

Sustainability & Transformation Plan

‘Prevention at Scale’

The Example of Diabetes Management & CVD



Purpose of this presentation

- Describe the context for closing the H&WB gap and rationale for Prevention at Scale within the STP
- Illustrate the challenge in Dorset in regard to one of our agreed priorities i.e. Diabetes and CVD.
- Describe some ideas about moving forward



Introduction

Why are we discussing Prevention at Scale?

- Because a sustained approach to prevention is one of a limited number of options that *may* reduce the burden of disease, demand and service costs in an ageing population.

What does it mean?

- We don't know - only really good examples are mass vaccination campaigns in response to national/global epidemics and sanitation infrastructure!

Challenges:

- **Language:** the word means differing things to differing people – often not recognised or reconciled.
- **Individual behavior change:** difficult, often needs legislation e.g. seat belts, but seen as an intrusion on personal liberty etc, we know little about behaviour change in a social media world.
- **Prevention Paradox:** Lots of people not at 'risk' have to change a little to benefit the population a lot!



Prevention at Scale – Themes and Approaches

1. Three themes – ‘outcomes’ we wish to prevent/improve

- **Diabetes & Cardiovascular Disease: *Why?*** High levels of early death and disease, High levels of health and care utilisation. High investment.
- **Alcohol: *Why?*** Diverse societal outcomes across multiple agencies with high societal costs. Medium investment.
- **Mental Health/Musculoskeletal Disease: *Why?*** Highest global causes of loss of quality of life: large numbers of the population affected by long standing reduction in quality of life; high levels of productivity loss to society and local employers; low investment.

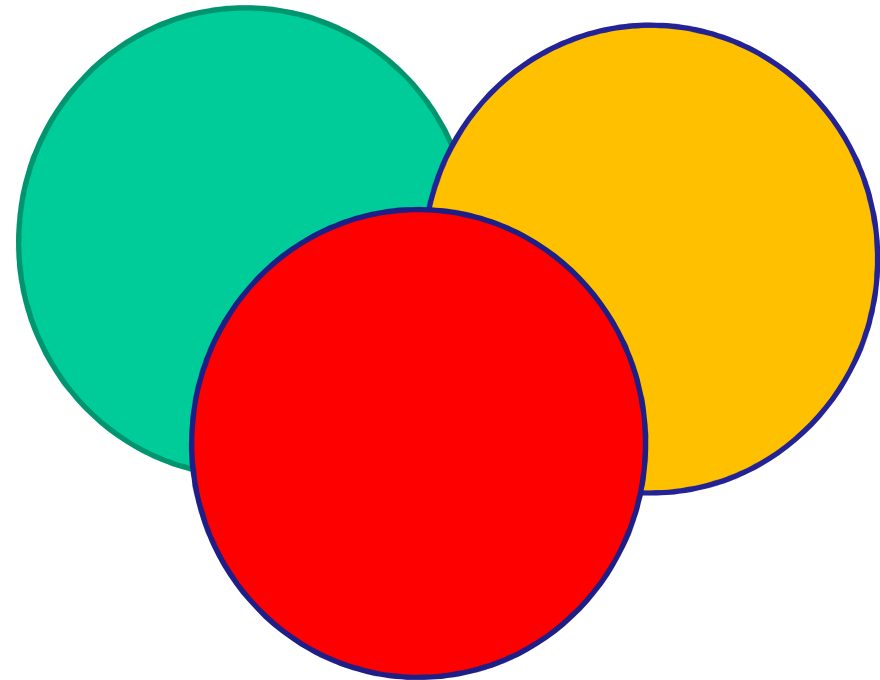
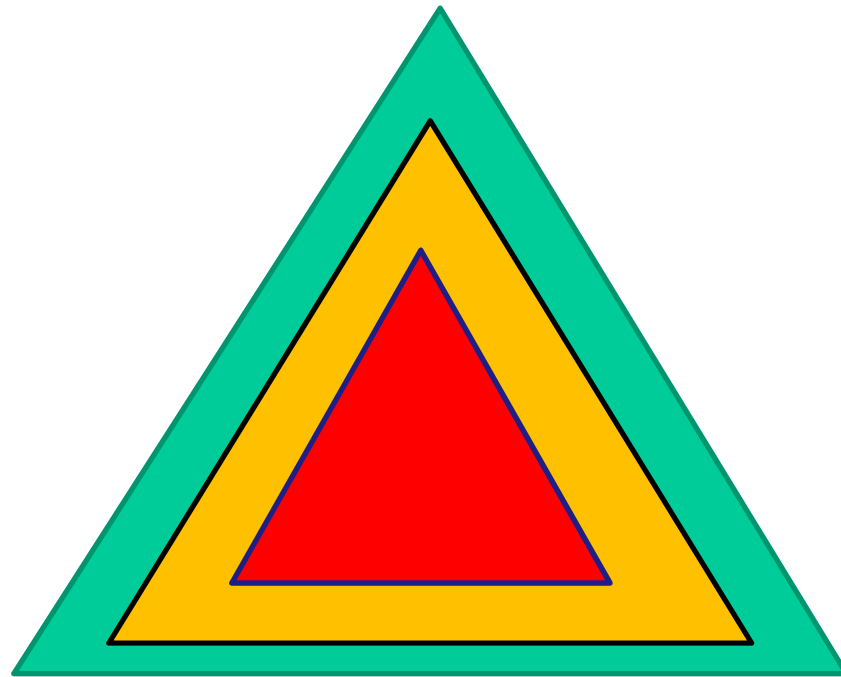
2. Three approaches: Individual + Organisational + Place based



