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Barnet Cardiovascular Disease Prevention Programme

2022 – 2026

Date last updated: 27th June 2022

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About this programme

Why?

Although health has improved over the last 30 years, over the last 10 years improvements in mortality rates have slowed.

Cardiovascular disease (CVD) is the one of the largest causes of premature mortality in deprived areas. It is one of the major causes of deaths in under 75s in Barnet (55.0 per 100,000 population) and is the single largest cause of inequality in premature mortality between the most and least deprived areas. **There remain significant opportunities for the prevention of CVD** through both primary prevention, early detection, public health action, and secondary prevention - clinical care (especially primary care) to reduce the burden of risk factors and maximise the uptake of known effective care.

We need to respond to a changing landscape brought by COVID-19 which has highlighted persisting health inequalities in our society, including in Barnet. CVD and the risk factors for CVD (which are themselves unequal), increase the chance of severe illness or death from COVID-19. In 2019, The National CVD Prevention System Leadership Forum (CVDSLF) set out 7 x 10-year ambitions for CVD, underpinned by an aim to reduce inequality in CVD deaths.

Areas of focus for CVD Prevention in Barnet need to be agreed, in line with both national ambitions and local priorities.

What?

4 year programme
2022-2026

Aim: to develop a CVD prevention programme to reduce prevalence of CVD, improve management of risk factors, reduce premature mortality and inequalities in outcomes.

The programme aims to be complementary to and not replace what is being planned and done locally.

The programme will be guided by:

- Local needs
- Evidence from existing and planned interventions
- Knowledge of what has worked in other areas partnership working
- Innovation
- Regional and national drivers

2 year action plan
2022-2024

Aim: to detail proposed outcomes and activities to meet those outcomes to be carried out over a two year period, and longer where it effective or requires and extended length of time to embed properly.

We want the action plan to be further refined and validated through engagement with the CVD Prevention Task & Finish Group and the wider Barnet Borough Partnership (BBP).

The agreed CVD Prevention Programme Action Plan will be taken forward through the CVD Prevention Task & Finish Group with periodic update to BBP Delivery Board and the Health and Wellbeing Board.

Development

This programme and action plan has been co-produced with system partners across the Barnet Borough Partnership (BBP) through the CVD Prevention Task & Finish Group, as part of the BBP inequalities workstream.

Input has been sought through a series of task & finish group meetings, a detailed mapping exercise and system wide partnership workshops, involving representatives from primary and secondary care, community providers, voluntary and community sector, faith groups and local authority officers, who have collectively driven the priorities and actions presented.

Cross cutting themes

- **Health inequalities: geographical, deprivation; populations at risk; inc. people with learning disabilities and serious mental illness**
- **Integration, transformation and partnership work**

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Contents

DRAFT

List of abbreviations

- ABC - AF, blood pressure & cholesterol
- AF – Atrial fibrillation
- AWM – adult weight management
- BBP - Barnet Borough Partnership
- HBP – High Blood pressure
- CCG – Clinical Commissioning Group
- CHD – Coronary Heart Disease
- COPD – Chronic Obstructive Pulmonary Disease
- CVD – Cardiovascular Disease
- CVDSLF - CVD Prevention System Leadership Forum
- DSR – Directly Standardised Rate
- FAB – Fit and Active Barnet
- GP – General Practice/Practitioner
- HbA1c – blood sugar
- HCA – Health care assistant
- HENRY – Health, Exercise and Nutrition for the Really Young
- LBB – London Borough of Barnet
- LDL – low-density lipo-protein
- LTC – Long Term Condition
- LTC LCS – Long Term Condition Locally Commissioned Service
- MDT – multi-disciplinary team
- MECC – Making Every Contact Count
- NCL – North Central London
- NDPP – National Diabetes Prevention Programme
- NHS – National Health Service
- NHSE & I – NHS England & Improvement
- NICE – National Institute for Health and Care Excellence
- OHID – Office for Health Improvement & Disparities
- PAM – Patient Activation Measure
- PCN – Primary Care Network
- PH – public health
- PHE - Public Health England
- PWLD – people with learning disabilities
- QOF – Quality and Outcomes Framework
- RF – risk factor
- SATOB - smoking at time of booking
- SATOD - smoking at time of delivery
- SMI – serious mental illness
- TIA – transient ischemic attack
- UCLP – UCLPartners
- VCS – Voluntary & Community Sector

Return to contents

DRAFT

Background

Prevention is at the heart of the NHS Long Term Plan. In addition to substantial commitments to tackle obesity, alcohol and smoking, the Plan includes a major ambition to prevent 150,000 strokes and heart attacks over the next ten years by improving the treatment of the high-risk conditions – hypertension (high blood pressure), high cholesterol and atrial fibrillation (AF).

National NHS context: premature mortality & risk factors

The NHS Long Term Plan (2019) & Global Burden of Disease Study (2017) set out the current position and areas of focus:

- Top 5 causes of early death for the people of England include:
  - Heart disease
  - Stroke
  - Dementias
- Top risk factors that cause early death in England include:
  - Smoking
  - High blood pressure
  - Obesity
  - Poor diet
  - Alcohol & drug misuse
  - Air pollution
- Life expectancy stalled or fallen for most deprived 10%
- Some parts of population are at substantially higher risk of poor health and early death:
  - Black, asian & minoritised ethnic communities
  - adults with a learning disability
  - people with serious mental illness (SMI)
- CVD is the largest cause of premature mortality in deprived areas
- CVD is the single biggest area where the NHS can save lives in the next 10 years
- Preventable through action on:

1. **Early detection and optimal treatment of CVD**. People routinely knowing their 'ABC' (atrial fibrillation (AF), blood pressure, cholesterol) through use of digital technology and VCS, public sector and NHS staff.
2. **Improving the effectiveness of the NHS Health Check** – working with VCS, community pharmacy and GPs
3. **Better support for heart failure patients through increased access to testing in primary care & multi-disciplinary teams (MDTs)**
4. **Fast and effective action for people suffering cardiac arrest –** building a national network of community first responders and defibrillator
5. **Increase access to cardiac rehabilitation**

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Background

There are a number of CVD prevention programmes underway at a national, regional and local level.

