# Cardiovascular Disease Prevention

# 4 Year Plan

East Sussex County Council and NHS Sussex

April 2026/30

# Authors

| | |
|---|---|
| Thomas Gollins-Perronne | Health Improvement Specialist: NHS Health Checks and Alcohol Harm Reduction. |
| Suneeta Kochhlar | Clinical Director and Clinical Lead for CVD Prevention and Women's Health, NHS Sussex. |
| Lisa Douglas | Head of Clinical Outcomes NHS Sussex. |

# Contributors

| | |
|---|---|
| Aifric Müller | Health Improvement Specialist: NHS Health Checks and Alcohol Harm Reduction. |
| Allan Sarling | Age UK, Commercial Manager |
| Anthony Statham | Active Sussex |
| Casey Ingold | Health Improvement Specialist: Tobacco Lead. |
| Dan Ford | One You East Sussex Head of Service. |
| Ellie Mason | Health Innovation KSS, Programme Manager – Cardiovascular Disease/Respiratory |
| Fiona Collins | South Downs Health and Care LTD, Chief Operating Officer |
| Frank Powell | Beacon Surgery, Practice Manager |
| Hattie Deacon | One You East Sussex NHS Health Check Lead. |
| Hayley Martin | Health Improvement Principal, Healthy Ageing |
| Kerry Ashenden | Tobacco Dependence Treatment Services Midwife. |
| Marie Hockley | Deputy Chief Officer Community Pharmacy Surrey and Sussex. |
| Michael Watson | Public Health Commissioning Information Specialist. |

| | |
|---|---|
| Nicky Saynor | Health Improvement Programme Manager, OHID Southeast, DHSC. |
| Nicola Blake | Health Improvement Principal: Health Behaviours and Health Checks. |
| Peter Aston | Deputy Head of Joint Commissioning, Integration, and Health & Wellbeing (Cross-Sussex). |
| Sarah Keeling | Strategic Lead for Tobacco Dependence Treatment Services at ESHT. |
| Sarah Nash | Health Improvement Specialist: Physical Activity, Obesity and Tobacco. |
| Steve Mannawring | Hasting Voluntary Action |

## Sponsors

| | |
|---|---|
| Ben Brown | Public Health Consultant. |
| Rob Tolfree | Public Health Consultant. |
| Darrell Gale | Director of Public Health. |

# Contents

# Definitions

| Term | Definition |
|---|---|
| CVD | Cardiovascular Disease |
| DHSC | Department for Health and Social Care |
| ESHT | East Sussex Health Care Trust |
| HbA1c | Glycated haemoglobin or **H**aemoglobin **A1c** |
| HOIOB | Health Outcomes Improvement Oversight Board |
| ICT | Integrated Community Teams |
| NHS | National Health Service |
| OHID | Office for Health Improvement and Disparities |
| OYES | One You East Sussex |
| QRISK | **Q**uantifying **R**isk of **C**ardiovascular **D**isease |
| TDT | Tobacco Dependence Treatment |

# Overview

Cardiovascular disease (CVD) remains a leading cause of premature mortality and ill health in England and is a major contributor to health inequalities. Nationally, CVD accounts for approximately one in four premature deaths and continues to place significant demand on health and care services (Raleigh, Jefferies, & Wellings, Cardiovascular Disease in England, 2022). Prevention and early identification of cardiovascular risk factors are therefore essential to improving population health outcomes and reducing avoidable illness.

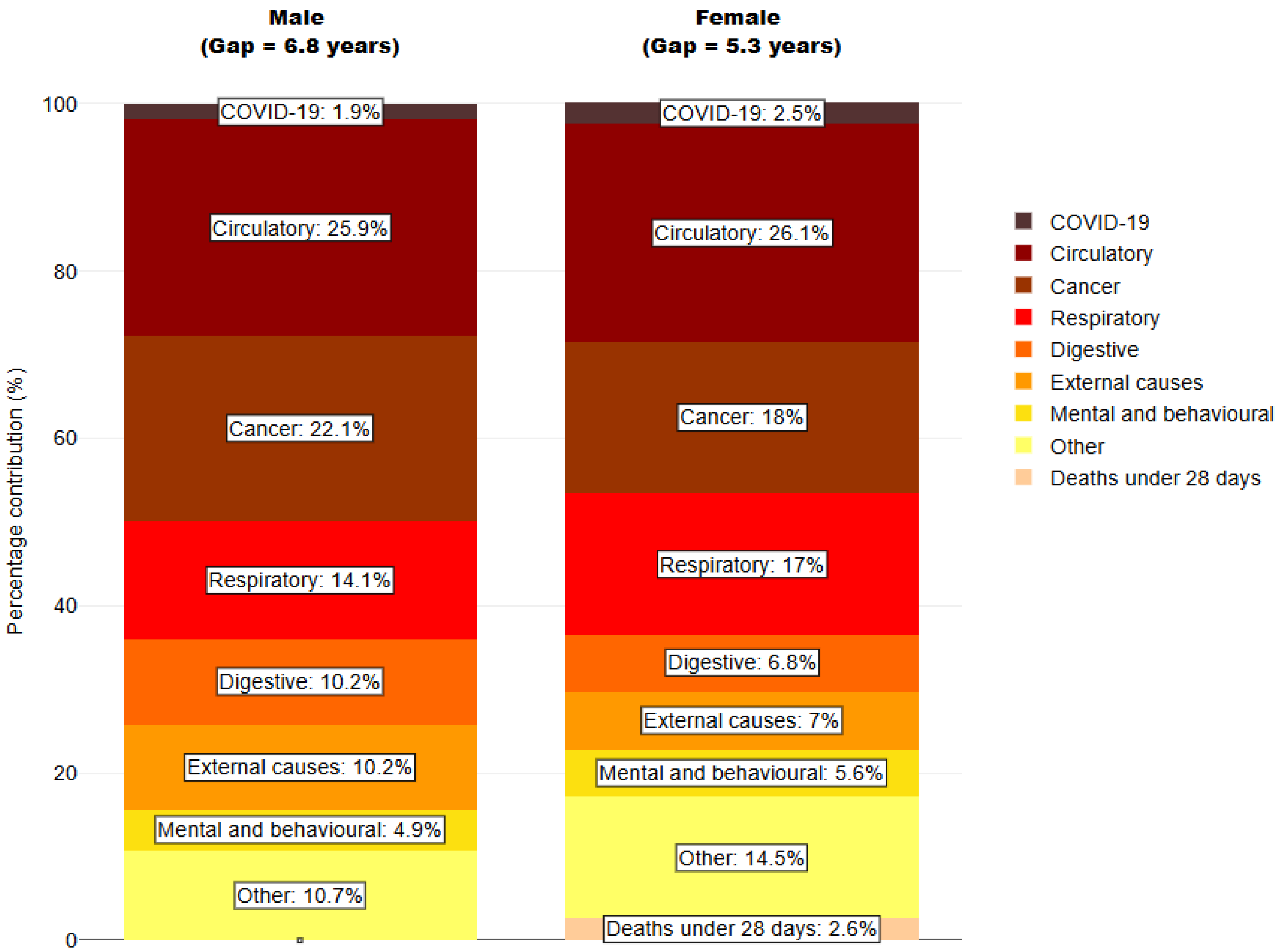
The national Fit for the Future: 10-Year Health Plan for England establishes a new direction for health and care based on three transformational shifts: moving care from hospital to community, from analogue to digital, and from sickness to prevention (Department of Health and Social Care, 2025).

CVD prevention aligns closely with the national Fit for the Future priorities, particularly the shift towards prevention and delivering more care within community settings. There is also a clear focus on reducing health inequalities, including the ambition to halve the gap in healthy life expectancy between the most and least deprived populations, making CVD prevention an important area for improving outcomes across communities.

Nationally, the NHS Cardiovascular Disease Prevention Programme supports the delivery of targeted action to improve the identification and management of key cardiovascular risk factors. The programme prioritises improvement across the ABC pathway; Atrial Fibrillation, Blood Pressure and Cholesterol, alongside increased uptake of NHS Health Checks and strengthening referral into behavioural support services (NHS England, 2023).

Within East Sussex, circulatory diseases make a substantial contribution to health inequalities. There is a clear difference in life expectancy between residents living in the most and least deprived areas, with circulatory disease representing the largest contributor to the life expectancy gap in males and females *(figure 1)*.

*Figure 1: Breakdown of the life expectancy gap between the most and least deprived quintiles of East Sussex by cause of death, 2022 to 2023*




Source: Office for Health Improvement and Disparities based on ONS death registration data and provisional mid year population estimates for the relevant years, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2019.

Effective prevention of cardiovascular disease requires coordinated action across the full prevention pathway. This includes:

- Primary prevention, focused on reducing modifiable behavioural risk factors such as smoking, unhealthy diet, physical inactivity, and harmful alcohol use, and supporting individuals to maintain good cardiovascular health.
- Secondary prevention, aimed at identifying individuals at increased cardiovascular risk and optimising management of clinical conditions such as hypertension, atrial

fibrillation and raised cholesterol, including programmes such as NHS Health Checks and ongoing clinical management for those living with cardiovascular disease.

> This CVD Prevention Action Plan has been developed through collaboration across system partners in East Sussex, including NHS Sussex, East Sussex County Council, primary care, secondary care, community services, and voluntary sector organisations.

The plan provides a coordinated framework to strengthen prevention activity, improve detection and management of cardiovascular risk factors, and support residents to live longer, healthier lives.

# Neighbourhood Model for CVD Prevention

CVD prevention in East Sussex will be delivered through a neighbourhood-based model aligned with the national Neighbourhood Health Framework and the development of Integrated Care Teams (ICTs) (Department of Health and Social Care, 2026).

