Greater Manchester Cardiovascular Prevention Plan

For people from across Greater Manchester (GM) to come together to support our system's ambition for delivering better quality of life and healthcare outcomes for all through tackling cardiovascular disease (CVD):

1. An improvement in population health.
2. A reduction in health inequalities aligned to CORE20+5 ethos.
3. The delivery of better more personalised care through the transformation of community-based care.

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1. Overview

1.1. Cardiovascular disease or CVD is a general term for conditions affecting the heart or blood vessels and includes angina, heart attacks, strokes and heart failure. People with high cholesterol (Hyperlipidaemia), high blood pressure (Hypertension), diabetes and an irregular pulse (known as AF) are at significantly increased risk of CVD and these are known as the *"high risk conditions",* which are in themselves, often related to lifestyle factors such as diet, smoking, physical activity and weight. These lifestyle factors are also associated with wider demographic factors such as education, employment, social support and deprivation. CVD Prevention encompasses consideration of all of these, ultimately aiming to keep people healthy and well.

1.2. CVD has been identified as the single biggest area where our NHS can save lives over the next 10 years. Not only does it contribute to the gap in life expectancy between the rich and poor, it is also the leading cause of premature death and health inequalities across Greater Manchester (GM) where heart & circulatory diseases will kill more than 1 in 4 people.

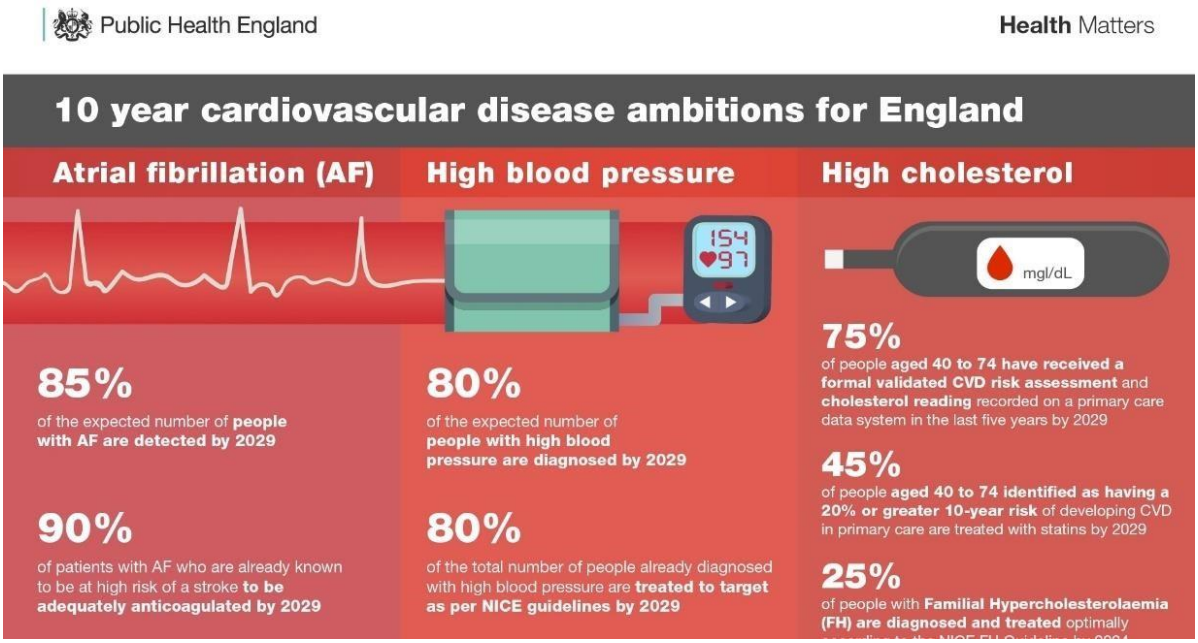

Figure 1: 10 Year CVD Ambitions for England[1]

[1] Public health England (2019). Health matters: preventing cardiovascular disease. Available at https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/healthmatters-preventing-cardiovascular-disease

1.3. CVD is highly linked to inequalities, with significant unfair differences in outcome between citizens of differing ethnicity and level of deprivation. NHS England's Core20PLUS5 model[2] specifically describes the importance of hypertension case finding and optimisation, cholesterol optimisation and smoking cessation in the reduction of inequalities as part of a Population Health Management (PHM) approach to care.

Tackling CVD is critical to narrowing the gap in outcomes between different groups of people within our population.

1.4. COVID-19 has not only highlighted but exacerbated long-standing socio-economic inequalities in the UK. Indeed, a map of child mortality from 1851 bears striking similarities to a map of COVID-19 mortality rates, which in turn map almost identically to CVD prevalence rates.

