Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

CVRM Strategy

Prepared by : Dr Nazish Khan CVD Clinical Lead

Dec 2025

Overview: Cardiovascular Renal Metabolic (CVRM) Conditions Prevention and Management Strategy & Delivery Plan

Purpose: Provide the justification for and a framework against which a multimorbidity approach to the identification and management of cardiovascular risk factors can be adopted.

Opportunity:

(i) Transition from single condition to multi-condition reviews taking into consideration cardiovascular, renal and metabolic (diabetes, overweight/obesity) conditions

(ii) Improve patient outcomes through the delivery of personalised person-centered care in a community based setting

(iii) Adopt a PHM approach to address health inequalities in addition to the variation in disease prevalence and management recognising the significant variation in the uptake of evidence based interventions (pharmacological and non-pharmacological)

(iv) Develop novel innovative models of care delivery

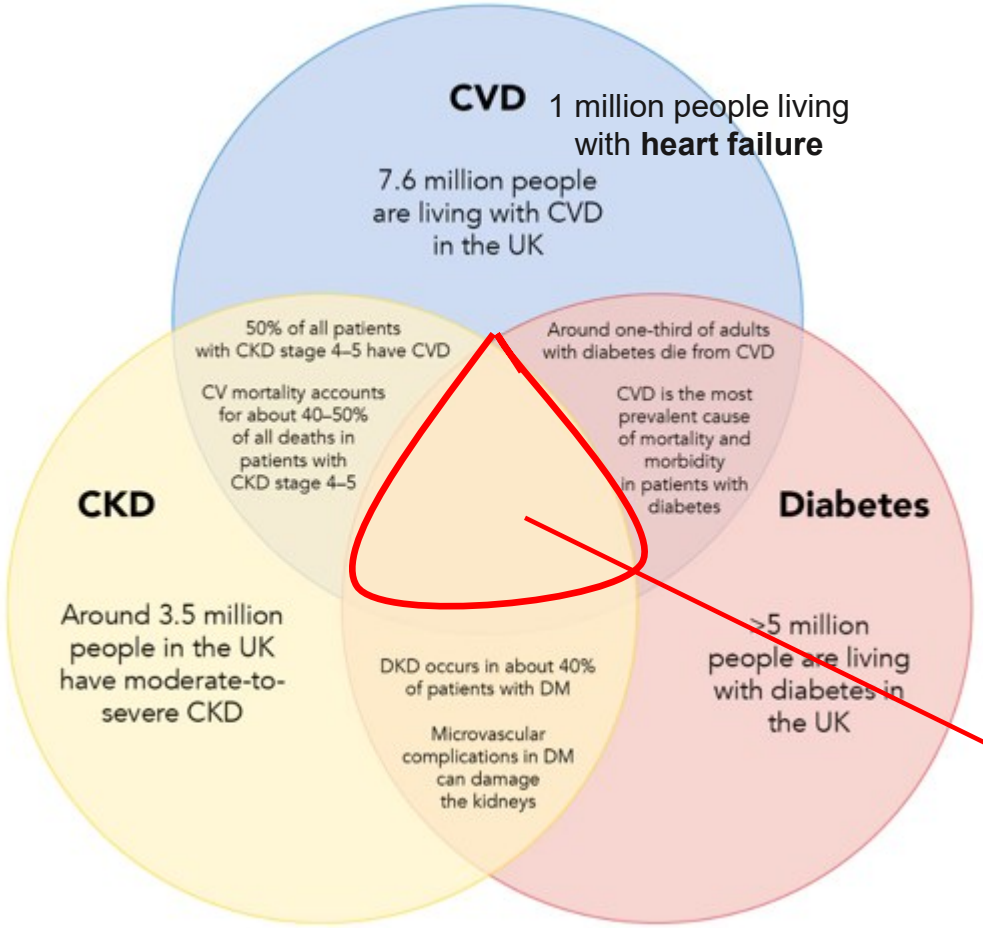
Proposed solution: Adopt a CVRM approach to patient management; early identification, optimised management (including lifestyle and behaviour) delivered by multidisciplinary teams working collaboratively in a community based setting

Evidence: 72% of the population are living with >2 CVRM conditions, increased rates of complications due to poorly controlled diabetes, increased incidence of admissions due to heart attacks and strokes, increasing prevalence of obesity

