ROTHERHAM BOROUGH COUNCIL – REPORT HEALTH & WELLBEING BOARD

1.	**Meeting**	**Health & Wellbeing Board**
2.	**Date**	**02/06/2014**
3.	**Title**	**Reducing Potential Years of Life Lost**
4.	**Directorate**	**Public Health**

5. Summary

Over 7,000 potential years of life are lost among Rotherham residents from causes considered amenable to healthcare. This is about 1,600 years higher than expected when compared with the national average. The main direct causes are circulatory disease, cancer and respiratory disease.

Rotherham Clinical Commissioning Group (RCCG) have committed to reducing Potential Years of Life Lost that are considered amenable to healthcare by 200 years per year over the course of their 5-year strategy.

The key to achieving this aim is partnership action to make the most of the services that have already been commissioned.

6. Recommendations

HWBB members to:

- note the actions that the CCG intend to pursue to reduce potential years of life lost
- support the CCG in implementing these actions

7. Proposals and details

Although life expectancy at birth has improved in Rotherham, the gap with England hasn't narrowed. There is also an inequality between the life expectancy experienced by the most and least deprived areas within the borough.

The root causes of these inequalities are the wider determinants of health; however, these determinants result in ill health which is the direct cause of death. In Rotherham, the direct causes of the bulk of the inequalities in life expectancy are circulatory disease, cancer and respiratory disease. This is the case for both the gap between the borough and the England average and within the borough between the most and least deprived areas.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. Some of these deaths could have been avoided had effective healthcare been provided when they were alive. About 7,000 PYLL are lost each year in Rotherham through causes considered amenable to healthcare. This is over 1,600 years more than

might be expected based on the England average. Rotherham CCG have commited within their 5-year strategy to reduce amenable PYLL by an average of 200 years per year.

The main drivers of the excess of PYLL in Rotherham are the same as the drivers of inequalities in life expectancy; namely, circulatory disease, cancer and respiratory disease. Figures describing within borough inequalities in PYLL are not published; however, the drivers are likely to be the same.

Within the new commissioning landscape, tackling amenable premature mortality will require a coordinated partnership approach involving RCCG, NHS England South Yorkshire and Bassetlaw Area Team (SYBAT), Rotherham Metropolitan Borough Council Public Health (RPH), The Rotherham NHS Foundation Trust (TRFT), General Practice (GP) and the wider membership of the Rotherham Health and Wellbeing Board (HWBB). To support this, NHS England (NHSE) in partnership with the Commissioning Assembly, NHS Improving Quality and Public Health England have developed a toolkit of potential local actions across the system that RCCG could lead or support actively in order to narrow the gap. The full shopping list of potential actions can be found at http://www.england.nhs.uk/ourwork/sop/red-prem-mort/.

The tables on the following pages outline the proposed interventions that have been prioritised based on their likely impact in reducing PYLL in Rotherham. The interventions are geared towards prevention and early intervention and supporting people with long term conditions. In addition, they are likely to benefit our most disadvantaged citizens the most and will help to reduce health inequalities.

Reducing mortality from cardiovascular disease

Circulation problems account for nearly a 1,000 of the excess of years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
All HWBB Partners actively promoting NHS Health Checks	GP delivered NHS healthcheck programme; previously one of the best performing in the country; however, current performance in decline and significant between practice variation.	RPH to adapt national marketing materials to promote awareness of programme. GPs to support improved uptake by adapting invitation method to their specific populations. GPs to ensure clinical follow-up of people identified as having or being at risk of cardiovascular disease are engaged in and in receipt of appropriate lifestyle and/or pharmacological intervention. RCCG and SYBAT to make use of relevant levers to facilitate improvement in GP quality in relation to the NHS Health check.	HWBB RPH GP RCCG and SYBAT	1404 QALYs gained based on national uptake assumption of 80% (gain is shared between preventable and amenable mortality)
Making (sure) Every Contact Counts (MECC) through effective referral into stop smoking services	MECC adopted in principle by the NHS in Rotherham however this has not translated into increased referral into lifestyle services.	RCCG to ensure referral of current smokers to smoking cessation is a fundamental part of all pathways in and out of secondary care. RCCG to consider commissioning a national referral systems to facilitate above.	RCCG TRFT	165+ QALYs gained based on 2,350 extra referrals to stop smoking services (gain shared between reduction in CVD, Respiratory and Cancer mortality)
Improved detection and management of atrial fibrillation (AF)	There are relatively high rates of undiagnosed cases of AF and treatment varies across the country. National Enhanced Service for anticoagulant monitoring.	RCCG to work with local practices to target people at risk of AF and ensure appropriate pharmacological interventions in line with NICE guidelines. RCCG to consider promoting use of the Guidance on Risk Assessment in AF (GRASP-AF) tool by local GPs.	RCCG GP	70 fewer PYLL
Increased utilisation of cardiac rehab	Cardiac rehabilitation available for all patients following heart attack; uptake is higher than average but still some scope for further improvement. At present, patients with heart failure (HF) have no cardiac rehab following acute admission.	RCCG to commission increased capacity in cardiac rehabilitation units and use contracting levers to encourage providers to increase access to rehabilitation for currently under-represented groups including women and people from certain ethnic groups.	RCCG TRFT	26 fewer PYLL. Intervention also has potential to reduce readmissions for exacerbation of HF.

