Cheshire and Merseyside
Health and Care Partnership

Advancing Cardiovascular Disease Prevention in Cheshire and Merseyside

Supporting local communities to lead healthier and longer lives

September 2022 – September 2029

Contributors to this Strategy Document:

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Executive Summary

Cardiovascular Disease (CVD) is the biggest contributor to the gap in life expectancy in the Northwest of England and a leading cause of premature death and health inequalities in Cheshire and Merseyside (C&M).

It is associated with deeply embedded inequalities, particularly in relation to deprivation, certain ethnic minority groups, other demographics (e.g., working age males) and underserved or vulnerable communities (e.g., those with severe mental illness).

CVD is largely preventable through a healthy lifestyle and the early detection and control of key risk conditions; atrial fibrillation (AF), high blood pressure (hypertension, BP) and high cholesterol (the 'ABC' of CVD prevention).

In C&M it is estimated that improved blood pressure control alone could prevent around 1,500 additional heart attacks and strokes in C&M over the next 3 years.

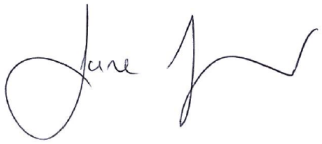
It is for these compelling reasons that we, in Cheshire and Merseyside, have a dedicated focus on CVD Prevention and that we are seeking to further advance on the progress.

Our strategy "Advancing CVD Prevention" builds on our existing work and sets out an innovative whole-system, population-health approach that empowers clinicians, non-clinical partners, patients and communities across Cheshire and Merseyside to work together to prevent cardiovascular disease. A multidisciplinary and multiagency CVD Prevention Group will provide strategic oversight and robust ICS-level governance that fosters new partnerships and strategic alliances. This collaborative cross-sector partnership working will provide a positive step change in outcomes at the pace and scale that is necessary.

Our strategy is being published in a time of unprecedented change within the health and care system and provides a golden thread from National Ambitions for Cardiovascular Disease (known as the ABC Program), the Four Pillars of recovery (a program focusing on CVD prevention recovery post pandemic) and is aligned with our own Integrated Care System objectives and the Core 20plus5 priorities for improving health inequalities.

1. Improve population health and healthcare to reduce deaths from cardiovascular disease (CVD)
2. Tackle unequal CVD outcomes and access to prevention opportunities, and deliver against Core20PLUS5 priorities
3. Enhance productivity and value for money
4. Support broader social and economic development including through a focus on improving cardiovascular health of the working age population

Jane Tomkinson



Senior Responsible Officer for the Cheshire and Merseyside Cardiac Board Program (including CVD Prevention)

Context

For the purposes of this document, the term CVD Prevention is defined in line with the wider NHS CVD Prevention and Recovery Plan.

Hence for the purposes of this document, CVD is used in the context of ABC. Recent PHE modelling shows that if the national ambitions for AF and BP were achieved across Cheshire and Merseyside, within 3 years 460 heart attacks and 1,440 stokes might be prevented, collectively saving the NHS over £25m.[1] CVD prevention is also a core element of the Cheshire and Merseyside ICP strategy.

CVD Prevention Golden Thread

Vision	**Cheshire and Merseyside communities will have the best possible cardiovascular health**			
Aims	Achieve and where possible advance on the **National Ambitions** for atrial fibrillation (AF), high blood pressure (BP) and cholesterol detection and management by 2029 (with year-on-year progress being made towards that goal).			
	Support delivery of the ICS objectives: • Improve population health and healthcare to reduce death from cardiovascular disease (CVD) • Tackle unequal CVD outcomes and access to prevention opportunities, and deliver against Core20PLUSS priorities • Enhance productivity and value for money • Support broader social and economic development including through a focus on improving cardiovascular health of the working age population			
Objectives	**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 use CVD data to target populations with unwarranted variation and inequalities • Utilise routine and bespoke data sources (e.g. CIPHA dashboard, CVD PREVENT, Model Health Systems) • We will risk stratify patients and raise awareness of comorbidity and the whole patient experience) • We will work as a CVD prevention network to compliment and support prevention within neighbourhood teams	• We will utilise CVD prevention groups, leads, and networks to coordinate and improve care pathway and CVD prevention • We will facilitate collaboration and alignment with other ICS programmes e.g. population health/ digital/virtual ward and remote monitoring opportunities • We will further develop our system wide Happy Hearts website to support education and training opportunities	• We will support primary care, reach patients in innovative ways and work with partners across the system e.g. BP@ home, community pharmacy checks, voluntary sector community outreach • We will work with higher education to explore research opportunities • We will bring forward proposals for a Prehab Prevention model that compliments CVD-R rehab	• We will build on national and local communications campaigns that signpost patients to services and build public and professional awareness of CVD prevention • We will learn from and share patient stories • We will bring forward proposals that help support psychological behaviour change of risk factors
Enablers	Improvement resources and funding, cross-sector partnerships, research and innovation, communications and engagement, digital transformation.			
Delivery	• Cheshire and Merseyside wide delivery where a 'do it once' approach is appropriate (our 'cross-cutting themes') • Place-based delivery (localised Place level delivery tailored to the population) • Support at PCN, pharmacy and practice level for specific improvement projects and initiatives			

[1] University of Sheffield. 2020. CVD Prevention Predictive Modelling. https://cvd-prevention.shef.ac.uk/

Our strategy embodies collaborative working with existing ICS, local and regional workstreams that support healthy behaviours (e.g. smoking cessation, physical activity, healthy weight, reducing harm from alcohol, Making Every Contact Count, mental health and wellbeing) and that reduce inequalities through upstream actions (e.g. All Together Fairer, Anchor Institutes, Prevention Pledge).

The Four Pillars:

Programme deliverables build on the four 'pillars' set out in the national CVD Prevention Recovery Plan.

1. **To monitor and target** unwarranted variation we will use routine and bespoke CVD data sources (e.g. CIPHA dashboard, CVD PREVENT, Model Health Systems) to risk stratify patients and to target populations with unwarranted variation and inequalities

2. **To support system leadership,** we will utilise CVD prevention groups, leads and networks to coordinate and improve care pathways and CVD prevention, and facilitate collaboration & alignment with other ICS programmes e.g. Population health, Digital and Primary Care programmes

3. **To support a system-wide response** we will support primary care to reach patients in innovative ways (e.g. BP@home) and work with cross-sector partners in a range of settings (e.g. community pharmacy checks, voluntary sector and community outreach approaches)

4. **To raise public awareness** of CVD prevention we will build on national and local communications campaigns that signpost patients to services and build public & professional awareness of CVD prevention, and build in patient stories for optimal impact

Delivery will happen both at Place, and where a 'do it once' approach is appropriate, C&M wide. It will be enabled by cross-sector partnership working, communications and engagement, and Innovative delivery models and digital approaches will play a key role.

Our Vision, Aims and Objectives

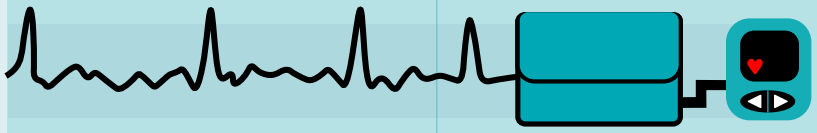
Our vision is for Cheshire and Merseyside communities to have the best possible cardiovascular health.

We will achieve that by reducing the number of preventable heart attacks and strokes through improvement activity focused specifically on the 'ABC' conditions, targeted upon the communities and individuals in greatest need.

We will remain focused on the objectives set within the Long Term Plan but will also respond to the incremental targets that are set along the way to help us to reach our intended goals.

