HIN 2023 CVD Fellowship Quality Improvement Workshop Welcome!

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Health Innovation Network South London

Welcome, Housekeeping and Aims of the day

Housekeeping

Table allocation

Aims of the day

- Learn a range of quality improvement methodologies, to be used as part of your CVD projects and beyond
- Network and meet primary care colleagues from primary care across south London

Agenda

Time	Item
9:30 – 9.45	**Arrival and Registration**
9.45 – 10.00	**Welcome** - Introduction and outline of the day
10.00 – 10.30	**Liberating structure** - Getting to know each other
10.30 – 11.15	**Data and defining a problem statement** - Intro to QI & your projects - Problem statements and sources of data
11.15 – 11.30	**Break**
11.30 – 12.30	**Developing an aim** - Identify a target group and writing a SMART aim - Process mapping / journey mapping
12.30 – 1.15	**Lunch**
1.15 - 2.30	**Developing a plan** - PDSA game - Stakeholder mapping - Planning your project
2.30 – 2.45	**Break**
2.45 – 3.25	**Measuring and tracking your project** - Process vs outcome measures - What a run chart / statistical process control chart is
3.25 – 3.50	**Paired feedback** - Present to another table
3.50 – 4.00	**Next steps and close**

The QI training is supported via a Daiichi-Sankyo grant

Meet other Fellows

Mad Hatters Tea Party *Etiquette*

1) You’re going to be given a sentence
2) Finish each of the sentences with one a short phrase
3) Stay curious, dig deep
4) Don’t over think - it’s quick fire
5) There are no right or wrongs!
6) Switch roles 1 ding
7) Find someone new at 2 dings

90 seconds each…

If I had an extra 5 hours a week, I would…?

90 seconds each…

I have chosen the clinical area for my project because…?

90 seconds each…

My favourite thing about the area of south London I work in is…?

1, 2, 4, all

- Reflect individually
- Discuss in a pair (2 mins)
- Discuss in a group of four (4 mins)
- All discuss common themes as a group

1, 2, 4, all

What I'm hoping to get out of the Fellowship is...?

What is quality improvement?

What is quality improvement?

Yale – 8 Steps of Strategic Problem Solving

1. Define the problem
2. Set a SMART objective
3. Conduct a Root Cause Analysis

4. Develop Alternative strategies
5. Compare possible strategies
6. ….. And select one!

7. Create an implementation plan
8. Create an evaluation plan

Develop a shared understanding of the problem

Move systematically toward a solution

Execute

What is quality improvement?

Or simplified even further:

- Identifying an issue
- Understanding the problem through reviewing data
- Developing a “theory of change” – developing ideas for solution
- Implementing your solution –measuring and adjusting your solution as you go

HIN South London - CVD Prevention Fellowship Project Form

Speeding up the best in health and care, together

Identifying your issue

Understanding your issue

Developing your solution

Measuring and adjusting your solution

Evaluation and reflection

Clinical area
AF, hypertension, cholesterol, CKD, Heart Failure

Problem statement
What are you trying to address

Target group
Who is your specific population for this project (e.g. from UCLP searches)

Baseline data
What will you be using to measure your project / what your starting data is

SMART aim
Specific, measurable, achievable, realistic, timely

Stakeholder mapping think about who else needs to be involved in your project

Who	Why	How	When

Plan
What is the best way to deliver the change? What will you do to deliver this project? When will you do these?

Progress of the Project

Time period	Metric:	Reflections and actions
Month 1		
Month 2		
Month 3		
Month 4		
Final		

Learnings from the project – Challenges / barriers faced
What was difficult and how did you try to overcome this?

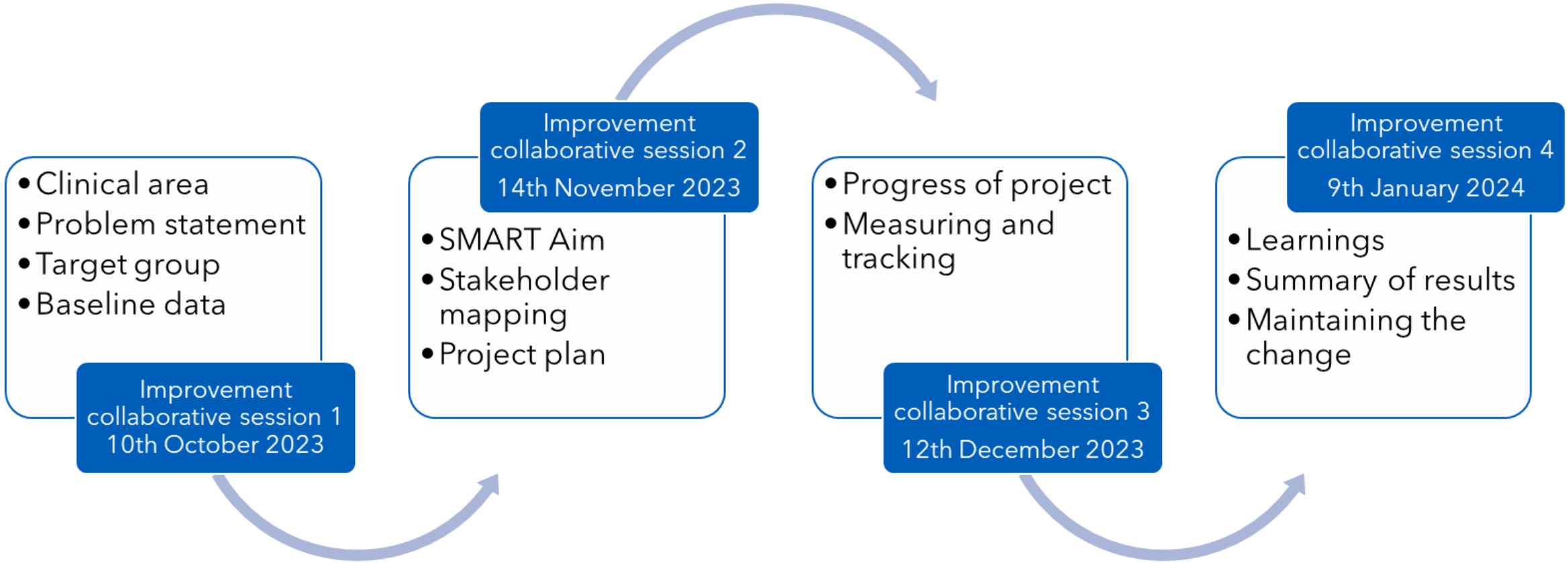
Learnings from the project - Successes
What worked well and why?

Summary of the results
What happened because of the project – both the data and other changes

How will the change be sustained

Patient or stakeholder story or feedback
Please share a story of the impact on patients, and / or share any feedback you received from patients or stakeholders

Improvement Collaborative Sessions



Defining your problem

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Preparation

Implementation

Review

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Defining your problem

Where do you start?

What does a good problem statement look like?

- Focuses on one problem
- Based on facts / data
- Does not include suggested solutions
- Concise and clear language

Example: We have a large number of patients aged 18 and over with GP recorded hypertension, who have not had a blood pressure reading within the preceding 12 months

How do you define your problem?

- Look at data!
  - We have lots in healthcare!
  - Think about qualitative and quantitative sources?

- Then there are techniques you can use to break that down further – root cause analysis to understand what is driving the problems
  - Fishbone diagrams
  - 5 whys
  - Process and journey mapping

