

Evaluation of the North East London diabetes risk stratification and management intervention

Final report

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Introduction

UCLPartners team

UCLPartners is an Academic Health Science Partnership. We bring together expertise from the eight Higher Education Institutions and the ARC North Thames to provide rapid and flexible evaluations across the region. This is complemented by our in-house teams with expertise in real-world technology evaluation and implementation, quality improvement, network development and engagement, Learning Health Systems, and multi-disciplinary education. We have an extensive network of Patient and Public Involvement panels and seek to actively involve patients from a diversity of backgrounds and experiences across our work. In addition to supporting partners with their response to Covid, a key clinical priority is cardiovascular disease prevention and supporting the management of long-term conditions.

Background and context

Throughout the COVID-19 response, older people and those living with Long Term Conditions (LTCs), including hypertension and diabetes, have been at greater risk from COVID-19. Across North East London (NEL), COVID-19 has also widened health inequalities across its diverse population, highlighting further the importance of managing LTCs proactively to improve health outcomes. The area of interest for this evaluation is diabetes, though it is expected that the learning from this work will be used for other LTCs going forward. Along with introducing new roles and digital technologies, the priorities for NEL include reducing variation and inequalities (for example, half of the type-2-diabetes population lives in the most deprived areas) and improving self-care and self-management.

Following further exploratory work, it has been agreed that teams in NEL will further develop and implement a diabetes risk stratification tool to identify and prioritise patients with diabetes for follow up and use the technology AccuRx Florey to support the improved management of these patients.

Funding for this programme of work has come from NHSX, to support the accelerated spread and scale of remote monitoring as part of the COVID-19 response and recovery. Funding for the evaluation has been provided by the Digital First team within NHSE/I London Region, which oversees the delivery of efficient digital transformation across London to enhance population health.

Description of tools

The **Diabetes Risk Stratification Tool (v5)** was developed by the Clinical Effectiveness Group at Queen Mary University of London, in partnership with Dr Shaine Mehta, Clinical Lead. The search tool was created as a part of quality improvement initiative, with a main focus of matching the risk stratification groupings to local workforce, making it easier for local teams to use the tool. The tool identifies all patients with type 2 diabetes and stratifies them into priority levels, based on clinical and social factors (Figure 1).

The CEG distributed the tool to EMIS practices across NEL from April 2022.

Figure 1: Summary of Diabetes Risk Stratification Groups (NEL Onboarding webinar, April 2022)

Type 2 Diabetes Risk Stratification priority groups

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

High risk		Medium risk		Low risk
Staff type: Group 1 – Diabetes Specialist Nurse Staff type: Group 2 - GP or experienced clinician review		Staff type: Group 3 - Prescribing Support Pharmacists (PSPs) Staff type: Group 4 – GP or other primary care review		Staff type: Group 5 - HCA/ other appropriately trained staff
Group One Hba1c >9%	Group Two Patients with at risk characteristics with: <ul style="list-style-type: none"> • Stroke or TIA in last 12 months • Foot ulcer in last 3 years • eGFR < 45 • Metabolic syndrome • Patients with CHD in the last 12 months 	Group Three Patients with Hba1c 7.5 to 9% with any of the following: <ul style="list-style-type: none"> • BAME • Mild to moderate frailty • Previous CHD/ TIA > 12 months ago • BP >/140/90 • Proteinuria or Albuminuria 	Group Four Patients with missing care processes or annual reviews or increased risk (high BMI, Q risk, high BP) <ul style="list-style-type: none"> • BMI > 30 • BP>140/80 • No urine ACR in last 24months • No annual review in last 24 months • No Q risk recorded • Q risk>10% however no statin prescribed since Jan 2021 • Interpreter needed • Learning Disability • Housebound 	Group Five All other patients

The **AccuRx Diabetes Pre-Appointment Florey Questionnaire** is sent to patients via SMS to help gather information that would be useful ahead of a diabetes review appointment. Patient responses can be coded and saved directly to their record. The questionnaire covers lifestyle, habits, BMI, blood pressure, medicines adherence, consequences of diabetes and provide space for patients to raise any queries (Figure 2). Having this **information available prior to the appointment** can facilitate a more **holistic approach to reviews**.

Figure 2: Summary of AccuRx Diabetes Pre-Appointment Florey Questionnaire (NEL Onboarding webinar, April 2022)



Approach

Evaluation aim and objectives

The overall aim of this evaluation is to understand whether the implementation of a risk stratification tool and AccuRx Florey for people living with type 2 diabetes in North East London was successful.

To meet the overall evaluation aim, the following objectives were identified:

1. Determine the extent to which practices have successfully adopted the interventions
2. Determine the uptake of the interventions and describe the patient characteristics
3. Determine any additional benefits arising from adoption of the interventions for patients and practitioners
4. Determine the factors that have enabled or hindered successful implementation of the interventions

UCLPartners have used a mixed-methods approach where quantitative and qualitative data has been collected and analysed to address the evaluation objectives. Our approach utilises insights from staff and analysis of activity data from the AccuRx CCG Dashboard to provide insights into evaluation objectives.

The data was collected through:

1. One-to-one interviews with GP practice staff
2. AccuRx Florey activity data
3. Quality and Outcomes Framework (QOF) data to describe current landscape of diabetes mellitus

The following is a formative evaluation due to early stage of programme (having launched in April 2022) and limited data available. The findings therefore describe the current state of the programme, as of August 2022, and provide recommendations for development and spread of the programme moving forward.

Qualitative research

UCLPartners team completed nine interviews with GP practices in NEL to understand their perceptions of innovation, their ways of using the risk stratification and Florey tool and what improvements could be made to either. Practices were selected in collaboration with NEL team, taking into account engagement from individual practices, to gather insights from early adopters which could help inform practices at earlier stages of implementation.

Semi-structured interviews were conducted, providing an opportunity to explore ideas and themes in more detail if useful and build on knowledge throughout the process. Outputs were thematically analysed and triangulated with other data sources to identify themes and set findings in context.

Quantitative research

The quantitative research focused on exploring diabetes prevalence in NEL and GP practice engagement and activity with AccuRx Florey.

