Managing Cardiovascular Disease for High-Risk Patients

A Practical Guide for GP Practices

Version 1, August 2024

Health Innovation South West

NHS Cornwall and Isles of Scilly

Cornwall and Isles of Scilly Integrated Care System

CORNWALL COUNCIL
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Purpose of the toolkit

The purpose of this toolkit is to support GP practices to tackle local health inequalities by identifying and efficiently managing patients at high risk of developing cardiovascular disease (CVD) through a tried and tested approach. This approach involves automated searches for high-risk patients, identification of patients in deprived areas, proactive patient invites, and delivery of cholesterol and hypertension checks for these patients.

The toolkit is designed to be an accompanying resource for practices involved in the **Reducing Health Inequalities** project run by Cornwall Council, Cornwall and Isles of Scilly Integrated Care Board and Health Innovation South West.

In addition to this toolkit, support is available to participating practices from Health Innovation South West, Cornwall and Isles of Scilly ICB, Cornwall Council and local championing practices. Further details can be found in section 4. To access this support, please email libby.dawe@healthinnovationsouthwest.com.

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1. Introduction to the project

This project builds on work that was part of NHSE's Innovation for Health Inequalities Programme (InHIP) in 2023, which was delivered at several other practices in deprived areas of Cornwall. More information about InHIP can be found here.

As such, this work is closely aligned with the national Core20PLUS5 approach (see Figure 1 below) and aimed at reducing health inequalities. This approach, delivered in a primary care setting, prioritises cardiovascular health for the Core20 cohort – those living in Index of Multiple Deprivation (IMD) 1 and IMD 2 areas – and those at greatest risk of developing cardiovascular disease (CVD) – in the UK, a person living in the most deprived area is nearly 3 times more likely to die from CVD than a person living in the most affluent area. By inviting those from the CORE20 population and therefore at greater risk of CVD, this project is helping to reduce health inequalities and improve access to the care pathway for those who need it most. The approach is flexible and can be adjusted to best support individual practices and existing clinical/staffing structures.

Hypertension case finding has been identified as one of the five key clinical areas of health inequalities. By taking this unique approach, patients with previously undiagnosed hypertension or high cholesterol can be prioritised for treatment. In turn, population health outcomes will improve, strokes and heart attacks can be avoided, practices improve their Quality and Outcomes Framework (QOF) registers and emergency admissions can be reduced.

