Meeting:	Health, Housing and Adult Social Care Scrutiny Committee
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Portfolio of:	Executive Member for Health, Wellbeing and Adult Social Care

Scrutiny Report: Tackling cardiovascular and metabolic disease: York's Healthcheck Programme

Subject of Report

1. The UK's biggest cause of early death, from a physiological perspective, is cardiovascular disease (CVD), a group of conditions affecting the heart and circulation system in any part of the body. Diseases such as stroke, ischaemic heart disease and heart failure are responsible for around a quarter of all premature mortality.

2. Metabolic diseases, such as diabetes, are related to CVDs from a physiological perspective, and at population level there are a significant number of people living with them both as comorbidities. Together they are a large cause of early disability and mortality.

3. Part of the council's public health work aims to prevent these diseases, both through tackling the risk factors and through early identification and treatment. A primary route for this is through the commissioning of the NHS Healthcheck programme, a statutory duty of the local authority.

4. This report updates committee members on the NHS Healthcheck programme, as well as the wider context around cardiovascular and metabolic diseases in the city.

Policy Basis

5. Reducing the burden of cardiovascular disease in York will contribute to the aspirations in the council plan to reduce health inequalities, given that those in the most deprived 10% of the population are almost twice as likely to die as a result of CVD than those in the least deprived 10% of the population. It also aligns to Goal 8 of the Joint Health and Wellbeing Strategy 2022-32 to 'Improve diagnosis gaps in dementia, diabetes and high blood pressure to above the national average, and detect cancer at an earlier stage'.

Recommendation

6. Scrutiny committee are recommended to note and comment on this report.

Background

<u>Key priorities and outcomes for cardiovascular and metabolic disease</u>

7. There are a large number of conditions which could fall under the category of cardiovascular and metabolic diseases, but for the purposes of this report the focus is on a number of these which have the highest disease burden in the population.

8. Prevention priorities for these conditions broadly flow from the national CVD prevention programme, and can usefully be categorised using two tiers of prevention:

    - Primary prevention, focussed on:

        - High blood pressure (hypertension), which is present in around a quarter of the population and defined as a person having blood pressure of 140/90mmHg when measured at a pharmacy or GP. Prevention includes both avoiding the risk factors for high blood pressure (including obesity, poor diet, salt intake, sedentary activity, smoking) and early detection and treatment-to-target either through lifestyle modification and / or medication (e.g. anti-hypertensives)

- High cholesterol, which is present in around six in ten adults in the UK and is measured by the levels of Low Density Lipoprotein (negative for circulatory health) and High Density Lipoprotein (positive for circulatory health) in the blood. Prevention includes both avoiding the risk factors for high cholesterol (including obesity, poor diet, sedentary activity, smoking) and early detection and treatment-to-target either through lifestyle modification and / or medication (e.g. statins)

- Atrial fibrillation, which is present in around one in every 50 persons in the UK and is detectable through measuring pulse rhythm followed by a confirmatory electro-cardiogram (ECG). Prevention includes both avoiding the risk factors for atrial fibrillation (including obesity, poor diet, sedentary activity, smoking) and early detection, the point of which is appropriately treat patients and to identify those who meet the criteria for anti-coagulation therapy to lower their risk of future stroke.

- Secondary prevention, focussed on:

  - Treatment-to-target of high cholesterol and high blood pressure in those who have had a past CVD event (such as a heart attack)

  - Chronic kidney disease (CKD), which is undiagnosed in around 1.2 million people in the UK; prevention includes detection of CKD in those with risk factors, management of stage progression, and control of blood pressure, CVD risk, proteinuria and painkiller use

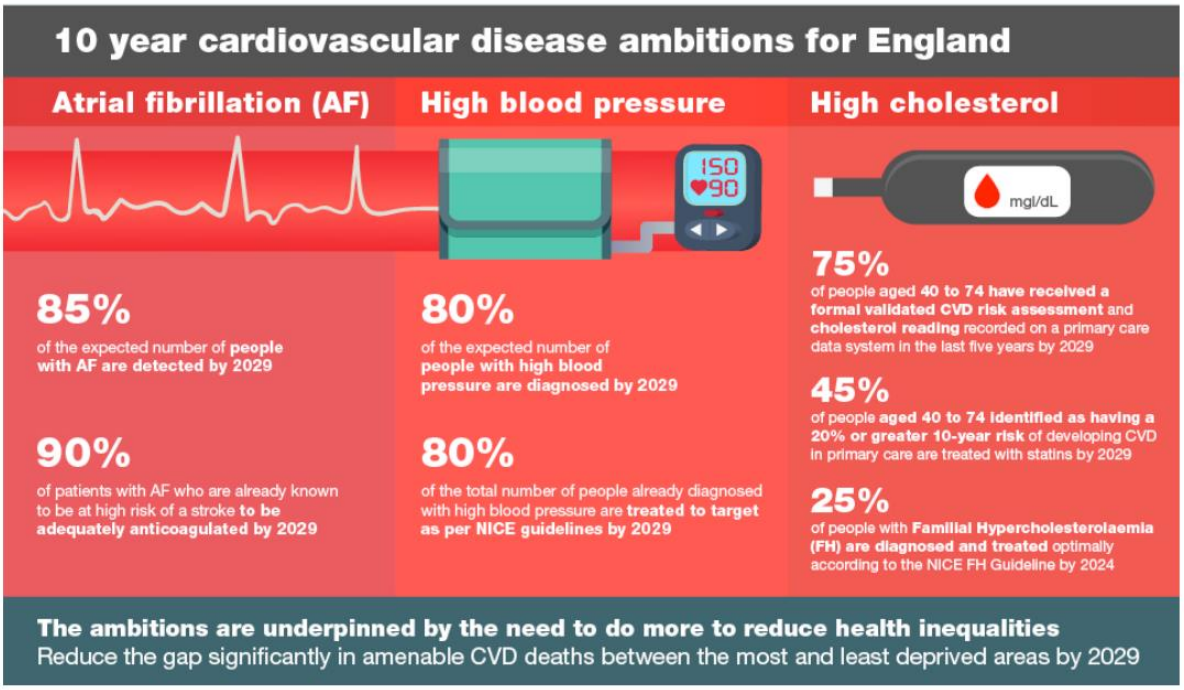
  - Identifying through genetic screening those who have a genetic condition called Familial Hypercholesterolaemia (around 1 in 250), where blood cholesterol levels are very high from a young age, and starting those with the condition on lipid-lowering therapy

