REPORT TO:	Health and Wellbeing Board
DATE:	17th September 2013
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Hypertension – a joint approach
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform members of Halton's Health and Wellbeing Board of the identification of Hypertension as a priority through the champs approach to prioritising areas for healthcare action and the implications for Halton.

2.0 **RECOMMENDATION: That the Board note**

1. **that Hypertension is a key cause of premature mortality in Halton;**

2. **there is underdiagnoses of hypertension nationally and in Halton; and**

3. **endorse the future plans for action in the area of Hypertension**

3.0 **SUPPORTING INFORMATION**

3.1 Champs is a collaborative service, where nine local authority public health teams work together to enable greater access to public health expertise and advice in Cheshire and Merseyside.

3.2 Local public health teams, under the leadership of their Director of Public Health, are fundamental to the delivery of the Champs public health collaborative service and are leading on key areas of work to improve health and wellbeing for their populations. They are supported in this by the Champs support team which enable local teams to work together effectively to achieve better quality services, increased value for money and improved health outcomes for the local populations of Cheshire and Merseyside. The team is the engine room to facilitate co-operation, knowledge transfer, contacts, networking and development for colleagues working in public health.

3.3 Champs is collaborating with local NHS partners across Cheshire and

Merseyside in order to support joint programmes of work for population health care. Given the competing demands and to support the delivery of this objective the Champs healthcare leads group require clear priorities that are objectively defined.

3.4 A project took place to identify and agree the priorities that will be used to inform the work plan for healthcare public health. It was led by a Public Health Consultant from Halton. This paper outlines the process used and the local implications of this.

4.0 Prioritisation

Using a two stage approach data was collected and compared to chosen priorities of healthcare partner organisations including 12 Clinical Commissioning Groups, nine Health and Wellbeing Boards, Strategic Clinical Networks and Public Health England

4.1 The methodology used has been recognised nationally and the process is being presented at a national conference. An abstract on the prioritisation approach has been accepted as a poster to the PHE conference in 17-18th September 2014. (See Appendix1)

4.2 Findings from Prioritisation

Three local priorities matched those generated by the data: mental illness (highest cost to NHS), cancer (largest cause of premature mortality) and unplanned/urgent care (high rate of 30 day re-admissions). These concur with Halton CCGs priorities.

The review highlighted priorities not chosen by partners. These are hypertension (largest disease register), liver disease (worst rate of premature mortality) and respiratory disease (large cause of hospital admissions). Much of the cause of liver disease relates to alcohol which is already a Halton HWB priority. A respiratory strategy is already in development locally. Hypertension was chosen as a key area for action at the last CCG primary care model development workshop in August.

4.3 The findings have been shared with a range of local partners which has in turn influenced the way in which the Champs team is developing its work plan. There has been early informal sharing of these findings with the relevant CCG commissioners during the writing of the Better Care Fund proposals as the public health consultant lead for this project was Halton based. Preliminary sharing of results with partners has been welcomed, with requests for additional support on priorities from the SCNs and the Merseyside Primary Care Strategic Forum. The latter has chosen to focus a stream of work on hypertension.

