

CVDACTION Implementation playbook

A step-by-step guide to using the CVDACTION dashboard and implementing the wider CVDACTION framework.

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Introduction

This playbook tells you about what CVDACTION is and how it can help you and your patients.



Background

Cardiovascular disease (CVD) causes a quarter of all deaths in England and accounts for a fifth of the life expectancy gap between people living in the most affluent areas compared to those living in the most deprived.

CVD is also highly preventable, not just through lifestyle changes but also through the treatment of high-risk conditions that include atrial fibrillation, high blood pressure, high cholesterol, diabetes, non-diabetic hyperglycaemia (pre-diabetes) and chronic kidney disease.

Despite robust evidence showing that using NICE recommended treatments in these conditions is highly effective at preventing heart attacks and strokes, under treatment is widespread and longstanding. This is partly because managing these conditions is not easy in real world primary care consultations where multi-morbidity, complexity and time pressure is the norm.

CVDACTION

The challenge is not having data ... but having data we can action.

We are often awash with data in primary care. But data is of limited value if we don't have the capacity to act on it.

CVDACTION bridges the gap between data and action in real world primary care. It is designed to make it much easier for clinicians to spot people at high risk of CVD because they are not optimally treated with NICE recommended therapies. Optimising care in these patients will drive a step change in prevention of heart attacks and strokes.

CVDACTION is a smart data tool that brings together the key metrics for CVD prevention in one place. It shows you the gaps, opportunities and inequalities in preventive care so that you can plan your improvements, prioritise safely and fit workload to capacity.

For more information and a short video summary of CVDACTION click here.

CVDACTION provides teams with high quality data that is easy to action and time-saving in real world clinical practice.

- Complements *CVDprevent*, the national audit, with a focus on **high impact treatments in high risk conditions**.
- Takes comprehensive GP data across 85 indicators and integrates into **simple dashboards** at practice, PCN or system level – wherever GP data is stored. The search queries are built for EMIS, SystmOne and SQL.
- Identifies patients not receiving optimal treatments and **stratifies to safely prioritise** so that clinicians can have maximum impact and safely phase workload over time.
- Generates patient lists in **manageable 'chunks' to fit capacity and workflow**.
- Enables **efficient co-morbid care**, managing multiple risk factors in single consultations rather than multiple.
- **Health inequality filters** enable targeted CVD prevention in patients who are on suboptimal therapy and also at higher risk because of deprivation, ethnicity, severe mental illness or learning disability.
- Simple integrated CVDACTION guides help clinicians and non-clinicians to optimise treatment and wider proactive care, including support for education, self-management and behaviour change.

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How to get started with CVDACTION

The essential steps you need to take to successfully implement CVDACTION locally.

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Set up

During set up we will support to make sure you have everything in place needed for successful implementation. Key steps include identifying clinical and operational leads for your project and confirming what technical approach to CVDACTION will work best locally.

Communication & engagement

CVDACTION is all about enabling primary care to do things differently. This has to be locally owned and locally led. Our learning to date has shown that leads and team members need time to explore CVDACTION and the linked resources, to understand how it can help them and their patients and consider how best to adapt for local use.

We have a range of resources to support staff engagement including:

- CVDACTION introduction slide deck.
- UCLPartners' Size of the Prize: for every Integrated Care Board in England you can see how many heart attacks and strokes could be prevented in three years by optimising blood pressure and cholesterol management to reasonable levels of ambition. Data can be viewed for ICBs and PCNs.
- Explore the CVDACTION dashboard with dummy data.

Top tip: you cannot engage enough!

Spend time ensuring all staff understand CVDACTION, their roles and how doing things differently in this way benefits them and their patients. Regularly brief and engage them on the programme and available resources, explore any questions or concerns that they have, help them to adapt pathways to minimise duplication and release capacity, and feed back data so that they can see the impact they are having on their patients' care. A lot of great resources for clinical and non-clinical staff are embedded in the CVDACTION dashboard – make sure you share them with the staff who do not access the dashboards directly.

