Cardiology
The interface between Primary and Secondary Care

Dr A Daniels – GP, Cardiff
South East Wales Cardiac Network
The view from secondary care…

Referral to treatment times targets

“Clinics are full of patients who shouldn’t have been referred”

NSF targets for angiography.

“Not enough patients with angina are being referred by GPs for further management”
The view from primary care…

“We are told not to admit, not to refer, not to investigate, and not to treat. We are told to spend more time with our patients. What are we supposed to do with them?”
Quality, productivity and efficiency

• Productivity is a measure of output from a production process, per unit of input e.g. the number of problems solved per unit of time spent.
• Efficiency looks at the value of the output compared to the cost of the input.
• Productivity is lowest when patients’ problems are not solved
• Efficiency is lowest when clinicians are involved in low value work
What we say to dogs

Okay, Ginger! I’ve had it!
You stay out of the garbage!
Understand, Ginger? Stay out of the garbage, or else!

What they hear

blah blah GINGER blah
blah blah blah GINGER blah blah
blah blah GINGER blah
blah blah GINGER
Topics covered

• Primary Care and the GP contract
• QOF
• GP referral
  – Why are people referred between primary and secondary care?
  – Reasons for variation
• Experience of primary care in England

• How can we ensure that people with cardiac problems have the right treatment, in the right place at the right time?
General Medical Services (GMS) Contract

• Implemented in Wales in April 2004.
• Funding streams for
  – Essential services
  – Additional services
  – Enhanced services
  – Quality and outcomes framework.
Enhanced Services

• elements of essential or additional services delivered to a higher specification, or services outside the normal scope of primary services, designed around the needs of the local population.
• Enhanced services are commissioned by Local Health Boards and can be contracted from any provider, not just GMS contractors.
• There are three categories of enhanced services:
  – Directed (DES) – all LHBs must commission or provide
  – National (NES) – all LHBs should commission or provide but not mandatory
  – Local (LES) – optional commissioning of services based on local needs
• Ring-fenced allocation with a spending floor set which is the minimum amount that must be spent on enhanced services although LHBs are free to spend more.
C&V Enhanced Services

- **Direct**
  - Influenza 65-74
  - Influenza 75 +
  - Influenza at Risk
  - Swine Flu
  - Care of Mental Illness

- **National**
  - INR Level 1
  - INR Level 2
  - INR Level 3
  - INR Dom Visits

- **Local**
  - IUD Insert, IUD Review, Depo Provera
  - MMR, Flu, HPV, Pertussis
  - Drugs Misuse
  - Minor Injuries
  - Gonadorelins
  - Enhanced Minor Surgery, Extended Minor Surgery
  - Diabetes
  - Nexplanon
  - Learning Difficulties
  - Diabetes A, Diabetes B
  - ESA
  - Homeless
  - INR Level 4
  - Near Patient Testing
  - Non UK Citizens
  - Wound Care
Introduction to QOF

• QOF introduced as part of the 2004 GMS contract.
• QOF rewards contractors for the provision of quality care and helps to standardise improvements.
• Contractor participation in QOF is voluntary.
• Changes are made to QOF each year following negotiations between NHS Employers, and the General Practitioners Committee (GPC) of the BMA.
• NICE responsible for managing an independent and transparent approach to QOF from 2009.
• 2013-14 is the first year that there will be differences between QOF in England and Wales
4 Domains

- Clinical
- Public Health
- Quality and Productivity
- Patient Experience
Clinical Domain

- Atrial fibrillation (AF)
- Coronary heart disease (CHD)
- Heart failure (HF)
- Hypertension (HYP)
- Peripheral arterial disease (PAD)
- Stroke and transient ischaemic attack (STIA)
Clinical Domain (cont)

- Diabetes mellitus (DM)
- Hypothyroidism (THY)
- Asthma (AST)
- Chronic obstructive pulmonary disease (COPD)
- Dementia (DEM)
- Depression (DEP)
- Mental health (MH)
- Cancer (CAN)
- Chronic kidney disease (CKD)
- Epilepsy (EP)
- Learning disabilities (LD)
- Osteoporosis: secondary prevention of fragility fracture (OST)
- Rheumatoid arthritis (RA)
- Palliative care (PC)
Disease registers

