NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

Primary Care Commissioning Committee

Date: 30th April 2019
Time: 09:00am – 10:45am
Location: Vassall Centre, Bristol, BS16 2QQ

Agenda number: 11

Report title: Primary Care Quality Report

Report Author: Bridget James, Associate Director Quality, Jacci Yuill, Lead Quality Manager and Kat Tucker, Quality Support Manager
Report Sponsor: Jan Baptiste-Grant, Director of Nursing and Quality

1. Purpose

The purpose of this report is to provide the Committee with an update on quality measures for primary care (General Practice). This monthly metric update includes recently published CQC inspection reports, Friends and Family Test (FFT) data and Flu vaccine update following 2018/19 review. The specific domain focus for this month is Mental Health and Cardiovascular Disease.

2. Recommendations

The committee is asked:

- To note the updates on monthly quality data, and the specific information regarding Mental Health and Cardiovascular Disease care.

3. Executive Summary

CQC*:* Since last reported one practice has had a CQC report published. This practice received an overall rating of 'Good' and a rating of "Outstanding" in the "Well-Led" Domain.

Friends and Family test (FFT)*:* Data for February showed a compliance rate of 76%, which is above the national average of 62%. Whilst this is a slight deterioration from the January figures, this remains significantly improved from previous months. Further contact will be made

with the practices which did not submit February data to ensure that this improves further and is sustained.

Mental Health Data: Of the six Mental Health indicators BNSSG is above the national average for four, with two indicators showing poorer performance than the England average. All practices have kept the same overall rating for Mental Health from 2016/17 to 2017/18. Further information regarding the work being undertaken by the Localities and Medicines Optimisation teams can be found in the paper.

Cardiovascular Disease Data: Of the seventeen indicators for Cardiovascular Disease ten saw BNSSG as on or above the national average, for six of the indicators where BNSSG is below the national average this is by less than 1%. Ten of the indicators saw an improvement in BNSSG from 2016/17 to 2017/18.

Further information regarding the work being undertaken regarding Cardiovascular Care can be found in the separate paper presented to the committee.

4. Financial resource implications

There are no specific financial resource implications highlighted within this paper.

5. Legal implications

There are no specific legal implications highlighted within this paper.

6. Risk implications

Actions to address any highlighted risks have been added to the paper under each section

7. Implications for health inequalities

Monitoring of primary care quality and performance will highlight any areas of health inequalities within BNSSG, which will then be addressed accordingly.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Monitoring of primary care quality alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly.

9. Implications for Public Involvement

Whilst there has not been any direct consultation and communication with the public in the production of this paper, patient experience and public involvement is recognised as an important factor in reviewing and gaining assurance regarding primary care services.

Agenda item: 11

Report title: Primary Care Quality Report

1. Background

The purpose of this report is to provide the Committee with an update on quality measures for primary care (General Practice). This monthly metric update includes recently published CQC inspection reports, Friends and Family Test (FFT) data and Flu vaccine update following 2018/19 review. The specific domain focus for this month is Mental Health and Cardiovascular Disease.

2. Primary Care Monthly Quality Monitoring

a. Care Quality Commission (CQC)

One practice had a CQC inspection report published between 9th March and 8th April. It is noted that this practice received an overall rating of 'Good' and a rating of "Outstanding" in the "Well-Led" Domain.

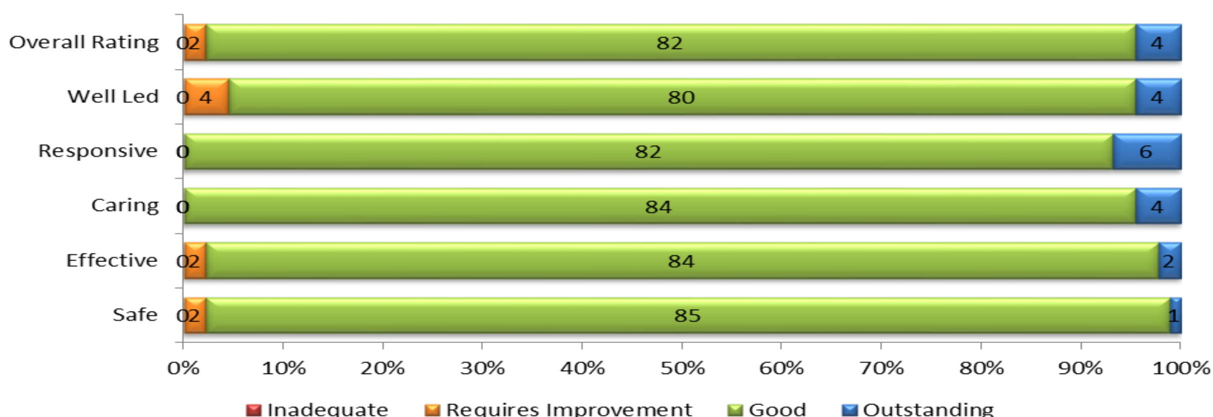
It is noted that the Old School Surgery CQC report whilst published on 18th March 2019, relates to an inspection which occurred in May 2018, the practice appealed the original report and this was partially upheld prior to publication in March 2019.

Figure 1: Recently published CQC ratings for domains

Practice	Publication Date	**Overall Rating**	Well Led	Responsive	Caring	Effective	Safe
Old School	18.03.19	Good	Outstanding	Good	Good	Good	Good

The below graph shows the overall CQC rating position of all practices within BNSSG. There are currently no practices with a rating of "inadequate" in any domain.

Figure 2: CQC ratings for domains for all BNSSG practices



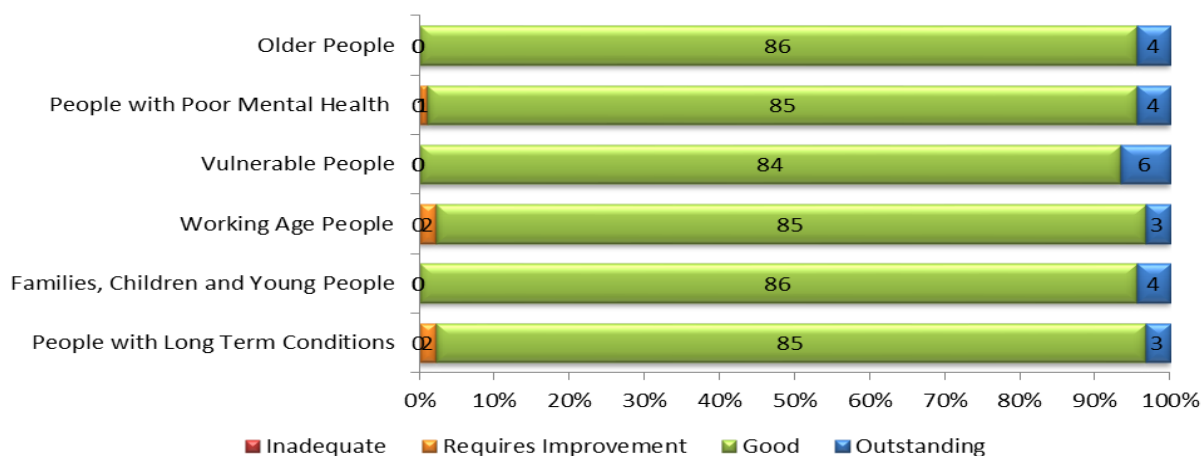
Within Primary Care the CQC also inspects the quality of care for six population groups, as shown in the table below Old School Surgery received a "Good" rating for all the population groups.

Figures 3: Recently Published CQC ratings for population groups

Practice	Publication Date	Older People	Long Term Conditions	Families, Children & Young People	Working Age People	Vulnerable People	Mental Health
Old School	18.03.19	Good	Good	Good	Good	Good	Good

The below graph shows the overall rating position of BNSSG practices for the six population groups.

Figure 4: CQC ratings for population groups for all BNSSG Practices



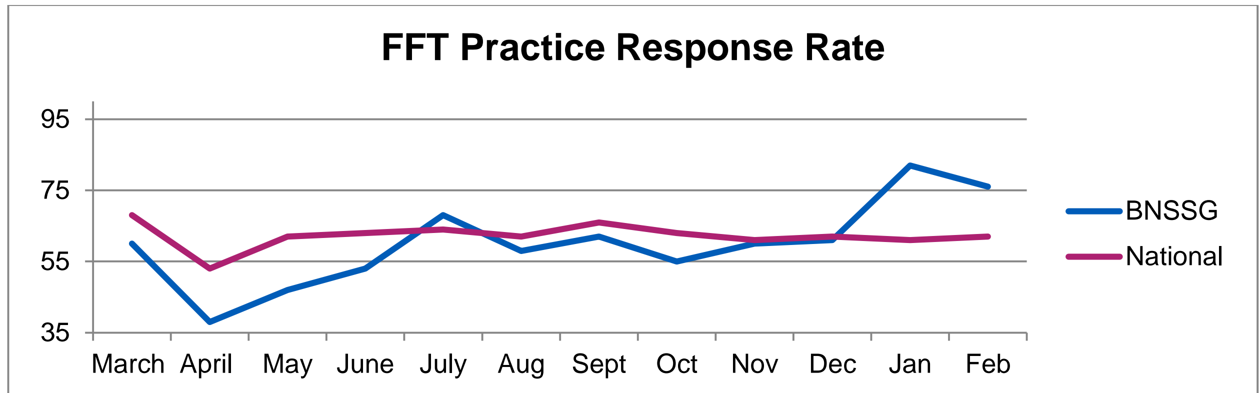
b. Friends and Family Test (FFT)

The Friends and Family Test (FFT) is a feedback tool that supports the principle that those who use NHS services should have the opportunity to provide feedback on their experience which can be used to improve services. It is a continuous feedback cycle between patients and practices. FFT is only one method of feedback that GPs receive; there are other robust mechanisms, such as the national annual GP Patient Survey and outcome measures which can also be utilised. FFT for each practice can help to inform current and prospective patients about the experiences of those who use the practice's services and help mark progress over time. FFT data is published on the NHS England website.

Response rates: The most recent results for the Friends and Family Test (FFT) data are for February 2019. This shows that 62 BNSSG CCG practices submitted their data to NHS England as contractually required. This is a compliance rate of 76% which is above the

national rate of 62%. Whilst this is a slight deterioration from the January figures, this remains significantly improved from previous months. Further contact will be made with the practices which did not submit February data to ensure that this improves further and is sustained.