AccuRx Florey activity data was extracted from the AccuRx CCG Dashboard and filtered by region to extract data for North East London CCG. This data includes weekly summaries of the number of Diabetes Pre-Appointment Questionnaires sent and received by GP practices, updated on a weekly basis. Data was extracted from the period Feb 14th 2021 to August 14th 2022.

QOF 2020-2021 data (NHS Digital, 2021) was extracted to generate insights on diabetes prevalence, register sizes and list sizes of GP practices in NEL. Deprivation data for GP practices in NEL was extracted from National General Practice Profiles (OHID, 2019). Practices from both QOF data and the AccuRx CCG dashboard were mapped to practices in NEL using a list of GP practices published monthly by NHS Digital.

Data on practices who engaged with the pilot practice scheme and with the onboarding webinar was provided by the NEL team. These lists were merged and mapped to practices in NEL using the list of GP practices published monthly by NHS Digital.

The data was analysed in MS Excel and RStudio 2022.02.2.

Context setting

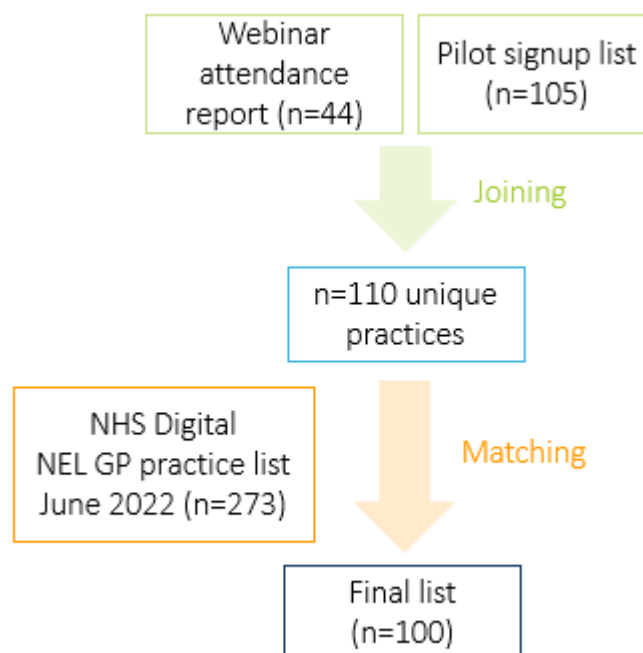
Diabetes Pre-Appointment Florey Questionnaire

The programme involves both risk stratification and Florey distribution, however the quantitative analysis refers to Florey usage only, not risk stratification, due to lack of data on number of practices actively using the risk stratification tool.

Engagement

From the 273 GP practices identified across NEL, 83 had sent a Florey in this time period (83/273 practices, 30%).

The onboarding webinar in April had 146 registered attendees from 44 GP practices. 105 practices had also signed up to be pilot practices as part of this work. Both lists of practices were shared by NEL ICB with UCLPartners and 100 of those practices were successfully matched to the list of GP practices (June 2022).



Practices across the region were categorised based on their adoption (whether or not they sent a Florey) and engagement (whether they registered for the webinar or signed up to be a pilot practice), into four categories (Figure 3):

1. Adopted and engaged: 37/273 practices, 14%
 - a. Practices who have sent more than 1 Florey in the time period AND registered for the onboarding webinar or signed up to be pilot practices
2. Adopted, not engaged: 18/273 practices, 7%

- a. Practices who have sent more than 1 Florey in the time period but did not register for the onboarding webinar or sign up to be a pilot practice
- 3. Not adopted, but engaged: 63/273 practices, 23%
 - a. Practices who registered for the onboarding webinar but did not send a Florey in the time period or sign up to be a pilot practice
- 4. Not adopted, not engaged : 155/273 practices, 57%
 - a. Practices who neither attended the onboarding webinar, sign up to be a pilot practice nor have sent a Florey

Some practices may not fit neatly into these categories and may require more support:

- **Not adopted, but testing:** 28 practices only sent one Florey in this time period, which could reflect a “test” by the practice for the feasibility of using the Florey. Gathering feedback from these practices could be particularly useful.
- **Adopted but ineligible to be engaged:** Some of these practices, at the time of data collection, would not have been eligible to be a pilot practice as they do not use the EMIS Health system, however they would still have access to the Florey tool and other versions of diabetes risk stratification so may become engaged in future.

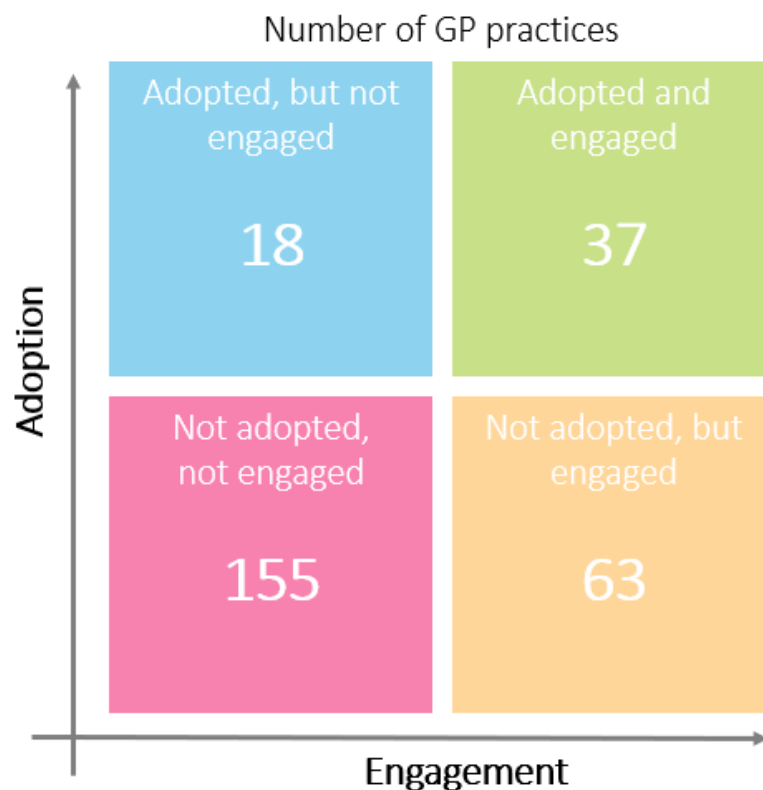


Figure 3: Adoption and Engagement Matrix of GP practices in North East London

Categorising practices in this way may help to identify where targeted communications and support would be most effective in NEL to promote engagement and adoption of Accurx Florey tool. Table 1 illustrates options for supporting each group of practices. Along with this categorisation, it would be useful to assess which of these practices also use risk stratification and consider this in categorisation of practices