PAS as part of the STP

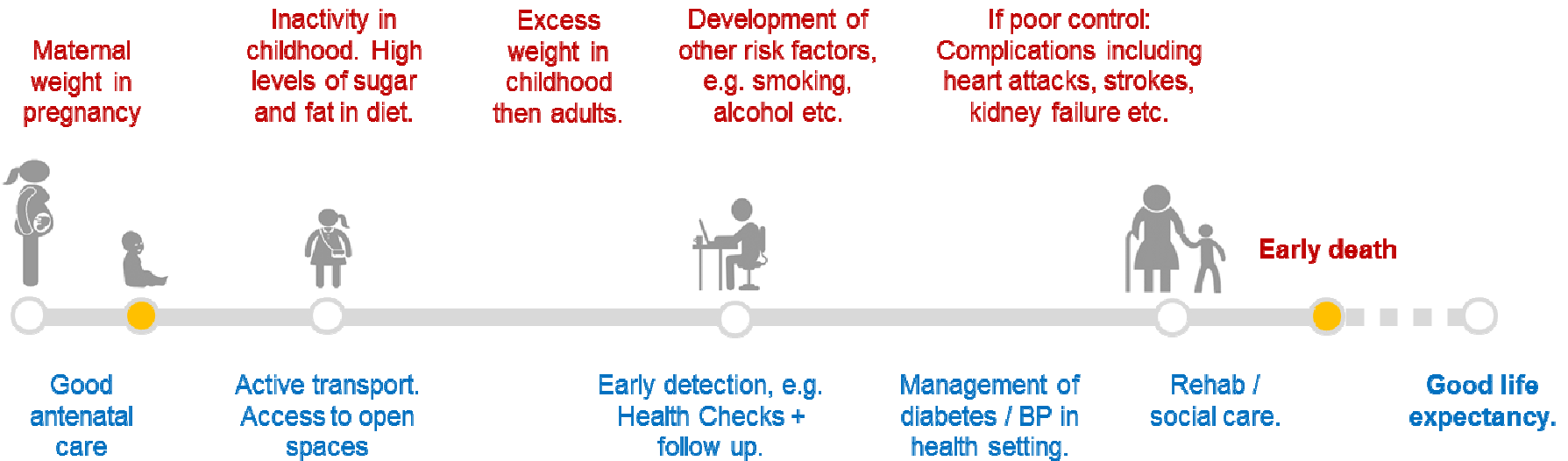
The STP describes three programmes PAS, ICS & acute network.
In practice these will have important areas of commonality both of
content and approach

As such that they might better be represented as below rather than
discrete parts of one triangle as per STP document



The natural history of diabetes and CVD.

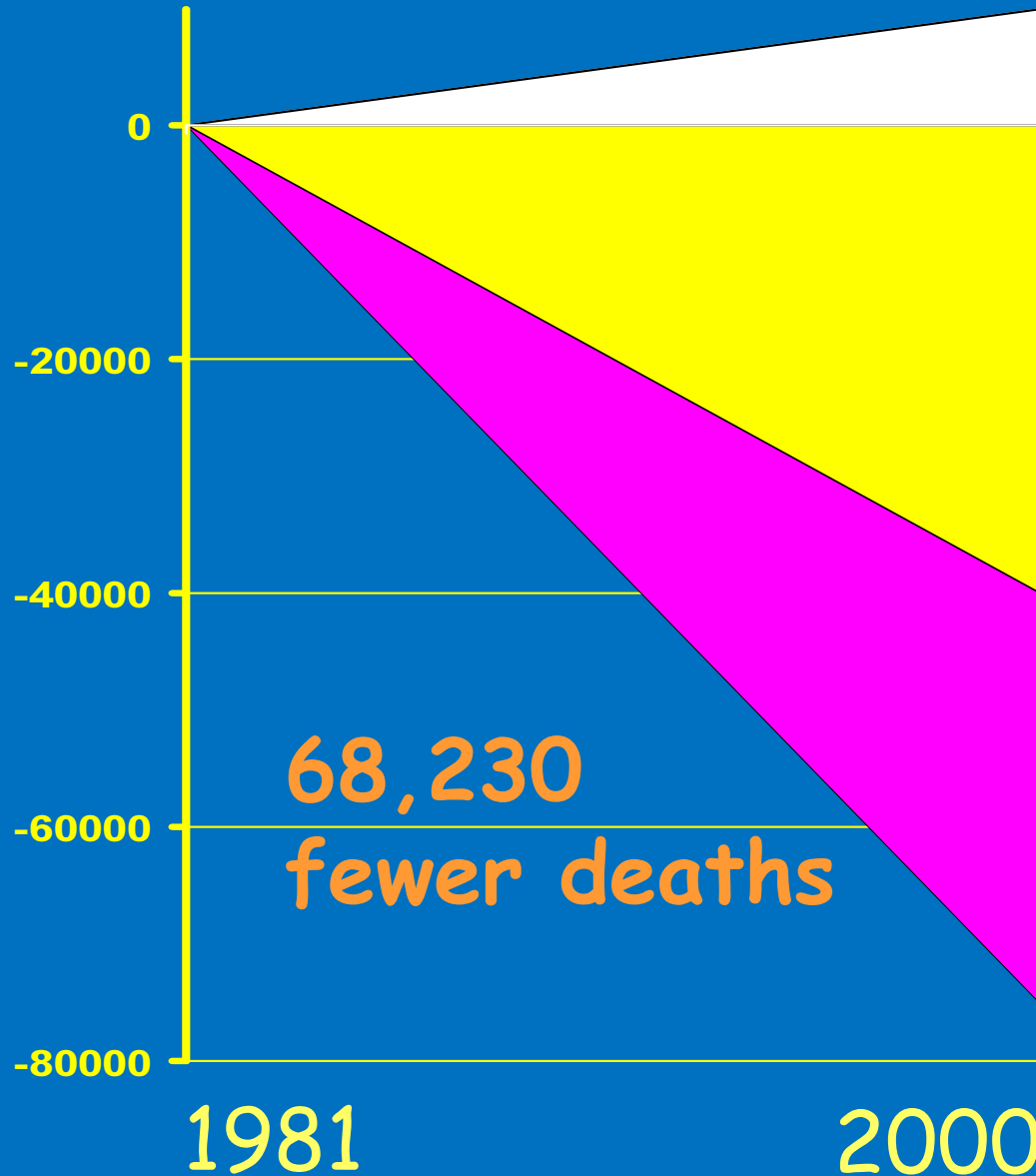
Risk factors...