Technical implementation

CVDACTION searches have been developed for SystmOne and EMIS. They are also available in Structured Query Language (SQL). The dashboards are built in Tableau and Power BI, using the templates that we provide. The CVDACTION team will help you to work through the most appropriate approach in your area.

Below are some examples of how CVDACTION has been configured in different local systems:

Mid and South Essex – Integrated Care System approach

In Mid and South Essex, they are using their central data analytics platform provided by Agem CSU to host CVDACTION. Agem used the SQL search queries to populate the CVDACTION dashboard in Athena using their primary care data sets. Primary care teams then use their Athena accounts to access the CVDACTION dashboard and view their patients' data.

North West London ICB – Whole System Integrated Care Dashboards (WSIC)

In North West London, they used their population health management platform (WSIC) to host CVDACTION centrally. They used the SQL search queries to populate the Tableau dashboard template. Users access their own patients' data by logging into the secure WSIC servers.

Sutton Primary Care Networks (SPCN) CIC – EMIS Enterprise

SPCN ran the CVDACTION search queries in EMIS Enterprise which was in place for all practices in the borough with appropriate date sharing agreements. Data was then extracted and fed into the CVDACTION dashboard in PowerBI located on a central server.

Wandsworth Federation – EMIS

Wandsworth Federation ran the EMIS search queries on each participating practice's clinical system, before combining the outputs using a python script, and then populating to populate the CVDACTION dashboard in PowerBI located on a central server.

Information Governance:

All patient level data extracted for CVDACTION is held locally. Practices will need to have shared data agreements in place to be able to run CVDACTION across multiple practices. The dashboards are designed so that data is only viewed by staff who have the appropriate permissions. CVDACTION relies on existing governance infrastructures to access sensitive information, mirroring any permissions that are in place.

Digital Governance:

CVDACTION is compliant with DB0129. Please contact the CVDACTION team for the documentation relating to this standard.

How to add local resources to the CVDACTION help bar

You can add local resources to CVDACTION.

The CVDACTION help bar sits on the right-hand side of every page in the dashboard and includes useful links to a user guide, clinical next steps for each condition, relevant NICE guidance and the wider Proactive Care Framework resources. The help bar can be adapted to include locally agreed pathways, protocols and other local guidance.

To do this you simply edit the table in the dashboard template, extend the rows and then add the relevant links to external resources, before refreshing the dashboard. Find a quick guide on how to do this here.

Prioritisation

CVDACTION identifies patients whose risk of heart attack and stroke can be substantially reduced by optimising the use of high impact, NICE recommended treatments.

A core aim of CVDACTION is to help teams manage their capacity and workflows. There are likely to be a lot of patients whose blood pressure is not controlled to target or whose cholesterol is sub-optimally managed for example. CVDACTION breaks this large workload into manageable chunks by stratifying into small cohorts and making it easy to prioritise safely.

For example, for patients whose blood pressure is not treated to target, CVDACTION shows you who is at highest risk – for example those whose BP is above180/120 followed by those whose BP is above 160/100.

Similarly, patients who have pre-existing cardiovascular disease are stratified into three groups to aid prioritisation:

1. People with CVD on no lipid lowering therapy – they are at very high risk of a premature cardiovascular event
2. People with CVD on a statin but at suboptimal dose or intensity
3. People with CVD who are on maximal statin but with non-HDLc not treated to target – these patients may be eligible for second line therapies

This simple stratification helps to decide what to prioritise and what to safely phase over time, and it creates manageable chunks of work for time pressured clinicians.

When deciding where to start, it may make sense to begin with **a single condition** where several indicators can be addressed in individual patients. This will increase the impact on the patients' health and save time for clinicians – by efficiently treating multiple risk factors in single consultations rather than single risk factors in multiple consultations.

