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Community of Practice

Supporting General Practice post COVID-19 recovery :

Primary Care Support for Long Term Condition management

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May 2020

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Supporting General Practice post COVID-19 recovery Webinar
PCN Community of Practice

Agenda

Time	Item	Lead
6pm	Welcome and introductions	Mandeep Butt
6:05pm	Update on UCLPartners Primary Care Support Package Group discussion	Dr Matt Kearney
6:25pm	Next steps: Hypertension and heart failure Community of Practice Poll	Helen Williams Mandeep Butt
6:40pm	Local case study: City and Hackney	Rita Shah and Sagal Hashi
6:55pm	Discussion and feedback	All
7pm	Close	Mandeep Butt

“LTC management is at risk of neglect during national emergencies”

But Recovery also offers major opportunity:

- To do things differently in primary care for the benefit of patients and clinicians
- To tackle variation in quality of care
- To target health inequalities
- To build capacity in the primary care workforce

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A Framework for Optimising LTC Management and Self Management post COVID-19

- Digital technology will be at the heart of catalysing change
- But even transformative technology dropped alone into the system will not be enough to deliver sustainable change
- Transformation that deploys new technology will also need support for pathway change and for capacity building in workforce and patients to do things differently
- UCLPartners has modelled this approach for asthma, COPD, diabetes, high blood pressure and heart failure
- The UCLP framework and implementation support is now commencing roll out across North Central London and parts of North East London and Mid & South Essex

Principles underpinning this work

- Virtual by default
- Mobilising and supporting the wider workforce (including pharmacists, HCAs, other non-clinical staff)
- Step change in support for self-management
- Digital innovation including apps for self management and technology for remote monitoring

Primary Care Support package includes

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1. Identification
   - Pre-defined searches with Sno-Med/Read codes
   - Virtual Training to undertake and access targeted searches

2. Stratification
   - Comprehensive stratification tools
   - Virtual training sessions on specific LTCs
   - Virtual clinical insight, where required

3. Management
   - Suggested pathways for local adaption
   - Detail as to staff types who can undertake interventions
   - Protocols for staff to follow informed by patient & public feedback
   - Virtual training sessions for different staff types with content adapted to the needs of the individual staff, e.g. HCA, clinical pharmacist

4. Enabling patient-self management
   - Self-management digital resources appraised and recommended
   - Support for implementation available

All intended for local adaption

The LTC Pathway – Asthma, COPD, Diabetes

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Principles:
- Virtual first
- Wider 1º care workforce
- Step change in self management
- Digital technologies

Identify
Search for risk groups via health records

Stratify
Low risk
Medium risk
High risk

Communicate
Text/letter/ call to let patient know they will hear from practice

Management
Match risk/need to professional role

High Risk
GP/specialist nurse/clinical pharmacist

Medium Risk
Nurse/clinical pharmacist

Low risk
Health Care Assistant

Resources: comprehensive search tools, protocols, scripts for HCAs, training, education, digital tools, project management, communities of practice uclpartners.com/work/support-for-long-term-conditions-during-the-covid-19-pandemic/

Clinical Advisory Group

Aiysha Saleemi, Pharmacist Advisor

Dr Deep Shah, GP

Helen Williams, Consultant Pharmacist

Dr John Robson, Reader in Primary Health care; Clinical Lead Clinical Effectiveness Group

Mandeep Butt, Clinical Medicines Optimisation Lead, UCLPartners

Dr Matt Kearney, GP, Programme Director UCLPartners AHSN

Professor Mike Roberts, Managing Director UCLPartners AHSN

Dr Morounkeji Ogunrinde, GP SPIN

Dr Nausheen Hameed, GP SPIN

Dr Sarujan Ranjan, GP and Health Tech Advisor

Dr Stephanie Peate, GP

Dr Zenobia Sheikh, GP & Primary Care Clinical Lead, UCLPartners

Conditions included:

- Asthma
- COPD
- Diabetes Type 2
- Cardiovascular Disease:
  - Hypertension and Heart Failure (in development), AF and high cholesterol

The following slides show indicative frameworks for stratification and management that can be adapted for local use depending on existing activity, workforce and pathways

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Asthma

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1. Long Term Condition Pathway: Asthma

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1 Identify & 2 Stratify

Search tool identifies patients with asthma who are at higher risk of deterioration. These patients are then stratified into high, medium and low risk depending on clinical characteristics and Asthma Control Test™ score.

