Report for: Heath and Wellbeing Board – 3 October 2016

Title: Cardiovascular Disease and Diabetes in Haringey and Islington – a population perspective and opportunities within the Haringey and Islington Wellbeing Partnership

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1. Describe the issue under consideration

1.1 This paper gives an overview of health and care needs relating to diabetes and cardiovascular disease (which includes heart disease and strokes) in Haringey and Islington.

1.2 This paper outlines opportunities to take a population based approach to improving outcomes for cardiovascular disease and diabetes, in a way that is financially sustainable, through the work of the Haringey and Islington Wellbeing Partnership.

1.3 There are particular opportunities relating to:

- Improvements in the health and social care model for people with diabetes and CVD, including early detection and prevention of cardiovascular disease and diabetes.
- Acting at population level to put preventative initiatives or policies in place that will keep people healthy.

2. Recommendations

2.1 That the Health and Wellbeing Boards note the issues raised in this paper and areas of good practice highlighted within the paper appendix attached.

2.2 That the Health and Wellbeing Boards note and comment on the opportunities for improving population health outcomes and value for money for cardiovascular disease and diabetes prevention and care through the Haringey and Islington Wellbeing Partnership.

3. Background information

3.1 Cardiovascular disease is a general term which describes a disease of the heart or blood vessels. Cardiovascular disease include strokes and heart disease. Because most cases of cardiovascular disease are a direct result of risk factors such as smoking and poor diet, the majority of cardiovascular disease is preventable.

3.2 Diabetes is a long-term health condition which is caused by the inability of the body to produce or respond correctly to the hormone insulin, which regulates blood sugar levels. Around 90% of people have type 2 diabetes which is closely linked to overweight and obesity (and is therefore generally preventable) and around 10% of people have type 1 diabetes, which is not linked to overweight and obesity and commonly starts in childhood or young adulthood.

3.3 Diabetes is not in itself a cardiovascular disease, but people with diabetes are at a greatly increased risk of developing cardiovascular disease, and the conditions are closely linked.

3.4 Population health needs and issues

3.5 Cardiovascular disease is a leading cause of death in both Haringey and Islington. As in the rest of the country, the numbers of people dying early (under the age of 75) from cardiovascular disease in Haringey and Islington has fallen in recent years. However, death rates in both boroughs still remain higher than the London average.[1]

3.6 Cardiovascular disease is also one of the major contributors to health inequalities – especially the gap in life expectancy – in Haringey and Islington.

3.7 Risk factors for cardiovascular disease and diabetes

3.8 Large numbers of people in Haringey and Islington have one or more risk factors for cardiovascular disease. For example, in Haringey and Islington.

- 1 in 5 people smoke
- 1 in 5 people have high blood pressure
- Nearly 2 in 3 people are overweight or obese (this is also the most significant risk factor for diabetes).

3.9 These risk factors are in turn linked to the wider social and environmental conditions that people live in.

3.10 Numbers of people with diabetes and cardiovascular disease.

[1] Source Public Health Outcomes Framework

3.11 Around 23,000[2] people (over 5% of the adult population) in Haringey and Islington are diagnosed with diabetes, with a further 6,000 estimated to have undiagnosed diabetes. National and local evidence suggests that people from South Asian, Black Caribbean, Black African and Turkish backgrounds are more likely to have type 2 diabetes.

3.12 A significant proportion of people with diabetes will also be living with other physical or mental health conditions. For example it is estimated that around 1 in 5 people with diabetes may also have some degree of depression.

3.13 The numbers of people diagnosed with cardiovascular disease is also significant, over 8,000 people are diagnosed with coronary heart disease and around 5,000 people have had a previous stroke in Haringey and Islington.[2]

3.14 Financial impact on health and care services

3.15 Benchmarking analysis (NHS Right Care) shows that Haringey CCG is spending £1.2 million more per year and Islington CCG £1million per year more on non-elective (emergency) care for cardiovascular disease compared to our best performing comparator CCGs. Much of this spend is due to heart attacks and strokes that could be prevented.

3.16 While we don't have firm figures on the proportion of adult social care spend that results from CVD and diabetes, we know that work in Greenwich identified that 66% of people in long-term residential care had at least one CVD diagnosis (including diabetes).

3.17 Taking a population approach to improving outcomes for diabetes and CVD in Haringey and Islington

3.18 In order to think about how we best improve population health outcomes for cardiovascular disease and diabetes it is helpful to look at different segments of the whole population, as described in the table below.

1. The whole population
2. People who are at high risk of developing cardiovascular disease or diabetes, (such as those who smoke or have pre-diabetes or high blood pressure)
3. People who are living with diabetes or cardiovascular disease

[2] Source: Quality Outcomes Framework 2014-15.

People who are living with diabetes and cardiovascular disease who have complex health and care needs. **Population segment**	**Example of size of population in Haringey and Islington**	**Local examples of existing approaches to improving outcomes.**
Whole population approaches	Over 500,000 people	Haringey obesity alliance Making every contact count Healthy High Streets
People who are at high risk of diabetes or cardiovascular disease	Over 100,000 people with high blood pressure. Over 80,000 people who smoke	Case finding for high blood pressure Diabetes prevention programme
People living with diabetes or cardiovascular disease	Over 23,000 people diagnosed with diabetes Over 8,000 people diagnosed with coronary heart disease	Care planning Self-management support Community diabetes nurses Value based commissioning for diabetes – The diabetes integrated practice unit.
People living with diabetes and/or cardiovascular disease who have complex health and care needs	Estimated as about 1% of the population (5,000 people)	Integrated locality teams

3.19 As captured in the table above there are many examples of good practice relating to the prevention and care of people with diabetes and cardiovascular disease in Haringey and Islington. There is further information on these examples in the accompanying slide pack:

3.20 However, in spite of the good practice highlighted above, there are still significant issues and gaps:

- There are large numbers of people who have cardiovascular conditions or diabetes but are not diagnosed.