10 year cardiovascular disease ambitions for England

Atrial fibrillation (AF)



85%
of the expected number of **people with AF are detected by 2029**

90%
of patients with AF who are already known to be at high risk of a stroke **to be adequately anticoagulated by 2029**

High blood pressure

80%
of the expected number of **people high blood pressure are diagnosed by 2029**

80%
of the total number of people already diagnosed with high blood pressure are **treated to target as per NICE guidelines by 2029**

High cholesterol

75%
of people aged **40 to 74 have received a formal validated CVD risk assessment** and **cholesterol reading** recorded on a primary care data system in the last five years by 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 by 2029

25%
of people with **Familial Hypercholesterolaemia (FH) are diagnosed and treated** optimally according to the NICE FH Guideline by 2024

The ambitions are underpinned by the need to do more to reduce health inequalities
Reduce the gap significantly in amendable CVD deaths between the most and least deprived areas by 2029

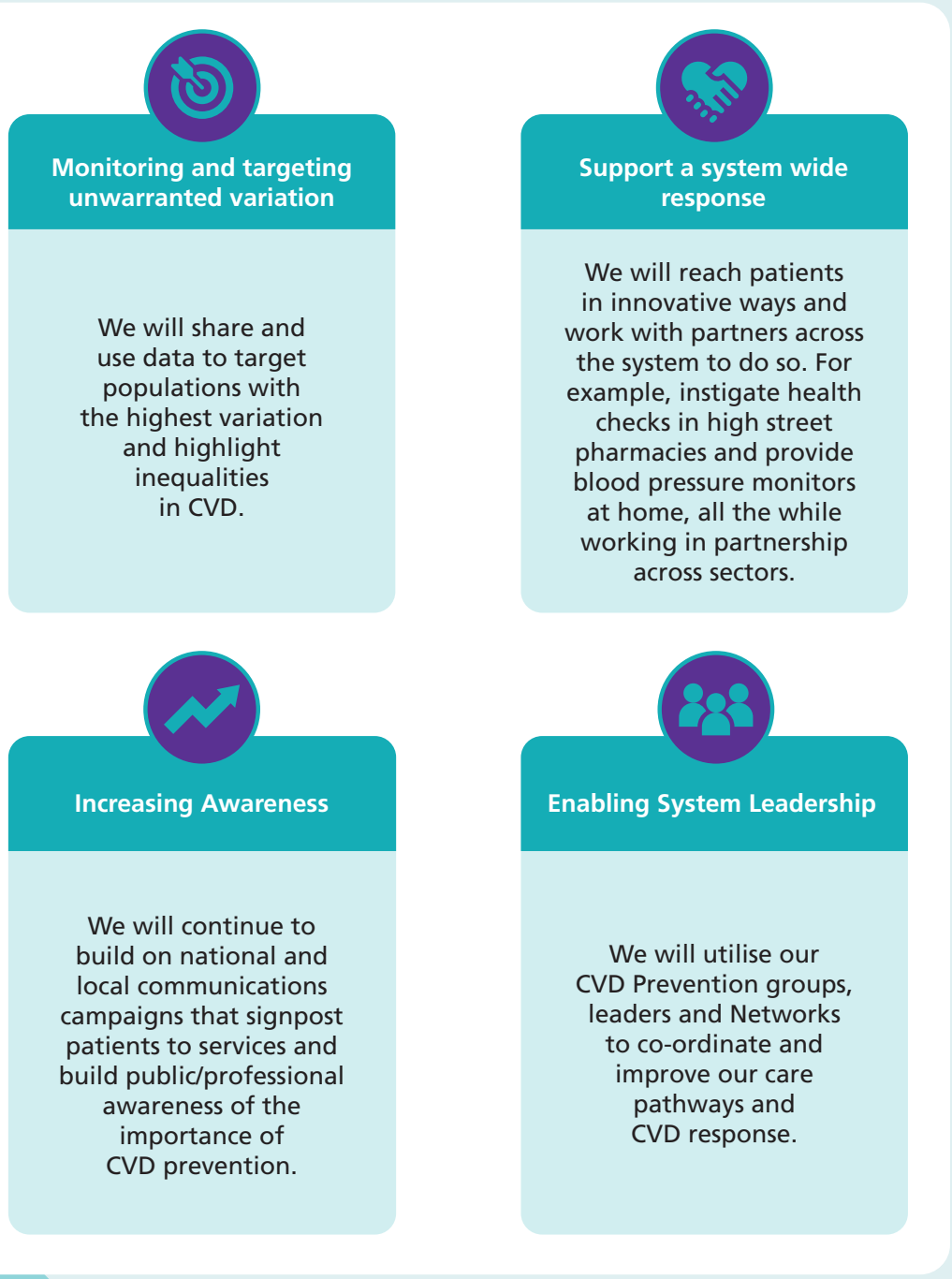
Figure 1 **– The Long Term Plan CVD Ambitions**

We will do this by improving population health and health care by preventing cardiovascular disease to reduce the life expectancy gap by tackling unequal access and outcomes to preventative care. By working together as a system, we will improve productivity and the effectiveness of our improvement efforts and make sure that we use our combined resources in the best ways to plan, design and deliver interventions and services at scale.

Our strategy therefore focuses on four high-impact objectives to meet our aim and deliver our vision. As recommended by the national CVD Prevention Recovery plan, our strategy has 4 pillars:

1. **To monitor and target unwarranted variation**
2. **To prioritise system leadership for CVD prevention**
3. **To support a system-wide response**
4. **To increase awareness**

Figure 2 **– The 4 Pillars of the Cheshire and Merseyside Advancing CVD Prevention**



The Case for Change

Improving CVD prevention is fundamental to the delivery of the overall Integrated Care Partnership strategy and has the potential to save the wider health and social care system significant amounts of money.

For example, successfully optimising the diagnosis and treatment of high blood pressure in line with the national Long-Term Plan ambitions would prevent 244 heart attacks in Cheshire and Merseyside.

At the same time though, the scale of work is significant and cannot be achieved without all stakeholders working to a unified and socialised overarching strategy by which our collective efforts can be harnessed and channelled.

That will require strong leadership, which can continue to be provided by the CVD Prevention Group as well as collective responsibility. That will be achieved through the widened membership of the Group as well as new partnerships (e.g. pharmaceutical companies) with that Group. The ICSs investment into CIPHA will be built upon to give the data that we need to guide our efforts and track our progress in meeting our goal.

Our use of digital technologies and innovative ways of working will continue (virtual wards for example) and we will further develop our emerging work with primary and secondary schools, as well as with higher and further education to support education and research into CVD prevention respectively.