National NHS context: CVDPREVENT & BP@Home

CVDPREVENT is a national primary care audit that automatically extracts routinely held GP data, covering diagnosis and management of six high-risk conditions that cause stroke, heart attack and dementia:

- atrial fibrillation (AF)
- high blood pressure
- high cholesterol
- diabetes
- non-diabetic hyperglycaemia
- chronic kidney disease

It will provide a foundation for professionally led quality improvement in individual GP practices across Primary Care Networks (PCNs). It will support primary care in understanding how many patients with the high-risk conditions are potentially undiagnosed, undertreated or over treated.

The first collection (for the year 2019-20) was at the end of December 2020. Data collection is now a quarterly extract.

BP@Home Service

Home blood pressure monitoring has been identified as a priority for CVD management as the NHS recovers from the COVID-19 pandemic to ensure that patients can manage their hypertension well and remotely, reducing the need to attend GP appointments.

NHS England & Improvement have distributed BP monitors around England so that patients can record their BP and send their reading to their GP for review remotely through the BP@Home initiative.

UCLPartners Proactive Care Frameworks

UCLPartners (UCLP) have developed real world frameworks to support proactive care of long term conditions in a post COVID-19 primary care.

The programme looks to identify patients at varying levels of risk by condition, using risk stratification tools. Then, utilising the breadth of the primary care workforce (e.g. health care assistants (HCAs), practice pharmacists) patients are contacted and proactively managed; given health & wellbeing advice, signposted to local support services and digital support tools to support remote and self management.

There are currently 6 (soon to be 8) high impact condition frameworks, of which 4 relate to CVD prevention: atrial fibrillation (AF), blood pressure, cholesterol and type 2 diabetes.

North Central London context

NCL Long Term Conditions Locally Commissioned Service

NCL CCG are designing a more consistent NCL approach to long term conditions care, via a pan-NCL LCS for patients and practices (the NCL LTCLCS). Initial focus will be on metabolic and respiratory conditions due to be introduced in early 22/23 with a preparatory period of up to one year.

NCL CVD and Stroke Network

Established, February 2022 - championing, commissioning and overseeing Proactive Care programmes and transformation initiatives across CVD & stroke prevention pathways and working to reduce health inequalities.

BP@Home

NCL were part of the pilot BP@Home programme: 3 PCNs in Barnet took part: PCNs 1W, 1D and 5.

Return to contents

DRAFT

Background

COVID-19 has brought a sharper focus on persisting health inequalities in our society, including in Barnet. CVD and the risk factors for CVD (which are themselves unequal), increase the chance of severe illness or death from COVID-19.

The National CVD Prevention System Leadership Forum set out 7x 10-year ambitions for CVD, underpinned by an aim to reduce inequality in CVD deaths.

National OHID context: CVD ambition

In 2019, the National CVD Prevention System Leadership Forum (CVDSLF) - made up of 40 organisations and convened by Public Health England (PHE) now Office for Health Improvement & Disparities (OHID) - set out 7x 10-year ambitions for CVD. These are:

- ✓ 85% of people with AF are detected and 90% are adequately treated.
- ✓ 80% of people with hypertension are detected and 80% are adequately treated.
- ✓ 75% of 40-74 year olds have had a CVD risk assessment and cholesterol check in the past 5 years and 45% of those identified as high risk are treated with statins.
- ✓ 25% of people with familial hypercholesterolaemia are diagnosed and treated.

These ambitions are underpinned by an overall aim to reduce significantly the gap in amenable CVD deaths between the most and least deprived by 2029.

COVID-19 and CVD

Those in **more deprived areas have higher likelihood of contracting and dying from COVID-19.**

CVD: 3.9x higher odds of severe COVID-19 disease and 2.7x higher odds of mortality.

Hypertension: 2.6x higher odds of severe COVID-19 disease and 2.5x higher odds of mortality.

Diabetes: 2.5x higher odds of severe COVID- 19 disease and 2.1x higher odds of mortality.

Current smoking: 1.8x higher odds of severe COVID-19 disease, but not mortality.

Obesity: significantly associated with severe COVID-19 disease and 2.2% higher odds of mortality.

