Attach 2

Wandsworth Clinical Commissioning Group

CARDIOVASCULAR DISEASE (CVD) PROGRESS REPORT - SEPTEMBER 2013

1. Purpose

The purpose of this report is to update the Wandsworth CCG Board on progress in developing and implementing services and initiatives which will improve the health outcomes for people with, or at risk of developing cardiovascular disease in Wandsworth. The focus is on the work carried out in the last year and plans for the next year.

2. Local Context

CVD is one of the main health issues identified in the Wandsworth Joint Strategic Needs Assessment for 2011. In 2010 there were 493 deaths related to cardiovascular disease (CVD) in Wandsworth. CVD is the leading cause of death (all ages) in Wandsworth accounting for one-third (32%) of all deaths in 2010. Compared to the England average the latest (2008-10) all ages mortality rate for CVD in Wandsworth was significantly higher (179.7 deaths in Wandsworth per 100,000 population compared to 167 for England). It is also significantly higher than the rates in other inner London PCT's (155.1). The CVD mortality rate in 2008-10 for people living in the most deprived areas of Wandsworth is 2.1 times higher than the overall mortality rate for persons who live in the **least** deprived areas of Wandsworth (SEPHO, 2012, p.16).

There is evidence of improvement. The all age CVD mortality rate in Wandsworth has decreased by a third (33%) since 2005 compared to 22% and 23% for England & Wales and London respectively. More recently, since 2008, the all age mortality rate in Wandsworth has decreased at double the rate (20%) of the decrease for England & Wales (9%) and London (11%). A similar trend is also seen for under 75 years old CVD mortality. These decreases have seen the yearly (as opposed to a 3-year average described above) mortality rates in Wandsworth reach a level that is similar or less than the yearly rates for England & Wales and London for 2010.

There are a number of well recognised factors which increase the risk of cardiovascular disease. These include smoking and being overweight or obese, having an unhealthy diet, a high salt intake or a lack of physical activity. Other conditions such as hypertension and diabetes also serve as risk factors for CVD. Wandsworth is an extremely diverse borough, with varying levels of deprivation and an ethnically diverse population. These factors lead to significant health inequalities. There is a 75% correlation between CVD mortality ratios for those aged under 75 years and socioeconomic deprivation by ward in Wandsworth. Mortality is also higher in particular ethnic groups. See appendix 2 for further information on prevalence of CVD risk factors/mortality across wards in Wandsworth.

3. Background

The Coronary Heart Disease (CHD) National Service Framework (NSF) was published in 2000 and was a 10 year strategy to reduced cardiovascular disease. Its target was to reduce mortality in people under 75 years by 40% (which it met, ahead of schedule). In Wandsworth an Implementation Group was established in 2004 to implement the NSF and at the end of the 10 years of the NSF, the group

continued its work and evolved into the CVD Clinical Reference Group. This multi-professional group, with patient input and clinical, commissioning and public health expertise was the model on which all the Clinical Reference Groups of our CCG was based.

4. Cardiovascular Disease Clinical Reference Group

The purpose of the Cardiovascular Disease (CVD) Clinical Reference Group (CRG) is to establish and implement the strategic intentions of Wandsworth Clinical Commissioning Group (CCG) in the commissioning of services and improving outcomes for people with, or at risk of developing cardiovascular disease in Wandsworth.

The CRG meets every two months and is chaired by Dr. Nicola Jones. The group membership includes two GP Clinical Pathway leads, Dr. Simon Mills (Battersea) and Dr. Lauren Bloch (West Wandsworth), representatives from Commissioning, Public Health, Local Authority and local providers to ensure health and social care representation as well as a lay representative to provide the patient voice. See appendix 3 for a list of CRG members.

5. Current work streams

The CVD Outcomes Strategy was published in March 2013 and outlines 10 key actions that will deliver improvements in patient outcomes and will also save money. See appendix 5. The CRG is working on initiatives in each of the 10 areas.

CVD represents a single family of diseases, linked by common risk factors. The overarching approach taken by the CVD CRG creates opportunities to identify and manage the multi-morbidity that exists in individual patients. Consequently the CRG has a vast number of clinical areas to cover and an expansive work plan. The CRG has therefore developed an annual work programme which outlines the key priorities.

The following areas of work are of particular importance in the current year:

- ***Cardiac rehabilitation***: This is an important intervention for people with existing CVD. The evidence base is strong and the patient groups who may benefit have expanded recently. The CCG has invested significantly in improving access to the service to all eligible patients and has commissioned an integrated service in line with the evidence base.

- ***Heart failure***: Patients are often frail and elderly, have multiple co-morbidities and commonly experience repeated admissions when the heart failure becomes unstable. The CRG is working closely with the HF team in the community and in the acute setting to ensure patients with HF are managed rapidly to prevent unnecessary admissions and receive high quality care in hospital. New investment has been approved to expand the specialist nursing service in the community and a CQUIN for 13/14 has been agreed to support the development of an integrated pathway redesign.

- ***Peripheral vascular disease***: Wandsworth is one of the few CCGs in England commissioning physical activity for patients with peripheral vascular disease. This innovation has been developed in partnership with vascular surgeons and public health colleagues.

- ***Chronic kidney disease***: As a result of public health data which shows that the prevalence of chronic kidney disease in Wandsworth is well below the expected level, the CRG has established case-finding project.

- ***Prevention and screening***: Wandsworth has an excellent track record of delivering NHS Health Checks, but there are some patients in the most deprived areas, potentially with the most to gain, who have not been offered the check. We are working with public health to encourage practices in these areas to increase their efforts.

