HIN 2024 Cardiometabolic Fellowship Quality Improvement Workshop Welcome!

@HINSouthLondon

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Health Innovation Network South London

Welcome, Housekeeping and Aims of the day

Housekeeping

- Fire exits posted
- Toilets
- Prayer rooms available
- Regular food and drinks – please enjoy!

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**
15. - 2.30	**Developing a plan** • PDSA game • Stakeholder mapping • Planning your project
2.30 – 2.45	**Break**
2.45 – 3.45	**Measuring and tracking your project** • Process vs outcome measures • What a run chart / statistical process control chart is
3.45 – 4.05	**Paired feedback** • Present to another table
4.05 – 4.15	**Next steps and close**

Meet other Fellows

Icebreaker

- **90 seconds - Move around and find one or more people who…**
  - **Had the same thing for breakfast**
- If you can't find anyone who had the same thing, find someone else who can't find someone
- Once you find a person / group you match with then introduce yourself.

Icebreaker

- **90 seconds - Move around and find one or more people who…**
  - **Works in the same borough as you or who works in a neighbouring borough**
- Once you find a person / group you match with then introduce yourself.

Icebreaker

- **90 seconds - Move around and find several people who…**
  - **Are planning to do a project in the same clinical area as you are (hypertension, diabetes, AF etc…)**
- Once you find a group you match with then introduce yourself.

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 - Cardiometabolic 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

Topic	Date
Improvement Collaborative Session One Searches, setting up project and tracking project	Tuesday 11th June 12.30 - 1.30pm
Improvement Collaborative Session Two Running your project	Tuesday 16th July 12.30 - 1.30pm
Improvement collaborative Session Three Drop-in session	Wednesday 14th August 12.30 - 1.30pm
Improvement collaborative Session Four Project closure and project form	Tuesday 24th September 12.30 - 1.30pm
Improvement collaborative Session Five Drop-in session: project form help	Wednesday 9th October 12.30 - 1.30pm

Defining your problem

HIN South London - Cardiometabolic 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

Preparation

Implementation

Review

Clinical area

AF, hypertension, cholesterol, CKD, Heart Failure

Problem statement

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Target group

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Defining your problem

Where do you start?

How do you define your problem?

- Look at data!
  - We have lots in healthcare! **What data sources do you use?**
  - 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 ie CDRC
- Other local dashboards – ie Hypertension Dashboard for SEL
- Searches available locally ie from your practice or PCN
- Feedback from patients & colleagues

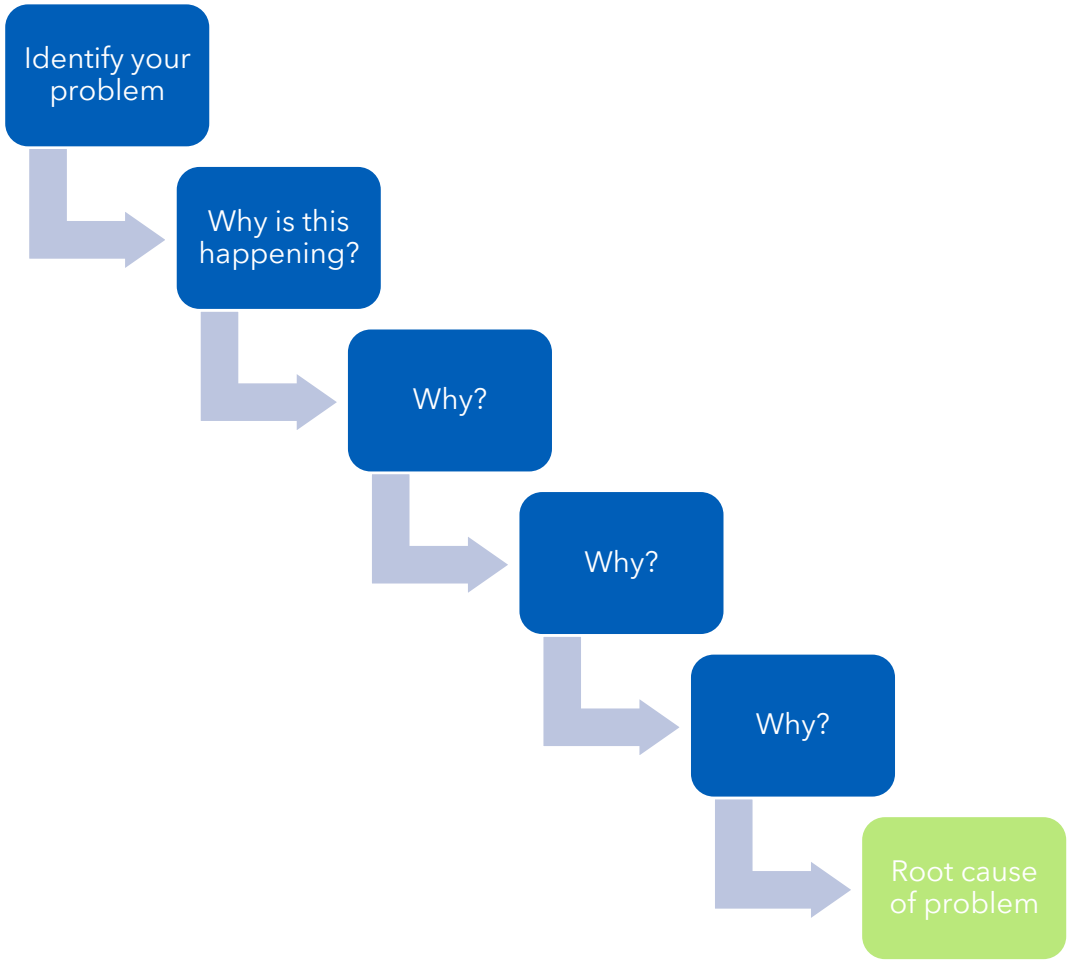
What does a good problem statement look like?

- 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

A very brief look at root cause analysis techniques…

5 Whys?

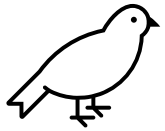

Identify your problem
Why is this happening?
Why?
Why?
Why?
Root cause of problem

The Jefferson Memorial example

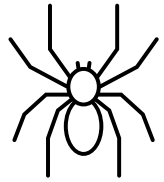
5 Whys?

Identify your problem

Why is this happening?

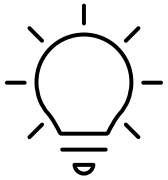


Why?