Figures 5: % FFT Response Rate



We have also presented the last three months data by both area and locality to show the variation. These are presented in the following two charts and include the overall BNSSG and the national averages in both.

Figure 6: FFT Response Rate by Locality

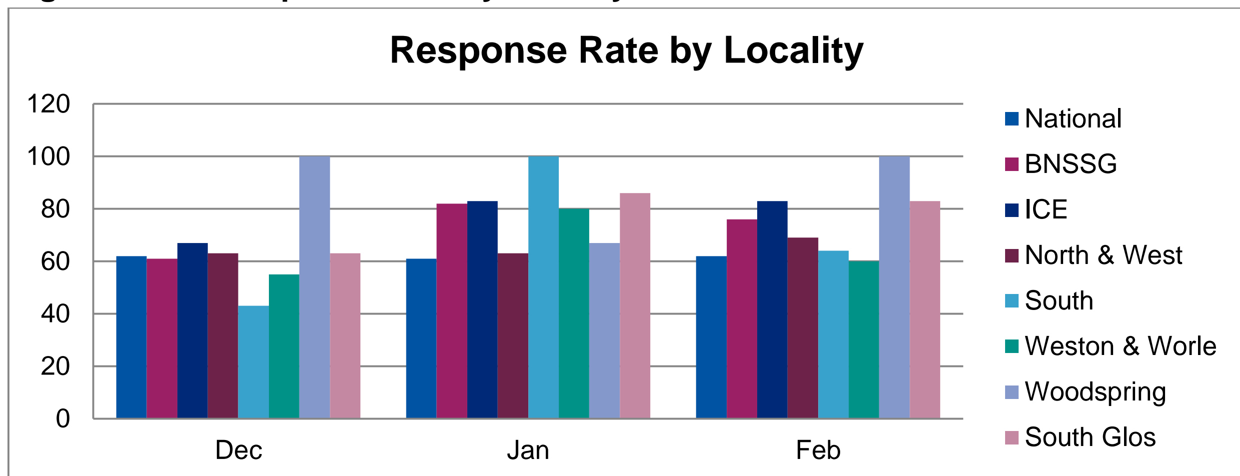
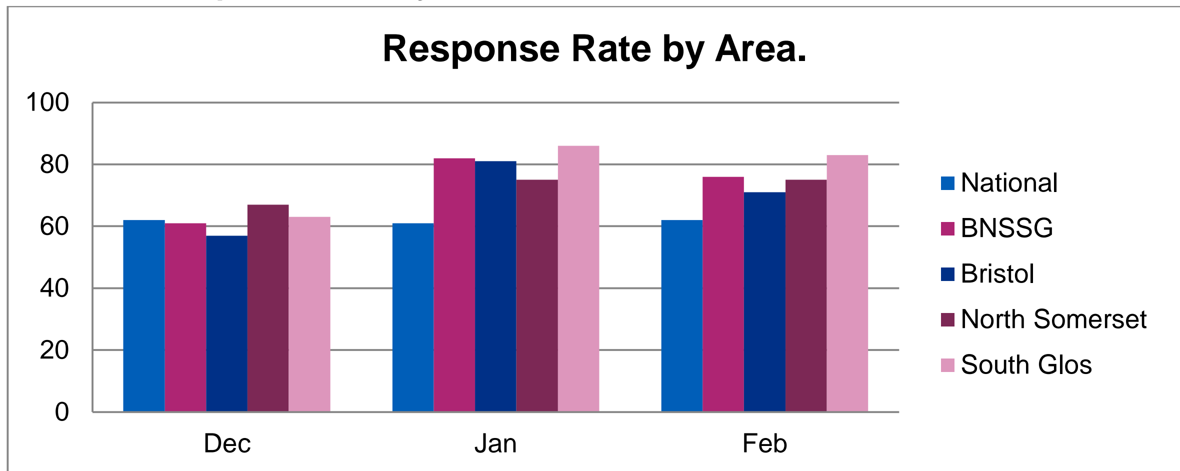
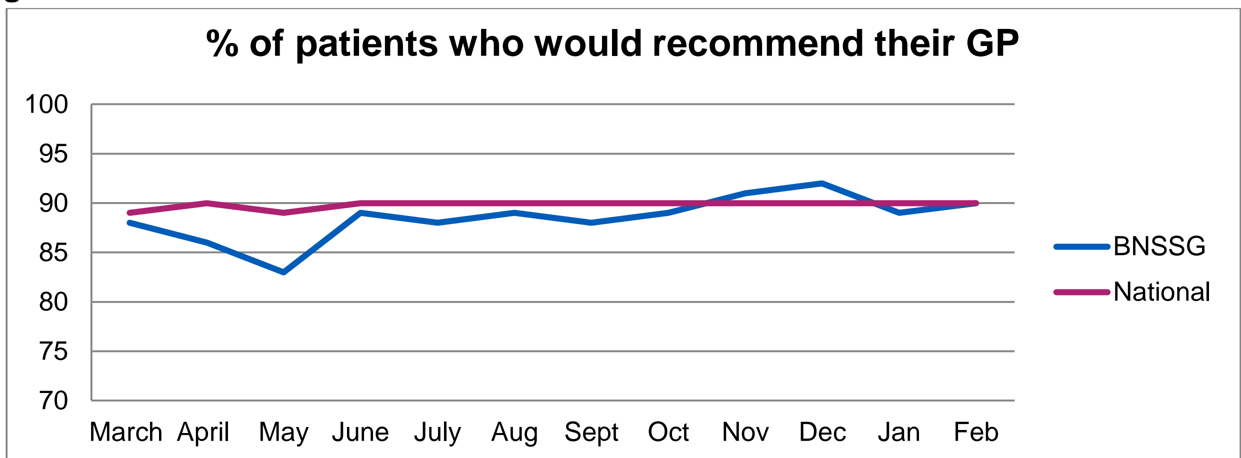


Figure 7: FFT Response Rate by Area



Recommendation rates: Across BNSSG CCG 90% of respondents would recommend their GP Practice; this is the same as the national average and a 1% increase from the previous month. The percentage of patients who would not recommend their GP Practice was 7%. This is the same as the previous month and 1% higher than the national average.

Figure 8: FFT Recommended Rate



Again this data has been presented by both area and locality for the last three months to show variation. These are presented in the following two charts and include the BNSSG and the national averages.

Figure 9: FFT Recommended Rate by Locality

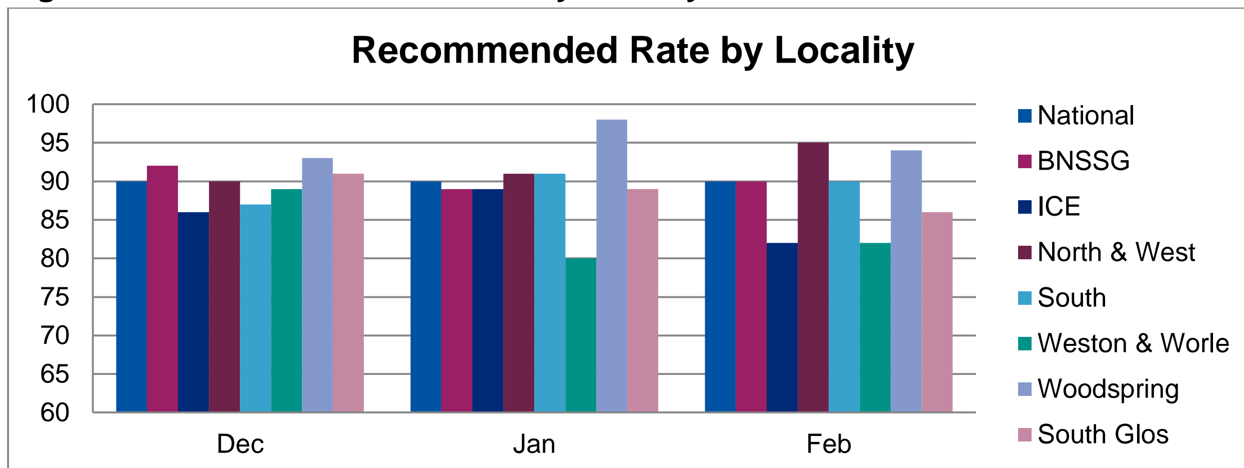
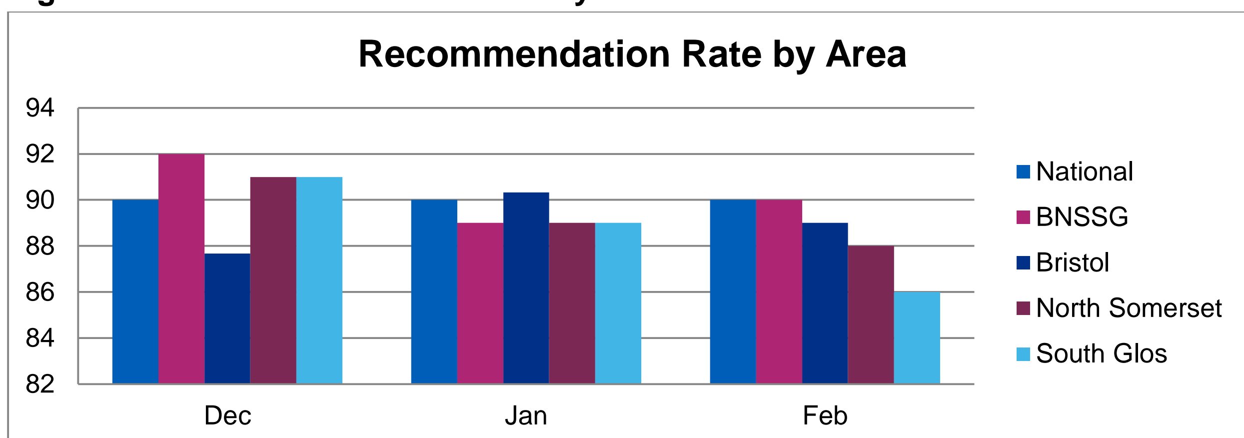


Figure 10: FFT Recommended Rate by Area



The total number of FFT responses received in February for BNSSG was 2464, this is a decrease from January. For those practices who submitted a response the numbers ranged from 0 – 207. On average this is 40 responses per practice, it is therefore important that Primary Care FFT recommendation rates should be triangulated with other patient experience data including complaints and the annual GP Patient Survey rather than viewed in isolation. The number of respondents for each practice on a monthly basis is small and therefore it is not possible in most cases to draw statistical significance at an individual practice level. However, practices use FFT as one of several patient feedback mechanisms which feed into their Patient Participation Groups.

c. Flu Update

The Quality Team attended The Seasonal Influenza Programme 2018/19 Review Conference and the following were key points of discussion:

A National Perspective was presented by Richard Peabody-Head of Respiratory Viruses and Influenza Public Health England.

