Impact of CVDPREVENT audit

CVDPREVENT is now in its 4th year and reporting on a quarterly basis.

CVDPREVENT

HQIP Healthcare Quality Improvement Partnership

IMPROVEMENT GOALS

To support primary care in understanding how many people with cardiovascular disease (CVD) or conditions that lead to a higher risk of developing CVD might be: undiagnosed; under-treated ; over- treated. Analysis and reporting of the audit supports systematic quality improvement (QI) to reduce health inequalities and improve outcomes for individuals and populations.

The CVDPREVENT audit is part of broader strategic objectives outlined in the NHS Long Term Plan (LTP) and national CVD Prevention (CVDP) ambitions to prevent 150,000 strokes, heart attacks and cases of dementia over the next ten years. The audit prioritises working with system partners to drive CVD QI at individual GP, Primary Care Network (PCN), and Integrated Care System (ICS) level.

NATIONAL

How the project provides evidence of quality and outcomes of care nationally

CVDPREVENT Mar 24 data evidences national improvement across the 3 key areas (the 'ABC') of CVDP

1. **Atrial fibrillation** (AF): the % of patients (at high risk of stroke from atrial fibrillation) treated with anticoagulation drug therapy medicine has increased and reached 91.5% LINK.
2. **Blood pressure** (BP): the % of patients with known hypertension treated with anti-hypertensive medication to NICE-recommended targets has increased (to 70.92%). LINK. This still falls short of the NHS Priorities & Operational Planning Guidance (NHS P&OPG) 24/25 target of 80%, however, an additional 346K people nationally have been diagnosed with hypertension since March 23. Variation between the best-performing and worst-performing Integrated Care System (ICS) for this indicator has narrowed by 5% points between Mar 21 (range 39-52%) and Mar 24 (range 66-74%) LINK.
3. **Cholesterol** (CH): the % of patients treated with lipid-lowering medications to lower cholesterol levels according to national standards has increased for both people **with** and **without** established CVD
   - 85% of people with CVD are treated with lipid-lowering therapy LINK
   - 62% of high-risk patients without pre-existing CVD are now prescribed lipid-lowering therapy, 3% short of the NHS P&OPG 24/25 target (65%) LINK.
   - However, there is still room for improvement with only 37% of people with established CVD treated to recommended levels LINK.

SYSTEM

How the project supports policy development & system management

- May 23 'Get Back in the Game Campaign' CVD Prevention Parliamentary Event - Dr P Green Guest Speaker and Chair Q&A
- Webinar Nov 23 'Call to Action - CVD Prevention' for the Pharmacy Profession – Speakers Helen Williams and Liz Corteville: 400 attendees LINK
- Quality improvement (QI) activities arising from the audit have gathered momentum.
- NHS England (NHSE) have been working with CVDPREVENT partners to create QI data packs along with a promise of funding for CVDP leadership in ICSs.
- The 2024 Annual Report has made recommendations to NHSE about raising national ambitions, especially around cholesterol-lowering.
- A Deep Dive: focused on inequalities in cholesterol management by sex for patients with CVD was highlighted in the recent PCCS 7th Annual Conference: Tackling Health Inequalities and CVD Through Innovation & Leadership LINK
- Using CVDPREVENT data, Regions and Systems have created their own local data dashboards to enable system management. E.g.:
  - NHSE North East and Yorkshire Analytics team working in partnership with the Yorkshire and Humber Long Term Conditions Network and the North East and Yorkshire Prevention team.
  - South East Region Local Knowledge and Intelligence Service
  - Hampshire and Isle of Wight LINK

LOCAL

How the project stimulates quality improvement

Spotlight on five ICSs trained in the Train the Trainer CVDP educational outreach approach: Hampshire and Isle of Wight (HIOW), West Yorkshire (WY), Frimley, South East (SE) and South West (SW) London.

	England	HIOW	WY	Frimley	SE Lond	SW Lond
BP Management to Target						
Mar 23	68.3%	63.4%	69.7%	67.5%	67.2%	69.7%
Mar 24	77.0%	68.5%	71.0%	73.1%	70.7%	72.6%
Difference	8.7%	5.1%	1.3%	5.6%	3.6%	2.9%
Improver place		3rd		Top	8th	
Cholesterol Management to Target						
Mar 23	27.9%	12.3%	30.9%	27.2%	29.2%	30.3%
Mar 24	36.9%	34.3%	38.1%	32.7%	34.6%	36.7%
Difference	9.0%	21.9%	7.2%	5.5%	5.4%	6.4%
Improver place		Top				

Other successful ICBs trained in CVDPREVENT QI:

- Cambridgeshire and Peterborough ICS: 2nd most improved ICS for BP management to target (5.5%)
- Mid and South Essex ICS and Black Country ICS: 2nd (19.5%) and 3rd (16.5%) most improved ICSs, respectively, for cholesterol management to target

PUBLIC

How the project is used by the public and the demand for it

Patient Panel – The Patients' Association and Patient representatives address important questions to ensure impact of the audit from a public perspective and gain patient insight e.g.

