

# Time for Action on CVD Prevention

**Quality Improvement data pack for**

**NHS Leicester, Leicestershire and Rutland Integrated Care Board**

**An output from the CVDPREVENT audit using September 2024 data**

# Purpose of this pack

To provide ICBs with data and practical actions to improve achievement in single risk factors, reduce variation between practices, and facilitate peer support within the system.

This quality improvement pack will cover:

1. Hypertension monitoring
2. Hypertension treatment to target
3. Prescriptions of lipid lowering therapies in patients at risk of cardiovascular disease (CVD)
4. Lipid treatment to target in patients with CVD

\*QRISK score over 20% but no previous CVD diagnosis

## Time for Action

Across NHS Leicester, Leicestershire and Rutland Integrated Care Board at the end of September 2024



**20,880 people** with hypertension did not have a recent blood pressure reading



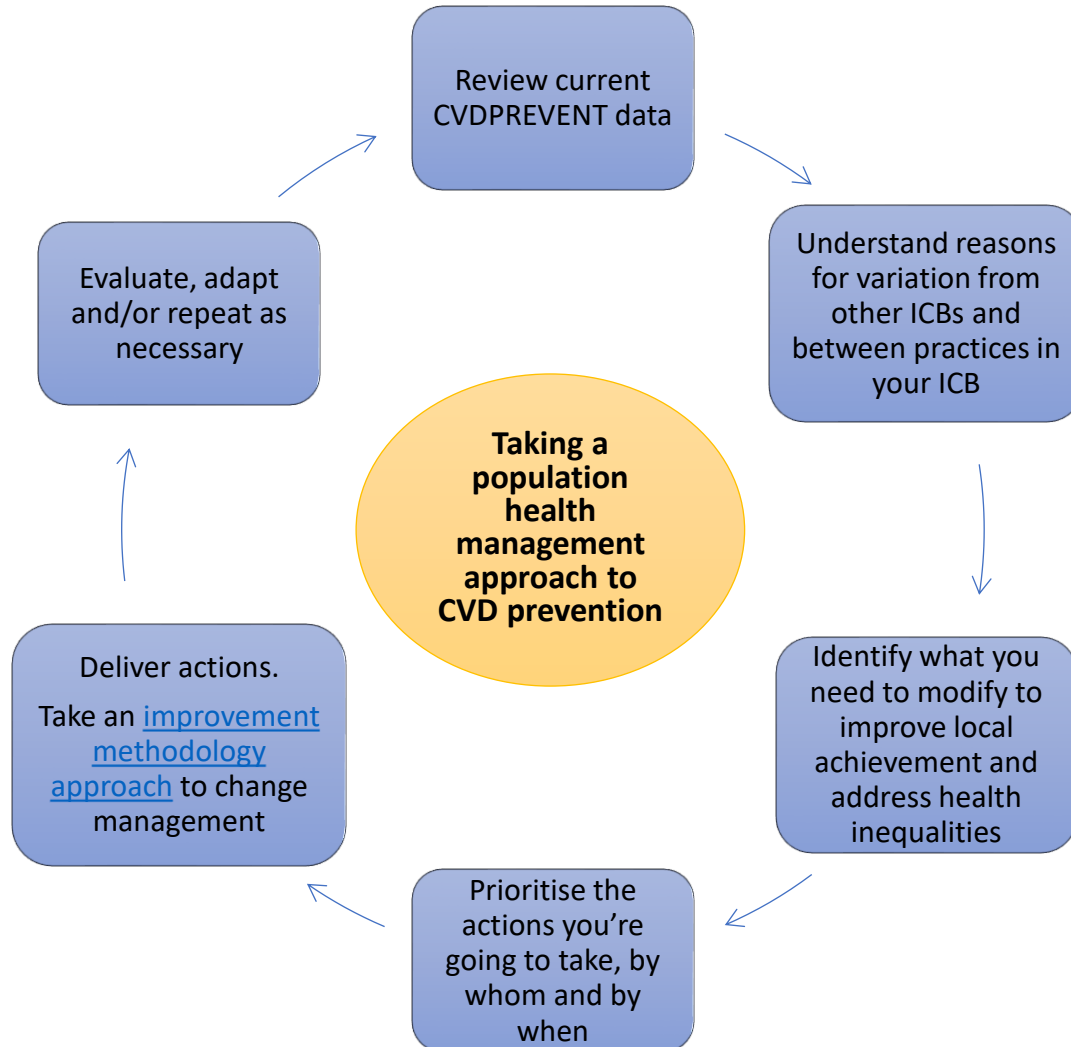
**59,755 people** with hypertension were not treated to the appropriate blood pressure threshold



