Cardiovascular Project Brief

Plan is ask practices to do the following:
Baseline audit – then work – then reaudit.

The RISKS we are addressing: Atrial fibrillation Blood pressure cholesterol
The Diseases we are targeting: Heart Failure, Coronary Artery Disease, Cerebro-Vascular Disease

Practices sign up to doing Baseline reports as at 1st September 2021

Atrial Fibrillation

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 or Warfarin
5. Percentage on AF register aged 75+ on Anticoagulant or Antiplatelet on PPI

CVD

1. Percentage on Register with high intensity statin Rx.
2. Report percentage of those on statin with a target non-HDL recorded
3. Report number of pts with Qrisk >20 with no exemption code in notes for statin in last year

Familial hypercholesterolaemia

1. Report register size of Familial hypercholesterolaemia

Heart Failure

1. Report Register size of Heart failure
2. Report % with documented Ejection Fraction in notes (Last 12m and ever)
    a. Report % with documented Presserved or Reduced Ejection Fraction (ever)
    b. Report % with Reduced Ejection Fraction
        i. HF Reduced Ejection Fraction % on beta blocker
        ii. HF Reduced Ejection Fraction % on ace-I or a2
        iii. HF Reduced Ejection Fraction % on eplenenone or spironolactone
            1. Report HF % On eplenenone or spironolactone and potassium in last year
3. Report % HF with NHYA classification in notes (Last 12m and ever)

4. Report % HF pts with a medication review in their records
5. Report % HF pts with a Heart Failure medication review in their records

Hypertension

1. Report Register size of hypertension
2. Report % of hypertensives with pulse rhythm documented
3. Report number of pts with Qrisk >20 with no exemption code in notes for statin in last year
4. 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]

5. Report number of hypertensives on a High-Intensity Statin with a Traget non-HDL recorded
6. Report number of over 70s with rhythm recorded

Supporting Resources

EMIS search are available for all of the above baseline searches.

A folder of Case Finding searches is also available, it is recommended that practices work through the patients identified in these searches to increase register size before completing the data quality work.

Searches are also available with patient lists highlighting work to do.

It is agreed that practice data will be shared at PCN and ICP level

Then practices by year end:

1. Add pulse rhythm and ethnicity coding to all CDM templates and record them by all staff to increase the level of AF detection
2. 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
3. Review Ardens case finding searches to improve disease registers for above disease registers

4. Review all Heart Failure pts to code type into records / enter Ejection Fraction and NHYA coding into notes/ and review treatment re NICE inc considering referral to Entresto clinic. Use HF medication review code done in HF pts.
5. Review all non-warfarin/noac AF pts for why none and/or take part in ICS audit
6. Review those on CAD/CVD registers not on high intensity statin to put them on if appropriate.
7. Review Statin/chol pts with no target set and those not at target
8. Consider refer to lipid clinic if if clinical diagnosis of FH or 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)
9. Review AF pts aged 75 or over on anticoagulant / antiplatelet for PPI to reduce admissions with bleeds

Practices will be asked to redo the searches at year end and see if improvement is made, a baseline data template will be provided to help monitor progress and demonstrate evidence of work done.

Payment:

14p paid up front
14p year end for work done.
Money may be more once pop established.

Most of work above can be done by – Pharmacists/ PA/ other roles – so little impact on GP workload. Practice could outsource at their expense.

Our Outcomes:

1. More accurate disease registers – helps planning of services
2. More pts with AF on correct treatment – less strokes
3. Better treatment of BP – less strokes and CVD and HF in long run
4. Better treatment of cholesterol – less disease
5. Better treatment for those at high risk – reduction in disease

Please read the Clinical Effectiveness Group guide on optimising CVD medications:

https://www.qmul.ac.uk/blizard/ceg/media/blizard/real-health/files/RH-CVD---Summary-Guidelines---Triple-Aim---28.10.19---DRAFT.pdf