2024 Cardiometabolic Fellowship Improvement Collaborative session 3

Welcome! Please introduce yourself in the chat

Wednesday 14th August 2024

12.30 – 1.30pm

@HINSouthLondon

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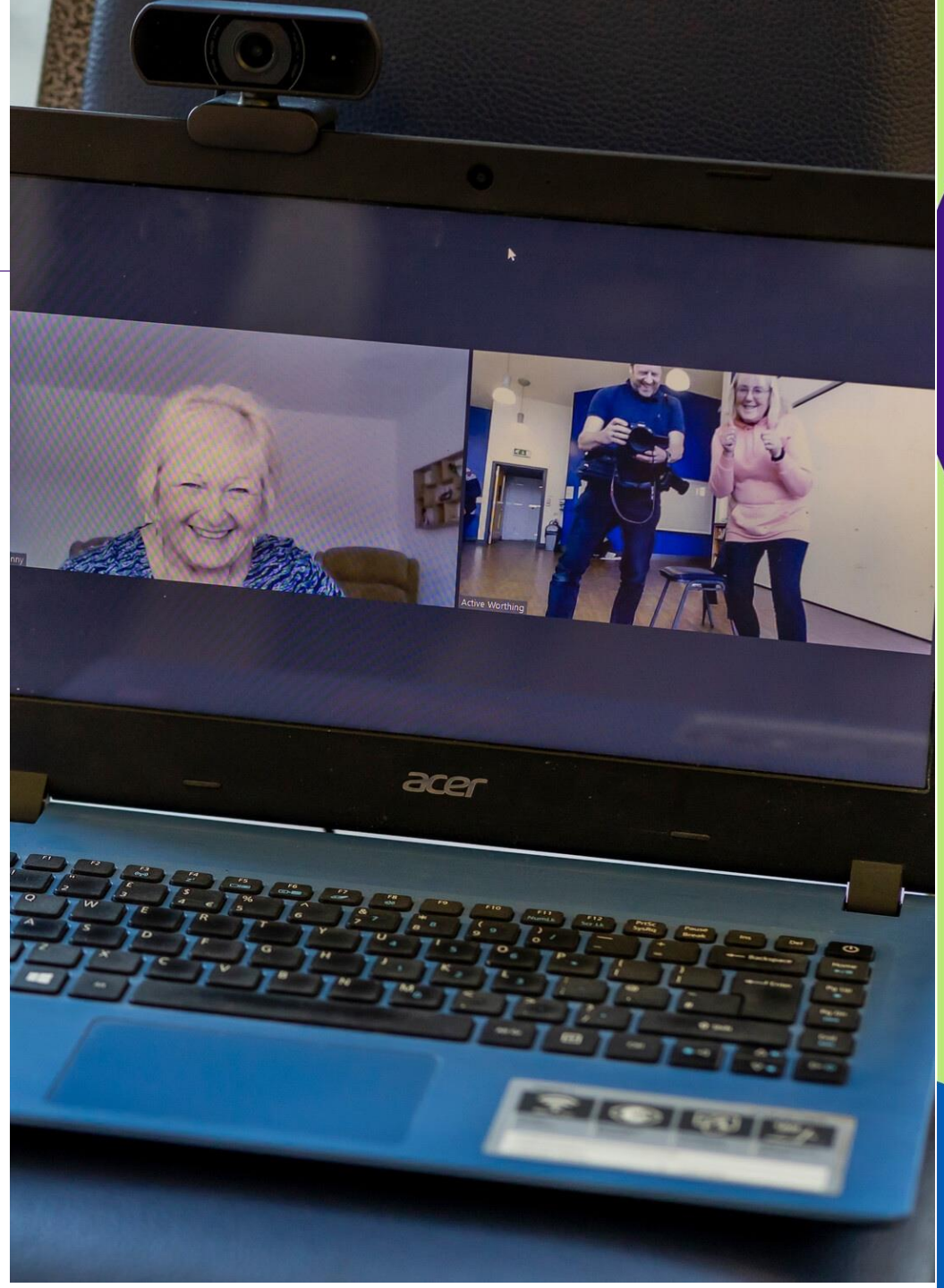
Health Innovation Network South London

Housekeeping

Welcome!