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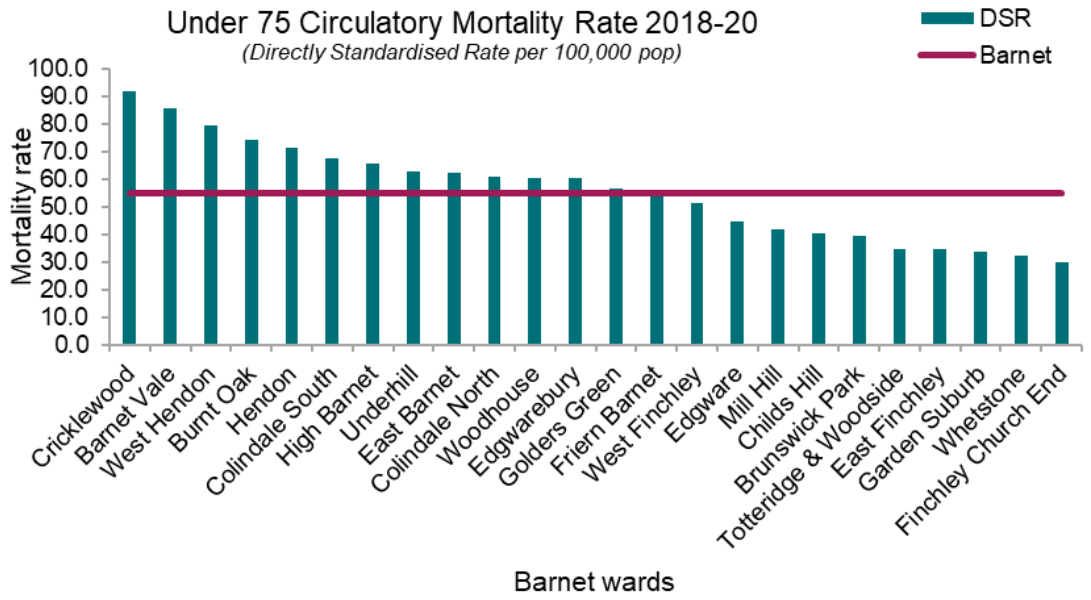
Background

Improvements in treatment for CVD and behaviour change has seen overall death rates from CVD decrease year on year but inequalities persist. To ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment.

Barnet context: premature mortality

- There is a life expectancy gap in Barnet:
  - Women in the most deprived areas live just over 6 years less than those in the least deprived areas.
  - Men in the most deprived areas live just under 7 years less than those in the least deprived areas.
- CVD is one of the major causes of deaths in under 75s in Barnet (55.0 per 100,000 population)
- Although the under 75 CVD mortality rate in Barnet continues to decrease and is in fact lower than that seen in London (69.1 per 100,000 population) or England (70.4 per 100,000 population), it varies considerably between the borough's wards, with clear links to deprivation
- The rate of under 75 CVD mortality in the Cricklewood (91.9 per 100,000 population), is more than triple that of Finchley Church End (30.1 per 100,000 population).



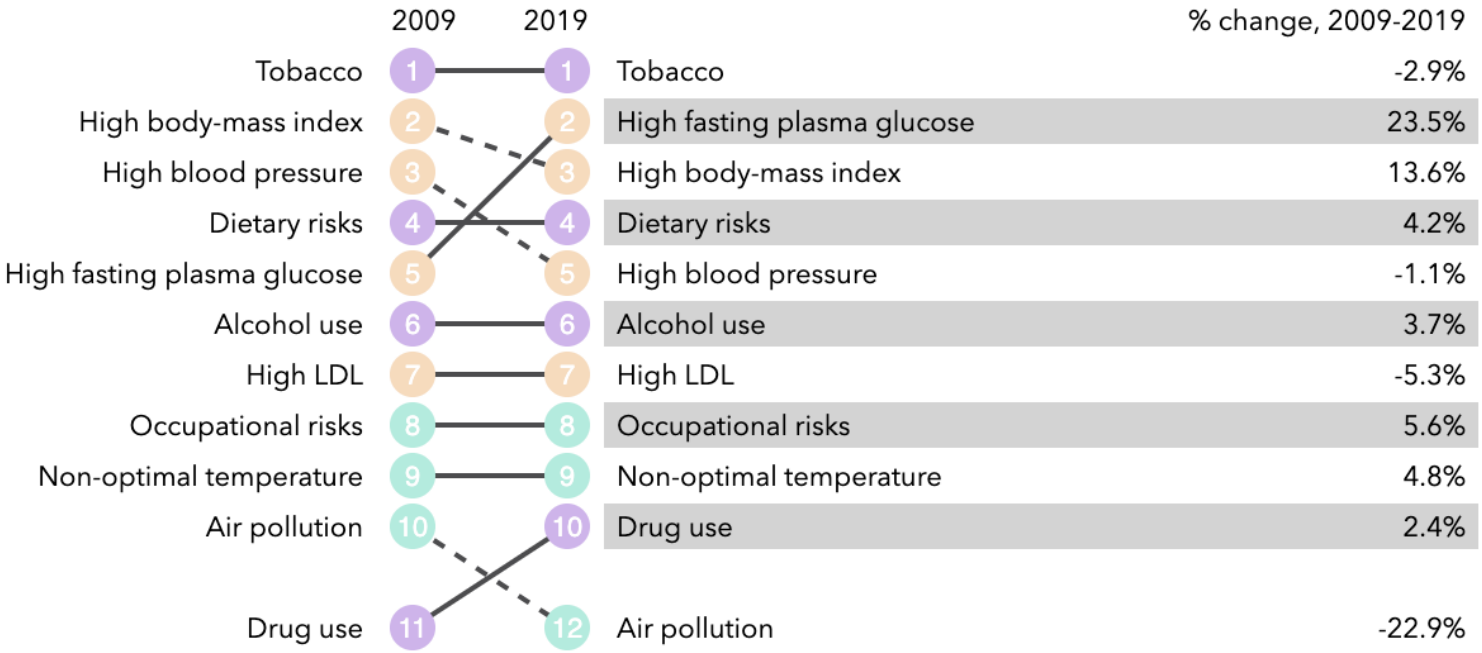
Return to contents

DRAFT

Background

There are many risk factors (RFs) for CVD, including metabolic, environmental and behavioural risks. The risks are not evenly distributed in society. Tackling these RFs can prevent CVD or reduce the risk of poorer outcomes in those already with CVD. In this programme, we are focusing on the top 3 behavioural risk factors.

