CVD Prevention Fellowship Sample Project Case Studies

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This resource has been produced with the support of a Daiichi-Sankyo grant

Health Innovation Network South London

CVD Prevention Fellowship Sample Project Case Studies for prospective 2023 Fellows

- This pack includes a sample of the project case-studies and patient stories shared by the **HIN CVD Prevention Fellows**; all primary care clinicians based in south London. You can find the full case-study slide deck here
- The projects were carried out as part of the **HIN CVD Prevention Fellowship**, a 7-month programme including CVD clinical education and quality improvement training.
- 2023 Fellows will be asked to identify a target area relating to CVD – in particular around hypertension, lipids, atrial fibrillation, familial hypercholesterolemia, and chronic kidney disease.
- Projects will run September to December 2023, but it is anticipated that as with the 2022 projects, they will continue to run after this time to support improvements for patients and CVD delivery.
- **When deciding on a project area please ensure you will have the support of your practice / PCN, and time. Projects took an estimated 4 to 6 hours per month.**
- If you have questions please get in touch at hin.cvd@nhs.net

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Feedback from Fellows

Really great project and new QI skills. Good opportunity to network with colleagues in wider area.

I would like to say thank you for the opportunity to join this group and learn more.

It has been a great project to be part of - has really helped to drive some changes that have long been needed. Thank you.

Overall, I'm glad I have done the fellowship. I feel it has definitely helped me to improve patient care for my CVD patients.

It's been a brilliant project and has really inspired me to make improvements in the health of the local community.

Great programme and great learning opportunity for primary care to upskill the workforce. Thank you.

Very educational and supportive fellowship programme. Hope this will be repeated next year.

The programme content was very beneficial and helped to focus on the improvements that are required and how I am able to assist in making these improvements.

Well done to all. Great effort and well delivered. Thank you for being aware and supportive of the workload in primary care and adapting your course as we go along to reflect this. Very supportive approach from you all and very approachable.

Sample Project Case Studies

1. Hypertension – Julia Parascandolo, Modality Lewisham PCN
2. Hypertension – Julie Scott, Wallington PCN
3. Lipids – Faiza Usama, Sadiya Ayaz & Tamara Al-Jabary, Wandsworth PCN
4. Lipids - Kamaldeep Sahota, Orpington PCN
5. AF - Amy Miller and Faiza Usama. Wandsworth PCN
6. AF - Marina Lambros, APL PCN
7. FH - Dr Emily Mei, West Wandsworth PCN
8. FH - Ann-dora Kwame, North Southwark PCN
9. Wellbeing Pop Ups - Dr. Sharon Raymond, Crisis Rescue Foundation

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Hypertension Case Study

Fellow Name: **Julia Parascandolo**

PCN: **Modality Lewisham PCN**

GP Practice(s): **ALL**

Lewisham

PROJECT AIM & TARGET GROUP

There has been Inconsistent follow up of patients presenting or reporting very high blood pressures, ie in UCLP Priority Group 1 ≥180/≥115mmHg (clinic) ≥170/≥110mmHg (home). This project aims to support 20% of patients identified in this group to reach a normal BP by end of August 2022.

As of 17/06/2022 there were 99 patients identified across the PCN.

OUTCOMES FROM THE PROJECT

- Recalled 99 patients over 1month period
- Multiple patients identified as "ghost patients"
- **Reduced number of patients in UCLP 1 group from 99 to 79 during this time (20.2%)**
- Plan to now roll out 12 week rolling quality improvement across PCN using QOF, IIF and UCLP searches to improve hypertension diagnosis, monitoring and treatment

CHALLENGES/ISSUES BARRIERS FACED

- Multiple "ghost patients"
- Some patients contacted were lost to follow up post initial call
- Biggest challenge was ensuring there was adequate time to contact patients

SUCCESSES OF THE PROJECT

- 20 patients no longer in the UCLP1 cohort
- Plan is to now try and roll out a bigger QI project along the lines of this project looking at other cohorts
- Working well with community pharmacies offering AMBP to diagnose hypertension
- GP colleagues appreciative of the audit for patients that have previously been lost to follow up with uncontrolled hypertension

LEARNINGS FROM THE PROJECT

- Lots of guidelines and searches already made to support a QI project for hypertension
- Focussing on the highest risk areas can make a difference to those previously lost to follow up with uncontrolled hypertension
- Really helpful to advise GPs of the plan (communication went out to patient's named GPs to expect results) and remind them of reviewing using CESEL guidelines and Ardens template

Hypertension Case Study

Fellow Name: Julie Scott

PCN: Wallington PCN

GP Practice(s): Park Road Medical Centre

Sutton

PROJECT AIM & TARGET GROUP

Review patients with a previously raised BP, who had not been followed up or treatment was not optimised. Began with UCLP priority group 3 to ensure the process was set up and running well in practice, also allowing staff to upskill and refine consultations before reviewing the higher risk cohorts of patients.