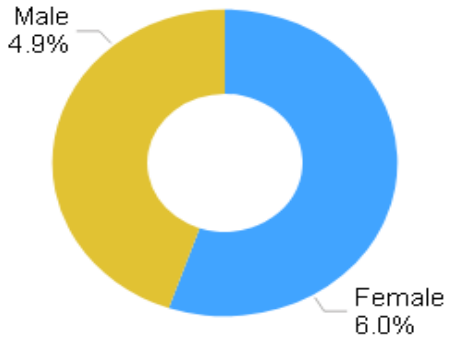
Value/benefits: improved patient outcomes and quality of life, reduction in unplanned hospital admissions and reduction in waiting list times, increased efficiency in clinical capacity. Improved socioeconomic benefits through increased economic productivity.

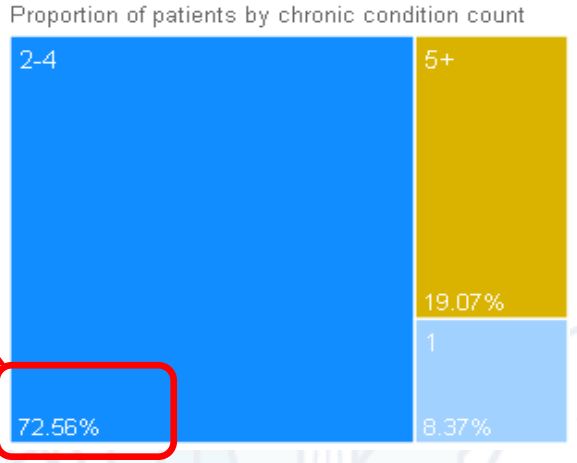
Recommendations: Endorsement of the strategy and delivery plan.
(Implementation can be undertaken using existing staffing resources. Industry support is currently being explored)

Current position



ICB Burden of Disease Population Segmentation





The interplay between CVRM conditions

Current position: burden of multimorbidity

PCN: Shropshire, Telford and Wrekin ICB

Condition: Hypertension

97,773

Key to delivering PHM is understanding the growth in patie
developing efficient connected care systems to manage th

Of the **94,512** patients with **Hypertension**

Comorbidity	Patients	Proportion with
Obese *	39,772	42.1%
Overweight	33,289	35.2%
Diabetes *	21,473	22.7%
Chronic kidney disease *	19,620	20.8%
Depression	14,959	15.8%
Cancer	11,407	12.1%
Coronary heart disease	10,950	11.6%
Asthma	10,353	11.0%
Atrial fibrillation	9,204	9.7%
Stroke	8,350	8.8%
COPD	4,954	5.2%
Chronic heart failure	4,080	4.3%
Dementia	2,921	3.1%
Peripheral arterial disease	2,409	2.5%
Hypothyroid	2,210	2.3%

