Detecting Hypertension in High-Risk Patients

Clinical area: Hypertension

Chinyere Ezewuzie
PCN: North Lewisham
GP Practice: Kingfisher Medical Centre

Aim

To identify new cases of hypertension within the target group based on ambulatory blood pressure monitoring (ABPM) readings (average daytime BP > 135/85mmHg); and to diagnose 20% of this group with hypertension by November 2024.

Problem statement

- There are a high number of patients with a blood pressure reading over 160/100 (UCLP priority group 2a) without a coded diagnosis of hypertension.

Baseline data

- An EMIS search identified 32 patients within the target group of patients with a last recorded blood pressure (BP) reading over 160/100, without a coded diagnosis of hypertension.

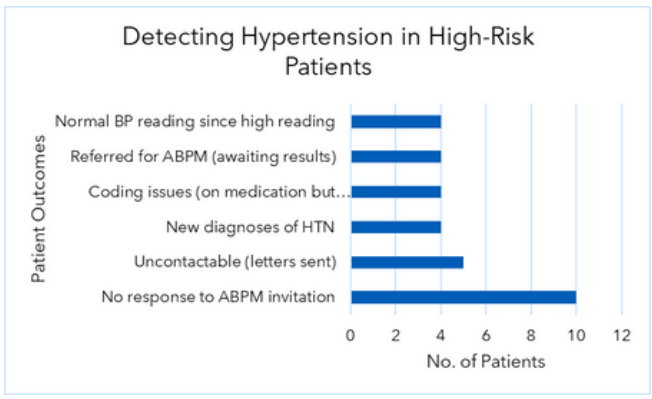
Aim and plan

- Contact identified patients explaining that they have been identified as someone who will benefit from an ABPM check.
- Identify if the patients have upcoming appointments, so patient can be offered a BP during the appointment.
- If the BP is still raised, refer the patient for ABPM.
- Invite any patients who have raised readings on ABPM for a follow up with a clinician to discuss the new hypertension diagnosis.

Summary of results

Several patients were diagnosed with hypertension which means that they can have the appropriate follow up and treatment. However, there were data quality issues. For example, some patients were recorded as having a BP >160/100, but on closer review of their notes, they had a normal BP reading later on, but as their BP was just recorded in free text on EMIS it was not picked up on the search. Additionally, a few patients were actually taking BP medications, but they were not coded as having hypertension on EMIS.
Of the 31 patients

- 10 have not responded to ABPM invitation
- 5 were uncontactable (letters sent)
- 4 new diagnoses of HTN
- 4 coding issues (on medication but NOT coded as HTN)
- 4 referred for ABPM (awaiting results)
- 4 normal BP reading since the high reading (written in free text so not picked up on EMIS search)



Learnings

- Patients who hadn't responded to ABPM invite had often not done breast & bowel screening or responded to NHS health checks and other QoF related invites from the surgery. I can consider going forward offering these patients an appointment to talk through these issues.

- The process of getting patients booked in for ABPM checks was efficient. I recently spoke to the local pharmacist about the long wait time at the hospital for several services e.g. 24hr ECGs and ABPM. I was pleased to hear that they had 2 ABPM machines and a short wait time. They also told me about other pharmacies providing the same service. It was good to build relationships with local services and we received results from them in a timely manner.

Sustaining the change

- There were several patients that did not respond to invitations for ABPM checks. I will continue to make attempts to get these patients to do this check, or at least come in for a self check blood pressure reading, in case the high reading on record was a one off reading. I will also send them information about the option to do BP readings in other community settings.

- I will speak with the admin staff to encourage them to check for BP readings or a new diagnosis of hypertension in clinic letters and to record it accurately on EMIS so that patients can have appropriate follow up.

Patient or stakeholder story or feedback

One patient responded very promptly to my invite for an ABPM check, I booked them in for this check at a local pharmacy. We received their results within 10 days and it confirmed a diagnosis of hypertension. They had an appointment with the practice pharmacist to discuss the results and agreed (albeit reluctantly) to start medication. This project helped diagnosis this patient with HTN and potentially avoid the consequences of uncontrolled HTN.

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Updating The Coding of CKD Patients

Clinical area: Chronic Kidney Disease

Luqman Dawud
PCN: Cheam and South Sutton
GP Practice: Cheam GP Centre

Aim

To re-code 20% (61) of patients with CKD by the end of October 2024 based on up-to-date eGFR and uACR so patients are correctly risk-stratified.

