KQuIP

Transplant First training day one
KQuIP Thames Valley Region
Monday 9th March 2020

KQuIP is supporting renal units in the Thames Valley to improve the quality of care people with renal disease. We aim to:

- Build leadership and QI capability for the future
- Build effective teams
- Work collaboratively, sharing and learning from each other's experiences
- Establish patient/family co-partnerships to work alongside health professionals
- Develop learning communities, growing from the collective successes and failures
- Adopt Quality Improvement methodology to deliver our desired outcomes

Around 20 health care professionals attended a session which aimed at learning from local data around transplantation, refining the aim of the project, and agreeing next steps.
The day was an opportunity to learn about the way each other work
QI Leads for the units are:
Reading—Emma Vaux and Patricia Nare
Oxford—Ed Sharples, Clare Snelgrove and Nick Hayward-Priest

Introduction

The afternoon started with a presentation from Thames Water, who want to share their priority services project for kidney patients. Leaflets describing this were distributed, and further information can be found in the slides, found here.
Emma Vaux welcomed the delegates to the session. She led a discussion around what has happened since the last meeting—delegates felt that the project has led to improved communications and more emails, and getting Oxford access to the CB5 system after 3 years of delay
At the previous event some change ideas had been identified, such as having transplant seminars for potential living donors, and better information for patients and donors. Both the Reading and Oxford units have been collecting data on their transplantation rates, and have created process maps showing the steps from referral to activation.

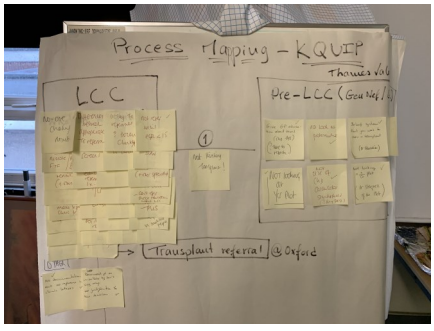
Reading Data

Emma presented the data which she has entered into Transplant First measurement tool: https://transplantfirst.renalreg.org/
The tool uncovered lots of people caught up in waiting area – due to decision making and investigations, for example a stress echo is an 18 months wait. Many patients are not being pre-emptively listed, reasons for this include:

- Beliefs
- Education focus on dialysis
- Patient information
- Non-standardised approaches
- Lack of documentation

Further information can be found in Emma's slides here.
Patricia Nare presented the process map for the low clearance clinic, and found that some of the problems identified were:

- Beliefs—the patient needs to earn a transplant
- Late referral to LCC
- GP education
- Patient unfit but no justification given
- Geography – difficult to make clinic for all
- Nobody chasing results for cardiology or other



Further information can be found in Patricia's slides here.

Oxford Data

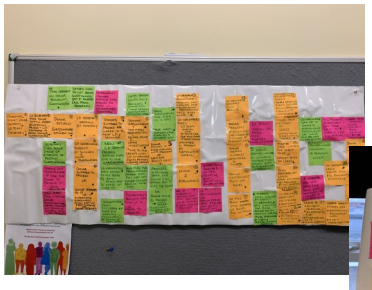
Ed showed the data collected from Oxford. The QI team at Oxford have been using the LifeQI tool: https://uk.lifeqisystem.com/projects/128146/general/
The discussion was around the median waiting times for transplantation, which were found to be higher than desired.
The team has been focussing on improving the Recipient Assessment Pathway, with future plans to have:

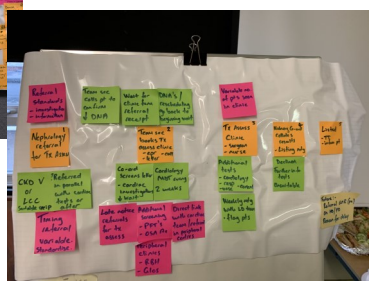
- Standardised referral timing, information and criteria
- Peripheral clinics

and Streamlining the Living Donation Pathway, so far findings are:

- Doctors/Nurses/HCA's have attended LD seminars on a weekly basis to improve understanding of the LD process
- Donor feedback has been excellent
- More efficient time management for coordinators- saving 9 hours total time spent in initial assessment clinic per week (per team)
- More convenient for donors who come forward at different time periods, due to work or location etc. (not all donors have to attend at the same time).

