HIN 2023 CVD Fellowship Data and Searches

Welcome! Please introduce yourself in the chat

Tuesday 21st August 2023

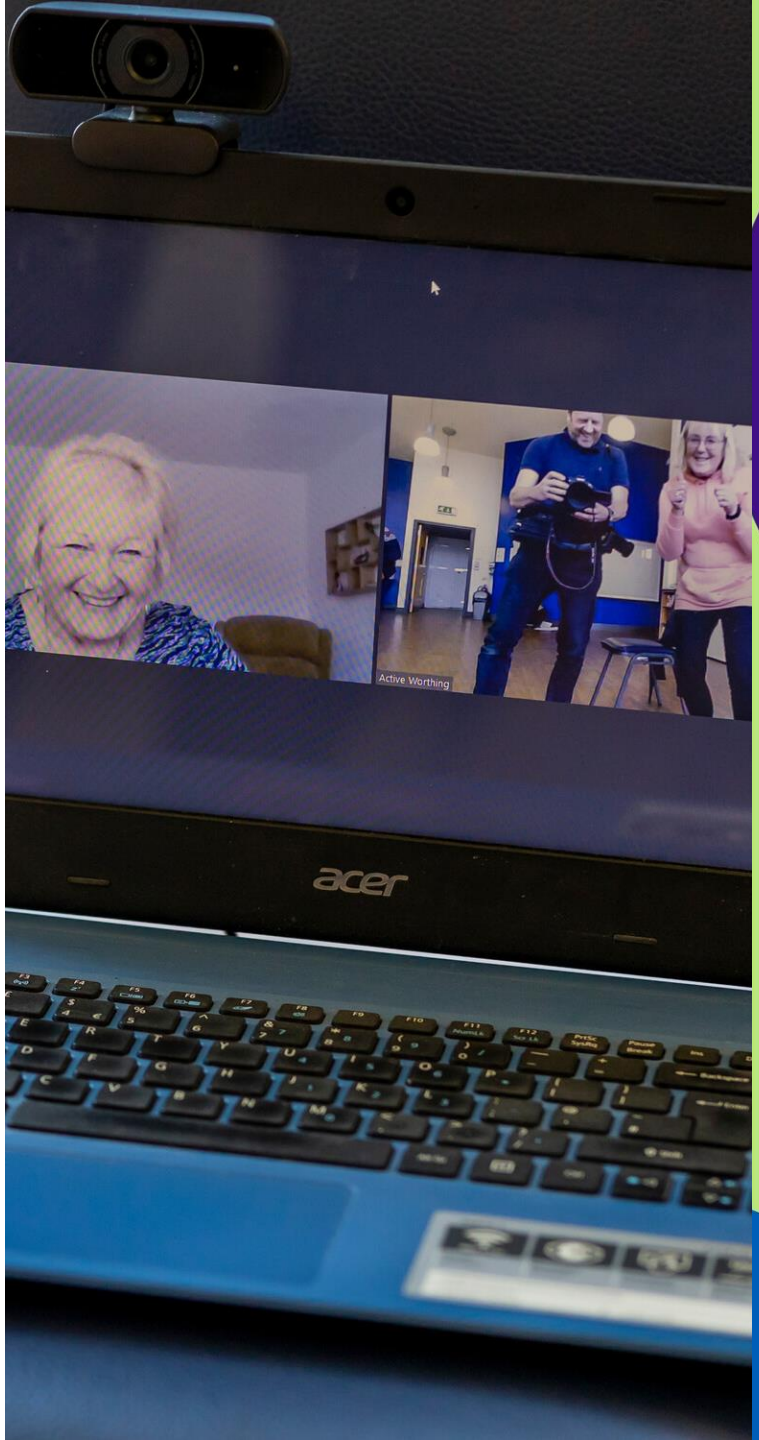
@HINSouthLondon

healthinnovationnetwork.com

Health Innovation Network South London

Housekeeping

- Please keep your microphone on mute when you're not speaking
- We will be recording today's session and for anyone who isn't able to join and other HIN Fellows
- Feel free to use the chat for any questions



Agenda

1. Welcome – Kristina Leonnet
2. UCLP Frameworks and Searches – Dr. Deep Shah, UCLPartners
3. Other data sources
4. 2022 Fellow experience – Faiza Usami
5. What next, and Wrap Up

Quality Improvement Project – First Steps

- Chosen clinical area –
  - Hypertension
  - CKD
  - Atrial Fibrillation
  - Lipids including FH
  - Heart Failure *Note new project option*

- **If you haven't chosen yours or are looking to change – need to do this by in person event 8th of September & let us know**

01

UCLP Frameworks and Searches

Dr Deep Shah

UCLPartners Proactive Care Framework for Hypertension

Doing things differently and at scale in primary care

UCLPartners

Cardiovascular Disease Prevention – A National and Local Priority

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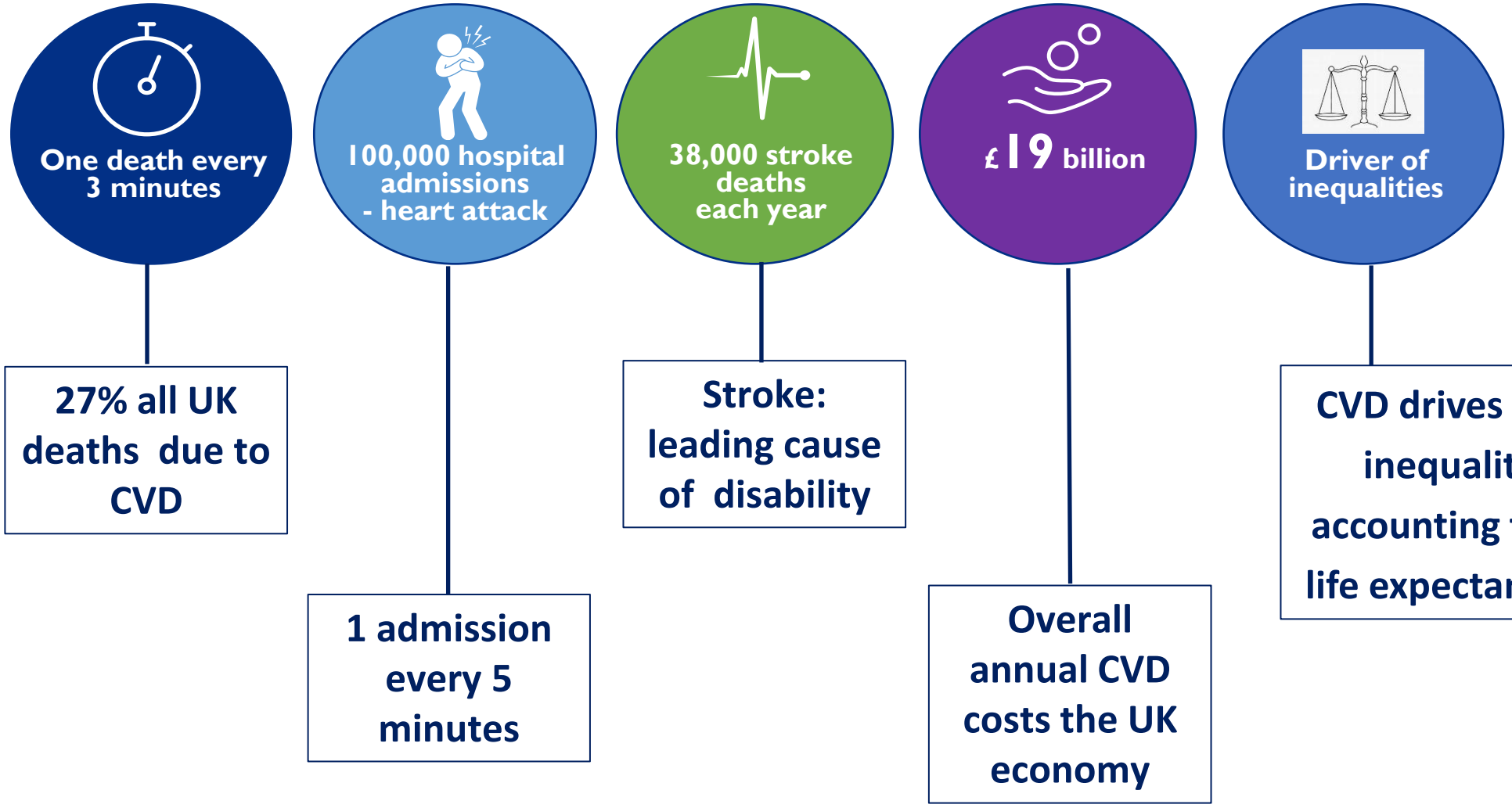
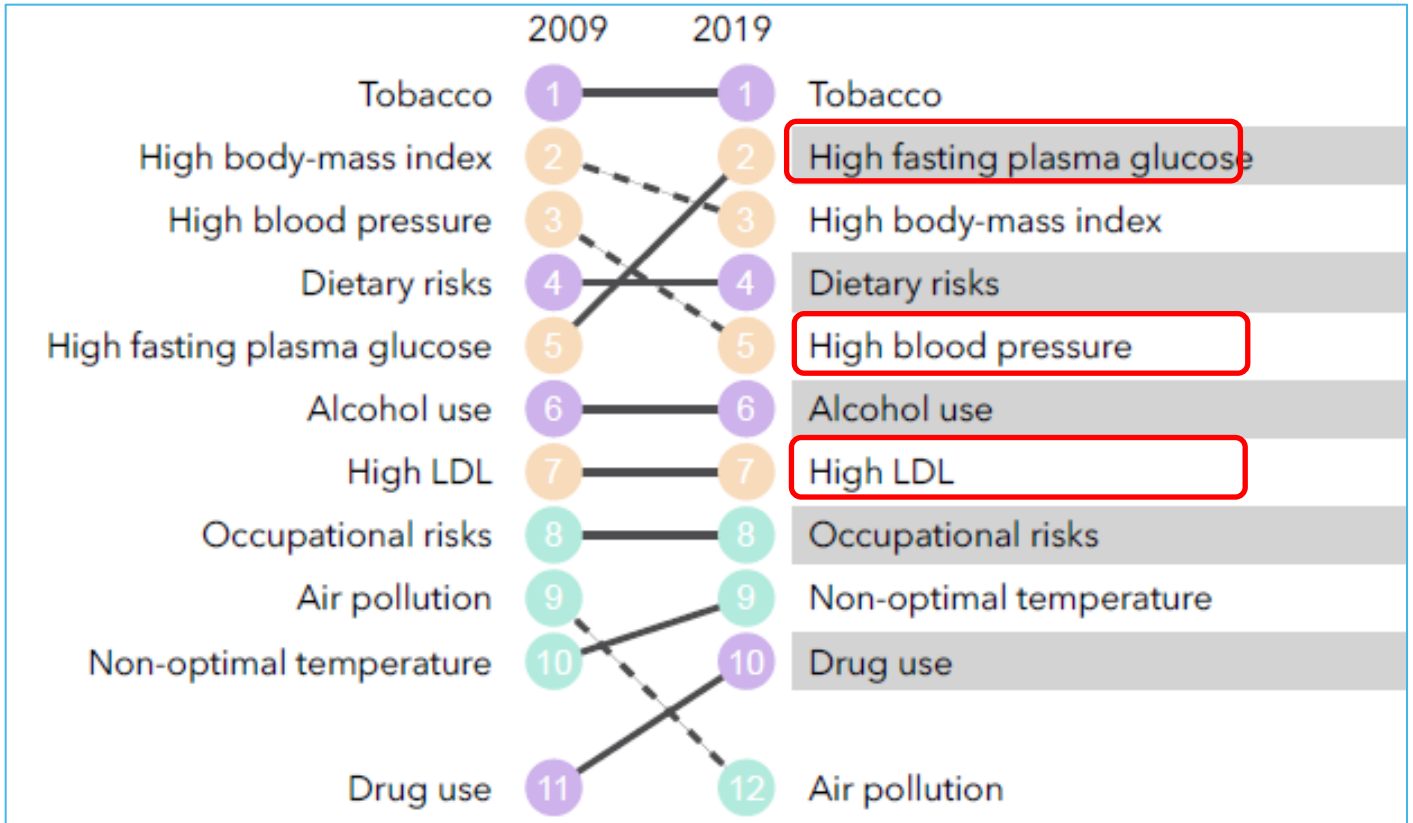


