MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015**	**Agenda - Part: 1** **Item: 9** **Subject: Stroke and Dementia Prevention** **Wards:**
Dr Tha Han Mr Gosaye Fida	**Approved by:** Dr Shahed Ahmed

1. EXECUTIVE SUMMARY

Colleagues from Public Health and CCG met to discuss the potential bid for health devolution for prevention of stroke and dementia. Although the bid was not submitted, it was felt that the HWB would be interested in the thinking.

Cardiovascular disease (CVD) is the biggest contributor to the life expectancy gap in Enfield; and the burden of stroke and dementia on the individuals, community, health and social care sector, is increasing. However, substantial proportion of stroke and dementia can be avoided by prevention, early detection and effective treatment. Moreover, preventing stroke and dementia will be in line with Health and Wellbeing Board strategic priorities. This paper will discuss the evidence around what could be done to prevent stroke and dementia with limited resources that will bring maximum return on investment for Enfield's health and social care economy.

In Enfield, the over 65 year-old population is likely to rise to 50,000 by 2025. In addition, the premature mortality rate from stroke in Enfield is higher than London and England average. Evidence suggests that substantial proportion of stroke and dementia can be avoided by early detection and effective treatment of their risk factors such as high blood pressure (hypertension), high cholesterol and atrial fibrillation (AF) alongside effective lifestyle interventions at a population level.

In Enfield around 650 people with known atrial fibrillation (AF) are not on anti-coagulants although they are clinically eligible. A further 2,700 people are estimated not to know they have AF. Likewise about 30,000 people are living with high blood pressure without knowing they have the condition.

Currently there are 1,888 people recorded as having dementia in Enfield. The analysis of Alzheimer society suggested that the economic impact of dementia in Enfield is likely to be about £60.9 million annually.

Enfield has also financial challenge as ECCG allocation in 2015/16 is 4.34% below target, which is equivalent to a £16.369m shortfall. Enfield Public Health is also faced with similar under allocation of budget. In 2014/15 Enfield's public health allocation was £43 per person, lower than the London average of £68 per person. These factors will inevitably limit the resources available for primary (lifestyle interventions) and secondary preventions.

Despite the challenges, Enfield has had a good track record in managing risk factors for cardiovascular disease, implementing healthy lifestyle initiatives for physical activity, smoking cessation, diet and nutrition, and tackling excess alcohol

consumption whilst also managing complex case of cardiovascular disease within the community.

RECOMMENDATIONS

Members of the Health and Wellbeing Board (HWB) are asked to note the content of this report.

3. BACKGROUND

Stroke and vascular dementia are the largest causes of disability and suffering in England. Nevertheless, substantial proportion of cardiovascular disease including stroke and dementia can be avoided by prevention, early detection and effective treatment.

Reductions in smoking prevalence and improvements in the detection and management of risk factors for cardiovascular diseases (CVD) have undoubtedly made a major contribution to the observed reductions in cardiovascular mortality. Despite reduction in cardiovascular mortality in recent years, Enfield still has higher rates of obesity and overweight than statistical neighbours, and higher prevalence of diabetes, making it a good ground for new incidences of stroke and vascular dementia in the years to come.

Enfield is also 14th of most deprived of the 32 London boroughs. 12 of Enfield twenty-one wards are the most deprived wards in England.

Enfield is also faced with a number of challenges to tackle the gap in life expectancy and health inequalities**.** Amongst the challenges include high levels of poverty, high levels of population mobility, and low public health and ECCG allocation that has all had impact on the depth and breadth of investment in preventive interventions.

2.0 Risk factors for stroke and dementia

Hypertension, diabetes, atrial fibrillation, smoking, poor diet, obesity and unhealthy workplaces are all risk factors for stroke and dementia. There is an excellent evidence base for stroke prevention in the short, medium and long term. Most of these risk factors are modifiable with sustained investment in lifestyle and secondary preventions in the primary care.