## Definition

Within East Sussex, neighbourhoods are defined as populations of approximately 30,000–50,000 residents, delivered through Integrated Care Teams (ICTs). These neighbourhood structures provide the primary delivery mechanism for prevention, enabling services to be tailored to local population need and delivered closer to where people live.

Neighbourhood-based delivery supports improved coordination between primary care, community services, local authority services, and voluntary and community sector organisations, enabling earlier identification of cardiovascular risk and more proactive management of individuals and population cohorts.

## Delivery Model

CVD prevention will be delivered through coordinated, multidisciplinary working, supported by population health management approaches. Delivery will focus on identifying individuals and population groups at highest risk and ensure timely access to prevention and treatment interventions.

Key delivery components include:

- Risk stratification, using tools such as QRISK and CVDPREVENT to identify individuals and population cohorts at increased cardiovascular risk
- Multidisciplinary team (MDT) working, bringing together primary care, community services, pharmacy, public health, and voluntary sector partners
- Proactive cohort management, enabling targeted follow-up of individuals identified at increased risk
- Population segmentation, supporting prioritisation of neighbourhoods and population groups experiencing the greatest burden of cardiovascular risk

## Core Functions

Within each neighbourhood, a set of core prevention functions will be delivered consistently to support the identification and management of cardiovascular risk factors.

These functions include:

- Delivery of NHS Health Checks to identify individuals at increased cardiovascular risk
- Case finding activity, including blood pressure (BP), atrial fibrillation (AF), and lipid identification
- Clinical optimisation, ensuring individuals receive appropriate clinical management and treatment

- Delivery of behavioural interventions, including referral into smoking cessation, alcohol support, physical activity, and weight management services
- VCSE outreach, supporting engagement with underserved populations and improving access to prevention services
- Strengthening referral pathways between clinical services and community-based support

## Governance and Ownership

Each ICT will support delivery of CVD prevention through locally agreed leadership and accountability arrangements. The focus of prevention activity within each ICT may vary depending on locally identified priorities; however, many neighbourhood-level priorities, such as smoking, obesity, hypertension and physical inactivity, contribute directly to cardiovascular risk reduction.

Where cardiovascular disease or associated risk factors are identified as local priorities, named leads will support coordination of prevention activity and partnership working across organisations.

# Overarching Priorities

## Priority 1: Strengthen System Leadership and Co-ordination

Establish strong system leadership to support coordinated delivery of cardiovascular disease prevention across East Sussex, with ICTs acting as the primary vehicles for neighbourhood-level delivery and accountability.

1. Establish a strengthened CVD Prevention Group with defined governance and reporting arrangements by October 2026.
2. Complete mapping of CVD prevention services, pathways, and delivery partners across East Sussex by October 2026 to identify duplication, gaps, and opportunities for alignment within neighbourhood delivery models.
3. Develop and implement a system-wide CVD performance dashboard by April 2027 to support shared oversight, accountability, and improvement across ICTs.

## Priority 2: Data Quality, Intelligence and Evaluation

Strengthen population health intelligence to support identification of high-risk cohorts, unwarranted variation, and opportunities for targeted intervention across neighbourhoods.

1. Ensure consistent extraction and reporting of behavioural risk factor data (including BMI, smoking and alcohol status) across all NHS Health Check delivery models by April 2027.
2. Develop and expand population health dashboards using data from NHS Health Checks and CVDPREVENT to support ICTs in identifying high-risk cohorts and unwarranted variation.
3. Develop population segmentation dashboards incorporating deprivation, ethnicity, age, and clinical risk factors at ICT level by April 2027.

## Priority 3: Strengthen Prevention Pathways and Clinical Follow-Up

Improve consistency in clinical management and follow-up of individuals identified at increased cardiovascular risk.

1. Increase the proportion of individuals with QRISK ≥10% who have a recorded statin decision by March 2030.

2. Increase hypertension treatment-to-target rates to meet the 65% local ambition by March 2030.
3. Improve CKD coding accuracy and detection through targeted training and audit processes implemented across practices by March 2028.

## Priority 4: Expand Community and Neighbourhood-Based Delivery

Strengthen delivery of prevention activity across neighbourhood settings, collaborating with community, voluntary and pharmacy partners.

1. Increase utilisation of community pharmacy hypertension case-finding services across eligible pharmacies by April 2027.
2. Expand neighbourhood-based delivery of prevention interventions through community and voluntary sector settings by March 2029, with a focus on underserved populations.
3. Raise awareness of and streamline referral pathways from NHS Health Checks (and other clinical interventions) into behavioural support services, including physical activity and weight management programmes.

## Priority 5: Strengthen Workforce Capability and Behaviour Change Support

Strengthen workforce capability to support consistent delivery of prevention and behaviour change interventions across neighbourhood settings.

1. Increase participation in NHS Health Check refresher training every 1–2 years by April 2028.

2. Continue to deliver Making Every Contact Count (MECC) training across health, community, and voluntary sector staff by March 2029.
3. Develop standardised communication materials to support consistent engagement with patients and communities.

## Priority 6: Reduce Inequalities Through Targeted Prevention

Reducing health inequalities will be achieved through targeted identification and support of high-risk populations and neighbourhoods using population health intelligence.

1. Define priority population cohorts based on clinical risk, deprivation, and population health data. Example:
   - Serious Mental Illness,
   - Learning Disability,
   - BMI 30+,
   - Ethnic Minority,
   - Smoking,
   - IMD 1,
   - Aged 50+,
   - Not had an NHS Health Check in the last 10 years.
2. Identify high-risk neighbourhoods and populations using NHS Health Check and CVDPREVENT data, supported by ICT-level population segmentation.
3. Prioritise clinical optimisation within high-risk populations and neighbourhoods identified through population health intelligence.
4. Align resources and targeted interventions to neighbourhoods and populations experiencing the greatest burden of cardiovascular risk.

# Timeline

The East Sussex CVD Prevention Action Plan will be delivered over a four-year period from 2026 to 2030, using a phased approach to support implementation, evaluation, and continuous improvement. Delivery will align with national priorities, including the transition toward prevention-focused healthcare outlined in *Fit for the Future: The 10-Year Health Plan for England (2025)*.

The phased approach below recognises that strengthening cardiovascular prevention requires initial investment in system infrastructure, followed by implementation and long-term optimisation. The approach has been developed within the context of ongoing financial pressures, workforce constraints and organisational change across system partners, and therefore prioritises sustainable and deliverable actions.

## Phase 1: Foundations (2026-2027)

**Focus:** Establish governance, intelligence and delivery infrastructure required to support coordinated cardiovascular disease prevention across East Sussex, working collaboratively with ICTs and system partners.

**Key outputs include:**

- Establish a strengthened governance framework for CVD prevention, including clearly defined roles, reporting arrangements, and system oversight through the CVD Prevention Group.

- Complete a comprehensive mapping of CVD prevention services and pathways, identifying duplication, gaps, and opportunities for alignment across primary care, secondary care, community services, local authority programmes, and voluntary sector provision, supporting alignment with emerging ICT delivery structures.

- Strengthen consistency and interoperability of data recording and reporting processes across NHS Health Check delivery models and primary care systems, enabling consistent monitoring of clinical and behavioural risk factors.

- Raise awareness and improve understanding of referral pathways among providers, ensuring consistent use of existing behavioural and clinical referral processes in line with NHS Health Check and national guidance.

- Strengthen links between primary, community and secondary care services, including cardiac rehabilitation and secondary prevention programmes, to support behavioural risk factor management following cardiovascular events.

- Undertake a workforce capability and training needs assessment, establishing a baseline understanding of workforce capacity, skills, and development requirements across the system.

## Phase 2: Implementation (2027/29)

**Focus:** Scale and operationalise cardiovascular disease prevention activity across neighbourhoods, supporting delivery through ICTs, improving clinical optimisation, strengthening referral pathways, and expanding delivery into community settings.

**Key activities include:**

- Support ICTs and system partners to deliver measurable improvements in clinical optimisation, including increased treatment-to-target performance for hypertension and cholesterol.

- Support expansion of prevention activity across neighbourhood settings, including NHS Health Checks, blood pressure case-finding, atrial fibrillation detection, lipid management, and behavioural support interventions delivered through primary care, community pharmacy, and voluntary sector partners.

- Strengthen consistent recording of statin decision-making across delivery models, ensuring individuals identified as eligible for treatment have clear and documented clinical decisions recorded within primary care systems.

- Support improved integration of behavioural support pathways across neighbourhood delivery partners, ensuring individuals identified with behavioural risk factors are consistently referred into smoking cessation, alcohol support, physical activity, and weight management services.

- Deliver structured workforce development programmes across partner organisations, improving practitioner confidence and capability in behaviour change conversations, clinical follow-up processes, and referral management.

- Support targeted engagement approaches across neighbourhoods, focusing on underserved populations identified through population health intelligence.

## Phase 3: Optimisation and Sustainability (2029/30

**Focus:** Embed cardiovascular disease prevention into routine neighbourhood practice, supported through ICTs, reducing inequalities in outcomes and sustaining improvements in clinical optimisation and population health.

**Key activities include:**

- Support sustained improvement in clinical optimisation across neighbourhood populations, meeting local ambitions for hypertension and cholesterol treatment-to-target and maintaining high performance in atrial fibrillation anticoagulation and statin decision-making.

- Demonstrate measurable reduction in inequalities in cardiovascular risk and outcomes across neighbourhood populations, supported by targeted prevention activity focused on high-risk and underserved groups identified through population health intelligence.

- Support embedding of population health management approaches within neighbourhood delivery, using risk stratification and population-level data (including NHS Health Check and CVDPREVENT datasets) to identify individuals at increased cardiovascular risk and inform targeted intervention.