Table 1: Suggested supporting activities for GP practices

Category	Description of support which could be offered
Adopted and engaged	<ul style="list-style-type: none"> • Ongoing communication • Establishing a Community of Practice • Support to facilitate collection of patient feedback
Adopted, not engaged	<ul style="list-style-type: none"> • Communication to engage practices and share the recommended pathway, including risk stratification and Floreys • Invitation to Community of Practice
Not adopted, but engaged	<ul style="list-style-type: none"> • Assess their readiness for the programme and capacity to implement • Connect them with similar practices successful in implementation • Identify the barriers to not using Floreys
Not adopted, not engaged	<ul style="list-style-type: none"> • Engagement with practices to ensure they have the resources and capacity to facilitate risk stratification and Floreys

Adoption and activity

From 14th February 2021 to 14th August 2022, 83 practices have used the Florey tool, with 22 of those adopting after the webinar (22/83 practices, 27%). On average, 5 new practices in NEL used the Florey tool every month, which was exceeded for 3 months after the webinar in April 2022 (Figure 4).

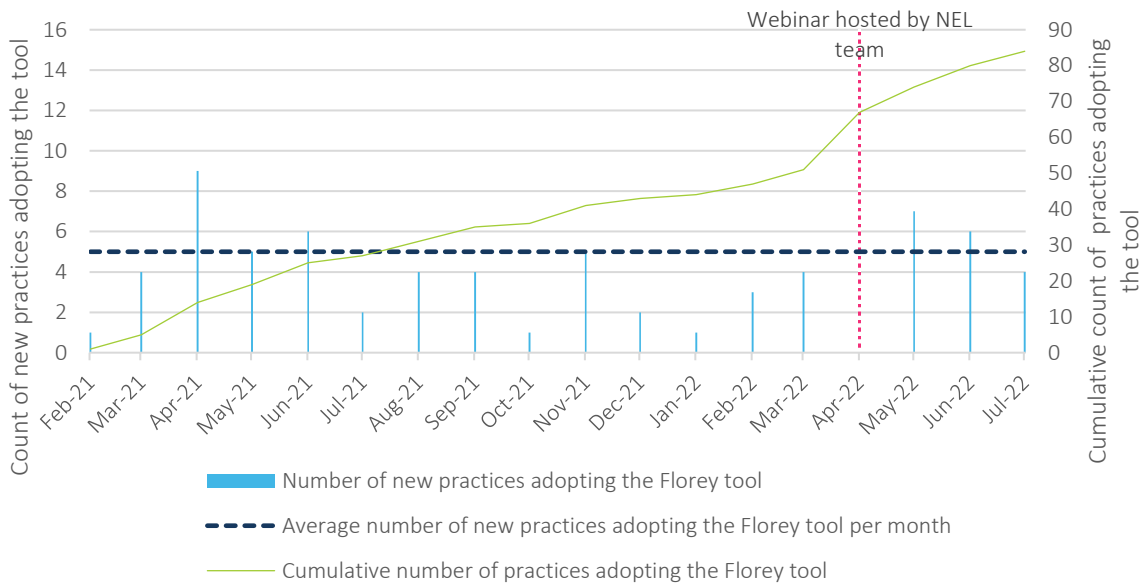


Figure 4: Diabetes pre-appointment Florey Questionnaire adoption, February-August 2022

A total of 8,604 Floreys have been sent across NEL from 14th February 2021 to 14th August 2022, with 5,027 (58%) sent since the webinar in April 2022 (Figure 5). On average, each adopting GP practice sent around 104 Floreys in that period, however, this average is heavily influenced by batch sending of Floreys, where hundreds of Floreys are sent to patients at one time. Approximately 28 practices (34% of adopting practices) sent only one Florey during this period. The total number of Floreys sent does not represent the total number of patients who received a Florey. Sometimes, a patient would be sent a new Florey if they don't respond to the initial message. The data dashboard does not collect patient information, and it is not possible to link Florey to a patient.

