Improving secondary prevention of coronary heart disease: using the new GP contract to drive change

This is the final article in a series examining how the Coronary Heart Disease Collaborative (CHDC) supports clinical teams to improve services for coronary heart disease. The focus in this issue is on secondary prevention services.

Introduction

The CHDC's secondary prevention work focuses on Standard 3 of the *National Service Framework for Coronary Heart Disease* (2000). This requires that primary care teams should know who has established heart disease (or who is at high risk of developing heart disease) and take steps to reduce further complications. There is a wealth of evidence to support this work and the National Service Framework (NSF) is explicit in how this should be achieved. The new General Medical Services (GMS) contract rewards practices for implementing high quality coronary heart disease (CHD) care; Personal Medical Services practices will also be agreeing similar standards with their primary care organisations.

The NSF recognises that all patients with established CHD are at the greatest risk of death, myocardial infarction and stroke, and recommends that these are treated as a priority. The next step is to identify and treat those people who do not have established CHD but whose risk is > 30% over 10 years. There are several widely used risk assessment tools to assist primary care practitioners to identify these patients. The main objectives in the secondary prevention of CHD are summarised in table 1.

The Collaborative approach

The essence of Collaborative working is the sharing of good practice and ideas. The CHDC collects and shares information through the online communication system, Rapport, and through regular workshops and forums. Project managers work with teams to support practices to make improvements in the care and management of their patients. Their approach is to review systems and make them more efficient, helping to improve the care and experience of patients and their families, and to provide a seamless service.

Improvements might be as simple as training staff to set up and run reports and to identify Read codes to validate CHD registers, or may involve enabling teams who already have good systems in place to refine their care further. For example, Moordown Medical Centre in Bournemouth has established regular chronic disease management clinics for patients with multiple pathologies to avoid duplicating visits to clinics.

Many practices actively seek their patients' advice when improving services. The CHDC strongly endorses this approach – its use of 'discovery' interviews (see previous articles in this series) facilitates patient-centred improvements. A comment from a patient during one of these interviews led North East Yorkshire and Northern Lincolnshire CHDC to revise guidelines for CHD annual reviews. The guidelines now include a review of sexual health and training for practice nurses, to enable them to deal appropriately with patients' problems.

Table 1. Main objectives in the secondary prevention of coronary heart disease

- Provide advice and support to stop smoking
- Address other modifiable risk factors – exercise, weight, diet
- Provide advice and treatment to keep blood pressure below 140/85 mmHg
- Prescribe or monitor the use of low-dose aspirin
- Ensure the meticulous control of blood pressure and glucose in diabetics
- Offer statins and dietary advice to lower total cholesterol to 5 mmol/L or by 25%, whichever is greater
- Prescribe an ACE inhibitor for those with left ventricular dysfunction
- Prescribe beta blockers post-myocardial infarction
- Prescribe warfarin or aspirin for patients over 60 years in atrial fibrillation

The GP's perspective

Of the six CHDC workstreams, primary care has most involvement with secondary prevention. Most general practices will already have a general policy on chronic disease management. It is likely to include nurse-led clinics, protocol-driven and evidence-based clinical algorithms, and collaborative working with community and secondary care staff. It is also likely to be patient focused.

An enthusiastic nurse practitioner or suitably trained practice nurse who can run these CHD clinics is a bonus. Not only can the nurse monitor patients, but he/she can also make therapeutic changes and freeing up general practitioners (GPs) for other things. Many nurses are undertaking prescribing courses and this is likely to have an increasing impact on their future roles.

Role redesign and the involvement of other practice employees is a common Collaborative approach. Recep-

Box 1. Case study – pooling resources leads to screening success in Ealing

Ealing's significant Asian population means there is a very high mortality from CHD. Until recently there was no systematic approach for general screening of patients for CHD risk in this community. Now, all relevant patients within 44 general practices are offered a comprehensive CHD risk assessment.

North West London CHD Collaborative worked with local GPs and staff from Ealing Hospital NHS Trust to pool resources. This approach allows the NHS to employ CHD nurses and facilitators who hold a weekly risk assessment clinic within each practice.

Invitation letters are sent to all patients aged between 35 and 70 years registered with local GPs. When these patients attend the clinic, a nurse takes their history, a blood test, an electrocardiogram (ECG), and measures blood pressure, body mass index (BMI) and body fat ratio. These data are recorded on a central database at Ealing Hospital and a report is generated identifying risks. A cardiologist and a nurse review the letters so that any problems can be acted on quickly. The report is then sent to both the GP and the patient around seven days after the examination. The nurse then also updates the practice CHD register as appropriate.