Outbreaks: GP Consultation rates were at a peak end January 2019. The levels were below 2017/18 and 2016/17. The highest level of outbreaks were dominated by care homes; a small number of schools and hospital outbreaks. Scotland and Northern Ireland have fully rolled out their school age programme so their outbreaks are lower than England and Wales. This will be commenced in the 2019/20 season across England and Wales.

Vaccine adult programme: The overall uptake was good in the over 65 and children's cohorts. However in the under 65s at risk cohort the highest uptake is in diabetic groups and much lower in the other at risk groups, especially those with liver disease.

Vaccine child programme: there has been a higher uptake since being delivered in schools. As the children move up through the school each year, having a flu vaccine becomes the norm, which has increased the uptake.

The Quality, Primary Care Contracts and Medicines Management Teams are working together to ensure that the requirements of the annual national flu programme for the 2019/20 flu season are met. The expected deliverables include:

- Supporting improvement in uptake and reducing variation, and ensuring the recommended vaccines are used
- Ensuring that there are clear arrangements in place to support oversight of the flu programme between October and March every year
- Supporting general practices to target at-risk population groups to improve uptake and coverage of the flu vaccination to achieve national uptake ambitions
- Having a named flu lead in place whose role is to ensure that practices have pre ordered sufficient vaccines and that there are mechanisms in place to monitor supply and demand and to drive up uptake of flu vaccine.

3. Focused Primary Care Quality Domain for April 2019 – Mental Health

This month's quality domain for further detailed analysis is GP Mental Health care as per the quality calendar presented to the PCCC which can be found in appendix 1.

Within the baseline annual data from the Primary Care Web tool there are six indicators regarding Mental Health Care that can be nationally benchmarked. The current General Practice indicators represent a consolidation of existing data sources, for example Quality Outcomes Framework (QOF), List Size, Demographics, Index of Multiple Deprivation, that

provides information to enable practice performance and quality to be analysed. The indicators are intended to support conversations to enable issues to be explored and underlying factors to be identified and addressed.

The six GP Mental Health indicators are as follows:

1. **MH01**:Percentage first choice generic Selective Serotonin Re-uptake Inhibitors (SSRIs)
2. **MH02:** Total number of average daily quantities (ADQs) for selected antidepressant prescribing per Antidepressants (BNF 4.3 sub-set) ADQ based Specific Therapeutic Group Age-sex weightings Related Prescribing Unit (STAR-PU).
3. **MH002**: Percentage of patients with a comprehensive care plan
4. **MH003**: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months
5. **MH007**: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption is recorded in the preceding 12 months
6. **DEP003**: Patients aged 18+ with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed between 10 & 56 days after the date of diagnosis

The practice level performance against each of the indicators has been aggregated to a domain rating of each practice; the following table shows the BNSSG position in 2016/17 and 2017/18.

Primary Care Quality Assurance Dashboard				
Domain	**Blue**	**Green**	**Amber**	**Red**
Mental Health Care 2016/17	**0**	**50**	**37**	**2**
Mental Health Care 2017/18	**0**	**50**	**34**	**2**

The number of practices is different for 2016/17 and 2017/18; this takes into account practices that merged during this time period. All practices have kept the same rating for Mental Health Care over the time period.

Overview

In 2017/18 the BNSSG average for four of the indicators was above that of the England average, two of the indicators however showed poorer performance than the England average (see table overleaf).

	1.% 1st choice generic SSRIs		2. ADQs for antidepressants		3. % care plans		4. % recorded BP		5. % recorded alcohol consumption		6. New depression diagnosis reviewed	
Good is	High		Low		High		High		High		High	
Year	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18
England	**63.9**	**63.7**	**1.43**	**1.45**	**90.3**	**89.5**	**90.4**	**89.9**	**90.7**	**90.0**	**83.6**	**82.8**
Highest Core City	71.1	70.6	2.05	2.18	93.0	93.2	93.7	93.5	93.1	93.2	86.7	88.5
Lowest Core City	55.8	55.1	1.36	1.40	83.6	83.8	87.4	87.0	89.0	88.2	79.8	79.7
BNSSG	**60.2**	**60.1**	**1.45**	**1.53**	**93.0**	**93.0**	**90.4**	**90.3**	**91.0**	**91.5**	**85.3**	**85.35**
ICE	58.4	57.7	1.37	1.37	92.0	92.0	88.9	88.9	88.7	88.7	81.5	81.5
North & West	60.6	61.2	1.33	1.43	94.1	94.1	91.9	91.9	90.8	90.8	85.6	85.6
South	59.3	59.3	1.47	1.53	93.1	93.1	89.4	89.4	90.0	90.0	84.4	84.4
Woodspring	61.8	62.2	1.35	1.42	94.7	94.7	92.7	92.7	94.5	94.5	86.8	86.8
Weston Worle & Villages	57.7	57.2	1.92	1.96	92.6	92.6	90.0	90.0	91.4	91.4	84.4	84.4
South Glos	63.4	62.7	1.34	1.43	92.3	92.3	92.5	92.5	92.4	92.4	87.3	87.3

Indicator 1 (MH001): 2017/18 data showed that 69.7% practices prescribing a lower percentage of first choice generic SSRIs than the England average. 8.1% of practices were prescribing more than 15% lower than the national average.

Indicator 2 (MH02): The percentage of average daily quantities of selected antidepressant prescribing for 2017/18 was higher than the England average in 56.9% of practices. 45.3% of practices were more than 15% higher than the England average. The majority of practices within Weston, Worle and Villages and South Locality were more than 15% higher than the England average.

Indicator 1 & 2 are used to support the 'Key therapeutic topics – Medicines management options for local implementation' publication by highlighting variation in prescribing across organisations. An improvement in these two indicators would help patients to improve their outcomes, take their medicines correctly, avoid taking unnecessary medications, reduce wastage of medicines and improve medicines safety. The Medicines Optimisation Team has been asked to look into this further to work with practices in order to improve these indicators.

From a review of the data it is evident that the higher rate of prescribing occurs in practices with high levels of deprivation, but fairly low Black, Asian and Minority Ethnic (BAME) populations. There is not a strong correlation between prescribing and deprivation alone, or

prescribing and BAME population, however the highest prescribing practices occur in practices with at least 90% white population and high deprivation. However, it is also known that lower rates in BAME populations may be due to the lack of engagement. To support this in the new BNSSG IAPT model of care has specifically focused on supporting these groups to ensure they receive the appropriate treatment to meet their particular cultural needs.

Indicators 3/4/5 (MH002/MH003/MH007): BNSSG is on target or above the England average across all these three indicators and just below the highest CCG Core Cities.

Indicator 6 (DEP003): The data shows that there are 40.6% of practices across all the localities, who are 15% above the England average for reviewing patients 18 and over with a new diagnosis of depression (in the preceding year - 1 April to 31 March), between 10 & 56 days after the date of diagnosis.

Locality Mental Health Projects to support patients in Primary Care

All six provider localities are progressing their locality transformation schemes and developing integrated care schemes for mental health. Below is an update of the plans in progress in South Gloucestershire and Inner City & East in Bristol.

South Gloucestershire

A collaborative project to support patients with low risk, moderate and chronic mental health needs is currently being developed through the Locality Transformation Scheme in South Gloucestershire, with similar projects to meet the specific needs of patient populations underway in the other localities. South Gloucestershire's approach to the Integrated Care – Mental Health work-stream is underpinned by key projects, which includes: the establishment of multi-disciplinary teams (MDTs) /virtual wards, a consultant support service and shared-care plans.

In terms of the specific indicators the improvements projects are as follows:

Total number of average daily quantities (ADQs) for selected anti-depressant prescribing per Antidepressants (BNS 4.3 sub-set) ADQ based Specific Therapeutic Group Age-sex weightings Related Prescribing Unit (STAR-PU)

An element of the multi-disciplinary teams/virtual wards for patients with complex mental health needs will be to oversee patient medication reviews in respect of concordance and safety protocols, which could be undertaken by community or practice-based pharmacists. GPs and AWP are to explore mutual support for non-acute prescribing and monitoring via a shared-care plan.

Percentage of patients with a comprehensive care plan
The aim is to create an individualised and structured shared-care plan, following the principles of the collaborative care model, for moderate to high risk/high dependency patients accessible by all involved organisations. This should include peri-natal patients who require early intervention to avoid escalating mental health conditions. Proposed outcomes include improved communication concerning these patients (mindful of confidentiality and data-sharing procedures) and reduced referrals & admissions to secondary mental health services with patients managed more effectively and offered a more tailored, individualised approach.

Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure and whose alcohol consumption is recorded in the preceding 12 months
One of the elements of the project – to establish MDTs/virtual wards – will be to ensure joint responsibility between GP practices and the mental health teams for health checks to be undertaken and recorded in the patients' records/care plans. The proposal is for health checks to be undertaken at the point of contact with any clinician able to administer them in order to improve patient health outcomes by ensuring that no opportunity is lost by the mental health team or primary care to ensure basic health checks are carried out.

Patients aged 18+ with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed between 10 & 56 days after the date of diagnosis
A key element of the shared care approach for patients with low risk, moderate and chronic health needs will be to ensure scheduled patient follow-ups following the creation of an individualised, shared-care plan.

Expected outcomes
Overarching proposed outcomes includes: improving the number of patients receiving improved shared care with Primary and Secondary care, with detailed care plans and health checks undertaken on an annual basis and to improve mental health QOF data for GP practices.

Inner City & East, Bristol

Three practices within the Inner City and East Locality are undertaking a Primary Care East Bristol Mental Health Pilot, the aim is to improve the pathway into Secondary Mental Health Services from Primary Care and supporting smooth service-user transitions back to Primary Care at the time of discharge from Secondary Care.

