PCN ROUNDTABLE
CARDIOVASCULAR DISEASE

Clinical directors (CDs) and cardiovascular disease (CVD) leads joined editor *Victoria Vaughan* to discuss the PCN CVD diagnosis and prevention service

Author: Victoria Vaughan. Front cover image: Getty Images
 First published 2023 by Pulse PCN, Cogora, 1 Giltspur Street, London EC1A 9DD.

PULSEPCN Cogora

DELEGATES

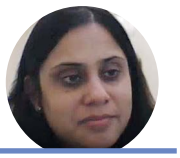
Dr Amisha Mehta
CVD champion, London borough of Westminster, covering four PCNs

Dr Arshad Khalid
Clinical director (CD), Fosseway PCN, Leicestershire

Dr Dan Bunstone
CD, Warrington Innovation Network, Cheshire

Dr Farzana Hussain
Former CD, Newham Central PCN, east London

Dr Laura Mount
CD, Central and West Warrington PCN, Cheshire



Dr Shanika Sharma
CD, West One PCN, east London

Chair Victoria Vaughan
Pulse PCN editor

Victoria The PCN cardiovascular disease (CVD) diagnosis and prevention service was introduced in October 2021 and began by focusing solely on improving hypertension case-finding and diagnosis. How has implementation of this service gone in your PCNs?

Farzana Newham PCN is a larger network with 67,000 residents and 74% black and minority ethnic (BME) [patients] and high deprivation levels. CVD is one of our biggest killers of young people.

Case-finding for hypertension and atrial fibrillation (AF) was already happening at practices. For example, my practice of 5,000 patients was involved in a hypertension pilot that was run by NHS England in conjunction with community pharmacy. Anybody over 40 can pop into the pharmacy to be assessed and given a 24-hour blood pressure monitor. It was so successful in our practice that we rolled it out to the whole PCN. A lot of the patients in our area are on zero-hours contracts and it's hard for them to keep appointments so being able to walk into the pharmacy has been really good.

With AF case-finding, we do pulse checks alongside flu jabs. Patients who are over 65 are coming in anyway, so we give healthcare assistants an extra minute to check the pulse while doing the flu jab.

Shanika About 18 months ago, we started work with UCL Partners on a familial hypercholesterolaemia (FH) pilot – a proactive care framework for the condition. It has really helped identify a cohort of patients who need more targeted interventions. It ran across two PCNs with a total population of 90,000 patients and was all about screening and cascade testing in primary care.

The evaluation found that if it was rolled out to all PCNs, it could potentially increase the FH diagnosis by 5% and then an additional 14% through the cascade testing.

We also did a population health management pilot focusing on hypertension because we're one of the most deprived boroughs in London. The main thing we identified was that it must be a holistic approach to wellbeing – health was identified as contributing to 20% of wellbeing, whereas 80% were the wider determinants - and that's helped to shape a lot of the health inequalities work that we've been doing.

When it comes to case-finding, [we are] thinking outside the box and going to places where residents often go, such as hairdressers or bingo. There was a pilot where we managed to pick up a lot of potentially hypertensive patients during a bingo game.

Dan In Warrington we've mainly focused on hypertension. We're using an app called Healthy You, which allows us to monitor and manage our patients remotely.

The remote care element has been amazing. The surgeries don't necessarily manage the patients – they maintain the practice lists, but all the work is done with a separate, dedicated team who look at lifestyle and medication treatments, and the patient is escalated to an advanced nurse practitioner when any prescribing is needed.

The audience we've picked initially is one that is probably disengaged or has been lost to follow-up for whatever reason. So we've had to use a variety of measures to reach out and engage our patients and it's been really effective.

We've prioritised the hypertensive patients with high blood pressure who aren't properly controlled, and will probably move on to screening later. The reason is we know these patients are there so we can get on and treat them. We've got around 1,000 patients onboarded across the PCN, and we've treated around 300 to 350 to date with around 250 in a treatment pipeline. I suspect we've probably prevented three to four heart attacks or strokes.