The **risk factors that drive the most death and disability in the UK** are:



	% change, 2009-2019
Tobacco	-2.9%
High fasting plasma glucose	23.5%
High body-mass index	13.6%
Dietary risks	4.2%
High blood pressure	-1.1%
Alcohol use	3.7%
High LDL	-5.3%
Occupational risks	5.6%
Non-optimal temperature	4.8%
Drug use	2.4%
Air pollution	-22.9%

Source: Global Burden of Disease study, UK profile

Examples of CVD risk factors in Barnet:

In 2019, **11.1% of the Barnet population were estimated to be smokers** (similar to London average). This hides variation, however. Higher rates of smoking were recorded in those with serious mental illnesses, routine & manual occupations, and (across NCL) living in more deprived communities.

Over half (57.7%) of adults aged 18+ in Barnet are overweight or obese (2019). The wards with highest prevalence of adult obesity are Burnt Oak, Colindale and Underhill.

Obese adults are 2.5 times more likely to develop high blood pressure and are 5 times more likely to develop type 2 diabetes, significant risk factors for CVD.

Return to contents

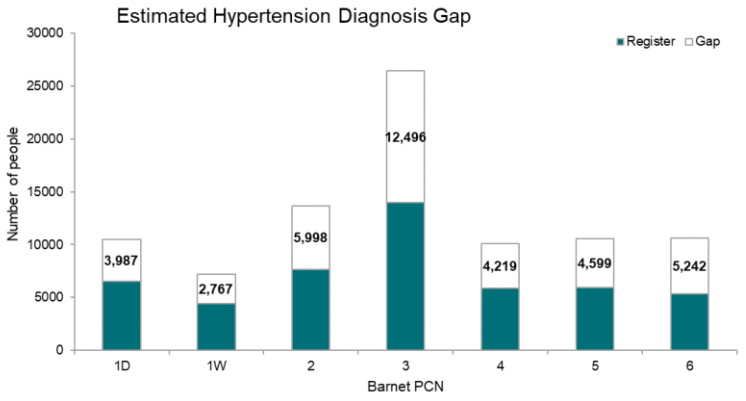
DRAFT

Background

National ambitions (CVDSLF) by 2029:
- ✓ **85% of people with AF are detected**
- ✓ **80% of people with hypertension are detected**

There is a large degree of variability by PCN and GP practice. We need to look to reduce this variation.

Barnet hypertension diagnosis gap

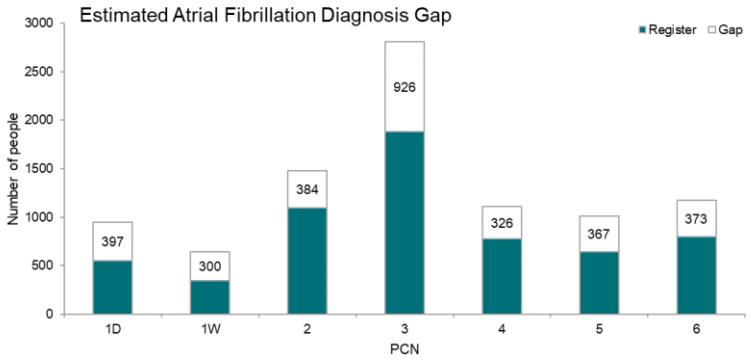


There are nearly 50,000 patients diagnosed with hypertension on the GP QOF Registers in Barnet (2020-21), and the estimated number of people living with hypertension for Barnet registered population is around 89,059.

This suggests around 39,000 people in Barnet may have undiagnosed hypertension.

Range of variation at practice level is 36% to 74% diagnosed

Barnet atrial fibrillation diagnosis gap

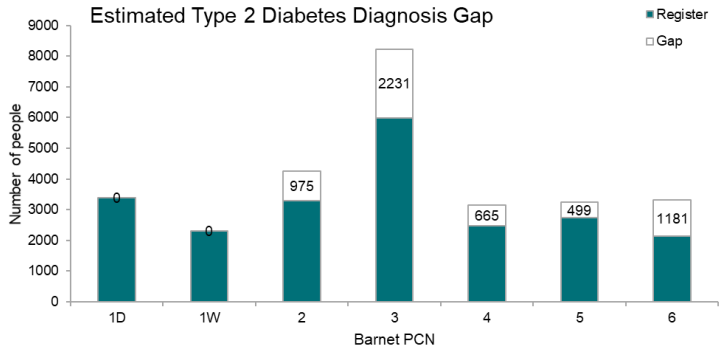


There are around 6,102 patients on the QOF AF register in Barnet.

It is estimated that only 67% of AF has been detected in the population (2020-21), suggesting around 3000 people in Barnet may have undiagnosed atrial fibrillation.

Range of variation at practice level is 32% to 100% diagnosed

Barnet diabetes diagnosis gap



The estimated total prevalence of type 2 diabetes in Barnet is 27,599 (diagnosed and undiagnosed) and there are around 22,336 patients with type 2 diabetes on the GP QOF register in Barnet (2020-21). This suggests nearly 5,550 people in Barnet may have undiagnosed type 2 diabetes.
Range of variation at practice level is 43% to 100% diagnosed.

There are an estimated 34,084 people in Barnet with non-diabetic hyperglycaemia or pre-diabetes (2015). While only 19,042 are on the QOF register (2020-21). Suggesting 15,000 people in Barnet have undiagnosed pre-diabetes and are at increased risk of going on to develop type 2 diabetes.

Source: QOF 202021, diagnosed figures. Estimated prevalence from the NCVIN, 2020. No. rounded to nearest 10.

