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Network Contract Directed Enhanced Service

CVD Prevention and Diagnosis: supplementary guidance

Version 1.0, 31 March 2022

Contents

Purpose

1.1 The Network Contract DES includes requirements for the delivery of a cardiovascular disease (CVD) prevention and diagnosis service by primary care networks (PCNs). This best practice guidance should help inform and support implementation and delivery of the Network Contract DES requirements. The supporting information in this document is purely advisory and should be read alongside the Network Contract DES and Guidance.

Background

2.1 CVD is the leading cause of death worldwide, with hypertension being the number one risk factor. CVD is strongly associated with health inequalities (the most deprived quintile of the population is four times more likely to die from CVD than the least deprived).

2.2 The Network Contract DES Specification aims to reduce the impact of cardiovascular risk factors – the ABCs of CVD (**A**trial fibrillation, high **B**lood pressure/hypertension and **C**holesterol) – and to improve awareness and identification of heart failure. From April 2022, the focus of the contractual requirements is expanded beyond improving the identification of hypertension to also incorporate:

- detection and management of atrial fibrillation (AF);
- addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH);
- earlier diagnosis of heart failure; and
- quality improvement across the PCN.

2.3 From April 2022, PCNs will also be required to undertake network development and quality improvement activity to support CVD prevention, laying the broader foundations of good preventative care, as PCNs work with systems to develop optimal CVD pathways. Pathways linked to CVD prevention include the AAC lipid pathway and the Community Pharmacy Blood Pressure Check Service**,** both of which are discussed in the appendices.

2.4 These interventions are supported through Quality and Outcomes Framework (QOF) and Investment & Impact Fund (IIF) indicators.

Workforce and leadership

3.1 PCNs may wish to consider training a range of staff in order to optimise their workforce flexibility. For example, blood pressure measurements and pulse rhythm checks can be carried out by both clinical and non-clinical staff; similarly, a variety of clinical or non-clinical staff can support patients with ambulatory blood pressure monitoring (ABPM) or home blood pressure monitoring (HBPM).

3.2 PCNs are also recommended to raise awareness of local CVD Prevention pathways with all their clinical staff, potentially supported by relevant clinical network groups and other organisations, who have a standing offer of support for PCNs, such as Primary Care Cardiovascular Society, or regional NHS England and Improvement clinical networks. This could be supported by a PCN's review of local data sets to establish the level of unmet need and to identify local health inequalities in the diagnosis of the ABCs of CVD prevention.

3.3 Each PCN is encouraged to nominate a lead for this work. This may be a GP, nurse, pharmacist, or other clinician, and may be a shared role. Defined leadership will be valuable to maximise opportunities to promote and coordinate best practice in CVD healthcare, encouraging consistency in service delivery and reducing inequalities. Leadership will also be important in facilitating engagement with cardiac networks and ICSs.

Supplementary guidance to support implementation of the service requirements

Service requirements	Supplementary guidance to help PCNs to deliver requirements
Hypertension – part a)	
a) Improve diagnosis of patients with hypertension, in line with NICE guidance	NICE guidance NG136 must be followed when offering appropriate follow ups to patients.

NG136, by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up.	Anyone with a blood pressure reading of 140/90mmHg in a clinical setting, or 135/85mmHg in a home or community setting, must have their blood pressure re-checked and if blood pressure remains high (with *either* the systolic or diastolic reading being higher than the limit above), the patient must be offered either ambulatory blood pressure monitoring (ABPM) (preferred) or home BP monitoring (HBPM) (where ABPM is declined or not tolerated) to confirm a diagnosis of hypertension. Where a patient is presenting with blood pressure higher than 180/120 mmHg in either reading, practices are advised to consider immediate treatment, or same-day specialist referral if there is evidence of target organ damage. If no evidence of target organ damage, the patient must be followed up in line with NICE guidelines, within no more than a week, which may include confirming diagnosis via ABPM or HBPM, and/or immediate treatment. Additionally, and as reflected in IIF indicator CVD-01, practices must proactively review historical records to identify patients who are not on the hypertension register, but whose last recorded BP was higher than 140/90mmHg. They are expected to be offered an appropriate follow up (a new blood pressure test plus diagnostic procedure if needed) to confirm or exclude diagnosis of hypertension. Searches of the system are expected to cover the last two years as a minimum. These patients are expected to be invited to the practice for an appropriate follow up in line with NICE guidelines.
Hypertension – part b)	
b) undertake activity to improve coverage of blood pressure checks, by: i. Increasing opportunistic blood pressure testing where patients do not have a recently recorded reading	i. NHS Health Check guidance, and QOF BP002, require practices to check the blood pressure of people who are aged 40 or over, the latter requiring that everyone over 45 should have had a blood pressure check in the last 5 years. Practices can invite people for Health Checks after the age of 40 to ensure that, in line with BP002, everyone over 45 has received a

