From: [redacted]
Primary Care Directorate: General Practice Policy
03-04-2025

Cabinet Secretary for Health and Social Care

Cardiovascular disease directed enhanced service (CVD DES)

Priority

1. Urgent. An early response would allow the circular to be issued to Health Boards.

Purpose

2. This urgent submission provides an update on the position reached in negotiations with the Scottish General Practitioners Committee (SGPC) on the proposal for cardiovascular disease directed enhanced service (CVD DES), with the aim for a circular to be issued to health boards as soon as possible.

Recommendation

3. You note the update on the negotiated position and approve the proposal for the CVD DES circular (Annex A) to be issued to health boards.

Context

4. The CVD DES is part of the operational improvement plan and was referenced in the First Minister's speech on 27 January.

5. The CVD DES contributes to the Scottish Government's Cardiovascular Risk Factors Programme.

6. A key objective of the Scottish Government's Cardiovascular Risk Factors Programme is to find those living with key modifiable risk factors that they are currently unaware of, and to optimise prevention, early intervention and care to therefore reduce patients' risk of developing CVD. We recognise that this needs to be done in innovative ways (e.g group consultations, community outreach) to reach people who often under-utilise healthcare services.

Key aspects of the service

7. Following initial input from British Medical Association (BMA), Royal College of General Practitioners (RCGP), Primary Care (PC) Leads, and CMO CVD programme, we have designed a service that focuses on pro-active case finding of CVD issues (e.g. hypertension, high cholesterol) in areas of high deprivation, encouraging innovative models to engage with those individuals.

8. Following extensive negotiations with SGPC, on both the clinical and costing aspects of the CVD DES, the SGPC have agreed the clinical arrangements and

costings, and that they will work with the Scottish Government to jointly promote the uptake of the service.

9. In terms of how this will be operationalised, General Practitioners (GPs) will be expected to identify patients on their practice lists at risk of developing CVD, and carry out appropriate checks on eligible patients. GPs will be informed of a capped amount of funding and the number of patients expected to be identified and offered checks. The payment will be made on an item of service basis per patient with flat fees per practice for running searches and considering innovative models of consultation. The capped amount will be based on the number of patients in each practice weighted by Standardised Mortality Ratio for Coronary Heart Disease Death and by Scottish Index of Multiple Deprivation (SIMD). This will ensure that funding is weighted towards practices with patients living areas of high deprivation, given there are more early CVD-related deaths in these areas.

10. Patients will be eligible for checks if they meet the following conditions:

- Are aged 35-60; and
- Have not received the full suite of CVD checks in the last 3 years:
    - a blood pressure check;
    - a lipid profile or key element of this;
    - a weight/BMI;
    - an assessment of glycaemic level such as blood glucose/HbA1c; and
    - a smoking status asked

11. GPs should then offer to provide the following CVD risk factors bundle check to identified patients (a toolkit for the CVD bundle will be live on the Right Decision Scotland 'RDS' from April to guide clinicians on pathways):

- Blood pressure assessment
- Lipid Profile assessment (TC and HDL will be required for ASSIGN)
- BMI
- T2D risk assessment questionnaire completion (which requires the height, weight and waist circumference measurement to be entered) followed by glycated haemoglobin (HBA1C) or fasting glucose (as per local board arrangements) if questionnaire shows high risk; and
- Smoking status

12. GPs should then use the results to create an ASSIGN score for each patient. The ASSIGN score is a risk assessment tool that estimates a 10 year risk of a person developing cardiovascular diseases such as heart attack and stroke. The score combines the following risk factors: age, total cholesterol, HDL (high density lipoprotein) cholesterol, systolic blood pressure, diabetes, family history of CVD, cigarettes per day and Scottish Index of Multiple Deprivation (SIMD) score and is calculated separately for women and men.

13. Patients will be offered a follow up appointment. Patients with ASSIGN scores within the normal range should be offered lifestyle advice. GPs should treat

patients with abnormal results or ASSIGN scores over the 10% threshold, as required, as part of the follow up appointment.

Costings

14. The costings for the CVD DES are detailed below, and have been agreed with SGPC. The full cost for the service has been cleared via the AO process, and is part of the 2025-26 budget for General Practice.