**23,810 people** at a high risk of CVD\* did not have a current prescription for lipid lowering therapy

Using the [UCLPartners Size of the Prize](#) resources, it's estimated that treating an additional 22,991 hypertensive patients to threshold in NHS Leicester, Leicestershire and Rutland Integrated Care Board would prevent **138 heart attacks** and **206 strokes**, saving **110 lives** and **£3.9M**.

# Quality improvement in CVD prevention



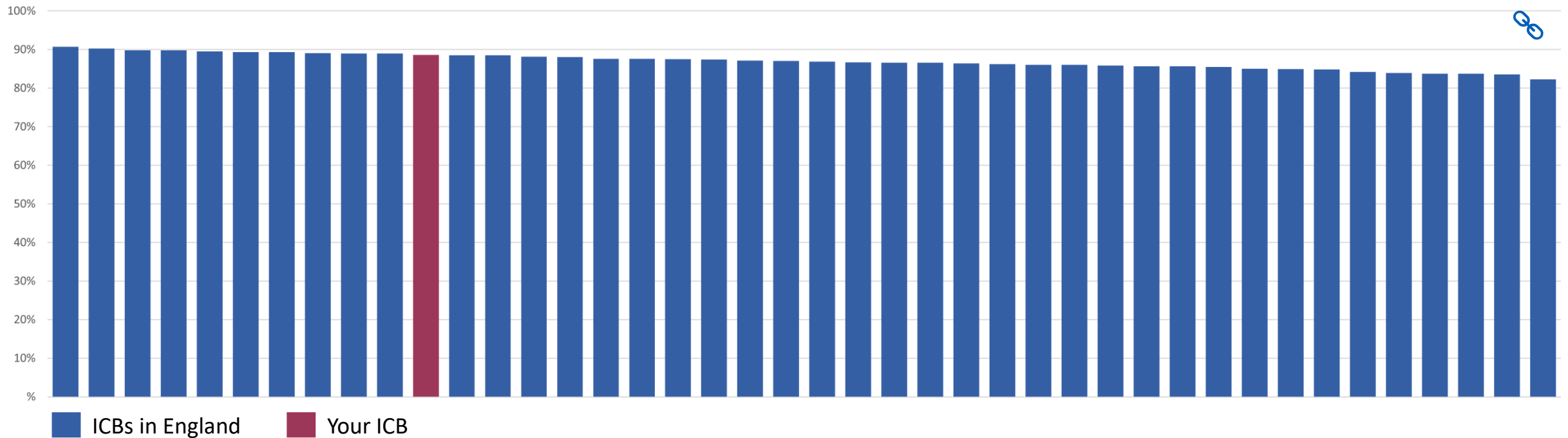
## Top tips to implement change for quality improvement

- **CVD clinical leadership** in ICBs and practices is key to facilitating continuous data-led quality improvement
- **Educational outreach** meetings provide protected and facilitated time to take a data-led approach. Outputs can range from simple actions to transformational change
- **Learning from local improvers** can highlight actions that could be relevant to your local context
- **Engagement with health innovation networks** and other relevant stakeholders is a crucial component of improvement and translating evidence into practice
- **Think equity-focused quality improvement** and prioritise reviews in people who are known to experience healthcare inequalities

