Time for Action on CVD Prevention

Quality Improvement data pack for

NHS Coventry and Warwickshire Integrated Care Board

An output from the CVDPREVENT audit using December 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 Coventry and Warwickshire Integrated Care Board at the end of December 2024

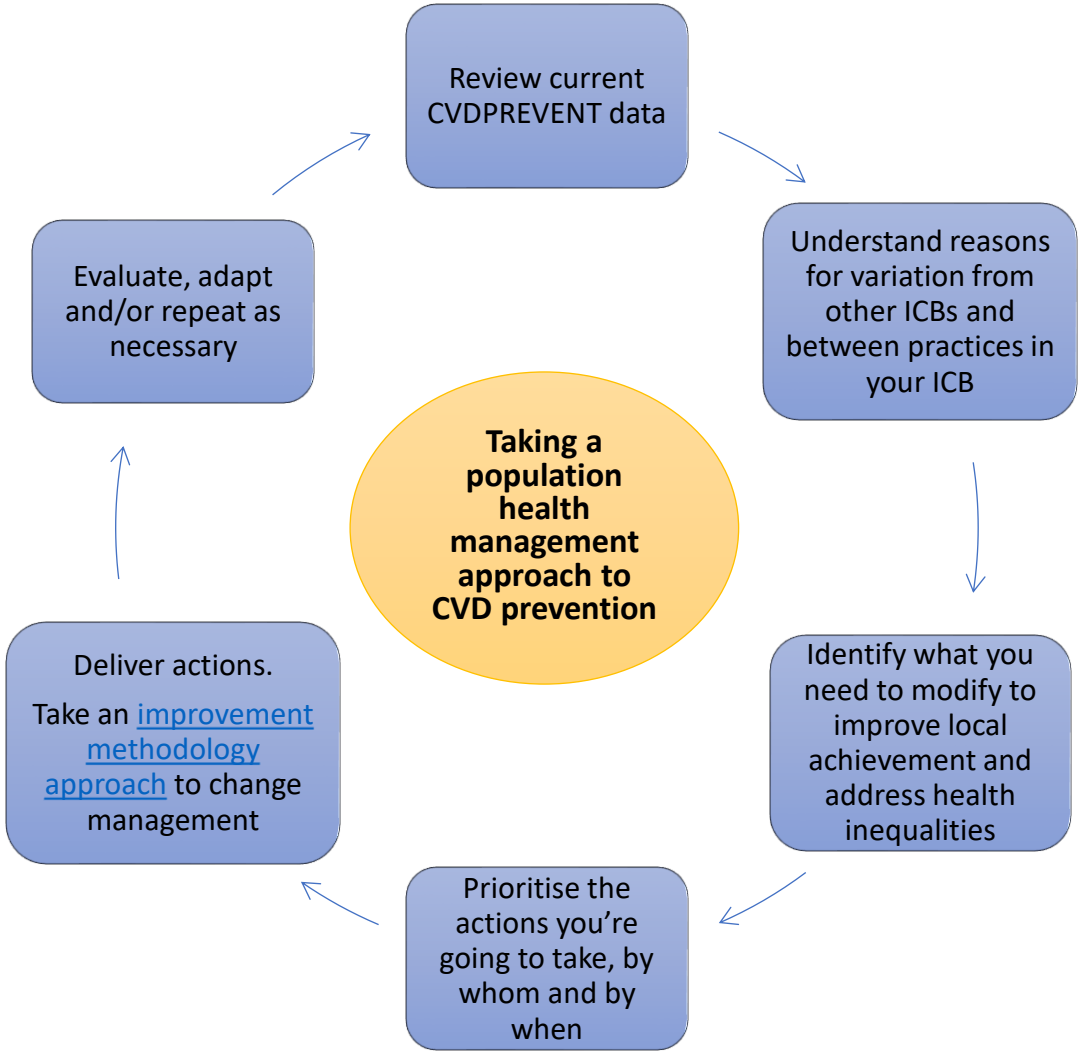
21,730 people with hypertension did not have a recent blood pressure reading

53,220 people with hypertension were not treated to the appropriate blood pressure threshold

18,300 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 21,414 hypertensive patients to threshold in NHS Coventry and Warwickshire Integrated Care Board would prevent **128 heart attacks** and **192 strokes**, saving **103 lives** and **£3.6M.**

