



Improving cardiovascular disease prevention across systems

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Key points

- Cardiovascular disease (CVD) is a leading cause of premature deaths, accounting for one in four premature deaths and affecting over 7 million people in the UK.
- Effective CVD prevention requires a combination of primary and secondary interventions and factors, and a view of health that goes well beyond the borders of the NHS.
- When healthcare systems can collaborate to share insight, coordinate resources and build trust across professional and organisational boundaries, they are better able to detect risk earlier, provide support closer to people's lives, and ensure consistent and equitable standards of care.
- The NHS Alliance and Q, with support from Novartis, worked with three integrated care boards to understand how they are working on this area, where prevention is gaining traction and where the gaps remain.
- This briefing explores examples of current practice emerging from these systems and barriers to progress. It also identifies seven key enablers for strengthening CVD prevention and supporting sustainable cross-system working.
- Taken together, the insights show that strengthening CVD prevention is as much about strengthening systems as it is about clinical practice and treatment.

Introduction

Cardiovascular disease (CVD) is a leading cause of premature deaths, accounting for one in four premature deaths and affecting over 7 million people in the UK. With four out of ten UK adults expected to be living with obesity by 2040, combined with an ageing population, CVD is a growing problem which could see an additional 2 million people living with CVD by 2040 ([Cancer Research UK, 2022](#); [British Heart Foundation, 2026](#)). This is a major challenge which the government estimates costs the NHS £10 billion each year ([UK Parliament, 2025a](#)).

This healthcare burden affects South Asian and African Caribbean ethnicities more frequently and is also more common in those with a severe mental illness. 2023 data indicates that those in the most deprived 10 per cent of the population were almost twice as likely to die prematurely from CVD than those in the least deprived 10 per cent ([UK Parliament, 2025b](#)). The NHS Long Term Plan positions CVD as a leading clinical priority and the single greatest condition where lives can be saved over the next decade ([NHS England, 2019](#)).

The case for prevention

CVD prevention depends on a combination of primary prevention interventions (tackling root causes and risk factors) and secondary prevention (preventing further cardiovascular events for those with established CVD). It requires:

- a prevention infrastructure that combines public health and population health management strategies to target preventable risk before it becomes disease
- accessible community-based services for both detection and support
- ongoing support for medication adherence and lifestyle changes
- the health and care system working in a coherent and mutually reinforcing way ([The King's Fund, 2025](#))
- clearly understood roles and responsibilities and well defined care pathways
- the ability of organisations to collaborate across the boundaries of primary care, community services, acute care, public health, and the voluntary and community sector ([NHS Confederation, 2024](#); [The King's Fund, 2025](#)).

Crucially, effective prevention also requires a view of health that goes well beyond the borders of the NHS, recognising the impact of social, economic and environmental conditions on cardiovascular risk.

The crucial role of healthcare systems

When systems can collaborate to share insight, coordinate resources and build trust across professional and organisational boundaries, they are better able to detect risk earlier, provide support closer to people's lives, and ensure consistent and equitable standards of care. Strengthening prevention, therefore, is inseparable from strengthening system working, and integrated care boards (ICBs) have a pivotal role in driving that shared endeavour.

With that in mind, as the organisations providing practical support for system improvement, we set out to understand how systems are already working on this area, where prevention is gaining traction and where the gaps remain.

This briefing captures the insights from a first-of-its-kind CVD programme delivered by the NHS Alliance and Q with support from Novartis. The programme was delivered as part of our System Improvement Support service. We worked with ICB teams across West Yorkshire, Birmingham and Solihull, and the Black Country between September 2025 and February 2026 to understand:

- the opportunities for CVD prevention
- the role improvement currently plays and how it is measured
- how it can align with organisational strategies to create large-scale change.

Intended for people working across organisational boundaries supporting CVD prevention, this briefing identifies the conditions the three ICBs needed to accelerate CVD prevention, reflecting on not just the interventions that improve prevention, but the organisational, leadership and partnership conditions that enable ICBs to deliver those interventions effectively and at scale.

Spotlighting examples of current practice and barriers to progress, it also highlights key enablers for strengthening prevention and supporting sustainable cross-system working.

About System Improvement Support

System Improvement Support is a service provided by the NHS Alliance and Q, which aims to strengthen system working and support large-scale change through improved collaboration across organisational boundaries. Drawing on our experience in creating the enabling conditions for systems change, we support health and care organisations to transform services and achieve sustainable improvement.

