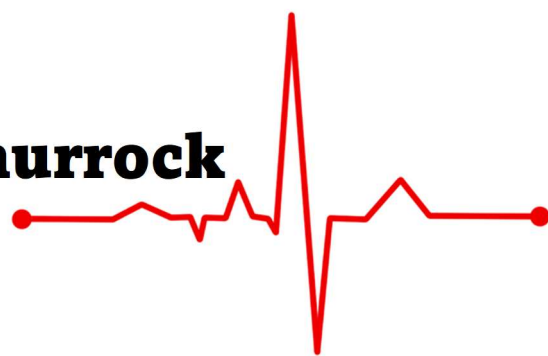


# Reducing the Impact of Cardiovascular Disease in Thurrock

*Annual Report of the Director of Public Health, 2022*



# Reducing the Impact of Cardiovascular Disease in Thurrock

## Annual Report of the Director of Public Health, 2022

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# Reducing the Impact of Cardiovascular Disease in Thurrock

## Annual Report of the Director of Public Health, 2022

### Foreword



In my first Annual Public Health Report for Thurrock, I have chosen to look back at the impact of the report from 2016, with a view to identifying further improvements in care for long term health conditions, looking through the lens of improving outcomes for cardiovascular disease (CVD).

The COVID-19 pandemic has highlighted the impact of profound and enduring inequalities in health across the country and CVD remains the clinical condition that contributes most to inequalities in premature mortality across the community. A relentless focus on improving quality of care for and reducing inequalities in CVD should not just improve CVD outcomes but also identify broader improvements in health and care services.

Much CVD care happens in General Practice, and many recommendations from 2016 were directed at this element of care. Despite the disruptive impact of the COVID-19 pandemic on General Practice, measurable improvements in quality of care for CVD since 2016 can be identified in Thurrock. However, we have also identified inequalities in CVD outcomes that can and must be addressed, including for people from a minority ethnic background, people living with serious mental illness and people with learning disability.

Thurrock Public Health Team will continue its close partnership working with local GPs to build on the gains made since 2016 and close the inequality gaps we have identified.

**Dr Jo Broadbent**

**Director of Public Health**

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### Executive Summary

The 2016 Annual Public Health Report for Thurrock[1] explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. A number of issues were highlighted, including variable access to primary care, differences in the quality of care between practices, and associated impacts on patients and consequent hospital admissions. The report made a series of recommendations to increase the effectiveness and cost-effectiveness of care in Thurrock across a range of health conditions. Much has changed since 2016, both proactively in terms of national health policy and local health systems, and reactively as a consequence of the Covid-19 pandemic. This report reviews progress since then for one of the LTC clusters outlined in the 2016 report: Cardiovascular Disease (CVD).

#### Why focus on Cardiovascular Disease?

Of all the disease groups, CVD causes the highest levels of premature mortality: 1 in 4 premature deaths (before age 75) in the UK are due to CVD and it is the leading contributor to health inequalities[2]. Analysis of local data shows that for mortality attributable to socio-economic inequality, CVD is also the greatest contributor in Thurrock, accounting for 35% of excess deaths[3]. Yet if risks are detected and managed in line with NICE guidance, focusing on CVD provides the greatest potential to reduce health inequalities and reduce premature mortality. As outlined by the World Health Organisation (WHO), the key behavioural risk factors for CVD are smoking, unhealthy diet/obesity, lack of physical activity, and harmful use of alcohol[4], all risks which can be ameliorated with support and appropriate policies.

#### What has changed since 2016?

Both national and local drivers of CVD care have developed since 2016. The NHS Long Term Plan, published in 2019, set out a range of goals for reducing the number of strokes and heart attacks and reducing the inequalities associated with CVD by 2029, with a particular focus on high blood pressure (hypertension).

Improvements in clinical pathways for CVD in Thurrock have been seen since 2016[2]. However, part-suspension of QOF during the pandemic has made it difficult to make direct comparisons with the findings of the 2016 report. (Moreover, exact comparison with the 2016 report is not appropriate due to nationally driven organisational change in primary care with the establishment of Primary Care Networks). Measurable quality improvements do include:

- Whilst it is not possible to attribute success to individual initiatives, overall analysis does show that numbers of diagnoses for hypertension across Thurrock have increased from 1,321 in 2016/17 to 2,567 in 2021/22. There is still a gap between current register numbers for cases of hypertension and the national target that 80% of expected cases be detected by 2029, but the gap is smaller in Thurrock than in other areas of MSE. When it comes to treatment of patients on the hypertension register, all four Thurrock PCNs are working beyond the national target for those aged over 80, and close to target for those below 80, and again are achieving higher rates of treatment to target than neighbours in MSE.
- There have also been improvements locally in the treatment of patients with atrial fibrillation, where Thurrock is already exceeding the national target, though when it comes to detection there is still a gap (of around 260 cases) between the current recorded prevalence and national target.
- There is still a significant gap between expected and diagnosed prevalence of high cholesterol, with fewer than one third of the expected numbers having a formal diagnosis but the quality of care for those on Coronary Heart Disease (CHD) registers is high.

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#### Key Findings and Recommendations

More detail on each of the findings, references and recommendations can be found in the full report.

	Key Findings	Recommendations
1	Most of Mid and South Essex is in the quartile in England with the most patients per GP, and the situation is worst in Thurrock, with 2,296 patients per GP (increased from 2,110 per GP in 2016), which is the third highest list size per GP in England.	Thurrock Integrated Care Alliance (TICA) should work with Mid and South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock PCNs, to avoid increasing health inequalities associated with access and quality in primary care.
2	The COVID-19 pandemic has exposed and worsened health inequalities. It has had adverse effects on people's physical and mental health, and on demand and access to health and care services, including prevention and management of CVD.	Refresh the whole-system focus on primary prevention of CVD post-COVID-19, including: <ul style="list-style-type: none"> <li>• Tobacco control</li> <li>• Reducing obesity</li> <li>• Focusing on healthy behaviours in early years</li> </ul>
3	The development of Integrated Medical and Wellbeing Centres (IMWCs) is an opportunity to deliver: <ul style="list-style-type: none"> <li>• More personalised, proactive care, with a more collaborative and flexible approach</li> <li>• An integrated service bringing together health, wellbeing and social care services in multi-disciplinary LTCs teams.</li> </ul>	Promote personalised, collaborative and holistic care planning, for example the House of Care using an evidence-based model, alongside instigating long term condition specialists and multi-disciplinary working within the IMWCs.  New models of working should include maximising potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new IMWC model.
4	The evidence base shows that: <ul style="list-style-type: none"> <li>• Focusing on the processes and tools of transformation is not sufficient when seeking a shift to co-production</li> <li>• Goals linked to the patient's starting point will be more successful</li> <li>• The Patient Activation Measure (PAM) can assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support</li> <li>• Health Coaching can support outcome improvement through</li> </ul>	In designing new holistic care models, TICA should specifically consider: <ul style="list-style-type: none"> <li>• That transformation programmes need to be built around how to achieve cultural shifts in practice</li> <li>• The benefits of health goals being contextualised within the patient's life and personal priorities</li> <li>• Adopting the Patient Activation Measure (PAM) to determine patients' engagement in managing their conditions, in order to benefit both individual patients and health professionals supporting them</li> </ul>

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	<p>motivational techniques and focusing on the individual's starting point</p>	<ul style="list-style-type: none"> <li>• Training a range of staff in primary care, integrated teams and preventative services in Health Coaching, prioritising patients identified through PAMs at the lowest levels of engagement</li> </ul>
5	<p>Whilst it is not possible to attribute success to individual initiatives, joint working between public health and primary care, such as Stretch QOF, have produced measurable improvements in quality of care for hypertension, CHD and atrial fibrillation since 2016.</p>	<p>Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.</p>
6.1	<p>Case studies of best practice consistently demonstrate the potential for the wider community health and care workforce to contribute to CVD prevention and diagnosis.</p>	<p>In seeking further improvements in care for specific CVD conditions (and other LTCs), services should consider developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists, Community Social Care roles) and considering how broader roles might enhance LTC services for patients.</p>
6.2	<p>Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health through improving CVD outcomes are likely to be gained by a focus on reducing gaps in diagnosis.</p>	<p>Implement systematic and targeted case finding for atrial fibrillation, CHD and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs.</p>
6.3	<p>Evidence suggests that the NHS Health Checks programme needs to be more targeted in order to increase uptake in those with most to benefit – which includes people living in more deprived areas and/or those from BME groups at the younger age limit.</p>	<p>Target NHS Health Checks for people at the younger age limit in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.</p>
6.4	<p>Thurrock has the second highest premature mortality rate in England due to CVD in people living with SMI in 2018-20. Heart disease is the second highest cause of death amongst people with a learning disability.</p> <p>Despite, this follow-up of risks identified during physical health checks is low – for example, fewer than 1/3 of those with SMI having high cholesterol were followed up in primary care in 2021/22.</p>	<p>Maximise uptake and associated follow-up of physical health checks for people living with SMI and who have a learning disability.</p>

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### Conclusions

Assessing the impact of initiatives put in place since 2016 to improve CVD outcomes is hampered by the impact of the COVID-19 pandemic on implementation, changes in access to primary care, the primary care workforce and data-capture, but there is evidence of measurable improvement in the quality of care for CVD in Thurrock since 2016. Given the impact of the pandemic, however, on widening inequalities, the case for improved identification and management of CVD is even more pressing.

The most recent Marmot review[3] stresses the need to re-focus on prevention in order to reduce the inequalities exacerbated by COVID-19. Given the high rates of smoking and obesity in Thurrock, increased identification and improved management of cardiovascular conditions will not alone address the inequalities currently associated with CVD in the borough; prioritising wider action to increase access to healthy foods, provide support for individuals to manage their weight, increase physical activity and reduce smoking is required. In addition, opportunities to identify those at increased risk of CVD, through NHS Health Checks and other case finding programmes, need to be targeted in areas of higher deprivation and for population groups with most to gain.

There have been some positive changes in primary care staffing since the 2016 report, but these are set against local and national concerns about ongoing workforce pressures, and Thurrock remains significantly under-doctored. The first IMWC to open has been in Corringham, where innovative practice in obesity can already be found. However, in Thurrock there is greater need in Tilbury & Chadwell and in ASOP, both in terms of constraints on primary care capacity and greater levels of patient need. These areas should therefore be prioritised for additional workforce capacity and adoption of new models of care, in order to avoid widening health inequalities further.

Despite the challenges of workforce pressures and the pandemic, there have already been improvements through initiatives implemented and developed since the 2016 report, notably the use of public health data to support practices, Stretch-QOF, and generation of additional workforce capacity with new roles in primary care.

Looking through the lens of CVD care, this report makes further recommendations on how holistic care activity could be directed to support different patient groups. The literature on changing models of care is clear that care for people with multiple needs requires to become more personalised, more coordinated and more collaborative if patients are to be engaged in optimising their health, and if both demand on the system and health inequalities are to be reduced. This means, for example, that Stretch QOF needs to be more holistic, focused on patient outcomes overall rather than individual disease targets. However, a shift towards more collaborative, co-produced care requires fundamental shifts in culture, investment in staff (for example training) as well as time to embed. Achieving this at the same time as seeking to reduce variation between and within PCNs and manage workforce constraints is a significant challenge. Time, training and opportunities for co-production and shared reflection on cultural change, in addition to continued collaboration between public health and primary care to understand the data driving and measuring this work, are needed to support this shift.



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#### **Long Term Conditions covered in this report**

- Hypertension (High blood pressure)
- Atrial fibrillation (a heart rhythm problem, characterised by a rapid, irregular heartbeat)
- Raised cholesterol (Coronary Heart Disease; CHD)
- Familial hypercholesterolaemia
- People who have had a stroke or TIA (transient ischaemic attack, also known as a mini-stroke)
- Diabetes – CVD related risk only (people with diabetes are at increased risk of CVD and a range of other complications)

# Reducing the Impact of Cardiovascular Disease in Thurrock

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### 1. Introduction

The 2016 Annual Public Health Report for Thurrock[1] explored the sustainability of health and social care systems in Thurrock, with particular reference to Long Term Conditions (LTCs) amongst adult residents. The report, which was extensive, highlighted a number of issues including variable access to primary care across the Borough, differences in the quality of care between practices (affecting both the detection and management of LTCs), and associated impacts on patients, their health status and consequent hospital admissions. The report made a series of recommendations to increase the effectiveness and cost-effectiveness of care in Thurrock. These included:

- A new model for Primary Care to address under-doctoring (lower than average ratio of GPs to residents), especially in the Tilbury and Chadwell area
- Mechanisms to case-find and diagnose patients
- Recommendations to reduce avoidable demand on secondary (hospital and community specialist) care
- Support to improve the management of LTCs in primary care

Much has changed since 2016, both proactively in terms of national policy and local health developments, and reactively as a consequence of the COVID-19 pandemic. The 2016 report examined the identification and management of a wide range of LTCs and disease groups. This report, the 2022 Annual Public Health Report for Thurrock, considers progress in improving LTC care through the recommendations of that report by reviewing one of the LTC clusters outlined in the 2016 report: Cardiovascular Diseases (CVD). Of all the disease groups, CVD causes the highest levels of premature mortality and health inequalities, and detecting and treating CVD, in accordance with NICE guidance, has the greatest potential to reduce health inequalities and reduce premature mortality.

One in four premature deaths (death before the age of 75) in the UK are due to cardiovascular disease, and it is the leading clinical contributor to health inequalities. However, if risks are correctly identified and managed, CVD is also the most preventable cause of premature mortality. As set out by the World Health Organisation (WHO), the key behavioural risk factors for CVD are smoking, unhealthy

#### What is Cardiovascular Disease?

Cardiovascular disease (CVD) is a set of conditions that affect the heart or blood vessels. They include, most commonly:

- Coronary heart disease
- Heart attack
- Heart failure
- Stroke

People with certain Long Term Conditions (LTCs), including atrial fibrillation, high blood pressure, and raised cholesterol, are at higher risk of ill-health or death from CVD, but this is reduced if these conditions are identified and treated. The risk of developing these conditions increases with age, for people with a family history of heart disease, people with Diabetes, and for people from south Asian, Black African or African Caribbean backgrounds. However, healthy behaviours and effective treatment reduce the risk of acquiring these long-term conditions.

Reducing health risk behaviours— not smoking, maintaining a healthy weight and diet, being physically active, and moderate alcohol consumption – reduces the risk of developing these conditions in the first place.

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diet/obesity, lack of physical activity, and harmful use of alcohol, all risks which can be ameliorated with support and appropriate policies. The 2017 Global Burden of Disease study[4] found that whilst there have been reductions in smoking rates over the last 30 years, England is in the worst performing group of the 22 countries studied for levels of physical activity, Body Mass Index (BMI – an indicator of healthy weight) and diet.

After outlining the population of interest, this report first provides an overview of national and local contextual changes since 2016: those originating from national policy, and those arising due to the pandemic. It then briefly outlines the findings of the 2016 report relating to primary care workforce, and to prevalence and admissions due to CVD. Next it considers the impact of the 2016 report through summarising current data on CVD along with data on health inequalities in Thurrock, and initiatives on CVD put in place after the 2016 report. A literature review (presented here in summary but full text available) then sets out additional areas for potential improvement in the detection and management of CVD LTCs. The report concludes with a range of recommendations for building on the 2016 report and further improving CVD prevention and management locally.

### **Why focus on CVD risks?**

One in every 20 people with untreated high blood pressure will have a stroke in the next three years

One in every two people with untreated Atrial fibrillation will have a stroke in the next three years.

### *BUT*

For every 1% increase in patients identified and registered as at risk, 65 strokes could be prevented over 3 years.

## 2. Why Focus on Cardiovascular Disease?

With a rate of 74.5 per 100,000 residents, Thurrock has a higher rate of premature (ie under age 75) mortality from cardiovascular diseases than the East of England (62.9/100,000) and England (70.4/100,000) (PHE, 2017-19 data). In 2020, CVD accounted for 18.5% of deaths in Thurrock in 2020 and 13.8% of deaths in those aged under 75. CVD is also the most significant contributor to mortality attributable to socio-economic inequality in Thurrock, accounting for 35% of excess deaths[5].

However, much CVD is preventable, and as outlined below there are significant opportunities to save lives, improve quality of life for patients, and reduce health inequalities associated with poor CVD outcomes. The national ambition, set out in the NHS Long Term Plan in 2019 and further detailed by Public Health England[6], is to prevent 150,000 CVD events (in England) over the 10 years to 2029, through increased detection of risk factors and a higher quality approach to the management of CVD conditions. Locally, if the health of adult Thurrock residents were typical of that in the national population, this would translate to preventing 370 CVD events by 2029 (equivalent to 1.1% of non-elective CVD admissions per year). However, as rates of mortality and morbidity in Thurrock from CVD are already higher than nationally, this should be very much a minimum target.

Addressing CVD requires a multi-layered approach that can be best conceptualised as a pyramid (see Figure 1). At the base are universal actions also termed 'primary prevention' (e.g. local and national policies such as easy access to affordable fruit and vegetables), then actions that promote and sustain healthy behaviours (such as support to stop smoking). Further up the pyramid is increased activity to identify risk factors and early diagnosis of CVD LTCs, some of which needs to be targeted to groups or areas where prevalence is

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higher than average, and finally the smallest number of people require effective clinical management of LTCs and secondary prevention to prevent adverse outcomes. When opportunities for primary prevention are maximised, fewer people need complex and costly clinical intervention, as shown in the 2022 report from the Thurrock Integrated Care Alliance: Better Care Together Thurrock: The Case for Further Change[7]. That strategy (BCTT Strategy) includes analysis of the extent of avoidable admissions and associated costs from increased CVD prevention, and sets out in more detail the plan to transform and integrate adult health, care and third sector services across the district. This APHR report complements that BCTT report by focusing on the actions taken since 2016 to reduce the burden associated with CVD in Thurrock and the changes in healthcare since then, and the potential for further action, with the aim of reducing the health inequalities associated with CVD in Thurrock.