- ***Stroke***: A stroke sub-group has been established to ensure that patients who have had a stroke have access to high quality services.

More detail on these areas and the other work-streams is available in appendix 1.

6. Significant CVD proposals

Heart Failure

Wandsworth CCG commissions a community based specialist heart failure nursing service. The aim of the service is to support patients with heart failure in optimising their long-term management, to self-manage and to provide urgent input to prevent an acute hospital admission during exacerbations or de-compensation.

The service was first established in 2005 and was an innovative approach which complemented the new acute service at St George's NHS Trust. In the last 2 years the service has had some additional investment but this has not been enough to keep up with the increasing demand. Patients are living longer with heart failure due to effective treatment and the service cares for people with greater complexity, both in the acute setting, and in the community. A recent audit requested by the CVD CRG, highlighted that:

- The service is not consistently able to provide the urgent input required to prevent patients being admitted to an acute trust
- There are heart failure patients being discharged from acute trusts who would benefit from supported discharge into this specialist community based service, but some patients are not being seen in the service. This is partly due to capacity, but partly because the patients are not being referred into the service from the acute setting.

As a result of these concerns, the CVD CRG is supporting the service through:

- Releasing additional investment to increase staff capacity within the community based service
- Working with Tunstall Healthcare UK Ltd to develop Telehealth services within the existing heart failure care pathway. This will enable the specialist service to identify patients whose long-term management would be enhanced by remote monitoring, therefore freeing up time for the staff to spend face to face time with patients in most need
- Identifying appropriate heart failure patients within primary care who would be suitable for onward referral into the specialist service to prevent patients being admitted to an acute trust

In 2012/13, St George's NHS Healthcare Trust commissioned GE Healthcare to support the Trust's service improvement programme along the Acute Coronary Syndrome (ACS) pathway. In order to address the issues highlighted above, it has been agreed that the Trust will use the same service improvement techniques. Wandsworth CCG is therefore committed to supporting the Trust in this work over the coming year.

7. Recommendations

The Wandsworth Clinical Commissioning Group Board is asked to:

- Note the progress made in the development of cardiovascular disease services and initiatives in the past 12 months;
- Note the plans for future development in the coming 12 months.

Appendix 1: Cardiovascular Disease Work Programme

Primary Prevention (Risk Factors and Lifestyle)	2012/13 report	Progress on current year 2013/14 Initiatives
Hypertension	In August 2011, NICE issued new guidance on the management of hypertension in adults which focuses on improved identification of hypertension and targeting treatment to the right people in the future using 24 Hour ambulatory blood pressure monitoring (ABPM) as a diagnostic tool. In 2012/13, the CCG commissioned a 24 Hour ABPM service within primary care. The perceived benefits were that by providing this service in primary care, the CCG would reduce the number of referrals to secondary care; improve access and waiting times for the service as well as ensuring more accurate identification of hypertensive patients resulting in fewer false positives and therefore a reduction in the growth of monitoring. During the first year of service provision, 1520 patients had an ABPM.	Monitoring and evaluation are on-going.
Physical Activity	In 2012, Wandsworth Public Health Department delivered the Exercise on Referral Scheme, Physical Activity Clinics and the Specialist Exercise Scheme. The referral schemes were run in partnership with the local leisure supplier, DC Leisure. These services are aimed at helping patients who are at risk of developing or already have serious long term conditions to benefit from an increase in physical activity. Key information from the services found that: • In 2012/13, over 700 people were referred to the Exercise Referral Scheme • 45 people were referred to the Specialist Referral Schemes, significantly lower than the number of patients in Wandsworth	Wandsworth Public Health department has recently commissioned the physical activity services from DC Leisure on a contract until September 2014. This will include the Exercise on Referral and Specialist Scheme. The Physical Activity Clinics have now been built into the initial assessment process of the referral schemes. The schemes will now offer a reduced cost to patients at £2 a session for the duration, one of the lowest costs in London. To accommodate the rising numbers of patients with a BMI of over 45 (very high), all the DC Leisure referral tutors are now qualified in a relevant obesity and diabetes qualification. The Specialist Scheme will accommodate the Peripheral Vascular

	who were diagnosed with COPD or CVD history. • Latchmere, Furzedown, and Queenstown had the highest number of referrals. • There were almost 800 referrals to the Physical Activity Clinics, with over 50% attendance rate. • Services were available across the borough, specifically within Balham, Latchmere, Putney, Roehampton, Tooting and Wandle Leisure Centres.	Disease pathway for patients who are referred via this – see below A new online referral management system will soon be launched – "Refer-All". This will allow a streamlined approach for all referrers to physical activity, Health Trainers and other life-style services. The commissioned provider DC Leisure will be using this as their sole referral management system.
Obesity	Public Health re-tendered the weight management services for adults and children in 2011/12 which began delivery in April 2012. There are weight management services for school aged children and adults delivered mostly through groups which are available in community and health settings across the borough. An obesity prevention service is delivered in early years settings and includes healthy lifestyle courses for families, post natal weight management programmes and Healthy Wandsworth accreditation for early years sites. Public Health also commissioned the delivery of obesity awareness training for front line staff. Almost 400 staff were trained over the year. The adult weight management provider, MEND, closed down its business and the contract was transferred to Mytime Active.	Weight management services are continuing. Mytime Active is delivering the early years and adult weight management programmes. The Healthy Weight Strategy and action plan is being refreshed along with an Obesity profile report to support the needs assessment. A borough-wide steering group is being established to oversee the implementation of the strategy. Presentations are taking place with Locality Commissioning Groups to discussed how GPs can increase referrals to obesity services.
NHS Health Checks	The NHS Heath Check Programme is a National Cardiovascular Disease Primary Prevention Programme with the aim of reducing heart disease, kidney disease stroke and diabetes. The NHS Health Check is offered to eligible people who are either registered with a Wandsworth GP or resident in Wandsworth and are aged 40 to 74, and have not previously been diagnosed with any form of Cardiovascular Disease. Since its start in 2009 Wandsworth has been recognised as one of	In April 2013 responsibility for the commissioning and delivery of the NHS Health Check Programme transferred with the Public Health function to the Local Authority. Public Health have commissioned Solutions4Health to run the Community Outreach NHS Health Check Programme; which will complement the provision of checks within Primary Care by providing the programme in selected community settings targeting our high risk

