CVD Prevention Fellowship Project Case Studies

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This resource has been produced with the support of a Daiichi-Sankyo grant

Health Innovation Network South London

CVD Prevention Fellowship Project Case Studies

- This pack includes project case-studies and patient stories shared by the **HIN CVD Prevention Fellows**; all primary care clinicians based in south London.
- The projects were carried out as part of the **HIN CVD Prevention Fellowship**, a 7-month programme including CVD clinical education and quality improvement training.
- To put their new skills and knowledge into practice the Fellows were asked to **identify a CVD prevention need** in their surgery/PCN and set up and deliver a **quality improvement project** to address it.
- Collectively the projects impacted **63 GP surgeries** across all south London boroughs.
- Most projects are still ongoing, and they have led to **long-term changes** in the way CVD conditions are managed in primary care in south London.
- No resources for backfill were made available, the Fellows delivered the projects **on their own time**. Some projects helped the surgeries obtain financial incentives under the primary care DES.

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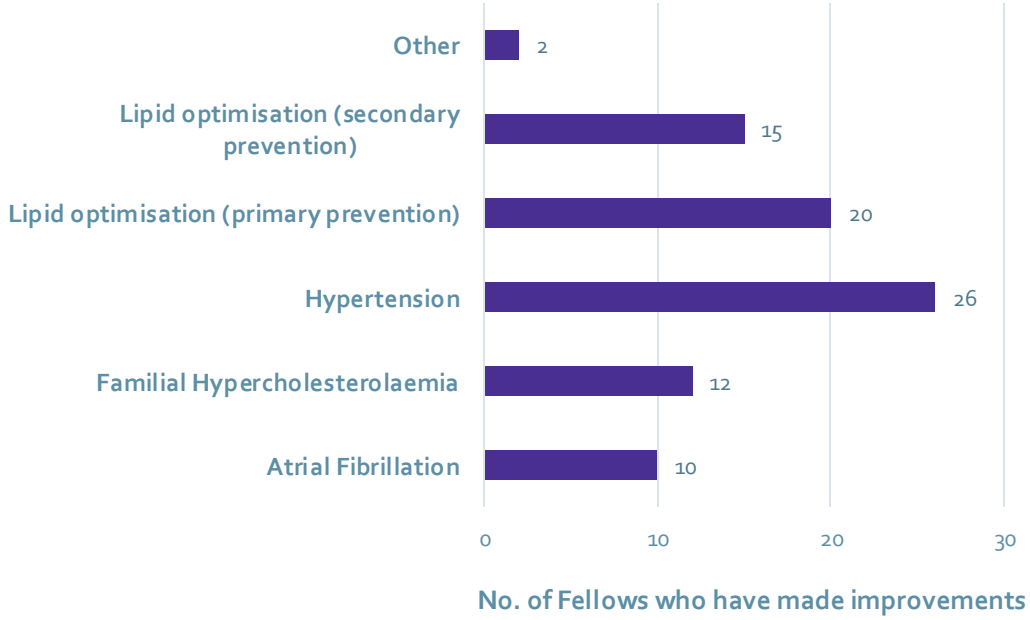
Findings from Fellowship Evaluation Survey

- 98% agree they feel **more confident in delivering care to my patients at risk of CVD** as a result of the CVD Prevention Fellowship.
- 96% agree they are **supporting their colleagues more with CVD care** as a result of the CVD Prevention Fellowship. E.g. raising awareness, sharing educational materials.
- 95% think their **patients at risk of CVD have benefited** as a result of the CVD Prevention Fellowship.
- 72% of Fellows **did not know about the HIN** before the Fellowship and 98% would **recommend working with the HIN to a colleague**

Areas where improvements have been made in Fellows' practice:



Patient feedback and stories

Stories shared by Fellows of patients they saw throughout their project and feedback from patients given to Fellows during their project.

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Patient Awareness & Gratitude

One of my patients was very grateful that I may have potentially saved his life and prevented his quality of life from drastically being affected (should he have had a heart attack). He said that he did not understand the seriousness of his high cholesterol concentration. Without my persistence in attempting to contact him, he would not have bothered.

Patient Appreciation

Patients have been very happy with the clinic as they are able to contact me directly, and follow-up has been consistent and productive. Many patients have expressed appreciation for my commitment to manage their BP and cholesterol.

Patient Appreciation

I have frequently received feedback from patients that they felt they received the best review of their condition at my hypertension clinic. They commented that they felt informed about their condition and therefore felt confident to self-manage their condition now they were regularly checking their BPs at home i.e., they knew what was a normal BP and what was high so could request a review if concerned.

Patient Gratitude - Statins

The Lipid Optimisation Project was generally very well received. Even those patients who chose not to commence a statin often expressed their appreciation at being contacted and given the opportunity. In some cases patients were lost to follow up and never continued on statins initiated just before or during the Covid pandemic. We were able to include them again in correct monitoring pathways and restart their treatment.

Patient Gratitude

Patients have been very happy with the clinic as they are able to contact me directly, and follow-up has been consistent and productive. Many patients have expressed appreciation for my commitment to manage their BP and cholesterol.

Patient Gratitude - Statins

"Thanks for giving me the information about statin. I did not realise that statins had anything to do with protecting the heart. I just thought it was to reduce cholesterol which I have been trying to do by good diet and exercise. Although sometimes I like to enjoy myself a little and eat the unhealthy stuff. I take my atorvastatin daily and I have not felt anything so no side effects . Looking forward to the next blood test."

Patient Story - Hypertension

I have reviewed a patient whose blood pressure was 180/106 to start with, treatment was optimised, and patient was managed alongside the multidisciplinary team i.e., doctors, nurse and health and wellbeing coach. Patient was educated on diet, exercise and adherence to medication. Patient was followed up and blood pressure went down to 132/95 at last review. This means that patient has moved from priority 1 to priority 3. I realised that education and follow up is important in CVD prevention also contribution from other team members.

Another patient's blood pressure was 166/125, I followed the same process of review, follow up, referral and working in a team. Patient blood pressure reduced to 145/85. I realised various factors can contribute to hypertension. In this patient's case who had mental illness and social issues, working with specialist group such as: social prescribers, some of patients' social needs have been addressed which could contribute to the improvement of the patients' blood pressure. This bring me to the realisation that the management of CVD is not just pharmacological but need to consider non-pharma logical means as well.

Patient Story - Hypertension

A patient had a systolic BP above 200 and diastolic above 100 when I initially saw him. Initially, he was reluctant about being on BP medicines as he feared the potential side effects of the medicines and did not understand the long-term effects of high blood pressure. After addressing his fears, sharing information about the risks of uncontrolled hypertension, and giving reassurance that we are here to support and help him if the medicines cause a problem (i.e. can be stopped and switched to an alternative), we started BP medication. I am delighted that when I saw him again, despite the challenges with a few missed appointments due to his work commitments, he was taking his BP medicines regularly and his BP was within the normal range. He was thankful for my support and I was very pleased to have been able to help.

Patient Story - Medication

I spoke to a 76-year-old male who had a myocardial infarction in 2020. He was discharged with Atorvastatin 80mg at night. However, he reported muscle aches soon after and despite a trial of a dose reduction and alternative statins, he stopped lipid modification treatment completely. During my review, when we discussed lipid management, he was keen to have treatment but did not want to restart statins. We discussed the option of Ezetimibe and went through benefits and risks. He said this option was never offered to him. He was happy to trial this on following up a few months later he was still taking this tablet and reported no adverse effects.

Patient Story - High Cholesterol

I had a 52yo patient who had had a stroke aged 42yrs old, who was not taking any current medication. Picked up via search, secondary prevention priority 1. Initial consult June 2022. We ran blood tests – TC 5.0mmol/L, LDL 3.3mol/L, non-HDL 3.8mmol/L. Counselled him and gave him Heart UK information on statins. Discussed CV risk and why it's important for him to take it even though feels well. Follow up call two weeks later, and he agreed to initiate atorvastatin 20mg OD.

Sept 2022 blood test results came back showing change - TC 3.3mmol/L, LDL 1.3mmol/L, non-HDL 2.0mmol/L

Patient Story - Statins

A patient with high cholesterol and QRISK of 25 % with background on fatty liver and raised ALT, GGT. Explaining the effects of alcohol on liver and statin on liver, also increased side effects for statin, oppose to untreated hypercholesterolaemia. After lengthy consultation and persuasion patient agreed to reduce alcohol and commence on statin. This patient was discussed with gastro before giving statin.

Patient Story – BP & Statins

Patient blood pressure had not been monitored for 5 years since his last raised BP on his record. On following him up, he responded on second attempt with a slightly raised BP reading and I referred him to the Community Pharmacy for 24 hrs ABPM which came back raised. Blood test was requested, his Qrisk 2 score on calculation was > 10% and I started on medications. ECG requested was checked by GP to indicate LVF , GP subsequently requested further tests and referred him to Cardiology. Feedback was "thank you for chasing and getting my raised blood pressure treated."

Patient Story - FH

Patient presented with a case of hypercholesterolemia and was advised on statins, after thorough consultation it was identified as a case of Familial hypercholesterolaemia. Patient was referred to secondary care for further investigation and was thankful to us as children were offered testing as well.

Patient Story - DOAC

Contacted a patient to get a blood test and weight for DOAC review. After the blood test I contacted him again as renal function has improved and he should be on the high dose of DOAC. He was very grateful and he felt that the surgery was working hard to look after their patients.

Patient Appreciation – BP Pop Up

It is a very good service. Good for people who cannot see their doctor... Was good to get my BP checked.

Keep on doing this, very beneficial. Good to focus on this community, can sometimes feel forgotten.

Patient Story - ISH

A homeless service user with Ischemic Heart Disease (ISH) and complex medical conditions had not been seen by a GP for 8 years. He had been advised he couldn't register with a GP as he had no official ID and no address. One of the CRF team went along with him to the nearest GP surgery to the pop up and supported him to get registered.

Feedback from Fellows

Really great project and new QI skills. Good opportunity to network with colleagues in wider area.

I would like to say thank you for the opportunity to join this group and learn more.

It has been a great project to be part of - has really helped to drive some changes that have long been needed. Thank you.