The new system allows around 8,000 assessments a year in Ealing and all relevant patients in the 44 practices are offered screening. A five-year repeat cycle is planned, so a patient's risk can be reassessed at least every five years. The scheme is now being extended to Hounslow to take in patients from an additional 26 GPs; this means that a further 4,000 assessments will be carried out each year.

Apart from the benefits to patients, this service now provides excellent value for money and fits very well with the new GMS contract. Data collected from this provides good information on the prevalence of CHD within the community, which can be used to support the commissioning process.

- For further information, contact: Jane Wrigley, Lead Nurse Coronary Risk Prevention Service jane.wrigley@eht.nhs.uk

Table 2. Impact of the new GMS contract on CHD

The main differences from the existing GMS contract and the new GP contract (agreed between the British Medical Association and the NHS Confederation, on behalf of the Department of Health) are as follows:

- It is a practice-based contract – between the whole practice (not just the GPs) and the Primary Care Organisation (PCO), using nationally agreed terms.
- Individual GP lists will cease.
- For the first time, practices will be paid for delivering quality patient care, through the Quality and Outcomes Framework (QOF)
- The current GP 24-hour responsibility for patient care will end, and PCOs will have the responsibility of delivering out-of-hours care.

The CHD element of the QOF could generate a maximum of 101 points, which for the average-sized practice, would represent an income of £7,575 in 2004/5 and £12,120 in 2005/6. This is a significant improvement on how GPs are currently funded to deliver CHD care. Many practices are already aiming to score over 75% of the total points. Working with the CHDC can make a significant contribution to achieving this.

tionists and healthcare assistants can be trained to take blood and blood pressure measurements, for example, which also can add to their job fulfilment. Most importantly, the patient must be consulted. Tailoring care plans to their own need is crucial – the CHDC believes patient concordance rather than compliance will be this decade's watchword.

The Collaborative philosophy particularly benefits primary care as it helps to overcome the traditional isolation of many practices. This approach enhances and extends existing good habits such as self-reliance, patient focus and team working.

Improving services for patients and carers

The CHDC encourages teams to work in the following three areas:

- to know patients
- to treat them well
- to link to others.

In working towards these goals, practices will be well on their way to achieving the GMS Quality and Outcomes Framework points for CHD care (see table 2).

Know your patients

All practices are required to have CHD registers, using agreed Read codes. These should be used to manage the condition of CHD and 'at risk' patients. Ensuring these registers are valid and up-to-date is an ongoing process depending on GPs, nurses and administrative staff using effective systems and procedures.

For example, when Berkshire CHDC worked with practices in Reading PCT to validate their registers, 131 additional CHD patients were identified from eight practices. These patients are now receiving invitations for annual reviews.

A case study in Box 1 shows how screening for CHD was tackled in Ealing, where there is a high Asian population.

Treat them well

The CHDC's goal to treat patients well focuses on providing structured, organised care, which is convenient for the patient. The NSF specifies the clinical treatments necessary but CHDC programmes support practices, PCTs and trusts to devise and implement innovative and patient-centred means of delivering this care.

At the Denmark Road Medical Centre in Bournemouth, process mapping facilitated by the Dorset and Somerset CHDC identified that there was no systematic process for following up any patient who had missed their annual review. Now, those patients who do not attend receive a telephone consultation.

In Sunderland Teaching PCT, the Northern Network of Cardiac Care CHDC helped practices to improve attendance at secondary prevention clinics. Letters of invi-

Box 2. Case study: new approach to patients' annual review in Southampton

At Bitterne Park Surgery in Southampton, the nurse-led annual CHD review was dependent on a part-time member of staff. This led to problems ensuring that all patients were appropriately reviewed and the practice decided to look at new ways of increasing attendance and improving patient choice.

A quarterly evening session for patients plus a family member or friend was introduced. Any patients not on a statin or who had not been reviewed in the last year were invited as a priority. They were asked to complete a lifestyle questionnaire and bring it along to the meeting, which was co-ordinated by a team including practice staff, the community dietitian and the British Heart Foundation liaison nurse. The evening included combined group education sessions on diet and heart physiology, plus a personal session with the practice nurse and GP to look at medication and review symptoms.

During group consultations, access issues were addressed and these sessions also provided peer support to patients allowing practice staff to work more effectively. Completed lifestyle questionnaires enabled administrative staff to update information on the clinical system, using appropriate Read codes, ensuring an accurate CHD register. Clinical staff now have more time to spend with the patient during the consultation.

Choices have been offered: patients can attend for review during the evening or day, they can choose whether to bring a friend or relative, whether they want peer support, and whether they want to 'meet the experts'.

