



# BRADFORD'S HEALTHY HEARTS



Bradford Districts  
Clinical Commissioning Group

## Bradford Healthy Hearts

Programme update

Kath Helliwell

# Programme update

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1. Statin switches project finished with some great results in cholesterol reduction
2. Great progress in SPAF over 500 pts on OAC, 64% baseline 76% current achievement
3. Clinical assembly work progress to date
4. Website development. A few examples will be presented later today
5. Launch of work stream 5a-CVD risk reduction in patients with QRISK2>20%

# Programme update

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6. Quality premiums (QP) for 14/15 and 15/16
7. Hypertension planning phase and hypertension in QP - discussion today
8. Application for the GP pulse award, Health foundation bid to move BHH to West Yorkshire, HSJ award
9. Professor Huon Gray and Directors from PHE visit in Oct 15
10. Work to launch 2 schemes for public aimed to reduce obesity and salt intake



# BRADFORD'S HEALTHY HEARTS



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## Bradford Healthy Hearts

Projects update



# BRADFORD'S HEALTHY HEARTS



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## Bradford Healthy Hearts

Statin switches project update

Maciek & Youssef

# Statin Switches

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1. Project has finished with over 5000 patients switched
2. We looked at a large sample (n=500) of patients that were switched and we have seen a consistent 0.4-0.5 reduction of total cholesterol
3. Simvastatin 40mg vs Atorvastatin 40mg – potential publication



# BRADFORD'S HEALTHY HEARTS



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## Bradford Healthy Hearts

Stroke prevention in AF project update

Youssef , Maciek

# SPAF

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Over 500 patients started on OAC

Feedback reports in your pack

All tools activated in BHH group and AF template  
developed

CHADVASc protocol developed

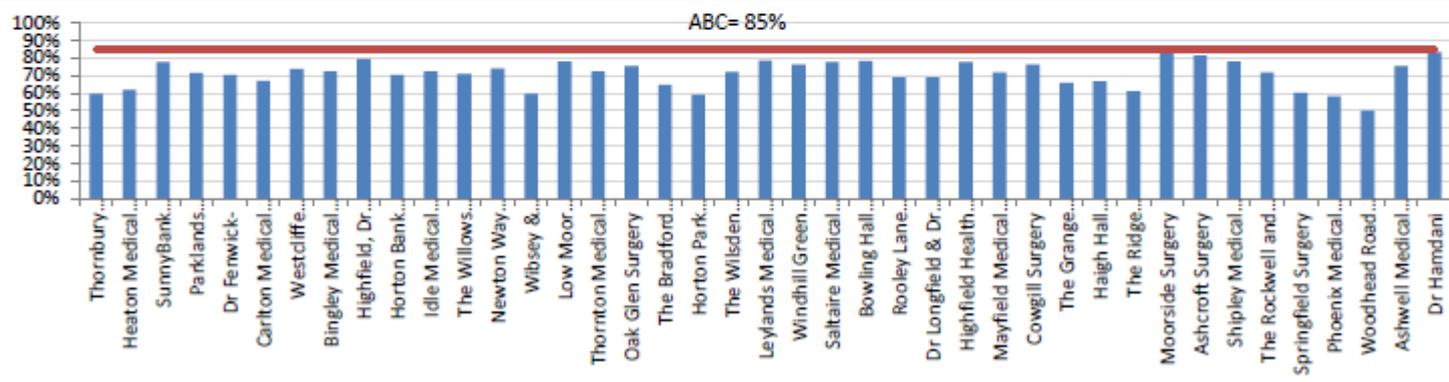
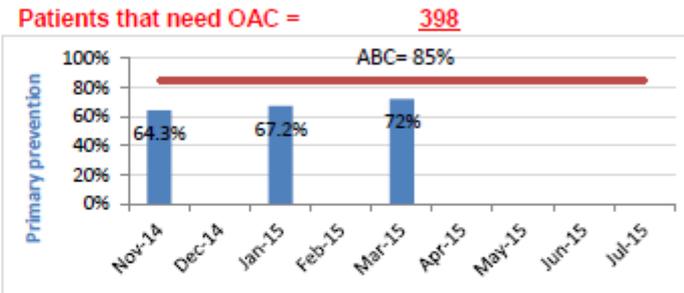
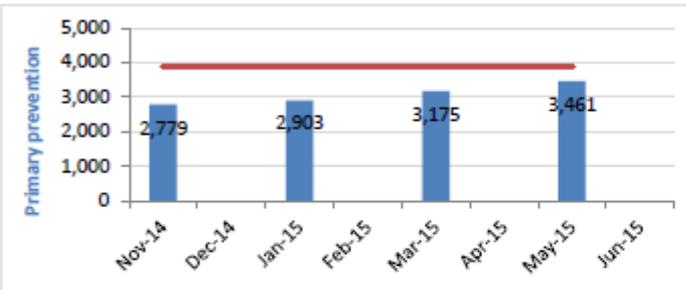
# SPAF to date (includes caveat hence interpret with caution)

## New ABC=85%

### AF Feedback Report - June 2015

### Summary Feedback

Aim of BHH SPAF is to anticoagulate a minimum of 85% of patients with CHA2DS2-VAS $\geq$ 1 in the next 12 months.



\*ABC - Achievable benchmark of care was calculated using the local data hence it should be attainable by all.