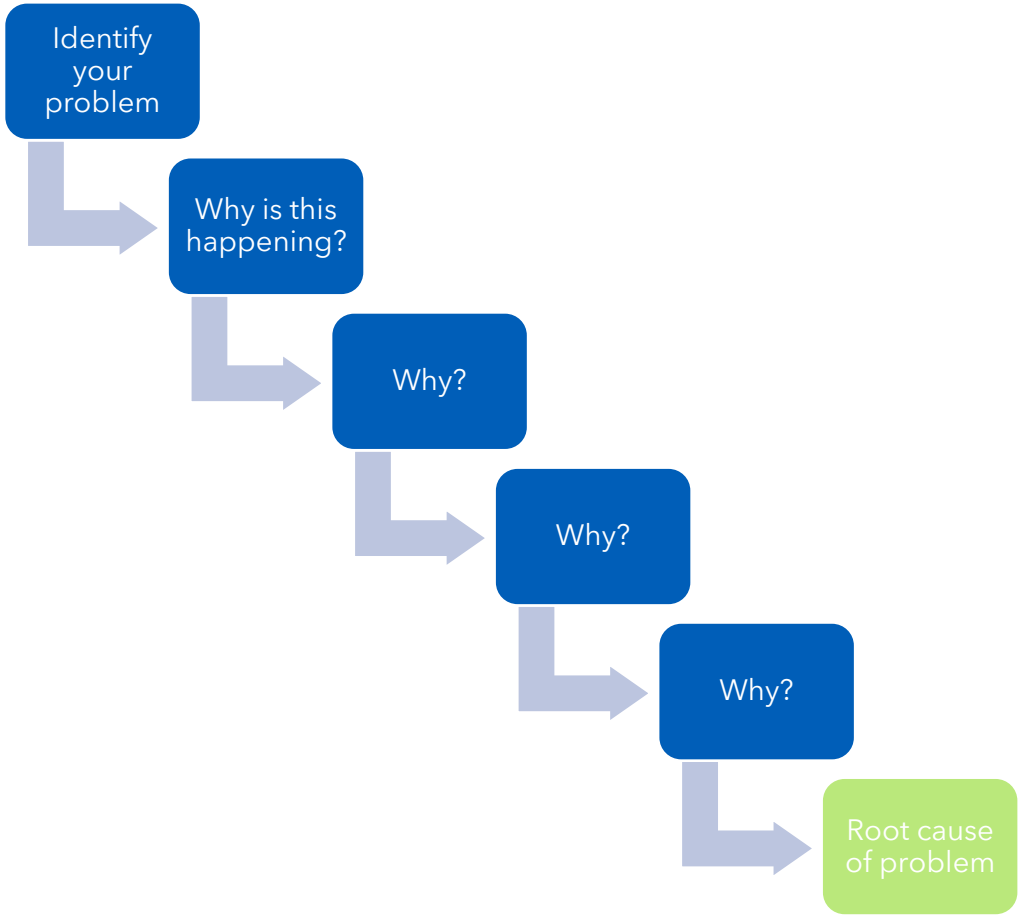
- These root cause analysis techniques can help you take your problem statement and start developing a clear aim and think about potential solutions

Data to help you understand your problem

- HIN Fellowship Data Dashboard
- CVD Prevent
- QOF data
- UCLP searches
- Eclipse data (primarily SWL practices)
- Other searches
- Other local dashboards – ie Hypertension Dashboard for SEL
- Searches available locally ie your practice or PCN may have some
- Feedback from patients & colleagues

A very brief look at root cause analysis techniques…

5 Whys?

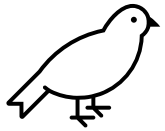

Identify your problem
Why is this happening?
Why?
Why?
Why?
Root cause of problem

The Jefferson Memorial example

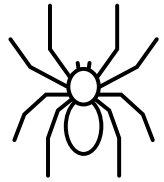
5 Whys?

Identify your problem

Why is this happening?

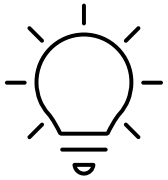


Why?



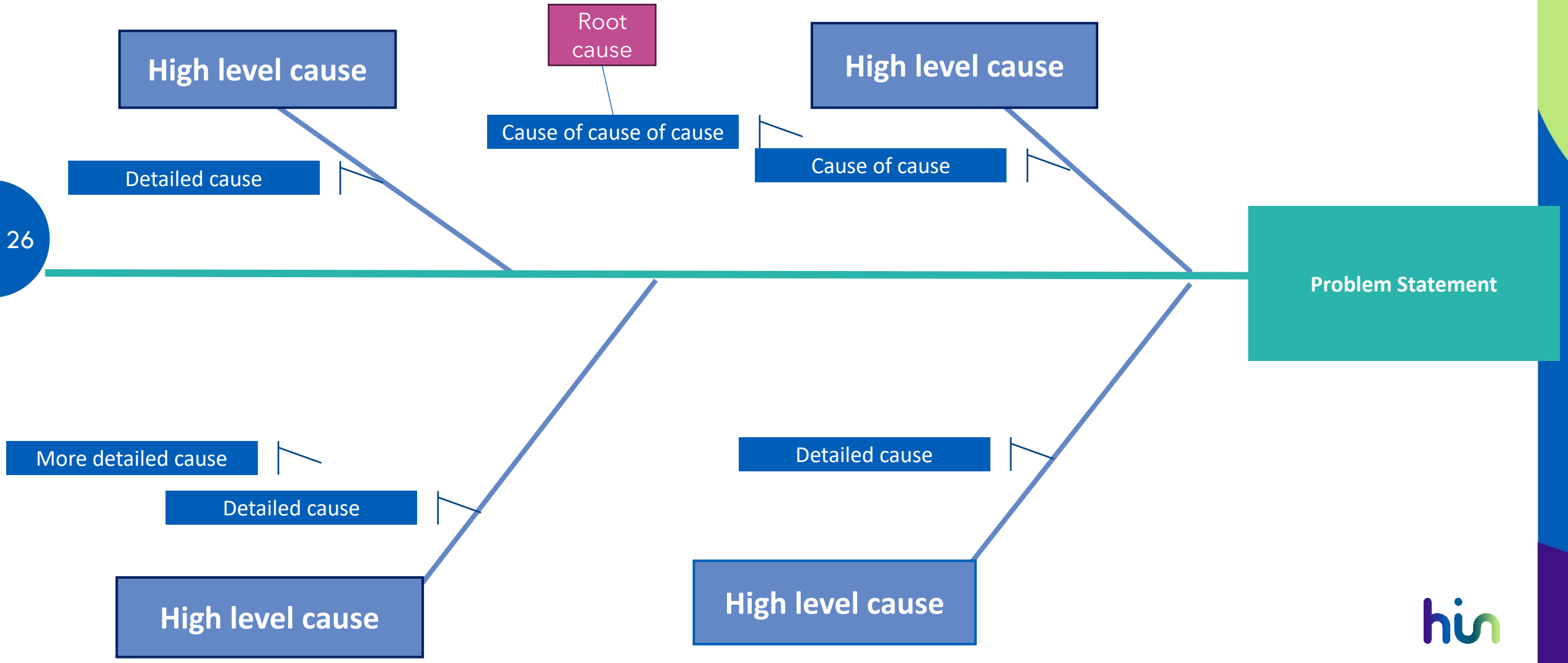
Why?

Why?



