



Primary and secondary prevention: baseline assessment

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Anna Kilpin
Senior Project Manager
North West London Cardiac Network
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Executive Summary

The North West London Cardiac Network has obtained, and has access to, a considerable amount of information about primary and secondary prevention, however, no structured assessment of services available and infrastructure has yet been completed at sector level. The production of a baseline assessment of primary and secondary prevention in South West London and the recent re-establishment of the Network's Primary Care Sub-group prompted the Network to undertake a comprehensive assessment of primary and secondary prevention in North West London.

A considerable amount of information was collected to produce a baseline assessment, all of which can be viewed in the subsequent report. In summary, however, the main findings were as follows:-

- ❖ **Prevalence of primary and secondary prevention:** as expected, given the centrality of cardiac care in NHS service provision, there is considerable evidence of primary and secondary prevention within the primary care setting in North West London, and progress and advancements in service delivery. The sector has a high number of GP with a Specialist Interest (GPwSI) in Cardiology, which has contributed to the development of community cardiac services, and innovatory approaches to cardiac care. Furthermore, there is a vast range of employees contributing to the provision of primary and secondary prevention, both clinical and non-clinical.
- ❖ **Similarities between PCTs:** consistency across the eight PCTs is discernible in a number of areas that feature in the report. Generally in the Quality Outcomes Framework (QoF), achievement is higher for certain CHD targets than others (eg. practices across the sector tend to perform less well against the clinical outcome targets). The PCTs tend to have the same staff groups delivering primary and secondary prevention services, however, the quantity differs. The PCT systems in place for general practice in IT, audit, governance and support are generally similar with more activity in some areas than others. Where there is variety discernible amongst practices within a given PCT, this is generally reflected in the other PCTs, for example, the use of CHD risk tools.
- ❖ **Differences between PCTs:** certain PCTs have evidently progressed further in primary and secondary prevention within the primary care setting. The number of cardiology GPwSIs differs considerably across the PCTs from four to none, which seems to have influenced (or may have been determined by) the development of community cardiac services. Achievement against the QoF varies significantly with certain PCTs consistently performing well, and others consistently performing below average when compared with their counterparts. Links with secondary care vary with the existence of cardiac groups often ensuring better communication channels. The emphasis on primary prevention differs across the sector, with some PCTs advocating its importance and purchasing software tools to assist with the identification of patients at risk and others not yet considering it a priority.

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1. Introduction

The North West London Cardiac Network re-established its Primary Care Sub-group in May 2007 comprised of CHD leads, commissioners, GPs with a specialist interest in Cardiology, GPs, practice nurses and pharmacists. The purpose of the group is to act as the main driver across the Network for providing guidance, advice and recommendations to the Network Board to influence the delivery of cardiac care on sector wide initiatives affecting primary care across North West London.

The Network has obtained, and has access to, a considerable amount of information about primary and secondary prevention, however, no structured assessment of services available and infrastructure has yet been completed at sector level. In December 2005, the South West London Cardiac Network completed a baseline assessment of primary and secondary prevention in the sector. With the re-establishment of the North West London Cardiac Network's Primary Care Sub-group in May 2007, it was deemed an opportune moment to undertake a similar baseline assessment in North West London.

The findings of the baseline assessment will be used as a benchmarking tool for the composite PCTs in North West London, and to inform work undertaken by the Primary Care Sub-group.

2. Methodology

The baseline assessment conducted by the South West Cardiac Network was reviewed and used as a draft template. The information obtainable from electronic sources (such as the Quality Outcomes Framework (QoF)) was identified, and the remaining information required compiled into questionnaire format (see Appendix 1). The questionnaire was distributed to the CHD leads in each of the eight PCTs in North West London initially, and followed-up with a visit from the Network primary care lead. Where information was not immediately available, appropriate PCT personnel were contacted.

The baseline assessment was produced using electronic sources (referenced throughout the document) and the questionnaire results.

3. Quality Management and Analysis System (QMAS) data 2005/06

PCT ↓	No of practices	Sum of list sizes	CHD total points (achieved)	CHD total points (achieved/available)	Sum of CHD register counts	CHD unadjusted prevalence	Sum of hypertension register counts	Hypertension unadjusted prevalence	Sum of diabetes register counts	Diabetes unadjusted prevalence
Brent	71	342,752	7,016.6	97.8%	7,051	2.1%	35,845	10.5%	15,928	4.6%
Ealing	82	368,598	8,178.7	98.8%	9,365	2.5%	39,904	10.8%	15,418	4.2%
Hammersmith & Fulham	32	189,293	3,151.2	97.5%	3,525	1.9%	15,696	8.3%	5,236	2.8%
Harrow	40	229,704	3,918.2	97.0%	6,916	3.0%	28,337	12.3%	10,846	4.7%
Hillingdon	52	262,572	5,186.0	98.7%	6,960	2.7%	29,779	11.3%	9,701	3.7%
Hounslow	60	251,943	5,907.9	97.5%	6,140	2.4%	26,894	10.7%	9,794	3.9%
Kensington & Chelsea	44	184,295	4,293.2	96.6%	3,535	1.9%	14,177	7.7%	4,436	2.4%
Westminster	51	244,899	4,898.1	95.1%	4,918	2.0%	18,555	7.6%	6,446	2.6%

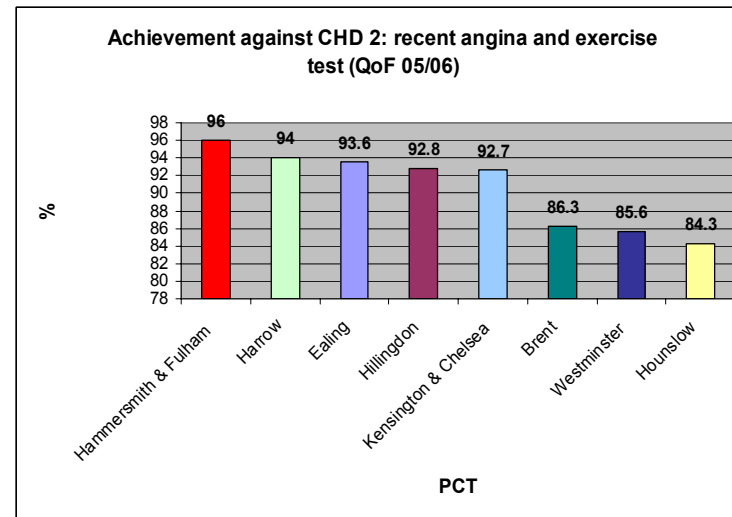
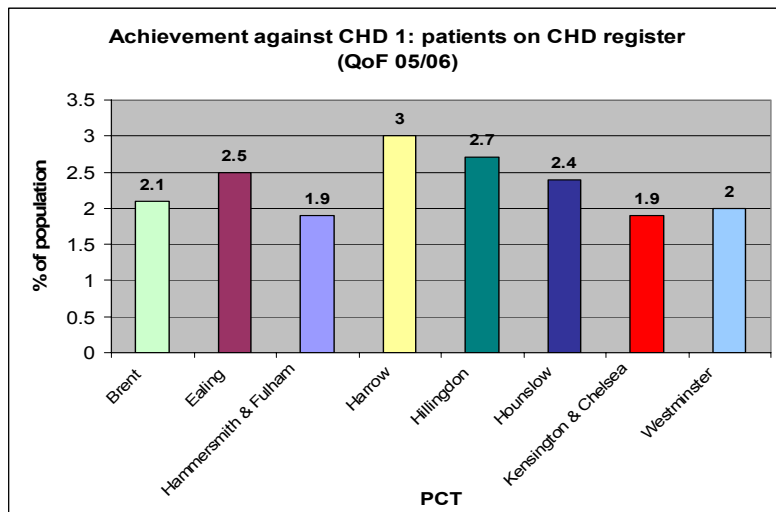
The above data was taken from the NHS Information Centre for Health and Social Care website (www.ic.nhs.uk) and is for 2005/06. Validated 2006/07 data was unavailable when this assessment was produced, however, will be displayed on the Information Centre website in the autumn.

