Mid and South Essex Community Collaborative

Cardio Vascular Disease (CVD) Programme

Mid and South Essex Community Collaborative

Joint Committee

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25th July 2024

Our MSECC Strategic priorities

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This year we agreed 4 strategic priorities. These include:

Priority (1/4)	Why?
Building Resilient and Healthier Communities	• Better management of people's long term conditions • People receive early diagnoses, intervention, care & support • Optimise people's ability to self-manage • Optimise prevention • Improved people's experience of care

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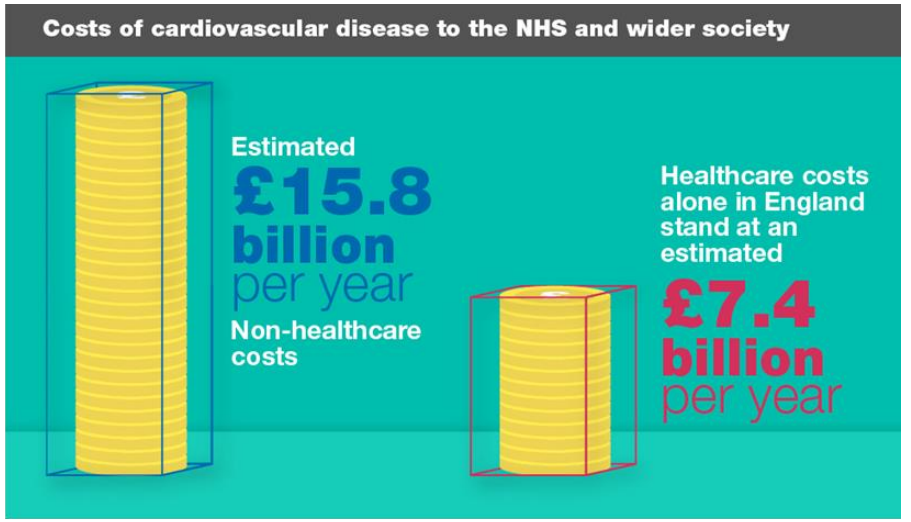
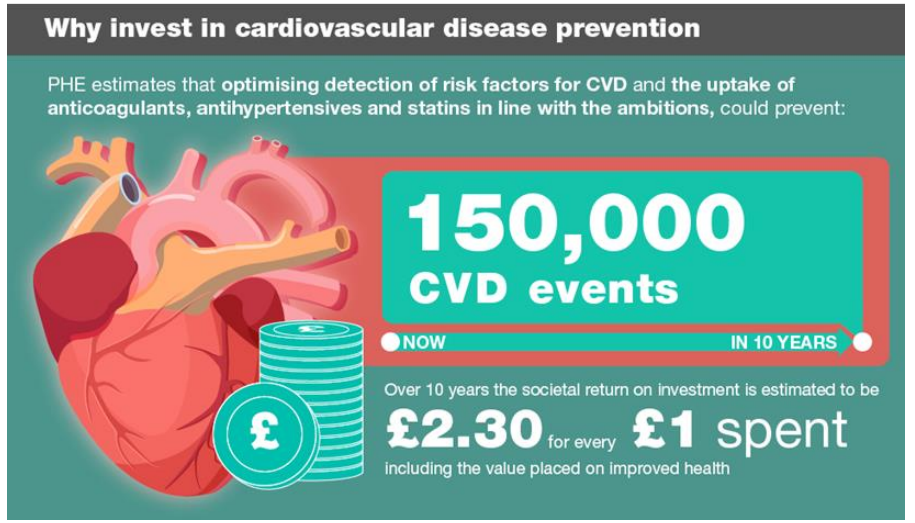
CVD Programme – National Context

- CVD causes 1 in every 4 deaths in England, with significant associated costs to the UK economy (see figure).
- Life expectancy rates were increasing until 2011, primarily due to reducing mortality from CVD. Over the last decade this has plateaued.
- The cardiovascular burden is unequally distributed, with several-fold higher prevalence in more deprived groups.
- In order to achieve the ambitious 150,000 events avoided target in the NHS Long Term Plan, optimising detection and treatment of Atrial Fibrillation (AF), hypertension, and high cholesterol is a priority (see figure).

