

**Joint Action on Chronic Diseases
and Promoting Healthy Ageing
Across the Life Cycle**

**Good Practice in the Field of Health
Promotion and Primary Prevention**

**United Kingdom (Other than Northern
Ireland)**

Country Review

Prepared by the European Platform for Better Oral Health in Europe



Author

Prof. Kenneth Eaton

Dimitri Varsamis



This Country Review has been developed based on the questionnaire 'Good practice in the field of Health Promotion and Primary Prevention' developed by EuroHealthNet, as part of Work Package 5, Task 1 of JA-CHRODIS.

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Background

JA-CHRODIS is a European collaborative initiative that brings together over 60 partners from 26 European Union Member States. The collaborative partners are from areas including the national and regional departments of health and research institutions. They work together to identify, validate, exchange and disseminate good practice approaches for chronic diseases across EU Member States, and facilitate the uptake of these approaches across local, regional and national borders. The focus of JA-CHRODIS is on health promotion and primary prevention, with an additional focus on the management of diabetes and multi-morbid chronic conditions. One of the key deliverables will be a 'Platform for Knowledge Exchange', which will include both an online help-desk for policy makers and an information portal which provides an up-to-date repository of best practices and the best knowledge on chronic care.

Work Package (WP) 5 focuses on these objectives in relation to the package's theme: *Good Practice in the Field of Health Promotion and Primary Prevention*. Furthermore, **the objectives of WP 5 are to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations**. This will involve the identification, review, and validation of health promotion and primary prevention interventions for **cardiovascular diseases, stroke, and type 2 diabetes and their modifiable behavioural and social risk factors**. WP 5 will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The following **Country Review** provides an **overview of the health promotion and primary prevention situation and approaches for cardiovascular disease, stroke and type 2 diabetes in UK**. This review outlines relevant policies; implementation mechanisms; good practices, and whether and how they have been identified; and forecasting and cost-effectiveness studies that have been undertaken on the topic in UK. The authors of this report have also identified current gaps and needs of promotion and primary prevention of chronic diseases. The information in this report will contribute to subsequent WP tasks, namely the identification, exchange and transfer of promising practices to promote health and prevent strokes, cardiovascular disease and type 2 diabetes in UK.

The Health Promotion and Chronic Disease Prevention Landscape

Policy design and implementation

Health outcomes such as life expectancy continue to improve in the United Kingdom (UK) thanks to improved social conditions, advancing medical and scientific knowledge, a highly trained professional workforce and massive investment in the healthcare system. However, these improvements mask a widening gap between the health outcomes of the wealthiest and the most deprived communities.

Illustrative statistics

- In England people living in the poorest areas will die an average of 7 years earlier than those living in the richest area.
- In England, the average difference in disability free life expectancy between the poorest and richest areas is 17 years.
- In Scotland men living in the most deprived areas will, on average, die nearly 11 years earlier than those in the least deprived areas.
- Unskilled workers are twice as likely to die from cancer as professionals.

Sir Michael Marmot was tasked by the UK government to review the current inequality challenges facing the UK. This report – Fair Society, Healthy Lives - was published in early 2010 and received support from across the political spectrum.

The report stressed that tackling health inequalities was a matter of social justice, with real economic benefits and savings, and called for action to tackle the social gradient in health outcomes. Also in 2010, the UK Parliament's Committee of Public Accounts confirmed that the gap in life expectancy between people in deprived areas and the general population has continued to widen. The Committee noted that whilst the National Health Service (NHS) in England spends around 4 per cent of its funding on prevention that individual local health bodies (PCTs') spending on prevention is not readily identifiable and that the extent of the NHS' contribution in tackling inequalities is unclear.

In the United Kingdom, health promotion and chronic diseases overarching policy development for the four constituent home countries (England, Scotland, Wales and Northern Ireland) takes place within the Departments (Ministries-equivalent) of Health for each country. As a result there are variations from home country to home country. Policies are initiated, developed and approved centrally, with input from regional and local health authorities/boards and from patient groups such as Diabetes UK and from clinicians and academics with an interest in the areas concerned.