Root cause of problem

Fishbone Diagrams



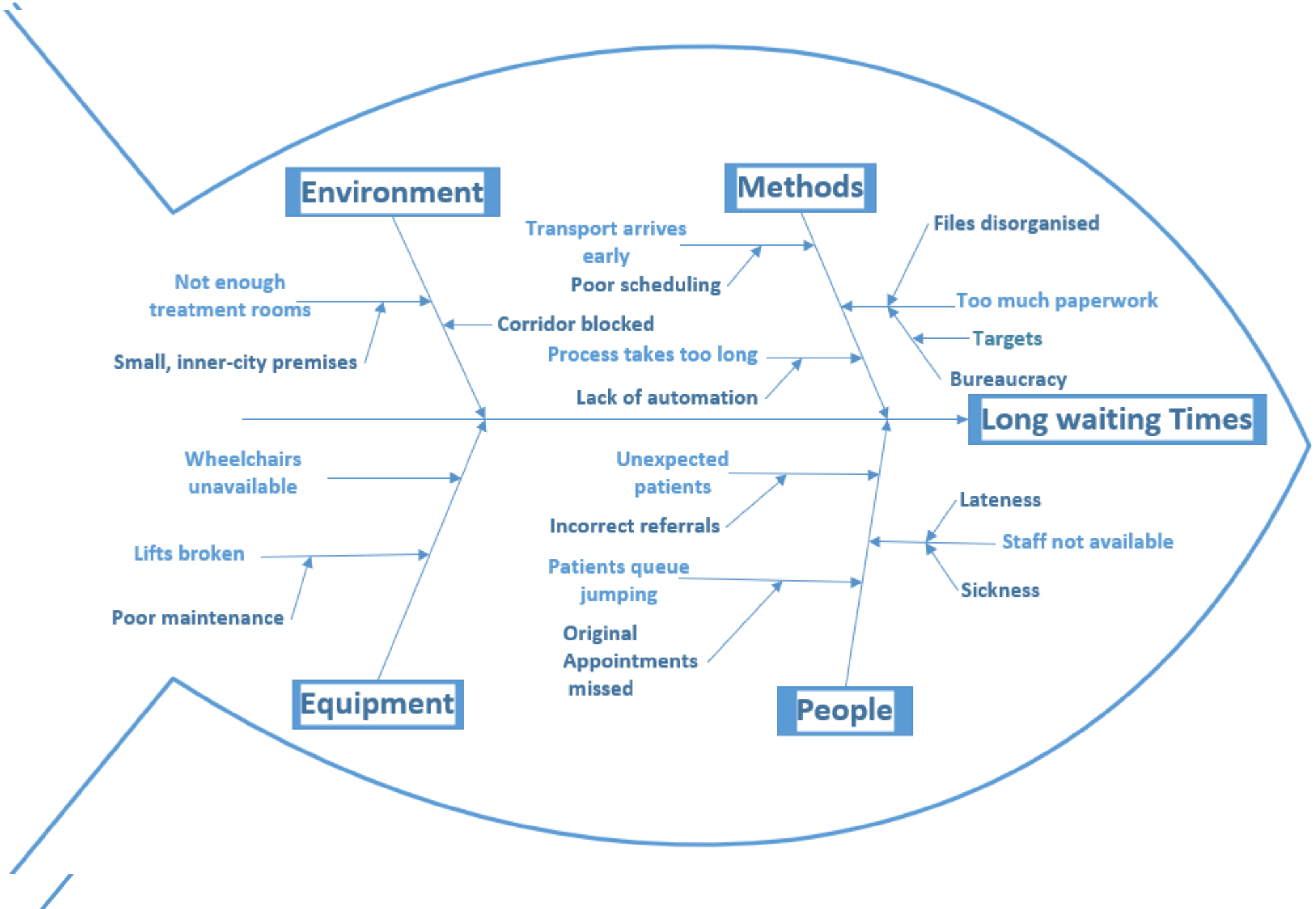

Environment
Methods
Equipment
People
Long waiting Times
Not enough treatment rooms
Small, inner-city premises
Corridor blocked
Wheelchairs unavailable
Lifts broken
Poor maintenance
Transport arrives early
Poor scheduling
Process takes too long
Lack of automation
Unexpected patients
Incorrect referrals
Patients queue jumping
Original Appointments missed
Files disorganised
Too much paperwork
Targets
Bureaucracy
Lateness
Staff not available
Sickness

Table exercise – Problem Statement

- Look at the data on your table
- For your clinical area think about what are the "problems" you may wish to fix
- Develop a problem statement for your sample project

- If time - think about why that may be happening (using 5 whys or fishbone)

Problem statement
What are you trying to address

Break (15min) -
Talk to three people you haven't yet met
(and enjoy tea & coffee)

Identifying baseline data and target group
Developing your SMART aim

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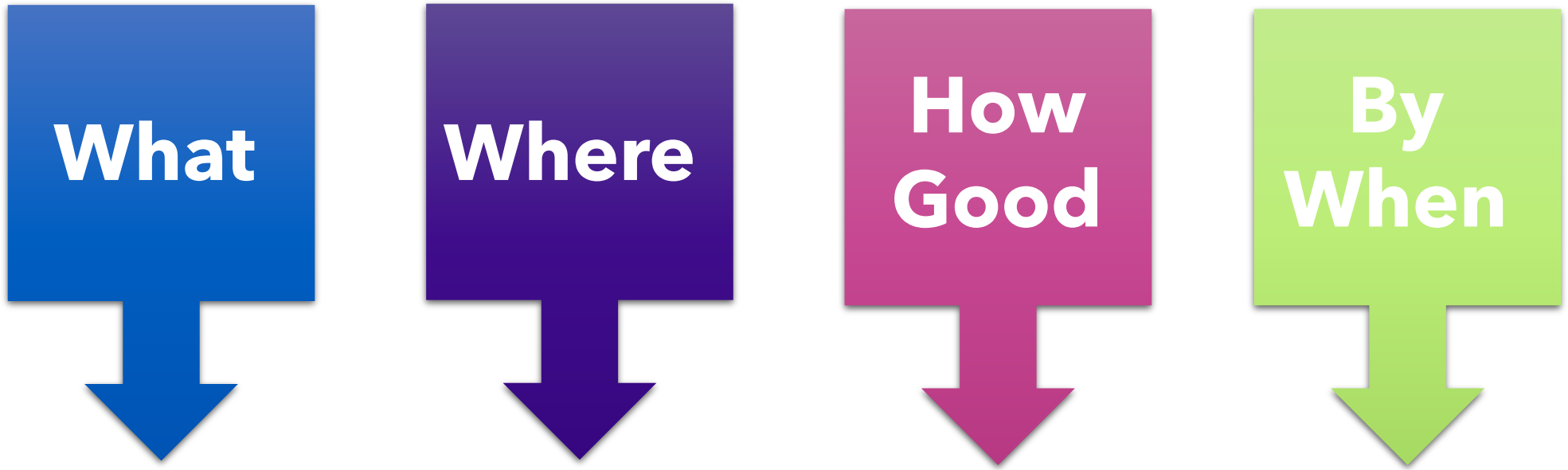
- **Problem statement**
  - We have a large number of patients aged 18 and over with GP recorded hypertension, who have not had a blood pressure reading within the preceding 12 months
- **Target group**
  - People over 18 on hypertension register who have not had a BP reading within the preceding 12 months
- **Baseline data**
  - We have 500 people on our hypertension register who have not had a blood pressure reading within the preceding 12 months

SMART

Specific	Measureable	Achievable	Relevant	Time-bound
Be specific about what you want to improve	Include a measurement that will evidence improvement	Set a realistic target, make sure it is achievable	Link your aim to the trust's strategic aims	Include a timeframe for your project

Setting a SMART aim for your project



What	Where	How Good	By When
Reduce the number of patients on the hypertension register w/o a BP reading in the last 12 months	at Springland Practice	by 10% (Or by 50 patients)	by January 2024

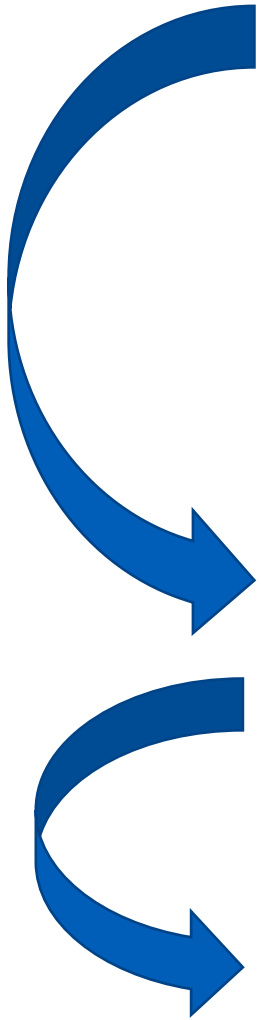
Table excercise – SMART AIM

- In your groups, identify the baseline data & target group for your sample project
- Set a SMART aim for your sample project - WHAT, WHERE, HOW GOOD, BY WHEN

Target group
Who is your specific population for this project (e.g. from UCLP searches)
Baseline data
What will you be using to measure your project / what your starting data is
SMART aim
Specific, measurable, achievable, realistic, timely

Process Maps & User Journeys - a useful tool

Process Maps & User Journeys



Help you to look at a process and identify –

- What happens at the moment?
- What do we know? What don't we know?
- Who is involved at each stage?
- How do people experience each stage?
- How well does it work? Where are the opportunities for improvement?