Flat fee per practice for innovative consultations	Flat fee per practice to conduct patient searches	Item of service payment per patient treated	Total cost of CVD DES	Total number of patients to be seen in 25/26
£250	£100.30	£95	£9,834,750.00	100,000

Monitoring and evaluation

15. We are currently working on the basis that item of service payment will be made using an automated system. This is being developed by NHS National Services Scotland (NSS). Compared to a proforma declaration (the option considered for payment verification), this will allow us to monitor uptake of the service in real time, as well as provide further assurance that the bundle of work as specified in the contract is being carried out.

16. Output and outcome measures will be used to demonstrate changes in diagnoses for those patients who accessed the service, as well as the number of those patients who have accessed treatment for CVD related conditions (such as type 2 diabetes, hypertension and obesity).

17. We will monitor the outputs of the programme regularly and instigate any adjustments which might be necessary to ensure we are receiving the data we require to evidence impact

18. SG economists are in the process of developing a Scottish model which can demonstrate the health impact and cost savings of identifying and managing the CVD risk factors which will be treated through the CVD DES and wider CVD programme. The economists are currently speaking to experts in Scotland about how applicable the English estimates are, and which Scottish data sources would be appropriate. An initial run of the model is planned for the end of April. This will initially provide quite crude data, but will give some ballpark figures, and further development can take place to refine estimates over the coming months.

Verity House Agreement Implications

19. None

Financial and Legal Considerations

20. The CVD DES has been cleared through the AO process and is within the budget for General Practice. The CVD DES was referenced by the First Minister in his speech on 27 January.

Sensitivities

21. The costings for the CVD DES have been negotiated with SGPC. SGPC are considering formal dispute which we are currently exploring options to avert (advice pending). Officials have balanced the need to build goodwill in negotiations with value for money in agreeing a cost within this context and to also ensure we have a good basis for any future negotiations on enhanced services.

Quality Assurance

22. This Submission has been approved Susan Gallacher, Deputy Director for General Practice.

Conclusions and next Steps

23. Should the Cabinet Secretary approve the proposed CVD DES, officials will issue the circular to health boards once the appropriate reporting functions are in place which is estimated to be within the next month.

[redacted]
Primary Care Directorate, General Practice Policy

Cabinet Secretaries and Ministers Copy List	For Action	For Information Portfolio interest	For Information Constituency interest	For Information General awareness
Cabinet Secretary for Health and Social Care	X			

Officials Copy List
DG Health & Social Care Chief Medical Officer [redacted] Tim McDonnell

Officials Copy List
Susan Gallacher [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] [redacted] Health Comms SpAds Admin Jennie Gollan

Annex A

Draft circular for issue to Health Boards

CARDIOVASCULAR DISEASE PREVENTION SCHEME – DIRECTED ENHANCED SERVICE

Dear colleague

Summary

1. This circular provides guidance to Health Boards and GP practices on a new Directed Enhanced Service (DES) to identify patients at risk of developing cardiovascular disease (CVD), and thereby help prevent the development of CVD.

2. This circular also gives directions to Health Boards on behalf of Scottish Ministers detailing the payment arrangements (Annex B), which must be made under the DES.

3. The DES has been agreed with the Scottish General Practitioners Committee (SGPC).

Background

4. CVD is the second largest cause of the overall disease burden and second most common cause of death after cancer. It causes 25% of all deaths in Scotland, with 4,478 avoidable CVD deaths in under 75s. In addition, mortality from coronary heart disease is five times higher in Scotland's most deprived areas, compared to the least deprived.

5. Many people do not know they are living with CVD risk factors. 1.3 million people in Scotland are estimated to have high blood pressure, but only 24% of adults with high blood pressure are treated and controlled. In the adult specific population around one in three adults were recorded as having high blood pressure as part of the Scottish Health Survey.

6. A key objective of the Scottish Government's Cardiovascular Risk Factors Programme is to find those living with key modifiable risk factors that they are currently unaware of, and to optimise our early intervention and care to therefore reduce patients' risk of developing CVD. We recognise that this needs to be done in innovative ways to reach people who often under-utilise healthcare services (e.g. group consultations, community outreach).

