Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of heart failure**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

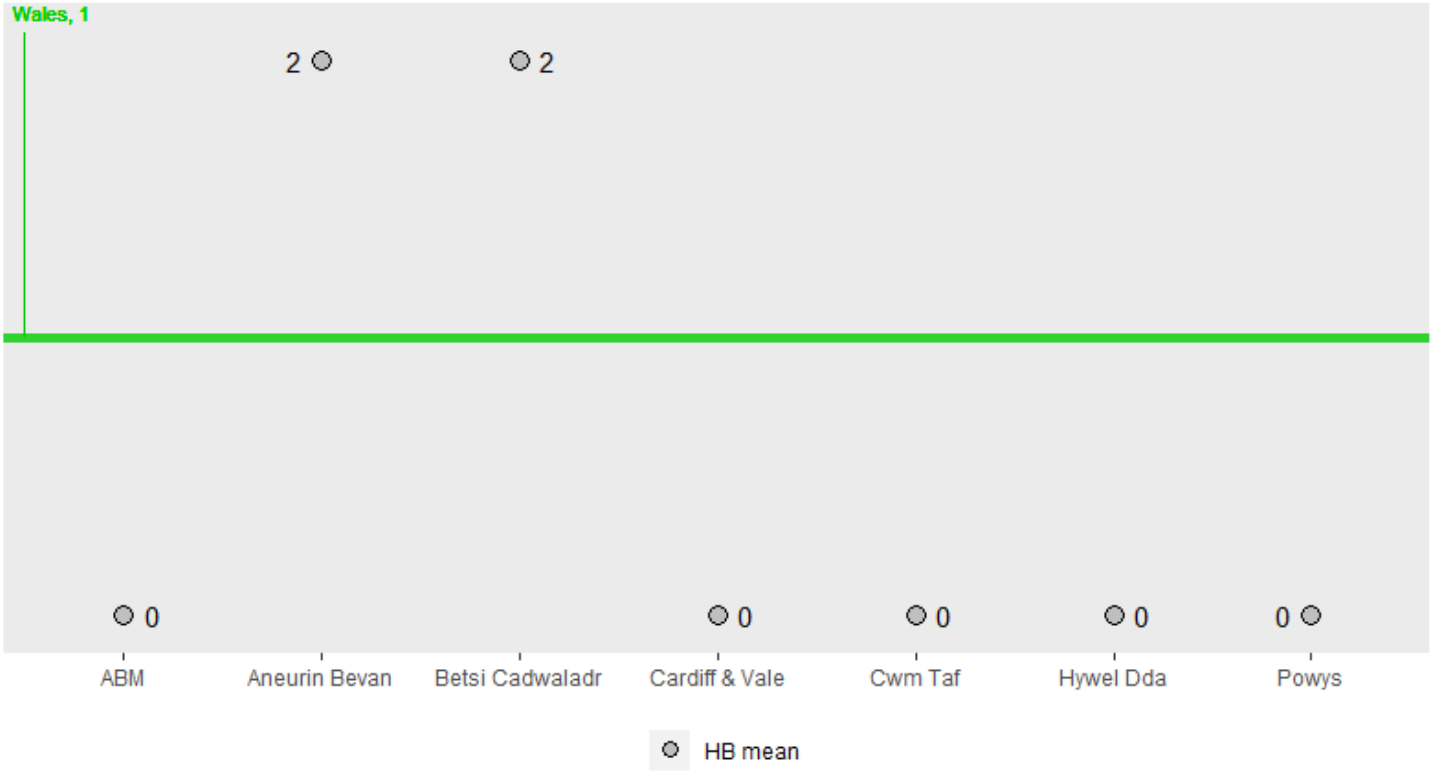
ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- In Wales cardiovascular diseases are a leading cause (18%) of DALYs and, together with cancer, are the main causes of years of life lost (*Health and its determinants in Wales*; PHW 2018; link).
- About 82% of the DALYs due to cardiovascular disease are attributable to known risk factors (*Health and its determinants in Wales*; PHW 2018; link); this underpins the importance of prevention efforts.
- The inverse care law (Hart 1971) states that the availability of good medical care tends to vary inversely with the need for it in the population served. The Inverse Care Law (ICL) Programme, established in the South Wales valleys, aims to increase ascertainment of people with or at risk of cardiovascular disease and cancer and supports them to make healthy behaviour changes.
- Key policy on heart failure is set out in the *Heart conditions delivery plan* (WG 2017; link).
- Indicators for this topic are reported via Primary Care Measures.

