Thames Valley & Milton Keynes Strategic Clinical Networks –

Summary – Cardiovascular Recommendations

September 2016

We trust you will find this commissioning guidance for the Cardiovascular agenda in Thames Valley and Milton Keynes for 2016/17 useful.

This year there are two main differences in our approach:

- We heard from you that it was a valuable resource which would be made more valuable by bringing together the advice from our partners as well. This now includes support and guidance from PHE, the Oxford AHSN and HEE.
- This year as well as bringing you this guidance as a web portal which aims to be intuitive, convenient and more detailed - we are able to provide pdf copies of the guidance which should aid accessibility and provide an opportunity to print and share should you so wish.

While the Guidance is segmented by the clinical areas covered by the SCN, we would like to stress some underlying principles:

- Prevention is a key priority for all and is everyone's responsibility. We are pleased to partner with PHE and bring their message to you with ideas for what needs to be addressed, examples of how it can be done and the potential gain from the initiatives.
- The integration of mental and physical health is key to providing holistic patient-centred care. This is gaining traction in clinical areas such as perinatal mental health, cardiovascular disease and serious mental illness, the entire long term condition agenda and end of life care.
- With the significant proportion of health care burden on patients and the system related to long term conditions, the importance of the TV LTC transformational programme cannot be overemphasised. The traction that programme has gained in primary care now needs to be firmly embedded and systematised.
- The current push for system working gives us all the opportunity to contribute in different ways and at varying levels towards the same aim. We hope this guidance will provide an opportunity to connect widely and pose questions, share good practice and offer practical solutions. Your SCN leads contact details can be found at the end of this guidance (alongside your other clinical network leads)

Commissioner Recommendation-Hypertension

Improve management for patients with high blood pressure

Aims to increase the proportion of people with a hypertension diagnosis whose blood pressure is optimally managed to less than 140/90mmHg

Seeks to achieve this by implementing innovative approaches to managing hypertension consisting of;

a) regular systematic audits of practice registers (using practice audit tools such as EMIS or GRASP-BP) to identify diagnosed hypertensives with suboptimal BP control
b) developing the role of community and general practice based pharmacists to monitor and control blood pressure (BP) of sub-optimally managed hypertensives, support adherence to drug regime and advise on lifestyle change; and
c) wider use of self-monitoring by patients to help eliminate false-readings and provide a clearer picture of the BP over time

Commissioner Recommendation-NDPP - Readiness

- Partnerships should be able to commit to generating a minimum of 300 referrals per 100,000 population per annum to be eligible for selection
- Partnerships should have sufficient readiness to proceed. Further details are identified in the readiness toolkit (attached), with a need to demonstrate;

Readiness Toolkit – NHS Diabetes Prevention Programme

This document has been developed as a template checklist to support Health
Programme. Learning from demonstrator sites, and first wave sites has been

Not all elements of this document will apply depending on your local context, a
may apply.

1. **Readiness Assessment**

- Undertake a readiness assessment across the partnership considering:
  - CCG and partner organisation engagement and commitment to dia
  - Robustness of existing registers of patients at high risk of diabetes
  - Commitment to supporting implementation including clinical and m
    resource to support delivery.

2. **Implementation / Local Project Management**

Action

  - CCG and partner organisation engagement and commitment to diabetes prevention (e.g. CCGs, LA's partnership agreement, how engaging with primary care, how linking with clinical leads in CCGs, who will they lead on what)
  - Identification of lead organisations and established governance. This is a crucial role and they will be required to act as point of contact for the national programme, the source for reporting in & out, to co-ordinate the programme. They will also receive the funding for project management.
  - Commitment to supporting implementation including clinical and managerial resource and financial resource to support delivery. A contribution is given towards project management once an EOI bid is successful to support implementation.
  - Robustness of existing registers of patients at high risk of diabetes or work in progress to address this (e.g. how will referrals be generated, how many people are on registers)

Commissioner Recommendation-Cardiac Rehabilitation

- Commissioners should ensure that your local cardiac rehabilitation service is registered with, and submitting data to the NACR audit.
- To create case for change, the NACR can provide a local data report to determine current programme performance, and how close to meeting the minimum standards your local services are.

Commissioner Recommendation-Familial Hypocholesteraemia

Reviewing existing CCG provision and scope for comprehensive service development. This could be locally or working collaboratively with STP partners. Review the opportunities for comprehensive case finding in primary care and ensure the most recent NICE guidance is fully implemented so that:

- Healthcare professionals should offer all people with FR a referral to a specialist with expertise in FH for confirmation of diagnosis and imitation of cascade testing
- Cascade testing using a combination of DNA testing and LDL – C concentration measurement is recommended to identify affected relatives of those index individuals with a clinical diagnosis of FH. This should include at least the first, second ad when possible third – degree biological relatives.
- The use of nation – wide family – based, follow up system is recommended to enable comprehensive identification of people affected by FH

Further information can be accessed online at:

- https://heartuk.org.uk/stains-and-treatments/ldl-apheresis/find-a-unit
- https://www.bfh.org.uk/heart-health/conditions/familiar-hypercholesterolaemia

Commissioner recommendation – Diabetic foot

- Commissioners and providers should ensure best practice guidance is implemented and local foot care pathways (as described in guidance) and outcomes are regularly reviewed, included by ensuring participation in the national Diabetes Foot Care Audit
- All CCGs should commission a diabetes foot care pathway across all settings, including inpatient care, emergency care and general practice to ensure timely referral from primary care through to the MDT. The relationships between the foot protection service and the MDT should be clearly defined.
- All inpatients with diabetes should receive foot checks, foot protection and access to specialist foot care, if required, during and on discharge
- Root cause analysis should be conducted for all major amputations
- CCGs and providers should actively participate in foot networks (TVSCN – diabetic foot group) to share learning

Commissioner recommendation-Early Supported Discharge - Stroke

- Ensure all Thames Valley and Milton Keynes Stroke patients are directed to a Hyper Acute Stroke Unit (HASU) for first 72 hours of care
- Ensure comprehensive access to ESD services (current range across Thames Valley & Milton Keynes treated by an ESD team: 20.3% – 61.3%)
- Ensure stroke rehabilitation services are provided 7 days a week
- Ensure comprehensive access to 6 month reviews (current variation in Thames Valley & Milton Keynes ranges from 1% – 73%)

Commissioner Recommendation-Early Supported Discharge

- Ensure all Thames Valley and Milton Keynes stroke patients are directed to a HASU for first 72 hours of care
- Ensure comprehensive access to ESD services (current range across Thames Valley and Milton Keynes treated by an ESD team – 20.3% - 61.3%)
- Ensure stroke rehabilitation services are provided 7 days a week
- Ensure comprehensive access to 6 month reviews current variation in Thames Valley and Milton Keynes range from 1% - 73%)