Initiation of SGLT2 inhibitors for patients with CKD

Clinical area: Chronic Kidney Disease and CVD Prevention

Kendall Todd
PCN: Morden
GP Practice: Stonecot Surgery & Central Medical Centre

> Reviewing patients in depth allows you to have good conversations with them about CKD

Aim

By January 2024, review records of 50 patients eligible for dapagliflozin or SGLT2-I and arrange an appointment to discuss their eligibility and initiation using shared decision making.

Problem statement

At this practice, we have a cohort of patients who have Chronic Kidney Disease (CKD) and are eligible for Dapagliflozin, a sodium-glucose co-transporter 2 inhibitor (SGLT2i) but have not yet been offered this.

SGLT2 inhibitors work to reduce glucose reabsorption in the renal proximal convoluted tubule, thereby reducing pressure and inflammation in the kidneys and ultimately reducing kidney damage. Through the DAPA-CKD trial it has been shown that the addition of Dapagliflozin to a patients current treatment regime can significantly reduce the risk of declining kidney function, end stage kidney disease and all cause mortality.

Baseline data

I will be using a Merton CKD pilot search which searches for patients who are coded as having CKD and could be eligible for Dapagliflozin. It breaks it down into:
1)T2DM and CKD - not taking SGLT2i - starting data is 122 patients (88%) are eligible for SGLT2i. 22/122 patients are on an SGLT2i already.
2) CKD no T2DM, eGFR 25-75, uACR>/= 22.6, ACE/ARB - eligible for Dapagliflozin - baseline data is 8/8 patients eligible - 100%

Plan

- Run the search and save it onto an Excel spreadsheet so that more patients are not added to the list.
- Every week, allocate an hour to review 10 patients to see if they fit the criteria for SGLT2i. This may require Advice and Guidance support if they are complex, or a discussion with the clinical supervisor.
- Book eligible patients in for a medication review to discuss further.
- Update Excel spreadsheet regarding outcome of conversation and decision.

Summary of results

In total 73 patients of 112 were reviewed:

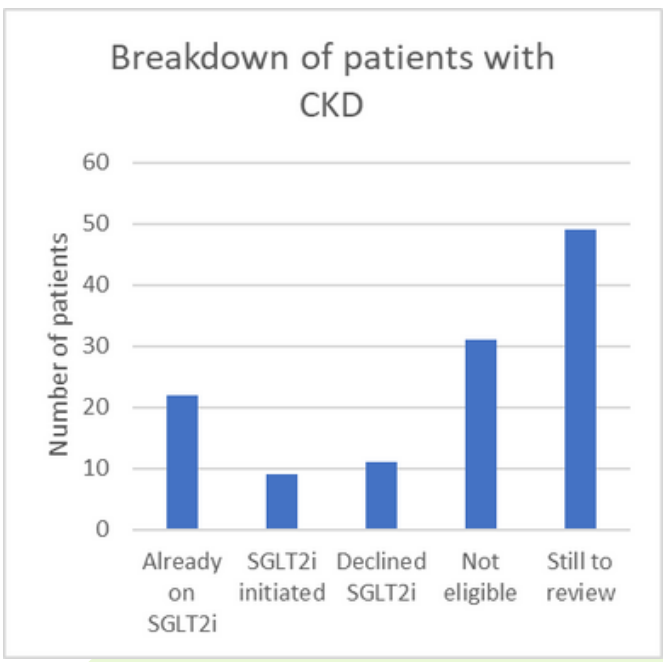
- 22 of those reviewed were found to already be on an SGLT2i
- 9 had an SGLT2i initiated and
- 11 declined.
- 31 were found to not be eligible for SGLT2i at this time

Learnings

Reviewing patients in depth allows you to have good conversations with them about CKD and has given me the time to review their medication too. This was not just from the CKD management perspective (ACEi, Dapagliflozin, Statin, blood pressure control), but also reviewing all their medication if there has been a decline in kidney function as this is often overlooked and dose adjustments are not made. Although the focus of this project has been CKD, it has allowed us to review patients with general cardiovascular disease as the two conditions tend to go hand in hand.

Sustaining the change

Morden PCN has secured funding towards a CKD project. It will look at coding as well as medicine management and will allow us to embed what we have already started in this project to a greater level through better call and recall processes and educating clinicians.



- Patients who declined had a telephone consultation to discuss and shared decision making applied
- Patients not eligible had their notes reviewed or A&G. Frailty, incontinence, palliative care, multiple morbidity taken into account.
- There is still ongoing work to review all patients.

Patient or stakeholder feedback

Overall feedback from patients is positive as they are given time through their consultation to understand what CKD is and what we do to manage it, as well as time to ask any questions.
From a practice point of view, we have made a good start in terms of reviewing patients medication for CKD but overall CVD too.

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Updating Coding for Patients with CKD to Increase CVD Prevention

Clinical area: Chronic Kidney Disease and CVD Prevention

Dr Sana Shahid
PCN: Merton East
GP Practice: Cricket Green Medical Practice

Aim

To review the notes of all patients who have had an eGFR <60 in the last 3 years and re-code or send for up to date testing as required, by the end of January 2024.