# Tools in SystemOne

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*Big thank you to Dr Newell and Bingley Medical Practice for developing and sharing the AF template they use to improve patient care*

*The template is being used for the BHH programme and hopefully will help everyone to drive improvement in Stroke prevention in AF .*

*BHH team*

# Tools in SystemOne

Pathology Drawing Auto-Consultation Settings

Patient Home

Continue Configure

- **!! Reminders**  
**patient can only accept appointments after 10am due to COPD** [Cancel](#) [More](#)
- **🔊 Recalls**  
**29 Oct 2014 COPD - Mini Review Pending** [Seen](#) [Cancel](#) [Awaiting Results](#) [Follow-on / Supersede](#) [More](#)
- **🏠 Pathology/Radiology to Archive** [Inform or Archive Pathology and Radiology](#)  
Haemoglobin A1c level - IFCC standardised - **Borderline - Need to repeat test:** *blood sugar a bit high please repeat in about 2-3 weeks* [Inform / Archive](#) [More](#)  
Serum electrolyte levels;Serum alanine aminotransferase level;Serum cholesterol level - **Satisfactory - Other (Keep LTC/CDC appt.)** [Inform / Archive](#) [Mo](#)  
Haemoglobin A1c level - IFCC standardised - **Abnormal, but expected - Other (Keep LTC/CDC appt.)** [Inform / Archive](#) [More](#)
- **⚠️ Patient Status Alerts**
  - 🧠 Memory Assessment:** *Dementia DES needs Memory Assessment* [Action](#) [More](#)
  - 📊 CHADS<sub>2</sub> VASC = 2** not on OAC (not declined in 2015/16): **OAC RECOMMENDED.**  
*Annual risk of stroke = 2.9% Annual risk of stroke when on OAC = 1.2%* [Action](#) [More](#)
  - ▲ Dementia "At Risk" Patients:** *This patient has been identified as "At Risk" of Dementia. Criteria has been taken from the Dementia Identification Scheme service.* [Action](#) [More](#)
- **📊 QOF Alerts** [Process QOF Alerts](#)
  - Atrial Fibrillation - There is no action associated with this QOF alert** [More](#)
  - COPD - COPD003 - Record Review and MRC dyspnoea score** [Action](#) [More](#)

# Tools in SystemOne

(see their Home Page for an estimate of their current risk)

The risk of stroke is significantly reduced by anticoagulation, and this usually outweighs the small increased risk of significant haemorrhage.

 [CHADSVASc calculator online](#)

 Launch OAC Treatment options

About



### **WARFARIN INR 2-3**

Patient's ANNUAL risk of ischemic stroke+thromboembolism with warfarin INR 2-3 =**1%**

Relative risk reduction: 66%  
Absolute risk reduction: 1.9%  
Chance of benefit per year: 1 in 51

### **RIVAROXABAN 20mg once daily**

Patient's ANNUAL risk of ischemic stroke+thromboembolism with rivaroxaban =**1%**

Relative risk reduction: 66%  
Absolute risk reduction: 1.9%  
Chance of benefit per year: 1 in 51

### **APIXABAN 5mg twice daily**

Patient's ANNUAL risk of ischemic stroke+thromboembolism with apixaban =**1%**



Pause

outcome

For patients where Warfarin is used, consider using Rivaroxaban or Apixaban for their anticoagulation

outcome

show recordings from other templates

show empty recordings

# AF QOF achievement

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New QOF indicator this year to assess all pts  
on AF register with CHADVASc score

BDCCG =80%

# AF QOF achievement

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New QOF indicator this year to assess all pts  
on AF register with CHADVASc score

BDCCG = 80%

BC CCG = 23%

# The SPAF championship

## How to win an Ipad



Clinical champion and practice team that achieve **highest improvement** will become SPAF champion and win an Ipad

We will measure it as a proportion of pts on OAC/AF register \*1000.

We will compare baseline to performance before next education event (Mid project Championship)

Winner is the practice that will achieve highest improvement (difference between baseline and current performance )