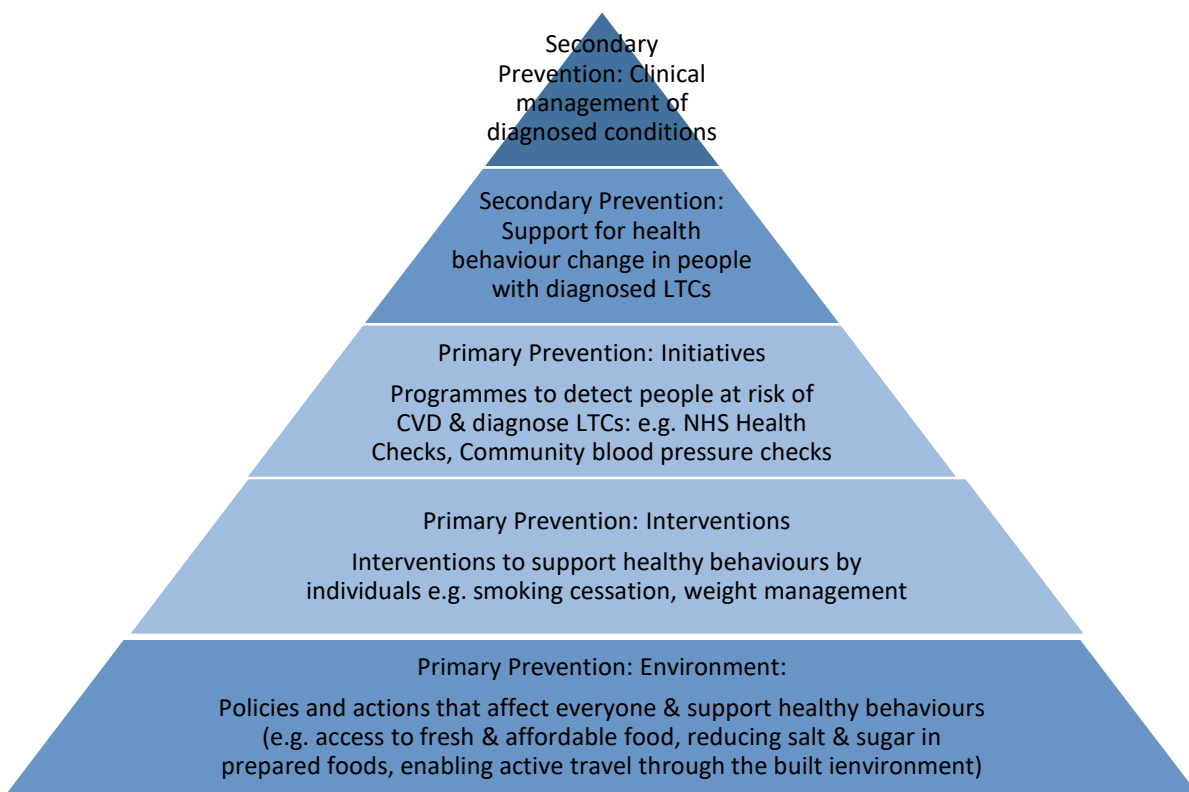


Figure 1: Actions required to reduce the impact of cardiovascular disease

Healthy behaviours are key to both preventing and reducing the risk of cardiovascular conditions (primary prevention), and to limiting the impact of diagnosed CVD conditions (part of secondary prevention). Moreover, risk factors for CVD, and prevalence of CVD conditions, are higher amongst people living in the most deprived areas where residents have poorer access to health care – a situation known as the Inverse Care Law. The 2016 report found evidence of this in Thurrock, with fewer available healthcare appointments per head than in the least deprived parts of the district. However, since then the former Thurrock CCG (whose functions have since July 2022 been subsumed by the Mid & South Essex Integrated

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Care System: MSE ICS) has taken action to address this by increasing the number of clinicians available in primary care (See section 5.6 for further information).

Figure 2 provides a schematic overview of the categories of patients who may benefit from a more systematic approach to CVD identification management. Patients most at risk of poor health outcomes, but with most to gain, are those with undiagnosed conditions (shown in in red), and those whose conditions are not adequately managed (shown in orange). Our analysis of hospital data in the 2016 APHR – refreshed for this report, is that these patients experience avoidable hospital admissions, along with those patients in the buff circle, whose condition/s are recorded in primary care but whose condition/s are poorly controlled (for example whose blood pressure is not at or below the NICE-recommended minimum levels), and those in the amber circle whose conditions are not only poorly managed but not recorded in primary care records. This focus on improved detection and treatment of risk factors aligns with the goal in the NHS Long Term Plan to prevent 150,000 CVD events nationally by 2029[8].

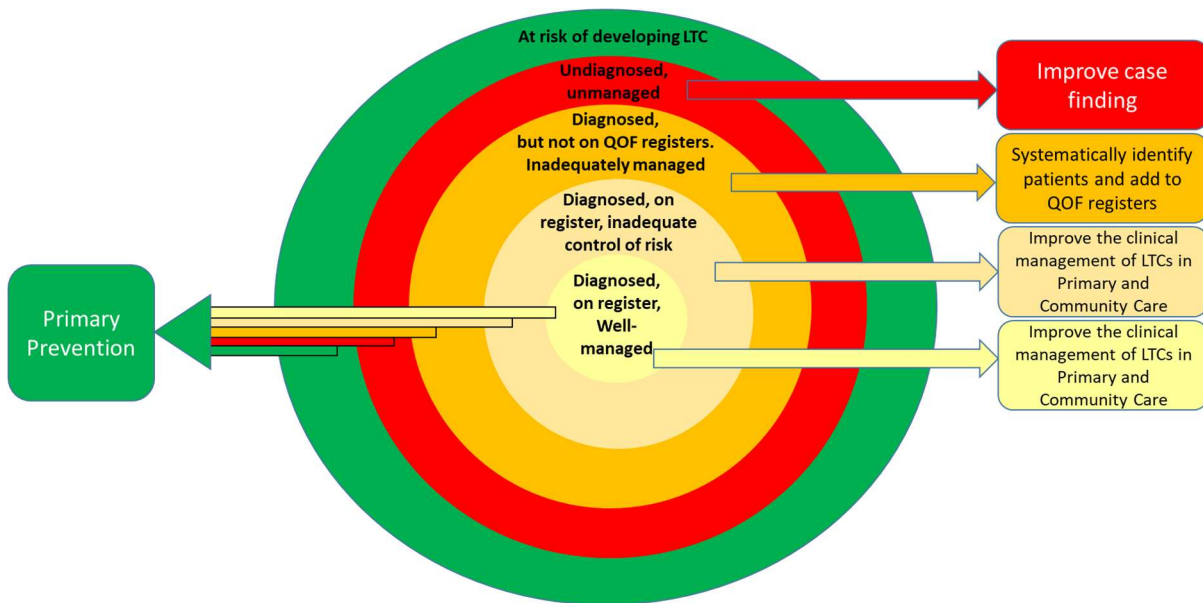


Figure 2: Segmentation of patient groups relating to CVD

Improving outcomes for patients with known or hitherto un-identified CVD risks not only benefits individuals, it also reduces pressures in both primary and secondary care. The majority of adults in Thurrock, as elsewhere, make very limited use of health services.

Analysis for the BCTT[7] has identified that in Thurrock, greater use of health care is associated with age and increased morbidities. In Thurrock, just 1% of the population, typically aged over 65 and with high levels of frailty and/or LTCs, account for 8.8% of the spend on A&E attendances and 26% of the spend on hospital admissions. Moreover, circulatory diseases (including CVD and diabetes) account for the highest proportion of hospital costs compared with other types of disease such as cancers: £5.23M in 2019-20. (This situation is not unique to Thurrock: evidence on healthcare utilisation in England suggests more than a quarter of the population accounts for more than half of all primary and secondary healthcare use[9].) As the 2016 APHR

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outlined, many of these admissions could be avoided with better identification and management of cardiovascular conditions, as well as through increased identification of those at risk, benefitting both residents and the local health system.

### 3. Context

#### 3.1 National Policy Changes

Since 2016 there have been significant developments in national healthcare policy, with the publication of the NHS Long Term Plan [2] in January 2019. This acknowledges the challenges facing the health care system in relation to access, the workforce, increasing demand, joined-up care, quality of care and health inequalities, and outlines how these challenges may be addressed locally and nationally. Organisationally it has led to the creation of Integrated Care Systems, which bring together not just healthcare organisations (including hospital Trusts) but Local Authorities and the Voluntary & Community sector at sub-regional level. A system priority for the NHS Long Term Plan is digital transformation, though it should be noted that the pandemic has led to rapid developments in this area, arguably faster than would perhaps have been achieved otherwise.

The NHS Long Term Plan focuses on a number of clinical priorities, two of which are Cardiovascular Disease and Stroke, with the overall goal of preventing 150,000 strokes, heart attacks and dementia cases and reducing the inequalities associated with CVD by 2029. To achieve this, national objectives include:

#### Cardiovascular Plan

1. Improving the effectiveness of approaches such as the NHS Health Check
2. Supporting people with heart failure and heart valve disease to access increased testing including in primary care
3. Working with partner organisations to increase the number of people who know their AF, high blood pressure and high cholesterol (ABC) status
4. Increasing access to cardiac rehabilitation
5. Improving community first response and defibrillator access
6. Expanding access to testing for familial hypercholesterolaemia to increase identification from 7% to 25%

#### Stroke Plan

- Prevention through increased identification and support for ABC Increased access and quality of rehabilitation services (including working with partners such as the Stroke Association)

Building on these objectives, the National CVD Prevention System Leadership Forum[6] has determined a set of specific ambitions to reach the NHS LTP goal:

- Detection of atrial fibrillation to increase from 79% to 85% of those expected to have the condition; Management (those at high risk of stroke to be anticoagulated) to rise from 84% to 90%.

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### Does this report align with other strategies and plans for Thurrock?

Thurrock's Health & Wellbeing Strategy (2022-26) has recently been refreshed. With the vision "Levelling the Playing Field" it endorses a whole systems approach for addressing inter-generational health inequalities and variation in service access and outcomes. A statutory document (which must therefore be taken into account by Mid & South Essex ICS when planning health services locally), it covers 6 domains encompassing health outcomes and wider determinants of health. Priorities include creating the four Integrated Medical Centres (priority 3B), improvements in the identification and holistic management of LTCs (priority 1C) and primary prevention of chronic diseases through reducing smoking, obesity, lack of physical activity and substance misuse (priority 1A).

The Better Care Together Thurrock: Case for Further Change strategy sets out in more detail the plan to transform and integrate adult health, care and third sector services across the district. This strategy endorses the Human Learning Systems (HLS) approach, which recognises the dynamic nature of complex systems like healthcare. It describes how HLS principles, which include co-design and co-production, continuous learning and refinement, supported by quantitative and qualitative data, will be adopted and used to ensure that care is built around outcomes for individuals, not inputs.

Thurrock's Brighter Futures Strategy concerns the wellbeing of children & young people in the district.

- Detection of hypertension cases to increase from 57% to 80% of those expected to have the condition; management (treated to target as per NICE) from 56% to 80%.
- Detection of raised cholesterol to increase from 49% to 75% of those expected to have the condition; management of high cholesterol from 35% to 45% (focused first on increasing initiation of statins to people with a  $\geq 20\%$  risk of developing CVD within 10 years).

### What is your ABC?

Knowing three things:

- If you have atrial fibrillation
- Your Blood pressure
- Your Cholesterol level

The local implications of these targets are explored in section 5.4 below.

In order to meet its stated aims, the NHS Long-Term Plan signalled further development and diversity in the primary care workforce, with an expansion of roles in primary care. These include Paramedics, Pharmacists (of particular relevance to people with LTCs to support adherence to medication) and Physician Associates (who provide diagnostics under the supervision of a GP, with the aim of freeing up clinical capacity and reducing GP workload). Other roles are more holistic, such as Social Prescribers, and aim to address specific wellbeing and social needs which impact health. Alongside these workforce developments, the Primary Care section of the NHS LTP aims to bring together mental and physical health, focusing on 'person' and 'place', with outpatient clinics brought to the community, and more community teams providing support in the home. This is to be achieved in part through the creation of Primary Care Networks (PCNs). These are informal organisations (i.e. not legal entities) that encourage collaboration between GP Practices, Dentists, Pharmacists and other healthcare providers including mental health.

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### 3.2 Changes to Health & Care Services in Thurrock

Organisationally, Thurrock CCG is now one of four Alliances within Mid & South Essex Integrated Care System (formerly Mid & South Essex HCP), which, alongside Thurrock Health & Wellbeing Board and Thurrock Integrated Care Partnership, make strategic decisions about funding and commissioning of healthcare services.

Locally, GP practices have grouped into four PCNs:

- ASOP: 6 practices with c. 40,000 patients from Aveley, South Ockendon & Purfleet)
- Stanford-le-Hope & Corringham (SLH): 6 practices with c. 33,000 patients
- Tilbury and Chadwell: 5 practices with c.37,000 patients
- Grays: 10 practices with c.73,000 patients

Practices within PCNs are expected to collaborate to make best use of staffing and practice across the PCN and to work together to share good practice and address quality concerns. In 2021, Mid & South Essex HCP published a new Primary Care Strategy which commits to supporting both the leadership and management within PCNs and the increased collaboration and integration between community services and primary care that the locality focus brought by the introduction of PCNs in the NHS Long Term Plan makes possible. An example is the Integrated Mental Health Team set up in ASOP in 2020, in which mental health specialist staff (employed by EPUT) work alongside primary care staff. This team provides support to people who need more specialist care than can be provided in primary care, but who do not meet the threshold for secondary care services; the team also supports people with severe mental illness to manage their physical health.

Even before the national and MSE strategies were introduced, Thurrock had already made progress in some of these areas. As outlined in chapter 2 of Thurrock CCG's Adult Place Based Strategy[10], Physician Associates and Paramedics were recruited in 2017 to address pressures and quality concerns in Tilbury & Chadwell PCN, and Thurrock CCG took responsibility for primary care planning locally. Thurrock Council had already brought in Local Area Coordinators, providing social support to individuals and communities – for example helping with entitlement to benefits, dealing with debt and money problems, and connecting people to volunteering schemes. The next steps are to build on this progress across all four PCNs locally.

### 3.3 The COVID-19 Pandemic

This report is concerned with CVD specifically, rather than the impact of the pandemic on the health of Thurrock residents overall. However, it is clear that some common general themes arising from the pandemic will have further exacerbated the gap between health demand and supply, including for the prevention and management of CVD, as follows:

- There have been changes to the way healthcare is provided, and to how patients access support, with growth in 'virtual' appointments; difficulties or perceived difficulties accessing healthcare during lockdowns; and increased waiting lists for secondary care which may in turn impact on



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demand for primary care. As an example, May 2020 saw the lowest number of primary care appointments provided (53,242) and within this, the lowest proportion of face-to-face appointments (52.5%) and home visits (< 10). It is important to note that whilst the increase in virtual appointments may be positive for many patients, many others are digitally excluded, which risks exacerbating health inequalities associated with age and deprivation. As of autumn 2021, 100% of Thurrock practices responding to the Practice Access Survey were open core hours. However only 42% were providing same day appointments face-to-face against a target of 100%. A fifth of clinicians were still working from home, limiting the availability of face-to-face appointments.

- There have been adverse effects on people's physical and mental health. These include worsening of health due to reduced (or perceived reductions in) access to health care, fear of contracting COVID-19 reducing help-seeking, capacity constraints leading to longer waits for treatment and elective surgery, and Long COVID<sup>1</sup>. The pandemic is also likely to have had an adverse impact on the number of people with long term conditions managed to clinical targets, further widening the health inequalities associated with CVD. Children are also affected, with NCMP data showing increased rates of obesity amongst children in reception class and year 6.
- In order to ensure that the COVID-19 vaccination programme could be rolled out as fast as possible, Government released General Practice from many of the requirements associated with QOF (primary care Quality Outcomes Framework<sup>2</sup>), firstly to manage capacity during the first part of the pandemic, then to release capacity for the COVID-19 vaccination programme. In practice, this has meant delays to the usual schedule of reviews for people with CVD conditions on the QOF disease registers. In addition, practices were twice directed to suspend locally commissioned services not related to COVID-19, affecting delivery of services such as NHS Health Checks.
- Finally, but significantly, the pressure of meeting the increased demand for healthcare at the same time as having to adapt practice or service delivery on an ongoing basis, has had an impact on the health and wellbeing of healthcare staff.

Most importantly, COVID-19 has exposed and worsened health inequalities. People living in more deprived areas, people with learning disabilities (LD) and people from Black, Asian and other minority ethnic groups have experienced higher mortality from COVID-19. This is related to a variety of factors such as housing conditions, but also in part to the severity and mortality of COVID-19 being increased amongst individuals

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<sup>1</sup> Long COVID is described by the NHS as experiencing symptoms 12 or longer after having COVID-19. See <https://www.nhs.uk/conditions/coronavirus-covid-19/long-term-effects-of-coronavirus-long-covid/>

<sup>2</sup> QOF (Quality Outcomes Framework) is a primary care incentive scheme set up in the mid 2000s to improve the quality of care. QOF targets focus attention on detection of patients with particular risks (e.g. smoking) and improved management of a wide range of long term conditions including those covered in this report.

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with diagnosed CVD or risk factors. Research[11] has identified, for example, that amongst people admitted with COVID-19 before November 2020, hypertension was associated with 2.6x higher risk of severe COVID-19 and 2.5x higher odds of mortality, odds were highest for people with coronary heart disease (CHD; 3.6x higher mortality). Severe COVID-19 was associated with smoking and mortality with obesity (odds 1.8x higher and 2.2x higher respectively). (The research also identifies the incidence of acute cardiovascular events and cardiac complications that follow admission with COVID-19.)