Problem statement

I identified a problem with CKD coding at the practice in which patients who had a previous eGFR result below normal were not coded. This was therefore affecting further CVD prevention management as the patients were not on the CKD register.

I found 135 patients who have had an eGFR <60 in the last 3 years and have not been coded.

Baseline data

135 patients identified who have had an eGFR <60 in the last 3 years and have not been coded.

Ardens search via EMIS has revealed the above number.

Plan

Invites will be sent out to patients for blood tests and then CKD coding will be applied accordingly.

Contact patient via text or phone if elderly/only landline number available. Patients with text messages will be given the opportunity to respond back to me or the Registrar if they have any queries.

Summary of results

Out of 135 patients:

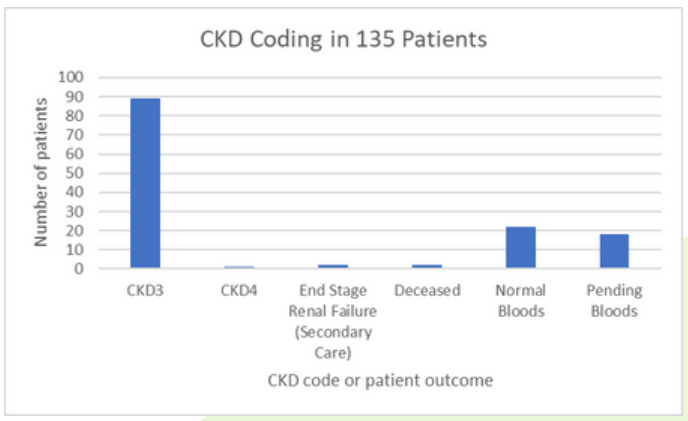
- 89 were coded as CKD3
- 1 patient was coded as CKD4
- 2 patients were end stage renal failure under secondary care
- 2 unfortunately passed away during this time
- 22 patients were identified as not having CKD as their repeat bloods were normal
- 18 patients required up to date bloods to improve coding and this will be done once results become available.

Learnings

- Time was the biggest inhibiting factor due to the huge pressures on General Practice.
- Due to open access to patient records, coding automatically increased contact from patients who wished to discuss this 'new' diagnosis'. We have been booking routine appointments to address this with patients and so far it has been working well.
- Consultations can be challenging especially as this 'disease' is not symptomatic. This was addressed by sharing patient leaflet from the UK Kidney Association.
- Increased awareness of CKD amongst colleagues and its significance in prevention of CVD-it is a forgotten risk factor.

Sustaining the change

- Audit will be presented by the GP trainee at the practice meeting next month
- Repeat audit in 3 months to complete cycle
- Encouraged colleagues to code so that further management and discussion with patient can start taking place eg Statins, Dapagliflozins, requesting urine ACRs etc
- A flow chart will be shared with colleagues to aid diagnosis and management in primary care.
- Accurx template will also be set up to ease sharing of patient information leaflet
- This audit has now opened doors to considering further projects. Aim is to encourage colleagues especially new trainees and students looking for projects, to get involved in running searches on CKD patients, requiring statins, up titrating ACE inhibitors etc



Patient or stakeholder feedback

Discussions are in progress. One patient was shocked to hear this and very keen to engage with further management. Statins have been commenced following consultation, with patient's permission

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AF Screening in Complex Hypertension Clinic

Clinical area: Atrial Fibrillation

Natasha Thaladi
Location: GSTT Complex Hypertension Clinic

Aim

To improve AF detection and screening in pharmacist led complex hypertension community clinics in Bexley by screening all patients who are booked into face to face appointments with the pharmacist from November 2023 to January 2024.

Problem statement

There is currently a lack of screening patients for AF in community hypertension clinics delivered by the pharmacist.

Baseline data

Baseline: Zero, nil patients currently being screened for AF.

We will be offering screening to all patients who are booked in for a face to face appointment with the pharmacist.

Plan

- All patients at Bexley F2F appointments will be offered screening.
- Deliver patient education during visit regarding AF, risk of stroke and reason for screening.
- Refer patients with abnormal readings for 12 lead ECG via Bexley cardiology service.

Summary of results

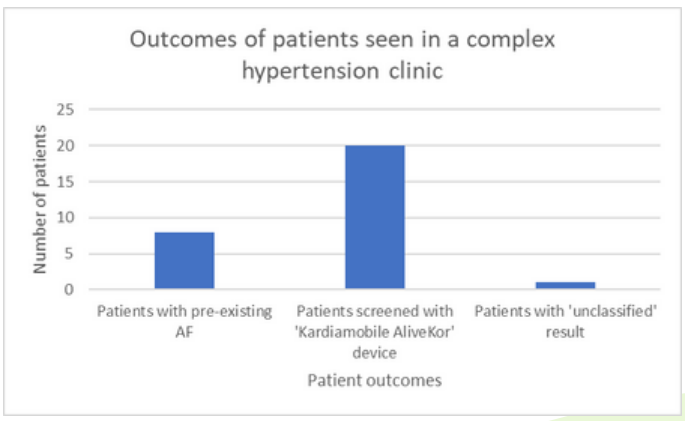
- 28 patients were seen in complex hypertension clinic in this time, of which 8 patients already had AF.
- 20 patients were therefore screened using the 'Kardiamobile AliveKor' device.
- One of these patients had a result which was 'unclassified' despite multiple tests. This patient will be followed up and referred for a 12-lead ECG if required.