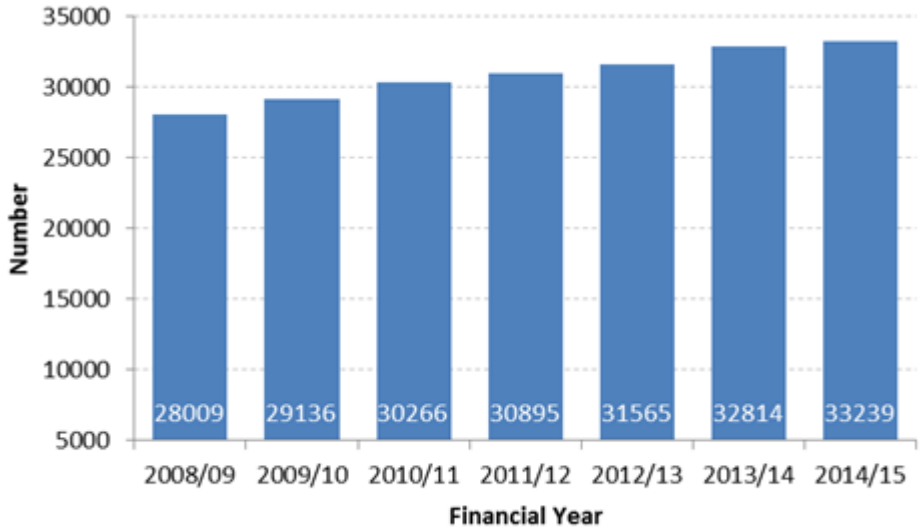
3.0 Track record of success

Enfield has a track record in managing risk factors to stroke and cardiovascular disease that would otherwise lead to increased risk of vascular dementia.

3.1 Hypertension

- In Enfield, is making a good progress over the years in identifying and controlling those with blood pressure. In 2014/15 there were additional 5230 people compared to the baseline year (2008.09) who had their high blood pressure controlled making the total number of patients with early detection and management of their blood pressure to 33,239 in the borough (figure-1).

Figure-1 The number of people whose blood pressure is controlled

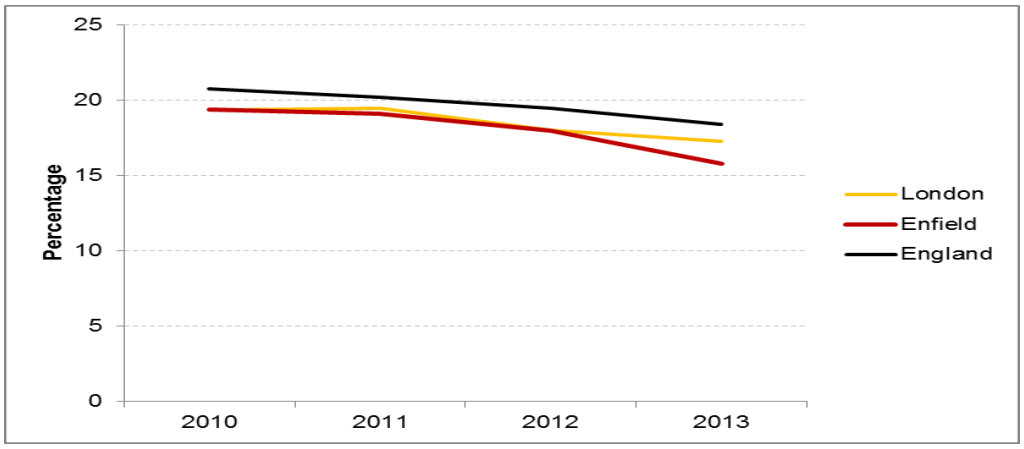


Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

3.2 Smoking

- Following the establishment of a Tobacco Control Alliance in 2010, Enfield's adult smoking prevalence is down to about New York levels. Smoking prevalence in Enfield continues to decrease – it is now 13.6% compared to 17% in London and 18% in England.
- Smoking prevalence amongst 15 year olds is 3.5%; the second lowest in 32 London boroughs

