are achieving higher rates of treatment to target than neighbours in MSE.

- There have also been improvements locally in the treatment of patients with atrial fibrillation, where Thurrock is already exceeding the national target, though when it comes to detection there is still a gap (of around 260 cases) between the current recorded prevalence and national target.
- There is still a significant gap between expected and diagnosed prevalence of high cholesterol, with fewer than one third of the expected numbers having a formal diagnosis but the quality of care for those on Coronary Heart Disease (CHD) registers is high.

Key Findings and Recommendations

More detail on each of the findings, references and recommendations can be found in the full report.

	Key Findings	Recommendations
1	Most of Mid and South Essex is in the quartile in England with the most patients per GP, and the situation is worst in Thurrock, with 2,296 patients per GP (increased from 2,110 per GP in 2016), which is the third highest list size per GP in England.	Thurrock Integrated Care Alliance (TICA) should work with Mid and South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock PCNs, to avoid increasing health inequalities associated with access and quality in primary care.
2	The COVID-19 pandemic has exposed and worsened health inequalities. It has had adverse effects on people's physical and mental health, and on demand and access to health and care services, including prevention and management of CVD.	Refresh the focus on primary prevention of CVD post-COVID-19, including: • Tobacco control • Reducing obesity • Focusing on healthy behaviours in early years
3	The development of Integrated Medical and Wellbeing Centres (IMWCs) is an opportunity to deliver: • More personalised, proactive care, with a more collaborative and flexible approach • An integrated service bringing together health, wellbeing and social care services in multi-disciplinary LTCs teams.	Promote personalised, collaborative and holistic care planning, for example the House of Care using an evidence-based model, alongside instigating long term condition specialists and multi-disciplinary working within the IMWCs. New models of working should include maximising potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new IMWC model.
4	The evidence base shows that: • Focusing on the processes and tools of transformation is not sufficient	In designing new holistic care models, TICA should specifically consider:

	when seeking a shift to co-production • Goals linked to the patient's starting point will be more successful • The Patient Activation Measure (PAM) can assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support • Health Coaching can support outcome improvement through motivational techniques and focusing on the individual's starting point	• That transformation programmes need to be built around how to achieve cultural shifts in practice • The benefits of health goals being contextualised within the patient's life and personal priorities • Adopting the Patient Activation Measure (PAM) • Training a range of staff in primary care, integrated teams in Health Coaching, prioritising patients identified through PAMs at the lowest levels of engagement
5	Whilst it is not possible to attribute success to individual initiatives, joint working between public health and primary care, such as Stretch QOF, have produced measurable improvements in quality of care for hypertension, CHD and atrial fibrillation since 2016.	Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.
6.1	Case studies of best practice consistently demonstrate the potential for the wider community health and care workforce to contribute to CVD prevention and diagnosis.	In seeking further improvements in care for specific CVD conditions (and other LTCs), services should consider developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists, Community Social Care roles) and considering how broader roles might enhance LTC services for patients.
6.2	Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health through improving CVD outcomes are likely to be gained by a focus on reducing gaps in diagnosis.	Implement systematic and targeted case finding for atrial fibrillation, CHD and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs.
6.3	Evidence suggests that the NHS Health Checks programme needs to be more targeted in order to increase uptake in those with most to benefit – which includes people living in more deprived areas and/or those from BME groups at the younger age limit.	Target NHS Health Checks for people at the younger age limit in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.

6.4	Thurrock has the second highest premature mortality rate in England due to CVD in people living with SMI in 2018-20. Heart disease is the second highest cause of death amongst people with a learning disability. Despite, this follow-up of risks identified during physical health checks is low – for example, fewer than 1/3 of those with SMI having high cholesterol were followed up in primary care in 2021/22.	Maximise uptake and associated follow-up of physical health checks for people living with SMI and who have a learning disability.

Conclusions

Assessing the impact of initiatives put in place since 2016 to improve CVD outcomes is hampered by the impact of the COVID-19 pandemic on implementation, changes in access to primary care, the primary care workforce and data-capture, but there is evidence of measurable improvement in the quality of care for CVD in Thurrock since 2016. Given the impact of the pandemic, however, on widening inequalities, the case for improved identification and management of CVD is even more pressing.

The most recent Marmot review[3] stresses the need to re-focus on prevention in order to reduce the inequalities exacerbated by COVID-19. Given the high rates of smoking and obesity in Thurrock, increased identification and improved management of cardiovascular conditions will not alone address the inequalities currently associated with CVD in the borough; prioritising wider action to increase access to healthy foods, provide support for individuals to manage their weight, increase physical activity and reduce smoking is required. In addition, opportunities to identify those at increased risk of CVD, through NHS Health Checks and other case finding programmes, need to be targeted in areas of higher deprivation and for population groups with most to gain.

There have been some positive changes in primary care staffing since the 2016 report, but these are set against local and national concerns about ongoing workforce pressures, and Thurrock remains significantly under-doctored. The first IMWC to open has been in Corringham, where innovative practice in obesity can already be found. However, in Thurrock there is greater need in Tilbury & Chadwell and in ASOP, both in terms of constraints on primary care capacity and greater levels of patient need. These areas should therefore be prioritised for additional workforce capacity and adoption of new models of care, in order to avoid widening health inequalities further.

Despite the challenges of workforce pressures and the pandemic, there have already been improvements through initiatives implemented and developed since the 2016 report, notably the use of public health data to support practices, Stretch-QOF, and generation of additional workforce capacity with new roles in primary care.

Looking through the lens of CVD care, this report makes further recommendations on how holistic care activity could be directed to support different patient groups. The literature on changing models of care is clear that care for people with multiple needs requires to become more personalised, more coordinated and more collaborative if patients are to be engaged in optimising their health, and if both demand on the system and health inequalities are to be reduced. This means, for example, that Stretch QOF needs to be more holistic, focused on patient outcomes overall rather than individual disease targets. However, a shift towards more collaborative, co-produced care requires fundamental shifts in culture, investment in staff (for example training) as well as time to embed. Achieving this at the same time as seeking to reduce variation between and within PCNs and manage workforce constraints is a significant challenge. Time, training and opportunities for co-production and shared reflection on cultural change, in addition to continued collaboration between public health and primary care to understand the data driving and measuring this work, are needed to support this shift.

Long Term Conditions covered in this report

- Hypertension (High blood pressure)
- Atrial fibrillation (a heart rhythm problem, characterised by a rapid, irregular heartbeat)
- Raised cholesterol (Coronary Heart Disease; CHD)
- Familial hypercholesterolaemia
- People who have had a stroke or TIA (transient ischaemic attack, also known as a mini-stroke)
- Diabetes – CVD related risk only (people with diabetes are at increased risk of CVD and a range of other complications)