Learnings

- Patients had very positive feedback, amazed by the technology and what it can detect.
- Many patients were really interested to know about AF and risk factors.
- It was positive to use the opportunity in the HTN clinic to educate patients about AF. Patients liked that we were looking at CVD prevention and not just focusing on HTN alone.
- At the start of the project GSTT introduced EPIC which was challenging initially. Eventually I was able to build letter templates including the AF screening.
- Confirming the pathway if possible AF were detected was challenging as this varies by borough and GP practice.

Sustaining the change

As the screening is very easy to do using the device and does not take much time in clinic, we will be continuing this service in our complex HTN clinic in Bexley. We plan to implement the same in the F2F clinics opening soon in Lambeth and Southwark. The onward referral pathway will be different (via GP) for these PCNs.
I would like to be able to create AF/stroke information leaflet that can be sent via 'my chart' function straight to the patient to increase awareness and education.



Patient or stakeholder feedback

I have had really positive feedback from patients on using the devices. Many are amazed by the technology advances, interested in knowing about AF and symptoms. They were glad to hear that along with hypertension, other risk factors for CVD was being considered. I felt I was making a positive impact on patient care/CVD prevention because I was able to do the screening but also take the opportunity to educate the patient on AF/stroke/symptoms to look out for.

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Offering Statins to Patients with CKD to Reduce Risk of CVD

Clinical area: Chronic Kidney Disease and CVD Prevention

Grace N.S Kimuli
PCN: Croydon Supernetwork
GP Practice: Greenside Medical Practice & Country Park Practice

Aim

To initiate Atorvastatin in 80% of the patients on the CKD register who are not on a statin and have no urine ACR by January 2024.

Problem statement

We have patients aged 18 years or over with CKD (Categories G3a to G5) who are currently not prescribed a statin, and records do not specify if statin is declined or clinically unsuitable.
A search for patients on the CKD register who are not prescribed a statin and have no urine ACR yielded a list of 55 patients. Of these, 24 patients were excluded, due to frailty (3), under secondary care (11) or over 84 years (10).
This left a final cohort of 31 patients.

Baseline data

A search for patients on the CKD register who are not prescribed statin and have no urine ACR yielded 32 patients from Greenside Medical Practice and 23 patients from Country Park Practice.The 2 practices together form Greenwood Group Practice making a list of 55 patients.

Plan

- Run searches of patients on CKD register with no statin or urine ACR.
- Assess search results
- Send text messages for urine ACR for all patients.
- Follow up
- Monitor and review statin at 3 months

Summary of results

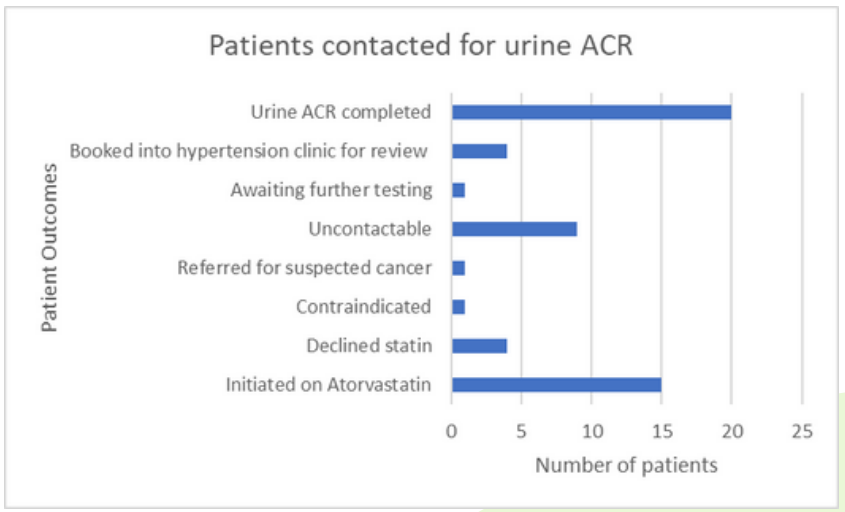
- Of the 31 patients, 15 were initiated on Atorvastatin, 4 declined statin, 1 was contraindicated, 1 patient was referred for suspected cancer and 9 were uncontactable and 1 is awaiting further testing.
- Patients' BP was opportunistically reviewed and 4 patients were booked into my hypertension clinic for review and medicines optimisation.
- 20 of the 31 patients had their Urine ACR completed.
- For those who declined the interaction was used to initiate conversation about statins which means that future discussions about statins will be a lot easier.