The CVD System Improvement Support programme

The CVD System Improvement Support programme, supported by Novartis, was delivered at a time of significant change and challenge for participant organisations – and the health and care system as a whole. CVD leads across all areas experienced significant uncertainty regarding future funding, structures and roles.

Despite the challenges faced by ICBs in this context, we were able to support them to identify clear enablers for cross-system working at different levels of the system to maximise the effectiveness of CVD prevention.

Programme participants

We worked with three ICBs in parallel processes, supporting them to explore the challenges and barriers to their CVD prevention work and to understand opportunities to improve local collaboration, across places, primary, secondary care and public health.

- West Yorkshire ICB
- Birmingham and Solihull (BSOL) ICB
- Black Country ICB

Enablers for cross-system working

The shift towards prevention requires a whole-systems approach based on coordinated action from all local partners ([The King's Fund; 2025](#)). At the centre of this approach is the need for a shared vision, clear commitment to reducing health inequalities and making sure there is consistent access to treatment and services across local populations. This needs to be driven by systematic CVD risk management and programme delivery that is led by partnerships beyond health and care.

Through our work with West Yorkshire, Birmingham and Solihull and the Black Country ICBs, we identified seven key opportunities to build on existing strengths in CVD prevention and wider system dynamics. A range of effective joint delivery models are already emerging that show system working is developing.

1. Clinical and workforce models

The systems we worked with felt that neighbourhood multi-disciplinary teams (MDTs) were an important feature of any solution driving CVD prevention.

In Calderdale, a pharmacist-led CVD management clinic is being trialled, focused on hypertension and lipid optimisation, targeting high-risk populations. This is providing a more direct and targeted resource for patients than they would get through standard care, and the clinic structure is helping to shape the work in central Halifax overall. It is being managed through extended workforce and shows an example of effective primary care and wider workforce models while also demonstrating better integration between primary and secondary care.

2. Community and outreach models

All three ICBs have invested in community and faith outreach as part of working with communities through culturally competent engagement campaigns and community champions. Understanding where standardisation supports prevention and where more local variation is needed to ensure communities are supported.

In Kirklees, community champions were trained to signpost, support blood pressure and atrial fibrillation (AF) checks to develop trust with local communities. Public health and local authority colleagues are actively engaged, recognising the role of deprivation, housing,

food access and social justice. This opens up opportunities to align NHS prevention efforts with non clinical levers such as wider health inequalities.

A local initiative in Dudley called Pressure Drop is aimed at increasing blood pressure detection in high risk communities by setting up pop up BP stations in community venues such as mosques, barbershops, shopping centres and workplaces. The programme focuses on preventing progression to CVD by improving early detection, offering opportunistic checks in trusted community settings and referring individuals into primary care pathways for follow up. It was supported by aligning equity goals with Quality and Outcomes Framework (QOF) incentives.

3. Data infrastructure

Participants mentioned the value of integration of primary and secondary care datasets to support identification and management of high-risk patients, including undiagnosed hypertension, atrial fibrillation, high cholesterol and lipid as well as chronic kidney disease.

4. CVDPREVENT Dashboard

In West Yorkshire, participants shared that 98 per cent of GP practices are feeding into the CVDPREVENT dashboard, which means there is potential to make sure this holds up-to-date GP practice coverage.

In Black Country, pharmacist-supported optimisation clinics have demonstrated measurable improvement in CVDPREVENT metrics. This shows that targeted identification and medication optimisation at practice level can shift population outcomes at scale.

Leeds' population health management infrastructure is supporting a more proactive approach to CVD prevention, including risk stratification to identify individuals most likely to have undiagnosed hypertension. The linked Leeds Data Model enables structured analysis across primary, secondary and community datasets, helping the system target its prevention efforts ([Leeds Health and Care Partnership](#)). However, operationalising these insights depends on national information governance (IG) frameworks, digital capacity in primary care and workforce availability for follow up.

// You need a model where whoever sees the patient – paramedic, district nurse, pharmacist – can check BP, spot risk and feed it into the system. **//**

BSOL/Black Country participant

5. Standardised treatment protocols and pathway optimisation

Participants in West Yorkshire highlighted variation across clinical pathways and identified an opportunity to reduce unwarranted variation by adopting shared CVD clinical guidelines, with consistent prescribing practices and agreed thresholds for intervention and escalation.

