



CARDIOVASCULAR DISEASE CARE

BEST PRACTICE

HEART UK is a national charity dedicated to preventing premature deaths caused by high cholesterol and cardiovascular disease (CVD). We work to raise awareness of the risks of high cholesterol, campaign for better detection of those at risk, develop and provide materials such as booklets and patient education materials and a telephone helpline for the public run by dietitians and cardiac nurses, in addition to providing education support and professional development for health care professionals.

As part of our ongoing work, HEART UK have identified CVD best practice locally across England.



CURRENT CHALLENGES

More than 7.4 million people in the UK have CVD. While deaths from CVD have continued to decline year on year, CVD still accounts for 27% of all deaths in the UK and at an annual cost of £9 billion to the health service.¹ Currently, service providers are struggling to meet the increasing demand for CVD services as the prevalence of the disease rises.

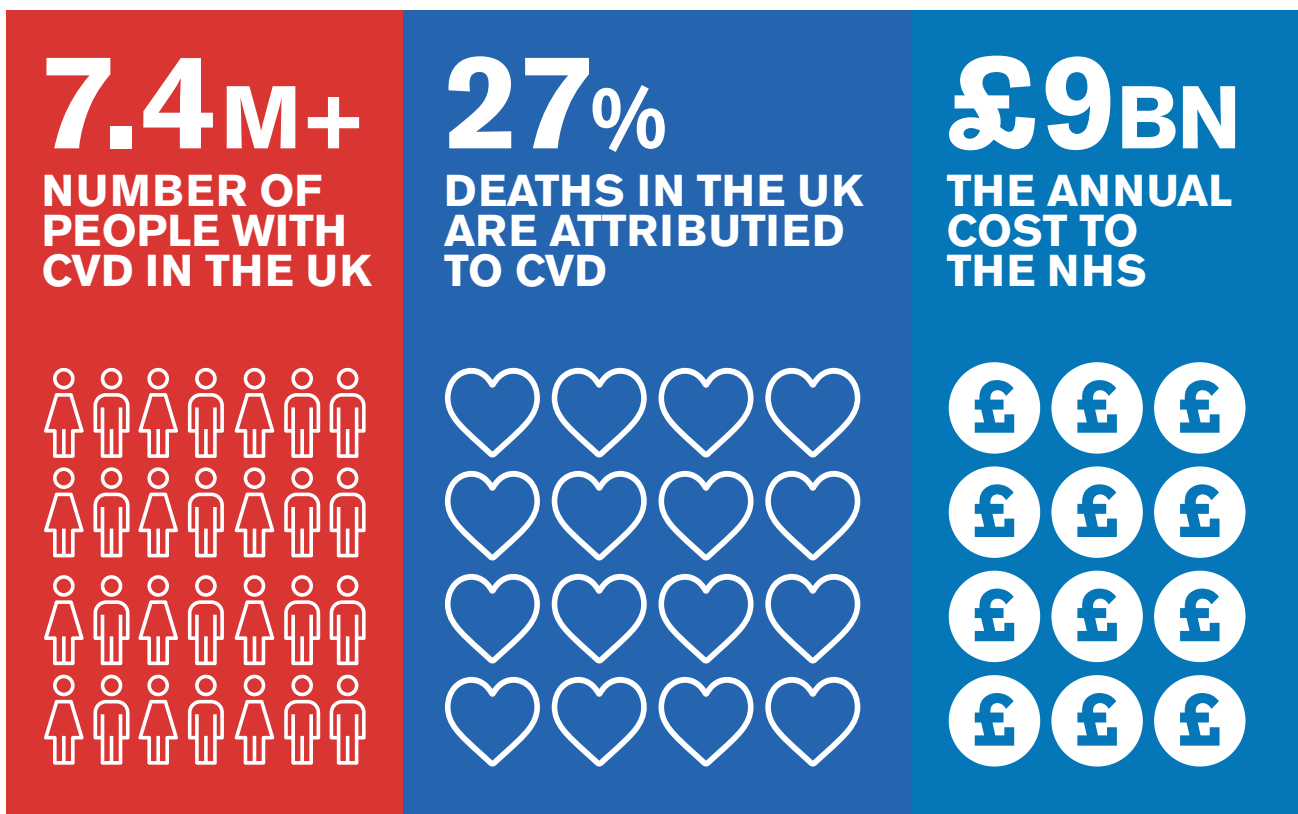
A HEART UK survey has also found that knowledge of cholesterol and CVD amongst the general public is poor:

- 53% of people were either wrong or unsure about the ages that you can access an NHS Health Check
- 28% of people between the age of 45-54 had never had their cholesterol levels checked
- 49% of people over the age of 65 did not know their cholesterol levels

Changes throughout our healthcare system, such as moves to adopt integrated healthcare systems, aim to bridge the important gap between primary and secondary care, inclusive of community and acute care services which are especially relevant for people living with CVD.