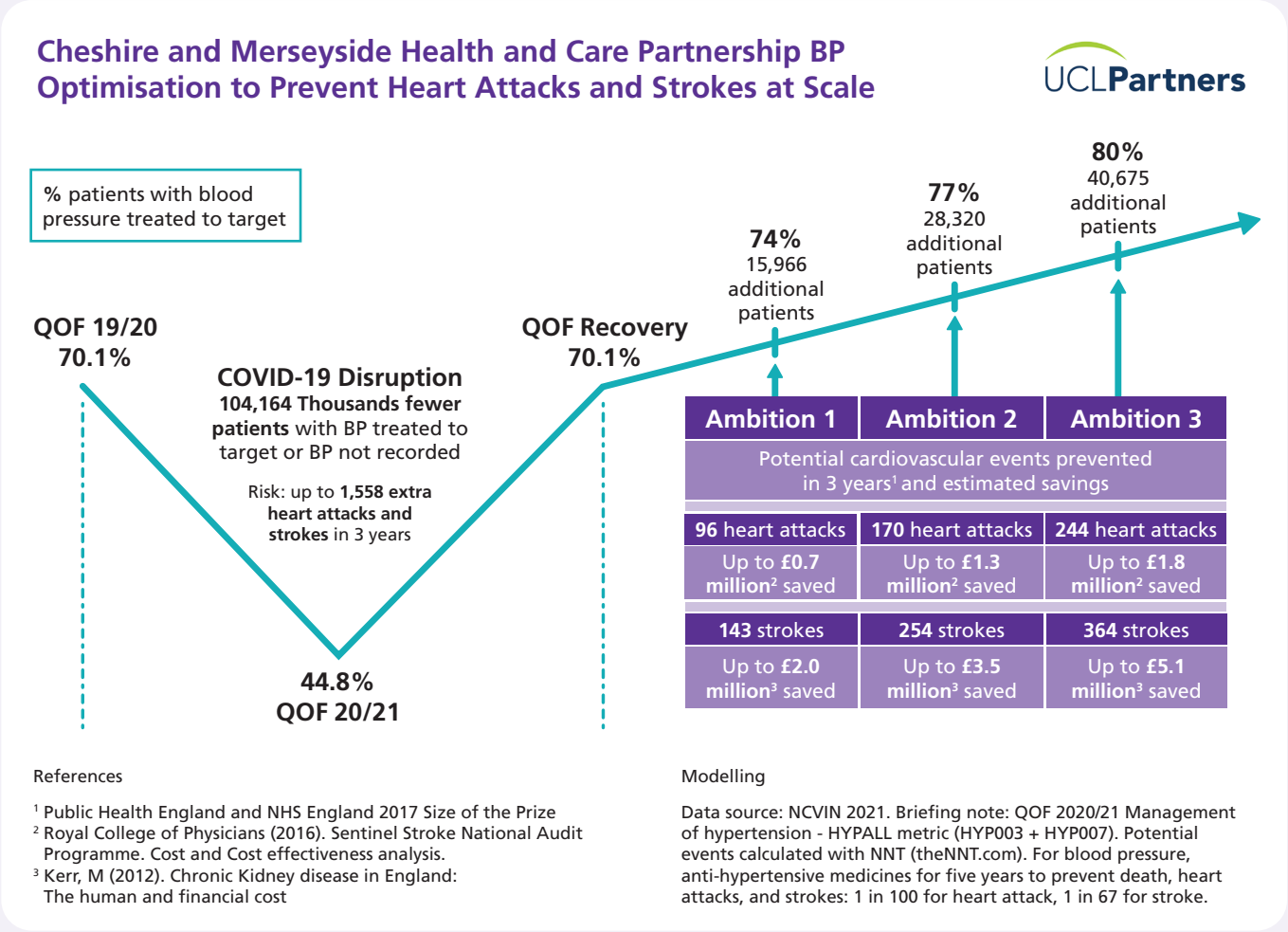


Figure 3 **– The Size of the Prize for Cheshire and Merseyside**

Cardiovascular Disease and Health Inequalities

CVD deaths rise in line with levels of deprivation; it is one of the conditions most strongly associated with health inequalities with those living in the most deprived areas being twice as likely to die prematurely of CVD than those in the least.[2]

As well as living typically shorter lives, those in more deprived communities are more affected by the ABC conditions.

Those in the most deprived communities are 30% more likely to have high blood pressure than those in the least (the biggest single risk factor for heart attack and stroke) and according to the Global Burden of Disease Study 2016, CVD accounts for 16% of total Disability Adjusted Life Years (DALYs) in North West England, the second largest disease burden in the country.[3]

The COVID-19 pandemic has also had a significant impact on the diagnosis, monitoring and treatment of 'ABC' conditions. Recent analysis shows that blood pressure recording within General Practice significantly reduced with fewer diagnosis of the ABC conditions being made; the reduction in blood pressure control alone during the pandemic could lead to 1,558 additional heart attacks and strokes over the next 3 years.[4]

Our strategic approach must therefore focus efforts on those communities located in areas of high deprivation, experiencing the greatest burden of CVD and at most risk of ill-health, and utilise the Core20plus5 framework. That initiative highlights clinical areas on which to focus to reduce health inequalities. High blood pressure case finding and optimisation, and optimisation of lipid management are Core20plus5 priorities.

This strategy sets out an innovative whole-system, population-health approach that aims to empower clinicians, non-clinical partners, patients and communities across Cheshire and Merseyside to work together to prevent cardiovascular disease.

It will guide our work and build upon the current CVD prevention programme to advance CVD prevention across Cheshire & Merseyside, by building upon the outputs from the region-wide 'Advancing CVD Prevention' workshop event on 30th June 2022. Through coordinated cross-sector actions to prevent CVD, via the delivery of a Cheshire & Merseyside wide CVD prevention strategy, Cheshire and Merseyside ICS will help its communities to live longer, healthier lives (see also Appendix 5 for other relevant population health programmes). Our region has a rich history of collaborative working within the CVD Prevention space that this strategy and its ambitions capture. Where possible we will seek to exploit all opportunities to accelerate our work in this area.

Our strategic aspirations for Cheshire & Merseyside firmly support improvements to population health to help our residents lead longer and healthier lives by avoiding cardiovascular ill health.

Within that context heart attacks and strokes are the leading cause of such ill health and premature deaths. They in turn create further pressure on our health and social care systems and adversely affect the lives of those directly affected as well as their friends and families.

Therefore, focusing our improvement efforts on the ABC conditions will help us to reduce the incidence of CVD, and specifically the numbers of heart attacks and strokes by optimising therapies for those with the ABC conditions and those most at risk of developing them by identifying them at an early stage and ensuring that they are treated appropriately and are given life-style advice and support.

[2] NHS England. 2022. www.england.nhs.uk/ourwork/clinical-policy/cvd/

[3] Public Health England. 2016. Action on cardiovascular disease: getting serious about prevention. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/556135/Action_on_cardiovascular_disease-getting_serious_about_prevention.pdf

[4] UCLPartners. 2022. Size of the Prize – Cheshire and Merseyside Health and Care Partnership BP Optimisation to Prevent Heart Attacks and Strokes at Scale

Psychological Factors and Mental Health

There are strong and well-established relationships between stress, anxiety, depression and increased risks of cardiovascular disease: both in terms of disease onset, disease progression and premature death.

Clinical evidence clearly indicates the risk potential for persistent psychological distress to lead to increased hypertension, raised heart rate and increased cortisol levels, that can further increase cardiovascular health risks.

Psychological factors can also profoundly influence rehabilitation and recovery, being integral moderating factors on behavioural change (e.g where health beliefs, culturally-bound beliefs and psychological state can be highly influential on illness-related behaviour) and where experiences such as social isolation, social withdrawal, hopelessness or a sense of learned helplessness, can all be significant factors, predicting poorer health outcomes and which have psychological underpinnings, amenable to change, through relevant support.

The standardisation of psychological support into cardiovascular care and rehabilitation pathways, in order to expand care, will support improved rehabilitation and disease prevention ambitions.[5]

[5] Cheshire & Merseyside ICP. 2022. "Case for Change for a 'Strategy at Scale' for Clinical Health Psychology & Clinical Neuropsychology, for the provision of appropriate Psychological Support in Physical & Neurological Long-Term Conditions"

What will success look like?

By 2029 Cheshire and Merseyside will have achieved and preferably exceeded the national ambitions for the detection, management and control of atrial fibrillation, high blood pressure, and high cholesterol.

We will also have reduced health inequalities within our communities and improved access to rehabilitation and 'prehabilitation' to better meet the integrated physical, psychological and mental health needs of our communities.

We will have improved access to, and the uptake of CVD prevention interventions, particularly in currently underserved communities and groups where unwarranted variation in care and outcomes is most evident.

In recognition of the importance of 'upstream' preventative activity we will have made every contact count and will have strengthened the interdependencies across key ICS programmes to deliver healthy communities (e.g. 'All Together Fairer') and improved health-related behaviours (e.g. our tobacco control, dietary, obesity and physical activity workstreams) as detailed within Appendix 5.

Meeting those aspirations will mean that we have supported our stakeholders across primary, secondary, community care and public health to deploy effective care pathways and preventative interventions to:

1. Identify and treat Atrial Fibrillation (AF) and reduce AF related strokes
2. Improve the identification and management of BP to reduce heart attacks
3. Improve the management of cholesterol to reduce heart attacks and strokes
4. Improve the identification of Familial Hypercholesterolemia

Alongside this we will have supported our population and communities to:

1. Be educated about blood pressure, atrial fibrillation and cholesterol
2. Manage their own health and be empowered to be their best selves
3. Take advantage of health advice and opportunities to improve their health

This will be achieved through facilitation of local population engagement across Cheshire and Merseyside using several vehicles to engage:

1. Engagement sessions held both virtually and face-to-face to reduce digital exclusion. The purpose of the sessions will be to provide short presentations related to CVD and the ways in which it can be prevented, providing key messages, signposting and offering Q&A sessions.

2. Communication link to be established which is easily accessible for users and again which provides relevant links, signposting, FAQs.

3. Engagement surveys to initially understand how people want to be communicated with and to begin to understand where the gaps in knowledge and information lie to support a targeted approach to prevention.

