

# Cardiovascular Disease (CVD) Prevention Fellowship 2023 Case Studies



# Fellow name: Catherine Sedgwick

## PCN: South West London

### GP Practice: The Nelson Medical Practice

#### Clinical area: Chronic Kidney Disease and CVD Prevention



## Follow-up eGFR Testing to Identify CKD in At-Risk Individuals

### 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 appropriate management.

### 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.

### Project plan

In order to address this problem I will inviting batches of identified patients to undertake an eGFR and uACR test. I will then code them appropriately based on the results. I will send text messages to those who have mobile phone and call those who do not. The text message will have 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 and 6 patients records were reviewed without needing to contact them. 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 to reduce CVD risk. Renal damaging medications could be ceased for patients found to have CKD. 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 from the project

- Using personalised wording in the text message and ability to text back increased completion of the testing.
- 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.
- 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.
- Clinicians have acknowledged usefulness of laminated poster re CKD in their rooms and highlighted my role in our January MDT clinical meeting.


#### Contact Details

# Fellow name: Grace N.S Kimuli

## PCN: Croydon Supernetwork

### GP Practices: Greenside Medical Practice & Country Park Practice

### Clinical area: Chronic Kidney Disease and CVD Prevention



## Offering Statins to Patients with CKD to Reduce Risk of CVD

<p><b>Problem statement</b></p> <p>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.</p> <p>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).</p> <p>This left a final cohort of 31 patients.</p>	<p><b>Aim</b></p> <p>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.</p> <p><b>Project plan</b></p> <ul style="list-style-type: none"><li>• Run searches of patients on CKD register with no statin or urine ACR.</li><li>• Assess search results</li><li>• Send text messages for urine ACR for all patients.</li><li>• Follow up</li><li>• Monitor and review statin at 3 months</li></ul>	<p><b>Summary of results</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Patients’ BP was opportunistically reviewed and 4 patients were booked into my hypertension clinic for review and medicines optimisation.</li><li>• 20 of the 31 patients had their Urine ACR completed.</li><li>• 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.</li></ul>	<p><b>Learnings from the project</b></p> <p>Team work is so vital in QI processes. By having everyone’s buy in, I was able to achieve great results.</p> <p>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.</p> <p>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.</p>
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# Fellow name: Kendall Todd

## PCN: Morden

### GP Practices: Stonecot Surgery & Central medical Centre

### Clinical area: Chronic Kidney Disease and CVD Prevention

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

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## Initiation of SGLT2 Inhibitors for Patients with CKD

### 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.

### 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.

### Project plan

- Create list of patients
- Every week, allocate an hour to review 10 patients to see if they fit the criteria for SGLT2i.
- Book eligible patients in for a medication review to discuss further.
- Update excel spreadsheet regarding outcome of conversation/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

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.

### Learnings from the project

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. 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 2 conditions tend to go hand in hand.

### Contact Details



# Fellow name: Dr Sana Shahid

## PCN: Merton East

## GP Practice: Cricket Green Medical Practice

## Clinical area: Chronic Kidney Disease and CVD Prevention



### Updating Coding for Patients with CKD to Increase CVD prevention

#### 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.

#### 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 testing as required, by the end of January 2024.

#### Project plan

Invites will be send out to patients for blood tests and then CKD coding will be done 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 from the project

- 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.

#### Contact Details

# Fellow name: Sylvie Keumajou

## PCN: South Southwark

GP Practices: Tessa Jowell Health Centre & Parkside Medical Centre

Clinical area: Chronic Kidney Disease and CVD Prevention



### Increasing Testing for Patients with Possible CKD

#### Problem statement

We have identified that there are 178 patients aged 18 or over with possible chronic kidney disease with an eGFR <60 who have not had an eGFR repeated in 2 years.

#### Aim

To code as many patients as possible with CKD, optimise therapy in 50% of patients and ensure appropriate management and referral where possible by the end of January 2024.

#### Project plan

- Patients aged over 18 with eGFR <60 who have not had eGFR repeated in 2 years will be referred to have their eGFR and uACR repeated.
- I will then code patients with up to date CKD coding.
- The project was to be carried out across two practices by completing a search for patients who met the criteria.
- The project was discussed at the clinical meeting and the reception team and trainee pharmacist were involved in the project to ensure that the process was running smoothly.

#### Summary of results

178 patients were identified with 37 at Parkside Medical Centre and 141 at Tessa Jowell Health Centre.

