NHS
Lancashire and South Cumbria
Integrated Care Board

Transforming Cardiovascular Disease Prevention in Lancashire & South Cumbria

A system wide approach to reducing health inequalities and improving life expectancy, delivered across place-based populations

September 2022 – September 2029

INNOVATION AGENCY

Lancashire & South Cumbria Cardiac Network

NHS North West Coast Clinical Networks

NHS
Lancashire and South Cumbria
Integrated Care Board

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Executive Summary

In Lancashire & South Cumbria (L&SC), there are around 230,000 people currently living with heart and circulatory diseases, also known as cardiovascular disease or CVD. Cardiovascular disease (CVD) causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. CVD, whilst often preventable, continues to be one of the main causes of premature mortality across the region, with 13,355 excess deaths (Mar 20 – Apr 22) with CVD listed as a cause of death across the Northwest.

CVD has been identified by the NHS Long Term Plan as the single biggest area where the NHS can save lives over the next 10 years, as CVD is often preventable through a change in lifestyle, early diagnosis and management of the ABC(D) conditions (Atrial Fibrillation, Hypertension (High Blood pressure), High Cholesterol (including Familial Hypercholesterolemia – FH). The British Heart Foundation (BHF) estimates that heart and circulatory diseases will kill more than 1 in 4 people in L&SC. However, if we can successfully diagnose and optimally manage patients with high blood pressure alone, it is estimated that 142 heart attacks and 212 strokes could be avoided across L&SC over 3 years – with a financial saving of over £4 million to the system.

Our CVD Prevention Strategy is based on taking a whole system approach with all stakeholders working together to share their expertise, knowledge and resources to improve the cardiovascular health of L&SC. Using population health data and taking a Core20Plus5 approach, we will gain a full understanding of the health inequalities experienced across our place-based partnerships (PBPs) and will know what really matters to specific communities within them. This means that we can tailor our approaches to match the need, and therefore transform, the prevention and progression of CVD.

Our strategy will focus on prevention of the ABC(D) conditions of CVD. We have based the delivery of our vision around the 4 pillars of the National NHS England document '*How the NHS is working to restore diagnosis and management of cardiovascular disease',* as well as the 3 regional objectives already identified: -

- Use the best available data
- Bring CVD programmes together under one ICS programme
- Prioritise National directives that will have the most local impact

We will be designing and delivering interventions and quality improvements at both an ICS wide and PBP level, in the most effective way for the system.

Along with the vision outlined in this strategy, one of our aspirations is to not only improve the CVD health of our population and bring down the number of heart attacks and strokes, but by using a population health focus and a whole system approach, we have an opportunity to improve the overall health of our population and the localities that people live in.

VISION	To take a whole system approach to cardiovascular disease prevention in Lancashire and South Cumbria, reducing variation of the disease and outcomes across our region, resulting in improved life expectancy and reduced health inequalities, in line with Long Term Plan timescales
AIMS	• Restore identification and monitoring of CVD risk factors to pre-pandemic levels • Achieve the national ambitions for atrial fibrillation (AF), high blood pressure (BP) and Cholesterol (C – inclusive of FH) detection and management by 2029, demonstrating sustained improvement. Support the prevention of 150,000 heart attacks, strokes and dementia cases as per the Long Term Plan • Adopt a whole system, health Inequalities approach to prevention, to improve population health across L&SC and deliver the CVD priorities of Core20Plus5 as well as reducing variation • Reduce cardiovascular disease (CVD) mortality and morbidity • Improve the cardiovascular health of the working age population thereby having a social and economic impact • Ensuring that prevention (CVD) remains a high priority across the population and the system
OBJECTIVES	**Deliver against the four pillars of the national CVD Prevention Recovery Plan, which closely align to L&SC ICS priorities**

Pillar 1: Monitor and target unwarranted variation	**Pillar 2: Enable system leadership**	**Pillar 3: Support a system wide response**	**Pillar 4: Increase public awareness**
We will	**We will**	**We will**	**We will**
• Use data to identify target populations where unwarranted variation and inequalities exist. • Access data sources (CVD PREVENT, Aristotle, MHS etc) • Embed quality improvement at scale • Utilise risk stratification tools to identify at risk patients • Encourage and support a data driven approach	• Create an ICS/B CVD prevention infrastructure to ensure system collaboration • Identify and coordinate leads and networks to improve care pathways and CVD prevention • Align & Collaborate CVD Prevention with other ICS workstreams e.g., Primary Care, Digital and Population health • Support Clinical leads to deliver improvements at scale and encourage innovation	• Strive to create and environment and reach our patients with a 'personalised' approach • Work with all ICS workstreams and partner organisations on CVD, across the system and make every contact count • Coordinate and upscale existing evidence-based effective initiatives and innovations e.g., BP@ home, community pharmacy checks, NHS Healthchecks VCFSE outreach • support primary care through partnership working and a system wide response	• Collaborate with patients and carers to provide insight for our population • Share and create, where necessary, communications campaigns raising awareness of CVD • Promote and co-ordinate opportunities to educate the public using existing channels and opportunities • Promote our local system resources, signposting patients to support & raising CVD awareness across the population, both publicly and professionally

1. Use the best available data	**2. Bring CVD programmes together under one ICS programme**	**3. Prioritise National Directives that will have most local impact**

ENABLERS	Funding, QI toolkits and resources, system working, regional infrastructure to drive change and prioritise resources, organisational partnerships, community engagement, innovation (digital & non), access to data and Comms & Engagement resources, including social media
DELIVERY	• System wide delivery and leadership with a dedicated workstream for CVD prevention • Place based delivery (tailored to the needs of specific populations and communities), with quality improvement focus • Enhanced support and co-ordination in Primary Care (PCN, pharmacy and practice) around improvement initiatives (organisational delivery) • VCFSE delivery where possible, to increase community impact

Context of the Strategy

What is CVD?

In Lancashire & South Cumbria (L&SC), there are around 230,000 people currently living with heart and circulatory diseases, also known as cardiovascular disease (CVD)[1]. CVD causes a quarter of all deaths in the UK and is the largest cause of premature mortality in deprived areas. CVD, whilst preventable, continues to be one of the main causes of premature mortality across the region, with the data from the Office for Health Improvement and Disparities (OHID)[2] stating that there were 13,355 excess deaths (Mar 20 – Apr 22) with CVD listed as a cause of death across the Northwest.