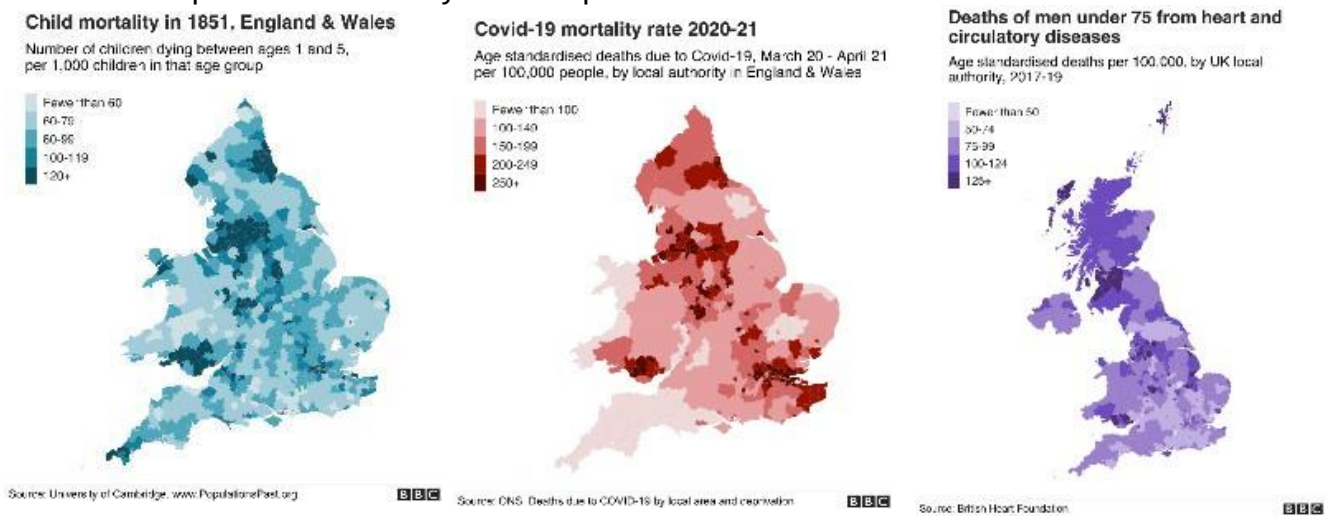

Figure 2: Links between CVD, Inequalities and COVID-19[3]

1.5. Minority ethnic groups and people with CVD and high-risk conditions such as obesity, diabetes and hypertension contributed to over 75% of the deaths from COVID-19 during 2019/20.

Reducing the prevalence of CVD and co-morbidities is, in itself, an important factor in mitigating against the future adverse health impacts of *Living with COVID-19.*

[2] NHSE (2020). Core 20PLUS5. Available at https://www.england.nhs.uk/about/equality/equality-hub/nationalhealthcare-inequalities-improvement-programme/core20plus5/

[3] BBC (2021). Dying too young: Map shows little has changed in 170 years. Available at https://www.bbc.co.uk/news/health-57730353

Supporting the initiatives that drive improvement in the core determinants of health cannot be underestimated, and work is ongoing across the ICS and at Place to support those huge cross-cutting agendas. The priority in the short term would be to align the myriad of programmes that currently exist in an effort to minimise duplication and improve return on investment. An example of such programmes are smoking cessation and weight management services, with several different initiatives across and within localities, leading to duplication, confusion and missed opportunities.

1.6. In 2022, NHS England published the National CVD Prevention Recovery Plan[4], a framework for local CVD prevention programmes. In line with this, the GM system CVD Prevention plan will initially focus on **recovery** and the **systematic detection and optimisation** of people with the 'ABC' of CVD risk conditions (AF, high BP and high cholesterol).

1.7. Figure 1 describes the GM plan-on-a-page for CVD Prevention Improvement.

1.8. Our initial **GM key objective for CVD improvement** is to support recovery from COVID-19 and return performance to pre-pandemic levels.

Our vision is for all GM stakeholders to work together to enable our system's ambition to tackle CVD; we want to ensure we support a better quality of life and healthcare outcomes for all through our agreed aims:

- Recovery from COVID-19
- Meet the national ambitions for the detection and control
- Reduce inequalities
- Support ICS priorities

1.9. While this initial plan does seem to focus mainly on clinical areas, the underlying complexity and overlap with social and wider determinants of health means that a concerted system wide response will be required, combined with new ways of working with and for our communities and starting to really change the dialogue from one about *patients* to *people*.

[4] NHSE (2022). National CVD Prevention Recovery plan. Available at https://www.england.nhs.uk/publication/cardiovascular-disease-prevention/

FIGURE 1: GM CVD Prevention Plan-On-A-Page

Our vision is for all GM stakeholders to work together to enable our system's ambition to tackle CVD; ensuring we support a better quality of life and healthcare outcomes for all.

Our agreed aims are to:	**Deliver improvements in population CVD prevention by:**	**Reduce health inequalities as aligned to CORE20+5 by:**	**Deliver better, more personalised care by:**
	• Making CVD a priority through winter • Supporting uptake of CPCS • Agreeing adherence to GM CVD standards • Agreeing monitoring & reporting via strong governance	• Restarting health checks using high risk stratification	• Working with communities to overcome barriers • Co-producing services • Transitioning to person centred-care

To deliver our aims we have set our key GM principles for the improvement of CVD Prevention:

Our GM principles are to:	**Support system leadership. We will:**	**Monitor and target unwarranted variation. We will:**	**Support a system-wide response. We will:**	**Raise public awareness. We will:**
	• Establish GM CVD Prevention Oversight Group • Enable CVD leads within Place and PCNs to improve care through provision of agreed tools, guidance, and strategies to make a difference locally • Develop of a CVD Recovery and Prevention Strategy that identifies shared priorities across all LTCs and embed within other work programmes • Facilitate system level coordination/alignment of CVD Prevention related activities	• Support Places to use CVD Prevent audit data to target populations based on CVD inequalities and variation in care. • Create minimum standards for ABC conditions, aligned to CVD Prevent • Investigate systems for automated audit and feedback on performance • Create GM CVD Dashboard using shared care record, with a view to understanding variation and inequalities	• Support transformation of community based care. • Support general practice to recover the management of key risk factors in AF, hypertension and hypercholesteremia • Support/create GM toolkits for o AF/Hypertension detection, diagnosis and management o Secondary Prevention Lipid Mmt o Post MI pathway improvement o Integration/collaboration with community pharmacy & PCNs • Develop/signpost to workforce competencies and education programmes	• Support and standardise GM locality Train the Trainer schemes, public engagement and advertisements, community and asset-based models of delivery • Communicate campaigns to encourage more people to get their blood pressure checked • Engage with the public via VCSE organisations to inform the development of a CVD Prevention Strategy • Deliver a series of messages to raise awareness of CVD.

