Contents of Guidance

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• Stroke (including TIA)
• Cardiovascular & Serious Mental Illness
The wider guidance – System working as core

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)
Thames Valley CVD Approach

Strategy & Guidance

Prevention
- Hypertension
- NDPP Readiness
- Cardiac
- Diabetes

Transformational
- Heart Failure Management
- Cardiac Rehabilitation
- Familial Hypercholesterolemia

Transactional
- Thames Valley Performance
- National Diabetes Audit
- Diabetic Footcare
- Inpatient Care

Performance Management
- Atrial Fibrillation – Prevention
- Stroke Performance
- Stroke Reconfiguration
- Transient Ischaemic Attack (TIA)
- Early Supported Discharge

Cardiac Rehabilitation
Heart Failure Management
Familial Hypercholesterolemia
Thames Valley Performance
National Diabetes Audit
Diabetic Footcare
Inpatient Care
Atrial Fibrillation – Prevention
Stroke Performance
Stroke Reconfiguration
Transient Ischaemic Attack (TIA)
Early Supported Discharge
The SCN CVD priorities are drawn from a number of sources including the:

- CVD Outcomes Strategy
- Relevant NICE guidance
- Five Year Forward View
- Right Care STP ambitions;
- and local priorities – where appropriate.

The CVD contribution goes beyond pure advice or project management to support CCG and provider ambitions working across a lifecycle of projects with a focus on realisable benefits – to the patient, the commissioner or the service provider.

SCN can share national and local data, helping improve local data quality and using the resultant findings to prioritise impacts interventions. Links to n.b. – assurance process?

Transformational SCN contribution is to lead change across geographies and organisations.

Working across local health economies the SCN offers evidence based approaches working at scale.

Strategy, Guidance and Leadership

Delivery of Change

Level of Partnership required

Performance Management

SCN offers solutions and promotes more widely, local solutions that individual CCGs or providers have shown to be effective.

Transactional

SCN can share national and local data, helping improve local data quality and using the resultant findings to prioritise impacts interventions. Links to n.b. – assurance process?
Hypertension

Thames Valley – the missing 250,000

Diseases caused by high blood pressure are estimated to cost the NHS £2bn every year.

Over 5 million people are undiagnosed hypertensive.

High BP accounts for 13% of visits to GP.

People from deprived areas 30% more likely to have High BP.

Optimal BP Target for patients with diagnosed hypertension is < 140/90 mmHg.
The recorded prevalence of hypertension is well below the estimated prevalence for England as a whole, and for CCGs in Thames Valley. This implies that 256,000 people in Thames Valley have undiagnosed hypertension.

### Table: Prevalence of hypertension (per cent)

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<th>Expected hypertension</th>
<th>Diagnosed Hypertension prevalence</th>
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Source: NCVIN: Cardiovascular disease profile - Cardiovascular risk factors, April 2016

It is estimated nationally that 58% of those with hypertension (diagnosed or undiagnosed) are on treatment and of these 63% have their blood pressure below 140/90mm Hg.
Evidence Base

In the Public Health England guidance on high blood pressure, it explores actions across the spectrum of organisations for Prevention, Detection, and Treatment of high blood pressure with recommendations for action.

In summary key approaches identified are:

Prevention

- Reducing salt and improving overall nutrition
- Improving calorie balance to reduce excess body weight.
- Systematic behaviour change interventions on diet, physical activity, alcohol, and smoking.
- Promote clinical leadership, engagement and education on detection of high blood pressure in primary care (all staff groups) using opportunistic testing
- Improving take-up of the NHS Health Check
- Pro-active provision of testing for high-risk and deprived groups of all ages via:
  - Systematic approaches in general practice (auditing records for unresolved high blood pressure readings and high risk adults to follow-up, supported by call and recall).
  - Outreach testing beyond general practice, particularly through pharmacy (in order to access those groups least likely to otherwise present, such as younger men, low income households and those in deprived areas).
Hypertension - Investigation, treatment and care

- Local leadership and action planning for system change: Partners working together to reduce variation and improve outcomes for all, in particular:
  - Providing system leadership (with primary care engagement and ownership at the heart).
  - Highlighting variation in care and outcomes, as well as cost and impact
  - Developing models of co-ordinated, personalised care, particularly for individuals with co-morbidities.

- Support HCPs to focus on key clinical challenges building education, training, tools, leadership and incentives in line with NICE guidance, especially for:
  - Using the registered population list to implement rigorous call and review systems.
  - Prescribers and dispensers providing advice on lifestyle changes
  - Control among those with high CVD risk.
  - Prescribers feeling confident to intensify treatment using the stepped approach proposed by NICE by adding in additional classes of drugs.