Measures of success will apply to C&M, as well as to each 'Place'. Likewise, 2029 is a long-term timeframe, and so our predicted trajectories to achieving our goals (through reference to the CIPHA dashboard) will be tracked against a locally set benchmark (that will be set once CIPHA data is available) and which take account of any shorter term targets set for us. The following long-term outcomes focused KPIs will therefore be used:

1. AF diagnosis rates, and treatment to target levels

2. High BP diagnosis rates, and treatment to target levels

3. High cholesterol diagnosis rates, and treatment to target levels

4. Diagnosis rates of Familial Hypercholesterolemia

5. The numbers of strokes within the adult population each year

6. The numbers of heart attacks within the adult population each year

DELIVERING THE FOUR PILLARS

Monitoring and targeting unwarranted variation

We will measure our progress by using a range of routinely available and new, bespoke data sources, tools, and evidence.

Doing that will give us greater insight and granularity about progress, will provide fresh opportunities to expand our programmes into new 'places' and will guide targeted interventions for the populations and communities most in need.

We will use national, sub-regional, locality, Primary Care Network and practice-level data to monitor and report on progress, identify priority groups and risk-stratify patients, and inform targeted quality improvement work and other interventions (e.g. using tools such as the national BP ICS self-assessment to benchmark our work programme to inform future efforts).

We will use output and outcome measures. The CVD Prevention group will monitor and publish progress and the Cheshire and Merseyside Cardiac Network CVD Prevention Programme Lead will report through to the ICS accordingly. We will access national level data through the Model Health System (which is published by the Cardiac Pathways Improvement Programme) to help us to understand variation in outcomes.

In addition, the CVD Prevention Group has partnered with NHS Benchmarking as an Early Adopter within the CVDPREVENT Audit to use its Data and Improvement Tool to support local quality improvement work.

At an ICS level, the CVD, Stroke and Respiratory CIPHA dashboard will provide local data. This dashboard will provide user defined non-patient identifiable data drawn directly from the combined Cheshire and Merseyside primary care record to identify variables and populations of interest.

It is highly granular and will enable variation within our populations and groups of interest to be identified through the analysis of that population's underlying characteristics (e.g. disease, location, demographic, ethnicity etc).

At a Primary Care Network and practice level, locally developed AFQI and BPQI case finding tools and UCLPartners Proactive Care Framework toolkits will be used for case finding and risk stratification.

Like the UCL Partners Proactive Care Frameworks, the AFQI and BPQI tools enable patients to be identified from GP Practice registers and support risk stratification. Primary care partners will also be encouraged to access the financial payments which incentivise work in support of CVD prevention (for example, the payments under the Direct Enhanced Service contract and Quality Outcomes Framework).

Our KPI for this pillar is the extent to which the CVD, Stroke and Respiratory CIPHA dashboard can provide the data needed to benchmark and monitor progress.

DELIVERING THE FOUR PILLARS

Enabling system leadership

Our whole-system CVD prevention strategy builds on the long-standing commitment, existing reporting infrastructures and progress already made by partners across Cheshire and Merseyside towards achieving the national 10-year CVD prevention ambitions.

Cheshire and Merseyside already has a strong CVD prevention work programme and reporting framework in place.

Since 2021, it has been supported by the Cheshire & Merseyside Cardiac Network and prior to this has greatly benefited from the work of its system partners such as the Champs Public Health Collaborative and the Innovation Agency.

This structure is well established and encompasses work coordinated directly through the CVD Prevention Group (e.g. AFQI) as well as regional programmes (e.g. BP@home) and local initiatives managed 'at place' (e.g. the targeted NHS Health Checks programme).

These existing workstreams form a significant proportion of the new Advancing CVD Prevention work programme that will be managed through the CVD Prevention group (see appendix 6). In the future, wider partnerships with the third sector and pharmaceutical sector will be explored so that everyone with a vested interest in reducing cardiovascular disease can work together under a single unified strategy.

The strategy also builds on the outputs from the region's 'Advancing CVD Prevention' workshop event on 30th June 2022, which brought together key stakeholders from the nine Cheshire and Merseyside 'Places' and facilitated the collation of the work happening 'at place' (i.e. appendix 6).

Each 'Place' will be represented at the CVD Prevention group by a nominated Place lead, to support each locality to advance its CVD prevention plans whilst coordinating and maximising the opportunities for sharing and expanding good practice across the region. Appendix 1 contains a checklist for each Place to use to review its work programme against.

Clinical leadership has been embedded within the CVD Prevention group, with four Primary Care leads recruited to the group (two of which are funded through the Cardiac Network and two jointly funded by the Network and Cardiac Board).

The CVD Prevention group will continue to report through to the Cardiac Board which will in turn report through to the ICS.

In addition, the Cheshire and Merseyside Cardiac Network CVD Prevention Programme Lead will oversee engagement with other relevant ICS programmes, groups and Boards (e.g. the Diabetes and other networks, the Population Health Board, Digital First in Primary Care programme etc.) to optimise interdependencies and opportunities to work in partnership with other ICS programmes on relevant workstreams to ensure that all the CVD prevention work underway across the region takes account of each other to avoid unnecessary duplication (for example, the programmes detailed in appendix 5 that address tobacco control, weight management, physical activity, etc.).

The CVD Prevention group will report on core programme deliverables to the Cardiac Board, and in doing so act as both an ICS-level strategy delivery group while providing an assurance framework against the national CVD prevention recovery plan.

Our KPI for this pillar is the level of engagement with the programme at place, by care providers, supporting agencies and patients.

DELIVERING THE FOUR PILLARS

Supporting a system wide response

Stakeholders across primary, secondary and community care, the Academic Health Science Network, public health, voluntary sector, clinical networks and local authorities ('Place') will be supported to co-develop and deliver priority CVD prevention interventions and care pathways in their respective organisations and sectors.

For impact at pace and scale, new ways of working and digital technologies have an important role in supporting, enhancing and expanding beyond historical general practice delivery models of CVD prevention.

A range of approaches in different health and community settings will therefore be used to make every contact count and improve the systematic and targeted detection, diagnosis, management and control of 'ABC' conditions.

Our flagship digital innovations and programmes will continue to facilitate widespread adoption of new delivery models and quality improvement work (e.g. BP@home, Digital First in Primary Care, Virtual Wards, BP kiosks, apps) whilst provisions will be made to guard against digital exclusion. Opportunities to improve the local availability of new digital tools (e.g. app & web-based tools to support self-directed health improvement and monitoring) will also be explored and pursued.

Innovative pilots will be supported to improve service uptake in target groups (e.g. targeted NHS Health Checks pilots) while the continued roll out of new NHS services will extend CVD prevention delivery to the wider primary care team (e.g. new community pharmacy BP testing services). The evaluation of these pilots and innovations will build a local evidence base, while supporting a learning culture and a sector-led improvement approach.

Delivering the strategy will also support the delivery of the NHS Core20plus5 programme and help to reduce health inequalities in those local communities most at risk of poor CVD outcomes.

The CVD Prevention group will liaise and support other relevant programmes and system leaders (see appendix 5; Core20plus5, Population Health Board, ICS Primary Care lead etc) to ensure that the CVD Prevention group's work prioritises those at the highest risk and those who are most disadvantaged within our populations, as well as remaining sighted on other work underway within the region. This joined up approach enables a single system wide CVD prevention response that spans existing work programmes, while remaining responsive to the wider system ask.

Our KPI for this pillar is the increase in the use of BP@home and remote monitoring technologies (as proxy measures for patient/service user empowerment).

DELIVERING THE FOUR PILLARS

Increasing awareness

The CVD Prevention group will support its stakeholders (e.g. Primary Care Leads and Place Leads) to implement a robust communications plan that will underpin two-way dialogue and engagement across clinical and non-clinical professional stakeholders and their respective networks, and between the CVD prevention and other ICS programmes.

Support will be sought from the ICS to ensure interactions with Primary Care regarding CVD prevention take account of the wider ICS communications plans and opportunities.

We will also empower our local communities to reduce their CVD risk, and support their family, friends and colleagues to do the same by raising public awareness of key CVD prevention messages relating to 'ABC' conditions (including the importance of CVD prevention checks, medical management and opportunities to improve self-care) and health-related behaviours (e.g. smoking, alcohol, obesity, physical activity etc).