  - Management of type 2 Diabetes, a metabolic condition where the body becomes resistant to the hormone insulin and is unable to control glucose levels in the blood; prevention opportunities include the new Diabetes Remission programme, attendance at structured education, the improvement of lifestyle factors including obesity,

regular eye screening (diabetic retinopathy), ensuring good quality care through an annual review process where '9 care processes' should be undertaken, as well as good medical management where the intended outcome is blood glucose controlled within a target range.

- Heart Failure, including detection and access to diagnostics, self management and remote monitoring, and appropriate and access to cardiac rehabilitation

9. There are a variety of national targets and outcomes for these areas, and the following graphic summarises the key national ambitions around primary prevention:



Trends in cardiovascular and metabolic disease in York

10. The table below summarises the key data around the burden of cardiovascular and metabolic diseases in York, compared to national trends.

11. In summary, York has higher rates of disease affecting people towards the end of life (heart failure, stroke) and lower levels of disease affecting people earlier in life (hypertension, atrial fibrillation).

12. Around a third of patients with hypertension are not treated to their target blood pressure, around two thirds of patients with a history of CVD are not treated to their cholesterol target, and around a third of patients with atrial fibrillation eligible for anticoagulation (to reduce the risk of future stroke) are not on this medication. This represents significant missed prevention opportunity.

	Vale of York GPs	**National**	**Data source**
Atrial Fibrillation prevalence	2.8%	2.4%	CVDPrevent
Hypertension prevalence	15.6%	16.2%	CVDPrevent
CVD event prevalence	6.6%	6.1%	CVDPrevent
Chronic Kidney Disease prevalence (stage 3a-5)	3.5%	3.9%	CVDPrevent
Hypertension patients treated to BP target (all ages)	67.2%	66.8%	CVDPrevent
People with a history of CVD treated to cholesterol target	31.2%	30.9%	CVDPrevent
People with atrial fibrillation eligible for treatment treated with an anticoagulant	90.5%	90.5%	CVDPrevent
	City of York GPs	**National**	**Data source**
Stroke prevalence	2.1%	1.8%	QOF
Diabetes prevalence	5.4%	7.5%	QOF
Peripheral Arterial Disease prevalence	0.6%	0.6%	QOF
Heart Failure	1.1%	1.0%	QOF
Diagnosis gap for Diabetes	71.3% of cases diagnosed	78.0% of cases diagnosed	QOF
Diagnosis gap - Hypertension	71.4% of cases diagnosed	76.4% of cases diagnosed	Local calculation

13. Additionally, a number of other trends can be seen in this data:

- The proportion of the population affected by cardiovascular disease has been decreased gradually over the last few decades, due in part to the introduction of preventive medical treatment (e.g. statins) and reductions in smoking prevalence

- The proportion of the population affected by diabetes and hypertension has been rising over the last decade, for instance in 2009/10 Vale of York GP practices had 10,197 diabetics, rising to 18,486 diabetics in 2022/23, due in part to trends in diet and physical activity.

- There are significant inequalities in cardiovascular diseases and metabolic diseases, for instance the Health Survey for England

shows that people from the most deprived areas are 30% more likely than the least deprived to have high blood pressure, and the condition disproportionately affects some ethnic groups including black Africans and Caribbeans.

14. It is also important to acknowledge that local prevalence figures displayed above are more accurately *detection* figures, especially for diseases where in the early stages there are no symptoms (for instance hypertension, atrial fibrillation and sometimes diabetes). This means that the data is a product of the underlying prevalence in the population *and* our success in identifying people living with the disease asymptomatically so that they can be treated. This is shown in the fact that around 30% of people estimated to be living with diabetes and around 30% of people estimated to be living with high blood pressure in York are not diagnosed (diagnosis gap). This represents again a significant missed prevention opportunity.

