Barnet Cardiovascular Disease Prevention Programme: Action Plan

2022 – 2024

DRAFT

Contents

DRAFT

List of abbreviations

- AF – Atrial fibrillation
- AWM – adult weight management
- BBP - Barnet Borough Partnership
- HBP – High Blood pressure
- CCG – Clinical Commissioning Group
- CVD – Cardiovascular Disease
- FAB – Fit and Active Barnet
- GP – General Practice/Practitioner
- HCPs – Health care professionals
- ICS – Integrated Care System
- LBB – London Borough of Barnet
- LTC – Long Term Condition
- LTC LCS – Long Term Condition Locally Commissioned Service
- MECC – Making Every Contact Count
- NCL – North Central London
- NDPP – National Diabetes Prevention Programme
- PAM – Patient Activation Measure
- PCN – Primary Care Network
- PH – public health
- PWLD – people with learning disabilities
- SATOB - smoking at time of booking
- SATOD - smoking at time of delivery
- SMI – serious mental illness
- VCS – Voluntary & Community Sector

Return to contents

DRAFT

Implementation of the CVD Prevention Programme & Action Plan: *How it was developed*

The programme & action plan has been developed in collaboration with a broad coalition of local partners including strong representation from community groups and clinicians. It has been co-produced applying the Barnet Borough Partnership principles. The programme incorporates work that fall within the scope of CVD prevention being implemented at sector and borough level, adding value to those initiatives by identifying connections between different programmes and adding actions where there are gaps.

DRAFT

Priority area 1: Population awareness & activation

Return to contents

Strategic objectives	Strategic actions	Action outcome measures	Delivery team
1.1 Barnet residents are aware of risks CVD and how to help themselves **2.2 Barnet residents at increased risk feel empowered to take action** **3.3 Underserved communities are supported to understand risks and take action**	Understand resident awareness of CVD risks, prevention and available services through focus groups with high-risk groups	Change in percentage of self-reported awareness of CVD prevention in the population	LBB Adults & Healthcare Public Health
	Develop a communications plan to raise awareness of CVD risks, prevention and available services (including promotion of available self-referral routes)	A communications plan developed	LBB communications (Public Health)
	Collate and co-produce materials for resident education on CVD risks and prevention, customising where needed with communities	A suite of materials curated	LBB Adults & Healthcare Public Health in collaboration with Voluntary & Community Sector and clinical reference group
	Develop a suite of case studies to showcase impact of services to use for communications with the public and health care professionals	Case studies developed	LBB Adults & Healthcare Public Health and LBB Public Health Commissioning LBB communications (Public Health)
	Develop a dedicated area on CVD Prevention on the new public health microsite as a hub for information	An online hub dedicated to CVD Prevention in Barnet launched	LBB communications (Public Health)
	Deliver targeted communications, webinars and events to communities about CVD risk, prevention and services, including self -referral routes in collaboration with VCS & health champions	Number of webinars/events delivered that demonstrate an improvement in understanding	VCS in partnership with LBB communications (Public Health)
	Maintain the suite of MECC factsheets and promote as a resource of simple information, advice and signposting for health & wellbeing for frontline staff and volunteers	Page views of barnet.gov.uk/MECC page Number of downloads of MECC factsheets	LBB Adults & Healthcare Public Health
	Peer support workers/ health champions to deliver information sessions on CVD risks and prevention in local community groups and faith communities	Number of sessions delivered Number of residents engaged	Groundworks Inclusion Barnet
	Evaluate the impact and reach of the communications approach and adjust plan	A refreshed communications plan	LBB Adults & Healthcare Public Health and LBB communications (Public Health)