To deliver these principles for CVD prevention improvement, we will work to an agreed set of standards with an aligned minimum data set

Our agreed Standards of Care	**Secondary Prevention**	**AF**	**Blood Pressure**	**Cholesterol**
	• Support High Risk Stratification and proactive reviews using PHM approach • Tackle those at highest imminent risk of a CVD event (very high blood pressures, AF and not anti-coagulated, CVD and lipids not to target)	• Adherence to the recommendations outlined in the GM toolkit for people with AF and not anticoagulated	• Adherence to the recommendations outlined in GM Hypertension Toolkit • Ensuring appropriate completion of training and education aligned to role	• Adherence to the recommendations outlined in GM secondary prevention lipid pathway, • Centralised GMCR dashboards, creation of matching searches aligned to pathway, new GM standard

2. The GM picture

2.1. GM has amongst the highest rates of heart attacks and strokes in our region and England as a whole. In GM we have had significantly more people dying earlier than would be expected, which has largely been driven by excess deaths across the range of cardiovascular diseases and illnesses. Much of the ill health and many of the deaths associated with CVDs are **preventable** by modifying risk factors and the use of readily available evidence-based, cost-effective interventions and treatments.

Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) (Persons, 3 year range) 2017-2019

Directly standardised rate per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	40,666	28.1	27.8	28.3
North West region	6,766	34.9	34.1	35.8
Manchester	418	49.3	44.6	54.3
Tameside	263	44.3	39.1	49.9
Rochdale	237	43.3	38.0	49.2
Oldham	237	41.9	36.8	47.6
Bolton	285	39.3	34.9	44.1
Salford	202	36.8	31.9	42.3
Wigan	332	35.9	32.2	40.0
Bury	167	33.1	28.2	38.5
Trafford	175	30.2	25.9	35.0
Stockport	231	28.8	25.2	32.8

Source: Office for Health Improvement and Disparities (based on ONS source data)

Figure 3: Under 75 mortality rates from CVD considered preventable (2019)[5]

2.2. GM's stroke admission rate is the highest in the region which is important as stroke is the leading cause of disability, accounts for a significant portion of social care spend and with an estimated societal cost of £26 billion per year[6], while ultimately diminishing our populations quality of life.

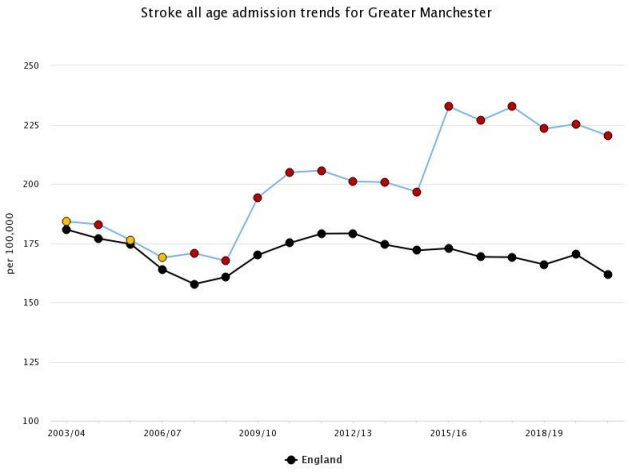

Figure 4: Stroke all age admission trends for GM (2018/2019)

[5] Office for National Statistics (2019). Under 75 mortality rates from CVD considered preventable. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2020

[6] Patel et al (2020). Estimated societal costs of stroke in the UKL based on a discrete event simulation. Available at: https://academic.oup.com/ageing/article/49/2/270/5679684

2.3. Many of the underlying risk factors such as physical inactivity, obesity and diabetes have worsened as a result of the COVID-19 pandemic. If concerted system wide action is not pursued, we may see a further increase in our rates of heart attacks and strokes. This will significantly increase the pressure within the acute sector and on social care.

Area	Estimated smoking QOF prevalence	Smoking status recorded in last 12 mths	Smoking: record of offer of support and treatment (15+, last 24mths)	Patients with record of blood pressure (45+, last 5yrs)	Obesity QOF prevalence (18+)
England	16.5%	93.8%	89.7%	89.5%	10.5%
STP	18.2%	94.1%	89.6%	90.3%	11.6%
Bolton CCG	18.2%	94.4%	88.4%	93.9%	14.1%
Bury CCG	16.4%	93.5%	90.6%	90.9%	10.9%
H'wood Mid'ton & R'dale CCG	20.2%	94.5%	91.6%	92.1%	13%
Manchester CCG	19.9%	92.7%	86.5%	86.2%	9.8%
Oldham CCG	18.9%	94.4%	89.5%	90.5%	13.4%
Salford CCG	20.5%	94.5%	91.6%	90.2%	12.4%
Stockport CCG	15.2%	94.6%	90.6%	90.3%	9.9%
Tameside and Glossop CCG	20%	94.3%	91.9%	90.5%	11.2%
Trafford CCG	13.4%	92.8%	91.6%	89.4%	10.5%
Wigan Borough CCG	16.9%	95.2%	90.1%	91.3%	12.8%

Figure 5: The impact of known risk factors to CVD across GM.