Implementation is at a regional and local level. Recently, In England, local government has become involved with public health, including prevention of diseases. The delivery of prevention policies is

made by clinicians, social workers and others.

Funding is allocated by the Health Departments of the four home countries to local organisations, who purchase care from clinicians and others. In Scotland these are 12 Health Boards. In England, there are 433 Local Authority / Councils and each one is responsible for buying (or providing directly) the public health and promotion services at local level.

In England, The Department of Health is the Ministry-equivalent to other countries.

<https://www.gov.uk/government/organisations/department-of-health>

Since 2013, it has devolved a lot of policy making, powers and funding to separate bodies. Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. They exist to protect and improve the nation's health and wellbeing, and reduce health inequalities. PHE is an executive agency of the Department of Health.

<https://www.gov.uk/government/organisations/public-health-england>

PHE is therefore the national-level body setting the policy and strategic direction of public health and promotion, while, the delivery became a legal duty of local authorities in April 2013.

Overall, public health is the duty of local authorities, while it used to be a combination of local health bodies and local authorities.

A relatively small amount of funding for prevention can come from charitable organisations with interest in particular diseases. However, most of these funds are focused on research

Government policy

England

In 1997, the Labour Government put tackling health inequalities at the heart of its health agenda and issued a number of policy documents and related targets. For example in 2004 the Department of Health (DH) set a target to reduce the gap in life expectancy in local authorities with high deprivation and the population as a whole by 10 per cent by 2010. The administration also recognised the importance of improving the life chances of children in order to tackle inequalities – for example the Every Child Matters agenda, which included improving economic wellbeing as one of five key goals, and a commitment was made to halve child poverty within a decade.

Yet despite the good intentions and investment neither target – to reduce the life expectancy gap or to halve child poverty – was met.

The current coalition Government has expressed a commitment to reduce health inequalities and voiced support for the Marmot (2010) review. Within public health policy, great emphasis has been placed on finding new ways to change behaviour by encouraging personal responsibility for health, the transfer of responsibility for public health to local authorities, and incentivising positive outcomes (details of which can be found in the public health white paper Healthy Lives, Healthy People). Under these plans, direct responsibility for delivering improvements in health inequalities has therefore been placed with Local Authorities and local Health and Wellbeing Boards.

http://www.rcn.org.uk/_data/assets/pdf_file/0007/438838/01.12_Health_inequalities_and_the_social_determinants_of_health.pdf

NHS Health Check Programme

The NHS Health Check is a programme, delivered in England, that aims to prevent heart disease, stroke, diabetes and kidney disease, and raise awareness of dementia both across the population and within high risk and vulnerable groups. It first commenced in 2009 but became a legal responsibility of local authorities in April 2013.

Local authorities are required to offer an NHS Health Check to individuals between the age of 40 and 74 years once every five years. The NHS Health Check is made up of three key components: risk assessment, risk awareness and risk management. During the risk assessment standardised tests are used to measure key risk factors and establish the individual's risk of developing cardiovascular disease. The outcome of the assessment is then used to raise awareness of cardiovascular risk factors, as well as inform a discussion on, and agreement of, the lifestyle and medical approaches best suited to managing the individual's health risk. Further information on how the programme should be delivered can be found in the best practice guidance and other associated guidance here: <http://www.healthcheck.nhs.uk/>

Every quarter local authorities return information on the number of people in their local eligible population that have received an offer of an NHS Health Check and those taking up the offer. The data is published annually on the Public Health Outcome Framework (Indicators 2.22i and 2.22ii) www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/par/E12000004

Blood pressure

Public Health England has made stimulating and supporting activity across the system to improve our performance on high blood pressure a new work programme for 2014-15. The central piece of work this year is to develop with partners across the health system (nationally and locally, within and beyond the public sector) a shared vision and action plan to:

- tackle modifiable risk factors to support prevention of hypertension
- increase early detection of hypertension
- achieve better clinical and community systems for managing hypertension

- improve public awareness and understanding of hypertension
- reduce inequalities in hypertension outcomes.

