LONDON BOROUGH OF CAMDEN	WARDS: All
REPORT TITLE NCL Heart Health Programme & Integrated Heart Failure Service in Camden and Haringey	
REPORT OF Director of Proactive Care and Long-Term Conditions, North Central London Integrated Care Board	
FOR SUBMISSION TO Camden Health and Wellbeing Board	**DATE** 10 July 2024

SUMMARY OF REPORT
This paper provides an update on work to improve heart health outcomes in North Central London (NCL), including development of a NCL Integrated Care System Heart Health programme that aims to bring the work of different organisations across the health and care system together to improve blood pressure detection and management, and a new Integrated Heart Failure Service in Camden and Haringey.

Local Government Act 1972 – Access to Information
No documents that require listing have been used in the preparation of this report.

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RECOMMENDATIONS
That the Health and Wellbeing Board note the report.

Signed:

Amy Bowen, Director of Proactive Care and Long-Term Conditions, NCL ICB

Date: 28th June 2024

1 Purpose of Report

1.1. This report provides the Board with an update on key work in North Central London (NCL) to drive improvement in heart health outcomes, aligning to NCL Integrated Care System's (ICS) Population Health and Integrated Care Strategy. There are two components to this update:
1) An overview of progress to establish an NCL-wide Heart Health programme;
2) An overview of the new Integrated Heart Failure Service in Camden and Haringey.

1.2. NCL ICS's Heart Health Programme, with an initial focus on improving detection and treatment of high blood pressure, aims to improve heart health outcomes and reduce inequalities across all five boroughs in NCL. This report sets out why high blood pressure has been chosen as a focus in the context of NCL's Population Health and Integrated Care Strategy ambitions; provides an overview of key work programmes across NCL and within Camden relating to high blood pressure; and outlines the scope of the emerging Heart Health Programme.

1.3. The Integrated Heart Failure Service spans primary, secondary care and community services across Camden and Haringey, aiming to achieve an end-to-end integrated pathway for managing Heart Failure. This paper provides an overview of the service objectives, pathways, intended outcomes and next steps.

1.4. These programmes of work are closely aligned to local priorities in Camden and the work of the Health and Wellbeing Board. In order to maximise the success of the NCL ICS Heart Health Programme we are keen to ensure that we are linking in with all relevant borough opportunities. We are also keen to hear from Board members as to how we can continue to drive engagement support for the Integrated Heart Failure Service, within and across Camden's local services.

1.5. The Board is asked to;

- Note the proposed areas of work, and opportunities identified;
- Provide suggestions of where we may make improvements in the work areas identified, and where there may be additional opportunities to engage with or draw upon local expertise or work programmes;
- Suggest opportunities and means to best engage with local partners to drive success across both programmes of work, and;
- Provide suggestions on how we can best work together on these programmes, and how the Board would like to be updated moving forward.

2. Background and context

2.1. Cardiovascular diseases (CVD) is one of the biggest killers and most common causes of premature mortality (deaths under the age of 75) in NCL, and nationally. CVD is largely preventable and treatable.

2.2. CVD is also a key driver of health inequalities. Heart disease and stroke account for just over 20% of the gap in life expectancy between those living in the most and least deprived areas nationally, while premature mortality from CVD is almost twice as high in the most deprived 10% neighbourhoods nationally compared to the 10% least deprived.

2.3. Recognising this, heart health is one of the five key population health risks identified in the NCL ICS Population Health and Integrated Care Strategy.

2.4. Opportunities to improve heart health outcomes span the clinical pathway, ranging from reducing prevalence of key risk factors such as smoking, through early diagnosis and treatment of high blood pressure, to improving models of care for conditions such as heart failure.

2.5. With the overarching ambition within the strategy to tackle inequalities and deliver integrated care in NCL focussed on prevention, early intervention and proactive care, the initial system-level focus for delivery on heart health is on the detection and treatment of high blood pressure, however this will likely evolve over time. Alongside this, however, there are numerous other work programmes at borough-level that will drive wider improvement in heart health. The new Integrated Heart Failure Service in Camden and Haringey, presented here, is one such an example.