Source: QOF 2020/21, diagnosed figures.

Return to contents

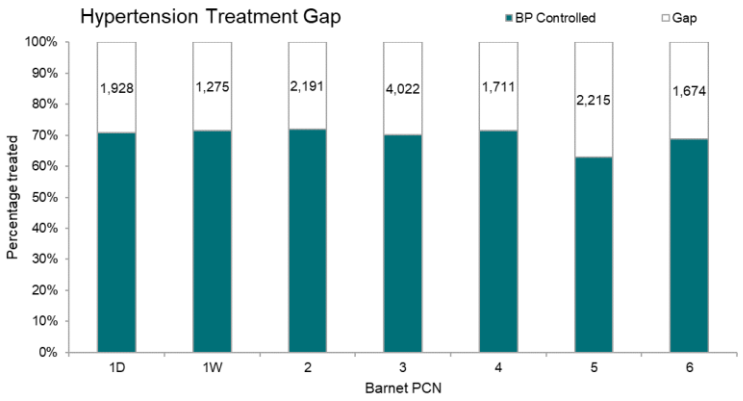
DRAFT

Background

National ambitions (CVDSLF) by 2029:
- ✓ **80% of people with hypertension are adequately treated**
- ✓ **90% of people with AF are adequately treated**

There is a large degree of variability by PCN and GP practice. We need to look to reduce this variation.

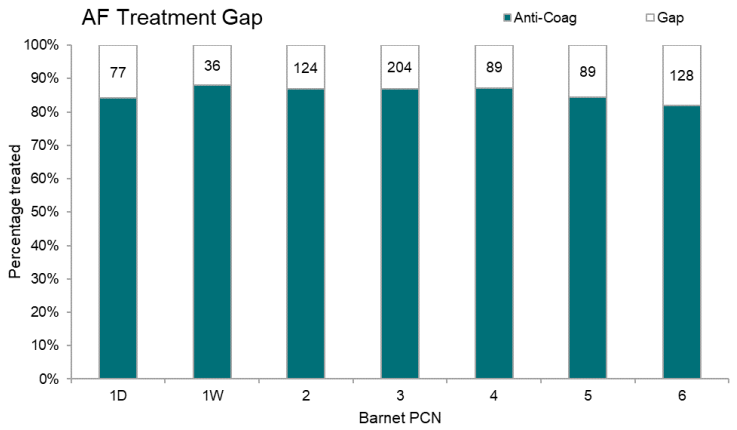
Barnet hypertension treatment gap



Around 15,000 of the patients registered with hypertension in Barnet do not have their blood pressured controlled to the QOF suggested level (2019-20)

Range of variation at practice level is 50.2% and 85% treated to NICE guidance

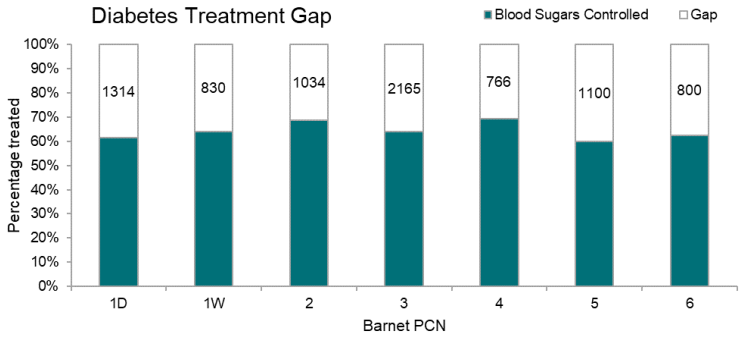
Barnet atrial fibrillation treatment gap



Around 747 of the patients registered with atrial fibrillation in Barnet are not anticoagulated (2019-20)

Range of variation at practice level is 70.7% and 96.7% treated to NICE guidance

Barnet type 2 diabetes treatment gap



Around 8,000 patients on the diabetic register do not have their blood sugars controlled to the level suggested in the QOF contract (2019-20).

This is only 1 of 3 treatment targets for diabetes in adults: HbA1c (blood sugar), cholesterol and blood pressure set by NICE.

Source: QOF 2019/20, treatment figures

Return to contents

DRAFT

Background

We will incorporate neighbourhood working into the CVD Prevention Programme by focusing some of the activities on Grahame Park Estate; a population in Barnet who are disproportionately affected by CVD and related risk factors.

CVD, Grahame Park & the Neighbourhood Model

CVD Prevention & Grahame Park

We know cardiovascular diseases (CVD) are a major cause of preventable illness and premature mortality in Grahame Park and this population are disproportionately impacted by certain risk factors, i.e. smoking and alcohol consumption.

The Healthy Heart Peer Support Project will have an initial focus on delivery in Burnt Oak and Colindale, in which Grahame Park is part. This will be in collaboration with local voluntary organisations and community groups.

What is the Neighbourhood Model?

The Neighbourhood Model is, first and foremost, a place-based approach. There is an emphasis on using local insight, and making use of local assets, to meet the unique needs of residents. It will also be coproduced with residents - they will be involved in the conception, design, steering, and management of interventions, rather than only being consulted occasionally.

High blood pressure is the most prevalent condition (11.6%) amongst residents.

Smoking prevalence is higher in Grahame Park (19.1%) than London (14.9%).

Cardiovascular diseases are the leading cause of excess deaths.

Hospital admissions for alcohol-attributable harm are some of the highest in Barnet.

Over 6 in 10 children aged 10-11 are overweight or very overweight.