ELIGIBLE PATIENTS AND ACTIONS

Eligible patients

7. Patients will be eligible for checks if they meet the following conditions:

- Are aged 35-60; and
- Have not received the full suite of CVD checks in the last 3 years:
    - a BP;
    - a lipid profile or key element of this;
    - a weight/BMI;
    - an assessment of glycaemic level such as blood glucose/HbA1c; and
    - a smoking status asked

Actions

8. Contractors will be expected to identify patients on their practice lists at risk of developing CVD and carry out appropriate checks on eligible patients. Contractors will be informed of a capped amount of funding and the number of patients expected to be identified and offered checks. The payment will be made on an item of service basis per patient. This will be based on the number of patients in each practice weighted by Standardised Mortality Ratio for Coronary Heart Disease Death and by Scottish Index of Multiple Deprivation (SIMD).

9. Contractors should search their patient lists to identify eligible patients and should use local knowledge to target patients in higher deprivation. Practices signing up to the Enhanced Service will also receive a downloadable ESCRO tool (created by NHS NSS and their contractors, Albasoft), which is suitable for use on desktops and displays an eligible population report (people aged 35-60 who have not received the full suite of CVD checks in the last 3 years) at a patient level, using data held on practice servers. This list is grouped by Scottish Index of Multiple Deprivation (SIMD) using reference tables of postcode/SIMD that are embedded in the existing ESCRO data pump already deployed on every practice server to support the vaccination programme.

10. The target population of this enhanced service are characterised by "missingness" so contractors should consider whether innovative modes of engagement (e.g. group consultation, community outreach) are the most appropriate methods of engaging with their eligible patients.

11. Contractors should then provide the following CVD Risk Factors bundle check to identified patients (a toolkit for the CVD bundle will be live on the Right Decision Scotland 'RDS' from April 2025 to guide clinicians on pathways):

- Blood pressure assessment
- Lipid Profile assessment (TC and HDL will be required for ASSIGN)

- BMI
- T2D risk assessment questionnaire completion (which requires the height, weight and waist circumference measurement to be entered) followed by glycated haemoglobin (HBA1C) or fasting glucose (as per local board arrangements) if questionnaire shows high risk; and
- Smoking status

12. Contractors should then use the results to create an ASSIGN score for each patient. Please refer to the CMO letter on launch of ASSIGN v2.0.

13. Contractors should then offer patients a follow up appointment. Patients with ASSIGN score and wider results within the normal range should be offered lifestyle advice to support onward health.

14. Contractors should treat patients with abnormal results/ ASSIGN v2.0 scores over the 10% threshold/ ASSIGN 1.5 scores over 20% threshold, as required as part of the follow up appointment (with guidance in RDS Risk Factor toolkit to support clinicians). Please note the guidance in the CMO letter on ASSIGN for any interim use of v1.5 in embedded calculators in GP IT.

15. Six months after the follow-up appointment, for patients with original high ASSIGN score or abnormal results only, contractors should repeat the bundle of tests as set out in paragraph 11.

16. A code list will be shared to allow the key interventions above to be coded in a standardised way for evaluation.

Timing and reporting arrangements

17. Contractors are asked to participate in the CVD prevention programme between 1 April 2025 and 28 February 2026. Contractors are asked to notify Health Boards within one month of receipt of this circular by XX 2025 if they wish to participate in this Service.

Claims for payments

18. As set out in Annex A, payments will be made on an Item of Service basis for consultations on a monthly basis, via use of the ESCRO tool, with a flat fee for the identification of the target group and consideration of innovative models.

19. Payment will be made automatically via PSD to contractors, based on automated reporting using ESCRO, using a list of codes to be shared in due course.

Action and Enquiries

20. NHS Boards are requested to action this guidance and ensure that their primary medical services contractors are aware of it.

21. In the event of any enquiries on this circular, please contact Michael Taylor.

Yours sincerely

Susan Gallacher
Deputy Director General Practice Policy Division

Annex B
PAYMENT ARRANGEMENTS

The Scottish Ministers give the following directions to Health Boards.

1. Contractors who have entered into an arrangement with a Health Board as part of that Health Board's Enhanced Services CVD prevention scheme will be reimbursed in accordance with the paragraphs below.

2. Payments applicable to GMS contracts are set out below.

3. A flat payment of £250 will cover initial planning time – including consideration of the innovative models outlined in paragraph 6 – and a flat fee of £100.30 will be paid per practice to conduct patient searches.

4. An item of service fee of £95 will be paid on a monthly basis, via use of the ESCRO tool, for each patient who:
   - receives the full CVD bundle of checks subsequentially carried out; and
   - completes the clinical review appointment.