- Support prevention becoming routine practice across neighbourhood delivery models, enabling coordinated behavioural and clinical interventions across primary care, community pharmacy, voluntary sector organisations, and community services.

- Strengthen neighbourhood-level insight by supporting ICTs to monitor performance data, identify unwarranted variation and inform local improvement activity.

- Implement continuous programme evaluation and service improvement using performance monitoring and outcome data to refine delivery models and support long-term sustainability.

# Reporting

Responsibility for coordinating delivery of the East Sussex CVD Prevention Action Plan will sit with the East Sussex CVD Prevention Group, which will be chaired by Public Health. The group will provide a multi-agency forum to support coordination across system partners, maximise alignment between initiatives and strengthen pathways related to the identification and management of cardiovascular risk factors.

Recognising that delivery of cardiovascular disease prevention requires shared ownership across the system, the group will work collaboratively with NHS, primary care, community pharmacy, voluntary sector, and Integrated Care Team (ICT) partners to support delivery of prevention activity at neighbourhood level.

Public Health will continue to lead coordination of the CVD Prevention Group, with governance arrangements reviewed periodically to ensure leadership structures remain appropriate and aligned with wider system responsibilities. Opportunities for shared or coleadership arrangements with partner organisations will be explored as neighbourhood delivery models continue to develop.

The CVD Prevention Group will bring together partners across GP practices, secondary care, community pharmacy, local authority services, voluntary and community sector organisations, and relevant system partners. The group will support delivery across the prevention pathway, including NHS Health Checks, clinical risk management, and behavioural support services.

Progress against the CVD Prevention Action Plan will be reviewed regularly and will also align with Surrey and Sussex Integrated Care Board (ICB) requirements where appropriate and will support collaborative working with emerging Integrated Care Team (ICT) structures as these develop.

Given the evolving nature of ICT arrangements, reporting relationships will remain flexible to ensure alignment with emerging neighbourhood-based models of care and system priorities.

## Monitoring and Performance

Delivery of the CVD Prevention Action Plan will be monitored through a structured performance framework to ensure progress against agreed priorities and to support continuous improvement.

| Domain | Indicator | Data Source | Reporting Frequency |
|---|---|---|---|
| NHS Health Checks | Uptake (%) | NHS Health Check dataset | Quarterly |
| Hypertension | Treatment-to-target (%) | CVD PREVENT | Quarterly |
| Lipids | Lipid optimisation (%) | CVD PREVENT | Quarterly |

| Domain | Indicator | Data Source | Reporting Frequency |
| --- | --- | --- | --- |
| AF | Anticoagulation (%) | GP records | Quarterly |
| Behavioural Support referral from an NHS Health Check | Referral (%) | OYES | Quarterly |
| Workforce | Staff trained (%) | Training records | Annual |

## Risk and Mitigation

| Risk | Potential Impact | Mitigation |
| --- | --- | --- |
| Changes to (and mobilisation of new) ICB structures | Disruption to reporting lines | Maintain flexible governance arrangements |
| Workforce capacity constraints | Delayed implementation | Prioritise phased training delivery |
| Data quality limitations | Inaccurate reporting | Standardise data recording processes |
| Financial pressures | Reduced delivery capacity | Align actions with national programmes |

## Health Inequalities

Reducing inequalities in cardiovascular disease outcomes remains a central focus of this action plan. Activity will prioritise populations experiencing the greatest burden of cardiovascular risk, including individuals living in areas of deprivation, working-age adults, and underserved ethnic groups. Delivery will align with national Core20PLUS5 priorities and local population health intelligence.

## Review and Refresh of the Action Plan

This action plan will be reviewed annually to assess progress; update priorities where required and ensure continued alignment with national and local strategic direction. A full refresh of the plan will be undertaken prior to March 2030.

# East Sussex Cardiovascular Disease Action Plan 2026/30

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Priority 1 | Phase 1-3 | Establish and sustain governance arrangements for cardiovascular disease prevention across East Sussex | Formalise governance arrangements for the East Sussex CVD Prevention Group, including reporting routes aligned with NHS Sussex ICB governance structures, and regularly review arrangements to ensure continued alignment with system priorities and evolving integrated care models. | Public Health / ICB / ICT | Governance framework agreed and reviewed annually | Clear accountability and sustained system oversight | October 2026 onwards | Must remain adaptable to evolving ICT structures and wider system governance arrangements. |
| 2 | Priority 1 | Phase 1 | Improve coordination across partners delivering cardiovascular | Continue delivery of quarterly East Sussex CVD Prevention Group meetings, supported by structured reporting from delivery partners. | Public Health | ≥4 governance meetings held annually | Improved system coordination and shared oversight | April 2026 and ongoing | Builds on existing multi-agency governance arrangements |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | disease prevention | | | | | | and structured partner reporting. |
| 3 | Priority 1 | Phase 1 | Improve understanding of cardiovascular disease prevention delivery across the system | Conduct system-wide mapping of cardiovascular disease prevention services and pathways across primary care, secondary care, community services, VCSE and pharmacy partners. | Public Health / ICB / ICT | System-wide service and pathway mapping report completed | Identification of duplication, gaps, and opportunities for alignment | December 2026 | Provides baseline understanding of current delivery landscape and identifies opportunities for alignment. |
| 4 | Priority 1 | Phase 2 | Strengthen integration of prevention pathways within emerging Integrated Care Team (ICT) | Develop and maintain a standardised cardiovascular prevention pathway directory and align monitoring processes with ICT reporting arrangements to support | Public Health / ICB / ICT | Pathway directory available and monitoring aligned with | Improved pathway clarity and neighbourhood-level coordination | March 2028 | Supports development of consistent referral pathways and integration with emerging |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | delivery structures | coordinated delivery and performance oversight. | | ICT structures | | | ICT reporting structures. |
| 5 | Priority 1 | Phase 1 | Improve accessibility, uptake and equity of CVD risk identification and prevention | Review and evolve the NHS Health Check programme in line with emerging national policy and digital NHS Health Check developments | Public Health / Office for Health Improvement and Disparities | Local NHS Health Check delivery model reviewed and aligned with emerging national NHS Health Check Online guidance by 2027 | Increased and more equitable uptake of NHS Health Checks, leading to earlier identification and management of cardiovascula r risk | Ongoing, subject to national rollout and guidance | Align local delivery with emerging national NHS Health Check Online guidance and rollout timelines.<br><br>Ensure digital approaches complement rather than replace face-to-face provision to |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | avoid widening inequalities. |
| 6 | Priority 1 | Phase 2 | Improve continuity of cardiovascular care and behavioural risk factor management following cardiovascular events | Strengthen integrated pathways between primary, community and secondary care services, including cardiac rehabilitation and secondary prevention programmes | ICB / Public Health / ICT / ESHT | Improve referral, uptake and continuity of care for patients accessing cardiac rehabilitatio n and secondary prevention services. | Improved coordination of care, increased uptake of secondary prevention support, and reduced risk of recurrent cardiovascula r events | April 2028 | Support improved continuity of care and equitable access to cardiac rehabilitation and secondary prevention services. |
| 7 | Priority 2 | Phase 1 | Improve quality and reliability of cardiovascular risk factor data | Review and maintain standardised NHS Health Check recording and extraction processes and optimise data | Public Health / GP Practices / | Consistent data recording and | Reliable and consistent behavioural | April 2027 | Includes ongoing review of recording and data |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | across delivery systems | transfer between delivery systems, ensuring consistent and accurate recording of behavioural and clinical risk factor data across primary care and community delivery models. | One You East Sussex | extraction processes | and clinical data | | transfer processes across NHS Health Check delivery models. |
| 8 | Priority 2 | Phase 1-2 | Strengthen performance monitoring and reporting across cardiovascular prevention activity | Implement routine reporting processes to monitor NHS Health Check delivery, referral outcomes, and behavioural engagement across delivery models with OYES. | Public Health/One You East Sussex | Routine reporting established and maintained | Improved performance oversight and programme monitoring | March 2028 | Supports routine reporting of delivery activity and behavioural referral outcomes. |
| 9 | Priority 2 | Phase 1-2 | Strengthen population health intelligence to support targeted | Review and enhance population health dashboards to support segmentation by deprivation, ethnicity, age, and clinical risk | Public Health Intelligence | Enhanced dashboards available to support | Improved targeting of prevention activity and | December 2027 | Builds on existing dashboards and |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | prevention activity | factors, applying national segmentation tools alongside local population insight to identify high-risk populations at PCN and ICT level. | | targeted prevention planning | reduction in inequalities | | incorporates national segmentation tools and local insight. |
| 10 | Priority | Phase 3 | Sustain evaluation and continuous improvement of cardiovascular prevention programmes | Use CVDPREVENT and local intelligence to monitor variation and conduct routine evaluation of programme effectiveness, supporting ongoing prioritisation of improvement activity across practices and populations. | ICB / Public Health Intelligence / Clinical Leads | Priority practices identified annually and evaluation completed | Continuous improvement in clinical optimisation and prevention delivery | March 2030 | Enables continuous monitoring of variation and supports targeted improvement activity. |
| 11 | Priority 3 | Phase 2-3 | Improve hypertension detection and treatment-to- | Implement targeted hypertension improvement programmes across priority practices and sustain treatment-to-target | ICB / GP / Pharmacy | Sustained improvement in hypertension treatment- | Improved blood pressure control | March 2030 | Aligns with national hypertension ambitions and pharmacy-led |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | target performance | performance through ongoing monitoring and support. | | to-target performance | across population | | case-finding initiatives. |
| 12 | Priority 3 | Phase 2-3 | Improve lipid management and statin prescribing consistency | Strengthen lipid optimisation processes through improved statin decision-making, monitoring of prescribing variation and targeted improvement support where required. | ICB / GP Practices / Pharmacy | Increased proportion of eligible patients with recorded statin decision | Improved cholesterol management and reduced cardiovascular risk | March 2030 | Supports improved statin decision-making and reduction in treatment variation across practices. |
| 13 | Priority 3 | Phase 2 | Improve follow-up processes and coding accuracy for cardiovascular risk factors | Establish consistent follow-up processes and strengthen coding accuracy for conditions such as CKD to support effective management of high-risk individuals. | Public Health / ICB / GP Practices / Pharmacy | Standardised follow-up processes implemented | Improved identification and management of high-risk individuals | March 2028 | Includes strengthening identification and coding of high-risk |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | conditions such as CKD. |
| 14 | Priority | Phase 2-3 | Strengthen identification of cardiovascular risk and sustain long-term risk reduction | Increase uptake of community and pharmacy-led detection opportunities and maintain strong performance in anticoagulation, tobacco dependency, and population risk reduction initiatives. | Pharmacy / ICB / Public Health / Secondary Care / One You East Sussex / ICT / GP Practices | Increased detection of undiagnosed risk factors and sustained performance in priority clinical indicators | Reduced cardiovascular events and emergency admissions | March 2030 | Includes community detection initiatives, anticoagulation performance, and tobacco-related prevention pathways. |
| 15 | Priority 4 | Phase 1-3 | Expand access to NHS Health Checks across community and | Identify and implement opportunities to expand NHS Health Check delivery across community venues, workplaces, and outreach settings, and | Public Health / One You East Sussex | Increased number of community and workplace | Increased accessibility and uptake of NHS | March 2030 | Builds on existing community delivery models and |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | workplace settings | sustain delivery across established community sites. | | delivery locations | Health Checks | | workplace-based pilots. |
| 16 | Priority 4 | Phase 1-2 | Strengthen targeted engagement and communications to increase uptake among underserved populations | Deliver targeted engagement and communication approaches informed by population segmentation, behavioural insight, and local communication campaigns to improve awareness and uptake of NHS Health Checks. | Public Health | Targeted campaigns delivered in priority populations | Increased uptake among underserved groups | March 2028 | Informed by population segmentation, behavioural insight, and local communicatio ns approaches. |
| 17 | Priority 4 | Phase 1-2 | Improve referral into behaviour change and prevention services to maximise opportunity for direct referral. | Review and strengthen referral processes and develop accessible pathway guidance to support confident referral into behavioural support services across multiple providers. | Public Health / One You East Sussex / ICT | Referral pathways clarified and materials distributed across providers | Increased referral into prevention and behaviour change services | March 2028 | Supports consistent referral into behavioural support services across multiple providers. |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| 18 | Priority 4 | Phase 2-3 | Strengthen VCSE and place-based delivery of cardiovascular prevention | Work with VCSE organisations, pharmacy, and community partners to deliver place-based cardiovascular prevention activity, including targeted outreach through community venues and rural settings such as those identified through ICT priorities. | Public Health / One You East Sussex / VCSE / ICT | Priority community partners engaged and delivering prevention activity | Improved reach of prevention messaging and community engagement | March 2030 | Includes collaboration with ICT partners and use of community venues and networks. |
| 19 | Priority | Phase 2-3 | Sustain neighbourhood-level prevention delivery across ICT populations | Strengthen collaboration with primary care and community partners to maintain consistent delivery of prevention interventions and support engagement across neighbourhood populations. | Public Health / ICB / ICT | Prevention activity delivered across ICT areas | Sustained neighbourhood-level prevention delivery | March 2030 | Supports sustained delivery of prevention activity across neighbourhood populations. |
| 20 | Priority 5 | Phase 1 | Establish a clear understanding of | Conduct system-wide mapping of workforce capability and | Public Health / ICB / ICT | Workforce capability | Workforce development | March 2027 | Provides baseline |

| | Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|---|
| | | | workforce capability and training needs across cardiovascular prevention delivery | existing training provision, identifying priority roles and gaps to inform workforce development planning. | | and training needs assessment completed | priorities identified | | understanding of workforce capacity and development needs. |
| 21 | Priority 5 | Phase 2 | Improve workforce confidence in delivering behaviour change conversations | Deliver structured behaviour change training programmes, including Making Every Contact Count (MECC), across priority workforce groups delivering prevention messaging. | Public Health / ESHT / ICB / One You East Sussex / ICT / Pharmacy/ GP practices | ≥85% of priority staff trained | Increased workforce confidence in behaviour change conversations | March 2028 | Supports consistent behaviour change conversations across health and community settings. |
| 22 | Priority 5 | Phase 2-3 | Strengthen VCSE workforce capability to | Provide targeted support and training opportunities to strengthen VCSE workforce | Public Health / VCSE Partners | VCSE workforce support | Increased VCSE contribution | March 2030 | Strengthens community-based |

| Priority | Phase | Aim of Action | Key Action | Organisational Lead | Target | Desired Outcome | Timescale | Notes |
|---|---|---|---|---|---|---|---|---|
| | | support community prevention delivery | capability in delivering cardiovascular prevention messaging and referral into services. | | programme delivered | to prevention delivery | | prevention capability through targeted support. |

# CVD non-modifiable risk factors

## Age

Age is one of the strongest predictors of CVD risk. The likelihood of developing cardiovascular disease increases significantly with age due to the cumulative effects of vascular ageing, prolonged exposure to risk factors, and the development of chronic conditions such as hypertension, diabetes, and dyslipidaemia (National Institute For Health and Care Excellence, 2023; North & Sinclair, 2012). Cardiovascular risk assessment tools used in England, including QRISK3, incorporate age as a key determinant of an individual's estimated 10-year risk of developing cardiovascular disease (Cox, Coupland, & Brindle, 2017).

Older adults experience a higher prevalence of clinical risk factors associated with cardiovascular disease, including raised blood pressure, atrial fibrillation, and type 2 diabetes. As the population ages, the number of individuals living with cardiovascular disease and associated long-term conditions is expected to increase, placing additional demand on health and care services (Public Health England, 2019). Supporting healthy ageing and early identification of cardiovascular risk in middle age remain essential components of effective prevention strategies.

Population ageing presents a significant challenge for health systems nationally and locally. The national *Fit for the Future: 10-Year Health Plan for England* highlights the importance of prevention and early intervention across the life course to support healthier ageing and reduce avoidable long-term illness (Department of Health and Social Care, 2025). Targeted prevention approaches that identify risk earlier in life can help reduce the long-term burden of cardiovascular disease and improve population health outcomes.

## Sex

Sex is an important determinant of CVD risk, with differences observed in both the development and presentation of cardiovascular conditions. Males are generally at higher risk of developing cardiovascular disease at a younger age compared to females, although the risk for females increases significantly after menopause (Betai, et al., 2024). Differences in biological factors, including hormonal influences and vascular physiology, contribute to variation in cardiovascular risk between males and females.

In 2024 cardiovascular disease was reported as a leading cause of death in women nationally (Tayal, et al., Advancing the access to cardiovascular diagnosis and treatment among women with cardiovascular disease: a joint British Cardiovascular Societies' Consensus Document, 2024). There is increasing recognition that symptoms of cardiovascular disease may present differently in females, which can contribute to delayed diagnosis and treatment. Understanding sex differences in cardiovascular risk supports improved prevention, earlier detection, and more effective management across the population.

## Family history of cardiovascular disease

A family history of cardiovascular disease is an important non-modifiable risk factor and reflects both genetic predisposition and shared environmental influences. Individuals with a first-degree relative who experienced premature cardiovascular disease are at increased risk of developing cardiovascular conditions themselves (Chacko, Sarma, Harikrishnan , Zachariah, & Jeemon, 2020). Family history is included as a variable within cardiovascular risk assessment tools, including QRISK3, to support more accurate estimation of an individual's future cardiovascular risk (Dijkstra, et al., 2023).

Recognising the role of family history in cardiovascular risk supports earlier identification of individuals who may benefit from preventative interventions. This includes earlier cardiovascular risk assessment, lifestyle interventions and, where appropriate, pharmacological treatment to reduce long-term cardiovascular risk.

## Ethnicity

Ethnicity is recognised as an important determinant, with variations in the prevalence of cardiovascular conditions observed across different ethnic groups. Certain communities, including South Asian and Black ethnic groups, experience disproportionately higher risk of CVD and diabetes and may face inequalities in outcomes and access (Razieh, et al., 2022; Raleigh, Jefferies, & Wellings, Cardiovascular Disease in England: Supporting Leaders to Take Action, 2022).

Cardiovascular risk assessment tools used in England, including QRISK3, incorporate ethnicity as a variable to improve the accuracy of cardiovascular risk prediction across diverse populations (Cox, Coupland, & Brindle, 2017). Understanding differences in cardiovascular risk by ethnicity supports the development of targeted prevention strategies and helps ensure equitable access to services.

# CVD clinical risk factors

### Hypertension

Hypertension, or high blood pressure, is one of the most significant modifiable clinical risk factors for CVD and is strongly associated with increased risk of stroke, heart attack, heart failure, and kidney disease.

Hypertension is a key priority within the NHS Cardiovascular Disease Prevention Programme, forming part of the national ABC approach (Public Health England, 2019). Increasing the identification of individuals with undiagnosed hypertension and improving the management of those with diagnosed hypertension are essential to reducing preventable cardiovascular events and improving long-term outcomes (Pathak, Poulter , Kavanagh , Kreutz, & Burnier , 2021).

National clinical guidance recommends routine measurement of blood pressure and early identification of individuals with raised blood pressure to support timely treatment and management (NICE, 2023). Risk assessment tools such as QRISK3 support clinicians in identifying individuals at increased cardiovascular risk and determining the need for intervention, including lifestyle support and pharmacological treatment.