▼ PCM national variation

ⓘ Primary Care Measures (PCM) are a set of care quality indicators for primary care in Wales. The charts below emphasise variation between and within health boards; for further information see here. Beneath the charts are improvement action options that may inform cluster IMTPs. Variation is a natural phenomenon and can be healthy e.g. it can be a deliberate result of innovation in primary care settings that seeks to test improvements in processes or deliver better care outcomes. Variation that is observed in a healthcare context may be referred to as *inequality*; inequality that is judged to be both avoidable and socially unjust is termed *inequity* (sometimes alternatively described as *unwarranted variation*).

Variation in heart failure 3-year rolling SMR per 100,000 population under 75 years of age, by health board, 2014–2016 (*Source*: PCIP, Nov 2019):



▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.
- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.

▼ ⓘ Tell me about: Prevention

Definitions:

- Zola's river analogy is a useful way of thinking about prevention of ill health (Zola 1970). It describes **primary** prevention (stopping everyone from falling into a river and coming to harm e.g. never smoking), **secondary** prevention (ensuring any individuals at risk who do fall in get to safety quickly; minimising the chance of complications through early identification and intervention e.g. screening) and **tertiary** prevention (search-and-rescue for those taken downstream; mitigating the worst consequences of established disease e.g. vascular surgery).
- The Welsh Government definition of prevention is broader: working in **partnership** to co-produce the best outcomes possible, utilising the strengths and **assets** people and places have to contribute.

Building a healthier Wales (Feb 2019) sets out six key principles for implementing prevention in Wales:

- Adhere to the **five ways** of working (as outlined in the Well-being of Future Generation Act).

- Commit to investing in **evidence-based** interventions (where available or evaluate small and scale up if appropriate).
- Ensure evidence-based interventions have sufficient **scale** and **reach** to make a measurable population impact and to reduce inequalities.
- Ensure services are provided to a sufficient **quality** to achieve the best possible **outcomes** for each intervention; continually improve by drawing upon quality improvement techniques.
- Balance intervention benefits for **short and long-term** outcomes (including investing in one sector to realise a return in another).
- Optimise **value** by taking an agile approach to evaluating interventions and approaches and disinvesting in those that do not yield benefit/ value.

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent heart failure or limit disease progression

- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).
- The importance of reducing these behavioural risk factors is reiterated in the *Heart conditions delivery plan* (WG 2017; link). Of particular relevance to primary care clinicians, the plan recommends supporting intensive targeted interventions to specifically address smoking prevention and cessation uptake with target groups; ensuring that every contact with health and care services is used to both prevent smoking uptake and encourage cessation; supporting interventions within targeted age groups to increase participation in physical activity; and considering physical activity interventions within a settings approach.

▼ Modify clinical risk factors to prevent heart failure or limit disease progression

- Optimise primary/ secondary preventive actions for hypertension (CRF-001), high body mass index (childhood [CRF-002] and adult [CRF-003] obesity), and other modifiable clinical risk factors (e.g. high total cholesterol [see NICE CG181] and high fasting plasma glucose [see LTC-004]).
- The importance of reducing these clinical risk factors is reiterated in the *Heart conditions delivery plan* (WG 2017; link). Of particular relevance to primary care clinicians, the plan recommends ensuring those identified with a higher than expected blood pressure measurement are offered an appropriate referral pathway for management of their condition in order to help reduce the known risks; ensuring effective interventions and pathways for prevention, treatment and management of childhood obesity are routinely available and systematically implemented, including antenatal

interventions; and supporting intensive targeted interventions to specifically address weight and diet issues within deprived communities.

▼ **Encourage uptake of vaccination against influenza to reduce comorbidity**

- Optimise uptake of influenza vaccination (IDP-001).
- Influenza may trigger acute myocardial infraction and vaccination is integral to CHD [the predominant cause of heart failure] management and prevention (*Heart* 2016;102:1953–1956).
- People aged six months to less than 65 years with chronic heart disease were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ **Focus on improving detection of heart failure**

- Increased ascertainment of those at risk, with confirmation of a diagnosis of heart failure, will affect prevalence proportion. Higher cluster prevalence may reflect one or more of higher population disease prevalence; opportunity to improve delivery of behaviour change interventions; opportunity to improve identification and/ or management of clinical risk factors; access to health care; or the effectiveness of case finding.
- For signposting to relevant NICE guidelines/ quality standards relating to detection of heart failure as a source of potential improvement actions, see below.