Group 1 criteria

- Any biologic therapy
- Frequent steroid therapy
- Frequent antibiotics
- Tiotropium
- Combination inhaler (LABA+ICS) at a high daily steroid dose
- ICS with:
  - Leukotriene Receptor Antagonist
  - Theophylline
- Plus individual patients where clinician concern

Group 2 criteria

- Exacerbation of asthma in last 12 months
- Prednisolone and/or antibiotics in last 12 months
- Asthma patients with 6+ issues of SABA per year
- Asthma patients on LABA *but no corresponding issue of an inhaled corticosteroid (ICS) inhaler*
- Asthma patients with 3+ issues of SABA in last 6 months *with no corresponding issue of an inhaled corticosteroid (ICS) inhaler*

Group 3 criteria

- Inhaled corticosteroids in last 6 months
- SABA in last 12 months

Phase for later review

Asthma Control Test™ (ACT) to risk stratify

Score <15 → **HIGH RISK**

Score 15-20 → **MEDIUM RISK**

Score 20-25 → **LOW RISK**

*The Asthma Control Test™ provides a snapshot as to how well a person's asthma has been controlled over the last four weeks and is applicable to ages 12 years or older. Available here: www.asthma.com/additional-resources/asthma-control-test.html

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3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

	High risk	Medium risk	Low risk
Staff type to contact	GP/ Nurse specialist/ Specialist Respiratory Pharmacist	Clinical Pharmacist/ Practice nurse/ physician associate	Health Care Assistant
Intervention	• Titrate therapy, if appropriate • Ensure action plan in place • Check adherence, inhaler technique (video) , spacer advice • Rescue packs prescribed if necessary • Review of triggers, e.g. hay fever • Exacerbation safety netting • Follow up and referral as indicated	• Check optimal therapy; Titrate, if appropriate • Review triggers, e.g. hayfever • Check adherence, inhaler technique (video), spacer advice • Exacerbation management advice • **Repeat ACT as per recommendation from ACT test result and escalate to GP/Nurse if red or amber**	• Check inhaler usage & technique; signpost to education; spacer advice • Exacerbation management advice inc. mild hayfever symptoms • Signpost to appropriate information for: Lifestyle information/management of stress • Smoking cessation support • Exercise • Appropriate resources

Digital Support Tools to support patient self-management

Inhaler Technique: www.asthma.org.uk/advice/inhaler-videos/ www.rightbreathe.com
Asthma deterioration: www.asthma.org.uk/advice/manage-your-asthma/getting-worse/
General Health Advice www.asthma.org.uk/advice/manage-your-asthma/adults/
Smoking Cessation: www.nhs.uk/oneyou/for-your-body/quit-smoking/personal-quit-plan/ www.nhs.uk/smokefree/help-and-advice

COPD

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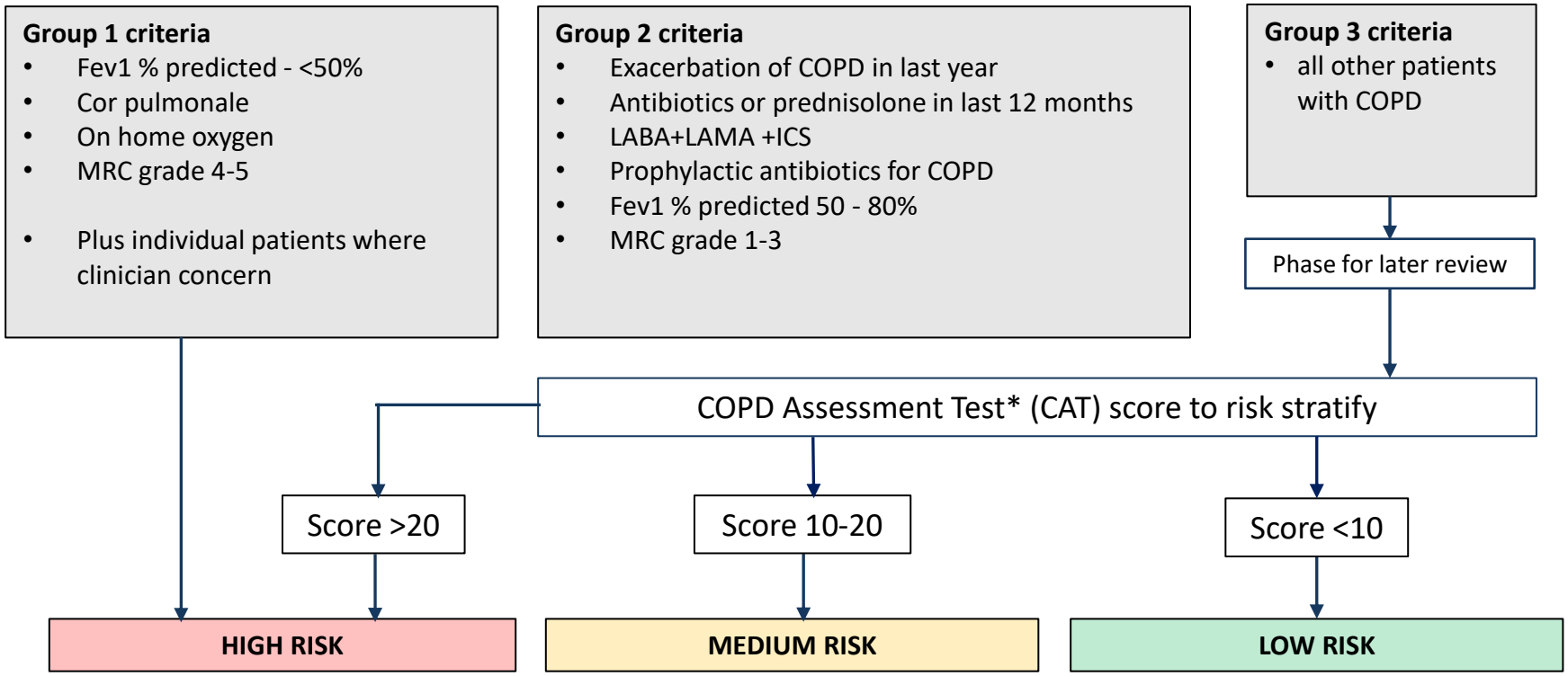
1 Identify & 2 Stratify