Payment Verification

5. Prior to issuing payments in accordance with the above, Health Boards must require contractors and providers who have entered an arrangement with a Health Board's enhanced services CVD prevention scheme in terms of the DES Directions 2018 to sign a declaration to confirm that they are meeting the requirements of the DES Directions 2018.

MONITORING AND EVALUATION OF CARDIOVASCULAR DISEASE DIRECTED ENHANCED SERVICE (CVD DES)

Purpose

This paper sets out a summary of the monitoring and evaluation that will be required as part of the CVD DES, expected to benefit 100,000 people in Scotland.

Monitoring

1. We are currently working on the basis that item of service payment will be made using an automated system. This is being developed by NHS National Services Scotland (NSS). Compared to a proforma declaration (the option considered for payment verification), this will allow us to monitor uptake of the service in real time, as well as provide further assurance that the bundle of work as specified in the contract is being carried out.

2. This will be operationalised through payment being made by practices using a specific range of codes to evidence they have done the work. For example, for the GP appointment element of the service, practices will use the "cardiovascular risk assessment" and "primary prevention of cardiovascular disease" to code for the lifestyle appointment for normal ASSIGN scores and abnormal ASSIGN scores respectively.

3. As the two codes above are not regularly used by practices (n.b. only 3,000 uses in the last year), this method will also allow us to isolate with confidence those who benefit from the Enhanced Service compared to those benefitting from CVD prevention activities through core GMS services.

Evaluation

Output and Outcome indicators

4. As we can with confidence isolate the group of patients benefitting from this service, we will then be able to see at aggregate level increases in the following 'output' indicators flowing from the programme, (specifically for those patients who accessed the service) :

    a. Diagnosis of hypertension
    b. On antihypertensive medications
    c. Diagnosis of dyslipidaemia
    d. High ASSIGN score on the correct regime for lipid lowering medication
    e. Diagnosed Type 2 Diabetes (T2D) and diagnosed pre-diabetes
    f. On prescribed medication for T2D and/or actively on the T2D Remission programme
    g. Referrals to the T2D Prevention programme
    h. Diagnosis of obesity

i. Up to date smoking status recorded
j. Smokers actively on quit your way programmes
k. Smokers on Nicotine Replacement Therapy (NRT)

5. This will allow us to evidence what illness has been proactively identified through the service with a view to controlling.

6. Given that a six month follow-up will be scheduled to those with scores out with the normal threshold (in addition to any further monitoring required), we are going to look at the following indicators:

   a. Diagnosis of dyslipideamia (or who are in remission) in whom the lipid profile (results in the preceding 12 months) is within maintenance levels; for people with ASCVD - Is LDL-C <1.8mmol/L or non-HDL-C < 2.5mmol/l; for Non ASCVD, a >40% reduction in LDL-C, or non-HDL-C reached

   b. Diagnosis of hypertension (or who are in remission) in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading).

   c. Diagnosis of T2D and have completed the T2DR programme and achieved remission

   d. Diagnosis of hyperglycaemia (Prediabetes or T2D levels) who have completed the T2DP programme in whom their glyaemia levels (results in the preceding 12 months) are under 42

   e. Diagnosis of obesity and on treatment in whom their % body weight loss (measurements taken in the preceding 12 months) is 10% or more

   f. Have undertaken other remission/weight management programmes; and achieved a minimum 10% weight loss (measurements taken in the preceding 12 months)

Impact Modelling - the Health Economy Impact

7. SG economists are in the process of developing a Scottish model which can demonstrate the health impact and cost savings of identifying and managing the CVD risk factors which will be treated through the CVD DES and wider CVD programme. The economists are currently speaking to experts in Scotland about how applicable the English estimates are and which Scottish data sources would be appropriate. An initial run of the model is planned for the end of April. This will initially be quite crude data but will give some ballpark figures and further development can take place to refine estimates over the coming months. This is based on the English model: Size of the Prize for high blood pressure (uclpartners.com)

- Size of the Prize programme in England states that if just 80% of people with diagnosed high blood pressure were on optimal treatment, around 16,000 heart attacks and strokes would be prevented in just three years with savings to the NHS of £180 million.

- Applying this to a Scottish population (based only on relative population sizes and not taking into account differences in the structure of the populations, different baseline severity and prevalence, and assuming similar levels of effectiveness), 1,546 heart attacks and strokes could be prevented with a saving of £25 million to the NHS in Scotland (assuming equivalent health service delivery costs and approaches in Scotland and England).

