

KQuIP/UKRR Regional Day **Yorkshire & Humber**

6th July 2017 – 10.10-11.30

What do the data tell us – primary, secondary and tertiary care

Scott Anderson, Public Health England

Youseff Beaini, Bradford & Districts CCG

Fergus Caskey, UK Renal Registry

Richard Baker, NHS England

**‘THINK
KIDNEYS’**

KQuIP



Public Health
England

Using primary care data sources to improve kidney care

Scott Anderson
PHE LKIS (Yorkshire and the Humber)
6 July 2017
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Raw data sources

Tools

- NHS Rightcare
- PHE's National Cardiovascular Intelligence Network (NCVIN)

How to identify possible areas for improvement



There are a number of raw data sources relevant to primary kidney care

QOF (Quality Outcome Framework)

Survey data, often used to produce modelled estimates eg HSE (Health Survey for England)

Programme budgeting



Raw data sources

Tools

- NHS Rightcare
- PHE's National Cardiovascular Intelligence Network (NCVIN)

How to identify possible areas for improvement



That data is used to inform data packs, profiles and interactive tools

NHS Rightcare:

Commissioning for Value packs

NCVIN (National Cardiovascular Intelligence
Network), part of PHE (Public Health England):

Profiles

- Kidney disease
- Diabetes
- High Blood Pressure

Interactive tool - Fingertips

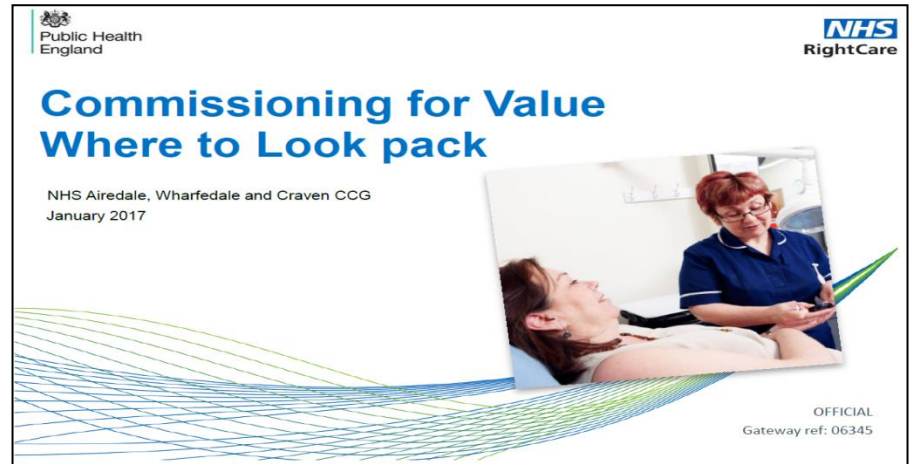


NHS Rightcare aims to improve population-based healthcare

Programme focusses on improving value and on reducing unwarranted variation

Where to Look packs highlight the top priorities and best opportunities

- by CCG
- by pathway

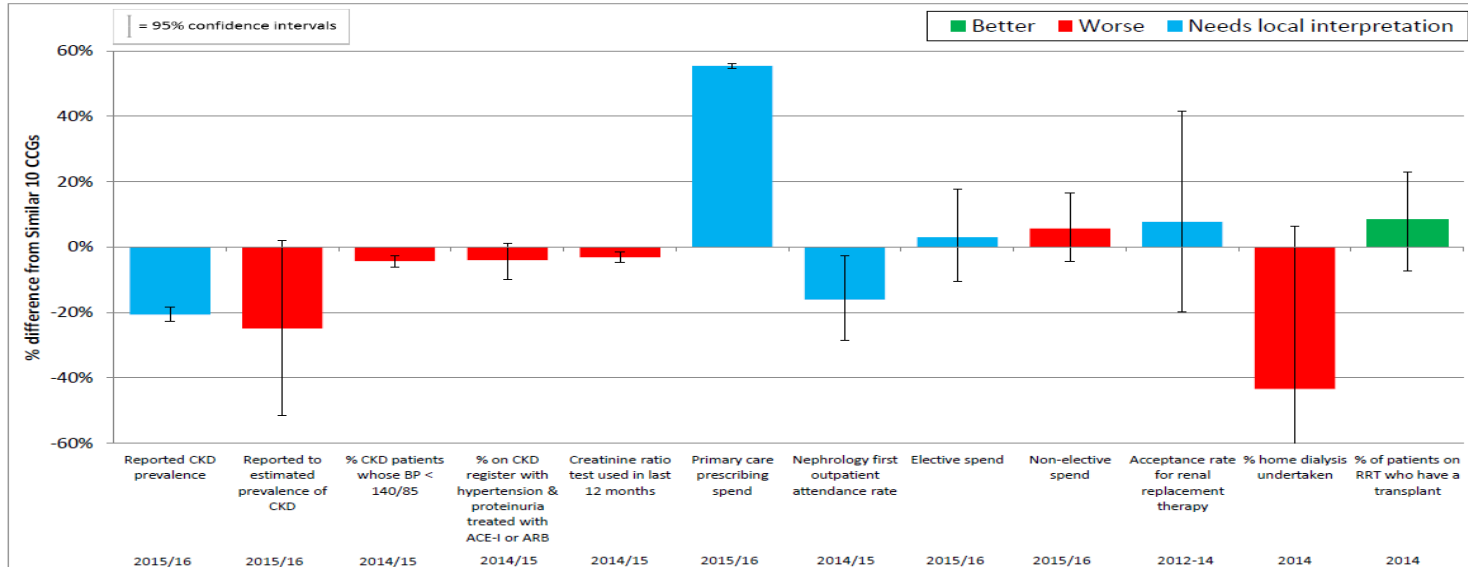




The Renal pathway benchmarks against 10 similar CCGs on key measures of primary care

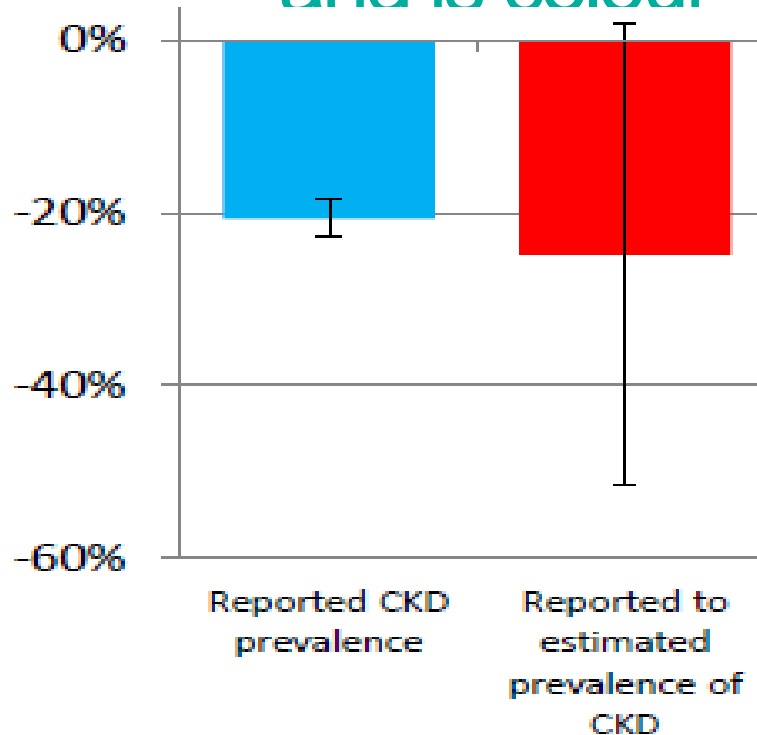
Programme focusses on improving value and on reducing un-warranted variation

Renal pathway





Each indicator has a confidence interval and is colour-coded



Here, for *Reported CKD prevalence* ie diagnosed, the CCG is 20% lower than the average of its similar 10 CCGs. This could be either good (it's keeping CKD down) or bad (it's not diagnosing it). This difference is statistically significant.