Search tool identifies patients with COPD who are at higher risk of deterioration. These patients are then stratified into high, medium and low risk depending on clinical characteristics and COPD Assessment Test result.



*The COPD Assessment Test (CAT) is a questionnaire for people with Chronic Obstructive Pulmonary Disease (COPD). It is designed to measure the impact of COPD on a person's life, and how this changes over time
www.catestonline.org/

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3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

Stratification	High risk	Medium risk	Low risk
Staff type to contact	GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant
Intervention	• Titrate therapy if appropriate • Ensure action plan in place • Check adherence & inhaler technique • Spacer advice • Rescue packs – prescribe if needed • Exacerbation safety netting • If MRC 4/5 - offer Pulmonary Rehab via video consultation /My COPD App	• Check optimal therapy; titrate if appropriate • Check adherence & inhaler technique (video) • Spacer advice • Exacerbation management advice • Repeat CAT test at 4 weeks and escalate to GP/Nurse if red or amber	• Check medication compliance - regular inhaler usage. Signpost to education (video) • Spacer advice • Lifestyle info/ stress management/ exercise • Smoking Cessation advice • Exacerbation management advice • Signpost to British Lung Foundation and other resources

Digital Support Tools to support patient self-management

MyCOPD app offering patient information & education, inhaler technique, online pulmonary rehab classes, smoking cessation support, self-management plan.

Overview of COPD – diagnosis, treatment, and managing flare ups: www.blf.org.uk/support-for-you/copd

Step-by-step guidance on physical activity : https://movingmedicine.ac.uk/disease/copd/#start

Type 2 Diabetes

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Long Term Condition Pathway: Type 2 Diabetes

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1 Identify & stratify

Search criteria

Demographics
- Age

Co-Morbidity*
- Cardiovascular disease
- BMI
- Dementia
- SMI
- Learning Disability
- Palliative care

Social Determinants
- Falls history
- Housebound

Medication
- Previous hypoglycaemia
- Drug interactions
- Insulin

Biochemical Markers
- eGFR
- HBA1c

**Specific codes for frailty, foot disease and retinopathy will be added in version 2*

Multifactorial Risk Stratification Tool ceg **produces a composite risk score**

Version currently set out for EMIS with System One to follow

High risk | **Medium risk** | **Low risk**

3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide; check HBA1C up to date, provide information on risk factors, eg smoking cessation, diet and exercise, waist circumference

	High risk	Medium risk	Low risk
Staff type to contact	GP/Diabetes Specialist/ Nurse	Clinical pharmacist/ Nurse/ Physician Associate	Healthcare Assistant