- Feel free to introduce yourself in the chat
- Please change your name by clicking the three small buttons on top right of your video or clicking the three dots near your name
- We will be answering your questions today and sharing project updates- so place them in the chat or raise your hand to come off mute
- It would be great if everyone could have their cameras on



Introductions

- Pedro Bandiera
- Nathan Beencke
- Margaret Connolly
- Stephanie Atta
- Sally Irwin
- Claire Torkelson

Drop in Session!

- Please raise your hand to ask project-related questions, or share any updates

- How are things going? Consider-
  - What are your challenges? Roadblocks?
  - Are there any components of the of the QI process that you need further clarification?
  - Do you have challenges specific to your circumstance that require one-on-one support?
  - Is there anything you'd like to get the group's feedback on?

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%

Your Name:								
Date Review initiated	Patient	NHS Number or name	Sex	Age	Contacted date	Intervention made	Outcome	Comments
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	13							
	14							

Tracking your project

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

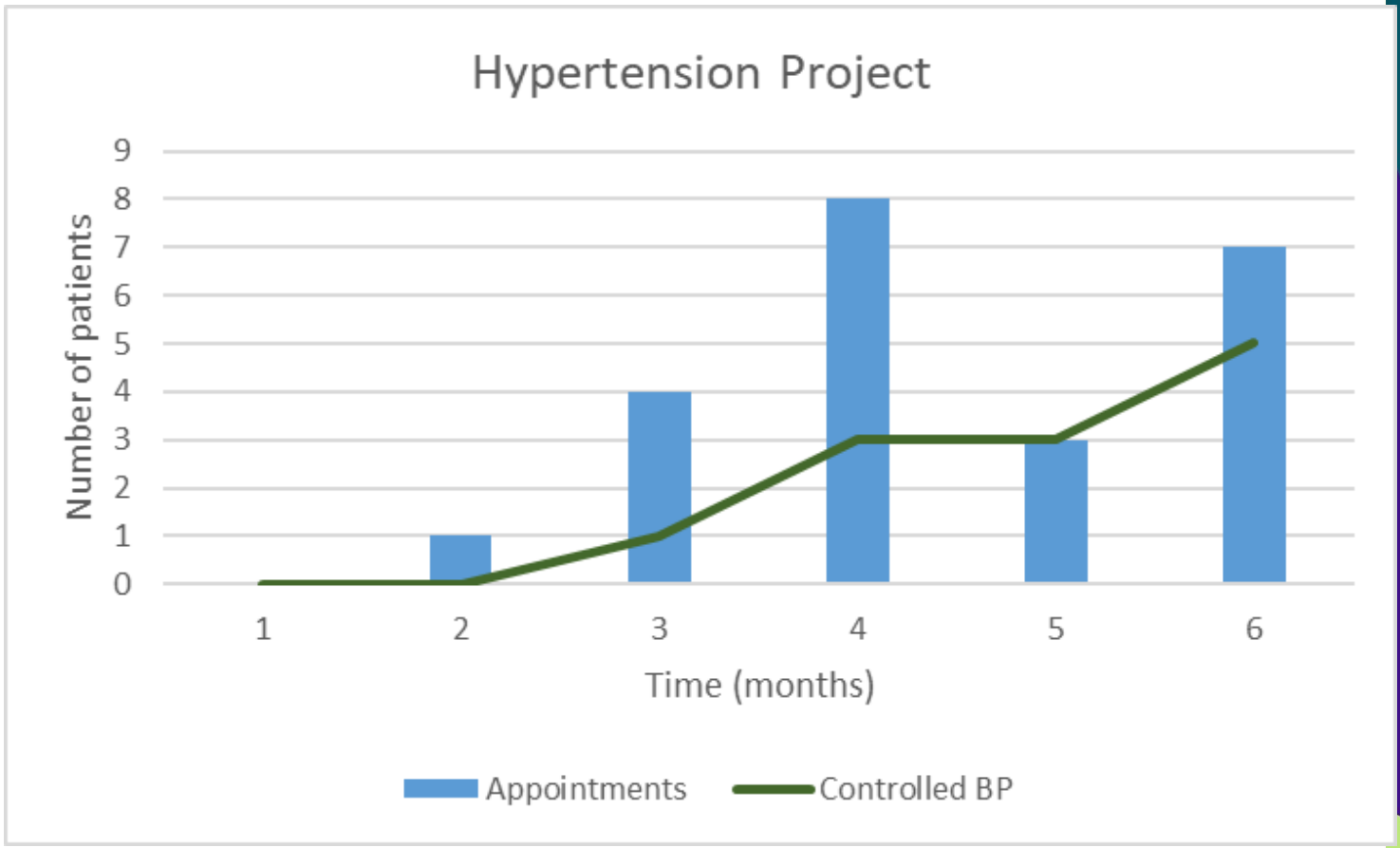
No.	TEXT	U+E	ACR
1	8/11	✓	✓
2	23/11	✓	✓
3	01/11	✓	✓
4	23/11	✓	✓
6	8/11	✓	✓
7	8/11	✓	✓
8	23/11	✓	✓
9	25/10	✓	✓
10	25/10	✓	
12	25/10	✓	✓
14	01/11		
15	8/11	✓	✓
16	25/10	✓	✓
17	01/11	✓	✓