For *Reported to estimated prevalence of CKD*, the CCG is 25% worse than the average. However, this difference is not statistically



Packs are also available for each STP (Sustainability & Transformation Partnership) showing all constituent CCGs

Renal pathway



	2015/16	2015/16	2014/15	2014/15	2014/15	2015/16	2014/15	2015/16	2015/16	2012-14	2014	2014
	Reported CKD prevalence	Reported to estimated prevalence of CKD	% CKD patients whose BP < 140/85	% on CKD register with hypertension & proteinuria treated with ACE-I or ARB	Creatinine ratio test used in last 12 months	Primary care prescribing spend	Nephrology first outpatient attendance rate	Elective spend	Non-elective spend	Acceptance rate for renal replacement therapy	% home dialysis undertaken	% of patients on RRT who have a transplant
(to Best 5)		8,150 Ppl.	2,582 Pats.	173 Pats.	1,826 Pats.				£1822K		29 Pats.	33 Pats.
Airedale,	▼	▼	▼	▼	▼	▲	▼	▲	▲	▲	▼	▲
Craven	▼	▼	▼	▲	▼	▲	▼	▼	▲	▲	▼	▼
Bradford City	▼	▼	▼	▲	▼	▲	▼	▼	▲	▲	▼	▼
Bradford Districts	▼	▼	▼	▼	▼	▲	▼	▼	▼	▲	▼	▼
Calderdale	▼	▼	▼	▲	▼	▲	▼	▲	▼	▼	▲	▼
Greater Huddersfield	▼	▼	▼	▲	▼	▲	▼	▼	▼	▲	▼	▲
Leeds North	▼	▼	▼	▼	▼	▲	▼	▼	▼	▼	▼	▲
Leeds South and East	▼	▼	▼	▼	▼	▲	▼	▲	▲	▼	▼	▼
Leeds West	▼	▼	▼	▲	▲	▲	▼	▲	▼	▼	▼	▼
North Kirklees	▲	▲	▼	▼	▼	▲	▲	▼	▼	▼	▼	▼
Wakefield	▼	▲	▼	▼	▼	▲	▲	▼	▼	▲	▼	▼
Harrogate and Rural District	▼	▼	▲	▼	▼	▲	▲	▼	▼	▲	▲	▼



Further relevant indicators are available from the Diabetes and Heart Disease pathways

Renal

	2015/16	2015/16	2014/15	2014/15	2014/15
	Reported CKD prevalence	Reported to estimated prevalence of CKD	% CKD patients whose BP < 140/85	% on CKD register with hypertension & proteinuria treated with ACE-I or ARB	Creatinine ratio test used in last 12 months
STP opportunity (to Best 5)		8,150 Ppl.	2,582 Pats.	173 Pats.	1,826 Pats.
Airedale, Wharfedale and Craven	▼	▽	■	▽	■
Bradford City	▼	▽	■	△	■
Bradford Districts	▼	▽	■	■	■
Calderdale	▼	▽	▽	△	■
Greater Huddersfield	▼	▽	■	△	■
Leeds North	▼	▽	■	▽	■
Leeds South and East	▼	▽	■	■	■
Leeds West	▼	▽	▽	△	△
North Kirklees	▲	△	■	■	■
Wakefield	▼	△	■	■	■
Harrogate and Rural District	▼	▽	△	▽	■

Diabetes

2015/16	2015/16	2015/16	2015/16
Diabetes prevalence, 17+	% diabetes patients cholesterol < 5 mmol/l	% diabetes patients HbA1c is <59 mmol/mol	% diabetes patients whose BP < 140/80
	3,444 Pats.	4,214 Pats.	5,446 Pats.
▲	■	■	■
▲	△	■	■
▲	■	■	■
▼	■	■	■
▼	▽	■	■
▼	■	■	■
▼	■	■	■
▼	■	■	■
▼	■	■	■
▼	■	■	■
▲	△	■	△
▲	▽	■	△
▼	△	■	△

Heart Disease

2015/16	2015/16
Hypertension prevalence, 18+	Reported to estimated prevalence of hypertension
	21,840 Ppl.
▼	▽
▼	■
▼	■
▼	■
▼	■
▼	■
▼	■
▲	■
▼	■
▼	▽



There is clear variation across CCGs

Renal

Heart

Disease

	2015/16	2015/16	2014/15	2014/15	2014/15
	Reported CKD prevalence	Reported to estimated prevalence of CKD	% CKD patients whose BP < 140/85	% on CKD register with hypertension & proteinuria treated with ACE-I or ARB	Creatinine ratio test used in last 12 months
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Bradford Districts	▼	▽	■	■	■
Calderdale	▼	▽	▽	△	■
Greater Huddersfield	▼	▽	■	△	■
Leeds North	▼	▽	■	▽	■
Leeds South and East	▼	▽	■	■	■
Leeds West	▼	▽	▽	△	△
North Kirklees	▼	△	■	■	■
Wakefield	▼	△	■	■	■
Harrogate and Rural District	▼	▽	△	▽	■

Diabetes

	2015/16	2015/16	2015/16	2015/16
	Diabetes prevalence, 17+	% diabetes patients cholesterol < 5 mmol/l	% diabetes patients HbA1c is <50 mmol/mol	% diabetes patients whose BP < 140/80
		3,444 Pats.	4,214 Pats.	5,446 Pats.
Airedale, Wharfedale and Craven	▲	■	■	■
Bradford City	▲	△	■	■
Bradford Districts	▲	■	■	■
Calderdale	▼	■	■	■
Greater Huddersfield	▼	■	■	■
Leeds North	▼	▽	■	■
Leeds South and East	▼	■	■	■
Leeds West	▼	■	■	■
North Kirklees	▼	△	■	△
Wakefield	▲	▽	■	△
Harrogate and Rural District	▼	△	■	△

	2015/16	2015/16
	Hypertension prevalence, 18+	Reported to estimated prevalence of hypertension
		21,840 Ppl.
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Greater Huddersfield	▼	■
Leeds North	▼	■
Leeds South and East	▼	■
Leeds West	▼	■
North Kirklees	▼	■
Wakefield	▼	■
Harrogate and Rural District	▼	▽



NCVIN profiles for Kidney disease are available as hard-copy or on-line as an interactive tool

Public Health England
Cardiovascular disease profile - Kidney disease
June 2017

NHS Leeds South and East CCG

Background

This chapter of the cardiovascular disease profiles focuses on kidney disease and is produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England. Each profile is made up of four chapters which look at coronary heart disease (CHD), diabetes, kidney disease and stroke. This profile compares the CCG with data for England, a group of similar CCGs and the West Yorkshire Sustainability and Transformation Partnership (STP).

Key information

In 2015/16 there were 7,389 people aged 18 years and over who had been diagnosed with chronic kidney disease (CKD) in NHS Leeds South and East CCG. This represents 3.5% of the registered population aged 18 and over.

In the CCG the CKD QOF clinical indicator achievement varied at practice level in 2014/15. The indicators were removed from QOF in 2015/16.

The acceptance rate onto Renal Replacement Therapy (RRT) in NHS Leeds South and East CCG is 78.8 per million population compared to an England rate of 107.9.

There were 202 NHS Leeds South and East CCG residents receiving RRT in 2014. The number of residents receiving RRT between 2009 and 2014 has increased by 26.3%.

In NHS Leeds South and East CCG in 2014 the percentage of people receiving RRT who have had a renal transplant was 55.9%, a further 2.5% received home dialysis and 41.6% received hospital dialysis.

