Clinical Effectiveness South East London (CESEL)
Guidance on the Ardens searches: Type 2 Diabetes, Hypertension & CKD

Latest update: October 2024

Ardens searches are updated via your Practice EMIS or via the ICB / CCG EMIS enterprise. Sign up for the Ardens Newsletter for the latest information on search updates.

This document contains searches updated to 30 September 2024. It will not include Ardens search updates made after this date. The document will be updated in January 2025.

To learn more about Ardens searches: **Locate and Use EMIS Searches and Reports**
Watch Ardens **recorded webinars** and sign up for **upcoming webinars**

CESEL Practice Facilitators

Please contact your Borough Facilitator for further support with searches or to arrange a CESEL visit to your Practice or PCN.

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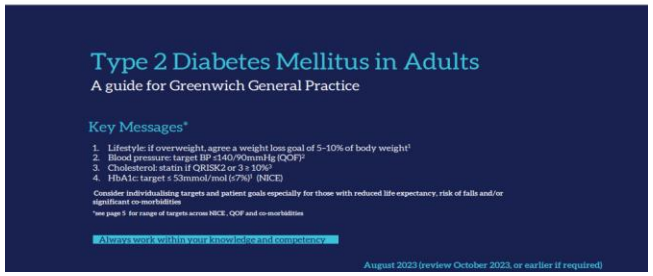
Clinical Effectiveness
South East London

Contents

Ardens Type 2 Diabetes searches



Have you seen our clinical guides?

Google ‘CESEL’ to find our Diabetes clinical guides & resources.

Ardens Type 2 Diabetes Searches – 8 Care Processes and 3TTs

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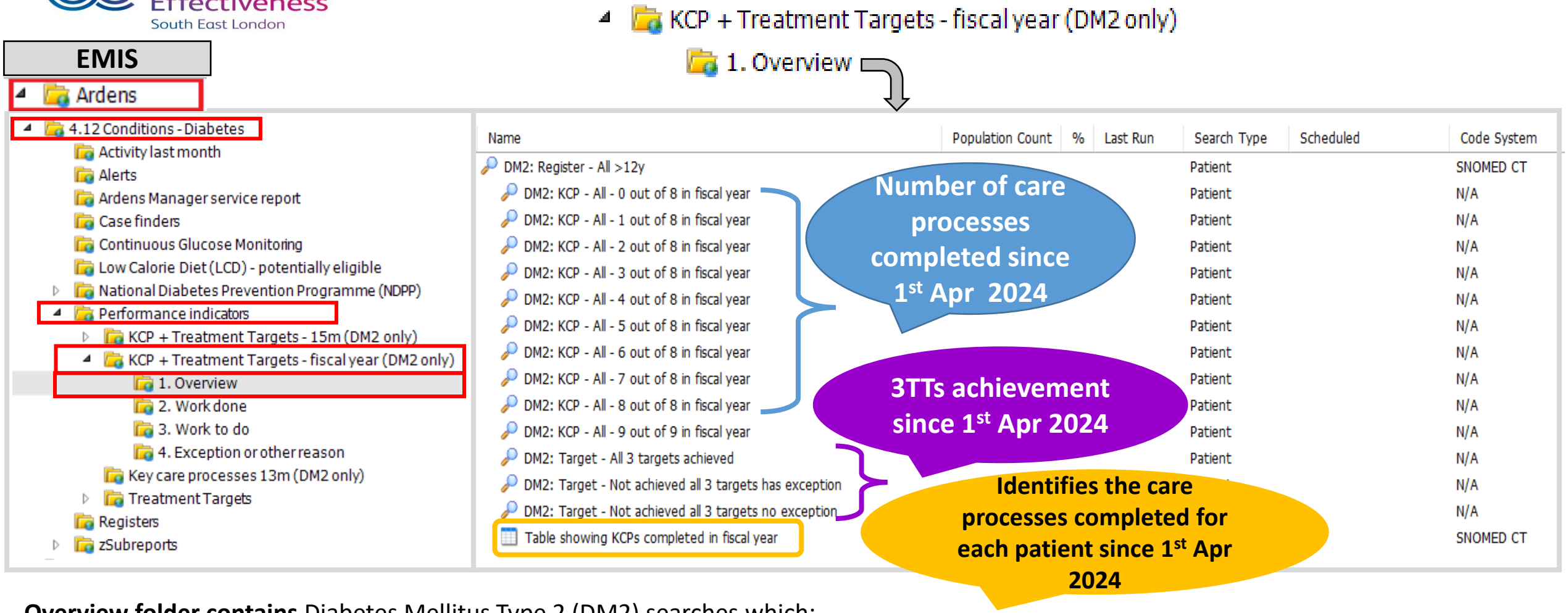

Overview folder contains Diabetes Mellitus Type 2 (DM2) searches which:

- **Identify which DM2 patients have had 0, 1, 2, 3 etc Key Care Processes (KCP) since 1st Apr 2024**
- **Identify which DM2 patients have achieved or not achieved the All 3 Treatment Targets (3TTs) since 1st Apr 2024**
- **A Table (List Report):** where each row represents a patient, and columns represent a care process. A date is listed under each care process. Where a date is not listed, it indicates the Key Care Process has not been completed in the fiscal year. (since 1st Apr 2024)

Ardens Type 2 Diabetes Searches – 8 Care Processes and 3TTs

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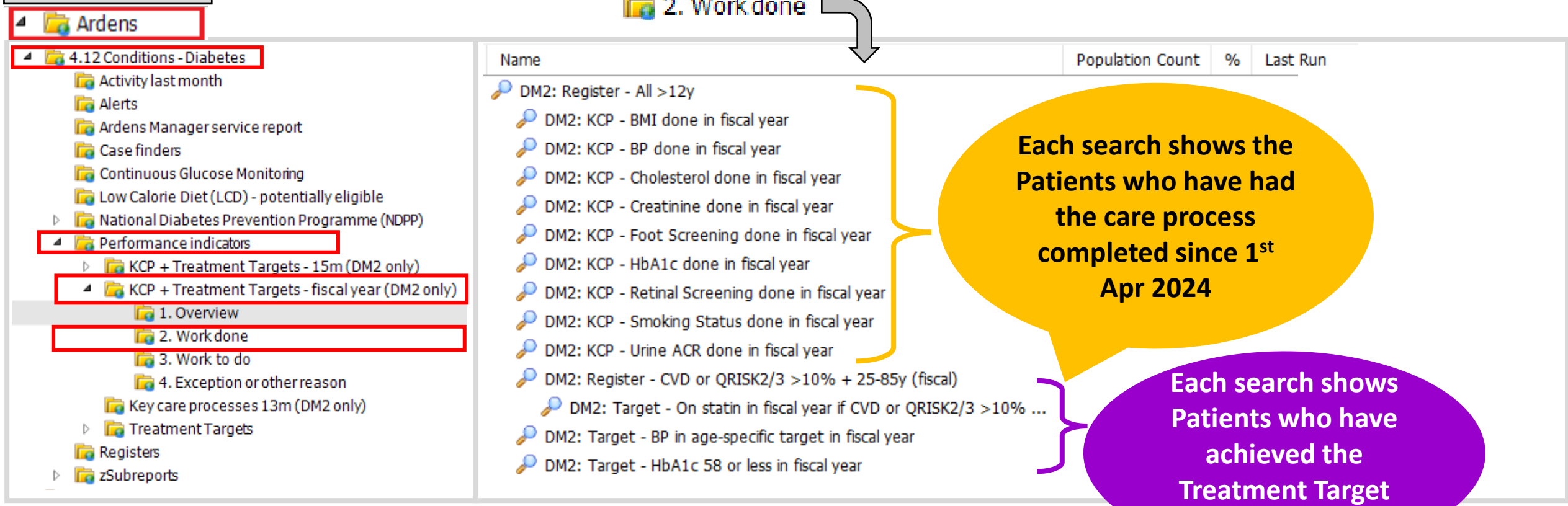