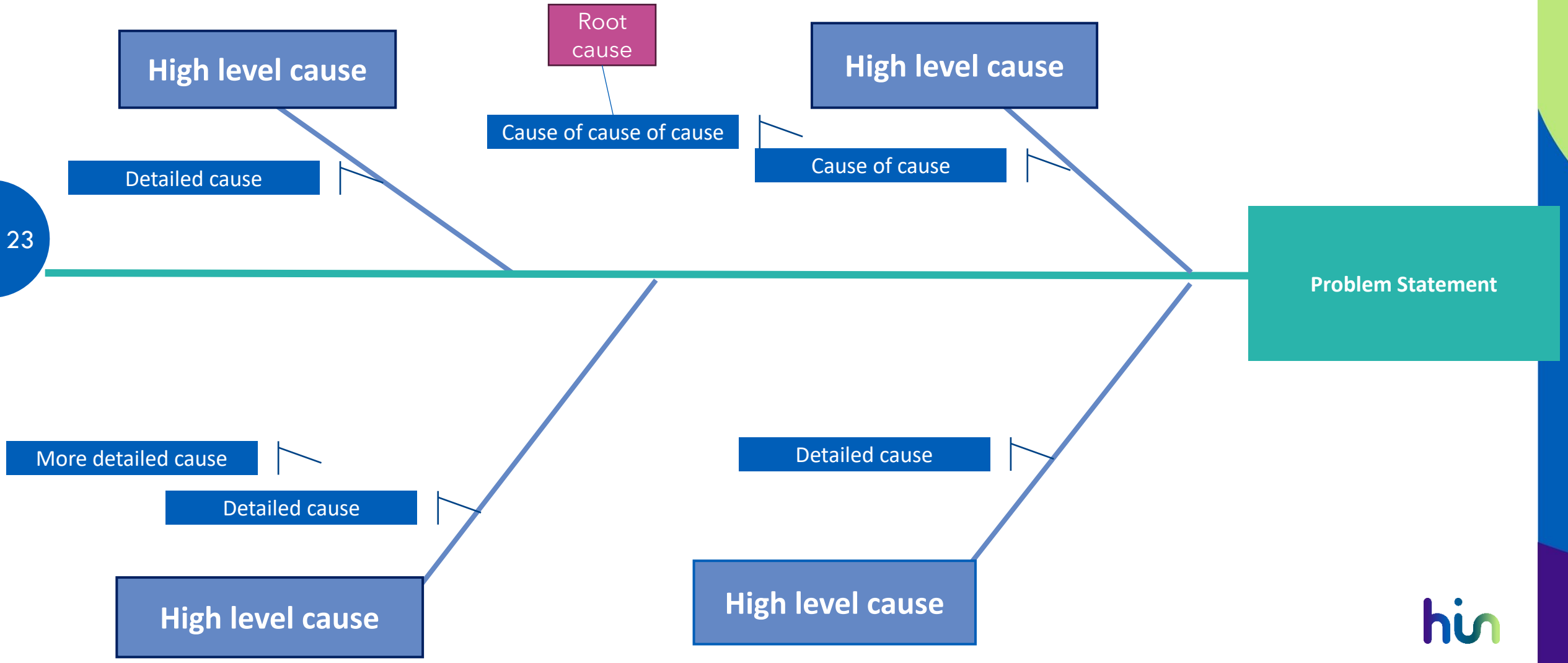
Why?

Why?



Root cause of problem

Fishbone Diagrams



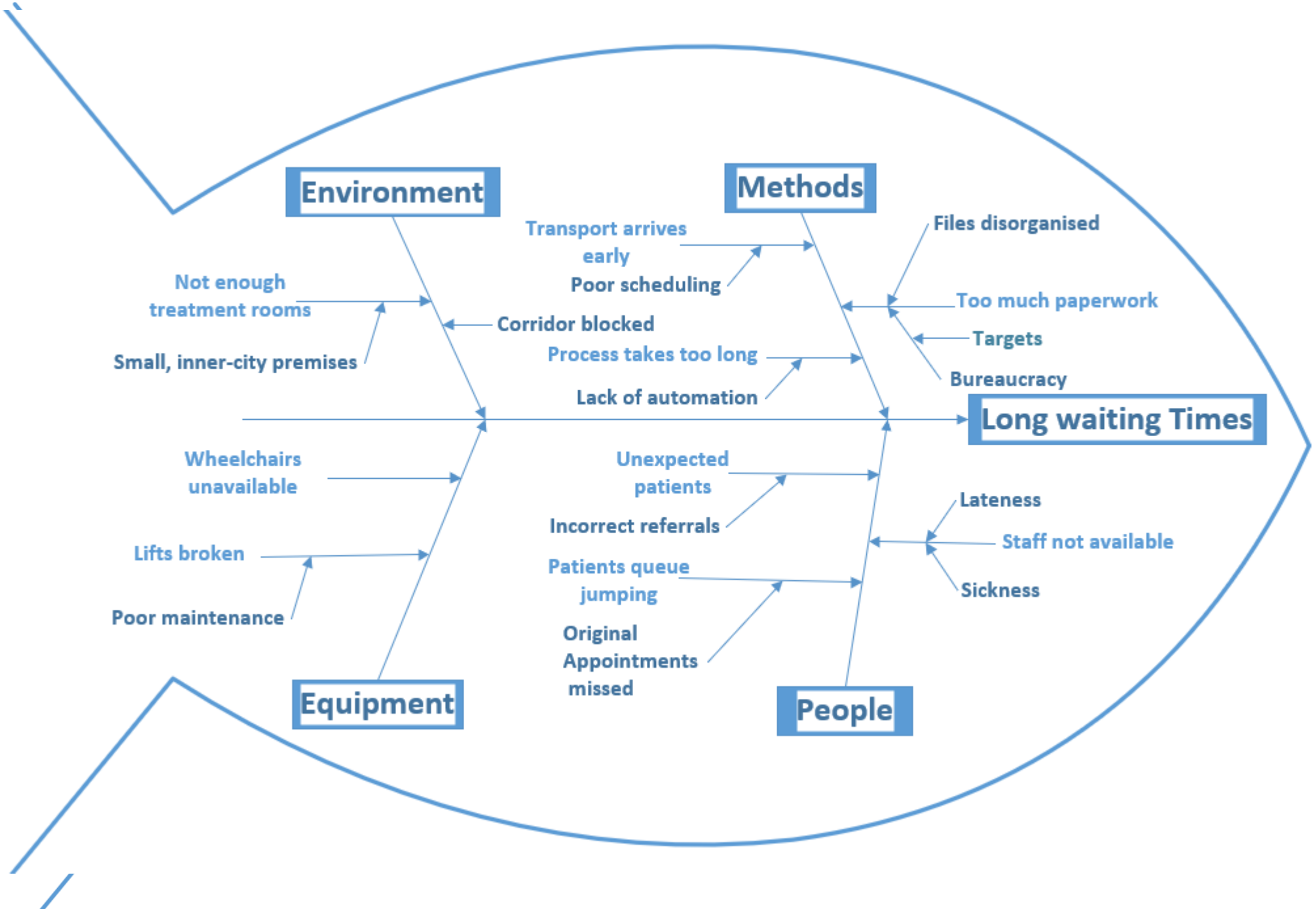

Environment
Methods
Equipment
People
Long waiting Times
Not enough treatment rooms
Small, inner-city premises
Corridor blocked
Transport arrives early
Poor scheduling
Process takes too long
Lack of automation
Files disorganised
Too much paperwork
Targets
Bureaucracy
Wheelchairs unavailable
Lifts broken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

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

Problem statement
What are you trying to address

Remember – A good problem statement…

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

To do:

- 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. Keep it concise.

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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.

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

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

We have a large number of patients aged 18 and over with GP ed hypertension, who have not had a blood pressure g within the pre ing 12 months

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

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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

- **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.

