Barnet Cardiovascular Disease Prevention Programme: Action Plan

2022 – 2024

Contents

List of abbreviations

- AF – Atrial fibrillation
- AWM – adult weight management
- BBP - Barnet Borough Partnership
- HBP – High Blood pressure
- CVD – Cardiovascular Disease
- FAB – Fit and Active Barnet
- GP – General Practice/Practitioner
- HCPs – Health care professionals
- ICB – Integrated Care Board
- 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

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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.

Priority area 1: Population awareness & activation

Strategic objectives	Strategic actions	Action outcome measures	Delivery team	Timeline
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	Baseline awareness Change in percentage of self-reported awareness of CVD prevention in the population	LBB Living Well, Aging Well Public Health	Year 1, Q2
	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)	Year 1, Q2
	Collate and co-produce materials for resident education on CVD risks and prevention, customising where needed with communities	A suite of materials curated	LBB Living Well, Aging Well Public Health in collaboration with Voluntary & Community Sector and clinical reference group	Year 1, Q4 (1 pack per clinical condition, completed each quarter)
	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 – 8-12 developed in the Year 1	LBB Living Well, Aging Well Public Health and LBB Public Health Commissioning LBB communications (Public Health)	Year 1, Q4 To be determined as part of communications plan.
	Develop a dedicated area on CVD Prevention on the new public health microsite (Your Health Barnet) as a hub for information	An online hub dedicated to CVD Prevention in Barnet launched	LBB communications (Public Health)	Year 1, Q1
	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) Groundworks	Year 1, Q1 – 4 1-2 events per quarter
	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 Living Well, Aging Well Public Health	Year 1, Q3 – 4
	Peer support workers (as part of Healthy Heart Peer Support Project) to deliver information sessions on CVD risks and prevention in local community groups and faith communities	Number of sessions delivered Number of residents engaged	Inclusion Barnet	Year 1, Q1 – 2
	Evaluate the impact and reach of the communications approach and adjust plan	A refreshed communications plan	LBB Living Well, Aging Well Public Health and LBB communications (Public Health)	Year 2, Q1 – evaluate impact Year 2, Q2 – refresh approach

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Priority area 2: Behavioural risk factor detection & management

Strategic objectives	Strategic actions	Action outcome measures	Delivery team	Timeline
2.1 Reduce prevalence of smoking in deprived communities	Map CVD need, service availability and uptake	Detailed tartan rug of under 75 mortality by ward - by gender, ethnicity & deprivation; Baseline service provision/access (mapping) Baseline % of service uptake	LBB Insight & Intelligence	Year 1, Q2
	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	Year 1, Q3 Healthy Living Hubs will interrogate this
	Simplify referral processes (if necessary)	% referrals from HCPs	LBB Living Well, Aging Well Public Health and Primary Care	Year 2
	Deliver MECC (brief advice) training to frontline staff and volunteers across the Barnet Borough Partnership	Numbers trained	LBB Living Well, Aging Well Public Health	Year 1, Q4
	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 ICB Primary Care Team (Barnet) and LBB Living Well, Aging Well Public Health	Year 1, Q4
	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 (PH Team) and LBB Public Health Stop Smoking Service	Ongoing
	Embed use of DrinkCoach into primary care referral pathways	Development and implementation of GP primary care pathway for alcohol % uptake of online alcohol test and online coaching sessions	NCL ICB Primary Care Team (Barnet) and LBB Public Health Commissioning	Year 1, Q3
2.2 Reduce number of residents drinking to harmful levels	Deliver alcohol brief intervention training to clinical, non-clinical staff and voluntary & community sector	Implementation of Substance Misuse Strategy	LBB Public Health Commissioning	Year 2, Q1
	Scope and delivery of Healthy Living Hubs	Borough Task & Finish Groups established and concluded Implementation of Healthy Living Hubs Pilot at Borough Level	The Royal Free Group (PH Team) and Barnet Healthy Living Hub T&F Group	Year 1, Q2 Year 2, Q4
	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	Year 1, Q1 – Q3 (Grahame Park Vape Project)
	Deliver hyper-targeted interventions relating to weight management for people with learning disabilities (PWLD) and develop clear referral pathway	Implementation of the Food Plan Number of people with learning disabilities accessing weight management services	LBB Public Health - Healthy Environment team and Barnet Learning Disability Service	Year 1, Q2 (- Q4) – Tier II dietetics service Year 2, Q4 - Referral pathway
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	Year 1, Q2
	Development and promotion of self- referral to adult weight management programmes	% uptake local weight management services	LBB Greenspaces & Leisure and LBB communications (Public Health)	Year 1, Q1 Ongoing promotion
	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	Ongoing
	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 - Healthy Environment team and Barnet Food Working Group	Food Plan Launch, Year 1, Q2 DES training, Year 1, Q2 Food offer, Year 2, Q4
	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 Learning Disability Team	Year 1, Q4

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Priority area 3: Clinical risk factor detection & optimal treatment

Strategic objectives	Strategic actions	Action outcome measures	Delivery team	Timeline
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	Ongoing
	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	Year 1, Q2 (6 month extension)
	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 ICB Primary Care Team (Barnet) with general practice	Year 1, Q2
	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	Year 1, Q3
	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 ICB Primary Care Team (Barnet) with general practice LBB Living Well, Aging Well Public Health NDPP provider	Ongoing
	Support NCL projects to improve equity of access to the NDPP	Demographic of NDPP participants compared with National Diabetes Audit (NDA)	LBB Living Well, Aging Well Public Health NDPP Provider	Ongoing
	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 Living Well, Aging Well Public Health Community pharmacy	Year 2, Q4
	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 ICB (Barnet)	Year 1, Q2
	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	Ongoing

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Priority area 4: Self care & sustainability

Strategic objectives	Strategic actions	Action outcome measures	Delivery team	Timeline
4.1 People with behavioural risk factors are empowered to sustain behaviour changes **4.2. People with clinical risk factors feel empowered to manage their condition**	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 Living Well, Aging Well Public Health	Year 1, Q2 – possible extension
	Support the NCL roll out of Diabetes transformation programme structured education workstream	Scoping review completed Implementation of a single hub model for structured education	NCL ICB and NCL LTC Steering Group	Year 1
	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 Living Well, Aging Well Public Health LBB communications (Public Health)	Year 2

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

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