KQuIP/UKRR Regional Day
East Midlands

13.00 – 13.45 - LUNCH

‘THINK KIDNEYS’

KQuIP

KQuIP/UKRR Regional Day
East Midlands

13:45 - 14:45

Quality Improvement – theory and practical application

A3 Thinking - Suzanne Horobin, East Midlands Clinical Network

'THINK KIDNEYS'

KQuIP

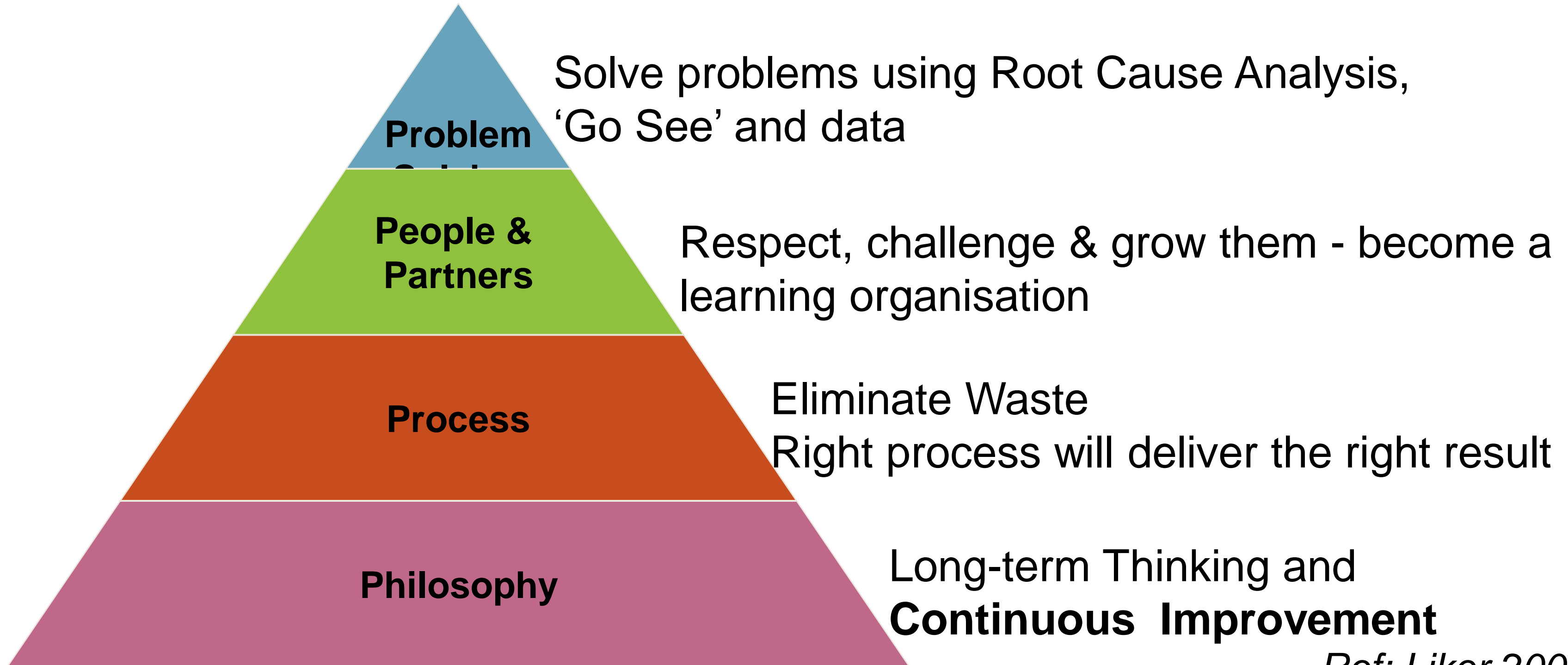
A3 Thinking

Suzanne Horobin

Lean/Toyota Production System

- A management system (philosophy)
- Focus on creating value for customers
- Continuous improvement using PDCA cycle
- Engaging and developing staff
- Eliminating waste

What is Lean?