2 national objectives for CVD Prevention

- Increase the % of pts with hypertension treated according to National Institute for Clinical Excellence guidance to 80% by March 25
- Increase the % of pts aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 25





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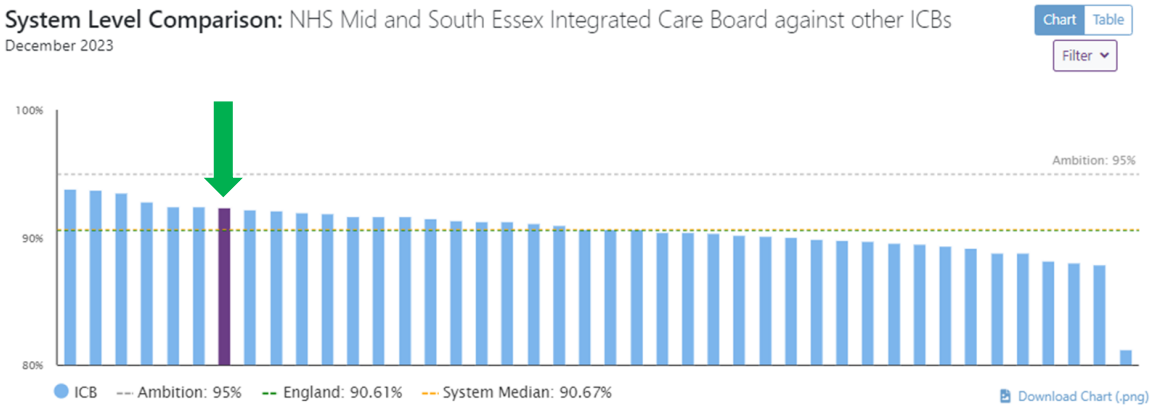
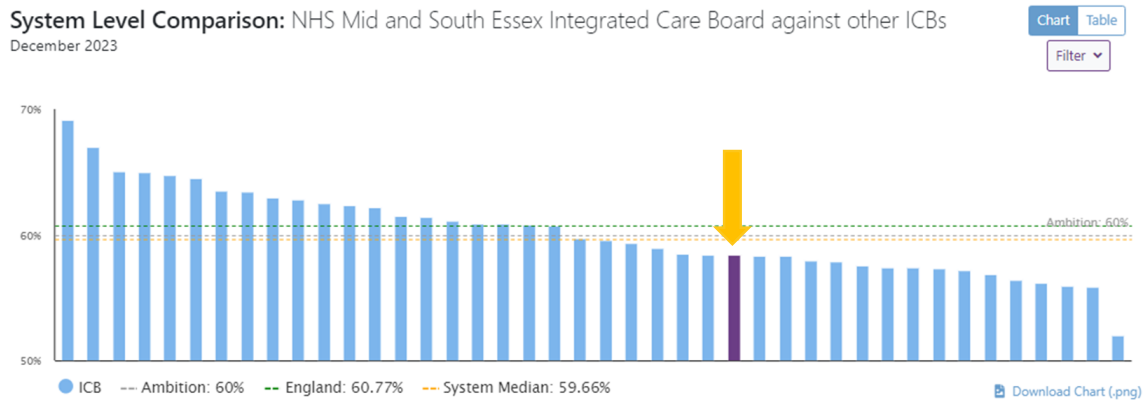
MSECC CVD Programme – Local Context

MSE is underperforming when it comes to CVD outcomes for hypertension and hypercholesterolemia

CVDP002AF: Percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anticoagulation drug therapy

