DEEP END: EOE

Training Hub
CAMBRIDGESHIRE & PETERBOROUGH

Reaching your patients in Deep End Practices with LTCs!

Dr Jessica Randall-Carrick

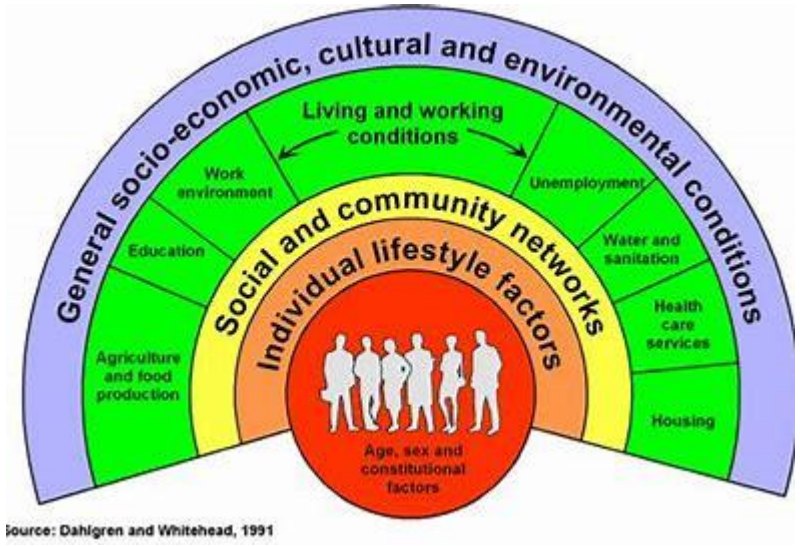
@DeepEndEoE

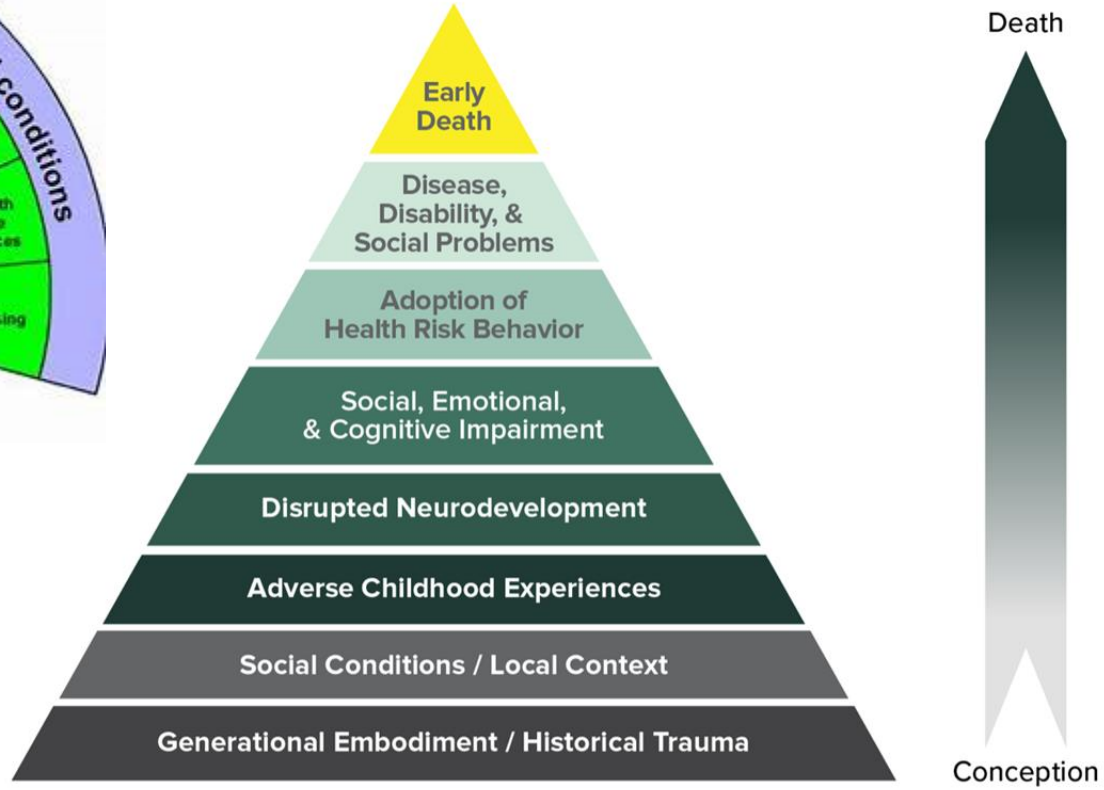
www.deependeastofengland.co.uk

REACHING YOUR PATIENTS IN DEEP END PRACTICES WITH LONG TERM CONDITIONS!

- How do ACEs impact LTCs?
- What LTCs perpetuate Inequality?
- What methods work?
- Never forget the community!

Adverse Childhood & Community Experiences (ACEs)





Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Deep End: EoE
Sept 2023

ACEs Can Accumulate and Their Effects Last Beyond Childhood

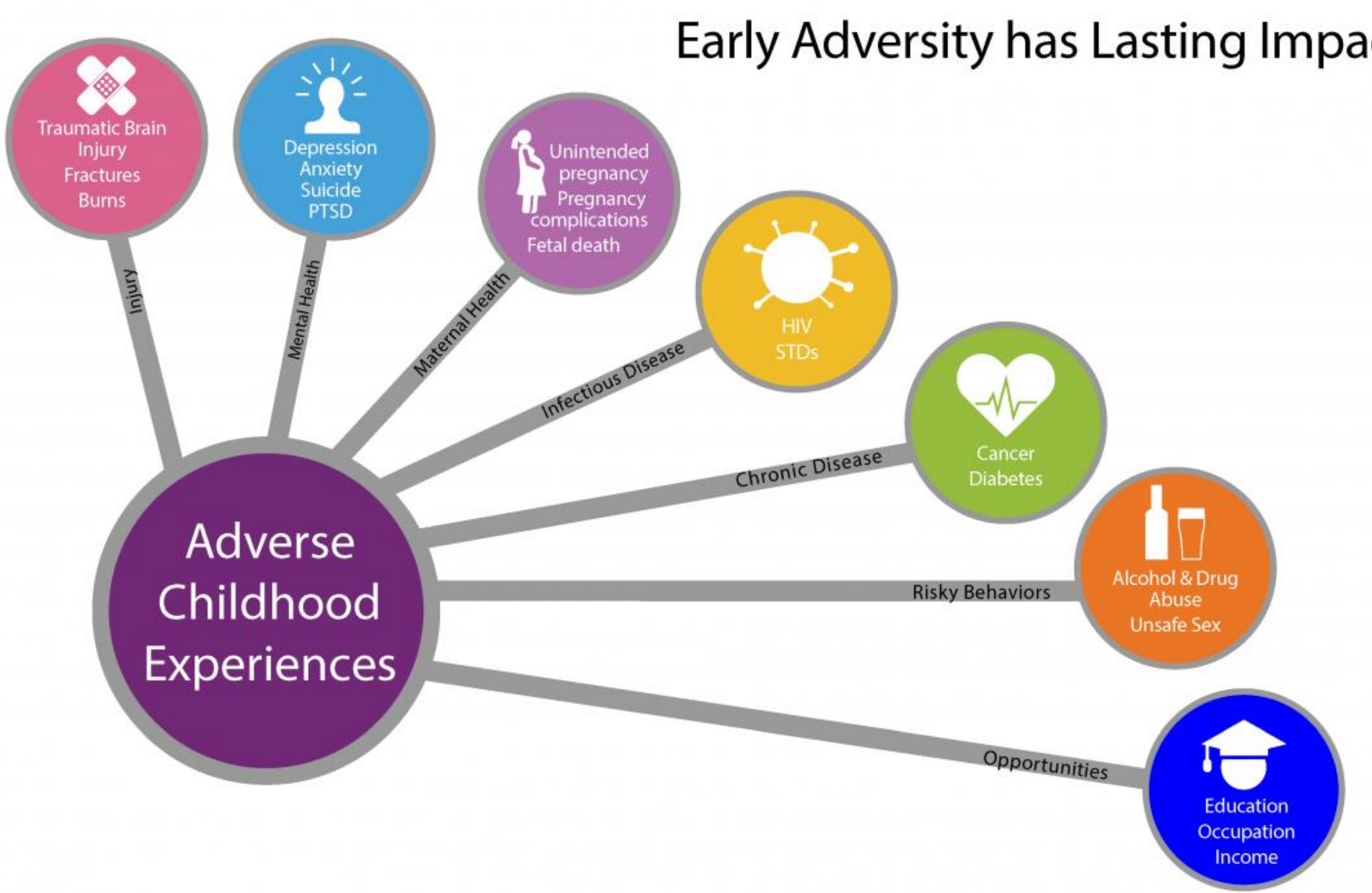
The effects of ACEs can add up over time and affect a person throughout their life.

Children who repeatedly and chronically experience adversity can suffer from **toxic stress.**

Toxic stress happens when the brain endures **repeated stress or danger,** then releases fight or flight hormones like cortisol.

This internal alarm system **increases heart rate** and **blood pressure** and **damages the digestive and immune systems**.

Toxic stress can disrupt organ, tissue, and brain development. Over time, this can limit a person's ability to process information, make decisions, interact with others, and regulate emotions. **These consequences may follow a person into adulthood.**



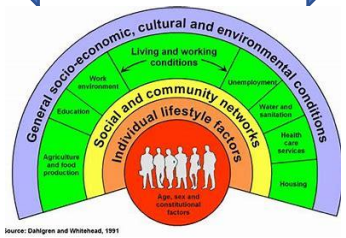
Centers for Disease Control and Prevention, Kaiser Permanente

Risk factors and CVD Prevention: Consider your Role – Where can you help?

