

LOCAL ENHANCED SERVICE
for
PRIMARY PREVENTION of CVD: CVD RISK MANAGEMENT
PROGRAMME

Service Level Agreement

Contents:

1. Introduction
2. Background
3. Service Outline
4. Aims of CVD Risk Management Programme
5. Service Specification
6. Coverage Incentive
7. Performance and Quality Measures
8. Education, Training and Support
9. Named Staff
10. References
11. Financial Details / Signature Sheet
12. Appendices 1 - 6

INTRODUCTION

All practices are expected to provide essential services and those additional services they are contracted to provide to all their patients. This enhanced service specification for the provision of CVD risk management outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond the scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

BACKGROUND

There are an estimated 44,000 people living in South Staffs aged 40-74 years without existing Cardiovascular Disease (CVD) but at high risk of developing CVD in the next 10 years. The PCT wants to identify all these people and offer treatment and lifestyle interventions to reduce their risk and improve their health. The establishment of registers of at risk patients in all practices is a standard in the National Service Framework for Coronary Heart Disease: 'general practitioners and primary health care teams should identify all people at significant risk of cardiovascular disease, but who have not yet developed symptoms and offer them appropriate advice and treatment to reduce their risks'.

Effective disease prevention in at risk patients will make an important contribution to the overall public service agreement (PSA) mortality target. Recent guidance from the National Institute for Health and Clinical Excellence (NICE) and from the Joint British Societies suggests the threshold for at risk patients should be a 10-year cardiovascular (CVD) risk of 20% or greater (which equates to a 10-year CHD risk of 15% or greater).

The primary prevention of CVD is also a local priority, the Staying Healthy programme was agreed by the PCT Board in October 2007. In addition the PCT will be monitored against its achievement of Vital Sign VSC23 (calculation and recording of vascular risk score).

"Putting Prevention First" National Programme

This CVD risk management LES forms part of the national programme, formally known as the Vascular Check Programme and now called "NHS Health Check". This LES specifically targets patients at highest risk (>20%). The national programme will eventually be for all adults age 40-74, a local population-based approach will be developed in the future.

SERVICE OUTLINE

This service specification sets out what is required for the systematic assessment of the population age 40-74 for risk of CVD and identification of patients at >20% risk of CVD (creation of at risk register), and subsequent management to reduce their risk.

The scheme will initially run until March 2011 and will be reviewed on an annual basis.

This specification will need to be reviewed in line with the national recommendations.

AIMS of CVD RISK MANAGEMENT PROGRAMME

The overall aim of this LES is to commission a systematic cardiovascular risk assessment and management programme from General Practices in order to improve health outcomes for the population of South Staffordshire. This will be achieved by:

1. Systematically assess all patients age 40-74 without existing cardiovascular disease using known or acquired information and the modified Framingham equation to assign a CVD risk score, through the Clinical Risk computer software programme (MSDi) (preferred option). Alternatively practices with EMIS-LV may batch process all patients age 40-74 using the QRISK2 tool.
2. Identify patients who are at >20% risk of cardiovascular disease (CVD) and offer them appropriate medical management and lifestyle support.
3. Refer all patients with >20% CVD risk to a lifestyle support programme to underpin the primary prevention programme.
4. Continue to raise awareness of those working with and for general practices in South Staffs, their patients and the population at large about the campaign to promote primary prevention of cardiovascular disease; and the existence and potential benefits of the associated lifestyle support programme.

SERVICE SPECIFICATION

Patient pathway attached at appendix 1.

1. Identification of patients at high risk of CVD

Practices will have already installed and run the MSDi Clinical Risk software (preferred option) or EMIS-LV QRISK2 batch processing tool. These use known and estimated data to calculate a CVD risk score. This allows prioritisation of patients most likely to be at highest risk.

NB Estimation of risk to prioritise patients is a short term measure, the CVD programme will move to a population-based approach over time with improved data quality for all patients.

Patients with a risk score >20% should be invited for a comprehensive risk assessment.