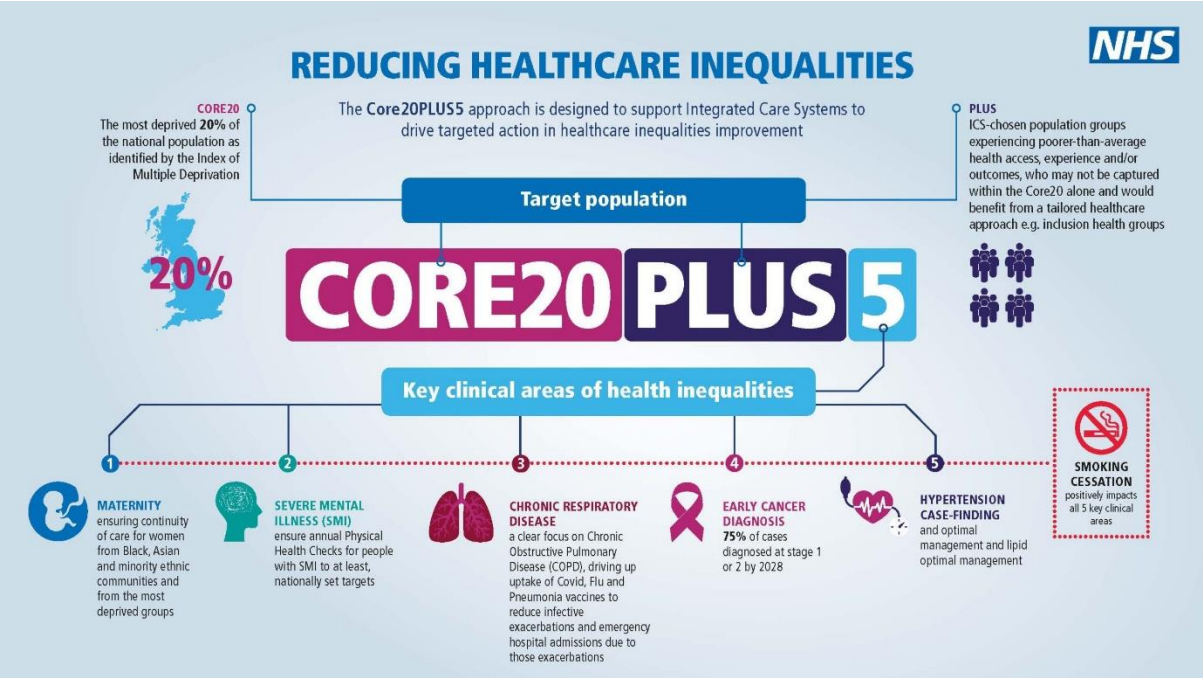

Figure 1: Core20PLUS5 infographic - NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

2. Step by Step process

In this section, the approach is broken down to guide practices through each of the three steps involved, which are as follows:

Further information on each of the steps is provided below:

2.1. Stratify patients into priority categories

GP practices initially run searches using the free UCLPartners proactive care frameworks for hypertension, primary cholesterol and secondary cholesterol. The frameworks include searches that risk stratify patients who are already on the register for hypertension and/or high cholesterol into clinical priority groups and subsequent management (see figure 2 below). The Public Health team then provides IMD level data for each patient's postcode, which is overlayed with the existing UCLP stratification results.

Practices can use the combined data obtained through the UCLP searches and IMD analysis to stratify these patients further, thereby prioritising those at greatest risk.

The UCLPartners Proactive Care Frameworks

The UCLP Proactive Care Frameworks were developed by primary care clinicians to help practices prioritise clinical activity by stratifying patients who are at highest risk (figure 2 example).

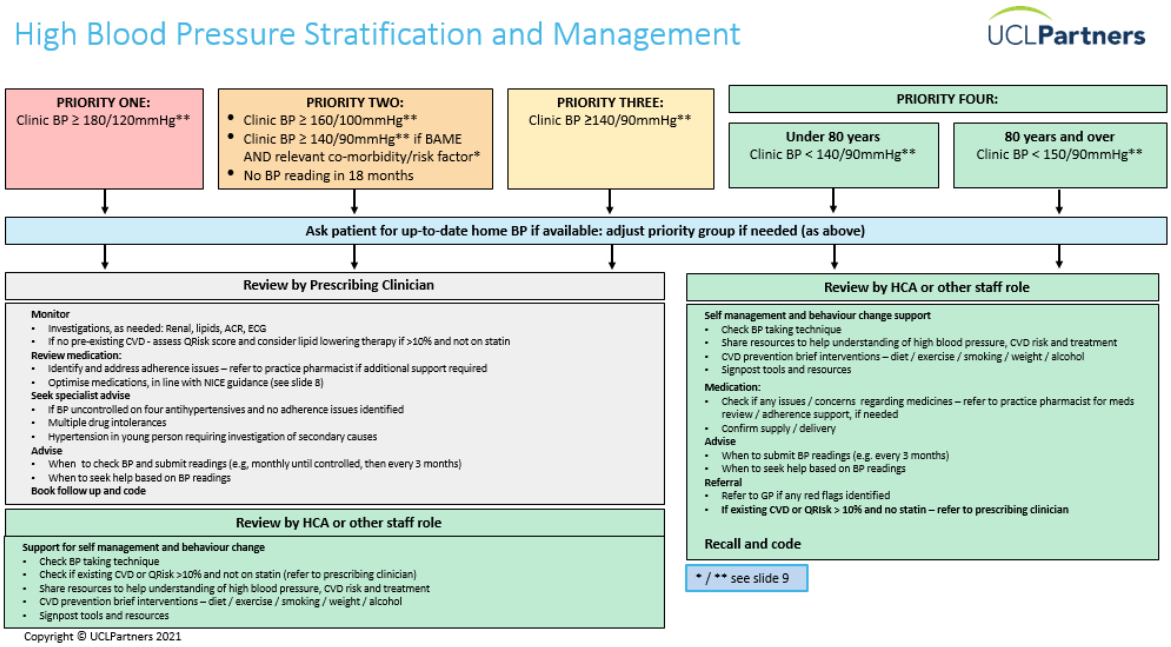

Figure 2: UCLP Proactive Care Framework

More information about these frameworks can be found here. The frameworks include a comprehensive search tool that can be embedded into EMIS and SystmOne to help risk stratify patients. These tools help manage those with pre-existing CVD who are not treated to target whilst also helping to identify those at risk who do not yet have a diagnosis of CVD.