2.4. Health Checks have been significantly affected by the COVID-19 disruptions across GM and there are also significant variations in performance across localities. Bolton has been excelling with over 50% of eligible individuals receiving a health check, whereas Tameside and Salford have the lowest performance. This is concerning as health checks were traditionally the main method of finding those with unknown high-risk conditions and intervening before they go on to have an irreversible event.

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	4,172,449	26.3	26.3	26.3
North West region	–	649,814	31.3	31.3	31.4
Bolton	–	39,515	51.6	51.3	52.0
Rochdale	–	28,447	48.2	47.8	48.6
Bury	–	25,217	46.3	45.9	46.7
Lancashire	–	157,729	44.8	44.7	45.0
Manchester	–	49,262	33.7	33.4	33.9
Blackburn with Darwen	–	13,014	32.5	32.0	32.9
Wirral	–	30,279	31.5	31.2	31.8
Wigan	–	26,852	30.6	30.3	31.0
Halton	–	11,069	30.5	30.0	31.0
Trafford	–	21,232	30.2	29.9	30.5
Knowsley	–	12,395	29.3	28.9	29.8
Warrington	–	18,035	28.8	28.4	29.1
Cheshire East	–	34,134	28.5	28.2	28.8
Blackpool	–	10,771	26.3	25.9	26.8
Stockport	–	22,137	25.6	25.3	25.9
Cumbria	–	39,588	25.5	25.2	25.7
Cheshire West and Chester	–	23,376	23.6	23.4	23.9
Salford	–	14,766	23.3	22.9	23.6
St. Helens	–	12,316	23.2	22.9	23.6
Liverpool	–	27,599	22.5	22.3	22.8
Tameside	–	13,556	20.8	20.5	21.2
Oldham	–	11,785	18.6	18.3	18.9
Sefton	–	6,740	8.2	8.0	8.4

Source:
Local authorities collect information on the number of NHS Health Checks offered and the number of NHS Health Checks received each quarter and return this data to Public Health England

Figure 6: Number of health checks received each quarter across GM.

2.5. The latest Global Burden of Disease[7] report published in Lancet last year revealed that hypertension for the first time is now the single biggest global risk factor for preventable deaths and disability adjusted life years. Hypertension alone accounts for roughly half of all strokes and myocardial infarctions and we currently still do not know 40% of the estimated population prevalence[8] . Of those we know about, only 60% of them are treated to target.

2.6. NHS Benchmarking has developed a national primary care audit tool to support systems to understand how many patients with CVD and/or the high-risk conditions are potentially undiagnosed, or under or over treated. The audit, known as CVDPREVENT will provide data to highlight gaps, identify inequalities, and opportunities for improvement in six high risk conditions that cause stroke, heart attack and dementia: atrial fibrillation (AF), high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia and chronic kidney disease.

2.7. The CVDPREVENT data that describes the current position in GM with relation to the detection, diagnosis and management of these high risk conditions can be found at https://www.cvdprevent.nhs.uk/data-explorer?indicator=20. Key facts from this data source highlights the following:

- While cholesterol has the biggest variation across GM, hypertension has amongst the least variation, with Salford at 66% and Bury at 54% of hypertensives treated to target. There are also significant differences between ethnicities and deprivation although this varies within each locality.
- People who have already had a heart attack or stroke are at the highest risk of a further event. Optimising the cholesterol of such people significantly reduces their future risk of CVD events. On average and across GM, we are only adequately controlling the lipids of 23% of the highest risk patients. That means 77% of people who have already had a stroke or heart attack have cholesterol levels likely to lead to another event. There is also significant variation in cholesterol management across GM with Wigan and Salford performing significantly lower than the other localities.
- Atrial Fibrillation is a major risk factor for stroke however this risk can be minimised with appropriate anti-coagulation. Overall, as an ICS, we are performing reasonably well with regards to detection and management of people with AF. The least deprived are however statistically more likely to be anticoagulated than the most deprived, although only just. Furthermore, people from south Asian and black ethnicities are more likely not to be anti-coagulated, although we have above national performance for those of mixed ethnicity. Most of the localities are comparable although HMR is outlying in this regard.

2.8. The varied demographic across our GM footprint means that there are no clear winners across our localities, with each Place falling short or excelling in differing

[7] Lancet (2019) Global Burden of Disease Report. Available at https://www.thelancet.com/gbd [8] Public health England (2017). Health matters: combating high blood pressure. Available at: https://www.gov.uk/government/publications/health-matters-combating-high-blood-pressure/health-matters-combating-highblood-pressure

areas. This variation highlights the importance of locality responsibility and understanding of local communities and their needs to drive local improvements and inform considered and thought-out plans.

2.9. Healthcare does not exist in a vacuum and there is often a complex interplay between healthcare, society, politics and economics. While our performance against nationally agreed health targets may be due to our high levels of deprivation, one could argue it could still be reflective of a lack of responsiveness and ultimately a failure to meet the actual or underlying needs of the people we serve. This highlights the complexity when considering CVD prevention and ultimately the need to transform care to focus more on people and their needs.

3. The GM CVD Prevention Plan

3.1. We need a system-led, concerted effort to detect, diagnose and manage three key high-risk conditions: • Atrial Fibrillation • Hypertension • Hyperlipidaemia

3.2. This GM CVD Prevention Plan addresses the need to respond to the national CVD Prevention Recovery Plan and builds on our existing workstreams, structures and networks. It sets out an innovative, whole-system, population-health approach that empowers clinicians, non-clinical partners, patients, and communities across our system to work together to prevent CVD by providing alignment and co-ordination across different parts of the system.