Disease prevalence social demographic analysis

NHS Shropshire, Telford and Wrekin

PCN: Shropshire, Telford and Wrekin ICB

Condition: Chronic heart failure

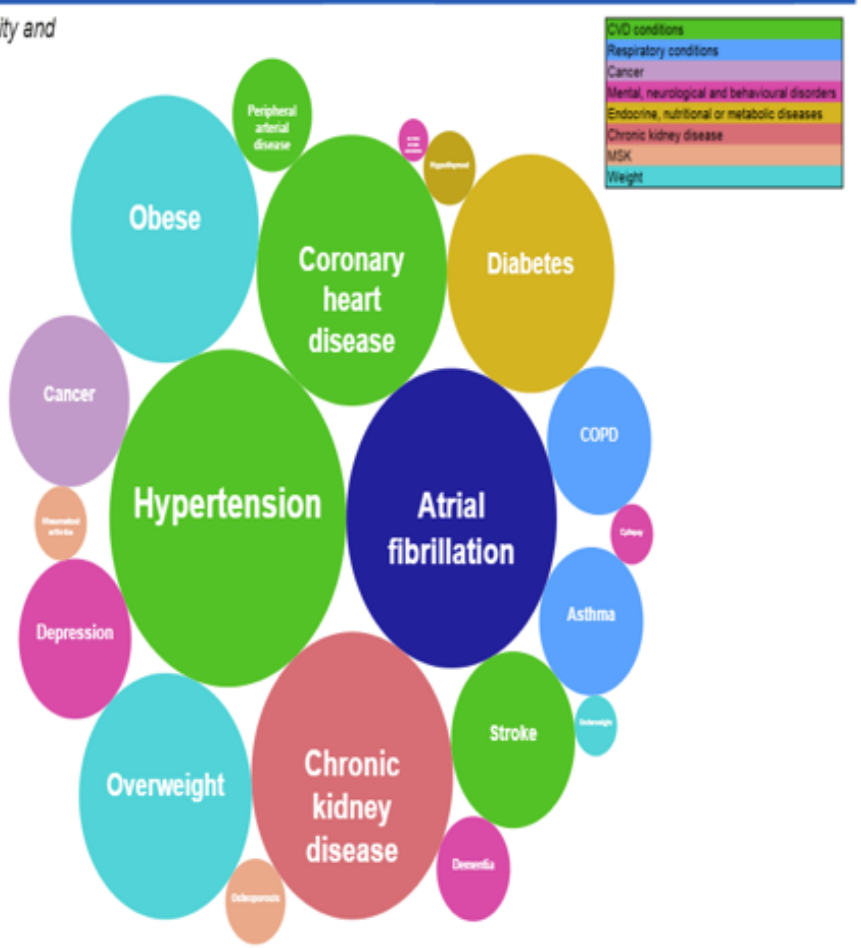
97,487

Patients have 2 or more conditions

Key to delivering PHM is understanding the growth in patients with multimorbidity and developing efficient connected care systems to manage their conditions.

Of the **6,516** patients with **Chronic heart failure**

Comorbidity	Patients	Proportion with
Hypertension *	4,028	61.8%
Atrial fibrillation	3,165	48.6%
Chronic kidney disease *	2,940	45.1%
Coronary heart disease	2,624	40.3%
Obese *	2,563	39.3%
Overweight	2,180	33.5%
Diabetes *	2,022	31.0%
Stroke	1,076	16.5%
Cancer	1,073	16.5%
Depression	921	14.1%
COPD	765	11.7%
Asthma	758	11.6%
Peripheral arterial disease	465	7.1%
Dementia	396	6.1%
Osteoporosis	245	3.8%



Current position: burden of multimorbidity

Aristotle: Prioritisation Matrix (admission rates/1,000)

TOP 5 for each condition	Atrial Fibrillation (rate per 1,000)	CHD (rate per 1,000)	CKD (rate per 1,000)	Complex LTCs (rate per 1,000)	COPD (rate per 1,000)	Diabetes (rate per 1,000)	Heart Failure (rate per 1,000)	Hypertension (rate per 1,000)	Peripheral Arterial Disease (rate per 1,000)	Stroke/TIA (rate per 1,000)
E05008167 - Ludlow North	54.43	61.48	114.21	202.20	31.02		24.25	266.22	12.13	47.66
E05008174 - Much Wenlock	50.77	55.87	95.29	171.30				245.32		38.00
E05008145 - Bridgnorth East and Astley Abbotts	46.92	52.84					22.26			
E05008136 - Abbey	46.11	49.04		161.51						
E05008137 - Albrighton	44.93	58.03					28.21		10.68	36.07
E05008191 - Tern			84.01					233.87		37.66
E05008166 - Ludlow East			83.10	162.93	31.73		22.16		12.59	
E05008153 - Church Stretton and Craven Arms			82.73	158.52				251.71		39.00
E05009972 - Dawley & Aqueduct					31.13					
E05009990 - St Georges					31.06	85.67				
E05009983 - Malinslee & Dawley Bank					29.87					
E05009995 - Wrockwardine Wood & Trench						85.71				
E05009988 - Park						85.54				
E05009974 - Dothill						85.10				
E05008183 - St Martin's						79.84				
E05008198 - Worfield							22.00			
E05009976 - Ercall								227.90		
E05008150 - Castlefields and Ditherington									11.59	
E05008160 - Harlescott									11.20	
E05009993 - Woodside										
E05009977 - Hadley & Leegomery										
E05008173 - Monkmoor										
E05009971 - College										
E05009987 - Oakengates & Ketley Bank										
E05009978 - Haygate										
E05009969 - Brookside										
E05009979 - Horsehay & Lightmoor										
E05009973 - Donnington										
E05009281 - Gobowen, Selattyn and Weston Rhyn										
E05008156 - Clun										
E05008138 - Alveley and Claverley										
E05009982 - Madeley & Sutton Hill										
E05009968 - Arleston										