Work Done folder contains Diabetes Mellitus Type 2 (DM2) searches which help the Practice:

- Identify which patients have had each Key Care Processes (KCP) completed since 1st Apr 2024
- Identify which patients have achieved each of the 3 Treatment Targets since 1st Apr 2024
- Please note for 'DM2:Target – BP age specific target' the definition of the target is:
- patients aged < 80 years Clinic BP 140/90 or Home BP 135/85 **OR** patients aged 80+ years Clinic BP 150/90 or Home BP 145/85

Ardens Type 2 Diabetes Searches – 8 Care Processes and 3TTs

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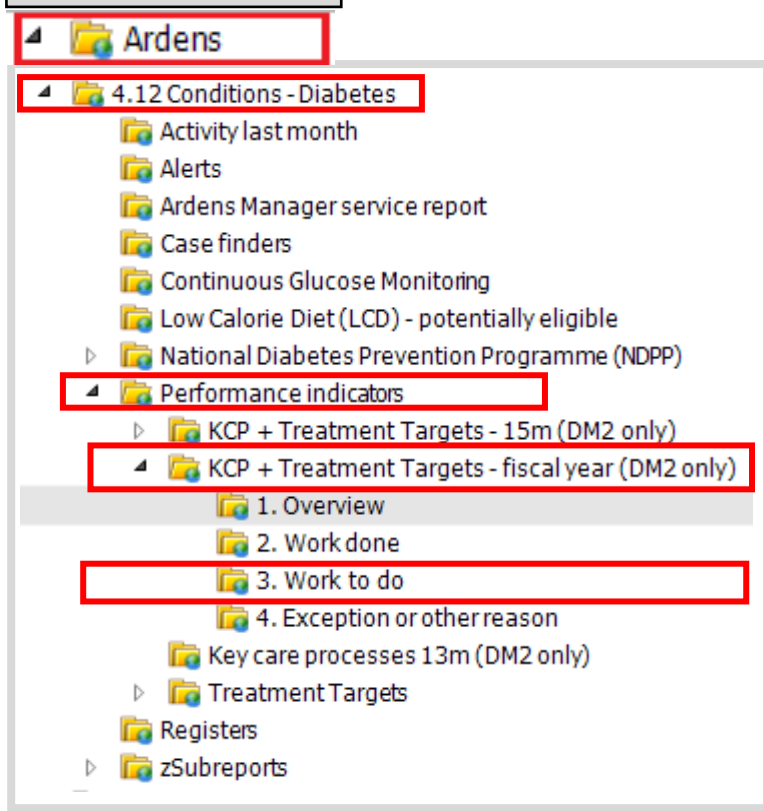

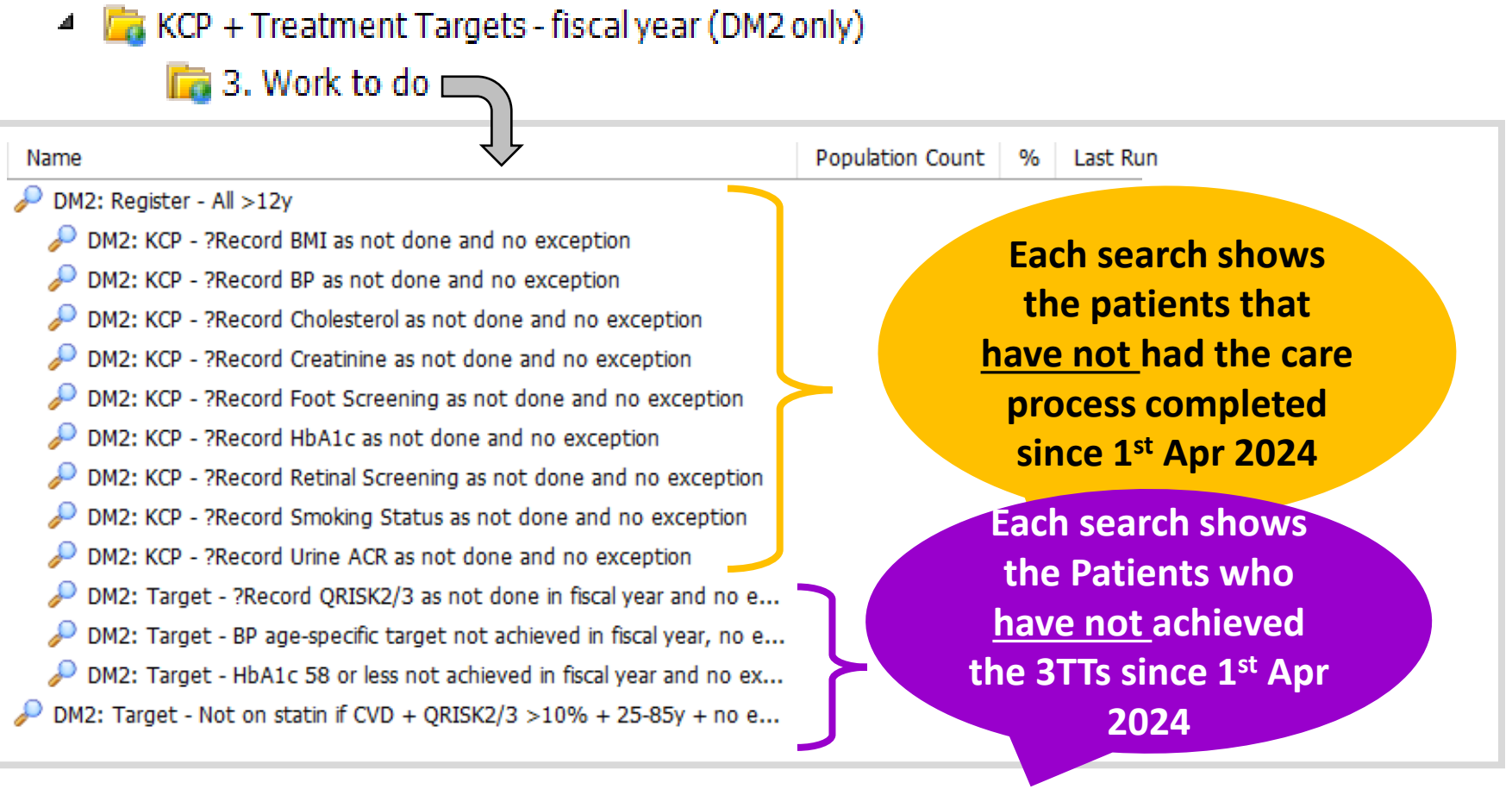

Work To Do folder contains Diabetes Mellitus Type 2 (DM2) searches which help the Practice:

- Identify which patients have not had the Key Care Processes (KCP) completed since 1st Apr 2024
- Identify which patients have not achieved the 3 Treatment Targets since 1st Apr 2024
- *Please note for 'DM2:Target – BP age specific target' the definition of the target is:*
  - *patients aged < 80 years Clinic BP 140/90 or Home BP 135/85* ***OR*** *patients aged 80+ years Clinic BP 150/90 or Home BP 145/85*

Ardens UCLP Diabetes Risk Stratification

(risk stratification based on HbA1c values. ***See next slide for definitions****)*

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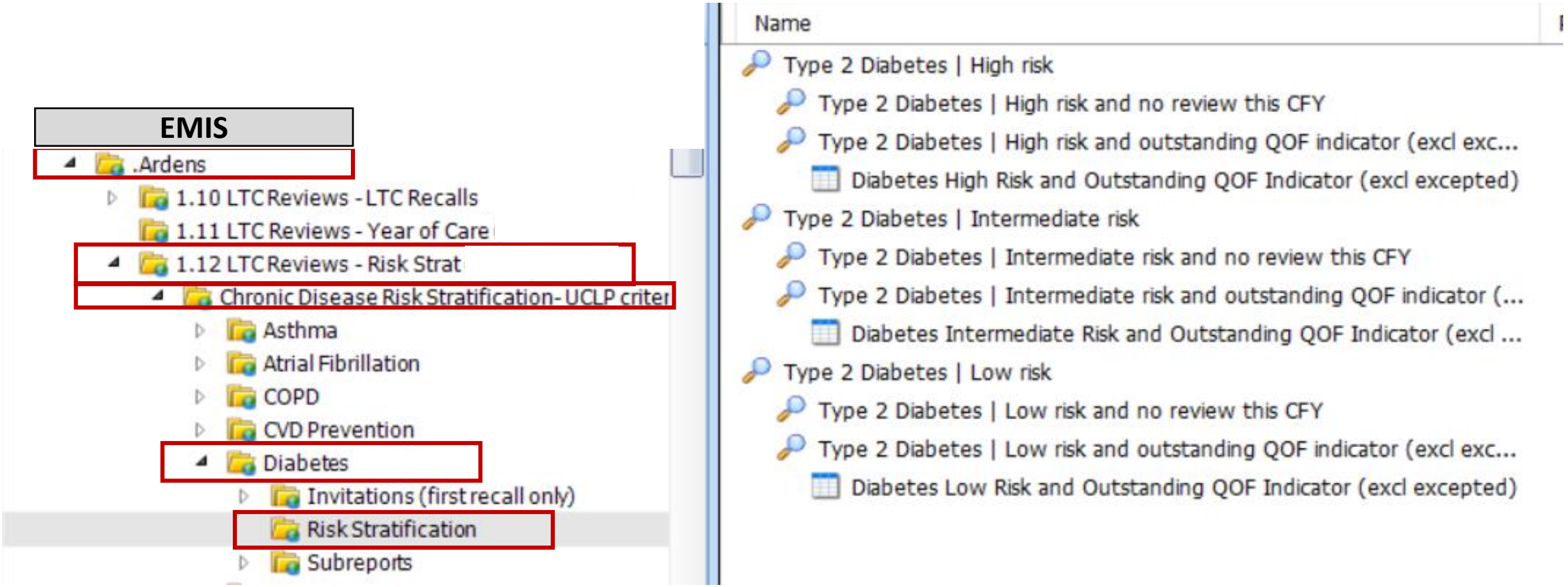

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UCLP Diabetes Risk Stratification based on latest HbA1c level.

Type 2 Diabetes stratification and management

UCLPartners

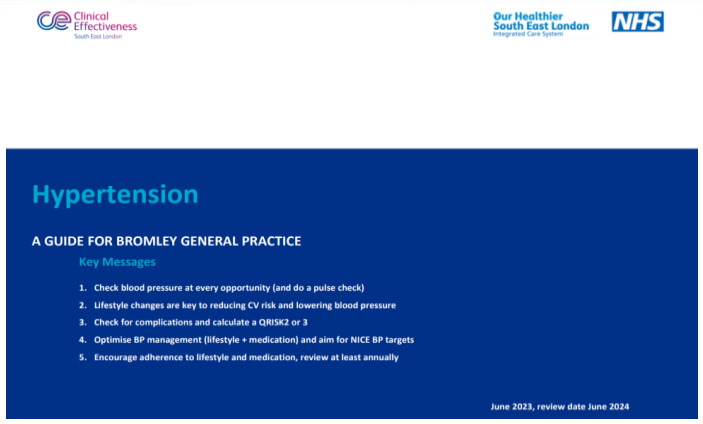
1 Identify & 2 Stratify

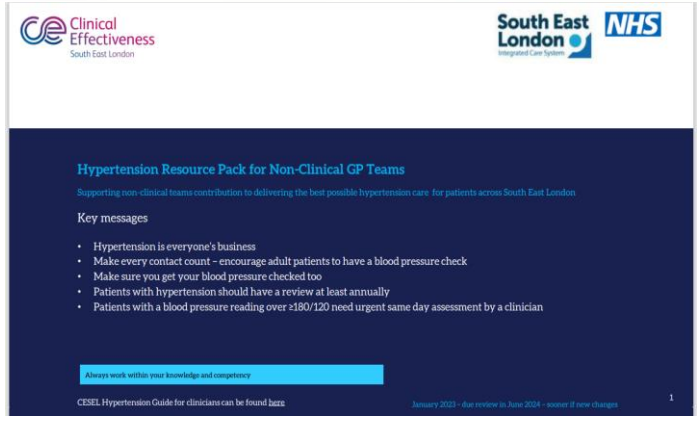
This search identifies all patients with T2 Diabetes. These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors and ethnicity

High risk		Medium risk		Low risk
Priority One **Hba1c >90 OR** **Hba1c >75 WITH any of the following:** • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure ** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse	**Priority Two** **Hba1c >75 OR** **Any HbA1c WITH any of the following:** • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Community diabetes team codes • eGFR < 45 • Metabolic syndrome (Except patients included in Priority 1 group)	**Priority Three** **Hba1c 58-75 WITH any of the following:** • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP≥140/90 • Proteinuria or Albuminuria (Except patients included in Priority 1 and 2 groups)	**Priority Four** **Hba1c 58-75 OR** **Any HbA1c WITH any of the following:** • eGFR 45-60 • BP≥140/90 • Higher risk foot disease or PAD or neuropathy • Erectile Dysfunction • Diabetic retinopathy • BMI >35 • Social complexity • Severe frailty • insulin or other injectables • Heart failure (Except patients included in Priority 1, 2 or 3 groups)	**Priority Five** **All others** (Except patients included in Priority 1-4 groups)

https://uclpartners.com/wp-content/uploads/T2-Diabetes-Framework_UCLPartners-LTCs-April-2021-v2.0.pdf

Ardens Hypertension searches





Have you seen our guides?

