

Board of Directors (in public)

Item 3.2

Subject: Regional CVD Prevention at Scale Programme
Date of Meeting: Tuesday 30th April 2019
Prepared by: Regional STP CVD Leadership Group
Presented by: Jon Develing – Director of Strategic Partnerships
Purpose of Report: For Note / Support

BAF Ref	Impact on BAF
5.4	

1. Executive Summary

Integrated Care System (ICS) across the North of England agreed to collaborate on a regional programme of at-scale CVD prevention with a focus on the detection and management of hypertension, cholesterol and atrial fibrillation. This paper summarises progress to date, provides details of the regional development framework, local priorities identified through a self-assessment exercise and options for the next phase of work.

2. Background

Nominated leads from each Integrated Care System (Director and Assistant Director of Strategic Partnerships from Liverpool Heart and Chest Hospital), supported by colleagues from PHE, NHSE, NICE, NHS Rightcare and British Heart Foundation formed a North-wide Task and Finish Group which has steered the programme's work to date through a small number of focussed meetings. A much wider set of regional and national stakeholders also participated in a one off regional workshop in Sept 2018.

Each ICS area has made progress in their own geography, details are set out in section 3.1, in addition the North-wide group has developed a 'Development Framework' against which local areas are able to self-assess. More details on this framework and the current assessment are to be found at Appendix 1, with a recommendation that achievement the 'Establishing' standards for these priorities are included in the 5 year plans being developed by each ICS.

While action at ICS level often constitutes prevention at scale there remain a number of areas of work where North-wide collaboration would be beneficial to ICSs and this paper puts forward options for taking this forward to support continuity of ambition while flexing to the new regional geographies in due course.

3. NHS Long Term Plan / Opportunity

NHS Rightcare identified large opportunities on bed days, elective and non-elective admissions and primary care prescribing for 'circulatory diseases'. They estimate a potential 1300 lives could be saved across the North by optimising care for these conditions. The potential contribution of closing the gaps for each ICS in terms of averted strokes and heart attacks are shown in table 1.