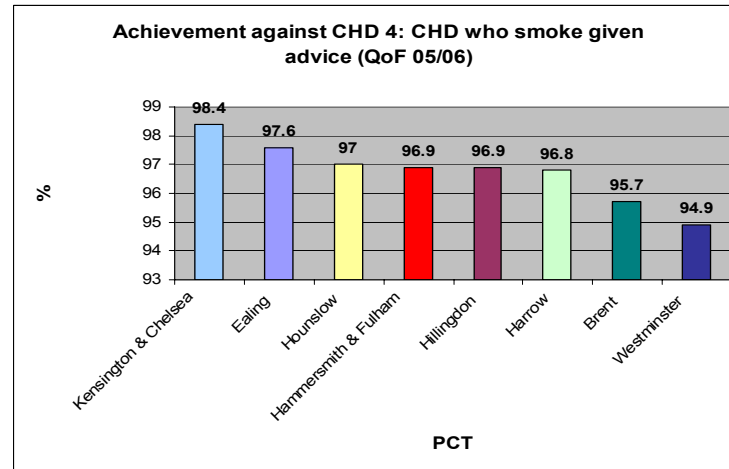
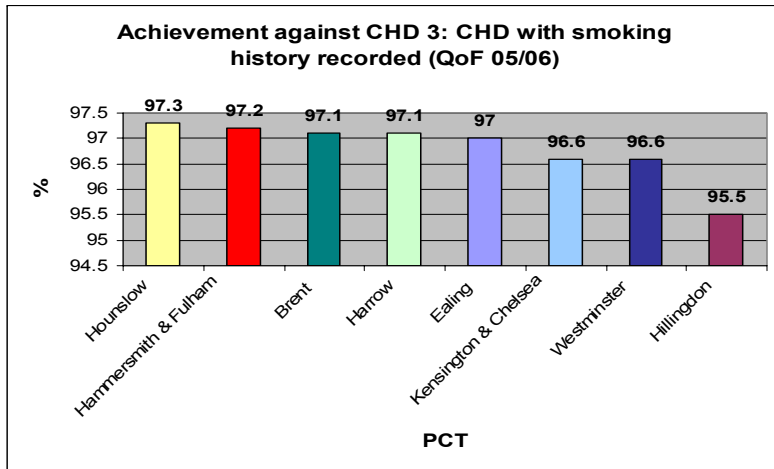
Quality Outcomes Framework (QOF) achievement data is available at SHA and England level, at Primary Care Trust (PCT) level (as displayed above), and at General Practice level.

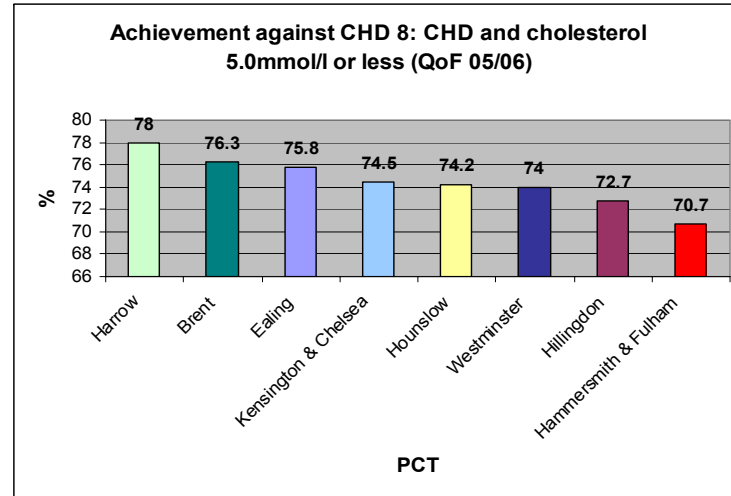
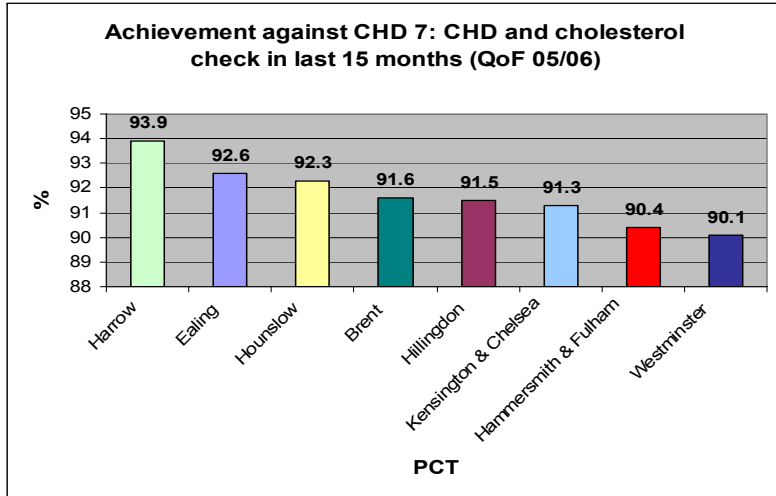
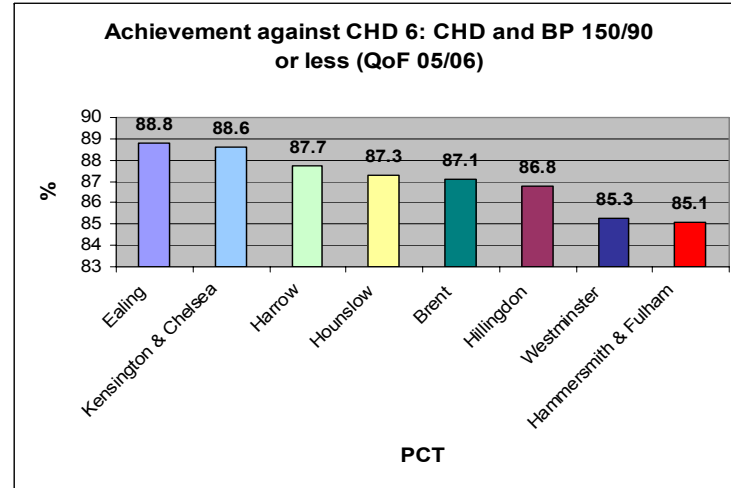
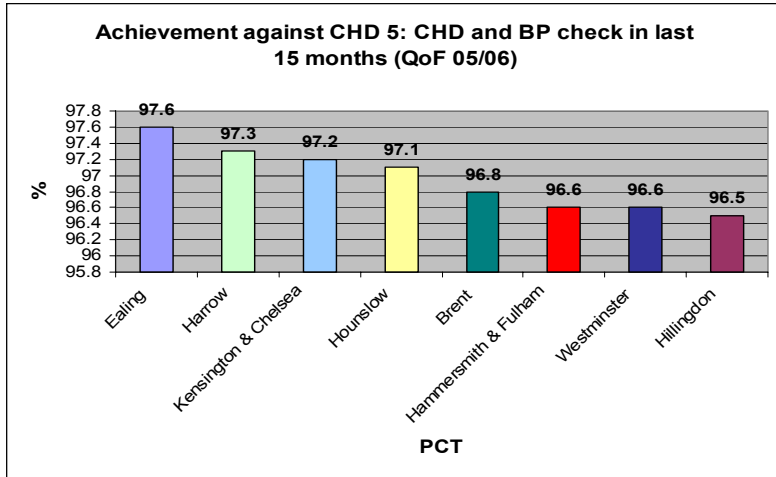
There is significant variation determinable across the sector in all the columns in the table above, which is worth referring to when considering the remainder of the baseline assessment.