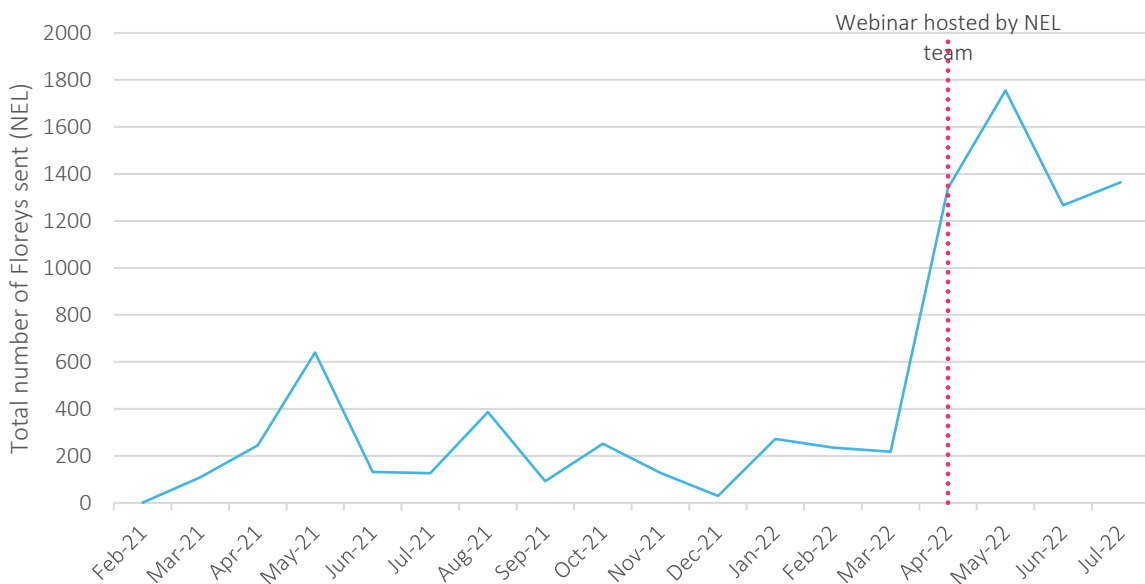


Figure 5: Total number of Floreys sent across North East London

Out of 8604 Floreys sent, 4974 Floreys were returned (56%). Due to the variation in protocols across the region, it is likely there is not a 1:1 ratio between number of Floreys sent and number of patients responding to these Floreys.

If the number of individual patients responding to Floreys could be identified, alongside number of Floreys returned, this would give a clearer indication of response rate. Collecting response rates for unique patients and collating more information about the patients who respond to a Florey would be important for measuring equity of access.

Spread

Data from the [Quality and Outcomes Framework, 2020-21](#) was used to characterise GP practices in NEL according to list sizes, register sizes of diabetic patients and prevalence of diabetes, and identify any trends in the types of practices which adopted and actively use the tool. Practices were also grouped by their deprivation score, extracted from [National General Practice Profiles](#) for the NEL region.

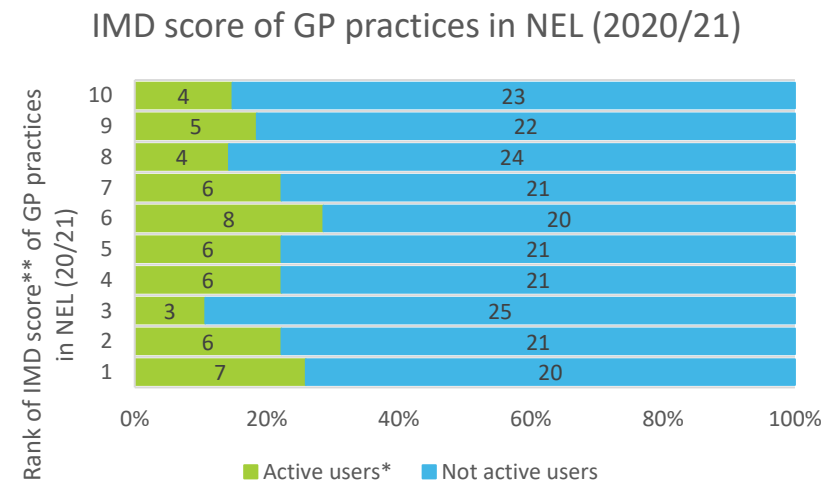
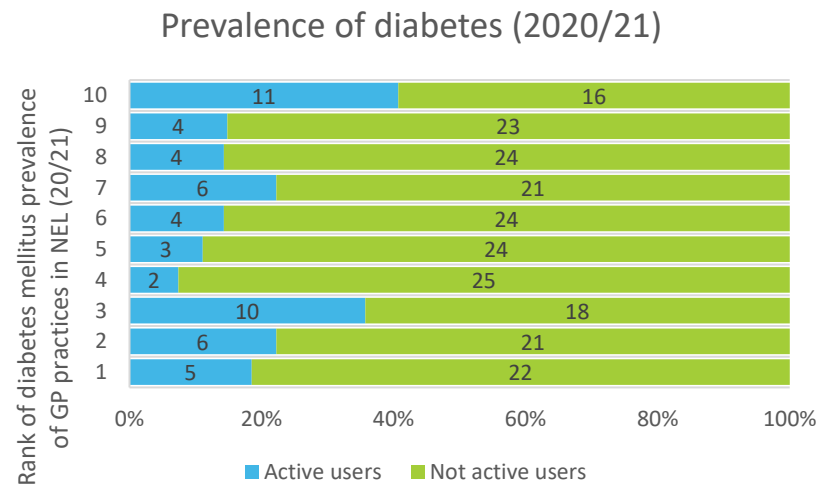
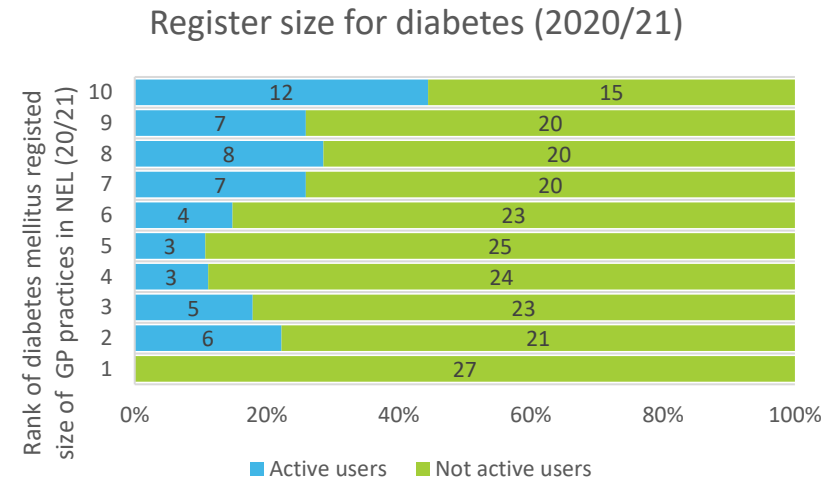
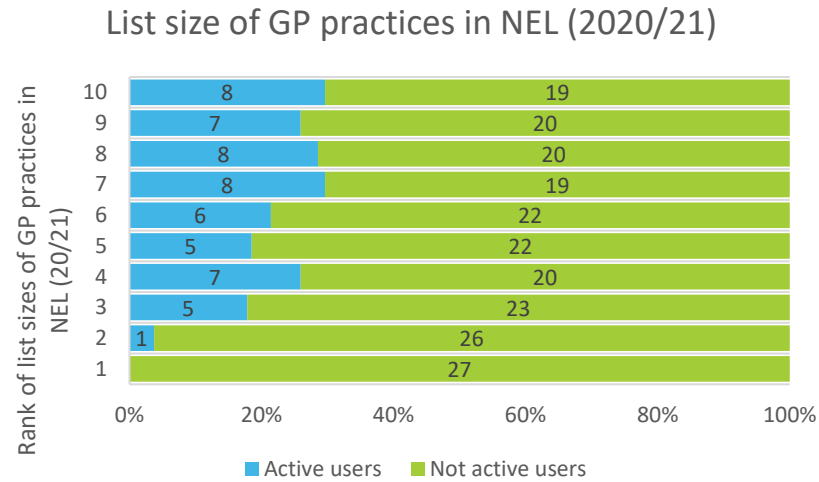
The register size of patients diagnosed with diabetes and prevalence of diabetes were used as an indicator the practices' volume of diabetic patients and their relative need for support for this condition. The list size was used as a descriptor of the size of practice, with the assumption that larger GP practices may be more prepared for innovation and digital transformation. Practices were also ranked across deprivation score, to identify if practices in more deprived areas are less likely to take up the tool.