But CVD is highly preventable…

Risk factors that drive most premature death and disability*

England

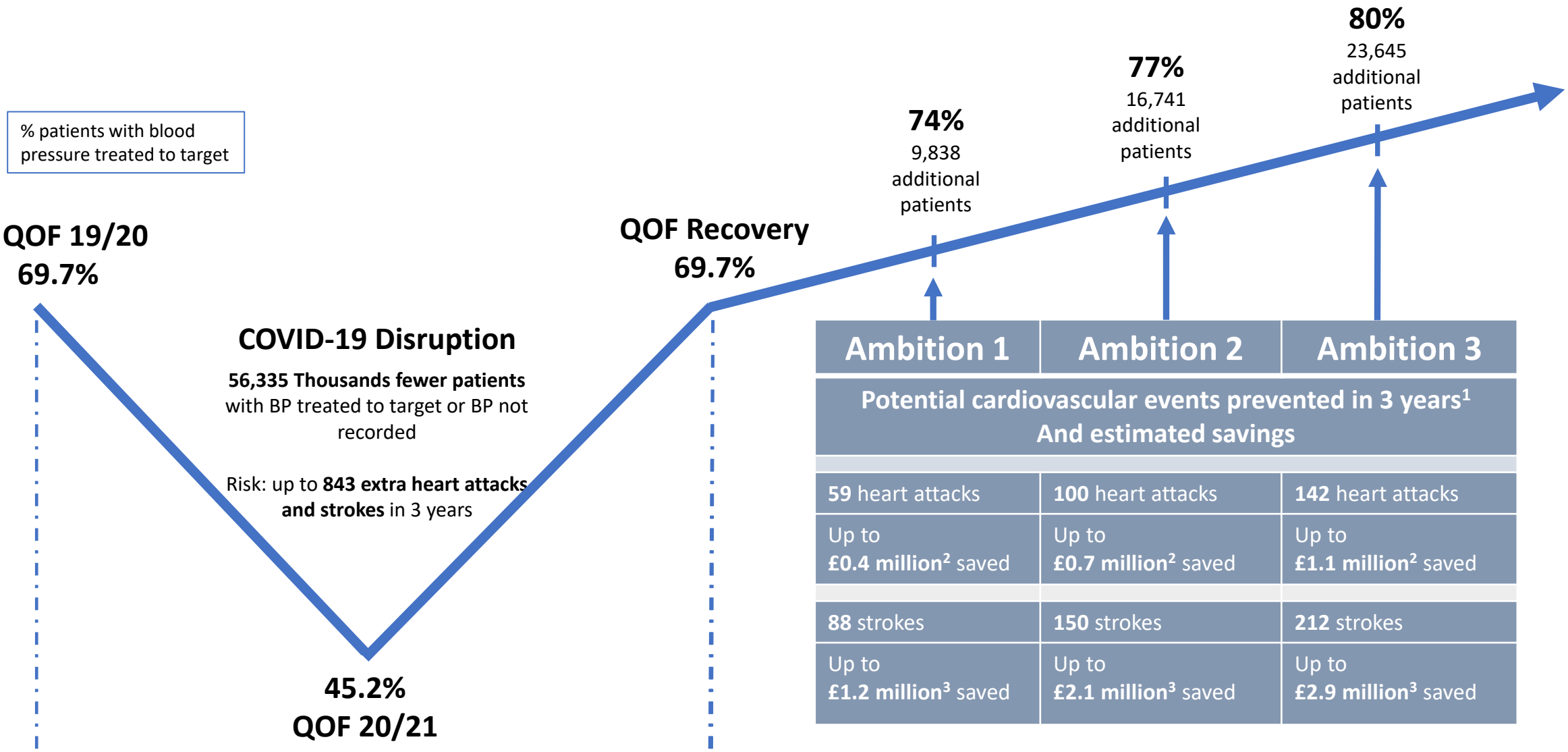


Treatment of high impact risk factors for CVD is very effective at preventing mortality and morbidity.
But under detection and under treatment is common.

*Global Burden of Disease Study 2019

Size of the Prize – Our Healthier South East London
BP Optimisation to Prevent Heart Attacks and Strokes at Scale

UCLPartners



Ambition 1	Ambition 2	Ambition 3
Potential cardiovascular events prevented in 3 years[1] And estimated savings		
59 heart attacks	**100** heart attacks	**142** heart attacks
Up to **£0.4 million[2]** saved	Up to **£0.7 million[2]** saved	Up to **£1.1 million[2]** saved
88 strokes	**150** strokes	**212** strokes
Up to **£1.2 million[3]** saved	Up to **£2.1 million[3]** saved	Up to **£2.9 million[3]** saved

References
1. Public Health England and NHS England 2017 Size of the Prize
2. Royal College of Physicians (2016). Sentinel Stroke National Audit Programme. Cost and Cost-effectiveness analysis.
3. Kerr, M (2012). Chronic Kidney disease in England: The human and financial cost

Modelling
Data source: NCVIN 2021. Briefing note: QOF 2020/21 Management of hypertension – HYPALL metric (HYP003 + HYP007). Potential events calculated with NNT (theNNT.com). For blood pressure, anti-hypertensive medicines for five years to prevent death, heart attacks, and strokes: 1 in 100 for heart attack, 1 in 67 for stroke.

The Challenge:
COVID-19 disruption and historical lack of capacity in primary care

Real World Primary Care:

- Complexity, multimorbidity and time pressures
- Soaring demand and shifting priorities
- Imminent winter pressures

Pandemic impact:

- Disruption of routine care in long term conditions
- Risk of poorer outcomes for patients and health inequalities
- An increase in health care demand

Historical challenge in long term condition care

- Late diagnosis, suboptimal treatment, unwarranted variation
- Lack of self management support
- Holistic care not always provided

UCLPartners Proactive Care
A Framework to address critical challenges in primary care

Aim

To improve care and free up capacity

Objectives

1. Support GPs to safely manage workflow and release capacity
2. Identify patients whose care needs optimising and start with those at highest risk
3. Systematic delivery of holistic proactive care by wider primary care workforce

Framework components

1. Systematic risk stratification & prioritisation tools
2. Locally adaptable resources to guide real world management of long-term conditions
3. Systematic use of wider primary care team (including ARRS roles) to deliver:
   - Structured proactive care
   - Structured support for education, self-management and behaviour change

Framework Development

1. Led by primary care clinicians
2. Based on NICE guidelines and clinical consensus
3. Patient and public support

Atrial Fibrillation, Blood Pressure, Cholesterol, Type 2 Diabetes, COPD, Asthma, Severe Mental Illness

UCLP Proactive Care Frameworks Overview: Cardiovascular Conditions

Healthcare Assistants/Health & Wellbeing Coaches and other trained staff

Self management e.g.	Education (signposting online resources), self care (eg BP measurement, foot checks, red flags), signpost shared decision-making resources (eg statins, anticoagulants)
Behaviour change e.g.	Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol
Support holistic care	Identify wider needs and signpost to eg social prescriber, care coordinator
Gather information e.g.	Up to date bloods, BP, weight, smoking status, run risk scores: QRISK, ChadsVasc, HASBLED

Risk Stratification & Prioritisation

- **Atrial Fibrillation**
- **Blood Pressure**
- **Cholesterol**
- **Diabetes**

Prescribing Clinician

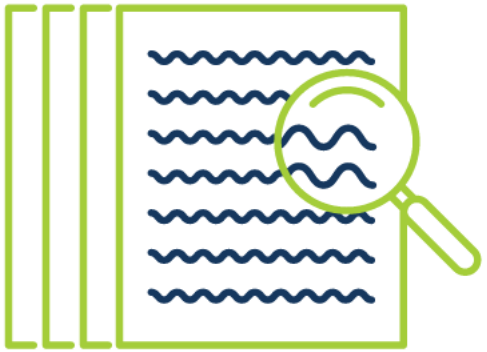
Optimise therapy and mitigate risk

1. Review blood results, risk scores & symptoms
2. Initiate or optimise therapy
3. Check adherence and adverse effects
4. Review complications and co-morbidities
5. CVD risk – BP, cholesterol, pre-diabetes, smoking, obesity

Frameworks to support primary care transformation

www.uclpartners.com/proactive-care

Discover support available to help with:



Search and risk stratification

Tools that can be used with EMIS (and SystmOne to follow), accompanied by user guidance. **View and download our search and risk stratification tools.**

Workforce education and training

Including protocols, guidance, videos and virtual training sessions to upskill the breadth of primary care team members to proactively support patients.

