

From hospital to community: Delivering an integrated neighbourhood approach to CVD prevention



This non-promotional policy report has been developed and funded by AstraZeneca, and informed by desktop research and a series of discussions with ICB leaders. It is intended for healthcare professionals and policymakers.

Executive Summary

Despite significant advances in recent years, cardiovascular disease (CVD) continues to impose a substantial burden on communities across the UK, with disparities in outcomes between different regions.^{1,2} The government's 10-Year Health Plan³, with its strategic shifts toward prevention, community care, and digital transformation, and ambition to create robust neighbourhood health services creates an unprecedented opportunity to transform how CVD prevention and management is delivered at the neighbourhood level.

Local NHS systems face substantial challenges in delivering effective CVD prevention and management. Services remain fragmented and operate in silos, limiting care coordination and missing vital prevention opportunities. Workforce capacity constraints are compounded by a shortage of healthcare professionals equipped to address the complex multimorbidity spectrum associated with CVD risk conditions. Securing adequate funding for innovative CVD prevention and management programmes remains challenging, particularly given 'invest to save' expectations where prevention investments often lack easily demonstrable in-year savings. Additionally, limited patient understanding of their conditions and available services further hampers effective care delivery. These systemic barriers result in suboptimal patient outcomes and inefficient resource utilisation, making CVD an ideal testing ground for neighbourhood health approaches given its requirement for coordinated action across multiple risk factors and care settings.

An effective neighbourhood model for CVD prevention and management encompasses several key components:



Neighbourhood health teams for CVD who bring together multidisciplinary professionals to deliver coordinated care closer to patients' homes, changing when and where patients are seen to improve accessibility and continuity.



Systematic medicines optimisation to ensure patients receive the right medications at the right time. Pharmacy will play a crucial role in this approach providing case finding services, medication reviews and adherence support.



Data and digital innovation to enable population health management approaches, using digital tools for early intervention and risk stratification to identify and support high-risk individuals.



Voluntary, Community and Social Enterprise (VSCE) integration would leverage community assets to access hard to reach populations and play a role in patient activation around knowing risk factors and how to manage your condition.

The underpinning enablers to make this a success include workforce development, data infrastructure and interoperability, financial incentives and local leadership.

National action must focus on creating the enabling environment through GP and pharmacy contract reforms, robust economic evaluation frameworks for interventions, sustained workforce investment in multidisciplinary skills for multimorbidity care, and national direction for technology procurement to ensure system compatibility and data interoperability standards. Local implementation should be led by Integrated Care Boards (ICBs) and local systems who understand their populations' CVD risk profiles. Effective models will build on existing community strengths, create genuine partnerships between all care sectors, and continuously track progress to ensure improved patient outcomes.

Introduction

Cardiovascular disease (CVD) remains one of the leading causes of death and disability across the UK, and outcomes vary significantly between different regions.^{1,2} This variation reflects not only the interplay of clinical, social and environmental factors that affect cardiovascular health, but also the differing nature of how CVD services are currently delivered across the healthcare system.

The current policy environment, including the 10-Year Health Plan and move towards neighbourhood health, provides an exciting opportunity to reimagine how we prevent and manage CVD at the local level. CVD is an ideal test-case for neighbourhood health approaches as CVD prevention requires coordinated action across multiple risk factors and management spans primary, secondary and community care.

This report examines how local NHS systems can overcome the current barriers to delivering quality care by implementing an integrated neighbourhood approach to CVD prevention and management. The government is already seeking to identify pockets of best practice in relation to joined-up working and innovation to pioneer an initial phase of the neighbourhood health programme.⁴

This report explores what best practice might look like from the CVD perspective, and what we can learn from existing approaches. It draws on discussions with experts from ICBs who work in long-term conditions and CVD, alongside comprehensive desk research.



This report examines how local NHS systems can overcome the current barriers to delivering quality care by implementing an integrated neighbourhood approach to CVD prevention and management.

Local variation in cardiovascular disease outcomes

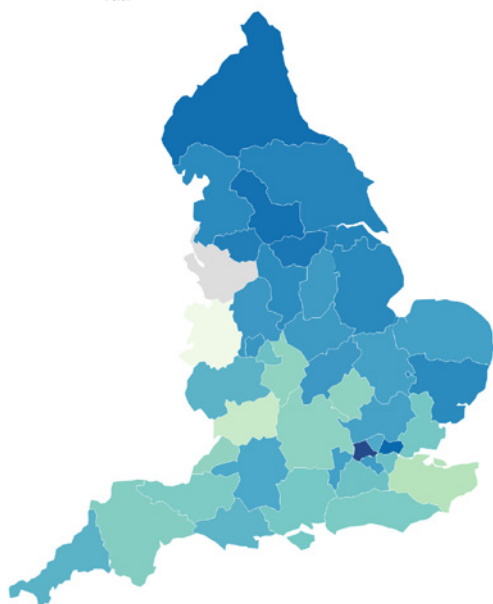
CVD is the leading global cause of death, and this is mirrored within the UK as a significant contributor to morbidity and mortality, with 7.6 million people estimated to have CVD⁵.

There are several linked conditions which act as risk factors for developing CVD – including hypertension, hypercholesterolaemia and diabetes, with the latter increasing the risk of CVD by 2 – 3 times compared to those without the condition.¹ CVD outcomes vary across the country and ICBs, as demonstrated in figures 1 and 2. For example, treatment of hypertension to target levels varied from 61% to 71%⁶, representing a 10% difference between best and worst performing areas. This variation is replicated across other indicators, for example lipid control and hypertension control in chronic kidney disease (CKD) patients.^{7,8} These geographic disparities indicate different approaches to care delivery, resource allocation and population characteristics across local systems, which adds an additional layer of inequality to the demographic disparities which already exist in CVD outcomes. Given these disparities, it is imperative that the NHS learns from effective models of care to deliver improvements in CVD prevention efforts at the local level.

Patients with CKD with a blood pressure reading to the treatment threshold

Percentage of patients by ICB with GP recorded CKD (G3a to G5) with an ACR of less than 70 mg/mmol, whose last blood pressure reading is to the appropriate threshold.