Return to contents

DRAFT

Background

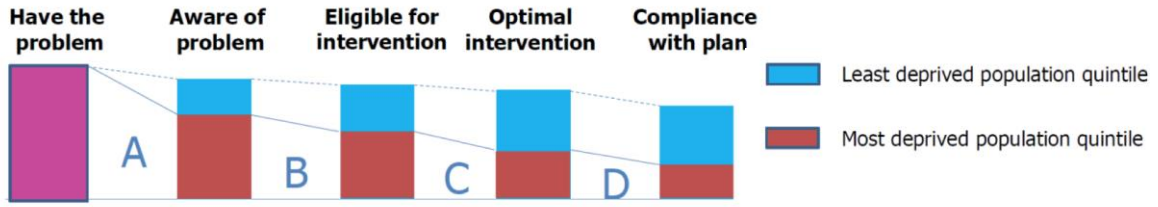
Intervention decay shows that there are inequalities at every stage of CVD prevention. From an individual recognising they are at risk of CVD, to them being able to sustain the optimal treatment plan.

Addressing inequalities

- Some groups are more likely than others to die prematurely (under the age of 75 years) from CVD. They are also more likely to have some key risk factors:
  - Men
  - People with serious mental illness
  - People from Black Caribbean and Black African ethnic backgrounds
- Not everyone who has a long-term condition (LTC) will be aware that they have it, and of those who are aware, not all will sustain optimal treatment - 'intervention decay'
- There is widening inequality between most and least deprived as progress through the different stages of intervention decay
- This CVD Prevention Programme aims to identify and tackle the drivers of inequality at each of these levels, with the goal of both reducing the intervention decay slope and decreasing disparity.
- The programme will consider both individual prevention programmes and overall risk of CVD, recognising that many who are at high risk of CVD will benefit from more than one preventative activity, and therefore successful integration and coordination of these different programmes will impact upon overall compliance.
- The programme is aligned with the NHS Core20PLUS5 approach to support the reduction of health inequalities at both national and system level.

Addressing Intervention Decay in heart disease for rapid impact

A	B		C	D
	Partnership	GP		
Social marketing programmes Community based focus to awareness raising Community Champions and Ambassadors	Frontline Making Every Contact Count (MECC) Enhanced focus on target communities: Share No Man's Land Health Check 'No wrong door' for health queries Single point of access/helpline Peer support: • Champions • Navigators • Advocates	Patient register search Flag: opportunistic review Health Check 'Hidden' CHD: • Diabetes • COPD • Severe Mental Illness • Learning Disabled	↑ consistency of clinical outcomes: • CHD • Hypertension • AF Upgrade TIA and stroke pathways	Structured self-management education Support ↑ completion of cardiac and stroke rehab Peer support to self-managed care Wrap-around socio-economic support Social prescribing



Intervention decay, Chris Bentley 2012

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CVD prevention in children & young people: Background

Many adults with risk factors for CVD will live in families so improving their outcomes will impact on children's health.

Preventing children and young people from taking up smoking, minimising alcohol consumption and healthy weight in children will shape the health outcomes of the adults of the future.

Young people in Barnet

- Almost a quarter of Barnet's population is 0-19 years old (approximately 99,000 young people)
- Over half (52%) of children and young people in Barnet are from Black, Asian and other ethnic backgrounds, compared with 30% across England.

Healthy weight

- Nationally there is concern at the continuing rise of childhood obesity and the implications of excess weight persisting into adulthood.
- Key findings within 2019/20 National Child Measurement Programme report for Barnet:
  - Levels of excess weight in Reception Children in Barnet has remained around 19%, which is slightly lower than London (21.6%) and England (23.0%).
  - Levels of excess weight in Year 6 Children in Barnet has remained around 34%, which is slightly lower than London (38.2%) and England (35.2%).
  - 1244 children in the Borough over the 91st percentile that would benefit from public health support.
  - Reports from young people and from teachers have highlighted the impact of COVID-19 on weight and physical activity.

Physical activity

Active Lives Children and Young People Survey for Barnet (academic year 2018/19) tells us that for 5 – 16-year-olds:

- 43.5% are active for an average of 60+ minutes a day
- 35.2% are active for less than an average of 30 minutes a day
- In a recent survey reflecting the impact of COVID measures in 2021:
- 87% of teachers believe children's physical fitness is worse and 78% of teachers believe children returned to school following COVID measures with excessive weight.

Smoking activity

- Of those young people that are smoking regularly at 16 years of age, 40% will remain lifelong smokers.
- 2.6% of Barnet's 15 year olds are regular smokers (nationally 5.5%)
- 21.8% had tried Shisha or other tobacco products
- 62% exposed to tobacco smoke in car and home 57% of this in the home.

DRAFT

CVD prevention in children & young people: Action

Healthy start

- Promote the importance of healthy body weight and a good diet before and during pregnancy.
- We will support parents and carers to establish a healthy lifestyle (diet and physical activity) for their children from a very early age.
- Support early year settings achieve the Healthy Early Year London awards
- Supportive programmes like Healthy start vouchers, Sugar Smart, HENRY

School age

- Support schools to achieve Healthy Schools London, whole school approach to food
- We will support children to develop skills and confidence in their physical ability and nutrition knowledge and ability to make informed decisions about their diet and activity.
- Supporting physical activity through programmes like the Golden KM
- Supporting programmes such as Sugar Smart, SMILE, Sugar Transfat, Great Junk Food debate etc.

Adolescent/ teenage

- We will support adolescents to maintain and deepen their skills, knowledge and confidence in their physical ability, nutrition knowledge and ability to make informed healthy choices.
- We will work with youth organisations to support them to promote access to a range of healthy food choices, lunch boxes and vending
- Supporting confidence building and skills programmes such as Ministry of Food

There is ongoing work to address these issues relating to children & young people in other programmes, therefore it is not being addresses within the scope of this programme.