Arshad Along with my CD role I'm transformation lead in cardiology in Leicester, Leicestershire, and Rutland (LLR), which has a population of 1.1 million, as well as CVD network role for LLR in NHS England.

"We've been running a pilot with Omron to remotely monitor
Dr Amisha Mehta

In December of last year, I found out we had access to £110,000 of NHS England money that had to be spent by the end of March in CVD. We had to think quickly, so we identified the five practices where incidence and prevalence of hypertension are below what we would expect, and then suggested the five PCNs use the funding however they wished to find new cases. By the end of March, we had found 545 new cases, which we thought was a result.

Amisha In Westminster, there are eight of us CVD champions working across four PCNs, which covers a total of 330,000 people, and we're working on different strategies of how to improve CVD across our PCNs.

It's only started in the last few months so we're at a phase where we're gathering information and data. I'm working with clinical lead pharmacists, and they have different strategies from GPs so that's very insightful.

GETTY IMAGES

If I had a magic wand I'd go to the people who don't go to the doctor. Go to the markets in east London and you see people who look sick

Dr Farzana Hussain

With regards to hypertension, we've been running a pilot with Omron for six months, which is remote monitoring via a digital platform. It's not the easiest way of formatting things because some people are not digitally savvy, though we hopefully have come up with strategies to make that work. And then over the last year we did a lipid pilot, which was successful.

Laura In West Warrington PCN we've undertaken a big transformation project – the Clinically Led Workforce and Activity Redesign (CLEAR) project, which is funded by NHS England. We've had the help of data analysts to look at where we could make meaningful impacts on the way we deliver care. It's not about trying to come up with a new model; it's looking at what we're doing now and how we can be more effective.

We're now moving to the implementation stage, which NHS England has given us more funding for. One of the workstreams is obesity and obesity case-finding. We've got three lifestyle coaches in the PCN now and a dietitian so we're keen to look at getting those people into a lifestyle MOT to impact on risk reduction.

We're also delivering the over-40s health check in a different way – in a similar model to the mass Covid clinics. It's a very cost-effective way of delivering care because you remove a chunk of work from practices to deliver en masse. We're going to expand that with new diabetes patients and pre-diabetes patients.

And we're big advocates of outreach. We've trained lots of our staff so everyone can take blood pressure and we go out to places in the community. In December, we're going to pilot our own team of blood pressure champions – people from the third sector who we'll train and then [send out with] a blood pressure machine.

The hope is that we can then roll that out and train 10 people every couple of months so there's a big team – a bit like Mental Health First Aiders in every workplace. You'd have blood pressure champions in every workplace and in every part of town and people would know that's someone they can talk to about their blood pressure and their lifestyle.

Victoria There are quite a lot of examples of existing pilots that you've built on. How much has the PCN service specification changed – or spurred you on – in what you were doing? It's not an investment and impact fund (IIF) indicator any more, of course, but did that help to get you to where you are now?

Dan I'd say it didn't help at all. If you look at the national attainment for QOF for finding and treating [high] blood pressure, it's above 90%. So, everybody's hitting the QOF targets, yet we know there's a massive gap. And there's no 'incentive' to address that. There was nothing in the contract that pointed us in the direction to do this and all the incentive to do it has gone.

Laura We found it interesting in the CLEAR project that they take a system-saving approach – that is, the system will save. But, obviously, as a GP, I'm interested in my patients and primary care effectiveness and productivity. So you've got to be careful who your audience is because you need to get them to do what you want them to do, and you've got to inspire them and motivate them in the right way. You can't just say I'm going to save the system this many hundreds of thousands of pounds.

Shanika All the work that we've shared so far has not been from the PCN specifications; it's been proactive work. The familial hypercholesterolaemia pilot, for example, was an expression of PCN interest that was in addition to the normal day-to-day PCN work.

And most of our funding to work on health inequalities has actually come through our partnership work because, although there's a push on PCNs delivering on health inequalities, there's no funding aligned to it.