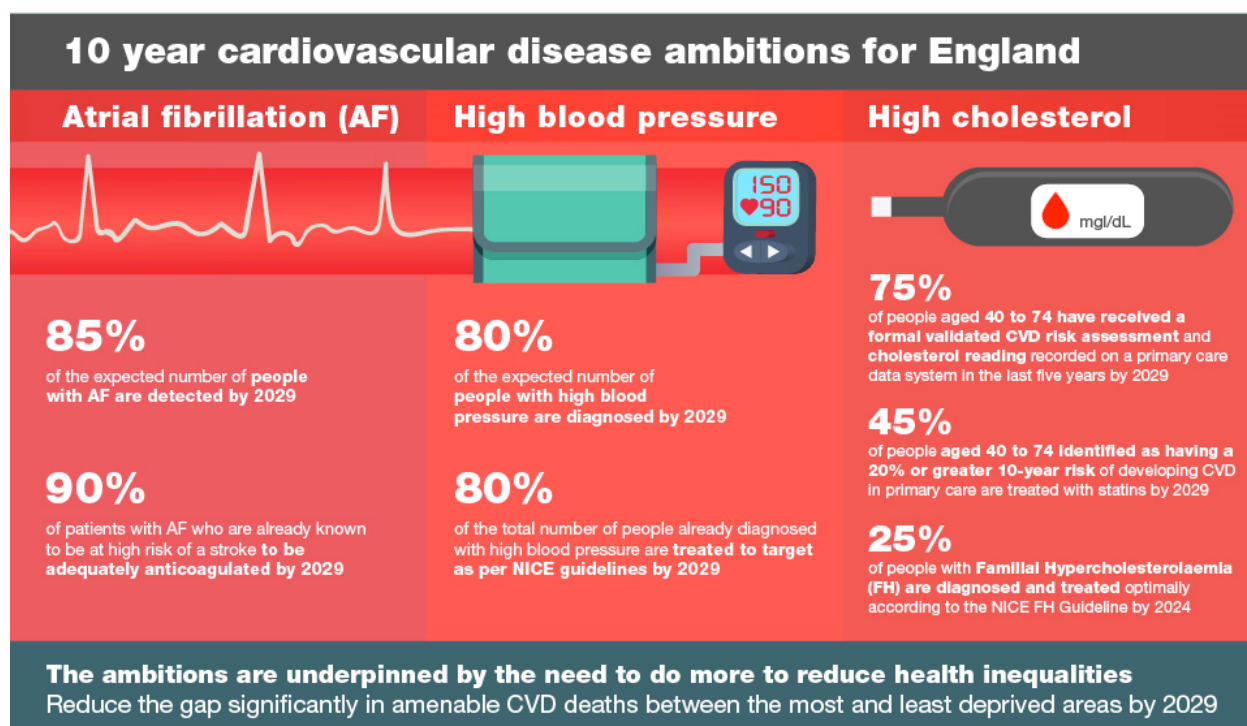
STP	Optimal treatment of diagnosed hypertensives averts within 3 years	Optimally treating high risk AF patients averts within 3 years	Financial opportunity (up to)	
			Hypertension	AF
LSC	300 heart attacks, 450 strokes	580 strokes	£8.5m	£9.7m
CM	460 heart attacks, 680 strokes	760 strokes	£12.9m	£12.7m
CNE	570 heart attacks, 840 strokes	870 strokes	£16.1m	£14.9m
GM	470 heart attacks, 700 strokes	560 strokes	£13.2m	£9.7m
HCV	260 heart attacks, 390 strokes	390 strokes	£7.4m	£6.6m
SYB	250 heart attacks, 380 strokes	380 strokes	£7.2m	£6.6m
WYH	420 heart attacks, 620 strokes	640 strokes	£11.9m	£10.7m
All North	2730 heart attacks, 4060 strokes	4180 strokes	£77.2m	£70.9m
Combined Total	Avert 2730 heart attacks, 8240 strokes within 3 years		£148.1m	

CVD has been identified as a priority in the NHS Long Term Plan (LTP) and many of the areas of work prioritised across the North have been recognised by national colleagues. The following LTP commitments can be supported by the work already undertaken and the plans ICSs are developing:

- *Working with local authorities and PHE, we will improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions. Working with voluntary sector partners, community pharmacists and GP practices will also provide opportunities for the public to check on their health, through tests for high blood pressure and other high-risk conditions.*
- *Where individuals are identified with high risk conditions, appropriate preventative treatments will be offered in a timely way. We will support pharmacists and nurses in primary care networks to case find and treat people with high-risk conditions.*
- *The creation of a national CVD prevention audit for primary care will also support continuous clinical improvement.*

The government has agreed to set out by Easter 2019 the details of how the programme's targets will be met.

National CVD ambitions which align to those in the NHS Long Term Plan have recently been published:



Atrial fibrillation (AF)

- 85% detected by 2029
- 90% treated by 2029

High blood pressure

- 80% diagnosed by 2029
- 80% treated by 2029

High cholesterol

- 75% cholesterol reading and CVD risk by 2029
- 45% aged 40 to 74 with $\geq 20\%$ risk of CVD treated with statins by 2029
- 25% with FH diagnosed and treated by 2024

The size of the prize figures given in section 3.0 demonstrate that across the North we have a long way to go in achieving these 10-year ambitions and we have agreed an approach which focusses on ensuring that when detection is increased, pathways for treatment are available. In this way we expect to move in tandem towards meeting detection and treatment targets. Consideration of how this can be monitored by ICSs is set out in section 4.0.

3.1 Progress to date in each STP/ICS

The first phase of the programme, bringing a focus to CVD prevention and the opportunity for

ICS CVD leads to come together to share learning, has resulted in the following progress being made on a local level.