# Hypertension – blood pressure monitoring

**CVDP004HYP:** Patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



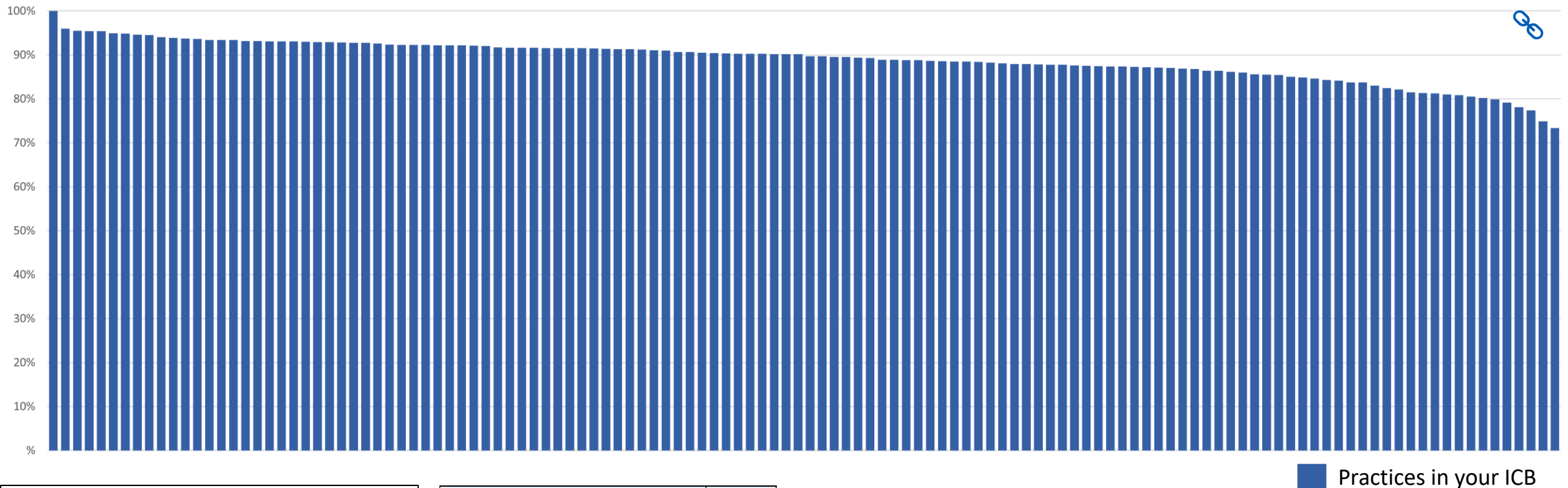
## Your ICB achievement benchmarked against all other ICBs in England

- NHS Leicester, Leicestershire and Rutland Integrated Care Board achievement (September 2024) = **89%**
- **20,880 people** aged 18 and over with GP recorded hypertension did not have a recent blood pressure reading within the preceding 12 months

# Hypertension – blood pressure monitoring

**CVDP004HYP:** Patients with GP recorded hypertension, with a record of a blood pressure reading in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the Tool and identify practices in your ICB



**Variation between practices in the ICB\***

73% – 100%

Top 5 practices - September 2024	%
Leicester City Assist Practice	100
The Uppingham Surgery	95.96
Highfields Medical Centre	95.46
The Anstey Surgery	95.4
Aylestone Health Centre	95.38

\*If the minimum value is missing, then there is a practice/s in the ICB that is participating in the audit but does not have a value for this indicator

# Hypertension – blood pressure monitoring

## Key actions to improve



- 1) **SEARCH** your GP clinical system for hypertensive patients without a BP reading in the preceding 12 months
  - Explore population health management tools that may be available within your ICB
  - Other pre-written electronic searches & tools are also available to help with risk stratification and prioritisation



- 2) **COMMUNICATE** with patients via batch text message, individual text message, phone call or letter
  - Prioritise patients where there are known healthcare inequalities in BP monitoring (e.g., working age males; black or mixed ethnicity)
  - Ask for a BP reading, for example:
    - An average home BP reading, where patients have access to a validated home BP monitor less than 5 years old (see [list of NHS recommended home BP monitors](#))
    - A BP reading taken in a local pharmacy participating in the NHS Community Pharmacy BP Check Service
    - A BP reading in the GP surgery



- 3) **AGREE** a process for managing BP readings received by the GP surgery, including recording on the GP IT system and actioning results
  - Some IT tools allow automated entry of BP readings on to the patient record
  - Agree a protocol for non responders that is reviewed for clinical safety