Our partnership was a collaborative group comprising public health, the local authority and the voluntary sector and we went to Northeast London integrated care board (ICB) and presented what we wanted to do to reduce health inequalities. That's where the PCN health inequalities lead project started. We had dedicated leads to focus on this because the demand and the capacity in primary care make it very difficult to do the day-to-day work let alone anything else such as all this proactive case-finding.

Arshad I'm really proud that we've been working for over a year to commission investigations from primary care. Historically, we've had considerable disparity between practices and PCNs, with the provision of 12-lead ECG, 24-hour Holter monitoring and 24-hour blood pressure monitoring. After quite a battle, we now have the hardware established in all the PCNs across LLR to provide those three tests, the funding stream for the performance of those tests and the separate payment aligned to the interpretation of the tests.

The hardware is with all the practices, not just the PCN, so all three of those tests are available immediately in practices. If there's a practice that doesn't want the risk of interpreting an ECG or Holter, the PCN has accepted the work, and there are people who have the expertise to manage the results.

In 28 years, no GP practice has been paid to do a 12-lead ECG, a 24-hour Holter or 24-hour blood pressure monitoring. So, it's a major breakthrough in terms of diagnostics in our region.

Laura We are paid a fee to perform an ECG and then the hospital is paid to interpret it. We may as well just print it off and look at it ourselves. We have not got functional reasonable access to 24-hour blood pressure monitoring, and we've stopped using it on the whole because it takes many months to get the report.

Our PCN just bought loads of blood pressure machines – hundreds of the lowest-price accredited blood pressure machines – and patients use them and return them. I go around at the end of the financial year, and I say: 'If you've got any little pots of money left, let us know'. From that, we got some of our blood pressure machines and some sats probes. We've also encouraged patients to buy [machines] when they can.

Farzana We have very good providers so we can access 24-hour blood pressure monitoring, and also our pharmacists can do that. For ECG, it's been a local enhanced service, but we don't do the interpretation. We have a private company to do that, which is working all right, as far as we can see.

In terms of funding, I'm not a fortune teller, but it's looking shabby. It's been reported that all 42 integrated care systems (ICSs) have overspent – that says something about government funding if everybody across the country has failed.

GETTY IMAGES

But I don't think we're going to see any more funding. Now that access is king or queen, along with the learning disabilities and flu vaccination, we might be in a position where a lot of this good work will go because it's not sustainable. I don't think there's anything at the moment in the PCN contract that incentivises anybody to do this work and, unless we fund it and prioritise it, I don't think it's going to happen. We are chasing every single penny, but actually, now, everything is about access.

Victoria Access is now all important. How are you balancing those hypertension patients you're finding with those already sick patients coming through the door?

Dan Practices are having difficulty meeting the demand, even before you look at anything else. So, I don't think there is a balance, actually. We are managing it by setting up an entirely new service; the hypertensive service that we run is its own thing.

Our thought is we're making interventions now so that, please God, in five years' time, patients are healthier and there is less demand on the service. It's a hypothesis but we've got to do something.

"We know how to keep people well but have to sell it differently
Dr Laura Mount

Farzana Many years ago, our clinical commissioning group (CCG) gave us self-service machines, which were very useful. Patients in my practice can just put their arm in and give our reception the results for the doctors to see. So, after the case-finding has been done, that's really good at monitoring hypertension.

But I did a bit of health promotion work recently and discovered that a lot of the public didn't know the difference between cardiac arrest and a heart attack. When half your population don't know the symptoms of a heart attack, and when to call for an ambulance, I doubt very much they'll know anything about the importance of blood pressure. And if our populations don't know why blood pressure control is important – that is, because you might die of a heart attack – then there's a problem.

As healthcare professionals, we often assume a lot of knowledge. I think education is needed, which will require funding.

Shanika We had some medical students from Imperial College London last year and they did fantastic work about why blood pressure is important. It was a series of videos that we sent out [to patients] with the blood pressure texts and we found that they really helped to push the numbers of people returning the results.

