Cardiovascular disease prevention and management in the community: Representing the voice of local people

Executive Summary

Please contact Healthwatch Norfolk if you require an **easy read**; **large print** or a **translated** copy of this report.

Postal address: Healthwatch Norfolk, Suite 6 – Elm Farm, Norwich Common, Norfolk, NR18 0SW

Email address: enquiries@healthwatchnorfolk.co.uk

Telephone: 0808 168 9669

Your voice can make a difference...

healthwatch Norfolk

Healthwatch Norfolk works with health and social care services in Norfolk to make sure that your views and experiences make a difference to the services we all use.

Call us on 0808 168 9669

Website: www.healthwatchnorfolk.co.uk Email: enquiries@healthwatchnorfolk.co.uk

Follow us on Twitter: @HwNorfolk Like us on Facebook: facebook.com/healthwatchnorfolk

Who we are and what we do

Healthwatch Norfolk is the local consumer champion for health and social care in the county. Formed in April 2013, as a result of the Health and Social Care Act, we are an independent organisation with statutory powers. The people who make decisions about health and social care in Norfolk have to listen to you through us.

We have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We are here to help you influence the way that health and social care services are planned and delivered in Norfolk.

Summary

Cardiovascular disease (CVD) is a general term that describes all diseases of the heart and circulation. It includes conditions that are diagnosed at birth to developed conditions such as coronary heart disease, atrial fibrillation, heart failure, and stroke. Cardiovascular disease accounts for more than 150 000 deaths a year in the United Kingdom, (Townsend et al., 2014) affects more than five million people, and annual costs exceed £30bn (Luengo-Fernandez, Leal, Gray, Petersen & Rayner, 2006)

Tobacco, alcohol, physical inactivity and poor diet are among the biggest contributors to most preventable disease; they are responsible for 42% of deaths (Bernstein, Cosford and Williams, 2010).The most successful means to reduce these risk factors are population-led interventions that involve a change in legislation, such as the banning of smoking in public areas (The Health Act, 2006). However, it is not feasible to tackle all risk factors with legislation and whilst public health campaigns such as Change4life are very successful, (Department of Health [DH], 2010a) these messages will not be enough to enable all individuals to change their behaviour and lead a healthier lifestyle.

We asked over 800 local people about the non-pharmaceutical interventions they access, or have accessed, in the community to manage the physical lifestyle risk factors associated with long term disease.

The first part of the report focusses on the experiences and perspectives of the local population with regards to the **primary prevention** of cardiovascular disease **(**interventions that delay the onset of CVD). We collected comments about the NHS health check – in particular to find out if those eligible are accessing their check and if not, why not. We were also interested in finding out the sort of advice health practitioners were offering during a consultation or routine appointment and how useful patients perceive it to be. Our findings strongly suggest that in order to *make every contact count*, brief messages about diet should be more concise, levels of physical activity better identified and more referrals made to community providers or initiatives that deal with "multiple risk factors", such as exercise referral schemes.

The **second part** of the report looks at the **secondary prevention of CVD**, (interventions to prevent the progression of the disease). We engaged with over 100 participants who attend phase 3 rehabilitation clinics and phase 4 exercise classes across Norfolk to understand how individuals with established CVD are supported so that their quality of life might be improved. Our 1-1 interviews with those individuals who have suffered a cardiac event gave us an invaluable insight into the importance of patient centred-care and the dual role of community exercise classes in their rehabilitative and re-preventative role. Our findings also suggest that phase 3 and phase 4 cardiac rehabilitation both have very distinctive roles to play in supporting

individuals to make healthy changes to their lifestyle and maintain them; therefore we suggest that both phases should be equally endorsed by commissioners and funded appropriately.

Key messages are explored and our findings suggest that national programmes and providers, whilst offering interventions that reach a higher proportion of the local population may i*ncrease* rather than *reduce* socio-economic and gender inequalities in the primary care setting. We consider that the expertise of smaller providers in reducing health inequalities should be recognised and properly integrated into existing local provision that has been more formally recognised.

There is a need to support commissioners to understand the contributions that community facing providers make in their role to prevent long term illnesses particularly in those who are more vulnerable. Meeting the unmet psycho-social and/or economic needs of individuals is time-consuming work that might not be considered cost effective because it involves lower numbers of people, yet case studies demonstrate that resolving the wider determinants of health enable individuals to make and sustain behaviour changes that lead to healthier lifestyles. Traditionally, data that is collected does not appear to fully reflect all the outcomes that community providers achieve and how they are intrinsically linked to improved physical health. This means that smaller providers may not be given an equal platform from which to showcase their work and inform the commissioning cycle. Services should not be destabilised because there is a gap in evidence based data or because the data is the "wrong sort". A greater effort to identify outcomes that matter in the prevention of cardiovascular disease including socio-economic ones could be made; impact measures could be standardised and made implicit in service level agreements.

