

Cardiovascular disease: identifying and supporting people most at risk of dying early overview

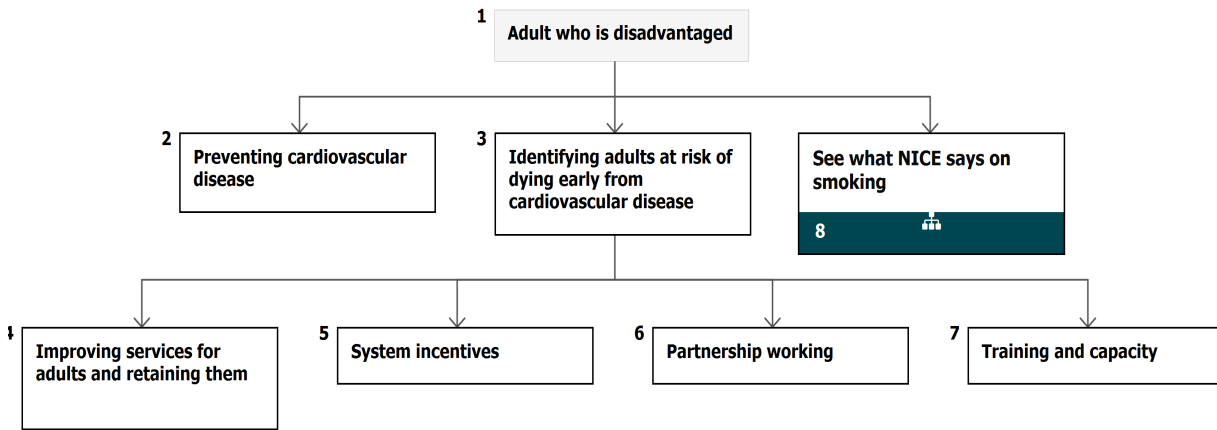
NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

<http://pathways.nice.org.uk/pathways/cardiovascular-disease-identifying-and-supporting-people-most-at-risk-of-dying-early>

NICE Pathway last updated: 15 August 2017

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Adult who is disadvantaged

No additional information

2 Preventing cardiovascular disease

See what NICE says on cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease in adults [cardiovascular disease prevention](#).

3 Identifying adults at risk of dying early from cardiovascular disease

Primary care professionals should use a range of methods to identify adults who are disadvantaged and at high risk of premature death from CVD. These include:

- primary care and general practice registers (for example, to identify adults who smoke; who are from particular minority ethnic groups; or who have family members who have had premature coronary heart disease)
- primary care appointments (for example, during routine visits and screening)
- systematic searches in pre-identified areas or with specific populations (for example, using direct mail or telephone)
- analyses of QOF data.

Those working with communities should use a range of methods to identify adults who are disadvantaged and at high risk of CVD. Methods to use include:

- health sessions run at a range of community and public sites, including post offices, charity shops, supermarkets, community pharmacies, homeless centres, workplaces, prisons and long-stay psychiatric institutions. (Lifestyle factors such as smoking or other indicators, such as blood pressure, could be used to identify those at risk)
- culturally sensitive education sessions that include a CVD risk assessment and which take place in black and minority ethnic community settings (including places of worship)
- outreach activities provided by community health workers (including health trainers).

Service providers should monitor these methods and adjust them according to local needs.

Service providers should encourage everyone who is disadvantaged to register with a general practice.

4 Improving services for adults and retaining them

Provide flexible, coordinated services that meet the needs of individuals who are disadvantaged. For example, this could include providing drop-in or community-based services, outreach and out-of-hours services, advice and help in the workplace and single-sex sessions.

Involve people who are disadvantaged in the planning and development of services. Seek feedback from the target groups on whether the services are accessible, appropriate and meeting their needs.

Gain the trust of adults who are disadvantaged. Offer them proactive support. This could include helplines, brochures and invitations to attend services. It could also include providing GPs with postal prompts to remind them to monitor people who are disadvantaged and who have had an acute coronary event.

Develop and deliver non-judgemental programmes to tackle social and psychological barriers to change. These should be tailored to people's needs. For example, they could make use of social marketing techniques. (Social marketing involves using marketing and related techniques to achieve specific behavioural goals.)

Ensure services are sensitive to culture, gender and age. For example, provide multi-lingual literature in a culturally acceptable style and involve community, religious and lay groups in its production. Where appropriate, offer translation and interpretation facilities. Promote services using culturally relevant local and national media, as well as representatives of different ethnic groups. Consider providing information in video or web-based format.

Provide services in places that are easily accessible to people who are disadvantaged (such as community pharmacies and shopping centres) and at times to suit them.

Provide support to ensure people who are disadvantaged can attend appointments (for example, this may include help with transport, postal prompts and offering home visits).