Quality improvement in CVD prevention



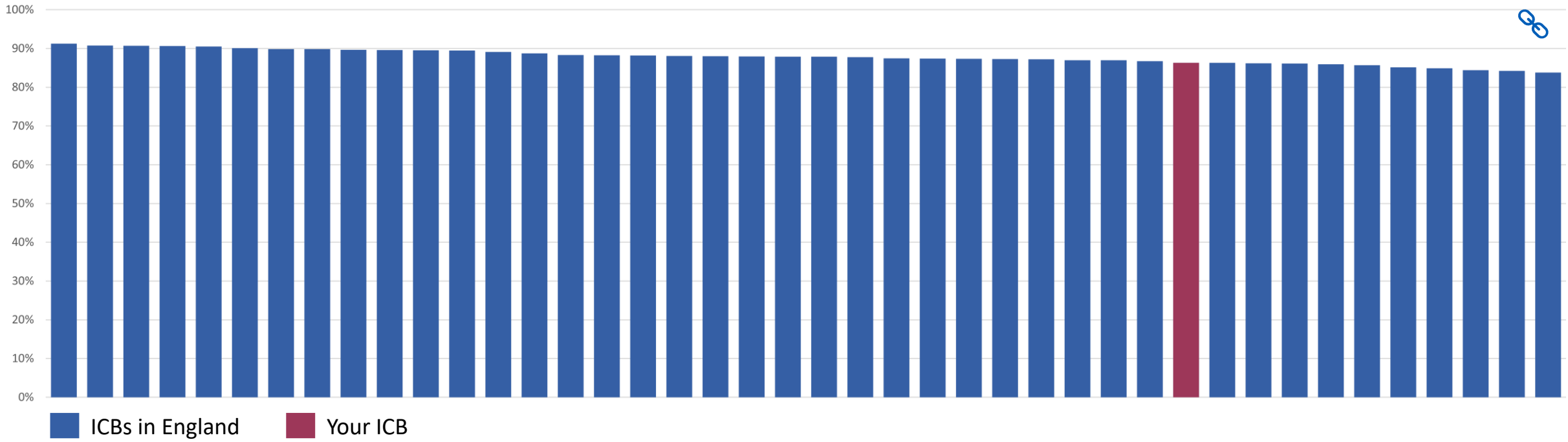
Top tips to implement change for quality improvement

- **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



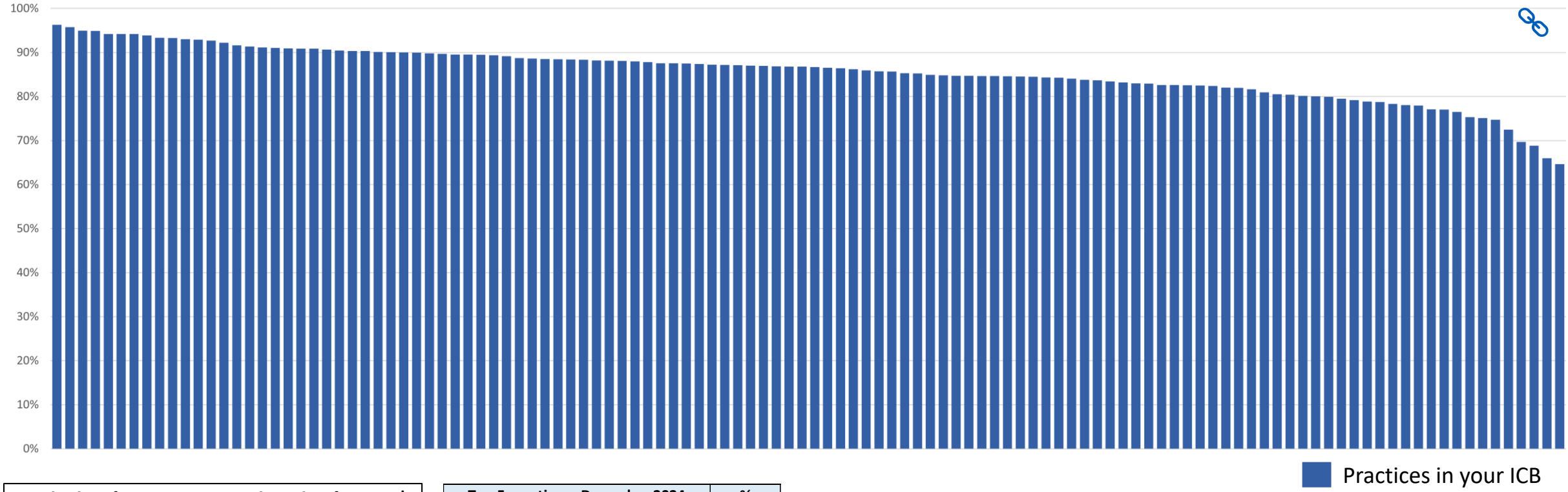
Your ICB achievement benchmarked against all other ICBs in England