Link to IMD
Link to NEL for CHD, MI, stroke, AKI, HF, PAD

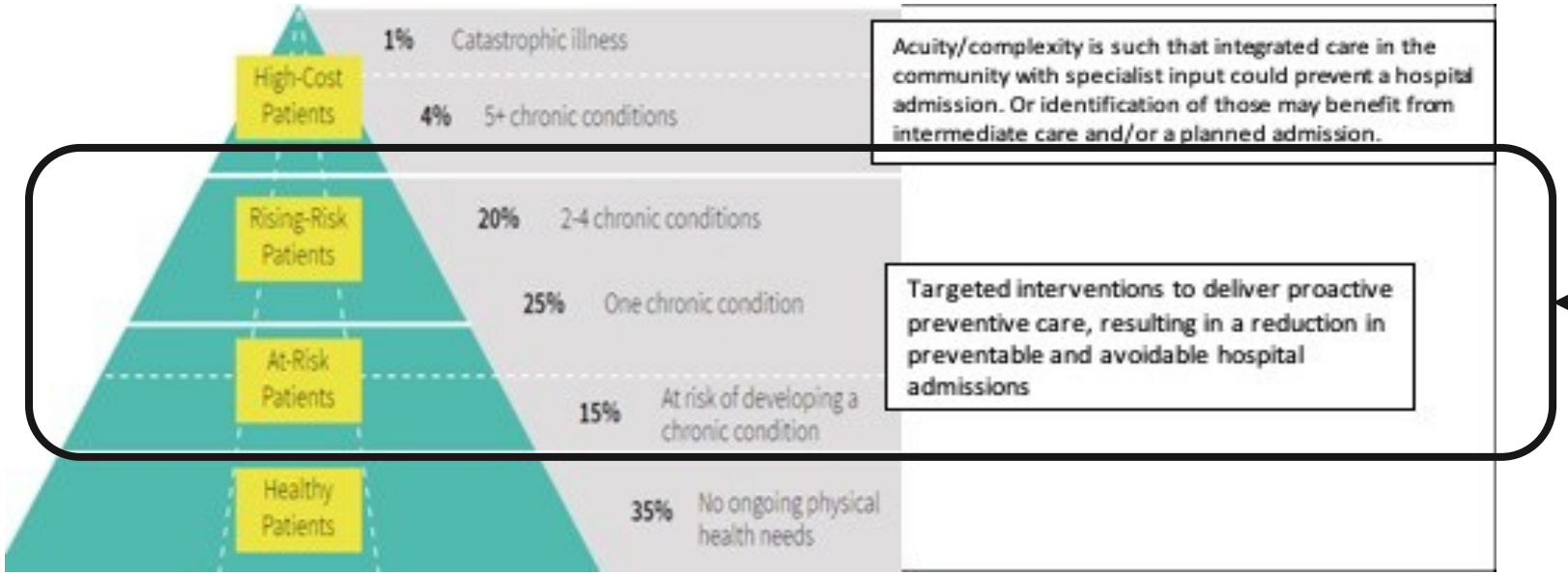
Current position

STW ICB CVRM Strategy and Delivery Plan

2025 - 2030

NHS Shropshire, Telford & Wrekin Strategy & Operational Delivery Plan to Optimise the Identification and Treatment of Cardiovascular, Renal, Metabolic (CVRM) conditions to improve overall cardiovascular health and well-being of the local population.

- Adopt a multi-morbidity approach to addressing cardiovascular risk factors.
- Earlier identification, timely diagnosis and optimised management using evidence based interventions (pharmacological, medical devices, technologies)
- Deliver proactive, preventive community-based care (consider pathway approach → ”prevent, detect, protect, perfect”)