The pandemic has also worsened and exposed structural inequalities associated with low income, insecure or low-paid employment, with associated increases in food and fuel poverty. Other factors which contribute to health inequity have also worsened including increased caring responsibilities and domestic abuse[12]. Some COVID-19 impacts are already evident – such as the increase in complexity of illness for patients who did not, or could not, access health care during lockdowns. Other impacts may be yet to emerge, particularly those relating to changing health behaviours, changed economic or family circumstances, and to Long COVID.

**RECOMMENDATION:** Refresh the focus on primary prevention of CVD post-COVID-19

#### 4. The 2016 Report – a summary of issues relating to CVD

In the 2016 Annual Public Health Report for Thurrock, the authors set out a vision and plans for a sustainable adult and social care system in the Borough. The report outlined a number of challenges within health and care system, considering staffing issues, financial pressures on secondary care, increases in demand for emergency care and the impact of all these on the health of Thurrock residents with long term conditions (including but not restricted to CVD). The report presented a number of ways in which health and care could be improved for Thurrock residents whilst making financial efficiencies. These included a specific focus on the detection and management of long-term conditions including CVD.

##### 4.1 Primary Care Workforce

One of the areas explored in the 2016 report was access to appointments in primary care. In common with many parts of the country, Thurrock experiences 'under-doctoring' - a lower ratio of clinicians to residents than average. Across Thurrock and the UK as a whole, there are variations in the ratio of patients to clinicians, a situation which is often exacerbated in the most deprived areas (an example of the inverse care law in action)[13]. It is important to note that this is not a reflection on individual practices, but a result of the way in which primary care has traditionally been funded, as well as a consequence of staffing pressures resulting from the age profile of GPs and Thurrock's proximity to London. In 2016, Thurrock was the 4<sup>th</sup> most 'under-doctored' CCG in England, with 2110 patients to every full-time equivalent GP compared with the England average (mean) of 1321, with the practice under most pressure having a ratio over five times that of England. In addition, all but five Thurrock practices in 2016 had a lower ratio of nurses than the England average. As the 2016 report makes clear, the ratio of doctors to patients is not the only factor affecting the availability of appointments. Nonetheless, as the 2016 Thurrock report outlines, difficulty accessing appointments in primary care is associated with increased hospital admission for CHD and Heart Failure, and under-capacity in primary care has impacts not just on patient care but also increases otherwise avoidable

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clinical exacerbations resulting in pressure elsewhere in the health system. As an example, it was estimated in the 2016 report that every 1% increase in availability of GP appointments would lead to a reduction of 109 emergency admissions for heart failure.

#### 4.2. Prevalence and Management of CVD in Thurrock in 2016

Public Health England (PHE) used a range of data to predict the prevalence rates of long-term conditions at General Practice, and now PCN, level. These could then be compared with the diagnosed rates reported through the QOF framework.

Analysis of QOF data in 2016 (comparing individual practice data from 2014-15 with 2016 PHE estimates) found significant gaps between the reported numbers of patients on disease registers for hypertension, stroke/TIA and CHD and the numbers that would be expected using PHE prevalence estimates (these take into account demographical variations between practices and PCNs). For example, in 2016 hypertension registers were on average 68% complete versus expected prevalence, with significant variation between practices. Table 1, from the 2016 Report[14], shows the recorded and expected prevalence for certain conditions (the original table included COPD), and the estimated number of patients yet to be diagnosed.

Long Term Condition	Recorded Prevalence (i.e. people already diagnosed)	Estimated Prevalence	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	1.51%	3.70%	3,540
Hypertension (2016)	14.08%	20.95%	10,983
CHD (2016)	2.78%	7.58%	7,521
Diabetes (2016)	6.3% (17+)	7.9% (16+)	2,109

Table 1: Estimated gap between expected and recorded prevalence of CVD conditions (adapted from the 2016 APHR)

Analysis of QOF data for the 2016 report also suggested concerns around the management and quality of care for many patients diagnosed with CVD conditions. There were significant gaps recorded for the number of patients treated to NICE-recommended clinical thresholds. For example, the number of patients diagnosed with atrial fibrillation with a CHA2DS2-VASc score >1 but not prescribed (or exception-reported) an anti-coagulant was 247. This is significant because 50% of these patients were estimated to be at risk of having a stroke within 3 years.

#### 4.3 Recommendations of the 2016 Report Relating to CVD

The 2016 APHR calculated the number of hospital admissions and A&E attendances that might be avoidable, if Thurrock patients were diagnosed and treated to target, and the potential cost-savings associated with the reduction in admissions, leading to the following recommendations:

- Further investigation of the GP practices with the highest rates of admission for 'ambulatory care sensitive' conditions (angina, congestive heart failure and diabetes), with the implementation of a practice scorecard and facilitating the sharing of best practice.
- Redesign and procurement of a healthy lifestyle service with a focus on those patients with LTCs
- Support for a whole system approach to reduce obesity prevalence

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- Implementation of a hypertension case-finding and Clinical Management Improvement Programme
- Treat more heart failure patients with effective medication, with support from the Public Health team via further analyses and the creation of bespoke SystmOne reports.
- Support more patients with effective blood pressure control (e.g. as above)
- Significantly increase primary/community care capacity in Thurrock including better skills mix of staff with GP surgeries
- Expediate building the four Integrated Healthy Living Centres (now Integrated Medical & Wellbeing Centres) in Purfleet, Tilbury & Chadwell, Grays and SLH

## 5. Thurrock in 2022

### 5.1 Health Inequalities in Thurrock, 2022

There is variation in health outcomes across Thurrock and between Thurrock and neighbouring areas, driven by broad and complex factors. Health inequalities between populations manifest as differences in life expectancy. In 2020, life expectancy was significantly lower in Thurrock than average across England for both men (78.3 years vs 79.4 years) and women (82.6 years vs 83.1 years), and the lowest in MSE ICS (see Figure 3)

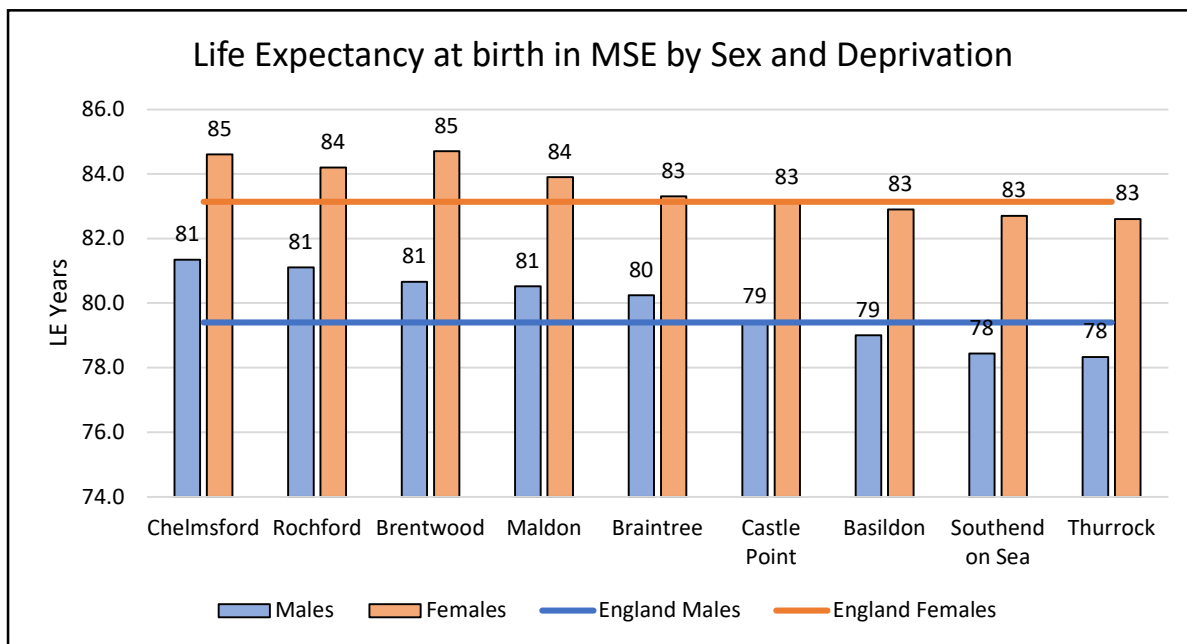


Figure 3 – Life expectancy at birth in MSE ICS at district level (ONS, 2020; Fingertips)

Healthy Life Expectancy (HLE) is how long an individual can expect to live in good health. Variation in HLE is a measure of the health inequity that exists within and between populations. HLE in Thurrock is 63 years for males and 61 years for females, but this hides considerable variation within the local community. Individuals in the least deprived parts of Thurrock can expect to live between 6.4 to 8.7 years longer than those in the most deprived areas. In terms of HLE, people in the most affluent areas of Thurrock experience 8 years more

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healthy life than those in the most deprived, with women in the most deprived areas experiencing 22 years in poor health.

In terms of socio-economic inequality, Thurrock has a larger proportion of its population clustered around the England average deprivation level than is typical for the country as a whole: around 11% of the Thurrock population live in the 20% least deprived areas nationally, and around 11% live in the 20% most deprived[15]. Overall, local data show that the local authority district of Thurrock has the 3<sup>rd</sup> worst mortality rate attributable to socioeconomic inequality in Mid & South Essex, with circulatory conditions being the greatest clinical driver[15]. Detailed information about the impact of socio-economic inequality on health in Thurrock can be found in the Thurrock Health & Wellbeing Strategy 2022-26[16].

Figure 4 shows the populations covered by the four PCNs in Thurrock, and their relative deprivation, clearly showing the difference in area-level deprivation for Tilbury & Chadwell and ASOP patients, and those in SLH and Grays.

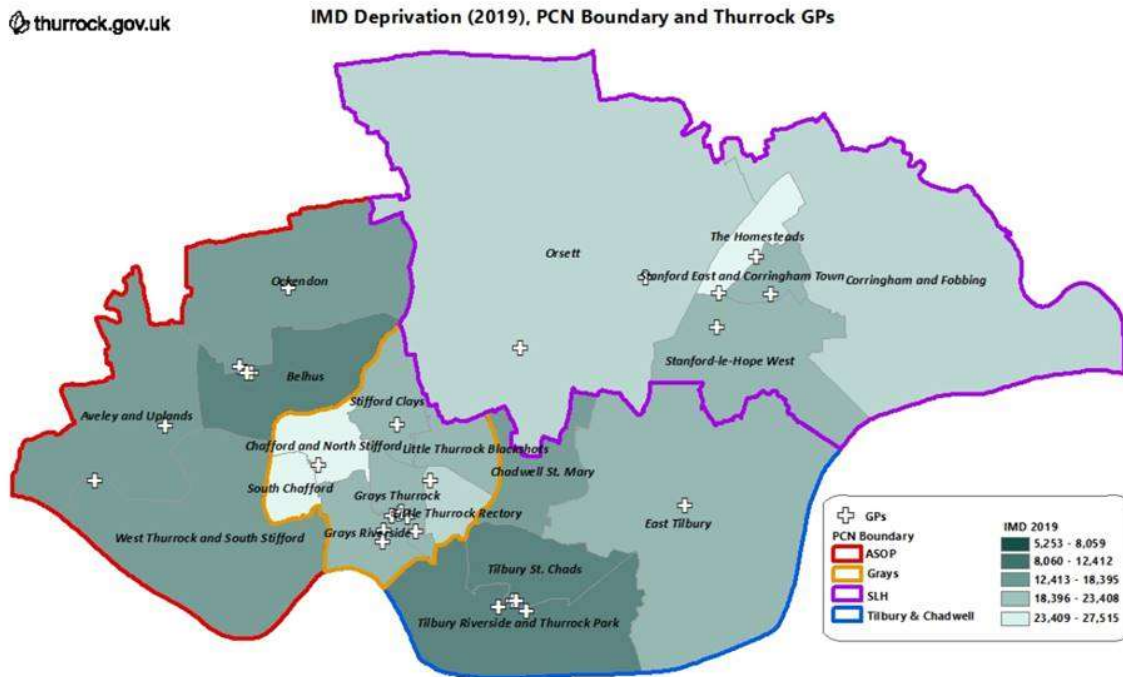


Figure 4: Map of Thurrock District, showing PCN boundaries and IMD 2019 ranks. A higher IMD rank indicates a higher level of deprivation.

### 5.2 Prevalence and Management of CVD Risks in Thurrock in 2022

As noted above, QOF reporting found under-diagnosis of CVD and variation in care quality across Thurrock practices in 2016; addressing this variation in quality between practices was a key reason for implementing the initiatives outlined above. The key question, therefore, is what difference this focus and activity has made to the detection and management of CVD conditions in Thurrock. For methodological reasons (including the fact that the earlier report analysed data by practice, but data are now presented by PCN, and

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the impact of COVID-19 on QOF data collection) direct comparisons are not made with the data in the 2016 report. Available data are used to assess trends, and to explore the situation now for three key areas of focus in the national CVD plan: hypertension, atrial fibrillation and familial hypercholesteremia.

### 5.3 Prevalence of CVD Conditions

Figure 5 below shows recorded prevalence of diagnosed CVD conditions across the four PCNs for the last period with full QOF data (2019/20 as reporting was paused for some indicators during the COVID-19 pandemic). Given the higher levels of socio-economic deprivation in the areas covered by the ASOP practices compared to Grays or SLH, true prevalence of CVD LTCs would be expected to be higher. As the comparison in Table 2 shows, the gap between estimated and recorded cases is highest in ASOP, representing a higher proportion of residents undiagnosed and untreated.

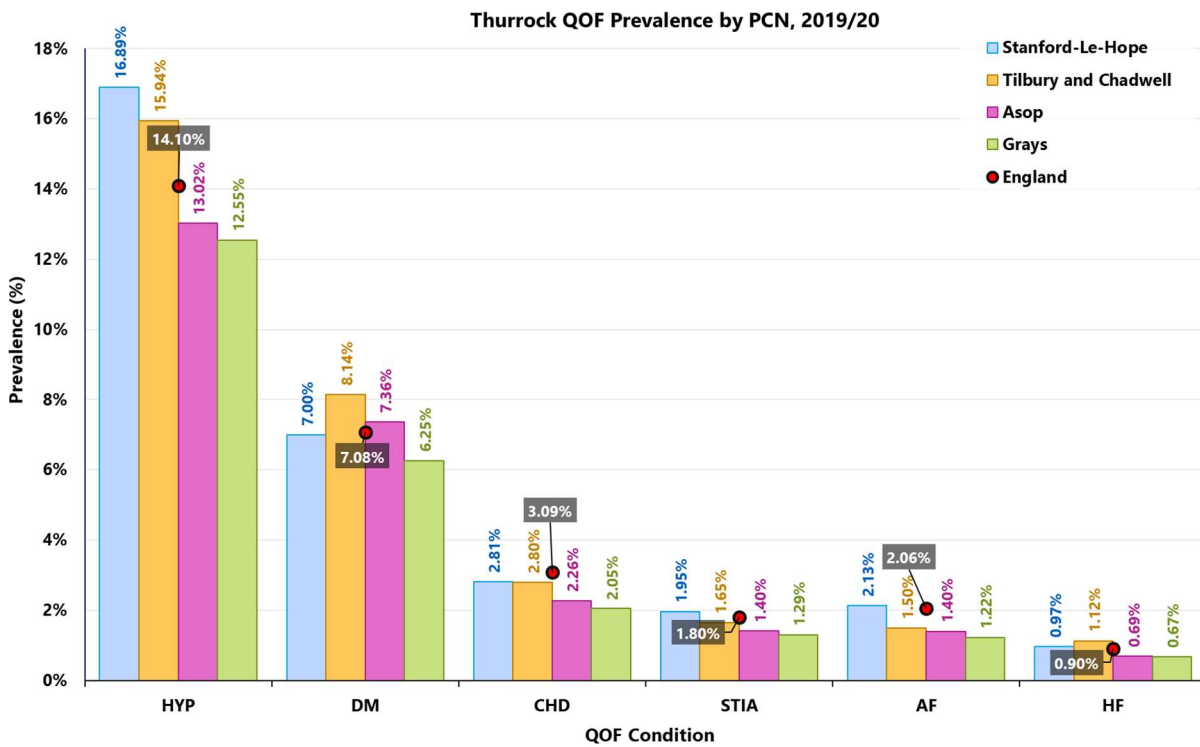


Figure 5: Prevalence of CVD long term conditions by PCN (2019/20 data, the latest available)

PCN	PHE Estimated Prevalence	Recorded PCN Prevalence 19/20
ASOP	20.20%	13.02%

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<b>Grays</b>	18.95%	12.55%
<b>SLH</b>	22.32%	16.89%
<b>Tilbury and Chadwell</b>	21.80%	15.95%

Table 2: Estimated Hypertension prevalence by Thurrock PCN (Source PHE)

In all four PCNs, hypertension is the CVD condition with highest recorded prevalence locally. It is also the most common risk condition for CVD mortality and morbidity in England, the most common morbidity across all LTCs amongst patients on primary care disease registers[9], and significantly associated with health inequalities. However, many residents have more than one CVD condition (with or without other LTCs). Figure 6 provides an illustration of the overlap between CVD conditions.