Digital resources

A selection of a clinically appraised digital resources to support patient activation and self-management in the home setting.

https://uclpartners.com/our-priorities/cardiovascular/proactive-care/

Search and risk stratification tools

CVD resources

Join the Proactive Care mailing list

Search and risk stratification tools

Please complete the form below to access the following tools:

- **UCLPartners Proactive Care Search and Stratification tools** – These tools support the Proactive Care Frameworks. Please select search tools required.
- **UCLPartners Long Term Conditions Recovery Search and Stratification tools** – These tools support the June 2022 RCGP Guidance on Long Term Condition Recovery and were commissioned by NHS @home as part of its broader work to support long term condition recovery.

The tools have been developed by our clinical team, working with the Clinical Effectiveness Group based at Queen Mary University of London. The search criteria draw on national guidance.

- Supporting resources

Salutation

Search and risk stratification tools

CVD resources

Join the Proactive Care mailing list

Introduction

Cardiovascular disease (CVD) contributes to a quarter of all deaths in people under the age of 75 and accounts for a quarter of the life expectancy gap between the rich and poor.

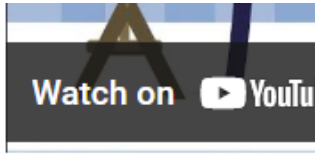
The NHS Long Term Plan sets the ambitious target of preventing 150,000 cases of heart attacks, strokes, and dementia over ten years, optimising the detection and management of atrial fibrillation, high blood pressure and high cholesterol.

Our Proactive Care Frameworks provide a platform for optimising clinical care and self-care for people with these high-risk conditions, supporting primary care teams to do things differently and at scale.

The following slide packs include pathways and resources to support clinicians treating patients with single or multiple cardiovascular conditions.

- Atrial Fibrillation
- Hypertension
- Lipid management including Familial Hypercholesterolaemia
- Type 2 diabetes

Protocols



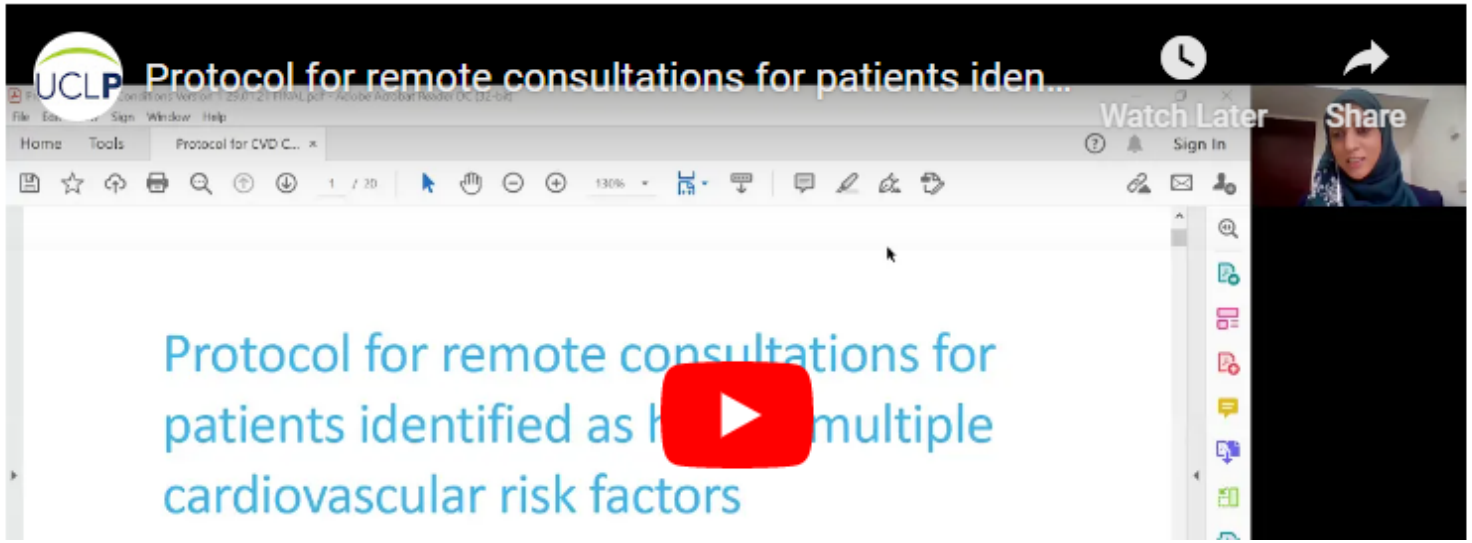
This video was cr
Punjabi, Bengali,
Kurdish Sorani, F
the full playlist.

The following protocols (suggested wording) to guide consultations could be used by Health Care Assistants (HCA), social prescribers, pharmacy technicians, physician associates or health and wellbeing advisors, depending on what workforce is available in your practice or PCN.

These are relevant to all of the conditions and can support management of low, medium and high risk categories.

- Patients identified as having multiple cardiovascular risk factors
- Type 2 Diabetes

The videos below goes through each protocol in detail and how to use them.



Education, training and resources to support self-management and behaviour change

Hypertension: stratification and management

UCLPartners

Healthcare assistants/ARRs roles e.g. social prescribers

Stratification & Prioritisation

Prescribing Clinician

Gather information e.g. Up to date bloods, BP, weight, smoking status, run QRISK* score

Self management e.g. Education (blood pressure, CVD risk), self care (e.g. BP measurement), sign post self care resources

Behaviour change e.g. Brief interventions and signposting e.g. smoking, weight, diet, exercise, alcohol

Priority One	**Priority Two**	**Priority Three**	**Priority Four**
BP >180/120mmHg**	2a. BP >160/100mmHg** 2b. BP >140/90mmHg** if BAME AND CV risk factors or co-morbidities* 2c. No BP reading in last 18 months	3a. BP >140/90mmHg** if BAME OR CV risk factors or comorbidities* 3b. BP >140/90mmHg** or >150/90mmHg** if ≥ 80 years	4a. BP <140/90mmHg** under age 80 years 4b. BP <150/90mmHg** aged ≥ 80 years

Optimise anti-hypertensive therapy and CVD risk reduction

1. Review: blood results, risk scores & symptoms
2. Check adherence and adverse effects
3. Review complications and co-morbidities
4. Initiate or optimise blood pressure medication
5. CVD risk – optimise lipid management and other risk factors

*QRISK 3 score is recommended to assess CV risk for patients with Severe Mental Illness, Rheumatoid Arthritis , Systemic Lupus Erythematosus, those taking antipsychotics or oral steroids

* / ** see slide 9

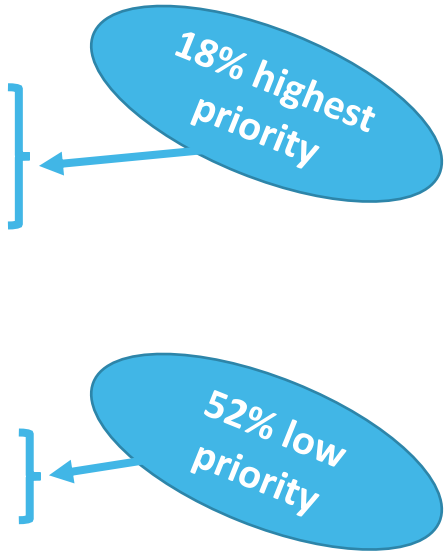
Example modelling (One London borough)

- Informs workflow and workforce planning
- Helps GPs meet QOF and other targets
- Shift between priority groups over time shows clinical impact