- If 90% of people with CVD in England were treated optimally with statins, almost 14,000 heart attacks, strokes and deaths would be prevented in three years.

- Applying this to a Scottish population (based only on relative population sizes and not taking into account differences in the structure of the populations, different baseline severity and prevalence, and assuming similar levels of effectiveness), 1,288 heart attack, strokes and deaths would be prevented.

8. Given that we will be able to isolate the interventions provided under the service, we will then be able to model the aggregate health economy impact of these interventions using an adapted version of the data above.

9. Note there will also be some practices who do not participate in the Service who we can use as a Control Group to compare with outputs/outcomes of participating practices.

References

(1) Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis - ScienceDirect Accessed on 31 March 2025;
Efficacy and safety of more intensive lowering of LDL cholesterol: a meta-analysis of data from 170,000 participants in 26 randomised trials - PubMed (nih.gov) Accessed on 31 March 2025.

Expectations on What Doing the CVD Bundle on people who have not had their metrics checked in last 3 years.

Our general assumptions are that:

- **A high proportion of adults in Scotland will have <u>at least</u> one of these risk factors undetected, as we know for adults** *(and this if for all ages up to the much older population, so that will effect these percentages, compared to the 35-60 age range for the enhanced services):*
  - That 1/3rd of adults have high blood pressure and that of these only 24% may be currently identified and treated
  - We know that only 1/3rd of adults are normal BMI, 1/3rd overweight BMI, and 1/3rd obese BMI
  - We know that 15% of Scotland's adults are smokers, but this will be much higher in lower SIMD groups.
  - We know that more than 1 in 4 deaths from heart and circulatory diseases in Scotland are associated with high HDL
  - UK data suggest 1 in 5 have DM or pre-diabetes (but higher numbers in key ethnicity groupings in England may contribute towards this). In Scotland the Scottish Diabetes Survey has a prevalence of roughly 6% T2DM likely 1.5% undiagnosed T2DM
  - It is estimated that up to a third of the Scottish adult population are living with prediabetes with the vast majority being unaware of this. Between 5-10% of those with prediabetes will progress to T2D every year, with rates of progression higher for younger patients, those with a high BMI and those who live in deprived communities.

- **There is close connection across these 5 risk factors, such a higher weight also linked to high BP, lipids etc, and we also know that the rising level of obesity is changing disease profile further.**

- **We also know that people in SIMD deciles facing the highest needs will have the poorest health and will have more of these risk factors, and more undetected risk factors. And of course people here are experiencing shorter life expectancy, shorter healthy life expectancy, and are making up a key part of the avoidable deaths (i.e. those under 75 whose deaths could have been avoided by intervention).**

- **Hence the reason we are running this national programme on CVD and the ES area of focus. By finding the undetected risk factors and then offering early intervention by way of medical treatment such as prescribing, or referral to smoking cessation, weight management services, type 2 diabetes remission programmes, or supporting the person with lifestyle change – we are aiming to find>optimise>reduce risk**

- **This will lead to care needs for primary care as per the duty of core GMS , and finding those that are missing and have high unmet needs is essential.**

- **There are of course strong economic arguments for prevention, as high end acute care for stroke, myocardial infarction, diabetic complications etc will all cost the**

whole system more, and take up more health workforce resource from more complex packages of care. For instance, the Institute For Fiscal Studies report the cost of obesity are:

- Around 3% of GDP, £58 billion per year (2020)
- GDP has risen by around 12% between 2020 and 2022 (ONS, 2023), so expressed relative to GDP in 2022 this would be £65 billion.
- Around one-third of this is costs to the NHS, social care, lost workplace productivity, and COVID.
- Around two-thirds is costs to individuals in reduced life expectancy and quality of life

Reducing Risk Can Make Fast and Significant Impact

- Lowering SBP by 10 mm Hg reduces major CVD events by 20%

- lowering LDL-C by 1 mmol/L gives 22% relative reduction in major CVD events

- HbA1c reduction by 11mmol/mol (1%) can reduce related mortality by 21% and MI by 14%

A collection of data that can give some indication – but not perfectly matched to the cohort that will be hopefully identified in the ES:

Lipids - Data from <u>Our future Health Clinics</u> in Scotland (in the first 5 months)(near pt testing not serum bloods)