Behavioural risks

- Smoking
- Nutrition
- Physical activity
- Alcohol consumption
- *Obesity*

Cardiovascular Disease



Clinical risks

- Hypertension
- Hyperlipidaemia
- Atrial Fibrillation (AF)
- Hyperglycaemia
- Chronic Kidney Disease (CKD)

C & P Behaviour risk : the headlines

- **Estimated smoking prevalence for C&P is higher than the England average: variation across PCNs liked with deprivation.**
- **Offer of treatment and support is significantly lower than the England – increasing trend pre Covid.**
- **Obesity prevalence for C&P is significantly lower than the England average with variation across PCNs.**

Public Health England

Health Matters

10 year cardiovascular disease ambitions for England

Atrial fibrillation (AF)

85%

of the expected number of **people with AF are detected by 2029**

90%

of patients with AF who are already known to be at high risk of a stroke **to be adequately anticoagulated by 2029**

High blood pressure

80%

of the expected number of **people with high blood pressure are diagnosed by 2029**

80%

of the total number of people already diagnosed with high blood pressure are **treated to target as per NICE guidelines by 2029**

High cholesterol

75%

of people **aged 40 to 74 have received a formal validated CVD risk assessment** and **cholesterol reading** recorded on a primary care data system in the last five years by 2029

45%

of people **aged 40 to 74 identified as having a 20% or greater 10-year risk** of developing CVD in primary care are treated with statins by 2029

25%

of people with **Familial Hypercholesterolaemia (FH) are diagnosed and treated** optimally according to the NICE FH Guideline by 2024

The ambitions are underpinned by the need to do more to reduce health inequalities

Reduce the gap significantly in amenable CVD deaths between the most and least deprived areas by 2029

Public Health England

Cardiovascular Disease Prevention: Risk Detection and Management in Primary Care

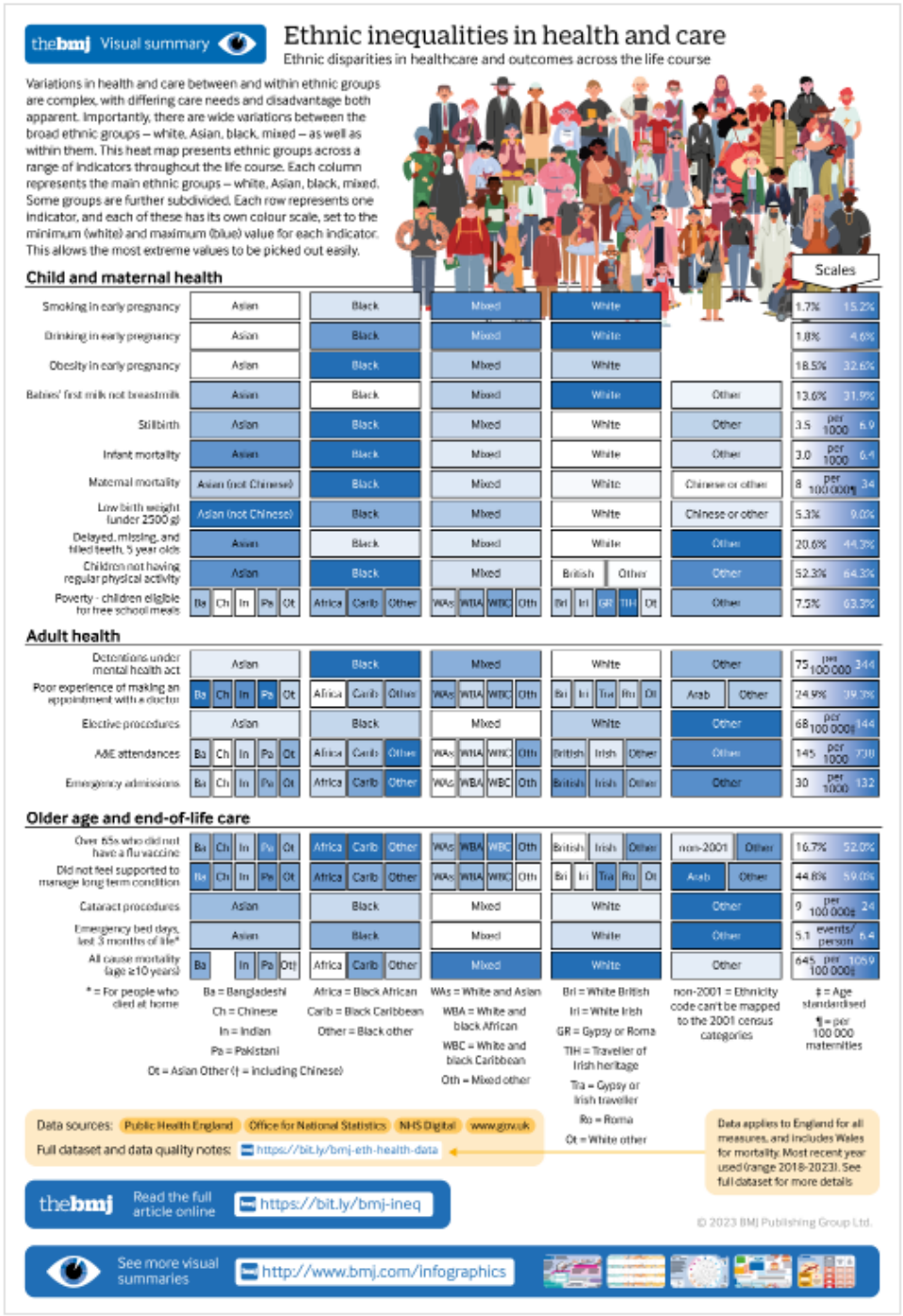
NHS RightCare

The Interventions	**Cross Cutting:** 1. NHS Health Check - systematic detection of high BP, AF, NDH, T2DM, CKD, high cholesterol, CVD risk 2. System level action to support guideline implementation by clinicians 3. Support for patient activation, individual behaviour change and self management					
	High BP detection and treatment	**AF detection & anticoagulation**	**Detection, CVD risk assessment, treatment**	**Type 2 Diabetes preventive intervention**	**Diabetes detection and treatment**	**CKD detection and management**
The Opportunities	5 million un-diagnosed. 40% poorly controlled	30% undiagnosed. Over half untreated or poorly controlled	85% of FH undiagnosed. Most people at high CVD risk don't receive statins	5 million with NDH. Most do not receive intervention	940k undiagnosed. 40% do not receive all 8 care processes	1.2m undiagnosed. Many have poor BP & proteinuria control
The Evidence	BP lowering prevents strokes and heart attacks	Anticoagulation prevents 2/3 of strokes in AF	Behaviour change and statins reduce lifetime risk of CVD	Intensive behaviour change (eg NHS DPP) reduces T2DM risk 30-60%	Control of BP, HbA1c and lipids improves CVD outcomes	Control of BP, CVD risk and proteinuria improves outcomes
The Risk Condition	**Blood Pressure**	**Atrial Fibrillation**	**High CVD risk & Familial H/ cholesterol**	**Non Diabetic Hyperglycemia ('pre-diabetes')**	**Type 1 and 2 Diabetes**	**Chronic Kidney Disease**

Detection and 2°/3° Prevention

The Outcomes	50% of all strokes & heart attacks, plus CKD & dementia	5-fold increase in strokes, often of greater severity	Marked increase in premature death and disability from CVD	Marked increase in Type 2 DM and CVD at an earlier age	Marked increase in heart attack, stroke, kidney, eye, nerve damage	Increase in CVD, acute kidney injury & renal replacement

The more ACEs or deprived circumstances, the higher the risk for these conditions



[Ethnic inequalities in health and care: Ethnic disparities in healthcare and outcomes across the life course | The BMJ]

Deep End: EoE
Sept 2023

EXAMPLES

Obesity – better coding & support (EDI) – use of LES

Pathway to Remission – for PwD – targeted communities & individuals

Practice workload – use of data to fill clinics

Pre-Diabetes – centralised mailshot

Diabetes 8CPs – SMS

Diabetes Structured Education – SMS & website

Primary & Secondary CVD prevention – SMS & website

Use of Community Assets

OBESITY – BETTER CODING & SUPPORT

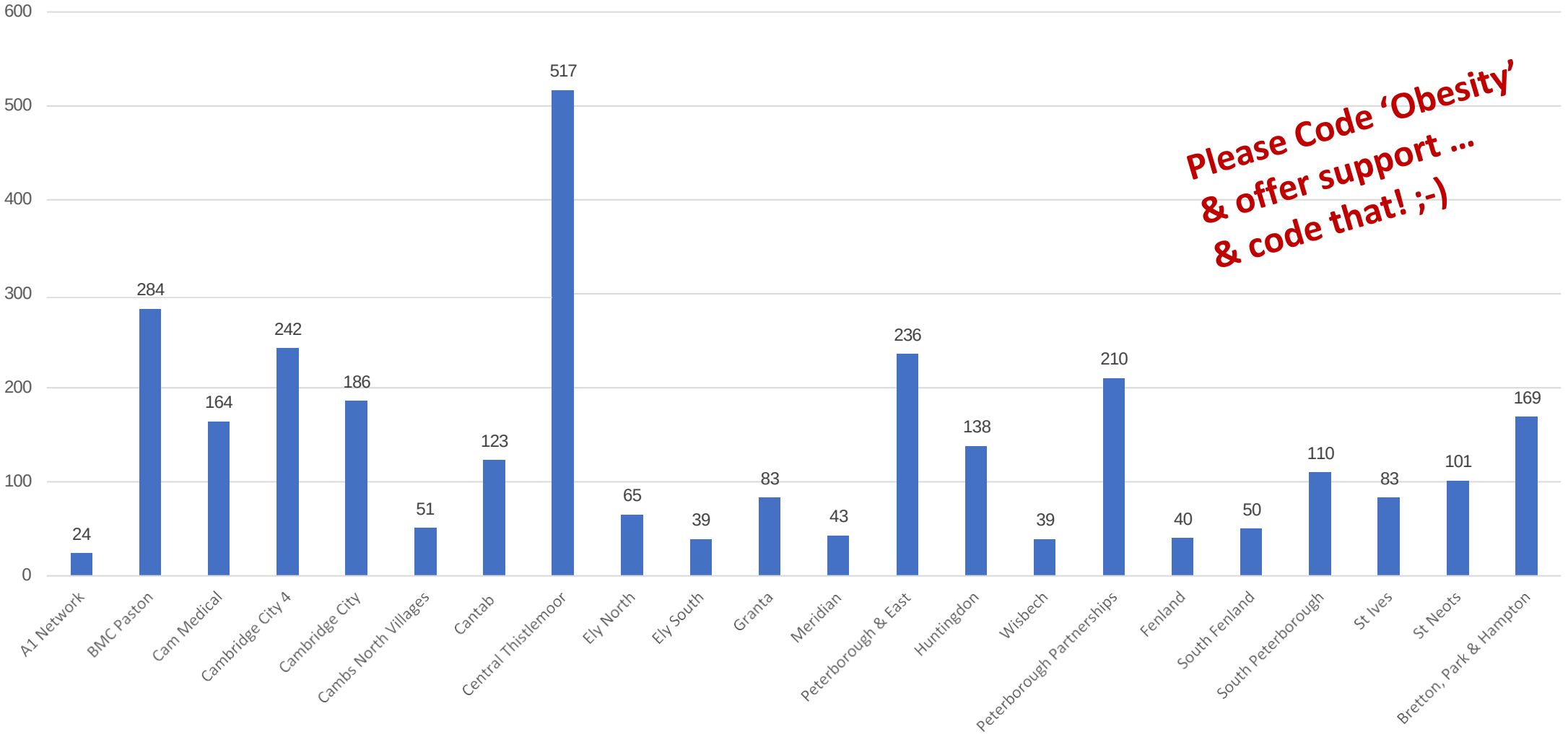
On average a Person living with Obesity (PwO) waits 6 years before a HCP raises the condition with them.