3. NCL's Heart Health Programme

Introduction

3.1. High blood pressure (hypertension) is the leading modifiable risk factor for early death from CVD. In NCL, there are challenges across the system in the prevention, detection, and management of high blood pressure in terms of overall performance, but also from an inequalities lens when looking across different communities.

3.2. There are high numbers of residents in NCL living with undiagnosed high blood pressure – whereas the true prevalence of high blood pressure across the population in NCL is estimated to be 21.4% (Public Health England, 2020), only 10.7% of NCL's patients are recorded on GP hypertension registers (EMIS, December 2023), In Camden, the prevalence gap is 11.9% (with diagnosed prevalence of high blood pressure 8.3%, compared to an estimated prevalence of 20.2%).

3.3. Across NCL, only two thirds of adults with diagnosed high blood pressure (65.9%, EMIS, December 2023) are treated to within the target (age-appropriate) blood pressure range, a long way off the national target of 80% being treated to target by March 2025. Rates in Camden were higher (67.6%, EMIS, December 2023), but still well below the national target (80%).

3.4. As well as across the population as a whole, there is significant variation in both detection and management of high blood pressure across different population groups, when defined by deprivation, ethnicity, age and gender.

For example, 62.8% of NCL patients who live in the 20% most deprived neighbourhoods nationally were treated to within target range, compared to 66.8% of NCL patients who live in the 20% least deprived neighbourhoods nationally (HealtheIntent (NCL's Population Health Management System), March 2024).

3.5. All partners across the system in NCL have a role in to play delivering improvements in high blood pressure, and there is considerable work already on which to build – such as local authority commissioned prevention programmes and NHS Health Checks, the new Long-Term-Conditions (LTC) Locally Commissioned Service (LCS), programmes delivered by the VCSE that tackle lifestyle risks and the wider determinants, as well as broader engagement and work with communities who experience the greatest inequalities.

3.6. There is significant benefit to be gained through a narrow, collective focus on high blood pressure, both improving NCL-wide performance and reducing inequalities. Given the range of roles, reach and expertise of different organisations across the clinical pathway and with different population groups, these benefits cannot be realised without whole system support and working directly with our diverse communities across NCL.

3.7. With no existing group focussed on the prevention and improvement of heart health outcomes locally, an NCL Heart Health Delivery Group has been established to provide oversight and leadership for this multi-year Heart Health programme.

3.8. The NCL Heart Health Delivery Group met for the first time in May 2024, with representation from across the NHS, including primary care, community and secondary care, the five local authorities, as well as the Voluntary Community and Social Enterprise (VCSE) sector.

3.9. The group is a collaborative that aims to bring partners together to integrate, optimise resources and make recommendations to individual organisations and NCL's ICP for decision. This includes facilitating sharing of learnings across different partners and programmes in NCL, reviewing the available quantitative data and qualitative insights to consider key areas of focus for the programme, as well as agreeing metrics and methods to monitor progress on improving blood pressure outcomes, particularly around addressing inequalities.

Work to improve detection of high blood pressure and tackle associated inequalities

3.10. To find those living with undiagnosed high blood pressure and ensure that we are reducing inequalities, the programme will focus on five key areas of work:

3.11. **Maximising the NHS Health Check offer across NCL** - NHS Health Check uptake varies considerably both within boroughs and across NCL. Uptake in Camden is higher than other NCL boroughs, but there is wide variation in

activity between different GP practices – some exceed their targets while others do none. We aim to maximising the NHS Health Checks offer across NCL through:

- Improved data and reporting, particularly relating to variation and inequalities in uptake. NCL data will be consolidated with local insights, for example, those from the Camden Public Health NHS Health Check Equity Audit currently underway.
- Sharing learnings and successes from alternative NHS Health Check models, such as proposed workplace-based health checks for manual/routine occupational staff groups in Camden, and Haringey's outreach NHS Health Check model that targets higher risk cohorts.
- Working with primary care partners on opportunities to improve NHS Health Check coverage, and integration with the new primary care Long Term Conditions (LTC) Locally Commissioned Service (LCS) (see paragraph 3.17 for further detail) case finding offer (which enables practices to prompt patients who have a high blood pressure reading but are not on the hypertension register to go for an NHS Health Check).

