Classification:	Decision Type:
Open	Key

Report to:	Cabinet	**Date:** 07 September 2022
Subject:	Investment in a population health management approach to coronary heart disease and long-term conditions	
Report of	Deputy Leader and Cabinet Member for Adult Care, Health, and Wellbeing	

Summary

1. This paper outlines a case for investment in data quality and project coordination to support the development of a population health management in primary care, with an initial focus on coronary heart disease (CHD).
2. CHD is the biggest single cause of death in Bury and, after COVID-19, the biggest cause of inequalities in life expectancy. CHD is also a major burden on health and social care services and on the wider local economy.
3. We are developing a whole-system approach to tackling CHD. This includes increasing systematic use of preventive interventions in primary care and reducing inequalities in this care and connecting to wider health improvement work in neighbourhoods.
4. This population health approach will depend on good quality data in primary care systems to allow measurement of uptake and inequalities in important preventive treatments. It will also require project coordination support to help ensure development and delivery of action plans to improve diagnosis and treatment and support reporting.

Recommendation(s)

5. That £550,000 from the public health reserves is invested in building population health capacity, including in data quality and project coordination over three years (financial years 22/23, 23/24, and 24/25) through the GP Federation to support a wider programme of work focussed on reducing CHD and inequalities in CHD.

Reasons for recommendation(s)

6. A population health management approach to reducing CHD and inequalities in coronary heart disease (and other long-term conditions) will depend on good quality data and project coordination. This investment supports the development of data and capacity that will enable this approach to be expanded to other major causes of illness and deaths and health inequalities.

Alternative options considered and rejected

7. The following options were considered:
    a. **Do nothing:** the lack of high-quality data on aspects of inequality such as ethnicity as well as aspects of care for people with CHD will prevent

the measurement and reduction of inequalities in CHD, limiting the primary care system's ability to identify and reduce inequalities in diagnosis and care for people with CHD and to improve uptake of preventive treatments.

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Background

1. Coronary heart disease (CHD) is the leading cause of death in Bury and, after COVID-19, the biggest contributor to inequalities in life expectancy. Deaths and emergency hospital admissions from cardiovascular diseases in Bury are higher than the English average. There are marked inequalities, with higher rates of CHD in more deprived neighbourhoods. But it is not only the most deprived communities that suffer more illness and death from CHD: around half of Bury's small areas have higher rates of CHD deaths than average for England.

2. Deaths and illness caused by CHD are preventable. Effective primary prevention can be achieved through physical activity, healthy weight and diet, and smoking cessation, as well as action on the causes of inequalities. Evidence based preventive interventions are also available in primary care, including blood pressure and lipid management therapies and vaccinations against flu and COVID-19. Currently, not everyone who could benefit from these treatments is getting them. In some cases, there are marked inequalities, which contributes to worse CHD outcomes in more deprived and ethnic minority communities.

3. We are developing a whole-system response to CHD. This includes connecting action on wider causes of CHD to preventive work through our Live Well services and to action in primary and secondary care. This approach will have Bury's neighbourhoods at its core. Although our initial focus is on CHD, our aim is to build a model for systematic population health management that can be applied across a range of important long-term conditions. The embedded paper provides further detail on this approach.

4. This paper focuses on the data and project support needed to ensure delivery of the primary care aspect. This includes increasing the number of people with CHD who get diagnosed, making sure those diagnosed get all the key aspects of preventive care, and reducing the inequalities in diagnosis and treatment. Further work by NHS commissioners has been done to include payment incentives that support improvements in diagnosis and treatment in

the locally commissioned service. This paper outlines a case for investment into data and project coordination to support practices in delivering these aims.

The importance of underpinning data quality and project coordination support.

5. Tackling CHD and other long-term conditions systematically will depend on good quality data in primary care systems to allow general practices, primary care networks, and others to understand diagnosis and uptake rates for key treatments among patients, including broken down by aspects of inequality, such as deprivation, unemployment, housing quality, ethnicity, and gender. The COVID-19 vaccination programme showed the power of being able to identify low uptake in groups of people defined by multiple characteristics (for example people of a particular ethnicity, age, and gender living in a particular neighbourhood). This allows much more targeted work than is normally possible, including outreach work to understand causes of low uptake. This intelligent use of data to guide diagnosis and care is the core of population health management. Our longer-term aim is for this approach to be applied across all long-term conditions.