Key facts	Local	Comparator CCGs	STP	England
Observed prevalence of CKD (per cent)	3.5	4.0	3.8	4.1
Estimated prevalence of CKD (per cent)	5.3	5.9	5.9	6.1
Patients diagnosed with CKD whom the last blood pressure reading is 140/85 or less (per cent)*	75.6	76.7	74.4	74.4
Number of people receiving RRT	202	-	2,133	49,842
Proportion of people receiving RRT with transplants	55.9	57.4	58.7	52.4
The acceptance rate onto RRT	78.8	97.6	94.6	107.9

* Data from 2014/15

Produced by the National Cardiovascular Intelligence Network (NCVIN) PHE publications gateway 2016691 © Crown copyright 2017

www.gov.uk/phe | http://fingertips.phe.org.uk/ Page 1

Public Health England
Home > Introduction > Data
Cardiovascular Disease Profiles

Risk Factors Diabetes Heart **Kidney** Stroke

Overview Compare Indicators Map Trends Compare areas Area profiles Definitions Download

Area type: CCGs Areas grouped by: Sub-region Benchmark: England

Area: NHS Wakefield CCG Sub-region: Yorkshire and Humber Search for an area: 10 most similar CCGs to Wakefield

Compared with benchmark: Better Similar Worse Lower Higher Not compared

Recent trends: - Could not be calculated - Increasing / Getting worse - Increasing / Getting better - Decreasing / Getting worse - Decreasing / Getting better - No significant change - Increasing - Decreasing

Date quality: Significant concerns Some concerns Inexact

Display Values Trends Values & Trends Export table as image

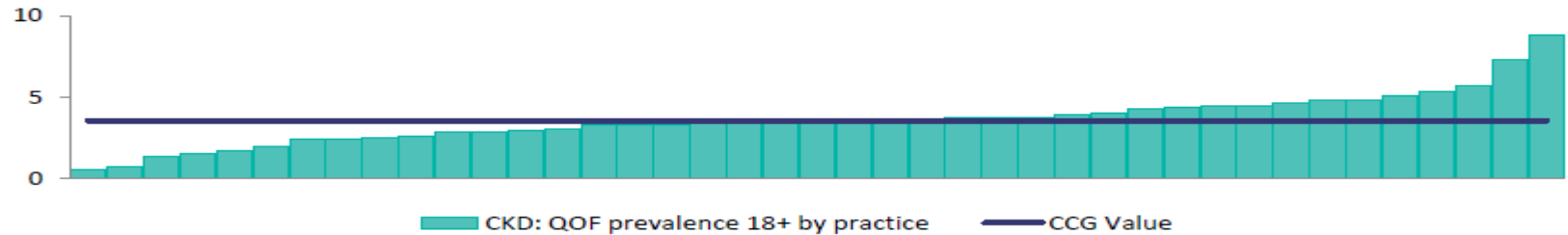
Indicator	Period	England	Yorkshire and Humber WES region														
			NHS Wakefield, Wakefield and Craven	NHS Barnsley CCG	NHS Bradford CCG	NHS Bradford City CCG	NHS Bradford Districts CCG	NHS Calderdale CCG	NHS Doncaster CCG	NHS East Riding of Yorkshire CCG	NHS Greater Huddersfield CCG	NHS Harrogate, Rotherham and Doncaster	NHS Halifax CCG	NHS Leeds South and East CCG	NHS Leeds South West and East CCG		
CKD: QOF prevalence (18+)	2015/16	4.1	4.3	4.0	5.1	7.3	2.6	3.8	3.9	3.5	5.0	3.6	4.1	5.0	3.8	3.5	3.1
CKD expected prevalence	2011	6.1	-	7.2	6.2	6.7	4.0	5.5	6.1	6.3	7.4	6.0	7.2	7.1	5.3	6.2	5.3
CKD002: Last BP reading measured in last 12mths is <=140/85 (den. incl. exc.) - retired	2014/15	74.4	74.4	70.7	72.9	72.6	72.5	73.6	74.7	70.5	72.7	74.6	75.2	75.4	74.1	71.9	75.4
CKD003: Hypertension treated with ACE inhibitor/ARB (den. incl. exc.) - retired	2014/15	76.4	76.2	74.0	70.9	70.1	77.2	74.8	80.1	74.9	76.7	80.2	79.3	79.1	80.7	79.2	79.4
CKD004: Urine albumin:creatinine ratio test last 12 mths (den. incl. exc.) - retired	2014/15	75.4	75.4	74.0	72.2	74.9	77.8	75.5	79.1	79.7	74.7	80.6	79.3	80.7	75.0	73.8	73.3
Pre-emptive and early transplantation rate (per cent starting RRT who have a working transplant at 90 days)	2009 - 14	10	-	10	5	8	7	10	18	5	9	12	17	18	6	15	11
RRT Modality at 90 days: % Transplant	2009 - 14	10	-	10	5	8	7	10	18	5	9	12	17	18	6	15	11
RRT Modality at 90 days: % Home dialysis	2009 - 14	21	-	15	15	24	5	17	16	20	29	20	12	25	21	14	9
RRT Modality at 90 days: % Hospital Dialysis	2009 - 14	69	-	69	61	69	69	74	66	75	64	69	72	56	73	71	81

Source: Cardiovascular Disease Profiles
<https://fingertips.phe.org.uk/profile/cardiovascular>

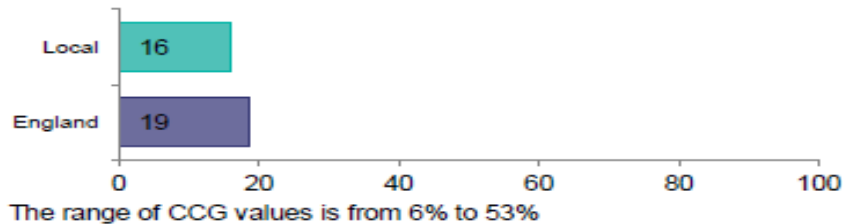


The hard-copy profiles contain further info relevant to primary care eg for Leeds S&E

Variation by general practice of chronic kidney disease prevalence, 2015/16 (per cent)



RRT patients presenting late (less than 90 days before RRT), 2013 and 2014 combined (per cent)





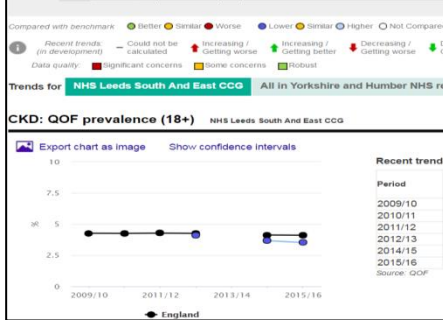
The interactive tool allows flexible views of the data and the option to download

Overview | Map | **Trends** | Compare areas | Area profiles | Definitions | Download

Area type: CCG | Areas grouped by: Sub-region | Benchmark: England

Area: NHS Leeds South And East | Sub-region: Yorkshire and Humber

Indicator: CKD: QOF prevalence (18+)



Look at trends

CKD: QOF prevalence (18+)

Area	Recent Trend	2015/16	Count	Value
England	-	-	1,672,806	4.1
Yorkshire and Humber NHS region	-	-	197,173	4.3
NHS Airedale, Wharfedale A...	-	-	5,002	4.0
NHS Bamsley CCG	-	-	10,386	5.1
NHS Bassettville CCG	-	-	6,529	7.3
NHS Bradford City CCG	-	-	2,105	2.5
NHS Bradford Districts CC...	-	-	9,755	3.8
NHS Calderdale CCG	-	-	6,702	3.9
NHS Doncaster CCG	-	-	16,163	6.1
NHS East Riding Of Yorksh...	-	-	12,913	6.2
NHS Greater Huddersfield...	-	-	6,696	3.5

Compare areas

Area profiles

Indicator	Period	Leeds South And East		Sub-region	England	England		Best/ Highest
		Recent Trend	Count	Value	Value	Worst/ Lowest	Range	
CKD: QOF prevalence (18+)	2015/16	-	7,389	3.5%	4.3%	4.1%	1.5%	8.2%
CKD expected prevalence	2011	-	-	5.3%	-	6.1%	2.9%	8.6%
CKD002: Last BP reading measured in last 12mths is <=140/85 (den. incl. exc.) - retired	2014/15	-	5,769	75.6%	74.4%	74.4%	67.3%	82.6%
CKD003: Hypertension treated with ACE inhibitor/ARB (den. incl. exc.) - retired	2014/15	-	482	72.9%	75.2%	76.4%	65.7%	86.3%
CKD004: Urine albumin:creatinine ratio test last 12 mths (den. incl. exc.) - retired	2014/15	-	5,781	75.8%	76.3%	75.4%	61.3%	84.4%
Pre-emptive and early transplantation rate (per cent starting RRT who have a working transplant at 90 days)	2009 - 14	-	-	11%	-	10%	3%	24%
RRT Modality at 90 days: % Transplant	2009 - 14	-	-	11%	-	10%	3%	24%
RRT Modality at 90 days: % Home dialysis	2009 - 14	-	-	9%	-	21%	4%	40%

Area profile



Similar CCG profiles are available for Diabetes and for High Blood Pressure

Public Health England
Protecting and improving the nation's health

Cardiovascular disease profile - Diabetes June 2017

NHS Leeds South and East CCG

Background
This chapter of the cardiovascular profiles focuses on diabetes and is produced by the National Cardiovascular Intelligence Network (NCVIN). The profiles are available for each clinical commissioning group (CCG) in England. Each profile is made up of four chapters which look at coronary heart disease (CHD), diabetes, kidney disease and stroke. This profile compares the CCG with data for England, and where data are available, a group of similar CCGs and the West Yorkshire Sustainability Transformation Partnership (STP).