Links to Ed, Clare's presentation is here, and Nicki's slides with more detailed information can be found here.





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Process Mapping

Process mapping is a way of creating a visual picture of how the pathway currently works, capturing the reality of the process, exposing areas of duplication, waste, unhelpful variation and unnecessary steps.

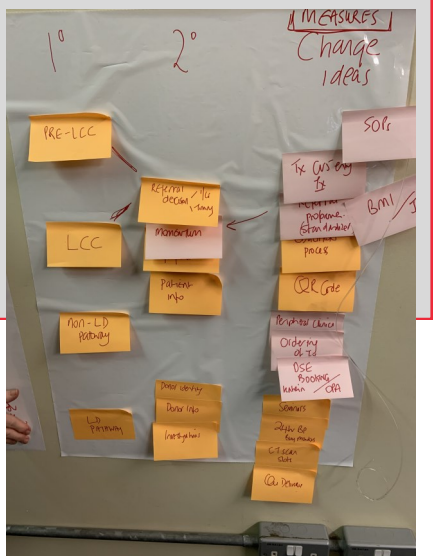
Patricia, Clare and Nicki have mapped out the processes and these were discussed. Below are some of the issues identified, together with some change ideas:

Issues identified:

- Labels not being consistent – meaning different things
- Anaesthetists asking for more investigations
- Oxford transplant referral form – old and not always used
- Nothing happens outside of clinic
- No sense of momentum
- "Wait list unfit" not always clear why in the notes
- Lots of people caught up in waiting area – due to decision making and investigations
- Stress echo 18 months wait
- Failing transplants falling through the net
- More locums and staffing issues – lack of standardised process, leading to drift/missing patients
- Clashing OPA with dialysis sessions lead to DNAs
- Transfers in from other units & not worked up
- Medical complexity increasing
- Waiting times/process delays for Reading patients
- Not looking to the plot
- Not looking to proteinuria
- Not using CKD calculator
- Beliefs – a patient need to earn a transplant
- Late referral to LCC
- GP education – give/refresh
- No Standardized practice
- Delay transplant referrals – no standard process/different opinions
- Late referral (eGFR<15/person unsuitable)
- Listed as unfit (BMI++) and no review or revisited
- Revisit transplant list decisions
- Patient unfit but no justification is given to the decision
- Need audits for transplant status
- Ask/inform patients about LRD
- Geography – difficult to make clinic for all
- Unit time to look to audits
- Why does it need to be seen first in LCC and only then have education
- Education process very long

Change ideas:

- Use reciprocal creatinine plot
- Transplant audits
- Standardise referral process
- Clarify investigation process prior to referral
- Reinvigorate RRT education
- Patient information
- Documentation
- Nephrologists/Surgeons/Anaesthetists – standardised test
- Referral and requests for investigations in parallel
- DNA patients – work with GPs? Use CB5 to run reports
- GP education
- Look at time from referral to activation
- Redesign the proforma
- CXR – go straight to Oxford?
- Referral – use NHS email?
- Nicki to run a seminar at RBH
- LKD questionnaire – Reading could give this to potential donors?
- Improve general information for LKD
- Nurse living donor seminars at referring centres
- EPAT (Electronic psychosocial assessment tool) to go live
- Work on a living donor website
- ? Home BP readings for donors rather than 24 hour BP
- Encourage kidney recipient/potential donors to attend LD seminars for educational purposes.
- Standardised referral timing, information and criteria
- Peripheral clinics



Aim, Driver Diagram and PDSA cycles

Emma led discussions on refining the aim for the project, developing a driver diagram and PDSA cycles. The group decided that the aim should be around the median waiting time, and agreed on:

"In 2 years, all those suitable for pre-emptive transplant are listed pre-emptively"

Delegates have been given templates to work on their driver diagrams and PDSA cycles, which will be shared at the next meeting.

Next Steps:

Teams at Oxford and Reading will develop their driver diagrams and plan their first PDSA cycles, based on the change ideas identified.
Julie will set up a conference call to discuss progress, visit units when able, and monitor and support progress.

Contact Julie at KQuIP for more information:
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