Of these 178 patients, 108 undertook follow-up testing. The results were:

- 9 followed lifestyle advice and returned normal eGFR results
- 95 were coded on CKD register
- 4 were referred to secondary care

At least 20% of those diagnosed with CKD have been reviewed and started on the appropriate treatment as per NICE guidelines.

This project was possible as a result of collaborative working relationship between the clinical team and the admin team.

#### Learnings from the project

- Diagnosing and coding was challenging and time consuming for many reasons.
- Many patients did not believe they had kidney disease because they did not have symptoms.
- Some patients had had blood test's at the hospital with no uACR and it was difficult to convince them to come and provide a urine sample.
- This project highlighted the importance of managing CKD to reduce risk of cardiovascular disease.
- This project was successful due to taking time to understand the patient's experience and expectation.
- It worked well due to working as a multidisciplinary team and educating the team.

#### Contact Details

# Fellow name: Heather Sagoe-Addy

## PCN: North Southwark

## GP Practice: Nexus Health Group

## Clinical area: Chronic Kidney Disease and CVD Prevention



### Identifying Chronic Kidney Disease in At-Risk Patients

#### Problem statement

Nexus Health Group has a patient list size of 76,000 patients. The CKD register is not reflective of number of patients who are likely to have the disease. Coding of CKD is not completed routinely.

We have identified 700 patients who have had two eGFR's below 60 in the last three years who are not coded for CKD.

#### Aim

Reduce the number of patients who have had an eGFR <60 without follow-up in the last 3 years by 10% by January 2024.

#### Project plan

- Identify eligible patients and determine project scale.
- Engage on-site clinical team for project discussion.
- Initiate patient contact using appropriate channels, starting with high-risk, lowest eGFR results within the next month.
- Develop standardised assessment protocol for comprehensive reviews, considering co-morbidities. Assess patient needs within two months.
- Receive and process test results. Regularly review patient list, ensuring clinicians file/code results appropriately. Conduct ongoing reviews post result processing.
- Implement a color-coded tracking system for easy visual tracking.

#### Summary of results

In total 70 patients were reviewed, which achieved the 10% goal. Of those patients:

- 19 patients were identified as having CKD and coded appropriately.
- 11 patients either did not complete their blood/urine tests or are awaiting results.
- 15 patients were uncontactable.
- Remarkably, 25 patients demonstrated a return of their recent eGFR to normal levels. Some of these patients were not contacted if their results were recently normalised.
  - Utilised the 'at risk of CKD code'
  - I will revisit this list and request further testing periodically.

#### Learnings from the project

- There was an improved general knowledge on CKD which positively impacted medication reviews and diagnosis, even outside the project scope.
- This project improved my communication skills with patients and fostered positive working relations with my healthcare colleagues.
- Some patients appreciated discussions/consultations and expressed readiness to improve their health conditions.
- The number of CKD diagnosis rose at the practice. This increase ensures that patients receive the necessary care and monitoring, allowing for appropriate prescribing and timely interventions.

#### Contact Details

# Fellow name: Dr Tariq Khalil

## PCN: South Southwark

### GP Practice: The Camberwell Green Surgery

#### Clinical area: Chronic Kidney Disease and CVD Prevention

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

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## Implementing Care Processes for CKD Patients Without Diabetes

### 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. The 8 care processes are: smoking, alcohol, BP, BMI, eGFR, Urine ACR, serum cholesterol and HbA1c.

For this project the ninth care process is kidney failure risk equation score (KFRE).

There are currently 201 non-diabetic CKD patients, of those:

- 26 (13%) have had 8 care processes complete
- 0 have had all 9 care processes complete.

### 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.

### Project plan

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

### Summary of results

- 52 (26%) have now had 8 care processes
- 51 (25%) have now had 9 care processes
- 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.
- Many patients who are not diabetic on the CKD register have benefitted from greater monitoring. Gathering this data has identified areas that require interventions, including blood pressures, cholesterol, weight and providing lifestyle advice.

### Learnings from the project

1. All stakeholders were motivated and keen to improve their knowledge of CKD and management of CKD patients.
2. Having staff skilled at creating searches and templates was beneficial and allowed us to modify them as required.
3. 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.
4. 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.

#### Contact Details



# Fellow name: Dr Tariq Khalil

## PCN: South Southwark

### GP Practice: The Camberwell Green Surgery

#### Clinical area: Chronic Kidney Disease and CVD Prevention

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

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## Updating Coding & Kidney Failure Risk Equation in CKD Patients

### 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.

### Aim

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.