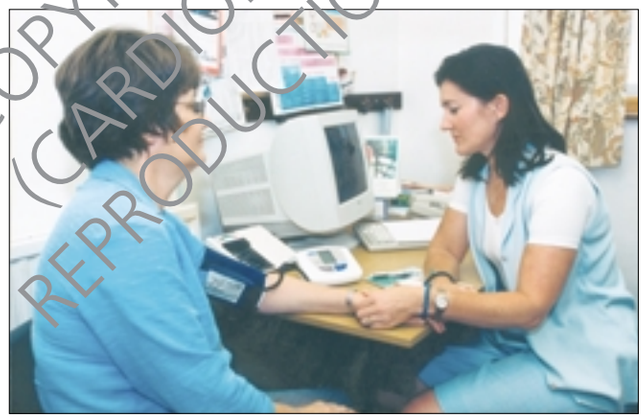
This has all helped to increase the practice's throughput of patients and it is expected that an additional 60 CHD patients will be reviewed each year.

- For further information, contact: Wendy Gray, Discovery Interview Manager 07884 003659

Box 3. Case study: innovative ways of working in Worcestershire

Bewdley Medical Centre has developed home self-monitoring of blood pressure (BP) for hypertensive patients, which reflects the beginning of a revolution in the management of chronic disease.

The practice invited all hypertensive patients to evening meetings to discuss home monitoring of BP, and then patients were opportunistically started on home monitoring. A secure web site was developed, www.heartsmartweb.com, to enable patients to enter their BPs and obtain advice about BP management. The site allows the practice to see their results and communicate between patient and clinician. Of a total practice population of 13,605, 1,942 patients are hypertensive patients. Of these, 383 have been started on home monitoring.



A patient at Bewdley Medical Centre has her blood pressure checked by a practice nurse. The practice has introduced home monitoring of blood pressure for many hypertensive patients

The innovation has been well received by patients and it has also improved care, saved doctor and nurse time, and reduced drug costs.

tation have been re-written, so that a number of different templates are available to practices to enable them to target different populations. A cartoon (from a birthday card designed by a patient in another collaborative programme) was adapted, tested and made available to practices to use on the reverse side of the letters. A mail merging facility was set up with help from the IT education and training department, which meant that the process of inviting patients to the clinic became easier. One practice achieved 100% attendance at their clinic; another practice achieved 80% response to the invitation letters by targeting specific groups of patients.

Boxes 2 and 3 show how two other practices helped improve secondary prevention. In Southampton, various changes have improved attendance at annual review sessions. Bewdley has introduced home self-monitoring of blood pressure.

Link to others

The CHDC's aim in sharing good practice is to provide a bridge and reduce any interface issues between primary, secondary and tertiary care.

For example, at Birmingham, Sandwell and Solihull CHDC, hospital consultants now add heart disease Read codes from an agreed list when writing to GPs. This has been popular with primary care. Dr Ian Walton, CHD lead of the Tipton Care Organisation feels that this is a great benefit to practices as it stops ambiguity and allows practices to create accurate disease registers.

Elsewhere, delays in mak-

ing an urgent referral to secondary care were identified by Blackburn with Darwen Primary Care Trust at a process mapping event. The team noted that there were five separate steps to fax an urgent referral to the rapid access chest pain clinic, causing delays in making the referral. Now, the GP uses a simple referral form, which is typed and faxed to the hospital on the same day.

One of the factors which has caused some concern in primary care has been the plethora of modernisation teams wanting to help. To reduce duplication, the CHDC encourages its project managers to team up with other modernisation initiatives in their area.

Carol Reilly from the Black Country CHDC, for example, arranged for all the following groups or individuals – PRIMIS/IT, clinical governance, an access facilitator, the CHD GP lead, the NSF Coordinator, medicines management/prescribing teams, a CHD Nurse, education and training, plus the CHD Collaborative – to meet to review ways to work together. Work in the 66 practices was divided between them and they now meet monthly to review progress.

Summary

The evidence for implementing the NSF is overwhelming. Ranging from the simple to the innovative, there are some excellent ways of achieving this, bolstering practice income and enhancing the care and experience of patients.

- For more information about the work of the CHDC, visit www.modern.nhs.uk/chd where you can find contact details for your local CHDC programme.

Acknowledgements

This article was prepared by CHDC GP national clinical leads, Dr Rob Colebrook and Dr Jonathan Shribman; and by national managers Susan Fairlie, Fiona Mackie and Gill Mathews.

Editors' note

This is the seventh article in the series on the work of the CHDC. Previous articles have included an overview (*Br J Cardiol* 2003;**10**:91-2); acute myocardial infarction (*Br J Cardiol* 2003;**10**:101-04); heart failure (*Br J Cardiol* 2003; **10**:189-92); rehabilitation (*Br J Cardiol* 2003;**10**:269-71); angina (*Br J Cardiol* 2003;**10**: 446-9) and cardiac surgery (*Br J Cardiol* 2004;**11**: 24-6).