The free resources are available by registering via the UCLP Framework website and include:

- Search and stratification tools for Ardens, EMIS and SystmOne (see priority categories above).
- Downloading and implementation guidance and resources for clinicians.
- Case studies and video clips from clinicians.
- Protocols for Health Care Assistants (HCA) and similar roles.
- Digital resources for staff and patients.

In addition to these resources, support for practices to implement these tools is available from the Health Innovation South West team.

2.2. Invite most at-risk patients to a health check

Once patients have been identified, GP practices design their local invite strategy for prioritising those patients that are in IMD 1 and 2 deciles and indicated as high priority by the UCLP searches.

The invite strategy can involve SMS message (e.g. by using Accurx) or telephone calls, whichever best suits the practice's clinical structure and patient population. This can be done by a variety of roles e.g. healthcare assistant (HCA), pharmacist, receptionist etc.

From previous iterations of this work, it has been observed that a much higher number of invitations can be sent out if using automated text messages. Using telephone invitation strategy, however, results in a much higher conversion rate of patients attending the appointment: about 50% compared to 33%.

Support with pre-existing SNOMED codes to track invites and attendance of CVD health checks is available. Using SNOMED codes also enables the design of bespoke reports and data collection on access and engagement.

2.3. Deliver CVD health checks

Practices then book invited patients in for a CVD health check (to identify hypertension, cholesterol and atrial fibrillation) with the appropriate staff member, i.e. nurse, HCA or pharmacist in their preferred setting. Typically, the health check includes a blood pressure check, cholesterol blood profiling, a pulse check, as well as brief lifestyle advice dissemination. Practices have on average allocated 10-15 minutes per patient. Please see the appendix for useful SNOMED codes.

Following the initial check, it is likely that there will be an element of follow-up care necessary as a result of the CVD health checks findings from high-risk patients. This could include information on smoking cessation, weight management, etc.

3. What are the incentives/benefits?

This project directly addresses health inequalities and seeks to ensure that those who are in most need of healthcare have the means to access it. By identifying patients at increased risk of developing CVD, healthcare advice and support can be provided before it becomes urgent. This reduces the strain on secondary care providers and lowers the number of hospital admissions, offering cost savings to the NHS and improving population health outcomes. Other benefits include:

- Improved CVD health outcomes for those living in the most deprived areas.
- Increased knowledge, confidence, and skills to implement innovative ways of working in their setting leading to optimised management of patients.
- Enhanced system-working, including multidisciplinary teams.
- Improved relationships between practices and system leaders in CIOS.

This project also aligns with QOF and can help generate points for each practice. The QOF indicators that align with this project are:

Indicator	Description	Points available	Thresholds
CHOL001	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, Stroke/TIA or Chronic Kidney Disease Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy	14	70-95%
CHOL002	Percentage of patients on the QOF Coronary Heart Disease, Peripheral Arterial Disease, or Stroke/TIA Register, who have a recording of non-HDL cholesterol in the preceding 12 months that is lower than 2.5 mmol/L, or where non-HDL cholesterol is not recorded a recording of LDL cholesterol in the preceding 12 months that is lower than 1.8 mmol/L	16	20-35%
HYP001	The contractor establishes and maintains a register of patients with established hypertension	6	N/A
HYP008	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	14	40-77%
HYP009	The percentage of patients aged 80 years or over, with hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, (or equivalent home blood pressure reading)	5	40-80%

AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	5	N/A
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)	12	40-90%
AF008	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA2DS2- VASc score of 2 or more, who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a vitamin K antagonist	12	70-95%

4. What support will be available to participating practices?

- This project is supported by Cornwall and Isles of Scilly ICB, Cornwall Council Public Health and Health Innovation South West until March 2025.
- A dedicated project manager will support participating practices with project set-up, contact materials and processes, insights collection for learning and support to manage implementation timeline.
- IMD data will be available from Cornwall Council Public Health and further support with data can be accessed through Health Innovation South West.
- Peer support will be available through CVD champions who have successfully implemented this approach in their local setting.