	the 'top performing' areas in the country. In 2012/13 42 out of 44 practices were offering the NHS Health Check and over 15,000 people were offered a check which exceeds the national target of offering 20% of our eligible population a check. Although overall performance is extremely positive, individual practice performance levels still vary across the borough. See appendix 3 for a more detailed report on NHS Health Check Practice Performance 2012-13. The performance of the NHS Health Check Programme to date is shown in the table below: **Year** / **Offered** / **Received** 2009/10 / Not recorded / 4733 2010/11 / 17959 / 10319 2011/12 / 21949 / 12133 2012/13 / 15984 / 12766 **Total** / **55893** / **39951** In 2012/13 a small LDX pilot programme was established in selected West Wandsworth practices using point of care testing for the cholesterol test as part of the NHS Health Check. This allowed for the check to be undertaken in one appointment without the need for an individual to have a blood test prior to their check.	populations. This programme will see an additional 700 NHS Health Checks delivered in the community, 75% of which will be targeted to the highest risk populations. This programme was formally launched on the 4th August at the Roehampton Festival and a number of mobile clinics have now been established. The LDX pilot evaluation report has been produced and shared with the West Wandsworth locality. The aim of the pilot was to improve the NHS Health Check process and support the delivery of the service in each practice. The results of the evaluation showed that in some practices the LDX machine added value to the delivery of the programme and enabled them to increase the number of checks completed. For those practices where the pilot had limited benefit the opportunity to transfer their machine to one of the other practices will be discussed. Advertising campaigns are a regular feature in 2013/14 with marketing placed in the Wandsworth Guardian and regular articles and adverts in Wandsworth Brightside. A number of training sessions for staff involved in the delivery of the programme have been set up for 2013/14; including CVD Risk Assessment Training for new staff and an update session. A programme of quality assurance for the implementation and delivery of NHS Health Checks will be implemented in 2013/14. Support will continue to be provided to encourage practices to meet their NHS Health Checks targets.

CVD Prevention	NICE has issued new guidance on Cardiovascular Disease Prevention. In June 2012 a paper was approved at the Adult Care and Health Overview and Scrutiny Committee agreeing that the PCT and LA would jointly implement the CVD guidelines. (These aim to provide a health promoting environment through the use of measures such as planning controls to limit the density of fast food outlets and use of contracts for the provision of food in leisure centres and schools). A baseline audit of compliance has been undertaken.	An action plan is in the process of being developed to address the gaps outlined in the audit.

Secondary Prevention	**2012/13**	**Progress on 2013/14 Initiatives**
Cardiac Rehabilitation and Acute Coronary Syndrome (ACS) Pathway	GE Performance Solutions supported St George's NHS Healthcare Trust to build internal capability for sustainable service improvement and integrated pathway redesign. Acute Coronary Syndrome was identified as the first integrated care pathway to be piloted as part of this process with the primary aims being to improve patient experience and quality of care, ensure better coordination of care between internal teams and external stakeholders as well as to support the delivery of savings. One of the key issues identified was that cardiac rehabilitation was not fully integrated within the pathway, therefore eligible patients were not being invited/completing rehabilitation programmes. For cardiac rehabilitation, the agreed measures of success were an increase in the % of eligible patients identified, invited and receiving rehabilitation.	The CCG secured recurrent investment to increase capacity within the cardiac rehabilitation service to ensure the implementation of an integrated pathway which meets national guidelines. Progress to date is that the new continuing cardiac care service specification has been amended so that it aligns with national guidelines as well as service improvement developments carried out as part of the ACS Integrated Care Pathway project. Once the specification has been approved by both the CCG and St George's NHS Healthcare Trust, it will be included within both acute and community contracts enabling the integrated care pathway to be formally commissioned and the additional secured investment to be released. This service improvement scheme is also being supported within primary care via the Quality Outcomes Framework (QOF) Quality and Productivity (QP) domain. The QP pathway focuses on the identification of patients who are considered suitable for cardiac rehabilitation and ensures onward referral into the service. This initiative will not only support the reduction in acute readmissions due to secondary cardiac events and unplanned procedures but also links to the CCGs priority in focusing on patient self-management.