Encourage and support people who are disadvantaged to follow the treatment that they have agreed to. For example, encourage them to use self-management techniques (based on an individual assessment) to solve problems and set goals. It could also involve providing vouchers for treatments (such as NRT). See NICE's recommendations on the principles of [behaviour change](#).

Routinely search GP databases (and other electronic medical records) to generate lists of patients who have not collected repeat prescriptions or attended follow-up appointments. Make contact with them.

Address factors that prevent people who are disadvantaged from using services (for example, they may have a fear of failure or of being judged, or they might not know what services and treatments are available).

Support the development and implementation of regional and national strategies to tackle health inequalities by delivering local activities which are proven to be effective.

Use health equity audits to determine if services are reaching people who are disadvantaged and whether they are effective¹. (For example, by matching the postcodes of service users to deprivation indicators and smoking prevalence.)

5 System incentives

Policy makers, planners and commissioners should support and sustain activities aimed at improving the health of people who are disadvantaged by:

- using relevant indicators to measure progress and compare performance across areas or organisations
- ensuring, wherever possible, that all targets aim to tackle health inequalities – and do not increase them
- ensuring exception-reporting does not increase health inequalities: commissioners of public health services should be provided with additional levers and tools to monitor and benchmark exception-reporting and to reduce persistent rates of exception coding
- considering the provision of comparative performance data to encourage providers to meet targets
- using local enhanced services to encourage providers and practitioners to identify and continue to support those who are at risk of premature death from CVD and other smoking-related diseases.

Provide incentives for local projects that improve the health of people who are disadvantaged, specifically those who smoke or are at high risk of CVD from other causes or are eligible for statins. Ensure the projects are evaluated and, if effective, ensure they continue.

¹ Health equity audits typically consist of six steps: 1) Agreeing partners and issues for the audit, 2) Undertaking an equity profile, 3) Identifying high-impact local action to narrow key inequities identified, 4) Agreeing priorities for

action, 5) Securing changes in investment and service delivery and 6) Reviewing progress and assessing impact.

Health equity audit: a self-assessment tool (Department of Health 2004).

6 Partnership working

Develop and sustain partnerships with professionals and community workers who are in contact with people who are disadvantaged. Use joint strategic needs assessments, local agreements, local partnerships, the GP contract, world class commissioning and other mechanisms. For further information, see what NICE says on [community engagement](#).

Establish relationships between primary care practitioners and the community to understand how best to identify and help adults who are disadvantaged to adopt healthier lifestyles. For example, they should jointly determine how best to support health initiatives delivered as part of a local neighbourhood renewal strategy.

Establish relationships with secondary care professionals (for example, those working in respiratory medicine and CVD clinics) to help identify patients at high risk of further cardiovascular events. Offer these patients support or refer them on, where appropriate.

Develop and maintain a database of local initiatives that aim to reduce health inequalities by improving the health of people who are disadvantaged.

Develop and sustain local and national networks for sharing local experiences. Ensure mechanisms are in place to evaluate and learn from these activities on a continuing, systematic basis.

Ensure those working in the healthcare, community and voluntary sectors coordinate their efforts to identify people who need help.

7 Training and capacity

Commissioners and service providers should:

- Ensure there are enough practitioners with the necessary skills to help people who are disadvantaged to adopt healthier lifestyles. (For examples of the skills needed see NICE's recommendations on [smoking](#) and the [standard for training in smoking cessation treatments](#) or updated versions of this.)
- Ensure practitioners have the skills to identify people who are disadvantaged and can develop services to meet their needs. (For a set of generic principles to use when planning and delivering activities aimed at changing health-related behaviour, see NICE's recommendations on [behaviour change](#). For advice on getting communities involved, see

- NICE's recommendations on [community engagement](#).
- Ensure service providers and practitioners have the ability to make services responsive to the needs of people who are disadvantaged. For example, they should be able to compare service provision with need, access, use and outcome using health equity audits. (For examples of the training and skills needed, refer to national organisations such as the Faculty of Public Health, British Psychological Society, Skills for Health and the Institute of Environmental Health.)

8 See what NICE says on smoking

[See Smoking](#)

Glossary

CVD

cardiovascular disease

disadvantaged

adults who are disadvantaged include (but are not limited to) those on a low income (or who are members of a low-income family), those on benefits, those living in public or social housing, some members of black and minority ethnic groups, those with a mental health problem, those with a learning disability, those who are institutionalised (including those serving a custodial sentence) and those who are homeless

high risk

if someone has a 20% or higher risk of a first cardiovascular event in the next 10 years they are deemed at high risk of cardiovascular disease

NRT

nicotine replacement therapy

QOF

quality outcomes framework

Sources

Cardiovascular disease: identifying and supporting people most at risk of dying early (2008)
NICE guideline PH15

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful

consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of

implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.