Obesity diagnosis depends on ethnicity – poorly taught & known

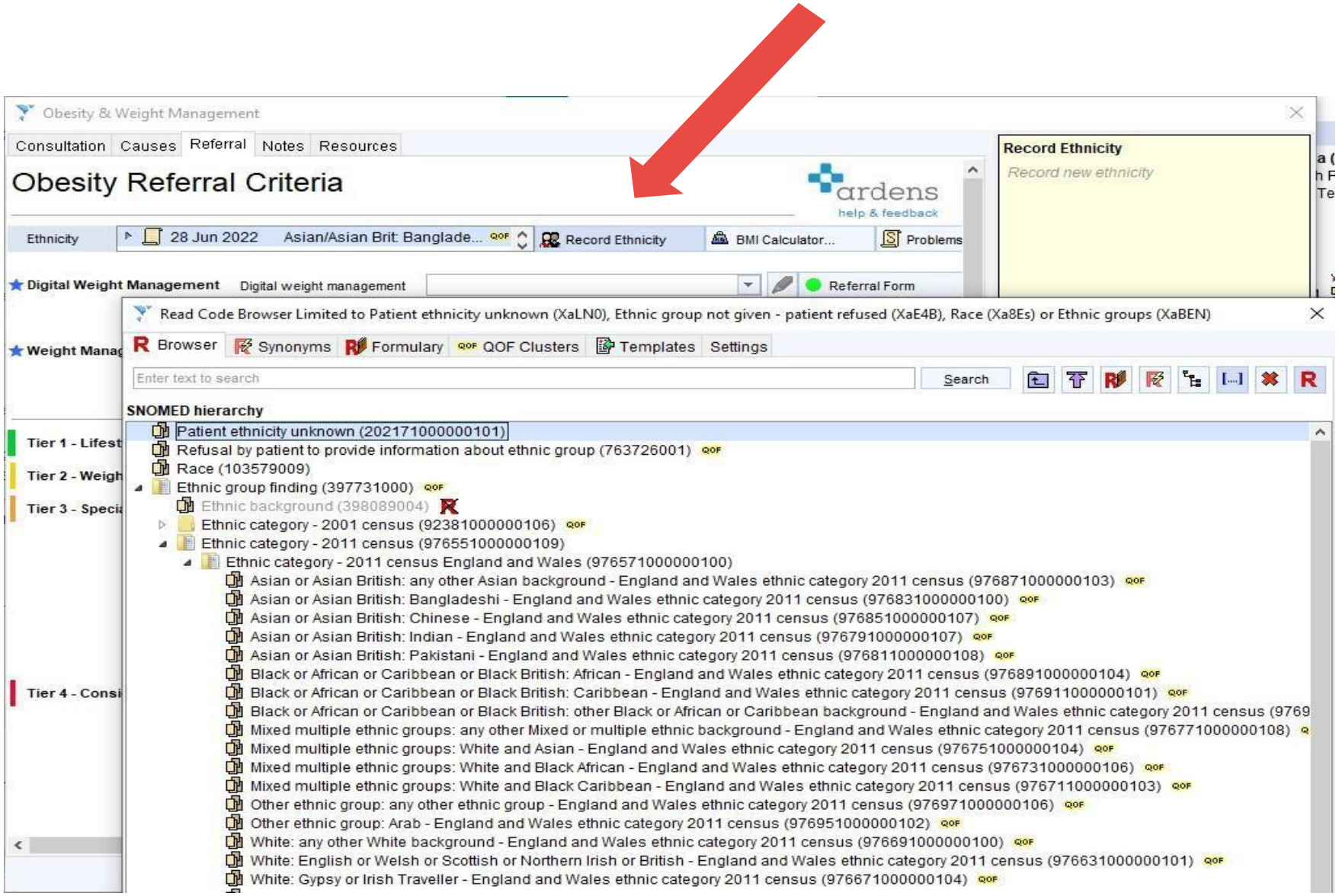
Consider a LES for positive change

Patients who are Overweight or Obese	1. If BMI recorded within the last 3 years and is raised (ethnic-specific) offer weight management services. 2. For those patients from a **Black or Asian ethnicity – a BMI of 23+ = overweight; a BMI of 25+ = obese** If no BMI recorded, then ensure that within the last three years there is a weight measurement and aspire to establish the BMI of at least 75% of practice population & if overweight or living with obesity, please offer Weight Management information 3. For those patients from a **White background: a BMI of 25+ = overweight; a BMI of 30+ = Obese** If no BMI recorded, then ensure that within the last three years there is a weight measurement and aspire to establish the BMI of at least 50% of practice population & if overweight or living with obesity, please record and offer Weight Management information. 4. For those patients with **no ethnicity recorded**, for example 'ethnicity unspecified' or 'ethnicity not recorded' practices should **contact patients** (eg using AccuRX florey or alternative) to aspire **to establish accurate ethnicity reporting** for at least 98% of practice population.
Eclipse	1. Practices are reminded that Eclipse is now updated automatically and is an excellent tool to support and facilitate the improvement of the care of their DM patients

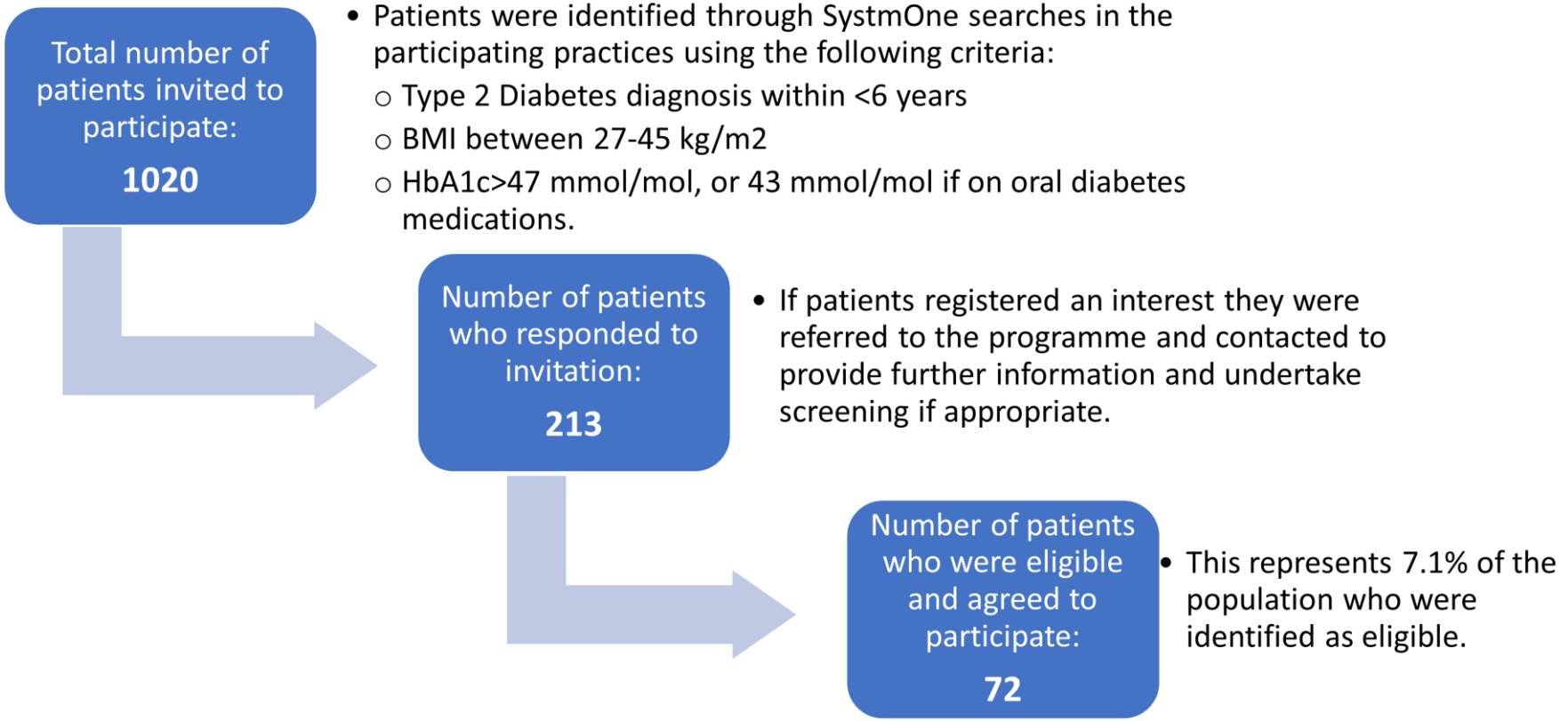
BAME Adults with BMI between 27.5-29.99 Not on the QOF OBTY REG: Patient Count