Ischaemic Heart Disease	2012/13	Progress on 2013/14 Initiatives
Heart Failure		The CCG secured investment to develop additional capacity within the Community Services Wandsworth Specialist Heart Failure Nursing service to ensure rapid response and longer term management for Heart Failure patients. As the Specialist Heart Failure Nursing service has been identified as one of the services that will be incorporated within the community services redesign programme, the service specification has been amended to reflect future service requirements. This service improvement scheme has also been included within the QOF QP domain. GP practices will conduct an audit of all patients on the heart failure QOF register, review each patient's individual care plan and identify those individuals who would benefit from onward referral into the Specialist Heart Failure Nursing Service. The initiative will support the reduction in acute readmissions due to secondary cardiac events and unplanned procedures. A recent internal audit by St George's has demonstrated very significant reductions in length of stay for patients with heart failure. The CVD CRG has asked for further investigation by the CQRG to understand what the impact of this has been on the quality of patient care.
Arrthymia	Identification and management of patients with atrial fibrillation (AF) prevents strokes and following the innovative Wandsworth pulse screening project, BP monitors, recommended by NICE, which detect possible AF, have been distributed in practices in Wandsworth.	
Stroke and TIA		As the CVD CRG covers a wide agenda, it was agreed to create a sub-group to focus specifically on stroke. Chaired by Dr. Lauren Bloch, the first stroke sub-group met in June 2013 with the purpose of agreeing the terms of reference including group membership, aims and

		objectives and work priorities for 2013/14. As a result, the group has agreed to focus on "Life After Stroke" with specific focus on the commissioning of 6 month reviews.
Chronic Kidney Disease	In 2012, NHS Kidney Care published the Kidney Disease Profile for Wandsworth CCG. Key information included within the profile indicated that • In 2011/12, there were 4,926 people aged 18 years and older included on the Wandsworth CCG CKD QOF register (Observed prevalence: 1.7%). It is estimated that there are 6,390 people with CKD who remain undiagnosed in Wandsworth (Expected prevalence: 4.0%). • Although Wandsworth CCG improved across four of the eleven CKD and CKD associated QOF clinical achievement indicators between 2010/11 and 2011/12, there is wide variation in the achievement of these indicators at practice level within the CCG.	As a result of these findings, the CCG secured funding to employ an EMIS Project Manager. The role of the EMIS Project Manager is to support GP practices in identifying patients who may at risk of developing of CKD using case-finding approaches and ensuring that these individuals are managed appropriately. The EMIS Project Manager is currently working with the Battersea Clinical Locality Lead to develop EMIS searches to assist with patient identification process. The audit will be piloted in 3 GP practices (one in each locality) in the first instance. Learning from the pilot will be reviewed with a view to rolling out the audit to all Wandsworth GP practices.
PCI		
Peripheral Arterial Disease	In August 2012, NICE published a clinical guideline on the diagnosis and management of lower limb peripheral arterial disease. The guideline indicated that all people with intermittent claudication should be offered a supervised exercise programme. This programme should involve 2 hours of supervised exercise per week for a 3-month period.	The current cardiac rehabilitation phase IV service is suitable for patients with intermittent claudication. A referral pathway has been developed to enable appropriate patients to access the service. The new referral pathway will be launched to Wandsworth GP practices at the Quality Outcomes Framework (QOF) Quality and Productivity (QP) Peer Review meeting in September 2013.

Enabling/ Cross-cutting projects	**2012/13**	**Progress on 2013/14 Initiatives**
Patient and Public Involvement	In June 2012, the CRG welcomed its first patient representative as part of the group membership. The CRG were keen to ensure that the representative was involved in all meetings and used their skills and personal experiences to	The CRG is currently working with Lifetimes (a local community and voluntary group umbrella organisation) to plan an event focusing on the prevention of cardiovascular disease. The aim of the workshop is to gain a better understanding of local

	ensure that the patient, user and carer viewpoint was included as part of discussions.	residents' awareness and perceptions of cardiovascular disease with a view to using this information to commission appropriate services to meet their health needs. The event will be taking place at The Penfold Centre, Wandsworth on 5th September and will include presentations, interactive workshops and group discussions. The CRG is conscious that one patient representative attending CRG meetings is insufficient to demonstrate true patient engagement. It is therefore hoped that there will be individuals at the community engagement event who would be interested in joining a CVD virtual group. Members of the CVD virtual group will be able to contribute to the work of the CRG via email.
Quality and Outcomes Framework		
Medicine Management	The South London Cardiac and Stroke Network (SLCSN) Prescribing Forum was established in 2006 to provide a forum for clinicians to identify consistent, cost effective prescribing for the benefit of cardiac and stroke patients in both primary and secondary care in South London. Since this date, Wandsworth CCG has worked closely with the SLCSN to endorse several prescribing guidelines. The guidelines are available on the following website: **http://www.slcsn.nhs.uk/prescribing.html**	From 1 April 2013, the SLCSN work programme has transitioned to the London Strategic Clinical Networks hosted by NHS England. However, there is no longer a Pharmacist Working Group (PWG) to continue developing prescribing guidelines. Depending on funding arrangements, there may be plans to employ a pharmacist to head a PWG.
Clinical Guidelines	All new guidelines produced by the South London Cardiac and Stroke Network were reviewed and if necessary amended and approved for local distribution. NICE guidelines relevant to CVD were also considered and implementation built into the CVD action plan.	Guidelines on familial hypercholesterolaemia recently approved and disseminated.
IT		
New Technologies		Tunstall Healthcare UK Ltd have been appointed by Wandsworth CCG to develop Telehealth services supporting patients with long term conditions such as Heart Failure, COPD and other long term

		conditions. This involves embedding the Telehealth technology within the care pathways, building links to the existing care pathways with Community Services Wandsworth (CSW). It aims to ensure the highest quality care is delivered efficiently to patients with long-term conditions. Telehealth helps provide quality care for patients within the home; enabling patients to feel more engaged with clinical staff and experience a reduction in anxiety. It supports patients to adhere to self-care regimes through telephone-based coaching to remote patient monitoring of vital signs. The programme is in its initial phase with a current focus on stakeholder management with programme implementation from September 2013. There will be a roll-out of 900 Telehealth kits. Evaluating the programme will be supported by Finnamore in jointly designing metrics with the CCG and Tunstall.