3.12. **Blood pressure checks in pharmacies -** 85% of NCL pharmacies (and 51 of 63 pharmacies in Camden) are registered to deliver free blood pressure checks to people aged over 40 years who haven't previously been diagnosed with high blood pressure. The service can be offered opportunistically, at the person's request, or by referral from general practices, and all readings are shared back to general practice. Since the programmes launch in October 2021, more than 73,000 blood pressure checks have been delivered in NCL and more than 10,000 in Camden (April 2024, SHAPE Atlas). There are opportunities to maximise uptake of NCL's community pharmacy high blood service through improved access to, and use of data to monitor activity, to drive uptake in more deprived areas, as well as optimise links with local offers (for example lifestyle and health promotion services).

3.13. **Drawing together the expertise of our system, particularly our VCSE and community partners, to ensure that we are deliver checks to those who are most in need –** We have a range of high performing community-based programmes in place within Camden and across NCL that aim to raise awareness of and tackle the risk factors of high blood pressure, as well as raising awareness of the importance of maintaining a healthy blood pressure. For example, the Camden Mobile Health Bus has successfully delivered outreach health screening to more deprived and ethnically diverse communities in the borough and has received positive feedback from staff and users. However, there have been challenges in follow-up, and measuring the long-term impacts of the service, as well as data collection and arranging access to primary care data. Other boroughs and NCL programmes have faced similar challenges, highlighting opportunities to share learnings and opportunities to address these – for example, signposting or direct referral to community pharmacy blood pressure checks where high blood pressure readings are identified at the Camden Mobile Health Bus or community testing events. Furthermore, with many shared communities living and working

across different boroughs, there may be opportunities to expand coverage or adapt successful programmes to other areas or communities.

3.14. **Work with clinicians and services in community and secondary care -** 42% of people with hypertension have another long-term condition, highlighting opportunities to ensure that we are making the most of every patient contact with the system (EMIS, December 2023). We will work our Provider Alliance, secondary and community services partners to ensure that we are optimising discussions and action on blood pressure across the healthcare system. This includes reviewing community and secondary care pathways (for example, outpatient or pre-operative pathways) to capturing whether and how these incorporate advice on optimisation on high blood pressure, and how they link back with primary care.

3.15. **Bringing together data and community insights to address need across our system, and monitor how we are doing at making changes -** We will use HealtheIntent (NCL's Population Health Management system) and broader system intelligence, including qualitative insights from staff and communities, to better understand uptake of NHS Health Checks and alternate health check models across NCL, to identify areas and groups with lower uptake, as well as potential reasons from this. We then aim to work collaboratively with community and VCSE partners to understand and devise models that are most effective in improving detection of high blood pressure, particularly amongst groups and communities who experience the greatest inequalities.

Work to improve treatment of high blood pressure, while tackling inequalities

3.16. To improve the treatment of high blood pressure and reduce inequalities, the programme will focus on four key areas of work:

3.17. **The newly implemented NCL Long-Term Conditions (LTC) Locally Commissioned Service (LCS) –** The LTC LCS aims to improve patient outcomes through providing a holistic, personalised and proactive model of care, as well as through incentivised outcomes and goal setting. High blood pressure management is one of the NCL-wide system outcomes which will be incentivised in 2024/25.

3.18. **Targeted work with communities across NCL -** There is a range of targeted work with communities being delivered across NCL to explore inequalities and barriers to care. For example, as part of the new primary care LTC LCS, Primary Care Networks (PCNs) receive an additional weighted payment for every patient in the LCS cohort who live in the 20% most deprived areas nationally; and for every patient who is of 'not White-British' ethnicity to support collaborative work with VCSE and grassroots organisations to reach underserved patients and communities. As outlined above, with common challenges across our boroughs, as well as shared communities who live and work across NCL, there is an opportunity to share

the insights and identify where successes may be adapted to other areas and communities.

3.19. **Work with clinicians and services in community and secondary care -** As outlined in the paragraph 3.14 through improved collaboration with the Provider Alliance, community and secondary care partners, we aim to better understand and optimise opportunities for system work on high blood pressure, delivered across the wider healthcare system.