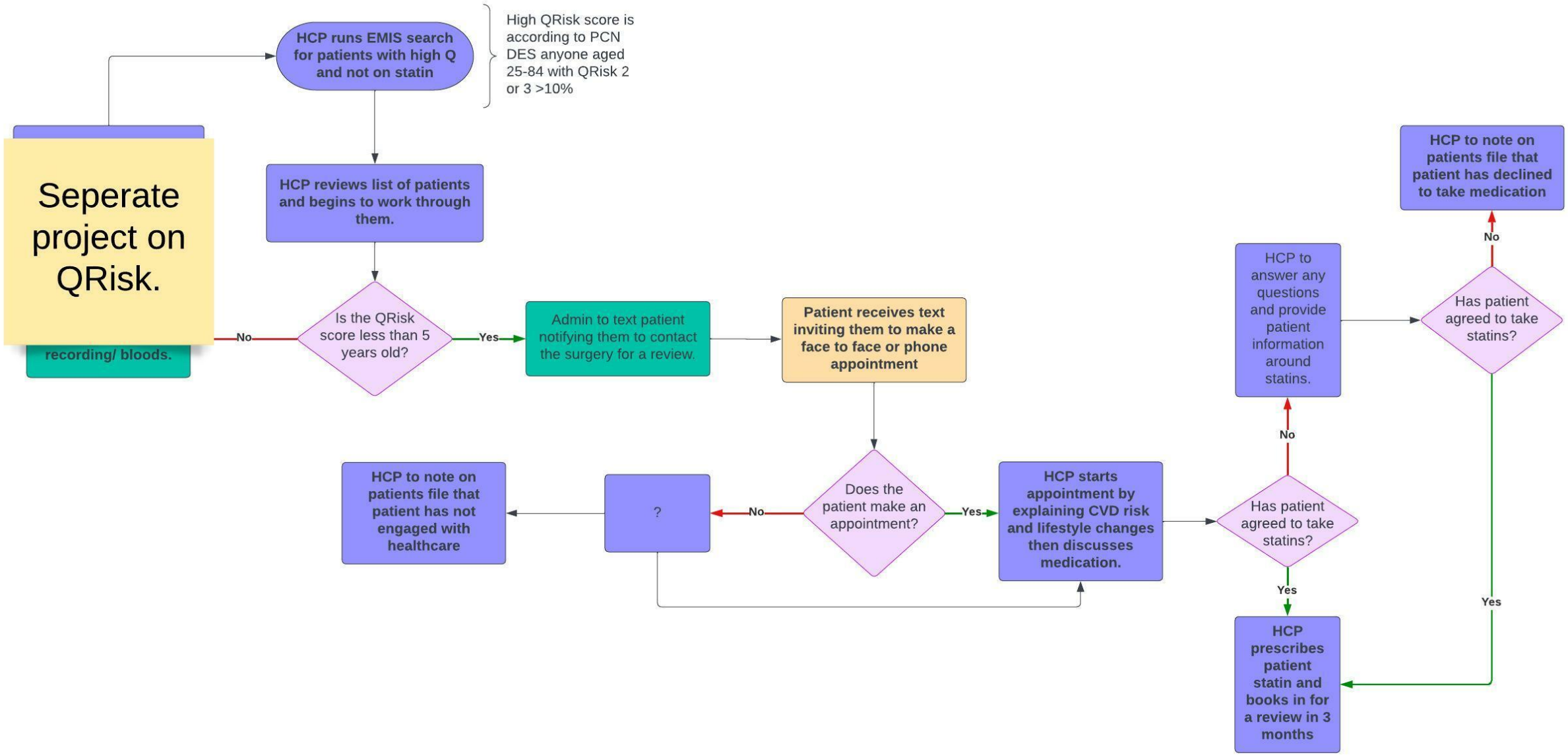
- What do you want to / need to change? What impact do you hope that will have?
- What will those changes look like? – Planning stage

- Try this out – PDSA Cycle

To note…

These are helpful tools but not something you have to do

Process Map


HCP runs EMIS search for patients with high Q and not on statin
High QRisk score is according to PCN DES anyone aged 25-84 with QRisk 2 or 3 >10%
HCP reviews list of patients and begins to work through them.
Seperate project on QRisk.
recording/ bloods.
Is the QRisk score less than 5 years old?
No
Yes
Admin to text patient notifying them to contact the surgery for a review.
Patient receives text inviting them to make a face to face or phone appointment
Does the patient make an appointment?
No
Yes
?
HCP to note on patients file that patient has not engaged with healthcare
HCP starts appointment by explaining CVD risk and lifestyle changes then discusses medication.
Has patient agreed to take statins?
No
Yes
HCP to answer any questions and provide patient information around statins.
Has patient agreed to take statins?
No
Yes
HCP to note on patients file that patient has declined to take medication
HCP prescribes patient statin and books in for a review in 3 months

Persona for User Journeys

Who?

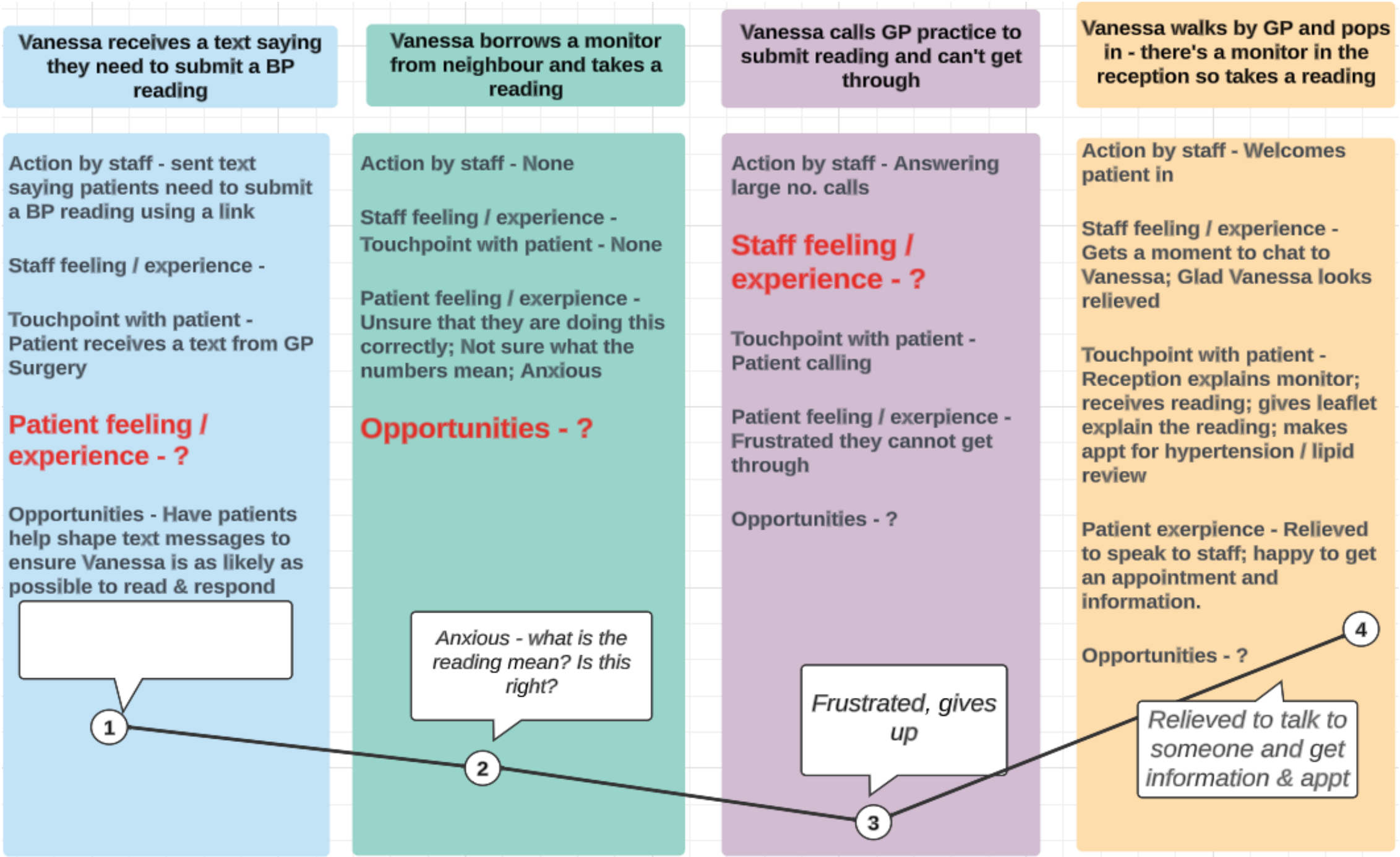
Vanessa, 50 years old, female, lives in Southwark.

Works full time as a designer, often working overtime.

Enjoys cooking, socialising, & plants. Is always very busy, struggles to find time to exercise.

Dx with high blood pressure & high cholesterol 3 years ago. Worried about what she's heard about the medications so has avoided them. Hasn't taken her blood pressure in a long time as very anxious it'll be too high.

Not very digitally literate.



Vanessa receives a text saying they need to submit a BP reading

Action by staff - sent text saying patients need to submit a BP reading using a link

Staff feeling / experience -

Touchpoint with patient - Patient receives a text from GP Surgery

Patient feeling / experience - ?

Opportunities - Have patients help shape text messages to ensure Vanessa is as likely as possible to read & respond

1

Vanessa borrows a monitor from neighbour and takes a reading

Action by staff - None

Staff feeling / experience - Touchpoint with patient - None

Patient feeling / exerpience - Unsure that they are doing this correctly; Not sure what the numbers mean; Anxious

Opportunities - ?

Anxious - what is the reading mean? Is this right?

2

Vanessa calls GP practice to submit reading and can't get through

Action by staff - Answering large no. calls

Staff feeling / experience - ?

Touchpoint with patient - Patient calling

Patient feeling / exerpience - Frustrated they cannot get through

Opportunities - ?

Frustrated, gives up

3

Vanessa walks by GP and pops in - there's a monitor in the reception so takes a reading

Action by staff - Welcomes patient in

Staff feeling / experience - Gets a moment to chat to Vanessa; Glad Vanessa looks relieved

Touchpoint with patient - Reception explains monitor; receives reading; gives leaflet explain the reading; makes appt for hypertension / lipid review

Patient exerpience - Relieved to speak to staff; happy to get an appointment and information.