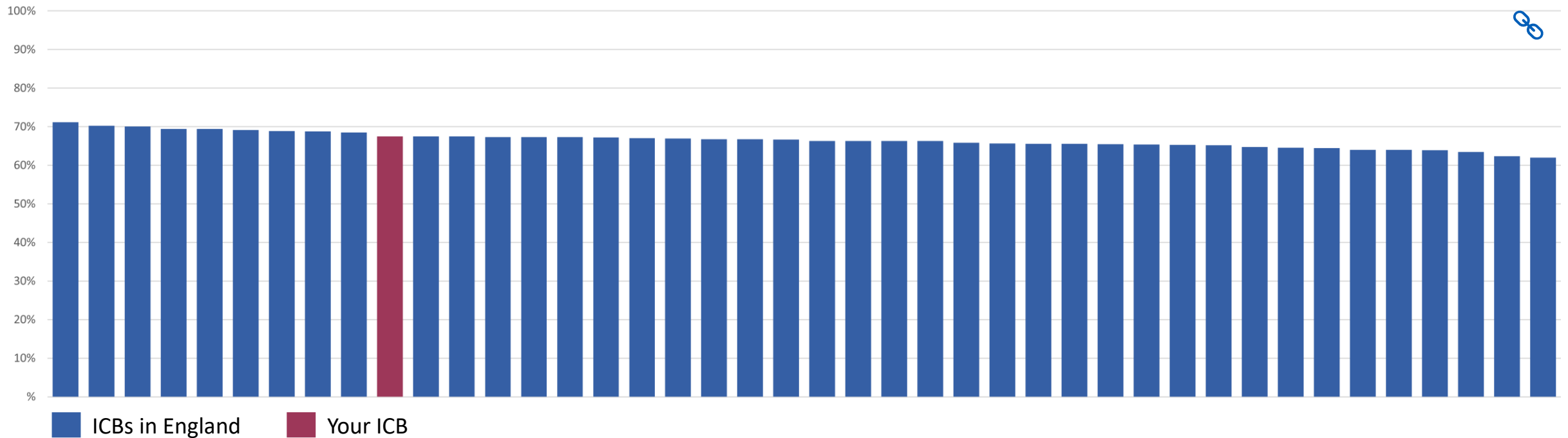


- 4) **ENSURE** call and recall for BP checks, at least annually

# Hypertension – treatment to target

**CVDP007HYP:** Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



## Your ICB achievement benchmarked against all other ICBs in England

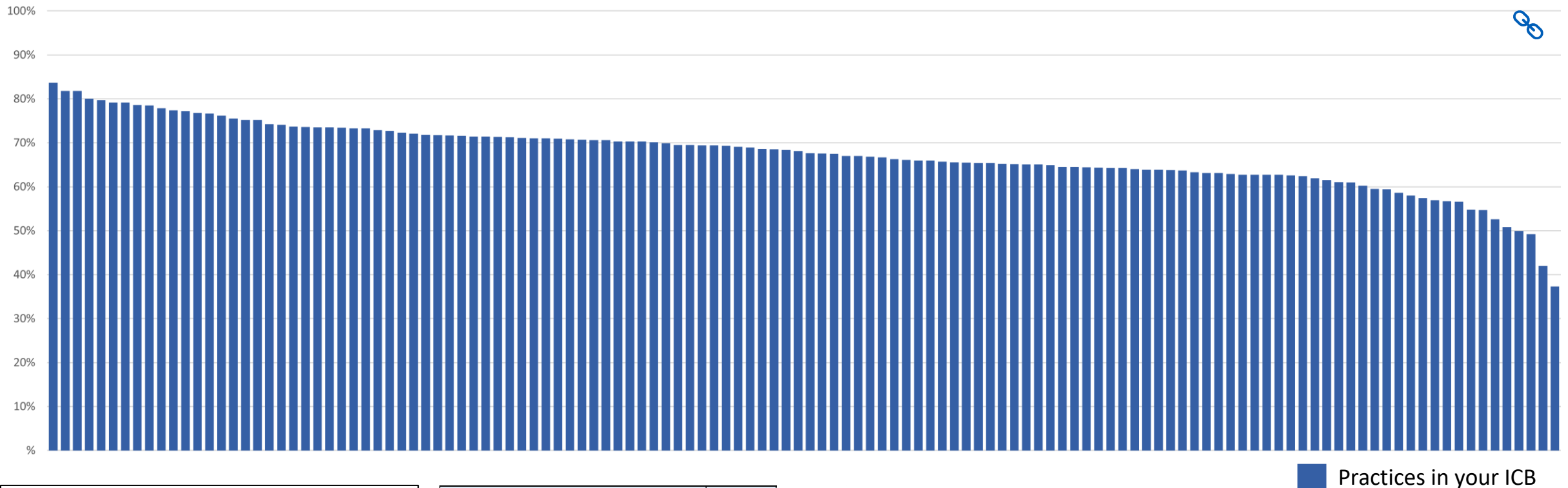
- NHS Leicester, Leicestershire and Rutland Integrated Care Board achievement (September 2024) = **67% (national ambition 80%\*)**
- In your ICB at least **22,991 people** with known hypertension need to be treated to meet the national ambition