- Why do you think that 30% of people with diagnosed high blood pressure are not being treated to threshold?
- Why do you think there are such large differences in diagnosis of atrial fibrillation across different levels by deprivation? What can be done to address this?
- What can be done to improve the level of patients being effectively treated for high cholesterol?

CVDPREVENT User Statistics

Data & Improvement tool yearly usage (Dec 23–24)
Total users – 2.9k; Total views – 306k
Average number of sessions per user – 6.3
Average engagement time – 9 min 54 seconds

CVDPREVENT Social Media

CVDPREVENT continues to engage with users on Social media with an increasing audience sharing updates to the data and the release of reports as well as engaging with stakeholders and awareness days.

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NATIONAL
How the project provides evidence of quality and outcomes of care nationally

Professor Bola Owolabi, Director – National Healthcare Inequalities Improvement Programme, NHSE
Cardiovascular disease is, sadly, one of the main causes of death and disability in the country, with evidence showing it is strongly linked to health inequalities. They include well-known conditions such as hypertension, stroke and heart disease, which can often be prevented by leading a healthy lifestyle. But we also know people living in the most deprived areas of England are far more likely to die from a heart condition than those living in the least deprived areas. This is why it's vital for GPs and their practices to optimise their use of CVDPREVENT – a powerful data and improvement tool – in a bid to reduce health inequalities and improve outcomes for patients and populations.

Veena Raleigh, Senior Fellow, The King's Fund
Preventing and managing CVD and its risk factors has the potential to improve population health and outcomes for patients, reduce health inequalities and ease pressures on overstretched health and care systems by reducing the demand for services. It will also reduce morbidity among the large numbers of people of working ages currently unable to work because of ill health.
CVDPREVENT is a unique and valuable resource for quality improvement and benchmarking, supporting GP practices to monitor and raise their game in preventing and managing CVD and its risk factors. The results are evident in the improving trends in many of the evidence-based indicators. CVDPREVENT is also an exemplar internationally, as few countries have such a comprehensive national clinical audit of CVD care in general practice. It is imperative that this valuable resource continues to support general practice in improving CVD care for their patients and reducing the morbidity and mortality impacts of CVD.

SYSTEM
How the project supports policy development & system management

Rod Watson, Senior Project Manager, Health Innovation Network South London
healthinnovationnetwork.com
I'm a regular user of CVDPREVENT – it helps me to identify data trends over time and I love that I can drill down to PCN and practice level data too. I often use the data in discussions with PCN and primary care clinicians.
The HIN South London runs a CVD Fellowship Programme. Last year's cohort comprised around 50 clinicians (including GPs, nurses, pharmacists and pharmacy technicians). The Fellowship Programme consists of a series of clinical webinars delivered by secondary care specialists alongside training on how to deliver a quality improvement (QI) project within the primary care setting. Over the course of 6 months, Fellows undertook their own surgery-based or PCN-wide QI project on one of these clinical areas chosen themselves. CVDPREVENT was presented as an example of how to use data to inform a QI project. All Fellows received training on this at a day-long workshop at the beginning of the Programme.
Working through examples in one of the clinical areas, application of CVDPREVENT identified how practices were performing and how to align their project with QOF targets. Fellows used this as the starting point of their QI project. Stratification of patient cohorts from this data was then undertaken to identify a target group for the project. Projects were written up in the form of a case study. A selection of case studies can be found here.

LOCAL
How the project stimulates quality improvement

Rachel Howard, Deputy Chief Pharmacist, NHS Hampshire and Isle of Wight
As national outliers in hypertension and cholesterol management; addressing this is one of our highest priorities for 2024-25. CVDPREVENT is integral to driving improvements in outcomes for our patients. We developed a dashboard utilising the raw data included in the audit, to help all system partners identify opportunities for improvement and areas of variation & inequalities which require a more targeted approach.
Within the past 12 months, we have used the CVDPREVENT data to form the basis of educational outreach events with our practice & PCN teams, helping teams to understand their data and identify how and where they need to improve. We have also recently shared CVDPREVENT data with the Hampshire & Isle of Wight Prevention Board (amongst other ICS meetings) to showcase our progress as the 3rd most improved ICS for BP treatment to target and the 1st most improved ICS for cholesterol treatment to target. We have also developed a key CVD Prevention incentivised intervention (LINK) for GP practices, using this data to highlight areas of healthcare inequalities

PUBLIC
How the project is used by the public and the demand for it

Jules Payne, Chief Executive, HEART UK - The Cholesterol Charity
CVDPREVENT is absolutely invaluable to us. This is the only reported cholesterol and Familial Hypercholesterolaemia information and it is great that it is publicly reported too.
Our Ambassadors and ChangeMaker's use the tool to see what is going on in their areas.
Also, the publications provide us with great insight on where things are at from a national perspective. This information really helps us better understand the position of both (our overarching objectives) – it may not cover everything we do, but it certainly has great value.

Rony Arafin, Director of Health Insights, British Heart Foundation
CVDPREVENT data is an invaluable resource, it provides greater insight into the cardiovascular health of England, which feeds into our analytical work, including our public-facing statistical resources. It's presentation of age-standardised prevalence data provides excellent insight to better understand the demographics of CVD, and inequalities relating to deprivation across the cardiac pathway.