The NHS Long Term Plan identified CVD as the single biggest area where the NHS can save lives over the next 10 years *(figure 1)*. In L&SC, our admission rates for heart disease (482.3 per 100,000) show us much higher than England (367.6 per 100,000). For Stroke, our under 75 mortality figures (15.3 per 100,000) are significantly higher than England (12.6 per 100,000). [3]

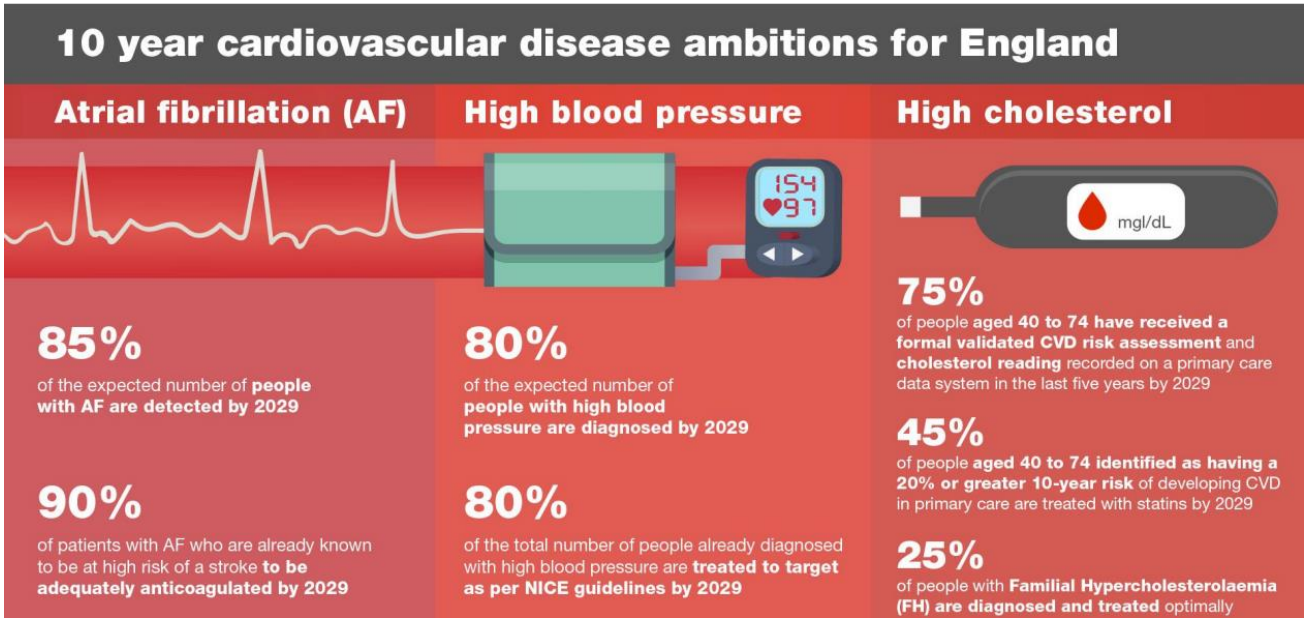


Figure 1 – The Long Term Plan CVD Ambitions

What are the risk factors?

Millions of people are unaware that they are living with serious but treatable conditions such as atrial fibrillation, high blood pressure (hypertension) and high cholesterol. These are known as the A-B-C conditions, which are 3 of the major causes of CVD. Whilst there are other conditions recognised within CVD (e.g., ASCVD), our strategy will be focussing on 4 areas; ABC(D), where the D represents weight management. And whilst there are several medical risk factors to be considered, the wider determinants of health also play a large part in preventing CVD in L&SC.

How can we prevent CVD?

As our CVD prevention strategy will show, we know we can do more to prevent this condition. Many risk factors are modifiable, and CVD is mostly preventable through lifestyle and behaviour change. For example, stopping smoking, reducing alcohol intake, maintaining a healthy diet and exercising regularly. However, there are several health inequalities that exist in L&SC which can prevent a low-

[1] Local Statistics - BHF
[2] Microsoft Power BI
[3] Public Health Profiles (Cardiovascular Disease - OHID (phe.org.uk)

risk CVD lifestyle being lived, such as the environment you reside in, the warmth and ventilation within your home and access to healthy food within budget. CVD is a major contributor to health inequalities, with people living in more deprived areas being over four times more likely to die prematurely (up to 15 years less). 19.4% of the population in L&SC live in the most deprived areas (England average 19.6%). Therefore, spotting physical and social risk factors early, reduces the chance of developing potentially life-threatening conditions including heart attacks, stroke and dementia. By detecting and managing both the physical and social risks once identified, will be key to preventing the onset, and progression, of CVD in L&SC over the next 7 years.

What impact did COVID-19 have?

The NHS urged people to come forward if they were worried about their heart throughout the pandemic, however the need to social distance and GP surgeries being closed to the public, meant Primary Care CVD prevention services such as the NHS health check were paused as health care responded to the pandemic and care was delivered and monitored remotely. Diversifying the way services could be accessed by patients was key to continuing care – both digitally and through organisational changes.

However, this meant that fewer people came forward for the kind of non-urgent/routine care where the early signs of CVD are often picked up, resulting in a reduction in diagnosis, monitoring and treatment of the A-B-C conditions. CVD Prevent data shows that for L&SC, there was a drop in recording hypertension across the population, of almost a quarter over the pandemic, which is the slowest of the ABC conditions to recover to pre-pandemic baselines.[4] UCLP modelling indicated that this drop in recording, could lead to an estimated 1,018 additional heart attacks and strokes in L&SC over a three-year period if not addressed.

CVD is a major contributor to health inequalities, with people living in more deprived areas being over **four times more likely to die prematurely** (up to 15 years less).

19.4% of the population in L&SC live in the most deprived areas

NHS England published its CVD prevention recovery document (*How the NHS is working to restore diagnosis and management of cardiovascular disease)* in June 2022, to help address the issues covid-19 had created. This strategy document follows the framework of the NHS CVD recovery document, and our local ICS population needs.

[4] Home | CVDPREVENT

Our Vision, Aims & Objectives

Vision

In Lancashire & South Cumbria, our vision is; -

To take a whole system approach to cardiovascular disease prevention, reducing variation of the disease and outcomes across our region, resulting in improved life expectancy and reduced health inequalities, in line with Long Term Plan timescales

Taking a whole system approach to improving the cardiovascular health of our population, we believe we can truly make a difference and add life to years as well as years to life. By having a full understanding of the health inequalities experienced across our place-based partnerships (PBPs) and knowing what really matters to specific communities within them, will mean that we can tailor our approaches to match the need, and therefore transforming the prevention, and progression, of cardiovascular disease.

Aims

For our vision to become a reality, there are six main aims that we need to work towards.