- An important feature of the QOF.
- Lists of patients registered with the contractor who have been diagnosed with the disease or risk factor described in the register indicator.
- Responsibility of the contractor to demonstrate that it has systems in place to maintain a high quality register and these registers may require verification.
- NHS CB may compare the reported prevalence with the expected prevalence and ask contractors to explain any reasons for variations.
## Atrial fibrillation (AF)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Points</th>
<th>Achievement thresholds</th>
</tr>
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<tbody>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
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<tr>
<td>AF001. The contractor establishes and maintains a register of patients with atrial fibrillation</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing management</strong></td>
<td></td>
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<tr>
<td>AF002. The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS\textsubscript{2} risk stratification scoring system in the preceding 12 months (excluding those whose previous CHADS\textsubscript{2} score is greater than 1)</td>
<td>10</td>
<td>40–90%</td>
</tr>
<tr>
<td><strong>NICE 2011 menu ID: NM24</strong></td>
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<tr>
<td>AF003. In those patients with atrial fibrillation in whom there is a record of a CHADS\textsubscript{2} score of 1 (latest in the preceding 12 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy</td>
<td>6</td>
<td>57–97%</td>
</tr>
<tr>
<td><strong>NICE 2011 menu ID: NM45</strong></td>
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<tr>
<td>AF004. In those patients with atrial fibrillation whose latest record of a CHADS\textsubscript{2} score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy</td>
<td>6</td>
<td>40–70%</td>
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<td><strong>NICE 2011 menu ID: NM46</strong></td>
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## Secondary prevention of coronary heart disease (CHD)

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<td>CHD001. The contractor establishes and maintains a register of patients with coronary heart disease</td>
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</tr>
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</tr>
<tr>
<td>CHD002. The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>17</td>
<td>53–93%</td>
</tr>
<tr>
<td>CHD003. The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less</td>
<td>17</td>
<td>45–85%</td>
</tr>
<tr>
<td>CHD004. The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March</td>
<td>7</td>
<td>56–96%</td>
</tr>
<tr>
<td>CHD005. The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti platelet therapy, or an anti coagulant is being taken</td>
<td>7</td>
<td>56–96%</td>
</tr>
<tr>
<td>CHD006. The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy, beta-blocker and statin</td>
<td>10</td>
<td>60–100%</td>
</tr>
</tbody>
</table>

*NICE 2010 menu ID: NM07*
Exception reporting criteria

• A. Patients who have been recorded as refusing to attend review who have been invited on at least three occasions
• B. Patients for whom it is not appropriate to review the chronic disease parameters il.
• C. Patients newly diagnosed or who have recently registered with the contractor who should have measurements made within three months and delivery of clinical standards within nine months
• D. Patients who are on maximum tolerated doses of medication
• E. Patients for whom prescribing a medication is not clinically appropriate e.g. those who have an allergy, contra-indication or have experienced an adverse reaction.
• F. Where a patient has not tolerated medication.
• G. Where a patient does not agree to investigation or treatment (informed dissent).
• H. Where the patient has a supervening condition which makes treatment of their condition inappropriate
• I. Where an investigative service or secondary care service is unavailable.
Public Health Domain

- Cardiovascular disease – primary prevention (CVD-PP)
- Blood pressure (BP)
- Obesity (OB)
- Smoking (SMOK)
- Public health – additional services
- Cervical screening (CS)
- Child health surveillance (CHS)
- Maternity (MAT)
- Sexual health (CON)
Quality and productivity (QP) domain

- Covers
  - Outpatient referrals
  - Emergency admissions
  - Patients at high risk of admission
- The contractor reviews data on secondary care activity
- The contractor participates in an external peer review with other contractors who are members of the same clinical commissioning group to compare activity data with that of the other contractors.
- The contractor engages with the development of and follows 3 care pathways for improving service delivery
Patient experience domain

• The contractor ensures that the length of routine booked appointments with doctors in the surgery is not less than 10 minutes.

• Allowances required for extra patients seen in a surgery session such that the length of booked appointment is not less than 10 minutes.