Please Code 'Obesity' & offer support … & code that! ;-)


Obesity & Weight Management
Consultation
Causes
Referral
Notes
Resources
Obesity Referral Criteria
ardens
help & feedback
Ethnicity
28 Jun 2022
Asian/Asian Brit: Banglade...
Record Ethnicity
BMI Calculator...
Problems
Digital Weight Management
Digital weight management
Referral Form
Record Ethnicity
Record new ethnicity
Weight Manag
Tier 1 - Lifest
Tier 2 - Weigh
Tier 3 - Speci
Tier 4 - Consi
Read Code Browser Limited to Patient ethnicity unknown (XaLN0), Ethnic group not given - patient refused (XaE4B), Race (Xa8Es) or Ethnic groups (XaBEN)
Browser
Synonyms
Formulary
QOF Clusters
Templates
Settings
Enter text to search
Search
SNOMED hierarchy
Patient ethnicity unknown (202171000000101)
Refusal by patient to provide information about ethnic group (763726001)
Race (103579009)
Ethnic group finding (397731000)
Ethnic background (398089004)
Ethnic category - 2001 census (92381000000106)
Ethnic category - 2011 census (976551000000109)
Ethnic category - 2011 census England and Wales (976571000000100)
Asian or Asian British: any other Asian background - England and Wales ethnic category 2011 census (976871000000103)
Asian or Asian British: Bangladeshi - England and Wales ethnic category 2011 census (976831000000100)
Asian or Asian British: Chinese - England and Wales ethnic category 2011 census (976851000000107)
Asian or Asian British: Indian - England and Wales ethnic category 2011 census (976791000000107)
Asian or Asian British: Pakistani - England and Wales ethnic category 2011 census (976811000000108)
Black or African or Caribbean or Black British: African - England and Wales ethnic category 2011 census (976891000000104)
Black or African or Caribbean or Black British: Caribbean - England and Wales ethnic category 2011 census (976911000000101)
Black or African or Caribbean or Black British: other Black or African or Caribbean background - England and Wales ethnic category 2011 census (9769
Mixed multiple ethnic groups: any other Mixed or multiple ethnic background - England and Wales ethnic category 2011 census (976771000000108)
Mixed multiple ethnic groups: White and Asian - England and Wales ethnic category 2011 census (976751000000104)
Mixed multiple ethnic groups: White and Black African - England and Wales ethnic category 2011 census (976731000000106)
Mixed multiple ethnic groups: White and Black Caribbean - England and Wales ethnic category 2011 census (976711000000103)
Other ethnic group: any other ethnic group - England and Wales ethnic category 2011 census (976971000000106)
Other ethnic group: Arab - England and Wales ethnic category 2011 census (976951000000102)
White: any other White background - England and Wales ethnic category 2011 census (976691000000100)
White: English or Welsh or Scottish or Northern Irish or British - England and Wales ethnic category 2011 census (976631000000101)
White: Gypsy or Irish Traveller - England and Wales ethnic category 2011 census (976671000000104)

CONSIDER SMS, LETTER & CALLS FROM PRACTICE EG VERY LOW CALORIE DIET (PTR)



I couldn't be happier. The programme for me has been easy to follow and I feel better than I have for years. To be able to say that my diabetes is in remission is amazing and I feel optimistic that I can keep it this way.

Mr A: Lost 17 kg, reduced HbA1c by 58 mmol/mol and achieved diabetes remission

Thank you so much, I am now no longer on diabetes or blood pressure medications. I found the programme difficult at times, but the results just show that it is worth it.

Mrs B: Lost 26 kg, reduced HbA1c by 34 mmol/mol and achieved diabetes remission

- On an individual basis, for some the programme was life changing.
- 40% achieved remission of T2DM; 20% achieved 15kg weight loss
- But high drop out rate (mostly due to £20pw cost to patient).
- The free NHS Pathway to Remission programme started Sept 2023 in C&P.

CONSIDER CENTRALISED SMS OR LETTER MAILSHOT EG PRE-DIABETES

C&P had poor no. of referrals to National Diabetes Prevention Programme

Had success with asking practices to send SMS mailshot – but not all practices participated

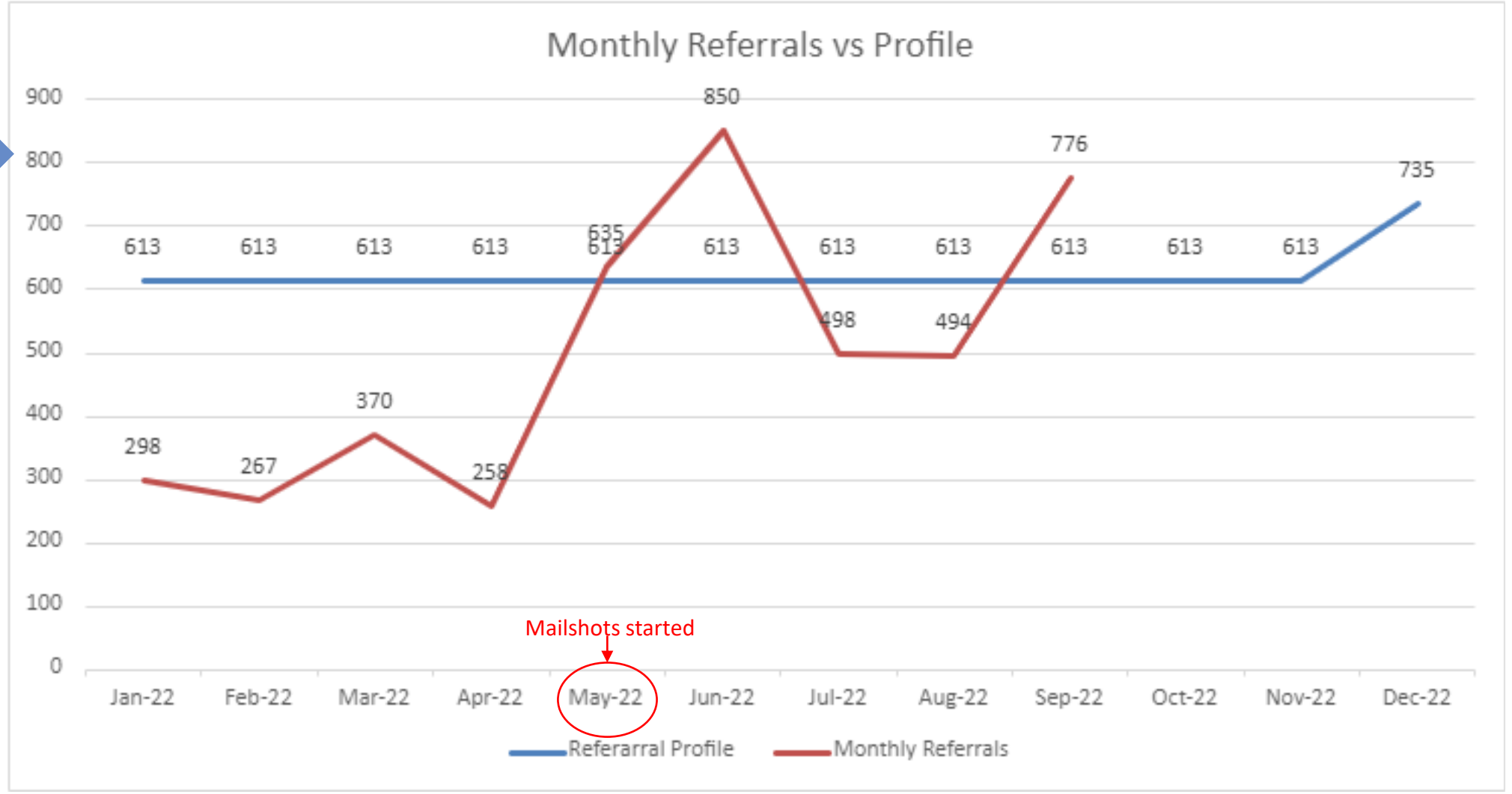
Centrally organised a Letter mailshot (on behalf of practices)

Staggered these with Provider

Targeted our more deprived communities first

National Diabetes Prevention Programme

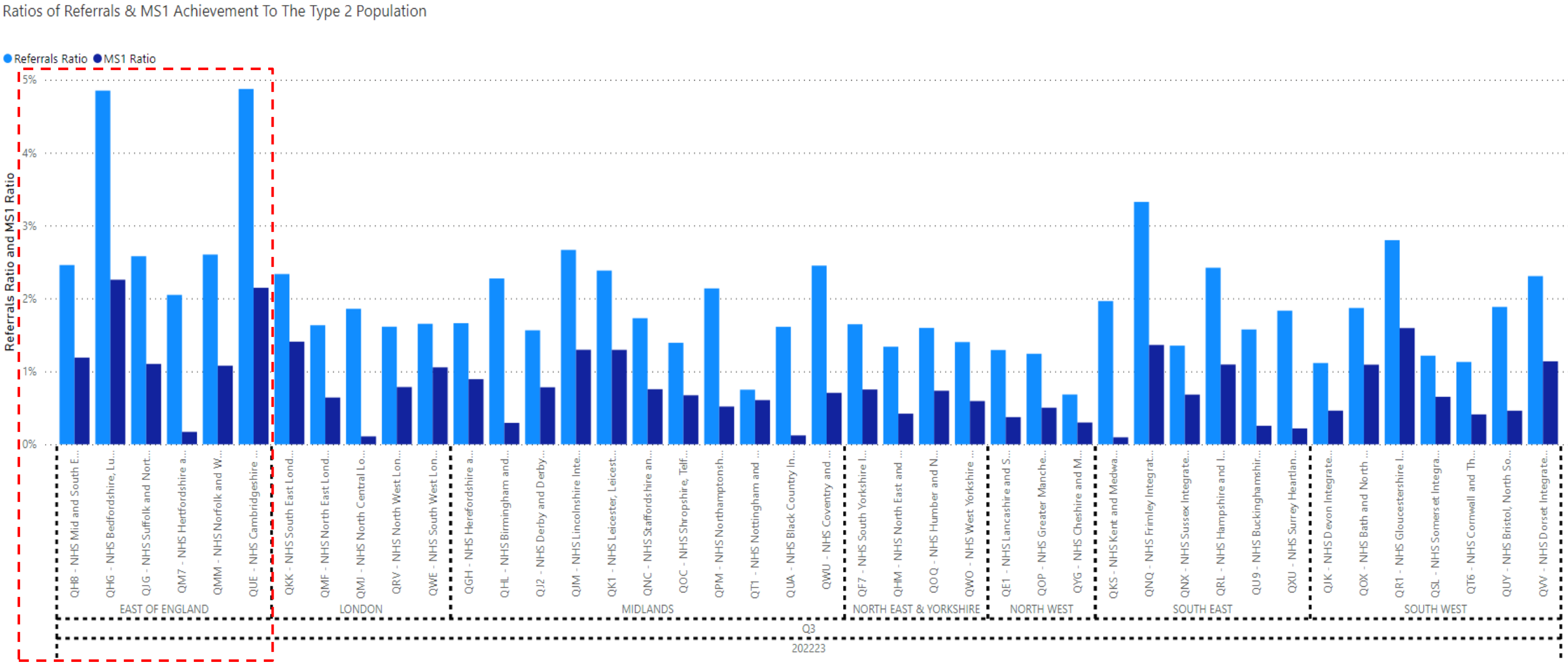
Jan 2024: profile goes >800!