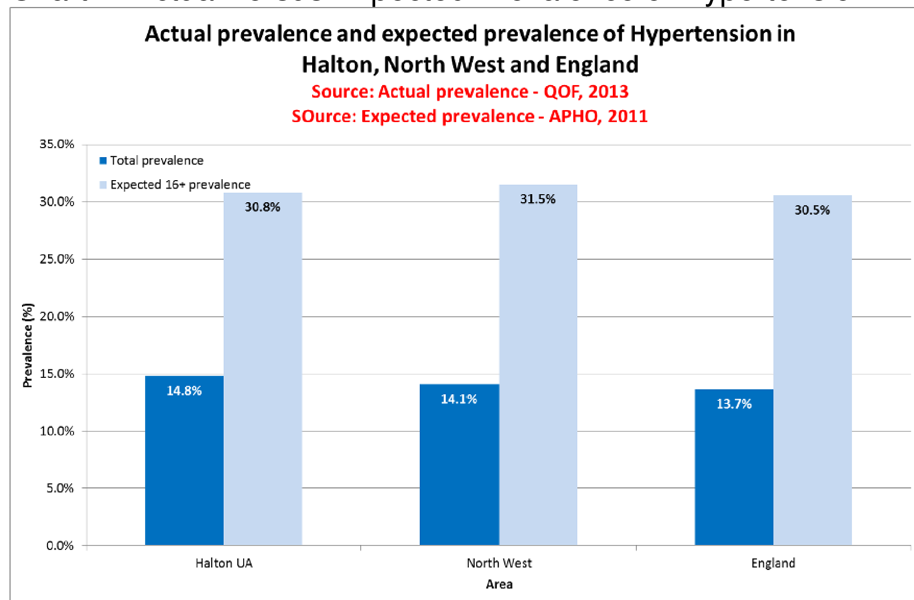
4.4 Hypertension was discussed as a key work stream at the CCG organised NHS IQ event in August. A working group has been formed to develop a system wide approach to tackling the issue.

5.0 Hypertension

5.1 There are currently 19,093 adults in Halton on primary care registers (QOF Registers) with hypertension. This represents 14.8% of the adult population.

5.2 There are an estimated 30.8 % people with Hypertension living in Halton. This means that about 20 000 adults have this condition but have not been diagnosed.

Chart 1. Actual versus Expected Prevalence of Hypertension



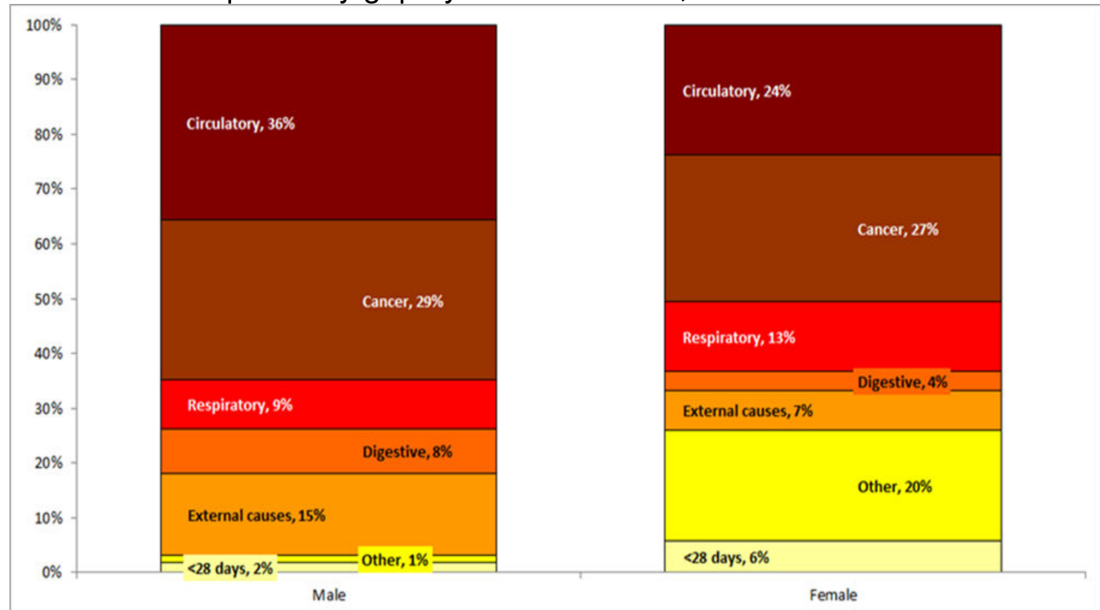
In chart 1 above the darker bar represents those with a diagnosis of hypertension and the lighter bar those who have hypertension but have not been diagnosed with it, this is the expected number based on modelled estimates.

