

Cardiovascular disease (CVD): Public Health outcomes and prevention priorities for the system. Integrated Care Partnership (ICP) meeting, 21 June 2023.

Norfolk and Waveney Population

The total population of Norfolk and Waveney is increasing and most of the increase is projected to be in those aged 65 years or older.

Between 2020 and 2040:

- The number of people aged 75+ will increase by 56%
- The number of 65–74-year-olds will increase by 20%
- The number of people aged 16-64 will increase by only 4%
- The number of people aged 5-15 will decrease by 4%
- The number of children aged 0-4 will increase by 7%

The communities with a greater proportion of people in later life are generally around the coast with some communities in central Norfolk around Swaffham and Dereham.

Increasing age leads to increased risk of long-term conditions including those linked to cardiovascular disease.

Inequality across Norfolk and Waveney in life expectancy

A male can expect to live to 83.3 years in Loddon but only 75.1 years in Great Yarmouth. A female can expect to live for 86.4 years in Southwold but only 81 years in King's Lynn.

The market town life expectancy gap is 8.2 years for men and 5.4 years for women, but between the most deprived and least deprived communities it is 9.2 years for men and 7.2 years for women.

Source: Local Public Health Intelligence calculations using NHS Digital Civil Registration Data and Fingertips <https://fingertips.phe.org.uk/profile/local-health/>

Norfolk and Waveney Map of Deprived areas on this slide

There are 42 communities across Norfolk and Waveney where some or all the population live in the 20% most deprived areas in England. However, none of these communities are in Broadland or South Norfolk.

Breckland

In Breckland there are six communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Dereham Central & Toftwood
- Swaffham
- Thetford North
- Thetford South
- Watton
- Wayland, Ellingham & Great Hockham

Great Yarmouth

In Great Yarmouth there are nine communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Caister on Sea
- Gorleston North
- Gorleston South & Beach
- Gorleston West
- Hemsby & Ormesby
- Southtown & Cobholm
- Yarmouth Central & Northgate
- Yarmouth North
- Yarmouth Parade

King's Lynn and West Norfolk

In King's Lynn and West Norfolk there are seven communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Fairstead & Springwood
- Gaywood Chase & Old Gaywood
- Hunstanton
- North Lynn
- Terrington & Clenchwarton
- Town, South Lynn & West Lynn
- Upwell, Delph & Emneth

North Norfolk

In North Norfolk there are two communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Cromer
- North Walsham

Norwich

In Norwich there are twelve communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Bowthorpe & West Earlham
- Catton Grove & Airport
- City Centre East
- City Centre West
- Earlham
- Heartsease & Pilling Park
- Lakenham & Tuckswold
- Mile Cross
- New Catton & Mousehold North
- Thorpe Hamlet & Mousehold South
- Town Close
- University & Avenues

Former district of Waveney

In the former district of Waveney there are six communities where some of, or all the residents in the community live in the 20% most deprived areas. These are:

- Beccles
- Gunton West
- Lowestoft Central
- Lowestoft Harbour & Kirkley
- Normanston & Oulton Broad East
- Pakefield North

What is driving the inequality gap?

Circulatory deaths made up about 20%-25% of the Life expectancy gap between most deprived and least deprived prior to COVID19 2017-2019.

Circulatory deaths made up about 17%-26% of the Life expectancy gap between most deprived and least deprived during the COVID19 pandemic in 2020-2021, this gap in life expectancy equates to about 1 year and 10 months for males and 9 months for females.

Emergency admissions for Circulatory related conditions

Emergency admissions for Circulatory related conditions account for about 12,500 admissions each year, more than 10% of all emergency admissions.

In Norfolk and Waveney, the annual number of emergency admissions for circulatory conditions are broken down as follows:

- Aortic aneurysm and dissection: 120
- Atherosclerosis: 245
- Cardiac arrhythmias (AF): 2,020
- Cerebrovascular diseases (stroke): 2,270

- Diseases of arteries, arterioles & capillaries: 170
- Diseases of veins & lymphatic system: 705
- Heart attack: 1,795
- Heart failure: 1,895
- Hypertensive diseases: 345
- Ischaemic heart diseases (IHD): 1,090
- Pulmonary heart disease and diseases of pulmonary circulation: 565
- Other: 1,250
- Total: 12,470

Trends in emergency and elective hospital admissions: circulatory conditions

- Admissions for heart attack and ischaemic heart disease are declining
- However, admissions for Stroke and heart failure have not reduced in the same way

Additional unplanned hospital admissions

- the core 20 population (most deprived 20%) experience 1,306 more admissions annually for circulatory conditions compared to the ICB average
- This also places extra demand on the system

Addressing inequalities is an opportunity to improve outcomes for those from the most deprived areas and reduce the demand on the urgent and emergency care pathway.

Practices with higher-than-expected admissions

Understanding which practices have higher than expected admissions helps to highlight those with the largest potential opportunity to reduce emergency hospital attendances.

We can identify the Practices and PCNs to plan the interventions.

If the practices with significantly higher admissions compared to the Norfolk and Waveney average had admissions as expected, then we could potentially reduce the number of emergency admissions per year by almost 1,000.

