# Cardiovascular Disease – OGIM - 2021

### Why change is needed

- Prevention, early detection, and treatment of CVD can help patients live longer, healthier lives. Too many people are still living with undetected, high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation (AF). We must utilise all opportunities to work with partners to ensure that people are able to access services that will allow them to prevent and detect health conditions, and upon diagnosis ensure that conditions are managed and optimised effectively. In primary care networks we will support all clinical staff including pharmacists to case find and manage people with the 3 key high-risk conditions described above (AF, Inadequately Controlled Hypertension, and Inadequately Controlled Lipids). In tackling the CVD agenda, there is an ambition to prevent 150,000 heart attacks and strokes.
- Behavioural risk factors such as poor diet, smoking and low physical activity, along with high blood pressure, high body mass index and high cholesterol are the main risk factors for cardiovascular disease. A large proportion of premature deaths in County Durham from CVD are preventable. An awareness raising of the impact public health interventions can have on CVD is important; whilst people are living longer, they are not necessarily living well and living with CVD contributes to this.

### Objectives

- Atrial Fibrillation (AF)
  - 30% reduction in No. of patients who have not been anticoagulated (where indicated).
  - 80% reduction in No. of patients who have not been risk assessed.
  - 50% reduction in No. of patients who are inadequately anti-coagulated when required.
- Hypertension
  - Increase in the number of patients detected with hypertension and to increase the number treated to bring blood pressure within recommended parameters.
- Inadequately Controlled Lipids
  - Improve the proportion of people who are likely to benefit from lipid modification who have been offered lipid modification.

### Goals

- Continue to work closely with Public Health Partners on the CVD prevention agenda (smoking, obesity and healthy living) and implementation of effective and equitable NHS Health Checks.
- Continue to work with partners to detect and medically optimise patients with AF to prevent stroke.
- Continue to work with partners to detect and medically optimise patients with hypertension to prevent CVD events.
- Continue to work with partners to detect and manage Inadequately Controlled Lipids, and to undertake cascade testing of family members to identify and medically optimise those with Familial Hypercholesterolemia.
- Improved systems to identify and manage patients with Heart Failure (access to echocardiograph / rehabilitation services).

### COVID - 19

**Short Term**

The pandemic has meant that projects have been paused and anticipated end points have now been extended. Projects that were due to yield results in 20/21 will now likely only see results in 21/22 at the earliest. It is hopeful that projects that required data cleansing as their primary goal may still be achieved in year, but this will be dependent on whether or not there is a second wave, and its impact, therefore could be subject to change. The negative impact on cardiovascular health as a side effect of lockdown, and the substantially worse prognosis of a person that contracts COVID-19 that has CVD as a comorbidity, puts greater importance on the need for these lists to be cleansed and correct to enable targeted intervention. People remain concerned about utilisation of NHS resources and work will be required with people to ensure they know it is safe to go to the doctors for preventative purposes (engagement with VCSE could help here). People who may have had CVD episode during COVID may have been concerned about seeking treatment and therefore there may be additional morbidity.

**Medium Term**

As described above the plan for the medium term is to complete projects that were put on hold during the initial grip of the pandemic and aim to get back on track. To accommodate this, dates for completion for several projects have been put back to 2021/22 for completion.

**Long Term**

The long-term goal for recovery is to get back on track to achieve the goals of the NHS Long Term Plan. This is outlined within the cardiovascular disease section of the document. The projects outlined in the Gantt Chart are specifically designed to meet these aims and objectives and is anticipated they can be achieved in the long term.

### Triple Aim Outcome Measures

| Health Outcomes | Patient Experience Outcomes | Workforce Outcomes |
|---|---|---|
| **1.** Reduction in the number of AF related stroke admissions. | **1.** Number of patients referred to cardiac rehabilitation. | **1.** Number of primary care pharmacists (per 100 000 population). |
| **2.** Increase in the number of patients treated to have BP within safe parameters therefore reducing admission for CVD conditions. | **2.** Waiting time for Cardiology. | **2.** Increased self-management activity (e.g. know your numbers, BP home check etc.) by patients which will increase availability of staff for other work. |
| **3.** Increase detected Familial Hypercholesterolemia to reduce prevalence of CVD particularly in younger adult age groups. | | **3.** Health and wellbeing score from Cardiology staff in the NHS staff survey for CDDFT. |