Identifying your issue

Understanding your issue

Developing your solution

Measuring and adjusting your solution

Evaluation and reflection

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AF, hypertension, cholesterol, CKD, Heart Failure

Problem statement

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We have a large number of patients aged 18 and over with GP ed hypertension, who have not had a blood pressure g within the p ding 12 months

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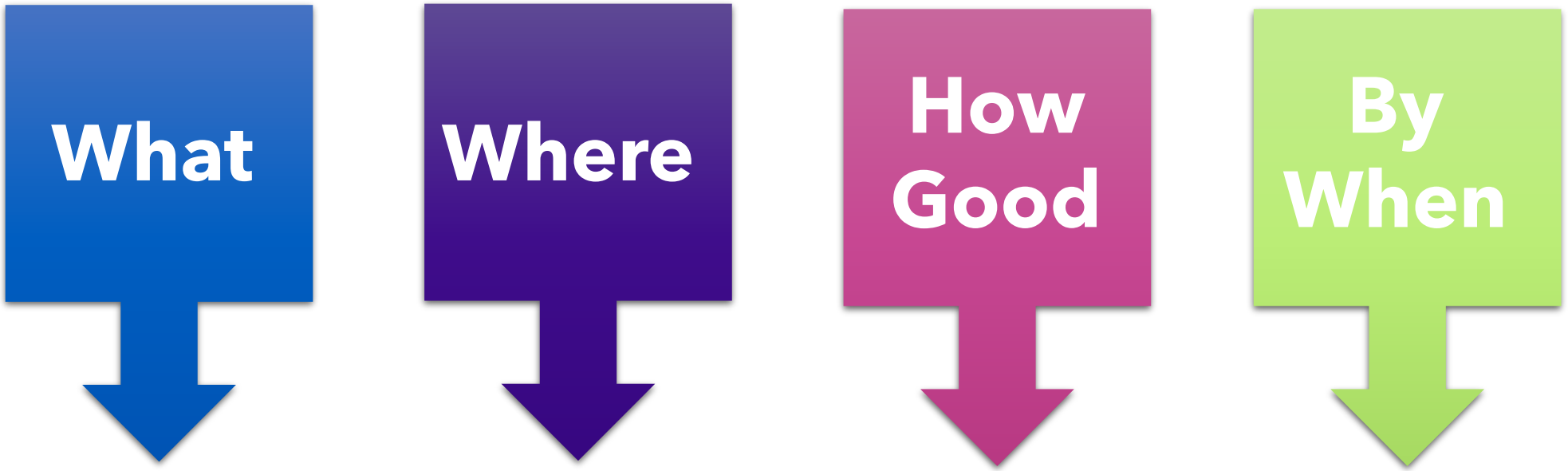
SMART

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



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 November 2024

Table exercise – 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 – and make it realistic**

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?

Then think about -

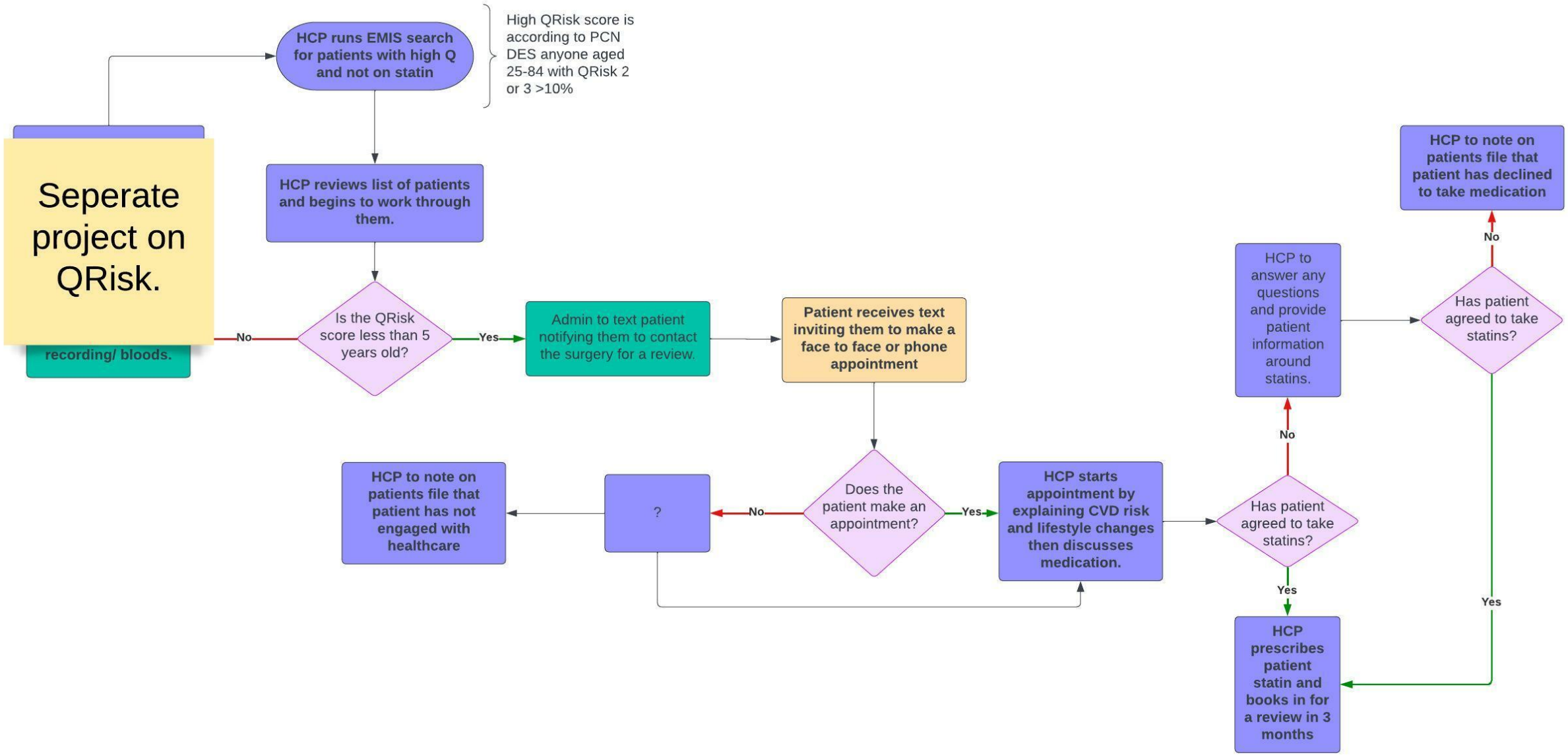
- What do you want to / need to change? What impact do you hope that will have?
- What will those changes look like? – Planning stage

- **Then try this out – use a 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

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 - ?

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 - ?

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 - ?

1

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

3 *Frustrated, gives up*

4 *Relieved to talk to someone and get information & appt*

To note…

Keep this in mind as you plan. Mapping a pathway / journey can help avoid challenges as you go forward.

LUNCH – ENJOY!

Agenda for the afternoon….

1. PDSA – Trying it in action
2. Stakeholder mapping
3. Planning your project
4. Break (approx. 2.30 / 2.45)
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 ~10 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 note –
  - 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

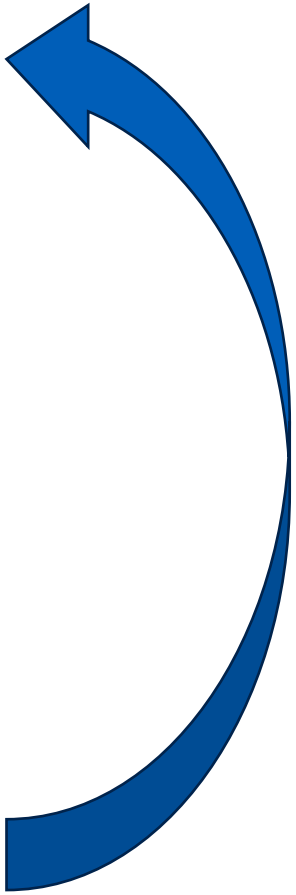
- As a group note –
  - What worked well?
  - What didn't?
  - How can you improve your plane?
- Refine your plane or build a new plane – object is for it to fly further and straighter (you hope...)
- You have 4 minutes in total!