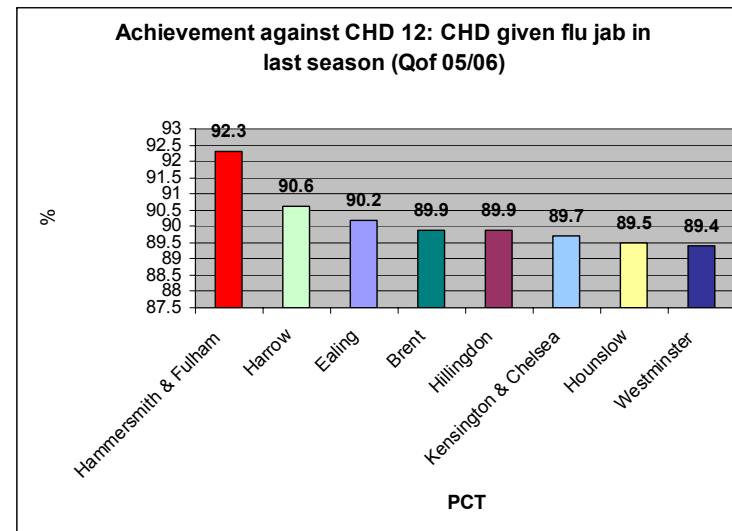
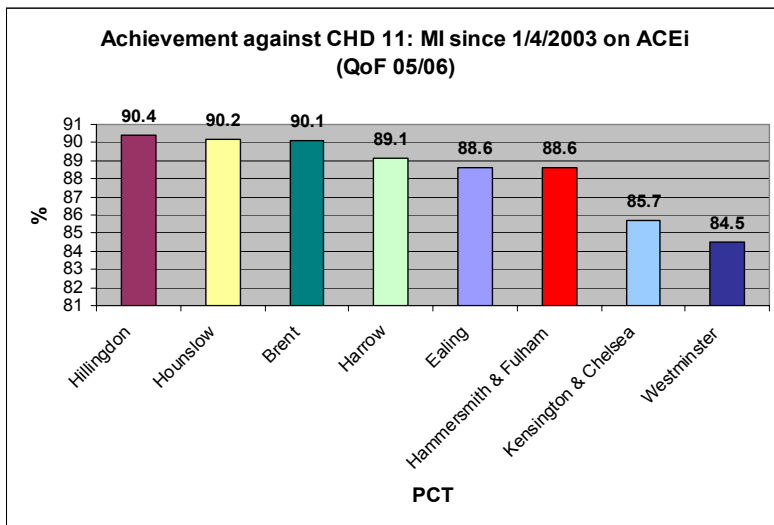
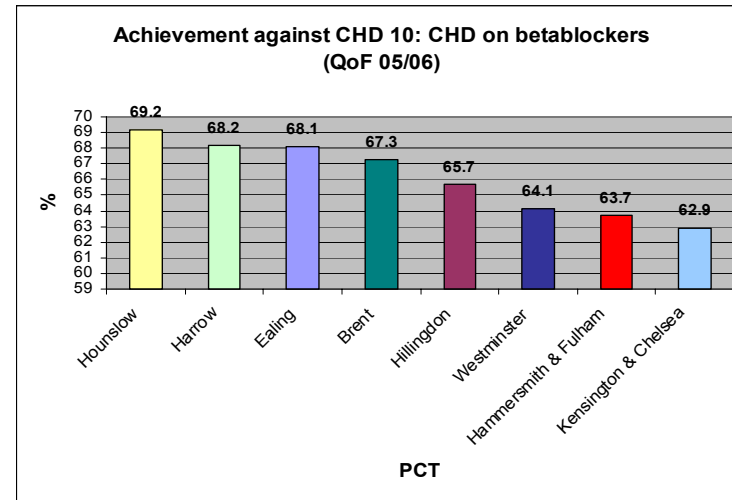
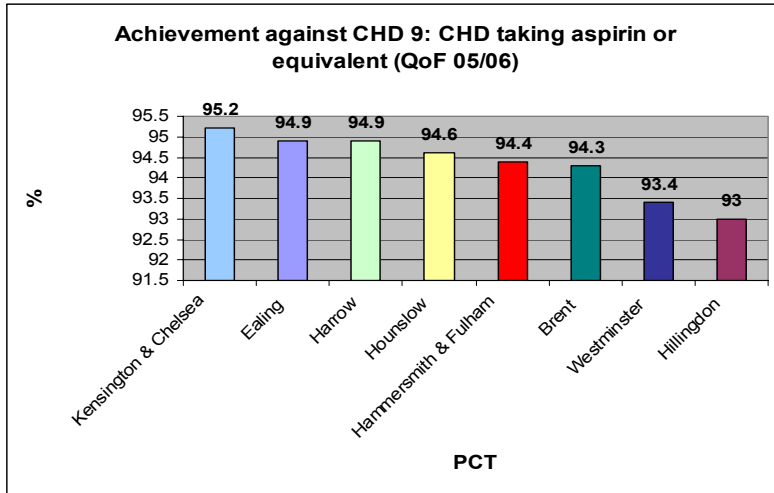
Achievement against QoF CHD targets across North West London (05/06)

The following twelve bar graphs show the achievement against each CHD targets of the eight PCTs in North West London in 05/06.









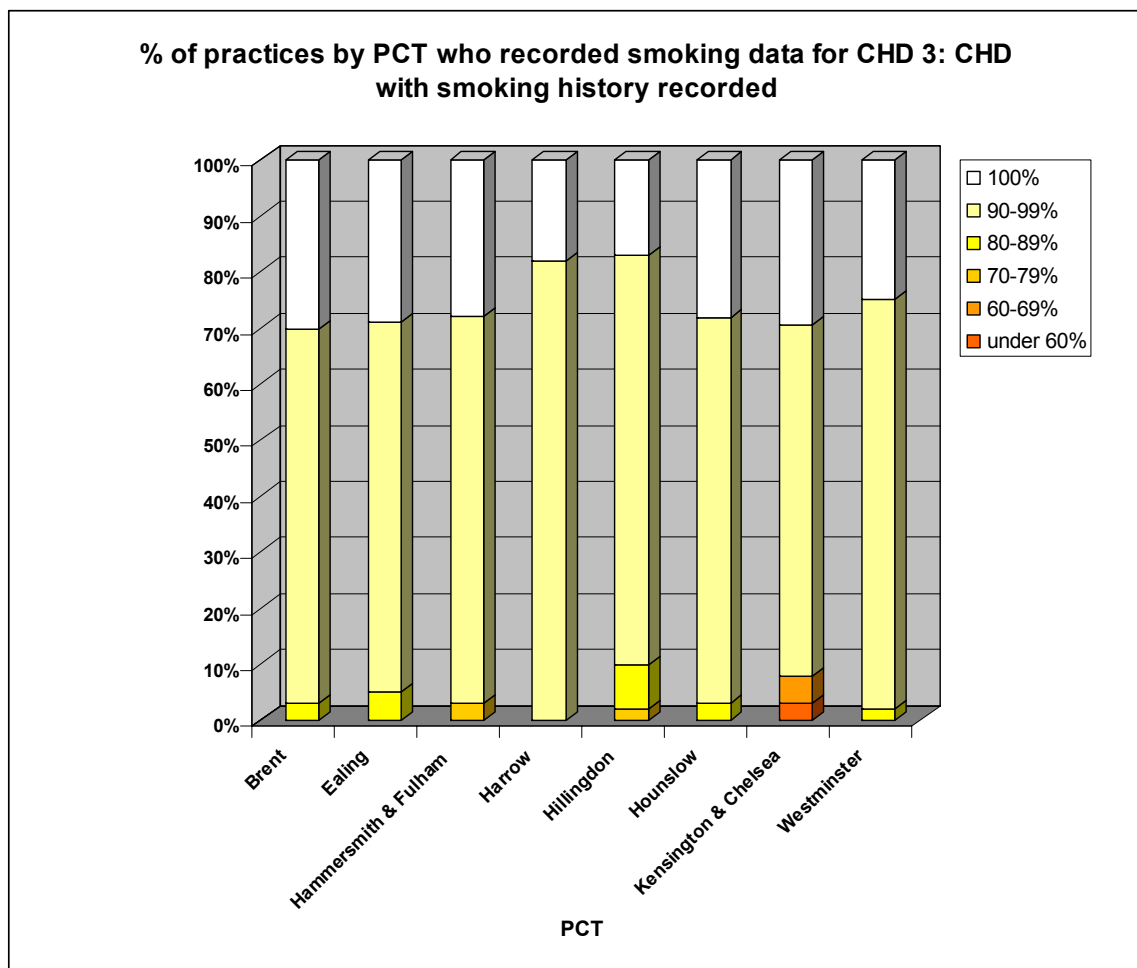
The bar charts above show the variation discernible across the sector in achievement against each of the twelve QoF CHD targets. The variation is within a 5% margin for seven of the indicators, however, it exceeds 5% for four, and in one instance exceeds 10% (CHD 2: recent angina and exercise test). This indicates that for certain targets some PCTs are performing significantly better than others.

Across the sector, there is considerable scope for improved performance for the outcome targets ie. CHD 6 (CHD and BP 150/90 or less) and CHD 7 (CHD and cholesterol 5.0mmol or less) where achievement is generally poorer than for the process focused targets.