Google ‘CESEL’ to find our Hypertension clinical and non-clinical guides.

Ardens Hypertension QOF Searches

Clinical Effectiveness

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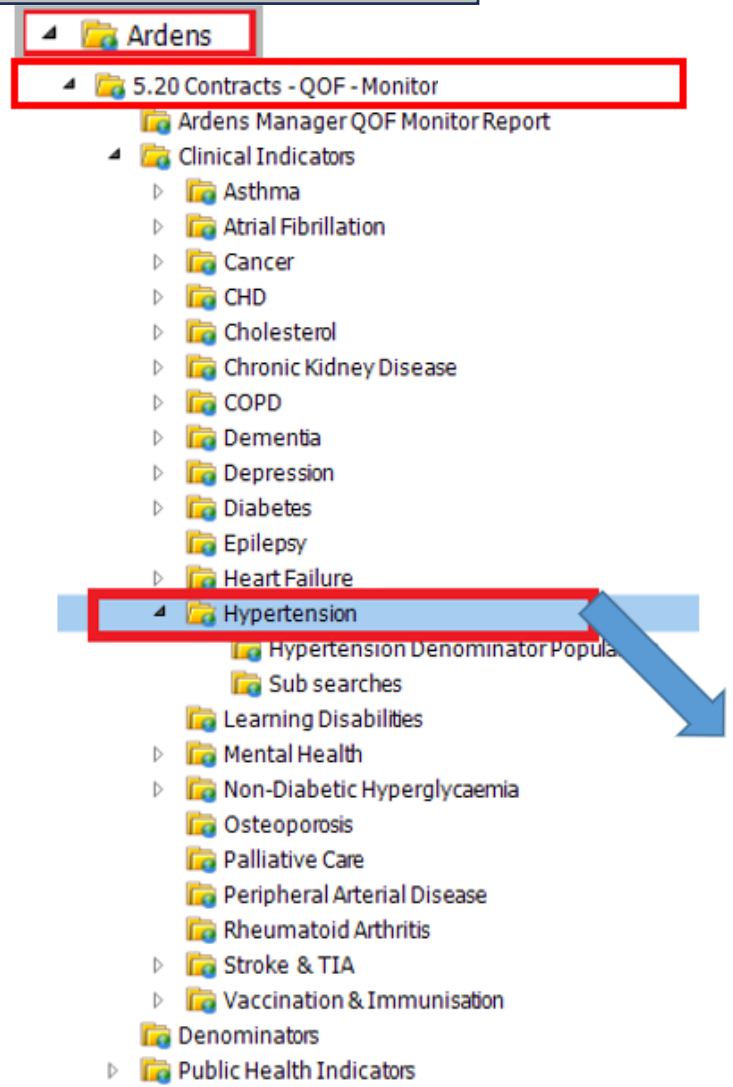

QOF 2024/25 Hypertension Indicators

Indicator	Points	Thresholds
Records		
HYP001. The contractor establishes and maintains a register of patients with established hypertension	6	N/A
Ongoing management		
HYP008. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (or equivalent home blood pressure reading)	14	40-77%
HYP009. The percentage of patients aged 80 years or over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (or equivalent home blood pressure reading)	5	40-80%

Clinic BP 140/90 = Home BP 135/85
Clinic BP 150/90 = Home BP 145/85

Name	Population Count
Hypertension Denominator Populations	
Sub searches	
HYP001: Register	
HYP008: Latest BP 140/90 or less in last 12m if 79y or under	
HYP009: Latest BP 150/90 or less in last 12m if 80y or over	

Ardens Case Finders
searches to improve QOF Hypertension Prevalence

Clinical Effectiveness

EMIS

- Ardens
- 5.00 Contracts - QOF - Case Finders
  - Asthma
  - Atrial Fibrillation
  - Cancer
  - CHD
  - CKD
  - COPD
  - CVA/TIA
  - Dementia
  - Depression
  - Diabetes
  - Epilepsy
  - Heart Failure
  - Hypertension
    - More detail
  - Learning Disabilities
  - Mental Health
  - Non-Diabetic Hyperglycaemia
  - Obesity
  - Osteoporosis
  - Peripheral Arterial Disease
  - Rheumatoid Arthritis

Searches

- Query HTN as in any of the reports below
- Query HTN as latest BP is home or ABPM + above age-specific target
- Query HTN as history of HTN or review or monitoring or plan
- Query HTN as on antihypertensives + issued L6M + high BP ever
- uery HTN as on antihypertensives + latest BP above age-specific target
- Query HTN as resolved but on antihypertensives
- Query HTN as suspected HTN without a more recent HTN excluded or white coat

Definitions

QOF | ?HTN	Includes all patients from the reports below. Provides a single report to cover each search criteria.
QOF | ?HTN as ABPM, HBPM or 24hr BP reading > QOF age specific target	These patients have had a high BP reading, indicative of hypertension, but have not got a code on their record to put them on the QOF hypertension register.
QOF | ?HTN as h/o HTN or review/monitoring/plan	These patients have a code on their record which indicates that they have had some sort of hypertension monitoring, but they do not have a code on their record to put them on the QOF hypertension register.
QOF | ?HTN as on antihypertensives + BP > QOF age specific target	These patients have a prescription for antihypertensive medication and have a record of high BP (anytime within the last 99 occurrences) but they do not have a code on their record to put them on the QOF hypertension register.
QOF| ? HTN as on antihypertensives + latest BP > QOF age specific target	These patients have a prescription for antihypertensive medication and their latest BP is high, but they do not have a code on their record to put them on the QOF hypertension register.
QOF | ?HTN as resolved but on antihypertensives	These patients have a current prescription for antihypertensives, but they are coded as 'hypertension resolved' – review the record and remove the resolved code if appropriate. The report will indicate the date of the resolved code and the most recent medication.
QOF | ?HTN as suspected HTN without a more recent HTN excluded or white coat	These patients have a clinical code of 'Suspected Hypertension' without recent coding to exclude Hypertension or White Coat (raised BP due to stress/anxiety of being in a clinical setting).

Ardens have created a list report ( ) for each search to enable Practices to easily access the BP values and contact details for patient follow up.

