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NHS

Update on NCL ICS Heart Health Programme and the Integrated Heart Failure Service for Camden and Haringey

Camden Health and Wellbeing Board
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Heart health is a leading cause of death and inequalities in NCL

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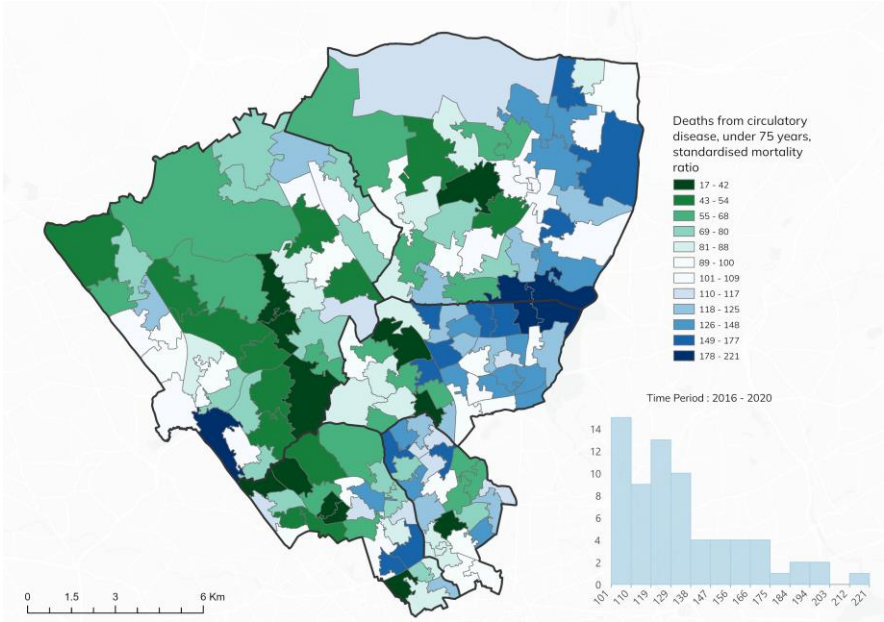
One of our biggest killers - 27% all UK deaths are due to cardiovascular diseases (CVD). It is also one of the most common causes of premature mortality - deaths under the age of 75

Largely preventable and treatable - Nearly 1 in 4 deaths under 75 years in NCL are avoidable - from causes that could have been prevented or treated*.

- 21% of preventable deaths and 39% treatable deaths from 1 January 2016 to 31 December 2020 were due to circulatory system (cardiovascular) diseases

Cause of 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
- Premature mortality from CVD is almost 2x as high in the 10% most deprived areas compared to the 10% least deprived



Source: Office for Health Improvement and Disparities, Local Health, Public Health Data for small geographical areas, https://fingertips.phe.org.uk/profile/local-health

Heart Health is therefore one of five key population health risks identified in the NCL ICS Population Health and Integrated Care Strategy.

- Our initial NCL system-level focus for delivery on heart health is on improving detection and treatment of high blood pressure, however this will likely evolve over time.
- Alongside this, 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, is one such an example.

*Preventable mortality refers to causes of death that can be mainly avoided through effective public health and primary prevention interventions (that is, before the onset of diseases or injuries, to reduce incidence). Treatable mortality refers to causes of death that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment (that is, after the onset of disease, to reduce case fatality).