We will seek to develop new relationships with primary and secondary education, to educate and empower our younger residents to take control of their health at an earlier age.

We will deliver C&M focused CVD prevention social media campaigns (targeted at those at highest risk) and support other relevant campaigns that share our ambitions (e.g. Blood Pressure UK's 'Know Your Numbers' week).

The current public-facing CVD prevention website, happy-hearts.co.uk, which focuses on 'ABC' conditions and signposts to local health and wellbeing support will be updated and improved to provide a range of locally-developed CVD prevention hard copy resources and support for community outreach initiatives, e.g. leaflets, z-cards, pull up stands and community testing guidelines.

Access will also be improved to CVD prevention checks and services, including through non-traditional community settings, e.g. the targeted restart of NHS Health Checks and use of health (BP) kiosks while facilitating the adoption and promotion of 'Making Every Contact Count' and other preventative health and wellbeing interventions progressed via different ICS programmes (e.g. Population health, Digital).

Our KPI for this pillar is the measure of reach and engagement for the Happy Hearts website and supporting social media campaigns (page impressions, 'likes', retweets, downloads etc).

How we will make this happen

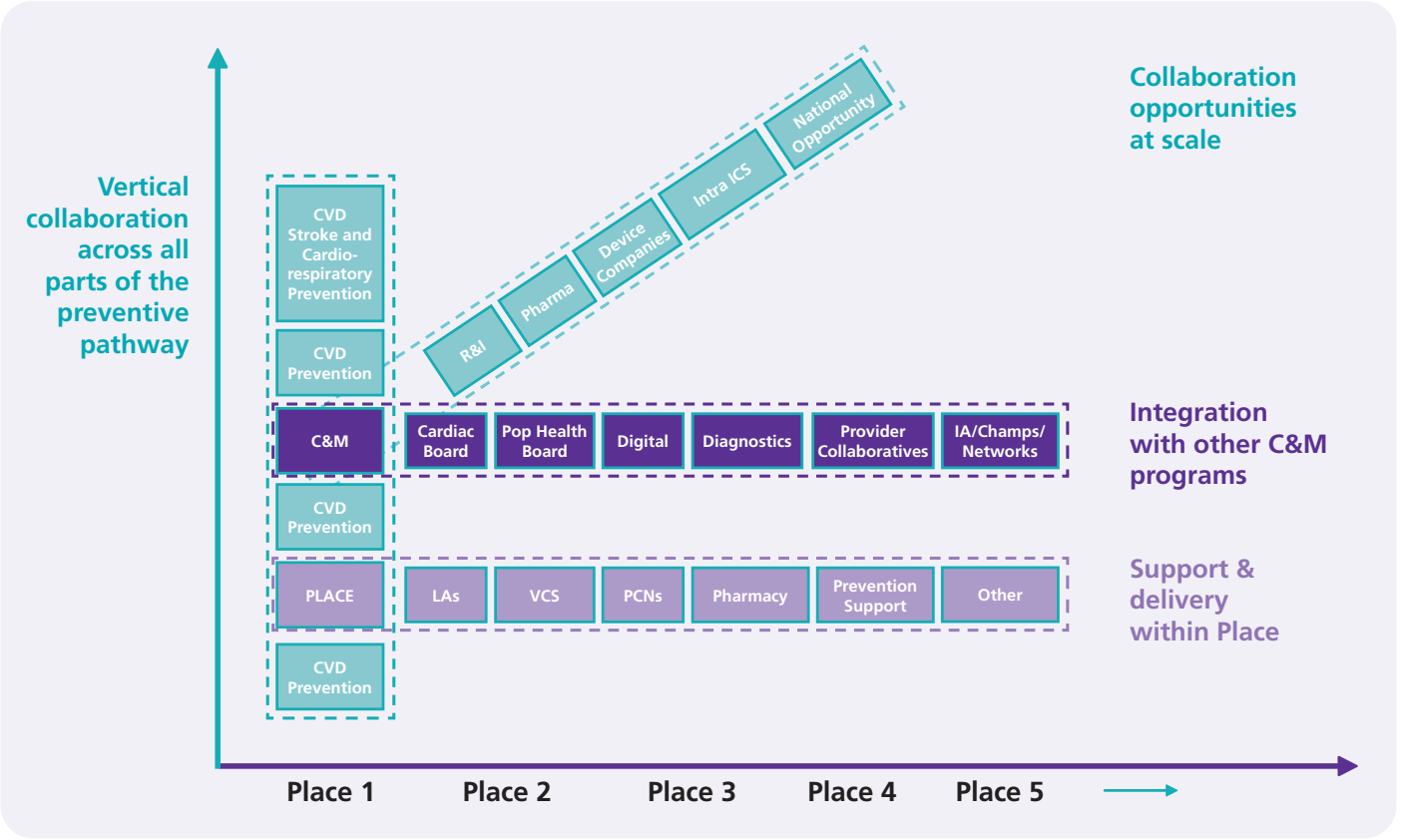
The CVD Prevention Group will continue to provide expert knowledge, leadership and guidance to our stakeholders in support of their ongoing CVD prevention efforts. It will continue to be supported by the Cardiac Board and the Cardiac Network's ICS CVD Prevention Lead.

Each Place will provide a clinical and operational CVD lead to deliver its ambitions and meet this strategy (see appendix 6) by working with the CVD Prevention Group and ICS lead.

Providers will work to make every contact count and contribute their resources (e.g. Business Intelligence and Data expertise) to support delivery of the overall strategy. They will also continue to work with Place, the Cardiac Board and Cardiac Network in support of our wider programme. Those wider system relationships are shown below in figure 4.

Figure 4 **– CVD Prevention; working at Scale and within Place**

It is acknowledged that the scope and ambition of this strategy will require additional financial resource. The CVD Prevention Group will seek to maximise income opportunities through the ICB, national programmes, competitive bids and new partnership working with organisations such as pharmaceutical and device companies. To minimise the capital requirements we will seek to embed cost reducing measures into ongoing BAU practices through initiatives such as virtual wards, BP@ home, digital innovation etc. The CVD Prevention Group will seek to promote innovative ways of working that might require non-recurrent funding to release greater benefits to the ICS (e.g. the DOAC programme) which will be raised as those opportunities arise.



APPENDIX 1

Place-Based CVD Prevention Delivery Plan Roll-out

To deliver the strategy each Place should consider the following;

- **I.** Does your Place have a named operational lead for CVD Prevention who is accountable for a Place level programme?
- **II.** Does your Place have a named and accountable clinical lead for CVD Prevention?
- **III.** Does your operational lead attend the CVD Prevention group and cascade information from that group to their Place peers?
- **IV.** Are your Place's risks, issues and barriers to change shared with the CVD Prevention group?
- **V.** Has your Place published a CVD prevention work programme that covers A,B & C and that aligns with the 4 Pillars? Is there a named and accountable project/programme manager?
- **VI.** Has your Place accessed the cross-cutting Cheshire & Merseyside wide programmes of work (e.g. Digital First in Primary Care) detailed within appendix 6?
- **VII.** Does your Place access support from the CVD Prevention group for its CVD prevention improvement plan?
- **VIII.** Is your Place using data to identify and target improvement activity and is that being drawn from the CVD, Stroke and Respiratory CIPHA dashboard?
- **IX.** Are other data sources also being used (e.g. data from the CVDPrevent Audit, the AFQI, BPQI and UCLPartners Proactive Care Framework toolkits for risk stratification)?
- **X.** Is your Place working with other relevant programmes (e.g. Core20plus5, Population Health Board) to ensure that your efforts prioritise those at the highest risk of cardiovascular disease and those who are most disadvantaged within your population, as well as remaining sighted on other work underway within the region.
- **XI.** Is your Place using the BP@home and Digital First in Primary Care programmes to support your CVD prevention work.
- **XII.** Is your Place working with all of your PCNs to help them to risk stratify patients so that those at most risk are prioritised and targeted?
- **XIII.** What work is your Place supporting/ delivering outside of Primary Care? What work is underway with the voluntary sector, secondary care providers, community care providers etc?