64.4 75.67

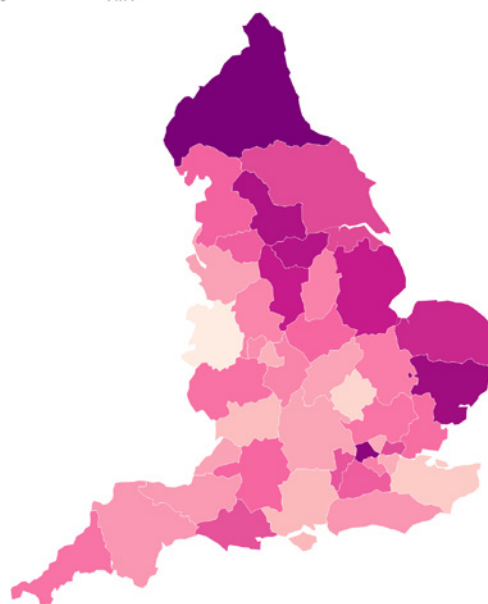


Source: CVDPrevent • Created with Datawrapper

Patients with hypertension whose last blood pressure reading is to treatment threshold

Percentage of patients by ICB with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

61.95 71.14



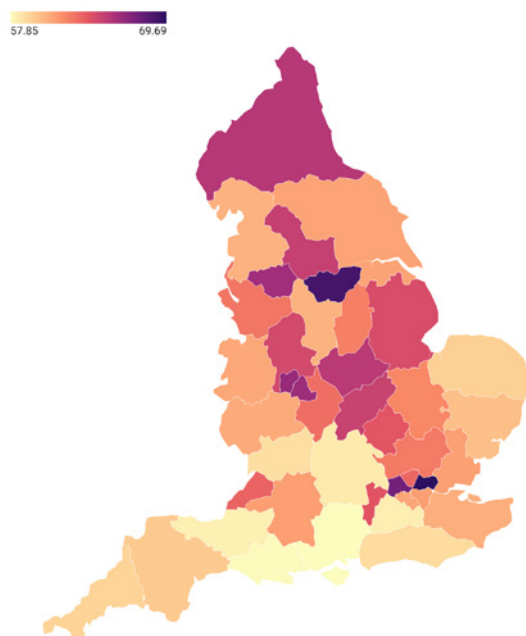
Source: CVDPrevent • Created with Datawrapper

Figure 1: Variation across England in patients treated to threshold for patients with CKD and hypertension^{6,7}

It is imperative that the NHS learns from effective models of care to deliver improvements in CVD prevention efforts at the local level

Patients with a QRISK score of 20% or more treated with lipid lowering therapy

Percentage of patients by ICB with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy.



Source: CVDPrevent • Created with Datawrapper

Figure 2: Variation across England in patients with a QRISK score of 20% or more treated with a lipid lowering therapy^a

The current and future state of NHS structures and opportunities for improving CVD care

The government has set out a vision to change the way the NHS works, embodied through three shifts – from treatment to prevention, hospital to community and analogue to digital³.

To deliver this vision, and as outlined in the 10-Year Plan, the system is going through a period of redesign – with the abolition of NHS England, merger of ICBs and transfer of responsibilities, and the proposed creation of neighbourhood health providers⁹. In this new system, the role of ICBs is going to shift to focus on 'strategic commissioning'⁹, with providers and neighbourhood health services taking on more responsibility for designing and delivering services which meet the needs of their populations. This creates challenges and opportunities for local systems to take the lead on improving population health more proactively and addressing some of the current barriers which prevent comprehensive and coordinated care for patients. CVD and CVD risk conditions are the perfect test case for a new neighbourhood approach to prevention. Policymakers have signalled that CVD prevention remains a key priority for the NHS at the national level³, creating an imperative for local organisations to develop and implement new approaches to deliver better outcomes. This has been operationalised in the 2025/26 planning guidance¹⁰ which outlines the need for health systems to prevent cardiovascular events by supporting GPs to target levels of blood pressure and lipid control. The NHS Performance Assessment Framework (NPAF)¹¹ which is used to assess local organisational performance against an agreed set of performance metrics for ICBs, has set out metrics related to the same CVD areas. Additionally, CORE20PLUS¹² outlines hypertension case finding and optimal lipid management as a key clinical area within which healthcare inequalities should be reduced. Local systems are already responding to this national direction, creating new approaches to deliver more efficient care that improves population outcomes while aligning with NHS strategic priorities. These pockets of best practice provide valuable blueprints for transformation that can be scaled and adapted across different contexts. However, this will require a coordinated response from stakeholders at regional, Integrated Care System (ICS), place and neighbourhood health level.

Current challenges

Currently, providing comprehensive care for patients with CVD and CVD-risk conditions, and bringing about innovation at the local level is challenging.

There are several areas which must be considered for implementation of new ways of working:



Fragmentation of services and siloed working – under conventional approaches to service organisation, healthcare professionals (HCPs) often operate in silos, lacking the integrated, holistic approach essential for managing CVD and associated comorbidities. This fragmentation is compounded by poor data and digital interoperability between systems and organisational boundaries that prevent seamless care coordination.



Scale constraints – while pilots and pockets of best practice within local systems exist and demonstrate positive change, there are frequently financial, technological, capacity, cultural and organisational barriers that prevent scaling of successful pilots across wider geographies.



Workforce challenges – many healthcare systems lack the critical mass of professionals equipped with the necessary skillsets for the transition to a more holistic model of care for CVD patients. There is an absence of adequate support for HCPs to develop the required skillset to manage patients holistically across the CVD spectrum.



Funding constraints – securing adequate funding for innovative CVD prevention and management programmes remains a significant challenge, particularly given the expectation of 'invest to save', as investments in prevention of long-term conditions such as CVD often do not have easily demonstrable in-year savings.



Barriers to patient activation – limited patient understanding of CVD risk factors, available services, and management strategies, create significant obstacles to effective case finding, patient recall, and ongoing engagement.

Securing adequate funding for innovative CVD prevention and management programmes remains a significant challenge

Strategic commissioning to improve population health and CVD outcomes

The reframed core purpose of ICBs is a return to strategic commissioning, through which they will be responsible for ensuring the best use of resources to improve population health.