Hypertension prevalence is more common among individuals living in more deprived communities, contributing to inequalities in cardiovascular outcomes. Individuals living in deprived areas are often more likely to experience risk factors associated with hypertension, including smoking, obesity, and physical inactivity, while also being less likely to have hypertension detected and managed effectively (British Heart Foundation, 2025). Addressing inequalities in the detection and management of hypertension is therefore essential to improving cardiovascular outcomes across the population.

Local data demonstrates that hypertension remains a significant clinical risk factor within East Sussex, with variation observed across population groups and geographical areas (Gollins-Perronne & Müller, 2025). Understanding patterns of diagnosis, treatment and control of hypertension supports targeted action to improve early detection and optimise management within primary care and community settings.

## Cholesterol and Lipid Disorders

Raised cholesterol and abnormal lipid levels are significant contributors to CVD, increasing the risk of atherosclerosis, coronary heart disease, and stroke. Elevated levels of low-density lipoprotein cholesterol (LDL-C) contribute to the build-up of fatty deposits within blood vessels, narrowing arteries and increasing the likelihood of cardiovascular events. Effective identification and management of raised cholesterol is therefore a key component of cardiovascular disease prevention (NICE, 2023).

Cholesterol management forms part of the national NHS Cardiovascular Disease Prevention Programme, specifically within the ABC approach (NHS England, 2023). Increasing the proportion of individuals receiving appropriate lipid-lowering therapy, particularly those identified as being at increased cardiovascular risk, is a major national priority to reduce preventable cardiovascular events.

Individuals identified as having a raised 10-year cardiovascular risk are typically offered statin therapy alongside lifestyle interventions, including dietary improvement, physical activity, and weight management, to reduce long-term cardiovascular risk.

The prevalence of raised cholesterol increases with age and is influenced by behavioural risk factors such as poor diet, physical inactivity, obesity, and diabetes (Cho, Lee, Shim, Song , & Kim , 2020). Inequalities in cholesterol management exist across populations, with individuals living in more deprived areas often experiencing higher levels of cardiovascular risk and lower rates of optimal treatment (NIHR, 2024).

Local data indicates that cholesterol management remains an important priority within East Sussex (Gollins-Perronne & Müller, 2025), particularly in relation to the proportion of individuals identified as being at increased cardiovascular risk who are receiving appropriate lipid-lowering therapy.

## Diabetes Mellitus (HbA1c)

Diabetes mellitus is a significant clinical risk factor for CVD, particularly type 2 diabetes, which is strongly associated with increased risk of coronary heart disease, stroke, and peripheral vascular disease (Siam , Snigdha , Tabasumma , & Parvin, 2024). Individuals living with diabetes are at substantially higher risk of developing cardiovascular complications compared to those without diabetes, largely due to the effects of elevated blood glucose levels on blood vessels and metabolic processes.

Glycaemic control, commonly measured using glycated haemoglobin (HbA1c), is an important indicator of diabetes management and is associated with long-term cardiovascular risk. Poor glycaemic control is linked to increased vascular damage, inflammation, and a higher likelihood of cardiovascular events (Gilani, et al., 2024). Diabetes prevalence is closely associated with other cardiovascular risk factors, including obesity, physical inactivity, and poor diet. Addressing diabetes as part of an integrated cardiovascular prevention strategy supports earlier intervention and reduces the risk of future cardiovascular complications.

## Atrial Fibrillation

Atrial fibrillation (AF) is a common cardiac arrhythmia and a significant clinical risk factor for cardiovascular disease, particularly stroke. AF causes an irregular and often rapid heart rhythm, which can lead to the formation of blood clots in the heart that may travel to the brain and cause stroke (Elsheikh, Hill, Irving, & Lip, 2024). Individuals with atrial fibrillation are at substantially increased risk of stroke compared to those without the condition, making early detection and appropriate management of AF essential components of cardiovascular disease prevention.

Local data indicates that AF remains an important contributor to cardiovascular risk within East Sussex, particularly in relation to early detection and the appropriate use of anticoagulation therapy. Understanding variation in diagnosis and treatment across the population supports targeted action to improve stroke prevention and reduce avoidable cardiovascular events (Gollins-Perronne & Müller, 2025).

# CVD Prevention Performance Across Sussex Places

## CVD Prevent

East Sussex performs strongly on AF anticoagulation, exceeding both national ambition and the national average, but remains below ambition for hypertension and lipid management indicators. Inequality gradients and practice-level variation may contribute to differences in performance across indicators; however, East Sussex practices demonstrate the narrowest variation and fewer extreme low-performing outliers than Brighton & Hove or West Sussex.

## Hypertension

Performance across CVD prevention indicators in East Sussex shows a mixed picture, with some improvement evident over the reporting period, although rankings remain relatively low compared with other areas nationally.

*Figure 2: Hypertension to target*

| Indicator | Area | Mar 2025 % | Ranking | Jun 2025 % | Ranking | Sept 2025 % | Ranking | National Performance % | Target 24/25 (%) |
|---|---|---|---|---|---|---|---|---|---|
| **CVDP007HYP** Hypertension: treatment to recommended age specific thresholds (all ages) | Brighton & Hove | 66.53 | 101/106 | 64.24 | 104/106 | 64.06 | 104/106 | 68.66 | 80 |
| | **East Sussex** | **67.64** | **97/106** | **66.1** | **90/106** | **66.49** | **95/106** | | |
| | West Sussex | 70.7 | 46/106 | 68.56 | 52/106 | 68.9 | 53/106 | | |
| | **Sussex** | **69.15** | **27/42** | **67.2** | **28/42** | **67.5** | **27/42** | | |
| **CVDP003CHOL** Cholesterol: QRISK 20% or more (high risk of CVD) treated with LLT | Brighton & Hove | 58.69 | 98/106 | 61.28 | 84/106 | 64.01 | 51/106 | 63.95 | 65 |
| | **East Sussex** | **58.11** | **102/106** | **59.54** | **95/106** | **62.1** | **77/106** | | |
| | West Sussex | 61.38 | 80/106 | 63.08 | 58/106 | 64.82 | 39/106 | | |
| | **Sussex** | **59.9** | **36/42** | **61.65** | **27/42** | **63.79** | **19/42** | | |
| **CVDP012CHOL** Cholesterol: CVD treated to cholesterol threshold | Brighton & Hove | 43.95 | 92/106 | 43.23 | 94/106 | 44.23 | 94/106 | 48.93 | N/A |
| | **East Sussex** | **45.8** | **79/106** | **45.41** | **75/106** | **45.87** | **83/106** | | |
| | West Sussex | 41.58 | 100106 | 41.02 | 101/106 | 42 | 101/106 | | |
| | **Sussex** | **43.34** | **36/42** | **42.83** | **36/42** | **43.63** | **38/42** | | |
| **CVDP002AF** AF: treatment with anticoagulants for those at high risk of stroke | Brighton & Hove | 89.64 | 104/106 | 90.41 | 97/106 | 90.14 | 97/106 | 91.72 | 90 |
| | **East Sussex** | **91.26** | **81/106** | **91.73** | **61/106** | **91.85** | **56/106** | | |
| | West Sussex | 90.94 | 92/106 | 90.94 | 88/106 | 90.81 | 91/106 | | |
| | **Sussex** | **90.94** | **35/42** | **91.19** | **31/42** | **91.14** | **29/42** | | |

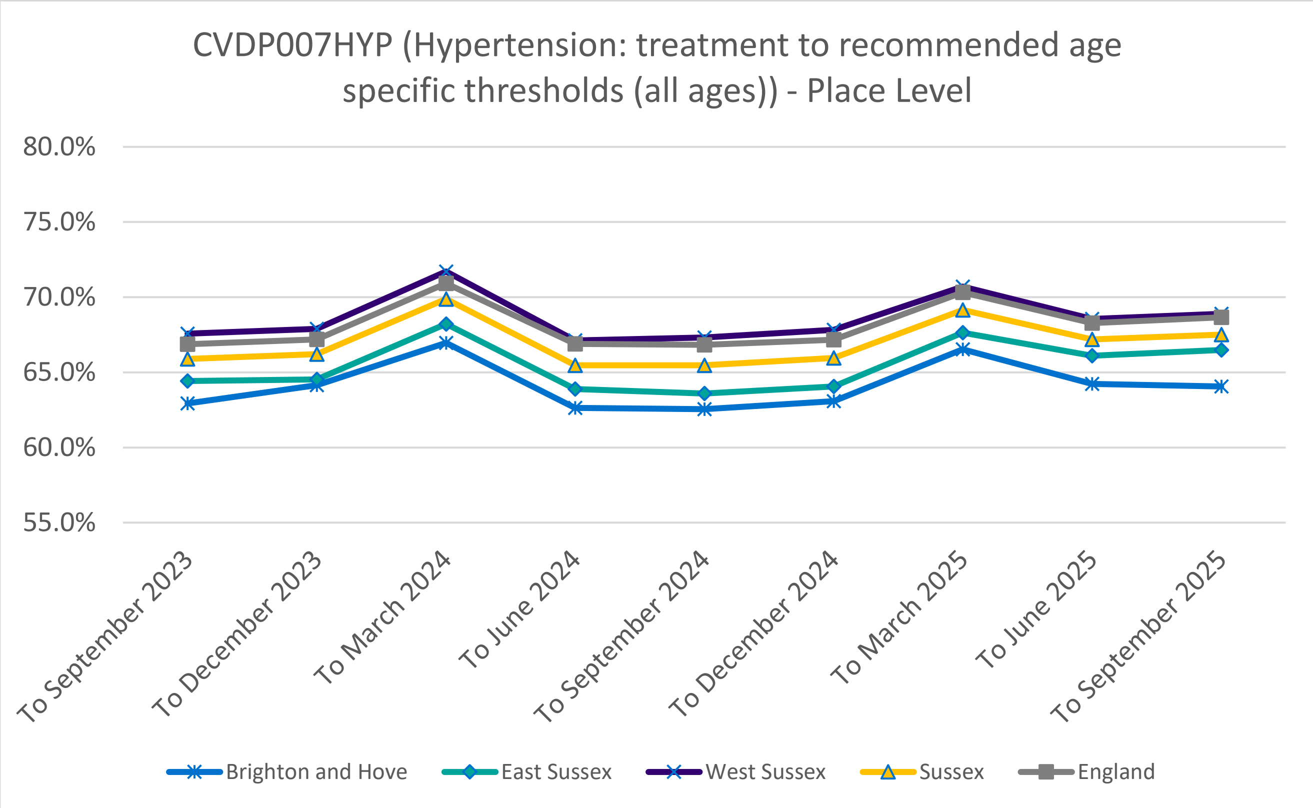
Hypertension management has shown gradual improvement, with the proportion of patients treated increasing from 67.6% in March 2025 to 68.5% in September 2025. However, East Sussex continues to rank in the lower quartile nationally (95/106), indicating that progress remains slower than required.