2023: referral profile is 735 a month

By region – Quarter 3 (2022/23) Ratio of Referrals and MS1 against Type 2 population

East of England Diabetes Network



Consider use of data to target your highest risk patients - practice & at PCN

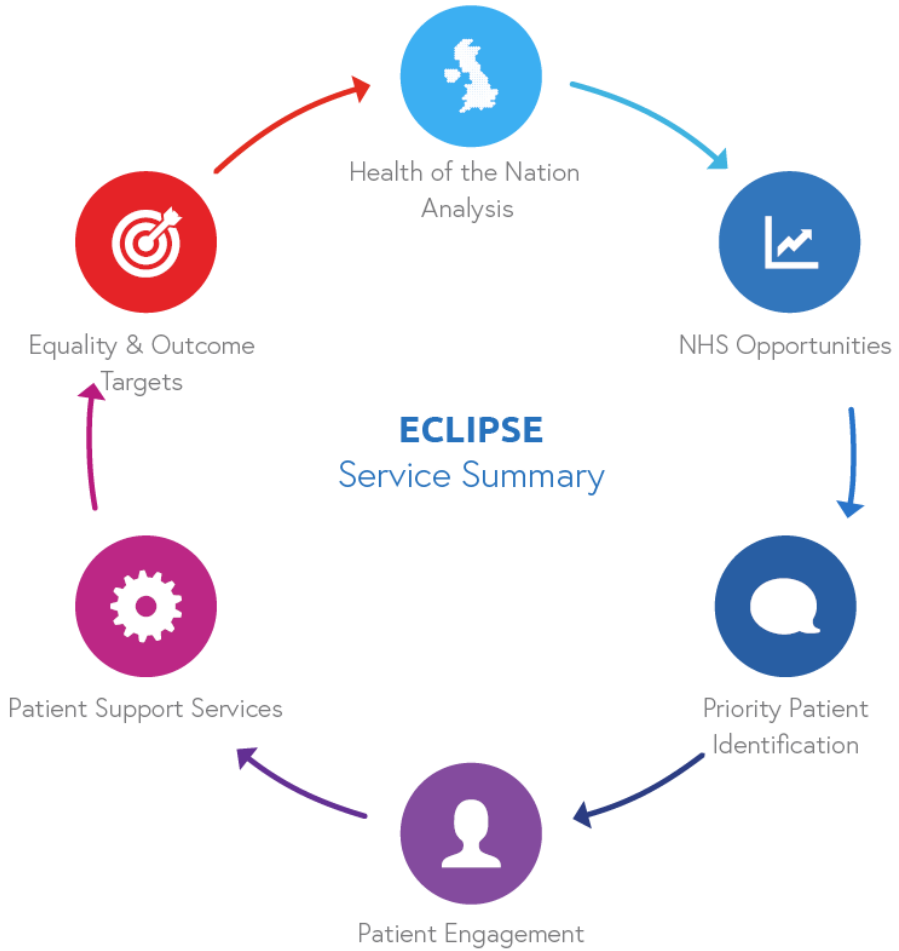
“This project has been a game changer.

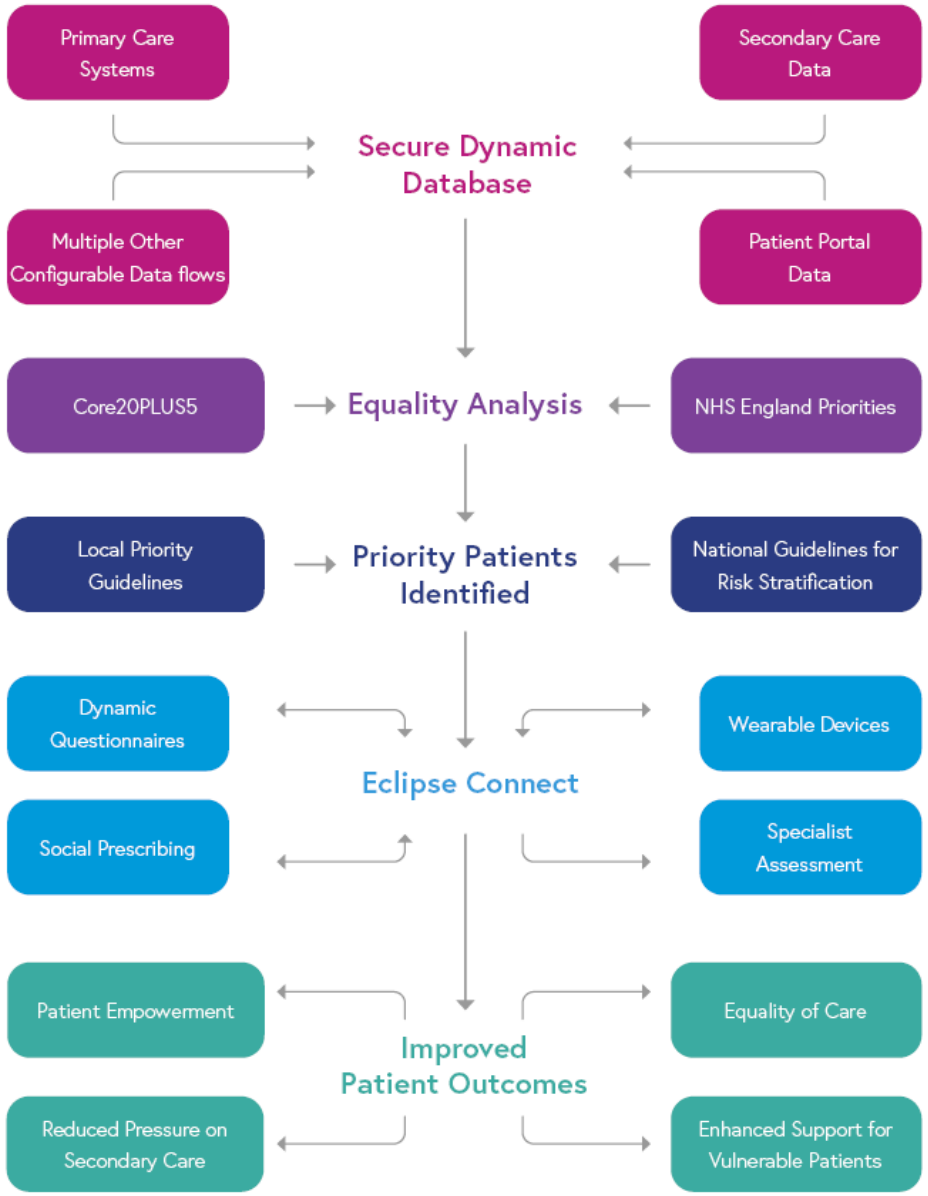
There has been a real improvement thanks to:
the support to create consistent processes that free up clinical staff time;
facilitating us to come together and engage as a group of practices within the PCN; and

→ **"training in digital tools such as Eclipse that give us real time information to identify gaps in care….**It’s a more efficient service but the real value is in keeping patients healthier for longer.”

Dr Mandeep Sira
GP & Clinical Director for Wisbech PCN

How ECLIPSE Works





CORE20PLUS5

Age / Gender

- Age 0-17 ○
- Age 18-40 ○
- Age 41-60 ○
- Age 61-80 ○
- Age over 80 ○
- Age 18 and over ○
- All Ages ◉

- Male ○
- Female ○
- All Genders ◉

Smoker

- Current Smokers ○
- Ex-Smoker ○
- Current Non-Smoker ○
- Smoking status not recorded ○
- All smoking statuses ◉

Core20 = DD 1-2

- Deprivation Decile 1-2 ○
- Deprivation Decile 1-4 ○
- Deprivation Decile > 4 ○
- All Deprivation Deciles ◉

BMI

- BMI >27.5 to 35 ○
- BMI >35 to 40 ○
- BMI >40 to 50 ○
- BMI > 50 ○
- All BMIs ◉

Estimated Qrisk3 score

- Estimated QRISK <=10% ○
- Estimated QRISK3 Score >10% ○
- Estimated QRISK3 Score >20% ○
- Estimated QRISK3 Score >25% ○
- Estimated QRISK3 Score >30% ○
- All QRISK3 Scores ◉

PLUS

- White ○
- Asian ○
- Black ○
- Ethnicity Unknown ○
- All Ethnicities ◉

- Learning Disability ☐
- Severe Mental Illness ☐
- Moderate/Severe Frailty ☐
- Dementia ☐
- Palliative Care ☐
- Depression ☐
- In Care Home ☐

- On Antipsychotics ☐
- On Gabapentinoids ☐
- On Benzodiazepine or Z-drug ☐
- On Benzodiazepine ☐
- On Z-drug ☐
- On Opiates ☐

Vaccinations

- Flu vaccination ○
- No flu vaccination ○
- Pneumococcal vaccine (last 5 yrs) ○
- No Pneumococcal vaccine (last 5 yrs) ○

