

# Cardiometabolic Fellowship

## 2024 Case Studies

**Fellow name: Shital Joshi**  
**PCN: Croydon GP Super Network**  
**GP Practice(s): Ashburton Park Medical Practice**  
Clinical area: Atrial Fibrillation



## Optimising Medication in Patients with AF

### Problem statement

By doing a UCLP search, patients have been identified on the AF register who are not on an anticoagulant.

### Aim

To review all the patients on the UCLP search to ensure they are on optimised medication by the end of October and increase routine checks for AF (manual pulse) in patients over 65 by the end of October.

### Project plan

- Run a UCLP search to identify target patients.
- Train myself and other members of the team to use the Kardia device for patients in the waiting room.
- Review patients on the AF register who are not on an anti-coagulant by August 2024.
- Learn about AF and review patients with the GP to ensure the medications are optimised by October 2024.

### Summary of results

- 48 patients were identified on the AF register
- 5 patients were not on an anticoagulant
- Initially 5 patient notes were reviewed
- The Kardia device was used on a total of 10 patients.
- 4 members of staff learnt how to use the device
- As a result of the project, the GP and I discussed the AF reviews and also discussed how we can add to the review about assessing for heart failure symptoms to ensure we proactively manage patients symptoms and optimise medication.
- We email the results to patients and upload them onto the patient record.

### Learnings from the project

I was able to review all patients on the AF register with no anticoagulant and all of them had a ChadVasc of less than 0. All patients had their creatinine clearance calculated within 12 months. Both of these results meant we are up to date with the DOAC monitoring.

Having the search now means we can run it every 6 months.

### Contact Details

# Fellow name: Blagomira Stoyanova

PCN: North Southwark

GP Practice(s): Penrose Surgery

Clinical area: Atrial Fibrillation



## Appropriate Treatment and Monitoring of AF patients

### Problem Statement

Assessing appropriate treatment and timely monitoring of patients who are coded as AF (n50) and ensuring their bleeding risk is reviewed periodically.

### Project plan

- Search for patients coded with AF
- Calculate CHADsVAsC score
- Calculate ORBIT score
- Invite patients for review

### Aim

To ensure every patient that has AF and a CHADsVAsC score of 2 or more (for women), 1 or more (for men) are on appropriate anticoagulation and are having regular blood tests and eGFR checks (based on renal function) to ensure any dose adjustment is done in a timely manner.

This will prevent undetected bleeding episodes and enforcing a system to remind patients to engage in regular monitoring.

### Summary of results

- Of all 50 patients 16% of patients had CHADsVAsC score of 0 and of those 16% only 12% are on a DOAC to reduce stroke risk despite knowing their risk is deemed extremely low.
- Of all the patients on a DOAC 4.3% had a CHADsVAsC score of 0 but decided to stay on medication.
- 28% of patients had not had recent blood tests or eGFR calculations and 4.3% required an urgent dose change due to reduced eGFR.
- Due to some patients still having outstanding blood tests, it is unclear whether any more urgent dose changes will be needed.
- Project is still ongoing.

### Learnings from the project

#### Challenges

- Coding at the practice is not consistent. Some conditions used in the analysis of CHADsVAsC were marked as past problems without them ever being resolved eg. controlled hypertension on medication but not resolved. This may have led to human error when recording results.
- Due to recent issues with a now resolved cyberattack on Synnovis labs, a delay in monitoring of some bloods was to be expected.
- Working solely meant that it was not possible to see all patients requiring review in the timeframe given.

#### Successes

- Review of patients and inviting them regularly for blood tests via sms.
- Enabling them to book blood tests via Swiftqueue to expedite the process.

#### Contact Details

# Fellow name: Chamila Wijesinghe

PCN: Orpington

GP Practice(s): Green Street Green Medical Centre

Clinical area: Atrial Fibrillation

“  
Working effectively as a team helped make the project achievable  
”

## Creatinine Clearance Review in Patients with AF

### Problem statement

We have a number of patients at our practice who are on a DOAC for AF and do not have an up to date creatinine clearance (CrCl).

Atrial fibrillation is responsible for 20% of all strokes and anticoagulation can reduce the risk of stroke by up to two thirds. Ensuring treatment for AF is optimised is important as using a lower dose may increase risk of embolic events and result in potentially preventable strokes and using a higher dose than indicated by the renal function and creatinine clearance (CrCl) may increase the risk of bleeding.

### Aim

To review notes of 20% of patients with AF and on a DOAC by the end of November 2024, including within this group all patients in UCLP Priority Group 4 (patients on a DOAC and no renal blood tests within the last 12 months) and those who do not have CrCl calculated within the last 12 months.

### Project plan

Create searches with support of admin team- manually review patient notes to see whether relevant information is available in order to calculate up to date creatinine clearance. If current info N/A, pt contacted by prescribing clerk for appointment. If does change indicated, prescribing clerk to book review appointment with clinical pharmacist. Share findings with practice team and continue monthly

### Summary of results

Of the 34 notes reviewed, updated creatinine clearance was calculated for 6 patients. From this, 2 patients were identified as having an improvement in their creatinine clearance to warrant them being on a higher dose of DOAC. Our prescribing clerks were notified of the 2 patients and subsequently appointments have been booked with one of our clinical pharmacists to arrange a review for the patient to ensure they are on an optimised dose.

The remaining 28 patients were either overdue blood tests or a weight check and they will be contacted either by text or phone to notify them regarding this. Once the relevant checks have been done and results available, their CrCl will be calculated and an appointment will be booked with one of our Clinical Pharmacist if a dose change of their DOAC is indicated.

### Learnings from the project

#### Challenges

- Initial difficulty in running the UCLP searches, the relevant searches were created manually by the admin team and run to identify the patient group.
- The Synnovis cyber attack in June caused some delay to the start of the project.
- Some patients appeared not to have had an up to date blood test but on contacting patients it was evident that bloods had recently been done at the hospital and although patients did not require the tests to be repeated, the results had to be manually added to the notes in order to calculate CrCl.
- Some difficulties faced with obtaining up to date weight for frail, housebound patients.

#### Successes

- Working effectively as a team helped make the project achievable.
- Increased confidence and knowledge in DOAC monitoring and being able to share this with other members of the practice clinical team.

#### Contact Details

**Fellow name: Dr Sinthu Visahan & Dr Dhulakshi Sachi**

**PCN: New Malden/Worcester Park**

**GP Practice(s):**

Clinical area: Atrial Fibrillation



## Incorporating AF detection in NHS Health Checks

### Problem statement

Atrial fibrillation (AF) often goes undetected in the NHS due to a lack of routine screening.

This is concerning because AF significantly increases stroke risk, especially when undiagnosed. Early detection through screening enables timely treatment with anticoagulants, drastically reducing this risk. The absence of AF screening in NHS Health Checks is a missed opportunity for stroke prevention.

Integrating AF detection into these checks, through methods like pulse checks or devices would enable early diagnosis. While challenges exist regarding cost-effectiveness and optimal screening methods, the potential benefits for public health make it a crucial area for improvement within the NHS Health Check programme.

### Aim

To increase incidental AF findings in NHS Health Checks at New Malden/Worcester Park PCN, prioritise thorough pulse checks in every assessment.

If an irregular pulse is detected, use a portable ECG to confirm potential AF. Ensure consistent and clear documentation of AF findings in patient records. Educate patients about AF and its risks through various channels like leaflets and online resources.

### Summary of results

Unfortunately we were unable to set up the clinic in a timely fashion due to the delays described elsewhere.

We will be following up with the project now that we have successfully managed to ensure the clinics are started.

### Project plan

We are initiating a community health project focused on early detection of atrial fibrillation. We have designed clinical pathways to offer NHS Health Checks on Saturdays to improve access for those unable to attend during the week.

These clinics will be run by a lifestyle coach who will provide a full NHS Health Check, including measuring blood pressure, cholesterol, and BMI and manual AF check. We are responsible for training this lifestyle coach to do this.

While the project prioritizes AF detection, the clinics offer a holistic approach. To support this, I have developed resources to educate staff involved and patients about the health checks, the conditions we are screening for, and how to interpret results.