<u>The NHS Healthcheck programme in York</u>

15. This diagnosis gap is in part the reason the NHS Healthcheck programme exists. The NHS Health Check is a simple check of your heart and metabolic health. Aimed at adults in England aged 40 to 74, it checks your vascular or circulatory health and works out your risk of developing some of the most disabling – but preventable – illnesses. It is free of charge, including any follow-up tests or appointments.

16. Around 1.3 million health checks are delivered each year, identifying 315,000 people living with obesity and 33,000 cases of hypertension, and preventing over 400 heart attacks and strokes. Additionally, a high level of modifiable risk factors (more than three-quarters of attendees had at least one elevated risk factor) are identified even among people aged under 50, prompting ‘teachable moments’ and lifestyle change.

17. All adults between 40 and 74 should be invited for a healthcheck every 5 years, but those with an existing cardiovascular or metabolic condition (e.g. diabetes or high blood pressure) are excluded, as the aim of the programs is to find undiagnosed and treatable conditions.

18. It is a statutory duty of public health teams in local authorities to commission or provide NHS healthchecks. The council’s public

health team commissioning our local primary care service provider, Nimbuscare, to deliver healthchecks in York.

19. At a healthcheck, the clinician will:

- measure height, weight and waist
- do a blood pressure test
- take a blood sample, in order to check cholesterol levels and maybe blood sugar (if indicated)
- ask questions about health including:
    - family history of CVD
    - smoking status
    - alcohol screening (AUDIT-C)
    - physical activity screening (GPPAQ)

20. The national programme intends to invite every eligible person between 40 and 74 to attend a healthcheck every five years. The Office for Health Improvement and Disparities (OHID) calculate the estimated eligible population for healthchecks each year, using census and NHS data. It includes anyone aged 40-74 but excludes those who are in prison or with an existing long term health condition. In 2023/2024 it is estimated there are 54,759 people in York who could have a healthcheck.

21. Nimbuscare are commissioned to deliver 2000 healthchecks per year, from at least six different locations across the city to enable easier access. As such, in a 5 year period, only 18.3% of the eligible population will receive a health check. Whilst the national programme intends only to *offer* a healthcheck to all eligible 40-74 year olds (i.e. no programme like this would see all those offered accepting and receiving a healthcheck), we recognise that with this number of healthchecks available we are not able to offer the number of checks which would match the national ambition. This is due to the limited finances available for these checks available within the priorities funded by the public health grant in York.

22. However, to focus delivery of the healthcheck programme in York (and deliver the best value for limited resource), in line with evidence that shows that the programme is most cost effective

when it has higher ‘yield’ (i.e. it finds more disease which can be treated) we have locally commissioned a bespoke programme, with targeted invitation criteria above and beyond the national requirements. This is in line with the findings of the Deanfield Review into NHS Healthchecks in 2021, and increasingly common across local authorities.

23. This means our proactive invite to residents (through e.g. text message or letter) is aimed at patients with risk factors, so the following targeting criteria are included:

- Those living in the 50% most deprived areas of York
- Those with a BMI of 30+ (27.5+ for some ethnicities)
- Current smokers
- Those with a past Alcohol AUDIT score 5+
- Those with a diagnosis of anxiety or depression

24. The contract stipulates that at least 75% of health checks meet these additional targeting criteria encouraging targeting of healthchecks, while allowing for those who are outside of the criteria to still receive their check. Patients who are eligible for a health check can request one by contacting Nimbuscare, with information on both the Council and Nimbuscare website.

25. Since October 2021, when the contract was awarded to Nimbuscare, the total number of health checks delivered is 5,249. The yearly breakdown can be seen in the table below:

	2021/2022 (Q2 & Q3 only*)	2022/2023	2023/2024
Health checks Offered	1,018	2,873	2,402
Health checks Completed	1,018	2,275	1,956
% met local target criteria	37.7%	72.7%	Not yet available
% referred to health trainers	54.1%	32.4%	Not yet available
*Shortly after the contract was awarded, there was a national campaign to increase uptake for COVID boosters (in Dec 21 – Jan 22). As Nimbuscare were the local provider for the mass vaccination site, health check staff were diverted to support the COVID booster campaign, which was agreed with the public health team given the priority of COVID response			

26. The programme has been broadly welcomed, and as the numbers above show, this approach now ensures that the most likely to benefit are being invited to a healthcheck, and that a good number attending have a ‘follow on’ pathway through the health trainer service in order to capitalise on a healthcheck as a teachable moment and move towards lifestyle change.

27. The public health team, in partnership with Nimbuscare, continue to develop the programme, and related / future developments include:

- The Community Pharmacy hypertension case-finding service, now offered blood pressure monitoring in pharmacies. 31 pharmacies are currently providing this service in York, and to date 7,718 checks have been made.

- The national bidding process for Workplace Healthchecks, which the public health team have recently submitted a bid for in conjunction with Nimbuscare.

- Digital healthchecks, positively piloted in Cornwall and potentially rolled out nationally.

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