• For contractors with only an open surgery system, the average face-to-face time spent by the GP with the patient is not less than 8 minutes.
GP referral trends

Estimations of past and future global warming

A1Fi: Low population growth, very high economic growth and energy use, intensive fossil fuel use
A2: High population growth, moderate economic growth and energy use, slow technical change
A1B: Low population growth, very high economic growth and energy use, balanced energy technology
B2: Moderate population growth, economic growth, energy use, and technical change
A1T: Low population growth, very high economic growth and energy use, renewable energy technology
B1: Low population growth, high economic growth, low energy use, energy efficiency only

Source: Climate Change 2007: The Physical Science Basis, Summary for Policymakers, Intergovernmental Panel on Climate Change
Why do GPs refer patients?

- Patients require specialist assessment which cannot be provided in primary care
- Patients require specialist treatment which cannot be provided in primary care
- When either patient or practitioner is not confident about management
QOF – CHD Referral Indicators

• Patients with newly diagnosed angina are referred for exercise testing and/or specialist assessment.
• Heart Failure should be confirmed by an echocardiogram or by specialist assessment.
• Percentage of patients with atrial fibrillation diagnosed after 1 April 2008 with ECG or specialist confirmed diagnosis.
Quality Requirements for the CHD NSF

Local Health Boards should have agreed and distributed guidelines for general practice covering:

- Referral to smoking cessation services.
- Referral guidelines for investigations available to general practice (for example, exercise tolerance test, echocardiography, other forms of functional assessment)
- Referral to rapid access chest pain assessment service
- Referral to the diagnostic heart failure clinic
- Referral to the Local Heart Failure Team
- Referral to rapid access arrhythmia services
- Referral for assessment by a consultant cardiologist
- Referral for assessment by a heart rhythm specialist
- Referral to cardiac rehabilitation services
Do guidelines work?

Strong evidence that clinical guidelines do not invariably provide the "successful outcome" aimed at by managers of service organization (Kendrick, 2000).
Variation of GP referrals

• Semi-structured interviews of a quarter of practices in Cardiff
• Practices provided with data on disease prevalence, corrected referral numbers and outcome measure compared to peers
• Some referrals discussed in detail
• Reasons for referral sought:
  – In general
  – In specific cases
Prevalence of CHD per list size
Factors influencing referral

• Clinical presentation – certainty of diagnosis, risk of missing diagnosis, gut feeling
• Patient factors - background knowledge of the patient –risk and behaviour
• GP factors – lack of confidence, past experience
Practices with above average referral rates

• Reduced clinician confidence
• Need clear information on what services are available and how these are accessed
• Real time access to guidelines and decision making support could reduce the need for referral
• Specialist advice could replace some referrals and provide timely advice
Practices with below average referral rates

- More likely to have a GP with an interest
- More likely to use guidelines for reference
- Would value an up to date directory of services
- Direct access to some investigations
- Direct access to consultant advice
- Referral pathway should be smoother especially for urgent cases – e.g. One-stop clinics for assessment and management
Discussion Points
common themes in all practices

General satisfaction with the referral process

Organisational factors which make referral necessary
• QOF drives referral
• Access to diagnostics:
  – Access to BNP blood test
  – Echocardiography
• Lack of information
  – Quality and timing of discharge information
  – More information on Clinical Portal- Echo, summary of the result.
  – more guidance on management in the letters back to GPs
Discussion Points
common themes in all practices

Support requested by GPs

- Education – generally valued but inconsistency of messages noted
- GP/cardiologist meetings to discuss clinical issues as well as service/management issues
- Virtual clinic - Access to advice from specialists phone or e-mail
  - ECG reading service
Summary of referral project

• **Referral is an important** component in solving patients’ problems
• There is a **huge variation** in patient referral which needs to be understood
• Unsupported **downward pressure** on referral may result in **dissatisfied patients** and doctors
• **Decisions to refer are complex**, involving the interplay of factors relating to the problem, the patient and the practitioner
• Referrals may reduced if a **range of solutions** are offered which address these factors
NO...NO...
I SAI'D I'VE GOT
ACUTE ANGINA