The role of health trainers in supporting behaviour change

The Royal Society for Public Health looked at the evidence for engaging the ‘wider workforce’ and particularly the role of health trainers in supporting behaviour change within their own communities, providing peer-to-peer support from a position of understanding and common ground.

The main aspect of the wider workforce to be considered was the health trainer service. Introduced by the Department of Health in 2004, the central aim of the programme is to reach out to marginalised groups, who often experience the poorest health outcomes. The service operates by recruiting trainers from within those communities to provide ‘support from next door’ rather than ‘advice from on high’.

Often referred to as ‘lay health workers’, this approach has been utilised in other countries; however, health trainers are a relatively new addition in the UK. According to the 2012 Data Collection and Reporting System (DCRS) report, at the time of publication, there were 2790 people employed as or training to be health trainers.¹²

Overall, the literature indicates that health trainers can achieve a high level of success; evidence shows that clients respond well to the health trainer approach with the majority achieving behaviour change.

It is clear from the literature that the health trainer programmes can be very successful in motivating and supporting sustained lifestyle changes amongst clients. These programmes are primarily targeting people from the two most disadvantaged quintiles and therefore, have the potential to address health inequalities. Whilst there are areas of concern, such as their ability to target men, progress has been made. There are, however, certain gaps in the literature, particularly in relation to cost-effectiveness, which need to be addressed. An analysis of the Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) indicates that the health trainer service has limited visibility in these documents (see appendix a); however, as has been shown above, this service is a worthwhile investment for local authorities.

<http://www.rsph.org.uk/download.cfm?docid=732B74B2-67C4-43CC-80A266C3647E2021>

Main public bodies and other organisations

Scotland

The main body at national level is NHS Health Scotland <http://www.healthscotland.com/index.aspx>

The main regional and local bodies are NHS territorial health boards

<http://www.scotland.gov.uk/Topics/Health/NHS-Workforce/NHS-Boards>

Local government- 32 local authorities also plays a part.

<http://www.scotland.gov.uk/Topics/Government/local-government>

Increasingly local planning is also involved

<http://www.scotland.gov.uk/Topics/Government/PublicServiceReform/CP>

Third sector organisations may be involved , particularly at community level: e.g.

British Heart Foundation <http://www.bhf.org.uk/heart-health/how-we-can-help/in-your-area/hearty-lives/glasgow--inverclyde.aspx>

Chest, Heart and Stroke: <http://www.chss.org.uk/>

England

In England, The Department of Health is the Ministry-equivalent to other countries.

<https://www.gov.uk/government/organisations/department-of-health>

Since 2 years ago, it has devolved a lot of policy making, powers and funding to separate bodies. Public Health England Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. They exist to protect and improve the nation's health and wellbeing, and reduce health inequalities. PHE is an executive agency of the Department of Health.

<https://www.gov.uk/government/organisations/public-health-england>

In England, the delivery of the NHS Health Check programme became a legal duty of local authorities in April 2013.

Overall, public health is the duty of local authorities, while it used to be a combination of local health bodies and local authorities.

Royal Society for Public Health

The RSPH is an independent, multi-disciplinary charity organisation, dedicated to the improvement of the public's health and wellbeing.

They have a membership of over 6,000 public health professionals encompassing a wide range of sectors and roles including health promotion, medicine, environmental health and food safety trainers.

Financing

The majority of healthcare spending is from the governmental allocations via the Department of Health to the National Health Service (NHS). There is no “top-up” funding, and very little private insurance usage. The funding therefore comes mainly from taxation.

Scotland

Public funds: NHS is totally tax funded and NHS Scotland has a policy of not utilising the private sector.

We are unable to replicate the methodology used in the England report (*Public Health and Prevention Expenditure in England: Health England report no 4, 2009*) to estimate the amount spend on prevention due to the way in which our data are collected, but the estimate of 4% on prevention (as found in that study) is thought to be a reasonable one.

England

Each year, local authorities receive a ring-fenced grant to spend on public health projects and programmes. It is expected that this funding is used to resource the delivery of the NHS Health Check programme.