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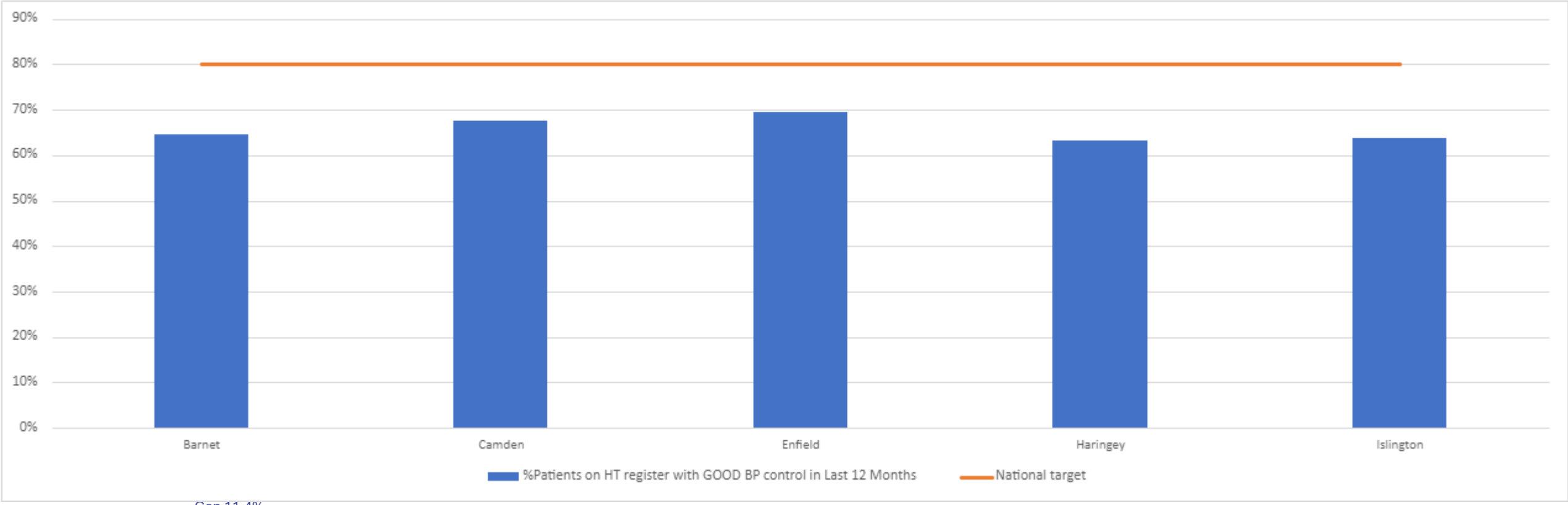
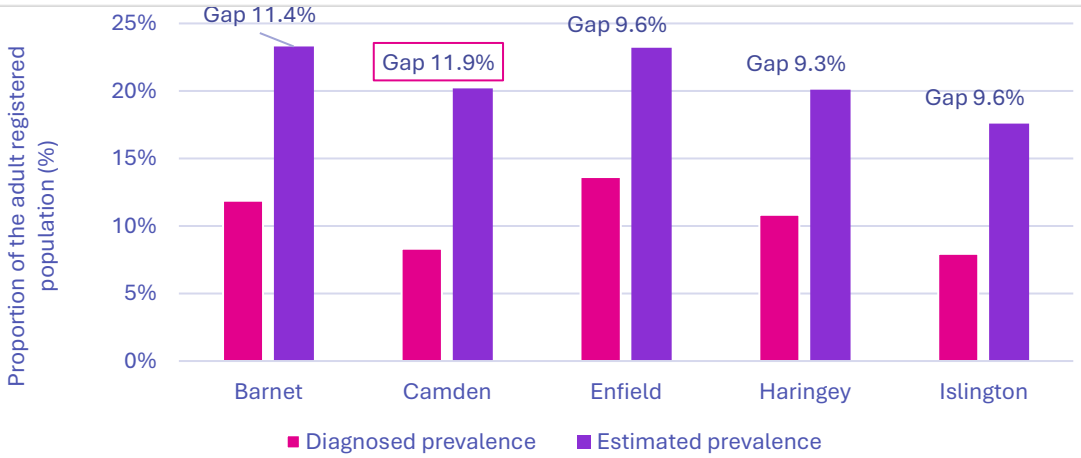
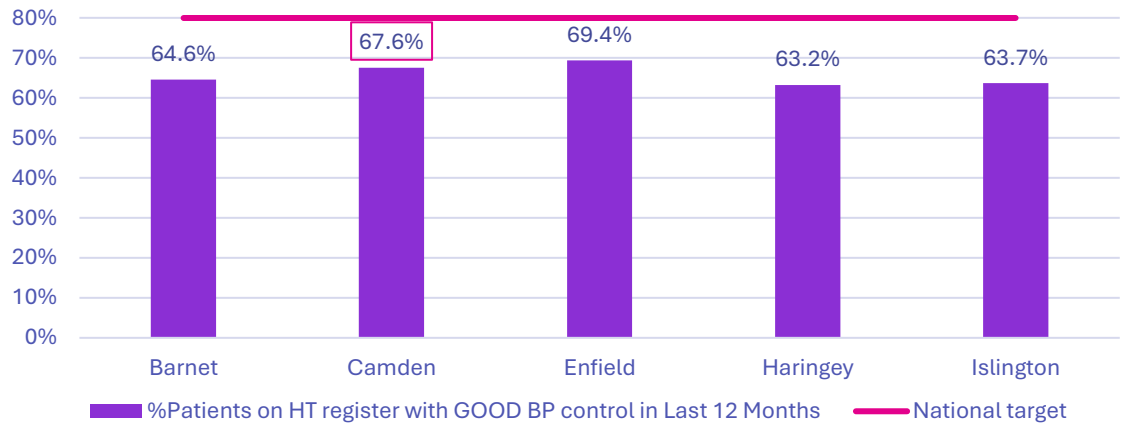
Establishing an NCL ICS Heart Health Programme





Source: *Diagnosed prevalence*: NCL patients aged 18 and over with GP recorded hypertension (EMIS extract, December 2023).*Expected prevalence estimates* 2014: Public Health England, published March 2020 Hypertension_prevalence_estimates__1_.ods (live.com).