Ref: Liker 2004

Lean/Toyota Production System

Leaders practice and coach PDCA

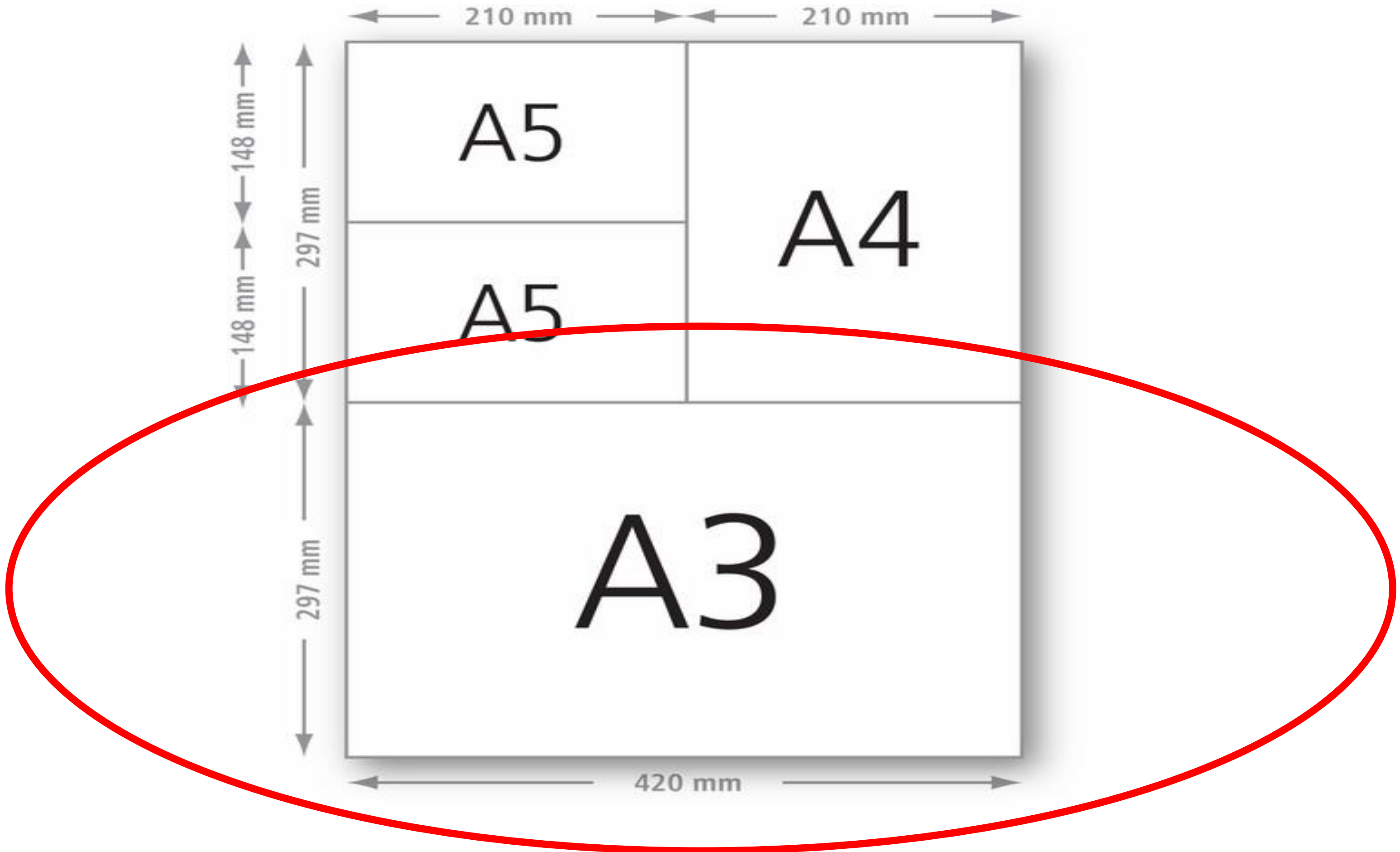
GO SEE

ASK WHY

RESPECT PEOPLE

What is A3 Thinking?

IN A 3127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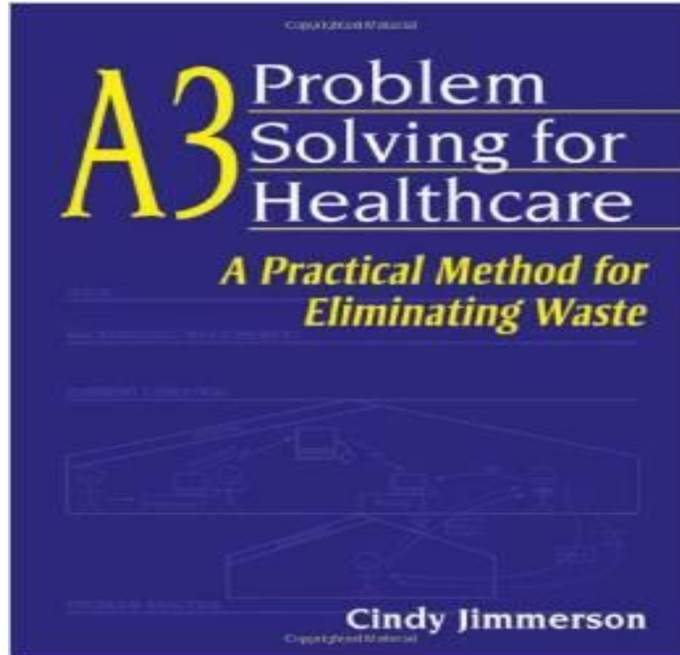
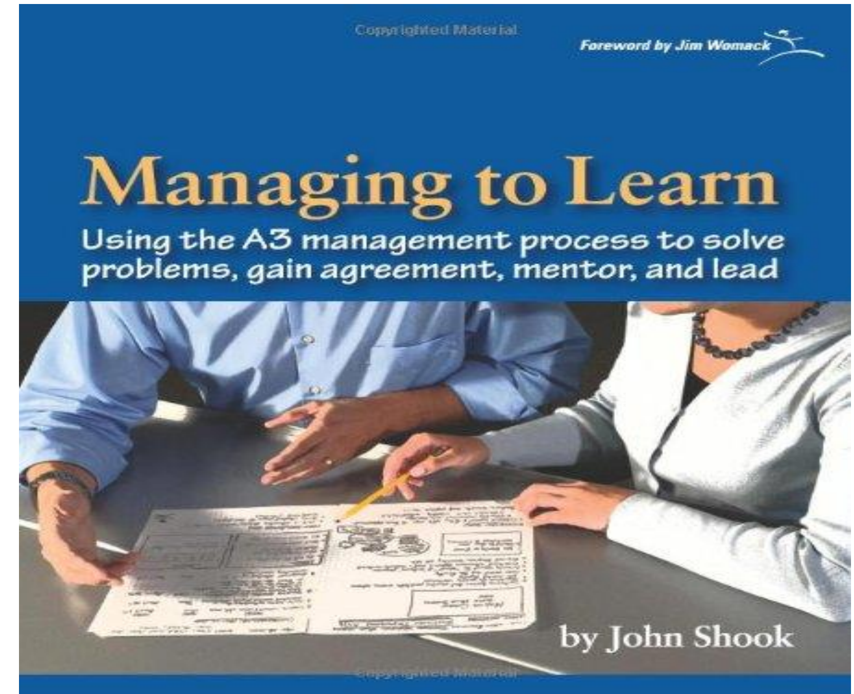
A3 Thinking