Problem statement

We have a substantial number of patients currently coded as CKD 3 to 5 in the practice who do not have a new code that includes uACR.

Baseline data

Emis search identified 307 patients coded as CKD 3 to 5 run 11/07/24. 3 of these patients have since been updated to the new codes. Of the remaining 304 patients: 18 patients are already under renal. 90% need a recent uACR, 70% need a recent eGFR.

Aim and plan

- Identified patients who require a recent uACR and/or eGFR will have bloods raised and a text sent to them to invite them for the screening.
- 10 patients will be invited for testing each week.
- A report will be run to identify when recent results are back.
- Once the test results are received, patients will be fully coded. If there are any issues with coding the patient, a task will be sent to the GP to resolve.

Summary of results

Overall, 80 patients were invited for uACR and eGFR testing via text message. To date:

- 32 patients have up-to-date results and have been re-coded
- 4 patients with queries regarding their CKD diagnosis. Task sent to GP to review
- 37 patients are still pending a current uACR
- 7 patients are waiting a current eGFR and uACR
- 51 patients have also had a recent uACR since the project began. They will be reviewed and re-coded if possible or further testing requested if needed.

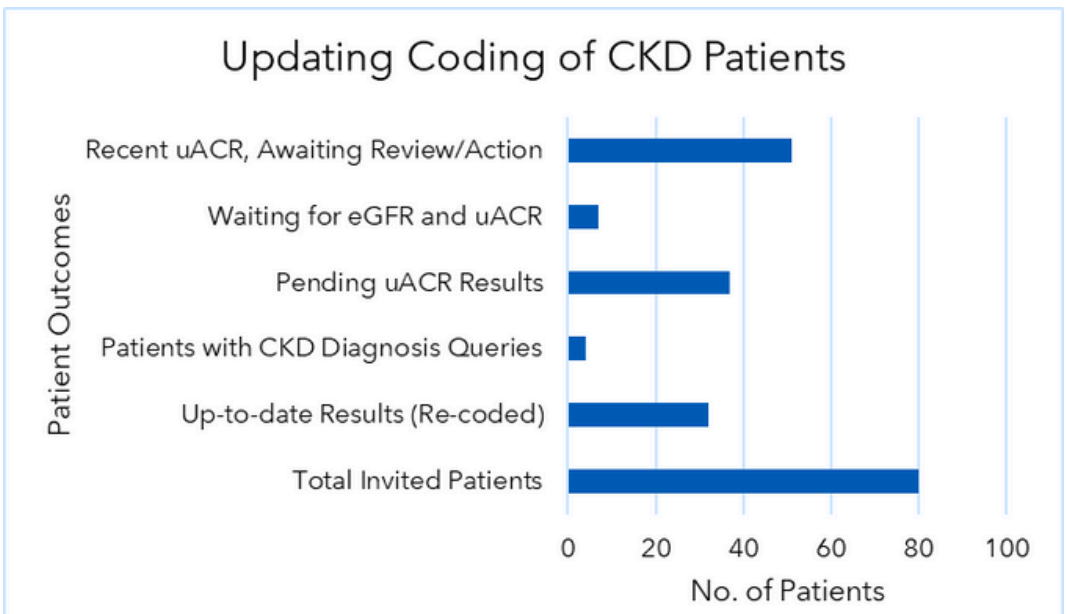
Learnings

Challenges:

- Getting time to focus on the project along with other work streams
- Not being in the practice everyday
- Limited availability of blood tests locally
- New reception staff joining. Needing to reinforce the message about the project and where to direct patients with queries.
- Issues with coding when results are back. Tasking GP and emailing HIN expert for support with these queries.
- Some patients are house bound so we need to see how we can get them tested

Successes:

- Staff were receptive to the project.
- Improved knowledge of CKD and management in primary care
- Coding has improved because of the project.
- Plans to continue the work
- More patients have been followed up due to increased testing and appropriate follow up.



Patient or stakeholder story or feedback

"GPs are happy the coding is being updated. The process compliments the current working practices so there has been no negative feedback to the work done so far."