### Learnings from the project

#### Challenges

The process of coordinating with the PM and PCN managers to start the health checks proved to be unexpectedly lengthy. This delay hindered our ability to achieve the project's outcomes within the desired timeframe. Despite our best efforts to expedite the process, the clinic was not established in time for us to gather and analyse results for the project.

#### Successes

- The project benefited from the widespread enthusiasm for improving patient access to NHS health checks and initiating AF screening. This positive reception was instrumental in achieving this clinic encouraging that everyone shared a commitment to improving patient care.
- The enthusiasm for facilitating better access to NHS health checks and enabling early AF screening demonstrated a strong desire to make a positive impact on patient health.
- The project was driven by a shared passion for improving patient well-being. The enthusiasm for expanding access to NHS health checks and AF screening reflected a genuine desire to empower patients to take control of their health.

#### Contact Details

# Fellow name: Hayley Liu

PCN: Lister PCN

GP Practice(s): Dr Aru

Clinical area: Atrial Fibrillation



## Detection of AF in patients eligible for NHS Health Checks

### Problem statement

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

There are patients at the practice who are at high risk, who may have Atrial Fibrillation (AF) without realising it.

### Aim

To carry out an NHS Health Check for 30 patients and to check their pulse rhythm manually to see if they have irregular regular pulse rhythm which will help us to detect AF as the Mydiagnostick device is still not available.

Apart from routine checks ie BP, weight and height, we also check their lipids and HbA1c using finger-pricked under the Point of Care service.

During the process if any patient is found to have irregular/irregular regular pulse rhythm, an appropriate referral will be made to the Clinical GP Lead and the Senior Pharmacist.

### Project plan

The project was discussed with the Senior Pharmacist then with the Clinical GP Lead, Practice Manager, TNA, HCA and Admin/Reception who were involved in the project to ensure that the process were running smoothly. The NHS Health check search was run by the Clinical GP Lead and exported the results by uploading to a CVS format. A total of 137 patients were identified with NHS Health Check that is due for all 3 Levels.

The search of patients who due for NHS Health check were printed, Level 1, 2 and 3.

Level 1 has 20 patients  
Level 2 has 11 patients  
Level 3 has 106 patients

### Summary of results

Many patients were happy we called them for NHS Health Check. About 96% patients are on NIL medicines, other 4% patients on inhalers and painkillers and creams. 90% patients have not seen their GP for many years and have not done blood test and have no updated blood from hospitals. They were appreciated we cared for them and checked on them. They all wanted to do HbA1c and lipids and other routine bloods as well.

At least 20% of patients have completed NHS Health check and no AF was detected. However, 2 patients restarted atorvastatin which was stopped many years after Qrisk was discussed with the patients.

Practice motivation to do other projects (patients with diabetes, hypertension or hypertension with CKD, heart failure to improve patient care has increased.

### Learnings from the project

The project has been a slow success as there were countless failed encounters and unobtainable/unrecognised mobile/landlines.

It takes at least 30mins to complete NHS Health check. Some patients were fine with this but some patients felt was a little too long even felt by one or two staff members as there was a lot to cover and ask patients.

Overall, patients were happy we invited them to NHS Health Check. They appreciated us taking the time to check on them and cared about their health and wellbeing. Qrisk % was discussed with patients so they have an idea about their health in 10 years and what ways they can prevent stroke and heart attacks or delay the progression of further damage to their organs. Two patients were on statin in 2023, but have not taking since then, after Qrisk % was discussed with patients they were happy to restart statin.

### Contact Details

# Fellow name: Latha Raghavan

PCN: Carshalton

GP Practice(s): Circle GP Surgery

Clinical area: Chronic Kidney Disease



## Testing and Coding of CKD

### Problem statement

Our surgery is needing to increase awareness amongst our clinical staff of regular testing for CKD and appropriate coding of CKD for our patients.

### Aim

To identify CKD in hypertensive patients aged between 18-50 years and improve the CKD coding in the surgery. Overall, we aimed to test and code 50% of the target group between June-October 2024.

### Project plan

- Identify 50 females and 50 males for the project by undertaking a randomised search of patients registered with the surgery with hypertension
- Invite the 100 randomly selected patients for blood and urine tests to screen them for CKD using Accurx messaging in order to review the uACR and eGFR of these patients
- Send out initial invite and two reminders over a four month period (June-October 2024) and call patients if necessary
- Ensure patients are correctly coded based on test results of their blood and urine tests

### Summary of results

Of the 100 patients contacted, 41 patients responded and had both a blood test and urine test completed between June-October 2024.

30 patients had normal uACR results and 11 patients had the following results:

- G1 A2 - 6 patients
- G1 A3 - 1 patient
- G2 A1 - 1 patient
- G2 A2 - 3 patients

The project helped clinicians to understand the importance of uACR for CKD coding.

Overall, the project helped increase awareness of CKD coding and importance of regular testing for CKD amongst clinicians in the surgery.

### Learnings from the project

It was challenging getting responses from the 100 identified patients. Some patients had already had their eGFR test completed and it was difficult to engage the patients in also getting a uACR test. To try and overcome this, we sent several reminders and tried calling patients..

We found starting the project early was beneficial and allowed us to have enough time to send several reminders and to try and call patients.

Having the Accurx messaging system helped us in sending reminder and messages to patients quickly. This also allowed us to attach a CKD leaflet for patients so they could better understand the importance of the CKD screening.

Additionally, having a phlebotomist in the surgery allowed the patients to be booked into the surgery for their test.

### Contact Details

# Fellow name: Leanna Ali

## PCN: Wallington

### GP Practice(s): Beeches Surgery

Clinical area: Chronic Kidney Disease



## Recording Blood Pressure for Patients with CKD

### Problem statement

11% of patients registered with our surgery with CKD 3-5 have not had a blood pressure reading recorded for them in the last 13 months.

### Aim

To holistically review 23 patients with CKD who do not have a recent blood pressure reading and optimise treatment, if necessary, by October 2024.

This includes optimising all medication (statins and antihypertensives).

### Project plan

- Text or call patients in target groups for up-to-date BP readings either at home, pharmacy or appointment with PCN Pharmacist/HCA by July 2024
- Update records with blood pressure readings coded for all patients who have responded by end of July 2024
- Where necessary, invite patients for a review with the PCN pharmacist to optimise medication (statins and antihypertensives) by August 2024
- Compare progress aims, look at what has been working well and what can be improved (whole team and practice level) by September 2024
- Re-run cycle with next set of patients and make changes if necessary
- Repeat plan

### Summary of results

- 1 out of 23 patients declined to have their blood pressure monitored. They did not have a diagnosis of hypertension, was not taking any anti-hypertensives and was counselled on the importance of monitoring blood pressure due to having CKD.
- 11 of 22 patients had elevated blood pressure and required a review to optimise medication. All of these patients had their medication optimised and had an average blood pressure below target.
- 18 of 22 (82%) patients now have their blood pressure to target.
- 3 of 22 patients were non-respondent. A letter has been posted to them to engage with the practice.
- 1 patient is still under review and is currently having medication optimised.
- A statin was initiated in 5 patients during review.
- Annual CKD reviews will now be conducted which includes a review of blood test, urine ACR, blood pressure and statin.

### Learnings from the project

We found that some patients did not engage well, and therefore we sent a lot of prompt SMS messages which detailed the need and importance to monitor blood pressure. Phone calls and letters were sent to patients where necessary.

I am based at this practice one day a week, so it was difficult to conduct this QI project alongside my usual workstreams with such limited time.

Teamwork with admin, reception and the clinical team was very important. The team were aware of the QI project and what it entailed which was beneficial for the project.

The coding of blood pressure worked well as the GP practice have trained staff to code blood pressure readings and to task a clinician if BP is above the recommended target as per NICE guidelines.

### Contact Details



# Fellow name: Luqman Dawud

PCN: Cheam and South Sutton

GP Practice(s): Cheam GP Centre

Clinical area: Chronic Kidney Disease



## Updating the Coding of CKD Patients

### Problem statement

We undertook an EMIS search in July 2024 which identified 307 patients coded as CKD 3-5. 90% of the patients need an up-to-date uACR and 70% of patients need an up-to-date eGFR.