### Project plan

1. Identify patient group and discuss with students and HCAs who are assisting.
2. Instruct and mentor students to undertake patient assessments.
3. Create a dashboard to demonstrate progress and missing data or interventions.
4. 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 from the project

- 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 HIN CKD group meetings, we had established that the worst values should be used so that patients would benefit from greater monitoring and interventions.

#### Contact Details

# Fellow name: Dr Zoe Spyvee

## PCN: South West Merton

### GP Practice(s): Grand Drive Surgery

#### Clinical area: Chronic Kidney Disease and CVD Prevention

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During this project the QOF CHOL001 has risen from 65% to 82% in January 2024, this is in part due to this project ...

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## Increasing Secondary Prevention Lipid Lowering Therapy in CKD

### Problem statement

As a practice we are routinely offering all patients with CHD/PAD/CVD lipid lowering therapy as secondary prevention. However, the approach may not be as consistent with patients who have CKD alone and no other cardiovascular disease.

There is a total of 322 patients on the CKD register. Of those 136 (42%) were found to not have an active statin or lipid lowering therapy prescription or code for not tolerated, declined or contraindicated within the last 6 months.

Of those patients, 97 were identified as CKD without other CVD, this is the target group.

### Aim

To offer 95% of the identified cohort of patients the opportunity to check their cholesterol and book an appointment to discuss lipid lowering treatment by March 2024.

### Project plan

- Discuss with relevant stakeholder at the practice.
- Provide update in clinical meeting regarding project and current treatment guidelines.
- Contact patients by text or call, on at least two occasions.
- Book appointments and review patients.

### Summary of results

Of the initial cohort of 97 patients:

- 16 patients started on statin
- 34 patients declined
- 15 patients LLT was not indicated
- 6 patients did not tolerate LLT
- 1 patients LLT was contraindicated
- 7 removed as no longer meeting criteria for CKD
- 5 patients were inactive
- 13 patients did not respond

### Learnings from the project

The number of patients declining lipid lowering therapy was high at 35% and on reviewing the notes many patients had already had discussions over preceding years regarding statin treatment and previously declined this.

As expected it was difficult to engage some patients in discussion around lipid lowering treatments due to a reluctance to take medications and concerns regarding statins. There were also some patients who felt concerned by a text message regarding CKD, despite the careful wording around this.

#### Contact Details

# Fellow name: Deborah Ologun

## PCN: Aplos Health

### GP Practice: Plas Meddyg Surgery

#### Clinical area: Hypertension



## Optimising Blood Pressure Management

### Problem statement

There are a number of patients aged 80 or over with hypertension in whom the last blood pressure reading is 180/90mmHg or over.

Additionally there are systems challenges which result in double coding of blood pressures submitted by patients, making it seem like their blood pressure is not well controlled when we run searches. This is then found to not be the case when the patients are called in for a review.

### Aim

To review the 30 patients in our target group whose blood pressure is not well controlled and help them to achieve control. To also look at coding issues alongside this.

### Project plan

- To recall all patients in target group. Patients encouraged to keep a diary of their readings.
- Reception given a protocol including for high readings to ask patients for a 7-day diary, and provide monitors if needed; for very high readings patients are sent to hospital.
- Readings will no longer be entered by reception - ensuring no duplication of entries.
- I will personally review all booked patients, optimising medications. Nurse appointments will be used to address medication adherence.
- Ongoing system aims to meet project goals, QOF targets, improve patient care, and reduce CVD risk.

### Summary of results

- 27 / 30 patients were reviewed as part of the project. They were reviewed and where needed booked for follow up appointments.
- The project helped improve patients care.
- We have reduced the risk of cardiovascular events in the highest risk group including encouraging patients to monitor their blood pressures at home, and increased medication adherence.
- We have continued seeing patients in other hypertension groups that need reviews and medication optimisation.
- The practice has also improved its procedures with regards to coding of blood pressure results.

### Learnings from the project

Getting the whole team involved helped the project. Reception and admin team had the greatest contribution - they ensured patients were booked in and recalled where necessary.

Recall was the most difficult part of this project - some patients were just impossible to get through to. Housebound patients were a difficult group to see. Initially we referred them to district nurses and community nurses, but could not monitor the appointments and progress.

### Contact Details

# Fellow name: Claire Dampier

## PCN: Aplos Health

### GP Practice: The Albion Suregry

#### Clinical area: Hypertension



## Blood Pressure Screening for Early Detection of Hypertension

### Problem statement

There is a high number of patients over 45 with no blood pressure reading on record for five or more years.