Opportunities - ?

Relieved to talk to someone and get information & appt

4

LUNCH – ENJOY!

Welcome back

Agenda for the afternoon….

1. PDSA – Trying it in action
2. Stakeholder mapping
3. Planning your project
4. Break (approx. 2.30)
5. Measuring and tracking your project
6. Sharing your projects
7. What next, and Wrap Up

PDSA

- Plan
  - Do
    - Study
      - Act

PDSA

- Get into **new** groups of 6 people - with as many new people as possible
- Introduce yourselves quickly

PDSA

- In 30 seconds come up with a group name
- Write your group name on 1 coloured pieces of paper

Then…

- As a group build ONE paper airplane using the coloured paper – the object is for it to fly as far as possible in a straight line
- You have 3 minutes (no papercuts please…)

PDSA

- Flying time (round 1)!
- One person come forward from each group to fly the plane
- Have everyone in the group record how far and how straight the plane flew (score 1 – 5)

PDSA

- As a group – What worked well? What didn't? How can you improve your plane?
- Refine your plane or build a new plane – object is for it to fly further and straighter (you hope...)
- You have 4 minutes in total!

PDSA

- Flying time (round 2)!
- One person come forward from each group to fly the plane
- Have everyone in the group record how far and how straight the plane flew (score 1 – 5)

PDSA

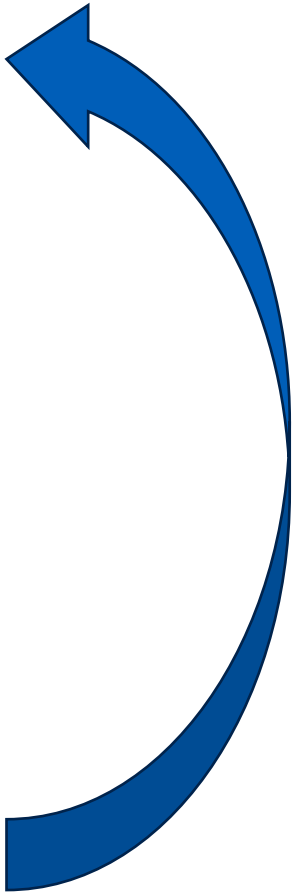
- As a group – What worked well? What didn't? How can you improve your plane?
- Refine your plane or build a new plane – object is for it to fly further and straighter (you hope...)
- You have 4 minutes in total!

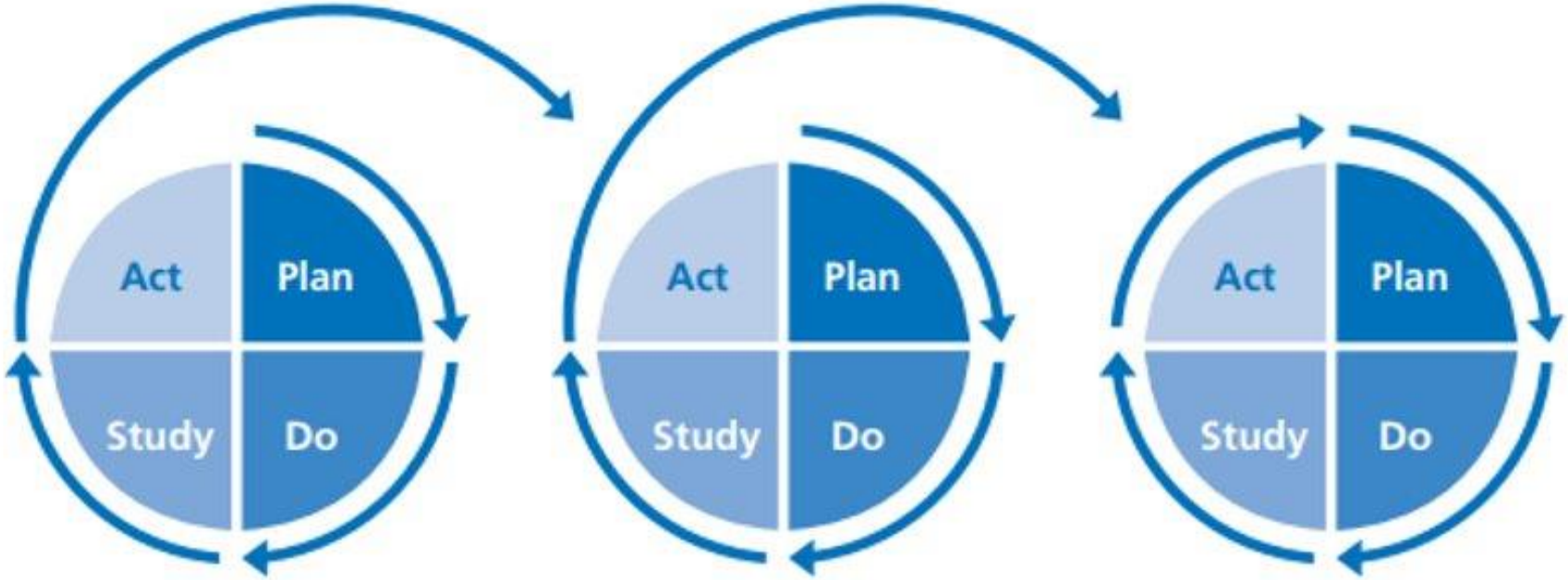
PDSA

- Flying time (round 3)!
- One person come forward from each group to fly the plane
- Have everyone in the group record how far and how straight the plane flew (score 1 – 5)

PDSA

- Plan – Planned what you were going to do
- Do – Built / refined and flew the plane
- Study – Looked at the data and how it compared to previous flights / Observed colleagues / Googled improvements
- Act – Decided what changes were needed to improve





- **Plan – To invite patients to take a reading at home, or use the new BP monitor you've placed in the waiting room**
- **Do - Invite 20 patients to take a reading at home and submit it via text, or come in for a reading**
- **Study - Record how many submit readings and how; Observe no one submitted via text – find out why (discover link didn't work)**
- **Act - Refine text message; Fix texting issue**
- **Repeat PDSA process**

Stakeholder Mapping

(be sure you are back with your project table)

Identifying your issue

Understanding your issue

Developing your solution

Measuring and adjusting your solution

Evaluation and reflection

Clinical area

AF, hypertension, cholesterol, CKD, Heart Failure

Hypertension

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To reduce the number of patients on the hypertension register BP reading in the last 12 months at Springland Practice by 50 patients) by January 2024.

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Who	Why	How	When

Plan

What is the best way to deliver the change? What will you do to deliver this project? When will you do these?

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Stakeholder Mapping For Your Project – The Who

Part of the planning stage

Helps to improve project delivery, gather insights, gain buy in, and manage expectations

- Who is involved already?
- Who else do you need to involve?
- Who is or will be impacted?
- Who could be influential?
- Who else can help you?

Stakeholder Mapping For Your Project

- Is there anyone you think may struggle to engage or support you – whom you need on board?
  - What might be their worries?
  - Other priorities?
  - Obstacles?
  - What are their wants / needs?
  - What would success look like to them?
  - What matters to them?
  - Who influences them?

Photos - **Claudio Caridi**

Table exercise – Stakeholder mapping

As a group – plan out the stakeholders for your project

- Who is involved in the project? Who do you need to involve?
- Who is impacted?
- Who could be influential?
- Why do they need to be involved?
- How will you involve them?
- When will you involve them if you haven't already?

Stakeholder mapping think about who else needs to be involved in your project			
Who	**Why**	**How**	**When**

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...takeholder mapping think about who else needs to be involved in your project

Who	Why	How	When
Clinical Director	Oversees work	Meeting	Next week
All staff	Will need buy in / help	Practice Meeting	27/9
Patient Adv Group	Patient insights	Extra meeting called, plus emails / calls	Start next week; meeting 3/10

Plan

What is the best way to deliver the change? What will you do to deliver this project? When will you do these?

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Planning your project

By this point you have already…

1. Identified what the problem is using data and other evidence (ie staff and patient feedback) to identify this.
2. Gather baseline data ie from searches
3. Identified your target area / group for the project
4. Set a SMART AIM
5. Identified where changes could be made
6. Identified who the stakeholders are, including thinking through who in your practice needs to be

You may have used root cause analysis, processes maps and / or user journeys to understand your problem in more detail

Now time to plan your project

Example project plan

Your plan might look like…

1. Text or call patients in target groups for an up to date BP reading, ie test at home, come in to use the machine in the waiting room, or make appt invite them in – 10 per PDSA cycle (Admin team, Sept – Nov 2023)
2. Update records and coding for patients with up to date test results (???, October 2023)
3. Where needed invite patients in for review – (Clinicians, October – Dec 2023)
4. Compare progress to aim - look at what is working well and what could be further improved. (whole team, monthly)
5. Rerun the cycle with next 10 patients ie change text language, call instead of text, call at a new time of day, suggest Community Pharmacy option (PDSA cycle).