There are three main elements of the pilot:
1) Improved direct communication between GPs and Consultant Psychiatrist, by means of a direct access electronic inbox for quick resolution of medication queries and advice as well as designated telephone appointment slots for case discussion.

2) Mental health assessments undertaken in GP practices, with referrals directly from GPs to registered mental health professionals (in slots bookable to the GPs so that they can select urgency directly), with the option of a limited number of follow up appointments available to service-users within their own practice. These assessments are then documented directly into EMIS for ease of access.
3) Recovery Navigators based within GP surgeries, accepting referrals from mental health professionals, offering up to three 1:1 sessions to support and sign-posting service-users to relevant services within their local community.

This pilot commenced in May 2018, with the recovery navigators being introduced in November 2018. The pilot is initially planned to run for 12 months with evaluation points at the end of each quarter.

Initial outcomes from the pilot include:

- Working relationships between primary and secondary care have improved through greater understanding of how respective services work which indicates secondary gains to service-user care and pathways
- Number of referrals made to triage by participating surgeries have reduced
- Number of referrals made to secondary care have reduced
- Routes set up to access Consultant Psychiatrist function within the pilot has been minimally used, although GPs have continued to seek medical advice for service-users from link Consultant Psychiatrist through pre-existing pathways

At the end of the pilot a comprehensive evaluation will be conducted by the locality and next steps agreed.

Physical Health Checks for Severe Mental Illness (SMI) in Primary Care

According to NHS England (Feb 2018) individuals living with SMI are not consistently being offered appropriate or timely physical health assessments despite their higher risk of poor physical health. In the Five Year Forward View for Mental Health, NHS England committed to leading work to ensure that by 2020/21, CCGs should offer NICE recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year. People living with SMI will have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

Dr David Soodeen, GP Clinical Lead for Mental Health and Carol Slater, Head of Transformation (Mental Health & Learning Disabilities) are leading on this project and gave assurance that this work is a priority for the CCG and plans are being developed for implementation. Dr Soodeen explained that with the evolution of Primary Care Networks it will be possible to manage issues more effectively which will include joint prescribing with

secondary care, integrated working with consultants and methods to measure and monitor achievement.

He also suggested that the levels of exception reporting for Mental Health patients will need to be analysed as it is likely that this cohort are those missing from the data captured by the Primary Web Tool. This action will be taken forward in the quality report recommendations.

Medicines Optimisation plans relating to Mental Health in Primary Care

The plan for the Medicine Optimisation Prescribing Quality Scheme for 2019/20 is a programme for all practices to undertake reviews to analyse the use of antipsychotics, Benzodiazepine and Z Drugs and Gabapentoids which is detailed in the table below:

Antipsychotics	• Review prescribing of antipsychotics in people with dementia and learning disabilities and ensure that the recommended annual physical health checks have been undertaken. • Provide assurance of appropriate use, looking at initiation, indication, effectiveness and monitoring in accordance with the NICE/Social Care Institute for Excellence (SCIE) guideline on dementia and the NICE quality standard on dementia and STOMP, Stopping the overmedication of people with a learning disability, autism or both. • For outcomes to be submitted with evidence of learning shared within the practice
Benzodiazepine and Z drugs	• Review of patients who have been prescribed these medicines for a prolonged period of time. • Review of processes when commencing new prescription to ensure these are for small quantities for short period of time. • For outcomes to be submitted with evidence of learning shared within the practice
Gabapentinoids	• Data collection of reviews complete and evidence of learning shared within the practice. • Results will be shared with local Pain Specialists in order to target education and review of complex patients in the future.

The BNSSG Formulary currently promotes local prescribing guidance around depression which can be accessed through:

https://www.bnssgformulary.nhs.uk/includes/documents/Prescribing%20for%20Depression%20v2%20May16.pdf (Appendix 2)

A Wellbeing Toolkit which is a Lifestyle Prescription is being developed to give to patients if they are feeling low or anxious (Appendix 3).

This work is aimed at reducing inappropriate prescribing for patients with Significant Mental Illness and Learning Disabilities and therefore improving the quality of life and optimal care provided to this patient group. It looks at alternatives to prescribing and empowering GPs and patients to use lifestyle interventions first. There will be the development of resources for use by GPs during consultations to signpost patients to alternative treatment strategies rather than issuing a prescription for a medication.

On line support for practice staff in recognising the signs of depression and crisis: The Zero Suicide Alliance has developed a free online training video for use by members of the public and health professionals to provide a basic understanding of how to support people who are showing signs of depression or crisis and offer guidance on how they can deal with such situations.

The link to this online resource has been circulated to GP practices encouraging all practice staff clinical and non-clinical to undertake the training. The training can be found at the following link:
https://www.relias.co.uk/hubfs/ZSACourse3/story_html5.html?utm_source=Relias&utm_campaign=Training-Landing-Page

4. The focused domain deferred from March 2019-Cardiovascular

This quality domain for March (which was deferred) requiring further detailed analysis was GP Cardiovascular care.

Within the baseline annual data there are seventeen indicators regarding Cardiovascular Care that can be nationally benchmarked.

The seventeen GP cardiovascular indicators are as follows:

1. **HYP006**:Percentage patients with hypertension in whom the last BP reading (measured in the last year) is < 150/90mmHg
2. **AF007:** Percentage of patients with AF who are currently treated with anti-coagulation therapy in whom there is CHADS2-VASc score of 2 or more.
3. **AF006**: Percentage of patients with AF in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the last year (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score 2 or more)
4. **BP002**: Percentage of patients aged 45 or over who have a record of BP in the preceding 5 years.

5. **CVDPP001**: In patients with a new diagnosis of hypertension aged 30-74, recorded between the preceding 1 April to 31 March (exc. Pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score of >20% in the preceding year: the percentage who are currently treated with statins.
6. **CHD002**: Percentage patients with CHD in whom the last BP reading(measured in the last year) is < 150/90mmHg
7. **CHD005**: Percentage pts with CHD with a record in the preceding year that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken
8. **CHD007:** Percentage patients with CHD who have had influenza immunisation in the preceding 1 August to 31 March
9. **HF002:** Percentage patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register
10. **HF003:** In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the % pts who are currently treated with an ACE-I or ARB
11. **HF004:** In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta
12. **PAD002:** Percentage patients with peripheral arterial disease in whom the last BP reading (measured in the last year) is ≤ 150/90 mmHg
13. **PAD004:** Percentage patients with peripheral arterial disease with a record in the preceding year that aspirin or an alternative anti-platelet is being taken
14. **STIA003:** Percentage patients with a history of stroke or TIA in whom the last BP reading (measured in the preceding 12 months) is ≤ 150/90 mmHg
15. **STIA007:** Percentage patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding year that an antiplatelet agent, or an anti-coagulant is being taken
16. **STIA008:** Percentage patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA
17. **STIA009:** Percentage patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March

The practice level performance against each of the indicators has been aggregated to a domain rating of each practice; the following table shows the BNSSG position in 2016/17 and 2017/18.

Primary Care Quality Assurance Dashboard				
Domain	**Blue**	**Green**	**Amber**	**Red**
Cardiovascular Care 2016/17	0	72	17	0
Cardiovascular Care 2017/18	0	81	8	0

There has been an improvement in the overall ratings of practices from 2016/17 to 2017/18 with nine practices going from an Amber rating to Green.

Indicator	Good Is	Year	England	Highest Core City	Lowest Core City	BNSSG	Inner City & East	North & West	South	Woodspring	Weston Worle & Villages	South Glos
1.% hypertension patients with BP < 150/90mmHg	High	16/17	83.4	87.6	81.8	83.1	82.8	83.8	84.0	81.4	81.7	83.6
		17/18	82.6	85.7	81.3	82.1	83.9	82.0	81.2	81.5	82.6	82.0
2.%AF anti-coagulation CHADS2-VASc 2 or more	High	16/17	88.4	90.4	86.9	88.4	91.6	90.0	89.8	85.7	85.6	88.6
		17/18	90.0	92.0	88.3	89.6	91.3	90.3	89.8	88.2	88.5	89.9
3.%AF assessed using CHA2DS2-VASc	High	16/17	96.9	98.7	96.4	97.3	97.5	97.7	97.9	95.8	97.8	97.1
		17/18	97.4	98.6	97.1	97.5	98.0	96.6	97.5	97.8	97.7	97.6
4.% over 45 with a BP in preceding 5 years	High	16/17	91.1	92.2	87.8	90.4	88.8	89.1	90.2	91.4	91.8	91.1
		17/18	90.9	92.2	88.4	90.2	88.3	89.1	90.3	90.9	91.7	90.7
5.New hypertension diagnosis with CVD risk score >20% treated with statins.	High	16/17	97.4	100	95.8	97.0	100	96.7	98.5	100	86.0	98.2
		17/18	97.3	100	95.9	97.3	100	100	100	96.9	100	93.7
6.% with CHD with BP reading < 150/90mmHg	High	16/17	92.4	94.1	91.3	92.7	92.6	93.7	92.2	93.8	92.4	92.2
		17/18	92.1	93.7	90.4	92.8	93.8	93.6	92.1	92.8	93.1	92.4
7.% with CHD with aspirin, an alternative anti-platelet therapy or anti-coagulation being taken	High	16/17	96.3	97.4	93.5	97.1	97.0	97.4	97.8	96.9	97.2	96.7
		17/18	96.2	97.4	94.2	97.1	97.4	97.1	97.5	97.0	96.7	97.1
8.% with CHD who had flu immunisation	High	16/17	95.8	97.4	93.5	97.2	98.8	97.1	97.5	96.7	98.6	96.0
		17/18	96.1	98.0	94.0	97.4	97.9	98.0	97.3	97.3	97.8	96.9
9.% with heart failure diagnosis confirmed by echocardiogram or specialist	High	16/17	95.1	95.7	94.1	94.5	95.7	95.0	94.6	95.0	93.9	93.5
		17/18	94.9	95.9	93.5	94.6	94.4	94.5	94.1	94.5	95.3	94.9
10.% with a heart failure diagnosis due to left ventricular systolic dysfunction who are treated with an ACE-I or ARB	High	16/17	99.2	100	96.9	99.6	98.9	100	99.3	100	100	99.8
		17/18	99.0	100	98.3	99.5	100	100	98.7	99.4	100	99.6
11.% identified in Indicator 10 who are additionally treated with a beta	High	16/17	92.5	95.3	88.6	91.5	89.2	95.3	88.5	92.9	91.6	92.8
		17/18	92.4	95.5	86.1	89.5	89.5	94.8	87.9	89.1	86.5	89.4
12.% with peripheral arterial disease with last BP reading < 150/90mmHg	High	16/17	90.8	94.0	88.8	89.9	90.4	92.6	87.4	91.8	89.5	89.6
		17/18	90.4	92.3	88.0	90.4	92.1	91.8	88.5	91.7	90.8	89.5
13. % with peripheral arterial disease aspirin or an alternative anti-platelet being taken.	High	16/17	93.5	95.8	91.8	93.5	93.4	95.3	94.2	93.8	92.8	92.1
		17/18	93.4	95.8	93.0	93.9	94.4	95.2	94.2	93.4	94.1	92.9
	High	16/17	88.1	91.1	87.5	87.7	88.3	89.3	86.4	88.2	87.1	87.5