▼ **Focus on improving management of heart failure to limit progression**

- Improving the quality of heart failure care will not lower prevalence, however, it may reduce the risk of complications/ future events; improve quality of life for the patient and their carers/ families; reduce inequity in health outcomes; or reduce (or increase) health and social care utilisation and costs.
- Indicator review for condition management (e.g. successful reduction of hypertension) is not included in the initial release of the PCNA tool; this is subject to improvements in PHW access to primary care data that would inform actionable intelligence.
- For signposting to relevant NICE guidelines/ quality standards relating to secondary prevention of heart failure as a source of potential improvement actions, see below.

▼ **Ensure awareness and implementation of NICE guidance/ quality standards**

- *Cardiovascular disease: identifying and supporting people most at risk of dying early*. Public health guideline [PH15] (Published date: September 2008) includes recommendations suitable for adoption by healthcare professionals. This guideline covers the risk of early death from heart disease and other smoking-related illnesses. It aims to reduce the number of people who are disadvantaged dying prematurely by ensuring people have better access to flexible, well-coordinated treatment and support.

- *Cardiovascular disease: risk assessment and reduction, including lipid modification*. Clinical guideline [CG181] (Published date: July 2014; Last updated: September 2016) includes recommendations suitable for adoption by healthcare professionals. This guideline covers the assessment and care of adults who are at risk of or who have cardiovascular disease (CVD), such as heart disease and stroke. It aims to help healthcare professionals identify people who are at risk of cardiovascular problems including people with type 1 or type 2 diabetes, or chronic kidney disease. It describes the lifestyle changes people can make and how statins can be used to reduce their risk.

- *Cardiovascular risk assessment and lipid modification*. Quality standard [QS100] (Published date: September 2015) sets out nine quality statements, any of which could form a focus for collective local improvement action. This quality standard covers identifying and assessing cardiovascular risk in adults (aged 18 and over) and treatment to prevent cardiovascular disease. It describes high-quality care in priority areas for improvement.

- *Chronic heart failure in adults: diagnosis and management*. NICE guideline [NG106] (Published date: September 2018) includes recommendations suitable for adoption by healthcare professionals [see Lifestyle advice]. This guideline covers diagnosing and managing chronic heart failure in people aged 18 and over. It aims to improve diagnosis and treatment to increase the length and quality of life for people with heart failure.

Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent heart failure or limit disease progression

- Optimise primary/ secondary preventive actions for smoking (BRF-001), unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004).

- The importance of reducing these behavioural risk factors is reiterated in the *Heart conditions delivery plan* (WG 2017; link).

▼ Modify clinical risk factors to prevent heart failure or limit disease progression

- Optimise primary/ secondary preventive actions for high body mass index (childhood [CRF-002] and adult [CRF-003] obesity).

- The importance of reducing this clinical risk factor is reiterated in the *Heart conditions delivery plan* (WG 2017; link).

▼ Encourage uptake of vaccination against influenza to reduce comorbidity

- Optimise uptake of influenza vaccination (IDP-001).
- Influenza may trigger acute myocardial infraction and vaccination is integral to CHD [the predominant cause of heart failure] management and prevention (*Heart* 2016;102:1953–1956).
- People aged six months to less than 65 years with chronic heart disease were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ **Ensure awareness and implementation of NICE guidance**

- *Cardiovascular disease prevention*. Public health guideline [PH25] (Published date: June 2010) includes recommendations suitable for adoption by a broad audience. This guideline covers the main risk factors linked with cardiovascular disease: poor diet, physical inactivity, smoking and excessive alcohol consumption. It aims to reduce the high incidence of cardiovascular disease. This, in turn, will help prevent other major causes of death and illness, such as type 2 diabetes and many cancers.
- *Cardiovascular disease: identifying and supporting people most at risk of dying early*. Public health guideline [PH15] (Published date: September 2008) includes recommendations suitable for adoption by a broad audience. This guideline covers the risk of early death from heart disease and other smoking-related illnesses. It aims to reduce the number of people who are disadvantaged dying prematurely by ensuring people have better access to flexible, well-coordinated treatment and support.
- *Community pharmacies: promoting health and wellbeing*. NICE guideline [NG102] (Published date: August 2018) includes recommendations suitable for a broad audience. This guideline covers how community pharmacies can help maintain and improve people's physical and mental health and wellbeing, including people with a long-term condition. It aims to encourage more people to use community pharmacies by integrating them within existing health and care pathways and ensuring they offer standard services and a consistent approach. It requires a collaborative approach from individual pharmacies and their representatives, local authorities and other commissioners.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.

- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments). Summarise this into the following box:

Type here

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here

Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

Type here

STEP H What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.