### Aim

The aim is to reduce the number of patients in this group by 25% by the end of January 2024.

### Project plan

- 1029 patients were identified as being in this group.
- The way to make this effective is to ensure it is communicated with all the team within the practice.
- Blood pressure readings should be asked for opportunistically to reduce the overall list size by all clinicians and prescription clerks.
- Patients will also be texted or called to ask for readings and will also be sent instructions to visit their local pharmacy or book an appointment at the practice if preferred.
- Raising awareness with patients will also help to improve future uptake.

### Summary of results

In total 78 patients were contacted, and of them:

- 60 did not respond
- 13 were found to be in range
- 2 booked appointments and were found to be raised. They are undertaking 7 day monitoring.
- 3 booked NHS health checks are were found to be in range
- Contacting patients was challenging as often we did not get a reply but I will continue the work to reduce this further.
- The self-check BP machine will be set up shortly which is a massive change for the surgery. This can be used for any patient requiring a one off BP reading.

### Learnings from the project

- Sending texts to the patients worked better than calling them as required less time. The texts sent to the patient asked them to reply with a blood pressure reading which they could either check themselves at home, at the local pharmacy or book in at the surgery. I think giving the patient options worked well also.
- Many patients in this cohort were difficult to contact.
- The other barrier faced was lack of understanding from the patients. It was hard to explain the importance of blood pressure monitoring.
- Assigning time to contact these patients was not always easy to arrange.

### Contact Details



# Fellow name: Dina Thakker

## PCN: Croydon Supernetwork

### GP Practice: Hartland Way

Clinical area: Hypertension



## Blood Pressure Screening for Early Detection of Hypertension

### Problem statement

There are a large number of patients who have not had a BP check in the last 5 years. The Nationally Commissioned NHS Community Pharmacy Hypertension Case Finding Service (HCFS). is an underutilised service in supporting these patients.

### Aim

Target 250 patients over 4 weeks (via text message), who are over 40 years of age who have not had a BP check in over 5 years.

The project will work with GP practices to develop a pathway in SWL so the HCFS service is utilised and optimised to support both parties in delivering their priorities.

### Project plan

- Involve practice manager and CVD lead within practice. Focus on one area which will help QoF and end of year reporting for the practice.
- Patient cohort selected in Oct/Nov using the search 'BP - no check 5 years'.
- Create an Accurx florey link so this could be tracked, coded back into EMIS so this would help QoF for EoY
- Test link works with a dummy patient Nov 23 and then continued to send these out Nov/Dec.
- Send first batch of 50 and track within Excel. Text next 50 batch week on week with last batch end Dec 2023.

### Summary of results

- The data was analysed in Jan 2024. From 274 patients, 250 patients were texted. From this data 23 patients reported going to a pharmacy.
- Also, we recognised that with patients who have not had a BP check in 5 years - behaviour change would be needed.
- Practice manager was able to understand the community pharmacy pathway better and saw the benefits of the approach in reducing practice workload and supporting EoY.
- Going forward we will develop a pathway for SWL, and comms for patients able to access pharmacies to use the service.

### Learnings from the project

- PCN pharmacist was great in facilitating the project
- The technology using AccuRx Florey's to send messages worked well
- Speaking to local pharmacies with regards to the message patients would receive was important, and to encourage input via the link on message so the BP is coded directly within the practice

#### Challenges:

- Working across SWL and engaging practice teams to create pathways to involve community pharmacy
- Limitation in texting allocations where practices have competing priorities e.g. Flu
- Limitation of capacity for re-call on the links sent to patients

#### Contact Details

# Fellow name: Enrico Mandello

## PCN: Stockwellbeing

## GP Practice: Stockwell Group Practice

## Clinical area: Hypertension



### Detecting Hypertension in a Hard to Reach Population

#### 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.

#### 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.

#### Project 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.
- 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 the project

- 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.

#### Contact Details

**Fellow name: Jenny Clout**  
**PCN: Grafton Medical Partners**  
**GP Practice: Trevelyan House GP Practice**  
Clinical area: Hypertension



## Addressing Health Inequalities in Hypertension Management

### Problem statement

To address the health inequalities from when English is not a first language regarding hypertension management

### Aim

S: Increase the number of patients' blood pressure to within range where an interpreter is required  
M: Measured using EMIS data for Trevelyan House patients  
A: This is initially a small cohort as I will be working alone, it can then be scaled to include other cohorts and surgeries  
R: Through understanding the barriers faced by this cohort, I will tailor communication to assist concordance  
T: Monthly targets to ensure I am on schedule with the project to be completed in February 1st.