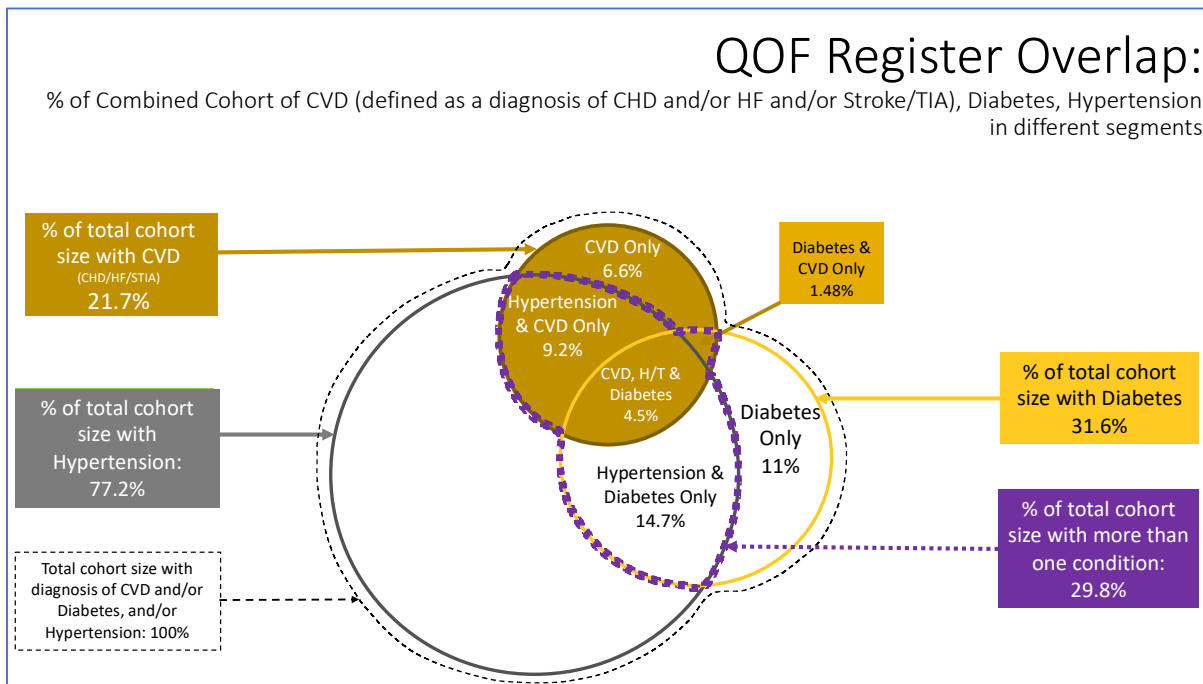


Figure 6: Overlap of recorded CVD conditions for patients on primary care registers

The more conditions a person lives with, the more frequent appointments and interactions they have with health professionals. However, initiatives implemented to improve prevention and management of CVD can lead to improvements for other disease groups (and especially for individuals with multiple LTCs) and inform actions to be taken across health and wellbeing services. In Thurrock, the highest rate of multi-morbidities is found in Tilbury & Chadwell PCN, consistent with higher socio-economic deprivation levels, with 45% of

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patients on a register having more than one LTC. Using the number of LTCs to signify complexity of health care need, table 3 shows the relative complexity of need in each PCN.

PCN	% of LTC individuals with more than 1	% of LTC individuals with more than 2
Grays PCN	40%	14%
Tilbury and Chadwell PCN	45%	17%
ASOP PCN	39%	14%
Stanford-Le-Hope PCN	42%	15%
<b>Total</b>	<b>41%</b>	<b>15%</b>

Table 3: Patients with multiple Long Term Conditions in Thurrock PCNs

#### 5.4 Measures of quality in the diagnosis and treatment of CVD conditions

PHE calculations show that the expected number of patients on primary care registers by April 2020 increased due to the increase in population. As in 2016, there are gaps between reported and expected prevalence for CVD conditions, as shown in Figure 7.

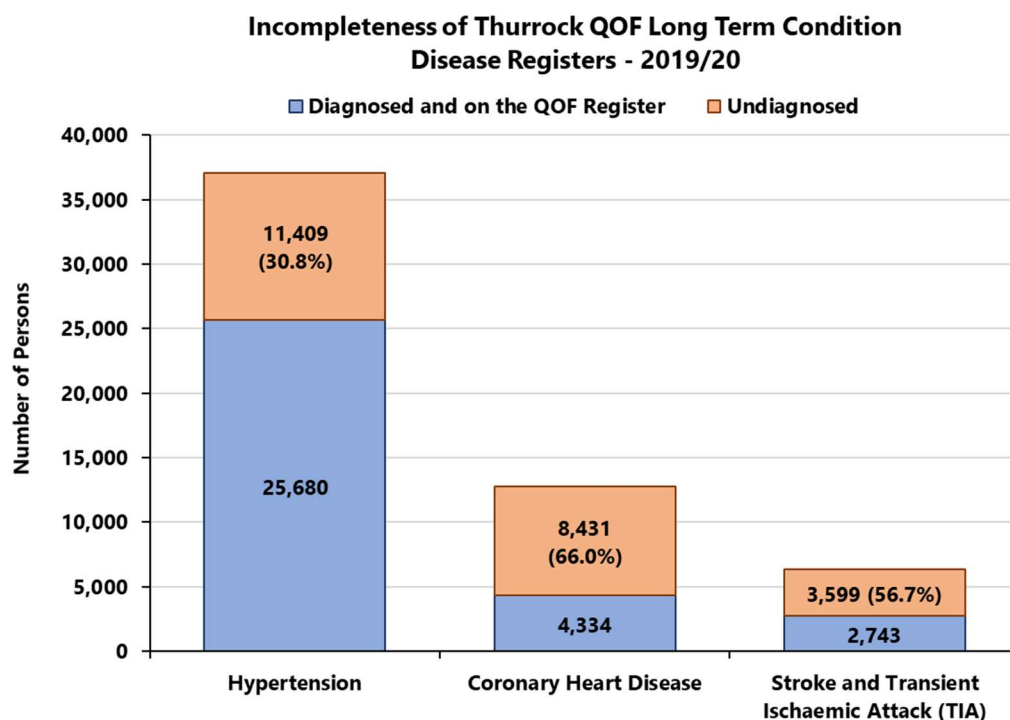


Figure 7: Difference between actual and expected numbers of patients recorded on primary care CVD registers

Further analysis, using 2019/20 data on hospital admissions data and QOF registers has suggested that some patients admitted to hospital due to a LTC or with stroke/TIA were not subsequently added to the relevant register in their practice. This is important because the purpose of primary care registers is to ensure



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patients with known CVD risks receive the correct treatment, and the analysis suggests an opportunity to improve clinical management for these patients.

Once patients are listed on QOF registers, practices are required each year to treat a set percentage of them to NICE-identified clinical treatment targets in order to attract payment. As with case-finding, there are gaps between the number of people recorded on QOF registers, and the number or percentage of those who are treated to target. Comparison with Thurrock's CIPFA neighbours (areas with similar demographics to Thurrock) does suggest that there are individual indicators where all the CIPFA neighbours struggle to reach target, for example two concerning blood pressure measurement (HYP007 and STIA010), others where most (including Thurrock) succeed, and a limited number where there may be some potential to close the treat to target gap, as for instance with the atrial fibrillation target shown in Figure 8.

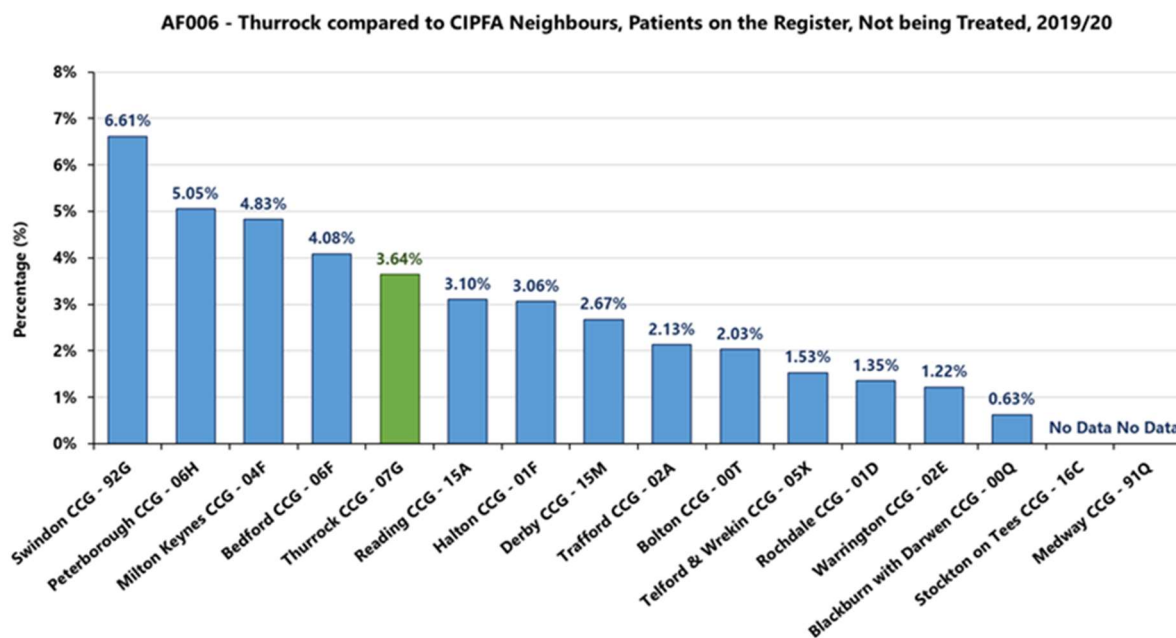


Figure 8: Comparison of Thurrock with similar authorities for the percentage of patients with atrial fibrillation not assessed using the CHA<sub>2</sub>DS<sub>2</sub>-VASc score

In general, quality of care for those on CVD primary care registers, as measured by QOF, is high and compares favourably to England averages and CIPFA neighbours (see below). This suggests that further improvements in population health are likely to be gained by a focus on reducing the gaps in diagnosis in particular.

#### Hypertension

Since 2016/17, diagnosis of hypertension has (with the exception of 2020/21, which was likely affected by COVID-19 restrictions) increased annually from 1,321 in 2016/17 to 2,567 in 2021/22. Attribution to individual elements of interventions to increase hypertension case-finding is unclear, but the combined result of measures implemented overall are positive. This is, however, balanced by individuals who leave the register, due either to the higher rates of CVD mortality in Thurrock or to resident mobility out of the area. Adjusting for population increase, this has resulted in a relatively constant estimated register completeness

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of between 67.6% and 70.0% in the period 2016/17 to 2020/21. Within Thurrock there is some variation present, with the highest underdiagnosis rate in ASOP, and the lowest in SLH.

Without these initiatives, it is likely that the percentage register completeness would have fallen. Population Health Management data shows that in 2019/20, the estimated completeness of hypertension registers was higher in Thurrock than in the other areas of MSE[15], suggesting that Stretch QOF and detection efforts applied in Thurrock have had an impact on clinical practice, despite the constraints of the pandemic.

There is a national target to reduce the current gap to 20% by 2029. This would require a further increase in case finding of around 650 individuals per year (over and above the 2,567 currently identified annually).

Data from 2020/21 reveals inequalities in blood pressure testing in primary care by age in particular (younger age bands being much less likely to be checked), with some inequality also persisting by sex and ethnicity, but not by deprivation [12]. Analyses also show an inequality in under-diagnosing in certain ethnic groups.

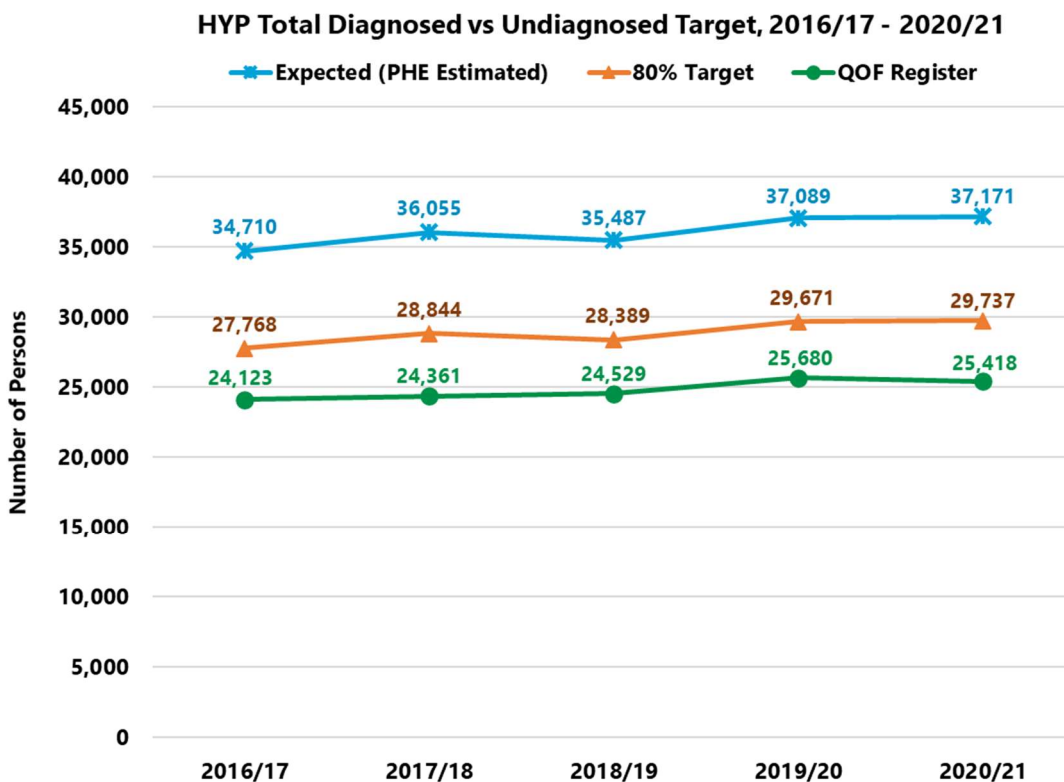


Figure 9: Increases in diagnosed cases of Hypertension between 2016-17 and 2021-2022

For treatment to hypertension targets (a measure of quality of clinical care), all four Thurrock PCNs are working beyond the national target for those aged over 80 (HYP007), and close to target for those under 80 (HYP003), as shown in Figure 10 below[2]. All PCNs are performing better on treatment to target than average for England for both age groups. Similarly, QOF treatment to target indicators were also higher in

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2020/21 in Thurrock than other areas of MSE, again suggesting that the combined initiatives in Thurrock have had a positive impact on clinical care.

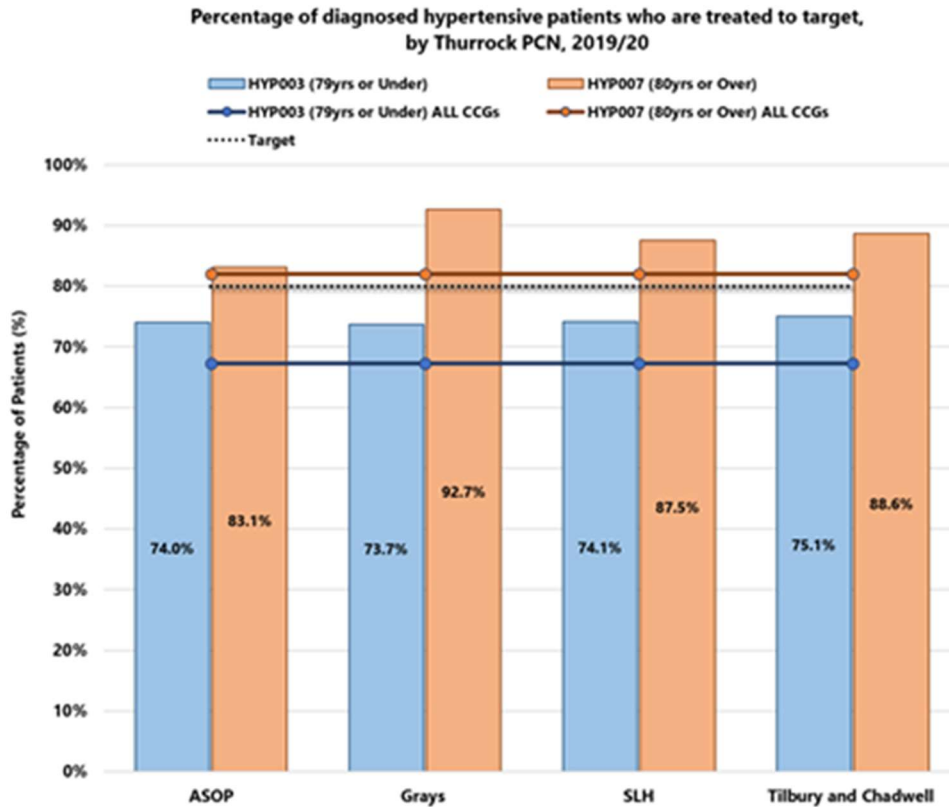


Figure 10 Thurrock patients on the hypertension register being treated to target

### Coronary Heart Disease and Hypercholesterolaemia

Total blood cholesterol is an important predictor of CVD events, particularly coronary heart disease. QOF registers for CHD include patients prescribed statins for atherosclerosis, and the national ambition is that 45% of adults aged 40-74 identified as having a significant risk of CHD are treated with statins. In Thurrock in 2016, 36.7% of the estimated prevalence of CHD was diagnosed. Unlike for hypertension, data from 2021/22 suggests that diagnosed prevalence has decreased to 30.7% with an estimated 9,615 residents having undiagnosed CHD. Whilst some of this decrease in detection rate is associated with increase in population, it is likely that factors related to COVID-19 (including access to primary care and the suspension of some QOF measures) will have had an adverse effect in this area.

For those who are on the CHD register, measures of therapeutic treatment and blood pressure management (QOF CHD005, 008, 009; 2019/20) show that Thurrock performs better than average for England and compares favourably to CIPFA neighbours, being the best performer in the group for blood pressure management in CHD[2].

Around 100 more Thurrock patients with familial hypercholesterolaemia have been identified since the 2016 report. The national target (25% of predicted prevalence range to be detected by 2024), applied to Thurrock is for 225 patients (at the upper end of the predicted range) with the condition to be identified. This target

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has already been exceeded. It is important to note that around 50% of men and 30% women with this condition will develop heart disease before the age of 55 so early detection through NHS Health Checks and practice screening could have significant impact on both morbidity and premature mortality.