### 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.

### Project plan

- Identified patients who require a recent uACR and/or eGFR will have bloods raised and a text invite sent to them to invite them for the screening.
- 10 patients will be texted and invited for testing each week, with a plan to increase this number if the volume is dealt with efficiently.
- 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 from the project

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.

### Contact Details

# Fellow name: Mei Chien Seit

PCN: Teddington

GP Practice(s): The Green and Fir Road Surgery

Clinical area: Chronic Kidney Disease



## Optimising ACEI and ARB

### Problem statement

Patients with both T2DM and CKD who are on angiotensin converting enzyme inhibitor (ACEI) or aldosterone receptor blocker (ARB) should have their ACEI or ARB increased to the maximum tolerated dose.

We identified 11 patients who did not have the maximum tolerated doses of ACEI or ARB.

### Aim

To ensure that 11 patients who are coded T2DM and CKD have their ACEI or ARB reviewed and where possible, to increase it to max tolerated dose by October 2024.

### Project plan

- Ardens search: obtain list of patients coded with both T2DM and CKD who are on ACEI/ARB. Downloaded onto Excel. There were 11 patients in the list.
- Pharmacy technician, GP partner and myself to go through list to identify patients who can have ACEI/ARB increased. As a result, only 7 patients were suitable for increased dose of ACEI/ARB.
- Once list was identified, pharmacy technician will call patients to explain the benefit of increasing dose of ACEI/ARB.
- If patient agrees for increased dose, pharmacy technician will prescribe increased dose, authorise by GP.
- Pharmacy technician will give appointment for U&E blood test for 2-4 weeks, and also advice to do BP reading when attending bloods test.
- If bloods and BP are ok and patient tolerating increased dose, further increase the dose. To be done over the phone.
- Repeat the steps until maximum tolerated dose.

### Summary of results

Of the 7 patients who were not on the maximum tolerated dose of ACEI/ARB, none had their dosage increased due to factors such as patient refusal, low blood pressure, and age considerations.

### Learnings from the project

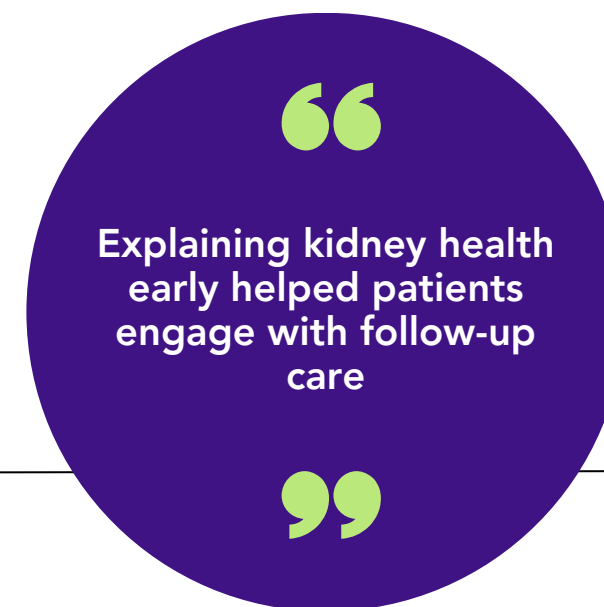
A challenge we faced during this project was that I relocated to another country during the project. However, I collaborate with the pharmacy technician and we stayed in regular contact via email, to ensure the project stayed on track.

Initially, we were disappointed with the project results. However, we realised that one possible reason was that our search criteria was too strict, leading to a small number of patients. If we were to loosen the criteria, we could include a larger number of patients, but this might become overwhelming. To address this, we would focus on prioritising younger patients who would benefit the most from early maximization of ACEI/ARB therapy.

Having a well-defined problem statement and clear objectives made it easy for me to articulate the project's rationale to stakeholders, who then fully supported the initiative as a result.

### Contact Details

**Fellow name: Chao Jiang**  
**PCN: Cheam and South Sutton**  
**GP Practice(s): James O’Riordan Medical Centre**  
Clinical area: Chronic Kidney Disease



## Improving Diagnosis and Management of CKD

### Problem statement

There are 30 patients with two most recent eGFR readings below 60, taken at least 3 months apart, who do not have a diagnosis of CKD

### Aim

Make the diagnosis of CKD and where appropriate, initiate statin and optimise blood pressure medication by then end of September 2024.

### Project plan

- Conduct a search for patients.
- Review patients’ notes.
- Schedule repeat blood tests and urine ACR for patients where necessary to confirm CKD.
- Arrange appointments.
- Provide lifestyle advice, review medications.
- Initiate or optimise cholesterol and blood pressure management medications.

### Summary of results

30 patients identified from the search, of these:

- 2 could not be contacted.
- 8 had repeated eGFR results above 60.
- 20 were diagnosed with CKD stage 3.

28 patients underwent a medication review, and of these:

- 1 had a change of lipid lowering therapy medication.
- 5 were started on statins.
- 3 patients had their blood pressure medications optimised.

I will continue to deliver the project in this manner, running the search on a monthly basis.

To improve efficiency, I will review patients' notes and use a text message template which will include the invitation for blood tests and urine ACR and explain the purpose of these tests.

### Learnings from the project

- The patient list was provided to the care navigator, who booked the appointments which helped to ensure patients were reviewed within the established timeline.
- At the beginning of the consultation, patients were informed that the focus would be on discussing kidney health and its importance. This improved patient engagement with follow-up tests and consultations.
- Poor patient engagement: Some patients do not respond to text messages or arrange blood tests as advised. To address this, I schedule a telephone appointment first to explain the purpose of the blood test and the importance of monitoring kidney health

### Contact Details

# Fellow name: Kiera Chapman

PCN: Cheam and South Sutton

GP Practice(s): Penrose

Clinical area: Chronic Kidney Disease



## Increasing ACR Testing Rates in Patients with Type 2 Diabetes

### Problem statement

The project aims to address the underutilisation of ACR (Albumin-to-Creatinine Ratio) testing and the suboptimal prescription of ACE inhibitors for Type 2 Diabetes patients who are at risk of or have early-stage diabetic nephropathy. This is critical to improving kidney outcomes and preventing progression to advanced kidney disease in diabetic patients.

### Aim

- Specific: Increase ACR testing rates in the 50 patients with Type 2 Diabetes and optimise ACE inhibitor use in those with elevated ACR or hypertension.
- Measurable: Achieve a 20% increase in ACR testing and a 15% increase in ACE inhibitor prescriptions within the target cohort.
- Achievable: Utilise systematic reminders, guideline adherence, and multidisciplinary collaboration.
- Realistic: Improvements are feasible within the scope of the selected cohort and available resources.
- Timely: Achieve these outcomes within 6 months, though delays from the cyberattack may extend the timeline slightly.

### Project plan

- Increase ACR testing rates through systematic reminders for both clinicians and patients.
- Conduct medication reviews to ensure patients with elevated ACR or uncontrolled BP are prescribed ACE inhibitors.
- Deliver educational materials to patients on the importance of kidney health and ACR testing.
- Month 1: Begin ACR testing reminders and flag patients eligible for ACE inhibitors.
- Month 2-4: Implement patient outreach and provide educational support on ACR testing.
- Month 5-6: Conduct follow-up audits and evaluate improvement in ACR testing and ACE inhibitor prescription rates.

### Summary of results

- ACR Testing: 20% increase in testing rates among the 50 patients.
- ACE Inhibitor Use: 15% increase in prescriptions for eligible patients.
- Patient Awareness: Greater understanding of kidney health and the role of ACR testing

### Learnings from the project

#### Successes

- ACR testing rates increased due to the implementation of automated reminders and staff education.

#### Challenges

- Difficulty in getting patients to comply with ACR testing schedules. Introduction of automated reminders and ad-hoc nurse-led education sessions to improve adherence.
- Recent cyber attacks caused temporary hospital lab shut down and disrupted testing

#### Contact Details

# Fellow name: Haleemah Chowdhury

PCN: Balham, Tooting & Furzedown

GP Practice(s): Streatham Park

Clinical area: Chronic Kidney Disease



## Improving Detection, Diagnosis and Statin Management in CKD

### Problem statement

Patients who have had previous so eGFR results are not always coded as having CKD. These patients may also not be currently offered the appropriate medications in line with NICE guidance.

### Aim

To review and diagnose 75% of patients identified as potentially having CKD and offer lipid lowering therapy in line with NICE guidance.