Sustaining the change

- We will continue to invite patients for screening and review the results to re-code patients.
- The aim would be to have an education session on CKD so all clinicians are aware of local guidance on managing and testing these patients and of the optimal medication

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Pharmacist-led Improvement of Hypertension

Clinical area: Hypertension

Amit Luthra
PCN: Lewisham Alliance
GP Practice: Triangle Group Practice

Aim

To bring at least 50% of patients with severe hypertension (above 180/120mmHg) to better therapeutically controlled BP levels within six months by conducting regular BP readings, medication reviews, and follow-ups for each patient identified in stratified searches.

Problem statement

Severe hypertension (above 180/120mmHg) is affecting a total of 73 patients within the PCN. These patients with poor blood pressure (BP) control are at risk of having a cardiovascular event and long-term macro/microvascular damage leading to complications and possible mortality.

Baseline data

Lewisham Alliance PCN consists of 5 GP's. When this cardiometabolic fellowship started earlier this year, across the PCN a total of 73 patients were identified to have severely high blood pressure (above 180/120mmHg) at baseline. An improvement in the blood pressure readings of this patient cohort will allow to qualitatively measure the success of the project.

Aim and plan

- PCN Pharmacist to run monthly searches on EMIS to identify patients with the most severe hypertension.
- Pharmacist to contact patients, arrange clinics, review meds regimen, prescribe new meds if needed, and educate on BP control.
- Conduct follow-up appts every 2-4 weeks to monitor BP control.
- Encourage lifestyle modifications.
- Track progress of BP control, and document any improvements or interventions.
- Identify patients who are not showing improvement and escalate as necessary.
- Some patients may require escalation, especially those whose BP remains uncontrolled and may require referral to secondary care.

Summary of results

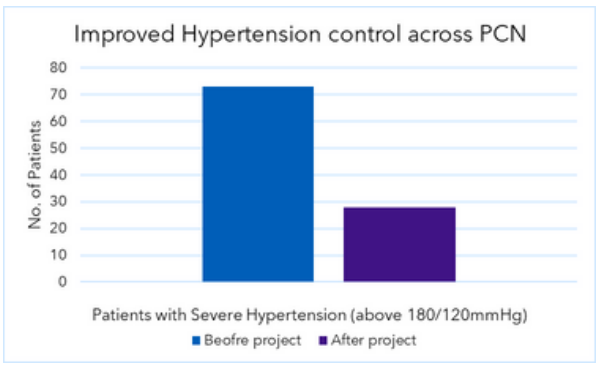
- Some patients whose BP had been recorded higher than 180/120mmHg had not had medication reviews or hypertension monitoring invites for over six months.
- Hypertension control has improved by 61% across the PCN – and we hope to improve this further collaborative.
- After re-running the searches in the PCN, we now have 28 patients in group 1 with hypertension over 180/120mmHg. Many of these patients are either non-responders or have already been referred to a GP colleague/secondary care.
- Alongside focusing on this target group (Group-1 of the UCL Partners Hypertension Risk Stratification Searches), I also reviewed hypertension control for some patients in Group-2 also, which has also improved.

Learnings

- Lewisham is a mixed multicultural community, for some patients in the cohort – English language was not their first spoken language, so language was a barrier sometimes that had to be overcome with interpreter services.
- An HCA was effectively trained and upskilled to take BP readings for patients.
- Attempting to reach out to patients who regularly did not answer their phones, did not reply to text messages, and did not attend appointments has been a challenge. We sent letters, text messages and emails accordingly.
- Patients feedback from themselves, family members and friends all reinforced the need to take time to educate our patients from a clinician's perspective. This helps the patient better understand this asymptomatic disease that they have and to take its implications more seriously.

Sustaining the change

- The PCN will work collaboratively to manage better hypertension control for our patients and prevent patients from remaining on such BP thresholds for prolonged periods. and to protect and promote the health of our patients. Patients who have not responded to 3 or more invites will be investigated by PM's/
- At a PCN level, we have a nominated person to run monthly searches and focus on patients within group 1 to ensure these patients are prioritised to have their BP control reviewed and addressed.



Patient or stakeholder story or feedback

"The receptionist was friendly and informative, and the Pharmacist was nothing but extraordinary. I'm really grateful for his compassion and medical knowledge and time. Lewisham hospital has been awful, brushed me off and I will be complaining to the Trust. Yesterday the GP Pharmacist was so patient and attentive to my medical needs and provided spot-on recommendations - even issued my prescriptions as per my needs without having to put a request in, arranged follow ups without me having to call back and get more stressed. I must commend him for his friendliness, patient focus, and welcoming attitude."