	TC < 5 mmol/L	TC >5 & <7.5 mmol/L	TC > 7.5 mmol/L (age <30) or 9.0 mmol/L (age >30)			Normal	High	Very High
40-49 years	684	939	12		40-49 years	42%	57%	0.7%
50-59 years	707	1,769	15		50-59 years	28%	71%	0.6%

<u>England health checks (40-74, offered every 5 years)</u>

% of all attendees for checks that then went on to be prescribed statins = 8%

% of all attendees for checks that went on to be prescribed antihypertensives = 11%

- **Avoidable mortality is 4.1 times higher in more deprived areas, comparing the most deprived 20% of areas in Scotland with the 20% least deprived areas.**

[Avoidable mortality | National Records of Scotland (nrscotland.gov.uk)]

- **Approximate annual cost for CVD inpatients of over £390 million. There were nearly 82,000 inpatient admissions for CVD in Scotland in 2022/23, nearly 8% of all inpatient admissions, with an average gross cost per inpatient treatment of £4,782.**

[Scottish Health Service Costs (publichealthscotland.scot)]

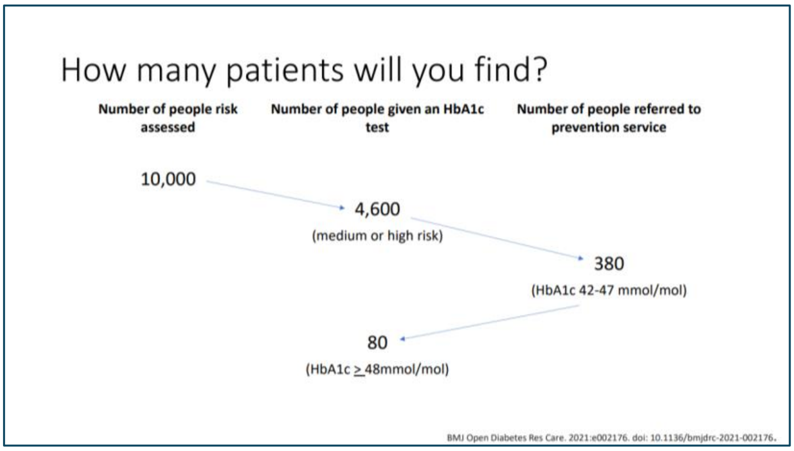
- **Cardiovascular diseases (including heart attacks and strokes) cause more than a quarter of all deaths in Scotland. These diseases cost the NHS £800 million and have a wider cost to society, which is estimated at £1.8 billion, each year in Scotland.**

[bhf-statistics-compendium-2023.pdf]

Age	% prevalence high blood pressure	Numbers prevalence of high blood pressure	% prevalence of untreated high blood pressure	Numbers untreated high blood pressure
16-24	7	6,000	1	6,000
25-34	5	49,000	6	45,000
35-44	12	72,000	9	62,000
45-54	29	190,000	19	130,000
55-64	45	359,000	28	220,000
65-74	59	360,000	25	145,000
75+	70	350,000	30	150,000
All adults	31	1,370,000	17	760,000

The above has combined the data from two tables (5.6 and 5.7) in the BHF report bhf-statistics-compendium-2023.pdf. The actual data comes from the Scottish Health Survey 2019.

Data from Dundee University and Tayside Community Pharmacy T2D assessment (did near pt testing for a HbA1C on abbot quality assured machine)



Monitoring and Evaluation Framework

Theory of Change

Current state	• Scotland has the UK's lowest life expectancy at birth and life expectancy is beginning to fall. The gap in healthy life expectancy between the most and least deprived is also increasing. Overall disease burden is forecast to increase by 21% by 2043, with Cardiovascular Disease (CVD) set to have the most substantial increase (34.4%). • In 2021, CVD was responsible for a quarter of all deaths in Scotland. When combined with diabetes, CVD is Scotland's largest cause of overall disease burden and second most common cause of death after cancer. CVD is also strongly associated with health inequalities. For example, in the last ten years mortality rates for ischaemic heart disease have typically been four to five times higher in the most deprived areas than in the least deprived. • Evidence showed that during the pandemic, as services swung necessarily towards the major new threat, there was a reduction in preventive care which contributed to excess mortality; for example, a study found reduced take up of interventions such as antihypertensive drugs. • Considerable efforts are being made to restore secondary prevention to pre-pandemic levels. However, to go further, we need extend the advantages of secondary prevention to groups that missed out even before the pandemic if we want to better address the current unmet need. • This programme has been set up to reduce CVD in Scotland, leading to improved life expectancy and healthy life expectancy for all. Through proportionate universalism approaches, it aims to significantly increase the identification and management of those with higher risk of CVD to reduce associated health inequalities.
Goal of the programme	• The overall goal of this programme is to reduce CVD mortality and morbidity in Scotland through improving the early identification and management of

