KQuIP/UKRR Regional Day
East Midlands

13.00 – 13.45 - LUNCH
KQuIP/UKRR Regional Day
East Midlands
13:45 - 14:45
Quality Improvement – theory and practical application
A3 Thinking - Suzanne Horobin, East Midlands Clinical Network
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?

**Philosophy**
- Long-term Thinking and Continuous Improvement

**Process**
- Eliminate Waste
- Right process will deliver the right result

**People & Partners**
- Respect, challenge & grow them - become a learning organisation

**Problem Solving**
- Solve problems using Root Cause Analysis, ‘Go See’ and data

Ref: Liker 2004
Lean/Toyota Production System

Leaders practice and coach PDCA

GO SEE
ASK WHY
RESPECT PEOPLE
What is A3 Thinking?
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
Plan

Do

Study

Act / Adjust

Plan

Do

Study

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

General awareness → Deeper understanding → Beginning skill development → Advanced skill development → Mastery

Learn → Do → Deliberate practice → Coach

“The Outstanding Organisation, Karen Martin
<table>
<thead>
<tr>
<th>Define the problem/opportunity</th>
<th>Current state</th>
<th>Goal</th>
<th>Waste identified</th>
<th>Root Case Analysis</th>
<th>Action plan</th>
<th>Results and measures</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why are you talking about it?</td>
<td>What happens now?</td>
<td>What are specific targets?</td>
<td>What are measures or identifiable waste?</td>
<td>What is the root cause of the problem?</td>
<td>Action - what, why and how?</td>
<td>What was your result?</td>
<td>Next steps</td>
</tr>
</tbody>
</table>

**A3 Lean Improvement**

**PLAN**

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**DO**

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<th>CHECK</th>
<th>ACT</th>
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A3 Lean Improvement

What's the problem?
How do you know?

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

What do you want?

Who is doing what and when?

What is the root cause of the problem?
How do you know what difference you have made?
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?
<table>
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<th>Question</th>
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<td>What do you want?</td>
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<td>Who is doing what and why?</td>
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A3 Lean Improvement

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<th>Who is doing what and where?</th>
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<td>How do you know?</td>
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<td></td>
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<tr>
<td>What do you wait?</td>
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What is the root cause of the problem? How do you know what difference you have made?
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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
Managing Access by Generating Improvements in Cannulation

Katie Fielding,
Co-Chair, BRS VA

Professional Development Advisor – Haemodialysis, Derby Teaching Hospitals NHS Foundation Trust
MDT Fellow, UK Renal Registry
Chair, Measurement and Understanding Workstream, KQuIP
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/1918050308446120/
• https://twitter.com/HaemodialysisVA
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

Pre-emptive
What it isn’t

HOW TO SUCK EGGS

EGG

GRANNY

SHAKE AN EGG
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?

Figure 3.11: Adult pre-emptive listing rates by centre, registrations between 1 April 2015 and 31 March 2016

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

Source: Annual Report on Kidney Transplantation 2016/17, NHS Blood and Transplant
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
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]
- Determining 'suitable' home dialysis patients
  - Develop patient exclusion criteria, dependent on local expertise

**Patients**
- 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
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?
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
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?
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