Population and Community Programmes addressing Multiple Risk Factors to Prevent Cardiovascular Disease (CVD): Addendum to qualitative study produced by Peninsula Technology Assessment Group for NICE

CVD Programme – Heart of Mersey (HoM) (see ref)

Robin Ireland, April 2009 (with acknowledgement of contributions and suggestions by colleagues)

Area covered in NW England (total population c 2 million)

1. How did you first get involved? Background to Heart of Mersey (HoM)

I was recruited as the Programme Director in October 2002. The initial project proposal was formulated after a visit by Merseyside organisations with an interest in CVD prevention to North Karelia, Finland in 2001. A management board was formed and funding was secured from Merseyside Health Action Zone (MHAZ). Sefton (MBC and PCT) agreed to host the programme on behalf of the Merseyside local authorities and primary care trusts involved in MHAZ (Knowsley, Liverpool, Sefton, St Helens and Wirral). My post was originally only of 12 month duration and my initial responsibility was to set up the programme.

HoM was formally launched in June 2003 and subsequently became a charity in 2005. A parallel social enterprise (HoM Partnerships) began trading in 2008.

The HoM programme focuses upon smoking and food, reflecting the evidence base of the most powerful of the modifiable risk factors for CVD (i.e. raised blood cholesterol, high blood pressure and tobacco smoking), and more specifically the big gains that can be achieved in reducing the three main risk factors for CVD by structural policy changes at local/ regional, national or European levels. Although the programme is focused upon reducing CVD prevalence, it also recognises the impact that poor nutrition and smoking can have on the wider public health agenda, for example on noncommunicable diseases such as obesity, Type 2 diabetes, many common cancers and reducing health inequalities. The two core programmes, food and tobacco control, are supported by two further programme areas, research and corporate communications.

The research programme delivers evidence-based research and the provision of data and statistics. It ensures that all aspects of the Heart of Mersey intervention are evaluated and reported on. The communications programme delivers advocacy and campaigning initiatives on behalf of HoM with the aim of influencing public health policy to support the prevention of CVD.

2. Were you aware of the theories behind the programme?

The programme draws upon the principles of the successful CVD intervention programme in North Karelia, The North Karelia project focused much of its work with the community (as opposed to individuals), and utilised four key theoretical frameworks for behaviour change; namely, *the behaviour change approach, the community-behaviour change approach, the innovation-diffusion approach and community organisation/social policy*. HoM adopts the first three theoretical approaches at the local and regional level together with their local and regional partners. However, the main focus is upon population based approach and social policy activity at both national and European level. There are key differences between the programmes however. For example, the North Karelia project focused much of its work within the community and galvanised the support and collaboration of organisations such as *Martta*, a national housewives' group. HoM has been aware from its early days that this approach would be difficult to replicate in Merseyside, or even the UK, without a substantial budget. Rather than trying to engage the population directly therefore, HoM has concentrated on influencing and engaging the policy makers.

3. Did the actual programme look like the plan programme?

Yes, although the initial programme only considered a single risk factor – poor nutrition - tobacco was added in 2004 once additional funding was secured. The programme has also benefited from two new primary care trusts joining HoM. A three-year service level agreement was secured between HoM and the Merseyside and Cheshire Directors of Public Health in April 2008 'for the provision and monitoring of key activities to prevent cardiovascular disease in Greater Merseyside and Western Cheshire'.

4. What are the main challenges of the day to day management of your programme?

Much of HoM's funding is obtained from six primary care trusts (Halton and St Helens, Knowsley, Liverpool, Sefton, Western Cheshire and Wirral). Although the Merseyside and Cheshire Directors of Public Health collectively support the added value HoM provides to local CVD prevention work, there is a

constant pressure to focus solely on local targets agreed through Local Area Agreements. It may be argued that national targets for CVD prevention including the existing National Service Framework for Coronary Heart Disease and *Putting Prevention First* also encourage an emphasis on individuals at risk rather than on addressing risk factors across the population.

The HoM programme considers the entire range of factors that promote or prevent population health rather than just personal health risks or disease. By adopting a population-based strategic approach, Heart of Mersey aims to create an appropriate environment for change which is sustainable via structural change. By creating healthier environments, the ultimate aim is to secure long term health benefits for the whole population of Merseyside and Cheshire.

Policy change is harder to monitor and evaluate than direct lifestyle modification programmes which are often concentrated in small geographical areas and effects may take place over a much longer time period. Thus local partners may not always readily be aware of the work of HoM or the impact its work may be having on the health of a local population.

5. What factors contributed to successful or less successful collaboration between professional groups/ organisations?

Heart of Mersey has benefited from its longevity and increased professional reputation in seeking successful collaborations with other organisations. It actively represents the collective voice of six PCTs in Cheshire and Merseyside in advocating for national policies to support behaviour change and contribute to reduced health inequalities amongst our population. The contributing PCTs recognise HoM's role as adding value and an upstream approach to their local CVD prevention work.