- Support individuals’ adherence to anti-hypertensive drug therapy and lifestyle advice: Building and monitoring patient activation, with particular emphasis upon:
  - Wider use of self-monitoring
  - Pharmacy support for improving the use of medicines
Selected Intervention - 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
In Dudley, practice-based pharmacists (PBP) worked with GP practices to identify patients with undiagnosed or sub-optimally managed hypertension. Using the EMIS search and report system, PBPs identified 11,000 hypertensives who were not treated to target and diagnosed 27,800 new hypertensives. This is projected to lead to cost savings of c£13m from avoided hospital admissions over 5 years.

Evidence
- Effectiveness: based on the Dudley pilot, 90% of GP practices achieved optimal treatment targets of 140/90mmHg for their hypertensive population (the standard is 50%, and inter-practice variation 6-99%).
- Costs: PHE estimates costs of c£28 to per new controlled person in year 1 (average cost of one 10 minute and three 5 minute consultations with a pharmacist at £64 hourly unit cost), based on the assumption that achieving a BP treatment to target for one patient will require 4 consultations with a PBP.
- Net savings: PHE estimates that system net savings would be c£14 p.a. per controlled patient over a 5 year horizon. Of these, c£5.75 would accrue to the NHS and c£7.91 would accrue to Local Authorities.
- Can be commissioned by CCGs or, if part of the NHS Health Checks, by LAs
- Can be delivered by GPs and / or pharmacists in primary in General Practice or community pharmacies

Progress indicators
- Hypertension prevalence
- Patients with hypertension in whom last blood pressure measure (last 12 mnths) is <=150/90 mmHg

References and further information
- High blood pressure map
- Toolkit for developing a local strategy to tackle high blood pressure
- PHE blood pressure resource hub
- NHS Health Check website
- NHS Right Care support and resources
- CVD prevention opportunities
- Hypertension profiles
- Making Every Contact Count resource hub
NDPP (National Diabetes Prevention Programme) Readiness

- Delivering the National ambitions for Diabetes Prevention & Obesity

As part of the wider strategy for Sustainability & Transformation Plans and CCG 2 year business planning – CCGs, Local Authorities and their wider partners are required to work together;

- To develop a comprehensive strategy to prevent obesity and diabetes, identifying opportunities to ‘make every contact count’, increase uptake of existing weight management services and take action to reduce obesogenic environments (the recent presentation by NCD for Obesity & Diabetes – Prof Jonathan Valabhji highlights the context, evidence and rationale for fastracking at-scale prevention – attached)
- Local authorities should work with NHS Health Check providers to ensure diabetes risk assessments and, where necessary, confirmatory bloods are provided to all people receiving a health check
- CCGs support GP practices to undertake audits of practice registers to identify the at risk population with existing non-diabetic hyperglycaemia, for example by promoting the use of audit tools to assist with case finding, such as that developed by PRIMIS.
National Diabetes Prevention Programme – Readiness

The Thames Valley region is pleased to be learning from our Berkshire colleagues who are embedded as first wave sites for the National Diabetes Prevention Programme (DPP) and now receiving referrals.

The National Diabetes Prevention Programme (NDPP) is a way of fast tracking prevention supported by NHS England and Public Health England. TVSCN supported a recent familiarisation event to coincide with second wave expressions of interest being sought during September 2016 for 17/18 roll-out.

 Commissioners should note:

STP footprints should be used as the standard geography for future phases of roll out. This will either involve filling in STPs with partial coverage or taking forward whole STPs for future phases of roll out. In most cases there is minimum population size of 1 million and / or 4 CCGs.

Nationally the NDA is supported because:

• it uses individual patient data and can identify the relationships between patient characteristics and their care/outcomes, for example, the NDA separates data for Type 1 and Type 2 diabetes, includes all ages and reports age-related breakdowns.
• it also has been linked with HES (complications) and ONS (mortality) data, so that day to day care can be linked to long term diabetes outcomes.
Commissioners should work with local stakeholders to ensure that:

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;

- 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)
Cardiac

The success of the Cardiac agenda can be viewed through data audit compliance which is very high, as the causal link between good management and the clarity this provides for commissioner and providers.

Transactional Change creating traction – Heart Failure as exemplar

The establishment of a Heart Failure Day Case Unit at RBFT is a strong case study in how new ways of working can open up improvements in ambulatory care.

With the new Unit offering a transactional change to the patient pathway (and offering a significantly improved patient experience) the SCN is now working with others to help surface other activities with potential benefits.