# BRADFORD'S HEALTHY HEARTS



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## Bradford Healthy Hearts

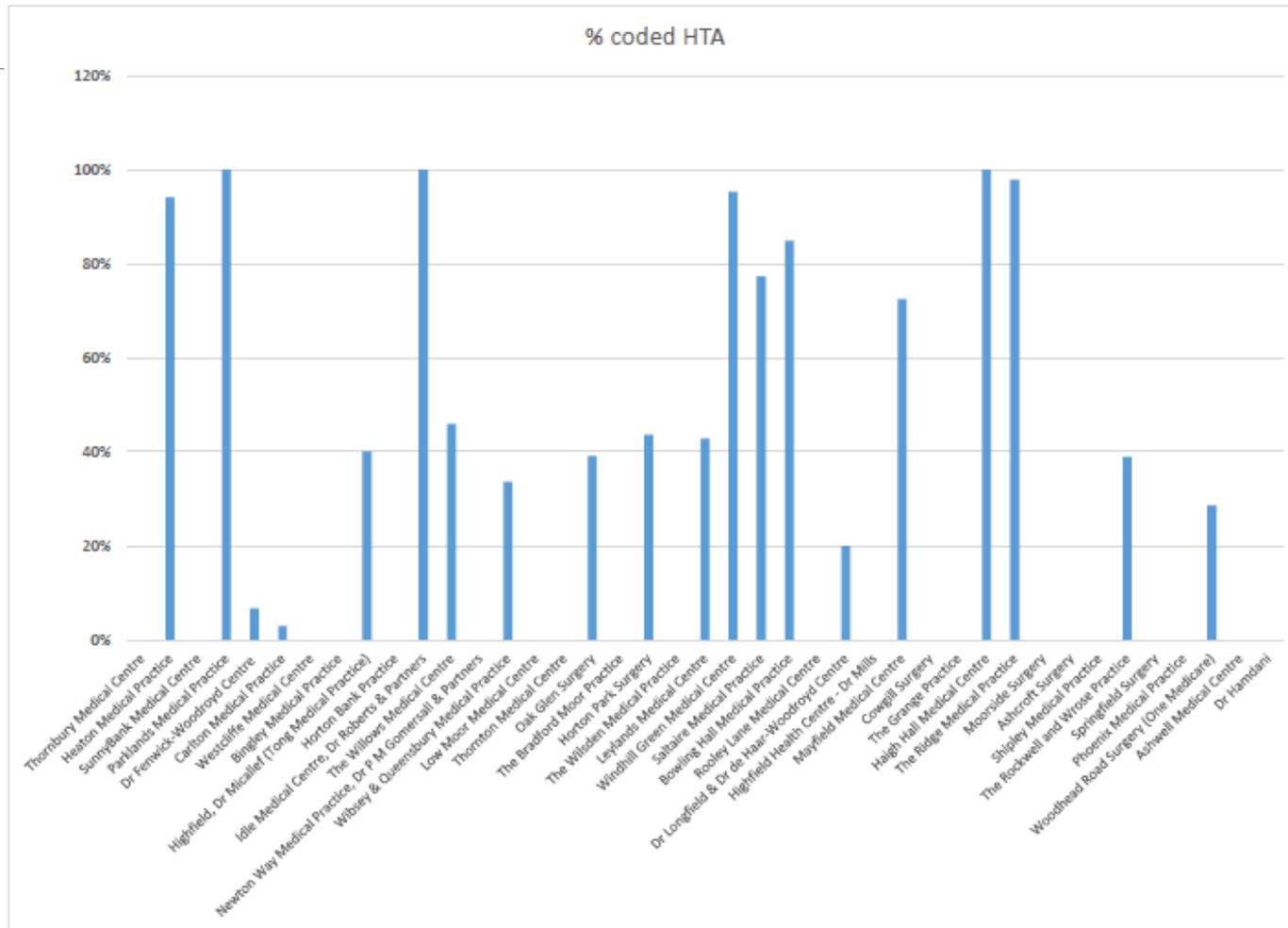
QP14/15 Prevalence of Hypertension

Maciek & Youssef

# QP 14/15

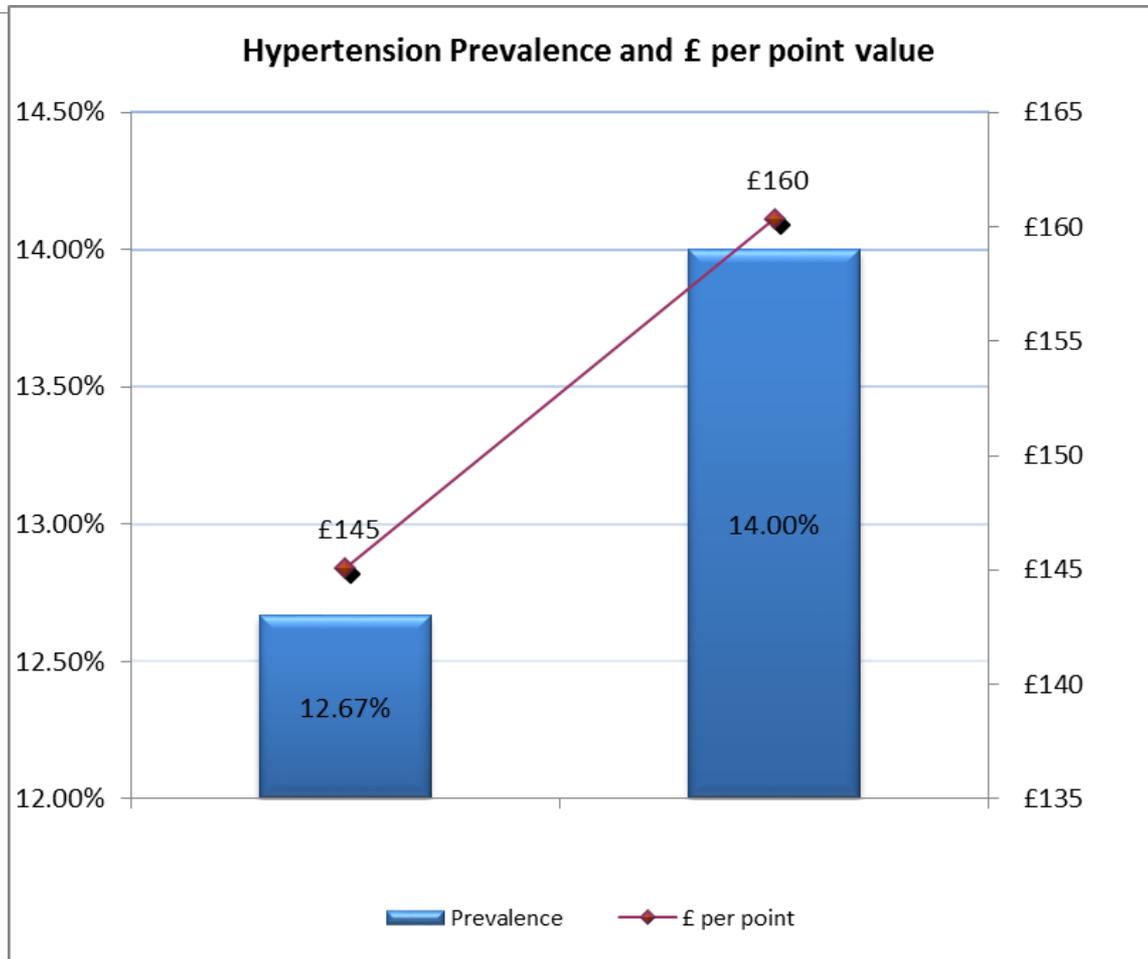
- 1. Patients on antihypertensive medications but not on register**
- 2. 3 or more reading  $>140/90$  and the last one is still above  $>140/90$**