Intervention	• **Medication:**
	  • Adherence
	  • Titrate as appropriate
	• **Monitoring**
	  • Blood sugar control
	  • Lipids/lipid lowering therapy
	  • BP and proteinuria
	• **Education (inc online tools)**
	  • Sick day rules
	  • DVLA guidance
	• **Review & Discuss Red flags**
	  • Vision: floaters/flashing lights
	  • Feet/skin : pressure areas; virtual skin integrity check
	  • Blood sugar control: hypos
	  • Infections
	  • Signposting and Escalation
	  • Diabetes community +- secondary care team/advice
	  • Recall & Code
		• **Medication:**
		  • Adherence
		  • Titrate as appropriate
		• **Monitoring**
		  • Blood sugar control
		  • Lipids/lipid lowering therapy
		  • BP and proteinuria
		• **Education**
		  • Sick day rules
		  • Signpost online resources
		  • DVLA guidance
		• **Review & Discuss Red flags**
		  • Vision: floaters/flashing lights
		  • Feet/skin: pressure areas; virtual skin integrity check
		  • Blood sugar control: hypos
		  • Infections
		  • Signposting and Escalation
		  • Recall & Code
			• **Medication:**
			  • Adherence
			  • Explore/ check understanding
			  • Confirm supply and delivery
			• **Education**
			  • Signpost online resources
			  • Risk factors – diet/lifestyle/smoking cessation
			  • DVLA guidance
			• **Review & Discuss Red flags**
			  • Vision: floaters/flashing lights
			  • Feet/skin: pressure areas; virtual skin integrity check
			  • Blood sugar control
			  • Infections
			  • Signposting and Escalation
			  • Recall & Code

Digital Support Tools to support patient self-management

NICE approved face to face programme, offering education, diet & exercise advice: www.mydesmond.com/home/

General info & advice: www.diabetes.org.uk/diabetes-and-me www.nhs.uk/apps-library/my-diabetes-my-way/

Expert input

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UCLPartners tested the Primary Care LTC approach with patient and public representatives via a virtual engagement session.

Communication	Patients were concerned about not having regular communication with their usual GP but would be happy to hear from someone who was confident and consistent in their messaging & who had access to their existing health information
Holistic approach	Support offered needs to consider more than just the specific condition the individual is calling about but take into account and be responsive to the person's wider mental and physical wellbeing.
Trust	Patients raised concerns of fraud or breach of confidentiality when being contacted. They also wanted to have a single number/ named person to call if they needed support urgently

Training and support package

Search

- Search tools
- Pre recorded webinar as to how to use the searches
- Online Q&A to troubleshoot challenges with delivery of the search tools

Workforce training and capacity building

- **Protocols** for contacting low, medium and high risk patient groups
- **HCA virtual training package*** :
  - How to use the protocols
  - Basic introduction to specific long term conditions
  - Practical training e.g. inhaler technique, peak flow
  - Health Coaching
- **Clinical Pharmacist/ specialist nurse virtual training package**
  - Specialist information on each condition
  - Health coaching

*can be adapted for different staff types

Digital Support Tools

- Evidenced-based, clinically selected digital tools identified to support with each pathway
- Implementation toolkits/ training as required

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Thank you

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Post COVID-19 Recovery:

Hypertension and Heart Failure

Helen Williams
Consultant Pharmacist for CVD

Hypertension and Heart Failure Pathway in progress – available on the LTC webpage in the coming weeks

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Thank you

For more information please contact

Helen Williams helen.williams11@nhs.net

Consultant Pharmacist for CVD

Community of Practice Poll

We would appreciate if you take a minute to complete the poll – results to be shared at the end of the session

NHS
City and Hackney
Clinical Commissioning Group

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Pharmacist Led Hypertension Review Project

Rita Shah, Project Pharmacist

Sagal Hashi, Joint Formulary Pharmacist

Aims and Objectives

Aim

To review and improve blood pressure in black patients (African or Afro-Caribbean origin) with uncontrolled hypertension (>140/90mmHg) through pharmacist led hypertension clinics.

Objectives

- Review and optimise antihypertensive medication
- Provide advice on lifestyle and nutrition
- Identify and understand reasons for poor adherence to antihypertensive medication

Method

Practice Support Pharmacists (PSPs) were tasked with setting up hypertension review clinics to review Black (African or Afro-Caribbean origin) patients with uncontrolled blood pressure.

Search Criteria	
Inclusion criteria	**Exclusion criteria**
Black (African or Afro-Caribbean origin) patients	Dementia
18 years of age or over	Palliative care patients
Last 2 blood pressure readings > 140/90mmHg (in last 12 months)	Pregnant patients
Patients on one or more antihypertensive	Patients referred to CVD specialist
	Patients recently diagnosed with hypertension (in last 6 months)
	Patients with renal disease

Process for Hypertension Review Consultations

Step 1

Organise Hypertension Clinics

- Inform practices of hypertension review project.
- Undertake searches and identify **10 patients** for review.
- PSP to liaise with reception staff to book in 30 minute consultations.