Learnings

- Team work is so vital in QI processes. By having everyone's buy in, I was able to achieve great results.
- Through the collaborative learning in the Fellowship I was able to tease ideas with colleagues, share challenges and solutions and find encouragement that I was not alone in the challenges I was facing and this kept me going.
- By having a stepped approach, I was able to identify areas of improvement in our practices, near misses and was able to ensure that inconsistencies in coding were rectified. Being systematic enabled me to balance the various demands on my professional and personal life.

Sustaining the change

Ongoing search of EMIS to identify patients with CKD and not on statin then educate and offer statin to them.
Work with the practice team to ensure proper coding of our patients as our searches can only be as good as our coding.



Patient or stakeholder feedback

A patient's ALT results (03/01/24) had gone up from 36 to 181 meaning statin that was initiated would need to be stopped. Her eGFR that was normally trending below 60 for years, had risen to 88. I found blood results dated 09/01/24 which indicated EGFR was 61 and the ALT was 36.
The patient was certain that she did not get any bloods done earlier than the 9th January so I suspected that the bloods results for 3/01/24 did not belong to my patient. After checking and confirming with other clinicians, I called the hospital lab and reported this incident. The lab consultant confirmed that the bloods did not belong to this patient, and they took them off patient's record and left a note saying "wrong blood in tube". A task was sent to medical secretary to record incident as significant error.

I had initially discussed alcohol intake and I had also advised the patient that she would need to stop taking the statin. However, I called her again, apologised and explained that bloods were not hers and they have been taken off her records. I advised her to continue taking her Atorvastatin.

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Optimisation of antihypertensive medication in patients at high risk

Clinical area: Hypertension

Ramat Popoola
PCN: North Bexley
GP Practice: North Health Medical Centre

Aim

To reduce the list of patients in UCLP Group 1 (highest risk) by at least 50%, through optimisation of antihypertensive medication and regular follow up of patients within the list. I will also use this opportunity to screen patient in the other UCLP Priority Groups, to see if their priority status has changed.

Problem statement

There are 26 patients at the practice in UCLP Priority Group 1 at very high risk from uncontrolled blood pressure (above 180/90)

Baseline data

We will run a search of patients on the UCLP-Priority Group 1 list on a monthly basis to monitor data. Currently we have 26 patients on the list.

Plan

- Initial recall process implemented within the practice.
- Patients on our initial list will be contacted via text message to invite them in for a review with the clinical pharmacist, followed up by a telephone call to the patients and then finally by a letter.
- This be implemented 2 weeks before our go live date so enough patients are booked in for the review.
- On a monthly basis, we will follow these patients up depending on the agreed management plan following the initial visit.
- Any new patients highlighted during the project will also be reviewed, however they will not be included in the final figures submitted.

Summary of results

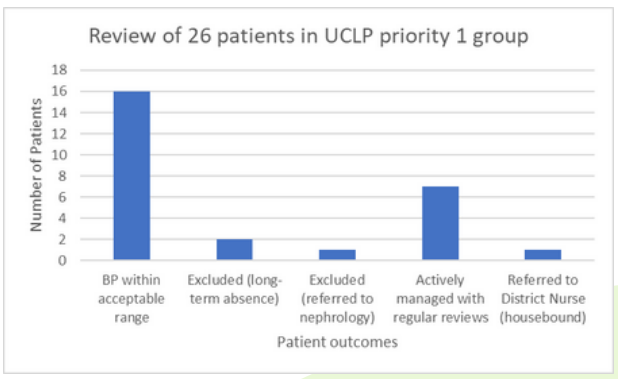
- Of the initial 26 patients at the start of the project, 16 of them now have their BP within acceptable range due to up to date readings, or appropriate optimisation of medication.
- 2 were excluded as they were away for a long time during the course of the project, 1 was excluded as they were referred to be managed by nephrology.
- 7 / 26 patients are now being actively managed with regular reviews scheduled by us.
- 1 housebound patient was referred to the District Nurse and is being followed up appropriately.
- New patients have been added to the list, they are also being managed regularly. We are now more intentional in our recall of patient for up to date BP check.
- New patients are been added to our hypertension register as we are testing more, hence detecting more patients.

Learnings

- Teamwork across the practice was amazing - our care coordinator is now our BP champion.
- Patients are now encouraged to submit their BP reading to the practice for a review by the pharmacist.
- One challenge was that multiple readings not being coded into the patient's record appropriately E.g. when blood pressure readings were not coded as "on examination blood pressure" they were instead free typed into the consultation. This made it difficult to search for recent blood pressure for these patients. This has now been resolved -it was discussed at clinical meeting the importance of coding BP to allow us to screen patient that needed review.

Sustaining the change

We aim to continue to run a monthly search of patients on the UCLP priority list. This will allow us to tailor make our appointment slots, to allow dedicated time to review them. The way we have approached this project will be our baseline for managing our patients going forward, as we have been able to reduce workload within reception by the utilisation of the booking link, where patient are able to book appropriate and convenient time for them.
The rest of the pharmacist within the practice have now been upskilled to manage hypertension to increase appointment capacity
We will also aim to book follow up for patient identified to ensure continuity of care and optimisation of condition and medication after any initial visit.



Patient/stakeholder feedback

This has been received positively by patients and the practice team alike. We did not seem to have a robust recall process for hypertension reviews. We have adopted some of the processes highlighted during the project to manage our patient more effectively.

