APPENDIX A - Updated Barnet Cardiovascular Disease (CVD) Prevention Action Plan 2024

This Action Plan for 2024 is intended to work with the Barnet CVD Prevention Programme 2022 – 2026, and replace the Barnet CVD Prevention Action Plan 2022 – 2024.

The CVD Prevention work in Barnet involves stakeholders from healthcare, the voluntary and community sector, public health, the wider council and the Barnet Borough Partnership. It also aligns with the North Central London Integrated Care System Population Heath and Integrated Care Strategy and national priorities to prevent and reduce cardiovascular disease.

CVD prevention and early intervention in community settings

Strategic aim	Actions	Key Performance Indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
1. **Adult weight management services (AWMS) tier 2** available to people who would most benefit	AWMS needs assessment and options appraisal Ongoing public health input to FAB and GLL AWMS GLL and Public Health work with primary care to optimise the quality and quantity of referrals to available AWM services	Completion of needs assessment and options appraisal GLL AWMS – % of referrals to starters, completers, and weight loss Improvement in AWM referral pathways	Decide if to commission further AWMS in 2024 Reduced percentage of adults (18+ years) classified as overweight or obese, and in population groups within Barnet	Annual	Public health, Live and Age Well Team Fit and Active Barnet (FAB) and GLL	PCNs BBP Neighbourhoods Team

2. **Physical activity** promotion to people who would most benefit for cardiovascular health	Promote physical activity to people in Barnet with low levels of activity	Number of people taking up GLL physical activity offers Number of people attending other physical activity groups in Barnet	Increased levels of physical activity in Barnet Increase physical activity in areas of higher deprivation and where there are lower levels of physical activity	Annual	Public health, Live and Age Well Team Fit and Active Barnet (FAB) Partnership - LBB and GLL	Primary care BBP Neighbourhoods Team
3. Community health screening – to compliment NHS Health Checks in areas where people are more likely to be living in poor health	Focus delivery in areas of high deprivation and offer to population groups at higher risk of CVD to reduce health inequalities. Ensure culturally competent promotion of service.	Complete mapping of community health screening locations Communications and promotion activity with VCS organisations to promote screening sessions Demographics of people attending screening sessions, percentage of attendees from population groups of focus	Evidence of community health screening delivery in geographical areas of focus Evidence of community health screening provided to population groups at higher risk of CVD and who are less likely to access healthcare Evidence of signposting to local preventative services and awareness of self-help resources	30.04.24 (end of Year 2 contract)	Public health, Live and Age Well Team GPDQ Ltd	LBB Insight and Intelligence team VCS networks in Barnet
4. **National Diabetes Prevention programme** to increase delivery in Barnet (provider is Live Well Take Control (LWTC))	Service improvement to reduce waiting times to start programme and increase completers LWTC and PH work with primary care to optimise the quality	Number of group sessions offered in Barnet Waiting times for initial assessment. Conversion rate from referral to initial assessment and from referral to milestone 1	Service improvements in NDPP in Barnet (reduced waiting times, increase conversion rates from referral to initial assessment and milestone 1, completers with >5% weight loss) Evidence of people joining NDPP following community	Annual	Live Well Take Control (LWTC) Primary Care	NCL NDPP Steering Group Public Health, Live and Age Well Team