6. Experience of similar initiatives in other localities has been that initial investment in auditing and improving data quality is needed. This enables the measurement of inequalities in diagnosis and care, targeting of work to reduce inequalities, measurement of progress in improving diagnosis and care, and underpins payment incentives. It will also support the development of the ability of neighbourhoods and primary care networks to use their own data to identify inequalities in care and to identify patients who may be missing out on treatments they could benefit from.

7. Investment in project coordination supports the development and delivery of action plans to improve diagnosis and treatment rates and the coordination of actions in primary care with action across the wider system. This will be particularly important given the large pressures on primary care and the wider health and care system that risk derailing preventive measures such as these that are needed to reduce pressure on the NHS and social care in the medium-term.

The economic case for action on CHD in primary care.

8. CHD is a significant contributor to costs in the health and social care system. In addition, costs to the wider economy are likely to exceed those to the healthcare system as people are unable to work and require ongoing care that may affect their carer's ability to work.

9. There is evidence that the key interventions targeted are likely to generate cost savings. For example, antihypertensive combination therapy is likely to save £140 to £920 per patient. And a health economic model from the Office of Health Improvement and Disparities suggests that a 10-percentage point

increase in the proportion of eligible patients receiving lipid management therapies in Bury could lead to net savings of £57,000 in year 1, £ 290,000 in year 2 and £600,000 in year 3.

Links with the Corporate Priorities:

10. The programme of work enabled by this investment is intended to support the development of a population health management approach in neighbourhoods that is focussed on tackling the biggest threats to health and causes of health inequalities. This supports the 'local' strand of the Let's Do It strategy.

11. The wider programme of work will adopt a whole-systems response including primary and secondary care, North West Ambulance Service, as well as linking to the voluntary sector. A range of groups have been consulted on this proposal and have contributed to its development. This has been done through the Population Health Delivery Partnership, GP leadership collaborative, Clinical and Professional Senate, and Integrated Delivery Collaborative. This supports the 'Together' strand of the Let's Do It strategy.

12. As CHD is the single biggest cause of death and a leading cause of years lived with disability and of inequalities in these, improvements in CHD contribute directly to the outcome in the Let's Do It strategy on reducing the life expectancy gap between our best and worst performing areas to under 13 years for men and under 10 years for women.

Equality Impact and Considerations:

13. The explicit aim of this proposal is to improve the quality of data on important protected characteristics and deprivation, along with the data quality on preventive CHD care. This will support the ability of primary care to discharge the NHS's "wider social duty to promote equality through the services it provides" (NHS constitution). By making inequalities in care more visible and focusing efforts where they can address these inequalities, this proposal is likely to have a positive impact on known inequalities in CHD and CHD care.

Environmental Impact and Considerations:

14. Environmental impacts are expected to be negligible.

Assessment and Mitigation of Risk:

Risk / opportunity	Mitigation

• Poor data quality undermines ability to measure and improve diagnosis and preventive care for CHD and to reduce inequalities in CHD care. • Pressure on health and social care systems, particularly primary care, undermines ability to progress preventive work on CHD.	• Investment as outlined in this paper in data quality. • Project support and coordination through GP Federation and inclusion of metrics relating to CHD care in the locally commissioned service.

Legal Implications:

15. This proposal is to use the reserve to invest in project management and data quality there is sufficient funding, the reserve can be used in this matter if Members are minded to agree.

Financial Implications:

16. There is sufficient funding within the Public Health reserve that has accumulated over the last few years to fund this. The funding will be utilised over a three year period and will be managed via the GP Federation within Bury.

Background papers:

A paper titled "A whole system population health response to coronary heart disease" provides more detail on the approach discussed here, including on intervention decay. This paper is available on request.

Please include a glossary of terms, abbreviations and acronyms used in this report.

Term	Meaning