Restore identification and monitoring of CVD risk factors to pre-pandemic levels
Achieve the national ambitions for atrial fibrillation (AF), high blood pressure (BP) and Cholesterol (C – inclusive of FH) detection and management by 2029, demonstrating sustained improvement. Support the prevention of 150,000 heart attacks, strokes and dementia cases as per the Long Term Plan
Adopt a whole system, health Inequalities approach to prevention, to improve population health across L&SC and deliver the CVD priorities of Core20Plus5 as well as reducing variation
Reduce cardiovascular disease (CVD) mortality and morbidity
Improve the cardiovascular health of the working age population thereby having a social and economic impact
Ensure that prevention (CVD) remains a high priority across the population and the system

Focussing on the six aims above, will advance CVD prevention, reduce the number of stroke and heart attacks and improve our population health. By concentrating on health inequalities as a region, addressing the needs of local communities and improving equitable healthcare for all, we would hope to see a reduction in excess mortality, not only in cardiovascular disease but overall.

Objectives

The NHS England national CVD Prevention Recovery plan sets out 4 distinct high-impact pillars/objectives, for localities to focus on to recover CVD prevention to pre-pandemic baselines and to improve CVD prevention going forward.

The four pillars are:

- monitoring and targeting unwarranted variation
- supporting a system-wide response
- increasing awareness
- enabling system leadership for CVD prevention

In April 2021, we held a Northwest stakeholder workshop to focus on what is important to L&SC, in order to transform CVD prevention across the region. This resulted in 3 main objectives which fit well with the National objectives; -

- Use the best available data
- Bring CVD programmes together under one ICS programme
- Prioritise National directives that will have the most local impact

Our strategy will focus on using the four pillars and the three regional objectives, to deliver our vision, designing and delivering interventions and quality improvements at both an ICS wide and PBP level, in the most effective way for the system.

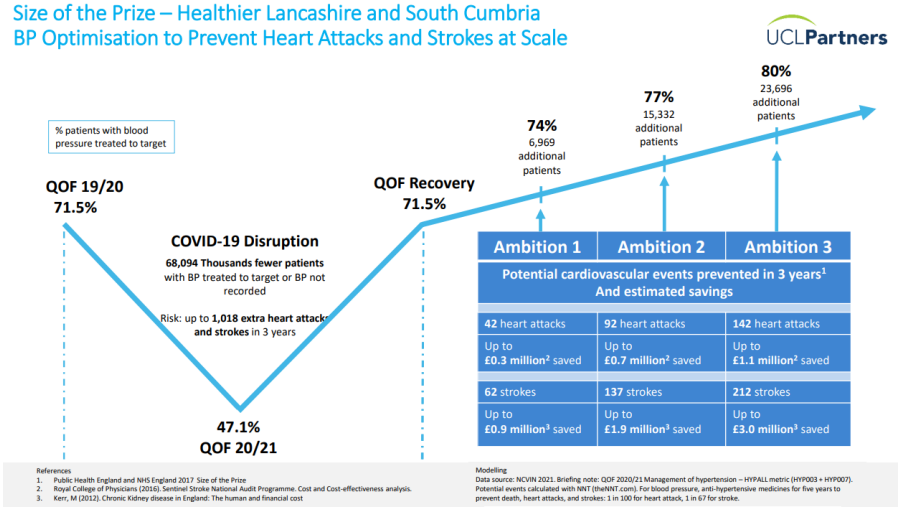
For Lancashire & South Cumbria, the 4 pillars relate as follows; -

Monitoring and targeting unwarranted variation	**Supporting a system-wide response**
We will **use the best data available** from local (Aristotle) and National (e.g., CVDPrevent, OHID) sources, to target populations with the highest variations, identified inequalities in CVD and population health, and those already confirmed as L&SC PLUS cohorts.	We will continue to work with all partners across the ICS, to reach patients and the population in innovative ways. For example, health checks in wider settings, community pharmacy checks, CVD roadshows and providing BP monitors @home. We will continue to prioritise evidence based, high impact interventions to have the most local impact and work with our place leads to inspire local activation
Enabling system leadership for CVD prevention	**Increasing awareness**
L&SC will utilise already established CVD Prevention groups, Clinical Networks and leaders, as well as introducing new governance within the ICS, to **bring CVD programmes together under one ICS programme**, to coordinate and improve our system wide response to CVD prevention. We will use this structure to highlight our progress in the strategy and ability to deliver across all our places	L&SC will continue to build on national & local communications and social media campaigns, signposting patients to services and support, both local and National, building an awareness across the system of the importance of CVD prevention. A data driven focus will support awareness of key areas of need

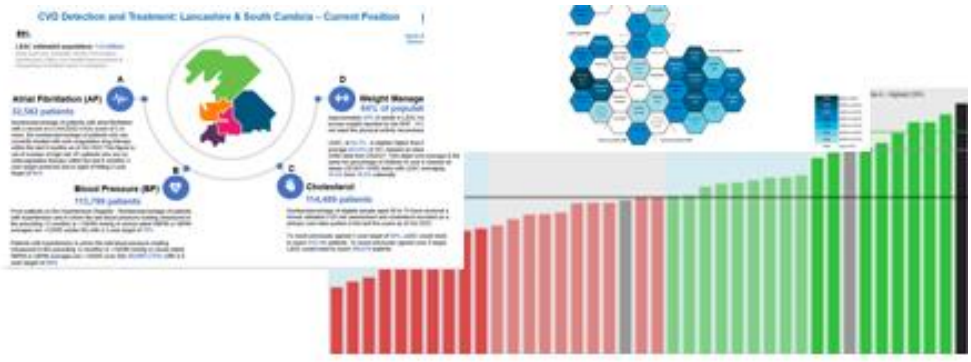
The Case for Change

The National case for change in CVD prevention has been widely promoted. How this relates to L&SC, is outlined below; -

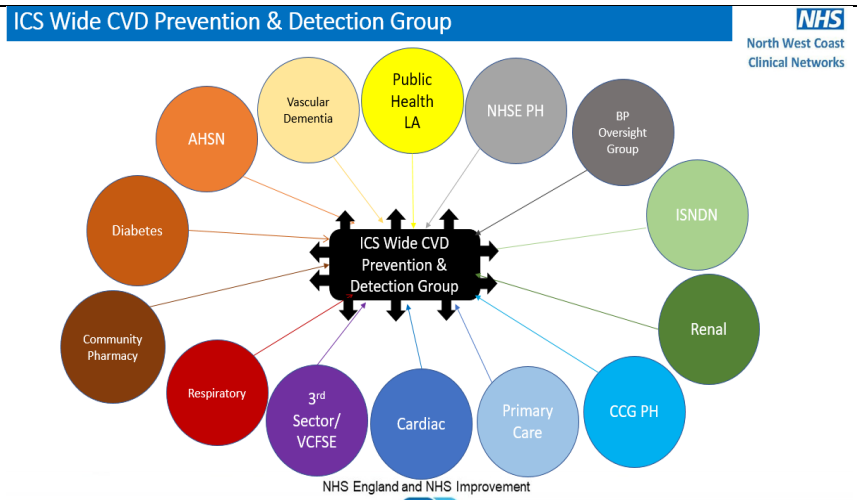
Focussing on CVD prevention, particularly hypertension management recovery, is a priority for the L&SC Integrated Care Board (ICB). Pre- pandemic, we knew that if we could successfully diagnose and optimally treat patients with high blood pressure alone, 142 heart attacks and 212 strokes could be avoided across L&SC over 3 years – with a financial saving of over £4 million to the system. This target has widened because of the pandemic, making the size of the prize even bigger.