By having the support of the local Directors of Public Health, HoM has usually had a strong relationship with its primary care trusts. Local authorities are harder to engage and traditionally look inward rather than outward to effective collective approaches. The latest proposal for a Liverpool City Region and a Multi Area Agreement provide new opportunities to work together.

At national level, HoM has participated in the Cardio & Vascular Coalition. It has worked closely with organisations such as the Faculty of Public Health

and the National Heart Forum in advocacy around saturated fats and food labelling and a wide range of partners in tobacco control advocacy. HoM's Big Food Debate in 2007 was endorsed by further partners including the British Heart Foundation and the UK Public Health Association.

At European level, HoM convened a new partnership including the European Heart Network, the European Public Health Alliance, the National Heart Forum and the North West Brussels Forum to form a European Agriculture and Health Consortium to advocate for a European health-promoting agriculture policy. This work has funded a European Policy Officer in Brussels.

6. What factors contributed to successful or less successful staffing?

As the programme was hosted by Sefton and physically located within the PCT headquarters, staff were employed by the PCT and thus had NHS contracts; this arrangement remained when HoM became a charity in 2005. Most staff have permanent contracts as there is no time limitation placed on the programme. Both the above are important factors in the securing of appropriately skilled and experienced staff.

HoM has a strong commitment to CPD and developing public health capacity with its programme team encouraged to experience a range of training; in particular, five staff have been supported to undertake appropriate masters' degrees and one to study for a doctorate. In addition, no less than ten staff and three of HoM's charitable trustees have visited Finland to participate in a noncommunicable diseases training week (including visiting North Karelia).

7. How was community engagement undertaken?

When HoM was first launched in 2003, it organised (along with the former Cardiothoracic Centre – NHS Trust) a *Big Heart Festival* at Aintree Racecourse – essentially this was a large regional health fair. This was accompanied by a major billboard campaign – *Smoke, Eat Crap, Don't Exercise*. These activities had the aim of generating media coverage and public awareness of the launch of Heart of Mersey on Merseyside and to help stimulate interest and engagement from key decision makers in the region.

Since 2005, after a final and third *Big Heart Festival*, no attempt has been made to engage directly with the community as Heart of Mersey. As previously emphasised, HoM's focus is on policy makers and opinion formers at local, regional, national and international levels. However, specific social marketing programmes around smokefree and food issues have been partially aimed at the community as well as political decision makers within councils and local organisations (such as hospitals and schools).

8. Once the formal period for the intervention was over, was there anything left?

Heart of Mersey did not have a 'formal period' for its intervention. Having been launched in June 2003, it has been in operation for nearly six years and there is no immediate aim for it to conclude. We recognise that such interventions need to be sustainable and long term. Heart of Mersey's long-term legacy may be measured through:

- Biomedical measures (such as cholesterol levels) as demonstrated through a repeat Health Survey of our local population
- Contribution to local/regional policy change (such as to hospital food procurement and pre-school food provision)
- Contribution to national policy changes (such as the Health Act 2006 – smokefree legislation)
- Contribution to European policy change (such as equal subsidies to all types of milk)

9. What were the main challenges of evaluating such a programme?

The importance of baseline data for CVD population based intervention programmes are essential and have been obtained for all major programmes. HoM therefore commissioned the "Health Survey for Greater Merseyside" in 2003 to provide a measure of the health experience of the population, in terms of cardiovascular disease mortality and morbidity and risk factors. The survey confirmed that cardiovascular disease in Merseyside citizens aged 65 plus is one third higher than the rest of the UK. It also exposed the stark inequalities in health that have contributed to the high levels of CVD in the

region. The survey added to earlier self-reported lifestyle surveys by including not only information on risk factors such as nutrition, smoking and physical activity, but also biomedical measures such as blood cholesterol levels. This provided baseline data of the current health status of the population: the core epidemiological profile. The Health Survey for Greater Merseyside is intended to be repeated in 2010 to assess changes in the local prevalence of CVD mortality and morbidity which will not only help to evaluate the impact of HoM, but the combined CVD prevention programmes in our region.

A big challenge for evaluation is obtaining data on changes in diet and nutrient intakes at the local level. Limited data is available from self-reported lifestyle surveys; proxy-measures such as obesity and /or dental caries in children may be used, but there is often a lag in detecting effects. Information on nutrient intakes such as saturated fat, salt and/or sugar at a local or sub-regional level would help to further evaluate the impact of HoM's core activities around food, as it is often small changes among multiple individuals in the population which can have huge impacts on disease prevalence in the population.

We are currently reviewing how best to evaluate our advocacy work and our influence on all levels of policy which may impact on public health.

10. Were there benefits of the programme that the evaluation was not able to measure?

See above.

- Increased local influence on national and European agenda, particularly through elected members
- Closer partnerships between local, regional, national and international partners (especially those working in public health)

Reference:

Lloyd-Williams F, Capewell S, Ireland R and Birt C. 'Delivering a cardiovascular disease prevention programme in the United Kingdom: translating theory into practice'. *European Journal of Public Health.* 2008. 18:357-359.