Figure-2 Declining trend in smoking prevalence in Enfield

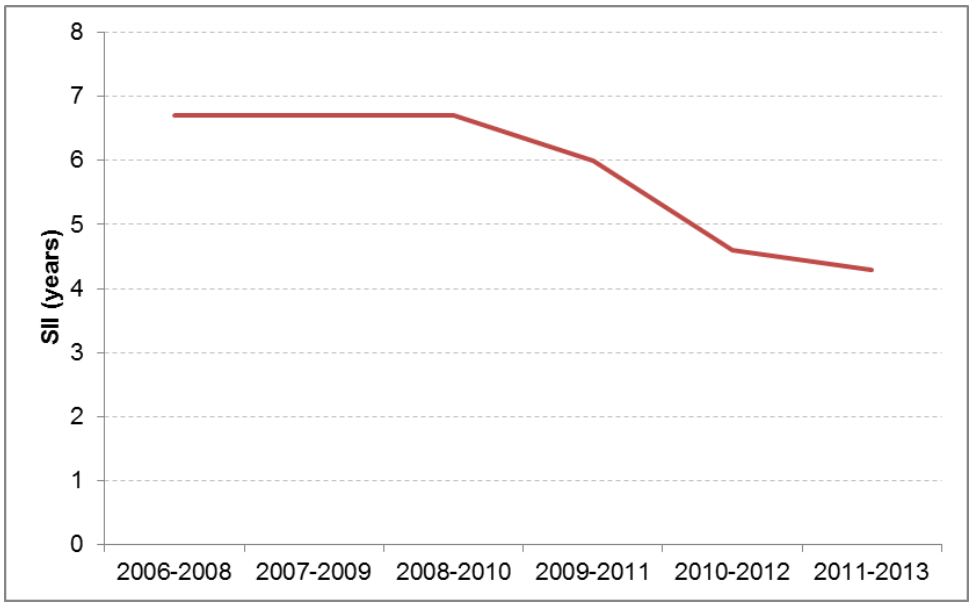


Source : Enfield Public Health

3.4 Reduction in Inequality

Life expectancy in Enfield has improved and there has been a major decrease in inequality for women. The measure of inequality called “Slope Index of Inequality” for Enfield shows a decrease in life expectancy in female population from 6.7 years, in 2008-2010, to 4.3 years in 2011-2013 (*Figure 3*).

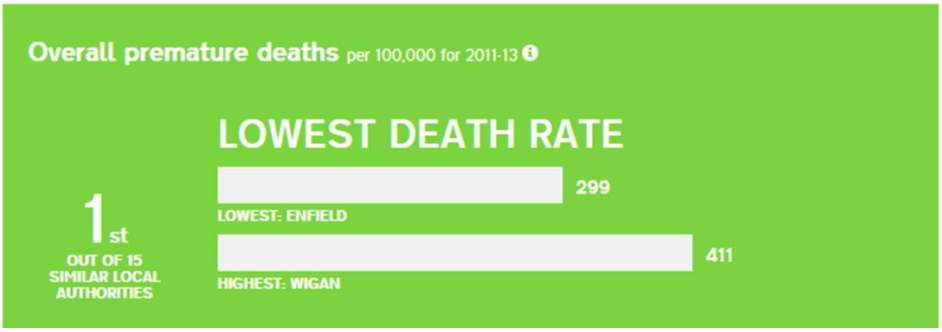
Figure-3 Trend of Slope Index of Inequality for Females, Enfield, 2006-2008 to 2011-2013



Source: Public Health Outcomes Framework, Public Health England

3.5 Best Premature Mortality in our peer group

All cause mortality for people aged under 75 years (referred as premature mortality) in Enfield is the lowest amongst the 15 local authorities with similar characteristics.



Source: Longer Lives, Public Health England

Other areas of performance where Enfield has made a good progress and in some respect exceeded performance of statistical peers:

- Best performing among statistical peers in premature mortality from Coronary Heart Disease, acute Myocardial Infarction and lung, colorectal cancer and survival of breast, lung and colorectal cancer.
- Reduced risk of stroke in patients with diabetes
- Reduced mortality from Chronic Obstructive Pulmonary Disease (COPD) for over 75 years old.
- One of cost effective stop smoking service that has higher success rate (61%) of quit than London and England average and has achieved the national quit target.