Related Work-streams	**2012/13**	**Progress on 2013/14 Initiatives**
Diabetes		
Smoking		The quality premium is a reward mechanism for CCGs for achieving improvements in the quality of services that they commission and for associated improvements in health outcomes and reducing inequalities. The quality premium paid to CCGs in 2013/14 will be based on four national measures and three locally selected measures. Cardiovascular disease is the leading cause of death in all ages in Wandsworth, accounting for 32% of all deaths in 2010 and compared to the national average, the CVD mortality rate in the under 75 years in Wandsworth is significantly higher. It was therefore proposed that one of the CCG local outcome measures is the reduction of

		cardiovascular mortality in the under 75 years. However, it was noted that there is a delay in the publication of mortality figures therefore this would be difficult to measure over the given timeframe. As a result, it was agreed that as smoking is a preventable cause of cardiovascular disease, the target should focus on increasing the number of referrals – target is 4800 referrals in 2013/14 - to the Smoking Cessation service as a preventative measure. A communication plan has been developed to raise awareness of the quality premium targets to member GP practices. The Smoking Cessation service was promoted as part of the Members Development Programme in July 2013 but will continue to be actively promoted via the Locality Managers in Members Forum.
Alcohol		Commissioning of alcohol services is a public health responsibility and PH is a member of the CRG. A alcohol strategy is in draft and the CCG is a member of the newly formed alcohol alliance.

Appendix 2 – Prevalence of CVD Risk Factors/Mortality across Wards in Wandsworth

Looking at these risk factors together shows that the wards of Latchmere, Roehampton, Tooting, Graveney and Furzedown are in most need in relation to CVD, as the combined z-scores set out in Table 1 show. (Composite Z-scores are a way of combining different types of data that are on different scales so that they are transformed to the same scale and combined for the purpose of ranking as shown below. For these CVD risk factors, the higher the Z-score of a ward the higher the need in relation to CVD for the ward is). The wards with the highest z scores have significantly higher CVD mortality ratios compared to the national average, are highly socioeconomically deprived and have a high proportion of 'at risk' ethnic population resident in them.

Table 1 Prevalence of CVD Risk Factors/Mortality across Wards in Wandsworth ranked by composite Z-score

Ward	IMD	Ethnicity % (Asian, black, mixed)	Hypertension	Stroke	Diabetes	CHD	Smoking	Obesity	CVD Mortality	Z-score
Latchmere	37.16	34.1%	9.8%	0.8%	5.0%	1.4%	22.5%	16.0%	146.8	1.57
Roehampton	32.88	18.3%	9.6%	1.0%	4.7%	1.8%	23.3%	14.3%	148.2	1.55
Tooting	27.61	37.1%	9.3%	0.9%	6.4%	1.7%	15.8%	13.1%	119.2	1.19
Graveney	27.36	34.6%	9.4%	0.8%	6.8%	1.7%	20.5%	13.6%	96.3	1.16
Furzedown	25.32	32.3%	9.2%	0.8%	4.9%	1.7%	16.3%	14.0%	108.7	0.76
West Hill	21.12	17.9%	9.2%	0.8%	4.0%	1.7%	20.0%	14.6%	133	0.71
Queenstown	28.19	26.9%	8.2%	0.8%	4.5%	1.4%	21.6%	14.1%	107.8	0.71
St. Mary's Park	22.59	13.9%	7.4%	0.7%	4.4%	1.9%	22.0%	13.6%	113.2	0.47
West Putney	20.45	10.7%	8.5%	0.9%	3.8%	2.0%	17.0%	11.3%	112.3	0.34
Shaftesbury	20.84	16.1%	8.8%	0.9%	3.2%	1.3%	19.9%	11.3%	96	0.07
Earlsfield	21.06	16.5%	8.3%	0.7%	4.1%	1.2%	19.5%	12.0%	108	-0.05
Southfields	15.17	20.2%	8.4%	0.6%	3.3%	1.3%	16.1%	10.8%	89.2	-0.48
East Putney	15.45	10.7%	7.2%	0.8%	2.9%	1.6%	14.4%	9.1%	89.2	-0.60
Nightingale	18.31	18.0%	6.2%	0.8%	2.8%	1.1%	13.5%	9.3%	118.6	-0.61
Fairfield	17.82	15.8%	6.7%	0.6%	3.0%	1.1%	18.3%	10.5%	91.8	-0.69
Bedford	21.85	21.8%	6.0%	0.6%	3.2%	1.2%	15.2%	10.1%	74.2	-0.73
Wandsworth Common	17.06	12.5%	7.1%	0.6%	2.6%	1.2%	14.7%	9.8%	91.8	-0.89
Thamesfield	11.88	6.6%	6.1%	0.7%	2.2%	1.2%	13.2%	8.1%	71.2	-1.41
Northcote	14.3	12.6%	5.8%	0.5%	2.6%	0.9%	13.3%	6.1%	97.4	-1.49
Balham	15.26	17.0%	5.8%	0.4%	2.4%	0.9%	13.0%	8.5%	69.1	-1.57

Source of data: Table extracted from Paper No 12-337 submitted to Wandsworth Local Authority Adult Care and Health Overview and Scrutiny Committee in June 2012. Data sources as set out below:

- IMD – Index of Multiple Deprivation 2010
- Ethnicity – Source: 2001 Census, Office for National Statistics
- Hypertension – the proportion of registered patients who are recorded as having high blood pressure - EMIS data extracted April 2012.
- Stroke – the proportion of registered patients who are recorded as having a stroke - EMIS data extracted April 2012
- Diabetes – the proportion of registered patients aged 17 years and over who are recorded as having diabetes – EMIS date extracted April 2012.
- CHD – the proportion of registered patients aged 16 years and older who are recorded as being smokers – EMIS data extracted April 2012.
- Obesity – the proportion of registered patients who are considered to be obese, having a Body Mass index of 30 or greater - EMIS data extracted March 2012.
- CVD Mortality – CVD Standardised Mortality Rate (SMR) 2004-08