ICS	Highlights
Humber Coast & Vale	<ul style="list-style-type: none"> • System leadership and prioritisation • Asset mapping complete • Healthy/happy hearts website • Commissioning FH service • Using practice based pharmacists to optimise management of hypertension • Detection in other primary care settings ie fire and rescue, some pharmacies • Developing a workplan which addresses multi morbidity
South Yorkshire & Bassetlaw	<ul style="list-style-type: none"> • CVD identified as an ICS priority • The prevention workstream has CVD as one of its three priority areas • SYB CVD Task Group established • AHSN are undertaking an innovation exemplar project to look at what is available to support CVD prevention work • Generally the ICS performs well against detection and management targets • AHSN has developed a methodology to identify those practices who may need targeted support and is contacting CCGs to offer support
West Yorkshire & Harrogate	<ul style="list-style-type: none"> • CVD (including diabetes) identified as a Health and Care Partnership (ICS) priority • Projects established to tackle AF, hypertension, lipids, and glycaemic control • RightCare and AHSN have played lead roles in supporting planning and delivery • Other key stakeholders include PHE, BHF and the two Local Pharmacy Committees (and through them Community Pharmacists) • Strong emphasis on patient and public facing comms • Programme has dedicated comms lead • Healthy hearts website established • Dashboards being developed to understand progress • Prevention at scale group coordinates action on key risk factors e.g. smoking, and public health actions across local authorities including MECC
Cheshire & Merseyside	<ul style="list-style-type: none"> • System leadership and prioritisation of CVD prevention in STP plan, tied into broader population health approach with prevention focus • Asset mapping complete • Healthy/happy hearts website • Areas of focus include: <ul style="list-style-type: none"> - Systematic support for community pharmacists through medicine use reviews (MURs)

	<ul style="list-style-type: none"> - Using third sector/non-traditional settings as delivery partners including Fire and Rescue service detection. - MECC training for all health professionals - Systematic support for adherence from community pharmacists
Lancs & South Cumbria	<ul style="list-style-type: none"> • CVD prevention (stroke and high blood pressure) identified as ICS priority • CVD (Stroke) prevention alliance established with strong clinical leadership and links with primary care development and Public Health England • Successful in British Heart Foundation Bid • Developing a MECC framework • Linking with implementation of National Diabetes Prevention Programme and NHS Health Checks • Developing links with other regions to spread the learning from involving Fire and Rescue services
Cumbria & North East	<ul style="list-style-type: none"> • Established a collaborative partnership between PHE, NHS RightCare and Northern England Clinical Network to steer the programme. Establishment of the CVD Prevention Advisory Group. • Established a new CVD Prevention Network • Organised and facilitated 2 stakeholder workshop events, one to scope and map current provision, one to begin prioritisation and action planning for CVD Prevention in local areas. 3rd event within year 1 to consolidate sharing and learning 13th March 2019 • Contributed to a 'North' approach to CVD Prevention with PHE regional colleagues and ICS/STP leaders through Northern Regional team. • Developed local logic model and action plan in line with the National logic model and 'Five Year Forward View' • Networked and engaged with a range of organisations- CCG's, Local Authorities and existing networks public health networks such as NHS Health Checks and Obesity and Physical Activity. • Articulated roles and nurtured working partnerships via the CVD Prevention Advisory Group and development of a 'Partnership Offer' • Consolidated relationships between partners through the new North East and North Cumbria CVD Prevention Network. • Established links - linking CVD prevention into workstreams and investigating further development opportunities e.g. community pharmacy; health and justice; mental health and Making Every Contact Count (MECC)

NHS Rightcare funding has supported the establishment of a number of Healthy Hearts websites, providing a single source of CVD information and a directory of services for both public and professionals. Websites are live for Bradford, Vale of York, Cheshire and Merseyside, West Yorkshire and Harrogate ICS, with work in progress for Cumbria and North East, Humber

Coast and Vale and South Yorkshire and Bassetlaw STPs and there's an ambition to achieve full ICS coverage.