APPENDIX 2
Atrial Fibrillation

About AF:

AF is a heart condition that causes an irregular and often abnormally fast heart rate. It is one of the most common forms of abnormal heart rhythm and a major cause of stroke. A patient with atrial fibrillation has a 5-fold increase in the risk of stroke and 20-30% of all strokes are attributed to this arrhythmia.

Not only is AF a major risk factor for stroke, but when strokes occur in those with AF, the patient suffers increased levels of mortality, morbidity and disability with longer hospital stays compared with stroke patients without. Moreover, AF-related strokes are 2.5-fold more likely to be fatal.

Treatment:

The pharmacological therapy recommended to reduce the risk of stroke in AF now only comprises of anticoagulants, with clear evidence to support the approach that anticoagulation with vitamin K antagonists (warfarin) or direct oral anticoagulants (DOACs) reduces the risk of stroke and mortality in patients with AF. A CHA2DS2-VASc score is used to risk assess patients.

Anticoagulation is recommended in men with a score of 1 or more and women of 2 or more and reduces stroke risk in these patients by around two-thirds. Patients are often offered a choice of warfarin or a DOAC but increasingly patients are choosing DOACs due to a reduction in the need for monitoring blood tests and the reduced risk of haemorrhagic stroke and intracerebral haemorrhage.

There is now regional guidance and support to switch patients onto an appropriate DOAC. That also offers considerable cost saving opportunities to our region (estimated at circa £7m per year).

The national AF ambitions state that by 2029:

- **85%** of the expected number of people with AF will be detected
- **90%** of patients with AF who are already known to be at high risk of a stroke will be adequately anticoagulated

Size of the Prize:

Are your Place's risks, issues and barriers to change shared with the CVD Prevention group?

In Cheshire and Merseyside:

A significant burden of under diagnosis and undertreatment for patients with AF exists in C&M; it is estimated that up to 500,000 people in the UK with AF remain undiagnosed with 60,000 people in Cheshire and Merseyside not being optimally treated.

Up to 12,000 of that Cheshire and Merseyside group remain undiagnosed. It's estimated that appropriate AF treatment would prevent 7,000 strokes and save 2,000 lives saved every year in England and prevent 364 strokes in Cheshire and Merseyside alone.

APPENDIX 3
(High) Blood Pressure

About high BP:

High BP is the leading risk factor for premature death causes more than half of all heart attacks and strokes. In England there are an estimated 5.5 million adults with undiagnosed hypertension with a further 2.2 million who have been diagnosed but who are not being treated to target (<140/90mmHG for those under 80).

Lowering blood pressure while reducing cardiovascular risk (through primary, secondary or combined prevention efforts) is highly effective at preventing heart attacks, strokes and premature death but delaying intervention beyond as little as 6 weeks leads to a statistically significant increase in the risk of an adverse cardiovascular events.

Within the last year, NHS (Core20plus5), the Faculty of Public Health, and the Royal College of General Practice have all endorsed the prioritisation of tackling high BP.

The national AF ambitions state that by 2029:

- **80%** of the expected number of people with high BP will be diagnosed
- **80%** of the total number of people already diagnosed with high BP will be treated to target as per NICE guidelines.

Prior to the COVID-19 pandemic, C&M had over 416,000 known high BP patients. In order to achieve the national ambitions it was estimated that a further 69,000 BP diagnoses were needed, and that a further 41,000 BP patients would need to be treated to target.

Size of the Prize:

Recent PHE estimates suggest that if all known high BP patients in C&M had treatment optimised, 460 heart attacks and 680 strokes could be prevented within 3 years.

Impact of the COVID-19 pandemic:

Nationally, diagnosis and recorded treatment to target for a range of CVD risk conditions were impacted, but hypertension diagnosis recovery has been slower than for AF and CKD.

For C&M, it is estimated that the impact of the pandemic on BP control (over 104,000 fewer BP patients recorded as treated to target) could risk an additional 1,557 heart attacks and strokes in three years.

Nationally, the COVID-19 pandemic has driven a cultural shift from clinic-based BP testing towards home BP monitoring, supported by the national BP@home programme.

Current workstreams:

The C&M BP Steering Group, CVD Prevention Subgroup and Digital First in Primary Care programme lead and oversee a number of BP workstreams:

- The Digital First in Primary Care programme has secured funding to scale up roll out the nationally led BP@Home programme across the region so that this approach becomes the default or business as usual approach for blood pressure monitoring.
- This dovetails with the Innovation Agency BP Optimisation work programme, which includes roll out of the BPQI tool (includes practice and PCN-level BP dashboards, best practice templates, and supports risk stratification at GP practice level).
- The Ardens/UCLP collaboration provides for template-based searches on the practice register that have already been incorporated in all Cheshire and Merseyside practices.
- The new national Pharmacy Blood Pressure Service is being rolled out at pace across C&M community pharmacies, providing BP testing and diagnosis, and promoting healthy behaviours to patients at risk of high BP. The service includes opportunistic testing and referrals from GP practices for named patients to receive a clinic-based BP checks.

Financial incentives in general practice that can support the BP ambitions include:

- **Quality Outcomes Framework** (with its target being that between 73% and 86% of those patients on the HTN/Diabetes/CHD or stroke register to have their systolic blood pressure managed to 150 or below).
- **The Investment and Improvement Fund** (whose target being to focus on undiagnosed hypertension with a view to increase the size of the practice QOF register by 1.2% and to review 50% of the patients not on that register who have a raised blood pressure).

APPENDIX 4
(High) Cholesterol

About high cholesterol:

Prolonged lower LDL-C (low density lipoprotein cholesterol) has been associated with a lowered risk of ASCVD in extensive research.

Regardless of the type of intervention, for every 1 mmol/L reduction in LDL-C, there is a reduction in annual CVD risk of 28%. Randomised controlled trials indicate that lowering LDL-C safely reduces CVD risk even at low LDL-C levels.

The national AF ambitions state that by 2029:

- **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
- **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

And by 2024:

- **25%** of people with Familial Hypercholesterolaemia (FH) are diagnosed and treated optimally according to NICE FH guidance

Size of the Prize:

The Cardiovascular Disease Prevention Return on Investment Tool, notes that "The single intervention with the highest net total savings in the short term (years 2-5) is to optimise the proportion of people taking statins, which is predicted to save over £700m in England by year five".[6]

Cheshire and Merseyside

ICS has significant numbers of undiagnosed and sub-optimally treated patients with high cholesterol.

E.g. in one Cheshire PCN alone, 2000 people with atherosclerotic CVD out of a population of the 36,000 people identified (via the University of Central London Partners Case Finding Tool) need lipid therapies optimisation.

Current workstreams:

C&M partners are supporting the adoption of proven interventions across the whole of the AAC NHS lipid pathway.

This includes high intensity statins, Ezetimibe and Bempedoic acid, as well as injectables including PCSK9i, which remain in the specialist domain, and more recently Inclisiran, which was approved for use by NICE in November 2021.

Lipids Advisory Group:

To facilitate optimisation of lipid therapies, the C&M Lipids Advisory Group is reviewing the Cheshire and Mersey Lipid Pathway to define how to deliver these treatments at the right point within the patient journey to avoid unnecessary delay, cost, and morbidity.

Their work also encompasses the Cheshire and Mersey Lifespan Approach to Lipids which is a decision aid for lipids that will support the wider pathway. This presents an opportunity to instigate the delivery of appropriate tests and therapies for people living with lipid disorders, from early diagnosis of FH in infancy, through case finding in young adults, and on to effective CVD risk assessment to lessen the likelihood that they will develop ASCVD while also reducing additional risk for those with the disease.

Familial Hypercholesterolaemia (FH):

Across the region there is also a significant incidence of undetected familial hyperlipidaemia (FH); <5% of people with FH have so far been diagnosed. FH is a key cause of premature CVD.

Future Opportunities:

Future opportunities will focus on promoting Child and Parent Screening for FH, providing educational opportunities for staff and incentivising the use of lipid lowering therapies in secondary care for patients who are not receiving therapies.

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784208/Cardiovascular_disease_prevention_ROI_tool.pdf

APPENDIX 5

Population Health Programmes

The CVD Prevention group will continue to work in partnership with other ICS and regional work programmes that also aim to reduce health inequalities and strengthen prevention.