Health Check

- NHS Health Check (last 5 yrs) ○
- No NHS Health Check (last 5 yrs) ○
- All patients ◉

PRISM EA

- High risk ○
- Medium risk ○
- Low risk ○
- No Activity ○
- All patients ◉

Apply Filters

**Please note that patients will need to fit all conditions selected to be returned*

	Total Patients (Childrens Asthma)	Total Patients in cohort	% Patients in cohort	
PRISM-Asthma18 VERY HIGH Risk	4546	**151**	3.32%	View
PRISM-Asthma18 HIGH Risk	4546	**525**	11.55%	View
PRISM-Asthma18 MEDIUM Risk	4546	**1950**	42.89%	View
Asthma with 6 or more Salbutamol Inhalers in last 12 months	4546	**351**	7.72%	View

Diabetes monitoring - unwarranted variation across our C&P PCN 8CP Achievement

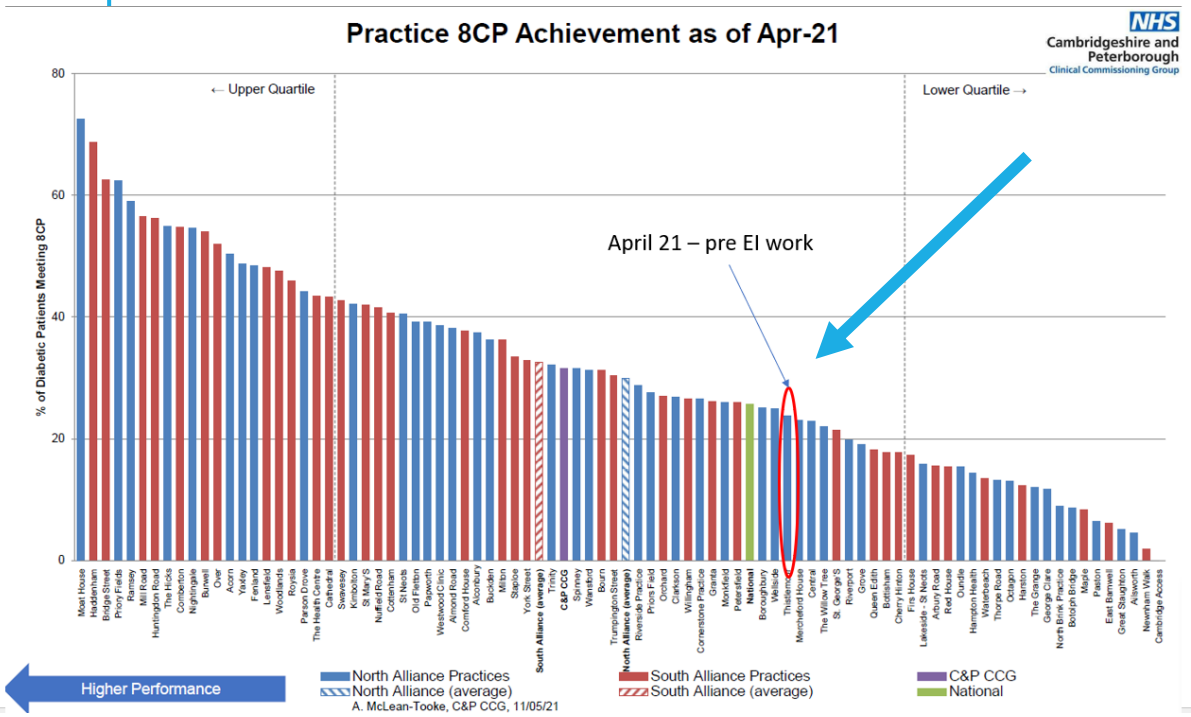
Eclipse
(Equality of Care Led Insights for Patient Safety & Engagement)

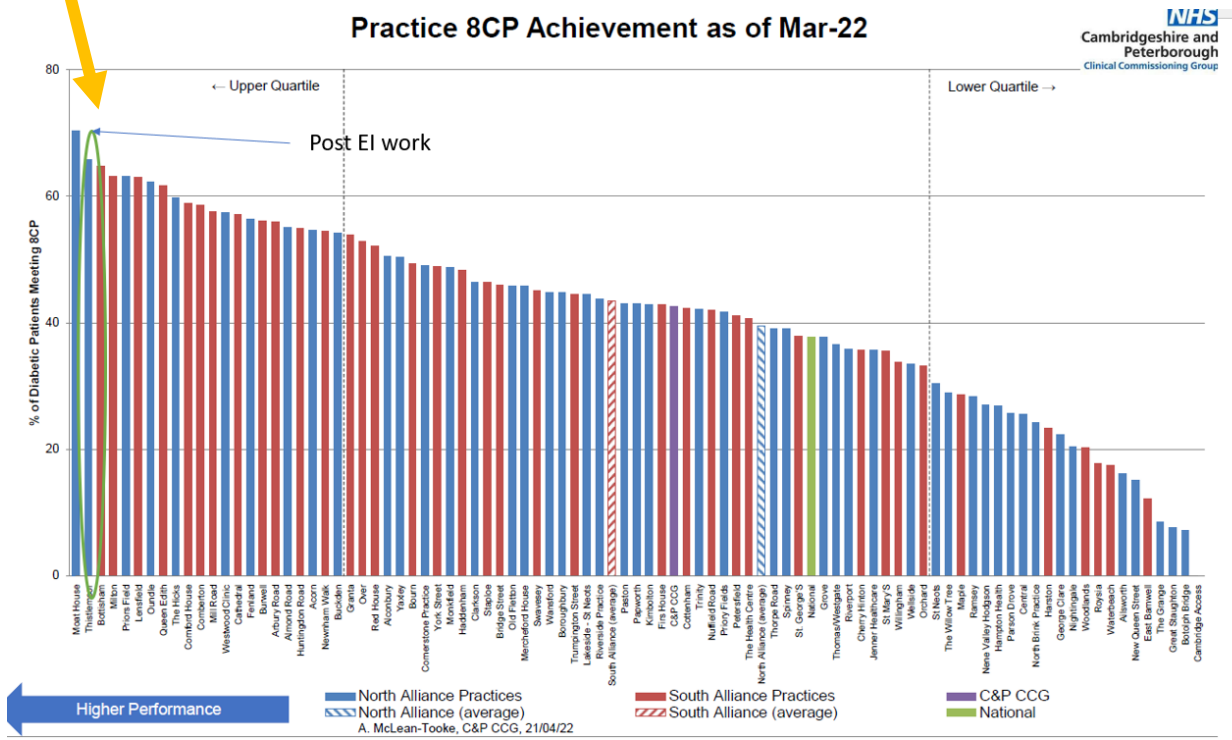
National Average – 18.2 %
ICB Average – 18.2 %

Name	Pop	Cond Count	Screen Count	Screen %	Rank
NATIONAL	27494237	1534545	279646	18.2%	
NHS Cambridgeshire and Peterborough CCG	1006902	53868	9792	18.2%	35 /74
Cantab PCN	54606	1190	350	29.4%	40 /221
A1 Network PCN	45900	2541	580	22.8%	111 /221
Ely South PCN	39312	2208	465	21.1%	150 /221
Central and Thistlemoor PCN	53306	2388	491	20.6%	166 /221
South Peterborough PCN	69452	3994	795	19.9%	189 /221
Granta PCN	54990	2833	556	19.7%	197 /221
South Fenland PCN	27283	1997	387	19.4%	211 /221
Ely North PCN	39286	2459	471	19.2%	219 /221
Peterborough & East PCN	60633	4036	773	19.1%	221 /221
BMC Paston PCN	43486	3214	615	19.1%	222 /221
Huntingdon PCN	44801	2571	488	19.0%	230 /221
Cambridge City PCN	49872	2501	469	18.8%	241 /221
Cambridge City 4 PCN	56906	2097	371	17.7%	269 /221
Meridian PCN	37530	1869	329	17.6%	272 /221
St Neots PCN	44546	2201	386	17.5%	276 /221
Cambridge Northern Villages PCN	49316	2228	378	17.0%	295 /221
Fenland PCN	29405	2534	422	16.7%	307 /221
Bretton Park and Hampton	31449	1820	257	14.1%	400 /221
CAM Medical PCN	46075	881	124	14.1%	401 /221
St Ives PCN	46024	2729	382	14.0%	402 /221
Peterborough Partnerships PCN	31440	1902	248	13.0%	429 /221
Wisbech PCN	46982	3673	453	12.3%	457 /221

Consider SMS from practice for a successful QIP:

Eg 8 Care Processes using Eclipse at Practice Level





950 Patients with Diabetes at a Deep End Practice.

April 2021: 25% delivery of 8 care processes.

60th/84 practices in the CCG.

Using Eclipse & Practice HCAs:

March 2022: 65% delivery of 8 care processes.

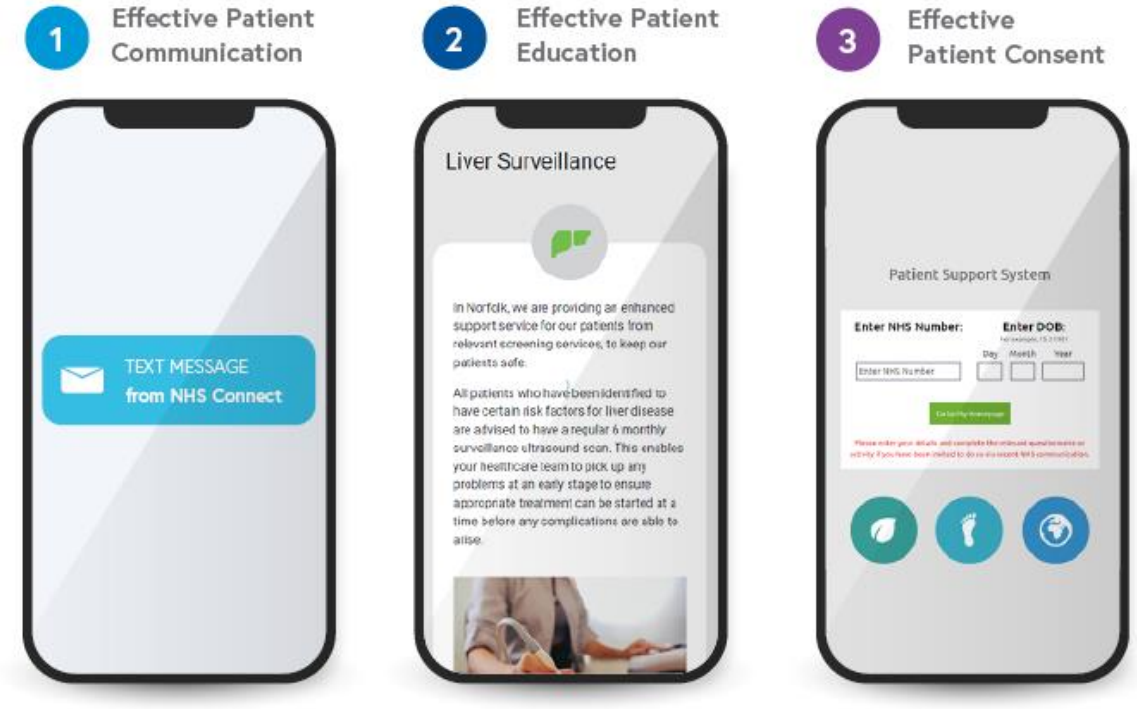
2nd in the CCG.

