HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE	Agenda Item 28 Brighton & Hove City Council

Subject:		**Preventing premature mortality audit (PPMA)**	
Date of Meeting:		**4 February 2015**	
Report of:		**Monitoring Officer**	
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Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 The purpose of the report is to provide HWOSC with an overview of an audit, commissioned by the Clinical Commissioning Group, looking at premature mortality in three diseases (cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD) or diabetes). The study aims to find potentially preventable risk factors and look at how to address them in future.

1.2 The CCG has managed to engage with all GP practices in the city, which is a first for this type of work in the country. Findings from the audit will be shared with colleagues regionally and nationally.

2. RECOMMENDATIONS:

2.1 That HWOSC members consider the information in the audit and comment on the preliminary findings.

3. RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

3.1 Brighton & Hove has significantly poorer (higher) mortality rates for causes considered preventable than other regions of England and the South East, and in particular higher under 75 mortality from respiratory disease. Around one third of all deaths in the city are in those aged 18-74 years and for many people under 75 years, deaths related to three key diseases (cardio-vascular disease (CVD), chronic obstructive pulmonary disease (COPD) or diabetes) can be prevented or averted.

3.2 The study aimed to determine potentially preventable risk factors for premature death from these conditions including:

- identification of disease
- quality of care
- lifestyles
- links between secondary and primary care

In order to look at what could be done in the future to prevent further ‘premature’ deaths.

3.3 Deaths from cancer were specifically not looked at (unless the patient had COPD or diabetes) as there had been a recent audit of cancer deaths in the city.

3.4 All GP practices across the city signed up to be part of the audit, a first for this type of work across the country which meant the CCG could provide a comprehensive analysis across the city. It has been requested by Public Health England that the work be highlighted at regional workshops around England on Primary Care and Health Inequalities.

3.5 The methodology included linking data from death registration records, primary care registers and lifestyles data, and secondary care admissions/attendance in the two years prior to death of 651 patients who died prematurely (aged 18-74 years) from or with the three conditions.

These deaths accounted for 32% of deaths of those aged 18-74, or 10% of all deaths in the city over the three year period from October 2010 to September 2013, totalling 6,546 years of life lost under the age of 75.

3.6 The work is in two phases; phase one is the data analysis described above – this has been completed. Phase two is an in-practice audit of medical notes for the patients in question.

3.7 Initial key findings can be grouped as follows. More information on each of these headings is in the appendix:

- **Age, gender and deprivation:** The majority of deaths were in patients aged 55-74 years and males and there is a relationship with deprivation but it is not the whole story. The rate in the east locality is almost double that in the central locality, and is significantly higher than the overall premature mortality rate for the city. Rates were significantly higher in Queen's Park, East Brighton, Hollingdean and Stanmer, and Moulsecoomb and Bevendean wards.

- **Lifestyles:** Rates of smoking, alcohol consumption above recommended levels and overweight/obesity were much higher than in the general adult population aged 18-74 years and those who were still smoking and drinking above recommended levels died significantly younger than ex or non-smokers and those drinking below recommended limits. There was little recording of advice or referral for lifestyles issues.

- **Practice disease registers:** Practices organise care for specific patients by maintaining disease registers of both those patients with established disease and those with risk factors and by providing systematic care to reduce risks, for example by managing blood pressure and cholesterol levels and by supporting patients to give up smoking. Around a third of patients dying from CVD were not on a related disease register in primary care and whilst most patients dying with COPD or Diabetes were, around a third were excepted from registers and may have been missing out on preventive care (patients can be excepted from registers for a number of reasons including patients not attending a review after three invitations, patients with terminal illness, newly registered patients, patients on maximum doses of medication or unable to take medication). The care of those who were on disease registers and not excepted was generally good. A

high percentage of patients on relevant disease registers were also on a depression register.

- **Secondary care:** Contact with secondary care services was high with the majority of patients having had at least one hospital inpatient admission in the two years prior to their death (60%), this was much higher for patients who died with COPD (81%) or diabetes (80%). This emphasizes the importance of this audit not just in terms of preventing death, but also time spent in ill health. There were patients not on disease registers in primary care who had had hospital admissions coded for the disease and so should have potentially been investigated further in primary care and placed on registers – the in-practice audit is looking at the details of these cases. A sizeable percentage of admissions were alcohol related, tying in with the findings from the primary care records and emphasising the need to support people with chronic conditions and alcohol issues better in the city.

- **Other emerging themes from the in-practice audit include:** Isolated patients; Alcohol; Complex medical problems; Obesity; Missed treatment; Sudden deaths; Multi-morbidity; End stage disease; Cancer and specifically lung cancer; Mental wellbeing and Housing.

3.8 Some action has already been taken to address the findings. The Public Health team and Clinical Commissioning Group have each committed to funding three extra FTE Health Trainers (a total of 6 - taking the team from 4 to 10 FTEs) to work with GP practices to be able to provide more coordinated support for individuals with chronic conditions to improve their health behaviours. The health trainer programme is a cost effective and well evidenced approach to reducing health inequalities and improving health outcomes. It works with individuals to take action across multiple health behaviours.

3.9 The findings are also being used in meetings with clusters of practices to share learning and to draw together suggestions for practice across the city.

4. COMMUNITY ENGAGEMENT AND CONSULTATION

4.1 None to this cover report.

5. FINANCIAL & OTHER IMPLICATIONS:

Financial Implications:

5.1 None to this cover report.

Legal Implications:

5.2 None to this cover report.

Equalities Implications:

5.3 None to this cover report.

Sustainability Implications:

5.4 None to this cover report.

Crime & Disorder Implications:

5.5 None to this cover report.

Risk and Opportunity Management Implications:

5.6 None to this cover report.

Public Health Implications:

5.7 The findings of the report will help to address premature mortality in the city.

Corporate / Citywide Implications:

5.8 None to this cover report.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 None to this cover report, which is presenting information.

SUPPORTING DOCUMENTATION

Appendices:

1. Update from the CCG