A3 Thinking

"It is much more than a tool, although it is commonly included in the "Lean Toolbox". As the method and document are understood and practiced, a new way to look at work and to ***think*** evolves, not just on the job, but in the activities of our daily lives"

Cindy Jimmerson – A3 problem solving for healthcare

A3 Thinking

“The widespread adoption of the A3 process standardises a methodology for innovating, planning, problem solving and building foundational structures for sharing a broader and deeper form of thinking. This produces organisational learning that is deeply rooted in the work itself – operational learning”

John Shook – Managing to Learn

Thinking deeply???

Command and Control

- Report problems up
- Someone else (eventually) comes up with a “fix”
- Front line staff implement the “fix” knowing it will likely fail

Another way

- Those who know the process (and the problems) are best placed to identify and remove the root cause to prevent recurrence

Ref – A3 Thinking for Healthcare - Jimmerson

Thinking deeply???

Intuitive problem solving

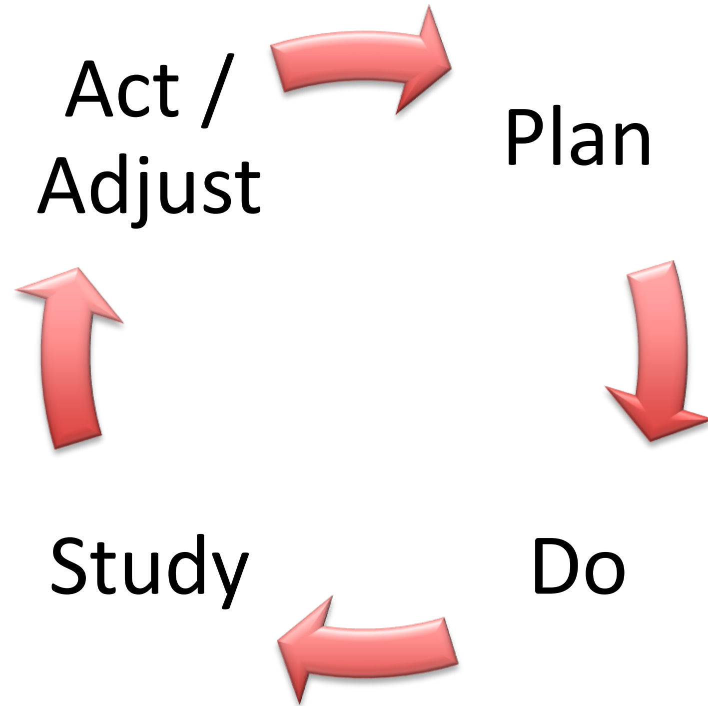
- "I know what the problem is"
- Quick fixes
- Work arounds

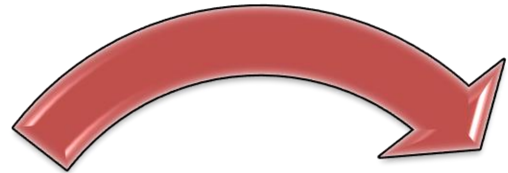
A3 thinking

- "What is the problem – REALLY"
- Understand true root cause
- Countermeasures
- Customer and staff focused

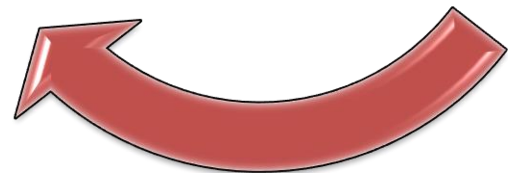
Ref – D Kahneman – Thinking, Fast and Slow