3.3. The programme of work is initially based on the principles set out in the National CVD Prevention Recovery Plan (Figure 7). Altered to fit our GM system, the GM plan focuses on recovery and winter resilience in addition to putting in place governance and structures intended to lead to transformation over the longer term.

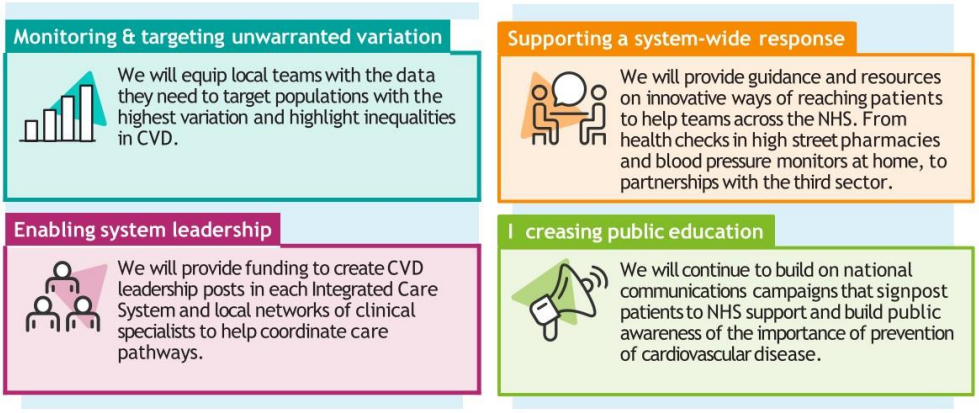

Figure 7: Key Principles: National CVD Prevention Recovery Plan.

3.4. The different strategies that can be employed to prevent CVD include public health interventions, screening and population health management. Public Health strategies may recommend small changes at the individual level that are "good for all" (e.g. 5-a-day, reduction of salt, sugar and trans-fats in processed

foods). High-risk strategies often bring larger benefits to those persons treated, and are "good for some", but require the explicit engagement of individuals.

3.5. Screening of individuals at high CVD risk can also be viewed as a strategy to detect sub-clinical CVD and care for these persons viewed as a mean to improve the prognosis of such subclinical CVD condition. Persons who have already developed CVD need to be treated to both improve their immediate prognosis and reduce the occurrence of further acute CVD events. Because persons who have already developed clinical CVD have a very high risk of developing further events, it is a priority to identify them and ensure they are optimally managed them to reduce their ongoing CVD risk.

3.6. GM's CVD Prevention Programme includes a mix of both high-risk interventions, public health initiatives and opportunistic screening, which all reinforce the other. For example, those people screened, and then effectively treated for CVD conditions may be inclined to support public health interventions, while implementation of public health interventions help sensitize the individuals about the need to adopt healthy behaviours and take long-term treatment when indicated.

3.7. Our GM **Principles for CVD Prevention Improvement** will support opportunistic screening, public health initiatives and high-risk strategies and include:

Principle 1 – To support system leadership

We will:

- Establish GM CVD Prevention Oversight Group.
- Enable CVD leads within Place and PCNs to improve care through provision of agreed tools, guidance, and strategies to make a difference locally.
- Develop of a CVD Recovery and Prevention Strategy that identifies shared priorities across all LTCs and embed within other work programmes.
- Facilitate system level co-ordination/alignment of CVD Prevention related activities.

Principle 2 – To monitor and target unwarranted variation

We will:

- Support Places to use CVD Prevent audit data to target populations based on CVD inequalities and variation in care.
- Create minimum standards for ABC conditions, aligned to CVD Prevent.
- Investigate systems for automated audit and feedback on performance.

- Create GM CVD Dashboard using shared care record, with a view to performance and inequalities.

Principle 3 – to support a system wide response

We will:

- Support transformation of community-based care.
- Support general practice to recover the management of key risk factors in AF, hypertension and hypercholesteremia.
- Support/create GM toolkits for o AF/hypertension detection, diagnosis and management. o Secondary Prevention Lipid Management. o Post MI pathway improvement.
- Integration/collaboration with community pharmacy & PCNs.
- Develop workforce competencies and associated educational/ support programmes.

Principle 4 – raise public and patient awareness of CVS prevention

We will:

- Support and standardise GM locality Train the Trainer schemes, public engagement and advertisements, community and asset-based models of delivery.
- Communicate campaigns to encourage more people to get their blood pressure checked.
- Engage with the public via VCSE organisations to inform the development of a CVD Prevention Strategy.
- Deliver a series of messages to raise awareness of CVD, stroke and diabetes symptoms.

3.8. We need to initially focus on recovery, restarting systematic detection and optimising secondary prevention of those at highest risk of a cardiovascular event. This is because there is the most to be gained and quickest return on investment for the system and economy. Over time and with a functioning oversight group, we can start to transform care with collaboration and alignment across the primary, secondary and tertiary prevention areas.

3.9. The delivery of these minimum standards will be measured against the nationally agreed CVD PREVENT audit data which will allow our system to gain a better understanding of variation in performance across GM. Data described in the CVD Prevent audit provides with quarterly pulls of data from GP computers. It

was last updated in June 22 and data is available down to the practice level across GM.

Based on the data, room for improvement and return on investment; our focus for the next 6 months is:

i. **To re-start systematic detection of the ABCs**

ii. **Optimise secondary prevention for the people at the highest risk of CVD**

- **Secondary Prevention of Hypertension**
- **Secondary Prevention of Lipids**

Re-establishing systematic detection of the ABCs

3.10. The GM CVD Prevention Oversight Group will prioritise the re-invigoration of NHS Health Check with a particular focus on high risk target groups to address inequalities in CVD mortality and morbidity which have been amplified by the Covid 19 pandemic.