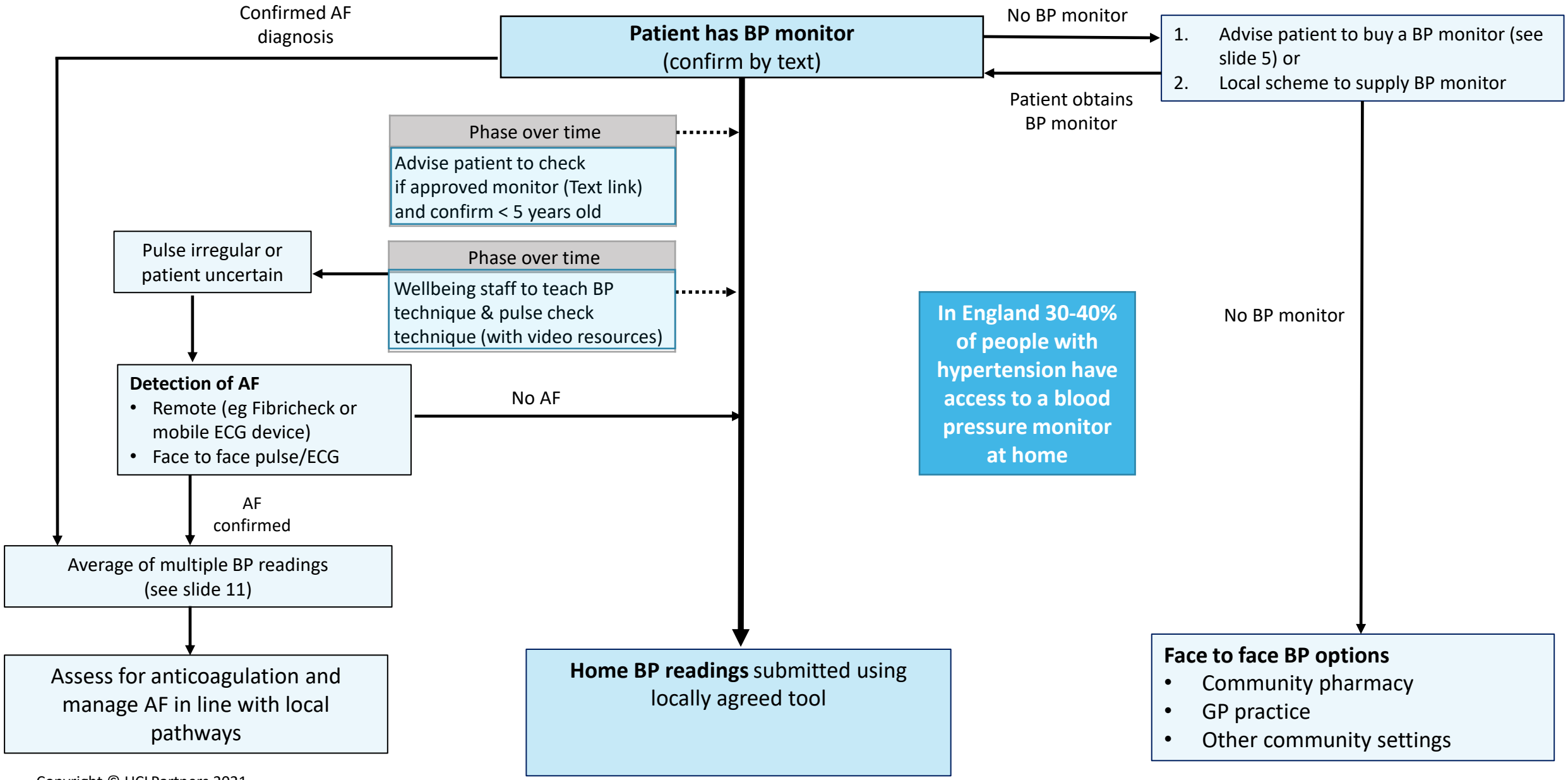
Borough level searches

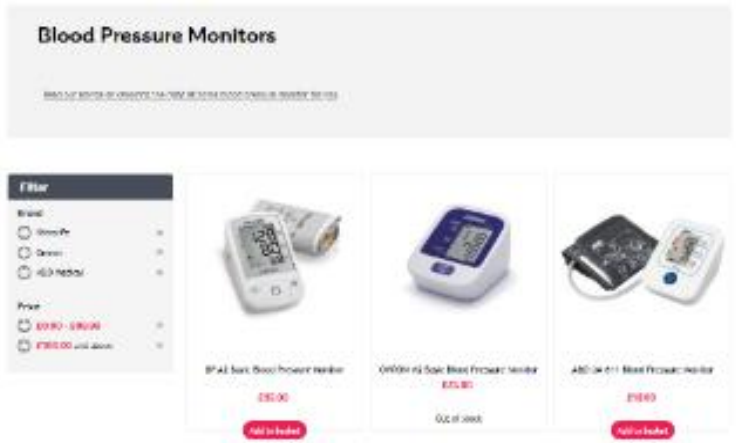
Total Population: ~446,000
Hypertension: 40,155

Priority Group	Definition	No. of patients	%
PRIORITY 1	Clinic BP ≥180/120mmHg	541	1%
PRIORITY 2a	Clinic BP ≥160/100mmHg	2,756	7%
PRIORITY 2b	Clinic BP ≥140/90mmHg and BAME + additional CV risk factor	3,827	10%
Priority 2c	No BP reading in last 18 months	5,902	15%
Priority 3a	Clinic BP ≥140/90mmHgBP if BAME or CVD, CKD, diabetes	3,818	10%
Priority 3b	BP ≥140/90mmHg - all other patients	2,347	6%
Priority 4a	BP < 140/90mmHg (under 80 years)	18,013	45%
Priority 4b	BP < 150/90mmHg (80 years and over)	2,951	7%

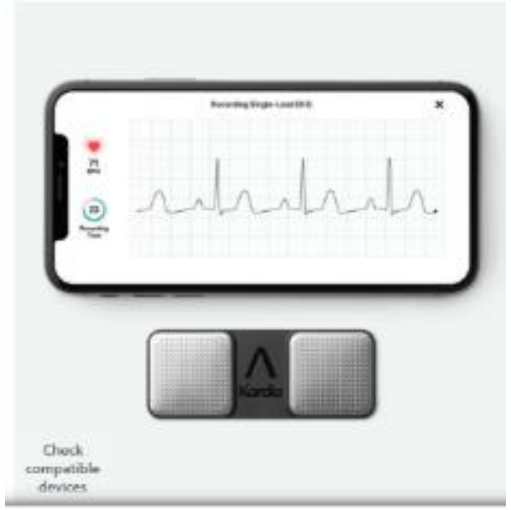


Home Blood Pressure Monitoring Pathway





KardiaMobile



Resources to support remote management

Lifestyle Modifications

Modification	Recommendation	Approximate Systolic Blood Pressure Reduction (mm Hg)[a]
Weight loss	Maintain normal body weight	5–20 per 10-kg weight loss
DASH-type diet*	Consume a diet rich in fruits, vegetables, and low-fat dairy products with reduced saturated and total fat	8–14
Reduced salt intake	Reduce daily dietary sodium intake	2–8
Physical activity	Regular aerobic physical activity (at least 30 min/day, most days of the week)	4–9
Moderation of alcohol intake	Limit consumption to 2 drinks/day in men and 1 drink/day in women and lighter-weight persons	2–4

*DASH, Dietary Approaches to Stop Hypertension. Effects of implementing these modifications are time and dose dependent and could be greater for some patients.

Vooradi S, Mateti UV. A systemic review on lifestyle interventions to reduce blood pressure. J Health Res Rev [serial online] 2016 [cited 2021 Apr 27];3:1-5. Available from: https://www.jhrr.org/text.asp?2016/3/1/1/173558

In monotherapy, most drugs achieve systolic BP reductions of ~ 10 to 15 mmHg

https://journals.lww.com/md-journal/Fulltext/2016/07260/Treatment_efficacy_of_anti_hypertensive_drugs_in.16.aspx

Wider Workforce to Support Proactive Care

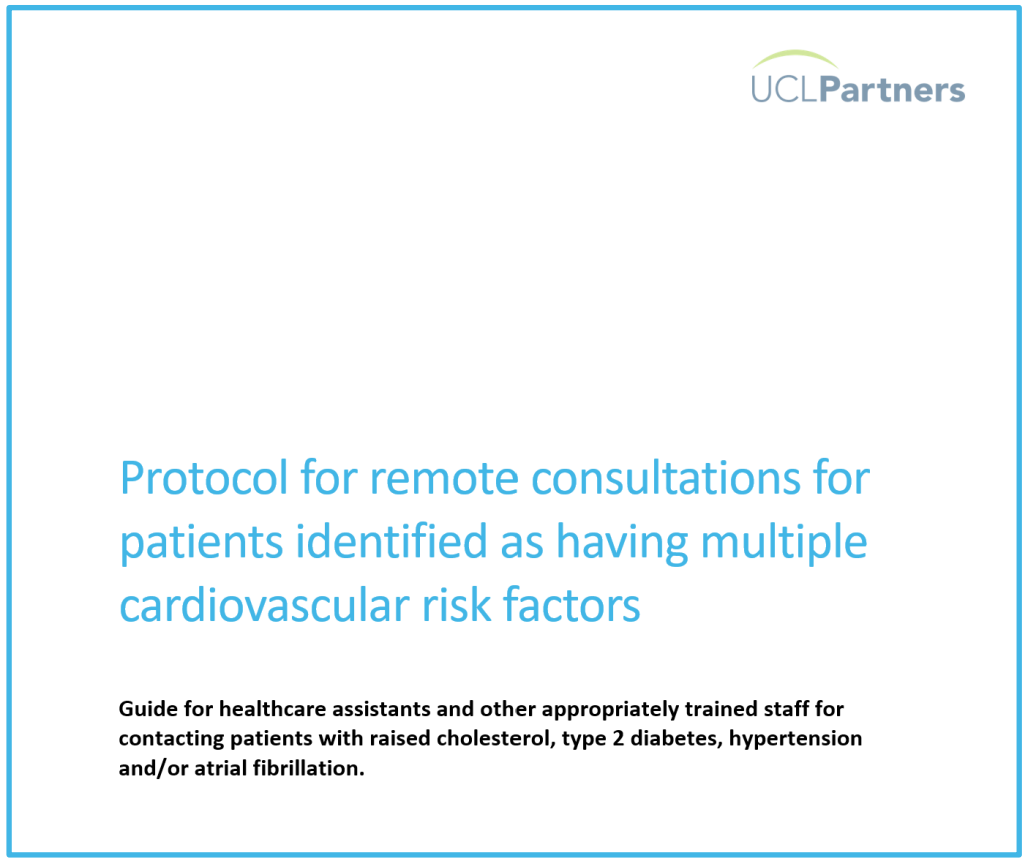
The wider workforce consists of:

- Healthcare assistants
- Health and Wellbeing Coaches
- Pharmacy Technicians
- Social Prescribing Link Workers
- Care Coordinators
- Nursing Associates

As well as…

- Physician Associates
- Clinical Pharmacists
- First Contact Physiotherapists
- Dieticians
- Podiatrists
- Occupational therapists
- Mental Health Practitioners

Resources for wider workforce to support patient care



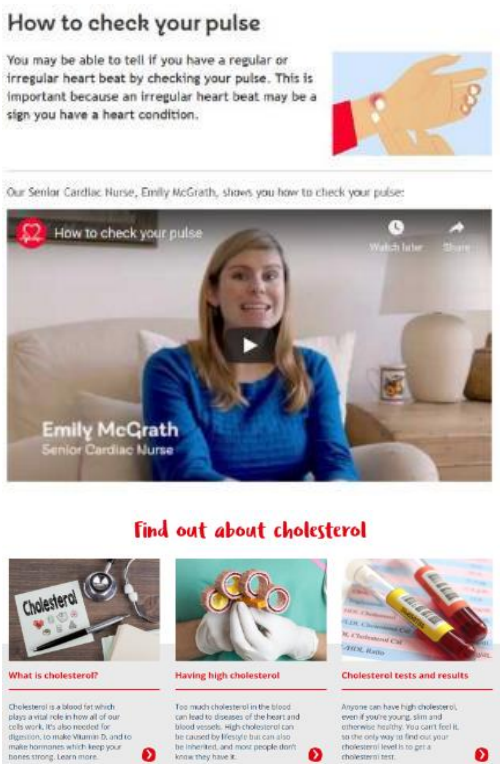
Guidance and resources for staff such as healthcare assistants, wellbeing coaches, and others delivering:

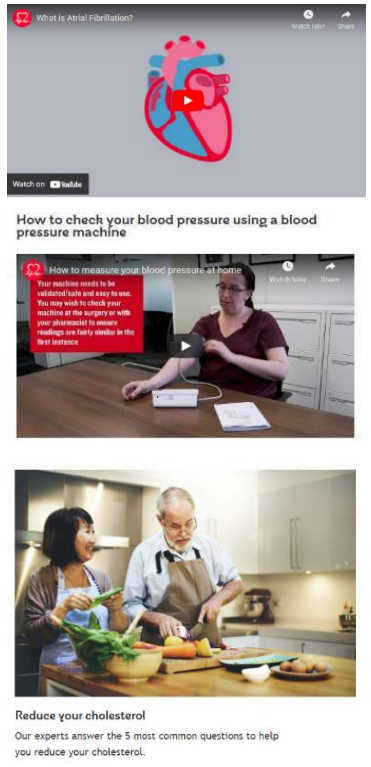
- Education
- Self management support
- Brief interventions for behaviour change e.g. smoking cessation, weight management

Why Utilise the Wider Workforce

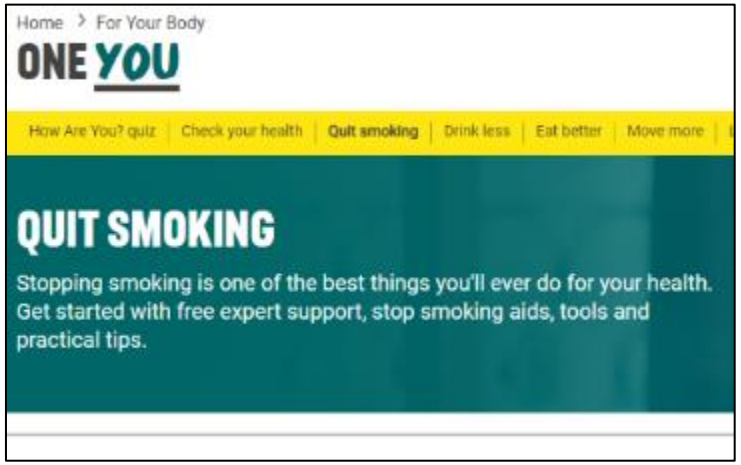
- Utilising a wider workforce is part of the 2019 NHS Long Term Plan.
- Assigning specific tasks to other members of the primary care team ensures GPs and other prescribing clinicians can focus on providing high quality clinical care.
- With appropriate training, these roles will have more time to provide:
  - Personalised care
  - Support education/self-management/behaviour change
  - Address patients' wider concerns, signposting to relevant clinical staff where necessary.

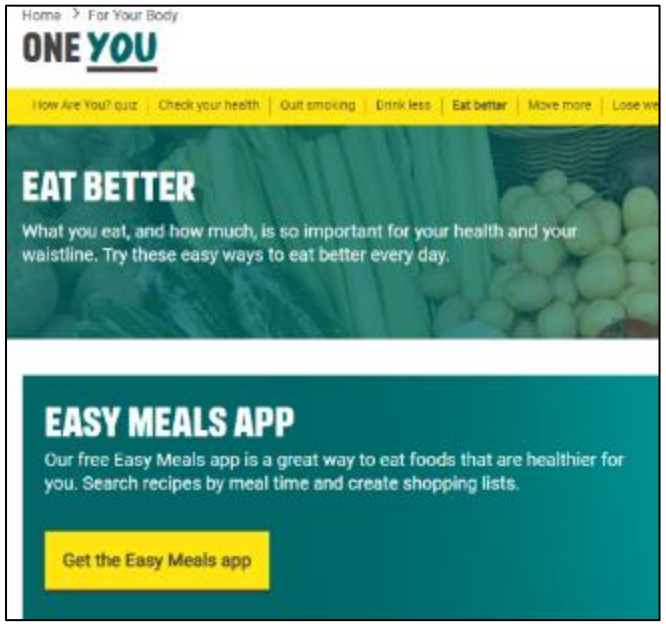
Resources for patients – supporting education and self-management