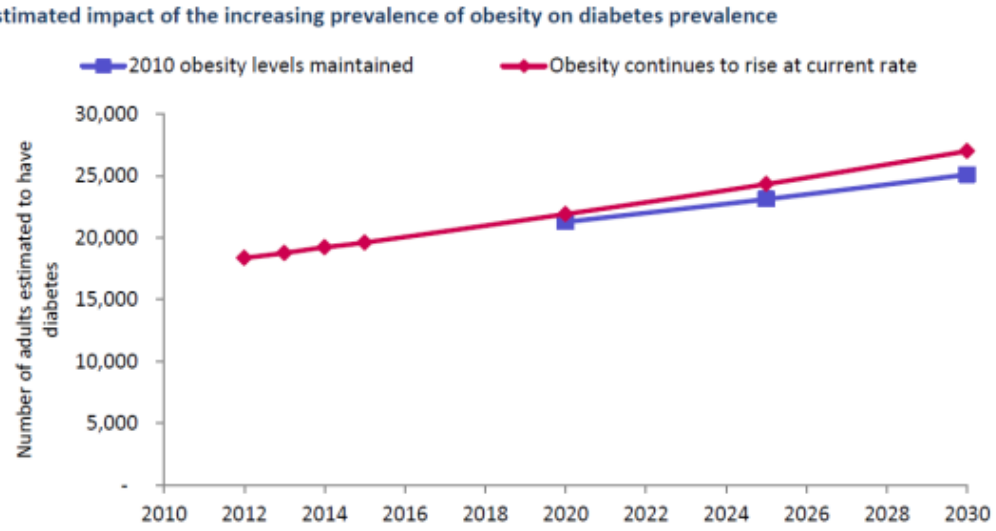
4.0 Case for change

Whilst Enfield is making a good progress in its commissioning of primary and secondary prevention to reduce the risk of cardiovascular disease, there are areas of concern that needs attention:

- Enfield has a population of about 324,000 and eighth of whom are 65 years or older (around 42,000 people), which is higher than London average of 11.5%.

- In the coming years, the number of people over 65 year old population likely to rise to 50,000 by 2025 and people with diabetes to almost double from the current 18,000 to 30,000 by 2030. Evidence suggests obesity account for 80-85% of the risk of developing type 2 diabetes; and it is likely that the rise in obesity in Enfield will contribute to the number of diabetes cases over the years (*figure-4*).

Figure-4 Estimated prevalence of diabetes



Source: National Diabetes Information Service using data from YHPHO diabetes model

We need to control the level of obesity in our population to maintain the prevalence of diabetes at the current level or below. Patients with cardiovascular risk factors such as diabetes and hypertension are likely to have the most complications and cost health and social care the greatest amount of money.

In Enfield, the prevention, early detection and management of many risk factors are improving however; they are long way away from having optimum impact on the burden of cardiovascular disease ;

For example,

- We have 41,041 people diagnosed with hypertension, and 9,476 of these patients blood pressure are not controlled properly adding 26,000 people living with undiagnosed hypertension.

- There were 309 emergency admissions due to stroke in Enfield in 2012/13. This equated to standardised rate of 120.4 per 100,000, as compared to England average of 125.2 per 100,000.

- In Enfield there are around 3,700 people who have previous history of stroke or Transient Ischemic Attack (TIA) and 7,700 people with Coronary Heart Disease and 1,800 people living with undiagnosed diabetes.

- Enfield's recorded prevalence of Diabetes is 7.1%, the 7th highest rate amongst London boroughs. The prevalence is above both London (6.1%) and England (6.4%) averages.

- Enfield has (80.9%) patients with hypertension whose BP is managed effectively. Although we are making good progress, our achievement to date is lower than the London average of 82.1% and 83.6% England average figure.

- Percentage of patients with diabetes in Enfield who has controlled blood pressure (89.4%) was the 5th lowest in the London boroughs, and below London (90.6%) and England (91.4%) averages.

- Whilst our performance in managing blood glucose (HbA1c<7) is reasonable; Data from 2013/14 a shows, there are about 2700 patients with HbAlc >9 in Enfield.

