How can Integrated Neighbourhood Teams (INTs) support improved clinical outcomes for cardiovascular disease (CVD) prevention across the Sussex Health and Care System in the primary care setting?

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1. Introduction

Cardiovascular disease (CVD) encompasses conditions affecting the heart and circulatory system. This includes heart disease, strokes and peripheral vascular disease.

CVD is a leading cause of morbidity and mortality, becoming more prevalent with increasing age. NHS Sussex data indicates that people living in more deprived areas are four times more likely to experience premature death due to CVD compared to those in least deprived areas. Sussex has an above national prevalence of CVD.

Broad cause of death contributing to the life expectancy gap between the most and least deprived populations in Sussex (2020-21)

This study reviewed CVD risk factors and outcomes in Sussex and considered how the emerging Neighbourhood Health Service, may support earlier detection and modification of CVD-related risk factors.

The 10-year plan refers to a shift in clinical care from treatment to prevention and proactive care. The recently published Modern Service Framework for CVD reflects case finding and optimisation of CVD-related risk factors.

Hypertension, Cholesterol and AF management at INT level, March 2025

Condition		Hypertension (%)	Lipids Primary Prevention (%)	Lipids Secondary Prevention (%)	Atrial Fibrillation (%)	Stroke: last BP TTT	CHD: last BP TTT
Brighton and Hove	East	65.99	59.87	44.19	89.11	71.97	73.85
	Central	68.74	56.49	45.28	90.28	76.5	78.48
	West	65.62	59.34	43.21	89.66	74.25	74.8
East Sussex	Eastbourne	65.87	60.23	45.01	91.05	72.98	77.18
	Hastings	68.65	60.21	42.05	89.22	73.98	77.2
	Lewes	63.76	56.23	47.55	89.92	74.24	77.11
	Rother	69.16	56.95	46.17	91.5	76.72	78.22
	Wealden	69.9	56.73	48.01	92.77	76.63	79
West Sussex	Adur	68.11	61.07	40	90.03	72.6	77.06
	Arun	69.49	62.8	39.89	91.44	77.43	77.98
	Chichester	72.86	60.54	41.58	93.03	78.87	80.67
	Crawley	74.22	65.9	43.9	93.14	80.14	81.26
	Horsham	73.77	62.14	42.17	92.21	79.79	81.65
	Mid Sussex	70.67	59.97	45.2	88.98	77.63	80.02
	Worthing	65.08	57.52	38.49	88.23	71.73	74
Sussex		69.15	59.3	43.34	90.94	76.07	78.16
National		70.31	63.62	48.25	91.92	77.54	80.22

Indicator	Indicator Description
Hypertension	Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months (March 2024). Source: CVDPREVENT
Cholesterol	Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy (March 2024). Source: CVDPREVENT
Atrial Fibrillation	Patients with atrial fibrillation (AF) whose latest record of a CHADS2DS2-VASc 2 score is greater than or equal to 2, and who are currently treated with anti-coagulation therapy (2023/24). Source: QOF

2. Aim

To evaluate how INTs can support improved clinical outcomes for CVD prevention across the Sussex Health and Care System in the primary care setting.