#### Atrial fibrillation

One of the concerns in the 2016 report regarding the detection and treatment of atrial fibrillation was the number of patients known assessed as at risk (using CHA2DS2-VASc) but not being treated with anti-coagulants (AF006). The number in 2016 was 247 patients, assessment using 2019/20 data finds that this has reduced, with 182 patients yet to be treated [2](out of 2,230, allowing for the number locally exempted due to personalised care adjustments). Thurrock is thus already exceeding the national target of 90% in this area and has made improvements in treatment since the 2016 report.

The other national plan target relating to atrial fibrillation is detecting 85% of predicted prevalence. Analysis of local data from 2019-20 suggests that 77% have been identified (are recorded on registers) so far, and around 260 cases are yet to be detected to reach the 85% target.

### 5.5 Inequalities and CVD

Nationally, premature mortality for all causes (deaths under 75 years) correlates with increasing deprivation, a pattern also found in premature mortality from CVD specifically. CVD is also one of the 5 key clinical pathways in the NHS Core20Plus5 approach to health inequalities<sup>3</sup>. Analysis of local data shows that Thurrock has the highest level of premature mortality in MSE ICS, with CVD being the largest underlying clinical cause. For mortality attributable to socio-economic inequality, CVD is the greatest contributor in Thurrock, accounting for 35% of excess deaths [12].

Whilst this report primarily concerns CVD, it is important to note the high health inequalities and lower life expectancy due to CVD associated with serious mental illness (SMI) such as schizophrenia or bipolar disorder, and the often complex interactions for those with multiple physical and mental morbidities[9]. For people with SMI, increased prevalence of smoking, diabetes and obesity contribute to increased risk of CVD and a three-fold excess death rate from CVD in those aged under 75 compared with the general population[17]. In Thurrock, this appears to be particularly acute, with the borough having the second highest premature mortality rate in England due to CVD in people living with SMI in 2018-20[18].

In addition, whilst rates of smoking and drinking are lower for people with learning disabilities than for the general population, other risks – notably poor diet, high rates of obesity, and low levels of physical activity – are higher [19] and heart disease is the second highest cause of death amongst people with a learning disability.

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<sup>3</sup>See <https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>

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Inequalities exist not just in CVD rates and outcomes between different community groups, but also in CVD diagnosis and quality of care. Primary care data extracted by the Public Health team in 2022 shows that for all CVD conditions, the diagnosis rate in Thurrock for all non-White ethnic groups is lower than for White groups, despite the higher prevalence of CVD among certain minority ethnic groups, particularly South Asian and Black Caribbean communities, compared to the general population[20].

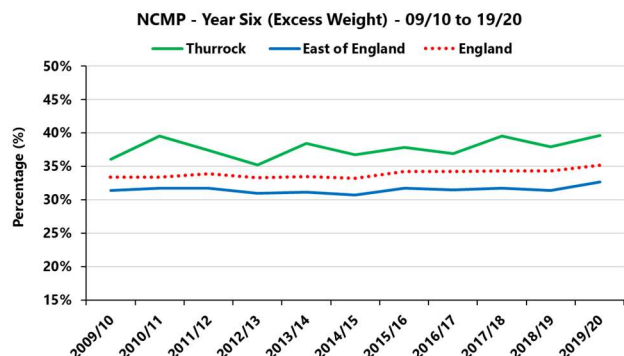
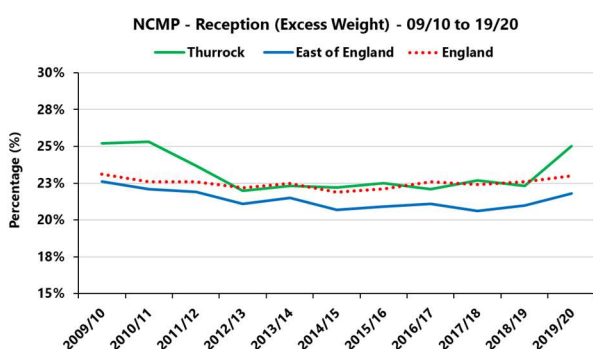
### 5.6 Health Behaviours and Health Inequalities

The behavioural risk factors for CVD are more prevalent in areas of higher deprivation and amongst certain population groups. People living in the most deprived areas of England are known to be 30% more likely to have high blood pressure, and four times more likely to die prematurely from CVD than those in the least deprived areas (pre-COVID).[6] The Global Burden of Disease study identifies that in 2019, tobacco use, high blood pressure and a variety of dietary risks are the greatest cross cutting health risk factors in Thurrock[21]. These are the factors that will have the greatest impact on population health and health inequalities as well as health and social care demand in future. Smoking and obesity are key modifiable risk factors for CVD that are strongly correlated with deprivation. This is borne out locally; estimates from PHE suggest smoking rates are highest in Tilbury & Chadwell PCN (22.0%) and lowest in Grays (16.6%), and at 17.5%, overall smoking prevalence in Thurrock in 2020 is significantly higher than both the England (13.7%) and Essex (13.2%)



averages. In 2022, primary care records indicated that 18.2% of adults in Thurrock were smokers. Rates of adult obesity are also higher, at 69.4% for Thurrock compared with 62.3% for the East of England. QOF data show variations between PCNs for obesity; again this shows the rate as lowest in Grays (9.5%). The highest rate is reported in SLH (11.8%), though this may be an anomaly due to higher quality of QOF reporting; rates in Tilbury & Chadwell and ASOP are both over 10%.

Rates of childhood obesity have also increased. The National Childhood Measurement Programme (NCMP) measures children’s weight in reception and year 6. Due to the pandemic, data for 2020-21 is not yet available, but as shown in figure 11, rates of childhood obesity in Thurrock have been consistently higher for Year 6 children than either national or East of England for several years and show a sharp increase for reception children.



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Figure 11: Childhood Obesity in Thurrock (NCMP data)

### 5.7 NHS Health Checks

Local Authorities are required to commission or provide NHS Health Checks as part of the national programme, which is the only mandated population-level provision for primary prevention, promotion of healthy behaviours, and identification of CVD risks. In Thurrock, NHS Health Checks are provided partly in general practice and partly by the Thurrock Healthy Lifestyles Service (THLS). (Checks are offered every five years to people aged between 40-74 who are not already on CVD registers but may have other LTCs such as asthma). Where CVD risk is found to be high, residents are given lifestyle advice, and referred to their GP for follow-up and clinical management as required (for example prescribing for hypertension or high cholesterol, or referral to the NHS pre-diabetes programme).

Local data, see figure 12 below, shows that of 22,132 health check invites sent in the five years 2016/17-2020/21, 14,016 health checks were conducted (based on 2022 GP registers).

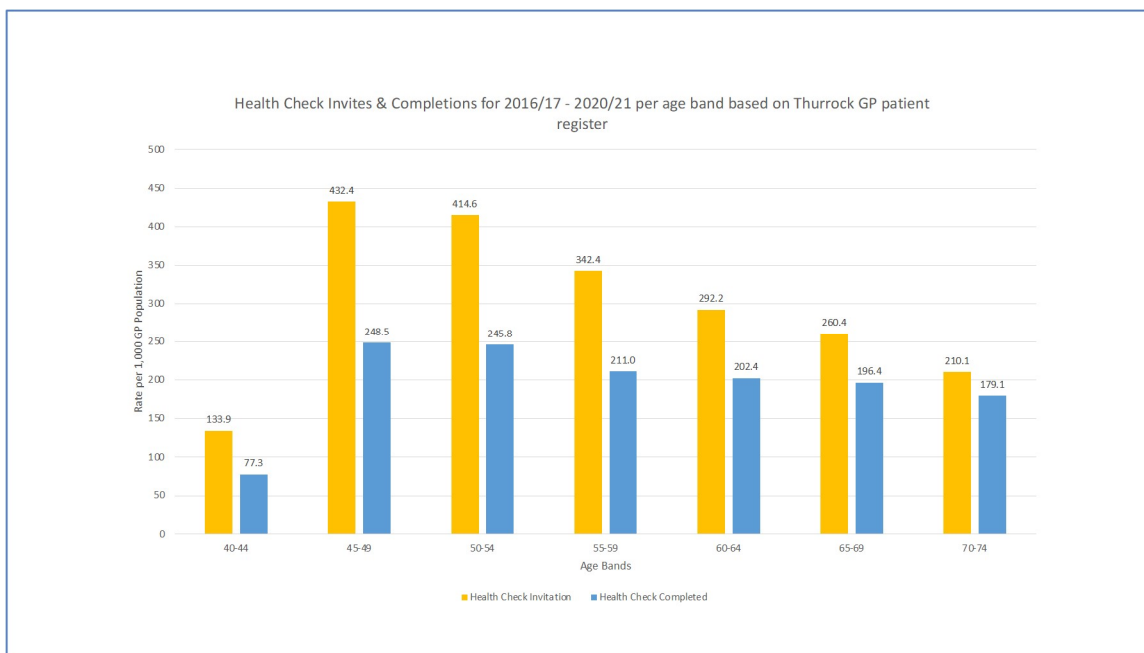


Figure 12 Invitations and Uptake of NHS Health Checks by eligible age band, Thurrock 2016-2021

Completed checks are higher amongst the older age groups, suggesting higher levels of engagement amongst older eligible residents. However, increasing engagement with younger age groups would enable more people to be supported to make changes at an earlier age, with potentially more impact on CVD in the long term.

Nationally, evidence (see summary literature review in section 9 below) suggests that the NHS Health Checks programme needs to be more targeted in order to increase uptake in those with most to benefit – which includes people living in more deprived areas and/or those from BME groups at the younger age limit – in order to contribute to a reduction in health inequalities. Currently, follow-up for those people identified as

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having higher CVD risk (for example requiring statins or blood pressure management) is dependent on individuals making contact themselves with their GP practice – a potential barrier.

**RECOMMENDATION:** Target NHS Health Checks for people at the younger age limit, in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.

### 5.8 Serious Mental Illness and Learning Disability Health Checks

Patients with a diagnosis of SMI or who have an LD should receive an annual health check covering various aspects of their physical health. Both of these checks differ to the NHS Health Check in that they are completed by different professionals (the PCN Mental Health Practitioners complete the SMI Health Checks and the LD nurses complete the LD Health Checks), and performance/uptake statistics are reported separately. Improving outcomes for people with SMI and LD is a shared responsibility; the checks are commissioned to ensure that the specific needs of these patient groups are identified and can be followed up in primary care and by other appropriate services.

In the case of the SMI Health Checks, there are a number of mandatory components (six), which must all be completed within the 12 month period in order to count as a complete check; along with a number of other components that, whilst they are not mandatory, they are recommended. Performance for the SMI Health Checks has traditionally been viewed as successful in that overall uptake of the check has increased, now 56%, close to the national target of 60% uptake; but less focus has been given to the follow up elements – i.e. the onward referrals/care that is given when a need is identified. This is particularly important for SMI patients, who already suffer from poorer cardiovascular health and subsequently have high rates of premature mortality due to cardiovascular health problems. Analysis of local data from 2021/22 has indicated that, for example, whilst the majority of SMI patients had their BMI recorded and a discussion logged about their weight, a low proportion of them had a record of onward support or advice (only 345/787 or 44% in 2018-20), and this is corroborated by low numbers of referrals received by weight management services following on from these checks. Similarly, out of 1,242 SMI patients eligible for blood lipid (cholesterol) interventions, only 383 had a follow up offer recorded (31%). This therefore could mean that preventative opportunities for early intervention are being missed in this higher risk group. Even within the SMI cohort, there are certain groups who are even less likely to have had the full checks completed, nor the onward interventions undertaken. The MSE ICS Population Health Management (PHM) team identified these to be younger adults (30-39 year olds), and those with an ethnicity record of Asian, Mixed or Unknown.

LD Health Checks also cover a number of questions about cardiovascular health, but the follow up activities/interventions are not routinely reported in the same way. So although it is reported that Thurrock performs well with LD Health Checks compared to other areas, it is unknown how successful they are in prevention of onset of further cardiovascular complications. A pan-Essex thematic review was undertaken of the LD deaths in 2021-22, and there were a number of recommendations posed relating to changing

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processes, improving partnership working, staff training and data validation, all of which should contribute towards improved physical health outcomes in the future. In particular the recommendations include:

- Annual Health Checks should be face to face and should cover all items specified so as to be a comprehensive check of physical and mental health, (not just height, weight and blood pressure) including a medication review and a review of any known conditions.
- Annual Health Checks must result in a Health Action Plan which is shared with the adult and anyone supporting them.

A Southend, Essex and Thurrock (SET)-wide LD forum, comprising of representatives from Local Authorities, NHS commissioners, providers and clinicians, is developing a programme of work aligned to delivering on these recommendations. Close working between this SET-level forum and Thurrock colleagues should ensure that prevention initiatives are prioritised and that there is no duplication. The forum colleagues have recently reviewed the paperwork around the LD Health Check for example to ensure the same easy read information is given out to all patients.

**RECOMMENDATION:** Maximise uptake and associated follow-up of physical health checks for people living with SMI and people who have a learning disability. A targeted approach to SMI physical health checks across younger age groups and lower uptake ethnic groups should be a priority.

### 5.9 Support with Healthy Behaviours

Many residents, both those known to have CVD conditions and therefore requiring support with secondary prevention, or those at greater CVD risk due to lifestyle factors (primary prevention), could benefit from support to manage healthy behaviours. Locally, THLS provides access to Weight Management programmes and support to stop smoking for residents of Thurrock. The 2016 APhR report included a recommendation that the service (at that point known as Vitality) be redesigned and procured with greater focus on lifestyle support for those with established LTCs. Changes were made to service management during 2017-18, including establishing a single point of access, but delivery remains largely as before. Redesign is still required in order to increase focus on delivery to those experiencing the greatest health inequalities - whether related to areas of deprivation or protected characteristics such as people with severe mental illness. Work is however underway to engage and train a wider group of staff such as social prescribers in delivering brief advice to support smoking cessation, but there could be opportunities to target and expand the provision of advice to people with LTCs through providing training to the new primary care roles within the four PCNs. Currently, services are as follows:

- The Stop Smoking service provides access to CBT with and without Nicotine Replacement Therapy or Vaping; it continues to operate as a telephone-based service since the pandemic in response to client demand. Clients can self-refer or be referred by a member of the primary care team including Social Prescribers, Local Area Coordinators and other Council Officers. Thurrock Public Health Team



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completed a Whole System Tobacco Control JSNA in 2021[22]. This recommended enhanced targeting of smoking cessation support to address inequalities. To address this during 2022-23 one practitioner is providing smoking cessation training and support to staff in GP practices in the 8 most deprived wards (funded through funds provided to help authorities manage and reduce the impact of COVID). MSE ICS Health Inequalities funding will also enable a further practitioner to offer support via employers, targeting those in routine and manual occupations, who have higher rates of smoking nationally.

- Limited support to lose weight for people above certain BMI thresholds is available, on referral from primary care, either via Slimming World or the Exercise on Referral programme with local leisure providers Impulse Leisure. The NHS in south Essex has also commissioned tier 3 obesity services. The review of the Whole System Obesity programme gives an opportunity to enhance alignment along the obesity pathway. Support for families with overweight and obese children continues to be offered in 2022/23 through BeeZee Bodies.
- There is some access to support through the Exercise on Referral programme with Impulse Leisure for residents with diagnosed LTCs needing targeted support to increase their level of physical activity, although this is only available in part of the district and on referral from a clinician. Capacity for enhanced access to free physical activity classes was expanded and diversified (for example including Zumba and Bootcamp) during 2021-22 using central government funding, however this funding stream has not been extended.
- There are a range of community and grass-roots physical activity offers and schemes in Thurrock, funded through a variety of routes. Active Thurrock<sup>4</sup> is a community activity network with representatives from Active Essex, Thurrock Council and local organisations within the statutory, voluntary and private sectors. Its recent *Find Your Active* campaign has provided universal encouragement and information about physical activity as we emerge from the COVID-19 pandemic.
- A number of pilots are underway to address obesity locally. These include the Corringham IMWC obesity pilot to deliver a holistic and personalised response to residents at high risk of obesity (see box below) and Active Minds, a pilot between Active Essex and Thurrock & Brentwood MIND to provide service users with free exercise opportunities to increase their confidence and better their physical and mental health. These pilots will be critically evaluated to determine the appropriateness and feasibility of future expansion.
- An integrated drug and alcohol misuse treatment service for adults is provided by Inclusion Visions Thurrock (IVT), an NHS service which is part of the Midlands Partnership NHS Foundation Trust. The service provides a single point of contact and a range of interventions focussed on the recovery of adults from illicit and other harmful drug and alcohol misuse for residents registered with a Thurrock

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<sup>4</sup> <https://www.activeesseximpact.org/thurrock>

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GP. Access to the service is via referral, self-referral and engagement with outreach initiatives undertaken by IVT. A young person's substance misuse treatment service is provided by Change Grow Live (CGL) Wize up.

Thurrock Public Health Team are leading on refreshing local health risk behaviour support programmes in order to reach their full potential to improve local health outcomes. This will include:

- Public Health will provide strong strategic leadership to engage with stakeholders across the system to reinvigorate the Making Every Contact Count (MECC) programme, incorporating a number of healthy behaviours, including smoking, alcohol, healthy weight and physical activity.
- The forthcoming Whole System Tobacco Control Strategy, based on the Tobacco Control JSNA, will consider both whole population and targeted approaches to reduce inequalities to meet the national smoking rate ambition of 5% by 2030. We already know that minority ethnic communities have been under-represented in the Stop Smoking service over the last 5 years, with 'White British' residents representing 85-92% of service users despite representing 80.9% of the Thurrock population. Targeted groups will include routine and manual workers, people living with mental health problems, and people from minority ethnic groups under-represented in the current service profile.
- Public Health are currently undertaking a refresh of the Thurrock Whole Systems Obesity Strategy, as the previous one is now out of date. The new strategy will have a key focus on reducing obesity related health inequalities, for example through expanding the Healthy Start scheme. Targeted consultation will be undertaken with groups at highest risk to ensure future delivery meets their needs. A review of the commissioning of local weight management and physical activity services will also be undertaken.
- Alongside the commissioning of weight management services, we will implement a 'Health in All Policies' approach to ensure that Whole Systems Obesity is everybody's business. There are also plans to implement a Thurrock pilot similar to the London Superzones programme. We will do this through the Planning for Healthier Places JSNA that is currently in development, which will form a key part of evidence for the Local Plan and influence relevant planning, development, and regeneration decisions.