3.2 Progress to date - Regional ICS development framework

A key output from the first phase of regional work is the ICS regional CVD development framework (see appendix 1). The framework describes what an emerging, established and excelling position looks like for hypertension, atrial fibrillation and cholesterol-detection, as well as for system leadership.

It is proposed that the 'Establishing' level in each domain of the development framework be agreed as a minimum level of ambition for ICSs in the North and that they agree to reflect this in the developing plans for implementing the NHS Long Term Plan.

The majority of ICSs have self-assessed against the development framework to help identify areas which would most benefit from a prioritisation of effort so that this can support local decision making. The framework is also intended to support sharing and learning between ICSs, it is not intended for managing performance. The priority areas identified by each ICS through their self-assessment against the framework are identified in section 7.0.

3.3 STP/ICS priorities

The framework has been developed for ICSs to use themselves and the approach taken in each area has varied. Detailed self-assessments have been shared by some of the ICS areas as have the priorities for action which are set out in the following table.

STP /ICS	Priorities for action
Humber Coast & Vale	<ul style="list-style-type: none">• To develop the vision and ambitions• To ensure we continually engage with the right people to shape and implement plans• Build on the information we already have to shape the development of our programme• Ensure learning from BHF hypertension project is shared• Develop workplan further based on development framework
South Yorkshire & Bassetlaw	<ul style="list-style-type: none">• Detailed mapping work ongoing across the 5 CCGs to identify what CVD prevention work is ongoing, areas of good practice and what work would make sense at an ICS level• Work ongoing to identify a clinical CVD lead and ensure greater clinical representation on the Task Group• Identify priorities and establish a workplan• Mapping of hypertension patient pathway to identify potential areas to streamline, utilise wider workforce and self-management tools• Initial focus on improved management of those already diagnosed with hypertension and reduction in variation across practices

	<ul style="list-style-type: none"> • AF : work to establish adequacy of anti-coagulation • Dyslipidaemia work to establish lipid baseline data across the ICS
West Yorkshire & Harrogate	<ul style="list-style-type: none"> • There is a clear vision of the outcomes expected • There is a clear delivery structure in place, which will develop as the project expands • The project builds on existing experience and practice within West Yorkshire and Harrogate • Progress will be reviewed to provide general and targeted support to ensure success
Cheshire & Merseyside	<ul style="list-style-type: none"> • Developing a single cardiorespiratory service model across the whole population. Starting within Liverpool we have established a single services cardiorespiratory group with clear objectives. • Atrial Fibrillation pilot in community pharmacies in Knowsley and Halton – identification of undiagnosed patients through the use of technology in the pharmacy setting. We are also working with the Fire and Rescue Service to develop an effective and seamless referral pathway for patients identified as potential AF cases through their Safety Checks. • Lipidaemia – developed a pathway for the identification, treatment and long term management of patients with high cholesterol (including Familial Hypercholesterolemia) which is now in the process of being shared with commissioners and primary care. • Cheshire and Merseyside has established a resource based upon contributions from each CCG (0.5% of CCG revenue allocations). Within this fund circa £8m has been allocated for STP programmes. Known as the `Transformation Funds` the CVD Board and the Prevention Board have been successful in securing non recurrent resource that will support implementation of national CVD ambitions: Blood Pressure strategy; new A.F. Pathway; and establishment of three Lipidaemia advisory teams. In addition the fund will support continued development of the Happy Hearts website.
Lancs & South Cumbria	<ul style="list-style-type: none"> • Build on progress made in developing a formal 5 year Lancashire and South Cumbria Stroke Prevention Strategy 2018 – 2023 including ensuring local implementation at an ICP level recognising the challenges that remain around key enablers such as clinical leadership, workforce capacity and development and sufficient financial resource allocation
Cumbria & North East	<ul style="list-style-type: none"> • Building collaboration and joint working with system partners • Healthy Hearts website • Further developing the CVD prevention network • Cardiology review and engagement event generating major focus on CVD prevention, aligning with emerging national <i>CVD prevention and cardiac</i> programme.