	key risk factors. It also aims to reduce inequalities by identifying and managing risk in people who often underutilise healthcare services. • This will be achieved by increasing people's awareness and knowledge of CVD and CVD risk factors, and increasing healthcare and community provision and outreach of preventative and proactive care. By reducing risks earlier this will prevent conditions escalating to their acute or chronic stages. This in turn will support sustainability of health and social care systems.
Inputs and Activities	The main inputs to the programme and activities that will undertake to increase identification and management of those at higher risk of cardiovascular disease include: **1. Primary Care Provision** • Improve access to and use of primary care data for CVD risk identification and stratification • Create new ASSIGN v2.0 tool and support access to and use of this in primary care to aid identification of people at risk of CVD. • Greater provision of ConnectMe BP monitoring in primary care • Development of best practice pathways and toolkits for use in GP practices that will encourage assessment (details of checks at end of document) ** of all 5 modifiable risk factors in people aged 30 to 74: - during annual reviews for those with a long term condition on list A* (list at end of document) - at a routine appointment in individuals identified as having one or more of the modifiable risk factors, or with non-modifiable risks factors making them more susceptible to CVD - in invitations to attend for assessment those not otherwise in contact with the practice **2. Primary care Directed Enhanced Service (DES).** • Funding allocated to practices opting in to support them to assess the 5 modifiable risk factors in people aged 35-60 who have not: received the assessment of all 5 modifiable risk factors in the last 3 years. **3. Community provision.** • Work with community planning partnerships and other stakeholders to increase provision of CVD risk factor identification and management pathways to the public available from locations

	outside of GP practices e.g. community pharmacies, leisure facilities and other outreach services **4. Training and education** • Provision of good quality staff training on CVD risk factor identification and management and having good conversations. • Establishment of a Learning network to support implementation of training in practice and new models of care e.g. group consultations. **5. Improved public awareness** • Creation of a Cardiovascular Hub on NHS Inform which includes information about CVD, the risk factors, what early interventions people can make themselves via lifestyle medicine approaches, and about when to discuss with a healthcare professional. • Activity to strengthen workplace understanding and early identification routes for CVD risks • Public campaign? • Promotion of self-assessment of risk and self-management tools?
Outputs	The Inputs and Activities result in the following Outputs: • Primary Care is doing more CVD risk factor checks as part of routine care or by invite. • Public access to CVD risk factor assessment is increased • Access to digital support eg Connect Me is increased • More people have their risk factors for CVD identified and are receiving active management (including treatment). • More people are being referred to new and existing national and local programmes to support CVD risk factor management. • Engagement with people at higher risk of CVD through modifiable and non-modifiable risk factors is increased • Primary Care and Community Health Staff have an increased awareness and knowledge of CVD risk factors. • The public are more aware of CVD risks factors and better understand how to identify and manage these

Outcomes	The Outputs will in turn produce a series of short, medium and longer term Outcomes: • More equitable access across the population to identification and management of CVD risk factors • Improved detection of CVD risk factors within the population • Improved management of CVD risk factors within population • People are taking more action to identify and manage their CVD risk factors • Staff feel supported, equipped and confident to deliver high quality secondary prevention
Impact	• Reduction of CVD burden • Reduction of CVD associated health inequalities in the population • Shift in the balance of care for CVD from reactive care towards proactive prevention • Improved life expectancy and healthy life expectancy for all (STRETCH AIM: To reduce avoidable mortality from CVD by 20% in 20 years)

***List A**

- Coronary heart disease
- Stroke or transient ischaemic attack
- Peripheral vascular/arterial disease
- Heart failure
- Abdominal aortic aneurysm
- Atrial fibrillation
- Diabetes (T1DM and T2DM)
- Prediabetes
- Chronic kidney disease
- Hypertension

****CVD risk factor checks:**

- a BP measure;

- a lipid profile or key element of this;
- a weight/bmi measure;
- Diabetes risk score and/or an assessment of glycaemic level such as blood glucose/HbA1c;
- a smoking status asked