	and quantity of referrals Deliver community events for diabetes awareness days & months, align with PH communications	Number of participants with >5% weight loss Community events delivered for Diabetes Week & World Diabetes Day	testing event and increased equity of access through these events Reduced type 2 diabetes prevalence in Barnet			
5. **Community Peer Support** to promote heart health and reduce hypertension for population groups at higher risk of CVD	Healthy Hearts Peer Support promote heart health, working with African, Caribbean and South Asian communities Translate learning from recent Barnet Healthwatch Core20PLUS5 connectors project to Healthy Hearts project	Number of very brief, brief, and extended brief interventions and multi-session courses delivered. Percentage of overall attendees from populations and areas of focus.	At least 400 residents from population groups of focus engaged in Year 2 Self-reported increased knowledge and behaviour changes that promote cardiovascular health Increased awareness of and confidence in accessing local health, care and other support services available	May 2024 (end of Year 2 of project)	Healthy Hearts Peer Support Team, Inclusion Barnet and Healthwatch Barnet	Public health, Live and Age Well Team BBP Primary Care Community pharmacies
6. **Reduction of substance misuse in Barnet**	Promotion of healthy choices information and support/treatment options for alcohol and drug users	Number of referrals to CGL and number of people in treatment. Number of completed audits via the Drinkcoach website.	Reduced number of hospital admissions from alcohol related conditions. Increased number of people in treatment. Set up alcohol treatment clinics based in GP surgeries.	Annual	Public health, Substance Misuse Team	Primary Care Homeless Healthcare CGL Drinkcoach

		Borough wide GP recording of alcohol use and GP referral into treatment.				

CVD prevention and early intervention – healthcare settings

Primary Care and Pharmacy

Strategic action	Actions	Key Performance Indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
7. **Smoking cessation services –** increased delivery in healthcare settings and community	Re-commission smoking cessation services and agree delivery model with GP Federation Promote uptake of smoking cessation services in population groups with higher prevalence and greater risk of harm	Agree smoking cessation services commission from LBB Public Health to GP Federation Uptake of vaping offer as smoking cessation aid (this is means tested and available across the borough)	Reduced smoking prevalence in Barnet Reduced inequality in smoking prevalence between general population and people with SMI / PWLD / routine and manual workers / people living in areas of highest deprivation Use evaluation of vaping offer as smoking cessation aid to inform decision on further use	Annual	LBB Public health - Smoking Cessation Team GP Federation	Primary Care Community pharmacies Acute trust (pre-op, inpatient and maternal smoking cessation)
8. **NHS England Community Pharmacy blood pressure (BP) check service** - increased awareness and delivery in Barnet	BBP Health Inequalities project to support increased delivery of NHSE Community Pharmacy blood pressure check service in two PCNs	BBP Health Inequalities project to support increased delivery in two PCNs – working with GP surgeries and local pharmacies, improve feedback of results from pharmacy to GP practice	Increased delivery of NHS E Community Pharmacy Blood Pressure Check Service Increased feedback of BP results from pharmacies to GP practices	April 2024 (end of pilot)	BBP Health Inequalities Team Community pharmacies	Primary Care Public Health, Live and Age Well team Local Pharmaceutical Committee

	Promote awareness of available services in the community	Promote awareness of services with VCS organisations				Medicines Management
9. **NHS Health Checks (HC) –** increase delivery in areas with high deprivation, to identify people with high risk of CVD and start risk reduction	Re-commission NHS HC and agree delivery model with GP Federation Work with PCNs / GP surgeries to increase delivery in populations more likely to have high risk of CVD	Agree NHS HC commission from LBB Public Health to GP Federation Analyse pattern of NHS HC delivery and identify areas to increase activity.	Increased delivery of NHS HC Increased uptake of NHS HC in patients living in areas of high deprivation, minority ethnic groups	Annual	Public Health, Live and Age Well team Primary Care GP Federation BBP Primary Care Team	BBP Neighbourhoods team
10. **Annual health checks for people with learning disabilities and severe mental illness** – optimise and support actions for CVD prevention	CVD prevention during and following annual health checks	Develop annual health checks further, to optimise CVD prevention	Evidence that annual health checks promote CVD prevention – including behavioural interventions and management of clinical risk factors	Annual	BBP primary care team Primary Care GP Fed BEH Barnet Learning Disabilities Service and Mental Health Commissioners	Barnet Mencap MIND in Barnet Public health
11. **Long term conditions locally commissioned service (LTC LCS)** to support CVD prevention	Development and delivery of LTC LCS	Sharing of best practice and improvement mechanisms between PCNs Engagement between primary care and VCSs to promote uptake of LTC LCS in Core20PLUS populations	Increased case finding – hypertension, hypercholesterolaemia, atrial fibrillation Improved management of hypertension (incentivised 2024/5 LTC LCS outcomes)	Annual	Primary care PCNs BBP primary care team	Public Health, Live and Age Well team NCL central team VCS orgs