The colours in the table indicate the ranking for each set of data (all data is subject to rounding):

- Red – 5 highest ranked wards for individual data sets e.g. IMD, hypertension, stroke
- Yellow – 10 middle ranked wards for individual data sets
- Green – 5 lowest ranked wards for individual data sets

Appendix 3 – CVD CRG Membership

The core membership is as follows:

Organisation	Role
Wandsworth Clinical Commissioning Group (CCG)	• GP Clinical Lead (Chair) • GP Locality Leads (Deputy Chair) • Commissioning • Medicine Management
Wandsworth Borough Council	• Public Health • Parks and Leisure Service

St George's NHS Healthcare Trust (including Community Services Wandsworth)	• Secondary Care Consultants
	  ○ Cardiologist
	  ○ Heart Failure
	  ○ Stroke
	  ○ Prevention
	• Community Services Wandsworth
	  ○ Heart Failure Specialist Nurses
	  ○ Cardiac Rehabilitation team

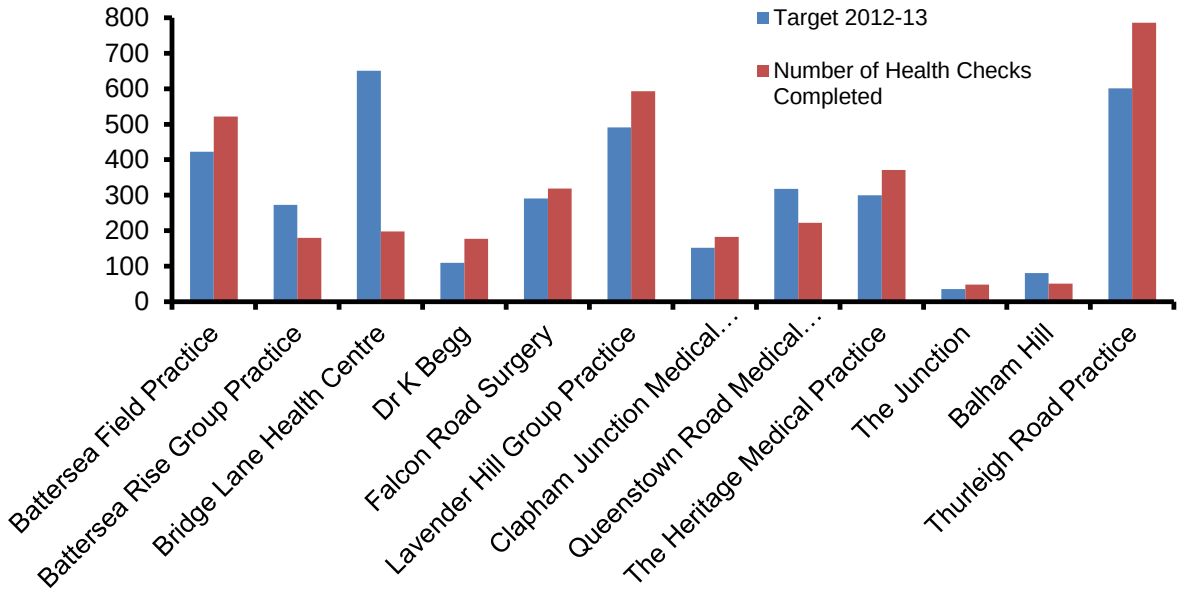
N/A	• Patient representative

Other members may be co-opted as necessary.

Where there are conflicts of interest, members of the Cardiovascular Disease Clinical Reference Group must declare an interest where appropriate.