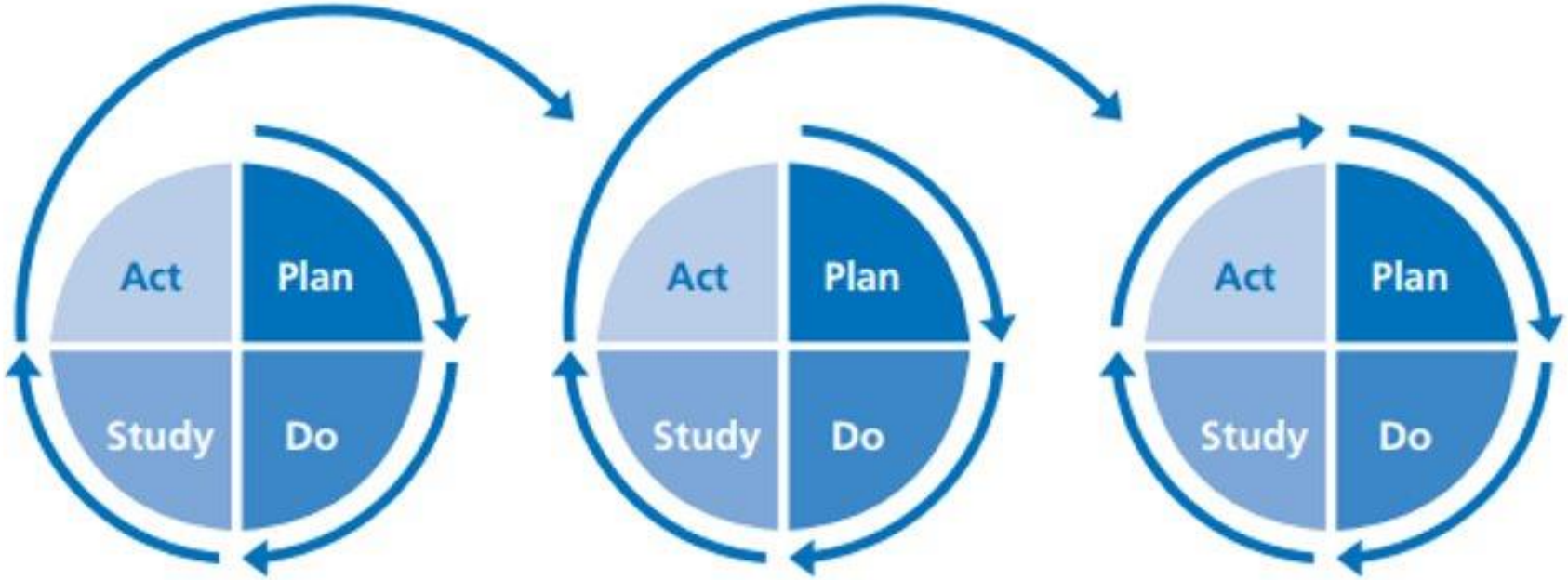
PDSA

- 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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Target group

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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

...ave 500 people on our hypertension register who have not ... 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 ... BP reading in the last 12 months at Springland Practice by ...50 patients) by January 2024.

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

Who	Why	How	When

Plan

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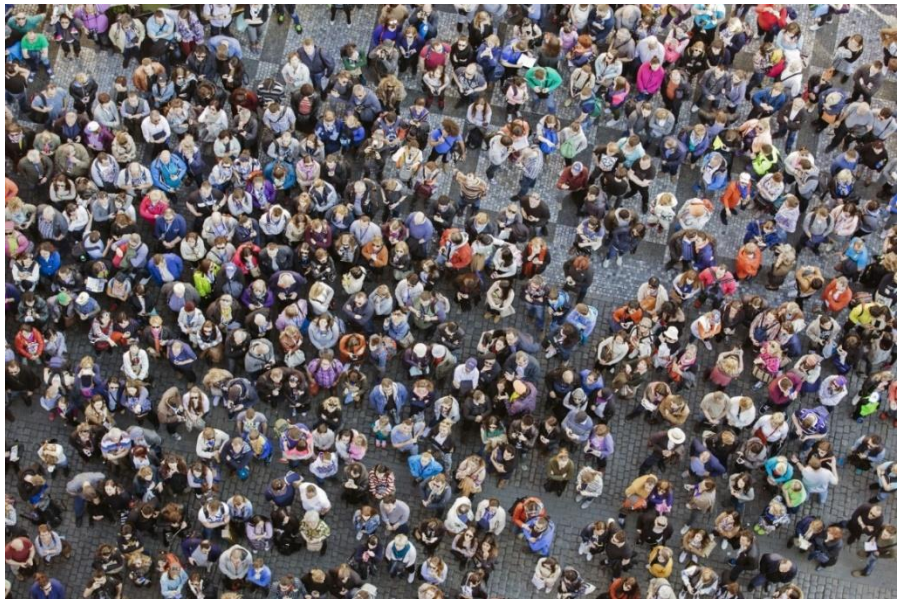
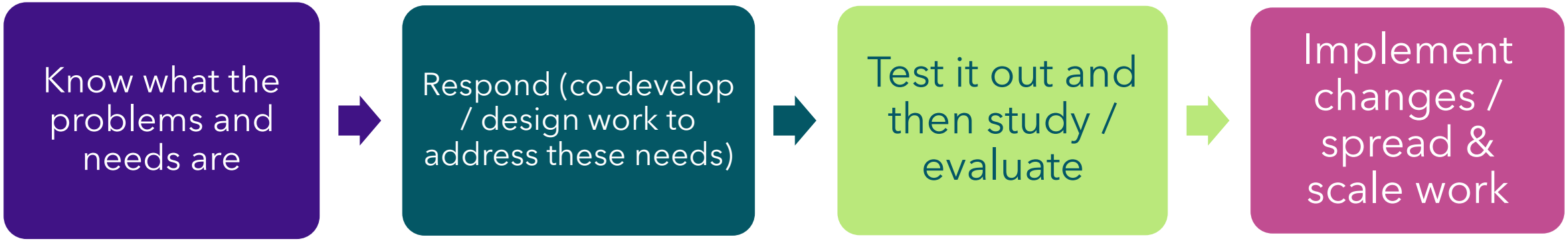
Stakeholder Mapping For Your Project – The Who

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 do you need to **inform**?
- Who else can **help you**?
  - Practically?
  - With information?
  - Influencing others?
  - Support?



Why should you involve **patients** in your work?



Guiding principles set out in:

UK standards for public involvement in research

NHS England guidance on patient and public participation in commissioning health and care.

What is PPIE (Patient and Public Involvement and Engagement)?

Diagram from: https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/

Patient Engagement for your project – think about…

- What value could engaging patier bring to the project?
- What might be different if patient were involved?
- How could you engage patients in your project?
- Do you have any concerns about engagement?
- Who could help you?

Stakeholder Mapping For Your Project

- As you map stakeholders think about if there is anyone you may struggle to engage.

  - What might be their worries?
  - Other priorities?
  - What are their wants / needs?
  - What would success look like to them?
  - What matters to them?
  - How do you feel about them?
  - Who influences them?
  - What do you have in common?
  - Can you help them? (reciprocity)

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?
- How could patients 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**

Planning Your Project

Identifying your issue

Understanding your issue

Developing your solution

Measuring and adjusting your solution

Evaluation and reflection

Clinical area

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Hypertension

Problem statement

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[illegible]takeholder mapping think about who else needs to be involved in your project

[illegible]	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, [illegible]	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?

Progress of the Project

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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

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)
2. Gathered baseline data ie from searches
3. Identified your target area / group for the project
4. Set a SMART aim
5. Looked at what is already happening, if anything
6. Identified where changes could be made
7. Identified who the stakeholders are, including thinking through who in your practice needs to be involved, who can help you, and who needs to be informed

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

Now it is time to plan your project!