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		

Simple Run Chart

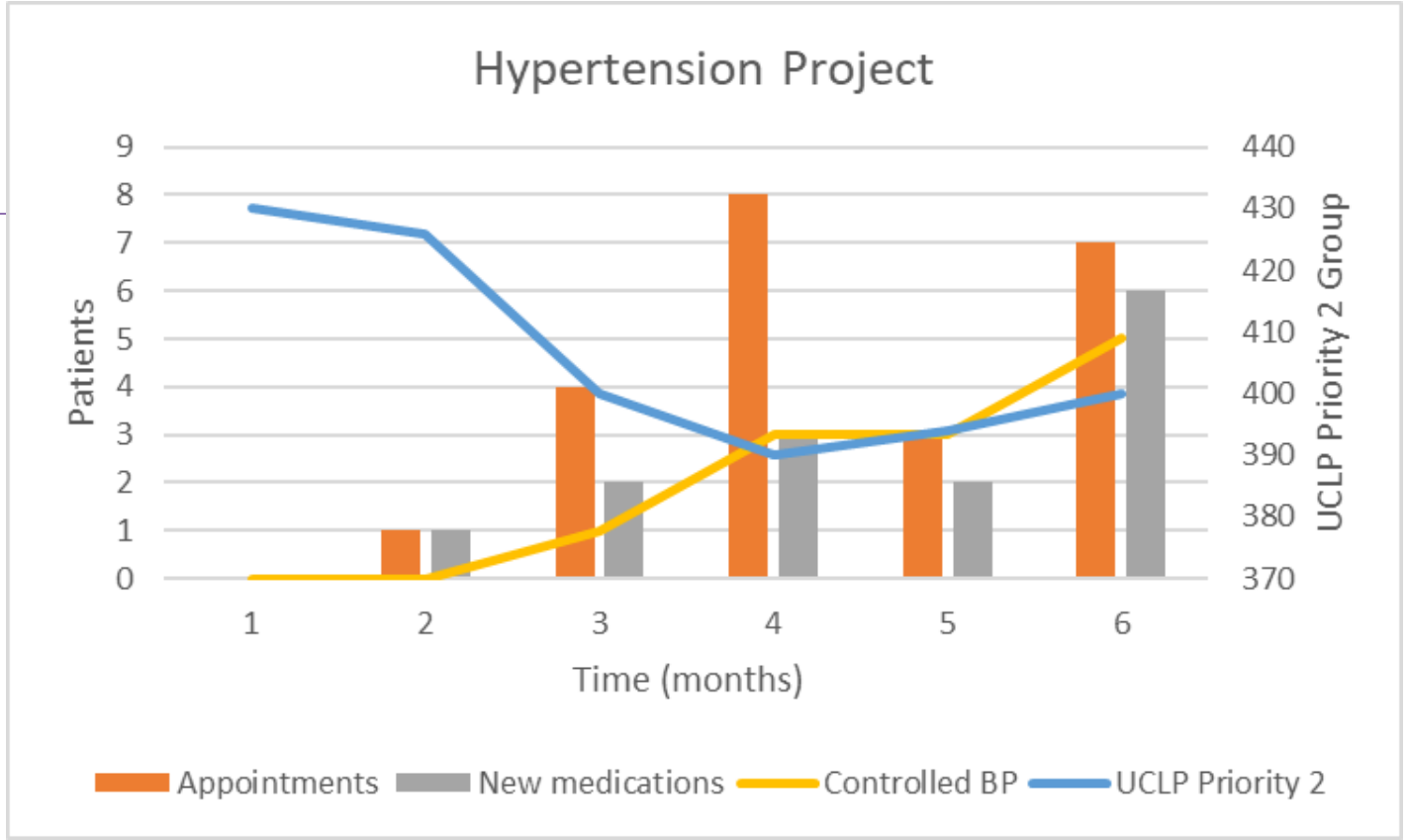
- Process measures shown as a bar graph
- Outcome measure displayed as a line graph