Key information
In 2016 there were 14,816 people aged 17 years or older who had been diagnosed with diabetes and included in GP registers in NHS Leeds South and East CCG. There were an estimated further 3,600 people who remain undiagnosed suggesting the total number of adults with diabetes in the CCG was approximately 18,400.

The percentage of people with type 1 diabetes who achieved the blood glucose target of $<=58$ mmol/ml (7.5%) in this CCG was 30.3% compared to 29.6% in England.

The percentage of people with type 2 diabetes who achieved the blood glucose target of $<=58$ mmol/ml (7.5%) in this CCG was 64.4% compared to 65.9% in England.

People with diabetes are at a higher risk of having a heart attack or stroke. In this area, people with diabetes are 86.3% more likely than people without diabetes to have a heart attack. This was lower than the figure for England which was 108.6%. People with diabetes were also 57.6% more likely to have a stroke. This was lower than the figure for England where there was a 81.3% greater risk.

Key facts	Local	Comparator CCGs	STP	England
Diabetes prevalence in adults (per cent)	7.0	7.1	6.8	6.5
Estimated total diabetes prevalence in adults (per cent)	8.6	8.8	8.8	8.6
People with type 1 diabetes who have had the eight recommended care processes (per cent)	45.5	39.5	41.3	37.3
People with type 2 diabetes who have had the eight recommended care processes (per cent)	67.7	57.1	61.6	53.9
People with type 1 diabetes who met blood glucose, blood pressure and cholesterol targets (per cent)	19.5	17.5	18.3	18.3
People with type 2 diabetes who met blood glucose, blood pressure and cholesterol targets (per cent)	39.3	42.4	40.0	40.4

Produced by the National Cardiovascular Intelligence Network (NCVIN) | www.gov.uk/phe | <http://fingertips.phe.org.uk/>
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Source: Cardiovascular Disease Profiles
<https://fingertips.phe.org.uk/profile/cardiovascular>

HIGH BLOOD PRESSURE
HOW CAN WE DO BETTER?
NHS Leeds South and East CCG

Why improve detection and management of high blood pressure (BP)?

The challenges:

- Over 24% of people in England are estimated to have high BP
- High BP is one of the leading causes of premature death and disability in England, according to the Global Burden of Disease study
- At least half of all heart attacks and strokes are associated with high BP and it is a major risk factor for chronic kidney disease, heart failure and cognitive decline
- High BP costs the NHS an estimated £2bn, while social care and productivity costs are likely to be much higher

The opportunities:

- Treatment for high BP significantly reduces the risk of heart attacks, strokes, heart failure and all-cause mortality
- Every 10 mmHg reduction in systolic BP reduces the risk of major cardiovascular events by 20%
- Treatment is very effective at lowering BP and at improving outcomes
- For every ten people diagnosed with high BP, seven remain undiagnosed and untreated - this is more than 5.5 million people in England
- One in three people with diagnosed high BP are not treated to target
- Achievement in other countries shows the potential for improvement - for example, in Canada the rate of people with high BP who achieve good control of BP

Turn the page to see the BP resource pack for your area

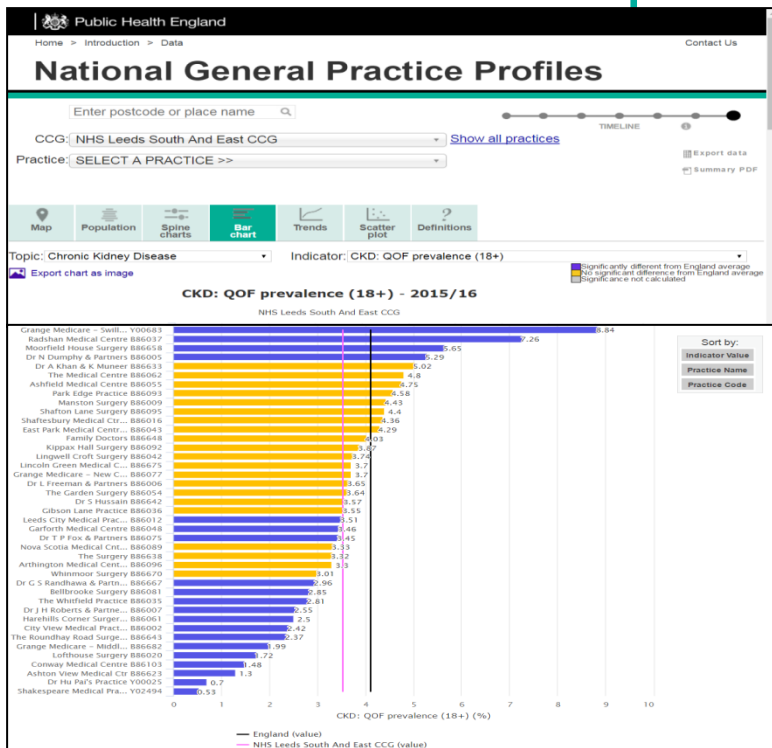
Includes practical guidance from GPs, nurses and pharmacists on how you can improve detection and management of high BP in your practice and CCG

Data collated and visualised by the National Cardiovascular Intelligence Network (NCVIN) in Public Health England

Source: British Heart Foundation, High Blood Pressure – how can we do better
<https://www.bhf.org.uk/healthcare-professionals/bp-how-can-we-do-better>



Further online profiles provide data for named individual practices



Source: National General Practice Profiles
<https://fingertips.phe.org.uk/profile/general-practice>



What I'll cover

Raw data sources

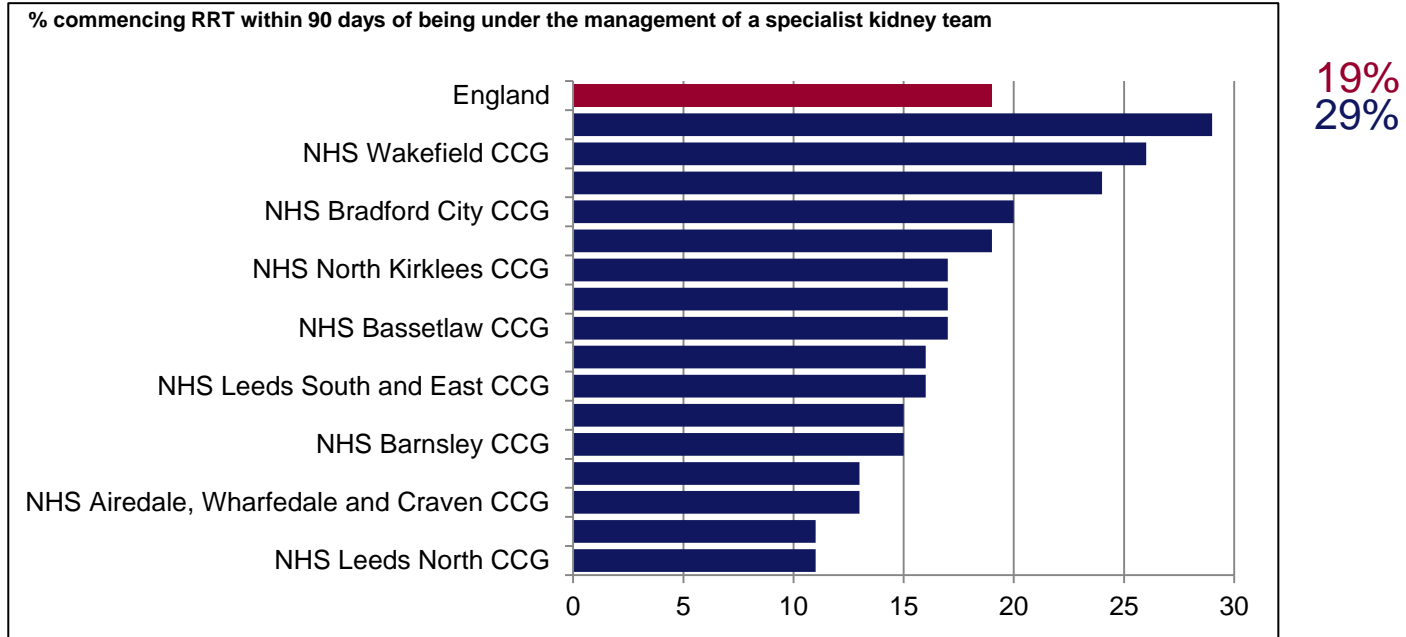
Tools

- NHS Rightcare
- PHE's National Cardiovascular Intelligence Network (NCVIN)