PHM Resources

- Aristotle/local dashboards
- Population segmentation
- Risk stratification

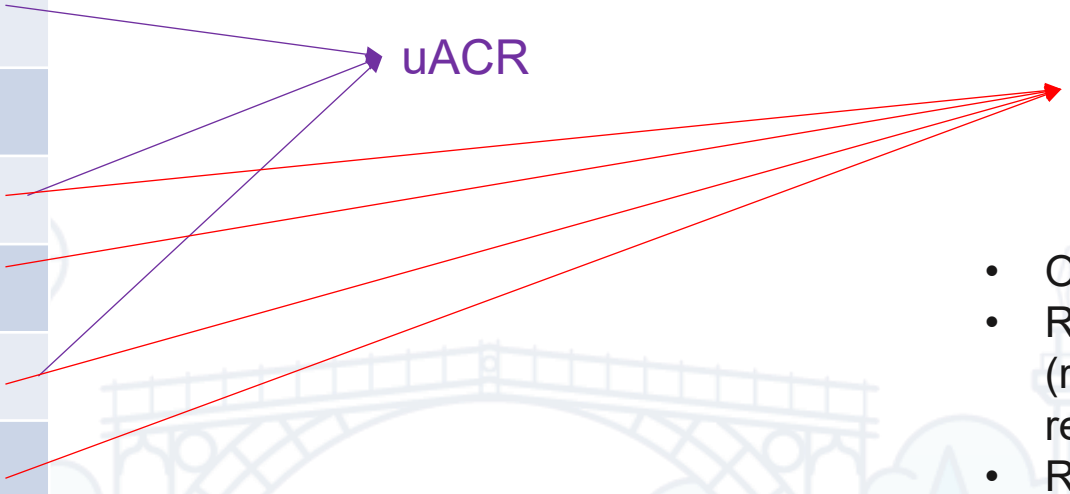
Maximising the impact of investigations and interventions?

Undertake a community/primary care-based multimorbidity LTC approach to risk factor management

Single diagnostic test used across multiple clinical pathways

Single pharmacological intervention with improved outcomes/prognostic benefit in multiple clinical conditions

Co-morbidity
Atrial Fibrillation
Hypertension
Hypercholesterolaemia
Chronic Kidney Disease
Heart Failure
Diabetes
Obesity/overweight



- On average 5mmHg reduction in SBP
- Reduction in rate of renal decline (reduced admissions due to AKI, reduced need for dialysis/Tx
- Reduction in HF hospitalisations
- 2-3kg (4-5%) weight loss

Smoking, alcohol, physical activity

Enablers

Enablers (local):

- PHM/Risk stratification tools
- Quality Improvement Framework (QIF Plus)
- Medicines Quality Commissioning Framework
- [CVRM Quality Improvement Funding Opportunity]
- Cross-sector multi-professional collaboration (MDT working)
- Joint Forward Plan
- Integrated Care Strategy
- STW Clinical Strategy (In development)

Enablers (national):

- QOF/DES
- 10YHP and 3 shifts
- 10YHP: CVD Medicines Service Framework (April 2026)
- 10YHP: Prevention Accelerators
- National Neighbourhood Health Implementation Programme

Alignment to 10YHP

- **Sickness to prevention:** Development of a Modern Service Framework with a focus on prevention to reduce premature deaths cardiovascular disease by 25% over the next 10 years, particularly in those under the age of 75 years. Development and implementation of "prevention accelerators" focusing on community led methods to address unwarranted variation in the uptake of high impact interventions across the CVRM space (including access medicines for weight management).
- **Hospital to community:** Development and delivery of neighbourhood health centres encompassing multiple services and disciplines in one setting, including diagnostics, rehabilitation support, social care input and mental health support.
- **Analogue to digital:** Incorporating remote monitoring and wearables to allow for earlier detection of conditions and improved monitoring of treatments and interventions; enabling patient self-management and the delivery of personalised care. Digital solutions can also increase access to many rehabilitation focussed services.

Life course approach to tackling CVRM related risk factors

Health awareness campaigns, improving overall health literacy

Early identification (opportunistic case finding), out-reach work

Point of care solutions to enable early diagnosis e.g. point of NT proBNP, POC uACR, POC-AI guided echocardiography

Equitable access to evidence-based interventions (pharmacological, digital, medical technologies)

Digital platforms to enable patient self-care e.g. weight loss, cardiac rehab, pulmonary rehab (possibility to enable PIFU)

Develop confidence and capability in primary/community care based setting with support from specialist services in the longer term enabling sustainability and enhanced workforce resilience