This strategic reorientation places population health management (PHM) at the centre of ICB functions, which NHSE recognise as essential for delivering integrated, person-centred care whilst reducing inequalities. This approach, underpinned by data, involves the transition from reactive treatment models to proactive, preventative care approaches. This paradigm shift is particularly relevant for addressing CVD prevention and outcomes, where a well-designed population health strategy can ensure that local systems are facilitated to target early identification and intervention for modifiable risk factors including diabetes, hypertension and hyperlipidaemia – preventing their progression to major cardiovascular events such as heart attacks, chronic kidney disease and stroke. In addition, embedding PHM in neighbourhood models can help to address the inequality in outcomes between different populations which exists in CVD, through a systematic data-driven approach which identifies at risk populations and those with the greatest need, facilitating targeted action against health inequalities.

ICBs are responsible for understanding the local context for their integrated care system (ICS), setting the overarching strategy which enables a population health and holistic approach to CVD care, and allocating funding to drive change, including through the commissioning of neighbourhood health services. At the local level, the design and delivery of services to target individuals with CVD and CVD-risk conditions will lie with providers – there is an expectation that there will be more integrated working across providers, in line with the direction set through primary care networks (PCNs), towards a joined up ‘neighbourhood health service’. The 10-Year-Plan sets out the strong intention for the development of neighbourhood health services, underpinned by a shift in health spending to support the investment in out-of-hospital care and developing these models. This includes the new contracts needed to implement neighbourhood health.

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How this translates into practice at the local level

Delivering effective neighbourhood-based CVD care requires several key components working together as an integrated system: reimagining neighbourhood models that break down traditional boundaries between primary and secondary care and make services more accessible to patients; harnessing data and digital tools to support population health management, care coordination, and early intervention; implementing innovative approaches to evidence-based treatment and medicines optimisation; and extending reach into communities through the voluntary, community and social enterprise (VCSE) sector. Together, these elements can inform the building blocks of a comprehensive neighbourhood approach to cardiovascular care.



Neighbourhood health as the foundation of integrated CVD care

There is clear direction from the government to shift towards a neighbourhood health approach, as detailed in the 10-Year Health Plan, providing a service that integrates health, social care and community services around local populations to deliver more care closer to home.

The value of neighbourhood health teams in supporting those with multiple long-term conditions has already been recognised⁴ through their aim to increase coordination and consistency in care, which provides a key opportunity to address the interdependent nature of the spectrum of CVD and CVD-risk conditions.

Effective neighbourhood teams for CVD should bring together diverse expertise:

- GPs with a long-term condition interest
- Community services such as community nursing, health visiting and allied health professionals
- Community pharmacy and clinical pharmacists
- Voluntary, Community, and Social Enterprise (VCSE) sector partners
- Specialist input e.g. cardiologists, nephrologists, endocrinologists, specialist diabetes nurses

A CVD focused neighbourhood team can address the holistic care of patients with CVD or with risk factors while increasing clinical capacity through utilisation of multidisciplinary team members. Their role can reach across the whole patient pathway, facilitating outreach into the community for early diagnosis, intervention and management. In doing so, a neighbourhood team can contribute to primary prevention through education and awareness and population health management (PHM), secondary prevention through early intervention including community-based health checks and hypertension case finding, and tertiary prevention through ongoing management such as treatment reviews and medication monitoring. Additionally, as noted in the 10-Year Health Plan, 'prevention accelerators' are a new delivery model for secondary prevention within neighbourhood health services, which focus on community-led methods to tackle unwarranted variation in uptake of high impact interventions – specifically for cardiovascular disease (CVD) and diabetes³. Through these prevention efforts, these teams can prevent the onset and propagation of disease and illness, which will reduce the impact of established disease across the CVD spectrum. The multidisciplinary approach which underpins integrated neighbourhood teams (INTs) requires a system-wide competency framework that enables collaboration across specialities and sectors to support their designated neighbourhood patch, with clear accountabilities.



Case study - Proactively managing population needs with Integrated Neighbourhood Teams (INTs) in Cornwall and Isles of Scilly ICB

Cornwall and Isles of Scilly are planning to invest £18m into INTs. As well as each INT having a range of primary and community care services the plan is to extend this to incorporate secondary care input from hospital consultants providing expert advice for their specialty such as diabetes, respiratory, cardiovascular disease or elderly medicine¹³. INTs are implementing population health management and personalised care approaches with use of artificial intelligence to identify those people most at risk of hospital admission. These individuals will then be contacted by their respective INT to have a targeted ‘what matters to you?’ conversation to check how they are managing their conditions, medications and circumstances. This will inform the co-development of a personalised care and support plan (PCSP) for the individual which can be accessed by other health and care professionals.¹⁴

Improving integration of primary and secondary care through neighbourhood health:

Another key element of neighbourhood teams is greater integration between primary and secondary care, to improve patient access to specialist care. This can be achieved through structured mechanisms such as joint clinics for diabetes or kidney disease for example, which should be enabled by formal neighbourhood working arrangements embedded within consultant’s job plans to ensure seamless patient care across care settings. This way of working also fosters sustainable knowledge transfer within members of the neighbourhood team, embedding long-term expertise and improving understanding of management in more specialised areas such as chronic kidney disease. This sustained knowledge base ensures that increased understanding among allied health professionals persists, leading to consistent identification of patients at risk, as members of the team can provide opportunistic screening for related CVD risk factors when seeing patients. Current contracting frameworks for primary care and NHS provider trusts lack the detailed specifications needed to deliver truly integrated care. While integration is encouraged systemwide, further work is required to identify the organisational arrangements and resource allocations that enable coordinated care delivery. This includes comprehensive mapping of workforce and estates to determine the optimal configuration for serving a defined population.



Case study – Integrated CKD clinics in Leicestershire and Rutland

The Leicester, Leicestershire and Rutland (LLR) Chronic Kidney Disease Integrated Care Delivery (LUCID) project aimed to integrate primary and secondary care to transform how care is provided for CKD in LLR. The initial LUCID initiative was a joint working initiative between the John Walls Renal Unit in Leicester, University Hospitals of Leicester NHS Trust (UHL) and AstraZeneca UK. This included running LUCID clinics which improve coordination between primary care and nephrologists, allowing primary care staff to get advice regarding ongoing management of these patients and threshold for referral. The potential cost saving was calculated at £830 per clinic through treating patients in primary care and in the community¹⁵. The virtual multidisciplinary clinics which were part of the LUCID project in the area also led to medication optimisation of 590 people with CKD.¹⁶ The programme also included an education programme which sought to close the gap between primary and secondary care for CKD by upskilling pharmacists, nurses and other clinicians in medication optimisation pathways. These professional education sessions have been delivered at ICS-wide events and to 18 PCNs.¹⁶

Changing when and where patients are seen:

As part of a neighbourhood integrated model of care, being able to change where patients are seen and move care closer to home reduces barriers to access¹⁷. By co-locating services and bringing together multiple professionals and specialists in community settings efficiencies can be unlocked for staff.¹⁸ This approach supports proactive, holistic care. Integrated community clinics can address multiple risk factors simultaneously, identify previously undiagnosed conditions, and provide immediate access to lifestyle interventions and specialist referrals where needed.