Main Findings

1. Primary Prevention of CVD: accessibility of health checks and the type of services people are referred to in order to alleviate the risks associated with cardiovascular disease.

2. Management of CVD shares the experiences of adults accessing community based cardiac rehabilitation in order to manage established CVD.

1.1 NHS Health Checks: Accessibility & Recruitment

- Overall men are reluctant to attend health checks or see their GP
- The average age of a male accessing a health check is older than the average age of a woman accessing a health check
- The majority of men interviewed were confused about what a health check is actually for
- Men told us they are reluctant to book an appointment with their GP.
- Men of working age would like the opportunity to have their health check at a pharmacy but did not seem to be aware this was an option.
- Our findings suggest that the male adults in our sample who accessed health checks lead more active lives and are likely to be more socio-economically advantaged
- Overall, 56% of adults suggested a health check should be available for adults under the age of 40 years
- The average age of an adult in our sample attending a

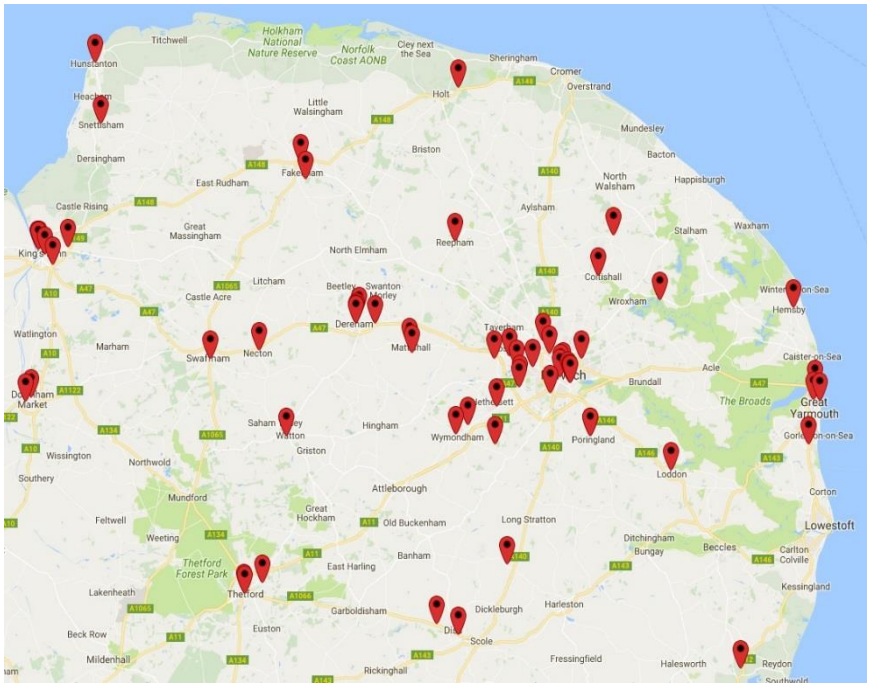

Figure 1. Map showing all engagement venues Feb -Oct 2016.

1.2 Health Checks - Brief advice

- Adults perceived they did not receive enough specific advice about how to reduce the physical risk factors associated with CVD.
- People commented that they did not consider there was room to explore mental health needs during a health check or during a routine visit.
- The immediate changes people made following a check or routine visit to the GP were around diet and exercise but comments suggest these changes were uninformed and unlikely to be sustained.

1.3 Community-based Interventions

- Referrals to services that are expert in alleviating single risk factors are consistent; by contrast, referrals to initiatives or programmes that include an exercise component are not. Local evidence we gathered suggests that community based interventions reduce more than one health outcome.
- Community-led services are good at being inclusive and reducing health inequalities.
- Community providers support people to maintain their behaviour changes.