How to identify possible areas for improvement



Step 1: identify potential CCG for improvement



Source: UKRR 2014

Note: 7 other CCGs in Y&H data suppressed due to low numbers



Step 2: examine related indicators - for Calderdale CCG, there are issues with identification & treatment of hypertension

Renal

	2015/16	2015/16	2014/15	2014/15	2014/15
	Reported CKD prevalence	Reported to estimated prevalence of CKD	% CKD patients whose BP < 140/85	% on CKD register with hypertension & proteinuria treated with ACE-I or ARB	Creatinine ratio test used in last 12 months
STP opportunity (to Best 5)		8,150 Ppl.	2,582 Pats.	173 Pats.	1,826 Pats.
Airedale, Wharfedale and Craven	Down	Down	Down	Down	Down
Bradford City	Down	Down	Down	Up	Green
Bradford Districts	Down	Down	Down	Down	Down
Calderdale	Down	Down	Down	Up	Green
Greater Huddersfield	Down	Down	Down	Up	Green
Leeds North	Down	Down	Down	Down	Down
Leeds South and East	Down	Down	Down	Down	Down
Leeds West	Down	Down	Down	Up	Up
North Kirklees	Up	Up	Down	Green	Down
Wakefield	Down	Up	Green	Green	Green
Harrogate and Rural District	Down	Down	Up	Down	Green

Diabetes

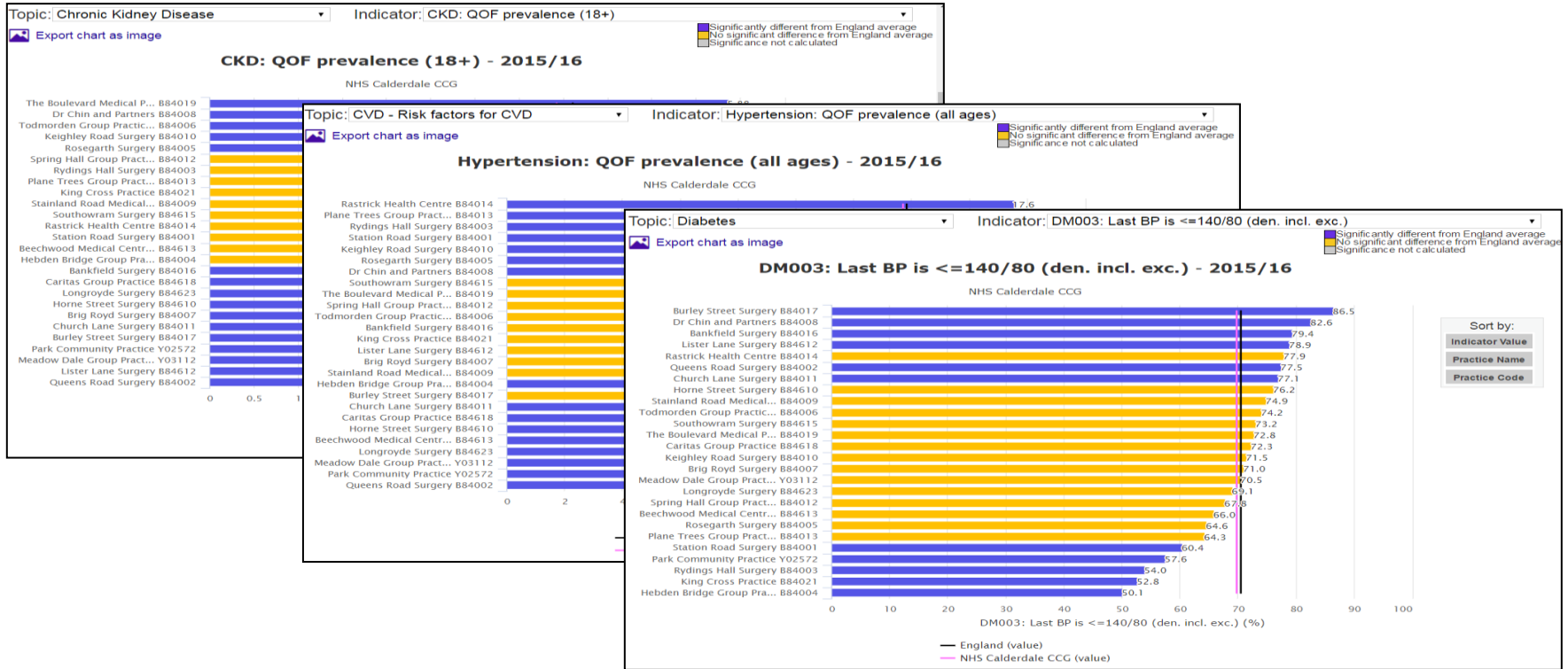
	2015/16	2015/16	2015/16	2015/16
	Diabetes prevalence, 17+	% diabetes patients cholesterol < 5 mmol/l	% diabetes patients HbA1c is <59 mmol/mol	% diabetes patients whose BP < 140/80
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Bradford Districts	Up	Down	Down	Down
Calderdale	Down	Green	Green	Down
Greater Huddersfield	Down	Down	Green	Down
Leeds North	Down	Down	Down	Down
Leeds South and East	Down	Down	Down	Down
Leeds West	Down	Green	Green	Green
North Kirklees	Up	Up	Down	Up
Wakefield	Up	Down	Green	Up
Harrogate and Rural District	Down	Up	Green	Up

Heart Disease

	2015/16	2015/16
	Hypertension prevalence, 18+	Reported to estimated prevalence of hypertension
		21,840 Ppl.
Airedale, Wharfedale and Craven	Down	Down
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Bradford Districts	Down	Green
Calderdale	Down	Down
Greater Huddersfield	Down	Down
Leeds North	Down	Down
Leeds South and East	Down	Down
Leeds West	Down	Down
North Kirklees	Up	Green
Wakefield	Down	Down
Harrogate and Rural District	Down	Down



Step 3: identify individual practices with potential to improve





Public Health
England

Using primary care data sources to improve kidney care

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BRADFORD'S HEALTHY HEARTS



Live longer, better



Dr Youssef Beaini

CVD Lead for Bradford and Airedale/Wharfedale/Craven CCGs

CVD Lead for Yorkshire and Humber Clinical Network

GP at The Ridge Medical Practice, Bradford

GPSI Cardiology

Tutor PwSI Diploma course, University of Bradford

Board Member, Primary Care Cardiovascular Society



CVD landscape in Bradford

- Still one of the **leading causes of death** in the UK and in the CCG – 350k population, 40 practices
- Bradford Districts CCG has the **7th worst CVD mortality rate under 75** in England
- Over **28% of all deaths under 75**
- **14.3%** of people have **hypertension**
- Over **21k have cholesterol above 4mmol/l**
- **CKD = CVD**



BRADFORD'S HEALTHY HEARTS

Bold and clear ambition

- By 2020, we will reduce cardiovascular events by 10% which will result in 150 fewer strokes and 340 fewer heart attacks
- We will no longer be the 7th worst CCG in the country!