Protective factors...



Outcomes for CVD: How do we explain these changes? A UK perspective: 1981-2000



Risk Factors worse +13%

Obesity (increase)	+ 3.5%
Diabetes (increase)	+ 5 %
Physical activity (less)	+ 4.5%

Risk Factors better -71%

Smoking	-41%
Cholesterol	-9%
Population BP fall	-9%
Deprivation	-3%
Other factors	-8%

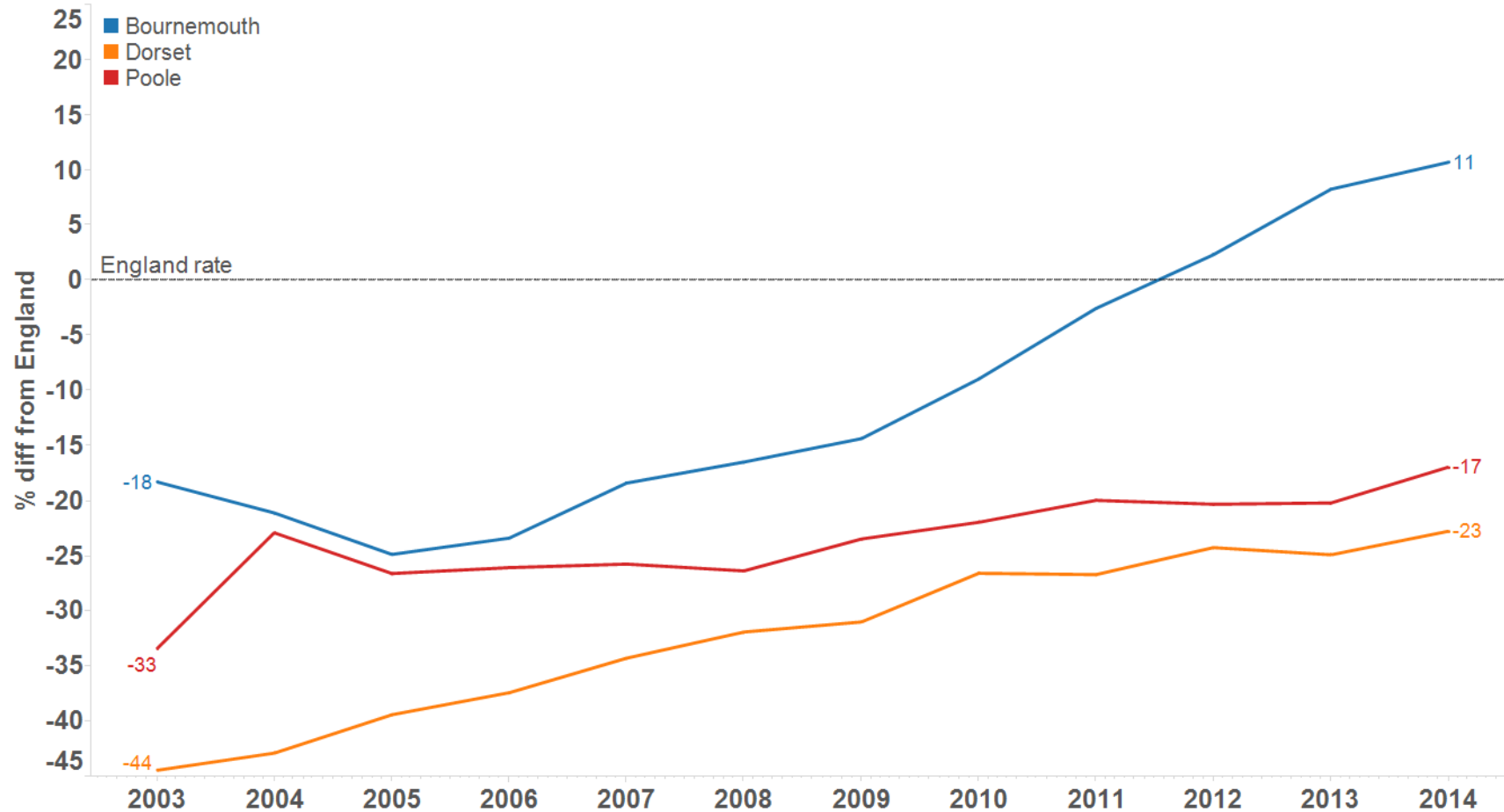
Treatments -42%

Heart attack	-8%
Secondary prevention	-11%
Heart failure	-12%
Angina: CABG & PTCA	-4%
Angina: Aspirin etc	-5%