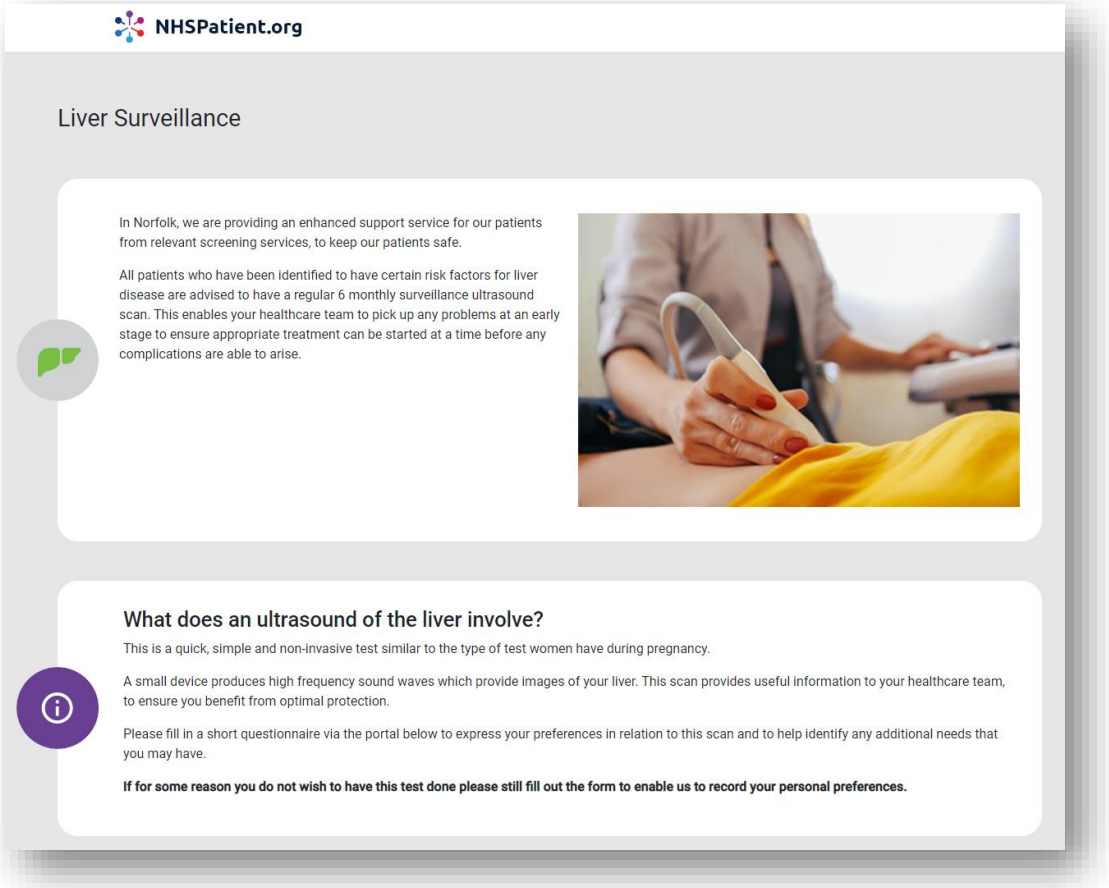
Consider Centralised SMS & Website

Eg Diabetes: Structured Education

- **Feb 2020:** Early Adopter Practices identified a need for Patient-facing app to deliver Structured Education.
- Collaborative work identified Grohealth.com (was ‘Diabetes Digital Media’) as preferred by practices; MyDESMOND was alternative option.
- COVID – significant impact on F2F education & delayed progress.
- Various Information Governance challenges (trailblazing initiative)
- **May 2023** – went live to patients
- University of Cambridge – independent evaluator

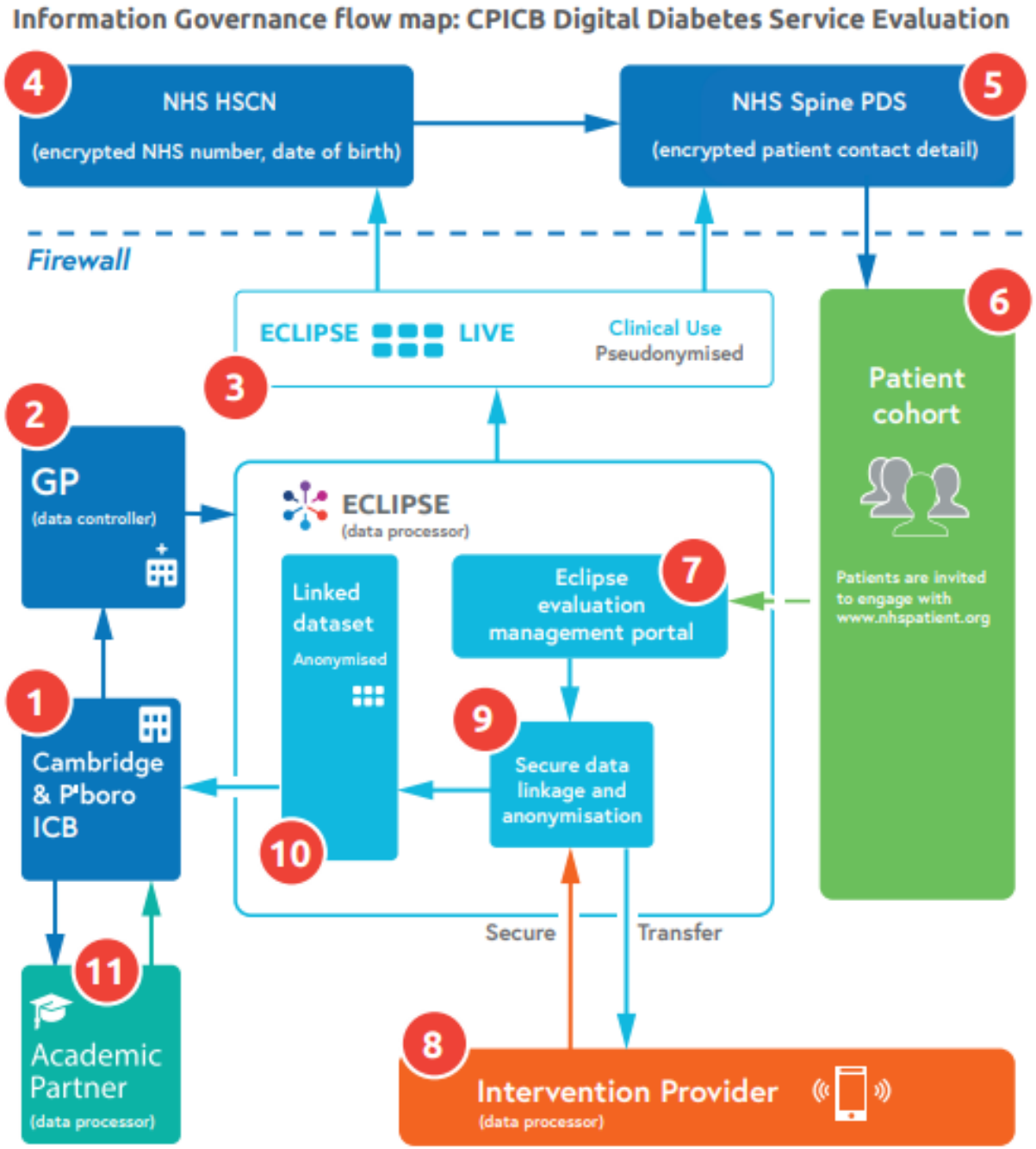
Pegasus Patient Engagement





Digital Diabetes Programme:

Information Governance



ECLIPSE
Cambridge & Peterborough Digital Diabetes Programme

Primary Objective

To compare the effect of two Type 2 Diabetes e-health interventions (Gro Health and MyDESMOND) on change in glycated haemoglobin (HbA1c) over 12 months in adults with type 2 diabetes.

Secondary Objectives

1. To evaluate the effect of MyDESMOND and Gro Health on:
    - body weight, blood pressure, lipid profile, modelled cardiovascular risk and medication use at 6 and 12 months
    - the probability of achieving clinically significant weight loss, good glycaemic control or diabetes remission at 6 and 12 months
    - psychosocial factors associated with successful weight control at 6 and 12 months.
2. To evaluate the cost-effectiveness of MyDESMOND and Gro Health.
3. To assess the uptake of and adherence to the two programmes by the target population.
4. To explore participant and practitioner experiences of the two programmes and the extent to which these programmes meet their needs.

Outcomes: Digital Diabetes Programme

11 “Deep End” GP practices consented to involvement in this programme and after matching for demographic differences, patients were randomised into one of the two app groups

5,321 text messages sent out

1,262 Patients 23.7% of patients indicated desire to take part and details passed to app companies

1,153 (91%) fully completed patients questionnaires received

630 Patients currently registered & receiving Diabetes: Structured Education via the two apps

Interim analysis due March 2024

CVDP009CHOL: Percentage of patients aged 18 and over with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.