Active users were identified as GP practices which had sent more than one Florey in the time period. Practices who had sent only one Florey were excluded as it was noted in interviews with practices that one Florey was often sent as a "test" of the Florey system, and therefore a single Florey did not indicate full uptake of the tool.

Across NEL, 55 GP practices can be characterised as *active users* (55/273 practices, 20%).

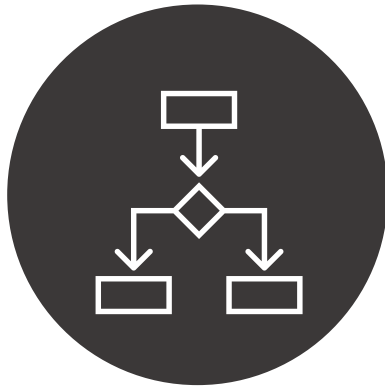
For each metric, all GP practices across NEL were ranked and distributed evenly into 10 groups according to their result, where a rank of 1 represents bottom 10% of practices and rank of 10 represents top 10% of practices based on the list size, register size for diabetes, and diabetes prevalence. IMD score data for each GP practice was ranked from 1 to 10 across the NEL region, , where a rank of 1 represents most deprived and rank of 10 represents least deprived GP practice. This cannot be directly compared to IMD decile, which ranks all small areas across England according to deprivation. The practices identified as *active users* did not indicate any clear trends across number of diabetic patients, percentage of diabetic patients, number of patients at a GP practice or by deprivation (Figure 6). However, the number of practices who can be characterised as *active users* is still relatively low (55/273, 20%).

Figure 6: Exploration of differences between active and non-active GP Practices for list size, register size, prevalence and deprivation



Findings

Insights gathered through interviews with GP practices have been triangulated with the data, and divided into four sections:



Process mapping

Illustration of variation of the process across NEL



Ways of working

Reflections on processes and pathways put in place to support the programme



Impact on workforce

Reflections on staff experience, the benefits and challenges of ways of working



Patient perceptions

Initial insights into patient experience and impact of the programme

Process mapping

We asked practices to summarise their pathway for recall of patients with diabetes, particularly highlighting where they use risk stratification and the Florey questionnaire. The “recommended pathway”, as described in the onboarding webinar is visualised alongside a description on areas of variation noted between the practices.