### Project plan

- Run the search and create excel spreadsheet with eGFRs and urine ACRs
- Review notes to identify whether patients need a urine ACR and renal profile or other investigations to ensure a holistic consultation
- Care coordinator to check list, create blood test forms, and arrange appointments with healthcare assistant.
- Aim for 5-6 patients per week.
- Then for these patients, named GP will file blood test results.
- Care coordinator will book with me to code the specific staging of CKD as appropriate to the blood test results.
- 30 minute appointments in my clinic to discuss this new diagnosis, counsel them about CKD, the risks of CVD, tailor lifestyle measures to manage this and offer statin in line with guidance

### Summary of results

- 51 patient were reviewed in total, of there
- 20 patients were newly diagnosed and coded with CKD stage 3-4 and offered statins.
  - 6 patients had resolved eGFRs.
  - 20 patients required an amendment or update of their CKD coding
    - 16 of these patients were already on statins.
    - 4 were offered statins.
  - 1 patient deceased.
  - 4 patients remain on the recall list.

Of the initial cohort of 51 patients;

- 16 patients accepted statin initiation .
- 6 patients declined statins.
- 2 patients have been given information about statins and wish to read further before deciding whether to start.

All clinicians at the practice are more actively monitoring for and diagnosing CKD when appropriate.

### Learnings from the project

30 minute consults worked great as it meant there was time for patient to absorb their new diagnosis and discuss conservative management as well as risk factors associated with CKD and the consequences of any overlapping conditions like hypertension or diabetes It gave time to be thorough and have a holistic approach, from gathering social history to tailor lifestyle advice, to identifying patients who could benefit from smoking cessation and weight loss or refer to health coaches. It allowed us time to discuss the risks and benefits of statin therapy in CVD risk reduction for patients with CKD, and look at LDL lipid targets.

To sustain this work a care coordinator will now search for undiagnosed CKD patients every 6-months to identify patients that may be missed. We are planning a CKD patient education day in spring for all practices in the PCN.

### Contact Details

# Fellow name: Chinenye Helen Unegbe

PCN: Carshalton

GP Practice(s): Circle GP Surgery

Clinical area: Chronic Kidney Disease



## Screening for CKD Among Patients with Hypertension

### Problem statement

Patients with hypertension are at risk of CKD, despite this they are not screened as frequently as recommended. This may contribute to low detection rates of CKD.

### Aim

We screen for hypertension in 100 patients with hypertension aged between 18-50 years and improve the CKD coding.

### Project plan

Randomly select 100 patients (50 female & 50 male) with hypertension to be contacted and screened for CKD.  
Compose an invitation letter for blood and urine testing and send these requests with a CKD information leaflet.  
Invite patients for screening through AccuRx messaging and send two reminders to follow up.  
Code patients as appropriate based on their results.

### Summary of results

Because of the project, there is an increased awareness amongst clinicians about CKD and the new coding. There is also knowledge about the importance of uACR in CKD screening and coding.

100 patients were contacted for testing and 41 undertook testing, of these:

- 30 returned normal results
- 6 patients were coded as G1 A2
- 1 patient was coded as G1 A3
- 1 patient was coded as G2 A1
- 3 patients were coded as G2 A2

### Learnings from the project

- It was difficult getting response from patients that have initially done eGFR to go back for uACR test.
- We tried to overcome this by sending several reminders and calling patients however very few responded.
- Having a phlebotomist in the surgery allowed patients to be booked for their blood test in the surgery
- The AccuRx messaging system helped us send out messages and reminders quickly
- This also allowed us attach a CKD information leaflet for the patients to better understand the importance of screening.
- Starting the project early availed us enough time to send several reminders.

### Contact Details

# Fellow name: Kate Tebbs

## PCN: Modality Lewisham

### GP Practice(s): Modality Lewisham (South Lewisham site)

Clinical area: Chronic Kidney Disease



## Optimizing Medications for Patients with CKD

### 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.

### 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 .

### Project plan

- Run a search in EMIS to identify patients with CKD 3-5, BP not to target, aged under 80yrs, based at South Lewisham site.
- 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.
- Conduct a CKD review in-line with CESEL guidelines
- Arrange any necessary follow up and record on spreadsheet any changes made to treatment
- Review the process, make changes, then invite the next 10 patients.

### Summary of results

18 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 from the project

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.

### Contact Details

# Fellow name: Oluwaseun Lawal

PCN: Wandsworth

GP Practice(s): Chatfield medical Centre

Clinical area: Diabetes



## Optimizing Lipid Therapy for patients with Type 2 Diabetes

### Problem statement

For secondary prevention of CVD in the general population, CKS recommended a 40% reduction in non-HDL cholesterol; however, the joint ABCD/RA guidance recommends aiming to reduce Total cholesterol to 4 mmol/L, LDL cholesterol to 2 mmol/L, and non-HDL cholesterol to 2.5 mmol/L.

An EMIS search identified 40 patients with Type 2 Diabetes Mellitus who have been prescribed a statin and have had a lipid blood test between July and September, with total cholesterol and LDL levels out of the target range.

### Aim

By April 2025, review 40 patients aged 18-75 with T2D who are currently on statins and not meeting their cholesterol targets. The aim is to optimise their lipid therapy in at least 70% of these patients to achieve optimal cholesterol levels.

### Project plan

- Define the search criteria and create an EMIS search to identify the patients.
- Review the patient list identifying those who need a medication review to assess compliance, as well as patients who need repeat lipid tests - intensify lipid medications as appropriate.
- This will require collaboration between myself, the pharmacist, and the GP to ensure these patients' lipid medications are optimised.
- The preliminary results of the project will be presented at the clinical meeting, along with an explanation of the cholesterol targets and the need for patients to meet these targets and signposting resources will also be provided to clinicians
- Once the repeat blood tests are due, the clinicians will be equipped to make these changes. At the six-month mark, we will measure the percentage of patients whose cholesterol levels return to within target ranges after the intervention.

### Summary of results

This project is still ongoing, but the process has provided us with the opportunity to:

- Review 40 patient notes
- Improve our methods for managing this group of patients and their lipid levels.

I hope that this will evolve into a sustainable audit that we can conduct quarterly, allowing us to reflect on our progress and make necessary adjustments.

### Learnings from the project

- Once I defined the problem and identified my patient population, the review process was straightforward. I believe the main challenge was getting started. Had I established these aspects earlier, the timeline could have been shorter.
- Having a strict set of criteria also helped to narrow the list, which was beneficial. This highlighted that this piece of work could be carried out sustainably, as the number I identified was manageable.
- This project highlighted the knowledge gap for some of the clinicians, which will be addressed in a clinical practice meeting.
- Upon reviewing some of the patients, it became clear that some would have benefited from appropriate signposting to either the Diabetes Lead GP or the pharmacy team. This issue will also be addressed at the upcoming clinical practice meeting.

### Contact Details



# Fellows names: Dr Akshala Sureshkumar and Sudeep Kalsi

## PCN: Nightingale

## GP Practice(s): Balham Park Surgery

Clinical area: Diabetes

“  
Increased awareness of cardiovascular health, especially among young patients, highlighted the clinic's impact  
”

## Lipid control and CVD Prevention in Type 1 and Type 2 Diabetes

### Problem statement

It was identified that at least 12% of patients with either Type 1 or Type 2 Diabetes at Balham Park Surgery are not meeting the LDL lipid target. These patients were identified as those diagnosed with T2DM, ages 18-49 years old, and with an LDL >1.8mmol/mol in the last 12 months.

### Aim

The aim is engage and initiate/optimize lipid lowering therapy in 50% of this young cohort of diabetic patients to prevent cardiovascular disease by lowering LDL to <1.8mmol.

Using an Excel spreadsheet of the 67 patients, we will keep colour code the number of patients who have engaged and the outcome of the consultation. Our goal will be to have tried to engage all patients by October 2024.

### Project plan

1. Create a "Lipid Clinic" with specialist clinician to call target population and book Face to face or telephone appointments
2. We have identified NICE "Patient Statin Decision" aid and HeartHealth.co.uk as PIL and resources for patients regarding medication and lifestyle options
3. We will text via AccuRX all patients resources after the consultation.
4. Keep a spread sheet of all the patients and colour code who we have contacted
5. Contact a patient maximum 3x if we are unable to book an appointment with them.