Step 2

Initial Hypertension Review Clinic

- PSP to review patients in the hypertension clinic.
- PSP to meet with the GP for a debrief following each clinic.
- PSP to record changes made onto EMIS and complete the data collection form.

Step 3

Follow Up Clinic at 3 months

- PSP to follow up the patient in clinic after 3 months and follow the hypertension protocol.
- PSP to meet with the GP for a debrief following each appointment.
- PSP to record changes made onto EMIS and complete the data collection form.

Step 4

Follow Up at 6 months

- PSP to follow up the outcomes for each patient with the GP at 6 months.
- PSP to complete and submit the final data collection form.
- Data to be analysed and a formal evaluation of the hypertension project to be completed.

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Pharmacist Led Consultation

Initiating the consultation

Gathering information

(using ICEF, TED, golden minute)

Physical assessment

Taking blood pressure and pulse

Explanation and planning

Suitable options for improving blood pressure control, including medication and improvements to lifestyle

Closing the session

Checking patient's understanding

Providing a safety net

Follow up

Based on Calgary- Cambridge consultation framework

Number of Consultations

426 patients

identified for a hypertension review

168 patients were not reviewed

Initial hypertension consultation

253 patients were reviewed

76 patients were not reviewed

Follow up consultation

117 patients were reviewed

60 patients not invited for follow up

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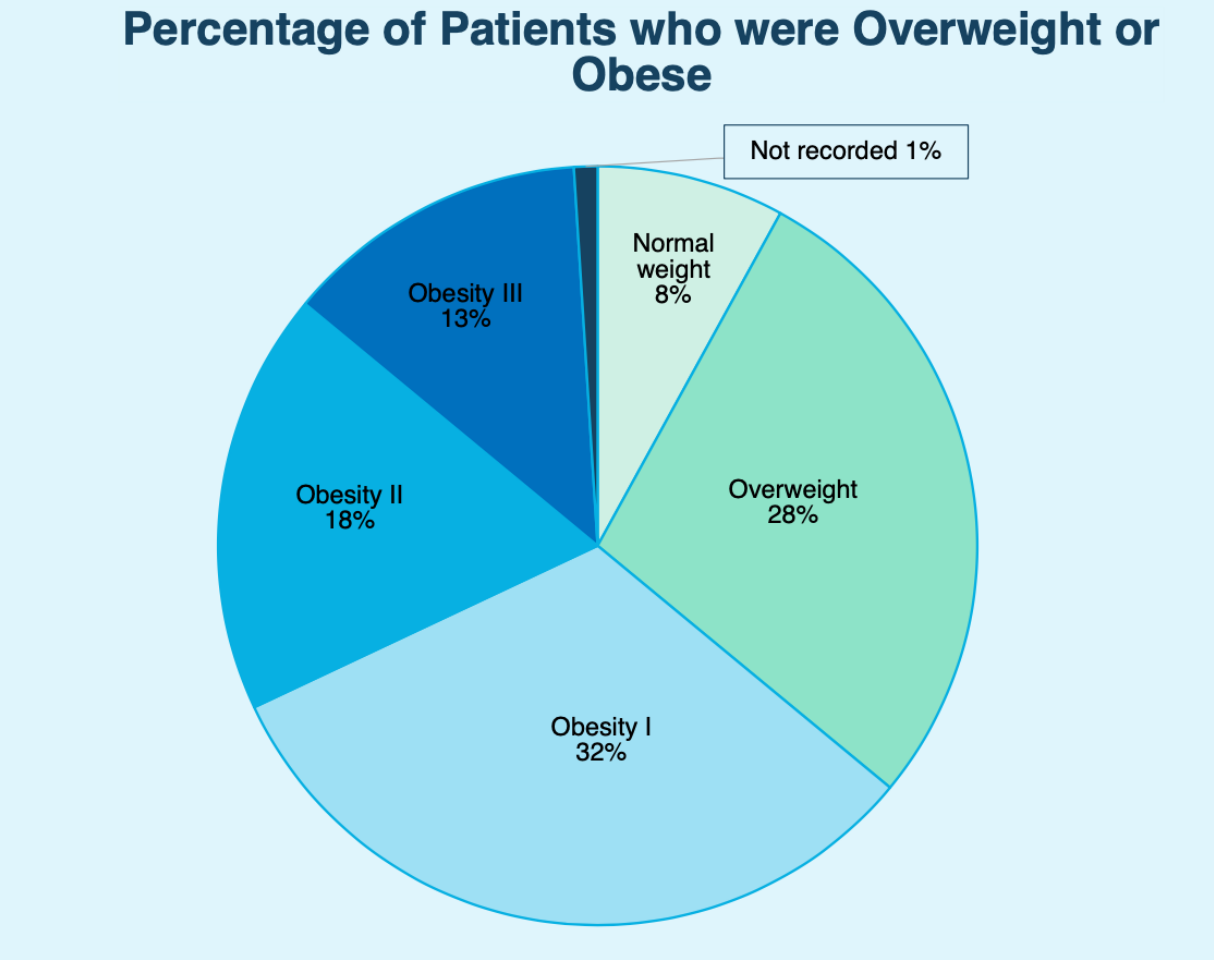
Lifestyle factors