Ardens – No BP check in 5 years?

This search examines patients aged 40+ years with no BP Check in the last 5 years, and no Hypertension coded.

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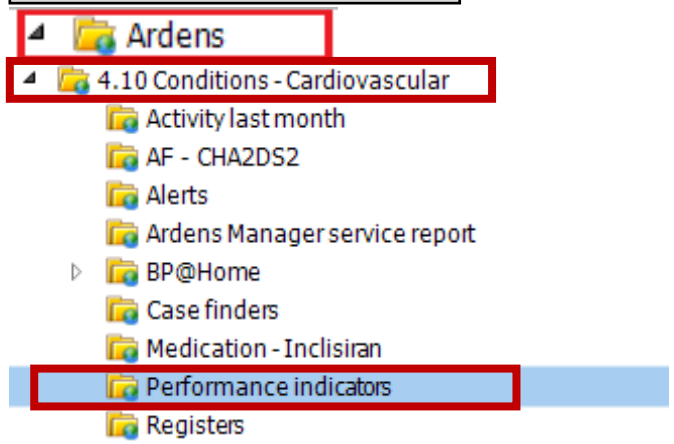
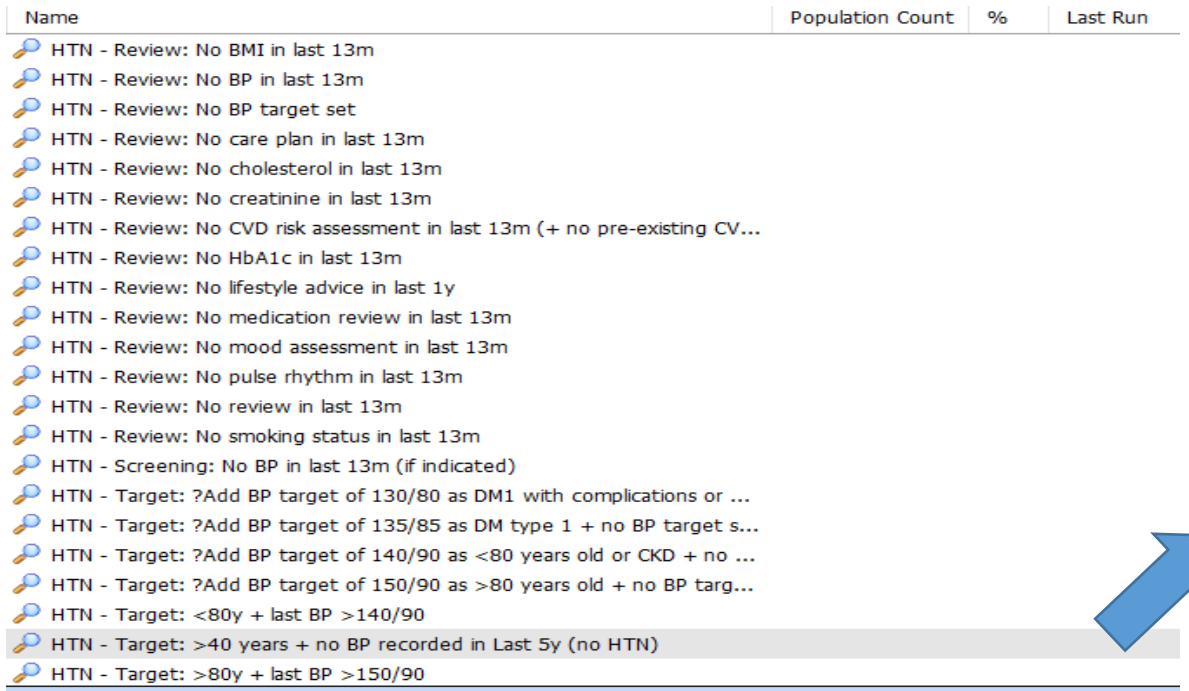


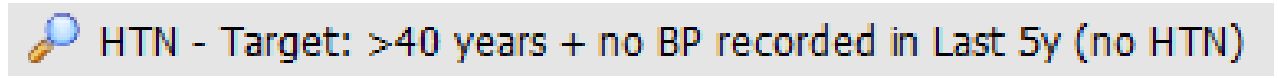


Please scroll to the penultimate 'HTN' search in the Ardens folder to locate the search.

This search excludes any patients coded with Hypertension.

After running this search, you could advise or text patients to attend the Practice or go to their local Pharmacy. The NHS link below enables the patient to find a Pharmacy near them.

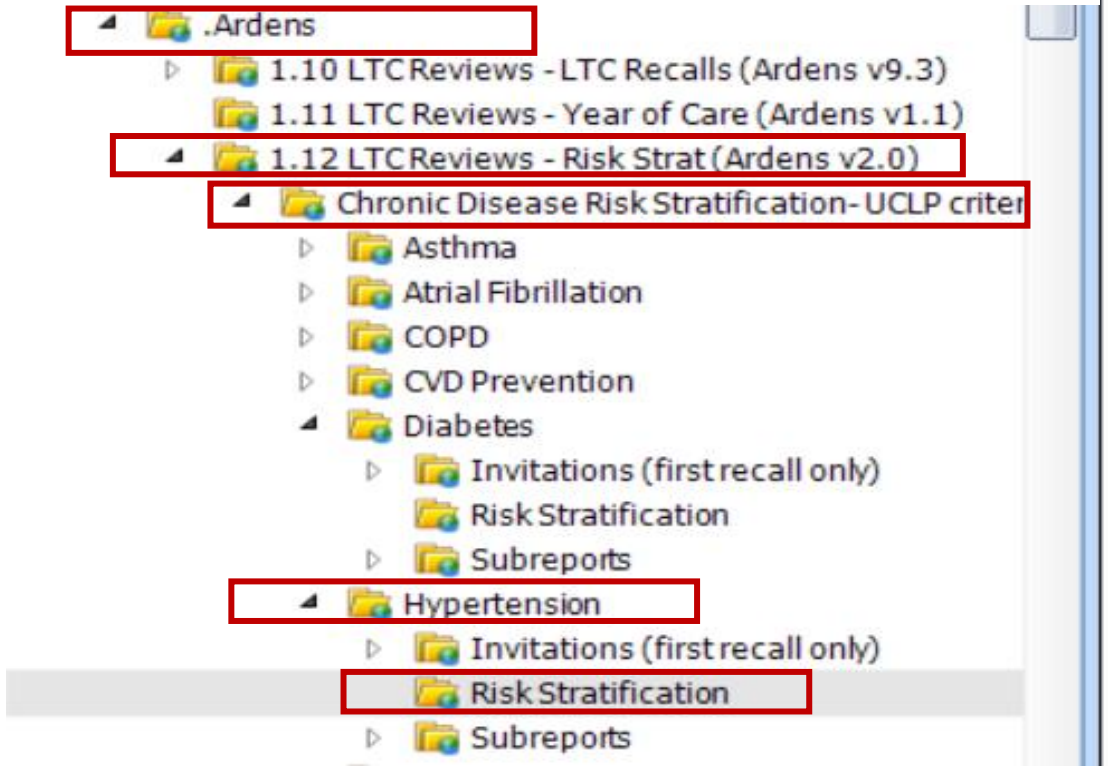
https://www.nhs.uk/nhs-services/pharmacies/find-a-pharmacy-that-offers-free-blood-pressure-checks