Detection and management of high cardiovascular risk also show signs of improvement. The proportion of individuals with a CVD risk score of 20% or more treated with statins increased from 58.1% to 62.1%, with a notable improvement in ranking from 102/106 to 77/106. Similarly, treatment rates for patients with established CVD improved marginally over the period.

Performance is strongest in stroke prevention, where anticoagulant treatment for patients with atrial fibrillation at high risk of stroke remains above the national average and above the target threshold, improving from 91.3% to 91.9%. Rankings also improved substantially from 81/106 to 56/106.

Overall, the data suggest incremental improvement across several indicators; however, East Sussex continues to perform below national comparators in key areas of CVD prevention.

*Figure 3: Hypertension - treatment to recommended age specific thresholds (all ages)) - Place Level*




Hypertension control in East Sussex continues to show gradual improvement and broadly follows the Sussex average over time; however, performance remains below comparator areas and national ambition. A recurring pattern is evident, with performance peaking in Quarter 4 before falling in subsequent quarters. This pattern is commonly observed across primary care indicators and likely reflects increased activity ahead of year-end QOF reporting. While improvements are evident, the cyclical nature of performance suggests progress may be driven partly by reporting and operational pressures rather than sustained year-round improvement, highlighting the need for a more consistent approach to hypertension identification and management across the year.

## East Sussex population groups experiencing worse Hypertension outcomes

Variation in hypertension outcomes across East Sussex indicates inequalities across demographic and population groups. Lower performance is observed among males compared with females, and there is a clear deprivation gradient, with outcomes generally poorer among individuals living in more deprived areas.

*Figure 4: East Sussex population groups experiencing worse hypertension outcomes*

| Inequality Breakdown | 09D - Brighton and Hove | 70F - West Sussex | 97R - East Sussex |
|---|---|---|---|
| Sex: Persons | 64.1% | 68.9% | 66.5% |
| Sex: Male | 62.3% | 67.4% | 65.2% |
| Sex: Female | 65.9% | 70.4% | 67.8% |
| National deprivation quintile: 5 - least deprived | 65% | 71% | 68.8% |
| National deprivation quintile: 4 | 66% | 68.9% | 67.7% |
| National deprivation quintile: 3 | 63.6% | 68.9% | 66.8% |
| National deprivation quintile: 2 | 60.9% | 65.9% | 64.8% |
| National deprivation quintile: 1 - most deprived | 63.6% | 60.4% | 62.6% |
| Ethnicity: White | 65.3% | 69.7% | 67.3% |
| Ethnicity: Other | 56.9% | 59.3% | 59.5% |
| Ethnicity: Not stated | 60.1% | 65.2% | 61.6% |
| Ethnicity: Mixed | 56.9% | 61.9% | 58.9% |
| Ethnicity: Missing | 58.2% | 64.4% | 62.4% |
| Ethnicity: Black | 56.5% | 57.3% | 54.7% |
| Ethnicity: Asian | 61.7% | 64.7% | 62.5% |
| Age group: 80+ | 75.1% | 79.3% | 76.5% |
| Age group: 60-79 | 65.5% | 69.4% | 66.4% |
| Age group: 40-59 | 54% | 57.2% | 54.8% |
| Age group: 18-39 | 47.9% | 51% | 47.9% |

The colour shading is used to illustrate relative performance within the dataset and should be interpreted as indicative rather than absolute. Green represents comparatively better performance, amber intermediate performance, and red comparatively poorer performance against national benchmarks.

Working-age adults, particularly those aged 18–39 and 40–59 years, also demonstrate lower rates of achieving recommended treatment thresholds compared with older age groups.

Differences are also evident across ethnic groups, with lower performance observed among several minority ethnic populations compared with White populations, particularly among

Black groups. However, interpretation of ethnicity data should be undertaken with caution due to incomplete recording and the relatively small population sizes within some groups, which may affect reliability.

Overall, these findings suggest opportunities for more targeted approaches to hypertension identification, treatment optimisation, and engagement among underserved groups to support reductions in inequalities and improve outcomes.

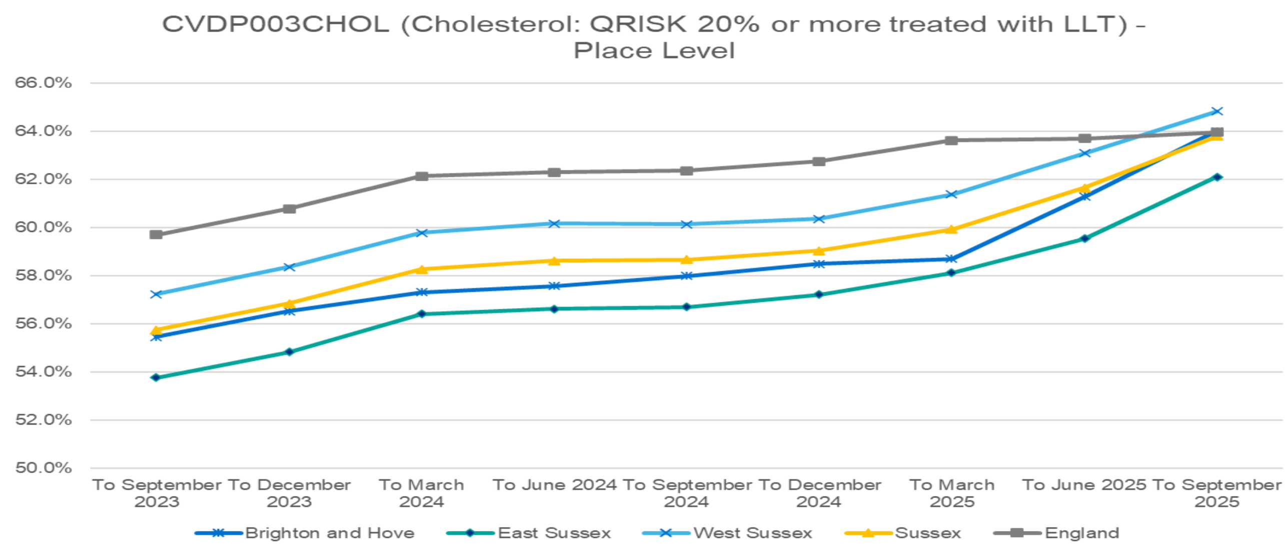
## Lipids

Raised cholesterol and abnormal lipid levels are significant contributors to CVD, increasing the risk of coronary heart disease and stroke. Effective identification and management of lipid levels is therefore a key component of cardiovascular disease prevention. Lipid management includes both primary prevention, which focuses on reducing cardiovascular risk in individuals without established cardiovascular disease, and secondary prevention, which focuses on reducing the risk of further cardiovascular events in individuals with existing disease. Improving lipid optimisation across these groups remains an important priority for reducing preventable cardiovascular events and improving long-term population health outcomes.

### *Primary Lipids*

While East Sussex initially performed below both the Sussex and national averages, the gap has narrowed over time, with more marked improvement observed during 2025. Despite this progress, performance remains slightly below comparator areas and there remains further opportunity to strengthen lipid optimisation among individuals with a QRISK score of 20% or more.

*Figure 5: Cholesterol - QRISK 20% or more treated with LLT - Place Level*




Patterns of primary prevention lipid optimisation in East Sussex demonstrate variation across population groups. Lower treatment rates are observed among females compared with males and among older adults aged 80 years and over. Younger adults aged 18–39 years also demonstrate lower levels of lipid-lowering therapy. Variation is also evident across deprivation groups, although patterns are less consistent than seen for hypertension outcomes. Interpretation of variation by ethnicity remains limited due to incomplete recording; however, lower treatment rates are observed among individuals with missing or unstated ethnicity. Improving recording completeness and targeting support towards underperforming population groups will be important to strengthen equity in lipid management.

Below, in Figure 6, variation in primary prevention lipid management across East Sussex demonstrates differences between population groups, although patterns are less consistent than those observed for hypertension outcomes. Lower treatment rates are observed among females compared with males, while adults aged 80 years and over show notably lower levels of lipid-lowering therapy compared with other age groups. Younger adults aged 18–39 years also appear to have lower treatment rates; however, interpretation should be undertaken with caution where population sizes are smaller.