Table activity – plan your sample project

- What will you do at each stage?
- Who will do this?
- When?

Plan
What is the best way to deliver the change? What will you do to deliver this project? When will you do these?

Break time / Cake time!

Measuring and tracking your project

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We have a large number of patients aged 18 and over with GP recorded hypertension, who have not had a blood pressure reading within the preceding 12 months

Target group

Who is your specific population for this project (e.g. from UCLP searches)

People over 18 on hypertension register who have not had a BP reading within the preceding 12 months

Baseline data

What will you be using to measure your project / what your starting data is

We have 500 people on our hypertension register who have not had a blood pressure reading within the preceding 12 months

SMART aim

Specific, measurable, achievable, realistic, timely

To reduce the number of patients on the hypertension register w/o a BP reading in the last 12 months at Springland Practice by 10% (50 patients) by January 2024.

Stakeholder mapping think about who else needs to be involved in your project

	Why	How	When
Clinical Director	Oversees work	Meeting	Next week
All staff	Will need buy in / help	Practice Meeting	27/9
Patient Adv Group	Patient insights	Extra meeting called, plus emails / calls	Start next week; meeting 3/10

Plan

What is the best way to deliver the change? What will you do to deliver this project? When will you do these?

1. Text or call patients in target groups for an up to date BP reading, in test at home, come in to use the machine in the waiting room, or make appt invite them in - 10 per PDSA cycle (Admin team, Sept - Nov 2023)
2. Update records and coding for patients with up to date test results (???, October 2023)
3. Where needed invite patients in for review - (Clinicians, October - Dec 2023)
4. Compare progress to aim - look at what is working well and what could be further improved. (whole team, monthly)
5. Rerun the cycle with next 10 patients in change text language, call instead of text, call at a new time of day, suggest Community Pharmacy option (PDSA cycle).

Progress of the Project

Time period	Metric:	Reflections and actions
Month 1		
Month 2		
Month 3		
Month 4		
Final		

Learnings from the project – Challenges / barriers faced

What was difficult and how did you try to overcome this?

Learnings from the project - Successes

What worked well and why?

Summary of the results

What happened because of the project - both the data and other changes

How will the change be sustained

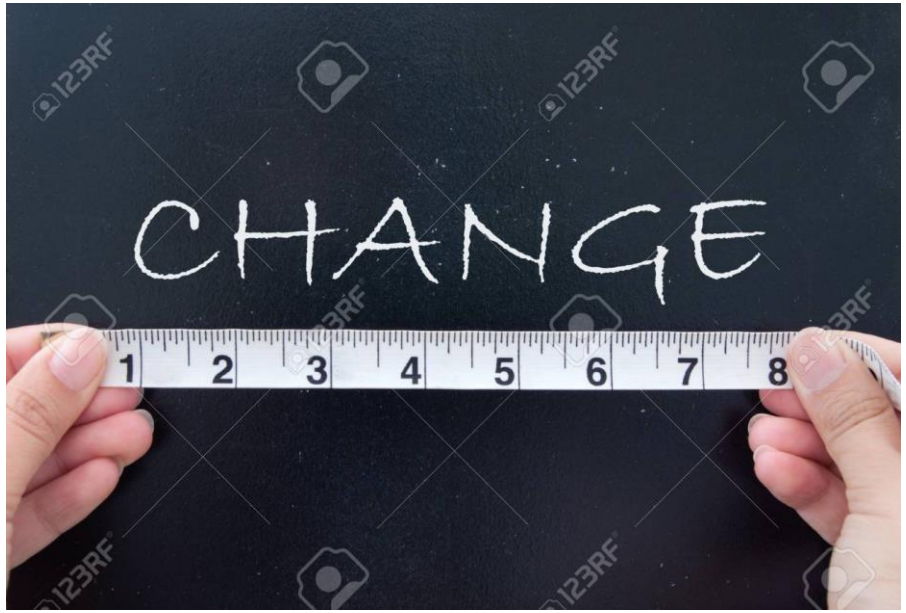
Patient or stakeholder story or feedback

Please share a story of the impact on patients, and / or share any feedback you received from patients or stakeholders

Why measure

All improvement will require change, but not all change will result in improvement

- Ensure there is an improvement
- PDSA – study the impact of the change
  - Decide what works and what doesn't
- Demonstrate improvement
- Share the success



Process Measures

Reflect the way the system and processes work to deliver the outcome

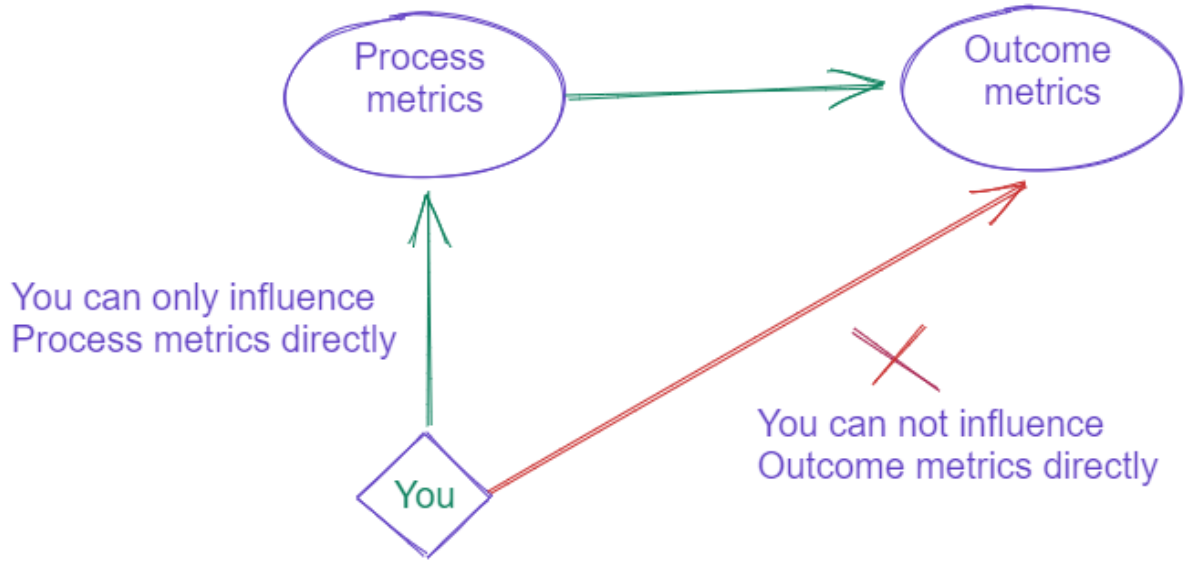
- The number of patients you reviewed
- The number of new prescriptions
- The % increase in appointments

Outcome Measures

Reflect the impact on the patient and show the result of the improvement work

- The number of patients who have a reduction in their blood pressure
- Number of new cases AF found
- The number of patients with a QRisk reduction of >20%

Process Measures Outcome Measures



Balancing measures or counter measures

These are the metrics you can track to ensure an improvement in one area isn't negatively impacting another area

- Is focusing on the highest QRisk patients negatively impacting the middle risk patients?
- Is increasing home blood pressure measurements reducing a group of patients checking their blood sugar level?