### Summary of results

- 63 patients contacted: 4x F2F and 47x Telephone appt
- 24 started/optimised therapy :
  - 20 started statin
  - 6 increased statin
  - 1 added Ezetimibe
  - 1 started Bempedoic/Ezetimibe
  - 1 achieved target on Atorvastatin 20mg therefore no change
- 4 DNA appointments - 2x attempts to rebook unsuccessful
- 5 awaiting repeat bloods to discuss results and plan
- 7 unable to contact - 3x attempts each over 5 months
- 22 declined statin - 3 declined any lipid therapy and 17 opted for lifestyle management and re-evaluation in 6-12 months, 2 declined to engage with lipid discussion
- 34/63 - Type 1 diabetics - 8 agreed to statin, 14 declined statin, 2 booked in for consultation
- 29/63 - Type 2 diabetics - 16 agreed to statin, 8 declined

### Learnings from the project

Scheduling patient consultations was challenging due to clinic commitments, often requiring flexible or on-the-spot appointments. Some patients preferred additional tests before starting statins, but overall engagement was positive. Increased awareness of cardiovascular health, especially among young patients, highlighted the clinic's impact. Clinicians also appreciated having a lipid specialist, resulting in proactive CVD prevention and consistent follow-up for lipid management.

### Contact Details

# Fellow name: Faiza Usama

## PCN: Wandsworth Prime

### GP Practice(s): Chartfield Surgery

Clinical area: Diabetes

“  
Patient education,  
increased awareness,  
and HCP involvement  
encouraged patients to  
submit BPs and arrange  
reviews

## Monitoring Hypertension in Patients with Type 2 Diabetes

### Problem statement

We have a significant amount of patients with Type 2 Diabetes, who last provided a Blood pressure measure out of the target range, and either have or are at risk of having hypertension. Many of these patients have not returned to the clinic in the last 3 months to be re-tested.

### Aim

- Identify patients on the register with type 2 diabetes, who have their last BP measure outside of target, and who have not been to clinic in the last 3 months
- Contact all the patients in 2 weeks' time
- Update blood pressure readings
- Invite for review to the patients with out of the range readings-timely review and follow ups in 2 weeks
- Contact non-responders from 1st call, maximum 3 attempts made to invite patients for a review.

### Project plan

Implement an approach to blood pressure management through annual reviews and opportunistic interventions for patients with out-of-range readings. By utilising Eclipse search functionality, we will identify patients whose blood pressure reviews are overdue within the past three months, whilst accounting for necessary exclusions. The project focuses on reviewing patients with elevated blood pressure readings to provide optimised treatment plans. We will proactively engage patients through accurx invitations, enabling prompt scheduling of reviews upon their response. This structured approach ensures consistent monitoring whilst maximising patient engagement through our digital platform.

### Summary of results

- Total Number =92
- Excluded T1DM=9
- Frail patients above 80=15
- Coding error=3-nondiabetic
- Patients abroad=not in contact=7
- Diabetes in remission=1
- Gestational diabetes=1
- Targeted population after exclusions =56
- 40 patients were contacted and offered BP:
  - 20 came back within range
  - 20 were offered meds optimization
  - 4 responded and medications were optimized for better BP control
  - non-responders invited for medication review with hopes to target them in due course.

### Learnings from the project

Lack of patient involvement and response was one of the biggest challenges. We discussed in practice to remind patients to submit BP readings quarterly. This may emphasise the importance of monitoring and will also provide opportunities in optimising blood pressure.

Patient education, increased awareness, and HCP involvement encouraged patients to submit BPs and arrange reviews. We addressed coding errors and cleaned our patient registry of those who have moved, however we still don't have a system in place to clean our records routinely.

### Contact Details

# Fellow name: Katherine Paterson

PCN: East Merton PCN

GP Practice(s): Cricket Green Medical Practice

Clinical area: Diabetes



## Implementing Year of Care appointments for Type 2 Diabetes

### 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.

### Aim

by the end of June 2024 a further 80 patients will have had the 8 care processes done, and by the end of September a further 320 patients will have completed their 8 care processes. The goal is 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.

### Project plan

Patients will be scheduled for a 30-minute "diabetes year of care" appointment with a healthcare assistant. During this session, all 8 key care processes (KCP) will be measured, including blood pressure, cholesterol, and blood glucose levels, urine ACR, foot and smoking checks, among others.

One week after this initial appointment, a GP and the practice nurse will review the patient's results and collaborate to create a personalised diabetes care plan with consideration for the patient's health goals. Patients will then be informed of their care plan details via follow up- either call or face-to-face. We will then update the patients records to reflect the completion of 8 KCPs.

### Summary of results

On 27th September we had increase the number of patients who had their 8 KCP measured to 184. This is a period of 17 weeks. On average we are completing 11 patients per week which is below the planned 25 patients.

### Learnings from the project

Our HCA was off during this period, and we did not have another member of staff to complete the initial year of care appointments. The study period was during the holiday period and if either the GP or lead nurse was on leave the diabetes triage clinic did not run that week. In a practice with 839 patients who have diabetes we need to increase the staff pool who can run this clinic and increase the number of HCA appointments available.

The recall process generally worked well but there were a few problems initially where the same patients were invited twice. Ongoing work is required with the care coordinators to ensure they understand the new diabetic review process at the practice. 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

### Contact Details

# Fellow name: Lauryn Murdoch

## PCN: North Lewisham PCN

## GP Practice(s): North Lewisham PCN

Clinical area: Diabetes



## Optimise Treatment for Type 2 Diabetes Patients with CVD risk factors

### Problem statement

We have a large percentage of adult patients with a diagnosis of type 2 diabetes mellitus (T2DM) and a documented QRisk2 or 3 score >10% or a diagnosis of cardiovascular disease (CVD) who are not prescribed a statin or other lipid-lowering therapy.

### Aim

To increase the percentage of patients aged 40-49 with Type 2 Diabetes, CVD or a Q-Risk 3 score  $\geq 10\%$  who are prescribed a statin by 5% in 5 months.

### Project plan

- Stakeholder engagement - gain permission from PCN manager and clinical directors to undertake project; discuss project with PCN diabetes team, explain importance of proposed intervention.
- Data collection - identify patient cohort in line with eligibility criteria & calculate up-to-date QRisk3.
- Book initial telephone reviews with clinicians from the diabetes PCN team (ANP and practice nurses) for initial conversation with patient about their heart risk and the benefit of lipid-lowering treatments.
- Individual clinicians to assess patient's suitability and willingness to start lipid-lowering treatment.
- Baseline blood tests to measure lipid profile and liver function, if not already done in the preceding 6 months for patients who consent to treatment. Calculate target non-HDL measurement for each patient.
- Organise 3-month follow-up with patients to re-measure lipid profile and liver function, to assess efficacy of treatment and ongoing suitability.

### Summary of results

70 aged 40-49y were identified as having a code of Type 2 Diabetes Mellitus and a high QRisk2 or 3 score. 40 patients (57.1%) were already prescribed a statin or other lipid-lowering therapy.

30 patients (42.8%) were not prescribed a statin or other lipid-lowering therapy. Within this group, 2 patients had established CVD (stroke and ischaemic heart disease). Aside from the 2 patients with CVD, QRisk3 scores were re-calculated for this patient group based on their most current EMIS data.

Had the project gone ahead, baseline HDL and LFTs would have been documented for patients. 2 process measures would have been evaluated:

- i) Number of new statin starts.
- ii) Number of codes of "statin offered" and/or "statin declined" on EMIS.

Outcome measures would have included:

- i) % of patients aged 40-49y with T2DM and at high risk of CVD or established CVD prescribed statin compared to the beginning of the project.
- ii) % of patients who met their target LDL reduction following commencement of statin.

### Learnings from the project

A meeting took place between the NLPCN team and CESEL in May to discuss the project and suggest collaboration on a training or reference resource for staff around diabetes and lipid management. They informed us that they were already working on a CESEL guide for lipid management, but would include a page dedicated to lipid management in T2DM.