### 5.10 Primary Care Capacity

#### 5.10.1 Appointment Availability

Ease of access to primary care is key to patient engagement and thus to effective management of LTCs. The pandemic led to rapid changes in access to, and availability of primary care. Overall, although there has been an increase in primary care capacity since the 2016 report, there are still significant concerns about the number of GPs in Thurrock- for example, the recent engagement exercise on Thurrock's Health and Wellbeing Strategy 2022-26 identified concerns about access to primary care as a key theme from the engagement[23]. This was also a recurring theme in recent conversations recorded by Thurrock CVS'

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Community Builders and aligns with national analysis which shows increasing workforce pressures for GPs, especially in areas of deprivation, with 1.4 fewer GPs per 10,000 patients in the most deprived areas than in the least deprived areas and associated risk of widening health inequalities[24]. Whilst the total number of appointments available in Thurrock has increased, with the number of appointments provided April-November 2021 exceeding that in the equivalent period in 2019-20 (pre-pandemic) by 6,791 (1.1%), this is a lower increase than for the other CCGs in Mid & South Essex (source: NHS Digital). Basildon & Brentwood CCG, by comparison, has seen an increase in appointments of 10.5% over the same periods.

Over the last two years there have been changes in the type of appointments offered and the staff providing them. A continued legacy of the pandemic is an ongoing lower proportion of face-to-face and home visits than pre-pandemic, with the proportion of face-to-face appointments provided in Thurrock between April-November 2021 being 26.3% lower than for the same period in 2019. As changes in staff roles and workforce constraints have coincided over the pandemic any perceived impact from changes in appointment type should be viewed with caution. It is known that the change in appointment types has, for instance, led to frustrations for patients having to access general practice via old telephone systems. However it is important to note that for some patients, increased flexibility in appointment types may be positive, enabling people to attend a telephone appointment during the working day; research from The Health Foundation in 2018[25] found that 30% of people with four or more LTCs (out of a list of 36 conditions) were of working age. Shifts in the type of staff providing primary care appointments in Thurrock appear to reflect the expansion of roles within the PCNs. Figure 13 provides an illustration, showing an increase in the number and proportion of appointments offered by nursing and 'other' staff compared with GPs.

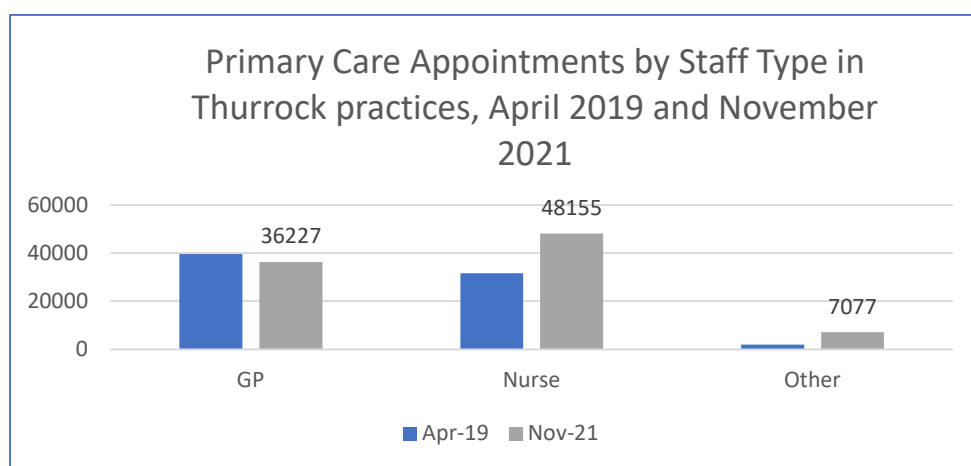


Figure 13: Change in primary care appointments by staff type

Data on types of appointment and type of professionals involved is not available at PCN level, but additional CCG provision in Tilbury & Chadwell since 2016 has improved capacity in that PCN. It is important to note that despite the improvements in Tilbury & Chadwell and the expected increase in additional roles due to the NHS LTP, Thurrock remains significantly 'under-doctored'. Analysis by the Nuffield Trust in April 2022[26] shows that most of Mid and South Essex is in the worst quartile for the number of patients per GP, but that the situation is worst in Thurrock, with 2296 patients per GP (increased from 2110 per GP in 2016), which is the third highest list size per GP in England.

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Early analyses by the PHM team suggest that primary care resources are not currently distributed equitably in relation to need, across Thurrock and beyond. Work is being undertaken to look at the impacts of this inequity and to estimate how we would “close the gap” to bring all areas in line with SLH – the PCN which currently has the most generous provision compared to population characteristics.

### 5.10.2 Skill mix in primary care

The Kings Fund, in their report on Innovative Models of General Practice[27] (which preceded the publication of the NHS Long Term Plan), stress that new roles in primary care should *supplement*, not *substitute*, traditional clinical roles. The 2016 APHR highlighted particular pressures in primary care in the practices that now form Tilbury & Chadwell PCN, which led to additional capacity being commissioned by the CCG. Analysis of the primary care workforce in Thurrock in November 2021 suggests a modest expansion in the number of full-time-equivalent pharmacists employed across the four PCNs (from 4.9 FTE in 2016 to 6.8 in November 2021), but a very limited increase in Allied Health Professionals or paramedics (0.5 and 1.0 respectively across all four PCNs). The largest increase in staffing since 2016 has been in the new role of Physician Associate, the largest number of whom work within Grays PCN. Overall, as shown in Figure 14 below, despite an increase in GPs and substantial reduction in locum doctors, the number of GPs across the four PCNs is lower (by 3.3 FTE) than in 2016.

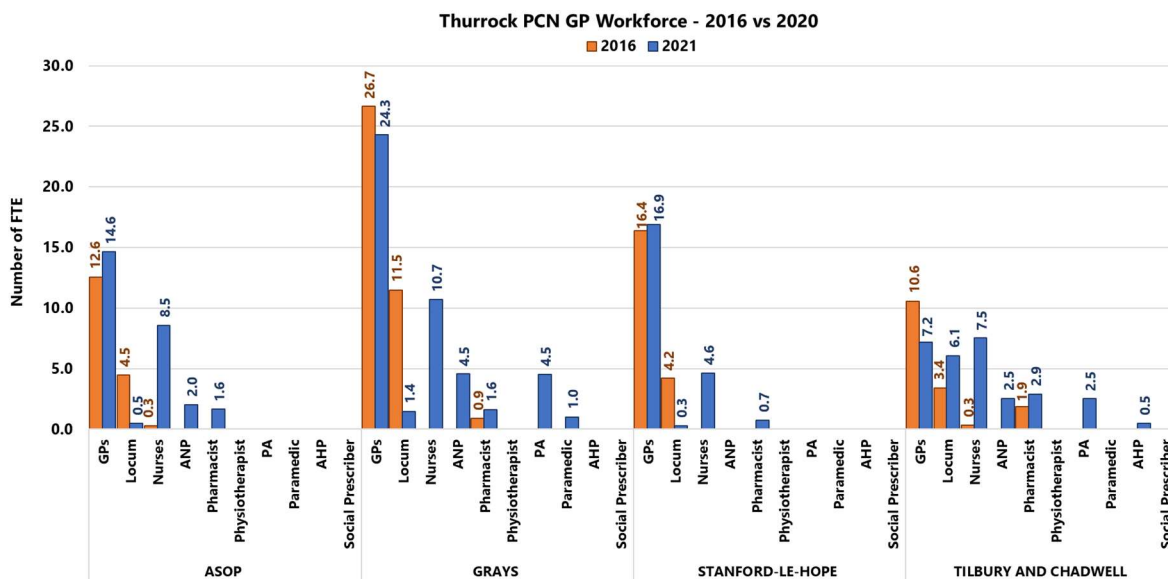


Figure 14: Primary Care workforce in Thurrock by PCN, 2016 to 2021

The published literature (see section 8 below) suggests opportunities for a broader health and care workforce in providing more personalised care in order to address both outcomes and health inequalities associated with CVD. This suggests there is still significant opportunity to increase staffing in the roles

**RECOMMENDATION:** Thurrock Integrated Care Alliance (TICA) should work with Mid & South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock to avoid increasing health inequalities associated with access and quality in primary care.

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outlined in the NHS LTP, in particular Allied Health Professions (AHPs) and Social Prescribers, within all four PCNs, providing that recruitment challenges for AHPs (an outer-London effect) can be overcome. However, whilst the new roles funded through the NHS Long Term Plan provide permanent additional appointment capacity, they are funded on a population basis, not taking account of issues of equity of access or health inequalities, and thus risk perpetuating the inverse care law in Thurrock.

#### 5.10.3 Patient views on primary care in Thurrock

The GP Patient Survey provides an annual snapshot of patients' experiences relating to access and quality of GP care. The 2021 survey was sent out in July to 6% of the practice population in Thurrock. Return rates varied across the 27 practices in Thurrock, from 21% to 48% (the national average being 35%). Whilst responses are higher than in the two previous years, it is important to note that the results are based on responses from only 2% of the total GP registered population in Thurrock. Respondents with a positive or negative bias may be more likely to respond, as may higher users of primary care services. However, the results serve as a snapshot on patient access and highlight issues of concern as well as areas of good practice.

In 2020, the first year of the pandemic, with associated changes to access and delivery of primary care, the survey showed lower satisfaction rates than in 2019 both nationally and in Thurrock. By 2021, patients appear to report improved ease of access, most notably in satisfaction with the type of appointment offered (75% locally and 82% nationally). Ease of access via phone in Thurrock remained much lower than the national average at 55% compared with 68%, but there are plans in the 2022 BCTT strategy for upgrading GP telephony and online systems[28].

The 2021 survey shows that Thurrock patients continue to score their experience of primary care below the national average, with 72% for 'overall experience' compared to 83% nationally (though the lower average score for Thurrock reflects a wide range of individual practice ratings, which range from 27% to 96%). At PCN level, SLH attracts the highest ranking and Tilbury & Chadwell the lowest. Analysis suggests that when a practice performs well or poorly in one area of the survey, this is likely to be indicative of performance (on the survey) overall. That said, whilst ease of use of online services shows a slight downturn both locally and nationally, Tilbury and Chadwell PCN shows as an exception, achieving the highest increase (11% improvement on 2020) across the four PCNs for this item. This is relevant because if the ambitions in the NHS Long Term Plan for reduction in cardiovascular disease and associated reductions in health inequalities are to be realised, additional staff, increased accessibility for patients, and changes in ways of working are essential.

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#### 6. From 2016 to 2022: Progress against the recommendations in the 2016 report

##### 6.1 Integrated Medical Centres

One of the recommendations of the 2016 APHR report was to expediate development of the Integrated Medical & Wellbeing Centres (IMWCs). Four are planned for Thurrock, in Corringham, Grays, Tilbury & Chadwell and Purfleet<sup>5</sup> by 2025. The geographical reach of these centres aligns with those of Thurrock's four PCNs, with some practices relocating into the new IMWCs. The four IMWCs are at different stages of development, with that in Corringham having opened during summer 2022. The timeline and site for Grays IMWC is yet to be determined. Outline business cases are being produced for Purfleet and Tilbury & Chadwell, with the latter expected to be a new build in Civic Square as part of wider regeneration in the town, and with funds confirmed (subject to commercial arrangements) by Thurrock Borough Council. Purfleet IMWC will also be a new build as part of regeneration of the area into a riverside destination by Purfleet Centre Regeneration Limited, for which outline planning consent has been given.

Creation of these IMWCs will be fundamental to the success of the BCTT plans for more integrated care, and aligns with both Mid & South Essex and Thurrock strategic plans. Once developed, these hubs will contribute substantially to effective management of LTCs as each will provide not just a core offer bringing together health, wellbeing and social care services in multi-disciplinary LTCs teams, but also have a specific focus on a particular set of conditions and diseases. Two IMWCs will focus on diabetes and on CVD, with access to co-located diagnostics and cardiology clinics. The expectation is that delivery of health, social and wellbeing services in a person-centred way within IMWCs will improve both efficiency and effectiveness of care for both individuals (for example reducing the need to attend additional hospital appointments) and the health system. The BCTT strategy envisages that THLS services will be aligned within the IMWC clinical model.

The multi-disciplinary LTC teams are expected to provide co-ordinated care for patients with one or more LTCs, led by the most appropriate clinician for the person (this could for example be a pharmacist, nurse or GPs). Teams will include specialist support for patients with more complex needs (e.g. housebound), mental health support (through IAPT or through NELFT for those with more complex needs), social prescribing/local care coordinators and healthy lifestyle practitioners able to provide health coaching.

##### **Corringham Integrated Medical & Wellbeing Centre Obesity Pilot**

This project aims to recognise obesity as a LTC to be addressed through a holistic way of working to address the relapsing nature of this condition that existing time limited models are unable to resolve. The project will use proactive case finding and personalised care planning to focus on clinical factors beyond BMI, plus impact of social and wider determinants of health.

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<sup>5</sup> For further details see Thurrock Integrated Medical Centres Model of Care, Version 6.0 December 2021

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When considering the care that will be provided from IMWCs, it is important to note that evidence on new models of care, such as the Primary Care Home (set out by the Kings Fund[27]) and the House of Care explored in the literature review below, and the Human Learning Systems approach as outlined in the BCTT[29], clearly suggest that more personalised, proactive care requires a shift in mindset as much as it does the implementation of new processes and systems. To be effective, personalised care requires a more collaborative and flexible approach that is community-focused, with patients and clinicians sharing decision-making, aided by continuity of care, coordinated care and associated information flows. This takes time, support and often training to adopt.

**RECOMMENDATION:** Promote personalised, collaborative and holistic care planning, using an evidence-based model, alongside long term condition specialists and multi-disciplinary working within the IMWCs. Maximise potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new Integrated Medical Centre model.

### 6.2 Initiatives for increasing detection and management implemented after the 2016 Report

Estimates of identified versus anticipated prevalence could be taken as suggesting that *all* anticipated cases can be detected, diagnosed, and treated. This is unlikely to be the case, for a variety of reasons including onset of other disease and patient choice when it comes to population level screening. However, what is clear is that, although the modelled prevalence is only a guide, identification and management of CVD and health behaviours influencing CVD outcomes can be improved, and that improvements not only benefit patients but introduce efficiencies into the healthcare system, as set out in the 2016 report. As a result of the 2016 report, a number of initiatives were put in place, funded by the Public Health Grant (to Local Authorities) and Better Care Fund (funded by Local Authorities and NHS). However, further work is needed to ensure that the aims of the Better Care Fund align with the priorities set out in the BCTT strategy.

#### 6.2.1 Stretch QOF

Payments through the national QOF scheme are capped (with the cap on what each practice can earn from each indicator varying across indicators), and practices generally achieve the level required to reach maximum payment. In Thurrock, 'Stretch-QOF' was implemented in 2017-18 and applied to a sub-set of individual indicators to support detection and referral for support managing behavioural risk factors (such as smoking) and higher quality management (to established clinical thresholds) for conditions including hypertension, atrial fibrillation, CHD, stroke and diabetes. Stretch QOF in Thurrock uses some of the existing QOF indicators and provides support and equipment, extending the threshold for payment to 100% of those eligible in order to promote and sustain practice beyond the national standard and thereby address inequity

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experienced by those not commonly included in activity to meet QOF payments. The scheme has been renewed annually since to reflect priorities and needs of the area.

### 6.2.2 Long Term Condition Practice Profile Cards

In order to ensure that improvements in primary care are informed by, and reflected in, practice data, from 2017 public health staff devised Practice Profile cards (updated annually) to support quality improvement visits to practices. The profile cards bring together detailed information on a range of health data for each practice including QOF performance, attendances at A&E, and patient experience. Each practice was offered an annual visit; although practices were prioritised for visits according to health needs, these were scheduled according to practice availability and ability to engage in the process. Practice quality visits were disrupted by the pandemic, but the profile cards have been updated and are in the process of being shared. In 2021 additional “deep dive” analyses such as for AF as shown in Figure 15 were also shared. These deep dives will resume shortly. The first one is suggested to be around stroke prevention.

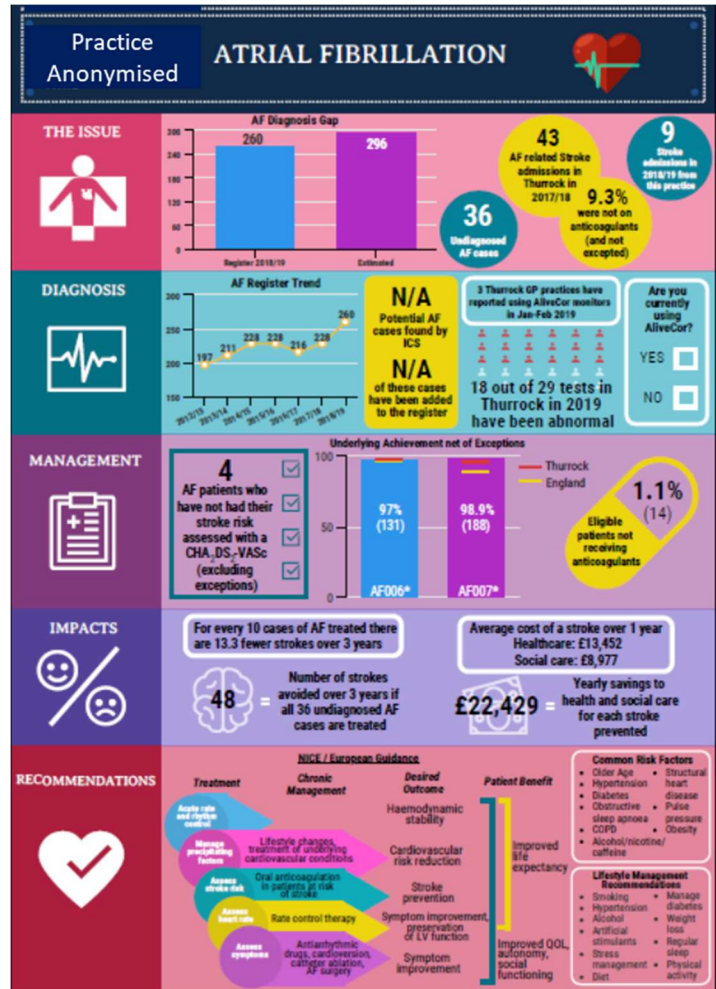


Fig. 15: A sample ‘Deep Dive’ practice profile card, showing the information typically shared with practices in Thurrock

**RECOMMENDATION:** Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.

Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health are likely to be gained by a focus on reducing gaps in diagnosis.