Table activity – deciding your measures

- In your groups, identify all the possible process and outcome measures that could be relevant to your project
- Discuss if any are not realistic to measure as part of the project
- Decide on which would best measure success

Barriers to measurement

- Time consuming
- Can be difficult when completed retrospectively
- Association vs causation
- Confounding

Collecting data

Things to consider

- Existing targets
- How you collect the information
- What you track
- How you track it

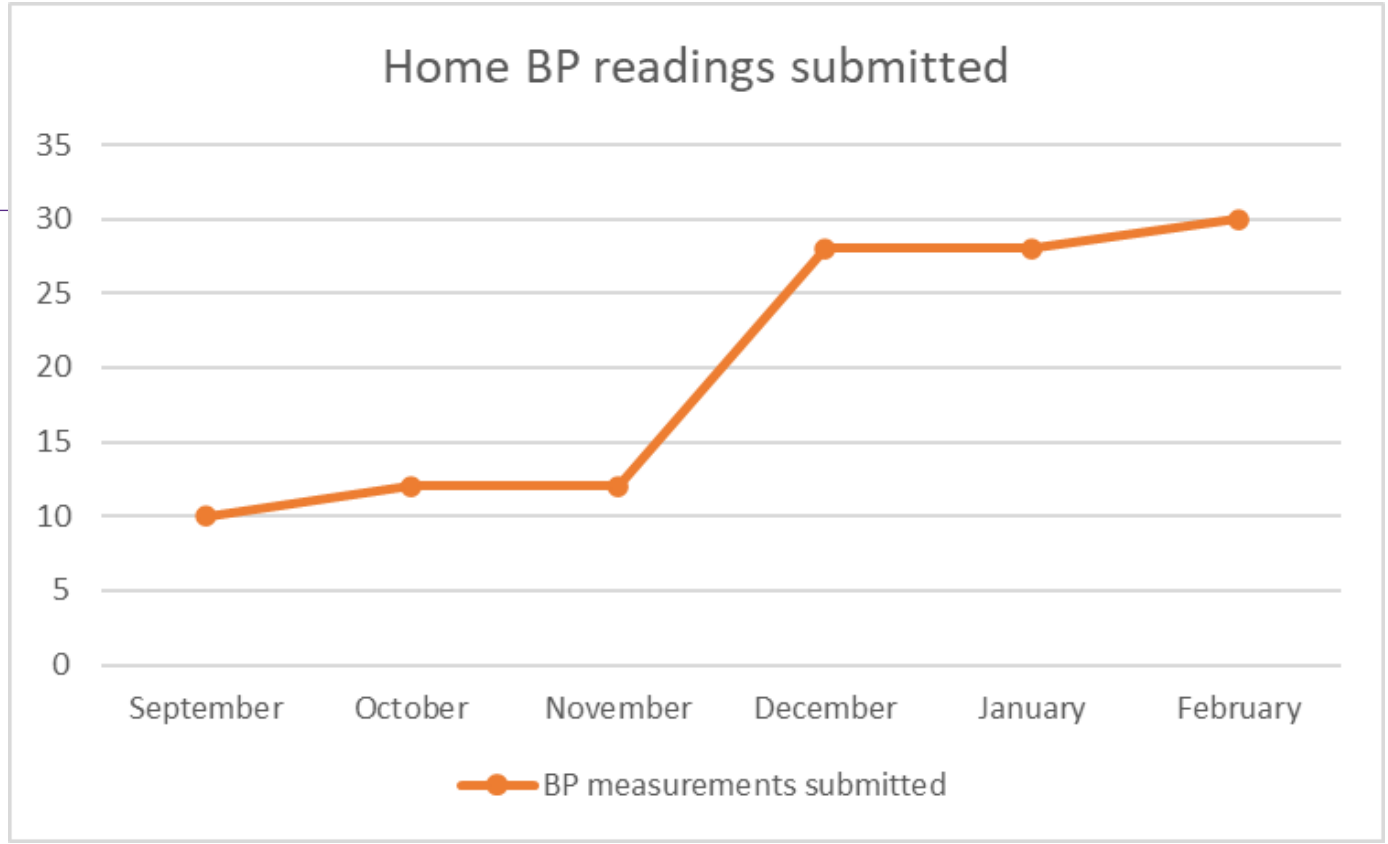
Qualitative feedback

- Gives a patient voice
- Useful in addition to quantitative information to tell a story
- You may use;
  - Surveys
  - Interviews
  - Feedback requests

Patient or stakeholder story or feedback
Please share a story of the impact on patients, and / or share any feedback you received from patients or stakeholders

Simple Run Chart

- The constant will be on the X axis – usually time
- The Y axis is your variable – usually the count



Months	Number of text messages sent	BP measurements submitted
September	0	10
October	15	12
November	15	12
December	40	28
January	30	28
February	30	30

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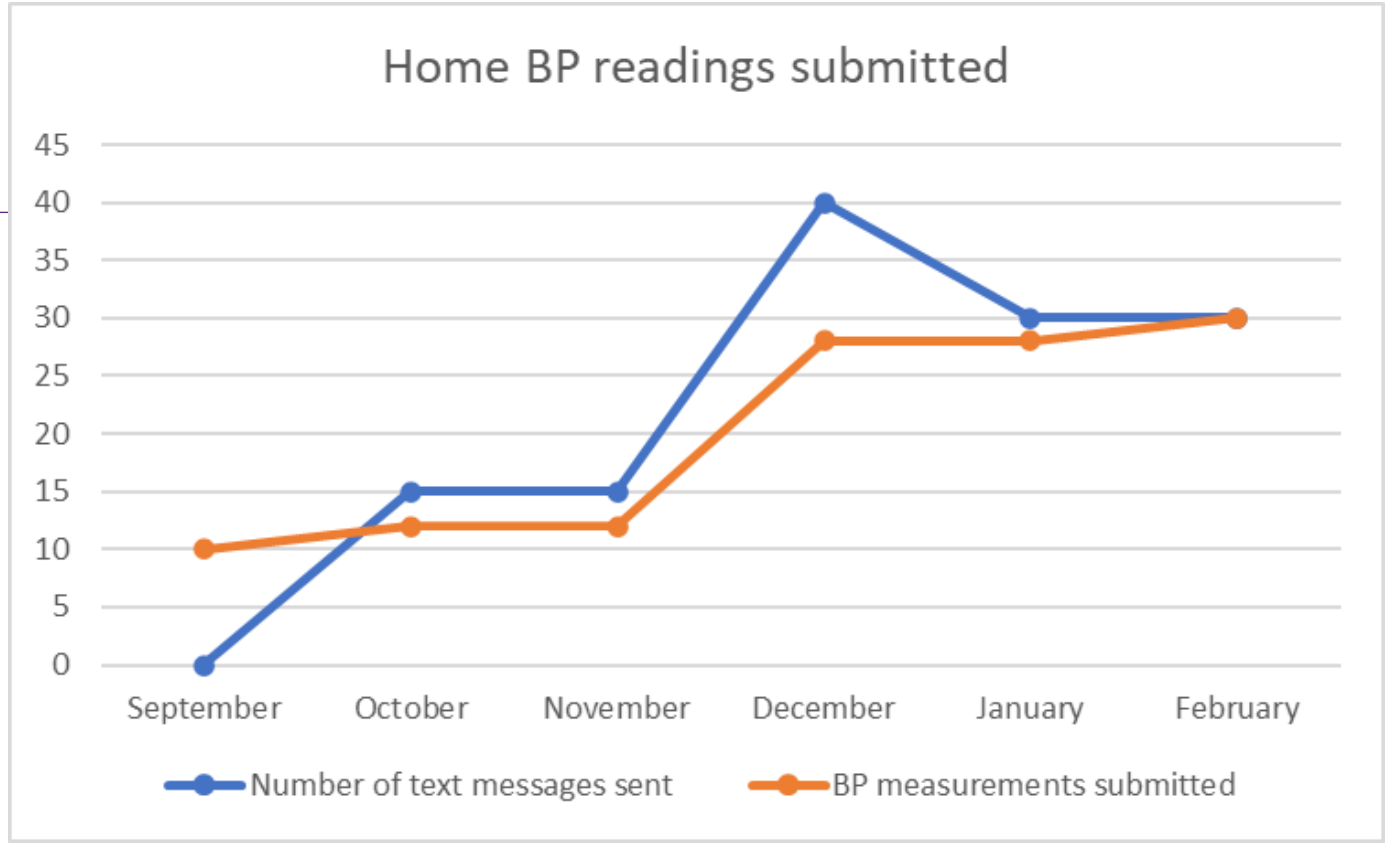