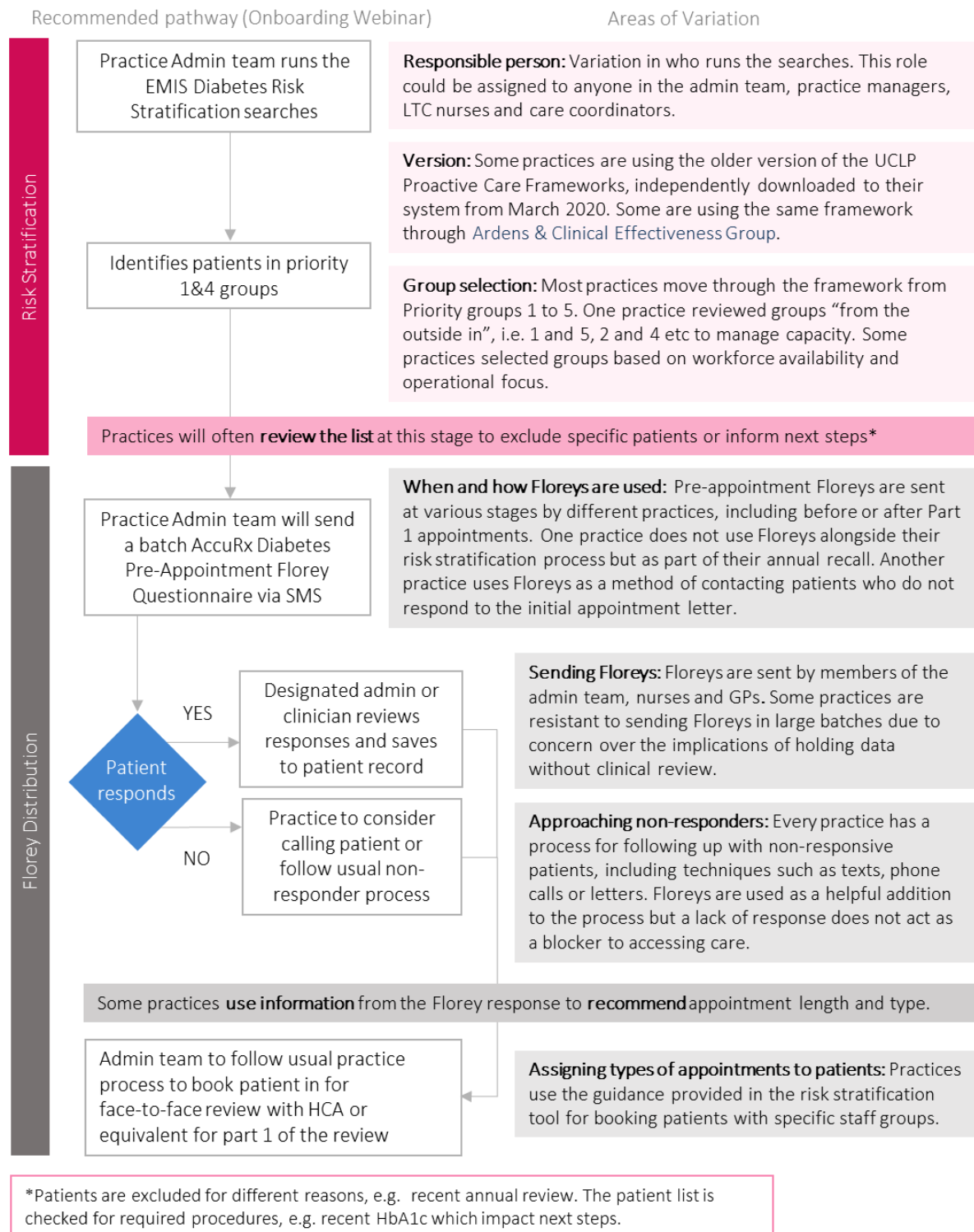


Figure 7: Illustration of the recommended pathway and variations across North East London

Ways of working: What's working well

Onboarding

All practices who attended the onboarding webinar found it useful. They found it was useful to walk through the process during the meeting and follow it along using the recording. They also reported it helped them to put the Florey tool into context. Not every practice had attended the onboarding webinar and had found out about the risk stratification and Florey through their clinical networks, which reflects what we found in the quantitative analysis, where 47% of practices using the Florey tool had not attended the onboarding session or signed up as a pilot practice.

"I was a little bit reticent because I didn't see what [the Florey] added. Because...there's not a lot in diabetes that's measurable from the patient's point of view...but they really helped me to understand actually, this is about changing the way you consult with the patient."

Advanced Nurse Practitioner

Flexibility in implementation

Primary care teams who are responsible for diabetes management across the ICB are diverse in their make up and approach. Allowing for flexibility in how practices implement these tools likely allows for greater adoption, to avoid practices not fitting into a "cookie cutter" approach. Practices across the region also serve diverse populations so local knowledge and adaptation of processes are important.

Innovation

Most practices that were interviewed had some experience of innovation already, through QI processes or implementation of digital tools. All practices were focussed on risk stratification and were doing some stratification before April 2022, such as with Ardens & CEG Risk Stratification searches. All practices had also used other types of Floreys, with similar user interfaces, to communicate with patients. This previous experience meant the practices we spoke to were comfortable in general with innovation and changing practices, and specifically with risk stratification and Florey usage.

"We're quite lucky in that we've got autonomy in doing what we want here...and implementing what we want to was quite easy."

Advanced Nurse Practitioner

Ease of use and implementation

All practices reported that implementing and using both the risk stratification tool and Florey was straightforward, with no issues reported in trying to use the tools on their systems.

“[the risk stratification tool] doesn't look scary. It's quite friendly.”

IT Administrator

(On the Florey) “Ease of use...it's literally a click of like two or three buttons”

Practice Manager

Ways of working: Areas for improvement

Consistency

Across all practices we interviewed, there was significant variation in what innovations (risk stratification or Floreys) they were using and how they were using them. Some teams are using an older version of the risk stratification tool from March 2020, downloaded independently from the UCLPartners website. Other teams had independently implemented the Florey tool prior to the launch of the programme. This variation may become an issue when evaluating the impact of the programme at a regional level.

Messaging

The programme involves two elements; risk stratification and Floreys. These elements have been used by most practices we interviewed, however they were not considered connected to each other and were often initiated by practices separately from each other and separate to the programme. More could be done to communicate how these tools are connected and their added value when used alongside each other.

Opportunities to improve risk stratification

Some practices have noted that although the risk stratification tool is very useful and an improvement on previous methods of stratification, manual review and editing of patient lists is still required. For example:

- Remove patients who have had an annual review
- Flag patients who need a new HbA1c measurement
- Flag which patients are in care homes

It is worth noting that for patients that are in a care home, the approach might need to be adapted (for example, if there is a need to conduct a foot check during a home visit). Flagging patients who are in a care home, and not excluding them from the stratification, will be beneficial.

If these elements could be integrated into the tool it would save even more time for the practices.

Resistance to Florey implementation

All practices have used Floreys previously, and although they all found them useful some had been resistant to implementing them on a wider scale due to previous experience with similar tools. For example, there were concerns over how the Asthma Control Test (ACT) is coded through the Asthma Florey, and the appropriate follow-up after receiving coded information. These concerns may have to be addressed upfront if the programme is to be scaled, with a specific focus on unintended consequences of receiving coded patient information.

Impact on workforce: What's working well

Note: The practices we interviewed were early adopters of these tools and so these reflections are likely biased towards practices more prepared for innovation.

*"I think it's improved the **quality of the consultation** where... the Florey has been returned and allowed us to do [our job], and also it **improved our job satisfaction**"*

Advanced Nurse Practitioner

Making best use of staff's time

Practices recognise that use of the risk stratification tool ensures that patient needs are always matched to staff capability and capacity. With use of stratification, the likelihood of unnecessary consultations reduces, and staff feel that their skills are being used appropriately.

"We can move the patients beforehand, triage them essentially, to the right clinician first time around."

Practice Business Manager

Support of the whole practice team

Both clinical and administration teams have reported that they feel the introduction and use of the risk stratification tool has neither added to their workload nor reduced it, however, it ensures their skills and time are being used in the most appropriate way. The operational leads are also supportive of these new ways of working because it provides structure and guidance for managing a diverse patient list, and its use supports the achievement of QOF targets.

"[Patients] don't get lost in the system the same way that they might have done in the past."

Advanced Nurse Practitioner

Flexibility in priority group selection

As practices do not need to adhere to guidance set out during the onboarding webinar, they can adapt it to their own needs. Practices have used the defined groups in the risk stratification tool, together with knowledge of their team's capacity and operational focus, to inform capacity planning in the short term. The clinical leads have also developed an implementation support pack that was distributed to practices.