5.3 Hypertension is a risk factor for cardiovascular disease which includes heart attacks and strokes. In addition certain behaviour such as drinking alcohol, high sugary and fatty food intake, smoking and poor physical activity increases the risk. There are some risk factors that are independent of behaviours such as age, sex, ethnicity and deprivation. Unfortunately across England 45% of hypertension remains undiagnosed until an acute event occurs.

5.4 Heart attacks and stroke (circulatory disease) is a leading cause of premature deaths locally. There are inequalities in how people are affected by heart attacks and stroke. The effect of deprivation increases the impact of the conditions by causing more deaths.

Chart 2 below is a scarf chart showing the breakdown of the life expectancy gap between Halton's most deprived quintile and Halton least deprived quintile. The life expectancy gap is the percentage increase in deaths between those who live in the lowest and highest areas of deprivation in Halton, caused by the main conditions listed below. From Chart 2 below, for men in Halton heart attacks and deaths occur 36% more in the most deprived groups and for women the figure is 24%

Chart 2. Life expectancy gap by cause of death, 2009-2011.



There appears to be variation between GP practices in identifying hypertension. For example, in Halton registered prevalence ranges from 8.8% to 17.6%. Chart 3 shows the % difference between the recorded diagnosis of hypertension and the modelled estimate in each practice.

Chart 3. Difference between expected and recorded prevalence

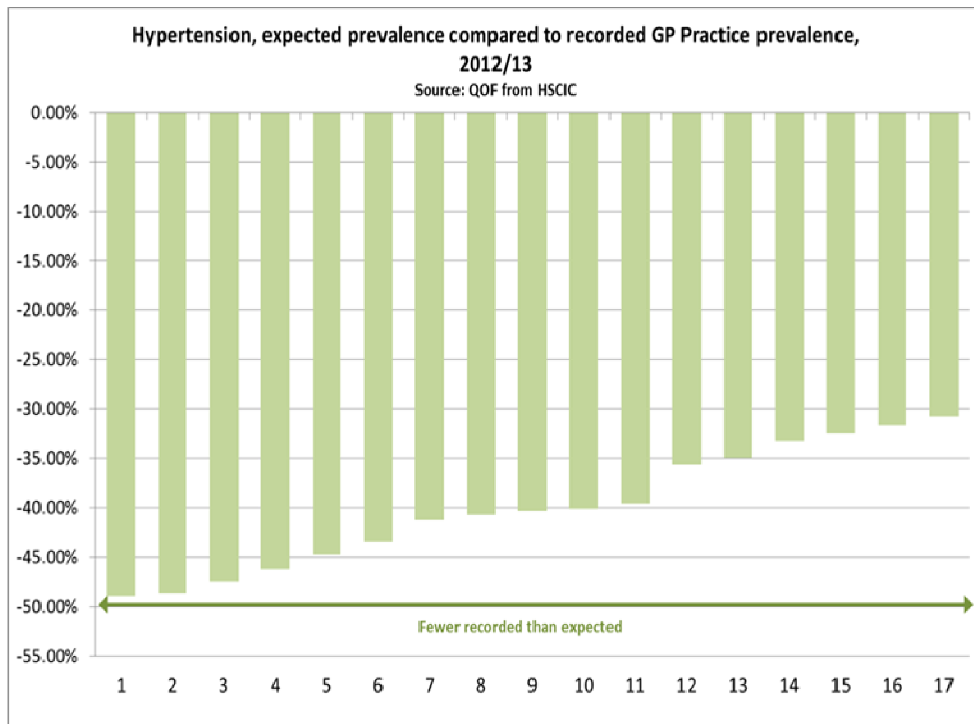
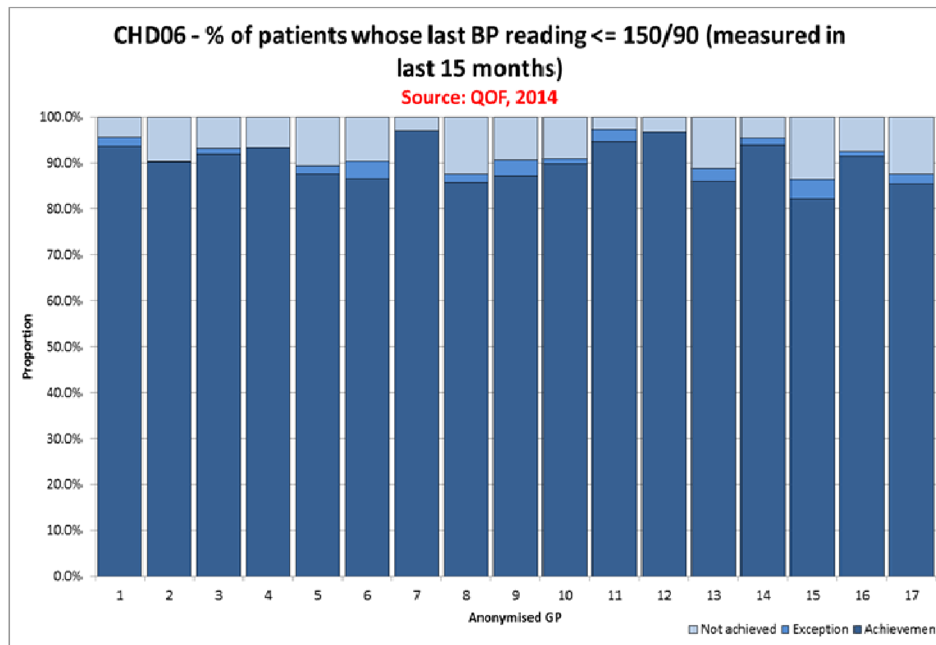