\*[NHS Priorities and Operational Planning Guidance 2024/25](#)

# Hypertension – treatment to target

**CVDP007HYP:** Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the Tool and identify practices in your ICB



**Variation between practices in the ICB\***  
 37% – 84%

Top 5 practices - September 2024	%
Brandon Surgery Dr R Kapur & Partner	83.7
Aylestone Health Centre	81.85
Dr R Kapur & Partners	81.78
Husbands Bosworth Medical Centre	80.02
St Peter's Med Centre (Mansingh & Meh)	79.74

\*If the minimum value is missing, then there is a practice/s in the ICB that is participating in the audit but does not have a value for this indicator

# Hypertension – treatment to target

## Key actions to improve



- 1) **SEARCH** your GP clinical system for hypertensive patients whose last BP is above the age-appropriate treatment threshold.
  - Patients may show as ‘not treated to target’ because their last BP reading was more than 12 months ago (see CVDP004HYP indicator). To rectify, follow the steps outlined in slide 6



- 2) **REVIEW** patients
  - [Risk-stratify and prioritise](#) patients with BPs further from target, according to CVD risk, and where there are known healthcare inequalities in BP management (e.g., working age males; black or mixed ethnicity)
  - Explore population health management tools that may be available within your ICB. Other pre-written electronic searches & tools (some free to NHS users) are also available to help with risk stratification and prioritisation
  - Consider utilising practice Additional Roles Reimbursement Scheme (ARRS) pharmacy workforce or other appropriately trained staff to gather information (up to date bloods, BP, weight, smoking status, run QRISK score), to encourage behaviour change and signpost to other information or services



- 3) **OPTIMISE** anti-hypertensive therapy and CVD risk reduction in line with [NICE](#) guidance
  - Review blood results, risk scores and symptoms
  - Review complications and co-morbidities
  - Assess CVD risk – optimise lipid management and other risk factors
  - Encourage self management and care of hypertension through patient education
  - Explore medicines taking behaviour and any barriers to adherence, including adverse effects
  - Initiate or optimise blood pressure medication; many people will require more than one antihypertensive