3.4 Further work

Secondary prevention of CVD is complex and while every ICS has made progress all have recognised that they have more to do. Sharing experience between ICSs has been important in getting this far and there is still a case for maintaining this mutual support over the next period. A small number of programmes could continue to add value from being facilitated at a north (or North East / North West) level. These include:

- support for the development of local guidelines on the management of high cholesterol;
- support for making every contact count; and
- the development and embedding of CVD prevention within primary care networks.

4. How might we measure progress?

Currently most of the information that ICSs need to monitor progress is held within GP practice systems and is partially extracted annually. The introduction of the national CVD Prevent audit will give ICSs the ability to track progress, review delivery and identify variation - but this is not expected to report until 2020. We anticipate the technical specification and business rules for this audit to be available from April 2019 and therefore those ICSs that already have processes in place or would like to develop them, can use this guidance to track their progress ahead of the national roll-out (with confidence it will be in line with the national audit). In the meantime each area has made use of the range of existing PHE, NHSE, NHS Rightcare and BHF resources that can help ICSs and localities to quantify the CVD prevention opportunity.

5. Conclusion and Next steps

The first phase of the North-wide work has supported ICS leadership of CVD prevention with the regional development framework created to support identification of priorities and opportunities to share good practice. The bulk of the work is now progressing at ICS level with a small number of programmes that would benefit from continued collaboration on a regional footprint (see section 7.). ICS nominees on the Regional Task and Finish Group have indicated that they would value the opportunity to stay connected at a larger geography to ensure they can continue to learn from each other. This does not necessarily need an STP leader to continue to sponsor the work but the ICS leaders might collectively agree to endorse an on-going arrangement for the next phase.

The options for further work are:

1. Refreshing the existing arrangements to maintain a regional group of ICS nominees, supported by ALB colleagues and with an ICS Leader offering programme oversight.
2. As above but with the chair drawn from the existing task and finish group (i.e not an ICS Leader)
3. 1) or 2) but on the new regional footprints
4. Next steps to be taken forward at individual ICS level without formal regional collaboration/coordination.

6. Recommendations

The Board of Directors are asked to:

1. Note the progress that has been made by the Task and Finish Group
2. Endorse the self-assessment framework
3. Endorse the minimum standards within the framework using the benchmark of an `Establishing` system for each of the domains.
4. Support the framework as a reference point for developing the CVD strategy for Cheshire and Merseyside.
5. Support the framework as a reference point for developing the future strategy for Liverpool Heart and Chest Hospital

Appendix 1 North of England CVD Development Framework

North of England CVD Development Framework

In 2018 the STP leaders and NHS RDs across the North of England agreed to support a North-wide focus on evidence-based, at-scale CVD prevention, namely hypertension, atrial fibrillation and cholesterol. This region-wide approach aims to support the adoption and spread of best practice and provide a focus for accelerating improvement. Working together STP/ICS colleagues, PHE, NICE, NHS E, BHF, NHS Rightcare and AHSNs have built and tested this development framework against which local areas and systems can self-assess and identify future priorities for action.

All STP/ICSs are at different stages and pages 2-5 set out our agreed standards for Emerging, Establishing and Excelling systems in four development areas:

- System Leadership and prioritisation
- Hypertension- Detection, diagnosis and treatment optimisation.
- Atrial fibrillation – Detection, diagnosis and treatment optimisation
- High cholesterol – Detection, diagnosis and treatment optimisation

Recognising that improvement is an incremental process the framework allows STP/ICSs to record their priorities for development against each of these four areas.

