ONESTOCKPORT
Health and Care Board

Stockport Provider Partnership Report: Cardiovascular Disease (CVD)

Report To (Meeting):	One Stockport Health and Care Board		
Report From (Executive Lead)	Paul Buckley, Director of Strategy & Partnerships, Stockport NHS Foundation Trust		
Report From (Author):	Kimberly Roberts (Senior Programme Manager, Primary & Community Care & Neighbourhoods), NHS Greater Manchester (Stockport)		
Date:	26th March 2025	**Agenda Item No:**	8
Previously Considered by:	N/A		

Decision		**Assurance**		**Information**	**x**

Purpose of the report:

This report provides an update on the cardiovascular disease (CVD) programme that forms part of the Stockport Provider Partnership, one of the Integrated Care Pathways of the Stockport Live Well Model (neighbourhood programme).

Key points (Executive Summary):

- The report identifies areas of focus that system partners have agreed to work together on, to improve pathways and health outcomes, increasing awareness on the lifestyle factors that can reduce cardiovascular risk, to ensure our Stockport residents can prevent and better manage health issues, to lead a happy and healthy life.
- Cardiovascular disease remains a leading cause (second overall) of death in Stockport, responsible for 25% of all deaths in 2022, with early heart disease deaths reaching a 14-year high.
- Our programme aim is to complement existing offers and services, utilising the assets available across our neighbourhoods to enable greater connectivity.
- The report highlights the progress made over the last 12 months, where Stockport partners have engaged with the community across our neighbourhoods.
- The future focus is to build on this progress, ensuring the cardiovascular workstream remains closely aligned to the emerging Stockport Live Well programme for neighbourhoods.
- We aim to further strengthen our approach, ensuring the voice of the resident is central to decisions on how we design and deliver our offer, ensuring services are tailored to the needs of our communities.

Recommendation:

It is recommended that Board **NOTE** the progress of the cardiovascular disease programme and support the future focus and planned development of the provider partnership workstream

1. INTRODUCTION

1.1. This report provides an update on the cardiovascular disease (CVD) programme that forms part of the Stockport provider partnership, highlighting areas of focus for system partners to work together on, to improve pathways and health outcomes, increasing awareness on the lifestyle factors that can reduce cardiovascular risk, to ensure our Stockport residents can prevent and better manage health issues to lead a happy and healthy life.

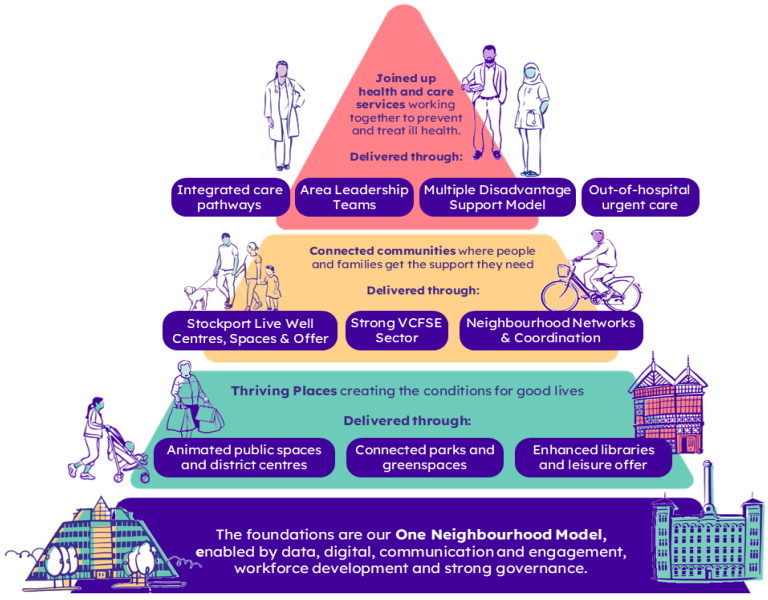
1.2. Cardiovascular disease remains a leading cause (second overall) of death in Stockport, responsible for 25% of all deaths in 2022, with early heart disease deaths reaching a 14-year high. Reducing modifiable risk factors and early detection can significantly reduce risks, saving lives and improving quality of life.

2. CONTEXT AND SCOPE

2.1. The cardiovascular disease workstream is one of the Integrated Care Pathways of the Stockport Live Well Model with priorities also closely aligned to the expected locality deliverables, within the NHS Greater Manchester Multi-Year Prevention Plan.