These include:
- Reviewing how earlier referrals for new HF patients can help GPs and others
- Developing diagnostic capability and one-stop clinics for patients
- Ensuring cardiac rehabilitation services can be optimised to improve patients care considering how the Berkshire West House of Care model for long-term conditions might be applied to cardiology conditions.

Local Best Practice - Adoption of Heart Failure ambulatory day care model

- Whitley Day Unit at Royal Berkshire Hospital Foundation Trust set up as pilot site in February 2015
- 27 patients treated between 23/02/15 to end June ’15
- 70% were discharged after treatment
- 30% admitted to the ward; of those 30% admitted – 37.5% were admitted for non-heart failure reasons
- 233 bed days saved in 4 months (equating to 700 days annually)
Cardiac Rehabilitation

Working with National Audit for Cardiac Rehabilitation and the British Heart Foundation, Thames Valley SCN is seeking to support:

• the monitoring and support of cardiovascular rehabilitation (CR) teams and commissioners in delivering high-quality and effective services, to evidence-based standards, for the benefit of all eligible patients in Thames Valley.

• mapping the extent of provision and highlighting inequalities in delivery against key service indicators at CCG, SCN, Health & Wellbeing Board and Cardiac Network levels for local programmes.

• working to determine the effectiveness of routinely delivered CR services on patient agreed outcomes, cardiovascular disease risk profiles and health and social care utilisation.

• commit to using audit and research data generated through the NACR which will inform:
  • NICE clinical guidance and service specification development
  • Clinical practice standards from national associations
  • NHS healthcare commissioning processes and decision making; and
  • the public and cardiac patient groups about how their local services are performing.
Cardiac Rehabilitation (cont)

**BACPR/NACR Certification**

Currently Wycombe General Hospital in the local TVSCN provider region are accredited units (excl FPHFT)

- The BACPR Certification was launched in June 2015, with 16 sites taking part in the initial pilot, and there are currently 14 Certified Programmes who have successfully gone through the certification process. Programmes must be entering data into NACR to be able to apply for the certification and use of this data helps NACR to determine whether programmes meet certain minimum standards.

- [Details and information on how to achieve BAPCR certification can be accessed at this link](#)

The key actions needed to achieve accreditation are;

- CR teams be entering data into NACR routinely.
- CR teams need to be the minimum standards (not gold standard).
- CR should be inviting priority groups, e.g. MI, MI/PCI, PCI, CABG, HF.
- Patients should be risked assessed prior to being exercised.
- The data shows acceptable wait times.
- The data will show the duration of programme.
- The data will show the percentage of service users completing cardiac rehabilitation.
- The mean wait time for each of the priority groups will be available.
- In addition to quality concerns commissioners and providers should also consider;
  - Local variations in access disparity / variation in care.
  - Lack of resources in many cases due to it not being a consultant lead service.
  - Long term investment reflecting growing demand; and
  - Clarity around commissioning arrangements – which services are provided to who and are suitable performance management in place.
Familial Hypocholesterolaemia

The effective identification and management of patients with Familial Hypocholesterolaemia (FH) remains one of the NHS CVD “10 high impact interventions” with a significant opportunity to impact effectively on the premature years of life lost in individuals and families.

Estimates suggest around 120,000 patients in the UK have FH (around 1 in 500 patients) and only around 1 in 6 cases are diagnosed in primary care. Patients with the most common form of FH have significantly increased risk of premature coronary heart disease (CHD) if left untreated:

- There is a greater than 50% risk of CHD in men by the age of 50; and a greater than 30% risk of CHD in women by the age of 60
- Patients and relatives of patients with FH have significantly improved outcomes when the following steps are in place:

There is a systematic approach to early identification of patients in primary care;

- Identified patients are initiated on high does statin therapy (where the target LDL is < 50% of baseline);
- There is systematic screening of patients relatives (cascade testing) and patients are subsequently managed in line with NICE guidance (CG71) identified earlier and treated with high dose statin therapy (where the target LDL is less than 50% of baseline); and
- where all patients with a family history of early CVD receive a lipid profile and thyroid function test
Familial Hypocholesterolaemia

Early TVSCN work in 2014 showed significant variation in FH service provision across Thames Valley and over the last two years service there have been a number of service developments:

- In West Berkshire there is an established service supported by BHF which now extends to cascade service for the children of FH confirmed parents who fall in the Berkshire / RBFT catchment: and;
- Commissioners in East Berkshire are working with Royal Brompton & Harefield Hospital to provide access to an established FH service. This offers an “easy to commission service” with patient identification and cascade testing as part of the offer.