We have excellent data available both nationally (CVDPrevent, BHF, Fingertips, NCVIN etc) and locally (Aristotle) but need to use it as efficiently and effectively as possible to make positive, system changes in CVD and Health Inequalities and to help understand and monitor where improvements have been made. Local leads will be supported and encouraged to make best use of their data to inspire action in their area



There are a lot of organisations and workstreams that are focussing on CVD, with some having strategies already in place (e.g., Stroke Prevention Strategy 2018-2023) which need bringing into one coordination point to avoid duplication and ensure standard messaging is provided. This Stakeholder group will have oversight of CVD prevention work and will provide strong system leadership.



There are several CVD initiatives taking place, both National and local. But with so many small pockets of improvement, it is difficult to know what is working and making a difference (and what isn't) and where digital technology and innovation can be harnessed, evaluated, and scaled up. Having so many asks on the same communities, can cause confusion and disengagement. Utilising the ICB CVD group will bring a more cohesive programme of work together in one place and deliver quality improvement at scale.

Cardiovascular Disease and Health Inequalities

In Lancashire & South Cumbria, we have a wealth of Population Health data from our Aristotle system and from CVDPrevent and Fingertips, that can support us to really target the communities that will gain the most benefit of CVD prevention.

We know that CVD is a major contributor to health inequalities and preventing CVD must address the fact that 40% of CVD deaths occur in the three most deprived deciles[5], with people living in those areas being over four times more likely to die up to 15 years prematurely. We also know that there is strong correlation between those living in the most deprived areas and other deprivation indicators such as low income and health deprivation & disability.

Conversely this also means that health inequalities are one of the biggest contributors to CVD. When looking at CVD prevention and behaviour change to modify ABC(D) condition risks via a change in lifestyle, it can be really challenging.

For example, barriers might be:

Increasing physical exercise	**Living Environment** – built up, no green space, no home space, hostility and fear outside the home, no time **Income** – can't afford gym membership, need to work more hours
Healthy Diet	**Living Environment** – takeaways everywhere, no access to healthy food **Income** – can't afford healthy food **Employment** – hours/shifts mean convenience food **Ethnicity** – cultural diet, family made

Looking at CVD prevention from a population health perspective means we can see where some traditional routes to CVD prevention won't work. This is the same when looking at diagnosis and treatment. It helps us to see where, and why, we need to do things differently. The Core20plus5 framework supports this view, especially whilst covering the B and C conditions, with it highlighting Hypertension and Lipids case finding and management, but we will take this framework approach for all 4 of the ABC(D) conditions in L&SC. Our strategy focuses on targeting efforts on those communities located in areas of high deprivation, such as Blackpool, Burnley and Blackburn that are at highest risk and experience a greater CVD burden.

The population health team in L&SC use the model in Figure 2 for the lifecycle of any condition. In terms of CVD Prevention, the focus is on the **predict** and **prevent** elements of the model.

> **Predict** is around using data, local knowledge, stakeholders, VCFSE and population insight, to understand where we need to be targeting resources.
>
> **Prevent** is around taking positive action to improve the expected and prevent CVD within those targeted areas, working as a whole system to ensure a holistic approach for the population identified.

[5] What-Good-Cardiovascular-Disease-Prevention-Looks-Like.pdf

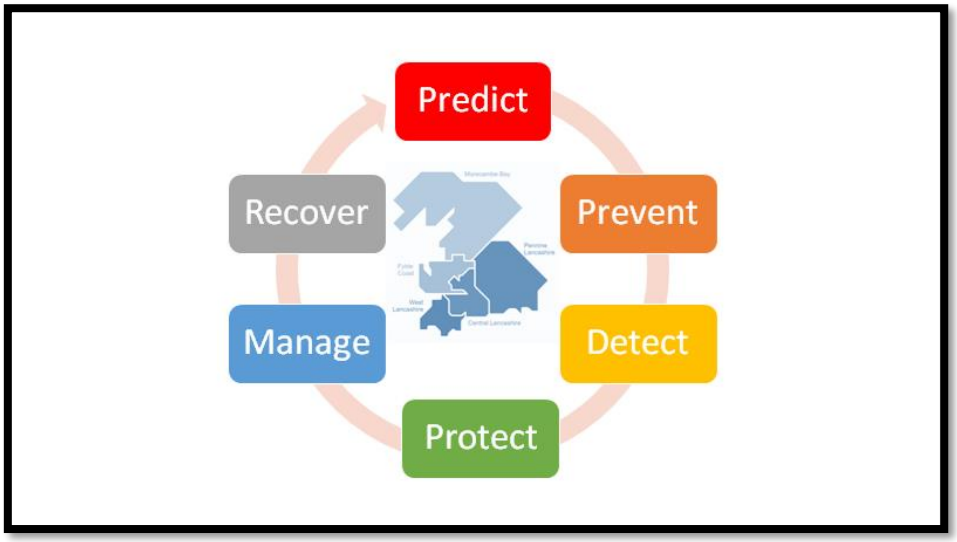


Figure 2 – Population Health model

The model follows disease progression through detect and protect (diagnosis) and manage and recover (management) for the ABC(D) conditions, which will in turn link to secondary and tertiary prevention. This strategy is focussed on CVD prevention and therefore, predict and prevent.

Estimates from OHID data shows that around 130,000 people in Lancashire & South Cumbria have undiagnosed hypertension (high blood pressure), with around 279,000 people already being diagnosed. All these people are at high risk of stroke and heart attacks, but those undiagnosed are at higher risk due to being unaware and therefore potentially not making any lifestyle changes to keep themselves healthy and well.

This means that our prevention work needs to cover a wide range of audiences and get to as many people as possible across L&SC, working as a whole system and engaging with our high-risk populations. We already have many initiatives taking place to address CVD prevention, some of which are population health targeted (e.g., Enhanced healthchecks, HARRI bus/Heart Heroes and Healthy Hearts roadshows) but many of which are not, and could be enhanced by using the HI data to refocus.

In L&SC, our CVD prevention strategy is to use a population health centred approach across the whole system. We want to look at CVD prevention (and detection and management) through a population health lens and see what we can do differently across all areas of the system, to; -

- increase the CVD health of the population and target those areas that require more focused attention
- empower all stakeholders to make a collective difference
- review interventions already taking place across L&SC to ensure we use resources wisely to have the greatest impact in the most efficient way
- take a community-based approach

It is one of our aspirations to not only improve the CVD health of our population and bring down the number of heart attacks and strokes, but by using a population health focus and a whole system approach, we have an opportunity to improve the overall health of our population and the localities that people live in.