Case study – Diabetes ‘super clinics’ in East Cornwall PCN

Diabetes ‘super clinics’ are being run in East Cornwall, demonstrating the value of integrated and collaborative teamwork. Run in the community, these clinics bring together 9 different health checks for patients with diabetes all carried out within a 30-minute appointment, including blood sugar, blood pressure, heart rate, cholesterol, urine, eyes and feet¹⁸. Normally, these health checks require patients to attend separate appointments, however these clinics speed up the process, making it easier for patients and allowing health professionals to work together. As a result of these clinics, patients attending have been screened for atrial fibrillation and received referrals to Healthy Cornwall, a council funded scheme for further health and wellbeing advice, and podiatry services for further support¹⁸.

Capitalising on the potential of pharmacy:

Pharmacy represents a critical component of integrated neighbourhood teams for CVD. Across the country, community pharmacy already plays a significant role in CVD prevention. There should be continued efforts to improve system confidence in pharmacy service, by increasing referrals to services such as hypertension case finding and building stronger relationships between pharmacies and GP practices. This can help to create synergistic working relationships that support integrated CVD pathways for medication reviews and counselling, case finding and blood pressure monitoring.

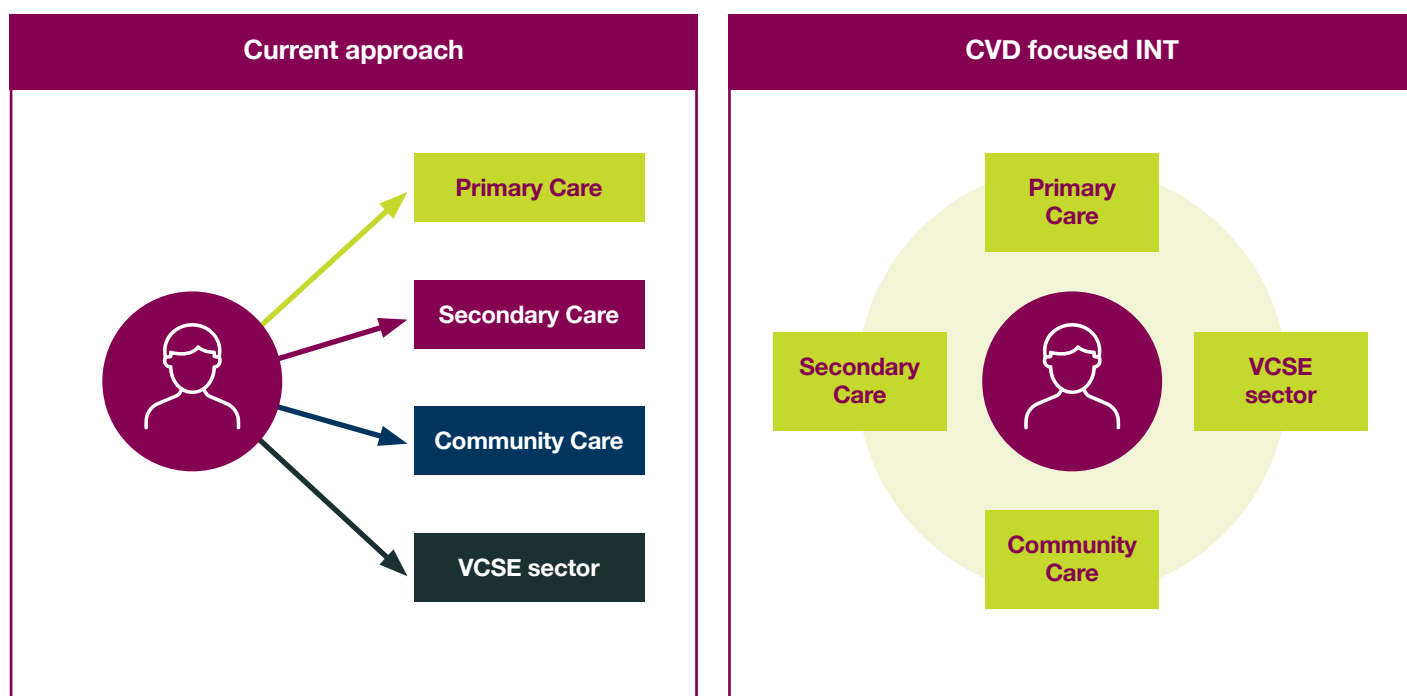


Figure 3: Patient interactions with providers currently compared to a focussed neighbourhood approach



Using data and digital to improve care

Data for population health and case finding:

Good quality, comprehensive data underpins effective population health strategy and enables targeted CVD interventions. At the provider level, good quality data is needed to enable identification of rising risks within specific population cohorts, supporting targeted preventative initiatives and earlier interventions for those most at risk. Population based indicators can be built into dashboards and patient lists to track progress for initiatives designed to improve CVD outcomes. CVDPREVENT, as a national audit of GP records, supports primary care in understanding how many people with cardiovascular disease, or conditions that lead to a higher risk of developing CVD, are potentially undiagnosed, under treated or over treated¹⁹. For ICBs, data can identify health inequalities in cardiovascular outcomes and inform targeted resource allocation and budget management for cardiovascular models of care and initiatives for those areas most at risk. For all levels of the system, linked data across providers and care sectors can drive greater understanding of local populations and needs and care pathways. While national initiatives such as CVDPREVENT and CVD Action provide valuable benchmarking and guidance, locally integrated datasets spanning all care settings are needed to enable the granular insight necessary for effective population health management and personalised care planning.



Case study - Monitoring and targeting unwarranted variation in Cheshire and Merseyside

As part of its “Advancing CVD Prevention Strategy”²⁰ Cheshire and Merseyside ICB is using national, sub-regional, locality, PCN and practice level data to monitor and report on progress, identify priority groups, risk stratify groups and inform targeted quality improvement work and interventions. At an ICB level it is using the CVD, Stroke and Respiratory CIPHA dashboard to provide local data, which is non-patient identifiable and drawn directly from the primary care record, to identify variables and populations of interest using characteristics such as disease, location, demographic and ethnicity.



