LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Managing Long term Conditions
Presented to the Health and Wellbeing Board by:	Jeremy Bennett Senior Integration and Transformation manager, LLR ICB Long Term Conditions team
Author:	Jeremy Bennett

EXECUTIVE SUMMARY:

This paper is a response to the request to update the H&WB about detection and management of Heart Disease in Leicester city. The paper provides brief overview of the profile of Cardiovascular Disease across LLR and summarises some of the initiatives being delivered by the ICB's Long Term Conditions team, with the focus on CVD in Leicester City.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Read and Note.

1: **Introduction:**

The challenge for the NHS of managing people with long term health conditions (LTCs) is widely recognised. Meeting this challenge forms a significant component of the LLR ICB Clinical Strategy and 5-year joint forward plan.

Nationally, at least 50 % of adults live with at least one long term condition with 25% having two or more LTCs. Likewise, nationally, LTCs account for 50% of all GP appointments, 64% of all OPD and 70% of hospital bed days. £7 out of every £10 of the total health and care spend in England is attributed to caring for people with LTCs.

Projections made by The Health Foundation[1] suggest that by 2040, not only will the number of people aged 85 years and older have increased but the average number of conditions they have will have increased to 5.7 (in 2019 this was 2.7).

Locally, the LLR population is estimated to be growing by 5% from 1.13 million in across LLR in 2021 to 1.18 million in 2027. This growth is more rapid in older age groups (13% increase in over 65s between 2021 and 2027)[2]. Using NHSE population and person insight (PaPI) data the number of people in LLR estimated to be living with at least one LTC will rise by 24%

2**: Managing CVD in LLR**

Primary Care delivers the majority of the work with new and existing patients, udne the Quality and outcome framework and the PCN DES

The Quality and outcome framework, at a General Practice level has a number of incentivised goals to manage patients. The PCN Direct Enhanced Service also has a number of CVD goals, at a PCN level, which PCNs receive a financial resource to deliver.

In addition, nationally community pharmacy is commissioned to deliver a Hypertension Case-Finding Service

Alongside this, the NHS Long term plan has a number of specific goals around CVD diagnosis and management.

Taken collectively, these provide the framework and the impetus for the delivery of care to LLR registered patients. The Long-Term Conditions team's key focuses for 2024/25 will be on detection and optimisation.

[1] Health in 2040: Projected Patterns of Illness in England, The Health Foundation: Health in 2040: projected patterns of illness in England - The Health Foundation

[2] 2018-based subnational principal population projections for NHS regions and clinical commissioning groups in England; Source: Office for National Statistics © Crown copyright 2020: National population projections - Office for National Statistics

3. Managing CVD in Leicester City

CVD, including stroke and disorders of the heart, account for a third of all deaths nationally and is a major contributor to the Leicester life expectancy gap[3].

- Over one in four deaths (28%) are from CVD in Leicester
- About 10,000 people in Leicester have a diagnosis of coronary heart disease
- 4,600 people are recorded as having had a stroke or transient ischaemic attack (TIA)

CVD is estimated to be responsible for 14% of life years spent in ill-health, second only to cancer.

4. Current initiatives to support detection and management of CVD in Leicester

Atrial Fibrillation (AF)
Untreated AF can increase the risk of stroke, heart failure and related problems. Detecting AF is done by identifying irregular pulses initially, and then ECG and Echo

The local rates of Atrial Fibrillation detection are below national averages , City's detection is at 1.1%[4], below the LLR and national averages (nationally detection is at 2.21%) . In addition, detection rates lower as deprivation increases
However, data shows that 93% of those detected are being treated

Therefore, our focus for AF is on detection and will focus on areas of the city with higher deprivation . We are working with the ICB Medecines Optimisaion team to develop and externally funded project to take opportunistic pulses in a number of settings , including community pharmacy and , wherever possible, the mobile vaccination unit .

Heart Failure
National prevalence of Heart Failure has been reported as 0.94%.But in Leicester , this prevalence rate is at 0.8%[5], detection in the city is lower than than the LLR mean of 1.2%

In addition, only 41% of LLR HF patients have had functional capacity
and medication reviews.Therefore , alongside our drive to detect more HF patients , our focus will be on management and optimisation .