59 patients were identified from UCLP searches as being in priority group 3 (a and b)

Aimed to review and optimise the BP management of 25% of patients (no. = 15) in priority group 3 by the end of 2022

OUTCOMES FROM THE PROJECT

12 patients have been contacted and recalled to date, 1 patient DNA'd.

Of the 11 patients seen to date, BP was controlled in 4 patients who will be reviewed annually.
1 patient has adjusted the timing for taking their medication to aid compliance.
1 patient has deferred increasing their medication due to travel plans.
1 patient decided not to increase their medication.

3 patients have had a 2nd review, 1 of whom has reduced their BP to below the NICE guideline target.

CHALLENGES/ISSUES BARRIERS FACED

- Patients with other comorbidities have been more complex, with other factors to be considered when measuring BP e.g., intermittent pain and migraines
- Holiday, sickness and other practice demands have limited the progression of the project
- Now the process is becoming more established, I have been asked to look at the patients identified in the DES IIF CVD cohorts – these reports appear to have identified people not previously identified

SUCCESSES OF THE PROJECT

- Supporting patients to better self-care
- Recognising that other patients not identified by the initial searches will benefit from this project

LEARNINGS FROM THE PROJECT

- Letting the whole practice, including all clinicians, know about the project
- Discussing the project, experiences, processes and progress regularly to ensure consistency e.g., in recalling the patient for review
- A better system for recalling patients is needed

Lipids Case Study

Fellow Name: **Faiza Usama, Sadiya Ayaz & Tamara Al-Jabary**
PCN: **Wandsworth PCN**
GP Practice(s): **Chartfield Surgery**

Wandsworth

PROJECT AIM & TARGET GROUP

Lipid Initiation as a Primary Prevention in 40 years + population with QRisk of 10% and more.

106 patients were identified.

The aim was to review as many patients as possible and where appropriate start on a statin or refer onto appropriate therapy.

OUTCOMES FROM THE PROJECT

106 patients identified in search with no other risk factors associated. Out of those:

- 10 were excluded because of wrong coding
- 45 patients were invited for blood tests
- 10 were contacted via Accurx to make an appointment to discuss statins
- 3 were started on statins
- 1 patient was sent for investigation of FH

CHALLENGES/ISSUES BARRIERS FACED

- Time management & peer support
- Running appropriate searches & coding
- Finding time to get together and implement plan
- Target group had to be changed twice:
  - Coding issue around ethnicity pulled small numbers
  - Errors in their medical history pr obably due to coding Issue.
  - Manually excluded anyone who had been prescribed a statin (or alternative e.g., Fibrate/ezetimibe) in the last 6 months

SUCCESSES OF THE PROJECT

- Able to generate data for patients eligible for Statin Initiation
- 5% patients improvement with up to date LFT after 3 months of lipid initiation
- We are trying to ensure we are now coding appropriately and where there are errors identified it is rectified
- Project is ongoing, this will be long term work

LEARNINGS FROM THE PROJECT

- We all learnt a lot through this fellowship, not only did it enhance our skills and clarity on CVD Risk management but also as a team learnt from our mistakes. Also learned about importance of correct coding
- Knew about expert opinion and support available through HIN CVD Project team, specialists support
- Teamwork and time management is a key. Lack of time management & support from other colleagues made an impact

Lipids

Fellow Name: Kamaldeep Sahota

PCN: Orpington PCN

GP Practice(s): Knoll Medical Practice

Bromley

PROJECT AIM & TARGET GROUP

This project aimed to address the significant unmet need with regards to cholesterol management in relation to secondary prevention. Data from UCLP shows there to be **147 patients with CVD diagnosis not on a statin.**

By the end of October the aim was to review 25% of these patients.