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Bradford Districts
Clinical Commissioning Group

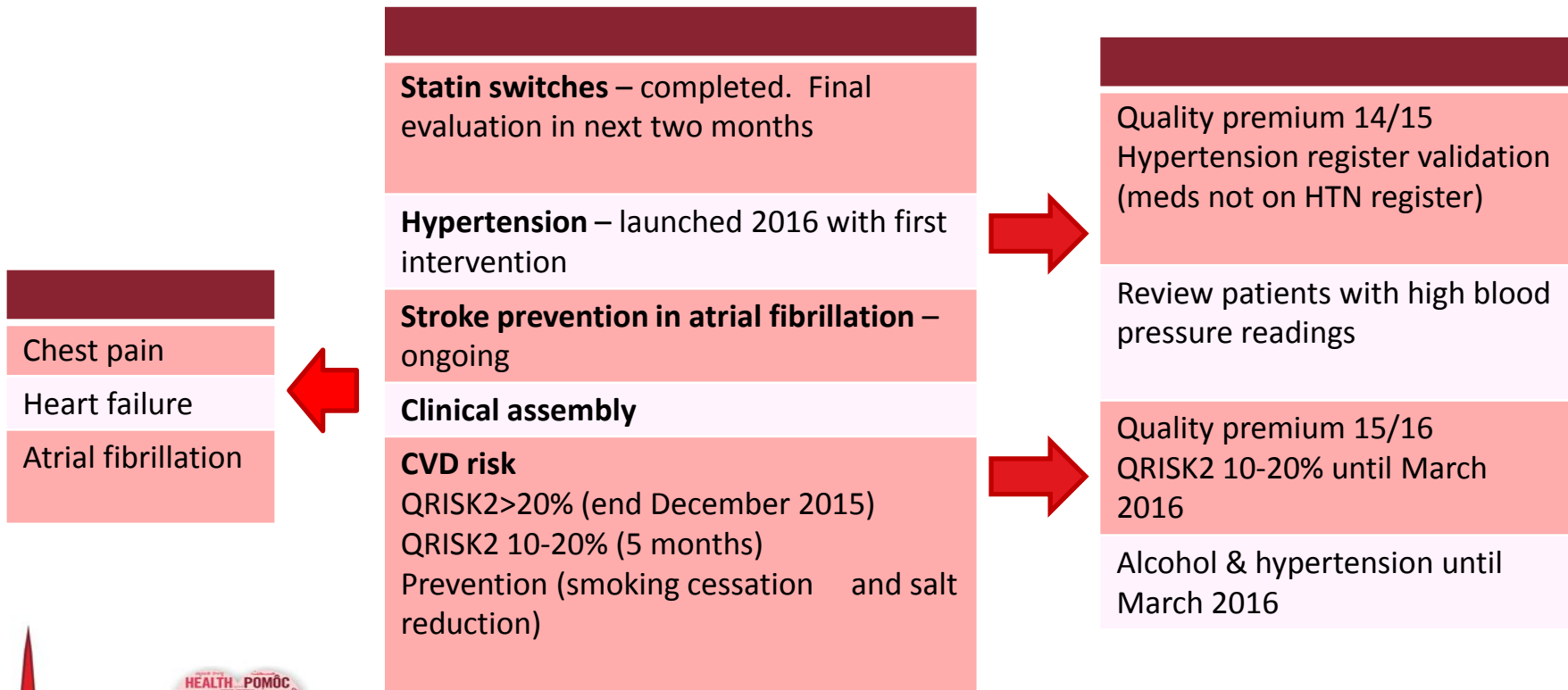
Clinical leadership - strategy

- Strategic - governing body, council of representatives, clinical board
- NHS Right Care - the story, workshop, clinical assembly
- Stakeholder involvement: primary and secondary care, pharmacists, voluntary sector, local authority
- Public engagement and patient involvement throughout
- Communications and engagement ++

Summary: wide-ranging engagement with a broad range of health care stakeholders including the hospital consultants, so GPs and consultants working together



Programme overview



Clinical leadership – delivering outcomes

- Credible (local clinicians, strong links to secondary care), clinical knowledge and personable
- Secondary care engagement: unified message across primary and secondary care, population approach, permissions
- Programme guidelines
- Regular educational and progress meetings, practice engagement at solution finding
- Developing clinical leadership across the system in primary and secondary care; lead clinician in practice (GP, practice nurse, pharmacist)



Clinical leadership – delivering outcomes

- Working with regional clinical network
- Data sharing, IT interventions (searches -streamlined into “work to do” rather than overload with searches; alerts in strategic places with easy access information to explain risk to patients, pop-ups), monthly dashboard, comparative performance
- Consistency and focus – eg few measures run repeatedly and then stopped
- Incentives – collaborative money, QoF
- Primary care support at CCG level, prizes, awards



Key success factors

- Its ‘our’ problem - CCG/practices/patients
- Primary care led solutions and owned by practices
- “Achievable benchmarks of care” [reducing unwarranted variation]
- Secondary care understanding the population
- Work at scale
- Workload-light for busy clinicians
- Proactive patient approach
- Flexibility
- Passion, enthusiasm and momentum!!



Our key questions

What's the target outcome?

How can we be smart about this?

Do we need to amend local clinical guidelines to achieve this?



So what have we done?

Cholesterol



Atrial fibrillation



Hypertension



BRADFORD'S HEALTHY HEARTS



Lipids / Statins



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Extra workload – the challenge of large scale QI

- Just for statin work, if done in traditional way with face to face appointments, would need:

An additional **26,000-39,000 appointments!**

- Overall Qrisk work: In one medium sized city in UK, estimated >40,000 with Qrisk 10-20%! (est 4.5 million patients in England)
- So NICE guidance might result in two to three visits per patient in first year = extra 80,000 - 120,000 appointments

- NICE mention limited capacity of healthcare!



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26,000 extra appointments? Or even 80,000??



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Examples of simplified approach - statins

- Same multi-faceted approach across the board
- Agreed protocol with secondary care, simplified, aimed at reduced primary care workload and “fire and forget” approach:
 - ❖ primary prevention: atorvastatin 40mg
 - ❖ secondary prevention: atorvastatin 80mg
- Work at scale with **letters** sent to patients rather than face-to-face consults. Supported by website, YouTube channel, wide ranging comms package, patient education sessions, patient participation groups.



Send letters without seeing patients?



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Statin switches (1)

- Over **6000 on simvastatin** with total cholesterol above 4 mmol/l or LDL >2 mmol/l were **switched to atorvastatin 40/80mg**: achieved 0.56 mmol/l reduction in LDL (and TC 0.5mmol/l) over 3 months (p<0.001).
Some patients had cholesterol improve from 8 to 3!
- Approximately 5,000 for primary prevention and approx 1,000 for secondary prevention

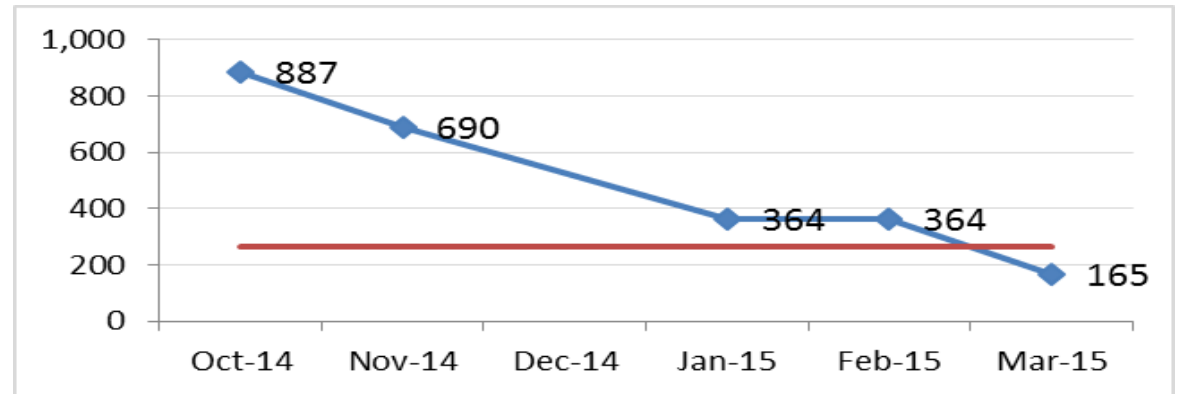
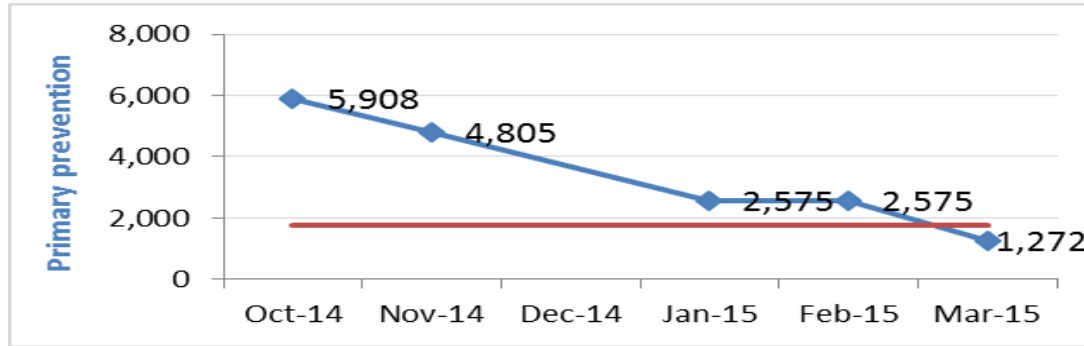