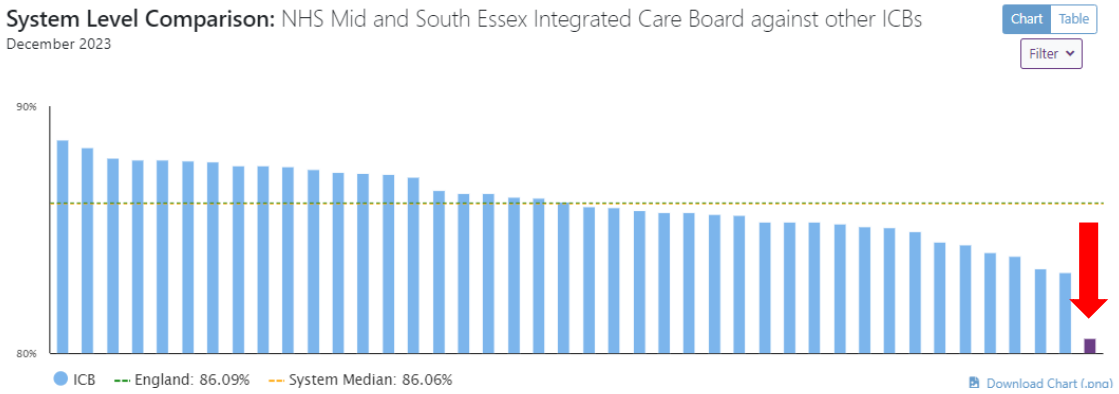


CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy



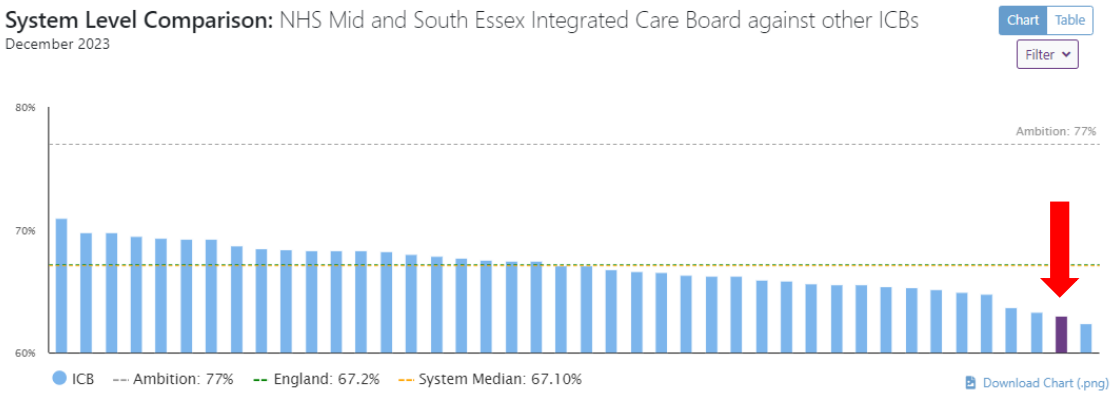
HYPERTENSION MONITORING

CVDP004HYP: Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months



HYPERTENSION MANAGEMENT

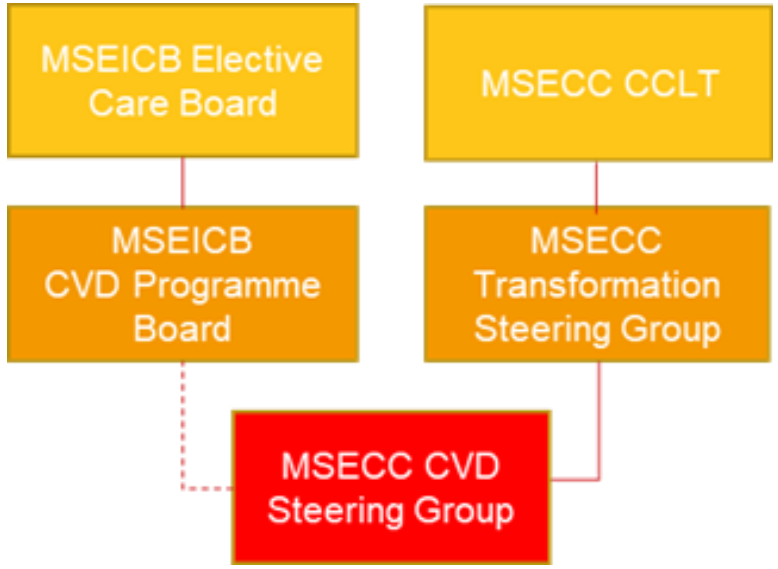
CVDP007HYP: Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold.



CVD PREVENT– December24

MSECC CVD Programme

- MSECC CVD Programme: *'How can community services positively contribute to improving outcomes for people with or at risk of CVD?'*
- 3 year contractual commitment
- MSECC CVD Steering Group
  - Chair & SRO Rita Thakaria
  - ICB Clinical lead for CVD (also primary care rep)
  - Public Health
  - Health Inequalities
  - Local Authorities
  - MSECC Operations
  - MSECC Communication & Engagement (incl patient)
- Programme Plan
- Programme Governance
- Support from NHS Provider (*Improving Equitably Programme*) and UCLP (*University College London Partners - CVD Action*)



MSECC CVD Programme – What?

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- Scoping & designing phase
- Hypertension focus
  - Supporting HT management in known patients
  - Case finding in at risk groups (where BP already taken)
- The early opportunity presented so far are…
  - Improving the unwarranted variation on what actions/signposting/advice the community workforce provide to patients when taking blood pressure as part of routine consultations
  - Improve the use of alerts/flags to enable community workforce to support those people with HT not managed to target (to encourage the attendance to annual reviews, blood pressure reviews and health check, for example)
- Development of a community guideline
  - Actions, recording and advice around blood pressure

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MSECC CVD Programme – Next steps

- Testing initially with target and keen service
- MSECC Data piece
  - Identify further target services within areas of deprivation
  - Identify further services with patients registered at target practices/PCNs
- Co-production
  - Understanding levers and barriers to support HT management
- Working with Alliances
  - To agree priority areas
  - to agree approach with developing Neighbourhood models
- Evaluation
  - Agreeing outcomes and metrics to monitor impact

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Questions?