Chart 3 above shows for each practice the percentage difference between what modelling suggests is the number of people with hypertension and the number who are diagnosed with it. In Halton the range is from about 30-50% more people who should be on practice registers. This matches the national pattern.

The variation also extends to management of hypertension. The primary care registers for hypertension records how many patients have had a blood pressure check and if this is optimal in a set time period. Chart 4 shows the percentage of people on the registers that have had optimal blood pressure measurements in the preceding 15 month period which is shown by the dark bars, the lightest much smaller bars show the percentage who have had no checks in the prior 15 months and the other show the exceptions which is those who have been excluded for some reason. It should be remembered that an equally high number are not benefitting from the optimisation of treatment and care as they have not been identified as hypertensive in the first instance. It is important to note that some variation is natural and should be expected and that patient choice is often a factor.

Chart 4. Hypertension management of current population



6.0 **Future plans**

The prioritisation process has identified Hypertension as a work area for action across the region. There are two key opportunities for a system wide approach to tackling Hypertension: identification and treatment optimisation

6.1 **Identification**- finding the missing 20 000

Modelling indicates that about 20 000 additional people in Halton could have hypertension. Finding these people will enable them have access to a range of lifestyle and treatment options which could prevent the risk of further cardiovascular disease.

6.2 Working together to promote NHS Health Checks - Of the 2179 people who had a NHS HealthChecks last year 8.5% (185 people) had a CVD risk score of 20 or above and 2.6% (57people) had hypertension. This indicates that by conducting more checks it is likely that more people with hypertension will be found. But the case finding needs to be scaled up.

6.3 Targeted NHS Health Checks and systematic searches – There may also be an opportunity to target NHS Health Checks using computer searches to identify those who; have a high CVD risk, other long term conditions, a number of known risk factors e.g. obesity, high levels of drinking alcohol; patients with more than one high blood pressure reading without a diagnosis and therefore not on register, or those who have had a borderline high blood pressure.

6.4 Other opportunistic interventions – There are a range of other interventions that could be used. For example blood pressure monitors in practice reception areas; targeting other at risk groups e.g. flu clinics, outreach and or a public campaign.

6.5 Insight work is required to understand why people who may be

hypertensive are not presenting to primary care. This will enable the appropriate shaping of a publicity drive and future social marketing approaches. Key questions remain as to why a cohort of individuals do not attend primary care.