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



Hypertension Run Chart

- Bar graphs indicate the process measures
- Line graph indicates outcome measures
- Move to october



Months	Appointments	New medications	Controlled BP	UCLP Priority 2
1	0	0	0	430
2	1	1	0	426
3	4	2	1	400
4	8	3	3	390
5	3	2	3	394
6	7	6	5	400

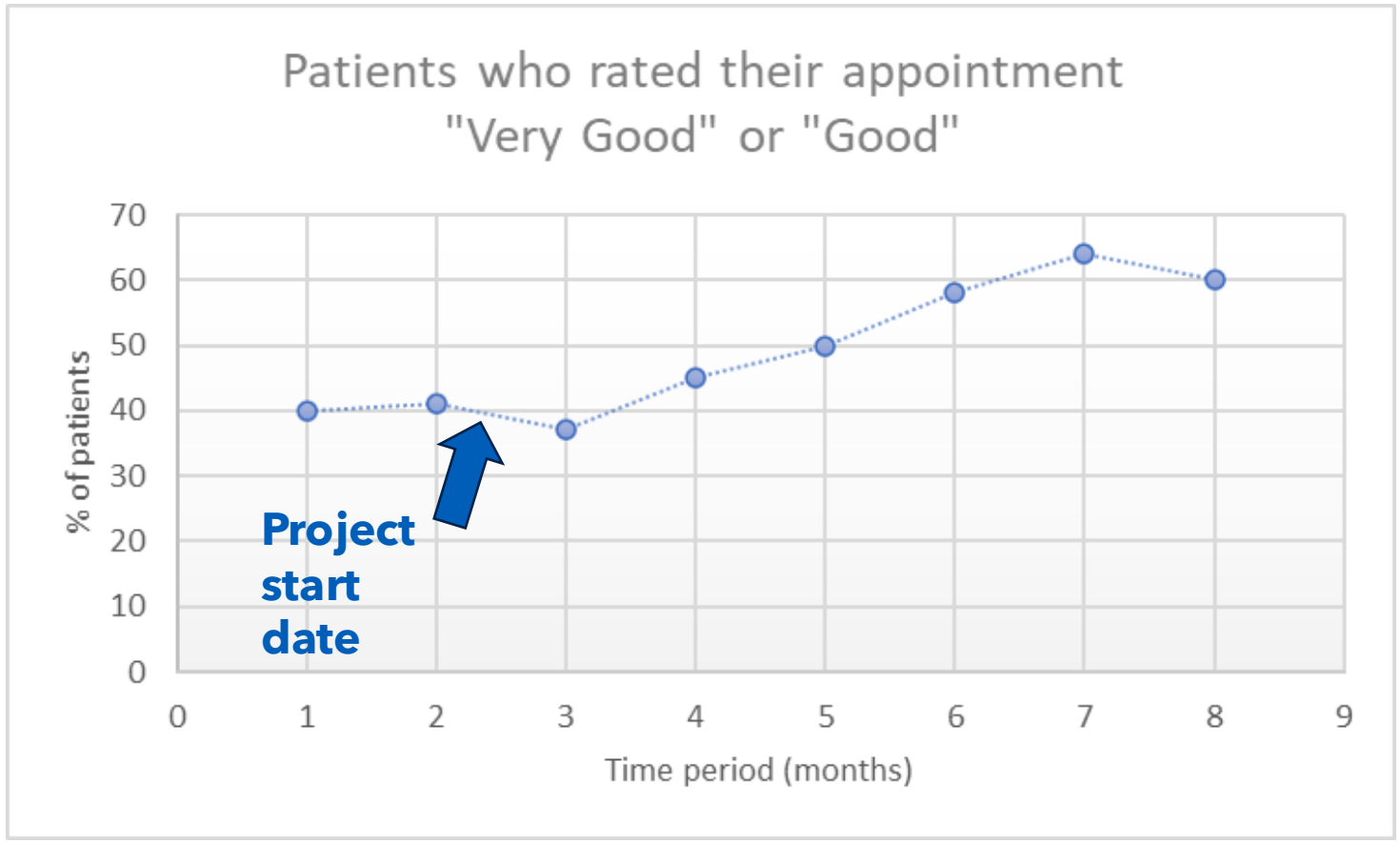
Patient feedback

Overall experience

Q32 **Overall, how would you describe your experience of your GP practice?**

- ☐ Very good
- ☐ Fairly good
- ☐ Neither good nor poor
- ☐ Fairly poor
- ☐ Very poor

Time period	Satisfaction
1	40%
2	41%
3	37%
4	45%
5	50%
6	58%
7	64%
8	60%



https://gp-patient.co.uk/downloads/2023/qandletter/GPPS_2023_Questionnaire_PUBLIC.pdf

Learnings

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?

Results and change

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

Sustaining Change

To consider…

- What are you doing that is **new or different** to how you normally work(ed)?
- What is working well?
- What is making a difference - for patients/ staff/ yourself/ others?
- What would you change if you continue the work?

Share - What would you like to keep doing, or do but do differently?

Share - What are the barriers for you continuing to do the things that are new or different?

To consider…

- **Do you want to continue the QI work?**
- What do you need to continue?
- What would help you to overcome these barriers?
- Who can you engage for help?
- Who else can you share what you are doing with?
- Are there others who might want to deliver this as well?

Fellow name: Catherine Sedgwick

PCN: South West London

GP Practice: The Nelson Medical Practice

Clinical area: Chronic Kidney Disease and CVD Prevention

Follow-up eGFR Testing to Identify CKD in At-Risk Individuals

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 appropriate management.

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.

Project plan

In order to address this problem I will inviting batches of identified patients to undertake an eGFR and uACR test. I will then code them appropriately based on the results. I will send text messages to those who have mobile phone and call those who do not. The text message will have 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 and 6 patients records were reviewed without needing to contact them. 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 to reduce CVD risk. Renal damaging medications could be ceased for patients found to have CKD.
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 from the project

- Using personalised wording in the text message and ability to text back increased completion of the testing.
- 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.
- 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.
- Clinicians have acknowledged usefulness of laminated poster re CKD in their rooms and highlighted my role in our January MDT clinical meeting.

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Contact Details