Appendix 4 - NHS Health Check Practice Performance 2012-13

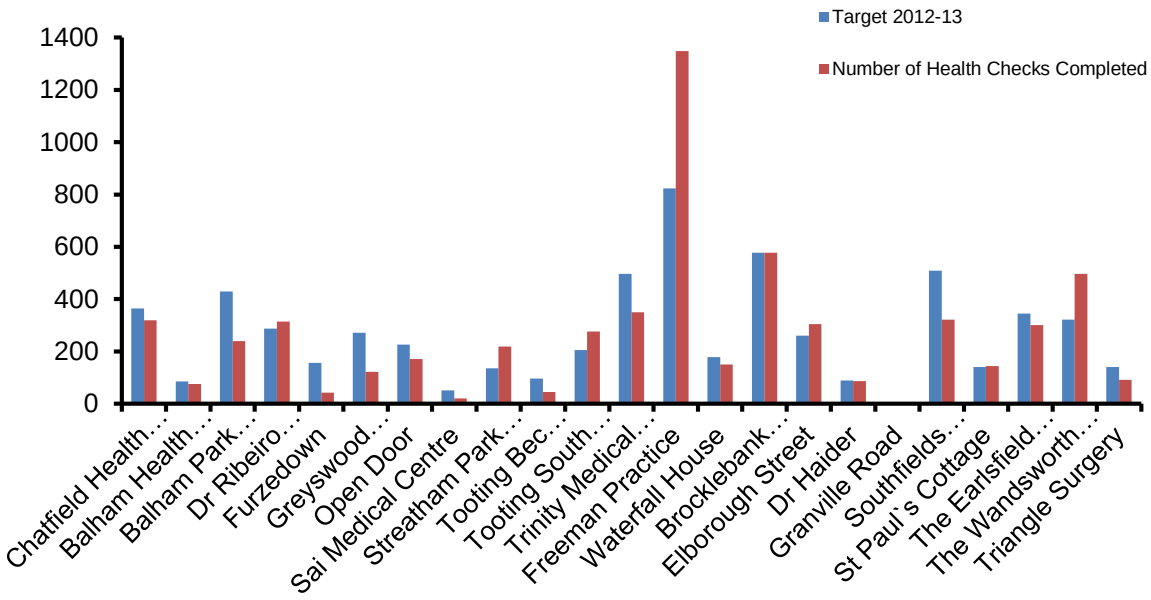
Battersea Locality



Total Target 3724

Total Achieved 3649

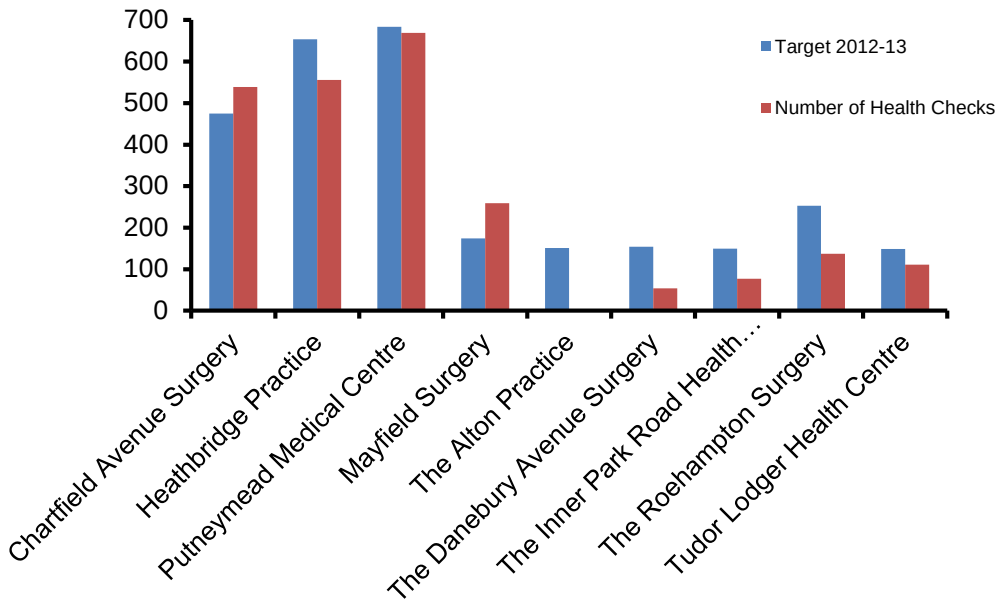
Wandle Locality



Total Target 6188

Total Achieved 6017

West Wandsworth Locality



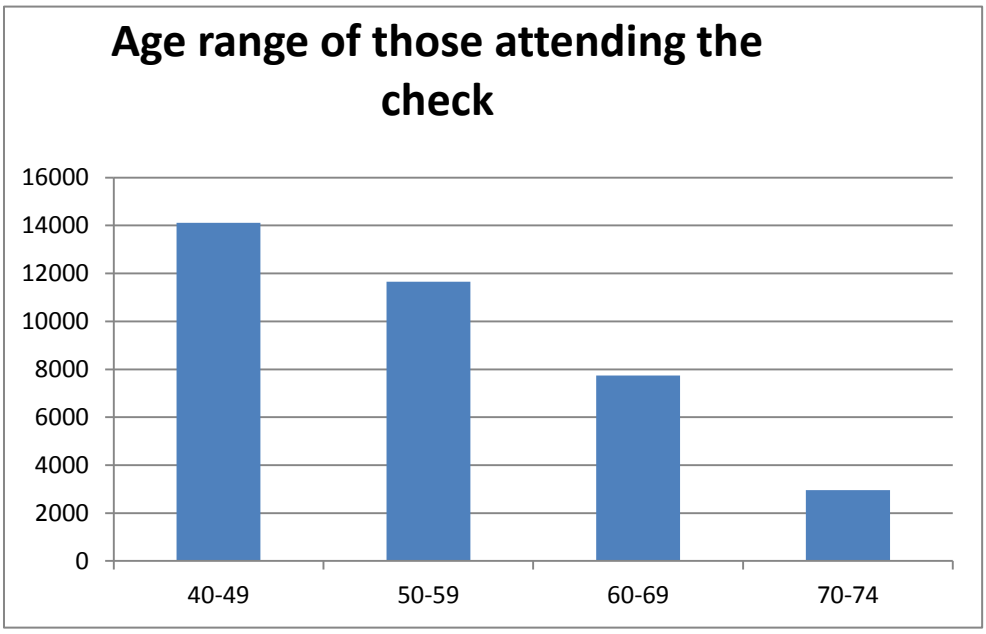
Total Target 2843

Total Achieved 2402

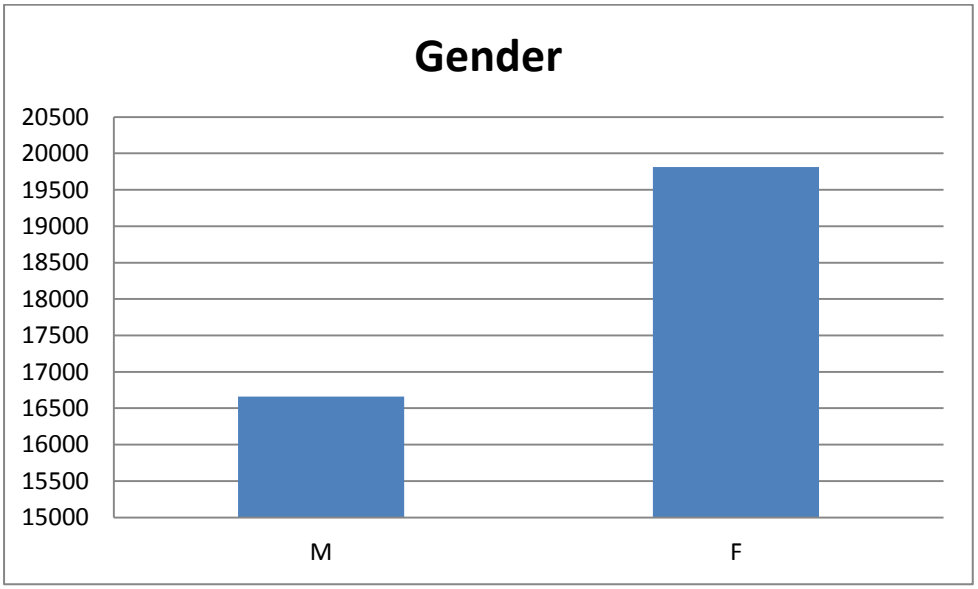
Yearly Performance Data

Year	Offered	Received
2009/10	Not recorded	4733
2010/11	17959	10319
2011/12	21949	12133
2012/13	15984	12766
Total	**55893**	**39951**

Age Range of those attending the check from October 2009 to 31st March 2013



Gender split of those attending the check from October 2009 to 31st March 2013



Appendix 5: CVD Outcomes Strategy

Ambitions	Actions
Manage CVD as a single family of diseases	1. The new improvement body in the NHS Commissioning Board (CB), NHS Improving Quality (NHS IQ), will work with all relevant interests to develop and evaluate service models to manage CVD as a family of diseases, in the community and in hospital. As part of this, NHS IQ will develop and test a standardised template that can be used in hospitals and in the community, and incorporated into service specifications, to assess fully patients with cardiovascular problems.
Improve prevention and risk management	2. Building on previous work from the Public Health Observatories, Public Health England (PHE) – working with the NHS CB and Health and Social Care Information Centre (HSCIC) – will make available benchmarked data about CVD risk factors and progress in tackling them, including data on NHS Health Check uptake, the problems identified, interventions offered, and outcomes. 3. NHS IQ will work with PHE, LAs and the NHS to support the successful implementation of the NHS Health Check programme.
Improving and enhancing case finding in primary care	4. The NHS CB will work with interested parties to develop new tools to support case finding in primary care. NHS IQ and the Strategic Clinical Networks will provide support to GP practices that have low detection rates for CVD.
Better identification of very high risk families/individuals	5. The NHS CB will take the lead, working with the Chief Coroner as appropriate; to improve the processes for identifying inherited cardiac conditions. The National Clinical Director for Heart Disease will work with all relevant stakeholders to develop and spread good practice in relation to FH and sudden cardiac death.
Better early management and secondary prevention in the community	6. The NHS CB will work with stakeholders to identify how to incentivise and support primary care consistently to provide good management of people with or at risk of CVD. This will include Department of Health (DH) asking NICE to review the relevant QOF indicators and promotion of primary care liaison with local authorities, the third sector and PHE to ensure optimal provision of prevention services, including secondary prevention.