Source: EMIS extract. 21 Dec 2023. *Definition of Good BP Control:* Patients aged 18 and over with GP recorded hypertension, in whom the last blood pressure reading (recorded in the last 12 months) is below the age-appropriate treatment threshold (140/90 mmHg or less in patients 79 and under and 150/90mmHg or less in patients aged 80 and over).
National target: NHSE 2024/25 priorities and operational planning guidance objective: to increase the proportion of patients with hypertension treated according to NICE guidance to 80% by March 2025. (Previous target was 77% by March 2024)

Opportunities to share and build on existing programmes across NCL

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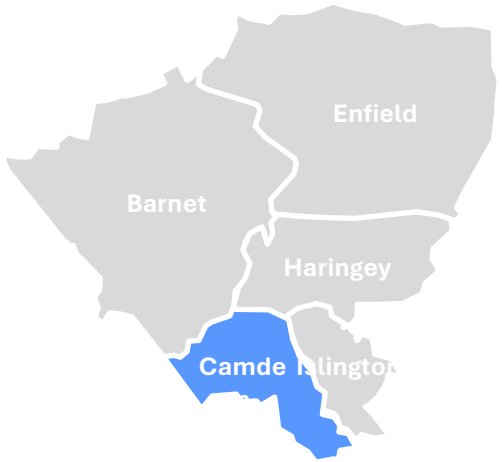
All partners across the system in NCL have a role in to play delivering improvements in high blood pressure, and, highlighted below there is considerable work already happening across Camden and across NCL that we can build on.



- **NHS Health Checks** - delivered by all 32 Camden GP practices. While uptake in Camden is higher than other NCL boroughs, but there is wide variation in activity between different GP practices - some practices exceed targets while others do none. Camden's Public Health team are currently undertaking an equity audit to understand variation in uptake and inequalities between different population groups
- **Camden's Mobile Health Bus** - a community outreach programme designed to detect risk factors for type 2 diabetes in those aged 30 to 70 years old in Camden. It provides education, signposting, and referrals to services to help prevent progression to diabetes.
- **Community Pharmacy Blood Pressure Service** - 85% of NCL pharmacies (and 80% 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.
- **Community Testing Events** – such as the diabetes testing events planned in Camden later this year.
- **Long-Term Conditions (LTC) Locally Commissioned Service (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.
- **Core20PLUS5 Community Connectors** – project to combat high blood pressure by offering free blood pressure checks and advice, run by the 5 NCL Healthwatch.

Establishing an NCL ICS Heart Health programme

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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.
- With endorsement from NCL's Integrated Care Partnership, and NCL Integrated Care System Heart Health Programme has been established.
- An NCL Heart Health Delivery Group has been established to provide oversight and leadership for this multi-year Heart Health programme.
- The 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.
- 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.

Key ambitions and focus areas for the programme

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Finding undetected high blood pressure and closing our prevalence gap, while tackling inequalities

- Maximising our NHS Health Checks, community pharmacy and broader health checks offer, drawing upon the expertise of our system, particularly our VCSE and community partners, to ensure that we are reaching those who experience the greatest inequalities
- Working with our Provider Alliance and partners to understand and optimise discussions and action on blood pressure in community and secondary care
- Bring together data and qualitative system insights to monitor and address need across our system, working with our communities, VCSE and broader partners to test these insights and drive targeted action

Treating people with high blood pressure to target, and addressing inequalities

- Improving treatment and outcomes through our NCL LTC LCS - providing a holistic, personalised, proactive year of care; taking a multimorbidity approach; and supporting general practice to get 'upstream' and focus on patient need over demand.
- Optimising management of high blood pressure through community and secondary care, particularly for those with multiple LTCs
- Drawing upon the expertise of our system partners and undertaking targeted work with our communities to understand and address barriers to care
- Using population health and inequalities data, alongside broader qualitative intelligence, to drive insights-driven action across system, borough and place

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

- Our 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.
- 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

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Key next steps for NCL's Heart Health 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 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

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Improving heart health through the Integrated Heart Failure Service in Haringey

New Integrated Heart Failure Service in Camden and Haringey

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The new and innovative Integrated Heart Failure Service in Camden and Haringey aims to achieve an end-to-end integrated pathway for managing Heart Failure, across primary and secondary care, as well as community services.