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Early Detection of Hypertension Amongst Patients Aged 25-50

Clinical area: Hypertension

Barbara Segurado
PCN: North Lewisham
GP Practice: Waldron Health Centre

Aim

To measure blood pressure in 40 patients aged 25-50 years old who smoke and/or have a BMI>30, between June and October2024

Problem statement

- In Lewisham it is estimated that 44% of residents have undiagnosed hypertension; NHS health checks target patients aged 40yrs+.
- The project is based on the early detection of hypertension and aims to target people at high risk of developing cardiovascular disease aged 25-50, including people of black and Asian ethnicity.

Baseline data

- A population search was conducted on EMIS to identify patients in the target group.
- This search was refined to specifically target individuals Male or Female from Black and Asian backgrounds, aligning with the project's focus on health equity and addressing disparities in healthcare access and outcomes.
- 40 patients were identified.

Aim and plan

- Contact patients via phone to schedule an appointment with me.
- Measure blood pressure (BP), height, and weight, alcohol and smoking status data during appointment and upload to EMIS
- Review results with a nurse, arrange, appointments with a hypertension nurse or GP if appropriate.
- Patients may also receive a BP monitoring form for a week if a potential new diagnosis of hypertension is identified, after which a follow-up review will be scheduled if required with a nurse or GP.

Summary of results

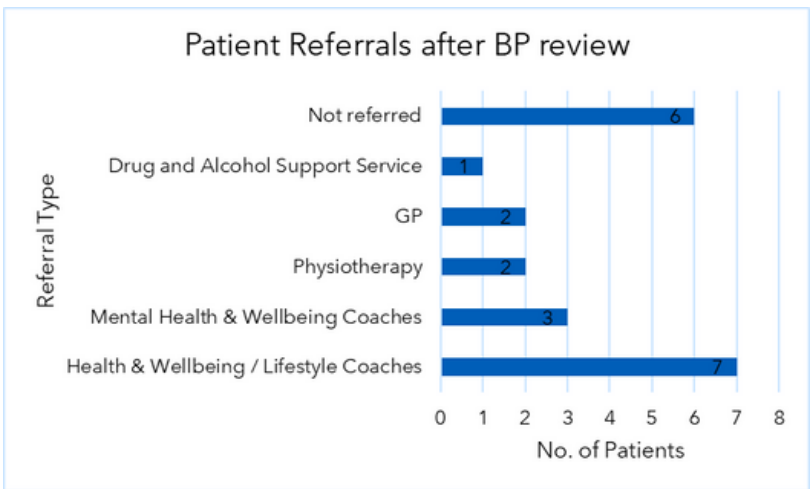
Patients with normal BP=95.3%% (N=20) were in range (<140/90mmgHG). Patients with an elevated BP= 4.7% % (N=1) being high (> 140/90mmHG) and they were referred appropriately.

- Referrals to Physio = 9.52% (2 pt)
- Referrals to Health & Wellbeing / Lifestyle coaches = 33.33% (7 pt)
- Referral to Mental Health & Wellbeing coaches = 14.29% (3 pt)
- Referral to GP = 9.52% (2 pt)
- Referral to outside organisation, Drug and Alcohol support service = 4.76% (1 pt)

Out of 21 patients who attended, 15 were referred to support services (Health & Wellbeing Coaches, Mental Health Coaches, Social Prescribers, or Physiotherapists). One patient had a safeguarding concern and was referred to in-house service teams. One patient was recalled to retake a blood test due to previous borderline results.

Learnings

- Originally a search was conducted to identify patients 25 to 40 years old, however this yielded a small result pool therefore the age limit was increased to 50 years old to expand the patient group.
- Most of the invitations sent by text or voicemail resulted in the patients not attending The strategy of personally contacting each patient via phone call to book and confirm their appointments proved to be highly effective. This approach ensured that every interaction was meaningful, often resulting in referrals to additional services that patients required during consultations, thereby conserving appointments with their primary GP.
- Furthermore, offering patients the opportunity to learn how to monitor their own BP, accompanied by relevant educational materials, was positively received. This initiative was both empowering and informative for the patients.



Patient or stakeholder story or feedback

The most impactful story involved a patient with unmanaged diabetes who was also experiencing abuse. They felt safe and comfortable enough to share their situation, allowing us to provide the necessary support, including an adult safeguarding referral.