The England report (*Public Health and Prevention Expenditure in England: Health England report no 4, 2009*) estimates the amount spend on prevention to be 4% of total spending.

Identifying Good Practice and existing databases

The following list contains links to many of the key collections of guidance and best practice, as developed or collated by the national body NICE:

National-level best practice Guidance on Lifestyle and wellbeing

<https://www.nice.org.uk/GuidanceMenu/Lifestyle-and-wellbeing>

National-level best practice Guidance on Diabetes and other endocrinal, nutritional and metabolic conditions

<https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions>

National-level best practice Guidance on Cardiovascular conditions

<https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Cardiovascular-conditions>

National-level best practice Guidance on Health inequalities

This briefing summarises NICE's recommendations for local authorities and partner organisations on population health and health inequalities. It is particularly relevant to health and wellbeing boards.

<https://www.nice.org.uk/advice/LGB4/chapter/introduction>

National-level best practice Guidance on Savings and Productivity and Local Practice Collections

<https://www.nice.org.uk/localPractice/collection>

Example of a local Savings and Productivity guide

Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease - Costing template

<https://www.nice.org.uk/savingsAndProductivityAndLocalPracticeResource?ci=http%3A%2F%2Fsearch.nice.org.uk%2Fresource%2FCG181%2Fhtml%2Fp%2Fcg181-lipid-modification-update-costing-template%3Fid%3Ddf55whr35aoz6vqfmwdn2ng2by>

Example of Raising Public Awareness of Atrial Fibrillation(AF) and an AF Detection Programme In Erwash, Derbyshire <http://www.atrialfibrillation.org.uk/files/file/Clinicians%20Area/130408-sh-2-Erewash%20case%20study.pdf>

See annex A to this response

Encouraging people to have NHS Health Checks and supporting them to reduce risk factors

Recommendations for local authorities and partner organisations that could be used to encourage people to have NHS Health Checks and support them to change their behaviour after the NHS Health Check and reduce their risk factors.

The NHS Health Check is a national risk assessment and prevention programme. Everyone attending NHS Health Checks will have their risk of developing heart disease, stroke, diabetes and kidney disease assessed through a combination of their personal details, family history of illness, smoking, alcohol consumption, physical activity, body mass index (BMI), blood pressure and cholesterol. They should then be provided with individually tailored advice that will motivate them and support any necessary lifestyle changes to help them manage their risk. Where additional testing and follow up is needed, people should be referred to primary care services. People aged 65–74 will be told about the signs and symptoms of dementia and informed about memory clinics if needed.

<https://www.nice.org.uk/advice/LGB15/chapter/introduction>

How NICE measures value for money in relation to public health interventions

This document summarises the approach NICE takes to assessing the cost effectiveness of public health interventions. It describes some of the basic concepts and terms and is a companion to the local government briefing on judging whether public health interventions offer value for money.

<https://www.nice.org.uk/advice/LGB10B/chapter/introduction>

Judging whether public health interventions offer value for money

<https://www.nice.org.uk/advice/LGB10/chapter/introduction>

Behaviour change: individual approaches

This guidance makes recommendations on individual-level interventions aimed at changing health-damaging behaviours among people aged 16 or over. It includes a range of approaches, from single interventions delivered as the opportunity arises to planned, high-intensity interventions that may take place over a number of sessions.

The behaviours covered relate to: alcohol, diet, physical activity, sex and smoking. However, the recommendations may also apply to behaviour change related to other health issues.

The recommendations are inter-linked and should be implemented together. They cover: policy and strategy, commissioning, planning, delivery, training and evaluation of individual-level behaviour change interventions. They also cover behaviour change techniques, the maintenance of change and organisational and national support.

The guidance is for: commissioners, managers, training and education organisations, service providers and practitioners with public health as part of their remit. It is particularly aimed at those who commission, design, investigate and deliver interventions to help people change their behaviour – and those who provide the training needed to carry out these activities.

<https://www.nice.org.uk/Guidance/PH49>

NHS Health Check

We identify case studies through our sub national networks. The WHO guidance on writing case studies is then used to write up their activity and publish it on the NHS Health Check website.