14.% with a history of stork or TIA with last BP <150/90mmHg		17/18	87.4	91.8	86.4	87.3	89.3	87.3	85.1	88.5	87.8	86.7
15. % with a stroke shown to be non-haemorrhagic taking antiplatelet agent or an anticoagulant in preceding year.	High	16/17	97.4	98.2	96.0	97.9	97.6	97.5	98.0	98.0	97.8	98.3
		17/18	97.2	98.3	96.0	98.0	98.0	98.3	98.4	98.1	98.1	97.3
16.% with a stroke or TIA referred for further investigation	High	16/17	88.6	91.4	86.8	87.9	86.9	87.8	88.3	89.6	84.7	88.8
		17/18	87.7	90.2	85.3	87.5	88.1	86.7	87.0	89.1	86.3	87.8
17. % with a stroke or TIA who had flu immunisation.	High	16/17	94.7	96.5	91.2	95.9	97.8	95.9	95.5	94.7	97.4	95.2
		17/18	95.1	97.7	93.9	96.0	97.3	97.1	95.5	94.6	97.8	95.4

This shows that for ten of the indicators BNSSG is on or above the national average, for six of the indicators where BNSSG is below the national average this is by less than 1%. Ten of the indicators saw an improvement in BNSSG from 2016/17 to 2017/18.

Further information regarding the work being undertaken regarding Cardiovascular Care can be found in the separate paper presented to the committee.

5. Patient Experience Quarterly update

a. Quarter Three Complaints

During Quarter 3 2018/19 NHS England received 33 complaints about GP practices in BNSSG, 28 of these were investigated and have received full responses. Of the five which were not fully investigated, one had already been investigated by the provider, for three no consent to investigate was received from the patient and one was a duplicate to a previously addressed complaint.

The three most frequent themes within these complaints were clinical treatment, including diagnosis issues, communication and staff attitude.

Of the 28 complaints fully investigated 4 were upheld, 8 were partially upheld and 16 were not upheld. Six (6) of the complaints were multi-agency complaints.

b. Locality Patient Experience

The Quality Team has met with the patient engagement locality leads. The actions from this meeting are to commence engagement and work with the Citizens Panel, Healthwatch Groups, Locality Care Forums, Care Opinion, Patient Engagement involvement in contract development and attendance at the Patient Participation Involvement Forum. The outcomes will be shared with PCCC in the September Quality report when patient experience is the focused domain.

6. CCG Actions/Next Steps

Details of actions/next steps for each area of Primary Care Quality are detailed within the above report. A summary of these actions are below:

- Ongoing discussions with Primary Care Contracting and Resilience Teams regarding outstanding issues following CQC reports, FFT results and practices listed as Red in the domain indicators.
- Practices not submitting FFT data will be contacted further.
- That work needs to be done in the areas of high prescribing involving localities, medicines optimisation and transformation teams.
- The Medicines Optimisation Team to target all GP practices to continue to adhere to the BNSSG Formulary Prescribing for Depression-Primary Care Pathway
- The Medicines Optimisation Team to work with practices that are above the total number of average daily quantities (ADQs) for selected antidepressant prescribing and address actions to rectify this and learn from those who are within target.
- The CCG to develop and implement screening/access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year.

7. Financial resource implications

There are no specific financial resource implications highlighted within this paper.

8. Legal implications

There are no specific legal implications highlighted within this paper.

9. Risk implications

Actions to address any highlighted risks have been added to the paper under each section.

10. Implications for health inequalities

Monitoring of primary care quality and performance will highlight any areas of health inequalities within BNSSG, which will then be addressed accordingly

11. Implications for equalities (Black and Other Minority Ethnic/ Disability/ Age Issues)

Monitoring of primary care quality and performance alongside practice demographic information will help to highlight areas of variation of services, which will then be addressed accordingly.

12. Consultation and Communication including Public Involvement

Whilst there has not been any direct consultation and communication with the public in the production of this paper, patient experience and public involvement is recognised as an important factor in reviewing and gaining assurance regarding primary care services.

13. Recommendations

- To note the updates on monthly quality data and the specific information regarding Mental Health and Cardiovascular Disease care.

Appendix 1 – Quality Domain Calendar
Appendix 2 - Prescribing for Depression
Appendix 3 - Mental Well Being Leaflet

Report Authors: Bridget James, Associate Director Quality, Jacci Yuill Lead Quality Manager, Kat Tucker, Quality Support Manager
Report Sponsor: Janet Baptiste-Grant, Interim Director of Nursing and Quality

Glossary of terms and abbreviations

Please explain all initials, technical terms and abbreviations.

Primary Care Operational Group (PCOG)	a sub group of the PCCC where operational issues are managed and/or escalated to PCCC
Primary Care Commissioning Committee (PCCC)	The CCG decision making body for anything related to primary care
Friends and Family Test (FFT)	A quick and anonymous way for any patient to give their views after receiving care or treatment across the NHS.
Care Quality Commission (CQC)	The independent regulator for all health and social care services in England.
Quality Outcomes Framework (QOF)	The Quality and Outcomes Framework is a system for the performance management and payment of general

	practitioners (GPs) in the NHS in England, Wales, Scotland and Northern Ireland.

Appendix 1: Primary Care Quality Calendar

Items reported every month:

- Care Quality Commission updates.
- Friends and Family Test data.
- Quality improvement updates.
- Quality escalations identified in month.

Items reported on a Quarterly Basis:

- Medicines Optimisation.
- Incident reporting

Month	Domain
October	Children
November	Update on National Annual Data
December	Cancer
January	Workforce & Resilience
February	Diabetes
March	Cardiovascular
April	Mental Health
May	Prescribing
June	Respiratory
July	Dementia
August	Urgent & Emergency Care
September	Patient Experience

NHS
Bristol
North Somerset
South Gloucestershire

Prescribing for Depression – Primary Care Pathway

NICE advocates a stepwise approach to managing common mental health disorders. It recommends offering, or referring people for, the least intrusive and most effective intervention first. Therefore, non-drug interventions (such as **cognitive behavioural therapy** [CBT]) should be the mainstay of treatment for many people with depression or GAD, with drugs generally reserved for more severe illness or when symptoms have failed to respond to non-drug interventions

Assessment of depression

Suggested rating scales include PHQ9 to screen and DSM-IV criteria (change from ICD-10 criteria in NICE CG 23)
A range of psychological and psychosocial interventions are recommended in the updated NICE guidance (CG 90)
Separate additional guidance is given on depression in adults with a chronic physical health problem (CG 91)

Consider immediate referral to Secondary Care if any of these apply:

1. Considerable risk of suicide, harm to others or severe self-neglect
2. Psychotic symptoms
3. History of elation or mania
4. Significant cognitive impairment
5. Pregnancy for peri-natal advice
6. Psychiatric co-morbidity or complex

Assessment of suicide risk

Patients considered being at risk of suicide or under 30 years old should be seen after one week and frequently until risk is considered no longer significant. All other patients should be seen after 2 weeks. All patients should be considered for drug and alcohol abuse

Mild depression

Active monitoring initially for 2 weeks. Arrange follow-up to monitor progress. If persistent or recurrent treat as moderate.
Evidence suggests possible benefits from peer support, self-help delivered without professional support and other low cost, low intensity psychosocial interventions

Evidence confirms that interpersonal therapy is an effective high-intensity psychological treatment for depression of all severities

Continue treatment for at least 6 months (longer in elderly) after resolution of depression.
Chronic/recurrent/treatment resistant depression should be treated for at least 2 years (life-long for some).
Referral for further psychiatric assessment may be necessary.

First line Treatment SSRI

Moderate/Severe, consider talking treatment and/or antidepressant. Antidepressant trial for 4 weeks - If patient has previous history of successful treatment, initiate prior therapy if appropriate.
Sertraline rated 'top' for effectiveness and acceptability
Citalopram has few interactions if patient on other medicines. 20mg (max dose 65yrs+, caution higher doses due to risk of QT interval prolongation)
Fluoxetine is less effective, long half-life may need long wash-out period, higher incidence of side effects. May be useful if patient has had success with it before
For older patients– **Mirtazapine** may be considered where SSRI problems of hyponatraemia or increased bleeding risk more likely. **SSRI Caution in patients with history of bleeding or on NSAIDs –consider adding a PPI. Hyponatraemia should be considered if drowsiness, confusion or convulsions occur.**

Consider highlighting first time antidepressant treatment on prescription so Community Pharmacy can offer support – provide patient with treatment leaflet

Second line Treatment SSRI

If no response after 4 weeks (6 weeks for older patients) – after checking compliance at 2/52, and confirming diagnosis. or if experiencing side-effects

Try an alternate first line SSRI as above (citalopram or sertraline)- Escitalopram may also be considered second line, especially for poor response – more expensive than first line choices, but good for effectiveness and acceptability

Third line treatment – other options

If no response after 4 weeks (check compliance, confirm diagnosis) or if experiencing side-effects,
Escitalopram – although an SSRI, can consider third line after sertraline and citalopram – effective and well tolerated (Caution dose QT interval)
Mirtazapine – Associated with weight gain and can cause sedation. SPC suggests FBC performed at any sign of infection. May be particularly useful in older patients, see first line treatment
Venlafaxine - less chance of withdrawal with MR formulation (longer half-life). 75mg dose acts as SSRI so little benefit. BP should be measure in patients on doses above 150mg.Associated with greater risk of death from overdose