Further details are available from Jane Breen via jane.breen1@nhs.net

However there remains scope to ensure that services are available to all FH patients across Thames Valley and working collaboratively, commissioners can ensure all FH patients and their families are supported

Familial Hypocholesterolaemia - Recommendation

- 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 FH a referral to a specialist with expertise in FH for confirmation of diagnosis and initiation 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 and when possible third - degree biological relatives
  - The use of a nation-wide family-based, follow-up system is recommended to enable early comprehensive identification of people affected by FH
Five million people in England are at high risk of developing Type 2 diabetes.

If current trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes.

It is currently estimated that the NHS spends about £10 billion on diabetes every year. This is 10 per cent of the NHS budget. The total cost (direct care and indirect costs) associated with diabetes in the UK currently stands at £23.7 billion. By 2020 the NHS England expectation is that there will be continued progress in the management of patients with diabetes and this will be achieved through a mix of activities.
Work to reduce the projected growth in incidence of diabetes by developing comprehensive strategies to tackle obesity and prevent diabetes, with the aim of referring 500 people per 100,000 population annually to an evidence-based Type 2 diabetes prevention programme.

Support more people to manage their own care effectively with an additional 10% of newly diagnosed people with diabetes to attend structured education per year to 2021 (as measured in the National Diabetes Audit).

This will lead to improvements in treatment outcomes and a reduction in complications associated with diabetes.

Improve the treatment and care received so that:

- All GP practices at least, match the current national median level of performance (40%) in relation to the 3 NICE recommended targets.
- Multi-disciplinary diabetic foot teams and access to specialist diabetes teams for inpatients is in place.
- Deliver reductions in incidence of microvascular and cardiovascular disease complications of diabetes.
- Increase GP participation in the National Diabetes Audit (NDA) so all CCGs are able to reliably measure their diabetes outcomes across the CCG Improvement and Assessment Framework (CCG IAF).

Healthcare professionals should collaborate with people who have diabetes through the care planning process to develop and achieve their individual goals, agreeing targets for blood glucose, blood pressure, and blood fats. These should be reviewed at least once a year for everyone with diabetes as this is crucial for optimum diabetes management.
Diabetes Datapacks

Attached are the most up to date indicators per TV and Milton Keynes CCG against;
• 8 care processes
• 3 care metrics
• Diabetic footcare treatment

Progress against National Diabetes Audit

Reflections on the NDA audit process includes guidance for Commissioners and General Practitioners (attached)

In 2014/15 of the 11 Thames Valley & MK CCGs, 9 of the 11 submitted 100% compliant data to the National Diabetes Audit (9 of 19 nationally providing 100% of data). Good data quality with sufficient levels of participation enables CCGs to reliably measure diabetes outcomes in the CCG Improvement and Assessment Framework (CCG IAF). Commissioners should maintain active participation in the NDA process.
Diabetic Foot Care

Recently provided NICE guidance combined with the STP requirements on Diabetes indicate the following processes need to be in place to deliver good quality and effective footcare:

• Comprehensive clinical pathway developed locally in collaboration with clinicians, commissioners and patients – November 2015
• Ensure they commission services in which adults at moderate or high risk of developing a diabetic foot problem are referred to the foot protection team
• Ensure they commission services in which adults with limb threatening or life threatening diabetic foot problem are referred immediately for specialist assessment and treatment, and the multi-disciplinary foot care service is informed

The commissioning process steps requires CCGs to;

• Review current treatment pathways with providers in order to consider whether adjustments to these pathways can be implemented
• Ensure the pathways in place have adequate capacity to enable earlier referrals of people at risk of foot disease to foot protection teams, and people with active disease to multi-disciplinary teams

In Autumn 2014, The Thames Valley Diabetic Footcare Group launched the “average to excellent” diabetic footcare workstream.

Working proactively as a group of clinical professionals and patients they have defined an optimal pathway which can be embedded locally across the region. Wider national developments have provided a similar pathway. Combining an offer from the local experts with either of these toolkits will enable local delivery of this national priority

Commissioner Recommendation follows (next slide)
Commissioner Recommendation – Diabetic Foot

- Commissioners and providers should ensure best practice guidance is implemented and local footcare pathways (as described in guidance) and outcomes are regularly reviewed, including by ensuring participation in the National Diabetes Foot Care Audit.

- All CCGs should commission a diabetes footcare pathway across all settings, including inpatient care, emergency care and general practice to ensure timely referral from primary care through to the MDT. The relationship 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 footcare, if required, during admission 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.
Diabetes Inpatient Care

Commissioners should:

• ensure through their contracts that all healthcare professionals working in hospitals are competent in diabetes care.
• ensure that hospitals have a specialist multidisciplinary foot care team that is compliant with NICE guidelines on diabetes foot care.