*Figure 6: East Sussex population groups experiencing worse lipid management outcomes*

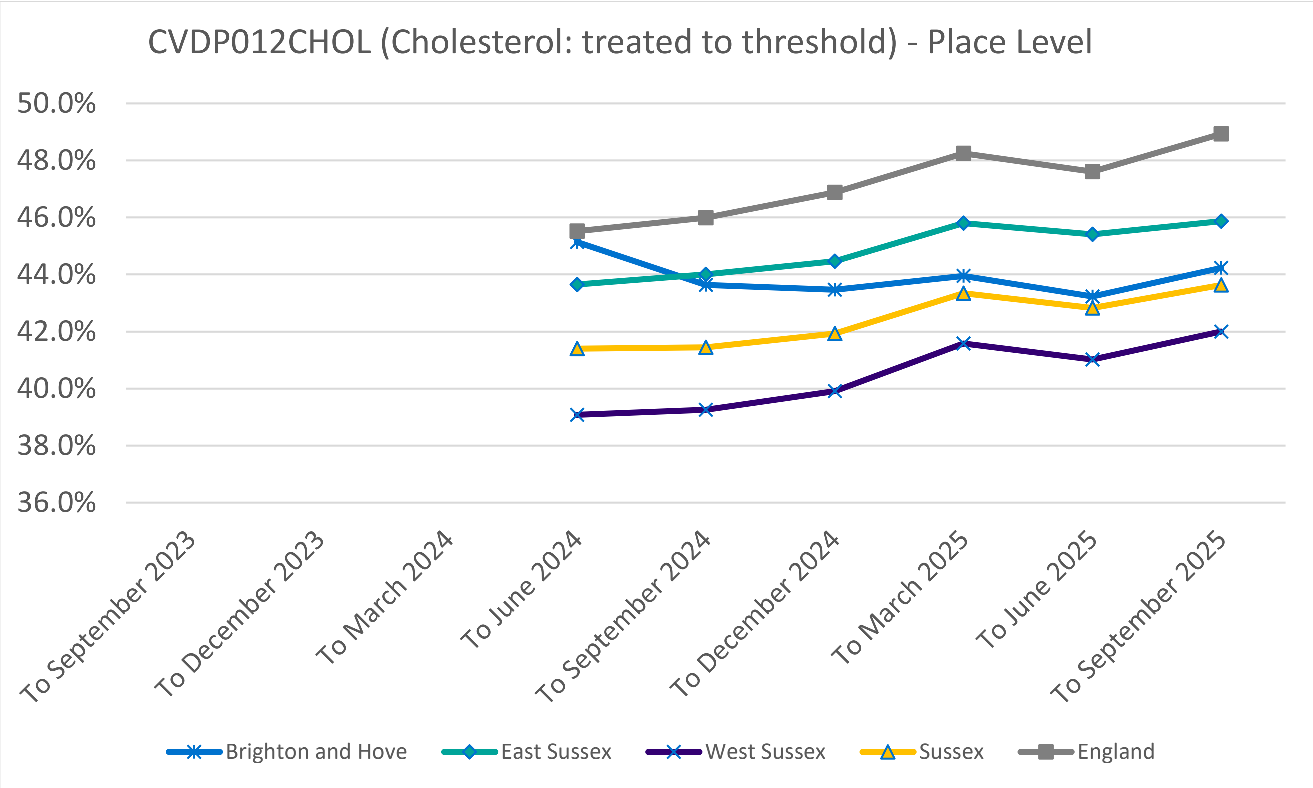
| Inequality Breakdown | 09D - Brighton and Hove | 70F - West Sussex | 97R - East Sussex |
|---|---|---|---|
| Sex: Persons | 64% | 64.8% | 62.1% |
| Sex: Male | 66.3% | 66.2% | 63.4% |
| Sex: Female | 60.5% | 63% | 60.2% |
| National deprivation quintile: 5 - least deprived | 58.4% | 63.2% | 60.5% |
| National deprivation quintile: 4 | 63% | 64.3% | 61.6% |
| National deprivation quintile: 3 | 63.5% | 66.1% | 62.4% |
| National deprivation quintile: 2 | 63.8% | 66.6% | 62.1% |
| National deprivation quintile: 1 - most deprived | 69.6% | 62.8% | 64.7% |
| Ethnicity: White | 64.1% | 65.1% | 62.4% |
| Ethnicity: Other | 65.5% | 63.5% | 68.4% |
| Ethnicity: Not stated | 60.9% | 58.8% | 58.2% |
| Ethnicity: Mixed | 71.4% | 72.9% | 70.5% |
| Ethnicity: Missing | 61% | 57.1% | 52.7% |
| Ethnicity: Black | 68% | 67.8% | 59.2% |
| Ethnicity: Asian | 67.1% | 71% | 70.9% |
| Age group: 80+ | 50.2% | 56.6% | 51.8% |
| Age group: 60-79 | 70.1% | 69.4% | 67.9% |
| Age group: 40-59 | 71.1% | 71.1% | 72.1% |
| Age group: 18-39 | % | 64.6% | 56.3% |

Variation is also evident across deprivation and ethnic groups, although a clear social gradient is not consistently observed. Lower treatment rates are seen among individuals with missing or unstated ethnicity recording, suggesting that data completeness may influence interpretation. Differences are also apparent across some ethnic groups; however, these findings should be interpreted cautiously due to potential limitations in recording quality and smaller population sizes.

### *Secondary Lipids*

Secondary prevention lipid management in East Sussex demonstrates a gradual and generally improving trajectory over recent reporting periods, reflecting progress in the proportion of individuals with established cardiovascular disease achieving recommended cholesterol thresholds. Performance in East Sussex compares favourably with other Sussex areas and remains above the Sussex average across the latest reporting period. However, despite these improvements, performance continues to remain below the England average and below the local ambition of achieving 50% treatment to target by 2025/26.

*Figure 7: Cholesterol treated to threshold - Place Level*




Although progress is evident, the pace of improvement suggests further opportunity to strengthen treatment optimisation among individuals with established cardiovascular disease. Continued focus on prescribing optimisation, medication adherence, routine monitoring, and review will be important to support further reductions in recurrent cardiovascular risk and improve achievement of treatment thresholds.

Below, in figure 8, patterns of secondary prevention lipid optimisation in East Sussex demonstrate variation across population groups. Lower treatment-to-target rates are observed among females compared with males, while adults aged 18–39 years demonstrate notably lower levels of achievement against recommended cholesterol thresholds. Lower rates are also observed among adults aged 40–59 years and among those aged 80 years and over compared with the 60–79-year age group.

*Figure 8: Population variation in secondary prevention lipid management*

| Inequality Breakdown | 09D - Brighton and Hove | 70F - West Sussex | 97R - East Sussex |
|---|---|---|---|
| Sex: Persons | 44.2% | 42% | 45.9% |
| Sex: Male | 47.8% | 47.1% | 50.6% |
| Sex: Female | 38.2% | 33.9% | 38.7% |
| National deprivation quintile: 5 - least deprived | 43.3% | 43.8% | 48% |
| National deprivation quintile: 4 | 44% | 42.3% | 46.4% |
| National deprivation quintile: 3 | 43.5% | 42.4% | 46.9% |
| National deprivation quintile: 2 | 43.5% | 39.1% | 43.7% |
| National deprivation quintile: 1 - most deprived | 45.4% | 36.1% | 42.6% |
| Ethnicity: White | 44.3% | 42% | 46.1% |
| Ethnicity: Other | 43% | 42.7% | 47.9% |
| Ethnicity: Not stated | 42.4% | 39.8% | 45.1% |
| Ethnicity: Mixed | 45.1% | 43.7% | 41% |
| Ethnicity: Missing | 42.6% | 40.1% | 40.3% |
| Ethnicity: Black | 40.4% | 37.1% | 42.5% |
| Ethnicity: Asian | 50.4% | 48.7% | 50.9% |
| Age group: 80+ | 41.6% | 40.3% | 43.9% |
| Age group: 60-79 | 47.8% | 44.9% | 49% |
| Age group: 40-59 | 38% | 35.4% | 38.7% |
| Age group: 18-39 | 27.7% | 21.5% | 20.7% |

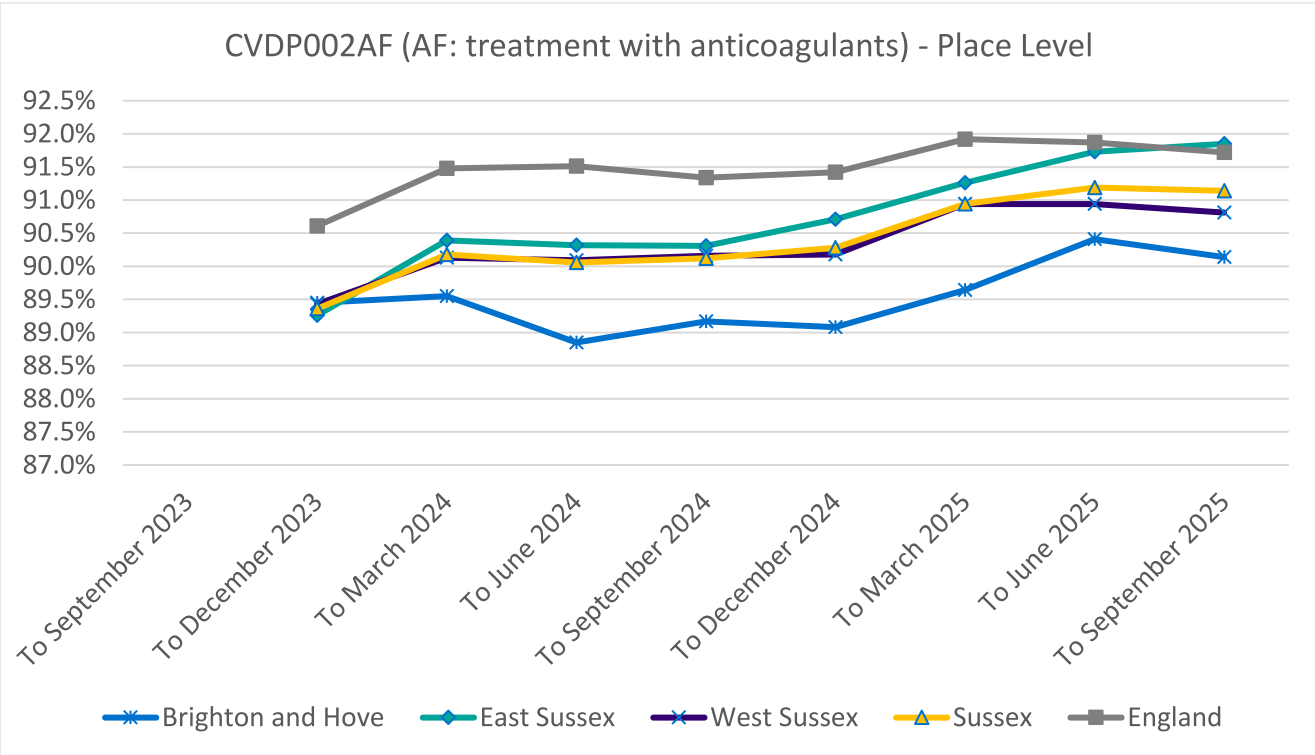
Variation is also evident across deprivation and ethnic groups, although a consistent social gradient is less apparent than for hypertension outcomes. Differences between ethnic groups are present; however, interpretation should be undertaken with caution due to incomplete ethnicity recording and smaller population sizes within some groups. Lower achievement is particularly evident among individuals with missing ethnicity data, highlighting the potential impact of data completeness on interpretation.