Case study - CVD prevention at a population level in Cambridgeshire & Peterborough ICS

Your Healthier Future is a CVD prevention programme across over fifty GP practices in the ICS and funded by Cambridgeshire County Council and Peterborough City Council. The programme uses GP data to identify patients who are at higher risk of cardiovascular disease and would benefit from early intervention²¹. Practices can choose how they wish to participate – either through practice-led engagement in which the primary care team contacts patients directly, carries out a review of health information and follows up as necessary, or centralised engagement through Eclipse in which a central team invites patients to participate through text message and gain additional information through a questionnaire which is then coded back into primary care systems for review. Participating practices receive additional funding for taking place in the programme, at a rate of £1000 if targets are met for practice-led engagement, and a payment of £400 for centralised engagement²². If individuals agree to be part of the programme they may be offered lipid modifying therapy, support for managing blood pressure and signposting to health checks.

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Digital shared care plans:

For effective population health management and neighbourhood models of care, digital care plans are key to provide oversight of the patient journey across sectors, integrating various aspects of care delivery and enabling multidisciplinary team coordination. Digital care plans provide the opportunity for a shared decision-making approach which is patient centred. They also enable real-time sharing of CVD risk assessments, medication changes, and clinical outcomes between primary care, community services, and secondary care, ensuring continuity of care and reducing duplication of assessments.

Digital tools for early detection and intervention:

Digital transformation is one of the three strategic shifts the government has outlined for transforming the NHS. The opportunity for using digital tools for CVD prevention and to support neighbourhood teams is significant. The NHS App expansion demonstrates growth in digital engagement, with around 11 million people using the app every month.²³ With significant funding commitments behind developing the App into the 'digital front door' for the NHS,^{23,24} there is an opportunity to embed CVD prevention initiatives within the App. This would involve allowing people to understand their level of CVD risk; make and receive CVD health assessments and personalised prevention plans; and being signposted to services they need, both digitally and face-to-face, allowing patients to take ownership of their health and improving patient activation. Integration of AI features such as 'My Companion' provide the opportunity for greater patient engagement regarding their conditions. Furthermore, the 10-Year Health Plan outlines ambitions to empower neighbourhood teams with access to a greater range of patient data, particularly through the use of wearables which can enhance continuous and remote monitoring of cardiovascular disease and related risk factors (e.g. glucose, blood pressure, stress)³. This data can then be integrated into the NHS App and is expected to be a standard part of care by 2028, facilitating proactive self-management and earlier intervention. From a service perspective, to enable early detection and opportunities for prevention in line with a population health management (PHM) approach, PHM platforms (such as Eclipse and RAIDR) enable proactive stratification of at-risk patients through data analytics. These patients can then be targeted for outreach and intervention either for primary or secondary prevention depending on their risk levels. Digital tools can also be used to enhance screening and accessibility, for example those which deliver key elements of the NHS Health Check in the community. Different digital tools have demonstrated multiple delivery models including patient self-completion via text message and hybrid approaches combining remote questionnaires with pharmacy-based blood pressure monitoring. A number of these platforms offer interoperability with principal GP systems such as EMIS and SystmOne.²⁵

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Case study - Using digital to enhance screening for CVD risk in West Yorkshire

In West Yorkshire, targeted screening to local communities is being rolled out, using app-based technology from PocDoc to provide a cholesterol profile, BMI, heart age estimate and 10-year risk for having a heart attack or a stroke. The technology provides results immediately, which also means it is ideal to roll out in community sites, with the first screenings being rolled out at University of Huddersfield's Get Set Goal team at community events, Healthy Heart Community Hubs in Wakefield and Community Pharmacy Independent Prescribing Pathfinder pilot sites.²⁶



Case study – Early detection of CKD in Sussex

Sussex Community NHS Trust partnered with Healthy.io to roll out a smartphone-powered at-home urine test to improve adherence to albumin to creatinine ratio (ACR) testing for detection of chronic kidney disease (CKD) in patients with type 1 diabetes. This ACR 'Adherence as a Service' includes patient onboarding, support to download the app, self-testing at home which supports patients through the process via the app and finally results which were available on primary care electronic patient record systems for review. The service improved adherence to ACR testing from 0% to 79% in consented patients who have been offered default model of care but had not attended.²⁷



Case study – Technology enabled community CVD prevention in Cheshire and Merseyside

Cheshire and Merseyside ICS have successfully demonstrated how technology can extend CVD prevention efforts into communities through the deployment of eight self-serve Wellpoint Kiosks across high-deprivation areas since September 2022. The kiosks, strategically placed in leisure centres, retail locations, and workplace settings, have engaged 13,000 users and delivered 15,000 health assessments, providing blood pressure monitoring, BMI calculations, and 10-year CVD risk estimates. The initiative has achieved significant impact with 83% of users reporting they were 'very likely' or 'likely' to modify their lifestyle²⁸, while successfully reaching target populations who typically have lower engagement with traditional CVD prevention services. This demonstrates how accessible, technology-enabled health screening can overcome traditional barriers to CVD prevention.

Digital tools for remote monitoring and ongoing management:

Remote patient monitoring technologies allow continuous tracking of key CVD indicators such as blood pressure or heart rate, allowing for early detection of deterioration and timely intervention. More widespread adoption of these types of technologies can reduce the need for routine face-to-face appointments, free up clinical capacity, and empower patients to take greater ownership of their condition management. NHSE's BP@Home initiative has been a positive step forward in the space, with local systems adapting the initiatives in their own ways and demonstrating how remote monitoring can be used to modify pathways. For example, within Dorset, in one PCN, patients on the BP@Home pathway were reviewed not just by GPs, but a mixture of nurses, pharmacists and GPs, which resulted in workforce efficiencies. In another, savings were demonstrated through the use of monitoring by an app rather than in face appointments.²⁹

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Implementing a systematic approach to evidence-based treatment through medicines optimisation

Medicines optimisation represents a cornerstone of effective cardiovascular risk management, requiring coordinated approaches across primary and secondary care within INTs.