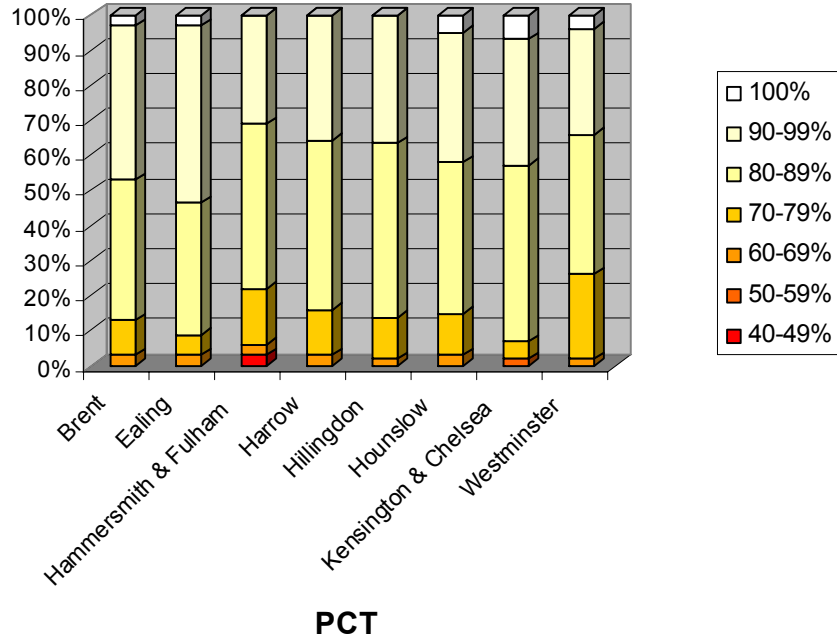
More detailed achievement against specific CHD targets

The four graphs below show achievement by PCTs in more detail for four of the CHD targets: CHD 3: CHD with smoking history recorded; CHD 6: CHD and BP 150/90 or less; CHD 8: CHD and cholesterol 5mmol or less; and CHD 9: CHD taking aspirin or equivalent.

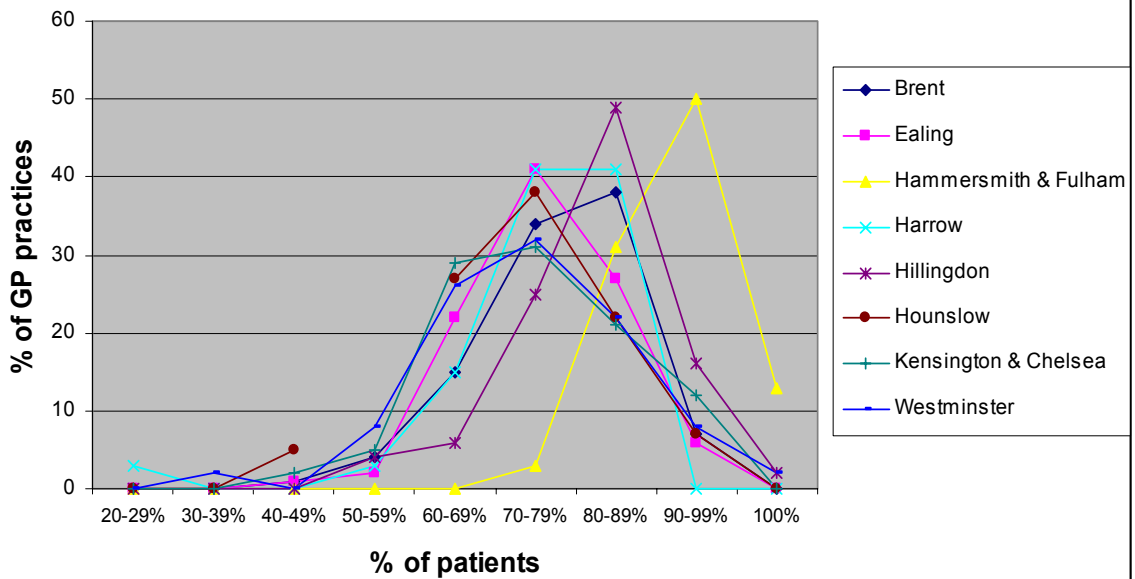
The achievement for each specific PCT is broken down into the percentage of practices achieving the target in 10% groupings. This demonstrates where there is both particularly high and particularly low achievement against the specific target compared with other PCTs.

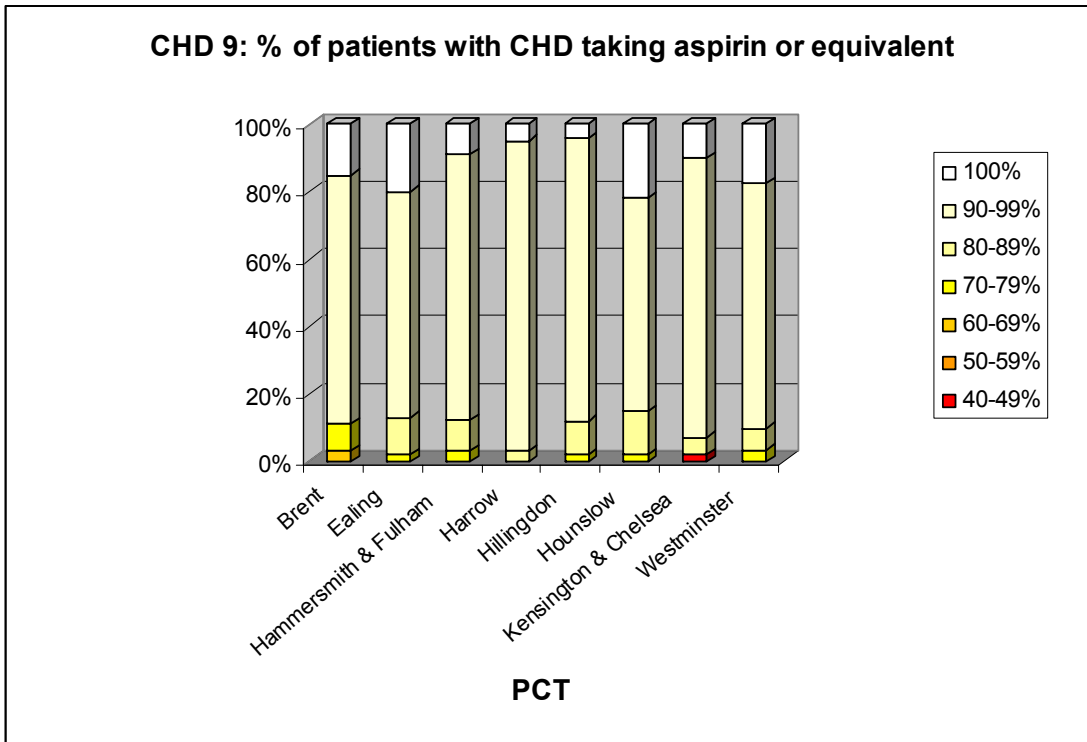


CHD 6: % of practices with CHD with BP reading (measured in last 15 months) of 150/90 or less



CHD 8: % of patients with CHD whose last measured cholesterol (within last 15 months) is 5mmol or less





The four graphs above demonstrate the variation discernible (as expected) amongst practices within a PCT area. In a given PCT area, high performance within certain practices does not preclude low performance within others and vice versa.

When analysing PCT achievement against the CHD targets, consideration of performance at practice level is advocated to identify specific areas of low achievement. Analysing performance within practice based commissioning groups provides a useful mechanism to target low performance if there is a geographical trend to its occurrence.

In addition to achieving against the QoF, high performance in the CHD targets contributes to ensuring adherence to the National Institute of Clinical Governance MI : secondary prevention guidance (May 07). The key priorities for implementation are listed in Appendix 2; in relation to smoking (CHD 3, CHD 4):-

All patients who smoke should be advised to quit and be offered assistance from a smoking cessation service in line with 'Brief interventions and referral for smoking cessation in primary care and other settings' (NICE public health intervention guidance 1).

Furthermore, prescribing features in the key priorities for implementation (see Appendix 2) which relates to a number of the other CHD QoF targets (ie. CHD 9, CHD 10, CHD 11).

