INTO-ACTION.HEALTH

CVDACTION

Delivering the primary care contracts
Improving population health

www.Into-Action.Health

INTO-ACTION.HEALTH

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

INTO-ACTION.HEALTH

- 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

CVDACTION smart data tool

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

INTO-ACTION.HEALTH

Easy-to-action data for real world primary care

1. Focus on **high impact treatments** that prevent heart attack & stroke
2. **Identifies patients** on suboptimal treatment or not treated to target
   - **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**
3. Data automatically filtered to target **health inequalities**
4. Improves care and outcomes, within capacity, and helps **meet QOF & PCN DES requirements**

Atrial Fibrillation

Blood Pressure

Cholesterol

Chronic Kidney Disease

Diabetes

Pre-Diabetes (NDH)

In development:

Heart failure

Obesity

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

INTO-ACTION.HEALTH

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_2DS_2VASc score; or AF with raised score but not on anticoagulants

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

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.

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.