Local Changes: Early deaths from CVD since 2003

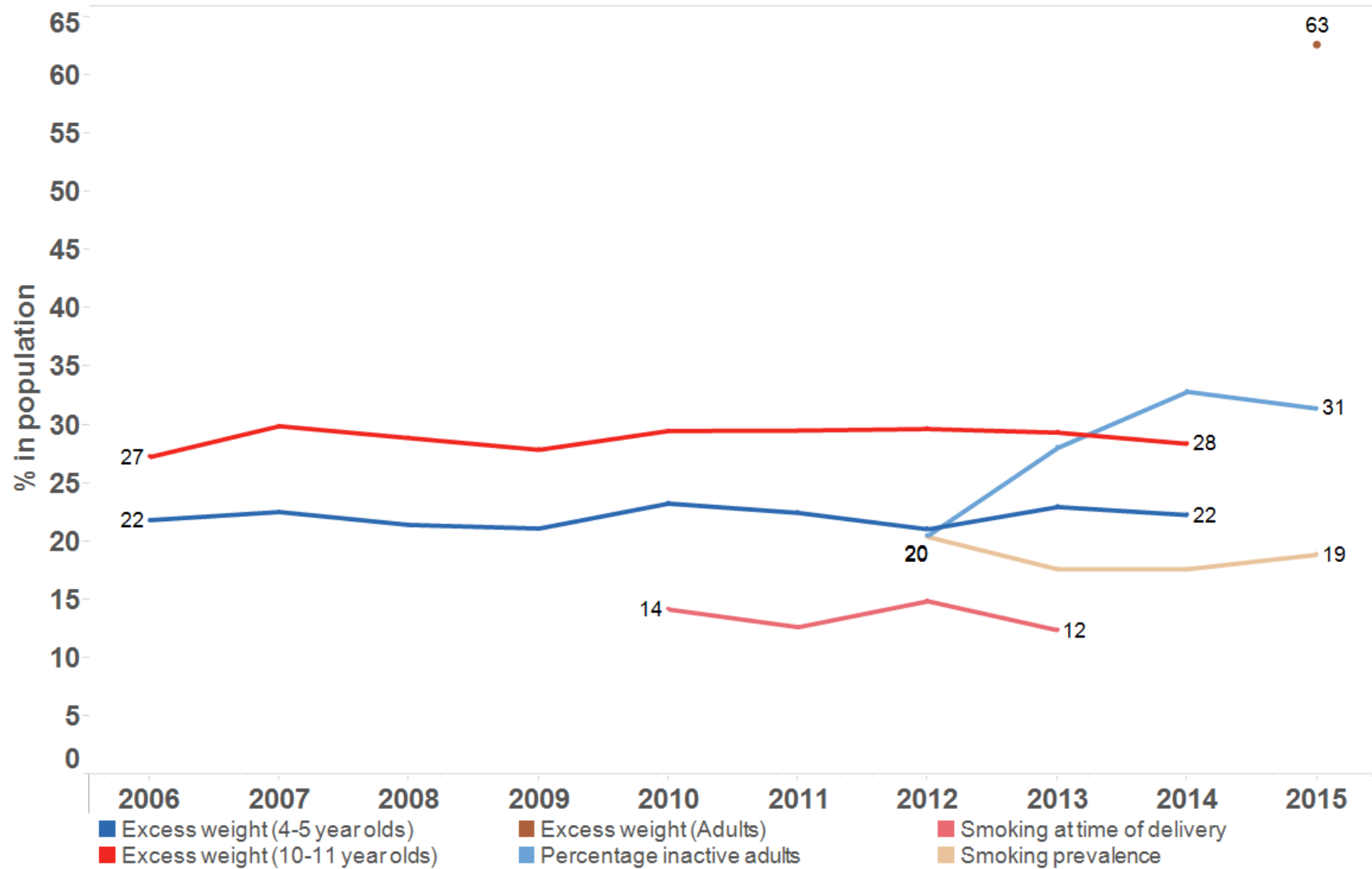
Changes in rates year on year

Difference in local rates compared to England



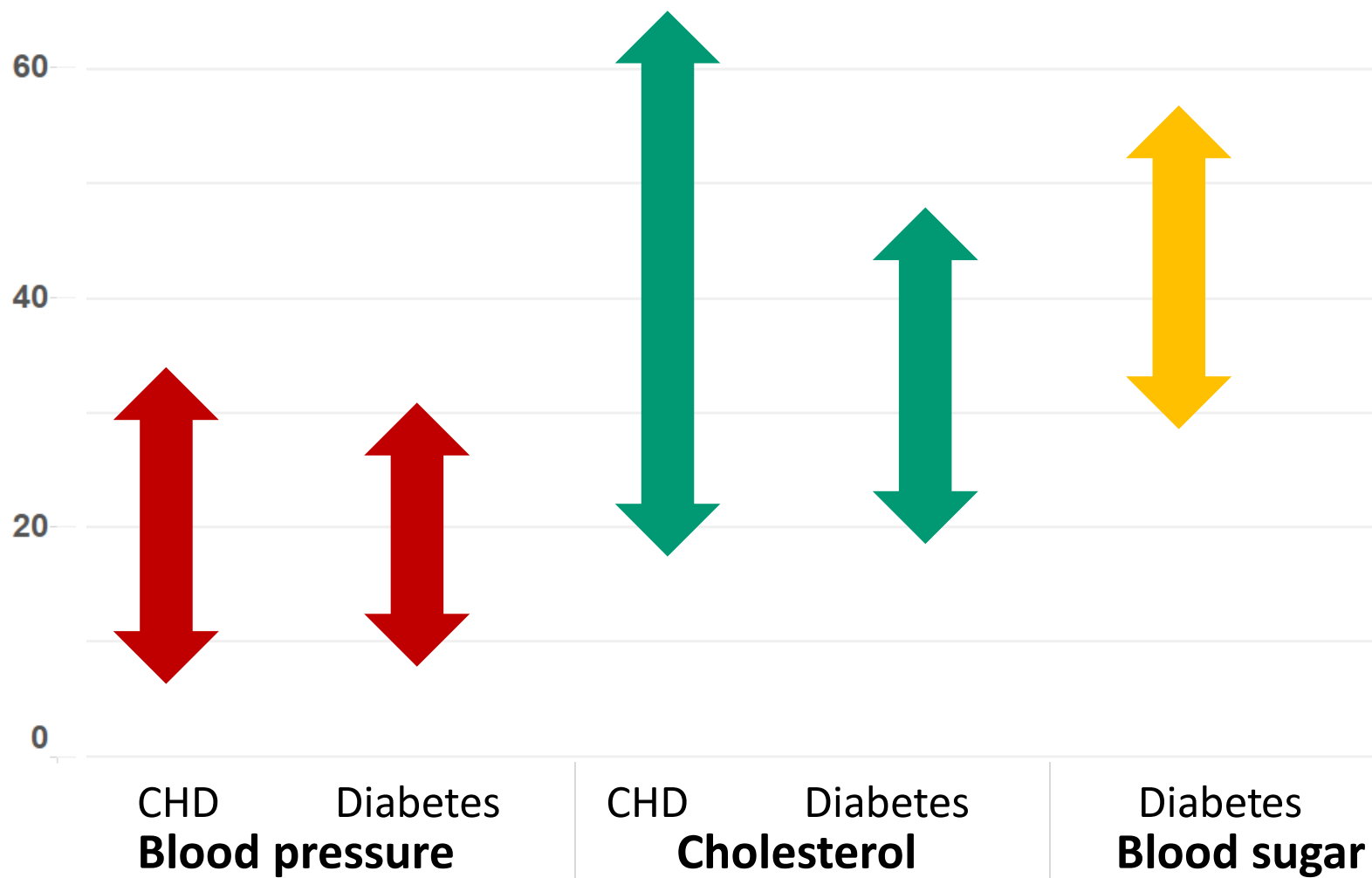
Explaining local changes?