4. Local PCT guidelines

PCT → Guidelines ↓	Brent		Ealing		Ham & Ful		Harrow		Hillingdon		Hounslow		Kens & Chel		Westminster	
	↓ Management		↓ Management		↓ Management		↓ Management		↓ Management		↓ Management		↓ Management		↓ Management	
	Prescribing ↓		Prescribing ↓		Prescribing ↓		Prescribing ↓		Prescribing ↓		Prescribing ↓		Prescribing ↓		Prescribing ↓	
Hypertension (primary prevention)	√	√	NICE	NICE	NICE	NICE	√	√	√	√	NICE	NICE	x	x	√	√
Hypertension (secondary prevention)	√	√	NICE	NICE	NICE	NICE	√	√	√	√	NICE	NICE	√	√	√	√
Dyslipidaemia (primary prevention)	√	√	NICE	NICE	NICE	NICE	√	√	√	√	NICE	NICE	Dietary advice	x	√	√
Dyslipidaemia (secondary prevention)	√	√	NICE	NICE	NICE	NICE	√	√	√	√	NICE	NICE	x	x	√	√
Diabetes	√	√	√	√	NICE	NICE	√	√	√	√	√	√	√	√	√	√
Stable angina	√	√	√	√	x	x	√	√	√	√	x	x	√	√	√	√
Management of CHD post MI	√	√	√	√	NICE	NICE	√	√	√	√	x	x	x	x	√	√
Heart failure	√	√	√	√	NICE	NICE	√	√	√	√	x	x	√	√	√	√
Atrial fibrillation	imminent		x	x	x	x	NICE	NICE	√	√	x	x	x	x	√	√
Anti-platelet	√	x	x	x	x	x	√	√	x	x	x	x	x	√	√	√
Obesity/weight management	√	√	√	√	NICE	NICE	√	√	x	x	Developing strategy		√	√	Joint with St Mary's Hospital pending	
Smoking cessation	√	√	NICE	NICE	NICE	NICE	√	√	√	√	x	x	√	√	x	x
Risk assessment tools (primary prevention)	x	x	NICE	NICE	BNF	x	BNF	BNF	√	x	Prevention strategy		x	n/a	√	√
Rehabilitation	√	n/a	NICE	n/a	x	n/a	√	n/a	x	n/a	x	n/a	√	n/a	√	n/a

(where respondents included NICE guidelines (National Institute of Clinical Excellence) this is shown in the table above; BNF = British National Formulary)

Across the sector, local guidelines have been developed for all the areas included in the question by at least one PCT. The variation is likely to be attributable to the varying stages of development of community services discernible across the sector. PCTs should ensure their local guidelines adhere to the MI: secondary prevention guidelines (May 07).

5. Access to services

PCT → Job role ↓	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster
Dietician	√	√	√	√	√	√	√	√
Smoking cessation	√	√	√	√	√	√	√	√
Physical activity	√	√	√	√	√	√	√	√
Psychology	One GPwSI in Psychology	√	√	acute sector provision	√	√	√	not specifically for cardiology
Patient education sessions	√	√	x	√	√	√	√	√
Weight management	√	√	x	√	informal	√	√	√
Phase 2 rehabilitation	x	√	√	√	acute sector provision	acute sector provision	√	√
Phase 3 rehabilitation	√	√	√	√	acute sector provision	√	√	√
Phase 4 rehabilitation	√	√	√	√	private provision in community	√	√	√
Heart failure rehabilitation	imminent	x	√	x	plans to introduce soon	x	x	future plans
Primary prevention clinics	x	x	x	√	adhoc provision	adhoc provision	x	x
Secondary prevention clinics	√	acute sector provision	acute sector provision	√	√	acute sector provision	√	x

Additional information provided:

- **Brent:** patient education sessions – expert patient programme (6 weekly ongoing), flexi-heart programme (once a month through Brent Heart of Gold Support Group), dietetics programme; primary prevention clinics – just risk registers
- **Ealing:** smoking cessation – pharmacy services providing advice and nicotine replacement therapy; weight management – pilot pharmacy scheme

- **Harrow:** physical activity – exercise on prescription/rehabilitation; patient education sessions – heart failure and cardiac rehabilitation; phase 4 rehabilitation – at various community venues around Harrow; heart failure rehabilitation – not permitted in community
- **Hounslow:** physical activity – exercise on prescription; healthy lifestyle co-ordinator; patient education sessions – expert patient programme, after discharge for MI
- **Kensington & Chelsea:** smoking cessation – currently with QUIT, moving to in-house; physical activity – exercise for health; psychology – counselling in majority of practices; patient education sessions – expert patient programme, XPERT for type 2 diabetes imminent; secondary prevention clinics – generally patients seen outside organised clinics
- **Westminster:** physical activity – cardiac rehabilitation/liaison team; patient education sessions – phase III rehabilitation and ‘healthy heart’ talks; weight management – individual reviews and group sessions; phase II rehabilitation – clinic or home visit; phase III rehabilitation – in primary and secondary care; phase IV rehabilitation – at two sports centres in Westminster

There are some gaps in access to services for a number of the PCTs. Generally, patients are able to access services in the acute setting where this is not possible in primary care. There is an absence of heart failure rehabilitation and primary prevention clinics in the majority of PCTs.

6. Clinical systems in GP practices

No of practices with clinical system in each PCT				
↓ PCT/system →	Emis	Torex	Vision	Other
Brent	58 (70%)	1 (1%)	24 (29%)	
Ealing	64 (88%)	2 (3%)	6 (8%)	1 (1%)
Hammersmith & Fulham	17 (55%)		14 (45%)	
Harrow	34 (85%)		6 (15%)	
Hillingdon	47 (92%)	2 (4%)	2 (4%)	
Hounslow	70% (estimate)		30% (estimate)	
Kensington & Chelsea	26 (60%)	2 (5%)	15 (35%)	
Westminster	30 (60%)		20 (40%)	

NB. some of the total practice numbers in the table above differ from the QMAS data shown previously – this will be attributable to the QMAS data being 05/06, and the above data being current

7. Use of CHD risk tools

CHD risk tools → PCT ↓	Framingham			Joint British Societies (JBS)			Oberoi		
	all	some	none	all	some	none	all	some	none
Brent		√				√		√	
Ealing	√				√			√	
Hammersmith & Fulham		√						√	
Harrow		√			√			√	
Hillingdon		√				√		√	
Hounslow		√			√				√
Kensington & Chelsea		√				√			√
Westminster		√			√			√	

Additional information provided:

- **Ealing:** both Emis and Vision have Framingham CHD calculators built in so all practices have access; all practices that participated in the CVD Local Enhanced Service agreement in 06/07 should have been using the JBS tool (ie 53 practices)
- **Hammersmith & Fulham:** all Vision practices have Framingham (14) and 28 practices have Oberoi installed to date, which has been purchased for all practices by the PCT

Both the Framingham and Joint British Societies' CHD risk tools are in use across the sector with the majority of PCTs having a combination of the two in operation. Tools that permit audits of entire practice populations for CHD/CVD risk (for example, Oberoi Clinical Observations software) are increasing in practices as primary prevention becomes more of a focus.

8. Incentives or local enhanced services (LES)

PCT ↓	Incentive/enhanced service	Details
Brent	1. GPwSI LES	<ul style="list-style-type: none"> • 2 GP with Specialist Interest (Cardiology); 1 Community Cardiologist • Funding support sessional work between £240-300 per session
Ealing	1. Prescribing Incentive Scheme	<ul style="list-style-type: none"> • Statin switch (audit of 10 and 20 mg Simvastatin) • Medicines management
	2. CVD risk scoring LES	<ul style="list-style-type: none"> • Implemented in 2006/2007; 53 practices participated; practices remunerated for identify patients at risk and treating
	3. CVD primary prevention – Ealing & Acton Commissioning Group	<ul style="list-style-type: none"> • Under development • Will include purchase of risk identification software
Hammersmith & Fulham	1. 'At risk' registers LES	<ul style="list-style-type: none"> • Specification under development
Harrow	none	
Hillingdon	none	
Hounslow	none	
Kensington & Chelsea	1. Primary prevention	<ul style="list-style-type: none"> • Part of specification for PMS additional services
	2. Smoking cessation	<ul style="list-style-type: none"> • Paying level 2 providers ie. GPs, practice nurses, community pharmacists, to take people through four weeks; £60 per patient
	3. Anti-coagulation	<ul style="list-style-type: none"> • Monitoring warfarin in the community; nurse-led clinics
Westminster	1. Anti-coagulation	<ul style="list-style-type: none"> • INR monitoring
	2. Prescribing incentive scheme	<ul style="list-style-type: none"> • Patient medical reviews
	3. CVD at risk LES	<ul style="list-style-type: none"> • Introduction imminent; identification of people at risk and improved data collection to permit more effective identification and subsequent monitoring

There is some consistency in the Local Enhanced Service agreements established across the sector. They broadly cover the following areas: GPwSIs, prescribing, primary prevention and anti-coagulation.

9. Staffing (working time equivalents)

PCT → Post ↓	Brent	Ealing	Hammersmith & Fulham	Harrow	Hillingdon	Hounslow	Kensington & Chelsea	Westminster
CHD nurse specialist	2.53	-	-	1.5	1.8	-	-	1
Heart failure nurse specialist	2	2	-	1.5	2	-	1	1
Info management & technology facilitator	1 or 2	2	4	2	-	6	3	0
PCT pharmacist	7	6	4	3	1	5	4	11
CHD lead	1 (provider services)	1 (public health)	Service Development Mgr for Long Term Conditions: vacant	1 (GP)	1 (Modernisation)	1	1	1 (public health)
Cardiac Rehab instructor	3	1	-	1	-	3	2	1

There is considerable variation across the sector in staffing for CHD services. This is likely to be attributable to the variety of service models in place and degree of service development within the community.