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Detecting hypertension in hard to reach population

Clinical area: Hypertension

Enrico Mandello
PCN: Stockwellbeing
GP Practice: Stockwell Group Practice

Aim

Diagnose with an ABPM all patients that have reading over 140/90 mmHg We aim to complete 20 ABPM each month to diagnose patients. We will count number of ABPM reports sent to the surgery via pharma outcomes.

Problem statement

In Stockwell undiagnosed hypertension is a huge health burden. Many patients don't attend their GP appointments when requested due to working hours, lack of time, disbelief in health care, and most importantly no symptoms. When patients have a blood pressure reading higher than 140/90 mmHg they are referred to Xyla for the ABPM test. Xyla average waiting time for the test is 3 weeks. We believe, increasing collaboration with community pharmacies, we would be able to target more people and we would be able to do an ABPM test as soon as someone has got a BP reading out of range. Referring patients to pharmacies will allow a quicker, more accessible investigation and diagnosis.

Baseline data

A list of 100 patients has been created and messages have been sent. 34 patients have agreed to attend the pharmacy for further investigations. The remaining patients have declined or prefer to do home blood pressure monitoring with their blood pressure machines.

GPs and healthcare professionals will also continue to refer new people to the pharmacy when required during consultations and reviews.

Plan

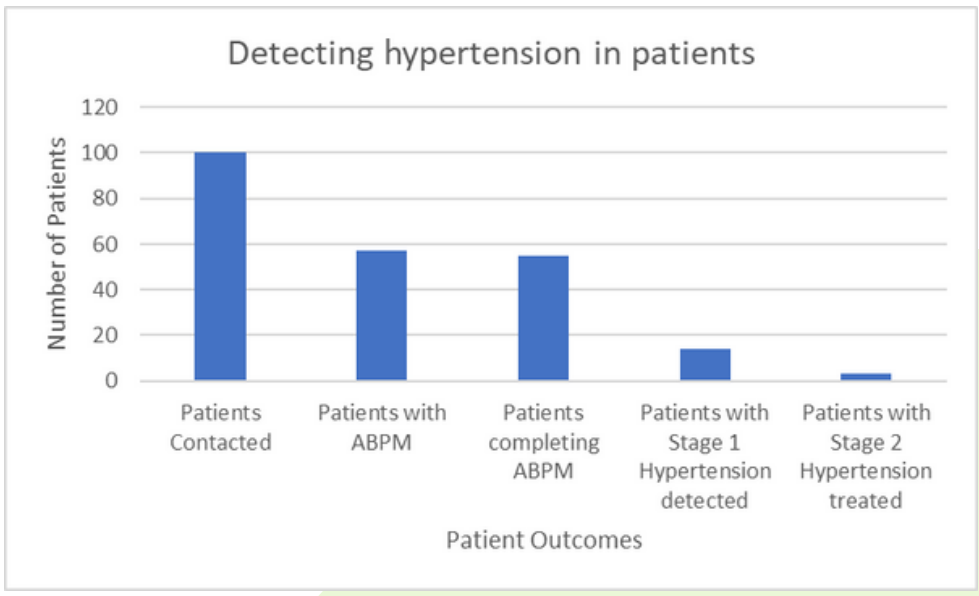
We will text all patients with overdue BP readings inviting them to attend the pharmacy for further investigation. The patient will show the text message to the pharmacy and an appointment will be booked.

Summary of results

- 100 patients were contacted.
- In total 57 patients had ABPM which 55 completed.
- 14 patients with stage 1 hypertension were detected. Patients received health lifestyle education to aim to reverse it. Patients were very pleased that their hypertension was detected quite early.
- 3 people with stage 2 hypertension started treatment. People can have their 24-hour BP tested within days after it has been requested.
- The system was so successful that surgery started referring people on the hypertension register who require annual monitoring for their clinical blood pressure.
- When people were attending the surgery and were asked to book an appointment with the pharmacy for an ABPM, they were going to the pharmacy straight away after finishing the appointment.

Learnings

- From patient feedback, we established people prefer to access their local pharmacy for the ABPM test. It is more straightforward, and this has increased the chances of the patient completing the test. Part of the success is due to the flexibility of the patient attending the appointment. Patients also were very pleased when we were discussing their ABPM report at the pharmacy, and we were reviewing healthy lifestyle choices to try to reverse a stage 1 hypertension diagnosis.
- Emails were too time-consuming so we switched to text messages, and it was very effective. Texting a patient to attend the pharmacy for an ABPM is much quicker than referring a patient for an ABPM through the surgery referral system.



Patient or stakeholder feedback

Patients are very satisfied with the service provided. A patient said he would do ABPM only because it has been offered in the pharmacy, he was not keen travel further.

Sustaining the change

Continuing collaboration between surgeries and pharmacies.

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Implementing 9 care processes for CKD patients without diabetes

Clinical area: Chronic Kidney Disease and CVD Prevention

Dr Tariq Khalil
PCN: South Southwark
GP Practice: The Camberwell Green Surgery

> Clinicians dealing with results were more confident at discussing the ongoing management of CKD patients.