# Meds but not on register



# Meds but not on register

## QOF improvement (+1.3%)



# 3 or more BP>140/90

hology Drawing Auto-Consultation Settings 

**Patient Home**

Continue  Configure

## !! Reminders

**NEEDS SMEAR TEST** [Cancel](#) [More](#)

 [Pathology/Radiology to Archive](#) [Inform or Archive Pathology and Radiology](#)

Full blood count - **Normal - No Further Action** [Inform / Archive](#) [More](#)

Serum electrolyte levels;Serum TSH level;Liver function tests;Serum alkaline phosphatase level;Serum albumin level;Serum cholester

**Normal - No Further Action** [Inform / Archive](#) [More](#)

Haemoglobin A1c level - IFCC standardised - **Normal - No Further Action** [Inform / Archive](#) [More](#)

## Patient Status Alerts

 Possible hypertensive patient - QP14/15: *Consider investigation for hypertension or code as appropriate* [Action](#) [More](#)

**QOF** [QOF Alerts](#) [Process QOF Alerts](#)

**Cervical Screening - CS002 - Record cervical screening** [Action](#) [More](#)

# 3 or more BP>140/90

**Hypertension v31 2015/2016**

Other Details... [Exact date & time] [Wed 24 Jun 2015] [11:05] [X]

Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button [Hide Warning](#)

Hypertension Quick Entry | Hypertension Ruleset | Ref: Hypertension codes

### Hypertension Quick Entry

Newly diagnosed hypertensive patients - use CVD primary prevention template  
BP reading required every 9 months

BP [ ] mmHg [ ]

BP recording exception code  [ ]

Code for maximal BP therapy  [ ]

Hypertension exception reporting codes

- Excepted from hypertension qual indicators: Informed dissent (XaJ4f)
- Excepted from hypertension qual indicators: Patient unsuit (XaJ4e)
- Exception reporting: hypertension quality indicators (XaJ4P)

GPPAQ Physical Activity Index... Please note: When using the GPPAQ clinical tool, please remember to click 'Calculate' and 'Save to Record & Close'.

Brief intervention for physical activity completed  [ ]

Brief intervention for physical activity declined  [ ]

### Smoking Overview

**Tobacco smoking behaviour**

- 22 Feb 1993... Never smoked tobacco (XE0oh) **QOF**
- 23 Jul 2010... Never smoked tobacco (XE0oh) **QOF**
- 29 Mar 2014... Never smoked tobacco (XE0oh) **QOF**

Smoking status [ ]

Smoking cessation advice  [ ]

[Information] [Print] [Suspend] [Ok] [Cancel]