Rethinking how we approach CVD care, as healthcare providers become increasingly overburdened, is critical to ensuring that the UK continues to see CVD outcomes improve. Thinking innovatively about how this care is supplied, and how the disease is understood, is not only important in terms of real patient outcomes but will also save the health system money.

HEART UK has conducted a series of stakeholder interviews to establish CVD best practice locally across England. The examples featured in this toolkit are aimed at sharing best practice and encouraging other services in England to enact similar approaches that will support care improvements in CVD care.



Holistic care

Localising the provision of CVD care in the community can be an effective method of improving health outcomes, especially when considering the ability to target local populations. If done effectively, delivering CVD care within the community can relieve pressures on overburdened secondary care services, drive behavioural change and increase risk reduction. Studies across the UK have shown that services like rapid access chest pain clinics, that are based within the community, have been found to improve access, and reduce hospital admissions.²

² J. Downing et al 'Impact of a community-based cardiovascular disease service intervention in a highly deprived area', Heart, 2019

CASE STUDY:

'One-stop shop' for CVD care: Bringing a cardiology service into the community

INTERVIEW WITH DR CHRIS ARDEN



In addition to his role as a GP, Chris Arden was instrumental in the setup of community cardiac clinics in Southampton and Winchester where he currently works as a GP with a Special Interest (GPSI) in cardiology.

The community cardiology service operates a one-stop model, assessing patients with suspected heart failure, atrial fibrillation, palpitations, hypertension and valvular heart disease, with the ability to fast-track patients requiring further investigation or urgent attention. The community cardiac service provides echocardiography, ambulatory ECG, blood pressure and event recorder monitoring; whilst receiving consultant mentorship support from secondary care colleagues and working in partnership with specialist heart failure and cardiac rehabilitation nursing colleagues.

Developing a cardiology service in the community has simultaneously resulted in

reducing demand on the secondary care system and administrative costs, together with improving access to initial cardiovascular diagnostics in a more convenient setting for the patient. As a result, patients are able to access echocardiography in 3-4 weeks as opposed to the 6-week target wait time in England. Additionally, 82% of patients remain within the community care setting, not requiring onward referral. This pathway ensures patients get an enhanced level of support and advice within a community setting, including increasing access to GP-led cardiovascular diagnostics, 24-hour ECG, echocardiography and rapid access to hospital-based cardiology clinics when appropriate.

This community-based model has been extremely effective in Southampton and Winchester, demonstrating the positive value and impact of these services in improving the care and support of cardiovascular patients.



KEY TAKEAWAYS:

- **Localising care can reduce financial and administrative pressures facing secondary care providers.**
- **Being a 'One-stop shop' provider, the community cardiologist service can increase access to vital and lifesaving CVD diagnostics, reducing the need for emergency hospital admissions.**



OUTCOMES:

- **Reduction in cost through a reduction in emergency hospital visits and lower administration costs.**
- **Improved patient experience.**
- **Decreased wait time for diagnostic services.**

Healthcare inequalities

CVD is one of the conditions most strongly associated with health inequalities. In England's most deprived areas, people are almost four times likely to die prematurely than those in the least deprived. CVD is also more common where a person is male, older, has a severe mental illness, or ethnicity is South Asian or African Caribbean.³ Public Health England, through the Cardiovascular Disease Prevention System Leadership Forum, has set a number of ambitions to improve detection and management of CVD over the next 10 years, with a focus on reducing health inequalities. One way to achieve these ambitions is through developing novel strategies to reach ethnic minority populations.

3 J. Waterall, 'Public Health Matters: Preventing Cardiovascular Disease', Public Health England, 2019

CASE STUDY:

Reaching the hard to reach: Improving access in the South Asian Community

INTERVIEW WITH PROFESSOR KIRAN PATEL



Over 20 years ago Professor Kiran Patel recognised that there was a significant lack of understanding of major health conditions for South Asians, including diabetes and CVD. Inadequate guidance and community stigmas meant that significant health inequalities presented across the South Asian Community. The South Asian Health Foundation was established to highlight and address the substantial health inequalities for South Asian Communities in the UK.