Work streams and programmes include:

All Together Fairer

All Together Fairer is Cheshire and Merseyside's collaborative approach to reducing health inequalities in the subregion, informed by the country's leading voice on health inequalities, Professor Sir Michael Marmot.

All Together Fairer brings together public, private and third sector organisations with one shared aim: build a fairer, healthier Cheshire and Merseyside.

Anchor Institutions and the Prevention Pledge

'Anchor institutions' are usually large public sector organisations rooted in and connected to their local communities.

They can improve health through their influence on local social and economic conditions by adapting the way they employ people, purchase goods and services, use buildings and spaces, reduce environmental impact, and work in partnership.

The C&M Prevention Pledge aims to support and enable Trusts to become anchor institutions and systems leaders in prevention.

Core20plus5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.

The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. High blood pressure, high cholesterol and smoking are all key elements of this programme.

C&M Alcohol Harm Reduction Programme

Alcohol harm reduction is a priority for the Cheshire and Merseyside Health Care Partnership, each Health and Wellbeing Board in Cheshire and Merseyside and the NHS Long Term Plan.

Through collaborative work with partners across the whole system the programme will deliver targeted prevention initiatives to help improve lives.

C&M Obesity Strategy

A pioneering new programme of work was launched in July 2022 to reduce the levels of obesity and overweight across Cheshire and Merseyside.

Cheshire & Merseyside Cancer Alliance is working with Health Equalities Group – parent charity for healthy weight programme Food Active – on a project to lower people's excess weight. Whilst having a strong focus on food systems, diet and physical activity, the project is also seeking to addressing the longer-term social and commercial determinants of health such as employment, deprivation, housing, planning, transport, junk food advertising and education in relation to overweight and obesity.

All Together Active

All Together Active is Cheshire and Merseyside's strategy for the health and social care system to support the subregion's residents to become more physically active.

The strategy has been commissioned by the Cheshire and Merseyside's Population Health Board and has been developed by the two Active Partnerships in the subregion, Active Cheshire and MSP, supported by Sport England. All Together Active has been produced following an intensive consultation period with partners from across the public, private and third sector and sets out a number of approaches and initiatives to increase activity levels and create momentum and energy to ensure this goal is met.

Tobacco Dependency Workstream

The C&M Tobacco Dependency workstream, led by the C&M Cancer Alliance, focuses on improving access to tobacco dependency services for inpatients.

Making Every Contact Count

Making Every Contact Count (MECC) is a behaviour change approach that encourages people to make positive choices through individual, organisational and environmental interactions.

Workforce colleagues from NHS, local authorities, voluntary and community sectors give people simple and consistent messages and signpost them to services that can help improve their health and wellbeing.

The Cheshire and Merseyside vision is that all front-line staff will have the skills and confidence to have positive conversations about health and wellbeing as everyday practice. This could include behaviour changes such as stopping smoking or increasing physical activity.

ORCHA App project

Digital health offers some fantastic opportunities to support healthy living and long term condition prevention, right through to management of existing conditions.

Primary care in Cheshire and Merseyside have joined with ORCHA (the Organisation for the Review of Care and Health Applications) to provide access to libraries of reviewed apps so the population and our health and care professionals can find the best and safest.

Psychological factors, Mental Health and wellbeing

Psychological factors, mental health and wellbeing can have a profound effect on physical health and the likelihood of developing long terms conditions, including CVD.

Similarly, those experiencing physical long-term conditions (including CVD) are more likely to experience negative impacts on their mental health and wellbeing as a result.

There are opportunities to pull together psychological and medical care pathways in a more consistent, co-ordinated and streamlined manner across the system to improve the care of integrated needs (and thereby support improved clinical and rehabilitative outcomes).

Together with opportunities to frame those developments within a collaborative care approach with primary care mental health liaison services and IAPT services, more routinely, alongside exploring opportunities under the C&M ICS Suicide Prevention Programme and Mental Health Concordat to identify additional routes to help to break this negative cycle.

Office for Health Inequalities and Disparities Prevention programmes

Including obesity, smoking and alcohol

APPENDIX 6
CVD Prevention Work Programme

Cross-Cutting Work

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• AFQI and BPQI tools available across C&M to support detection, diagnosis, and risk stratification within primary care • CVD, Stoke & Respiratory CIPHA dashboard under development • C&M partnering with NHS Benchmarking to support use of CVD Prevent Audit data within improvement projects	• Cardiac Board for C&M in place • CVD Prevention group for C&M established • ICS CVD Prevention Lead in post • CVD Clinical Leads recruited to CVD Prevention group & Cardiac Network	• BP@home programme supports monitoring outside of typical locations • ICS level remote monitoring programme in place • Digital First in Primary Care programme supports greater adoption and use of technology within Primary Care to support detection and monitoring of conditions • Hypertension Accelerator programme in place to build on BP@home and Digital First programmes • FH service being piloted • DOAC optimisation programme (inc toolkit) underway • Lipids optimisation pathway being developed and Inclisiran project in place • HF care pathway launched • Regional/national Health Checks programme underway, with local supporting projects in place	• Happy Hearts website in place to support public education and raise awareness • Multi-agency and coordinated response/ support in place for national campaigns (e.g. Know your Numbers, Stoptober etc.) • BP Kiosks project supported across all 9 C&M places

APPENDIX 6
CVD Prevention Work Programme

Warrington

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• Arden searches built into primary care clinical systems • Primary Care ES for AF and HBP • BPQI included within Primary Care ES • Diabetes Health Inequalities funding supporting 3 PCNs • Increased access to BP machines and opportunities for opportunistic screening • BP kiosks in use • BP@home available to all patients	• GP clinical lead for LTC appointed in Sept' 22 • Primary Care Transformation Managers in post to support delivery of the improvement programme	• BP@Home pathways developed. Digitised submissions in progress • Telehealth pilot for Complex Conditions monitoring approved • Engagement with lipids management programme • Extended Access programme supporting CVD P catch up • Health checks being restarted • Community pharmacy – text messaging out to eligible patient cohorts for BP testing	• Patients receiving NICE approved videos to understand their condition with analysis in place to assess improvements in knowledge • Weight and obesity management programme expanded (including the Saxenda pathway)

APPENDIX 6

CVD Prevention Work Programme

Sefton, Southport and Formby

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• Digital bid in progress to fund self-service in surgery pods to capture BP readings, height and weight data • 2.5k BP@home monitors for Sefton practices, Ardens searches to identify patients at most risk with AccuRx floreys and texts in use • AF opportunistic testing and treatment project implemented, pharma funding secured to support • Joint working group formed to support Heart Failure pathway rollout • South Sefton pilot to improve uptake of SMI Health Checks	• CVD Clinical Lead in post	• 3-year contact in place to provide GPs with cardiology referral triage service in a community setting (including diagnostics and BP monitoring) • Joint working with secondary care (Merseycare and S&O NHS Trust) on integrated CVD care provision • LTC monitoring for HF and COPD, via remote monitoring in place • Heart failure Virtual Ward for Sefton patients delivered by LUHFT being rolled out to community HF teams • Local Eye Health Network Optometry First initiative underway to deliver AF and BP testing in Optometric Practices	• Remote telehealth monitoring for HF includes patient education to encourage self-management • BP monitoring at home to enhance patient knowledge and self-management of hypertension • Community cardiology service signposting patients to other NHS support service (e.g. active lifestyles, smoking cessation services, alcohol reduction programmes etc.) • Social media campaigns supported (e.g. Know your Numbers week)

APPENDIX 6

CVD Prevention Work Programme

Cheshire East

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• CURE smoking cessation MCHFT based smoking cessation support in place • Piloting pharmacist-led HF patient reviews in GP practices to improve documentation on registers and medicines optimisation • Heart Failure pathway rollout underway • One You Cheshire East Service targets CVD and is open to any resident meeting eligibility criteria (inc smoking cessation, physical activity, weight management etc.) • Wellpoint kiosks in use • Workstream in place to monitor variation in cardiovascular health over time	• Multi agency CVH Workstream meeting in place • CVH Dashboard in development • CVD Clinical Leads in post • Heart Failure MDT – new pathway for diagnosis, optimisation and escalation established	• MECC programme underway • Optician AF screening, Kardia mobile machines available with optometrists with direction to GP when appropriate • Improved coding and case finding for HF, Coronary Artery Disease and Cerebrovascular disease • 3rd sector grants available to support the programme • Green spaces project includes 'Lifestyle on Prescription' and utilising NHS transformation funding with multi-agency support	• Education/awareness raising via One You programme, COVID-19 'Swab Squad', Lifestyle on Prescription programme, weight management service, national Diabetes Prevention programme • Support for Know your Numbers including training for community volunteers • Automated Health Check kiosk in leisure centre in most deprived Cheshire East area