Aim

Review the 26 patients with 8CP complete and calculate the kidney failure risk equation score then add the code by 31/01/24.
Review additional 30 patients and ensure all 9 care processes complete by 31/12/23.

Problem statement

There are no formal 'care processes' for monitoring non-diabetic chronic kidney disease patients despite greater CVD risk.
In comparison - those with diabetes have the 8 care process and three treatment targets.

Non-diabetic CKD Patients = 201
8 CP done this FY (8CP = smoking, alcohol, BP, BMI, eGFR, Urine ACR, serum cholesterol, HbA1c) = 26 (13%).

9 CP done this FY (9CP = smoking, alcohol, BP, BMI, eGFR, Urine ACR, serum cholesterol, HbA1c and kidney failure risk equation score (KFRE)) = 0 (0%).

Baseline data

Non-diabetic CKD Patients = 201

8 CP done this FY (8CP = smoking, alcohol, BP, BMI, eGFR, Urine ACR, serum cholesterol, HbA1c) = 26 (13%).

9 CP done this FY (9CP = smoking, alcohol, BP, BMI, eGFR, Urine ACR, serum cholesterol, HbA1c and kidney failure risk equation score (KFRE)) = 0 (0%).

Plan

- Identify patient group and discuss with students and HCAs who are assisting.
- Instruct and mentor students to undertake patient assessments.
- Create a dashboard to demonstrate progress and missing data or interventions.
- Run searches and update dashboard to provide updates & review processes.

Summary of results

- Due to the project there is greater awareness of CKD.
- The number of patients on our CKD register has increased through improved 'screening', diagnosis and coding.
- Once on the register a larger number of patients are receiving a 'kidney function assessment' which involves eGFR and urine ACR tests.
- Furthermore, many patients who are not diabetic on the CKD register have benefitted from greater monitoring. Gathering this data through the eight care processes has identified areas that require interventions, including optimising blood pressures, cholesterol, weight and providing lifestyle advice.
- The ultimate aim has been to improve cardio-renal risks.

Learnings

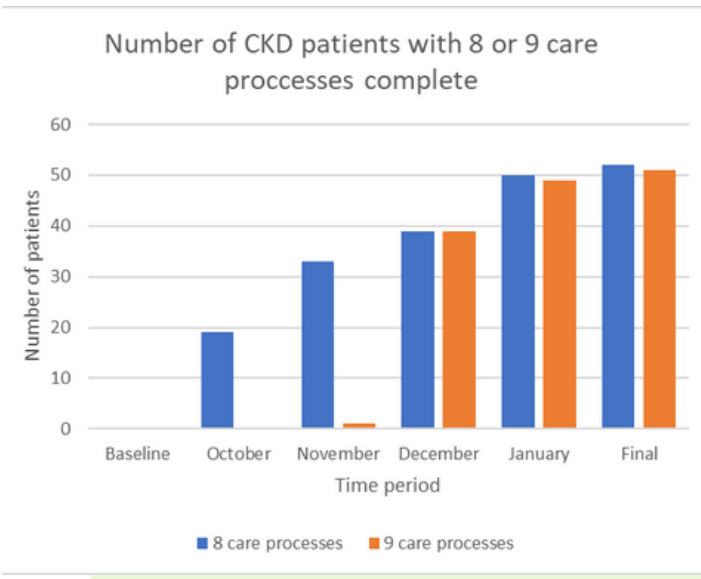
- All stakeholders were motivated and keen to improve their knowledge of CKD and management of CKD patients.
- Having staff skilled at creating searches and templates was beneficial and allowed us to modify them as required.
- We were able to incorporate the new recall lists and targets into existing processes. In particular administrative staff filled appointment sheets and arranged blood and urine tests.
- Initially, we struggled to get patients to do urine ACRs. Later we encouraged patients attending for the health check component of the 8 care processes to go immediately to the toilet to provide a sample before they left the building. This seemed to improve completion rates for the care processes.

Sustaining the change

We will incorporate renal reviews into our chronic disease recall systems.

Arranging regular blood and urine tests will be included in our monthly recall systems for high risk drug monitoring processes.

Our health care assistants regularly carry out NHS health checks on over 40 year old patients, and basic data collection tasks such as updates on smoking status, alcohol consumption, BP monitoring and recording BMI. With this they provide lifestyle advice, and arrange blood and urine tests. Therefore, they would be ideally placed to perform the same duties for those with CKD when these patients are added to their recall lists.



Patient or stakeholder feedback

Patients commented that they were surprised to hear that they had chronic kidney disease as this had not been emphasised in previous regular reviews. In addition, they were surprised to discover that there was a significant association with long term cardiovascular risks.

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Updating coding & Kidney Failure Risk Equation in CKD patients

Clinical area: Chronic Kidney Disease and CVD Prevention

Dr Tariq Khalil
PCN: South Southwark
GP Practice: The Camberwell Green Surgery

> We managed to code 98% of patients, including those who had not had tests prior to the start of the project

Aim

To re-code all patients with a urine ACR and eGFR this fiscal year with appropriate new SNOMED CKD codes and calculate their KFRE score by 31/01/24.