Jigsaw of total health

We can start to make a difference for people and reduce inequalities in outcomes by changing health behaviours and by improving clinical care.

We can make a difference and help reduce the need for urgent and emergency care in the core 20 (most deprived 20%) populations by:

- Working with people to change health behaviours (smoking, diet, exercise, alcohol, screening) – everybody's business, led by the Health Improvement Transformation Group.
- Ensuring better access to care:
 - Accessible financially and physically in the core 20 areas
 - Poverty proof services by considering transport costs and timing of appointments to negate the need for time off work etc.
- Focusing on even better quality of care (and improving patient engagement) both in primary care and in hospital.

Risk factors for CVD

Some risk factors for CVD can be reduced by changing health behaviours and some can be reduced through clinical care and secondary prevention.

Global Burden of Disease information highlights that high blood pressure, high blood sugar, high cholesterol, poor diet, obesity, tobacco and low physical activity all contribute to deaths due cardiovascular disease (source: <https://www.healthdata.org/gbd/2019>).

Clinical care and secondary prevention examples include:

- Hypertension management
- Blood glucose management

- Cholesterol management

Lifestyle can also help with the risk factors above and with:

- Alcohol
- Excess weight
- Diet (processed food, lack of fibre etc.)
- Smoking
- Physical Activity

Deprivation and Health Behaviours

As deprivation increases the proportion of people with risky health behaviour also increases. Therefore, opportunities are likely to be greater in the core 20 most deprived communities.

To reduce inequality in life expectancy due to circulatory conditions over the long term, we will have to address the deprivation related risks in health behaviours (smoking, physical activity, obesity, and diet).

Source: Office for Health Improvement & Disparities. Public Health Profiles.

<https://fingertips.phe.org.uk>

Size of the prize for Hypertension case finding and optimum management

There would potentially be an additional 17,000 patients with more than 100 heart attacks prevented and more than 150 strokes prevented if we are able to implement the CVD prevent successfully to diagnose more patients with hypertension and optimise the management the condition for patients.

If 80% of all patients with high blood pressure were treated to target for their age then over three years we might avoid 102 heart attacks, 153 strokes, save £2.8 million and close the life expectancy inequality gap. Currently across Norfolk and Waveney 62% of patients with high blood pressure are treated to target for their age (significantly better than England) but there are several PCNs where the proportion is lower than England.

Size of the prize for high cholesterol case finding and optimum management

By diagnosing more patients with high cholesterol and optimising the management of the condition there would potentially be more than 500 heart attacks and strokes prevented if we are able to implement CVD prevent successfully.

If 90% of patients with CVD were treated with statins then we might avoid 511 heart attacks and strokes over five years compared to 80% of patients with CVD on statins. across Norfolk and Waveney about 80% of patients with CVD are on statins (not as high as England) and there are several PCNs where the proportion is lower than England.

ICB CVD Board Operational Plan: four areas as requiring special attention:

- CVD Prevention (Including Atrial Fibrillation, Familial Hypercholesterolemia, Hypertension, Lipids Management)
- Heart Failure Improvement
- NSTEMI (non-ST elevated myocardial infarction) Outcomes
- Tackling Health Inequalities and CORE20PLUS5 action

The N&W ICB CVD Programme Board wishes to work with ICP Colleagues to ensure a joined-up approach in delivering our shared objectives.

Impact on wider society

CVD is a major issue for health and social care as 6.8 million people are living with cardiovascular conditions.

A chart showing costs of CVD to the NHS and wider society. It shows CVD-related healthcare costs in England were estimated to be £7.4 billion per year, and annual costs to the wider economy around £15.8 billion (Health Matters 2019).

Integrated care: common themes and components

From prevention to rehabilitation

Personalized, joined-up, coordinated, health and social care

Reducing inequalities

Decrease hospital admissions, reduce waiting times and hospital stays

Avoiding duplication, shared decision making

Care closer to the home

Hospital discharge could be a critical point for planning integration

Pathways should be developed from prevention to rehabilitation. Currently hospital discharge could be a critical point for planning integration, with involvement of social care (domiciliary and care homes, VCSE, along with the NHS (secondary, primary and community care); e.g., for medication, monitoring and follow ups; using telehealth, artificial intelligence, etc.

Recommendation:

- The ICB CVD Programme Board to work with ICP Colleagues to ensure a joined-up approach in delivering the areas identified for CVD management.
- Encourage and facilitate improved provision of integrated care, where all partners are involved.

... so as to improve the cardiovascular health of the population of Norfolk and Waveney and to reduce inequalities in outcomes.

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Glossary

CVD: Cardiovascular disease

Circulatory and heart conditions: mean same as CVD in this report

Core 20 population: The most deprived 20% of the national population as identified by the national Index of multiple deprivation (IMD)

ICB: Integrated Care Board

ICP: Integrated Care Partnership

IHD: Ischaemic heart disease

Hypertension: High blood pressure

Practices: General (GP) Practices

PCN: Primary Care Network

N&W: Norfolk and Waveney

VCSE: Voluntary, community and social enterprises



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