- NHS Coventry and Warwickshire Integrated Care Board achievement (December 2024) = **86%**
- **21,730 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*		
65%	–	96%

Top 5 practices - December 2024	%
The Forum Health Centre	96.29
Castle Medical Centre	95.75
St Wulfstan Surgery	94.93
Torcross Medical Centre	94.88
Westwood Medical H/Centre	94.19

*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

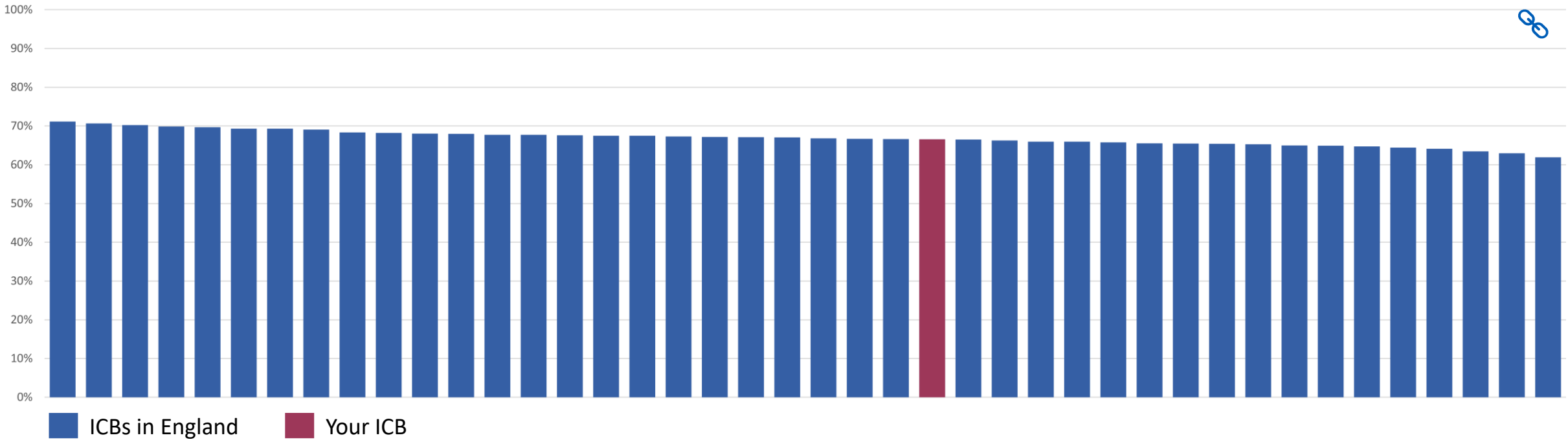
3) **AGREE** a process for managing BP readings received by the GP surgery, including recording on the GP IT system and actioning results
   - Some IT tools allow automated entry of BP readings on to the patient record
   - Agree a protocol for non responders that is reviewed for clinical safety