3.11. The NHS GM Data Quality Service have developed a GM wide suite of searches to support the NHS Health Check (The GM Health Check Searches) requirements in partnership with key stakeholders through a GM NHS health check task and finish groups. The searches capture:

- Reporting Requirements (eligible patients, invites, health checks complete etc.).
- Invitations (patient lists for invitation, in priority order).
- Outcomes (patients added to registers, CVD Risk >20%, placed on a statin following a health check).
- Brief Interventions (advice re various subjects) / Referrals (to different services)
- Data Cleansing (invite codes, QRISK codes etc. that may be missing).
- Quick Wins (1 element only of an NHS HC missing so that practices can contact patients).

3.12. The CVD Prevention Oversight Group will support the GM system to improve quality and uptake of the NHS Health Checks programme by:

- Supporting the implementation of The GM Health Check Searches across localities.
- Agreeing a GM NHS Health Check template that support quality improvement of the programme.
- Maximising opportunities for communication across our system.
- Agreeing pathways and protocols to support brief advice and onward referral to primary and secondary prevention programmes such as social

prescribing, NDPP healthier you, weight management and smoking cessations.

- Re-establishing the GM NHS Health Check steering group.
- Identifying of Director of Public Health leadership at system and place to allow GM to build on areas of good practice such as Manchester, Bolton, Bury and Rochdale and the previous GM NHS Health Check digital pilot.

4. Optimising secondary prevention for the people at the highest risk of CVD: Hypertension

4.1. With each 2mmHg drop in systolic blood pressure associated with a 7% reduced risk of death from coronary heart disease and a 10% reduced risk of death from stroke, there are huge system gains from tackling just hypertension. Achieving 80% of hypertensives treated to target is achievable and realistic and could have immense benefits for the system and our communities. Figure 8 describes GM's current performance to target.

While our performance is up 12% from our mid-2020 position, we still have a significant way to go to reach pre-pandemic levels and further still to reach our target of 80% of people with high blood pressure treated to target.

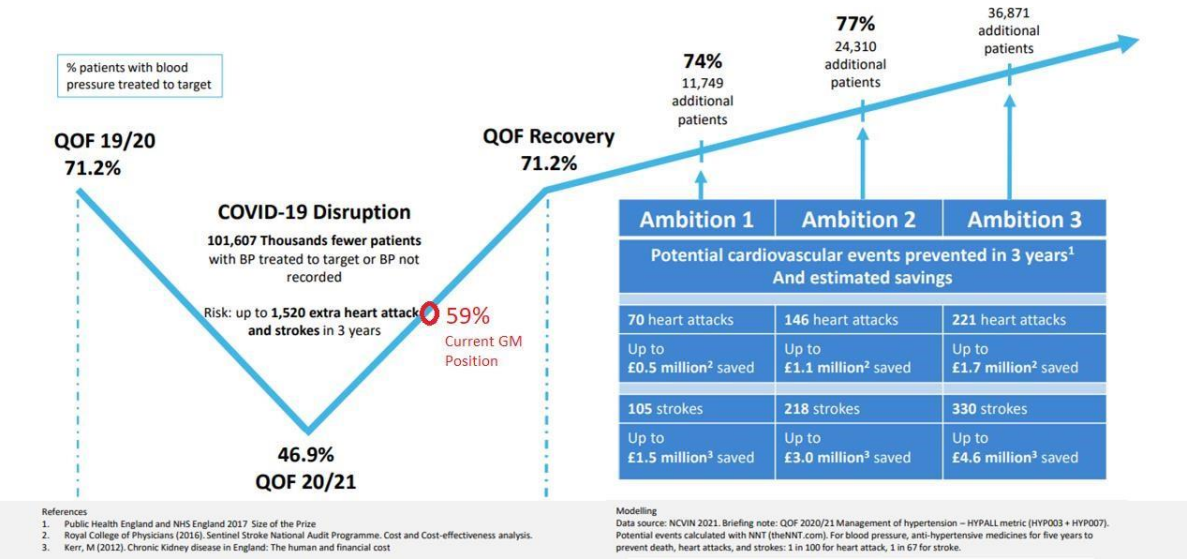

Figure 8: GM's performance for % people treated to target for hypertension.

4.2. General practice needs to focus on the appropriate assessment of people with single high BPs for the diagnosis of hypertension and appropriately managing those with very high blood pressures, through a population health management approach.

4.3. The wider primary care and community system should focus on case finding and opportunistic screening for those not already known to general practice, e.g. Community Pharmacy, Public Health outreach teams.

4.4. Figure 9 demonstrates how the programme of work uses a complexity informed systems approach to hypertension improvement targeting the whole pathway.