Provider Trusts should:

• have a diabetes inpatient specialist team to respond to referrals and provide support and training to generalist staff. Staffing levels should be reviewed by providers to ensure that people with diabetes can access specialist diabetes care when and where needed as seven day working is rolled out.
• monitor and review patient safety standards to implement improvements working across all parts of the hospital. This should include recording cases of diabetes-related severe harms on the corporate risk register and sharing evidence of any systems that have successfully reduced the incidence of these.
• ensure that everyone with diabetes receives foot checks, foot protection and access to specialist foot care if required during admission and on discharge from hospital.
• ensure that their nutrition policies meet the needs of the one in six of their patients who has diabetes.
• ensure that people with diabetes are enabled and supported to self-manage their diabetes where appropriate while in hospital.
Atrial Fibrillation – preventing Stroke

As one of NHS England’s “10 high impact changes for Cardiovascular Disease” – Improved management of people with diagnosed Atrial Fibrillation (AF), a number of Thames Valley localities have adopted a systematic approach to identifying and managing this patient group. Buckinghamshire CCGs with their secondary care partners have adopted a number of workstreams including:

• “Feel your pulse” patient information campaign
• Use of interface pharmacy
• “Don’t wait to anti-coagulate” information to practices
• Direct letter confirmations

This combined and systematic effort has seen effective results (data attached), and through joint networking, the Oxford Academic Health Science Network are now leading in the spread and dissemination of this approach.
Over the last 3 years, SSNAP data has shown improvements in stroke care across Thames Valley sites. The data suggests sustainable improvement has been easier to maintain in larger HASU units (national policy would indicate a HASU would normally treat between 900 + 1200 patients per annum) – click to access most recent data

**Stroke Performance across Thames Valley**

**SSNAP Scoring summary**
**(Team-centred Total KI level)**

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Note:
A SSNAP scoring system has been derived to provide a summary of performance based upon results for 44 key indicators which are grouped into 10 domains covering key aspects of stroke care. For Domains 1 – 10, the scores have been calculated and given a performance level (A-E). A is the best level and E is the worst.
In line with national guidance, all suspected stroke patients should be initially admitted to a Hyper-acute Stroke Unit. The evidence base continues to support this pathway.

Commissioners should continue to implement this approach with local partners and in line with ongoing negotiations. To help support local stroke reconfigurations, the recently provided NHS England stroke reconfiguration toolkit is attached here.
New Stroke guidelines are expected to be published in September 2016. Early indications are;

– that all patients with a Transient Ischaemic Attack (TIA) should be seen by a specialist neurovascular (TIA) service capable of assessing and treating patients within 24 hours of transient cerebrovascular symptoms.

Commissioners should ensure that the requirements of the new stroke guidelines are reviewed and commissioned services are able to deliver to the appropriate service standard
Across Thames Valley there remains considerable variation in the provision of Early Supported Discharge (ESD) for all stroke patients.

As one of NHS England’s “10 high impact changes for Cardiovascular Disease” – commissioners should work with local providers to ensure that suitable services are in place on a comprehensive basis

- 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 & 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%)
Cardiovascular & Serious Mental Illness

People with severe mental illnesses (SMIs) have more comorbid physical health conditions than the general population and this group die, on average, 20 years earlier than the general population. A proportion of these deaths are due to preventable physical conditions with estimates suggesting there would be up to 12,000 fewer deaths from cardiovascular disease (CVD) if people with SMI had the same outcomes as the general population.

- **There is strong evidence for a close association between SMIs and cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders.**

- It is also important to note that people with severe mental illness have almost 7 times more emergency inpatient admissions, and 3 times the rate of Accident & Emergency attendances, of which half were unrelated to mental health need; instead driven by urgent physical health care.

- The recently provided guidance from NHS England highlights the issue further and support commissioners to work with providers and patient groups to align both from a cardiovascular risk perspective, as well as addressing the parity of esteem agenda between physical and mental health (this is also highlighted in the TVSCN Mental Health guidance).

- Part of this recent NHS England guidance references tool and process which will help identify SMI patients at risk of cardiovascular disease, and recommends the best option for intervention or treatment.

- Opportunity to build on parity of esteem linking cardiovascular health and serious mental health.

The Lester (2014) tool (also known as the Lester Cardio-metabolic Health Resource) helps clinicians to assess the cardiovascular health of patients with SMI and recommends the best course of intervention and treatment – including thresholds for intervention. It brings together advice from a number of NICE guidelines and is also designed to take into account the impact of anti-psychotic medication on an increased risk of CVD in people with SMI.