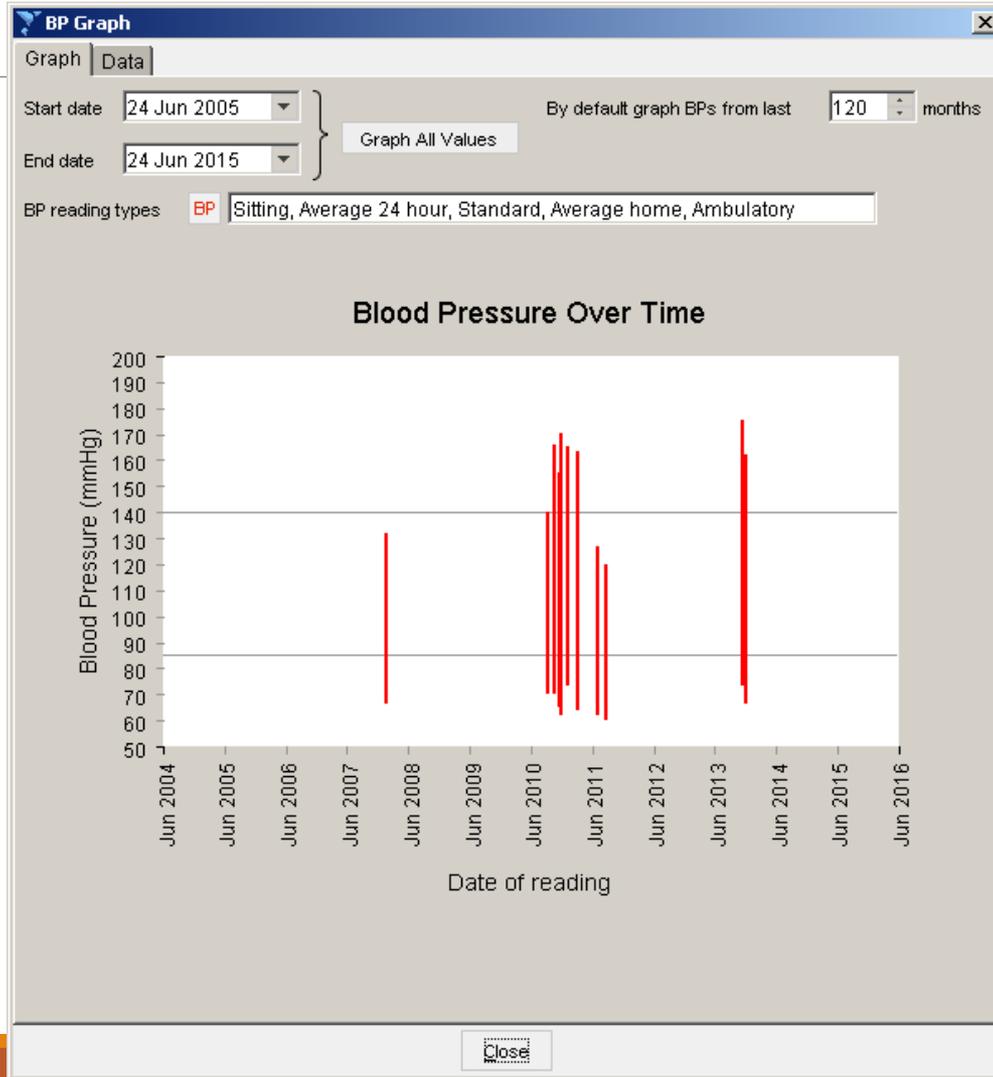
### BP

Date	Value
18 Feb 2008	BP 132 / 66 mmHg
05 Oct 2010	BP 140 / 70 mmHg
18 Nov 2010	BP 166 / 70 mmHg
09 Dec 2010	BP 155 / 65 mmHg
09 Dec 2010	BP 171 / 69 mmHg
03 Feb 2011	BP 165 / 73 mmHg
29 Mar 2011	BP 163 / 64 mmHg
27 Jul 2011	BP 127 / 62 mmHg
14 Sep 2011	BP 120 / 60 mmHg
12 Dec 2013	BP 175 / 73 mmHg
02 Jan 2014	BP 162 / 66 mmHg

Show recordings from other templates

Show empty recordings

# 3 or more BP > 140/90



# Hypertension prevalence extras increase to improve QOF

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HTN recall read codes but not on hypertension register

SBP >180 or DBP >110 hypertension very likely

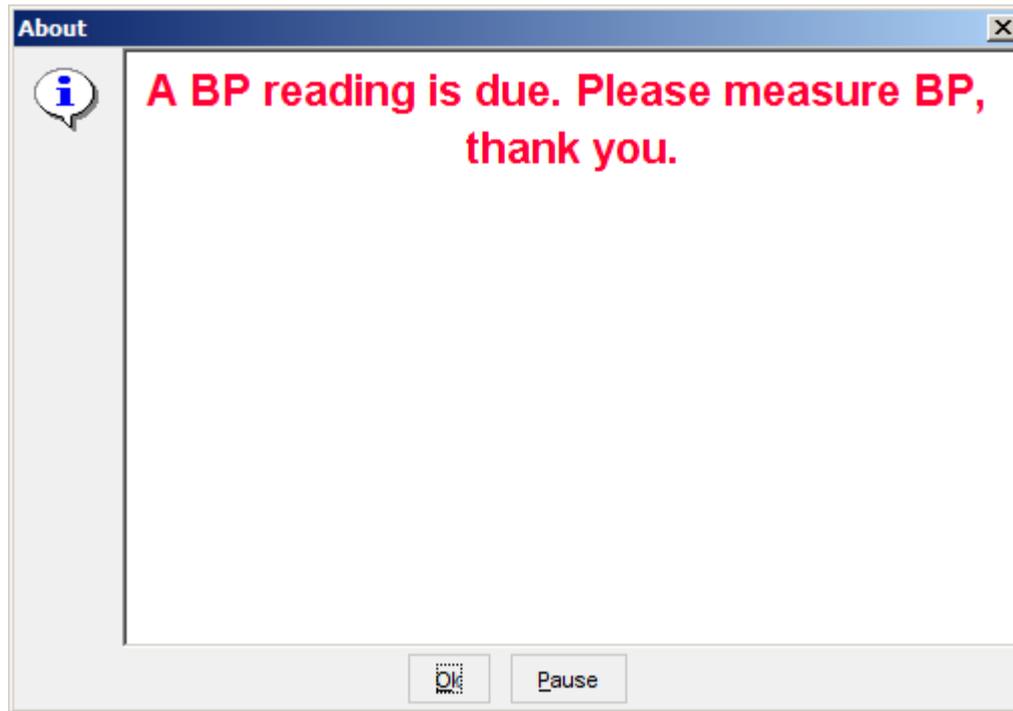
Canadian guidelines 2015 suggest to diagnose

hypertension based on one reading if SBP>180 or

DBP>110

# Others ideas ?

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# Next steps with QP14/15

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1. Review and code accordingly on medication but not on register.
2. Active review (e.g SBP>180) or opportunistically review patients with raised BP (patients alert will stay active ).
3. We need to start planning for QP15/16 QRISK2>10-20% (statin guide updated).