Scotland

1. Whether national or local we would expect activity to be evidence based. Evaluation methodology will vary dependent on the size of the programme and who is implementing it.
2. Primary prevention and health promotion are the responsibility of a specific policy team within the Scottish Government. Policies are developed by policy makers in collaboration with stakeholders. Analytical services within government and Health Scotland provide the evidence base if it is a national policy. Some programmes and policies will be national, others local.

There is a national performance framework and some of the actions will contribute to that: <http://www.scotland.gov.uk/About/Performance/scotPerforms/outcome/healthier>

Individual programmes may be evaluated by government internally or use external contractors or partner organisations – mainly Health Scotland.

We would expect local policies and programmes to be evidence based and here NHS Health Scotland have a crucial role in providing support and guidance for health boards. Health boards – which vary in size – will also have their own public health and health improvement professionals who help shape policy and programmes. Public health remains an NHS function in Scotland – unlike the new arrangements in England. Across all parts of the public sector – including the NHS and local

authorities- there is an increasing focus on prevention and on tackling inequalities.

Most activity must be funded from the general allocation given to health boards – but occasionally certain national programmes will have ring fenced money attached to them.

This illustrates some physical activity interventions in Glasgow in the years of the Commonwealth Games – some explicitly diabetes related.

http://library.nhsggc.org.uk/mediaAssets/library/nhsggc_healthnews_2014_06-07.pdf

3.

i. NICE guidelines (see above)

ii. SIGN guidelines on cardiovascular prevention , thromboembolism prevention,

<http://www.sign.ac.uk/guidelines/published/index.html#Otherv>

iii. Effectiveness evidence briefings from Health Scotland

<http://www.healthscotland.com/scotlands-health/evidence/effectivenessevidencebriefings.aspx>

iv. there are key pieces of data and evidence on the ScotPHO website

<http://www.scotpho.org.uk/>

v. Healthcare Improvement Scotland

http://www.healthcareimprovementscotland.org/welcome_to_healthcare_improvem.aspx

Forecasting studies

Scotland

1. NHS data collection at PHI routinely monitor activity <http://www.isdscotland.org/index.asp>

2. There is an annual diabetes survey

<http://www.diabetesinscotland.org.uk/Publications/SDS2013.pdf> and numbers and trends are used in forward planning.

3. The obesity route map <http://www.scotland.gov.uk/Publications/2010/02/17140721/14> contains projections for prevalence of overweight, of obesity, hypertension, stroke, angina, myocardial

infarction and type 2 diabetes. These are used in the associated obesity action plan.

<http://www.scotland.gov.uk/Topics/Health/Healthy-Living/Healthy-Eating/Obesity-Route-Map>

4. There is a stroke and CVD strategy which includes a section on prevention.

<http://www.scotland.gov.uk/Publications/2009/06/29102453/0>

5. There's a lot of information on specific policy areas within health here:

<http://www.scotland.gov.uk/Topics/Health/Services>, some of which will make reference to forecasts.

England NHS Health Check programme

- The genesis of the intervention was based on economic modelling developed specifically for the NHS Health Check programme. This demonstrated the programmes potential to prevent:
 - Between 650 to 2000 premature deaths,
 - over 4,000 people a year from developing diabetes
 - 1,600 heart attacks and strokes.

The programme could also detect at least 20,000 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and to improve their quality of life.

Cost-effectiveness studies

Long-term impact on healthcare resource utilization of statin treatment, and its cost effectiveness in the primary prevention of cardiovascular disease: a record linkage study

Authors, Alex McConnachie, Andrew Walker, Michele Robertson, Laura Marchbank, Julie Peacock, Christopher J. Packard, Stuart M. Cobbe and Ian Ford,

Eur Heart J (2013) doi: 10.1093/eurheartj/eh232 First published online: July 9, 2013

<http://eurheartj.oxfordjournals.org/content/early/2013/07/04/eurheartj.eht232.full>

- concluded that statins are cost saving.