Example project plan

Your plan going forward 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, July 2024)
2. Update records and coding for patients with up to date test results (???, July 2024)
3. Where needed invite patients in for review – (Admin & Clinicians, Aug to Oct 2024)
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 making changes if needed ie change the text language, call instead of texting, call at a new time of day, suggest Community Pharmacy option etc (PDSA cycle).
6. Repeat

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

HIN South London - Cardiometabolic Fellowship Project Form

Health Innovation Network South London

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

Prepara

Impleme

Clinical area

AF, hypertension, cholesterol, CKD, Heart Failure

Hypertension

Problem statement

What are you trying to address

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

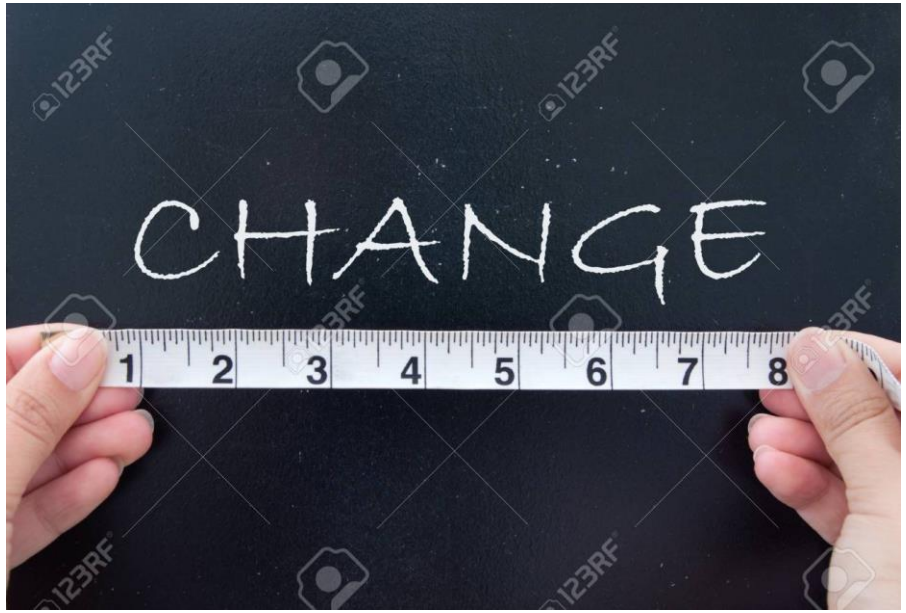
Patient or stakeholder story or feedback

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

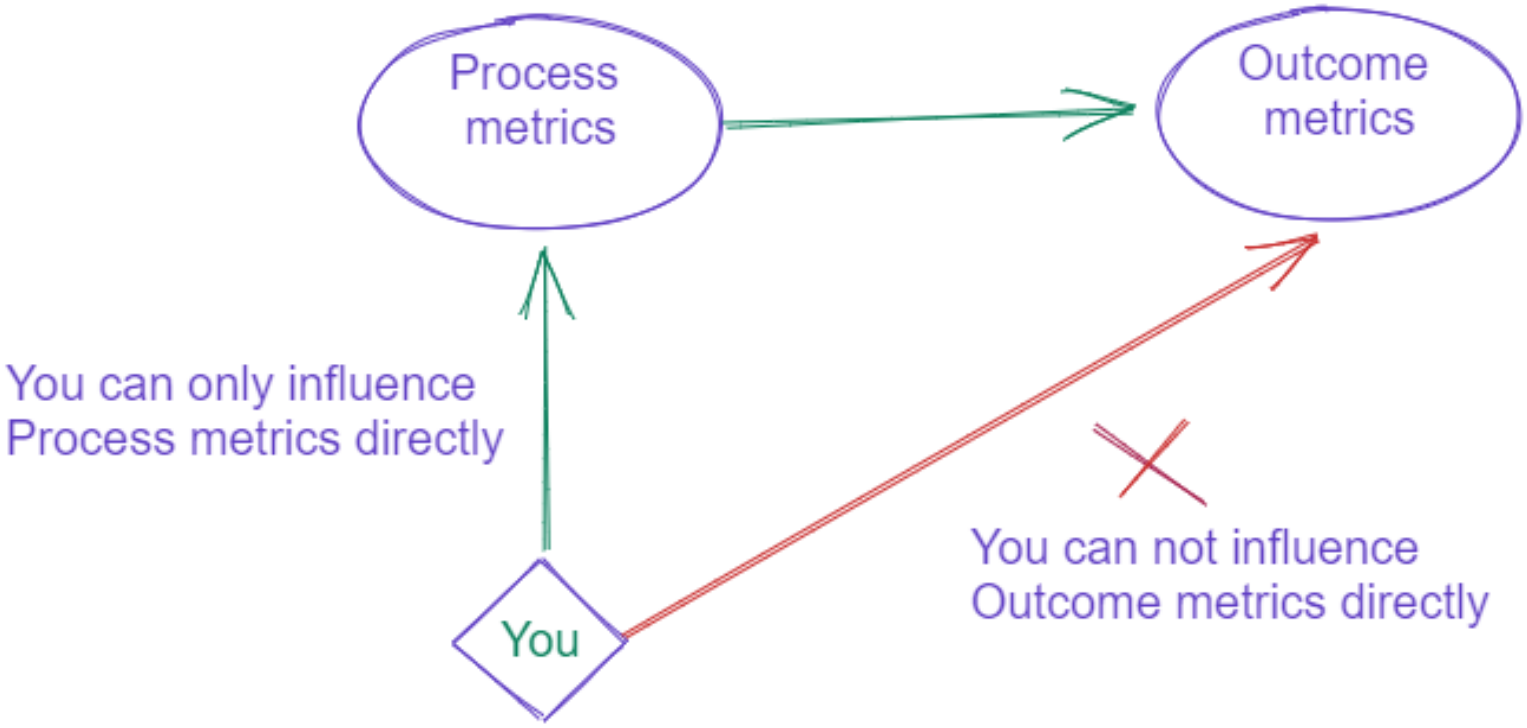
- The number of patients you reviewed
- The number of new prescriptions
- The % increase in appointments

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

Tracking your project

- Spend some time setting up a system
- Easiest to do as you go
- Different for every project

No.	TEXT	U+E	ACR
1	8/11	✓	✓
2	23/11	✓	✓
3	01/11	✓	✓
4	23/11	✓	✓
6	8/11	✓	✓
7	8/11	✓	✓
8	23/11	✓	✓
9	25/10	✓	✓
10	25/10	✓	
12	25/10	✓	✓
14	01/11		
15	8/11	✓	✓
16	25/10	✓	✓
17	01/11	✓	✓

No.	TEXT	U+A	ACR
37	25/10	✓	✓
38	25/10	✓	✓
40	22/11		
41	22/11	✓	✓
42	22/11		
43	25/10	✓	✓
45	25/10	✓	✓
46	22/11	✓	✓
47	8/11		✓
48	8/11	✓	✓
49	01/11		✓
51	22/11	✓	✓
52	8/11	✓	✓
53	08/11		

Tracking a project – spreadsheet option

#	Patient ID	Date contacted	Contact notes	eGFR	uACR	Coding	Notes
1	663 298 5580						
2	774 271 2628						
3	203 992 9304						
4	449 390 6235						
5	436 153 4462						
6	976 610 7327						
7	967 454 7207						
8	425 021 8449						
9	073 890 7928						
10	389 789 4718						
11	J. Gorski						
12	K. Paulsen						
13	T. Baptiste						
14	H. Lee						
15	D. Gray						
16	B. Leigh						