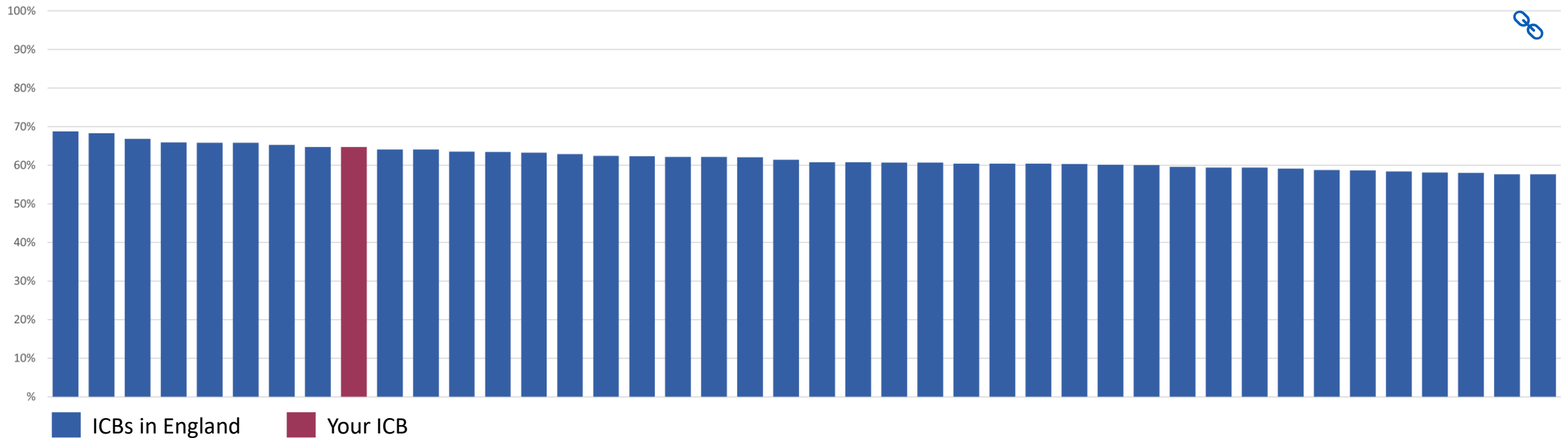


- 4) **ENSURE** call and recall for BP checks, at least annually

# Cholesterol – primary prevention of CVD

**CVDP003CHOL:** Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy.

Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



## Your ICB achievement benchmarked against all other ICBs in England

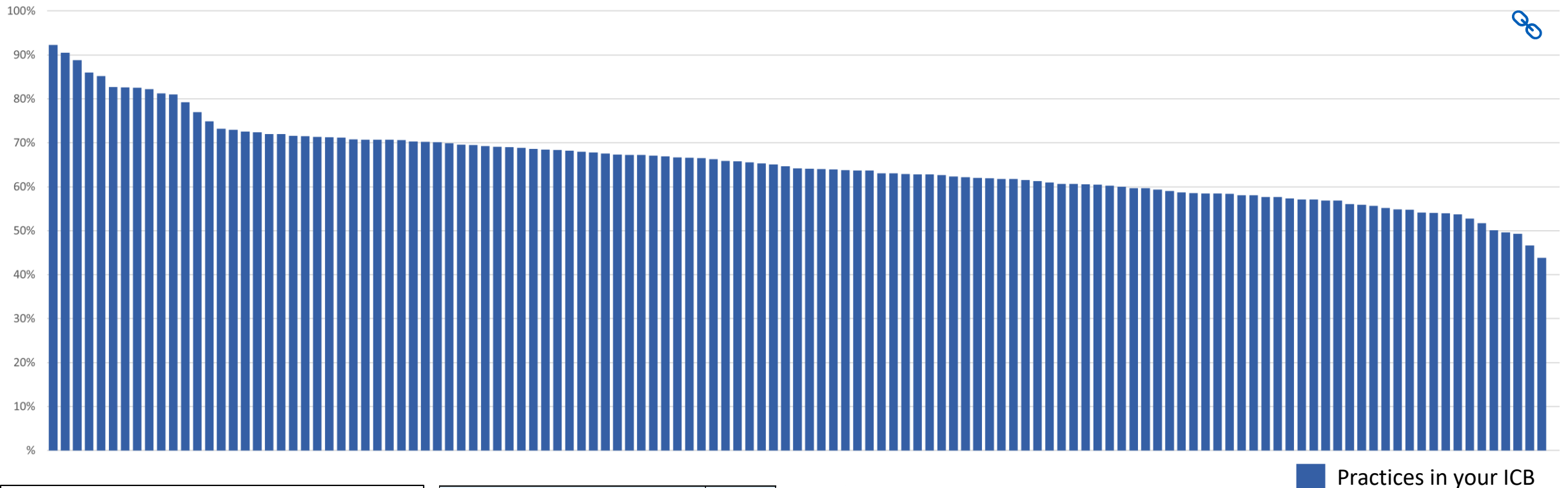
- NHS Leicester, Leicestershire and Rutland Integrated Care Board achievement (September 2024) = **65% (national ambition 65%\*)**
- In your ICB at least **170 people** at high risk of a cardiovascular event would need to be treated with lipid lowering therapy to meet the national ambition

\*[NHS Priorities and Operational Planning Guidance 2024/25](#)

# Cholesterol – primary prevention of CVD

**CVDP003CHOL:** Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy.

Click on the link icon in the top right corner to view this chart on the Tool and identify practices in your ICB



**Variation between practices in the ICB\***  
 % – 92%

Top 5 practices - September 2024	%
Dr R Kapur & Partners	92.31
Narborough Road Surgery	90.51
Brandon Surgery Dr R Kapur & Partner	88.78
Cossington Park Surgery	86.02
Al-Waqas Medical Centre	85.2

\*If the minimum value is missing, then there is a practice/s in the ICB that is participating in the audit but does not have a value for this indicator

# Cholesterol – primary prevention of CVD

## Key actions to improve



- 1) **SEARCH** your GP clinical system for patients at very high risk of CVD (QRISK > 20%) who are not prescribed a lipid lowering therapy
  - [Prioritise patients at greatest risk](#) and where there are known healthcare inequalities in lipid treatment (e.g., females, black and mixed ethnicity)
  - Explore population health management tools that may be available within your ICB. Other pre-written electronic searches & tools (some free to NHS users) are also available to help with risk stratification and prioritisation