Top tip: how to start

Consider starting with:

1. Patients who have both hypertension and CVD: focus on optimising both blood pressure and cholesterol management at the same time; or
2. Patients with chronic kidney disease or diabetes: focus on optimising the use of four high impact treatments: blood pressure treatment, lipid lowering therapy, renal angiotensin antagonists and SGLT2 inhibitors.

This multi risk factor approach will reduce the number of consultations needed, save time for the clinician and have much bigger health impact for the patient and local population.

Find out more about how the tool can be used to aid prioritisation in the video below.



Learn how the 'Demonstrator sites' prioritised their high-risk cohorts to align with local priorities in the case study section.

Tackling health inequalities

CVD is a major contributor to health inequalities, accounting for a fifth of the life expectancy gap between most and least deprived communities. CVDACTION can help you to target health inequalities – even in a single practice.

On each dashboard, clicking on the 'Demographics' button allows you to filter any indicator or group of indicators by factors such as deprivation, ethnicity or severe mental illness. The dashboard will then provide you with lists of patients in already vulnerable communities (e.g. most deprived quintile or those with severe mental illness) who are at increased risk of CVD because their blood pressure, cholesterol, CKD or diabetes is not optimally managed.

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Workforce & pathway planning

This section guides you through how to match your workforce to your clinical priorities and to optimise proactive care.



Capacity is a major challenge in primary care. CVDACTION helps with capacity by making it easy to prioritise – stratifying indicators so that clinicians can easily see where need and impact are greatest and safely phase work overtime. The dashboards generate manageable lists of patients that can be matched to capacity and workflow.

As you agree your clinical priorities in CVDACTION, consider which members of the clinical team are best placed to:

- Call and recall patients, send messages and book appointments.
- Provide the clinical review, face to face or remotely, in order to optimise management.
- Offer wider proactive care consultations, with structured support for patient education, self management and behaviour change.
- Provide clinical and operational oversight and on the ground facilitation.

Some examples of roles and responsibilities include:

Prescribing pharmacists or nurses

With the appropriate competencies can take on the clinical reviews and treatment optimisation with oversight from a senior clinician.

Wider ARRS roles (e.g. physicians associate, health and wellbeing coach, social prescriber)

These roles can provide the broader proactive care consultation, supported by the great resources that are embedded in the CVDACTION dashboard and the Proactive Care Frameworks:

- Providing structured support for education, self-management and behaviour change
- Addressing patients' wider concerns and signposting to social prescribers or other services

Escalating to relevant clinical staff where necessary, following appropriate red flag protocols.

Admin staff

Admin teams can organise call and recall, messaging to patients, and scheduling tests and appointments, with the appropriate training, templates and protocols, and oversight.

Operational Lead

The operational lead (e.g. a PCN Manager) can oversee implementation of CVDACTION across the participating practices, for example ensuring engagement sessions and access to clinical and proactive care resources for staff, organising training, ensuring technical support, trouble shooting, etc.

Clinical Lead

The clinical lead such as Clinical Director will provide overall programme leadership and oversight, supporting wide engagement, sharing the vision and ensuring that primary care teams feel supported to mobilise the wider workforce and transform pathways – both to improve care for patients and to free capacity through more proactive disease management.

CVDACTION Facilitator

This is a critical role to support practice teams in their day-to-day implementation of CVDACTION. See the CVDACTION Facilitator section for more detail.

Top tip: make a plan

Make a plan for rolling engagement/awareness sessions so that you include the wider team members who will have a part in delivering CVDACTION.

Find out more about workforce and pathway planning, explore these resources:

- Implementation workbooks designed to support new users implementing the Proactive Care Frameworks.
- Wider workforce webinar covering how the wider primary care workforce can be utilised to support the delivery of the Proactive Care Frameworks.
- Suggested essential training and education support for delivery of the frameworks.
- Example of staffing and resourcing.
- Consultation guide for ARRS roles supporting patient education, self-management and behaviour change.

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Once high-risk patients have been identified, and you have decided which groups to prioritise, the process of optimising their treatment can begin with support from the CVDACTION dashboard resources.