### Contact Details

# Fellow name: Onyiyozza Ozigi

PCN: North Lewisham PCN

GP Practice(s): North Lewisham PCN

Clinical area: Diabetes



## Provide a holistic care approach for young adults diagnosed with Type 2 Diabetes

### Problem statement

We have a large percentage of adult patients aged 18-30 with a diagnosis of type 2 diabetes mellitus (T2DM) and a documented hba1c reading  $\geq 58$ mmol who have not had intervention from a Nutritionist.

### Aim

To reduce the HbA1c mmol readings of patients aged 18-30 with Type 2 Diabetes by 5% within 5 months through targeted interventions in medication, lifestyle counseling, and regular progress reviews.

### Project plan

- Get consent from operations manager to incorporate part 1 clinic into care coordinator face to face appointments
- Identify patient cohort according to age range, check missing care process and HbA1c control.
- Set aside time for initial telephone care coordinator follow up to provide information to patients on importance of their annual Diabetes check. Offering intervention with Coach.
- Book patients into HCA and my care coordinator clinic for their part 1 review. Offering joint consultation with Diabetes Coach if required to help with engagement with cohort in attending their appointment.
- Baseline blood tests to measure lipid profile and liver function, along with HbA1c and Urine ACR.
- Organise further follow-up with patients and with the Diabetes coach to check patient's progress.

### Summary of results

On Monday 3rd June 2024, there was a cyber-attack on the laboratory servicing GPs in South East London

Routine blood tests were not able to be carried out. Patients in the cohort were offered checks without the routine blood tests. This was used as an opportunity to engage more with patients explaining that they shall be followed up.

This meant it was not possible to assess the impact of lifestyle intervention and increased engagement on the HbA1c mmol reading of patients.

6 patients out of 41 (14.63%) were found to have their most recent hba1c test reading to be 70mmol and above. All of them 6 out 6(100%) were documented to have consented for Diabetes Coach intervention.

If the project would have gone ahead as planned, baseline hba1c would have been repeated and documented for patients in 3 months' time. It would have been documented if there was a 5% reduction or close to that.

### Learnings from the project

A meeting took place with the Advanced Nurse Practitioner and the collaborative team at HIN.

I decided to focus on how many patients were choosing to consent with the referral to the Diabetes Coach.

### Contact Details

# Fellow name: Barbara Segurado

PCN: North Lewisham

GP Practice(s): Waldron Health Centre

Clinical area: Hypertension



## Early Detection of Hypertension Amongst Patients aged 25-50

### 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.

The project aims to screen younger patients at high risk of developing cardiovascular disease in the future due to factors such as ethnicity, obesity and smoking.

### Aim

To measure blood pressure in 40 patients aged 25-50 years old who smoke and/or have a BMI>30, between June and October 2024

### Project 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 (<140/90mmHG)
- 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 from the project

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.

### Contact Details

# Fellow name: Chinyere Ezewuzie

PCN: North Lewisham

GP Practice(s): Kingfisher Medical Centre

Clinical area: Hypertension



## Detecting Hypertension in High-Risk Patients

### 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.

An EMIS search identified 31 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

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.

### Project plan

- Request a list of patients in this target group from the recall team and send a text message explaining that based on their previous BP readings, they have been identified as someone who will benefit from an ABPM check.
- If the contact number on record is wrong, ask the reception team to send the patient a letter inviting them for a BP check and request up to date contact details.
- Identify if the patients have upcoming appointments, in which case add a note on the records so that receptionists and clinicians can offer a BP check in reception or 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, I found that 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 from the project

Patients who hadn't responded to invitation for ABPM, 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 forwards proactively offering these patients a face to face appointment to talk through these issues.

The process of getting patients booked in for ABPM checks was efficient. A few months ago, I spoke to the local pharmacist about the lengthy waiting time at the hospital for several services such as 24hr ECGs and ABPM. I was pleased to hear that they had 2 ABPM machines and a short waiting time. She also told me about some other local pharmacies providing the same service. It was good to build relationships with local services and we received results from them in a timely manner.

### Contact Details

# Fellow name: Jane Dolega-Ossowski and Sarah Bligh-Stewart

**PCN: Sevenfields**

**GP Practice(s): Novum**

Clinical area: Hypertension



## Hypertension Management - Engaging patients in their 40s from black communities

### Problem statement

25% (58 patients) of our Black African and Afro-Caribbean heritage patients on the hypertension register aged 40-50 have a blood pressure (BP) greater than 140/90 mmHg.

### Aim

To engage this group of patients in monitoring and managing their hypertension and to lower BP to clinic measurement 139/89 mmHg or home measurement to 135/85mmHg or less in four months.

### Project plan

- Identify target list
- Involve student nurse in contacting patients
- Go through list to see if still needs hypertension management
- Telephone and invite in for 15 minute appointment if not in target
- Those who do not respond send text and letter asking them to book an appointment
- Set aside 3 Saturday clinics in August running with 12 appointments in each and book others when convenient in weekly sessions
- Have health promotion material ready
- Have home blood pressure monitoring (HBPM) records available
- See each patient one to one. Make changes as necessary and arrange follow up for one month later

### Summary of results

- 7 Addressed and improved medication adherence
- 11 still following up
- 3 awaiting
- 5 referred to Social Prescribing/ Wellbeing Coach
- 2 referred UpUp weight loss programme
- 1 referral to cardiology

We have not managed to get all patients to target, we can see that they are on the journey and that this is important because trust and rapport are being built. We have seen patients becoming empowered and educated thus taking and choosing to take responsibility for their condition. The interactions were meaningful and we have changed our way of approaching hypertension in this client group.

### Learnings from the project

Contacting patients was challenging where telephone letter and text were unsuccessful. Patient work commitments meant it was difficult to attend appointments. We overcame this by offering Saturday, early morning and evening appointments. 15 minutes was not long enough for consultation, so increased the time to 20 minutes. We strived to make the consultations holistic allowing time for discussion and understanding of what's important to them. We took a cultural humility approach, that encouraged patients to attend appointments.

Patients appreciated the time to discuss their broader health and issues that might have an impact on their blood pressure.

Patients appreciated being listened to, understood and not just a medical focus as well as onward culturally appropriate referral to other agencies such as UpUp, psychological therapy, dieticians and social prescribing.

### Contact Details



**Fellow name: Amit Luthra**  
**PCN: Lewisham Alliance PCN**  
**GP Practice(s): Triangle Group Practice**  
Clinical area: Hypertension



## Pharmacist-led Improvement of Severe Hypertension

### 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.

### 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.

### Project plan

- PCN Pharmacist to run monthly hypertension searches on EMIS to identify patients with the most severe hypertension.
- Pharmacist to contact patients, arrange clinics, or home visits review current medication regimen, prescribe new medications where needed, and educate on BP control.
- Conduct follow-up appointments every 2-4 weeks to monitor BP control.
- Encourage lifestyle modifications, in addition to medication adjustments.
- Track progress of BP control, and ensure that any improvements or interventions (are documented with appropriate SnoMed codes to track outcomes.
- Identify patients who are not showing improvement and escalate cases 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 from the project

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.

### Contact Details

**Fellow name: Surinder Nehru**  
**PCN: North Bexley**  
**GP Practice(s): Slade Green Medical Centre**  
Clinical area: Hypertension

“  
Information leaflets in the waiting area were a great way of informing the public about the role of exercise and diet in reducing cardiovascular disease  
”

## Assessing Patients with no Blood Pressure Review

### Problem statement

Patients aged 40 to 70 have been identified with hypertension however have had no blood pressure review in the last year.

### Aim

S- patients to made aware of complications of uncontrolled Hypertension  
M- to see the percentage of patients who are contacted and were reviewed.  
A-attainable - To use different modes of communications with the patient cohort. Offering them to book appointment to see health care professional.  
R- Controlling blood pressure will reduce the risks of complications of the hypertension which is not well controlled.  
T- the period is 4 months.

### Project plan

- Use AccuRX to message patients, inviting them for a review and attach information leaflet.
- Email the patients about the review and necessity of it.
- Call the patients if there is no response to the SMS or email.
- Put up posters in the waiting areas of surgery to highlight the complications of hypertension.
- Putting alarms on the clinicians screens when seeing a patient for other ailments but the patient also needs to be seen for hypertension.
- Educate the target group about home BP monitoring and sending the results to surgery.