However, as part of the CVD Prevention Programme we should consider what a family approach might mean, especially for obesity.

Support when needed

- When children, adolescents and families are identified as needing support to achieve a healthy weight we will enable them to access relevant and appropriate support.

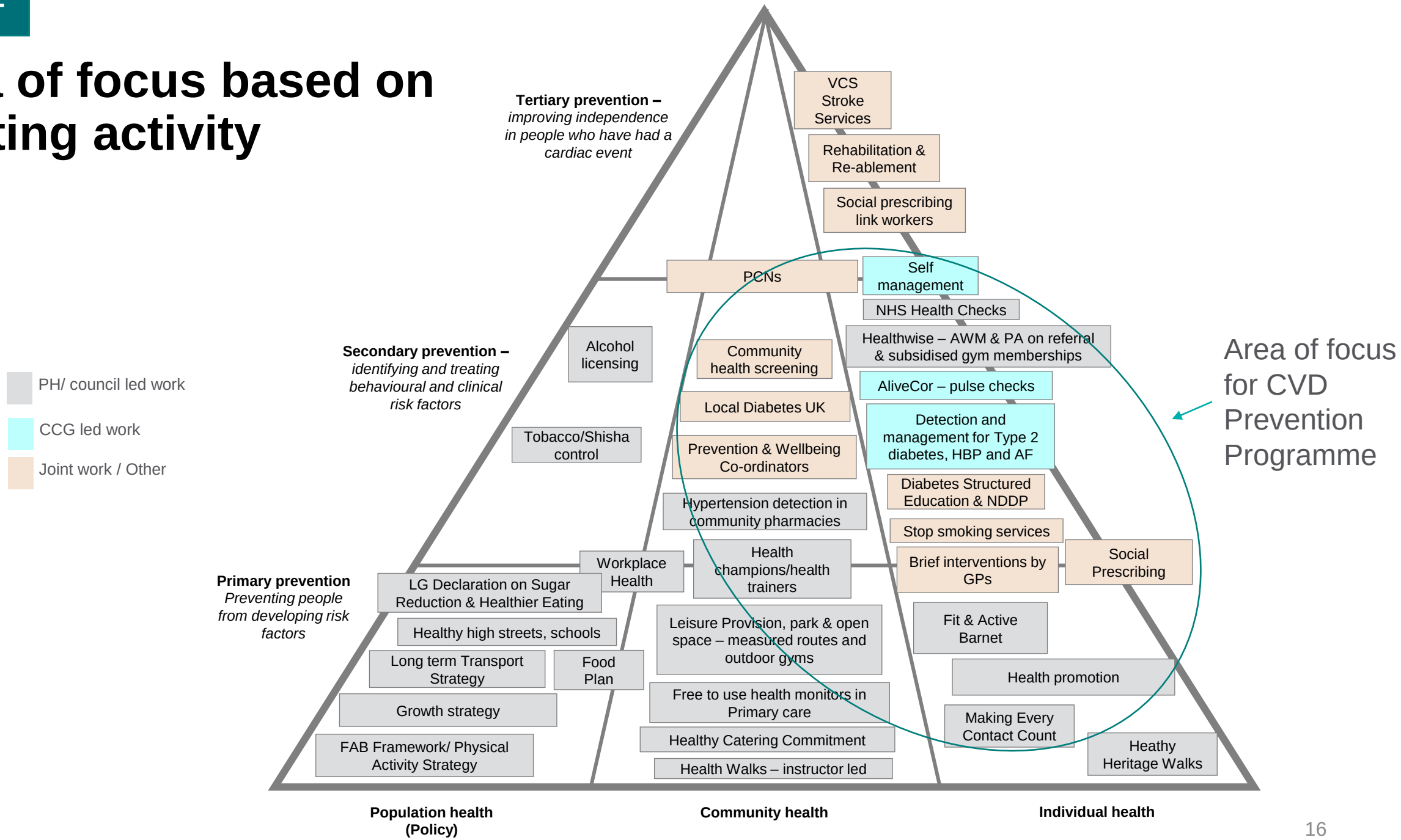
Smoking and other risky behaviours

- We will use education and campaigns to support healthier choices being the easier choices.
- We will champion health promoting environments, communities and settings
- We will support health promotion and improvement initiatives in places where children and young people are

Return to contents

DRAFT

Area of focus based on existing activity



Adapted from a previous draft NCL CVD Prevention Strategy

Return to contents

DRAFT

Areas of priority

The overall aims of this programme is to:

1. **Reduce the rate of premature mortality from CVD in Barnet**
2. **Reduce inequalities in premature mortality relating to geography, ethnicity, deprivation, people living with learning disabilities or severe mental illness**

Population awareness & patient activation

Behavioural risk factor management

Clinical risk factor detection & optimal intervention

Self care & sustaining change

Reduce racial, geographical and social inequalities in CVD outcomes

Return to contents

DRAFT

Priority outcomes: Population awareness & activation

Barnet residents aware of risks of CVD and how to help themselves

- Increased awareness of behavioural & clinical CVD risk factors through national and local campaigns
- Increased awareness of types of CVD and its consequences
- Increased awareness of the importance of early identification & checks available – *NHS health checks, community health checks, annual reviews, self assessment*
- Increased awareness of health behaviours that impact CVD risk – *diet, physical activity, weight management*