Reducing mortality from respiratory disease

Respiratory disease accounts for over 300 of the excess years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
Participate in pilot of care bundle for community acquired pneumonia.	In-hospital mortality for pneumonia is low; however, pneumonia is a major cause of inequalities.	RCCG to commission care bundle which ensures: • Perform and assess Chest x-ray within 4hrs of admission • Assess oxygen and prescribe target range for oxygen • Use of CURB 65 to risk stratify (Confusion of new onset, Urea >7mmol/l, Respiratory rate 30/min or more, Blood pressure <90mmHg systolic or 60mmHg or less diastolic, and age 65 or over) • Administer appropriate antibiotics within 4hrs of admission	RCCG TRFT	208 fewer PYLL.
Earlier and more accurate diagnosis of Chronic Obstructive Pulmonary Disease (COPD)	Although Rotherham has excellent treatment services for people with COPD, there is evidence that undiagnosed cases exist and that some patients have been incorrectly labelled as having COPD. Nationally, about a third of admissions for exacerbation of COPD is in people not previously known to have it.	RCCG to consider opportunities for systematic and opportunistic case finding of people with COPD. RCCG and GPs to consider the need for ensuring those performing and interpreting spirometry for diagnostic purposes have attained a nationally recognised level of competence.	RCCG GP	10 fewer PYLL
Maximising uptake of pneumococcal and seasonal flu vaccination	The World Health Organisation recommends at least 75% of the over 65 population needs to be immunised for seasonal flu. Rotherham achieved this in 2012/13; however, uptake in other risk groups of a younger age was only 55%.. Pneumococcal Polysaccharide Vaccination (PPV) uptake was over 73% in 2012/13. Given the prevalence of respiratory problems within the borough, a higher level of coverage for sesonal flu and PPV in all target groups may be justifiable.	SYBAT and RCCG to consider how to enhance local coverage of the Seasonal Flu and PPV. GPs to support improved uptake by adapting invitation method to their specific populations.	SYBAT RCCG GP	

Reducing mortality from cancer

Cancer accounts for nearly 300 of the excess years of life lost from causes amenable to healthcare.

Intervention	Where we currently stand	Proposed intervention	Responsibilities	Potential gain
Monitor variation in referral and diagnosis rates amongst local practices and work with local GPs to understand the reasons behind variance	There are significant variations in the patterns of GP referrals and outcome rates in relation to the diagnosis of cancer.	RCCG and SYBAT to undertake an analysis of referral patterns and outcomes at practice level, working with practices that have poorer outcomes to understand why there is variance. GPs can then be supported with tailored and focussed support around raising symptom awareness including use of best practice from other parts of the cancer network and Rotherham PH.TV.	RCCG TRFT GP RPH	Not quantifiable.

8. Finance

NICE have set a benchmark of £20,000 to £30,000 per Quality Adjusted Life Year as the upper limit of affordability for treatments available on the NHS. Using this benchmark, PYLL from causes amenable to healthcare could cost the local economy up to £210 million per year. The excess of PYLL in Rotherham over the England average equates to a cost to the local economy of about £48 million per year.

By focussing on getting the most out of existing services, the reduction in PYLL could be achieved at little or even no cost.

9. Risks and uncertainties

Where possible, estimates of potential reductions in PYLL have been calculated. These are all based on national average assumptions. Therefore, the actual reductions may be different. Given the excess of mortality locally, it's most likely that the reduction in PYLL will be greater.

10. Policy and Performance Agenda Implications

PYLL is monitored routinely as a part of the CCG Outcome Indicators and NHS Outcomes Framework; however, year on year changes can fluctuate up and down. Therefore, more frequent monitoring of PYLL is unlikely to provide assurance of improvement.

Suitable existing metrics include health check coverage and is published at least quarterly. Coverage of seasonal flu and pneumococcal vaccination coverage is also published annually. Smoking referrals from secondary care that result in a quit is a possibility that needs to be worked up further.

The CCG would need to consider how to monitor the impact of other interventions it decides to implement; however, qualitative measures of progress against action plans would be a reasonable option.

11. Background Papers and Consultation

12. Keywords:

[Keywords]

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