Problem statement

Currently only old SNOMED CKD codes are used and no Kidney Failure Risk Equation (KFRE) calculations are coded.

At this practice 96 patients have had a urine ACR and eGFR test this year however don't have the new SNOMED CKD code or KFRE score.

Baseline data

CKD patients who have had a urine ACR and eGFR this fiscal year = 96

CKD patients with new SNOMED codes and KFRE score this fiscal year = 0

Plan

- Identify patient group and discuss with students and HCAs who are assisting.
- Instruct and mentor students to undertake patient assessments.
- Create a dashboard to demonstrate progress and missing data or interventions.
- Run searches and update dashboard to provide updates & review processes.

Summary of results

- Due to the ease of using the online KFRE calculator, we were able to code all patients with an eGFR and urine ACR this fiscal year with the relevant new SNOMED codes. This included patients added since the start of the project.
- We were unable to code 3 patients with KFRE scores as they have never had an eGFR below 60, which is a requirement for the KFRE calculation.
- Having used the KFRE website, updated knowledge of the latest guidelines, we are more confident about monitoring and coding CKD appropriately.
- Furthermore, with greater use of the KFRE, a number of patients with a KFRE 5 year score greater than 5% have been referred to the relevant renal teams.

Learnings

- Once the code definitions and access to the online kidney failure risk equation became known, it was reassuringly simple to apply relevant codes and do the calculations.
- However, due to the potential risk of incorrect coding, the need to consider old values, and the importance of this to further management decisions I believe that this would require somebody with suitable experience and clinical knowledge.
- Many patients with Chronic Kidney Disease (CKD) diagnosed several years ago had improvements in their eGFR levels. When we tried to enter data into the Kidney Failure Risk Equation (KFRE), the equation was not validated for eGFR levels over 59. During our CVD Fellowship CKD group meetings, we had established that the worst values should be used so that patients would benefit from greater monitoring and interventions.

Sustaining the change

Having used the template, website and recognised the importance of coding, we will develop automated alerts that will prompt staff to invite patients for reviews at the appropriate times and frequencies.

The practice runs regular long term conditions' searches to ensure targets are achieved. Patients with chronic kidney disease are already included in these searches and these searches will be modified to check SNOMED coding is up to date and that KFRE scores are recorded annually.

Our chronic disease care plan templates have been modified to include blood test and urine ACR reminders for patients. These care plans are designed to advise patients to arrange regular reviews during birthday months. These care plans will be modified to include staggered renal reviews (eGFR and urine ACR) based on the frequency determined by the new SNOMED codes (see table).

Guide to Frequency of Monitoring (number of times per year) by GFR and Albuminuria Category			Persistent albuminuria categories Description and range		
			A1	A2	A3
			Normal to mildly increased	Moderately increased	Severely increased
			<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30mg/mmol
GFR categories (ml/min/1.73 m²) Description and range	G1	Normal or high	≥90	1 if CKD	1	2
	G2	Mildly decreased	60–89	1 if CKD	1	2
	G3a	Mildly to moderately decreased	45–59	1	2	3
	G3b	Moderately to severely decreased	30–44	2	3	3
	G4	Severely decreased	15–29	3	3	4+
	G5	Kidney failure	<15	4+	4+	4+

Patient or stakeholder feedback

Medical students found the template easy to use and this included the new SNOMED and KFRE codes so that these could be added during the reviews. The relevance of the coding will become more apparent over a period of time as recall systems start to be triggered after time periods documented in the frequency of monitoring table above.

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Follow up eGFR testing to identify CKD in at risk individuals

Clinical area: Chronic Kidney Disease and CVD Prevention

Catherine Sedgwick
PCN: South West London
GP Practice: The Nelson Medical Practice

Aim

By the end of February 2024 we will have a 75% reduction in the number of the patients who have not had a recorded follow-up eGFR test within 12 months of an initial eGFR result of <60.

Problem statement

Prevalence of CKD within The Nelson Medical Practice is lower than the national average, indicating that there may be issues regarding diagnosis or coding.
Under diagnosis as well as incorrect coding can lead to lack of management of the disease – which puts the patient at higher risk of resulting sequelae, including cardiovascular disease.

77 patients were identified as having an eGFR <60 within the last year with no repeat eGFR. These patients require a second test to be coded as CKD and receive

Baseline data

The above target group was searched using Ardens searches and on the 19th of October identified 77 patients - the baseline data.
To measure this project, I will monitor the number of patients in the target group identified above and I will also measure the number of patients from that group who are contacted.

Plan

Manual review of notes for each batch of patients about to be texted.
Texts to small number of patients at a time (for those with mobiles) with the ability for them to reply to text with any questions.
Groups from list to be contacted weekly until all have been contacted once.