Overall, I'm glad I have done the fellowship. I feel it has definitely helped me to improve patient care for my CVD patients.

It's been a brilliant project and has really inspired me to make improvements in the health of the local community.

Great programme and great learning opportunity for primary care to upskill the workforce. Thank you.

Very educational and supportive fellowship programme. Hope this will be repeated next year.

It has been a great project to be part of - has really helped to drive some changes that have long been needed. Thank you.

Well done to all. Great effort and well delivered. Thank you for being aware and supportive of the workload in primary care and adapting your course as we go along to reflect this. Very supportive approach from you all and very approachable.

Hypertension Project Case Studies

1. Anne-Marie Kitchen-Wheeler
2. Luca Proudfoot
3. Geeta Maharaj
4. Dr Shrabani Talukder, Alafiya Essaji and Gela Veshagh
5. Tinuola Adepitan
6. Bolanle Afariogun
7. Gifty Asamoah
8. Lilian Iroha
9. Julia Parascandolo
10. Ifeoma Mgbeh & Catherine Osibanjo
11. Elham Isa
12. Julie Scott
13. Catia Margarida da Silva Oliveira
14. Sukhjeet Kahai
15. Helen Ghebrezadik
16. Nuzhat Quraishi
17. Juliet Barnard
18. Pooja Bassi
19. Sharon Raymond

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Fellow Name: **Anne-Marie Kitchen-Wheeler**
PCN: **Beckenham PCN**
GP Practice(s): **Elm House Surgery**

Bromley

PROJECT AIM & TARGET GROUP

This project aimed to improve the identification and management of hypertension:
1. Improve diagnosis of hypertension through follow up of raised BP within 3/12.
2. Code hypertension if diagnosed- increased hypertension register.
3. Update with normal BP where previous was one-off. CVD-01 to do will decrease. Target should be <10% register i.e., 200 patients.

Hypertension register 31.3.22: 2096 patients CVD-02 search 3% CVD-01 to do Raised BP 927 patients. This includes patients with diagnosed and undiagnosed hypertension.

OUTCOMES FROM THE PROJECT

- 927 pts requiring follow up now reduced to 366. (72% original outstanding list now excluded). There are 120 patients requiring an intervention as follow up BP was raised
- We have increased the hypertension register from 2096 to 2157: an increase of 2.91%
- The CVD-01 search shows only 10% of the patients with raised BP listed after 1/10/19 having hypertension diagnosed or excluded and this is due to difficulty in entering review correctly so clears this search

CHALLENGES/ISSUES BARRIERS FACED

- The numbers involved at this practice are very large. When we messaged patients to have BP checked we weren't ready for the number of responses. We changed to accommodate this so all BP returns are processed by clinical pharmacists. Second and subsequent rounds have been much better managed
- There are issues with coding patients with normal BP Is not removing them from searches. Coding instructions/advice on using the IIF searches at the start of the financial year was absent. This has led to a lot of wasted time and incorrectly recorded consultations/reviews

SUCCESSES OF THE PROJECT

- Developed good practice at the main GP practice re the management of hypertension and follow up of raised BP
- I have grown in my competency as a clinician managing hypertension and hyperlipidaemia. I involved other clinicians and they developed their clinical skills and confidence
- There has been a focus on training and encouraging patients to record their BP at home - now routine
- Working with community pharmacies for ABPM has improved communication and got the community pharmacists more clinically involved which I believe they have enjoyed

LEARNINGS FROM THE PROJECT

- High BP reading follow ups need to be systemised and this has become our new practice
- Some of the coding can be frustrating e.g. a normal blood pressure cannot be coded without HBPM or ABPM. I have learned how to code for exceptions but revisiting reviewed patients to code correctly is time consuming. I will pass my learnings on to others

Fellow Name: **Luca Proudfoot**
PCN: **North Lambeth PCN**
GP Practice(s): **Hurley & Riverside Practice (HARP), South Lambeth Group Practice**

Lambeth

PROJECT AIM & TARGET GROUP

This project targeted patients in UCLP Priority Groups 1 & 2a, with a **blood pressure of 160/100 or above.**

Across South Lambeth and HARP there were 35 patients with last BP above 180/120 (UCLP priority group 1) and 190 patients with a BP of over 160/100 (UCLP priority group 2a).

The aim was to reduce this number by 50%.

OUTCOMES FROM THE PROJECT

We achieved a **reduction of 57%** in priority group 1: 20 out of 35 patients had their blood pressure optimised. Of the remaining 15, 10 were inactive for over 5 years, 3 were abroad and 2 patients still had not reached satisfactory control.

We achieved a **reduction of 51%** in priority group 2a. Patients were texted to book an appointment or submit a blood pressure reading and then be followed up.

CHALLENGES/ISSUES BARRIERS FACED

- The most effective way of reviewing patients was for a clinician to book the appointments themselves however, this is time consuming.
- There were also issues with coding and patients lost to follow up
- Also, maintaining ongoing communication with clinicians and keeping them engaged was challenging, as it is a massive target and not a quick win

SUCCESSES OF THE PROJECT

- There was a large reduction in patients at the highest risk of CV events due to hypertension
- This has enabled them to be targeted and other routine tests to be done to try and prevent other diseases earlier on

LEARNINGS FROM THE PROJECT

- To solve the issues faced the team we will run these blood pressure searches monthly and improve coding education amongst staff.
- We have created specially designed blood pressure follow up slots

Fellow Name: Geeta Maharaj
PCN: Hayeswick PCN
GP Practice(s): Wickham Park Surgery & Pickhurst Surgery

Bromley

PROJECT AIM & TARGET GROUP

This project aimed to help patients with uncontrolled hypertension and lack of up to date blood pressure readings to assist with the monitoring of medication.

Aim = to reduce patients in UCLP Priority groups 1, 2a and 2b by 50%.

UCLP Group	Wickham Park	Pickhurst Surgery
1	4	4
2a	37	40
2b	19	13

OUTCOMES FROM THE PROJECT

Data from Wickham Park and Pickhurst Surgery shows a 41% over all decrease in patients in all groups overall, 50% decrease in Wickham Park Surgery, 32% decrease at Pickhurst Surgery.

UCLP Group	Jun	July	Aug	Sept
1	8	7	6	2
2a	77	57	41	39
2b	32	30	26	28

CHALLENGES/ISSUES BARRIERS FACED

- Lack of capacity for booking appointments
- As the time went on Pickhurst Surgery started booking my slots for Medication Reviews. A practice decision, so I had less time to book appointments and review my patients
- Some patients were not responding to Accurx messages
- In May I started practicing in hypertension for the first time and established clinic slots in 3 surgeries. I was learning on the job and have never done a project like this. Although I recoded patients, did referrals etc, I did not log all this information

SUCCESSES OF THE PROJECT

- I now have a way of triaging BP readings in the surgery to improve patient safety. I am in the process of implementing a new workflow procedure in 2 practices
- Drs directly book patients with me
- I have made links with community pharmacies and know which offer BP checks and made referrals for ABPM to community pharmacy
- Many patients have had their BP decreased to within target levels. I have educated patients to take home readings and on lifestyle changes using the SEL Hypertension guidelines
- Patients have benefited from the continuity of care and have felt able to be honest about their lifestyle choices and medication decisions

LEARNINGS FROM THE PROJECT

- Over time I adapted my text messages, making them more personal to the patient
- Tinuola advised me to give the patient the option to use BP machine at reception and add options to my Florey text
- I found out about exemption coding for hypertension QOF as some patients were unreachable and it is clear they have moved out of the area
- I have learnt about different hypertension resources such as the BHF recipe finder

Fellow(s) Name: Dr Shrabani Talukder, Alafiya Essaji and Gela Veshagh

PCN: North Lambeth

GP Practice(s): Mawbey Group Practice

Lambeth

PROJECT AIM & TARGET GROUP

This project was targeting patients in hypertension priority group 2: Clinic BP ≥ 160/100mmHg; Clinic BP ≥ 140/90mmHg if BAME AND relevant co-morbidity/risk factor; No BP reading in 18 months.

For Mawbey Group Practice 299 patients were in this category at the beginning of the project.

This project aimed to improve BP monitoring and optimisation of treatment for these patients, to encourage patients to lead healthy lives and to improve education/awareness.

OUTCOMES FROM THE PROJECT

This project is ongoing.

At October 2022 there were 248 patients across the 3 groups: 2a, 2b and 2c).

This was a reduction of 17% from the start of the project.

CHALLENGES/ISSUES BARRIERS FACED

- Some patients did not understand the risks of having hypertension
- Patients had concerns about the medication - a common answer in my consultations were 'I understand but I don't want to be on more tablets'. It was difficult to help with hesitancy around medication
- It also took time for patients' blood pressure to be controlled

SUCCESSES OF THE PROJECT

- We worked collectively as a team, discussing the issues and created an implementation plan.
- The designed plan worked smoothly and the team continued to follow

LEARNINGS FROM THE PROJECT

- Some patients who had elevated BP were not diagnosed with hypertension. It was agreed with HCA that these patients would be passed to GPs to review rather than pharmacists

Bromley

Fellow Name: Tinuola Adepitan

PCN: Hayeswick PCN

GP Practice(s): Addington Road Surgery and Station Road Surgery

PROJECT AIM & TARGET GROUP

The project targeted patients with hypertension not treated to target in Addington Road and Station Road Surgeries. It focused on those with a BP over 140/90mmhg if under 80 years and BP over 150/90mmmhg if over 80 years, using the UCLP search. Aim was to reduce the number by 50% by September 2022.