Two PCTs do not have a cardiac rehabilitation instructor, which features in the NICE MI: secondary prevention guidance: *Cardiac rehabilitation should be equally accessible and relevant to all patients after an MI, particularly people from groups that are less likely to access this service.* (see Appendix 2). Where cardiac rehabilitation is not offered in the primary care setting, provision should be ensured in secondary care.

10. Community or secondary prevention groups

Name of group	Main objective	Referral process
Brent		
AA Heart Group	Peer support/networking	Hospital - leaflet
Brent Heart of Gold Group	Peer support/networking	Hospital - leaflet

Ealing		
Healthy Living Programme	Increasing awareness of risk factors	GPs/self-referral
Lollipop project	Identify patients at risk of CHD	GP referral
Heartlink	Patient support – managed and run by patients	Hospital
Hammersmith & Fulham		
none		
Harrow		
Patient heart support group	Support for heart patients	Through PCT services
Heart failure support group	Support for heart failure patients	Through PCT services
Hillingdon		
none		
Hounslow		
Heartbeat	To support patients	Details given to patients post-event
Asian Gymkana	To encourage lifestyle improvements eg walks amongst the Asian community	
Expert Patient Programme	Forum for patients to support each other	Through secondary care
Kensington & Chelsea		
Expert Patient Programme	To educate patients in self-management of long-term conditions	Advertised via practices/health professionals
Xpert: diabetes type 2	New programme commencing in Oct; NICE accredited scheme; targeting newly diagnosed patients	GP practices
Westminster		
Healthy heart talks	Primary and secondary prevention of CHD	Self-referral/GP/practice nurse
Exercise at Queen Mother sports centre	Primary and secondary prevention of CHD	GP/practice nurse

NB. Most PCTs will run an Expert Patient Programme, however, it is only listed for PCTs that highlighted it during data collection

The availability of groups beyond clinical services differs significantly for cardiac patients across the sector. Where there is an absence of support groups, PCTs could possibly explore the scope for linking in with groups within other PCT areas to ensure equity of support provision for patients across North West London.

11. Provision of comparative data at PCT level

Type of data → PCT ↓	QMAS	Local Delivery Plan	Prescribing	MIQUEST
Brent	√	√	√	?
Ealing	√	√	√	√
Hammersmith & Fulham	√	√	√	?
Harrow	√	√	√	?
Hillingdon	√	√	√	√
Hounslow	√	√	√	√
Kensington & Chelsea	√	√	√	x
Westminster	√	√	√ (PACT data for GPs)	x

12. Other audits aside from QMAS

Brent	None – other than local delivery plan return
Ealing	<ul style="list-style-type: none"> • Audits undertaken for Med 10 – some related to CHD drugs • Prescribing incentive scheme audits – some related to CHD drugs
Hammersmith & Fulham	<ul style="list-style-type: none"> • Oberoi tool audit – installed in all practices to enable establishment of practice-based CHD/CVD at risk registers • Equity audit – PEC 2005
Harrow	None – other than local delivery plan return
Hillingdon	<ul style="list-style-type: none"> • Mini audit – attendance at GPwSI heart failure clinics
Hounslow	<ul style="list-style-type: none"> • Audit facilitators – work with practices • Research audits
Kensington & Chelsea	None – other than local delivery plan return
Westminster	None – other than local delivery plan return

There is considerable consistency in the provision of comparative data at PCT level across the sector, although not all PCTs use MIQUEST data. With regard to audits, for half the PCTs, this is restricted to the Local Delivery Plan return, however, there are a few examples of additional auditing activity in primary prevention, research and prescribing.

13. GPs with Specialist Interest (GPwSI) in Cardiology

Name	Role	Area of interest	Location
Brent			
Dr Abdul-Majeed Salmasi	Associate Specialist-Community	<ul style="list-style-type: none"> CVD risk and hypertension General Cardiology 	North West London Hospitals Trust
Dr Wijith Wijeratne	GPwSI	<i>Currently not practicing</i>	
Dr Ajit Shah	GPwSI	<ul style="list-style-type: none"> Heart failure General Cardiology 	GP practice
Ealing			
Dr Onkar Sahota	GP with cardiac interest	<ul style="list-style-type: none"> Preventative cardiology Ischaemic heart disease Heart failure 	GP practice
Harrow			
Dr Amol Kelshiker	GPwSI	<ul style="list-style-type: none"> Generalist in cardiac care 	Alexandra Avenue Clinic
Dr Masood Farooqi	GPwSI	<ul style="list-style-type: none"> Generalist in cardiac care 	Roxbourne Health Centre
Dr Jayantha Wijeratne	GPwSI	<ul style="list-style-type: none"> Generalist in cardiac care 	Belmont Health Centre
Dee Hannah	PwSI	<ul style="list-style-type: none"> Generalist in cardiac care 	All three health centres above
Hillingdon			
D Sabby Kant	GPwSI	<ul style="list-style-type: none"> Heart failure 	Mount Vernon; HESA community clinic; Hillingdon Hospital
Dr Diviash Thakrar	GPwSI	<ul style="list-style-type: none"> Hypertension General cardiology outpatients 	HESA community clinic; Hillingdon Hospital
Dr Brett Thomas	GPwSI	<ul style="list-style-type: none"> Rapid Access Chest Pain General cardiology outpatients 	Hillingdon Hospital
Hounslow			
Dr Brigitte Unger-graeber	GP with cardiac interest	<ul style="list-style-type: none"> Echo/stress echo/ All aspects of non-invasive Cardiology 	West Middlesex University Hospital
Westminster			
Dr Sherif Helmy	GPwSI	<ul style="list-style-type: none"> Heart failure Angina Arrhythmia 	St Mary's Hospital
Dr Daniel Youngerwood	GPwSI	<ul style="list-style-type: none"> Heart failure ECGS/echo interpretation Atrial fibrillation/palpitations 	St Mary's Hospital

North West London has the greatest number of GPs with a Specialist Interest in Cardiology in the capital. Accredited GPwSIs are located in four of the sector's PCTs, with an additional two PCTs having GPs with a specific cardiac interest. The high number of GPwSIs has permitted much of the community cardiac care development in recent years.

14. Provision of practice nurse training in Cardiology

(in addition to the Cardiac Network Introduction to Cardiac Care Programme)

Brent	<ul style="list-style-type: none"> • On-going CHD training programme for GPs and practice nurses twice a month • Master classes where need identified for GPs/practice nurses
Ealing	<ul style="list-style-type: none"> • No specific training
Hammersmith & Fulham	<ul style="list-style-type: none"> • No specific training
Harrow	<ul style="list-style-type: none"> • Course for practice nurses run twice a year until recently
Hillingdon	<ul style="list-style-type: none"> • GEMS Cardiology training – ongoing programme for general practice staff
Hounslow	<ul style="list-style-type: none"> • Provision of training by cardiac specialist nurses in local hospital on heart failure and lipids; may be other sessions
Kensington & Chelsea	<ul style="list-style-type: none"> • Thames Valley University courses on CHD as part of IDR process
Westminster	<ul style="list-style-type: none"> • No specific training

15. Provision of practice manager training in Cardiology

Brent	<ul style="list-style-type: none"> • No specific training; invited to CHD training programme
Ealing	<ul style="list-style-type: none"> • No specific training
Hammersmith & Fulham	<ul style="list-style-type: none"> • No specific training
Harrow	<ul style="list-style-type: none"> • Invited to evening meetings as and when appropriate; adhoc basis
Hillingdon	<ul style="list-style-type: none"> • No specific training
Hounslow	<ul style="list-style-type: none"> • No specific training
Kensington & Chelsea	<ul style="list-style-type: none"> • IT training – nothing specific on CHD
Westminster	<ul style="list-style-type: none"> • No specific training

There is some training across the sector specifically in cardiac care, however, it is limited and often provided on an adhoc basis. The Cardiac Network established the Introduction to Cardiac Care Programme for practice nurses in March 2007 having identified a shortage of training provision for this specific staff group. This was intended to supplement the Certificate in Cardiovascular Medicine which was run in 2006 for GPs and specialist nurses. The Introduction to Cardiac Care Programme for practice nurses will be repeated in September/October 2007, when planning will also commence for the second cohort of the Certificate for Cardiovascular Medicine.