The NHSE Medicines Optimisation Executive Group provides a framework for ICBs to identify local priorities, recommending focus on at least five key opportunities aligned to population needs. Current national priorities include hypertension management, atrial fibrillation anticoagulation, lipid management, and appropriate prescribing of blood glucose monitoring equipment for diabetes patients. However, the high burden of cardiovascular disease and chronic kidney disease across England creates opportunities for ICBs to expand this focus to include heart failure management and CKD prevention medicines. INTs are ideally positioned to deliver medicines optimisation at scale. Clinical pharmacists working within primary care teams can conduct systematic medication reviews for high-risk cardiovascular patients, identifying opportunities to initiate or intensify evidence-based therapies. For example, data analysis can reveal patients with diabetes who are not receiving appropriate cardiovascular protection, or those with heart failure who remain on suboptimal medication regimens. The 10-Year Health Plan recognises the significant role of community pharmacists in long-term condition management³, particularly given their increasing ability to prescribe independently. This enables seamless management of cardiovascular conditions such as hypertension, which will be further enhanced by providing community pharmacists with access to the Single Patient Record.



Case study – Pharmacy-Led Hypertension Management in Nottingham West PCN

Nottingham West PCN has demonstrated the significant potential of pharmacy-led cardiovascular prevention through their innovative hypertension case finding and management service. The model was led by the PCN clinical director following an analysis which identified they were underachieving for hypertension diagnosis versus estimated prevalence³⁰. The service utilises prescribing pharmacists, pharmacy technicians and community pharmacy, adopting a population health approach and risk stratifying patients in line with NICE guidance. Participants were invited via text to opt into the pathway, and then choose between attending local pharmacies for ambulatory blood pressure monitoring or completing seven days of home blood pressure monitoring, with a clinical pharmacist reviewing all results and ordering additional investigations where clinically indicated, including blood tests, ECG and urinalysis. QRISK was also completed for each patient, and referrals for support were made where relevant such as exercise referral programmes, weight management, smoking cessation and social prescribers. All hypertension diagnoses where appropriate were managed by the pharmacy team until patients achieved optimal blood pressure control, at which point care was transferred back to GPs for annual follow-up. Outcomes from the initiative included a 26% hypertension diagnosis rate and 343 people diagnosed with hypertension in the first year. The initiative also demonstrated service efficiency through freeing up and estimated 3000 General Practice appointments over the three years³¹.

Nottingham West PCN has demonstrated the significant potential of pharmacy-led cardiovascular prevention through their innovative hypertension case finding and management service.



Extending reach into communities through VSCE engagement

The voluntary, community and social enterprise (VCSE) sector represents a strategic asset for cardiovascular disease prevention, offering unique capabilities to reach populations who traditionally experience poorer health outcomes and face significant health inequalities.

VCSE organisations provide trusted, embedded community presence that can extend the reach of health interventions into communities that services struggle to engage effectively, with particular strength in culturally appropriate interventions³² that address the specific barriers faced by diverse communities. VCSE organisations also play a crucial role in patient activation and self-management support. This can involve screening and awareness support in community settings, for example cholesterol or blood pressure checks in football clubs, faith centres or other trusted community venues that reach populations who may not typically engage well with healthcare services. Effective VCSE engagement requires formal partnership arrangements that recognise the sector's expertise while providing sustainable funding models. ICBs should develop commissioning approaches that value VCSE organisations' unique contributions and provide long-term security to enable effective service delivery and relationship building within communities.



Case study – Community-based hypertension case finding in Cornwall

Cornwall and the Isles of Scilly's "Know Your Numbers" campaign represents a model of how the Voluntary, Community and Social Enterprise (VCSE) sector can drive population-level cardiovascular disease prevention through innovative hypertension case finding. The NHS Cornwall and Isles of Scilly ICB has embedded VCSE partnerships at the heart of its target to reach more than 10,000 people annually to 'Know Your Numbers' and 'Ease Your Pressure', demonstrating how community-led approaches can scale preventive interventions effectively³³. Beyond checks being offered at community events and wellbeing festivals, as part of the campaign blood pressure monitors were made available to borrow free of charge from libraries across Cornwall and the Isles of Scilly³⁴. This utilises existing trusted community spaces as health access points, removes geographical and temporal barriers to blood pressure monitoring and integrates health prevention into routine community activities.



Case study – BEAT community-based HF screening with charity partners

A community-based heart and lung screening hub was created in partnership with Liverpool based charity, Everton in the Community (EitC). This partnership utilised the link with Everton football club to engage individuals who otherwise may have been more difficult to reach, and involved a health awareness coordinator from EitC to engage local communities. The team involved in the initiative included a cardiologist, specialist nurses, a psychologist, smoking cessation counsellors and volunteers from the Pumping Marvellous Foundation³⁵. Patients were screened for symptoms, BP, ECG and given a finger prick NT-proBNP test. In those which it was clinically indicated, an AI enabled echocardiogram was conducted. This initiative allows heart failure to be potentially diagnosed in 60 minutes³⁶, something which traditionally can take up to 6 months. In the initial pilot, there were over 1000 attendees, 32% were diagnosed with hypertension and 3% diagnosed with atrial fibrillation and 3% were newly diagnosed with heart failure.³⁵

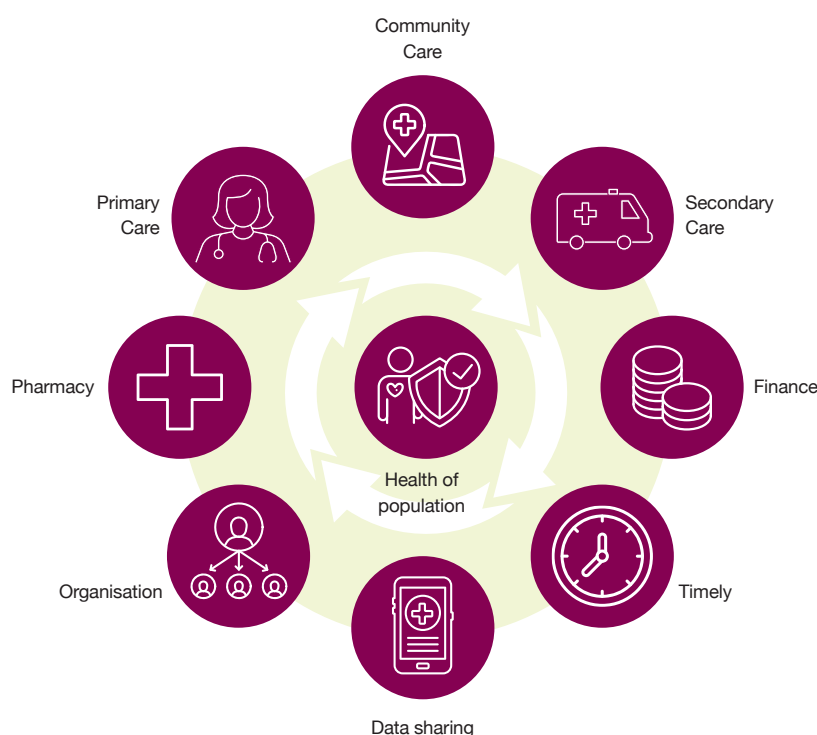
Underpinning enablers for effective neighbourhood CVD care