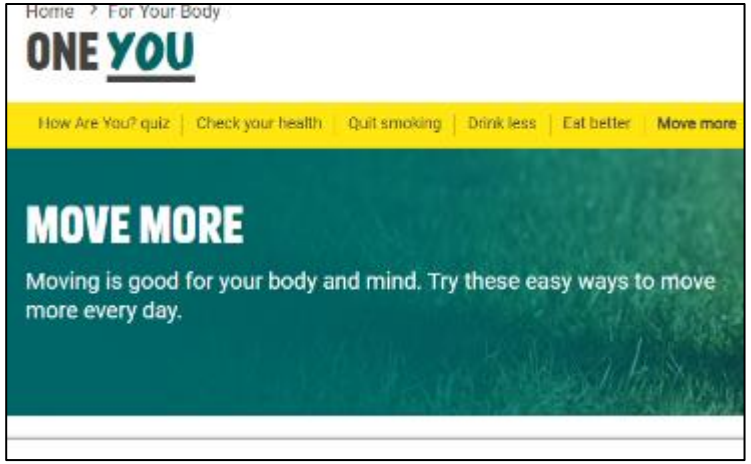


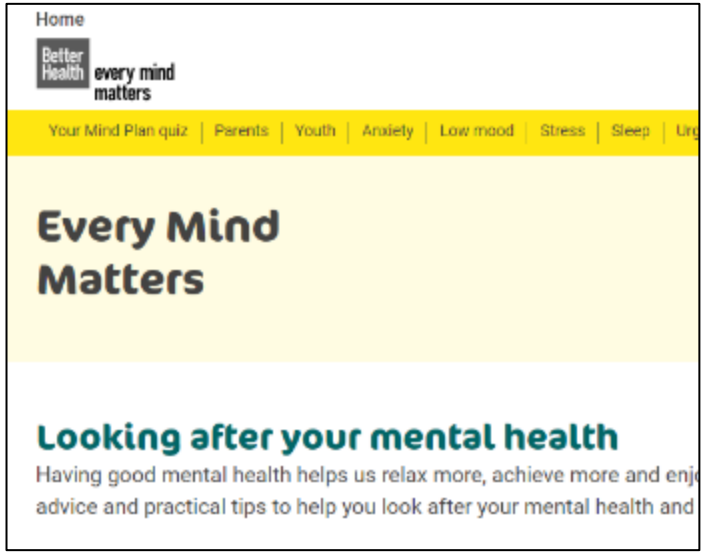


Resources to support behaviour change



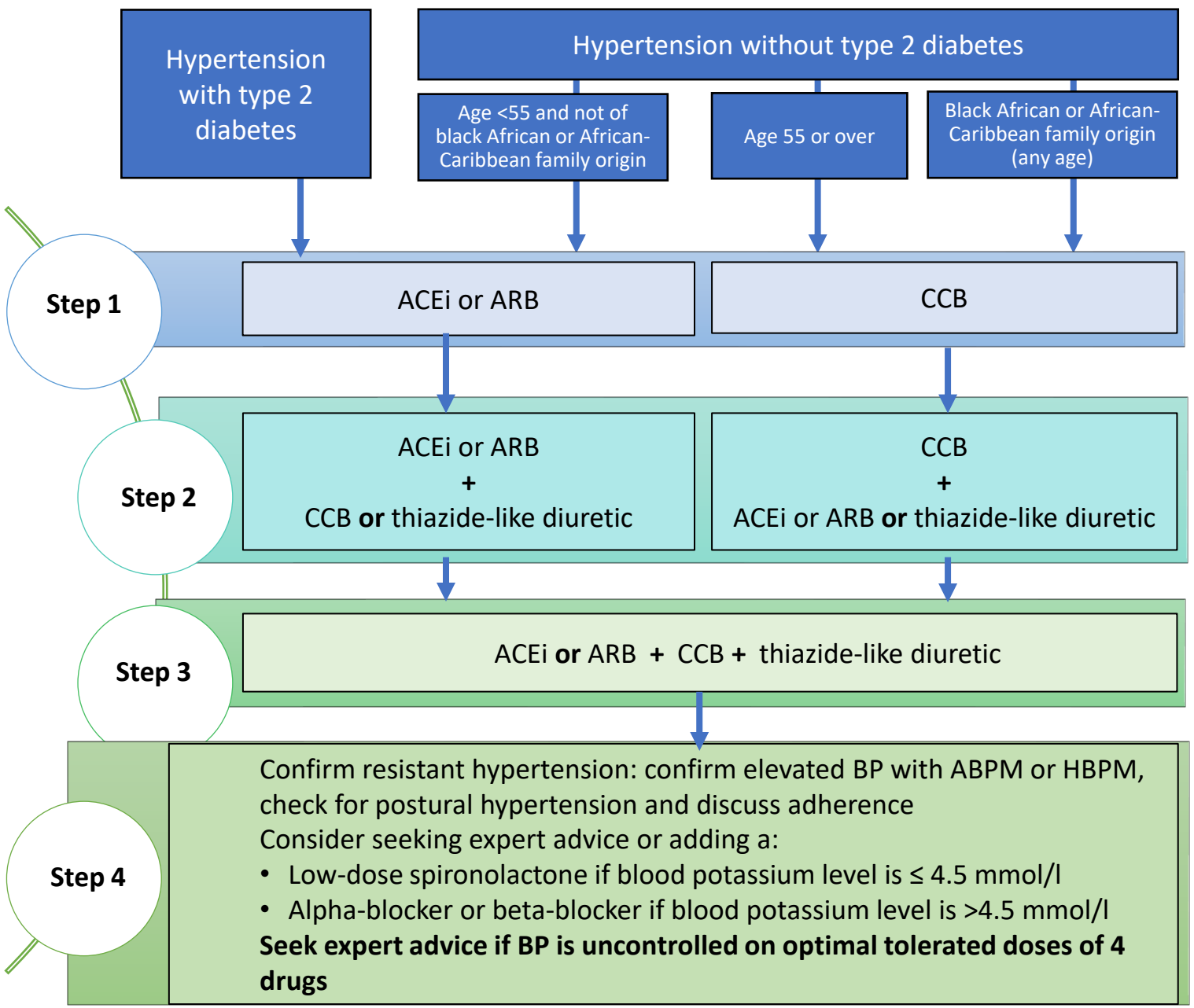






NICE Hypertension Treatment Pathway (NG136)

UCLPartners



Use clinical judgement for people with frailty or multimorbidity

Offer lifestyle advice and continue to offer it periodically

Monitoring treatment

Use clinic BP to monitor treatment
Measure standing and sitting BP in people with:

- Type 2 diabetes or
- Symptoms of postural hypotension or
- Aged 80 and over

Advice people who want to self monitor to use HBPM. Provide training and advice

Consider AMPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension

BP targets

Reduce and maintain BP to the following targets:

Age <80 years:
- Clinic BP <140/90 mmHg
- ABPM/HBPM <135/85mmHg

Postural hypotension:
- Base target on standing BP

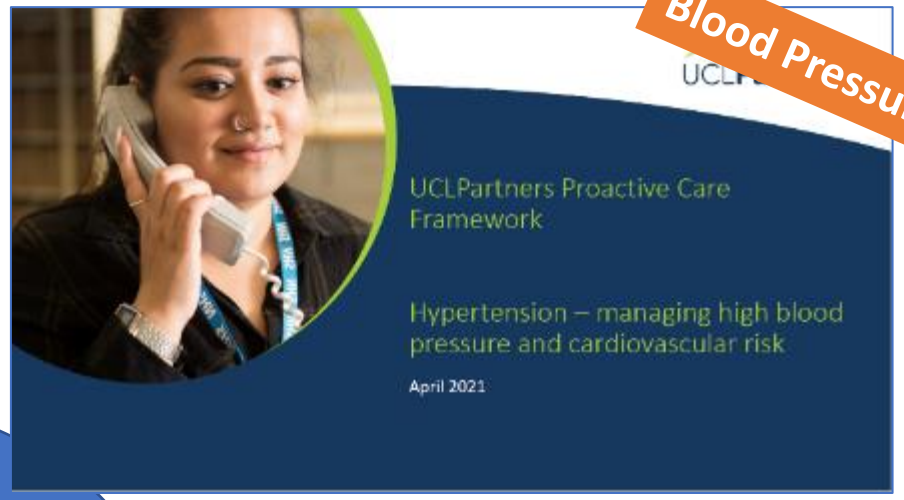
Frailty or multimorbidity:
- Use clinical judgement

Pathway adapted from NICE Guidelines (NG136) Visual Summary
https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517
Abbreviations: ACEi: ACE inhibitor, ARB: Angiotensin II Receptor Blocker, CCB: Calcium Channel Blocker, ABPM: Ambulatory Blood Pressure Monitoring, HBPM: Home Blood Pressure Monitoring

Resources for clinicians – supporting co-morbidity management

Atrial Fibrillation

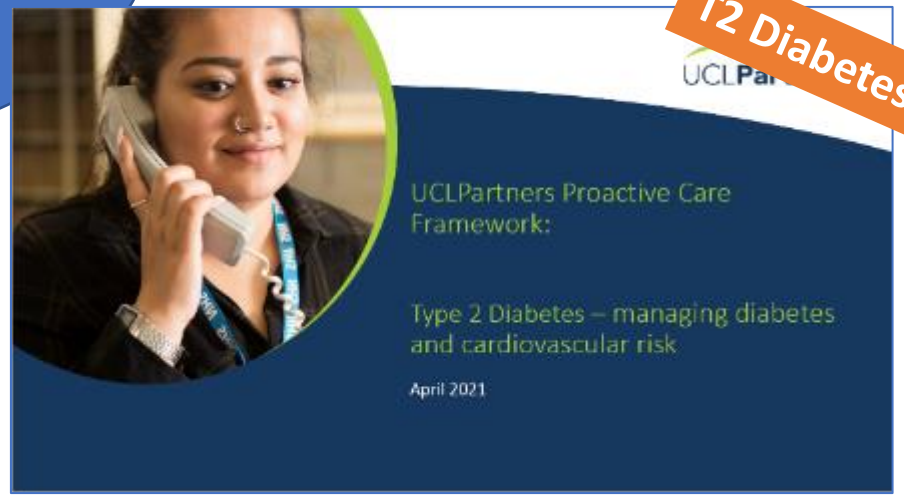
Blood Pressure



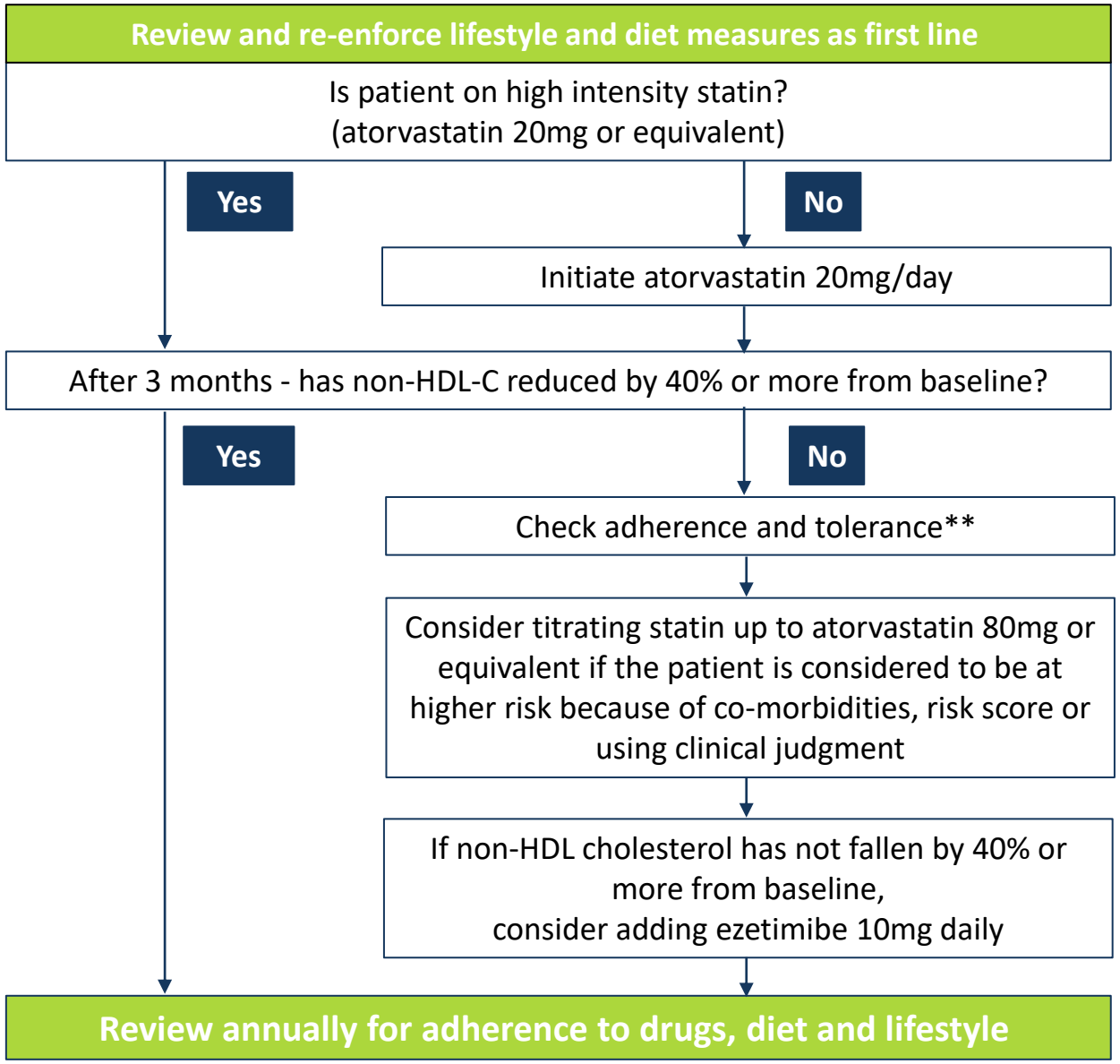
BP & Lipid management included in pathways for AF, BP, cholesterol and T2 Diabetes