In West Yorkshire, a key development has been the introduction of a new hypertension guideline, which supports a dual therapy approach rather than a traditional stepped escalation. This represents a shift to supporting earlier and more proactive optimisation of treatment.

6. Primary-secondary interface integration

Strengthening the primary-secondary interface was identified as a strong theme across all the ICBS we worked with. West Yorkshire ICB shared work to deliver across the ICB on cholesterol in primary care. The project supported primary care to optimise patients in different lipid lowering therapies. This was supported by lipid specialists from secondary care as an example of creating mutual responsibility of optimisation and improving relationships.

Participants also identified the need to clarify roles in prevention and identified a need for the shared CVD prevention framework. Participants in BSOL and Black Country spoke about the opportunity for a shared cardio-renal-metabolic vision, recognising the connection between these conditions and moving to holistic person-centred assessment rather than siloed disease approaches.

7. Financial alignment

Participants identified that better financial alignment was needed to support early intervention and support wider workforce models in CVD prevention.

Conclusion

Taken together, the insights from the programme show that strengthening CVD prevention is as much about strengthening systems as it is about clinical practice and treatment. The recently published cardiovascular disease modern service framework, originally introduced in the 10 Year Health Plan, has the potential to create greater urgency and provide clearer direction for how prevention can be prioritised and delivered across local systems ([Department of Health and Social Care and NHS England, 2026](#)).

Across each of the ICBs we worked with, the skill, experience and commitment of staff to improving cardiovascular outcomes and reducing health inequalities was immediately apparent. A range of programmes, both local and national programmes implemented locally, showcase tangible successes and improvements for local populations.

The programme demonstrates the value in systems having protected space to think and plan together, to understand their interdependencies, surface assumptions and compare experiences across places and sectors.

The key enablers build on this learning by setting out the practical shifts that can help translate commitment into coordinated action: clearer mandates, stronger interfaces, shared data, sustained community engagement, and leadership distributed across the system.

Taken together, they offer a route for these ICBs and their partners to consolidate what already works, address persistent barriers, and create the long-term foundations for more equitable, effective CVD prevention across their systems.

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Appendix: Programme methodology

The problem we aimed to solve

Our starting point was identifying what people understood by a whole-system approach to CVD prevention. This helped us define the boundaries and scope to create and test a shared vision with participants. This was particularly important for BSOL and Black Country as these two ICBs were in the process of clustering at the time.

// It's about using the resource where it's needed the most and not necessarily making it equal to everyone, more an equity-based approach. **//**

West Yorkshire participant

// Targeting from a health inequalities perspective, those populations that are most in need that are most likely to be impacted more. **//**

West Yorkshire participant

// Whole system means moving away from people identifying their role through their organisation and instead through the needs of the patient. **//**

BSOL/Black Country participant

From vision, we moved to understand what system shifts and changes were needed to realise the shared goal, and how ICBs could build on the existing assets, programmes and mechanisms to get there.

Programme phases

Preparatory phase

Having begun by agreeing a single overall programme lead and liaison to coordinate on behalf of each ICB, they each nominated CVD leads from across their geographies, with a wide range of roles from primary care, secondary care and public health. We also sought a balance between ICB level roles and place-based leaders.



Phase one: Onboarding systems

We conducted interviews with CVD leads across each area, aiming to understand the range of programmes taking place, priorities for the ICB as well as assets, strengths, enablers and barriers in their CVD prevention initiatives. These interviews ensured we could design our workshop around the specific needs of the ICB.

Throughout the programme, we made a conscious effort to engage with a wide range of ICB leads, as well as stakeholders across primary care, cardiology and public health. This approach was also reflected in the interviews.

Phase two: Diagnosis and prioritisation

We selected participants from across different parts of the system together as part of an all-day face-to-face workshop. Participants reflected on enablers and challenges and discussed priority areas where they could collectively put their energy to improve system-wide working on CVD prevention. Each workshop resulted in actions and next steps, as well as key questions and longer-term strategic questions for participants to consider.

Phase three: Emerging themes

Following each workshop, we produced a rapid synthesis of the discussions for programme participants to take away and focus future conversations.

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We represent, strengthen and support providers and commissioners of NHS care so that the NHS performs at its best and improves patient care across the UK.

Q is a membership community collaboratively accelerating the improvement of care in the UK and Ireland. We learn together, support each other and share insights to address health system challenges. Q is hosted by the NHS Alliance.

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