## Initiatives

| Project Gantt Chart | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 | BRAG |
|---|---|---|---|---|---|---|
| **1. Health Inequalities and Prevention** | | | | | | |
| CCG league tables for hypertension – level/ treated/ untreated. | | | | | | |
| Reduce variation of practice in the identification and management of high-risk conditions and audit & clean-up registers to ensure people are coded properly. Root cause analysis. | | | | | | |
| Bespoke Data packs with updated info showing current recent position. Healthy Hearts website to promote prevention in local areas. | | | | | | |
| AF Optimisation and Detection Programme – Pharmacist delivered project across all GP practices in the Southern Collaborative to include identification of patients from clinical systems, Pharmacist led appointment to risk assess, educate, and prescribe optimal medication, and an educational programme for Primary and Secondary care clinicians. CVDPREVENT audit will also be used in 2020. AliveCor rolled out to 12 practices. | | | | | | |
| NHS Health checks - targeted at people with estimated high CVD risk. | | | | | | |
| NEW: Develop a program to address CVD outside of people that attend primary care. | | | | | | |
| Hypertension Detection and Optimisation Programme – Data analysis, audit and education programme. Although slightly different versions, this will be replicated across the Southern Collaborative. | | | | | | |
| Hypercholesterolemia Programme – Data analysis and communication plan with all Primary Care to ensure patients are detected and are referred into a specialist Lipids clinic if found to have a cholesterol of 7.5mmol or more. These patients will be risk assessed and cascade testing offered to ensure this is prevented in future generations. This will be replicated across the Southern Collaborative | | | | | | |
| **2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)** | | | | | | |
| Review of Cardiac Rehabilitation services and aim to increase referral and uptake of cardiac rehabilitation during 2021/22. | | | | | | |
| In 2023/24, funding for wider roll out will be included in fair shares allocations to systems. This links to community for longer term rehabilitation following on from specialist services. | | | | | | |
| NHS Health checks check for hypercholesterolemia. | | | | | | |
| Prevention programmes and health checks commissioned by DCC, plus the public health stop smoking service, wellbeing for life and ways to wellbeing services all contribute to the prevention agenda and will reduce admissions. | | | | | | |
| Public and health care professional awareness work re: BP/Pulse/NHS health checks/ Wellbeing for Life/ Ways to Wellbeing/ Specialist Stop Smoking Service/ Whole System Approach to Obesity/ CVD Prevention Self-Assessment with work done on links to employment, housing, pollution, and poverty. | | | | | | |
| Recognition and understanding of wider determinants of CVD including protecting people from traumatic events, increasing physical activity, improving diet/nutrition, access to green spaces, reducing air pollution and working as a system to address these risk factors. | | | | | | |
| **3. Personalised Care** | | | | | | |
| Further development and utilisation of referral pathways for people at risk of CVD to Ways to Wellbeing / Wellbeing for Life Services commissioned by Public Health link with PCNs. | | | | | | |
| NEW: Implementation of referral pathways with Smokefree County Durham for people who are identified in general practice and secondary care as smokers. | | | | | | |
| NEW: Implementation of shared decision making within NHS Healthchecks to include patent activation, behaviour change and self-management measures. | | | | | | |
| **4. Mental Health and Learning Disabilities** | | | | | | |
| NEW: Ensure educational materials around CVD prevention and risk are developed with and for people with learning disabilities. | | | | | | |
| Lester Tool 2014 wider uptake for mental health services. | | | | | | |
| **5. Children** | | | | | | |
| Preventative measures for C&YP to address ACE's by utilising trauma informed care. | | | | | | |
| NEW: Active 30, Healthy Weight Alliance, Quality Standards Framework in Schools (potential to link to poverty agenda). | | | | | | |
| **6. Digital** | | | | | | |
| AliveCor has been nationally supported to help local partners identify AF. Investigation is ongoing to potentially roll this out further. Other schemes such as including a 'suspected AF' box on the diabetic podiatry screening sheet are being investigated. Use of a digital tool for the AF Optimisation and Detection Programme for patient stratification and identification. | | | | | | |
| Promotion of Heart Age Tool. | | | | | | |
| **7. Finance** | | | | | | |
| We will detect and medically optimise patients with AF to prevent stroke leading to savings via fewer AF related admissions and stroke episodes which can be re-invested into stroke and CVD services. | | | | | | |
| **8. Integration** | | | | | | |
| Pilot extended in pharmacies and re-modelled with formal GP feedback. Primary care led/paid for pulse checks to detect people with hypertension. | | | | | | |
| **9. Cultural Change** | | | | | | |
| Implementation of Making Every Contact Count across the health care system by health care professionals. | | | | | | |