DRAFT

Priority area 2: Behavioural risk factor detection & management

Return to contents

Strategic objectives	Strategic actions	Action outcome measures	Delivery team
2.1 Reduce prevalence of smoking in deprived communities	Map CVD need, service availability and uptake	Detailed map of geographical areas of focus Baseline % of service uptake	LBB Insight & Intelligence
	Understand awareness of and barriers to referral to lifestyle services within NHS and VCS	Identification of areas of focus for communications Identification of possible changes to referral pathways	LBB Public Health Commissioning
	Simplify referral processes (if necessary)	% referrals from HCPs	LBB Adults & Healthcare Public Health Primary Care
	Deliver MECC (brief advice) training to frontline staff and volunteers across the Barnet Borough Partnership	Numbers trained Number of patients offered brief advice and referral to lifestyle services	LBB Adults & Healthcare Public Health
	Scoping use of patient activation measurement (PAM) as part of implementation of the Long Term Condition Locally Commissioned Service (LTC LCS)	Agreed approach to capturing patient activation on primary care systems	NCL ICS Primary Care Team LBB Adults & Healthcare Public Health
	Secondary care trusts deliver their Long Term Plan for tobacco dependency (smoking cessation) – with a specific focus on pregnant women.	Number of pregnant women identified as smokers at time of booking (SATOB) Number of women smoking at time of delivery (SATOD) Number of referrals to stop smoking service from during pregnancy	The Royal Free Group and LBB Public Health Stop Smoking Service
2.2 Reduce number of residents drinking to harmful levels	Embed use of DrinkCoach into primary care referral pathways	% uptake of online alcohol test % uptake of online coaching sessions	NCL ICS Primary Care Team and LBB Adults & Healthcare Public Health
	Scope and delivery of Healthy Living Hubs	To be confirmed	The Royal Free Group
	Deliver hyper-targeted interventions for smoking cessation for routine and manual workers or areas of higher deprivation	Number of routine and manual workers or people from deprived populations accessing the Barnet Stop Smoking Service	LBB Public Health Stop Smoking Service
	Deliver hyper-targeted interventions relating to weight management for people with learning disabilities (PWLD)	Implementation of the Food Plan Number of people with learning disabilities accessing weight management services	LBB Public Health in all policies team and Barnet Joint Commissioning Team
2.3 Reduce prevalence of obesity in adults	Deliver hyper-targeted intervention to improve uptake of physical health checks to help people living with serious mental illness (SMI)	Number of people with SMI having a physical health check	Community Barnet with Barnet Federated GPs
	Development and promotion of self- referral to adult weight management programmes	% uptake local weight management services	LBB Greenspaces & Leisure LBB communications (Public Health)
	Delivery of Fit & Active Barnet (FAB) Framework to increase physical activity	Number of residents aged 16+years moderately active for at least 150 minutes per week (Sport England Active Lives Survey)	LBB Greenspaces & Leisure LBB Public Health
	Developing and delivering the Food Plan – promote healthy eating and supporting VCS organisations who work with people at greatest risk, to make sustainable changes to their food offer	Implementation of the Food Plan Long term: proportion of adults eating 5 fruit and vegetables per day	LBB Public Health in all policies team Barnet Food Working Group
	Ensure prevention measures are included in Support Plans/My Health Matters folders for people with learning disabilities	Changes if needed in standard support plans Number of people with people living with learning disability having annual health check	Barnet Mencap and Barnet Joint Commissioning Team

DRAFT

Priority area 3: Clinical risk factor detection & optimal treatment

Return to contents

Strategic objectives	Strategic actions	Action outcome measures	Delivery team
Detection and optimal treatment of: **3.1 Hypertension** **3.2 Atrial fibrillation** **3.3 Pre-diabetes & Type 2 diabetes** **3.4 Raised cholesterol**	Review and improve uptake of NHS Health Checks	Numbers (%) invited to an NHS Health Check Number (%) of NHS Health Checks delivered Reduction in diagnosis gap across the 4 key conditions	LBB Public Health commissioning and general practice
	Deliver community health screening pilot in areas identified by mapping and evaluate	Number of patients in target populations (geographical or high risk) screened Number of patients identified for onward referral	LBB Public Health commissioning
	Define approach for wider system to support primary care in the delivery of the LTC LCS as part of baseline year, including use of planned HealtheIntent dashboards	Approach defined	NCL ICS Primary Care Team with general practice
	Primary care delivery of the LTC LCS	Number diagnosed and optimally treated with: ❖ Hypertension ❖ Atrial fibrillation ❖ Pre-diabetes ❖ Type 2 diabetes ❖ Raised cholesterol	General practice
	Work with the new provider of the National Diabetes Prevention Programme (NDPP) and primary care to maintain and increase referrals	Number of gold standard referrals to the NDPP Number of self-referrals to the NDPP Number of attendances at first group (M1) on the NDPP Conversion from referral to attendance at NDPP	NCL ICS Primary Care Team with general practice LBB Adults & Healthcare Public Health NDPP provider
	Support NCL projects to improve equity of access to the NDPP	NDPP participants compared with National Diabetes Audit (NDA)	LBB Adults & Healthcare Public Health NDPP Provider
	Increase the number of community pharmacies offering detection (and management) of hypertension in areas identified by the PNA where there is lower coverage	Number of community pharmacies delivering blood pressure checks Number of patients identified with hypertension in community pharmacy	LBB Adults & Healthcare Public Health Community pharmacy
	Deliver hyper-targeted pilot intervention (geographical and high risk) to increase number of people diagnosed with hypertension in community pharmacy (potential expansion)	Number of patients identified with hypertension in community pharmacy in target population	LBB Public Health NCL CCG (Barnet)
	Scope and deliver hyper-targeted CVD prevention through the Grahame Park Neighbourhood model and expand if successful	Implementation of CVD prevention activities in Grahame Park	LBB Public Health

DRAFT

Priority area 4: Self care & sustainability

Return to contents

Strategic objectives	Strategic actions	Action outcome measures	Delivery team
4.1 People with behavioural risk factors are empowered to sustain behaviour changes	Delivery of peer support model through Healthy Heart Project and evaluate impact	Number of peer support sessions delivered Number of residents engaged by peer support workers	Inclusion Barnet LBB Adults & Healthcare Public Health
4.2. People with clinical risk factors feel empowered to manage their condition	Support the NCL roll out of new approach to structured education for diabetes	Number (%) referred to structured education for diabetes Number (%) uptake structured education for diabetes	NCL CCG
	Understand mechanisms for remote and/or digital support for people living with CVD, scope to pilot	Identified remote/digital support for people living with CVD	LBB Adults & Healthcare Public Health LBB communications (Public Health)

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

publichealth@barnet.gov.uk