2. Twaddle S, Bhatti F, Marshall M. (2011) *Prevention of ill-health in elderly people – an economic analysis*. Edinburgh: Scottish Government. <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/>

- Concluded that investment in smoking cessation was one of the “best buys”.

3. Kelly MP, McDaid D, Ludbrook A, Powell J. Economic appraisal of public health interventions. NHS Health Development Agency, 2005.

4. Screening for type 2 diabetes: literature review and economic modelling.

Waugh N, Scotland G, McNamee P, Gillett M, Brennan A, Goyder E, Williams R, John A.

Health Technol Assess. 2007 May;11(17):iii-iv, ix-xi, 1-125.

- concludes there is a case of screening for undiagnosed diabetes
-

5. Lawson KD, Fenwick EA, Pell AC, Pell JP. *Comparison of mass and targeted screening strategies for cardiovascular risk: simulation of the effectiveness, cost-effectiveness and coverage using a cross-sectional survey of 3921 people.*

Heart 2010 Feb;96(3):208-12. doi: 10.1136/hrt.2009

- Concludes that “Targeted screening strategies are less costly than mass screening, and can identify up to 84% of high-risk individuals. The additional resources required for mass screening may not be justified”.

NHS Health Check

The England NHS Health check programme, using economic modelling has estimated the cost effectiveness of delivering the programme: £3,000 per QALY.

Gaps and Needs

The key issues at the moment are:

- The transfer of all public health local commissioning and decision making from the local health boards to the Local Authorities.
- The lack of governmental support for public health interventions that would be unfavourable to industry (minimum alcohol pricing, plain packaging for cigarettes, fat content in food).
- The low priority given to long term health goals given by the health funding bodies, as they are expected to make savings on current budgets, therefore to think short term.

In relation to health promotion staff, the following work has been undertaken at Europe level:

Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe (CompHP)

Its aim was to develop competency-based standards and an accreditation system for health promotion practice, education and training that will positively impact on workforce capacity to deliver public health improvement in Europe.

The Royal Society for Public Health was the UK-lead for this project.

<http://www.iuhpe.org/index.php/en/comphp>

NHS Health Check

The NHS Health Check programme is based on guidance produced by the National Institute for Health and Care Excellence (NICE) - which reviews the clinical and cost effectiveness of interventions and advises on how to improve people's health and prevent illness- and on economic modelling undertaken by the Department of Health. Nevertheless, as with any new programme it is evident that we need to evaluate its implementation and impact. This has not been undertaken yet, therefore we are unable to suggest what the gaps are currently.

Annex A. An Innovative Approach to Screening for Atrial Fibrillation

This annex includes a supporting note and an example of good practice in preventing stroke by opportunistic diagnosis of atrial fibrillation. The example involved opportunistic screening of over 65 year-olds who were attending an influenza clinic. There appears to be no reason why the technique that was used could not be performed whenever a medical history is taken for example by healthcare workers such as Pharmacists, Dentists, Physiotherapists, etc.

Supporting Note on making the case for raising public awareness of Atrial Fibrillation (AF)

Case for Raising Public Awareness of Atrial Fibrillation

1. The prevalence of AF in the general population is 1.9% but it increases significantly with age to 10-15% in the over 80's. Thus, there are currently more than 950,000 people living with AF in UK.
2. 25-30% of people with AF are estimated to be undiagnosed and may be even higher if we were to include all people with paroxysmal AF (where patient are in AF only intermittently and for most of time have normal rhythm).
3. Only 23% of patients are adequately treated with the remaining being:
 - undiagnosed and untreated,
 - diagnosed and untreated,
 - diagnosed and undertreated (wrong drug or inadequate control of clotting).
4. Many patients are not treated even though they are known to have AF because of undue fear by patients or doctors of the side effects of warfarin, inconvenience of needing regular monitoring, concerns that patients are 'too frail' to receive treatment because of risk of falls or difficulties with compliance with medication or a lack of knowledge by doctors about the relative risks and benefits of anticoagulants and antiplatelet drugs. It is therefore important to improve GP attitudes and those of people with AF to warfarin, which could partly be addressed through a campaign.
5. AF increases the risk of stroke by about 6 fold, and strokes caused by AF are more severe with higher average mortality and longer term disability than other causes of stroke. Of people with known AF admitted with stroke, only about 30% are on anticoagulant treatment and some of those are likely to be in the group who are on treatment but without adequate control of clotting.
6. New NICE guidance on stroke published in June 2014 and the National Clinical Guidelines for Stroke (4th edition 2012) both state that antiplatelet treatment should not be used and that patients wherever possible should receive an anticoagulant (warfarin or one of the newer oral anticoagulants). Indeed, treatment with warfarin or the newer anticoagulants is widely available and the cost of warfarin in particular is low.
7. It is estimated that if AF was adequately treated, 7000 strokes per annum would be prevented and 2100 lives saved. An estimated saving of £85.2m would be made through the prevention of stroke. It would be important to therefore prioritise this as analysis suggests improved management could save thousands of lives, reduce people living with severe disability, and reduce cost to the NHS and wider support functions.

