Time for Action on CVD Prevention

Quality Improvement data pack for

NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

An output from the CVDPREVENT audit using June 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 Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board at the end of June 2024

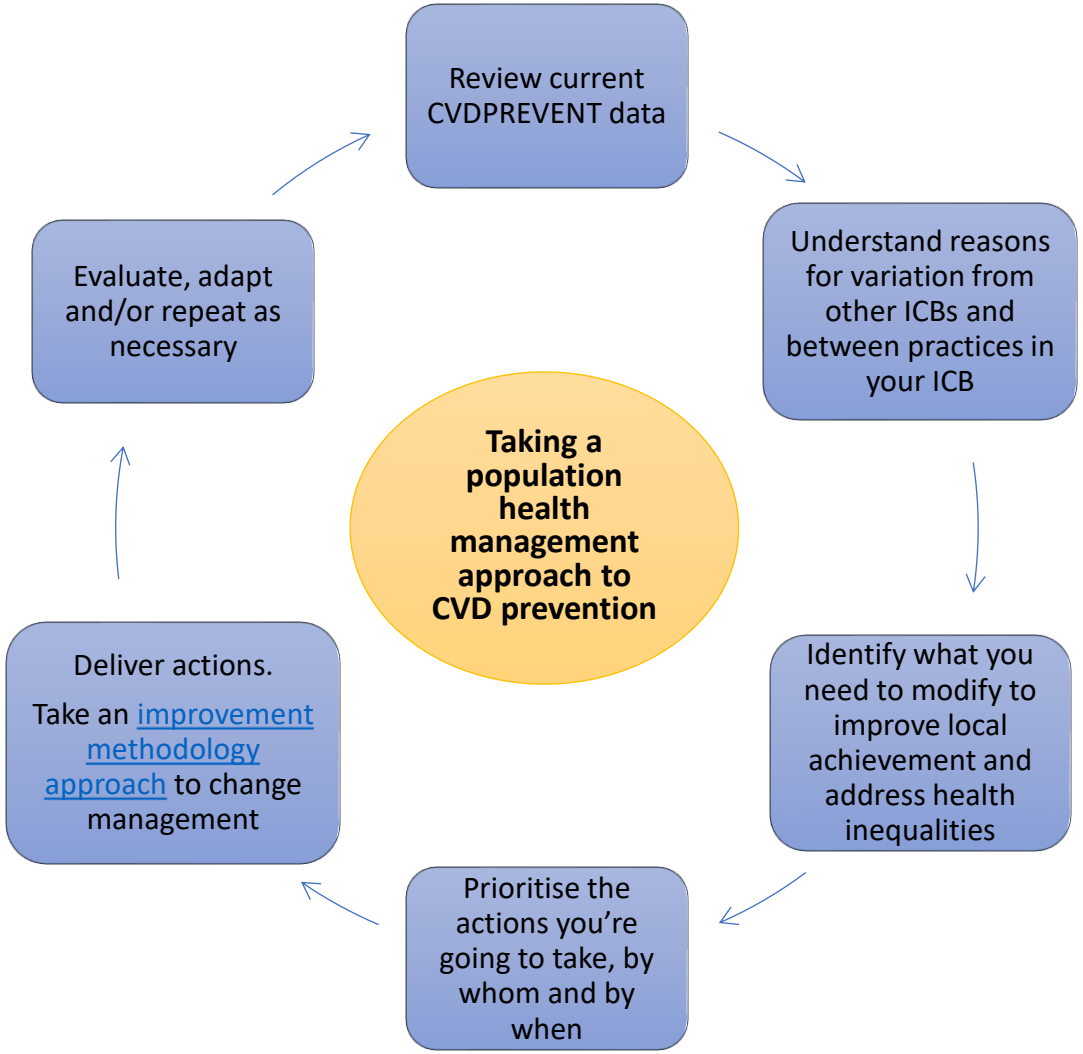
36,050 people with hypertension did not have a recent blood pressure reading

88,860 people with hypertension were not treated to the appropriate blood pressure threshold

35,180 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 37,807 hypertensive patients to threshold in NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board would prevent **227 heart attacks** and **339 strokes**, saving **181 lives** and **£6.4M.**