UCLP Priority Group	Addington Road	Station Road
1	19	10
2a	85	61
2b	10	23

OUTCOMES FROM THE PROJECT

- A total of 218 patients were contacted in both Addington and Station Road from May 2022 to September 2022 by Accurx text messaging and telephone calls.
- 116 patients were followed up
- 71 patients had blood pressure in the normal range when up-to-date BP readings were recoded
- 45 patients had treatments optimised with **BP now in normal range for 32 patients**
- Qrisk2 score were calculated and statin therapy were also newly started for some patients

CHALLENGES/ISSUES BARRIERS FACED

- Lack of response and engagement from younger cohort of patients despite texts and phone calls
- Changes to Accurx text messages fails to engage some patients
- Sending out information on BP to patients to improve understanding of condition still didn't work to gather a response from some patients

SUCCESSES OF THE PROJECT

- Up to date Patient record and follow-up, 53% of patients with up-to-date BP in normal range on follow-up
- Patient's BP optimised addressing problems with clinical inertia around antihypertensive therapy
- Treatment started/restarted for patients untreated or who had come off treatment
- Empowered patients and raised awareness of the importance of managing BP with drugs and lifestyles addressing hesitancy. Several patients bought BP monitors to use at home
- Raised awareness among practice staffs – GP, nurses, Pharmacists etc to check blood pressure with each contact with patients
- Good collaboration with Community Pharmacy, District Nurse, GP and Practice Staffs

LEARNINGS FROM THE PROJECT

- Good use of technology - follow-up of blood pressure readings is crucial in managing hypertension. For busy clinicians this can be achieved remotely using delayed Accurx text messaging to obtain future BP readings after optimising treatment
- Good use of technology- remote monitoring via Accurx for busy patients encourage use of home blood pressure monitoring
- Good collaboration with Districts Nurse and Community Pharmacists for busy and house bound patients

Fellow Name: **Bolanle Afariogun**
PCN: **Frognal PCN**
GP Practice(s): **Barnard Medical Group**

Bexley

PROJECT AIM & TARGET GROUP

This project aimed to identify and manage undiagnosed hypertension.

479 patients were identified as having a raised Blood pressure reading (≥ 140/90mmHg) after 1/10/2021 and not on the Hypertension register before 1/10/2022.

OUTCOMES FROM THE PROJECT

Of 479 patients identified with a raised Blood pressure reading (≥ 140/90mmHg) **85% were followed up appropriately**.

- 290 patients were identified as not having appropriate clinical follow up (ABPM or HBPM) to confirm or exclude HTN. (Group 1)
- 117 patients were identified as Patients on pharmacological management but not coded correctly (Group 2)
- A total of 169 patients were added to the HTN register of which 52 of these had HTN diagnosed/ excluded with the remaining coded appropriately.

CHALLENGES/ISSUES BARRIERS FACED

Time constraints for appropriate follow up was a challenge

SUCCESSES OF THE PROJECT

- Patients were happy about shared decision making with regards to deciding on lifestyle management or starting on BP medication.
- Patients happy about empowerment / involvement in their care.

LEARNINGS FROM THE PROJECT

- Data collection process for home BP reading via Accurx using batch texting
- Involvement of HCA's for BP measurements for those unable to self-monitor
- Now aware that patients can also provide ABPM data via local pharmacy loan

Fellow Name: Gifty Asamoah
PCN: South Southwark PCN
GP Practice(s): Brunswick Park Family Practice

Southwark

PROJECT AIM & TARGET GROUP

Problem being addressed: Only 49% of 821 patients aged 79 years or under on the hypertension register have a blood pressure >140/90mm/hg.

Target group: Patient's coded as hypertensive aged 79 years or younger with a blood pressure reading above target (.140/90mm/hg).

Aim of project is to increase to 77%.)

OUTCOMES FROM THE PROJECT

By 01/11/22, we have increased the number of patients on the hypertension register who are meeting target from 49% to 56% (an improvement of 7%). I.e. As of 01/11/22 56% of patients on the hypertension register aged 79 years or younger have a BP of 140/90 mmHg or less. BP clinics have been run most Mondays

This project is ongoing. There are still 403 patients to be seen altogether.

CHALLENGES/ISSUES BARRIERS FACED

- Addressing issues causing patients to not take their medication as prescribed.
- Appointments not being booked by reception due to workload and staffing issues.

SUCCESSES OF THE PROJECT

7% (about 57 patient) of patients on the BP register now have a well-controlled BP because of the project. I thoroughly enjoyed running the BP clinics, exploring the reasons for non-adherence and working together with patients to find a solution to barriers which suited them and they are comfortable with.

LEARNINGS FROM THE PROJECT

Not taking medication as prescribed was found to be due to many reasons:

- belief and perceptions about the medication e.g., preference for herbal medicine
- fear of side-effect of long-term use of medication
- lack of understanding of hypertension and the potential complications
- belief that when BP is controlled the medication can be stopped
- annual BP checks or recalls lost due to covid19
- Fear to get stuck on the medication for life
- patient preference to adopt lifestyle changes instead of medication
- lack of confidence/trust in the healthcare system

Fellow Name: Lilian Iroha
PCN: StockwellBeing PCN
GP Practice(s): Binfield Road Surgery

Lambeth

PROJECT AIM & TARGET GROUP

This project aimed to:

- Reduce the number of patients with hypertension and blood pressure above target by 35% by November 2022.
- Increase the number of patients aged 40 years and over with recorded blood pressure to 50% by November 2022
- Ensure appropriate follow up for patients with blood pressure above 140/90 and not on the hypertension register by end of February 2023

UCLP searches : Total 832

- Priority Group 1 = 9
- Priority Group 2a = 62
- Priority Group 2b = 91
- Priority Group 2c = 63
- Priority Group 3a = 99
- Priority Group 3b = 56
- Priority Group 4a (low risk) = 394
- Priority Group 4b (low risk) = 58

OUTCOMES FROM THE PROJECT

- Patients over 40 with a recorded blood pressure increased to 73%.
- Hypertension case-finding via ABPM led to the **diagnosis of Hypertension in over 20 patients.**
- Reviewed 7 of the 9 patients in the Priority 1 group, blood pressure now within target ranges. (77%)
- Ongoing case finding and review of patients with blood pressure above recommended targets

CHALLENGES/ISSUES BARRIERS FACED

- Time constraints
- Lack of staff to support with case finding
- Patients unable to check blood pressure at home
- Patients not responding to requests to send in their blood pressure

SUCCESSES OF THE PROJECT

- Huge increase in the number of patients over 40 with recorded blood pressure
- Team working with other members of the multidisciplinary team
- Started Hypertension clinics to follow up out of range readings
- Increased communication with patients when following up blood pressure

LEARNINGS FROM THE PROJECT

- Involve other staff to support where possible
- Ensure reception and admin staff are aware of escalation processes for high readings
- Ensure timely and appropriate follow up
- Send requests for blood pressure in small batches to ensure that these are followed up

Fellow Name: **Julia Parascandolo**
PCN: **Modality Lewisham PCN**
GP Practice(s): **ALL**

Lewisham

PROJECT AIM & TARGET GROUP

There has been Inconsistent follow up of patients presenting or reporting very high blood pressures, ie in UCLP Priority Group 1 ≥180/≥115mmHg (clinic) ≥170/≥110mmHg (home). This project aims to support 20% of patients identified in this group to reach a normal BP by end of August 2022.

As of 17/06/2022 there were 99 patients identified across the PCN.

OUTCOMES FROM THE PROJECT

- Recalled 99 patients over 1month period
- Multiple patients identified as "ghost patients"
- **Reduced number of patients in UCLP 1 group from 99 to 79 during this time (20.2%)**
- Plan to now roll out 12 week rolling quality improvement across PCN using QOF, IIF and UCLP searches to improve hypertension diagnosis, monitoring and treatment

CHALLENGES/ISSUES BARRIERS FACED

- Multiple "ghost patients"
- Some patients contacted were lost to follow up post initial call
- Biggest challenge was ensuring there was adequate time to contact patients

SUCCESSES OF THE PROJECT

- 20 patients no longer in the UCLP1 cohort
- Plan is to now try and roll out a bigger QI project along the lines of this project looking at other cohorts
- Working well with community pharmacies offering AMBP to diagnose hypertension
- GP colleagues appreciative of the audit for patients that have previously been lost to follow up with uncontrolled hypertension

LEARNINGS FROM THE PROJECT

- Lots of guidelines and searches already made to support a QI project for hypertension
- Focussing on the highest risk areas can make a difference to those previously lost to follow up with uncontrolled hypertension
- Really helpful to advise GPs of the plan (communication went out to patient's named GPs to expect results) and remind them of reviewing using CESEL guidelines and Ardens template

Fellow Name: Ifeoma Mgbeh & Catherine Osibanjo

PCN: South Southwark PCN

GP Practice(s): Dr Aru & Partners (Lister Primary Care Centre)

Southwark

PROJECT AIM & TARGET GROUP

This project aimed to optimise treatment of patients with unmanaged hypertension through lifestyle interventions and medication optimisation.

The target groups were:

Patients aged 79 or under with BP 140/90 mmHg and over within the last 2 years – **42 patients in this group.**

Patients aged 80 and over with BP 150/90 mmHg and over within the last 2 years – **1 patient in this group.**

OUTCOMES FROM THE PROJECT

Following delivery other searches were rerun and in the target groups there now were -

- Patients aged 79 or under with BP 140/90 mmHg and over within the last 2 years – **22 patients in this group.**
- Patients aged 80 and over with BP 150/90 mmHg and over within the last 2 years – **0 patients in this group.**

CHALLENGES/ISSUES BARRIERS FACED

- Failed encounters
- Not working at the surgery daily to follow up made this challenging
- White coat syndrome
- Patients were unaware of impact of raised BP concerning their health
- Patients unable to take time off work
- New patients added to the list due to raised BP following other investigations (therefore target population grew)

SUCCESSES OF THE PROJECT

- Patients were happy to be contacted regarding BP monitoring and medication review
- Patients provided home blood pressure readings
- Some patients discussed not taking medication as prescribed
- Patients said they would look to request their medications regularly to continue to take them
- Patients had discussions around lifestyle changes

LEARNINGS FROM THE PROJECT

- Team work is essential
- Patient centred care is effective
- Patient awareness and willingness helps

Fellow Name: **Elham Isa**
PCN: **Wallington PCN**
GP Practice(s): **Maldon Road Surgery**

Sutton

PROJECT AIM & TARGET GROUP

There are a high number of patients at risk of CVD with uncontrolled BP/ and unmanaged lipids at the practice, in particular people with BP of >140/90 if <80yrs, or >150/90 if >80.

Additionally, there are many hypertensive patients with high total/LDL cholesterol not on statins or on sub-optimal doses/intensity, and many had no QRisk coded.