References: 1.NICE Clinical Guidelines 90 http://www.nice.org.uk/CG90 (update to CG 90 April 2012) and 91 http://www.nice.org.uk/CG91 2. Cipriani, A., Furukawa, T.A., Salanti, G. *et al.* (2009) Comparative efficacy and acceptability of 12 new generation antidepressants: a multiple-treatments meta-analysis. *Lancet, 373*, 746-758. 3. WeMeRec. Antidepressant therapy in primary care. *This guidance is general and will not cover all eventualities; all clinicians retain professional responsibility for their prescribing*

Prepared Sue Mulvenna, Sasha Beresford May 2010. Updated Jules Cuthbert and Louise Byrne-Jones Jan 2015

This is a Lifestyle Prescription to keep you in the best physical and mental health

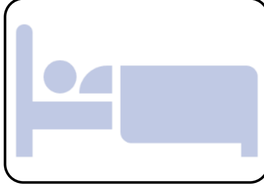
Wellbeing Toolkit

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Author: Dr Shaba Nabi: Apr 2019

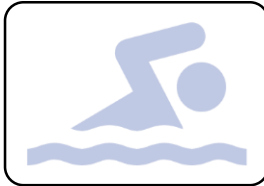
Tick any 3 boxes to start your change

SLEEP



- ☐ Fixed bedtime/wake-ups
- ☐ No screens 1 hour before bed
- ☐ Bedtime routine - > Read, Bath or Meditate
- ☐ Don't nap during the day
- ☐ Go outside often for daylight
- ☐ Caffeine before midday only
- ☐ Eat evening meal early

MOVE



- ☐ 15 - 20 mins per day
- ☐ Choose what you enjoy - > Dance/Cycle/Swim/Football
- ☐ Outside is best
- ☐ Do it with a friend
- ☐ Install "Couch to 5K"
- ☐ Install "Pacer App"- > build up step count gradually

EAT

- ☐ Mediterranean Diet - > Fruit/Nuts/Veg/Fish
- ☐ Omega 3 foods - > Mackerel/Salmon/Flaxseeds
- ☐ Limit processed/fast food
- ☐ Minimise alcohol/sugar
- ☐ No recreational drugs
- ☐ https://www.nhs.uk/live-well/eat-well/

RELAX

- ☐ Meditate for 10 mins a day
- ☐ Relax with Yoga or Fishing
- ☐ Separate work from home
- ☐ Do something creative
- ☐ Practise Mindfulness -> https://bemindful.co.uk/
- ☐ Install "Headspace App"
- ☐ Install "Beat Panic App"

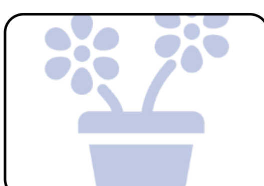
CONNECT

- ☐ Supportive relationships
- ☐ Meet friends face to face
- ☐ Limit time on social media
- ☐ Join activity groups/clubs
- ☐ Daily "me" time
- ☐ Engage with a hobby
- ☐ Write a journal including positive feelings/gratitude

PURPOSE

- ☐ Discover what you love
- ☐ Create meaning/direction
- ☐ Live by your values
- ☐ Consider voluntary work
- ☐ Learn something new
- ☐ Break vision into small goals
- ☐ Be kind to yourself & others
- ☐ Be part of your community

NATURE



- ☐ Get outside in all weathers
- ☐ Notice seasons changing
- ☐ Walk amongst trees
- ☐ Climb hills and cross lakes
- ☐ Plant flowers and grow veg
- ☐ Make friends with animals
- ☐ Discover your surroundings
- ☐ Try camping

HELP

Wellbeing Therapies (self-ref)

- ☐ Bristol: 0117 982 3209
- ☐ South Glos: 0117 378 4270
- ☐ North Som: 0300 300 0834

https://reading-well.org.uk/books/books-on-prescription/mental-health

- ☐ http://iapt.awp.nhs.uk/
- ☐ http://iapt.awp.nhs.uk/
- ☐ https://positivestep.org.uk/

Agenda item: 11

Report title: Cardiovascular Disease (CVD) Prevention

1. Background

As part of the process for reporting general practice quality measures to the Primary Care Commissioning Committee, each month there is a specific domain focus. Cardiovascular disease (CVD) is the domain focus this month. This is also an area of BNSSG system wide work as part of the Healthier Together and regional and national focus. Therefore in order to provide context to general practice quality measures for CVD, this report provides a description of the various national and regional ambitions and BNSSG current work.

2. Impact of cardiovascular disease

CVD is a significant cause of mortality and morbidity, being responsible for one in four premature deaths in the UK and 26% of all deaths in England in 2015. Furthermore, CVD is linked to health inequalities with premature death rates from CVD in the most deprived 10% of the population almost double those in the least deprived 10%[1]. In terms of prevention (managing atrial fibrillation, hypertension and cholesterol) this is mainly delivered by general practice.

3. National ambitions

There are a number of national and local ambitions, requests and requirement and potentially different pieces of work either in place or being scoped and considered across BNSSG for each of the three CVD secondary prevention areas of atrial fibrillation (AF), hypertension and cholesterol. Table 1 below summarises the ambitions and requirements from different organisations and roles and then more detail is given in the sections that follow.

[1] PHE, Action plan for cardiovascular disease prevention, 2017 to 2018: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/648190/cardiovascular_disease_prevention_action_plan_2017_to_2018.pdf

Table 1

Organisation	Ambition / Request / Requirement	Timescale for achievement	Data provided to CCG
Public Health England	**Request** – Prioritise CVD prevention on local STP/ICS plans focussing on hypertension, AF and high cholesterol; develop clear actions to reduce the population's CVD gap **Ambition** – Nationally, increase case finding; increase ' treatment', increase optimal management	By March 2019 By 2029	CVD prevention data pack for BNSSG with QOF 2017/18 data
NHS Long Term Plan	**Ambition** – NHS to work with local authorities to improve effectiveness of approaches such as NHS Health Check; individuals "with high-risk conditions" will be offered "appropriate preventative treatments" in a timely way; NHS will support pharmacists and nurses in primary care networks to case find and treat people with high risk conditions; creation of a national CVD prevention audit for primary care to support continuous clinical improvement.	To be confirmed by NHS England	-
NHS RightCare	**Requirement** – As one of the National Priority Initiatives, CCG to reach the average % achievement of its best 5 peer CCGs for: • People over 79 years old with hypertension in whom last blood pressure reading is 140/90mmHg or less (BNSSG = 53.8%, average of best 5 peers = 57%) • In people with AF with a record of a CHA2DS2-VASc score of 2 or more, the % of people who are currently treated with anticoagulation drug	By April 2021with milestones that begin in April / May 2019	NHS RightCare 2017/18 data packs on Cardiovascular Disease Prevention

	therapy (BNSSG= 84%, average of best 5 peers = 85.8%)		

NHS Long Term Plan ambitions

This plan states that:

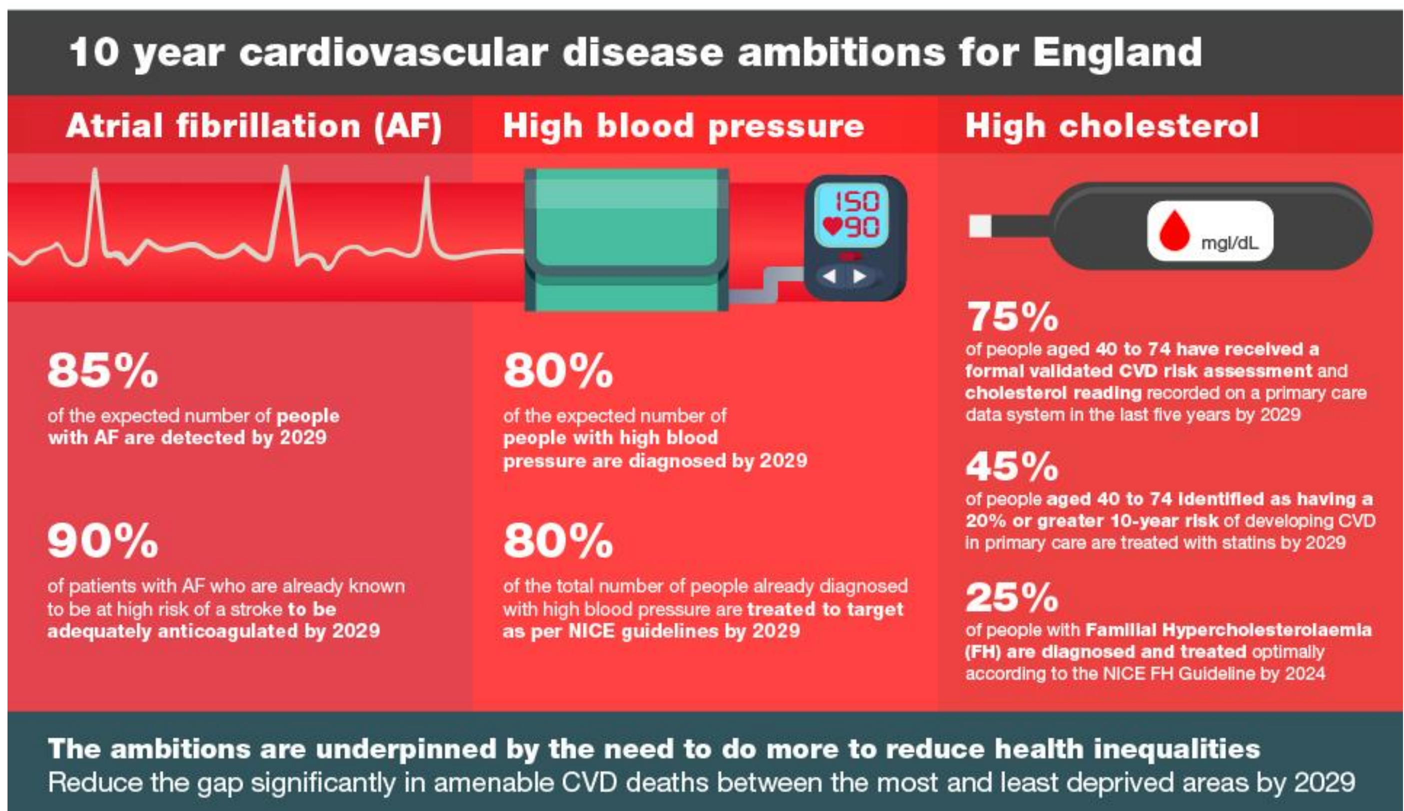
- Too many people are still living with undetected, high-risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation (AF). Other countries have made more progress on identification and diagnosis working towards people routinely knowing their 'ABC' (AF, Blood pressure and Cholesterol). Replicating this approach will be increasingly possible with digital technology, and major progress could be achieved working with the voluntary sector, employers, the public sector and NHS staff themselves.
- The NHS will work with local authorities and Public Health England (PHE) to improve the effectiveness of approaches such as the NHS Health Check, rapidly treating those identified with high-risk conditions. Working with voluntary sector partners, community pharmacists and GP practices will also provide opportunities for the public to check on their health, through tests for high blood pressure and other high-risk conditions
- Where individuals are identified with high risk conditions, appropriate preventative treatments will be offered in a timely way. The NHS will support pharmacists and nurses in primary care networks to case find and treat people with high-risk conditions. The creation of a national CVD prevention audit for primary care will also support continuous clinical improvement.