The results showed that **91%** of patients reviewed were either overweight **(28%)** or obese **(63%).**

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Adherence to antihypertensives

Level of adherence to antihypertensive medication	Number of Patients
Patient takes medication as prescribed	132 (52%)
Patient takes antihypertensive most of the time	34 (13%)
Patient takes antihypertensive some of the time	37 (15%)
Patients has stopped one or more antihypertensives	41 (16%)
Patient not taking medication at the correct dose/frequency	9 (4%)
Total	253

Results

117 patients were reviewed for an initial and follow up consultation.

The change in blood pressure was recorded for 114 patients:

- **66 (56.4%)** patients had a **reduction** in systolic blood pressure
- **44 (37.6%)** patients had an **increase** in systolic blood pressure
- **4 (3.4%)** patients had **no change** in systolic blood pressure

Reduction in systolic bp

Reduction in Systolic Blood Pressure	Number of Patients
1-10 mmHg	26
11-20 mmHg	11
21-30 mmHg	16
31-40 mmHg	7
41-50 mmHg	4
51-60 mmHg	1
121- 130 mmHg	1
Total	**66**

Reduction in systolic and diastolic bp

Stage of hypertension at initial consultation	Stage of hypertension at follow up consultation	No. Patients
Stages 3	Stage 3	1
	Stage 2	2
	Stage 1	1
	<140/90mmHg	1
Stage 2	Stage 2	2
	Stage 1	5
	<140/90mmHg	14
Stage 1	Stage 1	4
	<140/90mmHg	18
<140/90mmHg	<140/90mmHg	8
	Total	**56**

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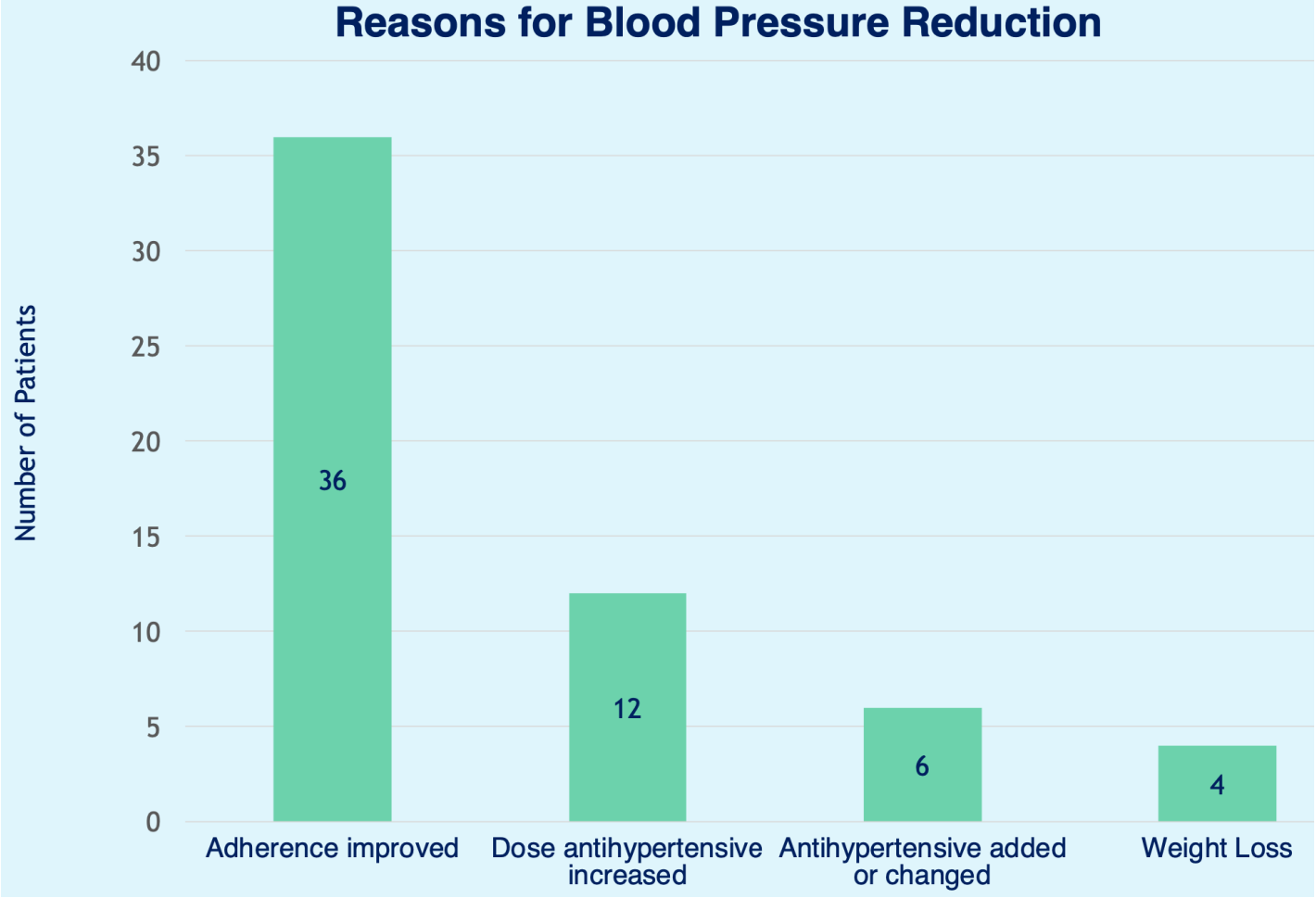
Reasons for reduction in bp