Delivering the Four Pillars – Monitoring & targeting unwarranted variation

Monitoring and targeting unwarranted variation
We will **use the best data available** from local (Aristotle) and National (e.g., CVDPrevent, OHID) sources, to target populations with the highest variations, identified inequalities in CVD and population health, and those already confirmed as L&SC PLUS cohorts.

We will use data and tools to; -

1. Raise awareness and access to the ABC(D) dashboard (Aristotle), which has only a 2-month lag and can be viewed at ICS, Places, PCN and GP level.
2. Work with all Places and PCN's to increase their awareness of ABC(D) current position in their locality through provision of CVDPrevent/Model Health System/Aristotle/BHF Inequalities data.
3. Work with individual PCNs to understand the data available, and to support them to improve the health of their population by using existing risk stratifying tools (e.g., BPQI), support tools and high impact interventions, whilst taking full advantage of financial incentives offered through DES/IIF opportunities.
4. Work with Places, PCNs, Practices and other system stakeholders, within our identified Core20Plus5 cohorts, to raise awareness of their ABC(D) position and Population Health data, to highlight target areas and to understand the challenges.
5. Work with individual GP Practices that fall in the Core20Plus5 categories, to deep dive into the data and support them with risk stratifying, quality improvement and support tools, on how to improve their population health for CVD as well as understand and use the data.
6. Monitor the data available to quickly highlight any areas of challenge that require support.
7. Use the data to measure change and improvement, via nationally identified metrics
8. Monitor & publish progress through the ICS Prevention Group (CVD) and the L&SC Network CVD Prevention Programme Lead will report through to the ICS Programme Board accordingly

Delivering the Four Pillars – Enabling system leadership

Enabling system leadership for CVD prevention
L&SC will utilise already established CVD Prevention groups, Clinical Networks and leaders, as well introducing new governance within the ICS, to **bring CVD programmes together under one ICS programme**, to coordinate and improve our system wide response to CVD prevention. We will use this structure to highlight our progress in the strategy and ability to deliver across all our places

The L&SC ICS is still in the 'forming' phase in terms of CVD prevention and governance structures, therefore our strategy looks at how we can form and promote a suitable structure to enable this pillar to be effective, utilising the vast knowledge, expertise, and interventions already within the system; -

1. Establish an ICS Prevention Group, with a focus on CVD (ABC(D) conditions) and the Predict and Prevent elements of Health Inequalities. To be led by Population Health and the Medical Directorate, with representation from all stakeholders working within CVD across the system in L&SC. This will enable a single point of reference in the system for all interventions, measures and outcomes to be discussed, challenged and/or improved. Outcomes/core programme deliverables will be reported from this group via the L&SC Cardiac Network CVD Prevention Lead to the Cardiac Board, ISNDN Board and ICS boards as required, including where opportunities for collaborative working and partnership lie.
2. Continue to harness the expertise of the Clinical Leadership in place across CVD groups (two of which are funded through the Cardiac & Stroke Networks and one through the Innovation Agency – Academic Health Science Network for the Northwest Coast)
3. Use the expertise of the Clinical Network and CVD Prevention Lead to ensure that the right stakeholders are being represented and that those within the group can influence change across the system within their organisation/Place/workstream.
4. Look to have a nominated CVD Prevention lead/champion allocated for each of the 4 Places in L&SC (and the 3 sub-places in Lancashire). This will ensure CVD prevention prioritisation, the cascade of information locally, awareness raising opportunities within other Place workstreams and continuity of prioritisation across each Place. A checklist for each Place, that can be used to benchmark current understanding and needs around CVD prevention, is available in Appendix 5.
5. Link with and build on the excellent work already underway around health inequalities in L&SC and embed that into the CVD prevention group overall "Transforming CVD Prevention work programme".
6. Coordinate and optimise learning from all CVD programmes from our stakeholders, under one ICS programme, looking at high impact interventions (e.g., NHS Healthchecks), national directives (e.g., BP@Home), local provision (e.g., Healthy Hearts, Community Pharmacy SMS) and gaps in service delivery. This will also include gaps in access and uptake across the population to services/interventions already in place and adopt improvements at scale. This will provide a system wide response to CVD (ABC(D) conditions).

Delivering the Four Pillars – Supporting a system wide response

Supporting a system-wide response
We will continue to work with all partners across the ICS, to reach patients and the population in innovative ways. For example, health checks in wider settings, community pharmacy checks, CVD roadshows and providing BP monitors @home. We will continue to **prioritise evidence based high impact interventions to have the most local impact** and work with our place leads to inspire local activation

There are already several initiatives taking place across L&SC, and through the work of organisations and workstreams such as the Clinical Networks and Innovation Agency, collaboration and innovation are well established. Part of our strategy is to ensure that this continues to be the standard and is built on throughout the ICS and the CVD programme: -

1. Continue to work with all stakeholders across the system, including but not limited to, primary, secondary, tertiary and community care, ambulance service, the Innovation Agency, Local Authorities (Places), OHID/Public health, VCFSE & patient voice groups, clinical networks (Stroke, Diabetes, Respiratory etc) and where appropriate, industry and local employers.
2. Deliver interventions at the most appropriate level - System, Place, PCN, Practice and PLUS, to provide the biggest impact across L&SC. Always joining up the system through the ICS Prevention Group.
3. Focus on full ICS system wide provision of high impact interventions, as highlighted by NHS England, such as Hypertension Case Finding, NHS Healthcheck, DOACs and Hypertension Treatment Optimisation). Where there is opportunity to provide a 'blanket' intervention, that will provide high impact in health and financial outcomes, then it should be taken at an ICS level.
4. Encourage our Places to develop and deliver CVD prevention plans, interventions, and priorities across their locality stakeholders, that provide local impact and address health inequalities that target those at highest risk, which differs across our geographies, ensuring the principles of Core20Plus5 are included within plans.
5. Reach our populations in a variety of ways that work for our communities. Using Population health data and Place organisational knowledge, to define what works well and what can have a positive local impact on CVD prevention (e.g., Enhanced Healthchecks, LA road shows, Heart Heroes, HARRI Bus etc).
6. Support the removal of traditional healthcare boundaries for those willing to embrace this, such as having a health check at work or using the community pharmacist instead of the GP.
7. Utilise digital technologies such as websites, apps and services, as innovative ways to deliver CVD prevention (e.g., BP@Home, NHS Digital healthcheck etc), where possible and where appropriate (e.g., digital exclusion).