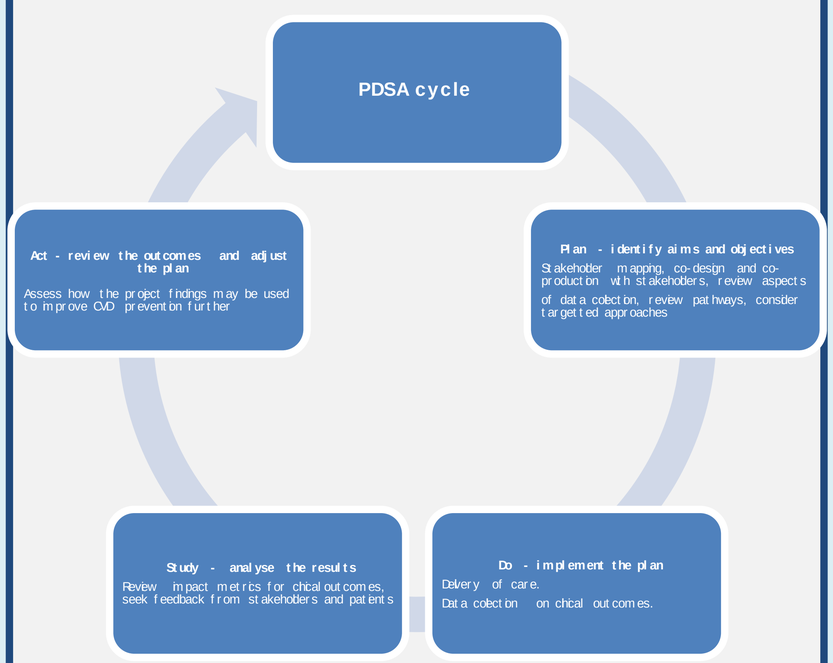
3. Objectives

- To undertake stakeholder mapping and build trusted relationships
- To work collaboratively on co-design and co-production with NHS Sussex, general practice, public health, community pharmacy and Voluntary, Community, and Social Enterprise (VSCE) stakeholders
- To create a community of practice to encourage a transformative approach to prevention
- Build a digital repository of resources
- To review aspects of data collection and analysis at an INT and GP practice level
- To consider targeted approaches to reduce health inequality
- To assess how the project findings may be replicated and scaled in other INTs. Sharing of learning at CVD regional and national groups

4. Achievements so far...

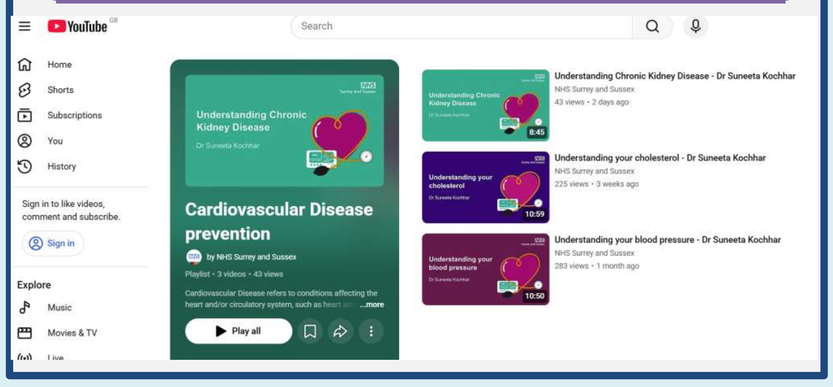
The project focussed on an INT in East Sussex where there was coastal deprivation and rurality over a large geography.

How effective leadership and change management in INTs support improved clinical outcomes for CVD prevention using the Plan-Do-Study-Act (PDSA) cycle



INT offer by Clinical Lead

Education and support of multidisciplinary workforce	Clinical education for GP practices, review of GP practice processes Education offer included webinar education programme and face-to-face teaching events
Data-driven approach	Regular peer benchmarking CVD outcomes data quarterly using bespoke dashboard. Review of NHS health checks using bespoke dashboard.
Working with community pharmacy	Text messaging and signposting to utilise advanced community pharmacy hypertension (raised blood pressure) pathway
Funding from pharmaceutical sector	Facilitation of arms-length funding from pharmaceutical sector to support lipid (cholesterol) lowering therapy
Collaborations with VCSE sector	Provision of written communications, easy-read materials Support for blood pressure monitor loan system in the community Support of behavioural risk factors by referral to healthy lifestyle services. Education of VCSE colleagues
Public awareness events and support for patient participation groups (PPGs). Creation of Digital Learning Resources	Support for 'Know Your Numbers' blood pressure national campaign. Multilingual and co-produced easy-read materials including videos for people with a learning disability.



5. Future impact

- The INT approach resulted in performance that exceeded expected trajectories, suggesting that ongoing neighbourhood working can support CVD prevention knowledge mobilisation.
- The arms-length pharmaceutical project delivered significant gain therefore this was replicated across 15 Primary Care Networks (PCNs).
- The community pharmacy pathway has been successfully replicated over much of Sussex.