# BRADFORD'S HEALTHY HEARTS



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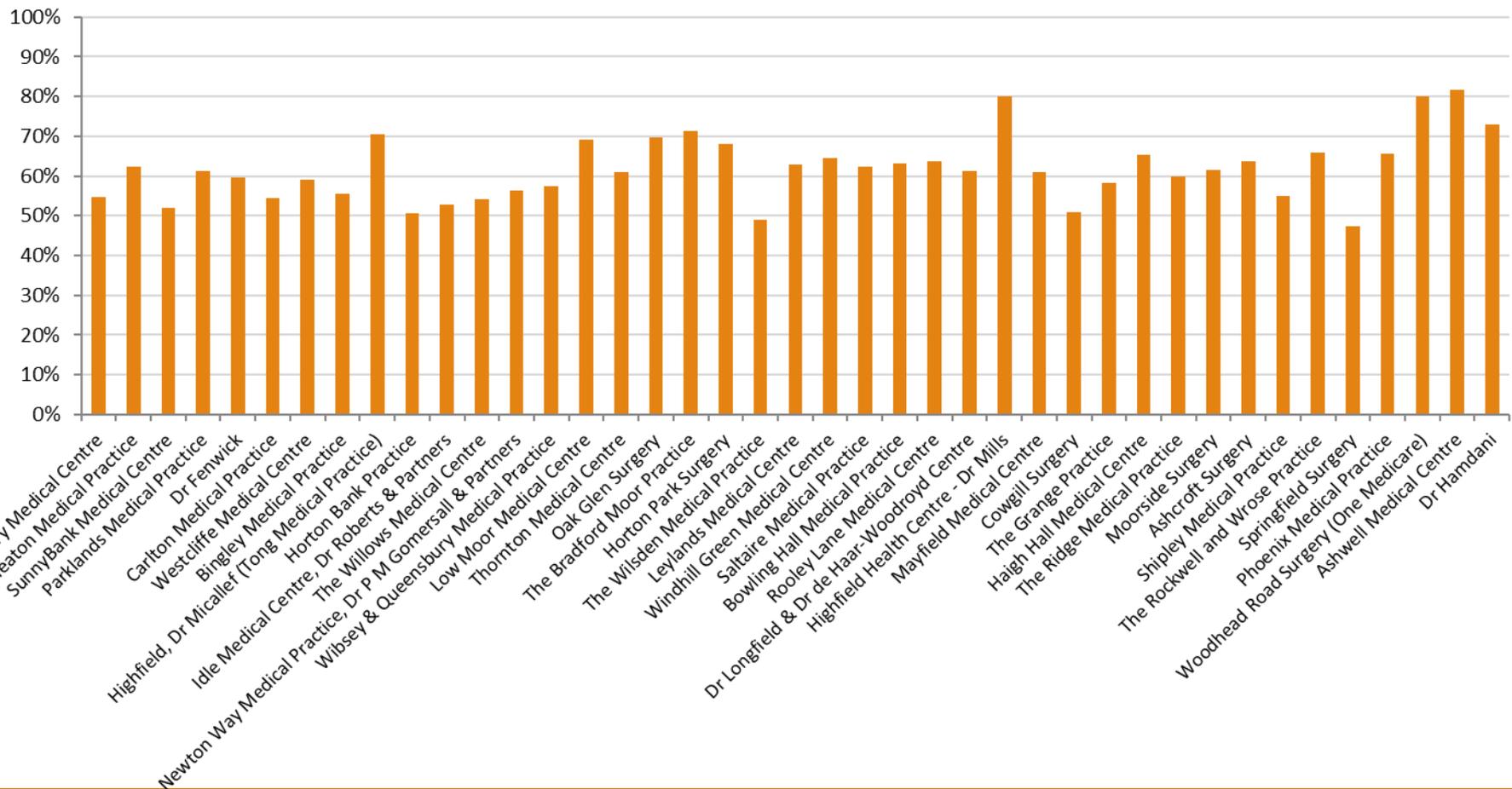
## Bradford Healthy Hearts

Youssef Beaini, Maciek

Maciek & Youssef

# Current achievement

## 62% with QRISK2 > 20% on a statin



# Aim of this project

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The aim of the project is to start 77% of patients with QRISK2 > 20% on a statin

Project duration 5 months (depends on the approach selected today )