3.20. **Using data and community insights to address need across our system and monitor how we are doing at making changes.** We aim to apply learning from the pandemic and approaches to improving immunisation uptake in NCL, and use quantitative inequalities data alongside broader qualitative intelligence to direct the focus of different elements of the heart health programme at a system and local level to ensure that we are reaching those who experience the greatest inequalities, emphasising and drawing upon the expertise and experience of our VCSE and community partners to assure quality of conversations, cultural sensitivity.

Building awareness on Heart Health, across system and delivery partners, and local communities

3.21. In order to improve population outcomes and maximise the opportunities provided by the programmes of work currently being delivered, along with additional potential patient and resident contacts across the system, we need to build awareness of the Heart Health Programme, and focus on high blood pressure across both delivery partners across the system, and local communities.

3.22. The system-facing communications workstream aims to support providers and other partners to understand their role in supporting the prevention, detection and management of high blood pressure, and to inform them of the work of the NCL Heart Health Delivery Group, and the Heart Health programme.

3.23. In addition, a planned public and resident-facing campaign will draw on learnings from national campaigns (such as the national ‘no clues’ campaign), work at London-level and across each of our boroughs. The campaign will raise community awareness around high blood pressure, including addressing modifiable risk factors, availability of blood pressure checks, and the importance of maintaining healthy blood pressure through treatment where needed.

Next steps

3.24. Key next steps for the NCL Heart Health Delivery Group and associated work programme include:

- Continue to develop the NCL Heart Health Delivery Group as a collective community of practice, ensuring that we have appropriate representation from across the pathway and system as the programme continues to evolve

- Build on the mapping work conducted to date on Heart Health activities across NCL to ensure that it is current and that learning across programmes is facilitated through the Delivery Group
- Review available quantitative data and qualitative insights to consider key areas of focus for the programme, particularly around closing the inequalities gaps
- Agree metrics and methods to use to monitor progress and set ambitions and trajectories across NCL for detection and management of high blood pressure, building on the goal-setting work already started as part of the new primary care Long-Term Condition Locally Commissioned Service.
- Hold an NCL Heart Health Event in Autumn/Winter 2024
- Ensure this work aligns with and supports broader regional and national work on Heart Health, such as the London Million Hearts and Minds initiative.

4. New Integrated Heart Failure Service Camden and Haringey

4.1. The new Integrated Heart Failure Service (funded by the national Health Technology Adoption Accelerator Fund (HTAAF)) is a new and innovative service spanning Camden and Haringey. It aims to achieve an end-to-end integrated pathway for managing Heart Failure, across primary and secondary care, as well as community services. With a particular focus on technology, the Integrated Heart Failure Service seeks to help patients manage their condition remotely, all the while increasing their self-confidence in managing their own condition.

4.2. The Integrated Heart Failure Service aims to support patients living with Heart Failure who are undiagnosed, who are stable, and / or who are deteriorating. Patients from all three cohorts would be eligible for remote monitoring, following clinical review. A detailed process map outlining the patient journey from screening through to multidisciplinary management, remote monitoring and discharge is included in the Appendix.

4.3. Key outcomes from the Integrated Heart Failure Service include:

- Reduction in the number of follow up appointments for patients with known Heart Failure, with an at-scale, dedicated Heart Failure service in primary care
- Reduction in A&E attendances for patients living with Heart Failure and those living with risk-factors.
- Reduction in the prevalence gap for patients with unknown Heart Failure across Camden and Haringey.
- Rapid up-titration of Heart Failure medications within 6-8 weeks via remote monitoring software.
- Wider utilisation of a digital stethoscope to support more early Heart Failure diagnoses in the community.
- Training, education and upskilling of clinical staff on Heart Failure through close collaboration between primary and secondary care.

4.4. As the new Integrated Heart Failure Service is rolled out across Camden and Haringey, we would welcome input from Board members as to how we can continue to drive engagement and support for the Service, within and across Camden's local services.

1. Finance Comments of the Executive Director Corporate Services

The Executive Director of Corporate Services has been consulted on the contents of the report and has no comments to add to the report.

2. Legal Comments of the Borough Solicitor

The Borough Solicitor has been consulted and has no comment to add to the report.

3. Environmental Implications

There are no environmental implications to this report.

4. Appendices

Appendix A: Update on NCL ICS Heart Health Programme and the new Integrated Heart Failure Service in Camden and Haringey

REPORT ENDS