2.1 Cardiac Rehabilitation: Phase 3

- Our questionnaire revealed that 97% of patients rated the phase 3 service as *excellent* and 3% said it was *very good*; comments suggest this is due to a *patient-centred approach*
- There were differences in how men and women had experienced physical symptoms leading up to their cardiac event
- There are differences in how men and women cope with the psychological impact post heart attack
- The majority of patients told us they were more confident about how to eat more healthily and the type of exercises they could do
- Survey results strongly indicated that the majority of people did not perceive they would feel confident to exercise in a group that was not led by a specialised instructor
- Over half of respondents indicated their confidence in medication was now lower than what it was when they were first discharged from hospital

2.2 Cardiac Rehabilitation: Phase 4

- Participants accessing phase 4 cardiac rehabilitation classes rated the service as *excellent*
- Patients enjoyed the opportunity to increase their levels of physical activity
- In phase 4, people started to build the resilience they need to re-integrate into the community, returning to work and for some, caring for relatives thus saving money for local services
- Participants told us that having accessed phase 4 classes they were now confident to exercise at home
- Our findings suggest that commissioners have neglected phase 4 cardiac rehabilitation to the point where the programme has become fragile and destabilised

Source: Fitter Norfolk. Community cardiac exercise class.

3. What this means

- The design of programmes and services impacts on health inequalities - increasing rather than reducing them
- Non-commissioned services, particularly those that take a holistic approach are not on the radar of commissioners and we think there may be missed opportunities to prevent primary and secondary CVD in the community
- The service user does not necessarily see their primary need as a cardiac one; we consider it is crucial that engagement with the service user takes place to identify unmet need and understand how this impacts on health
- Small providers appear to support people over and above their physical activity and dietary needs. This means that throughput is of high quality but smaller volume
- Comments strongly suggest that pharmacies play an important role in delivering the prevention and wellbeing agenda in Norfolk but are an underused resource
- Training for health practitioners to improve identification of wider health determinants, brief advice and signposting to community based initiatives that alleviate multiple lifestyle risks

5. Recommendationss

Evidence	Recommendation	For… (organisation)	Follow up HWN
• The majority of adults are not aware pharmacies offer health checks but men (in particular) told us they would prefer to access a health check at a pharmacy because it is less clinical and more accessible • Patients were confused over the change of appearance of pill size, shape and colour but were making appointments to see their GP rather than a pharmacist because they had not considered this to be an option • People told us they are more likely to speak *more openly* to a pharmacist about the wider determinates of health and are more likely to *listen to their advice* • Healthwatch contacted 52 pharmacies and just over half were able to offer a health check	**1. The role pharmacies have to play could be fully embedded into the Health Care system in the following ways:** i. GP practices offer patient choice re Health Checks in letter of invitations and over the 'phone ii. Health practitioners, including hospital clinicians and GPs, inform (cardiac) patients that pharmacies offer free drug reviews iii. Pharmacists receive support (training) so they better understand referral pathways to services that offer longer term lifestyle interventions - particularly those which increase levels of physical activity and support those with mental health needs iv. More staff are trained to carry out health checks in order to cope with demand	• Local Medical Committee • Local Pharmaceutical Committee	HWN to ensure findings inform GP/Pharmacy training
• Evidence gathered from service users accessing alcohol services in Norfolk told us that that depression will affect a person's ability to tackle the lifestyle risks associated with cardio-vascular disease	***2. Making Every Contact Count* - consider health checks and routine checks being used as an opportunity for health practitioners to :-** i. Identify "mild" mental health issues which prevent individuals from accessing support to lead healthier lives	• Public Health (Norfolk County Council) • Mental Health Commissioners • Local Medical Committee	HWN to ensure findings inform Making Every Contact Count strategy

• 80% of respondents indicated that mental health affects physical health more than any of the other traditional physical risk factors associated with CVD • Respondents did not think that tackling mental health was the role of the GP but they need to signpost people to someone who has the time to listen and is personable • Adults did not perceive they received lifestyle advice particularly around diet and levels of physical activity and some phase 3 cardiac patients wished the nutritional and exercise advice had been given much earlier. Men attending regular BP checks because there is cardiovascular disease in the family are not necessarily modifying their behaviour – checks are not seen as proactive • Inconsistent referrals to exercise referral schemes and community initiatives/schemes that offer holistic lifestyle interventions	ii. Ensure non-clinical community provision is included in mapping provision to respond to "milder" forms of anxiety and depression that require a socio-economic diagnosis rather than a clinical one iii. Train health practitioners to deliver more *specific* and *proactive key* messages about levels of physical activity and nutrition and how these are linked to health benefits iv. Increase referrals and signposting to services that support behaviour change and offer different ways in which to achieve good health outcomes, particularly those that include an exercise component v. Ensure referral pathways to and from services that offer longer term interventions are robust and eligibility criteria is understood		HWN to request update re medicine reviews and numbers of health checks in pharmacies (August 2017)