"[The HCA is] off for a month, that means we are very, very low on phlebotomy appointments and Part Ones...we need to shift our focus...each month we're focusing on a different thing."

Practice Manager

Patient centred care

Clinical staff support the use of the Florey and highlight the positive impact Floreys have on supporting patient centred care. Use of the Florey does not reduce appointment time but allows the patient and clinician to have a well-rounded conversation about their condition. Review of patient responses during the appointment has also allowed clinicians to unpick complex issues which would not normally be heard in the standard appointment. In particular, clinical staff praised the inclusion of sexual function and mental health in the questionnaire as these issues can often be overlooked. By allowing the patient to respond to all questions prior to the appointment, it also ensures points of care are less likely to be missed.

“The Florey allows you to have a much more motivational interviewing approach, because the patient is setting that goal for that consultation”

Advanced Nurse Practitioner

Impact on workforce: Areas for improvement

Inefficiencies in pathway

Use of the risk stratification tool and Florey automates and creates efficiencies in some parts of the Diabetes pathway but there are parts which require staff support. For example, raising a blood form is often completed as a separate, manual process. Some of the manual steps outlined in the process map as reported by practices (e.g., removing care home residents) have in fact been updated in the EMIS Risk Stratification searches developed by the NEL team, which highlights the variation in versions used across the region. Other manual steps reported by practices, such as removing patients who have had a recent annual review, provide opportunities to create more efficiency in the pathway.

It would also be beneficial for the types of Florey response to be coded (e.g., first response, second response) for teams to track responses. Practices also reported taking additional manual steps to optimise the search process. The main deciding factor for the time it takes to complete the process was patient response. Additional coding and reducing manual processes are opportunities to improve efficiency going forward.

“the issue is... that if we send out text messages to this patient, who hasn't got the lab test results, [there] is no point bringing them to the clinic.”

IT Administrator

Internal governance of tools

Although risk stratification was well understood, in some practices there was a lack of awareness across teams on the use and purpose of Floreys. This may be reflective of how simple the Florey was to implement and insert into processes that it could be done by the admin team independently of

clinical governance. Guidance should be made available for all relevant team members in the practice when Floreys are being distributed to patients.

Methods to share learning between practices

Each practice interviewed had developed a different process for using the tools provided to support patients. In these interviews, most practices expressed an interest in hearing how other practices are using the tools. Through this programme, there is opportunity to generate and share lessons across primary care in the NEL region, there is currently no specific forum to do so apart from staff-specific networks. We uncovered a wealth of insight from speaking to teams as a whole including operational leads, admin teams, nurses, pharmacists and GPs. A community of practice could be formed, led by NEL, to share lessons across the region and to support and inspire practices who have not yet adopted.

Mechanisms to feed back on tools

As previously noted, practices shared practical ideas in the interviews for potential improvements to the risk stratification tool and Florey. Those who had not attended the onboarding webinar would not be aware that there is a mechanism to provide feedback through NEL. More could be done to encourage feedback to the NEL team, in addition to directly requesting feedback from practices in all stages of adoption.

Patient perceptions: What's working well

Note: No practices we spoke to had actively collected patient feedback on the Florey tool. These reflections are therefore perceptions of the practice teams.

“it's a combination of seeing the people who need it the most, but also the fact that we get them to see the right person. When those two things are done well, patients are definitely appreciating it and telling us about it.”

Advanced Nurse Practitioner

Neutral response to Floreys

Although they have not asked for patient feedback on the use of the Floreys, practices have noticed very little hostility to them. This may be due to a biased sample of interviews, as most practices already use Floreys or SMS services for other conditions, so this form of communication from the practice is normalised. We heard that patients appear to have inherent trust in the messages as the practices very rarely receive calls from patients to check if the service is genuine, as a result, this does not add to the workload of the admin team.

Positive response to holistic approach to care

Practices did not have direct patient feedback from the Florey tool, but they noted a positive patient response to how diabetes appointments are changing. Use of risk stratification ensures patients are always seeing the most appropriate staff member and don't have to attend multiple appointments. Practices report that review of the Florey prior to the appointment has helped patients feel more heard and that the clinicians care about them as people, not just another task to be completed.

“there was trust between us because [the patient] saw, [with the Florey], that I was trying to do the best for him and it wasn't about an agenda and a box ticking exercise.”

Long Term Conditions Nurse

Addressing common concerns about remote monitoring and recall

Many of the common concerns around remote patient monitoring were raised in the interviews.

Digital exclusion: This was not seen as an immediate concern, as each practice had an alternative route to contact patients who could not complete a Florey. The platform also highlights where a text was undeliverable, indicating to the admin team that the patient perhaps does not have a smartphone.

Language barriers: Although this tends to be a concern around remote monitoring tools, some practices have found that using a Florey enables better communication with patients who have a language barrier as patients have more time to respond to questions. Interestingly, staff noted that many patients will ask their family or carers to respond for them via the Florey. However, they did add that if a patient does not have this support network in place, the inability to respond to a Florey could isolate them further.

Non-responsive patients: Floreys can act as another tool for recall teams to communicate with patients, particularly those less likely to respond to standard communication. Some practices have found a proportion of their patients who would not tend to respond to phone calls or letters do respond to a Florey as they feel they can be more open virtually, for example by admitting they are struggling to adhere to medication.

Patient perceptions: Areas to explore

Note: Practices could not share direct feedback from patients on the tools as this was not requested or collected. This section therefore gives recommendations on areas that could be explored to gather insights from patients and continuously improve this approach to reach as many patients as possible.

Creating feedback loops

No practices we spoke to had actively collected patient feedback on risk stratification or the Florey tool. Although unsolicited feedback has largely been positive, it is essential to gather patient opinions and insights in a systematic and ongoing way as this programme emerges. For risk stratification, PCNs or practices could engage with local patient forums to ascertain their perceptions of being grouped in this way. For Floreys, it would be efficient to gather patient feedback through the Florey itself, although, through discussion with the AccuRx team, we found that patient feedback is not routinely requested through SMS and, the Pre-Diabetes Appointment Florey cannot be personalised in this way. However, individual practices could generate new Florey templates to ask patients their opinions on using the Florey tool and what could be improved. A template could be designed at the ICB level and distributed to practices to gather this information and facilitate a patient-led approach to improvement.