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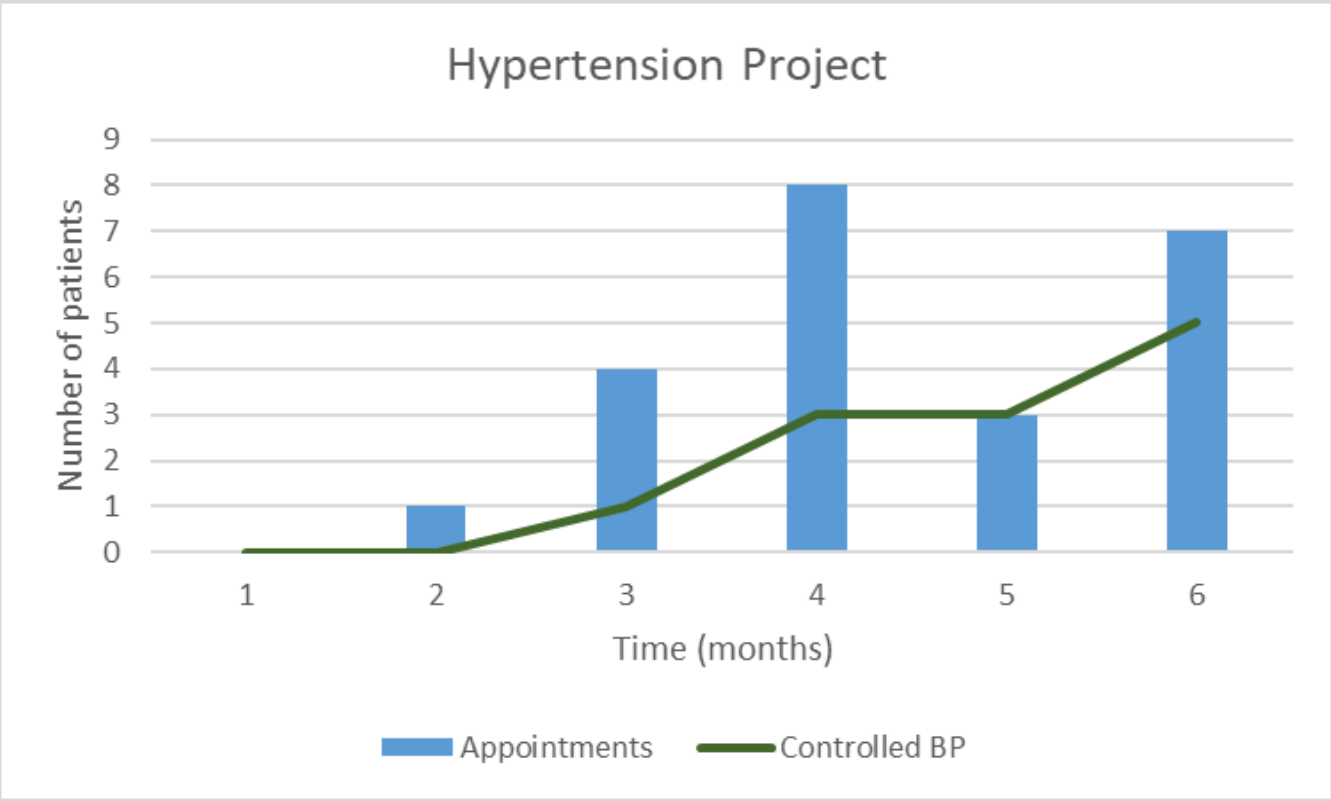
Simple Run Chart

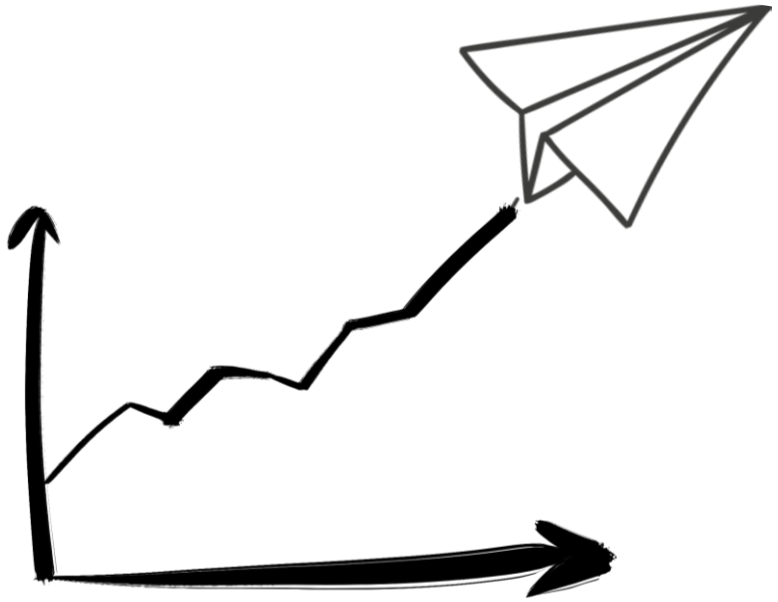
- Process measures shown as a bar graph
- Outcome measure displayed as a line graph



Months	Appointments	Controlled BP
1	0	0
2	1	0
3	4	1
4	8	3
5	3	3
6	7	5

Table activity – creating a run chart

- In your groups use the results of your paper plane PDSA game to create a run chart
- Did your iterations improve or worsen the flight of the paper plane?



Sharing Your Projects

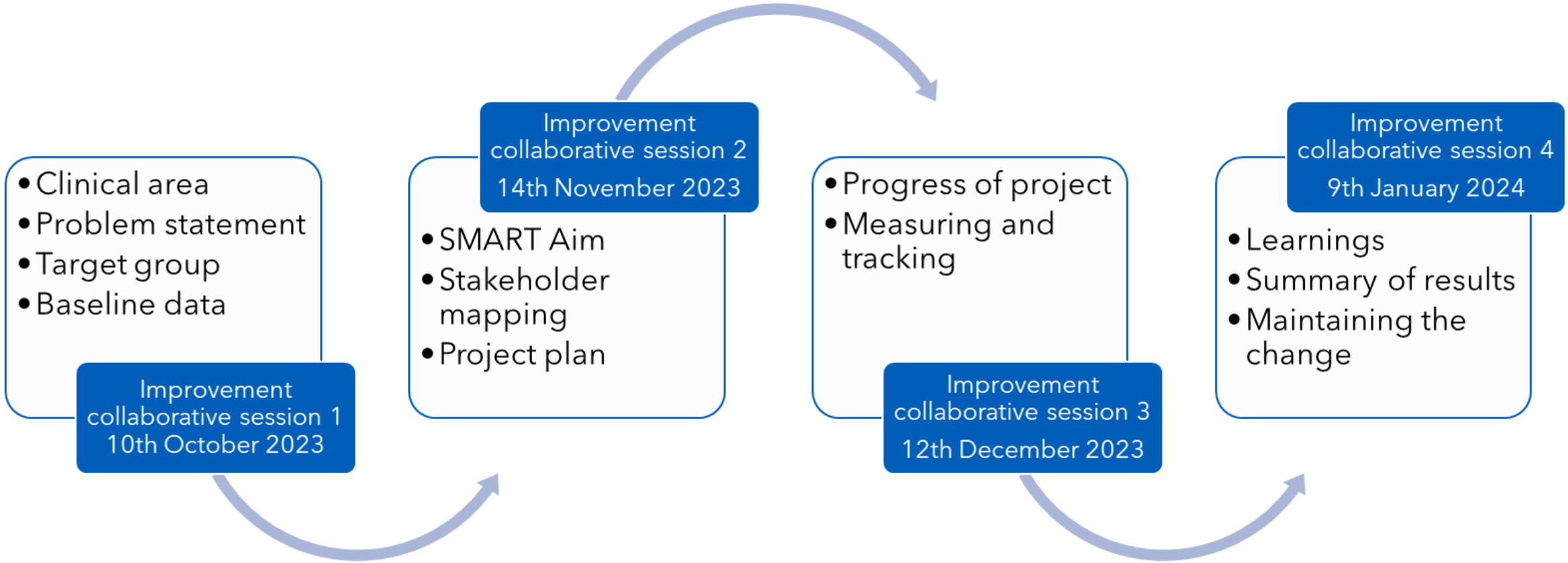
Table Activity - Sharing your projects

- Nominate someone to talk through your project
- Join up with the other table covering the same clinical area
- Share about your project – you have 5 minutes
- Other group you have 5 minutes to. -
  - ask questions
  - share thoughts on what you think is fabulous about the project
  - note any challenges you foresee

- Swap over

What’s next?

Improvement Collaborative Sessions



Date	Time	Webinar Topic	Speaker
September 20, 2023	1.00pm - 2.00pm	Atrial Fibrillation	Dr. Jonathan Behar
October 3, 2023	12.00pm - 1.00pm	Lipid Management and Familial Hypercholesterolemia	Professor Anthony Wierzbicki
October 10, 2023	12.30pm - 1.30pm	Improvement Collaborative 1	
November 1, 2023	12.30pm - 1.30pm	Chronic Kidney Disease and CVD (New for 2023)	Dr. Catriona Shaw
November 14, 2023	12.30pm - 1.30pm	Improvement Collaborative 2	
November 21, 2023	12.00pm - 1.00pm	Heart Failure / Ischaemic Heart Disease	Dr. Kalpa Silva
December 12, 2023	12.30pm - 1.30pm	Improvement Collaborative 3	
December, 2023 Date TBC	tbc	Behaviour Change	Dr. Nupur Yogarajah
January 9, 2024	12.30pm - 1.30pm	Improvement Collaborative 4	
January 2024 Date TBC	tbc	Mental Health	TBC
January 2024 Date TBC	tbc	Obesity	TBC
February 2024 Date TBC	tbc	The Future of CVD Care	Dr Antonio De Marvao
February 9, 2024	9.30am - 12.00pm	Final Learning Event	In person; Robens Suite – Guys' Hospital

Feedback time!