Relevant work and organisational priorities

8. The Secretary of State Call for Action on reducing mortality would require a system-wide focus on the big killers and reducing impact thereof; thus a campaign on CVD or respiratory would be suitably a priority.

9. Many SCNs and AHSNs, in collaboration with the CCGs in their geographies, are keen to work on reducing the risk from AF, which would increase the potential for collaborative working vertically, and presents with a delivery vehicle, as well as aligning with a strategic priority for both NHS England and PHE.

10. PHE has recently launched a 'Population based Stroke and Vascular dementia prevention programme', which aims to facilitate the collection of outcomes data on how different services across England are performing against agreed criteria and standards, and report back, comparing with other similar socio-demographies, in an effort to peer-learn and improve services in an evidence-based way. A public awareness campaign on AF would complement this work and allow for a means to raise profile and importance of both products.

11. The rationale for a public awareness campaign would be to:

- Persuade people with AF to understand their condition and treatment options, and demand anticoagulation from their doctors.
- Persuade the medical profession that they should not be ignoring AF or treating with ineffective treatments.
- Increase the number of patients with diagnosed AF by enhancing opportunistic case finding.

EREWASH Clinical Commissioning Group, Derbyshire

AF Detection Programme: Quality, Innovation, Prevention &

Productivity (QIPP) in Action

Background

NHS Erewash CCG Board identified the reduction of health inequalities with a specific focus on cardiovascular prevention as one of the key strategic priorities for Erewash CCG. In addition, the Erewash Local Strategic Partnership prioritised cardiovascular disease prevention. 33% of the deaths that contribute to the life expectancy gap between Erewash's most deprived area and the England average are due to cardiovascular disease.

The four CCG GP clinical leads identified the detection of Atrial Fibrillation (AF) as a priority area for work to support stroke prevention. By identifying people with atrial fibrillation and

ensuring that they received appropriate preventive treatment this would reduce stroke occurrences.

As at March 2012, there were 1,469 people on general practice registers in Erewash with a diagnosis of AF which is a prevalence of 1.52%. Four of the 13 practices have a population with AF higher than expected ratio with the remainder having AF population below expected levels. 'Atrial Fibrillation – detection and optimal therapy in primary care' has been highlighted as a potential high impact change by NHS Evidence. Atrial fibrillation (AF) is a major cause of stroke and also increases the risk and severity of stroke. Recognition and optimal treatment of AF is of particular importance as strokes due to AF are preventable.

The detection programme

Whilst the CCG was developing its plans for atrial fibrillation detection, from our research we found an innovative home use Blood Pressure machine which also detected atrial fibrillation. The machine has been used in other CCGs (e.g. Hull) to support AF detection programmes.

A cost impact assessment published in May 2012 by Newcastle Upon Tyne Hospitals and York Health Economics Consortium concluded that the machine when used in a primary care clinical setting is likely:

- ☑ To be cost saving to the NHS and personal social services over both the short and long term

in patients at relatively high risk of AF and therefore stroke

- ☑ To lead to the clinical benefit of reducing strokes in this patient group.