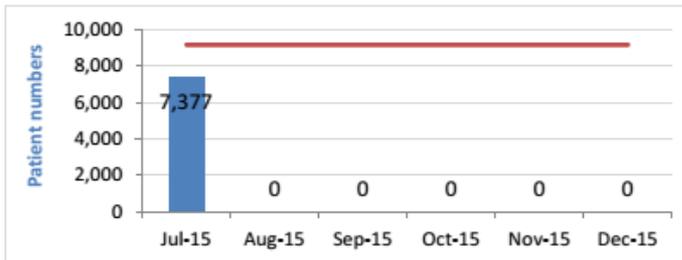
# Aim 15% increase n=1810

## Statin Switches Feedback Report - Jul-15

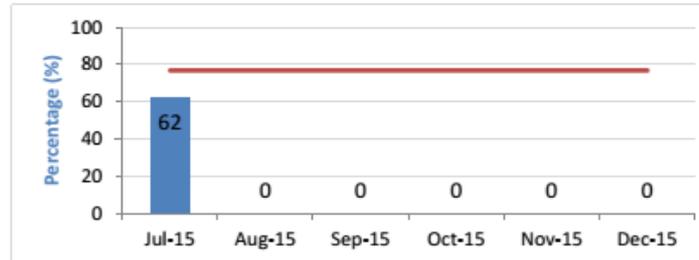
## Summary Feedback

The aim of the project is to start 77% of patients with QRISK2>20% on a statin by Dec 15

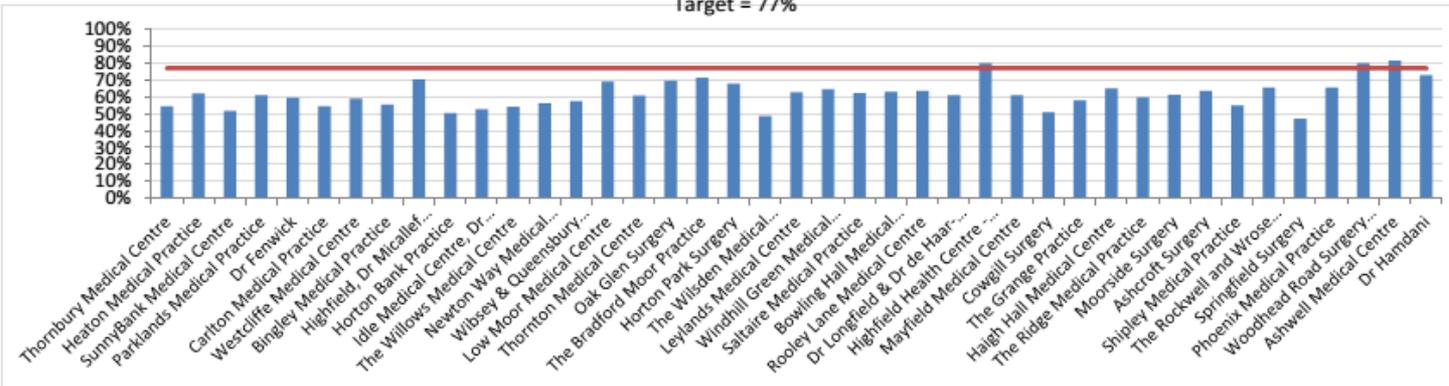
Patients needed to switch = **1,810**



% Patients needed to switch = **15**



Target = 77%



**BRADFORD'S  
HEALTHY HEARTS**

**NHS**  
Bradford Districts  
Clinical Commissioning Group

For more information or assistance with this project,  
please contact the project team on 07852550274

# Based on your feedback

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We amended searches

Tested approach and letters with patients

Set up a YouTube channel for BHH

Started recording video clips with FAQ re stain

# Potential approach

Identify group of patients that could safely be offered statin at scale.

Use opt in or opt out approach based on practice preferences.

Patients could get advice from website and or YouTube channel. The advice will be provided by local clinicians.

We are trying to find a current service provider who could answer any question that patients may have.

We involved pharmacists and they will educate patients when they collect a prescription .

Video clips BHH Youtube

# Patients that could be offered statin

QRISK2>20% and currently not on a statin

Exceptions:

All females under 55 years old

All drugs that could interact with atorvastatin (we will send a list after today )

BMI below 18

BMI not recorded in the last 5 years

ALT>120

Statin contraindicated

Statin sensitivity

# Patients that could be offered statin

QRISK2>20% and currently not on a statin

Exceptions:

Palliative care register

Warfarin prescribed

Cancer

LD register

Hemorrhagic stroke

Statin adverse reaction

# LFTs before you start statin ??

“The risk of raised ALT (transaminitis) is <1%. The risk of acute liver failure is negligible. So, from that point of view one may argue that a baseline ALT is not necessary at all”

I haven't seen any case of liver failure from statins in 10 years

**Dr Sulleman Moreea**  
**GOSK FRCS(Glag) FRCP**  
**Consultant Gastroenterologist/Hepatologist**

# Potential option

To offer statin without baseline LFTs

Check TC and LFTs 3 months after starting and never after unless indicated

?

# How to take this forward

Select a group of practices and pilot it.

Based on lessons learned from statin swishes go ahead and do it All.