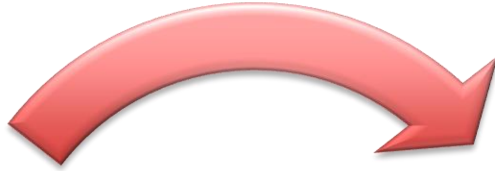
P D S A


Act /
Adjust
Plan
Do
Study



Do Plan





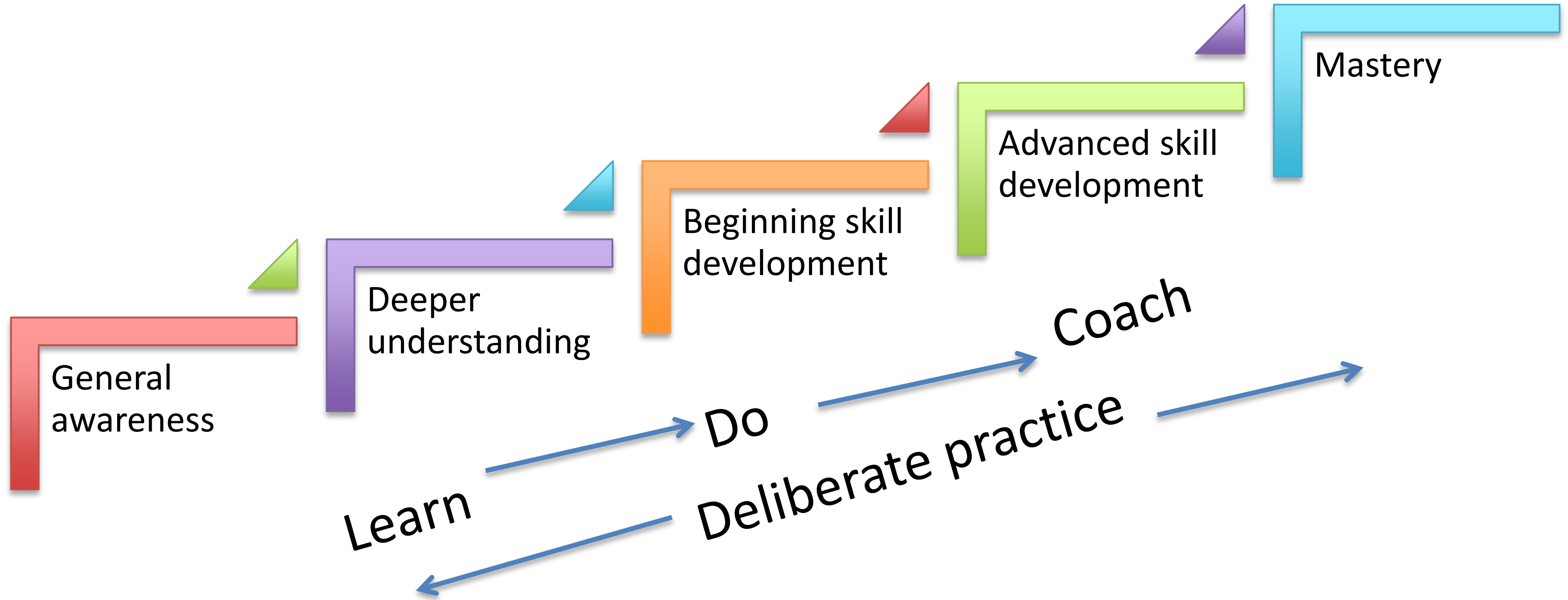
Do

Plan

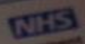
What does it actually mean?

	Phase	What is involved
Plan	Develop the hypothesis	1. Define and break down the problem
		2. Understand the current state
		3. Decide on your goal (future state)
		4. Root cause and gap analysis
		5. Identify potential countermeasures
Do	Conduct experiment	6. Develop and test countermeasures
		7. Refine and finalise countermeasures
		8. Implement countermeasures
Study	Evaluate results	9. Measure performance / outcomes
Act / Adjust	Refine Standardise Stablise	10. Refine and standardise – confirm the new process
		11. Monitor process performance / outcomes
		12. Reflect and share learning

Getting to “continuous”



“The Outstanding Organisation, Karen Martin



NHS Improvement

Author:
Version:

Date:
Agreed by:

Department
Team members:

A3 Lean Improvement

Define the problem/opportunity: (Why are you talking about it? What are you trying to solve/improve?)

PLAN

Current state: (What happens now? Be visual - value stream map, graphs, facts and measurements etc.)

PLAN

Goal: (State the specific target(s). State in measurable or identifiable terms)

PLAN

Waste identified: (Transport, Inventory, Motion, Automation, Waiting, Overproduction, Overprocessing, Defects, Skills)

PLAN

Root Cause Analysis: (What is the root cause of the problem? Use fishbone/cause and effect diagram, five why analysis)

PLAN

Future state: (What will it look like? Be visual - future state value stream map)

PLAN

Action plan

Action - what, why and how?	Who?	When?	Progress status
DO			

Results and measures: (What was your PDSA cycle? How long did you run it for? What data did you collect before and after the change? What did you find? Add charts, tables, and cost benefit analysis)

CHECK /ACT

Next steps: (Are there any remaining issues/problems? Is there any further follow up required?)

A3 Lean Improvement

NHS Improvement

Author:
Version:

Date:
Agreed by:

Department
Team members:

Define the problem/opportunity: (Why are you talking about it? What are you trying to solve/improve?)

What's the problem?

Current state: (What happens now? Be visual - value stream map, graphs, facts and measurements etc.)

How do you know?

Goal: (State the specific target(s). State in measurable or identifiable terms)

What do you want?

Waste identified: (Transport, Inventory, Motion, Automation, Waiting, Overproduction, Overprocessing, Defects, Skills)

Root Cause Analysis: (What is the root cause of the problem? Use fishbone/cause and effect diagram, five why analysis)

What is the root cause of the problem?

Future state: (What will it look like? Be visual - future state value stream map)

What will 'good' look like?
What are your countermeasures?

Action plan

Action - what, why and how?	Who?	When?	Progress status (ie completed, in progress)
Who is doing what and when?			

Results and measures: (What was your PDSA cycle? How long did you run it for? What data did you collect before and after the change? What did you find? Add charts, tables, and cost benefit analysis)

How do you know what difference you have made?

Next steps: (Are there any remaining issues/...)

Problem statement

- Not as easy as it sounds!
- The problem should exist in a process that exists to enable an organisation to achieve its purpose
- If it doesn't, it's a "pet project"
- "what we need to do is………" is not describing the problem – it is leaping to the solution!

Problem statement

- May have to be a vague statement until you know more
- "Go see" is a MUST DO – go to the place where the work happens and observe – avoid any temptation to change anything

  OH NO YOU DON'T – STEP AWAY AND JUST OBSERVE!!

Problem statements
…..or are they?!

X department outpatient clinic turnaround times are not meeting patients’ requirements

The rehabilitation team is breaching the waiting time standards in the Trust’s service contract

There is a need to develop a joint MDT for the two renal transplant centres

There isn’t a unified “not for cardio-pulmonary resuscitation” form in use in the region

The physiotherapy and occupational therapy teams need to align their practices

There is perception that access to the transplant list varies between the two regional centres

There is no …. service at [name] hospital

There is no …. service at [name] hospital

“In a recent survey, 60% of patients attending the renal clinic reported their dissatisfaction with having to travel to X to access the Y service”

The “Did Not Attend” rate for the …. service is currently at X% which equates to Y clinic slots.