### Project plan

- To ensure the data is correct through manually reviewing each patient record.
- To investigate the barriers to why their blood pressure is not to target using a short questionnaire via phone call.
- To try different methods of communication to assist with increasing knowledge and increased concordance.
- Additional printouts and templates including text messages in various languages to be created.
- To be completed on Thursday mornings before clinic begins.

### Summary of results

- 25 notes were reviewed and 15 patients were contacted, with a final sample of 7 requiring an interpreter.
- 18 patients had uncontrolled BP, of which 33% required interpreters.
- 57% with interpreters achieved target levels. Barriers extended beyond language, encompassing mental health, socioeconomic factors, multimorbidity, trust issues, disinterest, and fear.
- Initiatives involved teaching sessions on health inequalities and understanding the broader context
- For the future we are exploring working with non-health institutions like mosques and clubs.
- We will also use double appointments where an interpreter is needed and work with clinicians who speak more than one language.

### Learnings from the project

- Looking closely at and raising the awareness of health inequalities relating to blood pressure management. Using the Reducing Healthcare Inequalities guidelines to drive targeted action regarding blood pressure management.
- Establishing and trialing methods to address and assist protected characteristics and expanding it to other health conditions.
- Thinking critically about behaviour change and the barriers surrounding it.
- Addressing missed appointments and blood pressure monitoring - we used diverse communication methods and repeated follow-ups.
- Establishing actual reasons why patients are not engaging, likely this is multifactorial.

### Contact Details



# Fellow name: Ramat Popoola

## PCN: North Bexley

### GP Practice: North Health Medical Centre

Clinical area: Hypertension



## Optimisation of Anti-hypertensive Medication in High Risk Patients

### 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)

### Aim

Aim to reduce the list of patients in UCLP Group 1 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.

### Project 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 now have their BP within acceptable range due to up to date readings, or optimisation of medication.
- 7 of the 26 patients are now being actively managed with regular reviews scheduled.
- 1 housebound patient was referred to the District Nurse.
- 3 patients were excluded.
- New patients have been added to the list, they are also being managed regularly. We are more intentional in our recall of patients for their BP check.
- New patients are being added to our hypertension register as we are testing more, hence detecting more patients.

### Learnings from the project

- 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.

### Contact Details



**Fellow name: Dr Nabila Khan**  
**PCN: Mayday South**  
**GP Practice: London Road Medical Practice**  
Clinical area: Hypertension



## Treatment Optimisation in Hypertensive Patients

### Problem statement

There are a large number of patients at our practice who have a recorded blood pressure which is above the desired range, particularly in patients under 79 years of age.

### Aim

To review all the patients in the target group who are contactable (often abroad) to review BP and medication.

There are currently 584 patients age 79 and under in this group, and 142 patients age 80 and over.

### Project plan

- Work as a team—tasks divided amongst the group
- Project shared with rest of the clinical and non-clinical team at meetings
- All agreed we need to be proactive in BP review /coding and calling those who have not had their BP/bloods done this year
- Patients to be texted or called in small batches
- Share good practice /clinical nuggets from seminars
- All updated about improvements as the project went on
- PCN pharmacist has been giving us monthly data.

### Summary of results

- By end of January 2024 87% of patients age 80 and over who had a BP above target are now below 150/90
- 71% of patients age 79 and under who had a high BP are now below 140/90
- We continue to work on this - with an aim to increase this to at least 77% for those under 70 (QOF target)
- One nurse at the practice has been doing extra sessions to focus on the work with patients
- We have been reflecting on feedback from PCN pharmacists and at PCN meetings, and comparing ourselves with local practices

### Learnings from the project

- Time was a challenge - had to work around meetings. Having fewer longer meetings might have been better.
- Current method of searching and sending group text messages to a smaller number of patients, alongside calling patients (due to age / disability). We will continue this until March, and then start again.
- Patients have appreciated being called and reviewed.
- Using the Community Hypertension Service has worked well.

### Contact Details

**Fellow name: Sharmila Govindaraj**  
**PCN: Central Sutton**  
**GP Practice: The Health Centre, Robin Hood Lane**  
Clinical area: Lipids

“  
Patients were happy with  
better lipid control and  
their reduced risk of  
cardiovascular disease  
”

## Cholesterol Treatment Optimisation to Reduce CVD Risk

### Problem statement

There are a large number of patient on the CVD register that do not have their cholesterol levels treated to target. .