APPENDIX 6

CVD Prevention Work Programme

Cheshire West

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• Smoking cessation and weight management services via CWAC and other providers in place for residents • Community Based Enhanced Health checks pilot underway • Well point 'mini health check' kiosk operational • LA 'Wellbeing Champions' trained to carry out blood pressure checks • Active Cheshire carrying out workplace BP checks (pre-covid) • 'Live Well on the Water', Anderton Boat Lift delivering Health checks	• CVD Clinical Lead in post	• 3rd sector grants available to support the programme • Remote BP monitoring has 2.5K BP machines in practices using AccuRx floreys and texts with funding available to PCNs • LTC monitoring for HF, COPD, COVID and pregnant women using remote monitoring in place • Active Travel task force established, Healthy Weight declaration made, fuel poverty strategy in place, Natural Health Service established, Health Rangers promoting physical activity	• Education/awareness raising via Live Well programme, Cheshire Change Hub, Wellbeing Champions • VBA + training for smoking cessation for health professionals, housing associations and fire service in place • VBA 'Why Weight to Talk – How to have positive conversations about weight' for front line workers in place • Social media campaigns supported (e.g. Know your Numbers week)

APPENDIX 6

CVD Prevention Work Programme

St Helens

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• PCN level CVD data packs being developed • AF risk stratification tool being tested with GPs • Increased provision of BP monitoring machines in primary care to improve opportunistic screening • DOAC screening dashboard, systems to monitor drugs that can cause derangement of BP/Lipids/Hba1c patients overmedicated with antihypertensives search tool, case finding in telehealth to identify HF and COPD patients at risk of admission being developed • IIF focusing on initiating statins, FH referrals, deprescribing NSAIDS in HF or CKD, hypertension case finding and DOAC prescribing for AF	• CVD Prevention Lead in post (via Clinical Network) with plans for GP lead • Primary Care Place strategy includes prevention and LTC • Place CVD Prevention group established • HCAs trained to identify Warfarin patients appropriate for DOAC	• Support in place for continued BP@home rollout • Telehealth pilot for HF and COPD patients (with Merseycare and STHK) underway that can identify patients as soon as readings fall below key levels • COPD hub established • MDT being developed with Cardiologists to support complex DOAC/antiplatelet patients • A&E HF pilot underway to improve identification and diagnosis of HF patients	• Telehealth patients receive NICE approved videos to understand their condition with analysis in place to assess improvements in knowledge • 'St Helens Cares' programme will focus on education and prevention of CVD, particularly weight management and obesity reduction

APPENDIX 6
CVD Prevention Work Programme

Halton

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• Active AF/BP programmes underway in GP practices • Primary care enhanced services for ECG and anticoagulation in place • AFQI project with the IA underway to improve confidence around AF management • BPQI project underway to standardise care across Runcorn practices for hypertension checks • Lipid optimisation project with the IA underway • DOAC project underway • Insight work and literature review planned to review access and uptake of NHS Health Checks by priority groups • Central NHS Health Check clinics to run over evening and weekends to improve uptake • 'Community Connectors' being introduced to identify CVD and associated risk factors via NHS Health Checks under the Core20Plus5 programme	• Local Halton CVD Prevention Group established (pre COVID) • Local CVD education events held; detection, management and medicines optimisation	• Foyer Health Assessment Booth in use across Halton • BP checks in community pharmacy being delivered • Health Improvement Teams in place across 12 GP practices to deliver Health Checks • 'Exercise on Referral' program in place support condition management via specialist physical activity (including cardiac rehab and preventative condition management)	• Public engagement events delivered via Halton Health Forums, AGMS, PPGS, Patient groups, Halton community Radio • Local place website available (and supports Happy Hearts presence) • AF and BP Champions appointed, with training being provided to non-clinicians to screen and signpost • 'Holistic lifestyle review' appointments to be piloted for those diagnosed with CVD related risk factors (ABC) to have a brief intervention and receive specialist physical activity support based on conditions and medication. Interventions also linked to wider determinants of health

APPENDIX 6
CVD Prevention Work Programme

Wirral

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• BP@HOME programme has distributed 1400+ BP monitors to primary care • CVDPrevent Audit findings being reviewed by Wirral CVD Working Group • Local ES in place for anticoagulation monitoring • BPQI toolkit being rolled out with c.70% of practices having downloaded it • Lipid search/audit underway with IA • High INR pathway now under review	• GP Clinical Leads for CVD and Hypertension in post • DES being used to support PCN to address high cholesterol including the detection and management of FH	• New C&M Nurse led FH service is being developed	• Communications/updates from C&M CVD Prevention group and Cardiac Board are shared into Primary Care using local communications channels

APPENDIX 6

CVD Prevention Work Programme

Liverpool

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• Encouraging uptake of BP@Home across all GP Practices • Directing patients to utilise BP Measurement in community settings (e.g. Pharmacy) • Utilising BPQI to identify HT's with comorbidities, no BP measurement record in 24 months • Utilising QOF and IIF • Reducing inequalities through case finding and target pop groups with inequalities	• Managing unknown HT's through an inequalities lens • Training on BPQI being provided • BP Measurement training for PCNs/Social prescriber roles being offered	• FH and Lipid pathway work underway • Encouraging all Liverpool clinics in primary and secondary care to take routine patient BP measurements • Including wellbeing screening and BP measurements in Covid vaccination clinics • Encouraging GP Practices and PCN's to run BP Clinics • BP Measurement during Safe & Well visits (Liverpool Only)	• Know Your Numbers campaign supported

APPENDIX 6
CVD Prevention Work Programme

Knowsley

Pillar 1: Monitor & target unwarranted variation	Pillar 2: Enable system leadership	Pillar 3: Support a system wide response	Pillar 4: Increase public awareness
• BP@HOME programme has distributed BP monitors to support primary care and delivery within the Community • Directing patients to utilise BP Measurement in community settings as above and with support from Community CVD provider • AF risk stratification tool being tested with support from partners • Smoking cessation based programme in place which is delivered via our Public Health Colleagues support in place	• Well established Community CVD service has been commissioned via LHCH with robust and stretching KPI incentive targets • Place CVD strategy group developed to support PLACE priorities • ICP (Integrated Care Partnership) plans for Knowsley have CVD as a priority theme running through • Medicines management optimisation service supports CVD patients as part of ongoing Meds management	• Community CVD service which is delivered via LHCH have formed and continue to form strong relationships with partners within Knowsley, examples include VOLAIR who deliver all of the leisure services within Knowsley • Patients can also access wider Public Health prevention services via the LA offer, which offers wider Health benefits • Encouraging all Knowsley clinics/PCN's in primary and secondary care to take routine patient BP measurements • HF virtual ward to commence in partnership with LUFT to support patient's symptom management and education avoiding hospital admission • POCT for heart failure patients to reduce timely waits and duplication, supporting the phlebotomy service to reduce referrals into their service. Stroke rehabilitation virtual with new management of virtual app (ISLA care) • FH service developed with the innovation agency • TLHC opportunistic testing of cardiovascular disease raising awareness of secondary prevention and highlighting management of significant findings within the programme	• LHCH have undertaken some targeted prevention work with our Nursing and Residential homes and leisure centres within the Borough and continue to support Primary and Secondary Care partners on the Community CVD service and offer for patients • Working in partnership with schools to off CVD education and awareness in line with the prevention agenda opportunistic monitoring of BP, Pulse and cholesterol

Cheshire and Merseyside
Health and Care Partnership

To find out more

email: james.boyes@nhs.net
visit: happy-hearts.co.uk

INNOVATION AGENCY
Academic Health Science Network for the North West Coast

NHS
North West Coast
Clinical Networks

Cheshire & Merseyside
Cardiac Board