Improve acute care	7. To improve acute care: • The NHS CB will work with the Resuscitation Council, the British Heart Foundation and others to promote automatic external defibrillators (AED) site mapping/registration and first responder programmes by ambulance services and consider ways on increasing the numbers trained in cardiopulmonary resuscitation (CPR) and using AEDs; • PHE will continue to raise awareness of the signs and symptoms of CVD by running campaigns such as Act FAST and

	trialling new campaigns; and • All CVD patients should have access to what is recognised as the right treatment. This includes specialist teams and 24/7 services where appropriate. NICE guidelines (and quality standards) provide evidence for what is the right treatment and clinical commissioning groups (CCGs) will wish to use these to help inform their commissioning intentions in this area. NHS IQ, working with the Strategic Clinical Networks, will build on NHS Improvement's previous work to support commissioners and providers to deliver the right services.
Improve care for patients living with CVD	8. Building on good practice in CVD and more generally, NHS IQ, working with the Strategic Clinical Networks, will develop, evaluate and disseminate approaches to assessment and care planning for CVD patients. These will include a full cardiovascular assessment (see Action 1 above) and assessment of needs generally and access to: education to support self-management; psychological support; and, where appropriate, physical activity, rehabilitation or reablement programmes, advance care planning and planning for end of life care.
Improve end of life care for patients with CVD	9. The NHS CB will, through NHS IQ, continue to develop and evaluate the Transform programme in hospitals; improve end of life in the community including through spreading the electronic palliative care coordination systems (EPaCCS); and continue to run and use the VOICES survey as a means of monitoring quality of care at end of life
Improve intelligence, monitoring and research and support commissioning	10. In order to improve the use of information to drive improvement: • The NHS CB and PHE will look to establish a cardiovascular intelligence network (CVIN) bringing together epidemiologists, analysts, clinicians and patient representatives. The CVIN, working with the HSIC, will bring together existing CVD data and identify how to use it best; • The NHS CB will routinely make available information on the quality and outcomes of hospital based cardiovascular teams or services; • The NHS CB and HSCIC will make available comparative data on the quality of care provided for patients with CVD by general practices; • PHE will make available at local authority level comparative data on risk factors and CVD outcomes (see Action 2); and • The NHS CB and PHE will work with DH and the National Institute for Health Research (NIHR) to consider possible future research priorities'.