Patients are currently waiting X weeks for….

The …. team is causing delays for patient referrals

Current state

- What did your Go See tell you?
  - Photos
  - Verbatim comments – from patients and staff
  - Sketches / process maps
- What does the data show?
  - Is there any data?
  - What do you need to know?
- Who are the stakeholders?
- Why is this problem important?

Current state

- How many patients effected?
- What is the potential impact of the problem?
- Current costs (including the cost of poor quality)
- Current risks?
- Defects / re-work?
- Demand and capacity
- Who does the work now?
- What is the standard work now?

NHS

NHS Improvement

A3 Lean Improvement

Department

Team members:

Date:

Agreed by:

Author:

Version:

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Waste identified: (Transport, Inventory, Motion, Automation, Waiting, Overproduction, Overprocessing, Defects, Skills)

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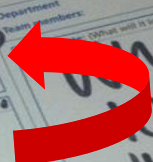

(What will it look like? Be visual - future state value stream map)

What will 'good' look like?

What are your countermeasures?

Action plan

Action - what, why and how? | Who? | When? | Progress status (ie completed, in progress)

Who is doing what and when?

Results and measures: (What was your PDSA cycle? How long did you run it for? What data did you collect before and after the change? What did you find? Add charts, tables, and cost benefit analysis)

How do you know what difference you have made?

Next steps: (Are there any remaining issues ...)

NHS
NHS Improvement

A3 Lean Improvement

Department
Team members:
Date:
Agreed by:
Author:
Version:

Define the problem/opportunity:
What's the problem?

Current state:
How do you know?

Goal:
What do you want?

Waste identified:

Root Cause Analysis:
What is the root cause of the problem?

Future state:
What will 'good' look like?
What are your countermeasures?

Action:

Who?	When?	Progress status

Who is doing what and when?

Results and measures:
How do you know what difference you have made?

Next steps:

Why?

Why?

Why?

Why?

Why?

Weedol
ROOTKILL PLUS
WEEDKILLER
Kills weeds plus roots
12 TUBES
OF LIQUID CONCENTRATE
Treats up to 360 m²
Visible results in 24 hours
Degrades in soil to allow replanting
No measuring
USE PESTICIDES SAFELY / READ THE LABEL

NHS

NHS Improvement

A3 Lean Improvement

Department

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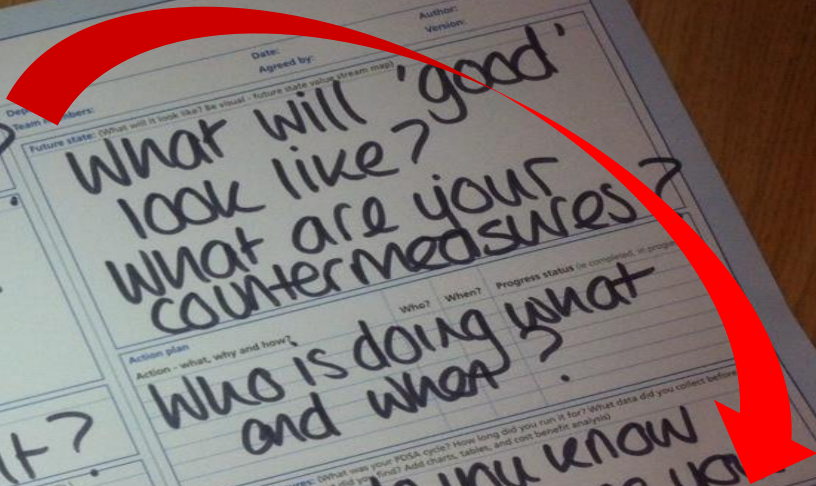


A3 Lean Improvement
NHS
NHS Improvement
What's the problem?
How do you know?
What do you want?
What is the root cause of the problem?
What will 'good' look like?
What are your countermeasures?
Who is doing what and when?
How do you know what difference you have made?

And most importantly of all……

Improvement doesn’t happen without **leadership** and leadership needs tools to create a culture of Continuous Quality Improvement

KQuIP/UKRR Regional Day
East Midlands

14:45- 15:00

Overview of KQuIP National Priority Projects

MAGIC – Vascular Access – Katie Fielding

Transplantation – Transplant First – Kerry Tomlinson

Home Therapies – Richard Fluck

'THINK KIDNEYS'

KQuIP

Managing Access by Generating Improvements in Cannulation

Katie Fielding,
Co-Chair, BRS VA

katie.fielding@nhs.net

Professional Development Advisor – Haemodialysis, Derby Teaching Hospitals NHS Foundation Trust
MDT Fellow, UK Renal Registry
Chair, Measurement and Understanding Workstream, KQuIP