Resources embedded in the dashboard

For each condition, the CVDACTION Dashboard help panel holds a range of resources to support clinicians and non-clinicians. These include a one page simple summary for each condition that captures the key elements of NICE guidance, and a separate button that links to NICE guidance and other resources. You can also find these resource packs here. There are also slide decks for each condition, designed to help clinicians with common challenges – the things that make implementation of guidance difficult in the real world such as statin hesitancy, second line therapies in lipid lowering, proteinuria management in chronic kidney disease and diabetes.

The value of rapid clinical optimisation

When treatment needs progressive titration to optimal levels (e.g. blood pressure medication), we suggest a process of rapid optimisation – for example reviewing the patients **every two weeks** or so and adjusting therapy until control is achieved. There is often no reason to wait longer, and optimising treatment quickly will reduce the patient's risk quickly. If the patient is able to provide their own blood pressure readings, these follow up consultations can be virtual. Rapid optimisation where clinically appropriate will lead to quicker risk reduction for the patient and more rapid population health impact. The Proactive Care Frameworks provide links to some high quality trusted resources for patients to help them understand their condition and to self manage.

Providing holistic proactive care

CVDACTION brings an opportunity not just to optimise clinical care but also to provide patients with more holistic proactive care – with structured support for education, self-management and behaviour change. These consultations delivered by members of the wider workforce in primary care, for example health care assistants, coaches, or care coordinators allow time to ensure patients feel heard, while providing key information and support to help them to live with and manage their condition.

The Proactive Care Consultation guide embedded in the CVDACTION dashboard and the suite of Proactive Care Frameworks provide some great resources to help staff undertake these consultations – with knowledge bites, key advice, motivational interviewing techniques and trusted digital links for patients.

You don't need to have every member of the wider workforce in your team to take this approach. For example, if you only have one or two ARRS roles, focus on competencies rather than job titles. In this way, team members who lack some of the skills required can be trained to achieve the necessary competencies, avoiding the need to recruit to additional roles.

Top tip: use the staff you have

Make sure you use the staff you have in place and adapt what you've got: plan around this configuration

For more details, you can visit our case study page.

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The CVDACTION Facilitator

The CVDACTION demonstrator programme has shown that having a Facilitator role is key to successful implementation. Find out more about the Facilitator role in this section.



The CVDACTION Facilitator role includes:

CVDACTION Champion

Sharing the CVDACTION vision, supporting PCN teams to implement the CVDACTION approach, socialising the Proactive Care resources.

Sharing CVDACTION outputs

To work with practices to ensure access to the CVDACTION dashboards across the PCN and ensure clinical and operational leads understand their outputs, and use them for prioritisation and work planning.

Workforce mapping

To work with the PCN to understand which members of the workforce are available to undertake pathway activities including: desktop review/triage patients, coordinate call and recall, ensure all test results are up to date before consultation, provide clinical optimisation, provide broader proactive care.

Workforce training

To coordinate training where required for members of the workforce based on the tasks they need to deliver and a review of competencies to identify any training needs. Find out more here.

Lived experience

To ensure the feedback and insights from any Patient and Public Involvement and Engagement groups are considered in the development of the care pathway.

Pathway

To map out and coordinate changes to the management pathways to ensure a systematic approach to optimisation and wider proactive care.

Checking progress

It is very important to regularly feed back data to teams showing how many patients have been optimised so that they can check progress, feed into learning cycles and see the impact on patients.

Top tip: the benefits of removing admin burden

Where the admin burden of managing call/recall and appointment scheduling is removed from clinicians, demonstrator sites have reported they are able to see a higher volume of patients. It is also likely that the proactive approach to care in CVDACTION, with accelerated optimisation of multiple risk factors and greater support for self management, is likely to reduce the demand for reactive care and single condition consultations.

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Find out how our Demonstrator sites implemented CVDACTION and how it is helping those using it.