• Men told us they would prefer to discuss their health at a pharmacy or in their workplace because it is *more accessible* and *less clinical* • 56% of adults considered health checks, or discussions about lifestyle behaviours should happen at an earlier age	**3.Health Checks could be made more accessible to men (in particular) of working age in socio-economically deprived areas by:** i. promoting the role pharmacies have a role to play (see Rec 1)	• Local Pharmaceutical Committee • Public Health (Norfolk County Council)	HWN to meet with public health commissioners to share findings (March 2017)

	ii. linking to work place schemes and involving employers to promote men's health iii. Engaging with men in their 30s-40s – promote the importance of prevention/offer mini health checks for under 40s		and request update re men's health checks (August 2017)
• Evidence strongly suggests the Tier 2 weight management offer increases socio-economic and gender health inequalities • The **referral pathway to Tier 2** weight management disfavours men : our findings strongly suggest men are less likely to access health checks • The **design of the Tier 2 weight** service disfavours men who associate dieting as being a female issue and have different attitudes around food consumption. A broader approach to tackling weight loss that includes an exercise element is more suitable as suggested by the 40% of men that attend exercise referral schemes • The triage system means that those deemed not to be suitable for the programme and unable to "show commitment" are more likely to be those who have complex needs and socio-economically more disadvantaged	**4. Demonstrate through assessment and evaluation that Tier 2 weight provision is equitable and should:** i. Be accessible for adults under the age of 40yrs (*as well as above*) ii. Record all outcomes including socio-economic Iii Be accessible for men (include an exercise component) iv Build on community assets	• Public Health (Norfolk County Council) • Clinical Commissioning Groups	HWN to share report findings with community providers and commissioner (Feb 2017) HWN will request a progress update re Tier 2 weight management provision (August 2017)

• Smaller providers have become destabilised and unable to demonstrate how they have modified behaviour change in individuals because outcomes are based on high throughput and does not reflect the link between psycho-social economic determinants of health and physical health	**5. Service provision that reduces the risks of CVD is carefully monitored, assessed and evaluated to inform the commissioning cycle by:** i. Standardising the data collected for preventative services; agree on impact measures that included socio-economic ii. Ensuring that at the point of awarding contracts these impact measures are implicit in service level agreements iii. Allocating resource to smaller providers to support them to capture this data/provide feedback iv. Capturing feedback from the local population and ensuring it informs commissioning v. Providing clear opportunities to review services and transparency about what works well and what doesn't	• Public Health (Norfolk County Council) • Clinical Commissioning Groups	HWN request a response (Feb 2017)
• Uptake to phase 3 rehabilitation classes in Norfolk is 44% below the government target of 85%. Local data also indicates that during a 3 month period in 2015/2016 there were significantly more women than men who were referred • Patients in phase 3 told us they do not perceive they will be ready to exercise independently or join a group that is not led by a level 4 qualified cardiac	**6a. More research could be carried out to understand the uptake to phase 3 cardiac rehabilitation and whether there are differences in gender uptake** **6b. Phase 4 Cardiac Rehabilitation is embedded fully into the cardiac rehabilitation pathway, so it provides a continuation of care that is structured and co-ordinated**	• Healthwatch Norfolk • Clinical Commissioning Groups (CCGs)	HWN to look at options for further work around uptake to cardiac rehab (March 2017) HWN to share findings with

instructor. More time is needed to ensure their behaviour changes are maintained Phase 4 is also preventative. It enables older people (65yrs+) to continue improving their mobility and flexibility and continue caring for partners at home Exercise referral is not the same as cardiac rehabilitation classes and this is made clear in NICE guidance The **savings** made **avoiding readmission** and social care are huge, but we consider the service has not been adequately supported	i. The service could be more fully understood- map existing provision across the county to include details of the types of classes or one-to-one offer provided, qualifications of instructors, numbers of participants, number of sessions per week, venues and times. ii. Clear accountability for the funding of this service. We suggest it is preventative (falls), re-preventative (CVD) and rehabilitative. Co-commissioning opportunities are explored. iii. There is a phase 4 co-ordinator who oversees the phase 4 offer across the county and looks for opportunities to share good practice iv. Data is collected that reflects impact and this is used to better inform commissioners	• Public Health (Norfolk County Council)	public health and CCGs and request a response (Feb 2017)