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Increase in systolic blood pressure

Level of adherence to antihypertensive medication	Number of Patients
1-10 mmHg	24
11-20 mmHg	12
21-30 mmHg	5
41-50 mmHg	1
51-60 mmHg	2
Total	**44**

Increase in systolic blood pressure

Reason for increase in systolic blood pressure	Number of Patients
Adherence remains poor	**13 (54%)**
Patient does not want to increase the dose or add any antihypertensive medicines	3 (12.5%)
Inaccurate reading as patients rushed to clinic or felt anxious	2 (8.3%)
PSP recommendation to initiate calcium channel blocker not actioned	2 (4.2%)
Patient referred by PSP to GP due to low pulse and feeling dizzy (diagnosed with heart block)	1 (4.2%)
Complex patient (Cushing's Syndrome)	1(4.2%)
Could not afford medicines	1 (4.2%)
Difficulty communicating with patient	1 (4.2%)
Total	**24**

Recommendations

- Evaluate the impact of including **regular adherence checks** in hypertension clinic consultations run by practice pharmacists and other healthcare professionals.

- Involve community pharmacists to work with practices to support adherence checks.

- Undertake another hypertension review project to include all patient groups with uncontrolled blood pressure.

- Undertake a qualitative patient survey to gain an insight into the patient's perspective about their condition, treatment and value of the consultation.

- Trial group consultations for hypertensive patients with uncontrolled blood pressure who are resistant to taking medication. This approach could be used to target adherence and help to motivate patients to lose weight, eat healthily, reduce alcohol consumption and promote smoking cessation.

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Pharmacist Led Hypertension Review Project in Black (African or African-Caribbean origin) Patients

Rita Shah, Sagal Hashi, Dr Chris Carvalho
City and Hackney CCG

Introduction

Black people (African or African-Caribbean origin) have a much higher prevalence of hypertension and subsequent cardiovascular disease, stroke, renal failure and dementia and therefore the potential risks associated with uncontrolled blood pressure are greater for this patient group.[1]

Data from the Queen Mary's University Clinical Effectiveness Group shows that blood pressure is well recorded across the population in City and Hackney. However the data shows that 5% of black patients have an uncontrolled blood pressure of >150/90mmHg compared to 2.5% of non-black patients. In addition 6.7% of black patients have either a systolic blood pressure of >150 mmHg or a diastolic of >90 mmHg compared to 5.4% in the non-black population. Black populations also appear to have uncontrolled blood pressure and/or abnormal blood pressures at an earlier age.[1,2]

Aim of Project

To review and improve blood pressure in black patients (African or African-Caribbean origin) with uncontrolled hypertension (>140/90 mmHg) by optimising treatment, identifying reasons for non-adherence to antihypertensive medication and providing lifestyle advice through pharmacist led hypertension clinics.

Objectives

1. Review antihypertensive medication according to NICE guidelines.
2. Provide advice on lifestyle and nutrition.
3. Understand reasons for poor adherence to antihypertensive medication and optimise treatment.