Local Changes in Risk Factors.



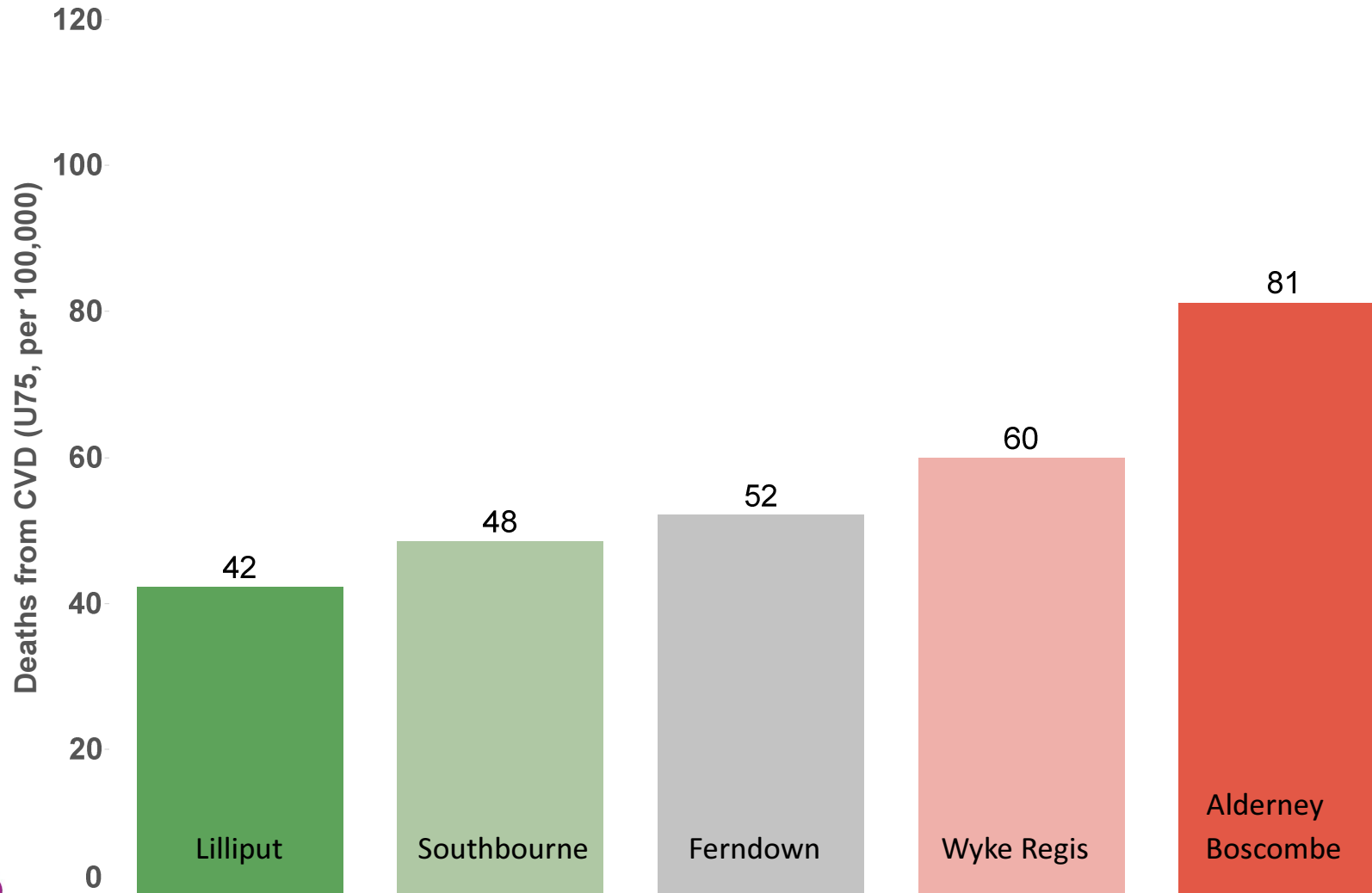
Explaining Local Changes?

2. Local differences in the management of people with risks



Explaining Local Changes?