2.2. Due to the interdependencies of diabetes and cardiovascular disease, these programmes of work are closely aligned, with the primary and secondary prevention elements and priorities delivered across both programmes of work.

Figure 1: Stockport Live Well Neighbourhood pillars and how they connect



3. DEVELOPING OUR APPROACH

3.1. The cardiovascular disease work programme includes 3 preventative workstreams, all with a task and finish group that focus on primary, secondary and tertiary prevention.

3.2. Our programme aim is to complement existing offers and services, utilising the assets available across our neighbourhoods to enable greater connectivity to support increased impact and outcomes.

3.3. The key actions identified by partners to support delivery of our approach are:

- Supporting Stockport Area Leadership teams to deliver a population health management approach, focusing on those most at risk and experiencing the most significant health inequalities in their communities

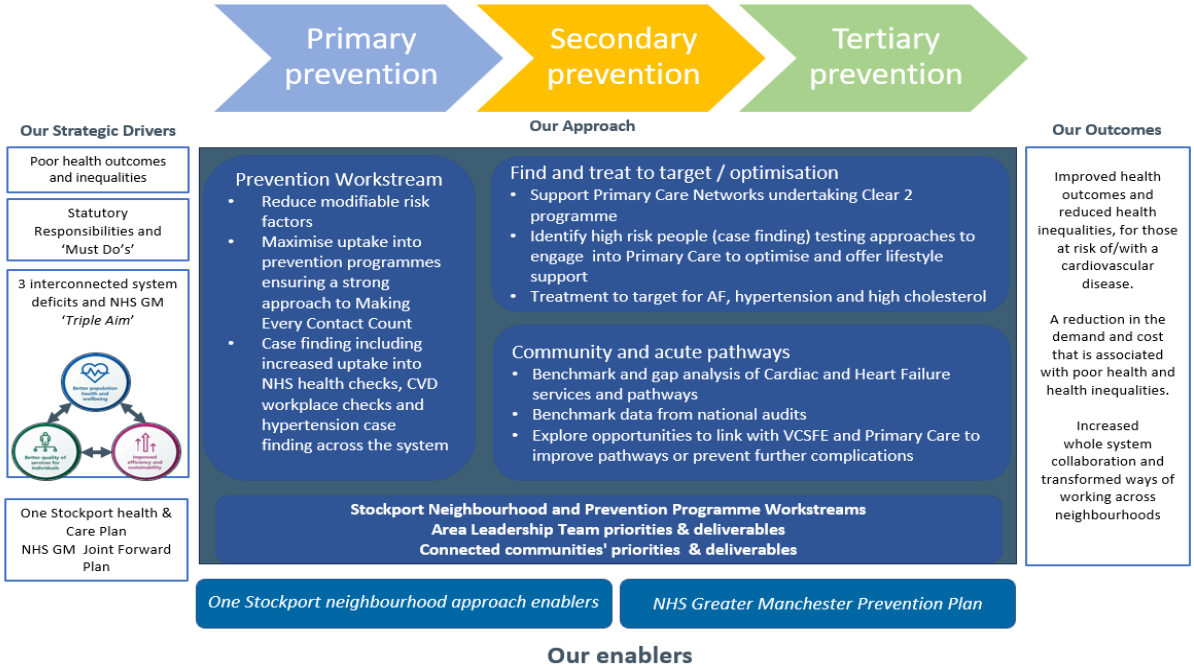
- Harness the capabilities of the Voluntary, Community, Faith and Social Enterprise sector (VSCFE) with the implementation of our approach across neighbourhoods

- Work with Stockport general practice on condition management through delivery of reviews for those known as being at highest risk of cardiovascular disease

- Maximise prevention opportunities with improved collaboration between the voluntary sector, primary care, community, mental health, and Stockport Foundation Trust to deliver prevention interventions

- Work collaboratively at a Stockport level to tackle the key determinants of health, reducing modifiable risk factors, so people are supported and empowered to adopt healthy behaviours