THINK KIDNEYS KQuIP

BRS VASCULAR ACCESS Special Interest Group

MAGIC
Managing Access by Generating Improvements in Cannulation

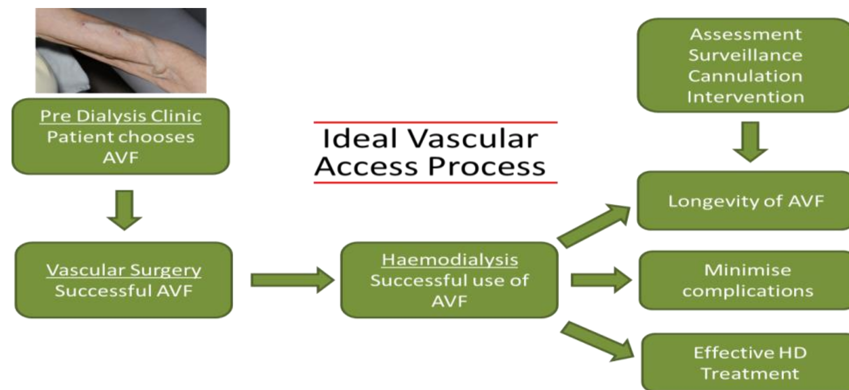
@Haemodialysis VA

BRS

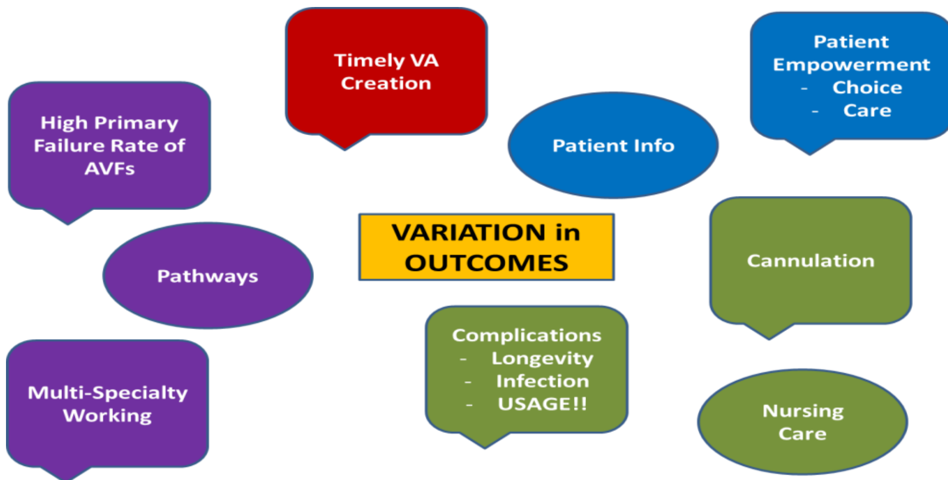
VASBI

AVF is gold standard for VA

- RA audit standards recommend 80% of prevalent dialysis patients dialyse via AVF, AVG or Tenckhoff
- Huge variation across the UK



There is more to AVF use than Vascular Surgery!!



Cannulation affects:

- Longevity of AVFs
- Patient experience of HD

- Cannulation is the centre of AVF rates
  - Prevention is better than cure
  - AVFs are formed to be used

- We can improve cannulation practice

MAGIC

- Managing Access to Generate Improvements in Cannulation
  - Quality Improvement project on cannulation practice
- Based on BRS / VASBI Cannulation recommendations
- Materials to support local implementation of the recommendations
- https://www.thinkkidneys.nhs.uk/kquip/magic/
- https://www.facebook.com/groups/191805030846120/
- https://twitter.com/HaemodialysisVA

katie.fielding@nhs.net

THINK KIDNEYS KQuIP

BRS VASCULAR ACCESS Special Interest Group

MAGIC Managing Access by Generating Improvements in Cannulation

@Haemodialysis VA

BRS

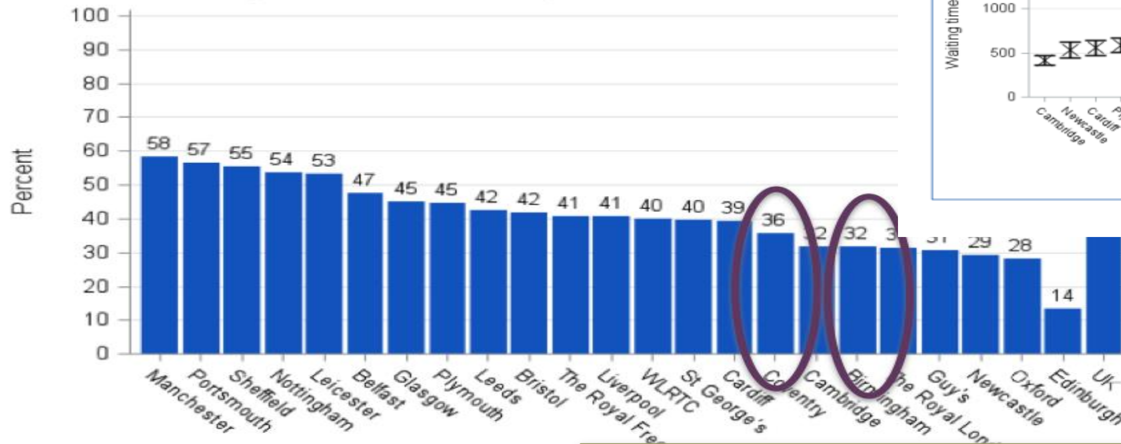
VASBI

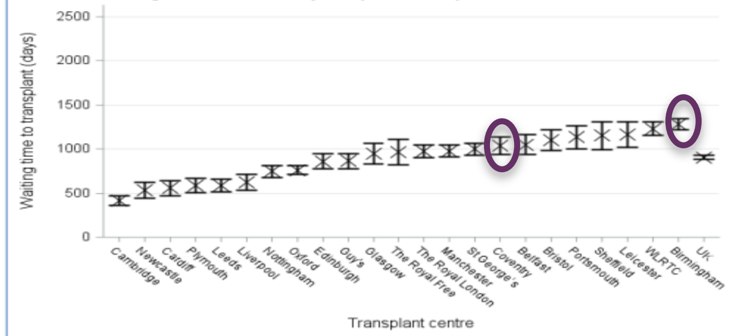
Transplant first: Addressing inequality of access to renal transplantation across the West Midlands

Kerry Tomlinson on behalf of sponsor group

East Midlands KQUIP/UKRR regional day

Why did we do it?





