

# **CVDACTION**

Delivering the primary care contracts Improving population health

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## 2025-26 GP Contract changes – focus on CVD prevention

## **QOF:** CVD secondary prevention – major shift in resourcing

- 141 QOF points moved from other areas to BP and cholesterol treatment
- Substantial increase in treatment thresholds for BP and cholesterol

## **PCN DES:** local capacity and access improvement payment (CAIP)

- Use digital risk stratification tools to risk stratify patients in accordance with need, including to identify those that would benefit most from continuity of care
- Payment £0.45 multiplied by the PCN's Adjusted Population

## The CVD Prevention Challenge in Primary Care



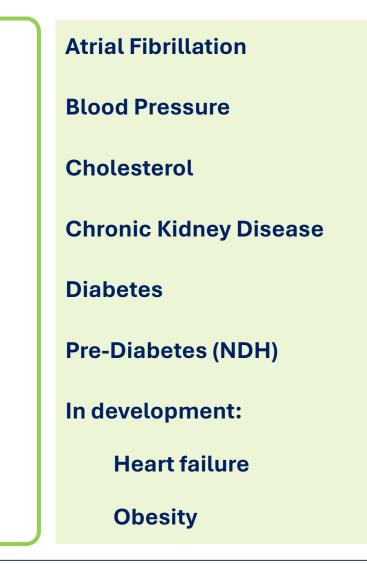
- The GP contract changes are part of a national focus on the Prevention Shift and on achieving the mission to reduce deaths from heart attack and stroke by a quarter in ten years.
- Providing NICE recommended treatment to people with high-risk conditions (like high blood pressure, cholesterol, CKD and diabetes) is highly effective at preventing strokes and heart attacks.
- However, under treatment is common eg 1in 3 people with hypertension are not treated to target and 1 in 6 people with CVD are on no lipid lowering therapy, and there is wide variation between practices
- This is because managing these conditions is difficult in real world general practice consultations where time pressure, complexity and multimorbidity is the norm
- CVDACTION has been designed to make it easy to spot patients at high risk of CVD who are on suboptimal therapy, and to take action in response to the data

# Easy-to-action data for real world primary care 1. Focus on high impact treatments that prevent heart attack & stroke

- **Identifies patients** on suboptimal treatment or not treated to target 2.
  - **Risk stratifies** by clinical priority and health care need with 85 indicators across multiple conditions
  - Makes it easy to **prioritise what's urgent** and what can be safely phased over time
  - Helps to manage multiple conditions/risk factors at the same time holistic for the patient, efficient for the clinician
  - Focuses on risk and capacity, reducing large numbers to **manageable** bites of work
- Data automatically filtered to target **health inequalities** 3.
- Improves care and outcomes, within capacity, and helps meet QOF & PCN **DES requirements**

## CVDACTION smart data tool

Risk stratification to support prioritisation, treatment optimisation & continuity of care



CVDACTION was developed by UCLPartners with unrestricted grant funding from Astra Zeneca & Boehringer Ingelheim



## **CVDACTION – identifying and stratifying patients with high-risk conditions in need of treatment optimisation**



#### Examples of single risk factor cohorts

- Hypertension with systolic BP >180 or 160-180
- CVD on no lipid lowering therapy, on suboptimal dose/intensity statins, or not treated to target
- CKD with >25% fall in eGFR in 12 months
- CKD with ACR above threshold and not on RAS inhibitors
- Diabetes and/or CKD not on SGLT2 inhibitors where indicated
- Diabetes with and without frailty with HbA1c above threshold
- Atrial Fibrillation not on anticoagulants with no CHA<sub>2</sub>DS<sub>2</sub>VASc score; or AF with raised score but not on anticoagulants

### Continuity of care filters

All indicators can be filtered to identify patients who would benefit most from continuity of care – eg multiple co-morbidities, frailty, frequent admissions or GP visits, severe mental illness.

#### Examples of multiple risk factor cohorts

- Hypertension with CVD on suboptimal BP and/or cholesterol treatment
- Hypertension with CKD with ACR above threshold not on RAS inhibitors
- CKD with hypertension or CVD on suboptimal BP or cholesterol treatment
- Diabetes with hypertension or CVD on suboptimal BP or cholesterol treatment
- Arial fibrillation with hypertension or CVD on suboptimal BP or cholesterol treatment

#### Case finders (potentially undiagnosed conditions)

Hypertension, CKD, diabetes, pre-diabetes

#### Overdue monitoring (eg BP, blood, urine)

Hypertension, CKD, diabetes, cholesterol

#### Health Inequalities filters

All indicators can be filtered by age gender, ethnicity, deprivation quintile, severe mental illness or learning disability to enable targeted action on health inequalities.