# New ways of working !

Chris Patterson



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## Bradford Healthy Hearts

### BHH website

### Sue Jones



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## Bradford Healthy Hearts Potential approaches To QRISK 10-20%



# QP15/16

**NHS England expects to see 10% improvement**

**Needs to be finished by March 2016**

**Some progress has been made since QP have been agreed, 108 new patients started on statin with QRISK2 10-20%**

# QRISK 2 > 10-20% potential approaches

**Offer statin at scale**

**Highlight any patients who can receive statin  
“remotely “**

**Offer statin on an opportunistic basis e.g. protocol that will remind you to offer statin with patient information to print**

**Review individual patients**

**Others ??**



# BRADFORD'S HEALTHY HEARTS



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Bradford Healthy Hearts  
Reduce Blood pressure in a  
population

# Two programmes for the public that will help reduce BP

## 1. Bradford's Biggest Loser

# Two programmes for the public that will help reduce BP

1. Bradford's Biggest Loser- A competition/challenge programme for the public aimed to identify BBL – a person that will loose a lot of weight (results will be display on BHH website)

We will involve all gyms and pools in Bradford

2. Healthy restaurant and healthy take away- A championship for local restaurants aiming to reduce salt use during cooking

3. PPG develop a group of patients with CVD (PPG we need your help)

# Self titration



Original Investigation | August 27, 2014

## Effect of Self-monitoring and Medication Self-titration on Systolic Blood Pressure in Hypertensive Patients at High Risk of Cardiovascular Disease

### The TASMIN-SR Randomized Clinical Trial **FREE**

Richard J. McManus, FRCGP<sup>1</sup>; Jonathan Mant, MD<sup>2</sup>; M. Sayeed Haque, PhD<sup>3</sup>; Emma P. Bray, PhD<sup>4</sup>; Stirling Bryan, PhD<sup>5,6</sup>; Sheila M. Greenfield, PhD<sup>3</sup>; Miren I. Jones, PhD<sup>3</sup>; Sue Jowett, PhD<sup>7</sup>; Paul Little, MD<sup>8</sup>; Cristina Penalzoza, MA<sup>7</sup>; Claire Schwartz, PhD<sup>1</sup>; Helen Shackelford, RGN<sup>3</sup>; Claire Shovelton, PhD<sup>3</sup>; Jinu Varghese, RGN<sup>3</sup>; Bryan Williams, MD<sup>9</sup>; F.D. Richard Hobbs, FMedSci<sup>1</sup>

[\[+\] Author Affiliations](#)

*JAMA*. 2014;312(8):799-808. doi:10.1001/jama.2014.10057.

Text Size: **A** A A

**This article was corrected** | [View correction](#)

# Self management

## Editorial

### Hypertension Self-Management A Home Run for Patients and Payers

David J. Magid, MD, MPH; Steven A. Farmer, MD, PhD

"People ... operate with beliefs and biases. To the extent you can eliminate both and replace them with data, you gain a clear advantage."

—Michael Lewis, *Moneyball: The Art of Winning an Unfair Game*

The book *Moneyball* tells the story of Billy Beane, the general manager of the Oakland Athletics, who collected detailed data and applied advanced statistical techniques to identify high-value baseball players.<sup>1</sup> Beane's data-driven, evidence-based approach to evaluating players ran counter to traditional baseball scouting techniques, which relied on subjective assessments (a batter's swing, a pitcher's mechanics) and time-honored performance measures (batting average, stolen bases) that correlate poorly with the ultimate outcome of winning games.

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#### Article see p 269

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Like traditional baseball scouts, the Centers for Medicare and Medicaid Services (CMS) often rely on subjective assessments rather than robust data to guide coverage decisions.<sup>2,3</sup> By law, CMS must cover reasonable and necessary health services for Medicare beneficiaries.<sup>4</sup> However, Congress did not define reasonable and necessary in the legislation that established Medicare. Further, CMS excludes consideration of cost or

which BP data from home monitoring is communicated regularly to healthcare providers, results in even greater improvements in BP control.

The study by Maciejewski et al<sup>12</sup> provides further evidence supporting this approach. The Hypertension Intervention Nurse Telemedicine Study (HINTS) was a randomized trial of patients who received care at Durham Veterans Affairs Medical Center primary care clinics. Patients were assigned to usual care or 1 of 3 intervention groups: nurse-administered behavioral management, nurse-administered, physician-directed medication management, or a combination of the 2. All intervention patients received home BP telemonitors that transmitted patient BP measurements to a clinic-based nurse. The behavioral management intervention promoted medication adherence and healthy behaviors. The medication management intervention had nurses, guided by hypertension treatment guidelines and physician oversight, adjust antihypertensive therapy based on the home BP data. Study outcomes included BP control and change in systolic BP.

In an earlier study, the investigators reported improvements in BP outcomes for intervention patients compared with control patients at the end of the 18 month study.<sup>10</sup> The current report assessed persistence of BP outcomes after an additional 18 months. Compared with usual care, BP control at 18 months after trial completion (36 months after randomization) was 17% higher

# Some other ideas

Manage resistant HTN effectively and or refer

Use a defined process for outreach (e.g., via phone, mail, email, text message) to patients with uncontrolled HTN and those otherwise needing follow-up

Contact patients to confirm upcoming appointments; instruct them to bring medications, medication list, and home BP readings; tell them to take medications as instructed on day of visit; if possible, instruct them on submitting home BP readings periodically via apps/portal

Measure, document and repeat BP correctly as indicated; flag abnormal readings

Implement frequent follow-ups (e.g., e-mail, phone calls, text messages) with patients to make sure they are continuing their medication

# Next steps

1. Review QP 14/15 especially on meds not on HTN register (for QOF)
2. If you want to win an Ipad in August review your AF patients, call them in if high risk
3. August meeting ???
4. Offer statin to QRISK10% and use the new statin guide
5. QRISK2>20% depending on discussion today
6. Contact your PPG group and ask them to get in touch if they would like to form a CVD group. We will do clinical training for them so they can educate patients in your practice.