Monitoring through apps and 24-hour [devices] offers a little bit of flexibility to patients. They often can't come into appointments for a blood pressure check because work won't let them or the cost-of-living crisis or other factors. So, a blood pressure machine at home is great.

The cost of prescriptions for patients is a huge issue too. I think a lot of people don't come forward because we turn around and say you've got hypertension, you need to be on medication and that's going to cost you £10 a month, potentially for the rest of your life. When people are having to make decisions as to whether they buy food, or whether they buy a blood pressure tablet, that's very difficult. So that's another thing we need to take into consideration for our populations.

Arshad We've got at least 10 machines that people can take home. We charge a nominal £10 or £15 deposit to make sure patients return them.

And we are taking delivery of some devices to make it easy for patients to diagnose AF separately from the 12-lead ECG. We will have to wait and see how people respond to that sort of technology. That will be funded by NHS England money we made a bid for.

Victoria What do you think the future is for the PCN CVD service?

Farzana It's great to see the champions in this roundtable – excellent people who care passionately and who are going above and beyond – but they're in small supply. There are 1,250 PCNs and most I talk to are struggling just to meet the contractual demands.

We know our registers don't match with the prevalence that there should be, so we know that there are a lot of undiagnosed cases – not just hypertension, lots of diseases. So, what I would like to happen, if I had a magic wand, is to go out to those people who don't go to the doctor. People look fine if you go to the Westfield shopping centre in Shepherd's Bush, but, if you down to the Stratford market in east London, people look sick so that's where you need to go. But all of it needs funding.

General practice is doing a lot of work to support the system, but that's not coming from the other side

Dr Shanika Sharma

GETTY IMAGES

Amisha Ultimately, if we do not have the funding, we won't be able to reach all the patients who require it.

We are thinking of using our community care workers to see if we can access these patients. However, feeding that information back to the general practice is another issue. Patients can go and get their blood pressure done but that information needs to reach the practice in an accurate way, a clinician needs to sign it off and prescribing [might be] needed. That's a lot more work than it seems.

Shanika In the last few years, there's been such a shift of workload from secondary care to primary care without resources following that work. So as a GP referring to cardiology, my referral is rejected if I've not done a 12-lead ECG, and 24-hour tape and echocardiogram and a 24-hour blood pressure monitor. And I'm told as a GP to do all these tests.

It seems like general practice is doing more work to support the system, but it doesn't seem like it's coming from the other side. So I think if we're looking to make real change and impact, it must be a system-wide response. The ICB needs to recognise that [reducing] CVD prevalence, morbidity and mortality is a responsibility across the board. It's not just for PCNs and primary care.

Arshad Shanika is absolutely spot on. In my strategic cardiology role with the long-term conditions board, we've done quite a lot of modelling to see where we'll be if we don't manage these problems.

If we look at the need for renal replacement – and this is where an awful lot of patients with CVD and diabetes are going to end up – what's coming is terrifying. And of course, the ICB is going to be picking up that the cost.

We've done the modelling to use as leverage to say if we don't go out there and make health checks more user friendly and more affordable for practices to deliver, we're going to have this need for renal replacement dialysis.

Dan Laura and I have got a bid in to the ICB and we're making a financial case. We're arguing that, when you invest, you save; we reckon we can do around a four or five-to-one return on investment purely for CVD. The NHS Confederation's recent research showed a return of investment of 14 to one for every £1 invested in community and primary care services.

So it might cost a few hundred quid to do a project, but it costs tens of thousands when a person has a heart attack – and that's just the cost to the healthcare system, not the cost to the economy or loss of work, or any of the other things that go with that.

Laura I echo what's been said. We're in a world where we've gone from clinical commissioning to financial commissioning – and it's quite sad for those who have worked in CCGs. We've lost sight of clinical quality and patient experience. We know what needs to be done – what our patients need and what the system needs to keep people well – but we're having to sell it in a different way and with a greater return than we ever did before.