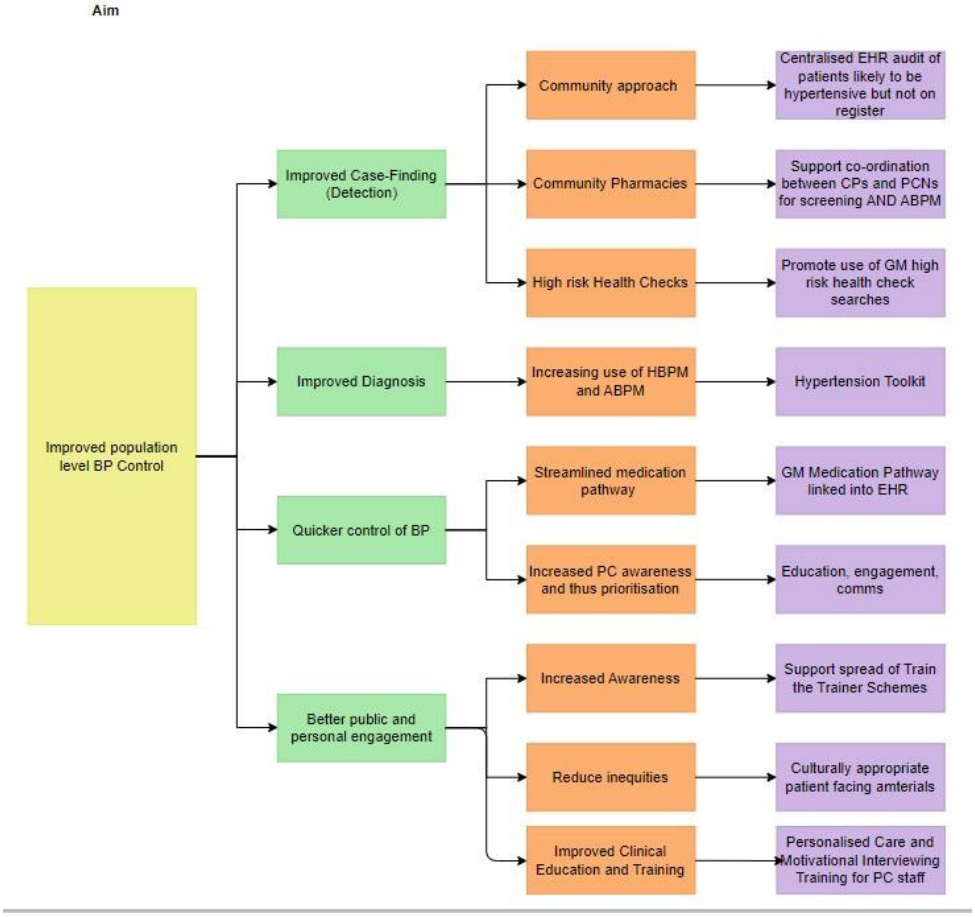

Figure 9: Systems approach to hypertension improvement.

4.5. The GM toolkit articulates the minimum standards supporting the delivery of Principle 2 and include:

- **Identification & Case-Finding:**
  All people with single raised BPs appropriately assessed for Persistent Hypertension (This aligns with IIF indicator CVD01).
- **Diagnosis:**
  All assessments for hypertension conducted using ABPM or HBPM (New indicator needed).
- **Treatment:**
  Treat to age appropriate Target (Aligns with QOF and IIF).
  Deliver a 10% yearly reduction in number of patients with last BP>180/120 through a high-risk stratification approach.

4.6. The toolkit supports delivery of Principles 3 and 4 by describing:

- Simplified Medication Treatment Guide (aimed at simplifying the medication pathway, incorporating community pharmacy and quicker control with less steps and fewer side effects).
- Examples of how Community Pharmacies could be used to reduce GP workload and improve outcomes for people with BP.
- Culturally appropriate and translated patient facing materials.
- Home Blood Pressure Monitoring Toolkit.
- GM VCSE and opportunistic BP screening standardised pathway/protocol.

5. Atrial Fibrillation in GM; recommendations for improvement

5.1. The most important intervention to reduce stroke risk with AF or having an irregular pulse is to ensure proper anti-coagulation. Overall, as an ICS, we are performing well as compared to England, and although most of our localities are comparable across all AF national targets, it is interesting to consider some key facts:

- Our least deprived citizens are statistically more likely to be anticoagulated than the most deprived citizens.
- People from Asian and black ethnicities are more likely not to be anticoagulated, although we have above national performance for those of mixed ethnicity.
- Only one of our localities would be considered an outlier which is HMR.

5.2. The GM ambitions for AF are:

- For 85% of the expected number of people with AF are detected by 2029.
- 90% of people with AF who are at high risk of a stroke have adequate anticoagulation by 2029.

5.3. The system-led response to the better management of Atrial Fibrillation will be through the implementation of the *"GM Toolkit for AF Improvement"* which focuses providing support and guidance for localities as they systematically approach the identification, diagnosis and treatment of people with AF.

5.4. This national programme of work focussed on the three key elements of the AF pathway:

- **Detect**:

  Raising public awareness of AF and the importance of pulse rhythm testing to identify those with undiagnosed AF.
- **Protect**:

  Supporting healthcare professionals to offer optimal anticoagulation medication to all those who would benefit.
- **Perfect**:

Supporting patients with their anticoagulation medication and supporting clinicians to review patients with AF.

5.5. The *GM Toolkit for AF Improvement*[8] supports delivery of Principles 3 and 4. It supports localities to investigate place-based data to embed improvement opportunities across the AF pathway including:

- A comparison of actual local AF prevalence to the NCVIN expected prevalence.
- The number of people in a locality with AF and at risk of stroke who are not receiving anticoagulation therapy.
- The number if people with an AF diagnosis who experienced an AF related stroke and how many were receiving anticoagulation therapy at the time of stroke.
- Comparison of local data with NHES CV ambitions for AF.

5.6. The toolkit will support localities drive:

- Earlier and better detection of AF through active case finding, screening and public awareness.
- Improved protection for individuals from AF related stroke through the initiation of anticoagulation therapy in line with GM medication pathways.
- Better treatment for people with AF through medicines optimisation, supporting adherence and self-management.