- Funded through the national Health Technology Adoption Accelerator Fund (HTAAF)
- With a particular focus on technology, HTAAF seeks to help patients manage their condition remotely, all the while increasing their self-confidence in managing their own condition.

HTAAF aims to support the following patient groups:

- Those living with Heart Failure but undiagnosed.
- Those living with Heart Failure and are stable.
- Those living with Heart Failure who are deteriorating.

Patients from all 3 cohorts would be eligible to remote monitoring, following clinical review.

The Patient Journey

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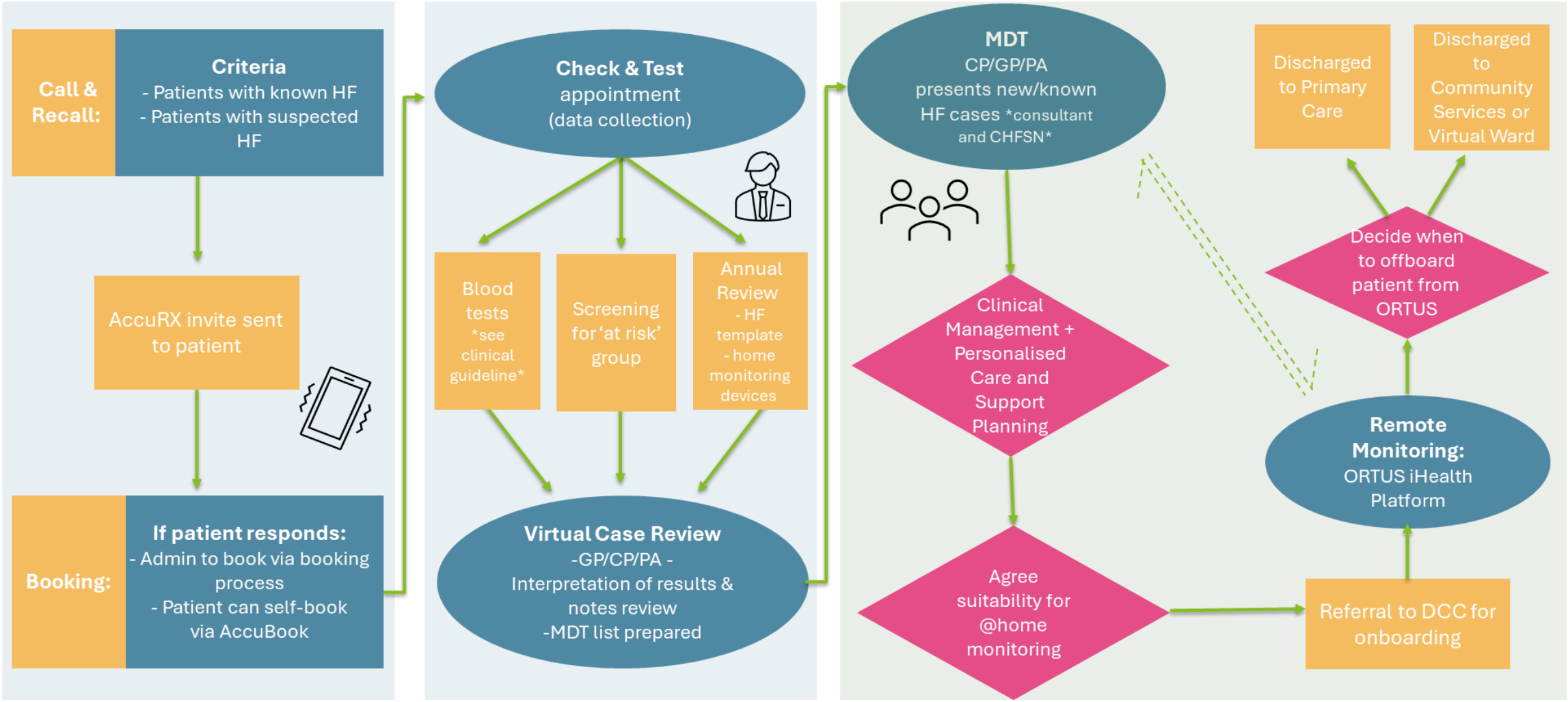
Part A – Screening & Diagnosis *(this can and will happen in parallel to Parts B and C)*

Part B – Check and Test/Mega Clinic (HCA-led)

Part C – Remote Monitoring



Key outcomes of the service

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Desired outcomes of the 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.

What we need help with

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- **Hearts and minds across the system**
- Standardising process
- Pump priming
- Moving resource around the patient to make a new BAU
- Estates
- Evolution not revolution
- Social self-sustainability

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