433 patients have been identified with cholesterol levels not within the target ranges - LDL <1.8, non-HDL cholesterol <2.5.

### Aim

To achieve cholesterol targets (LDL <1.8, non-HDL <2.5) in 25% of the target group by January 2024.

### Project plan

Create lipid clinic appointment slots to review cholesterol and lipid lowering therapy (LLT) medications. Review target group and ensure patients have up to date bloods, <3 months. Send out batch SMS with link to self-book into lipid clinic appointments.

### Summary of results

Out of the 433 patients in the target group, we managed to control cholesterol to target in 133 patients, which accounts for 30% of the total.

Clearer understanding of lipid lowering therapies and new cholesterol target levels was achieved amongst staff.

### Learnings from the project

- Education of the team, including starting a journal club with hospital consultants helped with clinical staff engagement.
- Treatment pathways were circulated.
- Lipid clinic slots were easier to book patients into.
- Creating a multi-disciplinary team was very effective.
- Due to capacity of blood test appointments, requests were staggered to not overrun services.

### Contact Details

# Fellow name: Mahtab Mahdavi

## PCN: Beckenham

### GP Practice: Cornerways surgery

#### Clinical area: Lipids



## Initiating Secondary Prevention To Reduce CVD Risk

### Problem statement

At Cornerways Surgery there are 62 patients who have a history of cardiovascular disease who are not taking a statin.

This group is the priority group 1 (highest risk) which was identified using the Prescribing Improvement Scheme EMIS searches. This places these patients at risk of further cardiovascular disease.

### Aim

The aim is to review all 62 patients coded with CVD and not on a statin at Cornerways Surgery by the end of January 2024.

### Project plan

- Undertake search for patients who meet the criteria.
- Create appointment slots for lipid clinic.
- Invite patients for blood test and then to book in for appointment.
- Discuss lipid lowering therapies and initiate treatment.

### Summary of results

Records were reviewed for all 62 patients. Of these -

- 15 started on statin/ezeimibe
- 8 - declined secondary prevention
- 12 contraindicated/not tolerated
- 5 under specialist review
- 1 inactive patient
- 5 live out of UK
- 3 indication not clear - need further review
- 13 treatment with statin not clinically indicated

I will continue to follow up with patients to improve the results.

### Learnings from the project

- I found patient education and effective communication is very important to enhance patient engagement
- This project has increased my knowledge and confidence in lipid management
- I have learnt how to communicate with anxious patients and those unsure about treatment.
- The patients identified in the study have benefited, as they have a greater understanding of lipid levels and the importance of starting and continuing on statins.
- Doing this project has created more of an awareness and more thought about statins, cholesterol levels and lipids, which will carry forward to the future patients we all see as a surgery.

#### Contact Details

# Fellows: Natasha Patel & Dr Naziha Khawaja

PCN: Sutton

GP Practice: James O'Riordan Surgery

Clinical area: Lipids



## Initiation of Statins for Secondary Prevention of CVD

### Problem statement

We have a large number of patients on the CVD secondary prevention register who are not on a statin or lipid lowering therapy.

There were 64 people of 349 (18%) on the Secondary prevention population who were Priority group 1 (highest risk) and not on a statin.

### Aim

To reduce the number of people not on a statin on the secondary prevention register by 50% to 32, by the end of the QOF year.

### Project plan

Review data and each case individually. Do a blood test to check LFTs and lipids if not done in the past 6 months. Contact each patient to discuss the reasons for commencing lipid lowering therapy.

### Summary of results

64 patients identified:

- 1 was deceased
- 9 excluded due to frailty
- 4 patients inactive on EMIS

Of the 50 patients remaining:

- 9 started on statin
- 5 declined
- 2 referred for advice and guidance
- 10 awaiting blood tests/results
- 14 awaiting follow-up
- 1 patient trialing lifestyle changes
- 5 non-contactable
- 4 coding issues with diagnosis

### Learnings from the project

1. Improved knowledge within the team as sharing of learnings and knowledge regarding lipids.
2. Patients better understand why they should be taking a statin, empowering patients to take more control of their health and are more able to make a better informed choice. Better patient understanding due to more time spent in consultations.
3. More patients have their blood tests up to date as a result of the work carried out
4. More pharmacists involved in CVD work.
5. Staff more aware regarding local lipid guidance and breaking barriers to increase statin prescribing and titrating doses and considering different regimes.