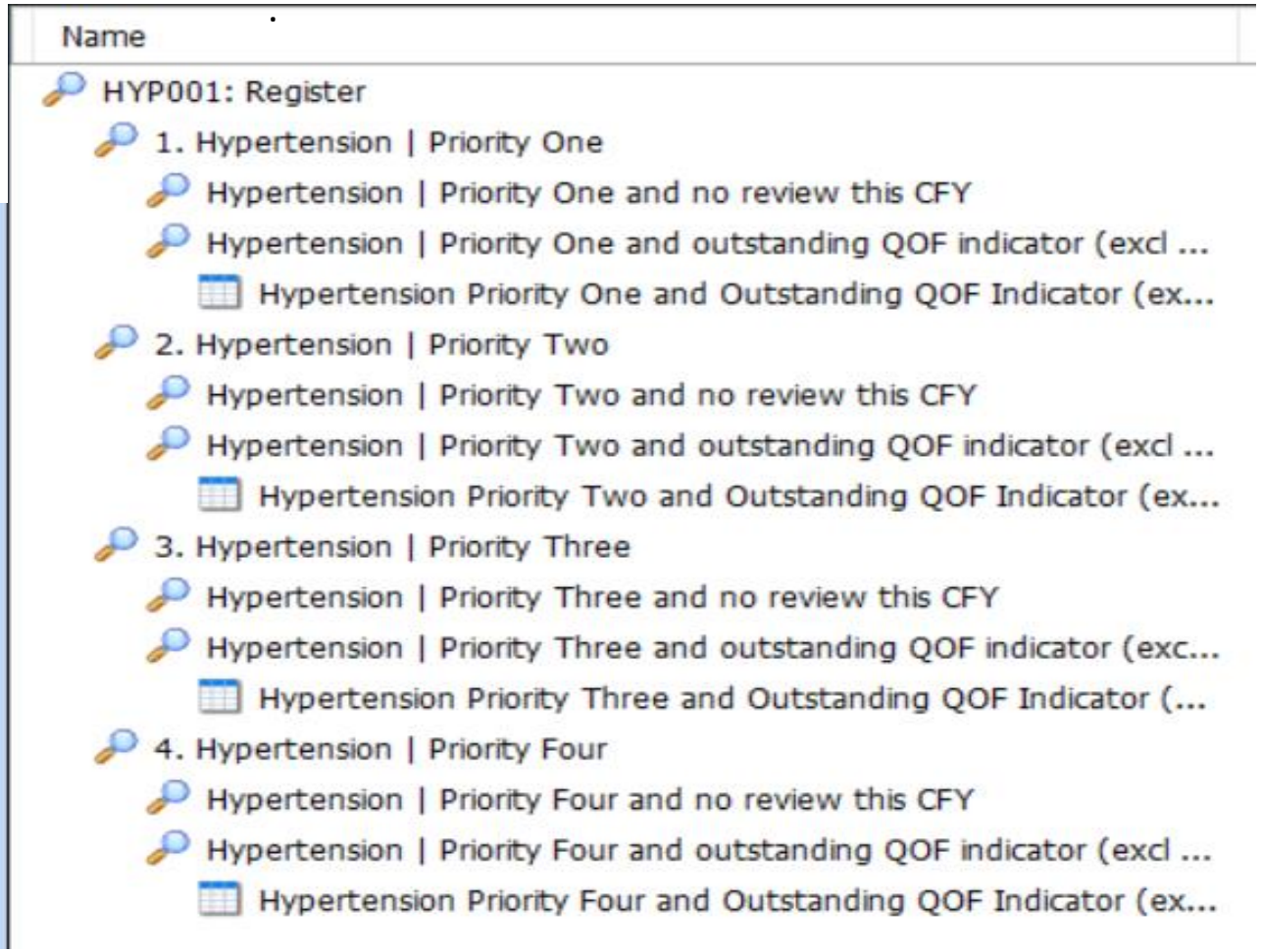


Ardens UCLP Hypertension Risk Stratification

*(risk stratification based on BP values. **See next slide for definitions**)*

EMIS





Ardens have created a list report ( ) for each Priority Group to enable Practices to easily access contact information for the patient and the date of the last review.

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UCLP Hypertension Risk Stratification based on latest BP values.

This search identifies all patients coded with Hypertension and risk stratifies them into priority groups based on their BP values.

Hypertension: stratification and management

UCLPartners

Priority One	Priority Two	Priority Three	Priority Four
BP >180/120mmHg***	2a. BP >160/100mmHg*** 2b. BP >140/90mmHg*** if BAME AND CV risk factors or co-morbidities** 2c. No BP reading in last 18 months	3a. BP >140/90mmHg*** if BAME OR CV risk factors or comorbidities** 3b. BP >140/90mmHg*** or >150/90mmHg*** if ≥ 80 years	4a. BP <140/90mmHg*** under age 80 years 4b. BP <150/90mmHg*** aged ≥ 80 years

- ** Co-morbidities / risk factors

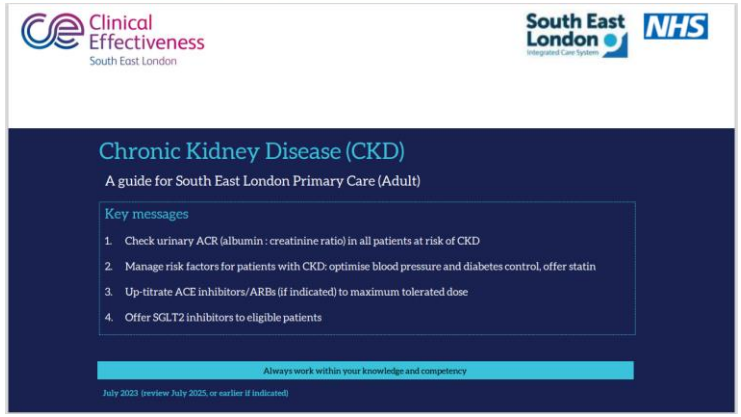
- Established CVD (prior stroke/TIA, heart disease, peripheral arterial disease)
- Diabetes
- CKD 3 or more
- Obesity with BMI > 35

- ***Clinic vs Home BP readings

Clinic BP reading	Equivalent Home BP
BP = 180/120mmHg	BP = 170/115mmHg
BP = 160/100mmHg	BP = 150/95mmHg
BP = 150/90mmHg	BP = 145/85mmHg
BP = 140/90mmHg	BP = 135/85mmHg

https://healthinnovationnenc.org.uk/wp-content/uploads/2023/08/23-03-03-Hypertension-Wider-Workforce-presentation-REVISED.pdf

Chronic Kidney Disease (CKD) searches



Have you seen our clinical guides?