Public Health England ambitions

Public Health England and NHS England jointly wrote to Sustainability and Transformation Partnerships (STPs) and CCGs in the South West in November 2018. The letter stated that:

- A collaborative South West CVD Prevention Board committed to supporting the upscaling of CVD prevention efforts by STP/Integrated Care Systems (ICSs) had been set up earlier in 2018
- The South West CVD prevention programme aims to increase awareness of effective interventions and highlight variation in care across the CVD care pathway, prioritising the diagnosis and management of high blood pressure, atrial fibrillation (AF) and high cholesterol in primary care, and improving cardiac rehabilitation services.
- PHE had published a report that reviewed data on the CVD gap in each South West CCG entitled 'Getting serious about cardiovascular disease in the South West'
- PHE Centres are being directed to hand over this programme of work to STP/ICSs by the end of March 2019
- Each STP/ICS to prioritise CVD prevention in local STP/ICS plans by March 2019, focusing particularly on hypertension, AF and high cholesterol; develop clear action plans to reduce their population's CVD gap; review the quality of their cardiac rehabilitation service provision, and the local contracting agreement.

Figure 1 Public Health England's 10 year CVD ambitions for England



NHS RightCare

The National 19/20 Planning Guidance set out the following requirements on CCGs:

"All systems will work with the NHS RightCare programme to implement national priority initiatives for cardiovascular …conditions in 2019/20."

On 10 April 2019 the CCG received further detail on the requirement of the national priority initiative for cardiovascular conditions. The achievement target is for each CCG to reach the average percentage achievement of the best five CCGs within its similar ten peer group of CCGs (based on 2017/18 baseline data) for:

- Optimal management of known patients with atrial fibrillation (AF), i.e. "In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy"
- Optimal management of known patients with hypertension, i.e. "The percentage of patients aged under 79 with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less"

4. BNSSG work

Healthier Together Prevention Programme

One of the workstreams of this programme is CVD risk factors and there is a CVD Risk Factors Implementation Group that is chaired by Viv Harrison, Public Health Consultant. The group has met once and at that meeting attendees agreed that the focus of the work would be on secondary prevention - physiological risk factors (blood pressure, cholesterol, atrial fibrillation) and reducing inequalities/variation in outcomes.

Other programmes of work are already addressing primary prevention across BNSSG and within the other Healthier Together Prevention Programme workstreams of Tobacco/Obesity and Physical Activity/Alcohol.

The focus of the group is on hypertension because this is a risk factor where historically, BNSSG (Bristol in particular) has not 'performed' well, has benchmarked poorly and also where there appears to be variation in estimated to reported prevalence and patients who are achieving the (former) target of 150/90 when GP practices are compared to their peers elsewhere in the country. This information, which has come from NHS RightCare, has been shared with three GPs. Following queries and hypotheses from them about the data and what it appears to be showing, it is being validated in. The draft delivery plan (see Appendix 1) for this group includes the following actions:

- Understand the validity of the hypertension prevalence and management variation in BNSSG
- Partners (people, commissioners, providers, and voluntary, community and social enterprise sector) to agree what outcomes we want to achieve
- Develop evidence-informed ideas for how to achieve the outcomes
- Develop a set of recommendations for implementation within primary care that is systematic and at scale

The validation work has already begun and the work to understand what outcomes we want to achieve will be led by the CVD Risk Factors Implementation Group and take place over the next two months.

Healthier Together Stroke Clinical Lead – stroke prevention

Dr Phil Simons is the GP clinical lead for the Healthier Together Stroke Programme. The programme's current focus is on the feasibility of reconfiguring stroke services in BNSSG. Dr Simons is keen to do work on stroke prevention and has been discussing this with Dr Shaba Nabi, CCG GP Clinical Lead for Medicines Optimisation. They would like to focus efforts and resources on hypertension management in people who have had a stroke or heart attack as they are considered to be at highest risk of having (another) stroke or heart attack if their blood pressure is not well managed. Their initial idea was to use the Prescribing Quality Scheme to support this. However 2019/20 QOF now supports better management of these patients. The work of the

medicine optimisation pharmacists can assist with any further work that is needed. Dr Phil Simons is now taking part in the Healthier Together Prevention Programme CVD risk factors workstream.

Don't Wait to Anticoagulate

This was an Academic Health Science Network and Bristol CCG project delivered in 2016/17. It aimed to support Bristol's general practices to reduce the burden of atrial fibrillation (AF) related Stroke amongst the registered population through:

- Use of standard risk stratification tools to identify patients with high risk of AF-related stroke who were not receiving appropriate anticoagulation. A comprehensive clinical review was then undertaken to establish if anticoagulation was required. People were empowered to partner with clinicians and share anticoagulation decisions.
- Optimisation of anticoagulation of AF patients who are currently unstable on Warfarin through improved compliance, or transfer to New Oral Anticoagulants in accordance with NICE Guidance (CG 180)

The evaluation showed that, given the numbers needed to treat to prevent one stroke (40), approximately six strokes would be prevented in one year as a result of the 230 additional people switched to optimal anticoagulation. It would be useful to understand AF and anticoagulation 'achievement' and processes in North Somerset and South Gloucestershire to establish whether any further work needs to be done. The CCG will do this work by end May 2019.

5. BNSSG CVD prevention performance

Over the last 12 months, we have received a range of data and information about how our health system, particularly primary care, is either 'performing' or how it benchmarks in the CVD prevention indicators of blood pressure, cholesterol and atrial fibrillation. The sources of information include:

- RightCare benchmarking information at GP practice level (this compares a GP practice with its peer elsewhere in England) and CCG level (see section above on Healthier Together Prevention Programme).
- Data from Public Health within "Getting serious about cardiovascular disease in the South West" and CVD prevention data pack for BNSSG with QOF 2017/18 data
- QOF data

All of this information needs to be looked at together to avoid the risk of inappropriate conclusions being made. An example of this is that for QOF 2017/18, all GP practices in BNSSG are either above target, on target or less than 15% below target for:

- HYP006 - % patients with hypertension in whom the last blood pressure reading (measured in the last year) is ≤ 150/90mmHg
- AF007 - % patients with AF who are currently treated with anti-coagulation therapy in whom there is a CHADS2-VASc score of 2 or more
- BP002 - % patients aged 45 or over who have a record of blood pressure in the preceding 5 years

– STIA003 - % patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is ≤ 150/90mmHg

However, it appears that when most of the GP practices are compared to their GP practice peers in England, they are not ‘performing’ as well in terms of people who are being ‘managed to target’. See Figure 2 for an **illustration** of this.

Figure 2 RightCare benchmarking information for Bristol (for illustration purposes – the same information is available for North Somerset and South Gloucestershire and shows similar “opportunities”) – each GP practice is compared with its equivalent elsewhere in England.
Key:

Red	Statistically significant opportunity to identify more people or improve clinical management - worse than the practice cluster (similar GP practices nationally) benchmark
Yellow with text	Not statistically significant opportunity to identify more people or improve clinical management
Yellow without text	Not statistically significant - better than the practice cluster (similar GP practices nationally) benchmark
Green	Statistically significant – better than the practice cluster benchmark

Individual practice names have been removed.