### Summary of results

Of the 223 patients selected:

- All patients were contacted
- 97 patients were assessed and had a medication review

The patients were made aware and educated about the significance of a well control blood pressure and thus preventing long term complications.

The home blood pressure monitoring was adopted by the patients it empowered them to manage their illness.

The remaining 126 patients will be recontacted.

### Learnings from the project

Successes

- Assessed 97 patients in cohort of 223 patients.
- Information leaflets in the waiting area were great with informing the public regarding the role of exercise and diet in reducing cardiovascular disease.
- Home blood pressure monitoring was used by the many patients as a simple way of controlling and monitoring blood pressure.
- Patients found it easy to send the record of blood pressure to the surgery and advice was provided by telephone call .

Challenges

- Dealing with different patient backgrounds and their beliefs and stigmas around hypertension

### Contact Details

# Fellow name: Meera Patel

PCN: Balham, Tooting and Furzedown

GP Practice(s): Bedford Hill Family Practice

Clinical area: Lipids



## Initiating Lipid Lowering Therapy

### Problem statement

A search created on EMIS has identified 74 patients found to have a raised QRISK and raised LDL >2.0/ HDL > 2.6 / Ratio > 3.0, many of which are not on a statin already.

### Aim

To have 50% of patients who are aged 25-80 years old with raised LDL>2.0/ HDL > 2.6/ Ratio >3 and QRISK >10% on a statin or equivalent lipid lowering therapy over the next 6 months.

### Project plan

- I have created a search to identify these patients and gone through the patient list to exclude any patients who cannot tolerate lipid lowering therapy
- I identified any patients who need a repeat blood test and QRISK
- I asked my pharmacy technician to get these patients booked in for this and re-check QRISK. She can then update the spreadsheet
- Once QRISK has been updated then the patient will be booked in with the pharmacist for statin initiation.
- I plan to have a minimum of 4 patients booked in per week over the next 6 months.

### Summary of results

- 26 out of 68 patients were on a statin already
- 5 had declined initiating a statin in the last 6 months and 1 patient had a QRISK of <10% when re-calculated.
- The remaining 36 patients were eligible to start a statin/lipid-lowering therapy.
- 4 out of 11 patients reviewed were successfully started on atorvastatin 20mg daily.
- A further 3 declined statin and 1 patient was unable to tolerate it and referred to a lipid clinic.
- 4 patients are booked into future appointments.
- Out of the remaining 21 patients, 7 need repeat bloods and BP and weight check and re-calculation of QRISK.
- The remaining 14 patients will be sent reminder text messages/ links to book in for blood tests, BP check and weight check.

### Learnings from the project

- Creating a new system for how lipids are reviewed by the clinicians meant that patients have been and will continue to be booked in to the appropriate appointments to review their CVD risk.
- Sending a simple text to patients to invite them in for a discussion worked really well as there was no medical jargon used. Keeping it brief meant that patients were not unnecessarily worried to come in to discuss their CVD risk.
- Using a spreadsheet to document who had been seen and whether they had successfully agreed to starting a statin or not helped to identify how many patients were left to review and allow us to arrange a follow up on statin initiation where appropriate to aid compliance.

### Contact Details

**Fellow name: Aneal Aujla**  
**PCN: The Crays Collaborative**  
**GP Practice(s): Crescent Surgery, Bromley**  
Clinical area: Lipids



## Optimising Statin Therapy for Secondary Prevention Patients

### Problem statement

A search using the UCLP framework identified a number of patients with pre-existing cardiovascular disease that were not on a statin (secondary prevention, priority group one).

### Aim

To review all 18 patients with pre-existing cardiovascular disease not currently taking a statin within 6 weeks.

### Project plan

- Run UCLP searches
- Identify cohort of patients in priority group one
- These were secondary prevention patients not on a statin
- 18 patients were identified in this cohort
- Time was set aside on a Friday when I worked at this surgery
- Patients were phoned and treatment optimisation discussed with them

### Summary of results

I managed to get a hold of 16/18 patients to do a review. Of these:

- 2/18 patients: statin was not indicated, patient was incorrectly coded with CVD
- 2/18 patients: was a new patient & hadn't requested statin from our surgery but had stocks from old GP surgery
- 1/18 patients had poor compliance hence not ordered but agreed to improve compliance
- 1/18 patients: had a stock-pile & so had not requested recently as they had accumulated surplus supplies but confirmed compliance
- 1/18 patients: awaiting diagnostic tests to confirm if CVD or not
- 1/18 patients: awaiting advice from specialist to see if statin actually indicated
- 7/18 patients: declined statin
- 1/18 patients: deceased since running initial search

### Learnings from the project

- Some of these patients had been contacted in previous years and had declined statins then
- Barriers went up when I was offering them a statin again
- Knowing and explaining the evidence-base for these medications worked well with patients.

### Contact Details

# Fellow name: Sylvie Keumajou

PCN: North Southwark

GP Practice(s): Nexus Health Group

Clinical area: Lipids



## Initiating Lipid Lowering Therapy for Patients with Increased CVD Risk

### Problem statement

Patients aged 18 years or over on the Nexus Health Group register with risk of cardiovascular disease (EGFR<60 and QRISK2>10) who are not on lipid lowering therapy for primary prevention.

### Aim

By the end of September 2024 more than 25% of patients will be offered lipid lowering therapy (Atorvastatin 20mg) for primary prevention

### Project plan

- Meet with other stakeholders, to discuss allocation of the projects and time needed to complete the project
- Run searches of patients with increased risk of CVD
- Assess results and exclude patients under secondary care (9) and patients who are over 85 years old (6).
- Send text messages or call patients, inviting them to book appointments to discuss statin initiation
- Some patients will be invited for blood test to address their concerns and their preferences
- Two hours a week was allocated to the project
- Follow-up and review in 3 months

### Summary of results

- Of the 94 patients:
- 71 were contacted
  - 39 were initiated on statin
  - 7 were restarted on statin 4 times a week
  - 3 were switched to ezetimibe
  - 2 were contraindicated
  - 3 patients died
  - 9 patients were uncontactable
  - 11 patients declined treatment

### Learnings from the project

- Incorporating the audit in the SMR and making it as part of medication review discussions has been effective
- Adding patients who are on ARB/ACEI on the list opened doors to have blood test during the cyber attack
- Some patients did not think that statin were effective at reducing CVD risk. During patient education, using the APL renal tool to show the fall in eGFR and using the CESEL guidelines to recommend statin has proven to be successful when offering statin
- Realising that I might need more than one consultation before offering statin and holistic care was as important.
- Giving patients medicine information (e.g statin patients decisions aid) gave them time to think about it and make an informed decision

### Contact Details

# Fellow name: Dr Raghu Lall

**PCN: North Merton**

**GP Practice(s): Mitcham Family Practice, Merton**

Clinical area: Lipids



## Optimising Statin Therapy for Primary Prevention of CVD

### Problem statement

Our Practice rate of general statin prescribing is lower than the average for other SWL Practices/England area - 4.04% of list size vs 5.19% for North Merton PCN, 5.6% for SWL CCG and 9.45% for England area.

### Aim

Target group:

- 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.

Aim: To increase statin prescribing by at least 20% in this group by 21/10/2024.

### Project plan

- The list of patients is allocated to 3 clinicians more or less equally.
- The 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 from the project

- 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.

### Contact Details

**Fellow name: Enoka Pamnani**

**PCN: The Crays Collaborative**

**GP Practice(s): Broomwood Road Surgery, Bromley**

Clinical area: Lipids



## Optimising Statin Therapy for Patients with Diabetes

### Problem statement

There are patients who have type 1 and type 2 diabetes who are not on a statin.

### Aim

To identify all patients with Type 1 and Type 2 Diabetes on our patient list, contact them and offer statin therapy to all of them within a 12 weeks timeframe.

### Project plan

- Look if patient was taking a statin in the past and if they were and have stopped, find out the reasons.
- Telephone (or face to face) to explain why they should be on a statin, and find out what they know about them.
- If bloods are needed, ask patient to have a blood test done first. If last bloods are within date, use shared decision making to agree for the patient to start a statin, using the Summary of National Guidance for lipid management.
- Arrange necessary monitoring and follow ups as needed.
- If patient declines a statin fully explain and document the risks and code correctly on EMIS.
- If a patient requests more information, send NICE patient decision aid on lipids via AccuRx.