3. Non individual factors – Poverty & Deprivation

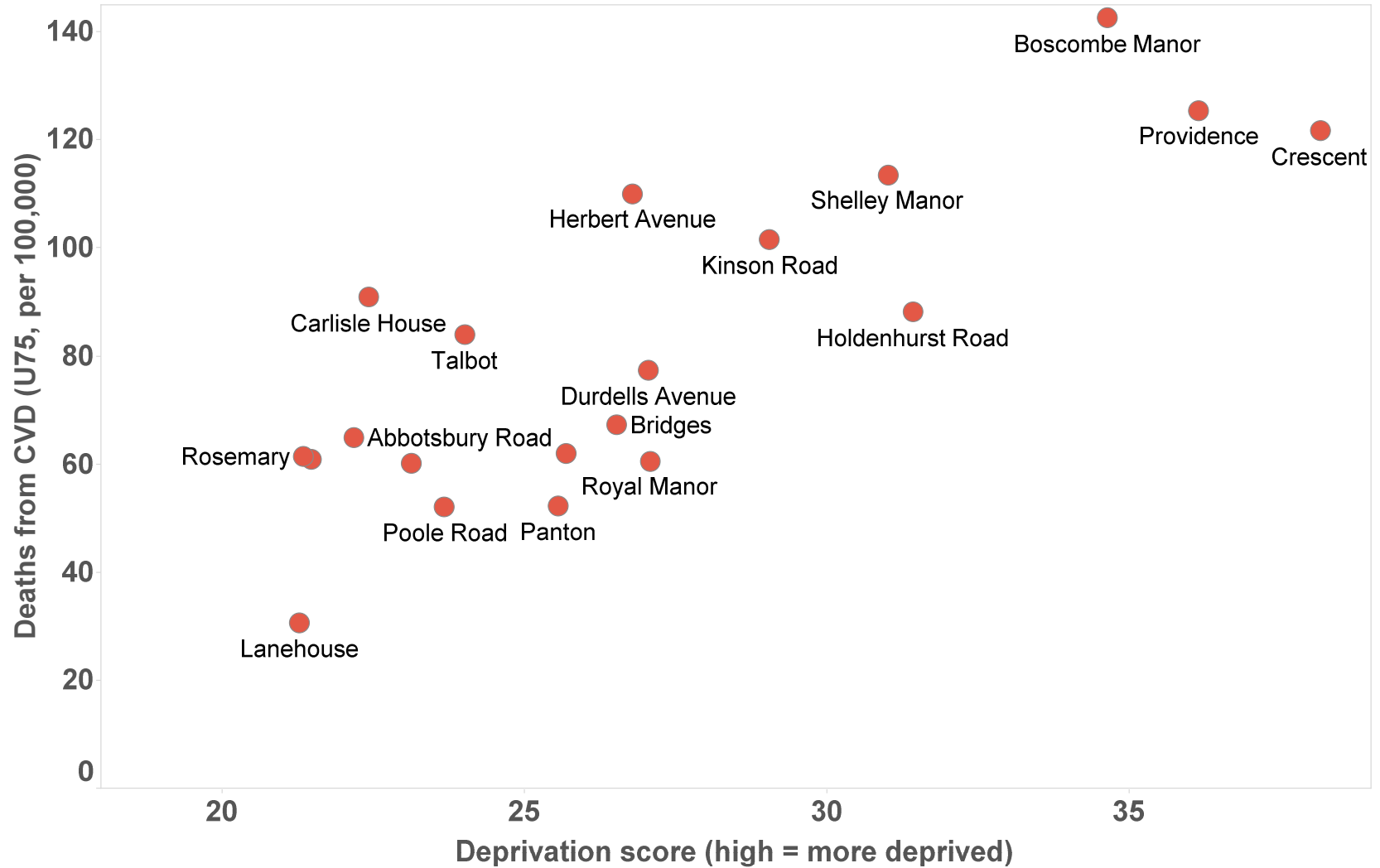


Least deprived...

...most deprived

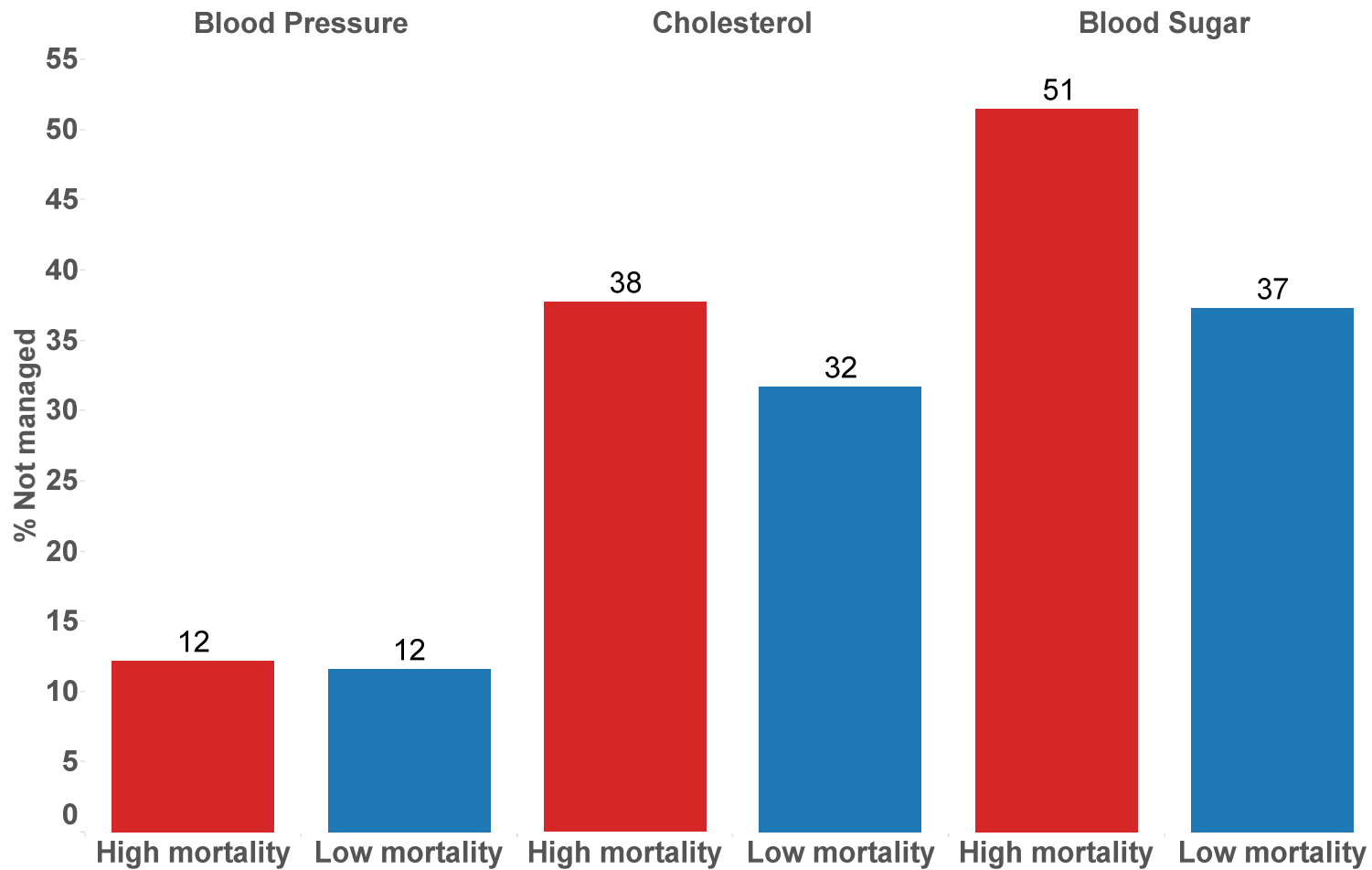
Explaining Local Changes?