Development Area	Emerging – All should be doing	Completed	Establishing- Good Practice (plus, all items identified in emerging)	Completed	Excelling- Going further/leading the way (plus, all items identified in emerging & establishing)	Completed
System leadership and prioritisation	<ul style="list-style-type: none"> • CVD prevention identified as a priority in the STP plan. • Vision and ambition agreed at STP level. • Working group established including Local Authority, CCG, Community and Acute Trusts and clinical representation as a minimum. • Stakeholders and system leaders have been identified across the pathway and include health, pharmacy, local authority, third sector and people affected. • Discovery/ design thinking sprint sessions to develop plans. • Work has been undertaken (or plan in development) to understand the problem including from the perspectives of those affected by or at risk of CVD. (This may be through design thinking or sprint activity.) • Mapping of existing activity, resources and community assets has taken place (or plan in development?). • Measured effectiveness of existing activity. 		<ul style="list-style-type: none"> • Consideration given to the evidence and return on investment in the project plan. INSERT MOPI & ROI TOOL link. • Defined project plan in place, with clearly identified priorities. • Reporting mechanisms established. • Funding identified as required. • CVD Prevention included in STP/ICS reporting mechanisms. • Primary care leadership identified to challenge unwarranted variation and drive quality improvement in detection and management. • Training for health professional mapped locally. (MECC & behaviour change. • Area has a communications approach supporting plan that is relevant for your area an ensures communications across the STP/ICS. It should make use of existing interfaces and resources such as Happy Hearts website and MECC link. Area is aware of skills gap and tackling this, features in plan. • Implementation projects developed at local levels • Sharing learning and gaps with North wide group. 		<ul style="list-style-type: none"> • Programme feeds in to wider prevention governance for the STP/ICS. • Data on progress routinely shared at practice and STP level. • Training for health professionals in place: MECC and Behaviour Change. To encourage health checks and support behaviour change of patients. • Implementation projects being rolled out at scale based on learning. • Excellent examples of people centred approaches. • Excellent examples of tackling skills gaps. • Built in evaluation and sharing learning at local, regional and national level. • Work/ interventions are being implemented consistently across the patch. 	

Development Area	Emerging – All should be doing	Completed	Establishing- Good Practice (plus, all items identified in emerging)	Completed	Excelling- Going further/leading the way (plus, all items identified in emerging & establishing)	Completed
Hypertension- Detection, diagnosis & treatment optimisation.	<ul style="list-style-type: none"> Asset mapping of existing activity across Local Authority and Primary Care including: <ul style="list-style-type: none"> NHS Health checks programme. Diabetes Prevention Programme. MECC Smoking Cessation Workplace Health Physical activity pathways NICE quality standards are used to help identify improvement priorities and reduce variation in care quality. 		<ul style="list-style-type: none"> Undertake systematic audit across practices. <ul style="list-style-type: none"> Identify people with possible undiagnosed hypertension. Identify people who are not treated to target. Consider use of practice-based pharmacists to optimise management of hypertension. Ambulatory blood pressure monitoring service for diagnosis. Mapped pathways (from emerging column) should be in place with referral pathways established. Ensure all patients are managed in accordance with NICE guidance. 		<ul style="list-style-type: none"> Systematic support for adherence from community pharmacists through medicine use reviews (MURs). BP self-test units e.g. in surgery waiting rooms, community pharmacies, leisure centres. Digital solutions for self-monitoring and treatment optimisation. Use lessons learnt from BHF BP funded projects including workforce, community pharmacy and third sector/non-traditional settings as delivery partners. Detection in other primary care settings and community assets such as: Fire and Rescue service. Community Pharmacy involved in detection and medicines review. (Data and tariffs to be negotiated locally). Healthy / Happy Hearts website. Training for health professionals on conversational skills/motivational interviewing to encourage checks/ simple behaviour change conversations. Training and adoption of MECC with CVD included For non-healthcare staff. 	