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#### 6.2.3 Diabetes in dentistry evaluation

Although not a cardiovascular disease in itself, diabetes is a risk factor for CVD. This pilot project is included here as an example of innovative work undertaken in the borough since the 2016 report to improve case-finding that appears replicable if time and resource constraints in dental practices (since amplified by changes due to the pandemic) can be addressed.

There is a known relationship between the prevalence and severity of periodontal (gum) disease and diabetes (and between treatment of periodontal disease and improvements in glycaemic control in diabetes). This suggests an opportunity for screening people attending dental appointments who may be at high risk of having undiagnosed diabetes. To test this, a pilot took place in 2017 with three dental practices in Thurrock- two for 12 months, one for 1 month. Adult patients attending appointments were first offered a diabetes risk survey then risk assessed as part of their dental appointment for periodontal disease. Those with BPE scores (measuring periodontal disease) over 3 were offered a HbA1c test (used for diabetes screening) and referred on to the National Diabetes Prevention Programme (NDPP) if the result was in the pre-diabetic range, or to their GP if in the diabetic range.

Overall, 262 people took part in the pilot, of whom HbA1c results suggested 26 were pre-diabetic and 5 diabetic, with onward referral to NDPP or GP for further investigation as indicated. Surveys of practice staff found that, whilst enthusiastic about the project, time constraints in dental services limited potential to implement it. Analysis suggests that screening is generally cost-effective especially when dental practices target only those patients likely to be at higher risk.

#### 6.2.4 Self-testing of Blood Pressure in GP surgeries and community hubs.

Blood pressure monitors were put into waiting areas in GP surgeries in 2018 and patients encouraged to test themselves and report the result to reception in order to improve case-finding. Despite fewer patients accessing surgeries in person during the pandemic, patients (including those already on hypertension registers) appear to have made use of the testing facility in Tilbury & Chadwell and Grays PCNs, during 2021 in particular. It would be interesting to explore reasons why patients in the other two PCNs have made less use of self-testing, or been less aware of the machines.

This project is distinct from the Blood Pressure at Home project managed by the ICS, which is a national pilot where initially patients meeting certain conditions were given a blood pressure monitor to monitor and better control their blood pressure at home. (Evidence suggests that people who are enabled to check their own blood pressure are also more likely to manage it well.) The criteria have since been relaxed and now anyone for whom their GP feels that this would benefit them can now receive a free blood pressure machine. The total number of Thurrock patients who have been given a device for home testing between March 2021-May 2022 to date is 8817. The expectation is that regular blood pressure readings will be provided to the surgery either through an app or by phoning the practice.

### 6.3 Summary of progress against 2016 Recommendations

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2016 Recommendation	Status in 2021	Comment
<p>... implementation of a practice scorecard and facilitating the sharing of best practice.</p>	<p>Practice profiles (scorecards) and linked quality visits established, though limited for past two years by pandemic pressures on both Public Health and Primary Care. Profiles have been updated in late 2021 to include deep dive on AF.</p>	<p>Practice profiles support delivery of Stretch QOF, which for 2022-23 has been redesigned to focus on a more personalised holistic approach (focusing on achieving collective not single indicators for each individual).</p> <p>Elements of national QOF were suspended twice during the pandemic, interrupting delivery on SQOF over the past two years.</p>
<p>Redesign and procurement of a healthy lifestyle service with a focus on those patients with LTCs</p>	<p>Service now provided in-house (known as Thurrock Healthy Lifestyles Service) with some improvements regarding access, but not redesigned</p>	<p>When capacity allows, the Public Health team are planning an options appraisal for sustainable future delivery of the health improvement services delivered by THLS.</p>
<p>Support for a whole system approach to reduce obesity prevalence</p>	<p>JSNA in 2018 led to a 3-year Whole Systems Obesity strategy including a goal to improve the identification and management of obesity (of particular interest for CVD). Analysis of any impact of 2018 targets and goals is currently underway. Refreshed WSO strategy to be approved during 2022, with a renewed focus on targeting inequalities.</p> <p>Combating Obesity project providing personalised care now underway in Corringham PCN, supported by the MSE ICS Population Health Management team.</p>	<p>Obesity is associated with poor COVID outcomes. Action plans in the strategy being reviewed and refreshed following COVID-19 pandemic.</p> <p>Lack of face-to-face primary care appointments is likely to have reduced opportunities to record BMI in primary care (and thus to offer brief advice and onward referral).</p> <p>Children and family interventions on obesity reduction are being linked to Family Hub development in Thurrock.</p>

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Implementation of a hypertension case-finding and Clinical Management Improvement Programme	Hypertension case-finding implemented and additional patients identified between 2017-18 and 2019-20.	Changes in access to surgeries due to the pandemic will have impacted results since 2019-20.  The BCTT strategy includes plans to develop a Case Finding Strategy building on gains since 2016.
Treat more heart failure patients with effective medication, with support from the Public Health team via further analyses and the creation of bespoke SystemOne reports.	Stretch QOF implemented in 2018, with practices paid for activity above QOF thresholds up to 100% of target, and reviewed annually since	Stretch QOF for 2022-23 has been redesigned to focus on a more personalised holistic approach (focusing on achieving collective, not single indicators for each individual).
Support more patients with effective blood pressure control (e.g. as above)	As above	As above
Significantly increase Primary/Community care capacity in Thurrock including better skills mix of staff with GP surgeries	Limited progress, but enhanced capacity in place in the PCN with most need (Tilbury & Chadwell)	Implementation of wider skill mix as set out in NHS LTP should add further capacity
Expediate building the four Integrated Healthy Living Centres in Purfleet, Tilbury & Chadwell, Grays and SLH	<p><b>Corringham IMWC</b> Building completed during 2022.</p> <p><b>Tilbury IMWC</b> Outline Business Case under review by NHS. Aim is to have this IMWC completed by 2025.</p> <p><b>Purfleet on Thames IMWC</b> Completion is expected by 2024.</p> <p><b>Grays IMWC</b></p>	<p>NELFT lead</p> <p>Thurrock Council lead</p> <p>Being developed by Purfleet Centre Regeneration Ltd</p> <p>MSEFT lead</p>

# Reducing the Impact of Cardiovascular Disease in Thurrock

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	The aim is to have Grays IMWC completed by 2025.	Timeframe is dependent on the extent to which the existing buildings on the Thurrock Community Hospital site can be repurposed.
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In summary, a combination of local developments in the last 5 years have sought to improve case-finding and management of CVD in Thurrock. There has been more success to date in some domains than others. Data from 2019/20 in the key areas provide a benchmark, but the part-suspension of QOF over the last two years has made it difficult to quantify the impact of the pandemic on the management of CVD in primary care, or to make adequate comparisons with the findings of the 2016 report. However, it is known that the pandemic has led to reduced opportunities for primary prevention, reduced access to primary care and a widening of systemic inequalities that may influence health behaviours and health service access, so the targets for detection and management of key CVD conditions remain highly relevant, and progress in these areas is essential if health inequalities are not to be widened further.

Thurrock continues to be under-doctored overall, as reflected in patients' experience of primary care in the borough. Although capacity constraints have eased in Tilbury & Chadwell PCN as a consequence of additional roles being commissioned, the higher levels of complexity in that population still leave a healthcare deficit. It is likely that in the other PCN areas there is still an equity deficit. Further analysis needs to be done to understand this and identify solutions. The additional roles proposed by the NHS LTP and MSE Primary Care strategy could go some way to addressing the ongoing workforce constraints in primary care if implemented in full and if time is given to building teams and organising care according to complexity of need not existing levels of engagement.

Viewed overall, there appears to be a gap between the system-level work underway on holistic approaches to obesity, smoking, development of community assets and integrated care (the IMWCs), and the focus on individual indicators through Stretch QOF. The proposed multi-disciplinary teams within the IMWCs bring opportunities to start closing that gap for people with CVD or at risk of CVD, particularly in ASOP, but only if care is personalised, holistic, coordinated and segmented to provide the most support to those with the highest needs. Practice quality visits and Time to Learn practice shut-down sessions could be used to identify best performance and promote peer to peer learning opportunities within and across PCNs.

## 7 Summary Literature Review

This literature review sought to identify evidence for improving both the detection or diagnosis of CVD LTCs, for improving the management and of these LTCs in primary care, and for primary and secondary prevention of CVD risk factors. The review is based largely on evidence identified by searches undertaken by NELFT

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library, with additional web searching and citation screening. The majority of studies reviewed for this report were UK studies of NHS provision.

The evidence used is a mix of policy documents, primary and secondary research, and case studies used to exemplify policy developments. The literature falls broadly into four subject areas:

- Models of care for primary care (with LTCs used as one of the drivers for change), typically policy papers or evaluations of NHS initiatives;
- Approaches to the management of LTCs: QOF and alternatives, often longitudinal cohort studies;
- Interventions for better management of LTCs and secondary prevention: principally ways of engaging patients in their care, drawn from a mix of research and case studies reported in policy papers; Primary Prevention and case-finding/detection: reviews of NHS Health Checks, reported case studies and research looking specifically at atrial fibrillation and hypertension.

Primary and secondary prevention, and management of conditions, is a wide-ranging area of enquiry in which definitions can vary or be loosely defined across studies (Health Coaching being an example). However, exploration of epistemological differences in models of care, behavioural or person-centred approaches to interventions are beyond the scope of this report. Measures of success also vary widely, from physiological outcomes, to health behaviours and health services use. Much of the evidence relating to primary and secondary prevention is observational case reports and/or relies on self-reports, which may not be generalisable. Very few qualitative studies were found for this report.

Management of long-term health conditions itself is a broad topic, covering a wide range of physical and mental health conditions. Much of the research focuses on LTCs generically, or on specific LTCs (notably diabetes, COPD and Mental Health). Arguably, this is as it should be, given the clearly acknowledged requirement in the literature that a shift is needed from managing individual conditions, as required by the QOF to a more holistic approach, as encapsulated in Thurrock's BCTT strategy. Aspirations are clearly expressed, both in terms of potential benefits to patients (improved health outcomes, improved agency leading to better engagement with treatment and adoption of health behaviours), and to health care systems (improved efficiency in primary care and less demand on the system). However, evidence of how long approaches or new systems should be trialled for, or of the practical and cultural factors associated with implementing new systems in primary care and how to address them, is lacking.

Policy papers from the Kings Fund [27], Nuffield Trust [30] and IPPR [31] present the theory for new models of care, clearly articulate the characteristics associated with good care, and provide examples of good practice. But whilst they identify some of the requirements for success (time to build relationships, training, and support in new ways of working – as opposed to new processes – increased skill-mix and so on), they lack detail on *how* to achieve cultural shifts in practice especially when change is to be implemented across an area rather than developed by individual practices which already have a strong drive for innovation. Roberts et al [32], in their report on a new cyclical approach to care and support planning for people with LTCs (the 'Year of Care' approach) which was first tested with patients with diabetes then extended to include people with CVD, articulate the steps in the care planning cycle and emphasise the co-produced nature of this approach. But they are clear that what is required is not new systems but a change in culture from the traditional medical model to a social model of care. The Thurrock BCTT strategy to transform adult

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health and social care draws heavily on the Human, Learning, Systems (HLS) approach to system transformation[33]. The HLS focus on cultural change and empowering the workforce to adopt a strengths-based approach, a learning culture and act as system stewards, offers opportunities to develop sustainable approaches to delivering holistic care.

Studies by Close et al [34] and Lugo-Palacios[35] et al explored the impact of an alternative, more holistic approach as an alternative to QOF in general practices in the south-west and north-west of England, but were unable to provide evidence of positive effect on health service use, clinical or patient outcomes. However, both were measuring success within a short timeframe, and one experienced difficulties in implementation. Close et al did however identify organisational changes in the participating surgeries that could be beneficial in the longer term, including time-savings and increased informal networks.

A common starting point for the literature on more personalised and holistic care planning for people with LTCs is the recognition that even those patients with multi-morbidities spend a very small proportion of their time with health professionals. Discussions about health goals therefore need to be contextualised within the patient's life, not just the time spent in the surgery.

Several of the studies in a Cochrane review from 2015[36], assessing the effect of personalised care planning, found that whilst results were mixed, factors increasing positive effects included more frequent contact and care from the patients' usual clinician. Several of the studies in that review used Patient-reported Outcome Measures (PROMs). More recently, there has been a shift towards 'Patient Activation', where instead of being *educated and informed by* health professionals (the 'expert patient' model), the patient is *collaborating with* them to identify goals which are personally relevant, and strategies to meet those goals. This approach requires prior assessment of the patients' level of engagement in managing their health needs; as set out by the Health Foundation. (Deeny, et al., 2018). Crucially, they identified associations between level of activation and health service use: out of the 9,348 patients studied, the 13% scoring at the highest level of activation had 38% fewer admissions, 32% fewer A&E attendances, and 18% fewer appointments in primary care. There is potential for bias in the research towards engaged patients (PAMs were assessed by survey with the 9,348 patients studied representing a 25% response rate), but the results are promising. Interestingly, the results also challenge traditional expectations about the association between deprivation and patient engagement – only half of those scoring at the lowest level were from the most deprived areas. The researchers then identify strategies such as health coaching which can be used to assist patients to move to a higher level of activation. In summary, PAMs appear to offer promise both at an organisational level, for stratifying and prioritising those patients needing most assistance to manage their care, and at an individual level as understanding the patient's starting point informs the work between healthcare provider and patient.

Turning to clinical management of individual LTCs, a number of case studies showcasing innovative approaches to management or secondary prevention are cited by NICE and NHSE. These include incentivising blood pressure management by pharmacists [37], and a Quality Improvement support package for primary care nurses in Cheshire [38]. Most recently, the Academic Health Sciences Network has developed (in collaboration with partners) a set of free, digital Proactive Care Frameworks for stratifying and prioritising patients already on CVD registers in order to optimise management of those most at risk post

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COVID [39]. The resources include search tools for SystmOne and guidance on the allocation of related tasks within the primary care workforce.

Some good practice examples focus on the development of systems and guidelines within primary care, such as an audit to identify patients at risk of familial hypercholesterolaemia in Kent[40]. Others showcase opportunities for both primary and secondary prevention amongst Allied Health Professionals such as Podiatrists and Physiotherapists, as well as in pharmacies. For example, providing MECC training to AHPs in Newcastle to enable them have more effective conversations about health behaviours [41], and AF screening at community podiatry clinics [42]. What these examples typically demonstrate is the potential for the wider community health and care workforce to contribute to CVD prevention, providing that some additional resource – be that financial, training and/or short-term support – is available to support implementation.

For individual patients, CVD conditions can be managed once diagnosed, but there appear to be gaps when it comes to strategies and programmes aiming to target and identify those at greatest risk of having these conditions. Research and reports of projects for detecting atrial fibrillation and hypertension in particular do suggest opportunities for rolling out programmes in a range of community settings from fire services to community nursing teams visiting housebound patients, but issues of generalisability and transferability will apply so local evaluation would be needed. Higher quality evidence for population screening appears limited and mostly confined to AF (screening being considered cost-effective for those over 65, see for instance Welton et al[43] and Lowres et al [44]). Katsoulis et al [45] and Iyen et al [46] used primary care records in longitudinal cohort studies to explore long-term outcomes for patients on obesity registers. Iyen et al found a small but stable increase in BMI over all groups (mean age 49.5, mean BMI 33.8 kg/m<sup>2</sup>) with those in the highest categories of obesity having the highest risk for CVD, heart failure and mortality. Katsoulis et al examined a wider age range and found that younger patients identified as overweight or obese were at significantly higher risk of moving to a higher BMI than older patients, moreover that age was a more important predictor of obesity than ethnicity or deprivation.

More generally, national policy and NICE guidance continues to promote the NHS Health Check for assessing CVD risk in people aged 40-74 and identifying people at greater risk of CVD, but evidence on uptake and impact is at best mixed. Recent systematic reviews of the NHS Health Checks programme present equivocal findings, especially in relation to Health inequalities, but do propose a more targeted approach in delivery going forward.

Adopting healthy behaviours is key to both prevention and management of cardiovascular risks, but many studies suggest mixed or limited effects in initiatives designed to support behaviour change. For those without currently identified CVD risk, the NHS Health Checks programme seeks to promote positive health behaviours and to refer individuals to local support and lifestyle services in order to reduce risks associated with obesity, smoking and low physical activity. However, the success of the programme at engaging those with most to gain and prompting health behaviour change appears limited. That said, there is much variation in the content and delivery of the NHS Health Checks programme across the country, so the generalisability of outcomes from NHS Health Check research needs to be assessed at a local level if targeted approaches are in place.