OUTCOMES FROM THE PROJECT

44 (30%) patients reviewed:

- 8 (19%) patients started on statin/ezetimibe
- 9 (21%) declined secondary prevention
- 6 (14%) patients advised on further blood tests to aid medicines management
- 6 (14%) patients with incorrect coding
- 6 (14%) treatment with statin not clinically appropriate
- 4 (9.5%) inactive patients (death or moved practice)

CHALLENGES/ISSUES BARRIERS FACED

- The main barrier for this project has been inconsistency in prescribing of statins by specialists in secondary care. Several people I have reviewed, have been discharged post stroke from hospital without statins and then to explain this omission to patients can be challenging
- Another aspect that has been time consuming for this project is incorrect coding and having to go back and check diagnoses

SUCCESSES OF THE PROJECT

1. Surpassing the target of patients to be reviewed by October 22
2. Starting lipid modification treatment in 19% of the patients reviewed
3. Support from prescribing lead to prioritise this work
4. Support from the multi-disciplinary team to review patients and start on treatment
5. Positive patient feedback about the proactive reviews undertaken

LEARNINGS FROM THE PROJECT

1. Patients want an open and honest discussion about statins
2. Shared decision making is key
3. Some patients had not been reviewed in over a year and were keen to discuss their health and medicines
4. Some patients have already made their minds up about statins. There is clearly more work to be done here by health care professionals in educating patients
5. Surgery coding needs to be reviewed to ensure accuracy of patient records

AF Case Study

Fellow Name: Amy Miller and Faiza Usama

PCN: Wandsworth Prime

GP Practice(s): Heathbridge Practice

Wandsworth

PROJECT AIM & TARGET GROUP

Aim 1 Increase % of patients (90%) on AF register with a CHA2DS2-VASC score within the last 12 months (QOF target).
Aim 2 Increase % of patients (95%) with AF with a CHA2DS2-VASC score > 2, or > 1 male, that are anticoagulated with a DOAC, or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist (IIF CVD-05).
Aim 3 New patients requiring anticoagulation for stroke prevention in AF offered and prescribed edoxaban first line (IIF CVD-06).
Aim 4 Increase % of patients (75%) prescribed a DOAC who have a renal function test, weight and Creatinine Clearance Rate recorded, plus a recording that their DOAC dose was either changed or confirmed (IIF SMR-03).
Aim 5 Increase % (100%) of patients prescribed a DOAC who have had a full blood count and liver function tests in the last 15 months (CQC Inspection).

OUTCOMES FROM THE PROJECT

As of 27/10/22 (project still ongoing as at step 3 of implementation plan:

Aim 1: Increased from 53% at baseline to 100%. 95 patients reviewed. Target achieved
Aim 2: Has increased from 83% to 90%. ~ 30 patients reviewed.
Aim 4: Has increased from 0% to 33%. 75 patients reviewed, reviews ongoing.
Aim 5: Has remained at 84%. Patients not yet reviewed.

CHALLENGES/ISSUES BARRIERS FACED

- Unexpected challenges: Some patients more complex than initially thought and may need liaison with MDT/specialist.
- Unexpected challenges: Lack of clarity/guidance from national PCN guidance around which codes to use to capture correct data for IIF targets. Confirmed codes by trial and error and running searches. Some patients have declined treatment; they do not want to start preventative treatment in some cases. All patients deemed to have capacity to decide this.
- Unclear why Aim 2 % is not higher – patients reviewed and all either prescribed DOAC or warfarin. May need to review whether code around DOAC not indicated/declined to be added to records.
- Limited time to carry out reviews, taking longer than expected to review number of patients to reach targets.

SUCCESSES OF THE PROJECT

- Systemic review of patients and significant interventions by project team to optimise anticoagulation treatment, reducing stroke risk and adverse events for patients taking a DOAC
- Improved achievement of QOF/IIF targets, increasing financial reward for the practice and PCN.
- Improved awareness of required clinical coding required to achieve above targets
- Increased efficiency within practice and better use of current staff skill mix
- Shared project implementation plan, amongst colleagues across the PCN so the same process can be carried out at nearby surgeries to improve their management of this cohort of patients and meet required targets
- Sharing of learning with HCP colleagues working in other geographical areas, to help them upskill in this clinical area and raise awareness
- Networking with peers

LEARNINGS FROM THE PROJECT

What worked well:

- Teamwork, being able to split the workload to achieve quick improvement to the QOF target around AF
- Ready-made QOF searches and templates to ensure relevant codes captured
- Support from GP and practice team. Protected time to carry out reviews
- Use of existing searches constructed by Ardens
- Support from PCN Clinical Director
- Access to specialists via HIN
- Positive patient feedback, making positive difference and significant interventions to patient care by optimising anticoagulation
- Access to secondary care haematology specialist via Kinesis for advice about complex clinical situations

AF Case Study

Fellow Name: Marina Lambros

PCN: APL

GP Practice(s): Lyndhurst Road Medical Centre

Bexley

PROJECT AIM & TARGET GROUP

Patients with CHA2DS2-VASc over 2 (or 1 for male patients) who are not on a DOAC and looking in to why this is. If suitable, discuss starting anticoagulation and refer for this to be initiated.

There were 302 patients who fell into this category.

The aim was to initially review 50 patients and ensure those who are suitable for anticoagulation are referred for this to be initiated.

OUTCOMES FROM THE PROJECT

56 patients reviewed.
They were either referred to anticoagulation or exempted as not suitable for referral.

The exemption happened when they had either already tried anticoagulation and this was contraindicated or not tolerated or they had refused a DOAC.

CHALLENGES/ISSUES BARRIERS FACED

- Getting the initial data was difficult as different people presented with different search results, further training on running unique searches would have possibly made the initial stages of the project a lot simpler
- Getting GP and/or pharmacist appointments for patients as they're fully booked quite quickly
- Several patients on warfarin with low TTR had already been trialled on a DOAC but had not tolerated it and had to switch back to warfarin. Further advice needs to be sought from the GP/specialist on how best to manage these patients

SUCCESSES OF THE PROJECT

- Enhanced learning on AF and anticoagulation
- Enjoyed looking at the pros and cons of DOAC vs Warfarin and being able to have a discussion with patients on this using enhanced knowledge on the subject has now been gained
- Positive feedback from the QOF administrator who monitors the data daily. This project has helped free up time to focus on other QOF areas, this in turn has been beneficial for a larger number of our patients

LEARNINGS FROM THE PROJECT

- Learned the importance of taking time out to look into patient's notes in detail to help optimise their care
- If availability permitted to spend longer on each medication review, then the outcomes would be more beneficial for the patient as more clinical areas would be covered and less things would be missed

FH Case Study

Fellow Name: Dr Emily Mei

PCN: West Wandsworth PCN

GP Practice(s): Putneymead Medical Practice

Wandsworth

PROJECT AIM & TARGET GROUP

Patients aged 29 years or under with a total cholesterol greater than 7.5 OR aged 30 years or over with a total cholesterol greater than 9.0 – who has not been assessed / referred for Familial Hypercholesterolaemia.

50 patients were identified from the possible FH search who had not been see to discuss their possible diagnosis / referral.

Aim to review these patients and refer where appropriate.

OUTCOMES FROM THE PROJECT

- Familial Hypercholesterolaemia teaching session to update knowledge and management plan of the clinical team
- The EMIS live alert algorithm identifies 100% of patients at highest risk of FH according to their cholesterol and prompts the clinician to action in real time which benefits over retrospective search

CHALLENGES/ISSUES BARRIERS FACED

- Time needed to complete the project, against demand and workload of being GP
- Other colleagues with different expertise like IT / EMIS protocol / systems analyst
- Systems manager left the practice during the project and lost valuable resource for expertise and advice
- The importance of a protocol to stop flagging to clinician once patient has been referred / if patient declines
- EMIS codes were not up to date with IIF requirements at one point

SUCCESSES OF THE PROJECT

Creation of a new, original protocol for EMIS to identify patients with cholesterol levels meeting FH requirements and alerting the clinician in real time. This will lead to the more prompt identification of at risk patients and lead to earlier referral / management / improvement of cardiovascular risk.

LEARNINGS FROM THE PROJECT

- A protocol based plan to enhance clinical care is one that can be adapted by others in the future. There is additional benefit of integrating the protocol to the electronic patient records
- Artificial intelligence is a valuable tool in supporting the clinician with identifying patients with cholesterol in the FH levels, however it should not distract / burden the clinician, otherwise it becomes a nuisance and reduces uptake

FH Case Study

Fellow Name: Ann-dora Kwame

PCN: North Southwark PCN

GP Practice(s): Bermondsey Neighbourhood Practices

Southwark

PROJECT AIM & TARGET GROUP

It was identified that across 3 practices there was a higher than expected number of patients on the FH register.