6.6 **Optimising Management**

Potential work areas include

- 'Deep Dive' from the Commissioning for Value/Right Care Team
- Audit of current management against NICE quality standards
- Developing locally agreed quality standards which reflect outcomes
- Develop a local network approach

All people with a diagnosis should as a minimum receive NICE recommended care and treatment. As mentioned earlier a CCG led working group has been formed and will be developing a system wide approach. A Halton cardiovascular disease strategy is in early development and the regional cardiovascular strategic clinical network and Merseyside primary care strategic forum have prioritised hypertension as a result of the Champs approach.

7.0 POLICY IMPLICATIONS

The prioritisation process identifies areas of work across Cheshire and Merseyside. Work programmes are being developed that will enable progress in local delivery of the national outcomes frameworks for the NHS and Public Health.

8.0 OTHER/FINANCIAL IMPLICATIONS

8.1 The diagnosis, treatment and follow-up of patients with hypertension is one of the most common interventions in primary care, accounting for approximately 12% of primary care consultation episodes. It is estimated that, in England alone, the cost of drugs used for lowering blood pressure is £840 million per year – almost 15% of the total annual cost of drugs in primary care.

8.2 The commissioning for value pack for CVD across Merseyside suggest that there are £830,000 opportunity costs that could be saved by reducing CVD related hospital admissions.

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

9.1 Children and Young People in Halton

None directly

9.2 Employment, Learning & Skills in Halton

Improving the health of individuals can have a positive impact on their long term employability.

9.3 A Healthy Halton

The early identification, early detection and prevention of a range of health issues including hypertension can contribute to healthier lives, thereby contributing to the aims and objectives of Halton's Health and Well Being Strategy.

9.4 A Safer Halton
None directly

9.5 Halton's Urban Renewal
None directly

10.0 RISK ANALYSIS

10.1 No risks identified.

11.0 EQUALITY AND DIVERSITY

No potential negative impacts are likely.

10.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Appendix A

Poster

Establishing priorities for healthcare public health in Cheshire in Merseyside

I Onyia, RA du Plessis

Introduction: Champs is a collaborative service, where nine local authority public health teams work together to enable greater access to public health expertise and advice to the NHS in Cheshire and Merseyside. Key priorities were identified to determine the work plan for the healthcare public health component.

Objective: To use an evidence based approach to determine the 2014/15 priorities for the healthcare component and to determine the relevance of those of local NHS partners using easily accessible healthcare data.

Method: The documented priorities of 12 Clinical Commissioning Groups, nine health and wellbeing boards, Strategic Clinical Networks and Public Health England were reviewed and themed. Robust data and intelligence was collated from national and regional statistical websites on: risk factors, disease prevalence and premature mortality. Data was contrasted against the chosen priorities. We then developed a matrix to score the health conditions identified. (See matrix opposite).

Results: Chosen priorities varied with individual organisations, notably Type 2 diabetes was already a priority across Merseyside but not in Cheshire (fastest growing disease register). Three local priorities matched those generated by the data: mental illness (highest cost to NHS), cancer (largest cause of premature mortality) and unplanned/urgent care (high rate of 30 day re-admissions). The review also highlighted priorities not chosen by partners. These are hypertension (largest disease register), liver disease (worst rate of premature morality) and respiratory disease (large cause of hospital admissions). Preliminary sharing of results with partners has been welcomed.

Future considerations: The next stage is to review activities being undertaken locally and share advice on effective interventions relating to the chosen priorities and reducing associated health inequalities.

Matrix

Topic	Magnitude	Impact	Amenable to intervention	Gaps	Cost/ Savings	Health Inequalities	Local Interest	Score
CVD Hypertension	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CVD Atrial fibrillation	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CVD Type 2 diabetes	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CVD Acute kidney injury	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CVD Hypercholesterolaemia	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Cancer	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mental illness	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Liver disease	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Respiratory disease	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Accidents and injuries	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

The Methodology

working together to improve health and wellbeing in Cheshire & Merseyside