ii. Undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups iii. Working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the Community Pharmacy Blood Pressure Check[1] Service.	blood pressure check within the last 5 years. ii. PCNs are required to improve access to blood pressure testing, with a particular focus on individuals and groups who may be at higher risk of undiagnosed hypertension but do not routinely access general practice. PCNs are able to identify their own way of seeking to improve coverage of testing. For example, and subject to local partnership agreements, by setting up opportunities for blood pressure measurement at community centres, places of worship, or shopping centres. Similarly, all reasonable opportunities to measure blood pressure within the practice should be taken, particularly for people who may be at higher risk. This may mean, for example, taking the blood pressure of patients during routine appointments, or after flu or COVID vaccination delivery (as was trialled by some areas in 2020/21). if they are overweight or suffer from comorbidities which predispose them to hypertension; or are a member of an ethnic or other demographic group that have a higher risk. iii. Alignment with the Community Pharmacy Blood Pressure Check Service will support delivery. This service will enable both opportunistic blood pressure testing and, where clinically indicated, clinic BP checks or ABPM, on behalf of a PCN, referring the patient back for confirmation of the diagnosis and treatment as required. Pharmacies have been able to choose to register to deliver the service since October 2021.

Atrial Fibrillation	
Improve the identification of those at risk of atrial fibrillation, in line with NICE	Use NICE guidance CG180 to guide the identification of people at risk of AF:

[1] The Community Pharmacy Hypertension Case Finding service has been renamed the Community Pharmacy Blood Pressure Check service.

guideline CG180, through opportunistic pulse checks alongside blood pressure checks undertaken in a clinical setting.	- PCNs are advised to ensure that all patients over the age of 65 under-going blood pressure checks have a heart rate and rhythm recorded. - Where an irregular heart rhythm is identified, a 12 lead ECG is expected to be used to confirm or exclude AF. - PCNs are expected work with external partners to ensure that, where BP checks are undertaken outside the GP practice, the heart rate and rhythm is also recorded and communicated to the GP practice alongside the BP reading.
Familial Hypercholesterolaemia	
Identify patients at high risk of Familial Hypercholesterolaemia (as defined in NICE guideline CG71, section 1.1), 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	Use NICE guidance CG71 to guide the identification of people at risk of FH. Systematically search primary care records for people: - younger than 30 years, with a total cholesterol concentration greater than 7.5 mmol/l and - 30 years or older, with a total cholesterol concentration greater than 9.0 mmol/l as these are the people who are at highest risk of FH. Secondary causes of hypercholesterolaemia need to be identified and addressed. It is recommended that FH risk be assessed in line with NICE guideline CG71, using Simon-Broome or Dutch Lipid Clinic Criteria; and where probable or possible FH is suspected, should be referred for further specialist assessment to include DNA testing in line with local pathways (the latter may be accessed via genomics hubs in some areas).
Cholesterol	
Offer statin treatment to patients with a QRISK2&3 score >= 10%, where clinically appropriate, and in line with NICE guideline CG181	Use NICE guidance CG181 for the identification and treatment of people at risk of CVD. - PCNs are expected to work with the local authority to ensure uptake and delivery of the NHS Health check is optimised for their population