- While there are many examples of excellent primary care for people with diabetes and cardiovascular disease, there is also evidence that many people are not receiving high quality primary care for diabetes and cardiovascular disease, much of which is about systematically applying interventions with a strong-evidence base such as tight blood pressure control and kidney checks in people with diabetes.

- There is a recognition that primary care is under-resourced, for example in terms of the numbers of practice nurses and GPs, particularly in Haringey. At present the majority of spend on diabetes and CVD care is on hospital care and high cost social care. As a system we do not have an effective mechanism for shifting investment towards primary care and prevention.

- People with long-term conditions often report feeling that they do not get the support that they need, and that their care is not joined up.

- Prevention services such as smoking cessation services are relatively small scale and are only reaching a small proportion of the at-risk population.

- Evidence-based self-management and patient education programmes are only being accessed by a minority of people with diabetes and cardiovascular disease.

- Our approaches for supporting local communities to improve their health and wellbeing could be improved.

- The environments that many Haringey and Islington residents live in do not make healthy choices easy for our residents.

3.21 Opportunities to improve population health outcomes and financial sustainability for diabetes and CVD care through the Haringey and Islington Wellbeing Partnership

3.22 The emergence of the Haringey and Islington Wellbeing Partnership provides an opportunity to improve our population-based approach to cardiovascular disease and diabetes. The partnership has a number of strengths.

- A strong understanding of our local population and their needs

- Strong, progressive relationships at senior levels already in place in local government and the NHS; across primary, community, hospital, mental health and social care
- A senior board overseeing the Haringey and Islington Wellbeing Partnership
- A proven track-record of delivering successful integrated care initiatives e.g. Integrated MH practice teams, Integrated Community Ageing Team, Learning Disability Partnership, ambulatory care

3.23 These strengths mean that the Haringey and Islington Wellbeing Partnership has the potential to be a vehicle that will drive improvements in cardiovascular and diabetes care and prevention.

3.24 There is a diabetes and cardiovascular disease work-stream of the Haringey and Islington Wellbeing Partnership and we have already begun to scope this area of work with our partners.

3.25 Some significant opportunities for collaborative working have been identified, as follows:

1. <u>Working as a whole system to develop a sustainable integrated model of clinical and social care for people with diabetes and cardiovascular disease</u>

3.26 This would build on previous collaborative working on value-based commissioning for diabetes, which is about working as a system to improve outcomes of care that have been jointly identified by service users and clinicians.

3.27 An integrated model of care has already been designed as part of the value based commissioning work for diabetes. The Haringey and Islington Partnership could help take this work forward by overcoming some of the barriers to current implementation, including stronger investment in and involvement of primary care, identifying appropriate estates for care delivery and developing integrated IT solutions.

2. <u>Whole population approaches to preventing cardiovascular disease and diabetes</u>

3.28 While improving the quality and value for money of the clinical and social care model for people with diabetes and cardiovascular disease is crucial, there are likely to be equally significant gains for population health and wellbeing by improving our whole population approach to prevention of cardiovascular disease.

3.29 Through the cardiovascular disease and diabetes work-stream of the Haringey and Islington Wellbeing Partnership we are looking to identify the population-wide approaches that will have the most impact on cardiovascular health and wellbeing and the best return on investment. This might, for example, build on and strengthen existing programmes in place in both Local Authorities, such as

the Making Every Contact Count approach to behaviour change and the Healthy Schools programme – and new approaches such as the Haringey devolution prevention pilot focus on tighter controls on tobacco and alcohol.

3.30 Links to the North Central London Sustainability and Transformation Plan

3.31 A number of the themes described in this paper are also acknowledged as part of the Case for Change for the North Central London Sustainability and Transformation Plan[3] including:

- Challenges in primary care provision
- A lack of focus on prevention across North Central London
- Gaps in early detection of disease
- Lack of integrated care and support for people with long-term conditions.

3.32 While the North Central London Sustainability and Transformation Plan will provide a framework to tackling some of these challenges, many of the solutions will need to be implemented at a local level, and the Haringey and Islington Wellbeing Partnership is a potential vehicle to do this.

3.33 Next steps

The opportunities outlined above will continue to be taken forward through the Haringey and Islington Wellbeing Partnership.

4. Contribution to strategic outcomes

4.1 This work relates to priorities identified in:

1. Haringey's Joint Health and Wellbeing Strategy 2015-2018
    - Increasing healthy life expectancy objective

2. Islington's Joint Health and Wellbeing Strategy 2013-16
    - In particular strategic outcome 2:
        - Preventing and managing long term conditions to enhance both length and quality of life and reduce health inequalities

5. Statutory Office Comments (Legal and Finance)

5.1 Legal

There are no legal implications arising from the recommendations in this report.

5.2 Finance

There are no financial implications arising from the recommendations in this report.

6. Environmental Implications

6.1 There are no significant environmental implications arising directly from this report.

7. Resident and Equalities Implications

7.1 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

7.2 A resident impact assessment has not been completed because an assessment is not necessary in this instance.

8. Use of Appendices

8.1 None.

9. Background papers

9.1 None.