UCLP Priority Groups:
2a: 47 patients (7%)
2b: 37 patients (7%)
Aim to reduce number of patients in priority 2a and 2b by 40% by November 2022

OUTCOMES FROM THE PROJECT

Recalled 47 patients from priority group 2a and optimised therapy. Recorded patients most recent BP readings, and currently optimising therapy for those still on high BP (while also managing their cholesterol).

Priority 2a at 29 , down 38% from 47 on 14/10/22. This work is ongoing.

CHALLENGES/ISSUES BARRIERS FACED

It took a very long-time getting clinicians and non-clinical staff together to process map. Eventually I spoke to PM who contacted partners to discuss current process with me, but it was over the phone and we had less time than I'd have wanted due to constraints. Nonetheless, the patient's journey was discussed, and a clear picture given to allow for process mapping.

SUCCESSES OF THE PROJECT

- We are now running a BP and Cholesterol clinic in the practice to continue to optimise both BP and lipid in our patients

LEARNINGS FROM THE PROJECT

- A wealth of knowledge was gained from the expert speakers, and I now have the confidence to lead on the CVD prevention initiative in my surgeries
- I have gained confidence and leadership skills to lead on QI projects, and on using quality tools to do so

Fellow Name: **Julie Scott**
PCN: **Wallington PCN**
GP Practice(s): **Park Road Medical Centre**

Sutton

PROJECT AIM & TARGET GROUP

Review patients with a previously raised BP, who had not been followed up or treatment was not optimised. Began with UCLP priority group 3 to ensure the process was set up and running well in practice, also allowing staff to upskill and refine consultations before reviewing the higher risk cohorts of patients.

59 patients were identified from UCLP searches as being in priority group 3 (a and b)

Aimed to review and optimise the BP management of 25% of patients (no. = 15) in priority group 3 by the end of 2022

OUTCOMES FROM THE PROJECT

12 patients have been contacted and recalled to date, 1 patient DNA'd.

Of the 11 patients seen to date, BP was controlled in 4 patients who will be reviewed annually.
1 patient has adjusted the timing for taking their medication to aid compliance.
1 patient has deferred increasing their medication due to travel plans.
1 patient decided not to increase their medication.

3 patients have had a 2nd review, 1 of whom has reduced their BP to below the NICE guideline target.

CHALLENGES/ISSUES BARRIERS FACED

- Patients with other comorbidities have been more complex, with other factors to be considered when measuring BP e.g., intermittent pain and migraines
- Holiday, sickness and other practice demands have limited the progression of the project
- Now the process is becoming more established, I have been asked to look at the patients identified in the DES IIF CVD cohorts – these reports appear to have identified people not previously identified

SUCCESSES OF THE PROJECT

- Supporting patients to better self-care
- Recognising that other patients not identified by the initial searches will benefit from this project

LEARNINGS FROM THE PROJECT

- Letting the whole practice, including all clinicians, know about the project
- Discussing the project, experiences, processes and progress regularly to ensure consistency e.g., in recalling the patient for review
- A better system for recalling patients is needed

Fellow Name: Catia Margarida da Silva Oliveira
PCN: East Merton PCN
GP Practice(s): Wide Way Medical Centre

Merton

PROJECT AIM & TARGET GROUP

Monitor and optimise patients BP who are in the highest risk category.

20 patients were detected in the Hypertension Priority Group 1. The aim was to reduce this number by 10% by November 1, 2022.

OUTCOMES FROM THE PROJECT

All the patients from the list were contacted either by a phone call, text message or both.

- 45% of the patients reviewed and managed.
- 5% (1 patient) went to group 2, 25% (5 patients) went to group 3 and 15% (3 patients) have Blood Pressure within normal range.
- Further management is needed for the group 2 and 3 patients - follow-up appointments are already booked.
- From the remaining 55%, one patient booked appointment after getting the text message and is being followed-up – they are doing a Home BP monitoring diary at present

CHALLENGES/ISSUES BARRIERS FACED

- Lack of time to contact patients as there were too many clinics to manage, and high demand
- Lack of availability from patients
- Patient hesitancy around treatment
- Lack of education/information about causes of hypertension, lifestyle and management
- Patients are not aware that Blood Pressure is out of range
- BP (>180 mmHg systolic) repeatedly recorded without follow-up or attempt to follow-up, even if last reading was 2 years ago

SUCCESSES OF THE PROJECT

- 45% of the high risk population (Hypertensive patients priority group 1) were reached and managed, although some of them are not yet fully controlled
- Increased knowledge and interest noticed from patients and adopting healthier lifestyle, engaging and joining Health Wellbeing Coaching programme, increasing exercise and decreasing smoking status and caffeine consumption

LEARNINGS FROM THE PROJECT

- Implementation, planning, management, assessment and evaluation of a project
- Implementation and development of new strategies to encourage people to engage in treatment and be involved and motivated to improve their health status
- I learnt to ask about habits that interfere with BP (I.e. high caffeine and salt intake which are very common) more often
- Do not assume that information is basic and everyone knows it
- People attend to appointments without taking BP tablets before
- Assess / query treatment compliancy as patients self-manage their medication sometimes

Fellow Name: **Sukhjeet Kahai**
PCN: **East Twickenham PCN**
GP Practice(s): **Cross Deep Surgery**

Richmond

PROJECT AIM & TARGET GROUP

This project targeted patients in UCLP priority groups 1 (clinic BP ≥ 180/120mm~Hg) and Priority Group 2a (clinic BP≥ 160/100mmHg).

The aim was to reduce the number in the target groups by 25% by end of October 2022.

It aimed to do this by reviewing coding, recalling patients for updated BP and optimising medication where appropriate.

OUTCOMES FROM THE PROJECT

Recalled 27 patients.

Optimised treatment for 12 patients based on home BP readings for 7 days, recoded 4 patients, 10 patients now have BP under control.

CHALLENGES/ISSUES BARRIERS FACED

- Absent or incorrect coding
- Lack of follow-up to high BP readings
- Protocols for hypertension management to be reviewed and tightened where necessary .

SUCCESSES OF THE PROJECT

- Increased awareness amongst clinicians
- Review initiated of surgery hypertension protocol
- Admin staff have increased awareness and training how to enter and code the BP reading correctly
- Greater achievement of hypertension targets
- Increased patient care
- Increased learning of effective and smarter audit processes
- Collaborative working as a team within the practice

LEARNINGS FROM THE PROJECT

- Clearer picture of where we are with hypertensive patients and the way forward
- Need to get current list managed correctly and then protocol to be discussed to address the issues found
- Needs to be a team effort, incl non-clinical team who take in the BP readings to ensure readings are flagged to clinicians
- To ensure the audit is SMART

Fellow Name: Helen Ghebrezadik
PCN: North Lewisham PCN
GP Practice(s): New Cross Health Centre

Southwark

PROJECT AIM & TARGET GROUP

This project aimed to optimise treatment of patients with unmanaged hypertension.

The target group was patients with clinic BP >180/120

There were 20 patients on this list at the start of the project.

OUTCOMES FROM THE PROJECT

- 1 patient is no longer registered, therefore 19 remained in this group, with it being unclear if 3 patients are still in the area
- 1 patient now has good BP control
- Rest of patients (15) are booked in for reviews OR we are trying to follow up with them

The project is ongoing.

CHALLENGES/ISSUES BARRIERS FACED

- Time barriers
- Patients who did not respond
- Working on reducing blood pressure can take some time

SUCCESSES OF THE PROJECT

- This will be a long-term piece of work
- EMIS was extremely useful at targeting high risk patients and will become a long-term tool to flag patients

LEARNINGS FROM THE PROJECT

- Allocated time is needed (planning for managerial session)

Fellow Name: Nuzhat Quraishi
PCN: North Lambeth
GP Practice(s): Hurley & Riverside practice

Lambeth

PROJECT AIM & TARGET GROUP

This project targeted patients with a BP over 160/120 with the aim of reducing their risk of CVD and optimising their treatment.

On the 1st June 2022 there were **32 patients with a BP of ≥ 180/120** (UCLP Priority Group 1) and **150 patients with a BP ≥ 160/100** (UCLP Priority Group 2).

OUTCOMES FROM THE PROJECT

All patients in both Group 1 and 2 were recalled/ contacted to book in for a blood pressure check at the surgery or to send in home blood pressure readings via text message.

On the 19th October there were **16 patients with a BP of ≥180/120** (group 1) - a reduction of 50% - and **144 patients with a BP ≥ 160/100** (group 2).

CHALLENGES/ISSUES BARRIERS FACED

- Patients not being followed up, and patients not attending blood pressure review appointments

SUCCESSES OF THE PROJECT

- There was a **50% reduction** in Priority Group 1 (patients with a BP of ≥ 180/120)

LEARNINGS FROM THE PROJECT

- Increased knowledge about blood pressure treatments, lifestyle advice, and using the SEL Hypertension guidelines more

Fellow Name: **Juliet Barnard**
PCN: **North Bexley**
GP Practice(s): **Slade Green Medical Centre**

Bexley

PROJECT AIM & TARGET GROUP

The aim for the project was to provide BP checks & optimise treatment for people with high blood pressure reading who hadn't had review in the past year.

There were over 100 patients in this group.

OUTCOMES FROM THE PROJECT

All patients were phoned or texted. Over half of the patient group have so far been seen for a new BP check. Patients with high reading received lifestyle advice and returned for a second reading. Many at this point had normal readings.

Those whose BP continued to be high have been referred to the clinical pharmacist.