			Delivery of LTC LCS in Core20PLUS populations			
12. Heart failure management	Improved management of patients with heart failure in primary care (incentivised 2024/5 LTC LCS outcomes) Review provision of cardiac rehabilitation, including counselling	LTC LCS incentivised outcome for 24/25 - % of people on HF register (with LVSD) and without contraindications on: a) ACEi or equivalent AND b) Betablocker	Improved management of heart failure	Annual	Primary care PCNs BBP primary care team Cardiology, secondary care	Public Health, Live and Age Well team NCL central team VCS orgs
13. Data analysis to monitor CVD prevention in Barnet	Monitor data regularly	See data table below in this document for healthcare measures	Monitoring identifies areas of change / where further action is required	Annual	Primary care, BBP Public Health	VCS orgs

Secondary Care

Strategic action	Actions	Key performance indicators	Outcome(s)	Delivery period	Lead	Other stakeholders
14. Demographic data analysis for people accessing secondary care and primary care for CVD	Review demographic data for Royal Free Trust cardiology services. Compare with primary care demographic data for CVD risk factors.	Analysis of data for Royal Free Trust cardiology services, by patient demographics Analysis of data from primary care for CVD and	Further understanding of local populations at highest risk of CVD and populations accessing primary and secondary care for CVD	Annual	BBP Royal Free Primary Care Barnet Public Health Live and Age Well Team	

		CVD risk factors, by patient demographics				
15. Smoking cessation services – secondary care	Promote uptake of smoking cessation services in population groups with higher prevalence and greater risk of harm	Maternal health programmes roll out Pre op / Acute services roll out	Reduced number of pregnant people smoking at delivery Reduce number of people smoking pre-operatively	Annual	Royal Free Barnet Public Health Smoking Cessation Team	BBP

Facilitators for CVD prevention and early intervention

- **Communications and engagement** activity from VCS organisations, the council, primary care, secondary care and pharmacies
- **Making Every Contact Count (MECC)** approach across the council, VCS partners and healthcare system
- **Workplace health promotion** to detect and reduce CVD risk factors
- **Wider work to create environments that promote CVD prevention**, such as through reducing air pollution, promoting healthy weight through the food environment and facilitating active travel

Also discuss at CVD T&F Group meetings

- Primary care-led work to identify and manage clinical CVD risk factors, including hypertension, atrial fibrillation, hypercholesterolaemia, diabetes
- Secondary care and cardiac rehabilitation

Data to monitor CVD prevention in healthcare settings Barnet (in addition to KPIs and outcome measures in this action plan)

Indicator	Level	Source	Most recent data
MORTALITY			
Under 75 mortality from all CVD	Barnet GP surgery	I&I Hub, Fingertips NCL pop health OF	2021/22
PREVALENCE			
Increase in prevalence compared to RightCare PCN similar 10 - Hypertension - Atrial fibrillation		Future LTC LCS dashboard	
BLOOD PRESSURE			
Percentage of patients aged 18 and over with GP recorded hypertension, who have had a blood pressure reading within the preceding 12 months	GP surgery	CVDPrevent	June 2023
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	GP Surgery	CVDPrevent Future plan for NCL pop health outcomes framework	June 2023
ATRIAL FIBRILLATION			
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	GP surgery	CVDPrevent Future LTC LCS dashboard	June 2023
HYPERCHOLESTEROLAEMIA			
Percentage of patients aged 18 and over, with no GP recorded CVD and a GP recorded QRISK score of 10% or more, CKD (G3a to G5), T1 diabetes (aged 40 and over) or T2 diabetes aged 60 and over, who are currently treated with lipid lowering therapy	GP Surgery	CVDPrevent	June 2023