Data and interoperability

Effective neighbourhood care and population health management must be underpinned by accurate, timely and accessible data.

This requires investment in data quality processes, standardisation of data standards and systems which make the data accessible. Facilitating data sharing across sectors (primary care, secondary care, community care) is key to improve care co-ordination and create more accurate and holistic views of individuals health, leading to better risk stratification and case finding. Data interoperability between different sectors supports the development of digital shared care plans, enabling health and care professionals across sectors to coordinate treatment decisions, monitor patient progress, and ensure continuity of care. This requires robust data sharing agreements between providers and the technical infrastructure that supports this information exchange.



Data interoperability between different sectors supports the development of digital shared care plans, enabling health and care professionals across sectors to coordinate treatment decisions, monitor patient progress, and ensure continuity of care



Financial incentives

ICBs are well-positioned as strategic commissioners accountable for ensuring optimal resource utilisation to improve long term population health outcomes for individuals with CVD and CVD risk conditions.

This becomes even more significant with the delegation of specialised services to ICBs, including chronic kidney disease pathways, providing commissioners with oversight of entire care pathways and opportunities for strategic resource allocation focused on primary and secondary prevention. CVD risk conditions are well placed for investment which aims to target areas for early intervention and prevention which reduce long-term costs by preventing end-stage conditions and costly conditions such as chronic kidney disease or heart failure. Given that almost £12 billion is spent on healthcare costs towards end of life care in the UK³⁷, a robust neighbourhood model can act as a framework for accurate advanced care planning. While shifting care toward prevention and community-based models faces challenges due to potential delays in demonstrating savings, some interventions can deliver returns relatively quickly. For example, secondary prevention for CVD through guideline-directed medical therapy has been shown to deliver health system savings in as little as 2 years.³⁸ Neighbourhood teams are well-positioned to realise these savings by improving identification of eligible patients and increasing treatment uptake. However, demonstrating the complete cost benefits of neighbourhood-based interventions and enabling the shift of funding from secondary care to integrated neighbourhood care requires robust costing models. These models must capture the full spectrum of impacts across multiple conditions and care settings, including reductions in emergency admissions and the cascading effects of treating one risk condition on other related conditions.

With the 10-Year Health Plan signalling a strong push for the use of financial incentives to reward organisations based on the quality of care and to improve outcomes, there is opportunity to embrace financial mechanisms which can drive this transformation and incentivise local systems to target outcomes for CVD. These mechanisms can provide a signalled funding shift from secondary care to a more integrated neighbourhood model. This sentiment is reflected in the 'year of care' payments³ proposed by the 10-Year Health Plan which aim to shift funding from hospital to community, and could mean all CVD related costs – including prevention, diagnosis, treatment and management could be a single annual payment shared across the neighbourhood team. This creates a powerful incentive for the entire neighbourhood health system to collaborate on early detection and proactive management of risk factors to prevent hospital admissions, which will incentivise better coordination between care sectors, including primary and secondary care. This would represent a more fundamental shift in payment structure than gainshare arrangements, however the latter can also be utilised where year of care payments have not been implemented to align financial rewards within neighbourhood health providers with improved CVD outcomes and concurrently encourage collaborative working. Enhanced service contracts can also be used to integrate CVD and CKD prevention services into routine healthcare delivery. The emphasis in advice and guidance services to reduce elective waiting lists presents an opportunity to increase uptake of medicines traditionally initiated in secondary care, with financial incentives encouraging primary care clinicians to increase prescribing of these medications. Additionally, locally developed Quality and Outcomes Framework (QOF)-style indicators have been demonstrated to be effective drivers of change in clinical practice. While the 25/26 GP contract has announced a renewed focus on QOF incentives geared towards CVD prevention, there is further opportunity to ensure that incentives are ambitious in their work across the pathway to increase early detection of CVD and CVD-risk conditions. Furthermore, with the increasing weight put behind patient experience, and the potential tie to provider payments, incentives can also be designed to reward positive patient outcomes. This is pertinent as many individuals with long-term conditions currently do not have positive experiences of multidisciplinary care, feeling listened to and being able to access advice to manage their condition.³⁹

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Workforce

Workforce diversification is another key enabler to delivering integrated and new models of care for cardiovascular disease.

The 10-Year Health Plan outlines the need to review skill mixes required for integrated neighbourhood teams, with more detail expected in a new ten-year workforce plan due later in 2025³. For more holistic models of care and truly multimorbidity models, consideration should be given to the broader spectrum of cardiovascular, renal and metabolic (CVRM) conditions to encompass those conditions which heavily impact CVD conditions. This requires a shift in workforce capabilities, moving beyond traditional single-conditions expertise and speciality siloes toward multimorbidity management skills that address the interconnected nature of these conditions. Members of a neighbourhood team, whether they are pharmacists, nurses or other allied health professionals should feel empowered to take ownership of initiatives and elements of patient's care, being supported where necessary. Incentivising nurses and other healthcare professionals to engage in professional development through master's level education, and in turn creating a strong workforce of HCPs empowered to undertake a multimorbidity approach to care. For ICBs, there needs to be strong expertise in population health data analysis and interpretation, requiring investment in analytical capabilities and training existing staff in new methodologies. Local health care systems and primary care should ensure they adopt a flexible approach, similar to the current Additional Roles Reimbursement Scheme (ARRS) scheme, to employing health professionals and allied health professionals to enable INT to recruit specialist roles like clinical pharmacists, social prescribing and care coordinators who can address the complex needs of high-risk cardiovascular patients.



