Cheshire East CVD Project - July 2021

Cheshire East ICP – “Cardiology” working group has successfully bid for and won £100K from the transformation pot to invest in primary care to improve the care of “heart” disease locally.

The aims of the project are:

- to look at the 3 big risk factors: AF, Blood pressure and Cholesterol (smoking is already the focus of a lot of work)
- the management of 3 conditions; Cerebro-vascular disease, ischaemic heart disease and heart failure
- to improve the coding, detection and thereby to improve the registers and the management of them.

The project will pay (14p per weighted patient on practice list size up front and 14p per weighted patient on completion) practices to do the following:

- a baseline audit;
- work on those 6 items including case finding but also optimising treatment then;
- re-audit with payment for completion of the work

We aim to maximise the percentage of this money that goes to primary care by capitalising on the CCGs investment in EMIS Enterprise to do the audits and ITs investment in Ardens searches to use them to help case finding. The South Cheshire GP Alliance will be providing IT support, at no extra cost to the system, to all practices in Cheshire East - writing the searches in EMIS Enterprise for the project and providing help with coding/queries.

This work aligns with the medicines management teams priorities and the prescribing incentive scheme and will help practices secure more income from QOF by increasing prevalence. The prevalence and other data can be used in ICS/ICP/PCN planning.

A lot of the work can be done by non-GP staff and the aim is to try and impact as little as possible on the access of a practice, though of course, we recognise there may be appointments generated to discuss changing/increasing treatments.

Work has been chosen to:

- embed change, e.g., changing existing templates
- capture more data for planning and to help us target disadvantaged groups e.g., collecting ethnicity data and paying by weighted list
- improve the long-term health of the population by targeting risk factors
- ensure in-year/short term benefits which might help reduce attendance at GPs/A&E and reduce events improving mortality/morbidity.

We are aiming for a light touch approach, but some verification of work done will be needed and the ICP Transformation Team will be working on how we do this – it will involve monthly searches showing improvement in coding and some evidence giving of lists of patients searched through. We hope this can be completed remoted in most instances.

Some support/instruction on how to do case finding / and the other work involved will be provided possibly using www.how2.training

This project targets areas that we believe are upcoming in the national CVD Prevent audit and the new IIF indicators so should help practices in Cheshire East get ahead of the game and realise benefits for patients early.

In summary:

- Taking part is voluntary
- On agreeing to take part, practices will receive half payment up front with final payment on completion – This will either be direct from the ICP/CCG or via the GP Alliance, (this is to be confirmed). Where appropriate, we currently feel 90% target threshold achievement is reasonable for full payment however we will review this in project in case of larger than expected workload. Evidence of no work done will incur repayment of up-front monies
- Taking part indicates a practice's willingness to share its data on these indicators across Cheshire East ICP at a non-patient and non-clinician identifiable level
- Dr Phil Coney and Dr Neil Paul, CHV Programme Clinical Leads will review the outcomes from the audits and searches to determine achievement
- Any appeals will be channelled through the ICP Transformation board.

For further information please contact:

- → Amanda Best, Amanda.best1@nhs.net – Head of Primary Care Development
- → Jacqueline Williams Jacqueline.williams13@nhs.net Associate Director of Transformation
- → Bev Price Beverley.price3@nhs.net – Primary Care Development Facilitator and CVH Project support

If you wish to participate, please confirm via email to Bev Price Beverley.price3@nhs.net by no later than 1st August.

Dr Neil Paul – Joint Clinical Lead

- ➢ Further information will follow once expressions of interest have been received.
- ➢ Some of the indicators may be subject to minor change during the project depending on things like discovery of better Snomed codes.

Appendix: 1 Baseline Audit

These searches will be provided in Emis Enterprise, which every practice needs to be signed up for, where they can be run centrally but also copied into practice for ID of Pts if needed.

