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Network Contract Directed Enhanced Service

Cardiovascular disease prevention and diagnosis: supplementary guidance

1 October 2021 Version 1.1

1. Purpose

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

2. Background

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

2.2 According to modelling data from Public Health England, more than 30% of hypertension cases remain undiagnosed, and prevalence is rising across all age groups. Levels of detection are expected to have fallen over the past year due to the impact of COVID-19 on routine blood pressure (BP) monitoring.[1] One of the central aims of the PCN CVD prevention and diagnosis DES specification is to facilitate actions to reduce the hypertension prevalence gap[2] to minimise population-level CVD risk.

2.3 The Network Contract DES Specification aims to reduce the impact of the A, B, Cs of CVD (atrial fibrillation, high blood pressure/hypertension and cholesterol). From

[1] In June 2021, the NHS England NHS Improvement Board announced the CORE20PLUS5 initiative to drive targeted health inequalities improvements in agreed areas, with a specific lens on ethnicity and deprivation; hypertension is one of the priority areas within this.
[2] The gap between those diagnosed and the modelled prevalence.

October 2021, the requirements are exclusively around improving the identification of hypertension. From April 2022, this is expanded to incorporate detection and management of atrial fibrillation (AF) and addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH).

2.4 From April 2022, PCNs will also be required to undertake network development and quality improvement activity to support CVD prevention, laying the broader foundations of good preventative care, as PCNs work with systems to develop optimal CVD pathways. This aims to support earlier identification of heart failure, which was highlighted as a priority in the NHS Long Term Plan,[3] improved diagnosis of FH, and better management of cholesterol.

2.5 These interventions will be supported through Quality and Outcomes Framework (QOF) and Investment and Impact Fund (IIF) indicators.

3. Workforce and leadership

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

3.2 To deliver this service, PCNs are required to review local data sets to establish the level of unmet need and identify local health inequalities in the diagnosis of hypertension. PCNs are also encouraged to raise awareness of local CVD Prevention pathways with all their clinical staff, potentially supported by relevant clinical network groups, who have a standing offer in support for PCNs, such as Primary Care Cardiovascular Society, or regional NHS England and NHS Improvement clinical networks.

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

[3] https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/cardiovascular-disease/

4. Community Pharmacy Case Hypertension Case Finding Advanced Service

4.1 From October 2021, the Community Pharmacy Hypertension Case Finding Advanced Service will support PCNs in improving access to blood pressure testing. The service will have two stages; the first is identifying people at risk of hypertension, and offering them blood pressure monitoring (a clinic check). The second stage, where clinically indicated, is offering ambulatory blood pressure monitoring (ABPM). Blood pressure test results will then be shared with the patient's GP (via NHS mail) to inform a potential diagnosis of hypertension. PCNs are required to work collaboratively with community pharmacies delivering this service, the work of which will contribute towards the relevant QOF and IIF indicators.

4.2 The aims and objectives of this service are to:

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

5. Supplementary guidance to support implementation of the service requirements

Service requirements	Supplementary guidance to help PCNs to deliver requirements
Part 1: From October 2021	
Hypertension – part a)	
From October 2021, a PCN must: a) Improve diagnosis of patients with hypertension, in line with NICE guidance NG136, by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up.	NICE guidance NG136 should be followed when offering appropriate follow ups to patients. Anyone with a blood pressure reading of 140/90mmHg in a clinical setting, or 135/85mmHg in a home or community setting, should have their blood pressure re-checked and if blood pressure remains high (with *either* the systolic or diastolic reading being higher than the limit above), the patient should be offered either ambulatory blood pressure monitoring (ABPM) (preferred) or home BP monitoring (HBPM) (where ABPM is declined or not tolerated) to confirm a diagnosis of hypertension. Where a patient is presenting with blood pressure higher than 180/120 mmHg in either reading, practices should consider immediate treatment, or same-day specialist referral if there is evidence of target organ damage. If no evidence of target organ damage, the patient should be followed up in line with NICE guidelines, within no more than a week, which may include confirming diagnosis via ABPM or HBPM, and/or immediate treatment. Additionally, and as reflected in IIF indicator CVD-01, practices should proactively review historical records to identify patients who are not on the hypertension register, but whose last recorded BP was higher than 140/90mmHg. They should be offered an appropriate follow up (a new blood pressure test plus diagnostic procedure if needed) to confirm or exclude diagnosis of hypertension. Searches of the system are expected to cover the last two years as a minimum. These patients should be invited to the practice for an appropriate follow up in line with NICE guidelines.

Hypertension – part b)	
b) undertake activity to improve coverage of blood pressure checks, by: i. Increasing opportunistic blood pressure testing where patients do not have a recently recorded reading ii. Undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups iii. Working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the NHS community pharmacy hypertension case finding service.	i. NHS Health Check guidance, and QOF BP002, require practices to check the blood pressure of people who are aged 40 or over, the latter requiring that everyone over 45 should have had a blood pressure check in the last 5 years. Practices can invite people for Health Checks after the age of 40 to ensure that, in line with BP002, everyone over 45 has received a blood pressure check within the last 5 years. ii. PCNs are required to improve access to blood pressure testing, with a particular focus on individuals and groups who may be at higher risk of undiagnosed hypertension but do not routinely access general practice. PCNs are able to identify their own way of seeking to improve coverage of testing. For example, and subject to local partnership agreements, by setting up opportunities for blood pressure measurement at community centres, places of worship, or shopping centres. Similarly, all reasonable opportunities to measure blood pressure within the practice should be taken, particularly for people who may be at higher risk. This may mean, for example, taking the blood pressure of patients during routine appointments, or after flu or covid vaccination delivery (as was trialled by some areas in 2020/21). if they are overweight or suffer from comorbidities which predispose them to hypertension; or are a member of an ethnic or other demographic group that have a higher risk. iii. Alignment with the NHS community pharmacy hypertension case finding service will support delivery. This service will enable both opportunistic blood pressure testing and where clinically indicated, clinic BP checks or ABPM, on behalf of a PCN, referring the patient back for confirmation of the diagnosis and treatment as required. Pharmacies will be able to choose to register to deliver the service from October 2021.

NB: Further guidance will be published prior to April 2022, to confirm the guidance relating to those elements of the CVD service that are required to begin on this date.