Cholesterol

T2 Diabetes



Optimisation Pathway for Patients with High Cardiovascular Risk* – Primary Prevention



Optimal High Intensity statin for Primary Prevention (High intensity statins are substantially more effective at preventing cardiovascular events than low/medium intensity statins)	
Atorvastatin	20mg
Rosuvastatin	10mg

* High cardiovascular risk:

- QRisk >10% in ten years
- CKD 3-5
- Type 1 Diabetes for >10 years or over age 40

** If statin not tolerated, follow statin intolerance pathway and consider ezetimibe 10mg daily +/- bempedoic acid 180mg daily

Statin Intensity Table – NICE recommends Atorvastatin and Rosuvastatin as First Line

Approximate Reduction in LDL-C					
Statin dose mg/day	5	10	20	40	80
Fluvastatin			21%	27%	33%
Pravastatin		20%	24%	29%	
Simvastatin		27%	32%	37%	42%
Atorvastatin		37%	43%	49%	55%
Rosuvastatin	38%	43%	48%	53%	
Atorvastatin + Ezetimibe 10mg		52%	54%	57%	61%

Low/moderate intensity statins will produce an LDL-C reduction of 20-30%

Medium intensity statins will produce an LDL-C reduction of 31-40%

High intensity statins will produce an LDL-C reduction above 40%

Simvastatin 80mg is not recommended due to risk of muscle toxicity

Shared Decision-Making Resources

Benefits per 10,000 people taking statin for 5 years	Events avoided
Avoidance of major CVD events in patients with pre-existing CVD & a 2mmol/l reduction in LDL	1,000
Avoidance of major CVD events in patients with no pre-existing CVD & a 2mmol/l reduction in LDL	500

Adverse events per 10,000 people taking statin for 5 years	Adverse events
Myopathy	5
Haemorrhagic Strokes	5-10
Diabetes Cases	50-100

Shared decision-making resources:

- BHF information on statins
- Heart UK: Information on statins
- NICE shared decision-making guide

Collins et al 2016 Lancet Systematic Review Lancet 2016; 388: 2532–61

UCLP Resources

1. Comprehensive search & stratification tools for EMIS and SystmOne
2. Protocols for HCA and similar roles to provide structured support for patient education, self management and behaviour change
3. Slide sets for clinicians – focus on the ***how to*** of optimising clinical management in real world primary care
4. Workforce training framework
5. Implementation guidance
6. Case studies
7. Digital resources for staff and patients
   - Understanding your condition
   - How to …… check your BP, check your feet, identify red flags etc
   - New technologies eg Healthy.io, fibricheck
   - Brief interventions eg smoking, diet, activity
   - Videos – eg running the search tools

www.uclpartners.com/proactive-care/

02

Other Data Sources

Kristina Leonnet

Your Project

- What clinical area is your project focusing on?
  - Hypertension
  - Lipids
  - FH
  - CKD - CVD Prevention
  - AF
  - Heart Failure *note new project option*
  - Not sure as yet

Please fill in the quick survey or if can't access this, put in the chat

Data sources

- Data to help you in choosing your project's focus area

  - HIN Fellowship Data Dashboard
  - BHF data
  - CVD Prevent
  - HIN Protected Characteristics Dashboard
  - QOF data

High Blood Pressure - a British Heart Foundation Resource - ICS report

South East London

E54000030 - 199 practices

no change from final STP geography

Did you know...?

28% of adults in the UK have high blood pressure (HBP; hypertension)

...that's 15 million adults

...at least half are not receiving effective treatment and millions are likely to be undiagnosed

Around **HALF** of heart attacks and strokes in the UK are associated with high blood pressure

High blood pressure is the leading modifiable risk factor for heart and circulatory diseases (CVD) in the UK **#1**

Refs (this column): latest health surveys (NHS Digital, Scottish Government) & BHF estimates; Global Burden of Disease (GBD) latest estimates

If you would like copies of our GP resource, or have any queries, please contact: HSITeam@bhf.org.uk

For more statistics and health intelligence visit: *www.bhf.org.uk/statistics*

Blood pressure - numbers for your area

Patients aged 45+ with a blood pressure reading (in the previous 5 years)

Your Area	England	QOF Code	Patients	PCAs	Done	%	to do
83%	85%	BP002	725,272	7,709	606,846	83%	110,717

Diagnosed HBP

13% of adults 18+ in your ICS area

England 16%

CVDP001HYP

MALE 13% FEMALE 14%

232,206 Patients with established hypertension (HBP) and on QOF registers in your area (HYP001)

DIAGNOSED HBP BY AGE BAND

18-39	40-59	60-79	80+
1%	12%	39%	62%

HBP prevalence increases with age, and UK health surveys show that *actual* prevalence is higher in deprived communities - however, in most ICS areas *diagnosed* prevalence is *lowest* where there is greatest deprivation, suggesting a significant diagnosis gap here > see comments on p2

HBP Diagnosed Prevalence in Your **Most** Deprived Communities 13%

In Your **Least** Deprived Communities (Quintile) 16%

Percentage of diagnosed HBP patients with controlled hypertension

	Your Area	England	code:
under 80s 140/90 mmHg or less	54%	57%	HYP003
over 80s 150/90 mmHg or less	68%	72%	HYP007

Indicator	Patients	PCAs	Controlled	%	Uncontrolled	Deprivation CVDP002HYP (18-79) Most	Deprivation CVDP005HYP (80+) Least
HYP003 <80yrs controlled HBP	180,255	11,895	103,791	54%	64,569	56%	58%
HYP007 >80yrs controlled HBP	39,062	991	27,308	68%	10,760	71%	69%

Please note statistics are latest available but may not reflect the current situation in your area

PCAs = personalised care adjustments; % = controlled as proportion of patients incl. PCAs

NB it is good practice to keep PCAs (exemptions) to a minimum

Coronary Heart Disease (CHD)

Percentage of CHD patients with controlled hypertension (HBP)

	Your Area	England	QOF:
under 80s 140/90 mmHg or less (last 12 months)	66%	67%	CHD008
over 80s 150/90 mmHg or less (last 12 months)	75%	77%	CHD009

Indicator	Patients	PCAs	Controlled	%	Uncontrolled
CHD008 <80yrs CHD contr HBP	25,514	1,117	17,488	66%	6,909
CHD009 >80yrs CHD contr HBP	9,942	218	7,625	75%	2,099

Stroke & TIA (Transient Ischaemic Attack)

Percentage of stroke/TIA patients with controlled hypertension (HBP)

	Your Area	England	QOF:
under 80s 140/90 mmHg or less (last 12 months)	60%	63%	STIA010
over 80s 150/90 mmHg or less (last 12 months)	73%	75%	STIA011

Indicator	Patients	PCAs	Controlled	%	Uncontrolled
STIA010 <80yrs Stroke contr HBP	15,912	1,013	10,135	60%	4,764
STIA011 >80yrs Stroke contr HBP	7,150	236	5,368	73%	1,546

Percentage of diagnosed HBP patients with reading in prev 12mths

79% England 82%

CVDP004HYP

Deprivation Most	Deprivation Least	Ethnicity BAME*
80%	76%	80%

Adults 18+ with GP-recorded hypertension

*BAME = Black, Asian & Minority Ethnicities (Includes Mixed & Other)

For further analysis (age, sex, deprivation) please refer to the CVDPrevent website https://www.cvdprevent.nhs.uk/

KEY FACTS ABOUT HIGH BLOOD PRESSURE (HBP), 'THE SILENT KILLER'

HBP rarely has symptoms so detection often relies on opportunistic and unplanned testing, or late presentation by people with complications of HBP

Effectively treating HBP significantly reduces the risk of heart attacks, stroke, heart failure and death

Every 10 mmHg reduction in systolic blood pressure reduces the risk of major cardiovascular events, such as heart attack and stroke, by around 20 per cent

Quality & Outcomes Framework - QOF 2021/22 snapshot data for March 2022 - NHS England (2022)

Codes beginning CVDP...are CVDPREVENT data for December 2022 - NHS England (2023)