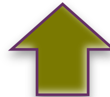
- UK RR 2014 report median time to listing
- 488, 598, 641, (683), 712, 765, 787, 867
- Y&H (147-1049)

+ Is it working?

UHB listings from all units

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

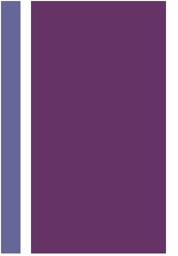
2013 2014 2015 2016



pre-emptive

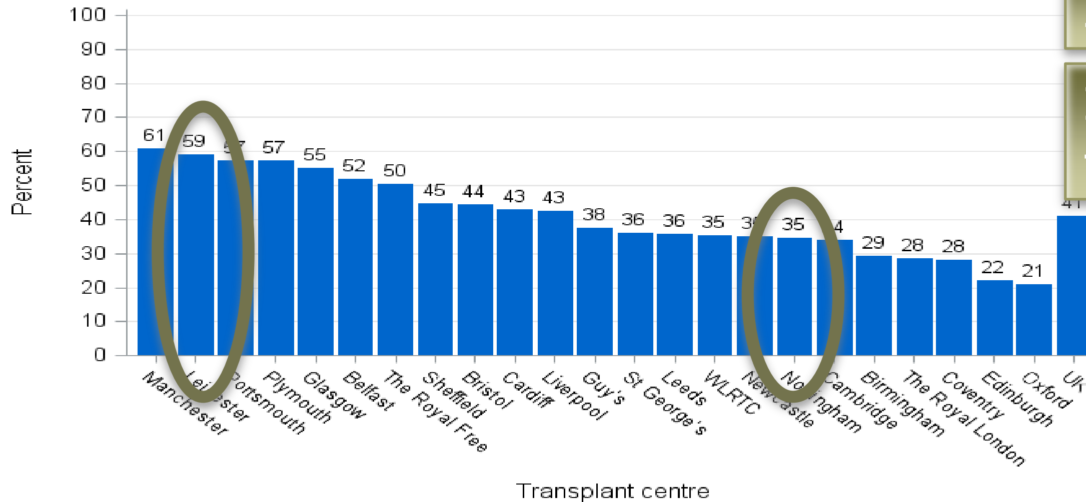
What it isn't

+ What it is



- Model for region wide QI
- Ready made data collection tool to understand why you don’t pre-emptively list more patients
- Some lessons learned that are likely to be transferrable
- Flexible around which part of pathway you want to concentrate on
- Potential support from KQUIP/UKRR

Why should you do it?



UHNM

Renal unit variability??

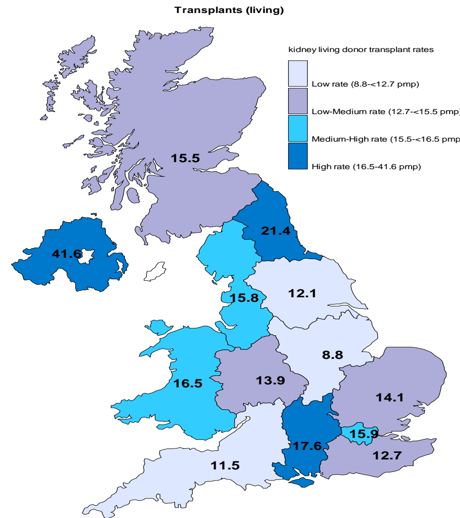
Patient characteristic variability (ATTOM)??

Source: Annual Report on Kidney Transplantation 2016/17, NHS Blood and Transplant

Living Donor rates

Figure 2.7 Living donor kidney transplant rates (pmp) by recipient country/Strategic Health Authority of residence

NHS Blood and Transplant



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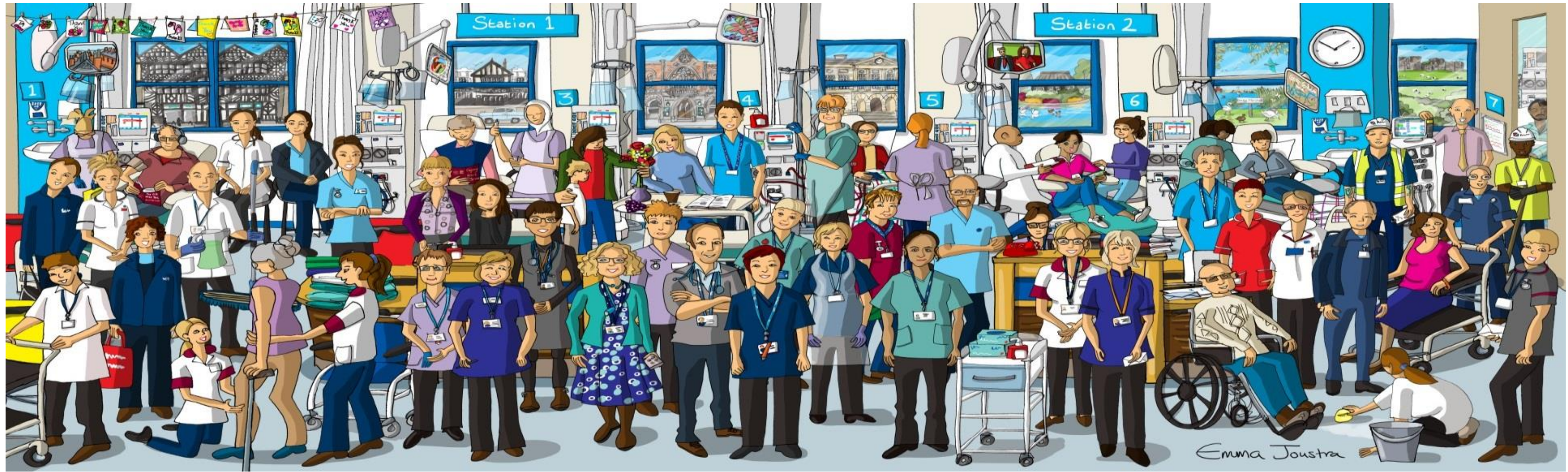
Transplant First



Home dialysis CQI

Elevator pitch

Why?