Quality improvement in CVD prevention



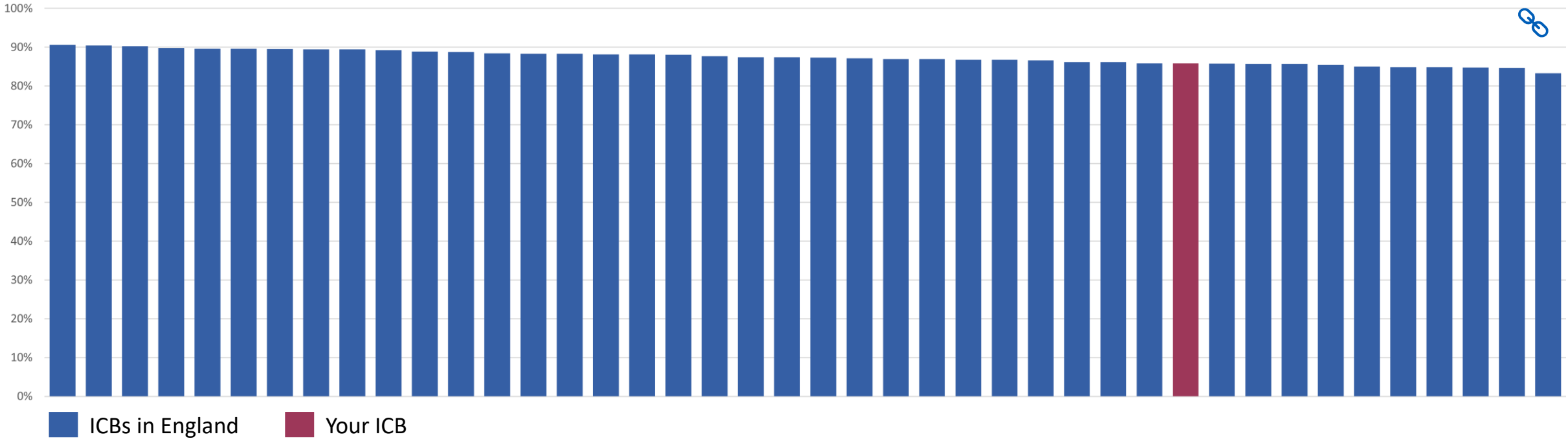
Top tips to implement change for quality improvement

- **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



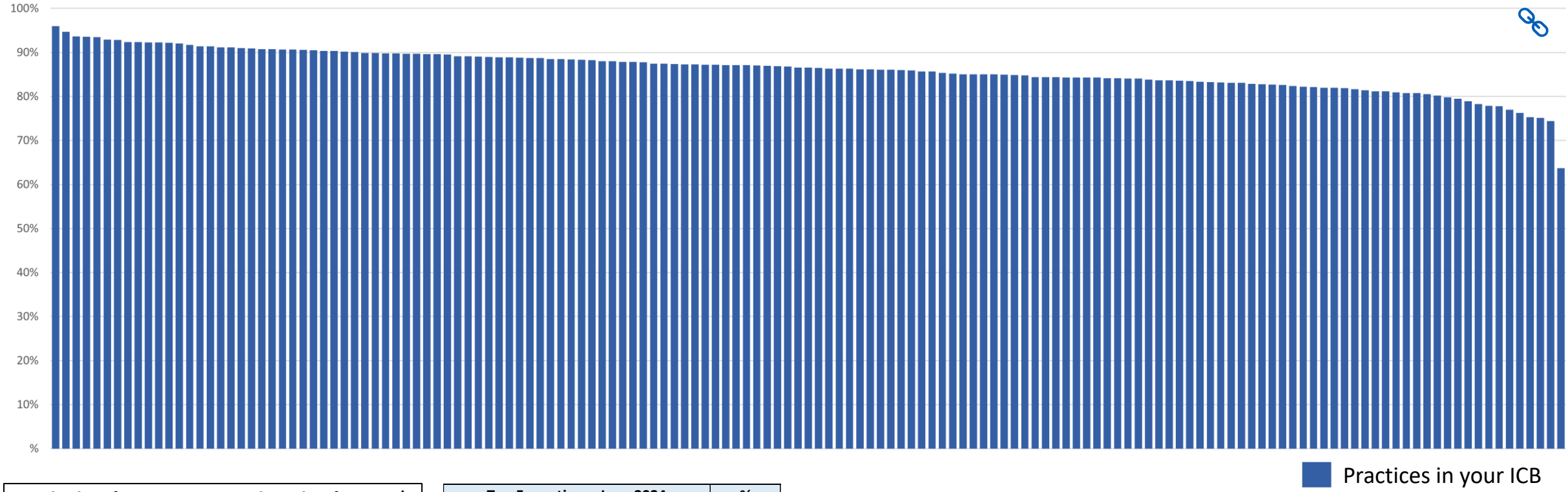
Your ICB achievement benchmarked against all other ICBs in England

- NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board achievement (June 2024) = **86%**
- **36,050 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*		
64%	–	96%

Top 5 practices - June 2024	%
Gladstone Road Surgery	96.01
The Rycote Practice	94.71
Abbey Medical Centre	93.61
Hungerford Surgery	93.6
Westwood Road Surgery	93.48

*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

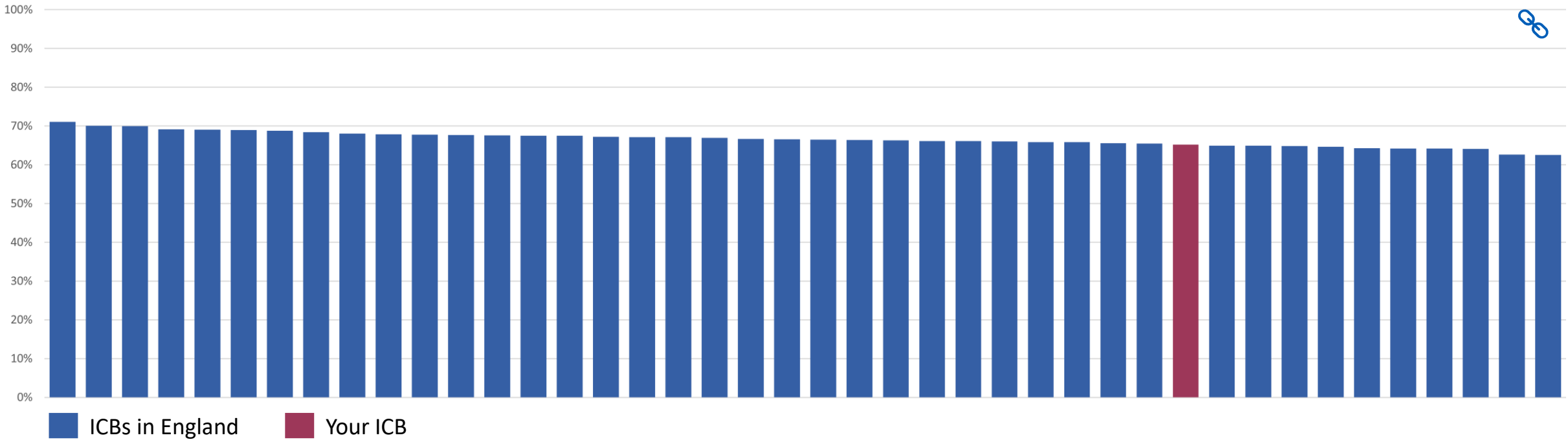
3) **AGREE** a process for managing BP readings received by the GP surgery, including recording on the GP IT system and actioning results
   - Some IT tools allow automated entry of BP readings on to the patient record
   - Agree a protocol for non responders that is reviewed for clinical safety