Three attempts should be made to contact patients. The first attempt should be in writing, subsequent attempts by methods as determined by the practice. This should be recorded in the patient's notes using the appropriate Read codes.

The term "NHS Health Check" followed by the strapline "helping you prevent heart disease, stroke, diabetes and kidney disease" should be used in all communications to fit with the national "Putting Prevention First" programme.

A suggested letter template and patient information leaflets on NHS Health Checks are available from the Dept of Health:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_097490
NHS Health Check leaflets should be used with the invitation letter. A stock of leaflets will be sent to each practice and additional leaflets will be available from the Resources Office at Sir Robert Peel Hospital.

Patients who do not respond should have a note added to their record so the option of CVD risk assessment can be raised opportunistically at their next visit. There will be a payment of £2.50 per patient for the administration associated with contacting patients at >20% risk .

2. Comprehensive individualised risk assessment

All patients identified at >20% risk of CVD (without existing CVD) will need to be invited for further blood tests (detailed in Appendix 2). Costs associated with carrying out pathology tests for the completion of individual patients' records will be commissioned through existing local arrangements. The CVD risk score will need to be re-calculated based on the test results using the modified Framingham equation or QRISK2 (EMIS-LV) and entered into patient's notes.

This will be followed by an appointment with a suitably qualified healthcare professional to carry out a comprehensive risk assessment taking account of additional variables not included in the modified Framingham equation and NICE clinical guideline 67 Lipid Modification (Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease; May 2008). Interpretation of CVD risk scores should always reflect informed clinical judgement. See Appendix 2 for further details. Healthcare professionals should discuss the process of risk assessment with the patient identified as being at risk, including the option to and potential implications of declining the service. To support this there is a frequently asked questions section on the NHS Choices website: (www.nhs.uk/nhshealthcheck)

The results of the consultation on risk assessment and the person's decision should be documented in the patient's notes using Read code templates in Appendix 3

Some patients may require additional tests to detect previously undiagnosed disease. These are detailed in appendix 2 and “Putting Prevention First - Best Practice Guidance”. Patients with newly diagnosed disease (eg hypertension, diabetes, CKD) should be added to the appropriate registers and treated through existing pathways.

3. Individual patient treatment / management

Patient management should be aimed at reducing overall risk - a multi-factorial approach to patient treatment is critical as this yields most benefit (NICE 2008).

Each patient should have an individual action plan developed which details the most appropriate lifestyle and pharmacotherapy options to reduce their risk. This should be recorded using the appropriate Read codes (appendix 3).

Patients should be fully involved in deciding what action to take to reduce their risk. Patient decision aids, such as those shown in Appendix 4a,b,c should be used as appropriate. In addition the British Heart Foundation information booklet “So you want to lose weight for good” may be useful.

Lifestyle changes could include stopping smoking, losing weight / improving diet, increasing physical activity or reducing alcohol consumption (NICE 2008). All patients should be referred to appropriate lifestyle improvement services as commissioned locally. Appendix 5 lists current lifestyle services that are available in each locality.

Patients should only be prescribed medication if lifestyle changes alone are insufficient to reduce their risk. Before offering lipid modification therapy for primary prevention, all other modifiable CVD risk factors should be assessed and their management optimised if possible (NICE 2008).

All prescribing should be in line with NICE clinical guideline 67 (Lipid Modification May 2008). Treatment for the primary prevention of CVD should be initiated with Simvastatin 40mg. If there are potential drug interactions, or simvastatin 40mg is contraindicated, a lower dose or alternative preparation such as pravastatin may be chosen. Higher intensity statins should not routinely be offered to people for the primary prevention of CVD.

Payment for 2 and 3 £26.00 per patient

5. Follow-up

All patients at high risk (>20%) should receive an annual follow-up to evaluate the effectiveness of any interventions and offer further treatment / lifestyle referral as necessary. Many patients will be captured through existing follow-up mechanisms eg hypertension registers. Guidance on follow-up for patients who are not captured through this route will be available at a later date.

COVERAGE INCENTIVE

An incentive payment scheme will be included within the LES to ensure that additional resources are available to target those hard to reach groups. These additional payments will be released on an annual basis.