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

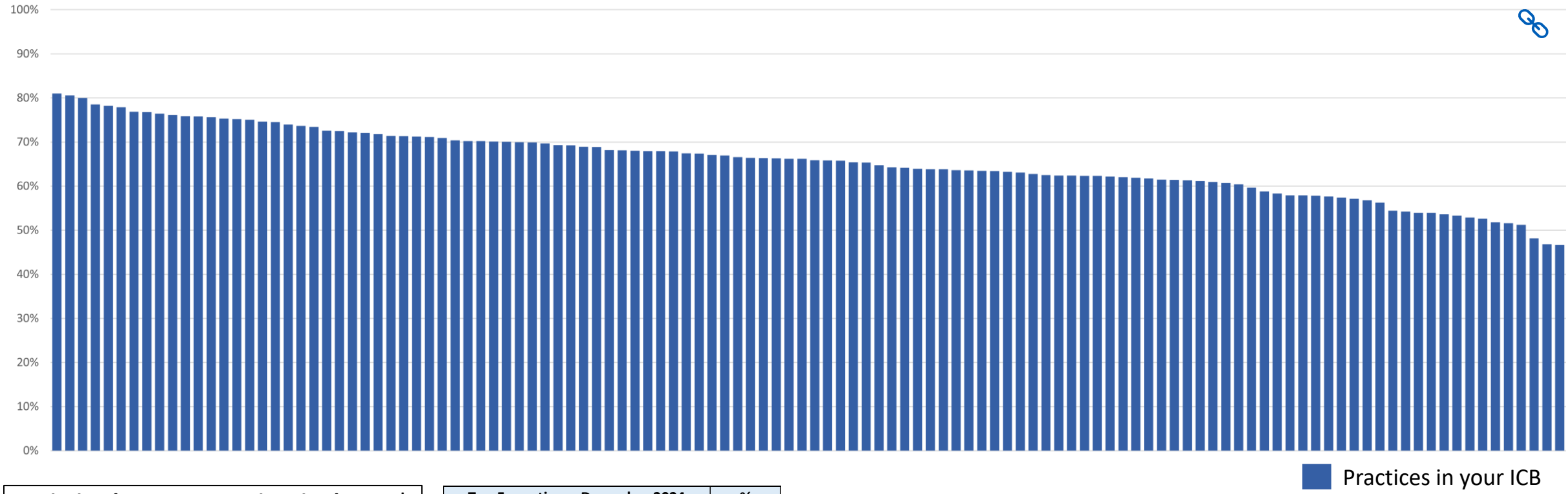
- NHS Coventry and Warwickshire Integrated Care Board achievement (December 2024) = **67% (national ambition 80%*)**
- In your ICB at least **21,414 people** with known hypertension need to be treated to meet the national ambition

*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*

47% – 81%

Top 5 practices - December 2024	%
Torcross Medical Centre	81.02
Walsgrave Health Centre	80.59
Phoenix Family Care	79.98
RIVERSLEY ROAD SURGERY	78.53
Fenny Compton Surgery	78.21

*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

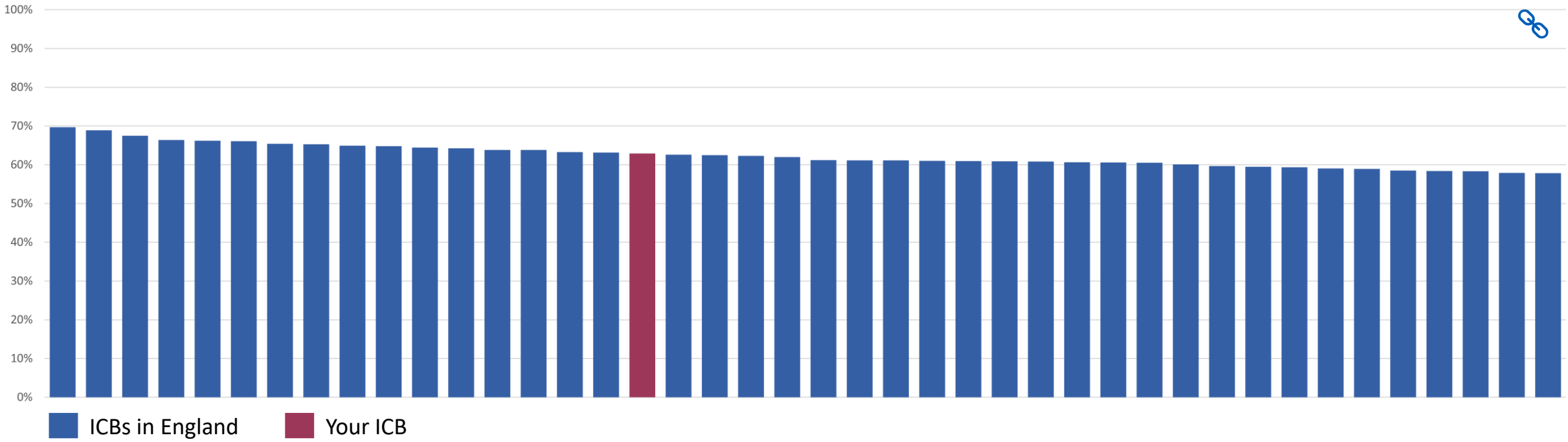
3) **OPTIMISE** anti-hypertensive therapy and CVD risk reduction in line with NICE guidance
   - Review blood results, risk scores and symptoms
   - Review complications and co-morbidities
   - Assess CVD risk – optimise lipid management and other risk factors
   - Encourage self management and care 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