	- PCNs must ensure QRisk scores are coded for people aged 40-74years, and where possible, 75-84 years. - PCNs must ensure that patients with a QRisk score ≥ 10% are identified, and that statins are offered using a shared decision-making approach in line with the NICE endorsed NHSE/AAC pathway for primary prevention - Statin intolerance is expected to be addressed in line with the NICE endorsed NHSE/AAC pathway
Quality Improvement	
Undertake network development and quality improvement activity to support CVD prevention including: i. Reviewing outputs from CVD intelligence tools (including CVDPREVENT, when available) and sharing key learning amongst PCN staff ii. Supporting the development of system pathways for people at risk of CVD through liaison with wider system partners iii. Collaboration with commissioners to improve levels of diagnostic capacity for 'ABC' testing, including availability of ambulatory blood pressure monitors (ABPMs) and electrocardiogram (ECG) monitors iv. Ensuring processes are in place to support the exchange of information with community pharmacies, including a process for accepting and documenting referrals between pharmacies and GP practices for the Community Pharmacy Blood Pressure Check Service	Each PCN is encouraged to nominate a lead for the delivering the CVD requirement – see para 3.3 – and to devote resources to network development and quality improvement, which may be assisted by the following: i. Intelligence tools will include the OHID fingertips tool, the national PCN dashboard, and the CVDprevent tool. Additional resources include the UCLPartners Proactive Care Frameworks. ii. The national Cardiac Pathways Improvement Programme has resources. Implementation is overseen by regional cardiac networks and will involve both ICSs and PCNs. iii. The Community Pharmacy Blood Pressure Check Service will support making ABPMs available to patients for the diagnosis of Hypertension. The development of community diagnostic centres will further support the increased availability of other diagnostic capacity, particularly ECGs. iv. It is recommended to focus initially on electronic transfer of BP readings from the Community Pharmacy Blood Pressure Check service. Locally commissioned systems are in place – including secure information portals –

	email using nhs.net accounts would also be suitable.

Heart Failure	
Support the earlier identification of heart failure (HF), through building awareness among PCN staff around the appropriate HF diagnostic pathway, and early identification processes for HF including the timely use of N-terminal pro B-type natriuretic peptide (NTProBNP) testing	To deliver this, it is recommended that PCNs: - Work with the wider system to facilitate access to the NTProBNP blood test; and to agree and implement a local heart failure pathway - Promote the use of NTProBNP amongst primary care clinicians, for people with symptoms or signs of heart failure, as described in NICE 2018 Chronic Heart Failure Guidelines, to aid early diagnosis; - Ensure that patients with suspected heart failure and a raised NTProBNP are referred urgently for further assessment.

Appendix 1: associated pathways

Lipid management

The AAC Summary of National Guidance for Lipid Management which have been endorsed by NICE and NHSE&I, gives guidance around newer lipid lowering therapies including bempedoic acid, Inclisiran, and PCSK9i mABs). The AAC guideline reflects the NICE technology appraisals for these drugs.

For primary and secondary prevention of CVD in high risk patients, the AAC NICE-endorsed pathways (Summary of national guidance for lipid management and Statin Intolerance Pathway) should be followed to optimise lipid management using the current recommended range of therapies, including high intensity statins, ezetimibe, Inclisiran and PCSK9 inhibitors (mABs).

To support the identification of patients at high risk of CVD in lipid optimisation, clinicians may wish to consider performing searches using a range of validated tools (available here), for example CDRC, FAMCAT 2, or UCLP Long Term Condition.

NHS Community Pharmacy Blood Pressure Check Service

Since October 2021, the Community Pharmacy Blood Pressure Check Service has supported PCNs in improving access to blood pressure testing. The service will have two stages; the first is identifying people at risk of hypertension, and offering them blood pressure monitoring (a clinic check). The second stage, where clinically indicated, is offering ambulatory blood pressure monitoring (ABPM). Blood pressure test results will then be shared with the patient's GP (via NHS mail or other secure electronic pathway) to inform a potential diagnosis of hypertension. PCNs should consider how they can work collaboratively with community pharmacies delivering this service.

The aims and objectives of this service are to:

- Identify people aged 40 years or older, or at the discretion of the pharmacist people under the age of 40 with high blood pressure (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm diagnosis and for appropriate management;
- At the request of a general practice, undertake ad hoc clinic and ambulatory blood pressure checks; and
- Promote healthy behaviours to service users.

Where community pharmacy BP monitors carry out pulse checks, these results should also be communicated to the patient's GP alongside any BP measurements.