3. Non individual factors – Poverty & Deprivation II



Explaining Local Changes?

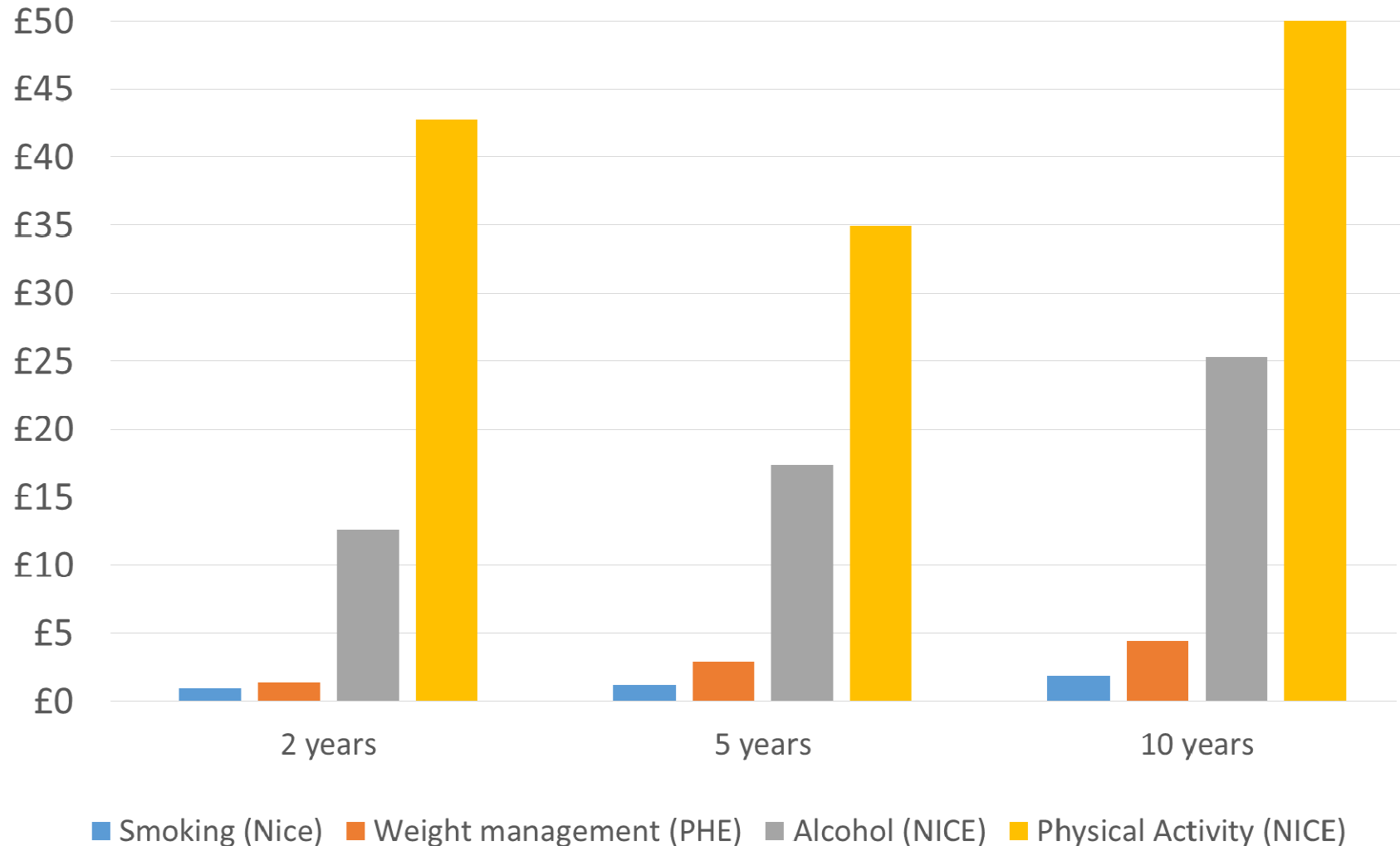
3. Non individual factors – Poverty & Deprivation III



Where should we focus?