Summary of results

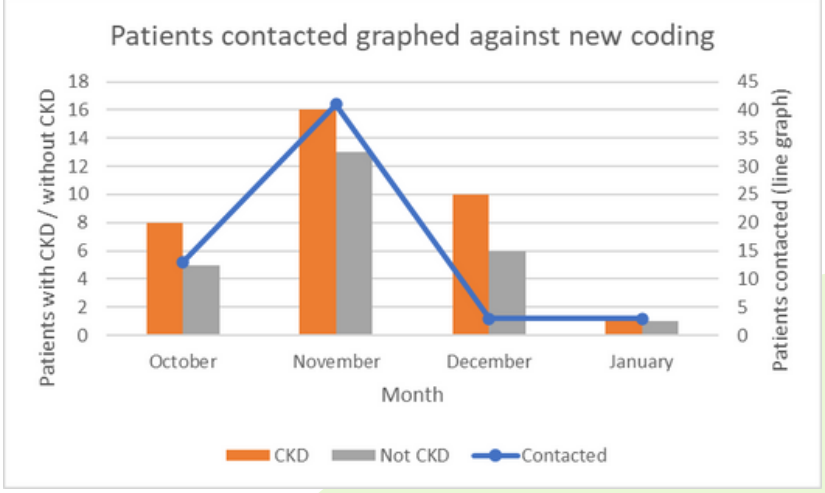
Of the 77 patients identified, 54 were contacted via text message or by phone. 35 were found to have CKD and were coded appropriately, and 25 were found to not have CKD.
The data has enabled correct coding which means best management of their condition. Clinicians are already offering statins plus other suitable medication to those coded with CKD – there is rising awareness within NHS about how management of CKD can reduce CVD risk. Clinicians have acknowledged usefulness of laminated poster re CKD in their rooms and highlighted my role in our January MDT clinical meeting.
Next time I will use a 'real time' excel spread sheet to log results as this will be much less time consuming than the handwritten charts I had to produce!

Learnings

- Wording of the original text message appeared personal
- Enabling patients to text back was helpful and they were more likely to complete the tests
- Ceased renal damaging medications for patients found to have CKD
- Patients becoming aware of importance of healthy kidneys and the role this plays in reducing risk of CVD
- For those without mobile phones (all age groups) – finding time to phone them takes longer. It can lead to conversations about many other health aspects.
- Time to do the project, I needed a minimum of an hour a week to go through the list/send texts/check results which was not always available depending on timetabling.

Patient or stakeholder feedback

A patient in her 40s. who rarely drinks any fluids had an isolated GFR of 48 hence needing repeat. Recognition from her was that she needs to maintain good fluid balance to protect renal function. Her GFR is now > 60, a work in progress. This has made a huge difference to behaviours/medications)



Sustaining the change

It is fairly straightforward to run a two- or three-monthly search for patients who need a repeat blood test and urine sample to check for CKD. Text messages this time around got a 70% success rate and I would like to continue this project as it is beneficial to patients.

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Using social media to increase patient engagement with AF screening

Clinical area: Atrial Fibrillation

Amish Patel
PCN: Selsdon, Purley, Coulsdon
GP Practice: Valley Practice

> I was able to bring my father along as he has a family history of stroke. It was reassuring to know he does not have AF.

Aim

To increase patient engagement for an Atrial Fibrillation Screening Programme in community pharmacy using social media, creating 4 digital assets and carrying out 150 AF checks from November 2023 to end of January 2024.

Problem statement

AF can go undetected and opportunities for testing are not always used.

Baseline data

This will be against the number of health checks we provide, which is 24. As part of the health check we do an AF check.

Plan

- Design 4 types of social media assets for AF Screening by identifying at risk groups and risks from AF and using patient feedback.
- Make required design changes (PDSA).
- Purchase Kardia device and train staff on its use and to use it in guest mode.
- Create a booking/appointment facility for the screening to be included with the digital assets. Set the link up on google analytics to identify those who do not go ahead and book an appointment
- Engage with local community groups re posting. Start campaign in Oct, posting every 2 weeks with 4 digital assets.

Summary of results

- The project was delayed due to winter pressures however 97 patients were screened.
- 71 were over 65.
- 23 responded to the pharmacy's social media platforms, and 74 to community platforms. 83 patients booked, 14 walked in.
- Screening increased month on month - from 8 in November to 76 in January.
- 1 case of possible AF was detected.

Learnings

- Time to refine the digital assets was a challenge - only got 2 assets created.
- Winter pressures impacted on delivery
- Set up phase was most time intensive so needed to allocate more time to this which was difficult with other work.
- The design team did a great job - having clear brief helped them to deliver.
- The campaign exceeded expectations showing the value of community platforms & social media for health service awareness / patient engagement.
- Had many people who were not regular users of the pharmacy attend screening. Local health promotion is equally as important as well as national campaigns
- Device was very easy to use.
- Booking system was used a lot and helped us manage workload.

Sustaining the change

Aim to highlight pharmacy services via social media in future.

I am considering setting up a community digital asset to post information about local and national healthcare initiatives (not just pharmacy specific) and supporting traffic to it by posting social media campaigns for various services on local community groups. Aim is to increase patient engagement.

Patient or stakeholder feedback

Patients not want to take up doctor's time with requests for health screening so this was very convenient and valued. I was able to bring my father along as he has a family history of stroke, it was reassuring to know he does not have AF.

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