5 Year Delivery Plan

Activity To be delivered by:	Year 1 25/26	Year 2 26/27	Year 3 27/28	Year 4 28/29	Year 5 29/30
Development of CVRM Strategy Co-develop CVRM strategy and implementation/delivery plan with system partners including primary, secondary and community care, VSCE, local authority, public health teams and citizens from STW. Develop programme delivery logic models describing impact outputs and outcomes. Develop a robust measurement plan with metrics and KPIs describing ROI which can support further development and delivery of initiatives be reinvested to enable improvements in CVRM outcomes.	✓				
Implementation of CVRM Strategy Ensure governance structure is in place to support delivery of the CVRM strategy. Develop local clinical, operational and PHM leadership to support implementation of CVRM strategy ambitions. PCNs/place-based teams to develop data driven and informed local action plans describing how they will address gaps in service provision and poor CVRM related patient outcomes. Working with the data analytics team to develop BI dashboards to monitor system, place, neighbourhood level delivery against the measurement plan.	✓	✓	✓	✓	✓
Enhancing system resilience, capacity and productivity Education & training, developing local clinical, operational and PHM leadership	✓	✓	✓	✓	✓
Supporting pathway transformation, adoption of innovation and implementation of new models of service delivery Align with national and local transformation initiatives e.g. hospital to community, sickness to prevention, analogue to digital. Continue to build on outputs from the STW Hospital Transformation Programme, Urgent & Elective Care Transformation initiative and the Diabetes and Cardiology Transformation Programmes. Support implementation of new models of service delivery including neighbourhood health teams, virtual ward and virtual integrate CVRM MDTs		✓	✓	✓	✓
Improving quality Align delivery of CVRM management to evidence-based guideline mandated best practice and reduce unwarranted variation in access, uptake, patient experience, patient outcomes and health and social impacts		✓	✓	✓	✓
Continual horizon scanning, demand signalling and working with industry and academia to identify opportunities to improve patient outcomes. Developing a research active system to attract commercial income into primary, secondary and community care; research active centres are associated with improved patient outcomes. Working with industry partners to enable adoption of innovation		✓	✓	✓	✓

Year 1 Key Milestones

Milestone	Target Date	Responsibility
Draft CVRM Prevention & Management Strategy including KPIs and metrics	November 2025	Strategy & Development Directorate/CVD Clinical Lead/Strategic Analytics Service
Socialise strategy with key system partners and seek appropriate approvals.	January – March 2026	Strategy & Development Directorate
Develop communication and engagement plan	January 2026	Strategy & Development Directorate/Insights & Involvement team
Socialise funding opportunity to undertake a CVRM related quality improvement/pathway transformation project (aligned with developing local clinical leadership)	January 2026	Strategy & Development Directorate
Deliver a CVRM workshop in collaboration with system partners; co-develop delivery/action plans (NB – opportunity to undertake a system needs assessment and to understand workforce planning requirements)	January 2026	Strategy & Development Directorate
Restructure CVD Prevention group into CVRM group with revised ToR and membership	February 2026	Strategy & Development Directorate/CVD Clinical Lead
Develop CVRM dashboard to describe progress against proposed KPIs and metrics *	January – March 2026	Strategy & Development Directorate/ CVD Clinical Lead/Strategic Analytics Service
Develop education and training support offer to enabled implementation of the CVRM strategy *	March 2026	STW Education & Training Hub/CVD Clinical Lead
Work with respective teams to ensure contents of Medicines Quality Commissioning Framework and System Quality Improvement Framework align to the CVRM Strategy *	March 2026	Medicines Management team/CVD Clinical Lead/Primary Care & PCN Development Lead

Year 1:
- PCNs/neighbourhood teams to use local population data to identify areas of greatest unmet clinical need aligned with the CVRM strategy e.g. Diabetes
- To propose local delivery/implementation QI plans to address clinical unmet need

Year 2:
- Delivery of QI projects, data capture to demonstrate ROI, business case development to allow for continuity
- Explore opportunity for adoption of innovation(s)
- Shared learning to enable system-wide scalability

Year 3
- Transition to multimorbidity LTC management

Data capture
Monitor delivery against KPIs
Measure impact
Describe ROI (e.g. reduction in unplanned hospitalisations, reduction in OPA)

Next steps

- Share Strategy for Information and endorsement
- Co-design workshops
- ICB Board approval – Spring 2026

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Thank you