- Enfield has the 4th highest hospital admissions rate for diabetes in female in London and the most deprived part of the borough being 2.5 times likely to have diabetes.

- In Enfield there are around 3,700 people who have previous history of stroke or Transient Ischemic Attack (TIA) and 7,700 people with coronary heart disease and 1,800 people living with undiagnosed diabetes.

- There were 309 emergency admissions due to stroke in Enfield in 2013/14. This equated to standardised ratio of 120.4, which means that the rate in Enfield was 20.4% higher than expected based on the England average.

- Every year, around 130 people die from stroke in Enfield, around 35 of those are residents aged under 75 year olds.

- In Enfield around 650 people with known atrial fibrillation are not on anti-coagulants although they are eligible. A further 2,700 people are estimated not to know they have AF.

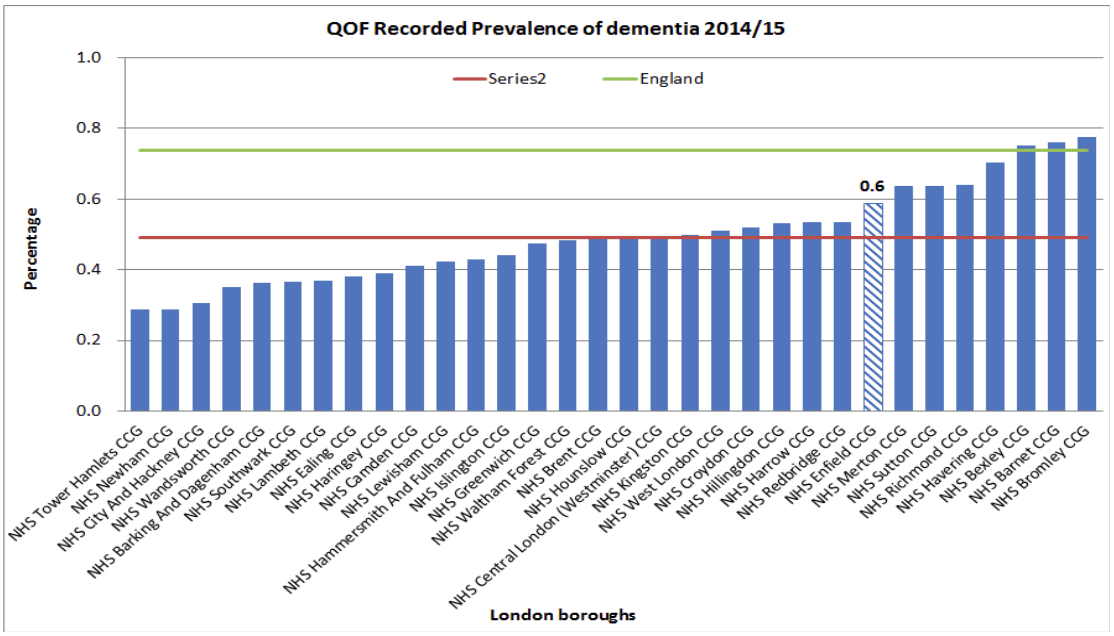
NHS England published commissioning guide in which it indicate the opportunities for CCG's to improve their commissioning outcomes, quality and efficiency if in ten areas of programme expenditure with highest spend. For Enfield, there is an opportunity to improve, may be increase efficiency savings, in cardiovascular disease commissioning if the ECCG were to equal it's commissioning to England average or bench mark.

5.0 Dementia diagnosis

Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include loss of memory, a decline in reasoning and communication skills as well as a gradual loss of skills needed to carry out daily functions and activities. Vascular dementia is the second most common form of dementia and can develop following a stroke.

The number of people with dementia is expected to increase in Enfield by approximately 20% over the next 8 years. In addition, there is an growing concern with undiagnosed dementia in the high risk group. Dementia prevalence in Enfield is higher than England average and most of our statistical neighbours (*figure-5*)

Figure-5 Dementia prevalence, 2014/15



Source: Public Health Outcomes Framework, Public Health England

There are however, a number of measures that can be used to help people cope with the symptoms of dementia and slow down the symptoms. Early diagnosis is therefore important in managing the disease and assists in getting appropriate support.