Tracking a project – spreadsheet option

#	Patient ID	Date contacted	Contact notes	eGFR	uACR	Coding	Notes
1	663 298 5580	20/03/2024	Text message				
2	774 271 2628	20/03/2024	text message, follow-up call				
3	203 992 9304	20/03/2024	Text message				
4	449 390 6235	20/03/2024	Text message				
5	436 153 4462	20/03/2024	text message, follow-up call				
6	976 610 7327	20/03/2024	Text message				
7	967 454 7207						
8	425 021 8449						
9	073 890 7928						
10	389 789 4718						
11	J. Gorski						
12	K. Paulsen						
13	T. Baptiste						
14	H. Lee						
15	D. Gray						
16	B. Leigh						

Tracking a project – spreadsheet option

#	Patient ID	Date contacted	Contact notes	eGFR	uACR	Coding	Notes
1	663 298 5580	20/03/2024	Text message	45	pending		
2	774 271 2628	20/03/2024	text message, follow-up call	60	complete		
3	203 992 9304	20/03/2024	Text message	25	complete		
4	449 390 6235	20/03/2024	Text message	23	complete		
5	436 153 4462	20/03/2024	text message, follow-up call	50	complete		
6	976 610 7327	20/03/2024	Text message	70	complete		
7	967 454 7207	13/04/2024	Text message				
8	425 021 8449	13/04/2024	text message, follow-up call				
9	073 890 7928	13/04/2024	Text message				
10	389 789 4718	13/04/2024	text message, follow-up call				
11	J. Gorski	13/04/2024	Text message				
12	K. Paulsen	13/04/2024	text message, follow-up call				
13	T. Baptiste						
14	H. Lee						
15	D. Gray						
16	B. Leigh						

Tracking a project – spreadsheet option

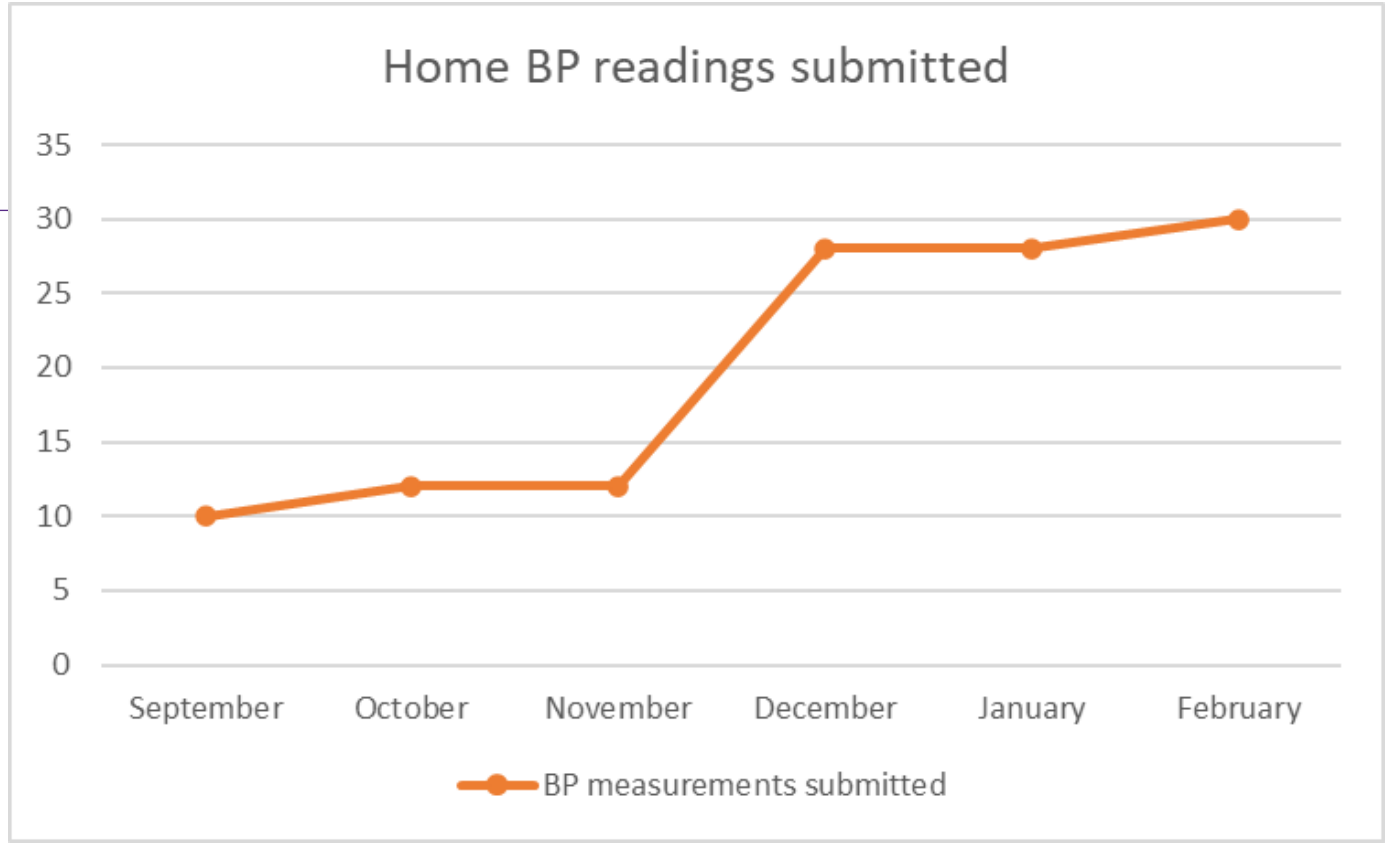
#	Patient ID	Date contacted	Contact notes	eGFR	uACR	Coding	Notes
1	663 298 5580	20/03/2024	Text message	45	pending	old	
2	774 271 2628	20/03/2024	text message, follow-up call	60	complete	updated	
3	203 992 9304	20/03/2024	Text message	25	complete	updated	
4	449 390 6235	20/03/2024	Text message	23	complete	updated	
5	436 153 4462	20/03/2024	text message, follow-up call	50	complete	updated	
6	976 610 7327	20/03/2024	Text message	70	complete	updated	
7	967 454 7207	13/04/2024	Text message	40	complete		
8	425 021 8449	13/04/2024	text message, follow-up call	45	complete		
9	073 890 7928	13/04/2024	Text message	60	complete		
10	389 789 4718	13/04/2024	text message, follow-up call	awaiting	pending		
11	J. Gorski	13/04/2024	Text message	25	complete		
12	K. Paulsen	13/04/2024	text message, follow-up call	awaiting	pending		
13	T. Baptiste	20/04/2024	Text message				
14	H. Lee	20/04/2024	Text message				
15	D. Gray	20/04/2024	Text message				
16	B. Leigh	20/04/2024	text message, follow-up call				