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Once individuals have been identified as at risk, however, some studies have investigated the effect of Health Coaching as an alternative to traditional patient information and education. Although different definitions are in use, the common elements are that coaching applies motivational techniques and is more focused on the patient's starting point – linking therefore to patient activation. (For exploration of the term Health Coaching see NHSE/I technical guidance [47]) Studies of health behaviour change rely typically on self-reporting and are therefore often considered subject to bias, with associated concerns over quality; moreover they are not usually specific to patients with CVD risk. A recent systematic Korean review [48] sought to address these methodological concerns, and pooled results from 15 RCTs of health coaching on health behaviours for adults with established cardiovascular risks, measured using a range of tools specific to each domain (Physical activity, Dietary behaviours, Health responsibility, Stress management and Smoking). Health coaching was provided by a range of staff within and outside healthcare (e.g. dieticians, fitness professionals), all of whom had received training. They identified small but significant effects for health coaching in all areas except smoking (which had the fewest studies). They found that coaching was easily implemented (much of the coaching in the included studies was delivered by telephone), with an 'optimal dose' of 30 or more sessions over a period of 6-12 months.



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### Conclusions

Whilst acknowledging the early gains in quality of care associated with QOF, the literature over the last five years clearly identifies the limitations of QOF from both a primary care and a patient perspective, turning instead to more holistic models and approaches for managing LTCs and prompting positive health behaviours. However, these are not always clearly defined, or evaluated over the long term; moreover, there is a lack of detail on implementation and addressing problems which could be aided by more qualitative research, particularly when change is required to address quality concerns, rather than generated by motivated innovators.

There are positive initiatives for detection and screening of atrial fibrillation and hypertension, though these may be dependent on resources being available to support implementation. NHS Health Checks may need to be targeted quite specifically in order to increase detection of those at risk and support behaviour change. Studies of patient activation levels and support to increase activation through interventions such as Health Coaching suggest promise for both individuals, primary care providers and health system use overall; however, the literature is also clear that these depend on a cultural shift towards co-production and a more social model of health care.

**RECOMMENDATIONS:** In designing new holistic care models, Thurrock Integrated Care Alliance should consider learning from the evidence base, and specifically consider:

- That transformation programmes need to be built around *how* to achieve cultural shifts in practice;
- The benefits of health goals being contextualised within the patient's life and personal priorities;
- Adopting the Patient Activation Measure (PAM) to assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support;

Training a range of staff in primary care, integrated teams and lifestyle services in Health Coaching. Roll-out Health Coaching within multi-disciplinary teams, prioritising patients identified through PAMs at the lowest levels of engagement.

In seeking further improvements in care for specific CVD conditions, services should consider:

- Further developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists) and considering how broader roles might enhance LTC services for patients e.g. MECC, opportunistic atrial fibrillation and hypertension screening in community clinics
- Implementing systematic and targeted case finding for atrial fibrillation and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs, and those living in more deprived circumstances
- Maximising uptake of NHS Health Checks, targeting higher risk groups such as those at lower ages in higher risk minority ethnic groups

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### 8. Conclusions

The 2016 APHR report highlighted concerns about workforce capacity in primary care, variations in the quality of care and the impact of poor identification and management of CVD and other long-term conditions. It quantified the potential benefits of action on these factors for the health system. Assessing the impact of initiatives put in place to address these concerns is difficult given the impact of the COVID-19 pandemic on implementation, changes in access to primary care, the primary care workforce and data-capture, but where impact is measurable, indicators show an improvement in quality of care for CVD in Thurrock since 2016. Given the impact of the pandemic, however, on widening inequalities, the case for improved identification and management of CVD is even more pressing.

The most recent Marmot review[3] stresses the need to re-focus on prevention in order to reduce the inequalities exacerbated by COVID-19. Given the high rates of smoking and obesity in Thurrock, increased identification and improved management of cardiovascular conditions will not alone address the inequalities currently associated with CVD in the borough; prioritising wider action to increase access to healthy foods, provide support for individuals to manage their weight, increase physical activity and reduce smoking is required. In addition, opportunities to identify those at increased risk of CVD, through NHS Health Checks and other case finding programmes, need to be targeted in areas of higher deprivation and for population groups with most to gain.

There have been some positive changes in primary care staffing since the 2016 report, but these are set against local and national concerns about ongoing workforce pressures, and Thurrock remains significantly under-doctored. The introduction of new roles such as Physician Associates and Social Prescribers is positive, and appears to have increased availability of appointments as well as providing more tailored support in areas such as mental healthcare. However, the funding that supports these roles is population based, not weighted to deprivation, so care should be taken to ensure that such innovations do not inadvertently widen health inequalities between higher performing practices with more capacity, and those facing greater challenge due to higher health needs and workforce pressures. Moreover, learning from these roles must be shared within and between PCNs.

Despite the challenges of workforce pressures and the pandemic, there have already been improvements through initiatives implemented and developed since the 2016 report, notably the use of public health data to support practices, Stretch-QOF, and generation of additional workforce capacity with new roles in primary care. Figure 16 shows how activity could now be directed to support different patient groups.

More generally, the literature on changing models of care and approaches to the management of LTCs is clear that care for people with multi-morbidities needs to become more personalised, more coordinated and more collaborative if patients are to be engaged in optimising their health, and if both demand on the system and health inequalities are to be reduced. This means, for example, that Stretch QOF needs to be more holistic, focused on patient outcomes overall rather than individual disease targets. However, a shift towards more collaborative, co-produced care requires fundamental shifts in culture, investment in staff (for example training) as well as time to embed – as has already been recognised in the BCTT strategy in regard to the adoption of a Human Learning Systems approach. Achieving this at the same time as seeking to reduce variation between and within PCNs and manage workforce constraints is a significant challenge.

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Review of the literature suggests that the principles underpinning the roles of long-term condition specialists in Thurrock needs to be articulated, understood and shared within and across the four PCNs if the ambitions for patient outcomes and health system savings are to be realised. Time, training and opportunities for co-production and shared reflection on cultural change, in addition to continued collaboration between public health and primary care to understand the data driving and measuring this work (not least the segmentation of patient groups), are needed to support this shift.

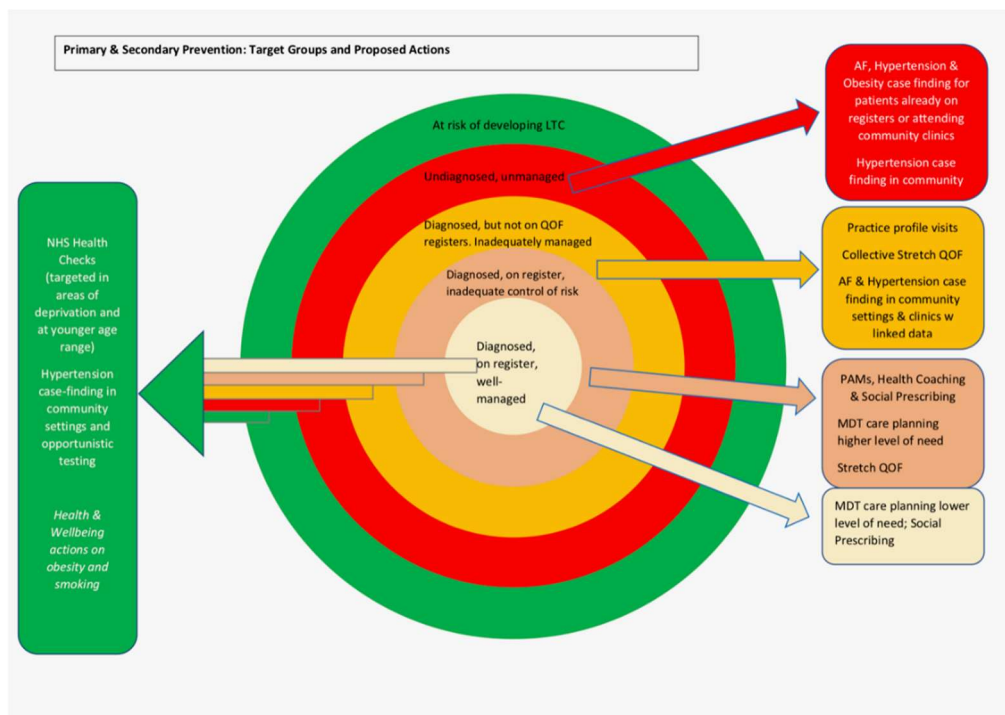


Figure 16: Proposed actions for patient groups to reduce impact of CVD

There is now a national drive for CVD prevention, particularly through improved identification and treatment of hypertension and atrial fibrillation, as part of the NHS Long Term Plan. Over the last 5 or so years, there has been a shift in evidence towards more collaborative and holistic models of care, and greater understanding of how to engage patients in managing their health and associated health behaviour changes (away from the expert patient and educational model) towards, for example, PAMS and Health Coaching, and an increase in innovative projects in the community for identifying those at risk of CVD. This knowledge, together with alignment with the national CVD plan, offer opportunities for both primary and secondary prevention in Thurrock, subject to robust evaluation. Much may rest on the development of the IMWCs for those patients with multi-morbidities and complex health and social care needs, especially those for whom the co-location of community services and mental health services with primary care may improve engagement. The first IMWC to open has been in Corringham, where innovative practice in obesity can already be found. However, in Thurrock there is greater need in Tilbury & Chadwell and in ASOP, both in terms of constraints on primary care capacity and greater levels of patient need. These areas should

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therefore be prioritised for additional workforce capacity and adoption of new models of care, in order to avoid widening health inequalities further.

### 9. Recommendations

**1. Thurrock Integrated Care Alliance (TICA) should work with Mid and South Essex ICS to prioritise support for new models of working and additional workforce capacity to practices within Thurrock PCNs, to avoid increasing health inequalities associated with access and quality in primary care.**

**2. Refresh the whole-system focus on primary prevention of CVD post-COVID-19.** To reduce inequalities, particularly given the widening of inequalities due to COVID, more resource and effort should be directed to primary prevention as well as addressing wider issues such as debt and fuel poverty

Thurrock has significantly higher rates of smoking and obesity than average for England; and smoking is the largest single modifiable factor contributing to health inequalities and preventable deaths. Specifically, as set out in Goal 1A of the 2022-2026 Thurrock Health & Wellbeing Strategy:

- Develop a Whole System Tobacco Control Plan for Thurrock. Through this, reduce the proportion of people in Thurrock who smoke, and the variation between community groups - focusing on residents in areas of higher deprivation and those with severe mental illness, with the aim of reducing smoking prevalence to 5% or less by 2030. Continue to train staff working with people in higher risk groups in smoking cessation.
- Implement the refreshed Thurrock Whole System Obesity Strategy (to be agreed 2022), again reducing both the proportion of people (children and adults) who are obese and with an increased focus on health disparities, both of place and protected characteristics, with an additional focus on obesity in pregnancy and early years. As part of this strategy, improve the food environment, leveraging positive community influences, to assist people in making healthy food choices and improve the physical environment to promote physical activity. The age profile of Thurrock is younger than the England average, and the risks associated with obesity increase with age. Ensure that the refresh of the Whole System Obesity Strategy identifies and promotes opportunities to identify and manage obesity and low levels of physical activity in younger adults, including during and after pregnancy before the risk of LTCs associated with obesity is exacerbated.
- Leverage opportunities within the new Family Hubs to implement activities promoting and supporting health behaviours in the early years, especially to reduce high levels of childhood obesity at age 5 and 11 in the district.

**3. Promote personalised, collaborative and holistic care planning, for example the House of Care using an evidence-based model, alongside long term condition specialists and multi-disciplinary working within the IMWCs. New models of working should include maximising potential for risk behaviour services to target support to patients, including those at higher risk of CVD, through joint working within the new Integrated Medical Centre model.**

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The integration of risk behaviour & wellbeing support services with the four IMWCs provides an opportunity to target NHS Health Checks to residents using social care and housing services, increasing uptake amongst groups who may not currently respond to invitation letters from GP practices.

Similarly, improved access to health risk behaviour support and coaching for residents attending mental health and community support services, as part of the long-term condition model of care, offers an opportunity to address some of the health inequalities associated with having learning disabilities or poor mental health. This will depend on effective collaboration between IAPT/NELFT, PCN Mental Health, THLS and the Voluntary and Community Sector to identify patients at highest risk. Designated Learning Disability support roles, that are able to support people at times of crisis, admission to hospital etc, could also help reduce avoidable health impacts for this cohort.

Transformation of care should centre around a change in culture from the traditional medical model to a social model of care. This should ideally be co-developed, for example using Human Learning Systems (as outlined in the Better Care Together Thurrock strategy). To support this and the following two recommendations, re-establish the Better Care Together LTC & Inequalities group to steer and support adoption of new ways of working to steer cultural change.

#### 4. In designing new holistic care models, Thurrock Integrated Care Alliance should consider learning from the evidence base, and specifically consider:

- **That transformation programmes need to be built around *how* to achieve cultural shifts in practice;**  
Focusing on the processes and tools of transformation used by innovators is not sufficient when seeking a shift to co-production and towards a more social model of care across all partners in a system.
- **The benefits of health goals being contextualised within the patient's life and personal priorities;**  
Evidence suggests that goals linked to the *patient's* starting point will be more successful.
- **Adopting the Patient Activation Measure (PAM) to assist in segmenting and prioritising patients with multi-morbidities and/or complex needs for care-coordination and support;**  
Evidence suggests that using the PAM to determine patients' engagement in managing their conditions can benefit both individual patients (by helping them identify goals which are personally relevant) and health professionals (by determining which patients have the most complex care-coordination needs and would benefit from interventions to help them manage their health condition). As a collaborative tool, PAM differs substantively from patient-reported outcome measures or patient education. Patient activation measures should not be limited to areas of higher health inequality only, as all levels of engagement are found across all socio-economic groups. Use of the PAM has also been recommended in the Mid & South Essex Self-Care JSNA (2021).

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- **Training a range of staff in primary care, integrated teams, prevention and risk behaviour services in Health Coaching.** Roll-out Health Coaching within multi-disciplinary teams, prioritising patients identified through PAMs at the lowest levels of engagement.

Health Coaching differs from traditional patient information and education as it is based on motivational interviewing approaches, and a collaborative process between patient and professional. Health Coaching can be offered in a range of settings, including by telephone. Evidence suggests Health Coaching can deliver positive changes in health behaviours, especially when targeted at patients identified as having low levels of activation.

Health Coaching and PAMs are new approaches built on a more collaborative, holistic approach to LTC management. Ensure opportunities to share learning between health coaches and other members of the primary care workforce, informally and at Time to Learn practice shut-downs.

5. **Continue to strengthen the links between public health and primary care, using data to inform improvements. Use Stretch-QOF and other approaches to promote case-finding and a strengths-based approach to improving outcomes, taking into account multi-morbidities, to promote holistic management of LTCs.**

**Given the high quality of primary care for those on CVD registers in Thurrock, the greatest improvements in population health are likely to be gained by a focus on reducing gaps in diagnosis.**

A case finding strategy is, as recommended in the BCTT strategy, is warranted to further build on gains in CVD diagnosis and management since 2016. This should include processes to identify patients diagnosed but not on QOF registers. Holistic approaches should be considered to reduce the risks of siloed practice that could flow from addressing CVD prevention targets in the NHS LTP individually, including for example through implementation of PAMs.

Practice Profile cards and other data should be provided at practice level within PCNs, to assist PCNs in recognising and addressing variation in practice. These could include a focus on levels of reported Personal Care Adjustments (previously QOF exceptions) to ensure that these do not contribute to health inequalities. Refresh the plan for quality visits to practices in order to prioritise reduction of health inequalities.

Use practice quality visits and Time to Learn practice shut-down sessions to identify best performance and promote peer to peer learning opportunities within and across PCNs.

6. **In seeking further improvements in care for specific CVD conditions, services should consider:**
  - **Developing Community and Allied Health Professional roles (e.g. Podiatrists, Physiotherapists, Community Social Care roles) and considering how broader roles might enhance LTC services for patients** (eg MECC, opportunistic atrial fibrillation and hypertension screening in community clinics).

As part of the IMWC clinical model, make more use of community roles including AHPs for atrial fibrillation and hypertension case finding in community clinics, as well as new roles in primary care such as Social Prescribers and ARRS roles. Ensure that AHPs, Pharmacists and new primary

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care roles have received training in MECC and are well informed about access to health coaching and lifestyle support services, and the relevance of these approaches for supporting their patients. The role of Community Pharmacies in CVD prevention warrants further consideration in Thurrock, with the potential contribution of pharmacists to primary and secondary prevention being reflected in future Pharmaceutical Needs Assessments.

- **Implementing systematic and targeted case finding for atrial fibrillation and hypertension, including targeting over 65s, those who are housebound, those with higher BMIs**

Consider use of portable devices such as AliveCor by community teams, as set out in the Health & Wellbeing Strategy. Ensure that training and support is available to assist with implementation of screening / case finding and that data on patients identified as requiring further investigation can be shared directly with general practice.

- **Targeting NHS Health Checks for people at the younger age limit, in groups known to be at higher and earlier CVD risk. This includes those in certain minority ethnic groups, smokers and people on obesity registers, as well as residents in areas of higher deprivation.**

Targeting NHS Health Checks as above should build on evidence of how best to engage those groups. Expanding delivery of health checks should include workplaces, collaboration with other community services (e.g. fire service) and a variety of venues and different days and times.

The principle of Universal Proportionalism which drives the NHS Health Checks programme provides authorities with the freedom to target invitations for checks at those at greater risk, whilst still enabling the general eligible population to access the health check on invitation. THLS should work with PCNs and individual practices, using software currently available to the team, to secure agreement to stratify and target health check invitations using primary care registers. In addition, consider with MSE partners how best to work within the constraints of the NHS Health Checks programme regarding the provision of checks for people working, but not resident in, Thurrock.

- **Maximising uptake and associated follow-up of physical health checks for people living with SMI and who have a learning disability.** A targeted approach to SMI physical health checks across younger age groups and lower uptake ethnic groups should be a priority.

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### Appendix 1: Literature Review

Identification and management of cardiovascular long-term conditions in primary care

Available from: <https://www.thurrock.gov.uk/public-health/other-public-health-reports>