- 2) **COMMUNICATE** with patients through batch text messaging, individual text message, phone call or letter
  - Consider making initial contact via a Pharmacy Technician, Healthcare Assistant, Social Prescriber or other team member with appropriate training
  - Update relevant clinical information and support education, self-management and lifestyle change
  - This approach will help to save clinician time while increasing the quality and quantity of personalised care for patients
  - Agree a protocol for non responders that is reviewed for clinical safety



- 3) **REVIEW** patients in accordance with the [Lipid Management Pathway](#) (primary prevention green section)



- 4) **OPTIMISE** therapy to achieve desired cholesterol-lowering outcomes
  - Provide annual medication reviews for people taking statins to discuss effectiveness of therapy, medicines adherence, lifestyle modification and address CVD risk factors

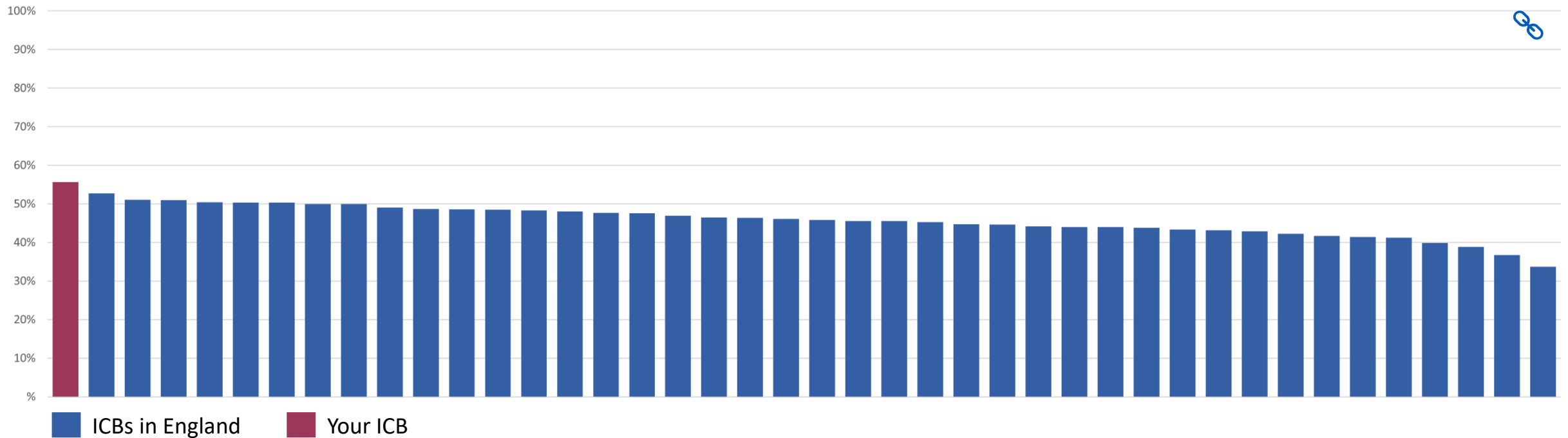


- 5) **ENSURE** appropriate call and recall processes are in place, at least annually

# Cholesterol – treatment to target in patients with CVD

**CVDP012CHOL:** Patients with GP recorded CVD (narrow definition), whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the CVDPREVENT Data & Improvement Tool