Through providing community engagement, clinical advice and research opportunities, the South Asian Health Foundation has been central in promoting improvements in the quality and access to healthcare for South Asians. Their specific cardiovascular working group ensures that the Foundation improves cardiovascular health, disease and healthcare for South Asians.

By tailoring resources to the languages of the South Asian Community, and by using popular South Asian iconography such as themes of Bollywood, the South Asian Health Foundation has worked to educate their community and dispel myths that concern specific conditions.

Alongside their annual conference, which brings together healthcare professionals who are interested in improving the healthcare outcomes for South Asians, the Foundation also hosts in-community events. Such events have provided a critical opportunity to screen the attendees for major health conditions, provide advice on healthy lifestyles and importantly generate awareness in the local community.



KEY TAKEAWAYS:

- Organisations such as the South Asian Health Foundation offer useful opportunities for partnership and collaboration for system leaders in accessing hard to reach communities.



OUTCOMES:

- Increased awareness, education, and understanding of CVD for a high-risk patient population.

Collaboration between healthcare professionals

Collaboration between healthcare professionals with different expertise and experience enables knowledge sharing and workforce development, which is both beneficial to the healthcare professionals involved, and their patients. The NHS England Interim People Plan is committed to this principal, particularly in regard to professional development.⁴ Also, as collaboration is becoming increasingly relevant with the reorganisation of NHS systems to a more integrated approach, individual localities are coming up with new ways to share knowledge and build relationships must be used, such as online platforms.

CASE STUDY:

Thames Valley health community WhatsApp group

INTERVIEW WITH DR RAJ THAKKAR



In 2019 Dr Raj Thakkar, Clinical Commissioning Director for Planned Care for Buckinghamshire CCG, Cardiac Lead for Oxford AHSN and Long Term Condition Lead for Thames Valley Strategic Clinical Network, sought to improve and encourage communication between healthcare professionals working in commissioning and primary care in the Thames Valley area. To achieve this, Dr Thakkar created a WhatsApp group for healthcare professionals. Initially composing of several healthcare and managerial personnel, the WhatsApp group has now grown into a communication channel that spans across the country.

Critically, as the group has grown, it now not only includes those interested in the organisation and delivery of primary care

but includes national and regional directors, providers, the third sector, dentists, pharmacists and other leading healthcare professionals from across the patient pathway.

Now with nearly 180 members, this national collection of healthcare leaders and interested parties is an effective communication channel that has created a sense of enthusiasm that urging people to deliver better care and share ideas and projects, helping to connect formerly disparate organisations and fostering a forum for debate.

By taking this collaborative approach, the Thames Valley WhatsApp Group provides an environment where professionals can accelerate improvements in care through sharing best practice and identifying opportunities to collaborate.



KEY TAKEAWAYS:

- Fostering professional collaboration does not always need to be costly and time consuming.
- Collaborating with those across regions and different professions, including non-health professionals can be more valuable than local collaboration.
- Many online platforms are available to support collaboration and easy to use.



OUTCOMES:

- Through taking a simple yet effective approach to healthcare communication, healthcare providers and system leaders have been able to forge an e-community that fosters a collaborative approach to CVD provision and unites geographically disparate clinicians.

Prevention

The NHS Health Check Programme is aimed to support prevention by offering a cardiovascular risk assessment that gives advice to adults in England. First introduced in 2009, its success has varied greatly across the country, due to differing levels of uptake. Despite the challenges in uptake, NHS Health Checks are an effective way of driving prevention, early diagnosis and public awareness of CVD.



CASE STUDY:

Leeds Health Checks

In response to the national 'Putting Prevention First: Vascular Checks and Risk Management' strategy, launched in 2009, NHS Leeds set an overall aim of reducing mortality rates from CVD and reducing the inequality gap across Leeds with an aim to reduce health inequalities for the poorest fastest. To achieve this the initial programme targeted specific practices with more than 30% of their practice population living in the most deprived areas of Leeds and targeted individuals considered to be at 'high risk' of CVD.

Since its roll out in 2011, NHS Health Checks have been offered to 90% of the eligible population over the last five years (2011-16). A key factor in achieving this success has been Leeds working in partnership with key stakeholders. In 2017, an audit on the Leeds NHS Health Checks showed that despite all Leeds GP practices offering the service, uptake was declining across the city and variation existed across practices.