1. Modifying Risks

£s returned for every £1 invested







Where should we focus?

2. Better managing existing conditions

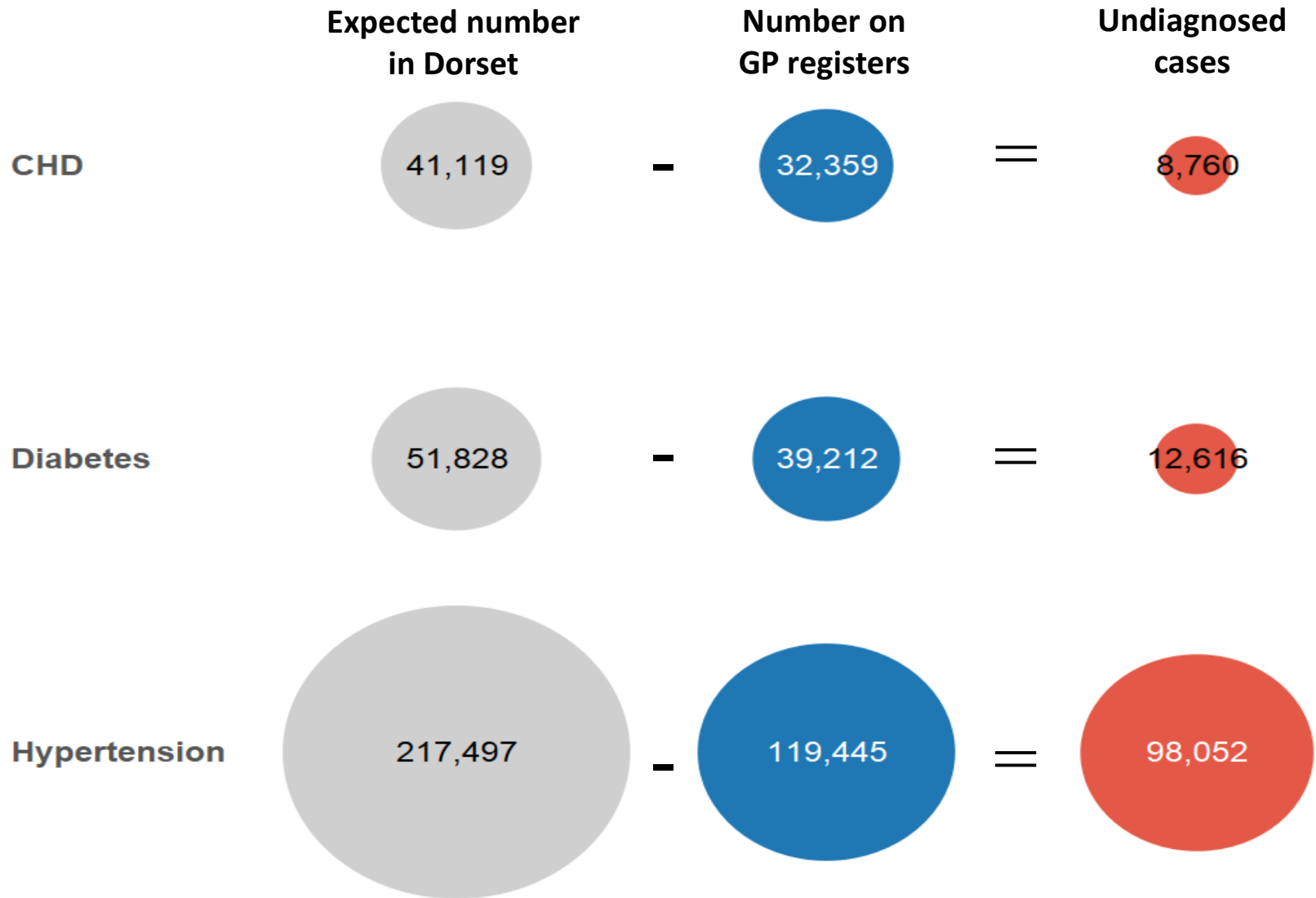
Better Blood pressure control in people with hypertension

In the next 5 years if every practice performed as top 25%

	Events avoided:	Costs saved:	
		NHS	Social Care
Stroke	 69	£755,200	£273,600
Heart attack	 46	£401,400	
Heart failure	 97	£133,700	
Deaths	 37		
		Total = £1.6m	



Finally: Do we know what we don't know?



Summary

- The scale of the challenge is huge and given how common the risk factors for CVD are, how many remain undiagnosed, and how many new ones arise every day it makes no sense focussing on routinely finding new cases in the general population.
- In terms of return on investment for population risks the best choice is promoting physical activity & reducing overweight in the whole population.
- We need effective broad based efforts for weight reduction/physical activity e.g
 - *Individual:* social /community movements - park run/pokemon go,
 - *Place based:* regeneration and green space e.g Boscombe, Melcombe regis
 - *Organisation:* 50% of NHS/LA staff , 5KM walk, 50% of days of the week
- Intervening as early as possible is clearly best + a focus on times of important transition in life e.g. obesity, diabetes and smoking in pregnancy.



Summary - II

- Clinical practice: the clear winner is better managing high blood pressure – but, variations, wherever they are measured, are a ‘failure’ of the whole system and not just one part.
- We all need to take responsibility for shifting the curve, 10% for people with hypertension in whatever setting with will make a real difference. We also need to invest more where the problem begins not ends.
- We need such approaches to be central to any new models of care and partnerships – e.g. Accountable Care.
- We need to move beyond an organisational mindset of ‘what’s in it for me’ to the system default position being ‘of course we can’ - beyond QoF points or PbR medals to sharing data in real time and making common consistent decisions on care.



The alternative is the perfect storm.....