1. Report Register size of AF
2. AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)
3. AF007. In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy
4. Percentage on AF register on Noacs/warfarin
5. Percentage on AF register on anticoagulant or antiplatelet on PPI
6. Report Register size of hypertension
7. Report percentage of hypertensives at target by group:

TABLE 3: Specific Office BP targets for hypertension (reduce by 5mmHg if ABPM or HBPM)

Condition	Target	Source NICE
≥ 80 years old	<150/90	NG136 (HTN) [2019]
General hypertensive target	<140/90	NG136 (HTN) [2019]
CKD without diabetes or significant proteinuria CKD with diabetes or significant proteinuria	<140/90 <130/80	CG182 (CKD) [2015]
T2DM regardless of renal, retinal or cerebrovascular damage	<140/90	NG136 (HTN) [2019]
T1DM without albuminuria or metabolic syndrome T1DM with albuminuria or metabolic synfdrome	<135/85 <130/80	NG17 (T1 Diab) [2016]
Chronic hypertension in pregnancy	<135/85	NG 133 (HTN preg.) [2019]
Post-stroke	<130	NICE CKS [2017]

8. Report % of hypertensives with pulse rhythm documented
9. Report number of over 70s with rhythm recorded
10. Report number of pts with Qrisk >20 with no exemption code in notes for statin in last year
11. Report Register size of Heart failure
12. Report HF reg size for HREF and HFPEF
13. Report % with documented EF in notes. Last year and ever
14. Report % HF with NHYA classification in notes *in last year
15. Report %of HF pts with a medication review in their records ?special code
16. Report HF % on beta blocker
17. Report HF % on ace-I or a2
18. Report HF % on spironolactone or eplenonone
19. Report HF % On spiron and K in last year??
20. Report register size of Familial hypercholesterolaemia
21. Percentage on Con Art Register with high intensity statin Rx.
22. Percentage on Cereb Vas Register with high intensity statin Rx
23. Report percentage of those on statin with a target LDL recorded
24. Report percentage at that target LDL

Appendix 2: Work practices need to complete by year end

1. Data collection
    a. Add pulse rhythm and ethnicity coding to all of practices existing CDM templates i.e those regularly used by practice and record them (the pulse rhythm and ethnicity) in the notes by all staff when patient seen at least once in year aiming to increase the level of AF detection and ethnicity recording.
2. Case Finding: To improve Prevalence
    a. Review all pts with BP >160/95 and no hypertension code to see if hypertensive if so code as such OR use other case finding for hypertension as below
    b. Review Ardens case finding searches in AF, FH Lipids, Hypertension, CVD CHD and HF (that every practice should have or we can copy around see appendix) to improve disease registers – training/instruction on what to do /how to do this can be provided. Alternatively, companies like ICS may be willing to do this for a practice as a subcontractor – cost to be met by practice from fees.
3. Review all Heart Failure patients (after case finding)
    a. code type of HF into records Preserved or non-preserved HF, enter last Ejection Fraction if known into notes and record NHYA grading into notes. Standard Snomed codes to be used (can be provided)
    b. then review treatment of each patient against NICE guidance including considering referral to Entresto clinic. We will determine if there is a suitable code for this to aid evidence.
4. AF pts
    a. REVIEW those not on an anticoagulation and treat as appropriate or exclude as refuse and/or take part in ICS audit – see attached details*
    b. Review AF pts on anticoag/antiplat not on PPI to see if they should be as guidance to reduce admissions with bleeds
5. Review those on CAD/CVD registers not on high intensity statin to put them on if appropriate.
6. Record in notes of patients on Statins their non-HDL target cholesterol based on baseline pre-treatment results and review those not at target to increase treatment See https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2020/04/lipid-management-pathway-guidance.pdf
7. Consider refer to lipid clinic if clinical diagnosis of FH (use the Simon Broome Criteria to diagnose FH or in absence of FH if TC>9.0mmol/L and/or LDL-C >6.5mmol/L and/or non-HDL-C >7.5mmol/L or Fasting triglycerides > 10mmol/L (regardless of family history)* hope to provide search for this

Appendix 3:

Interface-CS have a fully funded AF project that we would like all practices to sign up to. It meets the aims of this project and the medicines management scheme. Please see info and sign up asap.