### Contact Details



# Fellows: Audrey Lee Karan & Seema Thapliyal

## PCN: Croydon North

## GP Practice: Norbury Medical Practice

Clinical area: Lipids

“

The use of the decision aid was taken positively by patients as they felt more in charge of making a decision

”

## Offering Statins to Diabetic Patients for CVD Prevention

### Problem statement

Patients with type 1 diabetes who are not on a statin are at risk of cardiovascular disease.

In order to offer primary prevention of CVD we will search for these patients and offer statins.

### Aim

To offer lipid lowering therapies to 100% of patients with type 1 diabetes in 8 weeks.

### Project plan

Aim of the project to be shared with the clinicians and team involved. We will be looking to review all the type 1 diabetic patients on the register using Ardens search. Check the statin prescriptions, review if need optimisation.

### Summary of results

- ~60% of the target group were started on statins.
- The project summary was discussed with the team and barriers faced.
- The learnings i.e. how to run population search, coding, use of accurx, sending delayed accurx for patient reminders, making templates were shared.
- Project is ongoing and will continue to be used for other LTC management too ie patients on CKD register.

### Learnings from the project

- The fellowship helped us to enhance our skills not only for statin prescribing but also on how to manage CVD risk in primary care.
- We were able to answer patient concerns around statins using evidence.
- Being able to offer choices of times for appointments worked well.
- Team work with in the practice and time management was the key to deliver this project in practice.
- Learning and guidelines were shared across the guidelines for lipids prescribing were shared to improve prescribing.

### Contact Details

**Fellows: Dr Shahina Shaikh, Dr Poornima Joshi, Krishnaa Pandya**

## **PCN: Croydon Link**

**GP Practice(s): East Croydon Medical Centre**

Clinical area: Lipids

“

It is nice to know the GP is caring about my health and explanations received about why cholesterol management is important

”

### **Secondary Prevention in High Risk Patients**

#### **Problem statement**

We have patients with coronary heart disease, PAD, stroke, TIA or CKD who have not been prescribed lipid lowering therapy. 190 patients were identified through EMIS searches in September 2023.

#### **Aim**

Review 30% of patients with previous CVD who are not prescribed lipid lowering therapy by the end of January 2024.

#### **Project plan**

We plan to address this problem by creating a process map based on SWL guidance. We will run PDSA cycles to refine the process.

We used the UCLP framework and Ardens templates to structure the reviews, with a holistic approach around all CVD risk factors and using shared decision making.

#### **Summary of results**

We have reviewed 107 patients in total, which is 65% of the initial cohort.

- 18 agreed to start a statin
- 19 declined to start any form of lipid lowering therapy
- 7 patients wanted to think more about it and book a follow-up appointment
- 4 we are still waiting to confirm a diagnoses
- 6 patient we are waiting from a response from advised and guidance
- 47 patients were reviewed and found to be not suitable or did not meet the criteria for lipid lower therapy.

#### **Learnings from the project**

We identified that the practice would benefit from further education around CKD management and we organised the HIN CKD presenters to hold an education session.

We have improved our practice process for CKD detection and increased our CKD register by improving our coding.

Overall it had broadened everyone's understanding and importance of coding, how to diagnose CKD and what interventions are needed. This project will be developed further to look at CKD management and also CKD screening in hypertensive patients.

#### **Contact Details**

# Fellow name: Sandip Bhogal

## PCN: North Southwark

## GP Practice(s): Penrose Surgery

## Clinical area: Atrial Fibrillation



### Identifying AF Patients Not Prescribed an Oral Anticoagulant

#### Problem statement

There are patients at the practice who are at high risk of stroke due to not being anticoagulated.

#### Aim

To review the notes of all AF patients not prescribed an oral anticoagulant (no = 18) and identify if there is a clinical rationale for not being on an oral anticoagulant. This will take place between November and December 2023.

Where relevant follow-up arrangements will be made with the patient to discuss this with a member of the in-house pharmacy team.

#### Project plan

I will review patient notes, and make necessary arrangements for follow-up appointments.

I will also receive direct feedback from the in-house pharmacy team, who will do the same opportunistically, where practically feasible.

NB - there is currently a significant staffing shortage amongst all clinical groups, including pharmacy/pharmacy admin, which means I am likely to need to do the majority of the delivery.