Sustaining the change

With the support of my management and our team, we will continue doing blood pressure checks at patients aged 25-50 years old by booking appointments and also opportunistic Health Checks. Referring as many patients as possible to our services, thereby freeing up much-needed GP appointments.

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Review and Optimise Medication for CKD Patients Stage 3-5

Clinical area: Chronic Kidney Disease

Kate Tebbs
PCN: Modality
GP Practice: Modality Lewisham (South Lewisham site)

Aim

To review and optimise medication for CKD patients stage 3-5, under 80 years of age, with a BP last recorded not in the target range.

Problem statement

28% of patients at Modality Lewisham with CKD stages 3-5 do not have a last recorded blood pressure within the target range.

Baseline data

Number of patients on CKD register stage 3-5 who do not have a blood pressure in the target range and who are under 80 years old and registered at South Lewisham site (126 patients)

Aim and plan

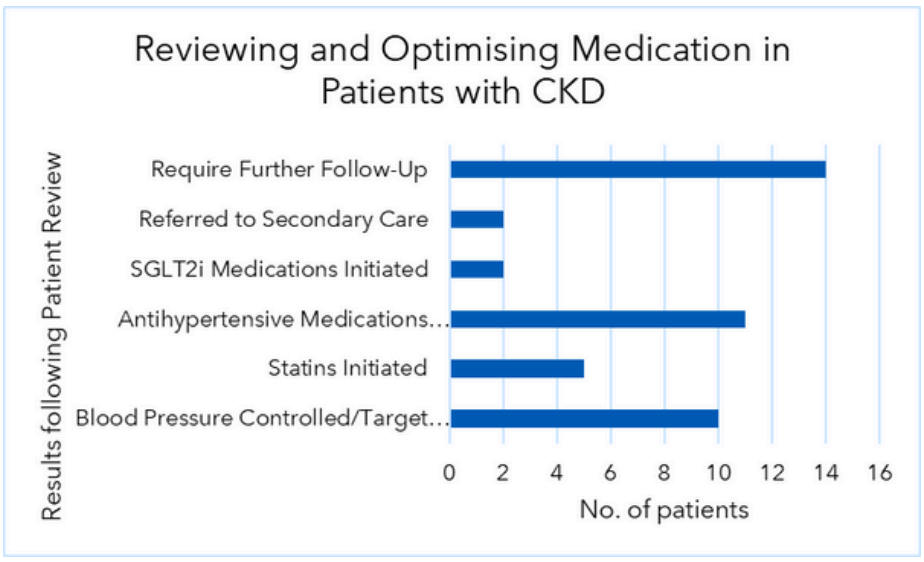
1. Run a search in EMIS to identify patients with CKD 3-5, BP not to target, aged under 80yrs, based at South Lewisham site
2. Invite 10 patients by telephone call to a face to face appointment for a CKD review with myself or our physician associate; make 3 attempts to contact each patient.
3. Conduct a CKD review in-line with CESEL guidelines
4. Arrange any necessary follow up and record on spreadsheet any changes made to treatment
5. Review the process, make changes, then invite the next 10 patients

Summary of results

- 8 patients were reviewed and blood pressure is controlled or treated to target in 10 patients.
  - 5 patients had statins initiated.
  - 11 patients had antihypertensive medications initiated or up-titrated.
  - 2 patients were initiated on an SGLT2i medication.
- Two patients were referred to secondary care and 14 require further follow-up after their initial consultation.
- Physician associate is now trained to undertake a CKD annual review in line with CESEL guidance following joint clinics we did together.
- My knowledge and skills at managing CKD as an individual clinician have increased and I am much more confident.

Learnings

- I was able to begin the process of optimising medication in the patients I saw and for most patients reviewed their BP control was improved and other meds optimised. I was able to educate patients about CKD and CVD risk. Many patients were not taking statins and I was able to start or restart statins in 5 out of 18 patients reviewed and also prescribed 2 patients with SGLT2i.
- The call and recall process was time consuming and long term I would need admin support or consider using different method such as text messages.
- The appointment length of 15 minutes was not sufficient, extending to 30mins allowed sufficient time.
- The nature uncontrolled BP meant that the vast majority of patients required several follow up appointments. This limited my capacity to take on new patients. I tried to overcome this by training the PA, but his capacity is also limited and time limited to provide training also.