In January 2012, Dr Neerunjun Jootun, GP clinical lead for the AF project agreed to trial one of the BP machines in his practice using the BP machine to take blood pressures during routine consultations. A paper was taken to the CCG Board in January 2012 which proposed a focus on AF detection. The CCG Board were keen to support work in primary care on atrial fibrillation detection and gave the go ahead for the clinical leads and commissioning managers to develop a full proposal to come back to the Board.

Since the AF Detection Programme commenced in Erewash in June 2012, NICE published the Technology Appraisal on the machine in January 2013 which stated that: “The case for adopting the home-use machine in the NHS, for opportunistically detecting asymptomatic atrial fibrillation during the measurement of blood pressure by primary care professionals, is supported by the evidence. The available evidence suggests that the device reliably detects atrial fibrillation and may increase the rate of detection when used in primary care.”

What was done and how it was done

It was agreed by clinical leads that using flu clinics as well as opportunistic screening during routine consultations were the best ways to target the at risk population aged 65 and over. The clinical leads reviewed the evidence on the use of the BP machine to detect AF and supported their use by general practices in Erewash to support the AF detection programme and preferred this to use of pulse palpation method. The AF detection programme was also developed as a QIPP scheme which would impact on reducing admissions for stroke as well as impact on other costs .e.g. rehabilitation and social care costs.

An updated paper setting out the proposed AF Detection Programme was approved by the Remuneration Committee in March 2012 and this decision was subsequently ratified by the Governing Body. A proposal to use the 2% transformation fund to purchase the BP machines for provision to general practice was approved by the Primary Care Trust.

The AF Detection Programme was launched at the Quest event on 13th June. This presented the case for the AF Detection Programme, launched the programme and trained the practice staff on use of the new BP machines.

Results

Between June 2012 and January 2013, the outcomes of the AF Detection Programme were:

- 6,556 people aged 65 and over have been screened for AF

- 37.0% of population aged 65 and over have been screened for AF – one practice has achieved an uptake of screening of 71.2%
- An additional 116 patients have been identified as having AF
- The percentage of patients diagnosed with AF has increased by an average of 7.7% across the GP practices
- The practice that has screened 71.2% of population aged 65 and over for AF has identified an additional 20 people with AF increasing the population with AF in the practice by 19%-
Modelling of the impact of the AF Detection Programme to date, 8 strokes will have been prevented of which 2 or 3 would have been fatal
- The saving in avoiding a stroke is £18,000 in NHS costs. A reduction of 8 strokes per annum in Erewash would save £144,000. The scheme will result in cost savings to the NHS and social care in both the short and long-term.

In addition, the lead GP Dr Neerunjun Jootun who conducted the initial pilot **of the home - use machine** found that the use of the machine had detected a number of patients with AF (who had the diagnosis later confirmed through ECG but on whom taking a pulse check, fibrillation could not be detected. This demonstrated additional diagnostic accuracy beyond use of pulse checks.

Conclusions

The AF detection programme helped to deliver an innovative and effective stroke prevention programme which supports delivery on a strategic priority and delivers real benefits in quality of life for patients. This programme truly helped to deliver the CCG's mission statement of Better Care, Better Health, Better Value.

Dr Neerunjun Jootun, Clinical Lead for the AF Detection programme commented:

“AF is the most common heart rhythm disorder and significantly increases an individual's risk of stroke if they are not receiving appropriate anticoagulation.

“Given the significant implications AF has, both on the health of individuals and in terms of subsequent cost to the NHS, we decided as a CCG to trial **the home-use machine** as a means of detection.

“The results of the programme clearly show how effective this device is in detecting AF.

“On more than one occasion the device detected AF but when a manual pulse was taken the AF could not be detected, which demonstrates the device has diagnostic accuracy beyond manual pulse checks.

“By trialling the device we increased the numbers of patients on AF registers across the GP surgeries by an average of nearly 8%.

“Those patients identified are now on appropriate anticoagulant medication to manage the significantly increased risk of stroke associated with AF.”

Contact for Further Information:

Helen Rose, NHS Erewash CCG, helen.rose@erewashccg.nhs.uk, 0115 9316100