CHALLENGES/ISSUES BARRIERS FACED

- Time for delivering the project – this has been on top of other existing work
- Staffing pressures have meant others aren't able to help with the admin side f delivering the project
- Some patients are unsure if diet or lifestyle changes will help and find it difficult to adopt these
- Some patients who were on medication didn't feel that lifestyle changes were needed – however some of these did still take the information on board and saw a reduction in BP
- Knowing how to give the information on risks

SUCCESSES OF THE PROJECT

- Given patients lifestyle and diet advice which has resulted in lowering of BP readings in some patients down to normal levels
- Working together with other staff to recall patients – in particular the GP's and the pharmacist
- Ability to deliver holistic support i.e, blood pressure, diabetes, cholesterol, asthma all check etc at the same time (multi morbidity template)
- Diabetes support also given to relevant patients – one reversed their diabetes and no longer needs medication

LEARNINGS FROM THE PROJECT

- Lifestyle advice and patients responding to this was effective for many of them in reducing BP readings
- The multi morbidity check in a 30 minute slot allows practitioners to get through all the checks – and thus QOF - as needed, and saves patients making multiple visits to the practice
- There are strong health outcomes from this approach

Fellow Name: Pooja Bassi
PCN: APL PCN
GP Practice(s): The Albion Surgery

Bexley

PROJECT AIM & TARGET GROUP

The aim of this project was to reduce the long-term effects of hypertension for our patient population who were at risk of health inequalities whilst offering them an option of digital communication.

352 patients were identified at practice level who were deemed in the health in equalities cohort (these patients were already on the hypertension register, IMD <3 and BAME). These patients either had no BP in last QOF year or BP out of target.

OUTCOMES FROM THE PROJECT

Invite sent out to all 352 patients.

Patients BP reviewed: 193 / 352
BP at target: 176

CHALLENGES/ISSUES BARRIERS FACED

- Poor response rate initially as patients though this was a scam. We sent out a welcome SMS from our practice to inform patients they were being onboarded the remote monitoring platform.
- Educating and informing our multidisciplinary team about Doctaly to encourage patient engagement
- During Covid pandemic we did have some staffing issues which caused inevitable delays to the project.

SUCCESSES OF THE PROJECT

- For this project at our surgery, we now have BP at target from 17% (60 patients) in May 2022 to 50% (176 patients) in October 2022. The BP being optimised for these patients would reduce the burden of complications of hypertension on the patient and our patient population

LEARNINGS FROM THE PROJECT

- Once patients were engaged they did seem to prefer the option of remote monitoring and the flexibility it offers of engaging beyond surgery opening times.
- The importance of safety netting which was built into this platform. A patient responded as having an emergency. The platform advised for him to call an ambulance, the following day we found that the patient had suffered a myocardial infarction.

Fellow Name: Dr. Sharon Raymond

Crisis Rescue Foundation
Vaxi Taxi Health and Wellbeing Pop Ups

Croydon

PROJECT AIM & TARGET GROUP

This project aimed to help reduce inequalities by conducting BP & BMI checks at health and wellbeing pop ups in south London. The project aimed to reach people with previously undetected and untreated CVD risk in communities with barriers to accessing the NHS, including those not registered with a GP and communities with barriers to accessing the NHS eg homeless, refugees, asylum seekers, sex workers etc

OUTCOMES FROM THE PROJECT

- Delivered 7 pop ups with BP checks in south London including at foodbanks, a festival, a homeless shelter, and community centres
- 202 BP checks were conducted
- 69 people – or 34% - had high blood pressure, above 140/90. They were referred to a GP for further support

CHALLENGES/ISSUES BARRIERS FACED

- No fixed team for pop ups
- Preparation for pop ups is extensive, including clarifying aim and SOP with stakeholders for each pop up, working with local stakeholders and staff to ensure smooth running, correct location, etc
- Briefing those staffing each pop up each time
- Ensuring each event is bespoke / meets local need i.e. interpreters, mental health information etc
- Engaging key staff from ICB in commissioning / getting involved

SUCCESSES OF THE PROJECT

- Large number of people seen with awareness of CVD increased
- Signposting to resources and support, to help enable patient autonomy and self care
- Mental health / general wellbeing checks also given at the pop ups
- Information given re BMI, diabetes risk reduction, signposting to other services
- Providing lunches, toiletries, transport (specifically a Taxi), clothing and other support
- *"A kind of medical Glastonbury taking NHS healthcare outside of the GP surgery walls and into the hearts of communities, thereby engaging people in getting more involved in their own health and wellbeing"*

LEARNINGS FROM THE PROJECT

- Importance of regularly liaising with key local services, including NHS, council, voluntary services, community organisations etc to help in planning a bespoke health and wellbeing event that meets the needs of potential service users, in particular groups experiencing barriers to accessing NHS care.
- The need to work through each step in the standard operating procedure for each event.
- The need to prepare for hitches that may arise in advance where these can be anticipated.

Lipid Project Case Studies

1. Faiza Usama, Sadiya Ayaz, Tamara Al-Jabary
2. Muna Naqvi
3. Kamaldeep Sahota
4. Momotaz Mac
5. Amit Seyan & Minal Karia
6. Nicola Jones, Koosh Patel & Paulina Laszczyk
7. Kayantha Sivalingam
8. Kirsty Chambers
9. Sayanthavie Sivasubramaniyam
10. Harriet Cunningham, Simon Frost and Chaandi Devgon
11. Fatemeh Roozbahani
12. Aanu Etukumoh
13. Rajesh Nagarajan
14. Tanya Walker

This resource has been produced with the support of a Daiichi-Sankyo grant

Fellow Name: Faiza Usama, Sadiya Ayaz & Tamara Al-Jabary

PCN: Wandsworth PCN

GP Practice(s): Chartfield Surgery

Wandsworth

PROJECT AIM & TARGET GROUP

Lipid Initiation as a Primary Prevention in 40 years + population with QRisk of 10% and more.

106 patients were identified.

The aim was to review as many patients as possible and where appropriate start on a statin or refer onto appropriate therapy.

OUTCOMES FROM THE PROJECT

106 patients identified in search with no other risk factors associated. Out of those:

- 10 were excluded because of wrong coding
- 45 patients were invited for blood tests
- 10 were contacted via Accurx to make an appointment to discuss statins
- 3 were started on statins
- 1 patient was sent for investigation of FH

CHALLENGES/ISSUES BARRIERS FACED

- Time management & peer support
- Running appropriate searches & coding
- Finding time to get together and implement plan
- Target group had to be changed twice:
  - Coding issue around ethnicity pulled small numbers
  - Errors in their medical history pr obably due to coding Issue.
  - Manually excluded anyone who had been prescribed a statin (or alternative e.g., Fibrate/ezetimibe) in the last 6 months

SUCCESSES OF THE PROJECT

- Able to generate data for patients eligible for Statin Initiation
- 5% patients improvement with up to date LFT after 3 months of lipid initiation
- We are trying to ensure we are now coding appropriately and where there are errors identified it is rectified
- Project is ongoing, this will be long term work

LEARNINGS FROM THE PROJECT

- We all learnt a lot through this fellowship, not only did it enhance our skills and clarity on CVD Risk management but also as a team learnt from our mistakes. Also learned about importance of correct coding
- Knew about expert opinion and support available through HIN CVD Project team, specialists support
- Teamwork and time management is a key. Lack of time management & support from other colleagues made an impact

Fellow Name: **Muna Naqvi**
PCN: **Wandle PCN**
GP Practice(s): **Elborough Street Surgery**

Wandsworth

PROJECT AIM & TARGET GROUP

This project aimed to improve the lipid management of patients who are already coded with cardiovascular disease.

Initially used EMIS lipid searches released by NHS digital in the early part of 2022. This gave an initial cohort of 100 patients on CVD register (LM reg) and **59 patients** in LMCX003 - those needing further management of their lipids.

OUTCOMES FROM THE PROJECT

The notes of all 59 patients were reviewed:

- 6 were excluded from further management due to being older than 84
- 5 had statin intolerance
- 4 were unsuitable for statins due to comorbidities
- 23 were offered changes in prescription or dosage and are awaiting review blood tests
- 7 are still to be contacted
- 13 seemed ok from their lipid parameters

CHALLENGES/ISSUES BARRIERS FACED

- Lack of dedicated time slots. This was all my own time, so I had to deliberately choose a cohort with a small sample size
- Needed admin help from the practice management to import the searches into EMIS; although video and guidance had been provided, I was unable to find it on EMIS
- Coding within patient records is also something that might need to be addressed on its own; in the past not enough emphasis has been put on the importance of correct coding but care cannot flow well without the ability to code and search

SUCCESSES OF THE PROJECT

- Improved learning and confidence to talk about CVD prevention to colleagues and to patients
- The Behaviour change talk helped me think about the whole patient rather than the problem that I perceived and was trying to rectify
- Improved understanding of coding for lipids
- Change in management and hopefully reduced CVD risk to many a patients

LEARNINGS FROM THE PROJECT

- The quality improvement project has really helped me with time management, prioritisation of tasks and how to set myself targets for further work
- The UCLP searches are a great tool and will help with my further work as I take a lead in diabetes management
- The information in the clinical webinars and the research behind guidelines were very useful
- The FH webinar was helpful to learn to differentiate between FH and other causes of increased lipids based on clinical presentation

Fellow Name: Kamaldeep Sahota
PCN: Orpington PCN
GP Practice(s): Knoll Medical Practice

Bromley

PROJECT AIM & TARGET GROUP

This project aimed to address the significant unmet need with regards to cholesterol management in relation to secondary prevention. Data from UCLP shows there to be **147 patients with CVD diagnosis not on a statin.**

By the end of October the aim was to review 25% of these patients.

OUTCOMES FROM THE PROJECT

44 (30%) patients reviewed:

- 8 (19%) patients started on statin/ezetimibe
- 9 (21%) declined secondary prevention
- 6 (14%) patients advised on further blood tests to aid medicines management
- 6 (14%) patients with incorrect coding
- 6 (14%) treatment with statin not clinically appropriate
- 4 (9.5%) inactive patients (death or moved practice)

CHALLENGES/ISSUES BARRIERS FACED

- The main barrier for this project has been inconsistency in prescribing of statins by specialists in secondary care. Several people I have reviewed, have been discharged post stroke from hospital without statins and then to explain this omission to patients can be challenging
- Another aspect that has been time consuming for this project is incorrect coding and having to go back and check diagnoses

SUCCESSES OF THE PROJECT

1. Surpassing the target of patients to be reviewed by October 22
2. Starting lipid modification treatment in 19% of the patients reviewed
3. Support from prescribing lead to prioritise this work
4. Support from the multi-disciplinary team to review patients and start on treatment
5. Positive patient feedback about the proactive reviews undertaken

LEARNINGS FROM THE PROJECT

1. Patients want an open and honest discussion about statins
2. Shared decision making is key
3. Some patients had not been reviewed in over a year and were keen to discuss their health and medicines
4. Some patients have already made their minds up about statins. There is clearly more work to be done here by health care professionals in educating patients
5. Surgery coding needs to be reviewed to ensure accuracy of patient records

Fellow Name: **Momotaz Mac**
PCN: **Riverview PCN**
GP Practice(s): **Valentine Health Partnership**

Greenwich

PROJECT AIM & TARGET GROUP

This project aimed to reduce the number of people with CVD not on a statin or a suboptimal statin.