Communicating with non-responsive patients

Although some practices found that the Florey tool did facilitate communication with patients who were previously non-responsive, they all noted that there is still a proportion of patients they are unable to reach by traditional or digital methods. The use of risk stratification and Floreys does not completely address this unmet need and practices are keen to face this issue. Further analysis into the characteristics of the non-responsive cohorts could be beneficial in order to target communications channels and other interventions as appropriate.

“I think...the people who don't want to respond, don't respond.”

Assistant Nurse Practitioner

Recommendations

Engagement

Adoption processes and standardising pathways

- Explore options to standardise pathways and the benefits of doing so

Further engagement with GP practices

- The report provides specific recommendations for engagement based on the current activation and engagement matrix

Continuous improvement

Gathering feedback from patients and staff

- Explore the possibility to gather patient feedback either directly, or indirectly through staff feedback

Communities of practice

- Creating a community of practice could support with activation and engagement across North East London

Benefits realisation

Activity and adoption

- Continue to review AccuRx dashboard to understand activation and engagement levels

Clinical outcomes

- Explore gathering outcomes data once sufficient time has passed since implementation, leaving enough time to detect clinically significant change
- The QOF data will not reflect time using Floreys until 23/24 – e.g. patient improvement, improved recall of patients
- Explore gathering prescriptions data from primary care

System outcomes

- Explore the impact of change in risk stratification profiles on staff and ways of working. Some practices have designated staff member follow-up according to level of complexity. Continue to work in partnership with GP practices on risk stratification tool keeping in mind the workforce and differences between GP practices
- Patients always seeing correct staff member for their level of complexity
- Onward referrals

Inequalities

- Explore primary care data to understand patient characteristics of those engaged and not engaged with the intervention
- It is worth noting that the version 5 of the tool already has a health equity search option. This will enable the practices to adapt the recall process for patients with certain characteristics.
- Explore if the coding for digital inclusion has improved over the duration of the programme

Wider reflections on the programme

Mindset change and all staff engagement

The underlying idea to the programme was to support changing the conversation from 'routine recall' to 'risk based recall'. It is interesting to observe that even if practices used a different tool, they accepted the approach of reviewing by risk. The significant part of the programme included stepping away from the standard GP approach to actively involve all primary care workforce.

Engagement with GP practices

Although clinical engagement presented a challenge and took time, the dissemination of the implementation pack was a good exercise and has contributed to activation of the practices. However, additional follow-up engagement, considering approaches to recall and developing recommended actions, might be necessary which would require additional capacity from the clinical leads and NEL team.

Key considerations for impact

Clinical teams have observed an increase in patients being more involved in their care. Having coded responses, enabled by the technology, along with the digital inclusion coding, highlighted where adaptations to the approach were necessary and contributed to including all patients regardless of their digital confidence levels. We recommend for the clinical team, in collaboration with NEL, to continue to review staff and patient perceptions over time to understand effectiveness of using the risk stratification tool together with an online form enabling practices to collect coded information.

Outcome measures

Evaluation Objective	Specific measure(s)/metric(s)	Metrics collection	Data Source(s)
1. Determine the extent to which practices have successfully adopted the interventions	<ul style="list-style-type: none"> Number of practices onboarded Number of practices adopting the risk stratification tool Number of practices adopting Accurx Florey Number of patients sent an Accurx Florey (out of the total identified/eligible patients) 	<p>All EMIS practices were offered risk stratification, although it is widely available. Pre-Diabetes Florey questionnaires are available for download for EMIS and SystemOne practices.</p> <p>Unable to determine as the same tool can be downloaded independently of the programme.</p> <p>Complete</p> <p>Complete - unable to say directly who is eligible (can estimate with QOF)</p>	Reporting by practices/NEL
2. Determine the uptake of the interventions and describe the patient characteristics	<ul style="list-style-type: none"> Number of patients completing the Accurx Florey Questionnaire Number of patients receiving an Accurx Florey that convert into a service contact (TBD) Health profile and demographic data (age, gender, ethnicity) 	<p>Complete with some caveats</p> <p>Not possible - varies depending on protocol used by practice</p> <p>Not possible - Accurx data systems cannot connect with GP systems directly</p>	Reporting by practices/NEL

<p>3. Determine the clinical outcomes for patients accessing the interventions</p>	<ul style="list-style-type: none"> · Blood Pressure · HbA1C · Urine albumin o creatinine ratio (ACR) · Number of patients pre and post practice onboarding that have no diabetes review code in last 6 months 	<p>Not possible</p> <p>Not possible</p> <p>Not possible</p> <p>Not possible</p>	<p><i>TBD – Primary care data</i></p>
<p>4. Determine additional benefits arising from adoption of the interventions for patients and practitioners</p>	<ul style="list-style-type: none"> · Proportion of timely reviews undertaken for target patients before and after implementation · <i>TBD</i> improvement against QOF measure · Increase in levels of patient confidence/satisfaction/activation · Onward referrals (smoking cessation, foot clinic, digital weight management programme (DWMP), low-calorie diet) · Prescriptions (folic acid, contraception) 	<p>Not possible</p> <p>Next QOF collection is in September. The intervention will not have been available for long enough to see significant improvement in measures.</p> <p>Not directly measureable, we have reflections from staff</p> <p>Not possible</p> <p>Not possible</p>	<p><i>TBD/patient interviews</i></p> <p><i>TBD – Primary care data</i></p>
<p>5. Determine the factors that have enabled or hindered successful implementation of the interventions</p>	<ul style="list-style-type: none"> · Staff interviews, exploring issues around training, dissemination of information, fidelity of approach, necessary adaptations, digital inclusion and inequalities, sustainability 	<p>Complete</p>	<p>Staff interviews</p>

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