% of 40-74 yr olds with >20% risk score	Additional payment / patient
50-70%	£3.00
70-90%	£5.00
90% +	£8.00

PERFORMANCE and QUALITY MEASURES

The performance and quality measures are outlined in appendix 6. These are supported by the Read codes (Appendix 3) and the GP clinical system templates from the Data Quality Team. Achieving the indicators is the responsibility of the practice team delivering the service to ensure consistent quality and promote primary prevention through lifestyle improvement.

A quarterly search of the Practice clinical system will be requested for payment purposes. This will audit the number of CVD risk assessments undertaken in the previous quarter which are eligible for payment (ie those with complete templates that meet the quality criteria specified – direct indicators).

The searches will be by MiQuest queries available from the Data Quality Team, who will be able to assist practices in running them and in producing a payment claim, a named report for the practice and an anonymised report for Public Health.

The expected numbers of patients on CVD risk registers in each practice will be calculated based on national data. A schedule will be developed with each practice to support them to meet this number over a period of 2 years.

The new QOF points for assessing CVD risk in hypertensive patients require practices to use the JBS or QRISK2 score. Any patients identified through CVD risk assessment as having hypertension will require additional scoring with JBS or QRISK2 to ensure consistency with QOF.

EDUCATION, TRAINING and SUPPORT

All risk assessments must be undertaken by Practice-employed clinical staff. This may be nursing and medical staff as appropriate to the approach taken by the Practice.

All staff involved in providing this service should be competent to do so. South Staffs PCT will organise CVD risk training for staff wishing to enhance their knowledge and skills in this area. Attendance at the training is compulsory.

NAMED STAFF

Each practice will have a designated senior clinical lead for CVD risk management.

In addition each practice will have a named practice manager to support the programme

REFERENCES

NICE clinical guideline 67 Lipid Modification (Cardiovascular risk assessment and the modification of blood lipids for the primary and secondary prevention of cardiovascular disease; May 2008)

Putting Prevention First. NHS Health Check: Vascular Risk Assessment and Management. Best Practice Guidance. Dept Health April 2009.
www.dh.gov.uk/publications

FINANCIAL DETAILS / SIGNATURE SHEET

		Notes
Admin	£2.50/pt	Includes up to 3 invitations for appt (at least one letter) and recording in pt record
Risk assessment	£26/pt for 40mins	With Band 5 nurse. Benchmarked against Insulin conversion LES which pays £20 for 30mins nurse time.
Coverage incentive	£3/pt assessed once >50% coverage achieved £5/pt >70% coverage £8/pt >85% coverage	To ensure hard to reach populations access programme To be paid at year end once coverage is reached
Total / pt	£28.50 for 0-50% £31.50 for 50-70% £33.50 for 70-85% £36.50 for >85%	

Phlebotomy:

Please complete the box below to describe how phlebotomy services are provided for the practice patients

Those practice providing in-house phlebotomy services will be paid £11 for every 12 patients seen under this LES (this is in line with the current ES LES rates)

Practice Name:

**LOCAL ENHANCED SERVICE
for
PRIMARY PREVENTION of CVD: CVD RISK MANAGEMENT
PROGRAMME**

This document constitutes the agreement between the practice and the PCT in regards to this Local Enhanced Service, as specified.

The practice needs to sign below and return this sheet to your Primary Care Manager.

Signature on behalf of the Practice:

Signature	Name	Date	Job Title/Position

Signature on behalf of the PCT:

Signature	Name	Date	Job Title
	Darrell Jackson		Primary Care Manager

The agreement is to cover the period commencing 1st April 2009 until 31st March 2011.

APPENDICES 1 - 6

- Appendix 1: CVD Risk management Programme Pathway
- Appendix 2: Clinical CVD Risk Assessment
- Appendix 3: Read Codes
- Appendix 4a: Lifestyle patient decision aid - Smoking cessation
- Appendix 4b: Statins: a guide for patients
- Appendix 4c: Eat Well plate
- Appendix 5: Lifestyle Services
- Appendix 6: Performance Indicators