Baseline from UCLP search:
Priority group 1 = 138
Priority group 2 = 81
Priority group 3* =279 *will complete if time

18+ with CVD and not on statin therapy (priority group 1) and 18+ with CVD on suboptimal intensity statin e.g., simvastatin (priority group 2). *If time will also look at 18+ with CVD on suboptimal dose (priority 3)

OUTCOMES FROM THE PROJECT

Contacted 26 patients. Managed to optimise treatment for 6 patients:

- initiated statin in 4 patients
- changed 2 patients from suboptimal simvastatin to atorvastatin

Opportunistically reviewed BP in 15 patients and optimised BP treatment in 6 patients.

CHALLENGES/ISSUES BARRIERS FACED

- Patients not responding to phone calls/text messages or booking appointment then not attending.
- Not having enough time in addition to doing regular practice work and impact on practice staff time to help with the project in addition to doing own work.
- Patient understanding, patient adherence to treatment – although this improved after educating the patient on why they were prescribed the statin or why initiation on statin was being suggested as in a lot of cases this had never been explained properly.

SUCCESSES OF THE PROJECT

I feel my CVD knowledge has improved and I feel more confident carrying out medication reviews on patients with CVD & initiating statins or making changes to statin therapy. I believe that as a result of me doing this project there has been an improvement in patient care at our practice and we will continue to reduce the number of patients with CVD who are not on a statin or on a suboptimal dose of statin.

LEARNINGS FROM THE PROJECT

To not beat myself up over not being able to initiate statins in as many people as I intended as this is a work in progress and getting people to change their mindset can take many appointments before success is achieved.
Putting time and effort into making the patient understand their condition better make it more likely for them to start a statin or adhere to their treatment regime. I had to call some patients back for a second or third time, which had an impact on my workload, but it was worth it when they agreed to start the statin.

Fellow Name: **Amit Seyan & Minal Karia**
PCN: **Central Sutton PCN**
GP Practice(s): **The Health Centre**

Sutton

PROJECT AIM & TARGET GROUP

There was a high number of people with raised cholesterol and QRISK (ie with a raised QRISK (QRISK 20+, CKD 3-5, T2DM if aged 40+), who are untreated and therefore at high risk of CVD. Baseline data from UCLP search shows that there were 292 patients in the high-risk category above.

Aim of the project was to reduce the number of people in the selected search group with untreated raised cholesterol by 20% by December 2022. This would be a reduction from 292 to 233 patients.

OUTCOMES FROM THE PROJECT

The project is ongoing.

As per the 1st November we have screened the notes of 60 patients, identifying several patients who had normal cholesterol values, and many that had out of date cholesterol results who have been invited in for repeat bloods and review.

8 patients so far started statins on.

CHALLENGES/ISSUES BARRIERS FACED

- A lot of patients on the UCLH search list had a QRISK >20% but a completely normal cholesterol. It was therefore very difficult to consider starting a statin on them
- It was also very time consuming as for the first few weeks we found that every patient we reviewed was not suitable.
- The other delay was getting up to date bloods. Some patients have a high cholesterol but haven't had this in a year or two so need a more up to date result before having a discussion

SUCCESSES OF THE PROJECT

- Collaborative working between ourselves in the practice
- Starting statin on even 1 patient who wasn't on it previously is a success that wouldn't have happened without this project!

LEARNINGS FROM THE PROJECT

- We as a practice have increased our knowledge and awareness on identifying patients with cholesterol readings that may fit the criteria for familial hypercholesterolaemia.
- There is also a greater awareness of the limitations of QRISK and how it can't be applied to all patients

Fellow Name: Nicola Jones, Koosh Patel & Paulina Laszczyk
PCN: Brocklebank PCN
GP Practice(s): Brocklebank, St Paul's Cottage & Haider

Wandsworth

PROJECT AIM & TARGET GROUP

This group targeted patients in Priority Group 1: QRISK ≥20% or CKD 3-5, or Type 1 diabetes ≥40 years AND not on a statin at risk of their first episode of cardiovascular disease.

At the start of the project there were the following number of patients in the 3 practices:
Brocklebank: 217
St Paul's Cottage: 67
Haider: 39

The aim was for 50% of patients in the target groups to be offered a statin in line with NICE guidance by the end of October, 2022.

OUTCOMES FROM THE PROJECT

Brocklebank: 217 patients
- 25 started on Atorvastatin.
- 62 Declined.
- 79 Non contactable.
- 42 not contacted due to age.
- 9 no longer indicated.

St Paul's Cottage: 67 patients
- 9 Started on Statin.
- 15 declined.
- 30 Non contactable.
- 13 not contacted due to age.

Haider: 39 patients identified.
- 11 declined
- 10 not indicated due to age
- 6 no longer indicated
- 3 not contactable
- 3 statin started
- 6 first call failed- second call booked

CHALLENGES/ISSUES BARRIERS FACED

- Blood testing availability – shortage, so patients cannot attend the surgery for blood test and need to use testing sites further away. This was needed for patient who had not had a blood test for over a year
- Busy practice workload with concurrent flu and covid vaccination programme
- Patient unwilling to take additional medications
- Side effects from previous statin use
- Common preconceptions associated with statins promoted by tabloids
- Some patients still haven't returned to the UK from prolonged stays abroad during COVID

SUCCESSES OF THE PROJECT

- Over 10% of population identified started on statin
- Many of those who declined were determined to make lifestyle changes so will be looking to seen an improvement in the their next QRISK
- Increased capacity in the MDT to have a conversation about prevention with the patient when QRISK of 20% is identified and treatment is started and followed up resourcefully

LEARNINGS FROM THE PROJECT

- Complex interventions prompting conversations about general health with potential of having a lasting impact on patients' prognosis and quality of life
- Learning to respectfully challenge common preconceptions about statins but also diet, exercise, smoking.
- Practicing consultation skills
- Practicing motivational interviewing
- Ongoing evaluation needed to assess lasting benefits of interventions; potential for long term research
- Significant improvement of clinical skills and knowledge of management of hypercholesterolemia and CVD
- Team working achieves so much more than working in isolation

Fellow Name: Kayantha Sivalingam
PCN: South West Merton PCN
GP Practice(s): Grand Drive Surgery

Merton

PROJECT AIM & TARGET GROUP

There are high number of patients aged between 25 to 84 years with QRISK >20% who are not prescribed a statin and are at risk of CVD, with unmanaged cholesterol levels.

Baseline data derived from the Investment and Impact Fund Searches for CVD identified 105 patients who might benefit from a statin treatment.

The aim was for 50% of identified patients prescribed a statin for primary prevention of CVD.

OUTCOMES FROM THE PROJECT

From running the search again in October 2022, 75% have been identified as being prescribed a statin for primary prevention.

CHALLENGES/ISSUES BARRIERS FACED

- As I was only onsite 2 days of the week or due to annual leave, there were delays in having discussions with eligible patients regarding statins.

SUCCESSES OF THE PROJECT

- It is promising to see 75% patients have been provided with a statin with the aim of reducing their CVD risk.

LEARNINGS FROM THE PROJECT

- It would have been advisable to save blood test forms and send the invites out, regarding statin therapy, at the same time for efficiency.

Fellow Name: Kirsty Chambers
PCN: Hills, Brooks and Dales
GP Practice(s): Herne Hill Group Practice

Lambeth

PROJECT AIM & TARGET GROUP

This project aimed for 100% of patients with pre-existing CVD to be offered statin therapy. > 80% patients in secondary priority 1 should be on a statin. > 90% patients in primary priority 1 should be on a statin.
Over 85% of patients prescribed statins to be on high-intensity statins.

The target groups were:

- Pre-existing CVD and not on statin (458/1580 patients)
- QRISK > 20% /CKD / T1DM not on statin (810/12766 patients)
- On statin but not high intensity statin (25%)

OUTCOMES FROM THE PROJECT

Worked through approximately 20% of identified patients in both priority 1 and 2 across the PCN.

Prescribing of statins and high intensity statins going well. The project is ongoing and we are awaiting open prescribing data to measure impact.

CHALLENGES/ISSUES BARRIERS FACED

- Searches produced higher numbers than expected.
- Some colleagues needed additional support on dealing with statin hesitancy in secondary prevention patients.
- Secondary prevention cohort continue to prove a difficult group to convince.
- Consultations were quite labour intensive due to 1) some patients requiring additional interventions; 2) most patients needed an initial call, then call back even prior to first initiation.
- Data figures appear occasionally to have gone backwards due to a huge uplift of patients in primary prevention cohort (> 500 pts). Struggling to get data to reflect the effort put in so far.

SUCCESSES OF THE PROJECT

- High intensity statin prescribing going very well. All clinicians aware not to start low intensity statins. Simvastatin scripts being reviewed and optimised at every prescribing opportunity.
- Overall clinician confidence in lipid management, awareness of pathways, and understanding of blood test results have improved.
- Changing culture towards statin side effects and language used.
- Patients proactively asking about statins after newsletter publication.

LEARNINGS FROM THE PROJECT

- Simple instructions are most effective for broader changes of practice – simvastatin no, atorvastatin yes.
- Recognising that it's a cyclical process rather than constantly moving forwards is important.
- Having confidence to realise when something is not working and approach it in a different way.
- Ensuring that changes put in place are sustainable or can continue when you're not there!

Fellow Name: Sayanthavie Sivasubramaniyam
PCN: Teddington PCN
GP Practice(s):

Richmond

PROJECT AIM & TARGET GROUP

This group targeted Q risk above %20 and not on statins – also included patients with type 1 diabetes >40years no statin and chronic kidney disease no statin.