16. Combined governance/Quality Outcomes Framework visits

Brent	<ul style="list-style-type: none"> Prescribing team visits practices to agree 3 General Medical Services (GMS) actions on prescribing; actions specific to each practice
Ealing	<ul style="list-style-type: none"> Approximately 31 practices visited every year; CHD and heart failure sometimes included as areas to verify (not included in 06/07 visits)
Hammersmith & Fulham	<ul style="list-style-type: none"> PCT visits a third of practices (in line with requirement to visit practices at least once every three years); focus in 06/07 - review of the quality of QoF indicator achievement against the backdrop of the practice's overall quality of service provision
Harrow	<ul style="list-style-type: none"> Not combined governance and QoF visits but approximately ¼ of practices receive full clinical and non-clinical QoF visit each year (visits determined by performance); visits for the purpose of verification and development; clinical and non-clinical support offered to poorly performing practices
Hillingdon	<ul style="list-style-type: none"> Governance and QoF visits not combined; conduct QoF visits on three-year rolling programme; practices re-sign their contractual obligations on annual basis
Hounslow	<ul style="list-style-type: none"> Rolling visit programme; if issues identified practice facilitators re-visit
Kensington & Chelsea	<ul style="list-style-type: none"> Governance and QoF visits combined
Westminster	<ul style="list-style-type: none"> Visits not combined; QoF visits carried out by Clinical Governance to identify areas of development and to offer support

17. PCT support provided to practices

Brent	<ul style="list-style-type: none"> Support in commissioning directorate specifically for practices Each Practice Based Commissioning (PbC) cluster has one linked manager
Ealing	<ul style="list-style-type: none"> Medicines management team – QoF, visits
Hammersmith & Fulham	<i>Information not provided</i>
Harrow	<ul style="list-style-type: none"> CHD specialist nurse and GPwSI support Developmental QoF visits for poorly performing practices IT support
Hillingdon	<ul style="list-style-type: none"> Educational support through GPwSIs Provision of education through PCT
Hounslow	<ul style="list-style-type: none"> IT support Prescribing (action plans where required) Audit facilitators Training as appropriate
Kensington & Chelsea	<ul style="list-style-type: none"> IT support
Westminster	<ul style="list-style-type: none"> Support required determined by Clinical Governance during visits; subsequent liaison with relevant teams eg. HR, IT etc

The table above includes information provided specifically for this baseline assessment, however, all PCTs provide generic support in addition to that listed above (ie. QoF visits, IT support, prescribing guidance).

18. Links with secondary care: input into meetings etc

Brent	<ul style="list-style-type: none"> • CHD Priority Action Group (every 6 weeks) • Cardiologist input into community clinics
Ealing	<ul style="list-style-type: none"> • Cardiac Care Network Meeting • Long Term Conditions Partnership Board Meetings (Older People)
Hammersmith & Fulham	<i>Information not provided</i>
Harrow	<ul style="list-style-type: none"> • CHD Strategy Meeting • Close links with Cardiac Nurse Consultant
Hillingdon	<ul style="list-style-type: none"> • Cardiology Steering Group: monthly • Heart failure nurses steering group: bi-annual
Hounslow	<ul style="list-style-type: none"> • CHD Strategy Group: every 2 months • Sub-groups with secondary care input
Kensington & Chelsea	<ul style="list-style-type: none"> • Heart failure steering group: every 2 months • Anti-coagulation: as and when required • Primary prevention: as and when required
Westminster	<ul style="list-style-type: none"> • Cardiac nurse supports post PCI clinic at St Mary's Hospital, and attends Cardiac Network meetings for cardiac rehabilitation, primary prevention and CVD management • Representation from secondary care on CHD Strategy Group • Involvement of Cardiologists and managers in development of CHD GPwSI pathways/strategic approach to service development

Links with secondary care vary across the sector with significantly more input both clinically and with regard to service development in some PCTs than others. The CHD groups in existence tend to include representation from secondary care.

19. Provision of services for primary care (and setting)

Service → PCT ↓	Rapid access chest pain clinic		Open access echo		BNP testing	
	primary	acute	primary	acute	primary	acute
Brent		√	√			√
Ealing		√		√	√	
Hammersmith & Fulham		√		√		√
Harrow		√	√		√	
Hillingdon		√				
Hounslow		√		√		√
Kensington & Chelsea		√		√		
Westminster		√				√

The development of community services has seen an increase in diagnostics within the primary care setting. This shift is likely to continue with the introduction of polyclinics, as proposed by Professor Sir Ara Darzi.

20. Recent innovations that have impacted upon services

Brent	<ul style="list-style-type: none"> • All open access echos reviewed by consultant in community clinics before being sent back to GPs • Diagnostics running alongside pathways – rapid access; tests before consultant appointments • Nurse supported clinics • Consultants run sessions in community; mentoring • Atrial fibrillation co-ordinator in community imminent
Ealing	<ul style="list-style-type: none"> • LOLLIPOP project – identification of patients at risk of CHD/CVD • Community-based lipid clinics • Community cardiac rehabilitation services – Oct 07 • Community B-type natriuretic peptide (BNP) testing pilot
Hammersmith & Fulham	<ul style="list-style-type: none"> • Purchase of primary prevention software (for all GP practices) to facilitate the production of primary prevention registers
Harrow	<ul style="list-style-type: none"> • Clinical Assessment Service (CAS) • Community diagnostics • Community heart failure clinics
Hillingdon	<ul style="list-style-type: none"> • Community heart failure nurses • GPwSIs – for last two years
Hounslow	<ul style="list-style-type: none"> • Development of practice registers through the QoF
Kensington & Chelsea	<ul style="list-style-type: none"> • Anti-coagulation – management in the community (11 practices) • Heart failure – community service
Westminster	<ul style="list-style-type: none"> • Imminent CVD at risk Local Enhanced Service Agreement • BHF community heart failure nurse

Generally, the innovations evident across the sector are related to the shift of care into the community and an increased emphasis on primary prevention. Where possible, learning should be shared across the sector when embarking on new initiatives that may already have been introduced elsewhere. The Network primary care sub-group provides a forum for sharing information and learning.

21. Links with practices/mechanisms used to sustain engagement

Brent	<ul style="list-style-type: none"> • E-mail distribution list for announcements • Cluster meetings • Intranet
Ealing	<ul style="list-style-type: none"> • PbC Steering Group • Monthly newsletter
Hammersmith & Fulham	<ul style="list-style-type: none"> • Close links with PbC group – managerial support
Harrow	<ul style="list-style-type: none"> • Close links attributable to joined up provision of heart failure/rehabilitation services
Hillingdon	<ul style="list-style-type: none"> • Practice based commissioning newsletter • Development of Clinical Assessment & Treatment Service
Hounslow	<ul style="list-style-type: none"> • Monthly GP newsletter
Kensington & Chelsea	<ul style="list-style-type: none"> • GP plenary – every 2 months • Practice based commissioning – run plenaries when need/demand identified
Westminster	<ul style="list-style-type: none"> • GP newsletter: ‘Just 10 Minutes’

22. Provision and funding of equipment in practices

Equipment → PCT ↓	ECG machine				Holter machine				BNP machine			
	all	some	none	funding	all	some	none	funding	all	some	none	funding
Brent		√					√				√	
Ealing		√					√			√ (6)		Practice based commissioning
Hammersmith & Fulham			√				√				√	
Harrow	√					√				√		
Hillingdon		√		Self-funded			√	Self-funded			√	Self-funded
Hounslow		√		Prescribing incentive scheme			?				?	
Kensington & Chelsea		√		PCT via localities; prescribing incentive schemes			√				√	
Westminster		√		Self-funded				√			√	

Additional information provided:

- **Kensington & Chelsea:** 24-hour continuous blood pressure monitoring in six practices; funded as part of PCT pilot

The provision of equipment in practices varies across the sector and within specific PCTs. An awareness of capacity and equipment within GP practices should inform pathway development to ensure against duplication and to fully utilise what is available. The involvement of GPs in service development as part of practice based commissioning should facilitate this.