## Your ICB achievement benchmarked against all other ICBs in England

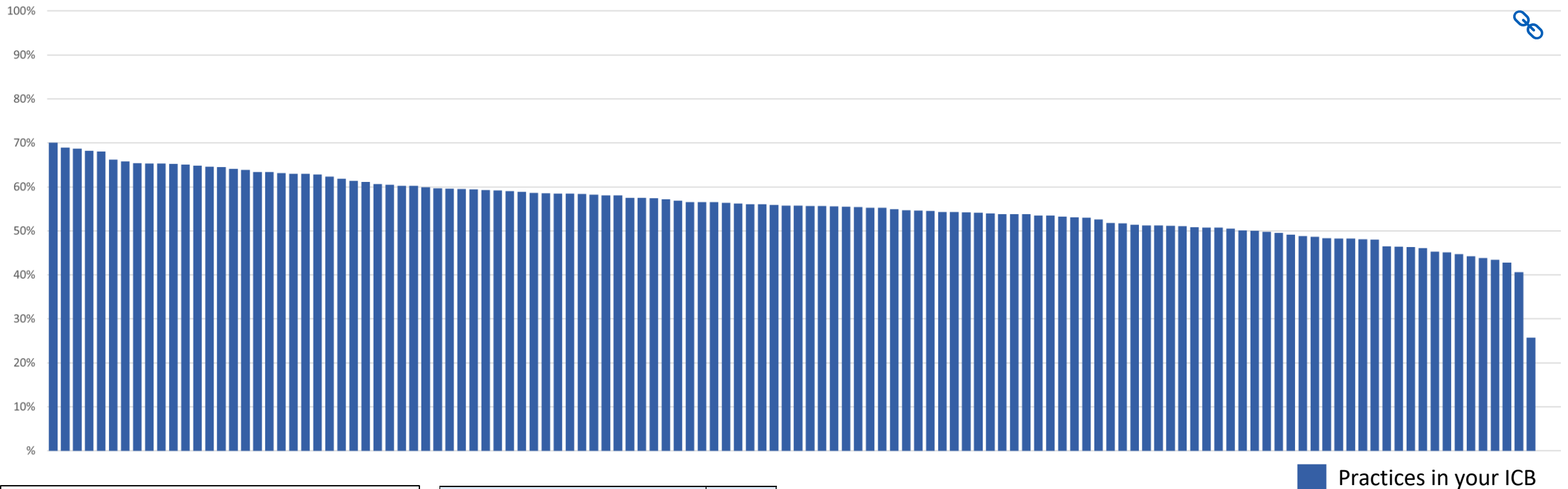
- NHS Leicester, Leicestershire and Rutland Integrated Care Board achievement (September 2024) = **56%**
- At least **23,085 people** with known CVD have not achieved recommended lipid-lowering levels

# Cholesterol – treatment to target in patients with CVD



**CVDP012CHOL:** Patients with GP recorded CVD (narrow definition), whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months.

Click on the link icon in the top right corner to view this chart on the Tool and identify practices in your ICB



Variation between practices in the ICB\*

% – 70%

Top 5 practices - September 2024	%
Brandon Surgery Dr R Kapur & Partner	70.05
Walnut St Med Ctr	68.91
Broadhurst St Med Pract (Ks Morjaria)	68.66
Highfields Surgery (R Wadhwa)	68.25
Cossington Park Surgery	68.09

\*If the minimum value is missing, then there is a practice/s in the ICB that is participating in the audit but does not have a value for this indicator

# Cholesterol – treatment to target in patients with CVD

## Key actions to improve



- 1) **SEARCH** your GP clinical system(s) for patients for patients with established atherosclerotic CVD whose cholesterol is not managed to target (aim for an LDL-C of  $\leq 2.0$  mmol/L, or non-HDL-C of  $\leq 2.6$  mmol/L)
  - [Prioritise patients at greatest risk](#) and where there are known lipid treatment healthcare inequalities (e.g., females; black and mixed ethnicity)
  - Explore population health management tools that may be available within your ICB. Other pre-written electronic searches & tools (some free to NHS users) are also available to help with risk stratification and prioritisation



- 2) **COMMUNICATE** with patients through batch text messaging, individual text message, phone call or letter
  - Agree a protocol for non responders that is reviewed for clinical safety



- 3) **REVIEW** patients in accordance with [Lipid Management Pathway](#) (secondary prevention **red** section).



- 4) **OPTIMISE** therapy to achieve and maintain target lipid levels
  - Initiate high dose high intensity statin; support shared decision making and address statin hesitancy
  - After 3 months check non-HDL-C; if  $\geq 2.6$  mmol/L, discuss options for second line therapies



- 5) **ENSURE** appropriate call and recall processes are in place, at least annually

To investigate the CVDPREVENT indicators further visit the Data & Improvement Tool at <https://www.cvdprevent.nhs.uk/>

If you have any queries, please contact the CVDPREVENT Support Team via: [nhsbn.cvdprevent@nhs.net](mailto:nhsbn.cvdprevent@nhs.net)

The CVDPREVENT Audit is funded by NHS England via the Healthcare Quality Improvement Partnership (HQIP).