Development Area	Emerging – All should be doing	Completed	Establishing- Good Practice (plus, all items identified in emerging)	Completed	Excelling- Going further/leading the way (plus, all items identified in emerging & establishing)	Completed
Atrial Fibrillation- Detection, diagnosis & treatment optimisation.	<ul style="list-style-type: none"> Asset mapping of existing activity across primary care. NICE quality standards are used to help identify improvement priorities and reduce variation in care quality 		<ul style="list-style-type: none"> Undertake systematic audit across practices using a recognized audit tool. <ul style="list-style-type: none"> Identify people with possible undiagnosed AF. Identify people with AF at high risk of stroke who are not anticoagulated or not maintained in the therapeutic range. Add pulse checking to existing GP and pharmacy enhanced services for people over 65. STP to link with local AHSN to work on AF detection and treatment programme. 		<ul style="list-style-type: none"> Agree local clinical consensus and pathway for anticoagulation including the place of Direct oral anticoagulants (DOACs). Maximise opportunities to make creative use of pulse detection tools such as mobile ECGs (Kardia, Watch BP) and other devices to support AF detection in routine care. New models of anticoagulation control e.g. patient self-monitoring and monitoring in community pharmacy monitoring. 	

			<ul style="list-style-type: none"> • Ensure all patients are managed in accordance with NICE guidance. • Consider use of Pan London AF Tool Kit. http://www.londonscn.nhs.uk/wp-content/uploads/2017/06/detect-protect-perfect-london-af-toolkit-062017.pdf • Reduce variation between GP practices. • Introduce quality improvement support for practices and other teams. 		<ul style="list-style-type: none"> • Systematic support for adherence from community pharmacists. • Detection in other primary care settings and community assets such as: Fire and Rescue service. • Community Pharmacy involved in detection and medicines review. (Data and tariffs to be negotiated locally). • Healthy / Happy Hearts website. • Training for health professionals on conversational skills/motivational interviewing to encourage checks/ simple behaviour change conversations. • Training and adoption of MECC with CVD included for non-healthcare staff. • Incorporating detection in novel settings and partnerships e.g. Fire and Rescue service safe and well checks, third sector organisations, podiatry etc. 	
Development Area	Emerging – All should be doing	Completed	Establishing- Good Practice (plus, all items identified in emerging)	Completed	Excelling- Going further/leading the way (plus, all items identified in emerging & establishing)	Completed

High Cholesterol- Detection, diagnosis & treatment optimisation.

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| <ul style="list-style-type: none"> Asset mapping of existing activity across Local Authority and Primary Care including: <ul style="list-style-type: none"> NHS Health checks programme. Diabetes Prevention Programme. MECC Smoking Cessation Workplace Health Physical activity pathways NICE quality standards are used to help identify improvement priorities and reduce variation in care quality | <ul style="list-style-type: none"> Maintain and improve systematic collection and audit of data on cholesterol levels, high CVD risk and possible familial hypercholesterolemia (FH) in practices to support detection and management. Commission local service for FH investigation and cascade testing. Strengthen risk assessment, detection and management through greater use of practice-based and community pharmacists and consider commissioning systematic support specifically for statin adherence from community pharmacy through medicine use reviews (MURs). Ensure all patients are managed in accordance with NICE guidance. | <ul style="list-style-type: none"> Achieve local clinical consensus and establish an integrated pathway for detection and management of raised cholesterol and CVD risk, which includes FH. <ul style="list-style-type: none"> Identify and investigate possible undiagnosed hypercholesterolemia and/or FH. Identify and address suboptimal lipid management. Training for health professionals on conversational skills/motivational interviewing to encourage checks/ simple behaviour change conversations. Community Pharmacy involved in detection and medicines review. (Data and tariffs to be negotiated locally). Training and adoption of MECC with CVD included For non-healthcare staff. |
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