Delivering the Four Pillars – Increasing Awareness

Increasing awareness
L&SC will continue to build on national & local communications and social media campaigns, signposting patients to services and support, both local and National, building an awareness across the system of the importance of CVD prevention. A data driven focus will support awareness of key areas of need

Increasing awareness is incredibly important within CVD Prevention, not only to the public, but also to the organisations who work within this area, to ensure that they are fully up to speed on services and interventions available. It's also paramount that we work together to ensure that there are no 'mixed messages' regarding CVD prevention – the same advice and information is provided from all stakeholders, and any campaigns and awareness raising is planned in a coordinated way.

1. The CVD Prevention group will work with the ICS Comms team on creating and implementing a system wide communications plan to engage all stakeholders and their respective comms teams around CVD prevention.
2. Awareness raising of National campaigns (e.g.- Know Your Numbers, Better Health) using social media, standard media and our stakeholders across the system to find innovative ways to reach our population.
3. Awareness raising with a call to action for our local communities and those identified as highest risk, to support their family and friends to take up ABC(D) initiatives such as NHS Healthchecks, locality BP checks, Pharmacy outreach and other bespoke initiatives taking place, as well as encouraging members of their communities to look at changing behaviours around CVD risk factors such as alcohol consumption, obesity, physical exercise and smoking.
4. Improve the L&SC public-facing CVD prevention website, healthierlsc.co.uk/healthyhearts, that covers 'ABC' conditions and signposts to local support, to include local CVD prevention resources, community outreach initiatives and localised advice from stakeholders, ensuring access for our diverse population.
5. Update, improve and promote the Making Every Contact Count (MECC) website (MECClink) to ensure that CVD prevention information provided during MECC touch points with colleagues across the system, is in line.
6. Raise awareness of the Healthy Hearts web page across the system, both public facing and throughout organisations as a professional resource.
7. Look to raise awareness and help to change behaviours early, working across the system with education partners to educate and empower younger L&SC residents to understand the benefits of being in control of their health at an earlier age.

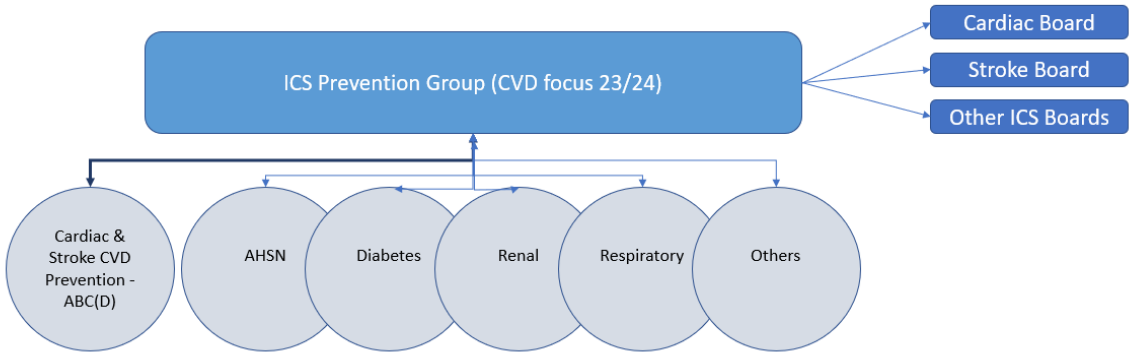
How we will make this happen

It is agreed and planned that the ICS Prevention Group will hold the overall work programme, reporting into a number of Boards both within the ICS, Clinical Networks, Well Being Boards and wider system.

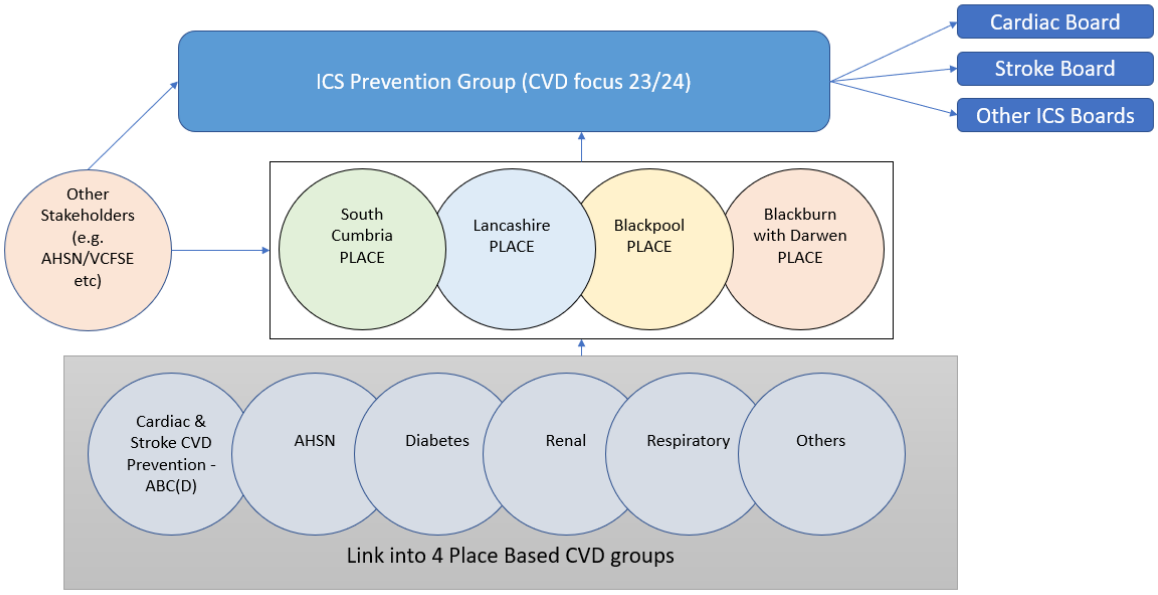
However, the structure underneath and above are yet to be determined as the ICS and Places are still forming and finding stability.

Below are 2 possible options that could work for L&SC;-

Option 1



Option 2



Final decisions will be made by the ICB in early 2023.

The Cardiac & Stroke Networks will continue to provide clinical lead expertise, expert knowledge, leadership and guidance to all our stakeholders in support of CVD prevention, supported by the Cardiac Network's ICS CVD Prevention lead.

It is understood that any programme of work will require resources and funding, therefore the system will work together to ensure that elements required within the Transforming CVD Work Programme are spread throughout the stakeholders so as not to drain resources of single organisations. The ICS Prevention group, supported by the clinical networks, will continue to source suitable income opportunities through national programmes, ICB, NHSE and any other avenues identified by stakeholders within the system. Where appropriate, working with industry will also be considered.

What will success look like?

Success for L&SC will be seen in a number of ways.