Overall, these findings suggest opportunities for more targeted follow-up, treatment optimisation and support for groups experiencing poorer outcomes, alongside continued efforts to improve the quality and completeness of demographic recording to better understand inequalities in care.

## Atrial Fibrillation

AF anticoagulation remains a sustained strength for East Sussex, with performance demonstrating a consistent upward trajectory over the reporting period. East Sussex continues to meet local ambition and, in the latest reporting period, has moved above the national average. Performance has improved steadily across sub-ICB areas and now sits within the national interquartile range, reflecting strong and sustained delivery of anticoagulation treatment for patients at increased risk of stroke.

*Figure 9: AF - treatment with anticoagulants - Place Level*




Although performance is strong, maintaining current levels and reducing unwarranted variation across population groups will remain important to ensure equitable access and sustain improvements over time.

# CVD behavioural risk

Behavioural risk factors play a central role in the development and progression of CVD and represent some of the most significant contributors to preventable illness and premature mortality. Key modifiable behaviours, including smoking, harmful alcohol consumption, physical inactivity, poor diet and excess weight, are strongly associated with the development of clinical risk factors such as hypertension, type 2 diabetes and raised cholesterol. Addressing these behavioural risks is therefore essential to preventing cardiovascular disease and improving long-term population health outcomes (Public Health England, 2019).

Interventions that support smoking cessation, healthier eating, increased physical activity, weight management and reduced alcohol consumption are recognised as among the most effective strategies for reducing cardiovascular risk across the population.

Behavioural risk factors are not evenly distributed across the population and are strongly associated with socioeconomic deprivation. Higher levels of smoking, obesity, physical inactivity, and harmful alcohol consumption are commonly observed in more deprived communities, contributing to inequalities in CVD outcomes. Targeted prevention approaches that address behavioural risk factors are therefore essential to reducing health inequalities and improving outcomes for populations at greatest risk (OHID, 2022).

Within East Sussex, behavioural risk factors remain an important contributor to CVD risk across the population. Understanding the distribution of smoking, alcohol consumption, physical activity, diet, and weight across local communities supports the development of targeted prevention programmes and enables the delivery of coordinated, population-level interventions (Gollins-Perronne & Müller, 2025). Supporting individuals to make sustainable behaviour changes through community-based services, healthcare interventions and public health initiatives remains a key component of reducing cardiovascular disease and improving overall health outcomes.

Data for behavioural risk factors can be found in NHS Health Checks Evaluation (Gollins-Perronne & Müller, 2025).

# Bibliography


Betai, D., Ahmed, A. S., Saxena, P., Rashid, H., Patel, H., Shahzadi, A., . . . Nazir, Z. (2024). *Gender Disparities in Cardiovascular Disease and Their Management: A Review.* Cureus.

British Heart Foundation. (2025). *Socioeconomic inequalities in heart and circulatory diseases in England: an analysis.* British Heart Foundation.

Chacko, M., Sarma, P. S., Harikrishnan , S., Zachariah, G., & Jeemon, P. (2020). *Family history of cardiovascular disease and risk of premature coronary heart disease: A matched case-control study.* Wellcome Open Res.

Cho, S. M., Lee, H. J., Shim, J. S., Song , B. M., & Kim , H. C. (2020). *Associations between age and dyslipidemia are differed by education level: The Cardiovascular and Metabolic Diseases Etiology Research Center (CMERC) cohort.* Lipids Health Dis.

Cox, J. H., Coupland, C., & Brindle, P. (2017). *Development and validation of QRISK3 risk prediction algorithms to estimate future risk of cardiovascular disease: prospective cohort study.* British Medical Journal.

Department of Health and Social Care. (2025). *Fit for the future: 10 Year Health Plan for England.* Gov.UK.

Department of Health and Social Care. (2026, March 17). *NHS England.* Retrieved from Neighborhood Health Framework: https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework#introduction-to-neighbourhood-health

Dijkstra, T., Heuvel , L. M., Tintelen , J. P., Werf, C. v., Langen, I. M., & Christiaans, I. (2023). *Predicting personal cardiovascular disease risk based on family health history: Development of expert-based family criteria for the general population.* Eur J Hum Genet.

Elsheikh, S., Hill, A., Irving, G., & Lip, G. Y. (2024). *Atrial fibrillation and stroke: State-of-the-art and future directions* . Science Direct.

Gilani, A., Umar, K., Gilani , F., Ahmad, M., Abbasi, M. S., Yaseen, M., . . . Safdar, S. (2024). *The Effect of Glycemic Control on Cardiovascular Disease Progression in Adults With Early-Onset Type 2 Diabetes: A Longitudinal Cohort Analysis*. Cureus.

Gollins-Perronne, T., & Müller, A. (2025). *NHS health check evaluation.* East Sussex County Council.

National Institute For Health and Care Excellence. (2023). *Cardiovascular disease: risk assessment and reduction, including lipid modification*. Retrieved from https://www.nice.org.uk/guidance/ng238

NHS England. (2023). *Cardiovascular disease (CVD)*. Retrieved from https://www.england.nhs.uk/ourwork/clinical-policy/cvd/

NHS England. (2023). *Cardiovascular disease high impact interventions* . Retrieved from https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/cardiovascular-disease-high-impact-interventions/

NICE. (2023). *Cardiovascular disease: risk assessment and reduction, including lipid modification*. Retrieved from https://www.nice.org.uk/guidance/ng238

NICE. (2023). *National Library of Medicine*. Retrieved from Hypertension in adults: diagnosis and management: https://www.ncbi.nlm.nih.gov/books/NBK547161/

NIHR. (2024). *Research explores how health care providers could improve cholesterol management and cardiovascular health in deprived communities*. Retrieved from https://arc-nenc.nihr.ac.uk/news/research-explores-how-health-care-providers-could-improve-cholesterol-management-and-cardiovascular-health-in-deprived-communities/

North, B. J., & Sinclair, D. A. (2012). *The intersection between aging and cardiovascular disease*. Circulation Research.

OHID. (2022). *Cardiovascular disease prevention: applying All Our Health*. Retrieved from https://www.gov.uk/government/publications/cardiovascular-disease-prevention-applying-all-our-health/cardiovascular-disease-prevention-applying-all-our-health

Pathak, A., Poulter , N. R., Kavanagh , M., Kreutz, R., & Burnier , M. (2021). *Improving the Management of Hypertension by Tackling Awareness, Adherence, and Clinical Inertia: A Symposium Report*. Am J Cardiovasc Drugs.

Public Health England. (2019). *Health matters: preventing cardiovascular disease*. Gov.UK.

Raleigh, V., Jefferies, D., & Wellings, D. (2022). *Cardiovascular Disease in England*. The Kings Fund.

Raleigh, V., Jefferies, D., & Wellings, D. (2022). *Cardiovascular Disease in England: Supporting Leaders to Take Action*. The Kings Fund.

Razieh, C., Zaccardi , F., Miksza, J., Davies, M. J., Hansell, A. L., Khunti , K., & Yates , T. (2022). *Differences in the risk of cardiovascular disease across ethnic groups: UK Biobank observational study.* Nutr Metab Cardiovasc Dis.

Siam , N. H., Snigdha , N. N., Tabasumma , N., & Parvin, I. (2024). *Diabetes Mellitus and Cardiovascular Disease: Exploring Epidemiology, Pathophysiology, and Treatment Strategies*. Rev Cardiovasc Med.

Tayal, U., Pompei, G., Wilkinson, I., Adamson, D., Sinha, A., David, H. S., . . . Kunadian, V. (2024). *Advancing the access to cardiovascular diagnosis and treatment among women with cardiovascular disease: a joint British Cardiovascular Societies' Consensus Document*. BMJ Group.

Tayal, U., Pompei, G., Wilkinson, I., Adamson, D., Sinha, A., Hildick-Smith, D., . . . Kunadian , V. (2024). *Advancing the access to cardiovascular diagnosis and treatment among women with cardiovascular disease: a joint British Societies' consensus document*. Heart.