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

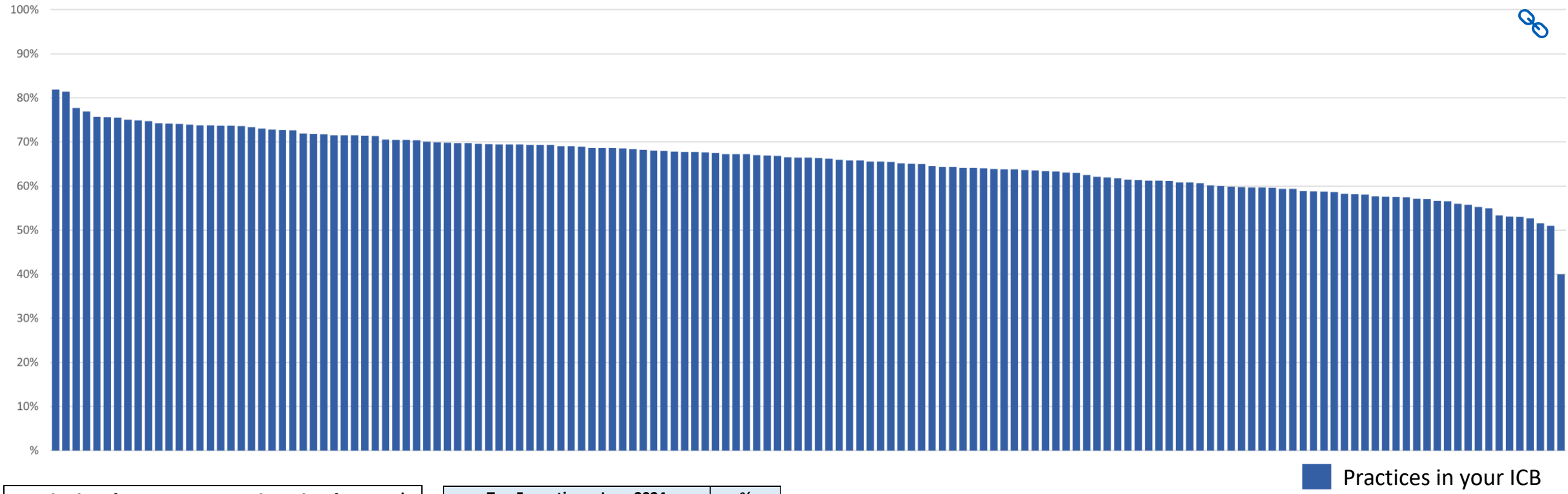
- NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board achievement (June 2024) = **65% (national ambition 80%*)**
- In your ICB at least **37,807 people** with known hypertension need to be treated to meet the national ambition

*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*

40% – 82%

Top 5 practices - June 2024	%
Stokenchurch Medical Ctre	81.86
BURFORD SURGERY	81.43
The Rycote Practice	77.69
Mortimer Surgery	76.89
Morland House Surgery	75.71

*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

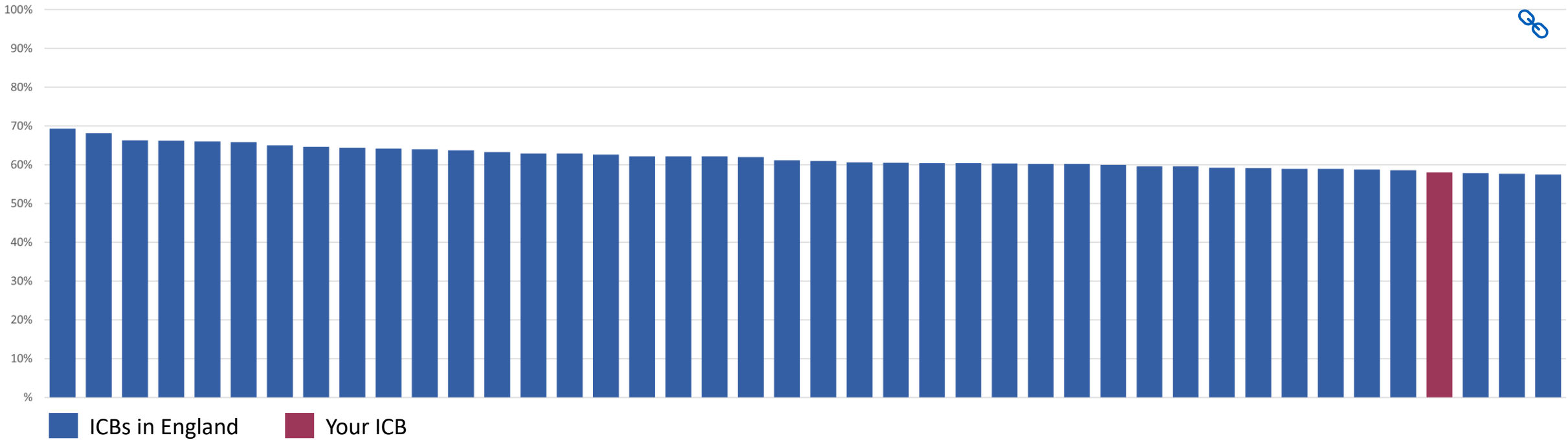
3) **OPTIMISE** anti-hypertensive therapy and CVD risk reduction in line with NICE guidance
   - Review blood results, risk scores and symptoms
   - Review complications and co-morbidities
   - Assess CVD risk – optimise lipid management and other risk factors
   - Encourage self management and care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