Statin switches (2)

- Innovative work at scale – letters sent out, supported by website, comms, large patient education programme.
- Used complex GP computer searches but simple output – one list of patients, sent letters to these and bulk switch repeat template, **takes 1-2 minutes.**



STATIN switch: outcomes achieved



QRISK2

- New NICE guidance on QRISK2 10-20%
- In Bradford 4% coded with QRISK2 10-20% (14,000)
- Another estimated 30-40,000 not yet coded/assessed
- 4,600 (32%) of patients with coded QRISK2 10-20% were on statin
- Potential problems with a full implementation due to lack of resources
- **QRISK2 (10-20 and >20%): overall, 7000** patients took up offer of statin. Preliminary figures show around 70-80% uptake but follow-up figures being compiled currently to assess longer term adherence



Total cholesterol range for QRISK2

Early results: (for QRISK 10-20%
and >20%)

- n=2163
- Mean total cholesterol reduction was **0.39 mmol/l reduction in that population**
- **P<0.001 for change**



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Stroke prevention in AF



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Examples of simplified approach: AF

- Education and mentoring programme based on NICE guidance. Nominated clinical champion in every practice in CCG. Regular meetings and public benchmarking against targets. Competitions.
- Complex searches in SystemOne but simple output: just one list of “work to do” for patients not on OAC
- Alerts on home screen and icon alerts in record with CHADSVASc score, stroke risk and also stroke reduction that would be gained by OAC (see screenshot). NNTs.
- Template (see screenshot)
- Use of pharmacists
- Use of industry-supported but independent education and review programmes such as APODI for those practices who wanted it (strict clinical governance framework)



CHADSVASc screenshot

SystemOne GP: Dr Youssef Beaini (Clinical Practitioner Access Role) at The Ridge Medical Practice - Patient Record

Discard Search Task Save Record Details Today Acute Sch Task Note

Start Consultation Next Event Event Details Pathology Drawing Auto-Consultation Settings

Clinical Administrative Patient Home

Continue Configure

Reminders
+75 Dr G James Cancel More

Patient Status Alerts
CHADS 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 enhanced service. Action More

Major Active Problems (2)



Summary of OAC treatment options personalised for patient's score

Configure

CHA2DS2-VASc score =2

NO THERAPY
Patient's ANNUAL risk of stroke+thromboembolism with no antithrombotic therapy=2.9%

WARFARIN INR 2-3
Patient's ANNUAL risk of ischaemic 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

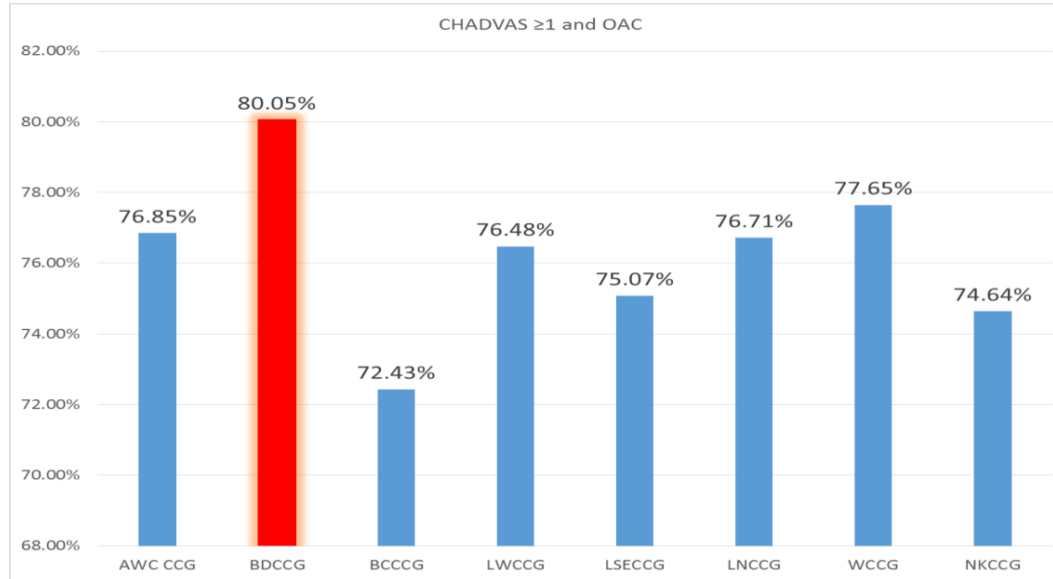
RIVAROXABAN 20mg once daily
Patient's ANNUAL risk of ischaemic stroke+thromboembolism with rivaroxaban =1%
Relative risk reduction: 66%
Absolute risk reduction:1.9%
Chance of benefit per year: 1 in 51

APIXABAN 5mg twice daily
Patient's ANNUAL risk of ischaemic stroke+thromboembolism with apixaban =0.8%
Relative risk reduction: 74%
Absolute risk reduction:2.1%
Chance of benefit per year: 1 in 47

Ok Cancel



AF across West Yorkshire (Feb 2016)



BD CCG: The highest achievement across West Yorkshire (which is 300-400 GP practices, total pop 1.5 million people). **May 2016**: even higher at **82% anticoagulated** and still rising.



Population impact

Mean CHADVAsc = 4, NNT to prevent one stroke = 11

Potentially programme could prevent 82 strokes (per 1.5-1.7 years depending on study)

Using NICE's assumption, cost of stroke = £11,000

This could potentially save £900,000

Also frees up 2,200 "bed days" per year in hospital



BRADFORD'S HEALTHY HEARTS



Hypertension



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Undiagnosed hypertension

- Estimated 37,000 with **undiagnosed** hypertension in the CCG.
- Started collaboration with the CDC in USA and developed two initiatives

Patients With Undiagnosed Hypertension Hiding in Plain Sight

Hilary K. Wall, MPH¹; Judy A. Hannan, RN, MPH¹; Janet S. Wright, MD¹

JAMA 2014

- Developed a system to:
 - ❖ Flag any patients with undiagnosed hypertension “hiding in plain sight”
 - ❖ Identify people on anti-hypertensive medication and not on a hypertension register – about 1% increase in prevalence achieved with just a few clicks of GP software. Completed over around 1-2 months



Aim of hypertension workstream

- Aim to achieve blood pressure control $<140/90$ for a minimum 76% of hypertensive patients in the next 2 years
- Baseline: 62% of patients to target
- Designed simplified treatment pathway based on European Soc Cardiology principles and world-class results from Canada and USA million hearts program



Simplified treatment protocol (with exceptions)

1. Amlodipine



2. Indapamide



3. Losartan



4. Spironolactone



Results of hypertension workstream

- Baseline achievement 62%; in order to get to 76%, just over 5,000 patients need to get their blood pressure under 140/90
- Already improved by nearly 5,000 patients over the first year! (vs planned 2 year program!) Now at just under 76% of patients to target <140/90



Combined outcomes

To date for Bradford's Healthy Hearts:

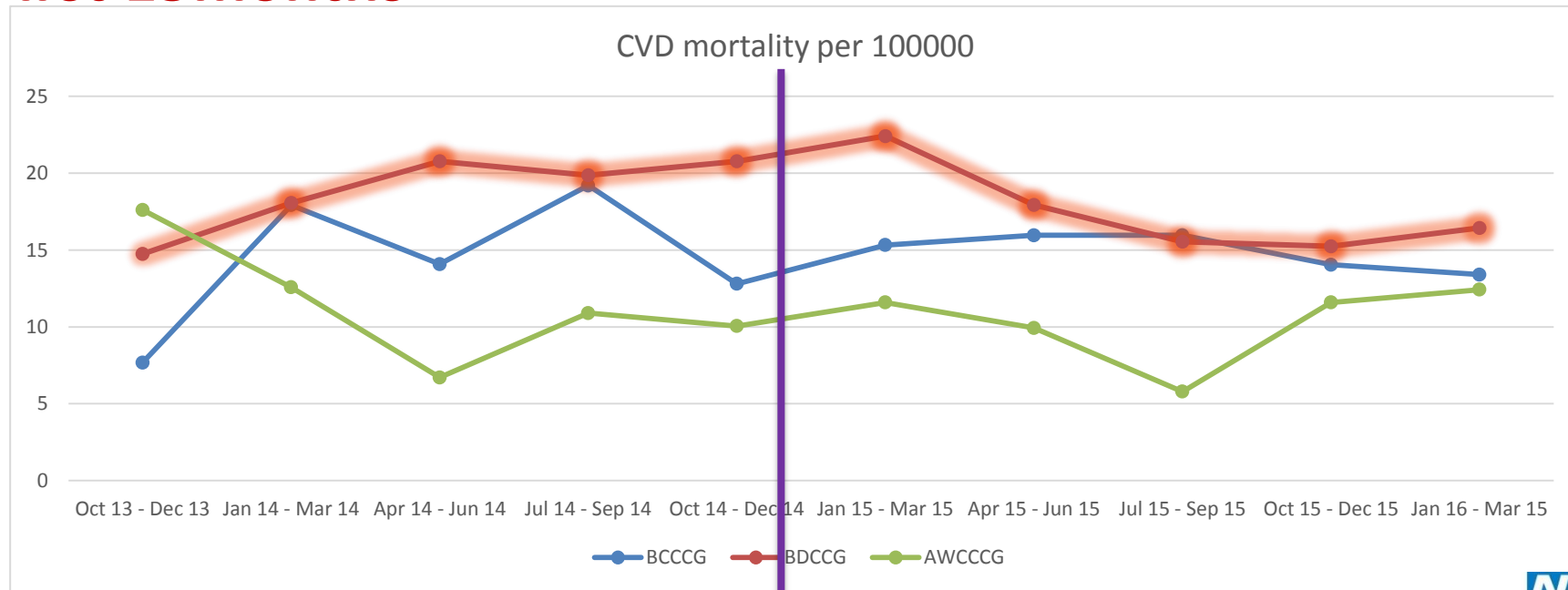
- Switched 6000 statins
- QRISK >20%: 4000 started on statins
- QRISK 10-20%: 3000 started on statins
- AF: >1000 started on OAC
- Hypertension: over 2,500 newly diagnosed, nearly 1% increase in prevalence. Nearly 5,000 with BP newly to target

Over 24 months, more than 21,500 people had an intervention that improved their health.



CVD mortality rate under 75 per 100,000 population pre-BHH versus post-BHH

First 15 months



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Percentage change in CVD mortality under 75 (absolute numbers)

Airedale, Wharfedale & Craven CCG

- Increased 3%

Bradford City CCG

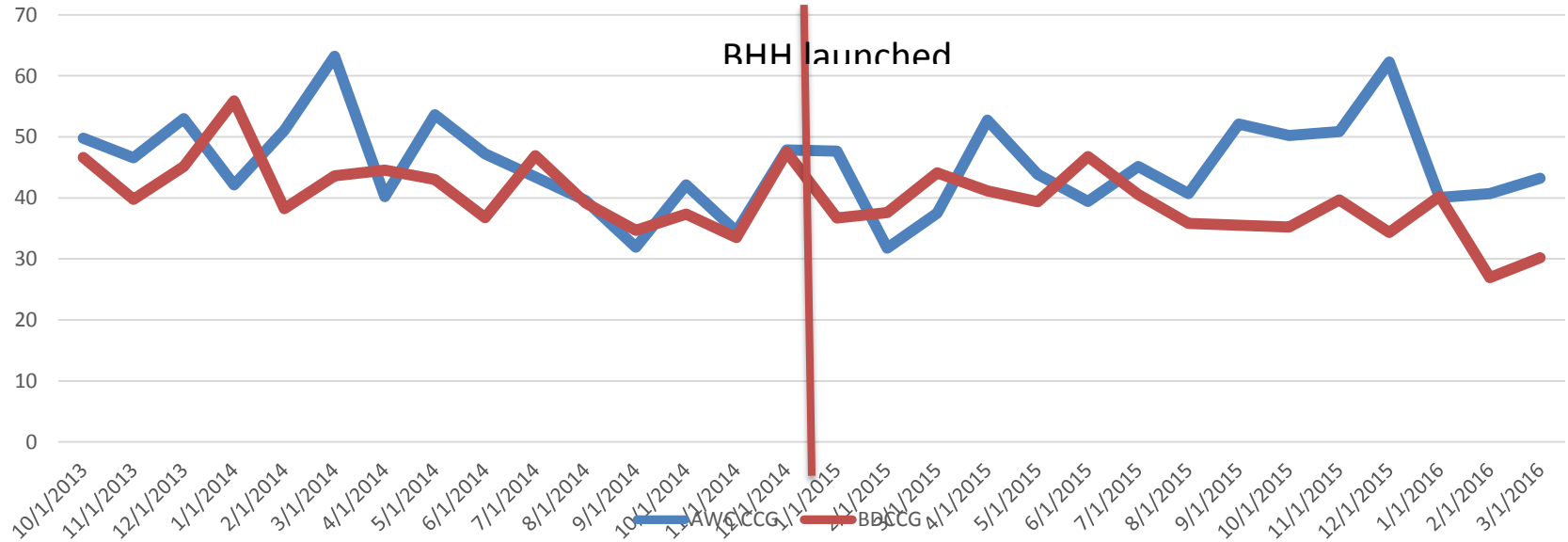
- Reduced 6.5%

Bradford Districts CCG

- Reduced 6.6%



Under 75 non-elective admissions for CVD (MI and stroke)



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Non-elective admissions before BHH intervention vs “control group”, AWC CCG

Airedale, Wharfedale & Craven CCG

- Mean CVD non-elective per month per 100,000 population = 46.4/m/100,000

Bradford Districts CCG

- Mean CVD non-elective per month per 100,000 population = 42.8/m/100,000

P = 0.1 for difference between groups

No statistical difference between groups



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Non-elective admissions after BHH intervention vs “control” group

Airedale, Wharfedale & Craven CCG

- Mean CVD non-elective per month per 100,000 population = 45.7/m/100,000

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- Mean CVD non-elective per month per 100,000 population = 37.6/m/100,000

P=0.003 for difference between groups

8.1 fewer admissions per month per 100,000



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Non-elective admissions: change over time*

Airedale, Wharfedale & Craven CCG

- CVD non-elective admissions change over time = -1% (-8 fewer CVD events)

Bradford City CCG

- CVD non-elective admissions change over time = +6% (32 additional CVD events)

Bradford Districts CCG

- CVD non-elective admissions change over time = -10% (-211 fewer CVD events)
- 137 fewer MIs and 74 fewer strokes



Conservative cost savings based on real outcome figures

Cost of stroke = £11,000

$74 * 11000 = £814,000$

Cost of MI = £5,500

$137 * 5500 = £753,500$

Gross savings £1,567,500

Net savings approximately £1,200,000 over first 15 months



Quote from BMJ

Winner, BMJ awards 2016:

“Inspirational leadership at scale, taking forward ambitious targets to tackle long standing public health challenges, and the engagement with the public whilst balancing demands on the clinical workforce was impressive.”



Summary

- Population-based mind-set and approach
- Engagement at all levels, across all organisations
- Multiple approaches to the population but **not** ‘please see your GP/PN to discuss further’
- Flog IT to produce what you want
- Be ambitious and brave!