Patient or stakeholder story or feedback

"I never understood why it was so important to take a statin before" – 52 year old with stage 3B+proteinuria CKD under renal clinic."

Sustaining the change

I am planning on delivering a teaching session in a clinical meeting about what I have learned from the project and about managing CKD. This will share the knowledge I have gained from undertaking the project and hope to improve the quality of care and awareness of CKD in our clinical team.
Our Physician Associate is now trained to undertake CKD reviews so we can book CKD patients who need optimising management with him now also.
I hope to take forward what I have learned to implement an annual call/recall process for our CKD patients.

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Optimising Statin Therapy for Primary Prevention of CVD

Clinical area: Lipids

Dr Raghu Lall
PCN: North Merton
GP Practice: Mitcham Family Practice, Merton

Aim

To increase statin prescribing in UCLP Primary Prevention Priority Group One by at least 20%.

Problem statement

Our Practice rate of general statin prescribing is lower than the average for other SWL Practices/England area .

Current status 4.04% of list size vs 5.19% for North Merton PCN, 5.6%for SWL CCG and 9.45% for England area.

Baseline data

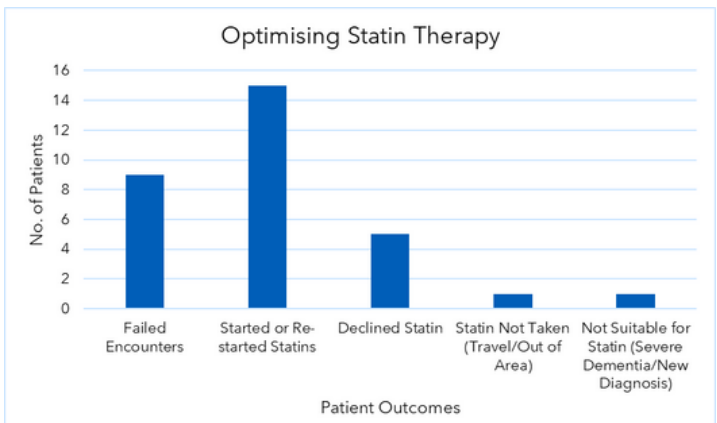
- The UCLP search on 10/6/24 revealed a Practice population of 2,945 of 25-84 years old with no CVD disease.
- The UCLP Primary Prevention Priority one search revealed 57 patients who are the highest risks of developing CVD but are not taking statin.
- A further search was implemented to exclude from this group those who refused statin previously or it was contraindicated, or patient was intolerant to the medication: this generated a final list of 31 patients
- ·20% or more Q risk - 17, CKD -14 and Type 1 DM over 40 years old - 0

Aim and plan

- The list of patients is allocated to 3 clinicians more or less equally - clinician to ensure blood test results are within the last 12 months (esp where Qrisk >20%) before booking patient. If not to arrange blood form to be collected well before appointment booking.
- Admin staff to book phone (or face-to-face, where appropriate) appointments with automatic text confirmation going to patients of these appointments.
- Clinician to review patient and start statin or record declined/not suitable or no contact.
- Practice Manager/Project Lead to review where failed contacts occurred or needs further review and book further appointment. Ensure all patients are attempted to be contacted on 2 different booking dates.
- Project Lead to review final list and arrange any mop up appointment booking where only 1 failed contact attempt has been made.

Summary of results

- 71% from the target group (22 out of 31 patients) were reviewed.
- 29% were failed encounters (9 out of 31 patients)
- Nearly 50% (15 out of 31 patients) were started or re-started statins
- 16% (5 out of 31 patients) declined statin; 1 patient was on repeat medication for statin but was not taking as was travelling/out of area and 1 patient was not suitable (severe dementia/new diagnosis of cancer)



Learnings

- Worked well with 3 clinicians sharing the workload in reviewing all the patients.
- The target set of at least 20% of patients on the review list to be started on statin was well achieved with nearly 50% of the patients being started on statin.
- Failed encounters: overcame by ensuring we booked patients at least twice for review when there is a failed encounter at first appointment. It was obvious from notes that some patients were abroad from lack of consultation note activity/not requesting repeat medications and these accounted for some of the failed encounters.
- CKD patients: a few patients were not aware of having these diagnoses and the explanation of why they have been diagnosed with condition before discussing starting statin.
- One clinician (GP) reluctant to start statin in patients with declining eGFR/developing CKD4 from CKD3. As Project Lead I reviewed 2 such patients and started statin appropriately.