Following a review of the service, a new model was suggested with an even stronger focus on reducing health inequalities. The refreshed NHS Health Check service targets groups who are most likely to receive the

greatest health benefits. The high-risk groups identified were people with a BMI >30 and deprived populations, whilst maintaining a universal offer to all the eligible population in Leeds. Other changes included increasing the flexibility of services, such as offering appointments at evenings and weekends within Primary Care Networks as well as GP practices. In 2014, the Leeds Health team were awarded with the NHS Health Check Award for 'Best Impact for Patient Experience'.

Ensuring that the NHS Health Checks programme has been communicated effectively has been critical to the success of the programme. Leeds City Council and Leeds Clinical Commissioning Group have worked closely with Public Health England to create bespoke marketing campaigns. They have used a variety of media, including posters, leaflets, billboards, radio campaigns, visiting groups, local magazines, press releases, video production and Facebook advertisements to communicate the importance of the service. Through utilising local data, Leeds have been able to target communities with low uptake rates and share specialist material to ensure resources are used efficiently.



KEY OUTCOMES:

- **Between 2011-2016, and as a result of the Health Checks Service between 2011-2016, 16,593 individuals were identified with a >20% 10-year CVD risk, 6,444 patients with hypertension and 2,236 at high risk of developing diabetes.**
- **Increasing uptake of the NHS Health Check in Leeds's most deprived patient populations has improved the prevention, identification and understanding of CVD in the city.**



TAKEAWAYS:

- **Uptake in NHS Health Checks can be improved when communications efforts are targeted, and the patient population segmented.**

Collaboration with the third sector

The third sector is a key component in the provision of health services. The work of voluntary and charity groups is critical in providing patients with additional support and advice in ways that the NHS is unable to. The flexibility and diversity of the third sector enables several third sector organisations to provide advice and support around prevention and post-diagnosis care, as well as advocacy and signposting. The third sector is a valuable partner for the NHS as demands on the health service grow.





CASE STUDY:

HEART UK Support

Charities like HEART UK provide on-the-ground support and expertise that is a vital resource for patients who need further advice about CVD. HEART UK operate several services that offer vital information about both living with CVD and CVD prevention.

HEART UK run a cholesterol helpline that is open Monday-Friday. This helpline is staffed by specifically trained dietitians and nurses who provide impartial support and advice to patients. To provide tailored support to ethnic minorities, on a Tuesday, HEART UK also provide this advice in Punjabi, Urdu and Hindi.

HEART UK have also established a Nutrition Academy, set up to support healthcare professionals with free and scientifically reliable advice on diet for lipid conditions

and other complex and rare disorders. The service also provides online training, forums for debate, teleconferences and other online resources to help support clinicians in making better informed decisions. Importantly, all the advice and guidance is vetted by HEART UK's dedicated Advisory Panel to ensure it is scientifically accurate.

Ensuring that healthcare professionals have a forum to share advice and discuss CVD is critical to ensuring good and equal access to care. Seeing a need for a forum of this type in the Familial hypercholesterolaemia (FH) space, HEART UK established the FH Intelligence Network. This network of system leaders and commissioners is able to pool knowledge to overcome challenges and identify solutions to aid the running of effective FH care provision.



KEY OUTCOMES:

- Working collaboratively with third sector partners can offer patients and healthcare professionals with additional support and increase the understanding and awareness of health conditions.



TAKEAWAYS:

- The third sector will run and organise a multitude of initiatives and programmes that look to supplement understanding.
- The Third sector should be called upon to offer expert advice and operate as a first port of call.

Checklist

In this document, HEART UK has identified examples of best practice CVD care from across England. Whilst the pressures faced by the health system are ever increasing, the challenges presented are not insurmountable when attempting to provide best quality care.

Therefore, when providing CVD care to a local population, HEART UK encourages all care providers to ensure that they provide the below Gold-Standard support, where possible:



Provide holistic care wherever possible, involving local professionals with a speciality in cardiology, for example GPs with Special Interests.



When providing support, ensure that hard to reach communities are considered and that tailored support is available, encouraging these groups to access care.



Ensure that professional collaboration is encouraged both locally and nationally via attendance at networking events and through other innovative forms of communication.