The project aimed to review patients on the FH register to confirm diagnosis and ensure appropriate management and referral where needed.

Additionally the project aimed to review patients not on the FH register who fit the Simon Broome criteria for potential FH diagnosis and management. A total of 90 patients fell into these groups across the 3 practices.

OUTCOMES FROM THE PROJECT

- A provisional management plan was devised and reviewed by the SEL Lipid specialist team. A systematic process guide for reviewing patients on the FH register was written.
- Identified 90 patients using the UCLP searches across three practices. 2 of the 3 practices were reviewed during the project, covering 54 patients.
- 40 patients out of the 54 were deemed to be unlikely to have FH.
- 2 patients had a confirmed FH diagnosis, 1 was referred to the lipid clinic, 3 referred for genetic testing, 4 were recommended for reviews. Coding was changed for 5 patients.

CHALLENGES/ISSUES BARRIERS FACED

- The review was time consuming as patient notes were not always clear – up to one hour per patient.
- Obtaining family history from notes could be a challenge, with patients having to be contacted for further information.
- Coding was identified as an issue.

SUCCESSES OF THE PROJECT

- FH register cleansed to better reflect actual FH patients.
- Better understanding of the FH pathway.
- Practice team educated on FH.
- PCN clinical directors keen to employ a PCN CVD lead to support management of CVD related conditions and improve education in this area across the PCN.
- Push to broaden this work to other practices in the PCN.

LEARNINGS FROM THE PROJECT

- Education and training for all primary care clinicians to support FH diagnonis and management should be made available, as misdiagnosis was identified as an issue
- Better coding is needed with FH patients
- It is important to exclude secondary causes of cholesterol before referral to FH specialist clinics.
- FH patients requiring 5-yearly follow ups with lipid clinicals need to be noted.

Vaxi Taxi Health and Wellbeing Pop Ups

Fellow Name: Dr. Sharon Raymond

Crisis Rescue Foundation

Croydon

PROJECT AIM & TARGET GROUP

This project aimed to help reduce inequalities by conducting BP & BMI checks at health and wellbeing pop ups in south London. The project aimed to reach people with previously undetected and untreated CVD risk in communities with barriers to accessing the NHS, including those not registered with a GP and communities with barriers to accessing the NHS eg homeless, refugees, asylum seekers, sex workers etc

OUTCOMES FROM THE PROJECT

- Delivered 7 pop ups with BP checks in south London including at foodbanks, a festival, a homeless shelter, and community centres
- 202 BP checks were conducted
- 69 people – or 34% - had high blood pressure, above 140/90. They were referred to a GP for further support

CHALLENGES/ISSUES BARRIERS FACED

- No fixed team for pop ups
- Preparation for pop ups is extensive, including clarifying aim and SOP with stakeholders for each pop up, working with local stakeholders and staff to ensure smooth running, correct location, etc
- Briefing those staffing each pop up each time
- Ensuring each event is bespoke / meets local need i.e. interpreters, mental health information etc
- Engaging key staff from ICB in commissioning / getting involved

SUCCESSES OF THE PROJECT

- Large number of people seen with awareness of CVD increased
- Signposting to resources and support, to help enable patient autonomy and self care
- Mental health / general wellbeing checks also given at the pop ups
- Information given re BMI, diabetes risk reduction, signposting to other services
- Providing lunches, toiletries, transport (specifically a Taxi), clothing and other support
- *"A kind of medical Glastonbury taking NHS healthcare outside of the GP surgery walls and into the hearts of communities, thereby engaging people in getting more involved in their own health and wellbeing"*

LEARNINGS FROM THE PROJECT

- Importance of regularly liaising with key local services, including NHS, council, voluntary services, community organisations etc to help in planning a bespoke health and wellbeing event that meets the needs of potential service users, in particular groups experiencing barriers to accessing NHS care.
- The need to work through each step in the standard operating procedure for each event.
- The need to prepare for hitches that may arise in advance where these can be anticipated.

Get in touch

For more information on the CVD Prevention Fellowship Programme email us at hin.cvd@nhs.net or check out our website at www.healthinnovationnetwork.com

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