Google ‘CESEL’ to find our CKD clinical guide.

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CKD Detect, Protect & Perfect Searches

What?	Who & Why?	*Where?* *Ardens > South East London > CESEL CKD Detect, Protect, Perfect*	When & How? Identify a *colleague in the Practice to run the Ardens search monthly/ quarterly*
CKD Detect **(Find more cases)**	CKD Detect is about finding patients with undiagnosed CKD or are at risk of CKD and require monitoring. Urine ACR is routinely used for screening for kidney disease in high risk populations such as those with Hypertension.	The Ardens search looks at the QOF Hypertension register and checks how many patients have had a **Urine ACR in the last 5 years.**	Run the Ardens search to identify the patients or use the APL Renal Tool. **Ask for a Urine ACR and an eGFR** at the next Hypertension annual review and sooner for patients with poorly controlled Blood Pressure.
CKD Protect **(Treat more with statins)**	CKD Protect is about treating more CKD patients with statins to reduce the risk of CVD related mortality.	The Ardens search looks at the QOF CKD register and checks how many patients have had a **statin prescription in the last 6 months**.	Run the Ardens search to identify the patients or use the APL Renal Tool (contact CESEL to access the tool). After **reviewing the patient's record, optimise BP and HbA1c control, offer ACE/ARBs and Statins if clinically appropriate.** Please refer to the management & prescribing guidance in the CESEL CKD Clinical Guide. Google 'CESEL' to navigate to the website and locate the CKD Clinical Guide.
CKD Perfect **(Treat more with SGLT2i)**	CKD Perfect is about treating more CKD patients with a Sodium Glucose co-Transporter-2 Inhibitor (SGLT2i) as they have been shown to delay the progression of CKD in patients with and without Diabetes.	The Ardens search looks at the QOF CKD register and selects those **with Diabetes and an ACR >= 3**, and checks how many of these patients have had a SGLT2i prescription in the last 6 months. The Ardens search looks at the QOF CKD register and selects those **without Diabetes and an ACR >= 22.6**, and checks how many of these patients have had a SGLT2i prescription in the last 6 months.	Run the Ardens search to identify the patients or use the APL Renal Tool. **After reviewing the patient's record, offer SGLT2i if clinically appropriate.** Please also review management & prescribing guidance in the CESEL CKD Clinical Guide. Google 'CESEL' to navigate to the website and locate the CKD Clinical Guide.
Uncoded CKD Stage 3 - 5 **(Uncoded CKD? - requires clinical review)**	Uncoded patients are less likely to be monitored or to receive early interventions to decrease CKD progression. The National CKD audit (2017) found uncoded patients have higher mortality and higher inpatient admissions, than coded patients.	The Uncoded CKD search is located here: *Ardens > 5.00 Contracts -QOF Case Finders.* The search looks for patients that could be coded as CKD stage 3 - 5 as their clinical record shows two eGFR results < 60 in the last 3 years. **These patients must be clinically reviewed before being coded as CKD.**	This search will provide the Practice with a list of patients to be reviewed by a **Clinician to determine if it is appropriate to code CKD in the patient record.**

Potential CKD Stage 3 – 5 Cases where is the Ardens QOF CKD Case Finder?

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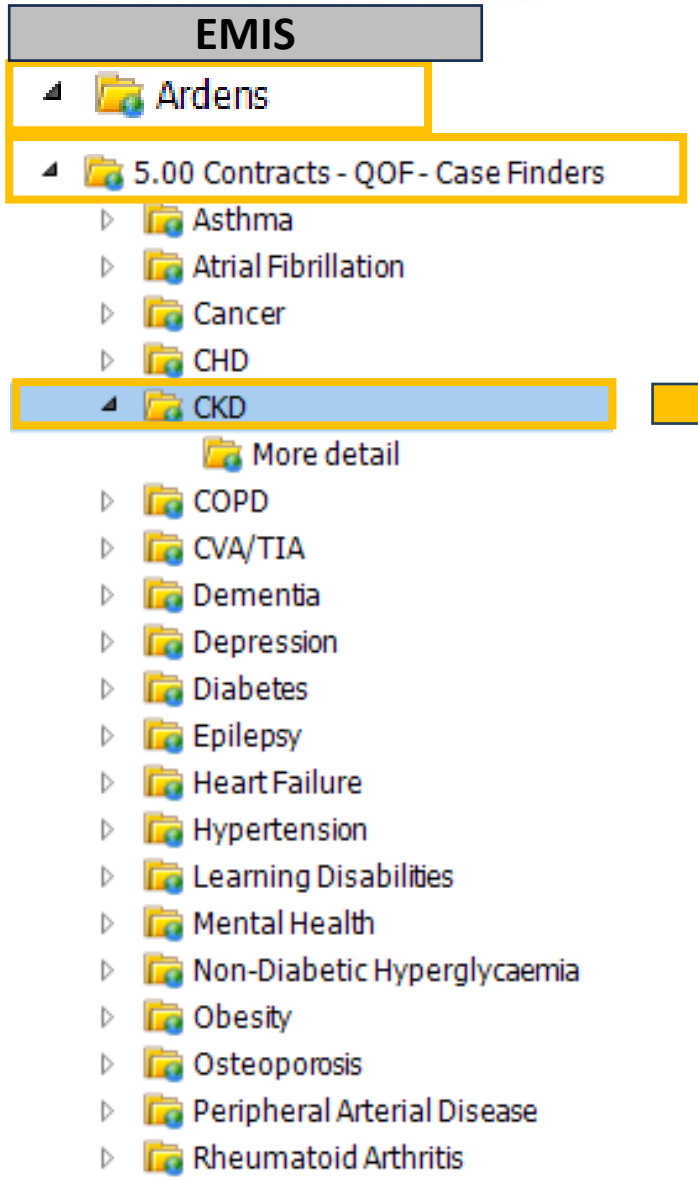


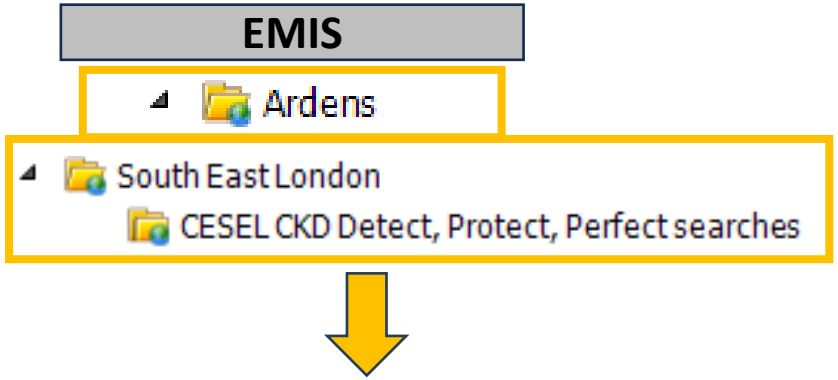
Ardens have created a list report ( ) for each search to enable Practices to easily access the eGFR values and contact details for the patient for follow up.