Recent evidence suggests that up to 72% of patients have some form of cognitive impairment after a stroke and secondary stroke prevention could reduce the incidence of vascular dementia. Thus, living healthy lifestyle can protect against the risk of developing cardiovascular disease and reduce the risk of developing vascular dementia. With early diagnosis and treatment it's possible to improve the quality of life for people affected by dementia.

6.0 Progress to date on tackling risk factors for Stroke and Dementia

In the section below we have outline some of the initiatives which have contributed to Enfield CCG and Council success in recent years could benefit with sustained investment to continue;

- Working with University College London Partnership (UCLP) in Enfield set up a pilot scheme called HILO' to facilitating High blood pressure control and lipid lowering prevention programme in patients at high risk of cardiovascular disease. The results are promising and the lesson from this if rolled out could benefit to tackle the raise of blood pressure in Enfield and beyond.

- Working with UCLP we have established an atrial fibrillation pilot to identify those at risk and provide medication for eligible patients to reduce risk of stroke.

- We have established in South East Enfield Diabetes Multi-disciplinary Team (MDT) meetings which are beginning to show real improvements to management of complex diabetes cases.

- We have established structured patient education programmes for diabetes called “conversation maps”, particularly targeted at deprived ethnic minority populations.

- We have placed health kiosks in virtually every GP practice to encourage assessment of risk of blood pressure.

- We have funded hypertension training provided by British Heart Foundation (BHF) for primary care professionals in Enfield.

- On the back of our Upper Edmonton Life Expectancy Conference, Health Education England funded (via NUMH) a health bus which visited our most deprived areas and identify numerous cases of undiagnosed hypertension cases.

- We have secured Haringey & Enfield North Central London (HENCL) funding for diabetes training for healthcare professionals in Enfield

- We have 1 Gold, 2 Silver and 17 bronze healthy schools awards; one of the best amongst the most in London Borough of Enfield

- We are the first local authority in the London to achieve GLA healthy workplace award and are rolling this out to other employers in the borough.

- Both Enfield CCG and previously Barnet and Chase Farm Hospitals have participated in the Global Corporate Challenge to improve staff health pilot.

- We work with local voluntary organisations and community groups, to identify the local community health and social care needs, develop and deliver strategies. e.g., work with Tobacco Control Alliance.

- Working in partnership with academic, voluntary sector, London and national NHS commissioning organisations to tackle risk of cardiovascular disease and stroke.

- NHS Health check is an intervention designed to detect ten year risk of vascular disease of adults aged 40 to 74 years old. In 2014-15 Enfield delivered 8083 health checks and identified at risk of cardiovascular disease (ten year risk ranging from 0 to 22%) and referred them to receive appropriate medication sign up to life style interventions.

- Enfield Health Trainers provide practical support to people wishing to improve their lifestyle. Approximately 80% of referrals to the service are related to obesity, physical activity or healthy eating. In 2014/15 financial year the service had 1598 clients' cases of which 901 were referrals GP practices.

- We have maintained funding for Smoking Cessation programme which has delivered 1604 quit in 2014/15.

- We are aiming to reach for 2 million in leisure centre Sports attendances this year.

- Enfield has received £30million grant from Greater London Authority to improve cycling in the borough.

7.0 Financial Implications

There is no specific financial implication for HWB to consider in this report; however, it will be important for the board to be aware of the possible impact of any savings made in the future on stroke and dementia prevention. The points below highlight some of the resource implications worth taking a note;

- NICE estimated that by providing anti-coagulant for eligible patients with Atrial Fibrillation (AF), £224,000/100,000 could be saved from stroke treatment. In Enfield, this could be about £552,124 per annum.

- The overall economic impact of dementia in the UK is estimated at an average annual cost of £32,250 per person (Alzheimer's Society).Given the number of people with dementia in Enfield (1880) the current economic impact of dementia is likely to be about £60.9 million annually in the borough.

- Evidence from 2013/14 data shows that diabetes related complications (Myocardial Infarction, Heart Failure, Stroke (Chronic Kidney and Renal Replacement) cost as high as £5,948,466 in Enfield.