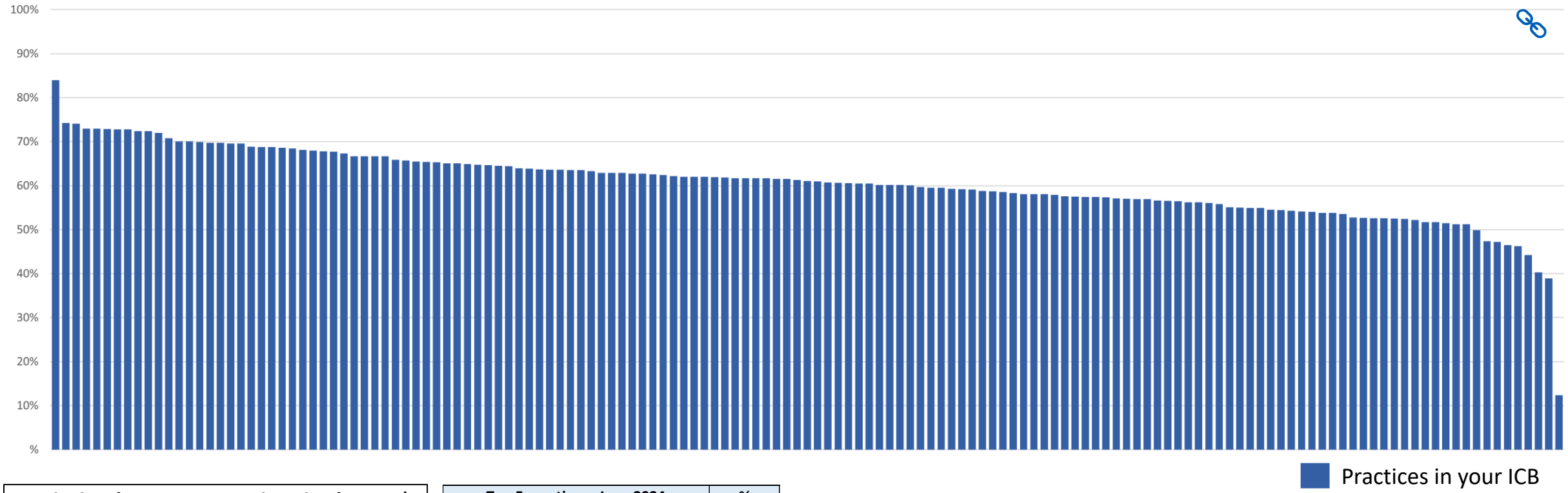
- NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board achievement (June 2024) = **58% (national ambition 65%*)**
- In your ICB at least **5,857 people** at high risk of a cardiovascular event would need to be treated with lipid lowering therapy to meet the national ambition

*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*		
12%	–	84%

Top 5 practices - June 2024	%
Abbey Medical Centre	83.95
Malthouse Surgery	74.25
Chatham Street Surgery	74.12
Woosehill Practice	72.98
Broadshires Health Centre	72.96

*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)