The CVDACTION Demonstrator sites took innovative approaches to pathway re-design to enable structured proactive care:

K&W South PCN (1 PCN, 67,000 patients)

- Clinical Director and Lead Pharmacist led engagement with practice teams.
- Specialist secondary care pharmacist delivered treatment optimisation and support for PCN pharmacists.
- ARRS roles provided holistic proactive care appointments.
- Facilitator provided structured support to practices with workforce mapping and training, pathway adaptation, ensuring access to the data, socialising proactive care resources for staff and developing scripts and templates.
- Early prioritisation of patients from black and minority ethnic communities and over 65s.
- Patients recruited to provide insights and inform pathways – including group consults and patient video based on patient feedback to support self management in high blood pressure.

See the full case study.

Wandsworth Federation (3 PCNs, 150,000 patients)

- Clinical Director led engagement with clinical and operational teams across practices.
- PCN pharmacists delivered treatment optimisation.
- ARRS roles provided holistic proactive care appointments.
- Admin team managed call/recall.
- Workforce support – training, structured oversight, templates.
- Health inequalities – targeted deprived populations, used community health champions to engage with communities, persistent contacts to encourage people to attend appointments, longer consultations with clinicians and ARRS roles.

See the full case study.

Sutton PCNs (4 PCNs, 215,000 population)

- Clinical Director and operational lead led engagement/coordination with practice teams.
- Centralised call/recall and pharmacist led clinics in central hub for clinical optimisation.
- Comprehensive workforce development – with scripts, training and oversight for non-clinical staff to improve communication and maximise support for patients.
- ARRS roles provided holistic proactive care appointments, including focus on wider patient needs and signposting to social prescribing and lifestyle services.
- Structured patient engagement to inform pathway design.

See the full case study.

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It is important to consider how CVDACTION will become business as usual in your area to keep the programme sustainable over time.



It is important to consider how CVDACTION will become business as usual in your area to ensure the implementation is sustained over time and becomes an integral part of routine practice.

Start by reflecting with your team on key aspects like identifying who will oversee the CVDACTION dashboard and determining how often data will be refreshed to inform decision-making. Regular reviews of progress and outcomes are also vital to maintaining focus and demonstrating the ongoing benefits to your patients and your team.

Sustainability also means preparing your team for the future. Consider whether role descriptions need to be updated to reflect CVDACTION responsibilities, how new team members will be introduced to the programme, and if there are any skill gaps requiring additional training. By addressing these elements early, CVDACTION can seamlessly integrate into daily operations and deliver lasting benefits to patient care.

The sustainability model is a diagnostic tool that helps health and care leaders assess the strengths and weaknesses of their improvement plans and predict the likelihood of sustaining changes over time. It should be used at the start of a project to identify areas for strengthening and revisited regularly to track and improve the sustainability score, enhancing the chances of long-term success. The model provides a total score based on the strengths and weaknesses in the implementation plans, helping predict sustainability beyond the project's duration.

Here are some key sustainability questions to work through with your teams when implementing CVDACTION:

- Who will review the CVDACTION dashboard?
- How frequently will you re-run the data that populates CVDACTION?
- Are there any skill competency gaps that need addressing in the workforce?
- Which staff need to have their role descriptions updated?
- How are you measuring progress?
- How are you measuring outcomes?
- How will new joiners to your team hear about CVDACTION and what they will need to do to support this work?

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Find all your resources from this guide in one place.



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CVDACTION introduction slide deck

UCLPartners' Size of the Prize.

Explore the CVDACTION dashboard with dummy data.

Quick guide to using the CVDACTION help bar.

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Implementation workbooks.

Wider workforce webinar.

Suggested essential training and education support for delivery of the frameworks.

Example of staffing and resourcing.

Consultation guide.

Resource packs from the dashboard.

The Proactive Care Frameworks.

The Proactive Care Frameworks Consultation guide.

The CVDACTION Facilitator

The Proactive Care Frameworks training resources.

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The Sustainability model.

Contact

For further information about CVDACTION

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