- AF is a major risk factor for stroke and is a contributing factor to one in five strokes. Early detection and treatment could prevent irreparable damage to the heart and reduce the risk of stroke, heart failure and other long-term complications.

- Evidence from UK Stroke Association shows in Enfield 657 patients with AF eligible for ant-coagulant didn't receive the treatment.

- We have 26,000 people living with undiagnosed hypertension and Enfield's has diabetes prevalence (7.1%), the 7th highest rate amongst London borough; a prevalence.

HWB are asked to take a note that the long term risks of under investment in the above preventive interventions (both lifestyle and secondary prevention) will result in further increase in the number of patients who would need a complex

package of care at later stage and may increase unnecessary hospital admissions and social care cost.

For further details on Enfield Health and Wellbeing Board (HWB) priorities for cardiovascular disease and healthy lifestyle please see appendix-1

Appendix-1

Impact on priorities of Health and Wellbeing Board (HWB)

1) Reducing health inequalities – narrowing the gap in life expectancy

Department of Health Cardiovascular Disease (CVD) Outcomes Strategy (2013) identified for commissioners and providers of Health and Social Care services ten key actions that will make a difference in improving outcomes for CVD patients in line with the NHS, Public Health and Adult Social Care Outcomes Frameworks. These were;

1) Managing CVD as a single family of diseases;
2) Improve prevention and risk management;
3) Enhancing case finding in primary care;
4) Better identification of very high risk families/individuals;
5) Better early management and
6) secondary prevention in the community and acute care
7) Improving care for patients living with CVD;
8) Improve end of life care for patients with CVD;
9) Improve intelligence, monitoring and research and support commissioning.

In addition, cardiovascular disease such as stroke and vascular dementia contributes to significant reduction in the gap of life expectancy and health inequalities.

2) Promoting healthy lifestyles and making healthy choices

Promoting healthy lifestyle and making healthy choices by all section of Enfield populations is one of the five key priorities of Enfield HWB. To this end Enfield Public Health has commissioned successful interventions to improve healthy lifestyle.

Cardiovascular disease (CVD) is addressed by several of the priority outcomes of Enfield Health and Well Being Strategy. The key aspirations of the priority outcome are; to work with primary and community care provisions to prevent unnecessary use of services and hospital admissions. More importantly, HWB support the prevention to be at the core of health and social care provisions and encourage services to provide opportunities to increase individual and group to consider changes in behaviours that we know have negative consequences for their health.

Enfield HWB also recognises that in many cases poor health can be avoided through better lifestyle choices and recognising risks to health. HWB advocates that early diagnosis of risks of disease, positive interventions and good quality service delivery will lead to people in Enfield enjoying better health and wellbeing into the future. It also acknowledges the lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

Appendix-2 Background Papers

1) Public Health Outcome Framework, 2015
2) Department of Health, Cardiovascular Disease strategic outcome, 2013
3) Health and Social Care Act, 2012
4) National Diabetes Audit , Secondary Users Service (SUS) data 2013/14
5) Health and Social Care Information Centre (HSCIC), 2015a)
6) Alzheimer's Society, Dementia 2014. Opportunity for change.
7) Enfield Dementia Strategy 2011-2016
8) Alzheimer society http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=418
9) Enfield Health and Wellbeing Board Strategy, 2014-2019
10) Cognitive Impairment after stroke , 2015 published evidence
11) National Cardiovascular Network for prevalence data , March 2015 PHE
12) Commissioning for value focus pack. Cardiovascular disease (CVD) pathway, Dec, 2014

Glossary of terms

CVD	Cardiovascular Disease
ASC	Adult Social Care
AF	Atrial Fibrillation
RCA	Route Cause Analysis
TIA	Transient Ischemic Attack
HWB	Health and Wellbeing Board
A&E	Accident and Emergency
JSNA	Joint Strategic Needs Assessment
NUMH	North University of Middlesex Hospital
BHF	British Heart Service
HENCL	Haringey Enfield North Central London
HbA1c	Hemoglobin A1c
MDT	Multi-disciplinary Team
ECCG	Enfield Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
UCLP	University College London Partnership