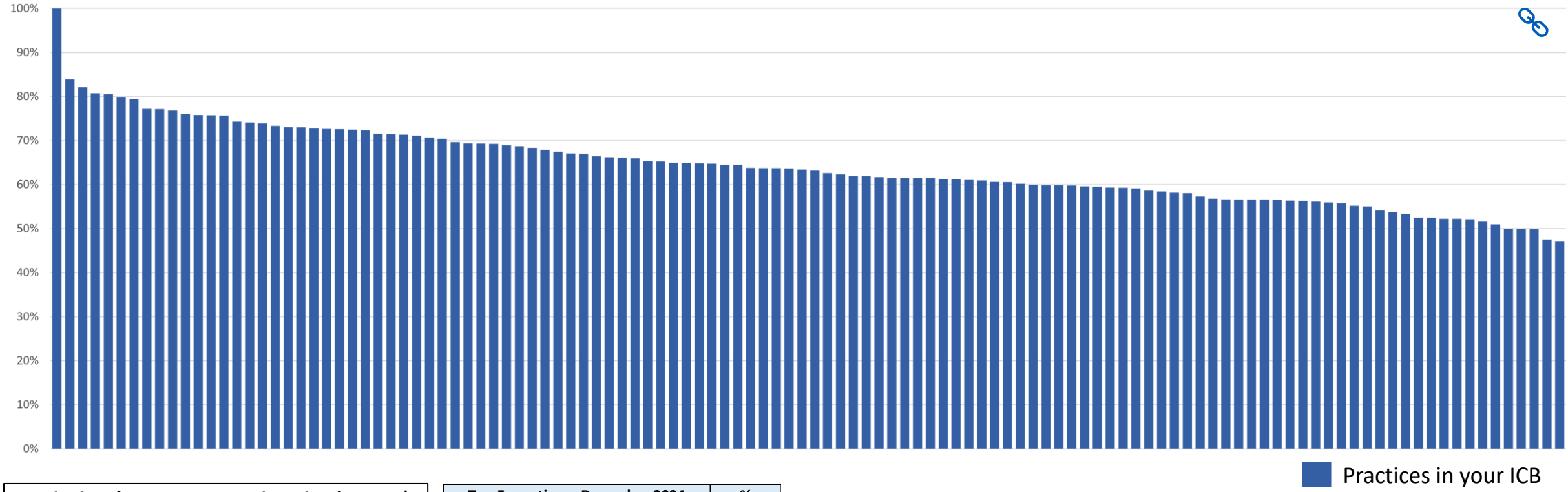
- NHS Coventry and Warwickshire Integrated Care Board achievement (December 2024) = **63% (national ambition 65%*)**
- In your ICB at least **1,049 people** at high risk of a cardiovascular event would need to be treated with lipid lowering therapy to meet the national ambition

*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*		
47%	–	100%

Top 5 practices - December 2024	%
Meridian Practice	100
Stockingford Medical Centre	83.89
Stoke Aldermoor Med Ctre	82.14
Edgwick Medical Centre	80.74
LONGFORD PRIMARY CARE CENTRE	80.55

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Cholesterol – primary prevention of CVD

CVDPREVENT

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)

