How can Integrated Community Teams (ICTs) 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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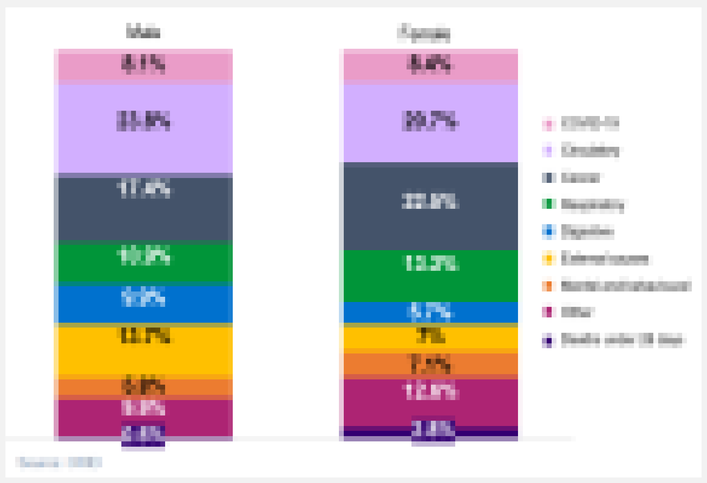
1. Introduction

Sussex has an increasingly ageing population with more people living with long-term conditions such as heart disease, stroke and circulatory problems. This group of conditions can be referred to as cardiovascular disease (CVD). CVD is the leading cause of death in Sussex, with South Asian and Black communities facing the highest risk. It is also the leading cause of death for people with learning disabilities in Sussex.



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

Raised blood pressure and smoking are the greatest risk factors for CVD, other risk factors include being overweight and diabetes.

In order to keep people living well for longer and to reduce the risk of them developing CVD, it is important to address these risk factors. Reviewing local data is helpful and it can guide how and where to deliver interventions.

This data can be reviewed for GP surgeries but also on a wider geography so that interventions can be planned at scale.

This project will consider how to address risk factors that contribute to the development of CVD, to improve the health of our local population.

The approach will involve looking at existing services and how their services may be best employed and how these link with GP surgeries.

This work will be supported by colleagues that are responsible for public health, community pharmacy and voluntary or community organisations.

2. Aim

The purpose of the knowledge mobilisation project is to evaluate how ICTs can support improved clinical outcomes for CVD prevention across the Sussex Health and Care System in the primary care setting.

3. Objectives

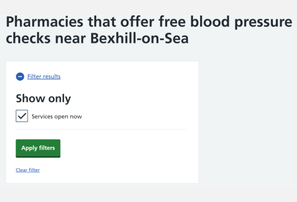
- To undertake stakeholder mapping and build trusted relationships
- Literature review to identify evidence-based recommendations
- To work collaboratively on co-design and co-production with NHS Sussex, general practice, public health, community pharmacy and VSCE stakeholders
- To create a community of practice and encourage a transformative approach to prevention
- To review aspects of data collection on clinical outcomes
- To perform data analysis on the above objective at an ICT and GP practice level
- To assess how the project findings may be used to improve CVD prevention in other ICTs. Development and implementation of CVD prevention model in further ICTs.

4. Achievements so far…

- **Stakeholder mapping**
- **Co-design and co-production with community pharmacy**

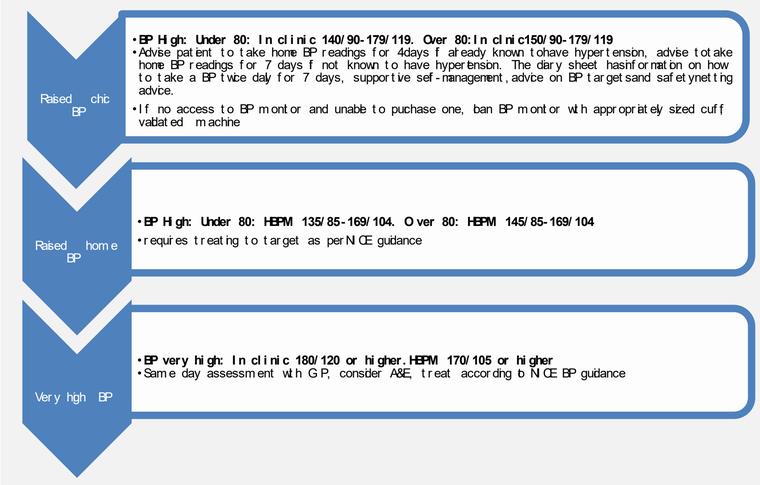
1. Offer of support of how to implement innovative pathway - AccuRx utilisation of texting initiative to increase collaborative working and identification of undiagnosed hypertension by using the NHS Community Pharmacy Blood Pressure (BP) Check Service.

2. Suggested text message content. A Postcode finder link is included within the text message so patients can choose a participating pharmacy. This link is updated nationally and provides information such as opening hours and contact details.



3. The LPC contacts pharmacies to ensure the process is cascaded so that pharmacies are aware GPs are texting patients and to expect referred patients .

4. Review of processes within GP surgeries to receive and act upon BP readings. Provision of patient pathway to demonstrate BP thresholds and interventions.



- **To review aspects of data collection on clinical outcomes**
- **Data analysis on the above objective at an ICT and GP practice level**

Hypertension, Cholesterol and AF management at ICT 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

5. Future impact

- Early detection and modification of risk factors.
- Promote health and wellbeing and reduce health inequality in those living with comorbidity.
- At-risk populations such as women, those living with serious mental illness and/or learning disability and other groups that may not engage with healthcare such as refugees and asylum seekers will be targeted.