The UHL Heart Failure team, working with the ICB , has successfully bid for money that will recruit staff to from PCNs across LLR , to develop a Heart Failure Champion model, which will focus on educating general practice on how to better manage Heart Failure in community setting . This builds on a successful Long Term Conditions champion model which delivered improvements in optimisation across specific disease groups .

[3] Cardio Vascular Disease in Leicester Adults: Joint Strategic Needs Assessment, Leicester City Council (2023): Cardiovascular disease in Leicester adults - jsna
[4] Source : CVD prevent - Quality Improvement | CVDPREVENT
[5] Public health profiles - OHID (phe.org.uk)

In addition, the UHL cardiac rehab team and the ICB have also received targeted cardiac rehab funds that will be used to develop more community based heart failure clinics , which are currently being set up across LLR

The fact that 48% percent of Heart Failure patients also have AF, means that we will ensure that both programmes have inter-visibility to maximise the impact for our resource.

Hypertension Case Finding and Management
Hypertension prevlance in the city is cyurrentl at 1.74% compared with an LLR mean of 2.16%.

The Hypertension programme has just started in city, focusing on those PCNs with the highest estimated number of undetected hypertensives.

This was based on an earlier LLR wide project, the asked practises to search using risk factors. And invite him in for a review. The project reviewed 5752 patients and identified and started to optimise 545 new hypertensives. Scaled up this means we have the potential to identify 12,000 new hypertensives across LLR.

In February, the PCN and Practice data, up to January 2024, was reviewed and identified. the 20 practices with the lowest rates of optimisation (or treatment to target) in the City.

The data set identified the optimisation gap for each practice (the number of patients that needs to be recorded as 'optimised' by 31/03/24) to meet the goal of having 77% of their Hypertensives optimised.

One of the key findings from this exercise was the recommendation for a focus of on those aged under 79 The rationale being that there is a much wider gap in numbers optimised for this age group.

Because Hypertension forms one of the City PCN's key priorities for their and well-being plan, there is considerable engagement from City practices and we are optimistic that results obtained before, will be replicated

To support this, additional capacity to identify hypertensives, is provided via the Hypertension Case-Finding Service , delivered by community pharmacies

We are working with colleagues in the Medicines optimisation team to develop Community Pharmacy as an enabler for the case finding programme.

Practices are being encouraged to make use of the mobile immunisation unit and set up community events or have the unit parked outside in their car parks where possible.

Community Connectors are being asked to support with raising awareness and education. For example, using the 'Know your numbers' initiative[6], and stressing the importance of undertaking blood pressure checks at community pharmacy.

Like AF, 79% of heart failure patients have hypertension, similar intervisibility and opportunistic checks will be undertaken.

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[6] Blood Pressure UK

Lipid management
One of our key priorities for lipid management has been to develop a service for Familial Hypercholesterolaemia (FH) FH is an inherited genetic condition where people have a high level of cholesterol in their blood, which leads to a greater than 50% risk of coronary heart disease in men (by age 50) and 30% in women (by age 60). Early diagnosis and treatment with statins reduces the CHD risk along with non-elective activity and premature mortality.

LLR ICB was working with partners across the midlands to develop a regional service
However, across the east midland collaborative , member ICBs have pulled out individually to the point where the midlands wide approach is no longer tenable.

In LLR the proposal is to utilise local provision, case find FH patients and co-operate with the existing West Midlands model to ensure support for LLR patients and their families with actual or suspected FH

. What does this mean for patient care?

Hypertension

- Increasing the number of patients on GP registers from 170,000 to 190,000 in 5 years, an additional 4,000 patients per year
- Increasing the number of people with hypertension who are well managed from 69% to 75% will be an increase from 117,000 to 142,000 an increase of 25,000 patients per year.

Atrial fibrillation

- Increasing detection from 79% to 90% in 5 years would mean an additional 3,200 patients on GP AF registers and an additional 2,400 patients managed on Direct oral anticoagulants (DOACs)

Familial Hypercholesterolaemia

- 0.4% estimated prevalence equates to 4,700 people in LLR.
- It is estimated that 330 of these people are identified. Increasing this to 25% (1,200) will be an additional 870 people.
- An additional 750 people would meet management targets (86%)

The impact of this will mean, that in 5 years, across LLR, we will prevent:

- 317 CVD events
- 102 new strokes
- 14 premature deaths

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