By addressing the six aims that we have outlined within this strategy; -

- We will have improved our outcomes for the detection, management and optimum treatment of atrial fibrillation (AF), high blood pressure (BP), high cholesterol (including FH) and weight management, year on year, achieving the national ambitions by 2029 and hopefully before.
- We will have followed the Predict, Prevent, Detect, Protect, Manage, Recover model as a whole system and
- improved the CVD (and overall) health of our population, reducing health inequalities and having a social and economic impact.
- We will have reduced CVD mortality and morbidity across L&SC.
- We will have embedded CVD Prevention across the whole system as a priority.
- We will have reduced heart attacks and strokes across Lancashire & South Cumbria,

By delivering the four pillars and our three regional objectives; -

Monitoring and targeting unwarranted variation	**Supporting a system-wide response**
Enabling system leadership for CVD prevention	**Increasing awareness**

We will have; -

- Used the best data available to target populations at the highest risk and to inform the system of our position
- Supported a system wide response by improving access and uptake to whole system, place based and targeted CVD prevention interventions
- Enabled system leadership to ensure that existing infrastructures and new governance work together and are in place, to bring all CVD programmes under one ICS programme
- Increased awareness to the population and the system, of CVD prevention messages, wider lifestyle and behaviour changes that can impact on CVD, the support, and initiatives available and the wealth of information and advice that can be used (Healthy Hearts, MECC etc)

By achieving our aims and delivering on the pillars, we will have ensured that the whole system has an understanding of:

- Atrial Fibrillation (AF) and reducing AF related strokes
- Hypertension (High BP) and reducing heart attacks
- High Cholesterol to reduce heart attacks and strokes
- Improve the identification of Familial Hypercholesterolemia

There will also be a number of KPI's and metrics devised to measure success, some of which have already been defined by NHSE through the Cardiac Pathway Improvement Programme and the ISNDN programme. These will be decided upon when creating the CVD prevention work programme.

Appendix 1 – Atrial Fibrillation

(from healthierlsc.co.uk/healthyhearts/atrial-fibrillation)

What is AF: When the heart beats normally, its muscular walls contract (tighten and squeeze) to force blood out and around the body. They then relax, so the heart can fill with blood again. This process is repeated every time the heart beats.

In atrial fibrillation, the heart's upper chambers (atria) contract randomly and sometimes so fast that the heart muscle can't relax properly between contractions. This reduces the heart's efficiency and performance.

Atrial fibrillation occurs when abnormal electrical impulses suddenly start firing in the atria. These impulses override the heart's natural pacemaker, which can no longer control the rhythm of the heart. This causes the person to have a highly irregular pulse rate.

The cause isn't fully understood, but it tends to become more common as you get older. It may be triggered by certain situations, such as drinking excessive amounts of alcohol or smoking.

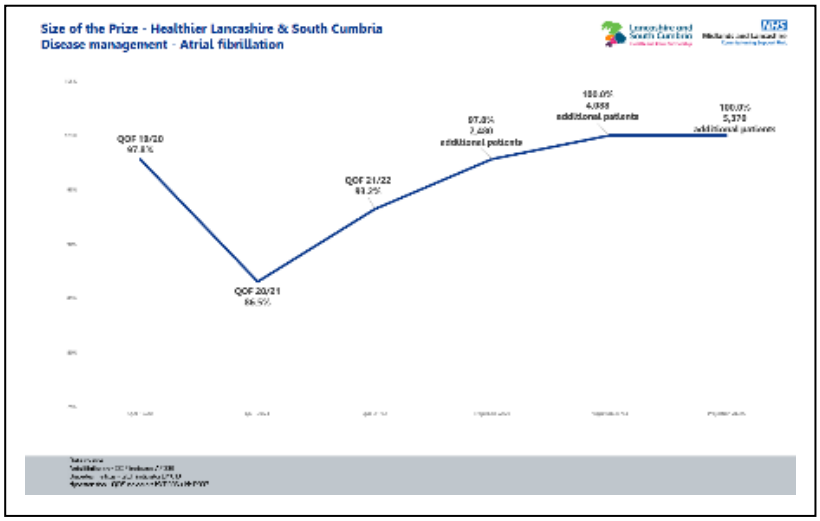
Treatment: Most people with AF will require an anticoagulant, but a small number of these won't as it depends on the risk.

Anticoagulation means that you take a medicine to reduce the chance of a blood clot forming and having an AF-related stroke.

Anticoagulant drugs like DOACs are the most effective treatments to reduce the risk of stroke in people with AF.

Some people with AF need medications to help control the rate and rhythm of their heart. These medications are most commonly beta blockers and anti-arrhythmic drugs.

Occasionally, a procedure such as ablation or cardioversion may be needed.



The national AF ambitions:

- Diagnosed 90% of all people estimated to have AF
- Treated (with anticoagulation) 90% of those with atrial fibrillation identified as High Risk

Size of the Prize: For L&SC to achieve 100% treatment in 23/24, going over and above pre-covid baselines (inclusive of annual AF increase estimates) we would need to *diagnose and treat* an extra 4,088 patients.

PHE estimate that by *optimally treating* known high risk AF patients in L&SC, 580 strokes could be prevented within 3 years.

Appendix 2 – (High) Blood Pressure

(from healthierlsc.co.uk/healthyhearts/blood-pressure-checks)

What is high BP: High blood pressure (also known as hypertension) is one of the most common health problems in the UK, affecting over a quarter of people in England.

Estimates suggest that over 130,000 people across Lancashire and South Cumbria have undiagnosed high blood pressure.

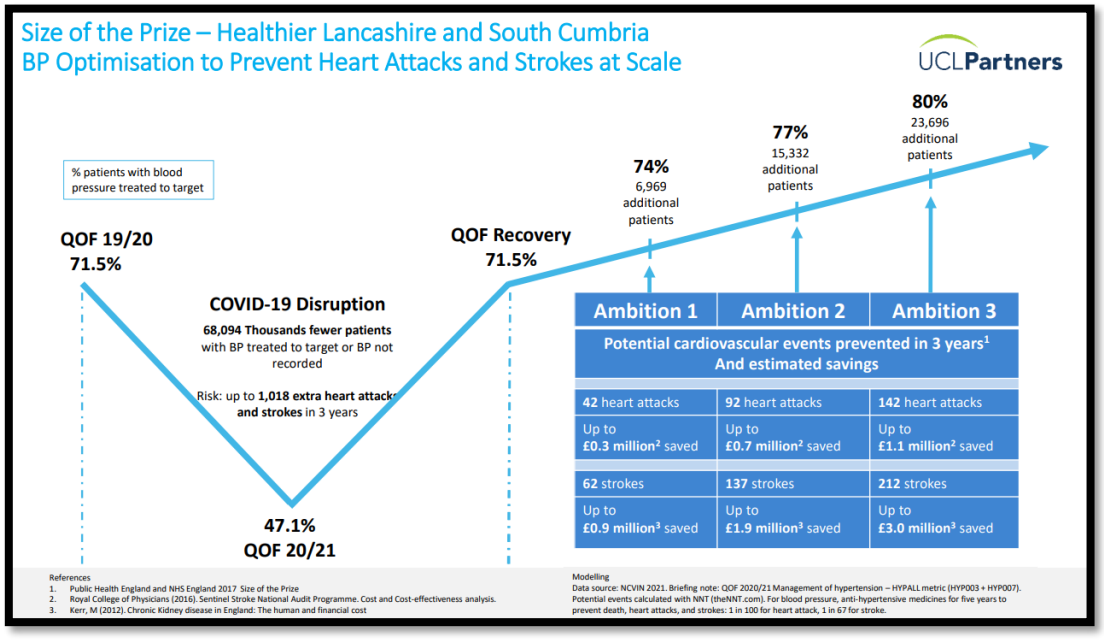
Treatment: First line management is simple lifestyle changes as outlined in the lifestyle section. If your blood pressure remains high, you may be prescribed medicine to control it. This will reduce your risk of having a heart attack or stroke. Most people require two or three medicines to reduce their blood pressure to recommended levels. It is sometime more effective to use two or more drugs which work on different areas of the body to reduce blood pressure and minimise the risk of side effects.