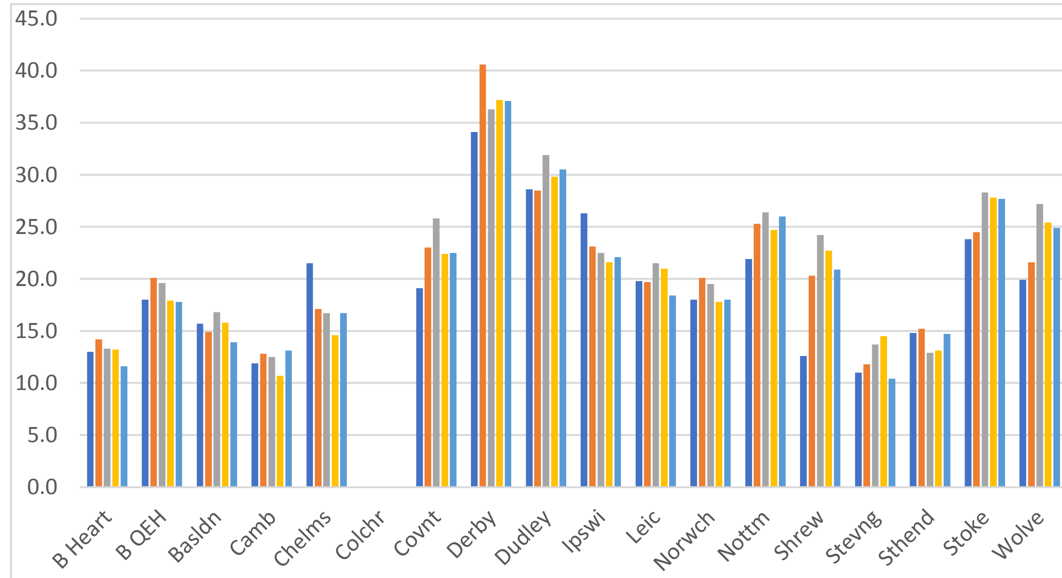


Figure 2 Midlands and East region % provision home therapy dialysis
(as a proportion of total centre dialysis population) for 2010, 2011, 2012, 2013, 2014)

Why?

- East Midlands home dialysis rates are above average ……
- ……… but it can still improve
- No change in last 4-5 years

- Patient groups identify the unmet need
- Individuals want to be involved
- Centres aspire to change but don’t know how

Why?

- This project is for
  - The entire team across the CKD pathway
  - The region
  - The commissioners
  - **The patients and their families**

DRIVER DIAGRAM: Home Dialysis

Aim: To increase the proportion of patients on home dialysis therapies in England

- **Clear Vision & Purpose**
  - Leadership
    - i) Organisational ii) Medical iii) Nursing iv) Patient Leadership
  - Organisational Culture
    - Values, behaviours & mindset
  - Expertise [Knowledge& skills]
- **Patients**
  - Determining 'suitable' home dialysis patients
    - Develop patient exclusion criteria, dependent on local expertise
  - Home dialysis training
    - Effectiveness & experience of training pathway
  - Patient awareness, recruitment & retention
    - Patient Education & Informed Choice; Patient & carer experience; Peer support; Carer support
- **Organisational Infrastructure**
  - Financial support
  - Training facilities
Commissioning dialysis consumables and machines
Home modifications
Access to respite care
  - Multidisciplinary team supported by community team

Why?

- It is challenging to change but …..
- ……. It is rewarding and fun.
- This region does much well but shares little – working together will accelerate progress to improve care.

KQuIP/UKRR Regional Day
East Midlands

15:00 - 16:00

Breakout Sessions

MAGIC – Vascular Access – Katie Fielding

Transplantation – Transplant First – Kerry Tomlinson

Home Therapies – Richard Fluck

THINK KIDNEYS

KQuIP

KQuIP/UKRR Regional Day
East Midlands

15:00- 16:00 - Breakout Sessions

You choose – consider the following questions :-

1. What does the data and national project mean for?

- Our unit
- Our region

2. Why the East Midlands region should take on one of the KQuIP projects as a region?

'THINK KIDNEYS'

KQuIP

KQuIP/UKRR Regional Day
East Midlands

16:00- 16:30

Feedback from Breakout sessions

Ron Cullen, CEO, UK Renal Registry

MAGIC – Vascular Access Break Out Group Feedback

Transplantation – Transplant First Break Out Group Feedback

Home Therapies Break Out Group Feedback

'THINK KIDNEYS'

KQuIP

KQuIP/UKRR Regional Day
East Midlands

16:00- 16:30

1. What does the data and national project mean for?

- Our unit
- Our region

2. Why the East Midlands region should take on one of the KQuIP projects as a region?

3. Which KQuIP priority project area will be adopted by the East Midlands?

'THINK KIDNEYS'

KQuIP

KQuIP/UKRR Regional Day
East Midlands

16.30 - 16:45

Closing Statement and Next Steps

Simon Roe, Clinical Director for Cardiovascular Disease, East Midlands CN

‘THINK KIDNEYS’

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