CVD Prevention Indicators 23/24

Helen Williams

Consultant Pharmacist for CVD, SE London and UCLPartners

National Specialty Adviser for CVD Prevention, NHSE

Overview

- CVD Indicators…
  - ICS level
  - QOF
  - PCN DES

  - [illegible]

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

NHS England

https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

Size of the Prize – South West London Health and Care Partnership
BP Optimisation to Prevent Heart Attacks and Strokes at Scale

NHS Objective 23/24

% patients with blood pressure treated to target

QOF 19/20
70.3%

COVID-19 Disruption

37,471 Thousands fewer patients with BP treated to target or BP not recorded

Risk: up to **560 extra heart attacks and strokes** in 3 years

49.6%
QOF 20/21

62.8%
CVDPrevent
Dec 22

QOF Recovery
70.3%

74%
6,596 additional patients

77%
12,005 additional patients

80%
17,415 additional patients

Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
40 heart attacks	72 heart attacks	104 heart attacks
Up to **£0.3 million[2]** saved	Up to **£0.5 million[2]** saved	Up to **£0.8 million[2]** saved
59 strokes	108 strokes	156 strokes
Up to **£0.8 million[3]** saved	Up to **£1.5 million[3]** saved	Up to **£2.2 million[3]** saved

References
1. Public Health England and NHS England 2017 Size of the Prize
2. Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3. Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling
Data source: NCVIN 2021. Briefing note: QOF 2020/21 Management of hypertension – HYPALL metric (HYP003 + HYP007). Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

CVDP003CHOL: Percentage of patients aged 18 and over with no GP recorded CVD and a GP recorded QRISK score of 20% or more, on lipid lowering therapy Proportion %

Quality Improvement | Data Extract | Metadata

All Persons Data

58%	57.74%	58.63%
Area value	System median	National value

https://www.cvdprevent.nhs.uk/data-explorer?period=7&area=8060&indicator=14

Hypertension – QOF 23/24

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%

Blood pressure checks – QOF 23/24

Section 4: Public Health domain

Blood pressure (BP)

Indicator	Points	Thresholds
BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15	50–90%

Blood pressure - PCN DES 23/24

- A PCN must:
  - improve diagnosis of patients with hypertension by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a BP of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded, including proactive review of historic patient records, to identify patients who have had a previous elevated BP reading but have not had an appropriate diagnostic follow up

Blood pressure – PCN DES 23/24

Undertake activity to improve coverage of blood pressure checks:

- increasing opportunistic blood pressure testing where patients do not have a recently recorded reading
- undertaking blood pressure testing at suitable outreach venues
- working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the Community Pharmacy Blood Pressure Check Service

Atrial Fibrillation – QOF 23/24

AF006. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA_2DS_2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA_2DS_2-VAS_c 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%

Atrial Fibrillation – PCN DES 23/24

In addition, a PCN must:

- improve the identification of those at risk of atrial fibrillation, in line with NICE guideline NG196, through opportunistic pulse checks alongside blood pressure checks undertaken in a clinical setting

Cholesterol - QOF 23/24
New cholesterol indicators for secondary prevention

Two new cholesterol indicators (worth 30 points~£36m) have been added to the 2023/2024 Quality Outcome Framework (QOF)

- % patients on the QOF CHD, PAD, Stroke/TIA or CKD Register who are currently prescribed a statin, or where a statin is declined or clinically unsuitable, another lipid-lowering therapy
- % patients on the QOF CHD, PAD, 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

https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00289-quality-and-outcomes-framework-guidance-for-2023-24.pdf

PCN DES 23/24

- Identify patients at high risk of Familial Hypercholesterolaemia and make referrals for further assessment where clinically indicated. This should include systematic searches of primary care records to identify those aged 30+ with Chol > 9mmol/L or with Chol > 7.5mmol/L aged less than 30.
- Offer statin treatment to patients with a QRISK2&3 score ≥ 10%, where clinically appropriate, and in line with NICE guideline CG181.

https://www.england.nhs.uk/wp-content/uploads/2023/03/PRN00157-ncdes-contract-specification-2023-24-pcn-requirements-and-entitlements.pdf

CVD Prevention Indicators 23/24

Helen Williams

Consultant Pharmacist for CVD, SE London and UCLPartners

National Specialty Adviser for CVD Prevention, NHSE