6. Hyperlipidaemia in GM; Our Position and Recommendations for Improvement

6.1. With each 1mmol/l reduction in LDL-C associated with a 22% relative reduction in major cardiovascular events, and with over 70% of our high-risk population suboptimally managed; we must also focus on this over the next 6 months.

6.2. A new GM standard for lipid modification for secondary prevention of cardiovascular will be introduced. This is in line with the local GM and national NHSE/AAC lipid pathway[10]. This new standard is:

- Patients at high risk of CVD (i.e. angina, stroke, MI, heart failure) require an LDLC <1.8 mmol/L and/or non-HDL <2.5 mmol/L.

6.3. The system-led response to the better management for hyperlipidaemia will be through the implementation of the *"GM Toolkit for Hyperlipidaemia Improvement"* which focuses providing support and guidance for localities as they

[8] AHSN network (2020). GM AF toolkit. Available at https://aftoolkit.co.uk/introduction-to-the-af-toolkit/ [10] NHSE (2021) Summary of the guidance for lipid management for secondary prevention of CVD. Available at https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2020/04/Summary-of-national-guidance-for-lipidmanagement-for-primary-and-secondary-prevention-of-cardiovascular-disea.pdf

systematically approach the identification, diagnosis and treatment of people with Hyperlipidaemia.

6.4. The *"GM Toolkit for Hyperlipidaemia Improvement" will* support the delivery of Principles 3 and 4 and contains an agreed:

- Secondary prevention lipids management medication pathway[9].
- Information leaflet for Primary Care Prescribers ordering/prescribing Inclisiran[10]
- Primary care lipids optimisation case-finding tool embedded within GP practice systems (EMIS, SystmOne, Vision), developed with GM system stakeholders and aligned to the GM Integrated Care Systems CVD prevention initiative.

6.5. Incorporation of the GM Lipids optimisation tool into the Greater Manchester Care Record (GMCR) will provide primary care stakeholders with a real-time view of patients requiring review at practice level. A key functional enhancement will be the ability to visualise data for patient characteristics including ethnicity, language spoken, language disability and gender at PCN and practice level. This will support the system's aim to reduce health inequalities for CVD.

6.6. Educational webinars, accessible for CPD portfolio points will be available to support clinicians to understand more about lipid management for secondary prevention of CVD and guidance and prescribing information for Inclisiran:

7. What will success look like?

7.1. By 2029, the GM system aims to have:

- Achieved the national ambitions for the detection, diagnosis, management and control of atrial fibrillation, high blood pressure, and high cholesterol.
- Improved access to, and the uptake of opportunistic screening and other CVD prevention interventions, particularly in currently underserved communities and groups where unwarranted variation in care and outcomes is most evident.
- Full system recognition for the importance of 'upstream' preventative activity, by supporting the ethos of *"Making Every Contact Count"* across our localities.
- Improved the relationships and driven better partnerships across system level programmes that support communities to be healthier.
- A cohesive approach to the reduction in CVD health inequalities across our system through the delivery of a population health improvement ethos.

[9] GMMG (2022) GM Lipid Management toolkit. Available at https://gmmmg.nhs.uk/wpcontent/uploads/2022/11/Lipid-Management-Pathway-for-Secondary-Prevention-of-Cardiovascular-DiseaseCVD-01.11.22-for-web.pdf

[10] GMMG (2022) Available at https://gmmmg.nhs.uk/wp-content/uploads/2022/11/Inclisiran-prescribersinformation-leaflet-13.10.22-for-web.pdf

- Improved access to cardiac rehabilitation, allowing the people of GM to access improved, integrated physical, psychological and mental health care.

7.2. We will have worked together to deliver these ambitious aims through a full pathway approach to service improvements. We will have developed, circulated, and embedded GM toolkits, pathways and processes that supported localities to:

- Improve the detection, diagnosis identification and management of BP to reduce heart attacks.
- Improve the management of cholesterol to reduce heart attacks and strokes.
- Improve the identification of Familial Hypercholesterolemia.
- Identify and treat Atrial Fibrillation (AF) and reduce AF related strokes.

7.3. These toolkits, pathways and processes will have enabled communities to:

- Self-care and self-manage their risk factors through better education.
- Take advantage of health advice and opportunities to improve their health.

7.4. We will have provided our localities with a set of standardised improvement measures that enable them to track progress to targets, highlighting success as we move towards our long-term outcomes for 2029. These measures for success will be:

- High BP diagnosis rates, & treatment to target levels.
- AF diagnosis rates, & treatment to target levels.
- High cholesterol diagnosis rates, & treatment to target levels.
- Diagnosis rates of Familial Hypercholesterolemia.
- The numbers of strokes within the adult population each year.
- The numbers of heart attacks within the adult population each year.

8. Conclusion

8.1. GM has the worst outcomes related to premature cardiovascular death in England. Furthermore, CVD is intimately linked with causing, worsening and perpetuating health inequalities, making this a major issue in GM.

8.2. Prevention means keeping well and CVD prevention covers many areas from education and housing, primary prevention and health checks through to optimally caring for those we already know have high risk conditions.

8.3. Achieving our ambition of not only recovering from COVID-19 but transforming health in GM needs contribution and involvement of many parts of our traditionally reactive and disparate system.

8.4. Due to the complexity with CVD prevention and the large scope the key to improvements will be **alignment and co-ordination** of different activities, programmes, and work streams to minimise confusion, duplication and missed opportunities.

8.5. While this initial plan does seem to focus mainly on clinical areas, the underlying complexity and overlap with social and wider determinants of health means that a concerted system wide response will be required, combined with new ways of working with and for our communities and starting to really change the dialogue from one about *patients* to *people.*