23. Joint-working with local authority

Brent	<ul style="list-style-type: none"> • Sports development department: facilities to do exercise training – cardiac/heart failure/long term conditions
Ealing	<ul style="list-style-type: none"> • CHD awareness events (annual) • Recommendations to Health Scrutiny Planning (influence planning) • Health promotion – healthy school co-ordinators
Hammersmith & Fulham	<i>Information not provided</i>
Harrow	<ul style="list-style-type: none"> • Starting to form links
Hillingdon	-
Hounslow	<ul style="list-style-type: none"> • Childhood obesity • Local Area Agreement (LAA): diet, lifestyle, exercise, smoking
Kensington & Chelsea	<ul style="list-style-type: none"> • Local Area Agreement (LAA): food and nutrition; childhood obesity • Joint Public Health Strategy: smoking • Exercise for health: originally led by PCT, now local authority
Westminster	<ul style="list-style-type: none"> • Joint Public Health Consultant in post (not CHD) • Joint Obesity Strategy • Westminster Tobacco Control Alliance (more local authority with PCT input)

There has been an increase in joint-working between PCTs and local authorities, which has been enhanced by the introduction of Local Area Agreements and a cross-organisational approach to public sector performance management. Where there are overlapping priorities, joint-working is advocated to maximise input from experts across health and local government, and to ensure against duplication.

24. Conclusions

The baseline assessment above provides an overview of cardiac primary and secondary prevention across North West London. The assessment is not comprehensive as some PCTs did not provide information for all the sections, however, it gives an insight into the provision of services, achievements and developments within cardiac care across the sector. The overarching findings are outlined below in three main areas:-

Prevalence of primary and secondary prevention: as expected, given the centrality of cardiac care in NHS service provision, there is considerable evidence of primary and secondary prevention within the primary care setting in North West London, and progress and advancements in service delivery. The sector has a high number of GP with a Specialist Interest (GPwSI) in Cardiology, which has contributed to the development of community cardiac services, and innovatory approaches to cardiac care. Furthermore, there is a vast range of employees contributing to the provision of primary and secondary prevention, both clinical and non-clinical.

Similarities between PCTs: consistency across the eight PCTs is discernible in a number of areas that feature in the report. Generally in the Quality Outcomes Framework (QoF), achievement is higher for certain CHD targets than others (eg. practices across the sector tend to perform less well against the clinical outcome targets). The PCTs tend to have the same staff groups delivering primary and secondary prevention services, however, the quantity differs. The PCT systems in place for general practice in IT, audit, governance and support are generally similar with more activity in some areas than others. Where there is variety discernible amongst practices within a given PCT, this is generally reflected in the other PCTs, for example, the use of CHD risk tools.

Differences between PCTs: certain PCTs have evidently progressed further in primary and secondary prevention within the primary care setting. The number of cardiology GPwSIs differs considerably across the PCTs from four to none, which seems to have influenced (or may have been determined by) the development of community cardiac services. Achievement against the QoF varies significantly with certain PCTs consistently performing well, and others consistently performing below average when compared with their counterparts. Links with secondary care vary with the existence of cardiac groups often ensuring better communication channels. The emphasis on primary prevention differs across the sector, with some PCTs advocating its importance and purchasing software tools to assist with the identification of patients at risk and others not yet considering it a priority.

The North West London Cardiac Network would like to thank everyone who has taken the time to provide information for inclusion in this report.

Appendix 1

Primary and secondary prevention: baseline assessment

1. Local PCT guidelines: which of the following are available and used

	Management	Prescribing
Hypertension (primary prevention)		
Hypertension (secondary prevention)		
Dyslipidaemia (primary prevention)		
Dyslipidaemia (secondary prevention)		
Diabetes		
Stable angina		
Management of CHD post MI		
Heart failure		
Atrial fibrillation		
Anti-platelet		
Obesity/weight management		
Smoking cessation		
Risk assessment tools (primary prevention)		
Rehabilitation		

2. Access to services:

	Y/N	Comments
Dietician		
Smoking cessation		
Physical activity		
Psychology		
Patient education sessions		
Weight management		
Phase 2 rehabilitation		
Phase 3 rehabilitation		
Phase 4 rehabilitation		
Heart failure rehabilitation		
Primary prevention clinics		
Secondary prevention clinics		

3. Clinical systems in GP practices:

	No of practices	%
Emis		
Torex		
Vision		
Other		

4. Use of CHD risk tools:

	All practices	Some practices	No practices
Framingham			
JBS2			
Adapted Framingham			
Oberoi			
Other			

5. Use of templates:

	All practices	Some practices	No practices
Secondary prevention			
Primary prevention			
Heart failure			
Stroke			
Diabetes			
Hypertension			
Other			

6. Incentives or locally enhanced services:

Incentive/enhanced service	Details
1.	
2.	
3.	
4.	

7. Staffing:

Post	No of WTE	Nature of role
CHD nurse specialist		
Heart failure nurse specialist		
Information management and technology facilitator		
PCT pharmacist		
CHD lead		
British Association of Cardiac Rehabilitation (BACR) instructor		
Community CHD nurse		
Other		

8. Community primary or secondary prevention groups:

Name of group	Main objective	Referral process
1.		
2.		
3.		
4.		

9. Provision of comparative data at PCT level:

Name of group	Y/N
Quality Management and Analysis System (QMAS)	
Local Delivery Plan (LDP)	
Prescribing	
MIQUEST	
Other	

10. Other audits aside from QMAS:

Name	Details
1.	
2.	
3.	
4.	

11. No of GPs with Special Interest (GPwSI) in Cardiology:
(information already obtained)

12. Provision of practice nurse training in Cardiology:
(information already obtained)

13. Provision of practice manager training in Cardiology:

Training	Details

14. Combined governance/Quality Outcomes Framework (QoF) visits:

.....

15. PCT support provided to practices:

.....

16. Links with secondary care: input into meetings etc

.....
.....

17. Provision of services for primary care (and setting):

Service	Primary care	Acute care
Rapid access chest pain clinic		
Open access echo		
BNP testing		

18. Recent innovations that have impacted upon services:

.....
.....

19. Links with practices/mechanisms used to sustain engagement:

.....
.....

20. Provision and funding of equipment in practices:

Equipment	All practices	Some practices	No practices	Funding
ECG machine				
Holter monitor				
BNP machine				
Other				

21. Joint-working with local authority:

Initiative	Details

Appendix 2

MI: secondary prevention

Secondary prevention in primary and secondary care for patients following a myocardial infarction

National Institute of Clinical Governance

May 07

Key priorities for implementation

A number of key priority recommendations have been identified for implementation and these are listed below.

- After an acute myocardial infarction (MI), confirmation of the diagnosis of acute MI and results of investigations, future management plans and advice on secondary prevention should be part of every discharge summary.
- Patients should be advised to undertake regular physical activity sufficient to increase exercise capacity.
- Patients should be advised to be physically active for 20–30 minutes a day to the point of slight breathlessness. Patients who are not achieving this should be advised to increase their activity in a gradual, step-by-step way, aiming to increase their exercise capacity. They should start at a level that is comfortable, and increase the duration and intensity of activity as they gain fitness.
- All patients who smoke should be advised to quit and be offered assistance from a smoking cessation service in line with 'Brief interventions and referral for smoking cessation in primary care and other settings' (NICE public health intervention guidance 1).
- Patients should be advised to eat a Mediterranean-style diet (more bread, fruit, vegetables and fish; less meat; and replace butter and cheese with products based on vegetable and plant oils).
- Cardiac rehabilitation should be equally accessible and relevant to all patients after an MI, particularly people from groups that are less likely to access this service. These include people from black and minority ethnic groups, older people, people from lower socioeconomic groups, women, people from rural communities and people with mental and physical health comorbidities.
- All patients who have had an acute MI should be offered treatment with a combination of the following drugs:

- ACE (angiotensin-converting enzyme) inhibitor
- aspirin
- beta-blocker
- statin.

- For patients who have had an acute MI and who have symptoms and/or signs of heart failure and left ventricular systolic dysfunction, treatment with an aldosterone antagonist licensed for post-MI treatment should be initiated within 3–14 days of the MI, preferably after ACE inhibitor therapy.

- Treatment with clopidogrel in combination with low-dose aspirin should be continued for 12 months after the most recent acute episode of non-ST-segment-elevation acute coronary syndrome. Thereafter, standard care, including treatment with low-dose aspirin alone, is recommended unless there are other indications to continue dual antiplatelet therapy.

- After an ST-segment-elevation MI, patients treated with a combination of aspirin and clopidogrel during the first 24 hours after the MI should continue this treatment for at least 4 weeks. Thereafter, standard treatment including low-dose aspirin should be given, unless there are other indications to continue dual antiplatelet therapy.

- All patients should be offered a cardiological assessment to consider whether coronary revascularisation is appropriate. This should take into account comorbidity.