Last reviewed and updated June 2023 - next update due late 2023

HIN CVD Dashboard

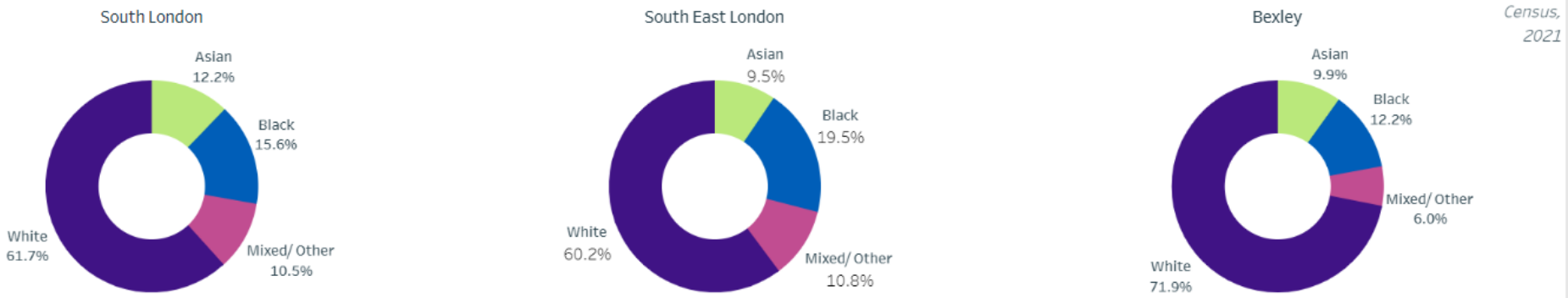
Details

HIN Protected Characteristics Dashboard

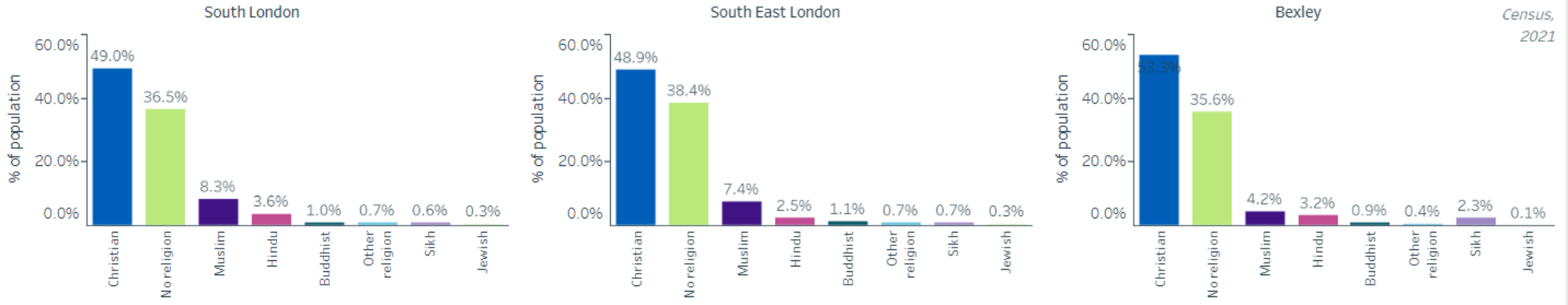
Ethnicity & Religious Beliefs

Select a borough: Bexley

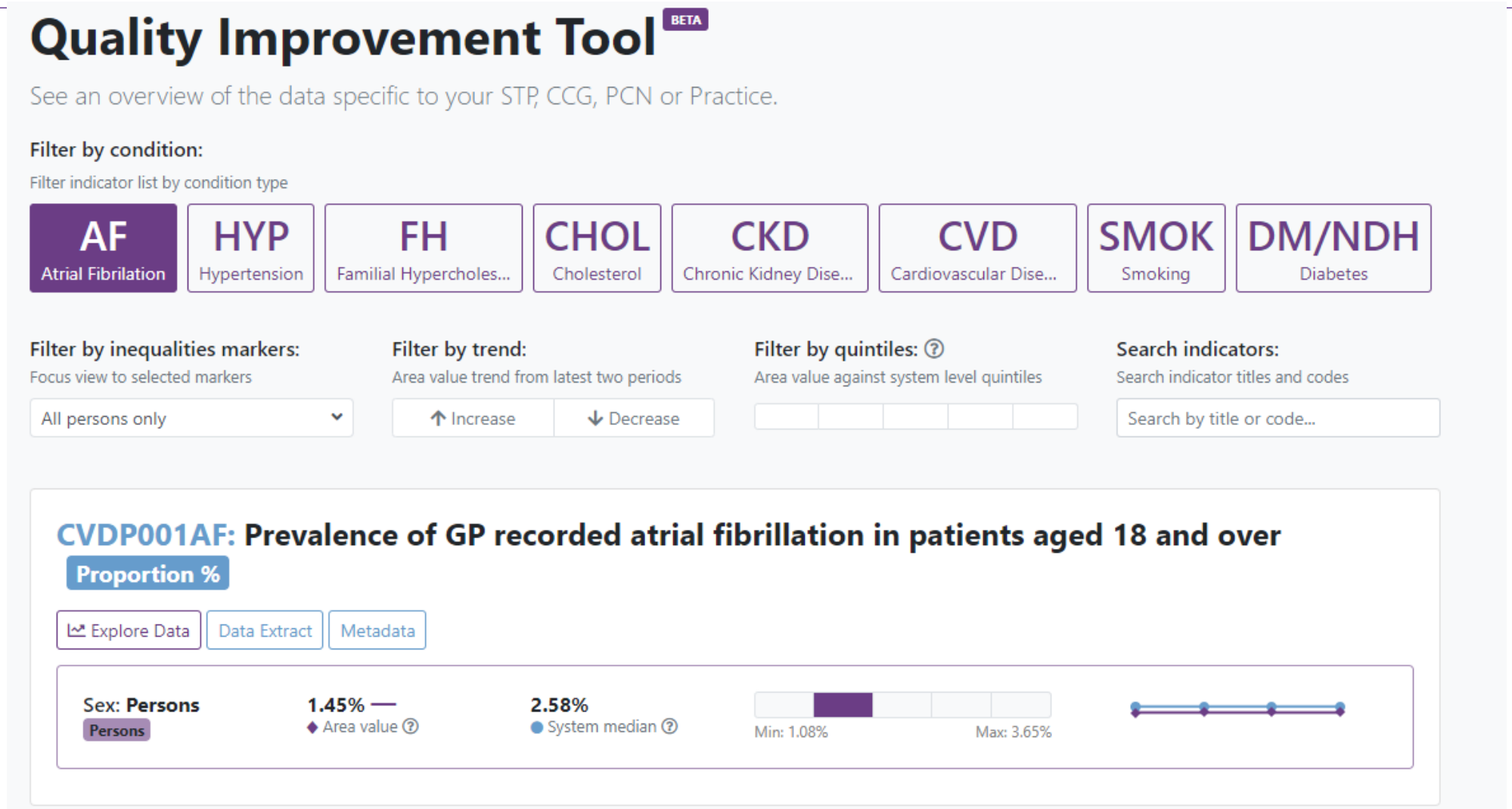
Ethnicity



Religious beliefs



CVD Prevent


Quality Improvement Tool
BETA
See an overview of the data specific to your STP, CCG, PCN or Practice.
Filter by condition:
Filter indicator list by condition type
AF
Atrial Fibrilation
HYP
Hypertension
FH
Familial Hypercholes...
CHOL
Cholesterol
CKD
Chronic Kidney Dise...
CVD
Cardiovascular Dise...
SMOK
Smoking
DM/NDH
Diabetes
Filter by inequalities markers:
Focus view to selected markers
All persons only
Filter by trend:
Area value trend from latest two periods
Increase
Decrease
Filter by quintiles:
Area value against system level quintiles
Search indicators:
Search indicator titles and codes
Search by title or code...
CVDP001AF: Prevalence of GP recorded atrial fibrillation in patients aged 18 and over
Proportion %
Explore Data
Data Extract
Metadata
Sex: Persons
Persons
1.45%
Area value
2.58%
System median
Min: 1.08%
Max: 3.65%

Quality Improvement Tool BETA

See an overview of the data specific to your STP, CCG, PCN or Practice.

Filter by condition:

Filter indicator list by condition type

AF Atrial Fibrilation | HYP Hypertension | FH Familial Hypercholes... | **CHOL Cholesterol** | CKD Chronic Kidney Dise... | CVD Cardiovascular Dise... | SMOK Smoking | DM/NDH Diabetes

Filter by inequalities markers:
Focus view to selected markers
All persons only

Filter by trend:
Area value trend from latest two periods
↑ Increase ↓ Decrease

Filter by quintiles:
Area value against system level quintiles

Search indicators:
Search indicator titles and codes
Search by title or code...

CVDP010CHOL: Percentage of patients aged 18 and over with GP recorded CKD (G3a to G5), who are currently treated with lipid lowering therapy. Proportion %

Explore Data | Data Extract | Metadata

Sex: **Persons**
Persons

56.77% ↑
◆ Area value

63.53%
● System median

Min: 12.39% Max: 96.15%

CVDP009CHOL: Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy. Proportion %

Explore Data | Data Extract | Metadata

Sex: **Persons**
Persons

78.45% ↑
◆ Area value

82.94%
● System median

Min: 1.44% Max: 100%

Other data sources

- Further data sources that can help to set baseline data, and enable you to measure your progress
  - All you have already used plus…
  - UCLP searches
  - Other local dashboards – ie Hypertension Dashboard for SEL
  - Searches available locally ie SWL CKD searches
  - Searches practice / PCN will have already run
  - Feedback from patients
  - Input from colleagues ie about challenges faced

Are there other sources of data you use in your work?
Please put this in the chat or come off mute and share.

Top tip – save copies of all your searches and data at the time you run a search / gather data. This will enable you to go back to track patients / progress through your project lifecycle.

03

Using data in your projects

Faiza Usami

04

What’s next?

What's next? 8th September in person day

- In person!!
- If your dietary or access needs have changed please let us know asap.
- If you have any questions about the day let us know.

Event	Date	Time
Introduction to Quality Improvement In Person Event	Friday 8th September	9.30am – 4.00pm

Can you help?
We need a few Fellows to run the UCLP searches for their projects' clinical area – to use in the numbers (not patient list) at the QI Day.
Please let us know if you can help!

What's next

Event	Date	Time
Atrial Fibrillation Webinar **Dr Jonathan Behar**	Wednesday 20th September	1.00pm – 2.00pm
Lipid Management and Familial Hypercholesterolemia Webinar **Prof Tony Wierzbicki**	Tuesday 3rd October	12.00pm – 1.00pm

Feedback time!