Barnet residents at increased risk feel empowered to take action

- Increased number of residents who know their ABC – AF, blood pressure & cholesterol
- Increased MECC conversations and very brief advice given by health champions and front line staff to inform of benefits of healthy behaviours and signpost to services
- Increased visits and click-through rates on LBB public health microsite

Underserved communities are supported to understand risks and take action

- Increased awareness in target communities of their increased risk relating to ethnicity, age & family history
- Improved resident health literacy so people have the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services
- Increased tailored communications to communities at higher risk of CVD e.g. multiple languages, easy read

Increased number of local workforce & volunteers trained in MECC, very brief advice & motivational interviewing

Return to contents

DRAFT

Stakeholders involved: Population awareness & activation

- **LBB Public Health**
  - Targeted awareness campaigns
  - Development of public health microsite
  - MECC training dissemination
  - Community health checks promotion
  - NHS Health checks promotion
- **VCS & community leaders**
  - Feedback resident voice/concerns/barriers
  - Disseminate key messaging to target communities
  - Co-design and support targeted awareness campaigns
  - MECC – very brief advice
- **Health services**
  - NHS health checks
  - MECC – very brief advice/opportunistic patient education
  - Motivational interviewing – patient activation measure

Population awareness & patient activation

DRAFT

Priority outcomes: Behavioural risk factor detection & management

Reduced prevalence of smoking in deprived communities

Increased number of routine and manual workers accessing Barnet Stop Smoking Service

Increased number of pregnant women identified as smoking at time of booking (SATOB) during early pregnancy are accessing Barnet Stop Smoking Service

Decreased number of women smoking at time of delivery (SATOD)

Increased number of hospital inpatients offered advice and support regarding smoking cessation if identified to smoke

Reduced number of residents drinking to harmful levels

Increased number of residents assessing their alcohol consumption through Drink Coach

Increased number of patients offered advice through brief intervention or a referral to drug and alcohol services in all health based settings if identified to drink to harmful levels or have alcohol dependence

Targeted interventions to population groups at risk of alcohol misuse delivered

Reduced prevalence of obesity in adults

Increased referral & uptake of both local and national adult weight management programmes, particularly from areas of deprivation

Approach to self and supported weight management for people with learning disabilities (PWLD) and severe mental illness (SMI) developed

Increased proportion of residents engaging in physical activity

Improved wrap-around support offer to build resilience around food budgeting and cooking

Increased invitations to and uptake of NHS health checks, community screening & utilisation of practice searches

Return to contents

DRAFT

Stakeholders involved: Behavioural risk factor detection & management

- **LBB Public Health**
  - NHS Health checks
  - Community health screening
  - Stop Smoking Service
  - Drink coach provision
  - Adult Weight Management (with LBB Greenspaces & Leisure)
  - Healthy eating
  - Targeted interventions
- **Health services**
  - Brief advice & interventions for smoking, alcohol, weight management
  - Referral to services: stop smoking, alcohol misuse, adult weight management
- **VCS & community leaders**
  - Awareness raising of risk factors & impact
  - Signposting to services

Behavioural risk factor management

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Priority outcomes: Clinical risk factor detection & management

Detection and optimal treatment of hypertension

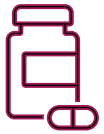
Detection and optimal treatment of atrial fibrillation

Detection and optimal treatment of pre- & type 2 diabetes

Detection and optimal treatment of raised cholesterol

Increased uptake of NHS Health Checks

Increased detection of 4 key clinical risk factors in general practice & community pharmacy



Increased proportion of patients with any of these clinical risk factors optimally treated

Increased referral to and uptake of the National Diabetes Prevention Programme (NDPP) by high risk populations

NB: General practice aspect to be delivered through the NCL Long Term Condition LCS

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Stakeholders involved: Clinical risk factor detection & management

- **General practice**
  - NCL LTC LCS delivery including:
    - NHS Health Checks
    - Increased detection of clinical risk factors
    - Brief advice & referral to lifestyle services e.g. NDPP, AWM, Stop Smoking, Alcohol misuse services, diabetes structured education programmes
    - Optimal treatment
- **Community Pharmacy**
  - Detection and management of clinical risk factors e.g. hypertension
- **LBB Public Health**
  - NHS Health checks commissioning
  - Community health screening
- **VCS & community leaders**
  - Support/host community screening events
  - MECC – signposting to services

Clinical risk factor detection & optimal intervention

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Proposed outcomes: Self care & sustainability

People with behavioural risk factors empowered to sustain behaviour changes

People with clinical risk factors feel empowered to manage their condition

Increased use of evidence based digital technology and health applications (e.g. NHS Apps) to support residents to manage both behavioural and clinical risk factors

Increased referrals into local behaviour change programmes:

- Weight management, nutrition & dietetic services
- Physical activity on referral
- Health walks
- Stop smoking services
- Drink Coach & substance misuse services
- VCS programmes
- LBB Public Health microsite

Increased referral and uptake of structured education programmes for type 2 diabetes

Residents have access to support from peers who share the condition and are from similar backgrounds

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Stakeholders involved: Self care & sustainability

- **LBB Public Health**
  - Stop Smoking Service
  - Alcohol misuse services
  - Drink coach provision
  - Adult Weight Management services (with LBB Greenspaces & Leisure)
  - Healthy eating promotion & education
  - Digital tools – scoping & pilots
  - Peer support projects
  - Public health microsite
- **General Practice**
  - Referral to above programmes and others including structured education, social prescribing, BP@Home
- **VCS & community leaders**
  - Peer support projects
  - Signposting

Self care & sustaining change

Accompanying CVD Prevention Programme Action Plan 2022-24 in separate document.

If you wish to collaborate on aspects of the programme or need further information contact:

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