Tracking a project – spreadsheet option

#	Patient ID	Date contacted	Contact notes	eGFR	uACR	Coding	Notes
1	663 298 5580	20/03/2024	Text message	45	pending	old	
2	774 271 2628	20/03/2024	text message, follow-up call	60	complete	updated	
3	203 992 9304	20/03/2024	Text message	25	complete	updated	Referred to secondary care
4	449 390 6235	20/03/2024	Text message	23	complete	updated	Referred to secondary care
5	436 153 4462	20/03/2024	text message, follow-up call	50	complete	updated	
6	976 610 7327	20/03/2024	Text message	70	complete	updated	Given lifestyle advice
7	967 454 7207	13/04/2024	Text message	40	complete	updated	
8	425 021 8449	13/04/2024	text message, follow-up call	45	complete	updated	
9	073 890 7928	13/04/2024	Text message	60	complete	updated	
10	389 789 4718	13/04/2024	text message x2, follow-up call	awaiting	pending	none	May have moved
11	J. Gorski	13/04/2024	Text message	25	complete	updated	
12	K. Paulsen	13/04/2024	text message x 3, follow-up call	awaiting	pending	none	
13	T. Baptiste	20/04/2024	Text message	23	complete	updated	
14	H. Lee	20/04/2024	Text message	50	complete	updated	
15	D. Gray	20/04/2024	Text message	38	pending	none	
16	B. Leigh	20/04/2024	text message, follow-up call	awaiting	pending	none	In hospital

Simple Run Chart

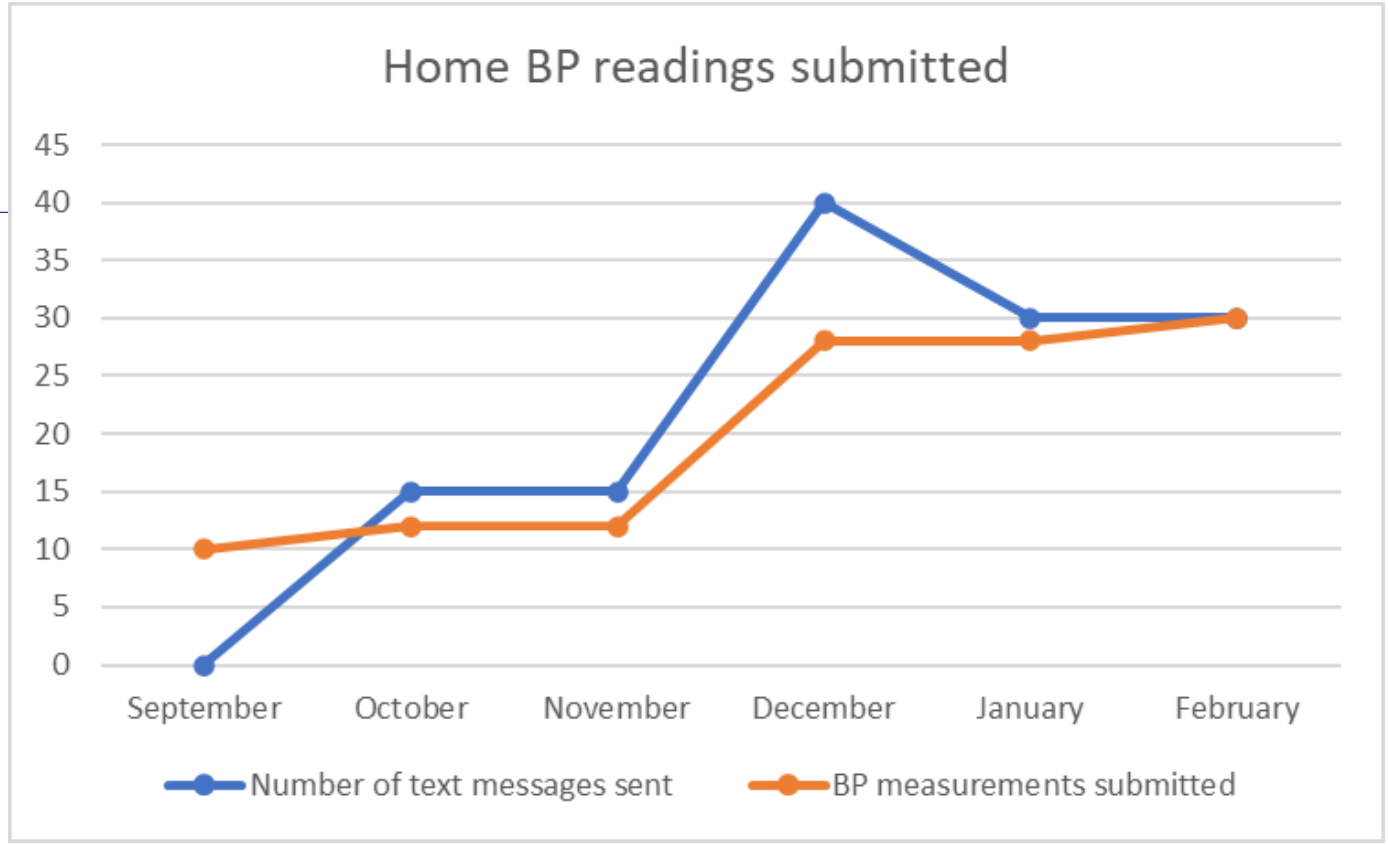
- The constant will be on the X axis – usually time
- The Y axis is your variable – usually the count



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

Simple Run Chart

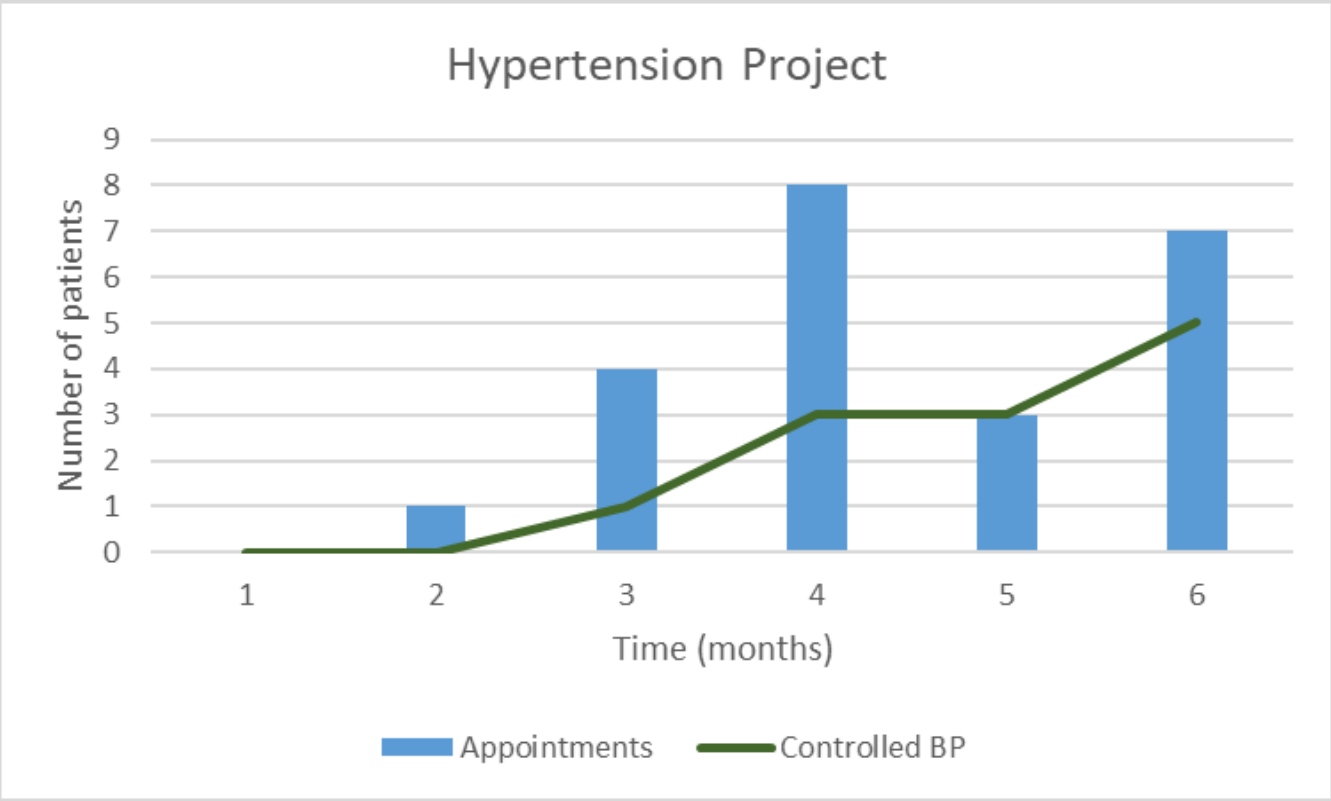
- The constant will be on the X axis – usually time
- The Y axis is your variable – usually the count