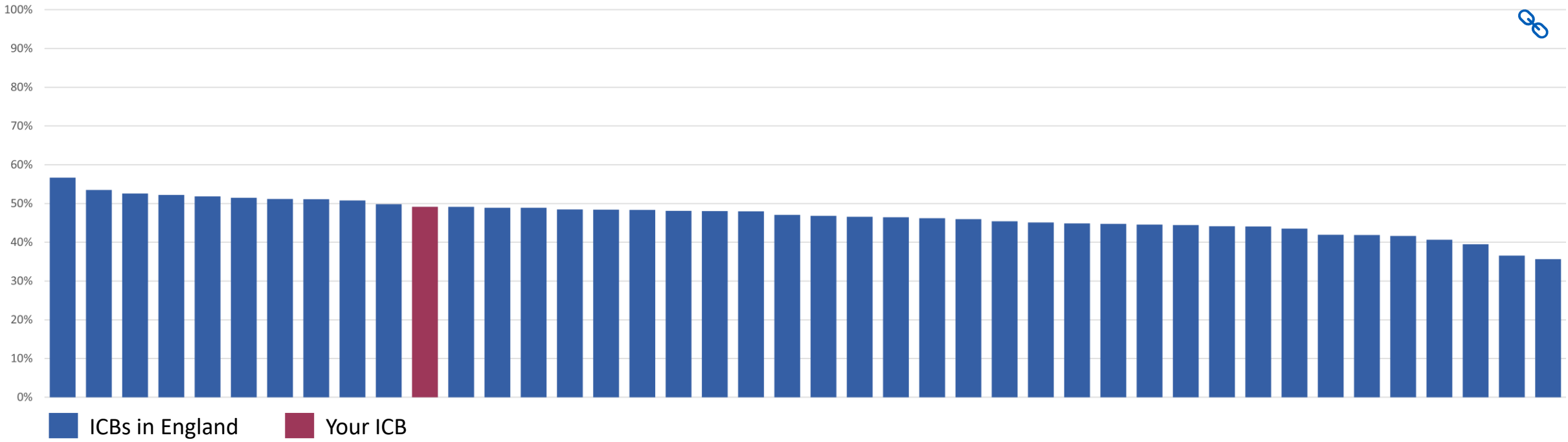
4) **OPTIMISE** therapy to achieve desired cholesterol-lowering outcomes
   - Provide annual medication reviews for people taking statins to discuss effectiveness of therapy, medicines adherence, lifestyle modification and address CVD risk factors

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



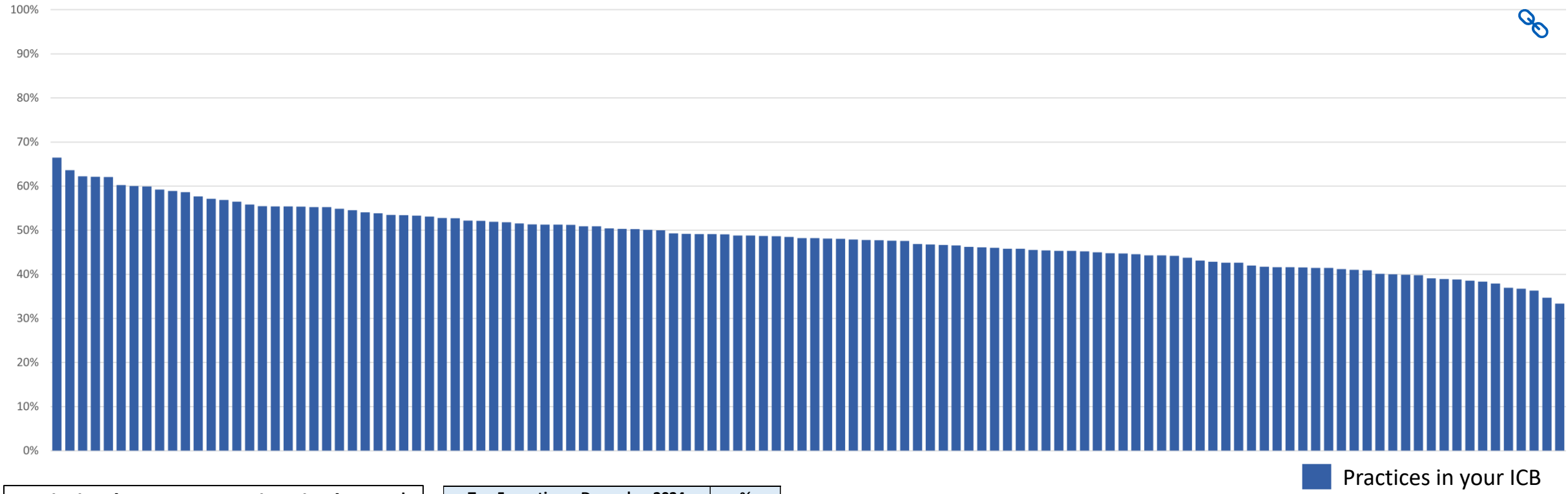
Your ICB achievement benchmarked against all other ICBs in England

- NHS Coventry and Warwickshire Integrated Care Board achievement (December 2024) = **49%**
- At least **22,750 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*		
33%	–	66%

Top 5 practices - December 2024	%
Westwood Medical H/Centre	66.48
WOLSTON SURGERY	63.59
Woodlands Surgery	62.24
Harbury Surgery	62.14
The Grange Medical Centre	62.04

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Cholesterol – treatment to target in patients with CVD

CVDPREVENT

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 ≤ 2.0 mmol/L, or non-HDL-C of ≤ 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 ≥2.6mmol/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

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