Case study - Enhanced health checks in Central and West Warrington (CCW) PCN

As part of the national Clinically-Led workforce and Activity Redesign (CLEAR) initiative, CCW PCN participated in a programme (Living Well) for CVD prevention. This involved comprehensive data analysis to determine local need and populations at high risk of CVD. A health check hub was then set up which utilised a multi-disciplinary team at no extra cost to the PCN by using new funding made available through the additional roles reimbursement scheme (ARRS) and PCN estates. The service expanded health checks to high-risk individuals and reached underserved communities, improving engagement and referrals to lifestyle management services. Early results show increased attendance among those with a South Asian background from 2% to 4.6% and those with an East Asian background increased attendance from 2% to 3.3%. In addition, attendance at local lifestyle management services increased from 1% to 14% and the PCN obesity register increased by 56% since the start of the project.⁴⁰

For more holistic models of care and truly multimorbidity models, consideration should be given to the broader spectrum of cardiovascular, renal and metabolic (CVRM) conditions to encompass those conditions which heavily impact CVD conditions.



Leadership

Successful implementation of models to improve CVD outcomes and facilitate population health management approaches for cardiovascular care requires dedicated leadership to spearhead initiatives and transformation.

This could encompass a dedicated ICB level steering group who can oversee the overarching strategy for CVD, which carries representation from designated place leads who coordinate local cardiovascular initiatives. This creates a governance structure which bridges strategic planning with operation delivery.

However, effective leadership must also address the significant cultural shifts required for integrated working between sectors and specialties. Leaders need to actively tackle professional silos by securing buy-in from different organisations and managing the transformation from traditional 'expert' MDT models toward truly embedded, community-based integrated teams. Clinical champions and leaders, for examples within PCNs, can drive frontline engagement and drive change in clinical practice. Leaders must articulate a clear vision for integrated cardiovascular care that transcends individual provider interests, fostering collaboration between primary care, secondary care, community services, and voluntary sector organisations. This requires leaders who can work across the whole system and have the confidence to drive forward change.



Case study – System leadership in CVD care in Cheshire and Merseyside

Cheshire and Merseyside demonstrate a robust model of system leadership in CVD prevention through its system wide, collaborative approach. At the heart of this is the CVD Prevention Group, with an appointed ICS CVD Prevention lead to coordinate system-wide initiatives. The model demonstrates effective integration of clinical leadership through four recruited PCN leads within the CVD Prevention group, ensuring frontline clinical expertise informs strategic decision-making. Each of the nine 'Places' across Cheshire and Merseyside has nominated Place leads who represent their localities within the CVD Prevention group, creating a direct link between system-level strategy and local implementation²⁰. This structure enables coordinated delivery of their whole-system CVD prevention strategy while maintaining local flexibility and facilitating the sharing of good practice across the system.

Leaders must articulate a clear vision for integrated cardiovascular care that transcends individual provider interests, fostering collaboration between primary care, secondary care, community services, and voluntary sector organisations.



What next?

The interconnected nature of CVD and the requirement for coordinated care across multiple settings make it an ideal testing ground for integrated neighbourhood models.

Fragmented and siloed care leads to poorer patient outcomes and misses critical prevention opportunities. However, given the variation in populations, organisations and current practices, it is unlikely that a nationally determined 'one size fits all' approach will be conducive to an optimal neighbourhood CVD service.

The publication of the government's 10-Year Health Plan provides a significant opportunity to advance integrated neighbourhood CVD care. The plan's commitment to establishing a neighbourhood health service, creates the ideal framework for implementing a coordinated CVD prevention model as discussed in this report. The plan specifically identifies cardiovascular disease as an early priority for developing modern service frameworks, which can also help to accelerate progress, and underlines the relevance of a robust neighbourhood model for CVD care.

There is a clear role at both national and local levels in developing robust and effective neighbourhood health models for CVD care.



National action: Creating the enabling environment

The government must create the enabling environment for neighbourhood health to flourish. This includes:



Contract reform and financial incentives - The 10-Year Health Plan's commitment to introduce two new contracts for GPs to work over larger geographies and lead new neighbourhood providers presents an opportunity to embed CVD prevention incentives from the outset. There must be relevant reforms to both GP and pharmacy contracts as crucial sectors in an effective neighbourhood model, including carefully designed financial incentives which align with and reward collaborative, prevention and outcome focussed CVD care.



Robust economic evaluation frameworks – Frameworks to develop full economic costing models are essential to demonstrate the true cost-effectiveness of integrated neighbourhood care and enable evidence-based investment decisions that reflect the wide-reaching financial benefits of integrated neighbourhood models.



Workforce investment - Sustained workforce investment should go beyond just increased capacity but allow for the multidisciplinary skills needed for effective multimorbidity care, and provide opportunity for health care professionals to upskill in this area. This should be reflected in the upcoming workforce plan.



Technology and data - The 10-Year Health Plan's ambition to make the NHS "the most AI-enabled health system in the world" will help neighbourhood teams to integrate and benefit from digitally enabled interventions to enhance CVD prevention and management. However, there must be national direction for technology procurement to ensure system compatibility and robust standards for data interoperability.



Local leadership: Designing for communities

While enablers must be established nationally, local systems and ICBs should lead the design and implementation of neighbourhood health models. The 10-Year Health Plan's commitment to make ICBs the strategic commissioners of local healthcare services and introduce "earned autonomy" provides the framework for local CVD innovation and optimum models.

This requires systems to:



Develop and maintain a population health focus – Local systems must know their population's CVD risk and design services around these risks. The 10-year plan's emphasis that neighbourhood health centres should begin "in places where healthy life expectancy is lowest" aligns with targeting CVD prevention where it can have the greatest impact. Systems should also build on existing strengths and design models which work well within their communities.



Embrace truly integrated working – There should be genuine partnerships created between primary and secondary care, community service, the VSCE sector and patients to ensure seamless models, with the relevant governance and cultural changes required to achieve this.



Track outcomes - Local systems must track progress to ensure that models are achieving improved outcomes for patients, and foster an environment of continuous improvement.

Each community faces unique challenges in CVD prevention and management, reflecting local demographics, existing services, and community assets. The most effective neighbourhood approaches will be those that build on existing strengths and adapt to local contexts.

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From hospital to community:

Delivering an integrated neighbourhood approach to CVD prevention



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