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

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

Take-away messages

- Process measures are what you control
- Outcome measures are what you are aiming to change
- Setting up a system will make your life easier
- The more information you provide, the more we are able to showcase your good work
  - Results with data can form graphs
  - Patient feedback is powerful
- 'Learnings' are your insights that will help others who want to do the same work – these are best captured as you go

Aim

By the end of February 2024 we will have a 75% reduction in the number of the patients who have not had a recorded follow-up eGFR test within 12 months of an initial eGFR result of <60.

Problem statement

Prevalence of CKD within The Nelson Medical Practice is lower than the national average, indicating that there may be issues regarding diagnosis or coding.
Under diagnosis as well as incorrect coding can lead to lack of management of the disease – which puts the patient at higher risk of resulting sequelae, including cardiovascular disease.

77 patients were identified as having an eGFR <60 within the last year with no repeat eGFR. These patients require a second test to be coded as CKD and receive

Baseline data

The above target group was searched using Ardens searches and on the 19th of October identified 77 patients - the baseline data.
To measure this project, I will monitor the number of patients in the target group identified above and I will also measure the number of patients from that group who are contacted.

Plan

Manual review of notes for each batch of patients about to be texted.
Texts to small number of patients at a time (for those with mobiles) with the ability for them to reply to text with any questions.
Groups from list to be contacted weekly until all have been contacted once

Summary of results

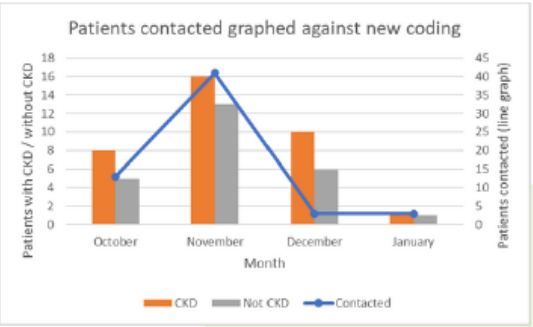
Of the 77 patients identified, 54 were contacted via text message or by phone. 35 were found to have CKD and were coded appropriately, and 25 were found to not have CKD.
The data has enabled correct coding which means best management of their condition. Clinicians are already offering statins plus other suitable medication to those coded with CKD – there is rising awareness within NHS about how management of CKD can reduce CVD risk. Clinicians have acknowledged usefulness of laminated poster re CKD in their rooms and highlighted my role in our January MDT clinical meeting.
Next time I will use a 'real time' excel spread sheet to log results as this will be much less time consuming than the handwritten charts I had to produce!

Learnings

- Wording of the original text message appeared personal
- Enabling patients to text back was helpful and they were more likely to complete the tests
- Ceased renal damaging medications for patients found to have CKD
- Patients becoming aware of importance of healthy kidneys and the role this plays in reducing risk of CVD
- For those without mobile phones (all age groups) – finding time to phone them takes longer. It can lead to conversations about many other health aspects.
- Time to do the project, I needed a minimum of an hour a week to go through the list/send texts/check results which was not always available depending on timetabling.

Patient or stakeholder feedback

A patient in her 40s. who rarely drinks any fluids had an isolated GFR of 48 hence needing repeat. Recognition from her was that she needs to maintain good fluid balance to protect renal function. Her GFR is now > 60, a work in progress. This has made a huge difference to behaviours/medications)

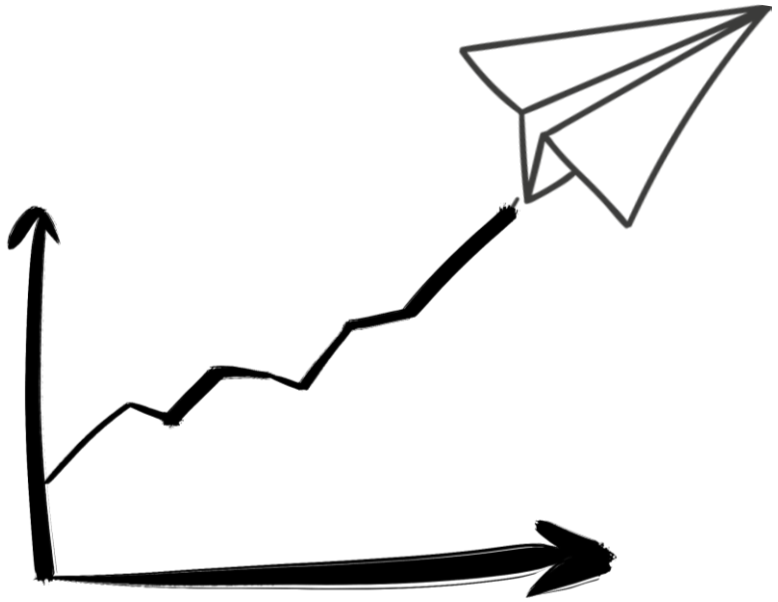


Sustaining the change

It is fairly straightforward to run a two- or three-monthly search for patients who need a repeat blood test and urine sample to check for CKD. Text messages this time around got a 70% success rate and I would like to continue this project as it is beneficial to patients.

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

Topic	Date
Improvement Collaborative Session One Searches, setting up project and tracking project	Tuesday 11th June 12.30 - 1.30pm
Improvement Collaborative Session Two Running your project	Tuesday 16th July 12.30 - 1.30pm
Improvement collaborative Session Three Drop-in session	Wednesday 14th August 12.30 - 1.30pm
Improvement collaborative Session Four Project closure and project form	Tuesday 24th September 12.30 - 1.30pm
Improvement collaborative Session Five Drop-in session: project form help	Wednesday 9th October 12.30 - 1.30pm

Clinical Webinars

Webinars	Date	Time
Hypertension Webinar Dr Tarek Antonios	Tues 30th April	12.30pm – 1.30pm
Atrial Fibrillation Webinar Dr Jonathan Behar	Tues 21st May	12.30pm – 1.30pm
Lipid Management and Familial Hypercholesterolemia Webinar Prof Tony Wierzbicki	Tues 4th June	12.00pm – 1.00pm
Chronic Kidney Disease and CVD Dr Catriona Shaw	Tues 18th June	1.00pm – 2.00pm
Mental Health Webinar Dr Mujtaba Husain	w/c 1st July	12.30pm – 1.30pm
Type 2 Diabetes Webinar Dr Neel Basudev & Dr Sophie Harris	w/c 15th July	12.30pm – 1.30pm
Heart Failure / Ischaemic Heart Disease Dr Kalpa Silva & Dr Susan Piper	w/c 5th August	12.30pm – 1.30pm
Behaviour Change Dr Nupur Yogarajah	w/c 16th September	12.30pm – 1.30pm

Feedback time!