The NHS RightCare CVD Prevention Pathway—making it work in the real world

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Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

### The Interventions

| Cross Cutting: | 1. NHS Health Check - systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk  
2. System level action to support guideline implementation by clinicians  
3. Support for patient activation, individual behaviour change and self management |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **Diabetes**   | Type 2 Diabetes preventive intervention  
Diabetes detection and treatment  
CKD detection and management |
| **High BP**    | High BP detection and treatment |
| **AF**         | AF detection & anticoagulation |
| **CVD**        | Detection, CVD risk assessment, treatment |

### The Opportunities

- **BP lowering prevents strokes and heart attacks**  
- **Anticoagulation prevents 2/3 of strokes in AF**  
- **Behaviour change and statins reduce lifetime risk of CVD**  
- **Intensive behaviour change (eg NHSDPP) reduces T2DM risk 30-60%**  
- **Control of BP, Hba1c and lipids improves CVD outcomes**  
- **Control of BP, CVD risk and proteinuria improves outcomes**  

### The Evidence

- **5 million undiagnosed, 40% poorly controlled**  
- **30% undiagnosed. Over half untreated or poorly controlled**  
- **85% of FH undiagnosed. Most people at high CVD risk don’t receive statins**  
- **5 million with NDH. Most do not receive intervention**  
- **940k undiagnosed. 40% do not receive all 8 care processes**  
- **1.2m undiagnosed. Many have poor BP & proteinuria control**

### The Risk Condition

- **Blood Pressure**  
- **Atrial Fibrillation**  
- **High CVD risk & Familial H/cholesterol**  
- **Non Diabetic Hyperglycaemia (pre-diabetes)**  
- **Type 1 and 2 Diabetes**  
- **Chronic Kidney Disease**

### Detection and 2°/3° Prevention

- **50% of all strokes & heart attacks, plus CKD & dementia**  
- **5-fold increase in strokes, often of greater severity**  
- **Marked increase in premature death and disability from CVD**  
- **Marked increase in Type 2 DM and CVD at an earlier age**  
- **Marked increase in heart attack, stroke, kidney, eye, nerve damage**  
- **Increase in CVD, acute kidney injury & renal replacement**
Principles of value based optimal design

Population focus
Focus on people and the population not the organisations.
Focus on those we don’t know as well as those we do

System thinking
Shared, common aim
Shared involvement in defining optimal and how best to use assets from across the system to achieve the aim

Value based
Think of value in two ways:
1. Allocative/Technical/Personal
   - Allocative – doing the right things
   - Technical – doing them right
   - Personal – no decision in the face of avoidable ignorance - works both ways!
2. Overuse/underuse
   - Overuse of lower value interventions
   - Underuse of higher value interventions
I think you should be more specific here in step two.

Then a miracle occurs...
### Implementation

#### Objectives

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<tr>
<th>Objective</th>
<th>Maximise Value</th>
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<td>Principles</td>
<td>Get everyone talking about same stuff</td>
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<tr>
<td>Phases</td>
<td>Talk about fix and future</td>
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<td>Demonstrate viability</td>
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<td>Isolate reasons for non-delivery</td>
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#### Phases

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<th>What to Change</th>
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<td>2 Indicative data</td>
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- **Where to Look**
  - Clinical leadership
  - Indicative data
- **What to Change**
  - Engagement
  - Evidential data
- **How to Change**
  - Effective processes
WORK HARD
AND
BE NICE
TO PEOPLE