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## 1. Financial Details

This agreement is for the financial year 2010/11.

Practices will be paid a £20 fee per patient screened for CVD in accordance with the requirements specified below on the basis that they will be screening a minimum of 10% of the target population per year, and giving them appropriate advice and intervention.

## 2. Service Background

Promoting health and wellbeing is an essential, core function of general practice. This service specification outlines an extended level of Health Screening to be provided within general practice settings.

Evidence shows that it is possible to identify patients at high risk of cardiovascular disease and to modify the risk factors for these diseases, through the provision of advice and treatment. This enhanced service will enable more people to be identified who are at risk of developing heart disease or stroke with a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability.

This will also sustain the continuing increase in life expectancy and reduction in premature mortality that are under threat from the rise in obesity and sedentary living. It would also offer a real opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities.

### Cardiovascular Disease

The term 'vascular disease' covers heart disease, stroke, kidney (renovascular) disease & peripheral arterial disease. Diabetes is also considered because of its intimate link to CVD. Vascular disease is the main cause of death & disability in England, and accounts for 38% of deaths & costs the economy an estimated £25.8 billion each year.

People of South Asian & African Caribbean origin are more at risk of vascular disease. There is also a social class gradient, with the lowest socio-economic groups most at risk.

A great deal of Vascular Disease is preventable e.g. Diabetes is preventable in 2/3 of people at high risk, every 1 mmol/litre increase in Fasting Blood Glucose increases the mortality risk from Ischaemic Heart Disease by around 20% & for Stroke by around 28%.

Tackling vascular disease is essential for decreasing the gap between the average age of death locally and the average age in England.

Factors that contribute towards developing a CVD are:

- smoking
- physical inactivity and a sedentary lifestyle
- high blood pressure
- raised cholesterol levels
- obesity

### 3. Service Aims

The enhanced service aims to:

1. Screen all patients between 40 -74 years of age who are not on a QoF disease register for CHD, Stroke, Hypertension, AF, Diabetes, Mental Health, or LVD for cardiovascular disease.
2. Identify patients who are at high risk of cardiovascular disease so that interventions can be offered to prevent disease
3. Develop a practice call/recall system that enables patients in the target group to be identified and recalled every 5 years for cardiovascular screening.
4. Identify those patients who already have cardiovascular disease so that they can be included on the disease register and managed appropriately

The PCT is committed to carrying out a vascular risk assessment in the next 5 years for all patients who fit into the above category. We will be seeking alternate methods of providing screening for patients whose practices are not a part of this Local Enhanced Service. Practices not providing this service are expected to allow and facilitate the process for patients to be screened by the PCT (in line with policies for information governance).

### 4. Service Criteria

#### Patient inclusion criteria

The service is targeted at all patients on the practice list aged between 40 to 74 years, without an existing CVD (IHD, Stroke, Hypertension, AF, HF, and Diabetes) or patients on the Mental Health Register (who should be screened for CVD as part of the routine reviews monitored through QOF) who have not had a cardiovascular screen within the past 5 years recorded by the practice

Practices signed up to offer this service are expected to screen 10% of their 40-74 year old patients per year.

### 5. Service Outline

The Local Enhanced Service will fund:

1. Identification of the patients in the practice who have not had a cardiovascular risk assessment in the past 5 years. No values (eg BP or cholesterol) more than 1 year old can be used to calculate that risk.
2. Undertaking a vascular risk assessment
3. Assessment of clinical risk of diabetes
4. Calculating a CVD risk score using an appropriate CVD risk tool decided on by the practice and used consistently (Framingham, JBS2, QRISK or QRISK2).
5. Establishing a system to follow up patients at high risk of cardiovascular disease.

6. There should also be appropriate mechanisms within the practice for referrals to the GP and to other healthcare professionals where indicated (e.g. dietary advice, health trainers)
7. All adults undergoing screening should receive a feedback of the results with care planning and an agreed action plan for the management of risk factors where necessary. All patients should also be given information regarding the screening programme, and target levels to reduce future risk of a cardiovascular event.

The contractor has a duty to ensure that staff involved in the provision of the service has the relevant knowledge and are appropriately trained in the operation of the service.

### Cardiovascular screening

Patients who fit the above criteria will have the following assessed and recorded on the clinical system:

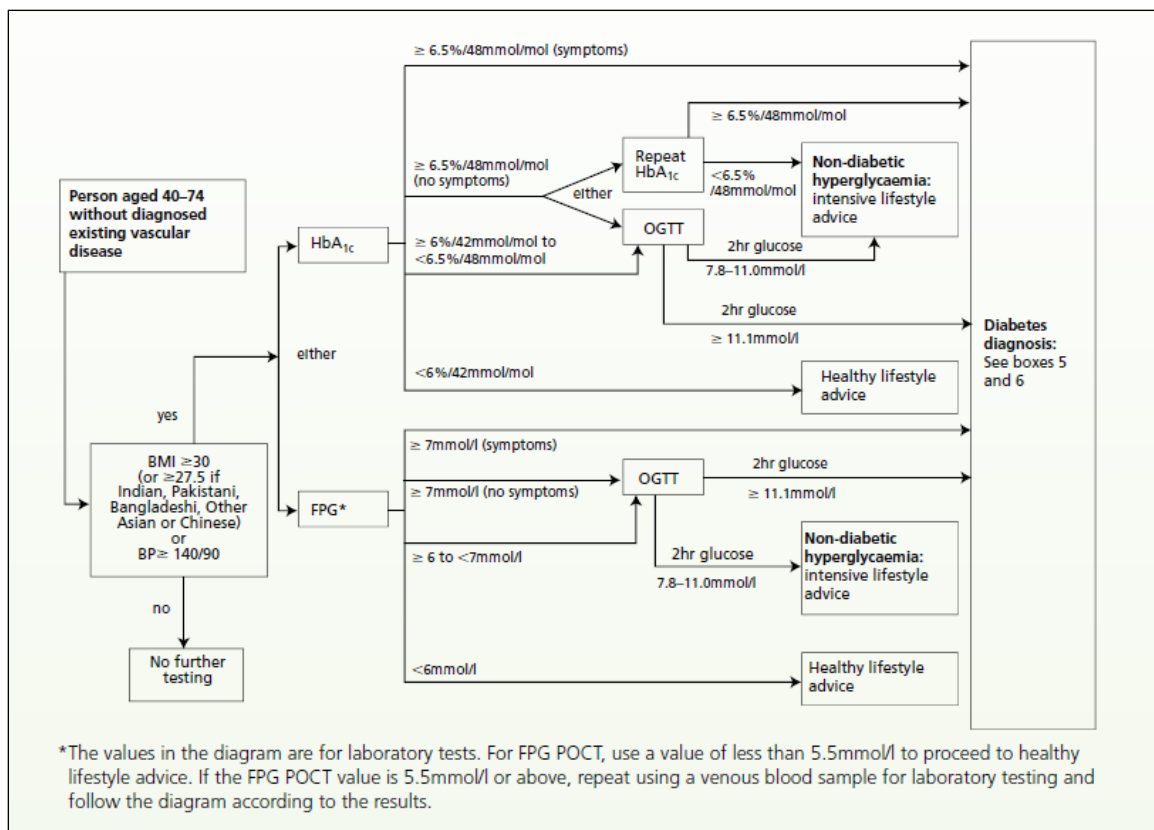
- Ethnicity
- BMI (based on height & weight)
- Waist circumference
- Systolic blood pressure
- Smoking status (those who have given up smoking in the past 5 years should be considered as smokers)
- Family history of premature CHD (parents and siblings: men < 55 years & women < 65 years)
- Family history of diabetes mellitus (first degree relative)
- Total, HDL, and Total Cholesterol: HDL ratio
- If clinically indicated - fasting plasma glucose (FPG) Note: patients who are normotensive with BMIs less than 27.5 do not need their glucose level assessed unless they have other risks e.g family history of DM, Polycystic Ovarian Syndrome, Gestational Diabetes etc.

There is new guidance on diabetes screening in the vascular risk assessment.

- All patients with a systolic BP equal to greater than 140 or a diastolic BP equal to or greater than 90 need a Fasting Plasma Glucose (FPG).
- All patients with a BMI equal to or greater than 30 must have a FPG.
- Patients of the following ethnicities must have a FPG performed if their BMI is equal to or more than 27.5:
 

Indian	Other Asian
Pakistani	Chinese
- All FPGs equal to or greater than 6.0 mmol/l need either a formal Oral Glucose Tolerance Test (OGTT) or a presumptive diagnosis of diabetes if significantly higher.

**Figure 1** - Diagrammatic overview for identifying people at high risk of having or developing diabetes, showing additional testing and treatment pathways



All patients who are being screened must have a lipid profile This can be carried out either prior to or following the assessment but must be within 11 months of the assessment. The screening assessment is not considered complete without this.

## 6. Service Outcomes

All patients will be given a CVD risk score, as well as information on reducing risk of a CVD by being aware of risk factors and intervention. The categories will be as follows:

CVD Risk Score	Category	Intervention
< 5%	Low Risk	Information Leaflet Any individual risk factors eg obesity should be targeted.
5% - 19%	Medium Risk	Advice/Prevention/Treatment
≥20%	High Risk	Statin Therapy + Advice/Prevention/Treatment

Note: for any practices using CHD risk then high risk is a CHD risk of ≥ 15% over 10 years.

The PCT will be seeking alternative providers to carry out CVD screening for those practices who are unable to do so.

## **7. Audit & Monitoring**

Practices will need to demonstrate that they have used an appropriate system to monitor this group of patients, and to follow up on any actions that are identified. They should also have a clear process to ensure that patients who are most at risk are screened (e.g. those who are over 60 and smokers).

Practices will need to produce an audit of the number of high risk patients that have been identified, as well as an audit of statin prescribing. Templates for providing this information will be given to practices to complete and return on a quarterly basis.

CVD and COPD prevalence will be monitored as this enhanced service should increase chronic disease prevalence, and we would also expect to see an increase in statin prescribing to provide intervention for patients who have been identified as being at risk.

Practices are expected to provide us with any additional data that may be requested to evidence the work carried out by the practice.

## 8. Signature Sheet LES 40

This document constitutes the agreement between the practice and the PCT in regards to this national enhanced service.

### Principle Signature on behalf of the Practice:

Signature	Name	Date

### Signature on behalf of the PCT:

Signature	Name	Date