A search shortlisted 217patients and the aim was to increase uptake by 10% (21 patients).

OUTCOMES FROM THE PROJECT

Recalled 15 patients and statins started for 9 patients.

Remaining 6 patients treatment declined due to intolerance/ ADR/ more information needed

CHALLENGES/ISSUES BARRIERS FACED

- Finding time to carry out the searches and send texts to patients
- Explaining benefits to patients who already come in with a negative view on statins due to feedback from family/ friends and the media

SUCCESSES OF THE PROJECT

- I was able to increase the uptake of statins in this cohort with a QRisk of >20%
- Enhanced my knowledge of CVD around the clinical areas (Hypertension, AF, FH and Lipids)

LEARNINGS FROM THE PROJECT

- Support from colleagues is key as it allows to delegating tasks and make the workload more manageable

Fellow Name: Harriet Cunningham, Simon Frost & Chaandi Devgon
PCN: Surbiton PCN
GP Practice(s): Central Surgery Surbiton

Kingston

PROJECT AIM & TARGET GROUP

Lipid optimisation in Secondary prevention – Priority Group 1 (people with established CVD not on a statin).

Out of 261 patients with established CVD, 21% were not on a statin.

The aim of this project was to increase the proportion of patients with established CVD on a statin to 90% (at start of project was 79%).

OUTCOMES FROM THE PROJECT

This is project is ongoing as we are still contacting those who replied yes to initiate statins.

As per November 2022 approx. an additional 20 patients were initiated on statins, reaching 87%.

CHALLENGES/ISSUES BARRIERS FACED

- Trying to decide on the target group and priorities initially.
- Co-ordinating with other staff supporting the project due to different working patterns.
- Some complex patients need more time to discuss treatment options e.g. due to previous intolerances, other potential interactions, liver derangement etc.

SUCCESSES OF THE PROJECT

- Early days but we have increased the number of patients with established CVD on a statin and will continue to work on this project.

LEARNINGS FROM THE PROJECT

- A great learning experience for setting up a QIP
- I have learnt a lot more about lipid management and in particular statin intolerance and how to manage this

Fellow Name: **Fatemeh Roozbahani**
PCN: **Teddington PCN**
GP Practice(s): **Thameside Medical Practice**

Richmond

PROJECT AIM & TARGET GROUP

Focus on Priority group one to reduce CVD risk:

Q risk above %20 and not on statins Qrisk above 20 – CKD 2-3- Diabetes and not on statins.

The search shortlisted 42 patients and the aim was to contact all and offer a statin.

OUTCOMES FROM THE PROJECT

Recalled 41 patients in priority group one and almost half of them agreed to start treatments.

The remaining patients either declined or treatment options were considered not suitable for them due to age and frailty.

CHALLENGES/ISSUES BARRIERS FACED

- The main challenge was time as I was not given specific time to contact those patients and had to do it around my routine clinic days hence could not complete other priority groups

SUCCESSES OF THE PROJECT

- I have gained a lot of information about different approaches towards addressing high Q risk in patients and how to support patients to make choices about their care

LEARNINGS FROM THE PROJECT

- It helps if other support staff contact patient to ask for up to date blood test before an appointment is booked with the pharmacist

Fellow Name: **Aanu Etukumoh**
PCN: **Aplos PCN**
GP Practice(s):

Lewisham

PROJECT AIM & TARGET GROUP

This project aimed to improve lipid optimisation for patients at risk of CVD. Searches returned 321 patients.

The aim was to improve the cholesterol and thereby reduce QRISK score.

OUTCOMES FROM THE PROJECT

Contacted 226 patients via AccuRx , blood forms generated for all contacted patients , statin initiated after discussion in 63 patients of which 22 have showed reduced total cholesterol .

Work is still in progress to cover the population captured in the search.

CHALLENGES/ISSUES BARRIERS FACED

- Failed encounters due to patients not contacting back either via AccuRx or calling the surgery
- Initial reluctance in statin due to misinformation

SUCCESSES OF THE PROJECT

- Initiated patients on statins and follow up calls confirmed compliance with medication

LEARNINGS FROM THE PROJECT

- This is ongoing work that needs to be continued so the gains do not get lost
- There needs to be adequate follow up of patients to ensure compliance

Fellow Name: Rajesh Nagarajan
PCN: Orpington PCN
GP Practice(s): Highland Medical Practice

Bromley

PROJECT AIM & TARGET GROUP

This project aimed to improve lipid optimisation for patients at risk of CVD.

A UCLP search for Priority Group 2 for Primary Prevention returned 173 patients.

The aim was to initiate 30% of patients onto a statin by October 2022.

OUTCOMES FROM THE PROJECT

All 173 patients were reviewed, either face to face or a review of notes and telephone call to commence on statin.

32 patients were initiated on a statin.

Project is ongoing.

CHALLENGES/ISSUES BARRIERS FACED

- Challenges were getting the bloods repeated as the QRISK data needed to be updated and contra indications for statin had to be ruled out
- More time consuming than expected and therefore extended

SUCCESSES OF THE PROJECT

- Reviewed all 173 patients from UCLP priority group 2
- Great support from specialist and team

LEARNINGS FROM THE PROJECT

- This is ongoing work that needs to be continued so the gains do not get lost
- Statin intolerance pathway and guidance on switching statins particularly useful
- Be proactive in managing Hypercholesterolaemia as the evidence is very clear of the benefits according to QRISK
- Having the shared care decision with patient

Fellow Name: **Tanya Walker**
PCN: **APL**
GP Practice(s): **The Albion Surgery**

Bexley

PROJECT AIM & TARGET GROUP

The aim was to review, contact and optimise lipids in over 58% of people aged 25-84 with QRISK 2 or 3 with more than 20% risk who are not currently on statin therapy.

The initial search returned 600 patients, so we decided to start by focusing on those under 69 (105 patients) and contact the others after completing this group.

OUTCOMES FROM THE PROJECT

The latest figures from Eclipse is that a 65% rate has been achieved, which is over the original target. Some patients did not respond, some declined, and some started a statin.

This project is ongoing and I am still actively targeting patients in this group.

CHALLENGES/ISSUES BARRIERS FACED

- The time involved to contact the patients
- Following up the results. Booking patients in for face-to-face appointments after the blood test had been done
- There is some resistance to starting statin therapy

SUCCESSES OF THE PROJECT

- Some patients were referred for familial hypercholesterolaemia
- Target was achieved
- General improvement in risk for the target group

LEARNINGS FROM THE PROJECT

- The initial search was key to identify the right patients
- Initially started with the list alphabetically, but it was much easier when changed to age as it allowed to prioritise the younger age groups
- Contacting patients via tests and allowing them to respond meant we could quickly follow-up the patients interested in the treatment

AF Project Case Studies

1. Marina Lambros
2. Amy Miller and Faiza Usama
3. Linda Edemafaka
4. Claire Chim Wai Zin

5. This resource has been produced with the support of a Daiichi-Sankyo grant

Fellow Name: Amy Miller and Faiza Usama
PCN: Wandsworth Prime
GP Practice(s): Heathbridge Practice

Wandsworth

PROJECT AIM & TARGET GROUP

Aim 1 Increase % of patients (90%) on AF register with a CHA2DS2-VASC score within the last 12 months (QOF target).
Aim 2 Increase % of patients (95%) with AF with a CHA2DS2-VASC score > 2, or > 1 male, that are anticoagulated with a DOAC, or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist (IIF CVD-05).
Aim 3 New patients requiring anticoagulation for stroke prevention in AF offered and prescribed edoxaban first line (IIF CVD-06).
Aim 4 Increase % of patients (75%) prescribed a DOAC who have a renal function test, weight and Creatinine Clearance Rate recorded, plus a recording that their DOAC dose was either changed or confirmed (IIF SMR-03).
Aim 5 Increase % (100%) of patients prescribed a DOAC who have had a full blood count and liver function tests in the last 15 months (CQC Inspection).

OUTCOMES FROM THE PROJECT

As of 27/10/22 (project still ongoing as at step 3 of implementation plan:

Aim 1: Increased from 53% at baseline to 100%. 95 patients reviewed. Target achieved
Aim 2: Has increased from 83% to 90%. ~ 30 patients reviewed.
Aim 4: Has increased from 0% to 33%. 75 patients reviewed, reviews ongoing.
Aim 5: Has remained at 84%. Patients not yet reviewed.

CHALLENGES/ISSUES BARRIERS FACED

- Unexpected challenges: Some patients more complex than initially thought and may need liaison with MDT/specialist.
- Unexpected challenges: Lack of clarity/guidance from national PCN guidance around which codes to use to capture correct data for IIF targets. Confirmed codes by trial and error and running searches. Some patients have declined treatment; they do not want to start preventative treatment in some cases. All patients deemed to have capacity to decide this.
- Unclear why Aim 2 % is not higher – patients reviewed and all either prescribed DOAC or warfarin. May need to review whether code around DOAC not indicated/declined to be added to records.
- Limited time to carry out reviews, taking longer than expected to review number of patients to reach targets.

SUCCESSES OF THE PROJECT

- Systemic review of patients and significant interventions by project team to optimise anticoagulation treatment, reducing stroke risk and adverse events for patients taking a DOAC
- Improved achievement of QOF/IIF targets, increasing financial reward for the practice and PCN.
- Improved awareness of required clinical coding required to achieve above targets
- Increased efficiency within practice and better use of current staff skill mix
- Shared project implementation plan, amongst colleagues across the PCN so the same process can be carried out at nearby surgeries to improve their management of this cohort of patients and meet required targets
- Sharing of learning with HCP colleagues working in other geographical areas, to help them upskill in this clinical area and raise awareness
- Networking with peers

LEARNINGS FROM THE PROJECT

What worked well:

- Teamwork, being able to split the workload to achieve quick improvement to the QOF target around AF
- Ready-made QOF searches and templates to ensure relevant codes captured
- Support from GP and practice team. Protected time to carry out reviews
- Use of existing searches constructed by Ardens
- Support from PCN Clinical Director
- Access to specialists via HIN
- Positive patient feedback, making positive difference and significant interventions to patient care by optimising anticoagulation
- Access to secondary care haematology specialist via Kinesis for advice about complex clinical situations

Fellow Name: **Marina Lambros**
PCN: **APL**
GP Practice(s): **Lyndhurst Road Medical Centre**

Bexley

PROJECT AIM & TARGET GROUP

Patients with CHA2DS2-VASc over 2 (or 1 for male patients) who are not on a DOAC and looking in to why this is. If suitable, discuss starting anticoagulation and refer for this to be initiated.