	Estimated CHD prevalence (55-79 years) (%)	Estimated CHD prevalence (%)	Estimated Hypertension Prevalence (%)	Reported to Estimated prevalence of CHD (%)	Reported to Estimated prevalence of Hypertension (%)	CHD patients whose BP <150/90 (%)	CHD patients whose cholesterol <5 mmol/l (%)	Hypertension patients whose BP <150/90 (%)
	2016	2011	2014	2016/18 (2011)	2016/17 (2014)	2016/17	2013/14	2016/17
A...	26 Ppl.	40 Ppl.	175 Ppl.	40 Ppl.	718 Ppl.	14 Pats.	22 Pats.	99 Pats.
R...	60 Ppl.	109 Ppl.	329 Ppl.	147 Ppl.	385 Ppl.	12 Pats.	20 Pats.	76 Pats.
CA...	62 Ppl.	182 Ppl.	344 Ppl.	76 Ppl.	975 Ppl.	22 Pats.	36 Pats.	105 Pats.
...	100 Ppl.	139 Ppl.	164 Ppl.	167 Ppl.	1050 Ppl.	10 Pats.	3 Pats.	61 Pats.
...	7 Ppl.	106 Ppl.	163 Ppl.	97 Ppl.	159 Ppl.	19 Pats.	16 Pats.	125 Pats.
...	132 Ppl.	360 Ppl.	1569 Ppl.		174 Ppl.	40 Pats.	36 Pats.	113 Pats.
.	47 Ppl.	114 Ppl.	85 Ppl.	150 Ppl.	580 Ppl.	15 Pats.		78 Pats.
....	13 Ppl.	88 Ppl.	265 Ppl.	85 Ppl.	847 Ppl.	23 Pats.	17 Pats.	141 Pats.
G...		119 Ppl.	203 Ppl.	179 Ppl.	364 Ppl.	12 Pats.	4 Pats.	101 Pats.
CA...	92 Ppl.	111 Ppl.	591 Ppl.	71 Ppl.	252 Ppl.	23 Pats.	9 Pats.	108 Pats.
R...	37 Ppl.	132 Ppl.	265 Ppl.	33 Ppl.	78 Ppl.	8 Pats.		22 Pats.
...	121 Ppl.	36 Ppl.	3 Ppl.	99 Ppl.	1002 Ppl.	41 Pats.	28 Pats.	114 Pats.
...	33 Ppl.	44 Ppl.		77 Ppl.	226 Ppl.	12 Pats.	20 Pats.	81 Pats.
...	54 Ppl.	106 Ppl.	100 Ppl.	102 Ppl.	806 Ppl.	16 Pats.	19 Pats.	70 Pats.
3...	6 Ppl.	65 Ppl.	261 Ppl.	102 Ppl.	447 Ppl.	15 Pats.	8 Pats.	106 Pats.
.	18 Ppl.	150 Ppl.	193 Ppl.	74 Ppl.	148 Ppl.	18 Pats.	21 Pats.	56 Pats.
...	53 Ppl.	125 Ppl.	642 Ppl.	49 Ppl.	953 Ppl.	5 Pats.	23 Pats.	133 Pats.
....	14 Ppl.	89 Ppl.	372 Ppl.	55 Ppl.	1283 Ppl.	40 Pats.		160 Pats.
O...	31 Ppl.	99 Ppl.	107 Ppl.	86 Ppl.	675 Ppl.	19 Pats.	28 Pats.	139 Pats.
...	236 Ppl.	230 Ppl.	670 Ppl.	99 Ppl.	686 Ppl.	17 Pats.	18 Pats.	
H...	42 Ppl.	124 Ppl.	180 Ppl.	105 Ppl.	824 Ppl.	24 Pats.	5 Pats.	79 Pats.
...	51 Ppl.	119 Ppl.	50 Ppl.	141 Ppl.	635 Ppl.	29 Pats.	44 Pats.	124 Pats.
L...	24 Ppl.	61 Ppl.	164 Ppl.	45 Ppl.	73 Ppl.	10 Pats.		43 Pats.
B...	84 Ppl.	118 Ppl.		38 Ppl.	740 Ppl.	28 Pats.	29 Pats.	63 Pats.
	62 Ppl.	109 Ppl.	158 Ppl.	24 Ppl.	1310 Ppl.	13 Pats.	12 Pats.	111 Pats.
...		48 Ppl.	18 Ppl.	76 Ppl.	694 Ppl.	2 Pats.	8 Pats.	56 Pats.
E...	15 Ppl.	65 Ppl.		119 Ppl.	609 Ppl.	12 Pats.	3 Pats.	60 Pats.
...				12 Ppl.	1641 Ppl.	36 Pats.	25 Pats.	151 Pats.
M...		176 Ppl.	282 Ppl.	220 Ppl.	952 Ppl.	22 Pats.	15 Pats.	174 Pats.
D...		21 Ppl.		92 Ppl.	9 Ppl.	18 Pats.	32 Pats.	40 Pats.
C...	29 Ppl.	75 Ppl.		148 Ppl.	710 Ppl.	4 Pats.	42 Pats.	80 Pats.
HC...		88 Ppl.	108 Ppl.	103 Ppl.	371 Ppl.			
U...	2 Ppl.			69 Ppl.	853 Ppl.	8 Pats.	22 Pats.	40 Pats.
...		113 Ppl.		175 Ppl.	943 Ppl.	24 Pats.	25 Pats.	140 Pats.
M...	20 Ppl.			26 Ppl.	878 Ppl.	2 Pats.	15 Pats.	38 Pats.
) ...	5 Ppl.		101 Ppl.	65 Ppl.	633 Ppl.	8 Pats.	6 Pats.	23 Pats.
...				47 Ppl.	333 Ppl.	8 Pats.	4 Pats.	48 Pats.
NI...	42 Ppl.	34 Ppl.	164 Ppl.	50 Ppl.	485 Ppl.		11 Pats.	
E...				81 Ppl.	861 Ppl.	14 Pats.	27 Pats.	60 Pats.
T...	20 Ppl.			34 Ppl.	1715 Ppl.	44 Pats.	35 Pats.	204 Pats.
CA...			43 Ppl.	12 Ppl.	100 Ppl.	4 Pats.		34 Pats.

6. Financial resource implications

These will need to be considered as part of the work and due consideration will need to be given to maximising the value the system and its population get from every pound.

7. Legal implications

None identified at this time.

8. Risk implications

There is a risk that we do not use our resources appropriately to improve CVD prevention, and consequently outcomes, in BNSSG due to:

- potential duplication of work
- lack of clarity of purpose and what we're trying to achieve
- not being specific enough about what we're trying to achieve
- not managing the information that is being given to us by different sources

These risks will be managed by the Healthier Together CVD Risk Factors Implementation Group.

9. Implications for health inequalities

CVD outcomes are a known area of health inequalities. Improvements in CVD outcomes at an overall population level have been made over recent years, however the gap in outcomes between various parts of the population has not narrowed at the same rate. CVD is linked to health inequalities with premature death rates from CVD in the most deprived 10% of the population almost double those in the least deprived 10%. The Public Health England ambition is to reduce the gap significantly in amenable CVD deaths between the most and least deprived areas by 2029.

10. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

The Healthier Together CVD risk factors workstream has to propose the outcomes that the work needs to achieve and for whom. The Public Health England ambition focuses on deprivation and we need to decide what the focus should be on in BNSSG, e.g. ethnic minorities; people with serious mental illness; people living in our deprived areas, in order to improve our population's health outcomes. By examining all the data and information available to the BNSSG health and care system, considering the available evidence on evidence of effectiveness of various interventions to achieve those outcomes and taking a value based healthcare approach, the workstream will be able to propose interventions that will narrow this gap.

11. Consultation and Communication including Public Involvement

The Healthier Together CVD risk factors workstream delivery plan includes work to agree with partners (people, commissioners, providers, and voluntary, community and social enterprise sector organisations) what outcomes in blood pressure control we should be achieving.

12. Summary

The Primary Care Commissioning Committee provides oversight on primary care (general practice) quality and this includes CVD prevention. The CCG Quality Team has been asked to provide information to the committee and was considering the information that they receive from Business Intelligence which was limited to QOF achievement in the indicators relating to atrial fibrillation, blood pressure and cholesterol. This information gives one perspective but the content of this paper shows that there is a wider context to be considered.

It is clear that CVD prevention is a priority both nationally and within the BNSSG health system. It is also clear that there are a number of different groups with differing ambitions and different data and information designing and implementing efforts to improve CVD prevention.

The BNSSG health and care system needs to create one effort around a shared, specific purpose and be clear about what it wants to achieve for its population given the resources that it has and use a value based healthcare approach to this. It needs to be explicit about the decisions that it makes, e.g. whether to focus efforts on detection, or management or both. The next meeting of

the Healthier Together CVD Risk Factors Implementation Group will bring together all the work described in this briefing to ensure that CVD risk factors improvement work on hypertension, in the first instance, is co-ordinated. In addition, it will need to contribute to the BNSSG system's five year plan in order to consider the national and regional ambitions for atrial fibrillation and cholesterol identification and management and how they are prioritised locally.

13. Recommendations

Primary Care Commissioning Committee is asked to note this update on cardiovascular disease prevention.

Report Author: Adwoa Webber, Head of Clinical Effectiveness
Report Sponsor: Peter Brindle, Medical Director, Clinical Effectiveness

Appendices

Appendix 1 – Healthier Together CVD Risk Factors Implementation Group Delivery Plan

Glossary of terms and abbreviations

Term	Definition
Cardiovascular Disease (CVD)	A family of diseases that includes coronary heart disease (CHD), stroke and peripheral arterial disease, as well as vascular dementia, chronic kidney disease, cardiac arrhythmias, type 2 diabetes, sudden cardiac death and heart failure. There are numerous common risk factors that lead to CVD, including smoking, high cholesterol, high blood pressure, poor diet, harmful drinking and physical inactivity.
Healthier Together	Our Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Partnership (STP). Thirteen local health and care organisations working together to improve health and care.
Hypertension	High blood pressure. This rarely has noticeable symptoms. If untreated, it increases your risk of serious problems such as heart attacks and strokes.
Atrial Fibrillation (AF)	A heart condition that causes an irregular and often abnormally fast heart rate
Public Health England (PHE)	National public health body which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
RightCare	A national programme that provides benchmarking data on outcomes and spend to help health and care systems identify opportunities for improvement and support systems to make improvements.

Cardiovascular disease

STP interdependencies with Acute Care Collaboration, Stroke Reconfiguration Board, Medicines Optimisation

Activity	Outputs/Outcomes	Impacts and timeline
Understand the validity of the hypertension prevalence and management variation in BNSSG	Pilot audit of practice-level data	Short term: improve blood pressure control and reduce prevalence of hypertension amongst BNSSG population. Medium-to-long term: reduce incidence and prevalence of conditions associated with hypertension including: cardiovascular disease; stroke; renal failure.
Gain consensus agreement from partners (people, commissioners, providers, and VCSE) about important outcomes in blood pressure control and develop evidence-informed ideas for how to achieve the outcomes	Agree patient-centred and clinician-relevant outcome set for monitoring and evaluation Develop a set of recommendations for implementation within primary care systematically and at scale	
Collaboration with Stroke Reconfiguration Board and Stroke Health Impact Team	Providing leadership for the stroke prevention work across BNSSG	Short term: improve blood pressure control and reduce prevalence of hypertension amongst BNSSG population. Medium-to-long term: reduce incidence of stroke and complications
Explore feasibility of local implementation of NHS England and PHE A-B-C initiative	Work with Medicines Optimisation group and others to explore secondary prevention of CVD and stroke	Short-term: better control and management of atrial fibrillation, blood pressure, and cholesterol
Continue implementation of NHS Health Checks across BNSSG	Local areas commission NHS Health Checks for at-risk groups; initiatives to increase uptake in eligible patients	Longer-term: reduced incidence of stroke, renal disease, cardiovascular disease, diabetes, dementia