Service providers should ensure that the NHS Health Checks Programme is supported, and due attention is given to increasing awareness and uptake of Health Checks locally.



Service providers should look to the third sector to support healthcare professionals and patients with tailored intelligence and knowledge.



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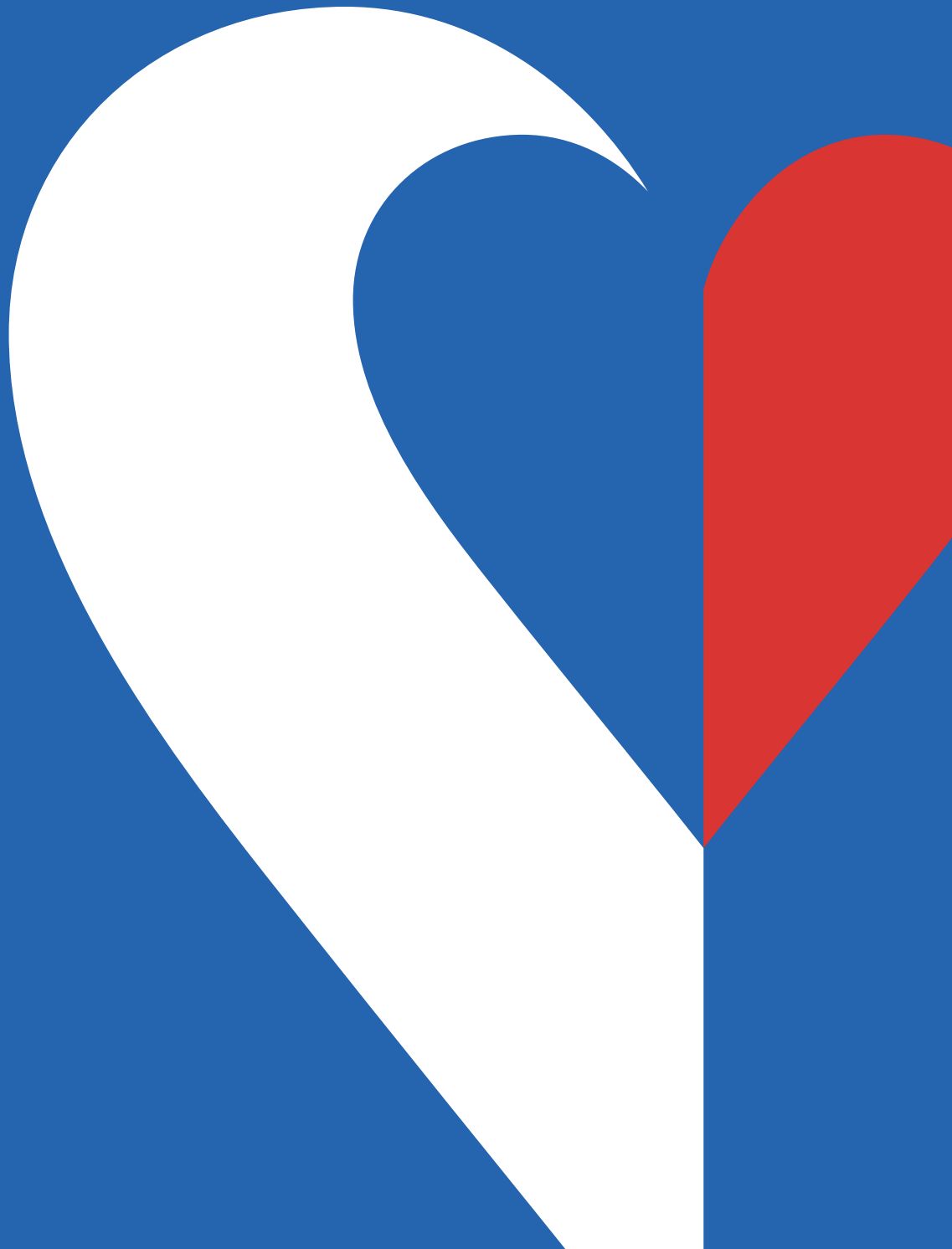
About us

HEART UK is the only charity in the UK that supports people with raised cholesterol as well as healthcare professionals that treat the condition. We strive to end premature death caused by cardiovascular disease.

Phone number: 01628 777046

Website: www.heartuk.org.uk

Email: simon.williams@heartuk.org.uk





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Registered address: 7 North Road, Maidenhead, Berkshire, SL6 1PE

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