There were 302 patients who fell into this category.

The aim was to initially review 50 patients and ensure those who are suitable for anticoagulation are referred for this to be initiated.

OUTCOMES FROM THE PROJECT

56 patients reviewed.
They were either referred to anticoagulation or exempted as not suitable for referral.

The exemption happened when they had either already tried anticoagulation and this was contraindicated or not tolerated or they had refused a DOAC.

CHALLENGES/ISSUES BARRIERS FACED

- Getting the initial data was difficult as different people presented with different search results, further training on running unique searches would have possibly made the initial stages of the project a lot simpler
- Getting GP and/or pharmacist appointments for patients as they're fully booked quite quickly
- Several patients on warfarin with low TTR had already been trialled on a DOAC but had not tolerated it and had to switch back to warfarin. Further advice needs to be sought from the GP/specialist on how best to manage these patients

SUCCESSES OF THE PROJECT

- Enhanced learning on AF and anticoagulation
- Enjoyed looking at the pros and cons of DOAC vs Warfarin and being able to have a discussion with patients on this using enhanced knowledge on the subject has now been gained
- Positive feedback from the QOF administrator who monitors the data daily. This project has helped free up time to focus on other QOF areas, this in turn has been beneficial for a larger number of our patients

LEARNINGS FROM THE PROJECT

- Learned the importance of taking time out to look into patient's notes in detail to help optimise their care
- If availability permitted to spend longer on each medication review, then the outcomes would be more beneficial for the patient as more clinical areas would be covered and less things would be missed

Fellow Name: Linda Edemafaka
PCN: Beckenham PCN
GP Practice(s): Elm House Surgery

Bromley

PROJECT AIM & TARGET GROUP

Target group are patients on AF register with a CHA2DS2DASc score of >1 not on anticoagulation but may require anticoagulation. Currently this is 19% of patients on AF register at Elm House Surgery.

This project aimed to review patients and reduce % who are untreated.

OUTCOMES FROM THE PROJECT

Reviewed 30 patients, reason(s) for stopping anticoagulant documented on GP medical record/secondary care clinical document but not coded on EMIS, one patient commenced on anticoagulant.

CHALLENGES/ISSUES BARRIERS FACED

- Reviewing multiple documents to understand why patients are not on DOAC can be time consuming

SUCCESSES OF THE PROJECT

1. Educating patients about stroke risks, and the need to consider anticoagulation as risks changes using CHA_2DS_2-VASc score and shared decision-making approach
2. Patients were grateful to have better understanding of clinical conditions that increases risk score thereby increasing the need for anticoagulation
3. Reviewing untreated patients allowed modifiable factors for AF to be reviewed e.g., lipid profile, borderline HTN and Non-Diabetic Hyperglycaemia

LEARNINGS FROM THE PROJECT

1. Better understanding of importance of coding appropriately in primary care
2. Need for ongoing review of patients coded as" anticoagulant not indicated" as CHA2DS2DASc score and related risk may change over time
3. QI projects improve focus on patient centred care.
4. Be prepared for project to change course, learn to adapt

Fellow Name: Claire Chim Wai Zin
PCN: The Lewisham Care Partnership PCN
GP Practice(s):

Lewisham

PROJECT AIM & TARGET GROUP

There are several patients who were changed to DOAC from warfarin and have issues with renal function.

This project aimed to review all patients on DOAC with no renal function in the last 12 months. This was 8% of patients on DOAC, a total of 40 patients.

OUTCOMES FROM THE PROJECT

- Recalled 20 patients in total and input renal function using blood test from the hospital
- Checked that the dose is still correct for current renal function using creatinine clearance calculation
- Some patients who are housebound were called and referred to district nurses for blood test and if possible a up to date weight

CHALLENGES/ISSUES BARRIERS FACED

- There were constantly more patient newly initiated on DOAC
- Some patient who had blood test done a year ago expired next month, so searches needs to be constantly re-run to capture patients with blood test which were expired
- Difficulty getting blood test for housebound patient. Sometimes it takes a long time for district nurses to schedule them in as it is considered as low priority
- Some patients were not in the country
- Patient whose DOAC were recently stopped
- Patient admitted to hospital

SUCCESSES OF THE PROJECT

- Patients are getting up to date blood test for DOACs and surgery is currently improving its recalls for this cohort of patients
- Monitor impact of DOAC on renal function, including for housebound patients

LEARNINGS FROM THE PROJECT

- I learnt to use the PDSA cycle and try do a little at a time and learn from it. Using the cycle brings me back to help trouble shoot what has not gone too well and what went well which can then improve the audit going forward
- Learning on how to incorporate into our daily work and schedule. I learn how to monitor DOACs. The webinars has been very useful. They have increased my knowledge on cardiovascular disease and help me improve my clinical management and safety

FH Project Case Studies

1. Thaarani Srisenthivel
2. Dr Emily Mei
3. Jibril Farah

4. This resource has been produced with the support of a Daiichi-Sankyo grant

Fellow Name: **Thaarani Srisenthivel**
PCN: **Teddington PCN**
GP Practice(s): **Hampton Wick Surgery**

Richmond

PROJECT AIM & TARGET GROUP

High number of patients aged 30 years and over with a serum cholesterol >9.0 or LDL-C >6.4 or non-HDL-C >7.5 (and not coded with familial hypercholesterolemia) are undiagnosed and untreated for familial hypercholesterolaemia.

There were 34 patients who fell within this target group.

The aim was to decrease the number of patients in this target group by 90% by the end of October 2022.

OUTCOMES FROM THE PROJECT

- 16 patients had normal levels of cholesterol concentration following a repeat blood test.
- 2 patients were referred to the lipid clinic
- **7 patients have pure hypercholesterolaemia diagnosis and have started treatment**
- **1 patient had their initial lipid clinic referral lost and was re-referred**

CHALLENGES/ISSUES BARRIERS FACED

- It was time consuming and challenging to contact patients who did not respond to any form of communication from the surgery
- Did not complete a coding review as recently changed systems
- Did not ensure patients already confirmed with the diagnosis were routinely reviewed at the lipid clinic (every 5 years)

SUCCESSES OF THE PROJECT

- Learned how to do searches on EMIS and re-run these searches
- **Educated other clinicians on familial hypercholesteremia** and the correct steps to follow for suspected familial hypercholesteremia
- Enrolled patients on the project from an another, bigger surgery
- Completing searches for cohort one and three for both practices
- 10 patients are now receiving optimised treatment for their lipids which will reduce their risk of heart attack or stroke

LEARNINGS FROM THE PROJECT

- Discovered that AccuRx can be set up for advance texting by setting a future date and time
- However, was not able to use this feature as needed to manually check that a blood test was not booked or blood test results were not pending

Fellow Name: **Dr Emily Mei**
PCN: **West Wandsworth PCN**
GP Practice(s): **Putneymead Medical Practice**

Wandsworth

PROJECT AIM & TARGET GROUP

Patients aged 29 years or under with a total cholesterol greater than 7.5 OR aged 30 years or over with a total cholesterol greater than 9.0 – who has not been assessed / referred for Familial Hypercholesterolaemia.

50 patients were identified from the possible FH search who had not been see to discuss their possible diagnosis / referral.

Aim to review these patients and refer where appropriate.

OUTCOMES FROM THE PROJECT

- Familial Hypercholesterolaemia teaching session to update knowledge and management plan of the clinical team
- The EMIS live alert algorithm identifies 100% of patients at highest risk of FH according to their cholesterol and prompts the clinician to action in real time which benefits over retrospective search

CHALLENGES/ISSUES BARRIERS FACED

- Time needed to complete the project, against demand and workload of being GP
- Other colleagues with different expertise like IT / EMIS protocol / systems analyst
- Systems manager left the practice during the project and lost valuable resource for expertise and advice
- The importance of a protocol to stop flagging to clinician once patient has been referred / if patient declines
- EMIS codes were not up to date with IIF requirements at one point

SUCCESSES OF THE PROJECT

Creation of a new, original protocol for EMIS to identify patients with cholesterol levels meeting FH requirements and alerting the clinician in real time. This will lead to the more prompt identification of at risk patients and lead to earlier referral / management / improvement of cardiovascular risk.

LEARNINGS FROM THE PROJECT

- A protocol based plan to enhance clinical care is one that can be adapted by others in the future. There is additional benefit of integrating the protocol to the electronic patient records
- Artificial intelligence is a valuable tool in supporting the clinician with identifying patients with cholesterol in the FH levels, however it should not distract / burden the clinician, otherwise it becomes a nuisance and reduces uptake

Fellow Name: Jibril Farah

PCN: Battersea PCN

GP Practice(s): Battersea Fields, Battersea Rise, Bridge Lane, Queens Town Road, Lavender Hill

Wandsworth

PROJECT AIM & TARGET GROUP

- Review all FH patients
- Identify potentially undiagnosed FH patients
- Refer those who are eligible to lipid clinic

OUTCOMES FROM THE PROJECT

- FH is probably underdiagnosed at the practice
- Significant room to improve drug therapy for FH patients
- Misdiagnoses of FH is likely common

CHALLENGES/ISSUES BARRIERS FACED

- Obtaining patient family history
- How to refer to lipid clinics

SUCCESSES OF THE PROJECT

- Identifying patients with FH on suboptimal treatment
- Referring high risk FH patients to lipid clinic
- Identifying new patients with FH

LEARNINGS FROM THE PROJECT

- Better clinical coding is needed with FH patients
- Lifestyle is a big cause of abnormal lipid profile
- FH patients need 5 yearly follow up with lipid clinic

Get in touch

For more information on the CVD Prevention Fellowship Programme email us at hin.cvd@nhs.net or check out our website at www.healthinnovationnetwork.com

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