Methodology

Practice Supports Pharmacists (PSPs) who work in general practice, but who are not normally patient facing, were tasked with setting up hypertension clinics to review Black (African or African-Caribbean origin) patients with uncontrolled blood pressure in practices within City and Hackney CCG. The PSPs attended a one day training session delivered by a consultant cardiovascular pharmacist. PSPs then searched GP records for patients using the specified criteria outlined in the project protocol and sent out a letter inviting them to an initial hypertension clinic. Patients were then followed up in clinic 1-3 months later. Outcomes were recorded on a data collection form, which was piloted prior to the rollout of the review clinics.

Results

PSPs reviewed 253 patients across 39 GP practices for the initial hypertension review.

Objective 1: Review antihypertensive medication according to NICE guidelines.
135 (53%) patients were on treatment according to NICE adult hypertension clinical guidelines. However, this does not take account of patients who could not tolerate first, second or third line therapy and therefore is an underestimation of prescribing in line with NICE guidance.

Objective 2: Provide advice on lifestyle and nutrition
PSPs asked all patients about their lifestyle, including diet, levels of exercise, alcohol consumption and smoking status. Weight and BMI were also measured during the initial consultation.

Percentage of Patients who were Overweight or Obese

The results showed that 91% of patients reviewed were either overweight (28%) or obese (63%).

Objective 3: Understand reasons for poor adherence to antihypertensive medication and optimise treatment
Of the 253 patients seen in clinic, PSPs identified that 121(48%) were not taking their medication as prescribed. The main reasons identified were:
- 10% of patients do not believe that their medication works to treat their hypertension
- 10% of patients forget to take their medication as prescribed and
- 6% of patients forgot to order an adequate supply of their medicines

PSPs used the Calgary-Cambridge model to undertake their consultation, identifying the reasons for non-adherence and discussing options with the patient to help them to improve their blood pressure control.

Results

Of the **253** patients seen for an initial consultation, **136** patients were not reviewed mainly due to patients not attending consultations, cancelling appointments or because follow up was not required as the patient's blood pressure during the first consultation was in the normal range.

Of the **117** patients who were followed up, blood pressure could not be accurately measured in 3 patients and the change in systolic blood pressure was as follows for the remaining **114** patients:
- No change in systolic blood pressure in **4** (4%) patients
- A reduction in systolic blood pressure in **66** (58%) patients
- An increase in systolic blood pressure in **44** (38%) patients

The table below shows the extent of reduction in systolic blood pressure of the 66 patients.

Reduction in Systolic Blood Pressure	No. of Patients
1-10 mmHg	28
11-20 mmHg	11
21-30 mmHg	15
31-40 mmHg	7
41-50 mmHg	4
51-60 mmHg	1
121-130 mmHg	1
Total	66

Reasons for Blood Pressure Reduction

PSPs documented potential reasons for any changes in blood pressure recorded between the initial and follow up consultations for 58 of the 66 patients. The bar chart below shows the main reasons identified by PSPs which could explain the reduction in systolic blood pressure observed.

Reasons for Blood Pressure Reduction

Conclusion

The hypertension review project has demonstrated that using pharmacist led consultations to review hypertensive patients can lead to an improvement in systolic blood pressure control. One of the main reasons leading to a reduction in systolic pressure was an improvement in adherence to antihypertensive medication. Pharmacists discussed adherence with each patient, identifying reasons why patients were not taking their medicines as prescribed and discussed the importance of blood pressure control on health outcomes. The second reason leading to a reduction in systolic pressure was due to PSPs reviewing and making changes to the patient's antihypertensive medication by uptitrating the dose or adding in or switching to another agent.

Systolic blood pressure was shown to have increased in 44 patients. 20 of these patients had a blood pressure that was still in the normal range (<140/90mmHg). Of the remaining 24 patients, 13 were still not adhering to their medication and 3 resisted making any further changes to their medication. There were multiple reasons for non-adherence including patients forgetting to take their medicines e.g. due to irregular patterns of work and patients not believing that their medicines were working and therefore not feeling motivated to take them. This data highlights the importance of regular discussions on adherence during hypertension clinics and the benefit that a pharmacist can bring in improving adherence to medication. Further work should be undertaken to evaluate the impact of regular adherence checks on blood pressure control.

References

1. NICE NG136; Hypertension in adults: diagnosis and management; August 2019
2. City and Hackney Clinical Effectiveness Group data

Thank you

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Questions

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Close

Official Launch on the 3rd June for Asthma and COPD

Next to follow will be Diabetes, Hypertension and Heart Failure - Launch date TBC

Future event: Community of Practice June 2020

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Thank you

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