Ardens QOF CKD Stage 3 -5 Case Finder Search

The search examines if a patient has had *two eGFRs < 60 (that are 3 months apart) in the last 3 years and no eGFR higher than 60 in the last 3 months*.

The Ardens search List report will show the details of these eGFR results so that these patients can be **reviewed and coded as with CKD, <u>if clinically appropriate</u>.**

CKD Detect, Protect & Perfect - where are the Ardens searches?



CKD Detect
(Find more cases)

- CKD | Detect | QOF hypertension register | ACR indicated
- CKD | Detect | QOF hypertension register | Urine ACR in last 5 years

CKD Perfect
(Treat more with SGLT2i)

- CKD | Perfect | QOF CKD with Diabetes | ACR >=3 | SGLT2i indicated
- CKD | Perfect | QOF CKD with Diabetes | ACR >=3 | SGLT2i in last 6 months
- CKD | Perfect | QOF CKD without Diabetes | ACR >=22.6 | SGLT2i indicated
- CKD | Perfect | QOF CKD without Diabetes | ACR >=22.6 | SGLT2i in last 6 months

CKD Protect
(Treat more with statins)

- CKD | Protect | QOF CKD register | Statin indicated
- CKD | Protect | QOF CKD register | Statin issued in last 6 months

Ardens searches that identify CKD Patients to Review

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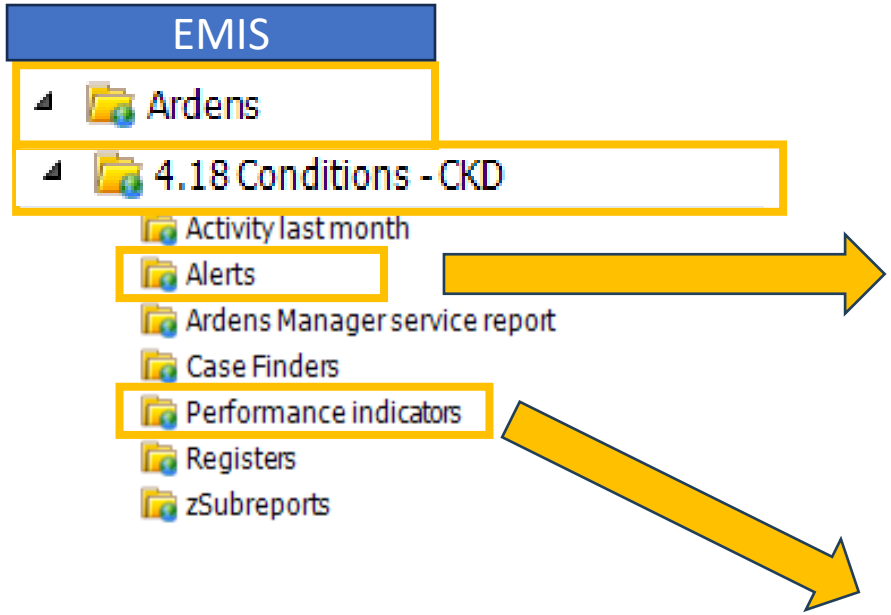

Ardens have more searches in the Performance indicator folder that may be helpful for quality improvement work.

Patients with Alerts

- ?Review as eGFR <60 in last 13m + no ACR in last 13m
- CKD - ?Consider dapagliflozin as CKD + on ACE/ARB + eGFR 25-75 + DM2 or ACR>22.6
- CKD - ?Start ACEi/ARB as indicated as ACR >=70 or ACR >=30 + HTN or ACR >=3 + DM
- CKD - ?Start LLT as CKD + G3A1 and above (and not dec/ci)

CKD Patients with no review in the last 13 months

- CKD - Review: No eGFR done in last 13m if CKD 3-5
- CKD - Review: No urine ACR in last 13m if CKD 3-5
- CKD - Review: No HbA1c in last 13m if CKD 3-5
- CKD - Review: No BP in last 13m if CKD 3-5

CKD Patients whose latest BP is not to Target

- CKD - Target: Latest BP not <130/80 mmHg if CKD 3-5 + ACR >70
- CKD - Target: Latest BP not <140/90 mmHg if CKD 3-5 + ACR <70

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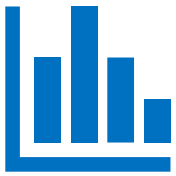
Helpful Resources

Where can I go for clinical guidance?
CESEL Clinical Guides – Google 'CESEL' to find our website & clinical guides on Hypertension, Diabetes, CKD, Asthma, Atrial Fibrillation (AF) and Depression & Anxiety.

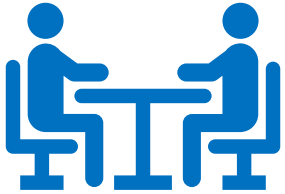
How do I improve coding?
Ardens Condition Templates – including a new Multi Morbidity Template. Ardens webinar on the template and tips on 2024/25 QOF metrics.
https://vimeopro.com/ardens/webinars/video/938192973



How can I access data on ….?
SEL Dashboards are available online for Hypertension, Diabetes and Core20plus5 (Health Inequalities). Please email bi@selondonics.nhs.uk to access these dashboards. CESEL can also provide data to help you monitor your quality improvement.

How do I reduce recall appointments for multi morbidity?
Ardens LTC Recall System A – recall the patient by month of birth for all their conditions at once. Ardens offer free training for your Practice, training@ardens.org.uk

How do I find more cases? How do I risk stratify? Any tools?
Ardens Case Finder searches - all QOF Conditions.
Ardens UCLP Risk Stratification searches – improve management of Hypertension, Diabetes, Asthma, AF & more.
APL Renal Tool – helps your Practice to detect and improve management of CKD.



Can I talk to CESEL about Quality Improvement & resources?
Yes, CESEL offer QI visits to Practices and PCNs.
CESEL Clinical Leads, Analysts & Practice Facilitators offer guidance, support, data, tools, education and training.

Have you signed up for Healthy IO? At home Urine ACR testing for Diabetes patients. Learn more here:
https://lp.healthy.io/south-east-london-gp-practices

Google 'CESEL' for our resources & contact us clinicaleffectiveness@selondonics.nhs.uk

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South East London Integrated Care System

NHS

Have you had a Practice or PCN visit from CESEL?

We would value your feedback. Please complete our survey by scanning the QR code or clicking here https://forms.office.com/r/2vbmqYVynx

Google 'CESEL' to find our clinical guides & resources or click here

If you would like to arrange a CESEL visit or have any questions, please contact the team at clinicaleffectiveness@selondonics.nhs.uk