#### Summary of results

- 18 patients were reviewed.
- Some patients who no longer had AF were identified, and were recoded. The importance of accurate coding was filtered down to the team at a subsequent team meeting discussion
- Of the 18 patients 11% were identified as not having a clear reason for not being anticoagulated. Following a review of their notes and subsequent consultations, they will be referred (with consent) to secondary care for consideration of DOAC use, as per local protocol. This may reduce their future risk of AF-associated stroke morbidity

#### Learnings from the project

- The project was compact and concise enough to predominantly be completed by one individual. If the priority areas were increased, it would have become unmanageable.
- There was a clear process in place to call in patients who needed to be reviewed to discuss prescribing an anticoagulant. An SMS template was created for this purpose.
- There was good joined up communication between myself and the in-house pharmacy team, who would be undertaking the patient reviews.
- A challenge was the lack of some of the important tools in anticoagulation risk assessment being embedded into our clinical systems.

#### Contact Details

# Fellow name: Thileepan Thevarajan

## PCN: Lewisham Alliance

### GP Practice(s): Nightingale Surgery

#### Clinical area: Atrial Fibrillation



## Identifying AF Patients Not Prescribed an Oral Anticoagulant

### Problem statement

There are a number of patients with AF who are not on anticoagulants despite it being clinically indicated.

### Aim

To identify patients in UCLP Priority Group One - patients with AF who have a CHAD2DS2-VASc  $\geq 2$  and are not anticoagulated, and discuss initiating anticoagulation with them, considering their clinical context including the ORBIT score. A decision will be made for 100% of identified patients by January 2024.

### Project plan

- I will work with the IT team to run the relevant searches to narrow down the patients with AF into the target group.
- For patients with CHAD2DS2-VASc  $\geq 2$  and who are not on anticoagulation, I will manually look through the patients clinical records to see if there is any reason for this.
- Where no reason is indicated I will contact the patient to discuss initiating anticoagulation.
- I will be assisted by our clinical pharmacist on this task and we will aim to complete by end of December 2023.

### Summary of results

Of 72 patients with AF:

- 25 had a CHAD2DS2-VASc recorded. 11 were  $\geq 2$ , of which 2 were not anticoagulated.
- 47 patients did not have a recorded score, of which 11 patients were not anticoagulated.

Combining these two groups, 13 patients were not on anticoagulants. 4 were identified who met CHAD2DS2-VASc criteria for anticoagulation and did not have a clinical contraindication, of these:

- 1 patient chose not to restart medication.
- 1 patient was in hospital.
- 2 patients could not be reached.

### Learnings from the project

- Large numbers of patients did not have a CHAD2DS2-VASc coded. This meant we could not easily run a search to check if they were / were not appropriately on anticoagulation based on scoring. Due to time constraints a decision was made to focus on patients who weren't on anticoagulation.
- Prescribing issues were identified in 2/4 cases who met CHAD2DS2-VASc criteria for anticoagulation and did not have a clinical contraindication. This highlighted communication issues in handover and GP taking over prescribing. Identifying this can avoid future errors.
- Contacting patients to discuss their anticoagulation was difficult.

### Contact Details



# Fellow name: Natasha Thaladi

## Location: GSTT Complex Hypertension Clinics

Clinical area: Atrial Fibrillation



### Atrial Fibrillation Screening in 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.

#### Project plan

- All patients at Bexley F2F appointments will be offered screening using Kardia Mobile device.
- 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.
- We hope to then roll this out in Southwark and Lambeth when these clinics also become F2F.

#### 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 from the project

- 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.

#### Contact Details

# Fellow name: Amish Patel

## PCN: Selsdon, Purley, Coulsdon

### Valley Pharmacy

Clinical area: Atrial Fibrillation

“  
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.  
”

## Using Social Media to Increase Screening of Atrial Fibrillation

### Problem statement

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

### 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.

### Project 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. Of those 97 patients;

- 71 were aged over 65 yo.
- 23 responded to the pharmacy's social media platforms
- 74 responded to community platforms.
- 83 patients booked an appointment
- 14 walked in without a booking.
- Screening increased month on month - from 8 in November to 76 in January.
- 1 case of possible AF was detected. The result was shared with the GP.

### Learnings from the project

- The campaign exceeded expectations showing the value of community platforms & social media for health service awareness / patient engagement. Time to refine the digital assets was a challenge.
- 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
- Booking system was used a lot and helped us manage workload.
- Winter pressures impacted on project delivery.
- Set up phase was most time intensive so needed to allocate more time to this which was difficult with other work.

### Contact Details

**If you would like any more information about  
this programme or to be involved contact:**

**hin.cvd@nhs.net**