### Summary of results

Of the 77 patients identified with Type 1 or Type 2 diabetes:

- 25 started statin therapy
- 18 declined statin therapy
- 15 wanted to make lifestyle changes and redo bloods in 6 months' time
- 10 wanted more information and to do their own research on statins
- 5 patients were non-contactable
- 2 were deceased
- 2 were inactive

### Learnings from the project

- Addressing misconceptions by providing evidence-based information to counter common myths and fears about statin use and letting them know that I do understand their concerns and worries.
- Also, engaging patients in shared decision-making to increase their commitment to starting therapy and offering to follow up myself so they get a sense of continued care from the same person.
- Being open about potential side effects and how to manage them and reassuring patients that not everyone experiences them but if they were to experience them they can book with me and speak to me who knows their story.
- Negative information from the media or anecdotal experiences from friends or family can contribute to patient fears about statin use.

### Contact Details

# Fellow name: Shabaz Akhtar

## PCN: The Crays Collaborative

### GP Practice(s): Derry Downs Surgery, Bromley

Clinical area: Lipids



## Optimising Lipid-Lowering Therapy for Patients with CKD

### Problem statement

Statins are used for primary prevention in those patients with chronic kidney disease (CKD).

There is an increased risk of cardiovascular disease (CVD) in people with CKD. Statins are a clinically effective treatment for preventing CVD and reducing the risks associated with CVD for people who have CKD.

Previous local meetings have shown data that those with CKD especially with stage 3 or above do not always get offered a statin or another lipid lowering therapy.

### Aim

To review over a 6 month period at least 80% of patients identified from a search who have chronic kidney disease and who are not on a lipid lowering therapy.

### Project plan

- Create a list of patients that require review
- Each week allocate set clinics for these patients to be reviewed and book between 3-5 patients for review
- Patients sent accurx text or called to book for appointments with pharmacist for review
- Create excel document of changes made and update accordingly
- Patients reviewed and coded correctly
- If they declined patient decision aids were sent to them and were equally coded correctly.

### Summary of results

- There were 103 patients identified on the CKD register and 32% (n=33) of them were not prescribed a statin or other lipid lowering therapy.
- Of these 33 patients, 52% of them were reviewed (n=17).
- To date, 7 of the 17 patients reviewed have been started on a statin or other lipid-lowering therapy.
- Due to the Synnovis cyber-attack, blood tests have been delayed and this project is ongoing.

### Learnings from the project

- Initially not all patients had baseline bloods done for which to discuss starting statin or other lipid lowering therapy, so needed to rebook the patient after bloods being done.
- To ensure efficiency of time, patients were first screened by a HCA or pharmacy technician to ensure baseline bloods were done prior to review with pharmacist.
- Some patients did not know they had kidney disease and coding was challenging at times.
- Having set clinics was helpful as staff knew when to book patients in with me and patients were contacted prior to review so were expecting a call.
- Also explaining to patients the evidence base and benefits of these medications in the context of CVD and CKD.

### Contact Details



# Fellow name: Wasim Miyanji

PCN: South Southwark

GP Practice(s): Dr Durston's Practice

Clinical area: Lipids



## Optimising Statin Therapy in Patients with ASCVD

### Problem statement

The NHS aims for 95% of patients with pre-existing atherosclerotic cardiovascular disease to be prescribed lipid lowering therapy in order to reduce their cardiovascular risk for further events.

In South East London, according to CVDPREVENT, 80.71% of patients are being prescribed lipid lowering therapy (as of December 2023 - prior to us starting our role).

The South East London Lipid Transformation Programme, which aims to improve cholesterol management in patients with pre-existing ASCVD, started in January 2024. This programme, led by the Acute Provider Collaborative, the SEL ICB and the Health Innovation Network, includes 3 clinical pharmacists who work at the interface, supporting practices with joint lipid clinics, quality improvement audits and educational sessions. The aim is for sustainable improvement, by increasing the confidence of primary care clinicians to manage cholesterol.

### Aim

Invite and review 72 patients (over the age of 18 and excluding palliative care) with pre-existing atherosclerotic cardiovascular disease identified in priority group 1 and initiate lipid lowering therapy in at least 10% of this priority group by August 2024.

### Project plan

- I will use a PDSA audit cycle.
- The first plan will be to identify these patients and call them in for review.
- I will collect anonymised data of patients in priority group 1.
- Once we have collected this data, we will analyse the outcomes to highlight any identified patterns of failure.
- We will provide feedback and negotiate with the clinical lead to implement change.
- After the initial cycle, we will re-audit to see if the changes have resulted in the achievement of our SMART aim.

### Summary of results

- A direct consequence of this project was that we have increased the uptake of lipid lowering therapies in our patients with confirmed ASCVD.
- 28 patients started on lipid lowering therapies, supporting the practice to achieve the NHS long term goal of 95%. They are currently sitting on 87% at the end of this project, with many other patients in the pipeline of starting therapy.
- As a result, we have reduced the cardiovascular risk of these additional 28 patients, supporting them to live longer and healthier.

### Learnings from the project

Unfortunately, routine blood test monitoring has not been available since May 2024. For this particular practice, it meant that many patients in priority 1 could not be safely started on therapy as we did not have baseline Lipids, Liver function tests and renal profiles. To overcome this, we identified patients who have had bloods within the last 6 months and invited them for a review. In addition, we identified the remaining patients and invited them for urgent bloods.

I was able to provide individualised educational sessions that met the needs of the clinical team. During this educational session, I provided anonymised patient examples, allowing each clinician to reflect on their work. It resulted in many of the clinicians doing a further CPD on lipid management.

### Contact Details

# Fellow name: Christiana Osmond

**PCN: Clocktower**

**GP Practice(s): Westwood Surgery**

Clinical area: Lipids



## Optimising Statin Therapy in Patients with ASCVD

### Problem statement

The NHS aims for 95% of patients with pre-existing atherosclerotic cardiovascular disease (ASCVD) to be prescribed lipid lowering therapy in order to reduce their cardiovascular risk for further events.

In South East London, according to CVDPREVENT, 80.71% of patients are currently prescribed lipid lowering therapy (as of December 2023 - prior to us starting our role).

### Aim

Invite and review all patients (over the age of 18 and excluding palliative care) with pre-existing atherosclerotic cardiovascular disease identified in priority group 1 and initiate lipid lowering therapy in at least 10% of this priority group within 3 months.

### Project plan

- I will use a PDSA audit cycle.
- The first plan will be to identify these patients and call them in for review.
- I will collect anonymised data of patients in priority group 1.
- Once we have collected this data, we will analyse the outcomes to highlight any identified patterns of failure.
- We will provide feedback and negotiate with the clinical lead to implement change.
- After the initial cycle, we will re-audit to see if the changes have resulted in the achievement of our SMART aim.

### Summary of results

- Of the 49 patients identified in Priority group 1, we were able to initiate lipid lowering therapy for 22 (44%)
- The immediate impact of this intervention includes a further reduced cardiovascular risk for these patients, contributing to improved CVD care and overall patient outcomes. Broader benefits include reduced cardiovascular events and decreased demand on secondary care services. The project has also addressed the challenge of inappropriate referrals to the lipid clinic, which often stem from a lack of confidence in managing statin intolerance and unfamiliarity with newer agents such as bempedoic acid and inclisiran within primary care.
- Practice systems have been optimised with up to date searches and alerts to identify uncontrolled hypercholesterolaemia during routine blood test reviews, ensuring patients meet NICE and NHS LDL-C thresholds.

### Learnings from the project

Early recognition of key stakeholders and their influence on the project helped streamline communications and processes effectively. For instance, we identified that the practice manager needed high-level project updates without clinical details, which prevented information overload and ensured all stakeholders received role-appropriate information.

The initial clinical audit revealed crucial areas for improvement that were essential to meeting the practice's long-term goals. These findings enabled the delivery of personalised feedback and targeted educational sessions specifically designed for the clinical team's needs. This tailored approach, acknowledging each practice's unique requirements, contributed significantly to increased prescribing of lipid-lowering therapies.

### Contact Details

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

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