Practices are encouraged to make use of this resource and share regular updates with the project manager. This will enable the team to ensure that a proportionate amount of resource is dedicated to the project and to investigate alternative resource if necessary. This approach is flexible and can be adapted to suit unique practice structure and population health needs.

To register interest and access this support, please contact Health Innovation South West by emailing Libby.Dawe@healthinnovationsouthwest.com.

5. What are the expectations?

Practices are encouraged to invite as many patients as capacity allows. At least 80% of patients identified as priority one should be invited to receive a health check, depending on practice size and invite methods.

As this project will use funding from public sources, public health outcomes and project progress will be monitored and reported. This will require each participating practice to communicate updates and share data with the delivery team. Support and resources are available to achieve this and learnings will be shared.

The practice team will be required to work with the project team to embed stratification tools as well as tracking tools for insights gathering. We would also ask for staff delivering the service to provide feedback via a survey or interview, taking no longer than 30 minutes. We would also expect staff to support the gathering of patient feedback, for example sharing information about a survey.

The project delivery team will be available to answer any queries throughout the duration of the project.

6. What are the time commitments?

Activity	Estimated time needed	Role required
Onboarding – reviewing contracts and agreements, meeting with project manager, familiarizing with project plan.	Approx. half day	Practice manager or designated deputy
Identify high risk patients using UCLP searches	Depends on number of patients - takes approx. 15 minutes per patient from case finding to consultation. Identification is quick but cleaning the patient data from the search and turning it into a contact list may take time (for instance, checking who should be exempt such as those on end-of-life care).	Nurse, pharmacist, practitioner, GP, practice manager, depending on IT skills
Invite patients to clinic	Depends on number of invites sent and method e.g. text, phone call.	Any available
Clinic appointment	10-20 minutes per patient, depending on extent of checks required	Nurse, pharmacist, practitioner, GP
Evaluation: insights gathering, feedback	Less than 30 mins for feedback	Staff involved in delivering checks

7. Appendix 1: Supporting Resources

Resource Name	Link	Comments
UCLPartners search and risk stratification tools	Search and risk stratification tools - UCLPartners	Information about how to download and use the UCLPartners search and risk stratification tools
CVDPrevent	CVDPREVENT	The Cardiovascular Disease Prevention Audit (CVDPREVENT) is a national primary care audit that automatically extracts routinely held GP data
Size of the Prize	Size of the Prize for high blood pressure (uclpartners.com)	Size of the Prize uses Integrated Care Board level data to demonstrate the potential for preventing heart attacks and stroke through optimisation of treatment for their common risk factors
Manchester Tool	CVD Prevention: Lipid Pathway – Resources for Health and Care - Health Innovation Manchester	CVD Prevention Toolkits for Health and Care professionals; developed in Greater Manchester
NHS Smoking cessation advice	Quit smoking - Better Health - NHS (www.nhs.uk)	Advice to share with patients on how to quit smoking

8. Appendix 2: SNOMED codes

Smoking status

Current smoker - 77176002
1-9 cigarettes or gram/day or equivalent - **160603005**
10-19 cigarettes or gram/day or equivalent- **160604004**
20-30 cigarettes or gram/day or equivalent - **160605003**
40+ cigarettes or gram/day or equivalent - **160606002**

Ex-smoker - 8517006
1-9 cigarettes or gram/day or equivalent - **266922007**
10-19 cigarettes or gram/day or equivalent - **266923002**
20-30 cigarettes or gram/day or equivalent - **266924008**
40+ cigarettes or gram/day or equivalent - **266925009**
Never smoked - **266919005**

Interventions

Smoking

Smoking cessation education (procedure) - **225323000**
Signposting to smoking cessation service (procedure) - **1084381000000100**
Referral to smoking cessation service (procedure) - **871661000000106**

Weight management

Patient advised about weight management (situation) - **698471002**
Signposting to weight management service (procedure) - **1083431000000109**
Referral to weight management service (procedure) - **1326201000000101**

Physical activity

Brief intervention for physical activity completed (situation) - **375031000000109**
Physical activity opportunity signposted (situation) - **526371000000102**

Alcohol consumption

Education about alcohol consumption (procedure) - **281078001**
Signposting to alcohol misuse service (procedure) - **1084171000000100**
Referral to alcohol misuse service (procedure) - **1099141000000106**