Sustaining the change

- To continue to sustain change by ensuring opportunistically highest CVD risk patients are offered statin
- ·Consider carrying out this CV project on patients with Q risk of 15-20% - this will increase statin prescribing in a wider patient group and help further with increasing our Practice statin prescribing rate towards the average for our CCG area.

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Implementing Year of Care Appointments for Type 2 Diabetes

Clinical area: Diabetes

Katherine Paterson
PCN: East Merton
GP Practice: Cricket Green Medical Practice

Aim

To have over 50% of type 2 patients completing 8 care processes in QOF submissions for 2024/25- at least 8% higher from years prior.

Problem statement

Many patients within our service diagnosed with Type 2 diabetes have not received any or all of their 8 care processes in the past 12 months.

Baseline data

Base line data – on 20th May 2024 we had 839 registered patients with type two diabetes. Of those, 40 have had the 8 key care processes (KCP) measured and recorded in their notes in this QOF year.

Learnings

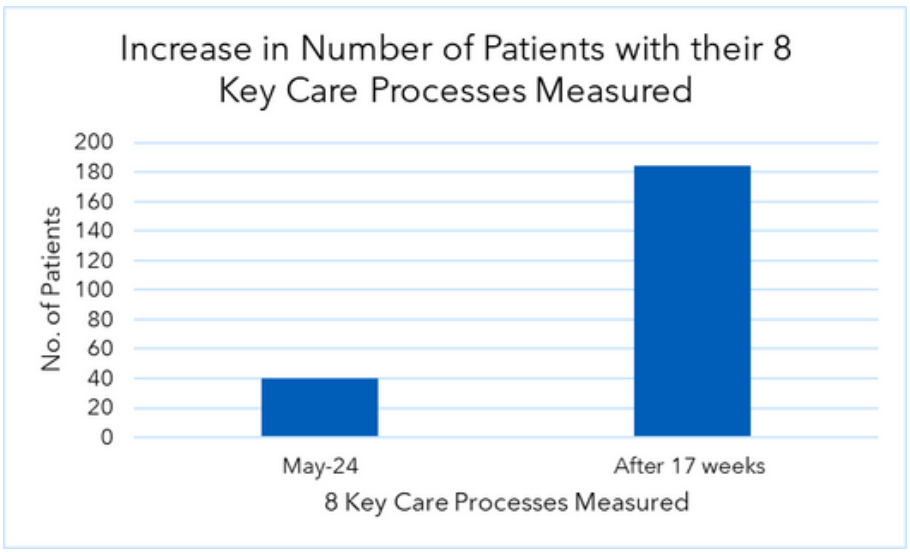
- The rate limiting step for this process is being able to measure the 8KCP processes and for this we need to look at the capacity of health care assistant appointments.
- All staff members need to be involved so everyone can explain the process to the patients who have diabetes and ensure that they are booked in the correct type of appointment.
- We would like to try the self-booking link for the diabetes year of care appointments and hope to do this soon.
- From patient feedback – some patients would like more information on lifestyle changes to consider how this can be delivered within the constraints of the health service– consider inviting to group consultations.
- Ensure the patient understands that the nurse who contacts them after the review is a diabetic nurse and not a triage nurse.

Aim and plan

- By the end of September a further 320 patients to have their 8KCP processes done.
- Patients will be booked for a 30 minute "diabetes year of care" appointment with our health care assistant. At this appointment they will have all their 8 KCP measured, bloods taken and urine ACR sent off.
- One week later the patients' results will be reviewed by a GP and the practice nurse, and an individual diabetes care plan will be made. The patient will be informed of their care plan either by text, telephone or a further face to face appointment with the appropriate clinician.

Summary of results

Within a period of 17 weeks we had increased the number of patients who had their 8 key care processes measured from 40 to 184.



Sustaining the change

- The nursing staff have reported that the demand for diabetes review appointments has reduced.
- The patients with diabetes have a clear plan in their notes and escalation of medication has been able to be done in a more timely manner.
- Staff members who have attended the diabetes triage clinic feel that their knowledge in diabetic medication has increased.

Patient or stakeholder story or feedback

If a new medication had been started: 18/25 patients reported felt involved in the decision process; 19/25 felt they received adequate information about how the medication worked and 16/25 considered they received enough information on lifestyle changes they could make.

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