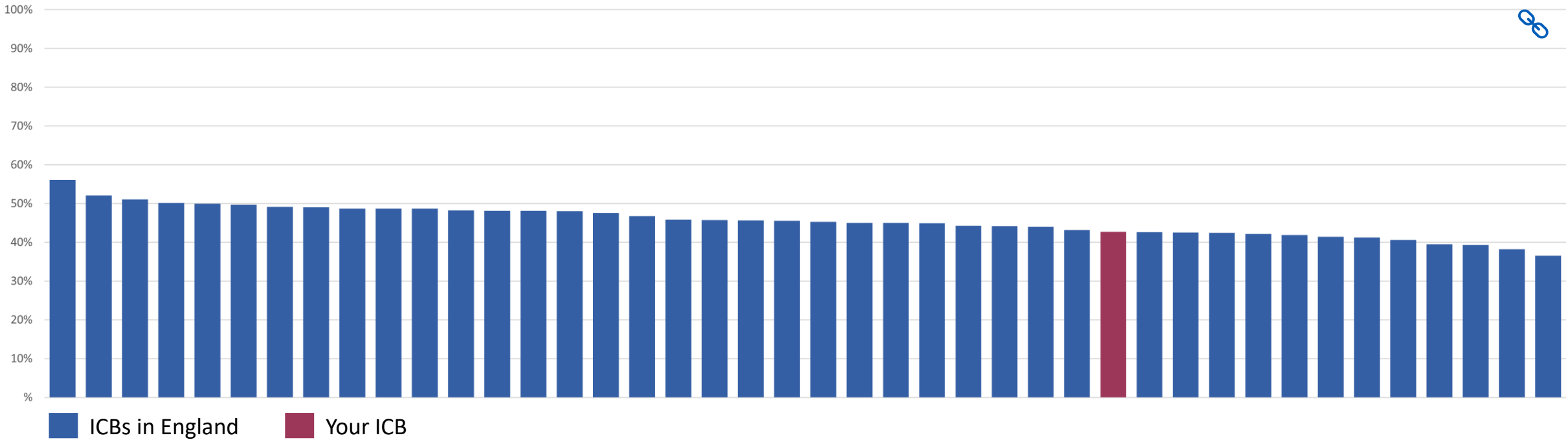
4) **OPTIMISE** therapy to achieve desired cholesterol-lowering outcomes
   - Provide annual medication reviews for people taking statins to discuss effectiveness of therapy, medicines adherence, lifestyle modification and address CVD risk factors

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



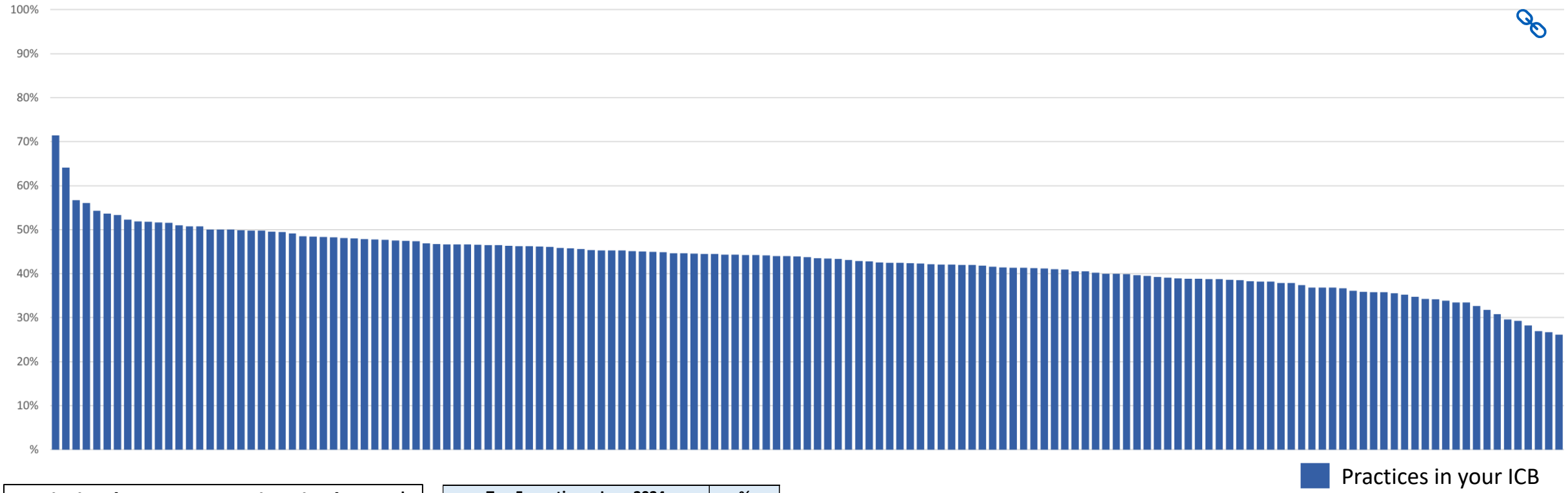
Your ICB achievement benchmarked against all other ICBs in England

- NHS Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board achievement (June 2024) = **43%**
- At least **42,180 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*

26% – 71%

Top 5 practices - June 2024	%
Kes@Northgate	71.43
Abbey Medical Centre	64.1
Malthouse Surgery	56.71
ASHCROFT SURGERY	56.03
Chalgrove & Watlington Surgeries	54.29

*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 ≤ 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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