Figure 2: Cardiovascular Disease Programme Approach



4. EXAMPLES OF WORK UNDERWAY

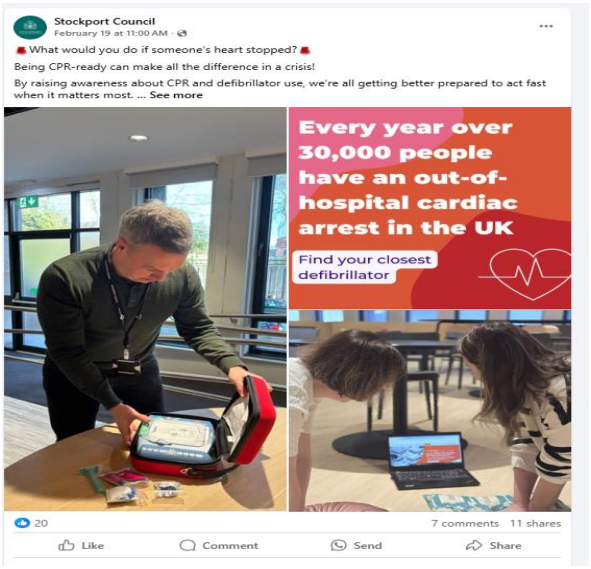
4.1. WORKPLACE HEALTHY HEART CHECK

Aims to identify early risk factors for cardiovascular disease and offer guidance on improving heart health. By February 2025:

- 1709 Health checks had been completed with 87 workplaces having been visited
- 24.3% of high blood pressure detected
- 27.7% health check undertaken on men aged 40+
- 17% of health checks completed with Stockport residents from the most deprived deciles

4.2. SOCIAL MEDIA CAMPAIGNS

Social media campaigns of where is the defib and RevivR, were delivered during heart health month (February 2025). There are further future campaigns planned for other related awareness days throughout the calendar year.



4.3. MAKING EVERY CONTACT COUNT WITH THE WINTER VACCINTAION ROVING VAN

Blood pressure checks undertaken, and brief advice given working alongside the Winter Covid and Flu vaccination roving van offer. This programme was supported by VCSFE organisations, who promoted the roving van offer also identifying priority areas for the van to be placed, to support a targeted approach to communities. Partners worked together to ensure the opportunity to make every contact count was maximised for health promotion.

4.4. VICTORIA LEADERSHIP TEAM

4.4.1. The team have delivered a project as part of the NHS Greater Manchester Clear 2 project, for proactive care. They have used data to predict those who may be at risk of cardiovascular disease and diabetes, testing a range of engagement approaches to contact and offer an NHS health check to all identified. Of the 743 residents engaged, the following diagnosis were made:

- 116 identified as Non-Diabetic Hyperglycaemia (Pre-Diabetes)
- 38 with hypertension
- 12 with fatty liver
- 19 with Diabetes
- 14 with chronic kidney disease
- 105 with obesity

4.4.2. All residents engaged have been initiated on required medications, supported with lifestyle advice, offered referral into wellbeing services or community groups and given brief advice to empower them to self-care, manage their condition and reduce future modifiable risk factors.

4.5. CHEADLE AREA LEADERSHIP TEAM

4.5.1. The team have achieved fantastic engagement over the last 12 months with the local Cheadle Mosque working in partnership to understand any health and wellbeing offers that would be welcomed by their community, utilising the time to build trust and develop effective community links. A new community event has been planned for the coming months to be held at the Mosque to focus on diabetes, cardiovascular health and signposting people to other essential services. One of the Mosque leaders has been invited to the next area leadership team meeting to discuss further how they would like to work together to support the needs of their community.

4.5.2. The examples above highlight some of the great progress made in the last 12 months, with Stockport partners collaborating across organisational boundaries to engage with our Stockport communities to ensure a broader impact and reach across our neighbourhoods.

5. FUTURE FOCUS

5.1. Build on the progress made during the last year, ensuring the cardiovascular workstream remains closely aligned and supportive to the emerging Stockport Live Well programme for neighbourhoods.

5.2. Further strengthen our approach, ensuring the voice of the resident is central to decisions on how we design and deliver our services ensuring they are tailored to the needs of our communities.

5.3. System wide training offer for ‘making every contact count’ so all frontline teams who are in contact with residents can give brief advice and navigate our residents in the community for earlier intervention and prevention.

5.4. Continue to streamline pathways between prevention services, primary and community care and Stockport Foundation Trust. Maximising opportunities for residents to receive services closer to home with closer collaboratively working between all partners involved in these pathways.

6. RECOMMENDATIONS

6.1. It is recommended that Board **NOTE** the progress to date of the cardiovascular disease programme and support the future focus and planned development of the provider partnership workstream.