Trying to be more active, losing weight if you are overweight, limiting salt and alcohol can all improve blood pressure – sometimes as much as taking one additional blood pressure medicine and with additional health benefits!

The national BP ambitions:

- Diagnosed 80% of all people estimated to have high blood pressure
- Treated (to NICE recommended blood pressure thresholds) 80% of those diagnosed with high blood pressure
- Expand the use of remote monitoring for BP

Size of the Prize: For L&SC to achieve the national ambitions (inclusive of annual Hypertension increase estimates) an extra 23,696 patients would need to be treated. This would result in an estimated 142 heart attacks and 212 strokes being prevented over 3 years, with an estimated cost saving of over £4 million.



Appendix 3 – (High) Cholesterol

(from healthierlsc.co.uk/healthyhearts/cholesterol)

What is high cholesterol: Cholesterol is a fatty substance known as a lipid and is vital for the body's normal function. It's mainly made by the liver but can also be found in some foods.

Evidence strongly indicates that high cholesterol can increase the risk of:

- narrowing of the arteries (atherosclerosis)
- heart attack
- stroke
- transient ischaemic attack (TIA) – often known as a mini stroke
- peripheral arterial disease (PAD)

This is because cholesterol can build up in the artery wall, restricting blood flow to your heart, brain and the rest of your body. It also increases the risk of a blood clot developing somewhere in your body. Your risk of developing coronary heart disease also rises as your blood's cholesterol level increases. This can cause pain in your chest or arm during stress or physical activity (angina).

What is Familial Hypercholesterolaemia (FH) (from The BHF website): FH is an inherited condition that is passed down through families and is caused by one or more faulty genes.

It's caused by a genetic mutation that means your liver is unable to remove excess 'bad' cholesterol, known as LDL. This means the LDL level in your blood remains high. Having FH means you're at a greater risk of getting heart and circulatory disease at an early age if it's left untreated.

If you have very high cholesterol levels or if you've had high cholesterol from birth, you may have FH. Having FH means you're at a greater risk of getting heart and circulatory disease at an early age if the condition is left untreated. Around 1 in 250 of the UK population has the condition, although many people are unaware they have it.

Treatment: Lifestyle changes, such as eating a healthy, balanced diet; taking regular exercise and giving up smoking, help to improve cholesterol levels.

You can swap food containing saturated fat with fruit, vegetables and wholegrain cereals. This will also help prevent high cholesterol returning.

But even the strictest low-fat diet can only lower your cholesterol level by up to 10%. This is why it will usually be recommended that you take statins if you are considered to be at high risk of a heart attack or stroke. But don't forget, making lifestyle changes will still reduce your risk of developing coronary heart disease.

The national cholesterol (lipids) ambitions:

- 75% of people aged 40 to 74 will have received a formal validated CVD risk assessment and cholesterol reading recorded on a primary care data system in the last five years (2029)
- 45% of people aged 40 to 74 identified as having a 20% or greater 10-year risk of developing CVD in primary care are treated with statins (2029)
- 25% of people with Familial Hypercholesterolaemia (FH) are diagnosed and treated optimally according to NICE FH guidance (2024)

Appendix 4 – Weight Management

What is weight management: Being overweight (or obese) can increase your risk of heart and circulatory diseases like heart attacks, strokes and vascular dementia.

Excess weight can lead to fatty material building up in your arteries. If the arteries that carry blood to your heart get damaged and clogged, it can lead to a heart attack. If this happens in the arteries that carry blood to your brain it can lead to a stroke or vascular dementia.

The biggest health risk comes from fat called visceral fat, which sits around our internal organs such as our heart and liver, and can:

- raise your blood cholesterol
- increase your blood pressure
- increase your risk of developing Type 2 diabetes.

Weight management, is trying to decrease your weight and therefore, remove some of the risks associated with being overweight.

Treatment: Losing weight can be hard, but lifestyle changes, such as eating a healthy, balanced diet, taking regular exercise and limiting alcohol consumption can all help.

The local ambitions:

- Digital Weight Management Programme take up: 4205
- Equity of service from Tier 1 to Tier 4

Appendix 5 – Possible Place Based CVD Prevention Questionnaire

Possible Place questionnaire to support delivery of the strategy (based on Cheshire with Mersey).

Does your Place have a named operational lead for CVD Prevention who is accountable for a Place level programme?	
Does your Place have a named and accountable clinical lead for CVD Prevention?	
Does your operational lead attend the CVD Prevention group and cascade information from that group to their Place peers?	
Are your Place's risks, issues, and barriers to change, shared with the CVD Prevention group?	
Has your Place published a CVD prevention work programme that covers ABC(D) and that aligns with the 4 Pillars? Is there a named and accountable project/programme manager?	
Has your Place input into the L&SC benchmarking exercise of system wide programmes of work?	
Does your Place access support from the CVD Prevention group for its CVD prevention improvement plan?	
Is your Place using data to identify and target improvement activity and is that being drawn from Aristotle and/or CVDPrevent?	
Has your Place already adopted risk stratification tools (e.g., BPQI and UCLPartners)?	
Is your Place working with other relevant programmes and workstreams that include CVD prevention (incl. detection & management) to ensure that prioritisation of those at the highest risk of cardiovascular disease and those who are most disadvantaged within your population, are considered?	
Is your Place using the BP@home and Community Pharmacy programmes (incl. BPCS) to support your CVD prevention work?	
Is your Place working with all your PCNs to help them to risk stratify patients so that those at most risk are prioritised and targeted?	
Is your Place working with the voluntary sector, secondary care providers, community care providers etc?	