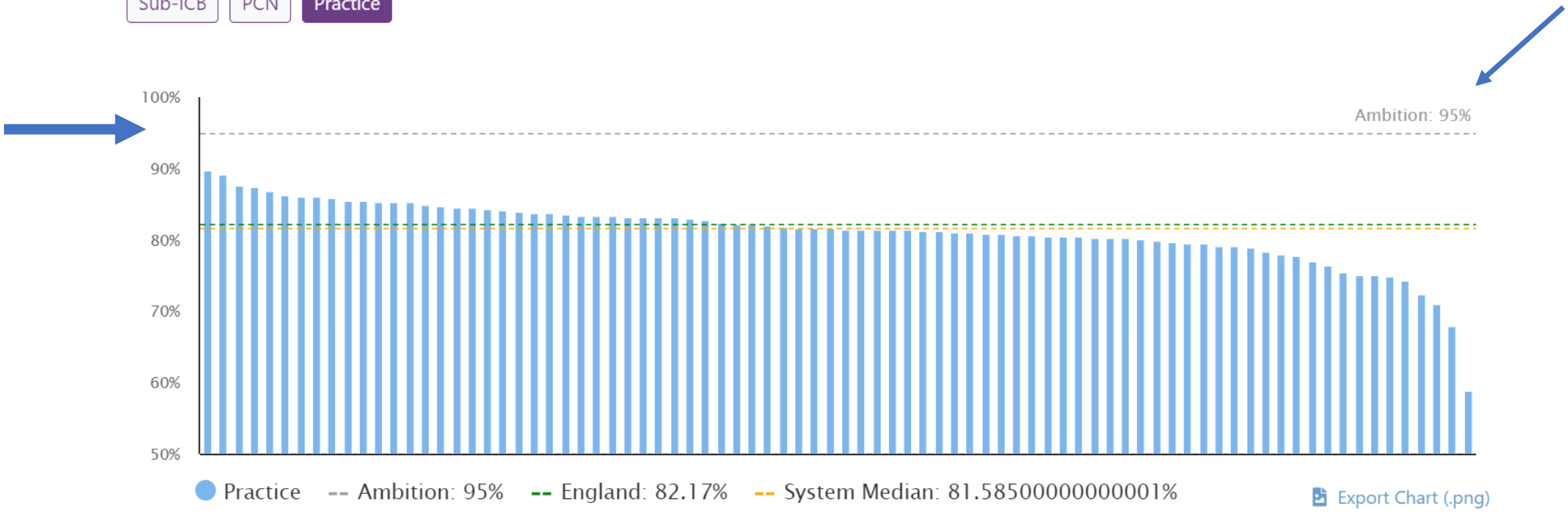
Area Breakdown: All Practices within NHS Cambridgeshire and Peterborough Integrated Care Board

March 2023

Chart | Table

Filter

Sub-ICB | PCN | Practice



ECLIPSE: DETECT – Consider Lipid Lowering Tx: SMS & Website

Cambridge and Peterborough Statin Optimisation Programme

Primary Objective

To target statin therapy for secondary & primary prevention in patient cohorts from deprived communities using Eclipse Population Health Tool.

Inclusion criteria

Secondary prevention dose:

- Those coded with ischaemic heart disease, stroke/TIA, peripheral arterial/vascular disease (age 25-84)

Primary prevention dose:

- Patients with T1DM (age >=40)
- Patients with CKD (age 25-84)
- Patients with QRISK3 >10%, including T2DM (age 25-84)

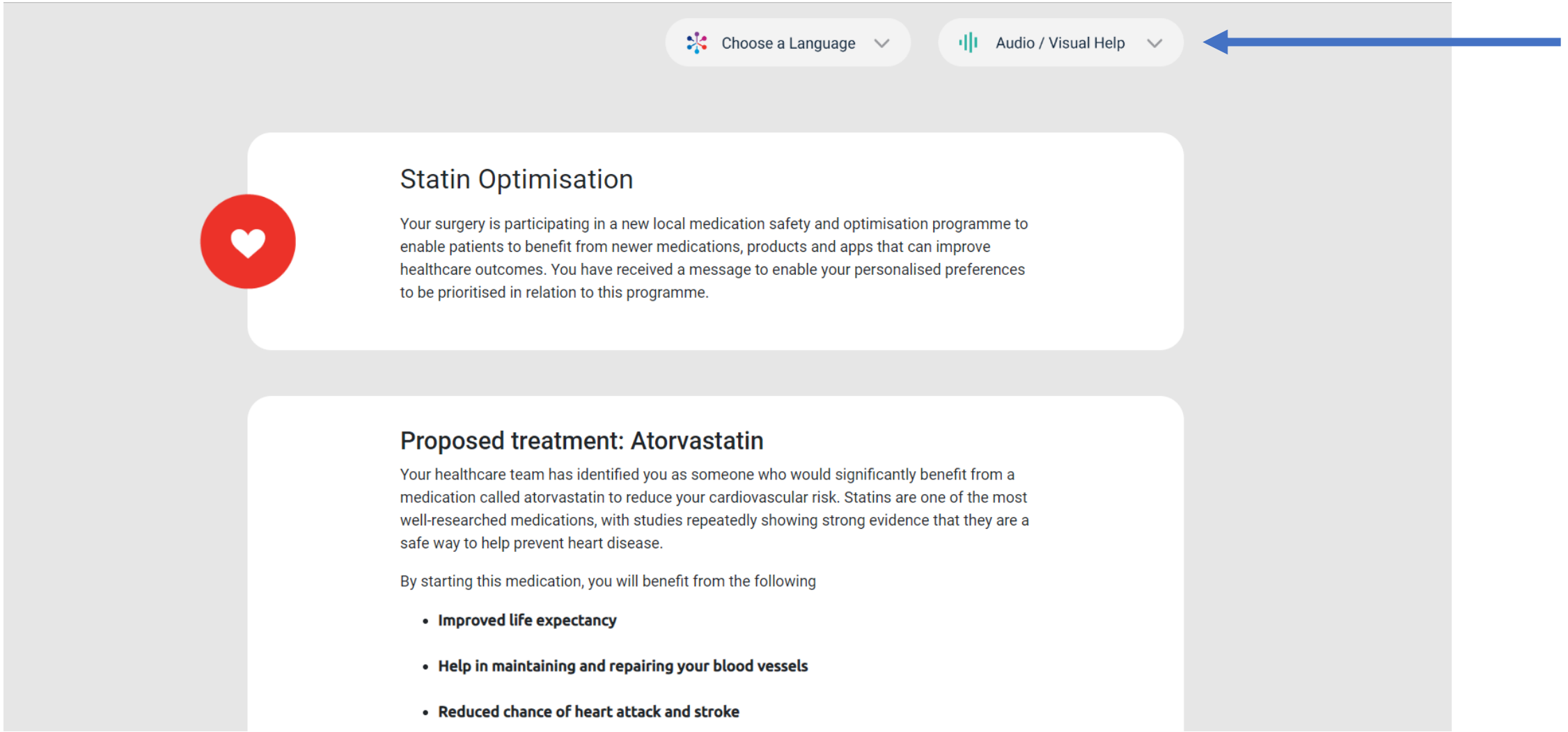
Bloods

- LFTs must be done in last 12 months and <3x upper limit
- ALT <165
- AST <144
- IF TFTs done in last 12 months, T4 level must be >5

Exclusion criteria:

- Currently on a statin
- Coded with:
  - statin contraindicated
  - adverse reaction/allergy to statin
  - statin declined in last 12 months
- Coded with chronic liver diseases and/or elevated liver enzyme profile
- Current pregnancy or breastfeeding

Patient engagement: text & call service



ECLIPSE: DETECT – Patient Engagement

- **Reduced chance of an emergency admission to hospital**

Please take two minutes to review the video below.

ECLIPSE: DETECT - Starting with Deep End Practices

Initial site to be East Barnwell, following which the remaining 5 in bold will be contacted.

Deep End Practices: C&P	IMD	'Rank'	Postcodes	Details
Nightingale Surgery (formerly Dogsthorpe Medical Centre)	39.59	13*	PE1 4QF	
Westwood Clinic	38.33	21*	PE3 7JW	
Central Medical Centre	38.08	24*	PE1 3BF	
Welland Medical (now Nightingale)	36.83	30*	PE1 4FS	
Thistlemoor Medical Centre	36.07	36*	PE1 3HP	
Trinity Surgery	35.78	37*	PE13 3UZ	
Willow Tree Surgery (formerly Bushfield)	33.07	49*	PE2 5RQ	
Clarkson Surgery	32.82	53	PE13 3AN	
Thomas Walker	29.54	85	PE1 2QP	
The Grange Medical Centre	25.63	127	PE3 6HA	
Old Fletton Surgery	25.25	135	PE2 8AY	
Bretton Medical Practice	36.89	29	PE3 8DT	
North Brink Practice	32.51	56	PE13 1JU	
Boroughbury Medical Centre	30.02	76	PE1 2EJ	
Parson Drove Surgery	29.77	81	PE13 4LF	
Paston Health Centre	29.74	82	PE4 6DG	
East Barnwell Health Centre	28.49	93	CB5 8SP	**Agreed as pilot site**

Enabling the Patient Voice

It is essential that **ALL patients are given an opportunity to feedback** their experience, suggestions and preferences in relation to each intervention.

Usually CORE20PLUS groups are disproportionately excluded.

ENGAGE WITH COMMUNITY

There are the unknown patients

Those who have not yet/recently sought healthcare

Unable to engage with our traditional pathways

Need to create intentional opportunities for relationships, rapport, trust & support

Day centres; School gates; Food Banks; Libraries; Places of Worship; Supermarkets; Cultural centres

EXAMPLES

Obesity – better coding & support (EDI) – use of LES

Pathway to Remission – for PwD – targeted communities & individuals

Practice workload – use of data to fill clinics

Pre-Diabetes – centralised mailshot

Diabetes 8CPs – SMS

Diabetes Structured Education – SMS & website

Primary & Secondary CVD prevention – SMS & website

Use of Community Assets

THANK YOU!

Deep End: EoE
Sept 2023